MEDICLAIM AWARDS FROM 1-4-2015 TO 30-9-2015

AHMEDABAD

In the matter of
Complainant – Mr. Mayur Sukhadia
Vs
Respondent - ICICI Lombard General Insurance Company Ltd.
Complaint No. AHD-G-20-1415-0368
Award Date: 23.04.2015
Policy No: 4128i/HP/77243502/00/000

The Complainant alongwith his family was covered under ICICI Lombard Complete Health Insurance Policy. He had approached this Forum for non-settlement of the claim of his wife, Smt Dipika Sukhadia and his son Master Harshil Sukhadia. Smt Dipika Sukhadia was hospitalized at Kalavati Hospital, Vadodara from 12.08.2013 to 18.08.2013 for Viral Fever with LRTI Consolidation Left lower Zone (Viral Pneumoniatis) and his son was admitted to Om Children Hospital and Neonatal ICU from 25.11.2013 to 30.11.2013 for Infective gastroenteritis with persistent vomiting with Dyselectrolemia with A.H. Sensorium with URI. The Company had rejected the claim as fraud. He had represented to the Company asking them to produce any document which proved it to be a fraud. However, the company had not responded. The claim was rejected under Exclusion clause 14 part III- " Fraudulent claims". The Respondent had also cancelled the policy. Aggrieved by their decision he had approached this Forum for redressal.

During the hearing the Representative of the Respondent were ready to settle the claim for Rs. 39,943 + Rs. 26,564 + Daily Cash benefit Rs. 14,000/- as per the terms and conditions of the policy.

AWARD

In view of the Representative's admission to reconsider the claim, the Respondent is hereby directed to pay Rs. 80,507/- alongwith an interest @ 12% p.a. from the date of claim to the date of settlement.

The Respondent is also directed to reinstate the cancelled policy without charging any premium for the gap, and provide the continuity benefit of the policy to the Insured.

In the matter of

Complainant – Mr. Ashish Harivadan Kalaigar
Vs
Respondent - The Oriental Insurance Company Ltd.
Complaint No. AHD-G-50-1415-0363

Award Date: 23.04.2015
Policy No: 171600/48/2014/5221

The Complainant alongwith his family was covered under Happy Family Floater Policy. Shri Harivadan Kalaigar, father of the Complainant was hospitalized at Girish Group of Hospital Pvt Ltd from 24.01.2014 to 28.01.2014 for Interstitial Lung disease and Lt. Ventricular failure. A claim for Rs.70,907/- was lodged with the Insurer. The claim was partially settled for Rs. 22,529/-. The claim amount for Rs.48,378/- was disallowed under exclusion clause 4.16 of the policy viz 'cost of external and/or durable medical /non-medical equipment'. It was observed that the Insured was admitted on 24.01.2014 and discharged on 28.01.2014. In the discharge summary the advise by the doctor was for O2 by Nasal Canula 2L/min required by Concentrator.

In view of the above policy terms and conditions, the instrument was purchased on the date of discharge on the advice of the doctor which meant that it was for the use at home. Hence as per the terms and conditions of the policy the decision of the Respondent was correct.

However, based on the submissions and the documents it is noted that the policy terms and conditions were never given to the Insured. Further, there was a wrong quoting of clause 4.8 in the repudiation letter instead of clause 4.16 of the mediclaim policy, therefore, complainant is entitled for compensation for the same.

In view of the facts and circumstances, the complainant is entitled for relief. The Complaint is admitted.

In view of the above, I direct the insurer to pay Rs. 25,000/- on ex-gratia basis.

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In the matter of

Complainant – Mr. Rasiklal P Chauhan
Vs
Respondent – The National Insurance Company Ltd.

Complaint No. AHD-G-48-1415-209,210,211 and 212

Award Date: 12.05.2015
Policy No: 311700/48/12/85/00004212 and 311700/48/13/85/00004457

The Complainant alongwith his wife Smt Ramaben Chauhan was holding mediclaim policy since 2002. The wife of the Complainant was hospitalised on different occasions at different hospitals. as tabulated below:

The Complainant represented to the Company for payment of deducted amount. As he was unsatisfied with the decision of the Respondent, he had approached this Forum for justice.

The Representative of the Respondent deposed that there were four claims of the Insured. The review of the decision of the TPA was done by their Regional Office. He said the balance amounts were deducted from the claims which were as per the terms and conditions of the policy. To a question about the details of deductions he was not able to explain. He was asked to give the details of deductions by next day evening. He agreed to submit the same.
Subsequent to the hearing the representative of the Respondent submitted the details. However, as asked by the Forum to the representative of the Respondent to specifically provide the bifurcations of the amount claimed by the Complainant and their deductions under the relevant clauses, the representative could not submit the same. However, all the four claims were examined in detail and the complaint was admitted partially.

AWARD

In view of the above, I direct the Respondent to pay Rs. 24,769 /- in addition to the amount already settled.

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In the matter of

Complainant – Mr. Hemendra A Mehta

Vs

Respondent : New India Assurance Company Ltd.

Complaint No. AHD-G-49-1415-0766
Award Date: 24.04.2015
Policy No. 14210034120100008241

The Complainant's wife Smt. Kalpana Mehta, was admitted to Globe Meridian Hospital for supportive treatment from 02.11.2013 to 03.11.2013 for bleeding and black clots. As Globe Meridian hospital did not have necessary equipments, Smt Mehta was shifted to Bhailal Amin General Hospital on 03.11.2013 and was discharged from the hospital on 06.11.2013. Bhailal Amin General Hospital had diagnosed her health issue as Diverticular disease of colon with diverticular bleeding from caecal diverticula. The Complainant lodged a complaint with this Forum on 28.03.2014 for an award directing the Respondent to settle the balance claim amount in his favour.As the Ombudsman had retired before it could be heard, the Forum had written to the Chairman of the Respondent to consider the complaint as per Rules. The Respondent thereafter, settled the claim for Rs. 9,350/- disallowing Rs. 16,818./- The Complainant again had approached this Forum on 28.11.2014 against partial repudiation of claim. As the parties to the dispute, could not arrive at a settlement, the case came up for hearing on 23.04.2015. It was observed that the TPA had rejected the claim based on clause 4.4.21 and 4.4.22. From the clauses 4.4.21 and 4.4.22 it is observed that in respect of hospitalization at Bhailal Amin Hospital and Globe Meridian service charges and non medical items are not payable. The Admission charges as per policy condition no.4.4.22 was payable. The other deductions from the hospital bill were as per the Terms and Conditions of the policy.

Hence the balance payment of Rs. 3350/- was payable. The Insurer had to go by the terms and conditions of the policy. Hence, claim on certain payments were excluded.

In view of the above, the complaint is, thus, allowed.

AWARD

In view of the above, I direct the insurer to pay Rs. 3350/- alongwith interest @ 12% p.a. on Rs. 3350/- from the date of filing the claim to the date of settlement.

In the matter of

Complainant – Mr. Kinjal Kantawala
Vs
Respondent - The New India Assurance Company Ltd.

Complaint No. AHD-G-49-1415-0373
Award date:12.05.2015
Policy No: 21010034140100002227

The Complainant alongwith his family was holding mediclaim policy since 2005. The wife of the Complainant was hospitalised at Shalby hospital from 20.05.2014 to 27.05.2014 for treatment of Acute Gastritis. The Complainant had incurred an expense of Rs. 62,302/- out of which Rs. 30,000/- was adjusted by way of cashless as the hospital was under PPN Hospital. When he preferred a claim for the balance amount of Rs.34,352/- including post hospitalization expenses, the TPA paid an amount of Rs.1350/- and disallowed Rs. 33,002/- on the basis of PPN agreement. The representative of the Respondent had approached the hospital authorities for the details. The Manager of the Shalby hospital had given a letter dated 24th April, 2015 stating the claim file given to MD India dated 23rd May, 2014 wherein they had mentioned a refund of Rs. 29,046/- to the said Patient was an error in entry which actually was supposed to be posted against the bill of Patient Ms. Gauthami Mantri and the related documents shown to the visited Insurance team.Further a mail from Shalby hospital to the TPA stated that due to system error there was an overcharging in the final bill and they were ready to refund an amount of Rs. 11316/- to the patient. All these issues had come up after the hearing. The Respondent had ample time i.e. from the date of claim filed till the date of hearing, the Respondent had not taken any initiative to look into the matter. The Regional Office of the Respondent had also taken the matter very casually. It seems the Insurance Company is not bothered about the PPN hospital charging any amount from the Insured, contravening the PPN MOU. The Company did not take action against the hospital on finding that the hospital authorities, despite being under PPN MOU, had charged an exorbitant amount from the Insured. The Respondent, from the Branch Office to the Regional Office is very callous and not sensitive and welfare of the Insured. The complaint is accepted.

By this careless and negligent actions, the Respondent has proved that they are very mechanical, insensitive and indurate.

In view of the above, the respondent is hereby directed to settle the balance amount to the Insured.

AWARD

The Respondent is hereby directed to pay balance amount of Rs. 33,002/- in addition to the amount already settled alongwith 12% interest.

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In the matter of
Complainant – Mr. Shantilal B Gandhi
Vs
Respondent - The Oriental Insurance Company Ltd.

Complaint No. AHD-G-50-1415-0367
Award date: 24.04.2015
Policy No: 141700/48/2014/3533/

The Complainant alongwith his wife Smt Ushaben S Gandhi was holding mediclaim policy since 1984. The wife of the Complainant was hospitalized at Parekh's Hospital from 12.11.2013 to 18.11.2013 for huge incisional hernia. When the complainant preferred a claim for Rs.1,72,581/-, the Respondent settled the claim for Rs. 64,368/-. During the hearing the Insurer was asked when Insured had taken treatment from PPN hospital recognized by the Insurer why deductions were done? Why only Rs.64,368/- was paid initially and after complaint to this Forum why second instalment of Rs. 81,000/- was paid ?. He had no answers for the same. He stated that he was not aware of the facts of the case and that he was sent to represent the case as the dealing Officer had proceeded on leave. The Forum took on record that the representative of the Respondent was not prepared with the case and he was not able to answer the questions that were asked during the hearing. It was observed that the Insured was covered under the Individual Health Insurance policy for a sum insured of Rs. 4 lacs. The Company had not given any bifurcation of the amount deducted to the Complainant nor to this Forum. They failed to reply to their Insured and allowed the TPAs to take decision on behalf of the Insurer. The Respondent had exhibited their callous attitude towards the senior citizen by not bothering to reply to his queries. In absence of the reply the insured has approached this Forum. The Complainant is having the policy since 1984.

The Insured during the hearing stated that the deductions were done as per the reasonable clause.. Here, the hospital in which the Insured had taken medical treatment was under PPN. The Insurer instead of taking up the matter with the hospital penalizes the Insured.In view of the facts and circumstances and the Representative of the Insured not able to explain the deductions, the complaint is thus admitted.

AWARD

In view of the above, the Respondent is directed to settle the balance claim amount of Rs.24,000/-(after deduction of the registration charges, excess medicine bill claimed and non-medical items) to the Insured alongwith 10% interest from the date of filing the claim till the date of settlement.

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In the matter of
Complainant – Mr. Ashok Kumar Ratilal Shah
Vs
Respondent – The Oriental Insurance Company Ltd.

Complaint No. AHD-G-50-1415-0480
Award date: 18.06.2015
Policy No: 141200/48/2014/7463

Brief facts of the case

The Complainant alongwith his wife was covered under Mediclaim Policy issued by the Oriental Insurance Company Ltd. Smt Ragini A Shah, wife of the Complainant was hospitalized at Dr Sanjay R Gandhi Hospital on 08.04.2014 for Left Eye Cataract surgery with Intraocular Lens (IOL). The Insured had preferred a claim for Rs. 38,500/-, the Respondent had settled the claim for Rs. 21,253/- and the balance amount was deducted citing clause 13.1; Reasonable. Customary and Necessary expenses.The deductions done by the TPA towards pharmacy and consultant charges, being before 30 days and after 60 days of admission for Rs. 505/- are in order. However, the deduction done by the TPA for the balance claim amount of Rs. 16,742/- under reasonable expenses was not justified. As per IRDA circular dated 20.02.2013 on "standardization in health insurance" Reasonable charges means the "charges for services or supplied which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness/injury". The Respondent has failed to submit Self Contained Note within the specified time limit and the same was submitted during the hearing. The Respondent was advised to desist from repetition of such things in future The Respondent's decision taken on deductions without the rate charts, on Surgery charges, O.T.charges, Anesthesia, pharmacy charges and Room rent are not fair. The partial settlement of the claim is arbitrary.The complaint is entitled for relief.

AWARD

As the Respondent failed to establish reasonable, valid and justifiable reason for the deductions they have made from their Insured's claim, the Respondent is hereby directed to pay a sum of Rs. 16,742/- in addition to the amount already paid to the Complainant.

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In the matter of
Complainant – Mr. Suhash V Lakhani
Vs
Respondent – the New India Assurance Company Ltd.

Complaint No. AHD-G-49-1415-0691

Award date: 18.06.2015
Policy No:21130334132500000044
Brief Facts of the case:
The Complainant alongwith his wife was covered under the Individual Mediclaim Policy-2007 by the New India Assurance Company Ltd. Smt Sita S Lakhani was admitted to Jay Hospital on 22.02.2014 to 24.02.2014 for Dysemmorhhoea. Against a claim of Rs 91,877/-, the Company had settled Rs.39,433/-. The amount was deducted under clause 3.13- 'reasonable and customary charges' and 'exclusions of non–medical items'.
As per IRDA circular dated 20.02.2013 on "standardization in health insurance" Reasonable charges means the "charges for services or supplied which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness/injury.
In view of the Respondent's failure to establish the deduction under the head reasonable and customary charges, the complaint is, allowed.
AWARD
In view of the above, I direct the insurer to pay Rs. 22,000/- in addition to the amount already settled.

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In the matter of
Complainant – Mr. Ajit R Shah
Vs
Respondent – United India Insurance Company Ltd.

Complaint No. AHD-G-51-1415-0493
Date of Award: 19.06.2015
Policy No. 060200/48/11/97/00020431

The Complainant was covered under Mediclaim Policy issued by the United India Insurance Company Ltd. The Complainant was hospitalized at various hospitals for chest discomfort and tests were done. It was revealed that there was a blockage in the heart vessel. He was admitted to Apex Heart Institute for CABG. The Respondent settled the claim for Rs. 2,85,648 against the claim of Rs. 3,42,150/-.

The Respondent failed to give detailed explanation on the amount disallowed to the Complainant or to this Forum. No specific reasons were given for the deductions.

AWARD

As the Respondent failed to establish valid and justifiable reasons for the deductions, the Respondent is hereby directed to pay a sum of Rs. 53,693/- deducting (Rs. 2409/- towards non consumable items and Rs. 400 /-towards registration charges), in addition to the amount already paid to the Complainant.

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In the matter of
Complainant – Mrs. Namrata R Bajaj
Vs
Respondent - The Oriental Insurance Company Ltd.
Complaint No. AHD-G-50-1415-0489
Date of Award:18.06.2015
Policy No. 141100/48/2014/12396

Brief facts of the case:

The Complainant alongwith her family was covered under the Happy Family Floater Policy issued by the Oriental Insurance Company Ltd. She had approached this Forum for non-settlement of the claim of her hospitalization at Dr. Trivedi's total health care Pvt. Ltd from 05.03.2014 to 08.03.2014. She was operated for Twisted left Ovarian cyst (salphingotomy with right ovarian cyst done laparoscopically). The Company had rejected the claim stating clause 4.3 of the mediclaim policy. Based on the oral submissions of the parties, read along with documents on record it was seen that the Complainant had taken the policy for the first time from the Oriental Insurance Company on 31.10.2013 and there was no record of previous policy mentioned in the schedule of the policy. The claim has been repudiated under clause 4.3 xiv viz surgery of genito-urinary system excluding malignancy, while the treatment was for twisted ovary cyst. Ovary is not a part of the genito-urinary system but it is an organ in the reproductive system. Had the cyst grown in the genitor-urinary system the repudiation under the clause 4.3 xiv would have been correct. The repudiation of the claim is under an irrelevant clause. The representative failed to show the portability clause in the terms and conditions of the policy issued to the Complainant. The approach of the Respondent towards the Complainant was very casual.

In view of the facts and circumstances, an ex-gratia amount of Rs. 30,000/- is granted to the Complainant

AWARD

The Respondent is directed to pay a sum of Rs. 30,000/- to the Complainant as an ex-gratia payment .

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In the matter of
Complainant – Mr. Vinod K Patel
Vs
Respondent – United India Insurance Company Ltd.

Complaint No. AHD-G-51-1415-0470
Date of Award:18.06.2015
Policy No. 1806012813P105461759
Brief Facts of the case:

The Complainant alongwith his family members were covered under the Individual Health Insurance Policy issued by United India Insurance Company Ltd. Smt Gauriben V Patel,the wife of the Insured was admitted to Aalok Orthocare Hospital from 02.04.2014 to 03.04.2014 for Left ear Tympanoplasty under Local anesthesia. Against a claim for Rs 67,247/- the Company settled Rs.15,792/-. The amount was shown to be deducted as per GIPSA package clause. The Complainant pleaded that in terms and conditions of the policy there was no mention about GIPSA policy condition

The Representative of the stated that the deductions were done by their TPA as per the policy conditions and GIPSA package. He said that the hospital where the Insured had taken medical treatment was under PPN Network. He was asked whether the complainant was informed about the PPN package. He answered in negative. He was told that the MOUs on PPN hospitals were signed by the GIPSA and the hospitals to which the Insureds are not parties. Unless informed the Insured would not be aware of the rates/fees for treatment of any disease. Under such a situation, the Insurer should recover any excess amount charged by the PPN Hospital from the hospital and not from the Insured. The Respondent expressed his desire to settle the claim amount for Rs. 47,064/-. (excluding the non-receipt of the bill for Rs. 4391/-)

In view of Respondent agreeing to re-consider the claim and settle Rs. 47,064/-, the complaint is closed through Mediation and the Insurer is directed to settle the claim.

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In the matter of

Complainant – Mr. Suresh J Shah

Respondent - National Insurance Company Ltd.

Complaint No. AHD-G-48/1415/0730

Date of Award:18.06.2015

Policy No. 380201/46/13/85/00000326

Brief facts of the case:

The Complainant alongwith his family members were covered under Tailor Made with Floater (HGP) policy from 2010. The Complainant was hospitalized at Niddhi Hospital and at Saviour Annexe Hospital for Pulmonary Nocardia, Chronic Renal Failure on HD and HTN + DM +IHD. He had lodged a claim for Rs. 4,33,000/-. The Respondent had rejected the claim citing clause No. 4.3 of the mediclaim policy..

The representative of the Complainant deposed that the policy was taken from the Respondent, National Insurance Company under Tailor Made policy from 08.11.2013 to 07.11.2014. She stated that they were having the policy for the last 4 years from 2009-10, 2010-11, 2011-12, 2012-13 and 2013-14. The subject claim was in the 5th year of the policy.

Observations:

The Insured had been having mediclaim insurance from different companies. The claim on dialysis was paid in the previous year as the policy carried a provision for the payment. The subject claim has been rejected as the subject policy did not carry any provision for the payment. In fact it had a specific clause excluding dialysis for two years.

The Insured had taken the policy for the first time in the year 2012-13 from the National Insurance Company Ltd. The claim had arisen in the 2nd year of the policy with National Insurance Company. Hence, as per the exclusion clause mentioned in the Certificate of Insurance, the claim was not-payable.

In view of the facts and circumstances repudiation of the claim by the Respondent is in order. The complaint fails to succeed.

ORDER

The Respondent's decision to repudiate the claim is upheld. The complaint is thus disposed off.

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In the matter of
Complainant – Mrs. Neeru S Madani
Vs
Respondent - The National Insurance Company Ltd.

Complaint No. AHD-G-48-1516-0016

Date of Award: 21-07-2015

Brief facts of the case:

The Complainant alongwith her family members was insured under Individual Mediclaim policy issued by the National Insurance Company Ltd. She had approached this Forum for non-settlement of the claim for her hospitalization at Bombay Hospital and Medical Research Centre for Myofascial pain Fibromyalgia from 16.09.2013 to 18.09.2013. The Company had rejected the claim under clause 5.4 and 4.10 of the mediclaim policy.

The Insurer's representative was asked to confirm as to how condition No. 5.4 was applicable. However, he was not able to explain the same but referring to the repudiation letter whereby it was stated that if the Insured had any clarifications he could contact them within 15 days from the receipt of the letter. . He was further asked to show the medical opinion on the basis of which the claim had been repudiated. He had referred to the opinion of Dr. Himanshu P Choliya who had stated that the hospitalisation was not justified and the claim was not admissible as per the policy terms and conditions (5.4 and 4.10). The representative was asked to explain as to how the doctor came to the conclusion about the application of clause No. 5.4 but he was able to explain. There was no definition on Active line of Treatment given in the policy. However, the representative did not agree. He was asked to show the definition in the policy. As he could not find the definition in the policy he agreed that there was no definition on the active line of treatment in the policy.

However, as the policy terms and conditions did not have any specific definition about the active line of treatment and as the policy terms and conditions were not sent to the Insured alongwith the policy schedule the complainant is entitled for relief.

The complaint is admitted.

AWARD

The Respondent is directed to settle the claim of Rs. 20,000/- on ex-gratia basis to the Complainant.

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In the matter of
Complainant – Mrs. Neeru S Madani
Vs
Respondent - The National Insurance Company Ltd.

Complaint No. AHD-G-48-1516-0016

Date of Award: 22.07-2015
Brief facts of the case:

The Complainant alongwith her family members was insured under Individual Mediclaim policy issued by the National Insurance Company Ltd. She had approached this Forum for non-settlement of the claim for her hospitalization at Bombay Hospital and Medical Research Centre for Myofascial pain Fibromyalgia from 16.09.2013 to 18.09.2013. The Company had rejected the claim under clause 5.4 and 4.10 of the mediclaim policy.

The Insurer's representative was asked to confirm as to how condition No. 5.4 was applicable. However, he was not able to explain the same but referring to the repudiation letter whereby it was stated that if the Insured had any clarifications he could contact them within 15 days from the receipt of the letter. He was further asked to show the medical opinion on the basis of which the claim had been repudiated. He had referred to the opinion of Dr. Himanshu P Choliya who had stated that the hospitalisation was not justified and the claim was not admissible as per the policy terms and conditions (5.4 and 4.10). The representative was asked to explain as to how the doctor came to the conclusion about the application of clause No. 5.4 but he was able to explain. There was no definition on Active line of Treatment given in the policy. However, the representative did not agree. He was asked to show the definition in the policy. As he could not find the definition in the policy he agreed that there was no definition on the active line of treatment in the policy.

However, as the policy terms and conditions did not have any specific definition about the active line of treatment and as the policy terms and conditions were not sent to the Insured alongwith the policy schedule the complainant is entitled for relief.

The complaint is admitted.

AWARD

The Respondent is directed to settle the claim of Rs. 20,000/- on ex-gratia basis to the Complainant.

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Complainant – Ms Soni N Narayani
Vs
Respondent – The New India Assurance Company Ltd.

Complaint No. AHD-G-49-1415-0699
Date of Award: 10-08-2015

Brief Facts of the case:

The Complainant was covered under the Individual Mediclaim Policy-2012 issued by the New India Assurance Company Ltd from 2003. Ms. Soni N Narayani was admitted to Tejas Hospital on 23.05.2014 to 24.05.2014 for Acute Moderate Dehydration with ulcerative colitis following colonoscopy. When a claim was lodged with the company for Rs. 16,858 the Company rejected the claim on the basis of clause 2.11. The Complainant's plea for settlement of her claim to the Company was not heard. From the records it is seen that the Indoor case papers and the other hospital papers were all hand written. The Respondent did not dispute this indoor case paper's time of admission and discharge. However on scrutiny of the indoor case papers it is noted that History : Vomiting , Diarrhea, pain in abdomen is stated as 2 A.M.(which is corrected to 2(P.M). Under the column of condition at Discharge: The charges for stay, injection, visit fee etc is written on it. The consent is not signed by the patient or the relatives of the patient. There is no signature of the doctor nor certified by the hospital authorities. The sheet do not record the name of the patient the timings of the medicines given etc. The certificate of the doctor, Dr. Rajendra S Shah dated 28.07.2014 given by the Complainant was after thought. The claim form filled in by the Complainant stated the timing of admission as 3.00 p.m. and discharge at 2.00 p.m. The Complainant during the hearing stated that she was not in a good condition. However, from the record it is found that she had visited Dr. Ashish Sethi's clinic on the same day i.e. 24th May, 2014 for consultation on OPD basis which proved that she was not on bed rest as told by her during the hearing. All these documents create a doubt whether hospitalization was actually done or not.

Thus the Forum refuses to accept the plea of the complainant for settlement of the claim as discrepancies found in the documents submitted to the Forum.

AWARD

In view of the facts and circumstances, the Respondent's decision to repudiate the claim is upheld. The Complaint, thus needs no intervention.

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In the matter of
Complainant – Mr John J Patel
Vs
Respondent – The New India Assurance Company Ltd.

Complaint No. AHD-G-49-1516-0102
Date of Award: 11-08-2015

Brief Facts of the case:

The Complainant alongwith his wife was insured under LIC Group Mediclaim policy 2008, issued by the New India Assurance Company Ltd. Mrs. Rekha Patel, wife of the complainant was admitted to Shlok Heart and Medical Hospital from 17.06.2014 to 20.06.2014 for anemia. The Company rejected the claim under exclusion clause vi General Debility, Run down condition. The Complainant's plea for settlement of his claim to the Company was not heard.

The Forum was of the opinion that why the certificate from Dr. Nilesh R Patel dated 30.08.2014 given by the Complainant was ignored to which the representative stated that there was no specific reasons for the same.

The clause vi of the mediclaim policy states: Convalescence , general debility, run down, condition or rest cure, congenital external and internal diseases or defects or anomalies are not payable.

The patient was aged 46 years. The doctor had opined that the anemia might have been due to poor intake of food or loss of blood through menstruation. Women usually at the age of above 45-50 attain menopause. Onset of menopause is heavy blood flow. The clause under which the claim has been repudiated carried the words general debility, run-down condition. The patient had not been weak generally. The cause of weakness is specific like loss of blood. This cannot be construed as general debility or run-down condition. In view of the facts and circumstances, invoking clause vi of the policy terms and condition was not correct

AWARD

In view of the above the Respondent is directed to pay a sum of Rs 10,968/- to the Complainant alongwith interest @ 9% p.a. from the date of receipt of claim papers to the date of payment.

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Complainant – Ms Paulomi M Desai

Vs

Respondent – United India Insurance Company Ltd.

Complaint No. AHD-G-51-1516-0084

Date of Award: 11-08-2015

Brief facts of the case

The Complainant was covered under Mediclaim Policy issued by United India Insurance Company Ltd. The Complainant was hospitalized at Dr Sanjay R Gandhi Hospital on 04.09.2014 and 11.09.2014 for Cataract surgeries on both eyes with ACRYSOF IQ Lens. Against the claim of Rs. 76,426/- (Rs. 38,341 + Rs. 38,085), the Respondent had settled the claim for Rs. 42,513/- (Rs. 21184 + Rs. 21329) and the balance amount of Rs.33,913/- was disallowed citing PPN clause.

The representative of the Complainant stated that he was having the policy from 13.03.2002 without break and had never lodged any claim. He stated that his wife had undergone cataract surgeries in both eyes on separate dates and the Company had not settled the claim. Further, he stated that no terms and conditions were provided alongwith the two page schedule of the policy.

The representative of the Respondent stated that the claim was deducted as per clause 3.25 of the terms and conditions of the policy. As per PPN clause certain package was agreed between the company and the PPN hospitals. He was questioned whether the Insured was informed about the PPN Hospitals. To which he answered in negative. He was asked to explain that in absence of the PPN agreement how could the Insured know about the PPN hospitals and know the rates? He had no answer to the Question

As there was a gross mistake by not paying even the amount payable under PPN clause, the representative was asked for the reason which he could not explain. The Divisional Manager had deputed the TPA alongwith the Officer instead of his presence in the hearing. The presence of a responsible Officer in the hearing was essential as the settlement of the claim had been shoddy. The approach of the Respondent was very casual as they had not replied to the complainant satisfactorily.

In view of the foregoing, the complainant is entitled for relief alongwith interest.

AWARD

The Respondent is hereby directed to pay the balance of Rs. 33,913/- alongwith 9% interest p.a. from the date of receipt of the claim papers to the date of payment.

Complainant – Mr. Piyush V Patel

Vs

Respondent - The Oriental Insurance Company Ltd.

Complaint No. AHD-G-50-1415-0710

Date Of Award: 11-08-2015

Brief facts of the case:

The Complainant alongwith his family was insured under the Happy Family Floater Policy issued by the Oriental Insurance Company Ltd. He had approached this Forum against non-settlement of the claim on his daughter's hospitalization from 17th April, 2014 to 19th April, 2014 at Shree Krishna Neonatal Hospital, 19th April, 2014 to 24th April, 2014 at Shaiva Critical Care hospital for Convulsion. Thereafter, again the Insured was admitted for pyrexia at Shaiva Neonatal and Pediatric Critical Care Hospital from 01.05.2014 to 07.05. 2014. The Company had rejected the claim stating clause 4.2 of the mediclaim policy. The complainant had stated that his daughter aged 5 ½ months was admitted to the hospital for the treatment of Pyrexia and the company had rejected the claim applying clause Nos. 4.2 and 4.3. He stated that the Company had not provided him the terms and conditions along with the policy schedule. He further stated that there were two hospitalizations; the first hospitalization was from 17th to 24th April, 2014 for convulsions and second hospitalization was from 1st May,2014 to 7th May, 2014 for fever.The Insurer's representative stated that the claim was rejected under clause 4.2 of the policy as the claim was reported within 30 days which was the waiting period for the new inclusion.

. To a question as to why the claim for second hospitalization was not paid ,he stated that the hospitalization for the same disease fell within 45 days hence it was treated as one claim. Based on the oral submissions of the parties read along with documents on record it was seen that the the Insured i.e. the daughter of the complainant was insured from the date of renewal i.e. 24.03.2014. His daughter was hospitalized from 17th April, 2014 to 19th April, 2014 at Shree Krishna Neonatal Hospital, 19th April, 2014 to 24th April, 2014 at Shaiva Critical Care hospital for Convulsion and for pyrexia at Shaiva Neonatal and Pediatric Critical Care Hospital from 01.05.2014 to 07.05. 2014. The first hospitalization had occurred within 30 days from the date of inception of the policy; hence the claim was not payable as per the terms and conditions of the policy.

However, since the second hospitalization was for pyrexia and not convulsion, the contention of the company that the claim fell within 45 days was not correct as the admission to the hospital was for another disease. Hence the claim for 2nd hospitalization becomes payable.

Moreover, as no terms and conditions were provided to the Insured, the Complainant is entitled for relief.

AWARD

In view of the facts and circumstances, the Respondent is directed to settle the claim for Rs. 35,000/- to the Complainant.

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MEDICLAIM

Date of Award: 30-09-2015

Complainant – Mr. Binod Kumar Jaiswal

Vs

Respondent – New India Assurance Company Ltd.

Complaint No. AHD-G-49-1516-0156

Brief facts of the case

The Complainant along with his wife was covered under Mediclaim Policy -2012 issued by the New India Assurance Company Ltd. The Complainant had the policy from 28.03.2004 with a sum insured of Rs. 1 lac. He had enhanced the sum insured to Rs. 2 lacs from the policy year 2014-2015. The Complainant was hospitalized from 22.03.2015 to 24.03.2015 at Baroda Laproscopy Hospital for cholecystectomy. Against the claim of Rs. 80,704, the Respondent had settled the claim for Rs. 45645 /- and the balance amount of Rs.35,059/- was disallowed citing limit of Sum Insured. The Respondent while settling the claim had considered Rs. One lakh as the sum insured instead of enhanced sum insured of Rs. Two lakh. Dissatisfied with decision of the Respondent, the Insured had approached the Forum for redressal of his grievance and settlement of the claim. The Complainant had stated that he was having the policy since the year 2004 and had not lodged any claim. His contention was that the subject policy was for Rs. 2 lacs. The agent had also assured him that the sum insured of Rs. 2 lacs would be applicable in case of a claim, hence he was eligible for the balance claim. He further contended that the policy did not carry any condition on applicability of enhanced sum insured on the subject for settlement of the claim. He prayed for full settlement of his claim.

The Forum re examined the claim settlement in the light of clause 5.11 and found that the sum insured considered for the calculation of reimbursement was correct and the claim has been accordingly settled by the Respondent.

AWARD

In view of the facts and circumstances, the Respondent's decision to repudiate the claim is upheld. The Complaint, thus needs no intervention.

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Complainant – Mr. Alkesh C Shah
Vs
Respondent - United India Insurance Company Ltd.
Complaint No. AHD-G-51-1516-0150
Date of Award:28-09-2015

Brief facts fo the case.

The Complainant along with his wife was insured under Super Top Up Medicare Policy issued by the United India Insurance Company Ltd. The complainant was hospitalized at Sterling Hospital from 29.09.2014 to 30.09.2014 for Small lymphocyte Lymphoma R-CVP protocol 4th cycle. Against a claim for Rs.65,586/-, the Company had settled Rs. 22,813 and rejected the claim for Rs. 32,890. The Complainant had stated that he was suffering from blood cancer from 27.06.2014. He was having mediclaim insurance with the New India Assurance company Ltd from 1992 for Rs. 2,00,000. He had taken super top up Medicare policy for Rs. 5 lakh with United India Insurance company Ltd.

As the representative utterly failed to present the case and explain why the deduction from the claim were made, the relevant clause etc. the Forum giving the benefit of doubt admits the complaint.

In view of the submitted documents, certificates and after hearing both the parties, the complaint is admitted.

AWARD

The Respondent is hereby directed to pay the deducted amount of Rs. 32,890/- along with interest @ 9% p.a. payable from the date of claim to the date of settlement to the Complainant.

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Complainant – Mr. Binod Kumar Jaiswal

Vs

Respondent – New India Assurance Company Ltd.

Complaint No. AHD-G-49-1516-0156

Date of Award:30-09-2015

Brief facts of the case

The Complainant along with his wife was covered under Mediclaim Policy -2012 issued by the New India Assurance Company Ltd. The Complainant had the policy from 28.03.2004 with a sum insured of Rs. 1 lac. He had enhanced the sum insured to Rs. 2 lacs from the policy year 2014-2015. The Complainant was hospitalized from 22.03.2015 to 24.03.2015 at Baroda Laproscopy Hospital for cholecystectomy. Against the claim of Rs. 80,704, the Respondent had settled the claim for Rs. 45645 /- .The representative of the Respondent had stated that the sum insured as in the policy year 2013-2014 was for Rs. 1 lac. The sum insured was enhanced to Rs. 2 lakh from the policy year 2014-2015. The representative of the Respondent stated that the claim was paid as per the policy clause no. 3.1.(Room rent 1% of sum insured) & 4.3.1 (24 months waiting period). They said that the claim was admitted as per clause 3.1 of the policy. As the claim has been settled as per the terms and conditions of the policy, there is no intervention needed in the decision of the Respondents.

AWARD

In view of the facts and circumstances, the Respondent's decision to repudiate the claim is upheld. The Complaint, thus needs no intervention.

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Complainant – Mr. Kumar H Nathani

Vs

Respondent – New India Assurance Company Ltd.

Complaint No. AHD-G-49-1516-0165
Date of Award: 30-09-2015

Brief facts of the case

The Complainant alongwith his wife was covered under Mediclaim Policy - 2012 issued by the New India Assurance Company Ltd. Smt Yamini Kumar Nathani, wife of the Complainant was hospitalized at Raghudeep Eye Hospital on 17.02.2014 and had undergone cataract and Descemet Stripping Endothelial Keroplasty (DSEK). The surgeries were combined. Against the claim of Rs. 1,43,685, the Respondent had settled the claim for Rs. 66,285/- and the balance amount of Rs.53,350/- was disallowed citing reasonable and customary clause.The Complainant stated that he was having the policy, from 1998. He said he had undergone combined surgery in his right eye and he had chosen the best available option for his health. He said the Insurance Company had put a ceiling on cataract surgery for which he had got only Rs. 24,000/- & had no dispute about the same. However, when there was no upper limit for the cornea surgery, the deductions made by the company was arbitrarily done which he did not agree. He prayed for settlement of his balance amount of claim

The Respondent had deducted the claim in case of cornea surgery citing customary and reasonable clause without providing the standard fees charged for the specific provider which was consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness/injury involved. This was mandatory as per the IRDA guidelines. Here the Respondent had failed to submit the said rate chart of other hospitals in and around the geographical area where the Insured was hospitalized. In absence of any rate charts or specifically pointing out the grounds for deductions towards the above mentioned charges, the deductions made by the Respondent was not in order. The deductions sheet produced to this Forum was by the Complainant secured through RTI which stated that Rs. 50,900 + Rs. 24,000/- Total Rs. 74900/- was paid whereas the complainant had received only Rs. 66,285/-.As the Respondent could not establish the valid reasons for the deductions done from the claim amount and the list of PPN hospitals and list of declined hospitals were not provided to the insured along with the policies, the Forum finds merit in the complaint. The same is admitted.

AWARD

The Respondent is hereby directed to pay the balance claim amount of Rs. 53,350/- to the complainant.

Date of Award: 14.08.2015

Complainant:- Shri B.R.Rana V/s Respondent :- National India Insurance Co. Ltd.

Complaint No. AHD-G-048-1415-0706

Partial settlement of Mediclaim

The Complainant was admitted in Ratnam Eye Hospital, Ahmedabad for Left Eye Cataract surgery on 21.10.2013 & was discharged on the same day. He had incurred total expense of Rs.55,000/-. His claim was partially settled for Rs.38,000/-. Deductions of Rs.17,000/- was made under policy Clause No.4.6- " cost of spectacles, surgery for correction of vision & treatment for cosmetic purpose".

There was no specific condition mentioned in the policy on the type, rate & quality of lenses to be used. Without any guidance or advice it would be difficult for an Insured to arrive at reasonable & customary charges for a surgery.

At the advice of the doctor the Complainant gave consent for multifocal lens. Had it been specifically mentioned in the policy terms & condition that the use & cost of unifocal lens only would be reimbursed in cataract surgery then the deduction could have been justified.

The Forum directed the Respondent to pay Rs.17,000/- to the Complainant.

Date of Award: 13.08.2015

Complainant:- Shri Gireesan C V/s Respondent :- The United India Insurance Co. Ltd.

Complaint No. AHD-G-051-1415-0709

Repudiation of Mediclaim

The Complainant was diagnosed with Left Renal Pelvic Calculi, Bulbar Urethtral Stricture & Swelling over right foot-front of ankle & for removal of Left DJ Stenting. He was hospitalized thrice from 16.10.2013 to 18.10.2013, from 21.10.2013 to 22.10.2013 & from 18.11.2013 to 19.11.2013 in Cheers Hospital, Ahmedabad. He had incurred total expenses of Rs.99,455.50. His claim was rejected on the ground that the hospital was 3 bedded and did not fulfill the criteria set by IRDAI. The Forum informed the Respondent's Representative about a circular dated 03.07.2013 issued by IRDAI vide which they had advised all operators to dispense with the minimum bed condition if the hospital was registered with the local authorities. The Respondent was also informed that some of the Insurers have included this clause in their policies. The related circular was shown to the Respondent's Representative for his knowledge.

The Forum directed the Respondent to pay Rs.99,456/- along with an interest @ 9%, from the date of claim to the date of settlement, to the Complainant.

Date of Award: 13.08.2015
Complainant:- Shri Pradip S Joshi V/s Respondent :- The Oriental Insurance Co. Ltd.
Complaint No. AHD-G-050-1415-0705
Repudiation of Mediclaim
The Complainant's wife Meenaben was diagnosed with CV Stroke with L Hemiparesis with Hyper Homocystania with Ht (newly detected) & was admitted in Acharya Nursing Home & ICU-ICCU, Vadodara on 06.03.2014. She was discharged on 09.03.2014 after treatment. He had incurred an expense of Rs.43,989/-. The Respondent had repudiated her claim by citing Policy Clause No. 4.8-"Convalescence, general debility, run down condition or rest cure, congenital external diseases or defects or anamolies, sterility, any fertility, sub-fertility or assisted conception procedure, venereal diseases, intentional self-injury/suicide, all psychiatric & psychosomatic disorders & diseases/accident due to & or use, misuse or abuse of drugs/alcohol or use of intoxicating substances of such abuse or addiction etc."
The treating Doctor's certificate cited by the Respondent didn't confirm that the Hyper Homocystenimia & cause of the CV Stroke were exclusively due to deficiency of Folic Acid & Vitamin B-12. He had used the words as may be or probable cause. He had not clearly stated that it was due to deficiency of Folic Acid & Vitamin B-12.
The Respondent failed to prove how the Clause No.4.8 was applicable. The Representative could not establish that in all patients, with deficiency of Folic Acid & Vitamin B-12, the general debility existed or had run down conditions. She was neither able to prove that the patients who had general debility or run down condition had deficiency of Folic Acid / Vitamin B-12.
The Forum directed the Respondent to pay Rs.43,989/- to the Complainant.

Date of Award: 13.08.2015

Complainant:- Sri Kantibhai F Patel V/s Respondent :- United India Insurance Co. Ltd.

Complaint No. AHD-G-051-1415-0697

Partial settlement of Mediclaim

The Complainant was admitted in Dr. Sanjay R Gandhi Hospital, Ahmedabad for the surgery of Right Eye Cataract on 05.08.2014 & was discharged on the same day. He had incurred total expense of Rs.35,524/-. His claim was partially settled for Rs.20,931/- & Rs.14,593/- was deducted stating that the said Dr. Sanjay Gandhi Hospital is a part of the GIPSA PPN. As per the MOU, the hospital was supposed to charge Rs.20,500/- & accordingly the amount was sanctioned by the TPA. The Complainant submitted that he was eligible for the claim of Rs.56,250/- as per Policy Condition No. 1.2.1-A , according to which Cataract Surgery could be paid up to 25% of Sum Insured or actual expense whichever is less is payable.

The Policy Terms & Conditions No. 1.2.1-(a)-clearly states that in case of Cataract "Actual expenses incurred or 25% of the sum insured whichever is less is payable." In the subject policy the sum insured is Rs.2,25,000/-, so 25 % of the sum insured comes to Rs.56,250/- & the Complainant had incurred the expenses well below the framed limit.

The Respondent failed to prove that a copy of PPN hospitals was given to the Complainant. The Complainant was not aware that the fees of Rs.20,500/- was to be paid for the Cataract Surgery to Dr. Sanjay Gandhi Hospital. The agreement was between Hospital & TPA. Neither the hospital nor the Respondent had brought the existence of the MOU on PPN hospitals to the knowledge of the Complainant. The hospital had violated the MOU & charged excess amount from the Complainant. The Customer in no way was responsible for such violation.

The Forum directed the Respondent to pay Rs.14,593/- along with an interest @ 9%, from the date of claim to the date of settlement, to the Complainant.

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Date of Award: 13.08.2015
Complainant:- Sri Vinod Goyal V/s Respondent:- The New India Assurance Co. Ltd.
Complaint No. AHD-G-049-1415-0713
Repudiation of Mediclaim
The Complainant was diagnosed with Sublevel Neovascular Membrane in Right Eye. He had taken treatment in Nishtha Retina Centre, Vadodara. He was admitted in the hospital on 18.08.2014 & discharged on the same day. He had incurred total expense of Rs.19,678.35. His claim was repudiated by the Respondent citing Policy Clause No. 4.4.23-ARMD.
Looking to the technological advancement of medical science & treatment, the procedure has to be changed where hospitalization may not be required for minimum 24 hours even though it requires the hospitalization as in the case of chemotherapy. Under these circumstances the application of Clause 2-2.3 vitiates the very purpose of availing of the latest advanced technology.
The Complainant had taken the treatment at the advice of the doctor. There must have been severity which could have lead Complainant to take such treatment at such an early age of 50 years.
The Forum directed the Respondent to pay Rs.19,678/- to the Complainant.

Complainant:- Shri Jinesh Shah
V/s
Respondent:- The National Insurance Co. Ltd.
Complaint No. AHD-G-048-1516-0086
Date of Award: 14.08.2015
Partial settlement of Mediclaim
The Complainant's spouse Smt. Jayaben was diagnosed with Incisional Hernia. Exploratory Laparotomy Adhesiolysis, Resection of Hernia Sac & tissue repair of the defect was done at CIMS Hospital, Ahmedabad during his admission from 01.12.2014 to 06.12.2014. The Complainant had incurred total expense of Rs.2,21,839/- & the Respondent had settled Rs.82,698/- only. The Respondent had stated that the partial settlement was approved based on the PPN Package.
The Hospital authority confirmed that they are not under PPN package with the MEDI Assist the TPA. Hence, the Respondent citing PPN package for settling the claim was incorrect.
The Forum directed the Respondent to pay Rs.71,058/- to the Complainant.

Date of Award: 14.08.2015

Complainant:- Shri Rajesh R Shah V/s Respondent:- The New India Assurance Co. Ltd.

Complaint No. AHD-G-049-1516-0073

Partial settlement of Mediclaim

The Complainant was diagnosed with Ischemic Heart Disease: ACS: Critical LAD/LCX. He had taken treatment in Baroda Heart Institute & Research Centre, Vadodara. He was admitted in the hospital on 26.10.2014 & discharged on 29.10.2014. He had claimed total expense of Rs.2,13,630/- out of which the Respondent had settled the claim for Rs.27,500/- partially. His claim was repudiated by the Respondent citing Policy Clause No. 4.1, 4.3 & 6 the enhancement of sum insured will not be available for illness, disease already contracted under the preceding policy period.

In one of the discharge summary of the Baroda Heart Institute & Research Centre it was mentioned as "HTN since 3 months" whereas in another case paper of the Insured available with the Respondent, the word "months" was corrected to "years" without any authentication. When questioned about the discrepancy, the representative replied that since the document initially submitted by the claimant was original & the second one was a xerox copy, they had considered the original document. The letter heads used in both the discharge summaries were also different. He agreed that he had not asked for any clarification from the hospital on the discrepancy on months & years. He stated that in future they would take care on such issues before attending the Forum.

The Forum had directly approached the Baroda Heart Institute & Research Centre, Vadodara by sending both the discharge summaries through mail on the next day of the hearing & asked them to confirm the duration of hyper tension of the patient. Ms. Manisha Rane, Manager-Operations of the hospital immediately confirmed by return e-mail that the insured was having hyper tension since 3 years as per their records. She had also sent the case sheet dated 26.10.2014 wherein a column on the past history viz. hyper tension has been answered as yes & the duration was clearly mentioned as 3 years. The Consultant Dr. Parvindar Singh had signed the case sheet.

The Complaint was dismissed.

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Date of Award: 14.08.2015

Complainant:- Smt. Nalini A Ghariwala V/s Respondent:- The Oriental Insurance Co. Ltd.

Complaint No. AHD-G-050-1516-0092

Partial settlement of Mediclaim

The Complainant had met with an accident while driving her two wheeler. Her left leg got fractured & was operated. She was advised to take rest for 3 months. She claimed 13 weeks TTD at the rate of Rs.5,000/- per week. The Respondent had repudiated her claim citing Policy Clause No.1-"Upon the happening of any event which may give rise to a claim under this policy written notice with all particulars must be given to the company immediately & in any case not later than 3 months." Here the intimation was received after 3 month & 27 days of the accident.

The Complainant had intimated her hospitalization to the New India Assurance Company Ltd. on very next day of the accident but had not intimated the Respondent on TTD claim. There had been specific agreement between two organizations & accordingly adequate time limit was granted for intimation of happening of any untoward incident. Her submission was that she was not aware of the benefit or procedure of intimation within 3 months. She requested for the condonation of delay in late submission of the claim intimation. The delay was by 27 days more.

IRDAI had provided for condonation of delay in late intimation & submission of the claim provided it was substantiated with a valid reason. In the subject claim, the Complainant had agreed that there was no other reason for the late submission except no knowledge of existence of such policy.

The Respondent had not disputed that the Insured had met with an accident & had under gone treatment for the same. The other Insurance Company had also settled her mediclaim. The IRDAI circular dated 20.09.2011 to all Insurers had provided for condonation of the delay if the delay was for a valid reason. The Insured's employer, in the interest of its employee, had purchased this policy. The copy of the policy was not shared with all the Insured although the premium got collected.

The Respondent was directed to pay Rs.25,000/- to the Complainant, on Ex-gratia basis.

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Date of Award: 14.08.2015

Complainant:- Shri Nikhil Trivedi V/s Respondent:- The New India Assurance Co. Ltd.

Complaint No. AHD-G-049-1516-0101

Partial settlement of Mediclaim

The Complainant was diagnosed with Swine Flu (H1N1). He had taken treatment in Bodyline Hospitals, Ahmedabad. He was hospitalized from 12.02.2015 to 17.02.2015. He had claimed total expense of Rs.61,508/-. The Respondent had settled Rs.24,959/- partially stating Policy Terms & Condition No. 2.1: "Room rent, boarding & nursing expenses as provided by the Hospital/Nursing Home not exceeding 1% of Sum Insured (excluding cumulative bonus) per day/actual whichever is less, is reimbursable". In the subject claim, the Sum Insured was Rs. 2 Lacs & so eligible room charges was Rs. 2000/- per day as against Rs. 4000/- per day (paid by the Complainant). As per policy condition Note No. 1 to Clause 2.3 & 2.4 the amount payable should be as per the entitled category. Accordingly, the deductions of other charges were made. The Respondent in reply to a question, on entitled category, had mentioned that there was no definition for entitled category in the policy.

The Government had issued instructions to take care of the Swine Flu patients & take preventive measures form its spreading to other patients. The Bodyline Hospitals, where the Insured was treated for Swine Flu, in line with the Government instruction had created an ICU Isolation room & put the Insured in it for the treatment. The hospital had explained the same vide its letter dated 25.03.2015 to the TPA of the Respondent.

The room occupied by the Insured, though basically was a room with a rent of Rs.2,000/- as found out by the Respondent, it was converted to an ICU like room. The claim should have been dealt with accordingly, as if the expenses had been incurred on being hospitalized in an ICU Room.

The Respondent had interpreted the entitled category as proportionate room rent (clause 2.1) and applied the same rule in reducing the other charges, proportionately, without a proper explanation on entitled category.

Considering the treatment availed, occupying an ICU room, as it was required & essential, except the Registration Charges of Rs.300/-, Pulse Oxymeter Charges of Rs.300/- & Service Charges of Rs.2,392/-, the claim amount was payable.

The Forum directed the Respondent to pay Rs.33,557/- to the Complainant.

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Date of Award: 8.06.2015

Complainant:- Mrs. Bhavika R Bhansali V/s Respondent :- The New India Assurance Co. Ltd.

Complaint No. AHD-G-049-1415-0490

Repudiation of Mediclaim

The Complainant was diagnosed with severe Dysuria with burning pain at ext. Meatus. She was not benefitted by medicines. She was hospitalized in Dr. Vivek Joshi Hospital, Rajkot from 14.02.2014 to 15.02.2014. Total expense incurred was Rs.16,681/-. Her claim was repudiated by the Respondent citing Exclusion Clause No. 4.4.11- "Charges incurred at Hospital primarily for diagnosis, x-ray or laboratory examinations or other diagnostic studies not consistent with or incidental to the diagnosis & treatment of positive existence or presence of any illness or injury for which confinement is required at hospital."

The Complainant had categorically mentioned in her complaint that she was having this ailment since August, 2012. Despite consulting renowned doctors, she could not get relief from her ailment. Therefore, she decided to consult a Doctor in Rajkot. When her ailment was not cured through medicines she was hospitalized & treated.

The treating Doctor had specifically mentioned in discharge card that the Complainant was operated. Treatment papers clearly proved the type of treatment she was given on 14th & 15th February, 2014. It is the Doctor who had advised the patient to get hospitalized after assessing the health conditions. Here also the Complainant was solely dependent on the Doctor & acted accordingly. As her disease had become chronic, on the advice of her doctor, certain tests were carried out to know & assess the cause of the disease. The Respondent had mechanically ignored this fact. The Respondent failed to prove before this Forum that the treatment was for diagnostic purpose only.

The Forum directed the Respondent to pay Rs.16,681/-.

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Date of Award: 18.06.2015

Complainant:- Smt. Smita K Patel V/s Respondent :- Apollo Munich Health Ins. Co. Ltd.

Complaint No. AHD-G-003-1415-0481

Partial settlement of Mediclaim

The Complainant was diagnosed with LV Diastolic Dysfunction & Anaemia with Vitamin B12 & D3 deficiency. She was hospitalized in Sal Hospital, Ahmedabad from 22.05.2014 to 24.05.2014. She had incurred total expense of Rs.25,000/-. The subject claim was repudiated by the Respondent on the ground that she had not disclosed the past history of Postpartum Cardiomyopathy while filling proposal form at the time of going for insurance cover.

The Policy was ported from The New India Assurance Co. Ltd. Earlier it was continued with The New India Assurance Co. Ltd since 2001. All necessary documentation for portability of the policy was carried out. The ailment Postpartum Cardiomyopathy occurred 16 years back at the time of pregnancy. The treating Doctor Atul R Parikh, vide his letter dated 02.07.2014, had clearly confirmed that it was fully cured & she never had any symptoms related to her old disease. Further, on pre-existing disease, declared &/or accepted, there is a waiting period of maximum 3 years as per the terms & conditions of the subject policy. Further, as per IRDAI circular dated 09.09.2011 the policyholder is eligible for the credit gained by the insured for pre-existing conditions & time bound exclusions if the policyholder chooses to switch from one insurer to another, provided the previous policy had been renewed without any break. As the current ailment was diagnosed 16 years back & when the current Insurer had verified the past claim history & personal history from the IRDAI or previous Insurer's portal the question of rejection of the claim & cancellation of the policy doesn't arise. The Respondent's representative confirmed that there was no claim history of the Complainant at the time of portability. The policy was religiously renewed & continued claim free since 2001 with previous Insurer. The Respondent had failed to prove that the Complainant was under treatment/medication for the Postpartum Cardiomyopathy, except mention of past history of ailment in discharge summary.

The Forum directed the Respondent to reinstate the subject Policy & settle the claim for Rs.23,176/- to the Insured.

Date of Award: 18.06.2015

Complainant:- Smt. Sonal R Mashru V/s Respondent:- The National Insurance Co. Ltd.

Complaint No. AHD-G-048-1415-0688

Partial settlement of Mediclaim

The Complainant's son was diagnosed with Dumoid, Lipoma Rt side of fore head & Excision Biopsy of lump on fore head was carried out at Bodyline Hospitals, Ahmedabad during his admission from 07.06.2013 to 09.06.2013. The Complainant had incurred total expense of Rs.40,823/- & the Respondent had settled Rs.26,107/- only. The Respondent had stated that the partial deduction was due to the reason that the procedure could have been done as day care treatment also that the Hospital was under PPN hospital.

The Respondent had failed to establish what was reasonable & customary charges. The Respondent's action in partial settlement without proper evidence on the clause is against the provisions of the IRDAI circular dated 20.02.2013 on standardization in health insurance reasonable charges. In absence of any comparative rate charts from various hospitals with similarly facilitated hospitals in the vicinity of the hospital where the insured had undergone the medical treatment, the deduction caused merely on assumption or without any base is arbitrary.

The Respondent's representatives were unable to prove that they had provided the PPN agreement copy to the Complainant along with rate chart. The representatives of the Respondent agreed that customary & reasonable clause could not be invoked when there was PPN agreement in place.

The Forum directed the Respondent to pay Rs.12,982/-.

Date of Award: 18.06.2015

Complainant:- Sri Gaurav Mudra V/s Respondent:- The Oriental Insurance Co. Ltd.

Complaint No. AHD-G-050-1415-0494

Partial settlement of Mediclaim

The Complainant met with an accident while driving his two wheeler. His left leg got fractured & was plastered. His treating doctor had advised rest for 41 days. He claimed 6 weeks TTD at the rate of Rs.5,000/- per week. The Respondent had restricted the TTD to 3 weeks on the opinion of its doctor.

From the reports & treatment papers it was confirmed that the Complainant sustained injury, due to fall from two wheeler vehicle. He was diagnosed with fracture on his left foot. The Panel Doctor of the Respondent vide letter dated 08.11.2014 had confirmed that the Insured's Doctor had advised him rest for 42 days. The Respondent reduced TTD settlement to 3 weeks instead of 6 weeks based on their panel Doctor's opinion. The Respondent had no proof to prove that the Complainant was not confined to bed for 42 days. They solely relied on their Panel Doctor's opinion which was based on treatment papers only & not by way of examining the patient's progress of his illness. The Complainant is a Development Officer with LIC of India. His job involves field related activities. So the opinion of the panel Doctor of the Respondent that-'the entire period of being unfit would not exclusively constitute a total temporary disablement'- doesn't apply in this case. For field activities, without vehicle, movement is difficult, especially with plastered foot. Further he was on sick leave from 10.05.2014 to 19.06.2014 & was treated by Dr. Vijay Upadhyay, M.S (Ortho) of the Accident-Fracture-X-ray Clinic & Orthopaedic Hospital, Gandhinagar. The treating doctor had advised rest after observing/examining his patient's progress in recovery after the accident. The Respondent's doctor who had not examined the Insured physically had expressed his opinion based on the papers made available to him. The treating doctor's advice is based on physical examination & observation. Under the situation, the treating doctor's advice holds prevalence over the opinion/suggestion of the other doctor who had not seen the patient & who had no expertise in the orthopaedic field. The Respondent Doctor is M.D & Complainant Doctor is Orthopaedic Surgeon.

The Respondent was directed to pay the balance 3 weeks Total Temporary Disablement, as claimed by the Complainant, Rs.5,000/- per week.

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Date of Award: 19.06.2015

Complainant:- Sri Kamal Singh Rajput V/s Respondent :- Bharti AXA General Insurance Co. Ltd.

Complaint No. AHD-G-007-1415-0694

Repudiation of Mediclaim

The Complainant had an accidental fall from his two wheeler on 20.03.2014 at night & sustained injury on Right Shoulder, Right Knee & back injury. He was admitted in Saikrupa Nigam Orthopaedic Hospital, Ahmedabad. He was discharged on 24.03.2014. He had incurred total expense of Rs.37,470/-. His claim was repudiated by the Respondent citing policy clause No. 6.1-Duty of Disclosure-Misrepresentation & Exclusion Clause No. 29- Charges incurred primarily for diagnostic purpose.

The Final Investigation mentioned to be carried out by Mr. Jayesh Raval is unsigned & without date. This raises the doubt about the authenticity of the report. In investigation report it was mentioned that incident took place at around 8.30 to 9.00 p.m & the Complainant was admitted in the Hospital around 10.00 p.m. As per the claim document, the reports were taken from Gurukrupa Digital X-ray, Sonography & Colour Doppler Clinic & the said clinic closes at 9.00 p.m. So doubt raised by the Respondent that it was not possible to carry out the reports when clinic was closed. No documentary evidence was produced by the Respondent to prove that the reports were fraudulent or was taken on another date. Same is applicable with the chemist bills.

The Respondent's representative confirmed that the treatment noted in the Indoor Case Papers matched with the first discharge summary. In indoor case papers line of treatment given was regularly noted, but surgical procedure was not noted. The treating Dr. Atul Nigam had mentioned in detail the procedure carried out on the Complainant, in the second discharge summary, submitted by the Complainant after denial of the claim. This raises doubt whether surgical procedure was actually done or not as surgical procedure was not noted in the Indoor Case Papers when all other line of treatment was noted regularly. Therefore the surgical procedure charges of Rs.12,000/- is not payable. There can never be two discharge summaries for treatment of particular illness. First discharge summary hold valid for considering the claim.

The Respondent solely relied on the investigation report & the same was carried out by a person who had no medical expertise. Had it been by any Orthopaedic Doctor it would have more authentic. There was no concrete proof to show that there was misrepresentation & that the hospitalisation was for diagnostic purpose only.

The Forum directed the Respondent to pay Rs.25,470/- to the insured.

Date of Award: 18.06.2015

Complainant:- Sri Shashikant R Jain V/s Respondent :- United India Insurance Co. Ltd.

Complaint No. AHD-G-051-1415-0693

Partial settlement of Mediclaim

The Complainant was admitted in Hi-Tech Clinic Pvt. Ltd., Vadodara for the surgery of Left Eye Cataract on 28.08.2014 & was discharged on the same day. He had incurred total expense of Rs.52,500/-. His claim was partially settled for Rs.33,097/-. Deductions for Rs.19,403/- were made under the various heads of policy terms & conditions. The Complainant submitted that he was eligible for the claim of Rs.50,000/- as per Policy Condition No. 1.2.1-A , according to which reimbursement under Cataract Surgery expense could be made up to 25% of Sum Insured or actual expense whichever was less.

The Policy Terms & Conditions No. 1.2.1(a) clearly states that in case of Cataract Surgery "Actual expense incurred or 25% of the sum insured whichever is less is payable." In the subject policy, 25% of the sum insured Rs.2,00,000/- is Rs.50,000/- & the Complainant had incurred expense of Rs.52,500/-. There was no specific condition mentioned in the policy on the type, rate & quality of lenses to be used. Without any guidance or advice it would be difficult for an Insured to arrive at reasonable & customary charges for a surgery especially, when there is a specific mention of reimbursement under Cataract surgery in the terms & conditions of the policy itself.

The Forum directed the Respondent to pay Rs.16,903/- to the Complainant.

Date of Award: 22.07.2015

Complainant:- Shri Pranay A Patel V/s Respondent :- Apollo Munich Health Ins. Co. Ltd.

Complaint No. AHD-G-003-1415-0791

Repudiation of Mediclaim

The Complainant was with diagnosed High Grade Fever, Rigor on & off & severe headache. He was hospitalized in Balaji Hospital, Ahmedabad from 04.10.2014 to 08.10.2014. He had incurred total expense of Rs.15,865.74. The subject claim was repudiated by the Respondent stating that as the patient was not available for the statement & as per the investigation, discrepancy was noted in medical records.

The Respondent in their repudiation letter had not mentioned the discrepancies were found in the medical records of the subject claim. The Respondent had not mentioned the date & time the investigator had gone to the hospital to investigate the subject claim. The Complainant had submitted all necessary treatment papers like indoor case papers & first consultation letter for the assessment of the claim. The Respondent was so callous on his approach that he didn't even care to give details in their repudiation letter on which date their investigator visited the hospital nor they felt necessary to mention what discrepancies they had found in the medical records.

The Forum directed the Respondent to pay Rs.10,000/- on Ex-Gratia basis.

Date of Award: 25.08.2015

Complainant:- Shri Bhavin R Panchal V/s Respondent :- Apollo Munich Health Ins. Co. Ltd.

Complaint No. AHD-G-003-1516-0122

Repudiation of Mediclaim

The Complainant's spouse Shwetaben was diagnosed acute gastroenteritis. She was hospitalized in Shivam Surgical Hospital, Ahmedabad from 16.06.2014 to 20.06.2014. He had incurred total expense of Rs.15,474/-. The subject claim was repudiated by the Respondent stating that due to non-cooperation from the treating hospital discrepancy was noted in medical records.

While going through the investigation report based on which the Respondent repudiated the claim the Forum noticed that the sequence in the admission register was in order, only the date of admission of the subject claim was entered after the date of admission of later cases. There was no overwriting or correction in the admission register. There could only be a mistake on the part of hospital staff while making entry in the admission register. The investigator should have obtained the copies of the subsequent pages of the register where from the Forum could arrive at a conclusion whether the hospital had a habit of manipulating their records for claim purpose. In the subject claim the Respondent failed to prove that the subject claim was fraud. The hospital is registered with the local authority, so as per IRDAI's revised guidelines, dated 03.07.2013 ref: IRDAI/HT/REG/CIR/125/07/2013, the minimum no. of bed requirement also doesn't apply in this case.

The Forum directed the Respondent to pay Rs.15.474/- along with interest @ 9% p.a from the date of claim to the Complainant.

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Date of Award: 30.09.2015

Complainant:- Sri Vikas L Agarwal V/s Respondent:- Bajaj Allianz General Insurance Co. Ltd.

Complaint No. AHD-G-005-1516-0151

Repudiation of Mediclaim

The Complainant was diagnosed with Undescended Testicle Unilateral. He had taken treatment in Smt. R.B.Shah Mahavir Super Speciality, Hospital, Surat. He was admitted in the hospital on 03.09.2014 & discharged on 06.09.2014. He had incurred total expense of Rs.1,00,168/-. His claim was repudiated by the Respondent citing Policy Exclusion Clause No. C20- "We will also not pay for claims arising out of or howsoever connected to the following: Any fertility, sub fertility, impotence, assisted conception operation or sterilization procedure".

The Policy Terms & Conditions Exclusion Clause No.20C clearly excludes treatments related to any fertility, sub fertility, impotence, assisted conception operation or sterilization procedure. The discharge summary also confirms that the Complainant was having past history of Oligospermia-low sperm count. The Complainant himself had given statement to the investigator that the treatment was for the improvement of the fertility. The treating Doctor's certificate dated 27.11.2014 post repudiation of the claim states that the surgery was done in view of chances to develop malignancy & not to improve fertility. However, this certification gets refuted by the consultation sheet which mentions "primary male infertility". Further none of the medical case paper speaks about possible malignancy or the purpose of the surgery was to prevent malignancy.

The Complaint was dismissed.

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Date of Award: 23.04.2015

Complainant:- Smt. Bhargaviben.V.Modi V/s Respondent :- Max Bupa Health Insurance Co. Ltd.

Complaint No. AHD-G-031-1415-0426

Repudiation of Mediclaim

The Complainant's Spouse was operated for thyroid in Yagnya Onco Surgical Hospital, Ahmedabad from 11.07.2013 to 14.07.2013. He had incurred total expenses of Rs.71,828/-. His claim was rejected on the ground that hospital is three bedded and did not fulfill the criteria set by IRDAI.

The Forum informed the Respondent's Representative about the circular issued by IRDAI on 03.07.2013 in which they advised all operators to dispense with the minimum bed condition if the hospital is registered with the local authorities. The Respondent was also informed that some of the Insurers have included this clause in their policies. The Respondent's Representative said that he had verified with many companies but had not come across a single company who had such clause in their policy & there was no such circular issued by the IRDAI. The Respondent's Representative was shown the circular & the Terms & Conditions of some companies. The Respondent's representative confirmed before this Forum that the hospital was registered with the local authority.

The Forum directed the Respondent to pay Rs.71,828/- along with an interest @ 12% p.a from the date of claim to the date of settlement to the Complainant.

Date of Award: 22.07.2015

Complainant:- Smt. Naynaben K Patel V/s Respondent :- Max Bupa Health Insurance Co. Ltd.

Complaint No. AHD-G-031-1415-0726

Repudiation of Mediclaim

The Complainant was admitted in Mayflower Women's Hospital, Ahmedabad for the surgery of Hysterectomy on 13.11.2014 & was discharged on 15.11.2014. She had incurred total expense of Rs.1,48,477/-. Her claim was repudiated by the Respondent stating non-disclosure of pre-existing condition of irregular periods (Menstruation).

The Respondent failed to prove that the proposal form contained specific questions & answers regarding irregular periods. The Complainant had submitted her Doctor's certificate which confirmed that irregular periods are common in women & that cannot be termed as pre-existing or it lead to Hysterectomy. The Respondent also didn't have proof which proved that the Complainant was under treatment of the fibroid, or had gone for any test/reports prior to inception of the policy. The Respondent's representative agreed, during hearing, to re-look in to the matter & revert to the Forum by afternoon. The Respondent had vide an email dated 21.07.2015 had agreed to settle the claim for 60% of the claim amount. The Insured had agreed that she had informed the Insurer vide letter dated 01.12.2014 that she had irregular periods for 2 years before the inception of the policy. She also stated that she did not consult any Gynaecologist/doctor during those to years on her gynaec issue. The Forum refused to accept the submission that she did not consult any doctor to rectify/address her health issue for 2 long years.

As agreed by the Respondent the Forum directed the Respondent to pay Rs.89,265/- to the Complainant.

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Date of Award: 30.09.2015

Complainant:- Sri Rajesh V Iyer V/s Respondent:- Star Health & Allied Insurance Co. Ltd.

Complaint No. AHD-G-044-1516-0160

Repudiation of Mediclaim

The Complainant was diagnosed with Multiple Sclerosis. He had taken treatment in Haria L.G Rotary Hospital, Vapi. He was admitted in the hospital on 10.12.2014 & discharged on 15.12.2014. He had incurred total expense of Rs.58,446/-. His claim was repudiated by the Respondent citing Policy Clause No.4-Conditions-7-"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 fraudulent or supported by any fraudulent means or device, misrepresentation/non disclosure at the time of proposal/ at the time of claim, whether by the Insured Person/s or by any other person acting on his behalf". Further citing Policy Clause No.4-Conditions-13 the Respondent had cancelled the policy & refunded the premium paid under the subject policy.

The treating doctor had clarified vide his letter dated 07.08.2014 that the patient (the Complainant) was having past history of Multiple Sclerosis since last one to two years instead of 2-3years. The Insured had signed the proposal form furnishing the personal details including his history on his health. The Insured was supposed to ensure that the facts mentioned in his proposal form are true. The hospital record of the Complainant specifically mentioned him to be a known case of multiple sclerosis & was on continued treatment. The Contract of Insurance are Contracts of "Uberrima fides", i.e, utmost good faith and every facts of material must be disclosed, otherwise, there is good ground for rescission of the Contract. The duty to disclose material facts has been by the Insured while proposing for Insurance. The Insured is under a solemn obligation to make a true and full disclosure of the information on all aspects which are well within his or her knowledge in the proposal form. It is not for the Proposer to determine whether the information sought for is material or not for the purpose of the Policy. In a Contract of Insurance, any fact which would influence the mind of a prudent insurer in deciding whether to accept or not to accept the risk is a "Material fact". By not mentioning the true facts on his health aspect in the proposal form the Complainant had knowingly suppressed his health conditions from the Insurer. The Insurer had correctly cancelled the Complainant's policy & refunded the premium.

The Complaint was dismissed.

Date of Award: 22.07.2015

Complainant:- Ms. Bhoomi Vachharajani V/s Respondent :- National Insurance Co. Ltd.

Complaint No. AHD-G-048-1516-0018

Repudiation of Mediclaim

The Complainant was admitted in Nanavati Well Hospital, Ahmedabad for the surgery of Uge Complex Ovarian Complecyst on 09.04.2014 & was discharged on 11.04.2013. She had incurred total expense of Rs.61,000/-. Her claim was repudiated by the Respondent citing Policy Clause No.4.1-"All diseases/Injuries which are pre-existing when the cover incepts for the first time. This exclusion will be deleted after three consecutive continuous claim free policy years in respect of all diseases provided, there was no hospitalization for pre-existing ailment during such three years of insurance." The claim has arisen in the very first year of the policy. In the proposal form there was a specific question asking for any treatment taken in last 3 years which was replied rightly in negative by the Insured. Had it been for last 10 years then She would have mentioned the history of hysterectomy operation, as the same was 6 years back. Further the Complainant had submitted the treating Gynaecologist's certificate, dated 05.06.2014, which confirmed that hysterectomy had no connection in developing ovarian cyst. The Respondent had not produced any proof or opinion countering the Complainant's doctor's opinion from any medical expert of the same or higher stature.

The Forum directed the Respondent to pay Rs.60,985/- along with an interest, as per the Protection of Policy Holders Interest Regualstions, 2002, from the date of claim to the date of settlement to the Complainant.

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Date of Award: 24.08.2015

Complainant:- Shri Dhrumin B Dalal V/s Respondent :- National Insurance Co. Ltd.

Complaint No. AHD-G-048-1516-0135

Partial settlement of Mediclaim

The Complainant's father was admitted in Muljibhai Patel Urological, Hospital, Nadiad for the surgery of Carcinoma Prostate Stage pT2cNx on 16.11.14 & was discharged on 22.11.2014. He had incurred total expense of Rs.5,46,021/-. His claim was partially settled for Rs.1,05,800/- & Rs.4,40,221/- was deducted by the Respondent citing reasonable & customary clause.

The submission of opposite party in defence of their limiting the claim is partially justified. As per the specific terms of this policy the per day room charges has been limited to Rs.2,500/- & accordingly all other related expenses are to be proportionately reduced. To that extent the Complainant's claim has to be scaled down. However, the opposite party's decision not to entertain expenses pertaining to Robotic assisted Prostate surgery under the guise of Clause No.2 of the Group Mediclaim Policy is totally misplaced. The Clause speaks of Customary & Reasonable expenses. Every patient's condition happens to be different & it demands specific intervention. In this case the patient has been diagnosed with Prostate Cancer & the surgery was specifically to take out the cancerous lump from the tiny prostate gland. Therefore, the surgeon's decision is alone justified as to what kind of surgery he would perform & the treating Doctor in this case is a very specialized one & his credentials are not questioned by the opposite party. What is Customary & Reasonable today would change with time. A case in example, would be Laproscopy Surgery. Therefore, we have to necessarily accept the Surgeon's decision as final.

In view of the above the complaint was admitted. As per the Respondent's letter dated 13.07.2015 the Complainant is eligible for Rs.64,851/- for medicines, Rs.17,500/- for room rent Rs.2,49,817/- towards other charges, after reducing proportionately. In total Rs.3,32,168/- was admissible out of which the Respondent had already paid Rs.1,03,000/- therefore balance Rs.2,29,168/- was to be paid.

The Forum directed the Respondent to pay Rs.2,29,168/- along with interest @ 9%, from the date of claim to the date of settlement, to the Complainant.

Date of Award: 25.08.2015

Complainant:- Shri Rashmikant A Vora V/s Respondent :- National Insurance Co. Ltd.

Complaint No. AHD-G-048-1516-0142

Repudiation of Mediclaim

The Complainant's spouse Smt Naynaben was admitted in Sterling Hospital, Ahmedabad for the treatment of Demyelinating Brain Disease Cerebral Autosomal-dominant Arteriopathy with subcortical infarcts & Leukoencephalopathy most likely. She was admitted on 05.06.2014 & discharged on 09.06.2014. He had incurred total expense of Rs.1,28,335/-. His claim was repudiated by the Respondent citing Policy Clause No. 4.11- " The Company shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any person in connection with or respect of: Genetical disorders/stem cell implantation/surgery".

The submission of the Complainant, in detail I have heard. The Complainant primarily believes that the disease cannot be totally & conclusively decided by the Doctors as related to genetics only. After having made a study on Demyelinating Disease through medical literature it was revealed that it is a disease of nervous system in which myelin sheath of neuron is damaged. This damage impairs the conduction of signals in the affected nerves. In turn, the reduction in conduction ability causes deficiency in sensation, movement, cognition or other functions depending on which particular nerves are involved. Some demyelinating diseases are caused by genetics, some by infectious agents, some by autoimmune reactions & some by unknown factors. Another disease diagnosed was Cerebral Autosomal Dominant Arteriopathy with Subcortical Infarcts & Leukoencephalopathy- CADASIL is an increasingly stereotyped mutations in the Notch3 receptor. CADASIL is a widespread angiopathy characterised by a degeneration of vascular smooth muscle cells (VSMCs) & the abnormal accumulation of electron-dense granular material called GOM & Notch3 protein, because of an impaired clearance. In both the studies it is not specifically mentioned that occurance of both the diseases is absolutely & only due to genetic disorder. In any of the consultation papers or reports also it was no where mentioned that the cause was genetic disorder. The medical opinion taken by the Respondent was that of M.D Physician/Cardiologist whereas the diseases are subject of Neurophysician. The Respondent should have obtained specific opinion on the cause of the diagnosed diseases that they were due to genetic disorder only from any Neurophysician, having equal stature as the treating Doctor.

The Forum directed the Respondent to pay Rs.1,28,335/- to the Complainant.

Date of Award: 23.04.2015

Complainant:- Sri Shital S Shah V/s Respondent:- The New India Assurance Co. Ltd.

Complaint No. AHD-G-049-1415-0362

Repudiation of Mediclaim

The Complainant's mother Smt. Hansaben had a complaint of shoulder & back pain. She consulted Dr. Jigar Shah, MS Ortho on 12.11.2013. He prescribed medicines & advised x-ray & MRI. She had severe chest pain & headache on 16.11.2013 & was admitted in U.N.Mehta Institute of Cardiology & Research Centre, Ahmedabad. She was diagnosed with HTN with unstable Angina with CAD-Insignificant. She was treated & discharged on 18.11.2013. On 19.11.2013 again she had the same compliant & she was rushed to Sal Hospital, Ahmedabad. There she was diagnosed with major depressive disorder. The Complainant incurred total expense of Rs. 33,625/- the claim of which was repudiated by the Respondent citing Policy Clause No. 4.4.6-" Convalescence, general debility, 'Run Down' condition or rest cure, obesity treatment & its complications congenital external disease/defects or anomalies, treatment relating to all psychiatric & psychosomatic disorders, infertility, sterility, use of intoxicating drugs/alcohol, use of tobacco leading to cancer". The Complainant further submitted that his mother never had past history of depression & she was treated for chest pain & headache only & depression was detected for the first time.

The Discharge Summary of U.N.Mehta Institute of Cardiology & Research Centre, Ahmedabad mentioned the Insured to be diagnosed with HTN, unstable Angina with CAD-Insignificant & was treated accordingly. In the clinical summary of the SAL Hospital also it was clearly mentioned that patient to be a known case of IHD, Insignificant Coronary Artery Disease. So it was proved that she had been given treatment for chest pain. Further, there is no mention in hospital papers about past history of depression. The Insured was re-admitted in SAL Hospital with same complaint which she had when she was admitted to U.N.Mehta Institute of Cardiology & Research Centre, Ahmedabad. On discharge she was advised to take Tablet Telvas-for high b.p, Tablet Metocard XL- to prevent angina, Tablet Neurobion Forte- it is a water soluble vitamin drug that focuses on providing B spectrum vitamins. It is necessary to keep these vitamins well balanced in the body to encourage a healthy metabolism, with B vitamins helping to regulate carbohydrate, protein and lipidic metabolisms. They also help to encourage a healthy gastrointestinal tract, central nervous system, cardiovascular system and regenerate nerve cells as well as maintain these systems after the initial application of the tablets. The tablets prescribed, after discharge, were not only for depression but there were tablets for high blood pressure & heart disease also. The Insured was having some sign of uneasiness that is why she consulted Orthopedic doctor on 12.11.2013, who advised MRI of Lumbo-Sacrel

Spine & prescribed medicines, for her back pain & shoulder pain. Subsequently, on 16.11.2013 she was hospitalized in U.N.Mehta Institute of Cardiology & Research Centre, Ahmedabad for severe chest pain & headache. As per the Policy terms & conditions, expenses incurred for carrying out reports or for medicines, prior to 30 days of hospitalization, are reimbursable.

The Forum directed the Respondent to pay Rs.30,000/- to the Complainant, as ex-gratia.

Date of Award: 23.04.2015

Complainant:- Sri Sanjaykumar M Gupta V/s Respondent:- The New India Assurance Co. Ltd.

Complaint No. AHD-G-049-1415-0366

Partial settlement of Mediclaim

The Complainant's spouse Smt. Murtilaxmi was diagnosed with Squamous Cell Ca of Cervix & was hospitalized in Devanshi Maternity & Surgical Hospital, Mehsana from 12.03.2013 to 22.03.2013. He had incurred total expense of Rs.1,40,908/-. The Respondent had settled the claim for Rs.1,08,143/- & deducted Rs.32,765/-. The Complainant submitted that there was no such policy condition as mentioned by the Respondent in their repudiation letter. The terms & conditions which he received were of 2007 & he couldn't find any such rule as mentioned for the deductions of the amount.

As undertaken by the Complainant to submit the bank statement showing 'the entry of cheque given to the Doctor' was received. The entry was not found & the accompanying letter of the Complainant stated that the said cheque, bearing no. 5, was not deposited by the Doctor for the reasons best known to him. This submission is not acceptable to the Forum as no person will leave cheque of Rs.30,000/- un-deposited. This clearly raises suspicion on the submission of the Complainant that he had made cheque payment to the Doctor although he had produced a bill issued by the doctor to have accepted the fee in cheque the bill did not carry any details of the cheque like date, drawn on , cheque no. etc. So, the payment made by the Respondent of Rs.10,000/- towards Surgeons Charges & Anaesthetist are in order as per the Terms & Conditions of the Policy. The other charges deducted by the Respondent under the head Note No. 1 under Condition 2 was correct. As there was specific mention in the condition as to at what rate the charges incurred under Clause 2.3 & 2.4 shall be reimbursed.

The Complaint was dismissed.

Date of Award: 01.05.2015

Complainant:- Sri Dharamshibhai.R.Luhar V/s Respondent:- The New India Assurance Co. Ltd.

Complaint No. AHD-G-049-1415-0374

Repudiation of Mediclaim

The Complainant's son was operated for Spasmodic Anus, Oedimatous Anal papilla with cryptitis, Sentinel Piles with chronic anal fissure & Extro internal hemorrhoids @ 11 'O' clock position. Laser Sentilectomy, Fissurectomy & Haemorroidectomy with Lord's procedure was performed under spinal anaesthesis. The Complainant incurred total expense of Rs.71,143/-. His claim was repudiated by the Respondent citing Policy Clause No. 2.15- the surgery was performed by an Ayurvedic Doctor & they were not allowed to perform allopathic surgery.

The treating Doctor Mukesh Patel, M.D (Ayurved) & registered with Gujarat Board of Ayurvedic & Unani Systems of Medicine with Registration No. GB-I-9966. The same was confirmed on the site of the Gujarat Board of Ayurvedic & Unani Systems of Medicine. But the treating doctor failed to submit approval given by the Government Body allowing him to perform this procedure. For every faculty there is a controlling authority & they are governed by their laid down guidelines. Here there was no proof which confirms that M.D (Ayurved) are allowed to perform or has been given certificate to perform surgical procedures.

The Forum directed the Respondent to pay Rs.71,143/- to the Complainant.

Date of Award: 22.04.2015

Complainant:- Smt Kokilaben J Parikh V/s Respondent:- The New India Assurance Co. Ltd.

Complaint No. AHD-G-049-1415-0378

Partial settlement of Mediclaim

The Complainant was diagnosed with Brvo Macular Edema & was treated with Avastin drug. She had incurred total expense of Rs.12,107/-. Her claim was repudiated by the Respondent citing Policy Clause No. 4.4.23- "Treatment for Age Related Macular Degeneration (ARMD), treatments such as Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External CounterPulsation (EECP), Hyperbaric Oxygen Therapy." She further submitted that she had undergone same treatment in 2006 & her claim was accepted in full by the Respondent.

The Policy Clause No. 4.4.23 clearly excludes the treatment for Macular Edema. The argument of the Complainant that her previous claim was admitted in full by the Respondent does not stand as the contract of general insurance is renewable every year & Terms & Conditions of the policy of a particular year forms terms of contract. Moreover, she had not submitted the circumstance under which the earlier claim was settled

The Complaint was dismissed.

Date of Award: 23.04.2015

Complainant:- Sri NagendraNath Nagar V/s Respondent:- The New India Assurance Co. Ltd.

Complaint No. AHD-G-049-1415-0464

Partial settlement of Mediclaim

The Complainant's wife Manjulaben was diagnosed with non-healing raw area with minimum discharge on right knee-other Septicameia. She was hospitalized in Milan Orthopedic & Fracture Care Hospital, Ahmedabad from 28.02.2014 to 01.04.2014. The Complainant had incurred total expense of Rs.2,09,417/- out of which Rs.1,77,205/- was paid after a deduction of Rs.32,212.

There was a totalling mistake in the claim form submitted by the Complainant to the Respondent. Instead of Rs.2,09,417/- the amount claimed was shown as Rs.2,22,917/-. The Complainant had produced indoor case papers from the date 25.03.2014 to 01.04.214 in which day wise active line of treatment was mentioned. The skin grafting was done on 24.03.2015 & patient was not allowed to move or bend her right knee. Regular dressing was done during her hospitalization & her health was regularly monitored from 25.03.2014 to 01.04.2014. This clearly confirms that her treatment was continued till the date of discharge. The Respondent had exhibited a callous approach towards their Senior Citizen customers. The reply given by the Regional Office

to the Complainant, dated 13.08.2014, was so casual that they have mentioned the reason which had no relevance to the deduction. A letter from the TPA of the Respondent & the Respondent itself have given different clauses for the deduction from the claim. The TPA's letter spoke about reasonable & customary clause while the R.O letter spoke about no active line of treatment. The Terms & Conditions of the Policy did not carry a clause on the active line of treatment. The Forum took a serious note of it & cautions the Respondent to be more vigilant in future.

The Forum directed the Respondent to pay Rs.32,212/- along with an interest @ 12% p.a from the date of claim to the date of settlement to the Complainant.

Date of Award: 13.07.2015

Complainant:- Sri Hasmukhbhai M Patel V/s Respondent :- The New India Assurance Co. Ltd.

Complaint No. AHD-G-049-1415-0717

Repudiation of Mediclaim

The Complainant was diagnosed with Obstructed Umbilical Hernia. He was hospitalized in Shree Bharti Vallabh Hospital, Ahmedabad from 05.03.2013 to 11.03.2013. Total expense incurred was Rs.54,618/-. His claim was repudiated by the Respondent stating that the subject hospital was in declined list. Claim as Cashless or Reimbursement from this hospital was not entertainable.

The Respondent had failed to prove that the declined list of hospitals was given to the Complainant along with Policy document. Considering the acute pain, the patient gets admitted to a hospital for relief. Moreover, the Insured was not provided with the declined list of hospitals. The Insured had acted as per the advice of his doctor.

The Forum directed the Respondent to pay Rs.54,618/- to the Complainant.

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Date of Award: 15.07.2015

Complainant:- Smt. Bijal Vinesh Shah V/s Respondent :- The New India Assurance Co. Ltd.

Complaint No. AHD-G-049-1415-0721

Partial settlement of Mediclaim

The Complainant was hospitalized in Aashray Clinic, Ahmedabad from 08.06.2014 to 15.06.2014. Hysterectomy operation was conducted on 12.06.2015. She had incurred total expense of Rs.1,04,420/-. Her claim was partially settled by the Respondent citing Policy Clause No. 2.1, 2.3, 2.4, and deductions were done from Assistant Doctor's fee, emergency visit charges and as non-medical items.

The deduction of Rs.1,200/-, towards excess room rent, by the Respondent was correct. Deductions under Clause 3.1(a) & (d) was wrongly made. Rs.4,312/- deducted proportionately becomes payable as the Note for proportionate deduction was applicable to Clause No.3.1(a) & 3.1(b) only. The Respondent rightly deducted the charges

of Rs.7,000/- of Assistant Doctor as the Complainant had failed to prove the medical necessity, when the treating Doctor herself was M.D (Gynaec). The deduction of emergency charges of Rs.1,000/- was aptly deducted by the Respondent as they fall beyond the scope of the policy terms & conditions. The Respondent had not clarified in detail about deductions under non-medicals items of Rs.1,505/-. Neither in their SCN they had mentioned or given any details. The Respondent had also not clarified to the Complainant about which items fell under the head non-medical items & how much they have deducted.

The Forum directed the Respondent to pay Rs.5,817/- to the Complainant.

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Date of Award: 15.07.2015

Complainant:- Sri Amrutlal G Parmar V/s Respondent :- The New India Assurance Co. Ltd.

Complaint No. AHD-G-049-1415-0731

Repudiation of Mediclaim

The Complainant was diagnosed with Age Related Macular Degeneration (AMD) in both eyes. He had taken treatment in Sudhakar Eye Hospital, Vadodara. He was hospitalised from 15.10.2014 to 16.10.2014. He had incurred total expense of Rs.7,337/-. His claim was repudiated by the Respondent citing Policy Clause No. 4.4.22.

The Policy Terms & Conditions Clause No. 4-Exclusions-4.23 clearly excludes Age Related Macular Diseases treatment. But the Respondent's TPA had wrongly quoted the condition No.4.4.22 in their repudiation letter dated 29.11.2014 which was a serious lapse. Moreover, instead of the Respondent the TPA had replied to grievance letter, violating the IRDAI Regulations.

The Forum directed the Respondent to pay Rs.3,600/-, as ex-gratia, to the Complainant.

Date of Award: 17.07.2015

Complainant:- Shri Pareshbhai V Mehta V/s Respondent :- The New India Assurance Co. Ltd.

Complaint No. AHD-G-049-1415-0753

Repudiation of Mediclaim

The Complainant was diagnosed with Infero-temporal Branch Retinal Vein Occlusion (BRVO) with Cystoid Macular Oedema (CME) in right eye & was admitted in Netralay, Ahmedabad on 22.09.2014 & discharged on 23.09.2014. He had incurred total expense of Rs.34,364/-. His claim was repudiated by the Respondent under Policy Clause No. 4.4.23 which read as" Treatment for age related Macular Degeneration (ARMD), treatments such as Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (EC), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy".

There is no specific exclusion, under the Policy Clause No. 4.4.23, for the treatment namely BRVO & CME taken by the Insured. The TPA's panel Doctor had confirmed that the treatment was not for ARMD. No medical literature had been produced. It was the duty of the Complainant to ask for the terms & conditions of the Policy. However, the Clause No.4.4.23 invoked by the Respondent was not correct when the treatment was not for ARMD, the fact which was confirmed by the TPA's doctor as well. The Respondent's representative referred to the 2010 circular where as the policy was revised in 2012. The Intravitreal Anti VEGF procedure was done in operation theatre in right eye. The Insured was hospitalized at the advice of the treating doctor as the doctor only can decide depending upon the gravity of the disease, age of the patient, health parameters of the patient etc. The patient has to act according to the advice from the treating doctor. The above treatment was performed to prevent permanent loss of sight. The Intravitreal Anti VEGF procedure can slow down the growth of abnormal blood vessels, vision loss & even reduce it.

The Forum directed the Respondent to pay Rs.17,000/-, as Ex-gratia, to the Complainant.

Date of Award: 22.07.2015

Complainant:- Sri Pramodbhai C Panchal V/s Respondent :- The New India Assurance Co. Ltd.

Complaint No. AHD-G-049-1516-0047

Repudiation of Mediclaim

The Complainant was diagnosed with UTI Prostitis. He was hospitalized in Shree Bharti Vallabh Hospital, Ahmedabad from 11.01.2015 to 18.01.2015. Total expense incurred was Rs.48,856/-. His claim was repudiated by the Respondent stating that the subject hospital was in declined list. Any claim as Cashless Reimbursement from this hospital were not entertainable.

The Respondent had failed to prove that declined list of hospitals was given to the Complainant along with the Policy document. It was evident, looking to the severity of the ailment, that a person will not think about the hospital being in the approved list, especially when the list was not provided. He would rush to the hospital known to him or as advised by his family doctor/relatives. The Respondent had not mentioned about the Complainant's acknowledgement having received the list of declined hospital. Even the appellant authority of the Respondent had not answered to the query raised on the revocation of the Shree Bharti Vallabh Hospital from the declined list of hospital, signed by 4 GIPSA Companies on 23.01.2014. The Respondent should have clarified to the Complainant about the letter of revocation submitted by him in their reply dated 17.12.2014. It was a pre-printed letter sent to the Complainant, without considering his appeal, judiciously. This really shows their callous approach towards their valued customers.

The Forum directed the Respondent to pay Rs.48,856/- along with an interest, as per the Protection of Policy Holders Interest Regualstions, 2002, from the date of claim to the date of settlement to the Complainant.

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Date of Award: 28.08.2015

Complainant:- Ms. Bhaminiben M Shah V/s Respondent:- The New India Assurance Co. Ltd.

Complaint No. AHD-G-049-1516-0129

Partial settlement of Mediclaim

The Complainant was diagnosed with Left Knee Medial Meniscal Tear. She had taken treatment in Dwarkesh Hospital, Vadodara. He was admitted in the hospital on 09.04.2014 & discharged on 10.04.2014. She had claimed total expense of Rs.86,445/- out of which the Respondent had settled the claim for Rs.44,478/- partially. Her claim was repudiated by the Respondent citing Policy Clause No. 2.1- "Room, Boarding & Nursing expenses provided by the Hospital/ Nursing Home not exceeding 1% of the Sum Insured (without Cumulative Bonus) per day or actual, whichever was less" & Note-1 under Policy Clause No.2 "The amount payable under 2.3 & 2.4 shall be at the rate applicable to the entitled room category. Incase insured opts for a room with rent higher than the entitled category as under 2.1, the charges payable under 2.3 & 2.4 shall be limited to the charges applicable to the entitled category."

The Insured was diagnosed with Lt. Knee Medial Meniscal Tear with Chondromalacia Patella. The meaning of Medial is-"it is situated near the median plane of the body or the midline of an organ." The meaning of Meniscus Tear is-"it is a common knee injury. The meniscus is a rubbery, C shaped disc that cushions your knee." The meaning of Chondromalacia Patella is-"it is inflammation of the underside of the patella & suffering of the cartilage. The cartilage under the knee cap is natural shock absorber & overuse, injury & many other factors can cause increased deterioration & breakdown of the cartilage." The Baker's Cyst can also be caused due to injury. During the course of investigation carried out by the Respondent the Insured had confirmed in writing that 2 months back she had a fall in the bathroom & since then she was having continuous pain. She had consulted Dr. Rajesh Shah, M.S (Ortho) who had in his certificate, dated 15.04.2014, confirmed her treatment since 04.02.2014. She was referred to Physiotherapist Dr. Swapnil Shah who diagnosed her case as Synovitis Lt. Knee-A protective membrane called Synovium, covers all the bones, tendons & cartilage of the knee. Synovitis occur when the protective membrane becomes irritated or inflamed. Traumatic & repeated injuries commonly cause Synovitis. From the above it is very clear that the diagnosed diseases can occur due to accidental injury also. The Insured had a fall was treated by an Orthopaedic Surgeon. In view of the above, the clause for waiting period of 4 years for the enhanced sum insured, applied by the Respondent is not correct. As the Baker's Cyst & Medial Meniscal Tear could be because of injury as well the Respondent's defense that the treatment was required due to

Osteoarthritis & Osteoporosis only cannot be accepted as beyond doubt.

The Forum directed the Respondent to pay Rs.15,484/- to the Complainant.

Date of Award: 30.09.2015

Complainant:- Shri Vasudev M Kadia V/s Respondent:- The New India Assurance Co. Ltd.

Complaint No. AHD-G-049-1516-0148

Repudiation of Mediclaim

The Complainant's spouse Smt. Indumati V Kadia was diagnosed with Acute Back Pain & Radiculopathy. She had taken treatment in Freedom Pain Clinic, Ahmedabad. She was admitted in the hospital on 27.10.2013 & discharged on 28.10.2013. He had incurred total expense of Rs.19,235/-. His claim was repudiated by the Respondent citing Policy Clause No. 2-Reasonable, customary & necessary expenses.

Transforaminal Epidural procedure is performed on OPD basis. After the injection, the patient could be kept under observation for few hours only. Thereafter the patient can be discharged. The treating Doctor failed to prove the severity of the treatment. Immediately after the procedure she was discharged from the hospital. There was no active line treatment given to the patient except the injection. There was no mention at what time the Insured was admitted & at what time she was discharged. It was difficult for the Forum to arrive at whether the Insured was hospitalized for more than 24 hours. No other document or report available with the Complainant which confirms the time of admission & discharge.

The Complaint was dismissed.

Date of Award: 07.10.2015
Complainant:- Sri Nitin N Selarka V/s Respondent:- The New India Assurance Co. Ltd.
Complaint No. AHD-G-049-1516-0163
Repudiation of Mediclaim

The Complainant was diagnosed with Morbid Obesity, Essential (primary) Hypertension & Gastro Oesophageal Reflux Disease. He had taken treatment in Asian Bariatrics, Ahmedabad. He was admitted in the hospital on 21.01.2015 & was discharged on the same day. He was again admitted to Asian Bariatrics, Ahmedabad from 20.02.2015 to 23.02.2015 for Bariatric & Hernia treatment. He had incurred total expense of Rs.5,38,547/-. His claim was repudiated by the Respondent citing Policy Clause No. 4.4.6 which deals with various diseases including obesity treatment & its complications.

The Policy Terms & Conditions Clause No. 4-Exclusions-4.6 excludes obesity Related treatment. The primary diagnosis was morbid obesity. In the discharge summary it was categorically mentioned in the complaints portion that progressive weight gain since 7-8 years. The Complainant was hospitalized for the treatment of Morbid Obesity, Essential Hypertension & Gastro Oesophageal Reflux Disease on 21.01.2015 at Asian Bariatrics. The surgery was performed on the same day & complainant was discharged on the same day. The Complainant was again hospitalized in the same hospital on 20.02.2015 for the treatment of GERD followed by Hypertension & Morbid Obesity+ GERD with Hiatus Hernia.

It was very clear in the subject claim that due to morbid obesity, the treatment was taken & in view of excess calories, as provisionally diagnosed in the discharge summary of admission dated 20.02.2015, treatment was given & the Forum was of the belief that the procedure for Hiatus hernia was a complication arising from the same.

The Complaint was dismissed.

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Date of Award: 20.07.2015

Complainant:- Sri Haresh M Patel V/s Respondent:- The Oriental Insurance Co. Ltd.

Complaint No. AHD-G-050-1415-0761

Repudiation of Mediclaim

The Complainant's father Sri Manilal Patel was diagnosed with Coronary Artery Disease. He was admitted in CIMS Hospital, Ahmedabad from 17.07.2013 to 19.07.2013. CAG & PTCA+ Stenting of native RCA was done. The total expense incurred was Rs.2,15,130/-. His claim was repudiated by the Respondent stating that the Policy was in 3rd Year & as per Policy Terms & Conditions Clause No. 4.1- Pre-existing health condition or disease or ailment or injuries are excluded for the first 4 years, in force continuously, with the Insurer.

There was no break in the Mediclaim policy period since 09.06.2008. While switching over to the Respondent in the year 2010, in the Policy certificate it was clearly mentioned 'Renewal Policy No.: UII 021600/48/09/41/00000936'. The Complainant had produced the terms & conditions of 2013-14 policy wherein under plan 2 it was specifically stated under 4.3(b) that following major ailments/treatments will be covered only from the 3rd year of the policy if continuously renewed without break & the claim shall be paid as per the limit of clause above. 4.3(b) (ii) covers- PTCA, CABG, Organ Transplant, Joint replacement due to degenerative conditions, Age related Orthoarthritis & Osteoporosis, Spinal Cord Operation including disc. The Policy was in the 4th year. Accordingly 75% of admissible claim amount or 75 % of Sum Insured whichever was less becomes payable. Further under condition no. 8 under the heading renewal of the policy under (d) it was specifically mentioned that "renewal continuity benefit will be considered for all policies of IRDAI approved general/ health insurance companies, health insurance or Mediclaim plans (group or individual) subject to no break in any previous or current policy subject to terms & conditions of this policy irrespective of any benefits in previous policies. The members should furnish the documentary proofs/details of all previous policies with membership proposal as well as at the time of claim to avail continuity benefit.

The Forum directed the Respondent to pay Rs.1,61,348/- along with an interest, as per Protection of Policyholders Interest Regulations,2002, from the date of claim to the date of settlement.

Date of Award: 22.04.2015

Complainant:- Sri Hitesh Jiyani V/s Respondent :- The Oriental Insurance Co. Ltd.

Complaint No. AHD-G-050-1415-0217

Repudiation of Mediclaim

The Complainant submitted that his father Laljibhai was admitted in Rudraksh Hospital, Ahmedabad for sudden onset of vomiting, gabhraman & mild abdominal pain on 28.12.2013. After treatment he was discharged on 30.12.2013. He had incurred total expense of Rs.10,755/-. His claim was repudiated by the Respondent citing Policy Clause 4.4.3. He requested the Forum to get his legitimate claim paid.

The respondent failed to prove that the diagnosis of the Insured with Gastritis, vomiting, uneasiness & mild abdominal pain was due to DM. Though the treating Doctor Naynesh Jeeyani had confirmed vide his certificate dated 27.02.2014 that the Insured was suffering from DM since 8 months the current treatment had no relevance with DM. The first consultation letter of the treating doctor clearly indicated that their prime focus was to stop vomiting. The Policy Clause 4.4.3 clearly restricts the payment of claim under diabetes up to 2 years. Here in this case the same is not applicable as the treatment was not solely for DM.

The Forum directed the Respondent to pay Rs.10,755/- to the Complainant with 2% interest over the bank prime lending rate from the date of claim to the date of payment.

Date of Award: 23.04.2015
Complainant:- Sri Manhar M Mehta V/s Respondent :- The Oriental Insurance Co. Ltd.
Complaint No. AHD-G-050-1415-0420
Repudiation of Mediclaim

The Complainant was provisionally diagnosed with Acute Viral Fever & later on diagnosed with Left MZ+ LZ Pneumonia & was admitted in Shivam Orthopadic Hospital, Ahmedabad from 27.10.2013 to 01.11.2013. He had incurred total expense of Rs. 45635.26. His claim was repudiated by the Respondent citing Policy Exclusion Clause No. 5.9-"Fraud/ Misrepresentation/ Concealment: The Company shall not be liable to make any payment under this policy in respect of any claim be in any manner intentionally or recklessly or concealed or non-disclosure of material facts or making false statements or submitting false bills whether by the Insured Person or Institution/ Organisation on his behalf. Such action shall render this policy null & void & all claims hereunder shall be forfeited. Company may take suitable action against the Insured Person/Institution/Organisation as per Law." The Complainant submitted that he had given the clarification letter dated 07.02.2014, of the treating Doctor.

The Treating Doctor Rakesh Sharma, in his letter dated 07.02.2014, had clearly clarified & confirmed that the Complainant was initially diagnosed with Acute Viral Fever but after investigation for fever & other symptoms they found him to have Left MZ+ LZ Pneumonia. He further confirmed that as per their record there is injection piperacillin+tazobactum(pipzo) & clav amo were given to the patient. No investigation was carried out by the Respondent to prove that the claim was fraud. It is evident from the papers that the Complainant was hospitalized & was treated for Pneumonia & injections were given to the patient. The Respondent had exhibited such a callous approach towards their Senior Citizen, having long standing & claim free relation with them. Before citing Clause No. 5.9- Fraud/ Misrepresentation/ Concealment they should have prudently investigated & dealt with the claim. The Forum condemns the act of the Respondent in labeling the claim as Fraud.

The Forum directed the Respondent to pay Rs.45,634/- to the Complainant.

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Date of Award: 22.07.2015
Complainant:- Smt Pranoti J Vaidya V/s Respondent:- The Oriental Insurance Co. Ltd.
Complaint No. AHD-G-050-1516-0022
Repudiation of Mediclaim

The Complainant's Mother Bhavsuta A Baxi was operated for Right Eye Cataract on 18.06.2013 & for Left Eye on 10.07.2013 at Aastha Eye Hospital, Ahmedabad. Total expenses incurred for both operations was Rs.42,521.05. The Complainant's claims were repudiated citing Policy Clause No. 4.3- Policy was in first year.

There was no break in the Mediclaim policy since 19.06.2009. While switching over to the Respondent in the year 2013, in the Policy certificate it was clearly mentioned Renewal Policy No.: 251100/46/12/8500000633. This clearly proves that the Respondent was very well aware that it was a case of shifting from one insurer to the other but no portability form was obtained. As per IRDAI circular on Portability of Health Insurance Policies, Ref: IRDA/HLT/MISC/CIR/030/02/2011 dated 10.02.2011, point no.3 clearly instructed that all insurers issuing health insurance policies shall allow for credit gained by the insured for pre-existing condition in terms of waiting period when he/she switches from one insurer to another or from one plan to another, provided the previous policy has been maintained without break. The Respondent had clearly violated these guidelines & harassed the Insured.

The Insurer was directed to settle both the claims i.e for Rs.21,260/- (dated 27.06.2013) & Rs.21,261/- (dated 17.07.2013) along with interest as per the Protection of Policyholders Interest Regulations, 2002 w.e.f 17.09.2013 i.e Rs.42,520+ interest.

Date of Award: 25.08.2015

Complainant:- Shri Devendrakumar N Patel V/s Respondent :- The Oriental Insurance Co. Ltd.

Complaint No. AHD-G-050-1516-0128

Repudiation of Mediclaim

The Complainant's father was diagnosed with Acute AWMI (CAD Singe Vessel) + PTCA with Stent to LAD was done in Kakadiya Hospital, Ahmedabad on 14.12.2014. He was discharged on 17.12.2014. He had incurred an expense of Rs.1,45,185/-. The Respondent had repudiated his claim by citing Policy Clause No. 4.1-"Any ailment, injuries/health condition which are pre-existing (treated/untreated declared/not declared in the proposal from) in case any of the person of the family when the cover incepts for the 1st time are excluded for such insured person up to 4 years of this policy being inforce continuously." The Respondent had submitted that as per the hospital papers the Insured was having history of Hypertension since last 5 years & the disease is pre-existing, is subject to Clause 4.1 & not payable.

From the available records & submissions during the hearing by the Complainant & the Opposite Party the decision of the Opposite Party in declining the claim looks questionable. The Complainant has been availing mediclaim policy from the year 2010 onwards, starting with United India Insurance Co. Ltd. In the year 2011-12 he switched to avail policy with the Opposite Party, & continued to insure whether under a group policy or under an individual one. The claim under discussion happened during the policy period 2014-15 & hospital records, at the time of admission, stated that the patient was suffering from HTN since past 5 years. The policy has a waiting period (Clause No.4.1) for 4 years for cardiac diseases, if it is pre-existing. Since 4 consecutive policy periods have been completed prior to the claim the claim becomes admissible, since the waiting period is over. I would not accept the plea of the Opposite Party that the group policy of 2011-12, even if it is their own Company, cannot be considered for continuity purpose as the terms & conditions were different. The said policy acknowledged continuity of the cover from the policy period 2010-11 issued by the United India Insurance Co. Ltd. making it a continuous coverage starting from 25.03.2010. Hence, I would accept that the claim is payable as per the policy terms.

The Forum directed the Respondent to pay Rs.1,45,185/- to the Complainant.

Complainant:- Shri Hemant P Shah V/s Respondent :- The Oriental Insurance Co. Ltd.
Complaint No. AHD-G-050-1516-0136
Repudiation of Mediclaim
Date of Award: 26.08.2015

The Complainant's spouse was diagnosed with Chronic Tenosynovitis & was admitted in Sneh Orthopaedic Hospital, Ahmedabad on 18.11.2014. She was discharged on 19.11.2014 after the treatment. He had incurred an expense of Rs.20,833/-. The Respondent had repudiated his claim by citing Policy Clause No. 2.3-Note "Procedures/Treatments usually done in Out Patient Department are not payable under the policy even if converted to day care surgery/procedure or as patient in the hospital for more than 24 hours." Another Exclusion Clause No. 4 was also cited for repudiation- " The Company shall not be liable to make any payment under this policy in respect of : Sub-clause 4.10- any expenses whatsoever incurred by any Insured person in connection with or in respect of expenses incurred at hospital or nursing home primarily for evaluation/diagnostic purposes which is followed by active treatment for the ailment during the hospitalized period."

From the Complaint, the Respondent's SCN & the submissions of the Complainant as well as the Respondent during the course of the hearing & other documents in the file it is evident that the hospitalization was for the purpose of investigation only. No active line of treatment was pursued during the course of hospitalisation. After the Biopsy the patient was discharged & as the result of the Biopsy was not positive the discharge certificate did not indicate any further line of treatment. Therefore, I do not find any fault or deficiency in the decision of the Respondent.

The Complaint was dismissed.

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Date of Award: 26.08.2015

Complainant:- Shri Pawan Agarwal V/s Respondent :- The Oriental Insurance Co. Ltd.

Complaint No. AHD-G-050-1516-0145

Repudiation of Mediclaim

The Complainant was diagnosed with CV Stroke with IHD-ld MI, D.M, Hypertension & S/P PTCA to LAD (2011) & was admitted in Shalby Hospitals, Ahmedabad on 16.12.2014. He was discharged on 19.12.2014 after treatment. He had incurred an expense of Rs.1,96,650/-. The Respondent had repudiated his claim by citing Policy Clause No. 4.1-"Any ailment, injuries/health condition which are pre-existing (treated/untreated declared/not declared in the proposal from) in case any of the person of the family when the cover incepts for the 1st time are excluded for such insured person up to 4 years of this policy being inforce continuously." Above policy was in 3rd year.

From the Complaint, the Respondent's SCN & the submissions of the Complainant as well as the Respondent during the course of the hearing & other documents in the file it is quite clear that the Complainant's hospitalisation had taken place within the waiting period of 4 years which has been specifically excluded under Clause No. 4.1 of the policy. The Respondent's repudiation of the claim is therefore as per the terms of the policy & cannot be found fault with. However, in very critical juncture of hositalisation the Respondent's representative TPA has caused enormous inconvenience & hardship to the Complainant by first allowing the cashless facility & then at the last moment of discharge from the hospital withdrawing the same. This could have been very well avoided. For this deficiency in the service, when the Complainant was in a critical stage of his life, I intend to compensate the Complainant.

The complaint was Dismissed, but the Forum directed the Respondent to

pay Rs.5,000/- as Ex-gratia to the Complainant.

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Date of Award: 23.04.2015
Complainant:- Sri Kunjan B Parikh V/s Respondent :- United India Insurance Co. Ltd.
Complaint No. AHD-G-051-1415-0461

Partial settlement of Mediclaim

The Complainant's wife Smt Hetal Parikh was diagnosed with Left Ear adhesive otitis & was operated on 18.04.2014 & discharged on 19.04.2014 from Dhawal Nursing Home, Vadodara. He had incurred total expense of Rs.52,080/- out of which the Respondent had settled Rs.42,324/- & deducted Rs.9,756/-. The Complainant had questioned the deduction of Rs.9,250/- (Rs.3,250/- deducted towards Instrument Charges, Rs.2,000/- towards Surgeon Charges & Rs.4,000/- towards Anaesthetist).

There is no mention in the policy terms & conditions that Instrument Charges shall not be payable separately & that they are included in Surgeon Charges & OT Charges. The Respondent had failed to establish what is reasonable & customary charges. The Respondent's action in partial settlement without proper evidence on the clause is against the provisions of the IRDAI circular dated 20.02.2013 on standardization in health insurance Reasonable Charges. In absence of any comparative rate charts obtained from various hospitals with similarly facilitated hospitals in the vicinity of the hospital where the insured had undergone the medical treatment, the deduction caused merely on assumption or without any base is arbitrary. So Rs. 2,000/- becomes payable. Amount paid by the Complainant towards Anaesthetist fees is a part and parcel of the Hospitalisation Bill. The Anaesthetist had rendered his services & accordingly had charged. The Anaesthetist, at the behest of the operating surgeon had visited the patient in the hospital as there was no in house anaesthetist. The

surgery could not have been carried out without anaesthesia. Therefore, the payment was directly made by the patient to the Anaesthetist & separate receipt was issued. Thus, though it had not been mentioned in the hospitalization bill, it is a part of the hospitalization of the Insured.

The Forum directed the Respondent to pay Rs.9,250/- to the Complainant.

Date of Award: 23.04.2015

Complainant:- Sri Mahendrabhai M Patel V/s Respondent :- United India Insurance Co. Ltd.

Complaint No. AHD-G-051-1415-0466

Repudiation of Mediclaim

The Complainant had undergone surgery for cataract on his Left Eye at Dr. Vijay Patel's Eye Hospital, Ahmedabad on 09.12.2013. He had incurred total expense of Rs.25,662/-. The claim was repudiated by the Respondent stating that the intimation on the treatment was given after discharge.

The Respondent's Representative himself confirmed that as per the Policy Terms & Conditions the intimation was to be made within 24 hours. In the subject claim the Complainant was discharged on 09.12.2013 at 11.00 a.m & the intimation was received by the TPA on 09.12.2013 at 01.15 p.m, i.e within 24 hours. The claim was payable as the intimation was well within the prescribed time & the term & conditions of the Policy. This shows that the subject claim was arbitrarily decided.

The Forum directed the Respondent to pay Rs.25,662/- along with an interest @ 12% p.a from the date of claim to the date of settlement to the Complainant.

Date of Award: 23.04.2015

Complainant:- Sri Vishnuprasad P Bhatt V/s Respondent :- United India Insurance Co. Ltd.

Complaint No. AHD-G-051-1415-0467

Partial settlement of Mediclaim

The Complainant had undergone Right Eye Cataract surgery at Jain Eye Associates, Vadodara on 17.01.2014. He had incurred total expense of Rs.49,387/-. The Respondent had settled Rs.40,000/- & deducted Rs.9,387/- under reasonable & customary surgical medical treatment clause.

There is a specific Policy Clause No. 1.2.1 on cataract surgery which reads as "Expenses in respect of the Cataract actual expenses or 25% of the Sum Insured whichever is less is payable." In the subject claim the Sum Insured was Rs.2,50,000/-. The 25% of Sum Insured was Rs.62,500/- & claimed amount was Rs.49,387/-. The claimed amount was within the limits of the Clause 1.2.1 of the Policy. A part of the claim amount, Rs.9,387/-, was arbitrarily deducted by the Respondent

citing irrelevant Clause No.3.33. This shows that the subject claim was arbitrarily decided despite the specific clause on surgery of cataract.

The Forum directed the Respondent to pay Rs.9,387/- to the Complainant.

Date of Award: 22.07.2015

Complainant:- Dr. Rupesh Mehta V/s Respondent :- United India Insurance Co. Ltd.

Complaint No. AHD-G-051-1516-0026

Partial settlement of Mediclaim

The Complainant was admitted in Raghudeep Eye Hospital, Ahmedabad for Right Eye Cataract surgery on 27.05.2014 & was discharged on the same day. He had incurred total expense of Rs.1,19,000/-. His claim was partially settled for Rs.57,225/-. Deductions for Rs.61,775/- were made under the policy terms & conditions clause No.3.23. The Complainant submitted that he was eligible for the claim of Rs.1,56,250/- as per Policy Condition No. 1.2.1-A , according to which reimbursement under Cataract Surgery expense could be made up to "25% of Sum Insured or actual expense whichever was less".

The Policy Terms & Conditions No. 1.2.1(a) clearly states that in case of Cataract Surgery "Actual expense incurred or 25% of the sum insured whichever is less is payable." In the subject policy, 25% of the sum insured Rs.5,00,000/- is Rs.1,25,000/- & the Complainant had incurred expense of Rs.1,19,000/-. There was no specific condition mentioned in the policy on the type, rate & quality of lenses to be used. Without any guidance or advice it would be difficult for an Insured to arrive at reasonable & customary charges for a surgery especially, when there is a specific mention of reimbursement under Cataract surgery in the terms & conditions of the policy itself. The Forum observed that when there was a specific clause on particular disease, it gets invoked.

The Forum directed the Respondent to pay Rs.61,775/- to the Complainant.

Date of Award: 22.07.2015
Complainant:- Shri Mehul B Shah V/s Respondent :- United India Insurance Co. Ltd.
Complaint No. AHD-G-051-1516-0059
Repudiation of Mediclaim

The Complainant's Son Hitanshu was diagnosed with acute panic attack due to major depressive disorder & restless leg. He was admitted in Jivandeep Hospital, Dholka for the treatment on 22.11.2014 & discharged on 25.11.2014. He had incurred total expense of Rs.13,152/-. His claim was repudiated by the Respondent citing Policy Clause No. 4.6 & due to discrepancies in date of admission.

The Hospital had charged the bill for 2 days admission only. There was a correction in the discharge summary also. The Policy Clause No.4.6 clearly excludes the treatment of Major Depressive Disorder. Clause No. 4.6 reads-" Convalescence, general debility, run-down condition or rest cure, obesity treatment & its complications including morbid obesity, Congenital external disease or defects or anomalies, treatment relating to all psychiatric & psychomatic disorders, infertility, sterility, veneral disease, intentional self injury & use of intoxication drugs/ alcohol."

The Complaint was dismissed.

Complainant:- Shri Mohanbhai V Prajapati V/s Respondent :- The United India Insurance Co. Ltd.
Complaint No. AHD-G-051-1516-0157
Repudiation of Mediclaim
Date of Award: 30.09.2015

The Complainant's spouse Smt. Pravinaben was diagnosed with Benign Paroxysmal Positional Vertigo & Vascular Headache. She was hospitalized from 20.07.2014 to 26.07.2014 in Saikrupa General Hospital, Ahmedabad. The Complainant had incurred total expenses of Rs.31,244/-. The Respondent had rejected the claim citing Policy Clause No.4.10 & 5.8- reasoning that the patient's radiological & pathological reports were normal which indicated that the patient was hospitalized for the purpose of investigation & check up & not for any active line of treatment.

The Complainant's spouse had a history of fall in the house. She was diagnosed with Benign Paroxysmal Positional Vertigo(BPPV)-causes brief episodes of mild to intense dizziness. One feels sudden sensation that he is spinning or that inside of the head is spinning. Further she

was also diagnosed with Vascular Headache; a classification for certain types of headaches, based on a proposed cause involving abnormal functioning of the blood vessels or vascular system of the brain; included are migraine, cluster headache, toxic headache, and headache caused by elevated blood pressure. The Complainant had submitted the chart of line of treatment given to her. It was the treating Doctor who was the best judge to decide/advise whether admission was essential or not. The medical opinion given by the panel doctor was a mere assessment of the case on the basis of the medical papers. The ground situation would have been different at the time of hospitalization & treatment. No official had visited the patient to confirm the sickness. The Complainant had also consulted other hospital as the Insured was not feeling well even after the treatment. MRI was carried out on the advice of the doctor & not the wish of the Insured or the Complainant. As the illness had relapsed failing the first treatment the MRI or any other diagnosis becomes essential & necessary to find the exact cause of the illness. Above all the clause No.5.7 cited in the SCN to the Forum as reason for repudiation of the claim was also not applicable as it dealt with fraudulent claim. The Respondent had failed to prove that the claim was fraudulent. In repudiation letter they had quoted policy clause No.4.10 & 5.8 which are not relevant to this claim as it dealt with AIDS, LAV etc. & mis-representation, mis-description etc. respectively. Technically, with application of wrong & irrelevant clause, the claim should not be repudiated. The Respondent was informed that they cannot just keep adding or changing clauses for repudiation from time to time as they feel like. The clause for repudiation which is applied & informed to the Complainant, that matters & counts & not the new clauses which they mention before the Forum. There is a serious lapse on the part of the Respondent & deficiency in providing service to the Insured.

The Forum directed the Respondent to pay Rs.29,174/- to the Complainant.

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<u>Complaint No.:-AHD-L-06-1314-320</u>

Complainant:-Sankalp S. Khankar V/s Bajaj Allianze Insurance Co.Ltd.

Claim for Accelerate Critical illness was rejected by the Respondent due to diagnosis was within 180 from the date of commencement.

The Respondent had produced Hospital record in this support which was clearly mentions that the disease was diagnosed within 180 days from D.O.C. which was under exclusion clause of the policy.

Award:-As complainant was died so the representative of the complainant has withdraw the complaint for file a death claim under above policy.

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Complaint No: - AHD-G-23-1314-725

Complainant: - Chetan D. Doshi V/S Iffco Tokiyo General Insurance Co. Ltd.

Claim for treatment of Tuberculosis of Spine was rejected by the insurer on the ground of Medically Necessary procedure clause.

The Respondent had submitted that under clause No. 12 of the policy they are unable to settle the claim

Award: - Complainant allowed for Rs.10000/- on Ex-Gratia basis.

Complaint No: - AHD -G-50-1314-744

Complainant:-Sh. Himanshu C. Patel V/S Oriental Insurance Co. Ltd.

Insurance company has rejected the claim of hospitalization for treatment of incisional hernia and hiatus hernia.

The Respondent had rejected the claim on the ground of Complaint's Pre existing disease excluded up to 4 years of this policy being in force continuously so claim is not payable under policy clause no. 7.14 (pre existing disease) and It has been observed that CABG scar is preexisting condition & epigastria hernia is a complication of pre existing CABG operation.

Award: - Complaint allowed for Rs. 10000/- on Ex-Gratia basis.

Complaint No: - AHD -G-49-1314-755

Complainant:-Sh. Harish Bhai B. Acharya V/S New India Assurance Co. Ltd.

Insurance company has rejected the claim of hospitalization for treatment of HTN, IHD AND ACUTE BRONCHITIS. And hospital was under declined hospital list.

The Respondent had submitted that the patient has taken treatment at the hospital which was declined by the insurance company. So the claim is repudiated as per clause no. 3.2 of the policy condition.

Award: - Complaint allowed full amount of claim.

Complaint No :- AHD -G-48-13

Complainant:-Smt. Dolorisa Louis V/s National Insurance Co. Ltd.

Insurance company has rejected the claim of hospitalization for treatment of TKR on the ground of; there are twelve days gaps between previous policy and current policy. So current policy treat as fresh policy and as per policy condition no. 4.3:-major illnesses are covered after 3 years, hence the claim is rejected by the company.

The Respondent had never ignored the circular No. 52/15/IRDA/Health SN/08-09 dated 31.03.2009 regarding for condone delays in renewal of the policy upto 15 days.

Award: - Complaint allowed for Ex-Gratia claim for Rs. 150000/-.

Complaint No: - AHD -G-50-1314-759

Complainant: - Sh. Amit Choudhary V/s Oriental Insurance Co. Ltd.

Insurance company has rejected the claim of hospitalization for treatment of Dental Injury due to Accident on the ground of patient was hospitalize with history of dental injury came for orthodontic fixation of appliance but appliances is falls under external prosthesis, and hospital does not falls under definition of hospital. So claim rejected as per clause no. 2(2.1) and 4(4.16).

Award:- Complaint Dismissed

Complaint No :- AHD -G-51-1314-780

Complainant:-SH. Jitendra V. Seth V/S United India Insurance Co. Ltd.

Insurance company has partial rejected the claim of hospitalization for treatment of both TKR. As claim was settled as per policy clause no. 4.3 there is 2years waiting period for major illness and as per clause no. 1.2 there is cap of maximum 70% of claim amount is payable for major surgery. In above case complainant has increased the S.I. according to above, complainant is entitled for first claim Rs. 87500/- (70% of eligible S.I. Rs. 125000/-) and for second claim 105000/- (70% of eligible S.I. Rs. 150000) so claim settled as per policy T & C.

The Respondent had applied clause No. 4.3 instead of clause No. 4.4, and they had never informed to the Complainant before hearing of the case. And the clause was silent about applicability of the enhance S.I.

Award: - Settle the claim only as per clause no. 1.2.1b i.e. 70% of the enhance S.I.

Complaint No: - AHD -G-49-1314-782

Complainant:-Sh. Gananesh Vyas V/S New Assurance Co. Ltd.

Insurance company has partial rejected the claim of hospitalization for treatment of Dengu Fever on the ground as Complainant has a policy with S.I. Rs. 100000 and as per policy condition he is entitled maximum 1% of the S.I. for Room & Nursing charges it comes 1000/- per day. The amount payable under clause 2.3 and 2.4 shall be at the rate applicable to the entitled room category. In case insured opts for a room with rent higher side than the entitled category as under 2.1, the charges payable under 2.3 and 2.4 shall be limited to the charges applicable to the entitled category. No payment shall be made fewer than 2.3 other than part of the hospitalization. The policy condition is silent on charges incurred during the course of emergency.

Award:- Allowed as Ex-Gratia basis.

Complaint No :- AHD -G-50-1314-795

Complainant:-Sh. Praful B. Brahmakshatriya V/S Oriental Insurance Co. Ltd.

Insurance company has rejected the claim of hospitalization for treatment of LEFT EYE SILICON OIL REMOVAL on the ground of Current illness Left Eye Silicon Oil Removal is since 16 years as per MMR form, which is preexisting disease and at the time of proposal this disease not declared by the Insured person. Above disease cover excluded from the date of first inception for continuously in force up to 4th year of the policy. According to claim papers that illness are before inception of the policy, so as per policy clause no. 4.1 claim is not payable.

The Complainant had declared his existing disease, and the Respondent was not able to prove that there was a co-relation between pre existing disease and current disease.

Award: - Allowed on Ex-Gratia basis.

Complaint No.:-AHD-G-51-1314-802

Complainant: - Sh. Yogendra A. Shah V/s United India Insurance Co. Ltd.

Insurance Co. had partial rejected the claim of hospitalization for treatment of Cataract Surgery under clause No. 3.11 of the policy as Reasonable and Necessary Expenses, and disallowed the amount of bifocal lens of Rs. 12110/-.The clause No.3.11 was not incorporated any wording regarding restriction for cost of lens.

Award: - Allowed on Ex-Gratia basis.

Complaint No.:-AHD-G-50-1314-824/825

Complainant: - Sh. Gangaram Patel V/s Oriental Insurance Co. Ltd.

Insurance Co. had partial rejected the Personal Accident TTD claim of the Complainant & his wife on the ground of on behalf of self treatment (being a doctor) and had not given treatment related papers of hospital, later on the Respondent had admitted one week TTD claim after receipt of more treatment papers.

Award: - Complainant's TTD claim was dismissed & his wife claim was admitted for three week

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Complaint No: - AHD -G-48-1415-011

Complainant:-SH. GOVIND BHAI M. PATEL V/S NATIONAL INSURANCE CO.LTD.

The Respondent had rejected the hospitalization claim on the ground of pre-existing disease k/c/o HTN since 5 years & taken regular treatment, as mentioned in the hospital papers. The Respondent had failed to provide any concrete proofs regarding treatment taken by the Complainant for HTN since last 5 years.

Award: - Complaint allowed for settle the claim as per rule.

Complaint No: - AHD -G-51-1415-090

Complainant:-SH. Hasmukh lal M. Patel V/S United India Insurance Co. Ltd.

The Respondent had partial rejected the amount of Rs. 52005/- (for Mask, Thermometer, Neb kit, HIV kit, Chest lead etc.) on the ground of clause No. 4.15 viz. reasonable and customary for the treatment of swine flu H1N1 treatment. But the Respondent had mentioned wrong clause No. in the letter which was sent to the Complainant.

Considering the gravity of the disease, the complaint is admitted.

Award: - Complaint allowed for full deducted amount.

Complaint No: - AHD -G-48-1415-095

Complainant:-SH. Mahendra B. Morkiya V/S National Insurance Co. Ltd.

The Respondent had rejected the hospitalization claim of the Complainant's daughter's maternity claim on the ground of (policy condition No. 2.1.4 the family size shall consist of the BOI account holder, his spouse and their two dependent children). The Complainant had failed to inform the Respondent about the change in the status of his dependent daughter after her marriage.

Award: - The complaint stands dismissed

Complaint No: - AHD -G-49-1415-149

Complainant:-Smt. Pragna U. Desai V/S New India Assurance Co. Ltd.

The Complainant was hospitalized for treatment of Falciparum Malaria for one day and further treatment taken at home on OPD basis, she was discharge on the ground of social reason. The Respondent had rejected the claim citing that the hospitalization was not required.

Award: - The complaint stands dismissed

Complaint No: - AHD -G-51-1415-152

Complainant:-Sh. Suvrut N. Chokshi V/S United India Insurance Co. Ltd.

The Respondent had partial settled the claim of Cataract surgery of the Complainant and deducted the claim for Rs. 17142/- under policy clause No. 3.11. The Respondent had deducted entire amount of Room charge, Anesthesia charge, Operation theater charge and Medicine charge. As per policy condition No. 1.2.1 (a) the claim was for Rs. 38544/- against the entitled amount for Rs. 112500/- (25% of S.I. RS. 450000/-).

Award: - The complaint allowed for deducted amount with interest.

Complaint No: - AHD -G-51-1415-167

Complainant:-Sh. Vipin Chandra Parikh V/S United India Insurance Co. Ltd.

The Respondent had repudiated the claim of hospitalization of the Complainant for the treatment of Bronchial Asthma on the ground of pre-existing disease since 1988. The policy was specially designed for senior citizen excluded all pre-existing disease; the subject claim since has arisen out of the pre-existing disease the Respondent had correctly repudiated the claim.

Award: - The complaint stands dismissed.

Complaint No: - AHD -G-48-1415-172

Complainant:-Smt. Devyani P. Bhavsar V/s National Insurance Co. Ltd.

The Respondent had repudiated the claim of hospitalization of the Complainant's husband for the treatment of Balovoposthits and acute pyelonephritis on the ground of pre-existing disease. The treating doctor had confirmed that the patient had maintaining the blood sugar control only from 2 to 2.5 years & the patient was admitted for above disease after 2 years, 1 month & 8 days from the date of policy inception.

Award: - The complaint stands dismissed.

Complaint No: - AHD -G-51-1415-183

Complainant:-Sh. Subhash Duttroy V/S United India Insurance Co. Ltd.

The Respondent had partial settled the claim of Cataract surgery of the Complainant and deducted the claim for Rs. 10500/- under policy clause No. 3.11 as customary & reasonably clause. As per policy condition No. 1.2.1 (a) the claim was for Rs. 31000/- against the entitled amount for Rs. 93750/- (25% of S.I. RS. 375000/-).

Award: - The complaint allowed for deducted amount.

Complaint No: - AHD -G-50-1415-214
Complainant:-Sh. Sashikant B. Devgirkar V/S Oriental Insurance Co. Ltd.
The Respondent had repudiated the hospitalization claim of the Complainant's mother stating that the Complainant had not submitted the documents. Whereas,the Complainant had produced an acknowledgement of the TPA against the receipt of the documents. The company's non submission of the SCN & it's absolutely non response to the insured is not acceptable.
Award: - The complaint is admitted with interest @ 2% over and above bank rate.

Complaint No: - AHD -G-49-1415-237
Complainant:-Sh. Prashant M. Upadhyay V/S New India Assurance Co. Ltd.
The Respondent had repudiated the hospitalization claim of the Complainant for the treatment of acute vertigo on the ground of hospitalization was primarily for diagnostic purpose only under the clause no. 4.4.11. The Complainant had written his letter that being a doctor he would like to find out root cause of the disease. So it could be concluded that the hospitalization of the patient was for diagnostic purpose.
Award: - The complaint stands dismissed.

Complaint No: - AHD -G-49-1415-350
Complainant:-Sh. Sudhir R. Rana V/S New India Assurance Co. Ltd.
The Respondent had repudiated the hospitalization claim of the Complainant's wife for the operation of gangrene on tip of right Toe, on the ground of hospitalization was less than 24 hours under the clause no. 3.4. The patient was admitted for few hours. Moreover, the above surgery cannot be treated as advancement of the medical technology.
Award: - The complaint stands dismissed.

Complaint No: - AHD -G-50-1415-354
Complainant:-Sh. Kalrav B. Patel V/S Oriental Insurance Co. Ltd.
The Respondent had repudiated the TTD claim of the Complainant for the operation of Cauda Equina Syndrome (CES) and after that the Complainant had taken bed rest for four months. The Complainant had claimed that it was due to fall from stair case. The Respondent had produced the copy of discharge summary stating that symptoms of above disease was from last three months & doctor recorded similar complaint in 2010. It is very difficult to accept the Complainant version of the fall from the stair case leading to aforesaid complication without any medical certificate or investigation reports.
Award: - The complaint stands dismissed.

Complaint No: - AHD -G-50-1415-358
Complainant:-Sh. Sunil B. Lodha V/S Oriental Insurance Co. Ltd.
The Respondent had repudiated the hospitalization claim of the Complainant's daughter stating that the Complainant had late submission of the documents. The Complainant had given his clarification of late submission of documents by 10 days with genuine reason. As per IRDA guidelines late submission of documents can be waived if other things are in order not followed by the Insurer. The Complainant had informed during hearing that he had received claim amount a day before the hearing and due to late settlement of the claim had demanded for interest.
Award: - The complaint is admitted for interest @ 2% over and above bank rate.

Complaint No. AHD-G-048-1415-0495.

Complainant: Mr.Anjankumar V, Vyas
V/s
Respondent: The National Insurance Co. Ltd.,
Date of Award: 17-06-2015

Brief Facts of complaint:

The Complainant had a National Mediclaim policy since 25.11.2004. He had submitted that he was paying the premium regularly without any break in policy. His wife Kalpanaben had fracture neck femur Lt. side. She was hospitalized in Jhanvi Fracture & Orthopedic Hospital, Ahmedabad on 03.06.2014 for (Persistent pain in Back, Knee,& Hip) treatment and surgery. The treating doctor had suggested investigation and pathological test to confirm the exact treatment and surgery. The surgery was performed on 04.06.2014. He had incurred expenses of Rs. 66,565,/-. He had registered a claim with the Respondent and submitted required documents for settlement of the claim. The claim was partially settled i.e by deduction of Rs. 8,000/-, with a reason that MRI was not related to the disease for which she was hospitalised.

The Respondent had deducted the claim amount Rs. 8000/- on MRI report, as unrequired report. The Complainant's treating doctor had justified the requirement of MRI report vide letter dated 12.09.2014. The insured had fracture in her neck femur Lt. side, whereas the MRI has been carried out on the knee. The insured had complained about persistent pain in back knee, hip joint, & inability to walk. The doctor accordingly, to find the cause had advised MRI of Lumber spine and knee with screening of hip.

AWARD

Taking into account the terms and conditions of the Policy of the Respondent with reference to the facts and circumstances of the case, materials on record, submissions of the parties and findings as above, the Respondent is here by directed to pay the claim amount of Rs. 8,000/- (Rupees Eight Thousand only)

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MEDICLAIM

Date of Award: 15-06-2015

Complaint No. AHD-G-049-1516-0473.

Complainant: Mr. Mukesh C. Patel
V/s
Respondent: The New India Assurance Co. Ltd.,

<u>The Brief Facts of the Complaint.</u>

The Complainant had two mediclaim policies with two different Offices of the same insurer, since 28.02.2000 & 03.08.2005. His daughter was hospitalised in the Ruchir Clinic, Baroda for the treatment of acute pain in her right side lower abdomen– acute twisted and ruptured right ovarian cyst, She had incurred an expense of Rs. 56,041/- towards the subject surgery and treatment. The Respondent had repudiated the claim as per policy (220300/34/13/01/000001692) clause No.4.3 (2) waiting period for specified disease. Hence, the Complainant had requested the TPA of the Respondent vide letter dated 12.03.2013 to consider the claim under policy No. 21500/34/13/01/00003610. The claim was processed by TPA and repudiated under policy clause No. 5.5 – fraud, misrepresentation and concealment. The Complainant had approached the grievance department of insurer. However, the request for settlement of claim was not accepted.

The Investigator, apart from finding the corrections in the one IPD paper, was not able to establish any thing contradicting the claim. The treating doctor had asserted the corrections to be authentic. The claim is, hence, admitted.

AWARD

In view of the foregoing, the Respondent is hereby directed to settle the claim of Rs.56041/- (Fifty six thousand and forty one only) to the Complainant.

MEDICLAIM

Date of Award:16-06-2015

Complaint No. AHD-G-050-1415-0482.
Complainant: Mr. Bhaumik D. Kansara
V/s
Respondent: The Oriental Insurance Co. Ltd.,

<u>The Brief Facts of the Complaint.</u>

The Complainant had taken health policy for his family since 06.10.2006, from different insurers through broker and regularly paid the premium. His mother aged 57 years was admitted in Sal hospital, Ahmedabad from 08.03.2013 for heart related disease. The Complainant had incurred an expense Rs. 29,900/- towards the subject heart treatment and treatment. He had lodged the claim with the Respondent and submitted all required documents with the Respondent for settlement of the claim. The Respondent had repudiated the claim stating that claim was registered in the 3rd year of the policy. The policy was since 2010. The said disease fell under pre existing disease and same is excluded for 4 years. The Complainant had approached the grievance department of the insurer.

The decision to repudiate the claim is highly arbitrary. The Forum noted that the full policy with terms and conditions was not issued to the Complainant.

The Complainant had been purchasing the mediclaim policies from the Respondent since October 2006 except for an intermittent period of 2 years during which he had purchase the policies from 2 other Govt. run G.I.Cs. Apart them this, if the companies (Govt. run) are put as one company, there is no gap or break in the policy. More over it is the agent/broker who purchases the policies for the Insured. The agent/broker of the Respondent should inform to the insured, about such shifting of business and the relavant consequences. The Insurer also had not printed or informed the insured of the loss due to such change in the companies. The insured should not be depriving of his benefit just because the insurer and its agent have failed to educate the insured. Under the circumstances, in view of the helplessness of the insured, The Forum admits the complaint.

<u>AWARD</u>

In view of the above, I direct the insurer to pay Rs. 20,000/- as ex-gratia.

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MEDICLAIM

Date of Award: 17-06-2015

Complaint No. AHD-G-048-1415-0495.

Complainant: Mr.Anjankumar V, Vyas
V/s
Respondent: The National Insurance Co. Ltd.,

Brief Facts of complaint:

The Complainant had a National Mediclaim policy since 25.11.2004. He had submitted that he was paying the premium regularly without any break in policy. His wife Kalpanaben had fracture neck femur Lt. side. She was hospitalized in Jhanvi Fracture & Orthopedic Hospital, Ahmedabad on 03.06.2014 for (Persistent pain in Back, Knee,& Hip) treatment and surgery. The treating doctor had suggested investigation and pathological test to confirm the exact treatment and surgery. The surgery was performed on 04.06.2014. He had incurred expenses of Rs. 66,565,/-. He had registered a claim with the Respondent and submitted required documents for settlement of the claim. The claim was partially settled i.e by deduction of Rs. 8,000/-, with a reason that MRI was not related to the disease for which she was hospitalised.

The Respondent had deducted the claim amount Rs. 8000/- on MRI report, as unrequired report. The Complainant's treating doctor had justified the requirement of MRI report vide letter dated 12.09.2014. The insured had fracture in her neck femur Lt. side, whereas the MRI has been carried out on the knee. The insured had complained about persistent pain in back knee, hip joint, & inability to walk. The doctor accordingly, to find the cause had advised MRI of Lumber spine and knee with screening of hip.

AWARD

Taking into account the terms and conditions of the Policy of the Respondent with reference to the facts and circumstances of the case, materials on record, submissions of the parties and findings as above, the Respondent is here by directed to pay the claim amount of Rs. 8,000/- (Rupees Eight Thousand only)

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Complaint No. AHD-G-051-1415-0491.

Complainant: Mr. Mukesh A. Balsara
V/s
Respondent: The United India Insurance Co. Ltd.,

Date of Award:15-06-2015

<u>The Brief Facts of the Complaint.</u>

The Complainant had mediclaim policy for his family member with the Respondent since 21.05.2008. His son was hospitalised in the Amit Hospital, Anand for the treatment of Acute Appendicitis He had incurred an expense of Rs. 31,989/- towards the subject surgery and treatment. The Respondent had partially repudiated the claim Rs. 8890/- under policy clause No. 1.2A, 1.2C, 1.2D clauses, like Room Rent charges not to exceed 1% of sum insured, cash memo not submitted etc. Hence, the Complainant had approached the grievance department of insurer. However, the request for settlement of claim was not accepted.

The entitled category of 1% sum insured applicable for all other deductions other than room rent was not properly defined in the terms and conditions of the policy.
The company had partially repudiated the claim citing clause No. The decision to partial settlement of the claim is arbitrary.
However, without Anesthesia surgery was not possible The deduction in laboratory charges were unfair. The Respondent is advised to have a human approach to the policyholder instead of a mechanical approach.

In view of the above, the complaint is, thus, allowed.

AWARD

In view of the above, I direct the insurer to pay Rs. 6,000/- ex gratia.

MEDICLAIM
Date of Award:

Complaint No. AHD-G-051-1415-0486.

Complainant: Mr. Navinchandra P. Bhavsar
V/s
Respondent: The United India Insurance Co. Ltd.,

<u>The Brief Facts of the Complaint.</u>

The Complainant had mediclaim policy for his family member with the Respondent since 31.07.2007. He was renewing the policy regularly. He was hospitalised in the Spandan Multi Speciality Hospital, Vadodara for the treatment of heart disease. He had incurred an expense of Rs. 2.25 lacs towards the subject surgery and treatment. The Complainant had lodged the claim with the Insurer and submitted required documents for settlement of his claim. The Respondent had repudiated the claim vide letter dated 04.08.2014 under policy clause No. 4.1, pre existing disease. The Complainant had submitted that he was 81 years old. Due to non receipt of documents required by the insurer, he could not reply.

The Representative of the Respondent had submitted that Hypertension related disease, heart disease and diabetes related disease were excluded. The claim documents submitted by the Complainant showed that he had HTN, D.M. since 35 years. The Representative of the Respondent deposed that the claim was repudiated as per policy clause No. 4.1 of the policy issued to the Insured.

The insured has been having the individual health insurance policy since 2007 i.e. six years and nine months had passed since the inception of the policy to the date of treatment in 2014.
The TPA had repudiated the claim as per policy clause 4.1; however the policy clause 5.14 was not taken in to consideration. The 5.14 clause states that " Pre existing disease/illness exclusions shall get deleted once the insured person completes three year claim free policy periods i.e. from 4th year onwards, the pre existing diseases exclusion conditions shall not apply provided no claims were made/ reported during the earlier three continuous policy periods with us".
Since more than 4 years have passed from the inception of the policy, the invoking of restriction clause was incorrect. The Respondent is advised to have a human approach to the policyholder instead of a mechanical approach. The complaint is admitted.

AWARD

In view of the above, the Respondent is directed to pay Rs. 1,50,000/- + Cumulative Bonus of Rs. 27250/- totaling to Rs. 177250/- to the Complainant.

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MEDICLAIM

Date of Award: 17-06-2015

Present: Shri. A. K. Sahoo, Insurance Ombudsman
Complaint No. AHD-G-051-1415-0689.

Complainant: Mr. Dilipbhai S. Shah
V/s
Respondent: The United India Insurance Co. Ltd.,

Brief Facts of complaint:

The Complainant had a Mediclaim policy since 2001.His previous claim on his cataract surgery was settled without any deduction by waiving the cap. He was hospitalized in CIMS Hospital Ahmedabad for Total Knee Replacement Surgery. He had incurred expenses of Rs. 1,65,488/-. His claim was partially settled with deductions like Admission fee, Service Charges and 70% of earlier Sum Insured, for major surgery for Rs. 21,588/-.

The Complainant had stated that he was having the policy since 20 years and was increasing the sum insured periodically. In the subject policy year, he was provided with the policy schedule only and not the terms and conditions of the policy. He submitted that being a senior citizen, the 70% cap should not be applied to his claim. The relevant policy condition and the deductions were also examined. The Respondent's deduction and application of the relevant clause for the deductions were found to be in sync with the cited policy terms and conditions and decides the cases as per the terms and conditions of the policy and cannot award any monetary benefit beyond the policy.

The complaint fails to succeed.

AWARD

In view of the foregoing facts, the Respondent's decision to settle the claim partially as per the policy contract is upheld without any further relief to the Complainant.

MEDICLAIM

Date of Award: 20-07-2015

Complaint No. AHD-G-018-1516-0027.
Complainant: Mr. Mithunkumar D. Patel
V/s
Respondent: The HDFC Ergo General Ins. Co. Ltd.,

<u>The Brief Facts of the Complaint.</u>

The Complainant's brother had taken insurance policy - Home Suraksha Plus from the Respondent. He had availed home loan from HDFC Bank. To protect their financial loss the bank had forcefully given HDFC Ergo – Home Suraksha Plus policy for the period from 25.01.2013 to 24.01.2018. The policyholder died on 21.09.2013. The Complainant had lodged the claim with the Respondent against outstanding Loan Amount Rs. 7,01,618/-under section 3 - Major Medical Illness & Procedures of the policy. The Respondent had informed about the rejection of claim vide letter dated 11.11.2013. The representative of Complainant had appealed to grievance cell of the Respondent, and submitted the treating doctor's certificate stating that the patient had Acute Kidney Injury. There was no previous history of Kidney disease..

<u>AWARD</u>

The Respondent is here by directed to make the payment of Rs. 2,00,000/- to the Complainant.

MEDICLAIM

Date of Award: 20-07-2015

Complaint No. AHD-G-018-1516-0027.
Complainant: Mr. Mithunkumar D. Patel
V/s
Respondent: The HDFC Ergo General Ins. Co. Ltd.,

<u>The Brief Facts of the Complaint.</u>

The Complainant's brother had taken insurance policy - Home Suraksha Plus from the Respondent. He had availed home loan from HDFC Bank. To protect their financial loss the bank had forcefully given HDFC Ergo – Home Suraksha Plus policy for the period from 25.01.2013 to 24.01.2018. The policyholder died on 21.09.2013. The Complainant had lodged the claim with the Respondent against outstanding Loan Amount Rs. 7,01,618/-under section 3 - Major Medical Illness & Procedures of the policy. The Respondent had informed about the rejection of claim vide letter dated 11.11.2013. The representative of Complainant had appealed to grievance cell of the Respondent, and submitted the treating doctor's certificate stating that the patient had Acute Kidney Injury. There was no previous history of Kidney disease..

<u>AWARD</u>

The Respondent is here by directed to make the payment of Rs. 2,00,000/- to the Complainant.

MEDICLAIM

Date of Award:20-07-2015

Complaint No. AHD-G-048-1415-0718.
Complainant: Mr. Bharatkumar R, Shah.
V/s
Respondent: The National Insurance Co. Ltd.,

<u>The Brief Facts of the Complaint.</u>

The Complainant had health insurance policy for his family since the year 2012. He was admitted in Vaishvi Orthopedic Hospital, Vadodara, for the treatment of Bucket handle medial Meniscustear with lateral meniscus tear with complete ACL tear left knee and had incurred an expense Rs. 51,836/-. He had lodged the claim with the Respondent. The Respondent had repudiated the claim under policy clause No. 4.1 (Mis Representation). However, his request for reconsideration of claim was not accepted by the Respondent.

. The Respondent had wrongly interpreted the MRI report and policy condition no. 4.1. The explanation was not called for from the Complainant for previous treatment.

Respondent's decision to repudiate the claim is arbitrary. Thus, the complaint is admitted.

<u>AWARD</u>

<u>The Respondent is here by directed to make the payment of Rs. 51,836/- with interest at a rate which is 2% above the bank rate prevalent from the date of repudiation i.e 15.04.2014 to the Complainant.</u>

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Bengaluru Centre

Medical Insurance:

Case No.BNG-G-051-1516-0068

Mrs.Jayamma V/s United India Insurance Co., Ltd.
Award dated 08.06.2015
Repudiation of Gr.Mediclaim:

Complainant is employee of Indian Institute of Management, Bangalore who had group Insurance with the said Insurer and filed a case against him for non-settlement of group medical insurance claim, for the hospitalisation with a symptoms of lower back ache and type 2 DM.

Insurer refused to settle the claim by stating that hospitalisation for investigation like MRI, NCV of lower limb, X-ray etc was done and advised only oral medicines. As no line of treatment found in hospital records, so refusal was as per the policy condition.

Taking into account the facts & circumstances of the case, the information and documents placed on record and the submissions made by both the parties hereto during the course of the Hearing, it is hereby concluded that the Insurer's decision to repudiate the claim is justified and does not warrant any interference at the hands of the Ombudsman. Hence, the complaint is DISMISSED.

Case No.BNG-G-0048-1415-0044

Mr.Sampath Kumar V/s National Insurance Co., Ltd.
Award dated 13.04.2015
Repudiation of Gr.Mediclaim:

Complainant'smother Smt. Ratnam was hospitalised and given medical treatment, for which medical insurance claim submitted was refused by the Insurer.

Insurer submitted that the claim was repudiated, as the hospitalisation was primary evaluation and diagnosis, which is not covered by the terms of policy.

Taking into account the facts & circumstances of the case, the information and documents placed on record and the submissions made by both the parties hereto during the course of the Hearing, it is hereby directed that the Insurer's decision to repudiate the claim is justified and does not warrant any interference at the hands of the Ombudsman. Accordingly complaint Disposed.

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Case No.BNG-G-035-1415-0007
Mr.Sajit Jayaram V/s Reliance Insurance Co., Ltd.
Award dated 27.07.2015
Repudiation of Gr.Mediclaim:
Complainant'sparent Smt.Parimala Jayaram under gone medical treatment and submitted claim to M/s Good health TPA services of the Insurer M/s Reliance General Insurance with whom his employer M/s Northern Operating Service (P) Ltd. had a group mediclaim insurance. But claim was repudiated by the TPA by stating that the admission to the hospital was for primary investigation and observation.

Insurer stated that patient admitted to the hospital to rule out the IBS without any significant symptoms necessitated for hospitalisation. However, the claim settle for Rs.46,376/-.

Taking into account the facts & circumstances of the case, the information and documents placed on record and the submissions made by both the parties hereto during the courseofthe Hearing, it is hereby directed that the Insurer should settle the claim as per the terms and conditions of the policy.Hence, the complaint is treated as allowed.
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Case No.BNG-G-050-1415-0061
Mr.NSubramanya Bhat V/s M/s Oriental Insurance Co., Ltd.
Award dated 29.04.2015
Repudiation of Gr.Mediclaim
Complainant filed a case against M/s Oriental Insurance Co. Ltd for non-settlement of claim for group medical claim under policy no.MAID No L 5012008992.Insurer stated that the treatment for Obesity, Bariatric Surgery and weight control programme is an exclusion under clause No. 4.17 of the policy terms, hence claim was repudiated.Opinion called from the independent Panel Doctor by this Forum, according to which hospitalisation was purely for the purpose of weight reduction and morbid obesity.
Taking into account the facts & circumstances of the case, the information and documents placed on record and the submissions made by both the parties hereto during the course of the Hearing, it is hereby directed that the Insurer's decision to repudiate the claim is justified and does not warrant any interference at the hands of the Ombudsman. Hence, the complaint is DISMISSED.
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Case No.BNG-G-055-1516-0150
Mr.Belia Shiva Prasad Rai V/s United India Insurance Co., Ltd.
Award dated 10.09.2015
Repudiation of Gr.Mediclaim
Complainant, his family and dependents covered under group medial Insurance of his employer M/s Software Parading Info Tech Ltd. Dr. Surendra Shetty the dependent of complainant, was hospitalised for treatment of Rituximab Infusion and Pemphigus vagaries. But claim was repudiated by the TPA of Insurer stating that line of treatment is not as per India medical treatment practice, but unproven/experimental treatment. Whereas,the consultant Surgical Oncologist stated in writing that treatment given under strict medical supervision after primary investigation and hence, considering all the fact of case and also on hearing both the parties, Insurer directed to settle the claim. So the complaint allowed.

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Case No.BNG-G-049-1516-0161
Mr.Govindaraju Ramachandran V/s New India Insurance Co., Ltd.
Award dated 28.08.2015
Repudiation of Gr.Mediclaim

Complainant filed a case against Insurer for non-settlement of claim under group medical insurance, which is taken by the complainant's employer M/s RNB India Development Centre.

Taking into account the facts & circumstances of the case, the information and documents placed on record and the submissions made by both the parties hereto during the course of the Hearing, it is concluded that the Insurer, has agreed, through the process of by way of conciliation/mediation, to settle the claim as per the terms and conditions ofthepolicy, to the extent of the expenses relating to fibroid removal only.

Case No.BNG-G-007-1516-0165
Mrs.Claret Lobo V/s Bharathi AXA Gen Insurance Co., Ltd.
Award dated 28.08.2015
Repudiation of Gr.Mediclaim

M/s Klubber Lubrication India Pvt. Ltd has insured his employer under group Insurance withM/s Barathi AXA Gen.Insurance Co. Ltd. Complainant is an employee of the Insured and claimed Insurance for hospitalisation of her husband for five different occasions. But, all claims were refused by the Insurer's TPA on ground of policy exclusions as the patient was known heavy smoker which lead to the lugs carcinoma and hospitalisation was for said carcinoma.

Taking into account the facts & circumstances of the case, the information and documents placed on record and the submissions made by both the parties hereto during the course of the Hearing, it is hereby directed that the Insurer's decision of repudiating the claim(s) under the Policy is justified and does not warrant any interference at the hands of the Ombudsman and Dismissed.

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Case No.BNG-G-0451-1516-0195
Mr. S A Jayaram V/s United India Insurance Co., Ltd.
Award dated 28.09.2015
Repudiation of Gr.Mediclaim
Complainant filed a case against Insurer for non-settlement of group insurance claim for hospitalisation and treatment of Coronary Artery disease and Hypertension.
Insurer's TPA M/s Vidal Health TPA service refused to settle claim by stating that hospitalisation for treatment of illness was due to pre-existing HTN. The decision of TPA maintained by the Insurer also.
During the Hearing, the Insured said he never suffered from HTN prior to the current group policy &two medical certificates dated 07.10.2014 and 23.12.2014 issued by Narayana Hrudayalaya, wherein it is recorded that Insured developed HTN only recently i.e. since one month. But, Insurer even after considerable lapse of time, failed to obtain the clarification for the contents above said letters. So, the benefit of doubt in this case can be given to the Insured and it can therefore be concluded that the Insured had only recently (three months before) contacted for hypertension i.e.after DOC of the current policy, thus, making hypertension a current illness and not a pre-existing, thecomplaint is allowed. Insurer directed to settle the claim on the basis of sum insured under the current policy, after adjusting amount already paid.

Case No.BNG-G-051-1516-0170
Mr. Vishnu Kalapur V/s United India Insurance Co., Ltd.
Award dated 04.08.2015
Repudiation of Gr.Mediclaim

Mr. Vishnu Kalapurhas preferred a complaint before this Forum on 15.05.2015, against United India Insurance Company Limited, for balance payment of mediclaim expenses incurred in respect of his father Mr. Ramesh Kalapur, the tailor made group mediclaim policy having been issued to M/s HCL Technologies.

The Insured lodged a claim with the Insurer for Rs.2,04,885/-, towards surgical treatment of cervical canal stenosis and for decompressive C3-7 laminectomy and L4-5 micro discectomy at BGS Global Hospital, Bengaluru. The Insurers settled the claim for a sum Rs.1,07,648/-. The Insured had opted for a Sum Insured of Rs.1,56,000/-, with a co-payment deduction clause of 25% on the total sum insured (for the policy period 2014-15) in respect of his parents. Accordingly, the eligible amount (after co-pay clause) works out to Rs.1,17,000/-. Since the hospital has offered a discount of Rs.9,352/- is the bill, the same has been adjusted against the maximum limit of Rs.1,17,000/- and accordingly, a sum of Rs.1,07,648/- (1,17,000-9,352) was settled by the Insurer as full and final payment of the claim.

The Insurers have submitted their self-contained note dated 31.07.2015, wherein it is stated that confirmation of details of settlement of the claim were communicated to the Insured both vide their RPAD letter dated 31.03.2015 and detailed calculation tabulation dated 14.05.2015.
On examination of the documents and the submissions made by the parties hereto, it is observed that the said policy is a specially designed tailor made group policy, to suit the needs of the Insured client. The terms & conditions of the standard mediclaim policy are not applicable to the tailor made group policy.
Apropos, this Forum observe that the Insurer have acted as per the terms & conditions of the policy and that theComplainant's representation seeking payment of the balance amount of expenses incurred by him is not tenable and as such, the case does not warrant any interference at the hands of the Ombudsman and, therefore, the case is dismissed.

Case No.BNG-G-049-1516-0265
Mrs. Gnaneshwari J V/s New India Asurance Co., Ltd.
Award dated 14.10.2015
Repudiation of Gr.Mediclaim

Complainant filed a case against Insurer for partial settlement of claim (i.e. Rs.5032/- instead of Rs.121000/-) for hospitalisation expenses of her daughter's illness cerebral Palsy.
Insurer neither submitted their SCN nor their representative made any submission during hearing.
Complainant approached Grievance Cell of the Insurer on 30/06/2015. There is a noting made on the face of the letter wherein it is mentioned that"We have gone through the claim papers and observe that this claim is payable underPolicy conditions". This has been signed by the Sr. Divisional Managerof DO 120700, Mumbai, RO3 &conveyed to Bangalore DO III on 17/08/2015.
This Forum is of the opinion that the said policy is a tailor made group mediclaim policy issued specially to cater to the needs of LIC employees and Congenital Internal Defects/Diseases are covered under Clause E, point 13 of the policy terms & conditions. Based on the above facts & circumstances of the case, the information and the documents placed on record and the submissions made by both the parties hereto, the Insurers are hereby directed to settle the balance claim along with interest @ 2% above bank rate, as per terms & conditions of the policy.

BHOPAL

BHOPAL INSURANCE OMBUDSMAN OFFICE

Case No.BHP-G-049-1415-0092

Mr. S. C. Shukla V/S The New India Assurance Co. Ltd.

Order No. IO/BHP/A/GI/0001/2015-2016 Passed on 15/04/2015.

Brief Background:

Mr. S. C. Shukla obtained a Janata Mediclaim Policy from The New India Assurance Co. Ltd.

As per the Complaint, he was operated on 17.06.2011 by Dr. Anant Joshi, Mumbai and also admitted in Khandepar Clinic there and got treatment. He preferred a claim of Rs.40,000/- towards operation charges but the Respondent Company paid only Rs.12,200/-. He made a complaint before the respondent company which was not considered.

The Respondent vide its reply dated 26.02.2015 have enclosed the copy of Janta Mediclaim policy, From the clarification letter dated 18.08.2014, the payments are payable as per prescriptions of the doctor and as per policy conditions payment has been made which has been found payable and the amount deducted are not payable under the policy conditions.

Findings and decision:

The Respondent TPA rightly calculated the eligibility as per policy terms and conditions and the complainant has got two claims for Rs. 12200/- towards full and final settlement of the claim. Further the complainant raised the point in August 2014 i.e. after three years of said treatment. Hence, the complaint stands dismissed without any relief.

Mr. Santosh Kumar Jain V/S The Oriental Insurance Co. Ltd.

Order No. IO/BHP/A/GI/0002/2014-2015, passed on 28/04/2015.

Case No.BHP-G-050-1415-0080.

Brief Background:

Late Mudit Jain, his legal heir of Mr. Santosh Kumar Jain obtained Mediclaim Policy from The Oriental Insurance Co. Ltd.

As per the Complaint his son had claimed for Rs.71,021/- and Rs.36,143/- as mediclaim .

Since, no replies were came with regard to the history of past conditions relating to his present illness in the claim, this claim was repudiated on account of Exclusion 4.1 and clause 5.8. regarding misrepresentation of facts.

Findings and Decesion:

the certificate of treating Dr. S.S. Nelson dated 1.3.13 confirms that the patient was suffering from Psoriatic Arthritis since September, 2011 and is being treated for it from January, 2012. From the medical documents on record, it is confirmed that the patient had contracted the disease in 2011 i.e. the second year of the policy, exclusion No. 4.2 was also mentioned as the reason for repudiation. The medical documents and difference in dates about detection of the disease, the pre-existing disease cannot be ruled out. Hence, the complaint stands dismissed.

Mrs. Durga Bai V/s ICICI Lombard General Insurance Co. Ltd.

Order No.IO/BHP/A/GI/0006/2015-2016 passed on 27/05/2015.

Case No.BHP-G-020-1415-0031

Brief Background:

The complainant had attended family planning camp on 27.01.2012 at village Dargada, where she had undergone for sterilization operation which resulted in to failure of sterilization, she gave birth to a girl child on 01.10.2012. The Government of India has launched family planning scheme covering all the beneficiaries under a group insurance policy, issued under a MOU between ICICI Lombard General Insurance Co. Ltd. and President of India through the Department of Health and Family Welfare. On account of failure of Sterilization, complainant preferred a claim for a compensation of Rs.30,000/- which is covered under section IC of the policy. but the respondent company has repudiated her claim on the ground that fund has been exhausted and delayed intimation.

FINDINGS & DECISION: as per MOU the Insurer will provide benefits to the beneficiary of the scheme. As per clause 9 "All claims arising under Section I-C (due to failure of Sterilization) shall be accepted from retrospective date i.e.20th November, 2005, In case of non-renewal or break in the policy or cancellation of the policy, all claims of Failure of Sterilization detected upto 180 days after the expiry of the policy shall be accepted and shall be treated as being detected during the policy. Since, the claimant is illiterate woman of a remote area, so it cannot be expected to know the technicalities of claim procedure. As per circular dated 20.09.2011 of the IRDA, the claim should not be rejected by the company in a causal way on the ground of delayed information. The plea taken by the insurer's representative about exhaust of the fund has no relevance

and devoid of any force. As per clause 32 Monitoring of the scheme(6), "The Central Committee will examine all repudiated claim and direct the Insurer to pay the claims falling under the terms of the policy." Complaint is allowed.

Mr. Kamlesh Maheshwari V/s Oriental Insurance Co. Ltd

Order No.: IO/BHP/A/GI/0004/2014-2015 passed on 20/-5/2015.

Case No.: BHP-G-050-1415-0081

Brief Background:
Mr. Kamlesh Maheshwari had taken a Happy Family Floater Mediclaim Policy from Oriental Insurance Co. Ltd.

As per the Complaint, the earlier policies were issued in the name of Mr. Kamlesh Maheshwari as a primary member of the family subsequently in the current policy premium was charged on the ground of highest age of the family member, and insurance company has charged the premium showing his mother's name as primary member of the family which resulted premium higher than earlier policies.

FINDINGS & DECISION:

From the circular no. HO/Health/2013/CR-6837 dated 04.11.2013 issued by the respondent company, it is crystal clear that "if two generation are covered e.g. husband, wife and children primary member would be the person of the highest age." Under para C for a family three generation, exclude the senior most generation and from the remaining two lower generations, the highest age member will be the primary insured and no excess premium was charged by them and policy issued is in order and as per company's guideline and system, Hence the complaint is allowed.

Mrs. Rajni Dubey V/s National Insurance Co. Ltd

Order No. IO/BHP/A/GI/0003/2015-2016 dtd 19/05/2015.

Case No.BHP-G-048-1415-0102

Brief Background:

The complainant had taken a Overseas Medical Insurance Policy from the respondent company. Complainant visited Australia where she fell ill on 07.11.2013. After arrival to India she lodged a claim for USD 194 with the respondent but her claim was not settled in absence of certificate of past disease.

Findings & Decision:

Since, the claim has been settled and payment has been made to the complainant towards full and final settlement and the complainant has also prayed for withdrawal of the case vide e-mail dated 31.01.2015 regarding settlement of her claim. Hence, the complaint stands dismissed.

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Mrs. Disha Neema (Complainant) V/s The Oriental Insurance company Ltd. (Respondent)

Order No.IO/BHP/A/GI/0019/2015-2016 Case No.BHP-G-050-1415-0180

Dated at Bhopal on 19th day of June, 2015

Brief Background:

The complainant had taken a Happy Family Floater Mediclaim Policy bearing no.151301/48/2015/3554 for the period 28.08.2014 to 27.08.2015 for sum insured Rs.1,50,000/- covering herself and her dependent parents from respondent company. It is further said that her father Mr. Pramod Neema had undergone cataract surgery on 08.10.2014. Thereafter she submitted the claim for reimbursement of Rs. 27,818/- under the policy document before the respondent company by submitting all the medical documents but the respondent has settle the claim for Rs.15300/- only after deducting Rs.12517/- in view of reasonable and customary charges.

The Respondent have settled the claim after deducting reasonable and customary expenses as per clause 3.12 and also deducted under the silver plan @10% of the admissible claim amount as the insured has to bear the same as per clause 4.23 and in view of policy documents the amount comes to Rs.15300/- which has already been paid to the complainant.

FINDINGS & DECISION:

After going through the discharge certificate, doctor's certificate, medicine receipts/cash memo pertaining to related medicines I come to the conclusion that the deduction as made by the TPA/respondent company does not appear to be reasonable and customary as the respondent company has deducted Rs.10817/- towards cost of the implants (lens) which was purchased by paying Rs.17400/- and deducted Rs.1700/- from Rs.5350/- which was professional charges. Thus, I found that the complainant is entitled for Rs.24652/- towards settlement of claim and before making the payment, the respondent may adjust the amount Rs.15300/- if paid earlier to the complainant.

Hence, complaint is allowed.

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Mr. J. S. Parihar (Complainant) V/s The Oriental Insurance Co. Ltd (Respondent)

Order No. IO/BHP/A/GI/0025/2015-2016 Case No. BHP-G-050-1415-0064

Award Dated at Bhopal on 25th day of June, 2015

Brief Background:

The complainant had taken a Happy Family Floater Policy bearing no.152801/48/2013/1422 for sum insured Rs.2,00,000/- he underwent surgery of Cardiac Ailment. the respondent has repudiated his claim on the ground of break in the policy and pre-existing disease while he has taken the policy for last 20 years i.e. since 1995-96 which was renewed by enhancing the sum insured from time to time till 2014-15.

FINDINGS & DECISION: from perusal of the aforesaid policies which commenced w.e.f. 03.09.2009, it appears that there was a break of 22 days in renewal of the above policy 152800/48/2010/538 and it is clear that there is grace period of 30 days of renewal. Apart from above said break, there was a break of 39 days in renewing the policy 152801/48/2011/883 from the period 02.11.2011 to 01.11.2012. In this way, it appears that the aforesaid policy no. 152801/48/2011/883 was renewed after 9 days of the grace period of 30 days. The notification of IRDA (Health Insurance) Regulations 2013 dated 16.02.2013 clearly provides that the insurer have to develop a mechanism for renewal of the mediclaim policy within 30 days and the period of delay in renewal should not be considered as break but inspite of that no coverage will be available for this period. Since, as per record, it is clear that the claim has not been

made for any period during the said break and renewal of the policy. complainant as a known case of hypertension but he respondent company could not satisfy by filing any medical literature or opinion of any expert cardiologist to show the cause of the said heart ailment in the valve from hypertension. In the present scenario, hypertension has become a life style disease and easily controlled with conservative Hence, keeping in view the above deliberations in mind, it appears me just and proper to allow the claim of the complainant on ex-gratia basis by way of equitable relief for Rs.50000/- (Rupees Fifty Thousand) only as full and final settlement of the claim invoking the provisions of Rule 18 of RPG Rules 1998.

Hence, Complaint is allowed.

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Mrs. Madhu Tahialyani ....
Complainant

V/s

The Oriental Insurance company Ltd.
..... Respondent

Order No.IO/BHP/A/GI/0020/2015-2016 Case No.BHP-G-050-1415-0171

Dated at Bhopal on 19th day of June, 2015

Award

Brief Background:

The complainant's husband Late Arjundas Tahilyani had taken a Happy Family Floater Mediclaim Policy her husband was admitted on 18/06/2013 for hospitalization and died on 27/06/2013 during treatment at Gurjar hospital Indore. It is also said that the complainant filed claim for expenses incurred during the treatment and the respondent has forwarded all the relevant claim papers to Vipul Medcorp TPA private Ltd. and the TPA has issued various letters to the complainant for compliance of queries but in absence of any response, they have closed the file.

FINDINGS & DECISION:

The record shows that the complainant sent the certificate from the treating doctor on 22.03.2014 to the respondent company as required and

the payment receipt (Xerox copy) are also available on the record. There is no dispute about hospitalization and treatment of the insured husband of the complainant who died during treatment. The respondent is also ready to settle the claim as admitted during hearing by insurer's representative. Hence, the respondent is liable to settle the claim and make payment of admissible amount as per policy document.

Hence, complaint is allowed.

Mr. P. D. Gupta ……

Complainant

V/s

The Oriental Insurance Co. Ltd. ……
Respondent

Order No. IO/BHP/A/GI/0023/2015-2016 Case No. BHP-G-050-1415-0018

Dated at Bhopal on 23rd day of June, 2015

Award

Brief Background:

The complainant had taken a Individual Mediclaim Policy. complainant has undergone for cataract operation, after operation the complainant submitted claim of Rs.35,600/- out of which the respondent has settled his claim for Rs.24,000/-. The respondent have contended., The basis of settlement was as per our policy terms and conditions and policy's clause no. 1.2 say that "The policy reimburses reasonable, customary and necessary expenses of hospitalization." The rated agreed by the TPA with hospitals was Rs.24,000/- under PPN and settled the claim accordingly to prevalent rates for the treatment taken by the insured.

FINDINGS & DECISION:

In view of policy condition no. 13 pertaining to expenses relating to reasonable and customary charges are not covered under the policy and the same have to be borne by the insured person himself. Therefore, the deduction made by the respondent are reasonable and sustainable in law. For the sake of natural justice, hearing was refixed for 23.06.2015 but the complainant was absent. Therefore, the case was decided on merit.

Hence, , the complaint stands dismissed.

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Mr. Rahul Mimrot (Complainant) V/s

Star Health And Allied Insurance Co. Ltd. Respondent

Order No. IO/BHP/A/GI/0026/2015-2016 Case No. BHP-G-044-1415-0170

Dated at Bhopal on 26th day of June, 2015

Award

Brief Background:

The complainant had taken a Star True Value Health Insurance Policy. complainant was admitted in Synergy Hospital, Indore due to weakness, pain in left half side body, headache and slurring of speech after discharge, the complainant lodged claim towards his treatment cost before the respondent but his claim was rejected on the ground of non disclosure of

material facts. On the ground of previous ailment since his birth and in the year 1989 he was operated. he made representation before the grievance cell of the respondent which was also rejected and his policy was cancelled and the refund was sent through demand draft.

FINDINGS & DECISION:

From perusal of the discharged slip it transpires that the complainant was admitted on 09.02.1989 at the age of four years in the said hospital with history of "Operated BT Shunt in 1986 for Tetrology of Fallots" surgery performed on 15.02.1989. patient was a follow-up case of tetrology of fallot which was operated and corrective surgery was done more than 20 years back. The complainant has himself admitted about undergoing operation of cardiac problem in 1989, admitted about undergoing surgery of congenital heart disease in the pre-authroisation request form as well as during hearing while the proposal form clearly shows that the complainant has given answer in negative i.e. "No" regarding consulting/ treating/ admitting for any illness and suffering from heart disease and answered "Yes" regarding his good health and free from physical and mental disease in the proposal form for taking the said insurance policy from the respondent company. Thus, it is established that the complainant/patient did not disclose the above material facts at the time of inception of the policy and as per exclusion, the company shall not be liable to make any payment under the policy in respect of 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. Hence, complaint stands dismissed.

Mr. Rajesh Agrwal.....Complainant

V/s

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

Order No. IO/BHP/A/GI/0021/2015-2016 Case No. BHP-G-050-1415-0175

Dated at Bhopal on 22nd day of June, 2015

Award

Brief Background:

The complainant had taken an Individual Mediclaim Policy. his wife underwent for treatment of aneurysm in the CHL hospital. Thereafter, he lodged the claim before the respondent who has settled the claim for Rs.1,00,000/- only. against his claim for Rs.2,20,466/- as per previous policy's sum insured of Rs.1,00,000/- and claim was not paid as per present policy. The respondent have admitted about taking the regular policy since 10/03/2009 to 09/03/2014 for sum insured of Rs.1,00,000/- which was enhanced at the time of renewal of the concerned policy bearing no. 151400/48/2014/5615 for the period of 10.03.2014 to 09.03.2015 for sum insured Rs.2,00,000/-.

FINDINGS & DECISION:

I have gone through the material placed on the record and submission made by both the parties. The discharge card shows that the patient was diagnosed for Lt. MCA Bifurcation Aneurysm and was operated on 23/09/2014. The records shows that complainant made a claim for Rs.2,20,466/- towards treatment claim form but claimed Rs.2 lac on the basis of sum insured under the above concerned policy. It appears that the complainant is under notion that he has enhanced sum insured Rs.2 lac "If the policy is to be renewed for enhanced sum insured then the restrictions as applicable to a fresh policy (condition 4.1,4.2 and 4.3 will apply to additional sum insured) as if a separate policy has been issued for the difference and the earlier limit of sum insured shall be applicable and not the enhanced sum insured". Thus, it is inferred from the record that the patient had pre-existing disease of hypertension and the above concerned policy enhancing the sum insured can be treated as fresh policy as per policy terms & conditions. It is also clear from the record that the claim has already been settled for Rs.1 lac as per sum insured of the previous policy .

Hence, complaint stands dismissed.

.....

Mr. Rajesh Pal…… ……Complainant

V/s

The Oriental Insurance Co. Ltd. …… Respondent

Order No. IO/BHP/A/GI/0022/2015-2016
Case No.BHP-G-050-1415-0177

Dated at Bhopal on 22nd day of June, 2015

Award

Brief Background:

The complainant has taken a Happy Family Floater policy. It is further said that the complainant has been continued his policy since 10/06/2009 for a sum insured of Rs.50,000/- up to 09/06/2012 and in sequence, he had taken another policy bearing no. 153800/48/2012/860 on 26/09/2011 from Ratlam branch office for a sum insured of Rs.1,50,000/- where as his previous policy no. 151400/48/2012/921 was already in existence and thereafter at the time of renewing the above policy during the period 2013-2014, the sum insured was enhanced for Rs.2,00,000/- in the policy bearing no. 153800/48/2014/719. It is also said that the complainant underwent By-Pass surgery on 26.06.2014 and after discharge, he presented his claim for Rs.1,88,821/- incurred by him for surgery to the company's TPA, has rejected his claim after admitting for Rs.50,000/- only.

FINDINGS & DECISION:

It is not in dispute that on the basis of representation made by the complainant after repudiation of the claim on the ground of pre-existing disease, Rs.50,000/- was paid to the complainant as per policy laid down conditions. It is also admitted by the complainant taken another policy bearing no. 153800/48/2012/860 on 26.09.2011for sum insured Rs.1,50,000/- during the existence of earlier policy by the complainant from another branch office situated in Ratlam and not from the previous branch from where the first policy was taken for the period 10.06.2009 to 09.06.2010 and another policy was renewed by enhancing the sum insured for Rs.2,00,000/- in the year 2013-2014 during which the by-pass surgery was done and claim was made.

In the result, the complaint stands dismissed accordingly being devoid of any merit.

Mr. Rakesh Shethi …… ……Complainant

V/s

National Insurance Co. Ltd. ……Respondent

Order No.IO/BHP/A/GI/0015/2015-2016 Case No.BHP-G-048-1415-0121

Dated at Bhopal on 15th day of June, 2015

Award

Brief Background:

The Complainant had taken Sampoorna Suraksha Bima policy. from National Insurance Company. It is further said that the complainant's mother underwent Cataract Surgery on 14/08/2014 and he lodged her mother's claim for Rs.22,494/- before the respondent but they have settled the claim for Rs.16,925/- after deducting Rs.5,568/- . The respondent have contended . The claim was settled for Rs.16,925/- against the claim of Rs.22,494/- to the insured as per reasonable & Customary Clause i.e. 3.11 of the policy - was deducted in various heads like consumable charge, surgeon/physician charge and room rent.

FINDINGS AND DECISION:

. It appears from the certificate cum bill that Surgeon/Physician charges was Rs.6,500/- which appears to be quite reasonable and deduction of Rs.2543/- towards Surgeon/Physician charges is improper and without any basis. Apart from it, the record shows that the Viscot

Injection of Rs.1600/- was utilized during the process of surgery which was not paid showing it consumable which is neither just not reasonable and is payable to the complainant as the said injection was used during cataract surgery. The respondent have not brought on record the terms and conditions of the aforesaid Sampoorna Suraksha Bima policy to show the reasonable and customary clause. However, customary and reasonably does not mean the deduction of more than 50% of amount towards surgeon/physician charges. Therefore, I arrive at the conclusion that the complainant is entitled for additional difference amount of Rs.4143/- (Rs.2543/- + Rs.1600/-) only. Hence, complaint is allowed.

Mr. Ramesh Kumar Sharma ..... Complainant

V/s

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

Order No.: IO/BHP/A/GI/0013/2015-2016 Case No.: BHP-G-050-1415-0114

Dated at Bhopal on 15th day of June, 2015

Award

Brief Background:

Mr. R. K. Sharma has taken a Two Wheeler Package Policy. his motor cycle met with an accident which was resulted into damage of the vehicle and intimation was given to the respondent to conduct necessary inspection/survey was conducted. surveyor who inspected the vehicle in presence of complainant and assessed the loss for Rs.1696/- only. The complainant had raised the query to the respondent and their higher authority but they have given a offer of Rs.2196/- under consideration of Nil Depreciation policy which was not acceptable to him.

FINDINGS & DECISION:

During the hearing, insurer's representative has stated that swing arm was not repairable as per estimate but later on, it was repaired which may be considered for making payment towards repair cost of said swing arm of the vehicle if found payable.

In view of the above facts and material placed before me, I do not find any other infirmity in the survey report. So, I do not any force in the contention of the complainant and I come to the conclusion that Rs.380/- (Rs.280/- as repair cost of swing arm and Rs.100/- as compulsory excess) should be paid to the complainant as full and final settlement of the claim in addition to Rs.2195/- as earlier settled amount. Hence, the complainant is entitled to get Rs.380/- only in addition to Rs.2195/- under the policy document.

Mr. Sachin Gupta
.....Complainant

V/s

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

Order No. IO/BHP/A/GI/0028/2015-2016 Case No.BHP-G-050-1415-0097

Dated at Bhopal on 30th day of June, 2015

Brief Background:

The complainant had taken a Happy Family Floater Policy.. It is further said that the complainant had mediclaim policy for more than 10 years from the respondent company. on 29.05.2013 it was found that his artery was 99% choked and angioplasty was attempted by the same doctor but wire could not cross the lesion, complainant underwent an angioplasty on 04.06.2013 in Fortis Escorts Heart Institute, New Delhi where he was hospitalized from 03.06.2013 to 06.06.2013 the respondent company dated 25th October by which they repudiated his claim due to break came in the policy and coronary artery diseases was covered after two years of the taking of the policy. and there was break of more than one and half month in the policy of 2010-11 and it was second year policy under which the claim was made. So, claim is not payable.

FINDINGS & DECISION:

Thus, it is clear from the above policy documents that there was a coverage of the complainant under the aforesaid policies issued and renewed by the respondent company from time to time. From perusal of the policy documents bearing no. 152109/48/2011/2809 which was

effective from 18.06.2010 to 17.06.2011 could not be renewed in time under the circumstances as stated in the complaint and for want of procedural knowledge of insurance matters regarding condonation of few days delay rather the above Happy Family Floater policy was issued w.e.f. 04.08.2011 to 03.08.2012 i.e. only after gap of 47 days while as per IRDA guidelines there is grace period of 30 days for renewal of the policy. Thus, it is clear that the above policy which was w.e.f. 04.08.2011 to 03.08.2012 was issued only after 17 days of grace period which was also renewed for the period 04.08.2012 to 03.08.2013 under which the claim was made The notification of IRDA (Health Insurance) Regulations 2013 dated 16.02.2013 clearly provides that the insurer have to develop a mechanism for renewal of the mediclaim policy within 30 days and the period of delay in renewal should not be considered as break but inspite of that no coverage will be available for this period. Since, as per record, it is clear that the claim has not been made for any period during the said break and renewal of the policy. it appears me just and proper to allow the claim of the complainant on ex-gratia basis by way of equitable relief for Rs.95,000/- only as lump sum towards full and final settlement of the claim invoking the provisions of Rule 18 of RPG Rules, 1998.

Hence, In the result, the complaint is allowed partly on ex-gratia basis.

Mr. Sameer Gupta…….

…….Complainant

V/s

The National Insurance Company Ltd.
…….Respondent

Order No.IO/BHP/A/GI/0024/2015-2016
Case No. BHP-G-048-1415-0094

Dated at Bhopal on 24th day of June, 2015

Award

Brief Background:

The Complainant had taken Individual Mediclaim Policy. the complainant was hospitalized at CHL Hospital, Indore from 15/05/2013 to 17/05/2013 for the treatment of high grade fever and later on, he was admitted in Bombay Hospital, Bombay from 18/05/2013 to 30/05/2013 for treatment of reactive arthritis and he preferred two claims before the respondent company and out of which the claim pertaining to CHL hospital was settled but Claim pertaining to Bombay Hospital was not settled due to non-compliances regarding submission of some medical documents and his claim was marked as No–Claim vide letter dated 30/09/2013 by the TPA of the respondent company.

FINDINGS & DECISION:

It is apparent that in the opinion of the said doctor the disease was not pre-existing. Nothing has been mentioned about plea of break in the policy as stated by the insurer's representative during hearing so, the above plea cannot be taken into consideration due to clear cut willingness of the respondent to settle the claim of the complainant. Hence, in view of the above readiness of the respondent for settling of the claim of the complainant and making payment due under the policy document, it is needless to discuss any other facts relating to merit of the case. The health insurance claim assessment sheet prepared by the TPA of the respondent brought on record by the insurer's representative also shows the net payable amount as Rs.2,74,007/- towards treatment claim of the complainant. In these circumstance, the respondent is liable to make payment of admissible amount towards treatment cost in the Bombay Hospital, Bombay under the policy documents.

In the result, the complaint is allowed to the extent of above observation.

.....

Ms. Tripti Vyas ....
Complainant

V/s

The Oriental Insurance Company Ltd. .....
Respondent

Order No.IO/BHP/A/GI/0017/2015-2016 Case No. BHP-G-050-1415-0140

Dated at Bhopal on 18th day of June 2015

Award

Brief Background:

The Complainant had taken a Individual Mediclaim policy bearing no. 151300/48/2014/7878 for the period 04/12/2013 to 03/12/2014 for sum insuredRs.1,25,000/- from the respondent covering herself. due to hair crake in her both eyes, she was admitted in Rajas Eye & Research Centre, Indore where in her both eyes lower temporal lattice with hole was diagnosed and Prophylactic surgery was performed and discharged on the same date. she lodged her claim before the respondent company, TPA had taken the advice of treating doctor who confirmed that complainant is a myopic patient suffering from lattice degeneration where peripheral retina becomes in lattice and cause holes due to degeneration and less blood supply which pertains to pre-existing disease and due to which her claim was repudiated

FINDINGS & DECISION:

As per Butterworths medical dictionary, the lattice degeneration of retina- a peripheral degeneration which may lead to retinal holes and detachment

and degeneration. The complainant has not brought on record any other previous policies. As per material available on the record, it is found that the patient had pre-existing disease of myopia and the complication of the same caused holes due to degeneration in the eyes of the patient. As per clause 4.1 "Any ailment/ disease/ injuries/ health condition which are pre-existing (treated/ untreated, declared/ not declared in the proposal form) when the cover incepts for the first time are excluded upto 4 years of this policy being in force continuously." Apart from it, there is mention of correction in right and left eye of the patient by the said treating doctor in the said hospital as appears from the certificate which is also not payable under policy condition no. 4.6.

Hence, the complaint stands dismissed accordingly.

.....

Mr. Vidya Sagar Malik .....Complainant

V/s

Royal Sundaram Alliance Insurance Co. Ltd.
.....Respondent

Order No.IO/BHP/A/GI/0012/2015-2016 Case No.BHP-G-038-1415-0154

Dated at Bhopal on 5th day of June, 2015

Award

Brief Background:

The Complainant had taken a Hospital Cash insurance Policy. the complainant's wife was hospitalized She was diagnosed to have scratching in the food pipe during Endoscopy on 10.01.2014 and subsequently after three days, a clot in the brain was found during City Scan and MRI. the surveyor came to them and asked for the medical history he honestly told that she was maintaining good health and never fell ill and was hospitalized last about 30 years back in the year 1983 for three days for delivery case and at time of delivery a mild high blood pressure tendency was detected which is very normal and presently a tablet Amlodipine 5mg is being taken by her daily as on date. but his claim was repudiated on the ground of Pre Existing Disease saying that she was having high blood pressure which caused the clot in the brain.

FINDINGS & DECISION:

. As per medical documents, Mrs. Shukuntala Malik had Acute Cerebellar ischemic stroke, Ataxia and Hypertension which was due to pre existing

hypertension which has also been confirmed with the discharge card issued on 28/01/2014 and also confirmed by the consultant nuro surgon who has opined that the insured patient has had acute cerebellar infract which was due to the pre-existing hypertension. At present, she is taking heavy dose of drugs like Ecosprin 325mg, Glycomet 250 mg and this type of medicines speaks itself that patient is suffering from " BP " for the long time and age of the patient plays vital role in the daily routine life and fitness of human being, possibility of maintaining a very good health at the age of 66 years is doubtful in this scenario. In these circumstances, the respondent cannot be held liable to make payment of claim as made by the complainant.

Hence, complaint stands dismissed.

****

Mr. Deepak Kumar Soni.....Complainant

V/s

Oriental Insurance Co. Ltd.....Respondent

Order No.: IO/BHP/A/GI/0031/2015-2016 Case No.: BHP-G-050-1516-0003

Dated at Bhopal on 25th day of August, 2015.

Award

Brief Background

Mr.Deepak Kumar Soni obtained a Mediclaim Insurance Policy. from Oriental Insurance Co. Ltd., complainant underwent operation for ailment of fissure at Johri Hospital, he preferred a claim for Rs.23,995/- to the respondent and respondent company has approved the claim for Rs.8,646/-only but the same was not accepted by him.

Findings & Decision :

From perusal of the discharge card issued by Johri Hospital, Jabalpur, it transpires that complainant was admitted on 06/12/2014 It is pertinent to mention here that complainant has admitted himself that his operation was performed at Johri Hospital by Dr. Mukesh Shrivastava, for which Rs.5,000/- has been paid to the Johri Hospital but he couldn't justify the dual receipt issued by Dr. Mukesh Shrivastava for the single operation performed on 06/12/2014. Under the letter head of Jabalpur Endoscopy Centre, Dr. Mukesh Shrivastava has issued a certificate dated 09/03/2015 (Near about 3 months later) stating that he has received Rs.15,000/- towards operation charges through complainant for the same operation. It is apparent that the respondent has processed and settled the claim on the basis of final bill issued by the Johri Hospital where operation was performed. To my mind, the final bill of the said hospital can only be considered for deciding the claim made by the complainant.

Hence, Complaint stands dismissed.

Mr. Gopal Bakode ..
.....Complainant

V/s

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

\Order No.IO/BHP/A/GI/0032/2015-2016 Case No. BHP-G-050-1516-0005

Dated at Bhopal on 25th day of August, 2015

Award

Brief Background:

Mr. Gopal Bakode had taken Universal Health insurance policy. from the Oriental Insurance company. his wife was underwent for treatment He incurred a sum of Rs.19,405/- towards treatment. After discharge, he preferred claim towards treatment cost of his wife before the respondent company but the same was repudiated on the ground of pre-existing disease .

The respondent have contended that during the scrutiny of the claim papers it was observed that patient was diagnosed from Acute gastritis, Rheumatoid Arthritis and Migraine and it was first year policy and patient had migraine since last 5-6 years and rheumatoid arthritis is a degenerative disease which develops in many years and acute gastritis is known complications of these disease hence the disease is pre-existing and so the claim was repudiated under exclusions 3.1 of the policy document.

FINDINGS & DECISION:

The proposal form shows that the column of pre-existing is blank against name of all the insured and the medical records revealed that the patient was suffering from various ailments before issuance of aforesaid policy. It cannot be believed that the complainant had no knowledge about the disease of his wife. Thus, it is established that the complainant had deliberately did not disclose the above material facts in the proposal form. The insurance contract is based on principles of utmost good faith and the complainant has violated the same.

The complaint stands dismissed accordingly.

Mrs. Kiran Kasliwal..... ....Complainant

V/s

Oriental Insurance Co. Ltd.....Respondent

Order No.: IO/BHP/A/GI/0033/2015-2016 Case No.: BHP-G-050 -1516 -0018

Dated at Bhopal on 27th day of August, 2015

Award

Brief Background

Mrs. Kiran kasliwal had taken Happy Family Floater Insurance Policy. from Oriental Insurance Co. Ltd., As per the complainant, her father-in law underwent for cataract surgery on 22.09.2014 in Rajas Eye and Retina Research Centre, Indore and incurred a sum of Rs.25,571/- towards cartaract surgery and medicines etc. After discharge from the hospital,

she preferred a claim for Rs. 25,571/- respondent company has settled her claim only for Rs. 15,300/- after deducting Rs.8,110

Findings & Decisions :

The clause 3.12 of the policy terms & conditions provides that the rate pre-agreed between network hospital and the TPA / company for surgical/ medical treatment i.e. necessary and reasonable for treating the insured person who was hospitalized is payable. Clause 4.23 of the policy document which under Silver Plan clearly provides the compulsory co-payment as the insured has to bear 10% of admissible claim amount in each and every claim. As per GIPSA PPN agreed tariff in Indore, the maximum charges are payable for Rs. 17,000/- for Phac + Cat.(IMP-Policy) Non MICS and for MICS Rs. 24,000/- as appears from mail dated 21.05.2015 sent on behalf of respondent to different branches on subject of rate of cataract surgery as per GIPSA PPN.

In the result, the complaint stands dismissed accordingly.

Mr.Kirti Kumar Joshi …..
…….Complainant

V/s

Oriental Insurance Co. Ltd……Respondent

Order No.: IO/BHP/A/GI/0034/ 2015-2016 Case No.: BHP-G-050 -1516 -0038

Dated at Bhopal on 27th day of August, 2015.

Award

Brief Background

The complainant Mr. Kirti Kumar Joshi had taken a Mediclaim Insurance Policy. complainant's father underwent for cataract operation at Hardia

Eye Hospital, Indore on He incurred a sum of Rs.30,894/- towards cataract surgery and after discharge from the hospital, he preferred a claim for reimbursement of Rs. 30,895/- to the respondent . Insurance Company settled the claim only for Rs.17,000/- after deducting Rs.13,893/- as reasonable and customary charges for non micro incision cataract.

The total amount Rs.17,000/- has been paid by the respondent which was reasonable and customary under clause 3.12 of the policy document and as per prevailing rate in Indore Geographical reason. Hence, the amount paid was correct and in order.

<u>Findings & Decision :</u>

The clause 3.12 of the policy terms & conditions provides that the rate pre-agreed between network hospital and the TPA / company for surgical/ medical treatment i.e. necessary and reasonable for treating the insured person who was hospitalized is payable. As per GIPSA PPN agreed tariff in Indore, the maximum charges are payable for Rs. 17,000/- for Phac + Cat.(IMP-Policy) Non MICS and for MICS Rs. 24,000/- as appears from mail dated 21.05.2015 sent on behalf of respondent to different branches on subject of rate of cataract surgery as per GIPSA PPN.

In the result, the complaint stands dismissed accordingly.

Mr. Amarlal Dawani …. ……Complainant

V/s

Star Health and Allied Insurance Co. Ltd……Respondent

Order No.IO/BHP/A/GI/0036/2015-2016 Case No. BHP-G-012-1516-0070

Dated Bhopal on 15th September day of 2015

Award

Brief Background:

The complainant's wife Mrs. Kiran Amarlal Dawani had taken Medi Classic Insurance policy. on 31/01/2015 she met with an accident as she fell down from the stair case at home and sustained spinal cord injury and was initially admitted to Apex Hospital but then refer to Bansal Hospital and during the treatment she died in the Bansal Hospital on 19/02/2015. complainant preferred the claim for reimbursement of the treatment cost of his deceased wife as his legal heir but respondent repudiated the claim on the ground of non disclosure of material facts

FINDINGS & DECISION:

I have gone through the material placed on the record. From the perusal of complainant's letter dated 12/09/2015, it is apparent that the respondent company have settled the claim of the complainant for Rs. 2,20,000/- towards full and final settlement and have also paid the said amount to the complainant through cheque no.886157 dated 10/09/2015 and the complainant wants to withdraw his complaint. Since, the claim has

been settled and paid to the complainant, so it is needless to discuss the merit of the case. Hence the complaint stands dismissed.

****

Mr. Amitabh Sarkar .....Complainant

V/s

Oriental Insurance Co.Ltd.....Respondent

Order No.IO/BHP/A/GI/0038/2015-2016 Case No. BHP-G-050-1516-0043

Dated at Bhopal on 17th September, 2015

Award

Brief Background:

The complainant as a account holder had taken a PNB Oriental Royal Medclaim policy from the Respondent company. complainant underwent for cellulites treatment for two days in Sidhanta Hospital, Bhopal and after discharge he lodged a claim for Rs.15,638/- towards his treatment his claim was denied by the respondent company. he was having the mediclaim policy continuously since 2003-2004 with United Insurance company and however last year being a account holder he was forced to shift his policy under portability service to the Oriental Insurance Co.Ltd. but respondent has been rejected on the ground of waiting period of 2 years

FINDINGS & DECISION:

It is pertinent to mention here that all the policies were issued by United India insurance without any break. The current policy was issued by Oriental Insurance company under the joint name of PNB-Oriental Royal Mediclaim policy because complainant is an account holder of Punjab National Bank. The IRDA circular no. IRDA/HLT/MISC/CIR/209/2011 dated 09/09/2011 provides for portability of the policy from insurer to

another insurer. the factum of having previous policies of United India Insurance Co. for more than four years cannot be lost sight of, so the rejection of the entire claim on the ground of waiting period of two years does not seem to be reasonable and proper. I feel. just and proper to allow the claim on an ex-gratia basis under RPG Rule 18, to pay Rs.5,000/- only as full and final settlement of the claim under the policy.

Hence, complaint is allowed in part.

Mr. Deepak Boriwal ….

…….Complainant

V/s

Star Health and Allied Insurance Co. Ltd……Respondent

Order No.IO/BHP/A/GI/0044/2015-2016 Case No. BHP-G-044-1516-0052

Dated at Indore Camp Office on 24th day of September, 2015

Award

Brief Background:

Mr. Deepak Boriwal had taken Mediclaim Insurance policy, he was hospitalized at Choithram Hospital & Research Centre, Indore from 12/02/2014 to 13/02/2014. After discharge, he preferred claim before the respondent for Rs.12,685/- towards his treatment cost as appears from impatient final bill which was rejected by respondent on the ground that hospitalization was not needed.

FINDINGS & DECISION:

I have gone through the material placed on the record and submission made on behalf of respondent. It is apparent from the record that the claim has been settled for Rs.12,161/- as full and final settlement and complainant has also submitted a petition for withdrawal of the case due to settlement of the claim. In these circumstances, the complaint is liable for dismissal. Hence, the complaint stands dismissed.

.....

Mr. Gajendra Bhandari .....Complainant

V/s

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

Order No.IO/BHP/R/GI/0035/2015-2016 Case No. BHP-G-048-1516-0061

Dated at BHOPAL on 11th September, 2015

Recommendation Order

Brief Background:

The Complainant Mr. Gajendra Bhandari had taken National Mediclaim policy from the Respondent Compamy. complainant underwent By-Pass surgery at CHL Hospital, Indore. and incurred sum of Rs.3,55,141/- out of which TPA has settled the claim for Rs.2,04,956/- after deducting Rs.1,50,185/-. The respondent have contended that claim settled as per GIPSA guidelines and have stated that as per GIPSA guideline.

During course of mediation, both the parties filed joint application (Mediation Agreement) duly signed by the complainant and the representative of respondent mentioning therein about settlement of the claim willingly and mutually and agreed to settle the subject matter of complaint as follows –

The Respondent National Insurance Co.Ltd is agreed to pay the amount towards balance claim for Rs. 39,750/- to the Complainant as full and final settlement of the above referred grievance/ complaint. The Complainant has also agreed for the same.

OBSERVATION

The respondent National Insurance Co. Ltd. is directed to pay the amount towards balance claim for Rs. 39,750/- only under the policy document .

In the result complaint is allowed.

Mr. Kamal Kumar Malviya ….

…….Complainant

V/s

Star Health Allied Insurance Co. Ltd……Respondent

Order No.IO/BHP/A/GI/0046/2015-2016 Case No. BHP-G-044-1516-0069

Dated at Indore Camp Office on 24th day of September, 2015

Award

Brief Background:

Mr. Kamal Kumar Malviya had taken Star True Value Health Insurance Policy. from the respondent. he was hospitalized at Rajas Eye and Retina Research Centre, Indore. He underwent for vitrectomy surgery during hospitalization. After discharge, he preferred claim before the respondent company for Rs.30,640/- towards his treatment cost as per bills which was repudiated on the ground of pre-existing disease.

For the sake of natural justice, hearing was held on 23/09/2015 at Indore Camp Office. Complainant was absent, Respondent's representative Mr. Ravi Tiwari, Manager was present and was heard who has filed the copy of discharge voucher and copy of letter dated 26.08.2015 regarding withdrawal of the complaint by the complainant due to settlement and payment of the claim.

FINDINGS & DECISION:

I have gone through the material placed on the record and submission made on behalf of respondent. It is apparent from the record that the claim has been settled for Rs.30,640/- as full and final settlement and complainant has also submitted a petition for withdrawal of the case due to settlement and payment of the claim. In these circumstances, the complaint is liable for dismissal. Hence, the complaint stands dismissed.

Mr. Labh Chand Jain ....

.....Complainant

V/s

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

Order No.IO/BHP/A/GI/0047/2015-2016 Case No. BHP-G-051-1516-0047

Dated at Indore Camp Office on 24th day of September, 2015

Award

Brief Background:

Mr. Labh Chand Jain had taken Maha Bank Swasthya Yojna Group Mediclaim Insurance policy. from United India Insurance company Ltd. he was hospitalized at Greater Kailash Hospital, Indore wef. 04/08/2014 to 09/08/2014. After discharge, he preferred a claim for Rs.1,18,034/-

towards treatment expenses and out of which Rs.13,680/- was deducted and balance amount was paid on the ground that no detail of hospital charges were given, while he had furnished all the informstions.

FINDINGS & DECISION:

I have gone through the material placed on the record and submission made on behalf of respondent. It is apparent from the record that the claim was processed regarding deduction of amount as claimed by the complainant and respondent have paid balance amount Rs.13,680/- to the complainant through NEFT and the complainant has also sent a letter to dismiss his complaint as the claimed amount has been paid by the respondent to him. In these circumstances, the complaint is liable for dismissal. Hence, the complaint stands dismissed.

.....

Mr. Pradeep Surena.....Complainant

V/s

Apollo Munich Health Insurance Co.Ltd.....Respondent

Order No.IO/BHP/A/GI/0040/2015-2016 Case No. BHP-G-003-1516-0017

Dated at Bhopal on 17th day of September,2015

Award

Brief Background:

Complainant sustained Gun Shot injury while attending marriage ceremony. and he got admitted at the Artemis Hospital, Gurgaon to cure from fracture due to accidental injury. the company rejected his cashless claim request on the ground of non disclosure of hypertension. his injury was mere an accident and it has nothing to do with hypertension but his claim was not settled on the ground of having hypertension.

FINDINGS & DECISION:

The discharge summary clearly shows that treatment was given only towards fracture shaft humerus with a butterfly fragment on account of history of gunshot injury while attending marriage ceremony and not for ailment of HTN and DM-II. No doubt, Under the aforesaid facts, circumstances, material on record and submissions made, I am of the considered view that the decision of the respondent company to repudiate the claim on the ground of non disclosure of ailment of HTN/DM is not justified and is not sustainable. Hence the complainant is entitled to get the admissible amount towards treatment cost within the limit of amount of sum insured under the policy document.

Hence, In the result the complaint is allowed with the above observation.

Mr. R.C. Tripathi…… ……Complainant

V/s

Oriental Insurance Co. Ltd. ……Respondent

Order No. IO/BHP/R/GI/0045/2015-2016 Case No. BHP-G-050-1516-0073

Dated at Indore on 24th day of September, 2015

Recommendation Order

Brief Background:

The complainant had taken Bhavishya Arogya Policy bearing policy. for sum insured of Rs.50,000/- for life time towards reimbursement of medical expenses up to Rs.50,000/- with the condition that the maximum

reimbursement in any single claim will be limited to Rs.20,000/- which was issued by the respondent company. He submitted a bill for reimbursement of Rs. 20,000/- on 14.04.2012 against the actual expenditure of Rs. 22,500/- on operation but payment of the same has not been made by the respondent company.

For the sake of natural justice, hearing held today dated 24/09/2015 at Indore Camp office During course of mediation, both the parties filed joint application (Mediation Agreement) duly signed by the complainant and the representative of respondent mentioning therein about settlement of the case willingly and mutually and agreed to settle the subject matter of complaint as follows:-

The respondent Oriental Insurance Company Ltd. is agreed to pay Rs. 20,000/-only towards treatment expenses to the complainant under the Bhavishya Arogya Policy no. 152901/94/0000/000024. The complainant has also agreed for the same.

The respondent Oriental Insurance Company Ltd. is directed to pay Rs. 20,000/-. In the result complaint is allowed.

Mr. Sandeep Rathi.....Complainant

V/s

National Insurance Co. Ltd.....Respondent

Order No.: IO/BHP/A/GI/0039/2015-2016 Case No.: BHP-G-048 - 1516 -0013

Dated at Bhopal on 17th day of September,2015.

Award

Brief Background

The complainant had taken Mediclaim Policy from the respondent. his minor daughter was suffering from congenital malformation of spinal cord, she underwent dithering of cord surgery (spinal deformity) at Heera Mongi Hospital, Mumbai during hospitalization complainant lodged claim before the respondent company for reimbursement of Rs.1,60,496/- towards medical expenses for treatment. the respondent company/TPA deducted Rs.66,113/- under various heads,

Findings & Decision:

The pediatric Neurosurgeon Dr.Naresh Biyani has clearly mentioned in his letter dated 14.03.2014 that his charges of Rs.40,000/- as mentioned in the bill no. 1055872 dated 15.11.2013 of the said hospital have been charged by the hospital for the specialized micro neuro surgical instrument which was brought by him. No doubt, it was a complicated pediatric surgery which was performed with the aid of said instrument costing Rs.40,000/- and as per policy terms & conditions the above surgical appliance is a separate item which has not been included in the O.T.

Charges, so the deductions made towards said instrument by the respondent is totally improper and unreasonable and not justified. the respondent is liable to make payment of Rs.40,000/- only towards charges of the said specialized instrument which was used for dithering of cord surgery of the complainant's minor daughter.

Hence, in the result complaint is allowed in part.

BHUBANESWAR OMBUDSMAN CENTER
COMPLAINT NO- BHU-G-050-1415-0037
Sri Niranjan Kar
Vrs
Oriental Insurance Co. Ltd., Bhubaneswar
Award Dated 17th Day of Apr., 2015

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

In brief, the case of the Complainant is that he took Individual Mediclaim Policy from the OP for himself and his wife and during the policy period the Complainant consulted the doctor with complains of pain in left shoulder since one week. The doctor advised for x-ray and MR scan of left shoulder and prescribed some medicines. After the treatment, he lodged a claim with the OP for Rs.7680/- for reimbursement. But the OP rejected his claim stating that the claim was related to OPD treatment and as per clause 2.3 of the policy the claim was not admissible as there was no hospitalization for the minimum period of 24 hours. So the Complainant approached this Forum for redressal.

The OP files SCN stating that the Complainant had taken a Mediclaim policy for himself and his wife since six years and renewing it every year. The Complainant had requested for reimbursement of a claim relating to the treatment of severely strained left shoulder without any need for hospitalization. As per policy condition no. 2.3, expenses on hospitalization are admissible only if hospitalization is for a minimum period of 24 hours with some exceptions as per sub head A, B and C.

At the time of hearing before this forum the Complainant appears and states that he suffered a severe tendon rupture on the left shoulder and went through the process of treatment including MRI. The expenses incurred for the treatment was approximately Rs.7,000/-. The Insurer declined the claim citing policy condition. However, he feels that this claim can be considered without hospitalization under clause no. 2.3(C). The representative of the OP submitted that the TPA has processed the claim and company agrees with the decision taken by it. The office has communicated the Complainant that the claim was not payable.

The contention of the OP is that the claim is inadmissible as per the

policy condition no. 2.3 which mandates 24 hours hospitalization with certain exceptions as noted under sub head A to C. The Complainant states that the claim can be considered under the exceptions granted under clause 2.3(C) of the policy. Photocopy of the Mediclaim Insurance Policy (Individuals) is readily available in the file. As per the policy the liability of the company arises in case of expenses incurred towards hospitalization and domiciliary hospitalization only upon the advice of the treating doctor.

Clause 2.3 (C) of the policy states the conditions when the minimum 24 hours hospitalization will not apply and a claim to come under this clause, the requirement is that there should be a need for hospitalization but due to technological advances its hospitalization is required for less than 24 hours.

Copies of the treatment papers as available have been examined. The patient was diagnosed to have ligament tear. The treating doctor has advised for X-ray and MR scan of left shoulder and subsequently advised for some medicines and shoulder muscle strengthening exercises. No where the doctor has advised for hospitalization or requirement for hospitalization. The treatment was purely on out- patient basis which does not come under the scope of the policy. In such circumstances, the claim of the Complainant is not maintainable. The Complainant's contention that his claim falls under clause 2.3 (c) is not substantiated by the policy conditions. Hence there is no need to interfere with the decision of the OP the complaint being devoid of any merit is dismissed.

BHUBANESWAR OMBUDSMAN CENTER
COMPLAINT NO- BHU-G-051-1415-0076
Sri Soumyajit Majumdar
Vrs
The Unitd India Insurance Co. Ltd., Bhubaneswar
Award Dated 20th Day of Apr., 2015

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

The case of the Complainant in short is that he has taken the mediclaim policy since 2005 and renewing it continuously with the OP. The Complainant was diagnosed with morbid obesity associated with HTN and type II diabetes and was advised metabolic surgery. As it was life threatening, he rushed to ILS Hospital, Kolkata for the surgery and incurred an expenditure of Rs.2,60,804/-. He lodged a claim with the TPA after the treatment but his claim was rejected stating that the claim is non-admissible under clause no.4.6 of the policy. As his representation to the OP, yielded no result, the Complainant approached this forum for redressal of his grievance.

The OP files SCN stating that the Complainant was covered under Individual Health Insurance Policy (Platinum policy). He was admitted to Hospital with a complain of gradually increasing body weight for 7 years and treated for morbid obesity. The claim was repudiated as per exclusion no. 4.6 which specifically excludes obesity treatment and its complications

including morbid obesity.

At the time of hearing the Complainant appears and submits that his claim for hospitalization expenses has not been paid under the pretext that the claim does not fall within the scope of the policy. He was hospitalized as he was suffering from type II diabetes, hypertension in addition to morbid obesity. The representative of the OP appears and submits that the claim has not been paid as morbid obesity which is the diagnosis as per the Discharge certificate and for which the hospitalization took place, is excluded from the scope of the policy.

Copies of the Discharge Certificate and certificate of the surgeon have been filed by the Complainant. In the Discharge Certificate, the Final diagnosis made by the doctor is Morbid obesity. The co-morbities are HTN+DM+Dyslipidemia. The patient was admitted with complain of gradually increasing body weight for 7 years. Certificate of the attending surgeon Dr. Om Tantia clearly states that the patient was suffering from Morbid obesity and advised for metabolic surgery to control DM, HTN and Dyslipdemia. Clause no. 4 of the policy speaks about the Exclusions under the policy and specifies the expenses disallowed by the company. Clause no. 4.6 specifically excludes obesity treatment and its complications including morbid obesity. Complainant has undergone treatment for morbid obesity and its related complications which are clearly excluded in the policy. Thus the Complainant is not entitled for the claim. Hence there is no need to interfere with the decision of the OP that the complaint being devoid of any merit is dismissed.

BHUBANESWAR OMBUDSMAN CENTER
COMPLAINT NO- BHU-G-049-1415-0083
Sri Chittaranjan Pal
Vrs
The New India Assurance Co. Ltd., Cuttack
Award Dated 22nd Day of Apr., 2015

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

In brief, the case of the Complainant is that he was covered under a Mediclaim policy for a sum insured of Rs.2,00,000/- with accrued bonus amount of Rs. 1,00,000/-. Suddenly he developed heart problem and treated with implant of a pacemaker and he incurred an expenditure of Rs.2,25,000/-. TPA allowed Rs.1,45,000/- as cash less settlement with the hospital. Complainant paid the balance amount of Rs.80,000/- and approached this forum for a direction to the company to allow the balance amount along with cost and compensation for the arbitrary action of the OP.

The OP files SCN stating that the complainant's claim was settled on cash less basis for Rs.1,45,000/- during hospitalization and for balance amount of claim he did not lodge any claim for reimbursement and filed a complaint with Hon'ble Ombudsman directly. After receiving the copy of the petition from Ombudsman office, claim documents were asked for and

on receipt of those documents the claim was subsequently settled for Rs. 52,917/- as per the terms and conditions of the policy. Thus a total amount of Rs.1,97,917/- was paid to the claimant. The deductions were made towards excess room rent and other heads as per terms of the policy.

At the time of hearing the Complainant submits that his claim was within the sum insured available to him and still the company withheld Rs.27,083/- arbitrarily. According to the representative of the OP, the claim has been settled after deducting the excess amount spent on room rent beyond the eligible limit and submitted the policy document and the calculation sheet as submitted by the TPA showing deductions under different heads. The calculation sheet shows the hospital has charged Rs.3300/- per day for room rent while the Complainant was entitled for Rs.2,000/- per day being 1% of the sum insured. The doctor's fees and OT & Investigation expenses amount to Rs.24,575/- and Rs.68,910/- respectively as per the bill and the deductions made are Rs.5,898/- and Rs.16,538/- with a remark 'as per entitled room category'. The non-medical expenses totals to Rs. 747/-.

As per the photocopies of the medical bills, hospital has charged Rs.3300/- only for bed charges for three days. The OP has simply forwarded the TPA's letter and not explained how it has calculated the Room rent, doctor's fees and OT & investigation charges to arrive at Rs.9900/-, Rs.24575 and Rs.68,910/- respectively as the bill shows different figures. The OP has not cited any policy conditions/clauses in support of such deductions/calculations.

The clause 3 of the policy T&C states how much is payable. Below the sub head of clause 3.1(d) the policy declares that reimbursement of room rent, boarding and nursing expenses shall not exceed 1% of the sum insured per day. In case of admission to ICU or ICCU, reimbursement or payment of such expenses shall not exceed 2% of the sum insured per day. In case of admission to a room /ICU/ICCU at rates exceeding the aforesaid limits, the reimbursement/payment of all other expenses incurred at the hospital, with the exception of cost of medicine, shall be effected in the same proportions as the admissible rate per day bears to the actual rate per day of Room Rent/ICU/ICCU charges. As observed above the room rent as per the hospital bill is Rs.3300/- only for 3 days. Thus per day room charge is Rs.1100/- only which is well within the Complainant's entitled room category of Rs.2000/- per day. As the room rent is within the limit, the Complainant is entitled to get the full amount of claim towards doctor's fees and OT & investigation charges excluding the non-medical items worth Rs.747/-. Hence the Complainant is entitled to the balance amount of Rs. 26336/- . The complaint is allowed in part. The OP is hereby directed to pay Rs. 26336/- without any delay.

BHUBANESWAR OMBUDSMAN CENTER
COMPLAINT NO- BHU-G-052-1415-0014
Subrat Kumar Behura
Vrs
Universal Sompo Gen. Ins. Co. Ltd., Mumbai
Award Dated 27th Day of Apr., 2015

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

The case of the Complainant in short is that he has taken IOB Health Care plus Policy from the OP through his Banker. During the policy period, he underwent Gall Blader stone operation and preferred a Claim by enclosing the medical bills. After may follow ups, he was informed that the claim was rejected on the ground that the treatment was taken for "CHOLELITHIASIS" which has a waiting period of one year from inception of policy as per policy exclusions. He wrote to the OP for reconsideration of his case but did not receive any response. Hence, he approached this forum.

The OP files SCN stating that the Complainant was admitted to hospital for treatment of cholelithiasis (presence of gallstones in the gallbladder) and undergone laparoscopic cholecystectomy. However, the disease falls under Exclusion-2 of the policy terms and conditions which provides that hospitalization expenses incurred during the first year of the policy for this disease is not covered. Since the treatment was availed within 1st year of the inception of the policy, the claim was repudiated under intimation to the Complainant.

Despite notice, the OP did not appear for the hearing. The Complainant appeared in person and stated what he has averred in his complaint petition. He further added that the Insurance company officials came down from their Head Office for a discussion with him and the Bank and assured some sort of settlement for a solution, which was followed up by the Bank Manager. He further stated that he had not received the policy and its terms and conditions and therefore, not aware of those terms and

conditions. He has received only the smart card.

Under the head Coverage of the terms and conditions of IOB Health care Policy, a list of items are given under the sub heading 'what we cover' and 'what we exclude'. Clause no.2 under the sub heading 'What we exclude' gives a list of diseases excluded in the first year of operation of the insurance. The said list includes 'stone in the urinary and biliary system'. The Complainant was hospitalized within the 1st year of the policy for removal of stone in the billiary system. As this clearly falls in the exclusion clause, he is not entitled to get the claim. Hence it is ordered that the complaint being devoid of any merit is dismissed.

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BHUBANESWAR OMBUDSMAN CENTER
COMPLAINT NO- BHU-G-012-1415-0023
Sri Jugal Kishore More
Vrs
Chola Mandalam MS GI Co. Ltd.
Award Dated 29th Day of Apr., 2015

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

In short, the case of the Complainant is that he took a health insurance policy from the OP covering himself and his wife and got it renewed. After 9 months of the first policy, the Complainant felt pain in his knee and consulted the doctor and as per his advice took medicines. As his pain persisted, he consulted his family doctor who advised him to get treated at Shalby Hospital, Ahemedabad. At the Shalby hospital, he was diagnosed with osteoarthritis and advised for Total Knee Replacement surgery. For the surgery he was hospitalized from 03.08.2011 to 10.08.2011 and incurred an expenditure of Rs. 2,58,342/- and lodged a claim with the OP for reimbursement of the medical expenses. But the OP repudiated his claim under pre-existing clause. Since osteoarthritis was not a pre-existing disease /condition with him as per the definition given in the policy, he requested the OP to reconsider his claim but the OP did not take any action on his request. Being aggrieved, he approached this forum.

The OP files SCN stating that a claim was made against hospitalization for osteoarthritis and on perusal of the claim documents it was found that the Complainant had history of bilateral lower limb elephantiasis since 20 years and left leg ulcer since 1 ½ years. The prescription dated 27.01.2011 confirms that Complainant is a known case of bilateral gross osteoarthritis which is a long standing advanced

condition and takes several years to progress to the present stage which is medically termed as Chronic Degenerative Disease of Knee Joints. The expert opinion was sought from an orthopedic surgeon who opined (after perusing the medical records of the Complainant) that the approximate duration of progression of the disease to the present stage will be about 2-3 years. Basing on the expert opinion, the claim was repudiated considering the existence of the disease since 2/3 years as per the exclusion clause C-1 which states that no indemnity is available for pre-existing diseases until 24 months of coverage of the insured person have elapsed, since inception of the first policy.

At the time of hearing before this forum the Complainant appears and states that he took the policy through the Indus Ind Bank which has tie-up with Cholamandalam MS GI Company. Before undergoing the surgery, he had informed the bank in writing and he was told orally that he can go ahead with it. But he was not paid the claim on the ground that the disease was pre-existing. However, this condition was not pre-existing as he had not taken any treatment, care or medicine for osteoarthritis prior to taking the policy. Even the policy condition does not specifically exclude knee replacement and hence he is entitled for the claim. The representative of the OP submits that the claim has been repudiated under the Exclusion clause, sub clause (a) which deals with pre-existing disease. As per the opinion of its panel of doctors, the treatment for the disease osteoarthritis is already a pre-existing condition and therefore, not payable as per the terms and conditions of the policy.

The OP has filed a copy of the orthopedics opinion of doctor who has certified "on perusing the records" that the approximate duration of gross osteoarthritis progress to present stage will be about 2-3 years". The opining doctor has not examined the patient in person. Based only on the medical records of the Complainant, he has given his view that the approximate duration is 2-3 years. The Discharge Summary of Shalby Ltd. does not state specifically about the duration of onset of osteoarthritis for which the surgery was done. OP's contention is that from the prescription dated 27.01.2011, it is confirmed that the Complainant is a known case of bilateral gross osteoarthritis, which is a longstanding advanced condition and takes several years to progress to the present stage. A copy of the said prescription is filed by the Complainant. Though the said prescription diagnosed the disease as gross osteoarthritis, no such comments that "the disease is a longstanding advanced one and takes several years to progress to the present stage", finds mention. Definitely this is the opinion of the OP. Nowhere in the prescription, the duration of the disease is mentioned. No other foolproof document is submitted by the OP to justify its action of repudiation of the claim as pre-existing. As the pre-existing exclusion clause is not applicable, the OP is liable to pay the claim. Hence it is ordered that the complaint is allowed. The OP is hereby directed to settle the claim of the Complainant without any delay.

BHUBANESWAR OMBUDSMAN CENTER

COMPLAINT NO- BHU-G-044-1415-0060

Sri Pradeep Kumar Mohapatra

Vrs

Star Health & Allied Insurance Co. Ltd., Bhubaneswar

Award Dated 04th Day of May, 2015

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

The case of the Complainant is that he took a health insurance policy from the OP for his family. During the second year of the policy, experiencing difficulty in breathing and anticipating any cardiac problem, the Complainant consulted doctors who advised him to go for Septoplasty + FESS immediately. The Complainant got admitted to Kalinga Hospital, Bhubaneswar and incurred an expenditure of Rs. 42,973/- for his treatment. He filed a claim after his discharge but the OP repudiated the same on the ground of pre-existing disease basing on the case history and ignoring the treating doctor's prescription. Being aggrieved, he filed this complaint.

The OP files SCN stating that as per Case History, "insured patient is a known case of type 2 diabetes Mellitus since 1 year/ presented with nasal blockage since 2 years". The claim was during the 2nd year of the policy; cashless treatment as well as reimbursement was denied as the Complainant underwent septoplasty for correction of DNS with chronic sinusitis which he was suffering before the inception of the policy. As per the Exclusion no. 1 of the policy the company shall not be liable to make any payments for pre-existing diseases until the expiry of 48 months of continuous coverage with the company.

At the time of hearing before this forum both the parties appear and state what is already averred in the complaint and SCN respectively. The Complainant further adds that the company has connived with the hospital, obtained documents from them and taken the decision which is based purely on the Case History by ignoring his treating doctor's prescription which is not justified. The doctor who has prepared the case history has neither examined him nor had seen him.

Admittedly the policy is running in its 2nd year. In the prescription dated 25.04.2014, the doctor has noted that the patient has a complaint of nasal blockage, headache, sneezing since '1yr'. Discharge summary dated 27.04.2014 reveals the clinical summary as "C/o- Headache, 1 year, H/O Nasal obstruction 1 year". These two documents show that Complainant was suffering from the disease since 1 year. But the case history submitted by the Complainant as well as the OP reveals that the patient is "a k/c/o T 2 diabetes since 1 year presented with nasal blockage since 2 years". So these documents are conflicting. In copy of prescription of doctor in his letter head Sai Bone & Joint Clinic and the out-patient card of first consultation, the duration of the disease is not specified.

The case history is the medical record which is maintained by a staff of the hospital by asking questions to the patient or a person who is aware about the medical condition of the patient at the time of admission. This is the first testimony given by the patient or his representative. The prescription of treating doctor on the pad of Kalinga Hospital is not his first prescription as the patient had consulted him on 24.04.2014 at his clinic "Sai Bone & Joint Clinic". The Discharge Summary was issued on 27.04.2014. The Complainant has accused that the OP has connived with the hospital authorities in manipulating the case history. But the case history was sent to the OP by the Complainant himself along with all other claim document. No evidence was presented by the Complainant that he had objected to the notings in the case history to the hospital authorities if it were wrong. The Complainant's accusation that OP has connived with the hospital is not acceptable. Hence the case history being the first recorded document is relied upon which records the presence of the symptom/disease for past 2 years. Therefore, the OP is not liable to pay the claim as the disease is pre-existing and falls under exclusion 1 of the policy condition. Hence it is ordered that the complaint being devoid of any merit is dismissed.

BHUBANESWAR OMBUDSMAN CENTER
COMPLAINT NO- BHU-G-038-1415-0010
Smt. Bandana Panda
Vrs
Royal Sundaram Alliance Insurance Co. Ltd., Chennai
Award Dated 5th Day of May, 2015

This is a complaint filed by the Complainant against repudiation of health claim by the OP- Insurer.

Brief case of the Complainant is that she was insured under a health policy issued by the OP and was hospitalized at M/S Panda Nursing Home, Dhenkanal for 10days for treatment. The disease was diagnosed as Complicated Malaria. Immediately after hospitalization, her husband intimated the insurer. She lodged a claim for Rs.47592/- by submitting all documents after discharge from the nursing home. The insurer repudiated her claim stating the same as a fraudulent one and threatened to cancel the policy. She made a representation for reconsideration but the OP stuck to its stand. So she approached this forum by lodging this complaint.

The OP files SCN stating that on getting claim intimation an Investigator was appointed to ascertain the veracity of the claim who on his first visit to hospital observed that the nursing home did not have any doctor, patients, chemist shop, ICU facility and laboratory. The Inpatient register was also not shown to him. All the indoor case papers were written in one go. Again the complainant also preferred to go to M/S Panda Nursing Home, Dhenkanal skipping Govt Hospital of Dhenkanal which does not happen in case of any emergency and thus he had concluded that it is a fraudulent case. They have also stated that due to repeated fraudulent claims made by the complainant they have repudiated the claim apart from

cancelling the policy as the complainant has tried to manipulate the medical records.

At the time of hearing before this forum the Complainant appeared personally and stated that she was taken to hospital when she was unconscious and during the course of her treatment several tests were conducted in the hospital. She was not taken out of hospital for any test and during her hospitalisation she was treated by 2/3 doctors. According to the representative of the OP, the claim was repudiated on the findings of the Investigator and averred what is already stated in their SCN further adding that the daily treatment record appears to have been written in one go by same person on a particular day and bears a particular date on each page raising doubt about their authenticity.

On a careful scrutiny of the photocopy of in-patient register, it is found that the name of Complainant's wife appears there and her date of admission and other details are as per the claim made by the Complainant. Record lacks any material to the effect that this in-patient register was not made available to the investigator at the time of his first visit. Since the said register obviously remains in the custody of the hospital authorities, the practice of fraud by the Complainant as alleged by the OP does not stand to reason. Moreover, in the Investigation Report, the portion meant for fraud and misrepresentation related column, is marked as 'NA'. The Investigator has nowhere written that it is a fraud claim. Absence of any in-patients, doctors, ICU at first visit of the investigator, does not prove any fraudulent act by the claimant. The Discharge Summary reveals that the patient was admitted in the nursing home with fever and chill & rigor with profuse vomiting with altered unconsciousness and no discrepancy in the papers are found. The OP's contention that the mention of one particular day, i.e. 08.10.2013 on each page of daily treatment record is doubtful does not stand as the date is preceded by the registration number of the patient. The registration no. is 52 dt. 8.10.13, which is recorded on each page. However, on the of X-ray, USG and ECG report, remarks were given that the tests were done outside and the patient was charged accordingly. For these tests the nursing home has charged in its own bill which is unlikely to happen. The bills and the reports should belong to the laboratory where these tests were done. Moreover, the Complainant has not furnished the reports for the said investigations and in her submission has stated that she had not gone out for any tests. As discussed above the entire event of hospitalization, the manner of keeping records, the billing for tests/investigations done outside the hospital raises many questions but the case of claim being a total fraud is not proved absolutely as the OP has not produced concrete evidence to establish the same. Therefore, the OP is liable to pay the reasonable hospitalization expenses incurred by the Complainant, as per the terms and conditions of the policy. However, the expenses claimed towards reimbursement of the investigations i.e. X-ray, ECG and USG, are not payable as discussed above. Hence it is ordered that the complaint is allowed in part. The OP is hereby directed to settle the claim of the Complainant without any delay.

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BHUBANESWAR OMBUDSMAN CENTER

COMPLAINT NO- BHU-G-048-1415-0123

Shri Subrat Ranjan Das

Vrs

National Insurance Co. Ltd., Bhubaneswar DO II

Award Dated 8th Day of June, 2015

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

Brief case of the Complainant is that he has taken an Individual Mediclaim Policy covering his mother who passed away after prolonged illness. He submitted the hospital and medicine bills and money receipts for an amount of Rs.37,820/- to the TPA for reimbursement. But it did not settle the claim in spite of continuous follow up. At last the TPA sent a Discharge Voucher settling the claim for Rs. 8006/- along with the reasons for deductions made from the claim but the Complainant refused to accept the same and complained to the OP because of the discrepancies. As the claim is still lying pending without any reconsideration, the aggrieved Complainant approached this forum for redressal.

The OP files SCN stating that as reported by the TPA, nowhere in the claim file / letter, it was mentioned that the patient had died at Neelachal Hospital. Further no Discharge Certificate/Death Summary or certificate was submitted in support of the death of Complainant's mother at the said hospital. In absence of such document, it was not possible to presume the death of the patient. As such it was taken as hospitalization for less than 24 hours which was not payable as per terms and conditions of the policy. Ambulance charge is payable in case the patient is shifted from residence to hospital or one hospital to another and admitted in ICU. Since the Ambulance bill does not bear the name of any hospital or organization, it was not considered. There is no prescription for Tegaderm charges and no specific mention is there in the policy condition, hence not allowed. The Complainant could not give the details of medicine charges for Rs. 8,100/- raised in bill no. 13778, dated 16.01.2013 of M/S Sun Flower Nursing Home provided by Deepak Medicine Store as mentioned in the said bill. For reimbursement under Mediclaim, original bills and money receipts are required not the carbon copy or duplicate. Considering all the above aspects the claim was decided.

At the time of hearing the Complainant appears and submits that the claim has been grossly reduced and the TPA has not asked for the Death Summary/Certificate. All other documents/bills have been submitted to the TPA. No copies of the claim papers are available with him. He reiterates that he is entitled for the full amount of Rs. 37820/-. The representative of the OP appears and admits that the TPA has not called for the Death Summary. The claim was assessed based on the bills submitted by the Complainant and after deduction of Rs.8100/- which the insured had agreed to.

Neither parties have filed the Treatment papers, Bills and Money

Receipts, Policy terms and conditions, Death/Discharge Certificate and in absence of these vital documents it is not possible to decide the quantum of the claim and points raised by both the parties.

The OP has submitted that the claim pertaining to Neelachal Hospital was denied as no Death Certificate/ Death Summary issued by the said hospital, was produced by the Complainant and the claim was considered as less than 24 hours hospitalization. Secondly, the Complainant's contention that Kalinga Hospital has provided only a carbon copy towards the Money Receipt for Rs.2,700/-, is not acceptable. For claiming reimbursement original money receipt needs to be submitted. Hence the Complainant is directed to submit the Death Summary issued by the Neelachal Hospital evidencing death of the patient at the hospital and the original Money Receipt of Kalinga Hospital and the OP has to consider the claim on that basis. The complaint is allowed in part. In case the complainant fails to submit either of the document to the OP, the claim would be decided by the OP accordingly but without any delay.

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BHUBANESWAR OMBUDSMAN CENTER

COMPLAINT NO- BHU-G-037-1415-0143

Sri Saroj Kumar Nath

Vrs

Religare Health Insurance Company Ltd., Bhubaneswar

Award Dated 23rd Day of June, 2015

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

The case of the Complainant is that he took a health insurance policy from the OP and in the second year of the policy, he lodged a claim for hospitalization. But the OP repudiated his claim for non–disclosure of pre-existing diseases and cancelled the policy. Since the Complainant has incurred an expenditure for his treatment, he approached this forum for payment of his legitimate claim.

The OP files SCN stating that the Complainant lodged a claim in the 2nd yr of taking the policy. Upon receiving of the cashless request, the company noted that the Complainant had a past history of diabetes mellitus, hypertension and critical kidney disease (CKD). The pre-authorization form clearly mentions the existence of diabetes and hypertension for the last 1 & 1/2 years. The Case Sheet and other documents reveal that the Complainant is a known case of diabetes (for 4 years), hypertension and CKD. On the basis of these confirmed history of pre-existing diseases, the cashless authorization was declined and policy was cancelled in accordance with the clause no.6.1 of the policy i.e. Disclosure to Information Norms. Neither in the initial policy nor in the renewal policy, the Complainant declared the pre-existing diseases.

At the time of hearing before this forum both the parties appear and averred what is already stated in the complaint and SCN respectively.

On a careful observation of the Request Form for cashless treatment, the question "Is the present illness related to a complication of any pre-existing illness or previous medical treatment" is answered as, Diabetes- Yes, since 1 ½ years, Hypertension- Yes, since 1 ½ years. The said request was denied by the OP on the ground of pre-existing disease of DM & HTN since 1 ½ years. The OPD prescription of Ayush Hospital clearly shows k/c/o HTN, CKD, Type II diabetes on regular hemodialyilis. The Case Sheet of Ayush Hospital gives a noting that k/c/o of DM from 4 years. The out-patient prescription of Kalinga Hospital support the pre-existing diseases of diabetes, HTN and CKD and had advised for immediate dialysis in view of the deteriorating clinical condition.

In the photocopy of the Proposal Form, the Complainant has mentioned the existence of any disease in negative. At the time of renewal of the policy, the Complainant has not declared the change in his health status and requested for increase in sum insured to Rs.10,00,000/- for insurance of himself. In the Medical Examination Report the Complainant has declared in negative regarding the existence of Cardiovascular & Circulatory System, Endocrine Glands & Exocrine glands and Urinary system although he is getting treated for HTN, diabetes and CKD. From these documents it is crystal clear that there has been deliberate misrepresentation and non-disclosure of material facts on the part of the Complainant. Therefore, the OP is not liable to pay the claim as the disease is pre-existing and falls under exclusion 4.1 c of the policy condition. As per the declaration clause (d) given in the Proposal Form and clause 6.1 of the Terms & Conditions of the policy, the policy shall be void at the option of the company and all premiums forfeited. So cancellation of the policy cannot be faulted with. Hence it is ordered that the complaint being devoid of any merit is dismissed.

BHUBANESWAR OMBUDSMAN CENTER

COMPLAINT NO- BHU-G-047-1415-0133

Sri Bijay Ketan Mishra

Vrs

Tata AIG General Insurance Company Ltd.

Award Dated 7th Day of July, 2015

This is a complaint filed by the Complainant against repudiation of health claim by the OP- Insurer.

The case of the Complainant is that he took a health insurance policy and renewed it for 2014-2015 during which period he was admitted to Aditya Care Hospital for chest pain where the doctors diagnosed the disease as CAD and UA. During hospitalization the Complainant applied for cashless facility which was denied by the OP. Therefore, on discharge he lodged a claim for reimbursement of hospitalization expenses. But the OP repudiated his claim on the ground of non-disclosure of pre-existing diseases i.e. diabetes and hypertension. The complainant represented to the Grievance Cell of the OP that as per the admission (on 17.08.2014) papers he was suffering from DM/HTN since 1 year which means the occurrence of these diseases is very well after the inception of the first policy and therefore there is no question of suppression of information on pre-existing diseases. Being denied by the Grievance Cell of the OP he approached this forum for redress of his grievance.

The OP files SCN stating that as past medical records were not received from the hospital, cashless authorization was denied. The Complainant approached the TPA for reimbursement of the expenses by submitting the documents. From the documents submitted by the Complainant, it was noted that the insured was under treatment for hypertension and diabetes prior to the inception of the policy. As per the consultation paper by Dr. S.K. Jangid of Sparsh Hospitals & Critical Care, it can be implied that the Complainant had these pre-existing ailments prior to the inception of the policy. On scrutiny of the Proposal Form it transpired that the Complainant has not disclosed the past medical history despite specific questions in it. In view of the same, the policy was terminated and the claim was repudiated on grounds of non-disclosure of material facts under intimation to complainant.

At the time of hearing before this forum the Complainant appears and states that his claim has been rejected by the insurance company on the basis of a copy of prescription of Dr. S.K. Jangid of Sparsh Hospital, Bhubaneswar which was apparently submitted through Aditya Care Hospital which appears to be a manipulated document. Since the basis of

repudiation is a manipulated document, his claim should be paid. He undertook to produce the OPD number of that period by the next day. According to the representative of the OP the claim has been repudiated since the case is a clear case of pre-existing disease as evidenced by the copy of prescription of the treating doctor and undertook to confirm and submit the source of the said copy within 7 days time.

As observed the only point of dispute is that whether the diseases HTN and DM are pre-existing at the time of taking the policy which will decide the fate of the case. The OP has relied upon one prescription dated 20.05.2013 by Dr. S.K. Jangid of Sparsh Hospitals & Critical Care(P) Ltd., Bhubaneswar in the name of Bijay Ketan Mishra in which it is stated " DM/HTN – 6 months" which the Complainant is claiming as a fake and fabricated one which was never submitted by him. At the time of hearing the Complainant undertakes to produce the OPD number at Sparsh Hospital during the related treatment period and the OP submits to give the source of the prescription received and relied upon by it.

The Complainant submits a letter dated 25.06.2015 stating that he tried to locate the missing medical papers but could not find the same. However he encloses photocopies of the alleged prescription dated 20.05.2013, the certificate of Dr. Sanjay Kumar Jangid dated 19.08.2014 and his present prescription dated 22.06.2015 by the same doctor of Sparsh Hospital to establish that the design and get up of the alleged prescription is different and the signature of the doctor is also not matching. On the other hand, the OP by its letter dated 30.06.2015 states that the documents of Sparsh Hospital were received at the time of cashless request by the TPA through the hospital. The document was submitted by the insured to the hospital and the hospital faxed that to the TPA for processing the cashless authorization.

Evidently the Complainant has failed to produce the OPD number of the Sparsh Hospital for the stated period. But from the records it is found that the Complainant has written to the Manager (Claims) of the OP vide his letter dated 02.09.2014 that he is submitting the claim form, a certificate from Dr. S.K. Jangid of Sparsh Hospital and other documents from Aditya Care Hospital, Bhubaneswar. The documents of Sparsh Hospital were misplaced by the Aditya Care Hosiptal Authorities during his shift from one bed to another and therefore he had to collect a certificate from Dr. Jangid. On a careful examination of the said certificate issued by Dr. Sanjay Kumar Jangid dated 19.08.2014 it was observed that Mr. Bijay Ketan Mishra was under his treatment for T2DM and hypertension since Sept 2013. The patient Admission Proforma and the Discharge Summary of Aditya Care Hospital mentions that "k/c of DM/HTN since 1 yr." All these documents indicate that the Complainant has suffered from the diseases of

hypertension and diabetes, after availing the policy and as such the diseases are not pre-existing to the policy.

On a careful examination of the statements by the OP regarding the source of the alleged prescription based on which the claim was repudiated, it is found that the statements are contradictory. In the SCN, the OP has stated that cashless authorization was denied to the Complainant as past medical records were not received by the TPA pertaining to hypertension, diabetes, heart disease and obesity suffered at the time of hospitalization. Hence the TPA called for the past medical records and since those were not received, the cashless request was rejected. Whereas in its present letter addressed to this forum, the OP has stated that the documents of Sparsh Hospital were received at the time of cashless request by the TPA through the hospital. The document was submitted by the insured to the hospital and the hospital faxed those to the TPA for processing cashless authorization. In view of these contradictory statements and also the forceful challenge of the veracity of the alleged prescription by the Complainant, I find that the decision taken by the OP cannot be sustained as the source of the main plank of their decision is shrouded in mystery. Hence it is ordered that the Complaint is allowed. The OP is hereby directed to settle the claim of the Complainant without any delay.

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BHUBANESWAR OMBUDSMAN CENTER
COMPLAINT NO- BHU-G-050-1516-0019
Sri Dilip Kumar Modi
Vrs
Oriental Insurance Co. Ltd., Cuttack Div. Office
Award Dated 20th Day of July, 2015

This is a complaint filed by the Complainant against repudiation of health claim by the OP- Insurer.

The case of the Complainant is that his son took a Happy Family Floater Policy from the OP and during the policy period the Complainant's granddaughter ate a naphthalene ball and was hospitalized at Surya Children's Medicare Pvt. Ltd., Mumbai. The concerned hospital advised treatment for more than 24 hours. But since the Complainant's son and his family were scheduled to travel to Canada next mid-night, the hospital was requested for earliest possible release without any danger to the health of the patient to which the hospital authorities obliged. However the hospitalization claim was rejected by the TPA and the OP on the ground of "hospitalization for less than 24 hours".

The OP files SCN stating that the policy issued stipulates vide its condition no. 2.3 under the heading "Hospitalization Period" that expenses on hospitalization is admissible only if hospitalization is for a minimum period of 24(twenty four) hours. However this condition can be relaxed only in case of specific treatment taken in the network hospital which are surgical procedures in a specialized centre. The child was hospitalized for less than 24 hours. As the requirement of minimum period of hospitalization under condition no. 2.3 of the policy was not satisfied, the claim for reimbursement of the hospitalization expenses was rejected.

At the time of hearing before this forum the Complainant appears and states that his granddaughter had accidentally swallowed a naphthalene ball and on doctor's advice was hospitalized for cleaning the stomach to avoid any poisonous effect. The hospital wanted to keep her under observation for at least 24 hours. However, since they had to leave for Canada, at their request, the hospital released her. Considering the circumstances, the claim should be settled. According to the representative of the OP the policy covers expenses incurred for hospitalization for a minimum period of 24 hours and since this period was less than the stipulated period, the claim was not paid.

From the Final Bill it is found that the baby was hospitalized for around 16 hours 20 minutes, i.e. less than 24 hours. Condition no.2.3 of the Policy Document clearly states that expenses on hospitalization are

admissible only if hospitalization is for a minimum period of 24 (twenty four) hours. Sub-clause A, B and C lay down the specific circumstances where this time limit will not apply. However the treatment of the insured is not coming under these exceptions allowed by the policy conditions. The terms and conditions of an insurance contract is binding on both the parties which have to be observed literally. As the minimum hospitalization period clause of the policy was not fulfilled, the Complainant is not entitled to get the claim. Hence it is ordered that the complaint is dismissed.
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BHUBANESWAR OMBUDSMAN CENTER
COMPLAINT NO- BHU-G-044-1516-0013
Mrs. Jyotirekha Patnaik
Vrs
Star & Allied Insurance Co. Ltd., Chennai
Award Dated 21st Day of July, 2015

This is a complaint filed by the Complainant against repudiation of health claim by the OP- Insurer.

The case of the Complainant in short is that she has taken a Senior Citizen Red Carpet Insurance Policy from the OP in the name of her mother-in-law for a sum insured of Rs.2,00,000/- and in the policy period from 08.03.2014 to 07.03.2015, her mother-in-law was hospitalized at KIIMS due to deficiency of salt and urine infection. The OP allowed Rs.10,000/- as cashless facility. But at the time of discharge, the OP asked for submission of previous records of RHD, AF and COPD which was not possible to submit at that point of time. So she has to pay the full amount and claimed for reimbursement. But her claim was repudiated by the OP stating that the disease AF was not disclosed at the time of taking the policy. However, the OP is well aware of the disease of AF as a claim was previously repudiated by it on the same ground in the year 2012 and the policy is renewed without break after that. She wrote to the Grievance Cell of the OP but the OP still denied the claim and cancelled the policy. Hence, the Complainant approached this forum objecting this unethical practice by the OP.

The OP files SCN stating that the insured was admitted at KIMS Hospital, Bhubaneswar and the diagnosis was Type II diabetes mellitus, Hypertension and Nephropathy. Initially the claim was rejected on the ground that the patient had heart disease (atrial fibrillation and shortness of breath) prior to the policy as revealed from the prescription dated 09.04.2008. On receipt of representation from the Complainant, the claim was considered after consultation with the specialists, for settlement under 50% co-payment as per terms & conditions of the policy for pre-existing disease since diabetes and hypertension was the disclosed pre-

existing diseases in the Proposal Form. The Claim has been settled for Rs.31,959/- against the submitted bill of Rs.78,474/- under 50% Co-payment as per terms & conditions of the policy.

Despite notice, the Complainant did not appear for the hearing. The representative of the OP appeared and submitted that the claim has already been paid and the policy has been reinstated.

The OP has submitted a calculation sheet showing the items allowed and disallowed with reasons. The OP has deducted Rs. 14,556/- with the remarks that HGT Iron profile, items like mask, cotton, diapers, needle, specican, gloves thermbophob, bed pan etc. and Invasive charges, Physio charges, HBA1C, thyroid panel, TSH and MRD etc. are not payable. Since the disease is pre-existing with the insured, there was a deduction of 50% from the admissible claim amount of Rs. 63,918/- as per Exclusion no.5 of the policy terms & conditions. At the time of hearing the OP's representative has stated that the cancelled policy has been reinstated. Since the OP has already settled the claim and reinstated the policy against which the complaint was filed, there is no need to go deep into the matter. Hence it is ordered that the complaint having already been redressed, is dismissed.

CHANDIGARH

CHANDIGARH OMBUDSMAN CENTER

CASE NO. CHD-G-050-1516-0340

Nikhil Garg Vs. Oriental Insurance Company Ltd.

ORDER DATED 09.09.2015 (Mediclaim)

FACTS: This complaint was filed against non-settlement of claim for treatment of malignant problem.

FINDINGS: During the course of hearing complainant stated that he is taking mediclaim policy of his mother since 02.08.2012 without any break. Unfortunately in 2014 his mother was diagnosed "T Cell Non Hodkin's Lymphoma-Stage-III for which she had to undergo sessions of Chemotherapy in PGIMER, Chandigarh. She was administered an injection-Rituximab. Its expenses of Rs. 39,250/- was denied by the Company.

During the hearing he clarified that owing to a problem of "Blood Cancer" a surgery was not conducted and cost of earlier five sessions of 'chemotherapy' was claimed under a health scheme of the employer and after exhaustion of limit the remaining amount was claimed under this policy. Company's representative stated that patient admitted and discharged on the same day and Rituximab/Ristova is not a 'chemotherapy' drug. The claim was denied as the hospitalization was less than 24 hrs otherwise treatment does not fall under list of exclusions/exceptions.

DECISION: Doctor has confirmed in writing that injection 'Rituximab' is an integral part of chemotherapy to treat blood cancer and Company's decision to reject the claim on the ground of admission less than 24 hrs is not justified. An award is given to settle the claim for reimbursement of admissible amount as per terms and conditions of the policy.

CHANDIGARH OMBUDSMAN CENTER

CASE NO. CHD-G-048-1516-0004

S. L. Sharma Vs. National Insurance Company

ORDER DATED: 01.06. 2015 (Medi-claim)

FACTS: This complaint was filed about denial of medi-claim insurance. The insured was obtaining insurance for the last more than 20 years and his premium cheque given against the policy for the period 29.06.2014 to 28.06.2015 was dishonored. But, despite the fact that he had approached the Company within two days with a demand draft for the insurance, he was denied policy by the Company.

FINDINGS: During the course of hearing, the complainant informed that he is a policy holder since 1985. On 29.06.2014, he had paid premium through a cheque to renew his policy, but as the cheque was returned un-paid by the bank, his policy was cancelled. Then, without losing time, he visited Company's office with a demand draft, but he was declined renewal insurance on the ground of excess permissible age limit. Thus, denial of insurance resulted in forfeiture of continuity benefits and cumulative bonus to him. On behalf of Company, it was stated that after the receipt of demand draft an attempt was made to enter details for a renewal insurance. Somehow, system rejected the same on the ground of insured's age beyond permissible age limit of 65 years.

DECISION: It was held that denial of renewal insurance was unjustified because the insured had approached Company within 30 days of grace period with a demand draft to ensure renewal insurance. Hence, Company

was asked to issue a policy from a fresh date against premium paid through demand draft by granting continuity and cumulative bonus benefits. However, it was held that that Company won't be liable for any claim falling in between the expiry date of last policy and the commencement of the fresh insurance.

CHANDIGARH OMBUDSMAN CENTER

CASE NO. CHD-G-051-1516-0156

Vijay Kumar Puri Vs. United India Insurance Company

ORDER DATED: 6th July, 2015
(Medi-claim)

FACTS: This complaint was filed about settlement of a hospitalization claim for an inadequate amount by the Company. The wife of the complainant was insured for Rs. 3,00,000/- under a policy for the year 2014-2015. She had undergone knee replacement surgery, which cost her Rs. 2,65,000/-, but Company settled its claim for Rs. 1,40,000/- only.

FINDINGS: During the course of hearing, the complainant informed that his wife had gone in for knee replacement surgery in Max Super Speciality Hospital, Mohali and a treatment cost of Rs.2,65,000/- was paid to the hospital. Despite, the fact that policy was for Rs. 3,00,000/-, its claim was paid for Rs. 1,40,000/- only. It was contended that even if the policy provided for 70% of available sum insured for a major surgery, a claim should have been settled for Rs. 2,10,000/ on the basis of available sum insured of Rs. 3,00,000/-. On behalf of Company, it was argued that insured had undertaken 'knee replacement' surgery that was about a degenerative/ progressive problem. Hence, benefit of enhanced sum

insured could not be given unless insured had 48 months of continuous insurance.

DECISION: It was held that decision of Company to settle a claim for Rs. 1,40,000/- is justified because treatment is about a degenerative problem, that takes long time to develop, whereas sum insured under the previous policies was on the lower side.

CHANDIGARH OMBUDSMAN CENTER

CASE NO. CHD-G-051-1516-0054

Anil Kumar Vs. United India Insurance Company

ORDER DATED: 6th July, 2015
(Medi-claim)

FACTS: This complaint was filed about denial of a hospitalization claim, wherein insured had sought reimbursement of Rs. 67,282/-, spent on the treatment of his wife, which was taken in a private hospital, in Gurgaon (Hry.). The claim was rejected by the Company on the ground of discrepancies in treatment record and doubts about the genuineness of the reported claim.

FINDINGS: During the course of hearing, the complainant informed that after experiencing a health problem, his wife was hospitalized in East West Medical Centre, Gurgaon and its claim was declined by the Company on the ground that hospital did not fulfill a criteria mentioned in the policy. He argued that an investigator deputed by the Company to verify facts from the hospital also recommended settlement of the claim and Company had already paid claims of other insureds about treatments taken in the same hospital. The representative of the Company informed that an investigation confirmed that a fake claim was lodged for obtaining an undue benefit. He pointed out that hospital failed to provide admission papers and bill books; IPD papers of the patient for 10 days were found written in a single hand-writing; laboratory, rooms and ICU were found in dirty condition and only one patient, doctor and nursing staff was found in the entire hospital.

DECISION: It was held that decision of the Company to reject the claim on the ground of doubtful hospitalization is justified as during hearing the representative of the insured failed to give a satisfactory reply to the queries about discrepancies highlighted by the investigation.

DELHI

In the matter of Sh. Shyam M. Bansal
Vs
New India Assurance Company Ltd.

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DATE:10.04.2015

1. **The complainant had alleged that his daughter was hospitalized as adviced by the doctor. The claim was rejected on the ground that treatment could be taken on OPD basis and hospitalization was not required.**

2. **The Insurance Company reiterated their written submission dated 14.08.2014. The patient was admitted for the purpose of investigation and no active treatment was given. As per panel doctor's report dated 02.08.2014 the patient had normal vitals at the time of admission and was admitted for investigation purpose. The case could be managed on OPD basis. Therefore, as per policy condition No. 4.4.11 claim was recommended for repudiation".**

3. **I heard both the sides the complainant as well as the Insurance Company. During the course of personal hearing the complainant alleged that his daughter was hospitalized for 2 days but the claim was rejected by the Company. The Insurance Company reiterated that the complainant had normal vitals at the time of admission and was admitted for investigation purpose. She could be managed on OPD basis. I find that patient was admitted with complaint of vomiting and was diagnosed acute gastritis with peripheral vertigo and was administered medication. Therefore the Company's contention that patient was admitted for investigation and could be treated an OPD basis is not justified.**
   The patient was admitted on the advice of the Doctor and not on their own volition. I hereby direct the Insurance Company to settle the claim for current hospitalization expenses only. Accordingly an Award is passed with the direction to the Insurance Company to settle the claim for current hospitalization expenses only.

In the matter of Sh. Roshan Khan
Vs
New India Assurance Company Ltd.

DATE:10.04.2015

1. **The complainant had reported a claim of Rs. 21880/- for expenses incurred towards hospitalization from 06.10.2013 to 10.10.2013 at Indra Nursing Home. All the necessary documents were submitted to the TPA. The claim was rejected by the company on the ground that Nursing Home was black listed.**

2. **The Insurance Company reiterated their written submission dated 06.04.2015. The complainant had taken the treatment from a hospital which was black listed. His claim was repudiated by the TPA as per the terms and conditions of the policy. However two claims of the insured were already settled by the Company which qualified the norms of the policy.**

3. **I heard both the sides, the complainant as well as the Insurance Company. During the course of personal hearing the complainant alleged that he was not aware of the fact that the hospital was black listed. Even the policy did not bear the stamp of the Company. The Insurance Company had repudiated the claim on the ground that the complainant had taken the treatment from the hospital which was black listed. The Insurance Company could not prove that the original policy with stamp of black listed hospitals was delivered to the complainant. The Company could not provide the POD details. I find that the policies submitted by the complainant during the personal hearing also did not bear any stamps showing list of black listed hospitals. The complainant approached the nearest hospital due to emergency for treatment and without any knowledge about the black listed hospitals. There is deficiency in services in as much as the Insurance Company did not keep the complainant informed about the list of blacklisted hospitals. The Insurance Company is directed to settle the claim. Accordingly an Award is passed with the direction to the Insurance Company to settle the claim as admissible to the complainant.**

In the matter of Ms. Asha Oberoi
Vs
New India Assurance Company Ltd.

DATE:10.04.2015

1. **The complainant had taken householder policy for more than 20 years from New India Assurance Company Ltd. She had preferred a claim for loss of her diamond earring in the month of July 2013. She lodged a FIR immediately and completed all the necessary formalities pertaining to the claim. The claim was refused by the company on account of policy being renewed in the name of complainant's husband who had already expired before the renewal of policy. The complainant had alleged that initially the policy was taken in joint name complainant and her husband. From 2001 onwards Insurance Company had issued the same policy in the name of her husband only. This was a lapse on the part of the Insurance Company and her claim should be settled.**

2. **The Insurance Company reiterated their written submission dated 06.04.2015. The complainant had taken a householders Insurance policy in the name of Mr. Inder Lal Oberoi for the period 21.06.2013 to 20.06.2014. Insured's wife lodged a claim for loss of her Diamond Tops on 27.07.2013. The investigator assessed the loss for Rs. 48500/- with the findings that the policy holder had died on 17.03.2013 but it was not informed to the Insurance Company. He advised the company to take legal opinion about admissibility of the claim. As per the legal opinion of the advocate it was opined that "if any policy has been issued in the name of a dead person then that policy has no validity in the eyes of law and the contract is void". In view of the legal opinion the claim was closed as "No Claim".**

3. **I heard both the sides, the complainant as well as the Insurance Company. I find that the complainant had taken the house holders insurance continuously from last 20 years. The policy was originally in the joint name. Due to shift of office, after the gap of 2 months the policy was issued by another office in the name of the deceased since 2002. The Insurance Company could not show that the proposal form was in single name or in joint name. The**

complainant alleged that the policy was originally in joint name and when it was changed to single policy was not known to her. Had it be in the knowledge of complainant that policy is in single name she would have changed the name of the Insured person in the policy at the time of renewal. Moreover she had insurable interest in the subject matter Insured even if the policy was renewed in the name of the deceased. Therefore the Insurance Company is directed to settle the claim. Accordingly an Award is passed with the direction to the Insurance Company to settle the claim as admissible.

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In the matter of Sh. Om Prakash Verma
Vs
New India Assurance Company Ltd.
DATE:09.04.2015

1. **The complainant had alleged that he had taken a mediclaim policy bearing no-32320034120100002163 from New India Assurance Company Ltd. He had submitted all the relevant documents to TPA, but Insurance Company did not settle the claim.**

2. **The Insurance Company reiterated their written submission dated 31.07.2014. The claim was closed as "No claim" on the grounds of non-compliance/non-submission of documents by the complainant.**

3. **I heard both the sides, the complainant as well as the Insurance Company. During the personal hearing the Insurance Company agreed to settle both the claims within a fortnight. Accordingly the complaint filed by the complainant is hereby disposed off.**

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In the matter of Sh. Avtar Singh
Vs
New India Assurance Company Ltd.
DATE:09.04.2015

1. **The complainant had alleged that he was hospitalized in central hospital on 04.07.2013 and was discharge on 05.07.2013. The complainant had submitted all the documents to the Insurance Company on 29.08.2013. The Insurance Company rejected the claim for late submission of papers.**

2. **The Insurance Company reiterated their written submission dated 07.04.2015. The Insurance Company had earlier repudiated the claim due to delay in intimation and hospitalization was less than 24 hours. The patient was admitted on 04.07.2013 at 10:45 pm and discharged on 05.05.2013 at 10:20 pm. As per policy condition minimum period of hospitalization should be 24 hours except for specified procedures/treatments. The Insurance Company had reviewed the claim and agreed to settle since the complainant had submitted a hospitalization certificate with duration of stay in the hospital for 24 hours.**

3. **I heard both the sides, the complainant as well as the Insurance Company. During the personal hearing the Insurance Company agreed to settle the claims within 15 days. Accordingly the complaint filed by the complainant is hereby disposed off.**

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In the matter of Sh. Nikhil Goel
Vs
New India Assurance Company Ltd.

DATE:10.04.2015

1. **The complainant had taken mediclaim policy valid from 29.12.2013 to 28.12.2014. His wife was admitted at Fortis Hospital from 12.04.2014 to 13.04.2014 and diagnosed of Primi with 31 weeks POG with deranged LFT and sugar levels. He had alleged that cashless claim was denied by TPA on account of policy condition that maternity and its related complications were not covered under the policy. Therefore he had applied for claim on reimbursement basis on 25.04.2014 and submitted all the papers to the TPA.**

2. **No written submissions were received from the company**

3. **The personal hearing was fixed on 08.04.2015. The complainant was absent and requested through letter dated 07.04.2015 that the case be decided on merits. The Insurance Company was present. I heard the company. The Insurance Company had rejected the claim on account that maternity and its related complications were not covered under the policy condition. I find that the discharge summary submitted by the complainant indicates in the history of present illness shows III trimester: recently diagnosed with GDM i.e. "Gestational Diabetes Mellitus". GDM usually occurs in pregnancy. In the policy condition No. 4.4.13 it is clearly mentioned that treatment arising from or traceable to pregnancy will not be payable. The Insurance Company had rightly rejected the claim. Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Sh. S.L. Jain
Vs
New India Assurance Company Ltd.
DATE:10.04.2015.

1. **The complainant was admitted at M.P. Heart Centre from 19.02.2014 to 24.02.2014. He was diagnosed HT, DM, COPD with Acute Asthmatic Bronchitis with Pulmonary Hypertension, Severe Obstructive Sleep apnea, Chronic Urinary obstruction and bilateral cellulites in lower limbs. TPA had settled the claim of Rs. 54125/- after deduction of Rs. 54000 for expenses incurred on CPAP machine. The complainant had alleged that the CPAP machine was purchased at the advice of the treating Dr J.S. Guleria as it was a life saving devise.**

2. **No written submission was received from the company.**

3. **I heard both the sides, the complainant as well as the Insurance Company. The complainant had requested for reimbursement of expenses incurred on CPAP machine. The Insurance Company had not allowed the charges for CPAP machine. I find that as per policy exclusion condition No. 4.4.15 the instrument used in the treatment of Sleep Apnea Syndrome (CPAP) is not payable. I find that the doctor has advised use of CPAP. However the policy condition No. 4.4.15 clearly stipulates that "instrument used in treatment of sleep Apnea Syndrome (CPAP) is not payable. Therefore, I see no reason to interfere with the decision of the Company. Accordingly the complaint filed by the complainant is hereby disposed off.**

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In the matter of Sh. Vimalendra Gupta
Vs
New India Assurance Company Ltd.

DATE:09.04.2015

1. **The complainant had taken mediclaim Insurance from New India since 01.09.2000 through citi bank and directly from 2006 onwards. When he submitted claim under the policy in July 2011 and Dec 2012 he came to know about sub limits in the policy conditions. He had alleged that there was no such condition in the policy incepting from 2000. The sub limits under the policy were introduced in the year 2006 and thereafter policy was renewed with sub limits. Again in the year 2012 some changes had been arbitrarily introduced in the policy. He had alleged that the policy should be renewed on the original terms and conditions in the year 2000 without any sub limits.**

2. **No written submission was received from the company**

3. **I heard both the sides, the complainant as well as the Insurance Company. The complainant had claimed that the changes were arbitrarily introduced in the policy. The policy should be renewed on the original terms and conditions. The Insurance Company reiterated that changes in the mediclaim policy conditions as and when implemented by IRDA were already known to the complainant and it was mandatory to issue the policy on the new terms and conditions. Therefore, I see no reason to interfere with the decision of the Company. Accordingly the complaint filed by the complainant is hereby disposed off.**

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In the matter of Sh. Arbindo Grover
Vs
New India Assurance Company Ltd.
DATE:10.04.2015

1. **The complainant had taken a mediclaim policy no. 31150034120100000831 with New India Assurance Company Ltd. The complainant was hospitalized on 29.09.2014 under emergency conditions and was taken to the hospital in an Ambulance. He reported a claim of Rs. 39,912/-for reimbursement of pre and post expenses but company had settled only Rs. 3053/- in addition to cashless settlement of Rs. 35652/- which was made to Max Hospital.**

2. **No written submission was received from the company**

3. **I heard both the sides, the complainant as well as the Insurance Company. The complainant reiterated that diagnostic test like MRI are not governed by clause No.2.1 relating to reimbursement of room rent not exceeding 1% of sum insured. The Insurance Company stated that previous policy was issued for sum insured of Rs. 1, 75,000/-. The sum insured was enhanced to Rs. 5. Lac on 21.10.2011. The claim was reported in the second year of enhancement of sum insured. As per policy condition enhanced sum insured will be applicable after 2 years waiting period. Therefore the claim was settled on the basis of previous sum insured of Rs. 1,75,000/-. The room rent is payable up to 1% of sum insured and other hospitalization expenses are paid in proportionate to room rent. Accordingly deductions in diagnostic charges, doctor's fee and room rent were made on the basis of sum insured under the policy. I find that as per policy clause No. 2.1 room rent is paid up to 1 % of sum insured and doctor's fee surgeon charges, diagnostic charges are payable at the rate applicable to the entitled room category in case the complainant opts for a room with higher rent than the entitled category. The claim was rightly settled by the Insurance Company as per terms and conditions of policy. Therefore, I see no reason to interfere with the decision of the Company. Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Sh. Jawaharlal Arora
Vs
New India Assurance Company Ltd.
DATE:10.04.2015

1. **The complainant had preferred a claim under LIC Group mediclaim policy issued by New India Assurance Company Ltd. He had submitted a total bill of Rs. 80,970.00 out of which an amount of Rs. 68,420.00 was paid to him after deduction of Rs. 12,550/-. He had written various letters to the company for knowing the reasons of deduction made by the company but he did not get any reply from the company. He came to know un officially that the bill of pre-hospitalization was not paid due to the fact that the same was not related to the ailment for which his wife was hospitalized. His wife was suffering from critical liver disease and bill of pre hospitalization was relating to the same illness.**

2. **The company reiterated the written submissions dated 07.04.2015. The patient fall down and sustained blunt injuries of right upper arm. She was admitted at Orchid Hospital from 15.09.2013 to 23.09.2013. The claim for hospitalization was settled as per policy conditions and pre-hospitalization expenses which were not consistent with the cause of hospitalization were not paid. The pre-hospitalization expenses were related to portal HTN with Chronic liver disease. The earlier claim in Aug 2013 for Chronic liver disease was already settled. Hence as per policy terms and conditions the pre-hospitalization expenses were not consistent with the current hospitalization hence deducted from the claim.**

3. **I heard both the sides, the complainant as well as the Insurance Company. During the course of personal hearing the complainant alleged that the bill of pre-hospitalization was not paid due to the fact that the same was not related to the ailment for which his wife was hospitalized. But the Insurance Company alleged that the pre-hospitalization expenses were related to portal HTN with Chronic liver disease which was not consistent with the cause of hospitalization hence the expenses of Rs. 12,550/- related to HTN with Chronic Liver Disease was not paid. I find that the complaint's wife was suffering from HTN Liver Disease before hospitalization;**

therefore, the Insurance Company had rightly settled the claim as per policy terms and conditions. The current hospitalization was due to fall and pre-hospitalization expenses were related to HTN and Liver Disease which was not consistent with the current hospitalization. Therefore, I see no reason to interfere with the decision of the Company. Accordingly the complaint filed by the complainant is hereby disposed off.

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In the matter of Sh. Tarun Gupta.
Vs
Star Health And Allied Insurance Company Ltd.
DATE:31.07.2015

1. **The complainant alleged in his complaint dated i.e. 11.11.2014 that he had taken health policy from Reliance General Insurance Company in 2008 and continued till 2012- 2013 and was ported to Star Health Allied company on 28.02.2013, the policy was renewed thereafter for policy period 28.02.2013 to 27.02.2014 for sum insured of Rs. 3 lacs and from 28.02.2014 to 27.02.2015 for enhanced sum insured Rs. 7 lac. In April 2014 he was admitted to Fortis Hospital, Okhla, for weakness and breathing problem and diagnosed with heart failing conditions, Global LV hypokinesia etc. He immediately reported his admission to Insurance Company through TPA for cashless payment. The company repudiated the claim on account of non disclosure of the pre existing disease and for being a known case of hereditary spherocytosis since the age of 11 years and notified to cancel the policy w.e.f. 06.10.14 without taking the cognizance of portability of policy from Reliance General Insurance where all these conditions were known to the previous insurer. He approached this forum for refund of claim of Rs.603890 + 18% interest till payment and continuation of policy.**

2. **The Insurance Company vide its e-mail dated 22.05.2015 submitted that the claim settled vide DD No. 37188 dated 03.03.2015 for Rs. 2 lac as full and final payment was received by complainant on 21.03.2015 restricted to the sum insured of policy with previous insurer.**

3. **I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing, the complainant reiterated that he had submitted the claim for the treatment of left ventrical in April 2014. The deterioration in Heart condition had been observed in April 2014 and does not relate to hereditary spherocytosis or IDDM. The Insurance Company reiterated that policy was taken in 28.02.2013 with portability from Reliance General and they had settled the claim restricting it to the previous policy sum insured of Rs. 2 lacs as per the portability condition. I find that the Insurance Company on review of the case had already settled the claim up to Rs. 2 lac (restricted to the previous policy sum insured i.e. Rs. 2 lac) even though the claim had been rejected as non-disclosure on 26.07.2014. The complainant had enhanced the sum insured to Rs. 7 lac for the period 28.02.2014 to 27.02.2015 vide policy no. P/161100/01/2014/014989. I observed that this is a super surplus policy and the liability under this policy shall attach only where the hospitalization expenses exceeds Rs. 3,00,000/- in one stretch and subject to 3 years waiting period for pre-existing disease. But in the instant case, I find that the present illness for which the claim arose was Atrial tachycardia. The discharge summary mentions that the patient was a known case of Type 1 Diabetes Mellitus, Hereditary Spherocytosis, Protein C Deficiency, Pancreatitis with Pseudocyst, Chronic Pulmonary Microthromboembolism, but there is no mention of the treatment given in this regard. The treatment in hospital, as per discharge summary, was for Atrial tachycardia and expenses arising therefore should be paid accordingly. Accordingly an award is passed with the direction to the Insurance Company to settle the claim at the sum insured for policy period 28.02.2014 to 27.02.2015.**

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In the matter of Sh. Kunwar Pal Singh Malik.
Vs
Star Health And Allied Insurance Company Ltd.
DATE;10.08.2015

1. **The complainant alleged in his complaint dated 06.05.2014 that he had taken the policy in 2010 and was admitted at Fortis Hospital on 01.01.2014. He submitted claim for hospitalization expenses. But the claim was rejected by Insurance Company, as the cause of disease was mentioned alcohol. He submitted that surveyor of Insurance Company had prepared a wrong report. After approaching Insurance Company, he approached this forum for redressal of his grievances.**
2. **The Insurance Company vide its SCN dated 09.07.2014 submitted that insured was admitted to the hospital with complaints of abdomen pain and haematemesis since 2-3 day and treatment was given for chronic liver disease, portal hypertension with UGI bleed. The claim was rejected on the ground that the hospitalization was related to an ailment which was result of alcohol intake. Insured patient is an alcoholic with h/o alcohol intake daily around 500 ml since 8 years and the most common cause for chronic liver disease is alcohol consumption. Therefore the claim was rejected under exclusion no. 10 of policy issued in which the company shall not be liable to make any payment in r/o use of intoxicating drugs/ alcohol. Hence, it was requested that the case was devoid of any merit and may be dismissed.**
3. **I heard both the sides, the complainant represented by his brother in law as well as the insurance company. The complainant reiterated his complaint dated 06.05.2014 and also submitted the summary of internal assessment critical care first assessment dated 02.01.2014. The summary does not show history of alcohol intake of around 500 ml since 8 years. He also stated that he had no liquor shop. The Insurance Company reiterated that**
insured patient was an alcoholic h/o alcohol intake daily around 500 ml since 8 years and the most common cause for chronic liver disease was alcohol consumption. Therefore the claim was rejected

under exclusion no. 10 of policy issued in which the company shall not be liable to make any payment in r/o use of intoxicating drugs/ alcohol. I find that complainant had been insured with the Insurance Company since 2010 and claim was reported in the 4th year of the policy. There is a discrepancy in IPD record submitted by the complainant and the Insurance Company. The critical care first assessment sheet provided by the complainant does not show the history of alcohol but the same critical care assessment sheet given by the company shows history of alcohol intake. I find that the handwriting in the form submitted by the Insurance Company is different from the one submitted by the complainant. The Insurance Company could not substantiate their contention with any legal documentary proof. It has also not been authenticated or certified by the hospital. The company also could not provide any proof that insured had a history of alcohol intake. Accordingly an award is passed with the direction to the insurance company to pay the claim to the complainant.

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In the matter of Sh.Harbans Lal Gupta.

Vs

Star Health And Allied Insurance Company Ltd.

DATE:31.07.2015.

1. **The complainant alleged in his complaint dated 20.06.2014 that he had taken family Health optima policy in 2011 and renewed thereafter. His wife was admitted on 19.02.2014 at Sri Ganga Ram Hospital for the treatment for resolution of co-morbid conditions as life saving procedure because of breathing difficulty, unable to do daily routine house hold/personal work, caused by morbid obesity. The claim was submitted for hospitalization expenses but was rejected by the Insurance Company on the grounds of exclusion clause no. 18 of the policy that company was not liable to make any payment in respect of any expenses for treatment of weight control services including surgical procedure for treatment of obesity. Complainant also enclosed a court judgment in favour of insured person. After approaching the Insurance Company, he approached this forum.**
2. **The Insurance Company vide its SCN dated 04.07.2014 submitted that complainant's wife was admitted to the hospital for gradual increase in weight and underwent laparoscopic sleeve gastrectomy**

done under GA. Company reiterated that as per exclusion no. 18 of the policy company was not liable to make any payments in r/o expenses incurred on weight control services including surgical procedure for treatment of obesity. Hence, it was requested that the case was devoid of any merit and may be dismissed.

3. **I heard both the sides, the complainant as well as the insurance company. I find that the complainant's wife was admitted on 19.02.2014 at Sri Ganga Ram Hospital for the treatment of resolution of morbid abesity and underwent laparoscopic sleeve gastrectomy done under GA but the Insurance Company had rejected the claim under exclusion clause no. 18 of the policy which states that " Company shall not be liable to make any payments in r/o expenses incurred on weight control services including surgical procedure for treatment of obesity.". It is now accepted worldwide that the best treatment option for morbid obesity is Bariatric Surgery wherein Laparoscopic Rouxen-y- Gastric Bypass is a treatment option. I feel that Insurance Company had wrongly rejected the claim. Now-a-days bariatric surgery is not a cosmetic weight loss procedure. It is a metabolic operation that involved cutting or by passing parts of the stomach and intestine-to-control or even get rid of diabetes. I find that the Centre Government Health Scheme, (CGHS) are also reimbursing the expenses for the treatment of the said diseases. The Laparoscopic Rouxen-y- Gastric Bypass surgery is a potentially lifesaving surgery and not a cosmetic surgery and helps in treating the disease like DM/HTN, which could be life threatening. In the present case the treating doctor has given the certificate dated 24.03.2014 stating that sleeve gastrectomy was done as a life saving measure for her morbid condition and for resolution of her comorbidities which was produced during the personal hearing. Hence, I hold that the Insurance Company is liable to settle the claim. Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant.**

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In the matter of Sh. Ramesh Kumar.
Vs
Star Health And Allied Insurance Company Ltd.

DATE:31.07.2015

1. **The complainant stated in his complaint dated 16.02.2015 that he had taken a mediclaim policy in Jun 2013. He was admitted to the New Manthan Hospital on 21.02.2014 and submitted his claim for hospitalization expenses which was rejected by the company due to "Non fulfillment of the criteria of hospital", that the hospital did not have the facilities as per the policy terms and conditions. He further submitted that he had given the registration certificate issued by Director Health Service, Government of NCT of Delhi, to the Insurance Company. After approaching the Insurance Company he approached this forum for settlement of his claim.**

2. **The Insurance Company vide its SCN dated 17.04.2015 reiterated that complainant was admitted at New Manthan Hospital which had only 6 beds and did not have the infrastructure as required under the policy terms and conditions. Hence, it was requested that the case was devoid of any merit and may be dismissed.**
3. **I heard both the sides, the complainant as well as the insurance company. Complainant reiterated that Insurance Company had not settled his claim after providing the registration certificate issued by Director Health Services, Government of NCT of Delhi certifying the hospital as having 6 beds. Insurance Company reiterated its submissions made in the SCN. I find that the New Manthan Hospital was registered by Director Health Service, Government of NCT of Delhi, the copy of registration certificate was also shown during the personal hearing. Further, complainant informed that Insurance Company had already settled the claim of other claimants who had been treated at the same hospital. The Insurance Company representative did not deny this fact, nor did the Insurance Company invalidate the certificate given by the Director Health Service, Government of NCT to the hospital. Thus in my considered view the current claim should be payable. Accordingly an award is passed with the direction to the Insurance Company to pay the claim to the complainant.**

In the matter of Sh. Hari Ram Gupta.
Vs
Star Health And Allied Insurance Company Ltd.
DATE:19.06.2015

1. **The complainant alleged in his complaint dated 05.08.2014 that he had take senior citizen Red Carpet Health Insurance policy which was in continuation since two years. He was hospitalized at Rajiv Gandhi Cancer and Research Institute for treatment of prostate problem and submitted his claim for reimbursement of expenses incurred on treatment. The Insurance Company has repudiated the claim more over cancelled the policy with a plea of non disclosure of facts. He also submitted that he had prostate problem in the year 2007 and after treatment he was perfectly ok and not suffered any disease. After approaching Insurance Company, he approached this forum for claim amount of Rs. 51991/-**

2. **The Insurance Company vide its SCN dated 10.09.2014 submitted that the Insured person was diagnosed as a case of metastatic CA prostate in 2007 and underwent TURP on 02.07.2007 and was on continuous medication till date. The insured had not disclosed any of the past medical history while proposing Insurance and answered 'No' to the cancer related question in the proposal form. This is non disclosure of material facts. Hence, it was requested that the case was devoid of any merit and may be dismissed.**
3. **I heard both the sides, the complainant as well as the insurance company. During the course of hearing the complainant reiterated that he had prostate problem in year 2007 and after treatment he was perfectly fit. He had taken the policy in 2011 and was hospitalized on 02.04.2014 for treatment of prostate problem. Insurance Company reiterated that the claim was rejected on non-disclosure of past medical history and non-disclosure of material facts. I find that complainant had the problem of prostate earlier and was under medication since 2007 continuously. I see no reason to interfere with the decision taken by the Insurance Company.**

4. **Accordingly the complaint filed by the complainant is hereby dismissed**

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In the matter of Sh. Surinder Kr Aggarwal.
Vs
Star Health And Allied Insurance Company Ltd.

DATE:22.06.2015

1. **The complainant alleged in his complaint that he had taken a foreign travel product Insurance policy on 28.02.2013 for S.A 250000/-USD for visiting USA which was valid from 06.03.2013 to 14.04.2013. On 21.03.2013 he fall ill in USA and admitted in a state hospital at Miami. After refusal of Insurance Company he arranged the amount of USD 2710 in USA from relatives and friend for advance money and payment of final bill of hospital after returned to India he lodged the claim for 2710 USD on 03.04.2013 and asked for the payment in USD. After prolonged correspondence and follow up the claim for 2610 USD was settled on 24.10.2013 i.e. after 7 months and that too in India rupees. Complainant also submitted that Insurance Company convert the claim amount of USD into Indian rupee as per the rate prevailing on 23.03.2013 i.e.@54.47 USD whereas the claim was settled in Oct 2013 when the rate of USD was Rs. 63 approx. This way he incurred a loss of Rs. 23940/- in exchange (USD 2610 x 9). After approaching Insurance Company he approached this forum for payment of exchange loss and interest thereon.**

2. **The Insurance Company vide its SCN dated 09.08.2014 submitted that Overseas policy was taken by complainant for 250000 USD.A claim for 2710 USD was lodged for the treatment taken on 21.03.2013 at USA and Insurance Company had settled the claim of 2610 USD in INR Rs. 142167/-vide cheque No. 042417 dated 24.10.2013, conversion rate of Rs. 54.47 on date of loss, i.e. date of admission 21.03.2013 after deducting 100 USD as per policy schedule. Hence, it was requested that the case was devoid of any merit and may be dismissed.**

3. **I heard both the sides, the complainant as well as the insurance company. The complainant reiterated his complaint. Insurance Company reiterated its SCN and stated that claim was settled on 24.10.2013 in Indian rupees as per the rate prevailing on 21.03.2013**

(i.e. date of admission) and as per general condition of the policy all claims payable to the insured person should be paid in Indian currency only. I find that Insurance Company had settled the claim correctly. I see no reason to interfere with the decision taken by the Insurance Company. Accordingly the complaint filed by the complainant is hereby dismissed.

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In the matter of Sh.Subhash Chander Bhatia.
Vs
Star Health And Allied Insurance Company Ltd.
DATE:02.07.2015

1. **The complainant alleged in his complaint dated 06.01.2015 that he had taken the family health optima policy in Feb, 2010 and on 24.02.2014 he was admitted in Fortis hospital for Cerebral Malaria with Multi Organ Failure. He lodged his claim for hospitalization expenses. The Insurance Company has rejected his claim on the account of non-disclosure of facts regarding previous illness which occurred in the year 2001 however in the proposal form the information was asked for last three year i.e. 2007. He also submitted that his disease was completely cured by 2001 follow up for the same was done for next three years and was declared complete fit. The certificate was also given by Fortis Hospital doctors that this disease had no relation with previous history and treatment of CA Urinary Bladder. Hence there was no question of non-disclosure of facts at the time of taking the policy in year 2010.After approaching Insurance Company, he approached this form for settlement.**

2. **The Insurance Company vide its SCN dated 10.02.2015 stated that the policy was issued on 10.02.2010 on the basis of information provided in the proposal form and medical examination report, incorporated with a pre existing disease exclusion of heart and its complication. Complainant had submitted his claim for mild grade fever and excessive drowsiness etc. From the discharge summary of Max Health Care it was noted that insured had a history of Transitional Cell Carcinoma urinary bladder and TURBT +right DJ stenting was done in 2001. Hence the claim was rejected for non disclosure of past medical history while proposing insurance. Insurance is based on utmost good faith the insured is expected to declare in the proposal form about the details of his ailments past**

medical history. In this case insured has not declared his pre existing disease which is a non disclosure of material facts. Hence, it is requested that the case is devoid of any merit and may be dismissed.

3. I heard both the sides, the complainant as well as the Insurance Company. During the personal hearing the complainant pleaded that he had the policy since 2010. He had not revealed about his treatment of CA Urinary Bladder because he was declared complete fit by the doctor in 2004. In the proposal form information was sought for the past three years. In this case he had taken the police since 2010, hence he was bound to give information as far back as till 2007. The Insurance Company reiterated that due to non-disclosure of CA Urinary Bladder they had rejected the claim. I find that complainant had concealed the past medical history of CA Urinary Bladder by stating "NO" under the heading insured person's details in serial number 5, 6 and 7 in proposal form. It is a case of non-disclosure. Therefore the Insurance Company rightly rejected the claim. I see no reason to interfere with the decision taken by the Insurance Company. Accordingly the complaint filed by the complainant is hereby dismissed.

In the matter of Sh. Pramod Kumar Jindal.
Vs
Star Health And Allied Insurance Company Ltd.

DATE:30.06.2015

1. **The complainant alleged that he had taken a family health Insurance policy on 15.10.2010. At the time of filling the proposal form he informed about his disease and filled the status of health of himself and family. On the basis of that Insurance Company had issued the policy. On 17.07.2013 he was hospitalized due to sudden pain. He submitted his claim for hospitalization expenses for the treatment of CAD-Left main with TVB,UA, severe LVEF 30% But the Insurance Company rejected his claim on the grounds of that the ailments were pre existing. After approaching Insurance Company, he approached this forum for settlement.**
2. **The Insurance Company vide its SCN dated 12.03.2014 submitted that complainant had the past history of the illness CAD past PTCA and surgery/treatment given in 2004 and 2007. Complainant did not disclose his past medical history while proposing insurance which is a clean and irrefutable evidence of misrepresentation/non-disclosure of facts. They also communicated the cancellation of cover to the complainant vide letter dated 27.06.2013 and informed that they intended to cancel the policy in respect of complainant. Hence, it is requested that the case is devoid of any merit and may be dismissed.**
3. **I heard both the sides, the complainant as well as the Insurance Company. Complainant reiterated that he had lodged the claim for treatment of CAD-Left main but it was rejected by the Insurance Company. He also submitted that he had disclosed about his past disease and status of health to the agent who filled the form. I find from the discharge summary and from pre authorization form that complainant had CAD-post PTCA in year 2004 and he had not disclosed his past medical history at the time of taking the policy. He had written "No" in the health related questions in the proposal form. He also could not prove that he had intimated the agent, who had filed the form. I see no reason to interfere with the decision taken by the Insurance Company. Accordingly the complaint filed by the complainant is hereby dismissed.**

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In the matter of Sh. Naveen Sharma
Vs
ICICI Lombard General Insurance Co.Ltd.

Date:24.09.2015

1. **Sh. Naveen Sharma submitted that his wife was hospitalized on 12.09.13 & discharged on 16.09.13. Claim documents were submitted but response from Company was delayed on the pretext that documents were being scrutinized. The Company then asked for purchase invoices of all medicine bills giving Batch no. and expiry date of medicines. All medical bills available were submitted but since Insurance Company kept on delaying for want of invoices he asked them to settle claim excluding medicine bills and that he would approach other forum for the same. He then received email from Company that his claim was being rejected as it was a fraudulent claim. He states that the claim was genuine and had been wrongly rejected by Company. He has now approached this forum for settlement of his claim. Amount sought is Rs.34, 000/- + Interest thereon+ compensation for harassment.**

2. **The Insurance Company had rejected the claim under part III of schedule, exclusion under clause 14, Fraudulent claims A- which states that if any claim is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or any fraudulent means or devices are used by the insured or by anyone acting on his behalf to obtain any benefit under this policy, claim will not be payable. The Insurance Company vide its self contained note dated 21.05.15 had reiterated the same.**

3. **I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing, the Insurance Company had stated that the claim was rejected under exclusion clause part-III-14, Fraudulent claims A- which states that if any claim is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or any fraudulent means or devices are used by the insured or by anyone acting on his behalf to obtain any benefit under this policy, claim will not be payable. The Insurance company stated that on the basis of the findings of the medical team i.e. multiple claims from same hospital,**

for the same insured whose attendance records could not be retrieved from the hospital, poor infrastructure facilities in the Hospital, pathologist untraceable, insured's non co-operation in meeting the team, inadequate query reply and non availability of the documentary proof in favor of medicine supply, all go to prove that the claim of the insured is merely a ploy to reap the benefits of insurance from the Company, and therefore rejected the claim. The complainant alleged that his wife was hospitalized in Navjivan Hospital Delhi for the period of 12.09.2013 to 16.09.2013 and had undergone treatment for gastroenteritis and high fever. I have perused the claim papers placed on record. The Insurance Company could not produce any supporting documents before the forum to prove their contention of fraud. The Insurance Company had relied upon the investigation report of Mr. Yogesh Kumar, Manager dated 17.01.2014 but the investigator had not provided any evidence corroborative/papers to prove his contention that the claim was found to be fraudulent. Hence, I hold that the Insurance Company is liable to settle the claim. Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant.

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In the matter of Sh. Som Chandra Jain
Vs
United India Insurance Company Ltd.

DATE:24.04.2015

1. **The complainant alleged that he was admitted in Metro Hospital for the period of 28.01.13 to 02.02.13 and diagnosed as COPD with Acute Exacerbation, DM (Type II), Hypertension. He had submitted all the necessary papers of the claim for reimbursement of Rs. 10,354/- only. He sought the relief of Rs. 86,272/- (Rs. 925- Claim amount+ 15000-Harrassment and mental agony+ Interest- Rs. 10,347). The TPA Vipul Med Corp TPA Pvt. Ltd. vide its letter dated 30.01.2013had denied the cashless facility on the ground of patient was a known case of COPD since 5 years and applicable S.I. of Rs. 1 Lac which was been exhausted including previous related case.**
2. **The Insurance Company vide its self contained note dated 18.07.2014 had reiterated that the TPA had settled the claim according to the S.I. available under the policy as the above policy has not completed 04 claim free years and hence the S.I. increased in 2009 cannot be allowed. The current claim was for COPD, for which**

TPA paid claim in March, 2009. Hence, the TPA had rightly approved the claim on the basis of the S.I. of Rs. 1 Lac+25% claim bonus.

3. **I heard both the sides, the complainant as well as the Insurance Company. The complainant had a mediclaim policy from United India Insurance Company Ltd. since 1998 and the policy was renewed from time to time without any break till 26.04.2013. The Insurance Company had taken the S.I. of Rs.1 Lac+25% CB for settlement of said claim whereas the S.I. for the period of policy 27.04.2012 to 26.04.2013 was Rs. 1.75 Lacs+25% CB and in earlier policies (from 27.04.2008 to 26.04.2012) also it was Rs. 1.75 Lacs. The claim should have been settled on the basis of S.I. Rs. 1.75 Lacs + 25% CB. The Insurance Company could not show the details of policies and as to the sum insured was reduced to Rs. 1 Lac. I find that the Insurance Company had wrongly taken the S.I. of Rs. 1Lac +25% CB while settling the claim whereas it should have been Rs. 1.75 Lacs + 25% CB as the complainant had the said S.I. of Rs. 1.75 Lacs since 27.04.2012 and in the policy also 27.04.2012 to 26.04.2013 it is Rs. 1.75 Lacs + 25% CB. During the course of hearing the representative of the Insurance Company had also agreed to settle the claim in the light of correct S.I. of Rs. 1.75 Lacs+25% CB. Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant as per the correct sum insured.**

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In the matter of Sh. Dhirender Nath Puri
Vs
United India Insurance Company Ltd.
DATE:23.04.2015

1. **The complainant alleged that he was admitted in Max Super Specialty Hospital in Saket for the period of 03.01.2014 to 22.01.2014 with the diagnosis of Urosepcis Septic Shock and acute kidney injury and was treated for the same. The Insurance Company had paid him Rs. 2 Lacs against the S.I. of Rs. 3 Lacs. The complainant sought the relief of Rs. 1, 00,000/- (difference of amount).**

2. **The Insurance Company had not submitted any self contained note and other relevant documents.**

3. **I heard the complainant. The Insurance Company was absent and none represented the Company. During the course of hearing the complainant stated that he was admitted in Max Super Specialty Hospital. The complainant had taken the policy in the year 2004 for S.I. Rs. 2 Lacs and subsequently enhanced to Rs. 3 Lacs in the year 2013. The Insurance Company had settled the claim on the basis of previous year S.I. i.e. Rs. 2 Lacs treating the ailment as pre-existing/old. I find that as per Doctor's Certificate dated 28.04.14 the complainant was treated for kidney injury which had no relevance to the disease hypertension which the complainant was suffering since last 05 years and there was no previous history of diabetes mellitus and CAD. The Insurance Company should have taken the S.I of current year policy i.e. Rs. 3 Lacs for settlement of claim as the disease urosepsis, septic shock and acute kidney injury are not pre-existing disease. The complainant had not taken any treatment in the earlier years also. The Insurance Company is directed to settle the claim of the basis of current year S.I. of the policy i.e. Rs. 3 Lacs. Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant.**

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In the matter of Sh. Ravinder Singh
Vs
United India Insurance Company Ltd.

DATE:23.04.2015
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1. **The complainant alleged that his wife was admitted in Max Devki Devi Heart and Vascular Institute from 15.07.13 to 19.07.13 and diagnosed as Morbid Obesity. He had submitted all the necessary papers of the claim to the Insurance Company/TPA for reimbursement of Rs. 3,53,389/- but the Company had rejected his claim under clause 4.5 (b) i.e. the treatment taken was for change of life/for cosmetic purpose falls under exclusion. He sought the relief of Rs. 3, 53,389/- from this forum.**

2. **The Insurance Company vides its self contained note dated 30.09.2014 had reiterated that the claim was rejected under exclusion clause no. 4.5 (b) which states that vaccination or inoculation or change of life or cosmetic or aesthetic treatment of any description are not payable. The patient was diagnosed with the condition "Morbid Obesity" for which she underwent "Laparoscopic Roux-en-y gastric bypass".**

3. **I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant had stated that his wife was treated for morbid obesity and Laparoscopic Roux-en-y gastric bypass a surgical procedure for treating morbid obesity was done on 16.07.2013 at Max Health Care. He had also produced the treating doctor's certificate from Max Health Care dated 26.07.2013 which reveals that Morbid Obesity is a serious disease that may be associated with severe complications many of which are life threatening. It is now accepted world wide that the best treatment option for morbid obesity is Bariatric Surgery wherein Laparoscopic Roux-en-y Gastric bypass is a treatment option. The Insurance Company had denied the claim under exclusion clause no. 4.5 (b) i.e. vaccination or inoculation. The Insurance Company had reiterated**
the same as in its self contained note dated 30.09.2014. I feel that Insurance Company had wrongly rejected the claim on the ground of

exclusion clause 4.5(b). Now-a-days bariatric surgery is not a cosmetic weight loss procedure. It is a metabolic operation that involved cutting or by passing parts of the stomach and intestine-to-control or even gets rid of diabetes. The Centre Government CGHS are also reimbursing the expenses for the treatment of the said diseases. As per doctor's certificate from Max Health Care Laparoscopic Rouxen-y Gastric Bypass Surgery is a potentially life saving surgery and not a cosmetic surgery and help in treating the disease. Hence, I hold that the Insurance Company is liable to settle the claim. Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant.

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In the matter of Sh. Rakesh Bansal
Vs
United India Insurance Company Ltd.

DATE:23.04.2015

1. **The complainant alleged that his daughter was admitted in Sir Ganga Ram Hospital from 06.02.13 to 18.02.13 and diagnosed as Vander Knapp disease with Epilepsy Acute Encephalopathy, Post Seizure/Trauma Psychosis. He had submitted all the necessary papers of the claim to the Insurance Company for reimbursement of claim amount of Rs. 1,76,869/- but the Insurance Company had rejected the claim on the ground that disease is genetic. He had sought the relief of Rs. 1, 76,869/- from this forum.**

2. **The Insurance Company vides its rejection letter dated 22.10.2013 had rejected the claim under exclusion clause no 4.14 which states that the genetic nature of disease is not covered in the policy. As investigated by the TPA the patient was diagnosed as Vender Knapp disease with epilepsy acute encephalopathy and past seizure/trauma psychosis for this she was managed conservatively and post seizure/trauma psychosis. The Insurance Company could not substantiate with any documentary proof that the said disease was genetic in nature. Hence, I hold that the Insurance Company is liable**

to settle the claim and reimburse the amount as admissible. Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant.

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In the matter of Sh. Rohit Nagia
Vs
United India Insurance Company Ltd.
DATE:23.04.2015

1. **The complainant alleged that he had applied for reimbursement of Rs/ 4, 04,230/- for the treatment of his mother's knee replacement. The S.I. under the policy was Rs. 1.50 Lacs for the year 2012-13 and 2011-12 Rs. 1,25,000. Against the claim bills submitted to the Insurance Company he had received Rs. 90,749/- only. He sought the relief of Rs. 9251/- from this forum. The said amount had been deducted by the Insurance Company on account of "Intra-Vitreal injections not payable in Medical Policy"**

2. **The Insurance Company vide its rejection letter dated 08.04.14 had apprised the Insured that Intra-Vitreal injection are not payable in Mediclaim policy.**

3. **I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the Insurance Company had accepted that it is nowhere specifically mentioned in the policy terms and conditions that the "Intra-Vitreal Injections" are not payable. I feel that the Insurance Company had wrongly deducted the amount of Intra-Viteral Injections as the same is not mentioned in policy terms and conditions. This fact had also accepted by the Insurance Company. Hence, I hold that the Insurance Company is liable to pay the amount of Rs. 9251/- towards "Intra-Vitreal Injection". According an award is passed with the directions to the Insurance Company to reimburse Rs. 9251/- alongwith 9% interest p.a. from the date of filing the claim and Rs. 10,000/- on account of mental harassment which the insured suffered.**

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In the matter of Sh. Dayal Motwani
Vs
United India Insurance Company Ltd.

DATE:15.04.2015

1. **The complainant alleged that he had undergone cataract surgery in January, 2012 for Right Eye at Sama Nursing Home and incurred Rs. 45,950/- on the treatment. The claim was settled by the Insurance Company for Rs. 24,566/- but he had returned the cheque to the TPA under protest. He had sought the relief of Rs. 45,950/- from this forum.**

2. **The Insurance Company vides its letter dated 04.07.14 had clarified to the Insured that cataract surgery is regulated as per GIPSA agreed rate of PPN Hospital Network Package. These rates are agreed by all major hospitals. In this case Rs. 24,556/- was paid to the complainant as per GIPSA package rate for Phaco Surgery procedure. The claim is settled as per policy terms and conditions.**

3. **I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant submitted that he had not been informed by the Insurance Company about GIPSA package, nor did the Insurance Company provide him the terms and conditions of the policy. I find that details of GIPSA package was not incorporated in the policy schedule/terms and conditions of the policy.**
   Thus the complainant could not have been aware of the condition. Hence, I hold that the Insurance Company is liable to pay the balance amount of claim. Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant.

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In the matter of Sh. Naresh Bansal
Vs
United India Insurance Company Ltd.

DATE:21.04.2015

1. **The complainant alleged that he was admitted in Sarof Hospital and Heart Institute from 05.08.2013 to 09.08.2013 and diagnosed with high grade fever for 4-5 days, pain abdomen and vomiting. He had incurred Rs. 38078/- towards the treatment. The TPA approved the claim of Rs. 8,000 but later rejected due to discrepancy observed in his age. He sought the relief of Rs. 38078/- from this forum.**

2. **The Insurance Company vide its letter dated 07.02.2014 had informed the complainant that cashless was denied on the ground that there was a discrepancy observed in the age of the patient. The TPA had denied the cashless as the age of the patient was not tallying with the policy record and complainant was advised to lodge the claim for reimbursement.**

3. **I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant had produced his D/L where the DOB is 24.4.1955. He was admitted in Hospital on 05.08.13 which makes his age 58 years at the time of his admission. The TPA had denied cashless facility on the ground that there was a discrepancy observed in the age of the patient and complainant was advised to lodge the claim with all the necessary papers with the Insurance Company for reimbursement which he had not done. During the course of hearing the Insurance Company agreed to have a relook the case. The complainant is directed to submit the necessary claim papers to the Insurance Company for reimbursement. The Insurance Company is directed to settle the claim as admissible as per terms and conditions of the policy. Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant.**

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In the matter of Sh. Gaurav Marwah
Vs
United India Insurance Company Ltd.

DATE:24.04.2015

1. **The complainant alleged that he was admitted in Sir Ganga Ram Hospital from 30.07.2013 to 03.08.2013 for the treatment of Ulcerative Colitis with Ileoanal Anastomosis with Ilea Pouch with IBS related Athropathy with Dimorphic Anemia. He had submitted all the necessary papers of the claim to the TPA/Insurance Company for reimbursement of Rs. 54,369/- but the Company had denied his claim under clause 4.1 of the policy under pre-existing disease. He had sought the relief of Rs. 54,369/- from this forum.**

2. **The Insurance Company vide its self contained note dated 04.07.2014 had reiterated that the claim was rejected under policy clause 4.1 of the policy i.e. pre-existing disease. The Insured had taken the Mediclaim policy for the first time in November, 2007. The Insured was suffering from Fistula, joint pain and ulcer in stomach as declaration made in the proposal form. The Insured had preferred a claim of hospitalization from 18.01.2008 to 19.01.2008 in Sir Ganga Ram Hospital for the treatment of "crohns disease with perennial Fistula with Ulceration". The Insured had also preferred a claim from 04.01.2010 to 09.01.2010 in City Hospital, New Delhi for the treatment of "Ulcerative Colitis with Leo-anal Anastomomis with S. Iron deficiency Anemia. Hence, two claims were preferred for the same type of disease which were pre-existing at the time of taking the policy for the first time in November, 2007.**

3. **I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing it is revealed that the complainant had taken the Mediclaim policy for the first time in November, 2007 renewed it upto 14.11.13 continuously. Earlier the insured had lodged a claim of hospitalization from 18.01.2008 to**

19.01.2008 in Sir Ganga Ram Hospital for the treatment of "crohns disease with perennial Fistula with Ulceration." He had also preferred a claim from 04.01.2010 to 09.01.2010 in City Hospital, New Delhi for the treatment of "Ulcerative Colitis with Leo-anal Anastomomis with S. Iron deficiency Anemia. So, it is apparent that the current claim (30.07.2013 to 03.08.2013) and previous two claims preferred were in respect of treatment taken for the same type of disease which were pre-existing at the time of taking the insurance policy for the first time in November, 2007. As per exclusion clause no. 4.1 of the policy any pre-existing disease/sickness is not covered unless the policy had run continuously for 03 claim free years. As the insured had preferred two claims under previous year's policy, for the same disease it could not be stated to be claim free years. I see no reason to interfere with the decision of the Insurance Company. Accordingly the complaint filed by the complainant is hereby dispose off.

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In the matter of Sh. D.P. Gupta
Vs
United India Insurance Company Ltd.

DATE:26.06.2015

1. **The complainant alleged that his son was admitted in Pentamed Hospital, Delhi from 25.08.2009 to 30.08.2009 in emergency and diagnosed as TIA with at axic hemiparesis, S.I. radiculopathy, and anxiety neurosis. He had incurred Rs. 47117/- towards treatment and submitted all the necessary papers of claim for reimbursement but the TPA (FHPL) had rejected the claim under investigation and evaluation clause. He had sought the relief of Rs. 47, 117/- from this forum.**

2. **The TPA (FHPL) vide its e-mail dated 23.09.2009 had rejected the claim on the ground of present hospitalization was for Investigation and evaluation of the ailment only. The investigations could have been done on OPD basis without the necessity of admission for the same. The second ground for rejection as per Insurance Company's letter dated 30.11.2009 was that the claim is in first 30 days waiting period.**

3. **I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the Insurance Company had reiterated that the claim was rejected on the ground of "present hospitalization is for Investigation purpose which can be done on OPD basis and the claim was in first 30 days waiting period. As per panel doctors of TPA the present hospitalization was not covered under this policy. The complainant alleged that his son was admitted in Pentamed Hospital, Delhi from 25.08.2009 to 30.08.2009 in emergency on the advices of treating doctor and diagnosed as TIA with at axic hemiparesis, S.I. radiculopathy, and anxiety neurosis. He further submitted that his son Master Dhruv Gupta was covered alongwith other family member (04 Persons) under Mediclaim policy from 16.08.2007 to 15.08.2008 under banc assurance scheme- Indian Overseas Bank Health Care plus policy.**

When he applied for renewal of the said policy for further period of one year, he had submitted the proposal form alongwith the premium of Rs. 4875/- to renew the policy from 16.08.08 to 15.08.2009 for the same coverage of 04 persons as in earlier policy. But the name of his son could not be mentioned in the policy schedule issued by the Insurance Company. He had brought this mistake to the notice of Indian Overseas Bank vide letter dated 25.08.2008 and requested for correction of the mistake and include the name of his son in the policy schedule and provide him the revised policy schedule. But neither the Bank nor the Insurance Company had corrected the policy schedule and provided him the revised policy schedule. The said policy was further renewed from 11.08.2009 to 10.08.2010 for four persons including his son. The claim in question falls under the said policy. On perusal of all the claim documents placed on record, I find that the name of the complainant's son could not be included in the policy due to over sight for the period 16.08.08 to 15.08.09 though the Bank/Insurance Company had collected the premium of 04 persons including his son Master Dhruv Gupta. In earlier policy and subsequent policy the complainant's son was covered. The complainant had written to the bank vide letter dated 25.08.08 to correct the error and include the name of his son in policy schedule but the bank did not make the necessary correction in the policy schedule. I feel that it is a mistake on the part of the Bank/Insurance Company by not including the name of the complainant's son in policy schedule despite charging the premium of 04 persons. The Insurance Company is hereby directed to include the name of complainant's son in the policy schedule for the period of 16.08.08 to 15.08.09.

Thus by doing this coverage of Master Dhruv Gupta, son of complainant would be in continuation since 03 years i.e. 16.08.07 to 15.08.08, 16.08.08 to 15.08.09, 16.08.09 to 15.08.10 and policy clause waiting period of 30 days shall not be applicable in this case. The present hospitalization which was for investigation and evaluation purposes which could be done on OPD basis as per the Insurance Company's statement. I observe that the complainant's son was hospitalized on the advices of the treating doctor. Therefore, hospitalization expenses incurred by the complainant should be paid to the complainant. Investigation and diagnostic expenses are not payable as per policy terms and conditions of the policy. Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant.

In the matter of Smt. Manu Bhasin
Vs
Oriental Insurance Company Ltd.

DATE:25.05.2015

1. **Smt. Manu Bhasin (herein after referred to as the complainant) had filed the complaint against the decision of Oriental Insurance Company Ltd. (herein after referred to as respondent Insurance Company) alleging non- settlement of mediclaim.**

2. **The complainant alleged that he was admitted in Holy Family Hospital from 05.05.2014 to 07.05.2014 and diagnosed as G4PiLiA2 at 30+4 weeks POG with previous LS CS. She had submitted the medical bills of Rs. 8138/- for reimbursement to the TPA/Insurance Company but she had not received the claim payment so far. She sought the relief of Rs. 8138/- from this forum.**

3. **The Insurance Company vide its self contained note dated 16.09.2014 had reiterated that the claim had been repudiated under policy clause no. 4.13 which states that any treatment arising from or traceable to pregnancy, child birth, miscarriage caesarian section, abortion or complication of any of these including changing in chronic condition as a result of pregnancy. The Insured had been informed in this regard vide letter dated 27.06.2014.**

4. **I heard both the sides the complainant as well as the Insurance Company. During the course of hearing the complainant had stated that the Insurance Company had not provided him the detailed letter of rejection of claim though the Insurance company had informed him about repudiation of claim vide its letter dated 27.06.2014. Hence the Insurance Company is hereby directed to provide the rejection letter to the complainant detailing all the reasons of repudiation of claim. Accordingly the complaint filed by the complainant is hereby disposed off.**

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In the matter of Sh. Rahul Aggarwal
Vs
Oriental Insurance Company Ltd.

DATE:19.06.2015

1. **The complainant alleged that his mother was admitted in Sunder Lal Jain Hospital for major surgery on account of comminuted Trochanteric fracture. She was admitted on 11.09.2013 and discharged on 17.09.2013. The treating doctor had advised her to undertake physiotherapy for about 03 months and the same can be taken at home or at the clinic. But due to major operation wherein ROD was placed, his mother was not in a position to move from bed, so doctor had arranged the visit of physiotherapist at home. The TPA had settled all other claim except the charges paid to physiotherapy factor for home visited. He sought the relief of Rs. 12,000/- from this forum.**

2. **The Insurance Company vide its letter dated 22.12.2014 had informed to the insured that the claim is not admissible as home visit charges for physiotherapy are not covered as per policy terms and conditions.**

3. **I heard both the sides the complainant (represented by his brother) as well as the Insurance Company. During the course of hearing the Insurance Company had reiterated that the amount of physiotherapy was deducted as the complainant had not submitted the proper bills/payment receipt. The complainant is directed to submit the proper bills of physiotherapy charges to the Insurance Company for reimbursement. Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant.**

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In the matter of Sh. Vinod Kumar Jain
Vs
Oriental Insurance Company Ltd.

DATE:25.06.2015

1. **The complainant alleged that he was admitted in Max Health Care from 21.05.14 to 25.05.14 for the treatment of syncope and collapse (pace maker). The total expenditure incurred towards the treatment was Rs. 5, 92,241/- out of which TPA had allowed only Rs. 2, 00,000/-. The S.I. under the policy was Rs. 7 Lacs since 29.08.2011 but the Insurance Company had considered the S.I. of Rs. 2 Lacs for the policy period 2009-10 before 04 years. He had sought the relief of Rs. 8, 07,571/- (Rs. 3,07,571+ 5 Lacs for mental agony and harassment) from this forum.**

2. **The TPA E Meditek vide its letter dated 28.05.2014 had clarified that S.I. was restricted to Rs. 2 Lacs (2009-10) for settlement as the disease pertained to previous years.**

3. **I heard both the sides the complainant as well as the Insurance Company. During the course of hearing the Insurance Company had reiterated that the patient was a known case of hypertension and pace maker was implanted when he was hospitalized in Max Health Care on 21.05.14. On 02.06.14 the patient underwent PTCA + stenting to LAD (DES) was done. The earlier S.I. under the policy was Rs. 2 Lacs and it had been enhanced to Rs. 7 Lacs since 29.08.2011. The Insurance Company had settled the claim considering the earlier S.I. of Rs. 2 Lacs treated the disease as pre-existing. The Insurance Company had not filed the SCN and other papers of the case to substantiate their claim. On perusal of the claim papers I find that as per discharge summary of Max Hospital dated 21.05.2014, the patient is a known case of hypertension and evaluated symptomatic Bradycardia due to complete Heart blockage and peacemaker was implanted on 23.05.2014. Thereafter, the patient was again admitted in Max Health Care on 02.06.2014 and on evaluation detected to be in CHB and CAG revealed double vessel disease (DVD) and PTCA+Stenting to LAD (DES) was done on 02.06.14. Considering all the facts and findings of the case, I hold that the Insurance Company had wrongly considered the previous year's policy S.I. of Rs. 2 Lacs as the disease HTN had no relevance with the disease for which the patient was treated in Max Hospital, vide discharge**

summary dated 21.05.14 and 02.06.2014. The Insurance Company could not substantiate their claim with cogent and reliable documents that the disease HTN had any relation with the disease for which the patient was treated. HTN and Diabetes are life style diseases which are controllable. The pre-existing disease in this case was HTN whereas the patient was treated for symptomatic Bradycardia due to complete heart blockage.
The Insurance Company also could not conclusively prove that HTN and diabetes led to symptomatic Bradycardia The Insurance Company should have taken the S.I. of Rs. 7 Lacs as revised in the year 2011-12 for settlement of the said claim. Hence, I hold that the Insurance Company is liable to pay the difference amount of claim to the complainant according to his eligible S.I. i.e. Rs. 7 Lacs. Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant.

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In the matter of Sh. Deepak Chawla
Vs
Oriental Insurance Company Ltd.

DATE:28.05.2015

1 **The complainant alleged that his wife was covered under Happy Family Floater Mediclaim Policy for S. I. of Rs. 3 Lacs. She was hospitalized in Rajiv Gandhi Cancer Institute and Research Centre, Delhi from 10.03.13 to 13.03.13 where she was treated for Carcinoma. He had lodged a claim of Rs. 96,618/- with the TPA/Insurance Company for reimbursement but the Insurance Company had repudiated the claim on the basis of clause 4.1 of the policy i.e. pre-existing disease. There was a break of 04 days in the policy which was renewed in 2010. He had taken a mediclaim policy with the Insurer from 12.12.2006 to 11.12.2007 and subsequently renewed from 12.12.2007 to 11.12.2008, 12.12.2008 to 11.12.2009, 12.12.2009 to 11.12.2010, 15.12.2010 to 14.12.2011, 15.12.2011 to 14.12.2012, 15.12.12 to 14.12.13. There was a gap of 4 days in renewal of the policy (2010-2011). The first claim was lodged with**

the Insurance Company in 2009 for Carcinoma disease. He sought the relief of Rs. 96,618/- from this forum.

2 The Insurance Company vide its letter dated 16.04.2013 had rejected the claim on the ground of pre-existing disease (clause 4.1 of the policy). There was break in renewal of policy for the year 2010-2011.

3 I heard both the sides, the complainant as well as the Insurance Company. I find that the complainant had policies from Insurance Company since 2006. There was a gap of four days in renewing the policy of 2010-11. The delay of 04 days in renewing the policy is condoned. The Insurance Company is hereby directed to settle the claim within one month. Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant.

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In the matter of Sh. R.K. Verma
Vs
Oriental Insurance Company Ltd.

DATE:28.05.2015
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1. **The complainant alleged that the cataract surgery of both his eyes was done at Tara Netralaya Hospital on 14.12.12 & on 27.02.13 and he remained in hospital for more than 48 hours. But both these claims have been repudiated by the TPA/ Insurance Company under exclusion clause 4.2 which excludes cataract for 02 years. After a few months of the cataract surgery there was swelling in both the eyes and he had taken the treatment at Dr. Shroff's Charitable Eye Hospital on 31.08.2013. The said claim had also been denied by the Company on the ground of "treatment was taken as an OPD & also the patient was prescribed of "avastin" which is not payable. The complainant had sought the relief of Rs. 11,965/- from this forum.**

2. **The Insurance Company vide its letter dated 25.11.13 and 01.10.13 had rejected the claims on the ground that "claim falls under two years waiting period clause". The policy inception date is 08.07.11 and the patient was admitted in Tara Netralaya on 26.02.13 for the treatment of cataract. Hence, the claim was denied under exclusion clause 4.2. the second claim at Dr. Shroff's Charity Eye Hospital dated 31.08.13 was rejected on the ground that "treatment was taken as an OPD which was not covered under the policy claim falls under exclusion clause 2.3"**

3. **I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the Insurance Company had informed that the complainant had not given the original medical papers of the claim to settle the claim.**
   The complainant is directed to submit all the original papers of the claim pertaining to the retina treatment and the injection avastin to the Insurance Company for reimbursement of claim. The Insurance Company is hereby directed to settle the claim as admissible on receipt of necessary mediclaim documents from the complainant.

Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant.

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In the matter of Sh. Praveen Kr. Gupta
Vs
Oriental Insurance Company Ltd.

DATE:25.06.2015
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1. **The complainant alleged that his wife was admitted to the Institute of Liver & Biliary Sciences for the period of 15.04.2013 to 21.04.2013 and diagnosed as Portal HTN (Non-bleeder, no varies). Acute or chronic liver failure (acute-unknown, chronic-NASN), Morbidities, D.M. HTN, Hypothyroidism etc. she was expired during treatment on 21.04.2013. The cause of death was Acute or Chronic Liver failure Sepsis with refractory septic shock. He had lodged the claim for reimbursement with the TPA/Insurance Company for Rs. 1, 88,885/- but the Insurance Company had denied the claim under pre-existing disease. He sought the relief of Rs. 1, 88,885/- from this forum.**

2. **The Insurance Company vides its self contained note dated 07.07.2014 reiterated that the claim was rejected under exclusion clause no. 4.1 i.e. pre-existing disease. As per doctor's certificate dated 11.06.2013 it is found that patient having ulcerative colitis since 06 years, hypertension since 6-7 years and recently detected D.M. The policy inception date is 28.12.2011 and the claim had been made in the 2nd year of policy. However, the pre-existing diseases are not covered for full 03 years under policy terms and conditions no. 4.1.**

3. **I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the Insurance Company had reiterated that the said claim is not payable under exclusion clause no. 4.1 i.e. pre-existing disease as the patient was having ulcerative colitis since 6 years, hypertension since 6-7 years and recently detected DM. The policy inception date is 22.12.2011, so it is clearly concluded that the present ailment is proximately related to past ailment so the ailment found to be pre-existing,**

hence the claim is denied under exclusion clause no 4.1. As per medical papers submitted by the complainant the patient was suffering from ulcerative colitis since 06 years and was treated for chronic liver disease. The policy is in 2nd year and there is a 03 years waiting period to cover the pre-existing disease. I find that the Insurance Company had rightly rejected the claim under clause 4.1 I.e. pre-existing disease. I see no reason to interfere with the decision of the Insurance Company. Accordingly the complaint filed by the complainant is hereby disposed off.

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In the matter of Sh. Manish Sharma
Vs
Oriental Insurance Company Ltd.

DATE:25.06.2015
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1. **The complainant alleged that he was admitted in Jaipur Golden Hospital on 10.12.2013 due to heart attack and remained in the hospital for 09 days. On 11.12.2013 he was shifted to Medanta Hospital, Gurgaon for Angiography. The Medical Bills of the hospital were Rs. 1, 67,340/- but the TPA had approved only Rs. 1 Lac. The S.I. under the Floater Policy was Rs. 2 Lacs. He sought the relief of Rs. 67,340/- (Balance amount) from this forum.**

2. **The Insurance Company vides its letter 17.01.2014 had apprised to the Insured that cashless settlement of Rs. 1 Lac was made to hospital directly by the TPA. As per the documents submitted to the TPA for cashless and reimbursement it was clearly mentioned T-2, D.M. since 6 years, and Nephropathy with sepsis. The S.I. under the policy was increased from the year 2010-2011 to Rs. 2 Lacs and prior to that the S.I. was Rs. 1 Lac. As the disease was since 06 years the claim was restricted to the S.I. of Rs. 1 Lac and settled in full and final settlement.**

3. **I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the Insurance company had stated that the patient is a known case of hypothyroidism with D.M. having a past illness history since 06 years. As the Insurer was admitted due to a disease which he was suffering since 06 years, therefore the claim of the patient is settled based on the S.I. of policy 2010/2546 having a S.I. Rs. 1 Lac because the enhanced S.I. will be**

applicable only after 04 years of enhancement which in case will take place in the next enhancement which in case will take place in the new renewal of 2014-15. The discharge summary revealed that he is a known case of hypothyroidism and was administered medication for the same. The S.I. was increased to Rs. 2 Lacs since the policy year 2010-11. On perusal of the claim papers placed on record I find that in the cashless request form it is mentioned that the patient was suffering from hypothyroidism with DM since 06 years. The S.I. under the policy at that time was Rs. 1 Lac and it was enhanced to Rs. 2 Lacs only from 2010-11 onwards. I feel that the Insurance e Company had rightly settled the claim considering the S.I. for Rs. 1 Lac for such disease as in case of increase in S.I. treatment of pre-existing disease and for a disease/ailment/injury for which treatment has been taken in the earlier policy period, the enhanced S.I. will be applicable only after four continuous renewals with the increased S.I. Accordingly the complaint filed by the complainant is hereby disposed off.

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In the matter of Sh. Vishal Dang
Vs
Oriental Insurance Company Ltd.

DATE:28.05.2015

1 **The complainant alleged that his wife was admitted in Action Medical Institute from 31.08.2012 to 05.09.2012 for the treatment of Enteric fever and incurred Rs. 25,719/- towards treatment. He had lodged the claim with the TPA/Insurance Company but his claim was rejected on the ground of "Expenses incurred at Hospital or Nursing Home primarily for evaluation/diagnostic purposes which is not followed by active line of treatment for the ailment during the hospitalized period." He sought the relief of Rs. 25719/- from this forum.**

2 **The Insurance Company vides its self contained note dated 03.11.2014 had reiterated and rejected the claim vide its letter dated 01.08.2013 under exclusion clause 4.11 of the policy 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 the hospitalized period.**

3 **I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the Insurance Company had stated that claim falls under Exclusion clause 4.11 of the policy i.e. "expenses incurred at Hospital or Nursing home primarily for evaluation/diagnostic purposes which is not followed by active treatment for the ailment during the hospitalized period or expenses incurred for investigation or treatment irrelevant to the diseases diagnosed during hospitalization or primary reasons for admission referral fee to family, doctors, out station consultants, surgeons fees, doctor's home visit charges/attendant/nursing charges during pre and post hospitalization period etc." The complainant had alleged that he was hospitalized from 31.08.12 to 05.09.12 on the advices of treating doctor as he was suffering from Enteric fever. I find that the complainant was hospitalized in the hospital on the advices of treating doctor, therefore hospitalized expenses incurred by the complainant should paid by the Insurance Company. Investigation and diagnostic expenses are not payable as per the policy terms and conditions. Accordingly an award is passed with the direction to the**

Insurance Company to reimburse the hospitalization expenses to the complainant.

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In the matter of Sh. Akash Mittal
Vs
Oriental Insurance Company Ltd.

DATE:19.06.2015.

1. **The complainant alleged that his father was admitted in NHMMI, Narayana, Raipur from 12.07.13 to 25.07.13 and diagnosed as Left Pica Syndrome & UTI. Thereafter he had also consulted two other doctors and taken the treatment for the same illness. He had filed the three claims with the Oriental Insurance Company Ltd. amounting to Rs. 1,074,782/-, Rs. 30,623/- and Rs. 25791/- for reimbursement but the Insurance Company had denied the claim as falling under two years waiting period. He sought the relief of Rs. 1, 62,468/- from this forum.**

2. **The Insurance Company vides its letter dated 02.12..2013 had repudiated the claim under exclusion clause no. 4.3 of the policy which states that the claimed expenses are related to ICICI HTN and CVA which are not payable in second year policy. (exclusion No. 4.3)**

3. **I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the Insurance Company had reiterated that the claim was rejected under exclusion clause no. 4.3 i.e. two years waiting period as the claimed expenses are related HTN & CVA which is not payable in second year of policy. However, the Insurance Company could not substantiate their contention with any documentary proof. On going through the discharge summary of NHMM1 Narayana Hospital, I find that the patient was admitted on 12.07.13 with complaint of vertigo, difficulty in swallowing with numbness in left face and right upper and lower limbs with slurring of speech since 02 days. I hold that it had no relevance with HTN& CVA and the Insurance Company had wrongly rejected the claim under the said clause 4.3. Accordingly an award is passed with the**

direction to the Insurance Company to settle the claim of the complainant.

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In the matter of Sh. Ashok Kumar Aggarwal
Vs
Oriental Insurance Company Ltd.

DATE:02.06.2015.

1. **The complainant alleged that he was admitted in BL Kapur Memorial Hospital from 21.01.14 to 22.01.14 and diagnosed as Internal Hemorrhoids, colonic diverticulae, Gastritis, cystitis. He had submitted all the necessary papers of the claim for reimbursement to the TPA/ Insurance Company for Rs. 22713/- but the Insurance Company had denied his claim on the ground of two years waiting period clause. He sought the relief of Rs. 22713/- from this forum.**

2. **The Insurance Company vides its letter dated 19.03.2013 had rejected the claim on the ground of exclusion clause 4.3 for the policy under two years waiting period clause. The patient was admitted for treatment of piles/fissure/fistula in anus which is excluded from the scope of cover for two years from the date of inception of the policy.**

3. **I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the Insurance Company had stated that the patient was admitted in the hospital on 21.01.14 for the treatment of colonic diverticulae which relates to the treatment of piles/fissure/fistule is excluded under policy terms and conditions no. 4.3 states "the expenses on treatment of the said ailment/diseases for the specified period are not payable if contracted and/or manifested during the currency of the policy." The said disease is not covered during the Ist year of policy. Hence, the Insurance Company had rightly rejected the claim under exclusion clause no. 4.3 i.e. two years waiting period. I see no reasons to interfere with the decision of the Insurance Company. Accordingly the complaint filed by the complainant is hereby dispose off.**

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In the matter of Sh. Rahul Garg
Vs
Apollo Munich Health Insurance Company Ltd.

DATE:18.05.2015

1 **The complainant alleged that his daughter was admitted in Indraprastha Apollo Hospital on 03.11.14 and diagnosed as Pre-B-Acute Lymphoblastic Leukemia. She was admitted in day care procedure for about half a day. He had incurred Rs. 26,000/- (approx) towards her treatment but the Insurance Company had rejected the claim on the ground of "this is a management of disease and a day care procedure". He sought the relief of Rs. 26,000/- from this forum.**

2 **The Insurance Company vide its letter dated 12.11.2014 had rejected the claim on the ground of exclusion clause Sec-I 11(a) of the policy which states that the submitted claim is for management of an ailment where the hospitalization is less than 24 hours and also not falling under day care procedures listed in the policy**

3 **I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant had stated that his daughter was admitted in Indraprastha Apollo Hospital on 03.11.2014 for removal of chemoport under G.A. as proper surgical treatment/procedure could not be done at home. The Insurance Company had reiterated that the removal of chemoport is not covered under the policy under the daycare procedure. Earlier the Insurance Company had allowed insertion/implantation of chemoport and the expenses of chemotherapy were also reimbursed by the Insurance Company. As the removal of chemoport is a surgical procedure and pertains also to earlier treatment, cannot be done at home, the Insurance Company had wrongly rejected the claim. Hence, I hold that the Insurance Company is liable to settle the claim. Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant.**

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In the matter of Sh. Amit Singh
Vs
Apollo Munich Health Insurance Company Ltd.

DATE:29.06.2015

1. **The complainant alleged that his brother was admitted in Apollo Hospital from 26.04.14 and diagnosed as post liver transplant and incurred Rs. 1, 92,820/- towards treatment. He died in the hospital on 28.04.14. He sought the relief of Rs. 1, 92,820/- from this forum.**

2. **The Insurance Company vides its letter dated 12.11.2014 had rejected the claim on the ground that "claim is for treatment of post liver transplant care which is a consequence/complication of alcohol/drug intake. Treatment related to alcohol abuse/substance abuse is excluded in the policy under sec VI c (IV).**

3. **I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the Insurance Company had reiterated the patient was treated for post liver transplant care which was a consequence/complication of Alcohol/drug intake. Treatment related to alcohol abuse/substance abuse is excluded in the policy under section VI c (iv). On perusal of the case papers placed on record I observe that as per certificate issued by Sat Guru Partap Singh Apollo Hospital dated 16.01.2014 the patient was a case of Alcoholic Liver Disease (ALD) with cirrhosis with ascites and was taking the medicine of Aldactone regularly for the said disease. The disease may be linked to alcohol intake as patient is alcoholic for the past 05 years.**
I feel that the Insurance Company had rightly rejected the claim under section VI C (iv) Substance abuse and de-addiction programs which states that "Abuse or the consequences of the abuse of intoxicants or hallucinogenic substances such as intoxicating drugs and alcohol, including smoking cessation programs and the treatment of nicotine addiction or any other substance abuse treatment or services, or supplies" as the patient was a known case of Alcoholic Liver Disease (ALD) with cirrhosis with ascites and also taking the medicine of Aldactone regularly for the said disease

I see no reasons to interfere with the decision of the Insurance Company. Accordingly the complaint filed by the complainant is hereby dispose off.

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In the matter of Sh. Anjeesh Jain

Vs
Apollo Munich Health Insurance Company Ltd.

DATE:18.05.2015.

1. **The complainant alleged that he was admitted in Kukreja Hospital from 09.10.14 to 11.10.14 for the treatment of viral fever. He had applied for cashless facility but the Insurance Company had denied the same on the ground of that "the stated ailment could have been managed on OPD basis and not requires hospitalization." The claim amount was Rs. 14,257/-**

2. **The Insurance Company vides its letter dated 10.10.2014 had denied the cashless facility on the ground that "the stated ailment could have been managed on OPD basis and does not require hospitalization." The Insurance Company had further advised to the complainant to submit the claim documents after completion of treatment for review on admissibility.**

3. **I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the Insurance Company had stated that they are ready to settle the claim if the complainant submits the required documents. The complainant is directed to submit the required documents to the Insurance Company for settlement of his claim. Accordingly the Insurance Company is directed to settle the claim as admissible within one month after receiving of necessary documents. Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant.**

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In the matter of Sh. Ravi Verma
Vs
Apollo Munich Health Insurance Company Ltd.

DATE:18.05.2015

1. **The complainant alleged that he was met with an accident on 13.10.14 and hospitalized in Medanta Hospital. The claim documents of Rs. 37720/- was submitted to the Insurance Company for reimbursement and Insurance Company had paid the said amount. He had again submitted a new claim on 05.12.14 for the reimbursement for the reimbursement post hospitalization expenses for the same injury treated on OPD basis and a new claim for hospitalization in Delhi pain Management for Neuralgic Sympathetic pain PIVD from 22.11.14 to 23.11.14. He had submitted all the necessary papers of the claim to the Insurance Company for reimbursement of claim but the Insurance Company had closed the claim file due to non-compliance of documents/queries.**
2. **The Insurance Company vide its letter dated 31.01.2015 had closed the claim as the complainant had not completed the requisite formalities to process and settle the claim.**
3. **I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the Insurance Company agreed to settle the post-submission of hospitalization claim on submission of the required documents by the complainant.**
   The complainant is directed to submit the necessary papers of post-hospitalization period to the Insurance Company to settle the claim. Accordingly the Insurance Company is directed to settle the claim as admissible within one month on the receipt of required documents. Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant.

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In the matter of Mr. Jaspreet Singh Sobti
Vs
Bharti AXA General Insurance Company Ltd.
DATE:19.06.2015

1. **The complainant alleged that his mother was admitted in Medanta Hospital from 28.07.2013 to 31.07.2013 and diagnosed as left adrenal mass (theochromocytoma), Hypertension, cervical spondylitis. The cashless facility was not provided by the hospital as the same was not in the penal list of Insurance Company. He had submitted the claim of Rs. 2, 24,000/- to the Insurance Company for reimbursement but the Company had settled only Rs. 66,786/- which the complainant had refused to accept. He sought the relief of Rs. 2, 24,000/- from this forum.**

2. **The Insurance Company reiterated its self contained note dated 14.08.2014 that the claim had been settled as per terms and conditions of the policy. The S.I. under the policy was Rs. 2 Lacs for the member. There is a restriction of 1% on room rent category and all other medical expenses would be payable in proportionate to entitled room category. In case insured opts for higher room rent category the difference between charges will be borne by the Insured. The Insurance Company had also stated that under exclusion clause no. 21 robotic instrument for surgery which was not payable.**

3. **I heard both the sides the complainant as well as the Insurance Company. During the course of hearing the Insurance Company reiterated that the claim was settled as per terms and condition of the policy. The S.I. under the policy was Rs. 2 Lacs and there was a restriction of 1% on room rent category and all other medical expenses would be payable proportionate to entitle room category. The Company had further stated that the complainant had opted usage of robotic instrument for surgery which was not payable under exclusion clause no. 21. On perusal of exclusion clause no. 21. I find that there is no mention of "robotic instrument" in the said clause and I feel that the Insurance Company had wrongly deducted the claim amount under the said exclusion clause. Hence, I hold that the Insurance Company is liable to pay the claim amount towards**

expenses on robotic instrument. Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant.

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In the matter of Mr. O.P. Gupta
Vs
Bharti AXA General Insurance Company Ltd.

DATE:19.06.2015

1. **The complainant alleged that his daughter (since deceased) was admitted in Fortis Hospital on 09.01.2014 and expired on 11.01.14 in ICCU itself. She was diagnosed as Pneumonia multi organ dysfunction and swine flu as per doctor's certificate dated 22.01.14. He had submitted all the relevant reimbursement of Rs. 1, 75,824/- but the TPA had paid only Rs. 1, 22,040/-. He sought the relief of Rs. 53,744/- (Difference of amount) form this forum.**

2. **The Insurance Company vide email dated 15.05.2014 had apprised the complainant of the details of deductions made by them on account of Medicines-Non medical as per policy terms and conditions. Hospital charges are payable proportionate to the room entitlement and hence proportionate deductions were applicable.**

3. **I heard both the sides the complainant as well as the Insurance Company. During the course of hearing the complainant stated that the details of deduction of Rs. 53,784/- by the Insurance Company/TPA were not given to him. The Insurance Company had stated that the details of deductions had already been provide by the TPA E-Meditek to the complainant vide letter dated 17.12.2014. The Insurance Company had again provided the copy of said letter to the complainant. Accordingly the complaint filed by the complainant is hereby disposed off.**

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In the matter of Sh. M.P. Bhardwaj
Vs
HDFC ERGO Insurance Company Ltd.

.DATE:22.08.2015

1. **The complainant alleged that he was admitted in Max Super Specialty Hospital for the period of 22.05.13 to 04.06.13 and again on 13.02.14 to 28.02.14 for the treatment of LBA & BL Ridiculer pain in lower limbs/Fort drops and power 40/50% loss knee/hips during duty hours. He had submitted all the necessary papers of the two claims for reimbursement amounting to Rs. 73,557/- and Rs. 1,67,328 respectively to the Insurance Company but the Company had denied the claim on the ground that policy covers the loss only if there is complete and permanent inability of usage of limbs. He had sought the relief of Rs. 73,557+Rs. 1, 67328/- and loss of job of 178 days.**

2. **The Insurance Company vide its letters dated 16.04.14 & 30.12.14 had rejected the claims on the ground that the losses claimed under the policy are not covered as per Sarv Suraksha policy terms and conditions. The Insured was suffering from low back ache and were diagnosed as demyelination/prolapsed inter vertebral disc with canal stenosis as per discharge summary and there was no residual motor deficit as per follow-up notes. The policy covers the loss only if there was complete and permanent disability of usage of limbs.**

3. **I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the Insurance Company had stated that the Insured was suffering from low back ache and was diagnosed to have Demyelination/Prolapsed Inter Vertebral Disc with canal stenos is and there was no residual motor deficit as per follow up notes. The policy covers the loss only if there is complete and permanent disability of usage of limbs. Since, the losses claimed by the complainant were not covered under terms and conditions of the policy the claim was closed as No Claim. The complainant stated that his claim falls under critical ailment/illness (section 1) and loss of job (section 4) of the Sarv Suraksha Policy. Due to accident/sudden critical ailment i.e. LBA & B/L Radicular pain in lower limbs/foot drops and power 40/50% loss knee/hips during**

duty hours. He had also claimed compensation under the "loss of job section" for 178 days. On perusal of the claim papers placed on record, I find that the Insured had not suffered any complete and permanent disability of usage of limbs. As per terms and conditions of the Sarv Suraksha plus Personal Accident policy the claim is payable only if the Insured suffered permanent and complete disability of usages of limbs for extension of any benefit of insurance under the policy. The Insured had also submitted claim under the category "loss of job" for 178 days. The claim under the section-4 "loss of job" is payable only if the Insured person lost his job due to retrenchment from his employer in view of mergers and acquisitions. In the instant case, the complainant was advised medical rest and there was no question of his having been retrenched. The complainant had not produced any document before this forum to substantiate his claim under this section. The Insurance Company had rightly rejected the claim as the claim does not fall under the definition/ scope of the policy conditions no. 4 i.e. "loss of job". I see no reason to interfere with the decision of the Insurance Company. Accordingly the complaint filed by the complainant is hereby disposed off.

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In the matter of Smt. Krishna Sharma
Vs
HDFC ERGO Insurance Company Ltd.

DATE:12.08.2015

1. **The complainant alleged that her husband had taken a policy of Rs. 10 Lacs from HDFC for security of our Home Loan but the Insurance Company had misguided them and sold a different policy like mediclaim. Her husband had died due to chickengunia and kidney failure. When she applied for reimbursement of claim the Company had denied the claim on the ground that the said ailments do not fall within the policy purview. She had sought the relief of Rs. 10 Lacs from this forum.**

2. **The Insurance Company vide its letter dated 20.11.14 had rejected the claim on the ground that Febrile illness, septicemia with shock, acute renal failure, severe metabolic acidosis with acute respiratory distress syndrome do not fall within the policy purview of Home**

Suraksha Plus. Major medical illness and procedures section of this policy covers listed critical illness only.

3. **I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant alleged that the policy was Home Plus Suraksha and her husband died on account of chickengunia and kidney failure. The Insurance Company had rejected the claim on the ground that the diseases for which the patient was treated do not fall within the policy purview of Home Suraksha Plus. The Insurance Company had stated that as per death summary Mr. Rajesh Sharma was suffering from Febrile illness, Septicemia with shock, acute renal failure, severe metabolic acidosis with acute respiratory distress syndrome. These ailments do not fall within policy purview. Major medical illness &procedures section of this policy covers listed critical illness only. On perusal of the claim papers placed on record and the policy conditions during personal hearing. I find that the Insurance Company had rightly rejected the claim as the ailments for which the patient was treated do not fall within policy purview. Hence, I see no reasons to interfere with the decision of the Insurance Company. Accordingly the complaint filed by the complainant is hereby disposed off.**

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In the matter of Sh. R.C. Agarwal
Vs
Bajaj Allianz General Insurance Company Ltd.

DATE:01.07.2015.

1 **The complainant alleged that his son was admitted in Max Health Care Hospital from 19.08.14 to 20.08.2014 and diagnosed as Coronary artery disease (CAD), unstable angina. He had submitted all the necessary papers of the claim to the Insurance Company for reimbursement of Rs. 2,55,763/- but the Insurance Company had denied the claim on the ground of non-disclosure of material facts. He had sought the relief of Rs. 2, 55,763/- from this forum. The Insurance Company had also denied the cashless facility and cancelled the policy.**

2 **The Insurance Company vide its self contained note dated 04.03.2015 had reiterated that the claim had been rejected under clause B-16 i.e. disclosure to information norms. As per discharge summary and other medical reports of the Insured dated 19.08.14 under diagnosis it is clearly mentioned that the insured suffered from coronary artery disease and unstable angina. There had been clearly mentioned that post PTCA+Stent to LAD was performed on the insured in 2002. But the same was not disclosed by the Insured at the time of taking the policy in 2010. This tantamount to mis-representation, non-disclosure of material facts. Hence, claim is not payable.**

3 **I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the Insurance Company reiterated that this is a case of non-disclosure of material facts as Mr. Sunil Agarwal was having history of coronary artery disease with PTCA 2002, which is prior to the inception of the policy i.e. 2010. The history of CAD with PTCA was not disclosed in the proposal form submitted for policy issuance and the policy was issued based on the declarations made by the proposer in the proposal form. This tantamount to misrepresentation, non-disclosure of material fact, hence claim was not payable. On perusal of claim papers placed on record, I find that as per discharge summary Max Hospital dated 19.08.2014 the patient was diagnosed as CAD. Unstable angina and Post PTCA+Stent to LAD (2002). The insured had not disclosed the**

material facts at the time of taking the policy in the year 2010 that he was suffering from CAD and unstable angina and post PTCA+Stent to LAD was performed in the year 2002. Hence, the Insurance Company had rightly rejected the claim. I see no reasons to interfere with the decision of Insurance Company. Accordingly the complaint filed by the complainant is hereby disposed off.

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In the matter of Sh. Ajeet Kasliwal
Vs
Bajaj Allianz General Insurance Company Ltd.
DATE:13.08.2015

1. **The complainant alleged that his wife was admitted in Institute of Liver and biliary Science from 02.04.13 to 08.05.13 and diagnosed as Gronulomatous Entorocolitis, Crohns diseases with superimposed? Tuberculosis, CDA1-293 (Moderate activity) fungal sepsis etc. She was again admitted in same hospital from 02.06.13 to 18.06.13 and diagnosed as Granulomatous Enterocolities, malabsorbtion syndrome, acute kidney injury, urinary tract infection etc. He had submitted all the necessary papers of the claim to the Insurance Company for reimbursement of amount of Rs. 7, 74761/-. But the Insurance Company had rejected the claims on the ground of pre-existing diseases. He had sought the relief of Rs. 7, 74,761 from this forum.**

2. **The Insurance Company vide its letter dated 19.02.2014 had rejected the claim under policy clause-C1 which states that benefits will not be available for any pre-existing condition, ailment or injury until 48 months of continuous coverage have elapsed after the date of inception of the first extra care policy. The claimant was known to be suffering from complaints since 01 year which was pre-existing and had not been disclosed on the proposal form.**

3. **I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the Insurance Company had stated that the claimant was hospitalized in Institute of Liver & Biliary Sciences from 02.04.13 to 08.05.13 & 02.06.13 to 18.06.13 for treatment of Granulomatous Enterocolities (crohn's Disease) with superimposed, tuberculosis, malabsorption syndrome, and fungal sepsis. As per discharge summary the claimant was known to be suffering from complainants since 01 year which was**

pre-existing to the policy inception i.e. 01.11.12 and had not been disclosed in the
proposal form. Hence, the claim was repudiated according to terms and condition of the policy. "Benefits will not be available under the policy for any pre-existing condition, ailment or injury until 48 months of continuous coverage have elapsed after the date of inception of the first extra care policy with them."
The complainant alleged that earlier his wife was covered under Group Mediclaim Policy from the same Insurance Company and that he had also taken the claims under the said GMP. On perusal of the claim papers placed on record, I find that the claim was rejected under pre-existing condition and non-disclosure of material facts in the proposal form. The patient was suffering from Granulomatous Enterocolities (crohn's Disease) with superimposed, tuberculosis, malabsorption syndrome, and fungal sepris since last one year. The policy (No.OG-13-1101-8416-0000456 from 01.11.12 to 31.10.13) was in first year. The complainant had not provided any documentary proof/evidence that earlier he and his wife were covered under GMP of the same Insurance Company and that he had also taken the claim under the said GMP. Nor did he provide any proof that he had applied for portability to convert/shift his policy form GMP to individual/Family Floater policy. In the absence of any documentary proof, the Insurance Company has treated the policy as fresh policy. The Insurance Company had rightly rejected the claim under policy clause C1 i.e. benefits will not be available for any pre-existing condition, ailment or injury, until 48 months of continuous coverage had elapsed, after the date of inception of the first extra care policy with them. In case of change in plan from a lower deductible plan to higher deductible plan this exclusion shall apply afresh only to the extent of the amount by which; the limit of indemnity has been increased (i.e. enhanced sum insured) if the policy is a renewal of Extra Care Policy without break in cover. There is also the fact non-disclosure of material facts in proposal form at point no. 13 the complainant had denied that he or any of his family members had any health complaints in the past four years and have been taking treatment/hospitalization. The complainant could not substantiate his claim that there was no medical problem prior to inception of the policy with cogent and reliable document. I see no reason to interfere with the decision of the Insurance Company. Accordingly the complaint filed by the complainant is hereby dispose off.

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In the matter of Sh. Jatinder Singh Sethi
Vs
IFFCO Tokio General Insurance Company Ltd.

DATE:10.08.2015

1. **The complainant alleged that he was admitted in Shroff Eye Centre on 07.06.14 for Cataract Surgery of his left eye. He had applied for cashless services but the TPA had approved the amount of Rs. 36029/- instead of Rs. 47,000/-. He had sought the relief of Rs. 11,000/- (difference of amount) from this forum.**

2. **The Insurance Company vide its authorization letter dated 30.05.2014 had provided the cashless approval of Rs. 36,029/-. The amount was deducted by the Insurance Company on account of co-payment of Rs. 9400/- on package charges and reinstatement charges of Rs. 1571/-**

3. **I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the Insurance Company had stated that the claim was settled as per terms and conditions of the policy which states that the hospitalization expenses incurred for treatment of any one illness under package charges of the Hospital/Nursing Home will be restricted to 80% of the package in hospitals outside the Preferred Provider Network". The amount of Rs. 36029/- was paid after deducting of the 20% co-payment due to package and reinstatement premium of Rs. 1578/- from the total claim amount of Rs. 47,000/- on perusal of the claim papers place on record. I find that the Insurance Company had rightly settled the claim as per terms and conditions of the policy and see no reason to interfere with the decision of the Insurance Company. Accordingly the complaint filed by the complainant is hereby dispose off.**

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In the matter of Smt. Narinder Kaur. Bagga
Vs
United India Insurance Company Ltd.

DATE:04.08.2015

1. **The complainant had alleged that she was admitted in Fortis Hospital on 06.10.2014 for the operation of Hernia & discharged on 08.10.2014. She had incurred Rs. 1, 38,000/- towards medical treatment. Her entitlement for the said disease was Rs. 75,000/- (25% of S.I. Rs. 3 Lacs) whereas she had been reimbursed Rs. 62,500/- by the Insurance Company. She had sought the relief of Rs. 12,500/- from this forum.**

2. **The Insurance Company had not submitted any self contained note.**

3. **I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the Insurance Company had stated that S.I. of Rs. 3 Lacs was enhanced in the policy year2014-15 (03.07.14 to 02.07.15). The complainant was admitted in Fortis Hospital from 06.10.14 to 08.10.14 and diagnosed as suffering from Supra Umbilical Hernia. The Increased S.I. could not be considered for the said disease as the same pertained to earlier years. Hence, the claim was settled for Rs. 62,500/- was in order. On perusal of the case papers placed on record I find that as per policy the maximum liability of expenses in respect of cataract, hernia, hysterectomy is actual expenses incurred or 25% of the S.I. whichever is less. The S. I. under the policy was Rs. 3, 00,000/- so the maximum limit is Rs. 75,000/- (25% S.I.) for the said specified illness. As per discharge summary of Fortis Hospital the patient was diagnosed as suffering from Supra Umbilical Hernia and Surgery was done on 06.10.2014. There is no mention in discharge summary that the disease of hernia for which the patient was treated pertains to the earlier period/ preceding policy period or that the patient was a known case of hernia. Hence, the contention of the Insurance Company that the disease pertains to earlier policy period could not be substantiated by the Insurance Company with cogent and reliable documents. I hold that the Insurance Company is liable to pay the difference amount of Rs. 12,500/- (Rs. 75000-Rs. 62500).**

Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant and pay the difference of claim amount of Rs. 12,500/-.

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In the matter of Smt. Madhu Rani Saini
Vs
Oriental Insurance Company Ltd.
DATE:10.07.2015

1. **The complainant alleged that she had taken a policy from Oriental Insurance Company Ltd. Bhavishya Arogya Policy on dated 09.05.2006. When she had surrendered the said policy to the Insurance Company she had been informed by the Company that refund amount is Rs. 44676/-. The original policy was surrendered to the Branch Manager, Oriental Insurance Company Ltd. on 06.09.2013 for refund of amount. But the Insurance Company had not paid the amount so far without any reasons for 12 months. She had sought the relief of Rs. 44676/- plus interest @ 12% of the delay.**

2. **The Insurance Company vide its letter dated 24.12.2014 had confirmed that the claim had been settled and an amount of Rs. 34,288/- had been refunded on 12.12.2014 through NEFT payment.**

3. **I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the Insurance Company had agreed to pay the difference of amount to the Insured. Accordingly Insurance Company is hereby directed to pay Rs. 10,388/- (Rs. 44676 - Rs. 34,288) along with Rs. 5000/- on account of deficiency in services Protection of Policy Holder's Insterest-2002 (PPHI- 2002) being delayed settlement of claim. Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant.**

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In the matter of Sh. Manish Gupta
Vs
United India Insurance Company Ltd.

DATE:23.09.2015.

1. **The complainant alleged that he was admitted in Centre for Sight on 14.03.14 under Day Care procedure for the treatment of Eye. He had incurred Rs. 23,485/- towards the treatment and submitted all the necessary papers of the claim to the Insurance Company for reimbursement but the Insurance Company had denied the claim under pre-existing disease clause. He had sought the relief of Rs. 23,485/- from this forum.**

2. **The Insurance Company vide its letter dated 12.08.2014 had rejected the claim under pre-existing disease as the patient had a history of operation of RD Left eye in 2007 and the policy was taken 10.10.2010 onward, hence the disease was pre-existing as per policy terms and condition 4.1 of the Health policy which excludes all the pre-existing disease.**

3. **I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the Insurance Company had stated that the claim of Rs. 23,485/- was rejected dated 14.03.14 under Exclusion clause no. 4.1 of the policy i.e. pre-existing disease. The complainant was operated in Centre for Sight hospital in the year 2007 for operation for RD left eye with buckle. The said policy was incepted since 10.10.2010. The disease for which the patient was treated i.e. left operated RD flat retina buckle removal on 14.03.14 which makes it pre-existing as per terms and conditions of the policy clause 4.1 which excludes all the pre-existing disease. On perusal of the claim papers placed on record, I find that the Insurance Company had rightly rejected the claim under pre-existing disease (exclusion clause 4.1). Hence I see no reason to interfere with the decision of the Insurance Company. Accordingly the complaint filed by the complainant is hereby disposed off.**

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In the matter of Sh. Mohinder Kr.Chaudhary
Vs
Oriental Insurance Company Ltd.

DATE:31.08.2015

1. **The complainant alleged he was admitted in Sir Ganga Ram Hospital from 23.08.14 to 25.08.2014 and diagnosed as CAD, Post PTCA+Stent to LAD (2012), unstable angina, single vessel disease. He had undergone coronary angiography which revealed single vessel disease and undergone PTCA with stent to PLV using Resolute Integrity 2.5*30mm with good end results. He had incurred Rs. 238130/- towards the medical treatment and submitted all the necessary papers of the claim to the TPA/Insurance Company for reimbursement of claim amount but the Insurance Company had rejected the claim on the ground of break in insurance of 06 days at the time of renewal of policy (2013-14). He had the policy from Oriental Insurance Company Ltd. since 2006. He had sought the relief of Rs. 2, 38,130/- from this forum.**

2. **The Insurance Company vide its letter dated 16.10.2014 had denied the claim on the ground of "there is a break/gap of 06 days between the policies of 2012-13 & 2013-14.**

3. **I heard both the sides the complainant as well as the Insurance Company. During the course of hearing the Insurance Company had stated that the policy of 2013-14 was treated as a fresh policy as there was a break of 06 days in renewal of policy (from the existing 06.07.2012 - 05.07.13 and the renewable from12.07.13 - 11.07.14) as such the claim was not payable. The complainant alleged that he had the policy from Oriental Insurance Company since 2006. On perusal of the claim papers placed on record I find that the complainant was indeed the policy holder of Oriental Insurance Company since 2006 without any break except in the year 2013-14.**

I condone the delay of 06 days and the Insurance Company is directed to settle the claim on its merits. Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant.

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In the matter of Sh. Arun B. Yadav
Vs
Oriental Insurance Company Ltd.

DATE:12.08.2015

1. **The complainant alleged that he was admitted in Max Health Care Hospital from 18.11.13 to 20.11.13 and diagnosed as Hypertension and obstructive sleep apnea and hyperpnoea syndrome (Moderate). He had submitted all the necessary papers of the claim for reimbursement of Rs. 31,273 but the claim was denied on the ground of "admission in Hospital was not required". He had sought the relief of Rs. 31,273/- from this forum.**
2. **The Insurance Company vide its e-mail dated 23.06.2014 had informed that the said claim was rejected under exclusion clause no. 4.10 i.e. "the patient had undergone investigations and evaluation only and no such active line of treatment was there".**
3. **I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the Insurance Company had stated that the claim was rejected under exclusion clause no. 4.10 which states that "Expenses incurred at hospital or Nursing home primarily evaluation/diagnostic purpose which is not followed by active treatment for the ailment during the hospitalized period." The complainant had alleged that he was hospitalized at Max Health Care Hospital from 18.11.2013 to 20.11.2013 on the advice of treating doctor as he was suffering from palpitation and increased breathlessness since 01 day. On perusal of the claim papers placed on record I find that the complainant was hospitalized on the advice of treating doctor, therefore, hospitalization expenses incurred by the complainant should be paid by the Insurance Company. Diagnostic and other expenses are not payable as per the terms and conditions of the policy. Accordingly an award is passed with the directions to the Insurance Company to reimburse the admissible claim amount to the Insured.**

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In the matter of Sh. Onkar Singh Khurana
Vs
Oriental Insurance Company Ltd.

DATE:29.06.2015

1. **The complainant alleged that his wife was admitted in Retina point on 01.08.2014, 01.09.2014 and 01.10.2014 for the treatment of left eye (CNVM) and injection Avastin was also given. The cashless facility was denied by the TPA Health India TPA Services Pvt. Ltd. He had submitted the claim bill of Rs. 90,000/- to the Insurance Company for reimbursement of amount but the Insurance Company had rejected the claim on the ground of "injection Avastin/Lucentia are injected in the Day Care and Hospitalization for minimum period of 24 hours in the hospital/nursing home is not required which is must to comply with condition no. 2.3 of the policy.**

2. **The Insurance Company vide its letter dated 25.09.2014 had denied the claim under clause 2.3 (c) which states this condition of minimum 24 hours hospitalization will also not apply provided, medical treatment and/or surgical procedure is:**

(i) undertaken under General or Local Anesthesia in a hospital/day care centre is less than 24 hours because of technological advancement and

(ii) which would have otherwise required a hospitalization of more than 24 hours.

3. **I heard both the sides, the complainant as well as the Insurance Company. I find that despite submission of all the necessary papers for reimbursement, the Company had denied the claim under exclusion clause no. 2.3 (c) on the ground that the Injection Avastin taken by the patient is not covered under the policy as it comes under OPD treatment. The complainant had stated that the claim for the same disease was also approved in the year 2010 and cashless was approved by the Insurance Company also through their TPA Alankit. This is a 3 months continuous course of the respective injection and was duly approved all the three times. The Insurance Company could not refute the charges/allegations**

made by the complainant. I feel that the Insurance Company had wrongly rejected the claim under clause no. 2.3 (c) as the discharge summary reveals that the patient was admitted in hospital on 01.08.2014 and discharged on 01.08.2014. Moreover, the Insurance Company had paid the claim for the same treatment in earlier years also, hence cannot be denied for subsequent claim.
I hold that the Insurance Company is liable to settle the claim. Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant.

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In the matter of Sh. Kuldeep Singh Bhalla
Vs
Oriental Insurance Company Ltd.

DATE:18.08.2015

1 **The complainant alleged that he was admitted in Max Hospital, Pitampura, Delhi on 24.11.2014 for the treatment of Right recurrent inguinal hernia with bladder diverticulum with sebaceous cyst at base of penis. He was discharged from the hospital on 28.11.14. In the hospital General Surgery was done cystoscopy with lap tranadominal inguinal hernioplasty (TAPP Repair) with sebaceous cyst excision performed on 25.11.2014. He had incurred Rs. 1, 34,227/- towards treatment out of which Rs. 64,403/- was paid by the TPA/Insurance Company. He had sought the relief of Rs. 69,824/- from this forum.**

2 **The Insurance Company vide its letter dated 22.01.2015 had apprised the details of settlement of claim to the Insured.**

(i)	**Rs. 50,000.00**	**Paid for Hernia treatment (Max Limit)**
(ii)	**Rs. 8190.00**	**Cystoscopy Diagnostic**
(iii)	**Rs. 6143.00**	**Excision of sebaceous**
	Rs. 64,333.00	**Total Amount paid**

As per terms and condition of the policy the excess amount was not settled under the said claim.

3 **I heard both the sides the complainant as well as the Insurance Company. During the course of hearing the Insurance Company had stated that the claim was settled according to terms and conditions of the Group mediclaim which was a Tailormade policy. On perusal of**

claim papers placed on record I find that the Insurance Company had rightly settled the claim as per terms and conditions of the policy. I see no reason to interfere with the decision of the Insurance Company. Accordingly the complaint filed by the complainant is hereby disposed off.

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In the matter of Sh. Deepak Karnani
Vs
Oriental Insurance Company Ltd.

DATE:19.06.2015

1. **The complainant alleged that he was admitted in Max Hospital from 22.09.14 to 23.09.14 and diagnosed with Pilonidal Sinus. He had submitted all the necessary papers of the claim to the TPA/Insurance Company for reimbursement of Rs. 65,000/- but the Insurance Company had denied his claim on the ground of two years waiting clause under the policy. The complainant further alleged that his policy was running with Oriental Insurance Company Ltd. since 2006 and there was a gap in renewal of policy (2013-14) of 12 days. He had sought the relief of Rs. 65,000/- from this forum.**

2. **The Insurance Company vide its self contained note reiterated that the claim was rejected under exclusion clause no. 4.3 (XV) which states that Pilonidal Sinus is not covered for first 02 years. There is a gap in renewal in the policy no. 271601/48/2013/2179 and 271601/48/2014/2448 (12days gap). So, the policy no. 271601/48/2014/2408 was treated as a fresh policy. The insured has been informed in this regard vide letter dated 15.12.2014.**

3. **I heard both the sides, the complainant as well as the Insurance Company. As per new Health Regulation-2013 the Insurance Company can suo moto condone the delay (upto 30 days) under grace period clause. It is not understood why the Insurance Company had not done so. I condone the delay and the Insurance Company is hereby directed to settle the claim within one month.**

Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant.

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In the matter of Sh. Ashok Gupta
Vs
Oriental Insurance Company Ltd.

DATE:19.06.2015

1. **The complainant alleged that he was hospitalized on 13.08.2014 for treatment but the Insurance Company had denied to settle the claim as there was a gap of 25 days in renewal of the policy 2013-14. Later on the Insurance Company had agreed to settle the claim on 50% of the bills amount. The reason given by the Company was that the illness was covered after 02 years from the date of commencement of first policy. As per IRDA Health Regulation dated 16.02.2013 the grace period for renewal of the policy is 30 days but the Insurance Company had not condoned the delay of 25 days. He had requested to settle his claim completely.**

2. **The Insurance Company vide its e-mail dated 11.11.2014 had informed to the Insured that there is a break in policy period for 25 days, accordingly policy no. 271400/48/2014/2945 is considered as fresh policy, hence claim denied by the TPA was right. With regard to condonation of break in policy period, the claim had already been reported under the said policy and the Insured approached the office of Insurance Company for condonation only just before the policy was expiring i.e. in the month of August, 2014.**
3. **I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing looking into the circumstances of the case, in my considered view the delay should be condoned and the claim be settled. I condone the delay and the Insurance Company is hereby directed to settle the claim within one month. Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant.**

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DEL-G-050-1415-0507
In the matter of Ms. Monika Malika
Vs
Oriental Insurance Company Ltd.

DATE:17.09.2015

1. **The complainant had alleged that her son Mr. Anuj Malik was admitted in Pushpanjali Medical Centre on 12.11.2014 for the operation of Hernia. The Operation was done on 15.11.2014. She had submitted all the necessary papers of the claim to the Insurance Company for reimbursement of Rs. 52,000/- but the Insurance Company had denied the claim under the two years waiting clause of the policy. Earlier she was insured with National Insurance Company Ltd. from:**
   i. **15.07.2011-14.07.2012 (NIC)**
   ii. **15.07.2012-14.07.2013 (NIC)**
   iii. **09.07.2013-08.07.2014 (OIC)**
   iv. **09.07.2014-08.07.2015 (OIC)**

2. **The TPA E-Meditek vide its letter dated 18.11.2014 had denied the cashless request on the ground of two years waiting period clause (Exclusion 4.3). The policy with Oriental Insurance Company Ltd. was in the second year. Hernia is not covered under Exclusion clause no. 4.3 sub section (iii).**

3. **I heard both the sides the complainant as well as the Insurance Company. During the course of hearing the Insurance Company had stated that the claim of operation of Hernia was rejected under Exclusion clause 4.3 III "two years waiting period." The said policy was running with Oriental Insurance Company in the second year. Earlier the Insured was having the policy from National Insurance Company. It was a fresh proposal in Oriental Insurance Company from 09.07.2013 and there was no portability request from the Insured. On perusal of the claim papers placed on record I find that complainant's son was operated on 15.11.2014 for Hernia. The policy issued by Oriental Insurance Company was in the 2nd year (policy inception was 09.07.13 to 08.07.14 and 09.07.14 to 08.07.15). The Insured had a policy from National Insurance Company**

(15.07.11 to 14.07.12 and 15.07.12 to 14.07.13). The Insured had not applied for portability to the Oriental Insurance Company before taking the policy to avail of the continuity/portability benefits although policy is renewed however, portability was not applied for as per the laid down procedure. There is a two years waiting period clause under the OIC policy for surgery of Hernia. In this case the claim arose in 2nd year of the policy. The Insurance Company had righty rejected the claim under exclusion clause no. 4.3 of the policy as the policy from Oriental Insurance Company was in 2nd year and the surgery of Hernia would be covered after two years of continuous policy from Oriental Insurance Company. I see no reason to interfere with the decision of the Insurance Company. Accordingly the complaint filed by the complainant is hereby disposed off.

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In the matter of Mr. Kamal Arora
Vs
Oriental Insurance Company Ltd.

DATE:17.07.2015

1. **The complainant had alleged that he was admitted in Vision Eye Centre, Delhi on 23.05.2014 for cataract eye surgery. He had submitted all the necessary papers of the claim to the TPA, Good health plan Ltd. for reimbursement of Rs. 53,721/- but the TPA had reimbursed only Rs. 31969/-. He had sought the relief of Rs. 18,200/- (difference of amount)**

2. **The TPA Good Health Plan Ltd. vide its e-mail dated 02.09.2014 had apprised the Insured that the claim had been settled for Rs. 31969/- as per policy clause No. 10 of Happy Family Floater which states that if any expenses which is not reasonable customary and necessary the same have to be borne by the Insured.**

3. **I heard both the sides the complainant as well as the Insurance Company. During the course of hearing the complainant submitted that he had not been informed by the Insurance Company about GIPSA package nor did the Insurance Company provide him the terms and conditions of the policy. I find that details of GIPSA package was not incorporated in the policy schedule of terms and conditions of the policy.**

Thus, the complainant could not have been aware of the said clause. The Insurance Company could not refute the charges/allegations made by the complainant. I find that

the Insurance Company has partially settled the claim and had apprised vide their self contained note dated 16.06.2015 that the amount of Rs. 18,200/- was deducted as per GIPSA package. Hence, I hold that the Insurance Company is liable to pay the balance amount of claim Rs. 16380/- (Rs. 18,200-10% co-payment) Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant.

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In the matter of Sh. O.P. Swami
Vs
Oriental Insurance Company Ltd.

DATE:31.07.2015

1 **The complainant alleged that his wife was admitted in Sir Ganga Ram Hospital form 20.07.2014 to 23.07.2014 and diagnosed as DM (Type-2), Hypertension, Dyslipidenia, Diabetic Retinopathy, Left Shoulder pain. He had submitted all the necessary papers of the claim to the Insurance Company for reimbursement of amount of Rs. 28,085/- but the Insurance Company had denied his claim under pre-existing disease. He was having the mediclaim policy from Oriental Insurance Company Ltd. since 23.06.2010 there was a delay of 36 days in renewal of policy prior i.e. 29.07.2011. the policy period are as under:-**

1) **23.06.2010 to 22.06.2011**
2) **29.07.2011 to 28.07.2012 (renewal gap of 36 days)**
3) **29.07.2012 to 28.07.2013**
4) **29.07.2013 to 28.07.2014**

He had sought the relief of Rs. 28,085/- from this forum.

2 **The Insurance Company had rejected the claim under pre-existing clause 4.1 and 4.2 of the policy. The patient Mrs. Meera Devi was suffering from DM (Type II), Hypertension, Dyslipidemia, Diabetic retinopathy, left shoulder periarthiritis. The patient had has past history of DM Type II since 1-3 years, HTN since 01 year. As the policy was still in 3rd year (Break in 2010-11 &2011-12). Hence, this claim was not admissible under policy condition no. 4.1 that any ailment/disease which are pre-existing (treated/untreated, declared/not declared in the proposal form), in case of any of the insured person of the family, when the cover incepts for the first time, are excluded for such insured person up to 04 years of this policy being in force continuously & 4.2 which states the expenses on treatment of following ailment/diseases/surgeries for the specified periods are not payable if contracted and/or manifested during the currency of the policy. If these diseases are pre-existing at the time of proposal the exclusion no. 4.1 for pre-existing condition shall be applicable in such cases.**

3 I heard the complainant. The Insurance Company was absent on the date of hearing and had not submitted the self contained note and other relevant papers of the case. The complainant stated that his wife was admitted in Sir Ganga Ram Hospital from 20.07.2014 to 23.07.2014 for the treatment of left shoulder pain since 01 month and diminished vision with floating opacity in left eye since few days. The Insurance Company had wrongly rejected the claim of his wife under pre-existing clause no. 4.1 and 4.2 of the policy. On perusal of claim papers placed on record, I find that the claim was rejected by the Insurance Company under Exclusion clause no. 4.1 and 4.2 i.e. pre-existing disease. Though the discharge summary of hospital reveal that the patient was suffering from DM-2 and hypertension since 02 years but on perusal of the same, I find that the patient was treated for pain in left shoulder which she was complaining since 01 month and not for DM-2 and HTN. I feel that the Insurance Company had wrongly rejected the claim under pre-existing clause of the policy as the disease for which the patient was treated does not came under pre-existing disease and covered even in the first year of policy. Hence, I hold that the Insurance Company is liable to settle the claim. Accordingly an award is passed with the directions to the Insurance Company to reimburse the admissible claim amount to the Insured.

In the matter of Sh. Ravi Kumar
Vs
Apollo Munich Health Insurance Company Ltd.

DATE:14.07.2015

1 **The complainant alleged that father was suffering from the disease Hernia. He had applied for cashless facility on 03.02.15 for operation of Hernia but the Insurance Company had denied the cashless request vide its letter dated 04.02.15. He had provided all the requisite documents to the Insurance Company for approval of cashless facility but he had not been provided the cashless facility by the Insurance Company and operation of his father could not be performed due to non-availability of cashless service. He had sought the relief of Rs. 2 Lacs from this forum.**

2 **The Insurance Company vide its letter dated 03.02.2015 had sought the documents to sanction the cashless request and vide its letter dated 04.02.2015 had rejected the cashless request.**

3 **I heard both the sides the complainant as well as the Insurance Company.**
During the course of hearing the Insurance Company had agreed to provide the cashless facility to the Complainant. Accordingly the Insurance Company is directed to provide the cashless facility to the complainant for the period in which he opts for the procedure/treatment.

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In the matter of Sh. Samyak Jain
Vs
United India Insurance Company Ltd.

DATE:17.09.2015

1. **The complainant alleged that he was admitted in Institute of Liver and Biliary Science for the treatment of "Urethral Stricture" from 19.06.2014 to 20.06.2014. He had submitted all the necessary papers of the claim with the Vipul Med Corp Pvt. Ltd. for reimbursement of Rs. 39,134/- but they had settled Rs. 31,867/- only. He had sought the relief of Rs. 7267/- from this forum.**

2. **The Insurance Company vide its email dated 15.10.14 had apprised the insured about the details of settlement of claim. As per submission of Insurance Company the TPA had rightly approved the claim on the basis of the previous S.I. of Rs. 4 Lacs in policy year 2011-12. The complainant had enhanced the S.I. in the next policy year 2013-14 from Rs. 4 Lacs to Rs. 5 Lacs. The S.I. shall be taken on the basis of the previous S.I. (On the recurrence of the same disease) when the disease was first detected. The complainant was admitted into the hospital for the treatment of Recurrent Strictural Urethra which is recurrence of the same disease for which the complainant had been paid a claim for an amount of Rs. 64059/- under previous policy with S.I. of Rs. 4 Lacs.**

3. **I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing, the Insurance Company had stated that the patient was admitted as a case of "Recurrent Strictural Urethra" which was a recurrence of the same disease for which the Company had earlier paid the claim for Rs. 64,059/- under policy no. 041703/48/11/97/0000503 with S.I. of Rs. 4 lacs only. The S.I. has been increased to Rs. 5 lacs in the subsequent policy no. 041703/48/13/97/00000690.**
The benefit of enhanced S.I. of Rs. 5 lacs would be applicable on complainant of 4 continuous renewals. Further the insured's room rent entitlement is Rs. 4,000/- (1% of applicable S.I.) per day while he opted a room for Rs. 5000/- . Policy clause 1.2 C &D restricts payment on proportionate basis in case the patient opted for a higher

category room. Hence, the amount paid i.e. Rs. 31867/- to the insured was in order and as per terms and conditions of the policy. On perusal of the claim papers placed on the record I find that the Insurance Company had rightly settled the claim according to terms and conditions of policy which states that in case of increase in sum insured, treatment for pre-existing disease and for a disease/ ailment/ injury for which treatment has been taken in the earlier policy period, the enhanced S.I. will be applicable only after 04 continuous renewals with the increased S.I. The patient was treated for "Recurrent Strictural Urethra" which is recurrence of the same disease for which he had been paid a claim for Rs. 64059/- under previous policy no. 041703/48/11/97/00000503 with S.I Rs. 4 lacs. The S.I. was increased to Rs. 5 lacs in the subsequent policy (041703/48/13/97/000690, from 15.07.2013 to 14.07.2014). I see no reason to interfere with the decision of the Insurance Company. Accordingly the complaint filed by the complainant is hereby dispose off.

In the matter of Ms. Radhika Chaudhary
Vs
Max Bupa Health Insurance Co. Ltd.

DATE:14.09.2015

1. **The complainant alleged that her husband was admitted in Max Hospital for treatment of Splenic thrombosis from 03.05.15 - 08.05.2015. The cashless claim was rejected. She had submitted all the necessary papers of the claim for reimbursement of Rs. 2, 49,898/- but the claim was rejected on the grounds that patient had history of seizure 7 years back (episode) and he was on medication for the same. She sought relief of Rs. 2, 49,898/-.**
2. **The Insurance Company vide its self contained note dated 13.08.2015 reiterated that patient was admitted at Max Hospital from 03.05.15 to 08.05.15 and underwent Laparoscopic splenectomy. On investigation of the case it was observed that as per ICP papers patient had seizure disorder and had one episode of seizure 7 years back and was on medication for seizure and still took medicine, but the same was not disclosed at the time of policy inception. Thus claim stands repudiated due to non-disclosure of material information.**
3. **I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing, the complainant stated that her husband had one episode of seizure disorder seven years back. The current hospitalization was for treatment of splenic thrombosis which had no relevance to seizure disorder. Her husband has been advised medicine for seizure as a precautionary measure for some time. The Insurance Company reiterated that from the ICP papers of the hospital and complainant's self declaration it was observed that patient had seizure disorder and had one episode of seizure 7 years back. He was on medication and still takes medicine. The claim was rejected due to non-disclosure of material information at the time of taking the policy. I find from ICP papers of the hospital dated 05.05.2015and anesthesia report dated 05.05.2015 of Dr. Nalini Dubey that patient had history of seizure 7 years back and was on "Tablet Encrorte chrone 250 mg which was stopped one week back" proves that disease was pre-existing. There is a self declaration of the patient on record where he has declared that he had a minor**

seizure attack 7 years back at his home town, Kanpur, and at that time doctor prescribed Encorate chrone 200 mg which he took sometimes in present days. The Hon'ble Supreme Court, in the case of Satwant Kaur Sandhu Vs New India Assurance (2009) 8 SCC 316, emphasized that insurance is a contract of utmost good faith on the part of the insured when an information on a specific aspect is asked for in the proposal form. An insured is under a solemn obligation to make a true and full disclosure of the information on the subject which is within his knowledge.

The Insurance Company is not liable to pay the expenses in case of non-disclosure of material information. In the present case, the complainant had not disclosed about his previous illness in the medical history column of the proposal form and had answered 'No' to all question. Had the insured disclosed in the proposal form that he was suffering from seizure since long this information would have influenced the decision of the insurer, as whether to reject the proposal being high risk or enhance the premium and issue the policy. By such non-disclosure, the insurer was deprived of the opportunity to assess the case in totality. In the instant case the insured had failed to declare the material facts. Accordingly the complaint filed by the complainant is hereby disposed off.

In the matter of Ajit Kumar Gupta
Vs
National Insurance Company. Ltd.

DATE:16.09.2015

1. **The complainant alleged that he underwent cataract surgery on 25.11.14 at "Centre for Sight." He had submitted all the necessary papers of the claim with Raksha TPA for reimbursement of Rs. 95000/- but they had settled the claim for Rs. 34000/- only. He had sought relief of the balance amount from this forum.**

2. **The TPA had settled the claim upto Rs. 34000/- as per GIPSA package for MICS. After receiving the grievances from the insured the claim file was reviewed by the Regional Claims Committee of the Company, who also supported the decision of the TPA. The insured had opted for FEMTO second laser in cataract surgery which is an advance and expensive technique. As per terms and conditions of the policy only reasonable and customary expenses are admissible,**

hence claim was settled for Rs. 34000/- as per package rate of GIPSA for cataract surgery.

3. **I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant reiterated that the claim for cataract surgery was partially paid by the Company. He requested for full settlement of claim.**
The Insurance Company reiterated that claim for cataract was paid as per package rate for MICS under Parivar Mediclaim Policy. On perusal of terms and conditions of
Parivar Mediclaim Policy I find that there is no mention in the policy that maximum liability for cataract surgery was Rs. 34,000/- . The complainant himself had opted for the advance surgery for cataract i.e. Femto second laser as is evident from the letter of
Dr. Kanak Tyagi, Sr. Consultant Ophthalmology of Centre for Sight and also admitted by the complainant, but the complainant was never informed either by the Company or TPA that expenses only for MICS are covered under the policy and expenses over and above the MICS would be borne by the insured. The Company could not substantiate their contention that the expenses paid to the claimant were reasonable and customary. Therefore, the Insurance Company is directed to pay the expenses for Femto Laser after deducting non-payable items. Accordingly an Award is passed with the direction to the Insurance Company to make the payments as admissible.

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In the matter of Beant Parkash Trehan
Vs
Max Bupa Health Insurance Company. Ltd.
DATE:29.09.2015

1. **The complainant's wife was hospitalized at Fortis Escorts Heart Institute on 11.04.2015. She was diagnosed as Hypertension, Type 2 Diabetes Mellitus, Right Bundle-Branch Block, Acute Coronary Syndrome, Coronary Artery Disease, and CAG: Triple Vessel Disease. She underwent Coronary Angiography and PTCA on 11.04.2015. A claim of Rs. 906041/- was reported by the complainant which was declined on frivolous and baseless grounds. He sought relief of Rs. 9, 06,041/- with interest.**

2. **The Insurance Company reiterated that the insured had applied for claim reimbursement of Rs. 906041/- for expenses incurred for hospitalization from 11.04.2015 -13.04.2015 at Fortis Escort Hospital. As per investigation conducted by the Company it was observed that patient had a history of diabetes since 25 years as revealed from the ICP papers. As per proposal form duration of diabetes was declared as 3 years whereas in medical examination records it was mentioned 6 years. There was misrepresentation of facts by the insured with regard to history of diabetes and no documentary clarification or doctor's affidavit was provided. Hence claim was repudiated due to gross discrepancy in history of diabetes.**

3. **I heard both the sides, the complainant as well as the Insurance Company. During the course of personal hearing the complaint stated that his wife was not suffering from Diabetes since 25 years. The Insurance Company reiterated that there was mis-representation of facts by the insured with regard to the history of diabetes. As per investigation conducted by the Company it was observed that patient had a history of diabetes since 25 years as revealed from the ICP papers and as per proposal form duration of diabetes was declared as 3 years whereas in medical examination records it was mentioned 6 years. I find that there is discrepancy in duration of Diabetes as disclosed by the complainant at various stages. Tenure of being diabetes had been declared as 3 years in proposal form, indicated as six years as per medical examination report and 16 years as per ICP papers. The complainant was on medication for diabetes as is evident**

from MER. However the Insurance Company had mentioned duration of Diabetes "since 25 years" as revealed from ICP papers under column "Family History of Cardiovascular diseases." I find that this document does not bear any signature of either the doctor or the Insurance Company or the complainant. Therefore the said document cannot be being accepted as documentary proof. It is evident from the ICP papers under column "cardiovascular duration of diabetes is marked as 16 years and signed by the complainant. As per underwriting guidelines of the Company submitted vide letter dated 12.08.15 under the signature of Dr. Kailash Shelke, Head underwriting "if the customer would have disclosed the duration of Diabetes more than 10 years at the underwriting stage itself, Company would have declined the proposal." The complainant had misrepresented the duration of diabetes at the time of taking the policy. Therefore, I see no reason to interfere with the decision of the Company. Accordingly the complaint filed by the complainant is hereby disposed off.

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In the matter of Sh. Ashok Goel
Vs
New India Assurance Co. Ltd.
DATE:14.09.2015

1. **The complainant's wife was admitted at Max Hospital on 15.04.2015. She was diagnosed acute severe vertigo with vomiting and drowsiness. An amount of Rs. 35396/- was paid by the Company on cashless basis against the bill of Rs. 86334/-. He sought the relief for balance amount of claim.**

2. **The insured had taken mediclaim policy for S.I. of Rs. 2, 50,000/-. The entitlement for room boarding and nursing charges was Rs. 2250/- per day (excluding cumulative bonus) and ICU expenses not exceeding Rs. 4500/- per day. The surgeon fee, operation charges and other charges were payable at a rate applicable to entitled room category. Hence the claim had been settled according to the room entitlement under the policy. The details of deductions were informed to the complainant by way of cashless approval dated 17.04.2015 as under: Room Rent- Rs. 6500/-, Doctor's fee- Rs. 3660/-, Medication- 0, Investigation charges- Rs. 39903/-, other charges- Rs. 559/-.**

3. **I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing, the complainant alleged that he was not reimbursed expenses incurred on any diagnostic charges by the Insurance Company. The Insurance Company reiterated that claim was settled as per terms and conditions of the policy. The insured was eligible for room rent of Rs. 2250/- per day (1% of S.I. of Rs. 2, 25,000/-) and other charges were paid at a rate applicable to the entitled room category as per policy condition 3.1 i.e. (a) Room rent and nursing expenses not exceeding 1% of S.I. (b) ICU not exceeding 2% of S.I. (c) others at a rate applicable to room rent category. The details of deductions were already informed to the complainant through cashless approval letter dated 17.04.2015. I do not find any infirmity in the decision of the Insurance Company. Therefore I see no reason to interfere with the decision of the Company. Accordingly the complaint filed by the complainant is hereby disposed off.**

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In the matter of Mr. Suresh Bhatia
Vs
Star Health & Allied Insurance Company Ltd.

DATE:14.09.2015

1. **The complainant is a policy holder of Health Policy from Star Health Insurance Company since 2009. His son fractured his right thigh on 23.12.2014. He was admitted in St. Stephen Hospital. The claim was rejected by the Company on the grounds that the patient was unable to speak. The Company has also deleted the name of the child from the policy. He sought relief of Rs. 64,216/- and mental agony.**

2. **The Insurance Company vide its self contained note dated 27.07.15 reiterated that the claim has been reported in the 6th year of insurance policy. The insured patient was admitted at St. Stephen's Hospital on 23.12.14 with diagnosis of Fracture Femur right. The cashless claim was denied on the grounds that patient is a known case of cerebral palsy which was not disclosed in the proposal form at the time of taking the policy. As the Insurance contract is based on utmost good faith it is the duty of the proposer to disclose all the material facts to the insurer to enable the insurer to evaluate the material facts and decide whether to accept or reject the proposal. As per the policy condition no-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 fraudulent or supported by any fraudulent means or device, misrepresentation/non-disclosure whether by the insured persons or by any other person acting on his behalf". The claim had been rejected due to non disclosure of material information.**

3. **I heard both the sides the complainant as well as the Insurance Company. I find from the discharge summary that complainant's son was a known case of cerebral palsy. The complaint did not disclose the fact in the proposal form at the time of taking the policy in 2009-2010. He has answered 'NA' to all the questions asked in the column "Medical History" in the proposal form. The proposal form was signed by the complainant. The Insurance Company came to know about cerebral palsy only when the pre-authorization form dated 23.12.2014 signed by the complainant was submitted to TPA for cashless approval of**

claim. The Insurance Company had rejected the claim on ground of non-disclosure of material information under policy clause no. 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 fraudulent or supported by any fraudulent means or device, misrepresentation/non-disclosure whether by the insured persons or by any other person acting on his behalf". The Hon'ble Supreme Court, in the case of Satwant Kaur Sandhu Vs New India Assurance (2009) 8 SCC 316, emphasized that an insured is under a solemn obligation to make a true and full disclosure of the information on the subject which is within his knowledge. The Insurance Company is not liable to pay the expenses in case of non-disclosure of material information. In the present case, the complainant had not disclosed his previous illness in the medical history column of the proposal form and had answered 'No' to all the questions. It is a case of non-disclosure. Therefore I uphold the decision of the Insurance Company. Accordingly the complaint filed by the complainant is hereby disposed off.

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In the matter of Sh. Nimai Chand Goswami
Vs
National Insurance Company Ltd.

In the matter of Sh. Sushil Kumar Garg
Vs
Royal Sundaram Alliance Insurance Company Ltd.

DATE:14.09.2015

1. **The complainant alleged that he underwent prostate surgery. The claim was settled on cashless basis but surgeon fee was paid upto 40% which includes all other doctors i.e. physician, anesthetist and pathologist. As per policy condition expenses reimbursed under the policy are limited to 40% of surgeon's fee (including assistant surgeon) of the total in patient hospitalization bill. The complainant alleged that fee of doctor, anesthetist and pathologist should not be included in limitation clause.**

2. **The Insurance Company had already informed to the complainant vide email dated 25.04.2015 and subsequent letters dated 24.04.2015 and 06.05.2015 that cashless had been approved for Rs. 69,000/- as per terms and conditions of the policy. The room rent was restricted to Rs. 2,500/- per day (1% of S.I. Rs. 2.5 Lacs) and doctor's fees was restricted to 40 % of the hospital bill.**

3. **I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing, the Insurance Company has informed that they had reconsidered the claim and agreed to pay the balance amount of Rs. 8455/- after deducting inadmissible charges as per terms and conditions of the policy. The complainant agreed for the same. Accordingly the complaint filed by the complainant is hereby disposed off.**

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In the matter of Sh. V.K. Kharbanda.
Vs
The National Insurance Company Ltd.

DATE:30.09.2015

1. **The complainant alleged that her wife met with serious accidents. She underwent dental treatment. All the papers were submitted to the TPA for reimbursement of Rs. 75000/-. The claim was rejected vide letter dated 03.07.2015. He sought relief of Rs. 75000/- from this forum.**
2. **The Insurance Company vide SCN dated 07.09.2015 reiterated that complainant's wife was treated for mobility of teeth due to which extraction and root conal treatment was done. There was no mention of any accident in the Ist prescription of Dr. Dheeraj Setia. The treatment was taken place on OPD basis. The claim falls under exclusion clause 4.16 which states dental treatment excluded unless arising due to accident.**

3. **I heard both the sides, the complainant as well as the insurance company. During the course of hearing, the complainant stated that teeth extraction of his wife was done due to injury in teeth consequent upon accidental fall at home. The Insurance Company reiterated that complainant's wife had taken the treatment for mobility of teeth due to which extraction of teeth and root canal treatment was done. There was no mention of any accident in the Ist prescription dated 28.11.2014 of Dr. Dheeraj Setia. The treatment had been taken in the clinic set up and under hospital definition setup. Hence the claim was rejected under exclusion clause 4.16 and 3.11 which states " Hospital means any institution established for in-patient care and day care treatment illness and/ or injuries and which has been registered as a hospital with the local authorities. Dental treatment unless arising due to an accident. I see no reason to interfere with the decision of the Insurance Company. Accordingly the complaint filed by the complainant is hereby dismissed.**

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In the matter of Sh. Dipayan Mazumdar
Vs
National Insurance Company Ltd.

DATE:01.09.2015

1. **The complainant alleged that he deposited the premium cheque on 29.04.2014 for renewal of Mediclaim policy which was due on 03.03.2014. The company had accepted the cheque but did not waive the gap and policy document for the period 04.03.2014 to 03.03.2015 was not issued. In the mean time his mother was hospitalized from 16.07.2014 to 08.08.2014. The claim was not processed by the Company.**

2. **The premium of policy no. 360901/48/13/85-3037 was due for renewal on 03.03.2014. The first cheque of premium was deposited late i.e. 15 days after the due date which had been dishonored. At the request of insured another cheque was accepted by the Company after 25 days of due date of policy with the instruction to the insured to submit the medical reports for waiver of 25 days gap at R.O, hence premium was deposited in P.D A/c. The insured had submitted the medical reports after 3-4 months of acceptance of premium hence the competent authority did not waive the gap and insured was advised to send the consent for issuing fresh policy but the company did not receive any reply from insured.**

3. **I heard both the sides the complainant as well as the Insurance Company. I find that premium cheque for renewal of Mediclaim policy had been deposited late i.e. on 17.04.2014 after 15 days of due date which was bounced and another cheque was deposited by the insured on 29.04.2014 which was accepted by the Company subject to condition that the gap period would be waived by the Competent Authority at RO with submission of medical reports by the insured otherwise it would be considered as fresh policy. The complainant had undergone medical tests in June and reports were submitted to the Insurance Company. The Insurance Company asked the insured on 17.11.2014 to submit medical certificate which was submitted on 20.11.2014. Finally vide letter dated 02.01.2015 Insurance Company had informed the insured**

about non waiver of gap in the renewal of policy by the Competent Authority i.e. after 7-8 months. This shows that there was deficiency in service on the part of the Company. The premium cheque was accepted by the Company which was cleared in 3 days but the whole procedure of waiver of gap took almost 7-8 months and finally the insured was informed about the inability of the Company to waive the gap. As per new Health Regulation-2013 the Insurance Company can suo moto condone the delay (upto 30 days) under grace period clause. It is not understood why the Insurance Company had not done so. The Insurance Company could not escape the liability after realization of premium cheque. Therefore the Insurance Company is directed to issue the policy from date of acceptance of premium cheque with continuity benefits. Accordingly the complaint filed by the complainant is hereby disposed off.

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In the matter of Sh. Rajesh Khanna
Vs
Star Health & Allied General Insurance Company Ltd.

DATE:23.09.2015

1. **The complainant's son was admitted in Cosmos Institute of Mental Health and Behavioral Sciences from 27.11.2014 to 02.01.2015. The patient was provisionally diagnosed as catatonia and prolonged unconsciousness due to unknown origin. The claim was rejected on the grounds that Company is not liable to make payment in respect of illness related to Psychiatric / Psychosomatic disorder.**

2. **The Insurance Company reiterated that the Insured patient was admitted at Cosmos Institute of Mental Health and Behavioral Sciences from 27.11.14 to 02.01.15 (37 days). The diagnosis was prolonged unconsciousness due to unknown origin. The provisional diagnosis was Catatonia under evaluation. As per the medical records the patient was admitted with catatonia, no organic brain disease, MRI and EEG and electrolytes were normal. The patient was treated in a Psychiatric centre with psychiatric drugs for a condition related to psychiatric / psychosomatic disorder catatonic depression. It is a type of depression where the person can remain speechless and motion less for an extended period. As per exclusion no. 10 of the policy, the Company is not liable to make any payment in respect of expenses incurred at hospital for treatment of psychosomatic disorder.**

3. **I heard both the sides, the complainant as well as the Insurance Company. During the course of personal hearing, the complainant stated that his son was provisionally diagnosed as catatonia under evaluation but the final diagnosis was prolonged unconsciousness due to unknown origin. The Company had rejected the claim because he was treated in a psychiatric centre. The Insurance Company reiterated that patient was unconscious for prolonged period. The provisional diagnosis was catatonia. As per medical records the patient had no organic brain disease, MRI, EEG and electrolytes were normal. The patient was treated with psychiatric drugs. As per exclusion clause no. 10 of the policy claim was rejected on grounds of treatment for psychosomatic disorder. I find from the discharge summary that patient was admitted with complaints of unconsciousness since 1 day, stiffness of neck and back muscles, maintaining postures for long hours, not responding to any stimuli. Provisional diagnosis was catatonia and patient was kept under evaluation for catatonia but the final diagnosis was prolonged unconsciousness due to unknown origin. I find that as per medical literature catatonia is a state of neurogenic motor immobility and behavioral abnormality characterized by muscular rigidity and mental stupor. In the instant case the Neurologist study i.e. MRI brain and EEG were normal. There was no brain disease. Even the final diagnosis was not catatonia as is evident from discharge summary. The Insurance Company had declined the claim under clause no. 10 of the policy which states that "the Company is not liable to make any payment in respect of expenses incurred at hospital for treatment of psychosomatic disorder." There is no evidence on record that the patient was diagnosed as suffering from catatonia. The final diagnosis was prolonged unconsciousness due to unknown origin. Hence in my considered view the claim is admissible. The Insurance Company is directed to settle the claim as admissible. Accordingly an Award is passed with the direction to the Insurance Company to make the payments as admissible.**

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In the matter of Sh. Manav Harsh Singh
Vs
Star Health Allied General Insurance Company Ltd.

DATE:13.08.2015

1. **The complainant was hospitalized in Mata Chanan Devi hospital on 28.09.2013. Before that he was hospitalized in Ganga Ram on 20.06.2013 and 17.08.2013, the claims were rejected on the grounds that chronic liver disease was due to alcohol intake.**
   The complainant had admitted that he had been taking the alcohol occasionally. After rejection of claim the policy was also cancelled and premium was refunded. He sought relief for claim settlement and continuity of policy since he had been continuously insured with Star Health Company since 2012.

2. **The Insurance Company reiterated its self contained note dated 20.07.2015 that the claim had been reported in the 2nd year of the policy. The complainant was admitted at Sir Ganga Ram Hospital from 25.06.2013 to 04.07.2013. He was diagnosed with chronic liver disease-alcohol related, alcohol dependence syndrome, acute bronchitis and depression. He was again hospitalized in Mata Chanan Devi Hospital from 28.09.2013 to 08.10.2013 for alcoholic hepatitis. The claim was rejected on the grounds that USG abdomen indicated alcoholic liver with ascites. The complainant was again admitted at Sir Ganga Ram Hospital form 18.08.2013 to 26.08.2013 with diagnosis of chronic liver disease-alcohol related decompensated (Esophageal Varices, Ascites, Splenomegaly), Alchohol Dependance Syndrome, Acute Bronchitis, Depression. The claim was rejected on the ground that insured did not disclose all material facts related to his aliment/ sickness at the time of taking the policy. As per policy condition no.7 that due to non-disclosure of pre-existing disease and mis-representation the Company shall not be liable to make any payments under the policy.**
3. **I heard both the sides, the complainant (represented by his cousin) as well as the Insurance Company. I find that complainant was hospitalized three times. He was diagnosed with chronic Liver disease related, alcohol dependence syndrome, acute bronchitis and depression. The claim was rejected on the ground that insured did not disclose all material facts at the time of taking the policy related to his aliment/ sickness. Hence as per policy condition no.7 that due**

to non-disclosure of pre-existing disease and mis-representation the Company shall not be liable to make any payments under the policy. As per Supreme Court judgment it is obligatory for the proposer to disclose the material facts at the time of filling the proposal form. The Insurance Company is not liable to pay the expenses in case of non-disclosure of material information; the case of non-disclosure does not debar the members of the family to continue the Insurance. The Insurance Company stated that the policy continues for the members of the family. The claim was rightly rejected by the Company. Accordingly the complaint filed by the complainant is hereby disposed off.

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In the matter of Sh. Naresh Soni
Vs
New India Assurance Company Ltd.

Date:13.08.2015.

1. **The complainant was hospitalized at Ganga Ram Hospital from 28.03.2015 to 31.03.2015. He was underwent prostate surgery using HOLEP (Laser Technique). The claim was sanctioned for Rs. 54,000/- for conventional surgery against the claimed amount of Rs. 1, 89,000/-. The complainant alleged that it was his prerogative to decide what treatment to be opted i.e. laser or conventional surgery and therefore he had opted for HOLEP. He sought relief for balance amount of claim.**

2. **The Insurance Company had not submitted any self contained note.**

3. **I heard both the sides the complainant as well as the Insurance Company. I find that Insurance Company had settled the claim as per GIPSA package for conventional surgery only. During the course of hearing complainant had submitted the pre-authorization approval given by TPA by way of which it is revealed that the complainant had been informed that full and final limit for GIPSA Package was Rs. 54000/- which was the maximum liability of the company for conventional surgery. But the complaint had opted for HOLEP (laser surgery) which was his individual choice. Any expenses beyond the policy conditions would have to be borne by the individual. I**

therefore uphold the decision of the Insurance Company. Accordingly the complaint filed by the complainant is hereby disposed off.

In the matter of Sh. Pankaj Kumar
Vs
Max Bupa Health Insurance Company Ltd.

DATE: 03.09.2015

1. **Complainant's wife was hospitalized at Fortis Hospital for USG missed abortion. The claim of Rs. 55000/- was turned down by the Company on account of irrelevant regulation that at least three adult members should be covered under the policy.**

2. **The Insurance Company reiterated its Self Contained Note dated 23.07.2015 that the patient was admitted at Fortis Hospital from 19.07.2014 to 20.07.2014 with complaints of "Benign Positional Vertigo since last night (on USG missed abortion)." She was diagnosed with Primigravida with 12.3 weeks pregnancy with missed abortion and underwent treatment. The policy opted by complainant is Family First Gold wherein as per policy terms and conditions under clause 2.7 of Maternity benefits sub clause 1b is applicable which states "We cover medical expenses for the delivery of a child and Maternity Expenses subject to the following: (b) The policy has a minimum 3 Adult Insured Persons including at least one male insured person." However in this policy as there were only 2 adults insured, thus, the claim was rejected by the Insurance Company.**

3. **I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant submitted that claim was rejected under policy clause 2.7 1(B) of Family First policy which states that at least three adult members should be covered under the policy to cover medical expenses for maternity. He also stated that had the clause known to them, they might not have taken the policy. The policy was issued to Mr. Pankaj Kumar and Mrs. Manisha Prajapati. He further stated that this clause was withdrawn by the Company in the policy year 2014-15. The Insurance Company reiterated that the complainant had opted Family First Gold policy wherein as per clause no 2.7 (1B) medical expenses for delivery of a child and other maternity expenses are covered only if the policy has a minimum of 3 Adult insured persons including at least one male insured person. Under the current policy there were only 2 adults insured therefore maternity expenses were not covered as per policy conditions. I find that the insured had**

taken the Family First Gold policy in the year 2011 and subsequently renewed the policy from time to time till 23.11.2015. At the time of taking the policy the insured was about 25 years old, in reproductive age group. The claim for the USG missed abortion was lodged in 3rd year of the policy. I observe that the Insurance Company has a Family Floater policy and a Family First Gold policy. The clause of 2.71 (b) is absent in the Family Floater policy and even in Family First Gold policy, this clause stands withdrawn in 2014 as is evident from the policy renewed in 2014-15. I am of the considered view that the Insurance Company failed in its duty as an insurer, in as much as the vital features of the policy were not made known to the complainant. Therefore, in my considered view, the Insurance Company is liable to settle the claim. Accordingly an Award is passed with the direction to the Insurance Company to make the payments as admissible.

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In the matter of Sh. Suraj Prakash
Vs
Star Health And Allied Insurance Company Ltd.

DATE: 13.08.2015

1. **The complainant alleged that he had taken a Health Insurance policy on 17.04.2010 and renewed on time. He lodged a claim for the disease Transitional cell carcinoma. The claim was rejected by the company stated non-disclosure of pre existing disease (Diabetes mellitus and CAD) on the proposal form. He further submitted that he was admitted for transitional cell carcinoma which was not related to pre-existing disease and it was clearly mentioned by doctor.**

2. **The Insurance Company vide its SCN dated 16.08.2014 submitted that insured was admitted at Medanta Global Health Pvt. Ltd. Delhi on 05.08.2013 and further 24.05.2013 and diagnosed with right upper Transitional cell carcinoma CAD (POST PTCA), diabetes mellitus, hypothyroidism. From the submitted records it was evident that he was suffering from diabetes, CAD, PTCA, in 1993, 1995, 1998 and 2008 before inception of the policy and had not disclosed the past medical history while proposing insurance which shows non disclosure of material facts. Hence, it is requested that the case is devoid of any merit and may be dismissed.**

3. **I heard both the sides, the complainant as well as the insurance company. The complainant reiterated that he had the policy since 2010. The first treatment for Right Upper Tract Transitional cell carcinoma was lodged in July 2013 which was not related to his pre existing disease diabetes and CAD. The Insurance Company reiterated its SCN that claim was rejected on the grounds of non-disclosure of CAD, DM and PTCA. In the case of Satwant Kaur Sandhu Vs New India Assurance (2009) 8 SCC 316, the Hon'ble Supreme Court emphasized that insurance is a contract of utmost good faith on the part of the insured when an information on a specific aspect is asked for in the proposal form. An insured is under a solemn obligation to make a true and full disclosure of the information on the subject which is within his knowledge. The**

Insurance Company is not liable to pay the expenses in case of non-disclosure of material information. In the present case, the complainant had not disclosed about his previous illness in the medical history column of the proposal form and had answered 'No' to all question had the insured disclosed in the proposal form that he was suffering from diabetes, CAD, PTCA, this information would have influenced the decision of the insurer, as whether to reject the proposal being high risk or enhance the premium. By such non-disclosure, the insurer was deprived of the opportunity to assess the case in totality.

Therefore I uphold the decision of the Insurance Company. Accordingly the complaint filed by the complainant is hereby disposed off.

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In the matter of Mr.Kailash Chander Wadhwa

Vs
The National Insurance Co.Ltd.

DATE: 28.04.2015

1. **The complainant underwent eye surgery at Pakrasi Eye Associates who is having an agreement with Fortis C DOC for performing operations at OT of Fortis Hospital for which Dr. Pakrasi shall pay a rent/lease. The complainant preferred a claim of Rs. 58375/- which was not settled by the Company on the grounds that bills were raised by Pakrasi Eye Associates which is not registered.**

2. **The Insurance Company reiterated vide SCN dated 12.06.2015 that the patient underwent MICS surgery at Fortis C DOC. The surgery was performed by Dr. S. Pakrasi who works in the name of Pakrasi Eye Associates from his office cum clinic. Dr. S Pakrasi has an agreement with the hospital Fortis C Doc. Whereby both the parties have agreed that Dr. S. Pakrasi shall be using the OT and other facilities of the hospital for treating patients for which he shall pay a rent/lease. Accordingly, the billing has been done in the name of Pakrasi Eye Associates and not Fortis C Doc. Though Fortis C Doc is registered with the authorities. Pakrasi Eye Associates is not registered. The TPA has denied the claim stating that as per policy**

terms hospital does not fulfill hospitalization. Hospital bill is in the name of Pakrasi and surgery was done in Fortis, hence claim is not payable.

3. **I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant had reiterated that the first claim for the Cataract Surgery performed at the same hospital had been paid by the Company in June 2013. If the Insurance Company has settled the first claim of the cataract surgery they are duty bound to settle the subsequent claim arising on the same problem i.e. cataract eye surgery. Therefore, I direct to the Insurance Company to settle the second claim of the complainant. Accordingly an Award is passed with the direction to the Insurance Company to settle the claim as admissible to the complainant.**

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In the matter of Mr.Satish Chander Bhatia

Vs
The New India Assurance Co.Ltd.

DATE: 24.07.2015

1. **The complainant alleged that he had undergone a brain surgery at Fortis hospital on 11.02.2013. He preferred a claim of Rs. 3, 62,546/- out of which a sum of Rs. 3, 16,826/- in two installment of Rs. 1, 58,413/- each was directly received by him through NEFT. Later on he had to return a sum of Rs. 1, 58,413/- to the TPA, due to system error the complainant had received the payment twice through NEFT. The complainant had alleged that claim was settled as per room rent entitlement i.e. 40% of room rent but nursing charges were clubbed with room rent which should be paid separately and other charges like consultation charges, surgeon charges and tests also should be paid @ 40% but Company had paid 35.29% of the claimed amount. He sought relief of Rs. 14,384/-**

2. **The Insurance Company reiterated vide SCN dated 10.07.2015 that it has been clarified that the earlier payment had been released due to technical error and necessary action had been taken to recover the excess amount. The admissible amount payable towards eligibility for hospital room rent (per day) had been strictly calculated as per applicable terms and conditions of the said policy. The eligibility for per day hospital room rent is Rs. 3000/- it being 1% of sum insured of Rs. 3,00,000/- under the said policy. The said amount of Rs. 3000/- is inclusive of charges for room boarding and nursing charges. Thus Rs. 21000/- has been allowed @Rs. 3000/- per day for 7 days.**

3. **I heard both the sides the complainant as well as the Insurance Company. During the course of hearing the complainant stated that as per policy terms and conditions room rent, consultation charges, surgeon charges and tests should be paid @ 40% but Company had paid 35.29% of the claimed amount. The Insurance Company could not explain the reason for discrepancy raised by the complainant. Hence Insurance Company is directed to refund Rs. 14,384/- within**

15 days. Accordingly an Award is passed with the direction to the Insurance Company to refund Rs. 14,384/- within 15 days.

In the matter of Mr. Gaurav Gandotra

Vs
Max Bupa Health Insurance Co.Ltd.

DATE: 20.08.2015

1. **The complainant had taken a family floater policy from Max Bupa covering himself and his family from 12.08.2014 to 11.08.2015. He had preferred six claims under the policy for Insured Mr. Gaurav Gandotra, Rishi Gandotra and the proposer Mr. Kuldip Gandotra The complainant alleged that:**

   (a) The Sales Executive, of Max Bupa had introduced a platinum policy but while issuing the policy Insurance Company had covered the proposer and his family under family first gold category with S.I. of Rs. 15 Lacs per member plus family floater of Rs. 50 Lacs, total coverage of Rs. 95 Lacs of S.I. under the policy . The Company had collected the premium towards the platinum policy but had given gold policy and terms and conditions of these policies are very much different in terms of medical benefits thereof.
   (b) There is deficiency in services by the Insurance Company.
   (c) Denial of claims on grounds of non-disclosure/mis-representation was illegal and unjustified. The claims in respect of the complainant (Mr.Gaurav Gandotra) are not for any pre-existing diseases and all the three hospitalizations have no co-relations with any pre-existing disease as certified by the treating doctors.

   In case of hospitalization of his father (Mr. Kuldeep Gandotra) the Insurance Company had paid the cashless bills in part. The Company had not taken any cognizance of certificates issued by the treating doctor. The Company had made

   deductions which were illegal and unjustified. The Insurance Company had denied the claim on one pretext or the other which has no relevance to the case.
   The complainant sought relief for reimbursement of bills in view of the certificates issued by the treating doctors.

2. **The Insurance Company reiterated their SCN dated 30.06.2015 that complainant had lodged various claims under the policy as per details:**

   A) **<u>Claim no. 99215:</u> Gaurav Gandotra: A claim of Rs. 343438 was lodged for Mr Gandotra who was admitted at Fortis Hospital from 16.08.2014 to 26.08.2014 with complaints of pain left knee and limited movements. He underwent Knee Arthroscopy.**

   B) **<u>Claim no.117889</u>: A claim of Rs. 224,418/- was lodged for Mr Gandotra who was admitted at Fortis Hospital from 06.09.2014 to 09.09.2014 with complaints of dizziness, loss of consciousness, shortness of breath and slurring of speech. He was diagnosed with acute vertigo**
   During the investigation it was observed that patient had undergone arthroscopy 13 years ago, had a history of allergy from RN-1, history of Asthma since 1 year and last dyspnic attack one week earlier to current hospitalization, diabetic since 8 months and history of liposuction done in 2012. The complainant did not mention these conditions at the time of taking the policy. Therefore the above 2 claims were rejected due to non-disclosure as per Definition 14 which states *Disclosure to information Norms states: The policy shall be void and all premiums paid hereon shall be forfeited to the company, in the event of misrepresentation, mis-description or non-disclosure of material fact."* and also because there was a waiting period of 90 days as per policy conditions no. 4(b) states *"90 days waiting period : We will not cover any treatment taken during the first 90 days since the date of commencement of the policy, unless the treatment needed is the result of an Accident or Emergency. Thus waiting period does not apply for any subsequent and continuous renewals of your policy".*

   C) **<u>Claim no. 114024</u>: A claim of Rs. 7, 56,079/- was lodged for Mr Gandotra who was admitted at Fortis hospital from 07.11.2014 to 21.11.2014 with complaints of cough breathlessness, fever and chest pain. He was diagnosed with fungal chest infection. During investigation it was found that complainant had stayed for four days in presidential suite (Rs. 75000/- per day) and 10 days in suite for Rs. 18,000/- per day. He is eligible for single private room as per terms and conditions of the policy and hospital had confirmed that tariff rate of single private room was Rs. 10,000/- per day. Therefore the excess room charges over and above the entitlement were not payable, even if the rooms of entitled category are not available in the hospital as per policy condition**

no. 22 ***Hospital Accommodation means: We will cover Reasonable Charges for Room rent for hospital accommodation."*** **With reference to clause 3(n)(c)(iii) stating** ***"For the purpose of Section 2 it is understood and agreed that if a hospital room as per the rent limit permitted by the insurance plan opted for, as shown in the products benefits table, is unavailable, then we will only be liable to make payment for a Hospital room that is actually occupied or as per the entitlement permitted by the plan opted for, whichever is lower. Further where Medical Expenses as linked with room rates, Medical Expenses as applicable to the room that is actually occupied or as per room rates entitlement under the plan opted, whichever is lower, shall be payable."***

D) **Claim no. 119203- Claim of Rs. 122844 was preferred for pre and post hospitalization expenses for insured Mr. Gandotra on account of admission on 07.11.2014 as detailed in para (E). Since the main claim for non-disclosure of material facts was not paid the pre and post hospitalization expenses were rejected.**

E) **Claim no. 121358- A cashless request for treatment of splenic Hydatid Cyst for admission of Rishi Gandotra for the period 01.02.2015 to 05.02.2015 was denied. The patient underwent laparoscopy treatment for Splenic cyst. He was admitted with complaints of dyspepsia and pain abdomen and had gastro esophageal reflux disease. The complainant did not provide any details or fill any form/consent letter to investigate the case thus the claim was declined on ground of non-co-operation and in case he will provide the authority letter to the Company, the case will be decided by the Company accordingly.**

F) **Claim no. 116486- Mr. Kuldeep Gandotra was hospitalized at Fortis hospital from 21.12.2014 to 25.12.2014 with complaints of High fever with breathing difficulty diagnosed with Acute Viral illness and Acute Gastritis. The claim was settled for Rs. 52,904/-. Proposer had applied for reimbursement of pre and post expenses of Rs. 86205/-out of which amount of Rs. 23,669/- was paid as per terms and conditions of the policy. The vaccination charges, health charges and charges not related with the diagnosis for which patient was hospitalized, were not payable as per terms & conditions of the policy.**

3. **I heard both the sides, the complainant as well as the Insurance Company. As regards <u>disputes in regard to mis-selling</u> of policy- a CD (recorded voice of complainant and sales executive of Max Bupa) was played during the course of hearing in presence of the complainant. The recording reveals that the complainant was told about the gold policy. The premium paid by the complainant of Rs. 131971/- was for Gold plan.**
The policy was explained to Mr. Gaurav Gandotra over the phone and had there been any miscommunication/misrepresentation with regard to policy product issued, the complainant could have called company for the clarification within 15 days free look period. I find that the brochure attached with the policy contains the three plans i.e. Gold Plan, Silver Plan and Platinum Plan benefits of all. However, the fact remains that the complainant had opted for Gold plan and paid the premium for gold plan as per the premium receipt dated 13.08.2014. The receipt was also shown by the complainant during the personal hearing wherein the mentioned plan opted for was Family first Gold. The premium calculator reveals that premium for Gold plan is Rs. 131971/- and the premium for Platinum policy is Rs 2, 55,795/- which was way higher than the premium paid by the complainant.
Hence the version of the complainant that premium was paid for platinum plan and policy was issued for Gold Plan is not substantiated in view of the premium paid receipt produced by the complainant.

<u>Dispute in claim in respect of Mr. Gaurav Gandotra.</u>

A) **<u>Claim no. 99215:</u> Gaurav Gandotra a claim of Rs. 343438 was lodged for Mr Gandotra who was admitted at Fortis Hospital from 16.08.2014 to 26.08.2014 with complaints of pain in left knee and limited movements. He underwent Knee Arthroscopy.**

B) **<u>Claim no.117889</u>: A claim of Rs. 224,418/- was lodged Mr Gandotra who was admitted at Fortis Hospital from 06.09.2014 to 09.09.2014 with complaints of dizziness, loss of consciousness, shortness of breath and slurring of speech. He was diagnosed with acute vertigo**
During the investigation by the Company it was observed that patient had undergone arthroscopy 13 years ago, had a history of allergy from RN-1, history of Asthma since 1 year and last dyspnic attack one week later, diabetic since 8 months and history of liposuction done in 2012. The complainant did not mention the

pre-existing conditions at the time of taking the policy. Therefore claim no.1 and claim no. 2 were rejected due to non-disclosure as per Definition 14 of the policy i.e. Disclosure to information Norms states: The policy shall be void and all premiums paid hereon shall be forfeited to the company, in the event of misrepresentation, mis-description or non-disclosure of material fact and also because there was a 90 days waiting period as per policy condition no. 4(b) which states the Company will not cover any treatment taken during the first 90 days since the date of commencement of the policy, unless the treatment needed is the result of an Accident or Emergency. Thus waiting period does not apply for any subsequent and continuous renewals of your policy". Thus the above two claims were rejected due to non-disclosure of previous medical condition of the complainant.

C) **<u>Claim no. 114024</u>: A claim of Rs. 7, 56,079/- was lodged and also because there was 90 days waiting period. Mr. Gandotra who was admitted at Fortis hospital from 07.11.2014 to 21.11.2014 with complaints of cough breathlessness, fever and chest pain. He was diagnosed with fungal chest infection. During investigation it was found that complainant had stayed 4 days in presidential suite (75000/- per day) and 10 days in suite for 18,000 per day. I find that he is eligible for single private room as per terms and conditions of the policy. The hospital had confirmed that tariff rate of single private room was Rs. 10,000/- per day. Therefore as per the policy condition no. 2.2 which states the excess room charges over and above the entitlement under the policy were not payable even if the rooms of entitled category are not available in the hospital.**

4. **<u>Claim no. 119203:</u> claim of Rs. 122844 was preferred for pre and post hospitalization expenses for insured Mr. Gandotra for admission on 07.11.2014.**

Since the main claim for non-disclosure of material facts was not paid the pre and post hospitalization expenses stands rejected. I find that in the case Mr. Gaurav Gandotra the complainant had not disclosed the material facts at the time of taking the policy. In the case of Satwant Kaur Sandhu Vs New India Assurance (2009) 8 SCC 316, the Hon'ble Supreme Court emphasized that insurance is a contract of utmost good faith on the part of the insured when an information on a specific aspect is asked for in the proposal form. An insured is under a solemn obligation to make a true and full disclosure of the information on the subject which is within his knowledge. The Insurance Company is not liable to pay the expenses in case of non-disclosure of material information. It is obligatory for

the insured to disclose all material information to the Company to enter into the contract of insurance. As per call recording on 10.08.2014 the complainant had replied "No" to questions asked about medical condition of the insured. The Insurance contract is a contract of good faith, had the insured disclosed his medical condition at the time of taking the policy, the Insurance Company had the choice to accept or decline in view of the adverse risk. In case of non-disclosure the Insurance Company in not liable to pay any expenses under the policy.

Dispute in claim in respect of Mr. Kuldeep Gandotra.

A) **Claim no. 116486: Mr. Kuldeep Gandotra hospitalized at Fortis hospital from 21.12.2014 to 25.12.2014 with complaints of High fever with breathing difficulty diagnosed with Acute Viral illness and Acute Gastritis. The claim was settled for Rs. 52,904/-. Proposer had applied for reimbursement of pre and post expenses of Rs. 86205/-out of which amount of Rs. 23,669/- was paid as per terms and conditions of the policy. The vaccination charges (as per S.No. 172 of non payable items list of IRDA), health charges and charges not related with the diagnosis for which patient was hospitalized were not payable as per terms & conditions of the policy under clause 2.12**

I find that Insurance Company had already settled the claim as per terms and conditions of the policy. As per Gold plan the insured was eligible for single private room however; in the instant case the complainant had opted the suite rooms at his own will. The complainant was eligible for single room. The hospital had confirmed that the tariff rate for single room was Rs. 10,000 per day. Accordingly excess room charges were deducted by the Company and vaccination charges and health charges not related to the diagnosis for which patient was hospitalized was not payable under the policy condition.

Dispute in claim in respect of Mr. Rishi Gandotra.

1. **Claim no. 121358: A cashless request for treatment of splenic Hydatid Cyst for Rishi Gandotra for the period 01.02.2015 to 05.02.2015 was denied. The patient underwent laparoscopy treatment for Splenic cyst. He was admitted with complaints of dyspepsia and pain a abdomen and had gastro esophageal reflux**

disease. The complainant did not provide any details or fill any form, consent letter to investigate the case thus the claim was declined for non-co-operation. I hold that this complaint is pre-mature as the complainant has yet to submit the reimbursement claim to the Company after completion of required formalities. There is no cause of action. Accordingly the complaint filed by the complainant is hereby disposed off.

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In the matter of Sh. Abhinav Gupta
Vs
Max Bupa Health Insurance Co. Ltd.

DATE:05.05.2015

1. **The complainant had taken Family Floater Health valid from 18.01.2012. His mother underwent knee replacement surgery at Adiva Health Care on 28.11.2013 and discharged on 05.12.13. The claim was rejected on the ground of non-disclosure of material fact that patient was suffering from knee pain and HTN since 2 years and it was not disclosed at the time of taking the policy.**

2. **The complainant had taken the health policy valid from 18.01.12 to 17.01.2013 which was subsequently renewed. The complainant mother was hospitalized for the period 28.11.13 to 12.12.13. She underwent knee replacement surgery. During investigation patient's husband disclosed that she had knee problem since 2 years and was on medication. She was also taking medicine off and on for HTN. She had a history of gall stone surgery in 2007. The pre-existing condition of the patient was not disclosed at the policy inception. The patient was suffering from knee problem prior to policy inception; hence claim was denied an account of pre-existing disease under policy clause 5(g) 3(ii) and 4(a).**

3. **I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant stated that his mother was suffering from knee pain and was on medication off and on. He further alleged that knee pain is not indicative that she was suffering from osteoarthritis. The Insurance Company had rejected the claim on non-disclosure of HTN and osteoarthritis grade IV. I find that the claim for knee replacement arose in the 2nd running year of the policy. The osteoarthritis grade IV is age related problem which develops over a period of time. The complainant also suffered from HTN and was on medication off and on. She had a history of gall stone surgery in 2007 which was also not disclosed at the time of taking insurance. The complainant admitted during the personal hearing that his mother was suffering from knee pain since 20 years. The discharge**

summary clearly revealed that patient had difficulty in walking and pain in both knees which had increased from last 3-4 months. This proves that disease was pre-existing I uphold the decision of the Insurance Company. Accordingly the complaint filed by the complainant is hereby disposed off.

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In the matter of Sh. Ankit Jain
Vs
Max Bupa Health Insurance Co. Ltd.

DATE:15.05.2015

1. **The complainant had taken Heartbeat Silver Health policy from Max Bupa Health Insurance Company Ltd. w.e.f. 09.06.2012 for his dependant parents for S.I. of Rs. 3 Lacs. His mother was admitted at Ganga Ram Hospital on 05.03.2014 and was discharged on 06.03.2014. She was diagnosed with Carcinoma Urinary Bladder. The claim was rejected due to non-disclosure of HTN.**

2. **The Insurance Company had rejected the claim vide letter dated 25.06.14 under policy clause 5G (3.2) due to non-disclosure of material facts. The claim was reviewed and the Insurance Company agreed to settle the claim.**

3. **I heard both the sides the complainant, as well as the Insurance Company. I find that claim arose in March, 2014 and claim was rejected in June, 2014. The Company did not renew the policy which was due for renewal on 08.06.2014. The Insurance Company reconsidered the claim and agreed to settle the claim on 28.04.2015 i.e. after a delay of one year. During this time the complainant suffered mental agony and stress I find that the Insurance Company had conducted the medical tests before renewing the policy and having found that the risk factor was adverse denied the renewal. I find that clause no. (J) of the policy states that renewal of the policy will not ordinarily be denied other than on grounds of moral hazard, misrepresentation and fraud. Thus there was no fraud or misrepresentation on the part of the complainant. Hence I direct the Insurance Company to reinstate the policy from the date when it was due for renewal i.e. 09.06.2014**

with continuity benefits on payment of premium by the complainant. During the course of hearing the Insurance Company agreed to settle the claim and renew the policy. I also observe that there is deficiency in service on part of the Insurance Company. The Insurance Company is directed to pay Rs. 10,000/- on account of mental harassment that the complainant suffered for almost a year. Accordingly an Award is passed with the direction to the Insurance Company to settle the claim as admissible and reinstate the policy of the complainant with continuity benefits and payment of Rs. 10,000/- on account of mental harassment.

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In the matter of Sh. Rohit Baweja
Vs
Max Bupa Health Insurance Co. Ltd.

DATE:11.05.2015

1. **The complainant alleged that he had taken a mediclaim policy valid from 25.03.2013 to 24.03.2014. He met with an accident on 22.06.2013. He was hospitalized at Asian Institute of Medical Sciences from 13.06.2013 to 13.07.2013. He suffered fracture of Femur left with compound fracture of Humerus. He had reported a claim of Rs. 7.5 Lacs approximately. The claim was rejected on the ground that patient had a history of asthma and ankylosing spondylitis which was not disclosed at the time of taking the policy.**
2. **The Insurance Company had reiterated that the complainant had taken the Heartbeat Gold Health Policy with S. I. of Rs. 5 Lacs, valid from 25.03.2013 to 24.03.2014. The Complainant was hospitalized at Asian Institute of Medical Sciences from 13.06.2013 to 13.07.2013 with complaints of pain and swelling over left thigh and left arm, he was diagnosed with compound fractures in left leg. During investigation, it was observed from the hospital records that patient had a history of Asthma and Ankylosing Spondylitis. The claim was rejected on the ground of non-disclosure of Asthma and Ankylosing Spondylitis at the time of taking the policy.**
3. **I heard both the sides, the complainant as well as the Insurance Company. I find that the claim was rejected due to non-disclosure of Asthma and ankylosing spondylitis. The complaint admitted that he was suffering from dust allergy which was informed to the agent who had filled the form before taking the policy. I find from the document submitted that in the pre-operative anesthesia evaluation record it was clearly mentioned that the patient had a history of Asthma and ankylosing spondylitis. He also suffered an attack of asthma in December 2012. Thus there was non-disclosure on the part of the complainant. However, it is clear that asthma and ankylosing spondylitis had no co-relation to the ground reason/disease for which he was admitted to the hospital. I therefore direct the Company to settle the claim at 75% of the sum assured. Accordingly an Award is passed with the direction to the Insurance Company to settle the claim as admissible.**

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In the matter of Sh. Surender Singh Yadav
Vs

Max Bupa Health Insurance Co. Ltd.

DATE:05.05.2015

1. **The complainant was admitted at Metro hospital on 27.09.2013 with complaint of chest pain. He was diagnosed with Acute Coronary Syndrome and submitted his mediclaim. The claim was rejected by the Company due to misrepresentation of material facts.**

2. **The Insurance Company had reiterated that the complainant had taken Health Insurance Policy from 20.06.2012 to 19.06.2013 which was subsequently renewed for 20.06.2013. The complainant was hospitalized at Metro Hospital from 27.09.2013 to 28.09.2013. He was diagnosed with Acute Coronary Syndrome, Post CAG. The discharge summary revealed that he was a known case of HTN and was on medication. In the proposal form under Q No. 34 the complainant had not disclosed HTN and thus the Company was deprived of the opportunity of proper underwriting. The present illness was related to HTN. The claim was rejected under the clause no. 5 (e) on the ground of non-disclosure facts.**

3. **I heard both the sides, the complainant as well as the Insurance Company. I find that the HTN is a lifestyle disease and manageable. The Company could not substantiate the fact that the patient was suffering from HTN prior to the inception of the policy. During the course of personal hearing the Insurance Company agreed to settle the claim within 15 days. Accordingly the complaint filed by the complainant is hereby disposed off.**

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In the matter of Sh. Vinod Goel
Vs
Star Health Insurance Co. Ltd.

DATE:05.05.2015

1. **The complainant alleged that he had taken the mediclaim policy valid from 12.03.14 11.03.2015. The said policy was continued from 12.03.2010. He was hospitalized at Jaipur Golden Hospital for the period of 20.06.2014-20.06.2014 for dialysis. The claim was rejected by the Company and subsequently the insurance policy was also cancelled. The claim was reviewed by the Company at the request of the complainant. The claim was settled and the payment of Rs. 43071/- and Rs. 50579/- were received by the complainant on 04.10.14 and 27.11.2014 respectively. But further claims were again rejected by the Company.**

2. **The Insurance Company had reiterated that the Company had reviewed the claim and settled the same as per terms and conditions of the policy in full and final payment after taking the consent from the complainant.**

3. **I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant contested that bills of dialysis were partially settled upto January, 2015. The subsequent bills from February to March, 2015 were still pending. The detailed assessment sheet along with reason of deductions was not given. The Company during the personal hearing submitted that the bills upto January, 2015 were already paid. The Company also submitted that the subsequent payment of bills was held up because of non-submission of original bills. The complainant is directed to submit the original bills and the Insurance Company to correlate and settle the claim.**
   The complainant had also raised the issue of deductions of injections on account of dialysis which the Insurance Company is directed to settle as admissible.
   The Company is directed to pay subsequent bills if supported by original bills.
   The deductions for injections administered during dialysis to be reconciled.

Accordingly an Award is passed with the direction to the Insurance Company to settle the claim as admissible.

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In the matter of Smt. Anu Verma
Vs
New India Assurance Co. Ltd.

DATE:18.05.2015

1. **The complainant alleged her husband was admitted in Max Super Specialty Hospital from 12.03.14 to 15.03.14 with the complaint of Vasculitis for IV Solumedrol. The Insured had submitted all the necessary papers to the TPA for reimbursement of medical expenses for hospitalization. The Insured had lodged a claim for cashless facility on 15.03.14 which was denied by the M/s Raksha TPA on the ground of exclusion clause no. 4.3 as per policy terms and conditions.**

2. **The Insurance Company had reiterated that the patient was hospitalized in Max Super Specialty Hospital from 12.03.14 to 15.03.14 with the complaint of polymorphic rash for 10 days and was diagnosed a case of Vasculitis (Erythema) Multiform/ Bullous Pemphigoid. The patient was given oral treatment (except one pain killer injection). As the treatment given could have been managed on OPD basis, hence the claim had been recommended for repudiation.**

3. **I heard both the sides the complainant as well as the Insurance Company. The complainant's husband was hospitalized at Max Hospital for 3 days dated 12.03.14 to 15.03.14 for the treatment of Vasculitis for IV Soulmedrol. The Insurance Company had repudiated the claim on the ground that skin disease/disorders are excluded for 2 years from the inception of policy and treatment could be managed on OPD basis. I find that the complainant had initially managed the treatment on OPD basis but when the illness became critical he was hospitalized at the advice of the doctor. As per the certificate dated 15.03.14 signed by the Director of Vascular Surgery submitted by the complainant, the patient was admitted in emergency and IV steroid admistration was necessary as life saving measure. The Vasculitis was a disease of veins which manifests on the skin. Therefore I direct the Insurance Company to allow**

reimbursement for hospitalization expenses as Vasculitis is a disease of the veins. Accordingly an Award is passed with the direction to the Insurance Company to make the payments as admissible.

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In the matter of Sh. Kalyan Patra
Vs
New India Assurance Co. Ltd.

In the matter of Sh. Virender Kumar
Vs
New India Assurance Co. Ltd.

DATE:18.05.2015

1. **The complainant alleged that he had taken the Family Floater Mediclaim since 16.11.2010 without any break. He was admitted in Rajiv Gandhi Cancer Institute and Research Centre on 11.05.2014 as diagnosed case of Relapse Hodgkin Lymphoma for stem cell collection done on 12.05.2014 under GCSF cover and underwent bone marrow transplant. The Insurance Company had denied the claim on the ground of exclusion clause no. 4.4.16 which states that stem cell implantation is excluded from the scope of cover. He had alleged that there is vital difference between implant and transplant in the medical field. The transplant involves the use of biological/human substance whereas the implant involves synthetic substance. Hence the claim for bone marrow transplant should be considered.**

2. **The Insurance Company had reiterated that the patient was hospitalized in Rajiv Gandhi Cancer Institute and Research Centre on 11.05.2014 as diagnosed case of Relapse Hodgkin Lymphoma and admitted for bone marrow treatment. The TPA had rejected the claim under policy clause no. 4.4.16 which states that genetic disorders and stem cell implantation/surgery are excluded from the scope of cover.**

3. **I heard the complainant. The Insurance Company was absent and none represented on behalf of the Company. I find that the complainant underwent bone marrow transplant. The claim was rejected on the ground that stem cell implantation/surgery are excluded from the scope of cover of the policy. The complainant alleged that bone marrow transplant was not a surgery. Bone**

marrow transplant involves transplant of living substance whereas implant involves use of synthetic/dead substance. I find that as per policy condition no. 4.4 "the stem cell implantation is excluded from the scope of cover, but in the instant case patient underwent transplantation not implantation". Hence, the policy clause is not applicable. I direct the Insurance Company to reimburse the claim upto the liability under the policy i.e. the sum insured. Accordingly an Award is passed with the direction to the Insurance Company to make the necessary payments as admissible.

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In the matter of Sh. Om Prakash Swami
Vs
New India Assurance Co. Ltd.
DATE:18.05.2015

1. **The complainant had taken mediclaim policy since 1999 with S.I. of Rs. 1.25 Lacs. The complainant's wife was admitted in Sir Ganga Ram Hospital from 20.07.2014 to 24.07.2014 for the treatment of pain in left shoulder, uncontrolled DM and eyes problem. He lodged a claim of Rs. 44,694/- out of which Rs. 16,609/- was paid by the Company. The complainant had further lodged a claim for reimbursement of pre&post hospitalization expenses amounting to Rs. 20,667/- out of which Rs. 1578/- was paid. The complainant sought relief for the balance amount with interest.**

2. **The Insurance Company had reiterated that the patient was admitted with diagnosis of Diabetic Retinopathy and hypertension. She was a known case of DM- type II and HTN for the past 2 years as per discharge summary and was on medication. The S.I. applicable was restricted to Rs. 1.25 Lacs which was available in the 2 years old policy. Accordingly the maximum payable room rent was Rs. 1250/- per day and the patient had opted a room for Rs. 4100/- per day. Since entitlement was of Rs. 1250/- only, all other charges were paid in proportion to the eligible room rent category except medicines and consumables as applicable under policy clause 3.1 (a) which stated "room, boarding and nursing**

expenses as provided by the Hospital not exceeding 1.0% of the sum insured per day" and 3.1(b) which stated "the intensive care unit (ICU)/Intensive Cardiac Care Unit (ICCU) expenses not exceeding 2.0% of the sum insured per day."

3. **I heard both the sides the complainant as well as the Insurance Company. I find that the complainant's wife was hospitalized for pain in left shoulder, diabetes, hypertension and retinopathy. The pre hospitalization expenses for diabetes were not allowed on the ground that the patient was already on medication for diabetes before the hospitalization and there was no prescription for medicines for pre-hospitalization bills. I find from the discharge summary that patient was on medication for the past 2 years for diabetes and HTN, but she was treated for diabetes also during hospitalization. Therefore, I direct the Insurance Company to pay the expenses incurred on medication for diabetes in post hospitalization only as per terms and conditions of the policy on submission of prescriptions for medicines for diabetes. Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant.**

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In the matter of Sh. Rohit Handa
Vs
New India Assurance Co. Ltd.

DATE:29.05.2015

1. **The complainant was hospitalized at Apollo hospital for the period of 01.04.2014 to 02.04.2014 for treatment of chronic prostatitis with hyperbaric oxygen therapy. The request for treatment on cashless basis was approved for Rs. 50,000/-. But when he applied for reimbursement of post hospitalization expenses the claim was repudiated under the policy clause 4.4.23 which states that the treatment of hyperbaric oxygen therapy was excluded under the policy.**

2. **The Insurance Company had reiterated that he was insured under mediclaim policy valid 29.09.2013 to 28.09.2014. He was admitted at Apollo Hospital from 1.04.2014 to 2.04.2014. He opted for prior approval on 26.03.2014 which was approved for Rs. 50000/- later on after submission of all the documents for reimbursement, the claim was repudiated on the ground that Hyperbaric Oxygen Therapy was excluded as per policy clause 4.4.23. Therefore earlier sanction of Rs. 50,000/- was also cancelled.**

3. **I heard both the sides, the complainant as well as the Insurance Company. I find that the complainant underwent prostatitis with hyperbaric Oxygen therapy on 26.03.2014. The claim was rejected on the ground that hyperbaric oxygen therapy was excluded as per policy clause 4.4.23. During the course of hearing the complainant contested that he had taken mediclaim policy since 2007. The terms and conditions of 2007 mediclaim policy do not include the clause 4.4.23. The clause 4.4.23 was incorporated in the policy in 2012. I find that the new terms and conditions were not provided to the complainant along with policy schedule. The Insurance Company failed to show proof of delivery of new terms and conditions to the complainant. There was deficiency in services on the part of the Company by not appraising the insured about any changes in terms and conditions of the policy at the time**

of renewal of policy and/or delivery of policy document. Therefore I direct the Insurance Company to settle the claim as admissible. Accordingly an Award is passed with the direction to the Insurance Company to make the necessary payments as admissible.

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In the matter of Smt. Malti Halder
Vs
New India Assurance Co. Ltd.
DATE:29.05.2015

1. **The complainant had alleged that her husband had taken a Janta Personal accident policy from New India Assurance Company Ltd. on 23.10.2000. Her husband met with an accident due to sudden fall of the building and died. The claim had not been settled by the Company.**

2. **The Insurance Company had reiterated that the Complainant was advised vide letters dated 25.03.2011 and 19.12.12 to submit status proof certificate issued by M/S G.T.F.S. but till date same was not provided. By virtue of order dated 06.07.1999 by the Hon'ble High Court, Calcutta, M/s GTFS was specially restricted to collect any premium from the category of FRIENDS and the present policy certificate issued in this matter was on 23.10.2000 which was much after the passing the aforesaid order. So, policy holder must have to produce Identity Card either of field worker, agent or investor from the competent authority of M/s GTFS. As the insured had not complied with the required documents hence, the claim was outstanding.**

3. **I heard the complainant. The Insurance Company was absent during the course of hearing. I find that Insurance Company had issued a certificate in respect of Group Janta Personal Accident Insurance Policy on 23.10.2000 in the name of Mr. Badal Halder through M/s Golden Trust Financial Services. The premium receipt was issued on 25.09.2000 by M/s Golden Trust Financial Services. The complainant's husband died in March, 2010 when the five floor building collapsed where he was working. The Insurance Company reiterated vide letter dated 10.02.2015 that as per the order of the High Court, Calcutta, dated 06.07.99, M/s GTFS was restricted to collect any premium from the category of 'Friends'. The present policy certificate was issued on 23.10.2000**

which was much after the passing of the order of High Court. The Insurance Company must be seized of the High Court Order when it issued the certificate in 2000. Hence Insurance Company is liable to settle the claim once the consideration premium has been accepted and the insurance contract has been made between the insured and the Company. Therefore I direct the Insurance Company to settle the claim as admissible. Accordingly an Award is passed with the direction to the Insurance Company to make the necessary payments as admissible.

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In the matter of Sh. Lakshman
Vs
New India Assurance Co. Ltd.

DATE:29.05.2015

1. **The complainant had alleged that the he had taken an Individual Mediclaim policy with sum insured of Rs. 1, 00,000/-. He was admitted at Batra Hospital for the period of 18.06.13 to 27.06.13 with diagnosis of fistula in Ano, severe anemia and esophageal ulcer. The Raksha TPA had paid Rs. 32,736/- against claimed amount of Rs. 80,511/-. The complainant had alleged that there was no difference in other charges in Batra Hospital in respect of room category except room rent. It was supported by a certificate dated 05.07.13 issued by Batra Hospital. Therefore the complainant had agreed for deduction of excess room rent amounting to Rs. 15340/- and approached this forum for excess deduction of Rs. 32435/- pertaining to other charges such as investigation test and consultation charges.**

2. **The Insurance Company had reiterated that complainant had taken an Individual Mediclaim policy with the sum insured of Rs. 1, 00,000 from New India Assurance Company Ltd. He was admitted in Batra Hospital in emergency. The maximum liability for room rent was not exceeding 1% of the sum insured under the policy. In this case the room rent eligibility was upto Rs. 2500 per day. The insured had opted a room with higher rent than the entitled category. Therefore other charges like surgeon fee, test and investigations and consultation charges were paid @ applicable to the entitled room category as per as per clause no. 2.1(a) & (b) which states that in**

case of admission to a room/ICU/CCU at rates exceeding the aforesaid limits, the reimbursement/ payment of all other expenses incurred at the Hospital, with the exception of cost medicines, shall be affected in the same proportion as the expenses admissible rate per day bears to the actual rate per day of room rent/ICU/CCU charges" (Clauses enclosed).

3. **I heard both the sides, the complainant as well as the Insurance Company. The complainant had requested for payment of claim according to General Ward. He had submitted the certificates dated 05.07.2013 &12.11.2013 confirming that lowest category in Batra Hospital was General Ward and the patient was admitted in 4 bedded ward as there was no bed available in General ward and all other charges (except room rent) for General ward and 4 bedded ward were the same. The Insurance Company had settled the claim on the basis of eligible room rent i.e. 1% of S.I. and all other charges except medicines were paid @applicable to the entitled room category as per clause no.2.1 (a) & (b). I find that the Grievance Redressal office vide letter dated 18.10.13 assured to reconsider the case on merits in case the charges of 4 bedded ward and General ward were found to be same. The complainant had submitted letters dated 05.07.2013 and 12.11.2013 from Batra Hospital confirming that General ward charges and 4 bedded ward charges were same for imaging, lab. Doctor's fee and blood bank. I find that no response was given by the Company even to legal notice dated 26.06.14 given by the complainant and also no acknowledgement of certificates dated 05.07.13 and 12.11.13 given by Batra Hospital submitted by complainant in response to GRO letter dated 18.10.13. Therefore the Insurance Company is directed to pay Rs. 32435/- to the complainant. Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant.**

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In the matter of Sh. Vijay Aggarwal
Vs
New India Assurance Co. Ltd.

DATE:18.05.2015

1. **The complainant had alleged that he had taken Mediclaim policy from New India Assurance Company Ltd. on 07.04.2010 onward for a S.I. of Rs. 1, 00,000/-. The S.I was enhanced to Rs. 3 Lacs under the policy period 07.04.2014 to 06.04.2015. His mother was admitted at Mata Chanan Devi Hospital from 18.05.14 to 2.06.2014. She was diagnosed with UTI septicemia. The Insurance Company had settled the claim on the basis of S.I. of previous policy i.e. S.I. of Rs. 1, 00,000 on the ground that DM and HTN was pre-existing, prior to enhancement of S.I. The complainant had alleged that UTI Septicemia was a bacterial infection and any one can suffer the infection, not only diabetic person.**

2. **The Insurance Company had reiterated that the patient was admitted at Mata Chanan Devi Hospital for the period of 18.05.14 to 02.06.2014 with complaint of fever since 3 days and pain in abdomen. She was diagnosed with hypothyroid, type-II DM, HTN, UTI with septicemia. The patient was a known case of DM since 5 years and was on medication. She was admitted with ailments which were directly linked and got worsened with DM like septicemia, UTI, HTN etc. As DM was existing prior to enhancement of S.I. which was the leading factor for ailment, hence S.I. for the claim had been restricted to S.I. of policy year 2010-2011 i.e. one Lac. Accordingly the amount of Rs. 1, 00,000/- had been paid directly to the hospital.**

3. **I heard both the sides, the complainant as well as the Insurance Company. I find that the patient was hospitalized from of 18.05.14 to 02.06.2014 and was diagnosed with UTI Septicemia. The S.I was enhanced to Rs. 3 Lacs in the same year under the policy period i.e. 07.04.2014 to 06.04.2015. The Company had rejected the claim on the ground that UTI was related to DM and Diabetes was pre-existing prior to enhancement of S.I. which was the leading factor for ailment. Hence S.I. for this claim had been restricted to S.I. of policy year 2010-2011 i.e. one Lac. I find that the UTI Septicemia is neither related to diabetes nor was it pre-existing. I direct the Insurance**

Company to reimburse the amount and settle the claim on the basis of enhanced S.I of 3 Lacs under policy period 07.04.2014 to 06.04.2015. Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant.

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In the matter of Smt. Lalita Rani
Vs
New India Assurance Co. Ltd.

DATE:18.05.2015

1. **The complainant had alleged that she was admitted at Surya Kiran Hospital on 04.06.14 for treatment of Chronic Cervictis with Acute Vaginitis and was discharged on 05.06.2014. The vaccine for prevention of cancer was given on 14.06.2014. The claim was rejected by the Company on the ground that hospitalization was done only for evaluation. The vaccine was injected after nine days of hospitalization for prevention of cervical cancer and not for treatment.**

2. **The Insurance Company had reiterated that the patient was admitted at Surya Kiran hospital on 04.06.14 for investigations to rule out the cervical cancer as her mother was suffering from cervical cancer. All the investigations had been done in a diagnostic centre situated outside the hospital. All the reports were normal and no active line of treatment was taken. The preventive vaccination for cervical cancer was administered after 9 days of hospitalization which was not payable as per policy condition no. 14. The patient was discharged at 10 p.m. in the night at her own request. The treating doctor had stated vide letter dated 24.08.14 that there was no medical justification for discharge at night. The claim was rejected on the ground that patient was admitted for investigations only which could be done out in the OPD. There was no active line of treatment and neither was follow up medicine advised.**

3. **I heard both the sides, the complainant as well as the Insurance Company. I find that the complainant was hospitalized in emergency with complaint of Chronic Cervictis with Acute Vaginitis. The Company had rejected the**

claim on the ground that patient was admitted for investigations only which could be done on OPD basis. There was no active line of treatment. I find from the discharge summary that complainant was given IV fluids and medicines during hospitalization. Therefore, the Insurance Company's ground for rejection of claim that there was no active line of treatment could be substantiated. Hence I direct the Insurance Company to allow reimbursement for hospitalization expenses and disallow expenses of vaccination for cervical cancer which is not payable as per exclusion clause no. F(iii) of the LIC group mediclaim policy. Accordingly an Award is passed with the direction to the Insurance Company to make the necessary payments as admissible.

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In the matter of Smt. Nisha Gupta
Vs
New India Assurance Co. Ltd.
DATE:18.05.2015

1. **The complainant was admitted at Sir Ganga Ram Hospital from 14.04.2014 to 16.04.2014. She reported a claim of Rs. 98,543/- out of which only Rs. 34169/- was paid by the Company. The Company had settled the claim on the basis of room rent eligibility under the policy. The complainant had alleged that the charges of Rs. 13,360 for CT scan and medicine and medical consumables (including cost of capsule endoscope) were fixed and do not vary according to category of accommodation. It was confirmed vide certificate dated 04.08.2014 issued by the hospital.**

2. **The Insurance Company reiterated vide its self contained note dated 12.05.2015 that the complainant was insured under mediclaim policy valid from 15.09.2013 to 14.09.2014 with S.I. of Rs. 2.5 Lacs. The claim was settled in proportion to eligibility of room rent under the policy. The maximum liability for room rent was not exceeding 1% of the sum insured i.e. Rs. 2500/- per day under the policy. The insured had opted a room with higher rent than the entitled category. Therefore other charges like surgeon fee, test and investigations and consultation charges were paid at the rate applicable to the entitled room category as per clause no. 3.1(a) & (b) which states that in case of admission to a room/ICU/CCU with rates exceeding the aforesaid limits, the reimbursement/ payment of all other expenses**

incurred at the Hospital, with the exception of cost of medicines, shall be effected in the same proportion as the expenses admissible bears to the actual rate per day of room rent/ICU/CCU charges" (Clauses enclosed).

3. **I heard both the sides, the complainant as well as the Insurance Company. I find that the Company had rejected the claim on the ground that the reimbursement/payment of all other expenses incurred at the Hospital, with the exception of cost of medicines, shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of room rent/ICU/CCU charges. I find from the bill of Ganga Ram Hospital that charges for capsule endoscopy was Rs. 4840/- and the capsule endoscope was of Rs. 28224/- which is a consumable medicine. Therefore cost of capsule endoscope is payable under consumable medicine. During the course of hearing the Insurance Company agreed to settle the claim for capsule endoscope. Accordingly an Award is passed with the direction to the Insurance Company to settle the claim for capsule endoscope.**

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In the matter of Sh. Sumeet Sharma
Vs
Max Bupa Health Insurance Co. Ltd.
DATE:18.05.2015

1. **The complainant was admitted at Gupta Multi Speciality Hospital for the period of 04.09.2013 to 10.09.2013 with complaint of high grade fever, body ache, and abdomen pain. The claim was not settled by the Insurance Company inspite of various reminders.**

2. **The Insurance Company reiterated vide its letter dated 08.05.2015 that the Company had issued a Health Insurance Policy for the period of Insurance from 28.06.13 to 27.06.2014. The Insured was hospitalized on 04.09.2013 and discharged on 10.09.2013.**
   The patient was admitted with history of high grade fever, body ache and pain abdomen specially in right hypochondrium, since last 3 days and diagnosed Enteric Fever with PIVID with Radiculopathy. He applied for claim reimbursement of Rs. 57,704/- on 04.09.2013. In the last hearing patient's mother had accepted that the patient met with an accident couple of years back and took treatment from Gupta Hospital, Vivek Vihar which clearly shows that there is non-disclosure of pre-existing condition due to which insured was having abdomen pain and had undergone PIVD. Thus taking into consideration non-disclosure of material facts, the Company is ready to settle the matter on partial basis, after deducting the charges related to pre-existing condition.
3. **I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the Insurance Company agreed to settle the expenses arising on account of dengue only. I direct the Insurance Company to settle the claim as admissible. Accordingly an Award is passed with the direction to the Insurance Company to make the necessary payments as admissible.**

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In the matter of Sh. A.K. Sharma
Vs
National Insurance Co. Ltd.

DATE:31.05.2015

1. **The complainant was admitted at Medanta Hospital from 27.01.2014 to 31.01.2014 for treatment of Heart Attack. He was insured with National Insurance Company Ltd. since 2003. The claim was settled on the basis of S.I. of Rs. 2.25Lacs+22500 C.B. under policy year 2009. He sought relief for balance amount of claim amounting to Rs. 71357/-.**

2. **The Insurance Company reiterated vides its e-mail dated 13.05.2015 that the insured was covered under Individual Mediclaim Policy for a S.I. of Rs. 50,000/- since 2003 which was continuously enhanced over time. He was hospitalized at Medanta from 27.01.2014 to 30.01.2014. He was diagnosed with Coronary Artery Disease, type II Diabetes and underwent PTCA with stent. The claim was settled on cashless basis for an amount of Rs. 247500/- (S.I Rs 2, 25,000/-+ CB 22500). They restricted the eligible S.I. of policy year 2009 as there was a history of Diabetes/HTN since 15 years. As per policy condition 4.1, 4.2, 4.3 waiting period shall apply on the enhanced S.I. as if a new policy. Since CAD to be pre-existing in the said case, the S.I. of policy year 2009 has completed 48 months waiting period. Hence claim was settled as per terms and conditions of the policy.**

3. **I heard the Insurance Company. The complaint was absent during the course of hearing. He had requested to decide the case on merits vide letter dated 20.05.2015. I find that complaint had taken mediclaim insurance since 2003 for a S.I. of Rs. 50,000/- which was continuously enhanced over time. The claim arose on 27.01.2014 for treatment of coronary artery disease and type II Diabetes Mellitus. The claim was settled on cashless basis after restriction of S.I. of policy year 2009 (Rs. 2.25 Lacs + Rs. 22500/- C.B.) as there was history of Diabetes/HTN since 15 years as per history stated by treating Doctor in the Internal Record of the Hospital. I find from the written submissions of the complainant that diabetes was detected in 2011 and there was no history of HTN. He has submitted five certificates dated 07.02.2014, 13.02.2014, 07.03.2014, 11.03.2014**

and dated nil obtained from doctors to certify that he developed diabetes type-II in 2011, has no past history of HTN and cardiac disease. The diabetes was under control with medicines. Thus, in my considered view, if the treatment was related to diabetes then it is pre-existing disease and he was not entitled to reimbursement on enhanced S.I. However in the said case he was admitted for coronary artery disease which was not pre-existing at the time of enhancement of S.I. therefore the settlement of claim for S.I. of 2009 policy on account of pre-existing diabetes and HTN is not justified. The Company cannot read something more into the terms and a condition of the policy is not correct. Therefore I direct the Insurance Company to settle the claim on the basis of S.I. of 5 lacs. Accordingly an Award is passed with the direction to the Insurance Company to settle the claim as admissible.

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In the matter of Sh. Hari Shankar Gupta
Vs
National Insurance Co. Ltd.

DATE:29.05.2015
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1. **The complainant was hospitalized at Max Health Care Hospital for the surgery of Prostate on 07.04.2014 and discharged on 11.04.2014. The TPA had settled only Rs. 55845/- against a total bill of Rs. 93837. He sought relief for the balance of the amount of claim**

2. **The Insurance Company had settled the claim as the maximum liability payable for prostate surgery was Rs. 55845/- under GIPSA Package**

3. **I heard both the sides the complainant, as well as the Insurance Company. During the course of hearing, the complainant alleged that policy received by him does not indicate PPN/GIPSA package. No terms and conditions were received with the policy schedule. The Insurance Company reiterated as per policy condition no. 3.4 "Preferred provider network (PPN)" which states "A network of hospitals which have agreed to a cashless packaged pricing for certain procedures for the insured person. The list is available with the Company/TPA and subject to amendment from**

time to time. Reimbursement of expenses incurred in PPN for the procedures (as listed under PPN package) shall be subject to the rates applicable to PPN package pricing."
I find from the policy condition that pricing list of procedures under PPN Package was with the Company and the TPA. The list was not a part of policy document being sent to the insured. Therefore insured was not aware about PPN/GIPSA package. During the course of hearing the Insurance Company could not show endorsement of GIPSA package in the policy condition. This is deficiency in service. Therefore I direct the Insurance Company to reimburse the balance expenses after deducting the non-payable items. Accordingly the complaint filed by the complainant is hereby disposed off.

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In the matter of Ms. Sunita Jain
Vs
National Insurance Co. Ltd.

DATE: 29.05.2015

1. **The complainant alleged that the mediclaim policy was in existence continuously since 1990. He had requested to increase the S.I. from 5 Lacs to 7 Lac, but the Insurance Company had issued two policies of 5 Lacs and 2 Lacs separately. He had lodged two claims one for himself and other for his wife. Both claims were settled on the basis of S.I. of Rs. 2 Lacs only. He sought relief for wrong deductions made in the claims.**

2. **The Insurance Company had not submitted any self contained note or any other related documents.**

3. **I heard both the sides, the complainant as well as the Insurance Company. I find that the complainant had requested to enhance the S.I. from Rs. 5 Lacs to Rs. 7 Lacs but the Insurance Company had issued two policies of Rs.5 Lacs and Rs. 2 Lacs each. Two claims were lodged under the policy. The claims were settled on the basis of S.I. of Rs. 2 Lacs only. The Insurance Company reiterated that policies can be issued for maximum S.I. of Rs. 5 Lacs which fact admittedly was not made known to the**

complainant, and instead of enhancement of S.I. to 7 Lacs two policies were issued simultaneously one for 5 Lacs and one for 2 Lacs. The Insurance Company explained that the 5 Lacs is (Parent Policy) and the second of enhancement of premium of Rs. 2 Lacs is (Child Policy). The Insurance Company admitted that the claims were erroneously paid on the basis of S.I. of Rs. 2 Lacs (child policy) and agreed to settle the claim. The Insurance Company is directed to reimburse the admissible amount after deduction of items not payable as per terms and conditions of the policy. Accordingly an Award is passed with the direction to the Insurance Company to settle the claim as admissible.

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In the matter of Mr. Bharat Bhushan
Vs
National Insurance Co. Ltd.

DATE: 29.05.2015

1. **The complainant alleged that he was holder of Mediclaim policy since 20 years. He had enhanced the S.I. from 1 Lac to 3 Lacs in the year 2010. He had heart problem since 2009. He had undergone open heart surgery and submitted a claim of Rs. 2,40,000/- the Insurance Company had paid Rs. 108000/-. He sought relief for balance amount.**

2. **The Insurance Company reiterated that the complainant had taken Varistha Mediclaim Policy in the year 2011 with S.I. under Section I (Hospitalization Expenses Cover) Rs. 1, 10,000/- S.I. under Section II (Critical Illness Cover) Rs. 2 Lacs. His first claim was paid for Rs. 99000/- after a deduction of 10% as co-payment. In the second claim available S.I. was Rs. 11000/- hence amount of Rs. 9900/- was paid after deduction of 10% as co-pay. The patient had undergone PTCA in 2009 before inception of policy. Hence S.I. for critical illness was not considered due to policy exclusion clause 5 of Section II of critical illness cover which states that "the Company will not be liable for a critical illness and/or its symptoms (and /Or its treatment) which were present in the insured person at any time before inception of the policy or date on which cover was granted to such insured person, or which manifest themselves within a period of 90 days from such date, whether or not the insured person had knowledge that the symptoms or treatment were related to such**

critical illness" Company is not liable for this critical illness or its symptoms or its treatment.

3. **I heard both the sides, the complaiant as well as the Insurance Company. I find that complainant had taken Varistha Mediclaim Policy in the year 2011. The sum insured was in two parts: hospitalization expenses cover for S.I. for Rs. 1, 00,000/- and critical illness cover for Rs. 2 Lacs. He had reported two claims under the policy. He underwent CABG in November, 2013. The Insurance Company had settled the claim under section I of the policy after deduction of Co- payment. The second claim for Malaria was reported in December, 2013 which was paid for Rs. 9900/- after deduction of co-pay since the available S.I. under section I was Rs. 11,000/-. The patient had history of HTN, CAD and Post CABG since 2009 as per discharge summary of the Metro Hospital. The policy definition of critical illness cover states that the Insurance Company will not be liable for a critical illness and/or its symptoms (and /Or its treatment) which were present in the insured person at any time before inception of the policy or date on which cover was granted to such insured person, or which manifest themselves within a period of 90 days from such date, whether or not the insured person had knowledge that the symptoms or treatment were related to such critical illness" Company is not liable for this critical illness or its symptoms or its treatment. In the instant case the patient had been suffering from heart disease before inception of insurance cover. As per his own admission he was suffering since 2009 which makes it pre-existing at the time of inception of policy. I find from the policy taken on 10.09.2011 under the column exclusion of PED is given as "NIL". The complainant had not corrected this fact also. The S.I. available in Sec-I and Sec II cannot be clubbed for reimbursement of hospitalization expenses. I find that Sec I is for hospitalization and Sec II for critical illness. Therefore, I uphold the decision of the Insurance Company. Accordingly the complaint filed by the complainant is hereby disposed off.**

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In the matter of Mr. N.K. Agarwal
Vs
National Insurance Company Ltd.

DATE: 29.05.2015

1. **The complainant alleged that his wife was hospitalized at Asian Institute of Medical Sciences from 14.01.14 to 18.01.14 for treatment of opticospinal demyelinating disease. The claim was repudiated by the Company on account of pre-existing disease. He had further alleged that the disease was first diagnosed in March 2012 after taking the policy. The patient had some burning problem in the year 2009, which was cured with medicine. He sought relief of Rs. 26925/- the balance amount after paying by State Bank of Patiala.**

2. **The Insurance Company reiterated vide letter dated 30.01.2015 that patient had taken mediclaim policy since 16.02.12. She was admitted at Asian Institute of Medical Sciences from 14.01.2014 to 18.01.2014 for treatment of opticospinal demyelinating disease. The claim was lodged in the 2nd year of the policy. As per the OPD consultation dated 24.01.2014 of Fortis Hospital patient had complaints of Transverse Myelitis since 2009. As per policy terms and conditions, the pre-existing disease is covered only after completion of 3 consecutive continuous claim free years. Hence claim was rejected as per exclusion clause no. 4.1 of the policy.**

3. **I heard both the sides, the complainant as well as the Insurance Company. I find that patient had taken policy since 16.02.2012. The first claim for Dorsal Myelopaty, Demyelinating infective arose in March 2012 within 37 days of inception of policy which was rejected on the ground that ailment was pre-existing. The current claim for treatment of opitcospinal demyelinating disease arose on 14.01.2014. The claim was lodged in the 2nd year of the policy. As per the OPD consultation dated 24.01.2014 of Fortis Hospital patient had complaints of Transverse Myelitis since 2009 i.e. prior to policy inception. This medical condition was also revealed in the first claim arose in March 2012. This shows that the disease was pre-existing prior to inception of policy and patient was on medication. The Insurance Company had rightly rejected the claim as per policy**

condition no. 4.1 which states that pre-existing disease is covered only after completion of 3 consecutive continuous claim free years. Accordingly the complaint filed by the complainant is hereby disposed off.

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In the matter of Mr. Ajeet Sharma
Vs
National Insurance Company Ltd.

DATE: 04.06.2015

1. **The complainant alleged that his wife had been suffering from uncontrollable diabetes since 3 years with frequent hospitalization and was on Insulin. She underwent duodenal lleal Interposition with sleeve Gastectomy and Cholecystectomy surgery for cure and management of diabetes. The claim was rejected on the ground that cosmetic surgery was excluded from the scope of the policy. He had alleged that treatment was taken to cure diabetes. It was not a cosmetic surgery. He sought relief of Rs. 3, 59,934/- and interest.**

2. **The Insurance Company reiterated that the patient had undergone bariatric surgery/sleeve Gastectomy with its cosmetic/aesthetic treatment. As per the opinion of panel doctor and Regional claims committee the claim was not payable as per exclusion clause 4.6 of BOI National Swasthya Bima Policy which states that "Cosmetic or aesthetic treatment of any description, change of life or sex or change operation. Expenses for plastic surgery other than as may be necessitated due to illness/disease/injury" are not covered under the scope of the policy. Hence the claim was not admissible.**

3. **I heard both the sides the complainant as well as the Insurance Company. During the course of personal hearing the complainant alleged that his wife underwent duodenal lleal Interposition with sleeve Gastectomy and Cholecystectomy surgery for cure and management of Diabetes. After the surgery she was cured of diabetes. The Insurance Company had rejected the claim on the ground that cosmetic surgery was not covered under the policy as per policy clause no. 4.6. he had also produced the treating doctor's certificate dated 06.10.2014 from Kirloskar Hospital which revealed that patient had been suffering**

with Type II diabetes mellitus fluctuating and uncontrolled since last 2 years with history of frequent hospitalization. The patient was advised the surgery called "Ileal Interposition with adjusted sleeve Gastectomy" as a long term cure for diabetes and to prevent diabetes related complications. I feel that Insurance Company had wrongly rejected the claim on the ground of exclusion clause 4.6.
Bariatric surgery is not a cosmetic weight loss procedure. It is a metabolic operation to prevent diabetes and other complications related to diabetes. As per doctor's certificate from Kirloskar Hospital duodenal Ileal Interposition with sleeve Gastectomy was a surgery to cure and prevent diabetes and not a cosmetic surgery. I hold that the Insurance Company is liable to settle the claim. Accordingly an Award is passed with the direction to the Insurance Company to settle the claim as admissible.

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In the matter of Mr. Anurag Sachdev
Vs
Religare Health Insurance Company Ltd.
DATE: 04.06.2015

1. **The complainant alleged that he had taken Health Insurance from Religare valid from 07.01.14 to 06.01.15. The policy was ported from Appolo Munich. His mother was hospitalized at Ganga Ram, Kolmet Hospital for the period 30.09.14 to 04.10.14 with complaint of throat infection and Sarcoidosis, severe oral ulcerations. He had submitted all the documents to the Company. The claim was rejected on the ground that insured was suffering from HTN for the last one year which was not disclosed at the time of filling up the proposal form.**
2. **The Insurance Company had reiterated vide their written reply that the complainant's mother was admitted with throat infection and sarcoidosis, severe oral ulcerations and dehydration in Ganga Ram Hospital from 30.09.14 to 04.10.14. She was suffering from HTN for the last one year and was on medication, which was not disclosed at the time of filling up the proposal form. The fact that patient was suffering from HTN had been accepted by the patient in the questionnaire and written statement. Therefore the claim was rejected as per clause 6.1 of the policy terms and conditions i.e. non-disclosure of hypertension.**

3. **I heard both the sides the complainant as well as the Insurance Company. I find that the Insurance Company had rejected the claim due to non-disclosure of HTN. During the course of hearing the**

complainant stated that his mother was not suffering from HTN, she was taking medicine for HTN off and on. I find that current hospitalization was for throat infection, sarcoidosis and severe oral ulcerations which has no connection with HTN. In this respect the observations of the Hon'ble State Commission of Delhi in case of Oriental Insurance V/s. Madhusudan Sharma, I (CPJ) 494 are applicable to the facts of this case. The Hon'ble State Commission has observed as under-

> ***"We have taken a view in large number of cases that disease like hypertension, diabetes, etc. are so common and are always controllable and unless and until patient has undergone long treatment including hypertension and remain in hospital for days and undergoes operation etc. in the near proximity of taking the policy cannot be accused of concealment of material fact".***

I find that this order is on all fours in the present case. Accordingly an Award is passed with the direction to the Insurance Company to settle the claim as admissible.

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In the matter of Mr. Sumeet Sagoi
Vs
Religare Health Insurance Company Ltd.

DATE: 22.06.2015

1. **The complainant alleged that the Insurance Company had disallowed Rs. 5500/- towards expenses incurred for Harmonic Scalp Tray. He had alleged that the harmonic scalp tray was necessary to carry the sample for biopsy.**

2. **The Insurance Company reiterated vide their written reply dated 10.07.14 that the complainant's lodged a reimbursement claim for Rs. 11,259/- of which Rs. 4391/- was reimbursed after making deductions towards:**
   1) **Rs. 1000/- Admission Charges**
   2) **Rs. 250/- Documentation**
   3) **Rs. 5500/- Harmonic Scalpel**
   4) **Rs. 118/- Food Beverages**

As per IRDA regulations costs for Harmonic Scalpel is part of operation theatre charges (as charged by the Hospital) and is not paid separately.

3. **I heard the Insurance Company. The complainant was absent due to ill health as informed by phone. The complainant alleged vide letter dated 02.04.2014 that Insurance Company had disallowed Rs. 5500/- towards expenses incurred for Harmonic Scalpel. The Insurance Company reiterated that Harmonic Scalpel is a part of operation theatre charges and is not paid separately as IRDA. I find from the hospital bill dated 23.11.2013 submitted by the Insurance Company vide self contained note dated 10.07.2014 that the charges for Harmonic Scalpel were mentioned under non-payable items by the hospital which proves that charges for scalpel was not considered under OT charges. Therefore charges for Harmonic Scalpel should be paid. Accordingly an Award is passed with the direction to the Insurance Company to settle the claim as admissible.**

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In the matter of Ms. Shashi Jain
Vs
Royal Sundaram Alliance Insurance Company Ltd.

DATE:26.06.2015

1. **The complainant alleged that all the original bills duly attested by the complainant were submitted to the Insurance Company. The claim was not settled by the Company on the ground that the documents were not original documents. The quantum of relief sought is Rs. 2, 66,984/-.**

2. **The Insurance Company had reiterated vide their written reply that the complainant took the health policy for the period covering 30.11.2013 to 29.11.2014 for herself and her family. The complainant made a claim in respect of hospitalization for knee replacement surgery on 17.02.2014. The complainant did not submit the original bills/receipts or discharge summary while intimating about the claim vide letter dated 20.03.2014. The**

Company requested het to submit original documents vide letter dated 23.04.2014 and 02.06.2014. The complainant had submitted self attested copies of claim documents only. Therefore due to non submission of original documents file was closed as per policy condition no. 1 which states "insured should submit all original documents within 30 days from the date of discharge from the hospital."

3. **I heard both the sides, the complainant as well as the Insurance Company. I find that complainant had submitted self attested deposit/advance receipt of payment only. The Insurance Company reiterated that complainant had not submitted the original bills hence, claim was closed. In my considered view the complainant should submit at least the final bills. The Company should make the payment after submission of original bills. Accordingly the complaint filed by the complainant is hereby disposed off.**

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In the matter of Mr. Praveen Chander Saxena
Vs
Royal Sundaram Alliance Insurance Company Ltd.

DATE: 26.06.2015

1. **The complainant alleged that he had taken Hospital cash insurance policy valid from 20.11.13 to 19.11.14. His mother was admitted at Kailash Hospital on 19.03.14 and later on shifted to Metro Hospital on 26.03.14 and discharged on 12.04.14. He had lodged a claim with the Company which was partially settled. As per policy condition Rs. 3000/- per day is payable if the patient is admitted in room for 24 hours and Rs. 9000/- per day is payable if admitted in ICU. He had received Rs. 72000/- under room benefits but the Insurance Company had not settled the claim for ICU inspite of several mail correspondences.**

2. **The Insurance Company repudiated the claim on the ground that the complainant's mother was admitted to M/s Metro Hospitals and Heart Institute from 26.03.2014 to 12.04.2014 for the ailment of Acute Chore Athetosis. The Insurance Company had paid a sum of Rs. 54,000/- + Rs. 51, 000/- + Rs. 3000/-+ Rs. 3000/- per day to the complainant vide e-transfer. It is stated that the complainant now has made a false allegation herein that the complainant's mother was in ICU care and therefore he is entitled to higher sum. The same is false and untenable, as the policy covered only daily benefits of Rs. 3000/- and not more than that. Further policy never provided any higher daily benefits for admission at ICU as being alleged by the complainant. It is submitted that the insured cannot claim anything which is outside the scope of the policy terms.**
3. **I heard both the sides, the complainant as well as the Insurance Company. I find that he had taken Hospital Cash Insurance Policy valid from 20.11.13 to 19.11.14. His mother was admitted at Kailash Hospital on 19.03.14 and later on shifted to Metro Hospital on 26.03.14 and discharged on 12.04.14. The complainant alleged that he had received Rs. 72,000/- under room benefits section of Hospital Cash Insurance but Company had not settled the claim for ICU admission charges. The Insurance Company reiterated that Hospital Cash Insurance policy covers daily benefits of Rs.**

3000/- and there was no provision for higher daily benefits admission at ICU as being alleged the complainant. The insured cannot claim anything which is outside the scope of the policy terms. Therefore, I see no reason to interfere with the decision of the Insurance Company. Accordingly the complaint filed by the complainant is hereby disposed off.

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In the matter of Sh. Manoj Kr. Agarwal
Vs
National Insurance Company Ltd.
DATE: 26.06.2015

1. **The complainant alleged that his wife was admitted at Saket Hospital from17.09.2014 to 18.09.2014. She underwent surgery for Diagnostic Hysteroscopy, D&C, and diagnostic laparoscopy with adhesiolysis with Mirena insertion with bilateral tubal ligation. The cashless claim was denied by the TPA. He had submitted all the documents to the Company but the claim was rejected on the ground of pre-existing disease. He had further stated that his wife was suffering from genital tuberculosis eleven years back which had no relation to the current illness.**

2. **The Insurance Company reiterated their written reply dated 19th May, 2015 that the complainant had taken mediclaim policy from 18.09.13 to 17.09.2014. His wife was admitted at Saket City Hospital on 17.09.2014. As per discharge summary patient was a known case of genital tuberculosis 11 years back received ATT, P2L2 with previous 2 LSCS with severe dysmenorrheal. She was admitted for diagnostic hysteroscopy + diagnostic laparoscopy +D&C + Bilateral tubal litigation. The claim falls under the Ist year policy. On the basis of investigation reports, discharge summary and opinion of panel doctor, it was found that the ailment was due to the past genital tubercular infection. Tubal litigation was done in hospitalization. The said disease fell under two years waiting period as per policy clause 4.3 and tubal litigation falls under exclusion clause no. 4.8 which states that "sterility, infertility/sub fertility or associated conception procedure are not covered."**

3. **I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant stated that his wife was suffering from genital tuberculosis eleven years back which had no relation with the current hospitalization for diagnostic hysteroscopy with diagnostic laparoscopy with DPC and tubal ligation. The Insurance Company had repudiated the claim on the ground that claim was reported in the first year of the policy and as per policy condition no. 4.3 (2Q) surgery related to genitor urinary system has 2 years waiting period and as per policy condition no. 4.6 treatment for sterility due to tubal ligation is not covered. I uphold the decision of the Insurance Company and I see no reason to interfere with the decision of the Insurance Company. Accordingly the complaint filed by the complainant is hereby disposed off.**

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In the matter of Mr. Shyam Kumar Poddar
Vs
Universal Sompo General Insurance Company Ltd.

DATE: 25.06.2015

1. **The complainant had alleged that he met with an accident on 1.06.2014 leading to fracture in his left shoulder. He was admitted at Jai Prakash Narayan, Trauma Centre and discharged on the same day. He had submitted all the necessary documents to the Company but the Insurance Company had rejected the claim on the grounds that hospitalization was less than 24 hours. He sought relief of Rs. 23,700/-.**

2. **The Insurance Company reiterated that the complainant was diagnosed with undisplaced left clevicle. He was treated with shoulder immobilizer. The said treatment is not listed in day care procedure list of the policy. The patient was admitted in the hospital on 01.07.14 at 18:35 and discharged on 01.07.14 at 20:33 hence 24 hours of hospitalization was not completed. Therefore the claim was not admissible as per terms and conditions of the policy.**

3. **I heard both the sides, the complainant as well as the Insurance Company. The complainant was treated for shoulder dislocation in Trauma Centre.**

The Insurance Company reiterated that the complainant was diagnosed with undisplaced left clevicle. He was treated with shoulder immobilizer. The said treatment is not listed in day care procedure list of the policy. It was an OPD treatment. The patient stayed in the hospital for 2 hours only; therefore claim was not admissible as per terms and conditions of the policy. I find that the patient was admitted on 01.07.2014 and discharged the same day within 2 hours as per the discharge summary. It does not fall within the terms and conditions of the policy- that hospitalization should be for 24 hours. I see no reason to interfere with the decision of the Company. Accordingly the complaint filed by the complainant is hereby disposed off.

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In the matter of Mr. Kunal Nath
Vs
Max Bupa General Insurance Company Ltd.

DATE: 26.06.2015

1. **The complainant had taken Health Policy valid from 11.02.14 to 12.02.15 before going to Germany. He had sudden severe unbearable pain in abdomen while he was in Germany. He rushed to India and underwent diagnostic tests at the advice of the doctor. He was admitted at RG Urology and Laparoscopy hospital from 25.04.14 to 26.04.14 and was operated for bilateral renal Calculi. He was also diagnosed Thalassemia trait through diagnostic tests. The Insurance Company had rejected the claim on grounds of non-disclosure of thalassemia. The complainant alleged that he himself was not aware about thalassemia at the time of obtaining the insurance. And as per National Thalassemia Welfare Society thalassemia minor or trait is not an adverse medical condition.**

2. **The Insurance Company had rejected the claim on the grounds that ailment falls under the clause 4(b) of the policy i.e. 90 days waiting period which states "we will not cover any treatment taken during the first 90 days since the date of commencement of the policy, unless the treatment needed in the result of an Accident or Emergency" and non-disclosure of material information. As per investigation non disclosure of thalassemia trait was evident.**

At the time of taking the insurance thalassemia was not mentioned in the proposal form.

3. **I heard both the sides the complainant as well as the Insurance Company. I found that the Insurance Company had repudiated the claim on grounds that ailment falls under the clause of 90 days waiting period and non-disclosure of thalassemia. During the course of hearing the complainant alleged that the claim falls under definition of medical emergency. Due to sudden severe unbearable pain in abdomen complaint had to be rushed to India from Germany and was operated for bilateral renal Calculi.**
The complainant came back on 22.04.14 from Germany and was operated on 25.04.14 at RG Urology and Laparoscopy Hospital which shows that he had to wait for 3 days before he was operated which means that it was not an emergency. I find that the claim was taken within 90 days of inception of the policy. This clearly falls the clause within 90 days waiting period as per policy terms and conditions. Therefore I uphold the decision of the Insurance Company. Accordingly the complaint filed by the complainant is hereby disposed off.

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In the matter of Mr. Debabrata Chakraborty
Vs
Max Bupa General Insurance Company Ltd.

DATE: 24.06.2015

1. **The complainant alleged that his wife was hospitalized at Apollo Hospital for treatment of anemia. The cashless request dated 13.10.14 was declined by the Company without providing any valid reason. He had submitted all the documents to the Company.**
The claim was rejected and an endorsement dated 11.11.14 had been issued by the Company without taking his consent to endorse modification in the policy in respect of his wife for Anemia under permanent exclusion. He sought relief of Rs. 57,649/-.

2. **The Insurance Company reiterated in their written submission dated 10.06.15 that Health Insurance Policy was issued for the period of**

12.06.14 to 11.06.15. The complaints' wife was admitted at Apollo Hospital on 03.10.14 for the treatment of severe iron deficiency anemia. The request for cashless treatment was denied due to non-disclosure of severe iron deficiency anemia at the time of taking the policy. The patient was treated for iron deficiency in October 2013 prior to inception of the policy as was evident from the prescription dated 13.10.2014 of the treating doctor of Apollo Hospital.

3. **I heard both the sides, the complainant as well as the Insurance Company. I find that cashless request of the complaint was rejected due to gross non-disclosure of material facts for severe iron deficiency anemia at the time of taking the policy.**
The pre-existing of anemia was declared by the complainant at the time of pre-authorization. During the course of hearing complainant alleged that the agent did not fill the correct information at the time of taking the policy. I find that the complaint had undergone iron therapy in October, 2013 as is substantiated from the treating Doctor's prescription of Apollo Hospital. The claim was rightly rejected by the Company. Therefore I uphold the decision of the Insurance Company. Accordingly the complaint filed by the complainant is hereby disposed off.

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In the matter of Mr. Anil Kr. Gupta
Vs
Max Bupa Health Insurance Company Ltd.

DATE: 26.06.2015

1. **The complainant alleged that he had taken Health Insurance Policy since 26.01.2012 from Max Bupa Health Insurance Company Ltd. He was admitted for the surgery of Lt. Hydrocele with Luts C (scrotal swelling). The claim was rejected on the grounds of non-disclosure of material facts about Hypothyroidism and HTN and cholecystectomy since 5 years and swelling in scrotal since 3-4 years. He had stated that the fact that he was suffering from HTN and hypothyroidism and was under medication was disclosed to the Company's official.**

2. **The Insurance Company reiterated in their written submission that as per investigation done by the Company, it was found that patient was suffering from scrotal swelling, decrease flow, increase frequency since 3-4 years, hypothyroidism since 5 years and cholecystectomy 5 years back which was not disclosed during policy inception hence claim was repudiated under policy clause 4 (a) and non-disclosure of material facts.**

3. **I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing complainant stated that he was not aware of scrotal enlargement, he presumed that scrotal swelling was due to mosquito bite. He was not aware of the fact that scrotal swelling was an illness. He had informed to the agent about his illness i.e. HTN, Hypothyroidism and cholecystectomy but the agent did not fill the form correctly. The Insurance Company reiterated that as per investigation done by the Company, it was found that patient was suffering from scrotal swelling, decrease flow, increase frequency since 3-4 years, hypothyroidism since 5 years and cholecystectomy 5 years back which was not disclosed during policy inception hence claim was repudiated under policy clause 4 (a) and non-disclosure of material facts. I find in the proposal form in the medical history the complainant had not disclosed any of the pre-existing disease. He has signed the form also. Therefore, I uphold the**

decision of the Insurance Company. Accordingly the complaint filed by the complainant is hereby disposed off.

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In the matter of Mr. Mukesh Kumar
Vs
Star Health & Allied Insurance Company Ltd.

DATE: 24.06.2015

1. **The complainant alleged that he had lodged three claims for treatment taken at Saroj Hospital, BLK Hospital and Max Hospital. All the three claims were rejected on the ground of non-disclosure of information about post medical history at the time of portability of policy from United to Star Health. He had alleged that proposal form was filled by the Sales Manager and he had shared all the information with the Sales Manager. It was the duty of the Insurance Company to verify all the details from his previous insurer before portability of policy.**

2. **The Insurance Company reiterated in their written submission that the complainant had switched over from United India to Star Health w.e.f. 27.03.14 covering himself and his family. In the proposal form No pre existing disease was disclosed for any of the family member. Therefore the policy was issued to the insured not incorporating any PED. Three claims were reported for admission on 25.08.14, 05.09.14 and 12.10.14 at Saroj hospital, BLK hospital and Max hospital respectively. The complainant was diagnosed acute cholecystitis with cholelithiasis with empyema gall bladder with intra abdominal adhesions. From the discharge summary it was found that complainant had history of HTN, and was on medication, history of disseminated and had Hoch's completed 18 months ATT course in July 2014. Before taking the policy from Star Health he was admitted at BLK hospital from 27.12.12 to 10.01.13 for treatment of Multiple sclerosis and disseminated tuberculosis and drug induced hepatotoxicity. On scrutiny of the record it is clearly evident that the insured was suffering from disease prior to the policy and on ATT at the time of inception. In the proposal form for all the questions relating to the**

health history of all the members it was mentioned as "No". The claim was therefore rejected under condition no.7 "Non disclosure and misrepresentation".

3. **I heard both the sides the complainant as well as the Insurance Company. The complainant stated that the form was filled by his agent and he had disclosed details to him. I find that before taking the policy from Star Health complainant was hospitalized for treatment of multiple sclerosis and disseminated tuberculosis. He was on medication prior to inception of policy. The Insurance Company had repudiated the claim under policy condition no. 7 for "non-disclosure and misrepresentation." The policy was cancelled by the Insurance Company. I find that policy was ported from United India to Star Health. The complainant admitted the fact that disease was pre-existing and that the information was shared with the agent. The agent did not fill the form properly. Although the complainant could not conclusively prove his contention, however, one cannot completely overlook the fact that in actuality it is primarily the agents who fill the forms. The ends of justice would be met if the Insurance Company could add the pre-existing diseases/non disclosures if in the exclusion clause no. 7 and renew the policy. Therefore Insurance Company is directed to renew the policy in respect of complaint incorporating the disease under exclusion clause as per terms and conditions. Accordingly the complaint filed by the complainant is hereby disposed off.**

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In the matter of Mr. Ashok Kr. Arya
Vs
Max Bupa Health Insurance Company Ltd.

DATE:17.07.2015

1. **The complainant alleged that he had taken Family Floater Health Insurance Policy from Max Bupa for the period of 06.02.13 to 05.02.14. His wife was admitted to Dr. Shroff's Charity Eye Center on 04.09.2013. She underwent cataract surgery. A claim of Rs. 33,521/- was lodged with the Company. The claim was rejected on the grounds that symptoms of cataract were prior to policy inception. Hence the claim falls under non-disclosure of material information.**

2. **The Insurance Company reiterated in their written submission that the complainant was issued a Health Insurance Policy from 06.02.13 to 05.02.2014. The patient was hospitalized on September 04, 2013 and was discharged on September 04, 2013 at Dr. Shroff's Charity Eye Center with complaints of cataract problem in the right eye and underwent MICS with Intra Ocular Lens (Laser Cataract Surgery). During the investigation it was found that the patient had and Primary Glaucoma since 4 years which was not disclosed at the time of inception of policy. Thus the claim was rejected under the policy terms and condition for Non-disclosure of material information.**

3. **I heard both the sides the complainant as well as the Insurance Company. I find that claim of cataract eye surgery was rejected by the Company due to non disclosure of Primary Glaucoma (PG) at the time of policy inception. During the course of hearing complaint stated that his wife was not suffering from any Glaucoma.**
The Insurance Company reiterated that policy was taken in February, 2013 and cataract surgery was performed in September, 2013. The patient had history of Primary Glaucoma since 04 years as per the certified copy of the medical papers of Shroff's Eye Centre which was not disclosed at the time of policy inception. I find from the certified copy of Shroff's Eye Hospital that the patient had history of primary glaucoma since 04 years which was not informed at the time of taking the policy. Therefore, I uphold the decision of the Insurance Company. Accordingly the complaint filed by the complainant is hereby disposed off.

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In the matter of Sh. Prem Chand Goel
Vs
ICICI Lombard General Insurance Co.Ltd.
DATE:22.06.2015

Sh. Prem Chand Goel has submitted that he is an ex-employee of NBCC Ltd. and he and his wife are covered under the above policy. His wife was treated at Medanta and the company has disallowed Rs. 40202/- (Rs. 14000/- towards Nursing charges at home and Rs. 26202/- of hospitalization claim) from the total claim amount. He states that terms of the policy allow reimbursement of 'Nursing expenses' if the disease is such that requires utmost care by a nurse. Treating doctor had recommended nursing in the discharge summary. His wife had been discharged with blood drain pipe & stitches which cannot be handled without nursing assistance. He states that alternative to hiring a nurse at home was that his wife would have had to continue in hospital for another week which would have further increased the hospitalization expenses. Further he states that he had taken minimum tariff single room, and that the hospital's room rent includes nursing charges which are also payable separately in addition to the room rent charges allowed upto 1.5 % of Sum Insured.. He says no maximum limit had been fixed for any medical charges except room-rent and the policy terms nowhere state that if insured is admitted in higher category, then insured will bear difference of all medical expenses in same proportion.. He has sought reimbursement of Rs. 40202/- and also Rs. 50,000/- as compensation for mental agony that he had to suffer.

The Insurance Company submitted in its SCN dated 13.01.2015 that excess amount claimed had been rejected on the ground that as per policy terms and conditions, excess room charges and proportionate expenses, and Nursing charges at home are not payable. Since the insured was admitted to a room in a higher category, the insured had to bear the difference of all medical expenses, as in final hospital bill, in the same proportion. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the Insurance Company had reiterated that the claim of wife of the complainant was processed and settled as per policy terms and conditions of GMP issued to employees of NBCC. The complainant had stated that he Insurance Company had wrongly deducted the

claim amount of Rs. 40202/- (Rs. 14,000/- towards Nursing charges at Home and Rs. 26202/- of hospitalization expenses). On perusal of the claim papers placed on record I find that the discharge summary of Medanta Hospital dated 29.01.14 revealed that the "patient requires nursing care at home for one week" after discharge from the hospital. The terms and conditions of Group Mediclaim Policy submitted by the complainant shows that at point no. 02 "Nursing exp will be reimbursed subject to specific recommendation of treating physician/doctors that patient disease is such which requires utmost care by a Nurse". The Insurance Company thus had wrongly deducted the amount of Rs. 14,000/- towards nursing expenses as the treating doctor had advised the Nursing Care at home. This is as per the discharge summary. Hence I hold that the Insurance Company is liable to pay the Nursing expenses. As regards deduction of Rs. 26,202/- towards other hospital expenses, the Insurance Company had submitted the details of deductions and on perusal of the same. I find that as per terms and conditions of Group Mediclaim policy issued by the Insurance Company to the ex-employer of the complainant M/s NBCC the capping/ceiling is 1.5% under room rent category of the sum insured and not on other items/heads of medical expenses. But the Insurance Company had applied the room rent ceiling on other items also which was not correct. Hence, the Insurance Company is liable to pay the amount which was wrongly deducted under O.T. Charges, anesthetist charges, consultation visit charges and surgeon charges. Amount deducted towards non-medical items i.e. Rs. 1217/- are in order, hence are not allowed. The Insurance Company is directed to refund the amount of Rs. 32735/- arising on nursing expenses and non applicability of room rent ceiling/capping on the items/ heads of medical expenses. Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant.

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GUWAHATI

Before the office of the Insurance Ombudsman

at Guwahati Centre

Complaint No. GUW-G-049-1516-0030

Sri Krishna Kr. Vijaya,----Complainant

Vs

The New India Assurance Co. Ltd.,- Insurer

Date of Award : 26.08.20152.

The complainant, Mr. Krishna Kumar Vijaya has stated in his complaint dated 02.07.2014 that he is having a mediclaim policy issued by The New India Assurance Co. Ltd., Tinsukia Branch and the policy is continuing since 14.03.2003. He had submitted a claim for Rs. 47,562.00 on 27.06.2013 against which he was paid an amount of Rs. 22,589.00 only towards settlement of the claim. The period of hospitalization was from 23.12.2013 to 26.12.2013

Being aggrieved by the decision of the insurance company the complainant approached this forum for Redressal of his grievance seeking monetary relief of full amount. 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 Annexure – VI A.

In view of the above and as the complainant's claim is on the same policy & period , the insurer is directed to waive the onus of co-payment on the complainant and pay the balance claimed amount without pro-rata deduction for availing higher category room within 15 days from the date of receipt of this award along with the consent letter from the complainant under intimation to this forum subject to submission of necessary documents by the complainant.

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OFFICE OF THE INSURANCE OMBUDSMAN
Guwahati Centre

Complaint No.;GUW-G-048-1415-0036

Mr.Pallav Kumar Bhattacharjee------ Complainant

Vs

National Insurance Co Ltd,---------- Insurer

<u>Date of Award ;20.05.2015</u>.

Complainant in his complaint dt. 24.10.2014 stated that he has taken a Mediclaim Insurance Policy (Individual) from National Insurance Company Limited w.e.from 1512.2013 to 14.12.2014 against Sum Insured of Rs.1,00,000.00 + CB amount Rs. 50,000/- under Policy No.200900/48/13/8500000501 and premium was paid as desired.During the policy period the complainant admitted in Apollo Gleneagles Hospital, Kolkata and diagnosed as with bladder out flow obstruction due to enlarged prostrate on 11/11/2013 and underwent surgery for the same on 14/03/2014 and discharged on 15/03/2014.He lodged the claim for Rs. 1,50,000/- approximately but the Insurance company settled the

claim for Rs. 76,000/- only. In this regard he requested the Incharge of Tezpur Office thrice but they did not response.

After careful evaluation of the submission of the claimant and the representative of the insurer and all the facts and circumstances of the case, it is felt that the complainant underwent surgery on package rate basis and the hospital was also a net work hospital. Therefore, the demand of break up in package rate by the insurance company is not at all tenable. Therefore, the decision of the insurance company is set aside and the insurance company is directed to pay the balance amount of Rs. 67,114/- along with pre and post hospitalization expenses as admissible under the policy within 15 days from the date of receipt of this award along with the consent letter from the complainant under intimation to this forum

Before the office of the insurance ombudsman

at Guwahati centre

Complaint No. :GUW-G-051-1415-0056

: Shyamapada Home Chowdhury----complainant

vs

: United India Insurance Co Ltd,---Insurer

Date of Award : 26.08.2015

The complainant had taken an Individual Health Insurance policy for himself and his spouse from United India Insurance Co. Ltd, for the period from 06.12.2013 to 05.12.2014, the sum insured was Rs.2,00,000.00. The policy was a renewal & continued from 03.12.2007.During the above policy period he was hospitalized several times due to his serious eye sight problem. As it is a genuine health hazard, it should be covered by the Health Insurance policy. But it is his utter surprise that the Insurer denied the claim mentioning it falls under exclusion clause.

After careful evaluation of the submission of the representative of the insurer and complainant and all the facts and circumstances of the case, it is opined that the claim was denied on specific clause for exclusion. Therefore, the decision of the insurance company is hereby upheld and the complaint is disposed of without any relief to the complainant.

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HYDERABAD

HYDERABAD OMBUDSMAN CENTRE

Complaint No. I.O.(HYD) G -11.50.284 / 2014-15

SRI A Prasanna Kumar VS. Oriental Insurance Company LIMITED

Award No. I.O. (HYD)/A/GI/0001/ 2015-16 Dt. 22.04.2015

INDIVIDUAL MEDICLAIM

FACTS

Sri A. Prasanna Kumar took Individual Mediclaim Insurance Policy for a Sum Insured of Rs.One lakh from 21.04.2012 to 20.04.2013 from the insurer. As per the complaint filed, the insured took treatment to his right eye for Choroidal Neovascular Membranes [CNVM] caused by Age Related Macular Degeneration. He was administered Lucentis injection, first, in the month of March 2013. As the vision has not improved, he continued to take the injection almost every month and the last injection was taken in October 2014. He preferred the hospitalization claim. The insurer rejected the claim citing policy condition 4.23 which reads as "out-patient diagnostic, Medical and Surgical procedures or treatments ...."

FINDINGS

During the hearing, it was informed by the insured that in spite of his repeated follow up, no communication was received from the Insurer. However, repudiation letter was sent by the TPA. The insurer could not produce copy of TPA letter repudiating the claim. The representative of the Insurer stated that the treatment was taken on OPD basis and as such the claim is not admissible as per condition 4.23 which reads as

"out-patient diagnostic, Medical and Surgical procedures or treatments ...."

DECISION

It was held that the decision of repudiation has to be taken and communicated by insurer to the insured and not the TPA who is an intermediary to process the claims. Moreover due to the technological advancements in the medical field, this particular procedure does not require minimum hospitalization of 24 hours. It is a fact that the injection has to be administered under controlled conditions. It was also found during hearing that the claimant is a loyal customer since 1967. The insurer's representative could not point out the specific provision in the terms of the policy, justifying rejection of the claim Hence the complaint was allowed directing the insurer to settle the claim without any further delay.

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HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.49.285/2014-15

SRI A Prasanna Kumar VS. The New India Assurance Co.Ltd

AWARD NO. I.O. (HYD)/A/GI/0004/ 2015-16 dt. 15.06.2015

INDIVIDUALMEDICLAIM

FACTS

Sri A Prasanna Kumar took Individual Health Insurance Policy with the insurer and covered himself for a SI of Rs. Two lakhs from 28.07.2014 to 27.07.2015. As per the complaint filed, the insured took the treatment to his right eye for Choroidal Neovascular Membranes [CNVM] by administration of Lucentis injection. He took the first injection in March, 2013. As the vision has not improved, he continued the injection almost every month and the last injection was given in October, 2014. He preferred the claim for reimbursement of expenses of Rs. 2 lakhs. The insurer rejected the claim citing policy condition 4.4.23.

FINDINGS

In the Self Contained Note the insurer stated that the complainant went to Visakha Eye Hospital, for regular eye check up. On examination, it was revealed that he was having a defective vision CNVM in his right eye due to (AMD) Age related macular degeneration. The insurer stated that the cost of Lucentis injection was not payable as per the terms and conditions of the policy. Further the insurer submitted that Age related

Macular degeneration treatment "Neither fall under definition of hospitalisation nor listed as Day Care Procedure" since Lucentis injection was not payable as per policy condition. The policy condition reads as: "All treatments like age related Macular Degeneration and or Choroidal Neo- Vascular Memmbrance done by administration of Lucentis / Avantis/ Macugen/ Avastin and other related drugs as intravitreal injection, Rotational field Quantum Magnetic Resonance, External counter Pulsation and Hyperbaric Oxygen Therapy are excluded under this policy". The insurer stated that the treatment given was administration of Intra Vitreal Lucentis injection. Though this injection was given in the operation theatre, the claim was not payable.

DECISION:

During hearing, complainant submitted a Doctor Certificate in support of his claim given by Dr. P Vasudev, Visakha Eye hospitals dated 05.03.2013 in which it was clearly stated that the insured was suffering from defective eye vision due to Choroidal Neo Vascularisation (CNVM) caused by Age related Macular degeneration (ARMD).which falls under exclusion clause 4.4.23 of the policy and hence the complaint is dismissed.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.53.0421/2014-15

SRI Ch.Srinivasarao VS. Cigna TTK Health.Ins. Co.Ltd

AWARD NO. I.O. (HYD)/A/GI/0006/ 2015-16 dt. 22.06.2015

MEDICAL INSURANCE

FACTS:

Sri Ch. Srinivasa Rao took Health Insurance Policy (Pro Health Protect) for a Sum Insured of Rs.2.5 lakhs with the insurer and covered himself from 14-10-2014 to 13-10-2015. As per the complaint filed, the insured was hospitalized on 12th Nov.2014 at Apollo Hospitals, Hyderabad and underwent Laparoscopic Appendectomy and was discharged on 14th Nov.2014. He preferred the claim for Rs.85000/-. The insurer repudiated the claim citing V2 clause, i.e. 30 days waiting period.

FINDINGS

In the Self Contained Note, the insurer stated that the complainant had purchased the health insurance policy through distance marketing for a sum insured of Rs.2.5 lakhs. The complainant was admitted in Apollo Hospital with acute appendicitis on 12th Nov.2014 and was discharged after Laparoscopic appendectomy. On scrutiny of the claim documents submitted by the complainant, it was noticed that the above mentioned illness was diagnosed on 6.11.2014. As the insured has contracted the illness during the first 30 days from the inception date of the policy, the claim was denied by the insurer. The insurer referred to the policy waiting period clause V.2 which reads as under:

"Any disease contracted and or Medical expenses incurred in respect of any pre-existing disease/ illness by the insured /insured person during the first 30days from the inception date of the policy will not be covered. This exclusion does not apply for Insured person having any health insurance indemnity policy in India at least for a period of 30 days related to prior to taking this policy and accepted under portability cover, as well as for subsequent renewals with us without a break"

DECISION:

On perusal of the papers, it was noted that. the first consultation for the ailment was on 6.11.2014, i.e. within 30 days from the date of commencement of policy. Both the parties had not filed any documents to state that the present policy was obtained by the complainant under portability to waive the waiting period clause. It is held that the claim arose within 30 days of commencement of risk and in the result the complaint is dismissed without any relief.

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HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.03.416/2014-15

SRI P Manoj kumar Reddy VS. Apollo Munich Health.Ins. Co.Ltd

AWARD NO. I.O. (HYD)/A/GI/0008/ 2015-16 dt. 22.06.2015

MEDICAL INSURANCE

FACTS

Sri P. Manoj Kumar Reddy took Optima Restore Floater Mediclaim Insurance Policy with the insurer and covered himself, his wife and his son for a floater SI of Rs. 5 Lakhs from 14.05.2013 to 13.05.2014. As per the complaint filed, his wife Smt. P. Uma Mallika was hospitalized on 05th March 2014 and was discharged on 15th March 2014 after undergoing treatment for 'meningitis'. The insured incurred Rs.3,63,028/- for the treatment and preferred the claim on the policy. The insurer denied the claim, on the ground of suppression of material facts, at the time of proposal, i.e. previous surgical history of 'Craniotomy' was not disclosed.

FINDINGS

In the Self Contained Note the insurer stated that pre-authorization form for cashless facility was received from the hospital and subsequently hospital submitted CT Scan Brain and IV contrast reports dated 5.3.2014. No mention of this was given in the proposal form and hence the claim and complaint was rejected under clause 5(u) of the policy. The complainant further represented that

meningitis was not at all related to the earlier undergone craniotomy surgery and for that reason the claim should have been admitted by the company. The insurer submitted that if it was known to the company about previous medical history of the insured person(s), the company could have declined the risk or accepted it with loading in premium or it could have imposed certain additional conditions and/or exclusions. The complainant had concealed material facts about his wife's prior medical history of craniotomy surgery at the time of entering the contract, in violation of principles of insurance contract.,

DECISION

From the submitted documents, it is seen that the complainant concealed the material facts about his wife's previous surgical history of craniotomy at the time of entering the health insurance contract with the insurer. The complainant being a well-educated person, should have taken care to give correct factual information in the proposal. I hold that the rejection of claim by the insurer, on the ground of non-disclosure/misrepresentation, does not require any intervention and hence the complaint is dismissed without any relief.

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HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.31.390/2014-15

SRI D Sriram VS. Max Bupa Health.Ins. Co.Ltd

AWARD NO. I.O. (HYD)/A/GI/0009/ 2015-16 dt. 25.06.2015

MEDICAL INSURANCE

FACTS

mr. D. Sriram took Family First Silver Health Insurance policy with the insurer and covered himself, his spouse, mother and children for a total Sum Insured of Rs. 29 lakhs (Family First Silver 5 Lakhs individual cover + Rs.4 Lakhs floater cover) from 30.4.2013 to 29.4.2014. As per the complaint filed, his wife, Smt. Radha Rani was hospitalized in Kadimi Hospital, Nalgonda on 20.4.2014 and underwent Laparoscopic vaginal hysterectomy (LAVH) and Ovariotomy on 21.4.2014 and was discharged on 27.4.2014. He submitted the bills for Rs.75874/-. The insurer denied the claim under PED exclusion of the policy.

FINDINGS

The insurer stated that Smt. D. Radha Rani, wife of the complainant was admitted in Kadimi Hospital, Nalgonda and underwent LAVH and Ovariotomy on 21.4.2014. On scrutiny of the claim documents, and as per the Lab Investigation Report collected by their Third Party Investigator, it was found that the insured patient had symptoms for 5 years and the period was much prior to the policy inception date. Basing on the Lab investigation report and on the in-house doctors opinion, the claim was declined under PED exclusion of the policy.

DECISION

It was held that the insurer declined the claim basing on their Third Party investigator's report and they have not furnished the report to the complainant in spite of his specific request. The proposal was accepted after pre-medical tests and examination by the panel doctor of the insurer. If there was any abnormality, that could have been noticed by the panel doctor during his pre-acceptance examination. No such findings were recorded in the examination report. And hence the complaint is allowed and the insurer is directed to settle the claim.

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HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G 11.44.016/2015-16

Dr K Subrahmaniyam Vs. Star Health and allied Insurance Co.Ltd

AWARD NO. I.O. (HYD)/A/GI/0014/2015-16 dt. 26.06.2015

MEDICAL INSURANCE

FACTS

Dr K. Subrahmaniam took Senior Citizen's Red Carpet Insurance Policy with the insurer from09.06.2014 to 08.06.2015 for SI of Rs.Five Lakhs. As per the complaint filed, he was admitted in Apollo Hospitals, Hyderabad on 25.08.2014 with complaints of fever with chills and rigors, associated with redness over left lower limb, below the knee. His ailment was diagnosed as Sleep Apnoea and Septecemia. He was discharged on 04.09.2014.He preferred the claim for Rs.3,26,030/-. The insurer repudiated the claimunder condition No. 7 of the policy,on the ground of non-disclosure of material facts at the time of proposal.

FINDINGS

the insurer submitted that the insured person/complainant preferred the claim during fifth year policy. .The insurer stated that, as per the indoor case sheet dated 27.8.2014, the insured was suffering from Diabetes Mellitus from last 30 years and had undergone surgery for Coronary Artery disease in the year 2000. The insured had not disclosed any of the above stated ailments/ previous medical history while proposing insurance with the company. Hence, the claim was rejected under policy condition No. 7,

DECISION

It was held that the complainant preferred the claim during 5th year policy and that the complainant had disclosed his previous medical history when he had obtained the first policy with the insurer in the year 2008 and substantiated it by submitting a copy of the policy wherein the previous medical history was clearly recorded by the insurer. It established that the complainant did not have any intention to hide his previous medical history. Considering the facts of the case, there is no reason for me to disbelieve his statement. The non-disclosure if any was unintentional and it was without any motive. Invoking condition No.7 of the policy, for a claim under 5th year policy, is unfair, particularly, in the light of the disclosure made in the initial policy. The insurer could have verified the old proposal when it was stated that it was a delayed renewal. As there was disclosure of previous medical history in the first policy taken by the complainant, and for the reasons stated above , the complaint is allowed.

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HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G 11.37.440/2014-15

SMT V Lakshmi Vs. Religare Health Insurance Co.Ltd

AWARD NO. I.O. (HYD)/A/GI/0016/2015-16 dt. 27.07.2015

MEDICAL INSURANCE

FACTS

Sri Bucha Reddy took Religare Health Insurance Policy with the insurer and covered himself and his wife for a Sum Insured of Rs. 3 Lakhs from 21.4.2014 to 20.4.2015. As per the complaint filed, the insured was admitted in Apollo Hospitals, Hyderabad on 19.8.2014 due to Cellulitis in his left leg. He was discharged on 24.08.2014.After discharge from the hospital, the insured passed away. Sri Satish Reddy, son of the insured, submitted the claim for reimbursement of hospitalization expenses at Rs.385000/-. The insurer denied the claim on the ground of pre-existing disease and also for non-disclosure of previous medical history of Liver Cirrhosis, at the time of proposal

FINDINGS

On perusal of the claim documents submitted, it was noted that the insured was a known case of DM, CKD and was on regular medication. As per the discharge summary, on admission, the insured person's creatinine and potassium levels were found to be high and immediate nephrologist consultation was taken and emergency dialysis was started. It was observed from the medical documents submitted, viz. Apollo Sepsis Action Plan it was a simple insect bite which later developed into an ulcer.. The proposer had not disclosed Liver cirrhosis of his father at the time of proposal and or at the time of Medical Examination of insured person(s). In the

Medical examination Report it was replied as 'No' to all the questions relating to previous medical history and conditions and this had resulted in non-disclosure of material facts at the time of taking the policy. Hence the claim was declined under exclusion clause 4.1 (c), i.e. waiting period clause of 48 months.

With the above submissions the insurer pleaded for dismissal of the complaint.

DECISION

It was held that the previous medical history/conditions were not disclosed either at the time of proposal or at the time of medical examination at the proposal stage even though the insured has pre existing diseases. The insurer obtained second opinion from an expert in the field and to the affect that it was due to pre-existing diabetes. On perusal of the documents filed before me and on facts of the case, I concur in the decision of the insurer in repudiation of the claim. In the result, the complaint is dismissed without any relief.

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HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G 11.51.0023/2015-16

Mr B S Swamy Vs. United India Insurance Co.Ltd

AWARD NO. I.O. (HYD)/A/GI/0020/2015-16 dt. 27.07.2015

MEDICAL INSURANCE

FACTS

Sri B. Sharanappa Swamy took Individual Health Insurance Policy with the insurer and covered himself and his wife for a SI of Rs.4,50,000/- and his three daughters for a SI of Rs. 3 Lakhs each, from 28.09.2014 to 27.09.2015. As per the complaint filed, the insured underwent cataract surgery, in his right eye, on 20.10.2014. He preferred the claim for reimbursement of his treatment expenses at Rs. 70000/-. The insurer settled the claim at Rs.19,000/- stating that it was the maximum amount payable for PPN net work hospital. He represented for review of the decision but in vain. Aggrieved, Sri B. S. Swamy filed complaint with this forum.

FINDINGS

the insurer stated that the claim preferred by the complainant was settled for Rs.19,000/- being the agreed rate by the hospital [PPN net workhospital] for Cataract surgery with unifocal lens. The complainant preferred Multi Focal Lens, instead of going for Unifocal Lens treatment, in terms of package which was very much available with the hospital as per the PPN rates. As the hospital was our PPN net work hospital, it was clear that the procedures agreed for packages would only be payable and if the insured opts for the treatment not defined as per the

PPN procedure list, the difference amount had to be borne by the insured only. The settlement made by the TPA was in order, and hence there was no further reconsideration of the claim amount made by the company.

DECISION

It was held that he complainant had undergone cataract surgery to his right eye at Clear Vision Eye Hospital on 20.10.2014 and intimated the TPA about his planned surgery on 18.10.2014. The cashless treatment request was declined by the TPA for non-submission of ID card which was not issued by them till date. He had undergone the surgery and preferred the claim. Though it was a PPN network hospital of the insurer, the services were not rendered to the complainant by the TPA. Hence, the hospitalization was to be treated as the one in non-network hospital. Hence, the PPN package rates would not apply. Further, in the policy, , there is no restrictive condition that the insured person was required to opt only for 'unifocal lens' for treatment of cataract. In the absence of such express condition in the policy, restriction of claim for a unifocal lens package rate is unjustified. Non-issue of ID card is a lapse on the part of the insurer and the complainant in this case, had been put to inconvenience on this score. Therefore, the insurer is directed to admit the claim for balance amount of Rs.51,000/- in terms of the policy. Further, the insurer is directed to pay 9% interest, on the admissible balance claim amount, from the date of payment by the complainant to the hospital, till the date of settlement. In the result, the complaint is allowed.

HYDERABAD – OMBUDSMAN CENTER

Complaint No. I.O. (HYD) G-11-03-024/2015-16

Ms. Sharvya Sarraf Vs Apollo Muich Health Ins. Co. Ltd.,

Award No. I.O.(HYD)/A/GI/0021/2015-16 Dated 27th July, 2015

Group Mediclaim:

FACTS:

Complainant was covered under Group Mediclaim Policy taken by her employer with the insurer from 07.01.2015 to 06.1.2016. She had undergone MRI guided High Intensity Focused Ultrasound treatment for her uterine fibroid and preferred claim for Rs. 2,87,481/-. The insurer rejected the claim stating that there was no necessity of Hospitalization and it was an OPD procedure.

FINDINGS:

The representatives of the insurer, on the other hand, reiterated the contents of the self-contained note. They referred to the hospital's website information, as to the procedure of MR-HIFU and stated that there was no requirement of 24 hours hospitalization and hence the denial of claim was justified.

DECISION:

Since the Jaslok Hospital had given a certificate about the in-patient treatment, for the procedure undergone by the complainant, the complaint is allowed.

COMPLAINT NO. I.O.(HYD) G-11-31-036/2015-16

Mr. A Srinivas Suman Vs Max Bupa Health Ins. Co.Ltd.,

Award No. I.O.(HYD)/A/GI/022/2015-16 dated 27th July, 2015

Individual Mediclaim:

FACTS:

Mr A. Srinivas Suman proposed his parents for cover under Heartbeat Health Insurance Policy (Silver Plan) of the insurer and covered them from 11.07.2013 to 10.07.2014. As per the complaint filed, the insured person Sri Sudhakar, i.e. father of the proposer was admitted in Dr Agarwal's Eye Hospital on 5.4.2014 and underwent Cataract operation to his right eye. He submitted the bills for reimbursement of the claim. The insurer denied the claim citing non-disclosure of material facts.

FINDINGS:

The representatives of the insurer stated that they have reviewed the claim and the Competent Authority had agreed to settle the claim as per the terms and conditions of the Policy.

DECISION:

In the result the complaint is allowed.

COMPLAINT NO. I.O. (HYD)/ G-11-31-081/2014-15

Mr. Anil Kumar Gupta Vs Max Bupa Health Ins. Co.Ltd.,

Award No. I.O. (HYD) /A/GI/023/2015-16 Dated 31st July,2015.

FACTS:

Mr. Anil Kumar Gupta took Family First Gold health Insurance Policy with the insurer and covered himself and his family consisting of seven members for a sum insured of 5 Lakhs + 15 Lakhs from 23.11.2013 to 22.11.2014. As per the complaint filed, Sri Niranjan Lal Gupta, father of the insured was admitted in Breach Candy Hospital, Mumbai on 4.3.2014 for treatment of 'Myasthenia Gravis with respiratory failure' and was discharged on 11.03.2014. He submitted the hospital bills for reimbursement of hospitalization expenses of Rs.9,32,000/-. The insurer declined the claim under clause 5g.3 (ii) stating that there was non-disclosure of previous medical history. FINDINGS:

The complainant's claim preferred for the treatment of his father's Myasthenia Gravis (MG) was declined by the insurer on the ground that the insured person suffered from the same ailment 10 years back and there was non-disclosure of the same, at the time of proposal.

The complainant accepted that his father had earlier suffered from MG but had not disclosed the details of its first diagnosis, duration of treatment etc. The MG, being a neurological disorder its non-disclosure would have affected proper assessment of risk by the insurer. Though there was disclosure of some information in the proposal form, the relevant information about MG was not disclosed.

DECISION: Hence, the complaint is dismissed without any relief.

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COMPLAINT No. I.O.(HYD)G-11-37-476/2014-15

Sri L . Krishna Reddy Vs. M/s Religare Health Insurance Co.Ltd.,

Award No. I.O. (HYD) /A/GI/0025/2015-16

FACTS:

Sri L. Raji Reddy took Health Insurance Policy with the insurer, under portability, and covered himself and his wife for a floater SI of Rs. 4 Lakhs from 4.07.2014 to 3.07.2015. He was hospitalized in Poulomi Hospitals, Secunderabad from 7.10.2014 to 13.10.2014 and 28.10.2014 to 1.11.2014 and had undergone treatment for heart ailment. Again he was hospitalized in Yashoda Hospitals, Hyderabad from 04.11.2014 to 08.11.2014 for metabolic encephalopathy and died on 8.11.2014. The claims preferred by his son, Sri L. Krishna Reddy, were declined by the insurer on the plea that there was non-disclosure of previous medical conditions of Hypertension and D M. .

FINDINGS:

On perusal of documents, it was observed that the insured person was covered under Health Insurance policy from 2009 and claim was preferred after 5 years of coverage. The proposal was accepted by the insurer on portability norms. As per portability norms, the new insurer is expected to obtain the details from previous insurer about credits gained on PED and claims history. Since the policy was ported after 4 years of claim-free coverage of the insured person, which fact was not contradicted by the insurer, all PEDs stand covered, as the insured person gains credit for the same. As per the contention of the insurer, the duration of HTN/DM was 2 years and the period was falling after commencement of policy with the previous insurer. Hence, it cannot be treated as pre-existing medical condition. The insured person had undergone pre-acceptance medical examination at insurer's authorized medical lab and as per the medical report, the noted hypertension readings were normal. The HBA1C report showed sugar levels in normal non-diabetic range. Duly taking into account the insurer's view point that normal results in the tests could be attributable to medication and, considering facts of the case and contentions of the insurer and noting in

hospital medical records, the claim deem it fit to allow the claim partially for an amount of Rs.3 Lakhs [Rupees Three Lakhs only].

DECISION:

In the result, the complaint is allowed in part.

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COMPLAINT No. I.O.(HYD)G-11-37-034/2015-16

Sri D Ashok Kumar Reddy Vs. Religare health Ins. Co. Ltd.,

AWARD NO.I.O. (HYD)/GI/0026/2015-16

FACTS:

Sri D. Ashok Kumar Reddy took Religare Health Insurance Policy with the insurer and covered himself for a Sum Insured of Rs. 5 Lakhs from 17.4.2014 to 16.4.2015. As per the complaint filed, the insured was admitted in Singari ENT Hospital & Research Centre, Vijayawada on 10.01.2015and had undergone ear surgery for Chronic Supportive Otitis Media (CSOM) and was discharged on the same day. He preferred the claim for reimbursement of treatment expenses at Rs.68138/-. The insurer denied the claim, stating that there was a specific waiting period of 24 months in the policy, for the treatment undergone by the insured.

FINDINGS:

The complainant preferred the claim, during first year policy, for ear surgery undergone by him on 10.01.2015. The insurer rejected the claim, as it fell under specific waiting period exclusion clause of the policy. On perusal of medical documents submitted by the complainant, I am inclined to agree with insurer's view and, there is no reason for me to disagree with the decision of the insurer. The insurance policy is a contract between the parties and terms and conditions apply equally to both the parties.

DECISION:

In the result, the complaint being devoid of any merit is dismissed without any relief.

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COMPLAINT No. I.O.(HYD)G-11-44-191/2014-15

Sri S. Shyam Prasad Vs. Star Health and Allied Ins. Co.Ltd,

Award No. I.O.(HYD) / GI/0029/2015-16

FACTS

Sri S. Shyam Prasad was covered under Family Health Optima Insurance Policy along with his spouse, for a sum insured of Rs.3 lakhs, from 6.3.2014 to 5.3.2015. As per the complaint filed, Sri Shyam Prasad was admitted in M/s Kamineni Hospitals, Hyderabad with a complaint of difficulty in walking on 8th May, 2014 and was discharged on 12.5.2014 after undergoing left knee surgery. He preferred the claim for Rs.2,08,234/-. The insurer rejected the claim under condition No.7 of the policy, i.e. mis-representation and/or non-disclosure of past medical history.

FINDINGS:

The representatives of the insurer submitted that the company reviewed the case and competent authority agreed to settle the claim for Rs.2,04,511/- as against the total amount of claim preferred by the complainant for Rs.2,08,234/-. The complainant consented for the proposed settlement amount.

DECISION:

Considering the facts of the case, an award was passed. Accordingly, the insurer is directed to settle the claim after restoring the policy.

In the result, the complaint is treated as allowed.

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COMPLAINT No. I.O.(HYD)G-11-50-414/2014-15

Smt. B Siva Parvathi Vs. M/s Oriental Insurance Co. Ltd.,

Award No. I.O.(HYD) / GI/0030/2015-16

FACTS:

Smt. B. Siva Parvathi was covered under Individual Mediclaim Policy, issued by the insurer, for a SI of Rs.75,000/- from 23.03.2013 to 22.03.2014. As per the complaint filed, she underwent Ayush treatment at Arya Vaidyasala, Kottakkal, Kerala from 21.09.2013 to 5.10.2013 for 'Vathavyadhi' and preferred the claim on her policy for Rs. 33,324/-. The insurer repudiated the claim stating that she had not undergone treatment in a Govt. Ayurvedic Hospital.

FINDINGS:

The complainant had undergone Ayurvedic treatment in Arya Vaidyasala, Kottakkal, Kerala. The claim preferred by her was declined on the plea that the hospital does not fit into the policy definition for admission of the claim. The Regulator clearly stated in Health Regulations 2012-13 that ayush treatment undergone in a govt. hospital or in any institute recognized by the govt. and/or accredited by Quality Council of India/ NABH or any other suitable institutions. The insurer appointed an investigator to know about the hospital and the investigator, Mr. Altaf Hussain, in his report confirmed that it fell under the purview of eligible hospitals for admission of claims by the insurer. In spite of the said report, the claim was rejected by the insurer relying upon the old policy terms and conditions.

DECISION:

In view of the above, an award was passed with a direction to the Insurance Company to admit the claim of the complainant in terms of the policy. Interest @ 9% p.a. shall be paid from 01.11.2013 till the date of settlement.

HYDERABAD OMBUDSMAN CENTRE
COMPLAINT No. I.O.(HYD) G -051.0338/2014-15
Sri G Ramakrishnarao VS. United India Ins. Co.Ltd

AWARD NO. I.O. (HYD)/A/GI/0032/2015-16 dt. 11.08.2015
MEDICAL INSURANCE

FACTS:

Sri G. Ramakrishna Rao took Individual Health Insurance Policy-2010(Gold) with the insurer and covered himself and his wife from 01.10.2013 to 30.09.2014 for a SI of Rs. One Lakh each. The policy was a continuous renewal from 1.10.1998. He was also covered under Corporate Group Mediclaim Policy, issued by his son's employer, for a SI limit of Rs. 3 Lakhs. As per the complaint filed, he was hospitalized in Apollo Hospitals, Hyderabad on 14.10.2013 for CAD-Angina. He was discharged on 16.10.2013, after implanting two stents. He incurred Rs.3,03,815/- for the treatment. The claim was preferred under his son's GMP with Oriental Insurance Co. The claim was settled by the Oriental insurer for Rs.2,58,120/- and balance amount of Rs.45,695/- was paid by him. He preferred the claim for balance amount under his individual health insurance policy with United India Ins. Co. The United India settled the claim for Rs.17015/- and rejected the claim for Rs.28,680/- stating that the 'co-pay' amount deducted under other policy, was not payable. He represented for review of the decision but in vain.

FINDINGS

On perusal of claim settlement details, it was noted that the Oriental Ins. Co. deducted a sum of Rs.28,680/- towards co-pay. The co-pay amount, in any policy, was needed to be borne by the insured. Hence, that amount was not paid under the policy. The representative of the insurer was asked to state if there was any specific condition on 'co-pay' in the policy. He replied that no specific condition was there in the policy.

DECISION:

It was held that there is no specific clause excluding reimbursement of co pay amount in multiple policies. On perusal of the Regulator's Health Policy revised regulations, it is clear that in case of coverage of insured person under multiple policies, for indemnification of hospitalization expenses, the contribution clause does not apply. The insured can exercise his option to choose the insurer for settlement of his claim. He will be indemnified by the insurer for the hospitalization costs incurred by him in accordance with the terms and conditions of the policy. The complainant had not re-claimed the hospitalization costs from the second insurer and he claimed only the un-settled amount. The deduction of 'co-pay' amount by the insurer is untenable, as per the terms of the policy. Hence, I direct the insurer to admit the claim for disallowed amount of Rs.28,680/-. Accordingly the complaint is allowed.

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HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G 11.48.345/2014-15

Sri G Veerabhadrarao VS. National Ins. Co.Ltd

AWARD NO. I.O. (HYD)/A/GI/0034/ 2015-16 dt. 11.08.2015

MEDICAL INSURANCE

FACTS

Sri G. Veerabhadra Rao took Individual Mediclaim Policy with the insurer and covered himself and his wife for a SI of Rs. 2.00 Lakhs each. As per the complaint made, he was hospitalized in M S Ramayya Narayana Hrudayalaya Hospital, Bengaluru on 28.10.2011 for heart ailment and underwent PTCA/stenting. He was discharged on 03.11.2011. The claim preferred by him for Rs.3,05,873/- was declined by the insurer, citing PED exclusion clause.

FINDINGS

In the Self-Contained Note, the insurer submitted that the complainant lodged the claim for reimbursement of hospitalization expenses, for PTCA/Stenting undergone by him, at Ramayya Narayana Hrudayalaya, Bengaluru from 28.10.2011 to 03.11.2011. The claim was preferred by him for Rs. 3,05,873/- as against the SI of Rs.2.00 Lakhs under the policy. The insurer submitted that, on perusal of claim documents submitted by the complainant, it was noted that the insured/complainant known hypertensive from 1998 and hyperlipidaemia from 2004. He was on medication for hypercholesterolemia and sub clinical hypothyroidism from 2004. On 28.10.2011, the complainant was hospitalized with symptoms of external angina and dyspnoea and had undergone surgical management. The complainant concealed the previous medical history at

the time of proposal, which was a suppression of material facts and a clear breach of utmost good faith. It was the first policy taken with the company. The PED exclusion clause 4.1 excluded all complication arising from pre-existing ailment/disease /injuries. Since insured person had long standing hypertension, before taking the policy with the company, any treatment for Coronary Artery Disease was treated as PED and hence the claim was declined under PED exclusion. The insured underwent stenting for Single Vessel Disease and was diagnosed as IHD-TMT Positive. In view of previous medical history and long standing hypertension, the rejection of claim under 4.1 exclusion, was justified.

DECISION:

The complainant admitted that he was hypertensive but he did not have any coronary artery disease or The fact of pre-existing Hypertension having been agreed to, there is no case for relief to the complainant with regard to his claim. Insurance is a contract and terms bind both parties equally. On facts of the case, I concur in the decision of the insurer in repudiating the claim. In the result, the complaint is dismissed without any relief.

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HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G 11.38.422/2014-15

Sri B.T.Kannan VS. Royal Sundaram Alliance Ins. Co.Ltd

AWARD NO. I.O. (HYD)/A/GI/0036/2015-16 dt. 12.08.2015

MEDICAL INSURANCE

FACTS:

Sri B. T Kannan took Hospital Cash Insurance Policy with the insurer and covered himself from 3.9.2009 to 2.9.2010. The policy was renewed subsequently for the years 2010-11, 2011-12 and 2012-13. The policy provides for daily cash benefit of Rs.2000/- for every 24 hours of hospitalization up to a maximum period of 180 days. As per the complaint filed, during the policy period from 7.09.2012 to 6.09.2013, the insured was hospitalized on 9.8.2013 due to heart ailment and was discharged on 15.8.2013. He preferred the claim for payment of daily hospitalization cash benefit of Rs.16200/- for his period of hospitalization. The insurer denied the claim citing pre-existing disease and/or suppression of previous medical condition, i.e. Diabetes.

FINIDNGS

On perusal of the claim documents submitted by the complainant, it was noted that he was a k/c/o D M type-II, from last 10 years and he was on regular medication. The period was prior to policy inception and hence the condition of Diabetes was pre-existing. The daily cash benefit was not payable for the hospitalization period due to pre-existing conditions and its related conditions and/or

complications if any. From the discharge summary and internal case sheets of the hospital, it was evident that the insured person was a known case of Diabetes for the last 10 years, which was further confirmed by the noting made in the Discharge Summary against history of previous ailments. Further, insurer stated that as per policy exclusion clause, the complainant was not entitled to the benefit under the policy.

DECISION:

It was held that in the absence of proposal to prove non-disclosure of material information, IRDA guidelines on PED definition were applicable and he was entitled to the benefit under the policy as all PEDs were covered after 36 months of coverage under the policy.On perusal of policy terms and exclusion clause of the policy it is seen that the policy exclusion 1 a & b is clearly worded, excluding payment of daily cash benefit in the event of hospitalization of insured person either due to any pre-existing disease, illness or medical condition and also for any heart, kidney and circulatory disorders in respect of insured persons suffering from pre-existing diabetes and/or hypertension. The complainant had pre-existing medical condition of diabetes and it was accepted by the complainant himself. Irrespective of whether there was disclosure or non-disclosure of pre-existing medical conditions, the complainant was not entitled to any benefit under the policy, as the policy clearly excluded payment of any benefit for heart ailments.

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HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G 11.20.070/2015-16
Sri S Mohan Gurunath Vs. ICICI Lombard Gen.Insurance Co.Ltd

AWARD NO. I.O. (HYD)/A/GI/0043/2015-16 dt. 27.08.2015
MEDICAL INSURANCE

FACTS

Sri S. Mohan Gurunath was covered under Health Protect Insurance Policy issued by the insurer from 21.10.2009, along with his wife for a floater sum insured of Rs. 4 Lakhs. The policy was continuously renewed up to 22nd, October 2015. As per the complaint filed, the insured underwent dental treatment due to tooth infection. There was three teeth extraction and replacement of teeth with implants through implant surgery. He incurred Rs.1,60,000/- for the treatment and preferred the claim. The claim was rejected by the insurer stating that there was non-disclosure of previous medical condition and dental treatment was not covered.

FINDINGS

In the self contained note, the insurer stated on scrutiny of the claim documents submitted by the complainant, it was noted that he was hypertensive for more than 10 years, i.e. before the inception of the policy. The same was admitted by the complainant in a statement given by him on 02.03.2015. The proposer was expected to declare true and complete information at the time of proposal whereas the complainant had suppressed the fact that he was suffering from hypertension. The policy excluded coverage in case

of non-disclosure of material facts in respect of previous health history or medical conditions, the complainant was not entitled for any benefits as policy was issued without the. The insurer stated that the complainant preferred the claim for extraction and replacement of teeth which was a permanent exclusion under part II of the schedule - exclusion 3(iii) of the policy.

DECISION

The complainant's dental treatment claim was rejected by the insurer under exclusion clause 5(g) of the policy. Policy excluded dental treatment unless necessitated due to accident. If accident necessitated any dental treatment, then also the policy does not admit any claim for cosmetic surgery/implants. It is held that the claim of the complainant for dental treatment was not admissible in terms of the policy.

On the plea of non-disclosure of previous medical history and/or conditions, the insurer cancelled the policy during sixth year of coverage for both the insured persons. No reason was attributed for cancelling the coverage to the proposer and wife of the complainant. The insurer has not proved the material non-disclosure by producing the original proposal form. Hence, I direct the insurer to reinstate the policy as cancellation is not justified.

In the result, the complaint is partly allowed. The insurer is directed to restore the policy.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G 11.51.059/2015-16
Sri R Janardhana Naidu Vs. United India Insurance Co.Ltd
AWARD NO. I.O. (HYD)/A/GI/0044/2015-16 dt. 27.08.2015
MEDICAL INSURANCE

FACTS

Sri R. Janardhana Naidu took Individual Mediclaim policy with the insurer and covered himself and his wife for a Sum Insured of Rs. 2 Lakhs and One Lakh respectively, from 31.3.2014 to 30.03.2015. As per the complaint filed, Smt. R. Manorama, wife of the complainant, was admitted in M/s. Sai Nikith Speciality Hospital and Laparoscopic Centre, Kothapet, Hyderabad on 15.3.2014 for deviation of mouth towards left side and was discharged on 16.3.2014. He preferred the claim for Rs.8868/-. The insurer rejected the claim under condition No.4.8 of the policy. After issuance of hearing notices by this office, the insurer informed that the claim was further reviewed by the competent authority and had approved for payment of the claim. The claim was processed by the TPA and paid Rs. 8376/- through NEFT on 13.08.2015.

FINDINGS:

The complainant attended the hearing on scheduled date, i.e. 17.08.2014 and stated that the insurer took 15 months to settle his

claim. He stated that he had made several follow-ups with the insurer and TPA for settlement of his claim. The claim was rejected on unreasonable ground though the incident was sudden and required immediate medical attention. He stated that the doctors planned for surgery to correcting her jaw which was diagnosed as 'right temporo mandibular joint dislocation'. It was corrected without surgery. He pleaded for consideration of his expenses incurred for telephone calls, follow-ups made during the last 15 months and interest around Rs.20,000/- apart from the total disallowed amount of Rs.492/-.

DECISION:

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On perusal of medical records filed before me, no reason was found to deny the claim citing policy exclusion 4.8 of the policy. The insured person was not admitted primarily for diagnosis and doctors planned to perform surgery, if the insured person did not respond to their treatment. As she responded and her lower jaw came to its right position, the complainant got her discharged from the hospital without going for any surgery which was estimated for Rs.30,000/-.

In view of the above, the insurer is directed to pay interest @ 9% from 01.05.2014 on Rs.8376/- till the date of payment. In the result the complaint is allowed.

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HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G 11.48.062/2015-16

Sri G Chandrasekhar rao Vs. National Insurance Co.Ltd

AWARD NO. I.O. (HYD)/A/GI/0046/2015-16 dt. 27.08.2015

MEDICAL INSURANCE

FACTS:

Sri G. Chandra Sekhar Rao took individual Mediclaim policy with the insurer and covered himself and his family members from 31.03.2013 to 30.03.2014 for a SI of Rs. 3.75 Lakhs, for each person. It was renewed for a further period of one year from 31.03.2014 to 31.03.2015. As per the complaint filed, the insured person, Smt. V. Rupa Rani, was diagnosed to have been suffering from Psoriasis with Psoriasis Arthritis. She was administered with 'Alzumab' injection on OPD basis and the reimbursement claim was preferred for cost of 4 infusions by the insured. The insurer rejected the claim stating that for infusion of the injection Alzumab, admission is not warranted

FINDINGS

The 'Alzumab' injection was to be administered in a hospital, under the supervision of a physician and it takes more than 2 hours for its infusion The treating doctor clearly stated in his certificate about the need for hospitalization, for administration of 'Alzumab'. The manufacturers of the drug, in their patient information sheet stated about the need for hospitalization of the patient for its infusion. The insurer rejected the claim stating that the admission of the insured person was only for the sake administration of injection and it was not payable, as 24 hours admission was not warranted. The complainant stated that the insurer covered day-care procedures and insisted him to submit day care summaries. He further stated that the hospital, wherein his wife had undergone the treatment, i.e. Srija Maternity & Nursing Home, had

clarified that the infusions were given on OP/Day Care Basis. It being a small hospital, they were not so systematic in maintaining the records for the cases like this. The insurer stated that six infusions were taken during the hospitalization period and claim was settled Rs.1,08,841/-. Subsequently, another claim was preferred for four infusions, by submitting only invoice copy with a doctor certificate for Rs. 1,35,563/-. But the complainant had submitted only a treating doctor's certificate, stating the necessicity of the injections. Hence, there was no hospitalization. It did not fall under post hospitalization claim to the earlier hospitalization, as it was not within 60 days from the date of discharge of the insured patient, from the hospital.

DECISION:

On perusal of the claim documents and hospital records it was noted that the complainant had preferred the claim by submitting only prescriptions and pharmacy invoices along with a medical certificate for payment of the claim. The hospital had not issued any admission report nor issued a bill for the bed and nursing charges, for the day of admission. The insurer stated that even for day care procedures, the hospitals issue discharge summaries and no such summaries were furnished by the complainant in spite of query raised by them. The insurer further stated that they have admitted all the claims that fell under pre & post hospitalization period also. In view of the above and on perusal of the documents filed before me and also on facts of the case, I concur in the decision of the insurer in repudiation of the claim and the complaint is dismissed

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G 11.47.0446/2014-15

Sri Harinarayana singamsetty Vs. TATA AIG Gen Insurance Co.Ltd

AWARD NO. I.O. (HYD)/A/GI/0047/2015-16 dt. 27.08.2015

MEDICAL INSURANCE

FACTS

MR.Harinarayana took Individual Accident & Sickness Hospital Cash Policy with the insurer from 18.01.2014 to 17.01.2015. It was a continuous renewal policy from 2009. The policy provided the in-hospital indemnity for sickness @ Rs.5000/- per person, per day, with a deductible of one day. As per the complaint filed, the insured got hospitalized from 25.04.2014 to 01.05.2014 for heart ailment. He preferred the claim for payment of hospital cash benefit under the policy. The insurer rejected the claim stating that the hospitalization cash benefit was not payable for pre-existing ailments. He represented for review of the decision stating that the claim was preferred by him during 6th year policy period and rejection of claim under PED exclusion was not justified.

FINDINGS

, the insurer stated that the complainant took the policy initially in the year 2009 and thereafter it was renewed continuously without any break. The claim was reported by the complainant on 02.05.2014 under In-hospital indemnity for sickness. As per the discharge summary, the medical history recorded by the hospital was "CAD, Unstable Angina, S/P CABG (1995) Old ASMI (1995) – Thrombolysed with Streptokinase, S/P PTCA + Stent to SVG, PDA (2008), DM Type II, Systemic Hypertension, Reduced LV Systolic Function, LVEF – 45%, BPPV". With the referred medical history, it was noted that the complainant was hospitalized for an ailment

which existed prior to inception of the policy, i.e. 17.01.2009 and he was on continuous medication. As such, the ailment was a complication of pre-existing disease and hence the benefit was not admissible under the policy. The insurer further referred to the definition of the pre-existing condition stated under General Definitions of the policy which reads as under:

Pre Existing Condition: a condition for which care, treatment, or advice was recommended by or received from a physician or which was first manifested or contracted within a period up to 5 year preceding the insured persons effective date of coverage, or a condition for which hospitalization or surgery was required within a period up to 5 years preceding the insured person's effective date of coverage as specified in the policy schedule.

DECISION

On perusal of the policy exclusions, it is observed that the insurer excluded the benefit for any hospitalization as a consequence of any pre-existing ailment/disease and/or conditions which is contrary to the general understanding of the proposer. As per the prevailing guidelines issued by the IRDA, all PEDs are covered after 48 months of continuous coverage, whether PEDs were declared or not at the time of taking the policy, provided there was no hospitalization during these years for those PEDs.. It was not placed on record by the insurer that there was subsequent hospitalization of the complainant for declared/undeclared PEDs from the date of inception of risk under first policy. The Complainant was covered under the policy for more than 48 months, i.e. more than the maximum waiting period under any health insurance policy to cover PEDs. In this case, the insurer is also guilty of ignoring the pleadings of the insured to the effect that his ailment was finally diagnosed as ` ENT problem' and that it had nothing to do with his heart problem. On this count itself the complainant is entitled to relief. The insurer is directed to

admit the claim in terms of the policy and to pay interest @9% P.A. from 1.6.2014 till the date of settlement for delay.

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HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G 11.03.0039/2015-16

Sri Sriram Madhav Kommu Vs. Apollo Munich HealthInsurance Co.Ltd

AWARD NO. I.O. (HYD)/A/GI/0048/2015-16 dt. 27.08.2015

MEDICAL INSURANCE

FACTS

Sri Sriram Madhav K took Optima Restore Health Insurance Policy with the insurer, from 29.04.2013 to 28.04.2014, for a SI of Rs. 5,00,000/-. The policy was renewed for the subsequent period from 29.04.2014 to 28.04.2015. As per the complaint filed, Sri Sriram Madhav met with road accident on 12.01.2015 and was admitted in Apollo Hospitals, Hyderabad on the same day. He underwent 'arthroscopic lavage of right knee' and was advised to undergo 'arthroscopic anterior cruciate ligament reconstruction after 5 weeks. The claim preferred by him was repudiated by the insurer citing non-disclosure of previous medical history. He stated that he had submitted relevant documents of his previous hospitalization and explained the queries raised by the insurer

FINDINGS

The complainant stated that he had met with a road accident on 12.01.2015 while riding a two wheeler. The X-ray revealed fractured right tibial spine and MRI revealed tear of CL and lateral collateral ligament. He was not found to be under influence of alcohol at the time of accident or on his arrival in emergency room of the hospital. MLC was registered by the hospital on 12.01.2015. He stated that he had undergone 'Arthroscopic Lavage Right Knee' and he was advised to undergo arthroscopic anterior cruciate ligament reconstruction

after 5 weeks from the date of discharge. The claim preferred by him for reimbursement of hospitalization expenses was declined by the insurer attributing his single episode of 'unconsciousness' as 'seizure disorder' The accident was occurred due to a skid from his bike. There was no evidence as to show that his skidding was due to a repetitive seizure disorder or it was established that the fall was due to alcoholic influence. The CT scan taken in 2009 did not indicate any neurological defect. He was not under any medication for this. . The policy was cancelled by the insurer in complete violation of IRDA guidelines. The insurer cancelled the policy to deny the future claim for his proposed arthroscopic anterior cruciate ligament reconstruction. The hospital shared the admission notes of the complainant and it was noted from them that there was a history of "Episode of Seizure in 2009 – No seizures in last 4 years". The noting in the discharge summaries of both the hospitalizations clearly proves that the complainant was a k/c/o seizures disorder from 2009. The complainant failed to disclose his earlier hospitalization details at the time of his proposal to the company. As there was a noted non-disclosure of previous medical history by the complainant, the claim was rejected and policy was terminated in terms of clause 5 (u) of the policy.

DECISION:

The complainant consulted the doctor who treated him earlier and got a certificate stating that the complainant was not a case of epilepsy /seizure disorder or any other organic brain disorder. The doctor further confirmed that the complainant had no neurological symptoms. The earlier episode happened in 2009 and the present hospitalization was in January 2015 for accidental injury case of It is held that there was no material non-disclosure as the isolated event was not diagnosed as 'seizures' and it was only a suspicion. In view of the above, the complaint is allowed with a direction to the

insurer to admit the claim, by reviving the policy, as per its terms and conditions.

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HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G 11.37.055/2015-16
Smt K Bala Kameswari Devi Vs. Religare Health Insurance Co.Ltd
AWARD NO. I.O. (HYD)/A/GI/0049/2015-16 dt. 23.09.2015
MEDICAL INSURANCE

FACTS

Smt. K. Bala Kameshwari Devi took Religare Health Insurance Policy with the insurer and covered herself and her husband for a floater Sum Insured of Rs. 5 Lakhs from 31.12.2014 to 30.12.2015. As per the complaint filed, Sri M. Gopal Rao, husband of the insured, was admitted in Care Hospitals, Hyderabad on 21.02.2015 due to heart attack. He was discharged on 02.03.2015 after undergoing PTCA stents to his diagnosed ailment of CAD- Double Vessel Disease. After discharge from the hospital, the insured, submitted the claim for reimbursement of hospitalization expenses at Rs.4,50,000/-. The insurer denied the claim on the ground of non-disclosure of personal habit of smoking, at the time of proposal.

FINDINGS

The insurer stated that on perusal of the claim documents and hospital records, it was noted that the insured person was a known smoker. It was observed from the medical Nutritional Assessment Form that the insured person was a chronic smoker. She made a wrong declaration that her husband was a non-smoker. . The

insurer further stated that they had obtained expert medical opinion from Dr. Ch. Ansari who opined that 'smoking contributes to pathogenesis of cardio vascular disease (CVD) through a variety of mechanisms and tobacco control is the single most cost-effective preventable cause of premature cardiovascular mortality and morbidity. The doctor opined that the habit of smoking had a relation to the disease suffered by the insured person. Hence, the claim was declined.

DECISION

On perusal of the other in-patient hospital record, submitted by the insurer, it was observed from the 'History Sheet', recorded by the hospital, on the date of admission, i.e. 22.2.2015 itself that against Personal History it was clearly recorded that the patient was 'Non-Smoker' and 'Non-alcoholic'. On going through the correspondence, between the complainant and the insurer, the complainant asked the insurer to prove that her husband was a 'smoker'. The insurer had not produced any other evidence to substantiate their rejection ground. The insurer relied only on one document, without giving any cognizance to the history recorded by the hospital in the 'history sheet'. Accordingly the complaint is allowed with a direction to the insurer to admit the claim in terms of the policy.

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KOCHI OMBUDSMAN CENTRE

Award No. IO/KOC/A/GI/0003/2015-16

Complaint No. KOC-G-051-1415-0111

Award passed on : 17.04.2015

Mr. A.V. Antony Vs The United India Insurance Co. Ltd.

Repudiation of Individual Mediclaim

The complainant and his family were covered under a Family Medi-care Policy of the respondent Insurance Company. He was hospitalized for the treatment of "CORONARY ARTERY DISEASE", from 14/05/2014 to 16/05/2014. A claim was preferred for reimbursement of expenses towards hospitalization which was repudiated by the Insurer. The dispute regarding this could not be resolved among them, a complaint was filed before this Forum.

The Respondent insurer is directed to Pay eligible claim.

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Award No. IO/KOC/A/GI/0004/2015-16

Complaint No. KOC-G-049-1415-0230

Award passed on : 17.04.2015

Mr. Jacob Mathew Vs The New India Assurance Co. Ltd.

Partial repudiation of Mediclaim

The complainant had taken a mediclaim policy from the respondent insurer for a sum insured of Rs. 1 lakh for the period 22.11.2012 to 21.11.2013. The complainant's wife was hospitalized and underwent surgery as advised by the doctors. The complainant has incurred a sum of Rs.81,434/- towards pre as well as post hospitalization expenses. In the two claims submitted for Rs.6,667/- and Rs.74,767/- the insurer has settled only an amount of Rs.2,803/- and Rs.43,879/-. An appeal was preferred, which was not satisfactorily responded to and only an amount of Rs.4,838/- was further allowed. Since the points put forward by the complainant was not considered in settling the claim, this complaint has been filed seeking settlement of the full claim.

The complaint is Dismissed.

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Award No. IO/KOC/A/GI/0006/2015-16

Complaint No. KOC-G-049-1415-0137

Award passed on : 17.04.2015

Mr. Swapan Kumar Saha Vs The New India Assurance Co. Ltd.

Repudiation of Individual Mediclaim

The complainant and his family were covered under a Medi-claim policy of the respondent insurer. He was hospitalized for more than 24 hours on 02/06/2014, due to severe headache. After discharge from the hospital, he submitted claim for reimbursement of hospitalization expenses which was repudiated by the insurer. His request to the insurer for reconsideration of the claim was in vain. Hence, he filed this complaint. Relief sought is for the full claim amount.

The Respondent insurer is directed to Pay eligible claim.

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Award No. IO/KOC/A/GI/0010/2015-16

Complaint No. KOC-G-049-1415-0025

Award passed on : 17.04.2015

Mr. Gisto Joseph Vs The New India Assurance Co. Ltd.

Partial Repudiation of Individual Mediclaim

The complainant had taken a mediclaim policy from the respondent insurer prior to 2007, covering himself, spouse and children. The complainant was hospitalized in 01/2014 and the total bill came to Rs.61,964/-. All the original records and documents were submitted to the insurer to prefer a claim. Thereafter the complainant received Rs.33,322/- through bank transfer. It is highly irregular to transfer the amount without giving any details to the complainant and an appeal was lodged for settlement of the full amount of claim. This complaint is filed as there is no response to the appeals filed and also seeking relief to the extent of disallowed amount of Rs.28,642/- along with interest at 12%, Rs.10,000/- for mental agony and Rs.6,500/- towards costs.

The complaint is Dismissed.

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Award No. IO/KOC/A/GI/0022/2015-16

Complaint No. KOC-G-048-1415-0184

Award passed on : 04.05.2015

Mr. Sali M.G. Vs The National Insurance Co. Ltd.

Repudiation of Individual Mediclaim

The complainant is covered under a mediclaim policy from the respondent insurer. The complainant was hospitalized in 05/2014 for laparoscopic Mini Gastric Bypass. A claim was preferred to the insurer which was repudiated citing clause 4.9 of the policy document. Appeal to the grievance cell of the insurer did not bring any result, hence this complaint seeking full relief of the amount claimed.

The Respondent insurer is directed to Pay 50% of eligible claim.

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Award No. IO/KOC/A/GI/0024/2015-16

Complaint No. KOC-G-048-1415-0098

Award passed on : 04.05.2015

Mr. Nizar Azeez Vs The National Insurance Co. Ltd.

Repudiation of Individual Mediclaim

The complainant had taken a mediclaim policy from the respondent insurer (Sum Insured 50000/-). In 06/2014, the complainant's wife was admitted to hospital for fever. After discharge, a claim was preferred with the respondent insurer. The insurer has settled a lower amount than actually reimbursable and hence this complaint. It is submitted that the complainant has paid room rent for three days at the hospital, whereas the Insurer has reimbursed only for two days.

The Respondent insurer is directed to Settle eligible room rent.

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Award No. IO/KOC/A/GI/0026/2015-16

Complaint No. KOC-G-051-1415-0136

Award passed on : 04.05.2015

Mrs. Dinna Sethi Vs The United India Insurance Co. Ltd.

Repudiation of Individual Mediclaim

The complainant had taken a mediclaim policy from the respondent insurer. In 04/2014, the complainant was hospitalized and incurred an amount of Rs.71,153/-. A claim was preferred with the respondent insurer who has settled an amount of Rs.26,688/- only. The coverage at the time of hospitalization was Rs.1,25,000/-. Appeal to the insurer was in vain hence this complaint seeking full claim settlement keeping the present sum insured as the limit.

The Respondent insurer is directed to Settle disallowed claim.

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Award No. IO/KOC/A/GI/0027/2015-16

Complaint No. KOC-G-051-1415-0079

Award passed on : 04.05.2015

Mr. K. George Mathew Vs The United India Insurance Co. Ltd.

Repudiation of Individual Mediclaim

The complainant is a businessman who has taken a mediclaim policy from the respondent insurer more than 5 years back and renewed without any break. The complainant's wife and daughter are also covered under the policy. The complainant's wife was hospitalized at Sree Agasthya Medical Centre from 13/06/2013 to 30/06/2013. The total hospitalization expenses came to Rs.27,550/-. The complainant submitted the entire set of medical records including the original bills within the stipulated date to the insurer and preferred a claim. The Insurer has rejected the claim and an intimation has been received on 12/11/2013 citing that the treatment was not taken at a Government hospital and hence not eligible for the claim. Appeal to the insurer did not bring any result and hence this complaint filed before this Forum seeking the following reliefs; a) allow the claim of Rs.27,550/-, b) Allow 12% interest from the date of claim submitted to the insurer, c) allow costs of Rs.5,000/- and d) an additional amount of Rs.15,000/- for causing mental agony and hardship.

The complaint is Dismissed.

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Award No. IO/KOC/A/GI/0038/2015-16

Complaint No. KOC-G-048-1415-0034

Award passed on : 07.05.2015

Mrs. Sobhana Vs The National Insurance Co. Ltd.

Repudiation of health insurance claim

The complainant had taken a Health policy named 'Baroda Health' from the respondent insurer National Insurance Co.Ltd for the period 26/5/2013 - 25/5/2014. The complainant has been covered for health insurance under the above insurer for a sum assured of Rs 3,00,000 since 2010. The complainant underwent treatment at a local Ayurvedic Chikilsalayam under a legally qualified cum Govt approved medical practitioner during the period 28/5/2013- 08/06/2013. She has submitted all the treatment particulars for reimbursement to the insurer. Despite the complainant providing all information and records regarding the genuineness of treatment undergone, her claim was rejected on the grounds that the treatment was not done under a Regd Medical practitioner. Appeal to the insurer that the Govt of Kerala has brought Ayurvedic practitioners namely Vaidyans to be treated as medical practitioners was not acceded to, hence this complaint.

The Respondent insurer is directed to Settle eligible claim.

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Award No. IO/KOC/A/GI/0039/2015-16

Complaint No. KOC-G-048-1415-0306

Award passed on : 07.05.2015

Dr. Girisankar Vs The National Insurance Co. Ltd.

Partial repudiation of Mediclaim

The complainant has taken a mediclaim policy from the respondent insurer (No 570504/48/12/8500000209). A claim was made for hospitalization expenses of the complainant's wife who was also covered under the policy. The respondent insurer has settled a sum less than actually spent by the complainant. The amount settled was due to the erroneous entry in the discharge summary that the illness was existing for more than 4 years, while actually it was present only for 18 months. The corrected discharge summary was submitted for reconsideration of claim, however no further settlement was done, hence this complaint seeking the full relief.

The Respondent insurer is directed to Treat SI as Rs.3 Lakhs and settle bill of Rs.1,27,008/-.

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Award No. IO/KOC/A/GI/0046/2015-16

Complaint No. KOC-G-051-1415-0090

Award passed on : 07.05.2015

Mr. B. Jayachandran Nair Vs The United India Insurance Co. Ltd.

Repudiation of Individual Mediclaim

The complainant has taken a mediclaim policy from the respondent insurer. The complainant was hospitalized in 12/2009 for treatment of various ailments. A request for cashless benefit was sent to the insurer and was sanctioned an amount of Rs.7,500/- as against the bill amount of Rs.29,958/-. Since the full bill amount was not sanctioned, the complainant was put to great hardship. The respondent insurer has not so far paid the claim, hence this complaint.

The Respondent insurer is directed to Pay eligible claim.

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Award No. IO/KOC/A/GI/0053/2015-16

Complaint No. KOC-G-018-1415-0342

Award passed on : 08.06.2015

Mr. Davies K.J Vs HDFC ERGO General Insurance Company Ltd.

Repudiation of mediclaim

The complainant had taken a Health policy from HDFC ERGO in 2010. In March2014 he was diagnosed with acute Promelocytic Leukemia from CMC Vellore. He took treatment for the illness at Amrita Institute of Medical sciences, Kochi. He had submitted all the bills and supporting documents for reimbursement claim to the insurer. The respondent Insurer repudiated the claim citing that the said disease was of a genetic disorder and not covered under the policy. The complainant has later provided certificates from Dr Neeraj Sidharthan, Haemotologist confirming that the disease of the insured was an acquired disease, a malignancy, and not a congenital disorder. Despite this, the respondent insurer still persisted with denying the claim, Hence this complaint.

The complaint is Dismissed.

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Award No. IO/KOC/A/GI/0059/2015-16

Complaint No. KOC-G-048-1415-0325

Award passed on : 08.06.2015

Mr. S. Govind Vs The National Insurance Co. Ltd.

Repudiation of mediclaim

The complainant was a member of the said policy from 2007 onwards. The insured met with an accident while playing cricket in 2010 and was admitted in Bharat Hospital, Kottayam and then taken immediately to Deepam Hospital, Coimbatore for surgery. On his discharge from hospital, he submitted the bills for reimbursement to the insurer's office. The complainant later had to leave for higher studies and authorised his mother to receive the claim amount. But there was no response from the insurance company and whenever they got in touch with the agent or office they were told that the file was with TTK, the TPA of Insurance company. Later they were told that the TPA had changed and they were unable to locate the file. The complainant states that till now he has not received any positive response from the insurer and hence this complaint.

The Respondent insurer is directed to Settle claim subject to production of evidence.

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Award No. IO/KOC/A/GI/0063/2015-16

Complaint No. KOC-G-048-1415-0217

Award passed on : 08.06.2015

Mr. A.U.George Vs The National Insurance Co. Ltd.

Rejection of claim under a health policy

The complainant states that he and his family members are covered under a Mediclaim policy. His son was bitten by a stray dog and underwent treatment at the Govt Medical college Kottayam. When the complainant approached the insurance company for reimbursement of the expenses, it was turned down, stating that the patient was treated as outpatient and the policy covers only hospitalisation expenses incurred as an inpatient in hospital for which minimum period of hospitalisation required is 24 hours. Appeal to the Insurer was in vain and hence this complaint seeking full reimbursement.

The Respondent insurer is directed to Reimburse eligible amount.

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Award No. IO/KOC/A/GI/0067/2015-16

Complaint No. KOC-G-044-1415-0284

Award passed on : 08.06.2015

Mr. Shibu M.S. Vs Star Health & Allied Ins.Co. Ltd.

Repudiation of health insurance claim

The complainant has obtained Family Health Optima – Accident care policy for the period 02/01/2014 to 01/01/2015 cover included for wife and two children. The complainant had taken a policy from the same insurer for the period 12/2010 to 12/2011 and renewed for one more year. Unfortunately it was not renewed for the subsequent year and a new policy was taken in 2014. In 04/2014 the complainant suffered cardiac problems while on duty and was hospitalized and later discharged on the advice to go for further treatment at the complainant's native place. On being hospitalized, the insurer was informed, however the cashless facility was denied. Later a claim was preferred with all particulars which was rejected by the insurer citing pre-existing illness. None of the records indicate that the complainant had this illness prior to inception of policy in 2014, hence this complaint is filed seeking full relief to the extent of the claim. The respondent insurer states that they have specific information of pre-existing illness and that the insured was suffering from cardiac problems before the inception of the policy. Hence they have denied the claim.

The complaint is Dismissed.

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Award No. IO/KOC/A/GI/0068/2015-16

Complaint No. KOC-G-044-1415-0352

Award passed on : 08.06.2015

Mr. Manoj. P.K Vs Star Health & Allied Ins.Co. Ltd.

Repudiation of health insurance claim

The complainant was covered under a policy from Reliance General Insurance Co. Ltd. for 7 years, when an agent of the respondent insurer induced him to take a policy from the respondent insurer. Accordingly he availed a policy in 03/2014. In 04/2014 feeling a swelling in the jaw area, the complaint underwent tests in a hospital which revealed that the swelling was due to bone tumour. A claim was preferred which was denied citing pre existing illness. Had the complainant continued with the earlier insurer, he would have been eligible for cashless facility also. Appeal to the insurer was in vain, hence this complaint.

The Respondent insurer is directed to Pay eligible claim.

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Award No. IO/KOC/A/GI/0069/2015-16

Complaint No. KOC-G-044-1415-0377

Award passed on : 08.06.2015

Dr. Oommen P Mathew Vs Star Health & Allied Ins.Co. Ltd.

Repudiation of health insurance claim

The complainant was covered under a FHOP policy from the respondent insurer since 11/2009. The complainant's wife was hospitalised in 12/2014 and underwent laparoscopic hysterectomy. A claim was preferred with the Insurer for the entire claim amount of Rs.1,12,890/-. The Insurer has authorized cashless only for Rs.64,762/-. This has caused great mental agony as the complainant had to pay the balance amount to get his wife discharged. A claim was submitted to obtain reimbursement for the balance. The same was repudiated by the insurer stating that the maximum has been already settled, hence this complaint as the appeal was not considered. Relief sought is to the extent of the disallowance and pre-hospitalization expenses.

The Respondent insurer is directed to Pay claim in full.

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Award No. IO/KOC/A/GI/0070/2015-16

Complaint No. KOC-G-044-1415-0370

Award passed on : 08.06.2015

Mrs. R.Prasanna Vs Star Health & Allied Ins.Co. Ltd.

Repudiation of health insurance claim

The complainant is insured under the Family health optima policy with Star Allied And Health Insurance Company Ltd. The complainant was hospitalized in 12/2014 and preferred a claim with the insurer. The insurer has rejected the claim as the treatment undertaken was Ayurvedic which is not covered under the policy (only Allopathic treatment is covered). Appeal to the insurer did not have any effect hence this complaint .

The complaint is Dismissed.

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Award No. IO/KOC/A/GI/0071/2015-16

Complaint No. KOC-G-051-1415-0231

Award passed on : 08.06.2015

Mr. Praveen Kamal Vs The United India Insurance Co. Ltd.

Partial repudiation of health insurance claim

The complainant was insured under a Mediclaim policy taken with the above insurer. The complainant submits that he was admitted at Medical Trust Hospital during the periods 21.06.2014 – 25.06.2014 and 02.07.52014 – 03.07.2014 for Left URS + laser Lithotripsy + left DJ stenting and left DJ stent removal. The total medical expenses for the treatment came to Rs.59,522.85. The claim proceeds sanctioned by the insurance company was only Rs.35,818/-. The insurance company states that the complainant is eligible only for 1% of the total sum assured towards room rent including nursing charges. As the complainant had claimed for a room rent higher than that eligible, all operation and connected expenses would be settled only for the proportionate charges. Appeal to the insurer that the hospital had confirmed that all expenses involving surgery and other allied expenses were independent of the accommodation provided, did not elicit any positive response. Hence this complaint seeking full reimbursement.

The Respondent insurer is directed to Reimburse amount deducted.

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Award No. IO/KOC/A/GI/0073/2015-16

Complaint No. KOC-G-051-1415-0309

Award passed on : 08.06.2015

Mr. Junaid M.M Vs The United India Insurance Co. Ltd.

Repudiation of health insurance claim

The complainant was covered under a Group Medi-claim policy of the respondent insurer. He was hospitalized from 20/05/2014 to 21/05/2014 for the treatment of RIGHT ACOUSTIC SCHWANNOMA. After discharge from the hospital, he submitted claim for reimbursement of hospitalization expenses which was repudiated by the insurer. His request to the insurer for reconsideration of the claim was in vain. Hence, he filed this complaint. Relief sought is for the full claim amount.

The Respondent insurer is directed to Pay eligible claim.

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Award No. IO/KOC/A/GI/0074/2015-16

Complaint No. KOC-G-051-1415-0188

Award passed on : 08.06.2015

Mrs. Selma Sajeev Vs The United India Insurance Co. Ltd.

Repudiation of health insurance claim

The complainant and her 2 daughters were covered under a Medi-claim policy of the respondent insurer for a period from 23/07/2013 to 22/07/2014. She was hospitalized from 07/05/2014 to 14/05/2014 for the treatment of heaviness on head and pain on left foot. After discharge from the hospital, she submitted claim for reimbursement of hospitalization expenses which was repudiated by the insurer. Her request to the insurer for reconsideration of the claim was in vain. Hence, she filed this complaint. Relief sought is for the full claim amount.

The Respondent insurer is directed to Pay Rs.9,314/-.

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Award No. IO/KOC/A/GI/0076/2015-16

Complaint No. KOC-G-051-1415-0253

Award passed on : 08.06.2015

Mr. P S. Sarath Chandran Vs The United India Insurance Co. Ltd.

Non-settlement of health claim

The complainant was insured under a Mediclaim policy taken with the above insurer. The complainant submits that he was admitted at Sunrise Hospital on 03/06/2013 and discharged the next day. He was suffering from continuous back pain and he was advised by the local nursing home where he was treated earlier to get further treatment at the Sunrise Hospital. The complainant submitted the bills and other papers to the insurance company for reimbursement. But till now he has not got the claim settled. Despite sending many reminders he has not received any positive response from the insurer. Hence this complaint.

The Respondent insurer is directed to Settle claim.

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Award No. IO/KOC/A/GI/0077/2015-16

Complaint No. KOC-G-051-1415-0323

Award passed on : 08.06.2015

Mr. Abdul Ashraf Vs The United India Insurance Co. Ltd.

Partial Repudiation of Individual Mediclaim

The complainant had availed protection of the individual health insurance policy from the insurer. The complainant's wife and son were also covered under the policy. The complainant's son was hospitalized and a claim for Rs.17,651/- was preferred, but only an amount of Rs.9,457/- was paid by the insurer. Appeals to the insurer was in vain and hence this complaint seeking full reimbursement of the entire claim.

The Respondent insurer is directed to Settle full claim after deducting ineligible room rent.

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Award No. IO/KOC/A/GI/0078/2015-16

Complaint No. KOC-G-020-1415-0285

Award passed on : 09.06.2015

Mr. Jayachandra Babu Vs ICICI Lombard General Ins.Co.Ltd.

Repudiation of Individual Mediclaim

The complainant had taken a health policy from the respondent insurer in 2009 and has been renewing the same without any break and so now, is eligible for cover for pre existing diseases as well as four years are over. The complainant had two claims which he submitted to the insurer for reimbursement. The claims were not only rejected, but the contract was terminated citing suppression of material information. The complainant had diabetes while taking the policy and was disclosed in the proposal form. The complainant was diagnosed as having hypertension after the policy was issued. However in the discharge summary in the present claim, the doctor has mentioned that the patient was suffering from hypertension & diabetes since 10 years. The Insurer alleges that the history of hypertension was not mentioned in the proposal form. This complaint is filed seeking relief from the unilateral action taken by the insurer in terminating the policy.

The Respondent insurer is directed to Settle the claim.

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Award No. IO/KOC/A/GI/0079/2015-16

Complaint No. KOC-G-003-1415-0341

Award passed on : 09.06.2015

Mr. Noel Joseph Vs Apollo Munich Health Ins. Co. Ltd.

Repudiation of health insurance claim

The complainant had taken an Optima Restore policy from the respondent insurer. A claim was preferred with the insurer in 01/2015 which has been repudiated. Hence this complaint.

The complaint is Dismissed.

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Award No. IO/KOC/A/GI/0080/2015-16

Complaint No. KOC-G-003-1415-0364

Award passed on : 09.06.2015

Mrs. Resmi Jayaram Vs Apollo Munich Health Ins. Co. Ltd.

Repudiation of health insurance claim

The complainant is holding a Medical Insurance from the respondent insurer for the last 6 years and there is no history of claims. The complainant was hospitalized in Lakeshore Hospital from 04/09/2014 to 09/09/2014. At the time of discharge, the complainant had initiated cashless benefit, which was refused by the insurer. Later all the original bills and documents were forwarded for consideration to obtain reimbursements. The insurer has denied the claim stating that as per the medical reports the complainant has undergone infertility treatment which is excluded from the policy. Appeal to the insurer did not bear fruit, hence this complaint seeking the full claim amount.

The Respondent insurer is directed to Settle full claim withsimple interest @ 9% p.a. from date of rejection till payment and cost of Rs.1,000/-.

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Award No. IO/KOC/A/GI/0081/2015-16

Complaint No. KOC-G-003-1415-0367

Award passed on : 09.06.2015

Mr. V.G.Ramesh Vs Apollo Munich Health Ins. Co. Ltd.

Repudiation of health insurance claim

The complainant had taken a mediclaim policy from the insurer for last three years. The complainant's daughter was hospitalized in 12/2014. Cashless benefit was denied and the complainant was advised to submit all bills and documents to obtain reimbursement. However, the claim was repudiated due to reason "hospitalization not required". The treating doctor has given another letter which was presented to the insurer. However the decision to reject the claim was upheld. This complaint is filed seeking full reimbursement of the claim.

The Respondent insurer is directed to Settle the claim.

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Award No. IO/KOC/A/GI/0082/2015-16

Complaint No. KOC-G-005-1415-0355

Award passed on : 10.06.2015

Mr. P.J.Rajesh Vs Bajaj Allianz General Insc Co. Ltd.

Repudiation of Health Insurance claim

The complainant was insured under a health insurance policy taken with the above insurer which was valid from 29/03/2014 till 28/03/ 2017. The complainant submits that he had a bike accident on 16/09/2014 and was immediately rushed to Alpha ENT Hospital due to excessive Nose bleeding. He was advised to undergo surgery and the same was conducted on 17/09/2014 and he was discharged the next day. The complainant states that he has spent more than Rs.30,000/- on the surgery and post surgical expenses. But his claim lodged with the insurer was rejected stating the reason that the said surgery did not come under the coverage of the policy. Hence this complaint.

The Respondent insurer is directed to Settle claim.

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Award No. IO/KOC/A/GI/0084/2015-16

Complaint No. KOC-G-012-1415-0278

Award passed on : 10.06.2015

Mr. Krishnadas V Vs Cholamandalam MS Gen. Insu.Co. Ltd

Repudiation of Individual Health claim

The complainant was insured under the above insurer for the last 3 years. The insured was admitted in hospital for brain hemorrhage on 01/01/2013. When he submitted the forms for reimbursement, the insurer rejected the claim citing reason of pre-existing illness. The complainant states that he had never availed of any treatment prior to 01/01/2013 and he has been denied claim on wrong reasons. Hence this complaint seeking relief to the extent of Rs.30,000/-.

The complaint is Dismissed.

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Award No. IO/KOC/A/GI/0086/2015-16

Complaint No. KOC-G-048-1415-0200

Award passed on : 10.06.2015

Mr. P.M. Mathew Vs The National Insurance Co. Ltd.

Repudiation of Health insurance claim

Complainant's wife is a health insurance policyholder since 2005. She availed treatment at Sevana Hospital, Pattambi during the period 23/06/2014 -25/06/2014. Their request for cashless treatment was turned down by the insurance company. Later they lodged the claim and sent all the bills along with the medical records to the insurer. Despite sending many reminders they have not got any response from the insurer. Hence this complaint.

The complaint is Dismissed.

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Award No. IO/KOC/A/GI/0087/2015-16

Complaint No. KOC-G-048-1415-0326

Award passed on : 10.06.2015

Mr. M.M. Mathew Vs The National Insurance Co. Ltd.

Partial repudiation of Mediclaim

The complainant was covered under both Medi-claim and Parivar Policies of the respondent Insurer. He was hospitalized on 24/08/2014 for the treatment of MILLER FISCHER and discharged on 05/09/2014. He got Cashless facility from the respondent Insurer to the extent of Rs.1,18,715/-. After discharge from the hospital, he submitted claim for the balance amount and received Rs.1 Lakh (maximum payable) under Parivar Policy. He had requested for a statement of claim calculation from the TPA, but in vain. His request to the insurer for balance of the claim amount was also in vain. Hence, a complaint was filed before this Forum. The main dispute is on accumulated cumulative Bonus.

The complaint is Dismissed.

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Award No. IO/KOC/A/GI/0090/2015-16

Complaint No. KOC-G-051-1415-0001

Award passed on : 10.06.2015

Mr. K D Shaiju Vs The United India Insurance Co. Ltd.

Repudiation of Individual mediclaim

The complainant and his family members were covered under an Individual Health policy of the Respondent insurer. The complainant states that his father was admitted in hospital in connection with cirrhosis of liver, but the total claim for expenses has been rejected by the insurer. Despite following up with the insurer, he has not got a positive response from them. Hence this complaint.

The complaint is Dismissed.

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Award No. IO/KOC/A/GI/0091/2015-16

Complaint No. KOC-G-051-1415-0002

Award passed on : 10.06.2015

Mr. K D Shaiju Vs The United India Insurance Co. Ltd.

Repudiation of Individual mediclaim

The complainant and his family members were covered under an Individual Health policy of the Respondent insurer. The wife of the complainant was admitted at PVS Hospital for uterus surgery on the. The total bills for reimbursement was Rs.43,696/- but the insurance company has reimbursed only an amount of Rs.7,203/-. Despite following up with the insurer, he has not got a positive response from them. Hence this complaint.

The Respondent insurer is directed to Settle claim excluding excess room rent.

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Award No. IO/KOC/A/GI/0092/2015-16

Complaint No. KOC-G-051-1415-0322

Award passed on : 10.06.2015

Mr. M. Subair Vs The United India Insurance Co. Ltd.

Repudiation of Individual mediclaim

The complainant and his family members were covered under an Individual Health policy of the Respondent insurer for the past 10 years. The daughter of the complainant Miss Sufaina had undergone treatment and operation for Mandibular Prognathism as per the advice of Dr Anil Kumar of Medical Trust Hospital. After the treatment, the Claim application along with the bills for Rs.1,09,313/- was referred to the insurer for reimbursement. The claim has been rejected by the insurer stating that the said treatment was of the nature of genetic disorder and hence not payable under the conditions of the policy. Even though the complainant has produced a certificate from the Doctor stating that the mentioned illness could be caused due to factors other than genetic, the claim has not been honored by the insurance company. The complainant had taken up the matter with their higher office but his appeal has been in vain. Hence this complaint.

The Respondent insurer is directed to Settle claim.

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Award No. IO/KOC/A/GI/0093/2015-16

Complaint No. KOC-G-050-1415-0298

Award passed on : 11.06.2015

Dr. Shibu C Thankachan Vs The Oriental Insurance Co. Ltd.

Repudiation of Individual mediclaim

The complainant is insured under Happy Family Floater policy from the respondent insurer from 02/2013. Due to a sport accident which occurred in 08/2013 and subsequent events, the complainant's left knee became unstable and had to undergo ACL reconstruction surgery. After the surgery a claim was preferred with the insurer which was repudiated. The reason for rejection was that the MRI contained a comment on presence of Osteoarthritis, which is specifically excluded under the policy for the first four years. Appeal to the insurer has not yielded any result, hence this complaint seeking full relief.

The Respondent insurer is directed to Pay claim.

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Award No. IO/KOC/A/GI/0096/2015-16

Complaint No. KOC-G-050-1415-0324

Award passed on : 11.06.2015

Mr. Anil Kumar. V Vs The Oriental Insurance Co. Ltd.

Repudiation of Individual mediclaim

The complainant had taken a Happy Family Floater policy from the respondent insurer w.e.f. 03.10.2012. The complainant underwent hospitalisation in 11/2014 for pedal edema. The echo taken at that time revealed ASD - Ostium Secondum and ASD closure was done on 07.11.2014. Subsequently a claim was preferred with the insurer which was repudiated citing clause 4.8 of the policy. Appeal to the grievance cell of the insurer did not yield any result, hence this complaint.

The Respondent insurer is directed to Settle claim for Rs. 1 Lakh.

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Award No. IO/KOC/A/GI/0097/2015-16

Complaint No. KOC-G-050-1415-0283

Award passed on : 11.06.2015

Mr. Raveendran V.G. Vs The Oriental Insurance Co. Ltd.

Repudiation of Individual mediclaim

The complainant and his wife are insured under PNB Royal Mediclaim Policy from 28/04/2014. The complainant's wife was hospitalised in 10/2014 and the insurer has denied the cashless facility. After the hospitalization the claim forms and other documents were submitted for reimbursement which was denied, hence this complaint seeking relief to the extent of Rs.46,658/-.

The complaint is Dismissed.

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Award No. IO/KOC/A/GI/0099/2015-16

Complaint No. KOC-G-044-1415-0274

Award passed on : 11.06.2015

Mrs. Lissy George Vs Star Health & Allied Ins. Co.Ltd.

Repudiation of Health Insurance claim

The complainant has taken a health policy from the respondent insurer for the period 18.10.2013 to 17.10.2014 covering herself and her son Sri Anto George. Anto George underwent treatment at Specialists Hospital from 15.05.2014 to 20.05.2014. A claim was preferred which was rejected by the insurer citing pre–existing diseases and suppression of material facts. The complainant has approached the Grievance department vide registered letter dated 03.12.2014, however the insurer has in their reply upheld the earlier decision to repudiate the claim. The complainant submits that there is no pre-existing disease and there is no suppression of facts and the insurer has no proof to show that the patient had these ailments earlier. This complaint is filed seeking full relief of the amount claimed of Rs.95,000/-.

The Respondent insurer is directed to Settle 50% of eligible amount on Ex-gratia basis.

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Award No. IO/KOC/A/GI/0100/2015-16

Complaint No. KOC-G-044-1415-0301

Award passed on : 11.06.2015

Mr. Mathew Joseph Vs Star Health & Allied Ins. Co.Ltd.

Repudiation of Health Insurance claim

The complainant has taken a health policy from the respondent insurer in 10/2008 covering himself, wife and 2 minor children. The complainant has renewed the policy without any break for the next 4 years, however the complainant could not renew the policy in time for the renewal for period 25.10.2012 to 24.10.2013. An agent has approached the complainant and assured him that a renewal drive was going on and on renewing it then, all earlier benefits would be carried over. On the basis if this assurance, the policy was renewed with commencement date as 15.01.2014. The complainant's wife experienced a lump in the breast and went in for an examination whereupon the attending doctor has recorded that the lump was seen 15 days back. As per the tests conducted the complainant's wife was diagnosed to have carcinoma and advised surgery, whereupon a request was given for cashless benefit to the respondent insurer. However the Insurer has denied the request stating that the cashless facility is denied as the policy was not in force at the time of onset of the disease. On denial of cashless the bill was settled by the complainant and a claim preferred with the insurer which was repudiated citing a break in policy of more than 45 days and as per condition No 9, the claim is not payable. Further the insured underwent Chemotherapy treatment for which separate bills and claim forms have been submitted to the respondent insurer for which there is no response, hence this complaint seeking the full eligible claim amount.

The Respondent insurer is directed to Settle claim.

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Award No. IO/KOC/A/GI/0101/2015-16

Complaint No. KOC-G-044-1415-0316

Award passed on : 11.06.2015

Mr. P.G. Rajappan Nair Vs Star Health & Allied Ins. Co.Ltd.

Repudiation of Individual mediclaim

The complainant has taken a health policy from the respondent insurer for his wife in 06/2013. On 17/08/2013 based on uneasiness over the chest part, she was taken to hospital for checkup and was diagnosed to have breast lump. Once the diagnosis was confirmed, the complainant's wife underwent treatment and chemotherapy at Lakeshore Hospital. The insurer was approached for the claim amount which was declined stating that the disease was pre-existing and there was suppression of material facts. At the time of taking the policy the agent had inquired about pre-existing diseases and the complainant had declared all the facts honestly which is mentioned in the proposal also. An additional questionnaire regarding questions on cancer were also answered honestly as "no" as the complainant or his wife was not aware of any such ailment. The agent has cautioned that no claim would be paid if the statements are untrue and hence all the full particulars were disclosed. The first diagnosis is after the waiting period of 30 days and the doctors have certified this fact, which was submitted to the insurer. Even though the claim is genuine the insurer has repudiated the claim, hence this complaint seeking full relief.

The Respondent insurer is directed to Settle claim.

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Award No. IO/KOC/A/GI/0102/2015-16

Complaint No. KOC-G-044-1415-0318

Award passed on : 11.06.2015

Mr. Sandeep. R Vs Star Health & Allied Ins. Co.Ltd.

Repudiation of Individual mediclaim

The complainant has taken a health policy from the respondent insurer. In August 2014 the complainant was diagnosed as having disc problems and resultant back ache and underwent Ayurveda treatment at Punarnava Ayurveda Hospital. The treatment started on 23/08/2014 and ended after 2 weeks. While undergoing treatment, the fact was informed to the insurer and they have verified with their visit. Upon submission of all documents the claim was rejected as the ailments treated for would be covered only after two continuous policy years. Appeals to the insurer had no effect, hence this complaint seeking full relief.

The Respondent insurer is directed to Settle claim of Rs.25,000/-.

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Award No. IO/KOC/A/GI/0107/2015-16

Complaint No. KOC-G-044-1415-0138

Award passed on : 22.06.2015

Dr. M. Rabeendran Vs Star Health & Allied Ins.Co.Ltd.

Repudiation of Health insurance claim

The complainant was covered under the Red Carpet Insurance scheme of the respondent Insurer (No P/181300/01/2013/004580). The complainant fell ill and was taken to Baby memorial Hospital on 05/09/2013 wherein he incurred expenses of Rs.1,30,000/- for hospitalization. After discharge, all the relevant records and bills along with the claim forms were submitted to the insurer. However the claim was repudiated on the ground that the ailments were due to use of Alcohol. There is no medical evidence to show that the ailments were due to use of alcohol and the rejection was purely arbitrary, hence this complaint seeking the full relief.

The Respondent insurer is directed to Settle claim.

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Award No. IO/KOC/A/GI/0108/2015-16

Complaint No. KOC-G-044-1415-0338

Award passed on : 22.06.2015

Mr. Binu Thomas Vs Star Health & Allied Ins. Co.Ltd.

Repudiation of Individual mediclaim

The complainant has taken a health policy from the respondent insurer (policy no P/181211/01/2015/001341). The complainant's son, also covered under the policy underwent an eye surgery and a claim was preferred with the insurer. The claim was denied by the insurer citing "Congenital external defect not covered under the policy". However the complainant submits that the reason does not stand as the surgery was done not to correct a congenital defect but to improve vision as can be confirmed from the discharge summary which states that the "deviation of BE Medical Rectus is noticed at the age of 2 years". Further it also mentions that it is not a cosmetic surgery, but to improve vision and needs to be monitored for the next 5 years. An appeal was made to the grievance cell of the insurer but there is no positive response from the department, hence this complaint seeking full relief.

The complaint is Dismissed.

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Award No. IO/KOC/A/GI/0110/2015-16

Complaint No. KOC-G-048-1415-0145

Award passed on : 22.06.2015

Mr. A.N.Rajappan Pillai Vs The National Insurance Co. Ltd.

Partial repudiation of Mediclaim

The complainant states that he had availed n Health policy BOI NATIONAL SWASTHYABIMA with the Respondent Insurer through his bankers Bank Of India. He submits that on the brochure he received from the bank on the scheme it was stated that the insured was allowed a free health check up on completing three continuous years. Accordingly he and his wife who were insured under the scheme got their health check up done at Amrita Hospital for which they had incurred an expense of Rs.8,740/-. A few days later because of some variation found in the TMT conducted during the health check, the complainant was advised to undergo an angiogram. He underwent the same on 26/03/2014 and incurred further expense of Rs.15,941/-. The complainant made a reference to the insurer for reimbursement for the total expense of Rs.24,681/-. The complainant states that he received only Rs.4,000/- under the claim and he has been denied justice by the insurer. Hence this complaint seeking justice.

The Respondent insurer is directed to Settle full claim.

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Award No. IO/KOC/A/GI/0111/2015-16

Complaint No. KOC-G-048-1415-0353

Award passed on : 22.06.2015

Mr. K. Suryanarayanan Vs The National Insurance Co. Ltd.

Partial repudiation of Mediclaim

The complainant is the holder of a mediclaim policy with the respondent insurer since 17/03/1988. The complainant is insured for Rs 2,00,000/- and an additional amount of Rs.62,500/- as bonus. On 31/7/2014 due to certain persistent discomforts, the complainant approached Baby Memorial hospital, Calicut. He was admitted for a day and a few medical tests were conducted. He was then referred to Aster Medi city to undergo a surgical procedure and he was admitted during the period 09/09/2014 to 13/09/2014. The total expenses incurred by him was Rs.12,362/- at Baby Memorial hospital and Rs.2,65,300/- on the surgery at Aster Medicity. The complainant filed his claim for total expenses of Rs. 2,77,662/- to the insurer, but was shocked and dismayed when he received only payments of Rs.10,742/- and Rs.1,48,770/- i.e., total reimbursement of Rs.1,59,512/-. Hence this complaint seeking relief to the extent of Rs.2,65,000/-.

The complaint is Dismissed.

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Award No. IO/KOC/A/GI/0115/2015-16

Complaint No. KOC-G-049-1516-0027

Award passed on : 22.06.2015

Mr. Sujith S Vs The New India Assurance Co. Ltd.

Repudiation of Individual mediclaim

The complainant was insured under a mediclaim policy. He was hospitalized in Lourdes Hospital due to a bike accident on 28/09/2014. The complainant has preferred a claim with the insurer which was repudiated due to the fact that the discharge summary mentions "breath smell of alcohol". Despite appealing against this unjust action to the insurer there has been no positive response. Hence this complaint seeking full claim amount.

The Respondent insurer is directed to Settle claim.

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Award No. IO/KOC/A/GI/0116/2015-16

Complaint No. KOC-G-049-1415-0305

Award passed on : 22.06.2015

Mr. R. Appukuttan Nair Vs The New India Assurance Co. Ltd.

Repudiation of Individual mediclaim

The complainant and his wife are covered under the Post Retirement Health Scheme taken by his employer with the respondent insurer. A claim for his wife's hospitalization was sent to the insurer in 11/2013 and the amount claimed was Rs.14,719/-. No response was forthcoming for months together and a letter was sent to the grievance cell of the insurer in 07/2014. The insurer has replied to the same only in 11/2014 and has informed that the claim is not payable. The complainant is retired with no other source of income and the actions of the insurer are highly unjust.

The Respondent insurer is directed to Settle claim.

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Award No. IO/KOC/A/GI/0117/2015-16

Complaint No. KOC-G-049-1415-0308

Award passed on : 22.06.2015

Mrs. Gayathri. M.S Vs The New India Assurance Co. Ltd.

Partial Repudiation of Individual mediclaim

The complainant along with her husband and daughter are covered under the mediclaim policy taken since 2000. The complainant was hospitalised from 09/10/2014 to 13/10/2014. The total expenses for hospitalization came to Rs.10,532/-, however a claim was made to the insurer only for Rs.6,147.49 being the medical expenses after disregarding the expenses charged for food etc. After a lot of follow up and complaints the insurer has credited an amount of Rs.5,375/- only. This complaint is filed seeking full relief for the entire claim amount.

The Respondent insurer is directed to Settle balance amount of Rs.772/-.

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Award No. IO/KOC/A/GI/0118/2015-16

Complaint No. KOC-G-051-1415-0229

Award passed on : 22.06.2015

Mrs. Gigi Jose Vs The United India Insurance Co. Ltd.

Partial repudiation of health insurance claim

The complainant was covered under an individual health insurance policy from the respondent insurer valid for the period 08/01/2014 - 07/01/2015. The complainant was hospitalized at St.Mary's Hospital twice as she had suffered palpitation. She continued her treatment there and later underwent surgery at Medical Trust Hospital. She has lodged all three bills for reimbursement with the said insurer. She states that she has not been reimbursed the full amount. Even though she had taken up the matter with their higher office her appeal has been in vain. Hence this complaint.

The complaint is Dismissed.

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Award No. IO/KOC/A/GI/0120/2015-16

Complaint No. KOC-G-044-1516-0010

Award passed on : 30.06.2015

Mr. Hari kumar. M Vs Star Health & Allied Ins.Co. Ltd.

Repudiation of health insurance claim

The complainant has taken a policy from the respondent insurer. On 23.09.2014 the complainant had to undergo tests and treatments due to chest pain after which an angiogram and angioplasty was done. A claim was preferred with the Insurer which was repudiated citing suppression of material facts. Appeal did not have any result, hence this complainant seeking full claim amount from the Insurer.

The complaint is Dismissed.

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Award No. IO/KOC/A/GI/0121/2015-16

Complaint No. KOC-G-044-1415-0281

Award passed on : 30.06.2015

Mr. Raveendran B Vs Star Health & Allied Ins.Co. Ltd.

Repudiation of claim under Individual mediclaim

The complainant is insured under Senior citizens red carpet policy for a sum insured of Rs.3,00.000/- in 06/2014. All necessary information has been given to the agent in order to process the application and was informed that no medical checkup need to be conducted. In 09/2014, the complainant has undergone tests in Lakeshore Hospital and based on the tests undergone an operation. The carcinoma was not detected until the tests were done at the hospital and until then the complainant was not aware of the disease. The discharge summary does not mention any pre existing illness, however the claim was rejected, hence this complaint seeking full relief.

The complaint is Dismissed.

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Award No. IO/KOC/A/GI/0123/2015-16

Complaint No. KOC-G-051-1415-0369

Award passed on : 30.06.2015

Mr. P.Sasidharan Vs The United India Insurance Co. Ltd.

Repudiation of Individual Mediclaim

The complainant was holding a valid medicalim policy from the Insurer. On 23/09/2014, the complainant was admitted to Amritha Hopsital due to Stroke and resultant paralysis. After discharge a bill for Rs 40554/- was submitted to the TPA on 4.10.2014. The first set of queries were raised on 15.10.2014 and replies were given on 04.11.2014. After which a series of emails with the same query has been received. All replies have been given including the one in the email, but the TPA repeatedly was sending the emails despite acknowledging the receipt of documents. Any number of visits, emails and follow up were in vain, hence this complaint is filed seeking the full relief of Rs.40,554/- and Rs. 10,000/- for mental agony.

The Respondent insurer is directed to Settle Claim + Cost 5000.

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Award No. IO/KOC/A/GI/0124/2015-16

Complaint No. KOC-G-051-1516-0036

Award passed on : 30.06.2015

Mr. G. Balachandran Vs The United India Insurance Co. Ltd.

Delay in settlement of claim

The complainant is paying premiums without fail on a mediclaim policy since 2008. A claim was preferred in 09/2013. Even after almost a year no reply was received from the Insurer. A letter was sent to the grievance cell for which also no reply was received, hence this complaint seeking the insurer to settle the claim immediately.

The Respondent insurer is directed to Settle eligible claim after submitting documents.

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Award No. IO/KOC/A/GI/0127/2015-16

Complaint No. KOC-G-023-1516-0007

Award passed on : 30.06.2015

Mr. Mathew Paattam Francis Vs IFFCO-TOKIO Genl. Insc. Co. Ltd.

Repudiaiton of Individual mediclaim

The complainant had a policy from the respondent insurer insuring himself and his family members. A claim was submitted for hospitalization of the complainant's daughter for Viral hepatitis at Karipal Hospital during the period 17/06/2014-21/06/2014. After her discharge all the original bills were submitted along with the claim forms. However the Insurer rejected the claim stating that "viral hepatitis" required no hospitalization. An appeal was sent to the Insurer for which there is no response, hence this complaint seeking full relief of Rs.8,813/- .

The Respondent insurer is directed to Settle claim.

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Award No. IO/KOC/A/GI/0128/2015-16

Complaint No. KOC-G-023-1516-0017

Award passed on : 30.06.2015

Mr. Sunil Kumar. P.D Vs IFFCO-TOKIO Genl. Insc. Co. Ltd.

Repudiation of health insurance claim

The complainant had a valid insurance policy from the respondent insurer. A claim was submitted to the Insurer for hospitalization of the complainant's wife which was repudiated by the Insurer. The total claim amount is Rs.18,095/-. The reason cited by the Insurer for rejecting the claim is that the patient was on oral medication and the admission was for investigation purpose only. An appeal was sent to the Insurer which did not have any response, hence this complaint seeking full relief.

The Respondent insurer is directed to Settle claim.

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Award No. IO/KOC/A/GI/0130/2015-16

Complaint No. KOC-G-020-1516-0022

Award passed on : 30.06.2015

Mr. A.E. Mathai Vs ICICI Lombard General Ins.Co.Ltd.

Non-payment of health claim

The complainant took membership under ICICI Lombard's "KudumbA Raksha Health Insurance Scheme' through Kulanada Grama Panchayath by remitting Rs.450/- as premium in August 2006. The complainant incurred an amount of Rs.5,113/- towards treatment expenses. The company has not settled the claim. Hence the complaint.

The complaint is Dismissed.

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Award No. IO/KOC/A/GI/0134/2015-16

Complaint No. KOC-G-016-1516-0035

Award passed on : 06.07.2015

Mr. Geever. P. K Vs Future Generali India Insurance Co. Ltd.

Repudiation of health insurance claim

The complainant had availed a Medical Insurance policy from the respondent Insurer. He was hospitalized on 12/12/2014 for the treatment of Neck swelling with pain and fever. He was discharged from the hospital on 15/12/2014 and a claim was preferred with the TPA of the Insurer. The claim was repudiated stating that the patient was hospitalized primarily for investigation purpose for which confinement is not required. His appeal to the grievance Cell of the Insurer for a re-consideration was also in vain. Hence, he filed a petition before this Forum seeking full relief.

The Respondent insurer is directed to Settle eligible claim.

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Award No. IO/KOC/A/GI/0135/2015-16

Complaint No. KOC-G-048-1516-0043

Award passed on : 06.07.2015

Mrs. Anitha. K.I Vs The National Insurance Co. Ltd.

Repudiation of Individual Mediclaim

The complainant and her children were covered under National Medi-claim policy of the respondent Insurer. She was hospitalized on 10/01/2014 for the treatment of Back pain and discharged on 14/01/2014. A claim was preferred with the Insurer which was repudiated stating that the hospitalization was unwarranted and it could have been done as an out-patient procedure. Her appeal to the grievance Cell of the Insurer for a re-consideration of the claim was also in vain. Hence, she filed a petition before this Forum.

The Respondent insurer is directed to Settle eligible claim.

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Award No. IO/KOC/A/GI/0136/2015-16

Complaint No. KOC-G-049-1516-0004

Award passed on : 06.07.2015

Mr. Prakash P.V. Vs The New India Assurance Co. Ltd.

Partial Repudiation of Individual Mediclaim

The complainant and his family were covered under a Medi-claim policy of the respondent Insurer. His son was hospitalized for the treatment of Dengue Fever on 27/11/2014 and discharged on 30/11/2014. A claim was preferred with the Insurer which was partially settled. His appeal to the grievance Cell of the Insurer for a re-consideration of the balance amount was also in vain. Hence, he filed a petition before this Forum.

The Respondent insurer is directed to Settle claim after deducting ineligible room rent.

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Award No. IO/KOC/A/GI/0146/2015-16

Complaint No. KOC-G-048-1516-0061

Award passed on : 14.07.2015

Mr. Jayaprakash K.P Vs The National Insurance Co. Ltd.

Repudiation of Individual mediclaim

The complainant had a medi-claim policy with the respondent Insurance company. He was hospitalized for the treatment of urinary infection. A claim was preferred with the Insurance Company which was partially settled. His dispute relates to deductions from the claim amount and demands full reimbursement of expenses incurred.

The complaint is Dismissed.

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Award No. IO/KOC/A/GI/0150/2015-16

Complaint No. KOC-G-038-1516-0001

Award passed on : 14.07.2015

Mr. Sumith Bhaskar R Vs ROYAL SUNDARAM ALLIANCE INSURANCE COMPANY LIMITED

Repudiation of Individual mediclaim

The complainant had availed a Health Insurance policy, covering his family members, from the respondent Insurer. His father was hospitalized on 12/01/2015 for the treatment of Stroke & Brain infection and discharged from the hospital on 22/01/2015. Two claims were preferred with the Insurer. Both the claims were repudiated stating pre-existing diseases and suppression of material facts, while taking the policy. His appeal to the grievance Cell of the Insurer for a re-consideration of the claim was also in vain. Hence, he filed a petition before this Forum.

The complaint is Dismissed.

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Award No. IO/KOC/A/GI/0151/2015-16

Complaint No. KOC-G-052-1415-0365

Award passed on : 14.07.2015

Mr. Vishal Philip Sam Vs Universal Sompo Gen. Insu. Co. Ltd.

Repudiation of Health Insurance claim

The complainant took a policy covering himself, father and mother from the respondent insurer (no 2817/51405583/02/000) and the policy has been renewed upto 30/05/2015. During 02/2014, the complainant's father was hospitalized with Carcinoma. The complainant has informed the Insurer and made a claim for Rs.1,39,600/-. All the necessary papers were submitted to the insurer. In the meantime the complainant's mother was diagnosed with Cancer and died on 29.09.2014. During this period some of the receipts got misplaced. The Insurer has informed that original bills have to be submitted for the claim to be processed. The complainant got duplicate bills issued from the hospital and forwarded them to the Insurer. The Insurer has informed that the claim cannot be processed due to lack of original bills, hence this complaint seeking full reimbursement of the bills.

The Respondent insurer is directed to Settle claim after receiving copies of bills.

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Award No. IO/KOC/A/GI/0152/2015-16

Complaint No. KOC-G-051-1415-0201

Award passed on : 14.07.2015

Mrs. Mary Benjamin Vs The United India Insurance Co. Ltd.

Non-receipt of claim amount under mediclaim

The complainant and her husband are covered under a medi claim policy with the Respondent insurer. She had been hospitalized in Medical Trust hospital in August 2011 and again later in October in the same year. The complainant states that she had submitted her bills for reimbursement to the office of the insurer. She submits that the service received from the insurer has been totally negative. She had been asked to submit various requirements and had to visit the office several times for her claim settlement. She states that the claim has been settled in installments. She is extremely unhappy with the services of the insurer and their TPA. She complaints that the TPA representative has been very rude and dis-courteous. She has not yet got the full settlement of the claim. The complainant also states that the insurer reports that an amount of Rs.6,881/- was sent to her account in April 2012, but she hasn't received the amount yet. She requests the Honorable Ombudsman to intervene and provide relief to her.

The Respondent insurer is directed to Pay Rs.6,881/- with SI @9%.

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Award No. IO/KOC/A/GI/0153/2015-16

Complaint No. KOC-G-051-1415-0345

Award passed on : 14.07.2015

Mr. Krishna Prasad K Vs The United India Insurance Co. Ltd.

Partial Repudiation of Individual mediclaim

The complainant and family are insured under a mediclaim policy from the respondent insurer. The complainant's wife had undergone a keyhole surgery at V G Saraf Memorial Hospital. A claim was preferred with the Insurer. The Insurer has settled only 25% of the old sum insured as against 25% of Rs. 1 lakhs which is the sum Insured in the year. Appeal to the Insurer did not have any result, hence this complaint seeking the 25% of the Sum insured of Rs.1 lakh.

The Respondent insurer is directed to Pay addl. Claim of Rs.12,500/-.

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Award No. IO/KOC/A/GI/0155/2015-16

Complaint No. KOC-G-051-1516-0049

Award passed on : 14.07.2015

Mr. K.N. Sukumaran Vs The United India Insurance Co. Ltd.

Repudiation of Individual mediclaim

The complainant had a Medi-claim policy with the respondent Insurer. His wife was hospitalized in January, 2015 for the treatment of disc complaints caused due to a fall. A claim for reimbursement of expenses towards hospitalization was preferred with the insurer which was repudiated by stating that only internal medication was given along with investigations. Hence this complaint seeking full relief.

The Respondent insurer is directed to Pay eligible claim.

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Award No. IO/KOC/A/GI/0156/2015-16

Complaint No. KOC-G-051-1516-0077

Award passed on : 14.07.2015

Mr. K.L. Antony Vs The United India Insurance Co. Ltd.

Repudiation of Individual mediclaim

The complainant had a Medi-claim policy with the respondent Insurer. A claim towards hospitalization was repudiated by the Insurer stating that Ayurvedic treatment is covered only when it is treated in a Govt. Hospital. The complainant had taken Ayurvedic treatment from a private Hospital, hence the claim was rejected. Since the dispute could not be resolved, a complaint was filed before this Forum.

The complaint is Dismissed.

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Award No. IO/KOC/A/GI/0157/2015-16

Complaint No. KOC-G-051-1516-0016

Award passed on : 14.07.2015

Mr. Ananda Padmanabha Pillai. G Vs The United India Insurance Co. Ltd.

Partial Repudiation of Individual mediclaim

The complainant and his family members are covered under the individual Health Insurance policy of the said insurer since 2007. The complainant was admitted in KIMS hospital at the Gastro Enterology dept, Trivandrum for the medical treatment of Constipation and related complaints. After getting discharged he lodged the bills for reimbursement to the insurer. The complainant states that even though he had spent Rs.23,108/-, he was sanctioned only Rs.7,462/-. On enquiring with the higher authorities, he was informed that the deduction was on account of him utilizing a room which was higher than his eligibility under the policy. The party is dissatisfied with the insurer and hence approached this office for relief.

The Respondent insurer is directed to Pay Rs.14922/-.

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Award No. IO/KOC/A/GI/0158/2015-16

Complaint No. KOC-G-051-1516-0011

Award passed on : 14.07.2015

Mr. R. Ramachandran Vs The United India Insurance Co. Ltd.

Repudiation of Individual mediclaim

The complainant and his wife were covered under a Medi-claim policy of the respondent Insurer. His wife was hospitalized on 12/10/2014 for the treatment of Rheumatoid Arthritis and discharged on 20/10/2014. A claim was preferred with the Insurer which was repudiated stating that the hospitalization was unwarranted and it could have been done as an out- patient procedure. His appeal to the grievance Cell of the Insurer for a re-consideration of the claim was also in vain. Hence, he filed a petition before this Forum.

The Respondent insurer is directed to Settle eligible claim.

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Award No. IO/KOC/A/GI/0159/2015-16

Complaint No. KOC-G-051-1516-0023

Award passed on : 14.07.2015

Mrs. Leela Ram Mohan Vs The United India Insurance Co. Ltd.

Partial Repudiation of Individual mediclaim

The complainant is covered under a mediclaim policy of the respondent insurer. A claim of Rs.16,250/- was submitted on 4th February for hospitalization of self. But only an amount of Rs.9,456/- was received. On repeatedly taking up the matter, further amounts of Rs.1,395/- and Rs.1,230/- were credited to her bank account. This complaint is filed seeking direction to the insurer to settle the balance claim of Rs.1,233/- or at least give a satisfactory reply.

The Respondent insurer is directed to Pay Rs.1233/-.

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Award No. IO/KOC/A/GI/0160/2015-16

Complaint No. KOC-G-044-1516-0062

Award passed on : 14.07.2015

Mr. Riju Shankar. S Vs Star Health & Allied Insurance Co.Ltd

Partial Repudiation of Individual mediclaim

The complainant and his family were covered under a health policy of the respondent Insurer. His daughter was first hospitalized on 21/12/2014 and again to another hospital on 22/12/2014, for the treatment of Fever and discharged on 29/12/2014. A claim was preferred with the Insurer which was partially settled. His appeal to the grievance Cell of the Insurer for a re-consideration of the balance of claim, was also in vain. Hence, he filed a petition before this Forum.

The Respondent insurer is directed to Pay Balance Rs.11781/-.

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Award No. IO/KOC/A/GI/0161/2015-16

Complaint No. KOC-G-044-1516-0042

Award passed on : 14.07.2015

Mr. T.C. Peter Vs Star Health & Allied Insurance Co.Ltd

Partial Repudiation of Individual mediclaim

The complainant and his family were covered under a health policy from the respondent insurer since 2012. A claim for hospitalization was submitted which was initially repudiated by the Insurer stating that there was suppression of material facts. Later on taking up the matter with their higher office an amount of Rs. 50,000/- was settled against the bill for Rs.1,16,657/-. The complainant also submits that for his two other bills also full amount has not been settled. The complainant states that he has been denied full reimbursement and requests the office of the Honorable Ombudsman to grant him justice.

The Respondent insurer is directed to Pay balance amount.

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Award No. IO/KOC/A/GI/0162/2015-16

Complaint No. KOC-G-003-1516-0058

Award passed on : 14.07.2015

Mr. Raveendran Pillai Vs Apollo Munich Health Ins.

Repudiation of Individual mediclaim

The complainant was covered under a Medi-claim policy of the respondent Insurer. He was hospitalized for the treatment of Cancer and a claim was preferred with the Insurer. The claim was repudiated by stating that the cause of Carcinoma was abuse of smoking and that he was alcoholic before the inception of the policy, hence this complaint seeking relief.

The Respondent insurer is directed to Settle eligible claim.

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Award No. IO/KOC/A/GI/0165/2015-16

Complaint No. KOC-G-020-1415-0381

Award passed on : 16.07.2015

Mr. Praveen Bhaskaran Vs ICICI Lombard General Ins.Co.Ltd.

Repudiation of Individual Health claim

The complainant was insured under a Health policy taken with the Respondent insurer from 2007 onwards. The insured was hospitalized for the period 04/08/2014 to 07/08/2014 at Ernakulam Medical Centre and underwent Laproscopic cholecystectomy under GA on 05/08/2014. The complainant lodged his claim for the expenses incurred of Rs 60,833/-. The respondent insurer rejected the claim alleging non disclosure of material information as per Part III of the Schedule. He has approached the Grievance cell of the insurer. Appeal to the insurer has not yielded any result , hence this complaint seeking full relief.

The Respondent insurer is directed to Pay the claim.

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Award No. IO/KOC/A/GI/0167/2015-16

Complaint No. KOC-G-048-1516-0013

Award passed on : 16.07.2015

Mr. Abraham George Vs The National Insurance Co. Ltd.

Repudiation of Individual mediclaim

The complainant was part of a group mediclaim policy. When availing an individual policy, the complainant gave reference of his earlier group policy in order to enjoy the benefits of continuity. However on receipt of his policy the complainant finds that there is no mention of earlier policy or the continuity benefits. On submission of all details all over again the Insurer has incorporated the benefits by way of alteration (hand written). In 09/2014, the complainant's wife underwent Hernia operation for which a claim was submitted. The claim has been rejected by the insurer as there was a break in the policy of 5 months. The claim of Rs 2 lakhs has been withheld since 10/2014. Letters to the head office of the Insurer and to IRDA has given no result, hence this complaint.

The Respondent insurer is directed to Settle eligible amount.

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Award No. IO/KOC/A/GI/0170/2015-16

Complaint No. KOC-G-051-1516-0065

Award passed on : 16.07.2015

Mr. George Xavier P X Vs The United India Insurance Co. Ltd.

Repudiation of Individual Mediclaim

The complainant and his family were covered under a Medi-claim policy of the respondent Insurer. His wife was hospitalized for the treatment of abdominal pain and underwent surgery. A claim was preferred with the company and it was partially settled. Subsequently, the complainant received a communication from the Hospital to remit further Rs.20,000/- as the TPA paid only Rs.20,000/- of the approved amount of Rs.40,000/-. Hence this complaint.

The Respondent insurer is directed to Pay Rs.20,000/-.

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Award No. IO/KOC/A/GI/0172/2015-16

Complaint No. KOC-G-051-1516-0051

Award passed on : 16.07.2015

Mr. C.K. Narayana Panicker Vs The United India Insurance Co. Ltd.

Partial Repudiation of Individual Mediclaim

The complainant had a medi-claim policy with the respondent Insurer. A claim was preferred with the Company for reimbursement of expenses towards hospitalization. Out of total claim of Rs.3,63,066/- the company has settled only Rs.2,56,211/-. The complainant demands the balance amount for which the petition is filed before this forum.

The Respondent insurer is directed to Settle balance amount.

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Award No. IO/KOC/A/GI/0173/2015-16

Complaint No. KOC-G-044-1516-0085

Award passed on : 16.07.2015

Mrs. Marykutty Johny Vs Star Health & Allied Ins.Co.Ltd.

Repudiation of Individual Mediclaim

The complainant was covered under a Senior Citizen Red Carpet Insurance Policy of the respondent Insurer. She was hospitalized twice in connection with the treatment of Pneumonia and Chronic Obstructive Pulmonary Disease. Claims were preferred with the Insurer for reimbursement of expenses towards hospitalization, which was repudiated. Hence, this complaint was filed before this Forum.

The Respondent insurer is directed to Settle claim.

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Award No. IO/KOC/A/GI/0174/2015-16

Complaint No. KOC-G-044-1516-0037

Award passed on : 16.07.2015

Mr. C. Hareendran Vs Star Health & Allied Ins.Co.Ltd.

Repudiation of Individual Mediclaim

The complainant had taken a policy from the respondent insurer. In 10/2014 the complainant was diagnosed at Justice KS hedge hospital, Mangalore as having Brain tumour on 28/10/2014 and was later operated upon in MIMS Hospital on 10/11/2014. All the relevant documents were produced before the Insurer, who has repudiated the claim. Stating there was delay in informing the insurer. Appeal sent to them has also no effect, hence this complaint seeking full relief.

The Respondent insurer is directed to Settle amount deducted.

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Award No. IO/KOC/A/GI/0175/2015-16

Complaint No. KOC-G-044-1516-0083

Award passed on : 16.07.2015

Mr. R Narayana Subramanian Vs Star Health & Allied Ins.Co.Ltd.

Repudiation of Individual Mediclaim

The complainant had a Medi-claim policy with the respondent Insurer. He was hospitalized for the treatment of CELLULITIES on 06/08/2014 and discharged on 15/08/2014. A claim was preferred with the Insurer for reimbursement of expenses towards hospitalization, which was repudiated by the Insurer. Hence, he filed a petition before this Forum.

The Respondent insurer is directed to Settle eligible claim.

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Award No. IO/KOC/A/GI/0180/2015-16

Complaint No. KOC-G-050-1516-0112

Award passed on : 27.07.2015

Mr. Mathew V K Vs The Oriental Insurance Co. Ltd.

Repudiation of Individual Mediclaim

The complainant was covered under a Medi-claim policy of the respondent Insurer. He was hospitalized for the treatment of some gastric problems. A claim was preferred with the TPA of the Insurer which was repudiated. His appeal to the Grievance Cell of the Insurer did not yield any result. Hence he filed a complaint before this Forum.

The Respondent insurer is directed to Settle eligible claim.

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Award No. IO/KOC/A/GI/0181/2015-16

Complaint No. KOC-G-051-1516-0123

Award passed on : 27.07.2015

Mr. Subeesh Unni Vs The United India Insurance Co. Ltd.

Repudiation of Individual Mediclaim

The complainant had a Medi-claim policy of the respondent Insurer. He was hospitalized and a claim for reimbursement of expenses towards hospitalization was preferred with the TPA. The claim was partially settled. The dispute on partial settlement of claim could not be resolved, a petition was filed before this Forum.

The Respondent insurer is directed to Pay Rs.15784/- after deducting disallowable items.

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Award No. IO/KOC/A/GI/0182/2015-16

Complaint No. KOC-G-049-1516-0091

Award passed on : 27.07.2015

Mr. George Nicholas Vs The New India Assurance Co. Ltd.

Repudiation of Individual Mediclaim

The complainant had a Medi-claim policy with the respondent Insurer. He was hospitalized for the treatment of Sleev Gastrectomy. A claim was preferred with the Company for hospitalization of self which was repudiated. The dispute regarding repudiation of claim could not be resolved, a petition was filed before this Forum.

The complaint is Dismissed.

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Award No. IO/KOC/A/GI/0183/2015-16

Complaint No. KOC-G-050-1516-0108

Award passed on : 29.07.2015

Mrs. Sarojini Amma .L Vs The Oriental Insurance Co. Ltd.

Partial Repudiation of Individual Mediclaim

The complainant was covered under a Medi-claim policy of the respondent Insurer. She was hospitalized for the treatment of vomiting and giddiness, from 21/01/2015 to 23/01/2015. A claim towards reimbursement of hospitalization expenses was preferred with the Company which was partially settled. Her appeal to the Grievance Cell of the Insurer was also in vain. Hence, this complaint.

The complaint is Dismissed.

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Award No. IO/KOC/A/GI/0185/2015-16

Complaint No. KOC-G-052-1415-0368

Award passed on : 29.07.2015

Mr. K H Riyas Vs Universal Sompo Gen. Insu. Co. Ltd.

Repudiation of health insurance claim

The complainant holds a policy from the respondent insurer. A claim on the life of the complainants wife was submitted which was rejected by the Insurer citing that pre-existing illness was not disclosed. The policy was taken through the bank and at that time for the questions "are you taking medicines for heart, ……." correct reply was given as no medicines were being taken. And for the last four years no claim was made. The Insurer has rejected the claim stating that the discharge summary states "insured diagnosed to have MVR 5 years back". But actually the discharge card states that the insured is diagnosed to have MVP 5 years back; MVP is a common heart ailment with no serious symptoms & does not require any treatment. The patient had 2 normal deliveries and if there was any serious heart problem then it would have come to attention then. There were no complications during pregnancies and the policy has run for three claim free years and hence the claim should be allowed.

The Respondent insurer is directed to Settle claim.

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Award No. IO/KOC/A/GI/0189/2015-16

Complaint No. KOC-G-044-1516-0081

Award passed on : 31.07.2015

Mr. Thoufeeq Vs Star Health & Allied Ins.Co. Ltd.

Repudiation of Health Insurance claim

The complainant and his family were covered under a Medi-claim policy of the respondent Insurer. His wife, Smt. Nasheeda Banu was hospitalized for the treatment of COPD. A claim was preferred with the Insurer which was repudiated. The complainant argues that some earlier claims were admitted by the Insurer, but this claim was repudiated. Hence, this complaint.

The Respondent insurer is directed to Pay claim.

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Award No. IO/KOC/A/GI/0190/2015-16

Complaint No. KOC-G-044-1516-0075

Award passed on : 31.07.2015

Mr. Ranjith Kumar V Vs Star Health & Allied Ins.Co. Ltd.

Repudiation of Individual mediclaim

The complainant had a taken a Family Health Optima Insurance policy (Medi-claim policy) from the respondent Insurer. He was hospitalized and a claim was preferred with the company which was repudiated stating that he was suffering from present ailment prior to inception of the policy. Since the disputes could not be resolved, a complaint was filed before this Forum.

The Respondent insurer has agreed to Settle claim for Rs.1.5 Lakhs. Hence complaint is dismissed.

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Award No. IO/KOC/A/GI/0191/2015-16

Complaint No. KOC-G-050-1415-0376

Award passed on : 31.07.2015

Mr. Jude Xavier. K.J Vs The Oriental Insurance Co. Ltd.

Repudiation of Individual mediclaim

The complainant is having a valid policy with the respondent insurer. The period of the policy is from 23.10.2014 to 22.10.2015. The complainant was admitted to AIMS, Kochi on 05.01.2015 due to fever & cough and was diagnosed to have Sarcoidosis Disease. Prior to this hospitalization the complainant had no illness. The complainant spent an amount of Rs.76,913/- towards the hospital expenses and submitted a claim to the Insurer. The claim was repudiated stating that the disease was pre existing and was excluded under clause 4.1 of the policy. Hence this complainant seeking full reimbursement of the expenses.

The Respondent insurer is directed to Settle claim.

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Award No. IO/KOC/A/GI/0192/2015-16

Complaint No. KOC-G-050-1516-0053

Award passed on : 31.07.2015

Mr. Ismail Y.P Vs The Oriental Insurance Co. Ltd.

Repudiation of Individual mediclaim

The complainant was covered under a Medi-claim policy of the respondent Insurer. He was hospitalized from 28/03/2014 to 29/03/2014 for the treatment of CAD. A claim was preferred with the Insurer which was repudiated stating that the admission was primarily for evaluations and no active line of treatment was there other than conservative regimen.

The Respondent Insurer is ready to settle the claim for Rs.11,138/-. Hence the complaint is Dismissed.

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Award No. IO/KOC/A/GI/0193/2015-16

Complaint No. KOC-G-050-1516-0050

Award passed on : 31.07.2015

Mr. K.A. Abraham Vs The Oriental Insurance Co. Ltd.

Repudiation of Individual mediclaim

The complainant had taken a Medi-claim policy from the respondent Insurer. His daughter was hospitalized for a dental surgery. The claim towards reimbursement of expenses towards hospitalization was repudiated by the Insurer stating that the dental treatment was not covered under the policy. Hence, this complaint.

The Respondent insurer is directed to Settle the claim.

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Award No. IO/KOC/A/GI/0194/2015-16

Complaint No. KOC-G-051-1516-0005

Award passed on : 31.07.2015

Mr. Sen Pattassery Vs The United India Insurance Co. Ltd.

Partial Repudiation of Individual mediclaim

The complainant and his family are covered under the policy since 2005. The complainant's wife had an operation to remove a cyst and along with that did a hysterectomy also. A claim was preferred with the Insurer. The Insurer has informed that only 25% of Sum Insured is payable as the procedure is hysterectomy. Any number of emails & follow up did not have any result hence this complaint seeking the full reimbursement of the claim.

The Respondent insurer is directed to Settle the claim.

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Award No. IO/KOC/A/GI/0195/2015-16

Complaint No. KOC-G-051-1516-0008

Award passed on : 31.07.2015

Mr. Baby Sebastian Vs The United India Insurance Co. Ltd.

Partial Repudiation of Individual mediclaim

The complainant is covered under a mediclaim policy from the respondent insurer since 1997 and being renewed every year. In 02/2014 a claim for Rs.1,01,836/- was lodged with the insurer. However it was not settled despite follow up. Finally the Insurer has responded that the TPA had sent letters and the claim was closed due to non receipt of documents as called for by the TPA. The original reports were not submitted as no condition in the policy states that the originals have to be submitted. The reports are meant for a qualified Doctor and contains report on private body parts of the patient. On 21.04.2014 a mail was received stating that the claim was approved for Rs.50,265/-. On enquiry with the Insurer as to how the claim was calculated, it was informed that the claim was restricted to 25% of Sum insured as per the policy conditions. The complainant had earlier filed a complaint with this forum in 2008 on the illegal practices indulged in by the Insurer and it was closed on the direction of the Ombudsman. The patient has undergone other procedures along with Hysterectomy and the limit of 25% is only for hysterectomy and hence the balance claim should be settled, hence this complaint seeking the following a) settlement of full claim b) removal of restriction in policy c) reimbursement of medical checkup cost d) interest of 12% on the claim amount and e) allow costs

The Respondent insurer is directed to Settle the full claim.

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Award No. IO/KOC/A/GI/0203/2015-16

Complaint No. KOC-G-048-1516-0095

Award passed on : 31.07.2015

Mr. T.J. Cleetus Vs The National Insurance Co. Ltd.

Repudiation of Individual mediclaim

The complainant was covered under a Medi-claim policy of the respondent Insurer. He was hospitalized on 28/03/2015 for the treatment of Chest pain and discharged on 30/03/2015. A claim was preferred with the TPA of the Insurer which was repudiated stating that the admission was only for evaluation and no active line of treatment was there. Hence the complaint before this Forum for getting reimbursement of claim.

The Respondent insurer is directed to Settle the claim.

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Award No. IO/KOC/A/GI/0204/2015-16

Complaint No. KOC-G-049-1516-0066

Award passed on : 03.08.2015

Mr. K.K. Sethumadhavan Vs The New India Assurance Co. Ltd.

Repudiation of Individual mediclaim

The complainant had a Medi-claim policy with the respondent Insurer. He was hospitalized for the treatment of chest pain. A claim was preferred with the Insurer for reimbursement of expenses towards hospitalization, which was repudiated by the Insurer. The dispute on repudiation could not be resolved among them, a petition was filed before this Forum.

The Respondent insurer is directed to Settle eligible claim.

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Award No. IO/KOC/A/GI/0205/2015-16

Complaint No. KOC-G-049-1516-0124

Award passed on : 03.08.2015

Mrs. Tessy Johnson Vs The New India Assurance Co. Ltd.

Repudiation of Individual mediclaim

The complainant had a Medi-claim policy with the respondent Insurer. She had been hospitalized for the treatment of Type II Diabetic Mellitus and Dyslipidemia. She preferred a claim for reimbursement of expenses which has been repudiated by the TPA. Her appeal to the Grievance Cell was also in vain. Hence, she filed a complaint before this Forum.

The Respondent insurer is directed to Settle the claim in full.

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Award No. IO/KOC/A/GI/0206/2015-16

Complaint No. KOC-G-051-1516-0097

Award passed on : 03.08.2015

Mr. Moideen Kutty Thoombath Vs The United India Insurance Co. Ltd.

Non-renewal of Individual mediclaim policy

The complainant was covered under a Medi-claim policy taken by his son from the respondent Insurer. His son resigned his job for taking employment abroad. The complainant tried to renew the same policy but he could not. Finally he agreed to take a Senior citizen Policy in which the cumulative bonus was not considered. The dispute regarding this led to file a Petition before this Forum.

The complaint is Dismissed.

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Award No. IO/KOC/A/GI/0208/2015-16

Complaint No. KOC-G-052-1516-0060

Award passed on : 10.08.2015

Mr. Leons Stalin Vs Universal Sompo Gen. Insu. Co. Ltd.

Repudiation of Individual mediclaim

The complainant has a health care policy from the respondent insurer taken in 2014. A claim was preferred with the insurer towards hospitalization of his mother for D8 Spinal tumour. The Insurer has rejected the claim as it was in the first year of the policy. The complainant has borrowed money from different sources to meet the hospitalization and medicine expenses and submits that full relief to the extent of the claim be allowed by this forum.

The Respondent insurer is directed to Settle eligible claim.

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Award No. IO/KOC/A/GI/0210/2015-16

Complaint No. KOC-G-049-1415-0380

Award passed on : 10.08.2015

Mr. John Varughese Vs The New India Assurance Co. Ltd.

Partial Repudiation of Individual mediclaim

The complaint has a mediclaim policy with the respondent insurer in which his spouse and 2 children were covered. The complainant has made three claims to the insurer which were settled partially. No details /reasons for disallowance has been given by the insurer despite repeated follow up, hence this complaint.

The Respondent insurer is directed to Pay Rs.2921/-.

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Award No. IO/KOC/A/GI/0211/2015-16

Complaint No. KOC-G-044-1415-0371

Award passed on : 10.08.2015

Mrs. Pushpavally Vs Star Health & Allied Insurance Co.Ltd

Repudiation of Individual Health claim

The complainant has taken a health policy from the respondent insurer. The complainant had a fall and had to undergo treatment and surgery at Renal Medicity (16.04.2014 to 23.04.2014). A claim was preferred with the Insurer which was repudiated. Appeals have not been considered positively, hence this complaint seeking relief of Rs. 62,000/- and interest thereon.

The Respondent insurer is directed to Settle eligible amount.

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Award No. IO/KOC/A/GI/0212/2015-16

Complaint No. KOC-G-016-1516-0009

Award passed on : 10.08.2015

Mr. Maneesh Mohan Vs Future Generali India Insurance Co. Ltd.

Repudiation of Individual mediclaim

The complainant had availed a Medical Insurance coverage for a period of one year from 26/12/2013 to 25/12/2014, from the respondent Insurer. He was hospitalized on 12/08/2014 for the treatment of BILATERAL AVASCULAR NECROSIS RT Hip stage 3 and Lt stage 2, and underwent surgery on 13/08/2014. He was discharged from the hospital on 13/08/2014 and a claim was preferred with the TPA of the Insurer. The claim was repudiated stating that the current ailment is pre-existing and the claim is within 48 months of inception of the policy (Exclusion clause 3.1). His appeal to the grievance Cell of the Insurer for a re-consideration was also in vain. Hence, he filed a petition before this Forum.

The complaint is Dismissed.

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Award No. IO/KOC/A/GI/0213/2015-16

Complaint No. KOC-G-048-1516-0134

Award passed on : 10.08.2015

Mr. John George Vs The National Insurance Co. Ltd.

Non-renewal of Individual mediclaim policy

The complainant and his wife were covered under a Medi-claim policy continuously from 2011 onwards. The Insurer refused to renew the same policy for the year 2014-15 and 2015-16. He appealed to the Grievance cell of the Insurer for renewal of the same policy. But no reply was received and hence he filed a complaint before this Forum for getting renewed the policy.

The Respondent insurer is directed to Renew the policy.

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Award No. IO/KOC/A/GI/0214/2015-16

Complaint No. KOC-G-048-1516-0028

Award passed on : 10.08.2015

Mr. K.M. Kabeer Vs The National Insurance Co. Ltd.

Partial Repudiation of Individual mediclaim

The complainant is having mediclaim policy from the respondent insurer since many years. The sum insured was increased in 2013-14 to Rs. One lakh. In 2014-15 the complainant's wife underwent an operation for which the expenses came to Rs.99,350/-. A claim was preferred which was partly repudiated by the insurer, hence this complaint.

The Respondent insurer is directed to Settle balance amount.

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Award No. IO/KOC/A/GI/0215/2015-16

Complaint No. KOC-G-044-1516-0019

Award passed on : 12.08.2015

Mr. Jayachandra Babu Vs Star Health & Allied Insurance Co.Ltd

Repudiation of Individual Health claim

The complainant had availed a Family Health Optima Insurance policy, from the respondent Insurer. He was hospitalized on 24/02/2014 for the treatment of RESECTION OF AFFECTED RIBS and discharged from the hospital on 13/10/2014. A claim was preferred with the Insurer. The claim was repudiated stating that the present ailment has commenced prior to the date of inception of the policy and suppression of facts while taking the policy. His appeal to the Grievance Cell of the Insurer for a re-consideration of the claim was also in vain. Hence, he filed a petition before this Forum.

The complaint is Dismissed.

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Award No. IO/KOC/A/GI/0216/2015-16

Complaint No. KOC-G-044-1516-0147

Award passed on : 12.08.2015

Mrs. Mary Pathrose Vs Star Health & Allied Insurance Co.Ltd

Partial Repudiation of Individual mediclaim

The complainant was covered under a Medi-claim policy of the respondent Insurer. A claim towards hospitalization and expenses for an amount of Rs.89,658/- was preferred with the Company but has been only partially settled for Rs.57,166/-. Her appeal to the Grievance Cell of the Insurer for the balance amount did not materialize. Hence, she filed a complaint before this Forum.

The Respondent insurer is directed to Reimburse expenses for Lab reports subject to production of the reports.

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Award No. IO/KOC/A/GI/0217/2015-16

Complaint No. KOC-G-051-1516-0111

Award passed on : 12.08.2015

Mr. K V Varghese Vs The United India Insurance Co. Ltd.

Partial Repudiation of Individual mediclaim

The complainant was covered under a Medi-claim policy of the respondent Insurer. He was hospitalized for the treatment of abdomen related complaints. A claim was preferred with the Insurer which was repudiated. His appeal to the Grievance cell of the Insurer was also in vain. Hence he filed a complaint before this Forum.

The Respondent insurer is directed to Reimburse expenses other than ineligible room rent.

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Award No. IO/KOC/A/GI/0218/2015-16

Complaint No. KOC-G-003-1516-0136

Award passed on : 17.08.2015

Mr. Sunish Mathew Vs Apollo Munich Health Ins. Co.Ltd.

Repudiation of Individual Health claim

The complainant was covered under an Easy Health Insurance policy of the respondent Insurer. A claim towards hospitalization was repudiated by the Company stating that the disease was pre-existing. His appeal to the Insurer was also in vain. Hence, he filed a complaint before this Forum for getting reimbursement of Rs.9,259/- towards reimbursement.

The complaint is Dismissed.

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Award No. IO/KOC/A/GI/0222/2015-16

Complaint No. KOC-G-048-1516-0121

Award passed on : 17.08.2015

Mr. P K Vijayan Vs The National Insurance Co. Ltd.

Partial Repudiation of Individual mediclaim

The complainant was covered under a Medi-claim policy of the respondent Insurer. He was hospitalized for the treatment of some illness and a claim was preferred with the TPA of the Insurer. The claim was partially settled without giving any convincing reply for disallowing some expenses. His appeal to the grievance cell of the Insurer was also in vain. Hence, this complaint.

The complaint is Dismissed.

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Award No. IO/KOC/A/GI/0223/2015-16

Complaint No. KOC-G-050-1516-0135

Award passed on : 17.08.2015

Mr. Thomas P A Vs The Oriental Insurance Co. Ltd.

Partial Repudiation of Individual mediclaim

The complainant was covered under a Medi-claim policy of the respondent Insurer. He was hospitalized for the treatment of CAD and underwent Angiogram. A claim was preferred with the TPA of the Insurer and it was repudiated. He appealed to the Grievance Cell of the Insurer for reconsideration, but in vain. Hence, this complaint.

The Respondent insurer is directed to Settle eligible claim of Rs9240/-.

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Award No. IO/KOC/A/GI/0225/2015-16

Complaint No. KOC-G-048-1516-0137

Award passed on : 21.08.2015

Mr. John Poochakattil Vs The National Insurance Co. Ltd.

Repudiation of Individual Mediclaim

The complainant and his wife were covered under a Medi-claim policy of the respondent Insurer. His wife was hospitalized for the treatment of her eye. A claim was preferred with the TPA of the Insurer which was repudiated. His appeal to the Grievance Cell of the Insurer was also in vain. Hence, he filed a complaint before this Forum.

The Respondent insurer is directed to Pay eligible claim with 9% interest and cost of Rs.5000/-.

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Award No. IO/KOC/A/GI/0226/2015-16

Complaint No. KOC-G-051-1516-0142

Award passed on : 21.08.2015

Mr. Shaju P J Vs The United India Insurance Co. Ltd.

Non-settlement of Individual Mediclaim

The complainant and his family were covered under a Medi-claim policy of the respondent Insurer. His daughter was hospitalized for the treatment of cancer and a claim was preferred with the Insurer. The complainant requests that the claim was not yet settled by the officials of the Insurer for which action should be taken against them and his eligible claim has to be settled soon.

The Respondent insurer is directed to Pay eligible claim with 9% interest and cost of Rs.5000/-.

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Award No. IO/KOC/A/GI/0227/2015-16

Complaint No. KOC-G-044-1516-0020

Award passed on : 21.08.2015

Mr. E.K. Cyriac Vs Star Health & Allied Ins.Co.Ltd.

Partial Repudiation of Individual mediclaim policy

The complainant has been a policyholder from 2011-14. In 2014, the complainant was admitted to hospital for treatment. The cashless facility was rejected citing pre-existing illness. The complainant was diagnosed as having hypertension and cervical spondylosis. The Insurer has stated in their letter that he had fainting spells at age 10/11, but was not mentioned in the proposal form. For this the complainant has explained that he did not remember what happened at age 10 and it is his mother who remembered the episodes. After convincing the insurer about the same, they have invited the complainant to the office under the pretext of settling the claim and showed a cheque for Rs.24,000/- drawn in the complainant's name and asked the complainant to sign a discharge for the same. On trying to renew the policy the complainant was informed that it could be possible only after the claim was settled. Since the grace period for remitting the premium was coming to an end, the complainant has sent the premium amount by way of DD to the Insurer. One Mr. Nanadakumar from the insurer informed that the renewal is accepted, but the claim is taken to a higher level. Since no information was forthcoming even after days, a letter was sent to the grievance cell, whereupon Mr.Nanadakumar assured that the policy and cheque would be dispatched shortly, however

the envelope received from them contained a letter stating that the renewal was rejected and a cheque was enclosed for Rs.10,826/- (which was actually not enclosed). This complaint is filed seeking relief for renewal of policy and claim payment in full.

The Respondent insurer is directed to Pay eligible claim.

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Award No. IO/KOC/A/GI/0228/2015-16

Complaint No. KOC-G-051-1516-0102

Award passed on : 21.08.2015

Mr. Rejeesh P Vs The United India Insurance Co. Ltd.

Repudiation of Individual mediclaim policy

The complainant had a Medi-claim policy with the respondent Insurer. He was hospitalized for the treatment of abdominal pain and claim was preferred with the Company, which was repudiated. He appealed to the Grievance cell of the Insurer for reconsideration of the claim which was also in vain. Hence, he filed a petition before this Forum.

The Respondent insurer is directed to Pay Rs.16,682/- with 9% int & cost Rs.5000/-.

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Award No. IO/KOC/A/GI/0230/2015-16

Complaint No. KOC-G-012-1516-0154

Award passed on : 01.09.2015

Mr. Sadik Sulaiman Vs Cholamandalam MS Gen. Insu.Co. Ltd

Non-settlement of Individual Mediclaim

The complainant had a Family Floater Group Health policy covering his family. He was hospitalized at KIMS Hospital from 09/04/2014 - 28/04/2014 for the treatment of gallstones, hereditary spherocyotis and has incurred an expense of Rs 2,51,424/-. His hospitalization claim preferred with the company has not yet been settled. His appeal to the grievance cell of the Insurer was also in vain. Hence, he filed a complaint before this Forum.

The complaint is Dismissed.

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Award No. IO/KOC/A/GI/0233/2015-16

Complaint No. KOC-G-049-1516-0101

Award passed on : 01.09.2015

Mrs. V.N. Geetha Vs The New India Assurance Co. Ltd.

Repudiation of claim under Individual mediclaim

The complainant was covered under a Medi-claim policy of the respondent Insurer. She was hospitalized for the treatment of D&C and a claim was preferred with the respondent Company which was repudiated. Her appeal to the Grievance Cell was also in vain. Hence, she filed a complaint before this Forum.

The Respondent insurer is directed to Settle claim + Cost 2000.

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Award No. IO/KOC/A/GI/0234/2015-16

Complaint No. KOC-G-051-1516-0092

Award passed on : 01.09.2015

Mr. Davis N.T Vs The United India Insurance Co. Ltd.

Repudiation of claim under Individual mediclaim

The complainant and his family were covered under a Medi-claim policy of the respondent insurer. His son was hospitalized for the treatment of epigastric pain, from 12/12/2013 to 14/12/2013. A claim was preferred with the Insurer and was repudiated. The disputes could not be resolved among them, a petition was filed before this Forum.

The Respondent insurer is directed to Settle eligible claim.

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Award No. IO/KOC/A/GI/0235/2015-16

Complaint No. KOC-G-048-1516-0079

Award passed on : 03.09.2015

Mrs. Prema Vijayan Vs The National Insurance Co. Ltd.

Repudiation of Individual Mediclaim

The complainant and her husband were covered under ''Varishta Medi-claim policy for senior citizens with the respondent Insurer. She was hospitalized for the treatment of severe pain over her knee joints. She underwent RFQMR, a unique technology which gives better result than conventional knee replacement. A claim was preferred with the Insurer which was repudiated stating that hospitalization is not warranted for the treatment. Hence, the complaint.

The Respondent insurer is directed to Settle 50% of the preferred claim.

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Award No. IO/KOC/A/GI/0236/2015-16

Complaint No. KOC-G-044-1516-0110

Award passed on : 03.09.2015

Mr. Prasanth V Vs Star Health & Allied Ins.Co.Ltd.

Repudiation of Individual Mediclaim

The complainant and his family were covered under a Medi-claim policy of the respondent Insurer. His wife was hospitalized for the treatment of pain on her knees and underwent surgery. A claim was preferred with the Insurer which was repudiated. His appeal to the Grievance Cell of the Insurer was also in vain. Hence, he filed a complaint before this Forum.

The Respondent insurer is directed to Settle eligible claim with 9% simple interest and cost of Rs.5,000/-.

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Award No. IO/KOC/A/GI/0237/2015-16

Complaint No. KOC-G-044-1516-0088

Award passed on : 03.09.2015

Mr. V P Sasidharan Nair Vs Star Health & Allied Ins.Co.Ltd.

Repudiation of health insurance claim

The complainant had a Medi-claim policy with the respondent Insurer and a claim towards hospitalization was repudiated. The reason pointed out by the Insurer for rejecting the claim was suppression of material facts at the time of taking the policy. The disputes relating to repudiation of claim could not be resolved among them, a complaint was filed before this Forum.

The complaint is Dismissed.

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Award No. IO/KOC/A/GI/0238/2015-16

Complaint No. KOC-G-044-1516-0131

Award passed on : 03.09.2015

Mr. Oommen P Mathew Vs Star Health & Allied Ins.Co.Ltd.

Repudiation of health insurance claim

The complainant was covered under a Medi-claim policy of the respondent Insurer. His claim towards hospitalization of his son was partially settled by the TPA/Insurer. His appeal to the Grievance Cell of the Insurer for balance of the claim amount was in vain. Hence, he filed a petition before this Forum for getting the balance amount of claim.

The complaint is Dismissed.

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MUMBAI

BEFORE THE INSURANCE OMBUDSMAN
MUMBAI & GOA
Mumbai Metropolitan Region
Excluding Navi Mumbai & Thane
Complaint No. GI-871 of 2014-2015
Award No. IO/MUM/A/ /2015-2016
Complainant: Shri Amit Kedia
with
Respondent : United India Insurance Company Limited

Complainant, Shri Amit Kedia approached the Forum with a complaint against the insurance company in the matter of non-settlement of his father's claim amounting to Rs.3.80 lakhs lodged under Policy No. 021200/48/13/20/3552 pertaining to stem cell therapy taken by him for Parkinson's (PSP) Disease. Records were perused and parties to the dispute were called for a personal hearing on 10/7/2015.

The complainant submitted that the stem cell culturing and therapy is carried out by Reelabs which is a highly sophisticated and state of art stem cell centre and it is here where the cells are grown and then implanted into the patient at the hospital where they have a tie up. Further, the policy issued to Shri Kedia did not expressly exclude stem cell therapy. The Insurance Company stated that the therapy was an unproven treatment, however, no documentary evidence were provided in support of their contention. Hence the Insurance Company is directed to review the case in its entireity considering the nature of treatment, the lab where is cultured and processed and the submissions made by the complainant at

the hearing, including visiting Reelab and obtaining information and clarification from them about the treatment and procedure, and inform their final decision to the Forum.

Pursuant to the hearing the Insurance Company vide their email of 9/9/2015 have informed the Forum that they had raised queries regarding the treatment to Reelab and they have informed as under :

1. **Reelab is an FDA licensed banking facility with GMP, GLP certification for the Lab.**
2. **As on today there is no law on stem cells and the DCHI and the FDA do not give any permission for stem cell treatments as it is not under their purview. It should not be viewed as we do not have permissions. There is no provision in law tog rant licenses for therapy.**
3. **Stem Cell treatment is a medical procedure and no permission is required/given for the same."**

All the documents submitted to the Forum have been scrutinized and it is noted that the Insured, Shri Ambika Prasad aged 62 years underwent stem cell therapy as a treatment for Parkinson's Disease. He was admitted to Kiran Care and Cure Hospital on 19/2/2014 for bone marrow aspiration and he underwent stem cell implantation on 20/2/2014.

A claim lodged with the insurance company was denied by them stating that the treatment undergone by the insured was an unproven treatment not covered under the policy and further the

Hospital/Laboratory were the treatment was taken did not fall under the criteria of Hospital as defined under the Policy.

Let us examine what is stem cell treatment and whether it is a standard medical treatment.

"Stem cells are the master cells of the human body. They can divide to produce copies of themselves and many other types of cell. They are found in various parts of the human body at every stage of development from embryo to adult.
Because stem cells are so versatile, they could potentially be used to repair and replace damaged human tissue. This procedure is considered experimental as it is being tested in clinical research studies, and is not yet available as a standard medical treatment. (downloaded from internet)

Further as per the documentary evidence received by the Forum in one of the cases lodged in the Forum regarding stem cell therapy, the National Apex Committee for Stem Cell Research & Therapy (NAC-SCRT) have stated - "As per the National Guidelines on Stem Cell Research 2013 at present , there are no approved indications for stem cell therapy other than the Hematopoietic stem cell transplantation (HSCT) for Haematological disorders. Accordingly all stem cell therapy other than the above shall be treated as investigations and conducted only in the form of a clinical trial after obtaining necessary regulatory approvals. Use of stem cells for any other purpose outside the domain of clinical trial will be considered unethical and hence is not permissible."

Based on the above informations, since the Forum has not received any other documentary evidence contrary to the above, there is no valid ground for the Forum to intervene with the decision of the Insurance Company.

Lastly, as per the Reelabs letter dated 18th February, 2014, "100 million bone marrow mesenchymal stem cell have a very good role in reversing symptoms of parkinsonism because of potential of inducing neural regeneration of the affected area…… consequently the symptoms of gait , imbalance , speech impairment if any, tremors should potentially improve significantly (about 15-25%) with stem cell infusions. Unfortunately, we won't be able to assure any improvement in this case. Reelabs shall do its best and shall offer support even after the therapy is completed…….".

From the above too, it is evident that the procedure is not a standard medical protocol for treatment of Parkinson.

If the Award is not acceptable to the complainant, he is at liberty to approach any other appropriate Forum for redressal of his grievance.

O R D E R

In the facts and circumstances, the complaint of Shri Amit Kedia against the insurance company in the matter of non-settlement of his father's claim in respect of Stem Cell Therapy taken by him is not tenable. The case is disposed of accordingly.

BEFORE THE INSURANCE OMBUDSMAN

(MUMBAI & GOA)

MUMBAI

Complaint No. GI-649/2014-2015

Award No. IO/MUM/A/GI- /2015-16

Complainant: Shri Arif Zakaria

Respondent: The New India Assurance Co. Company Ltd.

Shri Arif Zakaria was covered under Individual Mediclaim Policy (2012) No.111700/34/13/25/00/000637 for the period 18.08.2013 to 17.08.2014 for Sum Insured Rs. 3,00,000/- plus C.B. Rs.1,50,000/-, issued by The New India Assurance Co. Ltd. Shri Zakaria approached this Forum with a complaint against rejection by the Insurance Company of a claim lodged under the policy for his admission to Breach Candy Hospital from 27.03.2014 to 28.03.2014 for the treatment of Infected odontogenic cyst in mandible 5T5 impacted.

The Insurance Company vide e-mail dt. 03.08.2015 forwarded to the Forum, a scanned copy of the letter dt. 24.07.2015 issued by the complainant's treating surgeon Dr. Ashok V. Dabir stating that Biopsy of the cyst in mandible done before surgery was suggestive of Infected odontogenic cyst. After excision, the histopathological diagnosis was "Dentigerous cyst". He further stated that these cysts arise from dental lamina like many other diseases in the jaw bones. In Mr. Arif Zakaria's case, the cyst had expanded such that it could have caused a fracture, hence it was essential to perform surgery.

As per available information, a dentigerous cyst or follicular cyst is an odontogenic cyst - thought to be of developmental origin - associated

with the crown of an unerupted (or partially erupted) tooth. The cyst cavity is lined by epithelial cells derived from the reduced enamel epithelium of the tooth forming organ. Regarding its pathogenesis, it has been suggested that the pressure exerted by an erupting tooth on the follicle may obstruct venous flow inducing accumulation of exudate between the reduced enamel epithelium and the tooth crown. In addition to the developmental origin, some authors have suggested that periapical inflammation of non-vital deciduous teeth in proximity to the follicles of unerupted permanent successors may be a factor for triggering this type of cyst formation. Typically, dentigerous cysts are painless and discovered during routine radiographic examination, however they may be large and result in a palpable mass. Additionally as they grow they displace adjacent teeth. Treatment usually involves removal of the entire cyst and the associated unerupted tooth. In patients with very large lesion or who are unfit medically, marsupialisation is an option.

Exclusion clause 4.4.5 of the policy states "No claim will be payable under this Policy for Dental treatment or surgery of any kind unless necessitated by Accident and requiring hospitalization".

From the above it can be concluded that the surgery undergone by the complainant was for dentigerous cyst – odontogenic cyst which is related to formation of teeth and not caused due to any injury or accident, as rightly pointed out by the Insurance Company. Under the circumstances, in view of the express clause stipulated under the policy which excludes Dental treatment or surgery of any kind unless necessitated by Accident and requiring hospitalization, the Forum finds no valid reason to intervene with the decision of the Company and consequently, no relief can be granted to the complainant.

If this Award is not acceptable to the complainant, he is at liberty to approach any other appropriate Forum for redressal of his grievance, as deemed fit.

ORDER

The complaint of Shri Arif Zakaria against rejection by The New India Assurance Co. Ltd. of a claim lodged for his admission to Breach Candy Hospital from 27.03.2014 to 28.03.2014 for the treatment of Infected odontogenic cyst in mandible 5T5 impacted, does not sustain. The case is disposed of accordingly.

BEFORE THE INSURANCE OMBUDSMAN

(MUMBAI & GOA)

MUMBAI

Complaint No. GI- 403 of 2015-2016

Award No. IO/MUM/A/ GI- /2015-2016

Complainant : Smt. Asha Kothawala

Respondent : L & T General Insurance Co. Ltd.

Smt. Asha Kothawla who was covered under My Health Medisure Classic Insurance Policy issued by L & T Insurance Co. Ltd underwent Complex 3D decompression + PLF L4-L5 + un-instrumented fusion L3-S1 for the complaints of Lumbar Canal Stenosis + degenerative scoliosis + listhesis L4-L5 in P.D. Hinduja National Hospital & Medical Research Centre where she was hospitalized from 24.2.2015 to 2.3.2015. The claim of Rs.1,45,864/- preferred under the policy for the said hospitalisation has been repudiated by the Company on the ground that the ailment suffered by the complainant falls under waiting period of two years. Being aggrieved complainant approached this Forum for redressal of her grievance.

During hearing, Insurance Company was directed to refer the case to an independent specialist doctor and seek his opinion as to whether the

surgery was required as a consequence of fall or for degenerative/age related changes.

In response, Insurance Company forwarded to the Forum a copy of medical opinion sought by them from Dr. Apurva Patel, Consulting Orthopedic surgeon. Dr. Patel opined that : "1) Whether the present MRI report or any other medical reports confirm any injury, extent and nature of injury to spine? If yes according to you, what extent of trauma can lead to this condition? Whether degenerative changes may have contributed to this medical problem? : MRI report does not indicate any injury to the spine. The present condition as seen on the MRI is due to degenerative change in inter facetal jt between L4 & L5 due to Osteoporosis & Parkinson disease. 2) Possible cuase of Listehsis, lumbar canal stenosis, lumbar scoliasis as mentioned in the MRI report in this case ? : In this case the cause is degenerative due to Osteoporosis . Spondylolisthesis is type III (Degenerative, Secondary to articular degeneration). 3) Whether surgical procedure Complex 3D decompression + PLF L4-L5 + UN Instrumented fusion L3-S1 may be done only in cases of injury/trauma or it may be done in degenerative spine diseases? : Can be done in degenerative spine disease as well as in injury/trauma. 4) Any other relevant facts of the case that may have bearing on the possible cause of this medical problem? : History has bearing on this as degenerative disease the cause of this stenosis is progressive from Gr. I to Gr. III possibly 5-6 years".

The claim for the treatment of Lumbar Canal Stenosis + degenerative scoliosis + listhesis L4-L5 has been preferred on the first year of the Policy. Insurance Company repudiated the claim under Exclusion clause 3 which states that the Company shall not be liable to make any payment for any claim directly or indirectly caused by, based on, arising out of or howsoever attributable to all expenses along with their complications on treatment towards Osteoporosis if age related and Prolapse of Intervertibral Discs (other than caused by accident) during the first two years (24 months) of continuous operation of this Insurance cover. In the instant case, the specialist doctor has opined that the ailment suffered by the complainant was due to degenerative changes. Under the facts & circumstances, the Forum does not find any valid grounds to intervene in the decision of the Insurance Company.

In case of the Award being not acceptable to the complainant, she is free to approach any other appropriate Forum as she deems fit for redressal of her grievance.

O R D E R

The complaint of Smt. Asha Kothawala against the Insurance Company in respect of repudiation of her claim preferred under the policy towards her hospitalisaiton in P.D. Hinduja National Hospital & Medical Research Centre from 24.2.2015 to 2.3.2015 for Complex 3D decompression + PLF L4-L5 + un-instrumented fusion L3-S1 is not

sustainable. 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-1327/2014-2015

Award No. IO/MUM/A/ /2015-16

Complainant: Shri Badre Aalam Ansari

Respondent: Cholamandalam MS General Insurance Co. Ltd.

Late Smt. Noor Ayesha Badre Aalam Ansari, spouse of the complainant was covered under Health Insurance – Critical Health Line Insurance Policy issued by Cholamandalam MS General Insurance Co. Ltd. for Sum Insured of Rs. 10,00,000/-. Smt. Ansari was hospitalized to Nehru Chikitsalaya on 21.6.2013 for the complaints of Septicemia with shock with burst abd with respiratory failure with acute renal failure with lt. pneumonitis with respiratory failure with ARF with metabolic acidosis. Unfortunately, she passed away in the said hospital on 27.6.2013 due to Cardiopulmonary Arrest. When complainant preferred a claim under the policy, Insurance Company repudiated it stating that the ailment suffered by Smt. Ansari does not fall under the definition of Critical Illness. Being

aggrieved, complainant approached this Forum for redressal of his grievance.

Records were perused and parties to the dispute were heard during the personal hearing.

All the documents submitted to the Forum have been scrutinized. As per Discharge Slip of Shifa Hospital, Smt. Ansari was admitted there on 31.5.2013 with F.T.P. with Obstructed labour. She was grossly anemic and in low condition. After maintaining the vitals and arranging a few units of blood, LSCS was done on the same day and male baby was delivered. On 4.6.2013 her condition got deteriorated and on investigation, it was found that she had developed Acute Renal failure. On 5.6.2013 she was referred to higher centre i.e. Guru Shree Gorakshnath Chikitsalaya, Gorakhpur. She was diagnosed to have Septicemia with Acute Renal Failure and was treated with Hemodialysis. Thereafter, she was shifted to Savitri Hospital & Research Centre on 7.6.2013 where she was diagnosed to have "Uremic encephalopathy cause ARF cause Septicemia cause post LSCS SEPSIS and Burst Abdomen". On 21.6.2013 she was shifted to Nehru Chikitsalaya, where she succumbed to death on 27.6.2013 due to Cardiopulmonary Arrest. In the Death Certificate issued by the said Hospital, it is mentioned that she was suffering from Septicemic shock with burst abd. With Lt. penumonitis with Respiratory failure with Acute Renal failure with Mebabolic acidosis.

Let us examine the issue.

Under Section C : Critical Illness Cover – Kidney Failure requiring Regular Dialysis, the Policy has a clause to state that "End Stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (hemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out". In the instant case, it is noted that Smt. Ansari suffered from Acute Renal Failure post LSCS surgery. Hence, the ailment suffered by Smt. Ansari does not fit into the Critical Illness covered under the Policy i.e. "Kidney Failure requiring Regular Dialysis" as it covers end stage renal disease presenting as chronic irreversible failure of both kidneys to function and not Acute Renal failure. In the discharge card of Savitri Hospital, the diagnosis was clearly stated as - Uremic encephalopathy cause ARF cause Septicemia cause post LSCS SEPSIS and Burst Abdomen. Thus, going by the medical evidence on record, the Forum tends to agree with Company's contention that Smt.Ansari suffered from and died due to the post LSCS sepsis/complications. Since the policy specifically excludes the treatment arising from or traceable to pregnancy, childbirth, postpartum complications, the decision of the Insurance Company to deny the claim cannot be faulted with.

As regards the contention of the complainant that his wife died due to heart attack, it should be noted that the cause of death was "Cardiopulmonary Arrest" and not Heart Attack. Cardiopulmonary arrest is a sudden stop in effective blood circulation due to the failure of the heart to contract effectively or at all. Cardiac arrest is different from (but may be caused by) a myocardial infarction (also known as a heart attack), where blood flow to the muscle of the heart is impaired. Many non-cardiac conditions also cause Cardiac arrest. In the instant case, in the death certificate issued by the Hospital, it is clearly stated that she was suffering from Septicemic shock with burst abd. With Lt. penumonitis with Respiratory failure with Acute Renal failure with Mebabolic acidosis and there is no documentary evidence on record to indicate that Smt. Ansari suffered from Myocardial Infarction. Hence, the incidence suffered by Smt. Ansari does not fit into "First Heart Attack – of specified severity". Further, considering the fact that the ailment suffered by Smt. Ansari does not fit into the "Critical Illnesses" mentioned under the Policy, the issue of survival period is besides the point.

Under the facts and circumstances, the Forum does not find any valid reasons to intervene in the decision of the Insurance Company.

In case this award is not acceptable to the complainant, he may approach any other Forum as deem fit for redressal of his grievance.

ORDER

The complaint of Shri. Badre Aalam Ansari against the Insurance Company in respect of repudiation of his claim preferred under the Policy in respect of death of his wife in Nehru Chikitsalaya on 21.6.2013 does not sustain. The case is disposed of accordingly and stands closed at this Forum.

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BEFORE THE INSURANCE OMBUDSMAN
(MAHARASHTRA & GOA)
MUMBAI

Complaint No.GI-678 of 2014-2015
Award No.IO/MUM/A/GI /2015-2016
Complainant : Shri Bhanji Shah & Smt. Laxmiben Shah
Respondent : United India Insurance Co. Ltd.

Shri. Bhanji Shah & Smt. Smt. Laxmiben Shah were covered under Individual Health Insurance Policy bearing No.020100/48/13/97/00004039 issued by United India Insurance Ltd. for the period 24.7.2013 to 23.7.2014 for Sum Insured of Rs.2,00,000/- each. Shri. Shah lodged two separate claims under the Policy for Rs.36,663/- & Rs.38,249/- in respect of his and his wife's hospitalisation in Ashtavaidyan Thaikkattu Mooss Vaidyratnam Nursing Home from 10.2.2014 to 3.3.2014 for Granthi & Kesasada, Sandhigathavatha. Both the claims have been repudiated by M/s Raksha TPA Pvt. Ltd., TPA of the Insurance Company stating that the hospital in which the treatment was taken is neither a Government Hospital nor medical college hospital. Being aggrieved complainant approached this Forum for redressal of his grievance.

The records of the case have been perused and the parties to the dispute were heard during the personal hearing.

During hearing Insurance Company was directed to submit to the Forum : 1) The reasons and logic for settling the claims of other policyholders where the treatment is taken in the same hospital, 2) Documentary evidence to indicate that Vaidyaratnam Nursing Home is non-Government Hospital/Medical College.

In response, Insurance Company informed this Forum that the treatment from the said hospital is recognized for Government Employees but it is not a Government Hospital. Company further mentioned that the other claims have been erroneously settled by their TPA.

All the documents submitted before the Forum have been scrutinized. As per the discharge cards of Vaidyaratnam Nursing Home, the date of admission and discharge was 10.2.2014 & 3.3.2014 respectively for both Shri. & Smt. Shah. Shri. Shah had complaints of – Renal problem, difficulty to walk and stand, breathing difficulty and cough, obesity, umbellical hernia, low back pain and the final diagnosis of the Nursing Home was "Granthi". Smt. Shah had complaints of – H/o Hypothyroidism, hairfalling, pain on right shoulder elbow and wrist swelling on right hand, pain on right knee, difficulty to climb stairs, mild low back ache, cough, She was diagnosed to have – Kesasada, Sandhigathavatha.

It should be noted by the complainant that the disputes in this Forum are resolved based on the terms & conditions of the Policy on which the claim is preferred. In the instant case, Company has repudiated the claim under clause 2.1 of the Policy which states that – For Ayurvedic/Homeopathy/Unani treatment, hospitalization expenses are admissible only when the treatment is taken as in patient in a Government hospital/Medical college hospital. Company took a stand that the Nursing Home where the treatment was taken by both Shri & Smt. Shah is neither a Government Hospital nor a Medical College Hospital. Complainant also could not produce before the Forum a documentary evidence to indicate that Vaidyaratnam Nursing Home is a Government Hospital/Medical

College hospital. A copy of letter dated 25th July, 2000 addressed by Ministry of Health & Family Welfare to the Nursing Home only indicates that the said Nursing Home was empanelled by them for the treatment of Central Govt. employees and the members of their family and this does not prove that the said hospital is a Government Hospital. Under the circumstances, the decision of the Insurance Company to repudiate the claim under clause 2.1 of the policy appears to be in order.

If is also noted that neither the Insurance Company nor their TPA has examined the case in its entirety. It is noted that both Shri. & Smt. Shah were admitted in the Nursing Home during the same period. The admission was not for a specific ailment but for the bouquet of other complaints. It should be appreciated that Mediclaim Policy basically grants compensation in respect of the expenses on the treatment of the ailments where the presenting symptoms are so alarming that it requires immediate confinement in the hospital. In the instant case it is noted that both Shri. & Smt. Shah were admitted in the hospital for the age related generalized degenerative problems and had bouquet of complaints. Mediclaim policy does admit Ayurvedic treatment (if taken in Government/Medical College Hospital), but the hospital papers do not indicate that there was in fact an emergency situation requiring immediate indoor confinement in the hospital. On the contrary it was a planned hospitalisation to be treated leisurely and gradually from a chosen hospital.

Considering all these aspects and strictly in terms of the policy, the decision of the Company to repudiate the claim cannot be faulted with.

As regards complainant's contention of settlement of his claims based on the settlements of other claims by the Insurance Company in similar cases, it is be to appreciated that such decisions are not binding in any way and cases are awarded independently, based on its merits and relevant policy terms & conditions. In case this award is not acceptable to the complainant, he may approach any other Forum as deem fit for redressal of his grievance.

ORDER

The claims of Shri. & Smt. Bhanji Shah in respect of their hospitalisation in Ashtavaidyan Thaikkattu Mooss Vaidyratnam Nursing Home from 10.2.2014 to 3.3.2014 for Granthi & Kesasada, Sandhigathavatha resp. are not sustainable.

BEFORE THE INSURANCE OMBUDSMAN

(MAHARASHTRA & GOA)

MUMBAI

Complaint No. GI- 479 of 2014-2015

Award No. IO/MUM/A/ GI- /2015-2016

Complainant : Smt. Chandrika Kapadia

Respondent : The Oriental Insurance Co. Ltd.

Smt. Chandrika Kapadia, who was covered under Mediclaim Policy bearing No. 121200/48/2013/7003 issued by The Oriental Insurance Co. Ltd., for the period 9.10.2012 to 8.10.2013 for Sum Insured of Rs.4,50,000/- underwent the procedure of Vaginal Hysterectomy in Cumballa Hill Hospital and Heart Institute where she was hospitalized from 10.2.2013 to 13.2.2013. The complainant approached this Forum with a complaint against the Insurance Company regarding short settlement of her claim.

Records were perused and the parties to the complaint were heard

during the personal hearing. which was held on 29th April, 2015. Shri. Hardik Kapadia duly authorized by the complainant to appear on her behalf submitted that his mother Smt. Chandrika Kapadia was hospitalized in Cumballa Hill Hospital from 10.2.2013 to 13.2.2013. She was diagnosed to have Endometrial Hyperplasia with Polyps and underwent the procedure of Vaginal Hysterectomy. He said that for this hospitalization she had lodged a claim for Rs.1,88,855/- under the Policy and the same has been settled by the Company only for Rs.95,682/-. He said that disallowance of Rs.84,735/- from the surgeon & anesthetist's fees is not acceptable to him as these charges were levied by the hospital and they had no option but to pay the hospital bill. He requested for settlement of balance claim.

Insurance Company was represented by Smt. Hemlata Poojary, AM and she was assisted by Dr. Preeti of TPA. Smt. Poojary submitted that insured was covered for Sum Insured of Rs.4,50,000/- under the Policy and her claim of Rs.1,88,855/- in respect of Hysterectomy surgery underwent by her in Cumballa Hill Hospital has been settled by their TPA for Rs.95,682/-. She stated that the major deductions are under surgeon & anesthetist's fees under Reasonability clause of the policy. Dr. Preeti explained that the surgeon's fees of Rs.1,00,000/- and Anesthetist's fees of Rs.25,000/- are found to be very exorbitant. Against these fees, they have paid Rs.27,000/- and Rs.13,265/- resp. and disallowed the balance amounts under Reasonability clause of the Policy. Dr. Preeti explained that for the purpose of deciding the doctor's fees, they have compared the surgeons' fees charged by Kokilaben Dhiribai Ambani Hospital, Lilavati

Hospital, Bombay Hospital & Bhatia Hospital for the same procedure.

The complaint was regarding deduction of Rs. Rs.93,173/- the details of which are as follows:

Let us examine if the same are sustainable.

Sr.No	Description	Amount claimed in Rs	Amount deducted in Rs	Remarks
1	Surgeon's fees	1,00,000	73,000	Reasonability clause of the Policy. During hearing when the TPA doctor was asked whether the rates obtained by them are for the room category of Rs.4,500/-, she could not give satisfactory replies. Hence, during hearing, the Insurance Company was directed to obtain the rates of surgeon's fees for the procedure of Hysterectomy from Jaslok and Saifee Hospital for the room having rent of Rs.4,500/-. In no room available with rent of Rs.4,500/- to consider next higher room's charges. Company to re-examine the case and inform their final

				decision to this Forum within a period of 10 working days with proper data.
2	**Anesthetist's charges**	**25,000**	**11,735**	**Reasonability clause of the Policy.** **During hearing when the TPA doctor was asked whether the rates obtained by them is for the room category of Rs.4,500/-, she could not give satisfactory replies. Hence, during hearing, the Insurance Company was directed to obtain the rates of surgeon's fees for the procedure of Hysterectomy from Jaslok and Saifee Hospital for the room having rent of Rs.4,500/-. In no room available with rent of Rs.4,500/- to consider next higher room's charges.** **Company to re-examine the case and inform their final decision to this Forum within a period of 10 working days with proper data.**
3	**Non-medical**	**14,019**	**1737**	**Non-medical expenses.**

	expenses			**Company's stand sustainable.**
4	**Service charges**	**6701**	**6701**	**Not payable under the policy.** **Company's stand sustainable.**

In response, Insurance Company vide their letter dated 8th May, 2015 submitted the rates of Saifee hospital & Jaslok Hospital towards surgeon's fees and Anesthetist's fees as under :

Hospital	**Room Rent**	**Surgeon charges**	**Anesthesia**
Saifee Hospital	**Rs.6000/-**	**Rs.27,000/-**	**Rs.9,000/-**
Jaslok Hospital & Research Centre	**Rs.5,445/-**	**Rs.21,780**	**Rs.4,755/-**

Thereafter, on 12th June, 2015, Insurance Company informed this Forum that Jaslok Hospital is their TPA hospital and Saifee Hospital is their non-TPA hospital.

It should be noted by the complainant that the disputes in this Forum are resolved based on the terms & conditions of the Policy. Although, it is a fact that complainant was admitted in a hospital which she believed is the best hospital and the surgeon's fees differs from surgeon to surgeon as per his standing & competency, but it should also be noted that Mediclaim policy allows only for payment of expenses reasonably and necessarily

incurred. The Insurance Company has therefore compared the charges of Tertiary Care Hospitals and settled the claim accordingly. On comparing the data submitted by the Insurance Company post-hearing, it is noted that the fees levied by Cumbulla Hill Hospital towards surgeon & anesthetist's charges is quite exorbitant in comparison to that of Saifee Hospital for the same surgery. However, at the same time, the Forum is also of a view that the complainant has actually incurred these expenses on her surgery and generally the patients when admitted to the hospital hardly has any control over the surgeon's fees. It is further observed that the complainant had adequate Sum Insured under the Policy to cover her hospitalization expenses. Hence to be fair to both the parties and to resolve the dispute in the present matter, the Forum is of a view that it would be in order to allow 50% of the balance claim (50% of Rs.84,735/-) to the complainant towards full and final settlement of her balance claim.

In case this award is not acceptable to the complainant, she may approach any other Forum as deem fit for redressal of her grievance.

Under the circumstances, the decision of the Insurance Company is intervened by the following order :

ORDER

Under the facts & circumstances, The Oriental Insurance Co. Ltd. is directed to pay Rs.42,368/- to the complainant towards her balance claim

(surgeon & anesthetist's charges) in respect of her hospitalsiation in Cumballa Hill Hospital and Heart Institute from 10.2.2013 to 13.2.2013 for vaginal hysterectomy. There is no order for any other relief. The case is disposed of accordingly.

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BEFORE THE INSURANCE OMBUDSMAN
(MAHARASHTRA & GOA)
MUMBAI

Complaint No.GI-311/2014-2015
Award No.IO/MUM/A/ GI- /2015-2016
Complainant : Smt. Vijaya Kokate
Respondent : The Oriental Insurance Co. Ltd.

Master Shubham Kokate, son of the complainant was covered under Group Mediclaim Master Policy No. 131100/48/2012/11865 for the period 24.12.2011 to 23.12.2012 issued by The Oriental Insurance Co. Ltd. to the members of Shree Visha Shrimali 108 Jain Charitable Sanstha. Shri Kokate approached this Forum with a complaint against rejection by the Insurance Company of a claim lodged under the policy for the hospitalization of her son in Dr. Thakur's Ear Nose throat Hospital (Vedant Hospital) from 1.06.2012 to 2.06.2012 for the excision of Cholesteatoma and Tympanotomy.

All the documents submitted before the Forum have been scrutinized. It is noted that Master Subham was earlier admitted to Dr. Thakur's ENT Hospital on 16.2.2012 for adenoid operation and the claim for the said hospitalization had been settled by the Company for Rs.28,608/- under Policy No. 131100/48/12/11865. Thereafter, the child

was again admitted to the same hospital from 1.6.2012 to 2.6.2012 for (L) type I Tympanotomy with excision of Cholesteatoma. The claim preferred by the complainant under the policy towards this hospitalsiation has been repudiated by the Company vide their letter dated 9.10.2013. In the said letter Company has stated that – "As per terms of the policy, once the total claims paid touches 90% of the premium paid, the liability of the company ceases thereafter. Your claim was lodged after the out go on account of claims has crossed the 90% mark. Therefore, the insurance company is not liable for any payment under it." Complainant however contended that the policy document issued to him does not have any such condition.

On scrutiny of the documents produced on record coupled with the depositions of the parties to the dispute, it was observed that the Group Mediclaim policy issued by Oriental Insurance Co. to M/s. Shree Visha Shrimali Jain Charitable Sanstha (Trust) stipulates a condition stating "Once the total claims paid touches 90% of the premium paid, the liability of the Company ceases thereafter". Since the complainant lodged his claim after the outgo on account of claims had crossed the 90% mark, the Company rejected her claim relying on the said policy condition. The Forum observes that here the Company has related the total claims paid directly to the total premium collected for the policy. The Forum fails to understand the logic behind taking such a policy and how the insured Trust at all agreed for such a condition to be imposed in the policy. The said condition totally defeats the purpose of insurance and is also against the principles of natural justice as the insured is penalized for no fault on his

part just because his claim has occurred after the benefit restricted under the policy has been exhausted by the other beneficiaries. The Forum finds it difficult to understand that if the claims are to be restricted to 90% of the total premium, where is the insurance element in such a contract. Further, the Forum was given to understand by the Company that they have not sought the approval of the IRDA before issuing such a policy with a condition that once the total claims paid touches 90% of the premium paid, the liability of the company ceases thereafter. This Forum is of a view that this is nothing but the violation of principle of Insurance and totally defeats the purpose of Insurance. Under the circumstances, the Forum is unable to accept the stand taken by the Company and the decision of the Company is intervened by the following Order:

ORDER

The Oriental Insurance Co. Ltd. is directed to settle the claim for the admissible expenses incurred by the complainant on the hospitalization of her son in Dr. Thakur's Ear Nose throat Hospital (Vedant Hospital) from 1.06.2012 to 2.06.2012 for excision of Cholesteatoma and Tympanotomy. There is no order for any other relief. The case is disposed of accordingly.

BEFORE THE INSURANCE OMBUDSMAN
(MUMBAI & GOA)
MUMBAI

Complaint No. GI-421 of 2015-2016
Award No. IO/MUM/A/GI /2015-16
Complainant : Shri Vipul Vakil
Respondent : United India Insurance Co. Ltd.

Shri. Vipul Vakil was covered under Individual Health Insurance Policy bearing No. 1201002813P172831813 issued by United India Insurance Co. Ltd. for the period 26.8.2013 to 25.8.2014 for Sum Insured of Rs.5,00,000/-. He was hospitalized in Aastha Lifecare Hospital & Medical Centre from 22.8.2014 to 25.8.2014 for severe acute pancreatitis with impending ARDS/B/L Effusion. From this hospital he was shifted to Jaslok Hospital & Research Centre and there he was diagnosed to have Acute Necrotising Pancreatitis with Acute Respiratory Distress Syndrome and was discharged on request on 6.9.2014. Then he was admitted to BMC's KEM Hospital where he was diagnosed to have Acute Necrotising Severe Pancreatitis secondary to alcohol. When the complainant preferred a claim for Rs.5,28,374/- under the Policy towards the expenses incurred on these hospitalizations, Insurance Company invoked exclusion clause 4.6 of the Policy and repudiated the claim stating that as per doctor's consultation note, patient had h/o alcoholism since two years and the ailment suffered by him was a complication of alcohol intoxication. Being aggrieved complainant approached this Forum for redressal of his grievance.

Records of the case were perused and the parties to the dispute were heard during the personal hearing.

All the documents submitted to the Forum have been scrutinized. As per discharge card of Aastha Lifecare Hospital, Shril Vakil was admitted there on 22.8.2014 with c/o severe epigastric pain – 1 hr. back and vomiting – 2 episodes. He was diagnosed to have severe acute pancreatitis with impending/any ARDS /B/L effusion. From this hospital he was shifted to Jaslok Hospital, where he was diagnosed to have Acute Necrotising Pancreatitis with Acute Respiratory Distress Syndrome. CT Abdomen revealed – Severe necrotizing pancreatitis, bilateral pleural

effusion, splenic vein thrombosis, mild ascites. From this hospital on 6.9.2014 he was discharged on request and was admitted to KEM Hospital. In the indoor case papers of this hospital, it is mentioned as – "42 years old male patient not k/c/o major illness referred from Jaslok Hospital. H/O admission i/v/o first episode of acute alcoholic pancreatitis". As per "Pancreatitis Proforma", Shri. Vakil underwent "Open Pancreatic Necrosectomy". Against – "Addiction : Tobacco, Smoking, Alcohol", it is mentioned : (+ ve). The diagnosis was : "Acute necrotizing severe pancreatitis secondary to alcohol".

Pancreatitis is an inflammation of the pancreas, an organ that is important in digestion. There are a number of causes of acute pancreatitis. The most common, however, are gallbladder disease and alcoholism. Other causes include direct trauma, certain medications, infections such as mumps, and tumors among others. Smoking increases the risk of both acute and chronic pancreatitis. Necrotizing pancreatitis is a condition which sometimes develops as a complication of acute pancreatitis. Early complications include shock, infection, systemic inflammatory response syndrome, low blood calcium, high blood glucose, and dehydration. Respiratory complications are often severe. Pleural effusion is usually present. The question now important to consider is whether alcohol consumption is the whole and sole cause for "nacrotising pancreatitis" in the instant case. There is no doubt that alcohol is a pre-disposing factor and alcoholics are quite vulnerable and in absence of other apparent factors like gall stones, alcohol consumption may have played a dominant contributory role in causing nacrotising pancreatitis. Hence, it would be appropriate to examine the hospital papers as the same contain first and foremost information. Alcohol++, 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 recorded in hospital papers. In the instant case however it is very surprising to note that although the complainant had history of cigarette smoking and alcohol consumption the same has not been recorded in the discharge cards of Aastha & Jaslok Hospital for the reasons best known to them. This history was then revealed by the respective treating doctors at a later date. Complainant however has contended that his treating doctor in Jaslok Hospital, Dr. Sharad Shah has certified that the pancreatitis probably is not related to alcohol as Shri. Vakil was consuming very little alcohol. However, in the medical documents of KEM Hospital, against "Addiction - Tobacco, Smoking, Alcohol", it is mentioned : (+ ve) and moreover the diagnosis was : "Acute necrotizing severe pancreatitis secondary to alcohol". Exclusion clause 4.6 of the Policy empowers the Company to exclude from its scope, the expenses incurred on the treatment related to use of intoxicating drugs/alcohol. Under the facts & circumstances, the decision of the Insurance Company to repudiate the claim under exclusion 4.6 cannot be faulted with.

In case of the Award being not acceptable to the complainant, he is free to approach any other appropriate Forum as he deems fit for redressal of his grievance.

ORDER

The complaint of Shri. Vipul Vakil against United India Insurance Co. Ltd. on account of repudiation of a claim lodged by him in respect of his hospitalization in Aastha Lifecare Hospital & Medical Centre from

22.8.2014 to 25.8.2014 and in Jaslok Hospital & Research Centre from 25.8.2014 to 6.9.2014 for Acute Necrotising Severe Pancreatitis does not sustain. The case is disposed of accordingly.

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BEFORE THE INSURANCE OMBUDSMAN

(MUMBAI & GOA)

MUMBAI

Complaint No. GI-1246/2014-2015

Award No. IO/MUM/A/GI- /2015-16

Complainant: Shri Bhavin A. Desai

Respondent: Star Health And Allied Insurance Co. Ltd.

Shri Bhavin A. Desai along with his family members was covered under Family Health Optima Insurance Policy no. P/171113/01/2014/008417 for the period 30.09.2013 to 29.09.2014 for S.I. of Rs.3 lacs on floater basis, issued by Star Health And Allied Insurance Co. Ltd. Shri Desai approached this Forum with a complaint against repudiation by the Insurance Company of a claim lodged under the policy for his admission to P.D. Hinduja Hospital from 30.06.2014 to 04.07.2014 for the treatment of Infected Bursa Rt. Lateral Malleolus.

On scrutiny of the documents produced before the Forum it is observed that Shri Bhavin Desai alongwith his family members was covered with Star Health And Allied Insurance Co. w.e.f. 30.09.2009. On 30.06.2014 he was admitted to P.D. Hinduja Hospital, Mumbai with complaints of swelling in the right lateral malleolus with history of pain. He underwent wide local excision of infected bursa right lateral malleolus. As per notings in the hospital papers, patient had history of Sarcoidosis – diagnosed in the year 2001 with Lung and Renal Involvement – Renal Biopsy s/o Granulomatous tubule Interstitial Nephritis. After treatment, he was discharged from the hospital on 04.07.2014. Insurance Company denied the claim for this hospitalization on the ground that insured had not disclosed his history of Sarcoidosis while proposing for insurance to the Company while he only submitted his Chest X-ray report dt. 15.01.2009 suggestive of pulmonary TB alongwith the proposal form. The

complianant, on the other hand, argued that he had submitted his entire medical file alongwith the proposal form, but the Company's official only asked for a copy of the last medical report and accordingly collected only the Chest X-ray report dt. 15.01.2009. On perusal of the copy of the proposal form submitted by Shri Bhavin, it is seen that against the column asking for information on Medical History of any disease/illness suffered by the proposer in the past, he has mentioned "Last Report Xerox attached".

As far as the duty of disclosure is concerned, it is certainly the duty of a person to reveal all the important facts about the health status and pre-existing conditions, if any of the person to be insured while proposing for insurance as it is this information furnished in the Proposal Form which forms the basis of the contract of insurance between the Company and the insured person. Insurance contracts are governed by the principle of utmost good faith which requires both parties of the insurance contract to deal in good faith and in particular it imparts on the proposer a duty to disclose all material facts which relate to the risk to be covered. In the instant case, the insured had submitted a copy of the last medical report alongwith the proposal form, which was suggestive of positive existence of some disease viz. Pulmonary TB. In such an event it was the duty of the Insurance Company to ask for the previous papers to elicit the full medical history of the person. The Forum is of the view that by not doing so, the Company has chosen not to go deeper into the issue but to accept the proposal on the basis of whatever minimum documents provided to them. Besides, Shri Desai has not mentioned in the proposal form that he was not suffering from any disease and therefore having accepted the proposal on the basis of incomplete information/ documents, denial of the claim now by pleading that there was misrepresentation/non-disclosure on the part of the insured is not acceptable to the Forum. If the Company has equally erred in underwriting the proposal, the benefit of doubt in such a case will go in favour of the complainant since the Company has failed to establish their stand. The decision of the Company is therefore intervened by the following Order:

ORDER

Star Health And Allied Insurance Co. Ltd. is directed to settle the claim of the complainant Shri Bhavin A. Desai for the admissible amount of expenses incurred on his admission to P.D. Hinduja Hospital from 30.06.2014 to 04.07.2014 for the treatment of Infected Bursa Rt. Lateral Malleolus. There is no order for any other relief. The case is disposed of accordingly.

OFFICE OF INSURANCE OMBUDSMAN

MUMBAI METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE & GOA

Complaint No. GI-141/2015-16

Award No. IO/MUM/A/GI- /2015-16

Complainant: Mr Sharad B Nemani

Respondent: United India Insurance Co.Ltd.

Mr Sharad B Nemani is covered under Individual Mediclaim Policy No: 120300/48/12/36/00000230 for the policy period from 20.01.2013 to 19.01.2014 since 2011. The insured was admitted at Breach Candy Hospital on 30th August,2013 for severe neck pain and back pain and was discharged on 01.09.2013. MRI of spine and brain done on 30th August,2013. The Company repudiated the above claim under Policy Clause 2.3 hospitalization not justified as the same could have been done on OPD basis.

Mr Sharad B Nemani the complainant appeared and deposed before the Ombudsman in the joint hearing with the Company held on 8th October,2015 at 03.30 pm. The complainant has represented in his written statement that he is not agreeable with the decision of the Company.

The Forum asked the complainant to brief about his case. The complainant submitted that he was suffering from severe neck and back pain since so many years and his treating doctor Dr Ashwin B Mehta Cardiologist advised

him to get admitted at Breach Candy Hospital as it was difficult for him to manage the pain.

The complainant further submitted that as he was afraid of going inside the MRI machine and he is also a heart patient and therefore he was given anesthesia to undergo the above test which could not have been done on OPD basis.

The Forum asked the Company the reason for their denial. The Company submitted that patient was admitted at Breach Candy Hospital under Dr Ashwin B Mehta Cardiologist and only MRI of spine and brain done and no other active line of treatment was administered in the hospital. The Company also submitted that though anesthesia was given for the above test, it could have been done on OPD basis. The Company also stated that there is no notings of Orthopedic doctor of Dr Tanna in the indoor hospital papers.

The Forum therefore directed the Company to take a clarification from M/s Breach Candy Hospital with necessary NOC from the complainant on the following points :

1) **the need of admission in the hospital for MRI of spine and brain.**
2) **the reason for no notings of Orthopedic doctor Dr Tanna in the hospital papers.**

However, the Company vide their letter dated 9th December,2015 have submitted the indoor case papers of the hospital without obtaining any clarification from the hospital sought by this Forum.

The Forum observes in this case that the presenting symptoms of the patient during admission was only neck and back pain as per hospital records. The patient was mainly admitted for MRI test of spine and brain the reports were also normal and this could have been done on OPD basis and hospitalization not justified.

Therefore Company's denial on the ground of Policy Clause 2.3 which reads as under as this treatment could have been done on OPD basis cannot be faulted with : "Procedures/treatments usually done in out patient department are not payable under the policy even if it is converted as an in patient in hospital more than 24 hours. The patient could have been managed on OPD basis.

Though the Forum is able to appreciate the concern of the complainant in this regard, but it has also to be borne in mind that whenever any dispute arises, it is settled based on the terms & conditions of the policy under which a claim has arisen since these form the very basis of the contract between the parties.

The Forum therefore do not find any good ground to intervene with the same and pass the following Order. If this Award is not acceptable to the complainant, he is at liberty to approach any other Forum, as he may deem fit.

ORDER

The complaint of Mr Sharad B Nemani against United India Insurance Co.Ltd. for repudiation of his hospitalization claim for treatment of neck and back pain at Breach Candy Hospital from 30.08.2013 to 01.09.2013 does not sustain. The case is disposed of accordingly.

OFFICE OF INSURANCE OMBUDSMAN

MUMBAI METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE & GOA

Complaint No. GI-345/2014-15

Award No. IO/MUM/A/GI- /2015-16

Complainant: Mr Baburao V Patel

Respondent: Star Health & Allied InsuranceCo.Ltd.

Mr Baburao V Patel is insured under Senior Citizen Red Carpet Policy No: P/171114/01/2012/011580 for the period from 06.01.2012 to 05.01.2013 along with his wife Ms Chhaya B Patel. Ms Chhaya B Patel was admitted at P D Hinduja Hospital from 04.12.2012 to 15.12.2012 for left sided Empyema and underwent decortication which means surgical removal of fibrous peel that covers the lungs in third stage Empyema.

Discharge summary of P D Hinduja Hospital showed history of Diabetes Mellitus since 6 months, Non cardiac chest pain, known case of hypertension and diabetes, underwent hysterectomy in 1993, Hemithyroidectomy in 2003, passing recurrent stones in urine in the past. The Company has repudiated the above claim under policy condition no 7 Non disclosure and refunded the premium and the policy was also cancelled.

Mr Bhawesh Baburao Patel son of Mr Baburao V Patel duly authorized by him appeared and deposed before the Ombudsman in the joint hearing

with the Company held on 20th April,2015 at03.30 pm. The complainant represented that he is not agreeable with the decision of the Company and requested for settlement.

The Forum asked the complainant the reason for his grievance. The complainant submitted that his mother Ms Chhaya B Patel was admitted at P D Hinduja Hospital for left sided Empyema. The Forum asked the complainant whether they had disclosed patient's history to the Company at the time of taking insurance. The complainant submitted that when he had gone to the Office of Insurance Company his proposal form was filled up by an Agent and he was given to understand that any ailment or injury with signs or symptoms diagnosed and or received medical advice or treatment within 48 months prior to the inception of first policy. All these diseases were prior to 2006 and therefore he did not disclose the same. The complainant also submitted that the above policy had a waiting period of 12 months for all pre existing diseases.

The complainant also stated that his above claim arose in the second year of policy and he was charged loading of premium on the 3rd year renewal. After rejection of his claim and with continuous follow up the premium was refunded to him and the policy was also cancelled. The complainant had another policy with New India Assurance Company Limited and he had requested Star Health to return all his original papers after rejection of claim, so that he can claim the same from New India. However they returned all the documents in duplicate duly stamped and was insisting the complainant to give in writing that he is withdrawing the complaint.

The Forum asked the Company the reason for their denial. The Company submitted that patient was admitted for treatment of left sided Empyema and underwent decortication.

Discharge Summary of P D Hinduja Hospital history showed Diabetes Mellitus since 6 months, Non cardiac chest pain, known case of hypertension and diabetes, underwent hysterectomy in 1993, hemithyroidectomy in 2003, passing recurrent stones in urine in past and therefore they repudiated the above claim under policy condition no 7 Non disclosure and refunded the premium and cancelled the policy. The Forum asked the Company to show the original proposal form to which the Company replied that as in their Godown theft had taken place and the same is reported to police and therefore they are not in a position to submit the same. The Forum asked the Company the reason for not returning the original claim documents after rejection of claim to which the Company replied that written request was not made by the complainant.

The Forum observed that in the above case the patient had history of pre existing ailments before inception of policy, however the original/copy of proposal form is not submitted to the Forum. The Company is now directed to return all the original claim documents to the complainant the next day itself to enable him to get his claim from New India Assurance Co.Ltd.

The Forum asked the Company if the complainant would have disclosed her history at the time of taking insurance, what would be their stand to which the Company replied that they would not have issued this policy. The Forum asked the Company to produce a letter from their underwriting section to this effect.

Accordingly the Company vide their letter dated 21st April,2015 have submitted to the Forum as under :

1) **It is evident from the submitted records, that the insured patient is a known case of hypertension since 5 years, diabetes mellitus from 2006, gastroesophageal reflux disease from 2006, bilateral renal calculi since 3-4 years before 2006. osteoporosis from 2005, hypertryglyceridemia from 2003, nodular hyperplasia thyroid and underwent hemithyroidectomy during 2003, and hysterectomy in 1993. We have rejected the said claim 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".

2) **The point to be noted is this in respect of person whose proposals have been accepted for insurance. Acceptance or rejection of a proposal is an underwriting decision taken by the Insurer based on his assessment of the risk in question.**
3) **To assess the risk the most important input is the information provided by the proposer in the Proposal Form. Therefore the information provided in the Proposal Form and the failure to provide such information affects this assessment of risk. Had the information been provided in the Proposal form at the time of effecting insurance, the cover would have been declined. So in effect the effect of non disclosure is "Insurance" or "No Insurance".**

4) **It is an undeniable fact that by non disclosure the insured has deprived us of the right to do a proper assessment of risk (if declared by the proposer in the proposal form, that we would have actually refused him cover).**

The Forum observes that the insured Ms Chhaya B Patel was admitted at P D Hinduja Hospital for left sided Empyema . Hospital Discharge summary revealed history of Diabetes, hysterectomy, hemithyroidectomy, passing recurrent stones in urine in the past. The complainant had submitted during the hearing that his proposal form was filled by an Agent and he was given to understand that any ailment or injury with signs or symptoms diagnosed and or received medical advice or treatment within 48 months prior to the inception of first policy. As all these diseases were prior to 2006, he did not disclose the same. The Forum also notes that in the proposal form questionnaire of the Company there are two columns in the Medical History one is Any disease or any illness sustained preceding 12 months from date of proposal and the second one is Beyond preceding 12 months from date of proposal. The insured has not declared anything in the column Medical History at the time of taking insurance. Therefore the Company's denial of above claim under policy condition no 7 which reads as "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" cannot be faulted with.

Though the Forum is able to appreciate the concern of the complainant in this regard, it has also to be borne in mind that whenever any dispute arises, it is settled based on the terms & conditions of the policy under

which a claim has arisen since these form the very basis of the contract between the parties.

The Forum therefore do not find any good ground to intervene with the same and pass the following Order.

If this Award is not acceptable to the complainant, he is at liberty to approach any other Forum, as he may deem fit.

ORDER

The complaint of Mr Baburao V Patel against Star Health & Allied Insurance Co. Ltd. in respect of repudiation of his hospitalization claim of his wife Ms Chhaya B Patel at P D Hinduja Hospital from 04.12.2012 to 15.12.2012 for left sided Empyema and underwent decortication does not sustain. The case is disposed of accordingly.

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OFFICE OF INSURANCE OMBUDSMAN

MUMBAI METROPOLITAN REGION EXCLUDING NAVIMUMBAI & THANE & GOA

Complaint No. GI-498/2015-16

Award No. IO/MUM/A/GI- /2015-16

Complainant: Ms Shubhangi Shankar Dhadke

Respondent: Oriental Insurance Co.Ltd.

Ms Shubhangi S Dhadke is covered under Group Mediclaim Policy issued to M/s L & T Infotek bearing Policy No: 530000/48/2015/375 A/c – Ms Shubhangi Dhadke S R No 10610681 for the policy period from 1.10.2014 to 30.09.2015 for a sum insured of Rs.100000/- on floater basis. Ms Shubhangi was admitted at Swarna Child Care Hospital from 30.10.2014 to 10.11.2014 for Enteric fever with Hepatitis and lodged claim of Rs.58166/- on the Company. The Company conducted investigation and based on the Investigation Report there were certain discrepancies and therefore repudiated the above claim on the ground of Policy Clause 5.9 Fraud/Misrepresentation.

Ms Shubhangi Shankar Dhadke the Complainant along with her father Mr Shankar G Dhadke appeared and deposed before the Ombudsman in the joint hearing with the Company and TPA held on 17th December,2015 at 11.45 Am. The complainant has represented in her written statement that she is not agreeable with the decision of the Company.

The Forum asked the Company the reason for the above denial. The Company submitted that they had conducted investigation and based on the Investigation Report certain discrepancies were found out by them such as Leave record of the complainant received from L & T showed that Ms Shubhangi was present on 30th and 31st October,2014, total bill amount in IPD register it is mentioned as Rs.44166/- whereas the submitted hospital bill shows amount as Rs.58166/-. In the indoor case papers RMO Dr Krantiveer and Dr Achut both of them have taken daily round and treating doctor Dr B G Ranpise has not attended the patient and the hospital has charged Consultation charges of Dr B G Ranpise.

The Company further submitted that no consulting pathologist was attached to the Lab. Some of the pathological reports are not signed by the doctor. The Forum asked the Company whether they have asked the hospital the reason for keeping the patient in the hospital for almost twelve days to which they replied No.

The Forum asked the complainant the reason for discrepancy in her Leave record to which the complainant submitted that it is rectified by their HR Department and the proof of the same will be submitted. The Forum asked the complainant the reason for getting admitted in a Childcare hospital that too in Kharghar when she is residing in Mahim to which she replied that she has been going to this doctor at this hospital since childhood as she had fever problem.

The Forum observes lot of anomalies in this case and seek clarification both from the Company and the complainant detailed hereunder and submit to the Forum within a period of ten working days.

The complainant is directed to submit the Forum the evidence of rectification of her Office leave records by the authorized person in HR Department of L & T Infotech Company.

The Company was directed to seek clarification from the hospital with the consent of the insured on the following :

1) **the reason for difference in the hospital bill of Rs.58166/- submitted by the patient with the copy of their bill in their record for Rs.44166/-.**
2) **how consultation charges of Dr B G Ranpise is billed in the hospital bill when his name is not there in the indoor case papers?**
3) **the reason for admitting the patient for twelve days and the line of treatment given to her with evidence.**
4) **whether Swarna Laboratory was attached to this hospital and the reason for not signing the pathology reports by a doctor?**

On getting the above clarifications from the hospital authorities and also from the complainant, the Company was directed to revisit the above claim and submit their views to this Forum.

Accordingly the Company has submitted the following clarifications from the hospital dated 31st December,2015 which reads as under :

1) Amount of Rs.44166/- does not include the consultation charges of Dr B G

Ranpise i.e. Rs.14000/- Hence the difference.

2) **This patient Ms Shubhangi was admitted by Dr B G Ranpise himself and said advise of hospitalization is mentioned in OPD paper. This is a small Nursing Home and only Dr P S Moralwar and I admit patients here hence we do not have to specify the consultant. However my name is reflecting on admission paper.**
3) **Patient was admitted for 12 days because it took more time for the defervescence. The necessary text book references will be provided if required.**
4) **Swarna Laboratory is a hospital attached clinical laboratory hence signing of reports by pathologist is not mandatory. Necessary GR will be sent if required, However a pathological report i.e. blood culture is signed by the Pathologist.**

Besides the above clarifications received from the hospital, the Company has submitted their views detailed as under :

1) **Though the complainant has submitted a mail copy received by her stating that leave records corrected by HR, there is no proper evidence in the form of letter from HR of L& T Infotek.**
2) **Dr Ranpise has never treated the patient during hospitalization of 12 days and he justifies the stay of the patient for 12 days citing defervescence (abatement of a fever as indicated by decrease in body temperature). As per the indoor case papers only RMO's have taken daily rounds.**
3) **The difference amount of Rs.14000/- is not justified as the hospital chart shows consultancy charges of Rs.1000/- per day for 12 days amounts to Rs.12000/-.**

4) **The justification given that the patient was admitted by Dr B G Ranpise himself along with Dr P S Moradwar does not prove that Dr Ranpise has treated the patient. If he had treated the patient and given his advise on daily basis then surely his name would have been mentioned in the indoor case papers and the RMO's would have acted as per his advice.**
5) **Though Swarna Laboratory is a hospital attached Clinical Laboratory but the reports need to be signed by a qualified Pathologist in all hospitals.**

The Forum observes serious discrepancies such as in the leave records of the patient, discrepancy in the hospital bill amount, consultation charges of Doctor, the reason for such a long admission and the line of treatment given in the hospital. Neither the complainant nor the Insurance Company has produced conclusive documentary evidence to prove their stand points. It is felt that before arriving at a final conclusion in the matter, Insurance Company should have carried out detailed investigation in the matter. Company should have made thorough enquiries with the hospital authorities who were present at the material time. It is thus felt that on the basis of documents submitted by both the parties this Forum is not in a position to pass a fair judgement on this complaint. In order to probe further in this case, detailed investigation and examination of third parties viz. hospital authorities and the persons present during mishap is required, which cannot be resorted to by this Forum as it is empowered with only limited powers. Moreover to deal with this case, more evidences will be needed which require witnesses, summon them for deposition and ask for various evidences including cross examining outside parties, therefore it cannot be decided in a summary proceeding under the RPG Rules 1998 in view of limited authority of this Forum.

In view of this, the complaint stands dismissed from this Forum with a liberty to the complainant to approach any other Forum, she deems fit for redressal of her grievance. The case is disposed of accordingly.

BEFORE THE INSURANCE OMBUDSMAN

(MUMBAI & GOA)

MUMBAI

Complaint No. GI-234/2014-2015

Award No. IO/MUM/A/GI- /2015-16

Complainant: Dr. Puneet Mehrotra

Respondent: The New India Assurance Co. Ltd.

Complainant Dr. Puneet Mehrotra alongwith his spouse and son was covered under Individual Mediclaim Policy No.142000/34/11/01/00012997 for the period 09.03.2012 to 08.03.2013 for Sum Insured Rs.5,00,000/- each plus C.B., issued by The New India Assurance Co. Ltd. Dr. Puneet approached this Forum with a complaint against repudiation by the Insurance Company of a claim lodged under the policy for Surface abilative laser procedure in the left eye undergone by his son Mast. Krish Mehrotra at Mehta International Institute, Mumbai on 27.12.2012.

All the documents submitted before the Forum have been scrutinized. As per the Ophthalmic Report, Mast. Krish Mehrotra, aged 5 yrs was seen by Dr. Dr. Keiki R. Mehta, M.S. (Opth.) on 22.12.2012 with vision of 6/60+ in his left eye and 6/6 in his rigt eye with gross difficulty in fusion, virtually no steropsis with tentative diagnosis amblyopia in his left eye. He was advised to undergo Wavefront PRK procedure at the earliest as a technique to enhance his vision and help in fusion. Accordingly, he underwent Excimer Laser Advanced Surface Ablation technique using the Schwind AMARIS Laser using the ORCA Wavefront guided technology in his left eye on 27.12.2012 at Mehta International Eye Institute. The claim for the same was denied by the Insurance Company stating that the patient was admitted for high myopia, but the refractive

error was not high; hence it was a cosmetic surgery not payable as per Exclusion Clause 4.4.2 of the policy.

Amblyopia, or lazy eye, refers to a unilateral or bilateral decrease of vision. It is a problem caused by an underdeveloped optic nerve that results in the brain favoring one eye over the other. Both eyes must receive clear images during the critical period. Anything that interferes with clear vision in either eye during the critical period (birth to 6 years of age) can result in amblyopia (a reduction in vision not corrected by glasses or elimination of an eye turn). Amblyopia, the leading cause of unilateral visual impairment in children, is caused by inadequate stimulation of the visual system during the sensitive periods of visual development in childhood. It is the eye condition noted by reduced vision not correctable by glasses or contact lenses and is not due to any eye disease. The brain, for some reason, does not fully acknowledge the images seen by the amblyopic eye. This almost always affects only one eye but may manifest with reduction of vision in both eyes. It is estimated that three percent of children under six have some form of amblyopia. The most common causes of amblyopia are constant strabismus (constant turn of one eye), anisometropia (different vision/perception in each eye), and/or blockage of an eye due to trauma, lid droop, etc. If one eye sees clearly and the other sees a blur, the good eye and brain will inhibit (block, suppress, ignore) the eye with the blur. Thus, amblyopia is a neurologically active process. The inhibition process (suppression) can result in a permanent decrease in the vision in that eye that can not be corrected with glasses, lenses, or lasik surgery. Early detection and treatment offer the best outcome. If not detected and treated early in life, amblyopia can cause a permanent loss of vision with associated loss of stereopsis (two eyed depth perception). Most vision loss is preventable or reversible with the right kind of intervention.

In the instant case, Mast Krish was also detected of unilateral amblyopia with gross difficulty in fusion, virtually no steropsis and was advised to go in for Wavefront PRK procedure to enhance the vision in his left eye. As can be noted from the above information, if not corrected timely, it could lead to permanent decrease in vision with loss of steropsis which cannot be corrected with glasses, lenses or lasik surgery. Early surgery and intense postoperative amblyopia therapy can result in good visual acuity. In view of the same, I am unable to agree with the Company's contention that the treatment undergone by Mast. Krish was for cosmetic purpose. The decision of the Company therefore to repudiate the

claim citing Clause 4.4.2 of the policy does not sustain and is intervened by the following Order:

ORDER

The New India Assurance Co. Ltd. is directed to settle the claim of the complainant Dr. Puneet Mehrotra for the admissible expenses incurred for Surface abilative laser procedure in the left eye undergone by his son Mast. Krish Mehrotra at Mehta International Institute, Mumbai on 27.12.2012. There is no order for any other releif. The case is disposed of accordingly.

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NOIDA

MEDICLAIM

RUCHIR VERMA VS. STAR HEALTH

- **Complainant was insured with UIIC for 2 years and subsequently with Star Health for next 2 years. In the 4th year he was hospitalised for Recurrent bilateral varicose veins.**

- **The insurance company rejected the claim on the ground that the disease was pre-existing but the insured had not disclosed the medical history in the proposal form. Insured had undergone treatment for pre-existing disease in the third year of insurance which is admissible only on completion of four years from inception of policy.**

- **Complainant argued that the disease does not fall under the definition of pre-existing diseases since treatment of the said disease was taken more than 4 years prior to commencement of the policy.**

- **The Insurance company have not correctly interpreted the definition of pre-existing disease which pertains to disease contracted within 48 months prior to inception of policy. In this case the treatment of Varicose veins was done more than 48 months prior to inception of policy. Hence insurance company directed to pay the admissible claim amount to the complainant.**

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KAILASH CHANDRA GUPTA VS.NEW INDIA ASSURANCE

- **Complaint's wife was hospitalised for Psoriatic Arthritis and treated with infusion of Remicade Injection.**
- **The Insurance Company rejected the claim on the grounds that the expenses related to the ailments are excluded from the scope of the policy and as per internal circular of the insurance company Injection Remicade is not payable.**
- **Complaint contended that claim for similar treatment was approved and paid for similar hospitalization just two months prior to this case.**
- **Insurance company cannot repudiate claims on basis of internal circulars and guidelines and have to follow only printed terms and conditions of policy besides being consistent in their acceptance or denial of a treatment/medicine. Hence insurance company directed to pay admissible claim amount to the complainant.**

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MR. AJAY JAIN VS APOLLO MUNICH HEALTH INSURANCE

- **The complainant's wife Mrs. Poonam Jain suffered a fall in her house and was admitted to the hospital. Her X-ray revealed fracture in the backbone.**

- **The insurance company rejected the claim stating that the fracture was due to osteoporosis which was not covered as per policy terms and conditions. They claimed that there is no mention of fall. The complainant has provided documents which shows that the fracture was due to fall and detection of osteoporosis which is anyway age related disease came to notice during treatment of the patient.**

- **The basic dispute is whether fracture was due to fall or osteoporosis. The policy was given after thorough medical examination. From records, it is seen, the fact of fall was first recorded at Aligarh hospital which also finds mention in later documents. It appears the insured suffered fracture due to fall as recorded in doctor's prescription at Jeewan Jyoti Hospital & Research Centre, Aligarh and OPD card of Indian Spinal Injuries Centre, Delhi.**

- **The Insurance Company was not correct in rejecting the claim on the ground of old age related disease osteoporosis. The policy was given when the claimant was certainly not young and if it was given / renewal at a mature age of 60, the Insurance Company should have also known that she could have osteoporosis which as they themselves admit is a age – related degeneration of bones & joints. The Insurance Company is directed to pay the admissible claim amount to the complainant.**

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SH. AYUSH AGARWAL VS THE ORIENTAL INSURANCE CO. LTD.,

- **The complainant's daughter Ms Aashi Agarwal was admitted in the hospital with complaints of seizure disorder and episode of vomiting. Cashless request form mentioning that she is a patient of seizure since the year 2000, was submitted by the hospital to TPA. Pre Authorization approval for Rs. 15,000/- was given by the TPA. The insured was treated and discharged on 03-07-2013. The discharge summary mentions the patient to be known case of seizure disorder with final diagnosis as Generalized seizure with Right Parietal calcified spot.**

- **The claim was rejected by the Insurance Company stating that "expenses related to pre-existing ailments are not payable for first four years of policy since inception" (known case of seizure since 2000 & Policy since 2010).**

- **The complainant's main argument is that since the Insurance Company had initially considered their claim, there was no basis for denying it at later stage. The Insurance Company stated that they had misread the year 2000 as 2 years and had repudiated the claim on the ground of pre-existing diseases. However, in their SCN and other letters, they appear to have closed the claim not on the ground of pre-existing disease but on the ground of non-submission of documents. The insurance company to collect the original documents from the complainant and pay the admissible amount to the complainant.**

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SRI SAMEER BHATNAGAR VS APOLLO MUNICH HEALTH INSURANCE CO. LTD.

- **The complainant had a mediclaim policy with the National Insurance Company Ltd., since twelve years for an insured sum of Rs. 5 lacs. In 2012, Apollo Munich Health Insurance Company, he ported his mediclaim policy to Apollo Munich from 16-06-2012 for the same insured sum of Rs. 5 lacs. The policy further was renewed for the next 2 years without any break. At the time of porting the policy, he filled up a proposal form as required by the Insurance Company and as per the underwriting process of the Company, the complainant was subject to medical examination, based on the information given in the proposal form by the insured. No adverse medical history was mentioned by the complainant or the doctor in the proposal form and medical examination report.**

- **On 06-07-2014, the complainant was hospitalized for chest pain and breathlessness since seven days. Pre Authorization Form for cashless facility sent by the hospital to the Insurance Company mentioned history of spontaneous pneumothorax / consolidation in 2009. past treatment records and investigation report in support of diagnosis, revealed that the insured was hospitalized in 2009 and was diagnosed as a case of persistent pneumothorax and consolidation of Lt. Lung. Since these facts about the insured's health and treatment were not disclosed by the insured at the time of taking the policy, the company served a notice of 30 days to the insured for cancellation of the policy on account of suppression of material facts. On completion of the notice period, the policy was cancelled and cashless claim rejected due to non disclosure of facts under section 5 (u) of the policy terms and condition.**

- **The Insurance Company stated that the complainant being an agent was aware of policy terms and conditions and portability conditions. He had replied in the negative to specific questions (No. 3 & 4) raised by the doctor during medical examination as to whether he had received any medical advice or treatment or hospitalized in the past five years or suffered from shortness of breath. The Complainant contends that his**

policy cannot be considered as new one since he had ported his policy from National Insurance Company and he should enjoy all the benefits with continuity.

- **Portability of policy was not disputed. It is understood that when portability is allowed, the respective Insurance Companies share the details of past history of the policy holder also. Hence, even if it is accepted that earlier and new ailment are one and same, it stands covered by policy since the policy is to be considered in continuity. Thus the cancellation of complainant's son's policy was arbitrary and incorrect. Therefore insurance company directed to pay the admissible claim amount to the complainant and restore the policy of the son.**

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