Group Mediclaim Policy

Ahmedabad Ombudsman Centre
Case No. 11-002-0361
Mr. G K Mudra
Vs
New India Assurance Co. Ltd.

Award Dated: 23.5.2007

Repudiation of Mediclaim. The Insured was covered under Group Mediclaim for LIC Employees. The Insured suffered Knee Pain for which medical consultation took place. On the advice of the Orthopaedist, MRI and Sonography were done without hospitalisation. Claim thereof was repudiated. However, as per the policy conditions, expenses for MRI and Sonography are payable even if hospitalisation has not taken place. As such, Repudiation was set aside and the Respondent was directed to pay the full claim.

Bhubaneswar Ombudsman Centre
Case No. 11-002-0205
Sri Asish Chandra Satpathy
Vs
New India Assurance Co. Ltd.

Award dated : 09.08.2007

Insured Complainant was covered under LIC staff Group mediclaim policy of New India Assurance Co. Ltd . During the period of insurance insured complainant admitted to Global Hospital of Hyderabad on 25-12-2004 for treatment of irritable bowel syndrome. Insured complainant discharged on 27-12-2004 at 11.36 A.M. from that hospital and admitted in to Appolo Hospital Hyderabad on 27-12-2004 at 6.25 P.M. for treatment of Cervical spondalysis and lumbar spondalysis. Insured complainant was discharged from Appollo Hospital on 28-12-2004 at 3.54 P.M. Insured's claim for the imbursement of Rs 92333.49 has been repudiated by insurer on the ground that he was not under treatment of any disease at Global Hospital and did not complete the minimum duration of 24 Hours at Appollo Hospital violating the policy conditions.

During hearing Insurer representative stated that he had no disease nor referred by any local physician for treatment in Global Hospital. More over he was admitted to Appolo Hospital without any reference from any doctor and remained only for 21 hours and 29 minutes violating 24 hours mandatory period as per policy.

Hon'ble Ombudsman directed the insurer to settle the claim as there is no hard and first rule that 24 hours hospitalisation. Moreover he was suffering from nausea and passing loose motion with mucous since 3 -4 months and admitted in to Global hospital. The objection of insurer that he was not suffering from any disease is not acceptable.

Bhubaneswar Ombudsman Centre
Case No. 11-002-0181
Mr. Durga Charan Nayak

Vs

New India Assurance Co. Ltd.

Award Dated : 19.09.2007

Insured Complainant, an employee of LIC of India was covered along with her spouse under LIC staff group mediclaim policy of New India Assurance Co. Ltd. .Complainant's wife admitted in Capital Hospital ,Bhubaneswar for removal of Uterus and discharged on 17-06-2004. Insured lodged a claim of Rs. 6080/- with the insurer for re imbursement of medical expenses.

Insurer settled the claim for Rs 1547/ considering the bills and cash memos submitted by insured.

Insured complainant after receipt of that amount lodged the claim for less settlement. During Hearing insurer stated that insured failed to supply the prescriptions for the medicine purchased from M/s Janaki Medical Store.

Insured did not turn-up.

Hon'ble Ombudsman uphold the repudiation as insured failed to supply the corresponding prescriptions against which the medicine bills submitted.

Chandigarh Ombudsman Centre

Case No. : GIC/137/NIA/11/08

Ved Parkash Luthra

Vs

New India Assurance Co. Ltd.

Order dated: 9.08.07

Facts : Shri Ved Parkash Luthra was covered under Group Mediclaim Policy taken by LIC of India for its employees. His son Shri Manik Luthra met with an accident and had to undergo dental treatment. The claim lodged with the insurer was repudiated on the ground that admission was required. The complainant quoted order dated 9.5.07 of this forum wherein the insurer was ordered to pay the claim in respect of dental treatment undergone due to accident.

Findings : The insurer informed vide letter dated 26.6.07 that the claim in respect of treatment of Mr. Manik Luthra from 21.7.04 to 20.8.04 was lodged and the said claim was treated as 'no claim' on the basis of condition no. 4.7 of the terms and conditions of the policy which states that "cosmetic or aesthetic procedure including wear and tear is not covered unless arising from disease or injury and which requires hospitalization for treatment". It was stated that in the bills submitted no hospitalization was mentioned. It was further stated that complaint of the insured was time barred as more than 12 months had passed and as per their policy terms and conditions no complaint could be lodged against any claim after lapse of a period of 12 months from the date of repudiation i.e. 2004. On a query whether the treatment was taken after an accident, the complainant replied that his son had fallen in the bathroom. The insurer refuted the statement by stating that the clinic report stated that accident was due to a fall from the scooter.

Decision : Held that the two statements of the complainant were contradictory to each other. Hence contention of dental treatment due to accident could not be justifiably

proved. The repudiation of claim by the insurer was in order. The complaint was dismissed.

Chennai Ombudsman Centre
Case No. 11.02.1480/2007-08
Shri. P.Annadurai
vs
New India Assurance Co. Ltd.

Award Dated 27.04.2007

The complainant Mr.P.Annadurai approached this forum with a complaint against M/s New India Assurance Co. Ltd., Divisional.Office, Madurai, stating that he was covered under LIC Group Mediclaim policy with M/s. New India Assurance Co. Ltd. and he had made a claim for the hospitalization expenses of his wife Smt.A.Lakshmi for her treatment as in-patient at M/s.Vadamalayan Hospitals from 13.6.2006 to 15.6.2006 with the diagnosis Type 2 DIABETES MELLITUS WITH PERIPHERALNEUROPATHY WITH LUMBAR SPONDYLOSIS.

The representative of the insurer stated that the hospitalization charges incurred towards investigation were not consistent to the diagnosis and that the charges were generally for investigation purpose and were not followed by any active line of treatment and furthermore the insurer stated that the hospitalization was not warranted and hence the claim was repudiated.

The forum perused the documents and confirmed that the doctor who had examined the patient physically, when she presented with the complaints alone can decide whether the patient requires hospitalization or not and therefore 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 which does not carry any conviction and hence the insurer is not justified in rejecting the claim. The complaint is allowed.

Chennai Ombudsman Centre
Case No. 11.02.1482/2006-07
ShriS.Baskaran
vs
New India Assurance Co. Ltd.

Award Dated 27.04.2007

The complainant Mr.S.Baskaran, approached this forum with a complaint against M/s New India Assurance Co. Ltd., Divisional.Office, Madurai, stating that he had taken a LIC Group Mediclaim policy with M/s. New India Assurance Co. Ltd. and he had made a claim for the hospitalization expenses of his wife Smt.Shantha Devi for her treatment as in-patient at M/s.Apollo Speciality Hospitals, Madurai , from 4.4.2006 to 6.4.2006 with the diagnosis CERVICAL SPONDYLOSIS, LEFT BRACHIAL NEURALGIA II DEGREE HAEMORRHOIDS AND VERTIGO, after she had a fall in Nov. 2005 and continous pain thereafter.

The representative of the insurer stated that the patient was hospitalized and the treatment comprised only oral medicines and MRI scan which did not warrant hospitalization and therefore the claim was repudiated invoking policy exclusion 4.10 and condition 2.3(a) and furthermore she stated that they are prepared tp admit the claim for the expenses of MRI scan under non-hospitalisation charges, subject to verification of their policy conditions.

The forum perused the documents and confirmed that the patient had been trying several treatments as out-patient and since there appeared to have been no improvement, as a last resort she got admitted herself in the hospital and the doctor who had examined the patient physically, when she presented with the complaints alone can decide whether the patient requires hospitalization or not and therefore 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 which does not carry any conviction and hence the insurer is not justified in rejecting the claim.

The complaint is allowed.

Chennai Ombudsman Centre
Case No. : IO(CHN) 11.02.1148/2007-08
Shri K. Shanmugam
Vs
The New India Assurance Co. Ltd.

Award Dated : 23.08.2007

The complainant Shri K Shanmugam has stated that he is a retired employee of LIC of India and covered under LIC Group mediclaim policy with M/s New India Assurance Co. Ltd., His wife was hospitalized for the complaint of viral fever and other problems. His claim for the hospitalization and post-hospitalization claim for Rs.1200/- pertaining to his wife, were settled by the insurer. At the time of final review he had incurred another sum of Rs.3933/- towards tests, medicines. However, the insurer allowed only Rs.486/- towards the same. He represented to the insurer that these expenses were incurred for same illness, the expenses are incurred within 60 days which falls under post-hospitalization cover etc.,

The representative of the insurer stated that LIC Group Mediclaim is a specially designed policy where pre-existing diseases and maternity are covered. He had claimed Rs.3933/-. Based on the claim papers submitted by the insured they settled Rs.486/-. They allowed medicines for only 6 days, which fell within the 60 days stipulated period. The patient may be advised to continue with certain drugs/medicines for longer period, however, the moot point is whether the same is admissible under the policy or not. In this case, as per the terms and conditions of the policy, the insurer can consider the post-hospitalization only upto 60 days.

On perusal of documents it was established that the Insurer has allowed proportionate medical expenses towards post-hospitalization expenses in addition to Lab charges Rs.50/- and Consultation charges of Rs.190/-. The post hospitalization claim has been settled as per terms and conditions of the policy. The complaint is dismissed.

Chennai Ombudsman Centre
Case No. : IO(CHN) 11.04.1063/2007-08
Shri A R Srinivasan
Vs
The United India Insurance Co. Ltd.,

Award Dated : 2.07.2007

The complainant stated that he had retired from M/s United India Insurance Co. Ltd., and his family was covered United India Group Mediclaim Policy. His wife Smt. S Vedavalli had a fall on 15.09.2006 and was hospitalized at M/s St. Isabels Hospital from 15.09.2006 to 05.10.2006. He preferred a claim with the insurer for

Rs.1,67,010.54. The insurer settled his claim for Rs.1,30,744.21 disallowing an amount of Rs.36,266.33.

He contended that items disallowed included home nursing charges of Rs.28,500/-, cost of Accu Chek Strips' of Rs.5,199.93, Ambulance charges of Rs.1,830 /-, Telephone and Misc. Charges Rs.850/-. and Discharge procedure expenses of Rs 100/-.

The representative of the insurer stated that their medicalim policy does not provide for reimbursement of expenses for nursing charges at home. Also the company would not pay the Ambulance charges, telephone and other miscellaneous charges as they were beyond the scope of the policy.

On perusal of documents like Discharge summary, certificate given by the attending doctor regarding need for bedside nursing and after considering that the insured had suffered a Subtrochantric fracture which was a Complex fracture which takes a longer time to heal, an Exgratia award of Rs 15,000/- towards nursing charges was passed. The complaint was partially allowed on Exgratia basis.

Chennai Ombudsman Centre
Case No. : IO(CHN) 11.02.1054/2007-08
Mr K. S. Venkataraman
Vs
The New India Assurance Co. Ltd.

Award Dated : 2.07.2007

The complainant Mr K S Venkataraman said that he and his family are covered under LIC Group Mediclaim policy with M/s New India Assurance Co. Ltd., His wife was hospitalized at Vadamalayan Hospitals for 2 days for the complaints of generalized body pain, pain in the knees, profuse sweating, weakness and tiredness etc. She had hypothyroidism also. His claim was rejected by the insurer on the ground that the treatment did not warrant hospitalization and could have taken as outpatient. hence this complaint.

The representative of the insurer stated that during the hospitalization, the patient underwent USG abdomen and only blood and urine investigations were conducted. The patient was administered with oral medicines. There was no active line of treatment. Therefore by invoking Clause 4.10 of the policy exclusion they rejected the claim.

Documents like discharge summary. Case sheets were examimed. 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 . It was held that the basic pre-requisites for hospitalization as per the policy condition have been met with. However, it has been observed that the patient stayed in the hospital for 3 days, but the discharge summary and indoor case sheet did not reveal the patient's condition which was so severe, which require infrastructure of hospital for 3 days. The mediclaim policy will reimburse only reasonable and necessary expenses incurred towards hospitalization. Therefore, to render fair justice, the claim is allowed on ex-gratia of Rs.3000/- taking into consideration, investigations done like Scan charges etc which have been actually incurred.

Chennai Ombudsman Centre
Case No. : IO(CHN) 11.02.1066/2007-08
Shri N. Chidambaram
Vs

The New India Assurance Co. Ltd.,

Award Dated : 24.07.2007

The complainant Mr N Chidambaram stated that he was covered under LIC Group Mediclaim policy with M/s New India Assurance Co. Ltd.,. He was hospitalized at M/s Vadamalayan Hospitals for a day for the complaint of recurrent Giddiness and vomiting and the diagnosis was Benign Postural Vertigo with Mild Hypertension. His claim was rejected on the ground that during the hospitalization, he had undergone investigations and treated with oral medicines and this treatment did not warrant hospitalization. Hence this complaint.

The representative of the insurer stated Investigations conducted on the insured were found to be normal. He was not admitted on any emergency condition. As per the opinion of their Panel Doctor also the treatment did not warrant hospitalisation, hence they rejected the claim by invoking policy Exclusion clause 4.10.

It is evident from the discharge summary that the patient is aged 74 years, mild hypertensive with a problem recurrent episodes of Giddiness associated with vomiting for the past one week prior to the hospitalization. It appears, there was no improvement even after taking treatment as Outpatient, hence the complainant was admitted in the hospital and further treatments were given during the hospitalization. When a person has a problem and inspite of taking treatment as outpatient if there was no improvement, the attending doctor is the appropriate person to decide on 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. The complaint is allowed and direction is given to the insurer to settle the claim.

Chennai Ombudsman Centre
Case No. : IO(CHN) 11.02.1062/2007-08
Shri V. Valliappan
Vs
The New India Assurance Co. Ltd.,

Award Dated : 31.07.2007

The complainant Mr V Valliappan stated that his family was covered under LIC Group Mediclaim policy with M/s New India Assurance Co. Ltd.,. His wife was admitted at M/s Apollo Speciality Hospitals, Madurai .The diagnosis was Dyslipidemia, Peripheral Neuropathy, depression and gastritis. His claim was initially rejected on the ground that the treatment did not require hospitalization. Subsequently, the insurer offered Rs.17,191/- against the claim amount of Rs.28,336 stating that as per their panel doctor’s opinion only 2 or 3 days hospitalization was warranted for the said ailment. The complainant was not satisfied with the short settlement of his claim, hence approached this forum for the redressal of his grievance.

The insurer stated that as per their panel doctor’s opinion, only oral medicines were administered. The hospitalization was investigation purpose and hence the claim was not payable. They rejected the claim as per policy condition 2.1 and 4.10. Their regional Office had obtained a second medical opinion, which said hospitalization was required only for 2 or 3 days. As a customer-friendly measure they offered to pay Rs.17191/- for 5 days hospitalization.

Documents like discharge summary, indoor case sheet etc were perused. It is evident that the patient is aged 69 years, hypertensive with a past history of RTA with odontiud associated with burning sensation all over the body, had been in emergency ward only

after suffering from the burning sensation for nearly 10 days prior to the hospitalization. When a patient presents with complaints of discomfort, the attending doctor is the appropriate person to decide the necessity of hospitalization taking into consideration nature of the diseases and the specific physical condition of the person at that point of time. Direction is given to the insurer to settle the claim for 13 days. The complaint is allowed.

Chennai Ombudsman Centre
Case No. : IO(CHN) 11.02.1010/2007-08
Shri S. Varadharajan
Vs
The New India Assurance Co. Ltd.

Award Dated : 04.06.2007

The complainant Mr S Varadharajan, a retired LIC employee covered under LIC Group Mediclaim policy with M/s New India Assurance Co. Ltd., was hospitalized at M/s Vadamalayan Hospitals from 18.6.2006 to 20.06.2006 for his heart disease, diabetes and for chronic headache. His claim was rejected on the grounds that during hospitalization, investigations carried out were not consistent with the complaint, hence not admissible as per policy exclusion 4.10. The insured's contention was that he was a hypertensive and diabetic patient and on the date of admission he was having problem like chest pain, palpitation etc., in addition to throat pain, burning micturition .As he was 64 years old, as per the advise of his doctor he was hospitalized.

The representative of the Insurer contended the insured had undergone routine investigations and was treated with oral medicines. Investigations carried out were not consistent with the diagnosis and with the complaints of Chest pain and burning micturition. So they rejected the claim as per policy exclusion 4.10.

On perusal of various documents like Discharge Summary etc. it was evident the complainant was hypertensive, diabetic, with a problem chronic head ache and other ailments viz knee joint pain etc., hence hospitalized 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 . 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 justifed in rejecting the claim. However, this forum also observed that various other tests were conducted, which are of no relevance to the diagnosis of chronic head ache. Therefore, to render fair justice, the claim is allowed on Ex-gratia of Rs.4000/- towards CT scan and relevant hospitalization expenses which would have been reasonably and necessarily incurred towards chronic headache.

Chennai Ombudsman Centre
Case No. : IO(CHN) 11.02.1514/2006-07
Shri R.Chandrasekaran
Vs
The New India Assurance Co. Ltd.

Award dated 22.06.2007

The complainant stated that his family is covered under LIC Group Mediclaim policy with M/s New India Assurance Co. Ltd. He preferred two claims in respect of his wife for Rs 19232.00 and 18191.50 respectively. His claim for Rs.19232/- (under claim

number 290) was repudiated and in respect of claim number 297, the insurer rejected an amount of Rs.3366/- without any valid reason.

The forum pointed out to the insurer to submit a detailed working clearly stating items claimed, items allowed, items disallowed along with reasons, along with a tariff rate agreed by them with the hospital so that it will be possible to arrive at a fair conclusion.

On scrutiny of SCN and other documents submitted, discrepancies between the claim note and the working submitted by the insurer were observed. In respect of first claim direction was given to the insurer to settle the claim for Rs.19232/- in full. In respect of the second claim the insurer was directed to allow Rs.3603/- .

It was also observed that the complainant is obliged to furnish all relevant information that the insurer considers as having a bearing on the claim and shall cooperate to clarify all the points of doubts so as to enable them to arrive at a fair decision. The complainant did not submit all supporting documents to substantiate his stand so that the insurer could dispose off the claim as early as possible. Therefore, no relief is allowed towards penal interest or penalty as claimed by the complainant.

The complaint is partly allowed.

Chennai Ombudsman Centre
Case No. 11.04.1481/2006-07
Shri Sophan Jose
Vs
United India Insurance Co. Ltd.

Award Dated : 07.05.2007

The complainant stated that he was covered under AB Aroyagadan Group Mediclaim policy issued to Andhra Bank for the period 21.12.2005 to 20.12.2006. He was hospitalized at M/s.Ramakrishna hospital from 11.3.2006 to 13.3.2006(as per the advice of the attending physician), after having contracted chicken pox with complaints of fever, cough and rashes which compelled him to opt for Cashless Facility but was rejected by the TPA stating that hospitalization in his case is unwarranted..

The insurer replied that hospitalization is not warranted in the said case which the TPA also sided stating that the insured infact approached them for Cashless Facility after admitting himself in the hospital and since his claim was rejected he got himself discharged, fearing to bear the expenses out of his pocket.. Also, the TPA stated that chicken pox is viral infection for which medical intervention Is not required and if at all there is any need it will be for 7 - 15 days.and hence the claim is rejected.

The forum perused the documents and pointed out that the symptoms of high fever coupled with vomiting, giddiness and rashes would have compelled the insured for hospitalization, of course with doctor’s advice, and therefore it is to be acknowledged that the attending doctor who had examined the patient physically when he presented with the complaints alone can decide whether the patient requires hospitalization or not and the argument of the insurer that hospitalization is unwarranted and the treatment could have been taken as an out-patient without any supporting documents or reasoning is only a post-facto assessment and is not substantial and convincing enough and allowed the complaint.

Chennai Ombudsman Centre
Case No. : IO(CHN) 11.05.1513/2006-07
Shri. M Pichaimuthu
Vs

The Oriental Insurance Co. Ltd.

Award Dated : 30.05.2007

The Complainant Shri M Pichaimuthu stated that his daughter was employed in M/s Cognizant Technology Solution Pvt. Ltd.. The Oriental Insurance Co. Ltd, Chennai, issued a Group Mediclaim policy covering the employees and their dependents whereby he was also covered under the policy. He was hospitalized from 26.05.2006 to 29.05.2006. He represented that his daughter had declared that he was a diabetic patient at the time of proposing for insurance. He applied for cashless facility to M/s.United Health Care India Pvt. Ltd. Initially it was approved for Rs.1,00,000. After that, his claim was rejected stating that there was discrepancy in the duration of ailments.

The representative of the Insurer stated that they understood from their TPA that as per pre-authorisation letter, the patient was suffering from Diabetes Mellitus for the last one year. Details of duration and the ailments were called for but the patient has not furnished the same.

The documents like Pre Authorization letter, Discharge Summary, Certificate of treating Physician, Investigators report etc were perused. None of the reports or records revealed that the patient was diagnosed with Ischemic Heart disease on 13.03.2004 and there are no records to show that the patient was prescribed with Cardiac medicines. The Insurer failed to establish by way of any documentary evidence that the patient was diagnosed with the present ailment of Ischemic Heart Disease, and that he was aware of the same, at the time of proposing for insurance i.e on 1.11.2004. The Insurer also failed to establish as to how long the patient was suffering from HTN and IHD and that Diabetes was the sole contributory factor for the present heart ailment. Diabetes no doubt is a strong risk factor for Coronary Artery Disease but it has not been established in this particular case that it is the proximate cause for the heart disease of the insured. Under the circumstances, the insurer is not justifed in invoking policy exclusion 4.1 to reject the claim. The Complaint was allowed and direction given to the insurer to process and settle the claim as per terms and conditions of the policy.

Chennai Ombudsman Centre
Case No. : IO(CHN) 11.04.1007/2007-08
Shri.S Vasu Rao
Vs
The United India Insurance Co. Ltd.

Award Dated : 30.05.2007

The Complainant Mr S Vasu Rao stated that he was covered under AB AROGYADAAN GROUP MEDICLAIM Insurance policy which was given for deposit holders of Andhra Bank. by M/s United India Insurance Co. Ltd., He was hospitalized at M/s St. Isabel's Hospital, Chennai for the complaint of breathlessness and an Angiogram was done. He was told that he had suffered a heart attack and he was given treatment for that and advised to go in for an Angiogram in Chennai Kaliappa Hospital. He submitted the claim document for the reimbursement of hospitalization expenses, but the same was rejected on the grounds that the present hospitalization was for the pre existing disease of Diabetes, hence claim was not payable as per policy exclusion 4.1. He represented to the insurer that he had declared in the proposal that he was diabetic and had also produced a doctors' certificate that his ailment was not due to Diabetes. However, his claim was not settled, hence this complaint.

The representative of the insurer stated that the policy commenced on 04.08.2005 and within 8 months this claim occurred. Though the complainant states that he had

disclosed that he had diabetes in the proposal form, the office note from their Hyderabad office stated that he did not disclose the same in the proposal form. Hence they repudiated the claim as per the policy conditions since it was a pre-existing disease.

The representative of the TPA stated that Mr.Vasu Rao was admitted to hospital in a state of collapse. After 3 days of ventilation he was transferred from ICU to ward. He had suffered from Myocardial Infarction. He was suffering from Diabetes and Hypertension. They were the primary risk factors leading to coronary problems.

The Ombudsman advised the insurer to submit the copy of the proposal form stated to be given by the insured at the inception of the policy. Subsequently the insurer submitted a copy of the proposal on 22.05.2007 wherein he had declared that he was diabetic.

As per discharge Summary there is no indication regarding hypertension and the BP reading was 80/60. There are no substantiating documents produced by the insurer to establish that how long the patient was suffering from hypertension, whether he was aware of the same and the same was in existence prior to inception of the policy i.e. prior to 04.08.2005 so as to enable them to invoke the policy condition 4.1. The insurer is directed to process and settle the claim.. The Complaint is allowed.

Chennai Ombudsman Centre
Case No. : IO(CHN) 11.04.1126/2007-08
Mr R. S. Murali
Vs
The United India Insurance Co. Ltd.

Award Dated : 24.09.2007

The complainant Mr R.S. Murali stated that his family including his mother is covered under Group Mediclaim policy issued to credit card holders of M/s Canara Bank by M/s United India Insurance Co. Ltd, Bangalore. His mother was hospitalized from 21.09.2006 to 29.09.2006. After discharge she was sent home in an ambulance. She was totally bed ridden. They had engaged 2 nurses to attend to her including defecation cleaning and feeding. Out of his claim for treatment of his mother for Rs.21,540.50 towards the Domiciliary hospitalization, only Rs.1,540/- was allowed and Rs.8000/- under Private Nursing Charges and Rs.12000/- under Physiotherapy charges were disallowed with reason that the same are specifically excluded under 'Domiciliary Hospitalization Benefit', hence this complaint.

The representative of the insurer stated that as per the policy conditions private nursing charges and physiotherapy charges were not payable under domiciliary hospitalization benefit.

On perusal of the documents like the Policy copy of CANCOMFORT, Discharge summary and attending Doctor's certificated it was evident that the patient Smt S Uma Rani had been on domiciliary treatment for recurrent CVA from 01.11.2006 to 30.11.2006. Domicilliary claim of Rs.21,540.50 included Rs.12,000/- towards Physiotherapy and Rs.8000/- towards Nursing expenses. Under Domiciliary Hospitalization benefit, the policy shall not cover any expenses incurred towards Physiotherapy and Private Nurse facility and the same is specifically excluded. The insurer disallowed Rs.12000/- towards Physiotherapy and Rs.8000/- towards nursing expenses, since these expenses are specifically excluded under the CanComfort policy,. The complaint is dismissed.

Chennai Ombudsman Centre

Case No. : IO(CHN) 11.04.1144/2007-08
Mr R. S. Murali
Vs
The United India Insurance Co. Ltd.

Award Dated : 24.09.2007

The complainant Mr R.S. Murali stated that his family is covered under Group Mediclaim policy issued to credit card holders of M/s Canara Bank for the period from 01.11.2005 to 30.11.2006 with M/s United India Insurance Co. Ltd, Bangalore and the policy was renewed for the subsequent year 2006-2007. His father Shri Seikanta Rao was hospitalized at M/s Cancer Shelter, Chennai for CA Prostrate problem from 01.08.2006 to 08.09.2006. He submitted post hospitalization claim for Rs.7180.80, however the insurer disallowed Rs.4686/- on the ground that the expenses were incurred towards Lumbar spondylosis and not connected with the main claim of CA Prostrate.

The insured contended that the Nuclear Isothope Bone Scan study report dated 10.08.2006 clearly stated “Evidence of degenerative changes in Lumbar, dorsal, cervical vertebra, sacroiliac regions, knees and ankles are seen.”The Discharge Summary dated 11.09.2006 also specifically stated that the patient reported with pain in the back, quite severe, unable to bend and twist around the waist and Orthopaedic Surgeon’s opinion also made a mention of “Lumbar Spondylosis – a case of CA prostrate-Secondary Spread (Lumbar).He said that he had been regularly claiming for similar ailments for CA prostrate from 2001.

The TPA, the representative of the TPA stated that they have taken an opinion from their panel doctor viz. Dr.Shenoy who opined that Lumbar Spondylosis was unrelated to Prostrate Carcinoma. There was no hospitalization for Lumbar Spondylosis. Only medicines were prescribed and it was an outpatient treatment.

On perusal of Policy copy it is observed that policy wordings for Post Hospitalization states that only relevant medical expenses incurred during period upto 60 days after discharge from Hospital for disease / illness/ injury sustained will be considered as part of claim.

The discharge summary for the hospitalization revealed that insured was admitted with a complaint for the pain the back had had been given chemo & radiotherapy treatment. The Nuclear Bone study revealed that there was degenerative changes in lumbar, but there is also a remark that no significant changes have been observed compared to the scan done on 29.04.2005. Therefore, there are no recorded evidence available to establish that the insured was diagnosed with Lumbar Spondylosis and active treatment was given during the current hospitalization period No mention of lumbar spondolysis and treatment rendered has been made in discharge summary for the current hospitalization. Hence the expenses towards cost of medicines for treatment of lumbar spondolysis cannot be claimed as “Post hospitalization” in respect of hospitalization for treatment of cancer. The complaint is dismissed.

Chennai Ombudsman Centre
Case No. : IO(CHN) 11.02.1128/2007-08
Mr J. Victor Rajasekaran
Vs
The New India Assurance Co. Ltd.

Award Dated : 24.09.2007

The complainant Mr J Victor Rajasekaran (aged 41 years) has stated that he is an Administrative Officer working at LIC of India, Branch Office, Sankagiri and his family is covered under LIC Group Mediclaim policy with M/s New India Assurance Co. Ltd. The complainant Mr J Victor Rajasekaran was hospitalized for the complaint of Cough with expectoration 2 days. The diagnosis was LRI/Bronchitis and he was advised bed rest. He was given oral medicines and intravenous injections everyday. His claim was rejected on the ground that the ailment could have been treated as out patient.

The representative of the insurer stated they referred the claim papers to Dr.Ranganathan their panels doctor who opined the patient could have taken treatment as outpatient. At the time of admission to hospital he did not have any history of fever or chest pain. Their policy condition 1.0 states that only expenses that were reasonable and necessarily incurred by the insured person would be reimbursed. There was no active treatment during the period of hospitalization.

Documents like Discharge Summary etc were examined. 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. However it was observed that the patient stayed in the hospital for nearly 7 days but there is no substantiating evidence available to establish that the condition of the patient was so serious as to require 7 days hospitalization. The mediclaim policy stipulates that the insurer will reimburse only reasonable and necessary expenses incurred towards hospitalization. Therefore Ex-gratia for Rs.3500/- towards hospitalization expenses which would have been reasonably and necessarily incurred towards LRI / Bronchitis is allowed. Complaint is partially allowed.

Chennai Ombudsman Centre
Case No. 11.02.1480/2007-08
Shri. P. Annadurai
vs
New India Assurance Co. Ltd.,

Award Dated : 27.04.2007

The complainant Mr.P.Annadurai approached this forum with a complaint against M/s New India Assurance Co. Ltd., Divisional.Office, Madurai, stating that he was covered under LIC Group Mediclaim policy with M/s. New India Assurance Co. Ltd. and he had made a claim for the hospitalization expenses of his wife Smt.A.Lakshmi for her treatment as in-patient at M/s.Vadamalayan Hospitals from 13.6.2006 to 15.6.2006 with the diagnosis Type 2 DIABETES MELLITUS WITH PERIPHERALNEUROPATHY WITH LUMBAR SPONDYLOSIS.

The representative of the insurer stated that the hospitalization charges incurred towards investigation were not consistent to the diagnosis and that the charges were generally for investigation purpose and were not followed by any active line of treatment and furthermore the insurer stated that the hospitalization was not warranted and hence the claim was repudiated.

The forum perused the documents and confirmed that the doctor who had examined the patient physically, when she presented with the complaints alone can decide whether the patient requires hospitalization or not and therefore 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 which does not carry any conviction and hence the insurer is not justified in rejecting the claim. The complaint is allowed.

Chennai Ombudsman Centre
Case No. 11.02.1482/2006-07
Shri S. Baskaran
vs
New India Assurance Co. Ltd.

Award Dated : 27.04.2007

The complainant Mr.S.Baskaran, approached this forum with a complaint against M/s New India Assurance Co. Ltd., Divisional.Office, Madurai, stating that he had taken a LIC Group Mediclaim policy with M/s. New India Assurance Co. Ltd. and he had made a claim for the hospitalization expenses of his wife Smt.Shantha Devi for her treatment as in-patient at M/s.Apollo Speciality Hospitals, Madurai , from 4.4.2006 to 6.4.2006 with the diagnosis CERVICAL SPONDYLOSIS, LEFT BRACHIAL NEURALGIA II DEGREE HAEMORRHOIDS AND VERTIGO, after she had a fall in Nov. 2005 and continous pain thereafter.

The representative of the insurer stated that the patient was hospitalized and the treatment comprised only oral medicines and MRI scan which did not warrant hospitalization and therefore the claim was repdiated invoking policy exclusion 4.10 and condition 2.3(a) and furthermore she stated that they are prepared tp admit the claim for the expenses of MRI scan under non-hospitalisation charges, subject to verification of their policy conditions.

The forum perused the documents and confirmed that the patient had been trying several treatments as out-patient and since there appeared to have been no improvement, as a last resort she got admitted herself in the hospital and the doctor who had examined the patient physically, when she presented with the complaints alone can decide whether the patient requires hospitalization or not and therefore 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 which does not carry any conviction and hence the insurer is not justified in rejecting the claim.

The complaint is allowed.

Hyderabad Ombudsman Centre
Case No. : G 11.003.0346
Prof. N. Balasubramanian
Vs
National Insurance Co. Ltd.

Award Dated : 23.05.2007

The complainant's wife was covered under a Group Mediclaim Policy. She underwent Total Hip Replacement. The TPA rejected the claim on the ground that the last policy expired on 31.08.2003 and the current policy on which the claim was made commenced with effect from 01.06.2004. Thus, there was a break of 9 months. The complainant contended that there was a break in coverage from 01.09.2003 to 31.05.2004. It was due to a failure on the part of New India Assurance Co. Ltd. to act on a renewal instruction at the relevant time. He instructed the insurers on 11.08.2003 to cancel one policy and renew the other policy on the due date. The insurers promptly cancelled one policy but failed to renew the other one. The insurers contended that according to their

TPA panel doctor the disease takes long to develop. The policy was only 7 months old at the time of hospitalization and was deemed to be a fresh policy and pre-existing diseases were excluded.

Decision :

This appears to be a peculiar case where one insurer failed to act on the renewal instruction given by the complainant well in advance. The complainant cannot be penalized for this action of the insurers. The current insurers cannot be faulted for repudiating the claim on technical ground of break in insurance. The insurers too are not faulted for the rejection. The insurers are directed to pay an amount of Rs. 2,50,000/- as ex-gratia in the interest of equity and fair play. The complaint is allowed as ex-gratia.

Hyderabad Ombudsman Centre
Case No. : G 11.004.0337
Dr. P. Gopala Sarma
Vs
United India Insurance Co. Ltd.

Award Dated : 18.06.2007

The complainant was covered under Group Mediclaim policy issued to account holders of Andhra Bank. He underwent angiogram and CABG in August 2006. He received Rs. 1,50,000/- from the insurer under another policy (Group Mediclaim policy issued to members of IMA) but did not get the balance from the current insurer. The insurers contended that this was the first policy for 2006-07 for a sum insured of Rs. 50,000/- only. Therefore, as on the date of enrolment in the group policy (27.04.2006), he was having heart ailment and the claim was inadmissible in view of clause 4.1 which excludes all pre-existing diseases.

Decision :

Since the policy through Andhra Bank commenced only in April 2006, the insurers are justified in not allowing the claim for the balance amount in view of the pre-existing diseases clause. However, the insurers did not explain the delay in delivery of TPA cards. They are directed to pay compensation of Rs. 2,000/- to the complainant. The complaint is partly allowed.

Hyderabad Ombudsman Centre
Case No. : G 11.009.0034
Sri S. Gopalakrishnan
Vs
Reliance Gen. Ins. Co. Ltd.

Award Dated : 12.07.2007

The complainant and his family were covered under Group Mediclaim policy from New India Assurance Co. Ltd. from 01.11.2004 to 31.10.2005. The policy was renewed from 18.05.2006 to 17.05.2007 with Reliance Gen. Ins. Co. His son was admitted to hospital with complaints of backache on 23.06.2006 and was administered injection infliximab. Another dose was given on 17.07.2006. Both the claims were rejected by the insurers on the ground that hospitalisation was not warranted. The complainant contended that under the policy with New India Assurance Co. Ltd., 2 similar claims were settled by the same TPA. He even submitted a certificate from the treating doctor which stated that admission was necessary. The insurers contended that the TPA could have

considered the payment for the first 2 cycles of treatment as there was a probability that the patient could develop side effects after infusion of intravenous injection.

Decision :

It is noted with surprise that the same TPA chose to settle 2 of the earlier claims basing on the same certificate of the treating doctor. The insurers too submitted their expert's opinion which is only a generalisation. Nowhere has this opinion stated that admission was necessary. The insurers ought to have ascertained from the treating doctor whether the patient developed any side effects at all during the infusions and the reasons for admission. The complainant admitted his son only on the instructions of the treating doctor who has first hand information about the patient's health condition. The insurers are directed to process and settle the claims. The complaint is allowed.

Hyderabad Ombudsman Centre
Case No. : G 11.004.045
Sri T. Viswanadham
Vs
United India Ins. Co. Ltd.

Award Dated : 17.07.2007

The complainant was covered under Group Mediclaim policy issued to account holders of Andhra Bank for a sum insured of Rs. 1,00,000/-. He underwent CAG and the bill was settled by the TPA directly to the hospital. He was then advised to undergo CABG. The claim was rejected under clause 4.1 of the policy. The complainant did not mention that he had received Rs. 1,26,000/- reimbursement from his employer. This fact was not disclosed and it amounted to concealing material information with an intention to cheat the insurer. It is unbecoming of the complainant who is a public servant to take advantage of law by involving this office for personal gain. The complaint is dismissed.

Hyderabad Ombudsman Centre
Case No. : G 11.004.082
Sri B.V. Rajasekhar
Vs
United India Insurance Co. Ltd.

Award Dated : 14.08.2007

The complainant and his family were covered under the Andhra Bank –Arogyadaan group Mediclaim policy issued by United India Insurance Co. Ltd. The policy was renewed with a gap of 26 days. The complainant's wife Smt. Subbalakshmi was hospitalised for treatment of fibroid uterus and a claim was lodged. The claim was rejected stating that any expenses relating to fibroid uterus were excluded in the first year of insurance

Decision :

The discharge summary mentions the existence of the ailment for 12 weeks i.e it started during the current policy only. The insurers were not able to prove that the present disease was contracted during the earlier policy period or during the break in insurance. The insurers confirmed that there was a procedure for condoning the delay in renewal upto 30 days. The delay being purely technical, it is condoned and the insurers are directed to pay the claim of Rs. 21,723/-.

Hyderabad Ombudsman Centre
Case No. : G 11.004.0104

Sri P. Madhusudhana Rao
Vs
United India Ins. Co. Ltd.

Award Dated : 31.08.2007

The complainant was covered under a group Mediclaim policy from 22.11.2004 to 08.06.2005 for a sum insured of Rs.1,00,000/- which was renewed from 09.06.2005 to 08.06.2006 for an enhanced sum insured of Rs.3,00,000/-. The complainant was admitted in hospital on 17.07.2005 with complaints of pain in the left hip and surgery was done. A claim for Rs.1,95,903/- was lodged which was repudiated stating that the disease was pre existing. **Decision :**

The insurer while stating that the disease was pre existing resisted the complaint on the ground that the time limit to recover the claim under the policy as per condition no 5.11 of the policy had expired and urged to dismiss the complaint. The complainant confirmed that the rejection letter was received by him on 04.10.2005 and he had not made any representation against it. The condition no. 5.11 stipulated a time limit of 12 months to dispute the insurance company's stand. Thus the complainant had forfeited his right to claim and the complaint is dismissed as non-entertainable.

Kochi Ombudsman Centre
Case No.IO/KCH/GI/11-002-323/2007-08
Sri.M.J.Antony
Vs.
The New India Assurance Co.Ltd.

Award Dated : 28.06.2007

The complaint under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998 is against repudiation of a claim under a group medi claim policy under a policy of insurance issued for the benefit of employees and retired employees of LIC of India and their family members. The claim submitted by the complainant for hospital expenses for himself and his wife was partially or fully rejected by the insurer on the ground that the claim is time barred, no proper bill is produced, the hospitalisation was only for routine investigations etc. The entire records on the file were perused. It can be seen that major portion of the bill was disallowed as the complainant and his wife was hospitalized for routine cardiac evaluation only. They were given no particular treatment other than advised to continue their routine medicine. The hospital records are very specific that the patient was admitted for routine cardiac evaluation. As investigation was not followed by any treatment, the decision of insurer to repudiate the claim cannot be stated as unfair. Some bills were disallowed as the bills were not submitted within the time limit prescribed. The patient was discharged on 30.7.05 and the bill was submitted only on 14.10.05. No specific request for condonation of delay was given or no reasonable explanation was given for such delay. As such the decision of insurer to repudiate the claim cannot be considered as unfair. Some bills were rejected as the reimbursement was for in excess of 30 days pre-hospitalisation period. In almost all cases the bills were not submitted within the prescribed time limit and no specific reason for such delay was given or request for waiver also not given by the insured. As the insurer has sufficient reason to repudiate the claim, the decision of the insurer in repudiating the claim is upheld and the complaint is dismissed.

Kochi Ombudsman Centre
Case No.IO/KCH/GI/11-004-113/2007-08
Sri.Sanooj A. A.

Vs.

United India Insurance Co.Ltd.

Award Dated : 27.09.2007

The complaint falls under Rule 12(1)(b) read with Rule 13 of the RGP Rules, 1998. Pursuant to a proposal submitted on 1.3.06 the AB Arogyadan Group medi claim insurance policy was issued to the complainant as an account holder of Andhra Bank, covering himself and his family members for a sum assured of Rs.1 lakh. The policy commenced on 1.3.06. On 13.9.06 his father was admitted in KIMS on account of pain and swelling on his knees. After treatment he raised a claim of Rs.32234/- being the expenses incurred for treatment. The claim was repudiated on the ground that the disease was pre-existing. The patient was diagnosed to have acute synovitis left knee with effusion. The contention of the insurer is that according to medical opinion the present condition of the patient was developed over a period of time and not within a period of 5 to 6 months and hence the illness is a pre-existing one and hence they are justified in repudiating the claim. The doctor for TPA also submitted that hystopathological report shows that it was a chronic disease and hence it was not likely to develop within a span of 6 months. But it is to be noted that what is shown in the histopathology report is only an opinion by the pathologist and the opinion is not by treating doctor or by a surgeon. But the treating doctor and surgeon has diagnosed the illness as “Acute synovitis”. He has not diagnosed it as “chronic synovitis” Acute means beginning abruptly with marked intensity. Further the histopathology report shows that synovial fluid was sterile, that means there was no organism or bacteria present which itself suggest that the disease was of a recent infection. From the above discussion it can very well be confirmed that there is no material in the argument of insurer that the disease was pre-existing and hence the complainant is eligible to get the claim amount. An award is passed directing the insurer to settle the claim of Rs.32234/- with 8% interest till date of payment.

Kolkata Ombudsman Centre

Case No. 379/11/003/NL/09/2006-07

Sri Subhas Chandra Saha

Vs

National Insurance Co. Ltd.

Order Dated : 21.5. 2007

Facts & Submissions :

This petition was filed by the complainant against repudiation of a claim due to violation of policy condition nos. 5.3 and 5.4 under Group Mediclaim Insurance Policy issued to Golden Multi Services Club of G.T.F.S by National Insurance Company Ltd.

The petitioner, Shri Subhas Chandra Saha in his petition stated that he was covered under Group Mediclaim Policy for the period 23.06.2003 to 22.06.2004 along with his family in continuity of his previous insurance. He was admitted to S.S.K.M Hospital for the period 26.09.2003 to 27.09.2003 for treatment of HBV Infection. After discharge from the hospital on 27.09.2003, he submitted his claim to G.T.F.S on 10.11.2004 for reimbursement of hospitalization expenses for Rs.53,325/-, but the insurance company repudiated the claim on 13.09.2005 on the ground of belated intimation and submission of documents violating policy condition no. 5.3 & 5.4 of the Mediclaim Insurance Policy. He also stated that such condition as quoted in the repudiation letter was not found in the Certificate of Insurance and it was strictly irregular and unwarranted to invoke such conditions at the time of finalization of the claim. It was important that in the event of

hospitalization the family members run for recovery of the patient rather than complying with the conditions if at all available in the Insurance Certificate. He therefore, made a representation to the insurance company on 01.12.2005 for review of their repudiation decision but since no reply was received from the insurance company he filed this petition to this forum for relief of Rs.53,325/- plus interest plus cost.

The insurance company in their self-contained note stated that the claim intimation was made on 06.04.2004 after a lapse of 6 months 9 days from the date of hospitalization on 26.09.2003 and submitted claim on 10.11.2004 after a lapse of 1 year 1 month 13 days from the date of discharge from the hospital on 27.09.2003 and therefore there was non-compliance of policy conditions 5.3 & 5.4 of the mediclaim policy. The insurance company also had taken a general stand in defence of their repudiation decision like such conditions were printed in the back side of the proposal form duly signed by the complainant with his consent to abide by the terms and conditions of the policy at the time of insurance and since there was a violation of the conditions the policy became void and they were unable to accept any liability under the policy due to the said violation. They have also stated that since there was a violation, they did not scrutinize the claim documents to ascertain the admissibility of the claim, which were very much needed before settlement of the same.

Decision :

This office considered the facts and circumstances of the case as well as the materials available on records. Hon'ble Ombudsman was not satisfied with the arguments put forth by the complainant for consideration of waiver of delay in intimation of hospitalisation and delay in submission of claim papers for settlement of the claim. The delay was too long and a small delay on the part of the complainant could have been condoned. Therefore, it was 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. Though, the reasons were not satisfactory for waving the delay in intimation of the claim and delay in submission of the claim documents, keeping in view of the present status of the complainant, due to the illness he had been suffering, it was felt that grant of an ex-gratia payment of Rs.20,000/- which, would meet the ends of justice. Therefore, Hon'ble Ombudsman directed the Insurance authorities to pay Rs.20,000/- as an ex-gratia. The petition was disposed of accordingly.

Kolkata Ombudsman Centre
Case No. 392/11/003/NL/09/2006-07
Sri Amal Dhar
Vs
National Insurance Co. Ltd.

Order Dated : 21.5. 2007

Facts & Submissions :

This petition was filed by the complainant Shri Amal Dhar against repudiation of a claim under policy condition No.5.3 & 5.4 of Mediclaim Insurance Policy issued to Golden Multi Services Club of G.T.F.S. by the National Insurances Co. Ltd.

The petitioner, Shri Amal Dhar stated that he was covered under a Group Mediclaim Policy along with his family for the period 15.10.2003 to 14.10.2004. He lodged a claim for reimbursement of hospitalization expenses to the insurance company through G.T.F.S. on 18.08.2004 and submitted relevant documents on 09.12.2004 for his treatment at Dr. J.R.Dhar Sub-Divisional Hospital, Bongaon for the period 25.09.2003 to 30.09.2003 as he was suffering from P.V.O. The insurance company denied his

claim on the ground of alleged violation of condition No.5.3 & 5.4 of the policy due to delay in intimation and submission of claim. The complainant on receipt of repudiation letter dt.12.09.2005 from the insurance company represented to them contending that the conditions quoted in the repudiation letter was not found in the certificate of insurance and it was highly unwarranted that such condition were invoked at the time of finalization of the claim. It was also stated by the complainant that it was more important in the event of hospitalization to look after the recovery of the patient then to comply with the conditions if at all available in the insurance certificate. He also referred to the I.R.D.A.'s protection of Policyholder's Interest Regulation, 2002 and also case reference of District Consumer Dispute Redressal Forum in support of his claim. Since his representation yielded no result, the complainant filed this petition for relief of Rs.5,388/- plus interest.

In the self-contained note the insurance company stated that the claim was intimated by the complainant on 18.08.2004 after a lapse of 10 months 23 days from the date of hospitalization on 25.09.2003 and submitted his claim on 13.12 .2004 after a lapse of 1 year 2 months 13 days from the date of discharge from the hospital, i.e. 30.09.2003 which were treated as non-compliance of policy condition No.5.3 & 5.4 of Mediclaim Policy. In support of their repudiation the insurance company mentioned their points of defence of general nature namely the Insured was aware of such conditions as it was printed on the back side of the proposal form, duly signed by the complainant and given consent to abide by such condition and since there was a violation of the terms of the contract the policy become void and the insurance company could not accept any liability under a void policy and therefore, their repudiation of the claim was correct.

Decision :

This office considered the facts and circumstances of the case as well as the materials available on records. It was constrained to disagree with the arguments put forth by the complainant for consideration of waiver of delay in intimation of hospitalisation and delay in submission of claim papers for settlement of the claim. It was observed even at the time of hearing the complainant could not justify the reason for such inordinate delay in both the cases. It was clear that both the conditions were violated under policy conditions No.5.3 and 5.4 of the policy. Therefore, Hon'ble Ombudsman did not have any alternative, but to agree with the decision of the Insurance Company in repudiating the same. Therefore, this petition was disposed of accordingly without any relief to the complainant.

Kolkata Ombudsman Centre
Case No. 370/11/003/NL/09/2006-07
Smt. Madhuparna Bhowmik
Vs
National Insurance Co. Ltd.

Order Dated : 21.5. 2007

Facts & Submissions :

This petition was filed by the complainant against repudiation of a claim due to violation of policy condition no. 5.3 and 5.4 under Group Mediclaim Insurance Policy issued to Golden Multi Services Club of G.T.F.S by National Insurance Company Ltd.

The petitioner, Smt. Madhuparna Bhowmik stated that she was covered under a Group Mediclaim Insurance Policy issued to Golden Multi Services Club of G.T.F.S by National Insurance Company Ltd. for the period 23.02.2004 to 22.02.2005. She lodged a hospitalization claim under the policy to the insurance company on 18.02.2005

towards treatment of an injury suffered. She was hospitalized for the period 22.07.2004 to 27.07.2004.The insurance company denied her claim vide their repudiation letter dated 22.09.2005 due to delay in intimation and submission of the claim violating both the policy conditions no. 5.3 & 5.4. The complainant, on receipt of repudiation letter represented to the insurance company on 12.11.2005 stating that such conditions of repudiation were not available in the insurance certificate and therefore she was not aware of such conditions. She also stated that during the recovery of the patient one would hardly think about the compliance of the policy conditions. She referred in the representation about the IRDA Rules in respect of Protection of Policyholder' Interest Regulation Act 2002 and also case reference of the District Consumer Disputes Redressal Forum case no. 39/2005 about invocation of condition no. 5.3 & 5.4. In spite of her representation to the Insurer, the insurance company did not consider to settle her claim and therefore filed this petition for relief of Rs.20,000/-. The insurance company in their self-contained note dated 12.03.2007 stated that the insurance cover was granted to the complainant for the period 23.02.2004 to 22.02.2005 in continuity to the previous policy.

The intimation of claim was made on 18.08.2004 after a lapse of 34 days from the date of hospitalization on 22.07.2004 and the claim was submitted on 18.02.2005 after a lapse of 6 months 21 days from the date of discharge from the hospital on 27.07.2004 (there is no date of fitness mentioned in the fitness certificate issued by Dr. Amal Bhattacharya). The above lapses resulted non-compliance of the policy conditions no. 5.3 & 5.4 of mediclaim policy. They also stated that the said conditions were printed in the backside of the proposal form duly filled in and signed by the proposer with the consent to abide by the terms and conditions of the policy. Since the complainant violated such conditions the insurance company had no liability under a void contract and therefore they repudiated the claim.

Decision :

This office considered the facts and circumstances of the case as well as the materials available on records. The explanation given for delay in intimation for hospitalisation by 34 days, which was supposed to give within 7 days limitation period, was satisfactory and was hereby waived. However, the reason that they have handed over the claim papers to the agent and that too without taking any receipt for the same leading to delay in submission of claim papers was not tenable. Therefore, the condition under 5.4 was clearly violated. Hon'ble Ombudsman was constrained to reject the arguments put forth by the complainant for consideration of waiver for delay in submission of claim papers by 6 months and 21 days for settlement of the claim. On the other hand, he agreed with the decision of the Insurance Company in repudiating the same on the ground of delay in submission of the claim documents, as per the policy condition no.5.4. As delay in one condition 5.3 was waived and delay in another condition 5.4 was not waived, this office hold that the insurance company had done correctly to repudiate the claim. Keeping in view of the present status of the complainant and misplaced dependence on the agent, some ex-gratia payment could be granted which would meet the ends of justice. Therefore, an amount of Rs.8,000/- was granted as ex-gratia payment and directed the insurance company to pay the same. The petition is disposed of accordingly.

Kolkata Ombudsman Centre
Case No. 362/11/003/NL/09/2006-07
Sri Dibakar Halder
Vs
National Insurance Co. Ltd.

Order Dated : 21.5. 2007

Facts & Submissions :

This petition has been filed by the complainant against repudiation of a claim under Group Mediclaim Insurance Policy issued to Golden Multi Services Club of G.T.F.S by the National Insurance Company Ltd.

The petitioner, Shri Dibakar Halder stated that he along with his family members were covered under Group Mediclaim Policy for the period 15.10.2003 to 14.10.2004 in continuation of previous insurance. He lodged a claim to the insurance company on 18.10.2004 towards treatment of his wife Smt. Dipti Halder for incisional hernia, lower abdomen for Rs.38, 147.65 and the patient was admitted at Circular Nursing Home, Kolkata for the petiod 21.08.2004 to 05.09.2004. The insurance company denied his claim by their letter-dated 03.08.2005 on the following grounds: -

i) As per available documents the expenses towards cost of treatment of his wife was for a pre-existing disease.

ii) The patient had consulted a surgeon specialist and that is why it indicated that the patient had prior knowledge of her existing disease before insurance coverage.

On receipt of such repudiation letter from the insurance company the complainant filed his representation to the Insurer dated 14.09.2005 and 01.02.2006 questioning the grounds of repudiation as to:-

(a) Whether there was any stricture on the policy issued by G.T.F.S on behalf of insurance company that no one could visit a surgeon specialist directly and that a surgeon whom the patient visited performed the operation.

(b) On which document the insurance company ascertained that the patient was suffering from incisional hernia before taking insurance coverage.

It also stated by the complainant that the subject insurance policy was in continuity with G.T.F.S since 15.10.2002 and the treatment / operation was carried out in the month of August 2004 and no one will wait for such a long time for operation in order to get the medical reimbursement from the insurance company. Therefore, the insurance company's decision in repudiation of the claim was not justified and asked for proper enquiry in a justified manner so that he can get rid of financial difficulties by way of settlement of his claim. Since his representation yielded no result, he approached this forum for relief of Rs.38, 147/-.

The insurance company in their self-contained note dated 12.03.2007 stated that the policy was granted to the insured for the period 15.10.2003 to 14.10.2004 in continuation of previous policy. It was observed that the claim filed by the complainant was for repair of Incisional Hernia and Appendectomy was done to the patient, in the nursing home.

The claim file was forwarded to Dr. Soven Ghosh, panel doctor for his opinion with regard to admissibility of the claim. Dr. Ghosh had opined that the captioned claim was not admissible, as ailment (Incisional Hernia) was but for incision of previous operation, for which no claim was got by insured, which may only be possible if operation done was before policy inception (pre-existing) or operation was caesarian section (exclusion clause 4.12). In spite of request by the G.T.F.S vide their letter dated 23.11.2004 for submission of previous treatment papers the claimant did not submit the same and accordingly, the insurance company repudiated the claim vide their letter dated 03.08.2005 due to pre-existing disease.

Decision :

This office considered the facts and circumstances of the case as well as the materials available on records. It was clear from the records available that the expenses incurred, which could be referable to Appendectomy operation, were allowable and such portion of the expenditure for Appendectomy operation could not be repudiated, as this particular operation could not be treated as pre-existing disease. As per the definition of hernia in the Butterworths Medical Dictionary it was the protrusion of an internal organ through a defect in the wall of the anatomical cavity in which it lines, or into a subsidiary compartment of that cavity. Incisional hernia meant hernia through an operation scar. Occurrence of hernia could happen any time during the lifetime and existence of the scar inside the body. The evidence that was produced by the insurance company did not indicate when hernia had occurred. Therefore, there was no positive evidence to establish that hernia occurred before inception of the policy.

Under the circumstances, the ailments for which the operations were performed could not be treated as pre-existing diseases. Hon'ble Ombudsman did not agree with the arguments and reasons given by the insurance company in their self-contained note in repudiating the same and held those as not tenable. As both the ailments, due to was payable. Hence, the insurance company was directed to pay the entire claim as per the terms and conditions. Accordingly, this petition was disposed.

Kolkata Ombudsman Centre
Case No. 407/11/003/NL/09/2006-07
Sri Sailen Biswas
Vs.
National Insurance Co. Ltd.

Order Dated : 21.5. 2007

Facts & Submissions :

This petition was filed by the complainant against repudiation of a claim due to violation of policy condition no. 5.3 and 5.4 under Group Mediclaim Insurance Policy issued to Golden Multi Services Club of G.T.F.S by National Insurance Company Ltd.

The petitioner, Shri Sailen Biswas stated that he took a mediclaim insurance coverage for self and his family under a Group Mediclaim Insurance Policy issued to Golden Multi Services Club of G.T.F.S by the insurance company for the period 31.12.2003 to 30.12.2004 for sum insured of Rs.20,000/- and 15,000/- respectively. The complainant submitted his hospitalization claim for Rs.29,092/- to the insurance company on 31.01.2005 for treatment at Asansol West End Clinic & Nursing Home (P) Ltd., Asansol for the period 19.08.2004 to 28.08.2004 due to an accidental injury. The insurance company declined his claim vide letter dated 24.09.2005 on the ground of violation of policy condition No. 5.3 and 5.4 due to delay in intimation and submission of the claim documents respectively. On receipt of the repudiation letter the complainant represented to the insurance company on 11.08.2006 alleging that the cause of repudiation had no place in the Certificate of Insurance and he was not aware of such condition. He further stated that during hospitalization of the patient the members of the family hardly looked for insurance certificate and compliance of such conditions if at all available in the insurance certificate and he also stated that as per the IRDA's Protection of Policyholders' Interest Regulation 2002 the insurance company should have intimated to him the procedure for filing of the claim as is required from time to time. But the insurance company did not comply with such regulations. He therefore, requested the insurance company to consider his claim citing the judgement of Hon'ble District Consumer Disputes Redressal Forum, Hooghly. But since his representation

yielded no result he submitted his petition to this forum for relief of interest plus cost without mentioning any specific amount.

In their self-contained note dated 12.03.2007 the insurance company stated that the insurance cover was granted to the complainant for the period 31.12.2003 to 30.12.2004 in continuity of the previous insurance. The complainant intimated his hospitalization to the insurance company on 30.12.2004 after a lapse of 2 months 11 days from the date of admission on 19.08.2004. Again the complainant submitted the claim documents to the insurance company on 07.02.2005 after discharge from the hospital on 28.09.2004 resulting in delay of 4 months 10 days. The insurance company has taken a general defence with regard to their repudiation of the claim due to the violation of the conditions of contract and since there was a violation of the policy conditions they did not process the claim and stood by their repudiation decision.

Decision :

This office considered the facts and circumstances of the case as well as the materials available on records. Keeping in view that the claim papers had already been submitted within 30 days after the fitness certificate was given, Hon'ble Ombudsman proposed to condone the delay in intimation of the accident and submission of the claim papers, as the reasons cited by the complainant were satisfactory. The request of the insurance company was also agreed to and the insurance authorities were directed to investigate into the accident and review the decision of repudiation. It was also suggested that if the complainant was not satisfied with the decision of the Insurance Company, he should seek redressal from any other forum including this forum.

Kolkata Ombudsman Centre
Case No. 685/11/002/NL/02/2006-2007
Shri Arunangshu Sen Majumder
Vs
The New India Assurance Co. Ltd.

Order Dated : 12 .09 2007

Facts & Submissions :

This petition was filed by the petitioner against repudiation of a claim under Group Mediclaim Insurance Policy issued to L.I.C. of India by the New India Assurance Co.

The petitioner, Shri Arunangshu Sen Majumder, an employee of L.I.C. of India was covered under a Group Mediclaim Insurance Policy issued to L.I.C. of India by the Insurance Company for the period 01.04.2005 to 31.03.2006. The petitioner's claim that was sent to the Insurance Company by the Policyholder on 17.06.2005 was repudiated by the Insurer on 28.05.2005 on the ground that the petitioner was treated in a Clinic. The complainant did not agree to it and wrote a letter to the Insurance Company's Kolkata Divisional Office on 24.08.2005 through proper channel mentioning therein the points why he disagreed to the decision of the insurance company. The complainant stated that he was treated with Ultra Violate Ray Therapy – UVB (P) in RITA SKIN FOUNDATION at Salt Lake, Kolkata which was a Research Centre for Dermatology with operation facility in O.T. along with some beds. Association of Cutaneous Surgeons of India, Pune selected this foundation as a training institute for conducting certificate diploma course. The Govt. of West Bengal allotted the plot to this Skin Foundation and the Hon'ble Chief Minister inaugurated this foundation on 23.06.2002. The Competent authority and Bidhan Nagar Municipality gave licence for

O.T. and research etc. Therefore, the contention of the Insurer that such Center is merely a clinic, is not correct. In spite of his representation dt.24.08.2005 addressed to the insurance company through proper channel, his claim was not considered and therefore the petitioner filed this petition for payment of the claim along with interest for delay in payment.

The insurance company sent a self-contained note on 28.8.2007. According to the insurance company, the complainant lodged a claim for ultra violet ray therapy on skin. The TPA of the insurance company opined that the claim was repudiated on the ground that there was no hospitalization and the patient was treated on OPD basis. According to the insurance company, the complainant had taken 54 sittings for his ultra violet ray therapy and there was no confinement in the hospital for more than 24 hours, as per prevailing policy condition. According to them, this type of therapy could not be waived under policy condition no.2.3, as the duration of the treatment was less than 24 hours. They further stated that they had to rely on the opinion of the doctor of M/s. M. D. India TPA Service Ltd. and stated that they had taken into consideration that Rita Skin Foundation is not a hospital, but it is only a clinic.

Decision :

This office considered the facts and submissions of the case as well as the materials available on records. It is found that there were two conditions invoked by the insurance company for repudiation of the claim. Firstly the insurance authorities felt that Rita Skin Foundation is a clinic and not a hospital or a nursing home. At the time of hearing, it was stated by them that they did not make any efforts to find out whether RSF was a clinic or hospital. They did not even take into consideration the letter dt. 26.8.2005 issued by LICI in which it was categorically mentioned that RSF was actually a nursing home with beds.

Under the circumstances, we were unable to agree with the conclusion arrived at by the insurance company that RSF was a clinic and not a nursing home because of which the subject claim could not be payable.

Secondly, the claim was repudiated by invoking Exclusion Clause No.2.3 which inter-alia stated that expenses requiring hospitalization for minimum period of 24 hours were admissible. However, this time limit will not apply to specific treatments i.e. Dialysis, Chemotherapy, Radiotherapy, Eye Surgery, Lithotripsy (Kidney stone removal), Tonsillectomy, D&C taken in the Hospital/Nursing Home, Anti Rabies Vaccine (Rabies) and if the Insured was discharged on the same day the treatment would l be considered to be taken under Hospitalization Benefit.

However, any treatment other than as mentioned above which requires hospitalization for period of less that 24 hours weere covered provided;

a) The treatment should be such that it necessitates hospitalization and the procedure involved specialized infrastructural facilities in hospitals;

b) Due to technological advances hospitalization required is less than 24 hours."

The insurance company could not find out whether Ultra Violet Ray Therapy - UVB (P) to be treated as "Radiotherapy or not". According to the medical dictionary, Radiotherapy would mean the treatment of patient with ionizing radiation. The radiation included ultra violet radiation, which meant electro magnetic radiation having shorter wavelength than those of x-rays.

From this above definition, it was clear that Radiotherapy included Ultra Violet Ray Therapy. Therefore, the decision of the insurance authorities that there was no waiver

from 24 hours stay in the hospital for this type of therapy under condition no.2.3 in this case, was not tenable.

Therefore, the insurance company was directed to settle the claim.

Mumbai Ombudsman Centre
Case No. : GI-705 of 2006-2007
Shri Ramesh G. Kodwadkar
V/s
United India Insurance Co. Ltd.

Award Dated : 14.06.07

Shri Ramesh G. Kodwadkar is covered under Group Medical Policy issued by United India Insurance Co. Ltd. to Unique Mercantile Pvt.Ltd. for himself and family since 30.09.2003 till date. Complainant's wife Smt. Reshma R. Kodwadkar, aged 36 was suffering from irregular PV Bleeding with pain in abdomen with nausea. Sonography was done twice on 21.08.2004 and on 14.01.2005 reports of which showed Bulky Uterus with Coarse Echotexure. Treatment was given. Again there was bleeding Gynecologist was consulted and Total Abdominal Hysterectomy was done. Claim repudiated on the ground that present disease started in the first year of the policy under Exclusion Clause No. 4.3 of the Group Medical Policy "during the first year of the operation of the policy, expenses on treatment of Hysterctomy, etc are not payable."

Aggrieved by their decision, Shri Ramesh G. Kodwadkar, therefore, approached the Insurance Ombudsman for resolving the dispute Analysis of the case reveals that Smt. Reshma Kodwadkar was admitted to Pancholi Hospital for Hysterectomy when she started bleeding after stoppage of medicine.

On examination of medical record in file it has been observed that Smt. Reshma was having symptoms of the present problem in the 1st year of policy but not before the incept of the mediclaim policy for which she was taking treatment from Dr. Rekha D. Chordhekar. This operation was done during the 2nd year of policy and not operated in the 1st year and the ailment was not their at the inception of the policy. Under the above circumstances and facts, the claim was settled.

Mumbai Ombudsman Centre
Case No. : GI-748 B of 2006-2007
Shri Arunkumar N. Angolkar
V/s
The New India Assurance Company Limited

Award Dated : 29.06.07

Smt. Geeta A. Angolkar retired employee of LIC Of India, alongwith her husband Shri Arunkumar Nagesh Angolkar, were covered under the Group Mediclaim Policy of The New India Assurance Company Limited, Mumbai for a sum insured of Rs.2,00,000/- each. Her husband, Shri Arunkumar N. Angolkar, was hospitalized at P.D. Hinduja Hospital from 25.3.2006 to 27.3.2006 for Lower Back Pain for which he lodged a claim with the company for an amount of Rs.24,515/-.

The case was referred to the Panel Doctor of the company for opinion, who stated that the hospitalization of the insured in the hospital was purely for investigation purpose, which does not require hospitalization as the same could be done on OPD basis. Hence the claim was repudiated under Exclusion Clause 4.10 of the Mediclaim policy.

Not satisfied with the decision of the Company, Smt. Geeta Angolkar, approached the Ombudsman and sought intervention in the settlement of his claim with the company.

On perusal of the records pertaining to the hospitalization at Hinduja Hospital, it becomes apparent that a number of investigations were carried out but treatment given after discharge was calcium, multivitamins, sedatives and physiotherapy was suggested by the doctor. However, it is evident from the record that during hospitalization, investigations like MRI, CT Scan and various blood tests were carried out. The MRI of the Lumbo-Sacral Spine showed Sacralisation of L5 vertebral body with diffuse posterior annular disc bulges from L2/L3 to L4/L5 levels compounded by bilateral facetal arthropathy at L4/L5 level and mildly indenting the thecal sac with narrowing of bilateral neural formina at these levels with no obvious compression on the existing nerve roots. Post gadolinium study reveals enhancement of the left sided S1 nerve root intrathecally with no other abnormal intraspinal enhancement.

Any treatment can follow only after the diagnosis and in this case, the tests done should be treated as part of diagnosis and treatment of ailment for which confinement was required in the hospital. Medical management of the ailment/sickness after diagnosis by ways of tests should also be considered as part of treatment in the hospital. It is clear in this case that hospitalization and tests were resorted to for the evaluation of the disorder and deciding the line of the treatment which can be done only after due diagnosis. Only because the tests did not reveal any necessity for a major intervention and follow up treatment, diagnosis by way of tests cannot be ignored. As long as the tests were consistent with or incidental to the diagnosis and treatment, the claimant is entitled to reimbursement of expenses incurred for the said hospitalization.

The company has stated that it could have been done on OPD basis as well, therefore, the company has invoked the Exclusion Clause 4.10. as there was no active treatment. However, the hospitalization was done on the advice of a family physician and the back pain sometimes becomes severe and in such cases hospitalization becomes necessary. From the current year, the company now allows reimbursement of expense on MRI Scan even on OPD basis in respect of Group Mediclaim Policies. Keeping the practical side of the case and to strike a proper balance, I am inclined to award 50% of the hospitalization expenses.

Mumbai Ombudsman Centre
Case No. : GI-866 of 2006-2007
Shri Bhavanji S. Dhanani
V/s
The New India Assurance Co.Ltd.

Award Dated : 18.09.07

Shri Bhavanji S. Dhanani, was insured under the Group Mediclaim Policy issued by The New India Assurance Company Limited, Mumbai to the employees of LIC. He was hospitalised at Kenia's Eye Hospital on 23.02.2006 and 02.03.2006 for surgery of Cataract (both eyes). He preferred a claim for reimbursement of disputed amount of Rs. Rs.47,870/- including pre and post hospitalization expenses.

Complainant submitted that he had opted for operational package of Rs. 38,000/- for each operation, Phaco with Abberation free foldable IOL and company has paid Rs. 22,000/-per operation. He also submitted that aberration free foldable lens were

implanted and accordingly doctor has charged in the bill. He also explained that they had gone for Rs. 38,000/- package and mention of Phaco with foldable lens written on the Discharge Card instead of Abberation Free foldable IOL was not noticed. But when company raised the query, he submitted Doctor's Certificate clarifying the type of package and type of lens implanted.

The New India Assurance Co. Ltd., Divisional Office 120700 submitted that Discharge Card mentions "Phaco with foldable lens" and package for the same Rs. 22,000/-. Accordingly both the claims have were settled.

The confusion arose only because of the noting in the discharge card for which the Insured obtained a certificate from the treating doctor certifying the type of lens used. The Complainant has submitted clarification Eye Surgeon mentioning the type of lenses used during the operation and also the package of Rs. 38,000/- charged which includes Phaco with Abberation free foldable IOL. The Complainant has also submitted the Invoice of the lenses used in this case. In view of this there is no reason to disbelieve that the Hospital has used these lenses and charged for the same. Based on the above facts the Insurer was directed to pay the balance amount to the Complainant.