GENERAL INSURANCE ---MEDICLAIM -SYNOPSIS -FROM 1-4-2014 TO 30.9.2014
AHMEDABAD OIO

Case No.AHD-G-047-1314-0439

Mr. Bhavesh M Patel Vs. Tata AIG General Insurance Co. Ltd.

Award dated 7th April 2014

Repudiation of Mediclaim

Complainant was covered a hospital Indemnity for Sickness – Daily benefit policy and hospitalized for treatment of Enteric Fever for 5 days and claimed Rs.31,500/- was repudiated by the Respondent as per medical records and opinion of an independent doctor.

On scrutiny of available documents, the claim is not admissible as per policy provisions. Thus complaint dismissed.

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Case No. AHD-G-051-1314-0455

Shri Hasmukhbhai D. Sanghvi Vs. United India Insurance Co. Ltd.

Award dated 7th April 2014

Repudiation of Mediclaim

Complainant's wife underwent cataract surgery and claim lodged for the expense was repudiated by the Respondent giving reason that the intimation was received late which is a violation of policy condition No.5.4.

Cataract operation is a planned treatment which should be informed to the Insurer in advance but the subject treatment is informed after discharge from hospital hence complaint dismissed.

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Case No.AHD-G-049-1314-0456

Shri Ankit P Patel Vs. The New India Assurance Co. Ltd.

Award dated 9th April 2014

Partial repudiation of Mediclaim

Complainant treated for accidental injury and expense incurred for Rs.67,448/- was partially settled by the Respondent for Rs.44,091/- by deducting an amount of Rs.23,357/- as per policy condition No.4.4.4.

On scrutiny of available documents proved the Respondent's decision to settle the claim partially is valid and proper hence complaint dismissed.

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Case No.AHD-G-048-1314-0392

Shri Nalinkumar R Shukla Vs. National Insurance Co. Ltd.

Award dated 9th April 2014

Partial settlement of Mediclaim

Complainant underwent cataract surgery and expense incurred for Rs.23,547/- was partially settled by the Respondent for Rs.19,000/- by deducting and amount of Rs.4,547/- as per PPN tariff.

Respondent produced a list of hospitals who were under PPN provider network.

In view of this complaint dismissed.

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Case No. AHD-G-049-1314-0458

Shri Narendra G. Patel Vs. The New India Assurance Co. Ltd.

Award dated 9th April 2014

Partial repudiation of Mediclaim

Complainant's Cataract surgery and expense incurred for Rs.57,400/- was partially settled by the Respondent for Rs.24,000/- by deducting an amount of Rs.33,400/- as per policy condition No.2.4.

Complainant argued that his previous claim was fully paid by the Respondent so the current claim also should be paid full amount.

Respondent has proved with evidences that the deductions of claim amount as shown in their written submission were valid and proper.

Thus complaint dismissed.

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Case No.AHD-G-050-1314-0464

Mr. Ranbirsingh M Bagga Vs. Oriental Insurance Co. Ltd.

Award dated 9th April 2014

Repudiation of Mediclaim

Complainant treated for Supra Umbilical Hernia with reverse Abdominoplasty and expense incurred for Rs.1,62,632/- was repudiated by the Respondent under exclusion clause No.4.19 of the mediclaim policy.

As per medical report, patient was underwent huge incision hernia for repair and bariatric surgery due to overweight before 10 moths treated as obesity.

In view of this complaint dismissed.

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Case No.AHD-G-050-1314-0459

Mr. Anil V. Modi Vs. Oriental Insurance Co. Ltd.

Award dated 9th April 2014

Repudiation of Mediclaim

Complainant's wife underwent Knee replacement operation and expense incurred for Rs.1,76,000/- was partially given cashless facility for Rs.1.00 Lac by National Insurance Co. under Group Mediclaim policy. Remaining amount of Rs.76,000/- was repudiated by the Respondent under exclusion clause No.4.3.

There was cap of four years for subject treatment whereas claim was in the second year of the policy.

Thus complaint dismissed.

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Case No.AHD-G-048-1314-0446

Shri Atul J Sharma Vs. National Insurance Co. Ltd.

Award dated 9th April 2014

Repudiation of Mediclaim

Complainant's son treated for Acute Pylonephritis and expense incurred for Rs.45,111/- was repudiated by the Respondent giving reason that the said ailment was due to Ectopic Kidney and it is considered as congenital disease which is under exclusion clause 4.8.

On scrutiny of available documents and treatment papers proved the patient was a known case of ectopic kidney which is congenital. Thus complaint dismissed.

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Case No. AHD-G-049-1314-0445

Shri Bajranglal R. Kedia Vs. The New India Assurance Co. Ltd.
Award dated 10th April 2014
Partial repudiation of Mediclaim

Complainant hospitalized for treatment of Chest infection+ Acute Respiratory distress etc. and expense incurred for Rs.1,23,675/- was partially settled by the Respondent for Rs.88,001/- by deducting an amount of Rs.35,674/- under various terms and conditions and exclusion clause No.4.4.21, 4.4.22, 2.6 & 6 (d) of the policy.

Respondent has proved with evidences that the deductions of claim amount as shown in their written submission were valid and proper.

Thus complaint dismissed.

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Case No. AHD-G-049-1314-0468

Shri Rashmikant J Mehta Vs. The New India Assurance Co. Ltd.
Award dated 10th April 2014
Partial repudiation of Mediclaim

Complainant covered S.A of Rs.1,00,000 + 22,500/-CB. Out of this his wife treated eye surgery in her both eyes and claimed Rs.44,882/- was paid by the Respondent. Remaining amount of Rs.77,618/- was S.A. Out of this amount Complainant claimed for treatment of his wife suffered Adenocarcinoma of right colon stage III A was partially paid on cashless basis for Rs.65,000/- and remaining amount repudiated on the ground of pre-existing illness.

On scrutiny of available documents, the Forum also denied the remaining amount of claim hence complaint dismissed.

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Case No.AHD-G-048-1314-0457

Shri Mayurkumar J Bhatt Vs. National Insurance Co. Ltd.
Award dated 10th April 2014
Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Paralytic attack-bell's Palsy and expense incurred for Rs.42,514/- was repudiated by the Respondent as per terms and condition No.4.3 of the mediclaim policy.

Complainant was having policy since 2008 but there was no continuity. As per record, the subject treatment was in the second year of the policy and history of HTN since 10 years.

In view of this complaint dismissed.

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Case No.AHD-G-050-1314-0465

Mr. Dineshbhai M. Patel Vs. Oriental Insurance Co. Ltd.
Award dated 10th April 2014
Repudiation of Mediclaim

Complainant's wife hospitalized three times for treatment of various diseases and claimed three different amounts was repudiated by the Respondent on the following grounds:

First claim – treatment was for Systemic Scleroderma which is genetic disorder can not be payable. Second claim repudiated as per policy clause No.4.10 and third claim also genetic disorder under exclusion clause 4.5 which is not payable.

In view of this complaint dismissed.

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Case No. AHD:G-051-1314-0467

Mr. Sanjay R. Shah Vs. United India Insurance Co. Ltd.
Award dated 10th April 2014
Repudiation of Mediclaim

Complainant's father underwent Cataract Surgery and expense incurred for Rs.25,249/- was repudiated by the Respondent on the ground of late intimation of claim to the Insurance Co.

Cataract surgery is a planned operation and hospitalization is only 2-3 hours are required hence intimation should be in advance whereas the complainant informed the Respondent after discharge from hospital.

In view of this Respondent's decision is upheld and complaint dismissed.

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Case No.AHD-G-050-1314-0475

Shri Bharatkumar T Patel Vs. Oriental Insurance Co. Ltd.
Award dated 11th April 2014
Partial repudiation of Mediclaim

Complainant's wife underwent Kidney Transplantation and expense incurred for Rs.3,09,213/- was partially settled by the Respondent for Rs.90,000/- by deducting an amount of Rs.2,19,213/- as per exclusion clause No.4.1, 4.2 and 4.3. Respondent considered Old Sum Insured of Rs.1.00 Lac. As per clause 4.23, Insured has to bear 10% of admissible claim amount in each and every claim.

In view of this complaint dismissed.

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Case No.11-005-0441-13

Mr. Sanjaykumar Dhanuka Vs. Oriental Insurance Co. Ltd.

Award dated 11th April 2014
Repudiation of Mediclaim

Two separate claims were submitted by the complainant for the treatment of his father and mother were repudiated by the Respondent giving reason that his mother's claim was rejected due to non compliance of required documents and father's claim was for cataract surgery which was rejected on the grounds of pre-existing disease under exclusion clause 4.1 & 4.3.

Complainant was not attended the Hearing scheduled by this forum also non availability of treatment papers the forum also denied his claims hence complaint dismissed.

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Case No. AHD-G-049-1314-0488

Shri Dhirubhai M Swami Vs. The New India Assurance Co. Ltd.
Award dated 11th April 2014
Repudiation of Mediclaim

Complainant's son hospitalized for Dental and expense incurred for Rs.19,648/- was fully repudiated by the Respondent under exclusion clause No.4.4.5 of the Mediclaim policy.

On scrutiny of available documents, the Forum also decided that the claim is not admissible as per policy provisions. Thus complaint dismissed.

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Case No. AHD-G-049-1314-0489

Shri Nandkishor S. Parikh Vs. The New India Assurance Co. Ltd.
Award dated 21st April 2014

Partial repudiation of Mediclaim

Complainant treated for Coronary Artery Disease and expense incurred for Rs.50,986/- was partially settled by the Respondent for Rs.27,301/- as per policy condition No.2.1, 2.3 and 2.4.

On scrutiny of available documents, the Forum also decided that the claim settled by the Respondent partially is as per policy provisions. Thus complaint dismissed.

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Case No.AHD-G-023-1314-0494

Shri Mahendra G. Rathod Vs. Iffco Tokiyo Gen.In. Co. Ltd.

Award dated 22nd April 2014

Repudiation of Mediclaim

Complainant treated for Right Ureteric Calculus and colic acute pain and expense incurred for Rs.11,818/- was repudiated by the Respondent as per clause No.11.

On scrutiny of available documents, the Respondent proved with evidences that the claim is not admissible. Hence complaint dismissed.

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Case No. AHD-G-049-1314-0501

Smt. Raj R. Goel Vs. The New India Assurance Co. Ltd.

Award dated 23rd April 2014

Partial repudiation of Mediclaim

Complainant treated for Umbilical Hernia and expense incurred for Rs.2,38,844/- was partially settled by the Respondent for Rs.61,750/- as per PPN rate.

The Respondent has proved with evidences that the deductions of claim amount as shown in their written submission were valid and proper as per policy provisions. Thus complaint dismissed.

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Case No.AHD-G-051-1314-507

Mr. Kantilal M Patel Vs. United India Insurance Co. Ltd.

Award dated 23rd April 2014

Repudiation of Mediclaim

Complainant treated for HTN + DM and expense incurred was repudiated by the Respondent as per exclusion clause No.4.1.

Complainant was a member of Group Mediclaim policy which do not reveal pre-existing diseases.

As per hospital records, complainant was suffering HTN + DM since 4-5 years hence complaint dismissed.

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Case No.11-017-0453-13

Shri Viral J Raichura Vs. The Star Health & Allied Insurance Co. Ltd.

Award dated 23rd April 2014

Partial repudiation of Mediclaim

Complainant was covered a Senior Citizens Red Carpet Insurance policy and insured had declared in Proposal form that patient is having cataract and undergone Glaucoma for both eyes 8 days before taking the policy.

Insured treated for Recurrent Endophthalmitis and claim lodged was repudiated by the Respondent on the ground of treatment could have been on

OPD basis. Thereafter insured made several representations and repeated follow up claim reopened and considered 50% of total hospitalization amount and 7% of post hospitalization.

On referring the available records proved the Respondent's decision is right and proper hence complaint dismissed.

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Case No.AHD-G-044-1314-0493

Mrs. Vaishakha R. Mehta Vs. Star Health & Allied Insurance Co. Ltd.

Award dated 23rd April 2014

Repudiation of Mediclaim

Complainant treated for Iron Deficiency and Anemia and expense incurred for Rs.11,034/- was repudiated by the Respondent as per exclusion clause No.3.0.

First consultation paper is not available, Lab report is before hospitalization, No specific cause or symptoms of Iron Deficiency or Anemia mentioned in History sheet or Discharge card.

In view of this complaint dismissed.

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Case No. AHD-G-049-1314-0495

Shri Dilipbhai H Shah Vs. The New India Assurance Co. Ltd.

Award dated 23rd April 2014

Partial repudiation of Mediclaim

Complainant treated for Cervical compressive myelopathy with Lumber canal Stenosis and expense incurred for Rs.1,67,245/- was partially settled by the Respondent for Rs.77,559/- and balance amount of Rs.89,686/- rejected as per clause 2.3 and 2.4 of the mediclaim policy.

Complainant was a history of DM since last 20 years and policy incepted in 1997 so it is considered as pre-existing disease and no loading premium was paid for the same.

Thus Respondent's decision is upheld and complaint dismissed.

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Case No.AHD-G-048-1314-0508

Mr. Divyang K Bhatt Vs. National Insurance Co. Ltd.

Award dated 23rd April 2014

Partial repudiation of Mediclaim

Complainant's mother hospitalized for Acute Anterior Wall MI and total expense incurred for Rs.2,08,156/- was partially settled by the Respondent for Rs.1,35,987/- as per policy clause 3.12 and 3.29.

No case papers and Discharge summary was available for verification. This makes claim suspicious.

Thus Respondent's decision is upheld and complaint dismissed.

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Case No. AHD-G-049-1314-0486

Shri Arvind G. Patel Vs. The New India Assurance Co. Ltd.

Award dated 24th April 2014

Repudiation of Mediclaim

Complainant's wife treated for Ureteric stone and claim lodged for Rs.43,180/- was repudiated by the Respondent under policy clause 3.5. The insured patient was treated for the same illness before 15 days and claim paid for Rs.1,20,400/- so limit was exhausted for the subject disease.

In view of this complaint dismissed.

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Case No.AHD-G-051-1314-0512

Shri Upendra Patel Vs. United India Insurance Co. Ltd.

Award dated 24th April 2014

Repudiation of Mediclaim

Complainant underwent Cataract Surgery and expense incurred for Rs.35,822/- was repudiated by the Respondent as per policy condition No.5.4.

Cataract surgery is a planned operation which should inform to the Respondent in advance but Complainant informed after discharge from hospital. Thus complaint dismissed.

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Case No.AHD-G-051-1314-0515

Shri Maneklal V. Shah Vs. United India Insurance Co. Ltd.

Award dated 24th April 2014

Repudiation of Mediclaim

Complainant's wife underwent Lt. Eye Phacoemulsification with Aspheric Injectable IOL implantation and expense incurred for Rs.19,595/- was repudiated by the Respondent as per policy condition No.5.4.

Cataract surgery is a planned operation which should inform to the Respondent in advance but Complainant informed after discharge from hospital. Thus complaint dismissed.

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Case No.AHD-G-048-1314-0516

Mr. Maulik R Shah Vs. National Insurance Co. Ltd.

Award dated 24th April 2014

Repudiation of Mediclaim

Complainant's wife 29 years old insured treated for Pericardial patch closure of Ostium Secundum ASD with Femoral Bypass and expense incurred for Rs.1,24,147/- was repudiated by the Respondent under exclusion clause No.4.3. Further medical reports confirm the disease is congenital which was not covered in the policy.

In view of this complaint dismissed.

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Case No. AHD-G-049-1314-0521

Shri Biharilal R. Fadia Vs. The New India Assurance Co. Ltd.

Award dated 25th April 2014

Partial repudiation of Mediclaim

Complainant underwent Knee replaceent and expense incurred for Rs.1,89,885/- was partially settled by the Respondent for Rs.1,75,982/- as per policy condition No.3.13, 4.4.21, 4.4.22 and 2.5.

The Respondent has proved with evidences that the deductions of claim amount as shown in their written submission were valid and proper as per policy provisions. Thus complaint dismissed.

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Case No.AHD-G-050-1314-0506

Dr. Kamal M. Sondarwa Vs. Oriental Insurance Co. Ltd.

Award dated 25th April 2014

Repudiation of Mediclaim

Complainant treated for Avastine Injection for his retinal vain occlusion and expense incurred Rs.34,654/- was repudiated by the Respondent giving reason that subject treatment was not required for hospitalization and no discharge summary was provided by the hospital.

In view of this complaint dismissed.

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Case No.AHD-G-051-1314-0517 & 0518

Shri Jayantilal K Dutt Vs. United India Insurance Co. Ltd.

Award dated 25th April 2014

Repudiation of Mediclaims

Complainant two times hospitalized for treatment of Hypertension, B.P & Diabetes Mellitus and claims lodged separately was repudiated by the Respondent on the ground of pre-existing diseases.

Complainant was a known case of CABG 15 years back which was not disclosed in the proposal.

In view of this complaint dismissed.

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Case No.AHD-G-050-1314-0519

Dr. Vishal Y Mehta Vs. Oriental Insurance Co. Ltd.

Award dated 25th April 2014

Partial repudiation of Mediclaim

Complainant's wife underwent for Gall stone and CBD stones and expense incurred for Rs.1,67,781/- was partially settled by the Respondent for Rs.1,29,587/- by deducting Rs.38,194/- as per policy condition No.4.16, Service charges and admission charges etc.

Respondent given detailed break-up in their claim settlement sheet which is right and proper hence complaint dismissed.

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Case No. AHD-G-049-1314-0528

Shri Jaswantlal P. Soni Vs. The New India Assurance Co. Ltd.

Award dated 25th April 2014

Partial repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Acute Pancreatitis Gall Bladder Stone, HTN, DM etc and lodged two claims totaling Rs.1,92,590/- was partially settled by the Respondent for Rs.70.448 as per policy condition No.5.5.

Respondent given detailed break-up in their claim settlement sheet which is right and proper hence complaint dismissed.

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Case No.AHD-G-049-1314-0548

Shri Mahipal M Dalal Vs. The New India Assurance Co. Ltd.

Award dated 6th May 2014

Repudiation of Mediclaim

Complainant's wife hospitalized two times and two claims lodged for Rs.1,88,472/- and Rs.4,76,712/- was totally repudiated by the Respondent as per clause 4.1 and non-disclosure of material facts.

On scrutiny of hospital records, the insured patient was in known case of HTN, DM, Coronary Artery Disease, Hypothyroidism etc. These diseases were suffering since 30-40 years. But no, loading of HTN & DM and no details of pre-existing. Insured was expired during treatment.

In view of this complaint dismissed.

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Case No.AHD-G-044-1314-0550

Mr. Hareshkumar Sajnani Vs. Star Health & Allied Insurance Co. Ltd.

Award dated 6th May 2014

Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Infarct in Left Basal Ganglia ad right frontal region+ Accelerated HTN and claim lodged for Rs.19,258/- was repudiated by the Respondent as per exclusion clause No.1.

On scrutiny of hospital records, the insured patient was in known case of HTN since 15 years. Duration of policy is 2 years and 4 months and the subject treatment for a waiting period of 4 years.

Thus complaint dismissed.

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Case No. AHD-G-049-1314-0547

Shri Manish I Thakkar Vs. The New India Assurance Co. Ltd.

Award dated 5th May 2014

Partial repudiation of Mediclaim

Complainant hospitalized for treatment of Upper Ureteric Stone and lodged claim for Rs.56,280/- was partially settled by the Respondent for Rs.49,770/- by deducting Rs.6,510/- as per policy condition No.3.13.

Respondent given detailed break-up in their claim settlement sheet which is right and proper hence complaint dismissed.

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Case No.AHD-G-050-1314-0560

Shri Champaklal H. Doshi Vs. Oriental Insurance Co. Ltd.

Award dated 5th May 2014

Repudiation of Mediclaim

Complainant treated for Kidney stone and expense incurred for Rs.65,558/- was repudiated by the Respondent as per terms and conditions and exclusion No.4.9 of the policy.

On referring the available treatment papers proved the treatment was for AIDS or HIV positive and its complications including S.T.D.

Thus complaint dismissed.

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Case No. AHD-G-049-1314-0574

Shri M.K. Sikka Vs. The New India Assurance Co. Ltd.

Award dated 7th May 2014

Partial repudiation of Mediclaim

Complainant hospitalized for treatment of accidental injury and lodged claim for Rs.58,625/- was partially settled by the Respondent for Rs.25,884/- by deducting Rs.32,741/- as per Janta Mediclaim policy condition No.2.10 & 2.9.

Respondent given detailed break-up in their claim settlement sheet which is right and proper hence complaint dismissed.

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Case No. AHD-G-049-1314-0567

Shri Shrikant K Parikh Vs. The New India Assurance Co. Ltd.

Award dated 7th May 2014

Partial repudiation of Mediclaim

Complainant's wife hospitalized for treatment of L4-5 GII Degenerative Listhesis with Facet Arthritis and L4-5 TLIF operation and lodged claim for Rs.1,59,685/- was partially settled by the Respondent for Rs.1,31,296/- by deducting Rs.28,389/- as per policy condition No.3.13.

Respondent given detailed break-up in their claim settlement sheet which is right and proper hence complaint dismissed.

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Case No.AHD-G-051-1314-0568

Shri D. V. Dholakia Vs. United India Insurance Co. Ltd.

Award dated 7th May 2014

Partial repudiation of Mediclaim

Complainant treated for Posterior circulation stroke, Hyperhomocystinemia, k/c/o HTN, IHD etc and claim lodged for Rs.51,539/- was partially settled by the Respondent for Rs.25,403/- as per policy condition No.5.10 (4) and 1.2 (a).

Respondent given detailed break-up in their claim settlement sheet which is right and proper hence complaint dismissed.

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Case No.AHD-G-048-1314-0559

Mr. Vikrambhai N Shah Vs. National Insurance Co. Ltd.

Award dated 7th May 2014

Partial repudiation of Mediclaim

Complainant treated for Urinary track infection and expense incurred for Rs.31,665/- was partially settled by the Respondent for Rs.21,442/- by rejecting an amount of Rs.10,223/- under policy condition No.3.12.

Respondent given detailed break-up in their claim settlement sheet which is right and proper hence complaint dismissed.

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Case No.AHD-G-048-1314-0572

Mr. Govindbhai B Sathwara Vs. National Insurance Co. Ltd.

Award dated 8th May 2014

Repudiation of Mediclaim

Complainant underwent heart open surgery and claim lodged for Rs.2,14,735/- was repudiated by the Respondent as per terms and conditions and exclusion clause No.4.1.

Claim lodged in the first year of the policy and there is cap of 36 months for the subject treatment.

Thus complaint dismissed.

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Case No. AHD-G-049-1314-0580

Shri Ganpatbhai K Patel Vs. The New India Assurance Co. Ltd.

Award dated 8th May 2014

Partial repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Vaginal hysterectomy and lodged claim for Rs.82,877/- was partially settled by the Respondent for Rs.62,442/- by deducting Rs.20,435/- as per policy condition No.3.13.

Respondent given detailed break-up in their claim settlement sheet which is right and proper hence complaint dismissed.

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Case No.AHD-G-051-1314-0569

Mr. Somabhai A Prajapati Vs. United India Insurance Co. Ltd.

Award dated 8th May 2014

Repudiation of Mediclaim

Complainant's wife treated for Anal Fissure with Piles & Internal Hemorrhiah and expense incurred for Rs.24,280/- was repudiated by the Respondent as per policy condition No.5.8.

Complainant could not provide a correct date of birth of his insured patient hence complaint dismissed.

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Case No.AHD-G-051-1314-0575

Shri Pravin H. Vadilay Vs. United India Insurance Co. Ltd.

Award dated 9th May 2014

Partial repudiation of Mediclaim

Complainant treated for eye cataract surgery and expense incurred for Rs.16,890/- was partially paid Rs.11,160 by deducting an amount of Rs.5,629/- by the Respondent as per policy condition No.1.2.1.

On scrutiny of available documents proved the Respondent's decision to settle the claim partially is right and proper hence complaint dismissed.

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Case No.AHD-G-051-1314-0576

Mr.Rakesh A. Thakkar Vs. United India Insurance Co. Ltd.

Award dated 9th May 2014

Repudiation of Mediclaim

Complainant's 1 year old son treated for Upper Respiratory Tract Infection, Viral, Anemia & Nutritional and expense incurred for Rs.19,652/-

was repudiated by the Respondent as per policy condition No.2.13, hospitalization is less than 24 hours.

Further Policy condition No.4.8 excludes treatment of anemia, hence complaint dismissed.

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Case No.AHD-G-049-1314-0588

Shri Mehul V Patel Vs. The New India Assurance Co. Ltd.

Award dated 9th May 2014

Repudiation of Mediclaim

Complainant hospitalized for treatment of Megaloblastic Anemia + Pancytopenia and claim lodged for Rs.19,271/- was repudiated by the Respondent as per clause 4.4.6.

On scrutiny of hospital records, the insured patient was past history of Jaundice and claim lodged was in the first year of the policy.

In view of this complaint dismissed.

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Case No.AHD-G-050-1314-0578

Shri Paresh R. Kanojia Vs. Oriental Insurance Co. Ltd.

Award dated 9th May 2014

Repudiation of Mediclaim

Complainant's wife treated for Urinary Tract Infection and expense incurred for Rs.17,070/- was repudiated by the Respondent as per clause 4.3 of the Mediclaim policy.

As per medical records, the insured patient was Kidney Stone disease which is excluded for two years as per the policy clauses 3.8. Claim is in the first year of the policy. Thus complaint dismissed.

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Case No.AHD-G-049-1314-0571

Smt. Minaxiben P Doshi Vs. The New India Assurance Co. Ltd.

Award dated 9th May 2014

Partial settlement of Mediclaim

Complainant underwent Knee replacement surgery and expense incurred for Rs.1,01,526/- was partially settled by the Respondent for Rs.71,907/- by deducting 29,619/- as per policy condition No.4.4.21 & 2.10.

Complainant was paying premium as per Zone-III and treatment taken in Zone-I so eligible claim is 80% of the actual claimed amount.

In view of this Respondent's decision is upheld and complaint dismissed.

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Case No.AHD-G-051-1314-0589

Shri Jayesh R. Darji Vs. United India Insurance Co. Ltd.

Award dated 12th May 2014

Partial repudiation of Mediclaim

Complainant treated for Acute Appenditis and Acute Calculus etc. and expense incurred for Rs.88,203/- was partially paid Rs.69,609 by deducting an amount of Rs.19,194/- by the Respondent as per policy condition No.1.2.1, 1.2b, 1.2c and 1.2d. Again Respondent paid an amount of Rs.13,610/- after registering a complaint to this Forum and remaining amount of Rs.5584/- deducted as per exclusion No.4.6.

On scrutiny of available documents proved the Respondent's decision to settle the claim partially is right and proper hence complaint dismissed.

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Case No.AHD-G-050-1314-0596

Shri Nareshbhai K Shah Vs. Oriental Insurance Co. Ltd.

Award dated 12th May 2014

Repudiation of Mediclaim

Complainant's wife treated for NHL of Gum Plasmablastic with Seropositive and expense incurred for Rs.1,42,699/- was repudiated by the Respondent as per clause 4.9 of the Mediclaim policy.

As per medical records, the insured patient was HIV positive which is excluded from the policy clauses. Thus complaint dismissed.

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Case No.AHD-G-049-1314-0592

Shri Vinodbhai D Patel Vs. The New India Assurance Co. Ltd.

Award dated 12th May 2014

Repudiation of Mediclaim

Complainant treated for Sleep Apnea+ HBP+ Vitamin B12 deficiency+ Vitamin D3 deficiency and expense incurred for Rs.61,312/- was repudiated by the Respondent as per exclusion clause 4.4.11 and clause 1.0.

No active line of treatment except vitamin injections, were given to the patient. Thus complaint dismissed.

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Case No.AHD-G-051-1314-0595

Shri Sanjiv K Gurav Vs. United India Insurance Co. Ltd.

Award dated 12th May 2014

Repudiation of Mediclaim

Complainant's 12 years old son treated for Sinonasal Polyposis operation and expense incurred for Rs.19,276/- was repudiated by the Respondent under policy condition No.5.7.

On scrutiny of available documents, the Forum also denied the claim thus complaint dismissed.

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Case No.AHD-G-049-1314-0593

Shri Arvind N Shah Vs. The New India Assurance Co. Ltd.

Award dated 12th May 2014

Repudiation of Mediclaim

A 77 years old complainant treated for CAD and expense incurred for Rs.4,74,491/- was repudiated by the Respondent under exclusion clause No.4.1 and 5.5.

Complainant was a known case of DM since 25-30 years and his policy since 16 years. The subject treatment was related to DM and he was not paying the loading charges if he wants to cover for DM.

In view of this Respondent's decision is upheld and complaint dismissed.

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Case No.AHD-G-051-1314-0618

Smt. Seema N Pehaljani Vs. United India Insurance Co. Ltd.

Award dated 13th May 2014

Partial repudiation of Mediclaim

Complainant claimed for Rs.12,245/- as her total claim amount was Rs.35,019/-for treatment of Hysterectomy which was partially paid for Rs.18,750/- and wrongly deducted an amount of Rs.12,245/-.

Respondent settled her claim as per policy condition No.1.2.1 & 4.3 which is right and proper hence complaint dismissed.

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Case No.AHD-G-049-1314-0619

Shri Mayur D. Herba Vs. The New India Assurance Co. Ltd.

Award dated 13th May 2014

Repudiation of Mediclaim

Complainant treated for Psychiatric and Psychosomatic disorder and claimed was repudiated by the Respondent as per exclusion clause 4.4.6 and 4.4.12.

On scrutiny of available documents, the Forum also denied the claim thus complaint dismissed.

****

Case No.AHD-G-051-1314-0615

Shri. Anup Pillai Vs. United India Insurance Co. Ltd.

Award dated 13th May 2014

Repudiation of Mediclaim

Complainant treated for Acute Parianal abscess and expense claimed for Rs.18,550/- was repudiated by the Respondent as per exclusion No.5.3, 5.4, 5.6, 4.1 and 4.3.

Claim was in the first year of the policy, there is a waiting period of 2 years for the subject treatment. Thus complaint dismissed.

****

Case No.AHD-G-050-1314-0620

Shri Prembihari M Desai Vs. Oriental Insurance Co. Ltd.

Award dated 14th May 2014

Partial repudiation of Mediclaim

Complainant's treatment expense claimed for Rs.18,928/- was partially settled by the Respondent for Rs.5,420/- by deducting Rs.13,500/- as per policy clause No.4.26.

Respondent paid another two claims for hospitalization expense of the same patient on the same month of 3rd claim i.e., August 2012. Present claim was for physiotherapy expense which is taken at his residence only so doctors visit fee is not payable. Thus complaint dismissed.

****

Case No.AHD-G-050-1314-0611

Shri Jyotikumar Mukhopadhyay Vs. Oriental Insurance Co. Ltd.

Award dated 15th May 2014

Repudiation of Mediclaim

Complainant treated for Darkish pigmented area Rt. Sole and claimed Rs.1,29,341/- was repudiated by the Respondent under clause 4.1. First policy started on 19-11-2010 and date of biopsy on 04-08-2012.

History part of treating doctor stated that Darkish pigmented area Rt. Sole since from childhood. This is mole, which turn into mole cancer.

On scrutiny of available documents, the Forum also denied the claim thus complaint dismissed.

****

Case No.AHD-G-049-1314-0594

Mr. Sunil Variya Vs. The New India Assurance Co. Ltd.

Award dated 15th May 2014

Partial settlement of Mediclaim

Complainant's hospitalization expense claimed for Rs.55,176/- was partially settled by the Respondent for Rs.40,376/- by deducting Rs.14,800/- as per policy clause No.2.3.

Complainant's argument he is not aware of the rules and regulations of the policy is not acceptable by this Forum. Thus complaint dismissed.

****

Case No.AHD-G-049-1314-0623

Mr. Ramjibhai J Nada Vs. The New India Assurance Co. Ltd.
Award dated 15th May 2014
Partial settlement of Mediclaim

Complainant's wife hospitalized for treatment of Prolapsed Intervertebral Lumbar Disc L4 and expense claimed for Rs.61,900/- was partially settled by the Respondent for Rs.26,350/- as per policy clause No.2.

On scrutiny of available documents, the Forum also denied the claim thus complaint dismissed.

****

Case No.AHD-G-049-1314-0617

Shri Indravadan H Jani Vs. The New India Assurance Co. Ltd.
Award dated 15th May 2014
Partial settlement of Mediclaim

Complainant's wife underwent Cataract Eye surgery and expense claimed for Rs.59,340/- was partially settled by the Respondent for Rs.24,000/- as per policy terms and condition, maximum limit of cataract surgery is payable only Rs.24,000/-.

On scrutiny of available documents, the Forum also denied the claim thus complaint dismissed.

****

Case No.AHD-G-048-1314-0625

Shri Pratin B Shah Vs. National Insurance Co. Ltd.
Award dated 16th May 2014
Repudiation of Mediclaim

Complainant's 1 year old daughter treated for Ear infection and claimed Rs.49,761/- was repudiated by the Respondent giving reason that as per policy

condition No.4.3, 1 year waiting period is for the subject treatment and claim lodged was in the 1st year of the policy.

Thus complaint dismissed.

****

Case No.AHD-G-044-1314-0631

Shri Maheshbhai P Patel Vs. Star Health & Allied Insurance Co. Ltd.

Award dated 16th May 2014

Repudiation of Mediclaim

A claim amount of Rs.9,420/- lodged by the Complainant for treatment of himself for Acid peptic disease, Malaria & thrombocytopenia was repudiated by the Respondent as per policy condition No.7.

There is no 1st consultation report, no advice of doctor for admission and investigation report also proves the claim is fabricated.

Thus complaint dismissed.

****

Case No.AHD-G-044-1314-0632

Shri Maheshbhai P Patel Vs. Star Health & Allied Insurance Co. Ltd.

Award dated 16th May 2014

Repudiation of Mediclaim

A claim amount of Rs.9,336/- lodged by the Complainant for his wife's treatment of Acid peptic disease, Malaria & thrombocytopenia was repudiated by the Respondent as per policy condition No.7.

There is no 1st consultation report, no advice of doctor for admission and investigation report also proves the claim is fabricated.

Thus complaint dismissed.

****

Case No.AHD-G-044-1314-0633

Shri Maheshbhai P Patel Vs. Star Health & Allied Insurance Co. Ltd.

Award dated 16th May 2014

Repudiation of Mediclaim

A claim amount of Rs.8,311/- lodged by the Complainant for his daughter's treatment of Acid peptic disease, Malaria & thrombocytopenia was repudiated by the Respondent as per policy condition No.7.

There is no 1st consultation report, no advise of doctor for admission and investigation report also proves the claim is fabricated.

Thus complaint dismissed.

****

Case No.AHD-G-051-1314-0634

Shri.Ramesh M Patel Vs. United India Insurance Co. Ltd.

Award dated 16th May 2014

Repudiation of Mediclaim

Complainant's wife underwent Physiotherapy treatment and expense claimed for Rs.7,800/- was rejected by the Respondent as per policy condition No.5.5.

Respondent paid another claim for hospitalization expense of the same patient for the treatment of Knee replacement for Rs.1,07,000/-. Present claim was for physiotherapy expense which is taken at his residence only. Thus complaint dismissed.

****

Case No.AHD-G-049-1314-0639

Smt. Deeptiben R.Jhaveri Vs. The New India Assurance Co. Ltd.

Award dated 19th May 2014

Repudiation of Mediclaim

Complainant underwent Day care treatment for SACROCOCYGEAL LIGAMENT CALCIFIED and expense claimed for Rs.14,716/- was rejected by the Respondent as per policy terms and condition No.1.0 and 3.4.

Complainant's husband also treated for the same disease in the same hospital and claim lodged to this Forum.

On scrutiny of available documents, the Forum also denied the claim, thus complaint dismissed.

****

Case No.AHD-G-049-1314-0640

Shri. Anant R.Jhaveri Vs. The New India Assurance Co. Ltd.

Award dated 19th May 2014

Repudiation of Mediclaim

Complainant underwent Day care treatment for SACROCOCYGEAL LIGAMENT CALCIFIED and expense claimed for Rs.30,816/- was rejected by the Respondent as per policy terms and condition No.1.0 and 3.4.

Complainant's wife also treated for the same disease in the same hospital and claim lodged to this Forum.

On scrutiny of available documents, the Forum also denied the claim, thus, complaint dismissed.

****

Case No.AHD-G-051-1314-0622

Shri. Ravindrakumar G Shah Vs. United India Insurance Co. Ltd.

Award dated 19th May 2014

Partial repudiation of Mediclaim

Complainant claimed for Rs.22,740/- as his total claim amount was Rs.34,543/-for treatment of Kidney stone which was partially paid by the Respondent for Rs.11,803/- and wrongly deducted an amount of Rs.22,740/-.

On scrutiny of available documents proved the Respondent settled his claim as per policy condition No.1.2.(c) & Note 2 of the policy which is right and proper hence complaint dismissed.

****

Case No.AHD-G-049-1314-0621

Shri.Bhimjibhai R Rajpara Vs. The New India Assurance Co. Ltd.

Award dated 20th May 2014

Repudiation of Mediclaim

Complainant's wife treated for Knee replacement and expense incurred for Rs.1,88,803/-, out of this Rs.1.00 Lac paid under Group Mediclaim policy through the employer of his son and remaining amount of Rs.88,803/- was claimed to the Respondent was repudiated as per terms and condition No.4.1 & 4.3.

Complainant was covered Mediclaim with another company since 2001 and switched over with the Respondent with pre condition. Claim preferred within 10 months of the policy from the Respondent.

In view of this complaint dismissed.

****

Case No.AHD-G-048-1314-0650

Shri Mrugesh R Shah Vs. National Insurance Co. Ltd.

Award dated 20th May 2014

Repudiation of Mediclaim

Complainant's wife hospitalized two hospitals for treatment of Chronic Kidney disease and total claims lodged Rs.82,826/- was repudiated by the Respondent giving reason that as per policy condition No.4.1,4.2 & 4.3, 4.2 null and void, 4.1 pre-existing.

Insured patient was previously under group mediclaim Policy but portability was not applied.

In view of this complaint dismissed.

****

Case No. AHD-G-051-1314-0636

Shri Harilal D Tilwani Vs. United India Insurance Co. Ltd.

Award dated 21st May 2014

Repudiation of Mediclaim

Complainant's wife operated for Transitional Cell Carcinoma of Right Kidney and expense incurred for Rs.98,947/- was repudiated by the Respondent on the ground of suppression of material facts.

On scrutiny of available documents, the Forum also denied the claim, thus, complaint dismissed.

****

Case No.AHD-G-050-1314-0627

Shri Pareshbhai V Gajipara Vs. Oriental Insurance Co. Ltd.

Award dated 21st May 2014

Repudiation of Mediclaim

Complainant's 15 years old son underwent dental treatment due to accidentally fall from Activa and expense incurred Rs.45,425/- was repudiated by the Respondent as per policy terms and condition No.4.7.

Complainant has not produced any documentary evidence to prove the insured was hospitalized so treatment could have been an OPD basis. Thus Respondent's decision is upheld and complaint dismissed.

****

Case No.AHD-G-049-1314-0644

Shri Vipul B Rami Vs. The New India Assurance Co. Ltd.

Award dated 21st May 2014

Partial repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Jaundice and expense incurred for Rs.1,45,403/- was partially settled by the Respondent for Rs.15,000/-on cashless basis and remaining amount deducted as per policy condition and exclusion clause 4.4.16.

During the treatment, insured expired and treatment records proved the insured was suffering Hepatic failure with Wilson disease which is genetic disorder.

On scrutiny of available documents, the Forum also denied the remaining amount, thus, complaint dismissed.

****

Case No.AHD-G-048-1314-0635

Shri Jayantibhai J Shah Vs. National Insurance Co. Ltd.

Award dated 21st May 2014

Repudiation of Mediclaim

Complainant underwent Dialysis due to CGN-CRF and CKD and total claim lodged for Rs.26,658/- was repudiated by the Respondent giving reason that as per policy condition No.4.1 pre-existing.

Insured patient was previously under mediclaim Policy of Reliance General Insurance but portability was not applied. Complaint has also taken two claims from the previous Insurer which was not disclosed in the Proposal.

In view of this complaint dismissed.

****

Case No. AHD-G-051-1314-0649

Shri Pankaj K Shah Vs. United India Insurance Co. Ltd.

Award dated 22nd May 2014

Repudiation of Mediclaim

mplainant admitted for treatment of Unstable Angina, Acute LVF etc. and incurred expense for Rs.18,000/- was repudiated by the Respondent as policy condition No.5.5.

Complainant submitted claim papers after 3 months instead of within 7 days from the date of completion of treatment.

Main hospital bill was settled by the Respondent and the subject claim was for post hospitalization and also could not submit valid reason for late submission of post hospitalization.

In view of this complaint dismissed.

****

Case No.AHD-G-049-1314-0647

Dr. Digant Y Vaishnav Vs. The New India Assurance Co. Ltd.

Award dated 22nd May 2014

Partial settlement of Mediclaim

Complainant's mother hospitalized for treatment of Endomatrial Carcinoma operation and expense incurred for Rs.1,54,776/- was partially settled by the Respondent for Rs.91,361/- by deducting an amount of Rs.63,415/- as per policy clause 2.3 Note-2 and 3 (b).

On scrutiny of available documents, the Forum also denied the remaining amount, thus, complaint dismissed.

****

Case No.AHD-G-020-1314-0616

Smt. Binaben V Patel Vs. ICICI Lombard General Insurance Co. Ltd.

Award dated 23rd May 2014

Repudiation of Mediclaim

Complainant hospitalized for treatment of Enteric fever, Dysentery and UTI and expense incurred for Rs.46,516/- was repudiated by the Respondent as per part-II of the schedule, exclusion clause No.14.

On scrutiny of available documents, the Forum also denied the claim, thus, complaint dismissed.

****

Case No. AHD-G-051-1314-0657

Shri Surendra C Doshi Vs. United India Insurance Co. Ltd.

Award dated 23rd May 2014
Partial repudiation of Mediclaim

A claim amount of Rs.1,86,000/- was lodged by the Complainant for Knee replacement expense of his wife was settled by the Respondent 70% of the S.I as per policy terms and conditions under senior citizen Individual Health Insurance Policy.

Complainant received only Rs.84,000/- against Rs.1,86,000/-.

On scrutiny of available documents, the Forum also denied the remaining amount, thus, complaint dismissed.

****

Case No.AHD-G-049-1314-0653

Shri Bharat D Patel Vs. The New India Assurance Co. Ltd.
Award dated 26th May 2014
Partial settlement of Mediclaim

Complainant hospitalized for treatment of F.E.S.S operation and expense incurred for Rs.48,823/- was partially settled by the Respondent for Rs.28,065/- by deducting an amount of Rs.20,500/- as per policy clause 2.3 Note-2 and 3 (b).

On scrutiny of available documents, the Forum also denied the remaining amount, thus, complaint dismissed.

****

Case No.AHD-G-050-1314-0655

Shri Rohitbhai R. Mehta Vs. Oriental Insurance Co. Ltd.

Award dated 26th May 2014

Partial repudiation of Mediclaim

Complainant was covered Mediclaim policy for S.I Rs.1,00,000/. He underwent Cancer treatment and expense incurred for Rs.2,14,992/- was partially settled by the Respondent for Rs.90,000/- by deducting Rs.10,000/- as per policy special excess clause in all policies since 2003-04, i.e. @10% of each claim will be deducted in to the age of 63 years.

Complainant was not paying excess premium for pre-existing disease and he is 72 years old.

In view of this Respondent's decision is upheld and complaint dismissed.

****

Case No.AHD-G-049-1314-0630

Shri.Amrutlal A Patel Vs. The New India Assurance Co. Ltd.

Award dated 26th May 2014

Repudiation of Mediclaim

Complainant's 20 years old son hospitalized for ACL injury and expense incurred for Rs.5,950/- was repudiated by the Respondent giving reason that the purpose of hospitalization was not justified and discrepancies in the date of discharge and date of doctors' bill and also no first consultation paper.

Respondent also informed the claim lodged to another janta mediclaim policy for same treatment and got claim amount to the complainant.

Thus complaint dismissed.

****

Case No.AHD-G-049-1314-0654

Shri.Vipinchandra N Jikar Vs. The New India Assurance Co. Ltd.

Award dated 26th May 2014
Repudiation of Mediclaim

Complainant underwent Retinal treatment through Lucentis Injection in Mumbai and incurred expense of Rs.47,000/- was repudiated by the Respondent as per exclusion clause No.4.4.23.

On scrutiny of available documents, the Forum also denied the claim, thus, complaint dismissed.

****

Case No.AHD-G-049-1314-0661

Shri Suryakant M Parikh Vs. The New India Assurance Co. Ltd.
Award dated 27th May 2014
Partial settlement of Mediclaim

Complainant hospitalized for unable to walk or stand, tiredness, diabetes, HT, dyslipidemia, neuropathy, overweight, low back pain etc and expense incurred for Rs.4,33,706/- was partially settled by the Respondent for Rs.1,34,758/-and remaining amount deducted on various grounds as per policy clause 2.0 Note-1, 2;3, 2.4, 4.4.14, 2.7 etc.

First complainant underwent Ayurvedic treatment which is payable 25% of S.I if treatment taken in a Govt. Ayurvedic hospital whereas complainant took treatment in a private hospital at Kochi, thereafter from Lilavati Hospital, Mumbai which is under Zone-I and premium paying for Gujarat under Zone-III.

On scrutiny of available documents, the Forum also denied the remaining amount, thus, complaint dismissed.

****

Case No.AHD-G-048-1314-0663

Shri Atul J Rughani Vs. National Insurance Co. Ltd.
Award dated 28th May 2014

Repudiation of Mediclaim

Complainant's 14 years old daughter underwent operation of Ovarian Cyst and total claim lodged for Rs.31,409/- was repudiated by the Respondent giving reason that as per policy condition No.4.3, claim is payable after two of the inception of the policy.

This is the second year of the policy, thus complaint dismissed.

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Case No. AHD-G-051-1314-0664

Shri Ajay P Japee Vs. United India Insurance Co. Ltd.

Award dated 28th May 2014

Partial repudiation of Mediclaim

A claim amount of Rs.1,56,073/- was lodged by the Complainant for Intestine Cyst operation of his 16 years old son was settled by the Respondent Rs.50,000/- as per policy terms and conditions 1.2a, 1.2b, 1.2c and 5.9.4.

On scrutiny of available documents, the Forum also denied the remaining amount, thus, complaint dismissed.

****

Case No.AHD-G-051-1314-0671

Shri Haresh Mehta Vs. United India Insurance Co. Ltd.

Award dated 28th May 2014

Repudiation of Mediclaim

Complainant's son hospitalized for treatment of Left side pulmonary tuberculosis with pleural effusion and expense incurred Rs.6,35,451/-. Out of this amount Rs.4.00 Lacs settled by National Insurance Co. and Rs.1.00 claimed to the Insurer, was repudiated by the Respondent as per policy condition No.5.9.

On scrutiny of available documents, the Forum also denied the remaining amount, thus, complaint dismissed.

****

Case No.AHD-G-016-1314-0590

Shri Chetankumar M Patel Vs. Future Generali India Insurance Co. Ltd.

Award dated 28th May 2014

Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of abdominal pain, vomiting, low grade fever, body ache and weakness for which expense incurred for Rs.34,974/- was repudiated by the Respondent as per their policy condition No.8 which reads as "Fraud".

On referring the available documents, the forum also denied the claim hence complaint dismissed.

****

Case No.AHD-G-016-1314-0591

Shri Chetankumar M Patel Vs. Future Generali India Insurance Co. Ltd.

Award dated 28th May 2014

Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Inflamatory Bowel Disease and Small Bowel for which expense incurred for Rs.45,212/- was repudiated by the Respondent as per their policy condition No.8 which reads as "Fraud".

On referring the available documents, the forum also denied the claim hence complaint dismissed.

****

Case No.AHD-G-048-1314-0665

Mrs. Sweta J Fadia Vs. National Insurance Co. Ltd.

Award dated 29th May 2014

Partial repudiation of Mediclaim

Complainant treated for Idiopathic Thrombocytopenia Purpura and expense incurred for Rs.3,03,166/- was partially settled by the Respondent only for Rs.76,200/- under policy condition 4.1.

Respondent given detailed break-up in their claim settlement sheet which is right and proper hence complaint dismissed.

****

Case No.AHD-G-048-1314-0675

Mr. Ravindra R. Bhatt Vs. National Insurance Co. Ltd.

Award dated 30th May 2014

Partial repudiation of Mediclaim

Complainant claimed for an amount of Rs.11,091/- for pre and post hospitalization expense was partially settled by the Respondent over and above cashless claim settled for Rs.2,01,500/-. Claim settled as per PPN rate and as per Policy Terms and Conditions.

Respondent given detailed break-up in their claim settlement sheet which is right and proper hence complaint dismissed.

****

Case No.AHD-G-049-1314-0673

Dr. Pankaj Gupta Vs. The New India Assurance Co. Ltd.

Award dated 2nd June 2014

Repudiation of Mediclaim

Complainant's wife treated for dog biting and expense incurred for Rs.36,850/- was repudiated by the Respondent under exclusion clause No.3.6.

Complainant himself was running a nursing home, who is an M.D where his wife treated so Clause No.3.6 clearly operative in the subject claim. Thus complaint dismissed.

****

Case No.AHD-G-049-1314-0674

Shri Lalitkumar O Shah Vs. The New India Assurance Co. Ltd.

Award dated 2nd June 2014

Partial settlement of Mediclaim

Complainant's wife operated for Hystrectomy and incurred expense of Rs.49,671/- was partially settled by the Respondent for Rs.32,697/- and deducted Rs.14,274/- under various reasons like Policy terms and conditions No.2.1, 2.3, 2.4 etc.

On scrutiny of available documents, the Forum also denied the remaining amount, thus, complaint dismissed.

****

Case No.AHD-G-049-1314-0676

Shri.Jaladhi A Vasavada Vs. The New India Assurance Co. Ltd.

Award dated 2nd June 2014

Repudiation of Mediclaim

Complainant's daughter treated for Atrial Septal Defect and expense incurred for Rs.1,15,388/- was repudiated by the Respondent as per clause No.4.1, pre-existing disease.

As per treatment records, insured patient was a history of congenital defect since birth. Pre-existing disease covered after 4 claim free years from the inception of policy. The subject treatment was in the third year of the policy.

In view of this complaint dismissed.

****

Case No.AHD-G-050-1314-0680

Shri Vikram Bhatt Vs. Oriental Insurance Co. Ltd.

Award dated 12th June 2014

Partial repudiation of Mediclaim

Complainant's wife operated for Nasal Sinus with Septoplasty and expense incurred for Rs.40,177/- was approved by the Respondent for Rs.30,940/- by deducting an amount of Rs.9,237/- as per expert opinion of the Panel Doctor which was not acceptable by the Complainant.

Complainant demanded to get full claim amount on the basis of another expert doctor's opinion, which was not acceptable by the Respondent.

On scrutiny of available documents, the Forum also denied the remaining amount, thus, complaint dismissed.

****

Case No.AHD-G-050-1314-0681

Shri Vipul T Shah Vs. Oriental Insurance Co. Ltd.

Award dated 13th June 2014

Partial repudiation of Mediclaim

Complainant underwent Cataract surgery and expense incurred for Rs.41,745/- was partially settled by deducting Rs.10,062/- as per terms and condition No.4.6.

Complainant implanted Multi focal lens which primarily has a cosmetic purpose is not payable.

Hence Respondent's decision to deduct the claim partially is upheld and complaint dismissed.

****

Case No.AHD-G-051-1314-0678

Shri Indravadan B Zaveri Vs. United India Insurance Co. Ltd.

Award dated 13th June 2014

Partial repudiation of Mediclaim

Complainant underwent Heart Bypass Surgery and Myesthenia and total expense incurred for Rs.2,67,200/- was partially offered Rs.1,79,500/- which was not accepted by the Complainant and appealed to Higher authority for review. On thorough scrutiny of claim papers, some errors were observed in calculation and resettled to Rs.1,57,500/- .

As per policy condition No.1.2.1(b), Cardiac Surgery expense is restricted to 70% of the S.I or actual bill whichever is less. On scrutiny of treatment papers proved the insured patient was a k/c/o HTN, DM & Myasthenia Gravis.

In view of this complaint dismissed.

****

Case No.AHD-G-03-1314-0685

Shri Pramod K Bhatt Vs. Apollo Munch Health Insurance Co. Ltd.

Award dated 13th June 2014

Repudiation of Mediclaim

Complainant claimed two different hospitalization expenses for Rs.8,500/- and Rs.62,917/- for the treatment of Coarctation of Aorta for BDC with stenting was repudiated by the Respondent under section 6(e) & (vi) of the policy.

On referring the treatment records prove the disease is since child birth which is congenital, excluded from the policy conditions.

Further claim lodged within 3 months from the inception of the policy.

In view of this complaint dismissed.

****

Case No.AHD-G-049-1314-0682

Shri Ajitsingh M Ailsinghani Vs. The New India Assurance Co. Ltd.

Award dated 13th June 2014

Partial settlement of Mediclaim

Complainant operated for Piles and expense incurred for Rs.27,301/- was partially settled Rs.17,400/- by the Respondent by deducting Rs.9,901/- under various reasons like capping, non medical items, room rent on higher category etc.

Respondent explained all deductions in details which were accepted by this Forum and complaint dismissed.

****

Case No.AHD-G-049-1314-0684

Shri Kiritbhai S. Patel Vs. The New India Assurance Co. Ltd.

Award dated 16th June 2014

Repudiation of Mediclaim

Complainant hospitalized two times for poisoning illness and incurred Rs.3,11,576/- was repudiated by the Respondent under policy exclusion No.4.4.7 and 5.5.

Respondent has proved with evidences that the claim repudiated on the basis of all treatment papers like discharge summary, doctor's report, investigation reports shows the nature of disease is poisoning.

In view of this complaint dismissed.

****

Case No.AHD-G-051-1314-0677

Shri Pratap B Shah Vs. United India Insurance Co. Ltd.

Award dated 16th June 2014

Partial repudiation of Mediclaim

Complainant underwent Cataract Surgery in his both eyes and total expense incurred Rs.88,188/- was partially settled for Rs.80,000/- (Rs.40,000/- each) and remaining amount deducted as per terms and conditions and exclusion clause of the policy i.e. 1.2.1 & 3.11.

Respondent explained all deductions in details which were accepted by this Forum and complaint dismissed.

****

Case No.AHD-G-049-1314-0687

Shri Narendra K Paatel Vs. The New India Assurance Co. Ltd.

Award dated 16th June 2014

Partial settlement of Mediclaim

Complainant's wife treated for Metastatic Adenocarcinoma and expense incurred for Rs.1,21,799/- was partially settled by the Respondent for Rs.81,399/- by deducting Rs.40,000/- to the cost of Metal Billiary Stent on the ground of non availability of original bill.

As per policy condition, Insured has to produce all original Invoices and cash receipts for reimbursement of hospitalization claim.

In view of this complaint dismissed.

****

Case No.AHD-G-051-1314-0688

Mrs. Rashmi I Patel Vs. United India Insurance Co. Ltd.

Award dated 17th June 2014

Repudiation of Mediclaim

Complainant hospitalized for treatment of Spinal Cord Stenosis, HTN, Hypothyroidism etc. and expense incurred for Rs.29,349/- was repudiated by the Respondent as per terms and condition No.2.3.

Respondent obtained expert medical opinion who confirmed this is an OPD procedure.

Thus complaint dismissed.

****

Case No.AHD-G-049-1314-0689

Shri Arvind M Panchal Vs. The New India Assurance Co. Ltd.

Award dated 17th June 2014

Partial settlement of Mediclaim

Complainant operated for SLAP lesion, Pasta and impingement and expense incurred for Rs.94,219/- was partially settled Rs.88,838/- by the Respondent by deducting Rs.5,381/- under various reasons like Assistant charges, non medical items, post operative monitor charges etc.

Respondent explained all deductions in details which were accepted by this Forum and complaint dismissed.

****

Case No.AHD-G-049-1314-0694

Shri Jitendra R Prajapati Vs. The New India Assurance Co. Ltd.

Award dated 17th June 2014

Partial settlement of Mediclaim

Complainant's wife treated for Deviated Nasal Septum, Chronic Rhino sinusitis and left middle turbinate conch bullosa for which complainant lodged total claim of Rs.71,293/- was partially approved only Rs.16,261/- and remaining amount of Rs.55,032/- deducted by the Respondent under various clauses like 2.1, 2.3 and 2.4.

Respondent explained all deductions in details which were accepted by this Forum and complaint dismissed.

****

Case No.AHD-G-051-1314-0698

Shri Dinesh K Jani Vs. United India Insurance Co. Ltd.

Award dated 18th June 2014

Partial repudiation of Mediclaim

Complainant treated for Acute Urinary Retention due to impacted Prostatic urethral stone for which complainant lodged total claim of Rs.33,802/- was partially settled by the Respondent only Rs.22,501/- by deducting Rs.11,300/- as per policy clause No.1.2A, 1.2B, 1.2C & 1.2D.

Respondent explained all deductions in details which were accepted by this Forum and complaint dismissed.

****

Case No.AHD-G-049-1314-0705

Shri Nimesh U Shah Vs. The New India Assurance Co. Ltd.

Award dated 19th June 2014

Partial settlement of Mediclaim

Complainant treated for Acute Appendicitis and expense claimed for Rs.99,092/- was partially settled by the Respondent for Rs.61,750/- by deducting Rs.37,342/- under various clauses like 3.13, 4.4.1` and 2.3.

Respondent explained all deductions in details which were accepted by this Forum and complaint dismissed.

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Case No.AHD-G-051-1314-0696

Shri Vasant C Shah Vs. United India Insurance Co. Ltd.

Award dated 19th June 2014

Partial repudiation of Mediclaim

Complainant treated for Acute Gastro Enteric Diaheria & Vomiting for which complainant lodged total claim of Rs.22,189/- was partially settled by the Respondent only Rs.12,056/- by deducting Rs.10,133/- as per policy clause No.1.2A, 1.2B, 1.2C & 1.2D.

Respondent explained all deductions in details which were accepted by this Forum and complaint dismissed.

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Case No.AHD-G-049-1314-0704

Shri Rajesh M Parikh Vs. The New India Assurance Co. Ltd.

Award dated 20th June 2014

Partial settlement of Mediclaim

Complainant's wife treated for Cyst of Right Knee joint ganglion and expense claimed for Rs.63,579/- was partially settled by the Respondent for Rs.51,645/- by deducting Rs.11,934/- as per reasonable and customary under clauses like 3.13.

Respondent explained all deductions in details which were accepted by this Forum and complaint dismissed.

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Case No.AHD-G-005-1314-0703

Shri Rajesh K Jagetiya Vs. Bajaj Allianz General Insurance Co. Ltd.

Award dated 30th June 2014

Repudiation of Mediclaim

Complainant's 3 years old daughter hospitalized for accidental treatment and surgery of Rt. Hand and expense incurred for Rs.2,81,310/- was repudiated by the Respondent as per clause C1 & C2.

Claim preferred on second year of the policy and x-ray report and hospitalization papers shows the treatment was for Osteochondroms of proximal right radius and Ulna and not for accidental injury.

As per policy condition C1 & C2, subject treatment expense does not coverage during the 1st two years of policy.

Thus complaint dismissed.

****

Case No.AHD-G-051-1314-0686

Mr. Manish A Rana Vs. United India Insurance Co. Ltd.

Award dated 30th September, 2014

Partial settlement of Mediclaim

The complainant underwent treatment for bleeding duodenal ulcer at Sanjiv Clinic & Nursing Home, Surat. He was hospitalized from 21.01.2013 to 23.01.2013. The Complainant stated that he had submitted a claim with the insurer for an amount of Rs. 29,288/- which was partially settled by the Respondent for Rs. 20,738/-. The respondent had deducted Rs. 8,550/-. According to the Respondent the deductions were made as per Policy Condition 1.2C i.e- the bills pertaining to other than Hospital expense.

Although the Insurer has referred to Condition No. 1.2(C) of the Policy yet in the Policy document only 1.2(C) is not stated. It is only 1.1(C). Moreover, the TPA has allowed the medicines prescribed by Dr. Agrawal.Keeping in view the totality of the circumstances the Ex Gratia award of Rs. 5,000/- was passed.

Complaint No. AHD-G-049-1314-706

Name: Dungaram v/s New India Assurance Co. Ltd.,

Nature of Complaint: Mediclaim _ Partial repudiation of Medi-Claim.

Award Date : 30.09.2014 Amount of Relief Sought: Rs. 51228/-

Amount Awarded: Rs. 25000/-

The Complaint was against partial Settlement on Acute Appendicitis. An amount Rs. 51228/- was deducted citing the reason Camera charges and Surgeon charges under reasonable and customary charges. Both parties to the complainant was heard and the Ombudsman awarded Rs. 25000/- as exgratia payment.

Complaint No. AHD-G-023-1314-708

Name: Gautam A. Nandha V/s Iffco Tokyo Gen. Ins. Co. Ltd.,

Nature of Complaint: Motor - Repudiation – Certificate of Periodical Inspection was not valid on date of accident.

Award Date: 30.09.2014 Amount of Relief Sought Rs. 56191/-
Amount Awarded: Rs. 16000/- Ex-gratia

The Complainant car was hit by a speeding dumper. The entire claim of Rs. 56191/- was dis-allowed, stating that Certificate of Periodical Inspection was not valid on the date of accident. The respondent had deputed in house surveyor. The Respondent stated that the assessed loss would be Rs. 32345/-. The Complainant was paying the premium since 2010 and regularly renewed the policy. At the time of taking the policy and subsequent renewal the Respondent had not asked him to submit the C.P.I. After hearing the ombudsman awarded Rs. 16000/- as exgratia payment.

Complaint No. AHD-G-049-1314-709

Name: Kinjal S. Thaker V/s New India Assurance Co. Ltd.,
Nature of Complaint: Mediclaim -Partial settlement of Mediclaim- Surgery for Vocal Cord Cyst. Award Date: 30.09.2014 Amount of Relief Sought Rs. 14965/-
Amount Awarded: Rs. 7000/- Ex-gratia

The complaint was against the partial settlement on surgery for vocal cord cyst. An amount of Rs. 14965/- were deducted under various policy clauses like reasonable and customary charges, non medical items etc. The Respondent had not sent full policy with policy clauses. The complainant was also not informed about PPN package. The Respondent had shown charges for various hospitals for the same type of surgery however it was not provided to the Complainant. The complaint was heard and awarded for Rs. 7000/- as exgratia payment.

Case No.AHD-G-048-1314-0522

Shri Zilesh U Shah Vs. National Insurance Co. Ltd.
Award dated 28th April 2014
Partial repudiation of Mediclaim

Complainant's wife treated for Bilateral Ovarian Malignant Mass and expense incurred for Rs.1,87,828/- was partially settled by the Respondent for Rs.1,19,555/- by rejecting remaining amount of Rs.68,273/- as per clause No.2 of the mediclaim policy.

The policy is a Tailor made Group mediclaim, which appears to be a case of unconventional group policy.

Thus complaint dismissed.

****

Case No. AHD-G-049-1314-0532

Shri Bhipin R. Solanki Vs. The New India Assurance Co. Ltd.

Award dated 28th April 2014

Repudiation of Mediclaim

Complainant was covered a Group Mediclaim Policy issued to LIC of India for their employees and claim lodged for Rs.22,140/- for hospitalization expense was repudiated by the Respondent saying that the hospitalization was only for investigation purpose and there was no active line of treatment was given.

Moreover, as per treatment records, complainant was a known case of Neurogenic Bladder and H/o Cystoscopy and also Discharge Card was without signature.

In view of this complaint dismissed.

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Case No. AHD-G-020-1314-0570

Smt. Renukaben Y Patel Vs. ICICI Lombard Gen. Ins. Co. Ltd.

Award dated 7th May 2014

Non settlement of Mediclaim

Complainant's daughter treated for Ureteric Calculus and expense incurred for Rs.12,671/- was not settled by the Respondent by giving reason

that as per terms and conditions of the Group mediclaim policy the subject treatment will not be payable in first year of the policy.

The policy is a Tailor made Group mediclaim, which appears to be a case of unconventional group policy.

Thus complaint dismissed.

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Case No.AHD-G-049-1314-0637

Shri Ashvinkumar R Joshi Vs. The New India Assurance Co. Ltd.

Award dated 16th May 2014

Repudiation of Mediclaim

Complainant treated for Lumpectomy for infected Sebacious Cyst and expense incurred for Rs.17,399/- was repudiated by the Respondent on the basis of 24 hours hospitalization is not required.

The policy is a Tailor made Group mediclaim, which appears to be a case of unconventional group policy.

Thus complaint dismissed.

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Case No.AHD-G-049-1314-0643

Shri Aiyub M Malavat Vs. The New India Assurance Co. Ltd.

Award dated 20th May 2014

Repudiation of Mediclaim

Complainant was covered a Group Mediclaim Policy issued to LIC of India for their employees and claim lodged for Rs.27,600/- for hospitalization expense of his son was repudiated by the Respondent saying that the hospitalization was for Psychosomatic treatment which is under exclusion clause 9.6.

Moreover, as per treatment records, there was no temperature statement, no signature of any hospital authority in discharge summary, no advice for hospitalization etc.

In view of this complaint dismissed.

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Case No.AHD-G-050-1314-0652

Shri Nirav M Mody Vs. Oriental Insurance Co. Ltd.

Award dated 21st May 2014

Repudiation of Mediclaim

Complainant's mother underwent surgery for CAD and expense incurred Rs.1,15,000/- was repudiated by the Respondent as per policy terms and condition No.4.3.

There is a cap of 3 years for the subject treatment and previous policy details was not produced by the insured.

The policy is a Tailor made Group mediclaim, which appears to be a case of unconventional group policy.

Thus complaint dismissed.

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Case No.AHD-G-050-1314-0656

Shri Samir R. Rami Vs. Oriental Insurance Co. Ltd.

Award dated 26th May 2014

Repudiation of Mediclaim

Complainant's father underwent surgery for Non-ST elevation, Myocardial Infraction and expense incurred Rs.98,006/- was repudiated by the Respondent as per policy terms and condition No.4.3.

There is a cap of 4 years for the subject treatment and claim preferred in the 3rd year of the policy.

The policy is a Tailor made Group mediclaim, which appears to be a case of unconventional group policy.

Thus complaint dismissed.

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Case No.AHD-G-049-1314-0651

Shri Dineshchandra V Mehta Vs. The New India Assurance Co. Ltd.

Award dated 26th May 2014

Repudiation of Mediclaim

Complainant was covered a Group Mediclaim Policy issued to LIC of India for their employees and claim lodged for hospitalization expense of himself was repudiated by the Respondent saying that the hospitalization was not justified.

Moreover, as per treatment records proved the hospitalization was for observation. He was treated with Dynaper Injection and Neurobian Injection which could have been given on OPD basis.

In view of this complaint dismissed.

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Case No.AHD-G-048-1314-0458

Shri Shantilal M Kalariya Vs. National Insurance Co. Ltd.

Award dated 26th April 2014

Repudiation of Mediclaim

Complainant treated for Cerebral Vascular Accident (CVA) inter related to ICH+HTN +DM and expense incurred for Rs.23,321/- was repudiated by the Respondent as per clause No.4.1 of the mediclaim policy as pre-existing disease.

The policy is specially designed for the Account Holder of Bank of Baroda a Tailor made Group mediclaim, which appears to be a case of unconventional group policy.

Thus complaint dismissed.

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Case No.AHD-G-051-1314-0562

Shri Praful Harshe Vs. United India Insurance Co. Ltd.

Award dated 28th May 2014

Repudiation of Mediclaim

Complainant's father hospitalized for treatment of HTN+DM+ Severe Electrolyte Imbalance and expense incurred Rs.13,172/- was repudiated by the Respondent as per pre-existing disease.

As per hospital records proved the insured patient was suffering from DM since 30 years and policy incepted since 2005.

The policy is a Tailor made Group mediclaim, which appears to be a case of unconventional group policy.

Thus complaint dismissed.

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Case No.AHD-G-050-1314-0667

Miss Meghna Shah Vs. Oriental Insurance Co. Ltd.

Award dated 28th May 2014

Repudiation of Mediclaim

Complainant underwent Radiotherapy treatment for Tongue Cancer and expense incurred Rs.1,20,000/- was repudiated by the Respondent as per policy clause 7.16.

The policy is a Tailor made Group mediclaim, issued to R.D. Hospitality & Health Services which appears to be a case of unconventional group policy.

Thus complaint dismissed.

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Case No.AHD-G-048-1314-0666

Shri Pravinbhai P Thakkar Vs. National Insurance Co. Ltd.

Award dated 28th May 2014

Repudiation of Mediclaim

Complainant's wife treated for Coronary Angiography and expense incurred for Rs.7,400/- was repudiated by the Respondent as per clause No.4.10 of the mediclaim policy as Angiography report was normal and there was no active line of treatment.

The policy is specially designed for the employees of the Sayaji Industries, a Tailor made Group mediclaim, which appears to be a case of unconventional group policy.

Thus complaint dismissed.

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Case No.AHD-G-048-1314-0670

Shri Harshvardhan A Pandit Vs. National Insurance Co. Ltd.

Award dated 2nd June 2014

Repudiation of Mediclaim

Complainant preferred two claims in the first year of the policy, first claim for Rs.42,649/- for essential HTN and second claim of Rs.1,44,776/- for CABG which were repudiated by the Respondent as per policy terms and condition and exclusion clause No.4.1.

The policy is specially designed for the Account holders of the Dena Bank, a Tailor made Group mediclaim, which appears to be a case of unconventional group policy.

Thus complaint dismissed.

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Case No.AHD-G-049-1314-0683

Shri Kartik A Makwana Vs. The New India Assurance Co. Ltd.

Award dated 13th June 2014

Repudiation of Mediclaim

Complainant was covered a Group Mediclaim Policy issued to LIC of India for their employees and claim lodged for hospitalization expense of his wife's treated for Uterine prolapsed cystocle & rectocle and incurred Rs.52,121/- was repudiated by the Respondent saying that the hospital was not completed minimum criteria of 15 inpatient beds. So claim rejected as per policy terms and condition No.2.1.

The policy is specially designed for the employees of the LIC of India, a Tailor made Group mediclaim, which appears to be a case of unconventional group policy.

Thus complaint dismissed.

BHOPAL

BHOPAL CENTRE- NON LIFE-MEDICLAIM

Mr. Anand Vyas ..... Complainant

V/s

United India Insurance Co.Ltd. . ..... Respondent

Order No. IO/BHP/R/GI/0010 /2014-2015 Case No.: GI/UII/1104/04

As per the complaint and P-II form, complainant Mr.Anand Vyas had taken a Floater Mediclaim Policy bearing no. 190402/48/09/87/00000915 for the period of 26.09.2009 to 25.09.2010 for Sum Assured Rs.1,00,000/- under Group Mediclaim Insurance Policy as account holders of State Bank Of Indore which was issued by the respondent and received by the complainant subject to terms and condition. It is further said that he was treated in CHL Appolo Hospital, Indore and paid Rs. 1,21,000/- towards his treatment cost and he

lodged the claim before the respondent company for making payment of Rs 1,00,000/- the sum assured as mentioned in P-II form but his claim was repudiated on the ground of pre existing disease. It is further said that he has taken the policy on 26.09.2009 and his operation was performed on 03.09.2010.

The insurer respondent have contented in their SCN that the complainant had taken first time mediclaim insurance policy for the period from 26.09.2009 to 25.09.2010 and he was admitted in CHL Apolo Hospital from 01.11.2009 to 10.11.2009.and the hospitalization was for the treatment of HTN, CAD, Anterior Wall, MI, Tripple Vessel disease as per discharge summary and have further contended that the paitent was admitted for K/C/O HTN with CAD as such the disease becomes pre existing, so, it comes under exclusion clause 4.1 of the policy and this means that the disease for which treatment was received, was pre existing at the time of taking the policy for the first time.

<u>OBSERVATIONS</u>:-

From perusal of the policy document (xerox copy) brought on the record by the complainant, it is apparent that it has been clearly mentioned below the term description as "Floater Mediclaim Cover, Sum Assured Rs.1,00,000/- risk covered Indore Bank Arogya Scheme floater Mediclaim Policy, Special exclusion as per policy condition attached, subject to clause as per policy condition attached, special excess as per policy condition attached" which clearly shows that the policy terms and conditions was attached with the policy document and if the contention of the complainant is taken into consideration that he had not received any terms and conditions alongwith any letter, his contention becomes highly weak, unnatural and improbable in view of the facts that after receiving the policy document containing the facts mentioned about attachment of the policy condition, the complainant had not taken pain to make any correspondence with the respondent/ his concerned bank for sending the policy terms and condition and the complainant has failed to show that he made any correspondence either with respondent or with the concerned bank for sending the terms and conditions of the policy document which has been clearly mentioned in his policy document. Hence, I find no substance in the contention of the complainant regarding non receipt of terms and conditions of the policy document. Mr. Anand Vyas had taken first time mediclaim policy for the period from 29.09.2009 to 25.09.2010

Hence, on consideration of aforesaid facts, circumstances, material available on the record and submissions made by both the parties, I am of the considered view that the decision taken by the respondent company regarding repudiation of the claim of the complainant on the ground of clause 4.1 of the terms and conditions of the policy document is just, proper and reasonable and sustainable in the law and does not require any interference by this authority. Hence, complainant is not entitled for any relief as prayed for. In the result this complaint stands dismissed accordingly being devoid of any merit.

Dated at BHOPAL on 30th day of May, 2014

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Mr. Chhamanidhi Bari ..... Complainant

V/s

New India Assurance Co.Ltd. ..... Respondent

Order No.IO/BHP/A/GI/0053/2014-2015 Case No.: BHP-G-049-1314-0609

The complainant Mr. Chhamanidhi Bari was covered under a mediclaim policy bearing No.12070034120500000003 for the period of 01.04.2012 to 31.03.2013 which was issued by the respondent company to the insured Life Insurance Corporation of India under which the complainant was regular employee and member of the mediclaim policy. It is further said that due to falling ill he was admitted in nursing home and after treatment he lodged claim for Rs.37607/- towards the treatment in nursing home but the respondent company paid only 30,616/- after deducting Rs.6,991/- on 08.03.2013 . He approached the respondent company to show the ground of said deduction and payment of the deducted amount but his claim was not considered. Being aggrieved from the action of the respondent, the complainant approached this forum for relief of making payment of the deducted amount Rs. 6,991/- with interest.The insurer in their reply dated 12.09.2013 have contended that respondent has paid Rs.30,616/- to the LIC.Raipur D.O. on 11.03.2013 under the claim of the complainant under the aforesaid policy on the basis of hospital bill containing discount provided by hospital and declaration issued by the Dirghayu Nursing Home.

<u>Findings & Decision :</u>

I have gone through the material placed on the record and submissions made. From perusal of the reply dated 12.09.2013 and submission made by insurer's representative, it is clear that as per investigation report and hospital bill, the admissible amount after deducting the discount given by the hospital has been paid to the LIC, Raipur DO on 11.03.2013 under the said policy document regarding the claim made by the complainant. The copy of the information given under RTI Act to the complainant by the respondent that the

discount was given by the said nursing note. Hence, in these circumstances, the respondent is not liable to pay the balance amount as claimed.

Dated at BHOPAL on 24th day of September, 2014

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BHOPAL-MEDICLAIM AWARDS

Dr. A.P. Soni ..... Complainant

V/s

The Oriental Insurance Co. Ltd.....Respondent

Order No. IO/BHP/A/GI/0022 /2014-2015 Case No. GI/OIC/1010/82

As per complaint, the complainant had taken the individual mediclaim policy bearing no. 152900/ 48/ 2009/1023 (wrongly mentioned in place of 152900/ 2008/ 1023) for sum assured of Rs.3,50,000/- for the period from 31.03.2008 to 30/03/2009 which was issued by respondent subject to policy terms & conditions. It is further said that the complainant was diagnosed for Non-Hodgkin's Lymphoma and he was advised chemotherapy by the consultant and for which he had availed cash less benefit at Marble City Hospital Jabalpur for undergoing treatment since 31.08.2008 to 02.09.2008 and for which pre authorization of Rs.30,000/-was given from E-Meditek Solutions Ltd. and later final approval for Rs.60,371/- vide PAC No. EMSL/PAC/OI/112938/2008 dated 30.09.2008 was given. The original discharge card alongwith original bills and all original reports were sent to TPA E-Meditek Solutions Ltd. on 26.02.2009 by the hospital but he was informed that the payment to the said cashless claim was not released to the hospital till date and the hospital had issued a letter to deposit the payment against above admission and request was made several times to the Oriental Insurance Co.D.O. 1 Jabalpur for settlement of claim but no action has been taken till date and matter was still pending and various letters were written. It is further said that one more reimbursement claim for another chemotherapy from date of admission 08.03.2009 to 10.03.2009 was submitted to the E-Meditek Solutions Ltd. for Rs.63,697/- and this was also pending for settlement and a letter was sent to the Grievance Cell, Oriental Insurance Co. Delhi but no favorable reply had been received from their end also.

From the record, it appears that the original documents regarding payment of Rs.60,371/- were sent by the concerned hospital to the TPA of the respondent through courier and the hospital has also filed the correspondence made with the TPA and courier regarding loss of consignment no.148619 dated 16.09.2008. The respondent vide letter dated 25.11.2010 have informed to this forum that the case of the complainant had been disposed off by the TPA and all the documents are available with him but the respondent have denied about receipt of the documents with regard to both the claims by the company.

From the records, it is also apparent that the TPA had issued Preapproval Certificate No.1 for authorization amount Rs.60,371/- on the condition of furnishing the required documents. It has been established from the record that the necessary records documents were sent by the hospital to the TPA through courier vide letter 14.09.2008 but the consignment was lost as appears from the correspondence made. It appears that the claim for Rs.60371/- was held up on the ground of non availability of the original documents which was sent by the concerned hospital to the TPA of the company. Since the documents submitted to the Respondent/TPA were lost either in their office or during transit, the complainant can not be held liable.

So for as IInd claim of the claimant for Rs. 63697/- is concerned, the respondent has categorically mentioned in reply dated 21.06.2013 that all the papers were submitted to E-Meditek but claim was not settled and TPA has not submitted claim file to the D.O. Thus, it is also established from letter dated 20.06.10 & 21.06.2013 that the documents were submitted by the claimant to the TPA regarding claim for Rs.63697/- with discharge card, pathological test reports, medical bills. From the record, it has been established that the respondent have not taken any final decision regarding payment of his both claims as yet and for and want of any specific decision in the matter, the claimant could not make any proper representation to the respondent in connection with his two claims, in case it was dis-allowed as required under the provisions of RPG rules 1998 which touches the maintainability of the claim. Thus, it is established that the claims made by the complainant before respondent are still pending for want of original documents like discharge card, medical bills etc. and it is also established that payment of Rs.60,371/- has also not been made even after issuing the pre approval certificate for want of the original documents from the concerned hospital which was duly sent by the hospital to the TPA.

Hence, in the view of aforesaid facts, circumstances, material placed on the record, I am of the considered view that the complaint is premature for want of any final decision of the claim on account of non filing of original documents and representation before the company as such the complaint is liable for dismissal being premature.

In the aforesaid circumstances, the complainant may submit self attested photocopies of all the necessary required original documents for reimbursement of his claims before the respondent. The respondent Oriental

Insurance Co. Ltd. is directed to consider and settle both the claims of the complainant on the basis of self attested photo copies of required original documents or duplicate copies of documents from the Complainant/ Marble City Hospital & Research Centre, Jabalpur within one month and shall make payment of Rs.60,371/- directly to the said concerned hospital as per pre approval certificate issued to the said hospital on 02.09.2008. The respondent Oriental Insurance Co.Ltd is also directed to consider the payment of admissible amount for the claim of Rs.63,697/- in accordance with terms & conditions of the policy document to the complainant within one month from the date of receipt of this order and inform the final decision to the complainant under intimation to this office.

In the result, the complaint being premature stands dismissed with the above observation. In case complainant is aggrieved from the order of the respondent insurer, it will provide him a fresh cause of action to seek redressal of his grievance before appropriate forum in accordance with law.

Dated at Bhopal on 30th day of June, 2014
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Mr.Arvinder Singh Hora ....Complainant

V/s

Star Health Insurance Co. Ltd. ....Respondent

Order No. IO/BHP/A/GI/ 0056/2014-2015 Case No : GI/SHI/1007/34

The case of complainant in short is, that the complainant was a mediclaim policy holder with New India Assurance Co. Ltd since 2002 and his last policy was bearing no.451300/34/07/11/00002995 from the period 21.03.2008 to 21.03.2009. He changed the company to Star Health Insurance Co.Ltd. and took the policy bearing no. P/201115/01/2009/001909 from the period 21.03.2009 to 20.03.2010 after being told that all prevailing benefits will be given to him of previous policy. Meanwhile, his son was admitted to Dolphin Hospital on 01.10.2009 and was discharged on 05.10.2009. Thereafter, he lodged the claim towards treatment cost of his son submitting the detail bills to the respondent company but his claim was rejected. Then, he approached two times to the respondent company and last letter was given to them on 25/03/2010 but they have not given any reply to him.

The insurer in their reply (SCN) dated 10.02.2011 have admitted about the issuance of aforesaid policy for the period 21.03.2009 to 20.03.2010

covering the complainant, his wife and son Master Ashimeet Singh Hora, the dependent child and Ku. Harsimran Kaur Hora, the dependent child for sum assured Rs. 4,00,000/-. The respondent has stated in their SCN that they received the claim of Mast. Ashimeet Singh Hora for the treatment of Lymphangioma with acute Lymphangitis for the period 01.10.2009 to 05.10.2009 at Dolphin Hospital and research foundation, Indore and have contended that the patient was suffering from said complaints since 3-4 years as mentioned by the treating doctor in the medical certificate, so it is evident that the on set of the disease falls well before the 'respondent company's policy and since the patient was suffering from the said condition prior to the inception of the policy, hence the claim would be inadmissible as per exclusion no.1 of the policy and the company is not liable to make any payment under the policy until 48 months of continues coverage have elapsed since inception of the first policy with the company as such the claim was rejected and communicated to the complainant/ insured on 20.01.2010.

I have gone through the material placed on the record and submissions made by both the parties during hearing. It is admitted position that the above policy was issued by the respondent company subject to terms & conditions. From perusal of the aforesaid concerned policy issued by the respondent company for the period 21.03.2009 to 20.03.2010, it is apparent that the previous policy no. 451300/34/07/11/00002995 has been clearly mentioned in the column 'previous policy no.' and the above previous policy was issued by the New India Assurance Co.Ltd. and the above previous policy document (xerox copy) also shows the date of issuance of first policy as 21.03.2002. The respondent company has not challenged about continuity of the mediclaim policy from dated 21.03.2002 to 20.03.2008 issued by New India Assurance Co.Ltd. before taking the aforesaid concerned policy of the respondent. So, the conduct of the respondent company by mentioning the previous policy no. in the aforesaid policy issued by them is sufficient to prove that the policy was in continuity since 21.03.2002 to 20.03.2010. There was no provision of portability during the said period of insurance. The insurer's representative was also failed to show any break. The Exclusion at S.No.5 of policy terms & conditions provides that the exclusion 2, 3 and 4 shall not however applies in case of the insured person having been covered under any insurance cover with any of the Indian insurance company for a continuous period preceding 12 months/ 24 months respectively without any break and S.No.1 of exclusion provides that pre-existing disease as defined in the policy until 48 months of continuous coverage have elapsed since inception of the first policy with the company but the word company has not been clarified that whether word company is only concerned with the respondent or any other insurance company. Moreover, the insurer's representative has not submitted the xerox copy of the proposal form to show about any entry regarding pre-existing disease of the patient. So, adverse inference can be drawn. From the conduct of the respondent company by mentioning the previous policy no. in their policy document of New India Assurance Co.Ltd. , the continuity of the said medclaim policy can not be dislodged and the exclusion no.1 can not be made applicable

to deny the claim of the complainant. Though, the treating doctor has simply mentioned about past history with the duration of illness as 3-4 years but that duration has not been found mentioned in the discharge summary or any other medical document. So, I do not find any substance in the contention of insurer's representative regarding denial of the claim and respondent is liable to make payment of admissible amount towards treatment of complainant's son in accordance with the terms & condition of the policy document.

Hence, the respondent Star Health Insurance Co.Ltd. is directed to pay the admissible amount in accordance with the terms & conditions of the policy document to the complainant Mr. Arvinder Singh Hora within 15 days from the date of receipt of acceptance letter of the complainant failing which it will attract 9% simple interest p.a. from date of this order to date of actual payment. In the result, the complaint is allowed to the extent of above admissible amount.

Dated at Bhopal on 30th day of September, 2014
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Dr. Ajit Jain .... Complainant

V/s

National Insurance Co. Ltd... .... Respondent

Order No.IO/BHP/A/GI/0006 /2014-2015 Case No.: GI/NIC/1104/08

Brief Background

This complaint has been filed by Dr.Ajit Jain being son of policyholder and insured Mr.Prem Kumar Jain bearing Mediclaim Policy No. 321700/48/09/8500002362 issued by the respondent company praying therein to direct the respondent insurance company to make payment of Rs.84,388/- as per complaint and Rs.91,451/- including interest and cost of case as mentioned in P-II form. As per complaint, the complainant's father Mr.Prem Kumar Jain had taken Individual Mediclaim bearing policy no. 321700/48/09/8500002362 for sum assured 1,25,000/- for the period 28.10.2009 to 27.10.2010 covering the policy holder himself and his wife Smt. Rajkumari Jain which was issued by the respondent subject to the exclusion of heart disease and received by the policy holder subject to terms and conditions. It is further said that his father was admitted in the hospital on 04.10.2010 and after discharge on 10.10.2010, he lodged the claim before the respondent alongwith all the claim documents but his claim was rejected on

the ground that the ailment for which his father was admitted comes under the policy terms condition 4.1 which was related to heart disease, so, the claim was not payable while no treatment was done of his father related to heart ailment rather his father was treated for Renal Failure with Pulmonary Oedema which has no correlation with the disease mentioned in clause 4.1.

OBSERVATIONS:-

From perusal of the case file, it transpires that in compliance of order dated 20.01.2014, the respondent who was in possession of concerned proposal form have not brought on the record the same and no reasons has been shown for non production of the said required Xerox copy of the proposal form which is highly warranted for deciding the matter in the issue i.e. the pre existing disease of the complainant's father. So, adverse inference can be drawn for non production / with holding the said required proposal form. So, in absence of the said proposal form, it can be taken as true that the complainant's father had no such pre existing ailments.

It is also apparent from the record that the complainant has brought on record the policy document (xerox copy) from 28.10.2002 to 27.10.2011 after getting it renewed year to year with respect to the insured policy holder Prem Kumar Jain and heart disease has been shown as excluded in the policy documents. The respondent has not filed any reply/ SCN against the allegation made in the complaint regarding non payment of his claim towards treatment of his father except mere calculation chart vide letter dated 20.05.2014 for amount of Rs. 63,954/- only if it is found admissible. Thus, from the aforesaid facts, it is clearly established that the afore said diagnosed ailments are not related with any heart disease and as per IPD final cash invoice and calculation chart dated 20.05.2014 the amount of Rs. 63,954/- is also found reasonable in view of terms and conditions of the policy document.

On consideration of aforesaid facts, circumstances, material available on the record and submissions made by both the parties, I am of the considered view that the decision taken by the respondent company regarding repudiation of the claim of the complainant towards treatment cost of his father late Prem Kumar Jain during the aforesaid hospitalisation period is not just, fair and reasonable and is also not sustainable in law and complainant is entitled to get claim of Rs. 63,954/- (Rs Sixty three thousand nine hundred fifty four) only as admissible amount as per terms & conditions of the policy document. Hence, the respondent company National Insurance Co.Ltd. is directed to pay Rs. 63,954/- (Rs Sixty three thousand nine hundred fifty four) to the complainant Dr.Ajit Jain within 15 days from the date of receipt of acceptance letter from the complainant failing which it will attract a simple interest of 9% p.a. from the date of this order to the date of actual payment. Hence, complaint is allowed to the extent of the above amount only.

Dated at BHOPAL on 21th May, 2014

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Dr. Ajit Jain ..... Complainant

V/s

National Insurance Co. Ltd... ..... Respondent

Order No.IO/BHP/A/GI/0005/2014-2015 Case No.: GI/NIC/1009/76

As per complaint, the complainant's father Mr.Prem Kumar Jain had taken Individual Mediclaim Policy bearing policy no. 321700/48/09/8500002362 for sum assured 1,25,000/- for the period 28.10.2009 to 27.10.2010 covering the policy holder himself and his wife Smt. Rajkumari Jain which was issued by the respondent subject to the exclusion of heart disease and received by the policy holder subject to terms and conditions.

The respondent in their self contained note dated 13.10.2010 received in this office on 18.01.2012 have contended that the company have provided an insurance cover to the Mr. Prem Kumar Jain since 1998. He had gone for Coronary Artillery Surgery in 2001and since then heart disease were specifically excluded from the scope of policy cover and it was observed from the documents submitted by the insured that Mr.Prem Kumar Jain was known patient of diabetes, hypertension and heart disease since from last 23 years.

<u>OBSERVATIONS</u>:-

Admittedly, the complainant's father Mr. Prem Kumar Jain was insured and covered under the mediclaim policy. It is also admitted fact that the father of complainant was hospitalised on 18.03.2010, 23.03.2010, 04.04.2010 and 07.04.2010. It is also admitted fact that the complainant lodged the claim for Rs. 53,770/- as per complaint and 62,000/- as per P-II form but the respondent repudiated the claim of complainant in view of clause 4.1 of policy document.

From close perusal of the record, it transpires that there is two divergent opinion of the doctors about the co relation of heart disease or diabetes with the ailments suffered by the father of the complainant and treatment during hospitalization period. Firstly, I would like to discuss the opinion given by Dr. K.G.Agrawal to the respondent as per the requirement of the respondent and the said doctor in his report dated 08.06.2010 has clearly mentioned that as per file he (Prem Kumar Jain) was a known case of the diabetes and hypertension since last 23 years. His coronary artery bypass surgery was done in 2001. He had also developed nephropathy and ratinopathy. He was admitted in Curewell Hospital,Indore from 18.03.2010 to 20.03.2010 with the c/o Retention of Urine, from 23.03.2010 to 25.03.2010 with Atonic Urinary Bladder, from 04.04.2010 to 06.04.2010 with Atonic Urinary Bladder and from 07.04.2010 to 11.04.2010 with Hyponatremia (Low Sodium in blood) and

Atonic Bladder was due to diabetic nephropathy and hyponatremia is again known complication of diabetes, hypertension and heart disease and diabetes was pre existing. I would also like to discuss the opinion of Dr.Ashok Sethia brought on record on 26.12.2013 on date of hearing by the complainant which does not contain any date and without filing the same before the respondent at the time of lodging claim. From perusal of the said report of the Dr. Ashok Sethia, it transpires that the Doctor has reported that in March, 2010 he (Prem Kumar Jain) again developed the acute retention of urine and severe hematuria from urethra and admitted in emergency Curewell Hospital. After 3 days of discharge, patient pulled on his catheter due to his irritation again he was admitted for re-cathetertion and in all this respect, patient cardiac and diabetic or component was absolutely normal and all these complication are not with his heart disease or diabetes. From the above two reports are totally diversion on the point of matter in issue i.e. about any correlation of the said aliments for which insure was admitted and treated with his heart disease or diabetes.

The respondent has not brought on record the copy of the proposal form for the reason best known to the respondent. So, it can be viewed adversely but since there is divergent opinion in the report of the Dr.K.G.Agrawal submitted by respondent and Dr.Ashok Sethia submitted by the complainant on the point in issue to show any co relation with the heart disease or the diabetes and the aliments i.e. atonic bladder and hyponetremia and which requires oral evidence of an independent doctor as expert witness. So, the expert opinion in field of cardiology and diabetes as well as medical literature on the matter in issue in view of clause 4.1 of policy document is highly required. Both the parties have also not provided any other document to substantiate their contention except the two divergent opinions of doctors. This forum has got limited authority under the RPG Rules, 1998. It can only hear the parties at dispute without calling any witness (witness of fact or expert witness) nor summon them for their evidence (examination & cross examination) as it is beyond the scope of this forum. In order to resolve the issue, I am of the considered view that the evidence of expertise doctor in the said field of cardiology and diabetes may help in arriving at a just decision. Hence under the aforesaid facts and circumstances, this complaint stands dismissed with a liberty to the complainant to approach some other forum / court to resolve the subject matter of dispute.

Dated at BHOPAL on 12th May, 2014
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Amarjeet Singh Chawla…………………………………………… Complainant

V/s

United India Insurance Co. Ltd…………………………………………Respondent

Order No. IO/BHP/A/GI/0054/2014-2015 Case No. GI/UII/1009/75

As per complaint, the complainant had taken the mediclaim policy bearing no.050400/48/09/41/00000074 and medical card validity till dated 13.03.2011 which were issued by respondent. It is further said that he was treated in Asian Heart Hospital, Bombay from 15.03.2010 to 24.04.2010. Thereafter, he sent a letter dated 13.05.2010 to the respondent company at Hyderabad regarding payment of claim of Rs. 84,597/- alongwith concerned 6 bills but the letter sent through courier was returned as the Hyderabad office was shifted and thereafter, he also sent a letter on 02.06.2010 to head office of the company at Madras (Chennai) for passing his claim but no reply was received.

The insurer in their Self Contained Note dated 16.10.2012 have admitted about the issuance of the above policy with the period of insurance from 14.03.2010 to 13.03.2011 for sum assured Rs.5 lacs which was serviced by third party administrators- M/s Family Health Plan Ltd. Hyderabad and have also mentioned about taking treatment for Coronary Artery disease at Asian Heart Institute, Mumbai from 15.03.2010 to 24.04.2010 and total bills towards his treatment was for Rs. 84,607/-. The respondent have further contended that the insured had sent all the xerox copies of medical documents on 02.06.2010 and lodged the claim for Rs.84,607/- with the TPA towards treatment expenses and the TPA requested the insured vide their letter dated 10.08.2010 and 28.08.2010 to send original documents to process the claim but the insured has not sent any original document. Thereafter a reminder cum closure letter was also sent stating that if they do not receive the required details within stipulated time, they shall treat the claim as closed/ repudiated and no further correspondence will be entertained at a later stage but the claimant has not sent any reply for the final reminder also and the regional manager who has signed the SCN was agreed by the decision taken by the divisional office as well as their TPA in repudiation of the claim on the ground of non submission of the original documents inspite of letters and final reminder/ closure letter dated 14.09.2010 and prayed to dismiss the complaint.

<u>Findings & Decision :</u>

I have gone through the material on the record and submissions made by both the parties. From the record, it is apparent that the complainant had sent a letter dated 13.05.2010 alongwith the concerned 6 bills to the respondent company at Hyderabad and thereafter, he also sent a letter on 02.06.2010 to respondent company at Chennai for passing his claim. It is also clear from the record that the complainant had sent a letter dated 10.02.2011 to the Good Health Plan at Hyderabad Office enclosing all the original bills and receipts and the receipt of the above letter dated 10.02.2011 has also been acknowledged by the respondent company vide letter dated 22.02.2011 sent to the complainant communicating him that his letter has been forwarded to their TPA on 22.02.2011 and direction was given to contact the TPA also mentioning that

his letter was under process at their end and he was required to forward ID xerox. Thus, it is established that all the original medical documents enclosed with letter dated 10.02.2011 was under clear receipt of the respondent company which was forwarded to the TPA. So, the respondent company is fully liable about availability of the said original medical documents. Moreover, in view of the part hearing held on previous date, the complainant has also submitted the duplicate copies of all the original bills and receipts vide his letter dated 26.11.2013 on 27.11.2013 to the branch manager of the respondent company Raipur branch in clear signature and seal of the respondent company. So, it was the responsibility of the respondent company to process the claim of the complainant on the basis of duplicate bills, receipts and reports but the respondent company failed to discharge their duty/ responsibility for deciding the claim of the complainant made towards his treatment which reflects the callous attitude of the respondent company. The company has failed to show any other cogent reasons for closure/ repudiation of the claim of the complainant except non filing of original documents.

Hence the respondent company United India Insurance Co.Ltd. is directed to review the claim of the complainant on the basis of duplicate copies of all the original documents regarding treatment of the complainant as available in the office of respondent company or on submission of xerox copy of duplicate copy of all the concerned original documents and also make payment of admissible amount towards the claim made in accordance with the terms & conditions of the policy document within one month from date of receipt of acceptance letter of the complainant under intimation to this office. In the result, the complaint is allowed to the extent of above observation.
Dated at Bhopal on 26th day of September, 2014

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Mr. Arvind Neema ……………………………………………………………… Complainant

V/s

Reliance General Insurance Co.Ltd………………………………………… Respondent

Order No.IO/BHP/A/GI/0049/2014-2015 Case No.: GI/RGI/1011/94

The complainant Mr. Arvind Neema had taken Healthwise Policy bearing No. 2302792825005237 for different amount under different heads for the period of 18.08.2007 to mid night on 17.08.2010 covering himself, his wife Mrs.Lalita Neema and his two sons Harjit Neema and Aniket Neema which was issued by the respondent subject to terms & conditions. It is further said that he submitted claim papers & other documents after treatment of Diabetic foot as diagnosed after admission on 04.09.2009 and discharged on10.09.2009

from Bafna Hospital,Indore for Rs.26,879/- under aforesaid policy and he also submitted all the additional information as required by the TPA but his claim was rejected on 02.07.2010 by the TPA/respondent company on the ground of overwriting on discharge card and ICP as not verified. Being aggrieved from the action of the respondent, the complainant approached this forum for relief of making payment of Rs. 26,879/-and Rs.10,000/-only .

The insurer in their SCN dated 06.01.2011 have stated that the complainant had Abscess with cellulites at right foot as per first consultation letter of Dr.G.D.Malani and discharged with a diagnosis of Diabetic foot and his duration of Diabetes in discharge card & indoor case sheet history section deleted but treatment sheet dated 05.09.2009 shows it 2 years makes its duration 05.09.2007.The complainant was insured since 18.08.2007 and his first 30 days completed on 18.09.2007. This impels that he contacted diabetes within first 30 days or having pre-existence and due to correction and overwriting, its duration could not be decided correctly and claim was repudiated by the company due to violation of Terms & Condition no. 2 of Healthwise policy for non discloser of material facts in the proposal form.

Since the consumer case no.205/12 has also been filed and pending in the CDRF, Indore on the same subject matter. As per RPG rules, Section 13(3)(c), such a complaint cannot be further processed by this forum and is liable for dismissal. In the result, the complaint stands dismissed.
Dated at BHOPAL on 27th day of August, 2014
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Mr. Mahesh Chandra Sharma.. Complainant

V/s

Oriental Insurance Co. Ltd..Respondent

Order No. IO/BHP/A/GI/0040/2014-2015 Case No. GI/OIC/1205/07

The case of complainant in short is, that the complainant had taken individual mediclaim policy bearing no.151300/48/2011/6970 (wrongly mentioned as 151300/48/2011/0970 in P- II form) for sum assured Rs.2 Lakh for himself and his wife and dependent child for sum assured Rs. 2 Lakh each for the period 17/09/2010 to 16/09/2011. It is further said that he had undergone for cataract operation and lens implant and he lodged his claim with claim bill dated 08/03/2011 and 23/04/2011 for Rs. 35,878.50/- and 35631.80/- respectively for settlement before the respondent company but he received cheque no. 708323 dated 02/08/2011 for Rs. 24000/- and cheque no. 708318 dated 02/08/2011 for Rs. 24000/- from Vipul Medicorp TPA Pvt, Ltd. , Gurgaon and he was informed that in case of senior citizens, cataract operations claim bills are payable in full but the payments were not in tune of

his claim bills without showing the reasons for deductions. After being aggrieved against the partial settlement of his claim, he approached this forum for the said relief of payment of balance amount.

The insurer in their self contained note dated 30/05/2012 have admitted about undergoing the cataract surgery at Rajas Eye and Retina Research Centre and have contended that both the claims have been settled and paid (Rs. 24000 each against both the claimed amount) as per clause 3.12 and reasonable and customary charge for cataract surgery was processed in the claim and as per circular from New India HO/Health/CIR no. IBD. ADMN:2010:114 the maximum limit for cataract surgery was as Rs. 24000/- only.

The clause 3.12 policy terms and conditions deals with reasonable and customary surgical medical treatment expenses within the scope to treat the condition for which the insurer person was hospitalized. From perusal of the discharge voucher (Xerox Copy) dated 23/04/2011 and dated 07/05/2011, it is apparent that Rs. 24000/- for each claim was paid and received by the complainant towards full and final settlement of his claim and duly signed against both the claims separately on revenue stamp in full satisfaction and discharge of all claims present or future without making any protest on the discharge vouchers itself or just thereafter but the complainant had made protest about partial settlement of the claim as alleged only on 29/03/2012 vide his letter dated 28/03/2012 before the respondent company and which shows the delay in lodging the protest about the aforesaid payment. The circular brought on record by the respondent issued by the New India Insurance Co. shows the maximum limit of Rs. 24000/- only which cannot be made basis to decide the claim by respondent because no such circular has been issued by the respondent company with copy to the complainant but at the same time in view of the clause 3.12, the respondent has settled both the claims for Rs. 24000/- each. From perusal of the both the discharge vouchers dated 23/04/2011 and 07/05/2011, it is apparent that surgeon's charges have been deducted as per clause 3.12 while the surgeons fee has also been included in the head reasonable and customary expenses reimbursement under the policy terms and conditions and insurer's representative has also admitted that the surgeons fee has not been paid and as per maximum limit of cataract operation, the claim was settled. Since, no such circular has been issued by the respondent company to the complainant at the time of issuance of policy and even thereafter, so the above circular is not binding on the complainant. Hence,

Hence, on consideration of aforesaid facts, circumstances, material placed on the record, submissions made and the policy terms and conditions, I am of the considered view that the decision taken by the insurer towards payment of Rs. 24000/- per claim against two claims is not just, fair and reasonable and is not sustainable in law and complainant is entitled to get lump sum of Rs. 10,000/- as reasonable surgeon's fee towards his both the claims related to cataract operation.

Dated at Bhopal on 30th day of July, 2014

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Mr.Aishwarya Kumar Pandey

…………………………………………………….Complainant

V/s

Star Health & Allied Insurance Co. Ltd……………………………………………Respondent

OrderNo. IO/BHP/A/GI/0011/2014-2015 Case No. GI/SHI/1011/95

The case of complainant in short is that complainant Mr. Aishwarya Kumar Pandey had taken Medi Classic Individual Policy bearing no. P/201116/01/2010/000784 for sum assured Rs.50,000 covering himself and for sum assured Rs.50,000/- and covering his wife Smt.Rajeshwari Pandey for the period 17/11/2009 to 16/11/2010 which was issued by the respondent and received by the complainant subject to terms and conditions . It is further said that the complainant undergone treatment of Celebral Malaria at Sanjiwani Super Speciality Hospital, Satna after being admitted on 09/01/2010 and discharged on 15/01/2010 and thereafter, the complainant lodged his claim for Rs. 22,977/- towards his treatment cost before the respondent company which was not considered and they did not receive any reply from the respondent.

The respondent insurer in their self contained note have admitted about the issuance of aforesaid policy to the complainant and further contended that after evaluating the claim by their inhouse medical officers, it was found that the onset of the disease contracted by the insured fell within 30 days insured the waiting period as the commencement of risk was only from 16/11/2010 as such the claim was rejected under exclusion No.2 of the policy document vide letter dated 09/09/2010 (wrongly mentioned in place of 13/10/2010).

Findings & Decision :

I have gone through the material on the record and submissions made by both the parties regarding settlement of the claim on the basis of willingness shown by the respondent. So, it is needless to discuss the merit of the case in view of willingness towards settlement of the claim for admissible amount Rs.19,409/- subject to execution of the discharge voucher by the complainant. Since the complainant was not physically present, so, the consent given by his representative is immaterial. It is not disputed that the complainant was under gone treatment for the said ailment and incurred the said amount towards his

treatment and respondent company has found the admissible amount as Rs. 19,409/- against the claimed amount for which the respondent's representative has also shown his willingness to settle the claim for the said admissible amount.

Hence, on consideration of aforesaid facts and circumstances, material available on the record and submissions made by both the parties as well as the willingness shown by the respondent towards settlement of the claim amounting Rs. 19,409/- , I am of the considered view that the respondent is liable to make payment of Rs. 19,409/- after the settling the claim of the complainant. Hence, the respondent Star Health Allied Insurance Co. Ltd. is directed to settle the claim of complainant and make payment to the complainant amounting Rs. 19.409/-(Rs. Nineteen Thousand Four Hundred Nine only) as admissible amount as agreed upon to the complainant Mr. Aishwarya Kumar Pandey within 15 days from the date of receipt of consent/ acceptance letter from the complainant failing which it will attract a simple interest of 9% p.a. from the date of this order to the date of actual payment. Hence, complaint is allowed to the extent of the said amount only.

Dated at Bhopal on 29th day of May, 2014

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Dr. Nitin Adgaonkar.. Complainant

V/s

The New India Insurance Co. Ltd... .... Respondent

Order No.IO/BHP/A/GI/ 00 19 /2014-2015 Case No.: BHP-G-049-1314-0632

The case of complainant in short is that, the complainant Mr. Nitin Adgaonkar had taken a family floater Mediclaim Policy bearing no. 450501341203000000025 covering himself, his wife Dr. Deepali Adgaonkar and minor daughters Aditi and Avanti Adgaonkar for sum assured Rs.3,00,000/- for the period 21.09.2012 3.35 pm to 20.09.2013 11.59.59 pm on payment of total premium amount Rs. 12,059/- including service tax which was issued by the respondent company and received by the complainant subject to terms & conditions. It is further said that his wife Dr.Deepali Adgaonkar was under gone treatment after being admitted in Bombay Hospital & Medical Research Centre, Mumbai on 30.10.2012 for Right Neurogenic Thoracic outlet

Obstruction and was discharged on 03.11.2012 after surgery. Thereafter, the complainant lodged the claim for Rs. 1,48,412/- towards treatment of his wife before the TPA of the respondent company by submitting all the required documents with the cliam form but the company repudiated his claim under the provisions of 4.2 of the policy terms & conditions and communicated the same to the complainant and the complainant made representation to the TPA and the respondent but his claim was not settled.

The respondent have mentioned in their claim repudiation statement dated 13.05.2013 and letter dated 19.06.2013 that claim is not payable under the exclusion clause 4.2 of the policy terms & conditions which provides that any disease other than those as stated in clause 4.3 contracted by the insured person duing first 30 days from the commencement date of policy is excluded. This exclusion will not apply if the policy renewed with their company without any break. The exclusion does not apply to treatment for accidental injuries and the patient was admitted on account of Right Neurogenic Thoracic Outlet Syndrome which is a disease not an accident and she was first diagonised on 18.10.2012 which is within first 30 days from the commencement date of policy which is excluded as per terms & conditions of the policy.

The complainant has reiterated the versions made in the complainant and P-II form laying emphasis that terms & conditions of the policy was sent by the respondent which was received by him but there was no condition of 4.2 regarding 30 days exclusion and he has also filed the photocopy of the terms & conditions sent through letter dated 24.09.2012 attaching the terms & conditions of the policy document as such his claim is admissible and prayed to allow his claim. On the other hand, insurer's representative refuted the contention of the complainant and submitted that as per exclusion clause 4.2 of the terms & conditions of the policy document, the claim was not admissible & payable, so, it was repudiated though no SCN could be filed.

Admittedly, the above mediclaim policy was issued to the complainant by the respondent subject to terms & conditions. It is also an admitted fact that the claim lodged by the complainant for Rs. 1,48,412/- towards treatment cost of his wife has been repudiated by the respondent on the ground of clause 4.2 of policy terms & conditions. The mediclaim policy 2007 brought on record on behalf of respondent contains clause 4.2 which deals with 30 days exclusion and according to clause 4.2 any disease other than those stated in clause 4.3 below contracted by the insured person during first 30 days from the commencement date of policy is excluded. This exclusion will not apply if the policies renewed with their company without any break. The exclusion does not also apply to treatment for accidental injuries. From perusal of the record, it appears that the complainant has brought on record only the concerned policy under which the claim was lodged. Moreover the disease dignosed as per discharge card are not accidental injury. From perusal of the discharge summary and mediclaim medical report signed by the concerned attending doctor Dr. Mukund R. Thatte as well as the complainant the policy holder it transpires that the Neurogenic Thoracic Outlet Syndrom (right) was diagnosed and treatment was given for said ailment. From perusal of the prescription

dated 18.10.2012 after investigation the above said ailment was detected for which surgery was advised on 18.10.2012 itself and required treatment was given accordingly in the aforesaid hospital while the date of inception of the policy was 21.09.2012 which may attract the provisions of clause 4.2 of the policy terms & conditions-2007 brought on record on behalf of respondent but the fact cannot be lost sight off that the complainant was provided the copy of the terms & conditions of the policy documents vide letter dated 24.09.2012 of the respondent forming part of the aforesaid policy of the insured which started from clause 4.4 the permanent exclusions up to clause 4.22 and waiting period for specified disease. From perusal of the terms & conditions sent to the complainant by the respondent vide letter dated 24.09.2012 with the company's letter head which does not contain the said exclusion clause 4.2 and other clauses also and the disease mentioned against S.No.22 of waiting period clause totally differs from the terms & conditions filed by the respondent which speaks a volume and reasons for furnishing the said terms & conditions which was not even complete to the complainant with the letter dated 24.09.2012 are best known to the respondent and the respondent failed to give satisfactory reply about furnishing the said terms & conditions which did not contain the exclusion clause 4.2 as mentioned in the policy terms & conditions filed by the respondent. The insurer's representative has not challenged the above terms & conditions furnished to complainant vide letter dated 24.09.2012 as fake & fabricated. Insurance contract is based on 'Ut Most Good Faith' and both the parties are bound with the terms & conditions which is supplied by the respondent to the complainant policy holder with the policy documents and for any deviation or latches, the company will be held liable. The non filing of SCN shows the gross carelessness of the respondent and it also reflects that the respondent has nothing to say against the complainant's version.

Hence, the respondent The New India Insurance Co. Ltd. is directed to review and settle the claim of the complainant within one month from the date of receipt of this order in view of the policy terms & conditions which did not contain exclusion clause 4.2 and sent to the complainant alongwith letter dated 24.09.2012 and make payment of the admissible amount in accordance with the terms & conditions of the policy document furnished to the complainant and inform about the fresh decision in the matter directly to the complainant under intimation to this office. Hence, the complaint is allowed to the extent of above observation.

Dated at BHOPAL on 18th June, 2014
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Mrs. Prakriti Singh ....Complainant

V/s

United India Insurance Co.Ltd. ....Respondent

Order No. IO/BHP/A/GI/0052/2014-2015 Case No. BHP-G-051-1314-0683

The complainant's husband had taken a family medicare policy bearing no.190604/48/10/06/00000002 in which she was also an insured alongwith her husband and minor son for S.A. Rs. 1,50,000/- for the period 01.04.2010 to mid night of 31.03.2011 on payment of premium Rs.3,314/- which was issued by respondent company subject to terms & condition. It is further said that due to some problem in her leg, she was hospitalized on 04.08.2010 in Ladikar Hospital, Bilaspur where after treatment, she lodged claim for Rs.14956/- before the respondent company but after keeping it pending for two years, her claim was rejected on 28.02.2013. She also approached the Dy.General Manager of the company but no reply was given. Being aggrieved from the action of the respondent company, the complainant approached this forum for relief of making payment of Rs.14956/- towards her treatment cost.

FINDINGS AND DECISION:

It is admitted fact that the above policy was issued by the respondent subject to terms & conditions. Clause 4.1 deals with the exclusion which provides that 'any pre-existing conditions as defined in the policy, until 48 months of continuous cover age of such insured person have elapsed since inception his/ her first policy with the company. The discharge card shows that the patient was examined on 02.08.2010 in OPD with history of pain in lower procle radiating in left lower limb since 6 days and the patient was discharged on 09.08.2010 as per prescription dated 02.08.2010 with advice to continue traction at home while the date of discharge has been mentioned as 10.08.2010 in the discharge ticket for reasons best known to the complainant as well as hospital. It would not the out of place to mention here that the husband of the complainant Mr.Prashant Chandel has also filed a case regarding his mediclaim bearing no. BHP-G-051-1314-0676 in this forum before filing of the instant case in which he has also filed the policy document for the period 08.05.2012 to 07.05.2013 in which the name of his wife has been mentioned as Smt. Manisha Singh aged 39 years and son Jayaditya Chandel aged about 12 years 6 months and in the same case, a policy bearing no. 190604/48/09/06/00000006 for the period 01.04.2009 to 31.03.2010 in which the name of his wife has been mentioned as Smt. Prakriti Singh aged about 36 years and son Jayaditya Chandel aged about 10 years which reflects that Mr. Prashant Chandel was having two wives at the time of filing both the cases. So, legal complications cannot be ruled out whatsoever it may be. However, this case has been decided on the merit of the case not on the basis of the any other legal issue.

Under the aforesaid facts and circumstances, material on the record and terms & conditions of the policy documents, I am of the view that the decision taken by the respondent company for rejecting the claim towards treatment

cost of the complainant is perfectly justified and complainant is not entitled for the relief as prayed for. Hence, the complaint stands dismissed being devoid of any merit.

Dated at Bhopal on 23rd day of September, 2014

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Mr. Prashant Kumar Chandel ....Complainant

V/s

United India Insurance Co.Ltd. ....Respondent

Order No. IO/BHP/A/GI/0051/2014-2015 Case No. BHP-G-051-1314-0676

The complainant had taken a family medicare policy bearing no.191600/48/12/06/00000036 for himself and his wife and minor son for S.A. Rs. 1,50,000/- for the period 08.05.2012 to mid-night of 07.05.2013 on payment of premium Rs.3,214/- which was issued by respondent company subject to terms & conditions. It is further said that at the time of starting his motor cycle within one month from taking the policy, his leg was slipped and due to accident, he was admitted in the hospital where operation was done for slip disk. Thereafter, he lodged the claim towards his treatment cost for Rs.66,710/- before the respondent company which was rejected and payment was not made and he had the previous mediclaim policies of the respondent for year 2009-10 and 2010-11 under which no medical claim was made. He also approached the higher authority of the company but no reply was given. Being aggrieved from the action of the respondent company, the complainant approached this forum for relief of making payment of Rs.66710/- towards his treatment cost.

I have carefully gone through the material on the record and submissions made by both the parties. It is admitted fact that the above policy was issued by the respondent subject to terms & conditions with date of commencement of risk on 08.05.2012 till mid night of 07.05.2013. From the discharge card, it is clear that the complainant/ patient was admitted on 29.05.2012 and discharged on 04.05.2012 which appears to be slip of pen as in the claim form, the date of admission has been mentioned as 29.05.2012 and the date of discharge has been mentioned as 04.06.2012 for slip disk operation and required treatment. Thus, it is crystal clear that the complainant was hospitalized and treated for the said problem within 30 days from date of inception of the said mediclaim policy. As per clause 4.2 of policy document any disease other than stated in clause 4.3,contracted by the insured person during

the first 30 days from the commencement date of policy has been excluded under the exclusion clause. Moreover, the repudiation letter was sent to the complainant on 22.11.2012 through registered post but the complaint dated 04.12.2013 has been received 09.12.2013 which also touches the provisions of limitation for filing the complaint under RPG Rules, 1998.

Under the aforesaid facts and circumstances, material on the record, submission made and terms & conditions of the policy document, I am of the view that the decision taken by the respondent company for rejecting the claim towards treatment cost of the complainant is perfectly justified and complainant is not entitled for the relief as prayed for. Hence, the complaint stands dismissed being devoid of any merit.

Dated at Bhopal on 23rd day of September, 2014
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Mr. Ram Chandra Goyal.. Complainant

V/s

The Oriental Insurance Co. Ltd... ....
Respondent

Order No.IO/BHP/A/GI/ 0015 /2014-2015 Case No.: GI/OIC/1009/74

The case of complainant in short is that he had taken mediclaim policy bearing no. 151300/48/2010/6924 for sum assured Rs.75,000/- each for the period from 04.12.2009 to 03.12.2010 covering himself and his wife which was issued by the respondent. It is further said that the complainant suffered accidental injuries in his left wrist due to slip of his leg and falling on the ground on 17.01.2010 and since pain did not subside, so, he consulted Dr. P.Neema, Unique Super Specialty Centre on 18.01.2010 who after examination advised for x-ray and thereafter for plaster and to get second opinion, he consulted Dr.R.S.Saluja, MBBS, MS(Orth.) D.Orth, a very senior Orthopaedic Surgeon attached with Index Medical college & Hospital and Research Centre, Indore on 19.01.2010 who also advised for the plaster without further delay. Hence, the needful treatment was carried out by him on 19.01.2010 viz fixing the plaster for one month and tablets for seven days. The plaster was cut on 18.02.2010 for plastering he was hospatlised for about two and half hours. The treatment necessiated hospitalization and the procedure involved specialized infra structural facilities available only in hospital. However, due to technological advances, hospitalization is required for less than 24 hours. He was admitted at about 06.00 PM and was discharged at about 08:30 PM.

Thereafter, he lodged the claim before the respondent which was repudiated on the ground of revised provisions of policy conditions effective from 15.09.2006 while the claim was payable despite the fact that his hospitalization was less than 24 hours.

The insurer in their reply dated 08.10.2010 have contended that the claim was repudiated by their TPA M/s. Vipul Med Corp TPA Pvt.Ltd. and on the representation of the insured the claim was reviewed by the competent authority and they agreed with the opinion of the TPA and the repudiation is justified as per policy condition no. 3.11 and 4.23 as OPD treatment is not covered under the policy.

The complainant has reiterated the versions made in the complainant and P-II form and laid emphasis that as per circular letter dated 15.05.2008 of the respondent, the terms and conditions of the old policy is applicable and due to technological advances and special infrastructure facilities, hospitalization was not required for 24 hours and as per terms & conditions of his policy prior to 15.09.2006 and after completing age of 60 years, his claim is payable. On the other hand, the insurer's representative has refuted the contention of the complainant and submitted that as per policy condition no. 3.11 and 4.23, the claim was not payable.

<u>OBSERVATIONS</u>:-

Admittedly, the above mediclaim policy was issued to the complainant by the respondent subject to terms & conditions. It is also an admitted fact that cumulative bonus were given @15% to the complainant and @ 50% to his wife as per endorsement made in the concerned policy. The factum of said ailment and treatment is also not denied by the insurer. It is also admitted fact that claim has been repudiated under the aforesaid conditions of the said policy document.

From perusal of the record, it is apparent that there is an endorsement about allowing the cumulative bonus to insured and spouse @ 15% and 50% respectively which was made effective from 14.01.2010 to 03.12.2010 in the said policy and according to circular no. HI/HID/2008-2009/01/CR-6309 dated 15.05.2008 in option no.1, - in such cases all the terms, conditions, exclusions and exceptions including cumulative bonus provision as well as sum insured slabs of the pre-revised individual mediclaim policy will be applicable to the renewals where the policy have been continuously renewed and the beneficiary having completed 60 years of the age and above on or before 15.09.2006 will have two options to choose from and the endorsement it self in the policy for 2009-2010 showing cumulative bonus of 15% & 50% to complainant and his wife respectively shows that company has acceded to the request of the complainant. Though, actual policy prior to 15.09.2006 has not been filed by the complainant and benefit of circular no. 6309 dated 15.05.2008 is applicable only if there was continuous renewal with the

company without break and through endorsement dated 14.01.2010, it appears that the company have passed the benefit of said circular to the complainant and thus, it is established that there was continuous renewal without break and the policy terms & conditions prior to 15.09.2006 can be made applicable in the instant case.

Since the claim of the complainant has been repudiated by the respondent referring the condition no. 3.11 and 4.23 of the policy effective from 15.09.2006 where as in this case the policy conditions were effective prior to 15.09.2006. The condition no. 3.11 of the new policy from 15.06.2006 speaks about in-patient and condition no. 4.23 under exclusion clause of new policy speaks about exclusion on account of out patient diagnostic, medical or surgical procedures or treatments etc. There is no definition of in-patient in old policy but condition no. 3 resembling with condition no. 3.11 of new policy stipulates hospitalization for minimum period of 24 hours and no condition resembling with and/or similar to condition 4.23 of new policy appears in old policy. It is crystal clear that company has repudiated the claim referring the condition of the policy (new) effective after 15.09.2006 which was not applicable in the case of the complainant.

Hence, the respondent The Oriental Insurance Co. Ltd. is directed to review the claim of the complainant within one month from the date of receipt of this order in view of the policy terms & condition applicable prior to 15.09.2006 on the basis of the relevant documents made available to the company with the claim form earlier and inform about the fresh decision in the matter on its merit directly to the complainant under intimation to this office. Hence, the complaint is allowed to the extent of above observation.

Dated at BHOPAL on 11th June, 2014
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Mr. Ramesh Sahbani ....Complainant

V/s

Star Health and Allied Insurance Co.Ltd. ....Respondent

Order No. IO/BHP/R/GI/0001/2014-2015 Case No. BHP-G-044-1314-0678

As per complaint, the complainant Mr. Ramesh Sahbani had taken the Mediclassic health Insurance Policy bearing No. P/201100/01/2012/001922 for sum assured Rs.2,00,000/- for the period from 17.02.2012 to 16.02.2013

which was issued by the respondent and received by the complainant. It is further said that complainant was admitted in Manoria Heart Care Centre Pvt. Ltd., Bhopal for his treatment on 30.11.2012 and was discharged on 05.12.2012. He had also sent information to the respondent company. After discharge he lodged the claim for treatment expenses to the respondent but his claim was rejected.

The Respondent Insurance Company have admitted in their Self-Contained Note dated 11.03.2014 about issuance of the said policy to the complainant and also contended that number of discrepancies were observed during investigation regarding bills and some test reports and as such the claim was repudiated under the provisions of condition no. 7 of policy documents.mentioning therein about settlement of the claim willingly and mutually and agreed to settle the subject matter of complaint for Rs. 60,000/- towards treatment cost in respect of the mediclaim no. 0138212 for admission in Manoria Heart Care Centre Pvt. Ltd., Bhopal from 30.11.2012 to 05.12.2012 as full and final settlement of the grievance/ complaint.

1. **The Respondent Star Health And Allied Insurance Co. Ltd. shall pay Rs.60,000/- (Rs.Sixty Thousand only) towards treatment cost in respect of the mediclaim no. 0138212 for admission in Manoria Heart Care Centre Pvt.Ltd., Bhopal from 30.11.2012 to 05.12.2012 to the complainant Mr. Ramesh Sahbani as full and final settlement of the subject matter of the complaint on the basis of the policy document within 15 days from the date of receipt of acceptance letter from the complainant failing which it will attract a simple interest of 9% p.a. from the date of this order to the date of actual payment.**

Dated at BHOPAL on 7th day of May, 2014

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Mr. Rameshwar Namdeo ....Complainant

V/s

Tata AIG General Insurance Co.Ltd. ....Respondent

Order No. IO/BHP/R/GI/0047/2014-2015 Case No. GI/TAG/1212/48

The complainant Mr. Rameshwar Namdeo had taken an individual accident & sickness hospital cash policy bearing No. HCP 15000012888 for coverage amount per person for accident Rs.10,000/- per day towards individual accident and Rs.5,000/- per day towards sickness and Rs.25000/- as accident medical expenses reimbursement for the period 180 days w.e.f.10.11.2010 to 09.11.2011 for himself, his wife and his two children which was issued by the respondent and received by the complainant. It is further said that due to sickness & hospitalization in Karim Nursing & Maternity home,

Dewas. He lodged the claim to the respondent towards hospital indemnity which was rejected by the company on the ground that treatment was not consonant and there was no requirement of admission and no test for enteric fever was conducted. Being aggrieved from the action of the respondent, the complainant approached this forum for relief of making payment of Rs. 40000/- towards his claim.

The insurer in their reply dated 11.01.2013 have stated that as per terms & conditions in hospital indemnity for sickness, the period of confinement must be necessary and recommended by physician and as per experts medical opinion, it was evident that the patient had no severe symptoms requiring admission and nor any test for enteric fever found in the medical papers and treatment was not consonant with treatment as given. So, the claim was denied.

In view of the above facts, circumstances & mutual agreement, I feel just, fair & equitable to make following recommendations about settlement of the claim as full and final on the basis of mutual agreement between both the parties.

1. **The Respondent Tata AIG General Insurance Co. Ltd. shall pay Hospital Cash Benefit of Rs.25,000/- (Rs.Twenty Five Thousand only) under health care policy to the complainant Mr. Rameshwar Namdeo as per policy terms & conditions as full and final settlement of the subject matter of the complaint within 15 days from the date of receipt of acceptance letter from the complainant failing which it will attract a simple interest of 9% p.a. from the date of this order to the date of actual payment.**

Dated at BHOPAL on 13th day of August, 2014
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Mrs. Reeta Khetrapal ……………………………………………………Complainant

V/s

National Insurance co. ltd……………………………………………Respondent

Order No. IO/BHP/A/GI/0020/2014-2015 Case No. GI/NIC/1011/103

As per complaint, the complainant Mrs. Reeta Khetrapal had taken mediclaim policy bearing no. 321600/48/10/8500000268 for herself and her family members for the period 26/06/2010 to 25/06/2011which was issued by the respondent. It is further said that due to suffering from left knee pain, she was admitted in Jabalpur hospital and research centre on 06/08/2010for

treatment and she applied for cashless claim on 06/08/2010 before the TPA of the company and due to rejection of the same, the request was forwarded for reimbursement with all relevant documents in original but they have not intimated any progress in the matter to her and as mentioned in the website of medsave in the claim status that her claim has been rejected then she made a request to intimate reasons for rejection on 24/09/2010 but no response was received.

The respondent company vide his reply dated 02/12/2010 has only mentioned " that we are providing the self contained letter giving complete background/facts of the case along with copies of the decision as furnished by medsave health care TPA Pvt. Ltd. but no such self contained letter has been found attached with the said letter except the repudiation letter of their TPA mentioning hospitalization only for investigation and they have raised a query to provide hospital bills but it was not replied even after reminders and all these expenses are excluded vide exclusion clause no. 4.1 of policy and as such the TPA intend to repudiate the claim".

Admittedly, the above mediclaim policy was issued to the complainant policy holder subject to terms and conditions for the aforesaid period. It is also admitted fact that cashless facility was not given and the claim for reimbursement of Rs. 10,364/- has been rejected by the respondent company/TPA and intimation regarding rejection of the claim was learnt to the complainant through website of the TPA of the company. From perusal of the prescription dated 05/08/2010 it transpires that the complainant consulted Dr. Ajay Seth for complaint of left knee pain and Dr. had advised her to admit at Jabalpur hospital and also advised MRI of knee vit D3, Vit B2 and CBG, EPL, CRP tests but the complainant was admitted in the Jabalpur hospital and research centre on 06/08/2010 and discharged on 07/08/2010 as per discharge card and the complaint has failed to show any cogent reason for not admitted on 05/08/2010 at per advise of the Dr. while she had pain in her left knee. The complainant has also not brought on record the original hospital bill

which was required by the TPA of the company and reminders were sent for the same. From perusal of the record, it also appears that some test reports regarding blood, sugar has been filed while it has not been mentioned in the prescription and the discharge card also does not show about treatment received as nothing has been mentioned in the column of treatment received except the follow up. Thus, it is clear that above treatment could have been taken in OPD. From perusal of the letter sent by the complainant on 06/10/2010 to the TPA of the company, it is apparent that the complainant has admitted about having left knee pain since one and a half year which clearly establishes that the complainant had pre existing disease at the time of taking the said policy and as per clause 4.3 treatment for joint replacement due to degenerative conditions , age related arthritis and osteoporosis are not payable for first four years of the policy and as per clause 4.1 all diseases which are pre existing when the cover insepts for the first time, the benefits will not be available until 48 months continuous coverage has elapsed since inseption of the first policy and from the MRI of the left knee of the complainant, it has been found likely degeneration which clearly shows that knee joint ailment of the complainant was pre existing. From perusal the discharge card, it is apparent that no active treatment was given towards the said ailment of knee joint rather only investigations were done.

Hence, under the aforesaid facts, circumstances, material on the record and submissions made by both the parties, I am of the considered view that the decision taken by the respondent /TPA to repudiate the claim of the complainant under the terms and conditions of the policy document is just, fair and reasonable and is sustainable in law and does not require any interference by this authority. Hence, the complainant is not entitled for the relief as prayed. In the result, the complaint stands dismissed being devoid of any merit.

Dated at Bhopal on 19th day of June, 2014

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Mr. Shanti Lal Talera .....Complainant

V/s

The Oriental Insurance Co. Ltd. .....Respondent

Order No.IO/BHP/R/GI/0004/2014-2015 Case No. GI/OIC/1212/47

As per complaint, the complainant Mr. Shanti Lal Talera had taken a Oriental Bank Mediclaim Policy bearing no. 152800/48/2013/387 for Sum Assured Rs. 3,00,000/- covering himself and his wife Smt. Madhu Talera for the period from 23.05.2012 to 22.05.2013 which was issued by the respondent company and received by the complainant. It is further said that his wife Smt. Madhu Talera was admitted in Greater Kailash Hospital Indore on 19.07.2012 for the complaint of pain and treatment of swelling in left eye, tenderness over left eye and was diagnosed of Orbital Cellulitis-acute sub-periosteal abscess of the left orbit, probably secondary to infection in the nasal cavity and after discharge on 23.07.2012, he lodged the claim to the respondent towards the treatment cost of his wife but the respondent company did not admit his liability and his claim was repudiated as not payable.

The Respondent Insurance Company have admitted in their letter dated07.01.2013/ 09.05.2014 (SCN) about issuance of the said policy to the complainant under which complainant's wife Smt. Madhu Talera was also covered and have further contended that on scrutiny of claim documents, it was found that patient was admitted in Greater Kailash Hospital, Indore on 19.07.2012 for the treatment of swelling/ tenderness in left eye and doctors had diagnosed Orbital Cellulites Left Eye and Sinusitis. As per available documents, the patient had undergone medical conservative management for which there is waiting period of 2 years after the inception of the policy as the date of inception of policy was 23.05.2012. As per present policy conditions, this claim comes under exclusion 4.2. As such claim was not payable and repudiated.

In view of the above facts, circumstances & mutual agreement, I feel just, fair & equitable to make following recommendations about settlement of the claim as full and final on the basis of mutual agreement with both the parties.

1. **The Respondent Oriental Insurance Company Ltd. shall pay Rs. 24,150/- (Rs.Twenty Four Thousand One Hundred Fifty Only) the package charges**

as per TPA CCN-2402173, to the complainant Mr. Shantilal Talera towards treatment expenses of his insured wife Smt. Madhu Talera as full and final settlement of the subject matter of the complaint on the basis of the policy document within 15 days from the date of receipt of acceptance letter from the complainant failing which it will attract a simple interest of 9% p.a. from the date of this order to the date of actual payment.

Dated at BHOPAL on 9th day of May, 2014

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Mr. Sharad Kumar Halen .....Complainant

V/s

National Insurance Co.Ltd. .....Respondent

Order No. IO/BHP/A/GI/00 /2014-2015 Case No. BHP-G-048-1314-0613

The complainant Mrs. Sharad Kumar Halen had taken an Individual Mediclaim policy bearing no. 320102/48/12/850000/2281 for himself and his wife Smt. Usha halen for Sum Insured Rs. 2,25,000/- each and cumulative balance amount Rs. 35,250/- each for period 27.11.2012 to 26.11.2013 which was issued by the respondent subject to terms & conditions. It is further said that his wife was admitted in Shalvy Hospital, Ahamdabad, Gujrat on 19.03.2013 and underwent total knee replacement of both knees and was discharge on 25.03.2013. Thereafter claim was lodged for Rs. 2,62,250/- against the amount spent Rs. 5,45,109/- but his claim was settled only for Rs. One Lac and amount was deposited in his account through NEFT and rest amount was deducted showing reasons. Being dissatisfied with the deduction of Rs.1,62,250/- he sent a letter to the respondent company and TPA was called in the divisional office and was directed to give reply but no reply was given.

The insurer in their SCN dated 24.09.2013 have admitted about the issuance of the said policy covering Mrs. Usha halen also and about under going total knee replacement of both knee and settlement of the claim by TPA restricting the S.I. for Rs. 1,00,000/- being S.I. opted under policy no. 320102/48/88/50000/1806 as per individual mediclaim policy and the treatment for joint replacement was due to degenerative condition as related osteoarthritis and osteoporosis are not payable for first four year of operation of the policy and if these disease are pre-existing at the time of proposal will be covered only after 4 continuous claim free policy year under clause 4.3 of the policy document and based on the fourth year policy the TPA had release the S.I. Rs.1,00,000/- to the complainant.

Admittedly the above policy was issued to the complainant for S.I. Rs. 2,25,000/- each covering himself & his wife and bonus amount 37,250/- each for the aforesaid period and it is also admitted fact that complainant's wife underwent total knee replacement of both knees and settlement and payment of claim restricting for S.I. Rs.1,00,000/- only sum insured under the previous policy no. 320102/48/88/50000/1806. It is not disputed that deduction of Rs.1,62,250/- made by the respondent towards settling the claim under the policy terms & conditions 4.3. From perusal of the discharge voucher (xerox copy) 12.06.2013 duly signed by the complainant about payment of Rs. One lac by way of NEFT. It is apparent that the complainant was agreed to accept the said amount Rs. One lac as per details of acceptance in full satisfaction and final settlement of all claims present on future and the above discharge voucher also shows the reasons for deduction as S.I. exhausted against the bill under different heads and the complainant has not made any endorsement on the discharge voucher itself about showing his protest towards said payment rather he sent letter of dissatisfaction regarding the said deduction on 13.06.2002 . I am unable to understand what prevented him to make such protest on discharge voucher and complainant has failed to show any reason in this regard. Clause 4.3 of the concerned policy terms & condition clearly provides that treatment for joint replacement due to degeneratic conditions as related osteoarthritis and osteoporosis are not payable for first

four year of operation of the policy and if these disease are pre-existing at the time of proposal will be covered only after 4 continuous claim free policy years. The concerned policy document also contains the clause that for increasing S.I. more than 2/3 slab the waiting periods as in exclusions 4.1/4.2/4.3 of the policy shall apply on the enhanced SI as if it is a new policy. The benefit shall accrue for PED or waiting period diseases once the policy with enhanced SI completes the waiting period noted in the policy for these disease.

Thus it is clear that the benefit for said preexisting ailment or waiting period disease on the policy with enhance S.I. complete the waiting period of 4 years as mention in the terms & conditions of the policy document which came in to force w.e.f. 01.04.2007 with some change modification. The complainant has mentioned in his complaint that at the time of taking this policy in 2003 this clause was not present and initial 4 years of waiting period in 2007 but the complainant had not filed any policy from the year 2003 to the year 2007-08. General Insurance policies are annual contract, so the conditions applicable on the renewal date shall applied and not the conditions of policy effective from 01.01.2002 and since the terms of the concern individual mediclaim policy has already been revised w.e.f. 01.04.2007 the certain changes and modification. So the provisions of clause 4.3 as mentioned in the old policy of 01.01.2002 cannot apply in the instant case in view of the terms & conditions made effective from 01.04.2007 and the above waiting period of 4 years has not been waived in the concerned policy document. So, I

Section 9 of the policy terms & condition deals with the trip cancellation/ interruption due to accidental bodily injury or death of insured or a family member of insured and section 9(2) clearly provides about accidental bodily injuries of (1) Insured or (d) family member of insured. There is no dispute with the fact that death of the father of complainant/ insured was natural death which took place on 17.03.2011 which resulted cancellation/ interruption of the trip of the complainant. It is admitted fact that trip was cancelled on account of death of complainant's father. The pertinent question which is to be considered here is whether the policy terms & conditions covers

the natural death also. On close scanning of provision of section 9 of the policy terms & conditions, the word accidental is clearly mentioned against the word bodily injury or death of insured or family member of the insured. The insurance policy based on the principles of any contingency/ mis-happening to indemnity the insured as per terms & conditions of policy document. So, on legal interpretation of the provisions of section 9 of the policy terms & conditions, it is crystal clear that the death of either insured or the family member of the insured must be due to any accident as the word 'accidental' has been clearly mentioned before the word 'bodily injury or death' which can be taken as continuity of the word accidental and it was not necessary to mention the word accidental again before the word 'death' under section 9 which covers the trip cancellation/ interruption due to accidental bodily injury or death of insured or his family member. So, the contention of the complainant is misconceived and has no substance. Hence, the respondent is not liable to pay the claim as prayed for by the complainant.

Hence, under the aforesaid facts, circumstances, material on the record and the terms & conditions of the policy document, I am of the considered view that decision of the insurer to repudiate the claim of the complainant is perfectly justified and does not require any interference by this authority. Hence, complainant is not entitled for the relief as claimed. In the result, the complaint stands dismissed being devoid of any merit.

Dated at Bhopal on 05th day of August, 2014

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Dr. Shobha Soni .... Complainant

V/s

The Oriental Insurance Co. Ltd...Respondent

Order No. IO/BHP/A/GI/0016/2014-2015 Case No. GI/OIC/1010/81

As per complaint, the complainant had taken the mediclaim policy bearing no.152900/48/2009/1024 (wrongly mentioned in place of 152900/48/2008/1024) for sum assured Rs.3,50,000/- for the period 30.03.2008 to 29/03/2009 which was issued by respondent subject to terms & conditions. It is further said that the complainant was a mediclaim policy holder from the above insurance company since last 9 years and she has not taken a single claim earlier. It is further said that she was admitted in Marble City Hospital & Research Centre, Jabalpur for her treatment on 22.03.2009 and discharged on 29.03.2009 and thereafter she lodged the claim with the TPA E-Meditek towards her treatment cost on the basis of bill amount Rs. 52,714/- which was not paid by the TPA nor any information was given to her. The claim documents were submitted through the D.O.-I, Oriental Insurance Co. Ltd. Jabalpur and when the status of the said claim was inquired from the said TPA, she was informed that they have not received any documents under the said policy and on further inquiry about the same from the office D.O.-I, Oriental Insurance Co. Ltd. Jabalpur, no positive response was given and claim was still pending. The matter was also reported to the grievance cell of the company at Delhi but no replay has been given.

The insurer has not submitted any specific Self Contained Note rather has sent a reply letter dated 15.02.2011 against the instant complaint mentioning therein that the claims under mediclaim policy are disposed by their TPA E-Meditek Indore and on making contact with the said TPA, it was told that no claim information of Dr.Shobha Soni has been received to them and POD was demanded in case of information regarding her claim given by her earlier and it appeared that no further action was taken by Dr.Shobha Soni nor POD was given to the said TPA as such the complaint sent to the head office Delhi was closed and they are unable to give reply in absence of the documents.

<u>Findings & Decision :</u>

I have gone through the material on the record and submissions made by both the parties. From perusal of the letter dated 25.11.2010 sent to this forum by the respondent mentioning therein that the claim of the complainant has been disposed of by the TPA and all the documents are lying with them and vide their letter dated 21.06.2013 sent through E-mail, the respondent have mentioned that as stated by the complainant vide her letter dated 02.09.2010, claim documents were submitted to TPA through DO-I Jabalpur and TPA informed that they have not received the documents, so the claim was not settled by the TPA and TPA had not submitted the claim file to the D.O. From the record, it appears that the complainant had sent all the documents in original to the Divisional Manager, D.O.-I, Oriental Insurance Co. Ltd. Jabalpur vide letter dated 06.04.2009 regarding submission of claim documents. Though she has not filed any postal receipts/ courier receipts regarding dispatch of the said letter's but the respondent has admitted that all the documents are lying with the TPA vide letter dated 25.11.2010. It is apparent that the claim was held up on the ground of non availability of the original documents regarding the claim of Rs.52,714/- which was sent by the complainant to the office of the respondent company at Jabalpur. Since the document submitted to the respondent were lost either in their office or during transit from respondent

office to their TPA the complainant can not be held liable. The complainant had brought on record copy of the paid medical bills amounting Rs.52,714/- with discharge ticket, the pathological test reports, the medicine bills but from the record, it has been established that the respondent company has not taken any final decision regarding repudiation of her claim as yet and for want of any repudiation letter, the complainant could not make any proper representation to the respondent in connection with her claim in case it was disallowed as required under the provisions of RPG rules 1998 which touches the maintainability of this case. Thus, it is established that the claim made by the complainant before respondent company is still pending for want of original documents like discharge card, medical bills etc.

In the aforesaid circumstances, the complainant may submit self attested photocopies of all the necessary required original documents for reimbursement of her claim before the respondent and only then the respondent company shall consider and settle the claim of the complainant on the basis of self attested photocopies of required original documents like discharge card, medical bills, pathological reports etc. in case original documents are not made available in accordance with the terms & conditions of the policy documents within one month from the date of receipt of this order and inform the final decision to the complainant under the intimation to this office. In the results the complaint stands dismissed with the above observation.

Dated at Bhopal on 13th day of June, 2014
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Mr. Vijay Kumar Halen ………………………………………………………… Complainant

V/s

National Insurance Co. Ltd……………………………………………………… Respondent

Order No.IO/BHP/A/GI/00 /2014-2015 Case No.: GI/NIA/1207/29

The complainant Mr. Vijay Kumar Halen had taken a individual mediclaim policy bearing no. 320102/48/11/8500002238 covering himself and his wife Mrs. Bhagwanti Bai for Sum Insured Rs.1,75,000/- each and cumulative bonus 31000 each for period 27.11.2011 to 26.11.2012 which was issued by the respondent company subject to terms & conditions. It is further said that due to severe problem in joints and in order to avoid operation complainant's wife Mrs. Bhagwanti Bai was admitted in Greater Kailash Hospital, Indore and treatment was given in Operation Theater thereafter and in order to avoid any further complication she was kept in observation in one day and on the next

day she was discharged. Thereafter, he lodge the claim towards treatment of his wife before the respondent which was repudiated on the ground of O.P.D. treatment and he also sent letter to the Dy.General Manager but his claim was not considered.

The insurer in their reply dated 29.05.2013 have admitted about the issuance of the said policy to the complainant and have contended that the complainant's wife was treated in OPD treatment and she was admitted on 17.10.2012 to 18.10.2012 for intra-articular injection in knee, and it did not need any hospitalization as per finding of the medical experts and their TPA and they had also sought expertise opinion of their panel doctor Dr. K.G.Agrawal on technical issue and where it was confirmed that the procedure/ ailment shown in relevant documents and discharge card did not warrant any hospitalization and manageable under out patient management and as per above finding, the claims is not admissible under policy exclusion 4.23 and the complainant also informed on 06.03.2013.

I have gone through the material placed on the record and submissions made by both the parties and relevant provisions of policy terms & conditions. Clause 4.23 of the policy terms & conditions provides about the "out patient diagnostic/ medical/ surgical procedures/ treatments, non-prescribed drugs/ medical supplies/ hormone replacement therapy, sex change or any treatment related to this. During course of hearing the emphasis was given on behalf of respondent that as per expert opinion of their panel doctor Dr. K.G.Agrawal, it was confirmed from the discharge card and relevant documents that hospitalization was not warranted. From the perusal of opinion of Dr.K.G. Agrawal, (MBBS) the panel doctor of respondent has opine that hospitalization is not necessary for giving such injections and the injections given in joints was OPD procedure which does not cause any reaction so there was no need to keep such patient in observation and had also opine that claim is not admissible as per policy condition no. 4.10 and 4.23. On perusal of the letter (Xerox copy) dated 29.11.2012 of Dr. Ashok Shukla K. Desai, MS (ortho),FCPS,D'orth, consulting orthopedic surgeon, it is apparent that the said doctor has admitted about giving the said injection in operation theater and ha also mentioned she was hospitalized after the procedure for observation. Discharge Card shows admission on 17.10.2012 and discharge on 18.10.2012 after treatment of pain in both knee by giving said injection and some vaccine in Greater Kailash Hospital, Indore and Dr. Ashok Desai was the surgeon for providing the said required treatment of injection synvisc. It is only the treating doctor who can judge the admission and discharge of the patient and required treatment given. Since the above injuction was given both knee joints. So only the said doctor Dr.Ashok Desai could know about the complication/ reaction if any after giving said injection towards said ailment to the patient Smt. Bhagwanti Halen. The panel doctor Dr.K.G.Agrawal who is simply a MBBS and not orthopedic surgon/ specialist can not give any definite opinion about the requirement of the hospitalization for giving said injection and about any reaction and the opinion given by him that claim is not admissible it self reflects exceeding his jurisdiction as the company has only right to give such opinion and is shows that the panel doctor has acted and gave opinion as per

hidden instruction to him by the respondent. The expenses towards claim have not been disputed on behalf of respondent either in the reply or during hearing. So, I do not find any force in the contention advanced on behalf of insurer. Hence in the circumstances the respondent company liable to pay the admissible claims in accordance with the terms & conditions of the policy documents.

Hence, the respondent, The National Insurance Co.Ltd. is directed to review and settle the claim and make payment of admissible amount of the claim made by the complainant towards treatment of his wife within 15 days from the date of receipt of acceptance letter from the complainant failing which it will attract a simple interest of 9% p.a. from the date of this order to the date of actual payment. In the result, the complaint is allowed to the extent of the above amount only.

Dated at BHOPAL on 07th August, 2014

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BHUBANESHWAR

BHUBANESWAR OMBUDSMAN CENTER

COMPLAINT NO-11-005-1105

Sri Esety Anip Kumar

Vrs

Oriental Insurance Co.Ltd.,

Award Dated 27th Day of Aug., 2014

This is a complaint filed by the Insured-Complainant for partial repudiation of his Mediclaim by the Opposite Party-the Insurer.

It is stated by the Complainant sans unnecessary details that he took a Mediclaim policy from the OP and during the policy period he underwent his right eye operation and then his left eye operation on a later date for catracat at L.V. Prasad Eye Institute, Bhubaneswar. For those two operations he spent Rs. 37,740/- each from his own pocket. Subsequently he lodged the mediclaim through TPA M/S Alankit Healrtth Care and submitted all the relevant papers on 14.05.2012. Unfortunately the OP allowed the claim of latter eye operation and disbursed appropriate amount while it repudiated the claim of former eye operation on the ground of delay. Finding no alternative, the Complainant approached this forum.

According to OP the Complainant had to submit claim documents within seven days from the date of discharge from the hospital as per policy condition. But he submitted claim documents in relation to left eye operation after 64 days from the date of discharge from the hospital and those of right eye operation after 233 days from the date of discharge. Although delay of 64 days was condoned on satisfactory reason the delay of 233 days was not condoned. Hence the Mediclaim made by the Complainant in respect of his right eye was repudiated.

At the time of hearing, the Complainant reiterates that he submitted all the papers relating to his both eye operations to the TPA. Subsequently on his query he came to know that some papers were wanting in respect of his right

eye operation and for that reason his claim was repudiated. Immediately he submitted the required papers and in spite of that he could not get his claim for his right eye operation.

Mr. B.K. Dash, Sr. B.M. City Branch Office appeared on behalf of the OP. He repeated the plea taken in the SCN. He expressed his ignorance as to when the OP received information regarding operation of both eyes of the Complainant. He sought a week's time to come prepared with papers relating to left eye operation which had already been settled and disbursed. Curiously enough, on the second date of hearing he appeared and declared that the relevant papers could not be traced out in the Regional office, Bhubaneswar.

On a bare scrutiny of the photo-copies of the claim documents in relation to operation of both eyes, as produced from the side of the Complainant, it appears that the TPA received the same on 14.05.2012. The claims documents are in two separate bunches and contain the seal and dated signature of the TPA. Had the OP produced official records regarding submission of claim documents, it could have been cross-checked and easily ascertained the actual point of negligence or latches. However, failure on the part of the Sr. Branch Manager of the OP to produce the connected papers constrains me to draw an inference that there was no negligence on the part of the Complainant, particularly when the OP was found to have settled one of the informant's claims submitted at the same point of time. In such circumstances the Complainant is rightly entitled to get appropriate mediclaim in respect of his right eye operation from the OP. Hence it is ordered that the complaint is allowed and the OP is hereby directed to settle the mediclaim of the complainant in respect of his right eye operation without least delay on the basis of the papers submitted by him.

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BHUBANESWAR OMBUDSMAN CENTER
COMPLAINT NO- BHU-G-038-1314-1302
Sri Saidutta Mishra
Vrs
Royal Sundaram Alliance Insurance Co.Ltd., Chennai,
Award Dated 28th Day of Aug., 2014

This is a complaint filed by the Insured-Complainant with regard to dispute in premium paid to the Opposite Party-the Insurer.

Brief case of the Complainant is that his father Late Mahesh Prasad Mishra had a mediclaim policy from the OP. The expiry date of the policy was 07.04.2013. His father issued a cheque dated 16.04.2013 for Rs.3859/- being the premium amount which was received by the OP. Unfortunately, in the mean time his father expired on 23.04.2013. The Op informed vide their letter dt.23.04.2013 that the actual premium amount for the above policy was Rs.3930/- and as such there was a shortfall of Rs.71/-. So it asked for payment

of the shortfall amount within 7 days, lest the amount already received would be returned back. Since Late Mahesh Prasad Mishra died in the mean time the Complainant requested the OP to return the amount paid by him along with interest but the OP turned deaf ear. Finding no alternative the Complainant approached this forum.

Without filing SCN, the OP intimated this forum that the entire premium amount of Rs.3859/- had already been refunded to the Complainant.

In consonance with the intimation of the OP, the Complainant sent an information to this forum that he had received the disputed amount of Rs. 3859/- by cheque no.310930 dated 03.03.2014 from the OP. At the same time he expressed his intention to drop the complaint. Here in this case the only grievance of the Complainant was to get back the premium amount of Rs.3859/- paid to the OP by his deceased father. Since he has got back the amount, his grievance has already been redressed. In the circumstance the complaint is liable to be dismissed. Hence it is ordered that the complaint being already redressed is hereby dismissed.

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BHUBANESWAR OMBUDSMAN CENTER
COMPLAINT NO- 11-017-1111
Sri Arun Kumar Tikmani
Vrs
Star Health and Allied Insurance Co. Ltd., Bhubaneswar.

Award Dated 16th Sept., 2014

This is a complaint filed by the Insured-Complainant for partial repudiation of health claim by the Opposite Party-the Insurer.

It is said by the Complainant that he took Star Senior Citizens' Red Carpet Insurance Policy for his mother Smt. Gayatri Tikmani from the OP for a sum Insured of Rs.1,00,000/- for the period from 10.03.2010 to 09.03.2011 which was subsequently renewed for the period from 10.03.2011 to 09.03.2012. Since Smt. Gayatri Tikmani aged about 68 years was suffering from breast cancer at her right breast, she received medical treatment at Panda Curie Cancer Hospital, Cuttack and Hemalata Hospital, Bhubaneswar. In the treatment the Complainant spent a sum of around Rs.2,00,000/-. However after submission of claim regarding treatment expenditure the OP wrongly repudiated it. For this the Complainant approached this forum in Complaint no 14-017-0923 and got a favourable award on 22.11.2012. Then he received a part of his claim amounting to Rs. 20,160/- from the OP which overlooked the

other bills amounting to Rs. 1,30,883/-. Under such contingency the Complainant approached this forum again.

In spite of notice the OP did not file any counter/SCN.

At the time of hearing the Complainant openly declares that he has received a further sum of Rs.35,924/- from the OP, apart from his previous receipt of Rs.20,160/-. On a bare calculation his total receipt comes to Rs. 56,084/- as against his entire claim. However he makes it clear he has not verified the terms and conditions of the insurance contract nor can he say in which way he is entitled to the claimed amount. One Mr. Rajendra Sarangi, Consultant appears on behalf of the OP. He says with force that the OP has already made payment as per the terms and conditions of the contract and there is nothing outstanding to be paid to the Complainant.

I have thoroughly gone through the Terms & Conditions of the Star Senior Citizens' Red Carpet Policy. No doubt the sum insured is Rs.1,00,000/-. The policy contains clear specifications as to which medical expenses are payable by the insurer and what is to be contributed by the insured. It also indicates the exclusions. As the Complainant expressed before this forum that he had filed photo-copy of the bills in his previous case bearing Complaint no. 14-017-0923, the relevant record was referred for a just and proper redressal of the present grievance.

On a minute scrutiny of the available bills and other papers it is seen that the OP has made payment of Rs.20,160/- for the hospitalisation of the insured from 15.12.2010 to 18.12.2010. Later on the Complainant submitted certain bills in respect of hospitalisation of the insured on 08.11.2011 and from 28.11.2011 to 30.11.2011. When the connected bills are evaluated in the light of the terms & conditions of the insurance policy, it is found that the Complainant is no way entitled to get more than what the insurer has paid him in the second installment. The Complainant openly admits in this forum that he has received a cheque of Rs.35,924/- from OP on 10. 06 2013 , i.e., after lodging of the present complaint. Obviously, the Complainant has nothing more to get from the OP. Hence it is ordered that the complaint being devoid of any merit is hereby dismissed.

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BHUBANESWAR OMBUDSMAN CENTER

COMPLAINT NO- 11-002-1118

Sri Dinabandhu Mishra

Vrs

The New India Assurance Co. Ltd., Puri Branch Office

Award Dated 17th Sept., 2014

This is a complaint filed by the Insured-Complainant for partial repudiation of health claim by the Opposite Party-the Insurer.

Brief case of the Complainant is that he along with his spouse was having Senior Citizens' Mediclaim Policy from the OP since last 19 years without

having any claim. In the year 2010 he renewed the aforesaid policy related to the period from 27.12.2010 to 26.12.2011. Due to cardiac ailment, his wife Manjula Mishra was hospitalized at Aditya Catre Hospital from 10.05.2011 to 14.05.2011. As against a total hospital bill of Rs.3,42,353.00, the OP paid Rs.83,000.00 only. The Complainant found that he was entitled to get a further sum of Rs.57,000/- along with interest. So he approached this forum by lodging this complaint.

In spite of notice the OP did not choose to file SCN.

At the time of hearing before this forum, the Complainant appears and states that in his presence the representative of OP freshly calculated his wife's entitlement in the light of the terms & conditions of the health insurance policy. After due calculation it was found that the spouse of the Complainant was entitled to get a further sum of Rs.25,450/- from the insurer in full and final settlement of the grievance. The Complainant unequivocally declares his agreement to the said calculation. One Mr. B. Behera, Deputy Manager, appears on behalf of the OP. He says that as per clause 2.1 of the terms & conditions of the policy the Complainant is entitled to get a further sum of Rs. 25,450/- He submits a hand-written calculation sheet and states that the OP is ready and willing to pay the amount in full and final settlement of the claim.

Admittedly, the Complainant has already received Rs.83,000/- towards his wife's health-claim. The hand-written calculation sheet as submitted by the representative of the OP is found to be consistent with the terms and conditions of the Senior Citizens' Health Claim Policy. The most important fact is that the Complainant agrees to the said calculation in full and final settlement of his grievance. In such a predicament, I do not find any good reason to go further deep in to the matter as the OP also agrees to pay the amount. Hence it is ordered that the complaint is allowed in part. The OP is hereby directed to settle the claim as per the calculation sheet referred above.

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BHUBANESWAR OMBUDSMAN CENTER
COMPLAINT NO- 11-011-1112
Sri Sumanta Kumar Jena
Vrs
Bajaj Allianz General Insurance Co. Ltd., Bhubaneswar,
Award Dated Dated 17th September, 2014

This is a complaint filed by the Insured-Complainant for total repudiation of his health-claim by the Opposite Party-the Insurer.

Sans unnecessary details, the case of the Complainant is that he was having health insurance from the OP since last four years. In July 2012, he sustained left knee fracture due to fall. After necessary medical aid he continued to have pain in his left knee. So on 21.08.2012, he went to Apollo

Hospital and consulted with the doctor who advised him to get admitted to the hospital for investigation and treatment. Accordingly the Complainant got admitted to the hospital to conduct MRI on his left knee on 21.08.2012 and approached OP for cashless facility. Unfortunately even after lapse of twenty hours, no approval came from the OP for rendering cashless facility. As the Complainant was then not having much money to meet the medical expenses to conduct the MRI, he was compelled to leave the hospital after settling the hospital bill. He got discharged from the hospital on 22.08.2012. Then he applied to OP for reimbursement of the hospital expenses. But the OP repudiated the claim by letter dated 20.10.2012. Finding no alternative the Complainant approached this forum.

In spite of notice the OP did not choose to file SCN.

At the time of hearing the Complainant remained absent from this forum. According to the OP, they could not file SCN as they were busy in making investigation at their level. However, this case clearly fell under clause 15 of the terms and conditions of the policy. Since the Complainant claimed a sum specifically for diagnostic and investigation, he was not entitled for the same as per the said clause. The OP expressed his sorrowness for non-filing of SCN.

I have elaborately gone through the case file. Although the Complainant has made a claim of Rs.4200/- (Approximately), in his application given in Form P II, he has submitted no medical bill to this forum. Copy of the Discharge Summary indicates that he was admitted to Apollo Hospital, Bhubaneswar on 21.08.2012 for diagnosis of the injury to left knee sustained one month back and he was discharged from hospital on 22.08.2012 with some advice. OP's repudiation letter dated 20.10.2012, reflects that Complainant's claim was rejected as per Clause 16 of the Terms & Conditions of the policy on the ground that it was only an investigative procedure which did not support the need for hospitalisation and no treatment was administered on the patient.

The situation compelled me to go through the terms & conditions of the policy minutely. As it is seen the terms & conditions have been categorized under four heads- (1) Cover, (2) Definitions, (3) What the Company will not pay, and (4) Conditions. Clause 15 and 16 of the third category attract my attention much. Clause 15 says that medical expenses relating to any hospitalisation primarily and specifically for diagnostic, X-ray or laboratory examinations and investigations are excluded from payment by OP. Clause 16 reveals that medical expenses where in-patient care is not warranted and does not require supervision of qualified nursing staff and qualified medical practitioner round the clock are also excluded from payment.

Here in this case, the hospitalisation of the Complainant appears to be clearly for diagnostic purpose. He got admitted in the hospital to conduct MRI on his left knee so as to know the exact cause for which he faced difficulty in knee mobilization. This appears to be a form of investigation. The case clearly falls under clause 15 and as such the medical expenses incurred for the purpose is excluded from payment. Since the OP is not liable to make payment as per clause 15 of the terms & conditions of the Health Guard Policy, he is not entitled to get the same. Hence it is ordered that the complaint being devoid of any merit is hereby dismissed.

BHUBANESWAR OMBUDSMAN CENTER

COMPLAINT NO- 14-003-1116

Sri Bibhuti Bhusan Senapati

Vrs

National Insurance Co. Ltd., Mumbai DO VII.

Award Dated Dated 17th September, 2014

This is a complaint filed by the Insured-Complainant for delay in settlement of his Health claim by the Opposite Party-the Insurer.

Sans unnecessary details, the case of the Complainant is that he took a BOI National Swasthya Bima Policy for his family from the OP for the period commencing from 10.10.2011. On 10.04.2012 his spouse namely Santoshi Senapati underwent cataract operation of her right eye at LV Prasad Eye Institute of Bhubaneswar and submitted medical bills for Rs.13,970/- for claim settlement. Since the claim was not settled by OP, the Complainant approached this forum.

The OP took the plea that the Complainant submitted claim along with relevant documents on 22.06.2012 in respect of cataract operation dated 10.04.2012. Although there was a delay of 73 days in submission of claim with documents, the Complainant could not show any valid reason for the same. So the TPA repudiated the claim as per Clause 5.3 of the policy.

At the time of hearing the Complainant states that he did not receive the policy bond from the insurer till 21.05.2012 when duplicate policy was issued to him. Then he submitted his claim along with connected documents at Bhubaneswar office of the OP on 09.06.2012. There was absolutely no manner of latches or negligence on his part. So he is entitled to get the claim.

The OP does not dispute that the Complainant got the duplicate policy bond on 21.05.2012. But he emphasizes that as per clause 5.3 of the policy bond, the Complainant should have submitted the connected bills within 30 days from the date of discharge from the hospital. Since he failed to do so, his claim was repudiated.

It is well known that in a grievance of this nature the insurance contract forms the basis which binds the insured and the insurer. It is needless to mention here that the policy bond contains the terms & conditions of the contract upon which both the parties agree. Manifestly, any sort of claim is not sustainable in absence of those terms & conditions which binds both the parties with a piece of string.

Here in this case there is no dispute that the Complainant did not receive the policy bond till 21.05.2012 when a duplicate policy was issued to him. This fact becomes apparent from the photo-copy of the duplicate bond. No doubt Santoshi Senapati, wife of the Complainant underwent cataract operation on 10.04.2012. She was hospitalized and discharged on the same date. In absence of policy bond the Complainant waited till 21.05.2012 and after receipt of the duplicate policy, he submitted all the relevant papers on 09.06.2012. The TPA, Heritage Health Pvt. Ltd. sent those papers to the OP and the same appears to

have been received by the OP in its Mumbai office on 22.06.2012. Since the present claim arises out of the terms and conditions of the policy bond, the duplicate of which was issued to the Complainant only on 21.05.2012, it cannot be said that there was any sort of negligence or latches on his part by submitting claim in June, 2012. Even if for the sake of argument it is conceded that there has been some sort of delay, then in absence of any trace of negligence it can be condoned as the reason shown appears to be satisfactory.

Further the SCN indicates that the claim was repudiated by the TPA as per clause 5.3 of the policy. As I feel it is not a sound practice. The policy forms a contract between the insured and the insurer. So the repudiation, if made, is to be done by the insurer, not by the TPA which acts as an intermediary. In case of any grievance, it is the insurer which has to take a final decision. However having regard to the entire facts and circumstances of the case, the claim of the Complainant rightly deserves condonation. Hence it is ordered that the complaint is allowed. The OP is hereby directed to settle the claim of the Complainant without least delay.

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BHUBANESWAR OMBUDSMAN CENTER

COMPLAINT NO- 11-002-1108

Ms. Rupa Kanungo

Vrs

The New India Assurance Co. Ltd., Cuttack Branch Office,

Award Dated 19th Sept., 2014

This is a complaint filed by the Insured-Complainant for partial repudiation of medi-claim by the Opposite Party-the Insurer.

In short, the case of the Complainant is that she had made medi-claim insurance policy with the OP and during the policy period she had severe coronary distress and got admitted to Apollo Hospital, Bhubaneswar. After angiography she was discharged from hospital and later she submitted a claim for Rs.61,827/- through TPA, Heritage Health. But the OP disbursed a sum of Rs.43,824/- as against the said claim. Under such contingency the Complainant approached this forum for the residual claim of Rs.18,003/-.

The OP filed SCN stating that the insured paid room rent for Rs.7700/- for two days. As per clause 2.1 of the policy she was eligible to get room rent of Rs.4,000/-. This effected reduction in amount payable under 2.3 and 2.4 by 48.05% after being calculated as (3700/7700 x 100). Further few items were not allowed for want of detail bill, report etc. So the OP pleaded that the amount disbursed is strictly consistent with the terms and conditions of the policy.

At the time of hearing before this forum, the Complainant reiterates that the deductions made by the OP are thoroughly misconceived and she is entitled to get appropriate amount as admissible by the terms & conditions of the contract. One Mr. B. Behera, D y Manager appeared on behalf of the OP and openly admitted that at the time of calculation the fact of hospitalisation in ICU was inadvertently taken as hospitalisation in room. So a substantial mistake crept in to the calculation, particularly when it was made on the basis of the Note appended to clause 2.6 of the Mediclaim policy. However, he speaks that the OP is ready and willing to disburse appropriate amount as admissible by

the terms and conditions of the health contract.

On a minute scrutiny of the hospital bill it is seen that the hospital has charged room rent of Rs. 7700/- for two days including the charges for ICU for one day. As per clause 2.1 and 2.2 of the Mediclaim Policy, where the sum insured is Rs.200000/-, the Complainant is entitled to get Room and ICU charges of Rs. 6,000/- during those two days of hospitalisation, instead of Rs.4,000/- as earlier calculated by the OP.

As per clause 2.5, pre-hospitalisation medical expenses up to 30 days and according to clause 2.6, post- hospitalisation expenses up to 60 days are permissible. In respect of the present calculation, emphasis is laid on the Note appended to Clause 2.6. As per Note- 1, the amounts payable under clause 2.3 & 2.4 shall be at the rate applicable to the entitled room category. In case of admission to a Room/ICU/ICCU at rates exceeding the limits as mentioned under 2.1 and 2.2, the reimbursement/payment of all other expenses incurred at the hospital, with the exception of cost of medicines, shall be affected in the same proportion as the admissible rate per day bears to the actual rate per day of Room rent/ICU/ICCU charges. Since the Complainant is entitled to get ICU and Room charges of Rs.6,000/- as against actual room rent of Rs.7,700/- , the amounts payable under clause 2.3 & 2.4 shall be at the rate 6:7.7 . It is needless to mention here that the OP appears to have deducted Charges as against four items, namely, Out of hour medical service, Non-Invasive Procedure, Inadmissible Items and Nursing Charges and has rightly reimbursed cost of medicines. However, since, there has been a substantial change in the ratio by increase in the ICU and Room rent this would enhance the entitlement of the Complainant and she has to get the amount as permissible under the terms and conditions of the relevant policy. Hence it is ordered that the complaint is allowed in part. The OP is hereby directed to settle the claim of the Complainant in the manner as indicated above, without least delay.

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BHUBANESWAR OMBUDSMAN CENTER

COMPLAINT NO- 11-003-1124

Sri Vinay Kumar Choudhary

Vrs

The National Insurance Co. Ltd., Bhubaneswar DO I,

Award Dated 30th Sept., 2014

This is a complaint filed by the Insured-Complainant against total repudiation of his health-claim by the Opposite Party-the Insurer.

Brief case of the Complainant is that he took a Health Insurance policy from the OP for the period from 31.03.2012 to 30.03.2013 for Rs.5,00,000. While the said policy was effective, the Complainant fell ill and consulted Apollo Hospital, Bhubaneswar, Aditya Care Hospital, Bhubaneswar and Apollo Hospital, Chennai for treatment. Then he submitted his claim alongwith all relevant papers before the OP which repudiated the same. Finding no alternative the Complainant approached this forum.

The OP filed SCN and took the plea that the alleged hospitalisation was basically for investigation and evaluation purpose. No active line of treatment requiring hospitalisation was made. So the claim is impermissible as per clause 4.10 of the terms & conditions of the policy.

At the time of hearing, the Complainant only physically appeared and stated that he suffered from slow fever off & on. For that he consulted the doctors of Apollo Hospital, Bhubaneswar and Aditya Care Hospital, Bhubaneswar. But no disease was traced in him. Then he went to Apollo hospital, Chennai and got admitted. In spite of investigation no disease could be found in him. The Complainant adds that he has filed the photo-copy of the Discharge Summary which indicates urine infection. Since he received treatment for urine infection, he is entitled to the heath-claim.

The situation constrains me to travel through copy of the policy and copy of the Discharge Summary granted by Apollo Hospital, Chennai. Before going through those pertinent documents it should be kept in mind that there was no hospitalisation in either of the Hospitals at Bhubaneswar and therefore the expenses made by him in those two hospitals are not covered by the policy.

A careful scrutiny of the available documents goes to show that hospitalisation benefit is rendered by the insurance policy in question. It lays down definite terms & conditions under which expenses incurred by the policy holder are payable. Clause 4 of the Terms & conditions deals with Exclusions, where expenditure made by the policy holder are not payable. Clause 4.10 says that charge incurred at hospital or nursing home primarily for diagnostic, X-Ray or laboratory examinations not consistent with or incidental to the diagnosis or treatment of the positive existence of or presence of any ailment, sickness or injury for which confinement is required at a hospital or nursing home is not payable by the insurer.

Now let us concentrate on the Discharge Summary granted by Apollo Hospital, Chennai. It finds mentioned History of Present illness of the patient, Clinical examination, Course in the hospital & Discussion and lastly, Advice on discharge. The third heading "Course in the Hospital & Discussion" seems to be pertinent. It does not emit any scent of ailment and active treatment, although the Complainant reiterates that he received treatment for urine infection. Routine examination of urine & stool found to be normal. Urine culture shows growth of E-Coli. Opinion of the doctor was taken regarding urinary tract infection. The doctor advised watchful wait and against use of antibiotics. The entire course taken in the hospital does not give any scent regarding ailment in urinary tract of the patient requiring hospitalisation and active line of treatment in that respect. As it appears the Discharge Summary indicates a series of diagnostic and investigative processes and nothing more. To add to it the Complainant himself openly declares in this forum that no disease was detected in him.

Of course it is true that the Complainant submits photo-copy of a bunch of medical papers for verification of this forum. But all of them are found to be of Out-patient Department of the hospital, where there is no question of any hospitalisation. In absence of hospitalisation policy coverage is not attracted. So all those medical papers are of no help for the purpose of this medi-claim. In the circumstances it can be safely held that there is no trace of any disease in the Complainant requiring hospitalisation and active line of treatment. The consultations made at Apollo Hospital and Aditya Care, Bhubaneswar and hospitalisation at Apollo Hospital Chennai was clearly for diagnostic & investigative purpose, the expenses of which is boldly excluded by the terms

and conditions of the policy. As such the medi-claim of the Complainant is neither sustainable nor payable by the OP. Hence it is ordered that the complaint being devoid of any merit is hereby dismissed.

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CHANDIGARH OMBUDSMAN CENTER

CASE NO. CHD-G-049-1415-0183
Subash Jain Vs. New India Assurance Company

ORDER DATED: 4th August, 2014 Medi-claim

FACTS: This complaint was filed about denial of a hospitalization claim under an Individual Medi-claim policy on the ground of treatment of a 'pre-existing' ailment. The claim was lodged under the first year policy, which had commenced with effect from 19.08.2012 and surgical treatment was taken in February, 2013. The complainant had contested that knee treatment was about an accidental injury, wherein question of pre-existing ailment did not arise.

FINDINGS: The complainant pleaded that on a foggy day in January, during morning-walk, he accidentally collided with a pole and fell down. Thereafter, initially a treatment was obtained locally in Ludhiana. But, owing to deterioration of an internal injury and in the absence of a relief from pain, a surgical treatment was undertaken in Medanta the Medi-city Hospital, Gurgaon (Haryana). In support of his contention, he provided a copy of a treatment slip of Dayanand Medical College & Hospital, Ludhiana about an initial treatment on 17.01.2013. On behalf of Company, it was argued that 'discharge summary' of Medanta The Medi-city Hospital, Gurgaon clearly mentioned about an ailment of 'medial compartment arthiritis of right knee'. To substantiate a conclusion/ decision about treatment of a pre-existing problem, a copy of an investigation report of a Ludhiana-based diagnostic centre was also provided, wherein conclusion part mentioned about 'degenerative changes in both knees'.

DECISION: The decision of the Company to decline a claim on the ground of treatment of a pre-existing problem was held justified in the light of the fact that evidence adduced in the form of 'discharge summary' and an investigation report of a local diagnostic centre confirming patient's knee problem to be degenerative and progressive in nature was sufficient to prove existence of an ailment prior to commencement of an insurance in the first year with no past insurance history.

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<u>CHANDIGARH OMBUDSMAN CENTER</u>

<u>CASE NO. CHD-G-049-1415-0191</u>

<u>Rakhee Gupta Vs. New India Assurance Company</u>

ORDER DATED: 4th August, 2014 Medi-claim

FACTS: This complaint was filed about miss-selling of two separate Medi-claim policies to a couple, who are medical practitioners by profession. It was alleged that refund of premium was made after deduction from the paid amount and premium was accounted/ refunded in a wrongful/ irregular manner, which caused a lot of hardship.

FINDINGS: The complainant pleaded that both she and her husband gave separate cheques for an individual medical insurance for Rs. 8,00,000/-, when an Agent assured that all health-related problems are covered to the extent of full sum insured of Rs. 8,00,000/-. However, subsequently received policies mentioned 'cataract' surgery limited up-to Rs. 24,000/-, which belied an objective at the time of insurance. Thereafter, in response to a request for cancellation of policies within 'free look period', Company refunded premium after making a deduction and later on released the deducted amount. Both the policy documents, mentioned particulars of premium cheque of each other and refund of premium was received vide a consolidated credit entry. On behalf of Company, it was explained that both husband and wife had obtained insurance on 24.02.2014 by paying giving separate cheques for the identical amounts of Rs. 14,047/-. By handing-over an insurance book-let, terms and conditions of the policy were duly apprised to them. The policy documents were sent on the

same day and due to delay on the part of the courier, these were collected back for an early delivery. Then, after a receipt of a request for cancellation of policies on 27.02.2014, necessary formalities were completed and refund of premium was made on 27. 03.2014 through 'NEFT'. Being a recent introduction in Medi-claim policies, provision of 'free-look period' was initially omitted, but deducted amount of Rs. 7.028/- was refunded on 20.06.2014.

DECISION: It was viewed that after a refund of a total premium amount, there was hardly any relief to be considered. Besides, inadvertent omissions in accounting premium cheques of husband and wife for identical amounts against policies of husband and wife and refund through a consolidated amount could not be viewed as a gross deficiency/ fraudulent act. No relief was granted. Instead, it was held that under provisions of 'free look period' about deduction on account of any amount spent on medical check-up; stamp duty charges and proportionate risk premium, Company was free to recover excess paid amount

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CHANDIGARH OMBUDSMAN CENTER
CASE NO CHD-G-049-1314-0620
Gaurav Bhagat Vs. New India Assurance Company

ORDER DATED: 4th June.2014
Medi-claim

FACTS: This complaint was filed by a beneficiary employee about denial of a claim under group medi-claim policy, arranged by employer, Life Insurance Corporation of India for its serving as well as retired employes.

FINDINGS: During hearing, the Complainant stated that he was hospitalized in an eye care hospital for a complicated eye surgery and a sum of Rs. 95,000/- was incurred on a treatment, which was declined by the Company on the ground of a cosmetic treatment. He told that surgery was undergone only as a last resort after reaching a stage of near blindness, but despite submitting necessary clarifications in response to various queries raised during processing of the matter, a claim was initially not paid. He apprised that after the lodging of a complaint, the matter was decided by the Company after 11 months and a payment was released to him. On behalf of Company,

it was argued that an eye problem of the complainant was diagnosed as 'myopic astigmatism' of both eyes that was corrected through a surgery. It was clarified that the procedure is done for a correction of refractive error, which is essentially a cosmetic surgery and excluded under a specific policy clause. However, after receipt of a confirmation about high refractive error from the concerned hospital, the matter was referred for an expert opinion for settling a claim.

DECISION: It was viewed that a clarification from the concerned hospital was obtained after a long gap of time and the same caused an in-ordinate delay in settling an issue. Therefore, the Company was directed to pay an additional amount towards interest for a delay in paying a claim.

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CHANDIGARH OMBUDSMAN CENTER
CASE NO CHD-G-020-1415-0066
Anoop Anand Vs. ICICI Lombard General Insurance Company

ORDER DATED: 4th June.2014
Medi-claim

FACTS: This complaint was filed about denial of a hospitalization claim on the ground of non-disclosure of a pre-existing health condition.

FINDINGS: During hearing, the Complainant stated that he was a medi-claim policy holder of the Company for the last seven years. In February, 2014, he was diagnosed with a coronary single vessel disease, which necessitated hospitalization/ a surgical treatment on which a sum of Rs. 2,75,000/- was spent by him. However, its claim was rejected by the Company on the ground of a pre-existing health condition because the treatment record mentioned about 'hypertension' for the last 15 years. He stated that he had maintained condition of 'hypertension' well under control during the last 15 years and the same is evident from a free-claim insurance record over the last seven years. On behalf of Company, it was argued that from medical record it was observed that insured had a history of 'ulcerative colitis' and 'hypertension' for the past 15 years. As these ailments were not disclosed in the proposal form, a cashless facility

was denied. It was apprised that Company had called for additional papers for a review of a decision.

DECISION: It was viewed that Company's decision to deny a claim on the ground of non-disclosure of a life-style disease of 'hypertension' after a continuous insurance of seven years is not justified. Therefore, directions were given for the settlement of a claim as per its admissibility under sum insured available 4 years prior to the current policy.

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CHENNAI

THE INSURANCE OMBUDSMAN, CHENNAI

Complaint No. CHN-G-044-1314-0223

A Sivasankar Vs Star Health & allied Ins. Co. Ltd.

Award No. IO (CHN)/G/A/044/001/2014-15, dated 23.04.2014

The complainant had stated that his father is covered by the Insurer's Mediclaim policy from 13/07/2009. His father was hospitalized for the treatment of ACS, Dementia-Multi Infarct acute right parietal stroke, CKD. This was his first claim since inception of the policy from 13/07/2009. He further stated that while taking the insurance cover, he was made to believe that all the PEDs are covered and he himself filled the proposal form mentioned 'NIL' against the relevant section on 'previous illness details' without his knowledge.

The insurer had confirmed the continuity of policy period from 2009. The medical history of the insured traced to (a) Old CT – Old infarcts left occipito parietal Rt. Postal parietal/ Rt. Internal capsule, CVA (2003), Hyperlipidemia, hypothyroidism and endogenous depression. Again in 2008, the insured was hospitalized for Acute Rt. Parietal stroke, Multi-infarct state with cognitive impairement and known case of HTN and mild Asthma. But in the proposal form, the complainant had not disclosed all these PEDs. Hence the claim was rejected as per policy

Terms and conditions and cancelled the policy and refunded the premium of Rs. 1781/-.

The Forum had observed that the complainant had ab initio suppressed the material fact with regard to the existence of the ailments and previous treatments. As the proposal has been filled by the complainant, he is responsible for the material information provided therein. the rejection of claim under policy condition No. 7 and cancellation of policy and refund of premium as per condition No. 10 falls within the scope of the policy and justified.

Hence the complaint is Dismissed.

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THE INSURANCE OMBUDSMAN, CHENNAI

Complaint No.IO CHN- G-050-1314-0260

Mr. G. Ganeshram

Vs

The Oriental Insurance Co. Ltd.,

AWARD No. IO (CHN) /G/A/022/2014-15

Dated 29/4/2014

The complainant Mr. G. Ganeshram has stated that he was having individual mediclaim insurance with the insurer since 2005. Mrs. Geetha his mother was diagnosed for Diabetic Macular Edema and was treated by administering an Avastin Injection on left eye. The insurer rejected the claim citing clause No.4.23.

The insurer in their Self Contained Note has stated that though the Avastin Injection was given in operation theatre under anesthesia, this falls under Out Patient treatment which an exclusion under Clause 4.23 of their Policy.

During the hearing the complainant has submitted a brief case summary dated 9/4/2013 from Sankara Eye Hospital to reconsider their decision but the same was not considered. He stated that the injection was administered after giving anesthesia in an operation theatre and not in OPD.

The Clause 4.23 states "Out Patient Diagnostic, Medical or Surgical procedures or treatments, non-prescribed drugs and medical supplies, Hormone replacement therapy, sex change or treatment which results from or is in any way related to sex change.

The above clause does not specifically exclude treatment such as administration of injection like Avastin etc., which are done in the operation theatre but are not similar to the OPD treatments. When the Policy conditions are not clear with specific exclusions, the benefit of doubt has to be extended to the insured.

However, it is noted that the policy terms allow claims under the circumstances where (1) Hospitalisation for a minimum duration of 24 hours is required for the medical/surgical treatment or (2) Treatment given as one of the "Day care procedures" which are specifically mentioned in the Policy, waiving such 24 hours duration of admission in the hospital. In the instant case, it does not fulfill either of these conditions.

Though the injection was administered in an Operation theatre under topical anesthesia, it cannot be construed strictly as a treatment under the usual hospitalization benefit as envisaged under the scope of the policy, nor as a routine Outpatient treatment, considering the process of the treatment given in the instant case.

The complaint was allowed on Ex-gratia basis.

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THE INSURANCE OMBUDSMAN, CHENNAI

Complaint No.IO CHN- G-048-1314-0229

Mr. Uma Karthik AVSS

Vs

National Insurance Co. Ltd.

AWARD No. IO (CHN) /G/A/003/2014-15

Dated 30/4/2014

The Complainant stated that his cashless facility for his hospitalization for Scoliosis Correction surgery was denied by the Insurer's TPA stating that the ailment was congenital external. He is an employee of HCL covered under their Group Medi claim Policy and as per the terms and conditions provided by the insurers to his employer the ailments are covered.

The insurer in their Self Contained Note has stated that the claim was denied, since the treatment was relating to a congenital internal ailment as certified by the Doctor and the Policy does not cover such ailments.

As per Para-2 of the SCN it is stated that after getting full details of the treatment the TPA found that the treatment is congenital internal which is not payable under the Policy Terms and Conditions (Terms and conditions of the MOU is attached) Hence the approval was withdrawn. While making reference to MOU submitted alongwith the mail it is observed that on page No.14 under Congenital Diseases it is mentioned as "Hospital expenses for congenital internal diseases are covered and congenital external are covered only under life threatening conditions.

Under the circumstances explained above. The insurer was advised to settle the claim as per the terms and conditions of their Policy, as the concerned disease for which he underwent surgery is covered.

The complaint is allowed.

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THE INSURANCE OMBUDSMAN, CHENNAI
AWARD No. IO (CHN)/G/ 004 /2014-15 (Mediclaim)

Complaint No.IO(CHN)/G-044-1314-0232
Mr.S.Tamilarasu vs Star Health & Allied Ins. Co.Ltd.

1. **The complainant's claim for the treatment of Rheumatoid Arthritis was rejected by the insurer stating that the ailment was pre-existing based on the Medical Records. He represented to the insurer against the repudiation contending that he had policies with Bajaj Allianz from 15th July 2007 onwards continuously and switched over to Star Health from**

15/07/2010. He also contended that since he had policy cover for more than 48 months with an Indian insurance company, rejecting the claim under exclusion clause No.1 was not justified. But the insurer reiterated their stand alleging Non-disclosure of past health condition. Aggrieved by this, the complainant has approached this forum.

2. **The Insurer submitted that the claim was rejected as per the Exclusion No.1 of the policy stating that the ailment Rheumatoid Arthritis was pre-existing based on the Medical Record which mentions that the insured had undergone Synovectomy in the year 1993. The policy covers pre-existing ailments only after 48 months of continuous cover. Since the policy was in its fourth year only, the claim was not admitted. The past health condition was not disclosed in the proposal form.**

The Discharge Summary confirms the Diagnosis as RA-Active, Seropositive ,FC IV erosive and past history as Rt. Knee Mono Arthritis since 1993. Since the policy had run only 3 years with the insurer, the ailment was pre-existing and the claim was rejected under 'pre-existing disease exclusion clause' and 'non-disclosure' of the past health condition by the insured in the proposal form .

The policy was not switched over on portability scheme and in the year 2010 there was no such scheme in force. Therefore, in the absence of any specific endorsement on the policy, the cover with the previous insurer was not taken into account by the insurer.

Moreover, the pre-existing health condition was not declared in the proposal form at the inception of the policy in the year 2010, amounting to Non-disclosure of material facts.

So, the decision of the insurer to repudiate the claim on the grounds of pre-existing disease exclusion is justified and requires no interference at the hands of the Insurance Ombudsman.

The complaint is dismissed.

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THE INSURANCE OMBUDSMAN, CHENNAI
AWARD No. IO (CHN)/G/ 005 /2014-15(Mediclaim)
Complaint No.IO(CHN) /11-044-1314-0237

The Complainant stated that his claim for his mother's hospitalization was repudiated by the insurer on the ground that the treatment rendered did not warrant hospitalisation. He represented to the Grievance Cell

stating that the patient was immobile and confined to bed from 17/09/2012 and it was practically impossible to take the patient to the hospital on daily basis. She was treated with Physio therapy along with treatment for urinary incontinence and Osteo Arthritis. But his claim was not considered by the insurer.

The Insurer submitted that the claim was rejected as the insured was admitted only for Rehabilitation. Major portion of expenses (Rs.72,300/-)was incurred towards Nursing care. Moreover, the treatment involved Psychological treatment, Depression and Obesity treatments which are not covered under the policy. The rehabilitation treatment could have been carried out at home with the assistance of a Nurse, which did not warrant in-patient admission. So, the claim rejection is in order.

The policy in its preamble states that the hospitalization expenses "reasonably and necessarily" incurred for treatment of any illness upon the advice of the medical practitioner, would be reimbursed. But in the instant case, the reasonableness and the necessity for admission into hospital for the long duration of 130 days has not been substantiated by any medical records. Moreover, other than physiotherapy, psychological treatment for mental depression and Obesity treatment were also involved during the said hospitalization, which are not covered under the scope of the policy. In addition, it was not confirmed by the Hospital that the Special Nursing care was engaged upon the advice of the treating Doctor. The nursing charges are not included in the Hospital's Bill but a separate bill has been raised by Malar Patient care services. The break-up details of Hospital Bill for the Room Rent, Doctor Fees etc. are also not available.

Under the circumstances, in order to render justice to both the parties to the dispute, through the mediation, the Insurance Ombudsman is inclined to award an amount Rs.30,000/- (Rupees thirty thousand only) to the insured. The insurer is advised to pay the said amount to the insured.

The complaint is allowed.

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THE INSURANCE OMBUDSMAN, CHENNAI
AWARD No. IO (CHN)/G/007 /2014-15(Mediclaim)

Complaint No.IO(CHN)-G-051-1314-0272

Mr.Om Prakash Kothari vs United India Insurance Co.Ltd.,

The Complainant stated that the claim for the Cataract surgery for his wife was settled by the insurer for Rs.31625/- only, as against the total of Rs.67,000/-. He contends that the policy condition No.1.2.1 specifies that claim for cataract surgery is payable upto the limit of 25% of the sum insured. He represented to the insurer's Grievance Cell, who replied that only "customary and reasonable expenses" are payable for normal lens cost and not for the multifocal lens used for her and rejected the balance amount.

The Insurer submitted that as per the Policy condition 4.6 (b) only the reasonable, customary and necessary expenses are payable and therefore only the cost of monofocal lens was allowed and the cost of multifocal lens is not payable.

The insured got multifocal lens implanted as per her Doctor's advice. Since the cost of multi-focal lens would be definitely more than the Mono-focal lens, as construed by strict interpretation of the policy wordings (condition No.1.1), "Reasonable and necessary Expenses", the Medi-claim Policy provides for payment of expenses to treat the actual condition for which the insured is hospitalised, which indicates that the costs exceeding the actual necessity over and above the "minimum requirement" in respect of the treatment/ procedures have to be borne by the insured. But, at the same time, the insured's contention that the relevant condition to restrict the cost of IOL was neither made known to him by the insurer in the terms and conditions attached to his policy nor by the TPA on settlement of the claim, cannot be brushed aside.

The insurer is also expected to ensure that such important conditions relating to the LIMITS of claim for different ailments/surgeries are clearly incorporated in the policy terms and conditions. Restriction of the claim on the basis of the "reasonable and necessary" clause and exclusion clause Nos 4.6(b) or (c) are required to be clearly spelt out in the policy without any ambiguity.

Therefore, in order to render justice to both the parties to the dispute, the Insurance Ombudsman is inclined to grant an Ex-gratia of Rs.10,000/- (Rupees ten thousand only) to the insured, over and above the claim amount already settled to him.

The complaint is allowed as an ex-gratia.

Complaint No.IO(CHN)-G-003-1314-0231(Mediclaim)

AWARD No. IO (CHN)/G/ 008 /2014-15

Mr. M.Vinoth vs Apollo Munich Health Insurance co.Ltd.

The Complainant stated that he was covered under the health insurance policy with the insurer from 03/08/2010 onwards and during the policy period from 03/08/2012 to 02/08/2013, he was admitted into the hospital from 16/07/2013 to 18/07/2013 for surgical treatment for an injury in his jaw, following a fall from his two wheeler due to skidding, when it was raining. The cashless benefit was withdrawn by the insurer, though it was approved originally. His claim for reimbursement of Rs.117711/- was rejected by the insurer stating that the medical records confirmed that he was a known case of seizure disorder since past 10 years, which was not disclosed in the proposal form at the inception of the policy and also the insurer denied renewal of the policy. He represented to the insurer along with the previous treatment prescriptions, stating that he was having only "shivering for the past 10 months" and not "seizure for 10 years" which was wrongly recorded by the doctor and also pleaded that the injury had no relevance to the past medical condition. But the insurer had not responded to his representation. Aggrieved by this, the complainant has approached this forum.

The Insurer submitted that the insured was a known case of seizure disorder for the past 10 years, and the past medical condition was not truthfully declared by the insured in the proposal form, which amounts to non-disclosure. Hence the claim was rejected as per policy conditions and the renewal of the policy was denied.

His claim was repudiated by the insurer invoking the clause No. 7 (u) of the policy, for non disclosure of the past health condition namely "existence of seizure disorder for 10 years" as revealed by the discharge summary and medical records. The contention of the complainant that "the diagnosis 'Seizure disorder' has been mentioned "wrongly" in the pre-authorisation forms and also the Discharge Summary by the doctor" is not acceptable, since he has not produced any records to confirm whether the records were subsequently rectified or not.

Since the policy is issued based on the details furnished in the proposal form, the non-disclosure of material facts in the proposal form makes the contract of insurance void which has led to the denial of the claim by the insurer under the policy, in addition to refusal to renew the policy further as per condition No. 7(u).

Therefore, the decision of the insurer to repudiate the claim is justified,

The complaint stands dismissed.

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THE INSURANCE OMBUDSMAN, CHENNAI

Complaint No. CHN-G-051-1314-0235

K. N. Babu Vs United India Insurance Co. Ltd.

Award No. IO (CHN) /G/A/051/09/2014-15, dated 08.05.2014

The complainant had stated that his family members are covered by the mediclaim policy of the insurer from the year 2001 and there was no claim for the past 10 years. He was hospitalized for 8 days and lodged claim for Rs. 49,739/-. Out of 90% of the claim, that is, Rs. 44,886/-being the liability of the insurer, he was settled only Rs.30,886/-. Thereby there was a short settlement of Rs. 13,879/-. The insurer/TPA has taken more than seven months time to settle the claim.

The insurer in their SCN had stated that the claim has been scrutinized and settled strictly as per terms and conditions of the policy. From the reply of the grievance cell, it is learned that the complainant had lodged claim for Rs. 43,350/, but produced documents for Rs. 39,531/- only. This includes both pre and post hospitalization expenses. As per policy condition No. 1.2 (A), "Room, Boarding and Nursing Expenses as provided by the Hospital/Nursing Home upto 1% of sum insured per day. This also includes Nursing Care, RMO charges, IV fluids/Blood Transfusion/Injection administration charges and the like". The insurer had disallowed amounts under the limitation of 1% on room rent, Ambulance expenses etc.

It was observed that the complainant had intimated the within 24 hours of hospitalization. Hence the contention of the insurer that there was delay in informing the claim was not acceptable. It was also observed from the policy schedule under the optional covers: the item No.1 against the head "Ambulance charges" it is mentioned as 'yes', which leads to mean that the ambulance charges are payable. Subsequent on the complainant submitting the claim form and bills, the insurer had further sought clarifications with regard to diabetic ailment of the complainant which may not be relevant, but still, the complainant had clarified. Bank details of the complainant were given well in advance. Asking for the required documents repeatedly from the complainant in spite of his compliance shows that there is no coordination among the insurer/TPA and the local office. Therefore, the insurer is advised to settle the claim for Rs. 2060/- (Lab charges) + Ambulance charges applicable as per policy terms and conditions) with interest as per Protection of Policy Holders' Interest Regulation 2002 sec.9 (6).

The complaint is allowed partly with interest.

THE INSURANCE OMBUDSMAN, CHENNAI
AWARD No. IO (CHN)/G/010/2014-15
Complaint No.IO(CHN)-G-049-1314-0234(Mediclaim)
Mr.N.Arivazhagan vs The New India Assurance Co.Ltd.,

1. **The complainant stated that the claim for his daughter's hospitalization for undergoing Cholecystectomy was settled by the insurer disallowing Rs.66312/-taking into account the proportionate charges in respect of Op.Theatre Charges, Lab charges and Professional charges as applicable to the entitled Room rent category. His daughter represented to the insurer for reconsidering the balance amount contending that the Hospital charges are irrespective of the room rent. However, the Grievance cell reiterated their decision to restrict the claim in proportion to the entitled room rent.**
2. **The Insurer submitted that the claim preferred by the insured was settled as per the Limits applicable to the entitled room rent and proportionate deductions were made based on the entitled room rent category as per policy conditions 2.1, 2.3 and 2.4 and Note there under.**

   Taking into account the various aspects like (1) the policy condition stipulates 'restriction on various charges' depending on the Room Rent though not on "proportionate" basis and (2) the insurer's contention that "various charges of the hospital 'vary in direct proportion to the room rent' is totally wrong", (3) the normal/reasonable rates for cholecystitis surgery in 'A' grade Hospitals are definitely less than the charges collected by the hospital, in the instant case, as stated by the TPA, though the exact quantum is not ascertainable due to non-availability of relevant data, (4) the applicable sum insured is Rs.1,00,000/- based on which the entitled charges of hospital would also be reduced, the Insurance Ombudsman is inclined to award an ex-gratia of Rs.20,000/- (Rupees twenty thousand only), invoking the provisions of Rule No.18 of the Redressal of Public Grievances Rules, 1998, in order to render justice to both the parties to the dispute. Hence the insurer is directed to pay the said amount of Ex-gratia to the insured.

3. The complaint is allowed as ex-gratia.

Complaint No.IO (CHN)-G-038-1415-0024

Dr. M.R. Rajasekar
Vs
Royal Sundaram Alliance Ins.co.Ltd.

AWARD NO. IO (CHN)/G/A/ 011/2014-15

Dated 26/5/2014

The complainant stated that his wife Dr. Vasudha Rajasekar covered under the Policy had complaints of breast pain and was

evaluated and had undergone breast ultrasound, bilateral mammogram and PET CT Scan, which showed a suspicious lump in the upper outer quadrant of her right breast. She was admitted and as recourse, a wide local excision of right breast upper outer quadrant lump was done and tissue was sent for biopsy. She was discharged with diagnosis of "Carcinoma Right Breast T2NOMO". She subsequently underwent chemotherapy. In March 2014 the complainant has submitted the claim to the insurer who rejected quoting "two years exclusion clause" 3(b) of the Policy.

The insurer in their Self Contained Note (SCN) stated that the complainant had the policy with them from 27/04/2012. A claim was made under the said policy by the complainant for expenses incurred by him for treatment of Carcinoma right breast T2NOMO for his wife Dr. Vasudha Rajasekar. The claim was rejected as per the two year exclusion clause 3(b) for any type of Carcinoma.

During the hearing, the complainant had stated that he had taken the Policy for two years with Royal Sundaram Alliance Insurance Company for the period 27.4.2012 to 26.4.2014. In December 2013, his wife had some symptoms in the breast. A mammography was done. A lump was found and it was suggested to go for biopsy which was done and diagnosed as breast cancer for which surgery was done at Apollo Hospital during the period 8.1.2014 to 10.1.2014. He preferred cashless settlement of the claim which was rejected and subsequently the reimbursement of claim was also rejected by the insurer. He had drawn the attention of the forum that, under exclusion clause 3(a), it is for one year from the commencement date that any type of breast lump for any insured person is excluded. In that case the insurer denying the claim under exclusion of 2 years clause 3(b) is not justified and the claim should be payable since it has occurred in the second year of the Policy.

The insurer's representative was asked to read the repudiation letter dated 18/2/2014 wherein it is stated that the claim has been repudiated under exclusion clause 3(b) of the policy that

Carcinoma/Sarcoma/Blood cancer is excluded for 2 years from the date of commencement of the cover. He has also explained that as far as exclusion under 3(a) is considered, breast lumps can be both malignant and non-malignant to which the complainant being a doctor himself also agrees and as such carcinoma is specifically excluded for a period of 2 years.

It is observed from the Discharge summary of Apollo Hospital that the insured Dr. Vasudha Rajasekar was diagnosed as carcinoma right breast and surgery has been performed for right breast wide local excision +axillary SLNB. The insured's claims, both cashless and reimbursement, were repudiated by the insurer citing exclusion clause 3(b) of the Policy.

The policy condition 3(b) Two year Exclusion clearly states any type of Carcinoma/Sarcoma/Blood cancer is excluded for all insured persons for two years from the date of commencement of the cover.

The complainant's Policy commenced from 27/4/2012 and the insured person was hospitalized on 8.1.2014 and diagnosed by the hospital "Carcinoma Right Breast T2 NO MO.

In the instant case the insured's claim for the disease took place within 2 years from the date of commencement of the Policy. Hence the repudiation by the insurer is as per the policy terms and condition 3(b) is in order. Hence no interference is called for.

The complaint is Dismissed.

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THE INSURANCE OMBUDSMAN, CHENNAI
AWARD No. IO (CHN)/G/A-044-012/2014-15.(Mediclaim)

Complaint No.CHN-G-044-1415-011

Mr. Mannar Mannan, vs Star Health & Allied Insurance co.Ltd,

The complainant stated that his son's claim for acute liver failure and Hepatitis A, was repudiated by the insurer on the ground that the past history of Seizure disorder since the year 2005, was not disclosed at the time of availing the first policy in the year 2007. He represented to the Grievance Cell stating that the patient was cured of the seizure disorder in 2007 and the agent had not guided him properly to disclose such past ailments in the proposal form and more over the present ailments have got nothing to do with the past seizure disorder. His policy was cancelled and the premium was refunded.

The Insurer submitted that the cashless claim was rejected as the insured was a known case of seizure disorder since 2005. The reimbursement claim also was rejected since the Discharge Summary revealed that the patient was a known case of seizure disorder on treatment from 2004 to 2008. The past medical condition was not declared by the proposer in the year 2007 while availing the policy for the first time. Hence the claim was repudiated invoking condition No. 7 and the risk cover for this insured person alone was cancelled by giving Notice of cancellation and the premium was refunded.

Discharge Summary of Mehta Children's Hospitals P Ltd for the period from 26/12/2013 to 6/01/2014 reveal that the insured was a known case of developmental delay with seizure disorder and was on treatment from the year 2004 to 2008. It confirms that the child was admitted with complaints of generalized tonic clonic seizure lasting for 10 minutes- 2 episodes since one day. He developed seizures of GTCS type and mixed with myoclonic jerks for which treatment was given during the hospitalisation. Since the policy cover with the insurer started only from 10/08/2007, the pre-existence of the ailment and its non-disclosure in the proposal form is clearly established. The proposer is expected to go through the contents of the proposal form for its correctness in all respects before submitting it to the insurer. The complaint is dismissed.

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THE INSURANCE OMBUDSMAN, CHENNAI

Complaint No.IO CHN- G-050-1415-0001

Mr. Chetan Acharya

Vs

The Oriental Insurance Co. Ltd.,

AWARD No. IO (CHN) /G/A/013/2014-15

Dated 26/5/2014

The Complainant stated that he preferred a hospitalization claim for severe fever from 6/1/2014 to 9/1/2014. The claim was rejected by the insurer stating that it is primarily for evaluation/diagnostic purpose which is not followed by active line of treatment for the ailment during the hospitalization period.

The insurer had stated in their Self Contained Note that from the discharge summary it is observed that the hospitalization was only for lab investigation followed by various tests but not supported by active line of treatment and the illness does not require hospitalization as inpatient. The claim falls under their Policy exclusion clause 4.8 which states that "expenses incurred at Hospital or Nursing Home primarily for evaluation/diagnostic purposes which is not followed by active treatment for the ailment during hospitalization period".

On a reference to the bills submitted, it is observed that approximately 50% of the cost involved is towards lab examination and once the claimant was evaluated by general physician administered the medicines, the moment the results of various tests were available which are done for various situations, the further admission could have been avoided. Moreover at the time of the admission, except for generalized body pain and back pain associated with joint pain and fever, there was no other complaint.

In view of the above the rejection of the claim of the complaint in total by the insurer by quoting a wrong clause of the Policy is not fully justified. On the other hand the complainant has not provided the indoor papers sought by us to know the circumstances that made him hospitalized and the various investigations done during hospitalization. In order to render justice to both the parties to the dispute, the insurance Ombudsman is inclined to grant an ex-gratia of Rs.10,000/-

The Complaint is allowed as an ex-gratia.

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THE INSURANCE OMBUDSMAN, CHENNAI

Complaint No. CHN-G-044-1415-0036

V. Umasankar Vs Star Health & Allied Ins.Co.Ltd

Award No. IO (CHN)/G/A/044/014/2014-15, dated 26-05-2014

The complainant stated that he was having two health policies of the insurer with different type of Policy from 02/05/2011. When he made a claim the insurer had registered the same under both the policies. The claim was rejected by the insurer. The claim was repudiated for the reason suppression/ misrepresentation of facts. The insurer had also cancelled one policy and refunded the premium. But it was not encashed instead, returned to the insurer. The other policy was cancelled by removing his name. This policy is also expired subsequently for which no follow up from the insurer.

The insurer in their Self Contained Note confirmed that the claim has been reported during the third year of the policy and registered under both the policies. The were rejected on the grounds that the ailment was pre-existing and there was mis-representation of material facts in the proposal. They have also stated that the complainant is a known case of DM & HT for 8 years and was operated for CA rectum in 2005. The complainant is also a known case of Parastomal hernia and underwent hernia repair in 2010.

It was observed that both the rejection of claim under policy condition No. 7 and cancellation of policy and refund of premium as per condition

No. 10 fall within the scope of the policy and are justified. Therefore, No interference is called for in the rejection of the claim by the insurer.

Hence the complaint is Dismissed.

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THE INSURANCE OMBUDSMAN, CHENNAI

Complaint No. CHN-G-051-1415-0003

A Chelladurai Vs United India Insurance Co. Ltd.

Award No. IO (CHN) /G/A/051/015/2014-15, dated 27/05/2014

The complainant had stated that he and his family members including his father were covered by the group mediclaim of United India insurance issued in the name of his Company. His father is suffering from cancer in Oropharnyx & Oesophagus and taking treatment. He had submitted the claim towards Chemotherapy treatment taken on various dates. But the insurance company has rejected his claim stating that diseases caused due to intoxication drugs/ alcohol are excluded from the coverage. However, he was of the opinion that none of the medical records have mentioned smoking as cause for disease. He also added that the attending doctor was not able to confirm that the smoking habit caused the present ailment.

The insurer in the SCN stated that the group mediclaim policy was issued covering 663 employees and their family members for an opted SI on floater basis. The father of the complainant was with the case history of "Smoker – Beedi 10 per day for 10 years" and diagnosed as "Carcinoma Oropharynx and Carcinoma Oesophagus – lower 1/3". The claim was rejected invoking the clause 4.9 of the

policy terms and conditions which reads as, 'Convalescence…….. Intentional self injury and use of intoxication drugs / alcohol.

Though the literature and the opinion of attending Doctor reveals that smoking is one of the reason for cancer, in the present case it could not be established that smoking alone has contributed for the ailment. Moreover, the TPA has on its own included the word "Tobacco" under intoxicating drug under clause 4.9 of the group mediclaim policy which is not correct. The definition for intoxication also did not mention about smoking. Hence, in order to render justice to both the parties to the dispute, the Insurance Ombudsman is inclined to award an ex-gratia amount of Rs. 25,000/- (Rupees Twenty Five Thousand only).

The complaint is allowed Ex-Gratia.

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THE INSURANCE OMBUDSMAN, CHENNAI

Complaint No.IO CHN- G-048-1415-0031
Mr. Joharilal Choudry
Vs
National Insurance Co. Ltd.,
AWARD No. IO (CHN) /G/A/016/2014-15
Dated 24/6/2014

The Complainant stated that he was having an individual medi-claim insurance for a Sum Insured of Rs.2 lakhs and the Cumulative bonus of Rs.1 lakh. He preferred a hospitalization claim for Coronary Artery Disease and submitted the bills for Rs.3,77,715/-. The claim was settled for Rs.2,04,950/- disallowing Rs.58,650/-.

The insurer had stated in their Self Contained Note that the settlement of the claim by their TPA was as per Clause 3.12 and the quantum of settlement was as per GIPSA's PPN Package entered with the hospital.

On perusal of the complainant's claim, and the TPA's statement during the hearing that they have not written to the hospital concerned to refund the excess amount charged by them since they had an understanding with them as per GIPSA's PPN package for cashless or reimbursement claims, the insurer/TPA were advised to rework the

amount, who have stated that Rs.58,650/- is payable towards the difference. The insurer is therefore directed to pay the said amount to the insured, in addition to the claim amount already settled.

THE INSURANCE OMBUDSMAN, CHENNAI

Complaint No. CHN-G-044-1415-0014

B Narasimhan Vs. Star Health & allied Ins.Co.Ltd.

Award No. IO (CHN)/G/A/044/17/2014-15, dated 24-06-2014

The complainant stated that he was covered under the mediclaim scheme of the insurer from 30/03/2012 onwards and the current policy was for the period from 30/03/2013 to 29/03/2014. He was admitted in the hospital for Ca Rectum – Post anterior Resection and Diverting Ileostomy. His claim for the hospitalization was repudiated by the insurer on the ground that the past history of carcinoma since the year 2011, as evidenced by the medical records, was not disclosed at the time of availing the first policy in the year 2012.

The insurer in their SCN has stated that the claim was rejected as the insured was a known case of Ca-Rectum since 2011. The Discharge Summary revealed that the patient was a known case of Ca-Rectum from 2011. The past surgery namely "Ileostomy operation-2011" was declared by the proposer in the proposal form, Whereas for the specific question as to whether the proposer was suffering from "Cancer" was answered "No". The claim was repudiated invoking condition No. 7 and the policy was not renewed from its next due date.

It was observed from the proposal form, the insured had very clearly stated that he underwent Ileostomy operation in 2011 and the same is printed in the policy schedule. But the insurer did not seek any further clarification from the insured with regard to the Ileostomy surgery done in 2011. Moreover, this was the 2nd year of the policy and as per the schedule of the policy the pre-existing disease is covered from 2nd year onwards. Hence the plea of non disclosure of material facts is not tenable. As per Exclusions condition No. 5, "50% of each and every claim arising out of all pre-existing diseases as defined and 30% in

case of all other claims are to be borne by the insured". Hgence the insurer had processed claim and considered to pay 50% of the admissible claim amount i.e.Rs. 5,780/-.

Thus the complaint is Allowed.

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THE INSURANCE OMBUDSMAN, CHENNAI

Complaint No. CHN-G-049-1415-0014

M.V.T. MohanRam Vs M.V.T. MohanRam

Award No. IO (CHN)/G/A/049/0025/2014-15, dated 26.06.2014

The complainant stated that his claim for reimbursement of the expenses incurred towards hospitalization of his daughter for Schizophrenia was rejected by the insurer stating that the treatments relating to psychiatric disorders are excluded under the policy. The complainant contends that there is a difference between "Mentally ill" and "Mentally Retarded" and his daughter suffers from Mental illness only, which cannot be construed as Psychiatric disorder.

The insurer in their SCN has stated that the claim was repudiated since the treatment for Schizophrenia is a psychiatric disorder which is excluded under the specific exclusion clause No. 9.6, excludes "expenses incurred in respect of treatment relating to psychiatric and psychomatic disorders".

It is observed that the patient was treated with Antipsychotic drugs, individual psychotherapy and family couselling. As per the opinion of the TPA M/s. Medi Assist, Schizophrenia is a mental disorder characterized by a breakdown of the thought process and a deficit of typical emotional responses. They have produced the literature from 'Google search' dated 06/06/2014 to prove their stand that Schizophrenia is a psychotic disorder. The complainant has made a reference to an earlier claim paid for the same disease, however

neither any policy copy nor any policy condition has been provided. The policy exclusion No. 9.6 reads as "*Convalescence* ……. treatment relating to all psychiatric and psychosomatic disorders…… Under these circumstances, it is proved that the ailment for which the insured person was treated falls under exclusion and therefore, the insurer had rightly rejected the claim.

Hence the complaint is Dismissed.

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THE INSURANCE OMBUDSMAN, CHENNAI

Complaint No.IO CHN-G-020-1415-0045
Mr. K. Kasthuri,
Vs
ICICI Lombard General Insurance Co. Ltd.,
AWARD No. IO (CHN) /G/A/032/2014-15
Dated 27/6/2014

The complainant stated that he insured his son and daughter with the insurer since 7/5/2012. He made a request for a cashless settlement of his daughter's claim for hospitalization on 23/1/2014 and submitted all the requisite papers. On 24/1/2014 he received a mail informing that the claim is rejected as it was a pre-existing condition which his daughter had in 2004. He wrote several letters to the insurer informing them that his daughter had Idiopathic Aplastic Anemia in 2004 and the ailment itself comes to one in 10 lakhs of the population for no rhyme or reason and hence called idiopathic. The blood counts started falling all of a sudden in May 2013 as per the Hematologist whom he is consulting since 2005. Therefore the insurer contention that it a pre-existing ailment and hence the rejection was not accepted by him. He represented to the Grievance cell, who has not replied. Since no reply received from the insurer, he approached the forum.

The insurer in their letter dated 6/6/2014 has stated that the hospital has mentioned on authorization letter that "Aplastic Anemia" relapsed after 9 years. They requested the hospital authorities to furnish all the previous consultation papers with regard to the present illness

along with the history of present complaints including the onset, progress and duration of the illness with complete details of treatment. The concerned hospital had sent the treating papers of the insured which dated back to 2004. As per the said treating papers, the complainant's daughter was a known case for the same disease Aplastic Anemia which was diagnosed in 2004 and the cashless request made on 23rd January 2014 was made for the same disease. They denied the claim on the ground of non-disclosure of material facts as the insured failed to submit the previous consultation papers with regard to present illness and a request was made to the complainant to approach the company for the claim through reimbursement facility.

The insured had informed the insurer earlier that no treatment records are available as no further treatment was taken in between the previous treatment and present treatment. Therefore, the company reviewed the claim and decided to settle the claim giving the benefit of doubt to the complainant. They had sent a letter to the complainant for submission of required documents.

During the hearing the complainant presented his version. The Insurer had not turned up for the hearing. However a letter dated 6.6.2014 had been received by the forum that the claim was being reviewed and some documents were called for from the insured.

The insurer has sent to the forum an email dated 19th June 2014 stating they called for the documents from the complainant and the same are also received by them. They stated that the claim was under process and would be settled within 15 working days. Further the forum has been informed by the insurer vide their mail dated 27/6/2014 that they are settling the claim and the amount of settlement will be informed for our records shortly.

Since the claim has been re-examined by the insurer and the Forum has been informed that the claim would be settled shortly the complaint stands closed. The insurer is advised to furnish the details of settlement of the claim at the earliest.

The complaint is allowed.

THE INSURANCE OMBUDSMAN, CHENNAI
Complaint No.CHN-G-023-1314- 0238 & 239
Mr. V.Harikrishnan,
Vs
Iffco-Tokio General Insurance Co.Ltd,
Dated 23/7/2014

e Complainant stated that the two claims preferred with the insurer for his
spitalization on two occasions for treatment of Coronary Artery Disease (CAD)
s settled by them for Rs.60,645/- and Rs.1,21,681/- respectively, by cashless
ethod but the deductions made were not justified as per the policy conditions.

Insurer submitted their Self contained note (SCN) wherein they stated that
n the claims were settled under cashless facility. The hospital had raised two
erent invoices at the time of cashless and while processing. Moreover, the
ounts payable under item (2) and (3) stated under "what is covered" shall be at
rate applicable to the entitled Room Rent category which are "<u>proportionately</u>
<u>uced</u>" since the actual Room Rent was more than the entitled limit. The second
pitalization involves package rates applicable for deluxe room and hence the
m was restricted to 80% of the sum insured or Actual whichever is less, <u>with</u>
<u>portionate deductions on applicable charges based on the entitled room rent</u>
<u>egory</u>, along with the deduction of appropriate reinstatement premium.

perusal of the documents submitted the following points are noted:-

aim: (Hospitalisation from 31/03/2013 to 5/04/2013)

er Hospital Bill dt.5th April, 2013, the Bed No. is mentioned as 3304 (Delux) and Room Rent charged was Rs. 36,400/-for 4 days. The insurer has not furnished details of the actual room rent charged by the Hospital. Only the total Room t charged has been mentioned in the Hospital Bill which is Rs.36,400/-. wever, the complainant has furnished the said break-up details as : CCU charges s.10,200/per day for 2 days and Single room charges @ Rs.8000/-per day for 2 s. As far as CCU charge is concerned the insured is eligible for 2.5% of the sum ured (Rs.400000/-*2.5%)=Rs.10,000/- per day. For single room for 2 days as his eligibility @1% of the sum insured, the same comes to Rs.4000/-X 2 = 8000/-.So, the total room rent allowable under the claim works out to 28,000/-.Where as the insurer has allowed a sum of Rs.16,000/- only. refore, the excess deduction of Rs.12,000/- is payable to the insured.

n though the policy condition allows "proportionate deductions" in respect of pital charges, in case of actual room rent being more than the entitled room t, the insurer has not indicated anywhere the actual proportion applied by them educting the charges. Further the "Proportion" applied by the insurer <u>is not rect</u> in view of the wrong calculation of "actual room rent" as stated in (1) ve. Therefore the correct percentage of 76.92% (ie., 28000/36400 * 100) uld be applied for calculating the eligible charges for various expenses covered er the policy, namely Dr's consultation(Rs.11,200/-), estigation(Rs.24,345/-) Non-invasive Procedure (Rs.1870/-), Nursing&

pital Utilities (Rs.(Rs.1000/-) and Profile(Rs.7280/), Total = Rs.45,695/-. The uction of 23.08% should be effected on these charges as per the hospital bill. ordingly, out of the total amount of Rs.45,695/- as detailed above, a sum of 10,546/-only should have been deducted, and therefore, the excess deduction is ndable to the insured.

wards the Surgical Package (Rs.18,200/-) and Professional charges (Rs.6000/- otal Rs.24200/- as applicable for "Private room", the insurer has applied 20% uction for Package charges under the "surgical Package" and proportionate uction for the Professional charges as applicable to the room rent, which is not rder. When the hospital has provided the Package rates for Angiogram as licable for "Standard Bed" as Rs.16,950/-, the sum of Rs.7250/- may be ucted from Rs.24,200/- (restricting the total amount under these two heads to 16,950/-).So, the insurer has to revise the computation accordingly and refund excess deduction .

rd Pharmacy charges of Rs.11344/79 :- The insurer has not commented ything about this deduction in their Self contained Note. Therefore, the insurer advised to peruse the pharmacy bills and allow the admissible items deducting n-medical items if any, and pay the same after deducting 23.08%, as stated in e policy condition "What is covered" in item No.3 which includes Medicines, ugs, surgical appliances, diagnostic materials etc.

dical Administration charges of Rs.1000/- :- It may be re-examined by the surer ascertaining as to whether it is similar to Registration, service charges c. as provided in 1(c)of "what is covered".

erefore, the insurer is advised to revise their claim computation as above and y the difference in the claim amount to the insured after adjusting the cashless nefit and deducting appropriate premium for reinstatement as may be plicable.

<u>Claim:-</u>

ect of the second claim relating to the Hospitalisation from 8/4/2013 to /04/2013 for Redo CABG surgery, the following points are noted:

e insurer has not indicated the percentage of "Proportion" applied for deduction the hospital charges in respect of items (2) and (3) of "what is covered"

ace the Hospital has provided the details of Tariff for Cardiac Surgical Procedure opy of which has been submitted to the forum by the complainant) which shows at for General Room the Package rate for CABG is Rs.188000/- and for Single oom the same is Rs.228000/-. The insured was charged for Single Room ckage of Rs.228000/- (as per Bill this comprises of Rs.185900/- towards rgical Package and Rs.42100/- towards Professional charges.).So, it is clear at the billing has been done on the basis of a "Single Room" category only.

e insured is eligible for a room category of Rs.4000/- per day, for his sum sured of Rs.400000/-. The corresponding rent for Single Room was Rs.8000/-

r day (as declared by the insured),.So, the package rate applicable to General om ie., Rs.1,88,000/- may be considered for settlement of his claim, as stated the insured, since applying "proportionate deduction" to the package rate (as ne by the insurer) is not mentioned in the policy condition. Refer Note 1: under hat is covered"- which states "The Hospitalisation expenses incurred for atment of any one illness under prescribed Package Charges of the Hospital/ rsing Home will be restricted to 80% of the sum insured or actual, whichever is s." Here the "actual" is limited to the package rates applicable to "General om". Therefore the balance amount under this head may be worked out and be id to the insured after adjusting the cashless benefit extended to him already.

ical Administration charges may be re-examined by the insurer as to whether it mes within the scope of the condition No. 1(c) of "what is covered", and pay e same if it is payable.

e claim computation of the insured requires revision as above and appropriate emium towards reinstatement of sum insured may be deducted as deemed cessary.

complaint is allowed.

THE INSURANCE OMBUDSMAN, CHENNAI

Complaint No.IO CHN-G-052-1415-0079

Mr. M. Joseph Fithaly,
Vs
Universal Sompo General Insurance Co. Ltd.,
AWARD No. IO (CHN) /G/A/045/2014-15
Dated 25/7/2014

The complainant's claim for the treatment of Coronary Artery Disease (CAD) was rejected by the insurer stating that the ailment was pre-existing since the insured had undergone PTCA on 4.9.2008, whereas the policy starts from 16/10/2008 and that the said surgery was not disclosed at the inception of the policy on 16/10/2008.

The insurer in the Self Contained Note had stated that the claim was rejected as per General Condition No.2 of the policy stating that the ailment CAD was pre-existing based on the Medical Records, which show that the insured had undergone PTCA in September 2008. Since the policy was treated as a fresh one from 16/10/2008, after a break of 4 months, and the past health condition of CAD in September 2008 was not disclosed in the proposal form, which amounts to "Non-disclosure". Therefore the rejection of claim by their TPA is in order.
During the hearing the complainant has stated that in 2007 he had taken the first medi-claim policy through the Indian Overseas Bank who had tie-up arrangement with United India Insurance Co. Ltd., and he had declared everything to the bank. In 2008, he forgot to renew the policy in time and renewed it after 4 months i.e. 16.10.2008 to 15.10.2009. He had informed about the PTCA undergone by him at Jaslok Hospital in 2008. The entire amount of 3.7 lakh towards the procedure was paid by his employer. In 2009, suddenly he got the TPA ID Card from Universal Sompo and then came to know that the insurer has been changed. The bank had never informed him about the change of insurer nor did they ask for fresh proposal. He did not receive any policy or certificate of insurance for the year 2009-10 but the premium was debited from his bank account.

The insurer's representative was asked about non submission of their Self Contained Note(SCN) till 15/7/2014 and was advised to submit it in time in future. He was also asked to read the repudiation letter dated 10.1.2014 wherein the repudiation has been done under General Condition No.2 of the Policy. When asked to confirm whether the original policy for the year 2009-10 along with the copy of the proposal form was sent to the insured, the insurer had shown his inability to confirm. This is a violation of the protection of Policy holders' interest regulations 2002. The insurer has enclosed Annexure 4 with the (SCN) which is a proposal form without any date. Moreover, the proposer is said to be Mr. Joseph Fithaly, but the proposal was signed by Mrs. Infance Fithaly. Under the "column D" i.e. mediclaim history Col.No.1 to 5 are left blank. The insurer called for answers for the same and accepted the risk as such.

In view of the above, the insurer is directed to settle the claim of Rs. 2,64,546/- complainant as per their computation and ensure in future that the copy of the proposal along with the Policy is sent to insured.

The complaint is allowed.

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THE INSURANCE OMBUDSMAN, CHENNAI

Complaint No.IO CHN- G-031-1415-0087
Mr. Ankush Bedre
vs
Max Bupa Health Insurance Co. Ltd.,
AWARD No. IO (CHN) /G/A/047/2014-15
Dated 30/7/2014

The complainant stated that his wife Mrs. Mona Ankush Bedre underwent a procedure for treating Fibroid at M/s. Bharat Scans, on 24th January 2014. He submitted the claim for Rs.1,39,000/- to the insurer. But the insurer denied settlement stating that the symptoms as mentioned in the "Treatment

procedure" by M/s. Bharat Scans was pre-existing for 3 years.

As per the Self Contained Note (SCN) submitted by the insurer it is stated that Mrs. Mona Ankush Bedre was diagnosed with fibroid uterus. Fibroids are non-cancerous benign growths that develop in the muscular wall of uterus. She underwent treatment for the cure of fibroid uterus.

It is averred that one of the medical documents of Bharat Scans disclose that Mrs. Mona Ankush Bedre had complaints of heavy bleeding and back ache for last 3 years which makes the existence of ailments at least 6 months prior to inception of Policy. The insured is obliged to make full and frank disclosures of any and all pre-existing ailments complaints suffered in the proposal form. Non-disclosure by the insured has led to violation of clause I of terms and conditions and Clause 11 of proposal form. Therefore they rejected the claim.

During the day of hearing the complainant's wife Mrs. Mona Bedre came, but left without attending the hearing. However, the complainant's representation dated 18/7/2014 was read out.

The insurer's representative stated that the claim was repudiated on the basis of the documents submitted by the insured person. From the documents it is evident that she was admitted for management of fibroid uterus with duration of presenting complaints of heavy bleeding and back ache since 3 years and underwent procedure for MRI guided focused ultrasound treatment for fibroid. When asked for proof for the same she stated that it is mentioned in the treatment procedure given by the Bharat Scans reading as "Heavy bleeding, back ache-3 years, and frequent urination -6 months". She was also asked whether the complainant had represented to the Grievance Cell or not and any reply was given to the same. She has shown her ignorance about it.

1. **During the hearing the insurer has stated that the claim was repudiated since "Bharat Scans" has mentioned in their discharge summary against chief complaints as "Heavy bleeding, back ache – 3 years, frequent urination – 6 months." When the insurer's representative was asked to**

explain whether any clarification/explanation was sought from Bharat scans, she informed that no explanation was called for and they had made only internal enquiries, which revealed that "Bharat Scans" do not maintain the old records of the patients and hence the required clarification was not given.

Further on perusal of the documents the following points are noted.

a) **The insured was admitted at "Bharat Scans" on 24/1/2014 and discharged on 25/1/2014. She was diagnosed with Fibroid uterus and treatment was given by MRI guided focused ultrasound procedure, as a "Day care procedure" with less than 24 hours of hospitalization, as per the discharge summary signed by a Radiologist.**

b) **The claim preferred with the insurer for reimbursement of the treatment charges was repudiated vide letter dated 4.2.2014. The disallowance reason narrated in the said letter is in-complete. The letter only states that the duration of present complaint of heavy bleeding and backache was 3 years. <u>The actual reason for rejection of the claim is not mentioned and no relevant policy condition to that effect is quoted in the repudiation letter</u>.**

c) **The decision to repudiate the claim seems to have been taken by the insurer without ascertaining the facts about the exact duration of the symptoms of the ailment even after the insured made a representation to the insurer for reconsideration of their decision on the plea that the duration of the symptoms was wrongly mentioned by Bharat Scans in their report.**

   The insurer's representative informed the forum during the hearing that an investigator was in fact nominated by them to collect the details of duration of the symptoms of the ailment as per the records of "Bharat Scans"; but he could not get the same from Bharat Scans since they told him that such records were not maintained by them. It is strange that such a reputed centre "Bharat Scans" do not maintain such important records of their patients<u>. However, the insurer had not mentioned anything in their Self Contained note about this information.</u>

d) **In the email dated 24/2/2014 sent by the Customer Care addressed to the insured the insurer has simply stated that they stood by their decision to decline the claim, without referring to the actual reasons**

for rejection of the claim. The insurer is advised to follow the correct procedure while issuing repudiation letters and while narrating their decision.

e) However, the insured was informed of the actual reason for the rejection of the claim as evidenced by his communications to the insurer.

f) The insurer has considered only the aspect of Pre-existing disease (PED) for repudiating the claim. The PED aspect has not been clearly established by the insurer by way of any medical evidence.

2. **On the basis of the Discharge Summary it is noticed that the treatment namely the "MRI guided Focussed Ultrasound" was given in "Bharat Scans" as a 'Day care procedure'. As per Policy condition No.2.5 "Day care procedures" are covered where such procedures are done on an in-patient in a "Hospital" for a period of less than 24 hours. Obviously 'Bharat Scans' is only a diagnostic centre and not a hospital as per their definition provided under the Terms and Condition of the Policy Definition NO.12.**

3. **In accordance with the definition No.12 the hospital should comply with all the minimum criteria as stated in items (a) to (e) which includes "maintenance of daily records of patients and will make these accessible to the insurance companies authorized personnel". In the instant case, the treatments was neither taken in a "Hospital" nor were the relevant records accessible to the insurance company on demand as informed by the insurer's representative during the hearing.**

4. **As per claims procedure mentioned in the Terms and Conditions of the Policy under clause 5(I)(b) (1) – "In all hospitalization which have not been pre-authorised, the insurer must be notified within 48 hours of admission to the hospital or discharge from the hospital whichever is earlier. But as reported by the insurer in their SCN, it is noted that the insured filed his claim for reimbursement on 30/1/2014 only. So, this condition was also overlooked by the insurer or the delay is deemed to have been condoned by the insurer.**

5. **The complainant has produced only a certificate issued by 'Bharat Scans' clarifying the "duration" of the past history/symptoms, without any supporting medical records/evidences to substantiate his stand that the duration of the symptoms was only 6 months and not 3 years.**

6. **The insurer has alleged non-disclosure of pre-existing health problems in the proposal form. The clause I of Terms and Conditions and clause 11 of proposal form which cast an obligation on the part of the proposer to disclose all material information are referred to by the insurer in their SCN addressed to the forum. But the said conditions are not invoked by the insurer in their repudiation letter to the insured.**

7. **Therefore, on the basis of the foregoing points, it is clear that the claims deserves repudiation on invoking the 'Pre-existing disease' clause of the Policy but in view of the reasons that the insurer has not substantiated the relevant facts with full medical evidence to that effect and also that the claim processing was not done taking into account all aspects as discussed above, in order to render justice to both the parties to the dispute, the Insurance Ombudsman is inclined to grant an Ex-gratia of Rs. 30,000/- (Rupees Thirty Thousand only) invoking the provisions under Rule 18 of the Redressal of Public Grievance Rule 1998. The insurer is directed to pay the said amount of Ex-gratia to the insured.**

The complaint is allowed on Ex-gratia basis.

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THE INSURANCE OMBUDSMAN, CHENNAI

Complaint No.IO CHN-G-049-1415-0080

H Ramalingam Vs The New India Assurance Co. Ltd.

Award No. IO (CHN) /G/A/049/050/2014-15, dated 14.08.2014

The complainant is a policyholder of the insurer since 1997 covering his family members. He has stated that his wife Dr.

Rajalakshmi was hospitalized for treatment of Robotic TLH with Umbilical Hernia Repair. Out of his total claim amount of Rs. 3,65,399/-, he was settled Rs. 1,38,860/- and claimed the relief amount of Rs. 1,53,000/-.

The insurer in their Self Contained Note stated that on receipt of the representation from the insured, they have reconsidered the claim on Package basis for Rs. 1,16,150/- and in total Rs. 1,38,860/- has been settled including post hospitalization expenses. Since two procedures are involved in a single surgery 100% for the major surgery and 50% for the second surgery has been considered as per the PPN Agreement. Hence, the insurer contends that the claim settlement is in order.

It was observed that two procedures namely Robotic TLH with Umbilical Hernia Repair were done in a single surgical sitting. Though, as per the Agreement with the network hospital under the clause 5.2.2 for charging 100% of the package charges for the major procedure and 50 % for the 2nd procedure would be considered for settlement, such details are not forming part of the Policy terms and conditions. The insurer had settled an amount of Rs. 1,38,860/-. Applying proportionate clause, they have deducted Rs. 70,719/- from Rs. 1,57,500/- of robotic charges. The insurer instead of questioning the hospital authorities to consider robotic charges under PPN package, they have deducted a sum of Rs. 70,719/- from the robotic charges which is not justifiable. The complainant had also stayed in a room with higher tariff rate of Rs. 8,700/- against the eligible room rent amount as per policy is Rs. 2,000/-. Hence, in order to render justice to both the parties to the dispute, the Insurance Ombudsman is inclined to award an ex-gratia amount of Rs.75,000/-

The complaint is allowed as an Ex-gratia.

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THE INSURANCE OMBUDSMAN, CHENNAI

Complaint No.IO(CHN)-G-051-1415-0121

AWARD No. IO (CHN)/G/054 /2014-15(Mediclaim)

Mr.S.Arumugam vs United India Insurance co.Ltd

The Complainant stated that the claim preferred by him towards the expenses incurred for his wife's hospitalization was settled by the insurer for Rs.14,557/- in proportion to room rent entitlement, disallowing Rs.14,018/-. He represented to the insurer for reconsidering the balance amount contending that the Hospital charges are irrespective of the room rent. However, the Grievance cell reiterated their decision to restrict the claim in proportion to the entitled room rent. Aggrieved by this, the complainant has approached this forum.

The Insurer submitted that the claim preferred by the insured was settled as per the Limits applicable to the entitled room rent and proportionate deductions were made based on the entitled room rent category as per policy conditions 1.2 C and D -Note thereunder.

It is observed that the policy condition cited here in above, namely Note (1) under Clause 1.2 is vague and is subject to different interpretations as it nowhere says that the charges shall be limited by applying the proportion as the eligible Room Rent bears to the actual room rent. Although the insurer is justified in paying the Room Rent upto 1% of the sum insured as per policy clause, deducting all other charges mentioned under 1.2.C and D of the policy proportionately is not justified when a Room with a higher rent than the "entitled category" is occupied, since the policy condition nowhere allows such "proportionate deduction".

Therefore, taking into account the facts (1) the policy condition stipulates 'restriction on various charges' depending on the Room Rent though not on proportionate basis and (2) the insurer's contention that "various charges of the hospital 'vary in direct proportion to the room rent' is totally wrong", the Insurance Ombudsman is inclined to award an ex-gratia of Rs.3,500/- (Rupees three thousand five hundred only),

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THE INSURANCE OMBUDSMAN, CHENNAI

Complaint No. CHN-G-007-1415-0109

Karan Ashok Kumar Vs Bharthi Axa General Insurance Co. Ltd.

Award No. IO (CHN) /G/A/007/056/2014-15, dated 27.08.14

The complainant's wife was hospitalized and preferred claim for Rs. 66,171/-. The insurer had initially settled Rs. 23,975/- and on his protest an additional amount of Rs. 9,357 was settled. Thus the total claim amount settled was only Rs. 33,332/-. When he referred the matter to the insurer for settlement of balance amount, he was informed that the claim was settled on proportionate to the room rent which is 1% of the sum insured. Not satisfied with the reply, he had approached the Forum.

The insurer in their Self Contained Note stated that the insured had undergone treatment for severe Gastroenteritis, UTI & Gastroesophageal reflux disease and opted room category room rent for Rs. 3100/- per day. As per policy condition, room rent is restricted to 1% of SI for non ICU and 2 % for ICU subject to maximum of Rs. 5000/- for both. The amount payable towards surgeons, Anesthetists, medical practitioners, consultants and specialists, blood oxygen charges dialysis etc as per room rent category. As the complainant has opted for higher room rent category, the above condition was invoked and settled the claim for Rs. 33,332/- which is in order.

It was observed that the condition No. 10 of the policy simply says the heads of expenses mentioned therein will be as per the room rent category, but it does not specifically mention about proportionate to the room rent. The grievance cell of the insurer has also not made mention about the proportionate deductions. No enquiry was made from the hospital about the various applicable charges for a room rent of Rs 1,000/- and Rs.3,100/-. There are numerous communications and reminders from the complainant through email from 12/02/2014 to 27/05/2014 mailed to various officials of the insurer, but no proper reply was given by anybody. The TPA should have explained the liability of the insurer immediately on hospitalization making clear on the limit of other heads of expenses based on eligible category of room rent. . Hence, in order to render justice to both the parties to the dispute, the Insurance Ombudsman is inclined to award an ex-gratia amount of Rs. 9,000/-.

The complaint is allowed Ex-Gratia.

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THE INSURANCE OMBUDSMAN, CHENNAI
Complaint No.CHN-G-003-1415-0106
AWARD No. IO (CHN)/G/061/2014-15 (Mediclaim)
Mr.R.Vikram Kumar vs Apollo Munich Health Insurance co.Ltd.

The Complainant stated that he was covered under the insurer's mediclaim policy from 8/7/2010 continuously. He was admitted in Apollo Hospital for Acute Necrotizing Pancreatitis. His claim for reimbursement of the expenses was repudiated by the insurer on the ground that the pre-existing diseases of Hyper tension and Coronary Artery Disease suffered by him since 7 years were not declared in the proposal form at the inception of the policy from 8/7/2010.

The Insurer submitted that their decision to repudiate the claim of the complainant was based on the breach committed by the insured by not declaring in the proposal form the factual information relating to his adverse health conditions namely Hyper tension and CAD suffered by him prior to inception of the first policy.

The complainant contends that the alleged suppression of the past medical history was not deliberate since he pleads that the Agent was duly informed of the factual information of his past health conditions, who filled up the proposal form and it was simply signed by the proposer and he failed to verify the proposal form for its correctness.

The insurer has quoted the relevant provisions of the IRDA Protection of Policy Holders' interests Regulations, 2002 , referring to Sec.2 (d) on the definition of "Proposal form",and the insurer is justified in repudiating the claim invoking the condition No, VII (r) ii -on "Termination of the policy on the grounds of misrepresentation/non-disclosure of material facts by the insured".

However, as per IRDA's Regulation No.4 under Protection of Policy holders' Interests, Regulations , 2002, "It is the duty of an insurer to furnish to the insured free of charge , within 30 days of acceptance of the proposal, a copy of the Proposal form". This complaint could have been avoided had the insurer sent the copy of the proposal form to the insured,

immediately on acceptance of the proposal form, as envisaged in the IRDA Regulation No.4. Therefore, even though the decision of the insurer in repudiating the claim on the ground stated above is justified, in view of the lapse on the part of the insurer in not complying with the provisions of IRDA's Regulation No. 4 as stated above, the Insurance Ombudsman is inclined to grant an Ex-gratia of Rs.10,000/- (Rupees ten thousand only), The complaint is allowed as an ex-gratia.

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THE INSURANCE OMBUDSMAN, CHENNAI

Complaint No.CHN-G-020-1415-0108

Mr.G.Natarajan
Vs
ICICI Lombard General Insurance Co.Ltd

The Complainant stated that he was holding Medi-claim cover for himself and his wife for a sum insured of Rs.3,00,000/- each through "Family Protect Premier" policy of the insurer from 1.1.2008 onwards, continuously. When the policy was due for renewal from 1.1.2014, he approached the insurer for the renewal notice in December, 2013. He was advised by the insurer to remit a renewal premium of Rs.42,957/- as against the premium of Rs.19,248/- for the previous year (2013). When he asked the insurer for the reason for such an exorbitant increase in the premium charges, he was informed by the insurer that the "Family Protect Premier" policy was withdrawn and in its place, the new "Complete Health Insurance" with new and additional features has been introduced. The Floater sum insured of Rs.3,00,000/-has been offered under the new policy as against the individual sum insured of Rs.3,00,000/- under the previous year's policy. The complainant paid the premium under protest and availed the policy.

The Insurer submitted their Self contained note (SCN) wherein they stated that in accordance with the directives of Insurance Regulatory & Development Authority (IRDA) vide their Notification dt. 16/02/2013 under Ref: IRDA/REG/14/72/2013 issuing new Health Regulations, in order to standardize the health insurance products across the industry, all the existing health products which were not in line with the Health

Regulation, have been withdrawn from the market and are not available to the customers. Further all their existing customers have been offered the new product "Complete Health Insurance". Accordingly, a renewal notice was issued to the complainant who did not accept the revision in the premium rates. The sum insured of Rs.3,00,000/-each for the complainant and his wife has been considered and suitable rectification was made in the policy and the same has been communicated to the complainant.

The insurer has submitted to the forum a copy of the letter from IRDA under Ref: IRDA/NL-HLT/ICICI/P-H/V.I/24/2013-14 dt.1st May, 2013,, referring to Filing of the product "Individual Health Care" under F & U procedures and approving the withdrawal of the product subject to the following conditions:

1. **The withdrawn product shall not be offered to the <u>prospective</u> customers.**
2. **The insurer shall not compel the insured to migrate to other health insurance products/plan, if it is to the disadvantage of the insured.**
3. **The insurer shall send a notice to all the existing policy holders atleast 3 months prior to the date of withdrawal/ renewal.**
4. **The insurer shall follow all the circulars, guidelines & regulations issued by the Authority from time to time regarding withdrawal of the products.**

<u>The Insurer has not produced any evidence for having sent a Notice to the complainant atleast 3 months prior to the date of renewal of the policy. No Renewal Notice was sent by the insurer to the complainant and the premium hike was not informed in a proper manner.</u> Even after the insured expressed his unwillingness to accept the new product in view of certain disadvantages, the insurer had issued the new policy No.4128i/HPR/92130562/00/000 for the period from 1/1/2014 to 31/12/2014 by charging the premium of Rs.41,091/-, which is also on the higher side, compared to the premium collected for the period 1/1/2013- 31/12/2013. As per IRDA Health Regulations, 2013 , No. 5 (q) (i), under special provisions for Insured Persons who are senior citizens, "<u>The premium charged for health</u>

insurance products offered to senior citizens shall be fair, justified, transparent and duly disclosed upfront. The insured shall be informed in writing of any underwriting loading charged over and above the premium and the specific consent of the policy holder for such loadings shall be obtained before issuance of a policy."

Therefore it is clear that the insurer has violated the guidelines of IRDA with regard to "withdrawal of products" as follows:-

(i) Notice of withdrawal of the old product was not sent to the insured and no letter was issued by the insurer informing the changes in premium rates.

(ii) The insured should not be compelled to opt for other insurance products/plans if it is to the disadvantage of the insured, as per IRDA's guidelines. But in the instant case, though the insured expressed his option to continue the old policy since the new policy is to his disadvantage, the insurer has not considered his request and issued the new policy with effect from 1-1-2014.

Therefore, the insurer is directed to restore the complainant's and his wife's policies for the period 1.1.2014 to 31.12.2014 to maintain "status quo" ie., with the terms and conditions as applicable to the previous product which stands withdrawn. The insurer is also directed to relook at the premium charges that shall be applicable to the particular age group of the insured as per the policy for the year 2013 and the excess premium collected may be refunded to the complainant.

The complaint is allowed.

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THE INSURANCE OMBUDSMAN, CHENNAI

Complaint No.CHN-G-005/1415 /0137

Mr.Jitesh B.Lodha
Vs
M/s Bajaj Allianz General Insurance Co.Ltd

The Complainant stated that his claim for the hospitalization expenses incurred by him to the extent of Rs.4,06,825/-was settled by the insurer through cashless benefit, for Rs.2,25,000/- only. When claimed for the balance amount, he was informed that "due to existence of Hypertension (HT) for 5 years, his claim was limited to Rs.2,25,000/"-. He contended that HT was not in existence for 5 years and it was 'for 5 months' only. His second claim was also rejected on the same grounds since the maximum sum insured with cumulative bonus was exhausted for the same ailment.

The Insurer submitted their Self contained note (SCN) wherein they stated that as the insured had been suffering from HT for 5 years (as mentioned in the Discharge Summary) and since the Heart Disease for which the claim had been preferred in 2013-14 was the complication of HT, the sum insured prevailing at the time of contracting HT was taken into account. Hence, the current enhanced sum insured of Rs.3,00,000/- was not considered. The claim was settled as per the sum insured applicable for the policy period 2008-09 ie, Rs.1,50,000/- along with the cumulative bonus of Rs.75,000/-, as per policy conditions C-1 under Exclusions.

During the hearing, the complainant was asked to produce any supporting document which confirms that the HTN was detected 5

months back, but he had no such document. On being asked as to whether he had contested with the hospital about the alleged wrong recording in the history, he brought to the notice of the Forum his letter dt.24/03/2014 addressed to the Apollo Hospitals, and the reply letter dt.17/04/2014 received from the Hospital wherein it is stated that "regarding amendment in discharge summary, we regret to inform you that based on the documentation in medical record file of Mr.Jitesh B.Lodha (UHID-ACO1.0002678647) the provided information in discharge summary is correct." He has also produced a copy of his Registered letter dt. 25.6.2014 addressed to Asst. Director, Medical Services, Apollo Hospitals, Chennai-6, referring to the letter dt.17/04/2014 from the Hospital.

The complainant has not produced any authentic record to prove that the duration of HT was only 5 months and not 5 years as recorded in the Discharge Summary. Therefore, the insurer's relying on the information provided in the Discharge Summary, for processing the claim, cannot be faulted.

Hence, the decision of the insurer in restricting the claim to the pre-enhanced sum insured along with applicable cumulative bonus is in order.

The decision of the insurer in settling the claim as per the policy conditions stated above, does not warrant any intervention at the hands of the Insurance Ombudsman.

The complaint is dismissed.

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THE INSURANCE OMBUDSMAN, CHENNAI

Complaint No.CHN-G-044-1415-0172
Mr. M. Sunil Kumar
Vs
Star Health and Allied Insurance Co. Ltd
AWARD No. IO (CHN) /G/A/ 077/2014-15
Dated 16/9/2014

The complainant Mr. M. Sunil Kumar has stated that he insured his parents in the Policy from 2008 onwards. At the time of inception of the Policy, his mother had no pre-existing disease and the company also inspected and then only covered them. On 22/7/2013 his mother was hospitalized with severe bleeding in Apollo Hospital. He informed the insurer about the sudden hospitalization, and on the very next day they denied the claim stating the reason as RHD.

The insurer in their SCN dated 25.8.2014 stated that the claim has been reported in the sixth year of the Policy. The final diagnosis were (a) Systemic Hypertension (b) Rheumatic Heart Disease – S/P MVR (c) Adequate LV Function (d) Endometrial Polyp with bleed and the procedure done was Hysteroscopic Polpectomy. The insurer states that the insured has not disclosed any of the above, past medical history while proposing insurance with them. The Policy was also cancelled and they refunded the premium of Rs.3214/- on 24.9.2013.

During the hearing the complainant Mr. Sunil Kumar stated that he does not want to add anything to whatever representation he has given. As per his complaint, the insurer has declined the claim of his mother on account of the preexisting disease. He said that at the start of the Policy in 2008 there was no Pre-existing disease and the insurer also inspected and then approved the Policy. On 22.07.2013 his mother was admitted in Apollo hospital and he informed the insurer for cashless settlement but his claim was rejected on 23.7.2013 on account of existence of rheumatic heart disease. He further said that his policy is in the 6th continuous year and as per his understanding the Pre-existing diseases are covered after 5 years.

He was asked to confirm as to who has signed the proposal form and has confirmed that the proposal form was signed by his father and there is no mention of any preexisting disease. He was also asked whether he read and understood condition no.7 of the policy and was asked to read it during the hearing. He requested the forum to consider the claim.

The insurer's representative was asked to read the repudiation letter dated 13.09.2013, where they referred to the previous history of RHD and PTMC as stated in the discharge summary of Apollo hospital for admission from 10.7.2008 to 22.7.2008 wherein the previous history of PTMC in 1995, dyspnea on exertion symptoms since 2 years, cholecystectomy in 2004 and advised MVR surgery at that time.

The insurer told they rejected the claim because of non-disclosure of material fact and the Policy was cancelled after serving due notice for cancellation on account of misrepresentation and non-disclosure of material fact. Therefore, the claim has been rejected under Condition No.7 of the issued Policy which reads as follows: "The Company shall not be liable to make any payment under the policy in respect of any claim if such claim is in any manner or supported by any means or device, misrepresentation whether by the insured person or by any other person acting on his behalf".

Therefore, the decision of the insurer invoking the relevant clause of the Policy as stated above in repudiating the claim of the complainant is justified, and the Insurance Ombudsman is not inclined to interfere with the said decision of the insurer.

The complaint is dismissed.

THE INSURANCE OMBUDSMAN, CHENNAI

Complaint No. CHN-G-051-1415-0183
Mrs. P.C. Sreelakshmi
Vs
The United India Insurance Co.Ltd
AWARD No. IO (CHN) /G/A/051/081/2014-15
Dated 25/9/2014

The complainant stated that she underwent cataract operation on 27/4/2013 and submitted the claim for Rs.35,347/-. The insurer's TPA has initially settled Rs.24,000/- and after asking for the short settlement they paid a further amount of Rs.4,000/- totally she received Rs.28,000/- against her claim of Rs.35,347/- . She stated that as per the policy clause 1.2.1 she is eligible for (a) actual expenses incurred or 25% of the sum insured whichever is less.

The insurer in their Self Contained Note has stated that the insured preferred a claim for Rs.35,153/- and their TPA has rightly settled the claim for Rs.28,000/-. They settled the claim as per their Policy Clause 3.11 which states reasonable and necessary expenses.

During the hearing, the complainant's husband has stated that his wife Mrs. P.C. Sreelakshmi had a cataract operation in 2012 wherein an amount of Rs.28,000/- was settled by the TPA/Insurer. Again in May 2013 she underwent another surgery for the second eye wherein an amount of Rs.35,347/- was spent. However, the Insurer/TPA settled only Rs.24,000/- and when he represented to the insurer stating that the previous claim of Rs.28,000/- was settled, then the insurer released a further amount of Rs.4,000/- with the remark "No further claim is payable.

The Insurer's representative was asked to explain as to why initially Rs.24,000/- was settled when an amount of Rs.28,000/- was settled in the earlier claim to the complainant when the previous record was available with the TPA. In the settlement letter nowhere it speaks about any name of the nearby hospital having similar facilities charging Rs.28,000/-. The onus was on the insurer/TPA to

substantiate the amount of Rs.28,000/- which they have failed. Even the attitude of the TPA to settle in piecemeal is not appreciated.

The complainant's present submission of claim is reimbursement one only and it is reasonable.

The complaint is ALLOWED.

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THE INSURANCE OMBUDSMAN, CHENNAI

Complaint No. CHN-G-038-1415-0184

Mrs. P. Mareeswari
Vs
Royal Sundaram Alliance Insurance Co.Ltd

The Complainant stated that her husband Mr. Ponpandian was insured under the mediclaim policy with the insurer from 22/04/2009. He was hospitalized at Mercury hospital, Chennai from 16/02/2013 to 01/03/2013 with past history of DM/SHT/CAD – old AWMI and again admitted from 01/03/2013 to 20/03/2013 in Vijaya Hospital. The claim preferred with the insurer was repudiated on the ground that the insured was a known diabetic since 10 years, HT since 5 years and Coronary Artery disease since 7 years, which were existing prior to inception of the Policy. She represented to the insurer contending that her husband was suffering from DM and HT for the last 2 years only and requested the insurer to reconsider the claim. However, the insurer reiterated their decision to repudiate the claim.

The Insurer in their Self Contained Note has stated that the insured was covered by their Health Shield Standard Insurance commencing from 22/4/2012 to 21/4/2013. The claim was preferred for the hospitalizations in Mercury Hospital from 16/2/2013 to 1/3/2013 and thereafter in Vijaya Hospital for the period from 1/3/2013 to 20/3/2013 for "stroke". The internal case records from these hospitals revealed the history of the ailments suffered by the insured as "DM since 10 years and on medication with CAD since 7 years". Hence it is proved that the insured was suffering from these Pre-existing Diseases

(PED) much prior to the inception of the Policy. The Policy is in force for the last 38 months and as per Policy exclusion condition No.1, the PEDs are covered only after a waiting period of 48 months of continuous coverage. Hence the repudiation of the claim is in order.

During the hearing, the complainant has stated that her husband was having diabetes and HTN for the past 2 years only. The Policy has been continuously in force from 22/04/2009 onwards. She was asked by the forum as to who had given the history of the patient to the doctor. She confirmed that she had given the past medical history of the patient to the Doctor. As per the Discharge Summary of Mercury Hospital dated 1.3.2013, under the heading past history, it is stated as Diabetes Mellitus/SHT/CAD/old AWMI. But `the duration of these ailments are not mentioned in it. She told the forum that she had spent more than 7 lakhs and the Policy sum insured is Rs.1 lakh only. She requested the forum to direct the insurer to settle the claim.

The request for cashless authorization was sent by Apollo Hospital to the TPA of the insurer, wherein the history of DM/HT/CAD is given, but it does not bear the signature of either the insured or his representatives. Moreover, when the Hospitalisation was on 12th February, 2013, the cashless denial letter is dt.23/04/2013 which is not addressed to any one and does not bear the hospitalization details. The insurer's representative could not clarify for these discrepancies.

The insurer stated that no proposal form was collected by them at the inception of the policy since it was a tele-marketing sourcing of policy. As per IRDA's Protection of Policy Holders' Interests, Regulations, 2002, under Regulation No.4(4),it is stated that "where a proposal form is not used, the insurer shall record the information obtained orally or in writing and confirm it within a period of 15 days thereof with the proposer and incorporate the information in its cover note or policy. The onus of proof shall rest with the insurer in respect of any information not so recorded." Non-compliance of this provision by the insurer is a clear violation of the IRDA's guidelines.

Although the DM/SHT/CAD and old AWMI are stated in the Discharge Summary of Mercury Hospital and Vijaya Hospital, yet no

durations of these ailments are specified and also the complainant has very specifically stated that the duration of these ailments is only for 2 years.

However, it is noted that even though the complainant had represented to the insurer and to the forum to reconsider the claim on the plea that the duration of the above said ailments was only 2 years, no documentary evidence has been produced to substantiate her contention. The certificate dt.23/05/2012 issued by Rosemary Mission Hospitals mentions "Known Diabetic and Hypertensive" without any duration and diagnosed to have "Acute coronary syndrome and Acute Wall Myocardial Infarction". The complainant had not produced any record in proof of the actual date of diagnosis of the medical disorders suffered by the insured, namely DM and HT which are the risk factors for Heart Disease and Stroke. Therefore, in the absence of any medical record to substantiate the contention of the complainant, the insurer's decision to repudiate the claim invoking the policy exclusion clause on pre-existing disease cannot be fully unjustified.

Considering the lapses on the part of the insurer as discussed above and also the non-submission of documents by the complainant evidencing her contention that actual diagnosis of the ailments was made only two years back and not as contended by the insurer, in order to render justice to both parties to the dispute, the Insurance Ombudsman is inclined to grant an Ex-gratia of Rs.30,000/-(Rupees thirty thousand only), invoking the provisions of Rule No.18 of the Redressal of Public Grievances, Rules,1998.

The Complaint is ALLOWED as an Ex-gratia

OFFICE OF DELHI OMBUDSMAN
Case No.GI/Star/59/12
In the matter of Sh. Surinder Mohan Dawar
Vs
Star Health & Allied Insurance Company Ltd.

Award dated 13.08.14 relating to Non-settlement of mediclaim

1. **This is a complaint filed by Sh. Surinder Mohan Dawar (herein after referred to as the complainant) against the decision of Star Health & Allied Insurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to non settlement of mediclaim.**

2. **The complainant stated that his daughter underwent Squint Operation of both her eyes on 31.01.2012. He had given advance intimation to the insurance company regarding the operation of his daughter which was duly acknowledged by the company. He submitted all the necessary papers duly verified by the surgeon on 08.02.2012. The company vide letter dated 22.02.2012 repudiated the claim bearing no. CLI/2012/161100/01/28488 refereeing exclusion no. 8 of the policy on the ground that the squint operation is of cosmetic nature. On 09.03.2012 he submitted detailed reasons to Star Health & Allied General Insurance Company as to why squint is not a cosmetic surgery and substantiated his claim by attaching medical literature. On 03.04.2012, the insurance company again rejected his claim. He has come before the Hon'ble Ombudsman for settlement of his claim.**

3. **The insurance company, repudiated the claim as per exclusion no. 8 of the above policy, the company is not liable to make any payment under the policy in respect of expense incurred at hospital for cosmetic or aesthetic treatment of any description. During the personal hearing, also the company reiterated its written submissions. The company also stated that the patient was wearing glasses for the last 10 years.**

4. **I have heard both, the Insurance Company as well as the complainant. It is a fact that Reema Dawar daughter of the claimant had undergone a surgical procedure for treating squint eye on 31.01.2012. She was also discharged on the same day as day care procedure. The insurance company also stated that not only was the operation a cosmetic procedure but also since, it was a day care procedure therefore, on both the grounds the claim was not admissible.**

5. **I have considered the submissions of the complainant as well as of the representative of the company. The company has repudiated the claim as falling under the purview of clause no. 8 of the medical policy. Clause no. 8 of policy reads as "Cost of spectacles and contact lens, hearing aids, walkers, crutches, wheel chairs artificial limbs and such other aids". Therefore, the ground of rejection by the company on basis of clause no. 8 is not tenable. I have gone through the medical literature submitted by the complainant copy of which was also given to the insurance company. I quote from the "London Squint Clinic it is important to stake that squint surgery is not just cosmetic surgery. Squint surgery aims to improve working of the eyes and to reduce the negative health impact". A Squint surgery involves finding the muscle that move the eye, and attaching one or more of them to a new position on the eyeball. Because of the complex arrangement of the eye muscles, this new position turns the eye into a new direction which is what was done in the case of the claimant's daughter. It is not denied that a squint operation is a medical procedure. The patient was operated for dextrovision under local anesthesia by no stretch of imagination, therefore, it can be termed as a cosmetic procedure. With the advancement in technology today medical procedures have improved tremendously. Therefore I am inclined to hold that the patient need not have been hospitalized. I hold that the repudiation of the claim was unjustified. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 31870 to the complainant.**

Case No.GI/Star/65/12

In the matter of Sh. Sanjay Tyagi

Vs

Star Health & Allied General Insurance Company Ltd.

Award dated 18.08.14 relating to Non-settlement of mediclaim

1. **This is a complaint filed by Sh. Sanjay Tyagi (herein after referred to as the complainant) against the decision of Star Health & Allied General Insurance Company Ltd. (herein after referred to as**

respondent Insurance Company) relating to non settlement of mediclaim.

2. **Complainant stated that on 15.03.2012 at 5.00 a.m. his father felt chest discomfort so he took him to Metro hospital & Heart Institute on 15.03.2012 and was hospitalized as advised by the doctor immediately for conducting certain tests. The company rejected his claim of Rs. 22,760 on the grounds that this was a case of evaluation and investigation only.**

3. **The insurance company gave their written submissions on 05.08.2014 and reiterated the written submissions. The company pleaded that the claim is rejected on the basis of exclusion clause no. 13 which states "Charges incurred at Hospital or Nursing Home primarily for Diagnostic, X-ray or laboratory Examinations not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any ailment, sickness, or injury, for which confinement is required at hospital / nursing home".**

4. **Heard the complainant as well as the Insurance Company. The discharge summary submitted shows that the patient was admitted in CCU (critical care unit) on 15.03.2012 with symptoms of "left sided chest heaviness with palpitation gabrahat associated with breathing difficulty. and he was treated initially with antiplatelet, statins, I/V antibiotics and other supportive medication and discharged on 16.03.2012. A CAG (coronary Angio Graphy) was done on 15.03.2012 after the written consent of the family. CAG revealed non critical CAD (Coronary Artery Disease). He was advised for review after one week in Cardiac OPD and in case of emergency (chest pain, breathing difficulty, sweating, gabrahat ect.) to contact the emergency department.**

5. **The patient was admitted with symptoms of heart problem. The clinical diagnosis was prescribed by the Cardiologist. On the basis of the clinical diagnosis i.e. ECG etc. a CAG was performed to determine the quantum of blockage. The CAG is admittedly a diagnostic tool to enable the further line of treatment. Since the diagnosis was a noncritical CAD a conservative line of treatment**

was undertaken / prescribed. This line of treatment was in a sequential order to determine the severity of illness. The Insurance Company also admitted that the patient was hospitalized in emergency, in CCU for Chest problem in the early morning.

6. **After due consideration of the matter, I hold that the repudiation by the company under exclusion clause 12 (and not 13 as wrongly quoted by the company which reads as "Expenses on vitamins and tonics unless forming part of treatment for injury or disease as Certified by the attending Physician)" is not correct. I find that the complainant had informed the insurance company regarding the hospitalization within the prescribed norms laid down in the mediclaim policy. The complainant had further in his submissions and during the hearing, stated that the insurance company did not respond to his queries and neither gave any approvals till 4.00 p.m. of the 16.03.2012. Subsequently he had to pay the amount of Rs. 22,760 and got the patient discharged. "In the written reply to the Ombudsman the company have submitted several documents in support of their repudiation. I find that an email regarding claim intimation was sent by one Mr. Anthony working with Metro Hospital to Star Health & Allied Insurance Company Ltd. at claim.module@gmail.com on 15.03.2012 at 13:26 p.m. In response to the authorization**

request of the hospital the Star Health & Allied Insurance Company, repudiated the claim at 03:11 p.m. on 15.03.2012, with a foot note "please hand over the copy of the letter to the Insured Patient". All along the complainant has pleaded that the insurance company did not get back to him with the approval and he had to pay upfront to the hospital to get his father discharged. During the personal hearing the representative of the company did not refute this allegation. I find that on one hand the company had rejected the claim on 15.03.2012 in the afternoon by (3'O Clock) while the company's representative paid a visit to the hospital and the complainant in the evening (15.03.2012) wherein, he had assured him of the approval. I find that the insurance company had been giving fake assurances to the complainant when the claim had already been rejected. This has caused considerable harassment to

the complainant. I hold that the treatment / evaluation / investigation prescribed was consistent with and incidental to the diagnosis given at the time of admission. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 27,760/- {Rs. 22,760 claim amount + Rs. 5000 (on account of harassment)} to the complainant.

Case No.GI/RSA/58/12

In the matter of Smt. Maya Singh
Vs
Royal Sundaram Alliance Insurance Company Ltd.

Award dated 27.08.14 relating to Non-settlement of mediclaim

1. **This is a complaint filed by Smt. Maya Singh (herein after referred to as the complainant) against the decision of Royal Sundaram Alliance Insurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to non settlement of mediclaim. The complainant was represented by her son, Sh. Rajesh Singh.**

2. **Sh. Rajesh Singh stated that his mother fell at home and was hospitalized in Kailash Hospital from 14.11.2011 to 15.11.2011. She underwent "Cutaneous K. Wire fixation under C. Arm" under GA (General Anesthesia). The complainant lodged the mediclaim to the insurance company but the original documents including the x-ray film had been lost in transit just before submission to Royal Sundaram Insurance Company. Complainant submitted duplicate papers attested by CMO of Kailash Hospital, Noida. The claim was denied by the company on the ground of non submission of original papers. The complainant also stated that he has taken only one mediclaim policy from Royal Sundaram and he was not holding any other insurance. He has come to this forum with a request to settle his claim.**

3. **The Insurance company reiterated the contentions in their letter dated 17.08.2012 that complainant has availed Health Shield Gold Policy bearing no. HJ00005564000105. A claim was lodged under**

the said policy. The company sought for the original documents from the complainant vide their letter dated 30.12.2011, 06.01.2012 and 04.02.2012 but complainant submitted only duplicate copies of the documents. Complainant inspite of repeated requests failed to produce the original documents. The company rejected the claim on the ground of non submission of original documents as the same is the mandate of the policy terms and conditions.

4. **I heard both the company as well as the complainant. During the course of hearing the complainant pleaded that company has settled his second claim for admission in Kailash Hospital on 23.12.2011 for removal of "k. Wire" which was implanted during the first hospitalization period i.e. 14.11.2011 to 15.11.2011. The Insurance Company also did not deny the fact that the second claim was duly settled as all supportive documents in original were submitted. I find that the post operative procedure was for removal of "K. Wire" which was implanted during first hospitalization period. The insurance company has already approved and settled the post operative expenses. The complainant was admitted on 23.12.2011 for implant removal (K. wire) which was done by the same orthopedic surgeon in the same hospital on 14.11.2011. The duplicate bills substantiate the claim of the complainant.**

5. **After due consideration of the matter, I hold that the insurance company is liable to pay sum of Rs. 28,408/- to the complainant for expenses incurred on hospitalization period from 14.11.2011 to 15.11.2011. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 28,408 to the complainant.**

Case No.GI/OIC/26/12
In the matter of Sh. Jagmohan Negi
Vs
Oriental Insurance Company Ltd.

Award dated 12.09.14 relating to Non-settlement of mediclaim

1. **Sh. Jagmohan Negi had filed the complaint (herein after referred to as the complainant) against the decision of Oriental Insurance Company Ltd. (herein after referred to as respondent Insurance Company) alleging non settlement of mediclaim.**

2. **The Complainant had alleged non settlement of mediclaim. He was admitted in Medanta Hospital on 28.03.2011 for treatment of prostate cancer. His claim was rejected by Vipul Medcrop TPA Pvt. Ltd. on 31.03.2011 on the grounds that the "treatment in the form of Zolidronic Acid which is not a chemo drug". He has come to this forum with request to settle his mediclaim of Rs. 12,268/-.**

3. **The Insurance Company reiterated the written submissions and stated that the case was processed within the terms and conditions, exclusions and limitations of the mediclaim policy issued to him. The claim was considered as inadmissible as "Patient took treatment in the form of Zolidronic Acid which is not a chemo drug. Hence as per the Clause 2.3, the claim is not payable".**

4. **I heard both the sides, the Complainant as well as the Insurance Company. I observe that the claimant is a case of Carcinoma Prostrate and was advised Zoladria 4mg and received injection for the same on 28.09.2010 in daycare. He was discharged on the same day and was advised injection zolidronic acid 4mg at 6 monthly intervals. He got the same injection on 28.03.2011 which was rejected by TPA. I find that the claim for the said treatment given in September i.e 28.09.2010 was settled by the TPA on 24.12.2010. Accordingly an award is passed with the direction to the Insurance Company to make the payment of admissible amount to the complainant.**

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Case No.GI/OIC/67/12
In the matter of Sh. Amar Gopal Gambhir
Vs
Oriental Insurance Insurance Company Ltd.

Award dated 29.09.14 relating to Non-settlement of mediclaim

1. **Sh. Amar Gopal Gambhir had filed the complaint (herein after referred to as the complainant) against the decision of Oriental Insurance Company Ltd. (herein after referred to as respondent Insurance Company) alleging non settlement of mediclaim.**

2. **The complainant has alleged that his daughter Ms. Rupal Gambhir was operated for Keratoconus at Bharti Eye Foundation on 04-10-11 and incurred Rs.68, 884/- towards medical expenses. The claim was in the 2nd year of policy. As per complainant the problem was detected on 22-09-2011 during routine check-up of the eyes. He had filed claimed of Rs.68,884. His claim has been rejected on the ground of 'Genetic Disorder'. He stated that there is no family history of keratoconus and that the causes of 'Keratoconus' are not known to modern science. He has requested to reimburse the hospitalization expenses.**

3. **The Insurance Company reiterated their written submissions and stated that vide its letter dated 19-09-2012 had rejected the claim on 18-11-2011 on the ground of genetic disorder of disease as stated by complainant's doctor as per clause no. 4.15 of the policy. The exclusion thus is applicable to all cases of "Genetic Disorders" and is applicable even if it is claimed by the insured that there is no family history of Keratoconus.**

4. **I heard both the sides, the complainant as well as the Insurance Company. I find that the patient had approached the clinic on 22.09.2011with the complaint of dim vision in both the eyes. After investigations through pentacam on 24.09.2011, it was diagnosed as Keratoconus. This was surgically corrected on 04.10.2011. The Company rejected the claim on 18-11-2011 on the ground of genetic disorder of disease (as stated by complainant's doctor) as per clause no. 4.15 of the policy.**

5. The Mosby's Dictionary defines Keratoconus as "a non inflammatory protrusion of the central part of the cornea. More common in females, it may cause marked astigmatism; contact lenses usually restore visual acuity. The cause of the condition is unknown. Keratoconus is typically diagnosed in the patients adolescent years. In their letter dated 19.09.2012 addressed to the Insurance Ombudsman the Company admits that "Keratoconus is a gradual change and the condition usually begins between the ages of 15 and 25…….This position gradually reaching the stage where operating procedure is required takes a long time" (para 7 of the Company's letter dated 19.09.2012). The disease may require surgery for which several options are available including intrastromal corneal ring segments, corneal collagen cross-linking, mini asymmetri radial keratotomy. The patient underwent corneal cross-linking with Riboflavin. The Insurance Company rejected the case on grounds that the disease was pre-existing when the insurance was obtained. As stated earlier the exact cause of keratoconus is unknown. Some studies show that keratoconus corneas lack important anchoring fibrils that structurally stabilize the anterior cornea. This increased flexibility allows that cornea to "bulge forward" into a cone-shaped appearance. However, no one clearly explains it all and it may be caused by combination of things i.e. genetic, environment and endocrine system. From the presently available information there is less than a one in ten chance that a blood relative of a keratoconic patient will have keratoconus. The majority of patients with keratoconus do not have other family members with the disease. The complainant has also clearly stated that there is no history of keratoconus in his family. The possible cause of keretoconus that it is genetic has not been proven conclusively. The complainant had already stated that there is no family history of keratoconus. The disease even if it takes a long time to manifest itself is typically identified in the adolescent years which was not the case of the patient. The keratoconus was diagnosed only after various investigations were done at the age of 27. Since it cannot be conclusively proved that keratoconus was genetic. I give the benefit of the doubt to the complainant. Accordingly an award is passed with the direction to the Insurance

Company to settle the claim and make the payment of admissible amount to the complainant.

HYDERABAD

Hyderabad Ombudsman Centre
Case No. L-041-1314-0336

Mr. A. Subhash Chandra
Vs
SBI Life Insurance Co. Ltd.

Award Dated : 15.04.2014

Mr. A. Subhash Chandra filed a complaint that the Critical Illness Benefit under the policy taken by him from SBI Life Insurance Co. Ltd. was wrongly rejected by the insurer. Hence, he requested for settlement of the same.

On a careful consideration of the contentions placed on record by both the parties and the arguments put forth by them during the hearing, I find from the policy document and the definitions, under no. 12.1.3, that the illnesses that were covered were – Cancer, Coronary Artery Bypass Surgery (CABG), Heart Attack, Heart Valve Surgery, Kidney Failure, Major Burns, Major Organ Transplant, Paralysis, Stroke, Surgery of Aorta, Coma, Motor Neuron Disease and, Multiple Sclerosis. Further, under no. 12.2.3, "Heart Attack", the first occurrence of heart attack or myocardial infarction has been defined to mean death of heart muscle, due to inadequate blood supply, that has resulted in 'acute myocardial infarction'.

The argument of the insurer was that the life assured undertook the treatment which did not come under the definition of 'Heart Attack' as given under clause no. 12.2.3.2. of the policy schedule, which should satisfy that "Troponin T> 1.0 ng/ml". Further, as per the reports

submitted by the complainant, the Troponin Test was 'negative' and the life assured was diagnosed with 'Ischemic Heart Disease', acute posterior wall Myocardial Infarction and not the 'heart attack' as defined in the terms and conditions.

However, the complainant disputed the application of the definition of 'Heart Attack' based on the certification of his doctor. According to Dr. A.V. Subba Rao, MD, DM, FICC, Cardiologist, the ECG features of the life assured had shown s/o Acute Posterior wall Myocardial Infarction (called Heart Attack in lay terms). Further, based on Circulation 2006; 114: 1673-1675 Editorial on 'Cardiac Troponins', he had opined that a false negative Trop T test may occur although the patient had 'heart attack'. Since cardiac enzymes were elevated and patient had typical features s/o heart attack, he was managed in ICCU as a case of heart attack, and advised further management.

After going through the aforesaid opinion of Dr. A.V. Subba Rao, Cardiologist, it was observed that technically there was little difference in interpretation of 'heart attack', as per the terms and conditions of the policy and that the insurer rejected the benefit because of non-satisfaction of troponin test, though the complainant had 'heart attack'. In my opinion, the insurer has acted hastily, in concluding that there was no heart attack. I am informed that, in certain cases, an immediate troponin test could be negative, even though there is heart attack. Considering that the insured did suffer a Myocardial infarction, there is no denying the fact of his first heart attack. The insurer has resorted to too technical an interpretation.

In view of the aforesaid reasoning, in my considered view, it was a genuine case where the 'critical illnesses benefit' was to be extended to the life assured. However, since the definition of 'heart attack' as per

terms of the policy was coming in way in extending benefit to the complainant, I feel that the complainant should be compensated suitably, with an Ex-gratia payment.

In view of what has been stated above, the complaint is partly allowed and the insurer is directed to settle an amount of Rs. 2,00,000/- (Two lakhs only), under ex-gratia to the complainant.

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Hyderabad Ombudsman Centre
Case No. L-029-1314-0339

Sri Ajey Ghaligi
Vs
L I C of India
Award Dated : 19.05.2014

Sri Ajey Ghaligi filed a complaint stating that the claim under 'health protection plus plan' was partially repudiated by the insurer. Hence, he requested for settlement of the claim fully.

On a careful consideration of the written and oral submissions of both the parties and the documentary evidence adduced, it was observed that the insured person met with an accident and sustained injuries. As per the discharge summary of Apollo hospitals, it was diagnosed as a case of 'fracture of bimalleolar right ankle' and 'fracture of facial bone (bilateral maxillary bone & zygoma)'. Operation was performed on him for "Open reduction & internal fixation with 4mm 2 malleolar screw with washer for fracture medial malleolar & CRIF with rush nail for fracture lateral malleolus ankle done, Application of prime cast bilateral knee right leg and ORIF for fracture maxilla & zygoma with plate & screw done". It has been observed that this treatment figures in the list of "Surgical benefit annexure". The insurer's contention that

only maxilla and zygoma was done and no other part of face or oral area was involved appears to be a harsh and unreasonable interpretation resorted only to avoid the claim. The condition of the insured was a result of an accident and the insured person was grievously injured. The insurer's decision that such and such part of the body should have been injured/ treated in order to give the benefit under reference, is very unreasonable. It was a clear case of trying to avoid the claim on some pretext.

In view of the aforestated reasons, the insurer is directed to settle the claim of the complainant, in terms of the policy, without any further delay. In the result, the complaint is allowed.

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Hyderabad Ombudsman Centre
Case No. L-024-1314-0649

Mr. Pilla Kanaka Raju
Vs
India First Life Insurance Co.Ltd.

Award Dated : 29.05.2014

Mr. P. Kanaka Raju filed a complaint that medi-claim reimbursement under the policy taken by him from India First Life Insurance Co. Ltd. was wrongly rejected by the insurer. Hence, he requested for settlement of the claim.

On a careful consideration of the written and oral submissions of both the parties and the documentary evidence adduced by them, it was observed from the policy document issued to the complainant that as per Clause No. 8.1 (Waiting Period) of the terms & conditions of the policy, the ailment "Deviated Nasal Septum/Nasal & Paranasal Sinus Disorders" was imposed a Two years Waiting Period from the Plan Commencement Date. The policy in question commenced from 7.4.2012 and the life

assured was hospitalised on 25.9.2013, i.e., within 24 months of the commencement of the policy, for undergoing the treatment of 'Sepals corrosion' which comes under "Deviated Nasal Septum/Nasal & Paranasal Sinus Disorders". Hence, in my considered view, the insurer rightly rejected the reimbursement benefit quoting the policy conditions. The argument of the complainant that he did not have any knowledge about the terms and conditions of the policy and that the Agent of the insurer also had not explained them properly, do not merit any consideration since he was expected to go through the terms and conditions of the policy on receipt of the same within the 'cooling off' period itself. The terms and conditions of the policy were very much explicit and as such the insurer cannot be compelled to act beyond the scope of the policy. In view of the aforesaid reasons, I hold that the rejection of claim by the insurer does not warrant any interference. In the result, the compliant is dismissed without any relief.

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Hyderabad Ombudsman Centre
Case No. L-041-1314-0530

Mr. Kadavendi Badari Prasad

Vs
SBI Life Insurance Co.Ltd.
Award Dated : 06.06.2014

Mr. Kadavendi Badari Prasad filed a complaint that the claim of medical expenses reimbursement benefit was not settled by SBI Life Insurance Company Limited. Hence, he requested for settlement of the claim.

On a careful consideration of the written and oral submissions of both the parties and the documentary evidence adduced by them, it was observed that the insurer did not contest either the evidence submitted by the complainant with regard to his hospitalisation or the fact of ailment that he suffered for reimbursement of expenses. The insurer was only arguing that for 'bruises and abrasion', hospitalisation of 20 days was not justifiable. It appeared that the insurer wouldn't have objected to the claim, had the hospitalisation been for a short period. Considering the facts and circumstances of the case, I consider it fair, if the insurer settles the claim for 10 days of hospitalisation. As such, I would like to allow the reimbursement of hospitalisation expenses for a period of 10 days, as per the policy conditions.

In view of what has been stated above, the insurer is directed to settle the claim of the complainant, for reimbursement of Hospital Cash Benefit under the policy, for a period of 10 (Ten) days, in full & final settlement.

In the result, the compliant is allowed partly.

Hyderabad Ombudsman Centre
Case No. L- 029 -1314 – 525

Sri V Srinivasulu
Vs
L I C of India
Award Dated : 17.07.2014

Sri V. Srinivasulu filed a complaint stating that the Mediclaim under the Health insurance policy taken from LIC of India was wrongly repudiated by the insurer. Hence, he requested for settlement of the claim.

The complaint fell within the scope of the Redressal of Public Grievance Rules, 1998 and so it was registered. On a careful consideration of the written and oral submissions of both the parties and the documentary evidence adduced by the insurer, it was evident from the Discharge Record dated 24.6.2013 of NIMS hospital, Hyderabad that the insured/complainant was admitted on 23.05.2013 and the surgery was performed on 11.06.2013. He was discharged on 24.06.2013. There was no recording of 'DM' in the past history column. The progress record of the hospital, with the date 20.06.2013, pertaining to the complainant contained a noting as 'DM for 10 to 12 years', i.e. after 28 days of his admission in the hospital. It was further observed that the insurer had relied solely on that noting and repudiated the claim invoking Section 45 of Insurance Act, 1938. The insurer could not submit any contemporaneous evidence to vindicate their argument that the insured had knowledge of the pre-existing ailment or was taking treatment for that elsewhere. In the instant case, insurer repudiated the claim in the 5th year of the policy. Even if it is assumed that the insured was having past medical history, all pre-existing diseases were to be covered after the expiry of 4 years in the medi-claim policy. Section 45 can be invoked only in cases where there is suppression of material fact with fraudulent intentions. In the instant case, the insurer has not furnished any material in support of invoking Section 45 of the Insurance Act. Hence, I hold that the decision of the insurer in rejecting the medi-claim as erroneous.In view of what has been stated above, I hereby direct the insurer to settle the claim of the complainant, in terms of the policy. Considering the delay in settlement, the insurer is also directed to pay interest @ 9% p.a. from 01.08.2013 till the date of payment.In the result, the complaint is allowed.

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Hyderabad Ombudsman Centre
Case No. L- 029-1314 –0463

Sri Belli Anjaneyulu
Vs
L I C of India
Award Dated : 23.07.2014

Sri Belli Anjaneyulu filed a complaint stating that the claim for reimbursement of hospital expenses was wrongly rejected by the LIC of India. Hence, he requested for settlement of the claim as per the terms of the policy.

The complaint fell within the scope of the Redressal of Public Grievance Rules, 1998 and so it was registered.

On a careful consideration of the written and oral submissions of both the parties and the documentary evidence adduced by them, it is observed that while rejecting the claim of the complainant, the insurer solely relied on the noting of 'alcohol consumption' on the Progress notes of the hospital. It is common in the hospitals to elicit the information of patient about his medical condition/habits etc. from his close relatives/friends who accompany the patient at the time of hospitalisation. That procedure followed by the hospital authorities was for the simple reason that they didn't intend to disturb the patient. The answers given by the attendants on behalf of the patient may not always reflect the factual position. However, in the instant case, it was evident from the physical appearance of the insured during the hearing that he was not an alcoholic. One must appreciate that there is a vast difference between an alcoholic and a social drinker, who takes drinks only to keep company. The insurer also failed to furnish any other

contemporaneous evidence to vindicate their stand that he was an 'alcoholic'. Had the complainant been an 'alcoholic', his Liver, Kidneys, Lipid profile etc., would have got affected and such indications would have been reflected in the records of the hospital. But, no such evidence was submitted by the insurer / TPA in this case.

The claim of the complainant was repudiated by the insurer invoking Section 45 of the insurance act. The policy in question was taken in the year 2009, and the insured preferred the claim in the 4th year of the policy. As such, burden of proving the 'suppression of material fact' is rested with the insurer, if the claim was repudiated invoking Section 45 of the Insurance Act, 1938. In the absence of any sustainable documentary evidence, I hold that the insurer had erred in repudiating the claim of the complainant.

In view of the aforesaid reasons, I direct the insurer to settle the eligible amount of claim, to the complainant, in terms of the policy.

In the result, the complaint is allowed.

Hyderabad Ombudsman Centre
Case No. L- 29 -1314 – 455

Smt. Reddy Sujatha
Vs
L I C of India
Award Dated : 23.07.2014

Smt. Reddy Sujatha filed a complaint stating that the Mediclaim reimbursement under the policy taken from LIC of India was wrongly repudiated by the insurer. Hence, she requested for settlement of the claim.

The complaint fell within the scope of the Redressal of Public Grievance Rules, 1998 and so it was registered.

On a careful consideration of the written and oral submissions of both the parties and the documentary evidence adduced by them, it is observed from the policy document issued to the complainant, (i.e., "Jeevan Arogya Conditions and Privileges – Table 903") that Condition No.6 stipulated a 'General Waiting Period' of 90 days from the date of Cover Commencement, during which no benefits shall be payable in the event of Hospitalisation or Surgery. Besides that, a 'Specific Waiting Period' of 2 years from the date of cover commencement was also imposed, during which no payment would be made by the insurer for any claim of Hospitalisation or Surgery on account of certain treatments. Further, as per sub-condition no. (iv) of the 'Specific Waiting Period', Treatment for 'benign uterine disorders such as fibroids, uterine prolapsed, dysfunctional uterine bleeding etc.', was included.

The policy in question was issued commencing the coverage from 15.11.2011 and the complainant was hospitalised on 28.8.2013 for the treatment of 'Chronic Pelvic Disorder', which comes under Specific Waiting Period of 2 years; and by then the duration of the policy was 1 year 9 months and 13 days only. As such, it was evident from the Discharge Card of R.R. Hospital, Nandyal, that the treatment taken by the complainant was within the specific waiting period of 2 years, attracting the aforesaid condition and thereby she was not entitled to any benefit under the policy. Hence, I hold that the repudiation of claim of complainant was as per the terms and conditions of the policy, and the decision of the insurer does not need any interference.

In view of the aforesaid reasons, the complaint is dismissed without any relief.

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Hyderabad Ombudsman Centre
Case No. L-029-1314-0515

Mr. Naveen Shetty
Vs
L I C of India
Award Dated : 25.07.2014

Mr. Naveen Shetty filed a complaint stating that the medi-claim benefit under the Health Insurance policy taken from LIC of India, Udipi Division, was wrongly repudiated by the insurer. Hence, he requested for settlement of the claim.

On a careful consideration of the written submissions of both the parties and the documentary evidence adduced by the insurer, it is observed that the policy was taken on 28.10.2011 and as per the discharge summary of Kasturba hospital, Manipal the life assured was admitted on 27.04.2013 for Fissure in Ano. He underwent I&D on 30.04.2013 and was discharged on 06.05.2013.

The Clause No.6 of the policy, i.e. the Special waiting period, reads as under: *"No benefits are available hereunder and no payment will be made by the Corporation for any claim under the policy on account of hospitalisation or surgery directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following during the specific waiting period. The Specific waiting period shall be two years from the date of cover commencement in respect of each insured"*. The Clause 6(ii) of Specific waiting period of LIC's Jeevan Arogya Conditions and privileges clearly excluded *"treatment for anal fistula or anal fissure".* Thus, it can be seen from the above that hospitalization

and treatment of the life assured was within 2 years of taking the policy, and as such it attracted the lien on the coverage. Hence, I hold that the insurer had rightly repudiated the claim of the complainant in terms of the policy.

In view of what has been stated above, I do not find any reason to interfere with the decision of the insurer. In the result, complaint is dismissed without any relief.

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Hyderabad Ombudsman Centre
Case No. L-001-1314-0690

Mr. Lalit Joshi
Vs
Aegon Religare Life Insurance Co.Ltd.

Award Dated : 25.07.2014

Mr. Lalit Joshi filed a complaint stating that the Medi-claim reimbursement under the policy taken from Aegon Religare Life Insurance Co. Ltd. was wrongly rejected by the insurer. Hence, he requested for settlement of the claim.

On a careful consideration of the written submissions of both the parties and the documentary evidence adduced by the insurer, it is observed that there was considerable delay in submission of the claim, i.e. 34 months. The insurer could have rejected the claim at the first instance for delay in submission. However, it is evident from the e-mail dated 10.02.2014 that the delay was condoned/waived off by the insurer. The insurer repudiated the claim on 12.03.2014 precisely citing the same reason. Having waived off the delay once, the insurer cannot

now go back on the condonation of delay and repudiate the claim on the same ground. Coming to another reason of repudiation, i.e. non-submission of Indoor case papers, the fact that the other insurer viz. National Insurance Co. Ltd. has already settled the claim itself vouches for the genuineness of the claim. More so, the insurer did not make any attempt to obtain the Indoor case reports from the hospital which was a Network hospital figuring in the list of the insurer. Hence, I hold that the reason quoted by the insurer while rejecting the claim is not valid and that the insurer had grossly erred in repudiating the claim of the complainant.

In view of what has been stated above, I direct the insurer to settle the claim of the complainant, in terms of the policy.

In the result, the complaint is allowed.

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Hyderabad Ombudsman Centre
Case No. L- 029 -1415 - 061

Sri Punam Chand Jhawer
Vs
L I C of India, DO Karimnagar

Award Dated : 30.09.2014

Sri Punam Chand Jhawer filed a complaint stating that LIC of India, Karimnagar had short settled his mediclaim, under the health insurance policy taken from them. Hence, he requested for settlement of the full claim.

I have carefully considered the written and oral submissions of both the parties and the documentary evidence adduced by them. It is evident from the annexure list that the surgery to 'Gall bladder' very much figures in the list. As per the terms & conditions of the policy, the MSB is in the 'allowed' category. The Central Office of the insurer had also given very clear instructions in the form of a circular to all their offices to delete the words 'Gall Bladder' in Annexure II and to issue corrected booklets to the policies issued from 15.01.2010. In the instant case, the policy was issued in 07/2011, i.e. after 1 1/2 year of issue of that circular. However, the policy issuing office of the insurer did not implement their Central office instructions and failed to send the corrected booklets to the insured person. The insurer also did not send any communication to the insured about deletion of that ailment till the date of surgery in 09/2013, i.e. upto 3 1/2 years after the issue of the circular. Thus, the insured was allowed to continue with the belief that the said ailment was covered under the policy and that he was eligible for 60% of sum assured as MSB. This being the position, the principle of promissory estoppel comes into play and, I have no hesitation in concluding that the insurer is left with no other option but to honour the MSB claim in this case.

In view of the aforesaid reasons, I hereby direct the insurer to settle the eligible claim of complainant, i.e., 60% of sum assured as MSB, in terms of the policy.

In result, the complaint is allowed.

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OFFICE OF OMBUDSMAN KOCHI
Family health insurance

Complaint No. IO/KCH/GI/11-017-233/2012-13

Award No. IO/KOC/A/GI/0001/2014-15

Sri. K.P. Girishkumar Vs. Star Health & Allied Insurance Co.Ltd.

Award passed on 04.08.2014

The complainant had taken a family health insurance policy with M/s Star Health & Allied Insurance Co. Ltd. in June 2011. His wife, Smt.Jisha had fallen down while descending the stairs of SNGM College, Thuravoor on 19.08.2011. She was admitted to PS Mission Hospital, Kundannoor on 20.08.2011. After conducting surgery and completing other formalities, she was discharged on 22.08.2011. The complainant preferred a claim for Rs.11,258/- before the Insurance Company along with the necessary documents.

On going through the facts of the case, it is seen that the company has deducted only inadmissible charges from the claim of the complainant, viz., Rs.49/- towards consumables and Rs.75/- towards establishment charges. The complainant also agreed to accept the offer of the company. Accordingly, the company is directed to pay the amount of Rs.10,971/- after complying with the necessary formalities, but in any case, not later than 14.08.2014.

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Individual mediclaim

Complaint No. IO/KCH/GI/11-017-259/2012-13

Award No. IO/KOC/A/GI/0002/2014-15

Sri. C. Sukumaran Vs. M/s Star Health & Allied Insurance Co.Ltd.

Award passed on 06.08.2014

The complainant had taken Individual Mediclaim insurance policy in his wife's name , from the Respondent-Insurer on 02/05/2011 through intermediary Mr T.V Balakrishnan Nair of Respondent Insurer at Baroda.

During last week of May 2011, it was suspected that policy holder was having malignancy in left breast. . Examination at RCC, Trivandrum on 18/06/2011 also confirmed the malignancy and date of surgery fixed for 05/07/2011. Policyholder was admitted on 04/07/2011, operated on 05/07/2011 and discharged on 06/07/2011. Despite several mails & follow up, the claim is denied for the reason "pre existing illness not covered under the policy". The relief claimed is the entire claim amount repudiated by the Respondent Insurer.

The claim for reimbursement is for Rs.71566.90. The genuineness of the medical bills is not disputed. The Respondent-Insurer is liable to pay Rs.71566.90 to the complainant.

An award is passed directing the Respondent-Insurer to pay to the complainant an amount of Rs. 71,566.90 with 9% interest per annum from the date of filing of the complaint (09/07/2012) till the date of award.

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Mediclaim

Complaint No. IO/KCH/GI/11-002-274/12-13

Award No. IO/KOC/A/GI/0004/2014-15

Sri. Krishnakumar Vs. New India Assurance Co. Ltd.

Award passed on 07.08.2014

Sri. Krishnakumar, the complainant and his family members, were covered under Medi Claim policy from the respondent insurer for the period 09.10.2011 to 08.10.2012. He had submitted 2 claims under the policy on 23.11.2011 and 28.11.2011 in connection with the hospitalization of his father. Some amount was settled by the insurer through cash less facility. There was considerable delay in settling the balance amount of the claim and he received the cheques for the balance amount only on 23.02.2012. Those cheques were subsequently dishonoured by the bankers due to stop payment issued by the drawer. Fresh cheques issued in lieu of the dishonoured ones, were received by him only on 03.03.2012. His request to the insurer for adequate compensation for the delay in settlement was not considered by the company. Since the complaint could not be settled between them, a complaint was filed before the Hon'ble Ombudsman.

On going through the entire facts of the case, the undersigned is convinced that this is a fit case where the complainant should be compensated by the insurer for various omissions on their part. Award is passed directing the Respondent-Insurer to pay to the complainant an amount of Rs.1000/- (Rupees one thousand only) towards cost and intimate the compliance to the undersigned.

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Health insuance

Complaint No. IO/KCH/GI/11-017-314/12-13

Award No. IO/KOC/A/GI/0005/2014-15

Smt. Smitha Roslin Tom Vs. M/s Star Health & Allied Ins.Co.Ltd.

Award passed on 07.08.2014

The complainant had taken Mediclassic Individual Insurance policy for a Sum Assured of Rs1,00,000/- for the period from 12/07/2010 to 11/07/2011 and renewed for the next year. The complainant has undergone surgery for treatment for Keratoconus from Vasan Eye Care Hospital, Ernakulam on 14/03/2012. On 28th May 2012, complainant has received information that claim is rejected as hospitalization was not required. Hence this complaint .Relief sought is for the full claim amount.

The relief sought by the complainant is for obtaining the entire claim amount of Rs14872/-. No case could be made out by the complainant that the repudiation was wrong. The Respondent-Insurer, therefore, is not liable to pay Rs.14872/- to the complainant as it comes under exclusion no 18.

In the result, an award is passed for "DISMISSAL "of the complaint. No cost

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Health insurance

Complaint No. IO/KCH/GI/11-004-302/12-13

Award No. IO/KOC/A/GI/0007/2014-15

Smt. Beena Cherian Vs. United India Ins.Co.Ltd.

Award passed on 11.08.2014

The complainant had taken Individual Health Insurance policy for a Sum Insured of Rs.75,000/- for the period from 08/06/2010 to 07/06/2011 and renewed the next year(Policy no 100203/48/11/12/00000495). The complainant has undergone Hysterectomy during July 2011. A claim amounting to Rs 56250/- was made soon thereafter. The respondent Insurer has paid only Rs 18750/- .

The relief sought by the complainant is for obtaining the entire claim amount of Rs.56250/-and interest thereon @9%. No case could be made out that the repudiation was wrong. The Respondent-Insurer, therefore, is not liable to pay the balance claim to the complainant.

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Individual mediclaim

Complaint No. IO/KCH/GI/11-004-243/12.13

Award No. IO/KOC/A/GI/0009/2014-15

Sri. P Sundar Rajan Vs. United India Insurance Co. Ltd.

Award passed on 20.08.2014

The complainant had taken an Individual Mediclaim policy from respondent Insurer. The Insurer declined to admit the claim for operation of chorodial Neivascular Membrane in the right eye using Avastin on 28/05/2011 at Giridhar Eye Hospital. Since the claim was rejected further treatment claims on 5/6.09.2011 and 13/14.02.2012 were not submitted. Hence this complaint.

Award is passed directing the Respondent-Insurer to pay to the complainant an amount of Rs. 5,075/-. The payment shall be made within the period prescribed hereunder. No cost.

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Family Health plan

Complaint No. IO/KCH/GI/11-013-244/12-13

Award No. IO/KOC/A/GI/0010/2014-15

Smt. Hafsa Beegom Vs. HDFC ERGO General Ins.Co.Ltd

Award passed on 22.08.2014

The complainant's daughter Smt. Beegom Thanuja had taken Family Health plan from the Respondent-Insurer for the period from 30.07.2011 to 29.07.2012. The policyholder has consulted Dr. N.S. Sunil, Physician at Welcare Hospital, Vytila for severe back pain. After discharge, the claim for Rs.10,130/- was made before the Respondent-Insurer, but the same was rejected citing reason that the hospitalization was done only for investigation and evaluation. Hence nothing is payable.

The complainant has also produced enough evidence to show that the treatment is ongoing. Hence the Respondent-Insurer is liable to pay the claim. Award is passed directing the Respondent-Insurer to pay to the complainant an amount of Rs. 10,130/- *(with 9% interest per annum from the date of filing of the complaint (03/07/2012) till the date of award*).

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Mediclaim

Complaint No. IO/KCH/GI/11-005-266/12-13

Award No. IO/KOC/A/GI/0011/2014-15

Sri. P. K. Harris Vs. The Oriental Insurance Co.Ltd.

Award passed on 22.08.2014

The complainant had taken mediclaim policy from 2001 onwards from the respondent-insurer. The complainant has been admitted at Apollo hospitals from 02.02.2012 to 11.02.2012 in connection with periodic treatment associated with By-pass surgery etc. the bills amounting to Rs.2,70,308/- was forwarded to M/s E Meditek Services Ltd. Cochin (TPA) in time. The claim was repudiated citing Clause 4.10 of the policy. Hence this complaint. Relief sought is for the full amount of Rs.2,70,308/- with 18% interest.

The arguments advanced by the Insurance company to repudiate the claim are not convincing and deserve to be rejected.

Award is passed directing the Respondent-Insurer to pay to the complainant an amount of Rs. 2,70,308/- with simple interest at 9% per

annum from the date of complaint (11.07.2012) till the date of award and cost of Rs.1000/.

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Happy family floater

Complaint No. IO/KCH/GI/11-005-298/12-13

Award No. IO/KOC/A/GI/0012/2014-15

Sri. Manual Mohandas Vs. The Oriental Insurance Co. Ltd.

Award passed on 22.08.2014

The complainant had taken Happy Family Floater mediclaim policy for the period from 23.09.2010 to 22.09.2011. The complainant was hospitalized from 23.05.2011 to 26.05.2011. The Respondent-Insurer has not paid the claim. Hence this complaint.

The insurer has agreed to settle the claim of Rs.18,822/- subject to receipt of a note (report) on how the accident has occurred.

An award is passed directing the Respondent-Insurer to pay to the complainant an amount of Rs. 18,822/- *(with 9% interest per annum from the date of filing of the complaint (23/07/2012) till the date of award*).

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Family floater mediclaim

Complaint No. IO/KCH/GI/11-005-303/12-13

Award No. IO/KOC/A/GI/0013/2014-15

Dr. Sujith James Thomas Vs. The Oriental Insurance Co.Ltd.

Award passed on 27.08.2014

The complainant had taken Happy Family Floater mediclaim policy for the period from 27.11.2009 to 26.11.2010 and thereafter renewed. The complainant was hospitalized from 23.02.2011 to 24.02.2011 and 07.09.2011 to 08.09.2011 at Amrita Institute of Medical Sciences, Kochi in connection with chest pain, complaints of reflex symptoms etc. The Respondent-Insurer had rejected the claims stating that no specific disease is diagnosed and discharge medication prescribed with no active treatment given during hospitalization period.

The insurer has agreed to settle the claim of Rs.30,966/-. An award is passed directing the Respondent-Insurer to pay to the complainant an amount of Rs. 30,966/-.

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Mediclaim

Complaint No. IO/KCH/GI/11-002-339/12-13

Award No. IO/KOC/A/GI/0019/2014-15

Sri. Renjith K Babu Vs. The New India Assurance Co.Ltd.

Award passed on 04.09.2014

The complainant had taken Mediclaim policy for the period from 09/06/2011 to 08/06/2012 (Policy No. 112700/34/11/01/00000299). This policy covers hospitalization expenses of the insured subject to exclusions. Complainant's father had undergone treatment on 15th May 2011 for cardiac arrest. The bills were submitted to the then insurer and claim amounts received. On the advice of the Doctor, complainant's father was admitted to another hospital for CABG Procedure on 16th July 2011 and had surgery. The bills for this was submitted to the insurer. However, the claim was rejected citing pre-existing illness and the endorsement passed to this effect in the policy. Hence this complaint. Relief sought is for the full claim amount.

The relief sought by the complainant is for obtaining the entire claim amount. No case could be made out that the rejection was wrong. The Respondent-Insurer, therefore, is not liable to pay the claim to the complainant.

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Mediclaim

Complaint No. IO/KCH/GI/11-004-585/12-13

Award No. IO/KOC/A/GI/0020/2014-15

Smt. Meena Dhamodharan Vs. United India Insurance Co. Ltd.

Award passed on 04.09.2014

The complainant had taken an Individual Health Insurance policy NO. 101800/48/11/97/00000525 from the respondent-insurer. Her son was hospitalized from 31.01.2012 to 01.02.2012. Claim forms were submitted on 14.02.2012 claiming reimbursement of hospital expenses of Rs.3923.50 by the complainant. The insurer has rejected the claim citing Exclusion no. 4.8 of the policy. Hence this complaint.

The insurer is legally correct in repudiating the claim. However, I am satisfied that this is a fit case where Rule 18 of the RPG Rules is to be invoked so as to provide some kind of solace to the complainant/insured who is not in a good financial position. An award is passed directing the Respondent-Insurer to pay to the complainant an amount of Rs. 3,923.50.

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Health insurance

Complaint No. IO/KCH/GI/11-004-973/12-13

Award No. IO/KOC/A/GI/0023/2014-15

Sri. Haris K Vs. United India Insurance Co.Ltd.

Award passed on 05.09.2014

The complainant had taken Individual Health Insurance policy for a Sum Insured of Rs.75,000/- for the period from 22/06/2011 to 21/06/2012 (Policy no 101900/48/11/97/00000241). This policy covers hospitalization expenses incurred subject to restrictions and exclusions in the policy. The complainant's wife has undergone Ayurvedic treatment from a private hospital. A claim amounting to Rs 47627/- was made soon thereafter. The respondent Insurer has not paid the claim. Hence this complaint .Relief sought is for the full claim amount.

The relief sought by the complainant is for obtaining the entire claim amount of Rs.47627/-. No case could be made out that the rejection was wrong. The Respondent-Insurer, therefore, is not liable to pay the claim to the complainant.

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Mediclaim

Complaint No. Io/KCH/GI/12-004-550/12-13

Award No. IO/KOC/A/GI/0025/2014-15

Sri. E.K. Varghese Vs. United India Insurance Co.Ltd.

Award passed on 09.09.2014

The complainant holds a Mediclaim policy since 1996 with the Respondent-Insurer through their various branches, renewing every year. In 2012, the Respondent-Insurer had collected an annual premium of Rs. 11,715/- which was a very high increase compared to the earlier years. Complainant has sent a representation to the Headquarters of the insurer seeking their clarification on the exorbitant increase. However no reply was received by the complainant. Hence this complaint is preferred. Relief sought is Rs.6,952/-.

In the result, an award is passed directing the Respondent-Insurer to charge Rs.6,000/- only as premium for the year 2012-13 and to refund the balance to the complainant.

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Individual Health

Complaint No. IO/KCH/GI/11-004-893/12-13

Award No. IO/KOC/A/GI/0026/2014-15

Sri. K.P. Venugopal Vs. United India Insurance Co. Ltd.

Award passed on 17.09.2014

The complainant had taken a Individual Health Insurance policy NO. 101800/48/12/97/00000477 for Sum Assured of Rs.75,000/- from the respondent-insurer. He was hospitalized from 16/07/2012 to 17/07/2012. Claim forms were submitted claiming reimbursement of hospital expenses of Rs.5,640/- by the complainant. The insurer has

not settled the claim citing the reason that the procedures/investigation undergone could have been done as an outpatient and hospitalization was not really necessary. Hence this complaint. Relief sought is for Rs.5,640/-

An award is passed directing the Respondent-Insurer to pay to the complainant the entire claim amount less inadmissible.

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Health insurance

Complaint No. IO/KCH/GI/11-004-257/13-14

Award No. IO/KOC/A/GI/0027/2014-15

Dr K. Arjun Gopinath Vs. United India Insurance Co.Ltd.

Award passed on 17.09.2014

The complainant had taken a Individual Health Insurance policy NO. 101201/48/11/97/00002260 for Sum Assured of Rs.1,00,000/- from the respondent-insurer. He was hospitalized from 26/11/2012 to 28/11/2012. Claim forms were submitted claiming reimbursement of hospital expenses of approximately Rs.70,000/- by the complainant. The insurer has settled the claim to the extent of Rs 50000/- only claiming that the Sum Assured increase from Rs50,000/- to Rs1,00,000/- was made after diagnosing the ailment and hence hospitalization expenses only to the previous year Sum Assured extent can be reimbursed. Hence this complaint. Relief sought is for Rs35,000/-.

Award is passed directing the Respondent-Insurer to pay to the complainant the entire claim amount less inadmissibles (the amount already settled may be deducted).

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Family health policy

Complaint No. IO/KCH/GI/11-017-460/12-13

Award No. IO/KOC/A/GI/0033/2014-15

Smt. Shincy Vs. Star Health & Allied Ins.Co.Ltd.

Award passed on 19.09.2014

The complainant is covered under a policy taken from the Respondent – Insurer(policy no P/181213/01/2012/005483 family health optima Insurance for the period 31/08/2011 to 30/08/2012). Smt Shincy, wife of the policyholder, who is covered under the scheme was hospitalized from 21/03/2012 to 25/03/2012. The necessary claim forms were also submitted, however the Insurer has rejected the claim citing reason as "condition no 3 of the policy which states that full particulars of the event has to be informed within 24 hours to the insurer" which has not been done in this case.

The insurer has settled the claim and the letter of undertaking signed by the policyholder states that the full and final settlement has been received on the claim. Complaint is dismissed.

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Mediclaim

Complaint No. IO/KCH/GI/11-017-332/12-13

Award No. IO/KOC/A/GI/0034/2014-15

Sri. Vinod Kumar Vs. Star Health & Allied Ins.Co.Ltd.

Award passed on 19.09.2014

The complainant is a customer of the Respondent-Insurer with two policies with total coverage of Rs.15,00,000/-. He was hospitalized from 17/10/2011 to 10/11/2011 for "Uncemented Total Hip Replacement with Adductor tenotomy" The entire hospitalization expenses came to Rs.5,48,216/-. The necessary claim forms were submitted to the office of the respondent – Insurer , however only an amount of Rs.3,50,000/- was settled. Hence, this complaint. Relief sought is for the full claim amount and Rs.1,00,000/- as compensation for mental agony.

As per Rule 13 (3) (c) of the RPG Rules 1998, no complaint to the Ombudsman shall lie unless the complaint is not on the same subject matter for which any proceedings before any Court, or Consumer Forum or Arbitrator is pending or were so earlier. Complaint is dismissed.

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Senior Citizen Health insurance

Complaint No. IO/KCH/GI/11-017-414/12-13

Award No. IO/KOC/A/GI/0035/2014-15

Sri. T. X. Johan Vs. Star Health & Allied Insurance Co.Ltd.

Award passed on 19.09.2014

The complainant had taken a Senior citizen red carpet insurance policy in August 2011 under which his father was covered(policy No P/181200/01/2012/003359 for the period from 05/08/2011 to 04/08/2012. During October 2011, the complainant' s father (who is covered under the policy) suffered heart problem and was admitted to Lissie Hospital, Kochi. There the insured has undergone CAG and later PTCA. The total hospitalization charges has come to Rs 100201/-. The necessary claim forms were submitted for reimbursement, however claim has not been paid so far. On 25/05/2012, the complainant has received a letter from the Area Manager of the insurer stating that the claim has been rejected for due to the waiting period clause and suppression of material facts. Hence this complaint. Relief sought is for the claim amount.

The respondent Insurer could not prove conclusively that the insured had heart problems during the waiting period. Not revealing the long standing diabetes is a misstatement and should have been disclosed in the proposal. However that does not vitiate the admissibility of this claim. The claim for reimbursement is for Rs.1,00,201/-. The genuineness of the medical bills is not disputed. The Respondent-Insurer is liable to pay the actual admissible amount under the claim to the complainant.

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Health insurance

Complaint No. IO/KCH/GI/11-003-611/12-13

Award No. IO/KOC/A/GI/0036/2014-15

Sri. Suresh Bhaskaran Vs. National Insurance Co. Ltd.

Award passed on 19.09.2014

The complainant had taken a policy from the respondent Insurer in January 2012 (Hospitalisation Benefit Policy No 570203/48/11/8500002006 for the period from 05/01/2012 to 04/01/2013). The complainant's mother was covered under the policy. She was hospitalized on 05/06/2012 at KIMS , Trivandrum as an emergency case . On 10/06/2012, the complainant's mother was

discharged from the hospital and it was a Sunday, hence further authorization could not be obtained from the Insurer. The bills excluding Rs.25,000/- already authorized by the respondent Insurer was paid by cash by the complainant. All the papers for the claim (duplicates as the hospital had sent the originals directly to the Insurer) was sent to the Insurer for reimbursement. While the claim of the hospital was settled within a month, the complainants claim was rejected. On vigorously following up with the TPA and the Insurer, he received assurances from both that the claim was settled for approximately Rs 15,000/- . The complainant has received as full and final settlement Rs 15,764/- on 12/11/2012. Hence this complaint. Relief sought is Rs.1,295/-.

A case could not be made out for awarding any compensation. The relief sought by the complainant is not justified.

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Mediclaim

Complaint No. KOC-G-050-1415-0125

Award No. IO/KOC/A/GI/0038/2014-15

Sri. V. Aravindakshan Vs. Oriental Insurance Co.Ltd.

Award passed on 23.09.2014

The claim of the complainant has been repudiated by the respondent Insurer and Hon. Ombudsman has made an award upholding the repudiation, while a similar claim has been allowed in another case (Award No IO/KCH/GI/105/2008-09. Hence the award pertaining to the complainant should be set aside and reconsidered afresh.

The Officer representing the Respondent-Insurer submitted that the insurer was ready to concede the claim.

In the result, an award is passed directing the Respondent-Insurer to pay to the complainant an amount of Rs.30,492/-.

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Mediclaim

Complaint No. IO/KCH/GI/11-003-269/2012-13

Award No. IO/KOC/A/GI/0040/2014-15

Sri. M.T. Joy Vs. National Insurance Co.Ltd.

Award passed on 24.09.2014

The complainant had taken a Hospitalisation Benefit policy from the respondent Insurer (policy No 570700/48/10/8500004) in March 2011. Himself and his family members are covered under the policy. His son, Master Sanu Joy, was hospitalized at Aswini Hospital, Thrissur from 25.08.2011 to 27.08.2011 for Bilateral Testicular Vein Ligation. He submitted claim for reimbursement of expenses of Rs.30,781.92. The respondent-Insurer repudiated the claim stating that surgery of varicose veins is not payable for first two years of operation of the policy. Hence this complaint

The present claim does not fall under Exclusion No. 4.3 of the policy and the Respondent-Insurer is liable to settle the claim.

An award is passed directing the Respondent-Insurer to settle the claim (less inadmissible).

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Family medicare

Complaint No. IO/KCH/GI/11-004-518/2012-13

Award No. IO/KOC/A/GI/0041/2014-15

Sri. Sajimon K Varghese Vs. United India Insurance Co.Ltd.

Award passed on 24.09.2014

The complainant had taken a Family Medicare policy from the respondent insurer. The same was renewed for the period from 21/09/2011 to 20/09/2012 by paying a renewal premium of Rs.2421/- (Policy No 100200/48/11/06/00002276). The complainant's wife, who was covered under the policy, was hospitalized on 17/10/2011 with complaints of urinary incontinence, fecal incontinence, numbness of

back & thigh etc. The hospital has intimated the TPA for cashless service. The TPA has rejected the claim stating that the policy is in the first year and hence cashless benefit is denied. The patient was discharged on 25/10/2011 after extensive treatment. The policy is not in the first year as the renewal has been paid for the year 2011-12. The claim has been denied by the Insurer citing exclusions in the policy.

The respondent Insurer could not prove conclusively that the clauses 4.3, 4.11 and 4.13 of the policy exclusions were attracted. Hence, the Respondent-Insurer is liable to pay the actual admissible amount under the claim to the complainant.

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Health insurance

Complaint No. KOC-G-051-14-15-0075

Award No. IO/KOC/A/GI/0042/2014-15

Sri. John Daniel Vs. United India Insurance Co.Ltd.

Award passed on 24.09.2014

The complainant had taken a Individual Health Insurance policy from the respondent insurer. The same was renewed for the period from 10/03/2014 to 09/03/2015 by paying a renewal premium of Rs 10,274/-(Policy No 100200/48/13/97/00004773). The complainant was hospitalized for ayurvedic treatment and submitted a claim for Rs.23,000/- to the respondent Insurer. It was rejected by the TPA stating that the hospital did not have sufficient bed strength as required under the policy. Hence this complaint. Relief sought is for the full claim amount and compensation of Rs.23,000/-.

The respondent Insurer could not prove conclusively why the claim was repudiated under the clause of bed strength. Moreover, the insured is a senior citizen who took treatment under the bonafide belief that the claim will be reimbursed. Hence, making one time exception, invoking Rule 18 of RPG Rules 1998, the company may sanction his claim. Hence, the Respondent-Insurer is liable to pay the actual admissible amount under the claim to the complainant.

An award is passed directing the Respondent-Insurer to pay to the complainant the amount of admissible claim.

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Health Ins.

AWARD NO. IO/KOC/A/GI/0043/2014-15

Complaint No. IO/KCH/GI/11-004-533/2012-13

Dr R Padmakumar Vs. United India Insurance Co.Ltd.

AWARD PASSED ON 25.09.2014

The complainant had taken a Health Insurance policy from the respondent Insurer (policy No 100904/48/11/97/00001081) for the period from 18.11.2011 to 17.11.2012. He submitted a claim on the policy for Rs.48074/-. The sanctioned amount is only Rs.18888/-. From enquiry the complainant understands that the policy contained a clause limiting room rent to 1% of the Sum Insured, other charges are calculated based on the room charges. Clause 4.11 cannot be applied in this case and claim may be paid in full.

The room rent may vary depending on the size and facilities provided. However, chances of having rates for other services varying depending on the room opted are negligible. The Respondent-Insurer is liable to pay the claim including eligible room rent but excluding inadmissible under the policy.

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Mediclaim

AWARD NO. IO/KOC/A/GI/0044/2014-15

Complaint No. IO/KCH/GI/12-004-464/2012-13

Sri. V.R. Jayaprasad Vs. United India Ins.Co.Ltd.

AWARD PASSED ON 25.09.2014

The complainant had taken a Mediclaim Insurance policy from the respondent Insurer (policy No 101400/48/10/41/00004177) from 23.03.2011 to 22.03.2012. On the renewal becoming due, the complainant's bankers, i.e. Canara Bank had taken a Demand Draft and forwarded to the Respondent-Insurer at Karunagappally. However, this was returned stating that the DD should have been drawn on Trivandrum. During this time, the renewal date has expired. The

complainant is aged 57 years and if the policy is not renewed, it may be difficult to obtain a new policy considering his health condition. Relief sought for renewal of the policy and continuation.

It is understood that the complainant has taken a new policy with the respondent Insurer (policy no 101400/28/14/P10922759 for the period 03/04/2014 to 02/04/2015) pending this dispute.

An award is passed directing the Respondent-Insurer to renew the policy No 101400/48/10/41/00004177 with effect from 13.03.2012 by collecting renewal premium. The present policy to be treated as a continuation of the earlier policy so as not to deny the complainant any benefits under the policy.

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Health insurance

AWARD NO. IO/KOC/A/GI/0045/2014-15

Complaint No. IO/KCH/GI/11-004-328/2012-13

AWARD PASSED ON 26.09.2014

Sri. N. Govindankutty Vs. United India Insurance Co.Ltd.

The complainant had taken an Individual Health Insurance Policy (100900/48/11/97/00000337) for the period 16.07.2011 to 15.07.2012 from the Respondent Insurer. The complainant had preferred a claim towards medical expenses incurred for hospitalization from 21.02.2012 to 24.02.2012. The total amount was Rs.10,899.10 for which the Respondent-Insurer has settled Rs.8,088/-. No reason for reduction in amounts was given. There is a delay of 18 days. Hence this complaint. Relief sought is Rs.10,000/- for loss due to rejection of Cashless Facility, Rs.2,287/- for short settlement of bills and Rs.72/- towards interest on delayed payment.

No case could be made out either for loss due to rejection of cashless facility or interest for delayed payment. Since the respondent-Insurer has reimbursed all admissible items, the question of short settlement does not arise. The complaint is dismissed.

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Mediclaim

AWARD NO. IO/KOC/A/GI/0047/2014-15

Complaint No. IO/KCH/GI/11-005-412/12-13

AWARD PASSED ON 30.09.2014

Sri. K.P. Joshy Vs. The Oriental Insurance Co.Ltd

Sri.K. P. Joshy, the complainant was covered under a Medi-claim Policy from the respondent Insurance Company. He preferred two claims towards reimbursement of hospitalization expenses, to M/s. MD India Healthcare Services (TPA) Pvt. Ltd. Due to some delay in submitting the relevant documents, the TPA has requested the complainant to furnish the approval from RO authority for condoning the same. Subsequently, the RO authority informed the TPA that the delay in submission of documents has been condoned and the TPA has admitted the claim and released the payment.

Since the claims have already been settled by the respondent Insurer, the complaint is DISMISSED.

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KOLKATA

HEALTH INSURANCE CLAIM

Kolkata Ombudsman Centre
Case NO. 352/11/G2/NL/08/2012-13
Shri Bhaskar Sarkar
Vs
National Insurance Co.

Order dated : 14.08.2014
Facts and Submissions:

The complainant, Shri Bhaskar Sarkar has stated in his complaint dated 10.08.2012 that he met with an accident on 08.10.2010 and due to sudden injury and fracture on his right hand he went to a nearby Clinic (Sab's Clinic, Kolkata) under Dr. Subir Kumar Bose for immediate treatment and he could not be admitted into a hospital. He was also alone at the time of accident and due to unavoidable circumstances and for immediate treatment he paid all the necessary expenses for his immediate treatment i.e., x-ray, medicines, doctor's fees and other requirement for the treatment of fracture on his hand. The treatment was continued for two months.

He lodged a claim for Rs.6,734/- to the TPA of the insurance company M/s Medsave Healthcare (TPA) Ltd. for reimbursement. But after a lapse of considerable period of 9 months his claim was not settled by the insurance company. He represented to the insurance company on 21.06.2011 requested them to settle his claim. The

insurance company vide their letter dated 22.06.2011 intimated him that the claim papers could not be found in their office and hence they required a fresh set of claim and other documents for settlement of the claim. Therefore he submitted again one fresh set of claim papers to the insurance company on 08.07.2011. Subsequently, the insurance company's head office letter under Ref. No.HO/HIM/2012 dated 22.06.2012 repudiated the claim for non-intimation/ delayed submission that the date of hospitalization was 08.10.2010 whereas the claim was submitted on 19.11.2011 i.e., more than one year. He represented to the insurance company on 11.07.2012 against repudiation stating that his claim intimation along with all related original medical papers and reports were submitted to the insurance company on 02.11.2010 i.e., within 30 days from the date of injury and treatment requesting them to settle his claim. But the same was turned down. Being aggrieved by the decision of the insurance company, he approached this forum for redressal of his grievance seeking monetary relief of Rs.6,734/- as per 'P-II' form details. The complainant has given his unconditional and irrevocable consent for the Insurance Ombudsman to act as a mediator between himself and the insurance company and to give recommendation as per Form – P-III.

The insurance company in their written submission dated 11.10.2012 have stated that the insured Shri Bhaskar Sarkar met with an accident on 08.10.2010 and injured his hand. Shri Sarkar lodged his claim papers along with all related treatment papers by hand of one of their agent Shri Sujoy Som as claimed by the claimant. But there was no official proof of document submission to their office.

They further stated that on enquiry from their TPA M/s Medsave Healthcare (TPA) Ltd., Kolkata they denied any submission of claim

documents relating to the said claim. The concerned agent was called for and in presence of the official of the insurance company the problem would be solved by mutually between the concerned agent and the claimant was discussed but nothing fruitful happened. The insured reported to their Head Office and after that the claimant was advised to submit another set of claim papers to their TPA and the same was complied with by the insured which they have turned down subject to exclusion clause no. 5.3 of the policy.

The insurance company has also given their consent for the Insurance Ombudsman to act as a mediator between the complainant and themselves and give his recommendation for the resolution of the complaint.

DECISION:

Circumstantial evidence points at careless handling. Delay should not be the sole reason for denying the claim in view of the facts of the case. The claim was payable otherwise.

The insurance company is directed to settle the admissible part of the claim on ex-gratia basis. This exercise is to be completed within 15 days from the date of receipt of this award along with consent letter.

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HEALTH INSURANCE CLAIM

Kolkata Ombudsman Centre
Case NO. 363/11/G3/NL/08/2012-13Shri Ram Avtar Jalan
Vs
United India Insurance Co LTd.

Order dated : 14.08.2014
Facts and Submissions:

The complainant, Shri Ram Avtar Jalan has stated in his complaint dated 23.08.2012 that he was suffering from disseminated tuberculosis and for this reason HRCT scan of his chest was conducted on 07.11.2011 at Belle Vue Clinic, Kolkata. As there was not much improvement as per this scan report and after consultation with his family physician who advised to go for PET scan in Kokaliben Dhirubhai Ambani Hospital & Medical Research Institute, Mumbai to get a clear idea whether his treatment is going in the right direction or not. Accordingly, he went to the said hospital and conducted PET Scan (whole body) in the OPD on 29.11.2011 and there has been an all round improvement and was taking medicine as prescribed by Dr. Pawan Agarwal one of the family doctors.

He lodged a claim on 14.01.2012 for Rs.1,39,517/- to the insurance company for reimbursement. The insurance company vide their letter dated 29.02.2012 repudiated the claim stating that "the disease 'cancer' as per medical officers opinion the patient was not hospitalized as an inpatient and as per policy condition the claim is non-admissible under clause no.1.1 of the policy." He represented to the insurance company on 15.03.2012 against repudiation stating that he has not filed any claim

for the disease 'cancer' but have filed the claim for 'T.B' only along with all relevant documents including PET CT Scan dated 29.11.2011 requesting them to review and settle his claim. The insurance company reviewed the claim and informed him on 09.05.2012 that the claim was repudiated on the basis of the patient was not hospitalized as an inpatient, not on the ground of Cancer or T.B which was stated in their previous letter as per policy condition no. 1.1 of the policy. Being aggrieved by the decision of the insurance company, he approached this forum for redressal of his grievance seeking monetary relief of Rs1,39,517/- as per 'P-II' form details. The complainant has given his unconditional and irrevocable consent for the Insurance Ombudsman to act as a mediator between himself and the insurance company and to give recommendation as per Form – P-III dated 25.10.2012.

The insurance company in their written submission dated 30.11.2012 have stated that Shri Ram Avtar Jalan has conducted HRCT Scan of his chest on 07.11.2011 in Belle Vue Clinic. Further as per advice of the family doctors, he went to Mumbai for a PET Scan and for other check up and various tests were done at Kokilaben Dhirubhan Ambani Hospital, Mumbai as an OPD basis and stated that there has been all round improvement and was taking medicine as prescribed by Dr. Pawan Agarwal one of the family doctors. He lodged a claim form along with bill (air tickets which are inclusive of his wife) receipts, guest house accommodation charges without any treatment documents amounting to Rs.1,39,517/- for reimbursement.

They further stated that claim form submitted by the insured reveals that he was admitted in Kokaliben Dhirubhai Ambani Hospital, Mumbai on 29.11.2011 and discharged on 30.11.2011 under the advice

of Dr. V. Uma Shankar, MD of Belle Vue Clinic, Kolkata which appears to be not conformity. Moreover the insured has not submitted any admission advice, discharge summary from which it can be ascertained that he suffered certain disease and for which he to get hospitalized at Kokaliben Dhirubhai Ambani Hospital, Mumbai. Claim form submitted by the insured is also not complete in all respect i.e., what nature of disease/ illness he was suffering from and when disease was first detected, registration no of the doctor etc. are unanswered the reason for which is best known to the insured.

On scrutiny of the claim file the bills submitted by the insured are also found confusing. As per claim form the insured was admitted in Kokaliben Dhirubhai Ambani Hospital, Mumbai on 29.11.2011 and discharged on 30.11.2011. On the contrary he submitted guest house bill dated 29.11.2011 to 30.11.2011 towards room charges for the same period. Apart from he above, no documents have been submitted by the insured to substantiate his claim that he was admitted in the hospital for treatment. All bills, consultation fees are found to be an OPD basis. One of the receipt of OPD bill dated 01.07.2011 that the patient treatment was started from 01.07.2011 and completed on 20.11.2011. If admitted to a hospital, post hospitalization expenses of reimbursement could also be claimed but in this case no post hospitalization expenses were claimed by the insured. They also found from one bill dated 14.07.2011 of Bharat Scan, Chennai that he had done the CT chest & PET whole body on 16.07.2011 and subsequently PET CT whole body on 29.11.2011 in Kokaliben Dhirubhai Ambani Hospital, Mumbai and the insured is claiming his bill from 01.07.2011 i.e., five months back which is also outside the purview of the policy.

Subsequently their TPA M/s Heritage Health TPA Pvt. Ltd. sent the file for repudiation of the claim and accordingly they had also sent a letter of repudiation on 29.02.2012 stating the view of their TPA. They further stated that the actual clause of repudiation will be Clause 2.3 of the policy, wherein it is clearly stated in the policy that expenses on hospitalization for minimum period of 24 hours are admissible and in the instant case there is no proof that the patient was hospitalized as an inpatient. On receipt of the repudiation letter, the insured sent them a representation on 15.03.2012 informing them that he had suffered the disease cancer but have file it for TB and in support of his claim he enclosed a report of PET CT Scan dated 29.11.2011 from which it came to light that he suffers disseminated TB treated with AKT from July 2011 and the insured is claiming that he has claimed for TB is also not conformity with the claim form since the claim form submitted by the insured disease column is left blank. They uphold their decision of repudiation of the claim since various tests were done as an outpatient such as CT chest, whole body scan, HRT Thorax, CT, CD, TB, X-ray, Liver spleen CT Temporal Bone Mastoids, Pulmonary, Gastroenterology, oncology etc. which is not admissible.

The insurance company has also given their consent for the Insurance Ombudsman to act as a mediator between the complainant and themselves and give his recommendation for the resolution of the complaint.

<u>DECISION</u>:

The argument cannot circumvent legal provisions laid down in policy conditions. The Insurer's decision is upheld. The complaint is dismissed without any relief to the complainant. In the result, the complaint is dismissed accordingly.

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SYNOPSIS OF OMBUDSMAN AWARDS FROM 01.04.2014 to 30.09.2014 AGAINST NON LIFE CASES PASSED BY HON'BLE OMBUDSMAN, KOLKATA

HEALTH INSURANCE CLAIM

Kolkata Ombudsman Centre
Case NO. 372/14/G2/NL/08/2012-13
Smt. Kalpana Kanjilal
Vs
National Insurance Co Ltd.

Order dated : 14.08.2014
Facts and Submissions:

The complainant, Smt. Kalpana Kanjilal (Mother of Late Amitava Kanjilal the Insured) stated in her complaint (P form) that she donated her kidney to her son and for the same she was admitted into Rabindranath Tagore International Institute of Cardiac Sciences from 08.01.2010 to 19.01.2010. She lodged the claim to the TPA for her hospitalization expenses for an amount of Rs.84,277/-. Initially it was informed by the TPA that they settled the claim for Rs.55,000/- vide cheque no. 33248 dt. 16.08.2010 but according to the claimant she has not received any cheque and the claim is pending from their end in spite of several reminders. Being aggrieved by the decision of the insurance company she approached this forum for redressal of her grievance .

The insurance company in their written submission dated 30.11.2012 have stated that Smt. Kalpana Kanjilal was covered under Individual Mediclaim Policy for Sum Insured of Rs. 62,500/- (Sum Insured Rs.50,000/- and Cumulative Bonus Rs. 12,500/-). Smt. Kanjilal was kidney donor and for the same she was admitted into the hospital, incurred hospitalization expenses and lodged the claim to the Insurer an

amount of Rs. 84,277/-. According to them, their TPA have settled the claim for Rs. 55,000/- vide cheque no. 33248 dt. 16.08.2010.

DECISION:

Both the parties were advised to check their accounts and confirm the actual position. Having checked their accounts, the representative of the Insurance Company confirmed that the claim cheque amounting to Rs.55,000/- was issued but it was not encashed and became stale. They are ready to pay the claim through NEFT.

Hence, the insurance company is directed to pay the claim for an amount of Rs.55,000/- subject to consent of the complainant. At the same time the complainant is also hereby advised to cooperate with the Insurance Company providing Bank details for payment through NEFT (National Electronic Fund Transfer). This exercise is to be completed within 15 days from the date of receipt of this award along with consent letter.

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SYNOPSIS OF OMBUDSMAN AWARDS FROM 01.04.2014 to 30.09.2014 AGAINST NON LIFE CASES PASSED BY HON'BLE OMBUDSMAN, KOLKATA

HEALTH INSURANCE CLAIM

Kolkata Ombudsman Centre
Case NO. 380/11/G2/NL/09/2012-13
Shri Dilip Jain Vs
National Insurance Co.

Order dated : 14.08.2014
Facts and Submissions:

The complainant, Shri Dilip Jain has stated in his complaints dated 28.04.2012 and 29.08.2012 that he was suffering from burning pain in epigastric region, nausea & vomiting and was admitted in Mangalam Hospital, Jaipur, Rajasthan on 02.06.2010 where he was treated conservatively and was discharged on 04.06.2010. As per discharge summary, the diagnosis of the disease was '*Pulmonary Hypertension with upper G.I. Bleeding'.*

He lodged a claim on 23.06.2010 for Rs.10,965/- to the TPA of the insurance company, M/s Genins India TPA Ltd. for reimbursement. The TPA vide their letter dated 30.06.2010 asked to submit some documents viz. (i) doctor's advice for admission with brief details (ii) previous documents related to detection and treatment of variceal bleeding and (iii) prior all policy copies since inception. In reply he replied to the TPA that he does not have any previous papers. Subsequently the insurance company vide their letter dated 16.05.2011 repudiated the claim stating

that '*as per medical documents you had previous history of variceal bleeding but you states that you never had such ailment. So the claim is closed due to misrepresentation of material fact and treated the claim as 'No Claim'.* He represented to the insurance company on 29.06.2012 against repudiation requesting them to settle his claim. His appeal was not considered by them. Being aggrieved by the decision of the insurance company, he approached this forum for redressal of his grievance.

The insurance company in their written submission dated 18.12.2012 have stated that the insured Shri Dilip Jain was admitted in Mangalam Hospital, Jaipur on 02.06.2010 for follow up treatment of pulmonary 'hypertension with upper G.I. bleeding.' The patient was having past history of Endoscopic Variceal Ligation. The patient subsequently discharged on 04.06.2010. On queries about the past suffering of PHT the claimant initially declined about his suffering stating that he has not got any previous medical documents and it is the first time he is admitting in the hospital and previously he has no problem in medical ground. Their TPA M/s Genins India TPA Ltd. vide their letter dated 02.05.2011 repudiated the claim on the ground of suppression/ misrepresentation of material fact. The insured represented with them for reconsideration of his claim by submitting a prescription of Dr. Verma as consultant before going to take admission in the said nursing home.

They further stated that again and again the insured is suppressing about his surgery of endoscopic variceal ligation in spite of repeated request from their TPA the date of surgery and the present date of admission is just after 3 ½ months from the commencement of the 1st

year policy. As per record of Mangalam Hospital also stated that he was suffering from chronic liver disease, thickened wall portal vein, spleenomegaly etc. Therefore suppression / misrepresentation of material facts the date of first suffering could not be established and the claim was rejected as per exclusion clause no. 5.13 of the policy. The decision taken by their TPA is correct and they have no option but to close the file for misrepresentation of material facts due to hiding his initial suffering related to his claim.

DECISION:

Pre-existence of disease is established. Hence, Insurer's stand in repudiating the claim is justified. The complaint is dismissed without any relief to the complainant.

In the result, the complaint is dismissed accordingly.

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SYNOPSIS OF OMBUDSMAN AWARDS FROM 01.04.2014 to 30.09.2014 AGAINST NON LIFE CASES PASSED BY HON'BLE OMBUDSMAN, KOLKATA

HEALTH INSURANCE CLAIM

Kolkata Ombudsman Centre
Case NO. 383/11/G4/NL/09/2012-13
Shri Amit Poddar
Vs
The Oriental Insurance Co Ltd.

Order dated : 22.08.2014
Facts and Submissions:

The complainant, Shri Amit Poddar has stated in his complaint dated 31.08.2012 that his father Shri Prakash Poddar was suffering from chest pain and was admitted in Shree Vishudhanand Hospital & Research Institute, Kolkata on 28.06.2012 where he was treated conservatively and was discharged on 01.07.2012. As per discharge summary the diagnosis of the disease was '*unstable angina in a case of hypertension'.* Due to chest discomfort again he was admitted in Rabindranath Tagore International Institute of Cardiac Sciences (RTIICS), Kolkata on 01.07.2012 where he underwent PTCA with stenting to proximal LAD on 05.07.2012 and was discharged on 07.07.2012. As per discharge summary the diagnosis of the disease was *'single vessel coronary artery disease, hypertension'.*

At the time of hospitalization cashless facilities were denied by the TPA of the insurance company M/s E-Meditek – (TPA) Services Limited. He lodged two claims on 11.07.2012 for Rs.2,19,845 & Rs.17,660/- respectively to the TPA of the insurance company. The TPA vide their letter dated 18.07.2012 repudiated the claim stating that '*patient is a*

diagnosed case of SVCAD and hypertension. As per copies submitted this is the 2nd year running policy with the OIC, but as per policy exclusion 4.3 there are two years waiting period for hypertension and its related disorders. Hence this claim is recommended for rejection as per exclusion 4.3'. **He represented to the insurance company on 25.07.2012 against repudiation requesting them to reconsider his claim. The insurance company reviewed the claim and informed him vide their letter dated 28.08.2012 that their previous decision of repudiation is in order. Being aggrieved, by the decision of the insurance company, he approached this forum for redressal of his grievance seeking monetary relief of Rs.2,37,514/- plus interest.**

The insurance company in their written submission dated 17.12.2012 have stated that Shri Prakash Poddar the insured was admitted in Vishudanand Hospital, Kolkata for the period from 28.06.2012 to 01.07.2012 and the diagnosis of the disease was unstable angina, hypertension. Again he was admitted at Rabindranath Tagore International Institute of Cardiac Sciences, Kolkata on 01.07.2012 and was discharged on 07.07.2012. The diagnosis of the disease was hypertension single vessel coronary artery disease. He lodged two claims to them
for reimbursement.

They further stated that the date of inception of the policy was 20.04.2011 and the hospitalization occurred within two years of the date of inception of the policy. The hospitalization was pertaining to hypertension which is excluded for the first two years as per exclusion clause no. 4.3 of the policy. Accordingly, the claim was repudiated by their TPA vide their letter dated 18.07.2012. After getting repudiation

letter the insured represented with them on 25.07.2012. They reviewed the claim and informed him on 28.08.2012 that their previous decision of repudiation is in order.

DECISION:

We have heard both the parties on 18.08.2014, considered their written submissions and examined their documents. The Complainant's Mediclaim Policy originally incepted on and from 02.12.2007 and continued till 01.12.2011 without break with National Insurance Co. Ltd. This was not disclosed to the 2nd Insurer Oriental Insurance Co. Ltd., from which, the Complainant took a Family Floater Policy with higher sum insured. The Complainant informed the Insurer that due to white washing in his house, he could not submit the policy copy. However, he has submitted his earlier policies as evidences to this Forum. The Complainant preferred a claim under his Family Floater Policy of Oriental Insurance Co. Ltd., and the claim was repudiated by the Insurer as pre-existing disease of HTN excluded for the first year of inception of policy. This forum is of the opinion that disclosure would not materially affect underwriting decision. On the contrary, the complainant is deprived of No Claim Bonus enjoyed in his earlier policies. Although, portability was not yet in force till 30.6.2011, but the portability was introduced by IRDA to extend the Insured continuity benefits to the ported policy within the validity period of earlier policy. Therefore, the claim to be settled based on the policy coverage.

The Oriental Insurance Co. Ltd. is hereby directed to settle the claim as per Policy Terms & Conditions within 15 days from the receipt of this order along with Consent letter from the Complainant.

In the result, the complaint is allowed accordingly.

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SYNOPSIS OF OMBUDSMAN AWARDS FROM 01.04.2014 to 30.09.2014 AGAINST NON LIFE CASES PASSED BY HON'BLE OMBUDSMAN, KOLKATA

HEALTH INSURANCE CLAIM

Kolkata Ombudsman Centre
Case NO. 392/11/G1/NL/09/2012-13Shri Praveen Rastogi
Vs
The New India Assurance Co LTd

Order dated : 22.08.2014
Facts and Submissions:

The complainant, Shri Praveen Rastogi has stated in his complaints dated 25.07.2012 and 03.09.2012 that his wife Smt. Mamta Rustagi was suffering from appendicitis and was admitted at Divine Nursing Home Pvt. Ltd. on 08.04.2012 where she underwent laparoscopic appendectomy and was discharged on 11.04.2012. As per discharge summary the diagnosis of the disease was '*acute appendicitis'*.

He lodged a claim on 07.06.2012 for Rs.51,769/- to the insurance company for reimbursement. The insurance company settled Rs.41,443/- towards full and final settlement of claim. He represented to the insurance company on 04.07.2012 against partial settlement requesting them to settle his claim. But his representation was turned down. Being aggrieved, by the decision of the insurance company, he approached this forum for redressal of his grievance seeking monetary relief of Rs.10,291/-.

The insurance company in their written submission dated 12.11.2012 have stated that the insured lodged a claim for Rs.35,326/- towards hospitalization claim and Rs.16,443/- towards pre & post

hospitalization claim, out of which their TPA M/s Medicare TPA Services (I) Pvt. Ltd. has sanctioned Rs.25,000/- and deducted Rs.7,265/- because as per PPN package maximum limit for 'acute appendicitis' is Rs.25,000/- for sum insured of Rs.2 lakh and approved full amount of Rs.16,443/- towards pre & post hospitalization expenses.

On miscellaneous head an amount of Rs.3,061/- has been deducted as per terms and conditions of the mediclaim policy 2007. The details are as under :-

Sl. No.	Head	Deducted amount (Rs)
1	DVD-R	200.00
2	Service Charge	1786.00
3	Micropore	96.00
4	Mask	32.00
5	Collection Charges	35.00
6	Gloves	301.00
7	Chest Lead	80.00
8	Dressing	300.00
9	Cap	38.00
10	URO Bag	58.00
11	Microshield charges	95.00
12	Improper medicine bill	200.00
13	Sangofix	140.00
	TOTAL	3061.00

3. <u>HEARING</u> :

Both the parties were heard on 18.08.2014. The complainant pleaded that PPN package rate was not communicated to him by the Insurer at the time of taking the policy. He also pleaded that even after intimating the TPA of the Insurance Company in respect of admission of his wife Mamta Rastogi, the TPA did not inform him about the PPN Package rate. Moreover, he preferred his claim for reimbursement and not availed Cashless facility. Hence, PPN package rate is not applicable and he is entitled for his full amount of claim.

The Insurer pleaded that since the Complainant's wife admitted in Network Hospital, PPN package rates are applicable and their settlement was justified.

DECISION:-

The New India Assurance Co. Ltd. is hereby directed to pay a further amount of Rs.7,265/- towards reimbursement of claim to the complainant within 15 days from the receipt of this award along with the consent form from the complainant.

In the result, the complaint is partly allowed accordingly.

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SYNOPSIS OF OMBUDSMAN AWARDS FROM 01.04.2014 to 30.09.2014 AGAINST NON LIFE CASES PASSED BY HON'BLE OMBUDSMAN, KOLKATA

HEALTH INSURANCE CLAIM

Kolkata Ombudsman Centre
Case NO. 393/11/G16/NL/09/2012-13
Smt. Kasturi Majumdar
Vs
Star Health & Allied Insurance Co. Ltd

Order dated : 22.08.2014
Facts and Submissions

The complainant, Smt. Kasturi Majumdar has stated in her complaints dated 20.07.2012 and 16.08.2012 that she was suffering from shortness of breath and as per advice of Dr. Swayambhu Mukherjee on 19.08.2011 she was admitted in Fortis Hospitals, Kolkata on 28.08.2011 where permanent pacemaker implantation was done on 29.08.2011 and she was discharged on 31.08.2011. As per discharge summary the diagnosis of the disease was '*hypertension complete heart block, minor coronary artery disease'.*

She lodged a claim for Rs.2,09,070/- on 22.10.2011 to the insurance company. The insurance company vide their letter dated 22.11.2011 repudiated the claim stating that '*as your first policy commenced on 28.02.2011, the present complication/disease was present prior to the inception of the policy and therefore the complication of the patient was one of a pre-existing disease. As per exclusion clause no.1 of the policy, the company is not liable to pay any claim pertaining to treatment of pre-existing disease. This fact of the pre-existing disease was not disclosed to us while taking your first*

policy with us on 28.02.2011 which is a violation of policy condition no. 7 of the policy'. **She represented to the insurance company against repudiation on 20.03.2012 requesting them to settle her claim. The insurance company reviewed the claim and informed her vide their letter dated 28.03.2012 that their previous decision of repudiation is in order. Being aggrieved, by the decision of the insurance company, she approached this forum for redressal of her grievance seeking monetary relief of Rs.2 lakh as per 'P-II' form details. The complainant has given her unconditional and irrevocable consent for the Insurance Ombudsman to act as a mediator between herself and the insurance company and to give recommendation as per Form – P-III dated 06.12.2012**

The insurance company in their written submission dated 08.12.2012 have stated that Smt. Kasturi Majumdar was insured under policy no. P/191116/01/01/2011/002917 for the period from 28.02.2011 to 27.02.2012 with a sum insured of Rs.2 lakh. She lodged a claim with them for her admission in Fortis Hospital, Kolkata on 28.08.2011 where she was treated and discharged on 31.08.2011. The final diagnosis of the disease was hypertension/ complete heart block/minor coronary artery disease permanent pacemaker implantation was done on 29.08.2011. As per discharge summary the patient presented with Shortness of breath – class II severity for six months increased to class III severity for last three weeks, she is known case of hypertension – two years. ECG revealed complete CHB, CAG check and PPI was done. The permanent pacemaker implantation report also gives same report. The symptoms present prior to the inception of the policy, the claim is rejected on the ground of pre-existing disease as per exclusion clause no. 1 of the policy and she also failed to disclose the

fact that she had hypertension. Accordingly hey repudiated the claim vide their letter dated 21.11.2012.

DECISION:

We have heard both the parties on 18.8.2014. The Forum has decided that non-disclosure of Shortness of Breath by the Complainant would have attracted different terms & condition under the policy. This could not be developed in a month. As mentioned in the Discharge Summary that the patient is a known case of Hypertension for 2 years which has contributed to her present ailments. Subsequent change of statement of Discharge Summary is an afterthought.

The case has no merit and the Complaint is hereby dismissed.

In the result, the complaint is dismissed accordingly.

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SYNOPSIS OF OMBUDSMAN AWARDS FROM 01.04.2014 to 30.09.2014 AGAINST NON LIFE CASES PASSED BY HON'BLE OMBUDSMAN, KOLKATA

HEALTH INSURANCE CLAIM

Kolkata Ombudsman Centre
Case NO. 403/11/G8/NL/09/2012-13
Shri Amarjeet Singh Vs
Reliance General Insurance Co. Ltd., Kol

Order dated : 22.08.2014
Facts and Submissions:

The complainant, Shri Amarjeet Singh has stated in his complaints dated 28.06.2012 and 28.08.2012 that his wife Smt. Balbir Kaur was suffering from carcinoma in right breast and she was admitted in AMRI Hospitals, Kolkata on 22.04.2011 where she was treated conservatively and ultimately she expired on 27.04.2011. As per death certificate of the hospital, the cause of death was '*cardio respiratory failure in a case of carcinoma right breast complicated by DM, HTN, CKD'.*

He lodged a claim on 25.05.2011 for Rs.1,02,490.04 to the TPA of the insurance company M/s Medi Assist for reimbursement. TPA vide their letters dated 08.07.2011 and 20.08.2011 requested him to submit certain documents for settlement of his claim. Finally TPA vide their letter dated 14.10.2011 repudiated the claim stating that '*as probable etiology of the current ailment aggravated rather complicated by Type 2 DM, IHD, HTN, IHD due to chronicity of ailment and the history of pre-existing disease not disclosed at the time of inception of the policy claim may be repudiated under policy terms and conditions no. 2. Hence we regret our inability to admit the liability under the present policy conditions'.* He represented to the insurance company on 02.11.2011

against repudiation requesting them to settle his claim, but the same was turned down. Being aggrieved by the decision of the insurance company, he approached this forum for redressal of his grievance seeking monetary relief of Rs.1,20,306/- as per 'P-II' form details.

The insurance company in their written submission dated 11.01.2013 have stated that Shri Amarjeet Singh had lodged a claim for the treatment of his wife Smt. Balbir Kaur. As per death certificate issued by AMRI Hospitals, other significant conditions contributing to the death but not relating to the disease or condition causing it – MD, HTN, CKD were pre-existing in nature and not but were not disclosed in the proposal form at the time of taking the policy.

They further stated that the insured was covered under Reliance Healthwise Policy with effect from 24.04.2007 and admitted at Mohan Clinic on 26.10.2007 with complication of pneumonia and on verification of treatment sheet of respective hospital it was evident that patient had a history of diabetic nephropathy with particular drug dependency and under restricted diet which could not have developed within 6 months of inception of policy. Hence pre-existing in nature and as a result claim denied vide their TPA's letter dated 14.10.2011 on the ground of non-disclosure of facts at the time of inception of the policy.

<u>DECISION</u>:

We have heard both the parties on 18.08.2014, considered their written submissions and examined the documents. This Forum has decided that Pre-existence of DM in not proved. On the contrary, from the Case history sheet of Mohon Clinic dated 26.10.2007, specified that the patient Balbir Kaur was non-diabetic and therefore, pre-existence of

diabetes before the inception of policy in the year 2007 does not stand good. Therefore, the Insurer must settle the claim as per policy terms & conditions.

Hence, Reliance General Insurance Co. Ltd. is hereby directed to settle the claim as per policy terms & condition within 15 days from the receipt of this award along with the consent letter from the complainant.

In the result, the complaint is allowed accordingly.

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SYNOPSIS OF OMBUDSMAN AWARDS FROM 01.04.2014 to 30.09.2014 AGAINST NON LIFE CASES PASSED BY HON'BLE OMBUDSMAN, KOLKATA

HEALTH INSURANCE CLAIM

Kolkata Ombudsman Centre
Case NO. 407/11/G2/NL/09/2012-13
Shri Prag Das Damani
Vs
National Insurance Company Ltd
Order dated : 22.08.2014
Facts and Submissions:

The complainant, Shri Prag Das Damani has stated in his complaints dated 23.07.2012 and 12.09.2012 that he was suffering from carcinoma Glottis at B/L Neck and as per advice of the doctor he was admitted in Apollo Gleneagles Hospitals, Kolkata on 15.06.2011 where he underwent Microlaryngoscopy and was discharged on the same day. As per discharge summary the diagnosis of the disease was '*Left vocal cord polyp with right vocal cord polyp'*. Again he was admitted in the same hospital on 13.07.2011 where he underwent Radiotherapy and was

discharged on 01.09.2011. As per discharge summary the diagnosis of the disease was '*carcinoma glottis'*.

He lodged a claim for Rs.2,22,400/- to the TPA of the insurance company M/s E-Meditek (TPA) Services Ltd. Out of which at the time of second hospitalization the TPA of the insurance company settled Rs.95,000/- on cashless basis and Rs.74,500/- on 06.08.2012 towards full and final settlement of the claim. He represented to the insurance company on 12.09.2012 against partial settlement requesting them to settle his balance claim of Rs.52,900/-. But he did not get any favourable reply. Being aggrieved by the decision of the insurance company, he approached this forum for redressal of his grievance, seeking monetary relief of Rs..52,900/- , as per 'P-II' form details.

The insurance company in their written submission dated 14.12.2013 have stated that Shri Prag Das Damani was admitted in 'Apollo Gleneagles Hospitals, Kolkata on 13.07.2011 with the disease of carcinoma glottis at B/L Neck and was discharged on 01.09.2011 under cashless treatment benefit with the TPA. Their TPA M/s E-Meditek (TPA) Services Ltd. had directly paid Rs.1,69,500/- to the hospital for cashless benefit.

They further stated that there is an amount is still pending with their TPA which is causing a dispute with the claimant. They further stated that they may go for further payment for the redressal of complaint of the insured subject to authentication of documents.

DECISION:

We have heard both the parties on 18.8.2014, considered their written submissions and examined the documents. This Forum has decided the claim settlement was not proper by the TPA of the Insurer which did not explain to the Complainant the details of deductions. The confusion of Insurer and their pleading helplessness vis-a-vis the TPA is not acceptable. This Forum has found the Complainant's grievance and claim justified. Insurer has to pay the claim with interest @2% over and above the prevailing bank rate from the date of last settlement.

National Insurance Company Ltd. is hereby directed to pay Rs.52,900/- (Rupees Fifty-two thousand nine hundred only) subject to deduction of non-medical items if any and, as per IRDA Guidelines along with interest @2% over and above the prevailing bank rate from the date of last settlement of claim, within 15 days from the date of receipt of this award along with the consent letter of the Complainant.

In the result, the complaint is allowed accordingly.

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SYNOPSIS OF OMBUDSMAN AWARDS FROM 01.04.2014 to 30.09.2014 AGAINST NON LIFE CASES PASSED BY HON'BLE OMBUDSMAN, KOLKATA

HEALTH INSURANCE CLAIM

Kolkata Ombudsman Centre
Case NO. 406/11/G1/NL/09/2012-13
Shri Mrinal Kanti Ghosh Vs
The New India Assurance Company Ltd

Order dated : 10.09.2014
Facts and Submissions:

The complainant, Shri Mrinal Kanti Ghosh has stated in his complaints dated 15.06.2012, 29.07.2012 and 12.09.2012 that he was suffering from heart problem and on 12.04.2012 he felt down due to black out and was admitted in Divine Nursing Home Pvt. Ltd. Kolkata on the same day where pacemaker was implanted and underwent operation in his fingers of his right leg due to injury suffered at the time of blackout incident. As per discharge summary the diagnosis of the disease was '*complete heart block (PPM-DDDR Implanted)*'

At the time of hospitalization TPA of the insurance company M/s Medicare TPA Services (I) Pvt. Ltd. approved Rs.46,000/- on cashless basis. Subsequently he lodged a claim for Rs.45,856/- and enclosed a receipt copy for purchase of pacemaker for Rs.1.86 lakh for reimbursement. TPA vide their letter dated 15.06.2012 settled Rs.4,663/- towards full and final settlement of the claim. He represented to the insurance company on 22.05.2012 against partial settlement requesting them to settle his balance claim. But his representation did not yield any result. Being aggrieved, by the decision of the insurance company, he approached this forum for redressal of his grievance seeking monetary relief of Rs.50,663/- as per 'P-II' form details.

The insurance company in their written submission dated 04.01.2013 have stated that the insured Shri Mrinal Kanti Ghosh had lodged a hospitalization claim of Rs.91,356/- After processing the claim the total admissible amount comes to Rs.50,063/- out of which

Rs.45,400/- was paid to the hospital and Rs.4,663/- to the insured disallowing Rs.41,293/- as reason mentioned below :-

Room charges for Rs.10,000/- deducted as per clause 2.1 of the mediclaim policy (2007). As per clause 2.0 (Note 1) of Mediclaim Policy (2007) if the insured opts for a room with rent higher than the entitled category all other expenses shall be limited to the charges applicable to the entitled category.

Therefore, Rs.14,177/- is paid proportionately against doctor/ surgeon/ anesthetist/ assistant charges of Rs.31,900/- deducting Rs.17,723/-, Rs.2,800/- is paid proportionately against operation theatre charge of Rs.6,300/- deducting Rs.3,500/-, Rs.2,702/- is paid proportionately against investigation charge of Rs.6,080/- deducting Rs.3,378/-. Rs.600/- towards investigation charges are disallowed as the supporting reports have not been submitted. Service charge for Rs.5,696/- disallowed as per clause 4.4.22 of the policy. Other non-medical expenses like Mask Rs.112/-, dynaplast Rs.55/-, chest lead Rs.96/- and cap Rs.133/- disallowed as per clause 4.4.21 of the policy.

In addition to the above, the insured had lodged post hospitalization claim towards Aya charge amounting to Rs.500/-, which has been adjudicated as inadmissible expenses as per clause 4.4.21 of the policy.

In view of the above, their TPA has rightly settled the claim and they are in agreement with their views.

DECISION: We have heard both the parties, considered their written submissions and examined the documents submitted to this forum. It is

seen that the TPA of the insurance company has arbitrarily applied proportionate charges in accordance with the room rent for doctor's fee, investigation charges and other charges without verifying the fact that whether variable charges exists in the said hospital or not. Insurer was given time limit up to 22.8.2014 to confirm whether the variable charges exist or not in the said hospital failing which, the Complainant will be awarded for the balance amount of his claim without application of proportionate charges in accordance with the room rent. This Forum has also observed that the TPA did not take into calculation the cost of Pacemaker as the Complainant did not submit the original money receipt to them. In absence of the original money receipt of the Pace Maker purchased, the TPA has disallowed the same which is found justified. .

Since, the Insurer has failed to confirm this forum about the existence of variable charges in accordance with the room rent in the said Nursing Home within 22.8.2014; this forum has presumed that there is no existence of variable charges in accordance with the room rent and overruled the calculation of claim on proportionate basis in accordance with the room rent.

However, Complainant's total claim is now computed as under:-

Total Claim as per TPA	**...**	**Rs. 91,356.00**
Less: Non-admissible	**...**	**Rs. 17,192.00**
Total Valid Claim	**...**	**Rs 74,164.00**
Less: Claim paid	**...**	**Rs. 50,663.00**
Further payable	**...**	**Rs. 23,501.00**

After careful evaluation of all the facts and circumstances of the case, we are of the opinion that a further amount of Rs.23,501/- is payable to the complainant. The insurer Ltd. is directed to pay a further amount of Rs.23,501/- (Rupees Twenty-three thousand five hundred one only) to the complainant within 15 days from the date of receipt of this award along with the consent letter from the Complainant under information to this Forum.

The complaint is partly allowed accordingly.

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SYNOPSIS OF OMBUDSMAN AWARDS FROM 01.04.2014 to 30.09.2014 AGAINST NON LIFE CASES PASSED BY HON'BLE OMBUDSMAN, KOLKATA

HEALTH INSURANCE CLAIM

Kolkata Ombudsman Centre
Case NO. 408/11/G1/NL/09/2012-13

Mr. Golam Ziauddin
Vs
The New India Assurance Company Ltd

Order dated : 02.09.2014
Facts and Submissions:

The complainant, Mr. Golam Ziauddin has stated in his complaint dated 14.09.2012 that his father Mr. Golam Tohiuddin was suffering from hypertension and Ischemic Heart disease and was admitted in Burdwan Critical Care Unit Pvt. Ltd., Burdwan on 09.02.2012 where he

was treated conservatively and was discharged on 13.02.2012. As per discharge summary the diagnosis of the disease was 'recurrent transient ischemic attack with AR and single atrium'.

He lodged a claim on 01.03.2012 for Rs.18,027/- to the TPA of the insurance company M/s Medicare TPA Services (I) Pvt. Ltd. The TPA vide their letter dated 17.07.2012 repudiated the claim stating that 'patient is known diabetic and ischemic heart disease had history of shortness of breath for last 4-5 years and was under treatment. Member is covered under the policy since 20.03.2009. The member is presently admitted for transient ischemia attacks managed conservatively. Since the disease is pre-existing and prior to policy inception, hence present claim merits repudiation as per policy exclusion clause no. 4.1 of the N.I.A policy. He represented to the insurance company on 23.07.2012 against repudiation requesting them to settle his claim. But his representation did not yield any result. Being aggrieved, by the decision of the insurance company, he approached this forum for redressal of his grievance seeking monetary relief of Rs.18,027/- as per 'P-II' form details

The insurance company in their written submission dated 05.11.2012 have stated that the insured Mr. Golam Tohiuddin was admitted in Burdwan Critical Unit Pvt. Ltd. on 09.02.2012 and was discharged on 13.02.2012. He lodged a claim to the TPA of the insurance company M/s Medicare TPA Services (I) Pvt. Ltd. for the treatment of the disease of recurrent transient ischemic attack with AR and single arium. TPA vide their letter dated 17.03.2012 requesting the claimant to submit doctor's certificate regarding the period from the he was suffering from hypertension and ischemic heart disease. In response

TPA got a certificate of Dr. Anirban Mitra dated 23.04.2012 from the claimant wherein it was stated that the claimant is a patient of hypertension and ischemic heart disease since 2010.

They further stated that as per request of the TPA an investigation was conducted through their investigator. The report of the investigator and insured/ patient self declaration was self-explanatory. However, on scrutiny of the prescription of Dr. Santanu Ghosh dated 29.12.2011, it was found that the claimant was a patient of above mentioned problem/ disease for more than 4 to 5 years which is prior to inception of he policy i.e., 20.03.2009. After receiving the aforesaid documents including the report of investigation, prescriptions of doctors and medical reports, the said TPA being the claim adjudicating authority and doctor's panel passed an opinion that the said disease in question is pre-existing prior to policy inception. Hence, the said claim was repudiated as the same was not payable under the aforesaid mediclaim policy as per exclusion clause no. 4.1 of the policy. TPA vide their letter dated 17.07.2012 repudiated the claim and informed the insured accordingly.

DECISION:

We have heard both the parties, considered their written submissions and examined the documents submitted to this forum. It is seen that the claim was lodged in third year of the policy period. Period of pre-existence i.e., the basis of repudiation is not conclusively proved.

After careful evaluation of all the facts and circumstances of the case we are of the opinion that the decision of the insurance company to repudiate the claim is not beyond doubt and the same is set aside. The insurer is directed to settle the claim on ex-gratia basis within 15

(fifteen) days from the date of receipt of this award along with consent letter from the complainant.

The complaint is allowed accordingly.

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SYNOPSIS OF OMBUDSMAN AWARDS FROM 01.04.2014 to 30.09.2014 AGAINST NON LIFE CASES PASSED BY HON'BLE OMBUDSMAN, KOLKATA

HEALTH INSURANCE CLAIM

Kolkata Ombudsman Centre
Case NO. 409/11/G1/NL/09/2012-13

Shri Biswanath Mukhopadhyay Vs
The New India Assurance Company Ltd

Order dated : 12.09.2014
Facts and Submissions:

The complainant, Shri Biswanath Mukhopadhyay has stated in his complaint dated 13.09.2012 that he was suffering from pyogenic granuloma of right temporal region of scalp and was admitted in Saviour Clinic Private Limited, Kolkata on 22.05.2012 where he underwent surgery of pyogenic granuloma and was discharged on 23.05.2012. As per discharge summary the diagnosis of the disease was '*pyogenic granuloma of right temporal region of scalp'*.

He lodged a claim on 11.07.2012 for Rs.15,617.72 to the TPA of the insurance company M/s Heritage Health TPA Pvt. Ltd. for

reimbursement. The TPA vide their letter dated 19.07.2012 repudiated the claim stating that '*the patient was admitted for less than 24 hours hospitalization for excision biopsy of pyogenic granuloma of scalp. As per terms and conditions of this policy this claim is non-admissible under clause no. 3.4 of the policy.* He represented to the insurance company on 31.07.2012 against repudiation requesting them to condone for condone the gap of ten minutes of his hospital stay and settle his claim. The insurance company reviewed the claim and informed him vide their letter dated 28.08.2012 that their previous decision of repudiation is in order. Being aggrieved, by the decision of the insurance company, he approached this forum for redressal of his grievance seeking monetary relief of Rs.15,617.72 as per 'P-II' form details.

The insurance company in their written submission dated 20.11.2012 that the insured Shri Biswanath Mukhopadhyay preferred a claim to their TPA on 11.07.2012 along with claim documents for excision biopsy under general anesthesia. As per discharge summary of Saviour Clinic Pvt. Ltd. the insured was admitted to the clinic for the treatment and the duration of his hospital say was only 23 hrs. 50 minutes. TPA repudiated the claim on 19.07.2012 with the remarks "the patient was admitted for less than 24 hours hospitalization for excision biopsy of pyogenic granuloma of scalp. As per terms and conditions of the policy and the claim is non-admissible under clause 3.4".

They further stated that Shri Mukhopadhyay made an appeal on 31.07.2012 for condone the gap of ten minutes of his hospital stay. They sent the entire file to their higher authority for their valued advice in connection with the above claim. On 16.08.2012 the file was returned by their higher authority with the observation that repudiation of the said claim stands as per TPA. The insured was informed again vide their

letter dated 28.08.2012 that the claim is non-admissible under clause 3.4 of mediclaim policy (2007) .

DECISION

We have heard both the parties, considered their written submissions and examined the documents submitted to this forum. The complainant has approached this forum for repudiation of his mediclaim.

After careful evaluation of all the facts and circumstances of the case we are of the opinion that the decision of the insurance company to repudiate the claim is based on explicit policy terms and conditions. No relief is possible for the complainant.

The complaint is dismissed accordingly.

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SYNOPSIS OF OMBUDSMAN AWARDS FROM 01.04.2014 to 30.09.2014 AGAINST NON LIFE CASES PASSED BY HON'BLE OMBUDSMAN, KOLKATA

HEALTH INSURANCE CLAIM

Kolkata Ombudsman Centre
Case NO. 410/11/G4/NL/09/2012-13

Shri Devabrata Seth
Vs
The Oriental Insurance Company Ltd.,
Order dated : 12.09.2014
Facts and Submissions:

The complainant, Shri Devabrata Seth has stated in his complaint dated 12.09.2012 that his wife Smt. Tripti Seth was suffering from eye problem for several years and was admitted in Sankara Nethralaya, Kolkata on 21.11.2011 where 1st dose of intravitreal injection Lucentis was administered in her left eye and was discharged on 22.11.2011. Again she was admitted in the same hospital on 19.12.2011 & 25.01.2012 where 2nd and 3rd dose of intra-vitreal injection Lucentis was administered in her left eye and she was discharged on the same day. As per discharge summary of the three discharge summary the diagnosis of the disease was '*Choroidal Neovascular Membrane'.*

He lodged three claims on 25.11.2011, 21.12.2011 & 30.01.2012 for Rs.59,626/-, 43,593/- & Rs.32,448/- respectively to the TPA of the insurance company M/s Vipul Medcorp TPA Private Limited for reimbursement. The insurance company vide their letter dated 17.07.2012 repudiated the claim stating that '*the patient was treated for Choroidal Neo Vascular Membrane in left eye through intravitreal injection lucentis. Such treatments are OPD treatment and do not require hospitalization though the injection was given in the O.T. In view of the nature of treatment, it falls outside the scope of the health policy and is not admissible under the policy clause no. 2.3 of the mediclaim'.* He represented to the insurance company on 30.07.2012 against repudiation requesting them to reconsider his claim. The insurance company reviewed the claim and informed him vide their letter dated 30.08.2012 that their previous decision of repudiation is in order. Being aggrieved, by the decision of the insurance company, he approached this forum for redressal of his grievance seeking monetary relief of Rs.1,35,667/-.

The insurance company in their written submission dated 06.11.2012 have stated that the complainant lodged a claim to their TPA

M/s Vipul Medcorp TPA Private Limited. The said claim was repudiated by their TPA with an opinion that the patient has been treated for '*choroidal neo vascular membrane in left eye* '. As per case study by the doctor's of their TPA they observed that the patient has undergone treatment in her left eye through intravitreal injection lucentis. Such treatment are OPD treatment and do not require hospitalization. In view of the above, the claim merits repudiation under exclusion clause no. 2.3 of the policy condition and hence the claim under the above policy is not admissible.

We have heard both the parties, considered their written submissions and examined the documents submitted to this forum. The complainant has approached this forum against repudiation of his medical claim. It is seen that the ARMD is not specifically excluded by any policy condition and also because the injection Lucentis needs to be administered in the sterile environment of an operation theatre on multiple occasions, repudiation of the claim is not justified.

After careful evaluation of all the facts and circumstances of the case we are of the opinion that the decision of the insurance company to repudiate the claim is not justified and the same is set aside. The insurer is directed to settle the claim in full after deducting non-medical items if any, as per terms and conditions of the policy within 15 days from the date of receipt of this award along with consent letter from the complainant under intimation to this Forum.The complaint is allowed accordingly.

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SYNOPSIS OF OMBUDSMAN AWARDS FROM 01.04.2014 to 30.09.2014 AGAINST NON LIFE CASES PASSED BY HON'BLE OMBUDSMAN, KOLKATA

HEALTH INSURANCE CLAIM

Kolkata Ombudsman Centre
Case NO. 412/11/G8/NL/09/2012-13
Smt. Gunjan Beria
Vs
Reliance General Insurance Company Ltd

Order dated : 12.09.2014
Facts and Submissions:

The complainant, Smt. Gunjan Beria has stated in her complaint dated 07.09.2012 that due to fall in the bathroom on 10.04.2012 following which she sustained trauma of left ankle joint and was unable to stand up or walk with support on left leg. As per advice of Dr. Ashoke Kumar Das she was admitted in The Calcutta Medical Research Institute, Kolkata on 11.04.2012 where she underwent an operation on 18.04.2012 and was discharged on 24.04.2012. As per discharge summary the diagnosis of the disease was '*Bimalleolar fracture (left ankle)'.*

At the time of hospitalization request for cashless treatment was denied by the TPA of the insurance company M/s Medi Assist India TPA Pvt. Ltd. Subsequently she lodged a claim for Rs.1,88,036/- to the TPA of the insurance company for reimbursement. The TPA vide their letter dated 11.06.2012 & 23.07.2012 requested her to submit certain documents and the same was submitted on 07.08.2012 and requested

them to settle her claim. But her claim was not settled by the insurance company. Being aggrieved, she approached this forum for redressal of her grievance seeking monetary relief of Rs.1,88,036/- as per 'P-II' form details. The complainant has given her unconditional and irrevocable consent for the Insurance Ombudsman to act as a mediator between herself and the insurance company and to give recommendation as per Form – P-III dated 25.10.2012. However, after lodging complaint with this forum she further informed this forum vide her letter dated 04.12.2012 the insurance company settled her claim for Rs.71,089/- out of her claim amount or Rs.1,88,036/- but she did not accept the said amount.

The insurance company in their written submission dated 11.01.2013 have stated that the insured Smt. Gunjan Beria lodged a claim with their TPA M/s Medi Assist India TPA Pvt. Ltd. The claim was settled by them for Rs.71,089/-under contribution clause of the policy, being their share out payable amount of Rs.1,35,715/- of the claim. The sum insured was Rs.2,20,000/- (contribution clause – 14 under terms and conditions of the policy wordings).

They further stated that the insured was also covered under another mediclaim coverage vide policy no. 251100/46/11/8500001344 (TPA- E-Meditek ID No. 10102120018226A) for the period from 21.02.2012 to 20.02.2012 with a sum insured of Rs.2 lakh. Therefore, on this account, on the principle of their contribution came upto Rs.71,089/- and the claim was settled on that amount.

DECISION:

We have heard both the parties, considered their written submissions and examined the documents submitted to this forum. The complainant has approached this forum for repudiation of her mediclaim.

It is seen that the delay in settlement and non-communication of full facts to the complainant has effectively blocked any chances for claiming the balance from the second insurer. The responsibility lies with the TPA who was aware of the existence of the second policy by virtue of being the common TPA for both the Insurer.

After careful evaluation of all the facts and circumstances of the case we are of the opinion that it is the TPA's unwillingness to be of any assistance to the client that has created the impasse. The Insurer is directed to settle the entire claim and recover the balance amount from the errant TPA within 15 days from the date of receipt of this award along with consent letter from the complainant under intimation to this Forum. However, they may deduct the non-medical expenses if any, from the settled amount.

The complaint is allowed accordingly.

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SYNOPSIS OF OMBUDSMAN AWARDS FROM 01.04.2014 to 30.09.2014 AGAINST NON LIFE CASES PASSED BY HON'BLE OMBUDSMAN, KOLKATA

HEALTH INSURANCE CLAIM

Kolkata Ombudsman Centre
Case NO. KOL-G-051-1314-0803
Shri Ram Avtar Jalan
Vs
Reliance General Insurance Company Ltd

Order dated : 25.09.2014
Facts and Submissions:

The complainant, Shri Ram Avtar Jalan has stated in his complaint dated 17.05.2013, 17.06.2013 and 21.08.2013 that he was suffering from multi centric tuberculosis, on AKT and was admitted in Kokilaben Dhirubhai Ambani Hospital & Research Institute Hospital, Mumbai where he was treated along with related tests/ scans like PET CT etc. on OPD basis in July 2012, October, 2012, December 2012 and February 2013 without any hospitalization and subsequently hospitalized on 25.02.2013 and was discharged on 28.02.2013.

He lodged a claim on 02.03.2013 for Rs.35,000/- in connection with above hospitalization along with all relevant documents to the TPA of the insurance company M/s Heritage Health Services Pvt. Ltd. for reimbursement. The insurance company vide their letter dated 29.04.2013 repudiated the claim stating that patient taken investigation in OPD. As per policy terms and conditions under clause no. 4.10 this OPD claim non-admissible. He represented to the insurance company on 17.06.2013 against repudiation requesting them to review and settle his claim. The insurance company reviewed the claim and informed him vide

their letter dated 04.07.2013 that their previous decision of repudiation is in order. Being aggrieved by the decision of the insurance company, he approached this forum for redressal of his grievance seeking monetary relief of Rs.35,000/- as per Annexure –VIA details.

The insurance company in their written submission dated 19.12.2013 have stated that Shri Ram Avtar Jalan was admitted in Kokilaben Dhirubhan Ambani Hospital, Mumbai on 25.02.2013 and was discharged on 28.02.2013. However in the claim form it was observed that no supporting document such as discharge certificate had been submitted by the insured claiming amount to Rs.35,000/-. It was observed one of the report of PET-CT-SCAN dated 25.02.2013 of the above hospital referred by Dr. S.P.Rai that the said scan was done on 25.02.2013 and subsequently observed in another prescription from the said hospital prescribed by the said doctor on 26.02.2013 that the patient was referred from Kolkata for Miliancy Lesions in lung consolidation LLL, loculated Pleural Effusion left and multiple lesions in gluteal and sacral area. In the said medical certificate further reveals that the claimant was checked by PET CT on OPD basis in July 2012, October 2012, December 2012 and February 2013 along with related tests and scans without any hospitalization.

However on 05.03.2013 a letter communicated to their TPA M/s Heritage Health TPA Pvt. Ltd. by the claimant wherein he had stated that his nature of treatment does not require hospitalization as per treatment certificate issued by Dr. S.P.Rai of the above hospital. The claimant has further stated that the money receipt no. 4032 of Mandke Foundation for his stay is meant for patient who does not require admittance. Accordingly their TPA repudiated the claim vide their letter dated 29.04.2013 on the ground that the patient has taken investigation on

OPD basis which is not admissible as per exclusion clause no. 4.10 of the policy. Thereafter he represented with them against repudiation requesting them to review and settle his claim. However, they have reviewed the claim and informed him vide their letter dated 04.07.2013 that their previous decision of repudiation is in order.

DECISION:

Similar complaint lodged by the same complainant was dismissed by this forum (Vide Award No. IO/KOL/A/G1/0001/2014-2015). Accordingly, the insurer's decision to repudiate the claim under condition no. 2.3 and exclusion clause no. 4.10 of the policy is correct and the same is upheld without the need of hearing. The complaint is dismissed without any relief to he complainant.

The complaint is dismissed accordingly.

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SYNOPSIS OF OMBUDSMAN AWARDS FROM 01.04.2014 to 30.09.2014 AGAINST NON LIFE CASES PASSED BY HON'BLE OMBUDSMAN, KOLKATA

HEALTH INSURANCE CLAIM

Kolkata Ombudsman Centre
Case NO. 150/14/G11//NL/05/2013-14

Shri Sujit Rajak
Vs
ICICI Lombard General Insurance Co Ltd.,
Order dated : 02.09.2014
Facts and Submissions:

The complainant, Shri Sujit Rajak has stated in his complaints dated 11.04.2013 and 18.05.2013 that he was suffering from severe headache and neck pain for last two days along with anxiety and uneasiness for last one month therefore he was admitted in The Mission Hospital, Durgapur, Burdwan on 14.01.2012 where relevant investigations along with CT scan of brain and echocardiography were done and was treated conservatively. He was discharged on 16.01.2013. As per discharge summary the diagnosis of the disease was '*anxiety neurosis, hypertension'.*

At the time of hospitalization cashless facilities were denied by the insurance company vide their letter dated 16.01.2013. Subsequently, he lodged a claim along with all relevant documents in connection with the above hospitalization to the insurance company for reimbursement. But after a lapse of considerable period his claim was not settled. He represented to the insurance company through e-mail on 16.04.2013 stating that he was admitted in mission hospital Durgapur on 14.01.2013 with anxiety neurosis and hypertension and they had approved a cash amount of Rs.30,000/- on that very day but thereafter

they had rejected the claim on his discharge date i.e., 16.01.2013. He requested them to provide a written explanation why it was done so. But his representation was turned down. Being aggrieved, by the decision of the insurance company, he approached this forum for redressal of his grievance without mentioning any quantum of relied as per 'P-II' form details.

The insurance company in their written submission dated 17.09.2013 have stated that Shri Sujit Rajak, the complainant had taken a health insurance policy for the period from 12.04.2011 to 11.04.2013. The policy was issued to the complainant on the basis of information provided by the complainant with no declaration of pre-existing disease. They have received authorization request from the Mission Hospital for admission of the complainant on 14.01.2013. Accordingly query letter was issued to the hospital for submission of documents. However, on receipt of the documents they observed that the insured has diagnosed as the case of Anxiety Neurosis and he is under the treatment of anxiety neurosis.

They further stated that the treatment of 'anxiety neurosis' is a type of common psychiatric disorder, while all treatment of mental illness, stress, psychiatric disorder is excluded in clause 3.4 (xii) of the policy terms and conditions as the permanent exclusion. The complainant request for pre-authorization is rejected and the same was informed to the complainant vide their pre-authorization denial letter has been sent to the complainant. In view of the above the claim is not payable.

DECISION:

We have heard both the parties, considered their written submissions and examined the documents submitted to this forum. It is

seen that the Discharge summary shows that the complainant was admitted to Mission Hospital, Durgapur but no psychiatric medicine was prescribed to him during the three days of treatment except Alparax .5 mg, which is a sedative. The Insurer seems to have repudiated the claim in a mechanical way without proper application of mind.

After careful evaluation of all the facts and circumstances of the case we are of the opinion that the decision of the insurance company to repudiate the claim is not justified and the same is set aside. The insurer is directed to settle the claim as per terms and conditions of the policy within 15 days from the date of receipt of this award along with consent letter from the complainant under intimation to this Forum.

The complaint is allowed accordingly.

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SYNOPSIS OF OMBUDSMAN AWARDS FROM 01.04.2014 to 30.09.2014 AGAINST NON LIFE CASES PASSED BY HON'BLE OMBUDSMAN, KOLKATA

HEALTH INSURANCE CLAIM

Kolkata Ombudsman Centre
Case NO. 163/11/G1/NL/05/2013-14

Shri Rajib Ghosal
Vs
The New India Assurance Company Ltd.,
Order dated : 02.09.2014
Facts and Submissions:

The complainant, Shri Rajib Ghosal has stated in his complaint dated 23.05.2013 that his mother Smt. Sumita Ghosal was suffering from chest pain associated with nausea & sweating and was admitted in Vivekananda Hospital Private Limited, Durgapur, Burdwan on 28.09.2012 where he was treated conservatively and was discharged on the same day to enable her to move to other hospital for better management. She was admitted in the Mission Hospital, Durgapur on the same day i.e., 28.09.2012 where she underwent PTCA + Stent to RCA (culprit vessel) with VISION 3.0 x 28 mm and was discharged on 03.10.2012. As per discharge summary the diagnosis of the disease was '*CAD – ACS, CAG (28.09.12) - Triple vessel disease, PTCA + Stent to RCA (Vision 3.5 x 28 mm) 28.09.12, Moderate LV dysfunction, Hypertension'.*

At the time of hospitalisation cashless facilities were denied by the TPA of the insurance company M/s Heritage Health TPA Pvt. Ltd. on the ground of pre-existence as laid down in clause no. 4.3 of the policy. Subsequently, he lodged a claim on 31.10.2012 for Rs.1,75,890/- along with all relevant documents to the TPA of the insurance company in connection with the above hospitalisation for reimbursement. The TPA vide their letter dated 04.05.2013 repudiated the claim stating that '*looking at the policy inception date is 08.01.2011. Nature of the disease (Triple Vessel Coronary Artery Disease) with HTN, Hypertension is a direct risk factor for coronary artery disease (Triple Vessel Coronary Artery Disease). As per clause no. 4.3 (ailments pre-existing to hypertension are locked for 2 years), this claim is non-admissible.'* Being aggrieved, by the decision of the insurance company, he approached this

forum for redressal of his grievance seeking monetary relief of Rs.1.05 lakh as per 'P-II' form details

The insurance company in their written submission dated 18.07.2013 have stated that the policy had commenced from 08.01.2011. The complainant lodged a claim in connection with treatment of his mother in Vivekananda Hospital Private Limited, Durgapur, Burdwan and Mission Hospital, Durgapur, for the period from 28.09.2012 to 03.10.2012. The nature of disease was Triple Vessel Coronary Artery disease with hypertension. As per doctor's report hypertension was pre-existing for past 5 years. Hypertension is a direct risk factor for such a disease. As per clause no. 4.3 ailments pre-existing to hypertension are locked for 2 years. As such this claim is not payable. As per clause no. 4.1 pre-existing diseases are not covered since hypertension was a pre-existing one and the claim is not admissible. Hypertension is a causative factor for ACS.

They further stated that their TPA M/s Heritage Health TPA Pvt. Ltd. reviewed the claim and has finally repudiated the claim

DECISION:

We have heard both the parties, considered their written submissions and examined the documents submitted to this forum. It is seen that Hypertension has a clear waiting period for two years – hence the dispute regarding pre-existence by 5 years or 5 months is immaterial.

After careful evaluation of all the facts and circumstances of the case we are of the opinion that the decision of the insurance company to repudiate the claim is justified and the same is upheld without any relief to the complainant.

The complaint is dismissed accordingly.

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SYNOPSIS OF OMBUDSMAN AWARDS FROM 01.04.2014 to 30.09.2014 AGAINST NON LIFE CASES PASSED BY HON'BLE OMBUDSMAN, KOLKATA

HEALTH INSURANCE CLAIM

Kolkata Ombudsman Centre
Case NO. 217/11/G11/NL/06/2013-14

Shri Avijit Das Vs
ICICI Lombard General Insurance Co Ltd.,
Order dated : 02.09.2014
Facts and Submissions:

The complainant, Shri Avijit Das has stated in his complaint dated 17.06.2013 that his motor cycle Hero Honda Splendor (NXG) bearing registration number WB-40-U-9936 was covered under policy No. 3005/10858788/11142/000 for the period from 29.07.2011 to

28.07.2012 with an IDV of Rs.42,220/-. On 05.08.2011 at about 7.30 P.M under locked condition the said motor cycle was stolen from the front of his house and accordingly he lodged a complaint to the Coke Oven Police Station, Durgapur, Burdwan on 06.08.2011 which was duly received by the concerned police station. Thereafter the investigating officer of the said police station treated this complaint as an F.I.R on 11.08.2011 and a case was registered under Coke Oven Police Station vide F.I.R No. 84/11 dated 11.08.2011. The police authority started investigation and searching of the said motor cycle but found no result and finally submitted final report before the Court of ACJM, Durgapur which has been accepted by the Court.

He intimated the incident to the insurance company and lodged a claim with them on total loss basis for reimbursement. The insurance company vide their letter dated 07.08.2012 repudiated the claim stating that *'on perusal of the documents, it is found that the description of theft/loss as per F.I.R and statements given by you differs in sequence of events and are contradictory in nature. Please refer to declaration as contained in the claim form signed by you wherein it is declared If I have given/made any false or fraudulent statement/information, or suppressed or concealed or in any manner failed to disclose mal information, the policy shall be void & that I shall not be entitled to all/ any rights to recover there under in respect of any or all claims, past, present or future. Also it states no material information, which is relevant to the processing of the claim, which in any matter has a bearing on the claim, has been withheld or not disclosed. In the circumstances, you are therefore, informed that the above captioned claim as made by you hereby stands as 'No Claim'.* He represented to the insurance company through his lawyer on 04.10.2012 against repudiation requesting them to review and settle his claim, but his

representation did not yield any result. Being aggrieved, by the decision of the insurance company, he approached this forum for redressal of his grievance seeking monetary relief of Rs.42,220/- as per 'P-II' form details.

The insurance company in their written submission dated 20.08.2013 have stated that the insured complainant Shri Avijit Das had taken a two wheeler package policy under policy no. 3005/10858788/11142/000 for the period from 29.07.2011 to 28.07.2012. The complainant had claimed for the theft of his vehicle which was stolen on 05.08.2011. On perusal of the claim documents and further enquiry of the facts, they found that the complainant had intimated about the theft to the insurance company on 08.08.2011 after an unreasonable delay of 03 days and the same was intimated to the police on 11.08.2011, after an unreasonable delay of 06 days. As per terms and conditions of the policy, a theft claim should be intimated to the insurance company as well as to the police authority immediately.

However, they submitted that the National Commission in recent judgement interpreted the word "immediately" as under:-

'In the case of theft where no bodily injury has been caused to the insured, it is incumbent upon the respondent to inform the police about the theft immediately, say within 24 hours, otherwise, valuable time would be lost in tracing the vehicle. Similarly, the insurer should also be informed within a day or two so that the insurer can verify as to whether any theft had taken place and also to take immediate steps to get the vehicle traced.'

They further stated that the complainant had submitted a copy of the stamped letter by the police as an intimation of theft to the police with this forum. However, the letter does not contain any date. On enquiring about the same the complainant had informed them that he had informed the police vide his letter on 09.08.2011. Even though the intimation to the police was made on 09.08.2011, there is still unreasonable delay of 4 days. The complainant had failed to comply as per terms and conditions and there is a violation of policy condition. The claim should have been immediately lodged with the police and the insurance company. Due to unreasonable delay in intimation of claim with them they were unable to verify the actual cause of loss and were unable to take immediate steps to get the vehicle traced. Further, the vehicle could have travelled a long distance or may have been dismantled by that time and sold to scrap dealer. Hence, this did not allow them to carry out proper investigation at the time of theft and the scope to get the vehicle traced becomes negligible. The same was informed to the complainant vide their letter dated 07.08.2011.

As per FIR lodged with the police by the complainant dated 11.08.2011, it was mentioned in the F.I.R that the vehicle was stolen on 10.08.2011, however as per his intimation with them he has stated that his vehicle was stolen on 05.08.2011. The same is misrepresentation of facts and making false statements is against the declaration as contained in the claim form and signed by the claimant.

In view of the above the claim is not payable.

DECISION:

We have heard both the parties, considered their written submissions and examined the documents submitted to this forum. It is seen that in all places, the complainant mentioned the date of theft on 5.8.2011. Occurrence of theft is genuine as evidenced from the FIR & FRT and the Insurer has also not raised any question about the genuineness of the theft. The Motor Cycle was covered under comprehensive Insurance coverage in both the dates i.e, 5th & 10th August, 2011. Hence, the claim can not be repudiated on the basis of such dubious document.

After careful evaluation of all the facts and circumstances of the case we are of the opinion that the decision of the insurance company to repudiate the claim is not justified and the same is set aside. The insurer is directed to settle the claim after deducting policy excess if any from the Insured Declared Value (IDV) within 15 (fifteen) days from the date of receipt of this award along with consent letter from the complainant.

The complaint is allowed accordingly.

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MUMBAI OIO

Complaint No. GI- 721 of 2013-2014
Award No. IO/MUM/A/GI/566//14-15

Complainant, was covered along with his family under the group mediclaim policy of the within mentioned Company vide policy bearing number 260601/48/11/8500006361, valid for the period 29.7.2011 to 28.7.2012. the complainant and his wife were covered for a sum insured of Rs.1.50 lacs each whilst the other members were covered for a sum insured of Rs.1 lac each.
Claim arose under the policy when the complainant got admitted to Criticare multispeciality hospital on 16.2.2012 for heart ailments and underwent coronoary angiography. He then underwent EECP treatment from 24.2.2012 to 14.4.2012 and the preferred the claim on the insurance Company.
The insurer denied the claim contending that the said EECP treatment was an OPD procedure which did not require indoor confinement.
The scrutiny of the submitted papers reveals that the complainant underwent EECP treatment for his heart ailments vide 40 sessions and incurred an expense of Rs.97424.00
Let us now examine what EECP is all about. The medical internet sites have given the following information: " it is a non-invasive approach that has provided relief for many people. This treatment, which works in harmony with your heart, improves circulation to your heart muscles. EECP treatment acts to stimulate the opening of natural pathways around narrowed or blocked arteries. The name enhanced external counter pulsation explains what will happen during treatment. EECP is external because it is outside of your body and does not require surgery. Counter pulsation means that the EECP system pumps when the heart is resting. This increases blood flow to the heart. Counter pulsation stops pumping when the heart is working. This decreases the heart's workload, creating less oxygen demand. EECP treatment works with the normal rhythm of your heart to help your body heal itself. Patients receive EECP treatment on an outpatient basis. This treatment does not involve hospitalization or recuperation. Patients attend one hour sessions once a day." Although the literature says it is a line of treatment approved abroad, it is not clear if the same is approved by the Indian Medical Council or the FDA counterpart here.
From the above, it is observed that this line of treatment does not require hospital confinement and can be taken on outpatient basis and the course of treatment involved 40 sittings of one hour each. It must be noted here by the complainant that Mediclaim policy pays for only those treatments, which require hospital confinement barring only a few

exceptions under which the said treatment does not fall.
Though this Forum sympathizes with the complainant, the nature of treatment undergone by him does not fulfill the obligation of the mediclaim contract and hence his claim is not tenable.
The stand of the Company was upheld.
Award Dated 20.9.2014.

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Complaint No. GI- 447 of 2012-2013
Award No. A/319/2014-15

The complainant lodged a claim was lodged on the Company for treatment of macular hole. Of the amount of Rs.57480, the same was settled for an amount of Rs.31184 and the balance amount of Rs.26266 was denied and this said amount was towards purchase of face down positioning support recovery system. The Company contended that this was a durable medical equipment which was not covered under the policy. During the hearing, the complainant emphasized that this equipment was a must for the recovery and the Company was asked to get a medical opinion for the same. macular hole surgery involves use of c3f8 gas which requires strict prone position for adequate and effective tamponade. The device aids in making the patient more comfortable during the prone position thus ensuring better compliance. Though it is not used by everyone due to cost constraints, it is definitely useful for the patient."

As confirmed by the doctor c3f8 meaning perfluoropropane gas is injected intravitreously for sealing of the macular hole and after the said surgery, the patient needs to be in prone position for completing/aiding of the healing. The equipment purchased by the complainant helps in making the patient comfortable whilst maintaining such prone position. It is not part of the treatment to be mandatorily used by all patients but a gadget which can be bought by patients who can afford it for their comfort. Treatment/healing is possible despite the gadget too albeit with some amount of discomfort.

The eye surgeon too has opined on the same lines. Such gadgets are beyond the scope of the mediclaim policy and the decision of the Company of the Company was upheld.

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BEFORE THE INSURANCE OMBUDSMAN
(MAHARASHTRA & GOA)
MUMBAI
Complaint No. GI- 544 of 2042-2015
Award No. IO/MUM/A/GI -284 /2014-2015
Complainant: Shri Jay Mathuria
Respondent: The New India Assurance Co.Ltd

Complainant, Shri Jay Mathuria was covered along with his family under the mediclaim policy of The New India Assurance Co.Ltd vide policy bearing number 140103/34/09/11/00003438, valid for the period

5.2.2010 to 4.2.2011. From the submitted policy copies it is noted that the sum insured has been enhanced over a period of time and the first policy was incepted in the year 2000.

Claim arose under the policy when Smt.Vaishali Mathuria, wife of the complainant got admitted to Bombay Hospital & Research Centre on 22.6.2010 to 16.7.2010 for renal problem and underwent kidney transplantation. The claim was settled for the basic sum insured under the policy and the enhanced sum insured was denied contending that the claimed illness was pre-existing for the enhanced sum insured which was not acceptable to the complainant and he approached this forum for redressal.

During the hearing, the Company obtained an independent opinion dated 15.4.2014 from one Dr.Sharad Sheth, consulting nephrologist who has opined that based on the available information, it was not possible to come to any conclusion about the pre-existence of the disease and that de novo glomerulonephritis can progress to CKD and ESRD in a span of more than three m As per medical websites, Glomerulonephritis refers to an inflammation of the glomerulus, which is the unit involved in filtration in the kidney. This inflammation typically results in one or both of the nephrotic or nephritic syndromes. Glomerulonephritis may be temporary and reversible, or it may get worse. Progressive glomerulonephritis may lead to Chronic kidney failure, reduced kidney

function and end-stage kidney disease. As rightly pointed out by Dr.Sheth, the type of GN which the insured was suffering from is not known as there are no medical papers pertaining to that episode. However, from the write up above, it looks like the insured suffered from progressive GN as she was lead to chronic kidney disease subsequently because the probability of an otherwise healthy 40 years old individual becoming an ESRD or CKD patient is very lean in the absence of other co-morbidities.

The treating doctor, Dr.Billa has also issued another certificate dated 6.10.2010 stating that the End stage kidney disease of the insured could be related to the primary GN which she suffered in 1999.

The contention of the complainant that the kidney disease was of acute onset cannot be accepted in the absence of documentary evidence to prove the same. On the contrary, there is medical evidence to suggest that she was having underlying conditions which can lead to CKD and the same is not refuted either by Dr.Sheth (as he has stated that some type of GN can progress to ESRD) or her treating doctor, Dr.Billa. In her case, it can only be concluded that the GN suffered by her has nevertheless lead her to ESRD over a period of time.

Hence the stand of the Company was sustained.

Award dated 26.6.2014.

Complainant was covered along with his family consisting of his wife and son under the mediclaim policy 2007 of the within mentioned Company vide policy bearing number 15360034110100002113 for a sum insured of Rs.5 lacs each. The said policy was valid for the period 2.9.2011 to 1.9.2012 and from the submitted copy, it is observed that the policy was incepted for the first time in the year 2003.

Claim arose under the policy when baby Shaunak Mishra, son of the complainant got admitted to KEM hospital from 26.4.2012 to 30.4.2012 and underwent surgery for cleft palate. When the claim was preferred on the Company, the same was denied by them contending that the problem for which the child was operated was a congenital external disease which was an exclusion under 4.4.6 of the policy. This being not acceptable to the complainant, he represented to the forum for redressal.

During the hearing, the complainant submitted that he had obtained an opinion from his treating doctor, Dr.Avinash Deodhar clarifying that according to the doctor the said defect of the child was an internal deformity which was corrected by cleft palate repair surgery but the Company did not take cognizance of the same.

The company on the other hand countered this with an independent opinion stating as follows: " This boy who was operated for his cleft palate had his symptoms such as nasal regurgitation, difficulty in

swallowing milk since his birth. This has been stated by his patents while giving history to the doctors attending him. He was diagnosed as a case of cleft palate and was operated…parents of the patient knew that the child had problem of swallowing and regurgitation from birth, they knew that there was some abnormality with the child since birth i.e the problem was congenital..”

The forum observed during the hearing that the said doctor, Dr.Karandikar had not clearly stated whether the defect was external and accessible without any intervention of instruments and hence a detailed clarification on that count should be sought by the Company from the said doctor. A direction was given that the clarification so obtained should reach the forum on or before 15.10.2014. The opinion along with the clarification of the doctor was received by the forum and the doctor has elaborated thus: “ …This patient suffered from his birth and had all the pertaining signs and symptoms of cleft palate – a hole or effect in hard palate ad his parents were advised to treat him with surgery for the same. This condition… occurs due to failure of fusion of 2 parts of hard palate during development of the baby mother’s womb. This condition is present since birth and as it is in the mouth, it can be palpated of felt by finger easily as well as seen easily by anybody with the naked eyes…”

As the said definition was conforming to the definitions given by the Regulator for congenital external anamoly, the stand of the Company was upheld.

Award dated 9.12.2014.

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Complaint No. GI- 882 of 2014-2015
Award No. IO/MUM/A/GI/A/798/14-15
Complainant: Smt Mayurika Ajmera
Respondent: Bajaj Allianz Gen.Ins Co.Ltd

Complainant, Smt Mayurika Ajmera was covered along with her husband, Shri Virendra Ajmera under the mediclaim policy of the within mentioned Company vide policy bearing number OG-11-1901-8416-00000874 for a floating sum insured of Rs.10 lacs with a deductible per claim of Rs.3 lacs. The said policy was valid for the period 14.3.2011 to 13.3.2012. From the submitted documents it is observed that the policy was incepted for the first time in March 2011.
Claim arose under the policy when Shri Virendra Ajmera, husband of the complainant got admitted initially to Babsaheb Gawde hospital on 18.9.2012 for complaints of retrosternal chest pain with palpitation, perspiration and mild breathlessness. The hospital found anterolateral changes in the ECG, thrombolysed him and transferred him to Kokilaben hospital on 19.9.2012 for further management. However, not responding to the treatment given, the insured unfortunately expired on 7.10.2012.
The claim when lodged on the Company was denied by them under the ground of pre-existing ground of hypertension.
During the hearing, the complainant vehemently denied that the insured was hypertensive since last ten years and emphasized that he was diagnosed to be suffering from the same only from February 2011 and hence she was advised to submit copies of past medical papers of the insured if any.
Accordingly, the complainant submitted a copy of the discharge card of Jewel hospital for the period 14.6.2010 to 4.7.2010 where the insured

was diagnosed to be suffering abdominal and mediastinal tuberculosis with granular hepatitis with renal insufficiency and hyper protenemia. In the past history column, it is recorded as "no h/o DM/IHD/HTN, no h/o of asthma/tuberculosis in the past.."

The death summary issued by Kokilaben hospital for the period 19.9.2012 to 7.10.2012 is as follows: " This 55 years old male patient known case of hypertension on Losar, Pulmonary Koch's, chronic bronchitis presented to KDAH with anterior wall myocardial infarction with LVF received Elaxim outside. Patient was put on NIV and continued with decongestive measures. His Echo showed EF of 25%. Once stabilized, CAG was done which showed TVD. In view of recent MI surgery (CABG) was advised after internal….shifted to wards on 25.9.2012. On 27.9.2012, cough with haemoptysis with mild breathlessness, so Intensivist's and Pulmonologist's opinion was taken. HRCT done showed extensive ground glass opacities with consolidation with alveolar hemorrhage. Background of pulmonary edema, spuatum c/s sent. On 28.9.2012, became very breathless so shifted to ICU again NIV given. He became hypotensive, decreased urine output – needed diuretic infusion. Troponin – I came positive. BNP increased and inotropic support added, Patient was intubated and ventilatory support was given. Later IABP support was also added. Patient was covered with antibiotics as per sputum c/s report. Patient gradually worsened and MODS set in. On 7.10.2012, had cardiac arrest, Patient could not be revived. Patient declared dead on 7.10.2012 at 4.25 p.m."

In the instant case, the deterioration of the insured occurred more because of underlying lung problem than heart problem. The imaging of the lungs continuously showed ground glass opacity. Generally ground glass opacity occurs due to infectious processes (usually opportunistic) like chronic interstitial diseases, acute alveolar diseases and other causes. In his case, the complainant was already a known case of abdominal and mediastinal (pulmonary) Koch's and hence a very likely target for opportunistic infections. Though his initial problem for which he was admitted was heart ailments, after being thrombolysed, he was stable. In fact on 27.9.2012, his trouble started by way of cough with hemoptysis (meaning coughing up blood) and pulmonary edema and breathlessness. If we examine the blood investigations of the insured, it can be seen that his hemoglobin and hematocrit values were very low and gradually declining and the cause of which can be attributed to the alveolar hemorrhage (means bleeding from the lungs). Generally, rise in enzyme Troponin I indicates heart problem but can also be an indication in non cardiac problems such as pulmonary embolism or COPD. In the insured's case, he was having bronchitis and also alveolar hemorrhage which could have caused an elevation in Troponin I. Hence there are reasonable grounds to believe that the death was caused because of

lungs disorder. Even the cause of death certificate states pulmonary edema and bronchitis to be the causative factors in addition to the heart problem for his death. Hence, the question whether the hypertension was pre-existing or otherwise is not relevant in deciding this claim.
However, it is noted by the forum that the admission to Jewel hospital in June 2010 and the resultant diagnosis has not been disclosed by the complainant in the proposal form. Abdominal and mediastinal Koch's are serious disorders which should have been disclosed by the complainant at the time of taking the policy in March 2011. The complainant has also confirmed that the policy with New India which was valid since long and was still continued in her name after the unfortunate demise of her husband and that they had also received a claim of Rs.2.10 lacs for the same admission/claim. This being so, the policy of Bajaj Allianz can only be treated as a fresh policy for additional sum insured of Rs.10 lacs and cannot be treated as continuity of New India policy because that policy is still in force and the complainant has not migrated to this present insurance after discontinuing the same. The validity of the writing of Bajaj Allianz that their policy is in continuity with the New India Assurance policy is not clear to me and the reasons are best known to them. Nevertheless, no credit can be given for the coverage of New India as this policy is a fresh one for additional sum insured and there is definite non disclosure of material facts by way of withholding information regarding the diagnosis of abdominal and mediastinal Koch's (which are pertinent to the cause of present day ailment and resultant of the insured) whilst taking the present policy. That the ailments for which the insured was admitted and which was the cause of his untimely demise was both pre-existing and non disclosed by the complainant is evident.
Hence the stand of the Company was upheld although for different reasons.
Award dated 30.9.2014.

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BEFORE THE INSURANCE OMBUDSMAN
(MAHARASHTRA & GOA)
MUMBAI

Complaint No. GI-418/2012-2013
Award No. IO/MUM/A/GI- /2014-15
Complainant: Smt. Lily Golwalla
Respondent: United India Insurance Co. Ltd.

Complainant Smt. Lily Golwalla was covered under Individual Mediclaim Policy No.022000/48/10/20/00002704 for the period

11.02.2011 to 10.02.2012 for Sum Insured of Rs. 2,00,000/- with 50% C.B., issued by United India Insurance Co. Ltd.

In July 2011, Smt. Golwalla was detected of Cancer of the pancreas and was operated for the same at Jaslok Hospital. Out of the total expenses of Rs.8,34,000/- incurred for the same, she received an amount of Rs.5 lacs under the Group Insurance policy held by her daughter as an employee of EXIM Bank. For the balance amount, she lodged a claim under her policy with 'United India'; however the claim was not settled by the Company.

Insurance Company contended that the policy issued to Smt. Golwalla carried a permanent exclusion for "Any expenses arising out of Cancer of kidney alongwith any complications arising therefrom and all kidney diseases". Since the insured was treated for Solitary Metastases to Pancreas from Renal Cell Carcinoma, the claim stood inadmissible as per the Exclusion mentioned on her policy.

Smt. Golwalla argued that she suffered from cancer of the kidney and had undergone left radical nephrectomy 25 years back after which she had no health problems till the present treatment which was for cancer of pancreas and was in no way connected to her previous ailment. She also pointed out that she had not lodged a single claim and this was her first claim under the policy in all these years.

The case was examined by the Forum. As per information available from various internet sites, Renal cell carcinomas (RCCs) account for 2% of all cancers and have a predilection to metastasize to rare locations, including the pancreas. RCC is the most common primary tumor leading to solitary pancreatic metastasis. Although the majority of metastases occur within 3 years of radical nephrectomy, the appearance of metastatic disease many years after nephrectomy is a well-known feature of RCC. Since most pancreatic metastases are asymptomatic, routine long-term radiologic surveillance is necessary.

Also, the Discharge Summary of the hospital mentioned the diagnosis as "Solitary Metastases to Pancreas from Renal Cell Carcinoma" which implies that the present ailment was a complication of the Kidney Cancer suffered by her. In view of the same, the decision of the Insurance Company to repudiate the claim based on the Exclusion mentioned on the policy, cannot technically be faulted with.

At the same time, the fact cannot be totally overlooked that Smt. Golwalla is continuously insured under the Mediclaim policy of the Company since the year 1988 without any claim until the present one. Also, it needs to be taken into account that while the revised Health Insurance Policy introduced by the Company covers all pre-existing diseases after completion of 48 months of continuous coverage, the said benefit is not available to the persons insured under the old Mediclaim policy where pre-existing diseases are excluded permanently from the

scope of the policy, irrespective of their uninterrupted long coverage. It is not even known whether Smt. Golwalla, being a senior citizen at the time of introduction of the revised policy, was given an option to go in for the revised policy or not. In view of the same taking into consideration the long-term association of Smt. Golwalla with the Company coupled with a good claim experience, the Forum is of the opinion that it would be in the interest of justice to allow her some relief on ex-gratia basis. Under the circumstances, the decision of the Company is intervened by the following Order.

ORDER

United India Insurance Co. Ltd. is directed to pay to Smt. Lily Golwalla an amount equivalent to 50% of the Sum Insured alongwith C.B. available under the policy, on ex-gratia basis against the claim lodged by her for her hospitalization at Jaslok Hospital from 17.07.2011 to 10.08.2011 for the treatment of Cancer of the pancreas There is no order for any other relief. The case is disposed of accordingly.

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Complaint No. GI- 776(2013-2014)

Complainant: Smt. Sarita Rao
v/s.
Respondent: Star Health and Allied Insurance Company Ltd

Mrs. Sarita Rao was covered under Diabetes Safe Insurance policy and Family Health Optima Insurance policy issued by Star Health and Allied Insurance Company Ltd. She was admitted to Acharya Nursing Home, Kalyan from 08.03.2013 to 14.03.2013 with diagnosis of boil in her right thigh. After she was discharged from the hospital, when she preferred the claim to the insurer, it was rejected on the grounds that ailment suffered by her does not fall under three complications of diabetes covered under her Diabetes Safe policy and present ailment is complication of pre-existing disease i.e. Diabetes Mellitus.

Aggrieved by their decision, Mrs. Sarita Rao approached the Office of Insurance.Ombudsman seeking intervention in the matter of settlement of her claim.

After perusal of the records parties to dispute were called for hearing.

Star Health and Allied Insurance Company Ltd was represented by Dr. Arvind Thakkar. He stated that Diabetic Safe Insurance policy covers Diabetic Retinopathy, Diabetic Nephropathy and Diabetic Foot Ulcer

requiring micro vascular surgery. He added that Mrs.Sarita Rao was diagnosed of Carbuncle on thigh which does not fall under any of the above 3 complications. Hence claim was rejected under Diabetic Safe policy. Since the ailment suffered by the complainant is complication of pre-existing disease i.e. Diabetes Mellitus and a period of 48 months had not elapsed since inception of the policy, claim was rejected under Family Health Optima policy.

Ombudsman asked Dr. Thakkar whether diabetes is the only cause of carbuncle, to which Dr. Thakkar replied that it is complication of Diabetes Mellitus.

Smt. Sarita Rao stated that she has obtained Certificate from her treating doctor, Dr. Nitin Zabak wherein he has stated that Carbuncle is an acute infective disease which can also be seen in patients other than those suffering from Diabetes. Dr. Thakkar remarked that he is not in possession of the copy of the said certificate and requested the forum to grant him 10 days time to get expert opinion on this issue. The forum handed over the copy of the above certificate to Dr. Thakkar.

On hearing the deposition of both the parties to dispute, Ombudsman directed the company to get expert opinion on the issue whether ailment (Carbuncle) suffered by the complainant is only due to Diabetes Mellitus and inform their final stand to the forum within 10 days.

On 05.01.2015, the forum received a copy of letter dated 24.12.2014 sent by the company to the complainant stating that they have reviewed the case and has decided to settle the claim for Rs. 34,311/-.

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Complaint No. GI- 260 (2013-2014)

Complainant: Shri Shivcharan Wagh
v/s.
Respondent: United India Insurance Co.Ltd

Mr. Shivcharan Wagh was covered under Group Mediclaim Policy no. 030400/48/09/41/00003041 taken by Medicare Service Club issued by United India Insurance Co.Ltd. In the first week of August, 2010 he received a letter from Medicare Service Club asking him to pay Rs. 17090/- and submit the enrollment form though he was already insured with UIIC since 10 years. Unfortunately on 21.08.2010, he suffered from hyponatermia and was confined to indoor treatment in S.L. Raheja Hospital for few days .After he was discharged from the hospital, he contacted the Medicare Service Club official in 11/2010 as to why he is required to submit the enrollment form which is supposed to be filled by

the prospective customer. But the officials did not entertain his call. Thereafter he sent the cheque and the necessary papers to Medicare Service Club which was returned back to him stating that UIIC is not ready to accept his renewal request due to delay in submission.

Aggrieved by their decision, Mr.Shivcharan Wagh approached the Office of Insurance Ombudsman seeking intervention in the matter of renewal of his policy.

After perusal of the records parties to dispute were called for hearing.

The complainant Mr. Shivcharan Wagh along with his wife Mrs. Swati Wagh appeared and deposed before the Ombudsman. He stated that he along with his wife and daughter were covered under mediclaim policy with UIIC. He had paid a premium of Rs. 12851/- for period of from 01.03.2010 to 28.02.2011. He added that he had taken the policy on the basis of advertisement that there would be no medical test and premium will be debited from BOB credit card. He stated he was covered with UIIC since 10 years. When the Medicare Services Club returned his renewal cheque, he submitted all the necessary papers and cheque to United India Insurance Co.Ltd as was directed by UIIC official in churchgate. However he did not get any positive response from them and his policy was cancelled. He wrote several email to Grievance department of UIIC but they did not respond to those emails. He pleaded that since he had paid the premium till 02/2011, it was wrong on the part of the company to cancel the policy before its completion.
United India Insurance Co.Ltd was represented by Ms.S. Dharmambal and Ms. Harsha Mamtora. Ms. Dharmabal submitted that since they did not get necessary documents from the concerned Kolkata office for deposition, they requested Ombudsman to grant 3 weeks time to give their observations.

On hearing the deposition of both the parties to dispute, it is observed that Mr. Shivcharan Wagh was covered under Group Mediclaim policy issued by United India Insurance Co. Ltd and serviced by Medicare Service Club for period from 01.03.2010 to 28.02.2011. In August 2010, the complainant received letter from Medicare Service Club asking him to submit the proposal form along with premium amount for conversion of his Group Mediclaim to Individual Mediclaim policy. However his policy was discontinued from 01.10.2010 since he had delayed in submitting the proposal form along with premium cheque to the insurer due to his ill health. Inspite of his repeated followup with the insurance company asking for reason for discontinuing his policy, the insurance company did not give him any satisfactory reply. Since the policy was

valid as on the date of submission of cheque on 09.11.2010, the company is directed to send their observation within 3 weeks, as to why they did not act on it and accept his request for policy conversion from Group Mediclaim to Individual Mediclaim.

On 12.12.2014, the forum received letter dated 11.12.2014 from UIIC stating the following: " The complainant was covered under GMP taken by Medicare Service Club.. The policy no. 03040048094100003041 was valid from 01.07.2009 to 30.06.2010.
The policy expired on 30.06.32010 and as per Corporate decision not to continue the policies with the non employer-employee relationship that policy was not renewed from 01.07.2010 and the insured persons were given opportunity to migrate to Individual Health Insurance policies with a time from 19.11.2010.

Accordingly, notice was sent by Medicare Service Club to all Individual member for migrating their Health Insurance coverage to Individual policies and a letter to this effect was also sent to Mr. Wagh , the complainant on 05.08.2010 vide mentioning premium payable for coverage. That letter was received by Mr. Wagh on 06.08.2010 but after a long period of time premium cheque was sent to Medicare Service Club and the same was received by MSC on 30.11.2010. Since continuity of coverage cannot be given after 19.11.2010, we had refused to accept the premium after stipulated time frame and the cheque was returned to the complainant on 09.12.2010.

The complainant's statement that amount of premium was paid till 28.02.2011 and the policy was terminated on 02.12.2010 is not true. In fact the premium for the group policy was paid by Medicare Service club for a period from 01.07.2009 to 30.06.2010 after collecting subscription from individual member of the club. Presumably the date mentioned i.e. 28.02.2011 by the complainant is validity of membership with Medicare Service club and the amount paid to Medicare Service Club towards membership subscription. In fact he has not paid any money to Insurance Company.

The complainant has made On-line complaint to our Customer Care department and after reviving the matter they had closed the Online compliance by giving reply to the complainant. It is not true that the policy was cancelled before expiry of the terms. Allegation made by complainant that the policy was valid till 28.02.2011 is not correct at all. The policy issued by us is in the name of ANZ Card-holders expired on 30.06.2010 and thereafter it was not renewed. Hence alleged policy/Insurance coverage was not in existence."

The entire documents submitted to the forum are taken on record. Let us find out whether there is any merit in the complaint of Mr. Shivcharan Wagh:-

1) **As per copy of the policy no. 030400/ 48/ 09 41/ 00003041, it is observed that the period of insurance is from 01.07.2009 to 30.06.2010.**
2) **The complainant has submitted Certificate from Ms. Sunita Banerjee, Manager Relationship of Medicare Service Club which states "This is to certify that Mr. Shivcharan Wagh has opted for Group Medical Plan (Membership no. BOBMPOOO526A) of Medicare Service Club under Group Medsiclaim policy issued by United India Insurance Company Ltd. The present Master policy no. is 0300/48/09/41/00003041 is for coverage of Rs. 3 Lakhs for Mr. Shivcharan Wagh and his family and he has paid a consolidated amount of Rs. 12851/- for the period from 01.03.2010 to 28.02.2011 towards renewal of this Membership." Thus the Membership period of Mr. Wagh with Medicare Service Club is from 01.03.2010 to 28.02.2011 which was wrongly alleged by him to be insurance policy period .**
3) **On 05.08.2010, MedicareService Club sent a letter to the complainant asking him to send the enrolment form along with premium cheque before 31.08.2010 for migrating to Individual /Family Floater plan of United India Insurance Co.Ltd. The letter also clearly states that if they do not receive any communication from the complainant within 31.08.2010, then his policy will be cancelled from 1.10.2010.The complainant during the course of hearing has also accepted that he received the above mentioned letter in the first week of August.**
4) **Medicare Services had asked for extension in the time period from UIIC since it was difficult for them to inform all the members PAN India and then get the policy migrated into individual policies with the expiry of the card member policies. UIIC extended time limit till 19.11.2010.**
5) **The complainant had submitted the renewal premium cheque to Medicare Service Club on 30.11.2010.**
6) **Medicare Service Club vide letter dated 02.12.2010 returned the premium cheque to the complainant stating that UIIC was not accepting any premium as it was received beyond the stipulated date.**

Thus it is observed that the period of Group Insurance policy where in Mr. Wagh was covered ended on 30.06.2010. However UIIC gave an option to the policyholders to migrate to Individual policies along with continuity benefits by submitting the necessary enrollment form and premium by 19.11.2010. Unfortuntaely Mr. Wagh submitted the same

on 30.11.2010 which was much beyond the time frame originally given to him. Under these circumstances, the decision of the company to deny the request of the complainant to migrate into Individual policy is in order and the forum do not find any valid reason to intervene with the same.

Complaint No. GI- 803 (2012-2013)
Complainant: Ms. Suhasini Sharma
v/s.
Respondent: Bajaj Allianz General Insurance Company Ltd

Ms. Suhasini Sharma was covered under Individual Health Guard Policy number OG-12-1907-8401-00000224 issued by Bajaj Allianz Life Insurance Company Ltd. On 03.05.2012 Mrs. Suhasini Sharma was admitted to Saraswati Hospital as she was diagnosed with Malarial Fever with gastro enteritis. When she lodged the claim with the insurer it was repudiated on the grounds that there were discrepancies in the various hospital reports /records.

Aggrieved by their decision, Ms. Suhasini Sharma approached the Office of Insurance Ombudsman seeking intervention in the matter of settlement of her claim.

After perusal of the records parties to dispute were called for hearing.

Bajaj Allianz General Insurance Company Ltd was represented by Mr. Sandip Jadhav and Dr. Rashmi Sachdev. Dr. Rashmi Sachdev stated that the claim under policy no. OG-12-1907-8401-00000224 was repudiated stating the reason as 'Fraud' as per Condition D7 of the policy. The decision to repudiate was arrived on the basis of investigation which revealed the following:-

1) **Verification of the claimant could not be conducted as the claimant was out of town as confirmed by Claimant's father.**
2) **Verification of treating Doctor Mr. Prakash Khetani could not be conducted as the hospital refused to co-operate.**
3) **Verification of Hospital Bills could not be conducted as the hospital refused to show IP register.**
4) **Verification of Pharmacy Register book maintained by the Hospital could not be conducted as the hospital refused to co-operate. In fact the hospital does not have license to sell the medicines.**
5) **Dr. Rajesh, owner of the hospital provided the certified copy of Invalid Hospital Registration Certificate but failed to inform whether he had applied for renewal or not.**

6) **Certain contradictions were noticed in the statements of Mr. Rajendra Sharma and Hospital Authorities like as per the statement of Mr. Rajendra , patient was admitted in General Ward wherein Doctor's Charge is Rs. 300/- but they have been charged with Rs.700/- as Doctor's Fees. In addition to this, bed charges in General Ward is Rs. 250/-as verbally confirmed by the claimant's father and Hospital Authorities but in the final bill, it shows that insured has been charged Rs.1000/- as bed charges.**
7) **The investigator requested Dr. Rajesh to show in-house Saraswati Diagnostic Centre from where lab testing has been done but he refused and informed that there is no in-house lab and all test has been conducted from other lab-whose details he refused to divulge.**
8) **Who has signed as witness on admission form is not known to the father of the patient.**
9) **The signature of the patient in Admission form and claim form differs from the signature in NEFT form and PAN card.**
10) **The doctor provided certified copy of ICP papers to the investigators wherein following discrepancies were noted:-**
    - **No IP number is mentioned on admission form.**
    - **No time of discharge is mentioned on admission form.**
    - **2 antibiotic injections , Injection Otron (to stop vomiting),3 calpol tablets and cyclopean tab (for abdominal pain) were given to the patient every day till the date of discharge though she was not febrile and no complaints of pain in abdomen were recorded in ICP .**

Ombudsman asked Mr. Rajendra Sharma that since they stay in Kamothe, Navi Mumbai then why his daughter was admitted to Saraswati Hospital in Govandi, to this he stated that there is no hospital in Kamothe which is in the network of the insurer. Since they also have house in Govandi and Saraswati hospital is one of the Network Hospital of the insurer, they got her admitted to this hospital.

The forum observed that company has not mentioned in their written statement that Saraswati Hospital is in their Network Hospital.

Ombudsman remarked that since the said hospital is in the panel of the insurer and the same was recommended by the insurer to the policyholders through their websites, now they cannot allege that the hospital is not providing them with requisite information and that cannot be ground for repudiation of claim. As far as faulty line of treatment and discrepancies noticed in the various reports/hospital papers, the insurer should have got the same clarified from the hospital authorities and in

case the hospital did not co-operate necessary action should have been taken.
The company was directed to provide reasons as why they are not able to get the relevant information from the hospital authorities, though it is one of their Network. Since the company has also alleged that the claim is fabricated then what action has been taken against the hospital. The insurance company was required to submit their observations within 7 working days.

The forum directed the Complainant to get signature verification of Ms. Suhasini Sharma from the Bank where she is holding an account along with copy of pass book and submit the same within 7 working days. The complainant submitted the same on 10.10.2014.
On 4th November,2014 the forum received email from the company stating that " We are able to trace Dr. Khetani at Mahaveer Hospital, Govandi after a hunt in various hospitals of Chembur and Govandi. On going through the hospitalization documents, Dr. Khetani verbally confirmed that he have not seen the patient. He was not ready to mention anything on this letter head or stamp paper. He asked to prepare Questionnaire for the same and he will give the answer in Yes/No format with his signature and stamp. He mentioned "No" for the questions whether the handwriting and signature is of Dr. Khetani on hospitalization documents. He requested to deny the claim based on the same. Further he was not ready to write anything against the hospital citing reason that he shares very good relations with the hospital since past 15 years."
The Questionnaire for Treating Doctor signed by Dr. Prakash Khetani is

reproduced below:-

Answer

"1) Do you visit or have consultation at Saraswati Hospital,Govandi?

Yes

2) Do the clinical notes of hospitalization Indoor Case paper of Miss

Suhasini

Sharma bears your handwriting?

No

3) Does the Indoor case papers of Miss Suhashini bears your signature?

No

4) Have you treated Miss Suhashini Sharma on IPD basis at Saraswati

Hospital from 03.05.2012 to 10.05.2012

NA

5) Do you agree that your name has been misused by hospital in said

case ? NA"

On 24th November, 2014, Bajaj Allianz General Insurance Company Ltd sent an email stating that they have de –paneled Saraswati Hospital on 05.11.2014.

The entire documents submitted to the forum and deposition of both the parties to dispute is taken on record. It is observed that the company officials deposed that they were not able to conduct verification of treating doctor, Dr.Prakash Khetani and also of the hospital bills as the hospital authorities refused to co-operate with them. Though the insurance company noticed that Dr. Rajesh had provided them with Invalid Hospital Registration Certificate and there were many inconsistencies in various hospital bills and ICP papers, they failed to take any action against the hospital. It was the duty of the insurer to investigate whether such incidences had repeatedly occurred in the said hospital or it was first instance since this hospital was in their Network group and accordingly action should have been taken to avoid such incidences in future. Instead, on the basis of above findings the insurer simply repudiated the claim under condition D7
which states that " If you make or progress any claim knowing it to be false or fraudulent in any way, then this policy will be void and all claims or payments due under it shall be lost and the premium paid shall be forfeited ." Since the name of Saraswati Hospital, Govandi was published in various documents and their website by the insurer, it implies that they have recommended this hospital to the insured who can approach for treatment and be assured that claim will be settled. Though Saraswati Hospital is PPN hospital, the forum has observed that there

are glaring anomalies which are difficult to ignore. It is observed that Hospital records are not properly maintained .i.e. there is no mention of IP number in the admission form, time of discharge of the insured from the hospital is not mentioned and the line of treatment given is not consistent with the ailment diagnosed. On going through the hospital documents, it establishes that Ms. Suhasini had fever since 2-3 days, shivering, nausea+++, vomiting -4 times, pain in abdomen. However the complainant has not informed us what treatment she had taken prior to getting admitted in the hospital nor is the same mentioned in the hospital records. Also documents evidencing post- hospitalization followup are also not submitted. It is also noticed from the questionnaire signed by Dr. Khetani that he has not clarified whether his name is being misused by the hospital in the said case. Instead he has stated that he shares good relations with the hospital authorities for past 15 years.

From the above documents produced at this Forum, the material facts are contradicting in nature. To resolve a dispute of this nature where contradictory statements are placed, will involve detailed investigations, including cross examination of the Doctors who recorded the above noting. This Forum with a limited jurisdiction is not empowered to summon the hospital & Doctors which could not be held in the summary proceedings under the provision of the RPG Rules 1998. In view of this, the complaint is dismissed at this Forum with a liberty to the claimant to approach any other appropriate Forum for resolving her dispute.

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BEFORE THE INSURANCE OMBUDSMAN
(MAHARASHTRA & GOA)
MUMBAI

Complaint No. GI-1861 of 2011-12
Award No. IO/MUM/A/GI /2014-2015
Complainant : Shri. Pradeep Vyas/Shri. Hemant Vyas
Respondent : The Oriental Insurance Co. Ltd.

Late Shri. Pradeep Vyas was covered under Group Mediclaim Family Floater Policy bearing No.112200/48/2011/2210 (Platinum) issued by The Oriental Insurance Co. Ltd. for the period 25.2.2011 to 24.2.2012 for Floater Sum Insured of Rs.2,00,000/-. Shri. Pradeep Vyas was admitted to Unique Hospital & Polyclinic on 10.10.2011 and thereafter on 18.10.2011 was shifted to Kokilaben Dhirubhai Ambani Hospital. Whilst undergoing the treatment he died in the Hospital on 19.10.2011. As per medical certificate issued by Hospital, the cause of

death was Cardiogenic shock with Sepsis-Acute on chronic Pancreatitis-Chronic Liver Disease-Inferior Vena Cava Thrombosis. When a claim for Rs.2,20,400/- was preferred under the Policy, TPA of the Insurance Company repudiated it stating that patient was alcoholic and hence this claim is not admissible as per exclusion clause 4.8 of the Policy which excludes ailments arising out of the use of intoxicating drugs/alcohol. After perusal of the records parties to the dispute were called for hearing on 10.3.2014.

The claim has been repudiated by the Company based on the history of "chronic alcoholic" as recorded in the hospital/medicalpapers. Complainant's representative however contended that his brother used to consume alcohol occasionally and he was not a chronic alcoholic.

Pancreatitis means inflammation of the Pancreas. Alcohol consumption is the common cause of Pancreatitis. Chronic pancreatitis is a long-standing inflammation of the pancreas that alters the organ's normal structure and functions. It is usually the result of longstanding damage to the pancreas from alcohol ingestion. It is also possible for patients with chronic pancreatitis to have episodes of acute pancreatitis. In about 80 percent of the cases, acute pancreatitis is caused by gallstones and alcohol ingestion. Acute Pancreatitis is suspected when patient has symptoms and has risk factors such as alcohol ingestion or gall stone disease. Localized complications include fluid collections, pancreatic pseudocysts, pancreatic necrosis and infectious pancreatic necrosis. Alcohol consumption is the commonest risk factor to cause chronic liver disease. Infection and Thrombosis of blood vessels are the complication of Acute Pancreatitis.

In the instant case, Kokilaben Dhribhai Ambani Hospital has certified the cause of death as cardiogenic shock with sepsis due to Acute on Pancreatitis and Chronic Liver Disease. It is noted that Shri. Vyas had history of long standing alcohol consumption as the hospital/medical papers submitted before the Forum have clearly mentioned that Shri. Pradeep Vyas was a "chronic alcoholic since 15 years". As examined above alcohol ingestion is the common cause for both Pancreatitis and chronic liver disease. Viewed in this context, Company's decision to reject the claim under exclusion 4.8 based on the history recorded in the hospital papers, cannot be faulted with.

ORDER

The complaint of Shri. PradeepVyas/Shri. Hemant Vyas against The Oriental Insurance Co. Ltd. on account of repudiation of a claim lodged in respect of hospitalization at Unique Hospital & Polyclinic and Kokilaben Dhirubhai Ambani Hospital from 10.10.2011 to 19.10.2011 does not sustain. The case is disposed of accordingly.

BEFORE THE INSURANCE OMBUDSMAN
(MAHARASHTRA & GOA)
MUMBAI

Complaint No. GI-1581/2012-2013
Award No. IO/MUM/A/GI- /2014-15
Complainant: Shri Falgun Anil Kanani
Respondent: United India Insurance Company Ltd.

Complainant Shri Falgun Kanani was covered under Individual Health Insurance Policy No.021400/48/12/97/00000236 for the period 18.04.2012 to 17.04.2013 for Sum Insured Rs.5,00,000/-, issued by United India Insurance Co. Ltd. Shri Kanani experienced severe pain in neck and both shoulders for which he took some conservative treatment which did not give much relief. Hence he underwent investigations and after an MRI, was detected as suffering from Arnold Chiari Malformation Type I for which he underwent a surgery at Hinduja Hospital in June 2012. A claim lodged under the Health Policy for the same was rejected by the Company citing Exclusion Clause 4.1 of the policy which excludes all External & Internal Congenital diseases. Shri Falgun argued that though his ailment was congenital i.e. present since birth, he was not aware of the same until the age of 30. Further clause 3.10 of the policy provides for covering even pre-existing diseases after completion of a period of 4 years of continuous renewal whereas his policy had run continuoulsy for more than 10 years. He also pointed out that other policies issued by the same Insurance Company have a provision for coverage of internal congenital disease after a specific period while the terms and conditions of his policy were restrictive to that effect.

As per information available, Chiari malformations, types I-IV, refer to a spectrum of congenital hindbrain abnormalities affecting the structural relationships between the cerebellum, brainstem, the upper cervical cord, and the bony cranial base. It can cause headaches, fatigue, muscle weakness in the head and face, difficulty swallowing,

dizziness, nausea, impaired coordination, and, in severe cases, paralysis. The scale of severity is rated as Type I - IV, with IV being the most severe. Types III and IV are very rare. Type I is a congenital malformation and is generally asymptomatic during childhood, but often manifests with headaches and cerebellar symptoms. This type is difficult to diagnose and treat.

From the above it is clear that Arnold Chiari Malformation Type I suffered by the complainant is a congenital disease. Clause 4.1 of the Individual Health Insurance Policy permanently excludes all internal and external congenital diseases from the scope of the policy. Though the Forum is able to appreciate the case of the complainant in expecting the Insurer to settle the claim in view of the fact that even pre-existing diseases are covered after 48 months of continuous coverage, Health Insurance policy is an annual contract and whenever any dispute arises it is settled based on the terms and conditions of the policy under which a claim has arisen. It is to be borne in mind that this Forum has the inherent limitations in going beyond the provisions of the policy contract and the Forum examines cases in detail to see whether there is any breach of policy provisions while denying a claim and cannot grossly overlook the terms and conditions clearly spelt out in the policy and also approved by the IRDA. Under the facts and circumstances of the case, repudiation of the claim by the Company not being adversarial to the policy terms and conditions, cannot be faulted with.

ORDER

The claim of Shri Falgun Anil Kanani for reimbursement of expenses incurred for his hospitalization at P.D. Hinduja Hospital from 19.06.2012 to 25.06.2012 for the treatment of Arnold Chiari Malformation Type I with Syringomyelia C1-D1 is not sustainable. The case is disposed of accordingly.

BEFORE THE INSURANCE OMBUDSMAN
(MAHARASHTRA & GOA)
MUMBAI

Complaint No.GI-762 of 2012-2013

Award No.IO/MUM/A/GI- /2014-15

Complainant : Shri. Anuj Bhatia

Respondent : ICICI Lombard General Insurance Co. Ltd.

Complainant's spouse Smt. Alka Bhatia was covered under Home Safe Plus – Secure Mind Policy bearing No.4065/ICICI-HSP/1904607/00/000 issued by ICICI Lombard General Insurance Co. Ltd. for Sum Insured of Rs.29,10,000/- (Section I) for the period 24.6.2009 to 23.6.2014. Complainant approached this Forum with a complaint against repudiation by the Insurance Company of a claim under the Policy. The records were perused and parties to the complaint were heard during the personal hearing which was held on 21.7.2014

The analysis of the entire case reveals that as per medical papers on record, Smt. Bhatia was diagnosed to have Left Lung Collapse. Insurance Company took a stand that there has been no loss suffered by the insured as per the 9 major medical illness and procedures defined and covered under the Policy. Company repudiated the claim on the ground that ailment suffered by Smt. Bhatia i.e. Collapse Lung – left due to Bronchiectasis falls outside the purview of nine major medical illnesses and procedures defined and covered under the Policy as there is no evidence of major Organ Transplant. Complainant however is of a view that his wife suffered from irreversible left lung failure; however the lung transplant is not possible in India as the cost of the same is very high and there is a huge shortage of lung donors.

It should however be noted that the disputes in this Forum are resolved based on the terms and conditions of the Policy. In the instant case, under Section I, the Insurance Company has listed out 9 specific major illness and procedures as Insured Events which are covered under the Policy. Further, each Insured Event is specifically defined under the Policy and the "Major Organ Transplant" is one of the 9 listed Insured Events under the Policy. Major Organ Transplant is defined as the receipt of a transplant of one of the whole human organs viz. heart, lung liver, pancreas or kidney as a result of irreversible end stage failure of the respective organ. In the instant case, there is no doubt that Smt. Bhatia suffered from irreversible left lung failure. However, she was not treated by way of Lung Transplant. As the medical condition suffered by Smt. Bhatia and the treatment underwent by her falls outside the purview of nine major medical illnesses/Insured Events, Insurance Co. rejected the claim. The decision of the Insurance Company which is based on policy terms & conditions is found to be correct and hence cannot be faulted.

Whilst on the issue it is also noted that as per P-II form, the complainant has sought compensation of Rs.29,10,000/- which is the Sum Insured available under the Policy under Section I. The RPG Rule 16(2) states that – The Ombudsman shall not award any compensation in excess of which is necessary to cover the loss suffered by the complainant as a direct consequence of the insured perils, or for an amount not exceeding rupees twenty lacs (including ex-gratia and other

expenses), whichever is lower. Under the circumstances, since the compensation sought by the complainant exceeds the limit of Rs.20 lacs, on this count also, the complaint stands non-sustainable in this Forum.

ORDER

The claim of Shri. Anuj Bhatia in respect of loss suffered by him due to his wife's Left Lung Collapse is not sustainable. The case is disposed of accordingly.

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BEFORE THE INSURANCE OMBUDSMAN
(MAHARASHTRA & GOA)
MUMBAI

Complaint No.GI-102/2012-2013
Award No.IO/MUM/A/ GI- /2014-2015
Complainant : Shri. B. Bhadran
Respondent : United India Insurance Co. Ltd.

Shri. B. Bhadran along with his wife Smt. L. Sanumathi Amma and son Shri. Hridesh Bhadran was covered under Individual Health Insurance Policy bearing No. 120100/48/08/97/00014896 issued by United India Insurance Co. Ltd. for the period 22.2.2009 to 21.2.2010. Shri. Bhadran approached this Forum with a complaint against the Insurance Company about non-settlement of the claim lodged in respect of his son's hospitalisation in Lifeline General Hospital from 13.9.2009 to 26.9.2009. Records were perused and parties to the complaint were called for the personal hearing on 6.5.2014.

Shri. Bhadran submitted that his son's platelet counts were drastically dropped down, he was having high grade fever with chills, hence on 13.9.2009 he was taken to Life Line Hospital. In the hospital one Dr. Trimukhe was specially called by him from Criti Care Hospital to treat his son. He further mentioned that his son could not get any relief in the hospital and hence discharge was taken from the hospital and the further treatment was taken at Kerala. He said that if the Company was knowing that the hospital where his son was admitted was not registered, then how the Insurance Company has settled his second claim of the same hospital.

On behalf of Insurance Company it was contended that on receipt of claim documents, their Office had appointed M/s Hi Tech Medical Services to investigate into the claim and their investigator had observed the following discrepancies – 1) The hospital was not

registered with the local authorities and minimum of 15 beds' criteria was not fulfilled, 2) The address on the bill of the hospital and in the discharge card was different, 3) The IPD register, bill book and ICP were not available with the hospital, 4) Daily entries by the doctors/consultants were not available in the papers submitted to the Company, 5) Some of the medicine bills did not bear the name of the patient. He further mentioned that Dr. Babu of Lifeline Hospital has given his explanation on the above points in writing vide his letter dated 29.12.2009. In view of various anomalies/discrepancies/irregularities noted by them, the Company repudiated the claim.

On scrutiny of the entire case, this Forum also noted the following discrepancies :

1) **During hearing complainant admitted that his son was hospitalized at 8 o'clock in the night on 13.9.2009, whereas hospital paper has noted the time of admission as 9.30 a.m. on 13.9.2009.**
2) **The scrutiny of the copy of Indoor case papers reveals that except for medication details, nothing has been mentioned therein. The important details such as recording of daily visits of the doctors, doctor's advices and remarks, health status of the patient are missing. Moreover, Dr. Babu has confirmed in writing that daily entries by the consultant are not mentioned. However, in the bill, the hospital has charged Rs.20,000/- towards consultant's 20 visits and Rs.14,000/- towards RMO's 28 visits. Dr. Babu has further confirmed that bill book is not traceable bearing serial no.5048 and old IPD register is in the stores which bears the patient's name.**
3) **As per Tem./Pulse/Resp. chart of the hospital the patient had fever of 102 degree only on two days and he had no temperature above 101 degree during his entire stay in hospital. Moreover, from 22.9.2009 till 26.9.2009, his temperature reading was 98 degree. Also, the date wise noting in the indoor case papers are missing and no fresh findings were noted warranting hospitalization.**
4) **As per discharge card of the hospital, Shri. Hridesh had complaints of fever, generalized weakness, vomiting since 3 days and on admission; however during hearing complainant admitted that prior to his admission in the hospital, he had not taken any treatment from any other doctor.**
5) **During hearing complainant mentioned that in the hospital one Dr. Trimukhe was specially called by him from Criti Care Hospital to treat his son. However, the same has not been substantiated by documentary evidence as the hospital papers has no mention about daily entries of the consultant.**

Thus, apparently, major discrepancies are noted in the documents submitted in support of the claim and also as pointed out by the Insurance Company. Further, the complainant/hospital has failed to

substantiate the genuineness of the admission in the hospital with documentary evidence. Under the circumstances, the Forum does not find any fault with the decision of the Company to reject the claim in the present circumstances and the said decision is upheld.

As regards complainant's contention of admissibility of claim based on the settlement of the subsequent claim by the TPA, in a similar case, it is be to appreciated that such decisions are not binding on this Forum.

O R D E R

The claim of Shri. B. Bhadran in respect of hospitalisation of his son Shri. Hridesh Bhadran in Lifeline General Hospital from 13.9.2009 to 26.9.2009 for the complaints of Enteric Fever + Malarial Fever + Leukopenia is not tenable. The case is disposed of accordingly and the same stands closed at this Forum.

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BEFORE THE INSURANCE OMBUDSMAN
(MAHARASHTRA & GOA)
MUMBAI

Complaint No. GI-1049/2012-2013
Award No. IO/MUM/A/GI- /2014-15
Complainant: Shri Nagin Parekh
Respondent: The Oriental Insurance Company Ltd.

Shri Nagin Parekh was covered under Individual Mediclaim Policy for the period 15.06.2011 to 14.06.2012 for Sum Insured Rs.5,00,000/-, issued by Oriental Insurance Co. Ltd. On 01.01.2012, while Shri Parekh alongwith his wife and other members had gone for Hot Air Balloon ride, there was an accident resulting into injuries to some of the members including himself. He sustained fracture to his foot for which he was treated at the hospital. A claim lodged under the policy for the same was denied by the Insurance Company under Clause 4.20 stating that the accident was a result of his participation in a hazardous activity. He argued that the activity of Hot Air ballooning cannot be treated as a "hazardous activity" as compared with motor racing, scuba diving, hand gliding as the passenger does not have any role in the operation of the Hot Air Balloon which is operated by a pilot and co-pilot and he was only taking a joy ride therein which cannot be termed as "participation".

Moreover, the activity is approved by Gujarat State Tourism. He also mentioned that the claim of one of his co-passengers who was also injured at the time, was passed by the same TPA on behalf of some other Insurance Company, so how can the same activity be termed as 'hazardous' for one person and not for the other.

The issue whether hot air balloon flights can be termed as a "hazardous activity" was examined by the Forum. Hot air balloons operate on the very basic scientific principle that hot air rises. Many people practice ballooning as a sport, and some people also enjoy it as a relaxing recreational activity. Each balloon has a large bag called an envelope, attached to a sturdy gondola or wicker basket. In order to get enough lift, the air in the bag is heated with the assistance of a flame. As the air heats up, the balloon rises. The pilot can control the ascent by opening a valve to let air off, causing the balloon to drop again. When the flight is over, the pilot slowly lets out enough air to allow the balloon to drop to the ground. Being non-powered there is little steering capability for these craft, leaving them almost entirely at the mercy of winds. During the flight, the pilot's only ability to steer the balloon is the ability to climb or descend into wind currents going different directions. Control over ascent and descent is vital, and possible, but when it comes to velocity and direction, the huge balloon and its crew are utterly at the mercy of capricious winds. It is only by the use of these winds that a balloonist can "steer" his craft. Like hand gliders and kites, hot air balloons travel with the wind. The weather is the most important concern in hot air balloon safety. The National Transportation Safety Board, the U.S. agency that investigates accidents for the Federal Aviation Administration, has looked into a number of hot air balloon accidents. Most, but not all, of the accidents they investigated were caused by bad weather. The dangers of the sport include excessive (vertical or horizontal) speed during landing, mid-air collisions that may collapse the balloon, and colliding with high voltage power lines. It is the last of these, contact with power lines, that poses the greatest danger. Fires are not common, but often lead to explosions because of the close access to propane. There is anecdotal evidence to suggest that where these larger balloons are used without a rigorous licensing regime, the accident rate is many times higher than those in the more developed aviation environments. There is no body dealing with air ballooning regulations globally. Researchers have analyzed crash data for different modes of air travel and have found that the minimal regulations for hot air balloon rides may be making the tours more dangerous. The researchers specifically blame the lack of regulation covering these flights and suggest that extra safety measures, such as cushioned basket bottoms and restraints could save lives in the event of a crash.

In India, hot air ballooning is still in its nascent stage though it is slowly gaining popularity within the fraternity of adventure sports lovers. Balloonists claim that such accidents/fatalities are rare and that their sport is not particularly dangerous. Pilots say they can even be landed if they run out of fuel. But when one hits a power line, the result is almost always tragic. Hot air balloon rides are thrilling and beautiful, but not without risk. The study published in the journal Aviation, Space and Environmental Medicine, examines the number of injuries and death associated with hot air balloon crashes from 2000 to 2011. Researchers found that over this time span, there were 78 hot air balloon tour crashes, with 518 occupants being affected by the crashes. More than 80% of these crashes resulted in at least one serious injury or fatality. Most injuries sustained by passengers were broken leg bones. Most crashes occurred when the hot air balloon was landing with 65% of them involving hard landings. Collisions with power lines, trees, buildings and the ground accounted for 50% of all the serious injuries and all of the fatalities found in the study.

All the above information goes to show that Hot Air Ballooning is a hazardous activity. In the instant case also, the accident has taken place while the balloon was landing when due to the impact of hard landing, the pilot and co-pilot were thrown out as narrated by the complainant and the balloon again started rising in the air and had to be controlled by the occupants with great difficulty. Modern training systems and balloon technology mean that it is relatively uncommon for people to be injured in a hot air balloon accident but ballooning will always be an adventure and like all adventures carries a level of risk which cannot be equated with the risks/accidents involved in normal routine day-to-day activities as contemplated to be covered under an ordinary Mediclaim policy. The fact that it has been approved by the State Tourism does not necessarily imply that it will stand covered under the Mediclaim policy. As regards the complainant's argument that the claim of one of his co-passengers injured in the same accident has been paid by another Insurance Company, the reasons for the same are not known to the Forum and it may be noted that such decisions are not binding on this Forum.

In view of the above observations, the decision of the Insurance Company to repudiate the claim being based on policy terms and conditions, was found to be in order.

ORDER

The complaint of Shri Nagin Parekh against non-settlement by The Oriental Insurance Co. Ltd. of a claim lodged under the above-mentioned Mediclaim policy for his hospitalization for Fracuture of Calcaneum and Talus sustained by him due to an accident while undertaking a ride in

Hot Air Balloon on 01.01.2012, does not sustain. The case is disposed of accordingly.

BEFORE THE INSURANCE OMBUDSMAN
(MAHARASHTRA & GOA)
MUMBAI

Complaint No. GI-2388/2012-2013
Award No. IO/MUM/A/GI- /2014-15
Complainant: Shri Javedshabbirali Dawoodani
Respondent: National Insurance Co. Ltd.

Shri Javedshabbirali Dawoodani alongwith his family members was covered under Individual Mediclaim Policy No. 261400/48/11/8500008552 for the period 16.01.2012 to 15.01.2013 for Sum Insured of Rs.1,00,000/- each for himself, his spouse and his two sons and Rs.50,000/- for his daughter, issued by National Insurance Co. Ltd. Shri Dawoodani approached this Forum with a complaint against rejection by the Insurance Company of a claim lodged under the policy for the admission of his wife Smt. Salma Dawoodani to Prince Aly Khan Hospital from 20.06.2012 to 23.06.2012 for Lap. Incisional Hernia Repair.

It was contended on behalf of the Insurance Company that the patient had history of three surgeries of LSCS in the past, last being 6 years back and the hernia had developed at the site of the operation scar; hence the proximate cause of the current disease is Maternity/surgery for pregnancy and child-birth which is excluded under Clause 4.12 of the policy. The Company also forwarded opinion obtained from Dr. Girish G. Lad, M.S. which confirmed that the Multiple Incisional Hernia is a sequence of multiple (3) Caesarian Sections that Smt. Salma Dawoodani underwent (LSCS) within 6 years. The Complainant, on the other hand, felt that hernia is a separate development and should not be linked to her pregnancy after a duration of 6 years from the last surgery for child-birth.

On scrutiny of the documents produced on record, it is observed that Smt. Salma Dawoodani was admitted to Prince Aly Khan Hospital on 20.06.2012 precisely for incisional hernia repair with complaints of swelling/mass around incision since 2 years with the swelling increasing and pain around mass since 10 days. Analysis of the case revealed that in fact there are quite a few fall outs of pregnancy and child birth like severe infections, eclampsia, absence or delayed lactation etc. which would be excluded as arising out of same generic condition. In the instant case the very fact that there were 3 caesarian sections for delivery even if the last one was 6 years back, it would easily mean that

the abdominal wall was sufficiently weakened and thinned. While any abdominal surgery is always a provocation for developing into a potential hernia, Caesarian section is distinctly a trigger and a pre-disposing factor for incisional and umbilical hernia. In fact, the very expression of "swelling around the Incision" would mean that herniation was due to the incision which occurs usually with abdominal exploration. This is very commonly experienced by ladies following caesarian section. It is well known that a considerable time period may elapse after the primary surgery before an incisional hernia develops (if at all). In the instant case, it was visible since last 2 years.

In view of clear explanation in the hospital records about the nature, extent and cause of hernia due to past incisions coupled with the medical opinion obtained from a specialist doctor confirming the said fact, repudiation of the claim by the Company as per Exclusion Clause 4.12 of the policy cannot be faulted with.

ORDER

The claim of Shri Javedshabbirali for reimbursement of expenses incurred for the hospitalization of his wife Smt. Salma Dawoodani at Prince Aly Khan Hospital from 20.06.2012 to 23.06.2012 for Lap. Incisional Hernia Repair is not tenable. The case is disposed of accordingly.

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BEFORE THE INSURANCE OMBUDSMAN
(MAHARASHTRA & GOA)
MUMBAI

Complaint No.GI-1301 of 2012-2013
Award No.IO/MUM/A/GI /2014-2015
Complainant : Shri Bharat Bhiwapurkar
Respondent : Star Health & Allied Insurance Co. Ltd.

Smt. Rajashree Bhiwapurkar, spouse of the complainant, who was insured with Star Health And Allied Insurance Co. Ltd. under Policy No. P/171115/01/2012/009026 issued for the period 30.9.2011 to 29.9.2012 for Floater Sum Insured of Rs.3,00,000/- was hospitalized in Kaushalya Medical Foundation Trust Hospital from 11.9.2012 to

18.9.2012 with complaints of pain in abdomen with Lt. complicated ovarian cyst with abdominal distention and underwent Explaratory Laparotomy with (Lt) Oopherectomy with Adhesiolysis & Cystoscopy Bil. DJ Stenting. When complainant preferred a claim for Rs.1,49,843/- under the policy, Insurance Company repudiated the claim under pre-existing ailment clause and also stating that the pre-existing disease was not disclosed by the insured at the time of inception of the Policy.

Parties to the dispute were heard on 18th July, 2014. It was observed that the subject claim was reported on the first year of the policy. Company took a stand that insured had ovarian cyst removed in 2006 and had undergone hysterectomy with Right Oppherectomy in 2010 which falls prior to first incept of the Policy. The recurrent ovarian cyst is a complication of the ovarian cyst which was removed in 2006 and the present ailment is a complication of pre-existing disease and hence would fall under pre-existing ailment clause. Complainant however has contested that his wife underwent the present surgery after 66 months from the date of her previous Cystectomy surgery and also the treating doctor of his wife has certified that the present ailment is not a complication of pre-existing disease.

Analysis of the case revealed that Smt. Bhiwapurkar had history of Lap. Cystectomy done in 2006 and Total Abdominal Hystectomy with ® Oopherectomy in 2010. It appears that the complainant has not provided all the medical papers to the Forum. Whilst the medical papers of the year 2006 have been submitted to the Forum, the medical papers for the year 2010 have not been submitted by the complainant to this Forum for the reasons best known to him. Further, as per records, Smt. Bhiwapurkar underwent sonography on 3.9.2012 on the advices of Dr. R.H. Tanna; however the consultation paper of Dr. R.H. Tanna has not been submitted to the Forum. Although, it is a fact that the surgery for left ovarian cyst (Lt. Oopherectomy) was done after a period of 6 years from the date of earlier cystectomy surgery, but in absence of complete medical papers including that of the surgeries done in the year 2010, the complainant's contention that the current ailment is not a complication of pre-existing disease is not fully substantiated. Further, Smt. Bhiwapurkar also underwent the procedure of Adhesiolysis. In the "Operation Record, it is mentioned as – The abdominal cavity full of adhesions (omental dense), bowel & bladder adhesions. Typically, patients who have had any past surgical procedure in the abdominal, rectal or vaginal area can develop pelvic adhesions. In the instant case, Smt. Bhiwapurkar had history of past surgical procedures and that may be the risk factor to cause abdominal adhesions.

As regards the issue of non-disclosure of pre-existing ailment/surgeries, it should be noted by the complainant that any ailment, surgery – major or minor, whether material to the risk or not,

should be disclosed to the Insurance Company. In the instant case, Smt. Bhiwapurkar had past history of ovarian cyst/fibroid uterus/Cystectomy, Hysterectomy with Right Oophrectomy. The surgeries underwent by her was an important intervention in her health status and hence it should have been clearly disclosed by the complainant in the proposal form submitted to M/s Star Health. Since the pre-existing ailment and episodes of previous surgeries were not disclosed to the Insurance Company, it constitutes non-disclosure material to the contract irrespective of the fact whether it was material to the cause of loss/claim. Considering that Star Health was not provided with an opportunity to take appropriate underwriting decisions at the time of accepting the proposal, it would constitute non disclosure for which their rejection is in order.

O R D E R

The complaint of Shri. Bharat Bhiwapurkar with regard to repudiation of claim lodged by him in respect of hospitalisation of his wife Smt. Rajashree Bhiwapurkar in Kaushalya Medical Foundation Trust Hospital from 11.9.2012 to 18.9.2012 for Explaratory Laparotomy with (Lt) Oopherectomy with Adhesiolysis & Cystoscopy Bil. DJ Stenting is not sustainable. The case is disposed of accordingly and the same stands closed at this Forum.

BEFORE THE INSURANCE OMBUDSMAN
(MAHARASHTRA & GOA)
MUMBAI

Complaint No. GI-1641/2012-2013
Award No. IO/MUM/A/GI- /2014-15
Complainant: Smt. Bhavna B. Thakkar
Respondent: The New India Assurance Co. Ltd.

Smt. Bhavna Thakkar who was covered under Mediclaim Policy 2007 bearing No. 14010434110100001199 issued by The New India Assurance Co. Ltd. for the period 9.7.2011 to 8.7.2012 for Sum Insured of Rs.1,00,000/-, was hospitalized in Sanjeevani Surgical & General Hospital from 22.4.2012 to 28.4.2012 for the treatment of Acute CO2 Narcosis in c/o Sleep Apnoea. Her claim for Rs.93,401/- towards this hospitalisation has been repudiated by TPA of the Insurance Company stating that the cause of acute CO2 Narcosis in c/o Sleep Apnoea is Obesity Hypoventilation Syndrome and the obesity related treatment

and management is not payable under the policy as per exclusion clause 4.4.6.

Records were perused and parties to the dispute were called for personal hearing on 21.8.2014. Insurance Company contended that the term "obesity treatment and its complications" in clause 4.4.6 of Mediclaim 2007 refers to the treatment of obesity and complications of obesity. In the captioned case, the treating physician had certificed that the specific cause of the ailment was Obesity Hypoventilation Syndrome which is a case of obesity complication and hence the claim falls within the exclusion clause 4.4.6 of Mediclaim 2007 policy.

Obesity Hypoventilation Syndrome is a condition in which severely overweight people fail to breathe rapidly enough or deeply enough, resulting in low blood oxygen levels and high blood carbon dioxide (CO2) levels. The most effective treatment is weight loss, but it is often possible to relieve the symptoms by nocturnal ventilation with positive airway pressure (CPAP) or related methods. OHS is defined as combination of obesity, hypoxia during sleep and hypercapnia during the day, resulting from hypoventilation. Most people with obesity hypoventilation syndrome have concurrent obstructive sleep apnoea, a condition characterized by snoring, brief episodes of apnoea during the night, interrupted sleep and excessive daytime sleepiness. In OHS, sleepiness may be worsened by elevated blood level of carbon dioxide which causes drowsiness (CO2 narcosis). Sleep apnea is a type of sleep disorder characterized by pauses in breathing or instances of shallow or infrequent breathing during sleep. Risk factors for sleep apnea include being male, overweight, obese, or over the age of 40; or having a large neck size, enlarged tonsils, enlarged tongue, small jaw bone, family history of sleep apnea, gastroesophogeal reflux, deviated septum causing nasal obstruction, allergies, or sinus problems.

In the instant case, medical papers indicate that complainant was a k/c/o sleep apnoea. As examined above obesity is one of the risk factors to cause sleep apnoea. She further developed Acute CO2 narcosis and her treating doctor has certified that Obesity Hypoventilation Syndrome was the specific cause to develop Acute CO2 narcosis. As examined above, OHS is a condition in which severely overweight people fail to breathe rapidly enough or deeply enough, resulting in low blood oxygen levels and high blood carbon dioxide (CO2) levels. Thus, there is no doubt that the ailment suffered by the complainant was a complication of Obesity. The claim of the complainant has been repudiated by the Company under exclusion clause 4.4.6 which reads as – "Permanent Exclusion : Any medical expenses incurred for or arising out of Convalescence, general debility, 'Run down' condition or rest cure, obesity treatment and its complications, …….". A plain reading of this clause would mean that the

expenses incurred on weight loss treatment and the complications arising there from are excluded from the scope of the Policy. Although, weight loss is one of the treatment options for the patients suffering from OHS, but in the instant case weight loss treatment was not carried out. If it was the intention of the Company to exclude the treatment of obesity and complications of obesity, then the same should have been properly worded leaving no scope for interpretation. The Company's intention would have come out clearly had it been worded as – "Obesity and its complications & all treatments arising therefrom". The terms and conditions attached to the Policy document should be very specific and it should not mislead or be likely to mislead by ambiguity. It is strongly felt that there is indeed an ambiguity in the in the policy as regards the clause – "Obesity treatment and its complications", leaving scope for interpretation.

Although, it is fact that the ailment for which the complainant was admitted to the hospital was a complication of Obesity, but in view of the ambiguity in the policy wording as pointed out above, I would like to award 50% of the admissible expenses to the complainant to resolve the dispute in the present case.

O R D E R

The New India Assurance Co. Ltd is directed to pay 50% of the admissible expenses to the complainant in respect of expenses incurred by her on her hospitalisation in Sanjeevani Surgical & General hospital from 22.4.2012 to 28.4.2012 for the treatment of Acute CO2 Narcosis in c/o Sleep Apnoea. There is no order for any other relief. The case is disposed of accordingly.

BEFORE THE INSURANCE OMBUDSMAN
(MAHARASHTRA & GOA)
MUMBAI

Complaint No. GI-924/2012-2013
Award No. IO/MUM/A/GI- /2014-15
Complainant: Shri Deepak Nilkanth
Respondent: The New India Assurance Co. Ltd.

Shri. Deepak Nilkanth was covered under Mediclaim Policy 2007 bearing No. 13100034110100000831 issued by The New India Assurance Co. Ltd. for the period 26.5.2011 to 25.5.2012 for Sum Insured of Rs.3,00,000/- 10% CB. Shri. Nilkanth underwent L5-S1 Microendoscopic Dissectomy for the complaints of L4-L5 Disc with

Neurological Deficit in Saifee Hospital where he was hospitalized from 24.8.2011 to 26.8.2011. A claim lodged under the policy for the said hospitalizaion was repudiated by the Insurance Company. Aggrieved by the decision of the Company, Shri Nilkanth approached this Forum for settlement of the claim.

Records were perused and parties to the dispute were called for personal hearing on 13.6.2014. The claim for the above hospitalisation has been reported on the third year of the Policy. Insurance Company has rejected the claim under clause 4.3 which states that the Age Related Osteoarthritis has a waiting period of four years. During hearing, Complainant drew the attention of the Forum to a certificate issued by his treating doctor stating that Mr. Deepak Pandharinath Nilkanth was operated for acute on chronic prolapsed intervertebral disc. The complainant is a of a view of that the ailment suffered by him would fall under "Prolapse Inter Vertenbral Disc" which has a waiting period of two years.

Dr. Mukesh of TPA submitted that the MRI done immediately prior to hospitalisation, clearly indicates that the ailment suffered by the complainant was degenerative in nature. Due to degeneration, weakening takes place in a central part of the disc and because of pressure, central part of the disc gets prolapsed and it pressurizes the spinal cord and nerve root and results in radiculopathy, causing back pain. He stated that the ailment suffered by the patient was degenerative osteoarthritis which thereafter results in Prolapsed Intervertebral Disc.

In the light of the deposition made by Dr. Mukesh of TPA and the certificate issued by the treating doctor of the hospital, the Company was directed to seek an independent opinion from Orthopaedic doctor, as to whether the ailment suffered by the complainant would fall under the category of "Age related Osteoarthritis" or "Prolapse Inter Vertebral Disc" and re-examine the case in the light of the said opinion and revert back to this Forum.

In response, Insurance Company submitted their reply with a copy of opinion obtained by them from Dr. Ashith Rao, MS, Orth., D.Orth. Dr. Ashith Rao opined as under : "I have examined the reports and discharge card of Mr. Deepak Nilkanth. The X-ray report – a degenerative condition. The MRI revealed Multiple level disc dessication, focal disc protrusion at L1-2. Disc protrusion with annular tear at L4-5with compression of L-4 root with min compression on L5. Disc protrusion is diffusely seen in L5L1with S1 root on the Rt. Side compressed. All these findings suggest a degenerative disc changes in L1L2L3L4& L5. S1 spacer Disc herniation at 3 levels suggests canal compromise and early spinal canal stenosis. These are c/f signs of age-related degenerative disc disease". Company re-iterated their decision

by stating that degenerative disc disease is nothing but age related osteoarthritis and hence falls under clause 4.3 No.22 which attracts a waiting period of four years.

The Policy has a waiting period of four years for "Age Related Osteoarthritis". Osteoarthritis (OA) also known as degenerative arthritis or degenerative joint disease or osteoarthrosis, is a group of mechanical abnormalities involving degradation of joints, including articular cartilage and subchondral bone. OA commonly affects the hands, feet, spine, and the large weight bearing joints, such as the hips and knees, although in theory, any joint in the body can be affected. In the instant case, going by the finding of X-ray report and opinion given by Dr. Rao, the ailment would technically fall under the category "Age Related Osteoarthritis" which has a waiting period of four years.

This Forum however further observed that Policy has a waiting period of two years for "Prolapse Intervertebral Disc unless arising from accident". However, there is no clarity as to whether PID arising from degenerative conditions also would have waiting period of two years or the same would automatically fall under the category of "Age Related Osteoarthritis". Thus, in absence of any such specification in the Policy clause, there is a scope for different interpretations. The Forum strongly feels that the same ailment should not attract two different waiting period under two different headings. Thus, the clause – "waiting period of two years for Prolapse Intervertebral Disc unless arising from accident" is too vague. The terms and conditions attached to the Policy document should be very specific and it should not mislead or be likely to mislead by ambiguity. It is strongly felt that there is indeed an ambiguity in the in the policy as regards the waiting period for "PID", leaving scope for interpretation.

In the instant case, claim reported by the complainant is related to PID; however the same has been certified by the Specialist doctor as age related degenerative disc disease. Thus, in view of the ambiguity in the policy wording as pointed out above and to strike a reasonable balance, I would like to award 50% of the admissible expenses to the complainant to resolve the dispute in the present case.

O R D E R

The New India Assurance Co. Ltd is directed to pay 50% of the admissible expenses to the complainant in respect of expenses incurred by on his hospitalisation in Saifee Hospital from 24.8.2011 to 26.8.2011 for L4-L5 Disc with Neurological Deficit. There is no order for any other relief. The case is disposed of accordingly.

BEFORE THE INSURANCE OMBUDSMAN
(MAHARASHTRA & GOA)
MUMBAI

Complaint No. GI-1017/2013-2014
Award No. IO/MUM/A/GI- /2014-15
Complainant: Shri Shevgoor S. Kamath
Respondent: The New India Assurance Company Ltd.

Shri Shevgoor S. Kamath was covered under Individual Mediclaim Policy No.111200/34/11/01/00015776 for the period 29.03.2012 to 28.03.2013 for Sum Insured Rs.3,00,000/-, issued by The New India Assurance Co. Ltd. Shri Kamath approached this Forum with a complaint against rejection by the Insurance Company of a claim lodged under the policy for the treatment of Multiple Myeloma taken by him at S.L. Raheja Hospital, Mumbai on 25.02.2013.

Records were perused and a joint hearing of the parties to the dispute was held on 01.08.2014. On scrutiny of the documents produced on record coupled with the depositions of the parties, it is observed that Shri S.S. Kamath was diagnosed as suffering from Multiple Myeloma and has been receiving treatment for the same since March 2011 by way of chemotherapy and Radiation therlapy. After the conclusion of 1st stage of radiation treatment in October 2012, he was started on oral medicine treatment for six months from November 2012 and in between, had to be evaluated for post-radiation progress. The Insurance Company settled the claims lodged under the policy for chemotherapy and radiation treatment undergone by him while the claim for expenses of the progress evaluation undergone by him on 25.02.2013 was denied by the Company stating that it was an OPD consultation and did not fall within the time-limit prescribed under the policy for post-hospitalization treatment. The complainant argued that the progress evaluation was

part of the continuing treatment and was not for evaluation of a new sickness and when the Company has paid all the claims for the treatment taken by him previously and subseqent to the said claim, denial of the subject claim relying on changed policy terms and conditions was not justified.

On an analysis of the case, it is noted that the Mediclaim policy basically grants reimbursement of hospitalisation expenses with a certain restriction on the period of hospitalization viz. one month pre-hospitalisation period, the period of actual hospitalization and a post-hospitalization period of two months from the date of discharge. And in all these cases, the basic criterion of "hosptialisation" as such is not compromised but only relaxation of minimum period of 24 hours' hospitalisation is granted for specific treatments listed under clause 3.4 of the policy in view of lesser time taken now for the treatments as compared to earlier times due to advancement of medical science. The said list includes Parenteral Chemotherapy and Radiotherapy and accordingly the Company has settled the claims of the complainant for these treatments undergone by him from time to time. As regards the claim for progress evaluation done on 25.02.2013 however, it is seen that there was no indoor confinement in the hospital as the same was done on OPD basis. Moreover, it was merely a follow-up consultation and not for direct treatment per se. Also, it did not fall within the period of 60 days following main hospitalization to qualify reimbursement under the head "post-hospitalization expenses" under the policy. Hence the claim could not be admitted under the policy and denial of the claim by the Company was done as per policy terms and conditions. Only if the claim is admissible, the expenses falling under various heads listed under the policy viz. Room, Boarding, Nursing expenses, Surgeon, Aneshtetist, Consultant, Specialists fees, etc. would be payable. The complainant's argument that the policy terms and conditions were revised at the time of renewal due to which his claim stood denied, is not correct as the condition of 30 day's pre-hospitalization and 60 days' post hospitalization cover was very much there since the introduction of Mediclaim policy. Besides, it should be noted that Mediclaim policy is an annual contract and whenever any dispute arises it is settled based on the terms & conditions of the policy under which a claim has arisen.

It is admitted that the treatment of Cancer and similar other critical ailments require continued medical treatment entailing high expenditure but admissibility of these expenses is subject to the policy terms and conditions. It is to be borne in mind that this Forum has the inherent limitations in going beyond the provisions of the policy contract and the Forum examines cases in detail to see whether there is any breach of policy provisions while denying a claim and cannot grossly overlook the terms and conditions clearly spelt out in the policy and also approved by

the IRDA. Under the facts and circumstances of the case, repudiation of the claim by the Company not being adversarial to the policy terms and conditions, I do not find any valid ground to intervene with the decision of the Insurance Company in the matter and hence no relief can be granted to the complainant.

ORDER

The complaint of Shri Shevgoor S. Kamath against The New India Assurance Co. Ltd. in respect of repudiation of the claim lodged for post-radiation progress evaluation undergone by him at S.L. Raheja Hospital on 25.02.2013, does not sustain. The case is disposed of accordingly.

BEFORE THE INSURANCE OMBUDSMAN
(MAHARASHTRA & GOA)
MUMBAI

Complaint No.GI-867 of 2012-2013
Award No.IO/MUM/A/ GI /2014-15
Complainant : Shri. Anupam Jasani
Respondent : The New India Assurance Company Limited

Shri. Anupam Jasani who was covered under Mediclaim Policy (2007) No.14200034110100006927 issued by The New India Assurance Co. Ltd. for the period 12.10.2011 TO 11.10.2012 for Sum Insured of Rs.3,00,000/- 30% CB, was hospitalized in Bhatia Hospital from 23.5.2012 to 26.5.2012 where he was diagnosed to have Anxiety with Depression with Diabetes. When the claim of Rs.48,373/- was reported under the policy towards reimbursement of the expenses incurred on this hospitalization, TPA of the Insurance Company rejected the claim stating that expenses related to psychiatric disorders are not payable as per exclusion clause 4.4.6 of the Policy. Being aggrieved, complainant approached this Forum for redressal of his grievance. Records were perused and both the parties were called for personal hearing on 19.8.2014.

Complainant contended that mild anxiety or temporary depression should not be considered as psychiatric disorders as it is a temporary phenomenon and can be sorted out. He also pointed out that his blood sugar reading on 23.5.2012 and 25.5.2012 was very high and the treatment of diabetes has been completely ignored by the Company. Further, the haemoglobin level was low and required treatment for the same.

The Forum analyzed the case. In the instant case, in the indoor case papers of the hospital, it is clearly recorded that the complainant had complaints of – restlessness, disturbed sleep, increased thinking, depression, decreased confidence and s.i. and the final diagnosis made

by the hospital was Anxiety with Depression. During hospitalisation, Shri. Jasani was treated with antidepressant medications and on discharge also he was advised to continue the same. The further scrutiny of the papers do not indicate any treatment for physiological illness which needed confinement barring diabetes, for which he was treated, which would not have warranted the hospitalisation in isolation.

The term psychiatric disorder means a mental disorder or illness that interferes with the way a person behaves, interacts with others, and functions in daily life. Mental disorders are generally defined by a combination of how a person feels, acts, thinks or perceives. Depression is a common feature of mental illness, whatever its nature and origin. When a person suffers from depression, it interferes with his daily life and causes pain for both him and those who care about him. Whatever the symptoms, depression is different from normal sadness in that it engulfs a person's day-to-day life, interfering with his ability to work, study, eat, sleep, and have fun. Depression can make people feel profoundly discouraged, helpless, and hopeless. Depression and anxiety might seem like opposites, but they often go together. Medications are used to treat the symptoms of mental disorders such as schizophrenia, depression, bipolar disorder and anxiety disorders.

The policy on which the claim is lodged carries a specific clause to exclude the expenses incurred on Psychiatric disorders. It should be appreciated that the disputes in this Forum are resolved based on the terms and conditions of the policy on which the claim is preferred. As the Psychiatric disorder is a permanent exclusion under the Policy, Insurance Company rejected the claim, which appears to be in order.

As regards the issue of diabetes, it is noted that Shri. Jasani was treated for the same only with oral medication and for diabetes per se, there was no need for hospitalisation.

Under the circumstances this Forum does not find any valid ground to intervene with the decision of the Insurance Co.

ORDER

The complaint of Shri. Anupam Jasani against The New India Assurance Co. Ltd. in respect of repudiation of his claim lodged towards his hospitalization in Bhatia Hospital from 23.5.2012 to 26.5.2012 for Anxiety with Depression with Diabetes is not sustainable. The case stands closed at this Forum.

BEFORE THE INSURANCE OMBUDSMAN
(MAHARASHTRA & GOA)
MUMBAI

Complaint No. GI-2019/2012-2013
Award No. IO/MUM/A/GI- /2014-15
Complainant: Shri Tayebali Egmail Patrawala
Respondent: The New India Assurance Company Ltd.

Complainant Shri Tayebali Patrawala was covered under Individual Mediclaim Policy No.111200/34/11/01/00005018 for the period 24.08.2011 to 23.08.2012 for Sum Insured Rs.5,00,000/- plus C.B. Rs.95,000/-, issued by The New India Assurance Co. Ltd. Shri Patrawala was insured with the Company continuously since the year 2000. He lodged a claim under the above-mentioned policy for his hospitalization in June 2012 for the treatment of acute coronary syndrome. The hospital papers mentioned his past history as "Morbid obesity – B. wt. 124 kg. - k/c/o DM since 5 years on OHA. Habits – Smoking 10-12/day & occ. Whisky/vodka since 10-12 years". Based on the said history, the claim was denied by the Insurance Company stating that morbid obesity and habits of tobacco, occasional drinking are the major causes of the present ailment.

The insured argued that he suffered from and was treated for heart ailment and not for obesity and also produced a certificate from his treating doctor denying the history of smoking and drinking. In this connection, it may be stated that the history narrated before the doctor either by the patient or his/her representative is his or her own statement and hence cannot be totally overlooked. Every body would like to give exact narration to the doctor so as to enable him to make proper judgement with all the facts put before him so as to enable him to arrive at a correct diagnosis and adopt a proper line of treatment. In the face of patient's or his representative's own submission and admission which is received through the hospital papers, such

certificates produced after rejection of claim would be deemed as an after-thought and cannot be accepted.

Further, it is a well established fact in Medical Science that Smoking is a major risk factor for heart disease. Smoking harms nearly every organ in the body, including the heart, blood vessels, lungs, eyes, mouth, reproductive organs, bones, bladder, and digestive organs. Any amount of smoking, even light smoking or occasional smoking, damages the heart and blood vessels. For some people, such as women who use birth control pills and people who have diabetes, smoking poses an even greater risk to the heart and blood vessels. When combined with other risk factors—such as unhealthy blood cholesterol levels, high blood pressure, and overweight or obesity—smoking further raises the risk of heart disease. Smoking also is a major risk factor for peripheral arterial disease (P.A.D.). P.A.D. is a condition in which plaque builds up in the arteries that carry blood to the head, organs, and limbs. Coronary heart disease (CHD) occurs if plaque builds up in the coronary (heart) arteries. Over time, CHD can lead to chest pain, heart attack, heart failure, arrhythmias, or even death.

In view of the afore-mentioned information, Shri Patrawala being a k/c/o morbid obesity and diabetes, the contention of the Company that these factors coupled with his habits of smoking and occasional drinking could have led to his heart ailment cannot therefore be set aside. Clause 4.4.6 of the Individual Mediclaim Policy excludes payment of any medical expenses incurred for treatment of an ailment arising out of use of intoxicating drugs/alcohol/ tobacco. In the facts and circumstances of the case, the decision of the Company to repudiate the claim being based on policy terms and conditions cannot be faulted with.

ORDER

The claim of Shri Tayebali Patrawala for reimbursement of expenses incurred for his hospitalization at Prince Aly Khan Hospital from 25.06.2012 to 27.06.2012 for the treatment of Acute Coronary Syndrome is not sustainable. The case is disposed of accordingly

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BEFORE THE INSURANCE OMBUDSMAN
(MAHARASHTRA & GOA)
MUMBAI

Complaint No. GI-2401 of 2012-2013
Award No. IO/MUM/A/GI /2014-2015
Complainant : Shri Manoj Agarwal
Respondent : The Oriental Insurance Co. Ltd.

Late Shri. Ramniwas Agarwal, father of the complainant was covered under Group Mediclaim Tailor Made Policy bearing No.124500/48/2012/2565 issued by The Oriental Insurance Co. Ltd. to M/s Trisure Healthcare Trust for the period 10.6.2011 to 9.6.2012 for Floater Sum Insured of Rs.5,00,000/-. Shri. Ramniwas Agarwal was hospitalized in Hinduja Healthcare from 5.3.2012 to 19.3.2012 where he was diagnosed to have Septicemia with Respiratory failure with COPD with Secondary Fungal LRTI with AKI on CKD with IHD with poor LVF. When complainant lodged a claim for Rs. 6,58,906/- under the Policy, TPA of the Insurance Company repudiated the same stating that the the proximate cause of presting complaints and COPD is chronic smoking habit of the patient. Being aggrieved, complainant approached this Forum for redressal of his grievance.

The records of the case were perused and both the parties were called for hearing on 17.7.2014. In the instant case, complainant was suffering from Chronic obstructive pulmonary disease. In January, 2012, he was hospitalized in Lilavati Hospital for Lower Respiratory Tract Infection and within a period of two months, he was again admitted with similar complaints. This time, he also suffered from Respiratory failure, Septicemia and Acute Kidney Injury. Further, whilst undergoing the treatment in Bombay Hospital he passed away on 29.4.2012.

Chronic obstructive pulmonary disease (COPD) is a lung ailment that is characterized by a persistent blockage of airflow from the lungs. It is a life-threatening lung disease that interferes with normal breathing and is not fully reversible. The most common symptoms of COPD are breathlessness, abnormal sputum (a mix of saliva and mucus in the airway), and a chronic cough. Tobacco smoke (cigarette smoking) is the single most important risk factor for COPD). The lining of the airways becomes inflamed and permanently damaged by smoking. This damage cannot be reversed. COPD can cause respiratory failure. COPD prevents enough air from flowing in and out of the airways. In the setting of chronic obstructive pulmonary disease (COPD), lower respiratory tract infections, both acute and chronic, occur with increased frequency. Septicemia is a serious, life-threatening infection that gets worse very quickly. It can arise from infections throughout the body, including infections in the lungs, abdomen, and urinary tract. Sepsis commonly originates from abdominal or digestive system infections,

lung infections like pneumonia, bronchitis, or lower respiratory tract infections. Septicemia can directly injure kidneys.

As examined above, COPD patients are prone to respiratory failure and lower respiratory tract infection. In the instant case, Shri. Agarwal suffered from the same and further, septicemia and acute kidney injury was the fallout of his Lung disease. In the discharge card of Hinduja Healthcare, the history is clearly recorded as "Chronic Smoker". As examined above, the primary cause of chronic obstructive pulmonary disease (COPD) is tobacco smoke. Although, the complainant has contended that the history was erroneously recorded in the hospital paper, but said history is also appearing in the Bombay Hospital history sheet. The two hospitals cannot make a same mistake. The hospital papers being the first and foremost information cannot be ignored in the circumstances of the case. These papers cannot be prepared "by mistake" or negligently and the history is recorded as per the statement made to the hospital. Alochol, tobacco, smoking and other intoxicants can adversely affect many systems in the body and the role of these substances in the patient's problems can be easily judged by the history. The hospital records, which is a legal document cannot be changed by means of a simple certificate, submitted as a valid document to the TPA/Company following the discharge.

Considering these facts, Company's decision to reject the claim under exclusion clause 4.8 based on the history recorded in the hospital papers, cannot be faulted with.

ORDER

The complaint of Shri. Manoj Agarwal against The Oriental Insurance Co. Ltd. on account of repudiation of a claim lodged by him in respect of his father's hospitalization at Hinduja Healthcare from 5.3.2012 to 19.3.2012 for the treatment of Septicemia with Respiratory failure with COPD with Secondary Fungal LRTI with AKI on CKD with IHD with poor LVF does not sustain. The case is disposed of accordingly.

Complaint No. GI- 1657of 2012-2013
Award No. IO/MUM/A/ 497/2014-2015

Complainant, approached the Forum with a complaint against New India Assurance Company Limited in the matter of non-settlement of his wife's claim amounting to Rs. 95,000/- lodged under Policy No. 131500/34/11/002/12702 for treatment of Infraumbilical Hernia taken at Kirit Nursing Home.

In the case on hand, the admission of the Insured to the hospital was for treatment of Infraumbilica Hernia which is no doubt a

complication of Obesity as treating doctor himself has mentioned in his certificate that Hernia was due to fat and medical papers reveal that she was Obese (+).

The Insurance company's interpretation of clause 4.4.6 is that the policy excludes treatment of obesity and complication of obesity." However, it is not properly worded to give such an indication, as the said clause can also be interpreted to exclude obesity treatment (i.e. weight loss treatment/bariatric surgery etc.) and complications arising out of it. Hence, the Forum is constrained to hold the view that there was obvious ambiguity in the policy condition.

In the instant case, the insured underwent surgery for repair of umbilical hernia and not any weight loss treatment and therefore the present claim will not fit into the said exclusion.

If it was the intention of the Insurer to exclude obesity, its complications and also its treatment, then it should have been properly worded leaving no room for any misconception. The company's intention would have come out clearly had the exclusion been worded as follows - "Obesity and its complications and all Treatments arising out of the same."

The Forum feels that the terms and conditions attached to the policy document should be very specific and there should not be any ambiguity. Although it is a fact that the ailment for which the complainant was hospitalized was due to obesity, but in view of the ambiguity in the policy wording as pointed out above, I would like to award 50% of the admissible expenses to the complainant to resolve the dispute in the present case keeping in mind the fact that the Policy has been drafted by the Insurer.

Dated at Mumbai, this 23rd day of September, 2014.

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Complaint No. GI- 466 of 2012-2013
Award No. IO/MUM/A/ 87/2014-2015

Complainant, approached this Forum with a complaint against Insurance Company Limited vide his letter dated 11th June, 2012 in the matter of non-settlement of his Mediclaim amounting to about Rs. 27, 534/- lodged under Mediclaim Policy No.160800/48/10/20/4316. The claim was denied by the insurance company based on exclusion clause 4.10

It is noted from the medical papers that the complainant was diagnosed to have Right High Parital Stroke with Sensory Motor Neuropathy. Thus it is evident that there was a positive existence of an illness and it was a complaint which required attention more so, when the insured aged 69 years developed weakness in the left upper and

lower limbs. As regards investigations made at the hospital it should be accepted that only after the investigations, the precise diagnosis can be made. Hence there would not be any denying the fact that to arrive at a diagnosis some investigations would be necessary and in this case, considering the fact that there was a MRI done which gave the impression of acute infract in right frontal motor cortex and corticalatrophy with ischaemic foci in supratentorial compartment which needed a proper medical management, the contention of the company that there was no active line of treatment given is not tenable.

Under the circumstances, the insurance company was directed to settle the claim for the admissible expenses.

Dated at Mumbai, this 13th day of May, 2014.

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Complaint No. GI- 192 of 2012-2013
Award No. IO/MUM/A/444 /2014-2015

Complainant, approached the Forum with a complaint against Insurance Company vide her letter of 3rd May, 2012 in the matter of non-settlement of her claim amounting to Rs. 4.78 lakhs lodged under Policy No. OG-11-1904-8401-00003734 pertaining to hospitalisation of her daughter from 6/11/2011 to 14/11/2011 for treatment of intracerebral haemmorhage secondary to Arteriovenous Malformation (AVM).

Ms. Disilva, daughter of complainant was covered under Health Guard Individual Polilcy issued by Bajaj Allianz General Insurance Company for a sum insured of Rs. 5 lakhs. A claim was lodged with the Insurance Company during the second year of the policy which was denied by them as per Policy exclusion clause C3 –Congenital internal diseases or anamolies.

The complainant contended that her daughter never had any problem regarding her health in the past and there were no insurance claims made for her until this disputed claim. She had submitted two certificates one from her family physician and other from Dr. Manish Shrivastava, substantiating good health of her daughter, which were not considered by the Insurance Company. Further at the hearing she deposed that in the Mediclaim Medical Report filled in and signed by Dr. Anandh of Kokilaben Hospital, the doctor has stated that the disease was not caused due to any congenital defect. Hence the rejection of the claim was not acceptable to her.

During hearing the complainant as well as the Insurance company were directed to obtain clarifications from the treating doctor in view of the fact that medical websites on the subject states that AVM was a congenital disease.

Accordingly, the complainant submitted clarification from the treating doctor, Dr. Anandh B. which reads as under :

"AVM is a developmental anamoly which can come at any age , cause not known. It can bleed suddenly without any pre-existing symptoms. It is not congenital ie. present since birth."

On going through the above certificate it is noted that the doctor has stated that AVM is a developmental anamoly which can manifest at any age. Developmental anomaly as per Dictionary is a broad term used to define conditions which are present at conception or occur before the end of pregnancy and as per the medical dictionary developmental anamoly is defined as an anamoly established during intrauterine life, a congential anamoly". Hence, the doctor by writing that AVM is a developmental anamoly has admitted that it is an anamoly established during intrauterine life. What is non-congenital that he mentions in the certificate is the symptom of AVM i.e. bleeding or haematoma and not AVM per se. Even in the Mediclaim Medical Report filled in and signed by him, he has stated that the disease of Intracerebral Haematoma suffered by the Insured was not caused due to any congenital defect, i.e. the doctor has commented about intracerebral haematoma, which is a symptom of AVM, to be non-congenital and not about AVM per se.

The medical opinion obtained by the Company from by Dr. Ashutosh N. Shetty is clear to state that AVM is a congenital disease.

Based on the analysis made as above and confirmation about the disease being congenital as per the various medical websites available, there is no valid ground for the Forum to intervene with the decision of the Insurance Company.

Dated at Mumbai this 23rd day of September, 2014.

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Complaint No. GI- 106 of 2012-2013
Award No. IO/MUM/A/ 277/2014-2015

Complainant, approached the Forum with a complaint against Insurance Company vide her letter of 18/4/2012 in the matter of non-settlement of her claim amounting to Rs. 75,470/- lodged under Policy No. 140104/34/09/11/476 in respect of her hospitalisation at Surgicare Hospital from 9/11/2010 to 14/11/2010 for treatment of fracture. The

claim was denied by the Insurance Company on the ground of misrepresentation.

There is no doubt that there has been manipulation in the date of discharge which has been altered to 14/11/2010 instead of 12/11/2010. Since there is a remark in the ICP by the treating doctor on 12/11/2010 as " patient stable no fresh complaints – Discharge", the same date could be taken as the correct date of discharge. However, the Insurance Company raised a point that if the complainant is admitting that the date of discharge was written as 14/11/2010 by mistake in the discharge card, then why they had written the date of discharge as 14/11/2010 in the claim form when it was accepted by them that the correct date of discharge was 12/11/2010. In response to this the Complainant explained that they had not noticed the said discrepancy and it was not their intention to defraud the Company.

Insurance Company pointed out that the x-ray plates supporting the fracture was not submitted by the Insured. However, the complainant's representatives at the hearing produced a copy of the acknowledgement receipt issued by Medi-Assist for receipt of x-ray plates from the Insured dated 23/5/2011. Company to clarify in this regard.

After the hearing, the representative of the Company's TPA verified from their Office about the date of the Hospital bill and she was given to understand that the hospital had billed the patient upto 14/11/2011 and the Insured had paid the bill upto 14/11/2011 although, it was accepted by the Insured's representative that his mother was discharged on 12/11/2010.

In view of this, the Insurance Company was directed to submit a copy of the bill for the examination of the Forum and also send a copy of the same to the complainant, since they pleaded that they do not have any copy of the same, within 7 working days. The complainant is advised to go through the same and offer their comments, if any on the same within the above period.

Pursuant to the hearing the Insurance Company submitted the copy of the Surgicare Hospital Bill which shows that the date of discharge was mentioned as 14/11/2010 and the bill amount was Rs. 75,470/-. They have also submitted the receipt for the payment made by the complainant to the hospital for Rs.75,470/-.

On going through the same it is felt that if the complainant had agreed that 12/11/2010 is the correct date of discharge, and 14/11/2010 was wrongly written by the Hospital, then a question would arise as to why then he had paid the bill till 14/11/2010. What prevented him from bringing this error to the notice of the Hospital and get the bill rectified and paid the bill only upto 12/11/2010, since he accepted that his mother was discharged on 12/11/2010. This raises serious doubts about the

genuineness of the claim.

The Insurance Company had also sent a copy of the bill to the complainant as directed during the hearing, and he was advised to offer his comments on the same. However, the complainant has not submitted any explanation to the Forum.

Under the circumstances, there is no valid ground for the Forum to intervene with the decision of the Company to reject the claim as per Clause 5.5 (mis-representation/misdescription)

Dated at Mumbai, this 4th day of July, 2014.

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Complaint No. GI-1382(2012-2013)
Complainant: Mrs.Amita Bhave
Vs
Respondent: The New India Assurance Co. Ltd.,

Mrs. Amita Bhave, her mother Mrs. Sudha Shevade and her son Master Sahil Bhave were covered under policy number 12050034110100000023 issued by The New India Assurance Co. Ltd. Mrs. Sudha Shevade took treatment for Right Subretinal Hemorrhage at Wavikar Eye Institute on 19.07.2012 . When she preferred the claim, it was rejected on the grounds that treatment given is OP based treatment and Lucentis injection is excluded under Mediclaim policy norms.

Not satisfied with their decision, Mrs. Amita Bhave approached the Office of Insurance Ombudsman for redressal of their grievance and requested that claim be settled.
After perusal of the records, parties to dispute were called for hearing.

The New India Assurance Co. Ltd., was represented by Mr. Ganesh Swaminathan – Regional Manager and Mr. Duttatreya Pandey- AO. . Mr. Ganesh Swaminathan stated that since treatment given is OPD based and there is specific exclusion in the policy for treatment of Lucentis injection, the claim was repudiated accordingly. Mrs Amita stated that as per the policy issued to her, there is no such exclusion. Ombudsman directed Mr. Ganesh Swaminathan to go through the policy terms and conditions issued to the insured. On going through the copy of policy terms and conditions issued to the insured, Mr. Ganesh stated that last page wherein the said exclusion clause is included is not to be found.

Ombudsman directed the complainant to submit all the policy documents pertaining to any year before and one year after the claim period along with terms and conditions if available with her within 10 days to this forum.

On 27.02.2015, the forum received letter dated 26.02.2015 from the company stating the following:
"The insurer feel obligated to present the following:

a) **Mediclaim 2007 Bilingual which specially excludes Age Related Macular Degeneration under clause 6(g)**
b) **Copy of Mediclaim Policy 2012 issued to Mrs. Amita Bhave, Policy no. 12050034132500000019 valid from 15.03.2014 to 14.03.2015 which excluded Age Related Macular Degeneration under clause 4.4.22.**

The insurers would further like to submit that a copy of the policy is available to all freely on the link http://newindia.co.in/downloads/MediclaimPolicy-2007.pdf, wherein Age Related Macular Degeneration has been excluded. Mediclaim Policy 2012 may be perused at the link http://newindia.co.in/downloads/Mediclaim-2012-Policy.pdf wherein Age Related Macular Degeneration has been excluded under clause 4.4.22.It is further submitted that the aforesaid internet links do not require any special permission or access and can be perused by all."

On 03.03.2015, the forum received email from Mrs. Amita Bhave stating the following:
"With reference to your request, I do not have policy documents of earlier or next year available with me. However please note that the policy documents relevant for the year of complaint along with all other supporting have been already submitted to your office."

The entire documents submitted to this forum and deposition of both the parties to dispute is taken on record. On going through the policy terms and conditions, it is observed that Clause 6(g) states "All treatments like Age Related Macular Degeneration (ARMD) and or Chorodial Neo Vascular Membrane done by administration of Lucentis/ Avantis/ Macugen and other related drugs as intravetral injection, Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP) and Hyperberic Oxygen Therapy are excluded under this policy."

From the above it is evident that the rejection of claim by the company is as per policy terms and conditions.

Complainant: Shri Ashok Kumar
v/s.
Respondent: The New India Assurance Co. Ltd.,

Mr. Ashok Kumar was covered under mediclaim policy no. 140501/34/10/03/00020007 issued by The New India Assurance Co. Ltd. He was admitted to Alliance Hospital, Nallasopara on 19.08.2011 to 25.08.2011 with diagnosis of GI Bleed with acalculus cholecystitis with septicemia .When he lodged the claim with the insurer for Rs. 67580/- , it was repudiated on the grounds that ailment suffered by him was due to intake of alcohol. This not being acceptable to him, Mr. Ashok Kumar represented his complaint but the company upheld their stand of settlement.

Records were perused and parties to the dispute were called for a personal hearing. Mr.Ashok Kumar stated that he used to take alcohol but occasionally. Before his admission to the hospital, he had taken alcohol for the last time on 21.05.2011. He stated that he had submitted certificate from the doctor stating that the current illness is not related to intake of alcohol.

The New India Assurance Co. Ltd., was represented by Mr. Vijay Bavighar Asst. Manager who was accompanied by Dr. Nilesh-TPA . Mr. Vijay stated when the company received claim intimation from the complainant they investigated the case and it came to light that the complainant was occasional alcohol drinker. As GI Bleed (erosive gastritis) was result of alcohol consumption, claim was repudiated under clause 4.4.6. Dr. Nilesh stated that USG shows liver dysfunction and pathological reports shows rise in Alkaline phosphate and diffuse duodenum which are signs of alcoholism. The forum asked the doctor whether alcoholism is the single cause of liver dysfunction and rise in alkaline phosphate; to this Dr. Nilesh replied negatively and stated that basically this happens because of liver disease.

Ombudsman asked the company officials whether calculus cholecystitis has nexus to alcoholism and what treatment was given to the patient for this ailment, to this Dr. Nilesh stated that acalculus cholecystitis is an infective process and not related to alcoholism and the complainant was given several antibiotics to treat this disease.

Ombudsman also raised the query to the company officials whether occasional intake of alcohol causes gastritis and whether they have taken any expert opinion on this issue, to this Dr. Nilesh replied negatively.

However Dr. Nilesh brought to the notice of the forum that Certificate dated 19.10.2011 is signed by some other doctor on behalf of the treating doctor, Dr. Sunil Apotikar. Ombudsman remarked that such certificate cannot be taken as authentic evidence in this forum.
<u>Directions given by the forum :-</u> The company and the complainant were directed to comply with the following requirements within 10 working days

1) **Since company has not produced enough cogent evidence that occasional alcoholism can cause GI Bleed (erosive gastritis), the company was directed to obtain medical opinion from an independent Gastroenterologist and inform their final decision to the forum.**
2) **The complainant was also directed to obtain clarification from the treating doctor regarding cause for this ailment i.e. GI Bleed (erosive gastritis).**

On 14.10.2014, the forum received letter dated 14.10.2014 from the complainant wherein he had attached letter dated 10.10.2014 given by Dr. Sunil Apotikar which states " This is to inform that Mr. Ashok Kumar was admitted at Alliance Hospital on 19.08.2011 and was diagnosed with upper GI bleed due to erosive gastritis due to hyperacidity and acalculus cholecystits . The above illness was not due to alcoholism."

On 29.10.2014, the forum received email from the company where medical opinion of Dr. C. Vasudev , M.D., D.M. (Gastro) of Seven Hills was also attached which states that " Ashok Kumar , 38 year male admitted at Alliance Hospital in August 2011 had severe erosive and Duodenitis resulting in GI Bleed along with acalculus cholecystitis with deranged liver function tests was unlikely due to alcohol. LFT abnormalities can't be explained by occasional alcoholism and the whole picture of Clinical history, lab investigation reports are suggestive of some viral etiology. An alkaline phosphate never rises because of alcoholism. GGT rises due to alcoholism".

The entire documents submitted to the forum are taken on record. It is observed that Mr. Ashok Kumar was admitted to Alliance Hospital on 19.08.2011 with diagnosis of GI Bleed (erosive gastritis) with acalculus cholecystitis . History and examination sheet shows "Patient admitted with c/o fever intermittent, gradually ↑in the evening since 9-10 days. Yellowish discoloration of skin, 3- 4 episodes of vomiting, Malena 2 episodes, No DM/ HT, IHD, Pt. alcoholic – occasional intake." To the question no. 6 (1) in the Pre- Authorization form which relates to

personal history of alcoholism/ smoking/ Tobacco Chewing /Gutka/ Drugs, Mr. Ashok had answered that he occasionally used to take alcohol but has not consumed since 2 months. The contention of the company is that GI Bleed (erosive gastritis) was due to alcohol consumption and hence they repudiated the claim under clause 4.4.6 which states that claims arising as a result of use of intoxicating drugs/ alcohol are excluded.

The crux of the issue is that whether GI Bleed (erosive gastritis) in case of Mr. Ashok Kumar was the result of occasional Alcohol consumption. Dr. C. Vasudev , M.D., D.M. (Gastro) of Seven Hills had opined that in case of Mr. Ashok Kumar severe erosive and Duodenitis resulting in GI Bleed along with acalculus cholecystitis with deranged liver function tests was unlikely due to alcohol. He has also stated that abnormalities in Liver Function Test cannot be due to occasional alcoholism. The contention of Dr. Nilesh (TPA) that rise in Alkaline phosphate as per Liver Profile test dated 19.08.2011 is suggestive of alcoholism is totally not accepted by Dr. Vasudev who opines that alkaline phosphate never rises because of alcoholism. In case if GGT (Gamma-glutamyl transpeptidase) would have be done, it would have indicated the presence of alcohol which unfortunately was not done during his hospitalization. The Clinical history and lab investigation reports are suggestive of some viral etiology and not due to alcoholism. Also the treating doctor has certified vide letter dated 10.10.2014, that cause of Erosive Gastritis in case of Mr. Ashok Kumar is due to hyperacidity and acalculus cholesystitis .

From the above, it is established that current ailment of the complainant was not due to alcoholism. Also the insurer has not be able to prove with concrete evidence that Erosive Gastritis suffered by Mr. Ashok Kumar was result of alcoholism and hence scales are tiled in favour of the complainant

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Complaint No. GI-09 (2013-2014)
Complainant: Smt. Chhaya Mody
v/s.
Respondent: United India Insurance Co.Ltd

Mrs Chhaya Mody was covered under Individual Health Insurance policy no. 0204004811970013201 for sum assured of Rs. 7 lakhs issued by United India Insurance Co.Ltd. Mrs. Chhaya Mody was admitted to Beramji's Hospital, Girgaum from 24.09.2012 to 05.10.2012 with diagnosis Osteoarthritis of Knee with Spondylosis of spine .When she lodged the claim with the insurer, it was repudiated on the grounds that hospitalization was not justified as treatment given to her could have been taken on OPD basis.

Aggrieved by their decision, Mrs. Chhaya Mody approached the Office of Insurance Ombudsman seeking intervention in the matter of settlement of her claim.

On hearing the deposition from both the parties to dispute, Ombudsman observed that the complainant had lodged similar complaint with the forum, complaint no. being GI: 108 (13-14) under which the company has honoured the claim.

The company was directed to give its observations as to why claim has been rejected for Mrs. Chhaya's hospitalization when they had settled similar complaint of her husband.

On 05.12.2014, the forum received letter dated 02.12.2014 from the insurer stating that Mr. Bharat Mody was under Lumbar Treatment which is an IPD procedure and has to be done in hospital under the supervision of treating doctors whereas conservative treatment was given to his wife without use of such traction.

The entire documents submitted to the forum are taken on record. It is observed from the discharge summary of Beramji Hospital where Mrs Chhaya, was admitted from 24.09.2012 to 05.10.2012, that she had complaints of severe pain in knees since 6 months causing difficulty to stand /walk more than 5-7 mins, inability to climb more than 3-4 steps, walking with limping gait resulting in pain in back since 2-3 months. It is observed that her vitals were normal throughout her stay in the hospital from 24.09.2012 to 05.10.2012. The presenting symptoms do not show any emergency warranting immediate hospitalization. The discharge summary establishes that she was treated with Tab. Powergesic, TENS on knees, ULTRA on knees, Antiplast on knees, TENS on back, TENS on both legs, and ULTRA on back which are all OPD procedure. The husband of the complainant i.e. Mr. Bharat Mody has deposed that his wife was only given treatment form morning 9.00a.m. to 12.00 noon. To Q.9. of the Medical Certificate which is to be filled by the doctor which states "Nature of surgery /treatment given for present ailment, Dr. R. Bermaji has answered "Conservative treatment with intensive physiotherapy." Thus from the above , it is observed that there is no justifiable ground to contravene the decision of the insurer that hospitalization in case of Mr. Chhaya Mody was not required and it was an OPD procedure which was converted to IPD.

As far as claim settlement of Mr. Bharat Mody is concerned, it is observed that he was treated with Lumbar Traction which requires hospitalization necessitating supervision of treating doctors.
Hence the forum does not find any reason to intervene with the decision of the company in denying claim to Mrs. Chhaya Mody.
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Complaint No. GI – 404 (2012 – 2013)
Complainant: Shri Kaippilly Satheesan
V/s
Respondent : The New India Assurance Co. Ltd.,

Mr.Satheesan Kaippilly was covered under mediclaim policy no. 140500/34/10/11/00002816 from The New India Assurance Co. Ltd. In the year 2008 he suffered from hearing loss for which he took allopathic and homeopathic treatment. Since these treatments did not produce any positive results, he approached Sreedhareeyam Ayurvedic Eye Hospital and Research Centre where the doctors advised him to get admitted from 04.05.2011 to 16.05.2011.When he preferred the claim with the insurer, it was repudiated on the grounds that treatment taken by him did not warrant hospitalization.

The entire documents submitted to this forum are taken on record. It is observed from the Discharge Summary of Sreedhareeyam Ayurvedic Eye Hospital where Mr. Satheesan K.M. was admitted on 04.05.2011 that he was diagnosed of Badiriyam/SNHL i.e. hearing loss in both the ears. There are certain discrepancies that are observed by this forum which are presented below:

- **Letter dated 24.11.2014 submitted by Sreedhareeyam Centre states the following: "Sub: Discrepancies in Final Bill and in the Discharge Summary:……Sorry for discrepancies. As regards the scan image of initial case papers, clinical summary, we are not able to provide it, as it is against our principle. The patient came on 04.05.2011 with symptoms of loss of hearing on both ears since 2008. He consulted elsewhere and took medicines and had no improvements. He had severe headache frequently during work. He was admitted here on 04.05.2011 for specific Ayurvedic treatment viz Abhyangam , Karnapooranam, Kizhiswedam, Lepanam, Sirodhara etc. He was discharged on 16.05.2011." However IPD papers dated 04.05.2011 shows that he was discharged on 17.05.2011.**

- **As per discharge bill, Karnapooram was done 8 times, Lepanam – Karna was done 7 times, Kizhiswedham – Karna was done 13 times, Dhoopanam was done 23 times, whereas as per IPD Karnapooram was done 3 times , Lepanam –Karna was done 6 times, Kizhiswedham – Karna was done 12 times, Dhoopanam was done 11 times.**
- **IPD papers do not show any treatment being given on 16.05.2011 whereas course of treatment shown in discharge summary shows that he was treated with Kizhiswedham – Karna, Dhoopanam, Karnapooram and Lepam. Though vide letter dated 24.11.2014, the Dr. Johnnykutty Varughese has regretted for the discrepancies in the Final bill and the summary but it is observed that the hospital authorities have not shared the entire case papers i.e. initial case papers, clinical summary to prove their contention that details of treatment shown in Discharge Summary is true.**
- **It is observed from the IPD that the complainant was treated with Karnapooram, Lepanam –Karna, Kizhiswedham – Karna, Dhoopanam, Sirodhara, Sarvanga Abhyangam only on 12.05.2011 and 13.05.2011. In all other days, it was combination of 3-4 treatments. Also many of these treatments can be synchronized and hence the entire treatment per day would not be extended for more than 3-4 hours per day which could have been possible on OPD basis.**
- **From the above it is established that Sreedhareeyam Ayurvedic Eye Hospital do not maintain the records properly for the reasons best known to them and the contention of the company that discharge bill was exaggerated with increase in no. of treatments to prove that hospitalization was required in case of Mr. Kaippilly Satheesan cannot be completely ruled out.**

Thus from the above it is difficult to contravene the contention of the company that treatment taken by Mr. Kaippilly Satheesan could have been taken on OPD basis and the forum does not have any reason to interfere in the decision of the company to repudiate the claim. If the Award is not acceptable to the complainant, he is at liberty to approach any other appropriate forum for redressal of his grievance.

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Complaint No. GI – 144(2013 – 2014)
Complainant: Smt. Kantaben Khut
V/s
Respondent : Star Health and Allied Insurance Company Ltd

Mrs. Kantaben Khut was covered under Mediclassic Individual Insurance Policy no. P/171100/ 01/ 2012/ 009790 for sum insured Rs.1,50,000/- issued by Star Health and Allied Insurance Company Ltd. She was admitted to Dr. Bhute Nursing home, Chembur from 22.01.2012 to 26.01.2012 with diagnosis of Hemorroids with Fissure in Ano . When she preferred the claim with the insurer, it was repudiated under Condition 7 of the policy terms and conditions since several inconsistencies were observed in the claim records.

Star Health and Allied Insurance Company Ltd was represented during the course of hearing by Dr. Arvind Thakkar. He stated that the claim was rejected under clause 7 which states that " The company shall not be liable to make any payment under the policy in respect of any claim if such claim is in any manner or supported by any means or device, misrepresentation whether by the insured person or by any other person acting on his behalf." The company had conducted investigation and based on the investigation report, the claim has been rejected on the following grounds:-

1. **Jeevan Diagnostic Centre where pathological test of Mrs. Kantaben Khut were done is non- functional.**
2. **It is only collection centre for specimen.**
3. **It does not have the infrastructure to carry out the diagnostic investigation.**
4. **The reports of Jeevan Diagnostic centre bear the forged signature of Dr. Ketan Dewda. Certificate is given by Dr. Ketan Dawda stating that his technician has signed on his behalf and has also stated that Jeevan Diagnostic centre collect sample of patient and process it at**

prime diagnostic centre with whom they have tie up. Hence these reports are not authentic.

5. **Medical Certificate filled by the treating doctor shows that the patient had complaints of painful defecation and bleeding PR since 15-20 days whereas the consultation sheet dated 22.01.2012 shows that she had similar problems since 20-25 days.**
6. **Medical Certificate filled by the treating doctor shows that the patient was first consulted on the day of admission to the hospital i.e. on 22.1.2012 whereas the receipt was issued to the patient by Dr. Bhute on 16.01.2012 .**
7. **The patient was treated with Infrared coagulation with Lords procedure which is OPD treatment whereas the hospital has charged OT Charges, Anesthetist charges, Assistant Surgeon's Charges and In-patient Hospitalization charges etc. which is not justified.**

Dr. Thakkar stated that though she was diagnosed of Hemorroids with Fissure in Ano , the PR was not done as per consultation sheet dated 22.1.2012. He also stated that though the patient stays in Nallasopara, she had come all the way to take treatment at Chembur which sounds absurd.

Mr. Vinod Khut stated that some of their relatives had recommended Mr. Bhute for treatment of fissure. Hence they took their mother to the said hospital though it was far off from their residence.

The entire documents submitted to the forum are taken on record. Let us examine whether there is merit in case of Mrs. Kantaben Khut :

1) **It is observed that the insured did not provide any papers of pervious consultation but approached the hospital directly. As per the documents submitted by the insured, the first consultation was made on 22.01.2012 and without subjecting her to any internal investigation, she was diagnosed as suffering from Hemorrhoids and was immediately admitted to the hospital for surgery. Generally for hemorrhoids and its symptoms, at initial stage patients try conservative treatment like adopting dietary changes like diet with high in fiber or adding bulk laxatives are tired which prevents worsening of the condition. There are numerous creams and suppositories that can relieve anal irritation and pain. Inspite of this if the patient does not get relief, the surgical treatment or other outpatient treatments are resorted as last option. In the instant case, Smt. Kantaben had presenting symptoms only for 15-20 days prior to hospitalization. Further when she contacted the treating doctor, on the date of first consultation itself she got**

admitted to the hospital for Infrared Coagulation and Lords procedure which appears to be unusual.

2) **The company has contended that Infrared Coagulated procedure is an OPD Procedure which does not require indoor admission and intervention of anesthetist and Asst. Surgeon and forum concurs with the company's view point.**
3) **In the Indoor case papers, on 24.01.2012 it is mentioned "Pt. feels better with no previous complaints". Then the reason for keeping the patient till 26.1.2012 is not known.**
4) **Though as per certificate dated 26.01.2012, Dr. Bhute had advised Mrs. Kantaben for regular followup, Insured has not provided any post hospitalization OPD papers, bills etc.**
5) **The duration of initial complaints i.e. constipation. Painful defecation, weakness, giddiness, Bleeding PR is mentioned different in different medical documents.**
6) **There is also difference in the date of first consultation. The Medical Certificate filled by the treating doctor shows that the patient had first consulted on the date of admission to the hospital i.e. 22.1.2012 whereas the complainant has produced receipt for Consulting Surgeon's charges dated 16.1.2012 issued by Dr.Bhute .**
7) **The pathological reports of Jeevan Diagnostic Centre are signed by technician and not by the Pathologist Dr. Ketan Dawda which is against the Indian Medical Council Act, 1956.**
8) **While the patient is residing in Nallasopara, she chose to go to a hospital in Chembur for the reasons best known to her.**

Thus apparently, glaring discrepancies are noted in the documents submitted in support of the claim and also as pointed out by the Insurance Company. The forum thus, does not find any fault with the decision of the company to reject the claim in the present circumstances and the said decision is upheld.

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Complaint No. GI-1812 (2013-2014)

Complainant: Mrs. Nisha Kurup
v/s.
Respondent: The New India Assurance Co. Ltd.,

Mrs. Nisha Kurup was covered under Mediclaim policy 2007, policy no. being 140104/34/11/01/00005454 for sum insured of Rs. 3,00,000/- issued by The New India Assurance Co. Ltd. She underwent Myomectomy with Ovarian cystectomy on 01.08.2012 at Sanjeevani Maternity and General Nursing Home. When she preferred the claim, it was rejected on the grounds that she had taken treatment for infertility which is excluded as per policy terms and conditions.

Aggrieved by their decision, Mrs. Nisha Kurup approached the Office of Insurance Ombudsman seeking intervention in the matter of settlement of her claim.

The entire documents submitted to the forum and deposition of both the parties to dispute is taken on record. On scrutiny of the available documents, the following observations are made by the forum:-

1) **As deposed by Mrs. Nisha Kurup, she first consulted Dr. Meera Agarwal on 10.07.2012 for menstrual pain and bleeding. However the consultation sheet of the same date shows that her Menstrual history as '3-4/28 days, Reg' which is normal for a woman aged 37 years and there is no mention of menstrual pain and bleeding as deposed by the complainant during hearing. At the same time, it is observed that Dr. Meera Agarwal has noted "Not taken any treatment so far. Wants to conceive" which implies that she had consulted the doctor as she was planning for a child.**
2) **After 7 days , she consulted Dr. Krishna of Pooja Hospital and the consultation sheet dated 17.07.2012 shows "Planning for a kid, married since 1 year; M.H- 3-4 d/28-32 days , Moderate flow, painless." Even in this consultation sheet the doctor has not mentioned anything about menstrual pain and bleeding.**
3) **The complainant during the course of hearing had stated that Dr. Krishna had informed her that she had small fibroid in her uterus which did not require any immediate surgery. The Report of USG Pelvis dated 16.07.2012 also establishes that she had a tiny fibroid measuring 1.8x1.4cm and 3.0x 2.5 cm cyst in her right ovary. Generally, in such situation the patients go in for conservative treatment and oral medication since it is not accompanied with menorrhagia and will prefer to wait for few months to see the results rather than immediately undergoing laparoscopic myomectomy and ovarian cystectomy as seen in case of Mrs. Nisha Kurup. It is also observed that doctors recommend myomectomy as a procedure to restore fertility in women with fibroids.**
4) **The Certificate dated 03.01.2014 given by Dr. Ameet Patki of Fertility Associates stating that Mrs. Nisha Kurup had consulted in the month**

of July 2012 for severe menorrhagia and Dysmenorrhea cannot be accepted as her first consultation on 10.07.2012 and second consultation on 17.07.2012 with two different gynecologist showed normal menstruation cycle with moderate flow and there is no mention of patient suffering from menorrhagia and Dysmenorrhea in any of these consultation sheets.

From the above it cannot be ruled out that Mrs. Nisha did not consult the gynecologist for conception and infertility treatment and the doctors advised her to undergo various tests, which revealed that she was suffering from Fibroids in Uterus and Endometriotic cyst in Right Ovary for which she underwent treatment. Under these circumstances, it is difficult to contravene the contention of the company that treatment taken by Mrs. Nisha Kurup i.e. Diagnostic Hysteroscopy, Myomectomy with ovarian cystectomy was for infertility and the forum does not find any reason to interfere in the decision of the company to repudiate the claim.

Complaint No. GI- 601 (2013-2014)

Award No. IO/MUM/A/GI /2014-2015

Complainant: Mrs. Noorjahan Khan
v/s.
Respondent: The Oriental Insurance Company Ltd

Mrs.Noorjahan Khan was covered under Group Mediclaim Policy no. 131100/48/2012/11865 issued in favour of Shree Vishashreemali Trust by The Oriental Insurance Company Ltd. She was admitted to Kokilaben Dhirubhai Ambani Hospital from 06.07.2012 to 09.07.2012 with primary diagnosis of Irritable Bowel Syndrome. When she preferred the claim, it was repudiated on the grounds that claims under the group policy have exceeded 90% of the premiums paid under the policy.

Aggrieved by their decision, Mrs. Noorjahan Khan approached the Office of Insurance Ombudsman seeking intervention in the matter of settlement of her claim.

After perusal of the records parties to dispute were called for hearing

The Oriental Insurance Company Ltd was represented by Ms. Simmi Kumari A.O and Dr. Amit (Alankit –TPA) . Ms. Simi Kumari stated that Mrs. Noor Jaan Khan was admitted from 06.07.2012 to 09.07.2012 to

Kokilaben Dhirubhai Ambani Hospital with diagnosis of Irritable Bowel Syndrome. She stated that the company did not receive intimation of hospitalization within 48 hours of admission in the hospital. The insured had also delayed in submission of the claim papers. Hence claim was repudiated under condition no. 5.4 and 5.5 of policy terms and conditions.

Ombudsman stated that conditions related to intimation/submission of claim papers within stipulated time period are empowering clauses and not restrictive ones. Such conditions are incorporated in the policy for a disciplined way of administering the claim and the company cannot absolve themselves of the liability only on the ground of non –intimation and delay in submission of claim papers. The attention of the Insurance Company is also directed to the Circular no. IRDA/HLTH/MISC/CIR/216/09/2011 dated 20.09.2011 issued by IRDA in this regard. Unless the company has reasons to believe that the claim was lodged with a fraudulent intention, the rejection of claim only on the ground of non- intimation/delay in submission of the claim papers is not justified.

Ms.Simmi stated that claim was also repudiated on 90% stop loss basis since the total claims under the Master policy exceeded 90% of the premium paid. Ombudsman observed that the very purpose of insurance is defeated when claim under policy is rejected on 90% stop loss basis. Hence the company was directed to review the case and inform their final decision within 10 days.

On 12.02.2015, the forum received letter from the company dated 11.02.2015 wherein they have stated "The particular Group Mediclaim policy issued to the trust is tailormade policy designed to suit the need of the insured and the insurance company. It is not standard product but a tailor made policy. The condition of 90% was incorporated, based on the proposal and our recommendation to the competent authority at the corporate office. Therefore, after the contract was signed and the captioned condition of 90% was imposed, we cannot take a decision contrary to it. The decision on denial of liability under the claim taken by us remains unaltered because of limitation of policy conditions."
The forum is unable to understand how the company has issued the above Group Mediclaim policy to M/s Shree Visha Shrimali Jain Charitable Sanstha (Trust) with the condition imposed that 'Once the total claims paid touches 90% of the premium paid, the liability of the company ceases thereafter." The forum observes that here the company has directly related total claims paid to premium paid under the group policy and the forum is unable to understand how the Trust has also

agreed to this condition. The forum is of the opinion that the insurance company should be diligent while selecting the group members at the proposal stage to avoid anti-selection. Once that is done, all the admissible claims should be honoured thereafter. In my opinion, imposing the above condition is totally against principle of natural justice and the company cannot penalize the insured for no fault of his. The Forum is also unable to understand whether such policy has approval of IRDA. If the claim of an individual member of the group is to be restricted to 90% of the premium paid under the policy, then where is the insurance element?

Under these circumstances, the forum finds it difficult to accept the contention of the company that they have denied the claim of Mrs. Noorjahan Khan since the total claims under the policy have exceeded 90% of the premium paid and the forum directs the company to honour the above claim for the admissible expenses irrespective of the above condition imposed.

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Complaint No. GI-141(2014-2015)

Complainant: Mr. Naleen Khatau
v/s.
Respondent: The New India Assurance Co. Ltd.,

Mr. Naleen Khatau was covered under Mediclaim Policy no.111200341201000021 72 for a period from 09.06.2012 to 08.06.2013 for sum insured of Rs. 1,00,000/-.He was admitted to Ramkrishna Mission Hospital from 02.06.2013 to 03.06.2013 and thereafter to Kokilaben Dhirubhai Ambani Hospital from 03.06.2013 to 07.06.2013 for treatment of Myocardial Infarction. When he preferred the claim, it was repudiated on the grounds that his current ailment is direct complication of his smoking habits.

Aggrieved by their decision, Mr. Naleen Khatau approached the Office of Insurance Ombudsman seeking intervention in the matter of settlement of his claim.

After perusal of the records parties to dispute were called for hearing. The complainant Mr.Naleen Khatau along with his son Mr. Hardik appeared and deposed before the Ombudsman. He stated that as per policy clause use of tobacco leading to cancer is excluded and in his case he had suffered from Myocardial Infarction for which he was hospitalized. Hence rejection of claim is not justified.

The New India Assurance Co. Ltd., was represented by Mr. Hitendra Patel- Deputy Manager and Dr. Preeti – TPA. Mr. Patel stated that Mr. Naleen Khatau was admitted to Ramkrishna Mission Hospital from 02.06.2013 to 03.06.2013 with c/o of chest pain. He was then shifted to Kokilaben Dhirubhai Ambani Hospital from 03.06.2013 to 07.06.2013 for treatment of Myocardial Infarction. On going through the hospital records, they found that claimant was chronic smoker and present ailment was direct complication of smoking. He read clause 4.4.6 under which the claim was rejected.

Ombudsman observed that the said clause states that use of Tobacco leading to cancer is excluded whereas no where in the policy there is any exclusion relating to use of tobacco leading to Myocardial Infarction.

On hearing the deposition of both the parties to dispute, the forum directed the company to re-examine the case in light of the above observation of the forum and convey their final stand within 7 working days.

On 27. 02.2015, the forum received letter dated 26.02.2015 from the insurer which states "As per the observation from the indoor case paper, insured is a chain smoker (10-12 cigars per day). Insured is having family history of hypertension and Ischemic Heart Disease. Inspite of that, he was smoking cigarettes which are bodily injury or sickness due to willful or deliberate exposure to danger, intentional self-inflicted injury arising out of non-adherence to any medical advice. This falls under permanent exclusion for any medical expenses incurred under Permanent Exclusion Clause 4.4.7 and 4.4.6."

The entire documents submitted to this forum and deposition of both the parties to dispute is taken on record. It is observed from the Discharge Certificate of Ramkrishna Mission Hospital that Mr. Naleen Khatau was admitted on 02.06.2013 with complaints of Chest pain , retrosternal pain with h/o profuse swelling . The case papers of the same hospital shows that the patient is chain smoker and is in the habit of taking 10-12 cigarettes per day. The Discharge Summary of Kokilaben Hospital where the insured was admitted from 03.06.2013 to 07.06.2013 shows that he was diagnosed with Anteroseptal MI, Thrombolysed with STK, PTCA-LAD was done.

The claim preferred by the complainant has been repudiated by the company under clause 4.4.6 as is evident from the repudiation letter dated 23.01.2014. Clause 4.4.6 is reproduced below:-:

"Convalescence, general debility, Run –down condition or rest cure, obesity treatment and its complications, congenital external diseases/defects or anomalies, treatment relating to all psychiatric and psychosomatic disorders, infertility , sterility, use of intoxicating drugs/alcohol, use of tobacco leading to cancer are excluded."
It is confirmed that Mr. Naleen Khatau was in the habit of smoking cigarettes as revealed from the case papers of the hospital where he was admitted. The insured has also not denied this fact during the course of hearing. However it is observed that clause 4.4.6 does not exclude claims arising due to use of tobacco leading to Myocardial Infarction. Thus rejection of claim of Mr. Naleen Khatau under the above exclusion clause is not as per policy terms and conditions.

The company vide letter dated 26.02.2015 has stated that claim has also been rejected under clause 4.4.7. The forum is surprised to note that the company could not decide about the grounds of rejection before calling up their final decision to the beneficiary. Only after the hearing at the forum, the company is referring to the clause which very clearly shows that company do not know the reasons for which the claim should be repudiated. Moreover it should also be known to the company that no new grounds for repudiating /rejecting the claim can be taken subsequently other than those mentioned in the rejection/repudiation letter.

Under these circumstances, the scales are tilted in the favour of the complainant.

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Complaint No. GI- 037 (2012-2013)

Complainant: Shri Pritam Mistry
v/s.
Respondent: Star Health and Allied Insurance Company Ltd

Mr. Pritam Mistry was covered under Family Health Optima Insurance. In April 2010 when he was returning from Pune, his car met with an accident due to which he was badly hurt and was taken to hospital, the claim for which was duly settled by the company. After 3 months, he started getting pain in his lower back for which he was admitted to Asian Heart Institute from 02.08.2010 to 06.08.2010 with diagnosis of sciatica left lower limb, faecetal arthropathy with nerve root and dural

compression with disc extrusion. When he preferred the claim with the company it was repudiated under Exclusion clause 3 on the grounds that the current ailment was degenerative disease and not due to accident.

Aggrieved by their decision, Mr. Pritam Mistry approached the Office of Insurance Ombudsman seeking intervention in the matter of settlement of his claim.

After perusal of the records parties to dispute were called for hearing on 13.11.2014 at 3.45 pm.

Star Health and Allied Insurance Company Ltd was represented by Dr. Thakkar. He stated that claim was rejected on the grounds that current disc disease suffered by Mr.Pritam Mistry is degenerative and not a traumatic cause. The complainant was admitted on 9.4.2010 for RTA and in hospital papers there is no evidence of injury to his lower back. Hence the present condition is of fresh onset and not related to RTA. Hence claim was rejected as per exclusion clause 3 which states that company will not be liable to make any payments in respect of treatment of PID (other than caused by an accident) during the first two years. He submitted medical opinion of Dr.B. Pasupathy, Orthopedic Surgeon which confirms their contention. He stated that complainant was also operated 8-10 years back for extra growth of bone in his left leg which is not disclosed to the insurer at the time of taking policy. Ombudsman asked him whether this operation is in any way related to the current ailment, to this he stated that since they do not have any medical documents related to surgery done in past for over growth of bone, he is not able to comment on it.

Ombudsman asked Dr. Thakkar whether they have shared a copy of medical opinion taken from Dr. B. Pasupathy with the complainant to which he replied negatively. The forum gave a copy of the same to the complainant.

On hearing the deposition of both the parties to dispute, Ombudsman observed that the treating doctor of the complainant i.e. Dr. Sangale has given certificate stating that after RTA on 09.04.2010, the complainant had developed severe low backache and sciatica on the left leg whereas Dr. Pasupathy has stated that current ailment of the complainant is result of degenerative disease. Hence Ombudsman directed the complainant to show the Certificate issued by Dr. Pasupathy to his treating doctor and submit his (treating doctor's) opinion within ten days to the company under intimation to us. On receipt of the same, the company is directed to re-examine the case in light of the explanation

given by the treating doctor and inform the final stand of the company within 10 working days.

On 20.11.2014, the forum received email from the complainant wherein email received from Dr. Ramesh Sangle (treating surgeon) was attached which states "The degenerative disease is an ongoing condition and represents 'aging'. It basically represents 'decompensation' of the body's maintenance process. It is difficult to understand why only one disc and not the entire vertebral elements are not degenerated. Secondly this patient has improved thereafter and till date there are no clinical signs and symptoms of any form which indicate any form of degenerative process in his spine/other remaining discs. Had it been a degenerative disease, he would have shown further deterioration in his spinal column causing more health problems in the long standing post-operative period. Degenerative disease in a young boy is uncommon and the Certifying doctor has to define the degenerative condition which affects only that particular areas and leaves the other vertebrae and discs normal. With respect to my knowledge and my integrity, I do not agree and once again certify that his ailment – is not case of any degenerative disease. The patient's ailments and its cause are not degenerative by any standard."

On 13.12.2014, the forum received a copy of letter from Dr. Pasupathy to the Vice – President of Star Health and Allied Insurance Company Ltd which states that "According to MRI – Features are degeneration, no trauma induced changes. Surgery done is also for foraminotomy, facetectomy and three level disc excisions. This is done for degenerative spine as per MRI. This treatment is for degenerative spine and not for the traumatic affection. So this is not a traumatic salvage procedure."

On 13.01.2015, the forum sent an email to the company directing them to take independent expert opinion on the below mentioned issues and based on the opinion obtained, inform their final stand within 7 days to this forum:-
1) In the said case, the insured who is 24 year male, has suffered a trauma when his car met with an accident on Mumbai-Pune Expressway. As per the police papers, the car has turned turtle and has somersaulted before coming to a halt on the opposite lane. Hence it is quite possible that though there may not have been any fracture or apparent injury, the insured must have suffered <u>impact injury</u> to his back. Medical Websites state that <u>osteophyte formation can occur as part of bone healing process in trauma</u>. Could it have been possible in the case of this insured?
2) The CT/MRI of the spine taken in the month of April 2010, just after

the accident does not show any formation of osteophytes or disc prolapse or bulge. If the cause for the current ailment was degeneration, then could the same have occurred within a span of three months where he had to be operated in the month of July for disc prolapse? Generally, it is believed that when the cause of disc prolapse or bulge is degeneration, the pain gradually sets in and the patient has tingling sensation in the lower limbs followed by pain and restriction of movements etc. This is also generally treated by way of medical management first and only then in extreme cases does surgical intervention take place.
4) It is also known fact that herniated discs can occur due to an injury. In the instant case, the insured started experiencing acute back pain three months down the line after his accident and as per the discharge card, this was non radiating pain. His discs were also found prolapsed at several places with tear and bulge and he had to undergo surgery. In this case the insured is only 24 years old where his investigations of the spine do not reveal any deformity three months prior to the surgery. Can his complaints be treated as a degenerative disease?

On 23.01.2015, the insurance company submitted Specialist opinion of Dr. Pasupathy dated 21.01.2015 wherein he has stated as below:-

"I have perused the medical records once again relating to the above patient. As per discharge card during first hospitalization for Road Traffic Accident with head injury there was no evidence of injury to lower back. Hence the cause of acute low backache with sciatica left lower limb in 24 year old patient is non traumatic i.e. degenerative."

The entire documents submitted to the forum are taken on record. The crux of the issue is that whether the treatment taken by the complainant in Asian Heart Institute from 02.08.2010 to 06.08.2010 is for diagnosis of degenerative ailment or for trauma induced changes.On analysis of the case, it is observed that Mr. Pritam Mistry was admitted to Lokmanya Hospital on 09.04.2010 for Road Traffic Accident and was treated for Cerebral Edema with Extra Dural Hemorrhage with fracture of occipital bone. There is no mention of trauma to the spine in any of the medical reports. On 02.08.2010 he was again admitted with complaints of lower backache with diagnosis of Acute Low backache with sciatica left lower limb, facetal Arthopathy with nerve root and dural sac compression with disc extrusion. The MRI Lumbar Spine dated 14.07.2010 shows the "marginal anterior osteophytes noted along lumbar vertebrae.L3-4 Disc reveals diffuse posterior bulge, indents thecal sac.L4-5 disc reveals

broad based posterior herniation by 4.96 mn.... Mild Facetal arthropathy noted. L5-S1 disc reveals diffuse posterior bulge, indents thecal sac."

The forum had asked the company to get specialist opinion of certain issues like whether osteophyte formation in case of insured is due to bone healing process; if the cause of prolapsed disc is degeneration in case of Mr. Pritam Mistry, then why the same was not revealed in CT/MRI Report undergone by insured in April 2010 etc. However it is observed that the company has upheld their decision on the basis of certificate given by Dr. Pasupathy wherein the said doctor has not answered to the queries raised by the forum which is vital in arriving at a decision. Though ample opportunity was given to the company to substantiate their stand of repudiation, it is observed that company is complacent with the opinion of the doctor and has not taken serious note of the queries raised by the forum.

Under these circumstances, the benefit of doubt goes in favour of the complainant

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Complaint No. GI- 2318 (2012-2013)
Complainant: Smt. Rajas Patil
v/s.
Respondent: Iffco -Tokio General Insurance Co. Ltd

Mr. Moreshwar Patil was covered under policy no. 52210012 issued by Iffco -Tokio General Insurance Co. Ltd. Mr. Moreshwar Patil was admitted to Jnaneshwari Brain and Spine Centre, Panvel from 14.06.2012 to 24.06.2012 as he was unable to sit/stand or walk due to severe lower back ache. He was diagnosed with PIVD with sciatica. When he preferred the claim, it was repudiated by the insurer on the grounds that treatment taken by him did not warrant hospitalization.

This not being acceptable to his wife Mrs. Rajas Patil, she represented her complaint but the company upheld their stand of settlement. Hence she approached this forum with a complaint against the company for non settlement of the claim.

The entire documents submitted to the forum are taken on record.Let me examine whether there is merit in the complaint of Mrs. Rajas Patil:

1) **It is observed that the complainant had submitted ICP papers of hospitalization of Mr. Moreshwar Patil from 14.06.2012 to 24.06.2012 which was received by the insurer on 21.08.2012.On going through those papers, it is observed that there is no mention of Lumbar**

Traction applied to the patient during his stay in the hospital. The treating doctor, Dr. Bharat Naik has informed vide letter dated 18.10.2012 that he has forgotten to mention the same in Indoor Case papers. The forum is unable to comprehend the negligence on the part of the doctor. The complainant thereafter submitted new set of Indoor Case papers on 30.08.2012. The forum fails to understand the thriving reason for the hospital to issue duplicate ICP after the patient has been discharged wherein many difference were observed compared to the earlier ICP.

2) **It is observed that in this new ICP, on 14.06.2012 patient was given lumbar traction along with other medicines. However the doctor has not specified traction weights in ICP which is one of the most important aspects in applying traction.**
3) **ICP dated 15.06.2012 shows 'Ct all' which means whatever treatment was given on 14.06.2012 will continue on 15.6.2012. On 16.06.2012, the patient was administrated Amikacin only(therein no mention of traction) and Ct all is mentioned. Generally as per medical practice, whenever there is change in medication, 'Ct all' mentioned there after indicates that changed medication will be continued. However the doctor vide letter dated 17.11.2014 has informed that lumbar traction was given till the end as Ct all is mentioned on each date of ICP. The forum has also noted that in the earlier ICP which was submitted on 21.08.2012, there is no mention of 'Ct all' in any of the days.**
4) **There are contradictions in the statement made by the treating doctor. In his letter dated 17.11.2014, on page no. 2 of this letter, he has stated that if painkillers are given to patient, he can be treated on OPD basis. He has not treated Mr. Moreshwar Patil with painkillers as it has side effects. However in the same letter he has stated that he has prescribed cap. Tramazac (pain killer) to the patient on 19.06.2012 which is also evident from the ICP.**
5) **It is astounding to notice that old ICP which was submitted on 21.08.2012 does not show any treatment given to the patient from 19.06.2012 to 22.06.2012. Also the treatment given on 24.06.2012 appear prior to the treatment given on 23.06.2012.**
6) **Dr. Bharat Naik has informed vide letter dated 23.07.2012 and 17.11.2014 that Mr. Moreshwar was treated conservatively whereas the new ICP shows that traction was applied to the patient.**
7) **Generally it is the practice of the hospitals to charge for the traction given to the patient. However in the present case, the hospital has not included traction charges in their bill. The doctor without giving sufficient grounds has informed that they do not charge separately for traction which sounds absurd.**
8) **The hospital authority has informed that all the hospital case papers of Mr. Moreshwar were handed over to him which was also accepted**

by the complainant during the course of hearing .However the complainant had neither submitted the TPR and Nursing Chart to the forum nor to the company for reason's best known to her.

Thus from the above it is observed that there are many inconsistencies and contradictions in the line of treatment and statements made by the doctor and the complainant. In the absence of substantial documentary evidence, it is difficult to contravene the contention of the company that no active line of treatment was given to Mr. Moreshwar Patil and treatment given to him could have been done on OPD basis and the forum does not have any reason to interfere in the decision of the company to repudiate the claim.

Complaint No. GI- 95 (2014-2015)

Complainant: Mrs. Rupali Nawadkar
v/s.
Respondent: The New India Assurance Co. Ltd.,

Mrs. Rupali Nawadkar was covered under Group Mediclaim policy issued to M/s Maxx Moblink Pvt Ltd by The New India Assurance Co. Ltd. She gave birth to baby boy on 16.09.2013 but since the baby was born under extreme premature conditions, he had to be shifted to NICU at Neo Plus Children Hospital. However the baby expired on 23.09.2013. When she preferred the claim to the insurer, the company settled the claim pertaining to the Maternity Expenses and rejected the claim relating to treatment taken by her child.

Aggrieved by their decision, Mrs. Rupali Nawadkar approached the Office of Insurance Ombudsman seeking intervention in the matter of settlement of her claim.

After perusal of the records parties to dispute were called for hearing .

The complainant Mrs. Rupali Nawadkar appeared and deposed before the Ombudsman. She stated that her company had requested the insurer to deduct the premium pertaining to her child from the CD account maintained by them and pay the claim amount but the insurer and the TPA were not ready to accept it.

The New India Assurance Co. Ltd. was represented by Mr. G.M. Dave-AO. He submitted that Mrs. Rupali Nawadkar was covered under Tailormade Floater Group Mediclaim policy wherein Maternity Cover and

Baby Day One cover was available. The policy clauses very clearly state that Mid Term Additions are allowed under the policy only for newly wed spouse and newly born children only on receipt of complete and full premium. When claim under the policy was received for Maternity Benefit and treatment taken by her new born child, the company settled the claim pertaining to the Maternity expenses. However since no premium was charged for the new born child, the question of admitting liability does not arise. Also the insured had not send any intimation informing the birth of new born child. He defended the decision of the company.

On hearing the deposition of both the parties to dispute, Ombudsman directed the complainant to submit all the documents pertaining to communication between the company and the insurer/TPA relating to deduction of the premium pertaining to her child from CD account and settlement of claim amount within 7 working days.
On 03.03.2015, the forum received letter from the complainant wherein she had attached the following :

1) **Email exchanged between the insurer and her company official, wherein the insurer has stated that CD account balance as on 26.02.2015 was Rs. 4243/-**
2) **Email dated 01.02.2014 sent by Ms. Sonali Raizada HR- General Manager of Maxx Moblink Pvt Ltd to The New India Assurance Co. Ltd., for deducting applicable premium for new born baby of Mrs Rupali.**

The entire documents submitted to this forum and deposition of both the parties to dispute is taken on record. Mrs. Rupali was covered under Tailormade Floater Group Mediclaim policy which provides Maternity Benefit and Baby Day One cover. The Additional Clauses under the policy states that the newly born would be covered only on receipt of complete and full premium. Mrs. Rupali was admitted on 14.09.2013 to Health Hi-Tech Orthopaedic and Surgical Hospital and on 16.09.2013 she gave birth to baby boy. Since the birth of the baby took place within 6 months of pregnancy, the baby was very weak due to which he had to be shifted to NICU at Neo Plus Children Hospital. Inspite of the best efforts of the doctors, the baby could not survive long and expired on 23.09.2013. She submitted all the claim documents to TPA and they have confirmed that the same is received by them on 07.10.2013. The company settled the claim pertaining to Maternity Benefit but rejected the claim pertaining to the new born baby. The contention of the company was that they had not received any intimation about the birth of the child nor any necessary additional premium was received to cover him, hence they are

not liable for claim settlement pertaining to the new born. However the company should understand that Mrs. Rupali was admitted under emergency conditions to the hospital and the birth of the child was under extreme premature conditions. In such situation the full focus of the mother and other family members would be on the child. Also for a mother to lose her child within 8 days of its birth is too taxing , both emotionally and physically and in such situation to expect her to inform the insurer/ TPA about the child birth seems to be too demanding. Inspite of this, it should be appreciated that she had submitted all claim requirements within 30 days of her discharge from the hospital as stipulated in the policy terms and conditions. The forum is also of the opinion that since there was sufficient amount in the CD account of the company and the employer of the insured had also requested the insurer in February 2014 to debit the premium pertaining to the child and settle the claim amount, the insurance company as a special case should have considered the request.

Under these circumstances, The New India Assurance Co. Ltd., is directed to debit the necessary premium pertaining to the deceased child of Mrs.Rupali Nawadkar and pay the hospitalization claim for his admission to Neoplus Children Hospital from 16.09.2013 to 23.09.2013.

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Complaint No. GI- 95 (2014-2015)

Complainant: Mrs. Rupali Nawadkar
v/s.
Respondent: The New India Assurance Co. Ltd.,

Mrs. Rupali Nawadkar was covered under Group Mediclaim policy issued to M/s Maxx Moblink Pvt Ltd by The New India Assurance Co. Ltd. She gave birth to baby boy on 16.09.2013 but since the baby was born under extreme premature conditions, he had to be shifted to NICU at Neo Plus Children Hospital. However the baby expired on 23.09.2013. When she preferred the claim to the insurer, the company settled the claim pertaining to the Maternity Expenses and rejected the claim relating to treatment taken by her child.

Aggrieved by their decision, Mrs. Rupali Nawadkar approached the Office of Insurance Ombudsman seeking intervention in the matter of settlement of her claim.

After perusal of the records parties to dispute were called for hearing .

The complainant Mrs. Rupali Nawadkar appeared and deposed before the Ombudsman. She stated that her company had requested the insurer to deduct the premium pertaining to her child from the CD account maintained by them and pay the claim amount but the insurer and the TPA were not ready to accept it.

The New India Assurance Co. Ltd. was represented by Mr. G.M. Dave-AO. He submitted that Mrs. Rupali Nawadkar was covered under Tailormade Floater Group Mediclaim policy wherein Maternity Cover and Baby Day One cover was available. The policy clauses very clearly state that Mid Term Additions are allowed under the policy only for newly wed spouse and newly born children only on receipt of complete and full premium. When claim under the policy was received for Maternity Benefit and treatment taken by her new born child, the company settled the claim pertaining to the Maternity expenses. However since no premium was charged for the new born child, the question of admitting liability does not arise. Also the insured had not send any intimation informing the birth of new born child. He defended the decision of the company.

On hearing the deposition of both the parties to dispute, Ombudsman directed the complainant to submit all the documents pertaining to communication between the company and the insurer/TPA relating to deduction of the premium pertaining to her child from CD account and settlement of claim amount within 7 working days.
On 03.03.2015, the forum received letter from the complainant wherein she had attached the following :

3) **Email exchanged between the insurer and her company official, wherein the insurer has stated that CD account balance as on 26.02.2015 was Rs. 4243/-**
4) **Email dated 01.02.2014 sent by Ms. Sonali Raizada HR- General Manager of Maxx Moblink Pvt Ltd to The New India Assurance Co. Ltd., for deducting applicable premium for new born baby of Mrs Rupali.**

The entire documents submitted to this forum and deposition of both the parties to dispute is taken on record. Mrs. Rupali was covered under Tailormade Floater Group Mediclaim policy which provides Maternity Benefit and Baby Day One cover. The Additional Clauses under the policy states that the newly born would be covered only on receipt of complete and full premium. Mrs. Rupali was admitted on 14.09.2013 to Health Hi-Tech Orthopaedic and Surgical Hospital and on 16.09.2013 she gave birth to baby boy. Since the birth of the baby took place within 6 months

of pregnancy, the baby was very weak due to which he had to be shifted to NICU at Neo Plus Children Hospital. Inspite of the best efforts of the doctors, the baby could not survive long and expired on 23.09.2013. She submitted all the claim documents to TPA and they have confirmed that the same is received by them on 07.10.2013. The company settled the claim pertaining to Maternity Benefit but rejected the claim pertaining to the new born baby. The contention of the company was that they had not received any intimation about the birth of the child nor any necessary additional premium was received to cover him, hence they are not liable for claim settlement pertaining to the new born. However the company should understand that Mrs. Rupali was admitted under emergency conditions to the hospital and the birth of the child was under extreme premature conditions. In such situation the full focus of the mother and other family members would be on the child. Also for a mother to lose her child within 8 days of its birth is too taxing , both emotionally and physically and in such situation to expect her to inform the insurer/ TPA about the child birth seems to be too demanding. Inspite of this, it should be appreciated that she had submitted all claim requirements within 30 days of her discharge from the hospital as stipulated in the policy terms and conditions. The forum is also of the opinion that since there was sufficient amount in the CD account of the company and the employer of the insured had also requested the insurer in February 2014 to debit the premium pertaining to the child and settle the claim amount, the insurance company as a special case should have considered the request.

Under these circumstances, The New India Assurance Co. Ltd., is directed to debit the necessary premium pertaining to the deceased child of Mrs.Rupali Nawadkar and pay the hospitalization claim for his admission to Neoplus Children Hospital from 16.09.2013 to 23.09.2013.

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Complaint No: GI/100/2012-13
Award No: IO/MUM/A/GI- /2013-14
Complainant : Mr Kamlesh T Doshi
Respondent : The New India Assurance Co.Ltd.

Master Darshan Doshi nephew of Mr Kamlesh T Doshi is covered under Individual Mediclaim Policy No:110900/34/10/11/00006661 for a sum insured of Rs. one lac. Master Darshan was first admitted to Sanjivani Hospital from 22.12.2010 to 23.12.2010 and then to Shubham Hospital from 23.12.2010 to 01.01.2011 for communicated displaced of patella and lodged a claim of Rs.122786/-. He had a history of Road Traffic Accident by Motor bike at around 11.30 pm. While he was walking on the road he was knocked down by a motor cycle. The Company repudiated the above claim as the complainant did not provide a copy of MLC/FIR in spite of repeated reminders. Sanjivani Hospital had informed Virar Police station of the incidence in which the injuries were sustained. FIR was not done.

The Forum asked the complainant about the case. The complainant submitted that Master Darshan was knocked down by a scooter on 22.12.2010 around 11.30 pm and the public on the road had admitted him to Sanjivani Hospital Virar and later on the next day they shifted him to Shubham Hospital for further treatment. Sanjivani Hospital had informed the police authorities about the accident.

The Forum asked the Company the reason for their denial. The Company submitted that as there was no FIR and MLC and therefore they repudiated the above claim.

Under the circumstances the Forum observes that though there was no FIR/MLC the hospital authorities have informed the Police and thereafter the Police has not made any visit to the hospital. The Forum therefore directed the Company to honour the above claim for the admissible expenses and inform the payment particulars to this Forum within a period of ten days. Both the Company and complainant agreed for the same.

ORDER

The New India Assurance Co.Ltd. to comply with the directions given as above. There is no order for any other relief. The case is disposed of accordingly.

Dated at Mumbai this 2nd day of June,2014.

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