

Group Mediclaim Policy

Ahmedabad Ombudsman Centre

Case No. : 11-002-0242

Mr. A K Goswami

Vs

New India Assurance Co. Ltd.

Award Dated : 27-12-2006

Repudiation of Mediclaim due to late submission of Claim papers: The Insured was initially covered by a Group Mediclaim Policy for members of Winner's Business Link. Later after filling in a Proposal form, the Policy was renewed under Individual Mediclaim. The Insured after discharge from the Hospital submitted the Claim Forms to M/s Winner's Business Link. The Respondent could receive the papers only two months later. As such, the Claim was repudiated due to late submission of Claim papers. It was observed from the papers that the Insurer had printed the details of the Third Party Administrator who should be contacted in case of a Claim. The communication being quite clear, the Respondent cannot be made responsible for such lapse on the part of the Complainant. The Respondent does have powers to condone the delay in submission of papers only in extreme cases of hardship. Such not being in the present case, use of such discretion was not found to be merited. As such, the decision of the Respondent to repudiate the Claim was upheld.

Bhopal Ombudsman Centre

Case No. : GI/NIA/0906/059

Mr. C.V.Dubey

V/s

The New India Assurance Co. Ltd.

Award Dated : 10.11.2006

Mr. C. V. Dubey (hereinafter called Complainant) informed that he was covered under group Medi claim policy No. 712500/48/04/00012 (Certificate No. 712500/08059/GHFEB 2005) through City Bank Visa Card No. 4385 8790 1701 2000 with The New India Assurance Co. Ltd., Chennai (hereinafter called Respondent). As per the Complainant he was covered under group Medi claim policy No. 712500/48/04/00012 (Certificate No. 712500/08059/GHFEB 2005) through City Bank Visa Card No. 4385 8790 1701 2000 with the Respondent. In the said policy his brother Mr. Chandra Mohan Dubey was also covered. On 31.01.2006 his brother Mr. Chandra Mohan Dubey (hereafter called PATIENT) felt uneasiness and was rushed to M/S Niramay Hospital for immediate medical aid. Doctors advised the patient to go the M/S Bhopal Memorial Hospital & Research Centre, Bhopal. The PATIENT was immediately admitted and investigation in respect of CABG & AICD was carried out and due to extreme emergency bye pass surgery was carried out & AICD implanted during the period 06.02.2006 to 21.02.2006 and the patient was discharged on 21.02.2006. The intimation of the same was given to the Respondent on 03.02.2006. The Complainant also stated that he had incurred expenses of Rs. 6,12,979/- and as per the advise of the Respondent he send the medical claim bill for Rs. 2,50,000/- along with all supporting papers to their TPA i.e. M/S TTK Healthcare Services, Chennai on

02.03.2006. So far the Respondent TPA has not settled his claim and raising one query after the other and he is sending appropriate reply after consulting the concerned doctor of M/S Bhopal Memorial Hospital & Research Centre. Since the claim has not been settled, hence he has approached this office.

The Respondent in its reply-dated 03.11.2006 stated that they are servicing Citibank Credit Card Holders for Medi Claim and Personal Accident Insurance under their Master Policy called GOOD HEALTH POLICY and is issued to Citibank & Individual Good health Certificate would be issued to credit holders covering them and their family members based on the proposal submitted by them. Respondent also stated that in this case the PATIENT has been continuously covered under the Good Health Policy since 01.02.2004 for Sum Insured of Rs. 2,50,000/-. Diabetes Mellitus (DM) is the policy exclusion in respect of this PATIENT and the duration of DM (as per record) is 10 years. Further the PATIENT was insured for the period from 01.02.2005 to 31.01.2006, he was hospitalized for the period from 31.01.2006 to 06.02.2006 and diagnosed for Coronary Artery Disease (CAD)/Triple Vessel Disease(Heart Disease), known case of old IWMI, Hypertension, Diabetes Mellitus (DM) and had submitted the claim for Rs. 2,50,000/-. On receipt of claim bill their TPA M/S TTK Healthcare Services have requested for submission of indoor case papers to decide the claim. In this regard, the Complainant had submitted a certificate from the hospital authorities confirming that the PATIENT had old IWMI in the past and some time MI happens unnoticed. The PATIENT was a diabetic for the last 10 years and recently detected hypertensive. In this regard the Respondent also contended the following:-

1. Though the Complainant was covered under Good Health Policy earlier, there was a break in insurance for the period from 01.10.2002 to 31.01.2004.
2. A fresh proposal form was obtained for his Good health in Feb. 2004 policy.
3. So, far all practical purpose, GH Feb. 2004 is a fresh policy since the same was issued after break in insurance.
4. Diabetes Mellitus (DM) is the policy exclusion and duration of the same is 10 years.
5. Discharge summary confirms patient is known case of old IWMI.
6. Our GH Policy excludes not only the pre-existing ailments/diseases/disorders, but also the complications arising out of such pre-existing ailments/diseases/disorder.
7. Unless otherwise the Complainant/Patient informs the hospital authorities on the pre-existence of heart disease, the hospital authorities would have not mentioned "PATIENT is a known case of Old IWMI".
8. Otherwise, if the Complainant/ PATIENT are totally unaware having already suffered Old IWMI, then such silent MI is quite possible with the patients suffering from Diabetic Conditions.
9. When our Good Health Mediclaim policy excludes all complications arising out of pre-existing diseases or ailments or disorders, we are not liable to entertain the said claim.
10. On going through the claim folder obtained from their TPA, we find that the ECG (Graph) and the relevant report of the cardiologist on the basis of which the treating doctor, vide his certificate dated 27.02.2006 had mentioned about the possible "old IWMI" was not produced by the Complainant/ PATIENT along with the claim papers.
11. We had advised M/S TTK Healthcare Services to get the Indoor Case papers from the hospital directly, to ascertain whether his diabetic conditions would have been a contributing factor for the Myocardial Infraction and the present heart disease.

12. In the absence of Indoor case papers in the file, this aspect could not be ascertained at this stage. So, indoor case papers are to be obtained for which the Complainant may co-operate with the hospital. In the absence of indoor case papers, the claim could not be finalized by our TPA.

It is observed that the Respondent has asked their TPA i.e. M/S TTK Healthcare Services to get the Indoor Case papers from the hospital directly, to ascertain whether his diabetic conditions would have been a contributing factor for the Myocardial Infraction and the present heart disease. Hence it is clear that the Respondent has not yet finalized the settlement of the claim.

In view of the circumstances stated above, I am of the considered opinion that the decision of the Respondent not to settle the claim on this ground is fair and justified. Respondent is directed to depute some official and/or Investigator for obtaining the desired papers from the hospital authorities and to decide the claim on merit within 60 days. If the Complainant is not satisfied with the decision taken by the Respondent, the Complainant would be free to approach this forum with a fresh complaint. The complaint is thus disposed of.

Chandigarh Ombudsman Centre
Case No. : GIC/180/NIA/11/07
Pushpa Goel
Vs
New India Assurance Co. Ltd.

Order dated: 8.12.06

FACTS : Pushpa Goel was covered under Group Mediclaim Policy taken by LIC for its employees from DO Mumbai for the period 1.4.06 to 31.3.07. She filed claim for Rs. 18,430/- towards operation of eye of her daughter, which was not settled by the insurer.

FINDINGS : The insurer clarified that as per exclusion no. 4.14 of the policy document, reimbursement of laser treatment was possible only if refractive index was more than -7. In the instant case, the refractive error on the Left Eye was -5.25 spherical and -1.00 D cylindrical. In the Right Eye the refractive error was -4.00 D spherical and -4.00 D cylindrical. As per the opinion given by Dr. T.L. Gupta, who is on the panel of the insurer neither eye qualifies for reimbursement as neither eye had refractive index more than -7. The claim of the insured was that in the Right Eye refractive error was -4.00 D spherical and -4.00 D cylindrical. The total refractive error was thus -8.00. The point was discussed on telephone with Dr. Brar of Brar Eye Hospital who had performed the surgery. He was of the opinion that total of spherical and cylindrical refractive error should be taken into account. But he was not in a position to give a certificate that refractive error was more than -7.00.

DECISION : It was ordered that insurer would get a clarification from their Head Office and settle the claim accordingly.

Chandigarh Ombudsman Centre
Case No. : GIC/150/OIC/11/07
Jasvir Singh
Vs
Oriental Insurance Co. Ltd.

Order dated: 8.12.06

FACTS : Jasvir Singh's father Shri Surinder Singh was covered under the Kissan Credit Card Policy through Hoshiarpur Central Cooperative Bank, inter-alia covering

the risk of death/permanent disability. His father died in an accident on 12.10.05. He filed a claim with the insurer which was rejected on the ground that though the insured had died on 12.10.05, intimation to the company was given on 22.6.06 i.e. after the time limit of 30 days as per policy terms. He contended that as death certificate was received late, the insurer was intimated belatedly. Further due to sudden death of his father they were mentally upset. He urged intervention of this forum for settlement of claim at the earliest.

FINDINGS : The insurer clarified that the claim was rejected on the ground that as per terms and conditions of the policy he should have lodged the claim within 30 days of the death. On enquiry, he clarified that basic reason for adhering to time limit of 30 days was to enable the insurer to ascertain the bonafides of the accident resulting in the cause of death. The complainant was asked whether he had lodged any FIR or had a copy of PMR. He produced copies of PMR and DDR of Police Station, Garshankar. On perusal of these documents, it was found that Shri Surinder Singh died on 12.10.05 as a result of road accident.

DECISION : Held that the documents viz. PMR and DDR were sufficient proof to substantiate the cause of death. While agreeing with the insurer that the claim should have been lodged within 30 days, it was viewed that this technical hitch should not be the sole cause of rejection of the claim due to ignorance of the complainant about the existence of the policy and trauma undergone by the family due to sudden accident. The period of lodging the claim should not stand in the way of settling the genuine claim. Hence ordered to settle the claim.

Chandigarh Ombudsman Centre

Case No. : GIC/231/NIA/11/07

Kailash Jain

Vs

New India Assurance Co. Ltd.

Order dated: 4.1.07

FACTS : Smt. Kailash Jain was covered under Group Mediclaim Policy taken by LIC of India for its employees. Her husband Shri Subhash Chander Jain was also covered under the said policy as a dependent member. He underwent right eye surgery at Mirchia's Laser Eye Clinic, Sector-22, Chandigarh. A claim amounting to Rs. 18,500/- was submitted to the insurer. The insurer raised an objection for submission of 15 bed hospital certificate. She stated that as certified by Dr. Mirchia, this kind of surgery do not require hospitalization.

FINDINGS : The insurer informed that as per terms and conditions of the policy, the treatment has to be taken in a registered nursing home/ hospital or it should be a 15 bedded hospital. Neither of the certificates could be produced by the complainant. The position was checked up on telephone from Dr. Mirchia who mentioned that no clinic or nursing home is registered in Chandigarh, Mohali and Panchkula. The qualified medical practitioner certificate should be enough to cover insurance claims.

DECISION : Held that the repudiation of the claim by the insurer was not in order. The claim by the complainant was justified and should be paid as admissible. Hence ordered that admissible amount of claim be paid to the complainant by the insurer.

Chennai Ombudsman Centre

Case 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 hospitalised 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
Case No. : 11.02.1056/2006-2007
Shri. B. Omprakash
Vs
New India Assurance Co. Ltd.,**

Award Dated : 3.10.2006

Master Darshan Kumar was covered under Mediclaim Policy issued by New India Assurance Co. Ltd, for the period, from 06.06.2005 to 05.06.2006. He was hospitalized from 25.09.2005 to 27.09.2006 at M/s Vikram Hospital and he underwent surgery for KTP Laser Adenotonsilectomy + Turninoplasty. His father, Shri. B. Omprakash claimed for reimbursement of hospitalisation expenses of Rs. 68,781/-. However, his claim was settled only for Rs.30,000/-. Hence, he approached this forum for full settlement of his claim.

The insurer contended that as per the policy conditions, the Insurer could pay only reasonable and necessary hospitalisation expenses and justified that the amount paid by the TPA was in order by producing quotations of various other hospitals in the same standard in respect of the expenses for the same type of operation.

The forum stated that though the insurer has paid a reasonable and necessary expenses incurred, when the insured contacted the TPA of the insurer before hospitalisation, the TPA failed to inform about the exorbitant charges charged by M/s Vikram Hospital thereby giving an impression that there was nothing objectionable about exorbitant charges charged by M/s Vikram Hospital. Hence, the Ombudsman allowed an amount of Rs.10, 000/- on ex-gratia basis in addition to Rs.30,000/- already offered to the insured by the insurer.

**Chennai Ombudsman Centre
Case No. : 11.04.1107/2006-2007
Smt. Nandini
Vs
The United India Insurance Co. Ltd.,**

Award Dated : 11. 10.2006

The complainant represented that she was covered under Group Mediclaim Policy since 01.10.2003 with United India Insurance Co. Ltd., and the present period of

insurance was from 01.10.2004 to 30.09.2005. She was hospitalized from 09.07.2005 to 23.07.2005 for Total Knee Replacement. She submitted her claim papers to the insurer for reimbursement. However, the insurer repudiated the claim on the ground that the present ailment was pre-existing one.

The insurer contended that as per the discharge summary of the hospital where it was clearly mentioned that the insured was suffering from pain in right knee since 1 ½ years and it was severe for past three months. They arranged for an investigation. On the opinion of their Panel Doctor, which stated that the patient has Chronic Arthritis and she herself was well aware of the same, the insurer repudiated the claim.

The forum scrutinized the documents. The forum pointed out that the policy was incepted on 01.10.2003. To find whether the insured's disease is pre-existing or not, she should have suffered from the Rheumatoid Arthritis much before the inception date. Since the insurer has not conclusively proved the pre-existence of the disease before the inception of policy. Direction was given to the insurer to settle the claim as per policy terms and conditions.

**Chennai Ombudsman Centre
Case No. : 11.02.1151/2006-2007**

Shri. A. R. Narayanan

Vs

The New India Assurance Co. Ltd.,

Award Dated : 31.10.2006

The complainant stated that he and his wife were covered under LIC Group Mediclaim with M/s New India Assurance Co. Ltd. Due to the complaint of giddiness and vomiting his wife was hospitalised. He submitted the claim papers to the insurer for reimbursement. However, his claim for reimbursement of medical expenses was repudiated on the ground that the hospitalisation was for routine examination and the same does not fall within the scope of their policy.

The insurer contended that after conducting all tests for the insured like CT scan, X-Ray, Ultrasound of abdomen etc. that alone costed Rs. 15,715, there was no positive existence of disease. The insured was diagnosed to have Benign Positional Vertigo and Diabetes Mellitus and he was advised by the Doctor to use Har Cervical Collar. The insurer stated that the hospitalisation was for routine examination and not warranted admission hence they stated that their repudiation was in order.

On perusing the documents, the forum observed that the insured was suffering from giddiness and vomiting. The insured was advised to hospitalise by a duly qualified medical practitioner and she was diagnosed to have Benign Positional Vertigo and Diabetes Mellitus and medication has been administered. Since all these factors fulfill the policy condition, direction was given to the Insurer to settle the claim as per terms and conditions of the policy.

**Chennai Ombudsman Centre
Case No. : 11.02.1069/2006-2007**

Shri. K. Varadharajan

Vs

The New India Assurance Co. Ltd.,

Award Dated : 31.10.2006

The complainant stated that he is covered under LIC Group Mediclaim policy with M/s New India Assurance Co. Ltd.. He was hospitalised from 02.04.2005 to 03.04.2005 and diagnosed to have FUC of Chronic Pancreatitis. He submitted his claim papers to the

insurer for reimbursement of the medical expenses. However, his claim was repudiated by the insurer on the ground that the itching did not warrant hospitalisation and the medicines purchased were for routine treatment. Hence they repudiated the claim

The insurer contended that as per Discharge Summary, the admission was for the complaint of itching, but the insured was diagnosed as FUC of Chronic Pancreatitis. Since the insured does not produce the file in respect of the previous claim, they can reimburse the cost of the medicines under post hospitalisation expenses as requested by the insured.

The forum pointed out that the complainant failed to produce any documentary evidence that his present ailment i.e itching was so severe which necessitated hospitalisation. As per policy, expenses pertaining to illness should warrant hospitalisation. Direction was given to the Insurer to settle the claim under post hospitalisation benefit as per terms and conditions of the policy only if they had already settled the previous claim for the March 2005. Insurer was directed to furnish the settlement details to this forum.

Chennai Ombudsman Centre
Case No. : 11.02.1056/2006-2007

Shri B. Omprakash
Vs

The New India Assurance Co. Ltd.,

Award Dated : 31.10.2006

The complainant represented that he was covered under LIC Group Mediclaim policy with M/s New India Assurance Co. Ltd., He was hospitalised for complaints of abdominal pain and occasional vomiting, constipation, pain over both shoulders, numbness over palms and heels. He submitted necessary claim papers to the insurer for the reimbursement of hospitalization expenses. The insurer rejected the claim under exclusion clause 4.8 of the policy.

The Insurer contended that their panel doctor opined that the case sheet revealed that the complainant used to take alcohol and that was the cause for present complication, hence the same falls within the exclusion clause 4.8 of the policy. From the case sheet of the hospital, they understood that the insured used to take alcohol and stated that this could have been the reason for Pancreatitis. Hence they repudiated the claim.

The forum perused the documents. Forum pointed out the contradictions between the facts mentioned in the Discharge Summary and doctor's certificate and those mentioned in the internal case records. The Ombudsman also said that the complainant failed to substantiate the reason for the said discrepancies. The forum was not inclined to adjudicate the case due to conflicting reports submitted to the forum. Hence the case was dismissed.

Chennai Ombudsman Centre
Case No. : 11.02.1149/2006-2007

Shri. M.V.T. Mohanram
Vs

The New India Assurance Co. Ltd.,

Award Dated : 09.11.2006

The complainant stated that he and his wife were covered under L.I.C. group Mediclaim policy. His wife was hospitalized with complaints of sleeplessness, agitation and aggressiveness. She was diagnosed to have Schizophrenia, Hypertension and Diabetes Mellitus. The Doctor advised her with medicines and since it did not respond,

she was given Electro Convulsive Therapy for 15 days. He submitted the necessary claim papers to the insurer however, his claim was repudiated by the insurer on the grounds that while admission was claimed to have been made at M/s Anandpriya Hospitals, the bills for diagnostic services and pharmacy were from M/s Gemini Diagnostics and M/s Vadamalayan Dianostic Centre which made them to believe that the claim made was for an Outpatient treatment and not for an Inpatient treatment. Hence the Insurer repudiated the claim. The insured represented the insurer to reconsider his claim and stated that he had produced the bills pertaining to M/s Gemini Diagnostics and M/s Vadamalayan were due to the fact that M/s Gemini Diagnostics is owned by M/s Anandpriya Hospital itself and they also utilize the services of M/s Vadamalayan Diagnostics Centre in case of emergency.

The insurer contended that the insured had not produced proof of hospitalisation and also stated that there was no document to establish the necessity for treatment for such a long time as 22 days.

The Ombudsman questioned the insurer why could not they get clarification from the Hospital Authorities itself regarding the Bills. Insurer also agreed for investigation and stated that they would submit the same within 15 days. Subsequent to the hearing the insurer raised yet another issue invoked condition 2.1 of the policy for repudiating the claim stating that the Hospital has only 14 beds but they have not produced documents to that effect. Since the doctor in their discharge summary confirms the presence of 16 beds and the fact that she was administered ECT establishes the need for infrastructure of a hospital and hospitalisation. The attending doctor also certified that her aggressiveness necessitated hospitalisation and she was given ECT for 15 days. Hence direction was given to the insurer to settle the claim as per policy regulations and other procedural aspects.

Chennai Ombudsman Centre
Case No. : 11.02.1174/2006-2007
Shri. A.R. Kalyana Sundaram
Vs
New India Assurance Co. Ltd.

Award Dated : 16.11.2006

The complainant was covered under LIC Group Mediclaim Policy with M/s New India Assurance Co. Ltd. He had preferred for 4 claims , however the insurer has disallowed Rs.4054/- totally without any basis. The Insured contended that the pre-hospitalization expenses for 30 days and post hospitalization expenses for 60 days for diseases not relevant to the specific disease for which he was hospitalized should be reimbursed. His representations to the Insurer were not considered, hence he approached this Forum for redressal of his grievance.

The Insurer contended that except Rs.209 disallowed by them which was due to some clerical error, all other amount disallowed were as per their policy condition. Insurer also contended that they could not go beyond the policy conditions.

The Forum noted the exclusion clause which states that "Expenses pertaining to pre hospitalization , during hospitalization and post hospitalization for disease other than the relevant disease for which a person was hospitalized would not be covered under this Mediclaim Scheme." Under this case the complainant had claimed for expenses pertaining to disease which was not a relevant disease for which he has been hospitalized.. The Forum stated that there was no rationale behind the argument of the complainant with the present hospitalization. Hence the Forum dismissed the complaint.

Chennai Ombudsman Centre
Case No. : 11.02.1156/2006-2007
Shri. R. Manikandan

Vs

The New India Assurance Co. Ltd.,

Award Dated : 30.11.2006

The complainant Shri. R. Manikandan and his spouse were covered under a Group Mediclaim policy issued by M/s New India Assurance Co. Ltd. His wife was hospitalized for delivery. He submitted the claim papers for reimbursement of hospitalization expenses. However, the TPA rejected his claim on the ground that M/s Sri Saradha Clinic was not in conformity with the hospital as defined under the policy. The Insured contended that since it was an emergency situation, they took treatment at the said hospital for his wife.

The Insurer stated that the wife of the complainant had been treated in a hospital, which was not in conformity of the hospital as defined under the policy. Hence, they reiterated their stand.

The Forum perused the documents. It is observed that the complainant has not complied with the specific condition stipulated under the policy. It is noted that the insured was well aware of the stipulation and he was residing within the municipality limits of Madurai city and it is not that the insured was in a very remote place, which did not have hospitals catering to the stipulations specified in the policy. Hence the insurer is justified in repudiating the claim. The Forum dismissed the complaint.

Chennai Ombudsman Centre
Case No. : 11.02.1247/2006-2007
Shri. R. Sivasubramanian

Vs

New India Assurance Co. Ltd.

Award Dated : 29.12.2006

The complainant Shri. R.SivaSubramanian was covered under LIC Group Mediclaim Policy with M/s New India Assurance Co. Ltd. He was hospitalized and diagnosed to have type 2 DM, Systemic HT, Ischemic Heart Disease and Gout. He had claimed for reimbursement of hospitalization expenses, however, the Insurer invoking exclusion clause 4.1 of the policy repudiated his claim.

The Insurer contended that the hospitalization of the insured was for evaluation purpose only and did not warrant hospitalization. The discharge summary of the hospital also revealed that the patient was in normal condition at the time of hospitalization, hence reiterated their stand.

This Forum perused the documents. The panel doctor of the TPA was only a post facto assessment without knowing the actual condition of the patient at the time of admission. Since the insured did have some positive existence of a disease and the tests done were relevant to his health problems. Hence, direction was given to the Insurer to process and settle the claim as per terms and conditions of the policy.

Chennai Ombudsman Centre
Case No. : 11.04.1241/2006-2007
Shri. M. Velayutham

Vs

United India Insurance Co. Ltd.,

Award Dated : 25.01.2007

The complainant Shri. Velayutham was covered under Arogyadaan Group Mediciclaim policy issued through Andhra Bank by M/s United India Insurance Co. Ltd. for the period from 09.06.05 to 8.06.06. Since he had chest pain, he was hospitalized and underwent CABG. His claim papers were repudiated by the Insurer on the ground pre-existing.

The Insurer contended that the prescription of M/s Frontline Life Line Pvt. Ltd. stated the patient was a known diabetic patient and under medication. But the discharge summary stated that the patient was not diabetic. Since, there was contradiction, the insurer called for the internal case sheets from the hospital, but the hospital refused to furnish with the same, hence they have repudiated the claim under exclusion clause 4.1. of the policy.

This Forum perused the medical records and observed that the doctor's prescription alone contained a noting 'known diabetic', however the medical records pertaining to the hospitalization did not contain any recording of diabetes. If the patient had been a diabetic patient that would have been recorded in the medical records prior to surgery. Further to that, diabetes might be one among the risk factor for heart disease and not a sole contributing factor. The Insurer also failed to prove with substantiating documents to establish that the patient was diabetic prior to the inception of the policy. Therefore, direction was given to the insurer to settle the claim as per the terms and conditions of the policy.

Chennai Ombudsman Centre
Case No. : 11.02.1270/2006-2007
Smt. M. Mahalakshmi
Vs
The New India Assurance Co. Ltd.

Award Dated : 27.02.2007

The complainant Smt M. Mahalakshmi was covered under LIC Group Mediciclaim policy with M/s New India Assurance Co. Ltd. She was hospitalized since she had abdominal pain and vomiting. The Insurer on the ground repudiated her claim papers that the treatment did not warrant hospitalization and she could have taken treatment as an OP. She represented to the RO that she had acute pain and hospitalized as per the advice of the doctor.

The Insurer stated that they had obtained medical opinion and as per that opinion the scan showed maxillary sinusitis and the claimant was treated with oral medicine. They also contended that the course of treatment was silent regarding the abdominal pain and the insured was treated for DM and sinusitis.

The Forum perused the documents and found that the attending doctor had certified patient's hospitalization. In the hospital various other problems were diagnosed and treatment were given. Since symptoms of the same were not dominant in the patient at the time of hospitalization, these ailments did not warrant hospitalization and were not recorded as presenting complaints. Hence, a partial amount was allowed as an ex-gratia.

Chennai Ombudsman Centre
Case No. : 11.05.1301/2006-2007
Shri. Vijai Srinivasan
Vs
The Oriental Insurance Co. Ltd.

Award Dated : 16.03.2007

The complainant and his mother were covered under Group Mediclaim Policy with M/s Oriental Insurance Co. Ltd. from 05.10.2005 onwards. She was hospitalized for Coronary Heart Disease and submitted necessary claim papers to the insurer. However, his claim was repudiated on the ground that the disease was pre-existing.

The Insurer contended that as per their investigation report the Rheumatic Carditis might be a pre-existing one, hence they have repudiated the claim. When questioned about the nexus between the CAD and Rheumatic Carditis, the insurer had stated that they have acted as per their panel Doctor's opinion.

This Forum perused the documents. It was observed that no proposal form or medical examination was called at the time of proposal. Hence, the insured was not given to a chance to disclose the facts of his/her previous illness. It was also observed that the insurer had failed to establish the nexus between the CAD and Rheumatic Carditis and failed to prove whether the insured was having the said ailment before inception i.e. at least a day before inception. Hence, direction was given to the Insurer to process and settle the claim as per policy terms and conditions.

Chennai Ombudsman Centre
Case No. : 11.02.1392/2006-2007
Shri.T K Gopal
Vs
New India Assurance Co. Ltd.,

Award Dated : 28.03.2007

A complaint was filed by Mr T K Gopal stating that he is covered under LIC Group Mediclaim policy with M/s New India Assurance Co. Ltd., He had a chest pain on 21.04.2006, he rushed to M/s Aysha Hospital Pvt Ltd., hospitalized for further treatment and discharged on 22.04.2006. His claim was rejected by the insurer on the grounds that hospitalization was only for diagnosis/investigation purpose, hence the claim is not admissible under the policy. He contended that the hospitalization was for chest pain and as per the doctor's advice only he was hospitalized and treatment was taken.

The discharge summary revealed that the patient was having complaint of Chest Pain Left side since 1 hour prior to admission, pain was comprehensive in nature and was radiating to neck. The ECG produced by the complainant revealed that these reports were taken at 11.55 p.m. on 20.04.2006 and three times during hospitalization. It was evident during night time the patient had a chest pain which was comprehensive in nature and radiating to neck, hence considering the nature of problem the doctor advised for hospitalization and for further examination by way of ECG etc., and the patient was diagnosed as Tietze syndrome. The attending doctor who had examined the patient physically can only decide whether the patient requires infrastructure of the hospital and the argument of the insurer that the present hospitalization was only for investigation/diagnosis purpose without any supporting documents or reasoning is only a post facto assessment without seeing the patient at the time of hospitalization. The complaint is allowed and direction is given to the insurer to process and settle the claim as per terms and conditions of the policy.

Chennai Ombudsman Centre
Case No. : 11.02.1401/2006-2007

**Shri. N. Natarajan
Vs
New India Assurance Co. Ltd.**

Award Dated : 28.03.2007

The Complainant Shri N Natarajan stated that he was covered under LIC Group Mediclaim policy. He was hospitalized at M/s Lotus Eye Care Hospital (P) Ltd., from 20.06.06 to 21.06.06 for Cataract Surgery and incurred expenses of Rs.25,527.27 and submitted necessary documents to the insurer for the reimbursement of his claim. However, the insurer offered a settlement of Rs.12,957/- without any explanation for the short settlement. He represented to the Grievance Cell of the insurer against the offer of Rs. 12,957/- but, his representation was not considered, hence this complaint.

The Insurer contended that the amount charged by M/s Lotus Hospital is exorbitant and as per the policy they have reimbursed the reasonable and necessary expenses for the hospitalization. He also contended that their TPA M/s Medicare has a tie up with M/s Lotus Hospital and the package amount for this type of surgery was Rs.12,500/-.

The Forum perused the documents and it was observed that the patients are bound to have their own independent health problems and hence the scope of treatment would vary from person to person and it would not be fair to universally apply a common quotation without differentiating the health condition of the persons. Hence direction was given to the Insurer to settle the full claim amount subject to other terms and conditions of the policy.

**Chennai Ombudsman Centre
Case No. : 11.02.1415/2006-2007
Shri. K Jeyaprakash
Vs
New India Assurance Co. Ltd.,**

Award Dated : 29.03.2007

A complaint was filed Mr K Jayaprakash representing that his family is covered under LIC Group Mediclaim policy with M/s New India Assurance Co. Ltd., His wife Mrs.Selvamani developed giddiness and fainted when she visited Chennai, and she was hospitalized at M/s J V Hospitals from 21.7.05 to 22.7.05. The insurer with a reason that hospitalization was not warranted rejected his claim. His main contention was that considering the condition of his wife the doctor advised him to admit her in the hospital, hence the insurer is wrong in rejecting his claim.

From the documents produced, It was evident that the patient had a problem of breathing and some discomfort and as per the advise of the attending doctor she was admitted in the hospital and treatment was given. When a person presents with complaints of discomfort the attending doctor is the appropriate person to decide the necessity of hospitalization taking into consideration the specific physical condition of the person at that point of time. Any subsequent, post facto analysis and conclusion, done in retrospect, is at best only an approximation, which falls short of the real time assessment. Therefore, this forum is of the view that since the basic pre-requisites for hospitalization as per the policy condition have been met with the insurer is not justifiable in rejecting the claim. The complaint is allowed and direction was given to the insurer to settle the claim as per terms and conditions of the policy.

Chennai Ombudsman Centre

Case No. : 11.02.1397/2006-2007

Shri. V Archnuan

Vs

New India Assurance Co. Ltd.,

Award Dated : 29.03.2007

A complaint was filed by Mr V Archunan complainant that his family is covered under LIC Group Medclaim policy with M/s New India Assurance Co. Ltd., His mother was hospitalized at M/s Vadamalayan Hospital for the complaints of chest pain and giddiness due to loose motion from 15.04.2006 to 19.04.2006. His claim was rejected on the ground that the hospitalization was investigation purpose and his claim falls under the exclusion clause 4.10 of the policy. His main contention was that his mother was aged and it was due to her health problem only she was hospitalized insurer was wrong in rejecting his claim.

It was evident from the documents that the patient was aged 72 years having a problem of loose stools 5 to 6 times for 2 days with giddiness, weakness tiredness and stomatitis, and hence considering the age of the patient and the nature of the problem, the doctor advised for hospitalization and further examination by way of Carotid Doppler, CT Brain etc was done, and the patient was diagnosed with Hypertension and Enteritis. It is to be acknowledged that the attending doctor who had examined the patient physically can only decide whether the patient requires hospitalization. The argument of the insurer that the present claim falls under exclusion 4.10 viz charges incurred at hospital primarily for diagnostic purpose and is not incidental to the diagnosis is only a post-facto assessment without seeing the patient at the time of hospitalization, hence the insurer is not justified in rejecting the claim. The complaint was allowed and direction was given to the insurer to process and settle the claim as per terms and conditions of the policy.

Chennai Ombudsman Centre

Case No. : 11.02.14120/2006-2007

Smt. A Kanchana Devi

Vs

New India Assurance Co. Ltd.,

Award Dated : 29.03.2007

A complaint was filed by Mrs Kanchana Devi representing that her family is covered under LIC Group Medclaim policy with M/s New India Assurance Co. Ltd.,. Her Mother was hospitalized at M/s Vadamalayan Hospital from 23.02.2006 to 28.02.2006 for the complaint of chest pain and other illness. The insurer with the reason that hospitalization was not warranted and the treatment could have been taken as an outpatient rejected her claim. Her main contention was that the hospitalization was necessary for the recovery of her mother and to support her stand she relied on the copy of the certificate issued by the attending doctor.

It is evident from the documents that Mrs. A Velammal was having problem of chest pain on and off since one month with giddiness, difficulty in breathing along with other problems viz abdominal pain, cough with expectoration, pain in the left hand etc., and hence considering the nature of the problem the doctor would have advised for hospitalization and further by investigation the patient was diagnosed to have Acute on Chronic Bronchitis and Diabetes Mellitus Type II. It is to be acknowledged that the attending doctor who had examined the patient physically when she presented with the complaints, can only decided whether the patient requires hospitalization or not. Complaints like Chest pain, giddiness etc can be symptoms of major illness causing

alarm and apprehension at the time of its occurrence and hence only appropriate medical management, which includes investigative tests, can solve the problem. It is therefore reasonable to conclude that the test for the necessity of hospitalization should be the condition of the insured at the time when she consults the doctor at the hospital and not when she is discharged. The argument of the insurer that the treatment did not warrant hospitalization and could have been evaluated as an Out-patient without any supporting documents or reasoning, is only a post-facto assessment without seeing the patient at the time of hospitalization, hence the insurer is not justified in rejecting the claim. Hence complaint is allowed and direction was given to the insurer to process and settle the claim as per terms and conditions of the policy.

Chennai Ombudsman Centre
Case No. : 11.02.1561/2006-2007
Shri. M.B. Nagarajan
Vs
New India Assurance Co. Ltd.

Award Dated : 29.03.2007

The Complainant Shri. M.B. Nagarajan covered under Group Medical Policy with M/S New India Assurance Company Ltd., Chennai. He preferred three claims during 2005 with the Insurer for reimbursement of hospitalization expenses. However, the Insurer has not allowed the entire claim amount and disallowed a part of the claim amount particularly in respect of cost of medicines for the reasons (i) non submission of prescription (ii) the date of prescription was 30 days prior to date of hospitalization, hence claim did not fall under pre hospitalization benefit.

Since the same medicines were bought and used by the complainant as mentioned in the discharge summary, during the 30 days prior to the hospitalization, it reveals that medicines used during pre hospitalization was pertaining to the treatment taken during the hospitalization. Though the date of the prescription may not be just 30 days before the date of admission, It cannot be denied that the medicines bought and used pertaining to the treatment taken during the hospitalization. In view of the above, the Insurer is directed to reimburse the cost of medicines so bought and mentioned above. With regard to the second claim forum found no fault in respect of the decision taken by the Insurer.

In respect to the third item, it was to be noted here that the intention of the policy in allowing post – hospitalization expenses was that medicines taken for a period of 60 days after hospitalization and pertaining to the illness for which the hospitalization has taken place is reimbursable. In the said case, from the above, the following emerge:

- a) The medicines claimed in the third claim are the ones prescribed by the doctor to be taken during the post-hospitalization period.
- b) Though there is no bill for the purchase of these medicines during the post hospitalization period it is also confirmed by the insurer that the insured has not made any other claim for the same.
- c) The above two points gives credence to the contention of the insured that since he had purchased these medicines prior to hospitalization he used it during the post hospitalization period as per the advice of the doctor mentioned in the discharge summary.

Hence direction was given to the Insurer to settle the claim as stated by this Forum and the claim was allowed partially.

Chennai Ombudsman Centre
Case No. : 11.02.1414/2006-2007
Shri. K Vivekanandan
Vs

New India Assurance Co. Ltd.,

Award Dated : 29.03.2007

A complaint was filed by Mr K Vivekanandan, stating that his family stands covered under LIC Group Mediclaim policy with M/s New India Assurance Co. Ltd. His wife Smt V Saroja was hospitalized at M/s Vadamalayan Hospital for the complaint of swelling and pain in right leg from 08.03.2006 to 12.03.2006. His claim was rejected on the ground that hospitalization was not warranted. His main contention was that considering the severity of the illness his wife was hospitalized, and hence the rejection of his claim was not correct.

The documents submitted before this forum established that Smt V Saroja was a diabetic patient with a problem of pain and swelling in right LL, hence considering the nature of the problem the doctor advised for hospitalization, further investigations and close monitoring were done at the hospital and treatment were administered. It is to be acknowledged that the attending doctor who had examined the patient physically can only decide whether the patient requires hospitalization. The argument of the insurer that the treatment did not warrant hospitalization without any supporting documents or reasoning, is only a post-facto assessment without seeing the patient at the time of hospitalization, hence the insurer is not justified in rejecting the claim. The complaint was allowed and direction was given to the insurer to process and settle the claim as per terms and conditions of the policy.

Hyderabad Ombudsman Centre
Case No. : G 11.002.0145
Aduru Venkata Sessaiah
Vs

New India Assurance Co.Ltd.

Award Dated : 09.11.2006

The complainant was covered under the Group Mediclaim Policy issued to both serving as well as retired employees and their dependents of L.I.C. of India, for a sum insured of Rs. 2,00,000/-. He was admitted at Aysha Hospitals, Chennai, with complaints of difficulty in passing stools and swelling of lower limbs on and off since 2 months. He submitted a claim bill for Rs. 8577/- towards reimbursement of hospitalisation expenses incurred. The insurer rejected the claim vide letter dated 22.03.2006 on the ground that Moderate Hypertension did not warrant admission and that the patient was admitted for evaluation and not for treatment.

The complainant contended that he first consulted Dr. S.L. Narasimham of Sri Krupa Nursing Home, Kavali on 11.02.2005 for treatment of several problems like nocturnal cramps, dimness of vision, general debility, piles, and joint pains. He was advised complete body check up and surgery for piles. He was admitted in the hospital under the advice of the doctor and not out of his own will.

The insurers contended that they referred the file to one of their panel doctors who opined that "patient was admitted for evaluation only, not for treatment as per discharge records. The patient was admitted for evaluation, not for treatment."

Held

With regard to the "Course in the hospital /treatment", the patient was prescribed a battery of tests and was discharged after evaluation/ observation. The hospital papers available in the file do not reveal that any surgery was performed for piles. The papers do not speak about any treatment for this ailment also. Nowhere has the treating doctor mentioned about treatment given for "piles", the chief complaint for which he was advised admission. It appears he was treated for general debility (exclusion under the policy) and therefore advised series of tests. The insurer rejected the claim as per the terms and conditions of the policy, which is reasonable. The complaint is dismissed.

Hyderabad Ombudsman Centre

Case No. : G 11.002.164

Sri S.M. Shinge

Vs

New India Ass.Co.Ltd.

Award Dated : 29.12.2006

Sri S.M. Shinge, working as ADM in LIC, Belgaum was covered, along with his family members, under a Group Health Insurance Policy issued by M/s. New India Assurance Co. Ltd covering the employees of the Life Insurance Corporation of India. His wife Smt. Sudha Shinge, aged about 45 years was diagnosed to have "Chronic Myeloid Leukemia" (CML) on 25.06.2004.

The insurers paid the claims pertaining to initial hospitalizations at KLES hospital, where tests were also conducted. As per policy, pre-hospitalization expenses of 30 days and post-hospitalization expenses of 60 days are payable in conjunction with each admission to hospital or day treatment by chemotherapy.

Basing on investigation reports, the insurers held that payments of Rs.25302/- and Rs.24453/- (Shanthi Hospital 08.03.05 & post-hospitalization) were incorrectly done and demanded return of these claim amounts.

The insurers, also, repudiated the claims for hospitalisation, post-hospitalisation expenses amounting to Rs.35391/- and Rs. 25553/- with respect of admission at Sankalp Hospital on 25.06.05. The claims pertaining to Smt. Shinge's further hospitalisations from 27.08.05 to 29.08.05 at Sankalp Hospital and on 27.10.05 at K.L.E.S. hospital are yet to be disposed by the insurers.

The insurers, basing on their investigator's report, contended that Smt. Shinge was never admitted to these hospitals but only made up the documents to avail the benefits under the medical insurance scheme. They seek not only to repudiate the pending claims but also to recover all the claim amounts paid earlier.

Held:

Neither the insurer's representative at the hearing, nor the investigator in his report raised any doubts about the illness suffered by Smt. Shinge, its seriousness and the requirement/necessity of the treatment taken for the same. It is common knowledge that effects of the illness/side effects of the treatment show several symptoms, some of which would need hospitalisation. It is also not disputed by the insurers that Smt. Shinge was under treatment for Chronic Myeloid Leukaemia.

I am not inclined to accept, based on the facts before me, that the insurer had repeatedly paid claims, which were not payable.

I do not find any logic in the approach of the insurers. They had accepted the incidence of the illness and the line of treatment. At a much later date, they wake up and try to recover/stall the payments based on an ill-conceived technicality, which itself is based on a half-baked investigation report. Even if there were to be a technicality, the insurers ought to be fair and taking into account the totality of circumstances in the present case, should have offered ex-gratia settlement themselves. Their attempt to recover the earlier payments indicates lack of professionalism on their part.

I, therefore, direct the insurer (i) not to recover the amounts already paid to the complainant and (ii) to process the rest of the claims preferred by the complainant including the pre & post hospitalisation expenses corresponding to hospitalisation of June, August and October 2005 as per procedure, ignoring the investigation report.

Hyderabad Ombudsman Centre

Case No. : G 11.002.0173

Shri S S S Babu Rao

Vs

The New India Ass. Co.Ltd.

Award Dated : 19-01-2007

The complainant, an employee of L.I.C.of India, was covered under the Group Mediciclaim Policy issued to employees and their dependents for a sum insured of Rs. 80,000/- per person. His mother was operated for ovarian cancer at Chennai in October 2004. The complainant incurred expenditure of Rs. 60,649/- for the surgery. He lodged a claim with the insurer for reimbursement of hospitalization expenses. The insurer settled the claim on 30.05.2006 for Rs.12,029/-, as against the amount claimed of Rs. 60,649/-

The insurer's conceded that there was an error on their side in arriving at the balance sum insured available to the credit of the complainant's mother. After re-calculation they expressed their willingness to reprocess the claim and settle for the balance sum insured of Rs. 44,416/- under the policy.

Held

The insurers have a lot to explain for their callous and indifferent attitude. They did not bother to acknowledge the various calls made to them. I observe that the Regional Office too did not bother to reply to the complainant's representation. It is also noted that they sent a note totally unrelated to the complaint with this office. This speaks volumes about their sincerity of purpose.

In this case there is no doubt in my mind that the complainant was given a raw deal in the settlement of his claim. As such, in addition to the payment of the difference amount due to the complainant, I am inclined to award payment of interest as per IRDA: Protection of Policy-holder's Interest Guidelines, with effect from 30.05.2006, (the date of part payment), till the date of full payment.

Hyderabad Ombudsman Centre

Case No. : G 11.004.0204

Shri B Ganesh Rao

Vs

United India Insurance Co.Ltd.

Award Dated : 26-02-2007

The complainant covered his family members under a Group Medclaim Policy issued to employees of Ms Ivy Comptech for a floater sum insured of Rs. 1,00,000/- for the entire family 09.09.2005. In addition to this amount, the policy had a buffer sum insured of Rs. 1,00,000/- per family. The complainant's father, Sri B.Srinivasa Rao, was admitted to Yashoda Hospital on 07.02.2006 with complaints of hoarseness of voice since 2 months, difficulty in swallowing since 20 days etc. and was diagnosed to have Carcinoma Larynx.

The complainant lodged his claim for Rs. 2,43,277/- with Family Health Plan Ltd.(FHPL), the Third Party Administrators (TPA). However, the TPA, vide their letter dated 01.08.2006, rejected the claim stating, present hospitalisation was for the management of an ailment which was related to a pre-existing disease and excluded under clause 4.1 of the policy. The complainant contended that he joined the present employer on 01.09.2005 and immediately enrolled in the insurance scheme. The ailment was detected on 19.12.2005 .He also added that his father was also covered under a similar Group Medclaim Policy taken by his brother's employer at Bangalore for a sum insured of Rs.50,000/-. M/s T.T.K. Healthcare, the TPA under that policy, settled an amount of Rs. 50,000/- directly to the hospital. Therefore rejection of the claim was baseless and unfair.

Held

The insurers based their decision to reject the claim on their expert's opinion. This opinion does not establish with certainty that the disease was there in existence prior to inception of the policy. The doctor was not categorical in his assessment. He noted that "it would appear that the disease has been in existence for at least 4-6 months prior to the investigations." It is clear that this opinion is a vague assessment of the probability of the existence of the disease. In contrast to this, the 2 treating doctors, at KIMS and at Yashoda Hospital, note that the earliest symptoms were no more than 2 months old (from the date of the first diagnosis). This fact is also mentioned in the Case Records. Since the insurers were unable to place before me any concrete evidence in support of their stand, other than this opinion, the conclusion based on surmise about the pre-existence of the disease cannot be accepted.

Hence the complaint is allowed and the insurers are directed to settle the claim.

Hyderabad Ombudsman Centre

Case No. : G 11.008.0243

Ms.Lakshmi Prabha

Vs

Royal SundaramAlliance Ins. Co.Ltd.

Award Dated : 26-02-2007

Ms. Lakshmi Praba, aged about 21 years, working in Aargee Systems, Bangalore was covered under a Group Health Insurance Policy issued by M/s. Royal Sundaram Alliance Ins. Co. Ltd for the period 1.7.2006 to 30.6.2007. She was admitted to hospital from 8.8.2006 to 13.08.2006 with a complaint of pain in abdomen and vomiting of 2 days' duration. The diagnosis was 'Twisted Right Ovary Cyst' and a laparoscopic surgery was done on 9.8.2006. A claim was lodged with the insurers for the reimbursement of medical expenses of Rs.22,000/-

The insurers, however, rejected the claim on October 27, 2006 contending that the illness was pre-existing and that an ovarian cyst 7.4 x 3.5cm could not have developed over a period of one month.

The complainant stated that she had no malafide intention to deceive the insurer and that she had no symptoms of pain while joining the insurance scheme. Only on 2.8.2006 she developed pain. Thus, she submitted, her illness was not pre-existing. The insurers contended that though the complainant had no recognisable symptoms, the illness clearly manifested prior to the inception of the policy. They stated that they had repudiated the claim after due consideration of the medical records of the insured and after proper application of mind.

Held :

I heard both the parties and perused the documents submitted. The chief documents in the medical record of the complainant are (i) the abdomen scan dated 8.8.2006, (ii) the laparoscopy report dated 9.8.2006 and (iii) the Discharge Summary dated 31.08.2006.

The insurers have sought to justify, before me, their decision of rejecting the claim by relying on the 2 medical opinions they had obtained and their policy conditions. I observe, that out of the two medical opinions the insurers have placed before me, the one from Dr. Padmini Vasudevan has been obtained on 18.01.2007 i.e. much after their decision to reject the claim which was done on 27.10.2006. The medical opinion on which the insurers relied while taking their decision reads this cyst "could not have developed over a period of one month" and is "pre-existing".

The insurers admit in their note of 20th Jan 2007, that the insured had no recognisable symptoms. The opinion they had received from the doctor of their Third Party Administrators is not categorical as to how many months it would definitely take for such a cyst to develop. Also, it is not supported by any medical authority or standard text on the subject. I hold that the insurers and their TPA have been over-enthusiastic to reject this claim on a suspect opinion that "it could not have developed". These words, in my view do not give to the insurers the right to conclude that the disease was pre-existing. Since it has not been established with necessary authority that the disease was pre-existing, the benefit of the doubt ought to have gone to the insured.

I direct the insurers to settle the claim. The complaint is allowed.

Hyderabad Ombudsman Centre

Case No. : G 11.004.0200

Sri L Damodar

Vs

United Ins. Co.Ltd.

Award Dated : 12-03-2007

Sri Damodar and his family were covered under a Group Health Insurance policy "AB-Arogyadaan" issued by M/s. United India Insurance Co. Ltd., to the account holders of M/s. Andhra Bank. Sri Damodar's daughter Kum Vaishnavi, aged 7 years, was admitted to Rohini Medicare Pvt Ltd, Hanamkonda as an in-patient from 23.11.2004 to 30.11.2004 for Symptomatic Epilepsy (Neuro Cysteceosis). A CT Scan of the brain, done on 23.11.2004, gave an impression of "Tuberculoma left Parietal Region".

A request for cash-less hospitalisation made to the insurers' Third Party Administrators, M/s. Family Health Plan Ltd., was rejected on 25.11.2004 on the ground that pre-existence of the disease was not ruled out. The insured was advised to submit all documents for enabling consideration of reimbursement. Accordingly the insured sent the claim documents and the original bills to the TPA for which the insured received the acknowledgment cards confirming the receipt of the said mail by the TPA on 6.12.2004 and 22.12.2004.

However the TPA wrote to the insured on 31st May 2005 and 16th May 2006 stating that the original bills and Discharge summary were yet to be received by them.. On 1.8.2006 the insured approached the Regional Office of the insurers stating that he could not submit the originals again as he had already sent them to the TPA on 20.12.2004. He sought early settlement of his claim of Rs. 8300.55 from the insurers. However the insured did not receive any reply to his representation.

The representative of the TPA present at the hearing conveyed that on review they found the claim admissible and, based on the Divisional office's instructions of 9th February 2007 to accept xerox copies, had processed the payment of claim at Rs 5726/-.

I find the approach of the insurers' Regional office very strange. When a representation was received by then on 3.8.2006, they failed to act on it for over six months. The Regd Post acknowledgement cards for this representation as well as his letters to the TPA are available with the complainant. The insurers also argued that original documents are a must for processing. This argument of the insurers is totally unacceptable since it is clear that the TPA are unable to produce the letters and documents they received from the complainant. The Regional Office even overruled the proper approach exhibited by the Divisional Office as evidenced by the DO's instructions of 8.2.2007

I direct the insurers to settle the claim without any further delay. The complainant is awarded a compensation of Rs 1500/- for the trouble caused to him due to lapses on the part of the TPA and the insurer. The claim amount will carry interest at the rate prescribed in the IRDA: Protection of Policyholders Interests Guidelines. 2002 for the period 20.1.2005 (i.e, from about a month after receipt of documents by the TPA) till the date of hearing.

Hyderabad Ombudsman Centre

Case No. : G 11.004.0266

Sri Kondaveti Basavaraju

Vs

United India Insurance Co.Ltd.

Award Dated : 23.03.2007

The complainant and his wife were covered under a Group Medical Insurance policy. Smt. K. Venkayamma, underwent treatment at Visakha Hospital where she was admitted with history of weakness of left upper and lower limbs since one day. She was diagnosed to suffer from Carotid Embolic Stroke and was discharged after conservative treatment and physiotherapy. The TPA rejected the claim on the ground that the claim was not submitted within 7 days from the date of completion of treatment. The initial complaint was heard and vide award 32/2006-07 dated 29.08.2006, the delay was condoned and the insurers were directed to process the claim on merits.

The insurers vide their letter dated 21.09.2006 rejected the claim on the ground that the disease was pre-existing at the time of taking the policy. The complainant contended that he abided by the orders of this office and submitted all the medical reports and bills to the insurers. Paralysis was not a congenital disease. She was admitted to hospital for treatment of this disease for the first time in October, 2004. The insurer's allegation that she was a Cardiac patient and underwent Mitral Valve Stenosis was true except however that this surgery was performed 25 years ago.

The insurers contended that subsequent to the order by the Hon'ble Ombudsman, the insured submitted the medical records of the patient. Their panel cardiologist opined that "the patient was having Chronic Rheumatic Heart Disease, Severe Mitral Stenosis

for which she underwent OMV at Vellore. Mitral Stenosis is one disease which is known to produce Hemiplegia." He also added that in this case the pre-existing disease of Mitral Stenosis was responsible for the stroke. The panel neurologist opined that the patient was treated more for the cardiac problem. There was no evidence to suggest Carotid Embolic Stroke. As such treatment was given for a pre-existing ailment for which they were not liable to make payment.

Held

The insurers panel cardiologist stated categorically the hospital records indicated that the patient was mainly treated for cardiac problem. I note from the records that she was admitted with complaints of weakness of left upper and lower limbs since one day. The complainant in his complaint mentioned that his wife developed symptoms of weakness of limbs for the first time and was taken to the hospital. The insurers did not contest the fact that the complainant was admitted for treatment of paralysis.

Instead of indulging in hair-splitting arguments, I direct the insurers to be magnanimous and process the claim for the neurology portion of the claim. The insurers are directed to calculate the total claim payable as per the bills submitted and pay 50% of the same to the complainant.

Hyderabad Ombudsman Centre

Case No. : G 11.004.295

Sri Sahil J Paul

Vs

National Insurance Co.Ltd.

Award Dated : 30.03.2007

The complainant's mother was covered under the group mediclaim policy issued to M/s. GE Capital Services for the period 31.5.2005 to 28.5.2006. However, earlier to this date, she was admitted to Ruby Hall Clinic, Pune from 16.5.2005 to 21.05.2005 and underwent Coronary Angioplasty. The complainant incurred a total expenditure of Rs. 2,48,847/-. She had an individual mediclaim policy with another insurer (New India Assurance Co. Ltd.,) and she received claim of Rs.1,02,500/-

Sri Sahil Paul lodged a claim for the balance amount with his employer for reimbursement under the group policy issued by National Insurance Co Ltd. The claim was not considered as there was a violation of clause 5.4 which stated that a claim must be filed within 30 days from the date of discharge from the hospital.

The complainant stated that he had to get all the papers including the confirmation from TPA of M/s New India Assurance Co Ltd on the payment of Rs.1,02,500/-. Further, there was a confusion about the correct policy and he submitted the claim papers to the TPA (M/s Family Health Plan Ltd) of the current policy no 8500000056 issued for the period 31.5.05 to 28.5.2006, whereas his mother's treatment took place during the currency of the previous policy. However, even on submission to the correct TPA i.e M/s United Healthcare, the claim was rejected on the ground of delayed intimation. He sought condonation of the delay in submitting the papers to the insurance company.

Now on review and examination of the claim papers, the insurers stated that, the insurance coverage was available only for Sri Sahil Paul till 28th May, 2005. It is only with effect from the policy period commencing 31.5.2005 that the other members of Sri Paul's family viz his wife, son and mother were covered.

Held

The insurers' representative stated that they had granted medical insurance coverage to the employees of GE Capital Services based on the lists submitted by the employer. In case any employee/family member of the employee is not included in the list for any reason, no coverage would be available to such person. He also explained that there was a facility to add and delete names from the list following either entry into the employment of any person or quitting the said employment.

A new member's entry for the insurance coverage will be only from the date of incorporation of that name into the policy by way of endorsement. In the current case, the names of the family members were not included in the list given by the employer for arranging insurance under the policy no 8500000032 for the period 29.4.2005 to 28.5.2005 and thus the coverage was available only to Sri Paul. Therefore I consider the insurers' decision to be proper.

Kochi Ombudsman Centre
Case No. : IO/KCH/GI/11-005-080/2006-07
Sri.Cherian K.P.
Vs
The Oriental Insurance Co.Ltd.

Award Dated : 31.10.2006

The complaint under Rule 12(1)(b) read with Rule 13 of the RPG Rules, 1998 relates to repudiation of a medi claim under the Group medical Insurance Scheme for employees of M/s.Apollo Tyres. The complainant – an employee of the Co. – had got himself admitted at PVS Memorial hospital for one day from 15.4.2005 to 16.4.2005 for complaints of constipation. However, the records revealed that he was already a patient of cirrhosis of liver with a history of three earlier episodes of hospitalisation and the claim in dispute related to investigation and follow-up of the self-same disease. Medicines for cirrhosis of liver could be taken as an outpatient. The purpose of hospitalisation appeared to be for claiming insurance benefits and therefore the repudiation was upheld duly dismissing the complaint.

Kochi Ombudsman Centre
Case No. : IO/KCH/GI/11-003-108/2006-07
Sri.E.Jeevanandan
Vs
National Insurance Co.Ltd.

Award Dated : 30.11.2006

The complaint under Rule 12(1)(b) read with Rule 13 of the RPG Rules, 1998 relates to partial repudiation of a medi claim by the insurer under a group medi claim policy covering employees of M/s.Binani Zinc, Mumbai. The claim was paid by the insurer in two parts disallowing certain amounts for want of bills/supporting documents. Similarly, a portion of the claim was towards post-hospitalisation treatment which, again, was not payable beyond a specified duration. On a close scrutiny of the records, an amount of Rs.372/- initially paid by the complainant at the hospital was found payable but disallowed by the insurer. This Forum, therefore, directed the insurer to pay a sum of Rs.372/- additionally to the complainant in final settlement of the claim. The complaint was, thus, disposed of on merits.

Kochi Ombudsman Centre
Case No. : IO/KCH/GI/11-005-169/2006-07
Sri.C.K.Jose

Vs
The Oriental Insurance Co.Ltd.

Award Dated : 05.12.2006

The complaint under Rule No.12(1)(b) read with Rule 13 of the RPG Rules, 1998 arose due to partial repudiation of a medi claim by the insurer under the Group Medi claim policy issued favouring employees of M/s.Apollo Tyres. On 1.11.05, the complainant – an employee of the company – had an accidental injury when a shell weighing about 40 Kgs. fell on his left leg. After the initial treatment, the leg was plastered and a few times thereafter, he had medical consultation. Since the swelling did not subside, further tests were conducted and he had undergone a surgery to remove the block when it was detected that he had developed varicose veins. The insurer settled the claim for 42 days as against 82 days of benefits claimed for by the complainant saying that the rest of the treatment beyond 42 days was for varicose veins. However, the complainant insisted on the fact that he had no problems of varicose veins till the date of accident. From the medical records, it was also evident that the blockage, inflammation etc started only with the accident, which could be the sole reason for the problem. Going by the records, this Forum felt that the insurer's decision was not justifiable in the context and hence the Insurance Company was directed to settle the full claim for 82 days and thus the complaint was disposed of on merits of the case.

Kochi Ombudsman Centre
Case No. : IO/KCH/GI/11-004-149/2006-07
Sri.Jeffry Padamadan
Vs.

United India Insurance Co.Ltd.

Award Dated : 01.02.2007

The complaint under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998 arose out of non-settlement of a claim under a Group medi claim policy issued by the respondent through its agency M/s.Medicare Services Club, Kolkotta. The complainant and his family including his mother were members of the scheme. On 30.3.2006, the complainant's mother developed chest pain and, on admission at the Medical Trust Hospital, Angioplasty was recommended for and it was done. The agency of the insurer wanted to know the cost of the STENT used for the operation along with its bill. The complainant approached the hospital and they clarified by a letter that surgicals including STENTS were purchased by them in bulk from various suppliers and therefore they were unable to give a bill for the particular stent used for the operation. However, it is reported that the hospital had further estimated the cost of the stent at Rs.68900/-. Still, the agency of the insurer was hesitant to settle the claim although the Cochin office of the insurer had advised the agency to expedite settlement of the claim. Considering the circumstances of the case, this Forum advised the insurer/agency to take the price of the stent as Rs.68900/- as clarified by the hospital and proceed with settlement of the claim without insisting on a separate bill for the stent as the Hospital was unable to provide the same.

Kochi Ombudsman Centre
Case No. : IO/KCH/GI/11-002-265/2006-07
Sri.D.A.Dayanandan
Vs.

New India Assurance Co.Ltd.

Award Dated : 07.03.2007

The complaint under Rule 12(1)(b) read with Rule 13 of the RPG Rules, 1998 arose out of repudiation of a claim by the insurer under the Group Medi claim policy issued to LIC covering its employees and their dependents. The complainant, who retired from LIC, had certain problems called "Nidra Nasham" and "Sandhi Vatha". He was admitted in an Ayurvedic Hospital for a day between 2.7.2006 and 3.7.2006 and the rest of the treatment was taken as an outpatient. The insurer repudiated the claim on the ground that the hospitalisation for a day was only for diagnostic purposes not covered under the policy and the entire procedures could have been completed in OPD. On going through the records, it was found that the contentions raised by the insurer were genuine and the complainant had only tried to fulfill the minimum hospitalisation period of 24 hours as required under the medi claim policy. In the circumstances of the case, the complaint was found to have no merits whatsoever and hence dismissed accordingly.

Kolkata Ombudsman Centre
Case No. : 692/13/003/NL/12/2005-06
Shri Rabindra Mohan Dutta
Vs
National Insurance Company Ltd.

Award Dated : 20.11.2006

FACTS & SUBMISSIONS :

The complainant and his wife were covered under a Group Mediclaim Policy with National Insurance Company Ltd., Division III, purchased through 'Golden Multi Services Club' (GMSC) for the period 23.02.2003 to 22.02.2004. The previous policy expired on 22.02.04. While issuing this policy, the insurance company excluded "any disease arising out of heart" from the purview of coverage of the policy. On being questioned by the complainant, the insurance company stated that the previous policy expired on the midnight of 22.02.04 and the insurance company received the policy payment only on 23.02.04 and therefore, a fresh policy was issued in the evening of 23.02.04. Since there was a break in policy for one single day, it was treated as a new policy and the already existing heart disease was sought to be excluded. Though the complainant explained that there was no delay on his part and that it was not intentional, the insurance company refused to reconsider exclusion of "any disease arising out of heart". Hence, this grievance.

According to the insurance company, the cover for the policy expired in the mid night of 22.02.04 (Actually the insurance company in their self-contained note dated 21.08.06 had erroneously mentioned the date of expiry as 22.02.05) and the proposal form of the complainant had indicated "heart problem" since 26.08.2003. Since there was a break in the policy, the policy was treated as first year policy and the "heart diseases" were excluded.

Decision :

In our opinion, this delay in submission of renewal premium could not be held against the insured. According to the insurance company's letter dated 21.08.06, the medi claim policy was issued at 12 noon on 23.02.2004, which actually meant there was only 12 hours delay from the expiry of the previous policy. To consider 12 hours' gap in the renewal to be a reason for discontinuation of the cover, was too technical and harsh. From the submission of the insurance company that the insured was suffering from heart problem since 26.08.03 and since he was duly covered by the Group Mediclaim policy, it was felt that the imposition of restriction to exclude "heart problem" treating the policy as afresh, was not justified. The insurance company were directed to remove

“any disease arising out of heart” from the exclusion clause as it was already covered under the previous policy.

Kolkata Ombudsman Centre
Case No. : 645/11/003/NL/11/2005-06
Shri Ratan Kumar Agarwal
Vs
National Insurance Company Ltd.

Award Dated : 28.11.2006

FACTS & SUBMISSIONS :

The complaint was regarding repudiation of claim under Group Mediclaim on the ground that the claimant was not covered with the insurance company.

Shri Ratan Kumar Agarwal, the complainant, took a Group Mediclaim Policy through Venus Medicare Services (I) Ltd. (VMSIL), an authorized agent of the insurance company. The complainant paid premium of Rs. 1291/- to VMSIL and the related cheque was cleared on 19.05.2004. VMSIL gave a policy certificate to the complainant showing that both complainant and his wife Smt. Jyoti Agarwal were covered under the policy. A maternity claim for Rs. 9337/- was filed on 14.03.2005. National Insurance Company disowned their liability stating that the complainant and his wife were not covered under the policy. Despite representation, the insurance company did not settle the claim. Being aggrieved, the complainant approached this forum for redressal of his grievance seeking relief of Rs. 9,337/-.

The insurance company sent a self-contained note wherein they stated that they had entered into an MOU on 15.11.2002 with VMSIL. The objective of the above mentioned Service Club was to provide Group Mediclaim Policy for their members including their families and act as insured party for the purpose of insurance. As per the MOU mentioned above, the following extract is reproduced:

“Insurance certificate containing NIC’s logo may be issued to the members under joint signatures of both, NIC Ltd & VMS. It is mutually agreed that the society shall take all precaution to ensure that all such documents issued by NIC Ltd. are not misused in any manner. It is also agreed that VMS will provide the details of underwriting and the claim details every week to NIC Ltd. for reconciliation.”

The insurance company gave a letter on 01.10.04 to the VMSIL for cancellation of MOU. On 05.11.04, the insurance company filed an FIR to the Officer in-charge, Hare Street Police Station filing a complaint against VMSIL on the grounds of breach of terms of agreement, issuing fake policy/certificates to their members using the company’s brand name and logo without latter’s consent and knowledge.

The insurance company learnt in September’04 that the VMSIL were issuing fake certificates to their members without depositing premiums with the insurance company. They also found that the signatures on the certificates do not belong to any of the officials working in the insurance company. After these facts came to light, the insurance company gave 30 days notice on 01.10.04 proposing cancellation of MOU between them. Subsequently, on 01.11.04, the MOU was cancelled and an FIR was filed on 05.11.04. The insurance company maintained that they would not be responsible for any payment received by any person/s on behalf of VMSIL from their members other than the premium received by them in respect of the policy issued in favour of VMSIL and its members. The insurance company scrutinized the list of members submitted by VMSIL with requisite premium and found that the complainant’s name did not appear in the list. The complainant was informed of the same. Since no

premium was received from VMSIL in respect of the complainant, the insurance company could not entertain the claim.

Decision :

Under the Insurance Act, it is clear that the insurance cover shall commence only on receipt of premium from the insured. Since this being a Group Policy, VMSIL issued the certificate under the above referred paragraph of MOU to the individual member on receipt of premium money by VMSIL. This money had not been transferred to the insurance company and the certificate issued was proved to be fake. Therefore, it was obvious that no premium had been received by the insurance company for the commencement of the cover as per the Group Mediclaim policy. It was held that the insurance company should not be held responsible to pay the claim made under the above policy, whose cover did not commence, as the premium was not received by the insurance company. The complainant should seek relief with regard to amount paid to VMSIL from the appropriate authorities.

Kolkata Ombudsman Centre
Case No. : 604/14/002/NL/11/05-06
Shri Niranjana Adak
Vs

The New India Assurance Company Ltd.

Award Dated : 30.11.2006

FACTS & SUBMISSIONS :

The complainant's vehicle no. WB-33/8036 was insured with the New India Assurance Company Ltd. for the period 18.09.03 to 17.09.04. Consequent upon an accident of the vehicle on 26.07.04, the claim was lodged by the complainant for damages. Initially, the vehicle was surveyed by a surveyor and a note of agreement on the assessment was signed. After the vehicle was repaired, it was produced to RTA, Midnapore for renewal of fitness. The complainant claimed that repairing bills and cash memos were also submitted to the insurance company. But, before the re-inspection of the vehicle as required by the insurance company, the vehicle was stolen and an FIR was lodged with Ghatal Police Station. The insurance company did not settle the claim because the vehicle could not be produced for re-inspection. Hence, this complaint.

In the self-contained note, the insurance company stated that the complainant could not produce the repaired vehicle for re-inspection. After receiving the letter from the insured, the claimant was contacted by the surveyor but as the claimant failed to produce the repaired vehicle, the surveyor returned all the documents without conducting the re-inspection survey. They further stated that in spite of intimation for re-inspection, there was no response from the claimant. Subsequently on 18.07.05, the claimant intimated that the vehicle was stolen and that an FIR was lodged wherein it was stated that the date of occurrence of the event was between 14.01.05 and 20.01.05. During that period vehicle was not insured with the insurance company. The insurance company also stated that the claimant did not submit the repairing bills and that they would resubmit the file to the higher authorities after receipt of such documents.

Decision :

It could be seen from the above facts that the insurance company did not dispute the accident of the vehicle and its insurance cover. They had also taken all actions for survey of the damaged vehicle through their authorized surveyor. Only they could not get the vehicle re-inspected after the repair of the damaged vehicle. The point of

dispute was that the repaired vehicle was not produced in time for re-inspection and before it could be produced, the same was stolen. It is obvious that the actual liability could not be ascertained, as the re-inspection of the vehicle could not take place. Therefore, the insurance company did not settle the claim.

It was clear that the vehicle could have easily been re-inspected as bills and cash memos with regard to replacement of the parts of the vehicle indicate that the vehicle was repaired long before the theft that took place. There was no mention of the quantum of relief sought by the complainant and even the insurance company did not mention the quantum in their self-contained note. They also stated that they would take appropriate steps on receipt of bills and cash memos.

Under these circumstances, the complainant was requested to co-operate with the insurance company and send the bills and cash memos pertaining to the repairing works. At the same time, the insurance company were directed to complete the assessment of damages from the documents submitted by the complainant and settle the claim, since the re-inspection was not possible, as the vehicle had been already stolen.

Kolkata Ombudsman Centre
Case No. : 695/14/003/NL/12/2005-06
Shri Surendra Kumar Bhuwania
Vs
National Insurance Company Ltd.

Award Dated : 07.12.2006

FACTS & SUBMISSIONS :

The complaint was regarding delay in settlement of claim under Group Mediciam Insurance Policy.

The complainant, Shri Surendra Kumar Bhuwania stated that his son, Master Mayank Bhuwania was admitted to Marwari Relief Society for treatment. A claim for Rs.13,309.80 was filed with the Insurer's TPA, M/s. Family Health Plan Ltd. The TPA sought treating doctor's certificate giving details of present disease, past history and its duration. The complainant responded stating that there was no past history of ailment and the patient was admitted on an emergency basis. The TPA was informed according to the complainant that there were no documents other than the documents given by the hospital authorities. The complainant has also authorised the TPA to collect the details from the hospital authorities. The TPA did not settle the claim. The complainant represented to the Insurance Company seeking early settlement of the claim. Despite representation neither the Insurance Company nor the TPA settled the claim. Being aggrieved due to delay in settlement, the complainant approached this forum for redressal of his grievance. The complainant sought relief of Rs.13,309.80 along with interest and penal action against the Insurance Company.

The Insurance Company sent a self-contained note along with a copy of medical opinion on 4.7.2005 issued by Dr. Medha Ghugre. According to his opinion based on the medical records 'pre-existing' condition could not be ruled out. The details of the opinion were as under :-

The patient Master Mayank Bhuwania (14 yrs) was admitted from 15.02.04 to 16.02.04 at Marwari Relief Society Hospital ;

The diagnosis on the discharge certificate states "Seizure disorder";

Dr. R. Choudhury's prescription dated 15.02.04 does state that patient is diagnosed as having Convulsive Disorder (acute) ;

But at the same time Dr. Ambar Chakraborty's prescription dated 14.02.04 states that there is a past history of ? occasional myoclonic seizures ;

The same prescription dated 14.02.04 also mentions an EEG report stating " Predominant Lt.Cerebrotemporal – slow waves .

But the EEG report submitted by the patient is dated 18.02.04 ;

No other prescription previous to 14.02.04 have been submitted nor has the treating doctor certified the duration of the patient's ailment on our query ;

Since the first prescription (before hospitalization) submitted by the patient already states a previous history of the seizure and also mentions EEG report findings suggestive of epilepsy we cannot rule out a preexisting condition seeing that the policy is barely 2 months old.

Further according to the Insurer, Mediclaim Insurance Policy from National Insurance Co. Ltd., Division XI, Kolkata was issued through M/s. Venus Medicare Service (I) Ltd., effective from 17.12.2003 to 16.12.2004 for his family. The complainant had lodged a claim for the disease of Master Mayank Bhuwania to M/s. Family Health Plan Ltd., within 2 months from the date of commencement of the policy for hospitalization for the disease Seizure Disorder for the period from 15.2.2004 to 16.2.2004 at Marwari Relief Society Hospital. On going through the various documents submitted by the complainant the Family Health Plan Ltd., being TPA of the Insurance Company observed that the disease was known to the patient before taking the policy, as per doctor's prescription. Accordingly, the TPA informed the Insured on 11.3.2005 about the rejection of the claim as per policy terms and conditions by invoking exclusion clause no. 4.1 of the policy conditions.

On going through the facts/observations submitted by the Insurance Company, there were two medical opinions referred to by Dr. Medha Ghugre based on two prescriptions. One of the prescriptions referred to by Dr. Ghugre on 14.2.2004 given by Dr. Ambar Chakraborty which stated that there was a past history of ' ? Occasional myoclonic seizures '. The second prescription of Dr. R. Choudhury dt.15.2.2004 recorded convulsive disorder (acute). There was also doubt in regard to the EEG report submitted by the Insured was the same as the one referred to by Dr. Chakraborty. None of the medical records furnished indicated about the duration of the disease/illness.

Due to the contradictory opinions/observations from different qualified medical practitioners on the question of pre-existence of the disease, it was felt that a review of the decision by the Insurance Company should be called for. Therefore, it was directed that a specialist doctor might be appointed to give his opinion on the question of pre-existence of the disease based on the documents available. The complainant may also be allowed an opportunity to represent directly before the specialist doctor. After receiving opinion from the specialist doctor, the Insurance Company were directed to review the claim on the basis of opinion received from the specialist doctor. If the complainant was dissatisfied with the Insurer's decision, even after the review, he should have the liberty to approach to this forum once again for relief, if any.

Kolkata Ombudsman Centre
Case No. : 701/11/003/NL/12/05-06
Shri Udayan Banerjee
Vs
National Insurance Company Ltd

Award Dated : 05.02.07

Facts & Submissions :

This was a petition filed by the complainant on Group Mediclaim Insurance Policy taken from National Insurance Company Ltd. through Golden Multi Services Club (GMSC) of GTFS. The claim was repudiated due to delay in intimating the event and delay in filing the claim under policy conditions 5.3 and 5.4.

The complainant Shri Udayan Banerjee filed a claim under Mediclaim Policy for hospitalization of his wife Smt. Swati Banerjee due to a road accident. He sent the intimation of hospitalization on 03.03.04, 21 days after the accident on 07.02.04. However, the claim papers were submitted only on 02.11.04. As there was a delay in intimation beyond 7 days and submission of claim papers beyond 30 days, the insurance company repudiated the claim by invoking the policy conditions 5.3 and 5.4. The representations made by the complainant were of no avail. Therefore, he filed this petition for redressal of the above grievance.

The complainant further stated that the delay of 21 days for intimating the event of accident was mainly due to the local agent of GTFS, as he was pre-occupied with the treatment of his wife during that period. According to him, the small delay in intimation should be condoned. Delay in filing the claim, according to him, was due to fact that for any accident case, time is taken due to post-operative treatment by the concerned doctor and receipt of bills and documents after the completion of treatment. Therefore, he could not submit the bills within 30 days. He further stated that the delay was due to his frequent outstation tours necessitated by his profession. According to him, the claim papers had been submitted within a reasonable time after the fitness certificate was received from the hospital. He, therefore, requested for condoning the delay and settling the claim.

The insurance company sent a self-contained note, in which they stated that the claim had been repudiated invoking policy conditions 5.3 and 5.4. They further argued that their repudiation decision was correct by citing some leading ratio given by the Apex Court.

A hearing was fixed calling the complainant, the representatives of the insurance company and also the representatives of GTFS. The complainant and the representatives of the insurance company attended while no representative from GTFS attended.

The complainant while reiterating the argument mentioned above gave a copy of the fitness certificate from Dr. Bhaskar Das, in which it was stated that Smt. Swati Banerjee was suffering from Fracture (L) knee operation and she was under his treatment from 08.02.04 to 29.07.04. She was fit to resume normal duties from 30.07.04. Even allowing one month from 30.07.04, the claim papers should have been submitted by 30.08.04. It was pointed out to him that the claim papers were submitted on 02.11.04 fully after 3 months including the 30 days time. He was asked to explain what were the reasons for delay of two months from 30.08.04. According to him, he was busy with his professional work.

On the other hand, the representatives of the insurance company reiterated that delay in submitting the claim was more than 8 months and, therefore, by invoking the conditions 5.4 only, the claim could not be allowed.

Decision :

We condoned the 14 days delay in intimating the accident and, therefore, condition 5.3 is no longer operative. However, condition 5.4 becomes operative because the delay after 30.08.04 (one month after the date of issue of fitness certificate) was too long to be condoned. The complainant was accordingly, informed that condonation was not

possible unless he can give documentary evidence for a reasonable cause. At this juncture, the complainant stated that he has given all the papers to his agent, who was looking after the work of GTFS. When he was asked to produce any documentary proof for having handed over any paper to the agent, he was unable to produce the same. Under these circumstances, we were unable to condone the delay of more than 2 months from 30.08.04. However, keeping with the gravity of the accident and mental state of the husband due to such accident, we proposed to grant ex-gratia payment of Rs. 10,000/- (Rupees ten thousand) only while agreeing with the decision of repudiation of claim by the insurance authorities.

Kolkata Ombudsman Centre
Case No. : 770/11/003/NL/01/05-06
Shri Ashok Kumar Agarwal
Vs
National Insurance Company Ltd

Award Dated : 05.02.07

Facts & Submissions:

This petition was filed by Shri Ashok Kumar Agarwal covered under Group Medical Policy issued to Golden Multi Services Club (GMSC) of GTFS by National Insurance Company Ltd. This petition was for the claim of his own hospitalization treatment for brain parenchyma, which was repudiated for violation of policy condition 5.3 and 5.4 of the mediclaim policy.

Shri Ashok Kumar Agarwal filed a mediclaim for hospitalization in Tata Main Hospital, Jamshedpur for an amount of Rs. 48,332.93 towards treatment of brain parenchyma. He was admitted in the hospital on 23.08.04 and was discharged on 02.09.04. He sent the intimation of hospitalization to GTFS of National Insurance Company on 04.10.04 after 1 month and 10 days. Similarly, he submitted the claim on 09.11.04 after 2 months 6 days. The insurance company repudiated his claim by invoking the policy conditions 5.3 and 5.4 as there was delay in intimation under condition 5.3 and delay in submission of claim under condition 5.4. In the subsequent representation to the insurance company, the complainant stated that his family members were disturbed due to his critical condition from 23.08.04 to 02.09.04. He was also taken to Vellore after discharge for further consultancy and treatment and therefore, he could not intimate the hospitalization in time as also could not file the claim in time. He, therefore, requested for condonation of delay and settlement of the claim.

The insurance company sent a self-contained note, in which they stated that the claim had been repudiated invoking policy conditions 5.3 and 5.4. They further contended that their repudiation decision was correct by citing some leading ratio given by the Apex Court.

A hearing was fixed calling the complainant, the representatives of the insurance company and also the representatives of GTFS. During the hearing, the complainant stated that he was treated for brain parenchyma and was not in a position to take up his own affairs after the discharge on 02.09.04. He also went to Vellore for further consultation and stayed from 14.09.04 to 23.09.04. Though he was not hospitalized at Vellore, he could not intimate the hospitalization treatment of Tata Main Hospital, Jamshedpur, until he came back from Vellore. Therefore, giving him 7 days time from 23.09.04, the delay in intimation was only 4 days, as he gave the intimation on 04.10.04. He requested that this delay may be condoned. Similarly, if 30 days is reckoned from 23.09.04, the delay in filing the claim was only 17 days, as the same

was filed on 09.11.04 excluding the 30 days time given under the policy conditions. He, therefore, requested that this delay may also be condoned.

On the other hand, the representatives of the insurance company reiterated that they have correctly repudiated the claim. However, they stated that in the event Office of Insurance Ombudsman condones the delay in intimating and submitting the claim papers, they should be given an opportunity for processing the claims as per rules and regulations.

Decision :

We agreed with the reasons given by the complainant for delay in intimation and delay in submission of claim papers from the date of discharge as "reasonable" and we condoned the delay. As requested by the representatives of the insurance company, the insurance company were directed to process the claim expeditiously on merit and allow the same, keeping in view that the delay is already condoned.

Kolkata Ombudsman Centre
Case No. : 740/11/003/NL/01/05-06
Shri Ajit Kumar Das
Vs
National Insurance Company Ltd

Award Dated : 05.02.07

Facts & Submissions :

This petition was filed by Shri Ajit Kumar Das covered under Group Mediclaim Policy of Golden Multi Services Club (GMSC) of Golden Trust Financial Services Ltd. (GTFS), being under MOU with National Insurance Company Ltd. for implantation of pace maker to his wife. The claim was repudiated by invoking the policy conditions 5.3 and 5.4 due to delay in intimation of the hospitalization and delay in submission of the claim.

Shri Ajit Kumar Das and his wife Smt. Juthika Das were covered by the Group Medical Policy issued by National Insurance Company through GTFS for the period 01.12.2003 to 30.11.2004. This policy has been continuously renewed from 01.12.2001. Smt. Juthika Das was implanted with a pacemaker during the period 16.04.04 to 20.04.04. The intimation of hospitalization was made to the TPA on 18.05.04 and the claim was filed on 03.06.04. Therefore, there was a delay of 31 days under the policy condition 5.3 in respect of intimation of the hospitalization and 1 month 12 days in delay in submission of the claim under policy condition 5.4. The complainant, in his representation, stated that there was delay in collecting the papers due to severe state of tension and anxiety and, therefore, there was delay in intimation. Similarly, there was some delay in filing the claim. As the insurance company repudiated his claim even after giving the explanation for delay in submitting the claim papers, this petition has been filed seeking redressal of his grievance.

The insurance company sent a self-contained note, in which they stated that the claim had been repudiated invoking policy conditions 5.3 and 5.4. They further contended that their repudiation decision was correct by citing some leading ratio given by the Apex Court.

A hearing was fixed calling the complainant, the representatives of the insurance company and also the representatives of GTFS. The complainant stated that he sent a letter to the Manager, GTFS, who asked him to file that letter with the proof of having the insurance cover continuously and other documentation with regard to

hospitalization. This letter was definitely within 7 days from the date of discharge i.e., 20.04.04. However, according to the complainant, the required papers could not be collected in time and he could file the intimation letter only on 18.05.04, which was about 31 days from the date of discharge. He, therefore, requested that the delay may be condoned. With regard to filing of claim on 03.06.04, he stated that he filed the claim within 15 days from the date of filing of intimation letter i.e., 18.05.04. He, therefore, requested that this delay also may be condoned as getting the papers from the hospital, after discharge, took certain time.

On the other hand, the representatives of the insurance company reiterated that they have correctly repudiated the claim. However, they stated that in the event office of Insurance Ombudsman condones the delay in intimating and submitting the claim papers, they should be given an opportunity for processing the claims as per rules and regulations.

Decision :

We agreed with the reasons given by the complainant for delay in intimation and delay in submission of claim papers from the date of discharge and we condoned the delay. As requested by the representatives of the insurance company, the insurance company were directed to process the claim expeditiously on merit and allow the same.

**Kolkata Ombudsman Centre
Case No. : 795/11/003/NL/01/05-06
Shri Tapas Kumar Dey
Vs
National Insurance Company Ltd**

Award Dated : 05.02.07

Facts & Submissions :

This petition was filed by Shri Tapas Kumar Dey covered under Group Mediclaim Policy issued by National Insurance Company Ltd. through Golden Multi Services Club (GMSC) of GTFS. This petition was filed as the claim was repudiated under conditions 5.3 and 5.4 of the policy.

Shri Tapas Kumar Dey took a mediclaim policy through GTFS of National Insurance Company for sum insured of Rs. 20,000/-. He filed a hospitalization claim for his own operation of Gall Bladder stone at Care and Cure Nursing Home, Barasat for the period 10.12.04 to 13.12.04. He was advised rest from 10.12.04 to 09.01.05. Thereafter, intimation was given to the insurance company on 17.01.05 and the claim was filed on 08.03.05. But the insurance company repudiated the claim invoking policy condition no. 5.3 and 5.4. In his representation against the repudiation, the complainant stated that there was no family member to intimate the hospitalization within the prescribed time period. He was looking after his own affairs and, therefore, there was a delay in intimation and requested for condonation of the delay. Similarly, as he was looking after his own affairs, there was delay in submission of the claim and, therefore, requested for condonation of the delay under condition 5.4.

The insurance company sent a self-contained note, in which they stated that the claim had been repudiated invoking policy conditions 5.3 and 5.4. They further contended that their repudiation decision was correct by citing some leading ratio given by the Apex Court.

A hearing was fixed for 05.02.07 calling the complainant, the representatives of the insurance company and also the representatives of GTFS. During the hearing, the complainant stated that he was admitted in the hospital on 10.12.04 and discharged on

13.12.04 for Gall Bladder stone operation. The doctor gave a certificate that he should take rest from 10.12.04 to 09.01.05 and he would be medically fit to resume work from 10.01.05. Therefore, he could intimate the hospitalization on 17.01.05. Hence according to him, there was no delay as it was within 7 days from 10.01.05. Similarly, he submitted the claim papers on 10.03.05, 1 month 24 days from 17.01.05. This delay was due to the fact that he himself had to perform all the spadework like collecting documentation, bills, etc. to file the claim. He, therefore, requested that the delay may be condoned.

On the other hand, the representatives of the insurance company reiterated that they have correctly repudiated the claim. However, they stated that in the event Office of Insurance Ombudsman condones the delay in intimating and submitting the claim papers, they should be given an opportunity for processing the claims as per rules and regulations.

Decision :

It was surprising that the complainant, being the patient himself, could not intimate during the rest period, because intimation of hospitalization does not involve collecting of documentation from the hospital. We were unable to agree with the complainant that delay in intimation should be condoned. Similarly, the claim papers could have been filed immediately within one month from 10.01.05, being the date on which he was medically declared fit for resuming the duties as per the medical certificate. We were unable to agree with the complainant with regard to the explanation given by him for delay in submitting the claim. We were, therefore, constrained to agree with the decision of the insurance company for repudiating the claim. However, keeping in view that he was personally involved with his hospitalization and that there could be possibly some delay in both intimation and submission of the claim, we intended to allow him an ex-gratia payment for the hardship suffered by him to the extent of Rs. 9,000/- (Rupees Nine thousand) only.

Kolkata Ombudsman Centre
Case No. : 069/11/003/NL/04/2006-07
Shri Sudhanshu Sekhar Samal
Vs
National Insurance Co. Ltd.

Award Dated : 09.02.07

Facts & Submissions :

This complaint was regarding total repudiation of a claim on the ground of pre-existing disease under Group Mediclaim Insurance Policy.

The complainant, Shri Sudhanshu Sekhar Samal was covered under a Group Mediclaim Policy. He filed a hospitalisation claim on 20.07.2005 with the Insurance Company. The hospitalisation was for chest pain, breathlessness trouble etc. The R. M. O. while writing his prescription highlighted that there was occurrence of chest pain of the complainant for the last 2 to 3 years. The Insurance Company repudiated the claim on the strength of doctor's certificate stating that the disease was pre-existing in nature. After sending this complaint to this office, the complainant also wrote a letter to I.R.D.A. authorities. The Grievance Cell of the Authority categorically supported the repudiation made by the Insurance Company.

Decision :

The complainant was informed that the Grievance Cell of the IRDA Authority in which they requested the complainant to approach appropriate Judicial Channel for redressal had already taken a decision during the course of hearing.

Under the circumstances, the Insurance Ombudsman, Kolkata did not have any jurisdiction to change the decision already given by the I.R.D.A. authorities. Therefore, this office advised the complainant to seek relief by approaching appropriate Judicial Channel, if he desired.

Kolkata Ombudsman Centre
Case No. : 029/11/005/NL/04/2006-07
Shri Shalin R.Mehta
Vs

The Oriental Insurance Company Ltd.

Award Dated : 05.03.07

Facts & Submissions :

This petition was against repudiation of a claim under Group Mediclaim Insurance Policy issued in the name of Sanjeevani Health Club, who had an MOU with The Oriental Insurance Company Limited.

Shri Shalin R. Mehta stated that his wife, Smt. Julie S.Mehta, was covered as a member under a Group Mediclaim policy issued in the name of Sanjeevani Health Club for a sum insured of Rs.2 lakh (Floater cover), with additional maternity benefit of Rs. 50,000/-. Prior to this, the complainant and his wife were covered under the previous Group Mediclaim policy issued by National Insurance Company Ltd., Division – XV, Kolkata, to the same Group Insured for an overall limit (floater) of Rs.1 lakh, with maternity benefit, for the period 30.09.2003 to 29.09.2004. A maternity benefit claim in respect of Smt. Mehta was filed on 05.07.2005 with M/s Heritage Health Services Pvt. Ltd. for Rs.71,795/-. However, the said TPA repudiated the claim on the ground that as per Standard Group Mediclaim policy, a waiting period of 9 months was applicable to entertain any maternity benefit claim. The TPA contended that the claim did not qualify the above condition as the policy was incepted on 27.09.2004. Accordingly, the TPA repudiated the claim invoking policy condition 5.15c ii. Despite representation to the insurance company against the repudiation decision, the claim was not paid. Being aggrieved, the complainant has come before us for redressal of his grievance.

The complainant further stated that at the time of renewing the policy, both insurance company and Sanjeevani Health Club told the complainant that he would get all benefits, including maternity benefit. The complainant also informed in his application form that the pregnancy had already started and the club accepted it. So, this was a continued policy under Group Mediclaim and there was no question of repudiation under clause 5.15 C ii.

The insurance company stated that while proposing for the Group Mediclaim (Tailor Made) policy, the Group Insured ('Sanjeevani') concealed the material fact regarding past insurance with other Insurers, which would affect the root of the contract making it void. The Insured person was included in the policy on 27.09.2004 and she was hospitalised on 29.04.2005 i.e., after about 7 months from the date of inclusion in the said policy. In this connection, the Special Condition of Group Mediclaim Policy 5.15 C (ii) says, "waiting period of 9 months is applicable for payment of any claim relating to normal delivery or caesarian section of abnormal operation for extra uterine pregnancy. The waiting period may be relaxed only in case of delivery, miscarriage or abortion induced by accident or other medical emergency". Since, as per the above clause, 9 months waiting period can be relaxed only 'in case of delivery, miscarriage or abortion induced by accident or other medical emergency' and since the claim was not of that kind, the claim could not be entertained. The complainant did not submit any individual application or proposal form to the Insurer. The fact that the complainant's wife was

pregnant was not borne out in the information provided by 'Sanjeevani' while remitting the premium. Hence, the decision of repudiation of the claim was correct.

HEARING :

A hearing was fixed and both the parties attended. The complainant stated that the renewed policy was taken with a condition of pregnancy benefits and therefore, the claim was payable. The representatives of the insurance company stated that the delivery of the baby took place before 9 months of the policy cover, therefore, the claim was not payable as per the policy conditions. When they were asked whether the same condition would prevail if the policy is renewed and pregnancy occurs during the period of renewal cover, it was informed that the condition will prevail for every policy whether it was renewed or not. The representatives of the insurance company stated that repudiation was made only because of the above condition.

DECISION :

The representatives of the insurance authorities were informed that the condition would prevail year after year could not be acceptable because no women can claim pregnancy benefits under a mediclaim policy every time it would be less than 9 months. However, only those claims would be allowed if for every policy period the delivery takes place only after 9 months. We do not think this as an acceptable situation. After this argument, the representatives of the insurance company have graciously accepted that the claim could be paid in this case if the complainant had taken the renewed policy with benefits for pregnancy. On going through the records, it was found that the policy was renewed with such benefits by the Sanjeevani Health Club, being the Insured for the Oriental Insurance Company Limited. The previous policy was with the same Sanjeevani Health Club, but the Insurer was National Insurance Company Limited. We have subsequently, received a copy of National's policy, Group Mediclaim – Tailor Made with Floater, No. 2003/150100/46/03/ 8500000161 issued to Sanjeevani Health Club. The said policy covered the complainant's wife with Maternity benefit of Rs.50,000/-. The present Insurer should collect a copy of the previous policy as above, from 'National' for their record.

Under these circumstances, the arguments of the insurance company with regard to repudiation of the claim were not tenable. The insurance company were directed to pay the claim.

Kolkata Ombudsman Centre
Case No. : 243/11/003/NL/07/2006-07
Sri Goutam Das
Vs
National Insurance Co. Ltd.

Award Dated : 23.03.07

Facts/Submissions :

This petition was filed by the complainant against repudiation of a hospitalisation claim under Group Mediclaim Insurance Policy of Golden Multi Services Club of G.T.F.S, issued by National Insurance Co. Ltd. under condition Nos.5.3 & 5.4 of the policy.

The complainant Sri Goutam Das stated that he took a Mediclaim Insurance policy from National Insurance Co. Ltd. through G.T.F.S. for the period 01.02.2004 to 31.01.2005 for him and his family for sum insured Rs.20,000/- each. The complainant was admitted to Shree Jain Hospital & Research Centre, Howrah for the period 17.01.2005 to 25.01.2005 for treatment of Pericardial Effusion and the intimation of hospitalization was given to G.T.F.S. on 12.03.2005 and submitted claim documents on 18.04.2005.

The insurance company on receipt of the claim documents declined the claim on the ground of violation of policy condition Nos.5.3 & 5.4 vide their letter dt.16.01.2006.

On receipt of the repudiation letter the complainant made a representation to the insurance company on 27.02.2006 for review of the decision of repudiation on the following points in settlement of his claim, but no reply was given by the insurance company and for this the complainant filed his petition to this forum for redressal :-

In the petition the complainant contended that -

- i) such policy conditions were not incorporated in the certificate of insurance ;
- ii) the insurance company have not advised from time to time the procedure to be followed in submission of the claim as per protection of Policyholder's Interest Regulation 2002 ;
- iii) the insurance company did not also follow the provision of the aforesaid regulation that the status of claim to be communicated to the claimant within 30 days from the date of receipt of the papers ;
- iv) the clause as invoked was also subject to the rider that in the event of hardship the Insurer should call for the reasons for the purpose of waiving stringent provision of the aforesaid clause.

The insurance company stated that the claim intimation was made on 12.03.2005 after a lapse of 1 month 22 days from the date of hospitalization, i.e.17.01.2005 and submitted claim on 18.04.2005 after lapse of 2 months 23 days from the date of discharge from the hospital i.e. 25.01.2005. Accordingly, there was a violation of policy condition No.5.3 & 5.4 under Mediclaim insurance policy. It is further stated that such conditions are printed on the back of the proposal form and while getting insurance the complainant made declaration to have a knowledge and understood the terms and conditions of the policy on signing the proposal form and since there was a violation of such conditions the insurance company were unable to pay the claim.

Decision :

This office agreed with the views of the Insurance Company in repudiating the claim on the ground of delay in intimation of the claim and delay in submission of the claim documents under exclusion clause nos.5.3 and 5.4, as per the policy conditions. The complainant did not have the sufficient reasons to defend himself so that this office could waive the delay in intimation of the claim and delay in submission of the claim documents. Keeping in view of the monetary difficulties and the status of his employment, this office proposed to give an ex-gratia payment of Rs.10,000/- which, would meet the ends of justice. Therefore, it was directed to the Insurance authorities to pay Rs.10,000/- ex-gratia.

Kolkata Ombudsman Centre
Case No. : 257/11/003/NL/07/2006-07
Smt.Kalpana Bhowmick
Vs
National Insurance Co. Ltd

Award Dated : 23.03.07

Facts/Submissions :

This petition was filed by the complainant, Smt.Kalpana Bhowmick against repudiation of hospitalisation claim under Group Mediclaim Insurance Policy issued to Golden Multi Service Club of G.T.F.S. by National Insurance Co. Ltd.

The complainant stated that she took a Medical Insurance Policy from National Insurance Co. Ltd. through Golden Multi Service Club of G.T.F.S. for the period

08.03.2004 to 07.03.2005 in continuation of the previous insurance policy and was hospitalised in the Maple Nursing Home Pvt. Ltd., Kolkata for the period from 17.10.2004 to 20.10.2004 for treatment of Pyrexia of unknown origin and intimation of her hospitalisation was given to the Insurance Company on 09.11.2004 and submitted claim document on 07.02.2005. The Insurance Company on receipt of the claim papers repudiated the claim on 24.09.2005 on the ground of belated intimation and submission of claim violating policy conditions No. 5.3 and 5.4 of the policy. The complainant thereafter represented to the Insurance Company against such repudiation on 16.06.2006 stating the reasons for the delay in filing the claim. Since her representation did not yield any result, she approached this forum for redressal.

The Insurance Company stated that intimation of claim was made after a lapse of 22 days from the date of hospitalisation and claim documents were submitted to them by the complainant after a lapse of 3 months 17 days from the date of discharge resulting violation of policy conditions No.5.3 and 5.4 due to belated intimation and submission of the claim. The insurance company while defending their stand of repudiation also stated that the said conditions were printed on the back side of the proposal form and at the time of signing the proposal the proposer declared that he read and understood the terms and conditions of the policy and as there was a violation of the condition of insurance contract they had to repudiate the claim.

Decision :

It was observed from the records that there was a delay in intimation of the claim by 15 days, which ought to have been done within 7 days from the date of hospitalisation, according to the policy condition no.5.3. However, this office proposed to condone the delay in intimation, as the patient being a lady could not comply the same due to her stay in the hospital upto 20.10.2004. The delay in question under the policy condition no.5.4 could also be condoned, as she submitted the claim on 7.2.2005 after obtaining the fitness certificate on 15.1.2005, i.e. only 18 days after the date of fitness certificate.

Since both the policy conditions 5.3 and 5.4 were no longer operative, the Insurance Company should process the claim. Therefore, the Insurance Company was directed to process the claim.

Lucknow Ombudsman Centre

Case No. : L-G-19/11/02/06-07

Shri Raman Kumar Sinha

Vs.

New India Assurance Co. Ltd.

Award dated 28.11.2006

Shri Raman Kumar Sinha an officer in LIC of India covered under Group Mediciam Policy taken by his employer from New India assurance Co. Ltd. for the period 01.04.05 to 31.03.06 had lodged a complaint with Insurance Ombudsman for undue delay in settlement of claim by the Insurance Company in respect of dental treatment taken by his wife Smt. Sumita Jaipuriyar. The settlement of claim was delayed by the Insurance Company as in the opinion of the company the claimant was not providing necessary documents and was not assisting the company in reaching the correct decision in the matter. The complainant Shri Sinha had consulted Dr. Pankaj Mehrotra on 03.05.06 in respect of dental problems of his wife Smt. Sumita on 03.05.06. The doctor had advised for certain investigations prior to operation for surgical removal of maxillary cyst in upper right premolar region. The operation was performed on 29.05.06 at Chiranjeev Hospital and Heart Centre, Lucknow for which they had charged Rs.600/- . The surgeon Dr. Pankaj Mehrotra had charged Rs.25,000/-, for the process for which

he granted the receipt. On submission of the claim of Rs.25,600/- the settlement of the claim was being delayed by the insurer for following reasons :

1. The claimant was not submitting the reports of investigations & X-ray conducted as suggested by the consulting surgeon.
2. Cash memos/bills of the medicines advised after operation were also not made available.
3. Claimant had not presented his wife for examination by panel doctor of Insurer as advised by them.
4. The charges of operating surgeon were on a high side.

The claimant submitted that his bag containing the pathological reports and some of the cash memos of the medicines purchased was lost as it was stolen from a parking stand. He further stated there was no policy condition which obliged him to present his wife for examination by a panel doctor of the insurer. Condition No.5.6 of the policy cited by the insurer did not prescribe the same. The charges of Dr. Mehrotra were paid to him as demanded by him and none of the policy conditions prescribed any ceiling or the maximum charges to be paid which were to be reimbursed.

On considering the rival contentions and on the basis of documents and oral submission made by the parties, following conclusions were drawn.

1. The claim was shrouded with suspicion on account of non-submission of Investigation reports, cash memos/bills of medicines administered, copy of Admission Register of Chiranjeev Hospital and Heart Centre and exorbitant charges of Dr. Pankaj Mehrotra.
2. Since Chiranjeev Hospital & Heart Centre had issued receipt for Rs.600/- towards hospital charges, the same was to be reimbursed to the claimant.
3. Dr. Pankaj Mehrotra had charged Rs.25,000/- towards enucleation of maxilla cyst in right upper premolar region of Smt. Sumita but the charges on the face were on a high side. Even if the insurer had not prescribed any ceiling for the surgical process, one was supposed to act as a reasonable man and ascertain the charges from different doctors before finally selecting one who was technically qualified and whose charges were reasonable. Applying the test of reasonableness, the claimant was not entitled to a reimbursement of Rs.25,000/-.
4. Abhinav Dristi Hospital which is a reputed hospital of the city in its rate list has prescribed Rs.6000/- for such type of process. Rs.6000/- + 600/- was, therefore, awarded in full and final settlement of the claim of the complainant.

Mumbai Ombudsman Centre

Case No. : GI-18 of 2006-07

Shri T. C. Nambiar

V/s.

The New India Assurance Co. Ltd.

Award Dated : 12.12.2006

Shri Nambiar was earlier covered under Group Mediclaim Policy of New India, Tied DO, from July 1989 issued to the employees of Tata Consultancy Services where his daughter was employed. Shri Nambiar was hospitalised in 1994 for heart ailment at Breach Candy Hospital for which the DO settled his claim for Rs. 29,049/- which

included cost of angiography of Rs. 16,278/-. The group policy was in force only till June 2000 as his daughter later resigned from the job.

Thereafter after a gap of about 9 months, Shri Nambiar took a fresh Individual Mediclaim Policy from New India DO 111200 effective from 1/4/2001. He preferred two claims under the policy bearing No.111200/48/05/75035 (no policy copy in the file) in respect of his hospitalizations for Angiography and Angioplasty done at Asian Heart Institute on 27th April, 2005 and Jaslok Hospital on 13/10/2005 to 15/10/2005 respectively. Both claims were rejected by the Company's TPA – TTK Health Care, as these claims were for an ailment which was pre-existing

Analysis of the case reveals that Shri Nambiar was admitted to Asian Heart Institute for breathlessness since 2 months on exertion. CAG done revealed LCX 70% prox. RCA 100% prox. It was also recorded that earlier also CAG was done in 1994 when he had similar complaints and RCA then showed total occlusion. It was also recorded in the hospital papers that he was a known case of HTN since 1994. He was discharged on 15/10/2005 with an advice for PTCA. He was admitted to Jaslok Hospital for IHD, Atrial Fibrillation and PTCA was done on 13/10/2005. He was treated and discharged on 15/10/2005.

The Company rejected the claim as it was recorded that Shri Nambiar was a k/c/o Hypertension since 1994 as per the indoor case papers of the Asian Heart Institute. CAG was done in 1994 which showed RCA 100% and EF 40%.

From the various documents it was revealed that Shri Nambiar had complaints of chest pain in 1994 for which he was hospitalized at Breach Candy Hospital The Insured has also mentioned in the proposal form that he had received claim amounting to Rs. 65,000/- for hospitalization. However, in the column eliciting past illness/disease/surgeries he has not mentioned anything. All replies to Q.No. 13 (a) to (o) were negative. This tantamounts to non-disclosure of material information. Therefore, irrespective of any exclusions clause typed on the policy document, any disease pre-existing prior to the inception of the policy gets automatically excluded as per Exclusion Clause 4.1 of the Policy. In view of this, the decision of New India Assurance Company to repudiate the claim cannot be faulted.

Mumbai Ombudsman Centre
Case No. :GI-333 of 2005-2006
Shri K.K.Narayanswamy
V/s.

National Insurance Company Limited

Award Dated : 15.12.2006

Shri K.K.Narayanswamy alongwith his wife had taken a Group Mediclaim Policy through HDFC Credit Card issued by National Insurance Company Limited, Branch Office 501902 Chennai through Family Health Plan Limited from 28.10.2003.Smt Lakshmi Narayanswamy, wife of Shri K.K.Narayanswamy was hospitalized at Wockhardt hospital, Mumbai on 17.10.2005 for Acute Inferior Myocardial Infarction but unfortunately she expired on 20.10.2005. The cause of death was Terminal Cardio Respiratory Arrest due to acute IWMI with RV Infarction. When Shri Narayanswamy preferred a claim for the said hospitalisation, the TPA of the Company M/s Family Health Plan Limited repudiated the claim invoking clause 4.1 of the Mediclaim policy. Their contention was that as per the pre-authorization form the duration of Hypertension was 10 years and so the present ailment was related to Hypertension.

Not satisfied with the decision Shri Narayanaswamy approached this Forum seeking intervention of the Insurance Ombudsman in settlement of his claim of Rs. 73,376 + Interest. After perusal of the records parties to the dispute were called for hearing. On analysis of the case it is noted that the issue is centering around the exact duration of Hypertension for which the TPA/Company has rejected the claim. From the facts and circumstances it is noted that when the policy was taken by Shri Narayanaswamy for the first time in the year 2003 Hypertension pre-existed and the same was not disclosed in the proposal form filled in at the time of taking the policy. The next contention that whether Hypertension was the cause of Complete Heart Block ? To this it has been medically established that Hypertension is a high risk factor for Ischaemic Heart Disease. The primary factor in Hypertension is an increase in peripheral resistance resulting from vasoconstriction or narrowing of peripheral blood vessels. It has been well established in Medical Science that though hypertension and IHD are two separate diseases they are co-related on the basis of the common factor which is atherosclerosis. It is also well established in Medical Science that hypertension is a risk factor for cardiac diseases and coronary diseases are more frequent in those who have elevated BP than in those who are normotensive. It is further established that Smt Narayanaswamy was obese and was on irregular treatment which was also an additional risk factor which lead to Inferior Wall Myocardial Infarction with Complete Heart Block (CHB) which ultimately caused the death of Smt Lakshmi Narayanaswamy. Hence the repudiation of the claim by National Insurance Company Limited on clause 4.1 of the mediclaim policy cannot be faulted.

Mumbai Ombudsman Centre

Case No. : GI-237 of 2006-07

Shri Viresh A. Amodkar

V/s.

United India Insurance Co. Ltd.

Award Dated : 05.02.2007

Shri Viresh A. Amodkar covered his mother, Smt. Sulochana A. Amodkar aged 59 yrs for the first time on 30/9/2004 to 29/9/2005 through M/s. Unique Mercantile under a Group Mediclaim Policy. He preferred a claim in the second year of the policy , for cataract operation done in the month of December 2005. His mother was operated at Laxmi Eye Institute Lasik & Laser Centre, Panvel for cataract of left eye The claim was repudiated by the United India as per Excl. Clause 4.3 of the Group Mediclaim Policy

Analysis of the case reveals that Shri Amodkar covered his mother alone under the Group Mediclaim policy in the year September 2004-2005. Immediately in the following year on 14th December, 2005, Smt. Amodkar was admitted to Laxmi Eye Institute Lasik & Laser Centre for cataract operation. When a claim was lodged with the Company, they repudiated it under excl. clause 4.3 of the Group Mediclaim Policy on the basis of the opinion of their panel doctor who opined that Smt. Amodkar was suffering from diminished vision since 6 to 7 months prior to hospitalization i.e. since June 2005. Though the Insured underwent cataract operation in the second year of the policy, the symptoms were started in the first year of the policy.

The policy condition states that during the first year it would not consider some specified diseases in which cataract is included. In the present case, as per certificate of the doctor from Laxmi Eye Institute, Smt. Sulochana Amodkar had diminished vision from 6 to 7 months i.e. during the first year of the policy itself. "Diminished vision is a symptom of cataract as it progresses. During the first stage, the vision is distorted

particularly during night or in very bright light due to light sensitivity. As the cataract progresses severe visual impairment develops." (quoted from Taber's Cyclopedic Medical Dictionary).

The only point that comes here is whether the Insured's diagnosis of Cataract formation was before the policy was taken which would then mean a deliberate move to delay to take advantage under the policy. In the present case, the symptoms of Cataract developed during the first year of Policy and not before the inception of the policy. Therefore, the pre-existence has not been clearly proved by the Company although it would be safe to conclude that cataract does take time to develop and mature and normally the surgery is undertaken only when it is matured. Hence the possibility of pre-existence cannot be ruled out in such cases. However, the exclusion clause 4.3 is specific to exclude cataract and other specified diseases only in the first year and not for the onset of the disease. Since the Company has not provided any documentary proof that the cataract existed prior to the inception of the policy, the decision of the Company to repudiate the claim as per exclusion clause 4.3 is not sustainable since the hospitalization took place in the second year of the policy. The benefit of doubt goes in favour of the Insured.

Mumbai Ombudsman Centre
Case No. : GI-269 of 2006-07
Shri. Gajanand A. Padalkar
V/s.
National Insurance Co. Ltd.

Award Dated : 12.02.2007

Smt. Anuradha A. Padalkar was insured with National Insurance Company under M/s. Rukmini Chartiabale Trust Group Mediciclaim Policy for the period 14/11/2005 to 13/11/2006 for the first time. Smt. Anuradha Padalkar was admitted to Telang Nursing Home on 6/3/2006 at 9.30 a.m. and discharged on 7/3/2006 at 10 a.m. for Hypertension with chest pain. The claim preferred by her son, Shri Gajanand Padalkar under Mediciclaim Policy No. 020500/48/04/08059 for the period 14/3/2005 to 13/3/2006 was repudiated by the Company under exclusion clause 4.8 of the Group Mediciclaim Policy. Not satisfied with the decision of the Co, he represented his case for review with the Grievance Cell of the Company. Not receiving any favourable reply from the Grievance Cell, he lodged a complaint with this Forum against the Company and requested for interevntion of Ombudsman in the matter. Parties to the dispute were called for personal hearing on 19th January, 2007.

Analysis of the case reveals that Smt. Padalkar was admitted to Telang Nursing Home from 6/3/2006 to 7/3/2006. As stated in the hospital papers she was a known case of hypertension with cervical spondylosis since 1 ½ yrs. Diagnosis mentioned in the discharge summary "Hypertension with chest pain for observation ? IHD, On examination of the claim file, it was noted that there was no advice/recommendation of any physician/Medical Practitioner for admission to a hospital. It is noted from the hospital papers that she was admitted Hypertension with chest pain for observation ? IHD as mentioned in the discharge summary. It is also noted from the Indoor case papers that her B.P. readings were consistently normal. Treatment given were oral medications only. The Company also obtained an opinion of their panel doctor, Dr. Bandoorkwala, MD, DGO who opined that " Insured was admitted only for purpose of investigations and evaluation and not for any specific treatment. He further stated that this treatment could have been possible as an outpatient basis. Although she was suspected to have IHD, the same was not proved and no treatment was offered for the

same." Hence the claim would be falling under excl. 4.8. and the rejection of National Insurance Co. Ltd. is sustainable.

Mumbai Ombudsman Centre

Case No. : GI-241 of 2006-07

Dr. Tarun J. Sheth

V/s.

The Oriental Insurance Co. Ltd.

Award Dated : 28.02.2007

Dr. Tarun J. Sheth and Dr.(Smt.) Nayana T. Sheth were covered under Policy No. 121800/48/06/2693 issued by Oriental Insurance Company Limited for a period 9/8/2005 to 8/8/2006. Dr. (Smt.) Nayana Sheth underwent Left Cataract removal and lens implant surgery on 25/11/2005 at Iris Eye Centre for which she lodged a claim with the Company on 6/1/2006. However, she has not yet received any information in respect of her cataract claim from the Company. Subsequently, she was admitted to Nanavati Hospital on 5/2/2006 to 16/2/2006 for multisystem disorder with Lupus Nephritis. A claim for reimbursement of the expenses was rejected by the TPA under Exclusion Clause 4.1.

Analysis of the case reveals that Dr. (Shri) Tarun J. Sheth and Dr. (Smt.) Nayana T. Sheth were covered under Mediclaim Policy since 9/5/1997 –98 for a Sum Insured of Rs. 1 lakh each. The S.I. was increased to Rs. 3 lakhs each in the year 2001-02. Since then the policy was renewed continuously for Rs. 3 lakhs. In the year 05-06, Dr. Sheth sent the renewal cheque to the Company in time and a policy bearing No. 812/2006 was issued to him for the period 15/5/2005 to 14/5/2006. Consequent upon the dishonour of cheque the Company informed the Insured about the cancellation of the above –referred policy . A demand draft for the premium amount was paid by the Insured and a fresh policy was issued by the Company from 9/8/2005 to 8/8/2006.

Dr. (Smt.) Sheth underwent a left eye cataract surgery on 25/11/2005 at Iris Eye Centre for which a claim was lodged by Shri Sheth for which he did not receive any reply. The second claim of for Lupus Nephritis was rejected by the Company for the reason that Smt. Sheth was a k/c/o of HTN since last one year . She had a history of similar episode a year back i.e. in February 2005 which was before the inception of the policy and hence pre-existing.

The policy of 9/8/2005 was treated as the first year of the policy for which the Lupus Nephritis and HTN were considered as pre-existing as per excl. clause 4.1. The Insured was covered since May 1997 . The only break which came was due to bouncing of the cheque for which the Company was obliged to withdraw the cover already granted as a renewal which resulted into break of more than two months But looking to the past record of the Customer this Forum allows the benefit to the Insured of not to treat the past illness as pre-existing taking 8/2005 as the first incept of the policy but it should be May'97 when he took the first policy. In view of the above the company is directed to process both the claims.

Mumbai Ombudsman Centre

Case No. : GI-227 of 2006-07

Shri V.A. Muzumdar

V/s.

United India Insurance Co. Ltd.

Award Dated : 30.03.2007

Shri V.A. Muzumdar and his wife were covered under a Group Mediciclaim Policy of United India Insurance Co. Ltd. through Unique Mercantile India Pvt. Ltd since 31/3/2003. He preferred a claim for reimbursement of expenses under the Policy No. 021800/48/04/0129 for retina detachment of right eye for which he was hospitalized at Kumta Eye & Retina Clinic & Laser centre on 15th July, 2005. The TPA rejected the claim under excl. clause 4.1.

The Forum advised the complainant to submit supportive documents/reports of medical tests conducted before taking the policy and submit the same to the Company and the Company was asked to resolve the issue within 10 days.

As advised during the hearing, the Complainant submitted the copy of the Pre-acceptance Medical Reports vide his letter dated 15/3/2007 to the Company and a copy to this Forum. The Company has informed this Forum vide their letter dated 23/3/2007 that there was no change in their decision even after the scrutiny of the Medical Report and expressed their inability to entertain the claims for retinal detachment of both the eyes.

Analysis of the case reveals that Shri V.A. Muzumdar consulted Dr. Anand N. Kumta, M.S. Ophth, on 16/7/2005 for sudden diminished vision and he was advised surgery. He was admitted to Kumta Eye & Retina Clinic on 19/7/2005 for right eye total retinal detachment with severe myopia macular degeneration. He was operated and discharged the same day.

There is a clear noting in the first consultation paper about the h/o of cataract extraction 10 years ago and yag laser done 8 years ago and it also appears that the first consultation paper has been tampered with as there was something written about the patient's myopic condition which has been struck off to make it not readable. Also there is no attestation of the doctor if it were to be presumed that it was wrongly written by the doctor.

The Policy was issued to the Insured based on the Medical Examination including the eye examination. The Pre-medical Reports clearly noted in the Ophthalmic Examination column – “h/o high Myopia” and “cataract operation of both eyes” and had therefore, recommended exclusion of cataract and high myopia under the policy. The Company however, issued the policy without the specific exclusions mentioned in the Pre-medical reports, but the standard condition of exclusion of all pre-existing disease at the time of the inception of the policy is mentioned on the face of the policy document. Therefore, Cataract and Myopia are excluded from the scope of the policy. It is a medically established fact that progressive myopia leads to retinal detachment and blindness. Moreover, Shri Mazumdar entered the Mediciclaim Scheme with a history of cataract operation of both the eyes and diagnosed to have total retinal detachment with severe myopia macular degeneration. Since Myopia and cataract were pre-existing ailment excluded from the scope of the policy, the Insurer has rejected the claim under excl. 4.1 of the policy.

Subsequent to the hearing, the Complainant has submitted the copy of a report obtained by Sehat India Health Care Services (P) Ltd., Report No. 370 date of examination 13/12/2005 in which in reply to Q.No. 5 were as under:

Q.No. 5 Ophthalmic Examination : H/o High Myopia - 22

a) Near Vision – N b) Distant Vision – N

c) Colour Vision – N d) Ophthalmoscopic Examination – Kept Blank

Impressions : a) Presence of Cataract : Both eyes (cataract operated in '94)

This form was signed by the Medical Examiner Dr. Nitin Patil and by the Insured. On another form, named as Registration Details in the conclusion it was mentioned 'excluded cataract, high myopia.'

In the opinion of the panel doctor longstanding high myopia caused retinal detachment and in the opinion of the treating surgeon it was stated that Retinal detachment occurred in a small percentage of myopics. Thus both the Doctors have not opined with certainty. Under such conditions, the circumstances prevailing before the operation are to be taken into consideration. The insured was covered under the Mediclaim policy w.e.f. 31/3/2003 with high myopia and cataract operation in both the eyes.

In the light of the above analysis, this Forum does not find any justifiable grounds to interfere with the decision of the Company.

Mumbai Ombudsman Centre
Case No. : GI-143 of 2006-07
Shri Vallabhdas R. Thakkar
V/s.
National Insurance Co. Ltd.

Award Dated : 30.03.2007

Shri Vallabhdas R. Thakkar and his family were covered under Group Mediclaim Policy No. 260600/46/04/850001148 issued to the members of Winner Insurance Benefits Limited for the period 29/3/2005 to 28/3/2006. Smt. Hiraben V. Thakkar was hospitalized on 15/8/2005 to 19/8/2005 at Sanjeevani Nursing Home with complaints of fever with moderate grade & chills since 10 days. She was diagnosed as "Freshly detected decompensated cirrhosis of liver with Ascitis. When a claim was preferred, the Company's TPA, E-Meditek Solutions repudiated the claim for non-disclosure of material fact of past history of acalculous cholecystitis in 2004 and history of BT in the past.

On perusal of the papers it is observed that the claim has arisen in the first year of the policy. Smt. Thakkar was hospitalized at Sanjeevani Nursing Home & ICCU with complaints of fever and chill, bodyache, headache. Various investigations were done and tests for dengue and leptospirosis were negative. USG of the whole abdomen revealed cirrhotic type liver pattern with ascites and left gastric and splenic hilar collaterals. Ascitic fluid examination was abnormal. Hepatitis 'C' test was positive. The diagnosis was 'freshly detected decompensated cirrhosis of liver for which ascitic tapping was done. Ascitic Fluid test did not reveal any atypical or malignant cells. She was discharged on 19/8/2005. The TPA while processing the claim asked for certain informations like when Hepatitis C was detected, treatment records of 10 days prior to admission and the proposal form. In response to the above queries, the Insured submitted a certificate of Dr. Rajendra M. Kuruwa of Sanjeevani Nursing Home stating that the Hepatitis C was detected on 27/8/2005 for the first time. However, it is noted from the medical reports that the test for Hepatitis C was done on 17/8/2005 i.e. during hospitalisation which was detected positive. Pre-hospitalisation prescription paper dated 12/8/2005 mentions h/o acalculus cholecystitis in 2004. The same was not disclosed by the Insured in the proposal form. Hospital Papers mentions past history column as nil. However, in the hospital's follow up papers (i.e. Post hospitalization papers) dated 2/9/2005 mentions HCV induced cirrhosis, history of BT in the past. These two facts, viz. of acalculus cholecystitis in 2004 and history of BT are not recorded in the hospitalization papers. For better understanding of Cholecystitis we quote - "Cholecystitis is inflammation of the gall bladder. In acute Cholecystitis there is fever, gradually developing or sudden pain in the upper abdomen, nausea, vomiting

and visible but mild jaundice in about 20% of patients. In acute cholecystitis cholecystectomy is required. If this is not possible, the gall bladder should be drained and cholecystectomy should be performed at a later date." (quoted from Taber's Cyclopedic Medical Dictionary). Now let us understand the present ailment of the patient "Cirrhosis of the Liver with Ascitis" for which she was hospitalized. A chronic disease of the liver marked by formation of dense perilobular connective tissue, degenerative changes in the parenchymal cells structural alternation of the cords of liver lobules, fatty and cellular infiltration. Cirrhosis may be due to various factors such as nutritional deficiency, poisons (including alcohol, carbon tetrachloride and phosphorous) or previous inflammation caused by a virus or bacteria."

It is noted that the patient had suffered from Cholecystitis in 2004 and the same was not disclosed by the Insured while proposing for insurance in 2005. Also it is noted in the post hospitalization follow up paper that she also had a history of BT in the past which was also not disclosed. Insurance Contract is a contract of utmost good faith which means the Insured ought to disclose all ailments/diseases suffered by the Insured including minor or major surgical interventions affecting his health status. Non-disclosure amounts to suppression of correct health status which forfeits the contract.

In the light of the above analysis this Forum does not find any conclusive ground to differ from the Company's decision.

Mumbai Ombudsman Centre
Case No. : GI-385 of 2006-07
Shri Yeshwant H. Raorane
V/s.
United India Insurance Co. Ltd.

Award Dated : 30.03.2007

Shri Yeshwant H. Raorane took a Group Mediclaim Policy covering his wife and two children from United India Insurance Co. Ltd. DO 18, through M/s. Unique Mercantile Services P. Ltd. from 10/1/2001. He renewed the policy continuously and preferred a claim for reimbursement of hospitalization expenses incurred by him at Raj Orthopaedic Hospital for replacement of hip joints which was repudiated by the Company under Exclusion Clause 4.1.

Analysis of the case reveals that Shri Yashwant Raorane was admitted to Raj Orthopaedic Hospital on 10/2/2005 with complaints of pain in hip joints, unable to walk. He underwent total hip replacement (bilateral) on 11/2/2005. He was treated and discharged on 17/2/2005. His claim was repudiated by the Company under excl. clause 4.1. Upon receipt of a representation from the Insured together with a certificate from the treating doctor, Dr. Mukhi, the Company referred the case to their panel doctor, Dr. Kamlesh V. Joshi, Consulting Orthopaedic Surgeon who opined that "after examination of the pre-operative x-ray plates, it seems that the Insured is having gross bilateral OA (Hip) with destruction of both femoral heads which is of minimum four years duration along with mentioned cardiac problems." Based on the opinion of their panel doctor, the Company informed the Insured through Unique Mercantile, their final decision to repudiate the claim.

On careful scrutiny of the entire claim papers and medical papers available in the file, it is felt that the Insurer's reference to pre-existence is not fully proved and no documentary evidence has been brought on record by the Company to prove the same. The Medical records of 2003 submitted by the Insured established that he consulted Dr. S.P. Mathew, MD, for pain in the hip in 2003 and he was advised surgery in 2005 only when it could not be medically managed. However, the records does not indicate

the exact onset of the disease and therefore, does not fully serve the purpose of substantiating the Insured's stand that he never suffered from arthritis of any kind prior to March 2003. The Insurer's contention that the disease was pre-existing was based on opinion of their consulting Orthopaedic Surgeon and not on the basis of some reliable conclusive evidence, whereas in the prescription papers submitted by the Complainant, the history of pain in hip joints dates back to 2003 and the hospital records also note the history of two years and the Mediclaim insurance was taken in January, 2001. In view of the above analysis the rejection of the claim by the Insurer for pre-existing is not tenable.

Mumbai Ombudsman Centre
Case No. : GI-232 of 2006-2007
Shri Ram A. Yadava
V/s
The New India Assurance Co.Ltd.

Award Dated :

Shri Ram A. Yadava, was insured under the Group Mediclaim Policy of LIC Of India, of The New India Assurance Company Limited, Mumbai. He was hospitalised at Bombay Hospital from 28.3.2005 to 30.3.2005 for Right Eye Cataract Surgery. He preferred a claim for reimbursement of medical expenses of Rs.81,840/- incurred for his hospitalisation at Bombay Hospital and the Company, settled the claim for Rs.40,000/-.

Shri Yadava, represented to the Company vide letter dated 12th December, 2005 stating that he had submitted a claim for Rs.81,840/-, out of which the company settled his claim for Rs.40,000/- only without any justification. The charges are to be decided by the hospital and not arbitrarily by the Insurance Company. Bombay Hospital is a well known hospital and the bill was paid as per their rates. However, the Company vide letter dated 10th January, 2006 did not reconsider their decision and maintained their stand on payment of Rs.40,000/- considering the same as reasonable and necessary as per the provisions of the policy. Aggrieved with the decision of the company, Shri Yadava, approached the Ombudsman vide letter dated 11.7.2006 for intervention in the balance settlement of his claim with interest.

On going through the records, it is observed that Shri Yadava, was admitted for Right Eye Cataract Surgery, Phaco with PGOL (foldable) lenses under care of Dr.R.C Patel at Bombay Hospital from 28th March to 31st March, 2005. Generally for Cartaract Surgery the admission is for short duration but Mr. Yadava was admitted for three days. The certificate issued by Dr. Patel states that Mr. Yadava was scheduled for surgery on 29th March, 2005 but the same was carried out on 30th March, 2005 due to equipment failure.

The Company vide their written statement to this Forum has stated that Mr. Yadava had lodged a claim for Rs.81,840/- towards the Cataract Surgery on 'One Eye", the hospital expenses being Rs.74,877/- and balance towards the pre and post hospitalization expenses. There were no major complications or health ailment, associated with the surgery as per the report in this case. The cost of the lens was Rs.7750/- and the procedure involved was Phaco with PGOL Foldable lenses under Local Anaesthesia. The Surgeon's charges (Dr. R.C. Patel) was Rs.30,000/- and the Anesthetist charges Rs.10,000/-. It is noted that lens was supplied by Dr.R.C. Patel for surgery done in Bombay Hospital. Generally, consumables are supplied by hospital management and not the operating surgeon and for Cataract, generally it falls under the package charges. The Divisional Office has submitted that they have settled more than 700 Cataract claims in the last four years from the biggest hospitals including

Bombay Hospital in the city and best of Doctors. The maximum claim paid towards Cataract has not exceeded Rs.40,000/- in Deluxe Rooms.

The claim preferred by Shri Yadava was exorbitant and the Insurer referred it to their Panel Doctor, who opined that a maximum of Rs.40,000/- can be paid for the treatment, since there was no complication of Diabetes or other ailment. From the documents provided by the Company for comparative analysis, it is noted that Dr. R.C. Patel had charged Surgeon's fees of Rs.11,000/- only with Rs.3,667/- for anesthesia charges in a similar Cataract Surgery, Phaco with PGOL (foldable) lenses with a history of DM, HT in Bombay Hospital in February 2006 as against the Surgeon's fees Rs.30,000/- and anaesthetist charges of Rs.10,000/- to Mr. Yadava. The cost of lens of Rs.7750/- was charged separately and was supplied by Dr. R.C. Patel. The Surgeon's charges and anaesthetist charges were on higher side as compared to other similar claims. Hence a maximum amount of Rs.40,000/- was settled. The Company has also submitted an exhaustive list of claims settled by them for similar Cataract Operations done at various hospitals in the city, wherein the charges claimed and settled did not exceed Rs.40,000/-.

The Mediclaim Policy permits only reimbursement of reasonable and necessary charges incurred by the insured. Under the circumstances, we do not find any justifiable reason to interfere with the decision of the Insurer.

Mumbai Ombudsman Centre
Case No. : GI-232 of 2006-2007
Shri Ram A. Yadava
V/s
The New India Assurance Co.Ltd.

Award Dated :

Shri Ram A. Yadava, was insured under the Group Mediclaim Policy of LIC Of India, of The New India Assurance Company Limited, Mumbai. He was hospitalised at Bombay Hospital from 28.3.2005 to 30.3.2005 for Right Eye Cataract Surgery. He preferred a claim for reimbursement of medical expenses of Rs.81,840/- incurred for his hospitalisation at Bombay Hospital and the Company, settled the claim for Rs.40,000/-.

Shri Yadava, represented to the Company vide letter dated 12th December, 2005 stating that he had submitted a claim for Rs.81,840/-, out of which the company settled his claim for Rs.40,000/- only without any justification. The charges are to be decided by the hospital and not arbitrarily by the Insurance Company. Bombay Hospital is a well known hospital and the bill was paid as per their rates. However, the Company vide letter dated 10th January, 2006 did not reconsider their decision and maintained their stand on payment of Rs.40,000/- considering the same as reasonable and necessary as per the provisions of the policy. Aggrieved with the decision of the company, Shri Yadava, approached the Ombudsman vide letter dated 11.7.2006 for intervention in the balance settlement of his claim with interest.

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The Company vide their written statement to this Forum has stated that Mr. Yadava had lodged a claim for Rs.81,840/- towards the Cataract Surgery on 'One Eye', the

hospital expenses being Rs.74,877/- and balance towards the pre and post hospitalization expenses. There were no major complications or health ailment, associated with the surgery as per the report in this case. The cost of the lens was Rs.7750/- and the procedure involved was Phaco with PGOL Foldable lenses under Local Anaesthesia. The Surgeon's charges (Dr. R.C. Patel) was Rs.30,000/- and the Anesthetist charges Rs.10,000/-. It is noted that lens was supplied by Dr.R.C. Patel for surgery done in Bombay Hospital. Generally, consumables are supplied by hospital management and not the operating surgeon and for Cataract, generally it falls under the package charges. The Divisional Office has submitted that they have settled more than 700 Cataract claims in the last four years from the biggest hospitals including Bombay Hospital in the city and best of Doctors. The maximum claim paid towards Cataract has not exceeded Rs.40,000/- in Deluxe Rooms.

The claim preferred by Shri Yadava was exorbitant and the Insurer referred it to their Panel Doctor, who opined that a maximum of Rs.40,000/- can be paid for the treatment, since there was no complication of Diabetes or other ailment. From the documents provided by the Company for comparative analysis, it is noted that Dr. R.C. Patel had charged Surgeon's fees of Rs.11,000/- only with Rs.3,667/- for anesthesia charges in a similar Cataract Surgery, Phaco with PGOL (foldable) lenses with a history of DM, HT in Bombay Hospital in February 2006 as against the Surgeon's fees Rs.30,000/- and anesthetist charges of Rs.10,000/- to Mr. Yadava. The cost of lens of Rs.7750/- was charged separately and was supplied by Dr. R.C. Patel. The Surgeon's charges and anaesthetist charges were on higher side as compared to other similar claims. Hence a maximum amount of Rs.40,000/- was settled. The Company has also submitted an exhaustive list of claims settled by them for similar Cataract Operations done at various hospitals in the city, wherein the charges claimed and settled did not exceed Rs.40,000/-.

The Mediclaim Policy permits only reimbursement of reasonable and necessary charges incurred by the insured. Under the circumstances, we do not find any justifiable reason to interfere with the decision of the Insurer.

Mumbai Ombudsman Centre

Case No. : GI-39 of 2006-07

Shri Surendra Jalani

V/s.

New India Assurance Co. Ltd.

Award Dated :

Shri Surendra Jalani and his wife were covered under Group Mediclaim Policy issued to the employees of LIC of India by New India Assurance Co. Ltd. Smt. Jalani was hospitalized for Backache and investigations at Karuna Hospital on 14.6.2005 and discharged the next day i.e. on 15.6.2005. When a claim was preferred under the policy for Rs.9834/-, the Company rejected the claim under Exclusion Clause 4.10 of the policy. Not satisfied the Insured represented his case for review. Not getting any favourable reply to his representation the Insured then approached the Insurance Ombudsman.

The Company's view points and also the opinion of the panel doctor, Dr. Salma Khan have also been examined and analysis of the case reveals that Smt. Unnati Jalani consulted a doctor at Mathuradas Mathur Chikitsalay, Jodhpur for her backache on 8.6.2005. Her doctor advised X-ray which showed collapse of D11 which was further confirmed by digital X-ray as "compression fracture of body of D11". She was advised to consult an Orthopaedic Surgeon. She consulted Dr. M.L. Saraf, Orthopaedic

Surgeon of Bombay Hospital on 13.6.2005 who advised hospitalization. She then got admitted to Karuna Hospital on 14.6.2005.

Although Shri Jalani, has contended that the doctor advised to admit his wife, Smt. Jalani, for treatment and investigation, it is observed from the discharge card of Karuna Hospital, that the line of treatment given was oral medication, which does not require confinement in the hospital. Further the investigations done like MRI and X-ray Spine could have been done on OPD basis. Even the final diagnosis and indoor case papers mentions that the patient was admitted for investigation purposes and no other treatment was given to her. The documents do not reveal any exaggeration of symptoms of backache necessitating hospitalization.

In the facts and circumstances, the decision of The New India Assurance Company to reject the claim on the ground that the hospitalization was for observation and investigation purpose, which falls under Exclusion Clause 4.10 of the policy is sustainable.