Group Mediclaim Policy

Ahmedabad Ombudsman Centre
Case No. 11-002-0210
Mr. H I Bhatt
Vs
New India Assurance Company Ltd.

Award Dated : 24.11.2007

Partial settlement of Mediclaim: The Insured was covered under Group Mediclaim for LIC Employees. The complainant felt shortness of breath and unusual feeling on walking and even at rest for 10 days. On the advice of a Cardiologist, he went for Thallium Test. The Respondent disallowed Rs.8500/- paid for Thallium Scan Charge of Rs. 8500/- and Rs. 1784/- for medicines taken without prescription. During the course of hearing, the Respondent appreciated the rationale and admitted that the subject Thallium test was necessary and showed their preparedness to pay for the charges for this test. The Complainant too did not insist for other smaller items disallowed. In the end the Complaint was resolved through a mutual consent.

Ahmedabad Ombudsman Centre
Case No. 11-005-0199
Mr. S D Shah
Vs
Oriental Insurance Co. Ltd.

Award Date: 31.12.2007

Repudiation of Mediclaim: The Insured was admitted for treatment of defective vision of both his eyes in a Private Ayurvedic Centre. Claim was repudiated on the ground that the Group Policy excluded payment of Mediclaim unless the treatment is taken as an in-patient in a Govt Hospital/Medical College Hospital. The Complainant pleaded that the Hospital where the Insured was admitted is a well known Centre. Besides, he also pleaded that other Insurers have reimbursed Mediclaim for treatment done in this particular centre. However, since the provisions of the Policy being absolutely clear, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. 14-005-0178
Sri. A A Shah
Vs
Oriental Insurance Company Ltd.

Award Dated: 08.01.2008

Repudiation of Mediclaim: The Insured was admitted for treatment by Kshar Sutra application Private Ayurvedic Hospital. Claim was repudiated on the ground that the Group Policy excluded payment of Mediclaim unless the treatment is taken as an in-patient in a Govt Hospital/Medical College Hospital. Since the provisions of the Policy being absolutely clear, the decision of the Respondent to repudiate the Claim was upheld.

Ahmedabad Ombudsman Centre
Case No. 14-002-0155
Ms. R N Shah
Vs
New India Assurance Company Ltd.

Award Dated : 09.01.2008

Repudiation of Mediclaim: The Insured, an LIC Employee submitted Claim papers for Rs.741476/- under the Group Mediclaim Policy. She was eligible for reimbursement of Rs.60000/- as per her category. During the course of Hearing, the Respondent informed that the Claim file had been sent to the Vigilance Department of their Head Office. But now, they are in the process of finalising the decision. The Forum directed the Respondent to take a decision within 30 days.

Ahmedabad Ombudsman Centre
Case No. 11-005-0361
Mr. B P Panchal
Vs
Oriental Insurance Co. Ltd.

Award Dated : 18.03.2008

Repudiation of Mediclaim: The Insured was admitted for treatment of piles in a Private Ayurvedic Centre. Claim was repudiated on the ground that the Group Policy excluded payment of Mediclaim unless the treatment is taken as an in-patient in a Govt Hospital/Medical College Hospital. The Complainant pleaded that the Hospital where the Insured was admitted is a well known Centre. Besides, he also pleaded that other Insurers have reimbursed Mediclaim for treatment done in this particular centre. However, since the provisions of the Policy being absolutely clear, the decision of the Respondent to repudiate the Claim was upheld.

Bhubneshwar Ombudsman Centre
Case No.11-003-0204
Sri. Panchu Parida
Vs
National Insurance Co. Ltd.

Award Dated : 13.03.2008

Complainant along with his spouse were covered under Group Mediclaim Policy of National Insurance co. Ltd., Kolkata D.O. III for sum insured of Rs. 15000.00 each for a period of one year commencing from 15.09.2003. During currency of the policy complainant's wife Smt.Bharati Devi Parida was admitted to Government Hospital, Balipadar for lower respiratory tract infection. Insured complainant lodged a claim for reimbursement of Rs. 5883.00 towards medical expenses. Insurer repudiated the claim on the ground of non-submission of papers and fraudulent act by insured in purchasing Altacef injection, which has been long abandoned by its manufacturer.

Being aggrieved the insured complainant approached this forum.

Insurer did not file self-contained note.

During hearing Insurer remained absent. Insured complainant stated that as per prescription of Dr. K. C. Behera complainant has purchased the said injection from M/S

Madhuri Medical Store. Complainant exhibited the prescription and a letter from M/S Madhuri Medical Store to substantiate the claim.

Hon'ble Ombudsman directed the Insurer to pay Rs. 5883.00 to the complainant as Insurer failed to justify fraudulent act by the complainant.

Bhubneshwar Ombudsman Centre
Case No.14-002-0264
Smt. Bilasa Dei
Vs
New India Assurance Co. Ltd.

Award Dated : 18.03.2008

Insured Complainant insured her Trekker under passenger Carrying Commercial Vehicle Policy with New India Assurance Co. Ltd. for a period of one year commencing from 18.11.2003. During currency of the policy on 17.01.2004 the vehicle met with an accident. Insured complainant lodged a claim for an amount of Rs.94495.00. Insurer appointed a surveyor who assessed the loss for Rs. 13000.00. Insured complainant submitted the bills and cash memos to the Insurer for settlement of her claim. Insurer sat over the matter despite several correspondences by the complainant.

Being aggrieved the insured complainant approached this forum.

Insurer filed self-contained note stating that complainant did not respond to their letters and failed to submit the R.C Book, D/L, Route permit and bills/cash memos for which the claim could not be processed.

During hearing Insurer reiterated their stand taken in the self-contained note whereas the insured complainant stated that she had submitted all documents to the Insurer and exhibited Xerox copies before this forum. She was also aggrieved regarding the quantum of assessment made by the surveyor. During hearing complainant was directed to submit an affidavit regarding her submission of those documents to the Insurer.

Hon'ble Ombudsman assessed the loss for an amount of Rs. 33500.00 as the surveyor had drastically reduced the labour charges paid by the insured complainant and the surveyor without any rhyme or reason had not considered replacement of the parts.

Chandigarh Ombudsman Centre
Case No. : GIC/246/NIC/14/08
Manjul Singhal
Vs
National Insurance Co. Ltd.

Award Dated : 25.10.07

FACTS : Smt Manjul Singhal was covered under Group Mediclaim Policy issued through Instant Healthcare Pvt. Ltd for the period 22.7.06 to 21.7.07 for sum insured of Rs. 5 lakh. She was hospitalized in Apollo Hospital on 4.1.07 where she incurred an expenditure of Rs. 4,50,000/-. The claim lodged with the TPA/insurer had not been settled so far.

FINDINGS : The insurer informed that the TPA recommended repudiation of the claim on the ground of clause 4.2 of the terms and conditions of the policy regarding pre-existing disease as the discharge summary mentioned that the patient was having swelling of face and feet for the last 4-5 months. Since the treatment was given in

Dec'06-Jan'07, working backwards it meant that disease was contracted in July'06-Aug'06 which was within the first 30days of the commencement of the policy. Accordingly, the claim was repudiated as per exclusion clause 4.2 of the policy which states "The company shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any insured person in connection with or in respect of any disease other than those stated in clause 4.3, contracted by the insured person during First 30 days from the commencement of the date of policy. This condition 4.2 shall not however, apply in case of the insured person having been covered under this policy or Group Insurance Policy with any of the Indian Insurance Companies for a continuous period of preceeding 12 months without any break."

DECISION : As per exclusion clause 4.2 mentioned in the terms and conditions of the policy shown by the complainant "any hospitalization expenses incurred during first 30 days from the commencement of date of insurance cover except in the case of injury arising out of an accident". Held that the exclusion clause 4.2 mentioned in the repudiation letter of the insurer addressed to the complainant is at variance with the actual wording of the exclusion clause 4.2 of the terms and conditions of the policy which had been given to the complainant. Since the claim is not in respect of hospitalization expenses incurred during first 30 days from the commencement of the policy, the repudiation of the claim was not in order. Hence ordered that admissible amount of claim should be paid by the insurer to the complainant.

Chandigarh Ombudsman Centre
Case No. : GIC/476/NIA/11/08
Mahinder Singh Sachdeva
Vs
New India Assurance Co. Ltd.

Award Dated : 06.02.08

FACTS : Shri Mahinder Singh Sachdeva and his family were covered under Group Mediclaim Policy taken by LIC for its employees. The complainant alleged that he was admitted in Patiala Heart & Health Care Institute at 10.00 A.M. on 14.3.07 and was discharged at 1.00 P.M. on 15.3.07. He lodged a claim for Rs. 7877/-. However he was paid only Rs. 1500/- and the balance amount of claim was denied on the ground that hospitalization was less than 24 hours as per records submitted by him. The complainant stated that as the admission charges etc could not be arranged immediately, the amount was deposited at 12.30 P.M. on 14.3.07 and while discharging he was asked to clear the account which he did at 11.00 A.M. but he was discharged after the visit of doctor on duty at 1.00 P.M. A certificate from the treating doctor was also submitted with the insurer but the claim was not paid to him. He further submitted that now the insurer has raised another objection that he consulted Dr. Gandhi in his clinic not in the Hospital. Parties were called for hearing on 6.2.08.

FINDINGS : The insurer stated that as per records the time spent in the hospital was less than 24 hours and policy conditions do not entitle making payment for hospitalization for less than 24 hours.

DECISIONS : Held that the clarification given by the complainant amply justify hospitalization for more than 24 hours. Moreover we should be guided by the spirit of the terms and conditions of the policy and not by the wording in toto. Even if there was a short fall of an hour or so in the duration of the hospitalization, it needs to be condoned. It is hereby ordered that the insurer should make payment of the balance amount of claim to the complainant in view of clarification given by him making the stay

more than 24 hours. The shortfall of time in the duration of 24 hours as per records is hereby condoned. The payment should be made.

Chennai Ombudsman Centre
Case No. : 11.02.1147/2007-08
Mr. B. Soundappan
Vs
The New India Assurance Co. Ltd.

Award Dated : 5.10.2007

The Complainant Mr. B. Soundappan and his family was covered under LIC Group Policy with The New India Assurance Co. Ltd. His wife was hospitalized for the eye problem and diagnosed as myopia. She underwent surgery and submitted all the claim papers to the Insurer. However, claim was rejected as per the policy exclusion 4.14.

The Insurer contended that the complainant had claimed hospitalization expenditure towards right eye lasik laser treatment and left eye epilasik from 22.05.2006 to 23.05.2006. In the indoor case sheets, it was recorded that the patient has been using glasses for the past 14 years and contact lens for 4 years. Under LIC Group Mediclaim policy, a specific exclusion 4.14 was inserted during the renewal of the period 01.04.2006 to 31.03.2007.

The Forum pursued all the documents and observed that the clause 4.14 says that "Lasik laser treatment performed to get rid of spectacles and / or contact lenses unless the treatment is for Keratotomy of insured having more than (-7) refractive error, if the refractive error develops after the date of coverage, therapeutic reasons like recurrent corneal erosions, nebula opacities and non healing ulcers". Therefore, it emerges that a person suffering from refractive error or more than (-7) and if the same develops after the date of coverage, the Insured is eligible for this benefit. The Insurer argued that the patient was covered under the policy since 1997 and was suffering from refractive error prior to the date of coverage but failed to establish documentary evidence. Complainant has also failed to establish that his wife was not suffering from refractive error more than (-7) at the time of inclusion under Gr.Mediclaim Plicy. In the light of the above, Ombudsman had directed the Insurer to allow the claim on Ex-gratia basis.

Chennai Ombudsman Centre
Case No. : 11.02.1199/2007-08
Mr. G. Ramanujam
Vs
The New India Assurance Co. Ltd.

Award Dated : 05.10.2007

The Complainant Mr. G. Ramanujam has stated that his family was covered under LIC Group Mediclaim Policy with The New India assurance Co. Ltd. His wife is a diabetic patient and hospitalized for the immediate & constant observation as per the advices of the Doctor. He submitted the claim papers and his claim was rejected on the ground that there was no active treatment in the hospital.

The Insurer also clarified that usually all the claims made by this complainant are being settled but the present hospitalization was only for taking the routine tests for diabetes and to purchase medicines. This hospitalization was only for evaluation purpose.

The Forum pursued the documents and it is evident from the discharge summary that the patient is a diabetic, complaint of burning sensation all over the body, itching, numbness etc. The Forum is of the view that the basic pre-requisites for hospitalization

as per the policy condition have been met with, the insurer is not justified in rejecting the claim. Further, patient has been admitted for 2 days & given normal medicines, which were already prescribed for diabetes & neuropathy. No substantial evidence to establish for seriousness of the patient to admit in the hospital for 2 days. Considering the facts, this Forum has allowed the claim on ex-gratia basis.

Chennai Ombudsman Centre
Case No. : 11.02.1131/2007-08
Mr. P. Kasilingam
Vs
The New India Assurance Co. Ltd.

Award Dated : 05.10.2007

The Complainant Mr. P. Kasilingam states that he was covered under LIC Group Mediclaim Policy with M/s. New India Assurance Co. Ltd. He was hospitalized and taken treatment for his ailment. He submitted the claim papers. Insurer has repudiated the claim on the ground that hospitalization was not warranted and treatment could have been taken as out patient.

The Insurer contended that as per the MRI scan report, the complainant had suffered disc protrusion & he has been given oral medicines and local analgesic injections. Insured's earlier claim has been settled and the later one was repudiated because Insurer had obtained the panel doctor's opinion and it states that the present treatment did not warrant hospitalization. They also clarified that as per the policy conditions for the year 2007-08, scan charges could be reimbursed without hospitalization.

The documents were perused and this Forum revealed that there is a evidence from the discharge summary and MRI scan that the complainant had suffered with back pain radiating for the past 4 months and severe for the past 2 days. The attending doctor is an appropriate person to decide the necessity of hospitalization taking into consideration the 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 conditions have been met with, the insurer is not justified in rejecting the claim. Hence, direction has been given to allow the claim on ex-gratia basis.

Chennai Ombudsman Centre
Case No. : 11.02.1143/2007-08
Mr. V. Seshagiri
Vs
The New India Assurance Co. Ltd.

Award Dated : 18.10.2007

The complainant Mr. V. Seshagiri was covered under LIC Group Mediclaim policy with M/s. New India Assurance Co. Ltd. He was hospitalized at M/s. MV Diabetes Specialities Centre from 21.10.2005 to 24.10.2005 for his ailments. He preferred the claim with the Insurer for reimbursement of hospitalization expenses. Insurer has repudiated the claim on the ground that no hospitalization was warranted and only unnecessary investigations have been conducted.

The representative of the Insurer stated that the complainant has been hospitalized for swooning. But as per the discharge summary, the patient was admitted for stabilization of blood sugar with complaints of right great toe swelling. The hospital records did not show that he was admitted after he swooned. They had taken Doctor's opinion and decided that complainant was admitted for investigations and evaluated by various departments for routine checkup.

After perusing the documents by this Forum, it is evident that the patient was a diabetic and under medication. Discharge summary also recorded that at the time of admission, the fasting sugar level was high indicating unsatisfactory glycaemic control and the treatment was given to control blood sugars. Therefore, the complainant failed to establish by way of documentary evidence that the condition of the patient was such that it required infrastructure of a hospital. Since the complainant has failed to prove the necessity of hospitalization, the Forum has dismissed the complaint.

Chennai Ombudsman Centre
Case No. : 11.02.1145/2007-08
Mr. K. Varadharajan
Vs
The New India Assurance Co. Ltd.

Award Dated : 18.10.2007

The Complainant, Mr. K. Varadarajan has covered under LIC Group Mediclaim Policy with M/s. New India Assurance Co. Ltd. He has been hospitalized for the complaints of numbness both lower limbs, pain on both shoulders and numbness in both forearms. He preferred the claim for reimbursement of his medical expenses with the Insurer. He has not been received any reply from the Insurer. After approaching the Ombudsman only, he received repudiation letter stating that no active treatment was given during the hospitalization.

The Insurer has stated that the complainant was a regular claimant. The delay in sending the repudiation letter in the present claim was because of the delay in getting the indoor case sheet from the hospital. On perusal of the discharge summary and indoor case sheets, it appeared that he was not admitted to the hospital in an emergency condition as claimed by him and there was no mention about traction in the indoor case sheets. Their panel Doctor also opined that there was no active treatment and hence the claim repudiated.

After perusing the documents, the Forum has advised the Insurer to be prompt in replying to the complaints from customers. It has been observed from the indoor case sheets that the patient has admitted in the hospital due to complaints of numbness on both limbs & forearms for the past 3 months, palpitation and chest discomfort. There is no record of abdominal pain or vomiting in the internal case sheet at the time of admission as contended by the Complainant. As per discharge summary, he was suffering from diabetes, hypertension etc. The complaint underwent various tests viz. liver function test, blood sugar, amalare, CA 19-9, ultrasonagram abdomen, CT abdomen & pelvis. The same could have been done as an outpatient. The discharge summary also does not indicate that the condition of the insured was such that he had to be immediately hospitalized. The Forum therefore, stated that the Insurer's decision for repudiating the claim could not be faulted and the complaint is dismissed.

Chennai Ombudsman Centre
Case No. : 11.02.1146/2007-08
Mr. G. Venkatesh
Vs
M/s. New India Assurance Co. Ltd.

Award Dated : 29.10.2007

The complainant Mr. G. Venkatesh & his family was covered under LIC Group Mediclaim Policy. His spouse was hospitalized for delivery. He submitted the claim

papers to the Insurer for the settlement of the claim. The claim was settled partly. There was a short settlement.

The Insurer contended that the patient has incurred expenses towards the hospitalization of her second delivery. After delivery, family planning procedure was performed during the course of the stay in the hospital. As per the policy conditions, family planning expenses were excluded under exclusion 4.8. Since family planning was done during the hospitalization on a separate day, as per the opinion of TPA, 10% of the admissible amount was deducted towards the procedure.

The Forum has perused the documents and questioned the Insurer, the logic behind their decision to deduct 10%, they said that they could not get the exact amount incurred towards sterilization and hence as per the practice they have deducted 10% of the admissible amount. Further the complainant has not obtained any detailed working of maternity expenses and the expenses incurred towards sterilization separately. Therefore, the Insurer disallowed 10% of the admissible claim amount towards sterilization. The Forum also justified the stand of the Insurer and dismissed the complaint.

Chennai Ombudsman Centre
Case No. : IO(CHN) 11.02.1283/2007-08
Mr. K.Ravindran
Vs
The New India Assurance Co.,Ltd.,

Award Dated : 30.11.2007

Mr.K Ravindran, a retired HGA of LIC, had authorized LIC to deduct the annual Group Mediclaim premium from his Pension. The provisional premium of Rs.8,712/- which was the premium payable for 2006-‘07 as per the existing rate for a sum insured of Rs.3 lakhs for him self and his wife ,was deducted from his pension. However, the difference of premium of Rs 2,310/- could not be remitted by him in time due to his being away from home and therefore not having received the communication calling for the difference. Only on his return to Coimbatore, he could see the notice from LIC that he had ceased to be a member of the Mediclaim scheme 2006-07 because he had not remitted the balance premium within the stipulated date. His appeal to the Central office of LIC of India did not yield any positive result because as per the Central Office Circular dt 3rd Aug 2006, non payment of the difference in premium would result in cancellation of insurance cover in its entirety as well as forfeiture of the provisional premium already paid. The complainant contended that the letter of LIC dated 13.2.2006 clearly showed that the coverage was available for basic S.A. 1.2 lakhs and optional sum insured of Rs.3 Lakhs and a premium of Rs.8712/- had been deducted from his pension. It was not fair on the part of LIC of India/ New India to have totally removed him from the scheme.

The local office of M/s. New India Assurance contended that they were would to cover only those persons and their families as included in the list furnished to them by the O.S department of the designated LIC office. The designated LIC office contended that since the complainant had not remitted the difference in premium within the stipulated date as per their Central Office circular dated 3/08/2006 they had removed the complainant and his spouse from the scheme.

After hearing the parties and perusing the circular LIC Circular dated 5.4.2006 regarding renewal of Group Mediclaim Policy for the year 2006-’07. it was seen that LIC of India had given one more option for retired employees to join the scheme. Therefore to throw out a senior citizen who had already paid more than 80 % of the

premium well in time and had been unable to pay the balance of premium due to extraneous circumstances needed reconsideration.

In the circumstances to exclude a retired employee, who has been continuously insured since 1988 and who has remitted more than 80% of the premium well in time and unable to pay the difference, due to circumstances beyond his control , to summarily deprive him of a post retriral welfare measure is extremely harsh needed reconsideration. The matter should have been dealt in a more practical manner and reasonable manner in keeping with the spirit of the Circular No.ZD/1082/ASP/2006 dated 5.4.2006. Accordingly LIC and New India Assurance were directed as a special case without precedence,

1. To include complainant and his wife in the Group Mediclaim scheme for the year 2007-2008 with immediate effect, for the Entitled Basic Sum Insured of Rs.1.20, 000/- only.

(ii)The premium of Rs.8712/- already recovered from his pension deemed to be adjusted towards the premium for 2006-07 and 2007-08.

(iii) In view of (i) and (ii) above, the cover will be deemed to be continuous.

However Mr K Ravindran will not be entitled to claim any benefits for medical expenses incurred before the date of this award.

The Complaint is allowed.

Chennai Ombudsman Centre
Case No. : IO(CHN) 11.04.1260/2007 – 08
Mr. M.S. Venkatesan
Vs
United India Insurance Co. Ltd

Award Dated : 18.12.07

The Complainant Mr. M.S. Venkatesan had taken a group mediclaim floater policy covering his wife and son under the Indian overseas Bank Health Care Plus policy issued by United India Insurance Co. Ltd for account holders of Indian Overseas Bank for the period 11.10.06 to 10.10.07. Insured's wife Mrs. Jayanthi lodged a claim for reimbursement of maternity expenses for admission to hospital on 4.05.07. The TPA/Insurer declined the claim since the same falls under the waiting period as per the terms of the policy. The insured approached the forum contending that this provision is not mentioned in the document issued to him.

It is observed from the representative of the insurer that the document/clauses were sent to the customer through TPA/Bankers. The insurer could not vouchsafe for the wrong brochure received by the customer. The insurance certificate along with the conditions said to have been received by the insured did not contain the waiting period clause whereas the policy conditions attached with the policy according to insurer contain the waiting period clause. The origin of the misleading brochure is not established.

The computer generated clause is not the official document issued either by TPA or United India. It can be considered as a computer printout stating some of the benefits of the policy. The printed document submitted by the insurer mention the waiting period under the policy. Also as per the proposal and declaration, the insured has accepted for abiding by the policy terms as agreed by the Insurance Company and the Bank. In view of the same, the complaint is dismissed.

Chennai Ombudsman Centre
Case No. : IO(CHN) 11.04.1236/2007 – 08
Mr. Shankar
Vs
United India Insurance Co. Ltd

Award Dated : 24.12.07

The Complainant Mr. Shankar had included his family along with his father under the group mediclaim policy of his employer M/s Rane taken with United India since October 2000. The complainant's father Mr. V. Somasundaram was admitted into the hospital for Aortic valve replacement surgery and claimed Rs.2,07,177/-. The insurer has declined the claim on the ground that the ailment was pre existing at the time of taking the policy. Though the insured has the policy since 4 years the insurer depended on the doctors opinion which states that the ailment could have been present since 14 years. The insured contended that they were aware of the condition only in April 2004. Hence the insured approached the forum for settlement of the claim.

The representative of the insurer stated that their panel doctor opined that the disease might have been present before 14 years and hence they had declined the claim on the ground of pre existing condition. The insurer also stated that said disease could not be sudden and that it was chronic and existing for many years.

As per the policy issued by the insurer pre existing disease are excluded. The insurer submitted clarification from the panel doctor which says that Aortic valve disease is the result of rheumatic fever which affects persons in childhood. The Arotic stenosis is a gradually developing process leading to a stage where the valve has to be replaced, this stage will be reached after 12 to 14 years from the day of onset of stenosis. Another independent opinion obtained also mention the Aortic stenosis is largely asymptomatic for many years with ECG remaining normal. The report of 2004 indicates moderate aortic stenosis. The disease process would have existed for many years prior to diagnosis, but to quantify a time frame would be difficult. Aortic stenosis to warrant valve replacement takes very many years.

As per the opinion of the various medical experts, changes in the heart and its valves would have occurred only over a considerable period of time much more than 6 years, which culminated to the condition of the insured deteriorating to the extent of valve replacement. Since the same falls under pre existing condition exclusion of the policy which is not covered, the complaint is dismissed.

Chennai Ombudsman Centre
Case No. : IO(CHN) 11.05.1262/2007 – 08
Mr. N. Suresh
Vs
The New India Assurance Co. Ltd

Award Dated : 31.12.2007

The Complainant Mr. N. Suresh had covered his family under the group mediclaim policy issued by the New India Assurance Co. Ltd. The insured had claimed Rs,55,920/- towards maternity expenses along with expenses towards new born baby. The insurer had allowed only Rs.39,490/- since the insured had not submitted break up of expenses towards maternity and sterilization. The insured tried to explain the position and could not get positive results. Aggrieved by this the insured approached the forum .

The insurer obtained medical opinion towards the expenses incurred. As per the same there is excess charge in the bill and pre hospitalization is not required as well as presence of specialist doctors.

The claim payment of 75% was offered during September 2006 and afterwards proper reply to the insured's representation was not furnished. Further on the same day of writing to the hospital, reply was sent to insured justifying reduction of 25% from the claim amount. The panel doctor's opinion has not considered facts like pre delivery scan and the requirement of other doctors in addition to the lady doctor at the time of delivery based on the merits of the situation.

The insured also acted casually without much concern about the treatment given and reasonableness of the expenses. On the part of the insurer also, they were not inclined to reconsider their stand even after necessary clarification were submitted. It appears that the decision to disallow 25% of the claim amount towards sterilization expenses was taken without waiting for the clarification of the hospital authorities. Hence it is felt that the insurer need to disallow only 10% of the admissible amount towards sterilization charges, subject to the terms and conditions of the policy. The compliant was partly allowed.

Chennai Ombudsman Centre
Case No. : IO(CHN) 11.05.1313/2007-08
Shri R.Sadasivam
Vs
The Oriental Insurance Co. Ltd.

Award Dated : 12.02.2008

Shri R.Sadasivam, complainant was covered under a tailor made Group Mediclaim policy issued by the Oriental Insurance Co. Ltd. The complainant underwent cataract surgery - left eye at MIOT Hospital, Chennai. His claim for cashless facility had been denied and subsequently his claim for reimbursement of expenses of Rs 19,251/- was repudiated under exclusion clause 4.1. Even on appeal made to the Grievance Cell of the Insurer that cataract was not pre-existing, they upheld the decision of the of the policy issuing office but quoted exclusion clause 4.3 (first year exclusions) as the basis of repudiation instead of 4.1(pre-existing disease).

The insurer contended that the tailormade policy was loaded by 15% for extension of maternity cover and 10% for inclusion of pre-existing clause 4.1 only. Premium was not loaded for waiver of first year exclusion clause 4.3. The complainant was included in the group during the current policy year only. The complainant had undergone surgery for left eye cataract and the claim falls under exclusion clause 4.3 of the policy issued to the group.

Documents including the letter of the employer of the complainant asking for specific covers, tailor made policy schedule with terms and conditions, discharge summary, repudiation letters were scrutinized. Exclusion clauses 4.1 and 4.3 were as per standard wordings.

It was held that although 'Cataract' is specifically excluded in the Clause 4.3 of the policy, in this case it is evident from the copy of the policy schedule submitted by the Insurer that the insurer has collected extra premium for waiver of the clause "Pre-existing diseases". There was no specific mention in the schedule of the policy that the waiver is only in respect of 4.1 clause. All the three clauses 4.1, 4.2 and 4.3 are related to pre-existing diseases only. It is surprising to note how the insurer has restricted the waiver only to clause 4.1. Moreover if pre-existing condition is waived by the insurer, it is implied that all the pre-existing diseases whether it is longstanding

(4.1), or 30 days (4.2) or in first year (4.3) is deemed to be covered. Where the words of a document are ambiguous they shall be construed against the party who prepared the document. The contract is likely to be construed Contra Proferentem against the company in case of ambiguity or doubt. However, the contentions of the insurer could not be totally brushed aside as they have not loaded premium for removal of Exclusion Clause 4.3 under the scheme. Insurer was directed to pay a sum of Rs.15,000 on Ex-gratia basis.

Complaint was partly allowed on Ex-gratia basis.

Chennai Ombudsman Centre
Case No. : IO(CHN)/11.02.1369/2007-08
Smt.Radha Vijayaraghavan
Vs
The New India Assurance Co. Ltd

Award Dated : 25.02.2008

Smt.Radha Vijayaraghan has been covered the Group Mediclaim policy for City Bank credit card holders. She preferred a claim of Rs 26,920/- for her in-treatment for joint and muscle pain. Her claim was repudiated quoting exclusion clause 2.1.1 as the hospital did not have required number of in-patient beds and it was not a registered hospital. She requested them to consider the claim under Clause 1.1.e which states that hospitalization claims which were otherwise admissible under this policy, would be restricted to 20% of the sum insured subject to a maximum limit of Rs.25,000/- per claim. The wording in the clause “as otherwise admissible” could not be taken for granted that it implied conditions relating to Clause 2.1.1. The understanding of the clauses 2.1.1 and 1.1.3 with respect to the preamble clause 1.1. is defective in nature, since Ayurveda and Allopathy are different schools of medicines and each have a set of different conditions

The insurer stated that the insured was hospitalized and diagnosed for VATAVATAM. The claim was repudiated by invoking Clause 2.1.1. The hospital was not a registered hospital and it did not have 15 in-patient beds. The complainant had requested for reconsidering the claim invoking Clause 1.1.e which speaks of Non-Allopathic Treatment. This could not be considered .The implication of Clause 1.1.e is if the claim is found to be admissible taking into consideration of various provisions of GH Mediclaim policy, then the liability has to be restricted to 20% of sum insured or Rs. 25,000/- whichever is less, as far as non-allopathic treatment is concerned.

Documents such as treating doctors certificate, Copy of the Good Health Policy and the Terms and Conditions thereof were examined. It was seen as per Clause 2.1.1 ,“Hospital”, had to be a registered with local authorities or have besides other minimum criteria atleast a minimum of 15 in cities(or 10 in C class towns). The herein referred hospital, where complainant had taken treatment did not meet this minimum requirement.

As regards Clause 1.1.e, the intention of the insurer to put the wordings “As otherwise Admissible” is to ensure that claim becomes admissible only when other policy provisions are complied with. The terms and conditions printed in the policy are clear and do not give rise to any doubt or ambiguity. The preamble of the policy clearly states that to incur hospitalization/domiciliary hospitalization expenses for medical/surgical treatment it is necessary to be admitted at any Nursing Home/Hospital in India as defined as an inpatient and does not give any blanket permission to insurer to settle the claims for non-allopathic treatment as demanded by the insured.

The complaint was dismissed.

Chennai Ombudsman Centre
Case No. : IO(CHN)/11.04.1314/2007-08
Shri C.Kanniappan
Vs
The United India Insurance Co. Ltd

Award Dated : 29.02.2008

Shri C.Kanniapan, complainant was covered under the Group Mediclaim policy taken by his employer from United India Insurance Co. Ltd. He underwent Angioplasty in March 2006. The insurer had repudiated his claim for reimbursement of hospitalization expenses of Rs one lakh under exclusion clause 4.1(pre-existing disease). He contended that he was insured for over 10 years under the group policy of his employer and he had never made a claim in the past 10 years. Regarding the observation made in the discharge summary about his having Dyslipidemia and Diabetes for 10 years, he said that probably his wife had mentioned “10 months” but the hospital may have wrongly recorded as “10 years”. He submitted copies of the ECG with normal study taken in 1994 to this Forum. He had also undergone a treadmill test on 28.06.1994 and the result had been negative.

The insurer contended that as per records submitted by the client he was suspected/suffering from CAD during 1994 (10 years before) and advised to undergo treadmill test. The policy records revealed that they had been insured him only for the last nine years excluding the year of admission. Hence, they concluded that it was pre-existing and were constrained to repudiate the claim.

After hearing the contending parties and scrutinizing hospital records and test reports, opinion of panel doctor, leave records of complainant, it was held that, the insurer has not conclusively proved that the complainant was suffering from the ailment for the last 10 years and before the date of inception of the policy. The insurer has not collected any indoor case sheets or prescriptions for the medicines taken by him before the inception of the policy. The insured had produced the result of the treadmill test taken 10 years back to establish that he was not suffering from any heart problem before. He has not made any claim in the last 10 years. Even if the insured was taken to be suffering from Dyslipidemia for 10 years from the date of hospitalization, the date just falls a few months before the commencement of the scheme. It is a borderline case. Though the contention of the insurer is accepted that he was suffering from Dyslipidemia before inception of the policy it could not be the only reason for his heart problem. Insurer was directed to settle the claim .

Complaint was allowed.

Chennai Ombudsman Centre
Case No. : IO(CHN) 11.02.1393/ 2007-08
Sri.K.Dhanesh Vendhan
Vs
The New India Assurance Co. Ltd

Award Dated : 26.03.2008

Mrs Paramewsari, wife of Mr K.Dhanesh Vendhan working in LIC, Ooty who is covered under the group mediclaim policy had undergone caesarean delivery in a hospital in Ooty. The baby was pre-mature (birth weight was 1.5 Kgs.), and it had to be incubated. The baby also needed photo-therapy because it was inflicted with jaundice and the doctors at Ooty had advised him to take the child to Coimbatore for treatment, as the hospital did not possess any infrastructure for an advanced treatment of such nature. The baby was transferred to Masonic Medical Centre for Children, Coimbatore, and

was admitted at 4.30 pm on the same day. When the baby was shifted from Ooty, the mother was also discharged since the baby needed her at Coimbatore. The baby was given inpatient treatment for 15 days thereafter upto 21.3.2007. He had paid the premium for the baby at his LIC Branch office, on 22.3.2007. He submitted his claim for Rs.29,938/- towards hospitalization expenses at the two hospitals. But the insurer had restricted the claim to the expenses incurred only at the first hospital.

The insurer contended that as per the policy conditions clause 5.16.7, relating to Maternity expenses, the hospitalization expenses of the new born child can be considered only during the confinement period of the mother. In this case, the child was hospitalized in a different hospital after the mother was discharged from the hospital. Hence they regretted their inability to consider the request of the insured.

On scrutiny of the policy conditions, discharge summary of the two hospitals and hearing the parties, it was held that it is impossible not to look at the special circumstances of the present case. Since the child was born with some physical defects, child and mother were discharged from Ooty only for further treatment at Coimbatore (where they were transferred). Technically mother may have been discharged but treatment of the child was inevitable and since mother's presence was a necessity, it is to be considered as a continuous treatment under mother's sum insured. The expenses incurred for treatment of the baby is to be considered within the mother's sum insured and an exgratia of Rs 15,000/- was allowed.

Complaint was partly allowed on Exgratia basis.

Chennai Ombudsman Centre
Case No. : IO(CHN)/11.02.1353/2007-08
Mrs.G.Nalini Ranga
Vs
The New India Assurance Co. Ltd.

Award Dated : 31.03.2008

The Complainant Mrs. G. Nalini Ranga had covered her parents-in-law under the Group Mediclaim policy of her employer LIC with New India Assurance. Two claims submitted by her for hospitalization of her father-in-law and one claim in respect of mother-in-law were rejected by the Insurer.

The Insurer repudiated these claims on the grounds that the hospitalization was not justified in the first two claims submitted by the insured as per clause 1.0 and condition 2.3 of the policy. As far as the third claim was concerned, the insured had not submitted the required papers, in-door case sheet and proper bill from the Hospital.

The complainant in a letter to the Forum expressed her inability to attend the hearing and stated that all records provided by the hospitals had been submitted by her, in Original, along with the claim form. She has also stated that since her parents in law had taken treatment during their visit to their daughter, who lives in a rural area at Rajapalayam, she is unable to obtain any more records from the hospital authorities.

On scrutiny of the claim papers it was seen that all the treatments hade been availed of in hospitals situated at Rajapalayam. It appears that although the persons may have taken treatment for various ailments, the documentation required by the insurer for settling the claims have not been made available. It is the duty of the insured to make available all the hospital records and clarifications called for by the insurer in support of their claim.

However, in Claim No 3, considering the nature of ailment, treatment given and the papers that have been submitted, an Exgratia of Rs 2,000/- was awarded.

The complaint was partly allowed on Exgratia basis.

Chennai Ombudsman Centre
Case No. : IO(CHN)/11.02.1390/2007-08
Shri N.Guru Rao
Vs
The New India Assurance Co. Ltd.

Award Dated : 31.03.2008

Shri N.Guru Rao, a pensioner of LIC of India and his wife have been covered under the Group Mediclaim policy issued by the New India Assurance Co. Ltd. He has submitted two claims amounting to Rs.5482/- and Rs.4307/- pertaining to the hospitalization and post hospitalization of his wife. His wife was suffering from mental depression and she was obese. The treating doctor had advised her taking inpatient treatment. The insurer stating that hospitalization was not warranted since there was no active treatment during the hospital stay rejected his claim. The third claim was for Rs.2147/- towards reimbursement of CT scan expenses for himself. The insurer, stating that original bill was not produced rejected this claim also. The insurer had called for original receipt of the scan very belatedly and at that time it was not possible to obtain documents afresh from the hospital authorities. The insurer could have condoned the production of original bills. There was no intention to defraud the insurer.

The insurer stated that Mr.N.Guru Rao under guise of hospitalization has used the benefit for covering domiciliary benefits. He is in the habit of obtaining admission letters from Doctors. In an earlier case where Shri Guru Rao had gone to the Consumer Court, a doctor had certified that Shri Guru Rao used to compel the doctor for in-patient treatment. In the claim relating to the wife of the complainant, they have repudiated the claim as per conditions 1.0 and 2.3 (24 hours hospitalisation requirement). The patient was admitted in the hospital on 27.03.2007 at 09.00 a.m. and was comfortable at 07.30 p.m. on the same date and subsequent treatment details also shows that they were of diabetic and regular in nature. Also the post-hospitalisation expenses were towards patient's regular medicines. As per indoor case sheets, there were no tests taken for CAD or an ECG taken. The patient was admitted and lab tests were taken. It was observed from the records that the patient was a regular diabetic on continuous treatment. The records show that there was no serious condition warranting hospitalization. Hence they concluded that hospitalization was not necessary.

As regards the claim of Mr Guru Rao, they had repudiated the claim since he did not submit the original bill for the scan .He had informed them that the hospital had not issued an original receipt. But when the insurer took up the matter with the hospital, they furnished a duplicate bill and also informed that they had given the original bill to the complainant. There had been misrepresentation of fact.

On verification of the documents the insurer was told that if the insurer has sufficient proof of misdemeanor and not just supposition or hearsay, they could arrange for an independent investigation into such claims in a timely manner and bring these facts to the knowledge of the employer who will be in a position to deal with the matter suitably, since it is a group policy. Merely delaying a decision will not serve any purpose. The insurer was directed to reimburse the scan charges of Rs 1,800/- in respect of the claim of the insured. As regards the claims for the wife of the complainant, award of Rs 3,000/- in all, was allowed on on Ex-gratia basis.

The Complaint was partly allowed.

Hyderabad Ombudsman Centre

Case No.G-11-004-0164
Smt. K.L.Narasamma
Vs
United India Insurance Co. Ltd.

Award Dated : 18.10.2007

Brief facts : Smt. K.L.Narasamma was covered under Andhra Bank Arogyadan group mediclaim policy issued by UII Co. Ltd., from 29.1.2005 to 8.6.2005 for a sum insured of Rs.50, 000. The cover was renewed from 9.6.2005 to 8.6.2006 for a sum insured of Rs.300,000. The insured was admitted into NIMS Hospital on 25.5.2005 for heart ailment and she underwent coronary angiogram which revealed triple vessel disease. A claim for Rs.10,259/- was lodged with Family Health Plan Ltd., who were Third Party Administrators of the Insurers. Later she was admitted into Global Hospitals, Hyderabad on 22.6.2005 and after investigations CABG was done. Another claim for Rs.1,60,472/- was lodged. The insurers' TPA initially rejected the claims but upon appeal the insurers considered the claim for Rs.50, 000/-. Aggrieved with the decision of the insurer for not allowing the claim for the full amount, the complainant approached this office.

Complainants' contention: She opted for Arogyadan policy marketed by Andhra Bank and submitted a proposal on 29.1.2005 for a sum insured of Rs.3,00,000 and paid premium of Rs.381/-.She did not get any doubt about premium as she was told that premium would be collected on pro-rata basis in the first year of the policy. The ID cards were not sent to her till 05/2005 and she was surprised to find the amount of sum insured at Rs.50, 000 only. When enquired, she was told by the insurer that sum insured can be increased at the time of renewal. She paid Rs.4,643/- as renewal premium for sum insured of Rs.3,00,000 but the renewal card also was given for Rs.50,000 sum insured. After much follow up the same was rectified to Rs.3,00,000.

Insurer's contention: Though the insured had filled the proposal form opting for a sum insured of Rs.3,00,000, the premium was paid for Rs.50,000 only. The second hospitalization was towards continuation of the treatment of the first hospitalization. As per clause 6(a) of the policy, the treatment of illness within 105 days of the first claim has to be considered as one illness. Since the sum assured at the time of first hospitalization was Rs.50,000, they considered both the claims as one illness and settled for Rs.50,000.

Decision : The insurer sought attention to the provisions of Sec. 64 VB of the Insurance Act, 1938 and submitted that they are prohibited from granting any cover unless premium is paid in advance. Since the insured paid premium for Rs.50,000 only, the insured cannot claim relief based on her intentions. As is common knowledge, no contract would be complete by proposal alone. There should be offer, acceptance of the same with or without modifications and most essentially consideration for the same. In this case the consideration paid was for a sum assured of Rs.50, 000 only. The arguments put forth by the insurer are found to be justified and based on merit. Hence the complaint was dismissed.

Hyderabad Ombudsman Centre
Case No.G-11-004-0137
Sri Ansar Vs
United India Insurance Co. Ltd.

Award Dated : 25.10.2007

Brief facts of the case: The complaint is about non settlement of Hospitalization claim. The complainant and his wife Smt. Mariyamunnisa were covered under a Group Medi-

Claim policy issued by UII Co. Ltd. covering employees of Ramoji Film City (Eenadu Group) for the period 19.6.2006 to 18.6.2007. Smt. Mariyamunnisa underwent thyroidectomy on 26.12.2006 while she was admitted into Chaitanya Nursing Home, Rajahmundry from 25.12.2006 to 31.12.2006. A claim for Rs.10,988/- was lodged and the claim was rejected by the insurer invoking pre-existing disease clause of the policy.

Complainant's contentions: He stated that his wife complained of pain/swelling in the neck only in the first week of 12/2006 for the first time and the illness was not pre existing as alleged by the insurance company.

Insurer's contentions: The OP record dated 2.12.2006 of the patient at Gowtham ENT Hospital, Rajahmundry submitted to them by the complainant mentioned existence of the problem since 1996 in view of the noting " c/o Swelling @ Neck-96". The record submitted by the claimant also indicated consultation/ tests done on 27.9.2006. The ration card issued on 22.10.2005 clearly indicated swelling in the neck of Smt. Mariyamunnisa. Since insurance was granted for the first time on 19.6.2006, the claim for thyroidectomy is not payable in view of the pre existing disease exclusion clause of the policy.

Decision : The claimant's wife admitted that she consulted Dr. Ramana Rao of Gowtham ENT Hospital on 27.9.2006 and the doctor gave a confirmation letter to the insurer stating that Smt. Mariyamunnisa had swelling of neck since 1996. In view of the evidence produced by the insurer, the complaint was dismissed without any relief.

Hyderabad Ombudsman Centre
Case No.G-11-002-0211
Sri M.M.P.Srinivasa Rao
Vs
New India Assurance Co. Ltd.

Award Dated : 21.11.2007

Brief facts : Sri Srinivasa Rao, an employee of LIC of India was covered under a group mediclaim policy issued by M/s New India Assurance Company Ltd. covering the staff of LIC and their family members. His wife Smt. M.R.Rajeswari was admitted to Apoorva Hospitals, Vizag on 4.1.2007 with complaints diagnosed as DUB and Hernia. Total abdominal hysterectomy, hernia repair and appendectomy were done and she was discharged from the hospital on 10.1.2007. A claim for Rs.37,165/- was lodged with the insurance company. The insurance company settled the claim for Rs.30,445/- only and intimated the same to the insured. Sri Srinivasa Rao represented to the DO of the insurer for a review but to no avail

Complainant's contentions: He stated that his wife was suffering from gynaecological problem as well as hernia and consulted two doctors. Both doctors suggested that she should undergo surgeries for both problems. Both operations were conducted on the same day and in the same hospital. During the operation procedure, doctors observed appendix bulge and removed it. The insurance company reduced the claim amount from Rs.37165/- to 30,445/- without assigning any valid reasons.

Insurer's contentions: The insured submitted the hospital case sheet after a lapse of 40 days. They obtained expert medical opinion and disallowed certain amounts on the basis of doctor's opinion. They disallowed (1) Registration fee of Rs.170/- (2) Establishment charges of Rs.600/- (3) Service and dressing charges of Rs.650/- (4) Surgeon's fee reduced by Rs.5000/-. All the deductions were made as per policy conditions. They allowed higher amount on operation theatre charges and surgeons fee despite a suggestion from their doctors for scaling down on these items. They held that they processed the claim considering reasonableness of expenditure.

Decision: The insurer is found to rely on their doctor's opinion in disallowing certain amounts. The complainant was found to have represented to the insurer against the reduction, but the insurer had not taken any action to verify with the treating doctors/ hospital regarding the charges made. Considering the facts of the case, it was decided to allow a further amount of Rs.5650/- in addition to the claim amount offered by the insurer. Thus, the complaint was partly allowed.

Hyderabad Ombudsman Centre
Case No.G-11-004-0210
Sri G.Butchi Raju
Vs
United India Insurance Company Ltd.

Award Dated : 3.12.2007

Brief facts : Sri G. Butchi Raju, a retired Chief Engineer of APSEB enrolled into the AB Arogyadan group medical insurance policy given by M/s UII Co. Ltd., to the customers of Andhra Bank from 14.8.2004 to 8.6.2005, then from 20.6.2005 to 19.6.2006 and again from 21.6.2006 to 20.6.2007. The sum insured was Rs.1,00,000/-. He was admitted into NIMS, Hyderabad from 5.3.2007 to 7.5.2007 and had undergone CABG on 12.4.2007. Post operatively he developed bronchospasm and had CO2 retention. He also had pulmonary TB of left lung with fibrosis. He was kept on ventilator for 4-5 days. His earlier medical history included "old pulmonary Kochs with destroyed left lung". At NIMS he incurred an expenditure of Rs.205765/- and lodged a claim with M/s Family Health Plan Ltd., the TPA on 9.6.2007. Of this bill, an amount of Rs.1 lakh was paid to the hospital by the ex-employer of the insured. The insured sought payment of the sum insured from M/s UII. His claim was rejected on 11.7.2007 invoking pre-existing diseases exclusion clause.

Complainant's contentions: He stated that he did not take any treatment till 5.3.2007. He made a claim after coverage for three years under the policy and hence he should be paid the claim.

Insurer's contentions: Their TPA addressed two letters to the claimant on 22.6.2007 and 5.7.2007 seeking certain clarifications. As they did not receive any response, they invoked 4.1 of policy condition to reject the claim. Their TPA had conveyed them that the insured's present ailment arose out of his long standing DM, HTN and other diseases.

Decision: The insurer submitted copies of prescriptions pertaining to the insured's treatment/ consultations on 24.7.2000 and 15.3.2004 (Dr. Kotilingam); on 9.7.2003 (Dr. Ram Vijay Kumar); on 4.3.2003 (Dr. I. V. Rao); on 20.11.2002 (Dr. N.S.Murthy) and on 11.3.2004 (Dr. S.Abbayi). The pathological report dated 9.2.2003 showed sugar, triglycerides and cholesterol at higher than normal values. The complainant confirmed that he had DM, HTN, Asthma and lung problems prior to taking insurance for the first time on 14.8.2004. Dr. Abbayi's prescription contained a noting pointing heart ailment. The insurers submitted opinion of a cardiologist which referred to Dr Abbayi prescribing medicines on 11.3.2004 for IHD. In view of the evidence placed by the insurer, the complaint was rejected.

Hyderabad Ombudsman Centre
Case No.G-11-002-0222
Sri G. Parthasarathi
Vs
New India Assurance Co. Ltd.

Award Dated : 11.12.2007

Brief facts : Sri G. Parthasarathi, a retired employee of LIC was covered along with his wife under a group mediclaim policy issued by the New India Assurance Company Ltd. His wife, Smt. Laxmamma was admitted to Dr. Mohan's Diabetic Centre on 10.2.2007 with complaints of giddiness, weakness, joint pains and tingling sensation in both feet. She was treated and discharged on 19.2.2007. A claim for Rs. 32,004/- was lodged with the insurer, who settled it for Rs.22,843/- only. The insured was not paid the balance amount even after follow up.

Complainant's contentions: He stated that he submitted his claim on 28.2.2007 and after much persuasion and reminders the claim was settled for Rs. 22,843/- on 18.6.2007. He was not given details of disallowed amounts. He agreed for deduction of Rs.4320/-, being medicines purchased beyond 60 days after hospitalization. He submitted that despite his regular follow up his claim for balance amount was not settled.

Insurer's contentions: They disallowed (i) Regn charges of Rs. 110/- (ii) Misc. charges of Rs.291/- (iii) Bill No.988 for Rs.2190/- towards RBS reports (iv) Bill No.3095 for Rs.1755/- towards 27x10 disposable needles (v) Bill No.24147 (excess purchase for Rs. 55/-) (vi) Non receipt of authorized receipt for Rs.200/- (vii) Wrong totaling Rs.240/-. The total amount of disallowed bills came to Rs.4841/- and these amounts were disallowed in line with policy conditions.

Decision: The insurer's representative held that as per policy conditions non-medical expenses are not allowed as also bills not supported by proper prescriptions and reports. The complainant contended that blood sugar tests were done periodically while his wife was in hospital. He also submitted that no doctor would prescribe disposable needles and once an injection is prescribed, needle also is to be purchased.

After hearing both sides, it was decided to order the insurer to settle a further amount of Rs..3360/- (item nos. iii plus part of item iv)

Hyderabad Ombudsman Centre
Case No.G-11-002-0227
Sri M.G.K.Murty
Vs
New India Assurance Company Ltd.

Award Dated : 26.12.2007

Brief facts : The complaint is about short payment of medical expenses claim. Sri MGK Murty and his family were insured under a group mediclaim policy issued by New India Assurance Co., covering the employees of LIC and their dependents. The complainant's wife Smt. Jyothi was admitted into Simhadri Hospital, Visakhapatnam on 9.6.2007 where she underwent total abdominal hysterectomy. She was discharged from the hospital on 16.6.2007. A claim for Rs.42,148/- was lodged but the insurer approved the claim for Rs.27,498/- only. On representation, the insurer settled the claim for Rs.28,698/- and no reasons were given for reducing the claim amount. According to the complainant, the entire amount should be reimbursed.

According to the insurer, the claim was reduced as they found the theatre charges and surgeons fee to be on a high side. They also stated that they settled the claim for a revised amount of Rs. 28698/- after

receiving discharge voucher from the complainant in full and final satisfaction and having given a discharge, the insured is not justified in raising a dispute.

Decision : The insurer's representative stated that the claim was processed as per policy exclusions and reasonable expenses were reimbursed. They further stated that Simhadri Hospital is not a major hospital. They enquired from the same hospital and other similar hospitals about the expenses charged for similar surgery. They obtained quotation from the same Simhadri hospital, in which lower rates were quoted. Accordingly, they scaled down the reimbursable amount. They also stated that they disallowed non-medical expenses, as per policy conditions. After hearing both sides and after perusing the evidence, it was decided to uphold the decision of the insurer. The complaint was dismissed accordingly.

Hyderabad Ombudsman Centre
Case No.G-11-004-0253
Sri G. Keseswar Rao
Vs
United India Insurance Company Ltd.

Award Dated : 26.12.2007

Brief facts : The complaint is about non settlement of medical expenses. Sri G.Keseswara Rao had insured himself and his family under Andhra Bank Arogyadan Group mediclaim policy for the period 19.7.2006 to 18.7.2007. The sum assured was Rs.150,000 and this policy was a renewal of the initial policy from 19.7.2005 to 18.7.2006. The insured was covered under another policy of New India Assurance Co. Ltd for a sum assured of Rs.50,000 for the period from 18.7.2005 to 17.7.2006. The insured was admitted to Sri Mullapudi Venkata Ramanamma Memorial Hospital, Tanuku with complaints of sweating and heaviness in chest on 19.4.2007. He was referred to CARE Hospital, Vijayawada where Angiogram was done, which revealed 100% LAD occlusion. Rescue PTCA was attempted but could not be completed. Afterwards, the insured was shifted to Usha Mullapudi Cardiac Centre, Hyderabad on 7.5.2007 where CABG was done and he was discharged on 29.5.2007. The total expenditure came to Rs.244,049/- and a claim was lodged with M/s FHPL, the TPA. The claim was repudiated by the TPA stating that the hospitalization was for management of a pre-existing disease.

Decision: The complainant stated that he developed a sudden chest pain on 19.4.2007, which led to his treatment in various hospitals. He further stated that he obtained a mediclaim policy from New India Assurance Company after a medical examination and policy from them commenced on 18.7.2005. Since no objection was raised by M/s New India about his health condition, it is not correct for UII Co. Ltd. to say that his ailments are pre-existing.

The insurer submitted that the insured first obtained insurance from New India on 18.7.2005 and on the very next day had taken cover under Andhra Bank- Arogyadan policy for a sum insured of Rs.150,000/-. The policy given by New India was subject to exclusion of Diabetes, whereas he had declared as 'NIL' in the pre-existing diseases column of Andhra Bank-Arogyadan proposal. They also submitted that all discharge summaries issued by hospitals mentioned that the patient/insured was a known hypertensive and diabetic on treatment. It was also pointed out that the insured had applied to the government for reimbursement of his medical expenses. However, the insured did not disclose either to the insurance company or to this office about his approaching the Government authorities for assistance. From the record it was

observed that the complainant was not transparent while pursuing his complaint and lot of inconsistencies were observed in the submissions made by him. Hence, it was decided to dismiss the complaint.

Hyderabad Ombudsman Centre
Case No.G-11-002-0273
Sri N.K. Krishnankutty
Vs
New India Assurance Company Ltd.

Award Dated : 21.01.2008

Brief facts : The complaint is about non settlement of mediclaim under group health insurance policy issued to the customers of Citi Bank. The sum insured was Rs.5 lakhs per person and the insurance was in force from 1.12.2000 to 30.11.2005. Smt. Chitra Krishnankutty was hospitalised at Wockhardt Hospital, Bangalore from 19.9.2005 to 29.9.2005, where she underwent CABG on 22.9.2005. She lodged a claim for Rs.2,75,152/- with the TPA M/s TTK Healthcare Services Pvt. Ltd., in 03/2007. She was not given cashless services by the TPA stating that her disease was pre-existing. Her claim was finally rejected by the TPA on 16.4.2007 citing pre-existing diseases exclusion clause of the policy.

According to the complainant, the policy was taken in 2000 and he disclosed about the angioplasty undergone by his wife in 1995. According to him, the insurance company was aware of his wife's condition and accepted premium for several years.

According to the insurer, the treatment papers indicated that Smt. Chitra was suffering from heart problem for previous 12 years which was prior to the inception of the policy in 12/2000.

Decision : Both sides were called for a hearing on 4.1.2008 at Bangalore. The insurer's representative submitted a Good Health Policy certificate issued to Sri Krishnankutty and family under which all pre-existing diseases/ illnesses were excluded irrespective of whether they were declared or not. The complainant submitted that according to his understanding, all pre-existing diseases are to be covered after four years from inception of policy. The insurer stated that as per the terms of policy issued to Citi Bank's customers, the facility of covering pre-existing disease after a period of four years is not available. Since it was not in dispute that Smt. Chitra had heart related problems prior to 12/2000, the insurer was found to be justified in denying the claim as per policy conditions. The complaint was dismissed.

Hyderabad Ombudsman Centre
Case No.G-11-002-0325
Smt. P.V.Ashwini
Vs
New India Assurance Co. Ltd.

Award Dated : 21.01.2008

Brief facts : The complaint is about non settlement of medi claim under a group medi claim policy issued by M/s New India Assurance Co. Ltd., to the employees of LICHFL. Smt. P.V.Ashwini, an employee of LICHFL, Bangalore is covered, along with her parents under the group policy. Sri Vishnu, father of Smt. Ashwini was hospitalised from 17.4.2007 to 28.4.2007 with complaints of shortness of breath for 20 days and he was diagnosed to be suffering from chronic corpulmonale, cirrhosis of liver, DM-Type2 & Respiratory failure. In May, 2007, Smt. Ashwinin lodged a claim with the insurer for

Rs.42,331/- but the insurer rejected the claim under pre-existing diseases exclusion clause.

According to the complainant, her father's respiratory trouble was of sudden origin and not pre-existing.

According to the insurer, Sri Vishnu was a chronic case of corpulmonale and his other ailments were also chronic in nature.

Decision : According to the complainant, her father was admitted into the hospital with complaints of breathlessness and on admission he was discovered to be suffering from other ailments. The insurer's representative produced a copy of hospital record which indicated (i) previous hospitalisation 3 years back for similar complaints (ii) Hypertension since one year- on treatment (iii) Known alcoholic since 25 years.

Smt. Ashwini confirmed that her father was hospitalised three years ago, but contended that he was fully cured of those complaints. In view of the past medical record produced by the insurer, the complainant was asked to produce treatment papers pertaining to previous hospitalisation or to provide the details of hospital to support her contentions, which she failed to do.

As per standard medical dictionary, the disease chronic corpulmonale refers to a heart condition resulting from hypertension. From the record produced, it is evident that the patient was under treatment for HT for about one year before 04/2007. The enrolment of Sri Vishnu into the scheme was from 08/2006 and hence the insurer was found to be justified in rejecting the claim under the pre-existing diseases exclusion clause.

Hyderabad Ombudsman Centre
Case No.G-11-004-0311
Smt. Y. Rajarajeswari
Vs
United India Insurance Co. Ltd.

Award Dated : 25.01.2008

Brief facts : The complaint is about non-settlement of medi claim. Smt. Rajarajeswari was covered under a group mediclaim policy, covering members of M/s Unique Mercantile India Pvt. Ltd. The period of coverage was from 30.6.2006 to 29.6.2007. The insured lodged a claim for Rs.14,266/- for treatment of fever and Appendix in Solomon Nursing Home, Chirala from 3.10.2006 to 21.10.2006. The insurance company rejected the claim under 5.7 condition of the policy stating that the claim was fraudulent.

The insurer contended that the insured's name was inserted in the hospital records and that proper discharge summary was not produced by the insured.

Decision : Both sides were called to attend a hearing on 23.1.2008. The complainant claimed that her claim is genuine. The insurer's representative submitted that the hospital records were tampered with. They also complained that the hospital authorities did not cooperate with their investigator in the matter of verification of records. On perusal of the file it was observed that the hospital did not give a proper discharge summary. The diagnostic reports were submitted on a plain paper. It was also observed that the insured's particulars were inserted between two names at serial nos. 448 & 449. As the papers submitted by the insured were found to contain several deficiencies, the complaint was dismissed.

Hyderabad Ombudsman Centre

Case No.G-11-010-0299
Sri N. Santosh Kumar
Vs
IFFCO TOKIO General Insurance Co. Ltd.

Award Dated : 25.01.2008

Brief facts : Sri Santosh Kumar had insured himself and his family members under a group Medishiled policy, covering members of Golden Multi Services Club. The sum insured was Rs.50000 and the period of insurance was from 1.9.2006 to 31.8.2007. The insured's daughter, Baby Vaishnavi wad admitted into Rainbow Children's hospital, Hyderabad on 16.4.2007 with fever. The insured's request for cashless services was denied by TPA, M/s Paramount Health Services Pvt. Ltd. The insured submitted a bill for Rs.7908/-, but the claim was not settled. The reason given by the TPA for rejection of the claim was that it was not made in proper format.

The complainant stated that he was not guided properly in filling the forms.

Decision : Both sides were called for a hearing o 23.1.2008. During the hearing, the TPA's representative stated that the diagnosis given in the cashless facility request was not fully tallying with the discharge summary. From the papers it was observed that the complainant was denied cashless facility without assigning proper reasons. The TPA was found to be deficient in communicating with the insured about use of proper format. In view of the submissions made by both sides, it was decided to direct the insurer to re-examine the case once again and process the claim within one month from the date of this order.

Hyderabad Ombudsman Centre
Case No.G-11-004-0306
Sri N. Mahender Reddy
Vs
United Inida Insurance Co. Ltd.

Award Dated : 25.01.2008

Brief facts : The complaint is about non settlement of medi claim. Sri Mahender Reddy was insured under Andhra Bank Arogyadan group mediclaim policy. The sum insured was Rs.1,00,000 and the period of insurance was from 28.12.2006 to 27.12.2007. The insured member was admitted to Madhava Nursing Home, Secunderabad with complaints of frequent and burning urination on 2.3.2007. He was operated for enlargement of prostate and was discharged from the hospital on 9.3.2007. The claim was rejected by M/s Family Health Plan, TPA of the insurer, on 2.5.2007 under the first year exclusion clause. The complainant alleged negligence and callousness on the part of the insurer and their TPA in the handling of his claim. The insurer stated that their TPA rejected the claim as per medical opinion.

Decsiion : A hearing of both sides was held on 23.1.2008. As per the insurer, the insured underwent a surgery within three months from the date of the policy and the illness is specifically excluded under the first year exclusions list. In view of the policy conditions being very clear, it was decided to reject the complaint.

Hyderabad Ombudsman Centre
Case No.G-11-002-0292
Sri G. Satyanarayana
Vs
New India Assurance Co. Ltd.

Award Dated : 11.2.2008

Brief facts : Sri Satyanarayana, a retired employee of LIC was covered under the group mediclaim policy issued to the serving/ retired employees of LIC and their dependents. Smt. Kameswari, wife of Sri Satyanarayana underwent a cataract operation in the right eye and submitted a claim for Rs.12,454/-. The claim was partly settled and an amount of Rs.1,798/- was disallowed. Subsequently, she underwent cataract operation in the second eye also and a claim for Rs.12,200/- was lodged. This claim was settled for Rs.11,400/- by disallowing Rs.800/-. The complaint is about the deductions made from his two claims.

Decision : The complainant stated that the claims were settled with a delay (eight months and four months respectively) and no reasons were given by the insurer while disallowing some amounts. Later the insurers upon review settled the balance claimed amounts.

From the papers it was observed that the insurers have not responded to the several letters written by the complainant. The insurers are expected to have a proper grievance redressal mechanism and in the absence of such a mechanism, they ought to have communicated to the complainant about the facility for appeals. The insurer is found to have failed in their statutory obligation. Hence, the insurer was directed to pay an amount of Rs.1,000/- as ex-gratia to the complainant.

Hyderabad Ombudsman Centre
Case No.G-11-004-0320
Dr. B. Parameswar Reddy
Vs
United India Insurance Co. Ltd.

Award Dated : 11.2.2008

Brief facts : Dr. Parameswar Reddy was insured under a tailor-made group mediclaim policy, covering the members of Indian Medical Association, Andhra Pradesh. The period of insurance was from 14.10.2002 to 30.6.2007 and the sum assured was Rs.1,50,000/- per year. The insured was admitted to Sai Krishna Super Specialty Neuro Hospital, Hyderabad on 27.3.2007 with complaints of head ache, vomiting, giddiness, numbness of feet etc and he was diagnosed as having had post-circulatory stroke. A claim was lodged for Rs.16,502/-, which was rejected by the insurer stating that the claim was beyond the scope of the policy which covered only certain specified diseases..

Decision : The complainant contended that he was hospitalised after suffering posterior circulatory stroke and was treated for the same in the hospital. As per the insurer's contentions, the group policy covered only nine specified diseases. They stated that the insured had undergone ultrasound scan of abdomen, MRI scan of lumbar spine etc. which are not related to the diseases covered by the policy. They obtained specialist medical opinion as per which the insured had not undergone any tests which are required for a cerebral stroke. The insurer stated that the tests conducted have no relevance to the diagnosis reported and hence the claim was rejected.

A hearing was conducted on 6.2.2008.From the discharge summary it was observed that the diagnosis was given as 'Post Circulatory stroke' and stroke was one of the covered diseases. As per the specialist doctor opinion, 'patient had symptoms suggestive of posterior circulation stroke but had no signs of the same. He also did not undergo any investigations for confirmation of stroke like MRI scan of brain'. As the investigations done viz MRI LS Spine were found to be not consistent with the

diagnosis of insured disease, it was observed that the insurers were justified in repudiating the claim. However, a part of the tests undergone were for a disease covered under the policy. Hence, the insurer was directed to pay an amount of Rs.10,000/- to the complainant on ex gratia basis.

Hyderabad Ombudsman Centre
Case No.G-11-004-0381
Sri B.K.S.N.Babu
Vs
United India Insurance Co. Ltd.

Award Dated : 25.2.2008

Brief facts : Sri Babu was insured under the Andhra Bank Arogyadan group mediclaim policy for a sum insured of Rs.2,00,000 for the period 26.7.06 to 25.7.07. The policy was serviced by M/s Family Health Plan Ltd. Sri Babu was admitted to Global Hospitals, Hyderabad on 27.6.07 with complaints of lower back ache which was diagnosed as disc protrusion at L4-L5. He was discharged on 30.6.2007 after treatment. A claim for Rs.21,533/- was lodged with the TPA, but the same was rejected under the pre existing diseases exclusion clause.

Decision : The complainant stated that he was insured continuously for 3 years and sought payment of the claim. The insurer contended that the first insurance was effective from 29.7.04 and there was a gap in every renewal. A gap of 19 days was there in renewing the latest policy and therefore they considered it as a fresh policy. During the hearing, the complainant's representative told that the complainant felt back pain while on a trip to Dubai, which became severe and led to hospitalisation. The insurer's representative told that the disease suffered by the insured is in the form of a degenerative one and because of the gap in renewal they are justified in rejecting the claim. The argument of the insurer was found to be too general and they have not produced any evidence to show that the insured was having symptoms of the disease prior to the insured obtaining insurance cover. Hence the insurer was directed to settle the claim.

Hyderabad Ombudsman Centre
Case No.G-11-004-0368
Sri M. Laxman Rao
Vs
United India Insurance Co. Ltd.

Award Dated : 25.2.2008

Brief facts : Sri Laxman Rao was insured, together with his family members, under the Andhra Bank Arogyadan Group Medi Claim policy for the period 28.12.06 to 27.12.07. The sum insured was Rs.1,50,000 and M/s Family Health Plan Ltd., were the Third Party Adminstrators. Smt. Venkatamma, mother of Sri Laxman Rao was admitted to BBR Multi Specialty hospital, Hyderabad on 9.3.2007 with complaints of slurred speech and weakness. Cashless facility was denied by the TPA. The patient was treated for left hemiplegia and discharged on 16.3.07. A claim for Rs.29,485/- was lodged but it was repudiated by the insurer stating that her ailment was a pre-existing one.

Decision : The complainant stated that his entire family was covered under the group policy obtained by his employer M/s Tecumseh Products India Pvt. Ltd. since 31.12.1997. He further stated that the 4.1 exclusion clause did not apply in view of her

continuous insurance. The insurers contended that they were not aware of the continuous insurance and they came to know of it only when the complainant made a representation to their Regional office. They wanted to know the sum insured under the past mediclaim coverage and assured to settle the claim after getting necessary details.

During the hearing it became clear that the sum insured under the previous policy was Rs.1,00,000/-.The insurer was directed to process the claim within one month from the date of the order. The complaint was allowed.

Hyderabad Ombudsman Centre
Case No.G-11-002-0387
Smt. Nirjogi Aruna Kumari
Vs
United India Insuranc Co. Ltd.

Award Dated : 10.3.2008

Brief facts: Sri Nagaraju and Smt. Aruna Kumari were covered together with their three children under two AB Arogyadan Health Insurance policies issued by the insurer to the customers of Andhra Bank for the period 18.8.04 to 9.6.05. The insurance was renewed for one more year. Smt. Aruna Kumari was hospitalised from 13.11.05 to 14.11.05 at Care Hospital, Hyderabad with complaints of chest pain and shortness of breath. Sri Nagaraju submitted a claim for Rs.4,532/- to the TPA of the insurers but the same was rejected on 25.3.06 under the pre-existing diseases exclusion clause no 4.1.

Decision: Sri Nagaraju submitted that his wife underwent PTCA in 12/1996 and since then had not suffered any chest pain. According to him, his wife suffered chest pain on 13.11.2005 at 7.30 am and was admitted to Care Hospital at 9.30 am on the same day. The insurer stated that their TPA rejected the claim on 25.3.2006 and the complainant appealed to their RO only in 09/2007. They contended that only one year time is allowed for appeals and that the complainant forfeited his rights under the policy. The TPA's letter dated 25.3.2006 clearly mentioned about the appeal provisions and the complainant could not give any acceptable reasons for not making an appeal within the permitted period. The complainant also admitted that his wife underwent treatment for heart ailment in 12/1996. The insurers stated that as per the insurance all heart related ailments are excluded from the scope of the policy. The complaint was not allowed.

Hyderabad Ombudsman Centre
Case No.G-11-004-0350
Sri Shyam Rao Rathod
Vs
United India Insurance Co. Ltd.

Award Dated : 10.3.2008

Brief facts: Sri Shyam Rao and his family were covered under a Group Medi Claim policy 'Andhra Bank Arogyadan' for the period from 15.4.06 to 14.4.07. The sum insured was Rs.1,00,000 on a floater basis for the family. His son Master Abhinav Rathod was admitted to Sai Vani Hospital, Hyderabad on 24.7.2006 with complaints of cough, sputum, fever which was diagnosed as Pneumonia-right side. The insured's request for cashless facility was declined by the TPA, M/s Family Health Plan Ltd. The claim preferred by the complainant for Rs.96,024/-was rejected by the insurer/TPA on the plea that the disease was a pre-existing one. The present complaint is a sequel to the rejection of the claim.

Decision: According to the complainant, his son was healthy at the time of joining the policy and he had fever only for 8 days prior to the admission into Sai Vani hospital. He also contended that had the disease been a pre-existing one, his son would not have survived for such a long period without treatment.

According to the contentions of the insurer, the insured was suffering from fever on and off for eight months and the insurance policy was in force for about three and half months only at the time of claim.

As per the hospital case sheet, “H/o fever since 8 months” was recorded as a part of case history. The complainant stated that the hospital notes were prepared without his knowledge. During the hearing, the complainant was advised to show the treatment papers. As per treatment papers, the first consultation was on 18.7.06, followed by consultations on 21.7.06 and 24.7.06. On the day of final consultation, the patient was advised hospitalisation in to Sai Vani Hospital. The TPA also sought an expert opinion which reads as follows: “This is definitely an acute condition and there is no evidence of any pre existing disease. Neurosis of pluma can occur within two weeks”. It was observed that the TPA after obtaining an expert opinion has not reconsidered the claim, which they ought to have done. As the insurers have not proved that the disease was pre existing, they were directed to settle the claim.

Hyderabad Ombudsman Centre
Case No.G-11-004-0402
Smt. Silvy K. Wilson
Vs
United India Insurance Co. Ltd.

Award Dated : 10.3.2008

Brief facts : Sri. Wilson and his family were covered under a group medi claim policy, covering the members of Unique Mercantile India Pvt. Ltd. The period of insurance was from 30.9.06 to 29.9.07 and the sum insured per person was Rs.50,000/-. A claim for Rs.27,261/- was lodged on account of the hospitalisations of Smt. Wilson for treatment of viral fever and pneumonia and of their son. The claim was rejected by the insurer stating that the hospital where treatment was taken did not fall under the definition of hospital mentioned in the policy and hence the claim was not admissible. Aggrieved, the complainant filed the present complaint and sought a relief of Rs.27,261/-.

Decision : She contended that initially the insurer offered to settle the claim, but later the claim was rejected. She stated that the company denied her claim intentionally.

According to the insurer, the case was enquired into by a professional investigator who reported that the hospital is not maintaining any in-patient register. They also pointed out that the bills were given on the letterhead of the hospital and the hospital had only two beds. They contended that the hospital did not meet the requirements stipulated in the policy. They added that there was no 24 hour care for the patients. On a perusal of the insurance certificate, it was found that Clause 2.1 stipulates that the hospital should have at least 10 beds in ‘C’ class towns to qualify for benefit under the policy. After examining the contentions of both sides, it was decided to reject the complaint.

Hyderabad Ombudsman Centre
Case No.G-11-010-0351
Sri Shankar Singh
Vs

Iffco Tokio General Insurance Co. Ltd.

Award Dated : 10.3.2008

Brief facts : Sri Shankar Singh was insured under a group medial insurance policy covering members of Golden Multi Services Club. The sum insured for medical cover was Rs.25,000 and the period of insurance was from 15.1.2007 to 14.1.2008. He was admitted to Remedy Hospitals, Hyderabad on 18.5.2007 with complaints of high fever, chills etc. He was diagnosed to have LRTI and was treated for the same up to 22.5.2007. A claim for Rs.13,390/- was lodged with the insurers. The claim was rejected by the TPA, M/s Paramount Health Services (P) Ltd., stating that the nature of ailment was chronic.

Decision : The complainant contended that his ailment was not a chronic one. During the hearing, the insurer's representative told that the master policy is being serviced at Kolkatta and assured that they would settle the claim.

Having heard both sides, it was felt that the insurer should have settled the claim in the initial stage itself. The insurer was asked to settle the claim within one month from the date of the order.

Hyderabad Ombudsman Centre
Case No.G-11-03-0317
Sri K. Umashankar Rao
Vs
National Insurance Co. Ltd.

Award Dated : 31.3.2008

Brief facts : Sri Umashankar Rao, an employee of Axis Bank was covered under a group medi claim policy obtained by his employer for the period 1.10.2005 to 30.9.06 from National Insurance Co. Ltd. He was admitted to Apoorva Hospital, Visakhapatnam on 24.10.2005 with complaints of change of voice and was discharged on the next day. His ailment was diagnosed as vocal cord palsy. He submitted claim papers in 12/2005 but his claim for Rs. 22,791/- was not settled. Sri Rao approached the RO of the insurer but his grievance was not attended to and hence he approached this office.

Decision : According to the doctors of the TPA of the insurer, hospitalisation of the insured was not required for the ailment reported. The TPA doctors were of the opinion that the insured was not given any treatment and only diagnostic tests were conducted during hospitalisation.. These tests could have been conducted in OPD itself, they felt.

The complainant submitted that he did not receive any letter rejecting his claim. He further stated that he was admitted into the hospital as he could not speak and only after diagnostic tests, his ailment was diagnosed as vocal cord palsy. The insurer's representative submitted that they received a claim for Rs.14,307/- only and the second bunch of bills for Rs.8484/- was not received by them. He pointed out that in the bills claimed only Rs.550/- accounted for room rent and the remaining amount was towards diagnostic tests and medicines purchased from outside the hospital. During hearing, the insurer's representative submitted that the claim was rejected by their TPA on 4.3.2006 and a rejection letter was sent. But as seen from record the TPA sent it to an incorrect address of the insured. This has led the insured to believe that the claim was still in process. The TPA and the insurers did not respond to the insured's reminders. The complainant was in hospital for a day and underwent tests/ assessment of various ailments. Though technically the policy excludes this type of expenses, considering the facts of the case and the deficiencies noticed on the part of the

Insurer/TPA in communicating their decisions, an ex gratia of Rs.5,000/- was awarded. The claim was partly allowed.

Hyderabad Ombudsman Centre
Case No.G-11-002-0428
Sri P. Bhaskara Rao
Vs
The New India Assurance Co. Ltd.

Award Dated : 31.3.2008

Brief facts : Sri Bhaskara Rao, a retired officer of LIC was covered along with his wife under the group medi claim policy obtained by LIC from the insurer. Smt. Padmavathi, wife of Sri Bhaskar Rao was admitted to Yashoda Hospital, Hyderabad on 23.10.2006 with complaints of lower back pain which was diagnosed as lumbar disc disease. She was discharged on 25.10.2006 after treatment. Sri Rao claimed an amount of Rs.23,739/- from the insurer as hospitalisation expenses and Rs.3909/- as post hospitalisation expenses. The insurer settled the claims for Rs.21,625/- and Rs.3,121/- respectively. Sri Bhaskar rao represented to the insurer several times for payment of the balance amount of Rs.2114/- and Rs.788/- but there was no response and hence this complaint.

Decision : The complainant stated that the insurer had not given him any reasons for disallowing a part of the claims. During the hearing the insurer's representative stated that they disallowed admission fee of Rs.200; Medical Administration charges of Rs. 63/- and allied expenditure of Rs.1850/-. As per standard procedure of claim settlement the admission fee and expenses which are not specific can be disallowed. From the submissions made by the insurer's representative it was observed that a part of the room rent claimed by the complainant was disallowed under the presumption that they are non medical expenditure. The expenses on medicines up to 60 days amounting to Rs.280/- are also to be paid. The insurers were directed to pay an amount of Rs.2130/- to the complainant, which were wrongly disallowed earlier. The complaint was partly allowed.

Hyderabad Ombudsman Centre
Case No.G-11-010-0420
Sri K. Narayana
Vs
Iffco Tokio General Insurance Co. Ltd.

Award Dated : 31.3.2008

Brief facts : Sri K. Narayana was covered under a group medishield policy issued to the members of the Golden Multi Services Club Ltd., for the period from 31.3.2006 to 30.3.2007. The sum insured was Rs.15000. The insured was admitted to Pragathi Cardiac Centre, Nizamabad on 26.10.2006 for coronary artery disease. He was treated and discharged on 29.10.2006. The claim papers along with bill were submitted to M/s Paramount Health Services Pvt. Ltd., the TPA of the insurer. The TPA closed the file without settlement for non submission of original bill and other information regarding history of hypertension, diabetes etc. The TPA issued a letter dated 25.3.2007 informing about closure of the file. Upon representation together with certificate from hospital, the insured still did not receive the claim.

Decision : The complainant contended that he never received any communication from the TPA to his representation. He sought a relief of Rs.7645/- from the insurer. The insurers stated that the insured is a known diabetic for three years and in the opinion

of their doctors, coronary artery disease has a direct relation to the insured's pre-existing disease. Hence they did not settle the claim.

From the records it was observed that the hospital bill was given on a letterhead and there was no proper discharge summary. But the fact remains that the insured was treated for three days in the hospital. The insurer's contention that existence of DM was the cause of coronary artery disease is not supported by any conclusive medical evidence or opinion. Hence, it was decided to allow an ex gratia payment of Rs.5,000/-.

Hyderabad Ombudsman Centre
Case No.G-11-004-0369
Sri H. Viswanatha Rao
Vs
The United India Insurance Co. Ltd.

Award Dated : 31.3.2008

Brief facts : The complainant filed this case claiming a relief of Rs.12,369/- following non settlement of medical claim by the insurer. Sri Rao and his wife were covered under the 'Cancomfort' group policy issued to the holders of Canara Bank's credit cards for the period 1.11.2006 to 31.10.2007. Smt. Savitri underwent eye treatment at Nethrdham Eye Hospital, Bangalore in 06/2007 and a claim for Rs.12,369.68 was lodged with M/s Medi Assist India Pvt. Ltd., the TPA of the isnurer. The claim was rejected by the TPA on 22.10.2007 stating that the treatment undergone by Smt Savitri did not warrant hospitalisation. Aggrieved by the decision of the insurer, the complainant approached this office.

Decision : Sri Rao stated that his wife underwent treatment in a network hospital and the treatment was taken as per doctor's advice. Smt. Savitri was under treatment at the same hospital since 2004 and drops and ointment were administered. In 06/2007, for her complaint of dry eyes, she underwent eye assessment and 'Smart 2 Plugs' were inserted. Sri Rao stated that they are under medi claim cover for about 10 years and that this was her first claim.

The insurers stated that the treatment could be done under OPD. They contended that the dry eye assessment on 5.6.2007 and insertion of plugs on 22.6.2007 were done as out patient under OP No.20536. The bill for Rs.10,000/- was also for OP No.20536. They also submitted that there was no surgical procedure involved in the treatment taken and there was no hi-tech procedure involved to qualify for reimbursement as per policy conditions.

From the record it was observed that hospital bills dated 26.5.07, 5.6.07 and 22.6.07 were under OP No.20536. The discharge summary also did not give any inpatient No. and it was found to be not in the format usually expected from reputed hospitals. The complainant elected to remain absent in the hearing session. Considering the advanced age of the insured and treatment taken from a Network Hospital, it was decided to allow an ex-gratia payment of Rs.7500/-.

Hyderabad Ombudsman Centre
Case No.G-11-003-0443
Sri A.S. Murty
Vs
National Insurance Co. Ltd.

Award Dated : 31.3.2008

Brief facts : Smt. Padma Laxmi along with her parents Sri A.S.Murty and Smt. Laxmi Murty was insured under a group health policy covering M/s Philips Electronics' employees and their families for the period from 1.4.07. Smt. Laxmi Murty underwent treatment for Osteoarthritis of both knees from 23.10.2007 to 12.11.07 at SBF Health Care Pvt. Ltd., Bangalore incurring Rs.50,000. A claim was lodged with M/s TTK Health Care Pvt. Ltd., TPA for the insurer. The claim was not settled and hence the present complaint.

Decsion : Sri Murty conveyed that his wife underwent RFQMR (Rotational Field Quantum Magnetic Resonance) treatment and it was not a magnetic or Natural Therapy. He also stated that a similar claim was settled by M/s New India Assurance Company Ltd.

The insurers contended that the treatment undergone was for a period of 21 days through routine day-care sessions of 60 to 90 minutes in OPD and that the treatment does not require hospitalisation as in-patient. The insurer's representatives relied on policy conditions and contended that the treatment taken by Smt Laxmi did not qualify for reimbursement under the policy in view of the clauses pertaining to treatment being taken as in-patient as defined in the policy. He added that for a valid claim to arise the necessity for hospitalisation needed to be established and the treatment should have been at a hospital as defined. They added that SBF Health Care Pvt. Ltd had not answered question relating to number of beds and availability of doctor/ nurse round the clock.

It was held that while the policy provides for payment of expenses incurred on hospitalisation as defined, the treatment taken by Smt. Murty for 21 days on day care basis was not falling within the limited scope of the given policy. The complaint was dismissed.

Kochi Ombudsman Centre
Case No. : IO/KCH/GI/11-002-198/07-08
Sri.T.N.Surendran
Vs
The New India Assurance Co.Ltd.

Award Dated : 14.11.2007

The complaint falls under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998. The employer of complainant, LIC of India, had taken a group medi claim tailor made policy covering their employees and dependents. While so a claim was raised by the complainant for a sum of Rs.16500/- towards hospital expenses of his son who is aged 29. The claim is repudiated by the insurer on the ground that his son is aged 29 and only dependent children upto age 21 is covered under the policy. He has submitted that once the recovery of premium was stopped on attaining 21 years of age, and AO told that on paying full premium cover can be extended to his son also and hence recovery of premium again started w.e.f. March 2006. He has also submitted that had it been informed him earlier, he would have taken policy from another insurer.

It was submitted by insurer that as per policy condition only male children upto 21 years is covered under the policy (upto 25 years, if pursuing whole time studies). As per practice LIC is paying premium in full in advance in the month of March every year and collecting the premium from the employees in instalments. Enrolment forms are collected by LIC and sent to claim settling offices. The verification of enrolment forms are done only at the time of claim. Here in this case recovery of premium was made by

LIC that too only after affecting insurance and policy is issued in favour of LIC. The employees are only beneficiaries. The policy condition is very specific that only dependent children upto age 21 is covered under policy. There is no dispute to the fact that the dependent children is aged 29. On account of deduction of premium by employer only he will not be entitled to get cover under the policy. As the premium was collected by employer, the employer is responsible for wrong collection. The liability of a person who has mistakenly collected money from another is only to return the same. It is to be noted that the employer had refunded the premium wrongly collected by them. Also there is no point in the submission that he would have taken a policy from some other insurance co. He has stated that premium was stopped on completing age 21 and thereafter recovery was made only from March 2006. This means that there was no insurance coverage for his son aged 29 for about 8 years. Hence this Forum is of the opinion that repudiation by insurer is correct and complaint is therefore dismissed.

Kochi Ombudsman Centre
Case No. : IO/KCH/GI/11-002-229/07-08
Smt.H.Meenakshi Jyothi
Vs
The New India Assurance Co.Ltd.

Award Dated : 15.11.2007

The complaint falls under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998. The complainant is an officer of LIC of India, who is covered under a group medical policy taken by LIC. She was admitted in KVM Hospital on 15.2.07 for MTP and discharged on 17.2.07. The claim was repudiated by the insurer and aggrieved by this she approached this Forum for justice.

The insurer repudiated the claim on two grounds. As per policy condition claim in respect of only first 2 deliveries are covered under the policy. The complainant already having 2 children, no more maternity expenses can be payable under the policy. Also voluntary MTP is excluded from the coverage of policy. Hence they are justified in repudiating the claim. In the complaint it is stated that MTP was done on the advice of doctor that continuation of pregnancy would be harmful to the foetus as there was heavy intake of medicine after an accident and hence it was not voluntary done, but only on account of advice of treating doctor and hence she is entitled for the claim.

As per Cl.4.10 of policy condition voluntary termination of pregnancy is not covered under policy. The contention of complainant is that medical termination was not done voluntary but due to compelling reasons. As she has taken drugs excessively following an accident, it will be harmful to foetus and hence MTP was done. But it is relevant to note that no where in discharge summary or medical report difficulty to foetus was mentioned. It simply states that pregnancy with drugs taken whether it effected foetus has not at all mentioned. There is no findings as to the condition of foetus. Also nowhere it was stated that drugs taken were harmful to foetus. Had any ailment been developed necessitating termination of pregnancy it would have been a termination under compulsion. But there is no case of having developed such an ailment. Hence it can be seen that this is a case of voluntary MTP. The complainant is having 2 children already, maternity expenses are also not payable. It can be seen that she has also undergone tubectomy, but tubectomy also is excluded as per policy conditions. The complaint is therefore devoid of merit and hence dismissed.

Kochi Ombudsman Centre

Case No. : IO/KCH/GI/11-002-204/07-08
Sri.K.Raghavan
Vs
The New India Assurance Co. Ltd.

Award Dated : 15.11.2007

The complaint falls under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998. The complainant being a retired LIC Officer, he along with his wife is covered under a Group medi claim policy issued to LIC. While the policy is in force, his wife Smt.Kasthuri undergone treatment for Filariasis from 15.7.06 to 29.7.06 at Institute of Medical Science. After treatment he had applied for reimbursement of Rs.23237/14 spent by him. Insurer sanctioned only Rs.14480/-. Aggrieved by this the complainant approached this Forum.

The contention of the insurer is that the entire bill is not payable in toto as the treatment was not taken in a hospital registered under local authority and also system of treatment was a new one. The system of treatment was a unique one comprising of Allopathy, Ayurvedic, Homeopathy and Naturopathy. They have allowed claim in respect of Allopathy and Ayurveda treatment and disallowed only expenses for Homeo treatment and naturopathy treatment.

The treatment was taken from Institute of Medical Science and Institute of Dermatology. In the explanatory note issued by Institute of Medical Science it is stated that the treatment given was a unique integrated treatment protocol comprising of Ayurveda, Homeo, Allopathy and Naturopathy, Yoga, Physiotherapy etc. The amount disallowed were Rs.1125/- for yoga therapy, Rs.4500/- procedural charges, Rs.100/- patient information sheet, Rs.3000/- Homeopathy consultation, Rs.50/- admission charge, Rs.70/- miscellaneous charge. As per exclusion clause 1(d) of policy condition non-medical charges like patient information sheet, admission charge, miscellaneous charge etc. are not payable. In the explanatory note given by the Institute of Medical Science, nature of treatment consisting of procedure charge appear to be of naturopathy. As per exclusion clause 4.13 naturopathy treatment is excluded from the policy. Hence yoga therapy and procedure charges also are not payable. Then the only question is whether Rs.3000/- for homeopathy consultation is payable. In the explanatory note it is stated that oral medicines are prescribed as and when required and in the present case no homeopathic medicines are given as it was found not necessary. Hence the amount of Rs.3000/- is not for administering any homeopathic medicine and only for consultation. But no homeopathic treatment was imparted. As per policy condition what is liable to be reimbursed only the expenses incurred for treatment as IP. As no homeopathic treatment was imparted this amount is also not payable. Hence this Forum is of opinion that partial repudiation by insurer is correct and the complaint is therefore dismissed.

Kochi Ombudsman Centre
Case No. : IO/KCH/GI/11-004-178/2007-08
Sri.Alex K Ipe
Vs
United India Insurance Co. Ltd.

Award Dated : 11.12.2007

The complaint falls under Rule 12(1)(b) read with Rule 13 of the RPG Rules 1998. The complainant was having a group medi claim policy covering himself and his family members from 8.9.04 to 8.6.06. During December 2005, his daughter met with an

accident suffering fracture and other injuries. The claim raised was admitted by the insurer. But during the treatment a steel rod was implanted which is to be removed after one year. For removal of this rod she was admitted to hospital on 16.1.07. But by the time the policy was lapsed, and it was revived only w.e.f. 12.7.06 after a break of 34 days. The claim was repudiated on the ground that the policy issued after revival was a new one and not a continuation of existing policy as there is a gap of 34 days. The treatment is for a pre-existing ailment.

The complainant has submitted that the delay in renewing the policy was due to the fault of insurer. They have not issued any renewal notice. Also he has not raised any claim during the period for which the policy was not in existence. The fact that the policy was lapsed and renewed only after 34 days of lapse was not disputed by the claimant. As there is a gap of 34 days in renewing policy, the renewed policy can be treated as a new policy only . The treatment taken was for removing a rod implanted before renewal of policy. Hence the treatment is for a pre-existing illness. As policy condition is very specific about its exclusion clause the repudiation is on valid ground and it has to be upheld. The complaint is therefore dismissed.

Kolkatta Ombudsman Centre
Case No. 010/11/003/NL/04/2007-2008
Shri Somnath Samanta
Vs.
National Insurance Co. Ltd.

Award Dated : 14. 12.2007

Facts & Submissions :

This petition was filed against partial repudiation of a claim under Group Mediclaim Policy of Golden Multi Services Club Ltd. issued by the National Insurance Co. Ltd.

The petitioner, Shri Somnath Samanta stated that he took a Mediclaim Policy from National Insurance Co. Ltd., Division – III, through Golden Multi Service Club Ltd. with a sum insured of Rs.20,000/- each for self and his mother Smt. Lakshmi Rani Samanta. The petitioner preferred a claim with National Insurance Co. Ltd., D.O.-III for the operation of Cataract R.E. of his mother. But though he had furnished all the necessary information and papers to the insurance company's TPA M/s. Family Health Plan Ltd., they rejected the claim vide their letter dt.28.04.2006 for delay in submission of the claim documents. After repudiating the claim the petitioner submitted representation to the insurance company on 17.02.2007, explaining the cause of his unintentional delay in submission of the essential papers. The complainant also stated that his mother had an eye cataract operation and there was no one to take care of her. Moreover, collecting of all documents for submission of claims depends on organizations/medical practitioners on whom he had no control and therefore the delay was issued to him does not mention the time limit by which the complainant was expected to submit the required documents and in absence of such information and as a lone member in his family he was unable to submit the documents in time. Therefore, the insurance company should have considered his claim but as the insurance company did not pay his claim, the complainant filed this petition for relief of Rs.6,079/- plus interest and cost.

The insurance company did not submit any self-contained note.

Decision :

This office considered the facts and submissions of the case as well as the materials available on records. Since the insurance company did not have any documentary

evidence to prove that the claim papers had been submitted to the TPA by the complainant beyond 90 days, this office presumed that the claim papers had been submitted to the TPA well within 90 days, as per the policy conditions. However, the TPA of the insurance company gave a letter to the complainant on 28.4.23006 repudiating the claim on a mere technical ground for delay in submission of the claim papers. Since these two facts could not be reconcilable at this stage, Hon'ble Ombudsman opinioned that the benefit of doubt should go to the complainant and accordingly, this office held that the claim was payable and directed the insurance company to pay the claim.

Mumbai Ombudsman Centre
Case No. : GI-605 of 2006-2007
Shri Navin R. Gangawane
Vs
United India Insurance Company Limited

Award Dated : 10.10.2007

Shri Navin R. Gangawane, was covered under the Group Mediclaim Policy of United India Insurance Company Ltd., taken through Unique Mercantile India Pvt.Ltd., Nasik for Sum Insured of Rs.15,000/-. He was hospitalized from 1.3.2005 to 10.3.2005 in National Accident & Gen. Hospital for treatment of Neck pain, < movements, bending, backache, generalized weakness, bodyache and as per the discharge card the diagnosis was Pelvic Inflammatory Disease.

When he lodged a claim with the company through Mercantile India Pvt.Ltd. the Company repudiated the claim vide letter dated 23rd November, 2005 and the TPA of the Company, Heritage Health Services Pvt.Ltd., repudiated the claim on 20.11.2006 stating that the patient was admitted for Pelvic Inflammatory Disease but as per opinion of Panel Doctor, the mentioned disease cannot happen to a male patient. Thus the claim is proved to be more of adjustments. Hence, they regretted their inability to settle the claim as it did not fall within the ambit of the Group Mediclaim Policy and treated it as No Claim.

Not satisfied with the decision of the Company, Shri Gangawane, approached the Ombudsman vide letter dated 8.12.2006 for intervention in the matter of settlement of his claim. He also represented to the company vide letter dated 22.3.2007 alongwith a certificate from Dr. Haeeb Shaikh, treating Doctor of National Accident & General Hospital, that the short form of PID ("Prolapse Intervertebral Disc" had been elaborated wrongly by the Resident Doctor in the discharge card & annexure III of Mr. Navin Ramakant Gangawane.

The company vide letter dated 7.12.2007 informed this Forum that the claim was rejected on 2.11.2005 on the ground that 'Pelvic Inflammatory Disease' cannot happen to a male patient. Now even though, it is taken as 'Prolapsed invertible disec' and it is wrongly written in 2 or 3 hospital records, they sought the opinion of their Panel doctor about the other aspects of the medical treatment and whether it really necessitates hospitalization and he is of the opinion that the treatment could have been done on OPD basis and needs no hospitalization on the following grounds:

1) Under the column 'findings' in discharge summary the treating doctor has simply given SLR + instead of giving the exact degree for each leg which will explain the intensity of disease.

2) Both physiotherapy and traction can be given on OPD basis.

3) No MRI done, which is necessary to confirm the cause of backache.

Hence they regretted their inability to reopen and entertain the claim.

Parties to the dispute were called for an oral deposition at a Hearing Camp held at Nasik on 20.9.2007. Shri Navin R. Gangawane appeared and deposed before the Ombudsman. He submitted that he was a member of Group Mediclaim Policy taken through Unique Mercantile

As per the discharge summary of Smt. Kamladevi Mittal Ayurvedic Hospital the diagnosis was Karigath Vath with Stholia. As per the clinical note from the Physician of Mittal Ayurvedic Hospital, the main complaints were severe backache, generalized weakness, dribbling urination, dyspnoea and whitish discoluration with pruritis over palms and feet. As such the patient was admitted in the hospital for Panchkarma treatment.

It is important to note that the contents of the mediclaim policy with all its terms and conditions should be read comprehensively to appreciate that certain treatment of this nature are covered or not under the mediclaim policy.

It is a fact that any treatment which could be obtained in house without getting admitted to hospital would be normally without any criticality or emergency situation, it would be coming under the exclusion clause.

The treatment received in this case at the hospital were ayurvedic medication, mixture and massage with oil. From the line of treatment, it is evident that for such oil massage treatment therapy, there is no need for hospitalization and one could avail package of such continuous treatment without admission to the Hospital. Such treatment cannot be obtained even on domiciliary hospitalisation since as per condition 2.4 of the Mediclaim policy domiciliary hospitalisation would be granted only when the condition of the patient would be such that he/she cannot be removed to the hospital/nursing home or a patient cannot be removed to the hospital or nursing home for lack of accommodation therein.

Going by the scope of the cover of mediclaim insurance policy it clearly says that upon the advice of a duly qualified physician/ medical specialist/ medical practitioner if expenses are incurred due to hospitalisation for medical/surgical treatment at any nursing home /hospital in India as an inpatient it would be payable.

This Forum had asked the complainant to submit the pre-hospitalisation and the report/treatment taken by Smt. Dedhia on 14.3.2004 and 20.10.2005 respectively have been submitted to this Forum which does not have any relevance to the hospitalization at Mittal Hospital.

The remarks of the MRI Spine Report dated 21.5.2006 taken after getting admitted Mittal Ayurvedic Hospital was as follows:

“The MRI spine showed an asymmetric post central herniation of L4L5 disc indenting the thecal sac and touching the right L5 nerve root. Mild ligamentum flavum hypertrophy was seen at this level but without significant canal compromise”.

On analyzing the records, it is noted that it was a conscious move by Smt. Dedhia to avail the treatment from Mittal Ayurvedic Hospital. Unfortunately under the terms of the Mediclaim policy this would fall under clause 4.10 where hospitalisation is not justified due to any serious emergency health status. The line of treatment given to Smt. Dedhia could be performed as an outpatient with proper advice and instructions. The Hospitalisation was not justified looking to the line of treatment given and the entire

treatment was of conservative nature which did not require any critical monitoring of health status. Accordingly, the decision of the Company to reject the claim on the ground that it does not warrant hospitalization for 30 days and could have been taken under OPD basis is therefore, sustainable.

ORDER

The claim of Smt. Chanda Dedhia, for the expenses incurred by her at Mittal Ayurvedic Hospital, for arthritis is not sustainable. The case is disposed of accordingly.

Mumbai Ombudsman Centre
Case No. : GI-315 of 2007-08
Shri Swapnil S. Tandel
Vs
United India Insurance Co. Ltd.

Award Dated : 02.11.2007

Shri Swapnil S. Tandel alongwith his father, Shri Suresh A. Tandel and mother, Smt. Usha S. Tandel were covered under the Group Mediclaim Policy No. 021800/48/023/2004 issued by United India Insurance Co. Ltd. to Unique Mercantile Services Pvt. Ltd. for sum insured Rs.75,000/- each for the policy period from 30.06.2005 to 29.06.2006. Smt. Usha S. Tandel was admitted to Arihant Heart Clinic with Chest Pain – Ischemic Heart Disease and Diabetes Mellitus. A claim for Rs.20,169/- was submitted to the Company. The Company settled the partial claim of Rs.16,085/-, disallowing 20% of the claimed amount.

Analysis of the case reveals that Smt. Usha S. Tandel was admitted to Arihant Heart Clinic from 06.05.2006 to 09.05.2006 with Chest Pain – Ischemic Heart Disease and Diabetes Mellitus. The Clinical Features in the Discharge Summary reveals – H/o chest pain with heaviness on exertion relieved on rest since 2 hours. H/o Dyspnoea on exertion relieved on rest. H/o Loss of appetite and headache. H/o DM on regular treatment well controlled. The special Instruction sheet of the hospital shows that the patient was given T.ablet Met, Tablet Enagril and Tablet Ombimex to control her diabetes. It is evident from the discharge summary that Smt. Ushal S. Tandel had a history of Diabetes Mellitus and was also given the above tablets to keep her diabetes in control. The Complainant had maintained in the hearing that his wife had no history of diabetes inspite of the fact that the hospital had recorded k/c/o DM & on Rx. The Company has disallowed 20% of the claim in view of the history of DM. The complainant has submitted that first medical policy was taken in 1995 but there is no proof on record for continuity of the policy without break. The policy on record submitted to us is for 30.06.2002 to 30.06.2005, for sum insured of Rs.75,000/- and the claim has arisen in May 2006. Thus it has not been proved that DM was before the inception of the policy. In the absence of any proof/history record in the inpatient record sheet, to prove DM as pre-existing, it is an arbitrary decision on the part of the Insurer to disallow 20% of the claim. In view of this, the benefit of doubt goes in favour of the Complainant.

Under the circumstances, the Insurer is directed to pay the balance amount deducted on ex-gratia basis to settle the dispute.

Mumbai Ombudsman Centre
Case No. : GI-224 of 2007-08
Shri Yash Nimdia

Vs

ICICI Lombard General Insurance Co. Ltd.

Award Dated : 22.11.2007

Shri Yash Nimdia & his wife Smt. Sonu Nimdia are employees of Tech Mahindra Ltd., Pune, and they are covered under Group Policy No.4016/0000587/01 from ICICI Lombard General Insurance Co. Ltd. They have a Health Card No. PUN – IL – T333-01-11721-A. Smt. Sonu Nimdia was admitted in Pune Hospital for an emergency Encircalage Cervix operation from 13.03.2007 to 14.03.2007. Shri Yash Nimdia submitted a claim to the Company for an amount of around Rs.17,000/-. The TPA, M/s. TTK Health Care settled a partial claim of Rs.10,000/- stating that as per the guidelines of the Insurer, the maternity limit is Rs.50,000/- and they have made a payment restricted to Rs.10,000/- as Smt. Sonu Nimdia had taken a luxury room. Shri Yash Nimdia represented his case to the Insurer by his various e-mails, but the Company stood their stand. Aggrieved by the partial payment of his claim, Shri Yash Nimdia approached the Office of the Insurance Ombudsman for intervention in the matter.

After perusal of the records, the parties of the dispute were called for a hearing on 06.11.2007 at 10.00 A.M. at camp Pune.

A joint hearing was to be held with the representative from ICICI Lombard General Insurance Company Ltd. and the Complainant. However, as the complainant did not turn up for the hearing deposition of representative of the Company was taken.

Shri Vishal Jain, Legal Manager, ICICI Lombard General Insurance Company Ltd. attended the hearing. He submitted a letter to the Insurance Ombudsman, dated November 06, 2007 stating that the Company is settling the claim and paying the customer the outstanding amount as per the policy terms and conditions. Amount claimed by the customer is Rs.6,796/-. They have requested us to consider the matter as settled and closed.

Since the Company has agreed for payment of the balance claim amount, we may treat the complaint as closed.

Mumbai Ombudsman Centre

Case No. : GI-140 of 2007-2008

Shri Atul Chandiya

Vs

The ICICI Lombard General Insurance Co.Ltd.

Award Dated : 03.12.2007

Shri Atul Chandiya was a member of the Group Health Policy issued to Kotak Mahindra Old Mutual Life Insurance Limited, and the Sum Assured was Rs.300000/- per employee Shri Chandiya, was hospitalized for Cervical Pain x C5-C6 Herniation. When Shri Chandiya preferred a claim towards the expenses incurred by him towards the above hospitalization, the TPA of the Company, repudiated the claim , on the ground that “the admission was primarily for evaluation of symptoms and no active line of treatment requiring need for hospitalization has been given.” Then Shri Chandiya approached the Insurance Ombudsman and sought justice.

Both the parties were given an opportunity to present their case at the personal hearing on 30.11.2007. The complainant did not turn up for the hearing . The ICICI Lombard General Insurance Company Representative submitted that as per the discharge card, the hospitalization of the complainant seemed mainly for the purpose of investigation of symptoms and no active line of treatment requiring need for

hospitalization was given. Hence the claim was not paid as per clause 3(10) of the Policy Conditions.

Now, the pertinent issue that has to be analysed is how far the Company's contention that hospitalization was not required as no active line of treatment was given to the patient, holds ground. From the documents on record, it is observed that IFT to neck and shoulder was given on all the days of hospitalization. Also, physiotheraphy was given and the various tests including ECG, X ray chest, MRI Cervical spine etc were done for arriving at a proper diagnosis. Also, the patient was constantly administered medicines to keep the pain under control. As per Clause 3.10, the Company shall not be liable to make any payment under this policy in connection with or in respect of any expenses whatsoever incurred by any Insured Person in connection with or in respect of charges incurred at Hospital or Nursing Home primarily for diagnostic, x-ray or laboratory examinations or other diagnostic studies not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any diseases, illness or injury whether or not requiring hospitalization/domiciliary hospitalization."

It is very clear in Shri Chandiya's case that the diagnosis and treatment happened in the hospital and investigations were conducted for further evaluation and Shri Chandiya was prescribed medicines and physiotherapy also. The tests done were consistent with and incidental to diagnosis and treatment of positive existence of a sickness.

Hence, the Company's stand was not tenable.

Mumbai Ombudsman Centre
Case No. : GI-637 of 2007-2008
Shri Omprakash Agarwal
Vs
United India Insurance Co. Ltd.

Award Dated : 07.02.2008

Shri Omprakash Agarwal (Retired) was a staff member of the United India Insurance Co. Ltd. United India Insurance Com Ltd. had taken out a Group Mediclaim Policy No. 120700/83/07/0000000463 from The Oriental Insurance Company Ltd. Shri Omprakash Agarwal submitted two claims, one was for Laser treatment of Right Eye where the claim amount was Rs.13,296/- and the second was for his hospitalization for Cataract Intraocular lens implantation of Left Eye at Bombay Hospital on 17.05.2007 and the claimed amount was Rs.42,322/- Both treatments were taken from Dr. R.C. Patel. He submitted the total claim for Rs.62,664/- to the Company. The Company vide their letter dated 14.08.2007 settled the claim for Rs.33,168/- disallowing Rs.29,496/- stating that "the present claim includes all domiciliary treatment and medication. As per terms and conditions of the policy, the claim is payable in respect of this particular treatment is restricted to reasonable clause and accordingly we will be restricting the claim amount to Rs.33,168/- towards both the claims after adjusting the domiciliary treatment medicines paid earlier". Shri Agarwal represented his case to the Grievance Cell by his letter dated 13.09.2007. Not receiving the balance claim amount from the Company, Shri Agarwal approached this Forum for the intervention of the Insurance Ombudsman for settlement of his full claim.

Shri Omprakash Agarwal is a retired employee of the United India Insurance Co. Ltd. who is covered under the Staff Mediclaim Scheme for retired employees. This being an extended scheme for staff mediclaim for retired employees, the matter has to be

settled internally and does not fall within the purview of this Forum, as the complaint is against ex-employer and not against the Insurer. In view of this, the complaint is closed at this Forum.

Mumbai Ombudsman Centre
Case No. : GI-510 of 2007-08
Smt. Ila R. Desai
Vs
The New India Assurance Co. Ltd.

Award Dated : 18.02.2008

Smt. Ila R. Desai, retired employee of LIC Of India, was covered under the Group Mediclaim Policy of The New India Assurance Company Limited, Mumbai for a sum insured of Rs.3,00,000/-. Smt. Desai, was hospitalized at Dr. Balabhai Nanavati Hospital from 20.9.2006 to 21.9.2006 for Breathlessness for which she lodged a claim with the company for an amount of Rs.25,276/- & Rs.1,624/- (Post Hospitalisation claim).

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 only for investigation purpose, which does not require hospitalization as only medicines were administered and no active treatment was given and the same could have been done on OPD basis. Hence the claim was repudiated under Exclusion Clause 4.10 of the Mediclaim policy vide letter dated 15.1.2007 and her subsequent claim for follow up treatment was also repudiated as the main claim itself was not payable.

Not satisfied with the decision of the Company, Smt. Ila Desai, approached the Ombudsman stating that both her claims were rejected by the company and proper justice has not been meted out to her in consideration of her claims and, therefore, sought intervention in the settlement of his claim with the company.

On an analysis of the records, it is noted that she gets frequent attacks of breathlessness for which she normally consults her Cardiologist for regular check-ups and since it was severe on 15th September, 2006, when she approached Dr. Akshay K. Mehta, Cardiologist, he advised her to get admitted under his care, but she got herself admitted only on 20th September, 2006 after a gap of 5 days. Although she has stated that no bed was available, she has not produced a certificate from the hospital to that effect and had there been an emergency, she could have been taken to another hospital. She was already suffering from Diabetes, Hypertention and was on Pacemaker. During her hospitalization, all tests and investigations carried out pertained to her complaint. However, it is evident that there was no emergency for hospitalization in view of the fact that she got admitted after five days and only investigations and tests were carried out during hospitalisation and she was discharged on the following day without any active treatment. Hence the decision of the company to repudiate the claim under Exclusion Clause 4.10 stating that the same could have been done on OPD basis is tenable.

In the facts and circumstances, I have no ground to interfere with the decision of the Company.