Group Mediclaim Policy

Ahmedabad Ombudsman Centre
Case No. 11.002.0249 / 2005 - 06
Shri Pratapbhai J. Joshi
Vs
The New India Assurance Co. Ltd.

Award Dated 19.1.2006

Repudiation of Group Mediclaim on the ground that the Patient was not dependant on the Employee : It was observed that the Patient (Son of the Policy holder) was aged 22 yrs on the date of the injury. As per the policy conditions, a financial dependant son can be covered upto his age of 25 yrs if pursuing full time higher studies in a recognized university. It was observed that the Patient had appeared for his graduation examination but had failed. Hence, he had to reappear the examination later. Since the Respondent could not prove that the patient was not a full time student or he was in some other pursuit to earn, he is not ineligible to be covered under Group Mediclaim. As such the Respondent was directed to pay the full claim amount.

Bhubaneshwar Ombudsman Centre
Case No. I.O.O./BBSR/11/-005-0026 / 2005 - 06
Shri Bijaya Prasad Patnaik
Vs
The New India Assurance Co. Ltd.

Award Dated 7.12.2005

Insured complaint, an employee of Oriental Insurance Company was covered under Staff Group Mediclaim Insurance Scheme Complainant was admitted to Narayan Jeevan Dan Hospital Pvt. Ltd., Berhampur on 16-12-2001 for respiratory infection and cardiac problem and discharged on 26.04.2002.

Complainant submitted a bill of Rs. 175,867.75 for reimbursement of expenses out of which room rent was Rs. 1,01,000/- Insurer obtained a certificate from Dr. S. Mohan Rao of Narayan Jeevan Dan Hospital that insured complainant was advised for under going cardiac Angiography and other tests elsewhere as these facilities were not available in the hospital.

On request complainant was admitted on humanitarian ground to provide constant supervision until he shifts to a cardiac centre. Insured was attending MKCG Medical and Hospital for his cardiac ailment as an out door patient and MKCG Medical College Hospital authorities advised for CAG on 26.12.2001 while complainant visited, but he paid no heed to it and prolonged his stay at Narayan Jeevan Dan Hospital. Insured settled the claim for an amount of Rs. 52,871/- on the ground that stay of the insured in a hospital having no facilities for vital tests like CAG and treatment of cardiac diseases for about five months was not for the purpose of treatment.

During the hearing complainant submitted that since he had no attendant to escort him to a hospital having CAG facilities and treatment for cardiac diseases, he had no other option than to prolong his stay in the hospital. Hon'ble Ombudsman upheld the partial repudiation of the insurer and passed a nil onward.

Bhubaneshwar Ombudsman Centre
Case No. I.O.O./BBSR/11/-002-00114 / 2005 - 06
Shri Chandramani Sethi
Vs
The New India Assurance Co. Ltd.

Award Dated 11.11.2005

Insured Complainant an employee of LIC of Indian covered under Staff Group Mediclaim policy with New India Assurance Co. Ltd. along with his spouse. Complainants wife was admitted to Capital Hospital, Bhubaneswar for child birth. Insured Complainant lodged a claim of Rs. 3808.15 towards medical expenses he has incurred for re imbursement. Insurer settled the claim for Rs 2308/ which the complainant did not accept and preferred this complainant.

During the Hearing insured was shown the bills of his expenses. Insurer stated that they have deducted the Pre Natal and post Natal expenses. On scrutiny it was observed that Insurer arbitrarily deducted these expenses, as the patient was admitted to hospital and expenses were incurred within the period specified in the policy under pre and post hospitalization period.

Hon'ble Ombudsman directed the insurer to pay Rs 3190 within 15 days of the from the date of receipt of consent letter.

Chandigarh Ombudsman Centre
Case No. GIC/91/NIA/11/06 2005 - 06
Shri Kulwant Singh
Vs
The New India Assurance Co. Ltd.

Award Dated 03.03.2006

FACTS : Shri Kulwant Singh is covered under Group Mediclaim policy taken by LIC from NIA for its employees. He met with an accident on 20.9.04 in Dalhousie, resulting in fractured leg. He got first aid from Gaurav Clinic, Dalhousie and was admitted in Dr. Ravi Pal's Clinic at Amritsar on 20.09.04 for 24 hours. He filed a claim for Rs.10564.92, with the Divisional Office, Amritsar which was rejected on 11.11.04 on the ground that he was treated in a hospital which had only four beds. He represented that as technology had advanced, longer term admission is not required. The fracture was set right and plaster was applied for few days week. He quoted relevant provision of policy stating that relaxation was admissible with regard to condition relating to minimum bed strength in case treatment does not require stay in hospital or nursing home in excess of 24 hours. He felt that condition of minimum beds was not applicable as he was admitted for 24 hours only.

FINDINGS : The complainant had stated in the complaint that guidelines provide for relaxation of condition regarding bed strength, the insurer cannot take this plea for repudiating the claim. In this connection he quoted the judgement of Punjab State Consumer Disputes redressal Commission in the case of LIC vs. Paramjit Kaur (1999) holding that while settling the claim guidelines are also required to be considered. He pointed out that internal guidelines of NIA provide for relaxing the condition regarding the number of beds, provided the period of hospitalization is not in excess of 24 hrs. He stated that he was entitled to benefit under these guidelines as he was admitted for 24 hours only. On behalf of the insurer it was pointed out that Hospital / Nursing home is defined in the policy as an institution which is registered as nursing home/ hospital with local authorities or should have at least 15 in-patient beds, fully equipped

operation theatre and qualified doctors. For class C towns, requirement of mandatory beds has been reduced to ten. He stated that in this case the hospital had only four beds and was not registered with the local authority. The point that insured has laboured hard in his representation was that claim should be processed as per the guidelines which stipulate that in case stay in hospital/nursing home is not in excess of 24 hrs and the hospital is not registered, the condition in respect of minimum number of beds will not apply. All other conditions are however applicable, if hospital is not registered. In the case of LIC vs Paramjit Kaur it has been held that internal guidelines are as much relevant for processing the claim as the policy conditions.

DECISION : Held that the stance taken by the insurer that the claim is not payable on the ground that mandatory condition of minimum number of 10 beds was not fulfilled is not tenable, as the insurer is silent on the implications of internal guidelines in this case. The complainant had brought this to the notice of the insurer in his representation dated 23.4.05. Therefore, held that the repudiation of claim was not justified and ordered that the claim be considered on merits by waiving the condition relating to minimum number of beds in accordance with internal guidelines, subject to fulfillment of other policy conditions.

Chennai Ombudsman Centre
Case No. IO (CHN) 11.2.1138 / 2005 - 06
Shri E. Krishna Murthy
Vs
The New India Assurance Co. Ltd.

Award Dated 03.10.2005

Shri E Krishna Murthy was covered under Group Mediclaim Policy of LIC taken with New India Assurance Co. Ltd., The Complainant was hospitalized from 14.04.2004 to 20.04.2004 for 'Post PTCA to RCA'. His claim was rejected by the insurer on the ground that the current hospitalization falls within 45 days of the previous confinement which took pace during the period of mediclaim policy issued by previous insurer M/s Oriental Ins. Co. Ltd., hence the present insurer M/s The New India Assurance Co. Ltd., was not liable for the claim. The complainant approached the previous insurer M/s The Oriental Ins. Co. Ltd., and they settled the balance amount standing to his credit under the previous year's policy. Since the total expenses were more than the sum insured under previous year policy, the complainant appealed for consideration of balance claim amount by the current insurer M/s New India Assurance Co. Ltd.

As per policy condition of M/s New India Assurance Co. Ltd., 'any one illness' shall apply and will be deemed to mean continuous period of illness and it includes relapse within 45 days from the date of last consultation with the hospital. It is also observed that M/s Oriental Insurance Co. Ltd., paid the initial claim, the relapse shall also fall under M/s Oriental Insurance Company's policy. The Oriental Insurance Co. Ltd., allowed the claim upto the sum insured. The Complainant is not entitled to the balance of the claim amount which exceeds the sum insured under the policy issued by M/s Oriental Insurance Co. Ltd., Hence the complaint was dismissed.

Chennai Ombudsman Centre
Case No. IO(CHN) / 11.02.1139 / 2005 - 06
Smt. A. Nithya Devi
Vs
The New India Assurance Co. Ltd.

Award Dated 24.10.2005

Smt. A. Nithya Devi, and her husband Shri. R. Subramaniam were covered under LIC Group Mediclaim Policy with M/s New India Assurance Co. Ltd., Mr. R. Subramaniam was hospitalized from 10.09.2004 to 11.09.2004 for 'BE Compound Myopic Astigmatism' for which he underwent 'BE ESIRIS custom Lasik' treatment. He claimed with insurer for reimbursement of medical expenses, but the same was rejected on the ground that any eye treatment or surgery taken for corrective, cosmetic or aesthetic purpose is not covered under the scope of the policy as per exclusion no. 4.7. She contended that if the refractive error was more than (–) 7 the claim is payable as per GIC guidelines. The refractive error of her husband was more than (–) 7, his condition was deteriorating as such the surgery became necessary. Hence, the surgery undergone did not fall under exclusion 4.7. During the hearing the insurer contended that the surgery was for alternative and mediclaim policy provided reimbursement of reasonable and necessary expenses. The insurer also raised a point that the surgery was conducted as Outpatient hence did not require hospitalization.

As per Discharge summary Shri Subramaniam was diagnosed to have compound myopic astigmatism of both eyes and as per summary he had myopic astigmatism to the level of (–) 8.5 in the right eye ad (–) 8.75 in the left eye for which he underwent 'BE ESIRIS Custom Lasik'. During the hearing the representative of the insurer accepted the surgery was not for cosmetic purpose. Hence exclusion 4.7 is not applicable to this case. As per GIC guidelines dt 15.9.1998 this claim is admissible under the policy. The attending doctor issued a certificate that the patient unable to tolerate bifocal spectacles hence advise to undergo ESIRIS Custom Lasik treatment and the surgery was not done for mere reason that the insured wanted to change the glasses from bifocal to near vision, but for correction of an disenabling disorder i.e. Myopic Astigmatism. The GIC circular 1998 which makes an allowance for relaxation in the limit of 24 hours hospitalization, hence technological advances necessitating only outpatient treatment which is also accepted under the ambit of the policy. Hence direction was given to the insurer to settle the claim

Chennai Ombudsman Centre
Case No. IO(CHN) / 11.02.1142 / 2005 - 06
Shri N. Venkaaraman
Vs
The New India Assurance Co. Ltd.

Award Dated 24.10.2005

Shri N. Venkataraman and his wife Smt. V. Lalitha were covered under Group mediclaim Policy for LIC. His wife underwent treatment for Left Eye on 08.03.2005 along with certain investigation. He preferred a claim with M/s New India Assurance Co. Ltd., but the same was repudiated by them on the ground that the investigation done did not warrant hospitalization and those tests could have been evaluated as an outpatient. More over, no discharge summary was available from the hospitals, routine examinations carried out, no specific treatment was given. The insurer also contended that as per condition no. 2.3 of the policy, expenses on hospitalization for a minimum period of 24 hours alone are admissible, in the instant claim there was no admission or the treatment warranted hospitalization for a minimum period of 24 hours.

From the records furnished it is observed that the treatment given to Smt Lalitha at Arvind Eye Hospital is not such that it required specialized infrastructural facilities which needed hospitalization, and therefore, the same could have been done as an outpatient. The major part of the claim for tests and investigations were done after her discharge from the hospital was done on an outpatient basis which again stands to

confirm that these tests were not of the magnitude that warranted hospitalization. The Mediclaim policy provides relaxation of minimum 24 hours of hospitalization when treatment necessitates hospitalization and requires specialized infrastructural facilities of the hospital but due to technological advances, hospitalization required is for less than 24 hours. The tests were not taken during hospitalization. The Preamble of the Mediclaim policy stipulates reimbursement of medical expenses for hospitalization necessarily incurred. From the documents submitted it was observed that the treatment / investigations availed / undergone by the complaint did not warrant hospitalization, hence the complaint was dismissed.

Chennai Ombudsman Centre
Case No. IO(CHN) / 11.02.1162 / 2005 - 06
Shri C. Karuppasamy
Vs
The New India Assurance Co. Ltd.

Award Dated 28.10.2005

Shri C. Karuppasamy and his wife Smt. K. T. Selvi were covered under LIC group mediclaim policy issued by M/s New India Assurance Co. Ltd., His wife was hospitalized from 23.03.2005 to 11.04.2005 for Periarthritis (L) (Frozen Shoulder) with Cervical Spondylosis. The complainant preferred a claim for Rs. 22,000/-. The Insurer allowed only Rs. 7790/- towards full and final settlement of the claim. He had not accepted the claim. He contended that he is eligible for entire claim amount as per terms and condition of the policy. Hence this complaint.

The Insurer contended that bills and supporting papers were not in order. As per the panel doctor's opinion they allowed 3 days hospitalization along with other charges since the hospital where the treatment was given did not give any rationale for admission for 19 days. The room occupied by the complainant was charged Rs. 200/- by the hospital, but the complainant claimed Rs.500/- (Ac Room). There are some discrepancies in the documents produced, hence they allowed Rs. 7790/-. This forum has to adjudicate following aspects.

1. As per the records, this forum observed it reasonable to allow hospitalization from 23.03.05 t 05.04.05.
2. It was established the complainant stayed in A/c room
3. As per the records no evidence available to establish discrepancies in the bills under hospitalization period.
4. No discrepancy in the date of procedure done and it is not correct for the insurer to argue that the patient was not admitted in the hospital upto 11.04.2005

Hence allowed room rent Rs.. 500/- per day and proportional nursing charges for 14 days. Also allowed entire cost of the medicine from 23.3.05 and all other charges like operation theatre charges etc.

Chennai Ombudsman Centre
Case No. IO(CHN) / 11.02.1183 / 2005 - 06
Shri S. Viswanathan
Vs
The New India Assurance Co. Ltd.

Award Dated 07.11.2005

The complainant, Shri S. Viswanathan, an employee of LIC of India, was covered under LIC Group Mediclaim Policy with the New India Assurance Co. Ltd. His claim for

reimbursement of hospitalization expenses was repudiated by the insurer on the ground that the complaints reported / diagnosed would not have necessitated hospitalizaiton. The insured represented that the hospitalization was necessary for normal routine check up and monitoring of his Blood Pressure and the necessity for hospitalization was certified by the attending doctor.

The insurer contended that as per discharge summary the diagnosis was 'Hypertension' and nothing except few tests were done. They also contended that the insured was administered with Tab Amlong and previously also insured had undergone the same check up by the same doctor as an outpatient and the line of treatment given does not warrant hospitalization.

The forum felt that the doctors certificate, which was obtained after one month from the date of hospitalization does not make any reference to shoulder pain or giddiness. The complainant has chosen to take a certificate from the attending doctor regarding the necessity of hospitalization for the purpose of representation only, after the claim had been rejected and that to for further reconsideration of claim. The discharge summary said nothing to substantiate that the Blood pressure was continuously monitored in the hospital and did not reveal the necessity of hospitalization. Further, the contention of the insured that the admission was necessitated in order to take cardiologist opinion does not stand justified since the insured did not present to the hospital with any cardiac related problems. Therefore, the ground on which insured was admitted in the hospital is not substantiated by any medical records produced before the Forum. Forum feels that submission of the said certificate does not warrant any consideration. In the light of the above, Forum felt that the case does not warrant any interference by this Forum, and the complaint fails.

Chennai Ombudsman Centre
Case No. IO(CHN) / 11.02.1209 / 2005 - 06
Shri K. Duraiswamy
Vs
The New India Assurance Co. Ltd.

Award Dated 18.11.2005

The complainant, Mr. Duraiswamy, an employee of LIC of India, was covered under Group Mediclaim Policy with The New India Assurance Company Ltd. The insured was admitted to KG Hospital Coimbatore for 'Fatty liver disease and mild mitral valve prolapse' and his claim for reimbursement was repudiated by the insurer on the ground that 'Treatment could have been taken as an outpatient and did not require hospitalization'. The insurer in their self contained note said that the admission has been done mainly for investigation / evaluation purposes and positive existence of disease, which warrants for hospitalization was not established. Hence, the claim was not payable as per exclusion clause 4.10 of the policy. Further, the hospitalization was less than 24 hours, and hence it did not meet with provision 2.3 of the mediclaim policy.

The document submitted before the forum was perused. As per discharge summary 'The insured was admitted with complaints of palpitation, joint pain and pain in the left iliac fossa since one week. Further due to recurrent respiratory allergy with cough present, irritation in the eye present, recurrent abdominal pain in the epigastric region present due to hyperacidity. No history of diabetes mellitus or systemic hypertension. Bowel and micturition habits are normal. The provisional analysis as per discharge summary is 'palpitation for evaluation.'

Shri B. Raja Gopal, investigator appointed by insurer confirmed that the patient knowingly got hospitalized for Master Health Check up and patient paid as advance immediately on admission. Normally, patient does not pay exact amount towards advance and from this it is evident that the patient had undergone Master Health check up only. Dr. Sakthivel, the orthopaedic surgeon's opinion that the physical condition of insured was not severe enough to warrant hospitalization. It is also noted that a major chunk of expenses of hospitalization were towards various investigation only. Further, the certificate from the attending doctor stated that the insured was evaluated completely and became better following analgesics and rest.

In the light of the above discussions, it becomes very clear that the condition of insured at the time of hospitalization did not indicate any severity or emergency and the admission was primarily for evaluation of palpitation which was in existence for 6 months prior to hospitalization. The investigations conducted and the medications prescribed in the form of analgesics and rest also did not warrant hospitalization. The insurer has further contended that the claim failed to meet the requirements of 24 hours hospitalization under the policy. It therefore impels the Forum to conclude that medical records contain discrepancy regarding the period of hospitalization.

As the necessity of hospitalization was not established sufficiently in the present case, coupled with misrepresent facts before the Forum, it was concluded that the insurer's decision does not warrant any interference and the complainant is not entitled to any relief.

Chennai Ombudsman Centre
Case No. IO(CHN) / 11.02.1175 / 2005 - 06
Shri M. Kanniappan
Vs
The New India Assurance Co. Ltd.

Award Dated 2.12.2005

Mr. Kanniappan, an employee of L.I.C. of India and his wife Smt. Vijayaklakshmi were insured under LIC Group Mediclaim policy with New India Assurance Company. Complainant's wife Smt. Vijayalakshmi was admitted in Raju Hospital from 1.7.05 to 4.7.05 with complaint of excruciating pain radiating from back to right lower limb. She was diagnosed to be suffering from "disk Prolapse/Cord compression/Lumbar Spondylosis/Cervic Spondylosis. The Insured's claim for reimbursement of medical expenses was repudiated by the Insurer on the ground that since the patient was not willing for surgery as recommended by the attending doctor, the hospitalization was merely for the purpose of evaluation.

AWARD : Insured contended that only because of the excessive pain and for an MRI investigation, his wife was advised to get admitted in Raju hospital. after MRI scan, attending doctor advised for surgery but at the same time, he also stated that physiotherapy can also be done if she was not willing to undergo surgery. She got discharged from the hospital since they were in a position to incur the hospitalization expenses. Moreover, since the hospital was far away from the their place of stay, she decided to undergo physiotherapy with another doctor nearby their place, where she also underwent pelvic traction. He also informed that his wife felt better with physiotherapy. Insurers, during hearing contended that Insured got admitted in the hospital only for the purpose of evaluation and also did not continue the line of treatment advised by the doctor and also no treatment was given during hospitalization, except that she continued with medicines after discharge. They also contended that major portion of the claim was towards MRI Scan, Room charges and

other routine tests only. In view of the contentions of both the parties, ombudsman directed the complainant to submit the records of physiotherapy to the Insurer within 3 days. Insurer was directed to obtain a specialist's medical opinion on the severity of the ailments and its requirement for hospitalization. The documents submitted by both the parties before the forum during and pursuant to the hearing were perused and it was felt that Insurer has repudiated the claim under exclusion 4.10 which reads as, that the diagnosis / investigations done in the hospital should be followed by treatment required to be taken in the hospital. Though she refused to undergo the spinal decompression surgery as suggested during hospitalization, the fact remained that it was followed by the advised course of physiotherapy, though not at the same place which was confirmed by the physiotherapy consultant. Therefore it was felt that Insurer's contention that there was no treatment availed in the hospital and therefore, the admission was for evaluation only is not tenable and hence Insurer was directed to pay the admissible medical expenses to the complainant.

Chennai Ombudsman Centre
Case No. IO(CHN) / 11.11.2005 / 2005 - 06
Shri R. Balakrishnan
Vs
The New India Assurance Co. Ltd.

Award Dated 5.12.2005

Shri R. Balakrishnan insured under LIC Group Mediclaim policy was hospitalized for facetal arthritis. Claim for reimbursement of medical expenses incurred was repudiated on the grounds that medical records submitted show that only an MRI scan did not warrant any hospitalization, since there was no specific treatment given apart from physiotherapy, medication and rest for 4–5 days.

AWARD : Ombudsman noted that necessity of hospitalization depending upon the condition of the patient at that time was a matter to be decided by the attending doctor. Ombudsman observed from the discharge summary that the complainant was admitted with complainants of back pain and the investigations also confirmed that the Insured was suffering from 'Facetal Arthritis' and was given physiotherapy and medication for his problem with the advise to continue the treatment after discharge also. It appears to the Forum that considering the age of the Insured (71 years), it is understandable that this kind of treatment, viz administering of physio-flexion exercise and IFT back should be done under observation and hence hospitalization was justified. Further, a regime of medication and injections have also been given and therefore, the stand of the Insurer that there was no specific treatment does not hold ground. In the light of the above, Ombudsman directed the Insurer to entertain the claim and pay the admissible medical expenses to the Complainant.

Chennai Ombudsman Centre
Case No. IO(CHN) / 11.02.1240 / 2005 - 06
Shri M. Guru Rao
Vs
The New India Assurance Co. Ltd.

Award Dated 16.1.2006

The Complainant was covered under LIC staff Mediclaim Policy with New India Assurance Co. Ltd. Complainant suffering from severe one sided head ache during the 1st week of March 2005 and it was unbearable even after taking drugs and hence he was admitted in M/s CSR Nursing Home on 6.4.05 for observations, diagnosis and

treatment. The complainant submitted claim papers towards hospitalization expenses and same was repudiated by the Insurer on the grounds that the treatment could have been taken on an out patient basis.

Complainant did not attended the hearing and no communication was received from him for his absence. Insurer, during the hearing, contended that their panel doctor opined that the treatment could have been taken as an out patient and did not require hospitalization. The Insurer also represented that they had arranged for investigation and contacted the attending doctor who informed that clinical condition of the complainant did not warrant hospitalization and the complainant wanted a letter for admission for hospitalization, for evaluation and management. Hence doctor issued certificate to that effect and produced a copy of letter issued by the attending doctor. Insurer also contended that on 7.4.05, Complainant's headache was better and was advised by the doctor for discharge on 7.4.05 but the Complainant got discharged only on 9.4.05 and submitted a copy of letter by the CSR Nursing Home.

Ombudsman perused the documents submitted and concluded that from the documents, it is well established that the condition of the patient did not warrant hospitalization and it was more due to the insistence of the patient himself that the admission was done. It was also observed by this forum that in the said case, Complainant failed to substantiate his claim and the necessity of hospitalization has not been established by him.

Hence complaint was dismissed.

Chennai Ombudsman Centre
Case No. IO(CHN) / 11.02.1226 / 2005 - 06
Shri K. V. Natesan
Vs
The New India Assurance Co. Ltd.

Award Dated 16.1.2006

The complainant and his family members are covered under LIC Group Mediclaim Policy with M/s New India Assurance Co. on 7.8.04, his daughter underwent surgery for high compound Myopic Astigmatism in both the eyes and preferred a claim for Rs.31,055/- Insurer repudiated the claim on the ground that the surgery for cosmetic purpose is not to be reimbursed. Complainant represented that the surgery was not done for cosmetic purpose and approached the forum for redressal.

Complainant, during the hearing contended that this is a claim of his daughter for the surgery conducted owing to refractive error in the right eye to the extent of minus 7.5 and in the left eye to the extent of minus 8.

Insurer contended that they referred the case to their Group Mediclaim Policy issuing Office at Mumbai seeking clarification on the admissibility of Epilasic Procedure under the scope of the policy issued, who informed that the lasik laser treatment was not covered (correction of Myopia) under the conditions and provisions of the policy issued to LIC and it falls under exclusion 4.7 (cosmetic or aesthetic procedure. Based on the above advice received from the policy issuing office, they have repudiated the claim.)

The forum perused the documents submitted by both the parties and pointed out that there was a specific circular issued by GIC dated 15.9.1998, stating that claim may be passed for keratotomy of insured having more than minus 7 refractive error and since the case in hand is on the same lines and that Complainant's daughter underwent surgery for refractive error more than –7 in both the eyes. Ombudsmen concluded that

the Insurer is not justified in repudiating the claim and directed Insurer to process and settle the claim as per terms and conditions of the policy.

Chennai Ombudsman Centre
Case No. IO(CHN) / 11.02.1236 / 2005 - 06
Shri M. R. Sundararajan
Vs
The New India Assurance Co. Ltd.

Award Dated 16.1.2006

Mr. M.R. Sundararajan, employee of LIC of India, was covered under Group Mediclaim for a sum Insurance of Rs. 2 Lakhs, with New India Assurance Co. Ltd., alongwith his wife, Mrs. Uma Sundararajan who underwent KTP laser Stapedotomy right ear at M/s. Vikram Hospital, Coimbatore. Claim was preferred for Rs. 66,547/- for which Insurer settled only Rs. 26,168/-. Complainant represented for the balance amount with the Insurer for which he did not receive any reply. Hence he approached this forum. During the hearing, the Complainant represented that the said hospital is well known for its hight standard of treatment and the success rate and that is the reason he has taken treatment in that hospital. Insurer, during the hearing, admitted that there is no dispute about the genuineness of the claim but their contention was that as per policy condition, only reasonable and necessary expenses incurred can be reimbured. In this case, it observed that the amount claimed by the complianant was on the higher side. Insurer also submmitted quotations obtained from three difference hospitals for the treatment of that particlar ailment and they also agreed to settle the claim for the highest quote which is Rs. 35,000/- Under the circumstances, this forum is of the view that the Insurer has been fair in determining the reasonable expenses payable which has been arrived at Rs .35,000/- plus cost of medicines. Hence Insurer was directed to pay Rs. 35,000/- towards hospitalization plus the cost of medicines after deducting amount already paid.

Chennai Ombudsman Centre
Case No. IO(CHN) / 11.02.1239 / 2005 - 06
Shri V. Balasubramaniam
Vs
The New India Assurance Co. Ltd.

Award Dated 20.1.2006

The Complainant was covered under the LIC Group Mediclaim Policy issued by New India Assurance Co. Ltd. Complaint reported to have been suffering from hoarseness of voice and related problems for more than one year and as treatment taken as outpatient under various doctors did not yield the desired results, finally, as per the advice of the doctor he was admitted in hospital for further treatment.

The insurer contended that the letter given by doctor has prescribed only the investigations vis x-ray, OGD scopy, Bronchoscopy, CECT Chest-plain and contract. He has undergone all these test and the result was normal and no abnormality was found. The diagnosis was Laryngitis. The total bill claimed was Rs. 3,500/- for tests, fee paid and room charges. He was admitted in the hospital for 3 days. Scan has been taken outside the hospital. All these tests do not require hospitalization and could have been done as outpatient. No treatment was given in the hospital. The doctor has prescribed some medicines including a vitamin tablet and the medicines were purchased only after his discharge.

The complainant contended that the doctor treating him, has to decide whether admission into the hospital is absolutely necessary or not and patient has to follow the advice of the doctor. Therefore, the rejection of the claim by the insurer was unjustifiable.

The Forum perused the documents submitted by both the parties and noted that no treatment was given to the complainant during the hospitalization. Condition of patient at the time of hospitalization as per medical records also does not give any indication of being serious enough to require hospitalization. Under the circumstances it can be reasonably concluded that the treatment primarily consisting of investigations could have been managed as an out patient. Therefore Forum concluded that the insurer is justified in repudiating the claim on the ground that the treatment did not warrant hospitalization.

Chennai Ombudsman Centre
Case No. IO(CHN) / 11.02.1285 / 2005 - 06
Shri N. K. Mahalingam
Vs
The New India Assurance Co. Ltd.

Award Dated 2.3.2006

The insured is a retired employee of LIC and covered under LIC group mediclaim policy issued by M/s. New India Assurance Co. Ltd. He reported to Vijaya Hospital with bloated stomach and severe pain and was advised by the attending doctor to get himself admitted for treatment and an endoscopy was done on him and after discharge from the hospital, he was prescribed some medicines. The insured preferred claim for reimbursement of medical expenses but the claim was rejected on the ground that the hospitalization was only for evaluation purpose.

The insured contended that the doctor suspected that the insured might be having some tumor in the stomach and hence advised him to get admitted to the hospital for treatment. Since, nothing was abnormal; the complainant got discharged the next day.

The insurer stated that the insured discharge summary submitted did not speak of all the ailments, which he was suffering from and contained only few details. The discharge summary revealed that he was investigated for upper GI endoscopy and examination is normal and no finding was mentioned. The doctor noted that insured did not have stomach pain and claim repudiated since there was no positive existence of disease and the admission was only for evaluation purpose.

Ombudsman pointed out that the mediclaim policy reimburses hospitalization expenses reasonably and necessarily incurred for illness/disease or injury sustained. In the said case the medical documents do not indicate any particular illness contracted by the insured. The investigative test are negative for any ailment and diagnosis is only normal epigastric discomfort felt after taking meals and does not have the dimension of an ailment requiring hospitalization. Thus necessity of hospitalization was not established. In the light of above, this forum view that the insurer was right in their decision to conclude that the hospitalization was not warranted.

Chennai Ombudsman Centre
Case No. IO(CHN) / 11.02.1222 / 2005 - 06
Shri P. C. Rasmi Varma
Vs
The New India Assurance Co. Ltd.

Award Dated 3.3.2006

The complainant covered under group mediclaim policy issued to the employees of M/s. WIPRO by M/s. New India Assurance Co. Ltd. The insured underwent a laser surgery for eyes on 6.12.04 at M/s. Vijaya Hospital and made a claim of Rs. 30,496/- for the reimbursement of medical expenses but the claim was rejected by the insurer for the reason that the surgery was cosmetic in nature.

Complainant contended that one of her colleagues had the same problem and she also underwent surgery and preferred the claim with the insurer and the claim was settled. Hence, she questioned why the insurer has rejected her claim and settled the other claim when the same rules should apply. The complainant also pointed out that the insurer has not written to her asking for the details of the claim of her colleague, and instead made her wait for one year and then repudiated her claim.

The representative of the insurer stated they have issued a policy covering all the employees, spouses and children of M/s. WIPRO Ltd. In this case the Doctor has certified that she has undergone laser surgery for correction of refractive error of –4.75 and –5.00 in her eyes. He submitted a copy of the GIC circular, which clearly states that claims for surgery for refractive error of more than –7 can only be settled. Since in this case the refractive error was less than –7, the same has been considered as surgery of cosmetic nature which was not covered under the policy. Hence, they had repudiated the claim. Since Insured did not quote the details of the case which is said to be settled of the same nature, they were not able to get the claim details of her colleague and clarify as to how the same had been settled.

The forum perused the documents submitted by both the parties. The forum noted that the exclusion clause in the policy specifically excluded surgery which is corrective or cosmetic or aesthetic in nature. There is also a GIC circular dt. 16.9.98 which states that Lasik survey for correction is payable where the refractive error exceeds –7. In the present case the certificate of M/s. The Eye Research Foundation dt. 8.2.05 states that the complainant was found to have refractive error of right –4.75 and left eye –5.00. In the light of the above discussion this forum awarded that the insurer is justified in their stand, in repudiating the claim.

Chennai Ombudsman Centre
Case No. IO(CHN) / 11.02.1257 / 2005 - 06
Shri T. Manickam
Vs
The New India Assurance Co. Ltd.

Award Dated 31.3.2006

The complainant Shri. T. Manickam is an employee of LIC and he and his family were covered under LIC Group Mediclaim Policy with New India Assurance Co. Ltd., His dependent son met with road accident on July 05, and sustained injuries and was hospitalized. He preferred claim with New India Assurance Co. Ltd. for hospitalization of his son. The insurer repudiated the claim on the ground that his son Mr. Senthil Kumar was not pursuing full time higher studies; hence he is not coming within the definition of dependent under the policy.

The insured contended that his son Mr. Senthil Kumar was less than 25 years, a regular college student and dependent on him, hence, he is covered under the policy and claim is payable.

The insurer stated that the policy was issued to LIC of India with a condition that son up to age of 21 years only can be covered. The Cover can be extended up to 25 years if pursuing full time higher studies in a recognized university. In this case Mr. Senthil Kumar has completed 21 years and as per course certificate issued by the university,

he is student of Distance Education correspondence institution and he was not a student pursuing full time higher studies during the period of insurance.

The Forum perused the documents submitted and observed that Shri. Snethil Kumar ceased to be student with the completion of his academic year in March-April 05 and there is no documentary evidence to establish the complainant is regular full student pursuing higher studies. Under the circumstances, the insurer cannot be faulted for repudiating the claim.

Hyderabad Ombudsman Centre
Case No. IO (HYD) / G - 14.005.137 / 2005 - 06
Shri Kurapati Das
Vs
The Oriental Insurance Co. Ltd.

Award Dated 17.10.2005

Complainant, a member of Group Mediclaim Policy issued to LIC of India. He underwent Bypass Surgery on 2.7.2003 He claimed only Rs. 43,477/- as army group insurance paid Rs. 1,03,000/-

Held: Insurer's representative during the hearing said that they would pursue with their Mumbai office and arrange for settlement at the earliest.

Hyderabad Ombudsman Centre
Case No. IO (HYD) / G-11.005.0114 / 2005 - 06
Shri B. Rangaiah
Vs
The Oriental Insurance Co. Ltd.

Award Dated 17.10.2005

Complainant was a member under Group Mediclaim Policy taken by LIC of India. He was diagnosed as having Ogilvie Syndrome and was hospitalized from 5.8.2003 to 18.8.2003. He claimed an amount of Rs. 27,382/- after long delay. The TPA settled the claim for Rs. 2,739/- only.

Held: The insurers are responsible for delay and deficiency in services. Ordered to pay the claim within one month with interest as per IRDA.

Hyderabad Ombudsman Centre
Case No. IO (HYD) / G-11.004.077 / 2005 - 06
Shri Mahadevan
Vs
The United India Insurance Co. Ltd.

Award Dated 25.10.2005

The complainant's wife was covered under Group Mediclaim Policy issued to Saving Bank Account Holders of Andhra Bank. she was under treatment from 22.11.2004 with complaints of giddiness, headache and occasional vomiting. She was admitted in Manipal Hospital on 25.11.2004 and was diagnosed to suffer from RHD. The claim was rejected on the grounds that the disease was pre-existing. The insurer contended that the disease developed two months after the inception of the policy. Patient was a known hypertensive and taking anti hypertension drugs. She was also diagnosed to have RHD which develops over a period of time due to heart damage from rheumatic fewer.

DECISION : On perusal of hospital documents, it is found that nowhere in the past history either hypertension or symptoms of RHD were mentioned and an experts opinion was obtained. Doctor opined that the patient could have had Asymtomatic Systemic Hypertension which can remain undiagnosed. Insured given benefit of doubt as she may not be aware of disease before the policy was taken. Complaint admitted.

Hyderabad Ombudsman Centre
Case No. IO (HYD) / G-11.002.231 / 2005 - 06
Shri P. Vasu
Vs
The New India Assurance Co. Ltd.

Award Dated 20.12.2005

The complainant and his family were covered under Group Mediclaim Policy issued to City Bank Credit Card holders. His wife was admitted into the hospital in June 2005 for back pain/disc prolapse. Against her claim of Rs. 148527/- the TPA settled for Rs. 110812/- Deductions were made on account of (i) some changes in the policy with effect from October 2004 renewal. The policy introduced sub-limits for various heads of expenses within the overall policy limits and also limited the per day room and nursing charges (ii) some of the expenses or bills pertains to period more than 30 days prior to hospitalization (iii) corresponding reports for tests were not submitted to TPA (iv) Ambulance charges though properly receipted were denied. The complainant contended that cashless facility was denied to him without giving any reason to him. Terms and conditions of the policy were changed without his prior consent. The insurer contended that the new provisions of the policy were sent by the bank to all their customers by way of renewal notices.

Held : The insurer's representative could not give any coherent reason for the denial of cashless service and made feeble attempt to take the excuse that the policy held by the insured was issued at Chennai. The insurer is directed to pay an amount of Rs. 7500/- towards compensation for hardships faced. As regards changes in the terms and conditions the insurer produced wordings in the certificates wherein reference was made to the reasons. Therefore, the contention that changes were unilateral is not accepted. The insurer cannot deny payment for two tests as there is a forwarding letter from the complainant dated 21.06.2005. Ambulance charges were also considered. Insurers are directed to pay totally Rs. 9220/- under various heads as stated above.

Hyderabad Ombudsman Centre
Case No. IO (HYD) / G-11.002.220 / 2005 - 06
Shri T. S. Vidyasagar
Vs
The New India Assurance Co. Ltd.

Award Dated 20.12.2005

The complainant, an Andhra Bank Credit Card holder was covered under the Group Mediclaim policy issued by the respondent company. He sustained a fracture 22 years ago to his left for arm and some plates and screws were fixed. He was hospitalized in June 2005 with complainants of intense pain. As secondary procedure they also removed the plates and screws. While doing so, a fresh fracture occurred to the radius. The claim was rejected on the ground that the disease was pre - existing.

The complainant contended that his was a fresh fracture and it was accidental and unforeseen. The insured did not inform about the treatment taken in the previous years. The policy was in force since 7 years.

Held : Surgical intervention was done on account of intense pain for about 15 days that was not relieved by medicines. His treatment cannot be said to be for a pre existing ailment. During the same surgery the doctors removed he earlier implants. The insurer appears to have a point here that they need not pay for the removal of the implants fixed following an earlier fracture when apparently he did not have insurance. But it is not in any way indicated or established that this removal had anything to do with the intense pain and the surgical intervention. Thus the treatment of this new fracture falls within the scope of the policy. I therefore, direct the insurers to pay 65% of the claim.

Hyderabad Ombudsman Centre
Case No. IO (HYD) / G-11.002.168 / 2005 - 06
Dr. Mohit Chandra Gupta
Vs
The New India Assurance Co. Ltd.

Award Dated 20.12.2005

The complainant and his wife were covered under the Group Mediclaim Policy issued to Canara Bank Credit Card Holders for a Sum insured of Rs. 2 lacs for the period 10.11.2004 to 31.10.2005. He was hospitalized on various dates from 09.08.2004 for the treatment Unstable angina and insertion of Pace Maker. He claimed on amount of Rs. 2,00,632/- The TPA rejected the claim on the ground that the disease was pre-existing and their policy exclusion No. 4.1 stated that reimbursement of expenses for illness/disease contracted during the break period will be treated as pre-existing and excluded from the scope of cover. The insurer contended that as per their records policy was taken for the period 1994-95, 1995-06 and later renewed for 199-98. They settled a claim for Rs. 1,71,050/- for the policy period 1997-98 for Coronary Artery Disease. The policy was not renewed for the year 1998-99 and for two years from 01.11.200 to 31.10.2002. The policy which expired on 31.10.2003 was renewed on 01.11.2004 with a break of 61 days. The complainant contended that he was regular Mediclaim Policyholder since 1995. He approached the Insurer in October 2000 for renewal. However, he was informed that the policy could not be renewed since he was 75 years old. He later got to know that the upper age limit was 80 years. Therefore, the break in insurance for the period 01.11.2000 to 31.10.2001 and 01.11.2001 to 31.10.2002 was unintentional and was only on account of the insurers refusal in granting coverage. The policy which expired in October 2003 was renewed with a break as he was out of the country and immediately upon his return he sent the cheque to the banker which was debited on 22.12.2003. However, insurer granted cover from 01.01.2004.

Held : The insurer is to be blamed for not informing the insured in advance about the denial of cover on attaining 75 years. They failed in their duty once again when the upper age limit was revised. The complainant is not responsible for the delay from 01.11.2000 to 31.10.2001 and 01.11.2001 to 31.10.2002. The insurers are directed to condone delay of two years and treat the policy as continuous. With regards to gap of 61 days there is a delay on the part of the banker and the insurer should have followed up. As a special case keeping in mind that the complainant is a senior citizen and insurance conscious right through I am inclined to award an amount of Rs. 1,00,000/- as exgratia.

Hyderabad Ombudsman Centre
Case No. IO (HYD) / G-11.003.115 / 2005 - 06
Shri Babu Hemashanker Maddala
Vs
The New India Assurance Co. Ltd.

Award Dated 20.12.2005

The complainant was covered under a Group Mediclaim policy issued to credit card holders of HDFC Bank for a Sum insured of Rs. 3 lacs for the period 01.03.2004 to 28.02.2005. He was admitted to hospital at Kolkatta on 18.06.2004 with complaints of Vertigo and difficulty in swallowing. He was diagnosed to suffer from Brainstem Ischaemic Stroke, Diabetes Mellitus (Type II), Hypertension and other disorders. He was later shifted to Lilavati Hospital, Mumbai for further treatment He preferred claim for Rs. 5,86,385/- The TPA rejected the claim citing exclusion clause 4.1 of the policy. The complainant contended that he mentioned in the proposal form that he was hypertensive and diabetic. Therefore, the insurer was aware of his health status even before the policy was issued. The discharge summary stated that the symptoms are of recent origin. He never suffered these symptoms prior to admission at Apollo Hospital, Kolkotta. The insurer contended that the patient was a known diabetic and hypertensive and was admitted to hospital within 3 months of inception of the policy. The Panel Cardiologist stated that there was a nexus between the present hospitalization and HTN and DM.

Held : The insurer produced a copy of the proposal form where the complainant declared that he was diabetic. The hypertension column was left unticked. The Panel doctors of the TPA are unanimous in their contention that pre-existing diabetes only increases the chances of neurological and cardiovascular disease. However, they have not stated specifically that the disease, for which claims are made, are solely caused by Diabetes Mellitus.

Hyderabad Ombudsman Centre
Case No. IO (HYD) / G-11.004.064 / 2005 - 06
Shri M. Gopala Rao
Vs
The New India Assurance Co. Ltd.

Award Dated 28.12.2005

The complainant was covered under a Group Mediclaim policy titled Arogyadaan issued to Customers of Andhra bank for a sum insured of Rs. 3 lacs. He consulted one Dr. Pera Raju during December 2004 to January 2005 who diagnosed him as suffering from Diabetic Nephropathy. He consulted another doctor, who advised him to under go Haemo dialysis 3 times a week commencing from 15.02.2005. He submitted various bills for the many treatments to the insurer for a total of Rs. 67,479/- The insurer rejected the claim on the ground of pre-existing disease. The complainant stated that he was requested by the Bank Manager to purchase the insurance, he only filled up the proposal and submitted it along wit premium cheque. He first fell unwell only in January 2005 and he was not aware of any pre-existing illness. The insurer contended that the ailment diagnosed develop over a period of time and definitely not within a short span of 6 months. The conditions developed due to long standing diabetes.

Held : Complainant was asked to submit the prescription of Dr. Pera Raju. The papers do not give any information regarding duration of the illness but makes a mention of

diabetic nephropathy. The treating doctor certified that Renal failure was due to diabetic nephropathy and LV Dysfunction. A second opinion was obtained by this office from an independent doctor who confirmed that diabetes of at least 10 years duration is required for any body to develop these complications. Occasionally, the duration of DM could be above 5 years. He has also pointed that Heart muscle, Kidney and Retina were involved. Since it is reasonably established that the disease has not arisen after taking the policy in June 2004, the decision of the TPA is not overruled.

Hyderabad Ombudsman Centre
Case No. IO (HYD) / G-11.002.0259 / 2005 - 06
Shri P. S. N. Raju
Vs
The New India Assurance Co. Ltd.

Award Dated 1.3.2006

The complainant was covered under a Group Mediclaim policy issued to employees of LIC of India. He underwent treatment for heart complaint, kidney problem etc. and claimed an amount of Rs. 25806/-. He received a cheque for Rs. 21,455/- with no break up or reason for deduction made known to him. When he represented the matter to the insurer they sent him another cheque for Rs. 2004/- in November 2005. The insurer contended that certain medical bills were without prescriptions, some other medicines were purchased against the one prescribed by the doctor, some uninsured items have been claimed, and the claimant signed the discharge voucher for full and final settlement.

Held : The insurer submitted that out of Rs. 2347/- previously disallowed, they were willing to consider Rs. 1538/- and an amount of Rs .600/- was disallowed as they were billed for generator, security, ayah, etc. There is no merit in the insurer's argument that these expenses do not form part of medical expenses. If the hospital decides to bill some of their room, board and nursing charges under some heads the insured should not be denied reimbursement of expenses genuinely incurred by him., The insurer is directed to pay Rs. 600/- under the head of Room, Board and nursing Expenses alongwith Rs. 1538/-.

Hyderabad Ombudsman Centre
Case No. IO (HYD) / G-11.004.0340 / 2005 - 06
Shri D. Venugopala Rao
Vs
The United India Insurance Co. Ltd.

Award Dated 1.3.2006

The complainant and his wife were covered under a Group Mediclaim policy issued to account holders of Andhra Bank for the period 09.03.2005 to 08.03.2006. His wife was admitted to hospital with complaints of Polyarthritis on 02.08.2005. The TPA rejected the claim on the grounds that the disease was pre-existing. The insurer contened that the insured was asked to submit a certificate from the treating doctor on the history of the complaint/illness but the insured did not comply with the TPA's request. It was held that the insurer would instruct the TPA to reopen the file and settle the claim. The insured is given 21 days time to submit the balance bills and the insurer is directed to process and settle the claim within 30 days of submission by the insured.

Hyderabad Ombudsman Centre

Case No. IO (HYD) / G-11.004.196 / 2005 - 06
Shri Kishanchand Vijay Vargi
Vs
The United India Insurance Co. Ltd.

Award Dated 20.01.2006

The complainant was covered under a Group Mediclaim policy issued to account holder of Andhra Bank for the Sum insured of Rs. 1 lac for the period of 21.07.2004 to 08.06.2005. He was admitted on 02.05.2005 with complaints of severe chest pain. He was advised to under go CABG on 07.05.2005. He preferred a claim for Rs. 20,8291/- Claim was rejected on the ground that the disease was pre-existing. The complainant contended that his father was taken to a hospital on 01.05.2005 with complainants of uneasiness and chest pain. He suffered a heart attack while undergoing treatment and was shifted to Care Hospitals, for further management. Although he was hypertensive, he was not a diabetic. While purchasing the policy he submitted ECG taken on 29.05.2004 which suggested normal reading. The disease was of sudden origin. The insurer contended that the TPA's Panel doctor opined that the disease as definitely pre-existing prior to inception of the policy. The ECG of the patient submitted at the time of purchasing the policy was not suggestive of normal reading. The complainant misguided the insurer while purchasing the policy.

Held : During hearing it was learnt that the complainant superannuated from APSRTC. The insurer was granted 15 days time to produce fresh evidence in support of their stand. A copy of the case sheet of the hospital was submitted. The doctor had clearly mentioned that the patient suffered from Severe Triple Vessel Disease. He was also suffering from Acute Pulmonary Disease. Further the complainant availed long periods of sick leave during his service which is indicative of his health condition. The ECG report furnished to the insurer while purchasing the policy is suspect. The report contains no details about the reading. The complainant did not declare his hypertensive status in the proposal form. There is a considerable evidence against the claim that cannot be brushed a side. Insurer's decision is upheld.

Hyderabad Ombudsman Centre
Case No. IO (HYD) / G-11.002.268 / 2005 - 06
Shri Y. Ramesh
Vs
The New India Assurance Co. Ltd.

Award Dated 23.01.2006

Complainant's mother covered under Group Mediclaim policy issued to employees and dependents of LIC. She was admitted to hospital on 22.12.2004 with complaints of fever with chills. She was diagnosed to suffer from enteric fever with general weakness. Claim was rejected on the ground that the hospital had 10 beds only. The complainant contended that the insurer initially rejected the claim as it was for 'general weakness' not covered under the policy. The treating doctor certified that treatment was given for Enteric Fever and nothing specific was given for general weakness. The claim was then rejected under the clause 2.1 relating to number of beds. The insurer contended that the hospital did not satisfy the parameters as laid down in the MOU.

Held : Repudiation was done in the most irresponsible manner. Policy conditions state that the hospital should qualify anyone of the 2 conditions-registration with local authorities or the number of beds. Insurer is directed to settle the claim and also pay an amount of Rs. 5000/- for mental agony.

Hyderabad Ombudsman Centre
Case No. IO (HYD) / G-11.002.358 / 2005 - 06
Shri R. Srinivasan
Vs
The New India Assurance Co. Ltd.

Award Dated 31.03.2006

Complainant was covered under Group Mediclaim policy issued to holders of Cancard from 01.11.2004 to 31.10.2005. He was admitted to hospital on 05.05.2005 for sudden onset of left-sided weakness and disorientation. He was diagnosed to suffer from hypertension and Diabetes Mellitus. The TPA rejected the claim on the ground that the disease was pre-existing and the treatment taken for general weakness was not covered under the policy. The insurer contended that the present ailment of hemorrhage was a complication of pre-existing HTN. It was observed that the insurer could not establish that the complainant had HTN prior to the inception of the policy. The insured stated that he was covered under the scheme since 1997. Their repudiation is not justifiable. The insured suffered a stroke and was consequently weak and this weakness is not the one, which is excluded under the policy as General Debility, Run Down condition. The insurer is directed to settle the claim.

Hyderabad Ombudsman Centre
Case No. IO (HYD) / G-11.002.374 / 2005 - 06
Shri J. M. Yogananda Murthy
Vs
The New India Assurance Co. Ltd.

Award Dated 31.03.2006

Complainant and his family were covered under the Group Mediclaim Policy issued to retired employees of LIC. His daughter underwent Lasik Laser Surgery for correction of High Myopic Astigmatism with Lattice Degeneration. he submitted a claim for Rs. 25734/-. The claim was rejected on the ground that the surgery was for cosmetic purposes and excluded form the scope of the policy under exclusion 4.5. The complainant contended that the surgery was performed only as a medical necessity. The MOU between LIC and the insurer states that an operation meant manual and operative procedures for correction of deformities and defects. This surgery came under this definition. The insurer contended that this surgery was usually done to avoid wearing Contact Lenses and spectacles. The insured brought to the notice of the chair an earlier decision given from this office wherein it was concluded that the surgery was a functional surgery and not being required to wear glasses only a by-product. The insurer confirmed that they pay for IOL implants. There is no reason as to why the insured should be denied payment for Lasik surgery. They are directed to honour and pay the claim without any further delay.

Hyderabad Ombudsman Centre
Case No. IO (HYD) / G-11.002.384 / 2005 - 06
Shri C. S. Sastry
Vs
The New India Assurance Co. Ltd.

Award Dated 31.03.2006

The Complainant and his family were covered under the Group Mediclaim Policy issued to retired employees of LIC. His daughter was alleged to have sustained a fall form the stairs and broken her teeth. She was taken to a Dental Clinic and some of her teeth

were removed. The complainant preferred a claim with the insurer for Rs. 34,232/ towards expenses. The claim was rejected on the ground that the insured person had taken only outpatient treatment at a clinic but not in a hospital as defined in the policy. Further the clinic was not registered with the local authorities. The complainant stated that in view of the emergency following the fall, they had to rush her to the nearest good dental surgeon. He further stated that he should not be penalized if the doctor elected not to conduct certain tests before treating his daughter. The insurer contended that spending a huge amount of Rs. 34,332/- even without the necessary X-rays, tests, reports etc. appeared unreasonably high. It is unreasonable to expect the insurer to pay in full, especially when the bifurcation of the bill was not provided. Total denial of the claim would be too harsh. A compromise settlement at about Rs. 20,000/- was agreed to in my presence.

Hyderabad Ombudsman Centre
Case No. IO (HYD) / G-11.002.370 / 2005 - 06
Shri A. Venakta Subramanian
Vs
The New India Assurance Co. Ltd.

Award Dated 31.03.2006

The Complainant was insured under a Group Mediclaim Policy issued to account holders of Corporation Bank. He submitted a claim for Rs. 52,207/- for expenses incurred on treating IHD. The insurer rejected the claim on the ground that he was hypertensive for 2 years on medication, which fact was not revealed in the proposal form. The complainant contended that he was in perfect health at the time of proposal. His hypertension for the previous 2 years cannot make his heart attack of June 2005 a pre-existing illness. The insurer ought to have put him through a medical test in case of doubt at the time of issuing the policy. The insurer contended that had the proposer mentioned true facts, they would have advised medical check up which would have revealed additional information; taken proper underwriting measures. The TPA and the insurer submitted that insurance contracts are based on utmost good faith and the proposer is expected to furnish all information that is material for the insurer to decide on the proposal. The cashless form filled in by the doctor mentions that the insured was suffering from DM and HTN both of which are risk factors for heart ailments. On hearing the submissions and perusal of documents, it is held that the insurers are justified in rejecting the claim.

Hyderabad Ombudsman Centre
Case No. IO (HYD) / G-11.002.0322 / 2005 - 06
Shri Nagarajappa Pallakki
Vs
The New India Assurance Co. Ltd.

Award Dated 1.03.2006

The Complainant covered his mother under the Group Mediclaim Policy for LIC Employees and Dependents. She was admitted to hospital for leg fracture on 29.03.2005. The insurer settled her claim for Rs. 14,960/- as against Rs. 21,129/- towards hospitalization expenses. The complainant was informed that the claim amount was reduced, as there was some discrepancies in the bills for drugs purchased from the pharmacy. The complainant contended that there was a deduction as the bills were not in sequential order and did not bear CST/KST Regn. Nos. The chemist clarified that the jumbling of serial nos. was purely a Clerical error. The shop was started in March 2005 with a drug license and they had applied for tax registration immediately. Since

the medicines were purchased in March itself, billing was done on the basis of drug Licence only. The insurers stated that since the drugs were indeed purchased, they were willing to pay the amount with a penalty of 10%. It was held that the panel investigator nowhere mentioned in his report that the bills were bogus or fake. The dealer clarified the reasons for the discrepancies. The insurer conveniently chose to ignore the explanation and could not explain during the hearing the reason for the doubt. The insurer did not apply his mind while shooting out a letter for part settlement. The insurers are directed to settle and pay the balance amount disallowed alongwith an amount of Rs. 5000/- towards compensation for mental agony and harassment.

Hyderabad Ombudsman Centre
Case No. IO (HYD) / G-12.002.0366 / 2005 - 06
Shri M. R. Chandrasekharan
Vs
The New India Assurance Co. Ltd.

Award Dated 31.03.2006

The Complainant covered himself and his wife under the Group Mediclaim Policy for LIC Employees and Dependant. He had paid Rs. 6466/- as his premium contribution for the coverage. His wife died on 08.05.2005 after 38 days of the commencement of the policy. No claim was lodged for reimbursement of expenses. The complainant sought for proportionate refund of premium for the balance period. He was informed that such a provision was not there. The insurer contended that the policy is on unnamed basis and there is no provision for additions and deletions. The insurer was also not aware about the sharing pattern of the premium payable between the employer and the employee. The insurer contended that the procedure followed for general group policies was not followed here. Since there was no provision for refund it was not allowed. It was held that LIC was implementing the scheme as per standard market practices of insurers with reference to entry and exit in a group policy even though the same may not have been incorporated in the current policy. The insurers cannot say that just because some wordings are not found in the policy, there is no provision for proportionate adjustments. The insurer is directed to refund the premium to the complainant in respect of his wife for the balance 10 months of the policy.

Kochi Ombudsman Centre
Case No. IO (KCH) / GI-11.003.66 / 2005 - 06
Shri P. V. Poulose
Vs
The National Isnurance Co. Ltd.

Award Dated 27.10.2005

The Complaint under Rule 12(1)(b) read with Rule 13 of the RPG Rules, 1998 relates to repudiation of a Group Mediclaim by the insurer. The Complainant's family was covered under a Floater Scheme by the insurer through M/s. Unison Service Corporation. Irinjalakuda for a period of one year from 15.1.2002 to 14.1.2003. Miss Nisha Poulose the daughter of the complainant had undergone a surgery for Appendicitis on 27.4.2002 at Carmel Hospital, Alwaye. The insurer had repudiated the claim based on the findings of the Investigator that the beneficiary had an earlier history of treatment for the same problem at Medical Trust Hospital. He had also obtained written statements from the beneficiary and her mother to substantiate his conclusion. But, the investigator had not adduced any evidence to prove his point and the insurer had blindly believed his version to repudiate the claim. The treatment of the

beneficiary in Medical Trust Hospital was reportedly for some other ailment and unless corroboratory evidence is adduced to show that it was also for appendicitis, the insurer had no case. On the whole, the Insurance Company could not substantiate their action in repudiating the claim and, therefore, the repudiation was set aside and the claim was ordered to be paid forthwith.

Kochi Ombudsman Centre
Case No. IO (KCH) / GI-11.005.123 / 2005 - 06
Shri M. Thanka Prakasam
Vs
The Oriental Isnurance Co. Ltd.

Award Dated 30.11.2005

The Complainant under Rule 12(1)(b) read with Rule 13 of the RPG Rules, 1998 relates to partial non -settlement of a group mediclaim benefit by the respondent. The complainant retired from the services of LIC and he was continuing the mediclaim policy even after retirement as per rules. His wife Smt. Irudaya Pushpam had undergone eye treatment at Arvind Hospital, Coimbatore in March 2003. Out of a total admissible amount of Rs. 11910/-, the insurer had settled only Rs. 1172/- and gave no reply for any correspondence from the claimant demanding the balance. Even for the hearing before this Forum, the insurer had neither submitted a self-contained note nor was represented. However, even in the absence of the insurer and written submissions, this Forum had gone through the records in detail and found no reason for disallowing the claim. In the circumstances, the insurer was directed to settle the balance of Rs. 10738/- to the complainant and the complaint was closed.

Kochi Ombudsman Centre
Case No. IO (KCH) / GI-11.002.160 / 2005 - 06
Shri P. K. C. Sekhar
Vs
The New India Assurance Co. Ltd.

Award Dated 01.12.2005

The Complaint under Rule 12(1)(b) read with Rule 13 of the RGP Rules, 1998 relates to repudiation of a Medical claim by the insurer. The Complainant retired from M/s. A. T.E. Enterprises. Mumbai on 30.7.1999. He and his wife were covered under the Group Mediclaim policy of NIA Co. Ltd., taken by is employer, till 31.3.2001. After a lapse of 70 days, he and his wife got themselves covered under Individual Mediclaim policy for the period 11.6.2001 - 10.6.2002, from NIA Ltd., Thalassery Branch, which was kept renewed without any break till date. The complainant had clearly stated in the proposal, the diseases which he and his wife were suffering from at the time of proposing for insurance. The claim put forth by the complainant for the treatment of coronary Artery Diseases of his wife Smt. Radha Chandrasekhar, in July 2004 was repudiated by the insurer since the disease was pre-existing when the cover incepted and is an exclusion as per the policy issued. The matter was thoroughly assessed by the Honourable Ombudsman, who in turn upheld the repudiation of the insurer and dismissed the complaint.

Kochi Ombudsman Centre
Case No. IO (KCH) / GI-11.003.111 / 2005 - 06
Shri P. K. Venu
Vs
The National Insurance Co. Ltd.

Award Dated 6.12.2005

The Complainant under Rule 12(1)(b) read with Rule 13 of the RPG Rules, 1998 relates to repudiation of a Group Medical claim preferred by the Complainant for the treatment of his wife. As per the records, there were two spells of treatment in this case and the complainant's wife had also a history of some OP treatments earlier for 3-4 months. The treatment from 15.7.02 to 22.7.02 was an outpatient procedure and the insurer was not liable to pay the claim. However, the inpatient treatment at Lisie Hospital, Ernakulam from 22.7.02 to 29.7.02 was to be paid and the insurer, after having conducted an investigation, was prepared to honour the second part of the claim. The insurer also stated that the amount admissible for the second spell of treatment was Rs. 3756.09. On verification of the records, the version of he insurer was found correct and therefore an amount of Rs. 3756.09 was ordered to be paid to the complainant in full and final settlement of the claim.

Kochi Ombudsman Centre
Case No. IO (KCH) / GI-11.005.208 / 2005 - 06
Ms. Florence E. D.
Vs
The Oriental Insurance Co. Ltd.

Award Dated 24.1.2006

The Complainant under Rule 12(1)(b) read with Rule 13 of the RPG Rules, 1998 relates to partial repudiation under a Group Mediclaim policy floated by the insurer for the benefit of Apollo Tyres employees. The complainant, a clerk in the Factory, sustained a fracture on her great toe (R) on 10.1.2005 and she was under plaster and medication for a period of 58 days from 10.1.2005 to 8.3.2005. The complainant had also problems of Osteo-Arthritis (knee) for the past two years and she was taking medication for Arthritis also during the said period. However, the insurer, after obtaining a clarification from the hospital maintained that the fracture-treatment was for a period of 35 days only and thereafter the facts were otherwise, even while she had arthritis, the instance complications had arisen only due to the ulcer caused by the application of plaster of paris upto the knee level. So, the entire treatment was for the toe-fracture and the ulcer caused by the plaster. For arthritis, apart from her regular medication, there was nothing else. Therefore, the insurer was advised to settle the claim at the relevant rate for all the 58 days claimed and the complaint was disposed of.

Kochi Ombudsman Centre
Case No. IO (KCH) / GI-11.005.200 / 2005 - 06
Shri s. Muralidharan
Vs
The Oriental Insurance Co. Ltd.

Award Dated 21.2.2006

The Complainant under Rule No. 12(1)(b) read with Rule 13 of the RPG Rules, 1998 relates to repudiation of a Group Mediclaim benefit claimed by the complainant from the respondent insurer. The complainant had alleged that he had sustained a fall in the bath room on 25.1.2005 and spent around Rs. 50,000/- on treatment - Ayurvedic and Allopathic. However, as per the Discharge summary issued by the Hospital, it was a case of LP sprain and Neuralgia which were not covered under the policy. The complainant had not sustained any bodily injury in the alleged accidental fall and the treatment for Neuralgia etc. were clearly outside the scope of the policy. In the

circumstances, the complainant's case had no merits worth consideration and therefore the complaint was dismissed.

Kolkata Ombudsman Centre
Case No. 640/14/003/NL/03/2004-2005
Sri. Ajay Bagaria
Vs
National Insurance Company Ltd.

Award Dated 20.01.2006

Facts & Submissions:

The complaint is regarding delay in settlement of claim under Group Mediclaim Insurance Policy.

The National Insurance Company Limited authorized M/s Venus Medicare Services (I) Ltd. of 19, R.N.Mukherjee Road, Kolkata - 700 001 to cover the latter's members under Group Mediclaim Scheme as per the terms and conditions agreed to between them. An additional 6% premium was charged for cashless facility through TPA services. The complainant's wife Smt. Ekta Bagaria was one such group member. Shri. Ajay Bagaria in his complaint dated 16.03.2005 and 'P' form details dated 28.05.2005 stated that on 09.10.2004, a claim for Rs. 33,572/- was filed in respect of treatment of his wife. Since, M/s Venus Medicare Services (I) Ltd. was closed, the complainant enquired several times with the insurance company, who directed them to the TPA. However, despite representation to both TPA and the insurance company, the claim was not settled.

National Insurance Company Ltd. stated that they did not receive any premium from M/s Venus Medicare Service Club (referred to as 'Venus' hereinafter)- the Insured under the agreement - in respect of Smt. Ekta Bagaria and, therefore, the claim of the complainant could not be entertained by them. They also stated that they had cancelled the Memorandum of Understanding with 'Venus' for various irregularities committed by them.

Decision : The complaint involves a claim under a Group Policy in which 'Venus' were the Insured and the complainant's wife was an individual member included in the group. As per Section 64 VB of the Insurance Act 1938 the insurance cover shall commence only on receipt of premium from the Insured. The Insured in this case, 'Venus' did not pay the premium required under Section 64 VB to the insurance company. The insurance company, therefore, was not obliged to issue policy covering the individual member in the absense of premium from 'Venus'. The amount paid by/on behalf of the individual member to 'Venus' cannot be construed as "premium" paid to the insurance company. If the amount collected by 'Venus' from the individual member was misappropriated by the former, such crime would be a subject matter of police investigation. The Insurer have in fact taken up the matter with police for various irregularities committed by Venus Medicare Services (I) Ltd. including misappropriation of the amount collected by them from individual members. But such police investigation is outside the purview of this forum.

In view of the non-receipt of the premium, the insurance company was not obliged to issue any police/certificate of insurance covering risk of individual member i.e., Smt. Ekta Bagaria, and action of the insurance company was justified.

Mumbai Ombudsman Centre
Case No. GI-374 of 2004-2005
Smt. Vasanti Ladoba Gaonkar

Vs

The United India Insurance Co. Ltd.

Award Dated 17.11.2005

Smt. Vasanti Ladoba Gaonkar was covered under Group Co. Branded Mediclaim Discounted Policy No. 21800/48/43/7007/2002 issued by The United India Insurance Company Ltd., D.O.. 18, Mumbai & Unique Mercantile India Pvt. for the period 30/6/2002 to 29/6/2003. She was admitted to S.L. Raheja Hospital at Mahim on 3/5/2003 to 8/5/2003 and was treated for Fever with Lower Lobe Pneumonia, Koch's & Type 2 DM. On discharge when she claimed the amount from the United India Insurance Co. Ltd, Mumbai Divisional Office 18, they rejected the claim on the ground that the disease is pre-existing in nature which falls under Exclusion Clause no 4.1 of the Group Mediclaim Policy. She was aggrieved at the decision and even after making representation when the matter was not resolved, she approached Insurance Ombudsman with her grievance against the Company. The parties were called for hearing. The analysis of the case would reveal that the rejection of the claim by the Company was primarily based on pre-existing illness i.e. DM for four years which was prior to the policy period. However, the insured raised a point that the treatment received by her was no way connected with diabetes and the company on subsequent review agreed to pay 50% of the claim. The same was offered to the insured, but she refused to accept it and requested for favour of re-examination by Ombudsman.

A close scrutiny of the file would, no doubt, reveal that the insured was a case of DM since last 4 years and was on Tablet Daonil. Pathological/Radiological investigations confirmed TB of lungs for which treatment was started. The insured had other accompanying ailments as well and had received treatment. However, the issue can be stretched further to mention that there was some form of pre-existence of illness viz. Diabetes which was treated alongside TB at the hospital. As the insured did receive antidiabetic treatment including diabetic diet etc., the claim amount for settlement can be critically reviewed from this angle. Accordingly, the insured cannot recover full amount from the Company and I decide that on this ground a minimum of 20% cost should be deducted to make the insured responsible to pay for the portion of pre-existing illness to meet the ends of justice.

Mumbai Ombudsman Centre

Case No. GI-564 of 2004-2005

Shri Pinaki Sen

Vs

The United India Insurance Co. Ltd.

Award Dated 30.12.2005

United India Insurance Co. Ltd., issued a Group Mediclaim Policy to SET India Private Ltd., covering their employees and family members. Shri Pinaki Sen and his family members were covered under the same policy. The claim was processed by M/s. United Health Care India Pvt. Ltd., Shri Sen's daughter Miss Treta Sen was admitted in Dr. Indu's New Born and Child Care Centre for dental ailment. After hospitalization, he lodged claim to the Company for reimbursement of hospitalization expenses incurred for his daughter's treatment. The Company referred the matter to its panel doctor, Dr. M.S. Kamath and also to Dr. Shyam R. Jamalabad, Dental Surgeon for their opinion. After getting their opinion, the Company repudiated the claim as per Exclusion Clause 4.5 under the policy.

The diagnosis as per hospital case paper is ''for dental restoration & periapical abscess in molar & incisor teeth." The clinical history noted ''H/o pain & swelling in

lower molar tooth since 2 months. Caritis in molar/incisor teeth.'' The treatment that followed was ''Abscess in lower molar and incisor were drained followed by RCT (Root Canal Treatment).'' The Company's rejection came only after scrutiny by another Dentist although not a pediatric dentist, on the basis of exclusion clauses 4.5 and dental treatment not covered as per clause 4.7, unless requiring hospitalization. The Company's consultant felt that the treatment could have been taken in any dental clinic. The Complainant has contested this view through the dentist Dr. Kher under whose care the patient was admitted to the hospital. Dr. Kher strongly felt that the Company's consultant did not do a proper analysis. It is important to note therefore, that in general dental treatment is not covered under the policy except for the treatment received in the hospital as a result of a necessity to get admitted. It should also be appreciated that for dental treatment of all kinds, the clinics are now equipped with all modern equipments and upgraded facilities conveniently replacing the need for hospitalization. On the basis of availability of treatment through specialists, the dental treatment in hospital is restricted to serious complications. But the clause says if there is injury or disease the treatment could be considered. The hospital records prove that there was periapical abscess i.e., around the apex of the root of a tooth, which had to be cleared. Hence there was existence of a disease as per the specialist. The next point of importance would be that the girl was of 5 years of age and it is admitted that she was not expected to cooperate for number of sittings for RCT and the surgery which required obviously General Anaesthetia in an Operation Theatre with good care by the Anaesthetic, needed hospitalization for proper management. It is no doubt possible to get the treatment done otherwise in a clinical but the benefit may be given to the patient who is an infant.

The child was only 5 yrs. and must have grown teeth within 2/3 years and the strict mouth hygiene was expected to be maintained to keep the teeth in good shape. If some gross deficiencies would be there be it would develop into serious complications in future. It was noted that "substantial decay" was there in incisor tooth which speaks of obvious defect requiring correction as we all know that the so-called "milk teeth" give way to regular teeth later and at the infancy a correction was necessary. The complainant also admitted at the hearing that the girl used to suffer from decay and brittleness of tooth which would clearly point towards" wear and tear' as noted in the Exclusion Clause 4.7. It would therefore be fair, logical and pertinent to say that some amount of correction for better dental hygiene was also the objective of the entire procedure and it was quite planned that way. However, the hospital record only mentioned that there was periapical abscess which has been noted for our purpose. Taking a balanced view, therefore, of all aspects of the matter and without violating the spirit of the exclusion clause so worded, I feel that equity would demand admission of the claim with a 30% cut of the admissible expenses.

Mumbai Ombudsman Centre
Case No. GI-194 of 2004-2005
Shri Frank M. Colaco
Vs
The Oriental Insurance Co. Ltd.

Award Dated 1.12.2005

Shri Frank M. Colaco was covered under LIC's Group Mediclaim Policy with The Oriental Insurance Company Ltd. On 22.07.2001 his wife Smt. Veronica Frank Colac was admitted in Cardinal Gracious Memorial hospital, Vasai under the care of Dr. Santosh Pillai and as per his advice Shri Colaco took his wife to Dr. J. S. Sorabjee of Bombay Hospital. Smt. Colaco was under the treatment of Dr. Sorabjee for Mediastinal

lymph node TB. Shri Colaco submitted hospital bills, records and documents to the Company. The Oriental Insurance settled the claim for Rs. 13,893/- as against the claim amount of Rs. 29,999/-.

The Complainant before this Forum was partial payment of claim in respect of Smt. Veronica Frank Colaco, although a few claim bills were forwarded to Oriental in respect of Shri Frank Colaco's claim pertaining to a different period which was not the subject of complaint. As regards Smt. Colaco's Claim it was admitted by her husband and Complainant Shri Colaco, that as no room was available in the Bombay Hospital treatment continued at his residence with the advice of Dr. Sorabjee. It appeared from Oriental written statement duly signed by the Divisional Manager that claim bills before 30 days of hospitalization and after 60 days of discharge i.e. pre and post hospitalization have all been considered. However, any bill beyond this period has been rejected by the Company under the provisions of Mediclaim Insurance Policy which was issued to LIC of India. They confirmed that this was the uniform practice with all claimants and Smt. Colaco has not been discriminated against. This Forum has examined the documents and felt satisfied that the norms have been correctly applied. Moreover it was noticed that the diagnosis was mediastinal lymph node TB which is a long drawn treatment not requiring special hospitalization but can be treated in-house over a period of time under a package therapy.

As Oriental has confirmed that all the bills after 60 days of discharge from hospital have been calculated and settlement was offered accordingly, I find no valid reason to intervene in the matter. Further, the Complainant's claim for mental torture does not come under direct consequence of the Insured peril as per RPG Rules 1998 Rule No. 16 (2) and therefore, disallowed.

Mumbai Ombudsman Centre
Case No. GI-421 of 2004-2005
Shri Ulhas Vengurlekar
Vs
The New India Assurance Co. Ltd.

Award Dated 2.12.2005

Shri Ulhas Vengurlekar an employee of Weizmann Forex Limited was covered under a Group Mediclaim Policy issued by the New India Assurance Com. Ltd., Divisional Office-111800 from 13.4.2002. Shri Ulhas Vengurlekar underwent left eye cataract surgery on 5.1.04 at Kripa Eye Clinic. When he submitted his claim for reimbursement to New India the Company repudiated the claim invoking clause 4.1 of he mediclaim policy. Shri Ulhas Vengurlekar represented to the Company and not receiving and favourable response approached this Forum. The facts of the case have been gone through and while going through the consultation note of Dr. Mukul Sharma, it is observed that the insured was suffering from dimmed vision in the left eye since 2 years and he was advised for cataract extraction. The insured was covered under mediclaim insurance since 13th April, 2002. The duration of 2 years mentioned by the doctor, the Company felt, goes beyond the date of insurance policy taken by the insured. Cataract is an exclusion for which all claims of cataract surgeries are not paid under the policy in the first year. It is a known fact that cataract sets in over a period. Quite often it takes years to mature. As an argument it could be mentioned that in all cases of cataract surgery done in the second year of the policy, the claim becomes payable automatically with a non-disclosed problem in clear vision by all those whose claims are settled by the Company. Still as a further argument it can be said that all cases of diminished vision need not be a cataract problem, it could be some other

complications. In that context merely the dim vision may not be known to be a cataract problem to the insured as a disease so as to declare in the proposal form for which seriously a charge of non-disclosure cannot be levelled against the Insured. Dim vision is a symptom which was revealed through a query by the Doctor. The actual diagnosis of cataract was done by a specialist Ophthalmologist only after the policy was taken. Based on this, a lenient view can be taken to offset the other settlements being made even with a veiled non-disclosure by virtue of the police terms.

In the facts and circumstances the claim of Shri Ulhas Vengurlekar is sustainable.

Mumbai Ombudsman Centre
Case No. GI-437 of 2004-2005
Shri Kiran S. Shah
Vs
The New India Assurance Co. Ltd.

Award Dated 5.12.2005

Shri Kiran S. Shah was covered with his family members under Group Mediclaim Policy issued by United India D.O. 9 for the Employees of Futura Polysters since 01.04.1997 to 31.3.2000 for varying Sum insured. Smt Jasuben Shah mother of Shri Kiran Shah was hospitalized for Left Hemiparesis. When a claim was preferred the Company repudiated the claim invoking clause 4.1 of the mediclaim policy. Not satisfied with the decision of the Company, Shri Shah represented to the Company which was also turned down. Aggrieved by the decision Shri Shah approached the Office of the Insurance Ombudsman. Records have been perused and hearing of the parties to the dispute was held. The relevant records produced to this Forum have been studied in details. The scrutiny of the records leads one to conclude that after rejection of the claim by the Company, the Complainant Shri Kiran Shah took various steps to prove that the duration of Hypertension was not correctly recorded. Taking this view to somewhat play down the aspect of non-disclosure or the confusion created by giving different history of Hypertension and also taking an extended view that 1st April, 1997 to 31st March, 2000 the policy was free from any claim it could be given a special consideration to reckon as continuous as a special case. In fact even taking above 4 years history, the 1997-98 period would be free from any history. Moreover New India has also not tried to prove by providing actual prescribed treatment record or medicines taken by Smt. Jasuben for Hypertension during this period say from 1997 to 2000 to this Forum. It is therefore, based only on somebody's statement before the hospital doctors. Taking this lenient view I consider that having reposed his faith in the system of Insurance and covering his entire family without making any exception or only insuring high risk, Shri Kiran Shah deserves to get some relief for which he took the policy. I, take this view that equity would be granted by allowing only. Rs. 20,000 being the original Sum Insured under the first policy taken from another Public Sector Organization. This would partially mitigate the hardship and meet the ends of Justice to resolve the dispute.

Mumbai Ombudsman Centre
Case No. GI-456 of 2004-2005
Shri Lalit Makhija
Vs
The Oriental Insurance Co. Ltd.

Award Dated 8.12.2005

Shri Lalit Makhija and his parents were covered under a Group Mediclaim Policy of Oriental Insurance Co. Ltd. since 1997 and in the year 2001 he took Individual mediclaim policy for the sum Insured of Rs. 1,50,000/- for himself and Rs. 3,00,000/- for his parents with an exclusion of coverage for heart disease, Diabetes and Hypertension. The claim arose during the policy period from 01.07.2003 to 30.06.2004 under policy no. 121100/48/04/1031. Smt. Jaishree Makhija, mother of Shri Lalit Makhija was admitted in Hinduja Hospital during the period 26.11.2003 to 29.11.2003 and the diagnosis was Degenerative Lumbar Spine along c Canal Stenosis. Shri Lalit Makhija preferred a claim of Rs. 32,630/- to Raksha TPA Pvt. Ltd. After scrutiny of the documents M/s Raksha TPA informed Shri Makhija about the non-admissibility of the claim as per Exclusion Clause 4.1 and 4.10 of the mediclaim policy.

The scrutiny of the file reveals that Smt. Jaishree Makhija was a “K/c/o Hypertension &Diabetes Mellitus on medicines.” As per records, she was admitted with “Leg Bilateral Swelling & giddiness & headache. Bilateral Cataract operation.” MRI Angio showed no fresh changes and MRI L/S showed significant spinal stenosis and the EMG showed bilateral sensory motor demyelinating Peripheral Neuropathy. It is noted that the policy had already an exclusion for heart disease and the ailments/ Complications arising out of diabetes and hypertension. The TPA and the Insurance Company held the view that essentially Smt. Makhija was admitted for evaluation of the status of her inability to move both the legs for which she had collapsed in the bathroom at her residence. The treatment followed thereafter was a series of tests which was diagnosed as “acute exacerbation of lumbar canal stenosis.” The MR Angiography had shown a small chronic infarct in the left basal ganglia / corona radiata.

It is an accepted medical fact that at the advanced age, Lumbar canal disease could be treated conservatively and more with physiotherapy which must have been done in the present case. However, there was no denial that there was positive existence of illness i.e. Lumbar Canal Stenosis and therefore the Company’s rejection cannot be accepted toto. In other words, even accepting the contributory role of DM/HTN, stand alone disease of lumbar canal stenosis becomes a subject for consideration. In the facts and circumstances, I am of the view that the specific exclusions under the policy not withstanding equity would be achieved by allowing 60% payment being the cost of investigation specifically for Lumbar Canal stenosis.

Mumbai Ombudsman Centre
Case No. GI-104 of 2004-2005
Shri Mahesh Sharma
Vs
The Oriental Insurance Co. Ltd.

Award Dated 15.12.2005

Shri Mahesh Sharma an employe of Life Insurance Corporation of India was covered under a Group Mediclaim Insurance Policy issued to LIC by The Oriental Insurance Company Limited for the period 1.4.2003 to 31.3.2004. When Shri Sharma preferred a claim to the Company for his wife Smt. Nanda’s hospitalization for maternity expenses, the TPA of the Company, repudiated the claim as per special policy condition where the policy covers Maternity Benefit Extension only upto 2 children and therefore, the expenses relating to the delivery of the 3rd child would not be payable. Not being satisfied with the decision of the Company, Shri Sharma represented to the Company and not receiving any reply approached this Forum for settlement of his claim. His main contention was that his claim was not for the third child but for the hospitalization

expenses incurred for his wife for the delivery expenses. It is observed from the Group Mediclaim Insurance Policy issued to Life Insurance Corporation of India by The Oriental Insurance Company Limited that as per clause 5.18(3) of the Special Conditions governing Maternity Expenses Benefit and terms of coverage state that "Claim in respect of delivery for only first two 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". Unfortunately the Insured Shri Mahesh Sharma is quibbling on the point for third child and the delivery expenses for the lady and is trying to segregate the two which is totally illogical. The lady only delivers the baby and the expenses incurred arising out of the delivery and subsequent complications if any would all be settled under Maternity Benefit Extension clause as applicable above. In that context the Insured had complete misunderstanding of the coverage.

Based on the above clause this Forum does not find any merit to interfere with the decision of The Oriental Insurance Company Limited.

Mumbai Ombudsman Centre
Case No. GI-319 of 2004-2005
Smt. Sunita L. Sharma
Vs
The United India Insurance Co. Ltd.

Award Dated 23.12.2005

Ssmt. Sunita L. Sharma was first covered under a Group Mediclaim Policy in the year 2001 for a Sum Insured Rs. 15,000/- issued by United India through Unique Mercantile Services Pvt. Limited and on renewal she increased her sum insured to Rs. 2,00,000/-. She was admitted to Krishna Nursing Home for Metastasis of lungs due to Vesicular Mole or Carcinoma Ovaries. When she claimed the amount from The United India they rejected the claim invoking Exclusion Clause 4.1 Aggrieved at the decision, she approached Insurance Ombudsman for redressal.

A joint hearing was held with Smt. Sunita L. Sharma and the representative of United India. However, the Company did not appear which was seriously viewed by this office. Smt. Sunita l. Sharma along with her husband Shri Lalit Kumar Sharma appeared and deposed before the Ombudsman. Shri Lalit Kumar Sharma submitted that the Company's denial of the claim was unfounded. Accordingly he demanded full settlement of the claim.

The analysis of the documents and medical records reveals that even prior to having Mediclaim policy, Mrs. Sunita Sharma was first hospitalized at Snehal Surgical & Maternity Home for Vesicular Mole which was evacuated under G.A. Her first policy was for Rs. 15000/- only and on renewal she increased her sum insured by Rs. 1,85,000/-. Within 3 months, she was hospitalized at Krishna Nursing Home for Metastasis of lungs due to Vesicular Mole or Carcinoma Ovaries and was started with Chemotherapy.

When she preferred a claim, United India rejected her claim as per clause 4.1. However the insured has stated that even though she was hospitalized for Vesicular mole before taking the policy, the same was not cancerous and they submitted a certificate of Dr. Rajashree Karkhanis to that effect. The issue fundamentally important and valid for our consideration would be the fact of hospitalization for some

investigation, in this case, the D&C done earlier twice and again for vesicular mole at Snehal Surgical & Maternity Home before the policy was taken. The relevant medical records were in possession of the insured and if she would have disclosed this hospitalization, Company would have taken appropriate decision on acceptance of the risk. The point is, the disease might not have been diagnosed as malignant at that point of time but that is not for the insured to weigh against the Insurer. His or her job is to disclose health status which was not done. Secondly the intention could be further attributed by the fact that the sum insured of Rs.15,000/- was jacked upto Rs. 2 lakhs, with this knowledge of disease... Based on this analysis the decision of the Company to reject this claim on grounds of 4.1 cannot be faulted.

Mumbai Ombudsman Centre
Case No. IO (MUM) / GI-423 / 2004 - 05
Shri Prasla Karim Ladji
Vs
The New India Assurance Co. Ltd.

Award Dated 30.12.2005

Shri Prasla karim Ladji was covered under a Tailor made Group Annual Mediclaim policy issued by the New India Assurance Co. Ltd., Mumbai R.O.I. for the period from 07.01.2002 to 31.12.2002. The claim arose under Individual Mediclaim Policy no. 130200/48/02/02959 for a period from 30.12.2002 to 29.12.2003. Shri Ladji was hospitalized at National Hospital on 19.06.2003 for Ischemic Heart Disease (IHD) with LVF and got discharged on 23.06.2003. He was again admitted to Suchak hospital on 26.06.2003 to 29.06.2003 and diagnosed as having IHD c SVT c LVF. Shri Ladji preferred claim for reimbursements of hospitalization expenses incurred at both the hospitals. The claim was processed by M/s. Medsave Healthcare Ltd. They rejected the claim under Exclusion Clause 4.3 of the Mediclaim policy which is applicable to disease contracted in first year operation of the policy. The Insured made a representation to the Company which was also not accepted.

The analysis of the records reveal that the past history recorded in both National Hospital and Suchak Hospital tallied with each other to record 'known case of IHD c CABG done 5 years back'. As the hospitalization was in June 2003 it would mean that Shri Ladji was operated for Bypass in 1998. At the hearing, his son could not produce any document to show that he was covered before 1998 nor was he able to show any document which confirmed that the claim was paid. The matter being opened it was scrutinised further to find that there was a policy no. 48/110900/99/16567/004 which could be taken as a Group Hospitalization Policy issued to insurance Awareness Group (IAG). The complainant produced a policy copy which was valid from 01.01.2000 to 31.12.2000 and even if one goes by the year of issue it would appear prominently that at best the policy was issued in 1999 as a Master Policy. Since this was after CABG (Bypass operation) the disease pre-existed as IHD. It is possible that Bandra D.O. got the business later from Emca D.O. and the TPA treated it as a first year policy and mistakenly quoted 4.3 Exclusion Clause which was issued to the Insured. However, New India clarified position and accepted the mistake and rectified it to be Exclusion under Pre-existing illness Clause 4.1 of the Mediclaim policy. Since the Insurance Policy was issued with terms and conditions and 4.1 exclusion excludes all disease existing at the inception of the policy, this Forum does not find any defect in rejecting the claim of Shri Ladji by New India Assurance Company.