Group Mediclaim Policy

Ahmedabad Ombudsman Centre
Case No. 14-002-0044
Sri. M R Shah
Vs
New India Assurance Co. Ltd.

Award Dated : 21-7-2006

Interest for Delay in settlement of Group Mediclaim:: The factum of hospitalisation for Total Knee Replacement operation or reimbursement was not in doubt. Since, the Category List of LIC Group Mediclaim was received very late, the Claims received therein could not be processed and this led to accumulation of pending cases. Again essential requirements like X-Ray reports, Discharge Card, PFC Sticker for TKR etc. had to be called for. There was claim for post-hospitalisation physiotherapy for 40 days. The Claim papers did not contain details thereof and the same had to be called for. The last requirement having been received on 23-12-2005 was settled on 5-1-2006. There was no malafide intention of the Insurer to harass the Complainant and delay the Claim. The Complainant appreciated the situation. The Claim having been paid, the complaint was taken to be disposed with a note of caution to the Respondent to tone up the process of settlement.

Bhopal Ombudsman Centre
Case No. GI/NIA/0606/027
Mr. Rajesh Verma
V/s
The New India Assurance Co. Ltd.

Award Dated 18.07.2006

As per the Complainant he is working in LIC as Sr. Assistant and posted at Shivpuri. He, his wife, two sons and Mother is covered by the Respondent under Group Medi Claim policy for which every month the premium have been deducted from his salary. His Mother went to Jabalpur and was admitted in M/S Mahakaushal Hospital at Jabalpur from 25.11.2004 to01.12.2004 due to sever heart pain. Thereafter she was brought to Gwalior and admitted in J. A. Hospital Gwalior and died on 08.12.2005. He also stated that he had incurred an expense of Rs. 36,308/- for which he had submitted the papers to the Respondent. He was under shock and was busy as he was the only male adult and all the responsibilities are with him. The Complainant stated that his father died on 03.05.2002 and one elder brother died on 09.01.2004. He has to look after his elder brother's wife and his children. The Respondent repudiated the claim on the basis of not intimating the claim in time..

The Respondent stated that this is Group Medi Claim Policy and the same has been issued by their Mumbai office to LIC wherein full terms and conditions of the policy have been furnished. In this instant case papers were received just after 11 months

and 24 days and no intimation of claim was received by them prior to 25.11.2005, as such they have not been able to provide provision of claim by the close of the year as on 31.03.2005. Respondent also contended that the Complainant's employer requested the Respondent's Mumbai office to consider the case sympathetically, in turn the Respondent's Mumbai office informed the Complainant's employer that they can not consider the request as their accounts for this period has been finally closed and all the outstanding claims has been cleared. Further they have not kept any provision for the same in their books of accounts.

It is also observed that the Complainant submitted the claim papers to the Respondent after about 11 months & 24 days and no immediate intimation of claim was given to the Respondent which is a clear cut violation of policy condition as regard to intimation of loss within 10 days. It is also observed that since the Complainant neither intimated about the claim to the Respondent in time nor have submitted the claim papers in stipulated time due to which the Respondent could not make any provision of the claim in their books of account at the close of the year i.e. as on 31.03.2005, hence the claim is not tenable at this stage.

Hence the complaint is dismissed without any relief.

Chandigarh Ombudsman Centre
Case No. GIC/292/NIA/14/06
Sanjeev Verma
Vs
New India Assurance Co. Ltd.

Award Dated 22.5.06

Facts : Sanjeev Verma was covered under Group Mediclaim Policy taken by M/s Rainbow Denim Ltd for the period 11.04.05 to 10.04.06 for sum insured of Rs. 1 lakh. He underwent surgery for removal of kidney stone on 10.6.05. The claim filed by him was repudiated on the ground that it pertained to a pre-existing disease. He clarified to the Sr. BM that he had first felt pain in right kidney a year and half ago. He presumed it to be a gastric problem. He had been undergoing indigenous treatments and consuming pain killers. The pain became so unbearable that he could not sleep during the night on 8.6.05. He discussed the matter with his friend Sarjivan Singla, who had undergone a surgical operation for removal of kidney stone some years ago in Sidhu Hospital Doraha. He took him to the said hospital and lithotripsy was performed. However, during discussion Sarjivan Singla mentioned to the treating doctor that he too was suffering from similar problem 6-7 years ago. It was wrongly recorded in the prescription slip that the complainant had renal colic for past six years. He urged that the claim be considered on merits. He also submitted clarification given by the treating doctor to the effect that as mentioned in the discharge summary, past history was nil which meant that disease was of recent occurrence. However, this explanation was not accepted in view of contradictory reports and the claim was repudiated. Feeling aggrieved, he sought intervention of this office for settlement of his claim.

Findings : On behalf of TPA Dr. Charu stated that the claim was rightly repudiated on the basis of case history as recorded by the treating doctor. The history was recorded as per version given by the complainant that he has been having problem for the past six years. That being so it is a pre-existing disease and as such not covered under the

policy. It was further stated that clarification given by the treating doctor does not have legal sanctity, as it appears to be an after thought.

Decision : Held that an important ingredient in relation to a pre-existing disease as per policy condition is that not only it should be a pre-existing disease, but it should also be in the knowledge of the insured. From the record it is evident that the complainant was not aware of fact that he had a stone in kidney. Even if it is assumed that he may have had the problem for past six years, he was unaware that it was that of kidney stone. Besides it cannot be imagined that a person who has a stone in the kidney will knowingly continue to suffer without being operated upon for such a long time and would wait for an insurance cover for reimbursement of expenses. Therefore, having regard to facts of the case held that repudiation of claim was not in order. The disease being not in the knowledge of the complainant, cannot be treated as a pre-existing disease. Therefore, ordered that claim be paid.

Chandigarh Ombudsman Centre
Case No. GIC/44/NIC/14/07
Subhash Chander Verma
Vs
National Insurance Co. Ltd.

Award Dated 29.8.06

Facts : Subhash Chander Verma was covered under Group Mediclaim Policy under health plus card scheme of HDFC. The policy issuing office was DAB-III Chennai. The policy was effective for the period 10.9.04 to 9.9.05 for sum insured of Rs. 2 lakh. He was hospitalized from 23.2.05 to 28.2.05 as he suffered chest pain. Initially he was admitted in Sarvodya Hospital, Faridabad on 16.2.05. Again on 23.2.05 he was admitted in Metro Hospital, Faridabad where he underwent angioplasty. He sought cashless facility for an estimated expense of Rs. 1,56,711 against which it was granted for Rs. 26,666 only by M/s Family Health Plan Ltd. The hospital raised the final bill for Rs. 1,47,711. He submitted bills on 12.3.05 for balance amount amounting to Rs. 1,18,052 together with relevant documents. Thereafter he sent several reminders to TPA on 6.4.05, 7.4.05, 6.5.05 and again on 26.6.05 for settlement of claim at the earliest. However, he did not receive any reply. Feeling aggrieved he filed a complaint for getting the claim settled at the earliest.

Findings : The Group Policy provided a sum insured of Rs. 50,000 as the basic sum insured and Rs. 1,50,000 as tertiary care sum insured in respect of specified major diseases. For the first claim of Rs.23,334, cashless facility was provided. For the second claim amount of Rs.1,42,711, after concession of Rs. 5000, a sum of Rs.26,666 was paid, which was the balance against the policy's basic sum insured of Rs. 50,000. The complainant preferred the claim for settlement of balance amount of Rs.1,16,045 paid by him to the hospital authorities. It was declined on the ground that the conditions stipulated in the policy provides that "the tertiary care sum insured could be utilized only for major diseases which included open heart surgery". As the present claim in respect of angioplasty done at Metro Heart Institute did not fall in this category, it was declined as per the terms and conditions of the policy. He learnt about the repudiation of claim, but the reasons for the same were not known to him, as he had not received any formal communication to this effect.

Decision : Held that the claim has rightly been settled. However, the complainant remained in the dark regarding the reason for non-payment of balance claim amount.

He kept on following up the matter with the insurance company and spent Rs. 2000 on correspondence and telephone calls made to the insurer and the TPA. The complainant was not given any reply for a year. Ordered that Rs.1500 be paid to the complainant on ex-gratia basis as token compensation for the harassment suffered by him.

Chandigarh Ombudsman Centre
Case No. GIC/207/NIC/11/06
B.J. Shah
Vs
National Insurance Co. Ltd.

Award Dated 17.8.06

Facts : B.J. Shah was covered under a group mediclaim policy for the period 10.12.04 to 9.12.05 for sum insured of Rs. 3 lakh. He underwent bypass surgery at Escorts Hospital Faridabad and incurred an expenditure of Rs. 2,78,140. He filed the claim with Family Health Plan Ltd, the TPA. It was repudiated on the ground that hospitalization was for management of an ailment relating to a pre-existing condition. He has been a policyholder since 1994. At the time of purchase of policy he had disclosed that he had undergone angioplasty in 1989 and policy was issued without any exclusion. He contended that grounds of repudiation were not in order as 16 years is too long a period for any condition to remain active without any symptoms. He stated that claim was genuine and should be paid to him.

Findings : The angioplasty undergone by him in 1989 was duly disclosed at the time of purchase of policy in 1994. He underwent bypass surgery 16 years later. During all these years no claim was filed. He argued that though he suffered from heart ailment way back in 1989, he was fully cured after angioplasty. The disease recurred in 2005 and recurrence cannot be equated with pre-existing. Besides, in case the claim relating to heart ailment was not payable, the policy should have been issued after excluding the specific disease. Dr. Monga from whom the opinion was taken expressed the view that clinically heart disease once incepted is never completely cured and treatment by angioplasty is considered as a conservative surgical intervention. He further opined that a person with or without treatment with angioplasty or medical treatment can remain without complaints or further exaggeration of the disease or can remain symptomatic with complaints like unstable angina with disease aggravating slowly. It cannot be concluded that the insured was completely cured merely because he did not have any complaint since 1989.

The complainant in turn forwarded another opinion of Dr Tarun who concluded that as there was no recurrence for 16 years, the insured could be treated as having been cured and thus it was not a pre-existing disease. The opinion was forwarded to the insurer for comments. Rather than offering comments, the Branch Manager, BO-I Faridabad informed vide letter dated 13.7.06 that liability has been accepted. The insurer was asked to clarify the basis of accepting the liability. In response, a copy of second opinion of Dr Monga given at the behest of the insurer, partially reviewing his earlier opinion was sent on the basis of which the claim was accepted. The perusal of second opinion revealed that Dr Monga essentially reiterated his earlier opinion, except that he mentioned that if there are no complaints and the person is not on medicines, he could for practical purposes be treated to have been cured.

Decision : As the claim was settled and grievance redressed, no further observation would have ordinarily be warranted. However, the manner in which the claim was

settled does raise some issues of propriety. The claim was repudiated on the ground that it pertained to a pre-existing disease. The complainant contended that it was recurrence and not a pre-existing disease. Therefore, the key question is whether it was to be treated as a pre-existing disease or recurrence. The complainant admitted that he suffered from heart disease prior to purchase of policy, way back in 1989, but claimed that as he did not have any complaint thereafter, it be treated as recurrence. However, Dr Monga lucidly expressed the view that "clinically heart disease (CAD or IHD) once incepted is never completely cured and treatment by PTCA (Angioplasty) is considered as conservative surgical treatment". The complainant expressed reservation against this opinion on the ground that it was given by a doctor on the panel of the insurer. For the satisfaction of the insured a copy of opinion was given to him, in good faith. He obtained another opinion from one Dr. Tarun, who gave cryptic definition of 'cure' and concluded that in this case as there has been no recurrence of the disease for sixteen years, the complainant could be treated as having been cured and thus it was not a pre-existing disease. Dr Monga reiterated that clinically heart disease cannot be considered as cured during or after completion of treatment- medical or surgical, yet any disease for which there are no specific complaints and patient is not on any medicines, can for practical purposes be considered as cured. He left it to the judgement of underwriter to take a decision regarding admissibility of the claim. By placing reliance on this somewhat non committal opinion, the claim was settled.

The insurer, for whatsoever reasons performed a somersault by admitting the liability on the basis of qualified opinion of Dr. Monga. Dr Monga had earlier rightly opined that heart disease once incepted is clinically never completely cured. In view of this categorical opinion, hair splitting between recurrence and pre-existing was uncalled for. However, the process of settling the claim casts a shadow of doubt as to whether the advice was managed or maneuvered to facilitate settlement. As the complaint was pending in this forum, even if the liability was to be admitted, the forum should have been taken into confidence Having held up the claim for so long, settling it in post haste, without furnishing clarification sought by this forum is rather objectionable. Some questions that remain unanswered are: (a) why reliance was placed on the second qualified opinion given by Dr. Monga? (b) what was the need for sticking so long to the view that the claim related to a pre-existing disease, if the liability was to be eventually admitted? and (c) why was this forum not taken into confidence before admitting the liability which was earlier contested vehemently. There is need to look into these issues in the interest of probity. With that end in view, ordered that a copy of this order be sent to the Chairman, National Insurance Company Ltd for his information and further necessary action.

Chandigarh Ombudsman Centre
Case No. GIC/299/OIC/14/06
Veena Duggal
Vs
Oriental Insurance Co.

Award Dated 17.8.06

Facts : Veena Duggal is an employee of Life Insurance Corporation, Unit –II, Patiala. A Group Mediclaim Policy was taken by Life Insurance Corporation of India for its employees from OIC for the year 2003-04. She was admitted in Sadbhavna Medical and Heart Institute on 1.11.03 due to complaint of dizziness, severe headache and

breathlessness. She submitted medical papers to M/s Paramount Health Services, Chandigarh, but claim was not settled despite her personal visits to the Divisional Office. She had to submit papers repeatedly. Every time she followed up with the insurer she was told that her claim was under process. She stated that she is patient of ILD (Interstitial Lung Disease) and was given oxygen at Sadbhavna Medical and Heart Institute after admission and CT Scan of her lungs was also done. She was referred to AIIMS, Delhi due to deterioration in her condition. She was advised oxygen inhalation for 16 hrs. Due to her serious condition she remained on leave for one year and five months. She sought intervention for getting the claim settled in view of her serious conditions.

Findings : The claim was repudiated by TPA after concluding that patient was admitted for investigations and the line of treatment provided could have been taken on OPD basis. In the discharge summary the timing of admission and discharge had been written with another hand and ink. Besides, the patient was discharged in a satisfactory condition and she was advised home-O2 therapy. It was, therefore, inferred that admission for 24 hours was managed to get the claim. Besides it was pointed out that no specific reference was made by hospital authorities for treatment in AIIMS On behalf of the complainant it was stated that on the date of admission she was in a precarious condition and suffered breathlessness and could not have been managed at home. He further pointed out that he was verbally advised to refer her to AIIMS and she has been taken to AIIMS. He also produced OPD slips issued by AIIMS.

Decision : Held that there is no doubt that the complainant's illness is serious, chronic and prolonged. Her ailment relates to some serious lung disorder, which is aggravating day by day and she suffers from breathlessness and has to be put on oxygen frequently for prolonged duration. In this background I would have no quarrel with the complainant that she was in a bad condition on the day of admission. Therefore hospitalization was necessary. The opinion of TPA that hospitalization was not warranted is not to be reckoned as the last word on the subject. As a doubt has been expressed that the time of admission and discharge are in different handwriting, the insurer is free to have it verified from the hospital within a period of ten days. In case the time recorded in the discharge slip is correct, the claim be settled.

Chandigarh Ombudsman Centre
Case No. GIC/135/NIA/11/07
Parveen Garg
Vs
New India Assurance Co. Ltd.

Order dated: 14.09.06

Facts : Parveen Garg is covered under Group Mediclaim Policy taken by LIC for its employees from NIA. He underwent dental flap surgery due to periodontitis. He filed claim papers and bills with the insurer through DO Ludhiana. The claim was repudiated on the ground that there was no hospitalization. He contended that during every sitting, he was hospitalized for four hours. He also got it confirmed from the treating doctor. However, there was no response from the insurer despite reminders. He stated that he had spent Rs. 25,000 on surgery during 27.11.05 to13.1.06. He could not bear so much expenditure and claim was repudiated without assigning any cogent reasons.

Findings : The Divisional Manager informed vide letter dated 21.8.06 that under Group Mediclaim Policy expenses are reimbursable only in the event of hospitalization for medical/surgical treatment. The complainant suffered from periodontitis and was not hospitalized. He took treatment on different dates. However as per policy conditions hospitalization is a must. It was also stated that the treatment taken by the complainant fell under exclusion clause 4.7 of the policy. The terms and conditions of the policy are different from the general mediclaim policy which permits reimbursement of charges for dental surgery for hospitalization of less than 24 hours. In case of policy for LIC employees, as per condition 2.3, exemption for purposes of reimbursement of dental treatment for less than 24 hours is not provided.

Decision : Held that repudiation of claim was in order as per terms and conditions of the policy. However grounds of repudiation should have been conveyed elaborately to the complainant explaining in detail why the claim was not payable. In that event, there would have been no misgivings.

Chennai Ombudsman Centre
Award No. 11.05.1323 / 2006-2007
Shri. K. Manichandar
Vs
Oriental Insurance Co. Ltd.

Award Dated 25.04.2006

The complainant contended that his father was covered under Group Mediclaim policy with Oriental Insurance Co. ltd Chennai from 01.04.2003 onwards and the same was continuously renewed. His father was hospitalised from 6.6.2005 to 17.6.05 and was diagnosed to have insignificant Two Vessel Artery Disease following an angiogram done on 08.06.2005 and a complete Heart Block for which a permanent Pacemaker implantation was done on 10.06.2005. The complainant stated that his father was hale and healthy until he met with an accident in 2003 and the discharge summary states that the patient underwent treatment for Hemi Replacement Arthroplasty after an accident and under the past medical history, it has been clearly stated that no previous history of DM,HT,PT,BA,IHD and Jaundice. The insurer repudiated the claim stating CAD/Pace maker implantation was a pre-existing one.

The Insurer stated that there was a contradiction in the discharge summary given by the Sri Ramachandra Medical Centre and the one given by Dr. G. Viswanathan. When questioned why they had not considered the earliest Discharge Summary, which had no history of pre-existing diseases, they said that they could not get the same from the Hospital. When asked why they link implantation of pacemaker, which was meant for improving the pulse rate to CAD, the insurer said that the proximate cause would be hypertension.

The forum after perusing the documents observed that the echocardiogram showed very minimal changes in the coronary arteries and based on the suspicion of coronary artery disease indicated in the earlier medical records an angiogram was done on him, which again revealed insignificant coronary artery disease. The pacemaker was implanted to clear the complete Heart Block. It was also observed that the only finding as recorded in Sep 2003 was the RBBB, which alone was not an indication that the patient might have developed a complete Heart Block in future. Both the findings in Sep2003 and in 2004 are subsequent to the inception of the policy in April 2003 and there are no medical records of the insured being aware of the problem prior to Apr

2003. Hence the Forum felt that the Insurer had not conclusively established the pre-existence of the disease and they are directed to settle the claim.

Chennai Ombudsman Centre
Award No. 11.02.1332 / 2005-2006
Shri K.N. Krishnan
Vs
New India Assurance Co Ltd

Award Dated 17.05.2006

The Complainant was an LIC employee covered under LIC Group Mediclaim Policy with The New India Assurance Co Ltd. He was hospitalised for EECP and submitted claim papers for reimbursement. However the claim was repudiated on the ground that his claim did not meet with the definition of hospitalization (inpatient) treatment and the admission in the hospital for one day was for the purpose of evaluation followed by a series of 35 outpatient EECP sessions.

The insured contended that he was an inpatient for more than 1 full day followed by 35 EECP sessions of treatment and eligible for the claim as per Condition No.2.4 of the policy and he was eligible even if the hospitalisation was for less than 24 hours.

The forum pointed out that the Cardio Thoracic Surgeon, considering the condition and age of the complainant recommended for EECP instead of CABGS. The complainant was hospitalized from 22.06.2005 to 24.06.2005 and taken treatment for EECP from 13.07.2005 to 22.08.2005. Therefore, the insurer is liable under the policy under the head 'Post Hospitalization' which covers relevant medical expenses incurred during the period up to 60 days after hospitalization on disease/illness. Hence direction was given to process and settle the claim as per terms and conditions of the policy.

Chennai Ombudsman Centre
Award No. 11.02.1006 / 2006 - 2007
Shri C.A. Ekambaram
Vs
M/s New India Assurance Co. Ltd

Award Dated 15.06.2006

The complainant represented that he and his wife were covered under LIC Group Mediclaim Policy with M/s New India Assurance Co. ltd. Suddenly his wife had severe pain in her leg and got admitted in the hospital. Operation was conducted and the corn was removed. The insurance company repudiated the claim stating that as per medical opinion, the present hospitalisation could have been done as outpatient.

The insurer contended that the complainant was not having any sickness or illness or any complication warranting treatment under hospitalisation. The patient was hospitalised for 24 hours and one minute, just to bring the claim within the scope of the Mediclaim policy. The insurer stated that the Doctor who performed the excision of the corn has written that the patient was having a corn in her right foot, which needs to be excised under local anesthesia and had not advised the insured for hospitalisation.

The Ombudsman observed that the medical documents do not reveal any severity or emergency in the condition of the patient, which warranted hospitalisation. The insured has not produced any record to establish that the admission was done as per the direction of the doctor or by recording of the severe condition of the patient. Hence

Ombudsman felt that the insurer's decision cannot be faulted with and Ombudsman dismissed the complaint.

Chennai Ombudsman Centre
Award No. 11.02.1042 / 2006 - 2007
Shri. M.V. Sankaran
Vs
New India Insurance Co. Ltd.,

Award Dated 28.08.2006

The complainant represented that he was a retired LIC employee and his family were covered under the LIC Group Mediclaim Policy with New India Assurance Co. ltd. His wife was hospitalised from 23.01.2006 to 25.01.2006 for treatment of Diabetes Mellitus. His claim was rejected by the insurer on the ground that the treatment could have been given as Outpatient, invoking exclusion clause No. 4.10 of the policy.

As per discharge summary for the year 2005 and 2006, it has been observed that the complainant's wife was hospiatalised for treatment and management of her Diabetes Mellitus and also number of other diagnostic tests like ECG, Echocardiogram, Treadmill test, Ultrasound of abdomen etc., have been done. The Mediclaim Policy covers only necessary and reasonable medical expenses incurred by the insured. Hence, direction was given to the insurer to pay the expenses incurred directly relating to the lab tests, other diagnostic tests, nursing and medication for the control of Diabetes Mellitus and disallowed other items which are not connected to the same.

Chennai Ombudsman Centre
Award No. 11.04.10777 / 2006 - 2007
Shri. P.S. Sundaram
Vs
United India Insurance Co. Ltd.,

Award Dated 22.08.2006

The complainant represented that he had taken a Mediclaim Policy for the period 01.11.2005 to 31.10.2006 under the Group Mediclaim Scheme offered by United India Assurance Co. Ltd. His wife was hospitalised on 02.12.2005 and she succumbed to her illness on 18.12.2005. He preferred a claim with the insurer, which was declined by them on the ground that his spouse was not covered under the policy.

The insurer contended that the proposal was submitted requesting for the coverage of Mr P S Sundaram only, the premium also paid only for Mr. P S Sundaram as per the premium schedule and no cover was sought and no premium was paid to cover his spouse, hence their repudiation was in order.

It has been observed that the complainant was trying to take advantage of pre printed form of the insurer i.e Income tax certificate issued for the purpose of tax benefit. It was established by the insurer that the proposal was submitted requesting for the coverage of Mr P S Sundaram and premium was also paid only to cover the complainant and it was not established by the complainant he had ever had an intention to cover his spouse under the policy, the complaint was dismissed.

Guwahati Ombudsman Centre
Case No. 14-002-0117/05
Mrs. Purnima Goswami
Vs
The New India Assurance Co. Ltd.

Award Dated 15.05.06

Facts leading to grievance of complainant : Complainant's husband Late Munindra Goswami, (as per the complaint) was covered under Group Mediclaim Policy of the New India Assurance Co. Ltd. (insurer) since 01-04-2001 under agency code 00202/48H as a LICI Zonal Club Member. During life-time he submitted on 24-03-2004 a claim for the re-imbursement of expenses amounting to Rs.80,000/- in connection with his treatment but her grievance is that after the death of her husband on 02-04-05 in spite of repeated pursuation this claim has not been settled yet, although another claim submitted in Feb.2005 was settled on 10.06.05 and hence this complaint seeking a relief of Rs.80,000/- with interests.

Counter-statements from opp.party/insurer : Without disputing the principal facts, although pointing to some minor discrepancies in name and agency code number etc., which may suggest confused identity of insured, the insurer/opposite party submitted that Group Medi-Claim Policy was issued to LICI covering Club-Member of its different categories of employees for period 01-09-2003 to 31-08-2004 and Late Munindra Goswami was a ZM Club Member with agency code 00202/48 H covered for a sum insured of Rs.60,000/-. That said Goswami reported to have undergone treatment at Dispur Polyclinic and Nursing Home w.e.f. 11-2-04 to 18-02-04 incurring expenses of Rs.43,299/- but during processing of the claim, it was observed on perusal of discharge certificate that the insured was diagnosed as suffering from chronic Liver Disease (Ethanol related) , i.e., a disease due to intake of alcohol, which is excluded from the scope of Group Mediclaim Policy under its Exclusion clause no.4.8. That receiving a representation the insurer approached the T.P.A. (Third Party Administrator) who reviewed the matter but maintained that the claim is not admissible.

Decision & Reasons : The claimant forwarded discharge certificate without any enclosures notwithstanding the fact that it has been mentioned in the discharge certificate that investigations were done and reports enclosed. The disease has been noted as

"C.L.D. (Ethanol related) e. H.E."

And it is explained in the self-contained Note that C.L.D. i.e., 'Chronic Liver Disease (Ethanol related) means disease which was due to intake of alcohol which act is excluded from scope of the Group Mediclaim Policy under its exclusion clause no. 4.8. Exclusion Clause No.4.8 is reproduced as below –

> "4.8 Convalescence, general debility, "Run-down" condition or rest cure, congenital external disease or defects or anomalies, sterility, venereal disease, intentional self-injury and use of intoxicating drugs/alcohol."

It may be noted also that death certificate forwarded by the insurer shows death of the insured was about 13/14 months later on 02-04-05 and cause of death was same/similar disease, i.e.,

Chronic Liver Perenchymal Disease

- C Secondaries in both liver lobe
- C Haemorrhagic ascitis followed by

  Hepatic Encephalopathy (H.E.).

Order : Concluding, we find interference from this end in the decision of insurer is not warranted. Matter stands closed accordingly.

Hyderabad Ombudsman Centre
Case No. G-032/2006-07
Sri. K. Basavaraju& Smt. Venkayamma
Vs
United India Insurance Co. Ltd.

Award Dated 29.08.2006

Admited For Stats. Purposes : The complainants were insured under a Group Mediclaim Policy issued to savings bank account holders of Andhra Bank. Smt. Venkayamma underwent treatment as in-patient from 8.10.2004 to 29.10.2004 with complaints of weakness of left upper and lower limbs since one day. While processing the request for Cashless facility, the hospital conveyed to the TPA that the patient was a known case of HTN, DM and IHD and she had Congenital Mitral Stenosis. Due to the fact that his wife was unable to ambulate by herself, and needed his assistance even for basic activities, the papers were not collected from the TPA. Further, she also sustained a fracture of femur during this period which only added to the delay. He stated that she was treated for Congenital Mitral Stenosis and was quite healthy all these 30 years and had also given birth to 3 children. The illness now suffered by her was a paralytic stroke and her claim merited settlement. The insurer contended that the insured was admitted within 38 days of commencement of the policy. The treatment was more in line with Congenital Heart Disease; the ailment appeared to be Cardio Embolic stroke which was a pre-existing condition. The claim was submitted about 14 months after the treatment was taken whereas it was mandatory to submit the bills within 7 days.

Held : In view of the treating hospital recording history of HTN and DM for the past 3 years and as the insured could not produce any correction or supporting evidence from the hospital the insurer's decision is upheld.

Hyderabad Ombudsman Centre
Case No. G-033/2006-07
Sri. T. Veerabhadraiah
Vs
United India Insurance Co. Ltd.

Award Dated 29.08.2006

Complaint Admitted : The complainant, his wife and family were covered under a group Mediclaim policy issued to savings bank account holders of Andhra Bank for the period 04.10.2004 to 08.06.2005 for a family floater sum insured of Rs. 1,00,000/-. For the previous 5 years, from 1999-2004, both the complainant and his wife had individual policies for Rs. 50,000/- and Rs. 30,000/- respectively. They were eligible for Cumulative bonus of Rs. 5000 and Rs.7500 respectively. The complainant's wife

reported headache during the 2nd week of October, 2004 and was treated for URTI, Sinusitis and Migraine. She was admitted on 07.12.2004, as the CT scan of the brain revealed the presence of a tumour. She was operated on 09.12.2004. The TPA approved the claim for Rs. 30,000/ since the limit on the earlier policy prior to enhancement was Rs. 30,000. They maintain that when the sum insured was enhanced from Rs. 30,000 to Rs. 1,00,000 in October the illness for which the claim was made was pre-existing and so the enhancement of Rs. 70,000/ was not allowable. The complainant contended that there was no enhancement as the sum insured was selected by rounding the total sum insured under the previous year's policy including bonus. He would have opted for a higher sum insured if he was aware of the disease. He came to know of his wife's disease only after CT scan which was done in December, 2004. When he sought the policy, his wife was in good health and had no complaints/ symptoms. The insurer contended that the tumour was slow growing and progressive in nature. As the ailment takes a long time to develop and as the insured was covered for only 2 months with the enhanced sum insured as on the date of admission, the TPA concluded that the ailment manifested prior to commencement of the policy.

Held : The medical papers including the Discharge Summaries and prescriptions are quite categorical that the earliest symptoms of the headache were only in the 2nd week of October even at which time it was diagnosed as a minor ailment. Thus on the facts and evidence on record, the insured person was unaware of the ailment or any symptom thereof when the proposal for the current insurance was made. The insurers are directed to pay.

The complaint is admitted for statistical purposes.

Hyderabad Ombudsman Centre
Case No. G-036/2006-07
Sri. N. Rajasekhara Rao
Vs
New India Assurance Co. Ltd.

Award Dated 14.09.2006

Recommendation : The complainant, an employee of LIC of India covered himself and his wife under the Tailor-made Group Mediclaim policy for a sum insured of Rs. 60,000/. His wife was admitted to hospital on 7.10.2005 with complaints of Ruptured Ovarian Cyst and underwent Right Oopherectomy. The complainant incurred an expenditure of Rs. 53,848/. Even after formally lodging the claim with the insurer, there was no positive response from them. He was orally informed that the claim was delayed as the charges were found to be on the high side. The insurer's doubts regarding the repeated blood tests and bedside x-rays was due to the fact that his wife was a diabetic and the treating doctor prescribed the tests on a hourly basis. Further even the x-rays were done only under the advice of the doctor and not out of his fancy. The insurer contended that their panel doctor was of the opinion that the charges levied by the hospital for the post-operative tests were on the high side. The insured did not submit either the Discharge Summary or the Case sheet.

Held : The insurer inordinately delayed the settlement of the claim. The insurer ought to have informed the insured the reasons for their inability in settling the claim for the amount claimed or should have sought clarifications from the treating doctor/hospital which they did not do. The insurer insisted that the insured would be reimbursed the

amount on submission of all test reports. However if the insured was unable to submit them, they were willing to settle the claim on "as if" non-standard basis @ 75% of the amount claimed. The complainant expressed his inability to submit all the test reports and also liaison with the hospital for the same. Since both parties agreed for a mutual settlement of the claim @ 75% of the amount claimed, Rule 15 of the RPG Rules,1998 was invoked and settlement as agreed by both parties recommended.

Hyderabad Ombudsman Centre
Case No. G-039/2006-07
Sri B. V. A. Rama Sastry
Vs
New India Assurance Co. Ltd.

Award Dated 14.09.2006

Complaint Partly Admitted : The complainant, an employee of LIC was covered under the group Mediclaim for a sum insured of Rs. 80,000/-. He was admitted on 25.01.2006 with complaints of severe abdominal pain. He was operated upon for stones in the gall bladder. Out of the total expenditure of Rs. 26,251/-, he was reimbursed an amount of Rs. 20,415/-. The complainant contended that the surgery was not a planned one. He paid the amount to the hospital as per the bill raised by them. He was unaware of the gender and the name of the surgeon who assisted the main doctor who performed that operation. Expenditure for HIV test, laparoscope, etc. were all prescribed by the doctors and billed to him by the hospital authorities. The insurer contended that they deducted the amounts as they were excluded under the scope of the policy. As regards the charges claimed for the Assistant surgeon, it is evident from the Case Sheet that this doctor did not assist the main surgeon on that day for this surgery.

Held : The insurer did not doubt the genuineness of the claim but only raised objections to some heads of expenditure. Charges claimed for HIV Test is not for the treatment of the disease, but a routine blood test prescribed by every hospital. The insurer's disallowance of Rs. 3150/- for Laparoscope, Anaesthesia. Gas, Duty Doctor and OT is extremely unjustified. Since the complainant did not demand this facility at the time of admission/ surgery, the insurer ought to have sought an explanation from the hospital instead of unilaterally reducing the amount. As regards the charges for the Asst. Surgeon, the insurer's stand is upheld. The insurers are directed to pay Rs. 3700 from the amount disallowed as per the narration given above.

The complaint is Partly Admitted.

Hyderabad Ombudsman Centre
Case No. G-040/2006-07
Sri N. l. Harnathka
Vs
New India Assurance Co. Ltd.

Award Dated 21.09.2006

Complaint Dismissed : The complainant and his wife were covered under a group Mediclaim policy given to holders of Canara Bank Credit card holders for the period 1.11.2004 to 31.10.2005. From 20.04.2005 to 19.05.2005. Sri Harnathka underwent treatment at Dr. Modi's Karjat Hospital for manipulation of spine and knee, oil therapy, steam therapy, mud therapy, and physiotherapy. He incurred an expenditure of

Rs.48000/. His wife also underwent treatment at the same place during the same period and she was also administered the same treatment. Her claim bill was for Rs. 10,000/-. The TPA rejected both the claims on the ground that the treatment was by naturopathy methods without medication or medical monitoring. The complainant contended that he consulted the expert as local doctors at Guntur failed to treat him. The same insurer had settled a similar claim from the same hospital for the same illness pertaining to his aunt. The insurer contended that the treatment by naturopathy was excluded from the scope of the policy. Further they stated that the treatment taken does not warrant in-patient treatment and therefore was out of the scope of the policy. As far as the claim for the spouse is concerned, physiotherapy is not a scientific treatment for blood pressure. Further there was no discharge summary or case sheet notes as is given in any hospital where in-patient treatment is administered.

Held : On perusal of the papers of the earlier claim in respect of the complainant's aunt, it is observed that the ailment suffered by her is not the same as that of the complainant. The insurer's stand that each claim has to be viewed on merits is noted and accepted. It is evident that no allopathic line of treatment which included drugs was given to the persons insured. The line of treatment was definitely not allopathic. The complaint is dismissed.

Kochi Ombudsman Centre
Case No. IO/KCH/GI/03/2006-07
Sri.M.Radhakrishnan
Vs
The New India Assurance Co.Ltd.

Award Dated 26.4.2006

The complaint under Rule 12(1)(b) read with Rule 13 of the RPG Rules relates to repudiation of a claim by the insurer under the Group medi claim policy issued to LIC employees. The complainant – a retired LIC official had undergone Root Canal treatment for "Caries Exposed Tooth" between 29.5.2005 and 26.7.2005 at Thoppil Medical & Dental Specialists Centre, Thrissur. Root Canal treatment, which did not required hospitalization, is excluded from the policy under Cl.4.7. The complainant was unable to prove that neither hospitalization was necessary nor that hospitalization was there at all. The fact is that sporadically between May 2005 and July 2005, he had obtained medical treatment at the above hospital. Since the conditions enshrined in the policy were not satisfied, the insurer was right in rejecting the claim and hence the complaint was dismissed.

Kochi Ombudsman Centre
Case No. IO/KCH/GI/05/2006-07
Sri.K.M.Jose
Vs
National Insurance Co.Ltd.

Award Dated 03.05.2006

The complaint under Rule 12(1)(b) read with Rule 13 of the RPG Rules, 1998 relates to repudiation of a Medi claim by the respondent insurer. The complainant was member of a Group Mediclaim policy floated by the insurer for the benefit of M/s.Janaseva Foundation, Thrissur by virtue of which the members were covered for insurance benefits for a period of 5 years from 23.01.2001 to 22.1.2007. The complainant had

undergone coronary angioplasty on 31.12.2004 and the insurer had rejected the claim for suppression of pre-existing diseases. The complainant himself admitted before this Forum that he was suffering from Diabetes and hypertension from 1990. The medical certificate issued by the Doctor at Lisie Hospital confirmed the Diabetes problem from 1988 and hypertension for an unknown duration. The proposal form submitted by the complainant had not disclosed any of these adverse health conditions. In such circumstances, the suppression of pre-existing diseases being very clear, the insurer's action in repudiating the claim and canceling the policy was found justifiable. The complaint was therefore dismissed.

Kochi Ombudsman Centre
Case No. IO/KCH/GI/06/2006-07
Smt.Nirmala C
Vs
New India Assurance Co.Ltd.

Award Dated 16.05.2006

The complaint under Rule NO.12(1)(b) read with Rule 13 of the RPG Rules, 1998 arose out of repudiation of a claim under the Group medi claim policy issued by the respondent covering LIC employees. The complainant – an employee of LIC had undergone dental treatment at Lakshmi Hospital, Aluva. She was in the hospital for one day 16-17/7/2005. The nature of illness was described as Dento Alveolus abscess that was not a disease as much as a degenerative disorder of teeth due to wear and tear. This condition was an exclusion under the policy vide Cl.4.7 of the terms and conditions thereof. The treating Doctor had also not mentioned it as a disease requiring hospitalization. Out of an amount of Rs.5000/- claimed for by the complainant, most part of the money was in relation to root canal treatment, which is normally done in O.P. sittings. In these circumstances, the insurer had repudiated the claim and this Forum found no reason to interfere with the said order. The complaint was therefore dismissed.

Kochi Ombudsman Centre
Case No. IO/KCH/GI/9/2006-07
Sri.D.SureshKumar
Vs
United India Insurance Co.Ltd.

Award Dated 01.6.2006

The complaint under Rule 12(1)(b) read with Rule 13 of the RPG Rules, 1998 relates to partial rejection of a claim under the Group medi claim policy issued by the respondent covering members of the Alappuzha Police Employees Co.Op.Society, which specifies a weekly compensation of Rs.1000/- to the affected member. The complainant sustained a fall from his motor bike on 18.4.2005 and had a fracture of middle finger – left hand. The hand was put on plaster and the complainant was advised 45 days of rest from 19.4.2005. However, on removing the plaster, the complainant had severe pain on the shoulder most probably as the hand was on plaster for a very long time and hence he was advised rest for another 17 days. Due to some overlap of information, the insurer had gained an impression that the shoulder pain was due to another

accident. The complainant clarified that there was no second accident as mistaken by the insurer. The shoulder pain was as a result of the immobility of the hand for a long time and therefore physiotherapy was required. The insurer had allowed compensation only for 6 weeks @ Rs.1000/- per week (Rs.6000/-) whereas the total claim for the extended period of medical leave included came to 8 ½ weeks. Since the matter was properly explained and proved by medical records the insurer was advised to revise the compensation to Rs.8500/- (for 8 ½ weeks) after disallowing 2 days for overwriting in the Medical Certificate. The complaint was thus disposed of on merits.

Kochi Ombudsman Centre
Case No. IO/KCH/GI/13/2006-07
Sri.Jeffry Padamadan
Vs
National Insurance Co.Ltd.

Award Dated 28.6.2006

The complaint under Rule 12(1)(b) read with Rule 13 of the RPG Rules, 1998 relates to delay in settlement of a medi claim by the insurer. The Medi care Service Club, Kolkata had insured its members under a Group Medi claim scheme. The complainant was a member there under. He had undergone medical treatment for gall bladder surgery in May 2004. According to the complainant, the claim papers including medical bills were handed over to the local representative of the Medi care Service Club. However, it is said that the Medi care Service Club or the T.P.A. had received no documents till December 2005. In the meantime, the complainant had addressed a representation to the Chairman of the Insurance Company. The complainant could not produce any reliable documentary evidence for having submitted the papers in May 2004 itself; nor there was any reliable follow up. In any case, the claim was settled by the insurer in March 2006 after disallowing certain small amounts for non-submission of bills etc. On the whole the complainant's contention of undue delay by the insurer could not be substantiated by him and hence the complaint was dismissed.

Kochi Ombudsman Centre
Case No. IO/KCH/GI/35/2006-07
Shri.P.Parameswaran
Vs
Oriental Insurance Co.Ltd.

Award Dated 20.9.2006

The complaint under Rule No. 12(1)(b) read with Rule 13 of the RPG Rules, 1998 relates to partial repudiation of a medi claim under the Group Medi claim policy covering the employees and ex-employees of the respondent company. The complainant - a retired employee of the company – was contributing to the scheme. His wife Mrs.Jayanthy had undergone Ayurvedic treatment for "Sandhigatha Vadam and Sirasoola" at Keraleeya Ayurveda Samajam Hospital & Nursing Home for 17 days from 3.3.06 to 19.3.2006 and barring the diet charges of Rs.2550/-, the rest of the claim was settled by the company. The company argued that the diet charges were not an integral part of the bill as it was mentioned in a separate bill. On verification of records, it was found that the boarding and lodging charges levied were genuine and the diet charges did constitute an integral part of the main bill. In Ayurvedic treatment, the patients take only the food served by the hospital as prescribed by the Doctors and in the case on

hand it was clear that the diet was supplied by the hospital only and therefore there was no scope for any confusion. The insurer was advised to settle the diet charges of Rs.2550/- and the complaint was disposed of.

Kochi Ombudsman Centre
Case No. IO/KCH/GI/34/2006-07
Sri.P.Sivadasan Nambiar
Vs
United India Insurance Co.Ltd.

Award Dated 19.9.2006

The complaint under Rule 12(1)(b) read with Rule 13 of the RPG Rules, 1998 relates to repudiation of a claim under the Andhra Bank Arogyadaan – group medi claim policy issued by the respondent covering SB Account holders of the Bank. The complainant and his wife were members of the scheme for Rs.1 lakh each. Originally the policy was issued on 9.6.2004 and it was renewed for a further period of one year from 9.6.2005 to 8.2.2006. In the proposal form itself, the complainant had mentioned that he was slightly hypertensive under oral medication. Suddenly on 13.8.2005, he had a chest pain and undergone investigation like X-ray, ECG, ECHO etc. He was diagnosed to be having Coronary Artery disease with hypertension and dyslipedemia. The complainant had, therefore, undergone By-pass surgery at Malabar Institute of medical Sciences, Calicut at a cost of Rs.1,31,040/-. The claim was rejected by the TPA/insurer saying that the diseases were pre-existing as the complainant was under medication for hypertension. However, there was no evidence to show that the controlled hypertension, which was already disclosed in the proposal was the solitary cause for the sudden heart problem. The complainant had no heart problem before 13.8.2005.Since it should, however, be perceived that hypertension is one of the factors for such problems, the claim was restricted to 50% of the total expenses and the complaint was disposed of.

Kochi Ombudsman Centre
Case No. IO/KCH/GI/29/2006-07
Shri.Thampy George
Vs
Oriental Insurance Co.Ltd.

Award Dated 12.9.2006

The complaint under Rule 12(1)(b) read with Rule 13 of the RPG Rules, 1998 relates to partial repudiation of a claim under the Group Medi claim policy issued in faovur of employees of M/s.Apollo Tyres. The complainant – an employee of the factory – had, due to a fall on 3.5.05 sustained bilateral contusion of the brain and compression fracture. He was in the hospital for 13 days and discharged on 16.5.2005. He was advised medical leave for atleast 3 months and based on this certificate, the insurer had allowed the benefits for 90 days only. Based on another certificate issued by one Dr.Johnson, the complainant claimed total benefits for 163 days. In any case, based on perusal of all relevant medical certificates, this Forum was able to compute the period of total disability to 139 days and therefore the benefits were allowed for a total period of 139 days instead of 90 days allowed by the insurer. With this modification, the complaint was disposed of on merits.

Kolkata Ombudsman Centre

Case No. 502/14/003/NL/9/2005-06
Smt. Tuppa Ray Basu
Vs.
National Insurance Company Ltd.

Award Dated 25.04.06

Facts & Submissions : The complaint was regarding delay in settlement of claim under Group Mediclaim Insurance Policy.

The National Insurance Company Limited authorized M/s Venus Medicare Services (I) Ltd. to cover the latter's members under Group Mediclaim Scheme as per the terms and conditions agreed to between them. The complainant was one such group member. Smt. Tuppa Ray Basu stated that after getting a copy of the agreement letter issued by the insurance company to 'Venus', she took cover under the said Group Mediclaim policy issued by the insurance company through M/s Venus Medicare Services (I) Ltd. The complainant paid premium of Rs.2,486/-. A maternity claim for Rs.40,077/-, against maternity benefit limit of Rs.50,000/-, was filed with the insurance company's TPA on 25.02.2005 along with necessary documents. However, despite reminder, the insurance company delayed settlement of the claim. Being aggrieved by the delay, the complainant has come before us seeking relief of Rs.42,882/-, including interest.

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. Tuppa Ray Basu, 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. The self-contained note of the insurance company is reproduced below :-

"We had entered into a Memorandum of Understanding on 15.11.2002 with M/s Venus Medicare Service Club having their local office at 19, R.N. Mukherjee Road, 2nd floor, Kolkata – 700 001. The objective of the aforementioned Service Club was to provide Group Mediclaim Policy for their members including their families and who are being prospected and/or have been inducted as members of Venus Medicare Service Club and act as Insured party for the purpose of insurance. Now, for the purpose of insurance, the insurer herein is National Insurance Co. Ltd. Division-XI and the insured is Venus Medicare Service Club.

In the last week of September, 2004, it came to our notice that Venus Medicare Service Club was issuing fake certificates to their members without depositing the premium with us. In some cases, it also came to our notice that the signature on the certificates issued to the members had no signature of any of our officials thus violating the terms and conditions of the MOU.

On noticing the same, we issued a letter to the Secretary of M/s Venus Medicare Service Club on 01st October, 2004 giving 30 days clear notice regarding cancellation of MOU entered between us and Venus Medicare Service Club.

On 01st November, 2004, we cancelled the MOU and on 05th November, 2004, we made an F.I.R with Hare Street Police Station giving the details which is self-explicit. On 18th December, 2004, there was an insertion in all the leading Daily Newspapers i.e., Hindi, English and Bengali on our cancellation of MOU with Venus Medicare Service Club.

In our notice, we had categorically mentioned that we shall not be responsible for any payment received by any person/s on behalf of Venus Medicare Service Club from their

members other than the premium received by us in respect of the policy issued in favour of Venus Medicare Service Club and its members.

Now, on scrutiny of the total list of members of Venus Medicare Service Club as submitted by them with the requisite premium we find that the name of Mrs. Tuppa Ray Basu does not appear in the list.

In view of the above, since no premium was received by us from M/s Medicare Service Club in respect of Mrs. Tuppa Ray Basu as such we could not entertain his claim."
(sic)

Decision : We are considering here a claim under a Group Policy in which 'Venus' were the Insured and the complainant was claimed to be 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.

The individual member might have paid some amount to 'Venus' but there was no evidence to establish that the amount paid represented "premium" paid to the insurance company. As per the MOU between the insurance company and 'Venus' premium was to be remitted by 'Venus' to the insurance company. It is alleged that 'Venus' did not pay the premium to the insurance company. Therefore, the amount paid by/ on behalf of the individual member to 'Venus' could not be construed as "premium" paid to the insurance company. In case the amount collected by 'Venus' from the individual member was misappropriated by them, they would commit a criminal offence. 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. To pursue such police investigation is outside the purview of this forum.

It was held that the insurance company, in view of the non-receipt of the premium, were justified in not issuing any policy/certificate covering the risk of individual member i.e., Smt. Tuppa Ray Basu. We, accordingly, decline to interfere with the action of the insurance company.

Kolkata Ombudsman Centre
Case No. 489/14/003/NL/9/2005-06
Sri Dhaneswar Kumar Mishra
Vs.
National Insurance Company Ltd.

Award Dated 25.04.06

Facts & Submissions : The complaint was 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. The complainant's wife Smt. Jayshree Mishra was one such group member. Shri Dhaneshwar Kumar Mishra stated that after getting a copy of the agreement letter issued by the insurance company to 'Venus', he and his wife took cover under the said Group Mediclaim policy issued by the insurance company to M/s Venus Medicare Services (I) Ltd. The complainant paid premium of Rs.3,160/-. A maternity claim for

Rs.13,855/- against maternity benefit limit of Rs.50,000/- was filed with the insurance company on 30.05.2005 along with necessary documents. However, despite reminder, the insurance company delayed settlement of the claim. Being aggrieved by the delay, the complainant has come before us seeking relief of Rs.14,548/-, including interest.

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. Jayshree Mishra 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. The self-contained note of the insurance company is reproduced below :-

"We had entered into a Memorandum of Understanding on 15.11.2002 with M/s Venus Medicare Service Club having their local office at 19, R.N. Mukherjee Road, 2nd floor, Kolkata – 700 001. The objective of the aforementioned Service Club was to provide Group Mediclaim Policy for their members including their families and who are being prospected and/or have been inducted as members of Venus Medicare Service Club and act as Insured party for the purpose of insurance. Now, for the purpose of insurance, the insurer herein is National Insurance Co. Ltd. Division-XI and the insured is Venus Medicare Service Club.

In the last week of September, 2004, it came to our notice that Venus Medicare Service Club was issuing fake certificates to their members without depositing the premium with us. In some cases, it also came to our notice that the signature on the certificates issued to the members had no signature of any of our officials thus violating the terms and conditions of the MOU.

On noticing the same, we issued a letter to the Secretary of M/s Venus Medicare Service Club on 01st October, 2004 giving 30 days clear notice regarding cancellation of MOU entered between us and Venus Medicare Service Club.

On 01st November, 2004, we cancelled the MOU and on 05th November, 2004, we made an F.I.R with Hare Street Police Station giving the details which is self-explicit. On 18th December, 2004, there was an insertion in all the leading Daily Newspapers i.e., Hindi, English and Bengali on our cancellation of MOU with Venus Medicare Service Club.

In our notice, we had categorically mentioned that we shall not be responsible for any payment received by any person/s on behalf of Venus Medicare Service Club from their members other than the premium received by us in respect of the policy issued in favour of Venus Medicare Service Club and its members.

Now, on scrutiny of the total list of members of Venus Medicare Service Club as submitted by them with the requisite premium we find that the name of Mrs. Jayshree Mishra does not appear in the list.

In view of the above, since no premium was received by us from M/s Medicare Service Club in respect of Mrs. Jayshree Mishra as such we could not entertain his claim."

(sic)

Decision: We were considering here a claim under a Group Policy in which 'Venus' were the Insured and the complainant was claimed to be 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.

The individual member might have paid some amount to 'Venus' but there was no evidence to establish that the amount paid represented "premium" paid to the insurance company. As per the MOU between the insurance company and 'Venus' premium was to be remitted by 'Venus' to the insurance company. It is alleged that 'Venus' did not pay the premium to the insurance company. Therefore, the amount paid by/ on behalf of the individual member to 'Venus' could not be construed as "premium" paid to the insurance company. In case the amount collected by 'Venus' from the individual member was misappropriated by them, they would commit a criminal offence. 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. To pursue such police investigation is outside the purview of this forum.

It was held that the insurance company, in view of the non-receipt of the premium, were justified in not issuing any policy/certificate covering the risk of individual member i.e., Smt. Jayshree Mishra. We, accordingly, decline to interfere with the action of the insurance company.

Kolkata Ombudsman Centre
Case No. 246/11/002/NL/7/2005-06
Shri Manik Chandra Agarwal
Vs.
The New India Assurance Co. Ltd.

Award Dated 25.04.06

Facts & Submissions : The complaint was regarding repudiation of claim under Group Mediclaim Insurance Policy.

The complainant's wife Smt. Manju Agarwala was covered under the above policy, the policy was renewed. In the year 2000 she became pregnant and went to Dr. Smriti Ghosh for her check up and she was under her treatment onwards. Suddenly, she felt some pain in her chest and Dr. Ghosh advised her to have a clinical check up by one Cardiologist. Smt. Agarwal went to Dr. A.Dutta, for her check up when Dr. Dutta advised some investigations. The patient underwent investigations like E.C.G, Blood Test etc. and it was revealed that she had some heart problem. The patient did not feel any heart trouble or pain previously. After finding out the heart problem the patient was admitted to Gandhi Memorial Hospital and then she was transferred to Calcutta Medical Research Institute where she was treated for her ailments. On release from the hospital she filed her claim for reimbursement before the insurance company. She filed all relevant documents. But the claim was repudiated by the insurance company on the ground that her disease was pre-existing and her claim was not admissible for reimbursement.

The complainant stated that the insurance company was not justified in rejecting the claim on ground of pre-existing disease. There were no earlier treatment papers and hence the question of submission of earlier documents or any clinical note or discharge certificate did not arise at the time of taking the policy. The patient was never admitted to any hospital or nursing home before the policy.

The complainant submitted that he lodged his claim through GTFS, Naihati Branch on 25.10.2000 along with hospital bill, medical bill, Doctors' fees bills, Matron fee bills and

test reports with Doctors prescription in original. He reminded The New India Assurance Co. Ltd. for settlement of the claim vide his letter dated 28.03.2001, 10.06.2001 and 20.07.2001. Finally, he received a reply from The New India Assurance Company Ltd., dated 22.08.2002 informing him that the disease was pre-existing and that he had not submitted documents regarding hospital and Discharge Certificates even though he had submitted all the documents. The complainant served a legal notice on 16.04.2003 but did not get any reply. He subsequently reminded the Assistant Manager and Assistant General Manager, The New India Assurance Company Ltd. He received a letter from The New India Assurance Company Ltd. dated 13.05.2003 informing him that they were taking up the matter with concerned branch office and would revert to him in due course.

But till today he did not receive any reply. Being aggrieved the complainant has come before us seeking relief of Rs.15,000/- along with interest.

The New India Assurance Company Ltd., Howrah Divisional Office repudiated the claim for non-submission of various treatment papers. The insurance company stated as follows:

"1. The Insured Smt. Manju Agarwala had its 2nd year policy of GTFS under Gr. Mediclaim Policy. Policy No. was 48-30165, effective date was from 15.07.2000 to 14.07.2001. 1st policy No. was 48-30092 effective from 15.07.1999 to 14.07.2000.

2. She got admitted for treatment of pregnancy with Rheumatic Heart Disease at CMRI, Kolkata from 20.08.2000 to 30.08.2000 (left hospital on risk bond) which can be ascertained from one prescription dt. 14.08.2000 of Dr. T.K.Datta (****). Her Rheumatic Heart Disease was also revealed from Investigation Report of CMRI (Echo date-23.08.2000). Our panel doctor opined Rheumatic Heart Disease is a late complication. Patient had suffered earlier Rheumatic fever and later developed the said disease (****).

3. We made correspondence on 12.01.2001 for submission of various treatment papers (****). But her husband did not submit any treatment papers, only asked for final settlement of the claim dt.28.03.2001 (****). Thereafter, after taking Panel Doctor's opinion we repudiate such claim on 22.08.2002 for non-submission of various treatment papers (****)."

Decision: We find that the insurance company repudiated the claim vide their letter dated 22.08.2002 for the following reasons:-

"1. You have incurred expenses towards treatment of pre-existing disease. In terms of policy exclusions for pre-existing disease the said expenses are not admissible under the policy, which please note. (**********)

3. You have consulted a Surgeon/Specialist who performed your operation. This indicates that you had prior knowledge of your existing disease. (**********)

5. Non-submission of earlier treatment papers, clinical notes during hospitalization, discharge certificate."

The patient at the time of hospitalization was suffering from illness for pregnancy, Rheumatic Heart Disease and Mitral Stenosis. But it was noted that the claimant in the claim form, under column – 4, did not mention the nature of disease/ illness or injury suffered. The Discharge Summary of Calcutta Medical Research Institute was also not available to the insurance company as the patient was released on risk bond. However, from the prescription of Dr. T.K.Dutta dated 14.08.2000, it was found that the patient

was suffering from pregnancy, Rheumatic Heard Disease and Mitral Stenosis. The RHD and Mitral Stenosis, had also been diagnosed in the Echo Cardiogram done on 23.08.2000. Apparently, the patient was admitted to Calcutta Medical Research Institute under Dr. T.K.Banerjee mainly for treatment of RHD.

It was noticed that the insurance company had asked the complainant for submission of related documents of previous illness and they also clarified in the letter that if they did not receive the particulars they would repudiate the claim as pre-existing after taking medical opinion from the panel doctor. Although the complainant made several correspondence for settlement of his claim, he did not submit any such documents as were required by the insurance company. We also note from the Advocate's notice that the patient was hospitalized at Gandhi Memorial Hospital, Kalyani before she was shifted to Calcutta Medical Research Institute. Obviously, the complainant must have had some documents of that hospital which might have given more light about the nature of illness the patient was suffering from. But the complainant did not produce these documents to the insurance company.

It was also noticed that the insurance company had obtained opinion from the panel doctor before repudiating the claim. Dr. Manjeesatha Chakraborty in her opinion dated 21.03.2002 gave her opinion as under :-

"After going through the supplied documents it is seen that the patient got admitted to hospital for Pregnancy with Rheumatic Heart Disease, though no proper discharge certificate with diagnosis is available , as the patient left hospital on risk bond, but it can be ascertained from the prescription dated 14.08.2000. Now the point to be noted is that Mitral Stenosis is Rheumatic Heart Disease is a late complication. So, the patient must have suffered from Rheumatic Fever earlier which later developed Mitral Stenosis. So the risk factor of her pregnancy that is Mitral Stenosis is a pre existing disease, which was the prime cause for her admission." In view of the above, it was held that the treatment for which the claim was made was for heart disease and not for pregnancy. The insurance company rightly asked for the previous treatment papers from the complainant and the complainant failed to produce them. Considering the evidence which are available and considering the opinion of panel doctor we are satisfied that the patient suffered from heart problem which was existing prior to the commencement of the policy. Accordingly, repudiation of the claim was upheld.

Kolkata Ombudsman Centre
Case No. 487/14/003/NL/9/2005-06
Sri Kumar G. Bahru
Vs.
National Insurance Company Ltd.

Award Dated 26.04.06

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. The complainant's wife Smt. Tanya K. Bahrus was one such group member. Shri Kumar G.Bahrus stated that after getting a copy of the agreement letter issued by the insurance company to 'Venus', he and his wife took cover under the said Group

Mediclaim policy issued by the insurance company to M/s Venus Medicare Services (I) Ltd. The complainant paid premium of Rs.2,486/-. A maternity claim for Rs.55,706.25, against maternity benefit limit of Rs.50,000/- was filed with the insurance company on 25/28.04.2005, along with necessary documents. However, despite reminder, the insurance company delayed settlement of the claim. Being aggrieved by the delay, the complainant has come before us for redressal of his grievances. No amount has been specifically mentioned towards relief sought in 'P' form. However, the complainant asked for settlement of his outstanding claim with interest in the original complaint.

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. Tanya K. Bahrus 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. The self-contained note of the insurance company is reproduced below :-

"We had entered into a Memorandum of Understanding on 15.11.2002 with M/s Venus Medicare Service Club having their local office at 19, R.N. Mukherjee Road, 2nd floor, Kolkata – 700 001. The objective of the aforementioned Service Club was to provide Group Mediclaim Policy for their members including their families and who are being prospected and/or have been inducted as members of Venus Medicare Service Club and act as Insured party for the purpose of insurance. Now, for the purpose of insurance, the insurer herein is National Insurance Co. Ltd. Division-XI and the insured is Venus Medicare Service Club.

In the last week of September, 2004, it came to our notice that Venus Medicare Service Club was issuing fake certificates to their members without depositing the premium with us. In some cases, it also came to our notice that the signature on the certificates issued to the members had no signature of any of our officials thus violating the terms and conditions of the MOU.

On noticing the same, we issued a letter to the Secretary of M/s Venus Medicare Service Club on 01st October, 2004 giving 30 days clear notice regarding cancellation of MOU entered between us and Venus Medicare Service Club.

On 01st November, 2004, we cancelled the MOU and on 05th November, 2004, we made an F.I.R with Hare Street Police Station giving the details which is self-explicit. On 18th December, 2004, there was an insertion in all the leading Daily Newspapers i.e., Hindi, English and Bengali on our cancellation of MOU with Venus Medicare Service Club.

In our notice, we had categorically mentioned that we shall not be responsible for any payment received by any person/s on behalf of Venus Medicare Service Club from their members other than the premium received by us in respect of the policy issued in favour of Venus Medicare Service Club and its members.

Now, on scrutiny of the total list of members of Venus Medicare Service Club as submitted by them with the requisite premium we find that the name of Mrs. Tanya K. Bahrus does not appear in the list.

In view of the above, since no premium was received by us from M/s Medicare Service Club in respect of Mrs. Tanya K. Bahrus as such we could not entertain his claim."

(sic)

Decision: We are considering here a claim under a Group Policy in which 'Venus' were the Insured and the complainant was claimed to be 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.

The individual member might have paid some amount to 'Venus' but there was no evidence to establish that the amount paid represented "premium" paid to the insurance company. As per the MOU between the insurance company and 'Venus' premium was to be remitted by 'Venus' to the insurance company. It is alleged that 'Venus' did not pay the premium to the insurance company. Therefore, the amount paid by/ on behalf of the individual member to 'Venus' could not be construed as "premium" paid to the insurance company. In case the amount collected by 'Venus' from the individual member was misappropriated by them, they would commit a criminal offence. 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. To pursue such police investigation is outside the purview of this forum.

It was held that the insurance company, in view of the non-receipt of the premium, was justified in not issuing any policy/certificate covering the risk of individual member i.e., Smt. Tanya K. Bahrus. We, accordingly, decline to interfere with the action of the insurance company.

Kolkata Ombudsman Centre
Case No. 249/14/003/NL/7/2005-06
Sri Raghav Raj Kanoria
Vs.
National Insurance Company Ltd.

Award Dated 26.04.06

Facts & Submissions : The complaint was regarding delay in settlement of claim under Group Mediclaim Insurance Policy.

Shri Raghav Raj Kanoria and his wife Smt. Sweta Kanoria were covered under a Group Mediclaim policy issued by the insurance company to M/s Venus Medicare Services (I) Ltd. A maternity claim for Rs.37,209/- in respect of Smt. Sweta Kanoria, was filed with the insurance company on 18.03.2005. Both the insurance company and 'Venus' were intimated about the claim in September 2004. The insurance company delayed settlement of the claim. Despite a number of reminders to the various authorities of the insurance company, the claim was not settled.

The complainant further stated that after he had filed the complaint with this forum, he received a letter of repudiation of the claim by the insurance company on the ground that the complainant and his wife were not covered with them as per the list of members submitted by 'Venus'. Being dissatisfied with the decision, the complainant represented to the CMD of the insurance company contending that the policy issued by the insurance company clearly mentioned the name of the complainant and his wife. He was not responsible if 'Venus' did not include their name in the list submitted to the

insurance company and he refused to suffer for Venus's mistake. Moreover, when the claim intimation was given in September 2004, neither the insurance company nor 'Venus' informed him at that stage that the complainant's name did not figure in the list of members. However, such representation did not result in payment of claim. Being aggrieved by the delay, the complainant has come before us seeking relief of Rs.47,209/-.

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. Sweta Kanoria 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. The self-contained note of the insurance company is reproduced below :-

"We had entered into a Memorandum of Understanding on 15.11.2002 with M/s Venus Medicare Service Club having their local office at 19, R.N. Mukherjee Road, 2nd floor, Kolkata – 700 001. The objective of the aforementioned Service Club was to provide Group Mediclaim Policy for their members including their families and who are being prospected and/or have been inducted as members of Venus Medicare Service Club and act as Insured party for the purpose of insurance. Now, for the purpose of insurance, the insurer herein is National Insurance Co. Ltd. Division-XI and the insured is Venus Medicare Service Club.

In the last week of September, 2004, it came to our notice that Venus Medicare Service Club was issuing fake certificates to their members without depositing the premium with us. In some cases, it also came to our notice that the signature on the certificates issued to the members had no signature of any of our officials thus violating the terms and conditions of the MOU.

On noticing the same, we issued a letter to the Secretary of M/s Venus Medicare Service Club on 01st October, 2004 giving 30 days clear notice regarding cancellation of MOU entered between us and Venus Medicare Service Club.

On 01st November, 2004, we cancelled the MOU and on 05th November, 2004, we made an F.I.R with Hare Street Police Station giving the details which is self-explicit. On 18th December, 2004, there was an insertion in all the leading Daily Newspapers i.e., Hindi, English and Bengali on our cancellation of MOU with Venus Medicare Service Club.

In our notice, we had categorically mentioned that we shall not be responsible for any payment received by any person/s on behalf of Venus Medicare Service Club from their members other than the premium received by us in respect of the policy issued in favour of Venus Medicare Service Club and its members.

Now, on scrutiny of the total list of members of Venus Medicare Service Club as submitted by them with the requisite premium we find that the name of Mrs. Sweta Kanoria does not appear in the list.

In view of the above, since no premium was received by us from M/s Medicare Service Club in respect of Mrs. Sweta Kanoria as such we could not entertain his claim."
(sic)

Decision: We are considering here a claim under a Group Policy in which 'Venus' were the Insured and the complainant was claimed to be 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.

The individual member might have paid some amount to 'Venus' but there was no evidence to establish that the amount paid represented "premium" paid to the insurance company. As per the MOU between the insurance company and 'Venus' premium was to be remitted by 'Venus' to the insurance company. It is alleged that 'Venus' did not pay the premium to the insurance company. Therefore, the amount paid by/ on behalf of the individual member to 'Venus' could not be construed as "premium" paid to the insurance company. In case the amount collected by 'Venus' from the individual member was misappropriated by them, they would commit a criminal offence. 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. To pursue such police investigation is outside the purview of this forum.

It was held that the insurance company, in view of the non-receipt of the premium, were justified in not issuing any policy/certificate covering the risk of individual member i.e., Smt. Sweta Kanoria. We, accordingly, decline to interfere with the action of the insurance company.

Kolkata Ombudsman Centre
Case No. 245/11/002/NL/7/2005-06
Shri Jharbarmal Agarwala
Vs.
The New India Assurance Co. Ltd.

Award Dated 26.04.06

Facts & Submissions : The complaint was regarding repudiation of claim under Group Mediclaim Insurance Policy.

Shri Jhabarmal Agarwala was covered under Mediclaim policy taken from The New India Assurance Co. Ltd. for the period 15.07.2000 to 14.07.2001. He suffered from increased urinary frequency with poor urine stream. He went to Christian Medical College, Vellore for treatment on the advice of Dr. S.B.Lahiri and underwent surgery as advised. He got himself admitted to the hospital on 25.06.2001 and discharged on 01.07.2001. He submitted all the treatment papers i.e., prescriptions, Cash Memos, Pathological Test Report and Diagnostic Test Reports in original to The New India Assurance Company Ltd., Howrah Divisional Office through G.T.F.S on 28.07.2001. The insurance company vide their letter dated 11.12.2002 and 24.03.2003 called for certain documents and the complainant stated vide his letter dated 18.04.2003 that he had written to C.M.C Hospital to send the documents and accordingly he submitted it to the insurance company. But the insurance company repudiated his claim vide their letter dated 27.05.2004 pleading non-submission of various treatment papers. He filed a representation dated 24.01.2005 to the Insurer's Regional Office who in turn replied on 11.03.2005 stating that the matter was being taken up. But his claim has not been settled. Being aggrieved, he has approached this forum for relief of Rs.15,000/- plus interest.

The New India Assurance Company, Howrah Divisional Office stated as under :-

1. Insured Mr. Jhabarmal Agarwala (55 years) had 2nd year policy vide No. 48-30165 effective from 15.07.2000 to 14.07.2001 issued under Group Mediclaim Policy through GTFS;
2. Insured was admitted with BPH (Prostate) and bilateral Hydrocele at CMCH, Vellore, Chennai from 25.06.2001 to 01.07.2001 and undergone operation BNI, Rt. Exicision and eversion of sac due to Benign Prostatic Hypertrophy (BPH) and Bilateral Hydrocele;
3. He firstly diagnosed under Dr. S.B.Lahiri dated 11.06.2001 at the age of 56 years suffering from retention of urine, enlargement of Prostate and Bilateral Hydrocele. No investigations were done before or after 01.06.2001. Then he hospitalized at CMCH, Vellore on 25.06.2001 for treatment. In the discharged certificate it was clearly mentioned that he had been suffering from Urinal disease 4 months back i.e., from April 2001. Size of Prostate was 20-25 grams. Though the type of disease itself has very very slow progressive and late age dependent, required investigations and medications periodically as per advice of Urologist. After that, operation management were done at the end and final stage;
4. We sought number of occasion for various treatment papers, prescriptions and investigation reports prior to 01.06.2001 and afterwards and also all prescriptions of CMCH (****);
5. Thereafter we repudiated such claim on 27.05.2004 for non-submission of required documents for which asked for;
6. Xerox copies of Policy Certificate, Claim Form Dr. prescription of S.B.Lahiri dt. 01.06.2001, discharged Certificate of CMCH and our correspondence are enclosed for your kind perusal".

Decision : We find that the claim was repudiated by the insurance company vide their letter dated 27.05.2004 on the following two grounds:-

a) The Insured incurred expenses towards treatment of pre-existing disease and such expenses for pre-existing disease were not admissible under the policy conditions;

b) The Insured did not submit various treatment papers prescription etc. for which the claim was being repudiated.

There was no dispute here that the disease for which the treatment was undertaken at Vellore was in the second year of the policy. Hence the first year exclusion of disease such as BHP and Hydrocele was not applicable in this case. Therefore, the ground on which the claim could have been repudiated would be only on "pre-existing disease" and insurance company must have to establish that the disease existed prior to the inception of the policy.

The policy under which the claim was made was for the period 15.07.2000 to 14.07.2001. This policy was a renewal of the earlier policy No. 48-30092. In the Discharge Certificate dated 01.07.2001, it was mentioned that the disease was 4 months old i.e., from April 2001. It was also found that the first consultation with the doctor was on 01.06.2001when advice for operation at Vellore was given. In the self-contained note the Insurer stated that the first diagnosis was on 11.06.2001 and that no investigation was done before or after 01.06.2001. There was no evidence that the disease was older than 4 months and that it existed prior to the commencement of the policy.

But the insurance company concluded that it was a case of pre-existing disease. They were of the view that the disease was slowly progressive with age and required investigations and medications and only at the end operation was undertaken.

The conclusion of the insurance company appeared to be based on inference but such inference was not based on evidence or records. It was an inference based on a general presumption about such disease without any particular reference in the specific case. Inference drawn on surmise and conjecture is not equal to diagnosis based on medical evidence.

It was found that the complainant had given sufficient particulars to the insurance company in support of his claim. When he was asked to produce additional particulars he called for the same from Vellore and submitted them to the insurance company. Instead of deciding the claim on the basis of the particulars the insurance company kept on asking for more particulars. It is not clear, what the insurance company was gaining by sitting on the claim. They could have decided the claim, if they wanted to, on the basis of evidence already available with them. The only inference that we can draw is that the insurance company did not proceed with the claim with an open mind. They were looking for some evidence/ excuse to repudiate the claim. This approach is neither just nor proper.

The grounds of repudiation pre-supposed that it was a pre-existing disease and therefore, expenses were not allowable. The other ground – non submission of documents - was taken to suggest that the complainant was trying to suppress material which would reveal that it was a pre-existing disease.

We are of the view that the insurance company failed to support their decision by any documentary evidence. They also did not refer to or rely on any specialist opinion from a doctor before repudiation of the claim. The decision of the insurance company was reversed and they were directed to allow the claim.

The complainant also claimed payment of interest for the delay in taking decision. We considered the facts of the case and allowed the claim. No further relief was called for.

Kolkata Ombudsman Centre
Case No. 324/11/003/NL/08/2005-06
Shri Pronab Dutta
Vs.
National Insurance Company Limited

Award Dated 19.05.06

Facts & Submissions : The complaint was regarding repudiation of claim under condition 5.3 and 5.4 of the Group Mediclaim Policy.

Shri Pronab Dutta had taken one Mediclaim policy for himself, his wife and daughter from National Insurance Company Ltd., through Golden Trust Financial Services (GTFS). He suffered from Cervical Spondylosis with history of Cervical injury and contacted Dr. Partha Ray on 06.03.2004 and got admitted to Mediview Clinic & Hospital on 06.03.2004 and was released on 14.03.2004. Intimation was given on 06.05.2004 and the claim papers were submitted on 04.06.2004. The delay in sending the intimation was caused by the serious sickness of the complainant and he had no assistance from family members, wife being seriously ill. The Insurer denied liability on ground of violation of condition 5.3 and 5.4 although they were not mentioned in the Certificate of Insurance. Being aggrieved, he sent a representation on 27.04.2005 to

the insurance company against the letter of repudiation dated 08.02.2005 and submitted as under :-

“The conditions (Condition No. 5.3 & 5.4) given in the letter for fulfillment of a claim were not given either in the policy certificate or in the claim form. So, I was not aware of such hard and fast rules of the company for settlement of the claim.

These rules should be given in the certificate, otherwise one could not get the genuine claim as of myself. Even now, I have good faith on the N.I.C. Ltd. and that’s why I continued the policy for the year 2004-05 even after happening of the claim.

I am very sorry if there would b e any fault on my part and requesting you kindly to review the claim and settle it.

I will be highly grateful to you for review and settlement of the claim”.

As there was no reply to the representation, the complainant approached this forum for relief of Rs.24,443.54 along with interest plus cost of hardship of Rs.10,000/-

National Insurance Company Ltd., Division – III, Kolkata stated that the claim was repudiated on ground of violation of condition No. 5.3 & 5.4 of the Mediclaim Policy. The following particulars have been submitted in the self-contained note:-

“Shri Gautam Bose, the complainant, has lodged a claim for Rs.24,443.59 towards expenses incurred for his hospitalization due to Cervical Spondylosis. (****) (Sic)

Cause of repudiation

“The insurance cover was granted from 08.05.2003 to 07.05.2004 in continuation to previous Policy.(****).

It is observed from the claim file that hospitalization has been intimated on 06.05.2004 after lapse of about 60 days from the date of admission in the hospital i.e., 06.03.2004 (****) and the claim has been submitted on 04.06.2004 after lapse of more than 2 months from the date of discharge from hospital i.e., 14.03.2004 (****) which are to be treated as non-compliance of Policy Condition 5.3 and 5.4 of Mediclaim Policy.

Insurance Policy is a contract between insurer and insured and at the time of taking premium it is the practice of the insurance company to accept the premium on the basis of proposal form, which is duly filled in and signed by the insured showing his consent to abide by the terms and conditions of the agreement.

Kindly be informed that the terms and conditions governing the contract were printed on the back of the proposal form signed by the insured and was subsequently printed on the back of Certificate issued to the insured. Hence under no circumstance the claimant can claim that he was not aware of the condition.

Causes like – ‘not known to us’, Field staff of GMSC did not give proper help’, ‘found the Certificate on later date and came to know the cover was there’ etc. are not to be considered as ‘reasonable cause’ within the meaning of Condition No. 1 as per our practice and you will appreciate this causes do not have any supporting evidence.

Kindly note we have condoned causes like claimant being pregnant at the time of incident of death of other family members nearest to the claimant and settled the claims from our end. It is also to be noted these claims were also repudiated on the first hand and subsequently reopened and settled on the basis of valid reasonable ground for delay with supporting evidence.

We would like to quote here the Supreme Court Judgment of (2004) 8 SCC between National Insurance Co. Ltd. Vrs. Public Type College which is as under:-

“It is settled law that terms of the policy shall govern the contract between the parties, they have to abide by the definition given therein and all those expressions appearing in the policy should be interpreted with reference to the terms of policy and not with reference to the definition given in other laws. It is a matter of contract and in terms of the contract the relation of the parties shall abide and it is presumed that when the parties have entered into a contract of insurance with their eyes wide open, they cannot rely on the definition given in other enactment”.

We also quote from Judgment on Civil Appeal No. 4366 of 1999 in the Supreme Court of India, which is as under:

“In the case of General Assurance Society Ltd. Vs. Chandmull Jain reported in 1966 (3) SCR 500 at pages 509-510, it was observed as under :

“In interpreting documents relating to a contract of insurance, the duty of the court is to interpret the words in which the contract is expressed by the parties, because it is not for the court to make a new contract, however reasonable, if the parties have not made it themselves.”

In the Condition No. 5.3 of Group Mediclaim Policy it is stated that ‘preliminary notice of claim with particulars relating to policy numbers, name of insured person in respect of whom claim is made, nature of illness/injury and name and address of the attending Medical Practitioner/Hospital/Nursing Home should be given by the insured person to the company within seven days from the date of hospitalization’.

In the Condition No. 5.4 of Group Mediclaim Policy it is stated that ‘final claim along with receipted Bills, Cash Memos, claim form and list of documents as listed in the claim form etc. should be submitted to the company within 30 days from the date of completion of treatment’.

Both the conditions mentioned above are printed in the backside of the Proposal Form. (****)

At the time of signing the above Proposal Form the insured declared that he has read and understood and/or explained to him and understood terms and conditions, exclusions of Insurance Cover and agreed to abide by the same. (****)

In view of the above the claim has been repudiated vide our letter dated 08.02.2005 due to non-compliance of Condition Nos. 5.3 and 5.4 of Group Mediclaim Policy. (****)”

Decision : There was no dispute that there was a delay with reference to the time limit laid down under condition No. 5.3 & 5.4. However, these conditions have an inbuilt provision to allow waiver of time limit in case of hardship and where it is proved to the satisfaction of the insurance company that the circumstances under which the Insured was placed it was not possible for him or for any other person to give such notice or claim within the prescribed time limit. In this case there is nothing on record to suggest that the insurance company sought and examined the Insured’s explanation for the delay. The insurance company repudiated the claim without allowing the Insured to avail of the benefit of waiver under the policy. Even after repudiation when the complainant represented against the decision by explaining the reasons for delay and seeking waiver the insurance company did not think it necessary to review their decision and consider the claim on merit. We are of the view that the prohibition under condition No. 5.3 & 5.4 does not become automatic unless the explanation given for the delay is rejected as not being due to extreme case of hardship. In other words, the merit of the delay is to be considered before invoking the prohibition under the condition. If the conditions No.5.3 & 5.4 are to be so applied unilaterally without

allowing any opportunity to explain the delay such claim should not have been entertained at all in the first instance. After having entertained the claim and then repudiate it on ground of delay denying an opportunity to explain the delay is against the principle of natural justice and against the principles laid down by the Courts.

While the insurance company were very particular about the time limit for receiving intimation they were not so particular while disposing of the claim. The claim papers were submitted on 04.06.2004 and the repudiation was made on 08.02.2005 – above 8 months after the receipt of the intimation. The delay on the part of the insurance company to dispose of the claim also violated the time limit laid down by the IRDA for processing such claim.

It was held that repudiation of the claim on ground of violation of condition No. 5.3 & 5.4 could not be sustained and the decision deserved to be reversed. As no other ground was given for repudiating the claim, it was held that the amount claimed was payable by the insurance company. The insurance company were directed to pay the claim.

We, however, did not find any merit in the claim for payment of interest and cost of hardship of Rs.10,000/- as there was no deliberate intention on the part of the insurance company to delay the decision.

In the note, the Insurance Company have given their comments on what constitutes reasonable cause and how the policy conditions are to be interpreted. Our views are as under :-

i) Reasonable Cause

The insurance company gave instances of what constitute reasonable cause and what do not. The insurance company have been fair enough to admit that in certain cases where the explanation for the delay was shown to be reasonable they allowed the claims even where the claim had earlier been repudiated. If this has been the practice followed by the insurance company, it is not clear why such procedure has not been followed while processing the present claim. In the instant case there has been no examination of the reasons for the delay at all either when the claim intimation was received or when there was a representation against the repudiation of the claim.

ii) Interpretational Issues

The insurance company have expressed the view that interpretation of the policy conditions should be made very strictly. The policy is to be construed only with reference to stipulations contained in the policy and not by any artificial/ farfetched meaning attributed to the words contained in the policy. They have relied on the following judgment of the Supreme Court in support of their contention:-

(a) General Assurance Society Ltd. Vs. Chandmull Jain reported in 1966 (3) SCR 500 at pages 509-510 ;

(b) (2004) 8 SCC between National Insurance Co. Ltd. Vrs. Public Type College”

We respectfully follow the principles laid down by the Apex Court. But there is nothing in the judgment, which militates against the view taken by us while interpreting the conditions under the policy. On the contrary, we hold that to apply a provision for delay against the complainant without applying the principle of natural justice, as has been

done by the insurance company, goes against the letter and spirit of the policy conditions.

Kolkata Ombudsman Centre
Case No. 360/11/003/NL/08/2005-06
Shri Goutam Bose
Vs.
National Insurance Company Limited

Award Dated 22.05.06

Facts & Submissions : The complaint was regarding repudiation of claim under condition 5.3 and 5.4 of the Group Mediclaim Policy.

Shri Goutam Bose had taken a Mediclaim Insurance Policy from National Insurance Company Ltd., for the period 31.03.2004 to 30.03.2005. His son Shri Saikat Bose was covered under the policy suffered from Viral fever – (High fever, Stomach pain, infection of Kidneys etc. etc.) and was hospitalized on 31.07.2004 at Megacity Nursing Home, Barasat. Bills for the medical expenses incurred were submitted on 16.11.2004 to National Insurance Co., through Golden Trust Financial Services (GTFS). Vide their letter dated 30.05.2005 the claim was repudiated on ground of violation of condition No. 5.3 & 5.4. The complainant stated that the conditions were not mentioned in the Certificate of Insurance. He represented against the repudiation letter dated 30.05.2005 vide his letter dated 01.07.2005 on the following grounds :-

“I take reference to your above stated letter and came to know that my claim has been closed as “No Claim” invoking Condition No. 5.3 & 5.4.

The contentions as quoted have not found its place in the Certificate of Insurance – the evidence of Contract as issued to me from your end. Unless such conditions are made available and known to the Insured Person it is highly irregular and unwarranted that such conditions are to be invoked at the time of finalization of the claim. It is therefore, essential that invoking of such conditions should be dropped forthwith.

It is all the more important that in the event of the hospitalization of the patient the members of the family hardly looks for the Insurance Certificate and complies with the conditions if at all available in the Insurance Certificate. This approach is opposite to the humanitarian concept of the Mediclaim Insurance.

Your attention may please be drawn to the Protection of Policyholders Interests Regulations 2002 wherein it is specifically stated that any procedure for claim filing has to be intimated to the Insured Person from time to time. This is a serious lapse on your part not to intimate me on this score at any level.

Similarly the intimation for denial or acceptance as per the provision of the above Regulations is to be communicated within thirty days from the date of submission of the papers. Unfortunately, in this instant case it is more than six months. I do feel that all these lapse on your part could hardly justify your stand to deny your liability.

Further, your attention is drawn to the judgment of the District Consumer Redressal Forum, District Hooghly in Case No. 39/2005 where the invocation of the conditions No. 5.3 & 5.4 has not been upheld by the court and the payment has to be released to the Insured Person as per the court award.

I trust you will be acting more rationally to attend to the matter without causing any harm financially and otherwise to the Insured person”.

As there was no reply to the representation, being aggrieved he has approached this forum for relief of Rs.5,747/- along with interest .

National Insurance Company Ltd., Division – III, Kolkata stated that the hospitalization had been intimated on 10.08.2004 after a lapse of 9 days from the date of admission in the hospital on 31.07.2004. The claim was submitted on 10.11.2004 after lapse of more than 3 months from the discharge from the hospital on 04.08.2004. As there was non-compliance with condition Nos. 5.3 & 5.4 of the Group Mediclaim policy the claim was repudiated. The following particulars were given in the self-contained note:-

"Shri Gautam Bose, the complainant, has lodged a claim for Rs.5,747.02 towards expenses incurred for hospitalization of his son Saikat Bose. (****)

Cause of repudiation

"The insurance cover was granted from 31.03.2004 to 30.03.2005 in continuation to previous Policy.(****).

It is observed from the claim file that hospitalization has been intimated on 10.08.2004 after lapse of about 9 days from the date of admission in the hospital i.e., 31.07.2004 (****) and the claim has been submitted on 10.11.2004 after lapse of more than 3 months from the date of discharge from hospital i.e., 04.08.2004 (****) which are to be treated as non-compliance of Policy Condition 5.3 and 5.4 of Mediclaim Policy.

Insurance Policy is a contract between insurer and insured and at the time of taking premium it is the practice of the insurance company to accept the premium on the basis of proposal form, which is duly filled in and signed by the insured showing his consent to abide by the terms and conditions of the agreement.

Kindly be informed that the terms and conditions governing the contract were printed on the back of the proposal form signed by the insured and was subsequently printed on the back of Certificate issued to the insured. Hence under no circumstance the claimant can claim that he was not aware of the condition.

Causes like – 'not known to us', Field staff of GMSC did not give proper help', 'found the Certificate on later date and came to know the cover was there' etc. are not to be considered as 'reasonable cause' within the meaning of Condition No. 1 as per our practice and you will appreciate this causes do not have any supporting evidence.

Kindly note we have condoned causes like claimant being pregnant at the time of incident of death of other family members nearest to the claimant and settled the claims from our end. It is also to be noted these claims were also repudiated on the first hand and subsequently reopened and settled on the basis of valid reasonable ground for delay with supporting evidence.

We would like to quote here the Supreme Court Judgment of (2004) 8 SCC between National Insurance Co. Ltd. Vrs. Public Type College which is as under:-

"It is settled law that terms of the policy shall govern the contract between the parties, they have to abide by the definition given therein and all those expressions appearing in the policy should be interpreted with reference to the terms of policy and not with reference to the definition given in other laws. It is a matter of contract and in terms of the contract the relation of the parties shall abide and it is presumed that when the parties have entered into a contract of insurance with their eyes wide open, they cannot rely on the definition given in other enactment".

We also quote from Judgment on Civil Appeal No. 4366 of 1999 in the Supreme Court of India which is as under:

“In the case of General Assurance Society Ltd. Vs. Chandmull Jain reported in 1966 (3) SCR 500 at pages 509-510, it was observed as under :

“In interpreting documents relating to a contract of insurance, the duty of the court is to interpret the words in which the contract is expressed by the parties, because it is not for the court to make a new contract, however reasonable, if the parties have not made it themselves.”

In the Condition No. 5.3 of Group Mediclaim Policy it is stated that ‘preliminary notice of claim with particulars relating to policy numbers, name of insured person in respect of whom claim is made, nature of illness/injury and name and address of the attending Medical Practitioner/Hospital/Nursing Home should be given by the insured person to the company within seven days from the date of hospitalization’.

In the Condition No. 5.4 of Group Mediclaim Policy it is stated that ‘final claim along with receipted Bills, Cash Memos, claim form and list of documents as listed in the claim form etc. should be submitted to the company within 30 days from the date of completion of treatment’.

Both the conditions mentioned above are printed in the backside of the Proposal Form. (****)

At the time of signing the above Proposal Form the insured declared that he has read and understood and/or explained to him and understood terms and conditions, exclusions of Insurance Cover and agreed to abide by the same. (****)

In view of the above the claim has been repudiated vide our letter dated 30.05.2005 due to non-compliance of Condition Nos. 5.3 and 5.4 of Group Mediclaim Policy. (****)”

Decision : There was no dispute that there was a delay with reference to the time limit laid down under condition No. 5.3 & 5.4. However, these conditions have an inbuilt provision to allow waiver of time limit in case of hardship and where it is proved to the satisfaction of the insurance company that the circumstances under which the Insured was placed it was not possible for him or for any other person to give such notice or claim within the prescribed time limit. In this case there is nothing on record to suggest that the insurance company sought and examined the Insured’s explanation for the delay. The insurance company repudiated the claim without allowing the Insured to avail of the benefit of waiver under the policy. Even after repudiation when the complainant represented against the decision by explaining the reasons for delay and seeking waiver the insurance company did not think it necessary to review their decision and consider the claim on merit. We are of the view that the prohibition under condition No. 5.3 & 5.4 does not become automatic unless the explanation given for the delay is rejected as not being due to extreme case of hardship. In other words, the merit of the delay is to be considered before invoking the prohibition under the condition. If the conditions No.5.3 & 5.4 were to be so applied unilaterally without allowing any opportunity to explain the delay, such claim should not have been entertained at all in the first instance. After having entertained the claim and then repudiate it on ground of delay denying an opportunity to explain the delay is against the principle of natural justice and against the principles laid down by the Courts.

It was noticed that while the insurance company were very particular about the time limit for receiving intimation they were not so particular while disposing of the claim. The claim papers were submitted on 10.11.2004 and the repudiation was made on 30.05.2005 – above 6 months after the receipt of the intimation. The delay on the part of the insurance company to dispose of the claim also violated the time limit laid down by the IRDA for processing such claim.

In view of the above, it was held that repudiation of the claim on ground of violation of condition No. 5.3 & 5.4 could not be sustained and the decision deserves to be reversed. As no other ground had been given for repudiating the claim it was held that the amount claimed was payable by the insurance company.

We, however, do not find any merit in the claim for payment of interest as there was no deliberate intention on the part of the insurance company to delay the decision.

In the note, the Insurance Company have given their comments on what constitutes reasonable cause and how the policy conditions are to be interpreted. Our views were as under:-

i) Reasonable Cause

The insurance company gave instances of what constitute reasonable cause and what do not. The insurance company have been fair enough to admit that in certain cases where the explanation for the delay was shown to be reasonable they allowed the claims even where the claim had earlier been repudiated. If this has been the practice followed by the insurance company, it is not clear why such procedure has not been followed while processing the present claim. In the instant case there has been no examination of the reasons for the delay at all either when the claim intimation was received or when there was a representation against the repudiation of the claim.

ii) Interpretational Issues

The insurance company have expressed the view that interpretation of the policy conditions should be made very strictly. The policy is to be construed only with reference to stipulations contained in the policy and not by any artificial/ farfetched meaning attributed to the words contained in the policy. They have relied on the following judgment of the Supreme Court in support of their contention:-

(a) General Assurance Society Ltd. Vs. Chandmull Jain reported in 1966 (3) SCR 500 at pages 509-510 ;

(b) (2004) 8 SCC between National Insurance Co. Ltd. Vrs. Public Type College"

We respectfully follow the principles laid down by the Apex Court. But there was nothing in the judgment, which militates against the view taken by us while interpreting the conditions under the policy. On the contrary, it was held that to apply a provision for delay against the complainant without applying the principle of natural justice, as has been done by the insurance company, goes against the letter and spirit of the policy conditions.

Kolkata Ombudsman Centre
Case No. 337/11/003/NL/8/2005-06
Shri Alok Rana
Vs.
National Insurance Company Limited

Award Dated 23.05.06

Facts & Submissions : The complaint was regarding repudiation of claim under condition 5.3 and 5.4 of the Group Mediclaim Policy.

Shri Alok Rana's wife Smt. Anjali Rana was hospitalized at Kothari Medical Centre, Alipore, Kolkata. She was suffering from Cholelithiasis from 15.07.2004 to 27.07.2004 and was operated on 20.07.2004. She had Mediclaim policy since 2003 which was being renewed without break. The bills for the medical expenses along with all

documents were submitted to National Insurance Company through Golden Trust Financial Services (GTFS). The insurance company repudiated the claim on 09.03.2005 for violation of condition no. 5.3 & 5.4 of the Group Mediclaim policy. The complainant represented against the repudiation letter dated 09.03.2005 vide his letter dated 30.03.2005 on the following grounds :-

"Your decision of turning down my claim appears to be unilateral decision on your part without communicating the provision before hand to the Insured Person with the requirement of submission of the claim and settlement thereof.

If by chance you look at the provision of the Certificate issued under your signature in respect of the Mediclaim Insurance you will feel shy of your failure or default in identifying the clause you are invoked in. Nowhere any such condition of seven days and thirty days provision as stated in condition 5.3 & 5.4 has been appearing. Secondly, you will appreciate that if any disaster occurs in the form of sickness or illness in the family it becomes very difficult for the patient family to trace out the Insurance Certificate for compliance with the requirement of the Insurance Company in obtaining claims.

It is also ridiculous to mention that you are invoking the condition no. 5.4 justifying the late submission of the documents from the date of discharge from the hospital but why are you intimating me after six months approximately and I do hope that the binding falls on either party not exclusively on the Insured/ Claimant.

I, therefore, feel that you will please reopen the file and arrange for the settlement of the claim without resorting to the clause or conditions as mentioned. Your good and sincere approach in this regard is appreciated".

Since the insurance company did not send any reply, we proceeded to dispose of the complaint on the basis of materials available on records.

We observed from the records that the complainant was covered under Group Mediclaim Policy through GTFS for the period from 15.09.2003 to 14.09.2004 covering self, Smt. Anjali Rana and Shri Arjun Rana for a sum insured of Rs.35,000/- each. It is also declared by the complainant in his 'P' form that the policy had been renewed without break since 2003.

Smt. Anjali Rana, wife of the complainant was hospitalized at Kothari Medical Centre w.e.f. 15.07.2004 to 27.07.2004 for treatment of Cholelithiasis. The admission was made as per advice of Dr. Anindya Kumar Das. According to the prescription dated 14.07.2004, the patient was primarily diagnosed for suffering from Acute Epigastric pain. The Discharge Certificate also showed that the patient was admitted with pain in abdomen for 3 days. There was no indication in the prescription as well as the Discharge Certificate that the patient had been suffering from such disease before the commencement of the policy.

The insurance company repudiated the claim for violation of condition No. 5.3 & 5.4. The complainant represented against the insurance company, but there was no reply.

Even assuming that there was a delay as alleged by the insurance company, there was nothing on record to suggest that the insurance company had applied their mind before repudiating the claim. Condition No. 5.3 and 5.4 being an inbuilt provision to waiver of time limit in case of hardship and where it is proved to the satisfaction of the insurance company that the circumstances under which the Insured was placed it was not possible for him or for any other person to give such notice or claim within the prescribed time limit.

There was no dispute here that there was a delay with reference to the time limit laid down under condition No. 5.3 & 5.4. However, these conditions have an inbuilt provision to allow waiver of time limit in case of hardship and where it is proved to the satisfaction of the insurance company that the circumstances under which the Insured was placed it was not possible for him or for any other person to give such notice or claim within the prescribed time limit. In this case there is nothing on record to suggest that the insurance company sought and examined the Insured's explanation for the delay. The insurance company repudiated the claim without allowing the Insured to avail of the benefit of waiver under the policy. Even after repudiation when the complainant represented against the decision by explaining the reasons for delay and seeking waiver the insurance company did not think it necessary to review their decision and consider the claim on merit. We are of the view that the prohibition under condition No. 5.3 & 5.4 does not become automatic unless the explanation given for the delay is rejected as not being due to extreme case of hardship. In other words, the merit of the delay is to be considered before invoking the prohibition under the condition. If the conditions No.5.3 & 5.4 are to be so applied unilaterally without allowing any opportunity to explain the delay such claim should not have been entertained at all in the first instance. After having entertained the claim and then repudiate it on ground of delay denying an opportunity to explain the delay is against the principle of natural justice and against the principles laid down by the Courts.

It was, therefore, held that repudiation of the claim on ground of violation of condition No. 5.3 & 5.4 could not be sustained and the decision deserved to be reversed. As no other ground had been given for repudiating the claim it was held that the amount claimed was payable by the insurance company.

Kolkata Ombudsman Centre
Case No. 339/14/003/NL/08/2005-06
Shri Radha Shyam Banik
Vs.
National Insurance Company Limited

Award Dated 26.05.06

Facts & Submissions : The complaint was regarding non-settlement of claim under Group Mediclaim Insurance Policy.

Shri Radha Shyam Banik's wife Smt. Sabita Banik was covered under the above policy. She was down with Gall Bladder Stone and was hospitalized at Dum Dum Municipal Specialized Hospital & Cancer Research Centre on 08.07.2004. She was operated upon and bills, voucher and other papers were submitted through Golden Trust Financial Services (GTFS) to the National Insurance Company on 23.09.2004. After a lapse of more than one year and despite reminders to the Insurer the claim was not settled. He has approached this forum for relief of Rs.11,769.60.

Since we did not receive the self-contained note from the insurance company even after sending reminders, we proceeded to dispose of the complaint on the basis of material available on records.

Decision : As per the claim papers and other documents available in the file it was found that the complainant's wife Smt. Sabita Banik was admitted in Dum Dum Municipal Specialized Hospital & Cancer Research Centre on 08.07.2004 to 11.07.2004 for treatment of Gallbladder Stone. As per the Discharge Certificate dated 11.07.2004

Laparoscopic Cholecestectomy & GA was done on 09.07.2004. There was no past history mentioned either in the discharge Certificate or in the prescription of Dr. Biswajit Saha, who was consulted by the patient on 09.06.2004. We find that the insurance company did not settle the claim. They also did not bother to send the self-contained note with regard to the action taken by them. It was presumed that they had no comments to offer for their inaction in disposing of the claim.

As there was no adverse material for repudiation of the claim, the insurance company were directed to pay the claim for Rs.11,769.60.

Kolkata Ombudsman Centre
Case No. 321/11/003/NL/08/2005-06
Shri Sukumar Chandra Ghosh
Vs.
National Insurance Company Limited

Award Dated 26.05.06

Facts & Submissions : The complaint was regarding repudiation of claim under condition 5.3 and 5.4 of the Group Mediclaim Policy.

Shri Sukumar Chandra Ghosh had taken one Mediclaim Policy for himself and his wife and daughter from National Insurance Company Ltd., through Golden Trust Financial Services (GTFS). He met with an accident on 25.07.2003 and was admitted, first, at Kalyani J.N.M. Hospital, Kalyani, Nadia and then at Peerless Hospital & B.K.Roy Research Centre, Kolkata on 26.07.2003 and was released on 01.08.2003. Intimation was given to the insurance company on 06.08.2003 and the claim was submitted on 20.02.2004. The delay in the intimation was caused by the serious sickness of the petitioner who was without any assistance from the other family members, except for his wife and a kid. The Insurer denied the liability on the ground that there was a violation of condition No. 5.3 & 5.4 of the Mediclaim policy. The complainant stated that there was no mention in the Certificate of Insurance that the claim must be filed within time limit under condition 5.3 and 5.4. He represented against the letter of repudiation dated 07.02.2005 on the following grounds:-

“With reference to the claim No. 10030046048504499 for treatment of myself, you informed me about qualification for settlement of a claim. Therein, you have stated that I have violated condition No. 5.3 & 5.4 for which you have declared it as “No Claim”.

But I have not found any such condition either in my Mediclaim Certificate or in the claim form.

It a policyholder should know all the requisite laws then that is another thing but as a common person it is unnatural that I should know all the laws.

I have submitted the claim on 20.02.2004 and you declared it as “No Claim” just after one year on 07.02.2005.

Moreover, I may cite an identical case i.e., Claim No. 46200485005065 which had been already settled by you. Then, where lies my fault ?

So, I am requesting you to review and settle the case as soon as possible”

As there was no reply to the representation, being aggrieved, he approached this forum for relief of Rs.25,613.31 along with interest plus cost of hardship of Rs.10,000/-

Decision : National Insurance Company Ltd., Division – III, Kolkata stated that the hospitalization in this case had been intimated on 06.08.2003 i.e., after a lapse of 10

days from the date of admission of hospital on 26.07.2003 and the claim had been submitted on 20.02.2004 after a lapse of 6 months from the date of discharge from the hospital on 01.08.2003. As there was a violation of condition No. 5.3 & 5.4 of the Group Mediclaim Policy, the claim was repudiated. The following particulars have been submitted in the self-contained note:-

“Shri Sukumar Chandra Ghosh, the complainant, has lodged a claim for Rs.25,613.31 towards expenses incurred for his hospitalization. (****)

Cause of repudiation

“The insurance cover was granted from 08.07.2003 to 07.07.2004 in continuation to previous Policy.(****).

It is observed from the claim file that hospitalization has been intimated on 06.08.2003 after lapse of about 10 days from the date of admission in the hospital i.e., 26.07.2003 (****) and the claim has been submitted on 20.02.2004 after lapse of more than 6 months from the date of discharge from hospital i.e., 01.08.2003 (****) which are to be treated as non-compliance of Policy Condition 5.3 and 5.4 of Mediclaim Policy.

In the Condition No. 5.3 of Group Mediclaim Policy it is stated that ‘preliminary notice of claim with particulars relating to policy numbers, name of insured person in respect of whom claim is made, nature of illness/injury and name and address of the attending Medical Practitioner/Hospital/Nursing Home should be given by the insured person to the company within seven days from the date of hospitalization’.

Insurance Policy is a contract between insurer and insured and at the time of taking premium it is the practice of the insurance company to accept the premium on the basis of proposal form, which is duly filled in and signed by the insured showing his consent to abide by the terms and conditions of the agreement.

Kindly be informed that the terms and conditions governing the contract were printed on the back of the proposal form signed by the insured and was subsequently printed on the back of Certificate issued to the insured. Hence under no circumstance the claimant can claim that he was not aware of the condition.

Causes like – ‘not known to us’, Field staff of GMSC did not give proper help’, ‘found the Certificate on later date and came to know the cover was there’ etc. are not to be considered as ‘reasonable cause’ within the meaning of Condition No. 1 as per our practice and you will appreciate this causes do not have any supporting evidence.

Kindly note we have condoned causes like claimant being pregnant at the time of incident of death of other family members nearest to the claimant and settled the claims from our end. It is also to be noted these claims were also repudiated on the first hand and subsequently reopened and settled on the basis of valid reasonable ground for delay with supporting evidence.

We would like to quote here the Supreme Court Judgment of (2004) 8 SCC between National Insurance Co. Ltd. Vrs. Public Type College which is as under:-

“It is settled law that terms of the policy shall govern the contract between the parties, they have to abide by the definition given therein and all those expressions appearing in the policy should be interpreted with reference to the terms of policy and not with reference to the definition given in other laws. It is a matter of contract and in terms of the contract the relation of the parties shall abide and it is presumed that when the parties have entered into a contract of insurance with their eyes wide open, they cannot rely on the definition given in other enactment”.

We also quote from Judgment on Civil Appeal No. 4366 of 1999 in the Supreme Court of India which is as under:

"In the case of General Assurance Society Ltd. Vs. Chandmull Jain reported in 1966 (3) SCR 500 at pages 509-510, it was observed as under :

"In interpreting documents relating to a contract of insurance, the duty of the court is to interpret the words in which the contract is expressed by the parties, because it is not for the court to make a new contract, however reasonable, if the parties have not made it themselves."

In the Condition No. 5.3 of Group Mediclaim Policy it is stated that 'preliminary notice of claim with particulars relating to policy numbers, name of insured person in respect of whom claim is made, nature of illness/injury and name and address of the attending Medical Practitioner/Hospital/Nursing Home should be given by the insured person to the company within seven days from the date of hospitalization'.

In the Condition No. 5.4 of Group Mediclaim Policy it is stated that 'final claim along with receipted Bills, Cash Memos, claim form and list of documents as listed in the claim form etc. should be submitted to the company within 30 days from the date of completion of treatment'.

Both the conditions mentioned above are printed in the backside of the Proposal Form. (****)

At the time of signing the above Proposal Form the insured declared that he has read and understood and/or explained to him and understood terms and conditions, exclusions of Insurance Cover and agreed to abide by the same. (****)

In view of the above the claim has been repudiated vide our letter dated 07.02.2005 due to non-compliance of Condition Nos. 5.3 and 5.4 of Group Mediclaim Policy. (****)"

Decision : There was no dispute here that there was a delay with reference to the time limit laid down under condition No. 5.3 & 5.4. However, these conditions have an inbuilt provision to allow waiver of time limit in case of hardship and where it is proved to the satisfaction of the insurance company that the circumstances under which the Insured was placed it was not possible for him or for any other person to give such notice or claim within the prescribed time limit. In this case there is nothing on record to suggest that the insurance company sought and examined the Insured's explanation for the delay. The insurance company repudiated the claim without allowing the Insured to avail of the benefit of waiver under the policy. Even after repudiation when the complainant represented against the decision by explaining the reasons for delay and seeking waiver the insurance company did not think it necessary to review their decision and consider the claim on merit. We are of the view that the prohibition under condition No. 5.3 & 5.4 does not become automatic unless the explanation given for the delay is rejected as not being due to extreme case of hardship. In other words, the merit of the delay is to be considered before invoking the prohibition under the condition. If the conditions No.5.3 & 5.4 are to be so applied unilaterally without allowing any opportunity to explain the delay such claim should not have been entertained at all in the first instance. After having entertained the claim and then repudiate it on ground of delay denying an opportunity to explain the delay is against the principle of natural justice and against the principles laid down by the Courts.

While the insurance company were very particular about the time limit for receiving intimation they were not so particular while disposing of the claim. The claim papers were submitted on 20.02.2004 and the repudiation was made on 07.02.2005 – nearly 1

Year after the receipt of the intimation. The delay on the part of the insurance company to dispose of the claim also violated the time limit laid down by the IRDA for processing such claim.

In view of the above, it was held that repudiation of the claim on ground of violation of condition No. 5.3 & 5.4 could not be sustained and the decision deserved to be reversed. As no other ground were given for repudiating the claim, it was held that the amount claimed was payable by the insurance company.

However, there was no merit in the claim for payment of interest and cost of hardship of Rs.10,000/- as there was no deliberate intention on the part of the insurance company to delay the decision.

In the note, the Insurance Company had given their comments on what constitutes reasonable cause and how the policy conditions are to be interpreted. Our views were as under :-

i) Reasonable Cause

The insurance company gave instances of what constitute reasonable cause and what do not. The insurance company have been fair enough to admit that in certain cases where the explanation for the delay was shown to be reasonable they allowed the claims even where the claim had earlier been repudiated. If this has been the practice followed by the insurance company, it is not clear why such procedure has not been followed while processing the present claim. In the instant case there has been no examination of the reasons for the delay at all either when the claim intimation was received or when there was a representation against the repudiation of the claim.

ii) Interpretational Issues

The insurance company have expressed the view that interpretation of the policy conditions should be made very strictly. The policy is to be construed only with reference to stipulations contained in the policy and not by any artificial/ farfetched meaning attributed to the words contained in the policy. They have relied on the following judgment of the Supreme Court in support of their contention:-

"(a) General Assurance Society Ltd. Vs. Chandmull Jain reported in 1966 (3) SCR 500 at pages 509-510 ;

(b) (2004) 8 SCC between National Insurance Co. Ltd. Vrs. Public Type College"

We respectfully follow the principles laid down by the Apex Court. But there was nothing in the judgment, which militates against the view taken by us while interpreting the conditions under the policy. On the contrary, it was held that to apply a provision for delay against the complainant without applying the principle of natural justice, as had been done by the insurance company, goes against the letter and spirit of the policy conditions.

Mumbai Ombudsman Centre
Complaint No.GI-269 of 2005-2006
Smt Khorshed K Rustomfram
V/s.
National Insurance Company Limited

Award Dated 26.04.06

Smt Khorshed K Rustomfram was covered under the Group Mediclaim policy issued by National Insurance Company Limited, D.O. XVI to the holders of Bank of India's Credit

Card holders through BOI's Unique Security Plan. Smt Rustomfram was hospitalized for right hip resurfacing and when she preferred a claim for the said hospitalisation the Company repudiated the claim invoking clause 4.1 of the mediclaim policy. Not satisfied by the decision of the Company Smt Rustomfram appealed to the Company to review her claim which was not done favourably. Hence being aggrieved she approached this Forum for justice.

The records have been perused and the parties to the dispute were called for hearing. Analysis of the case reveals that Smt Rustomfram alongwith her husband availed of credit card facility and was covered under mediclaim insurance offered by Bank of India through tie up arrangement with National Insurance Company Limited. At the time of entry Smt Rustomfram was 71 years of age and the Company admitted that there was no underwriting as all cardholders got into the scheme as per an Agreement for which the Company could do very little except to go by policy wordings of various exclusions which are automatically applicable. The particular claim was for Surgery of right hip and as per the medical version it was hip resurfacing. The diagnosis was very clear in mentioning that patient was Oestoarthritic and the investigation reports clearly confirmed deep degeneration of bones and Oestoarthritis alongwith various other diseases It is thus evident that the disease was well before the inception of the policy and she had entered into the mediclaim scheme with all the pre-existing ailments which were automatically excluded under the scope of the policy.

In the facts and circumstances of the case the decision of the Company to repudiate the claim is sustainable.

Mumbai Ombudsman Centre
Complaint No. GI-57 of 2005-2006
Shri M. C. George
V/s
The New India Assurance Co.Ltd.

Award Dated 09.05.06

The New India Assurance Co.Ltd. issued a Group Medicalim Insurance Policy to the employees and their dependents of Life Insurance Corporation of India. Shri M.C.George was covered under the same policy from 01.04.2004. He preferred a claim to the Company for treatment taken at home for burning sensation on both soles (feet). After taking the treatment, he preferred a claim to the Company for Rs.48,888/-. The Company informed the Insured that the domicilary treatments are not covered in the policy issued to LIC employees. The analysis of the case reveals that the rejection of the claim by the TPA duly supported by The New India Assurance Co.Ltd. was on account of the Insured Shri M.C.George claiming for Domiciliary Hospitalisation Benefit for the treatment received by him for his ailment. He felt that since he had a burning sensation on both soles (feet) he was unable to walk and therefore should be taken as immobilized and claim as per the policy provision. According to the Domiciliary Hospitalisation Clause the condition should be such that the patient should be medically advised not to be moved out to any hospital or nursing home because of extreme criticality in his health status. As per his own admission Shri George was suffering from severe burning sensation in his feet since 1999. He had taken allopathic treatment without any effect and later he moved to Kerala, his native place, to receive Ayurvedic treatment from reportedly a renowned hospital/doctor. While he was recovering, he had to come back to Mumbai on an urgent matter and he continued the same treatment through Dr.Rajeev C.Warrier from his house. This immediately points

to the fact that the problem was of a chronic nature for which the Insured consciously took a decision to take Ayurvedic treatment as he was advised that it would be the best form of treatment to give him durable benefit. He was recovering well when he had to return to Mumbai which is important to note. He had only the problem of the burning sensation on his feet for which he felt it is difficult to walk. Secondly, the most important point of availing Domiciliary Hospitalisation treatment as distinct from Hospitalisation would be immediate advice to Insurance Company and seeking their authority to carry on with Domiciliary Hospitalisation under strict medical advice arising out of a serious life threatening emergency situation. This was not the case as New India confirmed there was no advice from him nor was there any medical confirmation authenticating his critical health status. In his case, vital systems were normal except some mild Diastolic Dysfunction which was not at all severe to immobilise him. Shri George gave an argument that he created a hospital-like atmosphere in his house. All these cannot be considered conforming to the definition of Domiciliary hospitalisation in a hospital like situation as per terms of the policy. The fact that Insured could move to Kerala and come back to Mumbai and that he registered an improvement as per Dr. Warrier's certificate dated 06.07.2004, that he did not avail of any Ayurvedic hospital in Mumbai coupled with his own preference for Ayurvedic treatment from Dr. Warrier who happened to be his neighbour, the provisions of domiciliary hospitalisation not being applicable at all as examined, the rejection of New India in terms of Clause 2.4 read in conjunction with Clause 2.1 of the Medicalaim Policy is sustainable.

Mumbai Ombudsman Centre
Complaint No.GI-307 of 2005-2006
Shri Ashim Kumar De
V/s.
United India Insurance Company Limited

Award Dated : 02.06.06

Shri Ashim Kumar De had taken a Group Mediclaim Policy through Unique Mercantile Services Pvt Ltd from United India Insurance Company Limited, D.O. 18 covering himself, his wife and son for a Sum Insured of Rs. 85,000, 1,00,000 and 50,000 respectively for the first time on 31.3.2004. The said policy was further renewed under certificate no. 10137 for the period 31.3.2005 to 30.3.2006.Smt Kalpana De, wife of Shri Ashim Kumar De was hospitalized on 26.5.05 to 2.6.05 for complex endo hyperplasia and pan abdo hysterectomy. When a claim was preferred for the said hospitalisation the Company repudiated the claim invoking clause 4.3 of the Group Mediclaim policy. Not satisfied with the decision Shri De represented to the Company and aggrieved for not receiving any favourable response Shri Ashim Kumar De approached this Forum for not only the above said claim which was rejected by the Company but also for the earlier claim which was preferred by him to the Company for the hospitalisation of Smt Kalpana De at Ganorkar's fracture treatment centre and Maternity Home for D & C done on 5.10.04 to 6.10.04 and rejected by the Company.After perusal of records parties to the dispute were called for hearing .As per records it is evident that Smt Kalpana De was suffering from menorrhagia and obviously for quite some time as for which D & C was resorted to as the first step to get confirmed whether it would be effective in preventing further surgery like hysterectomy. The first point therefore, should be noted that Smt De came into the scheme from 31.3.03 with existing health status which was not disclosed and therefore formed pre-existing illness of which the Company was unaware.It would be apparent

from the clause that first of all there was selection against the Insurance Company in entering into the scheme at a time when complications were manifested and this can be reasonably confirmed from the medical evidences. Secondly the Company has tried to justify that any surgical operation connected with menorrahagia and fibromyoma cannot be payable as per the exclusion clause 4.3.

Based on the analysis and backed up by the medical evidence of actual treatment received by Smt De United India Insurance Company Limited's decision to reject the claim is sustainable.

Mumbai Ombudsman Centre
Complaint No. GI-197 of 2005-2006
Shri Chandrakant Mahadev Mulye
V/s
The New India Assurance Company Limited

Award Dated 14.06.06

Shri Chandrakant M Mulye an employee of Life Insurance Corporation of India was covered alongwith his family members under a Group Mediclaim Policy issued to LIC bearing No.120700/48/04/00050 for the period 01.4.2004 to 31.3.2005 covering all its Employees and their dependents. Smt Sharmila Mulye, wife of Shri C.M. Mulye was hospitalized at Nanavati hospital from 3.12.2004 to 22.12.2004 and had undergone operation for tumor. Shri Mulye had incurred an expense of Rs. 1,05,000 (approx) for the said hospitalisation and when he preferred a claim to New India, the Company settled the claim for Rs. 60,000/- being the maximum Sum Insured applicable for Shri Mulye under category III. On receipt of reduced amount of claim, Shri Mulye represented to New India stating that after the release of his Normal Grade Increment from February, 2004 he was eligible for higher Sum Insured of Rs. 80,000/- from the renewal period i.e. April, 2004 but the same was not being deducted . Only after the Auditors pointed out LIC collected the arrears of premium from April, 2004 and started deducting the premiums from his salary for subsequent months from November, 2004 onwards. His contention was that unfortunately the hospitalisation was in December, 2004, but it was after his entry to the higher category. Not receiving any favourable response from the Company he approached this Forum for justice. The records have been perused and it was found that Shri Mulye had already paid the premiums for a higher Sum Insured as per the salary sheets and the receipts of which were provided to this Forum for verification. LIC's records are clear and available on demand. The New India has to only ensure collection of arrears of premium for the purpose. In view of the facts and circumstances the decision of The New India Assurance Company Limited to restrict the Sum Insured to Rs. 60,000 is not tenable.

The New India Assurance Company Limited is directed to settle the claim of Shri C.M. Mulye as per increase in Sum Insured to Rs. 80,000.

Mumbai Ombudsman Centre
Complaint No.GI-237 of 2005-2006
Shri Rajesh J Sheth
V/s.
The New India Assurance Company Limited

Award Dated 10.07.06

Shri Rajesh J Sheth alongwith his family members were covered under GoodHealth (Group Mediclaim Insurance) Policy issued by The New India Assurance Company Limited through Citibank Solace Scheme . Smt Nirmalaben J Sheth, mother of Shri Rajesh Sheth was operated for Total Knee Replacement in Breach Candy Hospital, He had incurred an expense of Rs. 1,87,906 out of which New India settled only Rs. 1,00,000 leaving a balance amount of Rs 87,906 unpaid for which he represented to the Company/TPA which was not considered. Hence he therefore, approached the Insurance Ombudsman for his intervention in the matter. The records have been perused and the analysis of the case appears simple to the extent that the claim has been admitted and paid by the TPA of New India as per their policy provision and terms, while the Complainant felt he was short paid as per his policy coverage. The records submitted by New India show that the subject policy had Rs. 5 lakhs Sum Insured but as per the salient terms and conditions of Good Health Policy offer from The New India Assurance Company, for the mediclaim given to the members there are in–limits or cap on claims payable for specified ailments. The Good Health Policy is a different product marketed by the Company for Citibank Cardholders and the revised terms and conditions were intimated to Citibank being uniformly applicable to all members. In fact the Insured was covered under the policy as per the policy terms and conditions issued to all Cardholders but restriction on the limit of payment of claims for some specified illnesses is an underwriting policy of the Company and cannot be questioned. Secondly the Insured cannot mention about the benefits of Cumulative Bonus accruing therein as he has only chosen to the new policy and when he purchased the policy it was his responsibility also to ensure that the policy serves his purpose. All these issues cannot be taken as a complaint after the incident is over. It is also noted that the policy had specific amounts applicable under different diseases and it is found that Total Knee/hip surgery is pegged at maximum Rs. 1,00,000 per claim as per clause 1.2 of the Goodhealth (Group Mediclaim Insurance) policy. Based on this clause the Company's settlement is justified and there is no need for any interference by this Forum on this issue.

Mumbai Ombudsman Centre
Complaint No.GI-289 of 2005-2006
Smt Manumati Girish Shah
V/s.
The New India Assurance Company Limited

Award Dated 27.08.06

Shri Girish Shah alongwith his wife Smt Manumati Shah was covered under GoodHealth (Group Mediclaim Insurance) Policy issued by The New India Assurance Company Limited through Citibank Solace Scheme. It is reported that they were covered under the mediclaim scheme from 1996. Smt Manumati was hospitalized at Lilavati hospital and Research Centre, Mumbai from 17.7.05 to 24.7.05 for osteoarthritis and Total Knee Replacement was done. When a claim was preferred by Smt Manumati under policy the Third Party Administrator of the Company M/s TTK Health Care repudiated the claim stating that as per the discharge summary the Insured was having pain in the knee for 10 years and also that she had a past history of fracture in her right tibia at the age of 10 hence the disease was pre-existing . Based on this the claim was repudiated by invoking clause 4.1. Not satisfied with the decision of the Company, Smt Manumati represented to New India but the same was turned down. Hence being aggrieved she approached the Insurance Ombudsman for

his intervention in the matter. Her contention was that the pain in the knee was only for 2 years and in support of her contention she had enclosed a doctor's certificate wherein it was stated that the pain was only since 2 years and regarding the fracture that she had at the age of 10 years it was properly healed. She however stated that she was holding mediclaim policy continuously from 1996 and had not claimed till date and this was her first claim in 9 years. The records have been perused and it is clear that the TPA's rejection is only on the basis of pain in both knees since 10 years. The TPA has also raised the point of fracture in Tibia in childhood. The point which is important to note is the symptom of pain in the knees. It is a symptom which was not diagnosed which is very crucial to reckon. Initially pain becomes diffused and occurs sporadically which could be for various factors particularly for ladies immediately after the menopause. Nobody exactly remembers the date, time and year in respect of such complaints to have started first. It could be only approximate. The very fact that it was merely pain but not a diagnosis, it should be accepted that the condition deteriorated during the policy period to become unbearable to be cured through surgery. In fact this is the case as per the noting in the hospital case papers and we quote "Patient has gradually developed pain in B/L knee. Rt side pain has gradually progressed and now her daily activities are grossly affected". This is lucid and clear. It is unfortunate that the TPA ignored this noting and so did the Company to merely approve without application of mind. Finally how could the TPA mention about childhood fracture as a pre-existing condition. All such injuries in childhood get very fast healed completely without leaving any deformity.

In the facts and circumstances the decision of the TPA and the Insurance Company to reject the claim on grounds of clause 4.1. is hereby set aside and the complaint of Shri Manumati G Shah is held sustainable.

Mumbai Ombudsman Centre
Complaint No. GI-345 of 2005-06
Shri Mahendra Kotecha
V/s.
United India Insurance Co. Ltd.

Award Dated 01.09.06

Shri Mahendra K. Kotecha had taken a Group Mediclaim Policy No. 021800/48/04/00091 through Unique Mercantil India (P) Limited covering his daughter and son for a sum Insured of Rs. 25,000/- each. Ms. Dhruti Kotecha, daughter of Shri Mahendra Kotecha met with an accident . She was admitted to Doshi Hospital where she was treated. She was again admitted to Dr. Walvalkar's Nursing Home for cleaning and debridement of Haemotoma under LA and GA. The complainant lodged a claim with Unique Mercantile after a delay of about three months which was sent to the Company. The Company repudiated the claim invoking clause 5.4 of the Group Mediclaim Policy. Their contention was that the claim was not filed within 30 days from the date of discharge from the hospital.

If we look at the facts of the case, Ms. Kotecha was last discharged on 9/2/2005 and effectively the claim should have been lodged within 9/3/2005. Whereas it was received by United India only on 25/5/2005. United India Insurance Co. Limited also stated during the hearing that the claim file was incomplete, there was inordinate delay in the submission and also that there was no medical records. The complainant stated that since her treatment was continuing, they decided to submit the claim papers after the

full treatment was over and hence the delay in submitting the claim. However, the reason for delay was evidently because they wanted to submit all original records to the Insured's Employer for placing with Bajaj Allianz which caused the Insured's enormous delay. Ms. Dhruti Kotecha was also covered under Mediclaim Policy with Bajaj Allianz through her Employer and that she had preferred a claim under their policy. She admitted that she had submitted all the claim papers to them. It was, therefore, evident through records and also admitted by the Insured that she received bulk of the claim from Bajaj Allianz and only after obtaining the original claim documents submitted to Bajaj Allianz, she lodged a claim with United India for which there was substantial delay. All the above details were not furnished by the Complainant voluntarily but was extracted by detailed questioning by Insurance Ombudsman. It could have attracted an element of sympathetic consideration if the delay was pure and simple. It was proved that it was a case of deliberate suppression and withholding of information vital for consideration of the claim. Accordingly, the decision of the Company to reject the claim on ground of violation of condition 5.4 of the Policy is acceptable.

Mumbai Ombudsman Centre
Complaint No. GI-187 of 2005-06
Smt. Dimple F. Sabuwala
Vs
The New India Assurance Co. Ltd.

Award Dated 11.10.06

The New India Assurance Co. Ltd. issued a long term Tailor-made Group Hospitalisation Policy to Insurance Awareness Group who are a Social Organisation with no profit motive. One such Insured, Smt. Dimple F. Sabuwala No. 48/110900/10003 was covered for a period of ten years from 1/1/1999 to 31/12/2008 premium for which amounting to Rs. 8000/- had been paid by her.

The Insurance Company subsequently cancelled the policy as per Policy condition No. 11.8 However, on review when the business was found to be having adverse claim ratio , a premium loading was worked out, which was advised to the IAG . Since they did not agree to the loading, New India had no other option but to cancel the policy and a final letter of cancellation was issued to the the Insurance Awareness Group informing cancellation of these policies effective from 1/10/2002 vide their letter dated 24th September, 2002 as per the norms and guidelines framed by the Company.

The policy was cancelled w.e.f. 1st October, 2002. Smt. Sabuwala lodged a claim with the Company on 19th May, 2005, amounting to Rs. 98,646/-. in respect of her Caesarean Operation at Breach Candy Hospital to be performed on 8th April, 2005. Being aggrieved with the non-settlement of her claim due to cancellation of Policy, she represented to the Grievance Cell, for review, without any avail and therefore approached to this Forum to file her complaint.

This is a matter involving dispute relating primarily to the cancellation of the policy . This Forum is not equipped with powers to deal with such type of matter involving underwriting, procedural and administrative matters of the Insurance Company. Moreover, cancellation of policy is a condition under the policy and can be invoked by both parties under certain conditions. Accordingly, there cannot be any adjudication on such issues.

The RPG rules 12,13 read in conjunction with rule 15 and 16 evidently precludes policy matters of underwriting procedural or administrative nature from the scope of adjudication by the Insurance Ombudsman. However, it should be stated that the Insurance Company has the authority to cancel the policy as per terms and conditions of the policy with due notice to the Insured which, it seems was done as per the Policy provisions. Furthermore, the period of the claim being subsequent to the cancellation of the policy and there being no contractual relationships between the parties, further brings the claim outside the ambit of adjudication by the Insurance Ombudsman.

Mumbai Ombudsman Centre
Complaint No. GI-122 of 2005-06
Award No. IO/MUM/A/ 210 /2006-2007
Smt. Fatima Sarfraz Merchant
V/s.
The New India Assurance Co. Ltd.

Award Dated 13.10.06

Smt. Fatima Merchant was covered under a Tailormade Group Hospitalisation Policy issued by New India to IAG bearing No. 48/110900/99/07089 for the period 1/3/1999 to 28/2/2009 for a SI of Rs. 5 lakhs. New India subsequently cancelled the policy as per Policy Condition 11.8 effective from 1/10/2002 as per the norms and guidelines framed by the Company. Thereafter the Insured took a cover through IAG from National Insurance Company for a period from 1/1/2004 to 31/12/2004 for a SI of Rs. 5 lakhs. . Smt. Merchant renewed the National Insurance policy with New India under their policy No. 110900/48/04/87280 (1/1/2005 to 31/12/2005) under Individual Mediclaim Policy and the disputed claim has arisen under this policy. When Smt. Merchant lodged a claim with New India for the treatment of haemodialysis taken by her for Renal Failure in the month of Jan. 2005 and Feb. 2005 at Nanavati Hospital, the TPA – TTK repudiated the claim invoking clause 4.1 of the policy on the basis of the instructions received by the Company.

Analysis of the case reveals that Smt. Merchant was covered under Group Policy with National Insurance for the period from 1/1/2004 to 31/12/2004 subsequent to cancellation of group policy by New India in Oct. 2002. National Insurance appears to have honoured all the claims lodged by Smt. Merchant in respect of her dialysis treatment. Zerox copies of cheque issued by their TPA - E Meditek was submitted by the Complainant, Shri Merchant during the hearing. Shri Merchant informed that since New India by this time decided to cover the members of IAG under Standard Mediclaim Policy with an assurance of continuity of benefits, they shifted the policy back to New India. However he did not produce any evidence in support of his statement but it is clear from the letter dated 8/8/2005 addressed to Shri Kabir Dodhia, the AO (D) by the Divisional Office, who was instrumental in bringing the business to New India, which stated " We are in receipt of a letter from our Regl. Office Ref. MRO I:MISC:CL: SEK:05 dated 19/7/2005 stating therein we had given continuity benefit to this policy-holders(Individual Mediclaim Policy) which is in violation of our Mediclaim Policy issued from time to time. As directed by our Regional Office, we advise you to inform insured members of IAG that no continuity benefits and CB is allowed in this policy." The claim was lodged by the Insured in Jan. 2005 and Feb. 2005 ie. much before the said instructions was passed to the DO. However, during the processing of the claim they strictly went by the instructions of the RO to treat the renewals received from

other Public or Private Gen. Insurance Companies as fresh and to exclude all pre-existing diseases from the scope of the policy.

It is observed that the Company issued the guidelines mid-way through in 2005 to their Unit Offices as regards treatment of continuity benefits and accrual of CB under the Policy. Accordingly, the policy which was issued from 1/1/2005 to 31/12/2005 did not contain any exclusions while the policy from 1/1/2006 to 31/12/2006 had an exclusion of Renal Failure and its disorders. The instructions issued by New India were dated 8/8/2005 and 14/10/2005. The complaint before this Forum is in respect of specific two claims lodged in Jan. 2005 and Feb. 2005 which were repudiated by the Company as per the documents received from the TPA and the Insured duly corroborated by Dr. Balabhai Nanavati Hospital Consultation Papers. While the details of the claim was not available, this Forum is restricting its adjudication only to these two claims of Jan. 2005 and Feb. 2005 considering the fact that the instructions by New India were issued to their Divisional Office much later than February 2005.

In the facts and circumstances and based on the analysis and factual details given by the Company, it would be equitable to allow these two blocks of claim to be paid by New India following the principle that earlier, National Insurance also paid such claims under their policy despite the fact that the policy was transferred from New India to National Insurance.

Mumbai Ombudsman Centre
Complaint No. GI-209 of 2005-2006
Shri S.G.Karajgi
V/s
The New India Assurance Co.Ltd.,D.O.120300

Award Dated

The New India Assurance Co.Ltd., Mumbai had issued a Group mediclaim policy to LIC of India covering their ZM Club, DM Club and BM Club agents. Shri Karajgi is a member of the DM Club and covered for a sum insured of Rs.40,000/- since December,2001. Shri Karajgi was admitted to Dr.Metan Hospital for acute prolyne disc L4-5 Lumber Disc Syndros. He claimed Rs.21,463/- from the Company. The Company referred the matter to their panel doctor. Accordingly they informed the insured that since the disease for which he was admitted to the hospital was pre-existing hence the claim fell under Ex. Clause 4.1 of the Mediclaim policy. Not satisfied with the decision of the Company, Shri Karajgi approached Insurance Ombudsman with a plea to settle his claim.

The analysis of the case reveals that Shri S.G.Karajgi was admitted to the hospital for Acute prolyne disc L4-L5 Lumber Disc Syndros . The claim was repudiated on the grounds of pre-existing illness which was excluded from the scope of the policy as per Clause 4.1 of the Exclusion as the Company held the view that Acute prolyne disc L4-L5 necessitated Laminectomy and Discectomy would certainly indicate long standing complications. In fact, the Company received two medical opinions from their panel doctors. Let us first of all examine Lumber Mylography which confirmed the “E/o of a well defined filling defect at the L4-5 intervertebral disc s/o complete central prolapse intervertebral disc. Hypertrophied anterior spinal ligament indentation noted at L2-3, L3-4.” It is therefore quite clear that the Insured suffered from a case of complete central prolapse intervertebral disc and there was Hypertrophied anterior spinal ligament which indented at L2-L3, L3-L4. This would indicate positive existence of the

illness for quite sometime. Secondly, the doctor preferred to have Laminectomy as an option, which obviously indicate that medical management was not possible. “Laminectomy is an excision of a vertebral posterior arch, usually to remove a lesion or herniated disc.” This clearly points to duration of illness which resulted into complete central prolapse forcing the surgeon to excise this prolapsed disc which is known as discectomy and the very fact that surgery was done to relieve the pressure on the spine is indicative of long standing illness. The Insured, Shri Karajgi did forward a certificate from the hospital which mentioned in the footnote “ this trouble was not pre-existing disease which was sudden onset due to fall.” Unfortunately, if there would be a fall it should be mentioned in the hospital case reports and the indoor case papers together with previous history. In fact, if the insured was so sure about the fall, he would first mention about that to the hospital and moreover he should have lodged a claim well before this claim, as nobody with such a serious injury in the spine could sustain even a day. The sonography findings did indicate a slow process of development over a period leading to complete prolapse and requiring surgery.

In the context of the above analysis which is medically substantiated by means of hospital records, the repudiation of the New India is sustainable.

Mumbai Ombudsman Centre
Complaint No.GI-281 of 2005-2006
Shri Kapoorchand Sanghvi,
V/s.
National Insurance Company Limited

Award Dated

Shri Kapoorchand Sanghvi was covered under a Group Mediclaim policy No.250800/46/03/850000462 issued by The National Insurance Company Limited to Hindustan Lever Ltd., covering 23,281 Lifebuoy Soap users for the period 16.2.2004 to 15.2.2005. He was hospitalized for one day on 27.12.2004 at Bombay Hospital for Inguinal Hernia and was discharged with a remark that surgery was postponed due to medical reasons. He was again hospitalized at Bombay Hospital from 30.12.2004 to 3.1.2005 and Bilateral Hernioplasty was done. Shri Sanghvi, preferred a claim for Rs.37,485/- for his two hospitalizations which was rejected by the TPA, M/s Heritage Healthcare Services on the ground that the expenses for the treatment of Inguinal Hernia falls under Exclusion Clause 4.3 of the Group Mediclaim Standard Policy which means that claim occurring in the first year of the policy would not be payable. Shri Sanghvi represented to the company which was not considered for which he approached the Office of the Insurance Ombudsman vide his letter dated 9.12.2005 and 23.1.2006. The company was also asked to produce their records which have been examined.

As both the Company and the Complainant have given their written submissions with their respective viewpoints and the issues were focused, I applied my mind, analyzed the circumstances and felt that as per Redressal of Public Grievance Rules 1998, I may not call the parties for personal hearing instead an Award can be issued through analysis of the issues involved as per provisions of RPG Rules, 1998.

4.3 The records produced before this Forum makes it clear that Shri Sanghvi, was admitted for Inguinal Hernia, which was within the first year policy period and it therefore, clearly came under the provision of Exclusion Clause 4.3.

As the claim was made for treatment of Hernia, which came under the specific Exclusion of diseases excluded in the first year of insurance, the rejection of the claim by the Company is sustainable.