Group Mediclaim Policy

Chennai Ombudsman Centre
Case No. 11.5.1048 / 2005 - 06
Shri N. D. Prabhu
Vs
The Oriental Insurance Co. Ltd.

Award Dated 17.6.2005

The complainant' father, Shri Devivasigamani was insured under Group Mediclaim Policy from 03.11.2003 onwards. Shri Devivasigamani was hospitalised in Shri Ramakrishna Hospital, Coimbatore from 04.3.2004 to 12.3.2004 for Cholecystitis / Cirrhosis of Liver. The insured's claim for reimbursement of medical expenses was repudiated by the insurer on the ground that the patient had taken treatment for the above diseases from 14.1.2004 and since the claim was lodged just 4 months from the date of commencement of the policy, in all possibities, the patient must have had the diseases at the time of commencement of insurance and hence the same were pre-existing.

From the documents submitted before the Forum, it was observed that the insurer repudiated the claim the basis of their panel doctor's opinion that it was only 4 months since the date of insurance and in **all possibilities,** the patient must have had Cirrhosis and Cholecystitis during the time of taking insurance. It was obvious that the panel doctor's opinion was based on **mere possibilities** of the pre-existence of ailment and was not based on any **concrete proof** of the pre-existing of Cholecystitis and Cirrhosis of Liver in the insured. Probabilities and Possibilities, however strong, cannot eclipse the necessity for concrete evidence to prove pre-existence. On the contrary, there was a recording of the findings under procedure in the discharge summary, which mentioned Cirrhotic Liver, thereby indicating that Cirrhosis of Liver was detected only when the surgery for Cholecystitis was performed. The attending doctor, Dr. S. Radhakrishnan, had also clearly stated that all the investigations done prior to surgery did not reveal any evidence of Cirrhosis prior to surgery. There was a USG Report dated 14.1.2004 which also did not show any abnormality of the liver. Such being the case, and in the absence of any concrete evidence let in by the insurer, it was held that the stand of the insurer that Cirrhosis of liver was pre-existing to the commencement of the policy was not maintainable. As regards the pre-existing of Cholecystitis, the earliest record made available was the USG Report of 14.1.2004 which gave the impression of Multiple Gall Bladder Calculi. As per the certificate of Shri Ramakrishna Hospital, the first consultation, along with the Scan Report 14.1.2004, was on 19.2.2004 only when the isured was advised to have the operation at the earliest. Therefore, the insurer's stand that Cholecystitis was pre-existing to the commecement of the policy was devoid of any concrete evidence. Hence, the insurer's decision to repudiate the claim on more possibilities of the ailments being pre-existing, without any concrete evidence to prove the same, was not acceptable and hence the repudiation of the claim was not sustainable. The complaint was allowed and the insurer was directed to entertain the claim and pay the admissible medical expenses to the insured.

Chennai Ombudsman Centre

Case No. 11.5.1046 / 2005 - 06
Shri S. Ganesh
Vs
The Oriental Insurance Co. Ltd.

Award Dated 18.7.2005

The complainant, Shri S. Ganesh was insured under Group Mediclaim Policy No. 411700 / 961 / 2003 / MC with The Oriental Insurance Company Ltd. Divisional Office - VII, Chennai The policy was issued to M/s Tagros Chemicals India Ltd., Chennai, the employers of Shri S. Ganesh. Shri S. Ganesh was hospitalised in Kottakkal Arya Vaidyasalai, Pallavaram from 10.12.2003 to 12.1.2004 for Lumber Spondylosis for which he was given 'Panch Karma treatment'.

Shri S. Ganesh preferred a claim with the insurer for reimbursement of medical expenses. The insurer repudiated the claim on the ground that the treatment centre was different from what had been mentioned in the discharge summary and claim form and also the hospital did not fulfil the conditions stated in the policy.

From the records produced before the Forum, It was noted that Shri Ganesh was diagnosed for lumbar disc prolapse and was administered "Panchakama treatment" by the authorised dealer of Kottakkal Arya Vaidya Sala at Pallavaram. From December 2003 to January 2004. The insurer had repudiated the claim on the ground that the treatment centre did not conform to the policy norms. As per policy conditions, for liability to devolve under a mediclaim policy, the hospital where treatment was administered should either be a registered one or the hospital should have a minimum of 15 beds. In the present case, the treatment centre at Pallavaram had only 4 beds. The attending doctor had stated that Kottakal Arya Vaidya Sala situated at Kottakal was a registered hospital. This however did not entail that the Authorised dealer centre, which administers medicines, would also meet with the norm of registration as specified in the policy. The Kottakal Arya Vaidya Sala at Pallavaram was only an Authorised Dealer and the same had been confirmed by way of the list of authorised dealers provided by Kottakal Arya Vaidya Sala itself. It therefore emerged that the centre of Kottakal Arya Vaidya Sala at Pallavaram was only an authorised dealer and did not conform to the specification of "hospital" in the Mediclaim Policy.

However it was also brought to the notice of this Forum that Shri Ganesh had earlier in the year 2001, been afflicted by the same illness for which he had availed similar treatment in the same centre at Pallavaram and the claim was settled by the same Insurer. The Oriental Insurance Company Ltd. This acceptance of liability by the same Insurer under similar circumstances has led the Insured to believe that the treatment taken at Kottakal Arya Vaidya Sala Centre at Pallavaram would be reimbursable under the policy and hence he had repeated the treatment at the same centre. The Insurer, by honouring the earlier claim and not spefically informing the Insured about the non-admissibility of the claim, had given the message to the Insured that the treatment taken at the above centre meets with the conditions of the policy. Had the insurer appropriately informed the insured, he would have sought treatment elsewhere. However, the fact remains that the concerned doctor at Pallavaram, running a four bed treatment centre, not approved by Kottakkal Arya Vaidyasalai, Kottakkal, could not be termed as a hospital and did not confirm to the norms of the policy. However, since the insurer had settled an earlier claim for treatment taken at the same centre, the insured was not to be blamed fully for repeating the treatment at this centre. Hence, in order to meet the ends of justice, an ex-gratia payment of 50 % of the admissible claim amount was granted and the compliant was partly allowed.

Chennai Ombudsman Centre
Case No. 11.2.1069 / 2005 - 06
Shri V. Suresh
Vs
The New India Assurance Co. Ltd.

Award Dated 29.7.2005

The Complainant, Shri V. Suresh, an employee of LIC of India was covered under the LIC Group Mediclaim Policy issued by The New India Assurance Co. Ltd., Divisional Office 120700, Mumbai and the policy was serviced by the Insurer's Divisional Office 720200, Coinbatore.

The complainant's child, who was born on 18.5.04, was admitted in to the Neonatal Intensive Care Unit on 18.5.04 itself since she was a pre-term baby and needed Pre-term care. Shri Suresh availed insurance for an additional Sum Insured of Rs. 40,000/- for this baby on 18.5.04 itself. The wife of Shri Suresh was covered under the Group Mediclaim Policy of her Employer, viz., The LIC Housing Finance Ltd. Since the total medical expenses for the hospitalisation exceeded Rs. 50,000/- and the claim payable under maternity expenses was restricted to Rs. 50,000/-, Shri Suresh claimed for an additional amount of Rs. 13,792/- under the additional sum insured for which he had insured his baby. This claim for Rs. 13,792/- was repudiated by the Insured on the ground that as per policy condition no. 5 of maternity expenses benefit extension, the expenses in respect of a new born child while in the hospital during confinement period, were covered only under the mother's Sum Insured, and in the said case, since the mother was not covered under the same mediclaim policy, the claim was not admissible.

The Insured represented for reconsideration of the claim on the ground that LIC employees have been permitted to have independent medical cover for new born babies for 0-3 months with effect from 01.04.04 onwards and since he had availed of this cover, by payment of additional premium on 18.5.04, the entire medical expenses incurred on the child in the hospital were reimbursable under the policy. He further contended that the maximum limit of Rs. 50,000/- under maternity expenses extension was not relevant in his case since he had taken separate coverage for the infant for the first 3 months.

From the documents submitted before the Forum, it emerged that the treatment for the Pre-Term condition of the new born baby commenced at 1.45 AM on 18.5.04 whereas the premium for additioal sum insured for the baby had been remitted only at 3.18 PM on 18.5.04. The policy, provides for coverage for a new born child 0-3 months on payment of additional premium and in the said case, Shri Suresh had availed of the cover by paying premium at 15.18 hrs on 18.5.04. As per condition no. 5.18 of the policy, the new born child is covered for an additional sum insured once the child is declared for insurance by the Employee and premium in respect of the new born child is received by LIC.....

In the present case, the treatment for the ilness had commenced as early as 1.45 AM on 18.5.04 which was prior to the remitting of premium and commencement of the cover under the additional sum insured. It was therefore indisputable that the particular event giving rise to the said claim had commenced prior to inception of cover. As per the basic tenets of insurance, if a contingency, which was envisaged and covered under an insurance policy, had commenced / occurred prior to the inception of the policy with the awareness of the Insured, liability will not fall upon the Insurer in the said contract, since insurance primarily covers an unforeseen event. Since in the present case, the liability under the policy attached only from 3.18 PM on 18.5.2004, it

was held that the insurer could not be held liable for the particular contingency i.e. pre-term treatment for the new born baby, for which the claim was made. The complaint was dismissed.

Chennai Ombudsman Centre
Case No. 11.2.1410 / 2005 - 06
Shri N. Paneerselvam
Vs
The New India Assurance Co. Ltd.

Award Dated 29.7.2005

The Complainant, Mr. N. Panneerselvam & his wife, Smt. P. Vijayalakshmi were coverd under LIC Group Mediclaim policy issued by The New India Assurance Co. Ltd., DO 120700, Mumbai and serviced by their Divisional Office, Madurai for the policy period April 2004 to 2005.

Smt. P. Vijayakshmi was hospitalised at Apollo Hospitals from 05.4.04 to 14.4.04 with the diagnosis of Adenmyosis, for which she underwent Hysterectomy. Her claim for reimbursement of the medical expeses was repudiated by the Insurer, on the grounds that from the discharge summary issued by Apollo Hospitals, it was observed that the claimant was treated for Adenomyosis between the period 23.3.04 and 25.3.04 and therefore as per policy condition no. 3, the claim was to be paid by the previous Insurer who had issued the Policy for the period upto 31.3.04. The Insured then represented to the Paramount Health Services, TPAs of the previous insurer, The Oriental Insurance Co. Ltd., along with the claim documents. However, as there was no response to his repeated requests for settlement of his claim, he approached this forum. During the course of hearing, The Ombusman issued directions to The Oriental Insurance Co., to inform this forum regarding the status of the claim. However, Oriental Insurance Co. Ltd. did not respond.

It was observed from the records submitted before the Forum that Smt. P. Vijayalakshmi was admitted on 5.4.04 and the diagnosis was 'Adenomyosis, Induration right breast'. The clinical history of the insured stated that she was evaluated during her previous admission and diagnosed as Adenomyosis Uterus admitted for vaginal hysterectomy".

The Insurer stated that since the discharge summary indicated that Mrs. P. Vijayalakshmi had been treated for Adenomyosis between the period 23.3.04 to 25.3.04 the present claim was a continuation of the disease treated in March 2004 and hence the previous Insurer, namely The Oriental Insurance Co. is liable for this claim.

However, it was noted that the treatment for adenomyosis viz, Hysterectomy, was done on Mrs. Vijayalakshmi in the month of April 2004 and the expenses for the treatment were also incurred in the month of April 2004. At this point of time, she was covered by the group mediclaim policy issued by New India Assurance Co. Ltd. Though the discharge summary stated that Mrs. Vijayalakshmi was diagnosed as a case of adenomyosis Uterus during her previous admission (which would have been in the month of March 2004) the treatment for the disease of Adenomyosis was administered only in the month of April 2004. No proof of treatment for Adenomyosis taken prior to 1.4.2004 was produced before this Forum. For Condition 3 of the policy to be applicable, there should have been some treatment administered earlier, i.e. in March 2004, for the diagnosed ailment. However, in the present case, the insured was only diagnosed for the ailment without there being any treatment in March 2004. Hence, keeping in view this and the preamble of the policy, it was held that the ground of rejection of the claim did not hold good and the liability for the claim fell on New India

Assurance Co. Ltd. Therefore, the servicing office of the Insurer, namely New India Assurance Co. Ltd. DO 72300, Madurai was directed to pay the admissible expenses pertaining to the hospitalisation and the treatment for Adenomyosis. The Oriental Insurance Company Limited was directed to return all the claims documents to New India Assurance Company Ltd., Divisional Office 72300, Madurai, within 7 days for settlement of the claim. The complaint against the New India Assurance Co. Ltd., was allowed.

Chennai Ombudsman Centre
Case No. 11.2.1047 / 2005 - 06
Shri M. Aravindakshan
Vs
The New India Assurance Co. Ltd.

Award Dated 29.7.2005

The complainant, Shri M. Aravindakshan, a retired LIC employee was covered under LIC group Mediclaim Policy. Shri Aravindakshan was hospitalised in Rama Krishna Hospital, Coimbatore from 24.8.2004 to 25.8.2004 with complaint of giddiness and again from 4.10.2004 to 05.10.2004 in Kongunadu Hospitals, Coimbatore for the same complaint. His claim for reimbursement of medical expenses was repudiated by the insurer on the ground that their panel doctor had opined that the insured had taken treatment for complaints of Diabetes / IHD / Vertigo which did not require hospitalisation and could have been treated on an outpatient basis. Shri Aravindakshan contended that, at the time of admission his condition required hospitalisation and the attending doctors also had certified this.

From the medical records submitted in the case, it emerged that at the time of the first hospitalisation, i.e. from 24.8.04 to 25.8.04, the insured had been suffering from complaints of giddiness since one week. The insured contended that his giddiness was so severe that he was unable to walk and hence the doctor advised him to get hospitalised. The attending doctor had also certified that the patient was not able ot stand and walk even with support and since they suspected a brain stem stroke, he was admitted for further investigation and management. The situation described by the attending doctor, indicated a condition of emergency, wherein the insured needed immediate medical attention and monitoring by an infrastructure of a hospital. Though the subsequent investigations ruled out brain stem stroke and established labrynth vertigo but it was convincing enough that the condition of the insured at the time of admission was such that it necessitated hospitalisation. Therefore, an opinion of the panel doctor in retrospect did not justify the view that hospitalisation was not necessary. Under the circumstances, it was held that the insurer was liable to reimburse the medical expenses pertaining to the first episode of hospitalisation, i.e. from 24.8.04 to 25.8.04 in Shri Rama Krishna Hospital, Coimbatore.

Regarding Second episode of hospitalisation from 4.10.04 to 5.10.04 in Kongunad Hospital, it was observed that the presenting complaints stated that the insured was having complaints of “giddiness, **mild unsteadiness on and off** since 1 to 1 ½ months” The investigation done was only MRI of the brain and the treatment given was medication. The notings in the medical records of this hospitalisation did not indicate any emergency condition regarding the health of the insured which warranted hospitalisation. Further, the attending doctor, unlike in the first episode of hospitalisation, had not certified the necessity of this hospitalisation. Hence, this Forum concurred with the insurer that the same could have been taken on outpatient basis.

In the facts and circumstances of the case, it was held that the insurer was liable to reimburse admissible medical expenses for the first episode of hospitalisation in Shri Ramachandra Hospital, Coimbatore. The second episode of hospitalisation in Kongunad Hospital did not become eligible for reimbursement. The complaint was partly allowed.

Chennai Ombudsman Centre
Case No. 11.5.1411 / 2004 - 05
Shri A. R. Mohanram
Vs
The Oriental Insurance Co. Ltd.

Award Dated 12.8.2005

The complainant, Shri A. R. Mohan Ram, a retired employee of Life Insurance Corporation of India, and his wife, Smt. A. M. Saikumari, were insured under Group Mediclaim Scheme since inception of the Scheme in 1988. Shri Mohan Ram, preferred two claims for the treatment provided to his wife, Smt. Saikumari, during the period 2002 - 2003 for the ailment of "ATAXIA". The insured's claims were rejected by the servicing office of the insurer on the ground that Smt. Saikumari was suffering from "Ataxia" since 1985 and as she was covered under the mediclaim scheme from "Ataxia" since 1985 and as she was covered under the mediclaim scheme from 1988 onwards, the disease was "pre-existing". The Complainant appealed to the insurer for reconsideration of the claim on the ground that his wife was suffering from the ailment only from 1991 onwards and by mistake, he had stated that his wife was suffering from the ailment since 1985 onwards. Hence, the ailment was not pre-existing and he was entitled to the claim.

It was observed from the documents submitted before the Forum that the complainant's wife, Smt. A.M. Saikumari was afflicted with the ailment' "Ataxia" and needed life long treatment. The complainant had been preferring claims for the said ailment of his wife with the insurers since 1992 onwards and as per the complainant, the claims were settled by United India Insurance Company, the previous administrator of the scheme as well as the present insurers also. However the claim pertaining to the period 2002 - 03, under dispute before this Forum, was rejected on the grounds of pre-existence of the disease. Without going into the dispute regarding pre-existence of the ailment, it was noted that the LIC Mediclaim Scheme provides that the employees covered at the time of inception of the Scheme, i.e. 1988, will not be subject to the exclusion of pre-existing diseases. The relevant provision in the Scheme, as circulated by the insurer, The Oriental Insurance Company Ltd., Divisional Office XI, Mumbai, stated that "... Congenital diseases / ailment are included. However, the policy is subject to the pre-existing clause for new members which will be certified by LIC Offices while forwarding papers". There was also a Circular, issued by United India Insurance Company, the previous insurer, which stated that "... Regarding pre-existing exclusion, please note that pre-existing diseases of LIC employees and family members, who are covered under Group Mediclaim Policies since inception of the policy, are covered. However, employees / family members enrolled later on, pre-existing diseases are excluded ...".

In the present case, Shri Mohan Ram a retired employee of LIC, and his wife were covered under the Scheme since inception of the Scheme, i.e. from 1988 onwards. Hence, in the light of the pre-existing diseases exclusion clause not being applicable for employees and their family members, i.e. pre-existence of the disease, was found not tenable and therefore, the insurer was directed to entertain the claim and reimburse the admissible medical expenses to the insured. The complaint was allowed.

Chennai Ombudsman Centre
Case No. 11.2.1102 / 2005 - 06
Shri V. Suresh Kumar
Vs
The New India Assurance Co. Ltd.

Award Dated 18.8.2005

The Complainant, Shri V. Suresh Kumar, an employee of LIC of India, was covered under the LIC Group Mediclaim Policy. The complainant's wife, Smt. S. Manjula, who was also covered under the policy, delivered a baby by LSCS on 21.4.2004 at 3.29 P.M. in Apollo Hospitals, Madurai. The new born baby was admitted in NICU and given phototherapy as the mother, Smt. Manjula was a case of MVP and Mitral Regurgitation and the baby had mild icterus. The mother and child were discharged on 1.5.2004. The complainant declared the child separately for insurance on 23.4.2004 for an additional sum insured of Rs. 40,000/- and the premium was paid on 28.4.2004. The complainant submitted a claim for Rs. 85,980/-, in respect of expenses incurred for both mother and child for reimbursement, to the insurer. The insurer settled the claim for Rs. 50,000/-, which was their maximum liability under maternity benefit extention section of the policy on the ground that as per policy condition no. 5, the expenses in respect of new born child while in hospital during confinement, period are covered only under the mother's sum insured.

The complainant represented to the insurer's Regional Office at Coimbatore for reconsideration of the medical expenses on the ground LIC employees have been permitted to have independent medical cover for new born babies for 0-3 months with effect from 01.04.04 onwards and since he had availed of this cover, by payment of additional premium on 21.4.2004, the entire medical expenses incurred on the child in the hospital are reimbursable under the policy. He further contended that the maximum limit of Rs. 50,000/- under maternity expenses extension was not relevant in his case since he had taken separate cover for his new born baby.

The documents submitted before the Forum were perused. It emerged that the treatment for the new born baby stated on 21.4.2004 whereas, as per the confirmation received from the employers, LIC of India, the baby was declared for insurance on 23.4.04 and the premium for additional sum insured for the baby was remitted only on 28.4.2004 and intimated to the insurer on 29.4.04. The policy, no doubt, provides for coverage for a new born child 0-3 months on payment of additional premium and in the said case, Shri Suresh Kumar has availed of the cover by paying premium on 28.4.04. As per condition no. 5.18 of the policy, ***"the new born child is covered for an additional sum insured once the child is declared for insurance by the Employee and premium in respect of the new born child is received by LIC ...."*** In the case on hand, the treatment for the illness had commenced as early as 21.4.04 which was prior to the remitting of premium and commencement of the cover under the additional sum insured for the new born baby. It was, therefore indisputable that the particular event giving rise to the said claim had commenced prior to inception of cover. As per the basic tenets of insurance, if a contingency, which is envisaged and covered under an insurance policy, has commenced / occurred prior to the inception of the policy with the awareness of the Insured, liability will not fall upon the Insurer in the said contract, since insurance primarily covers an unforeseen event. Keeping this in mind, the insurer's stand that, on delivery, the child is covered only with mother's sum insured under maternity benefit extension section of the policy and both mother and the new born baby cannot be treated separately, is reasonable and cannot be faulted. Hence, it was held that the insurer's liability was limited to Rs. 50,000/- which was the sum

insured under the maternity benefit extension cover of the policy and since the insurer had already paid this amount, the complainant was not entitled to any further relief. The complaint was dismissed.

Chennai Ombudsman Centre
Case No. 11.5.1049 / 2005 - 06
Shri R. Govindarajan
Vs
The Oriental Insurance Co. Ltd.

Award Dated 22.8.2005

The Complainant Shri R. Govindarajan was covered under the LIC Group Mediclaim Policy. He was hospitalised at Apollo Hospital from 27.10. 2003 to 29.10.2003 with the complaints of "pricking sensation over left Axillary region". His claim for reimbursement of medical expenses was repudiated by the Insurer on the ground that the hospitalisation was for evaluation which is not covered under the policy as per condition No. 4.10. Shri Govindarajan represented to the Insurer for reconsideration of his claim on the grounds that all the tests done were on the advice of the reputed Consultant cardiologist, Dr. P. Ramachandran of Apollo Hospitals. He further contended that treatment has been given in the hospital after evaluation and he was advised further medication for the symptoms noted after admission, and had the evaluation indicated no treatment, the doctor would not have prescribed medicines.

It was observed from the notings in the discharge summary that Shri Govindarajan had complaints of breathlessness, chest pain, choking and pricking sensation in the left axilliary region which were significant enough for the attending doctor to suggest evaluation tests in the hospital. It was not that the insured was admitted in the hospital for a general health evaluation or did not have any health complaints at that point of time. Complaints such as breathlessness and choking sensation in any person could cause considerable anxiety and obviously, the attending doctor, in his wisdom, had advised for medical evaluation in order to assess the cause of the complaints. It was also noted that the complaints of pricking sensation, choking sensation, syncope etc. were not isolated incidents but have been afflicting the insured for 1 ½ months to 2 months and hence were serious enough for the attending doctor to take cognizance for further detailed evaluation. The insured has symptomatically improved during his stay in the hospital and on discharge, he was prescribed a regime of medication related to cardiac problems as well as for the other complaints. The entire process of the insured having presented with health complaints, diagnostic tests being conducted and the appropriate medication / treatment being prescribed, had taken place in the present case and hence the insurer's contention that the hospitalisation was only for evaluation was found not tenable and the insurer was directed to reimburse the admissible medical expenses to the complainant. The complaint was allowed.

Delhi Ombudsman Centre
Case No. GI / 512 / OIC / 04
Shri Nandlal Arora
Vs
Oriental Insurance Co. Ltd.

Award Dated 20.4.2005

FACTS OF THE CASE

The complainant is a retired employee of LIC. The claim made by him is in respect of the hospitalization of his wife, Smt. Swarn Kumari, for treatment of a fracture in her leg

caused by a fall in the house. Smt. Swarn Kumari was admitted in R. K. Nursing Home, Bareilly (where the complainant resides) on 13.02.2004 and was discharged next day (14.02.2004). The claim has been made under a Group Mediclaim Policy taken by LIC for the welfare of its employees.

The complainant stated that his wife was admitted in the hospital on the advice of the treating doctor.

Observations of Hon'ble Insurance Ombudsman :

After hearing the complainant and after careful consideration of the facts of the case, Hon'ble Insurance Ombudsman is of the view that the Insurance Company is clearly liable to pay the claim of the complainant. It is regrettable that they have not even bothered to send a reply to the complainant about the status of his claim.

In the result, Hon'ble Insurance Ombudsman passed the Award that the Oriental Insurance Company Limited shall pay to Shri Nandlal Arora the admissible claim amount (the amount claimed by Shri Nandlal Arora is Rs. 2696 plus another Rs. 10,000 as compensation for mental agony etc.), after due scrutiny of bills, in respect of the hospitalization of his wife, Swarn Kumari, in R. K. Nursing Home Bareilly from 13.02.2004 to 14.02.2004 for treatment of a fracture in the leg. The Insurance Company shall also pay interest at the rate of 8 % per annum on account of delay in the settlement of the claim.

As a rule, this Forum does not award any compensation for mental agony etc. No such compensation is warranted in this case.

The Award shall be implemented immediately.

Hyderabad Ombudsman Centre
Case No. IO (HYD) / G.11.002.0372
Smt. Lalita Narayanan
Vs
The New India Assurance Co. Ltd.

Award Dated 15.4.2005

The complainant's husband was covered under Group Mediclaim Policy issued by the respondent to Canara Bank Card Holders for the policy period 01.11.2003 to 31.10.2004. The policy excluded the disease of liver cirrhosis.

The complainant's husband fell down on 11.02.2004 and sustained a fracture to his left hand. He developed breathing problems on 18.02.2004 and was hospitalised. He expired on 28.02.2004 She preferred a claim of Rs. 3,76,798/- on the respondent which was rejected by them citing exclusion 4.1 wherein pre-existing diseases are not covered. However, the T.P.A. was willing to consider the claim for expenses incurred towards treatment of fracture.

The complainant contended that the death summary indicated that her husband had acute respiratory distress syndrome, multiple organ dysfunction syndrome, disseminated intra vascular coagulation, humerus (L) fracture, and chronic liver disease. The insurers could not consider expenses towards treatment of fracture as bifurcation of the expenses was not there and moreover the treatment was taken on outpatient basis.

A specialist's opinion was called for by the Ombudsman. The doctor in her opinion stated that the cause of death does not have any nexus with the pre-existing disease of liver cirhossis. Since this opinion was based on actual facts, the respondents are directed to settle and pay the claim.

Hyderabad Ombudsman Centre
Case No. IO (HYD) / G.11.002.007
Ms. H. R. Jayasimha
Vs
The New India Assurance Co. Ltd.

Award Dated 30.5.2005

The complainant, a retired employee of LIC of India was a member of the Group Mediclaim policy issued by the above insurer.

He underwent laser treatment for both eyes at Narayana Netralaya on 29.12.2004 and submitted a claim bill for Rs. 2,150/- towards reimbursement of hospitalization expenses. The insurers rejected the claim, vide their letter dated 8.2.2005, on the grounds that the insured - member submitted case summary as against discharge summary and that the treatment taken by the complainant was not as in - patient as envisaged in the preamble of the mediclaim policy issued to him.

It was held that the case summary submitted by the insured clearly states that he was in hospital from 1.30 p.m. to 3.00 p.m. on 29.12.2004. The data regarding admission time and discharge time can be culled out from the summary. Insistence of a separate discharge summary just to satisfy the claim settlement formalities is absurd.

Hyderabad Ombudsman Centre
Case No. IO (HYD) / G.11.002.028
Shri T. S. Venugopal
Vs
The New India Assurance Co. Ltd.

Award Dated 1.6.2005

The complainant was covered under the group mediclaim policy under Can Comfort Scheme specially devised for Canara Bank Credit Holders. The first policy was taken for the year 1993 - 94 with M/s. National Insurance Co. Ltd., The policy was later shifted to New India Assurance Co. Ltd. with effect from 1.1.1996 and was continuously renewed in chain without a break.

The complainant underwent angiogram and subsequently a coronary artery by - pass graft surgery in March, 1997 and the insurance company reimbursed an amount of Rs. 50,000/- to the complainant towards hospitalisation expenses.

In 2004, he complained of chest pain and underwent Angiograme / Angioplasty. He preferred claim for Rs. 1,74,416/- with the insurers towards reimbursement of hospitalisation expenses.

M/s Medi Assist, the Third Party Administrators (TPA) of the insurer, vide their letter dated 20.9.2004, approved the claim for Rs. 28,539/- as against his original claim bill of Rs. 1,74,416/-. The claim was settled in accordance with Can Comfort Policy Exclusion No. 415. This clause states “the policy being continuously in force and if increased benefits (higher benefit plan) are availed through the policy in force, the increased benefits are not applicable for those illness, diseases contracted / suffered during the previous policy period. The claim for the said illness / disease / disability if admitted shall be processed as per previous year’s policy limits only”.

It was held that the complainant was covered undr the scheme since 1996 and the policy issued to him without this clause 4.15. This condition was made known to him only in the year 2003. Charges in the scheme into which clause 4.15 was inducted was not informed to the policy holder. Hence, complainants claim for reimbursement should

be considered as per the terms and conditions of the policy without invoking clause 4.15.

Hyderabad Ombudsman Centre
Case No. IO (HYD) / G.11.002.012
Shri Batti Shankar Goud
Vs
The New India Assurance Co. Ltd.

Award Dated 13.6.2005

Complainant, an LIC employee, was covered under the group mediclaim policy with the respondent company for the period 1.4.2004 to 31.3.2005.

He was diagnosed to have enteric fever and was hospitalised on 1.4.2004 and discharged on 3.4.2004. He preferred a claim for Rs. 3,664/- The insurer processed the claim for Rs. 2,165/- and rejected an amount of Rs. 1,499/- on account of excess medicines purchased by him.

The complainant contended that the bill of Rs. 3,664/- was paid by him towards medicines and hospitalisation expenses as prescribed by the doctor / hospital.

Held : Insurers have been liberals and calculated claim for 3 days as against the investigator's observations. Complainant has not furnished the case sheet despite insurer's request for the same. The respondent company has been more than reasonable in allowing the claim. The complainant cannot be adamant in his stand of not furnishing required documents. With the papers available in the file. I believe that the insurer was fair in his calculation The insurers are directed to process and pay the claim for Rs. 2,165/- as calculated. Complainant's request for consideration of full amount is not justified.

Hyderabad Ombudsman Centre
Case No. IO (HYD) / G.11.004.045
Smt. Darsi Kanaka Durga
Vs
M/s. United India Insurance Co. Ltd.

Award Dated 19.7.2005

Shri Darsi Himachala Rao an employee of United India Insurance Co. Ltd. was covered under Staff Ground Mediclaim Scheme since 1984. He also covered his parents since then and allowed requisite premium to be deducted from his salary. He had also put up claims on earlier occasions and these claims were honoured. In the current case, the insurer was intimated even before Smt. Kanaka Durga was admitted into the hospital. Immediately, after the treatment, the necessary claim papers were submitted in July, 2003. However, the claim is not settled but once he was offered a partial payment of Rs. 90,000/- on 23.11.2004 without assigning any reasons for reducing the claim amount from Rs. 1,62,000/-. Complainant refused to accept the same.

The insurer contends that as an employee of the insurance co. he is expected to be aware of rules & regulations of the organisation and moreover he had wrongly included his father and mother as dependants, though rules clearly do not allow the inclusion of parents if any of the parent is drawing a pension of more than Rs. 1,500/- per month.

Held : In my view, making payment of some earlier claims cannot be taken as excuse for making wrongful claim once again. During the hearing, the respresentative of the insurer was asked to give the reasons for making an offer of partial payment. The

employee should have appreciated that even if the organisation made a mistake in making earlier payments overlooking or unaware of the fact that one of the parents is earning more than Rs. 1,500/- per month, it can not be counted on repeating such mistake.

The claim appears to have been made on the basis of some precedent. Since the complainant in the current case is not eligible to be included under the scheme, insurer is justified in not making the claim payment.

Hyderabad Ombudsman Centre
Case No. IO (HYD) / G.11.005.025
Shri S. P. Shanbagh
Vs
M/s. The New India Assurance Co. Ltd.

Award Dated 30.8.2005

The complainant, a retired employee of LIC was covered under Group Mediclaim Policy. He was admitted to hospital for cervical disorder during the period 31.7.2004 to 21.8.2004 and he preferred a claim for Rs. 70,444/-. Insurer settled the claim for Rs. 60,783/- on the grounds that the surgeon's fees was higher by 30 % and therefore, the claim amount was reduced.

Held : Reducing Rs. 9,375/- from the surgeon's fees is not correct. Nowhere in the policy conditions which were provided to the policy holders, the insured was directed to go to a doctor who is charging low fees. The insurer also informed that they do not have any prescribed fees structure. In the absence of such direction one cannot expect the insured to search for the doctors who charge low fees. The complaint is admitted.

Hyderabad Ombudsman Centre
Case No. IO (HYD) / G.11.005.75 / 2005 - 06
Shri K. P. Rajesh
Vs
Oriental Insurance Co. Ltd.

Award Dated 23.8.2005

The complaint under Rule 12 (1)(b) read with Rule 13 of the RPG Rules, 1998 relates to non-settlement of a claim under the Group mediclaim policy of LIC employees with the respondent insurer. The policy had commenced from July 2003 and in relation to maternity benefits, as per clause 12.3 (2) of the policy, the respondent contended that delivery expenses within a period of 9 months from the date of commencement of the policy was not payable. However, the contention of the insurer was not found acceptable in as much as that the policy conditions allowed laxity in relation to medical emergency. In the case on hand the caesarian section was under a medical emrgency and the insurer had erroneously rejected the claim In these circumstances, the plea of the insurer was not acceptable to this Forum and hence the rejection was set aside. The respondent insurer was directed to settle the full claim of Rs. 11,176/- subject to proper verification of bills and compulsory deductibles, if any.