GENERAL INSURANCE---AWARDS--- MEDICLAIM-CASES 1-10-2014 TO 31.3.2015

AHMEDABAD

Case No. AHD-G-049-1314-0712
Mr. Urvil T. Modi Vs. The New India Assurance Co. Ltd.

Award dated 24TH November,2014
Repudiation of P.A Mediclaim

The Complainant had submitted that during his visit to Kerala - Kovalam Beach, due to heavy wave in sea, he had sustained injury to his Rt.Knee. Since he was returning back Ahmedabad by evening train on the same day and as he was not feeling much difficulty, as such he had not taken any treatment at Kovalam. After arrival at Ahmedabad, he had consulted his family Physician Dr. Sudhir Modi, Ahmedabad for treatment on 30/11/2012.

As there was no relief and reduction in pain, and as per family doctor's the advice of his physician he had consulted Orthopedic Dr. Dipak Patel on 15/12/2012, X-ray was carried out, and treatment was started, however no facture was seen.

During last week of Dec-2012, he was out of station for his office work.

As there was no relief in pain, he again consulted Dr. Rajendra Patel (Ortho) and he was advised for X-ray and M.R.I. (Dr. Dipak Patel had also advised for M.R.I.) earlier.

M.R.I Report dated 20/03/2013 revealed that there was injury in right knee ligament, which could not been traced in X-ray. As per both doctors' advice, he was operated by Dr. Sanjay Trivedi on 16/04/2013. After discharged he was advised to report for follow up and subsequently consulted his doctor on 22/04/2013,29/04/2013,

and 13/05/2013, and then he also undergone the treatment of physiotherapy from Dr. Mona Raval from 15/05/2013 to 04/06/2013 and was rested up to 19/07/2013.

Claim was registered with insurance company on 18/04/2013 after the operation and all the required documents were provided for settlement of the claim.

Respondent had repudiated the claim vide letter ref. CLAIMHUB: 42/164/2013 dated 10/06/2013, with a reason that as per the Personal Accident policy terms and conditions clause no. 1 " upon the happening of any event which may give rise to claim under this policy , written notice with full particulars must be given to the company IMMEDIATELY "

The complainant has undergone the knee surgery after the MRI. The personal accident policy is to compensate as per the policy conditions for the number of days of loss sustained by the policy holder. The respondent had repudiated the claim stating that the intimation was delayed & the claim should have been lodged immediately on sustaining the injury and not on the date of operation/surgery. Whereas the complainant had claimed for the loss of his income post operation from the period 16/04/2013 to 21/07/2013.

Under the circumstances, the insurer should have referred the IRDA Circular No. IRDA/HLTH/MISC/CIR/216/09/2011 Dated 21/09/2011 on delayed claim. The respondent had not called explanation from the complainant for delay in lodging his claim.

The insurer had brought to our notice/attention the discrepancy as to the nature of accident in the two certificate dated 02/04/2013 issued by one Dr. Dipak Patel stating vehicular accident, two wheeler & another by Dr. Sanjay Trivedi of Gayatri hospital stating

the injury at Kovalam. He had stated that it was aggravated by a fall from the two wheeler. We observed that ACL tear was diagnosed on 20/03/2013 by M.R.I. i.e. before alleged vehicular accident.

Ex-gratia amount of Rs.12,000/- was awarded.

Case No.AHD-G-050-1314-0718

Mr. Arvind B Patel Vs. The Oriental Insurance Co. Ltd.

Award dated 19th November, 2014

Repudiation of Mediclaim

The Complainant had submitted that he had undergone Cataract operations on 09.07.2013 & 16.07.2013 & incurred total expense of Rs. 51,392/-. His claim was repudiated by the Respondent on the ground that there was a break in the Policy & Cataract claims are entertainable only after 24 months, provided policy has run continuously with the Respondent. The Complainant submitted that he had taken Oriental Royal Mediclaim Policy through Punjab national bank. He had been paying the premium regularly. First premium he remitted was for the Policy period 01.03.2011 to 29.02.2012. Towards second year renewal premium, he had given the cheque to the Punjab National Bank, Sola Road on 29.02.2012, for which he had enclosed the Bank's confirmation letter for verification.

From the name of the Policy itself it is very evident that there was a tie up between the Respondent & Punjab National Bank for Mediclaim Policy. It is the nationalized bank which had confirmed the receipt of premium cheque on stipulated date on behalf of the Company.

The Insurer has relied on Clause No. 4.2 of the Policy wherein Cataract is not covered for 2 years. However the 2013-14 Policy was also renewed without a break. The Claim had thus fallen in the third policy year.

Rs. 10,000/- as Ex-gratia in view of the certificate given by the bank that the premium was received on 29.02.2012 i.e on the date of expiry of the old policy.

Case No.AHD-G-048-1314-0728

Mr. Rajnibhai A Seth Vs. The National Insurance Co. Ltd.

Award dated 22nd November, 2014

Repudiation of Mediclaim

The Complainant submitted that he had chest pain recently. Firstly the cashless authorization was refused & on submission of claim representation to the Comapany's grievance cell he received mail from Company's TPA informing that the claim was not payable as same was reported within 3 years from the date of the commencement of the policy, with their remark that the patient is a known case of hypertension since June,2009 & it was a pre-existing disease that is prior to the coverage with the National Ins. Company. The Complainant submitted that it was not pre-existing as he had not suffered from this ailment earlier.

The Complainant had not disclosed the history of Hypertension since June,2009 in Proposal Form while applying for the Mediclaim cover. He had replied in negative to specific question asked for existing disease/illness/injury.

In the Discharge Summary of SAL Hospital it was clearly mentioned in clinical history that the Complainant was having hypertension since June, 2009. The Complainant's argument that current ailment has nothing to do with hypertension does not stand as hypertension is a factor in coronary artery disease & it is medically proven fact.

The complaint was Dismissed.

Case No.AHD-G-049-1314-0731

Mr. Tushar Mehta Vs. The New India Assurance Co. Ltd.

Award dated 20th November, 2014

Repudiation of P.A

The Complainant submitted that he was insured with the New India since last 6-7 years. His Wife Kalpanaben had met with an accident

while going on a two wheeler, Activa on 14.03.2013. She was advised 2 weeks rest by the Doctor. On intimation to the Respondent, the Doctor of the Respondent also visited & enquired with the Complainant's spouse about the accident. The claim was lodged for 2 weeks TTD which was repudiated by the Respondent on the ground that the Complainant's spouse was not covered under the Policy. He did not know how his wife's name was deleted from the last policy.

The Company was directed to make the payment of Rs. 1000/- i.e 2 weeks TTD, as the Complainant had not given anything in writing to exclude the cover of his wife. Moreover the proposal form was not filled & signed by the Complainant. Insurer's representative confirmed that they had sent copy of the Previous Policy as renewal notice & on the copy of the policy the name of the Complainant's spouse was deleted alongwith other corrections. The issuance of the policy based on such corrections was incorrect.

Case No. AHD-G-049-1314-0734

Mr. Manoj Jayantilal Nayak Vs. The New India Assurance Co. Ltd.
Award dated 24TH November,2014
Partial Settlement of Mediclaim

Due to abdominal pain, Harshaben M. Nayak, wife of complainant had consulted a doctor for the first time, the doctor had started the treatment after carrying out certain pathological test. She was diagnosed with Uretic stone and acute colic.

She was admitted in Astha Hospital Ahmedabad for the treatment of abovementioned disease from 05/06/2013 to 07/06/2013, & the operation was performed on 06/06/2013.

The complainant had incurred total expenses of Rs. 48187/- on her treatment and surgery.

After continuous follow up with the TPA/Respondent, the claim was settled on 11/07/2013 for Rs. 34222/-, a short settlement of Rs. 13960/-,for which details of deduction were made.

Policy Exclusion No. 3.13 describes the reasonable & customary deduction as the "charges for health care, which is consistent with the prevailing rate in an area or charged in a certain geographical area for identical or similar services". The respondent under this clause had deducted Rs. 12,000/-.

Policy exclusion 4.4.21 describes other excludes expenses " All Non Medical expenses including convenience items for personal comfort such as telephone, television, Ayah, Private nursing/barber or beauty services, diet charges, baby food, cosmetics, tissue paper, diaper, sanitary pads, toiletry items and similar incidental expenses are permanently excluded from the scope of policy".

No explanation was given to the Complainant as to how the reasonable & necessary charges were worked out. The respondent was unable to substantiate the deduction of the charges on its reasonableness.

The Complaint was allowed.

Case No.AHD-G-044-1314-0735

Mr. Gopalprasad Mansigka Vs. Star Health & Allied Insurance Co. Ltd.
Award dated 22nd November, 2014
Partial settlement of Mediclaim

The Complainant's representative, his Son submitted that on 22.10.2013 he had undergone Cataract surgery on his left eye in Nidhi Hospital, Ahmedabad & incurred expense of Rs. 26,477/-. His claim was partially settled for Rs. 12,000/-, citing 'maximum claim payable clause' from the Policy Terms & Condition.

The provision for Cataract Surgery were clearly laid down in the Schedule of the Medi Classic Insurance Policy. The provisions stated that up to Rs. 2,00,000 Sum Insured the limit for Cataract treatment shall be Rs. 12,000/- per person per policy period. The Complainant's representative produced the Policy Schedule containing above clause. The Respondent concurred the clause.
The complaint was Dismissed.

Case No. AHD-G-051-1314-0736
Mr. Rajendra P. Pathak Vs. The United India Insurance Co. Ltd.

Award dated 24TH November,2014

Partial Settlement of Mediclaim
He was admitted in Sterling Hospital Ahmedabad for the treatment of Lt. Vocal Cord Palsy (Post Viral Likely) Hiatus Hernia + Bilateral Basal disease from 04/06/2013 to 08/06/2013. He had incurred a total expense of Rs. 68,843/-.
Inspite of continuous follow up with TPA/Respondent the claim was settled for Rs. 47764/-, with short settlement of Rs. 20982/-.
The insurer had submitted that claim was rightly settled partially as per the terms, condition and exclusion no.1.1,1.2,1.2a, 4.16,4.21, and 4.4.21, of the policy.
The date & time of admission was checked and found that the Respondent had erred in calculating the number of days of hospitalisation as 4 days instead of 5 days.
The complaint was ALLOWED. The respondent was directed to pay the recalculated the claim amount Rs.9,398/-.

Case No. AHD-G-050-1314-0739
Mr. Viral Upendra Upadhyay Vs. The Oriental Insurance Co. Ltd.

Award dated 21st November,2014
Repudiation of Mediclaim

The Complainant was admitted in Aashna Orthopedic & Fracture Hospital Ahmedabad for the treatment of Intervertebral Disc Disorders, and from 07/03/2013 to 12/03/2013. The surgery was performed on 07/03/2013.

He had incurred a total expense of Rs. 48565/- towards treatment and surgery.

The Complainant had submitted a certificate dated 04/07/2013 from the treating doctor Dipak Bhatia (M.S.Ortho) that, the injury was accidental and not a pre existing disease.

The Complainant had submitted that his claim was repudiated on account of the treatment of inter vertebral disc disorder within a period of 2 years from the commencement of the policy unless caused by accident, which was an exclusion clause 4.3 of the policy.

The insurer had submitted that claim was rightly repudiated as per the terms, condition and exclusion of the policy.

The claim has arisen in the first year of the policy.

Policy exclusion 4.3 xx states that " The expenses on treatment/surgery of prolapsed inter vertebral disk unless arising from accident, for the specified periods (i.e. 2 years) are not payable if contracted and /or manifested during the currency of the policy" .

The respondent has not proved that the complainant had the disease pre-existing i.e. before the purchase of the policy or had acquired the disease within the period mentioned in clause 4.3 of the policy.

Infact, the treatment was done on an injury caused to the complainant as he was traveling in the auto rickshaw. Thus, it is an injury caused accidently and not a disease. However the spinal canal stenosis does not occure in one day.

Hence, the respondent classifying the injury as disease attracting clause 4.3 of the policy is not totally correct. Consequently, the rejection of the whole claim of the complainant is on a wrong ground.

The Complaint was allowed.

Case No. AHD-G-050-1314-0738

Kailashben N. Patel Vs. The Oriental Insurance Co. Ltd.

Award dated 24TH November,2014

Repudiation of Mediclaim

Complainant has stated that she was having policy since 30/08/2011, and the claim had arisen in the second year of the policy. She stated that while in the village, she had a hit on his left foot toe for which she had taken a treatment/medicine at home like applying soframycin etc. As she had no improvement she came to her son's place at Ahmedabad, after 2 days, for further treatment. At Ahmedabad she had consulted Sitaba Hospital on 4/2/2012 where she was diagnosed with acute cellulites in the left foot with first time detection of diabetes, and was advised for immediate hospitalisation for amputation of the left foot toe. She was hospitalized during the 31/12/2012 to 12/01/2013 at Mansi hospital.

She had incurred total expenses of Rs. 62732/- towards treatment and surgery.

The Complainant had submitted that his claim was repudiated on 12/02/2013, 22/03/2013 citing the terms and conditions no. 4.3 of the policy. Policy exclusion 4(4.3) - describes that the company shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any insured person in connection with or in respect of "During the period of insurance cover, the expenses on treatment/ailment/surgery of DIABETES for specified periods i.e. two years are not payable if contracted and or manifested during the currency of policy".

The respondent had not furnished the copy of proposal, terms and conditions of the policy and that the complainant was detected with diabetes for the first time, in the life of the complainant, the complaint is allowed on Ex-gratia basis for Rs.20000/-.

Case No.AHD-G-048-1314-0746

Mr. Chandrakant K Daxini Vs. The National Insurance Co. Ltd.

Award dated 22nd November, 2014

Repudiation of Mediclaim

Approximately 5-6 months back, before the operation in 2013 the Complainant had noticed a red mole on lower portion of the abdomen on his right side. He had consulted his family Doctor who advised him to consult a skin specialist. However, the skin specialist had further advised him to consult an Oncologist. Accordingly, he had contacted Dr. Hemant Shukla, who had diagnosed him of Hemangioma & advised surgical procedure which he underwent on 11.05.2013. He had spent an amount of Rs. 15,999/-.

The Respondent in their SCN dated 03.02.2014, has stated that while going through the claim papers it was observed that the hospitalization was for Hemangioma which was congenital external disease. Congenital External Disease are permanently excluded under the Policy.

Considering the fact that Hemangioma was noticed some 6 months back, it changed its colour from red to black & it bleed after 6 months & the medical literature produced by the Respondent, the Insurer was asked whether they could reconsider the claim ? The

Respondent agreed to reconsider the claim & stated that they would revert back by 21.11.2014 evening. On being asked to produce the consultation papers with the skin specialist & an Oncologist he sought time to produce it by evening of the day. The same were submitted by the Complainant in the evening.

While verifying Hemadree Oncosurgical Hospital papers, dated 13.05.2013, it was found that duration of the disease was clearly mentioned in the chief complaint, origin, duration, progress as "Mole on Right Chest was noticed for last 1 month". The treating doctor was unable to comment about the duration of the disease & whether it was Congenital External Disease.

The Insurer was advised to make the payment of the claim as per the terms & conditions of the policy & inform the settlement payment particulars to this Forum.

Case No. AHD-G-049-1314-0747

Mr. Vimal J. Bhalodi (Patel) Vs. The New India Assurance Co. Ltd.

Award dated 21st November,2014

Repudiation of Mediclaim

The Complainant's son Master Tanmay aged 11 had swelling on the right side mandible (lower Jaw), he consulted Dr. S.K. Dewan, (M.D.S) after treatment and pathological test he was diagnosed with benign dentigerous cystic lesion.

He was admitted Oral & Facio – Maxillary Surgical Hospital Ahmedabad for the treatment from 28/05/2013 to 30/05/2013. The surgery was performed on 28/05/2013 for removal of cyst.

He had incurred total expenses of Rs. 27488/- towards treatment and surgery.

The Complainant had submitted that his claim was repudiated with a reason that policy coverage was since one year, and current illness/surgery/treatment had a waiting period of 2 years from the date of first insurance.

The Complainant had submitted the certificate dated 30/07/2013 from the treating doctor S.K. Dewan (M.D.S.) that, the surgery was not a dental procedure, but was a surgical enucleation of a cystic lesion.

The Respondent's representative submitted that as per the medical documents, insured person's cyst was diagnosed as benign cystic lesion right side mandible which is dental in origin which attract policy exclusion 4.4.5, which describes that " Any Medical expenses incurred for or arising out of dental treatments (All type) except arising out of an accident are not payable".

Respondent had submitted that, E- Meditek (TPA) has obtained Dr. Tarun Shah's opinion, before repudiation of claim, which was available in their submission.

Dentigerous Cyst is defined as "A Dentigerous cyst is an Odontogenic cyst thought to be of developmental origin associated with the crown of an unerrupted tooth, and the cyst cavity is lined by epithelial cells derived from the reduced enamel epithelium of the tooth forming organ.

Taking into account the terms and conditions of the Mediclaim Policy 2007 of respondent with reference to the facts and circumstances of the case, materials on record, submissions of the parties and findings as at above, Respondent's decision to repudiate the claim cannot be intervened. In view of the foregoing, the complaint was DISMISSED.

Case No. AHD-G-049-1314-0749
Dr. D. C. Gandhi Vs. The New India Assurance Co. Ltd.

Award dated 24TH November,2014
Repudiation of Mediclaim

After pathological test, the Complainant was diagnosed as Proliferative Diabetic Retinopathy with Macular edema (sudden blindness) and advised for admission. He was admitted in Aso-Palov Eye Hospital, Ahmedabad from 25/01/2013 to 26/01/2013. The surgery was performed on 25/01/2013 in both eye.

He had incurred total expenses of Rs.69363/- towards treatment and surgery.

The Complainant had submitted that his claim was repudiated with a reason that all illness/surgery/treatment like ARMD and or Choroidal Neo Vascular Membrance done by administration of LUCENTIS/VANTIS/AVASTIN and other related drugs as Intravertal injection, RFMD and ECP were excluded under the policy.

The complaint was allowed in view of the absence of the relevant clause in the policy based on which the respondent had repudiated the complaint's claim.

Complaint No. AHD-G-50-1314-754
In the matter of
Complainant – Shri Pulkit N Shah
Vs
Respondent - The Oriental Insurance Company Ltd.

Award Date:22.11.2014
Policy No.171102/48/2013/4454

Shri Pulkit N Shah was covered under the Mediclaim Policy No. 171102/48/2013/4454 for the period from 13.08.2012 to 12.08.2013 issued by the Oriental Insurance Company Ltd.The

Complainant was hospitalized at Tata Memorial Hospital Mumbai from 04.04.2013 to 11.04.2013 and at Kailash Cancer Hospital and Research Centre, Vadodara from 14.05.2013 to 21.06.2013 for (R) Ca Tongue. When the complainant preferred a claim for Rs. 3,12,034.13 the TPA of the Company repudiated the claim under clause 4.8.The contention of the Respondent was that the Insured was having history of tobacco chewing and therefore, the claim was not admissible as per mediclaim policy clause 4.8.

The Complainant, Mr. Pulkit N Shah during the hearing deposed that he had taken a policy with the Oriental Insurance company Ltd in 2007 which was continuing till date. The sum insured is Rs. 3 lacs He was admitted to Tata Memorial Hospital on 04.04.2013 and diagnosed for Ca ® Lt border tongue and he had spent an amount of Rs. 1,36,097/-. Subsequently he had under-gone radiotherapy at Kailash Cancer hospital and research centre, Baroda, incurring an expenditure of Rs. 1,75,937/. The Insurer had rejected the claim under clause 4.8 of the policy due to mention of history of 'Tobacco Chewing "in the Tata Memorial hospital papers. The Complainant says that it is nowhere mentioned that cancer is because of chewing of tobacco and tobacco word is nowhere mentioned in the policy. There is no history of drug or alcohol use /misuse or abuse. However, the only reliance has been placed on the history of tobacco chewing which is not specifically stated in the policy but only word use of intoxicating substance is mentioned. The intoxication is defined in the Black's Medical Dictionary 41st edition as " a term applied to states of poisoning. The poison may be some chemical substance introduced from outside , e.g. , alcohol, or it may be due to the products of bacterial action, the bacteria either being introduced from outside or developing within the body". In view of the lack of clarity of intoxicating substances in the policy condition 4.8 and the definitions given herein above , Forum is inclined to allow the complaint as the exclusion clause is not strictly applicable.

AWARD

In the facts and circumstances the Insurance Company is hereby directed to settle the claim of Shri Pulkit N Shah on Ex-gratia basis for Rs. 1,50,000/- (One Lac Fifty Thousand only).

Case No.AHD-G-038-1314-0756

Mr. Jayesh Shah Vs. Royal Sundaram Alliance Insurance Co. Ltd.

Award dated 22nd November, 2014

Repudiation of Mediclaim

The Complainant had submitted a claim for Rs. 101000/- for the Traumatic Cataract Management at Raghudeep Eye Clinic Ahmedabad. However, the Insurer had settled the claim only for Rs. 7500/-. He was not satisfied & he represented to the grievance cell of the Insurer on 12.10.2012 which was replied by the Insurer on 12.11.2012 reiterating their earlier stand. The Complainant was asked to read the discharge card dated 18.05.2012 of Raghudeep Eye Clinic wherein under the surgical notes it is mentioned as right cataract surgery implantation of intraoccular lens. He was further asked to confirm the signatures on the claim form wherein the diagnosis is stated to be cataract surgery in right eye with implantation of intraoccular lens. He was also asked to read the policy condition about the cataract wherein an amount of Rs.7500/- is stated against cataract. He has also stated that he had produced a certificate from the treating hospital wherein it is stated that the charges for the patient who had Traumatic Cataract. However this certificate is signed by the Insurance Co-ordinator only.

All documents submitted by the Complainant's i.e discharge summary, claim forms all confirms it was a Cataract Surgery & implantation of Intraoccular Lens. Further the certificate produced by the Complainant stating Surgery of Traumatic Cataract is also signed by the Insurance Co-ordinator & not by the Operating Surgeon who is medically well qualified to justify.

The provision in the policy are very clear restricting the Cataract Surgery amount to Rs. 7,500/- & no other surgery related to eyes are covered.The complaint was Dismissed.

Complaint No. AHD-G-49-1314-757

In the matter of

Complainant – Mrs. Mrunalini V Jikar

Vs

Respondent - The New India Assurance Company Ltd.

Date of Award: 22.11.2014

Policy No: 22030034120100012079

Mrs. Mrunalini V Jikar(hereinafter called the Complainant) was covered under the Mediclaim Policy No. 22030034120100012079 for the period from 05.12.2012 to 04.12.2013 issued by The New India Assurance Company Ltd.The Complainant was hospitalized at Singhi Nursing Home, Mumbai from 06.03.2013 to 07.03.2013 for Hypotension with Lt forearm hematoma in case of acquired Haemophilia (Factor VIII) inhibitor.When the complainant preferred the claim for Rs. 2,18,670/- alongwith all the required documents, the TPA of the Company repudiated the claim under clause 4.4.16.The Insurer's representative was asked to read the repudiation letter 02.08.2013 and explain how condition no. 4.4.16 is applicable. He had read out the condition which says "Genetic disorders and stem cell implantation/surgery". He has also drawn our attention to the medical literature wherein it is stated that "Hemophilia is a well known ex-chromosomal inherited bleeding disorder. Acquired hemophilia is a rare but severe autoimmune bleeding disorder".

He had further brought to our notice that the Insurance Company has received a registered AD notice JN /4222/Sept. 2014 dated 25.09.2014 from Jagrut Nagrik, a voluntary consumer association asking the company to settle the claim failing which the complaint shall be filed at the Consumer Dispute Redressal Forum.

Keeping in view the facts stated above, the absence of the complainant, the intention of the complainant to approach the Consumer Forum after having served a notice through voluntary consumer organization, the complaint is dismissed.

AWARD

In the facts and circumstances, the complaint is dismissed.

Case No.AHD-G-048-1314-0760

Mr. P.S.Arha V/s National Insurance Co. Ltd.

Award dated 12th December, 2014

Repudiation of Mediclaim

The Complainant had submitted that he was admitted in Apollo Hospital, Ahmedabad from 12/04/2012 to 24/04/2012. Angiography & Bypass surgery were performed. He had incurred an expense of Rs.2,80,641.52. The Company repudiated the whole amount on the ground of pre-existing disease. Earlier, the Company's TPA had approved Rs. 12,500/- as cashless for Angiography. Later on the Doctor suggested Bypass Surgery & the TPA had initially approved Rs. 1,50,000/-. On the day of discharge due to typographical mistake committed by the hospital clerk some other patient's history, of DM-HTN-CAD, was mentioned in Complainant's discharge summary. Within an hour, the doctor had rectified the mistake through a certificate. But still Company's TPA suspended the Complainant's cashless facility. Despite several clarification, along with proofs, the Company's TPA Vipul Medicorp TPA Pvt. Ltd. & Company preferred to stick to their decision to repudiate the claim.

The Respondent's representative submitted that the claim was processed on the basis of the Hospital records. The subject claim was repudiated on the ground of the past history mentioned as CAG since 10 years & past history of HTN. The discharge summary was issued by the Apollo Hospital having repute in the medical field. Had they reconsidered the claim on the ground of corrected papers, it would have become a precedent for other claimants to approach them with doctored Discharge Summary.

Hospital had given Notarised Certificate in which they had admitted that it was a typographical error by the Typing Desk & they had

wrongly mentioned other patient's past history of HTN & CAD in Discharge Summary of the Complainant. The certificate of Dr. Abhijat Sheth, Director, Medical Certificate, Apollo Hospital, dated 18.08.2012, clearly confirmed that on admission, the patient had Diabetes Mellitus since 1 ½ Years & no history of HTN or IHD was noted in Pre-authorisation Request Note & Admission Assessment Request Note. Copies of Pre- authorization Note, Assessment Note & Consultant's Note dated 16.04.2012 confirmed D.M since 1 ½ years. Against HTN or IHD it was mentioned as 'No'. In the Consultant's Note also, dated 16.04.2012, it was clearly stated as Acute Coronary Syndrome since last 10 days.

The Complaint was allowed & Insurer was directed to settle the Claim with interest @ 2% over and above Bank rate, from the date of receipt of the Claim.

Complainant – Ms. Rajni G Basantani

Vs

Respondent - United India Insurance Company Ltd.

Complaint No. AHD-G-51-1314-771

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Date of Award: 11.12.2014

Policy No: 060300/48/11/97/00008651

Dr. (Ms) Rajni G Basantani (here-in-after called the Complainant) was covered under Individual Health Insurance Policy-2010 No. 060300/ 48/ 11/97/00008651 issued by United India Insurance Company Ltd for the period from 09.11.2011 to 08.11.2012. The Complainant had a fall in April, 2012 and had broken pelvic bone. She was treated for the same. The pain in her pelvic area recurred and the same was unbearable. The Complainant was admitted to Samved Hospital from 30.08.2012 to 05.09.2012 as she was not able to stand or move. She had undergone conservative treatment for the same. When pain did not subside, she went to Sterling hospital for further treatment. The doctors advised her to get admitted to Sterling hospital. She was treated there from

05.09.2012 to 10.09.2012 and had undergone various tests including the test for malignancy of bone. Physicians, Surgeons, Pathologist and Radiologist had attended to her ailment.

The claim was rejected by the Respondent by stating that hospitalization was primarily for diagnosis purpose, hence as per mediclaim policy clause 4.11. Based on oral submissions of the parties, read along with documents on record the findings are that during the stay in the hospital medicines were administered, various tests were undertaken alongwith physiotherapy. Even though the policy condition restrains from making payment on such ailment, it was observed that after admission in the hospital and treatment, the complainant's health had improved. She had to be admitted in view of her severe pain and case of no sensation of urine since 15-20 days. She also had Urinary Track Infection alongwith abdominal pain. The Complainant was suffering from bone resorption, pain and zero mobility. She was admitted and various tests were carried out.This is a case of exemption where the complainant herself being a doctor, was in severe pain, and to prove the pain she is detected with bone resorption of pubic rami . A patient may experience groin and leg pain that may prevent them from walking. X-rays and, in rare cases, MRI's will be used to diagnose a pubic rami fracture. Hence it is necessary to get admitted as per her attending doctor's advice. The finding of osteoporosis was possible after series of tests. The attending doctors would not carry out the tests for name sake. They were not able to detect the exact medical problem till the resultant finding. A patient getting admitted in a hospital, gets a feeling that he/she is put into such a place where she would get relief of her ailment. Moreover, in the present case she was administered with various medicines as treatment of her illness. Under such exceptional case, the insurer should not go into the policy conditions word by word.

In this case there was a necessity for the Complainant to get admitted to the hospital and undergo the diagnosis and treatment as advised by the treating doctors.

In view of the facts and circumstances, the complaint is allowed.

AWARD

In view of the foregoing, I hereby direct the Respondent to settle the claim of the Complainant on Ex-gratia basis to the extent to the limit of Sum Insured and the claim payment already done during the policy period as per the policy conditions.

Case No.AHD-G-044-1314-0778

Mr. Jayprakash N Zaveri V/s Star Health & Allied Insurance Co. Ltd.

Award dated 16th December, 2014

Repudiation of Mediclaim

The Complainant had felt pain in his chest & uneasiness on 28/03/2013. On consulting his Doctor, he was prescribed medicines and advised Angiography at DWTI-Prabhu General Hospital & Bankers Heart Institute, Surat. Angiography showed him to have Coronary Artery Disease. He was advised to go for Angioplasty. On 28/04/2013 he got admitted & Angioplasty was performed. He was discharged on 02/05/2013. He had incurred total expense of Rs.2,19,801/-.The Company rejected his claim stating that the claim had arisen within 30 days from the date of commencement of the policy. The doctor clearly had mentioned that he had chest pain from 28/03/2013 & was advised surgery. He had stated that it was no where mentioned in the policy that the heart ailments would not be covered if it happened within the initial 2 years of the policy. There were no such exclusions.

The Respondent's representative submitted that the Complainant was diagnosed with Ischemic Heart Disease, Unstable Angina, Double Vessel Disease & PTCA. As per the medical certificate issued by the treating doctor of the hospital, the date of first consultation was on 01.04.2013 & the hospitalization was on 28.04.2013.

In a reply to a question, since when was the patient suffering from the said disease? His answer was since 1 month from 01/03/2013, i.e calculating one month backward from the date of 1st consultation (01.04.2013). Hence, claim was rejected as the claim has occurred within 30 days (waiting period) from the date of commencement of the policy. The claim was rejected under Exclusion Clause No.1- Pre-existing, 2- Disease contracted within first 30 days from the commencement of the policy & 7- misrepresentation, of the policy. The Field Visit Report was also produced by the representative of the Respondent in which the Complainant's Son had given the history of Dyspnoea of Exertion since two months.

The Respondent failed to submit proofs before the forum to prove that the Complainant had taken treatment or had ever consulted for the treated disease before or within 30 days from the inception of the Policy. The Complaint was allowed. The Respondent was directed to settle the claim of Rs.2,00,000(equal to Sum Insured) as per rules.

Complainant – MR. C.M. Chandarana

Vs

Respondent - United India Insurance Company Ltd.

Complaint No. AHD-G-51-1314-0779/SN

Date of Award: 17.12.2014

Policy No: 066100/48/12/12/00001090

The representative daughter of the Complainant had appeared and stated that her father expired on 13.03.2014 and she was deposing on his behalf. She said that her father was having the policy since 1996. He was hospitalized in 2006 for LBBB (Left Bundle Branch Block) and had recovered well and he was living a healthy life. The Sum Insured was increased to Rs. 75,000 in the year 2011 and thereafter to Rs. 1 lac in 2012. In January, 2013 her father was hospitalized for angiography and blockage was detected and had undergone By-pass in February, 2013 for which he had preferred a claim to the United India. The Company had sent a voucher for Rs.60,000/- i.e. (Rs. 50,000 being old sum insured and cumulative bonus) . Her father had rejected the voucher. Her contention was that citing clause 4.1 was not correct because hospitalization for treatment of LBBB was in 2006, and 7 years had passed since then without any hospitalization or claim till 2013. The clause 4.1 was not applicable as per the judgment given by the State Commission, Delhi in a similar case. She also stated that LBBB and Triple Vessel Coronary Artery blockage are two different ailments hence it was not pre-existing as per the company's clause 4.1. She mentioned that the doctor who had treated her father had stated that LBBB is related to signal blockage and cororany artery blockage is blood supply blockage to heart.The literature on the diseases viz LBBB and Coronary Artery was examined.The award pronounced by the State Commission, Delhi has no relevance to the present case,As per the documents submitted the policy had run for 18 years and the claim for Coronary Artery Disease had occurred after 6.5 claim free years. The claim for LBBB was paid by the Company in the year 2006. He was altogether leading a healthy life and had increased the sum insured marginally. Nevertheless, the LBBB and the Coronary Artery Disease are interrelated.

The Forum could find no merit in the complaint and does not interfere in the Respondent's decision to offer Rs. 60,000/- to the Complainant.

AWARD

In view of the facts and circumstances, the decision of the Respondent to settle the claim for Rs. 60,000/- needs no interference.

Case No.AHD-G-050-1314-0781

Mr. Pramodkumar Sisodia V/s The Oriental Insurance Co. Ltd.

Award dated 18th December, 2014

Repudiation of Mediclaim

The Complainant submitted that there was disruption & bleeding in the eye. The eye surgery was performed. He further submitted that it was in the Company's own circular which mentioned that the claim on eye surgery was covered after 4 years, from the date of commencement, provided the policy was in continuation. He was insured since 2003. The Respondent had given various reasons for repudiating his claims at different point of time. Firstly, it was on non-continuation for 4 years. Secondly, that he had not intimated the Respondent about the illness. There were total 3 claims lodged with the Respondent. He stated that the Respondent had been trying to find one or the other reasons to disallow his claim. He had referred to the relevant clauses of the terms & conditions & the prospectus of the policy which stated that the claim was admissible.

The Respondent's representative submitted that they had received one claim only & the same was repudiated on the ground of the Policy Clause 2.3 which states that procedures/treatments usually done in out patient department are not payable under the policy even if converted to day care surgery/procedure or as in patient in the hospital for more than 24 hours.

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 Insurer was directed to pay a sum of Rs.85,500/- as ex-gratia payment.

Case No. AHD-G-049-1314-0785

Mr. Ketan N. Gohel Vs. The New India Assurance Co. Ltd.

Award dated 15th DECEMBER, 2014

Repudiation of Mediclaim

He had informed that due to abdominal pain and constipation he had approached Dr. Viral Shah on 03/04/2012 for treatment. As per his doctor's advice Sonography was done, on the same day. After Sonography his family doctor had advised him to meet Dr. Bhargav Maharaja of Shrey Hospital. Dr. Bhargav had also suggested to carry out certain medical tests. He was diagnosed with Carcinoma of Descending colon and was hospitalized from 10/04/2012 to 19/04/2012 for the treatment and surgery.

He had incurred a total expense of Rs. 2,48,648/- towards treatment and surgery.

The Complainant had submitted that his claim was repudiated citing policy condition/exclusion 4.2 (30 days waiting period).

The Representative of Respondent had stated that the claim was repudiated as per the exclusion clause No. 4.2 of the policy. On being asked, to calculate and show how it was 30 days from the date of treatment and not from the date of symptoms, the representative agreed that No. of days under dispute was more than 30 days.

As per the treatment papers, Dr. Bhargav Maharaja vide letter dated 04/04/2013, the complainant had the symptoms of cancer just before 7 to 10 days from the first consultation done on 03/04/2012. The policy had commenced from 24/02/2013. This meant the complainant had the medical problem within 40 days from the date of treatment and if 7 to 10 days spent on the symptoms were counted the number of days fall to 34 days to 31 days respectively.

The Complaint was allowed.

Complainant – Mr. Devendra Kumar
Vs
Respondent - National Insurance Company Ltd.
Complaint No. AHD-G-48-1314-0786

Date of Award: 17.12.2014
Policy No: 301800/48/12/8500013621

The Forum took on record the complaint dated 13.12.2013 of the Complainant for partial settlement of claim under mediclaim policy and the SCN dated 25.03.2014 of the Respondent.

The Complainant appeared and stated that he and his wife were having mediclaim policy for Rs.4 lacs each. His wife had undergone cataract surgery on both eyes. When two claims were lodged with the Respondent for Rs. 54,839/- and Rs.55,056/- the Respondent had disallowed Rs. 26,000/- under both claims. He said that the company had partially settled his claim citing that the operation involved cosmetic surgery. The Company had also raised the premium rates by 40% for which he did not object. He pleaded that his claim should be settled.

The representative of the Respondent deposed that the claim was for Rs. 54,839/- and they had paid Rs. 41,839/- after deduction of Rs. 13,000/- towards lens was as per clause 3.12, 4.6 and 4.7 of the mediclaim policy. He said that the Insured had used AT LISA 809 M of Zeiss multifocal lens which had additional benefit of improved vision. This was in contravention of the clause No.4.7 of the mediclaim policy. As per this clause the lens was considered as cosmetic part as it replaced the spectacles. The terms and conditions allowed payment for use of monofocal lens. He declared that the doctors in Ahmedabad were doing cataract operation with Multifocal lens at a cheaper cost of Rs. 18,000/- to Rs. 40,000/-. Here, since the total cost was high, the claim was restricted to Rs. 41,839/-. Based on oral submissions of the parties, read along with documents submitted to this Forum it is noted that the Complainant's wife was hospitalised for Right eye Cataract + IOL with Phacoemulsification under LA .The Respondent had disallowed Rs.13,000/- from the claim amount on account of reasonableness citing 3.12, 4.6 and 4.7 of the mediclaim policy .

It was noted that there was no clause which restricted payment towards multifocal. This was decided by the Respondent at their discretion. The Respondent agreed that they settle the claim on multifocal lens when the cost was less. In absence of the agreed

terms and conditions , the actions of the Respondent to settle the claim as per their discretion is considered as arbitrary especially when the policyholder objected to it. The Complaint is allowed.

AWARD

In the facts and circumstances, the Respondent is hereby directed to settle the claim for Rs.13,000/- as Ex-gratia. The Respondent is also directed that it should consider the claim on similar line if the complainant approached them for claim on left eye.

Case No.AHD-G-049-1314-0790

Mr. Chhaya R Chauhan V/s The New India Assurance Co. Ltd.

Award dated 18th December, 2014

Repudiation of Mediclaim

The Complainant submitted that her claim, for Hysterectomy operation, was partially settled by the Respondent. Her total claim was for Rs. 60,000 & the Company had settled her claim for Rs. 30,000 only. She requested the Forum that after deducting the higher room rent charges, proportionately, the balance amount should be reimbursed to her.

The Respondent's representative submitted that the claim was for Rs. 55000 & the same was partially settled. The subject claim was settled as per 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 Sum Insured was Rs. 1 Lac & so eligible room charges were Rs. 1000/- per day as against Rs. 2000/- per day (paid by the Complainant). As per policy condition Note No. 1 to Clause 2.3 & 2.4 the amount payable shall be as per the entitled category. Accordingly, the deductions of other charges were made.

The Respondent had failed to prove that Hospital was charging rates for services, mentioned under 2.3 & 2.4 of the policy conditions,

according to room category as the charges were not in proportion to the room rent.

The Respondent was directed to pay Rs.20,000/- as ex-gratia claim to the Complainant.

In the matter of
Complainant – Mr. Pravin Solanki
Vs
Respondent - The New India Assurance Company Ltd.

Complaint No. AHD-G-49-1314-791/SN
Date of Award: 17.12.2014
Policy No: 22150034120100004987

The Forum took on record the complaint dated 27.09.2013 on partial repudiation of claim of the Complainant and the SCN dated 12.02.2014 of the Respondent. The contention of the complainant was that he had mediclaim policy since 2001 which were renewed without break. The Company had deducted Rs. 7321/- stating pre-existing disease clause. He referred to the MRI report wherein it was mentioned that L5-S1 was a new finding and had no relevance to the earlier treatment. Hence it should not be treated as pre-existing. He also cited an RTI reply from the Insurance Company on pre-existing disease, where in it was mentioned that after 4 claim free years the disease would not be treated as pre-existing disease, for the purpose of mediclaim. As per the reply this disease did not fall in the pre-existing disease category. The representative of the Respondent deposed that the Insured was having Janata Policy for Rs. 50,000/- which was converted into Regular Mediclaim policy in 2007. The Insured had claimed for the Lumbar disc lesion in 2009 for which the claim was paid. He said when a claim was preferred by the Insured during the policy period 2012-13, Rs.11740/- was paid and Rs. 7321/- was disallowed as per clause 4.1., 2.1, 2.2, 2.3 and 2.4 of the mediclaim policy. The claim was restricted to Sum Insured of Rs.50,000/- . It was informed to the Representative of the Respondent that the rejection was based on clauses 4.1 and 2.1 of the mediclaim policy. He was told that he would not be allowed to bring in new points other than what has been communicated to the Complainant.

The claim was repudiated as conveyed to the complainant on the basis of condition 4.1 and 2.1 of the mediclaim policy. The claim has arisen in the 4th year of the policy As per the clause 4.1 if a claim arises within 4 years of the inception of the policy nothing becomes payable. Hence, the application of clause 4.1 is incorrect. However, Respondent had settled the claim on the basis of Rs. 50,000/- Sum Insured taking the old sum insured as per Janata policy. It was observed that as per MRI Scan of Lumbar Spine-Plain dated 11.02.2013 In view of the MRI, the disease being categorised as a new finding, the Respondent was asked to give his comment. The Respondent had nothing to add in this. When asked upon to produce a certificate or Independent doctor's opinion on this MRI and its finding the Respondent stated that no medical certificate /opinion of the doctor stating that there was a relation between the earlier operation and the current treatment taken by the Insured, was sought or available.

In view of the facts and circumstances, the complaint succeeds.

AWARD

In the facts and circumstances, especially when the Respondent has wrongly applied clause 4.1 on pre-existing disease, Respondent is hereby directed to settle the amount of Rs. 7321/- (Seven Thousand Three Hundred and Twenty One only).

Case No. AHD-G-050-1314-0792

Mr. Brijmohan T. Oza Vs. The Oriental Insurance Co. Ltd.

Award dated 15th DECEMBER, 2014

Repudiation of Mediclaim

The Complainant's wife was hospitalized in Sheth Hospital & Maternity Home, Ahmedabad from 07/08/2012 to 09/08/2012 for child birth and she was operated upon for caesarian section. He had incurred total expense of Rs. 33,962/- towards treatment and surgery.

The Complainant had submitted that his claim was repudiated stating the reason that the claim had arisen within the first year of the policy.

He stated that he had received only the certificate of insurance without the terms and conditions. The same was given by the agent only after repudiation of the claim.

The Respondent's representative didn't carry any proof to show that the terms and conditions were furnished to the Complainant along with the certificate of the policy.

He agreed that the policy showed continuity to the previous policy and did not make any mention about the exclusion or inclusion of any other clauses.

He also agreed that the previous policy had covered the maternity benefit.

The tailor-made group mediclaim policy was issued by two different offices of the Respondent. The first policy had covered the treatment related to pregnancy with certain provisions. However, in the second year, the issuing office had excluded the treatment related to pregnancy. This fact was not made known to the benefactors of the policy. This, had deprived the policy holders of their right under the IRDA Regulation on Protection of the policy holders' interest.

In view of the fact that the Respondent had not provided the terms and conditions along with the policy to give the policy holder a chance to understand the policy conditions, the Respondent's decision to repudiate the claim is wrong.

The Complaint was allowed.

Case No.AHD-G-049-1314-0793

Mr. Paresh J Shah V/s The New India Assurance Co. Ltd.

Award dated 18th December, 2014

Repudiation of Mediclaim

The Complainant submitted that he underwent right eye Cataract operation in August, 2013 for which he had incurred an expense of Rs.28000/- & the maximum limit of the admissible amount was Rs.24000/- as per the Respondent's guidelines. His claim was rejected stating the reason that the hospital was not registered with the local authorities under section 5 of Bombay Nursing & Hospitalisation Act, 1949. When the reason was brought to the notice of the Doctor he got his hospital registered as required by the Respondent. He had his left eye operated upon Cataract removal in the month of November, 2013 in the same hospital. He had lodged a claim with the Respondent. His second claim was admitted by the Respondent as the hospital was registered with the concerned authority by then. The Complainant also claimed that the doctor was a well known Opthalmologist with more than 10 years standing in the city. The Respondent did not raise an objection over this submission.

The Respondent's representative submitted that when the insured had lodged his 1st claim the hospital was not registered under section 5 of Bombay Nursing & Hospitalisation Act, 1949, but it was registered with local authorities under Shops & Establishment Act. Hence, the first claim was repudiated.

In the given circumstances, where the Opthalmologist, the hospital & the facility in the hospital remained the same & that there was no policy condition which guided the insured to find an Opthalmologist who had his hospital registered under Bombay Nursing & Hospitalisation Act, 1949. The Forum is inclined to admit the claim. Other conditions remains the same, except registration of the hospital the Respondent had settled the Complainant's second claim. While advising the Respondent to be more considerate & sensitive to its insureds, the Forum directed the Respondent to settle the claim by paying the amount of Rs. 24,000/-, claimed by the Complainant, on ex-gratia basis.

Case No.AHD-G-050-1314-0803

Mr. Kadambariben Vora V/s The Oriental Insurance Co. Ltd.

Award dated 18th December, 2014

Repudiation of Mediclaim

The Complainant's Spouse represented the case. He submitted that he was operated for Gall Bladder Stone & incurred expense of Rs.29000/-. His claim was repudiated by the Respondent on the ground that the policy was not in continuation & claim on Gall Bladder Stone operation was not covered for the first 2 years. He claimed that their policy had been for many years. He submitted that earlier the date of commencement of the policy was 16th May. In the instant case he had given the cheque for renewal on 15.05.2009 to the Respondent. He had produced a copy of a renewal notice, dated 14.04.2009, on which an inward stamp dated 18.05.2009 (manually corrected) was placed. The policy, thus, commenced with a new date 20.05.2009.

The Respondent objected to the insured's complaint on correction of the date. He said the Respondent should have collected the cheque on 18.05.2009 & through an oversight must have put 15.05.2009, as the collection date as 16th May & 17th May were holidays & after understand the error, the staff had corrected the date to the correct date 18.05.2009 & counter signed it as well.

The Respondent's representative submitted that the claim was repudiated citing Policy Clause No. 4.3-" During the period of insurance cover, the expenses on treatment of following ailment/diseases/surgeries for specified periods are not payable if contracted &/or manifested during the currency of the policy- Calculus Diseases for 2 Years."

In view of the facts that the inward stamp was corrected manually (raising a doubt on the exact date of collection of the cheque at the Respondent's Office), the Insured was not made aware about the grace period clause on premium payment, the Insured had been having the policy continuously for a long number of years & above

all giving the benefit of doubt to the Insured, the complaint was admitted.

The Insurer was directed to settle the claim for Rs.20,000/- on ex-gratia basis.

Case No. AHD-G-049-1314-0804

Mr. Suresh C. Bhatt Vs. The New India Assurance Co. Ltd.

Award dated 17th DECEMBER, 2014

Partial Settlement of Mediclaim

The Complainant's wife was admitted in the hospital, with a complaint of fever, rigor, not able to open mouth etc. he had incurred an expenses of Rs. 65,831/- out of which only Rs. 51,896/- was paid. Rs. 13,935/- was deducted with reasons like original bill not submitted and the treatment taken at home was not related to the subject illness.

He had submitted the bills and receipts of doctor who had charged for treatment taken at home as per the doctor's advice. He further added that the treatment taken at home was to avoid the hospital room charges and gloomy atmosphere of the hospital. His treating doctor's explanation for treatment at home and bills and receipt were not considered.

The representative of respondent had stated that the complainant's wife was admitted in the hospital, for which a claim was registered with them. The claim was rightly settled partially as per the terms and conditions of the policy. The amount deducted was towards treatment not related to disease and non- medical items.

The forum noted that a sum of Rs. 13935/- had been deducted from the claim of the insured as per opinion of Dr. Kiran Vadalia, and same was conveyed to complainant's employer. The respondent's

doctor has stated in his treatment papers that medicines for Rs. 13515/- was for diabetic treatment and U.T.I and Non Medical items costed Rs.420/-.

The Complaint was allowed.

Case No. AHD-G-050-1314-0812

Mr. Shankerlal Unaji Prajapati Vs. The Oriental Insurance Co. Ltd.

Award dated 18th DECEMBER, 2014

Repudiation of Mediclaim

In the year 2011, the Complainant had switched over his policy to Oriental Insurance Co. for the period from 07/05/2011 to 2012 and 07/05/2012 to 07/05/2013 for the sum insured of Rs. 2,00,000/-. He was hospitalized on 02/07/2013 for the treatment of kidney transplant surgery.

He informed that his wife had donated a kidney and had incurred an expense of Rs. 4,34,813/-. He had lodged a claim with the respondent.

His claim was repudiated by the respondent citing pre-existing disease clause and that a claim on pre existing disease was available only after completion of 4 years from DOC of the policy. He stated that he had lodged a claim in the fifth year of the policy. (Two Years insurance with United India Insurance co. + Third year of Policy).

The Respondent had stated that the claim was rightly repudiated as per and exclusion clause of the policy. The complainant was a known case of C.R.F and HTN since three and half years and he had registered the claim in the 3rd year of policy.

As per policy condition/exclusion no. 4.1 of the policy, "The Company shall not be liable to make any payment under the policy for pre existing health condition or disease or ailment/injuries which

treated/untreated/declared/not declared in the proposal form, for 4 years. further for the purpose of applying this condition, the date of inception of this policy taken from oriental insurance company shall be considered, provided the renewals have been continuous and without break in period.

The Complainant had submitted copies of policy without terms, conditions and exclusion. From available documents and during hearing, forum has noted that terms and conditions were not provided to the complainant by the respondent.

Respondent had not submitted copy of proposal form duly signed by members of policy holder.

The Complaint was allowed.

Case No. AHD-G-050-1314-0814

Mr. Jignesh L. Bhatti Vs. The Oriental Insurance Co. Ltd.

Award dated 9TH JANUARY, 2015

Repudiation of Mediclaim

The Complainant was hospitalized in Harikrishna Urosurgical Hospital, Ahmedabad from 02/07/2013 to 12/07/2013 for the treatment of Lt. Flank Pain etc.

He had incurred total expenses of Rs. 45,062/- towards treatment and surgery.

The Complainant had submitted that his claim was epudiated with a reason that as per the policy condition/exclusion 4.3 – treatment for stones in urinary system excluded from the scope of policy for two years.

From the treatment papers submitted it was noticed by them that complainant was a known case of PVNL + Litho. He was admitted for PVNL Twice and Litho – Once & Current hospitalisation was for B/L

Renal + Lt. Ureteric Stone and operated for Lt. VRSL+DJ Stanting + SWL to Lt. Renal Stone etc. which falls under exclusion clause no. 4.3 of the policy treatment of disease such as CALCULUS were not payable for first two years of operation of policy. Previous year policy was with other insurer, which was period not consider.

" The company shall not be liable to make any payment under the policy for pre existing health condition or disease or ailment/injuries which treated/untreated/declared/not declared in the proposal form, for 4 years. further for the purpose of applying this condition, the date of inception of this policy taken from oriental insurance company shall be considered, provided the renewals have been continuous and without break in period.

Without terms & conditions the issuance of the policy was incomplete.

Ex-gratia Rs.20,000/- was awarded.

Case No. AHD-G-051-1314-0815

Mrs. Neeta Rohit Nawab Vs. The United India Insurance Co. Ltd.

Award dated 18th DECEMBER, 2014

Partial Settlement of Mediclaim

The Complainant's mother was admitted in the hospital for her Rt. Breast Carcinoma treatment from 19.02.2013 to 22.03.2013 and had incurred a total expense of Rs.4,25,744/-. A claim for Rs.4,25,744/- was lodged with the respondent under both the policies. The respondent had settled claim for Rs.3,68,750/- under Individual Health Policy but the balance amount of Rs. 56994/- was not paid under Super Top Up Medicare Policy.

The claim was repudiated with a reason that at the time of taking the policy she had misrepresented and hid angioplasty treatment done on her on 26/01/2009.

He further stated that her mother had mentioned the Individual Mediclaim policy No.360300/48/09/20-00001927 of 2009 (for the period from 22.05.2009 to 21.05.2010) in the proposal form for Super Top Up Policy for verification.

The proposal for Super Top Up Medicare Policy was filled up by the agent and she had merely signed proposal form. The Company had issued the policy and collected the renewal premium for four years (even after intimation about the treatment for breast cancer). Hence, at the time of settlement of the claim in the third year of the policy, the question of misrepresentation or hiding of information should not be raised and repudiate the claim.

The complainant stated that neither the proposal form nor the policy stated any condition regarding history of hospitalisation within 730 days prior to the DOC of the policy.

The Individual Mediclaim Policy showed Cumulative Bonus of Rs.68000/- however the respondent had considered Rs.43000/- only for settlement of the claim.

The Respondent's representative submitted that at the time of taking the Super Top Up Medicare Policy, the Complainant had not disclosed her health conditions and had given incorrect answer to the her health related questions in the proposal form. She had not given the policy numbers of her individual health insurance policy for the last four years and not mentioned about the angioplasty done in 2009.

On her lodging the claim it was rightly repudiated as the Complainant had misrepresented and hid the information i.e.

Angioplasty surgery in the year 2009 – at the time of proposal. She stated that as per the eligibility criteria for Super Top Up Medicare Policy, the policy cannot be issued to a person with a history of hospitalisation or who had a claim during/preceding 730 days from the proposed date of commencement.

As regards the Cumulative Bonus, she admitted that it was a technical mistake and the policy showed wrong cumulative Bonus as Rs. 68750/- instead of Rs. 43750/-

The Respondent failed to verify the Complainant's previous policy. The respondent had not observed underwriting rules and used his/her prudence. The underwriting was lax and was not diligently. Had the Respondent's diligence been put to use the policy would not have been issued at all.

The Respondent had not verified the Cumulative Bonus mentioned in the Individual Health Insurance Policy before its renewal.

The Respondent had continued to collect premium even after the claim intimation giving a feeling that the policy is continued.

It wais concluded that the proponent had suppressed one crucial fact while the Respondent had not been diligent in underwriting and had committed multiple mistakes thereafter.

The lapses and negligence on the part of the Respondent, the complaint was allowed. The Respondent was directed to pay a Sum of Rs. 30,000/- as Ex-gratia payment.

Case No.AHD-G-048-1314-0816

Mr. Arvind R Patel V/s The National Insurance Co. Ltd.

Award dated 8th January, 2015

Repudiation of Mediclaim

The Complainant had been to Canada on 14.06.2013 to meet his Son. He had taken Overseas Medical policy for 150 days expiring on

10.11.2013. On landing at Canada, he had burning sensation while urinating. The burning sensation got aggrevated by evening. So he dropped in to a walk-in-clinic. He was given medicines for 5 days & treated with the same medicines for 5 more days. After 10 days things got worse & he was admitted in Trillium Hospital in Canada. After 24 hours treatment he felt better. He was advised to consult a Nephrologist. They consulted Dr. Graham who advised him blood & urine tests. When he contacted Dr. Graham with the reports he was given the appointment after 10 days. So they consulted his Son's Family Physician who advised that the reports are disturbing & needs urgent attention. As he felt he was not getting treated properly he flew back to India & got admitted to Apollo Hospital where he was cured within 5 days. In Canada he had incurred expense of $ 4,413.35. The claim was repudiated on the ground that the Complainant was suffering from Hypertension & Diabetes since 10 years & 3 years respectively.

The Complainant had produced a certificate of Dr. Shamik Shah, MBBS, MD (Int. Med.), DNB (Neph), ISN Fellow, who is a Critical Care & Transplant Nephrologist at Apollo Hospital, Gandhinagar who confirmed that the disease was not due to the presence of Type II Diabetes Mellitus & Hypertension. This certificate was issued by a specialist in Nephrology of a reputed hospital.

The Forum observed that the panel doctor has arrived at the conclusion of complications due to pre-existing disease from the papers produced by the Complainant. They have not carried out any independent examination to prove the reason for the rejection of the claim.The Respondent failed to prove medically & counter the certificate of Nephrologist, produced by the Complainant, that the disease was the direct cause of Hypertension & Diabetes.

The Respondent was directed to pay an amount of $ 3000/- on ex-gratia basis to the Complainant.

Case No. AHD-G-049-1314-0821
Mr. Nishank G. Modi Vs. The New India Assurance Co. Ltd.
Award dated 17th DECEMBER, 2014
Partial Settlement of Mediclaim

Hospitalisation for Treatment and surgery of Rt. Inguinal Hernia.

The representative of the insurer stated that the complainant was hospitalized for the surgery/ treatment of Rt. Side irreducible inguinal Hernia. This claim was partially settled as per the exclusion clause No. 3.13 which described the exclusion as that charges for health care, which is consistent with the prevailing rate in an area or charged in a certain geographical area for identical or similar services and all non-medical expenses including convenience items for personal comfort services, cosmetics, tissue papers, diapers, toiletery items.

The respondent had issued the policy schedule and terms and conditions but the list of hospitals approved as per the MOU between GIPSA, TPA, & Insurer were not given to the insured. The insured, in absence of the list had taken treatment from a hospital that is not listed in the PPN list of hospitals. Under such circumstances the insurer cannot expect the complainant to undergo medical treatment from the hospital expected by the insurer. The respondent had also failed to prove that the insured was aware of this fact. The repudiation of the claim of the insurer is arbitrary and improper.

The respondent was directed to make an ex-gratia payment of Rs. 10,000/-.

Case No.AHD-G-050-1314-0823

Mr. Rajesh Bhavsar V/s The Oriental Insurance Co. Ltd.

Award dated 7th January, 2015

Repudiation of Mediclaim

The Complainant while driving his two wheeler his vehicle slipped & his left foot sustained fracture. His left foot was plastered & he was advised to take rest for 1 month. The Certificate to take rest was given by Dr. P.J. Vinchhi M.S (Ortho) of the Gujarat Cancer Society Medical College Hospital & Research Centre. The Complainant also submitted that he was on sick leave for 1 month from 10.09.2013 to 09.10.2013. He claimed 4 weeks Total Temporary Disablement from the Respondent which was partially settled for 2 weeks only.

The Respondent reduced TTD settlement to 2 weeks instead of 4 weeks based on their panel Doctor's opinion. The copy of the Doctor's opinion was not produced by the representative of the Respondent before this Forum. The Respondent had no proof to prove that the Complainant was not confined to bed for 1 month. They solely relied on their Panel Doctor's opinion.

The Respondent was directed to pay the balance 2 weeks Total Temporary Disablement, as claimed by the Complainant, Rs.5,000/- per week.

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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Case No.AHD-G-051-1314-0836

Mr. Vijay K Mishra V/s The United India Insurance Co. Ltd.

Award dated 9th January, 2015

Repudiation of Mediclaim

The Complainant's spouse had bleeding & in pathological reports her platelet counts were 1000/cmm. She was diagnosed with immune thrombopcytopenbia purpura+hypothyroidism, and was admitted in the Sterling Hospital, Ahmedabad from 29.12.2012 to 31.12.2012. Treating Dr. Eva Bhagat,M.D, D.Ped had confirmed in her certificate dated 010.03.2013 that at the time of diagnosis the platelet count of patient was 1000/cmm. Patient with active bleeding & platelet count less than 10,000/cmm had a risk of intracranial bleeding anytime. Hence as per the advice of the doctor she was hospitalized for the same & not for any procedure. The Complainant incurred total expense of Rs.38,906/-. His claim was repudiated by the Respondent citing Clause No. 2.3- that the treatment could have been on OPD basis.

The Respondent failed to prove, medically, that when the platelet counts are less than desired level the same can be treated on OPD basis. The Respondent was silent, in repudiation letter, about platelet count. The reason for why the patient was hospitalized & was kept under observation was overlooked both by the Respondent & its TPA.

The Respondent was directed to make the payment of Rs.32,000/- with interest @ 2% over and above Bank rate, from the date of receipt of the claim to the date of payment of the claim.

In the matter of

Complainant – Mr. Madhavlal S Patel

Vs

Respondent - The New India Assurance Company Ltd.

Complaint No. AHD-G-49-1314-840

Award Date: 10.02.2015

Policy No. 210200/34/12/01/00007183

The contention of the Complainant was that he had cataract in his left eye. He had gone to Dr. Vasavda for his eye treatment. Doctor. Dr. Vasavda had tested his eyes and was advised to go to Dr. Nagpal who took various tests and advised further treatment. Dr Nagpal had told him that if he had insurance policies then he should get best possible treatment as he would get the medical expenses reimbursed by way of claim to the Insurer. Accordingly, 3 injections were given in the eye at an interval of one month each. Even after the treatment he was not able to read properly. As he had complained about that, he was told that irrespective of the claim admissibility he had given the medical certificate.

The Respondent rejected the claim under policy condition 2.6 Note 4 & Note 5. Note 4 note 4 read as "the amount payable for any cataract surgery will be limited to actual or maximum of Rs. 24,000/- which was less either for cashless or reimbursement". The Policyholder was not provided with the Terms and conditions. The Insured was provided with the policy schedule only giving him a feeling that the schedule was the policy. The Insured was placed in

dark and was not knowing what was payable or what was not payable.Under such a situation after the happening of the contingency, the Insurer cannot take shield under the Terms and Conditions which were not provided to its Insured. The Respondent, incidentally had not provided the copy of the policy and its terms and conditions to the Forum as well alongwith their Self Contained Note.However, the Forum was given a copy of the Terms and conditions of the Mediclaim policy from the Respondent during the hearing. The terms and conditions of the policy (2012-13) did not carry similar exclusion clause 4.4.23 where the wording of administration on Lucentis was not there.
Thus, irrespective of the Terms and Conditions being provided to the Insured, the claim was wrongly repudiated under 2.6 note 4.
The complaint ,thus, stands admitted partially.

AWARD

The Respondent is hereby directed to settle the claim for Rs. 25,000/- on ex-gratia basis.

Case No. AHD-G-048-1314-0843
Mr. Bhurchand B. Bothra Vs. The National Insurance Co. Ltd.
Award dated 11TH FEBRUARY, 2015
Repudiation of Mediclaim

The Complainant was admitted in the Hospital on 13.01.2013 for his treatment of I.H.D, and incurred total expenses of Rs. 31838/-. A claim was lodged with the Respondent insurance company.

The Complainant had stated that he did not have any disease earlier, and never took any medicine for H.B.P.

The Respondent had repudiated his claim with a reason that hospitalisation was due to IHD and he was k/c/o H.B.P & Cardiomyopathy which was considered as P.E.D.

He further stated that his treating doctor Hiten Barot had given letter dated 01.02.2013 that HTN was since last 3 months.

The Respondent had failed to prove the treatment of the insured for I.H.D. was due to HTN & Dilated Cardiomyopathy which was chronic in nature & P.E.D.

The respondent directed to pay the claim amount of Rs. 10,000 as Ex-Gratia.

Case No.AHD-G-048-1314-0845

Mr. Rajnikant J Vaja V/s The National Insurance Co. Ltd.

Award dated 10th February, 2015

Repudiation of Mediclaim

The Complainant's Daughter Ms. Ruchi was diagnosed with Acute Calculus Cholecystitis-Pyocoele/Empyema. She was hospitalized & operated on 04.09.2013. She was discharged on 07.09.2013. The Complainant had incurred expense of Rs. 49,033/-. The Company had deducted Rs. 15,275/- & settled the balance amount of claim. He had sought clarification for the deduction & demanded reimbursement of the deducted amount. He was told that charges of items that fell under non-medicals were deducted.

The TPA vide letter dated 13.01.2014 had asked for clarification on charges for items like syringes & gloves from the insured. On non-receipt of the explanation the deduction were made. These items were very much essential in performing surgery. The deductions towards this & other items under non-medical items exhibited negative approach of the Respondent.

The Respondent was directed to make the ex-gratia payment of Rs.5,500/-.

Case No. AHD-G-051-1314-0846

Mr. Yogesh S. Rathi Vs. The United India Insurance Co. Ltd.

Award dated 11TH FEBRUARY, 2015

Partial Settlement of Mediclaim

The Complainant's Son was admitted in the Hospital for treatment and surgery of Acute Appendicitis, and incurred total expenses of Rs. 66,843/-. Before hospitalisation he had asked the hospital doctor to issue a consolidated receipt for settlement of his claim with the insurer. However, for operation and anesthesia charges, separate bills and receipts were issued to him citing the doctor's income tax issue.

The Respondent had partially repudiated the claim with a reason that the company shall not be liable to make any payment on bills other than the hospital bills as per policy terms and conditions no. 1.2 c and its sub clause note2.

He had further stated that, he had submitted clarification from treating doctor that the surgeon had issued separate bill and receipt for the surgery, and he had visited his hospital regularly for surgery.

As per the terms and conditions, reimbursement on receipt other than that of the hospital is not payable. Yet as no surgery can be performed without a surgeon and his charges. The Complainant/Insured should have questioned the hospital as to why a separate bill was issued. He could even take up the issue with the hospital now.

The Respondent was directed to pay Rs. 10,000/- as Ex-gratia payment.

In the matter of

Complainant – Mr. Ambeyprasad A Parikh

Vs
Respondent - The New India Assurance Company Ltd.
Complaint No. AHD-G-49-1314-847
Award Date: 10.02.2015
Policy No. 210600/34/120/1000/13252

The had approached this Forum stating that the amount of Rs.15,000/- was disallowed from the surgery charges under reasonable and necessary expenses. Deductions of Rs.908/- as non-medical items and investigations charges for 2D Echo and ECG charges was not justified as total expense on these items amounted Rs.1700. He requested the Forum to consider his claim.

The Insurer's representative was asked to show the letter written to the Insured explaining the basis of reasonable and necessary expenses. However, she has referred to the PPN network hospitals under cashless benefit which was not applicable to reimbursement claim cases. No other reason was assigned to the reasonable charges for any other hospital having similar facilities in the same geographical area. The Insurer's representative was asked to confirm whether she would reconsider the claim for an additional sum of Rs. 10,000/- towards surgery charges and Rs. 200/- towards ECG charges. She agreed to consider the difference of Rs. 10,200/-.

AWARD

In view of the above, the complaint is admitted. The Respondent is hereby directed to pay Rs. 10,200/- as ex-gratia payment.

Case No.AHD-G-049-1314-0849

Mr. Shreyas R Shah V/s The New India Assurance Co. Ltd.

Award dated 10th February, 2015

Repudiation of Mediclaim

The Complainant's spouse Mrs. Rupal was diagnosed of Epigastric Hernia. She was admitted in Sanjivani Hospital, Ahmedabad on 05/07/2013 & discharged on 07/07/2013. The Complainant had incurred total expense of Rs. 38425/-. Out of which the Company had deducted Rs. 10,000 towards customary & reasonable expense for which the Complainant was not convinced.

The Respondent had failed to prove that Clause-3.13- on Reasonable & Customary Charges as it did not specifically state, in the Policy Schedule, that reimbursement shall be restricted to rates prevailing in particular area for particular disease. Cashless facility is an internal facility carried out by TPA & the Company, the Customer should not be punished.The Respondent was directed to make the payment of Rs.10,000/-.

Case No. AHD-G-031-1314-0851

Mr. Parshottambhai M. Bambhrolia Vs. The Max Bupa Health Insurance Co. Ltd.

Award dated 11TH FEBRUARY, 2015

Repudiation of Mediclaim

The Complainant's Son was hospitalized & incurred the total expenses of Rs.1,28,848/-.

The respondent repudiated the claim stating that he did not disclose his actual weight in the proposal form. (at the time of policy declared weight 70 kg.) hence as per policy clause no. 5e claim was denied.

The complainant had submitted that he had declared his son's weight 75 kg approximate on his assumption.

The repudiation of claim on non disclosure of material fact had not relation with present disease. The present ailment/treatment viral fever had no relation with the difference in weight.

The Complaint was admitted & ex-gratia of Rs.75,000/- was awarded.

Case No. AHD-G-050-1314-0855
Mr. Gaurav K. Madhwani Vs. Oriental Insurance Co. Ltd.
Award dated 13TH FEBRUARY, 2015
Repudiation of Mediclaim

The Complainant's Father had gone to Rajasthan on the eve of diwali where he had sudden chest pain and was admitted in the Kota Heart Institute Kota. The doctor had advised for angioplasty. He was admitted in the hospital for the treatment of IHD, D- CAD, AWMI Mild iv Dysfunction 45%. He had incurred total expense of Rs. 2,15,708/-. A claim was lodged with the respondent insurance company.

The Respondent had repudiated his claim with a reason that the hospitalisation for the abovementioned treatment fell under the exclusion clause No. 4.1 & 4.3 of the policy.(Pre Existing Disease & Specific waiting period).

The Complainant had submitted his doctor's certificated dated 06.01.2014 which stated that the present ailment was acute coronary event. There was no history or DM Type 2.

It was concluded that in absence of pre insurance medical report, to prove the existence of the HTN & DM, the treating doctors' certificate of the Complainant showing that HTN & DM were not pre existing and Dr.Mahesh Morsada's (of the Respondent) certificate dated 01.12.2013, the respondent had not sufficiently proved the disease pre existed. The repudiation of the claim is thus incorrect and without application of prudent mind.

The Respondents was hereby directed to pay Rs. 1,50,000/- on ex gratia basis.

Case No.AHD-G-048-1314-0856

Mr. Shreyas R Shah V/s The National Insurance Co. Ltd.

Award dated 11th February, 2015

Repudiation of Mediclaim

The Complainant was diagnosed with Abdominal Colitis+ Anaemia. He was admitted in Niramay Hospital, Ahmedabad from 27.07.2013 to 01.08.2013. He had incurred total expense of Rs.29,973/-. The Respondent partially settled his claim & deducted Rs.13,750/-. When the Complainant asked for clarifications on deduction of amount he was told that it was as per terms & conditions of the Policy. The Complainant submitted that except the policy certificate he was not provided with the terms & conditions of the Policy.

The certificate submitted by the Complainant did not carry the policy condition-'20% co-pay for claims of person above 55 years'.

The Respondent failed to prove that Schedule of the Policy was given to the Complainant along with Policy Certificate.

The Respondent was directed to make the payment of Rs.12,300/-.

Case No.AHD-G-049-1314-0864

Mr. Bhikhabhai B Patel V/s The New India Assurance Co. Ltd.

Award dated 13th February, 2015

Repudiation of Mediclaim

The Complainant's spouse Mrs. Rupal was diagnosed with Haemorrhoids & Fissure with sentinel tag. She was admitted in Dr. Devendra Kanaiyalal Hospital & Nursing Home, Ahmedabad on 19.08.2013 & discharged on 21.08.2013. The Complainant had incurred total expense of Rs. 45,857/-. Out of which the Company had deducted Rs. 18,200 towards customary & reasonable expense for which the Complainant was not convinced.

No investigation was carried out by the Respondent, regarding the rates charged by other hospitals with similar services in that particular area, to prove that excess charges were levied by the hospital.

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 IRDA 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.

The Respondent was directed to make the payment of Rs.18,000/-.

Case No. AHD-G-050-1314-0865

Mr. Shailan B. Desai Vs. The Oriental Insurance Co. Ltd.

Award dated 11TH FEBRUARY, 2015

Partial Settlement of Mediclaim

He was admitted in the Aashirwad Eye Hospital Navsari for Cataract surgery on both eyes on 21.06.2013 and discharged on the same day. He had incurred total expenses of Rs. 89,571/-.

The Respondent had approved only Rs. 50,782/- and deduced Total Rs. 38,789/- under the policy clause reasonable & customary charges, non medical items, admission charges etc.

The Respondent had not verified the rates of hospital as provided in the IRDAI Rules on reasonable and customary charges and had settled the claim partially. The decision to settle the claim partially is arbitrary.

The Complaint was admitted.

In the matter of

Complainant – Mr. Mayur K Panchal

Vs

Respondent - United India Insurance Company Ltd.

Complaint No. AHD-G-51-1314-868
Award Date: 11.02.2015
Policy No. 060600/48/11/06/00014326

The Complainant had incurred an expenditure of Rs. 24,176/-. The claim was rejected on the basis of late intimation and difference in age .The Insurer's representative was asked to confirm whether he was aware of the IRDA circular No. IRDA/HTHL/MISC/CIR216/09/2011 dated 20.09.2011. The Insurer's representative was not aware of the circular. On further being asked whether any investigation was carried out to know the reason for the delay in intimation/wrong intimation as well as the difference in the age of the Insured. He confirmed that no investigation was carried out. He was further asked whether there was any difference in the premium slab for the age group 50-55 years. He agreed that the premium slab was same for the proponent with age between 50-55 years. With no change in the premium, the rejection based on the age was incorrect. The Complainant was having the policy from 2009 from United India Insurance Company Ltd. The subject policy period was from 19.11.2011 to 18.11.2012.The Insured aged 53 years was admitted to Anand Surgical Hospital for Pyrexia and Koch's Abdomen on 09.04.2012.Intimation was mistakenly given to M/s Geninsindia via mail on 09.04.2012 at 12.25 p.m. instead of M/s Med Save Health Care.As per the schedule of the policy, the information of hospitalization during the period 2010-11 should be given to their TPA M/s Geninsindia and during the year 2011-12, it should be given to TPA M/s Med Save Health Care.

Based on the oral submissions read along with documents on record the findings are as follows:

As per IRDA circular No. IRDA/HTHL/MISC/CIR216/09/2011 dated 20.09.2011 intimation if not done in the stipulated time can be waived if other things are in order. Here claim form was submitted on 27.04.2012 which was well within the time frame.

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

AWARD

In view of the above, I direct the Respondent to settle the claim of the complainant condoning the delay in intimation.

In the matter of

Complainant – Mr. Satyanarayan D Agrawal

Vs

Respondent - The Oriental Insurance Company Ltd.

Complaint No. AHD-G-50-1314-873

Award Date: 11.02.2015
Policy No. 141200/48/2014/1442

The Complainant's wife was operated at Baroda Laproscopy hospital for umbilical hernia for the period 20.04.2013 to 27.04.2013 and he had incurred an expenditure of Rs.1,51,557/- against which he had got a reimbursement of Rs. 70,460/- He said he was satisfied with most of the settlement except for the cost of tacker for Rs. 18,000/- which according to the operating surgeon was required for the operation. He requested to the Forum to consider his claim for Rs. 18,000/- On being asked whether he had ever read the policy terms and conditions? He stated that he had never received the same and even never asked for the same

The Insurer's Representative stated that the claim for Rs. 18,000 was refused under policy condition 13.2 i.e. reasonable, customary and necessary expenses. He was asked to show how this clause was applicable when no similar facility or the charges in the geographical area were quoted to the Insured. He said that the decision was taken by their TPA. Absorba Tack 30TM New 5mm is a Single Use Abs /Fix Device which was also confirmed by the treating doctor. The tackers are used to fix the mesh and in this case no two meshes were used which was confirmed by the certificate given by Dr. Pankaj Khandlwal. As per IRDA circular dated 20.02.2013 in regard to 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. As required by

the IRDA circular mentioned at 3 above, the Respondent was supposed to verify the reasonability of the expense and charges by causing enquiry with similarly facilitated hospitals in the vicinity of the hospital where the insured had undergone medical treatment. In absence of any comparative rate charts produced by the Respondent ,the deductions made merely on assumption towards tackers was not fair.

In view of the facts and circumstances, the complainant is entitled relief.

AWARD

In view of the above, the Respondent is hereby directed to settle the claim of the complainant on Ex-gratia basis and pay Rs.10,000/- in addition to the amount already settled.

Case No. AHD-G-051-1314-0876

Mr. Bipinchandra P. Patel Vs. The United India Insurance Co. Ltd.
Award dated 11TH FEBRUARY, 2015
Partial Settlement of Mediclaim

The Complainant's wife was admitted in the Shalby Hospital Ahmedabad from 10.10.2013 to 13.10.2013 for his treatment and surgery of Rt. Knee Replacement, and incurred total expenses of Rs. 2,70,000/-.
The Respondent had approved Rs. 1,92,500/- considering the sum insured as Rs. 2,75,000/- instead of Rs. 3,25,000/-.

The claim was settled as per clause no. 1.2.1b, as knee replacement surgery fell under major surgery. Accordingly 70% of the sum insured or actual expenses, whichever was less paid.
The respondent had rightly applied policy clause and made the payment of the claim.
The Complaint was dismissed.

Case No.AHD-G-050-1314-0881

Mr. Bharat R Bahl V/s The Oriental Insurance Co. Ltd.

Award dated 12th February, 2015

Repudiation of Mediclaim

Complainant's mother Madhu Bahel had met with an accident in 2009 & was diagnosed with Rt Humerus+ Non union+ Infection+ DM=HTN. She was admitted in Khara Fracture & Orthopaedic Hospital, Ahmedabad from 23.05.2013 to 24.05.2013 and was operated for implant removal, sinus track excision. The Complainant had incurred expense of Rs.24,847/-. The Claim was repudiated by the Respondent citing Policy Clause No. 4.1-"Pre-existing health condition or disease or ailment/injuries.

The Complainant was regularly getting insured, disclosing preexisting disease of DM, HTN & Thyroid to his Mother. In 2005-06 & 2006-07 the Complainants were insured with The Oriental Insurance Co. Ltd., 2007-08 & 2008-09 policy was with National Insurance CO. Ltd., 2009-10 policy was with United India Insurance Co. Ltd. & since 2010-11 the policy was with The Oriental Insurance Co. Ltd. Except 2012-13 Policy all the earlier policies were taken under group policy. It was specifically mentioned in the insurance certificate that pre-existing disease was also covered. The subject claim policy was purchased under Individual capacity.

The Forum directed the Respondent to settle Rs.15,000/- as ex-gratia payment to the Complainant.

Case No. AHD-G-005-1314-0886

Mr. Yogesh K. Thakkar Vs. Bajaj Allianz General Insurance Co. Ltd.

Award dated 13TH FEBRUARY, 2015

Repudiation of Mediclaim

The Complainant had stated that his son was admitted but he was cured. Subsequently he had again developed the same problem in the year 2013 and the doctor had advised for operation. He was admitted in the hospital for his treatment and surgery of Bilateral Vesico-Ureteric Reflux Grade - II with Renal Scarring, and incurred total expenses of Rs. 56,702/-. A claim was lodged with the Respondent insurance company.

The Respondent had repudiated the claim with a reason that certain discrepancies and lapses in claim documents were not clarified satisfactorily.

It is a fact that the insured's son was admitted in the hospital for treatment of his health issue. The Respondent's investigator had also reported the same to the Insurer. As regards, the date of discharge, the complainant had given in writing to the investigator that his son was discharged on 25th August 2013. The hospital record, where over written on the date of discharge is observed the corroborates with the letter to the investigator.

The Complaint was admitted & ex-gratia amount of Rs.28,000/- was awarded.

Case No.AHD-G-049-1314-0887

Mr. Kalpesh D Shah V/s The New India Assurance Co. Ltd.

Award dated 12th February, 2015

Repudiation of Mediclaim

The Complainant met with an accident on 22.11.2012 & was diagnosed with fractured left leg. He was operated on 03.11.2012. Dr. Ajay B Shah, MS (Ortho) gave certificate on 22.11.2012 advising

rest of 4 months. He was further operated on 15.12.2012. He claimed Temporary Total Disablement (TTD) for 26 weeks. On 01.02.2013 & 01.04.2013 he requested the Respondent to send Orthopaedic Doctor to inspect his medical treatment but the same was not heeded to. On 22.05.2013 his claim was settled partially for 12 weeks, without giving satisfactory reason for not settling the claim for 26 weeks. The Respondent informed the Complainant that TTD for 12 weeks was settled as per the advice of their medical refree - MS (Ortho).

The Respondent reduced TTD settlement to 12 weeks instead of 26 weeks based on their panel Doctor's opinion. The copy of the Doctor's opinion was not produced by the representative of the Respondent before this Forum. The Respondent had no evidences to prove that the Complainant was not confined to bed for 26 weeks. They solely relied on their Panel Doctor's opinion.

The Respondent should have carried out inspection of the Complainant's health and satisfied with the sanctity of the claim. Merely by referring the file to a specialist doctor does not prove that the Complainant was confined to bed for 12 weeks only & not for 26 weeks.

In the claim form dated 10.04.2013 the treating Dr. Ashok R Shah had specifically confirmed that the Complainant was under treatment.

The Respondent was directed to pay the balance 14 weeks Total Temporary Disablement, as claimed by the Complainant, at the rate of Rs.3,000/- per week.

In the matter of

Complainant – Mr. Vandan B Bhatt

Vs

Respondent - The New India Assurance Company Ltd.
Complaint No. AHD-G-49-1314-888
Award Date:
Policy No. 210600/34/120/1000/19338

The Complainant stated that his father had a fall and was operated for fracture in the Chirayu Fracture Orthopaedic and Spine Hospital. He had claimed an amount of Rs. 90,325/- out of which the Insurer had paid Rs. 72,143/-. Thus, there is a short settlement of Rs. 18,182. The Respondent had settled the claim for Rs 72,143/- and rejected Rs. 18,182/- on the basis of reasonable and customary charges under clause 3.13. The TPA had deducted the amount based on reasonable and customary charges. They had not produced any rate charts of any other hospital in and around the geographical area where the Insured was hospitalized. As per IRDA circular dated 20.02.2013 on " standardization in health insurance", Reasonable charges meant "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 absence of any rate charts produced by the Respondent ,the deductions made towards surgery charges and consultation specialist fees is not fair.The Consultation specialist fees of Rs.1000/- for pre- operative check up was not included in the hospital bill. The said bill for Rs. 1000 was an OPD bill dated 13.08.2013 by Dr. Manoj Vithalani, Physician and Diabetologist.The doctor had visited the Insured to check the Insured before the operation. The hospitalization was from 12.08.2013 to 16.8.2013.

The complainant is, thus, entitled for relief partially.

AWARD

The Respondent is hereby directed to pay Rs. 11,600/- to the complainant on Ex-gratia basis in addition to the amount already settled.

In the matter of

Complainant – Mr. Mukeshbhai P Vekariya

Vs
Respondent - The Oriental Insurance Company Ltd.
Complaint No. AHD-G-50-1314-895

Award Date:
Policy No. 121300/48/2013/03578
The Complainant stated that he had taken the Happy Family Floater policy with Oriental. His mother was operated for cataract on 07.05.2013. He had spent an amount of Rs. 18,000/- which was repudiated by the Insurer under clause 4.3 stating that the treatment for cataract was excluded for the first two years. He was asked to show the original policy. However, he showed the schedule of the policy. He was further questioned as to whether he had understood the policy condition 4.3 and at any stage he had asked for the policy terms and conditions? He replied in the negative and said he was only 4th standard pass. The Insurer's representative was asked to read the rejection letter. As he was not having the repudiation letter, the Forum showed the copy of the letter and asked to confirm the reasons for repudiation. He had referred to the policy clause no. 4.3 and stated that the claim had arisen in the 2nd year of the policy whereas cataract was excluded for the first two years. On being asked whether the policy terms and conditions were sent to the Insured ? He stated that the policy pertained to his Mumbai Office and he was not aware of the same. On being asked, he examined the policy number 121300/48/2012/3749 for the period 30th June, 2011 to 29th June, 2012, wherein previous policy number 60500/48/10/41/00004217 with effect upto 02.07.2011 was stated as Insurance without break since 4 years. Under these circumstances the Insurer's representative was asked to

confirm whether he can re-consider the claim? He agreed to re-consider the claim.

AWARD

In view of the Respondent's admission to reconsider the claim, the Respondent is hereby directed to pay the claim of the Complainant for Rs.18,000/- as full and final settlement.

Case No.AHD-G-050-1314-0897
Mr. M.D.Savaliya V/s The Oriental Insurance Co. Ltd.
Award dated 13th February, 2015
Repudiation of Mediclaim

The Complainant was diagnosed with Recurrent Tiahyper Homocysteiomia (Paralysis) & hospitalized in Poojan Multi speciality Hospital, Ahmedabad from 26/06/2013 to 27/06/2013. He had incurred expense of Rs. 44,125/-. His claim was repudiated by the Company & the reason was not acceptable to him- Genetical disorders & stem cell implantation/surgery.

The Complainant had submitted treating Dr. Ronak Shah, MD (Internal Medicine), AFIH, Physician Cardiologist & Diabetologist, certificate dated 24.09 giving his opinion that it was not a genetic disorder. The cause for the same was stated as idiopathic i.e not known it occurs suddenly.

The Respondent's TPA Doctor had carried out further investigation to counter the treating Doctor's replies but the copy of his opinion was not produced to satisfy the Forum that it was congenital & what report or document helped him to arrive at the opinion.

The Respondent could have carried out 5-methyltetrahydrofolate(5-MTHF) Report to confirm whether Hyper Homocystenaemia was congenital or not.

The Forum directed the Respondent to settle the claim & pay Rs.44,125/- to the Complainant.

Case No.AHD-G-049-1415-0010

Mr. Deven R Mehta V/s The New India Assurance Co. Ltd.

Award dated 16th February, 2015

Repudiation of Mediclaim

The Complainant's daughter Vaishnavi was admitted in Amardeep Multi Speciality Children Hospital & Research Centre, Ahmedabad from 07/02/2013 to 08/02/2013 for the surgery of Bilateral Inguinal Hernia. He had incurred expense of Rs. 35,000/-. His claim was rejected by the TPA of the Company citing Clause No. 4.4.6. He had not received satisfactory reply from the Company about his claim. The Complainant had given the copy of sonography report carried out on 21.12.2009, the findings of which were normal.

In Policy Terms & Condition 4.3-"Waiting Period for specified disease/ailments/conditions: Sr. No. 9-Hernai of all types-Waiting period was of 2 years". The Insured was included in the mediclaim policy since 27.12.2010 to 26.12.2013. The subject claim was in 3rd year, after 2 years of waiting period.

The Respondent's TPA had not carried out further investigation &/or Reports to counter the treating Doctor's replies & prove that it was congenital.

The Forum directed the Respondent to settle the claim & pay Rs.35,000/- to the Complainant.

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.

In the matter of

Complainant – Gopal J Majithia

Vs

Respondent - United India Insurance Company Ltd.
Complaint No. AHD-G-51-1415-0013
Award Date: 16.02.2015
Policy No. 067402/48/12/12/06/0000033

The Complainant stated that his son was admitted to Sterling hospital, Rajkot on 28.09.2013 and was operated for appendicitis. When a claim for Rs. 61,737/- was lodged under the policy, the Company had deducted Rs. 21,600/- and paid the balance amount. The Representative of the Respondent stated that the TPA had deducted Rs. 22,915/- under clause 2.4 i.e reasonable and necessary expenses. The TPA had deducted the amount based on reasonable and customary charges. They have not produced any rate charts of any other hospital in and around the geographical area where the Complainant was hospitalized.This hospital was under PPN. An MOU had been signed between the Insurer, Hospital and the TPA. The

PPN is the Insurer's internal arrangement where the Insured is not a party to such arrangement. Under such situation, the arrangement made by the Insurer with the PPN and the payment charged by the PPN hospital should be reasonable. The Insurer, hence, at the time of claim cannot take a plea that the amount charged by their PPN hospital is unreasonable and deduct the expenses incurred by the Insured and reduce the claim amount arbitrarily.

In view of the facts and circumstances, the complaint is entitled for relief.

AWARD

In view of the above facts, the Respondent is hereby directed to pay a sum of Rs. 21,600/- in addition to the amount already paid to the Complainant.

Case No.AHD-G-005-1415-0020

Mr. Paresh Manek V/s Bajaj Allianz General Insurance Co. Ltd.

Award dated 17th February, 2015

Repudiation of Mediclaim

The Complainant was diagnosed with Acute Coronery Syndrom & was hospitalized in Managalm Hospital, Morbi from 16/07/2013 to 18/07/2013. Then again he had heart problem & was shifted to CIMS, AHmedabad on 26/07/2013. Angiography was performed. He claimed Rs. 71,652/-. His claim was repudiated by the Company. Complainant submitted that one of his relative had mentioned, inadvertently, to Doctors of CIMS that he was having DM since last 6 months. He confirms that he had no previous history of Diabetes.

The Respondent failed to prove the exact duration since when the Complainant was suffering from DM. Merely on the declaration of any relative the duration cannot be arrived at. In the subject Policy the commencement of risk was 14.02.2013 & date of admission in

the Hospital was 16.07.2013. The period between pre-existing & commencement of risk is very short.

The Respondent should have carried out concrete investigation & produced valid medical reports/proof to confirm the exact duration of the DM, before repudiating the claim.

The Forum directed the Respondent to settle the claim & pay Rs.35,000/- to the Complainant.

In the matter of

Complainant – Mr. Nitesh P Kapadi

Vs

Respondent - Oriental Insurance Company Ltd.

Complaint No. AHD-G-050-1415-0021
Award Date: 17.02.2015
Policy No. 530000/48/2013/128

The Complainant had suffered an accident on 05.08.2012 and was hospitalized. He intimated his employer LIC, the Policy Holder on 04.09.2012. The LIC intimated the Oriental Insurance Company on 08.09.2012. Finally the claim document was submitted to the Oriental Insurance Company on 18.04.2013.The Insurance Company repudiated the claim on the ground of violation of their policy condition i.e. delayed intimation /submission of documents, as well as violation of terms of the MOU for submission of claim documents.This Forum observes that the Complainant is an employee of the Life Insurance Corporation of India who have availed the policy and the Complainant is the beneficiary. Therefore, the Complainant has to inform his employer regarding the accident and the claim. In turn the policyholder, interacts with the Respondent Insurance Company regarding intimation and claim. The Complainant has acted within reasonable period of time to intimate his Employer who in turn have also intimated the Respondent, Insurance Company. However, a period of time has been taken, to compile the documents and finally file the claim papers to the

Insurance Company.The beneficiary and the Policyholder have acted within reasonable time and there does not appear to be deliberate delay. The Respondent's repudiation of the claim, in gross violation of the guidelines issued by IRDA regarding claims, where delayed documentation takes place is definitely incorrect.

In view of the above facts, especially the IRDA circular, the complaint is admitted.

AWARD

The Respondent is hereby directed to settle the claim taking into cognizance of the IRDA circular regarding delayed intimation and claim documentation .

Case No. AHD-G-051-1415-0023
Mr. Amber Anilkumar Bavishi Vs. The United India Insurance Co. Ltd.
Award dated 17TH FEBRUARY, 2015
Partial Settlement of Mediclaim

The Complainant was admitted in the Hospital for his treatment and surgery of Rt. Inguinal Hernia and incurred total expenses of Rs. 74551/- and lodged the claim with the Respondent. But the claim was approved for Rs.23296/- only and the Respondent had deducted Rs. 51,253/- as not payable under the policy clause 1.2c read with its Note No2.
The Respondent had settled the claim for a receipt of Rs.14000/- whereas a receipt for Rs.45000/- has not been paid for, despite the fact that both the receipts were issued by the same hospital and both the receipts bore the stamp and seal of the hospital. The Forum find the rejection of Rs.45000/- is not correct.

The Complaint was admitted.

Case No.AHD-G-023-1415-0026

Mr. Shivraj Singh Yadav V/s Iffco Tokyo General Insurance Co. Ltd.

Award dated 19th February, 2015

Repudiation of Mediclaim

The Complainant's Spouse Mrs. Vinod Kumari had been suffering from Chronic Kidney disease Stage-IV, HTN, Multiple Myeloma, Bradycardia since 2005. She was admitted & treated at Shalby Hospital, Ahmedabad from 30.05.2012 to 01.06.2012. He had claimed pre & post hospitalization medical expenses. Out of the total amount claimed, the Respondent had deducted Rs.14,489/-.

Out of the claim of Rs.14,489/- the Respondent had agreed to pay R.3838/- & stated that the balance amount of Rs.10,651/- was deducted towards the medicines purchased for consumption beyond 60 days (post hospitalization). It was found that deduction was in accordance with the Policy Terms & Conditions- viz. Condition No. 16-Post Hospitalisation-"Relevant medical expenses incurred during period up to 60 days after hospitalization on disease/illness/injury sustained will be part of hospitalization Expenses Claim".

As agreed by the Respondent, the Forum directed the Respondent to pay Rs.3,838/- to the Complainant.

Case No.AHD-G-023-1415-0027

Mr. Shivraj Singh Yadav V/s Iffco Tokyo General Insurance Co. Ltd.

Award dated 19th February, 2015

Repudiation of Mediclaim

The Complainant was admitted in the Hospital for Fever, Thrombocytopenia, CAD, DM-2 from 20.09.2012 to 21.09.2012. He had claimed pre & post hospitalization medical expenses. Out of total amount claimed, the Respondent had deducted Rs.13,506/- without giving any valid reasons.

The Respondent had not given valid reasons for the deductions of Rs.13,506/-. The Respondent should have specifically mentioned the reasons of the deductions.

On submission of the detailed Terms & Conditions of the Policy, it was found that as per Sr. No. 23, Coverage- What is covered Sr. No. 4, Medicines & Drugs were reimbursable. The Respondent had deducted the amount of Rs.13,506/- citing medicines names without giving any reasons. During the hearing the Representative of the Respondent was also not able to explain the reasons of the deductions. the Forum directed the Respondent to settle the claim & pay Rs.13,506/- to the Complainant.

Case No. AHD-G-050-1415-0035

Mr. Evan S. Higgens Vs. Oriental Insurance Co. Ltd.

Award dated 19TH FEBRUARY, 2015

Repudiation of Mediclaim

The Complainant had submitted that he was admitted in the Sanjivani Medical Hospital Ahmedabad from 25.07.2013 to 30.07.2013 for the high grade fever. He had incurred total expenses of Rs. 16,835/-.

The Respondent had repudiated his claim saying that as per the investigation report, due to mismatch in date of hospitalisation and date of discharge, and wrong address the claim could not be paid.

Inspite of the sending intimation on 26.07.2013 through email by his agent, the Respondent / Investigator had not paid visit to hospital

within reasonable time, and had obtained the statement at their office after a 3 months, by calling him in person.

The respondent was directed to pay the claim amount of Rs. 16,834/- with 2% interest above the prevailing bank P.L.R.

In the matter of

Complainant – Mr. Jayantilal K Dholaria

Vs

Respondent - The New India Assurance Company Ltd.

Complaint No. AHD-G-49-1415-0037
Award Date: 18.02.2015
Policy No. 212500/34/12/12/01/00002227

The Complainant had taken Insurance Policy covering his family members from the year 1996. The initial sum insured under the policy was Rs. 50,000 which was increased gradually. One of the Insured was hospitalized for joint knee replacement on 31.07.2013. The claim for Rs 1,87,500/- was lodged with the Company, but the Company settled Rs. 1,32,500/- being the total of the Sum Insured and the Cumulative Bonus available under the policy. The Complainant's plea was for balance payment of Rs. 51,807/-. The Representative of the Respondent stated that the Complainant had increased the sum insured from Rs. 1 lac to Rs. 1.5 lacs in 2011. As per the policy terms and conditions enhanced Sum Insured towards expenses for knee replacement would be payable only after 4 years. Hence, the claim was settled based on the original Sum Insured i.e.Rs. 1 lac + Bonus amounting to Rs. 32,500/-. Therefore, the demand for Rs.51,807/-by the Complainant was not tenable as the Sum Insured + Cumulative Bonus applicable under the policy got

exhausted with the payment of Rs. 1,32,500/-. Since the waiting period under clause 4.3 was for four years and the Sum Insured was increased in 2010 to Rs. 1.50 lacs and thereafter in 2012 to Rs. 2 lacs, the Sum Insured of Rs. 1 lac as in 2009 was only applicable. The Insurer had correctly applied the clause and made the correct payment.However, the Respondent is advised to explain always in detail to the Insured on the deductions from the amount claimed by him. The Respondent was also advised to handover the terms and conditions of the policy under intimation to this Forum.

AWARD

In view of the facts and circumstances, the decision of the Respondent needs no interference.

Case No.AHD-G-005-1415-0039
Mr. Rajendra Verma V/s Bajaj Allianz General Insurance Co. Ltd.
Award dated 20th February, 2015
Repudiation of Mediclaim

The Complainant was admitted in Mahavir Speciality Hospital, Waghodia Road, Vadodara on 15/10/2013 with the symptom of fever & swelling near naval area. After the due investigations & report he was diagnosed of Umbilical Hernia & got operated on 16/10/2013 by Dr. Ravi Sehgal. He was discharged on 22/10/2013. On 28/10/2013 he again had fever, vomiting & uneasiness so again admitted in the same hospital. But very next day he was referred to Shivani Hospital, Gotri Road, Vadodara because his current complaint was not properly attended by the incharge doctor, as well as it was Diwali Festive days & Doctor had a plan to go out station. Doctor himself suggested Shivani Hospital & was discharged & shifted on 29/10/2013. He was treated for Colitis & was discharged

on 04/11/2013.During all these hospitalizations he incurred expense of Rs.2,51,302/-.

The Complainant had submitted a letter dated 14.10.2013 of Mahavir Hospital where it was mentioned about the Insured being advised about Liposuction. However, this did not mean that he was not operated for hernia.

The Final Investigation was carried out by the Respondent's Dr. Satish Kanojia, Manager Claims on 24.12.2013. In this report, on page number 4, under point No. 2 of the Observations, it is mentioned that "there are chances that Liposuction may have been done in the name of abdominal hernia or both the surgeries could have been done together". However, this investigation conclusively doesn't exclude the surgery for hernia on the patient.

The Expert's opinion (Dr. Jignesh P Shah, M.S (Lap Gen. Surgeon), FMAS) dated 08.01.2014 was collected from Ahmedabad & the Complainant resided in Vadodara. As the opining Doctor had not examined the Insured, the opinion was given merely on the basis of papers produced before him. There was no physical investigation was carried to prove that surgery was for Liposuction.

Indoor Case Papers dated 16.10.2013 of Mahavir Superspeciality Hospital clearly confirms that Umbilical Hernia surgery was performed by Dr. Ravi Sehgal with Mash repair at 6.00 p.m with general anaesthesia.

Indoor Case Papers are having day to day line of treatment along with B.P & Pulse details.USG of Abdomen carried out by Dr. Jayesh Shah, dated 15.10.2013 confirms Umbilical Hernia wall defect of 9 mm.The Forum directed the Respondent to pay Rs.65,000/- to the Complainant.

In the matter of

Complainant – Mr. Uday Dinkar Harshe

Vs

Respondent - TATA AIG Insurance Company Ltd.
Complaint No. AHD-G-47-1415-0040
Award Date: 20.02.2015
Policy No. MRP 05000016384

The Complainant was covered under Maharaksha Personal Injury Plan Policy bearing No. MRP 05000016384.The said policy provided payment for daily benefit for each day an Insured is an In-patient in a Hospital due to accident or accidental injury. On 1st December, 2011 the Complainant accidently fell from a chair and was operated for spinal injury. He was under various treatment afterwards. His subject claim was for the hospitalization for the period 14.02.2014 to 12.03.2014 at Yogni Vasant Devi Arogya Mandir for bed sores. Total days of hospitalization was 27 days. His claim was that bedsores were as a result of his confinement to bed as he was immobilized due to the accident. The Respondent had rejected his claim contending that bedsore was a sickness and not an accident. The Representative of the Respondent stated that the Company had paid all the claims admissible as per the terms and conditions of the policy. The subject claim was not payable as it fell beyond the scope of the policy as defined under period of confinement. He referred to the certificate of Dr. Ravi Sehgal dated 23.05.2014 which stated that it was a disease and not an accident. The Respondent pointed out that if a confinement (hospitalization) is after 30 days from the last discharge from the hospitalization the said confinement (hospitalization) would be considered as a fresh one and all the exclusions of the policy would apply. This claim is the result of the hospitalization (because of bed sore) which is separated by more than 30 days from the previous hospitalization (due to accident). Therefore, they had not considered this particular claim. The accident was in 2011 and the claim for bedsore was in 2014.

The Forum is of the opinion that the whole confusion in the mind of the Complainant is because of his understating that his hospitalization due to bedsore is a direct consequence of the accident he had suffered. Whereas, the terms of the policy issued to him by the Respondent categorically states that if the confinements

(hospitalizations) are separated by more than 30 days, each one would be considered as unrelated.

In view of the terms and conditions of the policy, the decision taken by the Respondent is in order.

AWARD

In view of the facts and circumstances, the decision of the Respondent needs no interference.

In the matter of

Complainant – Mr. Uday Dinkar Harshe

Vs

Respondent - TATA AIG Insurance Company Ltd.
Complaint No. AHD-G-47-1415-0041
Award Date: 20.02.2015
Policy No. HCP15000011467

The Insured was covered under Individual Accident and Sickness Hospital Cash Policy .bearing No. HCP15000011467.This Health Care Policy provided for any one day of confinement regardless the number of Accidents, Injuries, Illnesses or Sicknesses for which confinement is required. On 1st December, 2011 the Complainant accidently fell from chair and was operated for spinal injury. He was on various treatment afterwards. His subject claim for the hospitalization for the period 14.02.2014 to 12.03.2014 at Yogni Vasant Devi Arogya Mandir was for bed sores. The total number of days of hospitalization was 27 days. His claim was that bedsores were as a result of his confinement to bed as he was immobilized due to the accident. Hence his claim be treated as accident and not due to sickness. However, the Respondent had considered his claim as that of sickness and paid it partially. Based on oral submissions read along with documents on record the Forum is of the opinion

that the whole confusion in the mind of the Complainant is because of his understating that his hospitalization due to bedsore was a direct consequence of the accident he had suffered. Whereas, the terms of the policy Individual Accident and Sickness Hospital Cash Policy issued to him by the Respondent categorically states that if the confinements (hospitalizations) are separated by more than 45 days, each one would be considered as an independent and not related to the previous one.

Under the circumstances, the Complainant's hospitalization during the period 14.02.2014 to 12.03.2014 due to bedsore would be considered as not related to the accident, since the said hospitalization had taken place long after his discharge from the previous one.

In view of the terms and conditions of the policy, the decision taken by the Respondent to pay on the basis of sickness is in order.

AWARD

In view of the facts and circumstances, the decision of the Respondent needs no interference.

Case No. AHD-G-049-1415-0074
Manmitsing K. Sikka Vs. The New India Assurance Co. Ltd.
Award dated 19TH FEBRUARY, 2015
Partial Settlement of Mediclaim

The Complainant got injured in a vehicular accident on 01.09.2012 He was admitted and treated, from 01.09.2012 to 04.09.2012. On discharge the treating doctor had advised him rest for 12 weeks. As the injury did not heal properly, he was again admitted on 25.12.2013 for surgery. The treating doctor had advised rest for 5 months from the date of accident i.e. 01.09.2012. A claim was lodged with the Respondent.

The Respondent had allowed compensation for 16 weeks compensation instead of 20 weeks. The treating doctor had recommended rest for 20 weeks.

In the matter of

Complainant – Mrs Mamta P Verma

Vs

Respondent - The New India Assurance Company Ltd.

Complaint No. AHD-G-49-1415-0085
Award Date: 20.02.2015
Policy No. 210600/34/120/1000/12266

The Complainant was insured with the Respondent since 2006. She was hospitalized at 'Long Life Hospital' for removal of lump from her Left Breast. She was admitted to the hospital on 09.07.2013 and discharged on 10.07.2013. When she had preferred a claim for Rs 39,443/-, the Company deducted Rs. 12,000/- the reason for which she was not aware. She wanted the amount refunded. Her treating/attending doctor had informed her that it was a reasonable charge and he had not charged anything in excess. Since she had paid the amount to the doctor she demanded settlement of balance claim amount of Rs.12,000/- .The Respondent had stated that they had deducted the amount on the basis of Reasonable and Customary

charges under clause 3.13 of the mediclaim policy. The Respondent's contention was that the claim was settled as per the policy terms and conditions. The deduction is effected as the amount claimed was much higher than the charges for similar charges/treatment in other hospitals which are under PPN arrangement.

However, alongwith their SCN the Respondent did not submit the said rate chart of other hospital in and around the geographical area where the Insured was hospitalized.The Respondent had not compared the rates/charges collected by other hospitals with similarly facilitated hospitals in the vicinity of the hospital where the complainant had taken medical treatment as required by the IRDA circular mentioned above. The partial settlement of the claim without observing the directives of the IRDA vitiates the spirit of insurance and causes agony in the insured. In absence of any rate charts produced by the Respondent, the deduction made towards surgery charges is incorrect and unfair. The complainant deserves relief. The Complaint is admitted.

AWARD

In view of the above facts, the Respondent is hereby directed to pay a sum of Rs. 12,000/- in addition to the amount already paid to the Complainant.

Case No. AHD-G-049-1415-0087

Mr. James V. Puthoor Vs. The New India Assurance Co. Ltd.
Award dated 20TH FEBRUARY, 2015
Partial Settlement of Mediclaim

The Complainant's wife was hospitalized & he had incurred total expenses of Rs. 25,527/-. The claim was settled for Rs. 11,449/- only and Rs.17,078/- was deducted with various reason stated to be under the terms and conditions of the policy.

The Respondent had partially settled his claim saying that "he had opted a room with higher rent than the entitled category hence, the charges payable was restricted to the charges applicable in the entitled category and other deduction were on service charges and non medical items".

The respondent had not provided the complete policy with its terms and conditions to the insured. As a result the insured is unaware of such terms and conditions under which the claim is reduced.

The Respondent was directed to pay Rs.16,993/-.

Case No.AHD-G-048-1415-0088

Mr. Amrutlal Cholera V/s The National Insurance Co. Ltd.

Award dated 20th February, 2015

Repudiation of Mediclaim

The Complainant had undergone medical treatment for Coronary Angiography & implantation of Pacemaker at Dhakan Hospital from 20.12.2013 to 24.12.2013. He had incurred total expense of Rs.2,14,572/. The Insurance Company had paid Rs.1,50,000/- only. He had increased the Sum Insured from Rs.1,50,000/- to Rs.2,00,000/- in August,2012. The surgery was done after 1 year & 3 months from the date of enhancement in the sum insured. The Complainant is of the opinion that DM & HTN had no correlation with this claim.

The Respondent had cited Clause No. 4.1, 4.2 & 4.3 to the Complainant through letter. However, the Respondent admitted that complete policy, with its detailed terms & conditions were not provided to the Insured. The Forum feels this is complete violation of the IRDAI guidelines under Protection of Policyholder's Interest, Regulations, 2002 (point No.7-1-m).

At the same time the Forum notices that the Insurer has put a rubber stamp impression on the Schedule of the Policy given to the Insured highlighting certain changes to the Policy terms but the Complainant never tried to ascertain from the Respondent the details & the implications of the rubber stamp impression.

In view of the above the Forum is inclined to accept the Respondent's version that the claim has been settled as per revised terms & conditions of the Policy, but by not making available the complete policy they have caused inconvenience, confusion & doubt in the mind of the Complainant.

The Forum directed the Respondent to make the payment of Rs. 10,000/-, as ex-gratia, to the Complainant.

Case No. AHD-G-003-1415-0089

Mr. Harshad T. Patel Vs. The Apollo Munich Health Ins. Co. Ltd.

Award dated 20TH FEBRUARY, 2015

Repudiation of Mediclaim

The Complainant was admitted in the Hospital for the treatment of Acute Lower Backache, para Muscle Spasm on both Lower Limbs. He had incurred total expenses of Rs. 33,275/-.

The Respondent had repudiated his claim saying that the hospitalisation for 7 days was only for investigation and evaluation.

The Respondent's mere suspicion that the admission was only for investigation is not prudent. The Complainant had undergone hospitalisation and the treatment on due advice of the doctor.

The Respondent was directed to pay of Rs. 33,275/-.

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.

Case No.AHD-G-051-1415-0091

Mr. Chandrakant S Patel V/s The United IndiaInsurance Co. Ltd.

Award dated 24th February, 2015

Repudiation of Mediclaim

The Complainant was hospitalized for implanting stent. He incurred total expense of Rs.2,77,000/-. Out of which the Company had made the payment of Rs.1,40,000/-. The Complainant submitted that he was having two mediclaim policies. One policy was having sum insured of Rs.2,00,000 & second Super Top up Policy with sum insured of Rs.5,00,000/-. His claim under regular mediclaim policy was settled for Rs.1,40,000/- stating in major surgeries only 70% of the sum insured was payable as per terms & conditions of the policy, which he was never provided with. Balance Rs.77,000/- was rejected due to non-disclosure of Valve operation done before 22 years. In the proposal for Super Top up Policy, question related to past hospitalisation within 5 years was asked. Since he had not taken any treatment within the last 10 years he answered the question as 'No'. He further stated that the claim under the Super Top Up policy was in the 3rd year.

The Respondent should have verified 1999 proposal form, to confirm any pre-existing disease or treatment which affects their risk assessment, as he was continuously renewing the policy with the Respondent since then. In their regular policy terms & condition the

waiting period for any pre-existing disease is 4 years. Here the Complainant was renewing the policy since 1999.

In the Proposal Form of the Super Top up Policy it was specifically asked in Question No. 13 about details of the hospitalization for the last 5 years. Therefore the Complainant had not mentioned about the Mitral Valve Replacement, which was done before 22 years.

The Respondent's Representative admitted that had the past history of Mitral Valve replacement was disclosed in the proposal form of Super Top up policy, the claim would have been paid as it was allowed after 2 years & the subject claim fell in the 3rd year.

The Forum directed the Respondent to settle the claim & pay Rs.72,364/- to the Complainant.

Case No. AHD-G-050-1415- 0092

Mr. Kiritkumar C. Mistry Vs. The Oriental Insurance Co. Ltd.

Award dated 25TH FEBRUARY, 2015

Partial Settlement of Mediclaim

The Complainant's wife was hospitalized for the Lt. Eye Cataract surgery, and incurred an expenses of Rs. 63981/-. The Respondent had partially settled the claim for Rs. 34,530/- only after deducting Rs. 29450/- (Rs. 14,000/- towards IOL charges, Rs.14,980/- Professional charges & Rs. 220/- Rs. 250/- under Non medical items.)

The Respondent had wrongly interpreted policy clause and deducted the claim amount arbitraly. The Respondent had not observed the provisions of IRDA circular on reasonable charges.

The respondent was directed to pay sum of Rs.15000/-.

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

Complaint No. AHD-G-51-1415-0093

Policy No. 060500/48/12/97/00017419

The Complainant stated that he had mediclaim policy since last 22 years which was renewed without break. He was hospitalized at Sterling hospital for left lower pole Parathyroid adenoma and had undergone Hyper Parathyroid Adenoma. It was a major surgery. When he preferred a claim for Rs. 1,46,729/- the Company had deducted Rs.41,858/- under clause 1.2 of the mediclaim policy. His representations to the company were not answered. His contention was that the policy terms and conditions provided by the Company, the wordings were so small that it was very difficult to read. Moreover, the terms and conditions should be in a local language so that the same is understood by all. The deductions done based on 1% sum insured for the room rent should not apply for all the charges which he had paid. The TPA had deducted the amount based on clause 1.2 of the mediclaim policy. The entitled category of 1% sum insured applicable for all other deductions other than room rent was not defined in the terms and conditions of the policy. The TPA had arbitrarily made deductions which were not reviewed by the Regional Office on the representation of the Complainant. The bills produced by the Complainant were studied. The Respondent is advised to have a human approach to the policyholder instead of a mechanical approach. They failed to reply to their Insured and allowed the TPAs to take their decision.

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

AWARD

In view of the above, I direct the insurer to pay Rs. 21,614/- in addition to the amount already settled.

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

In the matter of

Complainant – Mr. Shivlal B Toshniwal

Vs

Respondent - The Oriental Insurance Company Ltd.

Complaint No. AHD-G-50-1415-128

Award Date: 26.02.2015

Policy No. 141103/48/2013/8704

The Complainant deposed that his wife was admitted to the hospital as per her doctor's advice. The Company had rejected his claim on his wife's hospitalization stating that hospitalization was not necessary.The Representative of the Respondent stated that their TPA had rejected the claim earlier. The Representative was asked when the decision to admit the Insured was taken by her attending doctor, how had the Respondent repudiated the claim stating that the 'treatment required no hospitalization'? The

Representative replied that he had reviewed the case and referred the case to their panel doctor for decision. The Panel doctor had recommended payment of the claim the day before the hearing.

The Forum was of the opinion that had a judicious decision been taken in time, the settlement of the claim would have been long back. Moreover, the Respondent could have decided to pay, atleast, when the notice was received by them from this Forum. As there was delay in making the payment, the Respondent was advised to settle the claim alongwith 2% interest over and above the bank rate from the date of claim to the date of settlement.

AWARD

In view of the above, the complaint is admitted. The Respondent is hereby directed to settle the claim alongwith 2% interest over and above the bank rate from the date of claim to the date of settlement.

Case No. AHD-G-051-1415-0130

Mr. Kalpesh K. Mepani Vs. The United India Insurance Co. Ltd.

Award dated 27TH FEBRUARY, 2015

Repudiation of Mediclaim

The Complainant's son was hospitalized in Hospital for the Acute Cv Stroke treatment. He had incurred an expense of Rs. 62,890/-.

The Respondent had quoted policy clause No.5.11 and repudiated the claim.

The repudiation of the claim was under clause No. 5.11 viz. cancellation of the policy which the representative has agreed it to be incorrect reason for repudiation.

The Respondent had not investigated & verified the genuineness of the claim before repudiation of the claim as "No Claim", and had applied irrelevant policy clause for repudiation of claim.

The Respondent was directed to pay Rs. 62,890/-.

Case No. AHD-G-049-1415-0144
Mr. Rameshchandra B. Patel Vs. The New India Assurance Co. Ltd.
Award dated 27TH FEBRUARY, 2015
Partial Settlement of Mediclaim

The Complainant was admitted in Satya Hospital, Ahmedabad on 18.11.2013 for surgery of fissure and piles. He had incurred an expenses of Rs. 44,463/-.
The Respondent had partially settled the claim for Rs. 27,963/- and deducted Rs. 16,500/- under "Reasonable and Customary charges" clause.
The repudiation was not justified in absence of the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services and the nature of the illness / injury.

The respondent was directed to pay sum of Rs. 16,500/-.

In the matter of
Complainant – Mrs. Sumitraben C Patel
Vs
Respondent – The National Insurance Company Ltd.

Complaint No. AHD-G-48-1415-0146
Award Date: 27.02.2015
Policy No. 302100/48/13/8500000615

The representative of the Complainant (husband) appeared and stated that his wife was admitted to Darthi Orthopedic hospital for spine surgery. Against his hosptalisation claim of Rs. 80,339/- the Company had settled Rs. 62,384/-. He said the medicines that were disallowed by the company were purchased as per the doctor's advice. He said he had paid the operation charges to the hospital and that amount may be reimbursed. It was explained to him that as per the policy terms and conditions the Company had reimbursed a part of the claim amount towards the operation charges.

The Representative of the Respondent stated that the overall limit of Rs.31,250 was paid and under the head Consultant charges for Rs. 400 + Rs.7000, Anesthesia charges Rs. 3500 + Operation charges Rs. 20,350 were paid.

In respect of the medicines which were disallowed he was asked to explain the deductions. He stated that as per their TPA, the cost of the medicines were not reimbursed as they were not related to the treatment. He was asked to explain what were the medicines disallowed and why? He could not tell anything other than that it was disallowed by their TPA. He had given a copy of the prescription of the medicine to the Forum which were disallowed.

Since the representative of the Respondent was not able to explain the deductions, on the medicines for Rs. 2805/- the insured is directed to settle the claim of Rs. 2805/- to the Complainant.

AWARD

In view of the above, I direct the Respondent to pay Rs. 2,805/- in addition to the amount already settled.

Case No.AHD-G-051-1415-0147
Mr. Nipesh Shah V/s The United IndiaInsurance Co. Ltd.
Award dated 27th February, 2015
Repudiation of Mediclaim

The Complainant had an accidental fall from a scooter in January, 2014. His right leg knee ligament was torn. He was advised by his family doctor to consult Dr. Anang Joshi in Mumbai. He was diagnosed with Right Knee ACL insufficiency. He was admitted in Sportsmed, Mumbai between 17.02.2014 to 19.02.2014. He was treated with Arthroscopic Right Knee ACL reconstruction & Medial Meniscal repair on 17.02.2014. He had incurred total expense of

Rs.1,89,213/-. The Respondent had deducted an amount of Rs.72,677/-.

The entitled category of 1% sum insured applicable for all other deductions other than room rent was not defined in the terms and conditions of the policy. The TPA had arbitrarily made deductions which were not reviewed by the Regional Office on the representation of the Complainant. The bills produced by the Complainant were studied.

As regards the room rent, the 1% of sum insured is Rs.2,750/-. The Insured was thus eligible to avail a room with rent upto Rs.2,750/- & any amount higher than this would have to be borne by the Insured. The Complainant had utilized a room with a rent of Rs.2,700/- which was well within the limit. The Respondent's representative also agreed to this & further agreed on wrong deduction under Clause 1.2-C & D as the medical expenses incurred under various heads like surgeon's fee, anaesthesia etc. were within the entitled category.

On the deduction of Rs.20,270/- on the cost of stents & implants, the hospital had clearly issued a certificate confirming that they cannot issue an individual invoice for implants used during the operation as these were purchased in bulk. The Respondent should have carried out an deligent investigation for the reasonableness of the charges.

Similarly, on the deduction of Rs.38,511/- on consumables, the hospital had clearly issued certificate confirming that they didn't have TIN Number as it was not mandatory for the type of business carried out by the Company. The Respondent should have verified the sanctity of the certificate in case of any doubt.

This clearly proves that the Respondent had not carried out any investigation to rule out the excess charge aspect. Further, as per the Note No.1 to the Clause No. 1.2, "the amount payable under 1.2 C & D shall be at the rate applicable to the entitled room category in case the insured opts for a room with rent higher than the entitled category as under 1.2 A above, the charges payable under 1.2-C & D shall be limited to the charges applicable to the entitled category".

In the subject claim the Insured had availed a room where the room rent had not exceeded 1% of the sum insured as required under the condition No. 1.2. Hence, the concept 'entitled category' doesn't get invoked at all. The Complainant is entitled for relief & the Complaint, thus, stands admitted. The Complainant is entitled for the amount wrongly deducted by the Respondent.

The Respondent was advised to have a human approach to the policyholder instead of a mechanical approach. They had failed to reply to their Insured and allowed the TPAs to take their decision.

As the Insurer had wrongly interpreted the Clause 1.2 C & D & that considerable time had passed since lodging the dispute with the Respondent & the Forum directed to pay Rs.72,677/- claim to the Complainant along with an interest of 2% over & above the bank rate from the date of claim to the date of Payment.

Case No.AHD-G-049-1415-0148

Mr. Viral C Mewada V/s The New India Assurance Co. Ltd.

Award dated 16th March, 2015

Repudiation of Mediclaim

The Complainant's Spouse was admitted in Sheth Hospital, Ahmedabad for removal of chocolate cyst on 29.07.2012 through Laproscopy by Dr. Keyur Sheth. She was discharged on 31.07.2012. He had incurred total expense of Rs.37,384/-. His claim was

repudiated by the Respondent citing Policy Clause 4.4.6 "Primary Infertility". The Respondent had asked for the obstretic history of Jigisha Mewada & reasons of conducting operation duly certified by the treating Doctor. As per reply the reason for operation was primary infertility with chocolate cyst removal. However, the Complainant had submitted treating Doctor's certificate clearly mentioning that the surgery was primarily done for removing chocolate cyst & not for infertility.

The Respondent had relied on the treating Doctor's certificate dated 08.10.2012 in which she had confirmed that the reason for conducting operation was primary infertility & chocolate cyst both ovaries. The same Doctor had given another certificate dated 28.12.2012 confirming that patient had endometriosis with bilateral chocolate cysts, for which she needed laproscopic removal irrespective of whether she was expecting a child or not. The surgery was primarily for removal of chocolate cysts & not for infertility.

The Biopsy report dated 01.08.2012 also confirmed/diagnosed Rt. & Lt. Ovarian Cyst-Endometriotic Cysts.

It is clear from above that the Insured was operated for chocolate cysts. In the Discharge Summary also the diagnosis was Rt. Ovarian Complex Cyst.

The Doctor through his mail dated 8th June had stated that the cyst, irrespective of the couple planning for a child, needs to be removed lest it could lead to life threatening complications. Had the treatment been exclusively for infertility the Respondent would have been correct in repudiating the claim. However, the treatment is clearly for the removal of Chocolate Cysts. Therefore, the Complaint is admitted.

The Forum directed the Respondent to settle the claim & pay Rs.37,384/- to the Complainant.

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

In the matter of

Complainant – Smt. Komal T. Shah

Vs

Respondent - The Oriental Insurance Company Ltd.

Complaint No. AHD-G-50-1415-0150

Award Date: 18.03.2015

Policy No. 311500/48/2013/11075

The Complainant alongwith her family members were insured under mediclaim policy from 2010. The policy was taken through DHS. The details of the policy are:

1. **Policy from 13.07.2010 to 12.07.2011 from United India insurance company Ltd.**
2. **Policy from 26.07.2011 to 25.07.2012 from United India Insurance Company Ltd.**
3. **Policy from 27.07.2012 to 26.07.2013 from National Insurance Company Ltd.**
4. **Policy from 26.07.2013 to 07.03.2014 from The Oriental Insurance Company Ltd.**

The Insured was hospitalized at Rhythm Hospital and Diagnostic Centre from 31.01.2014 to 03.02.2014 for HBP + Ischemic CV stroke + Acute Gastritis + Anxiety neurosis. The claim was rejected by DHS vide letter dated 24.02.2014 by stating " Previous all policy copies required". The policy copies were submitted by the Complainant. However, as there was no response from the Company, the Complainant approached this Forum for settlement of claim.

The claim had arisen in the fourth year of the policy. There is a break in the policy for the period 2011 to 2012 for about 13 days. The terms and conditions of the policy says that the claim is payable for pre-existing disease if it arose after 4 years of claim free continuous policy. As per terms and conditions of the policy the claim is not payable.

However, the Respondent after receipt of the policy papers had not responded to the Complainant despite repeated reminders. The approach of the Respondent towards the Complainant was very casual. The non response caused enormous anxiety and harassment to the Insured and to the Complainant.

In view of the facts and circumstances, an ex-gratia amount of Rs. 10,000/- be granted to the Complainant.

AWARD

In view of the above facts, the Respondent is hereby directed to pay Rs. 10,000/- on ex-gratia basis.

Case No. AHD-G-050-1415-0151

Mr. Bhadresh B. Patel Vs. The Oriental Insurance Co. Ltd.

Award dated 20TH MARCH, 2015

Repudiation of Mediclaim

The Complainant's mother was admitted in Hospital for the complaints of headache - "on and off since 2 months". The surgery for Falcotentorial Meningioma was performed. He had incurred expense of Rs. 2,69,815/- for the subject hospitalisation. The claim was repudiated under policy clause No. 4.1, with a reason that the treatment was pre existing which could be covered after 4 years from the date of commencement of the policy, as the ailment was since the year 1998.

From the foregoing it can be concluded that the Complainant had suppressed the health related information. Likewise, the Respondent

had not provide the terms and conditions of the policy to the Complainant, & by not replied or informed about the admissibility of claim, the Respondent had also violated the IRDAI guideline of (Protection of Policyholders' Interests) Regulations, 2002.
The Respondent was directed to settle the claim for Rs10,000/- as ex gratia.

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.

Case No. AHD-G-050-1415-0154
Mrs. Pushpaben M. Shah Vs. The Oriental Insurance Co. Ltd.
Award dated 20TH MARCH, 2015
Repudiation of Mediclaim
The Mediclaim policy was since 20.10.2006. However, there was a break in policy period in the year 2007-2008. The policy was in the nature of Group Policy and underwritten at Mumbai. The business was canvassed by broker. The first policy covered pre existing disease, up to 2008-2009. The Complainant had submitted that he had informed about DM/HTN to the Respondent since 2009-2010. All the policy documents submitted showed pre existing disease as DM/HTN. However in year 2012-2013 it was not mentioned. She was admitted in the hospital for the treatment of HTN and DM and

incurred an expenses of Rs. 52,461/-. The claim was repudiated with a reason that the hospitalisation was for the treatment of old disease viz. HTN since 15 to 20 years and DM since last 6 years.
The Complainant was not provided the terms & conditions of the policy.

The point to be considered was whether the decision of the insurer's rejection of the claim under the policy clause No. 4.1 was correct.

From the foregoing it can be concluded that the Respondent had violated the terms and conditions of policy and had repudiated the claim. This is a violation of the laid down norms of the IRDAI. The decision to repudiate the claim is arbitrary, as the Respondent had not observed the laid procedure.the Respondent was directed to consider Rs. 12,776/-.

In the matter of

Complainant Ms. Rupa Dave

Vs

Respondent - The New India Assurance Company Ltd.
Complaint No. AHD-G-049-1415-0155
Award Date: 19.03.2015
Policy No. 21020034132500000801
The Complainant alongwith her family members were covered under Family Mediclaim (2012) Policy. The Complainant was admitted to Sterling hospital from 21.12.2013 to 22.12.2013 for Hepatitis C infection. When a claim was preferred for Rs.46,191/-, the Respondent rejected the claim quoting clause 2.2.of the policy. The contention of the Respondent was that as the patient was given only one subcutaneous injection, hence it was an OPD procedure and claim was not payable as per clause 2.2 of the policy. On observations it was found that the Complainant had mild fever with malise continuously for one month.She was also diagnosed Hepatitis

'C' after investigation.She was hospitalized for treatment of Hepatitis 'C.' She was administered virus specific PEG-Interferon injection and Tab. Ribavin. During the course of administration of injection the Insured developed breathlessness and fever. She was administered antipyretic following which her condition stabilized.The repudiation of the claim is mechanical as the treatment of Hepatitis 'C' with the administration of the crucial injection needed hospitalization for its resultant/possible complications.

In view of the facts and circumstances, the complaint is entitled for relief.

AWARD

The Respondent is hereby directed to consider the claim for Rs. 43,107/-.

Case No.AHD-G-050-1415-0157
Mr. Surendrakumar V/s The Oreintal Insurance Co. Ltd.
Award dated 16th March, 2015
Repudiation of Mediclaim

The Complainant's spouse Mrs. Ilaben was diagnosed with Sub Neovascular Membrane in both eyes & was admitted in Shivam Netralay, Ahmedabad on 20.11.2013 & discharge on 21.11.2013. He had incurred total expense of Rs.21,104/-. His claim was repudiated by the Respondent under Policy Clause No. 4.23 which reads as-"the drugs like Avastin or Lucentis or Macugen & other related drugs is given as intra vitreal injection. It is an OPD treatment the injection was given in the operation theatre. In view of nature of treatment it falls outside the scope of health policies. Hence, the treatment with administration of above drugs or any other is excluded from the scope of cover".

There is no specific exclusion, under the Policy Clause No. 4.20, for the treatment taken by the Insured.

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 4.20 vitiates the very purpose of availing of the latest advanced technology. Therefore, the Complaint is admitted

The Forum directed the Respondent to settle the claim & pay Rs.21,104/- to the Complainant.

Case No. AHD-G-050-1415-0158
Mr. R. Narayanan Vs. The Oriental Insurance Co. Ltd.,
Award dated 20TH MARCH, 2015
Partial Settlement of Mediclaim

The Complainant was admitted to Hospital (A PPN Hospital) for the surgery of Bilateral Inguinal Hernioplasty. He had not availed the benefit of cashless facility. The respondent approved only Rs. Rs.60,709/-, deducted Rs.16,026/-. The deduction were towards i.e. Co-payment, service charges, non medical items admission charges documents charges, food & ward facility bandage charges. The Post Hospitalisation bill dated 27.11.2013 Rs. 180/- of Apollo hospital was submitted on 24.01.2014, i.e. within 7 days of completion of treatment (discharge was 20.11.2013). However, it was not considered for payment. The claim was partially settled.

As per policy terms and conditions no where it is mentioned about the exclusion of service charges, hence the complainant is entitled for compensation for the same.

The Respondent was directed to pay the balance of Rs. Rs. 6445/- (Rs. 7161/- less 10% Co-Payment Rs. 716/-) towards the service charges.

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.

In the matter of

Complainant – Mr Kamlesh H Prajapati

Vs

Respondent - The Oriental Insurance Company Ltd.

Complaint No. AHD-G-50-1415-0168

Award Date: 19.03.2015

Policy No. 141100/48/2014/14199

The Complainant alongwith his family members were insured with the Respondent since 2011. The wife of the Complainant had undergone surgery for cataract at Dr. Sunil Shah's eye hospital on 30.01.2014. When he had preferred a claim for Rs 55,997/-, the Company deducted Rs. 27,380/- on the basis of reasonable and customary charges (Policy clause No.3.13).

The Complainant was covered under the Silver Plan- Happy Floater policy Individual Health Insurance policy for the period 2013-14 for a sum insured of Rs. 1.50 lacs.

The Respondent did not submit the said rate chart of other hospital in and around the geographical area where the Insured was hospitalized.

The Respondent had not compared the rates/charges collected by other hospitals with similarly facilitated hospitals in the vicinity of the hospital where the complainant had taken medical treatment as required by the IRDA circular.

In absence of any rate charts produced by the Respondent, the deduction made towards surgery charges is incorrect and unfair. The Respondent has also arbitrarily deducted Scan charges and O.T charges.

As per Dr. Sunil Shah, a new technological intraocular lenses Acrysof Toric IOL was used. He has stated that this is used in those patients who have pre-existing corneal astigmatism. Its unique technology enables the patient to see for distance without depending on the spectacles (or with less dependence on the spectacles. It takes care of both spherical and cylindrical refractive errors and gives better quality of vision. Here the deductions made by the Respondent was correct as the coverage under the policy doesn't provide for expenses to improve quality of life, in this case replacement /avoidance of spectacle, not necessarily required for cataract operation.

In view of the facts and circumstances the Complainant is entitled for payment of arbitrarily deducted amount.

AWARD

The Respondent is hereby directed to pay a sum of Rs. 10,000/- towards surgery charges, O.T. Charges and the scan charges in addition to the amount already paid to the Complainant after deducting 10% co-payment.

In the matter of

Complainant Smt Ushaben K Pande

Vs

Respondent - Religare Health Insurance Company Ltd.

Complaint No. AHD-G-037-1415-0171

Award Date: 19.03.2015

Policy No. 10033352

The Complainant alongwith her family members were covered under Mediclaim policy with the Religare Health Insurance Company Ltd from 02.09.2013 for a sum insured of Rs. 2,00,000/-. Initially they

were covered under Family Medicare Policy from United India since 01.09.2011 for a sum insured of Rs. 1.50 lacs. When the policy was taken from Religare in 2013 they had filled in a fresh proposal form and portability details were also informed to the Company. Medical tests were undertaken at the time of taking the policy. Since hypertension was detected, for Shri. Kailash Pande, an extra premium was charged for the Insured, Shri Kailash Pande, the husband of the Complainant. Shri Kailash Pande was hospitalized at Subhadra Gastro Surgery Hospital from 11.12.2013 to 13.12.2013 for Acute Calculus cholecystitis + Acute Appendicitis + Umbilical hernia. He had undergone Lap.Cholecystectomy and Lap. Appendectomy and open repair of umbilical hernia under General Anesthesia. When a claim was preferred for Rs 98,155/-, the Respondent rejected the claim quoting clause 6.1 of the policy.

re-operative assessment sheet dated 07.12.2013 by Dr. Shwetang G Pancholi, M.D. Consulting Physician and Cardiologist states H/o DM since 6 months takes Glyciphege 0.5 gm 0-1-0….. He is medically fit for surgery with normal risk of DM".The Insured was covered under the mediclaim policy from 2011 and had applied for portability as per IRDA guidelines introduced from 1st July, 2011. Under the portability the right is accorded to an individual health insurance policyholder to transfer the credit gained by the Insured for pre-existing conditions and time bound exclusions if the policyholder chooses to switch from one Insurer to another or from one plan to another plan of the same Insurer, provided the previous policy has been maintained without any break. Here in this case the policy was taken in 2011 and then from 2013 it was ported with the Respondent. Here for exclusion of any pre-existing diseases (in this case Diabetes Mellitus) the waiting period is 48 months (4 years).As the policy was in the third year, waiting period for 1 more year was necessary to get the benefit of exclusions from the policy.

The Insured had undergone surgery for Umbilical hernia alongwith, Lap.Cholecystectomy and Lap. Appendectomy. As the waiting period for Hernia was for two years and the policy has run for more than 2 years, the Insured is entitled for payment towards surgery of Hernia.

AWARD

The Respondent is hereby directed to pay Rs. 30,000/- towards the settlement of the claim for surgery of Hernia.

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.

Case No. AHD-G-051-1415-0174

Mrs. Truptiben N. Patel Vs. The United India Insurance Co. Ltd.

Award dated 18TH MARCH, 2015

Repudiation of Mediclaim

The wife of the Complainant Mrs.Truptiben was admitted in the Dr. Bhatt Maternity Hospital for the treatment for Uterus Irregular with Multiple Fibroid and surgery for Myomectomy. Before admission to the hospital she was referred to Dr. Prashant Trivedi, on 15.07.2013 for Hyperglycemia.

A claim was lodged with Respondent for Rs. 45445/- towards reimbursement of the expenses. However, the Respondent repudiated the claim considering the same as treatment of primary infertility citing policy exclusion clause No. 4.6 (the treatment of sterility, any infertility, sub fertility or assisted conception).

It was a fact that the complainant's wife had gone to the doctor primarily for infertility. However, the clinical examination by the doctor followed by several investigation revealed multiple fibroids and cyst in the uterus. The doctor advised immediate surgery.

The repudiation of the claim by the Respondent is myopic since it only took notice of initial visit to the doctor for treatment of infertility and ignored such serious complication like multiple fibroid/ cyst in the uterus associated with Dysmenorrhoea. This condition are independent of sterility / infertility. Therefore, resorting to policy exclusion no. 4.6 (exclusion of treatment of sterility) is unwarranted and arbitrary.

The complaint was admitted.

In the matter of

Complainant : Mr. Vikram V Shah

Vs

Respondent - New India Assurance Company Ltd.

Complaint No. AHD-G-49-1415-0175

Award Date: 19.03.2015

Policy No. 210100/34/13/01/00000978

The Complainant alongwith his family members were covered under Mediclaim Policy (2007). The wife of the Complainant was hospitalized at "MITR" (Mental Illness Treatment and Rehabilitation) Foundation from 21.05.2013 to 08.06.2013 and was diagnosed as major depressive disorder and basic schizophrenia. When a claim was preferred for Rs 39,900/-, the Respondent rejected the claim quoting clause 4.4.6 of the policy.

It is observed that the Insured was admitted to MITR Foundation for major depressive disorder and basic schizophrenia. The clause 4.4.6 excludes treatment relating to all psychiatric and psychosomatic disorders.

As the policy clearly excluded all psychiatric and psychosomatic disorders and the Insured was admitted for Schizophrenia which is a disease for mental disorder, the complaint of the complainant is dismissed.

AWARD

In view of the above facts, the decision of the Respondent needs no intervention

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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.

Case No. AHD-G-049-1415-0206

Mr. SAUGHAT PAL Vs. The New India Assurance Co. Ltd.

Award dated 18TH MARCH, 2015

Repudiation of Mediclaim

The group policy was issued for covering the LIC staff members. The Complainant's son Prasanna aged 4 was admitted in the hospital for the surgery of circumcision - Phimosis with tight prepuce. He had incurred an expense of Rs. 12,776/-. His claim was repudiated by the Respondent with a reason that the surgery of circumcision fell under exclusion of the policy.

The primary ground of repudiation of claim by the Respondent is clause No. 9.2 which excludes surgery for circumcision. However, the Respondent had ignored the qualifying elaboration mentioned in the clause which allows surgery of circumcision if warranted by injury or illness.

In addition the Respondent had resorted to clause 9.24 which excludes congenital external defects / diseases. The Respondent

referred to the doctor's certificate about the congenital condition. However, the Respondent had ignored the fact that there was infection which was of such nature that it required surgery. It is obvious that the surgery was not conducted merely to rectify the congenital condition but because of severe infection.

The Respondent was directed to consider Rs. 12,776/-.

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.

Complainant – Mr. Dinesh K Patel

Vs

Respondent - The Oriental Insurance Company Ltd.

Complaint No. AHD-G-50-1415-0218

Award Date: 18.03.2015

Policy No. 141100/48/2013/20204

The Complainant alongwith his family members were covered under Happy Family Floater Policy from 2012. The wife of the Complainant was hospitalized at Shraddha Hospital Heart care and Medicare from 27.12.2012 to 04.01.2013. She was diagnosed with multiple colonic & ileac ulcers Crohn's Disease ? + Koch's ?+ Bilateral small renal calculus + small umbilical Hernia. When a claim for Rs.43,107/- was preferred, the claim was rejected on the basis of clause 4 (4.3) of

the policy.The Complainant had taken the Policy bearing no. 141100/48/2012/20204 for the period 20.03.2012 to 19.03.2013 for the first time and the hospitalization was in the same year. The Insured was having abdominal pain + Nausea+ fever + vomiting + Weakness since few days before the hospitalization on 27.12.2012, the doctor had suspected Koch's and Crohn's disease but on investigation it was confirmed. During the hospitalization Colonoscopy was conducted.

The Colonoscopy established active chronic colitis with ulceration suggestive of Crohn's disease. Other findings of the Investigations were Bilateral small renal calculus, small umbilical hernia. A Claim for Rs. 43,107/- had been preferred. The Respondent rejected the claim under exclusion clause no. 4.3 which excludes surgery of hernia in the first two years from the inception of the policy.However, this decision of the Respondent is farfetched as no surgery for hernia was conducted. Small umbilical hernia was one of the diagnosis of the Investigations. The primary diagnosis has been active chronic colitis with ulcerations, suggestions of Crohn's disease. Therefore, to repudiate the claim just because small umbilical hernia was diagnosed alongwith others is totally arbitrarily and therefore, is absolutely wrong. The complaint is thus admitted.

AWARD

In view of the above facts, the decision of the Respondent to reject the claim is not tenable. The Respondent is hereby directed to consider the claim for Rs. 43,107/-.

Case No.AHD-G-050-1415-0221
Mr. Paresh B Doshi V/s The Oreintal Insurance Co. Ltd.
Award dated 17th March, 2015
Repudiation of Mediclaim

The Complainant met with an accident by falling down from the scooter & he was diagnosed with right tibia lateral condyle fracture, nasal bone fracture & 3+3 bottom upper front teeth were broken. He was operated on right tibia & nasal bone on 14.12.2013 in Jointline Hospital, Surat. He was advised 5 months rest for the recovery. He further submitted that he was totally disable from 13.12.2013 to

30.04.2014 to perform his duties. He had claimed for 18 weeks TTD @ Rs.3,000/- per week but the Respondent settled Rs.42,000/- only i.e 14 weeks only. He had submitted treating Doctor Jay Vankawala's certificate, dated 04.07.2014 confirming that patient was a known case of Addisons disease & taking tablet Wysolone (Steroid) since 1982, as per the discharge summary of K.E.M Hospital, Mumbai. He further confirmed that they had taken special care & given consideration by giving local anaesthesia through epidural. They had also taken care after operation because there were known complications due to steroid. He further opined that bone (Fracture) healing was also expected to be slower due to chronic steroid therapy. Due to all these reasons he advised the patient rest, medicines & exercise for a relatively longer period after discharge.

There was no mention in the Respondent Doctor's opinion whether he had considered the past history of Addison's disease to the Complainant. He had also not opined on whether steroids have impact on recovery in bone fracture.

The treating doctor has advised rest after observing/examining his patient's progress in recovery after the accident. The Respondent's doctor who had not examined the Insured but has expressed his opinion based on the papers made available to him. The treating docotr's advice is based on practical examination & observation while the Respondent's doctor's opinion is theoretical. Under the situation, the treating doctor's advice holds more value than the opinion/suggestion of the other doctor who had not even seen the patient.

The Forum directed the Respondent to settle the claim & pay Rs.12,000/- to the Complainant.

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.

Case No.AHD-G-048-1415-0239

Mr. Paresh B Doshi V/s The National Insurance Co. Ltd.

Award dated 17th March, 2015

Repudiation of Mediclaim

The Complainant was diagnosed with Phymosis & Retention of urine & was admitted in H.J.Doshi Sarvajanik Hospital & Medical Research Centre on 21.09.2013 & discharged on 22.09.2013. He had incurred total expense of Rs,11,700/-. His claim was repudiated by the Respondent citing Policy Clause No. 4.1- Pre-existing Disease.

The terms & conditions of the policy submitted by the Respondent specifically contain the exclusion of all pre-existing disease in Clause No. 4.1. There is no ground for interfering with the decision of the Respondent.

The Complaint was dismissed.

In the matter of

Complainant Shri K.Sethumadhavan

Vs

Respondent - The Oriental Insurance Company Ltd.
Complaint No. AHD-G-50-1415-0240

Award Date: 19.03.2015
Policy No. 141700/48/2014/5651

The Complainant alongwith his wife was covered under Mediclaim policy with the Oriental Insurance Company Ltd from 2002. The wife of the Complainant was admitted to Santhigiri Ayurveda Hospital and Research Institute from 03.08.2013 to 17.08.2013 for pain in both knees and swelling in both ankles. When a claim was preferred for Rs 36,745/-, the Respondent rejected the claim on three grounds:

1. **Ayurvedic treatments are not covered under the policy unless taken at a Government Hospital**
2. **The claim intimation was received by the Respondent on 31.8.2013 whereas the patient was discharged on 23.08.2013**
3. **Delay in submission of claim papers. The claim papers were submitted on 27.09.2013.**

The Complainant had claimed that Santhigiri Ayurveda hospital and Research Institute, Thiruvananthapuram, Kerala where his wife was admitted was a Division of Santhirigi Health care and Research Organisation (Santhigiri Research Foundation) recognized by the Ministry of Science and Technology, Government of India and Ministry of Finance, Government of India. However, the mere recognition by one Ministry doesn't give the Institution or its Division the status of a Government Hospital/Medical college.

The clause 2.1 of the policy states " In case of Ayurvedic/Hoemopathic/Unani treatment hospital expenses are admissible only <u>when the treatment is taken as an in-patient in Government Hospital /Medical College Hospital.</u>

The said treatment was not taken in a Government Hospital/Medical College Hospital. In view of the facts and circumstances, the complaint is dismissed.

<u>AWARD</u>

In view of the above facts and circumstances, the decision of the Respondent needs no intervention.

Case No. AHD-G-049-1415-0242

Mr. Jayantibhai R. Patel Vs. The New India Assurance Co. Ltd.

Award dated 18TH MARCH, 2015

Repudiation of Mediclaim

The policy commenced since 26.04.2002. However, there was a break in policy period in the year 2009. However, C.B. was allowed, which meant considered the renewal was with continuous benefits. The Complainant had submitted copies of the policy and paid the premium regularly. His sum insured was increased in the year 2009, The Increased in sum insured from Rs. 35,000/- to Rs.1 lac was not as per his choice but due to change in policy matters by Insurance Company. He was admitted in the hospital for 3 times during 23.11.2013 to 03.12.13 in 2 different hospitals for the treatment of unstable angina pain. He had incurred an expense of Rs. 2,76,664/- ,.However, the claim was repudiated with a reason that hospitalisation for the subject treatment was pre existing disease since last 12 years, and for pre existing disease the complainant had not paid the extra premium.

The complainant has been continuously availing health insurance coverage from the respondent since 2002. The Complainant had also honestly declared his health condition (of having undergone heart surgery). The change in the policy terms were introduced by the company 2007 bringing in specific term for senior citizens like the complainants. The change in policy terms required additional payment for coverage of pre existing disease which was not specifically brought to the knowledge of the Complainant insured. He continued to pay the premium religiously believing that he had been adequately insured since he had honestly made the declaration.

The Respondent's repudiation of the claim from the ground that extra premium has not been paid for pre existing diseases is nothing

but avoiding it liability. The deficiency lies with the respondent in not charging the appropriate premium. The blame can not be put on the insured. The failure of the Respondent to charge the extra premium in no way should leave to the penalization of the insured.The Respondent was directed to consider the claim of Rs. 2,76,664/- subject to the sum insured taking in to account the cumulative bonus.

In the matter of

Complainant Mr. Suresh M Bhikadiya

Vs

Respondent - Reliance General Insurance Company Ltd.

Complaint No. AHD-G-35-1415-0243
Award Date: 18.03.2015
Policy No. 160372282500852 8

Complainant alongwith his family members were covered under Reliance Health wise Policy. The wife of the Complainant was injured when plaster of the ceiling fell on her mouth during her sleep in the night of 01.02.2014. She had injured her lower lip and number of teeth got fractured. She was treated at Citilight Dental Clinic from 01.02.2014 to 22.02.2014. When a claim was preferred for Rs 25,477/-, the Respondent rejected the claim quoting clause 5 of the policy. The contention of the Respondent was that as the patient had managed the treatment entirely on OPD basis the claim was not payable as per policy terms and conditions.

There was no discharge card as treatment was taken on OPD basis. The claim was denied under clause 5 of the policy which excludes " Dental treatment or surgery of any kind unless requiring hospitalization with minimum of 24 hours stay and treatment." The injury of the insured to the face, forehead, lips and teeth were accidental. The treatment was taken in the hospital but not as an inpatient. Since the policy covers expenses incurred on hospitalization with minimum of 24 hours stay and treatment, the repudiation of the claim is in order.

AWARD

In view of the facts and circumstances, the decision of the Respondent needs no interference.

Case No. AHD-G-049-1415-0347
Mr. Ashok N. Bhandari Vs. The New India Assurance Co. Ltd.
Award dated 20TH MARCH, 2015
Partial Settlement of Mediclaim

The Complainant's wife was admitted in the hospital for the treatment of Uterine Fibroid. He had incurred an expense of Rs. 51,359/-, however his claim was settled for Rs. 32,909/- and Rs. 18,450/-was deducted with reasons like reasonable and customary charges and non medical items.
The policy copy with its complete terms and conditions had never been provided by the respondent which deprived him a proper knowledge of the terms and conditions.
The Respondent was directed to pay Rs. 18,000/-.

Case No.AHD-G-049-1415-0348
Mr. Bhupendra V Shah V/s The New India Assurance Co. Ltd.
Award dated 18th March, 2015
Repudiation of Mediclaim
The Complainant was diagnosed with Bilateral Reducible Inguinal Hernia & was admitted in Parth Surgical Hospital on 07.02.2014. He was discharged on 10.02.2014. He had incurred a total expense of Rs.1,03,718/-. His claim was partially settled by the Respondent, & Rs.29,615/- was deducted. The reason for the deductions given by the Respondent was Rs.25,500/- from Operation Charges & OT Charges under reasonable & customary charges (Policy Clause No. 3.13), Rs.2163 as non-payable non-medical items, Rs.452/- as for medicine purchased for consumption beyond 60 days post

hospitalization & Rs.1,500/- being consultation charges not pertaining to current ailment. The Complainant was not explained about the genuineness of deductions.

There is no dispute regarding the admissibility of the claim. The difference is because of higher charges paid by the Complainant in the hospital where he underwent the operation. The insurance coverage is designed to take care of the financial burden of the insured but to such an extent as it is considered necessary by reasonable standard. Therefore, there is a specific condition embedded in the policy indicating the limitation to the payment. Under the circumstances it would be difficult for this Forum to ignore this specific condition in the policy & interfere with the decision of the Respondent except in considering the consultation charges of Rs.1,500/- which the Complainant had paid for complication arising after the surgery. The Respondent had settled the medicine bills of Rs.427/- out of total claim of Rs.2,379/-, which includes consulting charges of Rs.1,500/.

The Respondent was directed to pay Rs.1,500/- to the Complainant.

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.

Case No. AHD-G-050-1415-0359
Mrs. Pravinaben C. Modi Vs. The Oriental Insurance Co. Ltd.,
Award dated 19TH MARCH, 2015
Partial Settlement of Mediclaim

The Complainant was admitted in Hospital for the surgery and treatment of Osteoarthritis of Rt. Knee. She had incurred an expense of Rs. 44,785/- for Post Hospitalisation. The Respondent had deducted 39967/-, out of which the dispute was only for deduction of Physiotherapy Charges of Rs. 24,000/- under policy clause No. 4.26 as doctors home visit charges cannot be paid.

The physiotherapy treatment having been taken at home the charges for visiting physiotherapist would come under this exclusion. The forum has no scope to interfere with the decision of respondent. However, the complainant consistently pointed out during the hearing that the policy copy with its complete terms and conditions had never been provided by the respondent which deprived her a proper knowledge of the exclusion. Therefore the forum was inclined to compensate the complainant on this count.

The complaint was granted an ex-gratia amount to 25% of the disputed Rs. 24,000/-.

Case No.AHD-G-050-1415-0207

Mrs. Kusumben B Shah V/s The Oriental Insurance Co. Ltd.

Award dated 18th March, 2015

Repudiation of Mediclaim

The Complainant was diagnosed with Anaemia-Iron Deficiency & was admitted in Bhatia Hospital, Mumbai on 30.09.2013. She was discharged on 02.10.2013 after treatment. She incurred expense of Rs.60,000/-. 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……..or addiction etc." The TPA had asked for cause of iron deficiency from treating doctor which was submitted by the Complainant. The treating doctor certificate confirmed that blood transfusion was required because of severely low Hb. The cause of the low Hb was iron deficiency (likely to be nutritional in nature).

It is clearly evident in the hospital papers that the Complainant was diagnosed Anaemia due to iron deficiency. The treating doctor vide his letter dated 25.01.2014 also confirmed that she had severely low Hb% the same is likely to be nutritional in nature. No disease was diagnosed by the Bhatia Hospital. Policy Clause No. 4.8 clearly excludes above treatment under general debility. Under the circumstances it would be difficult for this Forum to ignore this specific condition in the policy & interfere with the decision of the Respondent. The Complaint is thus dismissed.

The Complaint was dismissed.

Case No.AHD-G-051-1415-0352

Mr. Jayantilal M Patel V/s The United India Insurance Co. Ltd.

Award dated 19th March, 2015

Repudiation of Mediclaim

The Complainant was admitted in Eye Laser Centre, Surat for the surgery of Right Eye Cataract on 24.04.2014 & was discharged on the same day. He had incurred total expense of Rs.1,48,449/-. His claim was partially settled for Rs.33,500/-. Rs.1,14,949/- was deducted underthe head Reasonable & Customary Charges. The Complainant submitted that he was eligible for the claim of Rs.1,25,000/- 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 Complaint has emanated from the difference in amount reimbursed by the Insurance Company & the actual amount paid by the Complainant for his Cataract surgery. There is no dispute regarding the admissibility of the claim. The difference is because of higher charges paid by the Complainant in the hospital where he underwent the operation. The Bill of IOL of Rs.1,00,000/- clearly seems to be exorbitant. The insurance coverage is designed to take care of the financial burden of the insured but to such an extent as it is considered necessary by reasonable standard. No advantage should be taken of a provision of the insurance policy by either party to the contract. Under the circumstances this Forum is not inclined to interfere with the decision of the Respondent.

The Complaint was dismissed.

Case No.AHD-G-044-1415-0357

Mr. Yusufali Varteji V/s Star Health & Allied Insurance Co. Ltd.

Award dated 19th March, 2015

Repudiation of Mediclaim

The Complainant's spouse Smt. Razia Varteji was admitted in Criti Care Multispeciality Hospital & Research Centre, Mumbai for the treatment of Cerebrovascular Accident & Rheumatic Heart Disease with Mitral Stenosis on 17.11.2013 & was discharged on 21.11.2013. He had incurred total expense of Rs.50,000/-. His claim was repudiated by the Respondent citing Policy Condition No. 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 or supported by any means or device, misrepresentation whether by the insured person or by any other person acting on his behalf), hence the Complaint.

While going through the copy of the proposal form it is noticed that against the query whether the insured had illness before 12 months the space has been left blank which means the Insured had ignored that question whereas he had replied in negative to the query regarding illness during past 12 months from the date of the proposal.

The Respondent has resorted to this non-reply of the Complainant as deliberate suppression of vital & material information & denied the claim. Had the question been so vital to the underwriting of the risk the Respondent should have sought specific answer to this column before accepting the proposal. The Respondent's acceptance of the proposal despite the question having not been answered means either the questions were not vital or the Respondent waived the questions. Therefore, the repudiation of the claim under Clause No.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 or supported by any means or device, misrepresentation whether by the insured person or by any other person acting on his behalf) is not justified at all. The Respondent has to consider the claim.
As per the Policy Terms & Conditions under "Exclusions: 5- 50% of each & every claim arising out of all pre-existing disease" the Forum directed the Respondent to settle the claim & pay Rs.25,000/- (50% of the claimed amount) to the Complainant.

BHOPAL OIO

Abhishek Neema
……Complainant

V/s

The Oriental Insurance Co. Ltd.
……Respondent

Order No.IO/BHP/A/GI/0177/2014-2015 Case No. BHP-G-050-1314-0707

Award

Brief Background:

The complainant had taken a PNB-Oriental Royal Mediclaim Policy bearing no. 151200/48/2014/7271 for total sum insured Rs.3,00,000/- on payment of premium of Rs.4,620/- for the period 10/09/2013 to midnight of 09/09/2014 from the respondent company. As per complaint, he was admitted in the hospital for treatment/surgery for PHIMOSIS and all the documents required by

the TPA were submitted by him but the claim was rejected by TPA on the ground that the treatment given to the patient does not support the need for hospitalization, patient can be treated on OPD basis. Being aggrieved by the action of respondent company, the complainant approached this forum for the relief of claim amount Rs.16,644/- .

The insurer have contended in their SCN that the insured had submitted the claim papers to their TPA M/s MD India for hospitalization for one day in Robert Nursing Home, Indore and as per discharge card of hospital diagnosis was PHIMOSIS and as per their CRS explanation, it was observed that the treatment given to the patient does not support the need for hospitalization, patient can be treated on OPD basis as such the claim has been repudiated.

FINDINGS & DECISION:

I have gone through the material available on the record and the submission made by the respondent. The discharge card shows that the complainant was admitted on 19.09.2013 at 7.00 am in Robert Nursing Home and Research Centre, Indore and underwent treatment for the diagnosed ailment PHIMOSIS and was discharged on 20.09.2013 at 11.30 am. The certificate issued by Dr. Rajendra Punjabi of the said Nursing Home shows that the patient visited his clinic on 14.09.2013 for consultation and after examination he found that patient required circumsicion and the patient was advised to get admitted to hospital the surgery was perform on 19.09.2013 and since the patient was known case of diabetes and therefore required surgery to be perform in the hospital and the patient was kept under observation for 24 hours after the surgery. The surgery is also admitted by the insurer's representative. A doctor/surgeon is

only competent to decide the requirement of hospitalization seeing the physical condition, previous ailments like DM, BP, HTN etc. for giving required treatment of the diagnosed ailment. Hence I do not find any force in the contention of the insurer's representative that the treatment could have been done in the OPD.

Under the aforesaid facts & circumstances, material on record and submissions made, I am therefore of the view that the decision/action of the respondent company for repudiating the claim is not justified and is not sustainable. Hence, the complainant is entitled for the admissible amount in accordance with the terms & conditions of the policy document.

Hence, the respondent The Oriental Insurance Co. Ltd. is directed to review the claim and make payment of admissible amount to the complainant in accordance with the terms & condition of the policy document within 15 days from the date of receipt of acceptance letter of the complainant failing which it will attract 9% simple interest p.a. from date of this order to the date of actual payment. In the result, the complaint is allowed.

Dated at Bhopal on 20th day of March, 2015

Mr. Abhishek Neema.....Complainant

V/s

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

Order No. IO/BHP/A/GI/0189/2014-2015 Case No.GI/OIC/1103/124

Brief Background:

The complainant had taken a Individual Mediclaim Policy bearing no. 152600/48/2010/548 for sum insured Rs.1,00,000/- for the period 10.09.2009 to midnight of 09.09.2010 covering himself and his wife from the respondent company. It is further said that the Complainant was hospitalized in Unique Hospital, Indore for the treatment of vomiting and uneasiness and claim documents were submitted to TPA (MDINDIA Health Care Services(TPA) Pvt. Ltd. Indore) on 5.10.2010. Inspite of completing all requirements, the TPA did not pay the claim and repudiated the claim. The insurance company treated the sum insured as Rs.50,000/- instead of Rs.1,00,000/- The Respondent vide its letter dated 25.03.2011 have contended that since the claim was settled on the sum insured of Rs.50,000/- existed 4 years ago. Hence they concur with the decision of TPA M/s M.D. India.

FINDINGS & DECESION:

I have gone through the material on record and written argument submitted by complainant. After going through letter dated 01.02.2011 of the TPA, it is observed that the complainant was

having DM since 5 years back which has not been denied by the complainant in his written argument and has also not filed his discharge summary and first prescription except some receipts and test report. Hence, as per policy clause No. 08 "If the policy is to be renewed for enhanced sum insured then the restrictions as applicable to a fresh policy (condition No. 4.1, 4.2 and 4.3 will apply to additional sum insured) as if a separate policy has been issued for the difference, subject to medical checkup as per norms of the company, the cost of medical checkup shall be borne by the insured" and the applicable sum insured will be 5 years back i.e. Rs. 50000/- The complainant was admitted in the hospital from 27th August, 2010 to 1st September, 2010. Hence, deduction for an amount of Rs. 2500/- as 1% of S.I. for 5 days is quite genuine. Further deductions were made due to non availability of Investigation Reports and authentic bill receipts. The deductions made by the Respondent TPA are quite reasonable and justified under clause 8 of the policy condition. Under the aforesaid facts & circumstances, material on record, I am therefore of the view that the decision/action of the respondent is perfectly justified and is sustainable. Hence, the complainant is not entitled for the relief as prayed for. In the result, the complaint stands dismissed accordingly.

Dated at Bhopal on 20th day of March, 2015

Mr. Anil Kak ……

…….Complainant

V/s

The New India Assurance Co. Ltd.
…….Respondent

Order No. IO/BHP/A/GI/0157/2014-2015 Case No. BHP-G-049-1314-0647

Brief Background:

The complainant had taken the mediclaim policy bearing no. 45070034110100001031 for sum insured Rs.1,00,000/- for the period 23.092011 to 22.09.2011 covering himself from the respondent company. It is further said that he lodged his claim before the TPA of the respondent company on 24.07.2012 for payment of Rs.67500/- for purchasing and using equipment towards treatment of sleep Apnoea but the payment was not made to him. Being aggrieved from the decision of the respondent company, the complainant approached this forum for redressal of his grievance .

The insurer in their SCN have contended that that the insured had submitted his claim on 25.07.2012 for sleep disorder and their TPA M/s Vipul requested him by sending letter and reminders to submit original discharge card, final bill and receipts of hospital and hospitalization record etc. and in reply in queries of TPA, the insured submitted a letter dated 11.01.2013 mentioning that such type of case do not require hospitalization and only investigation confirmation and treatment so, the claim was closed in absence of complete document and since, there was no hospitalization for his

treatment so, as per policy conditions, no claim is admissible unless there is hospitalization of 24 hours.

For the sake of natural justice, hearing was held at Bhopal office. The complainant was absent but his representative as well as insurer's representative were present who were heard. The complainant's representative has admitted that no detail facts of ailment, treatment and expenses has been mentioned in complaint and P-II form and also stated that the claim was closed for want of original discharge card and hospital bills and submitted that equipment was purchased for treatment of sleep Apnoea and was used in OPD from 12.06.2012 to 30.06.2012 and also paid use charges for Rs. 2000/- . On the other hand insurer's representative has taken the stand as mentioned in the SCN and laid emphasis that day care treatment is not permissible and there was no hospitalization record to show the treatment in the hospital.

FINDINGS AND DECISION:

I have carefully gone through the material on the record and submissions made on behalf of both the parties. It is admitted position that the complainant has not filed any discharge card, final bills and hospitalization record to show his hospitalization for more than 24 hours. As per policy condition, there must be hospitalization for more than 24 hours and for day care procedure, it must be done in specialized day care centre. The documents brought on the record by the complainant show that the complainant paid Rs.57000/- for the purchase of a Remstar Auto A Flex Cpap and paid charges of its use for Rs.2000/- and also Rs.8500/- for sleep study to Dr. Pramod

Jhawar as outdoor patient and even his centre was not a day care centre. Any treatment in OPD as asserted by the complainant is not covered under the policy document. Thus, the claim made by the complainant does not cover under the terms and conditions of the policy documents. Hence, under the aforesaid facts and circumstances, the complainant is not entitled to get the relief as prayed. Hence, the complaint stands dismissed accordingly.

Dated at Bhopal on 18th March, 2015

Mr. Anoop Rai
.....Complainant

V/s

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

Order No.: IO/BHP/A/GI/0186/2014-2015 Case No.: BHP-G-049-1415-0015

Brief Background:

Mr. Anoop Rai (hereinafter called Complainant) obtained a Two Wheeler Package Policy No. 45210331120100002296 for the period 07.08.2012 to 06.08.2013 for IDV of Rs. 36,000/- from The New India Assurance Co. Ltd., (hereinafter called Respondent).

As per the Complaint, the complainant had purchased Honda CBF Stunner vehicle No. MP-49 MB-3953 consisting of Chasis No./Eng. No. ME4JC404B98036776/ JCYOE9064972 through the dealer of the vehicle. His vehicle was stolen and it was informed to the

respondent company and a claim was preferred before the respondent but they repudiated the claim as no claim. Being aggrieved with the decision of the respondent, he approached this forum for redressal of his grievance and making payment of Rs.36,000/-.

The Respondent vide its SCN contended that the GR-2 says before issuing the policy collect proposal form duly completed and signed by insured and GR-27 says if No claim bonus is allowed and insured is unable to produce the evidence of NCB entitlement from previous insurer, the new insurer obtain an declaration from insured in this comply. On the self declaration of complainant, branch allowed 20% NCB to the insured. The insured intimated the stolen of vehicle on 24.09.2012. After processing the claim, they came to know that insured has also taken two claims from previous insurer M/s Iffco Tokio General Inurance Co. under policy no. 77233790. The previous insurer also confirmed vide its mail dated 17.12.2013. Since, the insured has given the wrong declaration to their branch, the policy in respect of section I of the policy will stand forfeited accordingly, so the claim was repudiated.

For the sake of natural justice, hearing was held at Bhopal office. Both the parties were heard as mediation was failed. The complainant has narrated the facts as mentioned in the complaint. The insurer's representative has taken the stand as mentioned in the SCN/reply.

FINDINGS & DECISION:

I have gone through the material on record and submissions made during hearing. I have gone through the undertaking signed by the complainant dated 7.8.12 where it is clearly mentioned that the rate of NCB claimed by him is correct and if this declaration is found to be incorrect, all benefits under the policy in respect of section-I of the policy will stand forfeited. Further I have also gone through the evidence of email dated 17.12.13 of previous insurer confirming that the insured has got two claims paid during the policy period of 4.8.11 to 3.8.12 under policy No. 77233790. Thus I find that there is no scope for payment of the said claim under Section I of the General Regulations of the policy.

Under the aforesaid facts & circumstances, material on record, I am therefore of the view that the decision/action of the respondent is perfectly justified and is sustainable. Hence, the complainant is not entitled for the relief as prayed for. In the result, the complaint stands dismissed accordingly.

Dated at Bhopal on 26th March, 2015

Ashok Kumar Dokey .....Complainant

V/s

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

Order No.IO/BHP/A/GI/0151/2014-2015 Case No. GI/RGI/1101/115

Brief Background:

The complainant had taken a Reliance Travel Care Insurance Policy – For Senior Citizen bearing no. 2302502817000011 for the period 05/03/2010 to 06/06/2010 from the respondent company. It is further said that he fell suddenly ill after reaching to his daughter in USA where he took treatment in Huston (USA) and all the expenses of treatment including doctor fees was paid by his son in law through his credit card and inspite of having insurance, his treatment was not done on cashless and after return to Indore (India) he lodged his claim before the respondent company submitting all the receipts in original before the respondent company but the respondent paid only Rs.5182/- deducting USD300 on the ground of not furnishing bills/receipts. Being aggrieved by the action of respondent company, the complainant approached this forum for the relief .

The respondent vide its SCN dated 31.03.2011 have stated that the claim has been partly settled and they have not received original invoices of consultations nor any consultation notes and the deduction are appropriate as per policy terms and conditions.

For the sake of natural justice, hearing was held at Bhopal Office. The complainant was absent. The Insurer's representative was present who was heard as mediation could not be done in absence of complainant. The insurer's representative has taken the stand as mentioned in the SCN regarding partial settlement for want of consultation papers and bills/receipts about expenses of USD300.

FINDINGS & DECISION:

I have gone through the material available on the record and the submission made by insurer's representative. Admittedly, the claim was settled and Rs.5182/- was reimbursed to the complainant as partial settlement and USD300 was deducted as the doctor consultation papers and receipts were not provided. From close perusal of the record, I found that the complainant has not brought on record the bills/receipts of consultation papers as well as bills/receipts of the concerned doctor to show the expenses amounting USD300 towards his treatment. As per policy terms and conditions for claim settlement, the original bills, bouchers/reports and discharge summary must be submitted along with claim. Since, the complainant has not filed the original bills for amount USD75 dated 14.04.2010, USD75 dated 17.04.2010 USD75 dated 03.05.2010 and USD75 dated 01.05.2010 so, in view of the policy terms and conditions, the deduction of the USD300 made by the respondent is quite appropriate.

Hence, under the discussed facts & circumstances and the policy terms and conditions, I find that complainant is not entitled for the relief as prayed for. Hence, the complaint stands dismissed accordingly.

Dated at Bhopal on 10th day of March, 2015

Mr. Ashwin Jain
.....Complainant

V/s

Bajaj Allianz General Insurance Co. Ltd.
.....Respondent

Order No.: IO/BHP/A/GI/0170/2014-2015 Case No.: BHP-G-005-1314-0656

Brief Background:

Mr. Ashwin Jain (hereinafter called Complainant) obtained a Standard Fire and Special Perils Policy bearing no. OG-13-2302-4030-00000020 for the period 10.08.2012 to 09.08.2022 for sum insured of Rs. 30,00,000/- covering his property at Indore from Bajaj Allianz General Insurance Co. Ltd. (hereinafter called Respondent).

As per the Complaint, the complainant has taken a Standard Fire and Special Perils Policy for 10 years for his new flat w.e.f. 10.08.2012 with a premium of Rs.12781/- for comprehensive risks. After one year the representative of the respondent told that you have to take Burglary Insurance separately because burglary is not covered in the existing policy and he was issued another policy No. OG-13-2302-4001-00000488 for burglary insurance for a premium of Rs.360/- for one year of household contents for sum insured RS.2,50,000/-. His complaint is that after paying full premium and giving total information why the same was not covered in one policy and why another premium was charged for another policy. Being aggrieved

from the decision/action of the respondent company, he approached this forum for justice towards not getting complete cover despite paying full amount asked by the respondent company.

For the sake of natural justice, hearing was held at Bhopal Office. The complainant was present who was heard and the complainant has narrated the facts as mentioned in the complaint. The insurer's representative was absent which reflects gross negligence from the respondent company. Mediation was failed as the insurer's representative was absent.

<u>Findings and Decision:</u>

I have gone through the material on record and submissions made. From the record placed before me, I found that the original policy No. OG-13-2302-4030-00000020 i.e. Standard Fire & Special Perils Policy was issued under Annexure-I dated 10.8.12 where only dwellings were covered and not the household contents. Annexure was provided to the complainant alongwith the policy in question. Hence the question of covering household contents does not arise. The complainant was issued another policy for household contents for the S.I. of Rs.2,50,000/- with a premium of Rs. 360/- is quite genuine. The relief as prayed in the complaint and P-II form is vague. In my opinion the stand taken by the Respondent is quite justified and there is no scope to interfere in the decision taken by the Respondent.

Under the aforesaid facts & circumstances, material on record, I am therefore of the view that the decision/action of the respondent is

perfectly justified and is sustainable. Hence, the complainant is not entitled for the relief as prayed for. In the result, the complaint stands dismissed accordingly.

Dated at Bhopal on 19th day of March 2015

MrB.K. Arora ….. ……Complainant

V/s

The New India Assurance Co. Ltd.
…….Respondent

Order No. IO/BHP/A/GI/0155/2014-2015
Case No. BHP-G-049-1314-0685

Brief Background:

The complainant Mr. B. K. Arora was covered under Group Mediclaim policy bearing no.120700342000000003 for sum insured Rs. 1,10,000/- for the period 01.04.2012 31.03.2013 from the respondent company to the employees and their dependent of LIC of India. It is further said that the complainant has undergone for 2D-ECHO CARDIOGRAPHY without hospitalization as per terms and conditions of the policy and preferred a claim for Rs. 1500/- for reimbursement as expenses relating to diagnostic test without hospitalization is reimbursable for Echo test to the tune of Rs.1500/- under para 6.0 (A) of the circular of the respondent but the claim was rejected as only Echo test is admissible upto Rs.1500/- while the complainant had undergone for 2D Echo Cardiography. He also made representation before the respondent company but his claim

was not considered. Being aggrieved from the decision of the respondent company, the complainant approached this forum for redressal of his grievance towards payment of Rs.1500/-.

The insurer in their SCN/reply have stated that as per the circular the expenses relating to Echo test upto Rs.1500/- can be reimburse but the complainant has submitted documents for reimbursement of 2D Echo & Colour Doppler study for which they are unable to reimburse the same.

For the sake of natural justice, hearing was held at Bhopal office. The complainant was absent and written submission was filed laying emphasis for reimburse of Echo test to the tune or Rs.1500/- The insurer's representative, Mr. S. K. Chandrawanshi was present and was heard who has taken the stand as made in the SCN/reply letter and laid emphasis that the said test 2D Echo & Doppler Study is not covered under the terms and conditions and circular of the respondent company.

FINDINGS AND DECISION:

I have gone through the material on the record and submissions made by insurer' representative. The policy condition 5.17 and para 6.0 (A) of the circular of the company which relates to the expenses relating to the diagnostic test without hospitalization clearly shows about coverage of expenses of Echo test only to the tune of Rs.1500/- but does not cover the diagnostic test of 2D Echo & Colour Doppler Study. The complainant was undergone for 2D Colour Doppler Study on 19.02.2013 in Dr. Ballabh Bhai Nanavati Hospital, Mumbai. Since, the above diagnostic test 2D Colour Doppler is not covered under the policy terms and condition and circular.

Hence, the complainant cannot get the reimbursement of 2D Echo & Colour Doppler Study. In these circumstances and under the policy condition the respondent is not liable to reimburse the cost of said claimed Echo test. Hence, the complaint stands dismissed being devoid of any merit.

Dated at Bhopal on 18th March, 2015

Mr. Bal Mukund Agrawal……Complainant

V/s

The National Insurance Co. Ltd., Indore……Respondent

Order No.: IO/BHP/A/GI/0129/2014-2015 Case No.: BHP-G-048-1415-0120

Mr. Bal Mukund Agrawal (hereinafter called Complainant) obtained an Mediclaim Policy No. 320400/48/13/8500004261 for the period 1.11.2013 to 31.10.2014 for self and Smt. Vijay Laxmi from National Insurance Co. Ltd., D.O.-2, Indore(hereinafter called Respondent).

As per Complaint, the complainant was admitted in Rohit Eye Hospital and Child Care Centre, Indore for the treatment of his eyes and preferred two claims for Rs. 18400/- and Rs, 7500/- totaling Rs. 25900/- out of which Rs. 1900/- were deducted on various healds and paid only Rs. 24000/- He represented to the insurer for the

same vide his letter dated 28.10.2014 but there was no response from the Insurance Company. Being aggrieved by the action of respondent company, he lodged the complaint, the complainant approached this forum for the relief for making payment of Rs.1900/- + Rs.1000/- = Rs.2900/- as mentioned in P-II.

The Respondent in its reply-dated 7.1.15 stated that in the captioned matter the Complainant was admitted for Cataract Surgery at Rohit Eye Hospital, Indore with a diagnosis of left eye cataract and underwent Phacoemulsification Microincisional surgery. He preferred claims for Rs. 25900/- which was settled for Rs. 17360/- and pre hospitalization claim for Rs. 6370/-. It reiterated that as per GIPSA package in PPN Hospitals for cataract surgery for Rs. 17000/- (for non MICS surgery) and Rs. 24000/- (for MICS surgery). Since the claimant has undergone for cataract surgery MICS a limit of Rs. 24000/- has been sanctioned as per the policy terms and conditions.

For the sake of natural justice hearing was held at Indore camp office. The Complainant was present in person and the Respondent was represented by Mr. S. N. Dale, Divisional Manager of The National Insurance Co. Ltd., Indore. Both the parties were heard as mediation was failed who have narrated the facts as mentioned in the complaint and SCN respectively.

Observations:

I have gone through the materials on record and submissions made during hearing and my observations are summarized below.

There is no dispute that the Complainant was covered under the above-mentioned policy taken from the Respondent. During hearing it is shown that as per GIPSA package in PPN Hospitals for cataract surgery is for Rs. 17000.- (for non MICS surgery) and Rs. 24000/- (for MICS surgery). Since the claimant has undergone for cataract surgery under MICS a limit of Rs. 24000/- has been sanctioned as per the policy terms and conditions as reasonable and customary charge and is found genuine. There is no scope to settle his claim for further amount other than Rs.24000/- Based on the facts placed before me and as per policy conditions; the complainant is not entitled any relief from the respondent. Hence, the complaint stands dismissed.

Dated at Indore, on 27th day of February, 2015

Mr. B. Bandyopadhyay .....Complainant

V/s

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

Order No. IO/BHP/A/GI/0176/2014-2015
Case No. BHP-L-045-1314-0226

The complainant had taken a Family Health Optima Insurance Policy bearing no. P/201117/01/2013/000116 for sum insured Rs.3,00,000/- for the period 25/04/2012 to 24/04/2013 covering himself and his family member. It is further said that the complainant was admitted in AMRI Hospital, Kolkata on 28/04/2013 and was also admitted in Institute of Liver and Biliary Sciences,

Vanasnt Kunj, Govt. of Delhi and diagnosed as Hepato-cellular carcinoma. It is further said that he informed to respondent's office then respondent's representative came and verified while he was admitted in hospital but there is no response from respondent company till that day whether his claim is settled or not. Being aggrieved from the decision of the respondent company, the complainant approached this forum for relief of making payment of his claim towards hospitalization under the policy document as implied in the complaint though the complainant has not specifically clearly mentioned about the relief sought in the compliant.

The complaint was registered and prescribed forms were issued and replies were received from the complainant but the respondent company have filed the scan copy of reply on the date of hearing which reflects the gross negligence about filing the SCN.

The Respondent in their reply dated 2.3.15 have stated that the complainant had obtained policy No. P/201117/01/2013/000116 for the period 25.4.2013 to 24.4.2014 for S.I. of Rs. 300000/- which is a first year policy. The insured was hospitalized in Narayana Hrudayalaya MMI, Raipur for the period 18.2.13 to 19.2.13 and diagnosed as massive hematemisis, portal hypertension related bleed and Endoscopic Variceal Ligation was done. Further he was again admitted in AMRI Hospital, Kolkata on 28.04.2013 and discharged on 01.05.2013 and was diagnosis chronic liver disease with portal hypertension. As per indoor case paper dated 18.2.13, the patient is a known case of chronic liver disease with portal hypertension. All the findings showed that the insured patient was suffering from the disease even before the policy inception and not in the short duration of 10 months and the same was not disclosed by the insured in the proposal form. Hence the claim was rejected

under policy exclusion clause No. 1 i.e. pre-existing disease and prayed to absolve them from the complaint.

For the sake of natural justice, hearing was held at Bhopal Office. The complainant was absent. The complainant's representative, his brother was present. Both the parties were heard as mediation could not done due to absence of the complainant. The complainant's representative has narrated the facts as mentioned in the complaint and has stated that the above policy was renewed and one other policy was also taken w.e.f. 22.12.2012 to 21.12.2013 of the same company enhancing the sum insured Rs. Ten lacs but claim has been made under the above policy. The complainant's representative was not found not in know of all facts. The insurer's representative has taken the stand as mentioned in the SCN/reply.

FINDINGS & DECISION:

I have gone through the material placed on the record and submission made by both the parties. From the proposal form placed on record, it is evident that the complainant has filled "No" under column "has the proposed person suffered from any disease/illness irrespective of whether hospitalized or not or sustained any accident. Further Hospital Record shows that patient is a known case of portal hypertension with complaint of 3 episodes of hematemesis with melaena. Exclusion clause 1 of policy document, says that the company shall not be liable to make any payments under this policy in respect of any expenses whatsoever incurred by the insured person in connection with or in respect of pre-existing diseases defined in the policy until 48 consecutive months of continuous coverage has elapsed, since inception of the first policy with any

Indian insurer. However the limit of the company's liability in respect of claim for preexisting diseases under such portability shall be limited to the sum insured under first policy with any Indian Insurance Company. From the record, it is found that the complainant has mentioned "NO" about the details of other insurances if any. So, it is apparent that there was no other previous policy before taking the above concern policy to show any continuity so, it is clear that the above concern policy under which the claim has been made was the first policy for period 25.04.2012 to 24.04.2013 which was renewed from 25.04.2013 to 24.04.2014 as stated by complainant's representative. From the record, it is apparent that the complainant had pre-existing disease at the time of inception of the above concern policy and had undergone treatment for the pre-existing disease during the first year of the aforesaid mediclaim insurance policy and as per policy terms and conditions any claim arising out of pre-existing disease would be admissible only on completion of 48 months from the inception of the policy. Moreover, the complainant/insured had answered "NO" in the proposal form regarding any previous ailment/disease, treatment, surgery etc. during the last one year>one year while the medical documents available on the record shows that the insured patient was a known case of chronic liver disease with portal hypertension which cannot be developed in a short duration and which was not disclosed in the proposal form by the insured. Hence the claim of complainant does not seem to be justified. So, I do not find any reason to interfere in the decision taken by the respondent company for not considering the claim of the complainant.

Under the aforesaid facts & circumstances, material on record, I am therefore of the view that the decision/action of the respondent for not considering the claim of the complainant is perfectly justified and is sustainable. Hence, the complainant is not entitled for the relief as prayed for. In the result, the complaint stands dismissed accordingly.

Dated at Bhopal on 20th day of March, 2015

Mr. Brahma Singh
…….Complainant

V/s

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

Order No.: IO/BHP/A/GI/0164/2014-2015 Case No.: BHP-G-044-1314-0674

Mr. Brahma Singh (hereinafter called Complainant) obtained a Star Super Surplus Insurance Floater Policy bearing no. P/201113/01/2013/002884 for the period 05.03.2013 to midnight of 04.03.2014 for floater sum insured of Rs. 2,00,000/- covering himself and his son, Sidharth Singh from the Star Health And Allied Insurance Co. Ltd. (hereinafter called Respondent) and before the above policy he had two more policy of the same company covering his son and family members.

As per the Complaint, the complainant's son Mr. Sidharth Singh was admitted on 29.10.2012 in Narmada Trauma Centre, Bhopal and diagnosed as Brain Tumor cancer. Further his son was admitted in

Jawahar Lal Nehru Cancer, Hospital, Bhopal and taken treatment there in day care hospitalization. He lodged first claim towards reimbursement of treatment cost of his son for Rs.1,25,104/- out of which the respondent company paid only Rs.69,932/- after deducting an amount of Rs. 55,172/-. He also lodged second, third and fourth claim for Rs.70,967/-, Rs.11,754/- and Rs.5,480/- respectively before the respondent company but the respondent company rejected his all claims. Being aggrieved from the decision/action of the respondent company, he approached this forum for making payment towards treatment cost of his son for Rs.2,00,000/- as mentioned in P-II form.

The Respondent vide its SCN have contended that they have received various claims for treatment of Mr. Sidharth Singh which were settled at their end. In the said claim of Rs. 1,25,104/- for the treatment on 8.11.12 in day care hospitalization. Out of which an amount of Rs. 69932/- was settled. Further an amount of Rs. 30068/- was settled as balance sum insured available under the said policy after the settlement of previous claim. Under third year policy the claims were rejected as the oral medicines prescribed by the hospital and oral medication was not payable as per terms and conditions of the policy. Claims of insured patient Siddharth Singh for the first hospitalization claimed under the first year of policy were paid fully.

For the sake of natural justice hearing was held at Bhopal Office. Both the parties were heard as mediation was failed. The complainant has narrated the facts as mentioned in the complaint

and the insurer's representative has taken the stand as mentioned in reply/SCN.

Observations:

I have gone through the material on record and submissions made. The complainant's son Sidharth Singh was suffering from Brain Tumor Cancer for which the claims were lodged under first year policy i.e. P/201113/01/2011/002330 for the period 5.3.11 to 4.3.12 and for the admission from 2.5.11 to 18.5.11 in Chirayu Health and Medicare Pvt. Ltd. Bhopal. The complainant lodged a claim for Rs. 92007/- and the claim was settled for Rs. 81,235/- In the second year policy i.e. P/201113/01/2012/002844 for the period 5.3.12 to 4.3.13 where he was again admitted from 29.10.12 to 8.11.12 in Narmada Trauma Care, Bhopal and a claim for Rs. 1,00,000/- was settled. In the second year policy, two claims amount to Rs. 69932/- and Rs. 30068/- were settled as full sum insured under the policy. I found the dispute in the third year policy i.e. P/201113/01/2013/002884 for the period 5.3.13 to 4.3.14 where the claims were rejected due to oral medication which is not payable as per terms and conditions of the policy and the decision was communicated to the complainant. In respect to the cancer chemotherapy-day care procedure, the time limit will not apply for the procedure, taken in hospital/nursing home and the insured is discharged on the same day. But in the instant claims the complainant son was treated with oral medicines only and day care procedure was not done in the hospital. In my opinion the stands taken by the Respondent is quite justified and there is no scope to interfere in the decision taken by the Respondent.

Under the aforesaid facts & circumstances, material on record, I am therefore of the view that the decision/action of the respondent is perfectly justified and is sustainable. Hence, the complainant is not entitled for the relief as prayed for. In the result, the complaint stands dismissed accordingly.

Dated at Bhopal on 18th day of March 2015

Mr. D. K. Dave
.....Complainant

V/s

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

Order No. IO/BHP/A/GI/0193/2014-2015 Case No.BHP-G-050-1415-0065

Brief Background:

The complainant had taken a PNB-Oriental Royal Mediclaim Policy bearing no. 152104/48/2014/2022 for sum insured Rs.5,00,000/- for the period 03.01.2014 to 02.01.2015 covering himself and his family members from Respondent. It is further said that the Complainant fell sick and suffered urine block in March, 2014 and was admitted in Jaslok Hospital and Research Center, Mumbai. He incurred an amount of Rs.1,12,584/- towards his medical treatment but the Respondent Company have rejected his claim. Being aggrieved from the decision of the Respondent, he approached this forum for redressal of his grievance for payment of Rs.1,12,584/- .
The Respondent vide its SCN have contended that the above said policy is subject to terms and conditions & Exclusions and the

ailment for which treatment was taken by complanant falls in the list of Diseases/Ailments under Two Year exclusion clause 4.2 which is not covered in the first two year policy and as such the claim has been repudiated.

For the sake of natural justice, hearing was held at Bhopal Office. Both the parties were heard as mediation was failed. The complainant has narrated the facts as mentioned in the complaint and the insurer's representative has taken the stand as mentioned in reply/ SCN.

<u>Findings & Decision:</u>

I have gone through the material on record and submissions made by both the parties. There is no dispute that the Policy No. 152104/48/2014/2022 taken for the period from 3.1.14 to 2.1.15 is the first year policy and the complainant was admitted within 3 months from the inception of the first policy i.e. from 18.3.2014 to 22.03.2014 for the treatment of enlarged prostate and I have also gone through the policy condition No. 4.2 of the policy which says that the ailment/diseases/surgeries for the specified period are not payable if contracted and/or manifested during the currency of the policy. Further 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. I found that the disease i.e. column No. viii of clause 4.2 of the disease list, the surgery of benign prostatic hypertrophy is not covered upto 2 years from the inception of the policy.

Under the aforesaid facts & circumstances, material on record, I am therefore of the view that the decision/action of the respondent is perfectly justified and is sustainable. Hence, the complainant is not

entitled for the relief as prayed for. In the result, the complaint stands dismissed accordingly.

Dated at Bhopal on 31st day of March 2015

Mr. Govind
Patil……Complainant

V/s

The Oriental Insurance Co. Ltd.
……Respondent

Order No. IO/BHP/A/GI/0173/2014-2015
Case No. BHP-G-050-1314-0690

Award

Brief Background:

The complainant had taken an Individual Mediclaim Policy bearing no. 151100/48/2010/4790 for sum insured Rs. 50,000/- for the period 27/10/2009 to midnight of 26/10/2010 from the respondent company. It is further said that she underwent treatment in the Curewell hospital from 15.05.2010 to 17.05.2010. Thereafter, he lodged the claim before the respondent's TPA M/s M.D.India Health Care Services, Indore on 23/05/2010 and has submitted all the necessary documents which was not considered and claim was not paid nor any reply was given to him. Being aggrieved by the action of the respondent company, the complainant

approached this forum for redressal of his grievance towards making payment of Rs.10,844/- .

After registration of the complaint, the complainant submitted prescribed forms duly signed by him and but the respondent had not submitted SCN/reply rather has brought on record copy of letter dated 11.12.2014 of the draft repudiation statement for approval sent by the TPA to the respondent only on date of hearing mentioning therein that the claim has been closed as requites documents were not provided inspite of additional document request letter dated 17.05.2011 and 24.05.2011 viz attested photo copy of indoor case papers, patient health history information alongwith the day-to-day treatment chart from the hospital alongwith daily doctors visit notes that only the nursing chart or daily order sheet will not be accepted. The non filing of SCN clearly reflects the gross negligence of the respondent company and the respondent have not even filed the repudiation letter.

FINDINGS & DECISION:

I have gone through the material placed on the record and submission made. The discharge card (xerox copy) shows about the date of admission of the complainant on 15.05.2010 and discharged on 17.05.2010 from the Curewell Hospital Pvt.Ltd., Indore and the said discharge card also shows treatment undergone by the complainant in the said hospital for the diagnosed ailment. The OPD form dated 15.05.2010 also shows about the requirement of admission of the patient in the said hospital. The pathological reports available on the record shows about investigation. From the letter dated 11.12.2014, it appears that the claim has been closed

due to non compliance of the required medical documents by the insured i.e. attested photo copy of indoor case papers, patient health history information alongwith the day-to-day treatment chart from the hospital alongwith daily doctors visit notes while the complainant has clearly mentioned in his written submission dated 04.12.2014 that he has submitted all the requisite documents related to his claim to the respondent's office vide his letter dated 12.09.2010 duly acknowledge by the insurer on 17.09.2010 and also submitted vide letter dated 31.01.2014 and 10.04.2014 and all the claim formalities has been completed by him. It is clear that the claim has been closed due to non submission of some documents which does not appear to be just and proper as the complainant has already submitted the requisite documents before the respondent. In these circumstances, the respondent is liable to settle the claim after reopen/ review the claim of the complainant on the basis of documents already submitted or on submission of required documents if not submitted earlier.

Hence, the respondent Oriental Insurance Co.Ltd. is directed to reopen/review and settle the claim of the complainant on the basis of documents already submitted or on submission of required documents if not submitted earlier in accordance with the terms & condition of the policy document within one month from the date of receipt of this order under intimation to the complainant and to this forum. In the result, the complaint is allowed to the extent of above observation.

Mr. H. S. Shiledar .....Complainant

V/s

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

Order No. IO/BHP/A/GI/0175 /2014-2015 Case No. BHP-G-050-1314-0695

Brief Background:

The complainant had taken Individual Mediclaim Policy bearing no.152900/48/2013/2017 for total sum insured Rs.1,50,000/- for the period 13/10/2012 to 12/10/2013 covering himself and his wife. It is further said that he was hospitalized from 31.03.2013 to 09.04.2013 in Dr. M. R. Bhagwat Memorial Hospital, Raipur and after discharge he lodged the claim on 16.05.2013 for Rs.46,975/- before the TPA of the respondent company in which there was some delay but they repudiate the claim. Being aggrieved from the decision of the respondent company, the complainant approached this forum for relief of making payment of Rs.50,440/- towards his hospitalization as mentioned in P-II form.

After registration of the complaint, the complainant submitted prescribed forms duly signed by him and but the respondent have not submitted SCN/reply rather has brought on record a letter dated 10.03.2015 only on date of hearing mentioning therein that the claim is not payable on account of delay in intimation and late submission of claim as per terms & conditions of the policy and also mentioning that if claim is admissible the liability of the insurer comes for Rs.33,637/- only. The non filing of SCN clearly reflects the gross negligence of the respondent company.

The complainant was absent but has sent the written submission narrating the facts of the complaint and the representative of respondent company was present and was heard who stated that the case was closed due delay in intimation and late submission of claim form.

FINDINGS & DECISION:

I have gone through the material placed on the record and submission made. The discharge card (xerox copy) shows about the date of admission of the complainant on 31.03.2013 and date of discharge on 09.04.2013 from the Dr.M.R.Bhagwat Memorial Hospital and the said discharge card and investigation papers also show treatment undergone by the complainant in the said hospital for the diagnosed ailment. Since, the ground of repudiation as shown in the letter dated 10.03.2015 of respondent as well as during hearing is delay in intimation and late submission of claim form. As per IRDA circular No. IRDA/HLTH/ MISC/CIR/216/09/ 2011 dated 20.09.2011, it is clear that the insurers have been advised not to repudiate such claim on ground of delay in claim intimation/ document submission where the delay is proved to be for reasons beyond the control of insured. In the instant case, the complainant has mentioned in his complaint that he is a senior citizen aged about 83 years and his wife was also sick and hospitalized for two times between the period from 12.01.2013 to 29.04.2012 and he was in disturb mental condition, so he could not submit the claim in time. So, the reasons shown for the delay of lodging the claim before the respondent company appears to be proper and reasonable and it

should have been considered by the respondent company in settlement of the claim.

Under the aforesaid facts & circumstances, material on record, submissions made and policy terms & conditions, I am therefore of the view that the action/decision of the respondent company for rejecting the claim on the ground of delay in intimation and late submission of claim form is not justified and is not sustainable. Hence, the complainant is entitled for the admissible amount under the policy document.

Hence, the respondent Oriental Insurance Co. Ltd. is directed to reopen and settle the claim condoning the delay in the light of the IRDA circular and pay the admissible amount on the basis of hospital bills/receipts and medicine bills of pre and post hospitalization in accordance with the terms & condition of the policy document to the complainant within 15 days from the date of receipt of acceptance letter of the complainant failing which it will attract 9% simple interest p.a. from date of this order to the date of actual payment and submit compliance report to this office. In the result, the complaint is allowed to the extent of admissible amount only.

Dated at Bhopal on 20th day of March, 2015

Mr. Jagannath Rathore

……Complainant

V/s

Oriental Insurance Co. Ltd.
……Respondent

Order No. IO/BHP/A/GI/0156/2014-2015 Case No. BHP-G-050-1314-0692

Brief Background:

The complainant Mr. Jagannath Rathore was covered under Individual Mediclaim policy bearing no.151100/48/2010/4798 for sum insured Rs. 50,000/- for the period 27.10.2009 to 26.10.2010 from the respondent company. It is further said that he lodged his claim before TPA, M/s MD India Healthcare Services, Indore on 19.05.2011by submitting all the papers towards treatment cost of Rs.5397/- which was not paid by the respondent company. He also made representation before the respondent company but no reply was received by him. Being aggrieved from the decision of the respondent company, the complainant approached this forum for redressal of her grievance towards payment of Rs.5397/-.

The complaint was registered. The prescribed forms were submitted by the compliant duly signed by her but the respondent have not submitted the Self Contained Note showing the reason non availability of the record which reflects the gross negligence of the respondent company and has submitted the repudiation letter dated 24.01.2013 of the company along with draft repudiation statement for approval sent by TPA to the respondent company. The

respondent company have taken the plea in their repudiation letter that the claim has been repudiated under clause 4.3 of the policy terms and conditions. The policy terms and conditions has also been filed.

For the sake of natural justice, hearing was held at Bhopal office. The complainant was absent and sent a letter showing his inability to attend the hearing and has mentioned that he has submitted all the required document related to query of the insurer's TPA and also to this office. The insurer's representative, Mr. D. D. Charwande was present and was heard who has taken the stand as made in the repudiation letter and laid emphasis that the claim was made under concerned first year policy and so the claim was not payable under clause 4.3 of the policy docuemnt as there was waiting period of two years for the diagnosed ailment of HTN which was first detected.

FINDINGS AND DECISION:

I have carefully gone through the material on the record and submissions made by insurer' representative. The discharge card shows the treatment of the complainant who was admitted for complaint of fever with chakkar and weakness on 11.05.2010 and was discharged on 14.05.2010 after treatment and was diagnosed benine posture vertigo with HTN first detected in the Curewell Hospital, Indore. It is clear from the claim form that the claim has been made under the aforesaid mediclaim policy which was the first policy of the complainant issued by the respondent company. It is also apparent from the discharge card that he was given treatment for the diagnosed ailment which includes HTN and the complaint of

chakkar is the affect of HTN apart from fever three days back. The OPD form dated 09.05.2010 of the complainant shows the complaint of Giddiness, Ghabarahat, weakness and Headache but there is no mention of about fever and the complaint as made on 09.05.2010 and admission on 11.05.2010 without showing any reason for admission after two days in the said hospital reflects some otherwise which is best known to the complainant. As per clause 4.3 of the policy terms and conditions, the waiting period is two years for hypertension. Admittedly, the complainant was undergone treatment during the period of first year policy. Hence, in these circumstances, the respondent is not liable to pay the claimed amount under the clause 4.3 of the above policy document. Hence, the complainant is not entitled for the relief as prayed. In the result, the complaint stands dismissed.

Dated at Bhopal on 18th March, 2015

Mr. Jitendra Gupta
.....Complainant

V/s

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

Order No. IO/BHP/A/GI/0190/2014-2015 Case No.BHP-G-050-1415-0090

Brief Background:

The complainant had taken a Happy Family Floater policy bearing no. 151112/48/2014/708 for sum insured Rs. 5,00,000/- for the period 27/07/2013 to 26/07/2014 covering himself and his family members from the Respondent. It is further said that the complainant's daughter Ananya Gupta had undergone for the treatment and surgery for "Pathological Angula Deformity of Knees called GENU VALGUS popularly known as knock knees." He preferred a claim for reimbursement of treatment cost of his daughter with the Respondent Company which was rejected on the ground of "Congenital External Disease". Being aggrieved from the decision of the Respondent, he approached this forum for redressal of his grievance towards payment of Rs.96801/-.

The Respondent in their SCN have contended that the complainant's daughter Ms. Ananya's has undergone surgery of knee for disease "RICKETS LEADING TO GENU VULGARIS" and their TPA has denied the claim under policy terms and conditions, exclusion no. 4.8 as it is

congenital external disease. As per discharge card they mentioned that child was apparently alright one year ago after which she start developing pain in both legs and developing disease. Insured has not submitted any previous treatment papers and X-Rays. The respondent company agrees with the decision of the TPA.

For the sake of natural justice hearing was held at Bhopal Office. Both the parties were heard as mediation was failed. The complainant has narrated the facts as mentioned in the complaint and the insurer's representative has taken the stand as mentioned in reply/ SCN and laid emphasis that claim has been rejected under clause 4.8. The complainant has stated that there was some problem in his daughter's leg which collides and the leg started bending then he consulted in April, 2014 and operation was done in May, 2014.

<u>Findings & Decision:</u>

I have gone through the materials on record and submissions made by both the parties. The Discharge Card of Greater Kailash Hospital, Indore shows under history of present illness that child was apparently alright one year ago, after which she started developing pain in both the legs while running or walking long distances. Gradually, she developed knock knees. I observed from the certificate of treating Dr. Vivek Shrivastava placed on record which shows that the patient was operated for genu valgus which came after 9 year of her age as a sequeale of Vit. D deficiency (Rickets) which is seen even in children without any vitamin deficiency and classified as pathological condition attributed to sick physic as developmental anomaly. The response of physic varies with age, the nature of the disease nutrition and unpredictable. From birth to adolescence, there is a continuous change in the tibiofemoral angle

at the knee as part of the physiological evolution of limb alignment. From the medical literature brought on record by the complainant, it is found that pathological angular deformities of the knees may evolve and progress during childhood and adolescent growth and genu valgum as leg rotation deformities are caused by fluoride and calcium deficiency and the treating doctor Dr. Vivek Srivastava of the insured who is highly qualified Orthopedic Surgeon has clearly opined that the daughter of the complainant was operated for pathological developmental disease which was not congenital origin so, the above ailment certainly does not come under the exclusion clause 4.8 as the disease was not Congenital External Disease. The respondent company have brought on record the opinion of Dr. Ashish Mehrotra which does not contain any date who has opined that genu valgus deformaties was due to rickets but he has not mentioned that the disease was Congenital External Disease by birth while the treating doctor has opined that genu valgus may be caused due to many pathological condition including deficiency of vitamins. So, the report of the treating doctor cannot be dislodged. The respondent company have not brought on record any medical literature to show the ailment of the complainant's daughter for which she undergone treatment as Congenital External Disease. Thus the respondent company have failed to prove the ailment of the complainant's daughter as Congenital External Disease by birth.

Under the aforesaid facts & circumstances, material on record and submissions made, I am therefore of the view that the decision/action of the respondent company for repudiating the claim is not justified and is not sustainable. Hence, the complainant is entitled for the admissible amount as per policy document.

Hence, the respondent The Oriental Insurance Co. Ltd. is directed to settle the claim and make payment of admissible amount to the complainant under the policy document within 15 days from the date of receipt of acceptance letter of the complainant failing which it will attract 9% simple interest p.a. from date of this order to the date of payment and submit compliance report to this forum. In the result, the complaint is allowed to the extent of admissible amount only.

Dated at Bhopal this 27th day of March 2015

Mr. Kamlesh Maheshwari
.....Complainant

V/s

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

Order No.: IO/BHP/A/GI/0004/2014-2015 Case No.: BHP-G-050-1415-008

Mr. Kamlesh Maheshwari had taken a Happy Family Floater Mediclaim Policy bearing no. 152801/48/2014/1758 for the period 03.03.2014 to 02.03.2015 for sum insured Rs.1,00,000/- on payment of premium amount Rs.7,290/- covering himself and his family members from Oriental Insurance Co. Ltd., (hereinafter called Respondent).

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 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. Being aggrieved with the action/decision of the respondent, he approached this forum for redressal of his grievance and requesting refund of his excess premium amount and other charges Rs.10,000/- .

The Respondent have stated in the SCN that in view of claim experience and market scenario, they have reviewed the basis of calculation of premium vide their circular no. HO/Health/2013/CR-6837 dated 04.11.2013 so, according to the above mentioned circular, the policy of the complainant was renewed and premium was charged by the system according to revised calculation pattern.

For the sake of natural justice hearing was held at Bhopal office. Both the parties were heard as mediation was failed. The complainant has reiterated the facts as mentioned in the complaint. The complainant has stated that his mother Smt. Shakuntala Maheshwari was insured from before and making his mother as primary member was without his consent and prior intimation and no circular was informed about charging more premium showing his mother as primary member so, the difference amount of premium taken from him for issuing the aforesaid policy should be refunded by the respondent company. The insurer's representative has taken the stand as mentioned in the SCN/reply and laid emphasis that the premium amount has been realized from the complainant in view of the higher age of his family member who is mother of the complainant aged about 74 years old in view of the circular dated 04.11.2013 which was made known to the complainant so, claim for refund of difference amount towards premium is not payable.

FINDINGS & DECISION:

I have gone through the material on record and submissions made by both the parties. 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. Since, the required premium amount for renewal/issuance of the aforesaid policy has been realized by the respondent company in view of the aforesaid circular dated 04.11.2013 and paid by the complainant for taking the said policy for himself and his family member including his mother which reflects the implied consent of the complainant for taking the said policy on payment of the amount of premium as required. So, he cannot reprobate about making payment of the required premium as he was at liberty for not renewing his policy if he was dissatisfied with the enhanced premium at the time of renewal of the said policy. Thus, it is established the premium charged by the company and paid by the insured is according to terms and conditions of the above circular dated 04.11.2013.

Under the aforesaid facts & circumstances, material on record and submissions made, I am therefore of the considered view that the decision of the respondent for not considering the claim of the

complainant for refund of excess premium paid under policy terms & conditions is perfectly justified and is sustainable. Hence, the complainant is not entitled for the relief as prayed for. In the result, the complaint stands dismissed accordingly.

Mr. NandGopal Biyani
.....Complainant

V/s

The National Insurance Co. Ltd.,
.....Respondent

Order No.: IO/BHP/A/GI/0184 /2014-2015 Case No.: BHP-G-048-1415-0116

Mr. Nandgopal Biyani (hereinafter called Complainant) obtained a BOI National Swasthya Bima Policy No. 320205/48/13/8500000074 for the period 26.04.2013 to 25.04.2014 for self and his family from The National Insurance Co. Ltd. Insurance Co. Ltd., (hereinafter called Respondent).

As per the Complaint, the complainant was hospitalized from 24.03.2014 to 27.03.2014 in Breach Candy Hospital Trust, Mumbai for the treatment of Carotid Angioplasty and stenting due to brain stroke. He preferred a claim for Rs.5,13,260/- which was repudiated as No Claim due to pre-existing HTN and DM. Aggrieved with the decision of the Respondent, he approached this forum for payment of Rs.5,13,260/- .

The Respondent vide its SCN have contended that the complainant was hospitalized at Breach Candy Hospital Trust, Bombay and this hospitalization was for the treatment of Chronic Ischaemic Heart

disease as per discharge summary. The patient was diagnosed with left MCA Stroke due to left ICA steonsis with H/O Hypertension since 08-10 years and Diabetes Mellitus since 10 years vide details mentioned on prescription and policy inception. Hence claim has been repudiated under exclusion No. 4.1 pre-existing diseases and its complications are excluded for three years from policy inception date.

Findings and Decesion:

I have gone through the material on record and submission made during hearing, I have gone through the proposal form submitted by the Respondent at the time of hearing and I found that there is no mention of any preexisting disease in the column of existed diseases/injury/illness. The proposal form was filled in on 25.04.2013 and the policy was continued for the period from 26.04.13 to 25.04.2014. The complainant was diagnosed with Left MCA Stroke ICA Steonsis with H/o Hypertension since 8-10 years and diabetes mellitus since 10 years as per details mentioned on prescription dated 18.03.14 placed on record. As per policy condition No. 4 and 4.1, the company shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any insured person in connection with or in respect of all pre existing diseases. Such diseases shall be covered after the policy has been continuously in force for 36 months. Any complication arising from pre-existing ailment/disease/injuries will be considered as a part of the pre existing health condition or disease. The policy has been issued subject to exclusion of pre-existing disease of Hypertension, Diabetes, and Heart disease clearly mentioned in the

policy document itself. Thus, I find substance in the plea taken and made in the SCN on behalf of the respondent.

Under the aforesaid facts & circumstances, material on record, I am therefore of the view that the decision/action of the respondent for not considering the claim under the policy document is perfectly justified and is sustainable. Hence, the complainant is not entitled for the relief as prayed for. In the result, the complaint stands dismissed accordingly.

Mr. Navin Chaturvedi
.....Complainant

V/s

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

Order No.: IO/BHP/A/GI/0192/2014-2015 Case No.: BHP-G-050-1415-0089

<u>Brief Background:</u>

The complainant had taken a Private Car Package Policy No. 152104/31/POL/2007/MIG/367 for the period 06.05.2006 to 05.05.2007 for IDV of Rs.4,76,000/- from Respondent. It is further said that he had purchased FORD ICON vehicle No. MP-04 CA-3493 consisting of Eng. and Chasis No. 6 TA 9834 through the dealer of the vehicle. His vehicle was stolen in the midnight of 04-05-2007. A claim was preferred before the respondent with all the necessary information and documents but they repudiated the claim and

informed vide letter dated 25.05.2007 that they will pay the claim when he would submit the final report of Court of CJM. Being aggrieved from the decision of the Respondent, he approached this forum for redressal of his grievance towards payment of Rs.4,76,000/- . The Respondent vide its SCN have contended that after receiving the required documents, they recommended for settlement of the claim to their Divisional Office. They were instructed by Divisional Office through Regional Office that the competent authority has not agreed for the settlement of the claim on the grounds that papers have been submitted after nearly four years which is too late to consider the claim for payment and accordingly they informed the insured. Due to the said reasons, the claim has been closed.

Findings & Decision:

I have gone through the materials on record and submissions made by both the parties. There is no dispute that the vehicle in question was stolen in the night of 4.5.2007 between 12 pm to 5 am and FIR was lodged by the insured himself on 5.5.2007 at 20.30 hours at Kamla Nagar Police Station, Bhopal. It is observed that as per letter of respondent dated 25.5.2007 point No. 13, the final report from Court of CJM was demanded under CrPC 173 from the complainant. The said report was received by the complainant on 28.9.2011 as appears from date of issue of certified copy of order for acceptance of final order by the CJM which was placed in the branch of the Respondent on 29.09.2011. The matter was investigated and the claim was recommended for full and final settlement for Rs.4,76,000/- by the Branch Manager itself on 15.5.2014 to its higher offices but the claim was already closed for want of delayed submission of final report. Hence, under the discussed

circumstances, I find that there was no delay in submission of final report and other documents.

Under the aforesaid facts & circumstances, material on record and submissions made, I am therefore of the view that the decision/action of the respondent company for closing the claim for delayed submission of final report etc. is not justified and is not sustainable. Hence, the complainant is entitled for the claimed amount in accordance with the terms & conditions of the policy document.

Hence, the respondent The Oriental Insurance Co. Ltd. is directed to reopen and settle the claim and make payment of claimed amount to the complainant in accordance with the terms & condition of the policy document within 15 days from date of receipt of acceptance letter of the complainant failing which it will attract 9% simple interest p.a. from date of this order to the date of payment and submit compliance report to this forum. In the result, the complaint is allowed to the extent of admissible amount only.
Dated at Bhopal this 31st March of 2015

Mr. O. P. Verma
……Complainant

V/s

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

Order No. IO/BHP/A/GI/0168/2014-2015 Case No.BHP-G-044-1314-0705

Brief Background:

The complainant had taken a Medi Classic Health Insurance Policy bearing no. P/201116/01/2013/001866 for sum insured Rs.3,00,000/- for the period 21.12.2012 to 20.12.2013 covering himself from Respondent. It is further said that the Complainant was admitted in Mahakoshal Hospital, Jabalpur on 20.10.2013 for the treatment of Hypertension, Br. Asthma, Metabolic Encephalopathy and preferred a claim for Rs. 58,638/- which was repudiated by the respondent on the ground of pre-existing disease. The complainant having insurance policy since 09.12.2009 and this was his first claim with the respondent. The respondent repudiated the claim vide its letter dated 01.02.2014 mentioning that as per consultation report dated 14.12.2013, the complainant has SVT 10 years back. This fact was not disclosed by the complainant at the time of inception of the policy and hence, the claim was repudiated under policy condition no. 7 for non disclosure/misrepresentation of material facts. Being aggrieved with the decision of the respondent, he approached this

forum for redressal of his grievance and making payment towards his hospitalization expenses Rs.66,111/-.

The Respondent vide its SCN have contended that the claim has been reported in the fourth year of the policy. The complainant was admitted at Mahakoshal Hospital, Jabalpur on 20.10.2013 and discharged on 27.10.2013 and diagnosed as Hypertension, Bronchial Asthma and Metabolic Encephalopathy. As per clinical notes dated 22.10.2013, it is clearly noted as diagnosis, Hypertension with Bronchial Asthma with Pancreatitis and as per consultation report dated 14.12.2013, he has SVT 10 years back and is on T. Dilzem, CT brain shows per ventricular infarcts and as per their internal verification, the insured patient has hypertension from 4-5 years and undergone appendectomy in 1990 and hernioplasty in 2000. The insured has not disclosed any of the above past medical history while proposing insurance with them. In this case, the insured has not declared his pre-existing diseases in the proposal form, which is a non disclosure of material fact. Therefore, the claim has been rejected under condition No. 7 of the issued policy which reads as follows- "the company shall not be liable to make any payment under the policy in respect of any claim if such claim is in any manner or supported by any means or device, misrepresentation whether by the insured person or by any other person acting on his behalf." And prayed to absolve the respondent.

<u>Findings & Decision:</u>

I have gone through the material on record and submissions made by both the parties.

As per prescription dated 11.12.09 of Anant Institute of Medical Sciences, Jabalpur, it is found that the complainant was a known

case of Hypertension since 10 years. I also found in the history and physical examination record of Mahakoshal Hospital, Jabalpur that the patient was admitted for the treatment of HTN, Br. Asthma and pancreatitis from 20.10.13 to 27.10.13. The letter dated 14.12.2013 issued by Mahakoshal Hospital Pvt. Ltd. also shows that there was history of one episode of SVT 10 years back (Approx) of the patient. On perusal of the proposal form (xerox copy), I found that the complainant has given answer "No" in the column of medical history while he was in know of the fact that he was suffering from HTN from last 10 years and also suffer one episode of SVT 10 years back but this material fact was not disclosed in the proposal form by the complainant for taking the said policy. Thus, it is established that the complainant was suffering from pre-existing disease at the time of taking policy which was not disclosed. As per condition no. 7 of the policy document "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 whether by the insured person or by any other person acting on his behalf." In my opinion the stand taken by the Respondent is quite justified and there is no scope to interfere in the decision taken by the Respondent.

Under the aforesaid facts & circumstances, material on record, I am therefore of the view that the decision/action of the respondent is perfectly justified and is sustainable. Hence, the complainant is not entitled for the relief as prayed for. In the result, the complaint stands dismissed accordingly.

Dated at Bhopal on 19th day of March, 2015

Mr. Rajendra Kumar

Bhatia.....Complainant

V/s

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

Order No.IO/BHP/A/GI/0146/2014-2015 Case No. BHP-G-048-1314-0675

Brief Background:

The complainant had taken a Hospitalization Benefit Policy bearing no. 320100/48/12/8500003332 for sum insured Rs.25,000 + Rs.125000/- for the period 05/03/2013 to 04/03/2014 from the respondent company covering himself and his family member. It is further said that he went to Nasik on 16.08.2013 where he fell breathing trouble and cough and was hospitalized in Chopda Medicare and Research Centre, Nashik and remained hospitalized till 30.08.2013 and during investigation, infection was found in his lung. Since, he was not satisfy with the treatment in the said hospitalized so, he was admitted in Sujay Hospital, Bombay where he was recovered after treatment. In meanwhile his sleep study test was done in which sleep apnoea was diagnosed. He did not take treatment for obesity and the respondent company never took any information about his weight and he was never admitted for treatment of obesity so, the condition no. 4.19 is not applicable in his case but the company kept aside all the investigation and treatment papers and did not consider his claim. He made representation before the respondent company for considering his

claim but the same was not consider and claim was closed as no claim under policy condition no. 4.19. It would not be out of place to mention here that the complainant has not mentioned the policy no. in the complaint and wrong policy no. was mentioned in Annexure VI A which was corrected by the complainant at the time of hearing. Being aggrieved by the action of respondent company, the complainant approached this forum for the relief of claim amount Rs.1,98,500/- (Rs.1,50,000/- + Bonus) as mention in P-II form.

The insurer in their SCN have taken the plea that as per the recommendation of the TPA and seeking advice of their panel doctor, Dr. K. G. Agrawal, the claim was repudiated under exclusion clause no. 4.19 of the policy document.

For the sake of natural justice, hearing was held at Bhopal Office. Both the parties were heard as mediation was failed. The complainant has reiterated the facts as mentioned in the complaint and laid emphasis that he was never treated for obesity rather lungs related Pneumonia but admitted that his weight was 110 kg and at present is 93 kg but nothing was asked about his weight at the time of policy. The insurer's representative has taken the stand as mentioned in the SCN and laid emphasis that complainant was treated for obesity and condition arising there from so the claim was repudiated under exclusion clause 4.19.

FINDINGS & DECISION:

I have gone through the material available on the record and the submission made by both the parties. The discharge report (xerox copy) Chopda Medicare and Research Centre, Nasik shows the date of admission on 22.08.2013 and date of discharge on

30.08.2013 showing status other hospital and the history c/o sudden onset of severe breathlessness, orthopnoea since 30 minutes and past history T2 DM, HTN since one and half year, severe obesity. The discharge card of Sujay Hospital, Bombay shows the admission on 30.08.2013 of the complainant and discharge on 04.09.2013 and was diagnosed sleep Apnoea syndrome c TZ respiratory with morbid obesity with DM and the progress note shows about the treatment given to the complainant during hospitalization. Dr. K. G. Agrawal, MBBS, the panel doctor of the company has given his opinion that sleep Apnoea syndrome is a known complication of morbid obesity. Exclusion clause 4.19 of the policy document provides that treatment for obesity or condition arising therefrom (including morbid obesity) and any other weight control program/services/supply are not payable. The opinion given by the panel doctor is simply a MBBS and is not a specialist for ailment of sleep Apnoea syndrome, lungs diseases and morbid obesity as well as DM. From the progress note of the Sujay Hospital, it is apparent that several medicine and injection were given to the complainant during hospitalization and with the advice of alternate day weight but there was a complaint of breathing trouble and infection in lung as asserted by the complainant and only a pulmonary disease specialist doctor can decide from the medical documents of the complainant about the treatment of lungs infection including breathing trouble only or for obesity (morbid obesity) as diagnosed in the Sujay Hospital and Chopda Medicare Hospital and Research Centre, Nasik. Since, there is a dispute about the treatment of the ailment suffered by the complainant for breathlessness, orthoponea and the treatment of the sleep Apnoea syndrome which is know complication of morbid obesity as opined by the Dr. K. G. Agrawal,

the panel doctor of the company, the evidence(oral and documentary) particularly of a specialist doctor in the said field is essential to decide the nature of ailment and treatment given and only then, the claim of the complainant can be decided. This Forum has got limited authority under the RPG Rules 1998. It can only hear the parties at dispute without calling fresh witness, summon them for deposition, ask for various evidences including cross-examining outside parties which is beyond the scope of this forum. In order to resolve the issue, calling other witnesses may help in arriving at a just decision. Under this circumstances, the complaint is dismissed with a liberty to the complainant to approach some other Forum/Court to resolve the subject matter of dispute.

Dated at Bhopal on 10th day of March, 2015

Mrs. Rajni Dubey ……. Complainant

V/s

National Insurance Co. Ltd. ……Respondent

Order No. IO/BHP/A/GI/0003/2015-2016 Case No.BHP-G-048-1415-010

<u>Brief Background:</u>

The complainant had taken a Overseas Medical Insurance Policy bearing no. 80398839 Master Policy No. 251100/48/13/0570000001 for sum insured USD 50000 for the period 28.10.2013 to 05.01.2014 covering herself from the respondent company. It is further said that the 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. Being aggrieved with the action of the respondent company, the complainant approached this forum for redressal of her grievance towards making payment of her medical expenses for USD 194.

For the sake of natural justice hearing was held at Bhopal Office. The complainant was absent. Mediation could not be done due to absence of the complainant. The insurer's representative was present and was heard. The insurer's representative has submitted the claim settlement voucher duly signed by insured for Rs.5258/- on 27.02.2015 towards full and final settlement of her claim along with e-mail showing undertaking of the complainant to withdraw his claim from this forum as satisfied from claim settlement amount.

<u>Findings & Decision:</u>

I have gone through the material placed on the record and the petition filed today regarding payment of settled amount of claim under the aforesaid policy document and prayer of withdrawal of the case sent by complainant through e-mail. 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.

Mr. S. C. Shukla
……Complainant

V/s

The New India Assurance Co. Ltd. …….
….Respondent

Order No. IO/BHP/A/GI/0001/2015-2016 Case No.BHP-G-049-1415-0092

Brief Background:

Mr. S. C. Shukla (hereinafter called Complainant) obtained a Hospitalization Benefit/Janata Mediclaim Policy bearing no. 451400/34/10/14/00000536 for sum insured Rs.75,000/- for the period 25.01.2011 to midnight of 24.01.2012 covering himself and his wife from The National Assurance Co. Ltd., (hereinafter called Respondent).

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 for payment of remaining amount before the respondent company which was not considered. Being aggrieved with the decision of the Respondent, he approached this forum for justice.

The Respondent vide its reply dated 26.02.2015 have enclosed the copy of Janta Mediclaim policy, clarification letter against complaint and claims payment statement and discharged voucher without

mentioning any other facts in the said reply letter. 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:

I have gone through the materials on record and submissions made during hearing. There is no dispute that the treatment was taken by the complainant towards his right knee injuries. I have also gone through the terms and conditions of the Janata Mediclaim Policy which is placed on record where the benefits towards major surgery was restricted on various heads like room rent, OT charges, anesthetist fees and surgeon fees. The Respondent TPA rightly calculated the eligibility as per policy terms and conditions and the complainant has got two claims for Rs. 12200/- and Rs. 6435/- 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. In view of the policy terms and conditions, I find no ground to interfere in the quantum of amount settled by the Respondent under the policy document and the complainant is not entitled for any further relief from this forum. Hence, the complaint stands dismissed without any relief.

Mr. S. S. Sharma
……Complainant

V/s

The New India Assurance Co. Ltd.
……Respondent

Order No. IO/BHP/A/GI/0160/2014-2015 Case No.BHP-G-049-1415-00696

Brief Background:

The complainant's son, Mr. Viren Sharma had taken a Individaul Mediclaim Policy bearing no. 45140034130100000001 for sum insured Rs.1,00,000/- for the period 06.04.2013 to 05.04.2014 covering himself (policy holder) and his parents and family members from Respondent. It is further said that he undergone for his cataract operation of his right eye and his wife, the policy holder's mother, Mrs. Shashi Sharma was undergone for emergency treatment. He lodged claims towards his treatment cost and treatment cost of his wife as incurred by him for Rs. 5300/- and Rs.19253/- respectively before the respondent company but he was paid Rs.4990/- on 24.10.2013 after dis-allowing Rs.310/- under the head medicines and a sum of Rs.9571/- was credited in his SB account on 03.09.2013 reducing the claim by Rs.9682/- towards treatment of his wife which was absolutely unjustified. He made representation before the respondent for making payment of balance amount which was not considered. Being aggrieved from the

decision of the Respondent, he approached this forum for redressal of his grievance towards payment of deducted amount.

The complaint was registered and prescribed forms were issued. The prescribed forms were submitted by the complainant but the respondent company has not filed SCN/ reply except the claim payment statement and discharge boucher and calculation sheet. The non filing the SCN reflects the gross negligence of the respondent.

For the sake of natural justice, hearing was held at Bhopal Office. Both the parties were heard as mediation was failed. The complainant has narrated the facts as mentioned in the complaint and the insurer's representative has stated that deductions made are proper as per policy conditions.

Findings & Decision:

I have gone through the material on record and submissions made by both the parties. It is admitted that the claim has been settled dis-allowing some amounts. So, for deductions for Rs.310/- is concerned, the complainant has not brought on record any medicine bills to show the deductions in the hospital bills under head medicines and virtually has not raised any dispute at the time of hearing. As regards deductions for Rs.9682/-, as per policy terms and conditions 2.1, the entitlement of complainant's wife is 1% of the sum insured for the room, boarding and nursing expenses per day as provided and as per clause 2.6. Note-1. The amounts payable under 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 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. Since, the patient was admitted for three days in hospital with room rent of Rs.2200/- per day and nursing charges of Rs.350/- per day. The insured person is entitled for Rs.1000/- (1% of sum insured only) hence, there is 60.8% entitled deductions have been done in the claimed amount as appears from the TPA's mail dated 12.12.2014. I found that the deductions as shown in the claims payment statement of concerned TPA are proper and in accordance with the terms and conditions of the policy document.

Under the aforesaid facts & circumstances, I am therefore of the view that the decision/action of the respondent towards deduction of the aforesaid amount against the claim made by the complainant is perfectly justified and is sustainable. Hence, the complainant is not entitled for the relief as prayed for. In the result, the complaint stands dismissed accordingly.

Dated at Bhopal on 18th day of March 2015

Ms. Saloni Bindal
……Complainant

V/s

The National Insurance Co. Ltd.
……Respondent

Order No. IO/BHP/A/GI/0148/2014-2015 Case No.GI/NIC/1012/105

Brief Background:

The complainant Ms. Saloni Bindal had taken an Overseas Mediclaim Policy bearing no. 321100/48/10/0570000009 for the period 25.04.2010 to 23.06.2010 from the Respondent company for her visit to Los Angeles on 25.04.2010 and back from Los Angeles to Delhi via Bangkok on 20.06.2010 on a student round square conference Daly College, Indore to Chadwick School Los Angeles (California, USA) on student exchange programme for period of two months. her flight for Los Angeles to Delhi was cancelled/delayed due to technical reasons. She was taken to Hilton Hotel near Los Angeles airport but the baggage were not returned stating that baggage were left inside the Aircraft and it is not possible to retrieve at that hour and on next day on 21.06.2010, she reported to Airport but she could not travel as the Aircraft could not be repaired and again she was given a hotel boucher near Los Angeles Airport but her baggage was not returned on that day also and on 22.06.2010, she got a fresh booking confirmation for the same flight under the

same PNR for Los Angeles to Bangkok and Bangkok to Delhi on 24.06.2010. She finally landed at New Delhi and she found that her baggage was lost/misplaced containing Apple Laptop, Camera, personal belongings and US$500 and with great difficulty, her complaint for the missing bag was taken and thereafter, she got a call from Thai Airways office on 25.06.2010 that her missing baggage was traced and was being sent by Jet Lite Flight and baggage was returned in damaged condition. She preferred claim for US$500 on account of delay of checked in baggage, delay in travel, loss of hand baggage which was rejected by the Respondent/TPA as per policy terms and conditions. The complainant raised query that the terms and conditions were not provided to her the at the time of taking policy. Being aggrieved by the action of respondent the complainant approached this forum for redressal of her grievance and make payment of US$500 + Camera + Laptop.

The insurer in their SCN have asserted that the complainant lodged a claim on 28.06.2010 regarding delay in travel and delay in checked in baggage. The Respondent advised the insured to contact its TPA named M/s Heritage Health Service Pvt. Ltd., Mumbai and the TPA informed the complainant vide its letter dated 06.08.2010 that the incident reported does not fall within purview of policy coverage. Hence, the claim was not payable and have also taken the plea that the claim was for loss of checked in baggage and delay of checked in baggage under overseas mediclaim policy and in terms of section C, loss of checked in baggage, the claim is payable for total loss of checked in baggage and in terms of section D, delay of checked in baggage, the claim is payable for delay of more than 12 hours from scheduled arrival time at the destination for of baggage that has been checked in by an international airline for an international

outbound flight from republic of India and in this case it was neither a total loss case and only some item (Laptop, Camera, personal belongings) as per section C, nor it was for outbound flight as per section D, as it was during return journey to Delhi (India) which was an inbound flight. So, the claim was out of scope of policy coverage and has been rightly declined by their TPA and hence, the compliant is not sustainable.

Both the parties were heard as mediation could not be done due to absence of the complainant. The complainant's representative has narrated the entire event as made in compliant and stated that one bag was lost containing camera, cash and Laptop after check-in and policy terms was not supplied. The insurer's representative has taken the stand as mentioned in the SCN and laid emphasis that partial loss is not payable under section C and no claim is payable for delay in checked in of baggage under section D and complainant has not filed the receipt of Laptop and Camera said to have been lost.

<u>Findings & Decision</u>

I have gone through the material on record and submissions made by both the parties. In the letter dated 06.08.2010 sent by the TPA to the complainant and SCN/reply dated 01.03.2013, the provisions of the section C and Section D of the policy terms and conditions has been clearly mentioned. Section C deals with loss of checked in baggage which clearly provides that this insurance will pay up to the limit of cover shown in the schedule in the event of the insured person suffering total loss on checked in baggage as defined. The insurers reserve the right to replace or pay the intrinsic value of any lost article and no partial loss or damage shall become payable. The section D of the policy document deals with delay of checked in baggage which clearly provides that this insurance will pay upto the

limit of cover shown in the schedule for necessary emergency purchase of replacement items that the insured person suffers a delay of more than 12 hours from the scheduled arrival time at the destination for delivery of baggage that has been checked in by an international airline for an international outbound from the republic of India. From the record, it is apparent that during course of return journey, there was total two checked in baggage out of which one was delivered and one has been shown as missing or damaged containing ten kg. The record also shows that the complainant received one checked in baggage and alleged about loss of hand baggage containing above articles though nothing has been mentioned about loss of laptop, camera and cash US$500 except loss of hand baggage in the claim form submitted by the complainant. However, it is clear from the claim form itself that there was loss of one checked in hand baggage. So, there was a partial loss of checked in baggage and not total loss of checked in baggage which is not covered under section C of the policy conditions. Moreover, the complainant has not filed the bills/receipts for camera, Laptop and carrying US$500 and the complainant has shown the reason that it is not expected to retain the bills of personal belongings but it is well settled principles of law that one can claim of ownership/possession over any article only on the basis of filing necessary documents like receipts, bills etc. From the record, it is also clear that the complainant's baggage was delayed during her return journey to Delhi which was an international inbound flight and this incident is outside scope of policy coverage under section D. The complainant has alleged that the policy terms and conditions was not supplied to her but this matter should have been raised just after receiving the policy if it was so.

Under the aforesaid discussed facts & circumstances and the above conditions of the policy, I am of the considered view that the decision taken by the respondent company for declining claim of the complainant is justified and sustainable Hence, the complainant is not entitled for the relief as prayed for. In the result, the complaint stands dismissed accordingly.

Dated at Bhopal on 10 day of March, 2015

Mr. Sanjay Neema

…….Complainant

V/s

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

Order No.IO/BHP/A/GI/0139/2014-2015
Case No. GI/SHI/1302/62

<u>Brief Background:</u>
The complainant had taken a Family Health Optima Insurance Policy bearing no. P/201114/01/2012/002055 for floater sum insured Rs.3,00,000/- for the period 18/08/2011 to 17/08/2012 covering himself, his wife and two dependent children from the respondent company. It is further said that complainant's son Master Kavya Neema was hospitalized due to ailment of Henoch Scholein Purpura. Thereafter, he lodged the claim before the respondent company towards treatment cost of his son but his claim was rejected on the

ground that Kavya Neema had ailment of Cerebral Palsy while he was admitted for the aforesaid ailment and not for cerebral palsy. Thereafter, he made representation before the respondent company but no reply was given. Being aggrieved by the action of respondent company, the complainant approached this forum for the relief of claim amount (Rs.18,472/- + 5,000) = 23,472/-.

The respondent in their SCN have taken the plea that the insured is one of twins and cerebral palsy is present from birth and characterized by started growth and delayed milestones of development but the above fact was not disclosed at the time of inception of the policy. So, not withstanding the facts that the admission for the Henoch Scholein Purpura and not for cerebral palsy, the claim was rejected due to non disclosure of above facts/misrepresentation under condition no. 7 of the policy document.

FINDINGS & DECISION:

I have gone through the material available on the record and the submission made by the respondent. The proposal form (xerox copy) dated 13.08.2010 clearly shows that word "NO" has been mentioned about details of health history while the indoor case paper dated 10.06.2012 clearly shows that the insured Kavya Neema was a known case of cerebral palsy and as per prescription dated 12.06.2012 the complainant's son was prescribed Tizan which is prescribed for cerebral palsy. As per the medical literature submitted by the respondent cerebral palsy is the result of brain injury or brain malformation and it is now widely agreed that the birthing complication account for 10% of cerebral palsy cases and current research suggest that majority cerebral palsy cases result from brain injury prior to birth or during labour and delivery. The complainant

has not brought on record to show that his son Kavya Neema was not suffering from cerebral palsy before inception of the policy. The condition no. 7 of the policy document clearly provides 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 by the insure person or any other person acting on his behalf. Thus, it is established from the medical documents that the Kavya Neema was suffering from cerebral palsy at the time of inception of the policy and which was misrepresented/concealed fraudulently by mentioning "NO" in the proposal form regarding the health condition of the insured. I find substance in the contention of the insurer's representative. In the circumstances, the respondent is not liable to make payment of the claim as made. Hence, the complaint stands dismissed accordingly.

Dated at Bhopal on 9th day of March, 2015

Mr. Sanjay Patni
……Complainant

V/s

The National Insurance Co. Ltd.
……Respondent

Order No. IO/BHP/A/GI/0165/2014-2015 Case No.BHP-G-048-1314-0702

<u>Brief Background:</u>

The complainant's father late Chandmal Patni was covered under a Hospitalization Benefit Policy bearing no. 321700/48/13/8500000409 for sum insured Rs.50,000/-+ Cumulative Bonus Rs.13,750/- for the period 01.05.2013 to midnight of 30.04.2014 which was issued by the Respondent. It is further said that his father was fell down at home due to this, he was unable to walk so, he was admitted in hospital and died on 21.01.2014. He lodged the claim before the respondent company towards treatment cost but they rejected the same on the ground that his father was in depression whereas clarification letter of the Doctor was also submitted. Being aggrieved from the action/decision of the Respondent, he approached this forum for making payment of Rs.23,000/- only the treatment cost.

The complaint was registered and prescribed forms were issued which were submitted by the complainant duly signed by the complainant. The respondent has not filed the SCN/ reply rather have brought on record only repudiation letter dated 31.10.2013 mentioning therein that the patient was admitted with diagnosis K/C/O parkinsones, depression and HTN, pschycosis and treated accordingly, but as per policy terms & conditions, all psychiatric and psychosomatic disorders/ diseases are not payable and hospitalization was done for diagnostic purpose and various tests were performed which could be done on OPD basis. He was treated by oral medicines, no hospitalization was required, so as per Section 2(2.6) and 4(10) of individual mediclaim policy claim is not payable. Non filing of the SCN reflects the gross negligence of the respondent company.

For the sake of natural justice hearing was held at Bhopal Office. The complainant was absent but sent the letter dated 31.12.2014 clarifying the ground of rejection showing depression of his father while his father was admitted due to sustaining injury by fall. The Respondent was represented by Mr. Mahendra Jadhav, Div. Manager, of The National Insurance Co. Ltd. who has taken the stand as mentioned in the repudiation and fail to show the reason about non filing of the SCN.

Findings & decision:

I have gone through the materials on record and submissions made. From perusal of the discharge card of the patient as well as the prescription dated 01.07.2013 with k/c/o parkinsonism, depression and HTN and in history of as given by attendance fall at home on 01.07.2013 at about 8.30-9.00 am with complaint of pain body ache not responding properly and psychosis alongwith above known case ailment was diagnosed and as per the advice of the doctor he was admitted in Globle SNG hospital, Indore and required treatment was given alongwith some investigations and test. It is only the doctor who can decide about the admission of the patient after seeing the patient's physical conditions and it is also clear that the patient was remained in the hospital from 01.07.2013 and discharged on 04.07.2013. So, without any ailment, a person cannot get himself hospitalized and get treated. The discharge card itself shows the treatment given to the patient. The certificate dated 27.11.2013 also shows c/o about injury in lower back and hips which was ruled out by x-ray. So, the above treatment cannot be considered as OPD

treatment as stated on behalf of respondent company. In these circumstances the respondent is liable to make payment of admissible amount to the complainant.

Under the aforesaid facts & circumstances, material on record and submissions made, I am therefore of the view that the decision/action of the respondent company for repudiating the claim is not justified and is not sustainable. Hence, the complainant is entitled for the admissible amount in accordance with the terms & conditions of the policy document against the claimed amount.

Hence, the respondent The National Insurance Co. Ltd. is directed to review and settle the claim and make payment of admissible amount to the complainant in accordance with the terms & condition of the policy document within 15 days from the date of receipt of acceptance letter of the complainant failing which it will attract 9% simple interest p.a. from date of this order to the date of actual payment. In the result, the complaint is allowed to the extent of admissible amount only.

Dated at Bhopal on 19th day of March, 2015

Mr. Sanjeev Manghnani……Complainant

V/s

**The New India Assurance Co. Ltd.,
Bhopal……Respondent**

Order No.: IO/BHP/A/GI/0153/2014-2015 Case No.: BHP-G-049-1415-0034

Mr. Sanjeev Meghnani (hereinafter called Complainant) obtained a Family Floater Mediclaim Insurance Policy No. 450800/34/13/0300000065 for the period 5.7.13 to 4.7.14 for self, spouse and children for Sum Insured Rs. 500000/- from The New India Assurance Company, Indore (hereinafter called Respondent).

As per the Complaint, his wife Smt. Aashna Manghnani admitted in Dolphin Hospital & Research Foundation, Indore for the period 6.10.13 to 9.10.13 for surgery. After discharge from the hospital, he preferred a claim for Rs. 67973/- out of which an amount of Rs. 41310/- was sanctioned and received by him through NEFT. He represented to the TPA of Insurance Company who replied that as per reasonable and customary clause of policy this surgery cannot be payable above Rs. 40000/-. Aggrieved with the decision, he approached this forum to get his deducted amount of Rs. 26663/-.
The Complainant was present in person and the Respondent was represented by Mr. Avinash Joshi, Admn. Officer The New India Assurance Co. Ltd., Indore. Both the parties were heard as mediation was failed who have narrated the facts as mentioned in the

complaint. Inspite of our repeated reminders, the Self Contained note was note submitted by the Respondent even at the time of personal hearing also.

Observations:

I have gone through the materials on record and submissions made during hearing and my observations are summarized below.

There is no dispute that the Complainant was covered under the above-mentioned policy taken from the Respondent. The complainant has claimed an amount of Rs. 67973/- out of which and amount of Rs. 41310/- has already been paid to the complainant through NEFT. The dispute raised only for the balance claimed amount of Rs. 26,663/-. The insurer's representative during course of hearing after being satisfied with the query made by me has shown his good gesture keeping in view the policy conditions to review the claim on the basis of documents against total claim made and to settle about balance claimed amount. This forum has received a communication from the Respondent where the claim has been settled for a total of Rs. 55000/- out of which an amount of Rs. 41310/- has already been received by the complainant. The balance amount of Rs. 13690/- has also been settled and paid to the complainant with full and final satisfaction. Copy of discharge voucher and agreement for Rs. 55000/- were placed on record.

Since the claim has already been settled with the satisfaction to the complainant out of forum hence, the complaint stands dismissed without any further relief to the complainant.

Dated at Bhopal on 19th day of March, 2015

Mr. Santosh Kumar Jain
.....Complainant

V/s

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

Order No. IO/BHP/A/GI/0002/2014-2015 Case No.BHP-G-050-1415-0080

Brief Background:

Late Mudit Jain, the son of the complaint, Mr. Santosh Kumar Jain (hereinafter called Complainant) obtained a PNB-Oriental Royal Mediclaim Policy bearing no. 272900/48/2013/3629 for sum insured Rs.3,00,000/- for the period 24.06.2012 to of 23.06.2013 covering himself from The Oriental Insurance Co. Ltd., (hereinafter called Respondent).

As per the Complaint his son had claimed for Rs.71,021/- and Rs.36,143/- as mediclaim on 25.06.2010 and suddenly died on 19.07.2013 but the Respondent Company did not give the same till now. Being aggrieved with the decision of the Respondent, he approached this forum for making payment of claimed amount. The Respondent vide its SCN have contended that the complaint for two claims. In first claim no. 10802240, the patient was admitted with case of Psoriatic Arthritis. Queries were sent to the insured asking for the "certificate from treating doctor stating exact history of Psoriasis/ankylosing Spondalytis with first consultation papers. Instead, the claimant sent them the certificate for only the history of

"psoriatic arthritis", which was his current illness. In the certificate, the patient was said to be suffering from psoriatic arthritis from September 2011, whereas as per patients own statement in the claim form, the history of psoriatic arthritis is shown from January 2011 (which was changed to December 2012 in his second claim). As no replies came, the file was closed. In the other claim no. 10802225, the insured lodged a claim for the same illness. Since, no replies were came with regard to the history of past conditions relating to his present illness in the earlier claim, this claim was repudiated on account of Exclusion 4.1 and clause 5.8. regarding misrepresentation of facts.

For the sake of natural justice hearing was held at Bhopal Office. Both the parties ware heard as mediation was failed. The complainant narrated the facts as mentioned in the complaint and the insurer's representative has taken the stand as mentioned in the SCN. The complainant has stated that he could not get the reimbursement of his claim form Punjab National Bank for not returning his original documents inspite of oral request to the company.

<u>Findings and Decesion:</u>

I have gone through the materials on record and submissions made during hearing. It is found that Mr. Mudit jain was hospitalized from 23.11.12 to 24.12.12 and 20.2.13 to 21.02.13 in Silver Oak Hospital, Jabalpur for the treatment of Psoriatic Arthritis. In the claim form submitted by the deceased complainant Mr. Mudit Jain dated 25.2.13, he had mentioned the date of injury sustained or

disease/illness first detected is January, 2012 and 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. But the claims arose in the third year of the policy for Sum Insured of Rs. 300000/- The SCN submitted by the Respondent that the claims were repudiated under policy condition No. 4.1 i.e. pre existing disease. I have also gone through the letter dated 22.2.2014 i.e. after the death of the patient that this policy was first year policy while I found earlier two policies w.e.f. 24.06.2010 in continuation. The respondent submitted false information to the patient and that too after his death which was sent to his address given in year 2010 in proposal form while he had requested several time to change his address. In the said letter, exclusion No. 4.2 was also mentioned as the reason for repudiation. I have gone through the policy condition No. 4.2 and found that expenses on treatment under 4.2 (xxiii) Age related osteoarthritis and Osteoporosis are not payable upto three years from date the disease contracted or manifested during the currency of the policy. From the condition the disease contracted during currency of the policy and the claim arose in the second years of the policy hence the claim does not come under scope of above concerned policy. The respondent has also taken the plea of clause 5.8 of the policy in the SCN which says misrepresentation/misdescription of facts. I found no reference under the said clause rather clause 5.9 deals with the fraud/misrepresentation/concealment. The record shows the different dates about the detection of the disease suffered by the patient. The medical documents and difference in dates about

detection of the disease, the pre-existing disease cannot be ruled out so, clause 4.1 also attracts.

Under the aforesaid facts & circumstances, material on record, I am therefore of the view that the decision/action of the respondent is perfectly justified and is sustainable. Hence, the complainant is not entitled for the relief as prayed for. In the result, the complaint stands dismissed accordingly

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Mr. Satish Chouhan
.....Complainant

V/s

Bajaj Allianz Insurance Company Ltd.
.....Respondent

Order No.IO/BHP/A/GI/0169/2014-2015
Case No.BHP-G-005-1314-0601

<u>Brief Background:</u>

The complainant had taken a Health Ensure Policy bearing no. OG-12-2302-8409-00000639 for total sum insured Rs.2,25,000/- for the period 14.12.2011 to midnight of 13.12.2012 covering himself and his family member. As per complainant, he was hospitalized from 08.05.2012 to 14.05.2012 on the advise of Dr. Tripathi and informed to the respondent company. He preferred a claim before the respondent company but they repudiated his claim. Being aggrieved by the action of the respondent company, the complainant

approached this forum for redressal of his grievance towards payment of his treatment cost of Rs.17,686/-. The complaint was registered. The prescribed forms were issued which were submitted by the complainant duly signed by him but the respondent have not filed their SCN/reply. This reflects the gross negligence and callous attitude of the respondent company.

FINDINGS & DECISION:

I have gone through the material placed on the record and submission made. Since the Respondent has not filed their SCN/reply against the complaint made for redressal of the grievance regarding payment of claim Rs.17,686/- towards treatment cost of the complainant which reflects that the respondent company has nothing to say about not settling and making payment of the claim. The repudiation letter dated 03.07.2012 and 22.04.2013 brought on record on behalf of complainant sent by the respondent company to the complainant show about the condition D-6 and condition D-1 mentioning therein that in view of discrepancies noted in hospitalization documents and for want of any clarification on the discrepancies and lapses noted by the surveyor, the claim was repudiated but the respondent company has not brought on record the report of surveyor nor have furnished the detail particulars showing the discrepancy and lapses on during hospitalization. The prima facai the medical documents available on the record and cash memos and receipts do not show any discrepancy as alleged. So, in absence of the detail particulars for repudiating the claim and non filing the SCN, the respondent company is liable to settle and make payment of the admissible amount as per the terms and conditions of the policy document.

Under the aforesaid facts & circumstances, material on record and submissions made, I am therefore of the view that the decision/action of the respondent company for repudiating the claim is not justified and is not sustainable. Hence, the complainant is entitled for the admissible amount in accordance with the terms & conditions of the policy document against the claimed amount Rs.17,686/-

Hence, the respondent Bajaj Allianz Insurance Co. Ltd. is directed to review and settle the claim and make payment of admissible amount to the complainant in accordance with the terms & condition of the policy document within 30 days from the date of receipt of this order and acceptance letter of the complainant failing which it will attract 9% simple interest p.a. from date of this order to the date of actual payment under intimation to this forum. In the result, the complaint is allowed to the extent of admissible amount only.

Dated at Bhopal on 19th Day of March, 2015

Mr. Shyam Rao Salunke
.....Complainant

V/s

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

Order No.: IO/BHP/A/GI/0187/2014-2015 Case No.: BHP-G-049-1415-0141

Under the Redressal of Public Grievances Rules, 1998.

The complainant had taken a Private Car Package Policy bearing No. 45100031130100008385 for the period 05.03.2014 to 11.11.2014 for IDV of Rs.9,60,000/- from the respondent company. It is further said that he has purchased TOYOTA/INNOVA vehicle No. MP-15 BA-0023 consisting of Eng. No./Chassis No. 7371598/58515 through the dealer of the vehicle. His vehicle met with an accident on 07.03.2014 and intimation was given to the company on 08.032014. It is further said that a claim for repairing cost of Rs.1,23,000/- was preferred before the respondent and the respondent sent the bank draft for Rs.18,000/- only but he returned the voucher endorsing under protest and the payment was made on the basis of conditional voucher and the surveyor Mr. A. R. Mansoori prepared the wrong survey report and settled the claim wrongly and he made complaint in this regard before the company which was not considered. Being aggrieved from the partial settlement, he approached this forum for redressal of his grievance towards payment of total claimed amount.

The insurer in their SCN have stated that the amount Rs.18,000/- was paid to the complainant according to the survey report of the Mr. A. R. Mansoori, Surveyor and Loss Assessor, Indore who is a license holder of Govt. of India. The complainant has not given any other expert report against the allegation about survey report and claim amount. Hence, his complaint is not considerable.

For the sake of natural justice, hearing was held at Bhopal office. Both the parties were heard as mediation was failed. The complainant has narrated the facts as mentioned in the complaint and the insurer's representative has taken the stand as mentioned in SCN. The complainant has stated that the original claim was lodged

for Rs.1,08,000/- and claim was enhanced on the basis for supplementary bill for Rs.15,000/- for chassis repair. The insurer's representative has laid emphasis that as per market rate, the cost of parts were allowed and there was difference between estimate and bills and there is only dispute for Rs.15,000/- for chassis repair and supplementary estimate/bill was not submitted and the respondent company may consider about the repair of the chassis after verification.

Findings & Decision :

I have gone through the materials on record and submissions made by both the parties. It is admitted position that on the basis of survey report of surveyor Mr. A. R. Mansoori, the insurer's liability was turned for Rs.20,240/- showing salvage value of Rs.240/- after depreciation of metal and rubber parts. The payment of Rs.18,000/- only was made to the complainant by the respondent. The discharge voucher/satisfaction voucher shows the endorsement under protest for receiving Rs.18,000/- by the complainant. It is clear from the record that the complainant has not made any request for deputing any other surveyor on his own cost after challenging the report of the licensed surveyor Mr. A. R. Mansoori. The letter dated 02.04.2014 (xerox copy) sent by the complainant to the respondent company shows that he had submitted the bills for Rs.70.830/- for payment. The copy of letter dated 09.04.2014 sent to the respondent company shows that the original copy of chassis repair estimate/bill was sent which contains the endorsement received on 11.04.2014. The estimate shows the repair cost Rs.15,000/- for chassis repair which is said to have been not submitted by the complainant to the respondent. I do not find any infirmity or discrepancy in the survey report submitted by the license surveyor Mr. A. R. Mansoori. There is

no other survey report on behalf of complaint to rebut the opinion of the above surveyor. Thus, there is only dispute of Rs.15,000/- towards repair cost of Chassis and the insurer's representative has admitted that the said claim of chassis repair may be considered for Rs.10,000/- after verification.

Hence, under these circumstances, the complaint is entitled to get his claim settled towards chassis repair cost of Rs.15,000/- after taking opinion of the concerned said surveyor.

Hence, the respondent The New India Assurance Co. Ltd. is directed to settle and pay the cost of chassis repair on the basis of supplementary estimate/bill submitted by the complainant/on submission of the same if not available in the record of the company as per terms and conditions of the policy document to the complainant after taking opinion of surveyor within 15 days from the date of receipt of acceptance letter from the complainant failing which it will attract simple interest of 9% p.a. from the date of this order till the date of actual payment and submit compliance report to this office. In the result, the complaint is partly allowed.

Dated at Bhopal 26th March, 2015

Mrs. Sunder Bai

……Complainant

V/s

Oriental Insurance Co. Ltd.
……Respondent

Order No. IO/BHP/A/GI/0159/2014-2015 Case No. BHP-G-050-1314-0686

Award

Brief Background:

The complainant Mrs. Sunder Bai was covered under Individual Mediclaim policy bearing no.151100/48/2011/7321 for sum insured Rs. 50,000/- for the period 29.09.2010 to 28.09.2011 from the respondent company. It is further said that she lodged her claim before TPA, M/s MD India Healthcare Services, Indore on 13.06.2011by submitting all the papers towards treatment cost of age related cataract problem for Rs.14,690/- which was not by the respondent company. She also representation before the respondent company but no reply was received by her. Being aggrieved from the decision of the respondent company, the complainant approached this forum for redressal of her grievance towards payment of Rs.14,690/-.

The complaint was registered. The prescribed forms were submitted by the compliant duly signed by her but the respondent

have not submitted the Self Contained Note showing the reason non availability of the record which reflects the gross negligence of the respondent company and has submitted the repudiation letter dated 24.01.2013 of the company along with draft repudiation statement for approval sent by TPA to the respondent company. The respondent company have taken the plea in their repudiation letter that the claim has been repudiated under clause 4.3 of the policy terms and conditions. The policy terms and conditions has also been filed.

For the sake of natural justice, hearing was held at Bhopal office. The complainant was absent and sent a letter showing her inability to attend the hearing and has mentioned that she has submitted all the required document related to query of the insurer's TPA and also to this office. The respondent's representative has taken the stand as made in the repudiation letter and laid emphasis that the claim was made in the second year of the policy and the waiting period of two years was not completed and there was one month break in group mediclaim policy and the first individual mediclaim policy issued by the respondent company so, there was no continuity.

FINDINGS AND DECISION: I have carefully gone through the material on the record and submissions made by insurer' representative. There is no dispute about cataract surgery of the complainant in the Curewell Hospital, Indore. The above concerned policy document contains the previous policy no. 151100/48/2010/4747 which was the first Individual policy of the complainant which was issued for the period 27.10.2009 to 26.10.2010. The above first policy was taken after break of about one month of group mediclaim policy after lapse of the grace period

also. The clause 4.3 of the individual mediclaim policy terms and conditions clearly provides that the expenses on treatment of cataract are not payable if contracted during the currency of the policy and the waiting period for cataract is two years. Since, the claim was made during the second year of above mediclaim policy as there was no continuity of the group mediclaim policy and the above current policy under which the claim was made and waiting period for two years was not completed from the date of issuance of first individual mediclaim policy, hence in these circumstances, the respondent is not liable to pay the claimed amount under the clause 4.3 of the above policy document. Hence, the complainant is not entitled for the relief as prayed. In the result, the complaint stands dismissed.

Dated at Bhopal on 18th March, 2015

Mr. Suresh Handiekar……Complainant

V/s

United India Insurance Co. Ltd. ……Respondent

Order No. IO/BHP/A/GI/0140/2014-2015
Case No. GI/UII/1208/31

Brief Background:

The complainant was covered under a Group Mediclaim Policy bearing no. 190300/48/11/41/00002477 for sum insured Rs. 5,

00,000/- for the period 29/10/2011 to 28/10/2012 with his wife Smt. Asha. He preferred a mediclaim on 13.03.2012 for Rs.31,748/- and on 02.04.2012 for Rs.30,325/- towards treatment cost of his wife before the MedSave (TPA) but his claim was rejected on the ground of pre-existing disease. Being aggrieved by the action of the respondent company, the complainant approached this forum for redressal of his grievance towards payment of Rs.62,073/- (31,748/- + 30,325/-) with interest. The insurer in their SCN have stated that the insured opted for Bank Insurer's policy being Account Holder of Canara Bank, Palasia Branch, Indore for sum assured of Rs.5 lacs. The claims were preferred by the insured for the treatment of Ca Breast Cancer for Smt. Asha which were rejected by the authorized TPA. It is further stated that the main issue involved was admissibility of claim preferred by the insured for the existing illness i.e CA Breast, detected in the year 1995 before taking the policy and the first policy was issued by United India Insurance Co. from period 29.10.2009 to 28.10.2010 and prior to this the insured had previous policy no. 151301/48/2010/00626 for the period from 20.05.2009 to 19.05.2010 for a meager sum assured Rs.1.5 lacs. As against Rs.5 lacs the policy no. 190300/48/09/8700001559 should have been taken after the expiry of the policy no. 151301/48/2010/00626 i.e. with effect from 20.05.2010 to 19.05.2011 for Rs. 1.5 lacs only. As per exclusion clause 4.1 of the policy " All disease/ injuries which are pre-existing when the cover incepts for the first time. For the purpose of applying this condition, the date of inception of the initial Mediclaim Policy taken from any of the Indian Insurance companies shall be taken, provided the renewals have been continuous and without any break. However, this exclusion will be deleted after 3 consecutive claim

free policy years." No claim is admissible under exclusion no. 4.1 as stated above. Since, the policy was issued by this company in the year 2009-10 was fresh policy and the cliam was preferred by the insured within 3 years so, the claim was not admissible under exclusion clause 4.1. So, the claim was repudiated by the authorized TPA and also by the respondent company.

For the sake of natural justice, hearing was held at Bhopal Office. The complainant was absent but his representative Mr. H. A. Ghanekar, his Samadhi was present. The written submission has already been filed. The insurer's representative was also present. The complainant's representative as well as the insurer's representative were heard as mediation could not be done due to absence of complainant. The complainant's representative has narrated the facts as mentioned in the complaint and laid emphasis that there was continuity in the policy documents taken by the complainant from the respondent company and the Oriental Insurance Company and sum insured was enhanced for Rs.5 lacs in the policy bearing no. 190300/48/09/8700001559 for the period 29.10.2009 to 28.10.2010 which was renewed. The insurer's representative has taken the stand as mentioned in the SCN and laid emphasis that claim was lodged during the third year policy of the respondent company which was not admissible and not payable under clause 4.1 as, it was first policy and there was waiting period of three years claim free and before expiry of the policy taken from Oriental Insurance Company, the aforesaid policy for sum assured Rs.5 lacs was taken from the respondent company so, there was no continuity.

FINDINGS & DECISION:

I have gone through the material placed on the record and submissions made by both the parties. From close perusal of the record, it is apparent that the existing illness i.e. Ca Breast was detected in the year 1995 before taking the policy. The policy bearing no. 190300/48/11/41/00002477 under which the claim arose is of third year policy for Sum Insured of Rs. 5 lacs. The complainant himself has mentioned in the complaint about the existence of illness of Ca Breast of Mrs. Asha Handiekar, since 1995. The record shows that earlier policies were from Oriental Insurance Co. Ltd. but the sum insured was only for Rs. 1,50,000/-. Admittedly, the complainant had a policy of Oriental Insurance Company since 20.05.2004 to 19.05.2007 for sum assured Rs. 1,00,000/- which was renewed till 20.05.2009 to 19.05.2010 and the sum insured was also enhanced from one lac to 1.5 lacs during the policy period 20.05.2007 to 19.05.2008 which was continued to 19.05.2010 with the Orinental Insurance Company and a policy was taken from the respondent company bearing no. 190300/48/09/8700001559 from the period 29.10.2009 to 28.10.2010 enhancing the sum assured Rs.5 lacs which was taken during the existence of the earlier policy for the period 20.05.2009 to 19.05.2010 for Rs. 1.5 lacs from the Oriental Insurance Company. So, the policy bearing no. 190300/48/09/8700001559 for the period 29.10.2009 to 28.10.2010 for sum assured Rs.5 lacs can be treated as first fresh policy which was renewed from the period 29.10.2011 to 28.10.2012 under which the claim was made. However, the exclusion will be deleted after 3 consecutive continuous claim free policy years, provided, there was no hospitalization for the pre-existing ailment during these 3 years of insurance. Since the claim arose within 3 years from the inception of the fresh policy, the respondent is not

liable to pay the claim as per the clause no. 4.1 of policy. I find substance in the contention of insurer's representative. In these circumstances, the respondent is not liable to make payment as prayed for.

Under the aforesaid facts & circumstances, material on record and submissions made and policy terms & conditions, I am, therefore of the considered view that the action/ decision of the respondent company to reject the claim is perfectly justified and is sustainable. Hence, the complainant is not entitled for the relief as prayed for. In the result, the complaint is dismissed being devoid of any merit.

Dated at Bhopal on 9th day of March, 2015

Mr. T. C. Gangwal
.....Complainant

V/s

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

Order No. IO/BHP/A/GI/0171/2014-2015 Case No.GI/SHI/1205/12

<u>Brief Background:</u>

The complainant had taken a Senior Citizens Red Carpet Insurance Policy bearing no. P/201115/01/2012/001948 for sum insured Rs.1,00,000/- for the period 30.07.2011 to midnight of 29.07.2012 covering himself from the respondent company. It is further said that the Complainant was hospitalized in SAL Hospital, Ahmedabad for the treatment of CAD and preferred a claim for Rs.1,75,205/- against which the respondent settled the claim only for Rs.45,500/- as per policy terms and conditions. However, the complainant asked for reimbursement of Rs.75,000/- + Rs.9,500/- totaling Rs.85,500/-

and claimed for balance of Rs.39,000/- which was repudiated by the respondent company. Being aggrieved with the decision of the respondent, he approached this forum for redressal of his grievance and making payment towards his hospitalization expenses Rs.39,000/-.

The Respondent vide its SCN have contended that the respondent informed that as per policy condition 2% of sum insured for ICU charges/day, 1% of sum insured for room charges/day, 25% of sum insured for surgeon and doctor charges and 50% of sum insured is payable for investigation, medicines and other non medical items. Applying the above percentage, total deductions was for Rs.84,205/- and from net amount of Rs.91,000/-, 50% co-pay was deducted for pre-existing diseases as per policy terms. Under exclusion No. 5 of insurance policy, 50% of each and every claim arising out of all pre-existing diseases as defined and 30% in case of all other claims which are to be borne by the insured.

<u>FINDINGS & DECESION:</u> I have gone through the material on record and submissions made by the insurer's representative. The complainant has taken Senior Citizens Red Carpet Insurance Policy where some restrictions under room/nursing charges as 1% of S.I., ICU is 2% of S.I. and surgeon, anesthetist fees is limited to 25% of S.I. Inspite of this there is an exclusion clause of 50% of each and every claim arising out of all pre-existing diseases and 30% in case of all other claims which are to be borne by the insured. From the discharge summary of SAL Hospital Ahmedabad under clinical summary the complainant is a k/c/o hypertensive, diabetic, status post PTCA in 1994 but in proposal form nothing has been mention by the complainant about said medical history. The complainant

admitted for Coronary Artery Bypass Surgery which was done on 7.11.11. The total claim worked out as per policy condition is Rs. 91000/- where clause of 50% co payment was applied and Rs. 45500/- paid to the complainant seems to be justified.

Under the aforesaid facts & circumstances, material on record, I am therefore of the view that the decision/action of the respondent is perfectly justified and is sustainable. Hence, the complainant is not entitled for the relief as prayed for. In the result, the complaint stands dismissed accordingly.

Ms. Varsha Jotwani
.....Complainant

V/s

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

Order No. IO/BHP/A/GI/0191/2014-2015 Case No.BHP-G-050-1415-0111

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<u>Brief Background:</u>

The complainant had taken a Happy Family Floater policy bearing no. 152104/48/2013/149 for sum insured Rs. 5,00,000/- for the period 23/04/2012 to midnight of 22/04/2013 covering herself from Respondent. It is further said that she undergone for the treatment of irregular mensturation to the Anantshree Hospital and then she approached to Jawahar Lal Cancer Hospital and Research Center, Bhopal for further investigations such as ST Scan, FNAC etc. which were performed but diagnosis was not clear. They referred her to

the HCG Hospital, Bangalore where Laparoscopy Surgery was done and her right ovary was removed and according to biopsy report, it was a simple tumor. She preferred a claim for reimbursement of treatment cost with all medical papers to the Respondent Company which was repudiated as it is pre-existing one. he approached this forum redressal of her grievance towards treatment cost Rs.1,83,177/- which was clarified vide her letter dated 26.03.2015.

The Respondent have contended in the SCN that the competent authority has treated the claim as not payable vide letter dated 28.10.2013 on the ground that the illness was pre-existing to policy and as per policy terms and conditions, all pre-existing diseases are excluded for four years for the scope of policy under clause No. 4.1. The respondent company had not filed the copy of the terms and conditions of the policy document as well as copy of proposal form in support of his defence.

For the sake of natural justice hearing was held at Bhopal Office. Both the parties were heard as mediation was failed. The complainant has narrated the facts as mentioned in the complaint and the insurer's representative has taken the stand as mentioned in reply/ SCN and laid emphasis that the complainant had history of pre-existing disease of Ca Right Ovary since February, 2012 .

<u>Findings & Decision:</u>

I have gone through the materials on record and submissions made by both the parties. The important document placed on record is the certificate of Jawahar Lal Nehru Cancer Hospital and Research Centre, Bhopal wherein it has been mentioned that in the clinical history of hospital that the patient came to the Institute with the

complaint of irregular menstruation for two months in November-December, 2012 and Oligomenorrhea in February 2013 (but not in the Year February 2012) and abdominal distension since seven days. She was investigated further for the above complaints. Further I have gone through the discharge summary of treating hospital HCG, Bangalore which shows that the patient was not a known case of hypertension/diabetes/asthma and the patient underwent laparoscopic right salphingo oophpretomy on 08.04.2013 and the operative findings were Tumor arising from right ovary with adhesions to sigmoid colon and simple cyst + in left ovary and uterus mildly bulky with fibroids and discharge on 11.04.2013 and in final diagnosis the carcinoma ovary has been shown as ? (question mark) meaning thereby that there was no clear cut carcinoma right ovary was diagnosed. The patient was undergone for the treatment of irregular menstruation in Anant Shree Multispecialty Hospital, Bhopal where various investigations were carried out and she was further investigated in JNHRC, Bhopal for CT Scan, FNAC and finally she has underwent for Laparoscopy Surgery in HCG Hospital, Bangalore where her right ovary was removed and according to biopsy report as asserted by complainant that it was simple tumor. The respondent have not brought on record any medical document, treatment papers/investigation report to show the said pre-existing disease before inception of the policy except the clinical history of the complainant of JNCHRC, Bhopal showing Oligomenorrhea in February, 2012 which was wrongly mentioned as apparent from the certificate issued by the same doctor about correction of the year in the clinical history of JNCHRC, Bhopal. I found that the current illness is not a complication of Ca. Rt. Ovary which has been made as ? in final diagnosis and has been shown

since February 2012 as per JNCHRC, Bhopal while the patient had undergone treatment from 13.10.2012 and not from February, 2012. The respondent have not brought on record any OPD card showing the visit of the complainant at JNCHRC, Bhopal in month of February, 2012. The certificate issued by the doctor of the said reputed hospital regarding correction of the year as mentioned in the clinical history cannot be lost sight of in absence of any plea of fabrication of the said certificate and the respondent company should have considered the same. Thus, it is established that the respondent have failed to prove said pre-existing disease of the complainant before the inception of the policy.

Under the aforesaid facts & circumstances, material on record and submissions made, I am therefore of the view that the decision/action of the respondent company for repudiating the claim is not justified and is not sustainable. Hence, the complainant is entitled for the admissible amount in accordance with the terms & conditions of the policy document.

Hence, the respondent The Oriental Insurance Co. Ltd. is directed to settle the claim and make payment of admissible amount to the complainant in accordance with the

terms & condition of the policy document within 15 days from the date of receipt of acceptance letter of the complainant failing which it will attract 9% simple interest p.a. from date of this order to the date of payment and submit compliance report to this forum. In the result, the complaint is allowed to the extent of admissible amount only.

Mr. Vijay Kumar Halen …….
Complainant

V/s

National Insurance Co. Ltd……
Respondent

Order No.IO/BHP/A/GI/0161/2014-2015 Case No.: BHP-G-048-1314-0708

The complainant Mr. Vijay Kumar Halen had taken a individual mediclaim policy bearing no. 320102/48/12/8500002282 covering himself and his wife Mrs. Bhagwanti Bai for Sum Insured Rs.2,25,000/- each and cumulative bonus Rs. 39750/- each for period 27.11.2012 to 26.11.2013 which was issued by the respondent company subject to terms & conditions. The complainant was admitted in Shalby Hospitals, Ahmedabad with diagnosis of Osteoarthritis of Rt/Lt/Both knee and underwent total knee replacement for both knee. He lodged the claim for Rs. 1,25,998/- plus bonus with the respondent which was settled by the TPA of the Respondent restricting the sum insured of Rs. 100000/- being sum insured opted under the policy No. 32010248088500001807 as per individual mediclaim policy clause No. 4.3 & 5.12 and not on the face of the policy. The claim was settled for Rs. 70,498/- + Rs.28,504/- = total Rs.99,002/- as partial settlement. Being aggrieved of the action of the respondent, complainant approached this forum for the

relief of making payment of Rs. 1,25,998/- plus bonus towards treatment cost under the policy document.

The insurer in their SCN/reply have contended that the complainant was admitted in Shalby Hospitals, Ahmedabad with diagnosis of Osteoarthritis of Rt/Lt/Both knee and underwent replacement of both the knee. The respondent have taken the plea as per clause 4.3 and 5.12 and note on the face of the policy, the claim towards treatment for joint replacement due to degenerative conditions, age related osteoarthritis and osteoporosis are not payable for first four years of operation of the policy.

The complainant was absent but has sent the written statement mentioning about expense incurred and amount received towards partial settlement and has asserted that the waiting period already expired in 2007 of policy amount and he is eligible to received balance amount. The insurer's representative was present who was heard and who has taken the stand as mentioned in reply/ SCN and laid emphasis that claim has been paid as per sum insured of previous policy of Rs.1,00,000/- and not for enhanced sum insured and cumulative bonus is only considered when the claim is paid under current policy and not as per previous policy.

<u>Findings and Decesion:</u>

I have gone through the material placed on the record and submission made by insurer's representative and relevant provisions of policy terms & conditions. Clause 4.3 of the policy terms & conditions provides about that during the first one year of the operation of the policy, the expenses on treatment of Benign ENT disorder & surgeries like Tonsilectomy/Adenoldectomy/Mastoidectomy/Hernia, Hydrocele,

Congenital internal diseases, fissures/fistula in anus, piles sinusitis and related disorders, polycystic ovarian diseases, Non infective arthritis, undiscended testis, surgery of Genito urinary system excluding malignancy, pilonidal sinus, gout & reheumatism, hypertension, Diabetes, calculus diseases, surgery for prolapsed intervertebral disc unless arising from accident, surgery of varicose veins are not payable for first two years of operation of policy. Treatment for joint replacement due to degenerative conditions, age related osteoarthritis and osteoporosis are ot payable for first four years of operation of the policy. Further if the disease are pre-existing at the time of proposal, will be covered only after four continuous claim free policy years. I have also gone through the condition No. 5.12 of the policy which provides that Sum Insured under this policy can be enhanced only at the time of renewal upto next higher slab, if sum insured under expiring policy is upto Rs. 1,00000/- and next two higher slabs. If S.I. under expiring policy is above Rs. 1,00,000/- subject to satisfactory medical check up with regard to health of the insured person and acceptance of additional premium for the enhanced sum insured. However, continuing or recurrent nature of diseases/complaints which the insured has even suffered will be excluded from the scope of cover so far as enhancement of sum insured is considered. As per policy condition, the benefit shall accrue for pre existing disease or waiting period once the policy with enhanced SI completes the waiting period noted in the policy for these diseases. The complainant has mentioned in his complaint that he had taken policy on 27.11.2003 and regularly enhance the cover but has not filed any policy from year 2003 to 2007-08 and have brought on record the copy of the policy from year 2009-10, 2010-11, 2011-12, 2012-13. However, the respondent

have admitted about issuance of policy fro 27.11.2008 to 26.11.2009 which was continuously renewed upto 26.11.2013 enhancing the sum insured. General Insurance policies are annual contract so, the conditions applicable on the renewal date shall apply and not the conditions of the policy if taken on 27.11.2003 as the terms and conditions of the mediclaim policy has already been revised w.e.f. 01.04.2007 with certain changes and modification and the above waiting period of four years have not been waived in the concerned policy document. So, I do not find any force in the assertion of the complainant as made in the written statement of the complainant towards wrongfully deductions by the respondent in settling the claim and making payment of Rs.99,002/- only as per sum insured of the previous policy taken for period 27.11.2008 to 26.11.2009. Under the aforesaid facts & circumstances, material on record, I am therefore of the view that the decision/action of the respondent for settlement of the claim and payment of Rs.99,002/- only and not allowing the balance amount under the policy document is perfectly justified and is sustainable. Hence, the complainant is not entitled for the relief as prayed for. In the result, the complaint stands dismissed accordingly.

**Mr. Anand Maheshwari…….
Complainant**

V/s

**The New India Assurance Co.Ltd…….
Respondent**

Order No.IO/BHP/A/GI/0074/2014-2015 Case No.: GI/NIA/1105/12

The complainant Mr. Anand Maheshwari had taken a mediclaim Policy bearing No. 451302/34/08/87/00000363 for the period of 01.11.2008 to 31.10.2009 from the respondent company. It his further said that the complainant lodged the mediclaim for Rs.26,618/- on 25.09.2009 towards treatment cost of his son under the aforesaid policy but neither the claim was settled nor any reply was received even after sending the reminders. Being aggrieved from the action of the respondent, the complainant approached this forum for relief of making payment of Rs. 29,618/- towards treatment cost of his son.

The insurer in their SCN have stated that the complainant had filed a case no. 129/2012 before District Consumer Dispute Redressal Forum, Dhar for redressal of same subject matter which has been disposed off and payment of Rs. 39,120/- has also been made to complainant through cheque no. 51108 dated 30.04.2014 and prayed to dismiss the case.

<u>Findings & Decision</u>

Since the complainant had also approached CDRF, Dhar on the same subject matter and same has been disposed off on 04.12.2013 and the payment as per award of CDRF, Dhar has also been made to the complainant. Hence, as per RPG Rules, 1998 section 13(3)(c) such a complaint cannot be further processed by this forum and is liable for dismissal. In the result, the complaint stands dismissed.

Mr.Anand Mohan Sharma.....Complainant

V/s
Oriental Insurance Co. Ltd.
.....Respondent

Order No. IO/BHP/A/GI/0084/2014-2015
Case No : GI/OIO/1207/28

Brief Background:
The complainant's wife Mrs. Shashi Sharma was covered under a individual Mediclaim Policy bearing no. 151300/48/2012/7235 for the period 17.09.2011 to 16.09.2012 for sum assured Rs.2,00,000/- which was issued by the respondent. He had preferred a mediclaim for Rs. 86,143/- towards her treatment cost to the TPA of the respondent company after treatment from Rajshree Hospital, Indore from 28.02.2012 to 04.03.2012 but the respondent company released only 70,000/- and deducted Rs.16,143/-.
The insurer in their reply/SCN have stated that they have paid one cashless claim of Rs.70,000/- for disease Abdominal Hernia under aforesaid policy. Later on, difference amount (deduction made for non payable charges in cashless claim) Rs.16,143/- has been claimed by insured. The amount of Rs.430/- found admissible and paid and claim of difference amount was rejected under clause 3.12 of policy terms & conditions for non payable charges in cashless claim as per policy document.

Findings & Decision:

From the record, it transpires that after lodging the claim, the respondent company settled the one cashless claim of Rs.70,000/- and paid Rs.430/- which was found admissible and deducted Rs.15,713/- as non payable charges as per clause 3.12 of policy document.
It is found from the hospital bill of M/s Rajshree Hospital & Research Centre Pvt.Ltd., Indore that an amount of Rs.86,143/- were IPD final bill and Rs.70,000/- were paid by the Insurance Company to the concerned hospital but an amount of Rs. 16,143/- which was deposited by the complainant against receipt no. 1112014213 dated 28.02.2012 for Rs.5,000/- and receipt no. 1112014479 dated 05.03.2012 for Rs. 11143/- placed in the file were not taken care of and the complaint arose only for Rs.16,143/- .

Further on representation by the complainant, the TPA allowed an amount of Rs.430/- as exceeding authorization in main file and balance Rs.15,713/- is still pending for the payment to the complainant. I observed that an amount of Rs.100/- against dietician charges, Rs.938/- against service charges, Rs.1075/- against non medical item charges and Rs. 100/- against registration charges were deducted which are found genuine and reasonable as per terms & conditions of the policy but an amount of Rs. 13,500/- deducted against other charges as per clause 3.12 (reasonable and custyomary) is not fair and justified as not based any cogent reasons and no package papers have been filed for cataract operation. In these circumstances the respondent is liable to pay Rs.13,500/- only to the complainant.
Under the aforesaid facts & circumstances, material on record and submissions made, I am therefore of the view that the action of the respondent company for partial settlement of the claim is not justified and is not sustainable. Hence, the complainant is entitled for the balance admissible amount Rs.13,500/- in accordance with the terms & conditions of the policy document.

Hence, the respondent Oriental Insurance Co.Ltd. is directed to pay balance admissible amount Rs,13,500/- (Rs. Thirteen Thousand Five hundred Only) in accordance with the terms & condition of the policy document to the complainant within 15 days from the date of receipt of acceptance letter of the complainant failing which it will attract 9% simple interest p.a. from date of this order to the date of actual payment. In the result, the complaint is allowed to the extent of above balanced admissible amount only.

Mr. Anil Jaiswal .....Complainant

V/s

Oriental Insurance Company Ltd.
.....Respondent

Order No. IO/BHP/A/GI/0118/2014-2015
Case No.GI/OIC/110/60

Brief Background:

The complainant had taken an individual mediclaim policy bearing no. 151200/48/2011/654 for the period from 20.04.2010 to 19.04.2011for sum assured Rs. 2,50,000/- from the respondent. It is further said that he was admitted in Choithram Hospital, Indore in the mid night of 06.04.2011/ 07.04.2011 due to severe abdominal pain which was diagnosed as Acute Cholecystectomy and gallbladder was removed on 08.04.2011 and after discharge, he made claim for total bill of Rs. 53,806/- (including service tax Rs.5,024/-) but the TPA M.D.India health care services allowed Rs. 28,982/- only against the said claim and deducted Rs.6,000/- against surgery account, Rs.1125/- against OT charges account, Rs. 1,575/- against anesthesia charges, Rs.4,750/- in room rent charges account, Rs.500/- in doctor's charges account and Rs.3,176/- full service charges besides recovery of Rs.2706/- as 10% co-pay service tax and have also deducted the charges of IPD, certificate charges and registration fees which was not under dispute. He sent the letter for reimbursement of balance amount and in response of his

representation, the TPA has allowed Rs.9,306/- only and thereafter, he sent letter on dated 28.06.2011 for reimbursement of Rs.18,168/- to chief Regional Manager of the respondent company but his request was not considered. Being aggrieved by the action of TPA/respondent Company the complainant approached this forum for the relief of making payment of his claim of Rs.12804 /-.

The respondent in their SCN have contended that complainant had taken an individual mediclaim policy bearing no. 151200/48/2009/165 for the period from 22.04.2008 to 21.04.2009 for sum assured Rs.75,000/- from the respondent and the above policy was renewed for sum assured Rs.2,50,000/- from 20.04.2009 to 19.04.2010 and further renewed vide policy no. 151200/48/2011/654 from the period 20.04.2010 to 19.04.2011 and have also contended that though the sum assured was enhanced to Rs.2,50,000/- from Rs.75,000/- by changing from Individual Mediclaim policy to Happy Family Floater policy but the benefit of the enhanced limit of sum assured shall be available as per terms & conditions of this policy enumerated under clause 4.1,4.2 and 4.3 and will apply a fresh for enhanced portion of the S.I. for the purpose of these section and Rs. 4,878/- has been deducted under provision of 10% of co-payment as the 10% of claim amount was to be borne by the insured as per terms & conditions of Happy Family Floater policy silver plan and an amount of Rs. 4,750/- was deducted for room and nursing charges as TPA has allowed total Rs. 3,750/- for five days hospitalization as per the entitlement of the previous individual policy @ 1% of S.I. Rs.75,000/- and service charges Rs. 3,176/- was disallowed as there was no provisions of payment of service charges under the policy and registration charges Rs.400/- was disallowed by the TPA there being no provision for payment of

same and Rs.5,364/- was deducted observing the total amount paid by insured to the hospital in excess of overall amount payable to the hospital under all heads of charges, so the deduction made by TPA was found in order after review and which was communicated to the complainant also.

FINDINGS & DECISION:

I have gone through the material placed on the record and submissions made. As per record it is apparent that since the S.I. of Rs. 2,50,000/- under family floater policy was enhanced after renewal of previous indivual mediclaimpolicy for S.I. Rs. 75,000/- . So, the S.I. will be applicable only for Rs.75,000/- for pre-existing disease. From the record, it is also clear that the amount deducted by the TPA of Rs.4,878/- as 10% co-payment, Rs.4,750/- as bed charges and Rs.3,176/- as service charges is proper and reasonable in accordance with the terms & conditions of the policy documents. I find no discrepancy about the deductions made under the policy terms & conditions. In these circumstances, the complainant has claimed reimbursement of Rs. 18,168/- in the letter dated 28.06.2011 sent to the CRM of respondent company while he has claimed Rs.12,804/- as mentioned in the P-II form which shows variance. The complainant has already received Rs. 28,982/- and Rs.9,306/- against claim made. In these circumstances, the respondent company is not liable to make payment of the balance amount as claimed.

Under the aforesaid facts & circumstances, material on record and submissions made, I am therefore of the view that the action/decision of the respondent company for not considering the payment of balance amount as claimed is perfectly justified and is sustainable under the policy document. Hence, the complainant is

not entitled for the relief as prayed. In the result, the complaint stands dismissed.

Mr.Anil Kumar Jain .....Complainant

V/s

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

Order No. IO/BHP/A/GI/0095/2014-2015
Case No : GI/UII/1205/05

Award

Brief Background:

The complainant was covered under a mediclaim policy bearing no. 190300/48/11/41/00000553 for the period 13.05.2011 to 12.05.2012 for sum assured Rs.1,50,000/- from the respondent. He had preferred a mediclaim for Rs. 22,408/- towards his treatment cost to the TPA of the respondent company on 12.07.2011 after treatment of cataract extraction in Rajas Netra & Retina Reserch Centre,Indore from 06.07.2011 to 07.07.2011 but his claim was not settled by respondent company nor any written information was given to him regarding settlement of his claim. He also made a request before the Zonal Manager, Bhopal of the respondent company but his grievance was not redressed. Being aggrieved by the action of respondent company the complainant approached this forum for the relief of making payment of his claim of Rs.22,408/- towards his treatment cost with interest.

The insurer in their SCN dated 30.10.2012 have stated that the insured held previous two policies with their branch. It is further

said that the policy no. 191302/48/10/41/00000240 expired on 04.05.2011 and it was renewed vide policy no. 191300/48/11/41/00000553 for the period from 13.05.2011 to 12.05.2012. It is evident that the policy renewed with them was fresh after the lapse of 7 days period. The insured preferred the claim for Cataract Extraction under policy no. 191300/48/11/41/00000553, just within two months from the date of commencement of fresh policy. Since the same was not admissible in the first year policy and as per condition no.4.3 waiting period of one year for cataract extraction is a condition precedent and therefore the subject claim does not come under the purview of policy condition. During the first year of the operation of the policy with any of the public sector insurance companies, the expenses of treatment of disease such as cataract, benign etc. are not payable and if these diseases other than congenital internal disease are pre-existing at the time of proposal, they will not be covered even during subsequent period of renewal. So, the claim was repudiated by their TPA M/s Medsave Health Care Ltd. as under group mediclaim tailor made policy of Indore Bank Arogya scheme all the claims pertaining to group policies are to be built with by their nominated TPA and they have taken a proper decision to repudiated the liability as being a fresh policy and insured was also informed about the repudiation of claim.

<u>Findings & Decision:</u>

I have gone through the material placed on the record and submission made. From perusal of the record it is apparent that insured was covered under floater mediclaim w.e.f. 05.05.2009 to 04.05.2010 thereafter insured was covered under group mediclaim tailor made w.e.f. 05.05.2010 to 04.05.2011 and thereafter the

insured was covered under the policy bearing no.190300/48/11/41/00000553 w.e.f. 13.05.2011 to mid night of 12.05.2012. From the record, it also transpires that insured was admitted Rajas Netra & Retina Reserch Centre,Indore on 06.07.2011 and discharged on 07.07.2011 after cataract operation of his eye which relates to the policy period 13.05.2011 to 12.05.2012. From the policy documents brought on record by the complainant, it is also clear that the tailor made group policy no. 191302/48/10/41/00000240 which was effective from 05.05.2010 to 04.05.2011 was not renewed w.e.f. 05.05.2011 rather the same was renewed after a break of 7 days so the above concerned policy can be considered as fresh policy and the claim was made just within two months from date of commencement of fresh policy and as per exclusion clause no. 4.3 of the policy as mentioned in the SCN the waiting period of one year for cataract extraction is a condition precedent, so the same was not admissible in the first year of the policy. Since, due to break of renewal of the policy bearing no. 191302/48/10/41/00000240 from 05.05.2011 for further one year, the policy bearing no. 191300/48/11/41/00000553 cannot be treated as continued for deciding the claim. In these circumstances, the respondent is not liable to make payment of the claim as made for cataract operation.

Under the aforesaid facts & circumstances, material on record and submission made, I am therefore of the view that the decision of the TPA/ respondent company for repudiating the claim of the complainant is perfectly justified and is sustainable. Hence, the complainant is not entitled for the relief as prayed for. In the result, the complaint stands dismissed.

Mrs. Anooja Taose

.....Complainant

V/s

The National Insurance Company Ltd.....Respondent

Order No.IO/BHP/A/GI/0174/2014-2015
Case No.BHP-G-048-1314-0670

Award

Brief Background:

The complainant's husband Mr. Rajneesh Taose had taken a Hospitalization Benefit Policy bearing no. 320102/48/11/8500001119 for total sum insured Rs.4,00,000/- for the period 13.08.2011 to midnight of 12.08.2012 covering himself and his family member. As per complainant, she was admitted to Suyash Hospital, Indore for treatment of stroke on 09.01.2012 and preferred a claim of Rs.84,206/- towards her treatment cost before the TPA of the respondent company which was repudiated due to pre-existing disease excluded under policy condition No. 4.1. Being aggrieved by the action of the respondent company, the complainant approached this forum for redressal of her grievance towards payment of her treatment cost of Rs.4,00,000/- as mentioned in P-II form.

The insurer in their SCN have admitted about the issuance of the said policy under which the complainant was also insured and taken the plea that the complainant was admitted to Suyash Hospital Pvt. Ltd., Indore with C/o focal seizure in Rt. Upper limb, diplopia,

vertigo and vomiting being pre-existing disease excluded under scope of policy condition 4.1 which reads as: All diseases/injuries which are pre-existing when the cover incepts for the first time. However, those disease will be covered after four continuous claim free policy years. For the purpose of applying this condition, the period of cover under Mediclaim policy taken from National Insurance Company only will be considered. This exclusion will also apply to any complications arising from pre-existing ailment/disease/injuries. Such complications will be considered as a part of the pre-existing health condition and have also taken the plea if continuity of the cover is not maintain with National Insurance Co. Ltd., subsequent cover will be treated as fresh for application clauses 4.1, 4.2 and 4.3.

FINDINGS & DECISION:

I have gone through the material placed on the record and submission made. From the record it appears that the TPA of the company has clearly admitted that patient was admitted as a case of Stroke Rt-PCA for which she had undergone treatment and as per discharge summary the stroke Rt-PCA (NHI) was diagnosed on 09.01.2012. The respondent has not brought on record any medical document to show that the patient had old CVT even the MRI Venogram, MRI Brain with Angeography do not show about any symptom of old CVT which was done on 09.01.2012 and 10.01.2012 during course of hospitalization. The respondent has not filed any document to show the patient was suffering from HTN. Dr. K. G. Agrawal, who is simply a MBBS Doctor has given the opinion that the above disease of RT-PCA stroke was pre-existing without any previous medical record. He is neither neuro physician nor neurosurgeon so, his not competent to give opinion as he is not a

brain specialist. The record also shows that the mediclaim policy was continued since 2006 in Bajaj Allianz before taking the above concerned policy from the respondent. Though the above policy does not contain the previous policy no. of said policy but this fact can not be lost sight of . No doubt the NA has been mentioned regarding suffering from any diseases/illness in the proposal form submitted by the complainant's husband before respondent company for taking said policy. Since, from the record it is established that the complainant had no pre-existing disease from the time of inception of the said policy and the disease was diagnosed during course of hospitalization can not be considered as pre-existing without filing any previous medical document to prove the said disease as pre-existing. In the circumstances the respondent company is liable to settle the claim for admissible amount against the claimed amount Rs.84,206/- as per terms and conditions of the policy document.

Under the aforesaid facts & circumstances, material on record and submissions made, I am therefore of the view that the decision/action of the respondent company for repudiating the claim is not justified and is not sustainable. Hence, the complainant is entitled for the admissible amount in accordance with the terms & conditions of the policy document against the claimed amount Rs.84,206/-

Hence, the respondent The National Insurance Co. Ltd. is directed to review the claim and make payment of admissible amount to the complainant in accordance with the terms & condition of the policy document within 15 days from the date of receipt of acceptance letter of the complainant failing which it will attract 9% simple interest p.a. from date of this order to the date of actual payment. In

the result, the complaint is allowed to the extent of admissible amount only.

Mr. Anup
Pathak……Complainant

V/s

United India Insurance Co. Ltd.
……Respondent

Order No. IO/BHP/A/GI/0060/2014-2015 /
Case No. GI/UII/1003/126

<u>Brief Background:</u>

The complainant had taken a Mediclaim policy bearing no.191301/48/09/97/00000106 (wrongly mentioned in place of correct no. 191301/48/09/97/00000060 for the period 13.04.2008 to 12.04.2009 covering himself, his wife and two daughters Ku. Richa & Ku.Ritika which was issued by the respondent company subject to terms & conditions. It is further said that his wife Smt.Seema undergone treatment from 02.04.2009 to 03.04.2009 in Vishesh Hospital, Indore for pain at lumbo sacral region. Thereafter, he lodged the claim for Rs.17,000/- towards treatment cost of his wife but no action was taken and his claim was not considered. Being aggrieved by the action of respondent company, the complainant approached this forum for relief of making payment of Rs. 17000/- towards treatment cost of his wife.

The insurer in their Self Contained Note dated 23.04.2010 have admitted about the issuance of above mediclaim policy covering his wife also and have also mentioned about her admission on 02.04.2009 and discharge on 03.04.2009 in the Vishesh hospital for SSA effusion right hip and right SI joint and have contended that the claim was repudiated under exclusion clause 4.10 of the policy.

FINDINGS AND DECISION: I have carefully gone through the material on the record and submissions made. From perusal of the discharge summary of the Vishesh hospital, it transpires that Mrs. Seema Pathak, was admitted on 02.04.2009 with history of pain at Lambo Sacral region radiating to right hip region and right lower limb since last one year with swelling and patient was given conservative treatment such as some tablets and injection and was advised follow up after six weeks. From perusal of the record, it appears that several diagnostic tests like MRI of hip joint, LS spine and other pathological test of calcium, blood picture etc were done for diagnosis of the ailment only and the medicines were given to minimize the pain only as she remained in the hospital only from 02.04.2009 to 03.04.2009 and was not given any treatment for relieving her from the diagnosed ailment SSA effusion Rt.hip Rt.S/I joint. Thus, from the medical documents available on the record and the bills, it is very much clear that the hospitalization was only done for diagnostic and other pathological test for investigation and no active treatment was given to relieve from the symptoms of said diagnosed ailment and was advised for follow up after said short period of hospitalization. The exclusion clause 4.10 clearly provides that 'Charges incurred at Hospital or Nursing Home primarily for diagnosis X-ray or Laboratory examinations or other diagnostic studies not consistent with or incidental to the diagnosis and

treatment of positive existence of presence of any ailment, sickness or injury, for which confinement is required at a Hospital/ Nursing Home or at home under domiciliary hospitalization as defined'. Thus, in view of the discharge summary and conservative treatment given to the patient, to my mind the hospitalization was mainly for diagnostic tests for investigation and no active treatment was given towards recovery of the said diagnosed ailment and since the patient was having only complaint of pain and even not acute pain which could have been reduced and even cured by taking oral medicines/ any pain relieving injection at home without any hospitalization as she was suffering from said pain from last one year as per discharge summery. and the letter dated 12.08.2009 of the TPA shows that claim was not payable under exclusion clause 4.10. Hence, I find substance in the contention of insurer's representative.

Hence, under the aforesaid facts, circumstances and material available on the record and policy terms & conditions, I am of the considered view that the decision taken by the TPA/ respondent for repudiating the claim under the exclusion clause 4.10 of the policy document is perfectly justified. Hence, the complainant is not entitled for the relief as prayed. In the result, complaint stands dismissed accordingly being devoid of any merit.

Dated at Bhopal on 21st day of October, 2014

Mr.Arvind Kumar

Jain.....Complainant

V/s

United India Insurance Company Ltd.
.....Respondent

Order No.IO/BHP/GI/A/0142/2014-2015
Case No. GI/UII/1205/06

Brief Background:

The complainant was covered under group mediclaim Policy bearing no. 191302/48/10/41/00000627 with his son for sum insured Rs.3,00,000/- on payment of yearly premium of Rs.4,339/- for the period of insurance 12.06.2010 to 11.06.2011 from the respondent company. It is further said that he lodged the claim before the TPA of the respondent company for hospitalization and treatment of his son from 25.05.2011 to 29.05.2011 but they did not settle the claim till now. Being aggrieved by the action of respondent company, the complainant approached this forum for the relief of claim amount Rs. 7,178/- as mentioned in P-II for.

The insurer have contended in their SCN that the complainant's son was admitted in the hospital from 25.05.2011 to 29.05.2011 and intimation and documents were sent to TPA on 13.06.2011. The insured has submitted the photo copy of pre-authorization form but has not submitted any letter of intimation to TPA. So, claim was repudiated under policy condition no. 5.3 i.e. delay in intimation.
For the sake of natural justice, hearing was held at Bhopal Office. The complainant was absent. The insurer's representative was heard who has taken the stand as mentioned in the SCN regarding repudiation of the claim.

FINDINGS & DECISION:

I have gone through the material available on record. As per IRDA circular no. IRDA/HLTH/MISC/CIR/216/09/2011 dated 20.09.2011 "The Insurers' decision to reject a claim shall be based on sound logic and valid grounds. It may be noted that such limitation clause does not work in isolation and is not absolute. The Respondent needs to see the merits and good spirit of the clause. Rejection on claims on purely technical grounds in a mechanical fashion will result in policyholders losing confidence in the insurance industry, giving rise to excessive litigation. Therefore, it is advised that Respondent need to develop a sound mechanism of their own to handle such claims with utmost care and caution". In the instant case as per the complaint, the complainant has clearly asserted that after admission of his son on 25.05.2011, he sent pre-authorization application on 26.05.2011 to the TPA through hospital for giving cashless facility but no response was received till 29.05.2011 from the TPA. So, after depositing the amount, he got his son discharged from the hospital. The pre-authorization application dated

26.05.2011 sent to the TPA for cashless facility itself shows that TPA was informed about the admission on 25.05.2011 in the hospital and on going treatment. So, I do not think that any other type of intimation was required by the TPA as the pre-authorization form containing detail facts about admission of the son of the complainant can well be treated as intimation to the TPA. When the cashless facility was denied then it was informed to the Respondent and I found that the TPA is the agent of the Respondent to whom cashless intimation was given.

Under the aforesaid facts & circumstances, material on record and submissions made, I am therefore of the view that the action of the respondent company for rejecting the claim on the ground of late intimation to TPA is not justified and is not sustainable. Hence, the complainant is entitled for the admissible amount against the claim made in accordance with the terms & conditions of the policy document.

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

Mr. Ashok Khurana

.....Complainant

V/s

United India Insurance Company Ltd.
.....Respondent

Order No.IO/BHP/A/GI/0141/2014-2015
Case No. BHP-G-051-1314-0590

Brief Background:

The complainant was covered under mediclaim Policy bearing no. 190306/48/11/97/00001707 with his wife Mrs.Abha Khurana for sum insured Rs.4,00,000/- on payment of yearly premium of Rs.9,413/- for the period of insurance 28.03.2012 to 27.03.2013 from the respondent company. It is further said that his wife was admitted on 04.12.2012 in the hospital for treatment of breathing trouble and she was finally diagnosed a case of TVD and CABG was done on 10.12.2012 at Vishesh Hospital and was finally discharged on 26.12.2012 but on 07.01. 2013 she had infection in kidney and was again admitted to Vishesh Hospital, Indore and during treatment she was expired on 08.01.2013. Thereafter, he lodged the claim for Rs. 6,16,969/- before the respondent company and as per terms & conditions claim should be settled for Rs.3,78,000/- (Rs.22,000/- were claimed by him and paid by respondent company

during earlier illness) but the respondent company has settled claim only for Rs. 2.80 Lac which was not acceptable to him. Being aggrieved by the action of respondent company, the complainant approached this forum for the relief of claim amount Rs. 3.78 lacs towards hospitalisation and treatment cost.

The insurer in their SCN have stated that the complainant's wife was admitted in the CHL Hospital form 25.11.2012 to 27.11.2012 for Coronary Angography which was showing Triple vessel disease and she was advised for Coronary Artery By Pass surgery. On 04.12.2012 she was admitted in Vishesh Hospital for heart surgery which was performed on 10.12.2012 and she was discharged on 26.01.2012 (wrongly mentioned in place of 26.12.2012). The respondent company took the opinion from their panel Doctor Dr.Manish Bandeshte who opined that her high risk by pass surgery and valve replacement were done. They have received the hospital bill and supportive papers for Rs.5,54,740/-. As per the policy condition of 1:2:1 of the policy expenses in respect of major surgery 70% of sum insured was payable, so their competent authority has settle the claim for Rs. 2,80,000/- (70% of Rs.4,00,000/-) and Rs.22,008/- Rs. but the insured demanded Rs.3,60,000/- which was not considered as not justified as per terms & conditions of the policy.

FINDINGS & DECISION:

I have gone through the material placed on the record and submission made by both the parties. From perusal of the terms & conditions of the policy document, it is apparent that clause 1.2.1 clearly provides about restriction towards expenses in respect of major surgeries as actual expenses incurred or 70% of the sum

insured whichever is less and the major surgery includes cardiac surgery also and in the instant case, it is admitted fact that heart surgery was performed on 10.12.2012 of insured Abha Khurana, the wife of the complainant who expired on 08.01.2013. It is also admitted fact that the respondent company has settle the claim for Rs.2,80,000/- (70% of Rs.4,00,000/- the sum insured) and issued the discharge voucher to the complainant which was not accepted by the complainant. Since, the claim has been settled in accordance with the condition no. 1.2.1 of the policy document and I find no discrepancy towards the settlement of claimed amount in accordance with the terms & conditions of the policy document. I find substance in the contention of insurer's representative. In these circumstances, the respondent is not liable to make payment of Rs.3.78 Lac as prayed for.

Under the aforesaid facts & circumstances, material on record and submissions made and policy terms & conditions, I am, therefore of the considered view that the action/ decision of the respondent company to not considering the claim of Rs.3.78 is perfectly justified and is sustainable. Hence, the complainant is not entitled for the claim as prayed for. In the result, the complaint is dismissed being devoid of any merit.

Mr. Baban Rao

Bhamb.....Complainant

V/s

The Oriental Insurance Co.....Respondent

Order No.IO/BHP/A/GI/0162/2014-2015
Case No. BHP-G-050-1314-0687

Brief Background:

The complainant had taken a Individual Mediclaim Policy bearing no. 151100/48/2011/7240 for the period from 29.09.2010 to midnight of 28.09.2011 which was issued by the respondent. He preferred mediclaim for Rs.7,460/- towards hospitalization from 11.11.2010 to 18.11.2010 for treatment of positional vertigo before the respondent's TPA M/s M.D.India Health Care Services, Indore on 18.11.2010 alongwith all documents and also submitted required documents demanded by the TPA but no reply was given nor payment was made till date. He made representation before the higher authorities of the respondent but his claim was not considered. Being aggrieved by the action of TPA/respondent Company the complainant approached this forum for the relief of making payment of his claim of Rs.7,460/-.After registration of the complaint, the complainant submitted prescribed forms duly signed

by him and but the respondent had not submitted SCN/reply rather has brought on record copy of letter dated 01.03.2013 only on date of hearing mentioning therein that "as per claim documents received it has been observed that date of discharge was 08.11.2010 and the claim documents were submitted on 18.11.2010. Therefore, there was a delay in submission of 03 day. The claim documents were not submitted to them within 7 days of discharge from the hospital as such claim has been closed." The non filing of SCN clearly reflects the gross negligence of the respondent company.

FINDINGS & DECISION:

I have gone through the material placed on the record and submission made. The discharge card (xerox copy) shows about the date of admission of the complainant on 11.11.2010 and date of discharge on 18.11.2010 from the Curewell Hospital Pvt.Ltd., Indore and the said discharge card also shows treatment undergone by the complainant in the said hospital for the diagnosed ailment. The OPD form dated 01.11.2010 also shows about the requirement of admission of the patient in the hospital. Since, the ground of repudiation as shown in the letter of respondent dated 01.03.2013 as well as during hearing is delay of 3 days. As per IRDA circular No. IRDA/HLTH/MISC/CIR/216/09/ 2011 dated 20.09.2011, it is clear that the insurers have been advised not to repudiate such claim on ground of delay in claim intimation/ document submission where the delay is proved to be for reasons beyond the control of insured. In the instant case, the complainant has mentioned in his written submission that he is from weaker section, so he cannot be expected to know about the legal technicalities before submitting his claim.

There is simple delay of only 3 days in submission of claim documents which can be condoned in view of the above circular.

Under the aforesaid facts & circumstances, material on record, submissions made and policy terms & conditions, I am therefore of the view that the action/decision of the respondent company for closing the claim of the complainant on the ground of delay of only 3 days is not justified and is not sustainable. Hence, the complainant is entitled for the admissible amount under the policy document.

Hence, the respondent Oriental Insurance Co.Ltd. is directed to reopen/review and settle the claim condoning the delay in the light of the IRDA circular and pay the admissible amount in accordance with the terms & condition of the policy document to the complainant within 15 days from the date of receipt of acceptance letter of the complainant failing which it will attract 9% simple interest p.a. from date of this order to the date of actual payment. In the result, the complaint is allowed to the extent of admissible amount only.

Mr. Bharat Singh

Batham.....Complainant

V/s

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

Order No. IO/BHP/A/GI/0117/2014-2015
Case No. BHP-G-049-1314-0642

Brief Background:

The complainant was covered under a Group Mediclaim (Tailor Made) policy bearing no. 12070034130500000001 as a staff member of LIC of India for the period of 01.04.2013 to 31.03.2014 for sum assured Rs.1,10,000/- alongwith his family members. He preferred a mediclaim of Rs. 23,908/- towards his treatment cost during hospitalization from 20.04.2013 to 21.04.2013 in Kalyan Memorial & K.D.J. hospital, Gwalior before the respondent company but the respondent company only pays Rs. 3,025/- for making payment of balance amount he made representation before the respondent company but no reply was given till 08.09.2013. Being aggrieved by the action of the respondent company, the complainant approached this forum for the relief of making payment of Rs.20,883 /- as balance amount towards his treatment cost.

After registration of the complaint, the complainant submitted prescribed forms duly signed by him and respondent submitted SCN/reply.

The respondent have contended in their SCN that against the claim bills for Rs.23,908/- bills for Rs. 3125/- was found payable under the policy. The bills for Rs. 20,778/- where for the expenses incurred prior to 30 days of hospitalization which were not covered under the policy, so same were disallowed. The not payable medical bills pertains for the period September, 2012, December,2012, January,2013, February, 2013 etc and the single major bill for Rs. 11,180/- for MRI brain pertain to dated 08.02.2013 and similarly other bills also pertain to incurred prior to 30 days of hospitalization and accordingly Rs.3,125/- was paid to insured M/s LIC of India vide cheque no. 5358721 dated 24.06.2013 as full and final amount and the reasons for deduction of not payable amount was convey to him vide letter dated 01.11.2013 and prayed to dismiss the complaint.

For the sake of natural justice, hearing was held at Bhopal office. The complainant did not appear nor submitted any written submission and the insurer's representative was present and was heard who has taken the stand as mentioned in reply/SCN and laid emphasis that the payment of Rs. 3,125/- has been made as per policy terms & conditions and some bills were found without prescription and some bills were prior to 30 days of hospitalization which were not allowed as per policy document.

FINDINGS & DECISION:

I have gone through the material placed on the record and submission made. From close perusal of the record, it is apparent that the amount of Rs. 3,125/- was only found payable as per policy terms and conditions and the rest amount was not paid for want of prescription for some bills and finding some bills prior to 30 days of hospitalization under policy document. I find no discrepancy towards the deduction made in the claimed amount of the bills as the deductions were made in accordance with the terms & conditions of the policy document. I find substance in the contention of insurer's representative. In these circumstances, the respondent is not liable to make payment of the balance amount as prayed for.

Under the aforesaid facts & circumstances, material on record and submissions made and policy terms & conditions, I am, therefore of the considered view that the action/ decision of the respondent company to not considering the balance amount of claim is perfectly justified and is sustainable. Hence, the complainant is not entitled for the claim as prayed for. In the result, the complaint is dismissed being devoid of any merit.

Mr. Chandmal Patni .....
Complainant

V/s

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

Order No. IO/BHP/A/GI/0066/2014-2015
Case No. GI/NIC/1102/120

Brief Background:

The case of complainant in short is that the complainant had taken a mediclaim policy bearing no. 321700/48/10/85000000193 for the period 01.05.2010 to 30.04.2011 for sum assured Rs.50.000/-. It is further said that the complainant had lodged a claim for Rs.71,928/- towards his treatment cost but company did not settle the entire claim amount and according to sub limits of policy condition the amount of Rs.7,011/- was deducted but no information was given to him even after letters to the company/TPA. Being aggrieved by the action of respondent company, the complainant approached this forum for relief of making payment of Rs.7,011/- as per complaint and Rs..17,011/- .

The insurer in their Self Contained Note dated 21.03.2011 have contended that as per policy terms & conditions 1(a) which provides about the capping limits for the claim procedure and the company will pay such expenses as would fall under different heads mentioned in the policy document and will not exceed the sum insured and the cumulative bonus does include any sum insured to settle the claim and the company is not liable to make any other amount under the policy terms & conditions as the settled amount has already been paid to the complainant in accordance with the policy terms & conditions.

For the sake of natural justice, hearing was held at Indore office. The complainant did not appear. The insurer's representative Mr. M.K.Jadhav is present who narrated the facts as mentioned in the SCN. On perusal of record, it transpires that the letter of information

sent to the complainant at his address returned back with the endorsement of the postman that the addressee has been died. No legal representative has come forward during proceeding of this case after death of the complainant for further proceeding and even on the date of hearing.

Hence, in view of the fact that the complainant has died and no LR has been brought on record after death of the complainant to proceed further before hearing and even on the date of hearing. So, this case cannot be processed further. Hence under the circumstances this complaint is closed.

Mr.Chandra Kant Jain ……
…….Complainant

V/s

Oriental Insurance Co. Ltd.
…….Respondent

Order No. IO/BHP/A/GI/0080/2014-2015
Case No : GI/OIC/1302/64

<u>Brief Background:</u>
The complainant Mr. Chandra Kant Jain was covered under a mediclaim policy bearing no. 151400/48/2012/3290 for the period 06.09.2011 to 05.09.2012 for sum assured Rs.2,00,000/- which was issued by the respondent company. It is further said that previously

he was covered under mediclaim policy of Reliance General Insurance since year 2007 to 2010 and from year 2010 he was continuously covered under mediclaim policy of Oriental Insurance Co. He had preferred a mediclaim on 22.05.2012 for Rs. 41980/- towards his treatment cost related to Stone but his claim was rejected on the ground of exclusion clause 4.3. Being aggrieved from the action of the respondent, the complainant approached this forum for relief of making payment of his claim amounting Rs.41,980/-.

. For the sake of natural justice hearing was held at Indore Camp Office. The complainant did not appear rather complainant's brother Mr.Jitendra Jain appeared. The complainant's brother as well as the insurer's representative Mr.Murli Arora were heard as mediation could not be done due to absence of complainant. The complainant's brother has reiterated the facts as mentioned in the complaint and laid emphasis that the particulars about policy taken from Reliance General Insurance Company was filled-in in the proposal form, so the policy was continued from 2007 till date and prayed to allow the claim. On the other hand, the insurer's representative refuted the contention made on behalf of complainant and laid emphasis that the waiting period of two years was not completed for the claim made for the treatment of Renal Calculus which was pre-existing, so the repudiation of the claim was in order as per policy terms & conditions clause 4.1 & 4.3.

<u>Findings & Decision:</u>

I have gone through the material placed on the record, submission made on behalf of the complainant and insurer's representative and policy terms & conditions. As per exclusion no.

4.3 "Calculus disease is excluded from the scope of cover of Individual Mediclaim Policy for 2 years" and as per exclusion no. 4.1 of the policy document, the pre-existing disease 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 inforce continuously and for purpose of applying this condition , the date of inception of the mediclaim policy taken from Oriental Insurance Co. shall be considered provided the renewals have been continuous and without any break in period and clause 4.3 (xix) the waiting period of calculus disease is two years. The first policy document bearing no.151401/48/2011/3349 for the period 06.09.2010 to 05.09.2011 does not contain the previous policy no. and from the receipt of the said policy, it is also apparent that it was new policy and the above policy under which the claim has been made shows the number of aforesaid previous policy. Both the above policy documents of the respondent company do not contain any endorsement about continuity of the earlier policy taken from Reliance General Insurance Co. from year 2007. The complainant has failed to file any letter to show that he prayed for such endorsement at the time of taking the first policy from respondent company. Moreover, the certified copy of proposal form submitted on behalf of respondent also does not contain the particulars of policies of Reliance General Insurance Company as stated on behalf of complainant during hearing. Thus, from the policy terms & condition of policy document and material on record, it is established that the waiting period of two years was not completed at the time of making the claim for treatment of stone (Calculus disease) and the policy taken from the respondent company had also not completed two

years at the time of hospitalization. Hence, I do not find any force in the contention made on behalf of complainant.

Under the aforesaid facts & circumstances, material on record and submissions made and policy terms & conditions, I am, therefore of the considered view that the decision of the respondent company to repudiate the claim is perfectly justified and is sustainable and the complainant is not entitled for the relief as prayed for. In the result the complaint stands dismissed being devoid of any merit.

Mr.Devi Prasad Sen.....Complainant

V/s

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

Order No. IO/BHP/A/GI/0089/2014-2015
Case No : GI/UII/1207/27

<u>Brief Background:</u>

The complainant was covered as under group mediclaim tailor made policy bearing no. 1913071/48/10/41/00000756 under Indore Bank Arogya Scheme for account holders of State Bank of Indore for the period 13.08.2010 to 12.08.2011 which was issued by the respondent subject to terms & conditions. It is further said that

he lodged his claim before the TPA towards treatment cost of hospitalization as he underwent for brain operation in Bombay Hospital, Indore for the period 16.07.2011 to 20.07.2011 and 04.08.2011 to 10.08.2011 respectively but he did not receive any reply towards settlement of his claim towards treatment cost. Being aggrieved from the action of the respondent, the complainant approached this forum for the relief of making payment of Rs.1,07,448/- .

The insurer in their reply/SCN have taken the plea that the hospitalization was for the treatment of bilateral chronic subdural hemorrhage as per discharge summary. It was first mediclaim policy held by the insured w.e.f. 13.08.2010 and the hospitalization date was 16.07.2011 and the insured lodged the claim after 11 months from the first policy inception date and have further contended that the medical expert of their TPA opined that this case was diagnosed as a case of bilateral chronic subdural hemorrhage which is a chronic ailment and the diseases for which treatment was received by the insured was pre-existing at the time of taking the current policy and all the pre-existing disease have been excluded under the policy exclusion clause no. 4.1.

. The insurer's representative has submitted that the claim was repudiated on the ground of pre-existing disease of the ailment of brain for which operation was performed and the claim was made in the first year of the policy and amount of claim is not payable.

<u>Findings & Decision:</u>

I have gone through the material placed on the record and submissions made. From the perusal of the terms & conditions of the policy document of group mediclaim insurance policy under which the complainant was insured/beneficiary, it is apparent that as per exclusion clause 4.1 the company shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any insured person in connection with or in respect of all disease/ injuries which are preexisting when the covered incepts for the first time provided the renewal have been continuous and without any break. However, this exclusion will be deleted after 3 consecutive continuous claim free years provided there was no hospitalization for pre existing year during these 3 years of insurance. From the record, it is clear that it was first policy which was for the period for 13.08.2010 to 12.08.2011 and complainant has not brought on record any other previous policies to show its continuity. It is admitted fact that the complainant underwent operation of his brain as appears from discharge summary for hospitalization period 16.07.2011 with date of discharge 20.07.2011 and discharge summary for date of admission 04.08.2011 and date of discharge 10.08.2011 of Bombay Hospital Indore and in the discharge summary, it has been mentioned that there was history of open cholecystectomy done in 1995 and in the final diagnosis bilateral chronic subdural hemorrhage was found in the first discharge summary and recurrent bilateral chronic SDH was found in the second discharge summary and history of SDH evacuation was done on 16.07.2011 and evidence of mild mass effect on underline brain at right fronto parietal reason was also found. The age of patient has been shown 78years at the time of said operation of the brain twice. The prescription dated 15.07.2011 of the Bombay

Hospital Indore issued by Dr.Atul Taparia shows that the doctor has mentioned c/o chronic subdural hemorrhage of the brain. The medical expert report of the TPA of the company has also opined that the above diagnosed ailment of bilateral chronic subdural hemorrhage is a chronic ailment for which the treatment was received by the insured and was preexisting disease as mentioned in SCN only but the said medical expert report of the TPA of the company has not been brought on record. From perusal of proposal form (xerox copy) available on the record it is apparent that all the columns regarding suffering from any disease for which the complainant required any consultation or treatment are totally blank and inference can be drawn that the columns were left blank by the complainant/ insured for the reasons best know to both the parties and the above proposal form contains the signature of the complainant also but the respondent company have brought on record, the xerox copy of the proposal form on 12.08.2014 after hearing on 11.08.2014 without showing any cogent reason for not filing the same before date of hearing which certainly affected the right to controvert about showing the aforesaid columns as blank and in this way, the complainant could not get any opportunity to clarify about mentioning "yes" or "no" in the aforesaid column regarding suffering from the aforesaid preexisting disease if any. So, in absence of any clarification from the complainant, it is difficult to decide that under what circumstances, the above columns were left blank. The respondent company had opportunity to check this important information. So, blame cannot be put squarely on the insured alone.

Under the aforesaid facts & circumstances and keeping in view the above deliberations in mind, the insurer United India Insurance Co.Ltd. is directed to review and allow the claim on an ex-gratia basis and to pay 50% of the admissible amount as per policy document towards his claim as full and final settlement of the claim under the policy document within 15 days from date of receipt of acceptance letter of the complainant failing which it will attract a simple interest of 9% p.a. from the date of this order till date of actual payment. In the result, the complaint is partly allowed.

Mr. Dinesh Yashlaha.....Complainant

V/s

New India Assurance Company Ltd.....Respondent

Order No. IO/BHP/A/GI/0098/2014-2015
Case No. GI/NIA/1210/37

<u>Brief Background:</u>

Being aggrieved by the action/ decision of the respondent company, the complainant Mr. Dinesh Yashlaha as a beneficiary/ insured under Group Mediclaim (Tailor made) insurance policy no.

12070034110500000001 for the period 01.04.2011 to 31.03.2012 issued for employees and their dependent of LIC, approached this forum for redressal of his grievance towards making payment of wrongly deducted amount Rs. 2,550/- from the claim amount for undergoing his treatment for DVT ® lowerlimb HTN etc. during period of hospitalization in Bafna Hospital, Indore from 04.01.2012 to 14.01.2012 and post hospitalization with cost and mental agony as mentioned in P-II form.

The respondent in their reply/ SCN have taken the plea that as per clause 4.14 of Group Mediclaim (tailor made) insurance policy, injection (nursing charges) taken at home are excluded and not payable. Finally receipt should be with printed no. and name of the doctor. Receipt of Rs.1,000/- as produced was not in proper format, hence not payable and an amount of Rs.1,550/- for three injection has already been paid to the complainant on 07.11.2012.

For the sake of natural justice, hearing was held at Bhopal office. The complainant was absent. The insurer's representative was present who was heard who has taken the stand as made in the SCN and laid emphasis that as per clause 4.14 of Group Mediclaim (tailor made) insurance policy, injection (nursing charges) taken at home are excluded and not payable and Rs.1,550/- for three injection has already been paid to the complainant on 07.11.2012 and receipt of Rs.1,000/- was not in proper format and prayed to dismiss the complaint.

FINDINGS & DECISION:

I have gone through the material placed on the record and submission made. From perusal of the records, it transpires that cost of three injection Rs.1,550/- has already been paid to the complainant after filing of complaint. As per exclusion clause no. 4.14 "The doctor's home visit charges, attendant, nursing charges during pre and post hospitalization period, referral fee to a family physician, out station doctor, out station surgeon and out station consultants fees are not payable. The receipt for one thousand has also not been given in proper format as mentioned in the SCN. In these circumstances, the respondent company is not liable to make payment of balance amount as claimed.

Under the aforesaid facts & circumstances, material on record and submissions made and policy terms & conditions, I am therefore of the view that the decision of the respondent company for not considering the claim for balance amount towards nursing charges under exclusion clause 4.14 of policy terms & conditions is perfectly justified and is sustainable. Hence, the complainant is not entitled for the relief as prayed for. In the result, the complaint stands dismissed accordingly.

Mr.Gauri Shankar Rajguru .....Complainant

V/s

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

Order No. IO/BHP/A/GI/0106/2014-2015
Case No : GI/UII/1108/41

Brief Background:

The complainant was covered under a Floter Mediclaim policy bearing no. 191302/48/09/87/00000637 for the period from 15.06.2009 to 14.06.2009 for the sum assured Rs.3,50,000/- which was issued by the respondent company. He had preferred a mediclaim for Rs.2,89,540.46 towards his first hospitalization and for second hospitalization Rs. 69,934.79 and the TPA has settled his claim only for the first bill of Rs. 2,89,540.46 and did not settle the second hospitalization bill and various letters sent by the complainant were not acknowledge and no reply was given in this regard. Being aggrieved by the action of respondent company the complainant approached this forum for the relief of making payment of his claim of Rs.69,934/-.

For the sake of natural hearing was held at Indore camp office. The complainant assisted by his son and the insurer's representative were heard as mediation was failed. The complainant reiterating the facts of his case laid emphasis that the TPA demanded some documents as required to settle the second claim which was already sent to them but the claim was not settled and prayed to allow his second claim. The insurer's representative have admitted about the settlement and payment of first claim and also stated that the second claim is still under process and likely to be settled at the earliest.

Findings & Decision:

I have gone through the material placed on the record and submission made. The record clearly shows that the TPA of the company treated the claim as No Claim for want of the two required documents certificate from treating doctor confirming the likely cause of obstructive uropathy and USG report in original communicating the respondent company vide letter dated 13.10.2011 while the letter dated 31.10.2011 sent by the complainant to the concerned TPA clearly shows about sending the aforesaid required documents to the concerned TPA but the respondent company/TPA have not settled the second claim for the aforesaid amount even after submitting the aforesaid required document which certainly reflects the callous attitude of the TPA/ respondent company. In these circumstances, the respondent is liable to make payment of the admissible amount as per policy document for second claim made for Rs. 69,934/-.

Under the aforesaid facts & circumstances, material on record and submission made, I am therefore of the view that the action/decision of the respondent company for not considering the second claim of the respondent company for Rs. 69,934/- is not justified and is not sustainable. Hence, the complainant is entitled for the admissible amount towards the second claim of Rs. 69,934/- as per policy document.

Hence, the respondent United India Insurance Co.Ltd. is directed to reopen/review the claim of the complainant towards his hospitalization for the claim amounting Rs. 69,934/- as per policy document and shall pay the admissible amount against the treatment bills of Rs. 69,934/- on the basis of the documents

submitted by the complainant as required by the TPA/ respondent company as per policy document within one month from date of receipt of this order under intimation to the complainant and this office failing which it will attract simple interest of 9% p.a. from the date of this order till the date of actual payment of the admissible amount. In the result, the complaint is allowed to the extent of above observation.

Mrs. Gayatri Devi Agrawal
.....Complainant

V/s

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

Order No. IO/BHP/A/GI/ 0116/2014-2015
Case No : GI/UII/1109/55

<u>Brief Background:</u>

The complainant had taken a Individual Health Insurance Policy bearing no. 191302/48/09/97/00003266 for the period 31.03.2010 to 30.03.2011 for sum insured Rs.75,000/- covering her mother Mrs.

Saraswati Devi Agrawal from the respondent. The complainant's mother was hospitalized for her treatment on 30.04.2010 and discharged on 04.05.2011 and the TPA was informed on 30.04.2010. Thereafter, she lodged claim for Rs.32,108/- towards treatment cost of her mother under the policy document by submitting all the documents before the TPA of the respondent company but claim was not settled nor any reply was given. Being aggrieved by the action of respondent company the complainant approached this forum for the relief of making payment of his claim of Rs.32,108/- towards treatment cost of her mother.

The insurer have stated in their SCN that the claim was repudiated by their TPA on the basis of pre-existing disease as per policy exclusion 4.1 as the patient was covered under the policy since 2007 and the diseases was found present since 11.10.2006.

Findings & Decision:

I have gone through the material placed on the record and submission made. From the perusal of the previous policy documents from the year 2001 to 2009 it is apparent that the patient insured was covered under the aforesaid policies continuously. The insurer has not filed the copy of the proposal form. The insurer's representative has also conceded that the basis for repudiation of the claim is not applicable in the instant case as policy was continued since 2001 to 2009 before taking the concerned policy. Hence, in these circumstance in view of the admission made on the behalf of the respondent that the admissible amount is payable to the complainant, the respondent is liable to make payment of

admissible amount only to the complainant under the policy document.

Hence, I am therefore of the view that the repudiation of the claim by the respondent company is not justified and complainant is entitled for admissible amount only against the claimed amount as per terms & conditions of the policy document.

Hence, the respondent company United India Assurance Co.Ltd is directed to paid the admissible amount only against the claim amount as per terms & conditions of the policy document to the complainant within 15 days from the date of receipt of acceptance letter from the complainant failing which it will attract simple interest of 9% p.a. from the date of this order till the date of actual payment and submit compliance report to this office. In the result, the complaint is allowed to the extent of admissible amount only..

Mrs. Gayatri Khiwani .....Complainant

V/s

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

Order No. IO/BHP/A/GI/0111/2014-2015 Case No : BHP-G-050-1314-0698

<u>Award</u>
<u>Brief Background:</u>

The complainant Gayatri Khiwani, retired AAO from Oriental Insurance Co.Ltd. was covered under Group Mediclaim Insurance policy bearing no. 361500/46/12/8500000004 for the period from 01.04.2012 to 31.03.2013 and 361500/46/13/8500000005 for the period from 01.04.2013 to 31.03.2014 which was issued by the respondent company. She had preferred mediclaim for Rs.1,93,177/- which was incurred by her during the course of treatment of Retinopathy caused due to diabetes but the respondent found the claims as not admissible as per policy conditions

The insurer have filled different claim notes regarding treatment taken from 11.12.2012 to 14.12.2012, 02.01.2013 to 06.01.2013, 01.03.2013 to 02.03.2013, 02.05.2013 to 04.05.2013, 06.08.2013 to 09.08.2013, 20.09.2013 to 21.09.2013 by the complainant. The respondent have taken the plea that as per medical opinion of Dr.K.G.Agrawal, the hospitalization was shown to perform various tests done during the hospitalization from 11.12.2012 to 14.12.2012 could be done as OPD procedure and the hospitalization was not required for giving oral medicines during treatment and the policy does not cover the OPD treatment, so the claim was not admissible as per policy condition 4.10 and was repudiated. The respondent have taken the plea towards treatment cost for the hospitalization from 02.01.2013 to 06.01.2013 that the IV injection of Steroids were given and she was treated by oral anti hypertensive and anti diabetic medicines and on the basis of medical opinion of above doctor hospitalization was not required to give the said injection and was an OPD procedure so claim was repudiated as per condition 4.10 of the mediclaim policy. The respondent have taken

the plea towards treatment cost for the hospitalization from 01.03.2013 to 02.03.2013, that as per opinion of the above doctor the treatment was done as OPD procedure only and having no hospitalization so claim was repudiated as per condition 1.1 of the mediclaim policy. The respondent have taken the plea towards treatment cost for the hospitalization from 02.05.2013 to 04.05.2013, that as per opinion of the above doctor the treatment was done as OPD procedure only and having no hospitalization so claim was repudiated as per condition 1.1 of the mediclaim policy. The respondent have taken the plea towards treatment cost for the hospitalization from 06.08.2013 to 09.08.2013, that on scrutiny it was observed that the treatment taken by insured was as outpatient and the complainant failed to submit the discharge ticket which fell beyond the purview of the policy so the claim was repudiated as per condition of the policy. The respondent have taken the plea towards treatment cost for the hospitalization from 20.09.2013 to 21.09.2013 as per opinion of the above doctor the treatment was investigated and routine blood examination, iron injection and other supportive medicines were given and she was hospitalized only for one day and discharged on the request of attendant and overall treatments showed that hospitalization was not required so the claim was repudiated.

For the sake of natural hearing was held at Bhopal office. Both the parties were heard as mediation was failed. The complainant has reiterated that fact as mentioned in the complaint and narrated the details of six claims made by her for different periods as stated above towards her treatment of eye and has laid emphasis that though she was treated in Shankar Netralaya also but only

certificate was issued as hospitalization was not found necessary due to advance medical technology and has submitted the treatment documents and prayed to allow her claim towards treatment cost. On the other hand, the insurer's representative has reiterated the stand as made in their different claim notes available on the record and laid emphasis that in most of the claims there were diagnostic test reports and the complainant had not filed the discharge card relating to the treatment in Shankar Netralaya and only certificate had been filed and as per medical opinion of the panel doctor the above treatments were found as OPD procedure and no active treatment was given for the diagnosed ailment of eye, so the claims as made are not payable.

Findings & Decision:

I have gone through the material placed on the record and submissions made. From perusal of the record, it is apparent that, all the medical documents and some certificates brought on record are suggestive of the facts that the complainant had taken some treatment towards ailment in her eye and as well as anemia and swelling in lower limb. So, for the claim made for hospitalization from 02.01.2013 to 06.01.2013 is concerned, it is apparent that the steroid was also given as appears from discharge card and other medicines were also given with IV Fluids and the above claim was declined on the ground that it could be done as OPD patient but it is the doctor only who is competent to decide the admission of the

patient keeping in view his body condition and as well as symptoms and the effect of injection and other medicines given to the patient. So, I find that the hospitalization for the required treatment during 02.01.2013 to 06.01.2013 was perfectly justified and the repudiation of the claim for the said period cannot be said to be proper. So for other rest five claims are concerned, no doubt, the complainant has failed to file discharge card and filed some certificates and other documents to show the treatment and diagnostic tests. As per group mediclaim policy terms & conditions brought on record by the respondent, clause 2.3 clearly provides that expenses on hospitalization are admissible only if the hospitalization is for a minimum for 24 hours and as per clause (A) This time limit will not apply to eye surgery and some other surgery etc. Though, the complainant has not undergone any eye surgery rather had taken the treatment of retinopathy due to diabetes as mentioned in the complaint itself. So, from the medical record, it is apparent that the treatment taken in A.K.Hospital from 11.12.2012 to 14.12.2012, in L.V.Prasad Eye Hospital, Hyderabad 01.03.2013 to 02.03.2013, in Sankara Nethralaya from 02.05.2013 to 04.05.2013 again in Shankar Netralaya from 06.08.2013 to 09.08.2013 and in Red Cross Hospital, Bhopal from 20.09.2013 to 21.09.2013 for want of proper discharge card can be treated as OPD procedure for which the hospitalization was not required. However, the respondent company should have considered the said treatment of eye particularly in Sankara Nethralaya for the aforesaid period without any hospitalization due to advance medical technology though the restriction of hospitalization for 24 hours has been diluted for certain disease if the insured are discharged on the same day but nothing has been mentioned about restriction of hospitalization in cases of treatment

of some ailments due to advance medical technology. In these circumstances, the respondent is liable to make payment of the admissible amount towards treatment cost incurred during hospitalization from 02.01.2013 to 06.01.2013 under the policy document and the respondent is not liable to make payment of the rest claims.

Under the aforesaid facts & circumstances, material on record and submission made and policy terms & condition, I am therefore of the view that the action/decision of the respondent company for not considering the claim made for the expenses incurred during the period of hospitalization from 02.01.2013 to 06.01.2013 is not justified and is not sustainable. Hence, the complainant is entitled for the admissible amount towards the claim made for the hospitalization period 02.01.2013 to 06.01.2013 as per policy document and the complainant is not entitled to get any claim for the claim period from 11.12.2012 to 14.12.2012, 01.03.2013 to 02.03.2013, 02.05.2013 to 04.05.2013, 06.08.2013 to 09.08.2013 and 20.09.2013 to 21.09.2013.

Hence, the respondent Oriental Insurance Co.Ltd. is directed to reopen/review the claim of the complainant towards her claim for hospitalization from 02.01.2013 to 06.01.2013 and pay the admissible amount against the treatment bills submitted by the complainant under the policy document within 15 days from date of receipt of the acceptance letter of the complainant failing which it will attract simple interest of 9% p.a. from the date of this order till

the date of actual payment of the admissible amount. In the result, the complaint is allowed in part to the extent of above observation.

Dated at Bhopal on 2nd day of February, 2015

Mr. Gaurav Soni.....Complainant

V/s

Oriental Insurance Co. Ltd., Indore.....Respondent

Order No.: IO/BHP/A/GI/0154/2014-2015 Case No.: BHP-G-050-1415-008

Brief Background:

Mr. Gaurav Soni (hereinafter called Complainant) obtained a Mediclaim Insurance Policy No. 151301/48/2012/7556 for the period 9.3.12. to 8.3.13 for Sum Insured of Rs. 600000/- for his spouse and dependent childrens with parents from Oriental Insurance Co. Ltd., Indore (hereinafter called Respondent).

As per the Complainant his mother Smt. Sita Devi Soni was treated for Chemotherapy and lodged claim for Rs.37,474/- and she was again hospitalized on 8.7.2012 for the treatment of malignant neoplasm of breast and lodged a claim for Rs. 156969/- out of which Rs. 53474/- were sanctioned after deducting Rs. 1,02,995/-. Further she was hospitalized in Choithram Hospital & Research Centre, Indore on 05.02.2013 and claimed Rs.1,08,836/- which was still pending for the payment. He represented to the Insurance Company but there was no response. Aggrieved with the decision, he approached this forum for justice.

The respondent have submitted the Self Contained Note on the date of hearing which reflects the gross negligence of the Respondent Company. The Respondent in their SCN have taken the plea that they have approved Rs.53,474/- against the claim amount Rs.1,56,972/- under reasonable and customary clause comparing various hospitals of same category of Mumbai.

<u>Observations:</u>

I have gone through the materials on record and submissions made during hearing and my observations are summarized below.

There is no dispute that the Complainant was covered under the above-mentioned policy taken from the Respondent. The Complainant made a complaint for his three different claims i.e. for Rs.37474/- which has already been settled by the TPA of the Respondent and paid Rs.37,220/- which is also admitted by the complainant and also appears from discharge voucher duly signed by the complainant. Second Claim was placed for the deductions of Rs.1,02,995/- wherein no action has been taken till hearing. In the third claim for Rs. 1,08,836/-, there was a mere dispute of age mentioned in the discharge card which seems to be a typing mistake and nothing else. All other papers have been found in order. The insurer's representative has conceded that the respondent company is ready to settle the claim and pay the admissible amount as per policy terms and conditions. In the circumstances, the Respondent is liable to review and settle the claim as per admissible amount in view of Policy terms and conditions.

The Respondent is directed to review and settle the claim after waiving the age related mistake and make payment of admissible amount as per policy terms and conditions within 15 days from the receipt of the consent letter from the complainant failing which it will attract a simple interest of 9% p.a. from date of this order till the date of payment.

Mr.Gurdeepsingh

Waba……Complainant

V/s

Oriental Insurance Co. Ltd.
……Respondent

Order No. IO/BHP/A/GI/0085/2014-2015
Case No :BHP-G-050-1415-0040

The complainant Mr.Gurdeep Singh Waba was covered under a individual Mediclaim Policy bearing no. 152109/48/2013/222 for the period 26.06.2012 to 25.06.2013 for sum assured Rs.4,00,000/- which was issued by the respondent. He lodged the mediclaim for about Rs. 4,50,000/- on the basis of medical bills towards his treatment cost before the respondent company in December 2012 but the same was pending without disclosing any reason and no information was given regarding his claim. It is further said that he was operated twice once for knees and second time for heart within span of one month (July 20012 to August 2012) and he was also treated further in Asian Heart Hospital on 05.09.2012 so it was his priority to take care of his life as compared to submit the documents for mediclaim. Being aggrieved from the action of the respondent company for not settling his claim, the complainant approached this forum for relief of payment of claim amount of Rs.4,59,000/-.

The insurer in their SCN dated 05.06/09.06.2014 have stated that the claim related to heart ailment has already been paid for Rs. 150842/- under the policy document against the total sum insured Rs.4,00,000/- and have contended that Knee joint replacement claim was reported for the hospitalization period 24.07.2012 to 02.08.2012 as 2nd Claim under policy no. 152109/48/2013/222 and documents were submitted after 126 days from date of discharge as against the policy condition for submission "within 07 days from date of discharge/ last consultation from the hospital." So, there was delay of 126 days in submission of claim documents for reimbursement and they had recommended the case for condonation of delay to DO/ RO/ HO but the competent authority was not convinced with the clarification offered by claimant for inordinate

delay of 126 days in submission of documents and disowned the liability without prejudice.

For the sake of natural justice, hearing was held at Bhopal office. The complainant was present with his wife to assist him as his representative as he was unable to speak. The complainant' wife as his representative as well as the insurer's representative Mr. Mahesh Khambia were heard as mediation was failed. The complainant's representative has narrated the facts as mentioned in the complaint and admitted about payment of Rs. 150842/- and has prayed to allow the balance amount under the policy document condoning the delay of submitting the claim as the delay was on account of heart ailment which was taken on priorty basis. On the other hand the insurer's representative simply stated that the claim was not considered due to the delay of 126 days in submitting the claim and for want of receipt of Rs.84,000/- .

<u>Findings & Decision:</u>

I have gone through the material placed on the record and submissions made on behalf of both the parities. It is admitted position that the one claim relating to heart ailment has already been paid for Rs. 150842/- under the policy document. The bill cum receipt dated 02.08.2012 clearly shows about receipt of amount of Rs.2,54,565/- by the hospital concerned Laud Clinic, Mumbai paid by complainant in which the amount of 84,000/- has been included as appears from calculation. Though, the receipt of 1,70,000/- of the said clinic has been filed but the above bill cum receipt cannot be

dislodged for taking into account about receiving the total amount Rs.2,54,565/-. The insurer's representative has clearly mentioned in the assessment sheet that if found payable an amount Rs. 84,565/- is considered as bill cum receipt, their liability comes to Rs. 2,49,158/- only. Since, the ground of repudiation as shown in the SCN as well as during hearing is delay of 126 days while the payment of Heart ailment treatment cost has been made after 100 days, so the principle of estoppels applies. Moreover, as per IRDA circular No. IRDA/HLTH/MISC/CIR/216/09/2011 dated 20.09.2011, it is clear that the insurers have been advised not to repudiate such claim on ground of delay in claim intimation/ document submission where the delay is proved to be for reasons beyond the control of insured. In the instant case, naturally the insured complainant suffered heart ailment after replacement of knee joint and again, he was required treatment in Asian Heart Hospital on 05.09.2012, so certainly, it was the priority to take care of the life and only on recovery, the complainant was able to lodge the mediclaim. So, the reasons shown for the delay of lodging the claim before the respondent company appears to be proper and reasonable and it should have been considered by the respondent company in settlement of the claim.

Under the aforesaid facts & circumstances, material on record, submissions made and policy terms & conditions, I am therefore of the view that the action of the respondent company for not considering the claim of the complainant towards expenses of Knee replacement on the ground of delay of 126 days is not justified and is not sustainable. Hence, the complainant is entitled for the balance

admissible amount Rs.2,49,158/- as balance sum insured under the policy document.

Hence, the respondent Oriental Insurance Co.Ltd. is directed to settle the claim towards expenses of Knee Replacement condoning the delay in the light of the IRDA circular and pay the balance admissible amount Rs,2,49,158/- (Rs. Two Lac Forty-nine Thousand One Hundred Fifty-eight only) as balance sum insured in accordance with the terms & condition of the policy document to the complainant within 15 days from the date of receipt of acceptance letter of the complainant failing which it will attract 9% simple interest p.a. from date of this order to the date of actual payment. In the result, the complaint is allowed to the extent of above balance admissible amount as balance sum insured only.

Dated at Bhopal on 10th day of December, 2014

Totla.....Complainant

V/s

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

Order No. IO/BHP/R/GI/0079/2014-2015 **Case No. BHP-G-044-1314-0610**

The complainant's father Mr. Ashok Kumar Totla was covered under Senior Citizens Red Carpet Insurance policy bearing No. P/201114/01/2013/003045 for the period from 22.09.2012 to 21.09.2013 for S.A. 1,00,000/- which was issued by respondent company. It is further said that the complainant had applied for a claim ID L.I./2013/201114/0202571 due to his father's hospitalization on 23rd March, 2013 but claim was repudiated by the insurance provider on frivolous ground stating the ground of Chronic Renal Failure which could be pre-existing prior to policy inception and misrepresentation/ non disclosure of material facts and also cancelled the policy. Being aggrieved from the action of the respondent, the complainant approached this forum for redressal of his complaint.

The complaint was registered and prescribed forms were issued. Complainant submitted the required prescribed forms duly signed by him but the respondent company did not file the self contained note rather have brought on record a letter dated 04.11.2014 mentioning therein that they have settled the claim of the above insured and also sent DD to the insured directly for Rs.21,832/- as full & final payment of the bills for hospitalization claim as per terms & conditions of the policy and prayed to close the case.

Mr.Jayesh Totla who presented himself as well as the representative of respondent company Mr.Ravi Tiwari were heard. 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 –

1. **The complainant is satisfied with the claim settled towards hospitalization vide claim no.202571 for the period of hospitalization from 23.03.2013 to 29.03.2013. The claim was settled for Rs.21,832/- against the lodged amount of Rs.78,552/- as per policy document.**
2. **The respondent company is ready to reinforce the policy after making payment of due premium amount by the complainant w.e.f. the date of cancellation of policy no. P/201114/01/2013/003045 for the period from 22.09.2012 to 21.09.2013 as full and final settlement of the grievance/ complaint.**

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

The complainant is satisfied with the claim settled towards hospitalization vide claim no.202571 for the period of hospitalization from 23.03.2013 to 29.03.2013. The claim was settled for Rs.21,832/- against the lodged amount of Rs.78,552/- as per policy document.

The respondent Star Health & Allied Insurance shall reinforce the policy after making payment of due premium amount by the complainant w.e.f. the date of cancellation of policy no.

P/201114/01/2013/003045 for the period from 22.09.2012 to 21.09.2013 as full and final settlement of the grievance/ complaint within 15 days from the date of receipt of acceptance letter from the complainant under intimation to this office.

Mr. Jitendra Jadhav

……Complainant

V/s

The Oriental Insurance Co. Ltd.
……Respondent

Order No. IO/BHP/A/GI/0152/2014-2015
Case No. BHP-G-050-1314-0697

<u>Brief Background:</u>

The complainant was covered under the Group Mediclaim Policy bearing no. 151100/48/2009/2734 as a beneficiary for sum insured Rs. 50,000/- for the period 29/09/2008 to midnight of 28/09/2009 issued to the M/s Curewell Hospital, Indore as an insured. It is further said that he underwent treatment in the Curewell hospital from 30.12.2008 to 08.01.2009. Thereafter, he lodged the claim before the respondent's TPA M/s Vipul Medicorp Pvt.Ltd. on 09/01/2009 and has submitted all the necessary documents which was not considered and claim was not paid nor any reply was given to him. Being aggrieved by the action of the respondent company,

the complainant approached this forum for redressal of his grievance towards making payment of Rs.13,598/-.

After registration of the complaint, the complainant submitted prescribed forms duly signed by him and but the respondent had not submitted SCN/reply rather has brought on record copy of letter dated 09.12.2014 only on date of hearing mentioning therein that the claim has been closed due to non compliance of queries by the insured and as per queries some documents were required which were not furnished by the complainant and they are in the process of searching the original file as the claim pertains the F.Y.2008-2009. The non filing of SCN clearly reflects the gross negligence of the respondent company.

FINDINGS & DECISION:

I have gone through the material placed on the record and submission made. The discharge card (xerox copy) shows about the date of admission of the complainant on 30.12.2008 and discharged on 08.01.2009 from the Curewell Hospital Pvt.Ltd., Indore and the said discharge card also shows treatment undergone by the complainant in the said hospital for the diagnosed ailment. The OPD form dated 30.12.2008 also shows about the requirement of admission of the patient in the said hospital. The pathological reports available on the record shows about investigation. The sonography was also done on 30.12.2008 of the patient as appears from the material available on the record. From the letter dated 09.12.2014, has clearly mentioned in his written submission dated 04.12.2014 that he has submitted all the requisite documents related to his claim as well as documents related to query of the insurer's TPA. From the letter dated 09.12.2014, it is clear that the

claim has been closed due to non submission of some documents which does not appear to be just and proper as the complainant has already submitted the requisite documents before the TPA of the company. In these circumstances and the submission made by the insurer's representative, the respondent is liable to settle the claim after reopen/ review the claim of the complainant on the basis of documents already submitted or on submission of required documents if not submitted earlier.

Hence, the respondent Oriental Insurance Co.Ltd. is directed to reopen/review and settle the claim of the complainant on the basis of documents already submitted or on submission of required documents if not submitted earlier in accordance with the terms & condition of the policy document within one month from the date of receipt of this order under intimation to the complainant and to this forum. In the result, the complaint is allowed to the extent of above observation.

Mr.K.C.Jain ……

…….Complainant

V/s

New India Assurance Co. Ltd.
…….Respondent

Order No. IO/BHP/A/GI/ 077/2014-2015
Case No : GI/NIA/1201/74

The complainant's wife Mrs.Sulochana Jain was covered under a mediclaim policy bearing no. 450700/34/10/11/00000376 for the period 27.05.2010 to 26.05.2011 for sum assured Rs.1,00,000/- which was issued by the respondent company. He had preferred a mediclaim for Rs. 1,03,729/- on the basis of the bill towards treatment cost of his wife in CHL Apollo Hospital, Indore which was processed and settled for Rs.57,524/- against previous settled amount Rs.58,884/- vide discharge voucher dated 17.05.2011. It is further said that the TPA has applied proportionate deduction formula (in proportion to actual room rent paid and entitled room rent as per 2.1) for deductions for charges payable under 2.3 and 2.4 while he was pleading to allow him the lower category of package of Rs.54,000/- in which the room rent applicable was Rs.900/- per day while he had opted for package of Rs.70,000/- at that time due to emergency of surgery as bed for Rs.900/- was not available. Being aggrieved with the action of respondent company, he approached in this forum for redressal of his complaint for making payment of balance amount of Rs.23,132/-.

The insurer in their reply dated 02.12.2012 had taken the plea that the claim was settled under the policy terms & conditions no. 2.1on the basis of entitlement of room rent @ 1% of sum insured which was Rs.1,000/- per day as sum insured was Rs.1,00,000/- and the deductions were made as per policy conditions and the admissible amount Rs.57,524/- was paid to the complainant and the payment made to the complainant was totally correct.

For the sake of natural justice hearing was held at Bhopal Office. The complainant did not appear but has sent his written statement. The insurer's representative Mr.P.K.Mehta was heard as mediation could not be done due to absence of complainant. The complainant has reiterated the facts in written submission as mentioned in the complaint and has given emphasis that no where, it is mentioned proportionate deduction under 2.3 and 2.4 but it clearly states that charges shall be limited to the charges applicable to the entitled category and difference amount has been worked out as Rs.21,132/- which should be paid to him. On the other hand, the insurer's representative has laid emphasis that the deduction has been made properly in accordance with terms & conditions of the policy document in view of the entitlement of the room rent and admissible amount Rs. 57,524/- has been paid to the complainant and nothing more is payable.

<u>Findings & Decision:</u>

I have gone through the material placed on the record, written statement of the complainant and submissions made by insurer's

representative and policy terms & conditions. The clause 2.1 clearly provides about entitlement of the room rent not exceeding 1% of sum insured excluding bonus per day or actual amount whichever is less and as per policy terms and conditions, the amounts payable under clause 2.3 and 2.4 shall be at the rate applicable to the entitled room category and if the insured opts for higher room rent, then the charges shall be limited to the charges applicable to the entitled category and no payment shall be made under 2.3 other than part of the hospitalization bills. The discharge voucher duly signed by the complainant on 29.11.2012 clearly shows that payable amount 57,524/- has been paid to the complainant against his bill amount 103729/- deducting Rs.46,205/-. From the policy document, it appears that the complainant/policyholder had opted Zone III but the insurer has not brought on record the zone descriptions which wasfelt necessary for deciding this case and the required zone description from the respondent was called for which was sent through mail dated 19.11.2014. It has been found that the complainant had opted Zone III which is in order and nothing co-payment is applicable in claim amount in view of classification of the zones as the complainant's wife was treated in Indore which comes in Zone III while the 10% of co-payment is applicable availing treatment in Zone I.

From perusal of re-assessment discharge voucher of the TPA M/s Vipul Med.Corp.Pvt.Lrd.available on the record, it is found that a wrong deduction of Rs.44,845/- has been made under various bills showing reasons for deduction. I am of the opinion that as per terms & conditions of the policy document, there should not be co-payment of 20% and under radiology head, 50% deductions comes to

Rs.3750/- and similarly under OT consumables 50% deductions should be Rs.10,100/-. Thus, total deduction comes to Rs, 31,196/- in place of Rs.44,845/- as mentioned in deductions column. Thus, total admissible claim amount comes to Rs.72,533/-. The record shows that the respondent has already made payment of Rs. 57,524/- to the complainant, so, a difference amount of Rs. 15,009/- only is found payable to the complainant in accordance with the terms & conditions of the policy document and the deductions were not proper and not in accordance with the policy document. In these circumstances, the respondent is liable to make payment of admissible balance amount of Rs.15,009/- to the complainant.

Under the aforesaid facts & circumstances, material on record and submissions made and policy terms & conditions, I am, therefore of the considered view that the decision of the respondent company towards making payment of Rs.57,524/- only and deducting some admissible amounts also is not just and proper and is not sustainable and the complainant is entitled to balance admissible amount Rs.15,009/- only towards treatment cost under the terms & conditions of the policy document.

Hence, the respondent The New India Assurance Co. Ltd. shall pay Rs. 15,009/- (Rs.Fifteen Thousand and nine only) as balance admissible amount towards treatment of complainant's wife in accordance with terms & conditions of the policy document to the complainant within 15 days from date of receipt of acceptance letter of the complainant failing which it will attract simple interest of 9% from the date of this order till the date of actual payment. In the

result, the complaint stands allowed to the extent of above amount only.

Mr. K.L.Agrawal .....Complainant

V/s

Oriental Insurance Company Ltd.
.....Respondent

Order No. IO/BHP/A/GI/0097/2014-2015 Case No. BHP-G-050-1314-658

The case of complainant in short is that the complainant Mr.K.L.Agrawal was retired on 31.08.1997 from the services of the Oriental Insurance Co.Ltd as Divisional Manager from D.O.Kolhapur. On his retirement, he was enrolled under Group Mediclaim policy for retired officers. He has been paying annual premiums regularly. It is further said that his wife Mrs. Prem Lata Agrawal was examined in OPD of Narmada Trauma Centre, Bhopal by Dr. Rajesh Sharma, MBBS, D. Ortho. She was hospitalized under his advice, care and supervision on 31.05.2010 at 6.30 pm and was discharged on 01.06.2010 7.45 pm. This has been certified by attending surgeon and doctor of hospital vide certificate dated 15.03.2011 the claim papers and bills for Rs. 11,163/- were submitted on 20.06.2010 for hospitalization and supplementary bill for Rs. 21,185/- were submitted on 18.08.2010 for post hospitalization treatments for two months under cover of our letter dated 16.08.2010 which was

wrongly repudiated by the respondent company. Being aggrieved by the action/decision of the respondent company, the complainant approached this forum for relief of payment of Rs. 31,348/- towards treatment cost as per the policy document.

The respondent in their SCN have taken the plea that as per opinion of Senior Orthopedic Surgeon, it was found that it was not a case for hospitalization as based on the investigations and treatment documents and all the prescribed treatment could have been very well taken as outdoor patient and as per treatment certificate dated 11.09.2010 issued by Narmada Trauma Centre Pvt. Ltd. that Mrs. Agrawal was not advised for admission in the hospital for treatment of the ailments of complaints she had on 31.05.2010 and as such the claim of the complainant was repudiated Both the parties were heard as mediation was failed. The complainant has narrated the facts as mentioned in complaint. The insurer's representative has laid emphasis that it was case of OPD and admission was not required in the hospital.

FINDINGS & DECISION:

I have gone through the material placed on the record and submissions made. Though the respondent company has not made any dispute about the issuance of the policy and coverage of wife of the complainant Mrs. Prem Lata Agrawal but since the policy document is the basis of case and is a vital document which is highly essential in this case. However, in absence of the policy document or any other document showing the policy no. and coverage period, the order in being passed on the merit in view of the material placed on the record. From perusal of the certificate dated 11.09.2010 issued by Narmada Trauma Centre Pvt.Ltd. Bhopal with respect to the complainant's wife Mrs. Prem Lata Agrawal towards treatment given

in the said hospital on 31.05.2010 from 6.30 pm and discharged on 01.06.2010 on 7.45 pm, it is apparent that it has clearly been mentioned by the hospital authority that doctor had not advised for the admission. The discharge card of the complainant's wife clearly shows about the condition on admission as C/O pain over back only and no any other ailment and several investigations were done like MRI etc. and some medicines were advice on 08.06.2010 and the procedure performed has been shown as conservative. The complainant has not filed any prescription to show the requirement of admission in the said hospital. The complainant has brought on record the certificate of Dr. Rajesh Sharma issued on 15.03.2011 to show that the patient was advised for hospitalization on his advice on 31.05.2010 which appears to be after thought and has been filed only to remove the ground of repudiation so, it cannot be considered. Apart from it, the certificate of the senior orthopedic surgeon Dr. Ashish Malhotra brought on record by respondent clearly shows that in the above case, the admission of the patient Mrs. Prem Lata Agrawal in the hospital was not justified and the opinion for diagnosis low back pain was subjective diagnosis and not a definite diagnosis and outdoor treatment could have been given and investigations could have been done on the outdoor basis and the OPD paper of the concerning doctor dated 31.05.2010 does not show that the doctor has advised any admission to the patient. Thus it is established that it was the case of OPD treatment and the said admission in the hospital was not required.

Under the aforesaid facts & circumstances, material on record and submissions made, I am therefore of the view that the decision of the respondent company to repudiate the claim of the complainant is perfectly justified and is sustainable. Hence, the

complainant is not entitled for the relief as prayed. In the result, the complaint stands dismissed.

Mr. Kalyan Singh Sikarwar……Complainant

V/s

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

Order No. IO/BHP/R/GI/0112/2014-2015 Case No. BHP-G-044-1415-0029

The complainant was covered under a Mediclaim policy bearing no. P/161123/01/2013/002201 for the period from 01/02/2013 to 31/01/2014 for sum assured Rs.2,00,000/- which was issued by the respondent company. It is further said that he was admitted in the S.M. Hospital, Gwalior for Lt. Gynaecomazia and Lipoma from 23.05.2013 to 25.05.2013. Thereafter, he lodged a mediclaim for Rs.24,541/- towards his treatment cost before the respondent company but his claim was repudiated. Being aggrieved by the action of respondent company the complainant approached this forum for the relief of making payment of his claim of Rs.24,541/- towards his treatment cost.

The insurer in their reply/SCN have stated that the insured had renewed his third year of insurance policy with a gape of 4 months, therefore third year policy will be considered as a fresh hospital. It is further stated that as per specialist opinion ` patient has undergone webster's operation for Gynaecomastia and also excision of lipoma

arm. Gynaecomastia is a benign enlargement of male breast and is harmless and is not a disease and non malignant swelling and does not require surgery unless causing complications. As per exclusion no. 7 "the cosmetic or aesthetic treatment" is not covered under the policy, hence the claim has been rejected.

The complainant Mr. Kalyan Singh Sikarwar who presented himself as well as the representative of respondent company Mr. Ravi Tiwari were heard for mediation. Sincere efforts were made during mediation to resolve the subject matter of complaint. 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 claim.In view of the above facts, circumstances & mutual agreement, I feel just, fair & equitable to make following recommendations about settlement of the claim as full and final on the basis of mutual agreement between both the parties.

The respondent company Star Health and Alied Insurance Co.Ltd. is directed to pay Rs. 12,270/- only (Twelve thousand two hundred seventy) only to the complainant towards his treatment cost on the basis of the claim made under the policy document as full and final settlement of the grievance/ complaint within 15 days from the date of receipt of acceptance letter from the complainant under intimation to this office failing which it will attract simple interest of 9% p.a. from date of this order till date of actual payment.

Dated at BHOPAL on 10th day of January, 2015

Mr. Krishnan

Nair.....Complainant

V/s

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

Order No. IO/BHP/A/GI/0120/2014-2015
Case No.GI/OIC/1010/83

Brief Background:

The complainant was covered under Happy Family Floater Policy 151401/48/2010/1969 for sum insured Rs.1,00,000/- for the period 30.07.2009 to 29.07.2010 which was issued by the respondent company. He lodged his claim for Rs. 38,000/- towards treatment cost of his wife Prasanna Nair before the company which was rejected merely for the reason that his earlier policy of New India Assurance Co. was valid from 2002 under which no claim was made till 2010 and transferred to the respondent company in year 2009. He also made representation before the respondent company but his claim was not considered. Being aggrieved by the action of TPA/respondent Company the complainant approached this forum for the relief of making payment of his claim of Rs.38,000/-.

The insurer in their SCN have taken the plea that the insured approached them for insurance and proposal form was filled by himself and has not given any details of past insurance and remark was also given by them that no old insurance policy has been given for continuity benefit and this was the new proposal and as per

exclusion 4.3 the illness (hysterectomy) is excluded for 2 years from the policy coverage and claim is not payable according to policy condition.

For the sake of natural justice, hearing was held at Bhopal Office. The complainant did not appear and has sent letter dated 11.11.2014 enclosing some documents for consideration. The insurer's representative has taken the stands as mention in the SCN for rejection of the claim.

FINDINGS & DECISION:

I have gone through the material placed on the record and submissions made. From perusal of the proposal form (xerox copy) it is observed that is has been clearly mentioned that no continuity for given policy and new proposal and from above policy document itself, it is apparent that the policy document does not contain any previous policy no. and the complainant has admitted that earlier he had policy of New India Assurance Co. from 2002. As per policy terms and conditions 4.3 there is waiting period of 2 years for hysterectomy meaning thereby that the above illness has been excluded for 2 years from the policy coverage and in this case, the policy taken from respondent company was running in the first year and was rightly treated as new policy. In these circumstances the respondent company is not liable to make payment of the claim as prayed for.

Under the aforesaid facts & circumstances, material on record and submissions made, I am therefore of the view that the

action/decision of the respondent company to reject the claim of the complainant is justified and is sustainable under the policy. Hence, the complainant is not entitled for the relief as prayed for. In the result, the complaint stands dismissed.

Dated at Bhopal on 18th day of February, 2015

Mrs. Kusum Sankhla.....Complainant

V/s

United India Insurance Co. Ltd., Indore.....Respondent

Order No.: IO/BHP/A/GI/0137/2014-2015 Case No.: BHP-G-051-1415-0122

Brief Background

Mrs. Kusum Sankhla (hereinafter called Complainant) obtained a Mediclaim Insurance Policy No. 190300/48/13/00000881 for the period 6.6.2013 to 5.6.14 for Sum Insured of Rs. 2,00,000/- each for self and his husband Mr. Murlidhar Sankhla and her dependent childrens from United India Insurance Co. Ltd., Indore (hereinafter called Respondent).

As per the Complainant she was hospitalized in Suyash Hospital, Indore from 4.6.2013 to 7.6.2013 and preferred a claim for Rs. 34128/- with TPA of the Insurance Company who deducted Rs. 1800/- as procedure charges/bills after 30/60 days. Further His husband Mr. Murlidhar Sankhla admitted in Geetanjali Hospital, Indore and Sri Aurobindo Institute of Medical Sciences, Indore from 14.09.13 to 14.09.2013 and preferred a claim for Rs. 30988/- where

Rs. 2300/- were deducted on one day room charges as excess billing, nursing charges and other misc. expenses with no details. She represented for her deductions of Rs. 1800/-+2300/- totaling Rs. 4100/- from the Insurance Company but there was no response. Aggrieved with the decision, she approached this forum for justice.

As per SCN the Respondent contended that on receipt of hospital bills of Rs. 34128/- its TPA had examined the papers and found that the following bills are not payable as Rs. 1800/- under procedures charges which already included in hospital bill amount. In the hospitalization bills of her husband Mr. Murlidhar Sankhla, Rs. 500/- as other misc. charges, Rs. 300/- as nursing charges as excess billing made by the hospital and Rs. 1500/- as room rent as excess billing made by the hospital. It reiterated that its TPA has genuinely deducted the above amount due to excess billing by the hospital. Hence the complaint may please be dismissed.

Both the parties were heard and mediation was failed who have narrated the facts as mentioned in the complaint and SCN respectively.

<u>Observations:</u>

I have gone through the materials on record and submissions made during hearing and my observations are summarized below.

There is no dispute that the Complainant was covered under the above-mentioned policy taken from the Respondent. At the time of personal hearing, documents regarding hospitalization of the complainant were not placed before me either from the complainant or from the Respondent. As per Respondent an amount of Rs. 1800/- already included in Hspital Bills hence the amount was deducted. Further, the hospitalization bills of complainant husband

were placed before me of the different hospitals, where misc. charges of Rs. 500/- and Excess billing on account of room rent and Rs. 300/- were deducted as nursing charges excess billing from the hospital. I have gone through the hospital bills submitted at the time of hearing and found that the deductions were made as per policy conditions and there is no scope to get the medical expenses beyond policy schedule issued to the complainant.

Considering to the above facts, I find no reason to interfere in the decision taken by the Respondent as per policy condition. Hence, the complainant is not entitled any relief from the Respondent in this regard. Hence, the complaint stand dismissed without any relief.

Dated at Bhopal on 3rd Day of March, 2015

Mr. Lalit Kale
……Complainant

V/s

Oriental Insurance Co. Ltd.
……Respondent

Order No. IO/BHP/R/GI/0131/2014-2015 Case No. BHP-G-050-1415-0103

<u>Brief Background</u>:

Mr. Lalit Kale (hereinafter called Complainant) obtained a Happy Family Floater Insurance Policy No. 151401/48/2014/1849 for the period 06.07.13 to 05.07.2014 for Sum Insured of Rs. 3,50,000/- for self and his father Mr. Sudhir Kale from Oriental Insurance Co. Ltd., DO-IV, Indore (hereinafter called Respondent).

As per the Complainant his father Mr. Sudhir Kale hospitalized in Unique Super Speciality Centre, Indore from 26.9.13 to 27.9.13 for the treatment of #colles (left). He preferred a claim for Rs.18,620/- with the TPA of Insurance Company which was sanctioned only for Rs.13,050/- after deducting Rs.3195/- under various heads. He represented for his deducted amount but the reasons mentioned by the Insurance Company do not seem genuine. Aggrieved with the decision, he approached this forum for justice.

Vide SCN dated 22.1.15, the respondent submitted that an amount of Rs. 5,570/- was deducted on various heads like Registration charges, MLC charges, Glucometer Charges, consumables, preparation charges, telephone charges, part of room rent, excess Dr. fee and co-payment. The deductions were made as per policy condition and insured is not entitled for any claim.

For the sake of natural justice, hearing held today dated 27.02.2015 at Indore Camp office and sincere efforts were made during mediation to resolve the subject matter of complaint and the complainant Mr. Lalit Kale who presented himself as well as the representative of respondent company Mr. S. L. Dubepuriya were heard. 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 for Rs.1,095/- (Rupees One Thousand Ninety Five) only as full and final settlement of the grievance/complaint.

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

The respondent Oriental Insurance Co. Ltd. is directed to pay Rs.1,095/- (Rupees One Thousand Ninety Five) Only to the complainant as full and final settlement of the grievance/ complaint under the policy document within 15 days from the date of receipt of acceptance letter from the complainant failing which it will attract a simple interest of 9% p.a. from the date of this order till the date of actual payment and submit compliance report to this office.

Dated at INDORE on 27th day of February, 2015

Mr. M. H. Gupta
.....Complainant

V/s

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

Order No. IO/BHP/A/GI/0145/2014-2015 Case No.BHP-G-050-1314-0701

<u>Brief Background:</u>

The complainant Mr. M. H. Gupta was covered as a beneficiary under a Group Mediclaim Policy -Tailor made with floater bearing no. 361500/46/13/8500000005 for the period 01.04.2013 to midnight of 31.03.2014 with his family members which was issued by the National Insurance Co.Ltd. in the name of Oriental Insurance Co.Ltd.

as insured for the staff and retired employee of insured. It is further said that the complainant developed severe pain in his lower and mid back somewhere on 11.09.2013 so he consulted Dr.Anand Gupta orthopedic surgeon of Bombay Hospital, Indore who tried to control his pain but it could not be controlled and therefore he advised him to admit him in Bombay Hospital, Indore to control the pain by treatment and on the basis of investigation, it was diagnosed the fracture of D-11 vertebrae and when he felt little comfortable from the severe pain his medical consultant decided to discharge him from the hospital and recommended medicines for further treatment. The total period spent in the hospital was 21 hours. He lodged the claim towards treatment cost Rs.24,668/- which was repudiated by the Respondent Company invoking the policy conditions 2.3 & 4.10 of the group mediclaim policy. He made representation to R.O. also but their decision was maintained. Being aggrieved with the decision of the Respondent, he approached this forum for settlement of his claim.

The Respondent vide its SCN have contended that the complainant was diagnosed for Osteoporotic Collapse with anterior wedging # D11. He was hospitalized on 18.09.2013 at 03.14 hours and got discharged on 19.09.2013 at 10.31 hours as per discharge summary that reveals that the hospitalization was less than 24 hours which is an exclusion under clause no. 2.3. Further, the Respondent have taken the plea that there was no treatment and no admission was required as per expert doctor opinion. The case was dealt under conservative management as evident from the discharge summary, so it falls under exclusion no. 4.10 of the policy. As such, the claim

was appropriately repudiated and the complaint deserves to be quashed.

For the sake of natural justice hearing was held at Bhopal Office. Both the parties were heard as mediation was failed. The complainant narrated the facts as mentioned in the complaint and the insurer's representative has taken the stand as mentioned in the SCN/reply.

Findings & Decision:

I have gone through the material on record and submissions made by both the parties. The complainant has himself admitted in his letter dated 20.01.2014 sent to the G.M personnel of the respondent company that the total period spent in the hospital was 21 hours. In this way, he has not asserted that hospitalization period was more than 24 hours as required under the policy terms & conditions. The above facts also find support from the entries made in the discharge summary of the Bombay Hospital, Indore showing date of admission 18.09.2013 time 03.14 and date of discharge on 19.09.2013 time 10.31 am. Secondly, the discharge summary itself clearly shows that no active treatment was given to the complainant during hospitalization except the investigations and was dealt under conservative management. The discharge summary does not show about administrating any medicines on 18.09.2013 rather was advised some medicines with belt at the time of discharge. For the sake of argument, if it is taken into consideration that the complainant was given some medicines even then the provisions of hospitalization for more than 24 hours is not fulfilled. The opinion of Dr. Ashish Mehrotra, M.S.D.Orth. also clearly shows that the investigations could have been done on the outdoor basis and there

was no need for the admission. Thus, it is established that the treatment during the said hospitalization does not fulfill the condition of 2.3 regarding hospitalization for more than 24 hours and the patient was admitted for diagnostic tests only and no any active treatment was given which comes under the exclusion clause no.4.10 of the policy. Apart from it, on close perusal of the policy document brought on record, it is apparent that the above group mediclaim policy – tailor made with floater was issued in the name of Oriental Insurance Co.Ltd. as insured for the staff and retired employees of the said company by National Insurance Co.Ltd. but the complainant has made every correspondence with the insured Oriental Insurance Company and has also lodged claim in this forum after being aggrieved by the decision of the Oriental Insurance Co.Ltd. while the policy issuing company the National Insurance Co.Ltd. should have been made respondent which a serious infirmity.

Hence, keeping in view the entire facts and material on record, I find that the there is no merit in the complaint and is liable for dismissal. In the result, the complaint stands dismissed accordingly.

Dated at Bhopal on 10th day of March, 2015

Dr. M.C.Saxena

…….Complainant

V/s

United India Insurance Company Ltd……Respondent

Order No. IO/BHP/A/GI/0101/2014-2015
Case No. GI/UII/1203/80

Award

Brief Background:

Being aggrieved by the action/ decision of the respondent company, the complainant Dr. M.C. Saxena as a policy holder under Individual Health Insurance Policy no. 190306/48/10/97/00000031 for the period 22.04.2010 to 21.04.2011 covering himself and his wife and mother approached this forum for redressal of his grievance towards making payment of Rs. 30,125/- for undergoing treatment of his wife Mrs. Kirti Saxena for Uncontrolled T2DM and HT during period of hospitalization in Viraj Hospital, Vadodara from 12.04.2011 to 15.04.2011.

The respondent in their reply/ SCN have taken the plea that the patient was admitted in Viraj Hospital Vadodara for treatment weakness, giddiness, headache, vertigo since few weeks. She discharged from hospital on 15.04.2011 and various tests were performed and she was diagnosed to have controlled hypertension and diabetes and she was treated by Inj of Vit B12 and oral anti hypertensive and medicines for diabetes. It is further stated that the

purpose of hospitalization was do various tests which could be done as OPD procedure and confinement to hospital was not required in this case hence claim is not admissible as per policy condition no. 4.10.

For the sake of natural justice, hearing was held at Indore Camp office. Both the parties were were heard as mediation was failed. The complainant has reiterated the facts as mentioned in the complaint. Insurer's representative has taken the stand as made in the SCN and laid emphasis that during the investigation it was found as OPD treatment, so claim was not payable under clause 4.10 as hospitalization was not required.

FINDINGS & DECISION:

I have gone through the material placed on the record and submission made. From perusal of the discharge ticket (xerox copy) of Mrs. Kirti Saxena issued by Viraj Hospital Vadodara clearly shows that she was admitted in the said hospital on 12.04.2011 on account of symptoms of weakness, giddiness, headache, vertigo since few weeks increasing in nature and was diagnosed uncontrolled T2DM and HT and required treatment were given including injection of Vit B12 and investigations were also done. The respondent company has taken the plea that hospitalization was not required and the treatment could be given as OPD but it is the concerned doctor of the said hospital, who was only competent to decide about admission of patient Kirti Saxena in the said hospital on the basis of the physical condition of the patient, symptoms and required treatment to cure the patient. The patient remained in the hospital for about four days and it is not expected from any person that he/ she will admit in the hospital only for taking some medicine unless the sufferings are grave. The respondent have mentioned the

condition 4.10 for repudiation of the claim and submission was made that it was found as OPD treatment during investigation but clause 4.10 provides about 'injury or disease directly or indirectly caused by or contributed to by nuclear weapon/ materials' which is a exclusion clause and has no relevance with any OPD treatment as claimed by respondent. Thus, I do not find any force in the contention of insurer's representative. Though, first prescription to show the requirement of admission in the hospital has not been filed by the discharge card cannot be dislodged to decide the claim.

Under the aforesaid facts & circumstances, material on record and submissions made and policy terms & conditions, I am therefore of the view that the decision of the respondent company to repudiate the claim is not just and proper and is not sustainable. Hence, the complainant is entitled for the relief as prayed for to the extent of admissible amount only as per the terms and conditions of the policy. In the result, the complaint is allowed to the extent of admissible amount only.

Hence, the respondent company United is directed to review/ reopen the claim of the complainant and make payment of admissible amount towards treatment cost incurred as per policy terms and conditions to the complainant within 15 days from the date of receipt of the acceptance letter of the complainant failing which it will attract simple interest of 9% p.a. from date of this order to the date of actual payment.

Dated at Bhopal on 13th day of January, 2015

Mr. Mahesh Prasad Dixit.....Complainant

V/s

United India Insurance Co. Ltd., Indore.....Respondent

Order No.: IO/BHP/A/GI/0128/2014-2015 Case No.: BHP-G-051-1415-0082

Award

Brief Background

Mr. Mahesh Dixit (hereinafter called Complainant) obtained a Mediclaim Insurance Policy No. 190300/48/11/00003818 for the period 23.02.2012 to 22.02.2013 for Sum Insured of Rs. 2,00,000/- each for self and his wife Smt. Vijay Laxmi Dixit from United India Insurance Co. Ltd., Indore (hereinafter called Respondent).

As per the Complainant his wife Smt. Vijay Laxmi Dixit admitted in CHL Hospital, Indore from 29.01.2013 to 01.02.2013. After discharge from the hospital, he preferred a claim for Rs. 61496/- to the TPA of Insurance Company which was settled only for Rs. 39580/- The deductions were made on account of Room Rent, Ambulance Charges, Infusion pump and others. He represented to the TPA for the deduction of Rs. 17561/- for unnecessary deductions. But there was no response from the TPA. Aggrieved with

the decision, he approached this forum for justice. His wife expired on 27.11.2013.

The Respondent in its reply-dated 13.01.2015 stated that in the captioned matter, the Complainant's wife Smt. Vijaylaxmi Dixit was admitted in CHL Hospital, Indore from 29.01.2013 to 01.02.2013. A claim for Rs. 61496/- was preferred to the TPA which was settled for Rs. 39580/- The deductions were made by the TPA as Rs. 2500/- one day excess billing for room rent, Rs.1000/- as ambulance charges, Rs. 2700/- towards infusion pump and Rs. 11361/- which has already claimed in final bills, the insured submitted bills twice. It is reiterated that the deductions were made as per policy terms and conditions.

For the sake of natural justice hearing was held at Indore Camp Office. The Complainant was present in person and the Respondent was represented by Mr. Kishore Shete, Dy. Manager of United India Insurance Co. Ltd., Indore

<u>Observations:</u>

I have gone through the materials on record and submissions made during hearing and my observations are summarized below.

There is no dispute that the Complainant was covered under the above-mentioned policy taken from the Respondent. It is observed that the payment made by the respondent is in accordance with policy terms & conditions as full and final and deductions made are proper. The complainant was not present to say anything about the said deductions. Hence, the complaint is dismissed without any further relief to the complainant.

Dated at Indore on 26th Day of February 2015.

Manish Chhajed

.....Complainant

V/s

United India Insurance Company Ltd.
.....Respondent

Order No.IO/BHP/GI/A/0143 /2014-2015
Case No. GI/UII/1303/67

Brief Background:

The complainant had taken a Family Medicare Policy bearing no. 190402/48/11/06/00002524 for sum insured Rs.4,00,000/- on payment of yearly premium of Rs.8362/- for the period of insurance 27/03/2012 to 26/03/2013 from the respondent company. It is further said that he lodged the claim before the TPA of the respondent company for hospitalization treatment cost but they did not settle the claim till now. Being aggrieved by the action of respondent company, the complainant approached this forum for the relief of claim amount Rs. 40,507/-.

The insurer has contended in their SCN that the complainant suffered from Single episode of Unprovoked Seizure Disorder (GTCS) and admitted in Suyash Hospital and Bombay Hospital in Indore. Both the hospitalizations were for less than 24 hours and the panel Doctor of TPA opined that the hospitalizations were only for diagnostic purpose and not for any active treatment. Hence the expenses are not payable under policy condition no. 2.3 and 4.10.

For the sake of natural justice, hearing was held at Bhopal Office and both the parties were heard. The complainant narrated the facts as mentioned in the complaint and has also filed written submission. The insurer's representative has taken the stand as mentioned in the SCN regarding repudiation of the claim.

FINDINGS & DECISION:

I have gone through the material available on record and the submissions made by the respondent.

It is evident from the discharge cards of Suyash & Bombay Hospitals and bills & test reports that the complainant was admitted for diagnostic purpose and not for any active treatment. Further both the hospitalization was found less than 24 hours and the policy condition No. 2.3 and 4.10 imposed by the Respondent is quite reasonable. Hence, I do not find any interference in the matter. The complaint is dismissed without any relief.

Dated at Bhopal on 9th Day of March, 2015

Mr. Manish Kala .....Complainant

V/s

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

Order No. IO/BHP/A/GI/0149/2014-2015 Case No. GI/UII/1302/57

Brief Background:

The complainant had taken a Group Mediclaim (Tailor Made) policy bearing no. 190300/48/11/41/00002611 for sum insured Rs. 3,00,000/- for the period 04/11/2011 to 03/11/2012 covering himself, his wife, daughter and son. The complainant son Master Bhavya Kala aged 8 years was hospitalized in Jeevan Jyot Hospital, Thane for the treatment of Acute Leukemia(Myeloid) from 1.9.12 to 4.9.12. He was shifted to Horizon Hospital, Thane due to Septic Shock, AML, Cardiac Arrest and Pulmonary Edema with complaint of unconsciousness and respiratory distress. Unfortunately he was expired on 4.9.12. A claim for Rs. 154345/- was lodged with the Respondent which was rejected under policy clause 4.1 as pre existing disease. The patient was also hospitalized in Unique Hospital, Indore from 3.8.12 to 4.8.12 for multiple neck glands.

The respondent in their SCN have asserted that the complainant was having insurance policy from New India Assurance Co. Ltd. which was expired on 27.07.2011 and there was a break of 3 months. Further a fresh policy was issued for the period 04.11.2011 to

03.11.2012 by the respondent. The policy is to be treated as a fresh policy, hence the claim attracts exclusion clause no. 4.1 of the policy which read as "All diseases/injuries which are pre-existing when the cover incept for the first time. For the purpose of applying this condition, the date of inception of the initial Mediclaim Policy taken from any of the Indian Insurance Companies shall be taken, provided the renewals have been continuous and without any break." The respondent have further contended that as per claim documents, it was found that the patient was undergoing treatment on OPD basis since 09.09.2011 and as per their medical expert opinion this case was a sequel to recurrent respiratory ailment and the hospitalization was for the treatment of Acute Myeloid Leukemia as per discharge card as such the claim was rejected due to exclusion clause 4.1 of the policy document and prayed to dismiss the complaint.

For the sake of natural justice, hearing was held at Bhopal office. The complainant was absent but has submitted the written submission and the representative of respondent company was heard who has taken the stand as mentioned in reply/SCN.

FINDINGS & DECISION:

I have gone through the material placed on the record including the written submission and submission made by insurer's representative. From the record it is found that the complainant's son Bhavya Kala was covered under the policy taken from New India Assurance Co. Ltd. from the period 28.07.2010 to 27.07.2011 and thereafter his son was also covered under the aforesaid policy issued by the respondent company. The prescription dated 09.09.2011 filed on behalf of respondent clearly shows that the prescription contained the name Dhruv and not Bhavya Kala and

date has been mentioned in pen with overwriting over the date but the year mentioned appears to be '12' and above this date the stamp '9 Sep 2011' is affixed which appears to be manufactured. The said prescription contained the date seal of 18.07.2012 and 25.07.2012 showing follow up which appears to be unnatural. The prescription does not show any symptom of the patient except some general medicines. This prescription cannot be connected with the patient Bhavya Kala, so it cannot be considered on the basis of above facts. The all other medical documents brought on record on behalf of the respondent pertain to year 2012 from month July, August and September i.e. after inception of the policy issued on 04.11.2011 by the respondent. The respondent has failed to produce any cogent medical document/ prescription/ treatment paper to show about any previous ailment as pre-existing like heart, lung, cancer ailment (Leukemia) etc. Thus, it is established that the respondent have failed to prove that the insured late Bhavya Kala was having any pre-existing disease before inception of the policy. The Respondent have also failed to produce any opinion from an expert in their defence.

Hence, on consideration of aforesaid facts & circumstances, material on record and submissions made, I am of the considered view that the decision of the respondent company to reject the claim of the complainant is not justified and is not sustainable. Hence, the complainant is entitled for the admissible amount in accordance with the terms & conditions of the policy document towards his claim.

Hence, the respondent United India Insurance Co. Ltd. is directed to review and settle the claim and pay admissible amount in

accordance with the terms & condition of the policy document to the complainant within 15 days from the date of receipt of acceptance letter of the complainant failing which it will attract 9% simple interest p.a. from date of this order to the date of actual payment. In the result, the complaint is allowed to the extent of above admissible amount only.

Dated at Bhopal on 10th day of March 2015

Shri Manish Malik
.....Complainant

V/s

Max Life Insurance Co.Ltd.
.....Respondent

Order No.IO/BHP/A/LI/0264/2014-2015 Case No. BHP-L-032-1415-0432

Brief Background:

The complainant had taken policy bearing no. 741265235 and yearly premium of Rs.25,000/- from the respondent company. It is further said that he wanted to surrender the policy for which he wrote to the company but they did not pay any heed to his request. Being aggrieved by the action of respondent company, the complainant approached this forum for payment of surrender value under the policy.

The respondent have stated in their SCN dated 01.12.2014 that they are ready to pay the surrender value of the policy to the complainant towards full and final settlement of all his claims made before this office. The respondent have further added that they tried to contact

the complainant but could not succeed in doing so and prayed to pass an appropriate award.

For the sake of natural justice, hearing was held at Indore Camp office and both the parties were absent. Order is being passed on the basis material available on the record.

FINDINGS & DECISION:

I have gone through the material available on the record. Since the respondent is willing to settle the complaint and ready to pay surrender value of the policy towards full and final settlement hence there is no need to discuss the merit of the case. In view of the admission made in the SCN, respondent is liable to make payment of surrender value of the policy to the complainant.

Hence the respondent Max Life Insurance Co. Ltd. is directed to pay the surrender value of the policy to the complainant as full and final settlement within 15 days from the date of receipt of acceptance letter of the complainant failing which it will attract 9% simple interest p.a. from date of this order to the date of actual payment. In the result, the complaint is allowed.

Dated at Indore on 27th day of February, 2015

Mr.Manoj Gattani

.....Complainant

V/s

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

Order No. IO/BHP/A/GI/0071/2014-2015
Case No : BHP-G-035-1314-0612

Brief Background:

The complainant Mr.Manoj Gattani was covered under a mediclaim policy bearing no. 2302712825000247 for the period 11.09.2011 to 10.09.2012 for sum assured Rs.1,00,000/- which was issued by the respondent. He had preferred a mediclaim for Rs. 28,747/- towards his treatment cost to the TPA of the respondent company Indore on 31.08.2012 after treatment from City Nursing Home Pvt.Ltd. Indore from 20.08.2012 to 23.08.2012. but his claim was not settled by respondent company nor any reply was given to him regarding settlement of his claim.

The insured approached this forum for redressal of his complaint. The complaint was registered. The prescribed forms were issued which were submitted by complainant but respondent company did not file any reply or SCN against the complaint.

For the sake of natural justice hearing was held at Indore camp office. Both the parties were heard as mediation was failed. The complainant has reiterated the facts mentioned in the complaint and P-II form and stated that due to severe stomach pain and gastric problem, he was admitted in the said hospital and was given treatment and lodged his mediclaim before the company but no reply

was given about his claim while he had submitted all the bills and receipts. The insurer's representative has admitted that no SCN could be filed and he was not well aware with the detail facts of this case and has filed the terms & conditions.

Findings & Decision:

I have gone through the material placed on the record and submissions made by both the parties during hearing. It is admitted position that the above policy was issued by the respondent company subject to terms & conditions. From the prescription dated 18.08.2012 and the discharge slip showing the admission of the insure on 20.08.2012 and discharge on 23.08.2012 containing about conservative line of treatment given to the complainant during hospitalization and other test reports including sonography of the abdomen. It is apparent that the complainant was admitted in the said hospital and was given required treatment for his recovery of the problems suffered by him. The respondent company has not made any dispute about the hospitalization and treatment given to the complainant in the said hospital as well as expenses incurred by the complainant towards his treatment by filing any reply/ self contained note which reflects the lack of seriousness of the respondent company towards settling the claim made by the complainant before him and the respondent company have also failed to comply the provisions of Protection of Policyholders Interest Regulations, 2002 regarding giving reply of letters. Though, in the discharge slip nothing has been mentioned about the diagnosis and case summary, but since the respondent company has not challenged the genuineness of the discharge slip and other

medical documents neither during course of hearing nor by filing any reply. In these circumstances, the respondent company is liable to make payment of admissible amount towards his treatment cost according to terms and conditions of the policy documents to the complainant.

Under the aforesaid facts & circumstances, material on record and submissions made, I am therefore of the view that the action of the respondent company for not settling the claim of the complainant is not justified and is not sustainable. Hence, the complainant is entitled for the admissible amount towards his treatment cost under the policy document.

Hence, the respondent Reliance General Insurance Co.Ltd. is directed to settle and make payment of the admissible amount in accordance with the terms & condition of the policy document to the complainant Mr. Manoj Gattani within 15 days from the date of receipt of acceptance letter of the complainant failing which it will attract 9% simple interest p.a. from date of this order to the date of actual payment. In the result, the complaint is allowed to the extent of admissible amount only.

Dated at Bhopal on 13th day of November, 2014

Mr. Mohan Kaduskar.....Complainant

V/s

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

Order No. IO/BHP/A/GI/0062/2014-2015
Case No. GI/UII/1101/111

Brief Background:

The complainant had taken a Mediclaim policy bearing no.190303/48/08/97/00001149 for the period of 09.03.2009 to 08.03.2010 covering himself and his family members for Rs. 50,000/- for each member which was issued by the respondent company subject to terms & conditions. It is further said that the complainant was treated in November, 2009 for pain in waist in Vishesh Hospital, Indore and was admitted on 20.11.2009 and various tests were done like MRI, X-ray etc. and ailment of slip disk was diagnosed and advised for immediate operation but on the advice of his doctor friend, he undergone treatment in P.D. Patel Ayurved Hospital Nadiyad, Gujrat where he was admitted on 21.12.2009 and discharged on 08.02.2010 on the advice of the doctor and he was given Ayurvedic treatment and he was recovered from the illness. Thereafter, he lodged claim by submitting all the documents for total amount Rs.46,659/- towards his treatment cost but his claim was neither considered nor any reply was given till filing of the P-II form. Being aggrieved by the action of respondent

company, the complainant approached this forum for relief of making payment of Rs. 46.659/- towards his treatment cost.

The insurer in their Self Contained Note dated 19.05.2011 have admitted about the issuance of the said policy which was a renewal of previous policy and have contended that the main expenses incurred by the insured was found to be diagnostic reports only including MRI of the Vishesh Hospital, Indore from 20.11.2009 to 21.11.2009 was not admissible on the ground that the hospital stay was less than 24 hours and under exclusion clause 4.5 which deals with the diagnostic test and the other claim for hospitalization period in P.D. Patel Aurved Hospital & K.C.Amin Prasuti Gruh, Nadiyad from 21.12.2009 to 08.02.2010 was also not admissible under exclusion clause 4.14 as Naturopathy treatment has been excluded and moreover Ayurvedic is one of the lengthy process of treatment and it takes time to recover the patient and treatment of cervical spondylitis does not require any hospitalization as such the claim was not settled by the TPA.

For the sake of natural justice, hearing was held at Bhopal office. The complainant as well as insurer's representative Mr. Vijay K.Mehta were heard as mediation was failed. The complainant has narrated the facts as mentioned in the complaint and P-II form and stated that no intimation was given about rejection of his claim and the treatment given by the aforesaid Ayurved Hospital does not come under naturopathy treatment and prayed to allow his claim. On the other hand, the insurer's representative has simply stated that first claim amount was not considered due to not staying for 24 hours in Vishesh Hospital and other claim amount was not found payable due to the naturopathy treatment under clause 4.12 but due

to type mistake, it was mentioned as 4.14 in the SCN and complainant is not entitled for the claim as made.

FINDINGS AND DECISION:

I have carefully gone through the material on the record and submissions made by both the parties. From perusal of the discharge summary of the Vishesh hospital, Indore, it is apparent that the complainant was admitted on 20.11.2009 at 16:20:10 and was discharged on 21.11.2009 at 14:04:45 which does not full fill the requirement of 24 hours hospitalization to get the claim towards treatment in the Vishesh Hospital. So, the complainant is not entitled to get the amount of first claim Rs.10,400/- on account of staying in the said hospital for less than 24 hours. Now so for the other claim amounting Rs.36,259/- is concerned towards treatment cost in P.D.Patel Ayurvedic Hospital, Nadiyad which was attached with the J.S.Ayurved College managed by Maha Gujrat Medical Society, the treatment documents of the said Ayurved hospital Nadiyad clearly go to show that the complainant was admitted on 21.12.2009 for treatment of waist pain, cervical and lumber spondylosis and prostate and was discharged on 08.02.2010 after treatment from the said hospital but even after submitting the claim alongwith the documents, his claim was not considered by the TPA/ respondent and no intimation was given about any action taken in this regard which shows the callous attitude of the personnel of the company. The respondent has taken plea of exclusion clause no. 4.12 of the policy document during hearing which deals with exclusion of naturopathy treatment but in the case on hand, the complainant had undergone Ayurvedic treatment in the said Ayurvedic Hospital and the said treatment certainly does not come under the purview of naturopathy treatment and the insurer's representative have given

in writing on date of hearing that if the claim towards Ayurvedic treatment is found payable then Rs.36,059/- may be paid if the hospital was recognized by the Government though there is no such any condition in the terms & conditions of the policy document, however the above hospital is attached with J.S.Ayurvedic College, So, I do not find any force in the contention of insurer's representative for not considering the other claim towards Ayurvedic treatment and the respondent company is liable to make payment of admissible amount towards treatment cost of the complainant in the said Ayurvedic Hospital in Gujrat.

Hence, under the aforesaid facts, circumstances and material available on the record and policy terms & conditions, I am of the considered view that the action taken by the TPA/ respondent for not considering the other claim towards treatment cost in the said Ayurvedic Hospital under the exclusion clause 4.12 is not justified and is not sustainable in law. Hence, the complainant is entitled for the admissible amount only towards his treatment cost in the said Ayurvedic hospital.

Hence, the respondent United India Insurance Co.Ltd.is directed to pay the admissible amount towards treatment cost of the complainant in the aforesaid Ayurvedic Hospital under the policy document to the complainant Mr. Mohan Kaduskar within 15 days from the date of receipt of acceptance letter of the complainant failing which it will attract 9% simple interest p.a. from date of this order to date of actual payment. In the result, the complaint is allowed to the extent of admissible amount only.

Mr. Mohan Verma

……Complainant

V/s

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

Order No. IO/BHP/A/GI/0132/2014-2015
Case No. BHP-G-044-1415-0117

Brief Background:

The complainant had taken a Family Health Optima Insurance Policy bearing no. P/201100/01/2014/000275 for sum insured Rs. 2, 00,000/- for the period 03/06/2014 to 02/06/2015 covering himself and his family member. It is further said that the complainant was admitted in Narmada Trauma Hospital on 25/05/2014 and he was on ventilator from 29/05/2014 to 02/06/2014 then he was also admitted in Agrawal Hospital on 02/06/2014 and remained hospitalized from 02/06/2014 to 16/06/2014 and during this period he has renewed his policy. Thereafter he lodged the claim towards his treatment cost before the respondent company and they paid two lacs for the hospitalization period from 25/05/2014 to 02/06/2014 but did not pay for the hospitalization period from 03/06/2014 to 16/06/2014. Being aggrieved by the action of the respondent company, the complainant approached this forum for redressal of his grievance towards his hospitalization cost of Rs. 2 lacs .

For the sake of natural justice, hearing was held at Bhopal Office and both the parties were heard and the insurer's representative has submitted that the payment of Rs.2,00,000/-(Rupees Two Lacs) only

has been made to the complainant vide DD No.442546 on HDFC Bank of 17.01.2015, in full and final payment of hospitalization claim under subsequent policy no. P/201100/01/2015/000314. The complainant has also endorsed the above fact of settlement of claim and payment of Rs. Two lacs.

FINDINGS & DECISION:

I have gone through the material available on the record and the submission made by the respondent. On perusal of the letter dated 02.03.2015 of the respondent submitted by their representative on the date of hearing , it is clear that the payment of Rs.2,00,000/- (Rupees Two Lacs) only has been made to the complainant vide DD No.442546 on HDFC Bank of 17.01.2015, in full and final payment of hospitalization claim. Since the claim has been settled and paid to the complainant hence, in the circumstances, the complaint stands dismissed.

Dated at Bhopal on 02nd day of March, 2015

Dr. Mulchand Gurunani .....Complainant

V/s

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

Order No. IO/BHP/A/GI/0105/2014-2015
Case No : GI/UII/1106/26

Brief Background:

The complainant alongwith his wife Mrs. Lata were covered under a Indivual Health Insurance policy bearing no. 190306/48/08/97/00001189 for the period from 28.03.2009 to

27.03.2010 and 190306/48/09/97/00001002 for the period from 28.03.2010 to 37.03.2011 for sum assured Rs.2,00,000/- each which was issued by the respondent company subject to terms & conditions. He had preferred a mediclaim for Rs.65,697/- towards treatment cost of his wife for cataract surgery to the respondent company under the policy no. 190306/48/09/97/00001002 (2010-2011) but the respondent company deducted Rs. 25,147/- by giving baseless and false reasons that the claims were not supported by the hospital bills and he had also lodged another mediclaim under policy no. 190306/48/08/97/00001189 (2009-2010) for his spinal surgery for refund of wrongly deducted amount of Rs.1,000/- which also remained unsettled by the TPA. Being aggrieved by the action of respondent company the complainant approached this forum for the relief of making payment of his claim of Rs.2417/-+Rs.1,000/-.

The complaint was registered. The prescribed forms were issued which were submitted duly signed by him but the respondent did not submit the SCN/reply but deduction memo of cataract operation and deduction memo of nonpayment of Rs.1,000/- have been brought on record.

For the sake of natural hearing was held at Indore camp office. The complainant was absent. The insurer's representative was present and was heard as mediation could not be done due to absence of complainant. The insurer's representative has stated that the claim for cataract surgery was settled under the policy terms & conditions clause 1.2 which restricts the limitation for payment of cataract to the extent of 10% of the sum assured subject to a maximum of Rs. 25,000/- and the deduction of Rs.1,000/- was made as the hospitalization in Arihant Hospital was less than 24 hours, so the claimed amount is not payable.

Findings & Decision: **I have gone through the material placed on the record and submission made. From perusal of the record, it is clear that the claim amount towards cataract surgery has been settled in view of provision of clause 1.2 regarding cataract under hospitalization benefit of the policy terms & conditions and the complainant has failed to show about his admission in the Arihant Hospital for more than 24 hours for claiming the deducted amount Rs.1,000/- against his claim towards spinal surgery. Thus, I find force in the contention of the insurer's representative. In these circumstances, the respondent is not liable to make payment of the deducted amount as claimed.**

Under the aforesaid facts & circumstances, material on record and submission made, I am therefore of the view that the action/decision of the TPA/ respondent company is perfectly justified and is sustainable. Hence, the complainant is not entitled for the relief as prayed for. In the result, the complaint stands dismissed.

Dated at Bhopal on 27th day of January, 2015

Mr.Murlidhar

Neema……Complainant

V/s

Oriental Insurance Co. Ltd.
……Respondent

Order No. IO/BHP/A/GI/0075/2014-2015
Case No : GI/OIC/1207/26

<u>Brief Background:</u>

The complainant Mr.Murlidhar Neema was covered under family floater mediclaim policy bearing no. 151401/48/2012/5277 for the period 04.12.2011 to 03.12.2012 for sum insured Rs.2,00,000/- from the respondent. He had preferred a mediclaim for Rs. 21,141/- towards his treatment cost before the TPA but the TPA deducted Rs.1,575/- from the claim amount for which he made a complaint to the regional office, Indore but no reply was given. The TPA did not consider the S.A.Rs.2,00,000/- while settling the claim because there was waiting period of 2 years for DM and related diseases and they considered the sum insured of previous policy amounting Rs.75,000/-. Being aggrieved from the action of respondent, the complainant approached this forum for relief of making payment of Rs.1,575/-.

The insurer in their reply/ SCN have contended that the claim was settled for Rs.14,176/- and paid after deducting the not payable amount/ double claim amount/ receipt not in proper format against the claim bill for Rs.24,141/- and after rechecking of the documents, it was found that amount paid to the insured was correct and nothing is payable to him.

For the sake of natural hearing was held at Indore camp office. Both the parties were heard as mediation was failed. The complainant has narrated the facts as mentioned in the complaint and P-II form and laid emphasis that the claim has been settled taking the sum insured Rs.75,000/- as sum insured of previous policy. So, the deduction of Rs.1,575/- made on account of co-payment was totally wrong and he should have been reimbursed room rent @ Rs.2,000/- instead of Rs.750/- considering both the policies. On the other hand, the insurer's representative has laid emphasis that claim has been settled in accordance with the terms & conditions of the policy documents for sum insured Rs.75,000/- which was renewed enhancing the sum insured Rs.2,00,000/- which was family floater policy and the deduction of the said amount was proper and nothing is payable.

<u>Findings & Decision:</u>

I have gone through the material placed on the record and submissions made by both the parties and policy terms & conditions. From the record, it is apparent that the complainant was admitted for Insulin Dependent DM in the hospital and the above disease has waiting period of two years, so the sum insured liability of the claim was taken for Rs.75,000/- into consideration and accordingly, the room rent was paid @ 1% Rs.750/- per day as per policy terms & conditions and 10% co-payment as per family floater policy terms & condition amounting Rs.1,575/- was deducted and the net payable amount was found for Rs. 14,176/- only. It has been clearly mentioned in the policy document itself that "warranted that in case

the person covered under the policy has lodged any claim under the previous policy and the sum insured is enhanced under the current policy, for a further claim for the same disease during the current policy, the earlier limit of sum insured shall be applicable and not the enhanced sum insured". Thus, from the documents available on the record, it is clear that the claim was properly settled and no unwarranted deductions were made by the TPA/ company. Thus, I do not find any force in the complainant's contention. In these circumstances, the respondent is not liable to make any further payment as claimed.

Under the aforesaid facts & circumstances, material on record and submissions made, I am therefore of the view that the decision of the respondent company for deducting Rs.1,575/- as co-payment under the policy documents is perfectly justified and is sustainable. Hence, the complainant is not entitled for the relief as prayed for. In the result, the complaint stands dismissed accordingly being devoid of any merit.

Dated at Bhopal on 19th day of November, 2014

Mrs.Namrata Gupta

.....Complainant

V/s

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

Order No. IO/BHP/A/GI/0072/2014-2015
Case No : GI/RGI/1108/49

Brief Background:

The complainant Mrs.Namrata Gupta was covered under a mediclaim policy bearing no. 2302702825000477 for the period 19.05.2010 to 18.05.2011 for sum assured Rs.3,00,000/- which was issued by the respondent. She had preferred a mediclaim for Rs. 91,731/- for her laparoscopy surgery in Grater Kailash Hospital Indore by Dr. C.P.Kothari but the respondent company released only 65,324/- and deducted Rs.22,490/- (consumables used in surgery) which was not justified while the letter of the said doctor was attached.

The insured approached this forum for redressal of her complaint. The complaint was registered. The prescribed forms were issued which were submitted by complainant but respondent company did not file any reply or SCN against the complaint except settlement advice showing amount of consumables as non admissible.

For the sake of natural justice, hearing was held at Indore camp office. The complainant was absent. The insurer's representative appeared and was heard as mediation could not be done due to absence of complainant. The insurer's representative has laid emphasis that under the policy terms & conditions, the expenses

towards consumable items was not payable, so the said amount was deducted as not payable.

Findings & Decision:

I have gone through the material placed on the record and submissions made by the insurer's representative and policy terms & conditions which have been brought on record on behalf of respondent. From the record, it is apparent that after lodging the claim, the respondent company settled the claim and sent the settlement advice to the complainant finding net payable amount Rs.65,324/- alongwith cheque no.154693 dated 27.08.2010 for Rs.65,324/- only against her claim. The complainant has not shown that the said cheque was not received and cashed by her and she made the complaint about non payment of Rs.22,490/- only on 08.09.2010 which shows some delay about making protest towards deducted amount which was found non admissible by the company. As per clause 13 of policy terms & conditions, the medical charges only includes the consumable including cost of pace maker, cost of organ, artificial limbs etc. as long as these are recommended by the attending medical practicener and the consumables as mentioned in letter dated 07.09.2010 with reference to the complainant showing explanation regarding consumables do not find place in the head of medical charges as consumables. No doubt, the above items as mentioned in the letter dated 07.09.2010 might have been used as found essential in laparoscopy but the above items have not been included in clause 13 of the policy terms & conditions. Though, the respondent has not filed any SCN about the deducted amount but it has been clearly mentioned in the settlement advice dated 31.08.2010 that they will not entertained any clarification in respect of non admissible amount after 7 days from date of settlement and

the acceptance of the above mentioned cheque by the insured is in full and final settlement of the claim. Since, the complainant has not returned the above cheque after settlement of the claim, so it can be treated as full and final settlement. Apart from it, clause 13 of the policy terms & conditions do not include the above consumable items as mentioned in letter dated 07.09.2010. In these circumstances, the respondent cannot be held liable to make payment of deducted amount which was found as non admissible as consumable items.

Under the aforesaid facts & circumstances, material on record and submissions made, I am therefore of the view that the decision of the respondent company for settling the claim and making payment for Rs. 65,324/- and deducting Rs. 22,490/- as non admissible amount due to consumable items is perfectly justified and is sustainable. Hence, the complainant is not entitled for the relief as prayed for. In the result, the complaint stands dismissed accordingly.

Dated at Bhopal on 17th day of November, 2014

Mr. Nandlal

Khatri……Complainant

V/s

United India General Insurance Co. Ltd.
……Respondent

Order No. IO/BHP/A/GI/0061/2014-2015
Case No. GI/UII/1007/32
Brief Background:

The complainant had taken a Mediclaim policy bearing no.191301/48/09/20/00000232 from the respondent company for the period 07.06.2009 to 06.06.2010 covering himself for Rs.2,00,000/-. It is further said that he was admitted in Rajas Eye & Retina centre on 09.09.2009 and discharged on 10.09.2009 for eye treatment and thereafter, he submitted all the claim papers to M/s Medsave Health care for settlement of claim but same was rejected. He also approached the regional manager of the company to reconsider his claim but his claim was not considered. Being aggrieved by the action of respondent company, the complainant approached this forum for relief of making payment of Rs. 11500/- towards his treatment cost.

The insurer in their reply dated 08.10.2010 have contended that the complainant was given treatment of Intravitreal Avastinn injection which was an OPD procedure. Hence, was not covered as per the policy document as such the claim was repudiated.

For the sake of natural justice, hearing was held at Bhopal office. The complainant did not appear nor submitted any written submission. The insurer's representative Mr. Ramkishan Bourasi was heard as mediation could not be done due to absence of complainant. The insurer's representative has stated that injection which was given in the said hospital was an OPD procedure so, claim was not admissible as the said injection avastin falls outside the scope of their health policies under circular no. H.O.T.P.A./054:09.

FINDINGS AND DECISION:

I have carefully gone through the material on the record and submissions made. From perusal of the circular filed on behalf of respondent company, it is apparent that injection avastin falls outside scope of the health policies of the company and should not be entertained. The above injection avastin can be given as outdoor patient and the hospitalization is not at all required. The discharge summary also shows that the above injection was given to the patient during the aforesaid hospitalization in the said hospital which could have been given as outdoor patient. Thus, I find force in the contention of insurer's representation for repudiation of the claim.

Hence, under the aforesaid circumstances and material available on the record, I am therefore of the view that the decision of the respondent to repudiate the claim of the complainant is perfectly justified. Hence, the complainant is not entitled for the relief as prayed. In the result, complaint stands dismissed being devoid of any merit.

Dated at Bhopal on 21st day of October, 2014

Mrs. Neha Acharya

.....Complainant

V/s

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

Order No. IO/BHP/A/GI/00 /2014-2015 Case No : BHP-G-050-1314-0693

Brief Background:

The complainant Mrs.Neha Acharya was covered under a Group Mediclaim Policy bearing no. 121802/48/2011/1289 for the period 31.03.2011 to 30.03.2012 as an employee of M/s. Kotak Securities Ltd., Bhopal which was issued by the respondent. It is further said that she was on maternity leave from 19th March, 2012 till 2nd Septembre,2012. Thereafter, she lodged the claim before the respondent company for Rs.40,000/- towards medical expenses during hospitalization from 22.03.2012 to 23.03.2012 in Life Line Hospital Bhopal for delivery but her claim was not entertained by the respondent company due to delay in submission of documents. It is further said that she was in critical condition after delivery and the family members were also not in a peace full stake of mind, so the document got delayed. Thereafter, she approached higher authorities of respondent but her claim was not considered. Being aggrieved from the action of the respondent company for not considering her claim, the complainant approached this forum for relief of payment of claim amount of Rs.40,000/-.

The insurer in their SCN have stated that the claim is repudiated due to non intimation and non submission of claim papers for (6 months) which is violation of policy condition no. 5.4 and 5.5.

For the sake of natural justice, hearing was held at Bhopal office. The complainant was present. Nobody appears on behalf of respondent. The complainant has narrated the facts as mentioned in the complaint and stated that delay was caused due to her critical condition and in such situation saving life is important rather than submitting the documents in the office and prayed to allow her claim.

<u>Findings & Decision:</u>

I have gone through the material placed on the record and submissions made. It is admitted position that the one claim relating to heart ailment has already been paid for Rs. 150842/- under the policy document. The bill cum receipt dated 02.08.2012 clearly shows about receipt of amount of Rs.2,54,565/- by the hospital concerned Laud Clinic, Mumbai paid by complainant in which the amount of 84,000/- has been included as appears from calculation. Though, the receipt of 1,70,000/- of the said clinic has been filed but the above bill cum receipt cannot be dislodged for taking into account about receiving the total amount Rs.2,54,565/-. The insurer's representative has clearly mentioned in the assessment sheet that if found payable an amount Rs. 84,565/- is considered as bill cum receipt, their liability comes to Rs. 2,49,158/- only. Since, the ground of repudiation as shown in the SCN as well as during hearing is delay of 126 days while the payment of Heart ailment treatment cost has been made after 100 days, so the principle of

estoppels applies. Moreover, as per IRDA circular No. IRDA/HLTH/MISC/CIR/216/09/2011 dated 20.09.2011, it is clear that the insurers have been advised not to repudiate such claim on ground of delay in claim intimation/ document submission where the delay is proved to be for reasons beyond the control of insured. In the instant case, naturally the insured complainant suffered heart ailment after replacement of knee joint and again, he was required treatment in Asian Heart Hospital on 05.09.2012, so certainly, it was the priority to take care of the life and only on recovery, the complainant was able to lodge the mediclaim. So, the reasons shown for the delay of lodging the claim before the respondent company appears to be proper and reasonable and it should have been considered by the respondent company in settlement of the claim.

Under the aforesaid facts & circumstances, material on record, submissions made and policy terms & conditions, I am therefore of the view that the action of the respondent company for not considering the claim of the complainant towards expenses of Knee replacement on the ground of delay of 126 days is not justified and is not sustainable. Hence, the complainant is entitled for the balance admissible amount Rs.2,49,158/- as balance sum insured under the policy document.

Hence, the respondent Oriental Insurance Co.Ltd. is directed to settle the claim towards expenses of Knee Replacement condoning the delay in the light of the IRDA circular and pay the balance admissible amount Rs,2,49,158/- (Rs. Two Lac Forty-nine Thousand One Hundred Fifty-eight only) as balance sum insured in accordance with the terms & condition of the policy document to the

complainant within 15 days from the date of receipt of acceptance letter of the complainant failing which it will attract 9% simple interest p.a. from date of this order to the date of actual payment. In the result, the complaint is allowed to the extent of above balance admissible amount as balance sum insured only.

Dated at Bhopal on 10th day of December, 2014

Mr. P.K.Jain .....Complainant

V/s

National Insurance Company Ltd.
.....Respondent

Order No. IO/BHP/A/GI/0096/2014-2015
Case No. GI/NIC/1209/36

Brief Background:

Being aggrieved by the action/decision of the respondent company, the complainant Mr. P.K.Jain approached this forum for redressal of his grievance towards making payment of Rs. 60,377.90 for undergoing treatment of Mr. Padam Kumar under the policy bearing no. 320400/48/10/8500005340 in Bombay Hospital, Indore and CHL Apollo Hospital for the period of hospitalization in the year 2011.

The respondent have claimed in their SCN that as per report of the Bombay hospital the final diagnosis was found hyper tension with alcoholic withdrawal which was not covered as per policy condition 4.8 and 24 hours of hospitalization was also not completed

while Mr.P.K.Jain was admitted in CHL Hospital, suffering from Chronic Ischemic Heart Disease nor followed by any active treatment as such the claim was repudiated under clause 2.6 and 4.10.

For the sake of natural justice, hearing was held at Indore camp office. Both the parties were heard who narrated the facts as mentioned in complaint as well as reply dated 12.10.2012. The insurer's representative laid emphasis that the complainant has no insurable interest and has no locus standi as the policy holder is Mrs.Neelam Jain and Mr. Padam Kumar Jain is only insured, who is son-in-law of Mr. Prasann Kumar Jain, the present complainant.

FINDINGS & DECISION:

I have gone through the material placed on the record and submission made. This complaint has been filed by Mr. Prasann Kumar Jain who has signed as P.K.Jain on complaint and P-II form but has clearly mentioned his name as Prasann Kumar Jain in column of complainant while the copy of the policy document filed on behalf of complainant clearly shows the name of the policy holder as Mrs.Neelam Jain and other insured as Mr. Padam Kumar Jain also who is husband of Mrs. Neelam Jain. Since, this complaint has been filed by Mr. Prasann Kumar Jain who is neither policy holder nor insured, so he has no insurable interest in this case. Thus, it is clear that complainant has no locus standi to file this complaint and the complaint touches the maintainability under the provisions of RPG Rules, 1998 and as such it is not maintainable.

Under the aforesaid facts & circumstances, material on record and submissions made, I am therefore of the view that this case is not maintainable under the provisions of RPG Rules, 1998 and is liable for dismissal. Hence, the complaint stands dismissed.

Dated at Bhopal on 9th day of January, 2015

Mr. Pradeep Zanzari.....Complainant

V/s

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

Order No. IO/BHP/A/GI/0063/2014-2015
Case No. GI/OIC/1204/01

Brief Background:

The complainant had taken a Mediclaim policy bearing no.151200/48/11/18449 for the period of 21.03.2011 to 20.03.2012 covering himself for Rs. 2,00,000/- which was issued by the respondent company subject to terms & conditions. It is further said that after implantation of permanent pacemaker, he lodged the claim for Rs. 3,02,545/- after discharge from hospitalization from 13.12.2011 to 22.12.2011 while the sum assured was Rs.2,00,000/- but the amount paid by the respondent company was Rs.1,50,000/- only while he had supplied all the mediclaim bills of CHL hospital, Indore and investigation reports to the TPA and respondent company but instead of making payment of full amount, they paid less amount and closed their claim arbitrarily. Being aggrieved by

the action of respondent company, the complainant approached this forum for relief of making payment of Rs. 2,00,000/- towards his treatment cost.

The insurer in their Self Contained Note dated 20.11.2012 have admitted about the issuance of the said policy which was issued to the complainant and which was a renewal of the previous policies since 2001 and have contended that the claim was processed and settled for Rs.1,50,000/- but in the letter dated 30.06.2014, it has been mentioned that the policy was under continuous renewal from the year 2006 and have further contended that as the illness for which insured was hospitalized was since 2003, hence sum insured of four year back was applicable as per terms & conditions of individual mediclaim policy and the sum insured in the policy year 2007 was 1,50,000/- as such their TPA settled the claim and paid Rs.1,50,000/- by the TPA . The complainant as well as insurer's representative Mr. Rakesh Pius were heard as mediation was failed. The complainant has narrated the facts as mentioned in the complaint and P-II form and stated that the claim amount was not paid on the basis of amount of sum insured Rs.2,00,000/- while he has incurred more than 3,00,000/- for implantation of permanent pace maker as there was blockage in his heart and prayed to allow his claim. On the other hand, the insurer's representative has stated that the claim was settled for Rs.1,50,000/- and paid in accordance with the terms & conditions of the policy document on the basis of sum insured of four years back policy taken by the complainant and complainant is not entitled for the claim as made.

FINDINGS AND DECISION:

I have carefully gone through the material on the record and submissions made by both the parties. As per 4.1 of the policy terms & conditions 'Pre-existing health condition or disease or ailment/ injuries : 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 up to 4 years of this policy being in force continuously'. From the record, it is apparent that the complainant had previous policy issued by the respondent company and the sum insured for the policy year 2007-2008 was Rs.1,50,000/- which was enhanced from Rs.85,000/- to 1,50,000/- and the above fact is admitted by the complainant also. The policy document from the period 21.03.2011 to 20.03.2012 was for sum insured Rs.2,00,000/- covering the complainant. From the above policy document it is apparent that it has been clearly mentioned that 'Warranted that in case the person covered under the policy has lodged any claim under the previous policy and the sum insured is enhanced under the current policy, for a further claim for the same disease during the current policy, the earlier limit of Sum Insured shall be applicable and not the enhanced sum insured'. Thus, it is established from the terms & conditions of the policy document itself that the earlier limit of sum insured under previous policy shall be applicable and not the enhanced sum insured. So, I do not find any force in the contention of complainant. In these circumstance, respondent is not liable to make payment on the basis of enhanced sum insured in accordance with the terms & conditions of the policy document.

I am therefore of the view that the action of the respondent for not considering about the payment of full claim amount in accordance with the terms & conditions of the policy document is perfectly justified and is sustainable in law and does not warrant any interference by this authority. Hence, the complainant is not entitled for the full claim amount as made in the P-II form. In the result, the complaint stands dismissed being devoid of any merit.

Dated at Bhopal on 27 th day of October, 2014

Mr.Praveen R. Singhania

…….Complainant

V/s

Reliance General Insurance Co. Ltd.
…….Respondent

Order No. IO/BHP/A/GI/ 0073/2014-2015
Case No : GI/RGI/1009/62

Award

Brief Background:

The complainant's wife Mrs.Archana Singhania was covered under a mediclaim policy bearing no.2302792825005677 for the period 14.09.2009 to 13.09.2010 for sum assured Rs.2,00,000/- which was issued by the respondent. He had preferred a mediclaim for Rs. 14775/- towards treatment cost of his wife for non consummation of marriage before the TPA Medi Assist of the respondent company, Indore on 02.03.2010 but his claim was rejected and thereafter he

also submitted photo copies of all the Indoor Case paper for settlement of the claim but no reply was given.

The insurer in their self contained note dated 06.01.2011 have admitted about the issuance of the said policy in which the complainant's wife was also covered and have contended that she was diagnosed as non consummation of marriage and advice septum repair and have further contended that looking to her complaint after six months of marriage life i.e.15.01.2008, she had undergone treatment on 13.02.2010 after two and half years of marriage. So, treatment was not done for non consummation of marriage but for child birth which attracts policy exclusion 6 and further contended that she was admitted in hospital on 13.02.2010 at 08.58 am and was discharged on 13.02.2010 on 04.14 pm as per discharge card and medicine bills which violates terms & conditions no. 7 as she was admitted for less than 24 hours and same was corrected in the discharge card as there was overwriting and have also contended that the treatment was done for Vaginismus for child birth as such the claim was repudiated under clause 10 and 28 of the policy terms & conditions.

For the sake of natural justice hearing was held at Indore camp office. The complainant was absent. The insurer's representative was heard as mediation could not be done due to absence of complainant. The insurer's representative has laid emphasis that the non consummation of marriage is treatment for infertility which was not covered under clause 10 and charges incurred for diagnosis and not consistent with ailment is not payable and hospitalization was less than 24 hours as there was overwriting on the date of discharge in the discharge card. So, the claim is not payable under clause 10 and 28 of policy terms & conditions.

Findings & Decision:

I have gone through the material placed on the record and submissions made and policy terms & conditions. The prescription dated 12.02.2010 clearly shows that the patient Mrs. Archana Singhania went for routine checkup, non consummation and Vaginismus to the Baser Gynocology and IVF Centre and the discharge card shows the admission of the complainant's wife in Suyash Hospital Pvt.Ltd., Indore on13.02.2010 at 08.58 am and the date of discharge has been mentioned as 14.02.2010 at 02.58 pm by making an overwriting on the figure 13 without any initial or seal of the doctor concerned and in the history non consummation of marriage and seeking advice and treatment for Vaginismus has been mentioned and the discharge card does not show any active treatment towards said ailment rather only evaluation under anesthesia of feuton's repair. The case sheet shows the admission date as 13.02.2010 in printed letter but the date of discharge 14.02.2010 has been mentioned in pen which reflects otherwise. Thus, the date of hospitalization for more than 24 hours has become disputed. Apart from it, the clause 10 of the policy terms conditions deals with policy exclusion regarding treatment of sterility also and clause 28 also excludes the charges incurred primarily for diagnostic studies not consistent with treatment of any disease for which confinement is required in a hospital and clause 6 also excludes about any treatment for child birth and in those cases, the company is not liable to make any payment. The complainant did not appear to clarify about the overwriting made in the discharge card and to clarify the above terms & conditions of exclusion clauses. In these

circumstances, the respondent company can not be held liable to make payment towards the said treatment cost of complainant's wife.

Under the aforesaid facts & circumstances, material on record and submissions made, I am therefore of the view that the decision of the respondent company to repudiate the claim of the complainant under policy terms & conditions is perfectly justified and is sustainable. Hence, the complainant is not entitled for the relief as prayed for. In the result, the complaint stands dismissed accordingly.

Dated at Bhopal on 17th day of November, 2014

Mr. Prem Mohan Middha.....Complainant

V/s

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

Order No. IO/BHP/A/GI/0058/2014-2015 Case No. BHP-G-050-1314-0633

Award

Brief Background:

The complainant had taken a Mediclaim policy bearing no. 152100/48/2013/544 for the period 10/09/2012 to 09/09/2013 for the sum assured Rs.2,50,000/- which was issued by the respondent company. It is further said that he was regularly

renewing the mediclaim policies from 2009-10, 2010-11, 2011-12, 2012-13 & 2013-14 without break. It is further said that the complainant underwent treatment in Akshay Hospital, Bhopal from 12.12.2012 to 24.12.2012 in Iinstitute of Liver and Biliary Sciences, New Delhi from 31.12.2012 to 03.01.2013. 21.01.2013 to 24.01.2013, 16.03.2013 to 26.03.2013 in the said institute and lodged claim before the TPA of the company for Rs. 2,14,314.00 but his claims were rejected by the TPA of the company under policy terms & conditions clause 4.8 on the ground of history of alcohol intake while in the MMR of Akshay Hospital it, was clearly mentioned that the disease detected for the first time and was not related due to use of alcohol or drugs and discharge summary of the said Institute of Liver, New Delhi, there was no history of alcohol intake, blood transfusion, Major surgery, IV drug abuse, and there was no history of HTN/CAD/T.B. and he never took alcohols. So, terms & conditions of 4.8 will not apply in his case. Being aggrieved by the action of respondent company, the complainant approached this forum for relief of making payment of claim amount Rs.2,14,314/- regarding claims lodged before TPA as mentioned in his letter dated 19.08.2013 sent to the DGM of respondent company and Rs.3,05,075/- including the fifth claim towards his treatment in the said liver institute amounting Rs.90,781/- as mentioned in the P-II form. The complainant has not mentioned the amount of claim in his complaint dated 26.09.2013.

The insurer in their Self Contained Note dated 02.06.2014 have admitted about the issuance of said mediclaim policy to the complainant and have contended that the claim was repudiated under policy condition 4.8 on the basis of history of alcohol as per

history sheet of Akshay Hospital, Bhopal and the patient was known case of HTN/CAD/Varicose Veins and ailment of chronic liver disease on the basis of USG report dated 19.12.2012 and the insured has not submitted the treatment consultant certificate stating exact cause of illness with specific duration and any investigation reports done in last 3-4 years which shows patient's conditions healthy, liver in normal condition (USG, CT SCAN, MRI, any other) inspite of several reminders.

The complainant as well as insurer's representative Mr. Satish Chouhan were heard as mediation failed. The complainant has reiterated the facts as mentioned in the complaint and P-II form and has stated that he was perfectly all right till 2011 and was suffering from mild fever and weakness for one year after 2011 and there was no typical problem. So, no special treatment was taken for fever and due to inflation sum assured was increased and due to some gidiness and weakness, he was admitted in Akshay Hospital, Bhopal and thereafter he also took treatment in Institute of Liver and Biliary Sciences, New Delhi after being referred from Bhopal Memorial Hospital and Research Centre at different periods from 21.12.2012 to 12.09.2013 and he lodged the claims towards his treatment cost before the respondent company but his claim was rejected due to intake alcohol under clause 4.8 of policy document while as per USG report dated 28.08.2012 which was called for by the respondent company for reconsidering his claim clearly shows liver as normal and the discharge summary of the said liver institute also shows that there was no history of alcohol intake. So, the repudiation was not proper and prayed to allow his claim. On the other hand, the insurer's representative has laid emphasis that the repudiation was due to intake of alcohol as per history sheet of Akshay Hospital,

Bhopal under clause 4.8 of policy conditions and the insured was suffering from chronic liver disease which was due to intake of alcohol and complainant is not entitled for relief as prayed for.

FINDINGS AND DECISION: I have carefully gone through the material on the record and submissions made by both the parties and policy terms & conditions. The respondent has not disputed about the period of treatment undergone in the aforesaid hospitals. It is clear from repudiation letter dated 30.04.2013 that the claim has been rejected under the provisions of general exclusion 4.8 which provides that Convalescence, general debility, "run down" condition or rest cure, congenital external diseases or defects or anomalies, sterility, any fertility, sub-fertility or assisted conception procedure, venereal diseases, intentional self- injury/suicide, all psychiatric and psychosomatic disorders and diseases/ accident due to and or use, misuse or abuse of drugs/ alcohol or use of intoxicating substances or such abuse or addiction etc. and the respondent company has taken the plea of repudiation of the claim particularly on the ground of history of intake of alcohol causing chronic liver disease. So, the burden lies on the respondent company to establish that the insured was habitual intake of alcohol and the said chronic liver disease was caused due to intake of alcohol before taking the policy. The respondent company has simply brought on record the history sheet of Akshay Hospital dated 24.12.2012 of the complainant in which it has only been mentioned that alcohol left 35 years. The letter dated 21.03.2013 sent to the Institute of Liver and Biliary Sciences New Delhi does not indicate any chronic liver disease on account of intake of alchohol rather only hepatopulmonary syndrome and hepatic hydrothorax (Child category- B 8/15) was diagnosed and was referred to the said

hospital at Delhi for further investigation and management USG report dated 28.08.2012 submitted by the complainant to the respondent company as required for reconsidering his claim clearly shows that liver was normal in size and shows normal homogenous echopattern. No focal lesion seen. Intrahepatic biliary radicals normal. Portal venous channels and hepatic veins normal. Porta hepatis shows normal caliber of portal vein and CBD. No focal lesion seen at porta. Thus it is established that the liver of the complainant was normal on 28.08.2012. The history sheet of Akshay Hospital shows that he was admitted in hospital on 21.12.2012 for complaint of 'Chakkar and Nausea'. The MMR report dated 27.12.2012 also shows that as per USG report dated 28.08.2012 liver was normal and disease was not caused directly or indirectly due to the use of alcohol or drugs and the discharge summary for admission on 21.01.2013 of the Institute of Liver and Biliary Sciences, New Delhi also shows that patient was symptom free till December, 2012 when the swelling reappeared followed by loss of appetite. USG done in same hospital suggested chronic liver disease following which patient came to ILBS for further treatment and there is no history alcohol intake blood transfusion, major surgery, IV drug abuse and there is no history DM/HTN/CAD/TB and likewise the discharge summary dated 25.03.2013 also shows that there was no history of alcohol intake. The discharge summary for admission dated 31.12.2012 of the insured also shows that the patient was admitted for evaluation and management of chronic liver disease for which the cause was unknown and for jaundice. Thus, from the medical documents, discharge summary, USG report available on the record, it is established that the cause of liver disease was unknown and there was no history of alcohol intake and patient was symptom free

till December, 2012. The respondent has not brought on record USG report dated 19.12.2012 to show any abnormality in the liver and has not brought any cogent medical document/ expert opinion that the said liver disease for which the insured undergone treatment in the said liver institute of Delhi was only due to intake of alcohol by the insured and have also failed to bring on record any document to show any liver disease before taking of first policy of year 2009-10. So for the requirement of investigation reports in last 3-4 years showing patient condition healthy and liver in normal condition is concerned, it appears as highly unwarranted as it is natural human conduct that healthy person does not go through any investigation unless he falls ill and since the patient was symptom free till December, 2012. So there was no question of investigation with regard to the condition of his liver and so for consultant certificate stating exact cause of illness is concerned, it has clearly been shown in the discharge summary that the cause was unknown about the chronic liver disease. So, the above required document was also not necessary to decide the claim rather it appears that the above documents were called for only to linger the settlement of claim of the complainant while the vital USG report dated 28.08.2012 was submitted by the complainant to the respondent company as required for reconsidering the claim. Thus, I do not find any force in the contention of insurer's representative for repudiation of the claim under clause 4.8 of the policy document. In these circumstances, the respondent is liable to make payment of admissible amount towards treatment cost for the claim lodged.

Hence, keeping in view the entire facts and circumstances and material available on the record and policy terms & conditions, I am

of the considered view that the decision of the respondent to repudiate the claim of the complainant under clause 4.8 of the policy terms & conditions is not justified and is not sustainable in law. Hence, the complainant is entitled for the admissible amount against the claims lodged before the respondent company under the concerned policy document.

Hence, the respondent Oriental Insurance Co.Ltd. is directed to settle and make payment of admissible amount towards treatment cost regarding the claims lodged before the respondent company under the concerned policy document within 15 days from date of receipt of acceptance letter of the complainant failing which it will attract simple interest of 9% from date of this order to the date of actual payment. In the result, the complaint is allowed to the extent of admissible amount only.

Mr. R. S. Pyasi
.....Complainant

V/s

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

Order No.: IO/BHP/A/GI/0188/2014-2015 Case No.: BHP-G-049-1415-0115

Brief Background:

The complainant was covered under a Group Mediclaim Insurance Policy bearing No. 12070034105000000001 for the period 01.04.2013 to 31.03.2014 and also under said group mediclaim insurance policy bearing no. 12070034140400000002 for period 01.04.2014 to 31.03.2015 for self and his family from the

Respondent. It is further stated that he had undergone investigations from different Eye Specialist. Finally on 31.03.2014, he visited to Dr. Himanshu Shukla, "Retinal Specialist" who diagnosed Eye disease as Avastin and started treatment from 04.04.2014 onwards. He preferred a claim before the respondent company which was repudiated as the disease Avastin is mentioned in exclusion clause of the text of Group Mediclaim Policy terms and conditions for the year 2013-14 and they also agreed that the disease Avastin has not been excluded from the current year 2014-15 policy terms and conditions. Being aggrieved by action of the respondent company, the complainant approached this forum for relief of making payment of Rs.33,000/-.

The insurer in their SCN have stated that the complainant was suffering from the disease Avastin since the year 2013 when the disease was excluded from the scope of policy terms and conditions (Exclusion clause No. 9.0 of financial year 2013-14) though the insured underwent treatment of LE Avastin and RE Avastin on dates 04.04.2014 and 18.04.2014. The disease is not excluded in the current year policy (Exclusion clause F of financial year 2014-15) and the disease Avastin is proximate cause due to which claim is not admissible as the treatment was continued from last year 2013.

The complainant did not appear but has sent the written submission. The insurer's representative was heard who has taken the stand as mentioned in the SCN but admitted that the Avastin is not excluded under the policy of 2014-2015 when the injection was taken.

<u>Findings & Decisions:</u>

I have gone through the materials on record and submissions made. The complainant has mentioned in his written statement that he had

taken treatment in year 2014-15 and under the policy of 2014-15 and the so called Avastin is covered for mediclaim which is used for retinopathy but his claim was rejected on the ground that the disease was not listed for reimbursement as it occurred in year 2013-14. The policy condition clause 9.20 has excluded the Avastin and other related drugs as intra vertal injection but the insurer's representative has admitted that the Avastin is not excluded under the policy period 01.04.2014 to 31.03.2015. Since, the said treatment (Avastin Drug) was given on 04.04.2014 and 18.04.2014 i.e. under the policy period of 2014-15 and it is quite irrelevant that when the disease was diagnosed. Thus, I do not find any force in the contention of insurer's representative about repudiation of the claim. Hence, the respondent company is liable to make payment of the treatment cost as claimed as per terms and conditions of the policy document 2014-15 to the complainant. So, the decision of repudiation is not justified.

Hence, the respondent The New India Assurance Co.Ltd. is directed to settle the claim and make payment of the treatment cost to the complainant in accordance with the terms & condition of the policy document 2014-15 within 15 days from the date of receipt of acceptance letter from the complainant failing which it will attract simple interest of 9% p.a. from the date of this order till the date of actual payment and submit compliance report to this office. In the result, the complaint is allowed under intimation to this forum.

Mr.R.K.Judah.....complainant

V/s

Max Bupa Health Insurance Co. Ltd.
.....Respondent

Order No. IO/BHP/A/GI/0081/2014-2015
Award
Brief Background:

The complainant's wife Mrs. Flavia Judah was covered under a health policy bearing no. 30038428201302 for the period 23.05.2013 to 22.05.2014 for sum assured Rs.2,00,000/- which was issued by the respondent. He had preferred a mediclaim for Rs. 28,460/- towards treatment cost of his wife for removal of Lipomas by operation in Child Care Centre & Hospital, Bhopal from 08.06.2013 to 10.06.2013 but his claim was rejected by respondent company . Being aggrieved from the action of respondent company, he approached this forum for relief of making payment of his claim amounting Rs. 28,460/- towards treatment cost of his wife.

The insurer in their SCN dated 09.05.2014 have admitted about the issuance of the above policy and stated that the policy was issued to complainant on 06.06.2011 and complainant's wife was admitted at Child Care Centre on 09.06.2013 for complaint of multiple lipoma over both ankles and forearms and underwent surgery for removal of multiple lipoma. The complainant's wife was suffering from lipoma for last 3-4 years but insured did not disclose this fact at the time of inception of policy and claim was declined in compliance with clause 4(a) of terms and conditions and claim decline letter was sent to the customer stating that "The claim was denied for being

preexisting disease and suppression of material facts as it was also not disclosed at the time of inception of policy." So, the claim was declined. The complainant as well as insurer's representative Ms. Jina Mullick were heard as mediation was failed. The complainant has reiterated the facts as mentioned in the complaint and stated that his wife had complaint of some swelling in both ankle and both shoulders and wrist which was diagnosed as multiple lipomas and operation was performed and her medical checkup was done at the time of inception of policy and there was no concealment of above facts and there was no pre-existing disease. On the other hand, the insurer's representative laid emphasis that the claim was denied being pre-existing disease and suppression of material facts as it was not disclosed at the time of inception of policy and claim was declined in accordance with clause 4 (a) of the terms & conditions of the policy.

<u>Findings & Decision:</u>

I have gone through the material placed on the record and submissions made by both the parties during hearing. The prescription dated 05.06.2013 (xerox copy) shows only multiple swelling of both wrist and ankle pain, swelling back of shoulder (L) side and multiple lipomas was diagnosed for which the insured underwent excision of lipomas as apparent from discharge card and only old case has been mentioned without mentioning any period and medical examination report of panel doctor of respondent company has clearly answered in negative about any abnormality and deformity in general appearance at the time of examination of insured and has opined that diabetes controlled on medication for which discloser was made by insured and the respondent have failed

to show that ailment of lipomas was the cause of DM type II for which waiting period of 48 months was necessary. So, the above diagnosed disease cannot be said to be pre-existing in absence of any previous medical record prior to inception of policy but the complainant has himself admitted in the e-mail sent to the company that slight swelling was observed by Mrs.Judha since last 3-4 year back but as it was not giving any trouble, so, it was not shown to any doctor but when it increased giving slight pain, it was shown to Dr.Modi first time on 05.06.2013 and he suggested for operation. Since, the panel doctor of the respondent is responsible for his omission to note the said deformity/ abnormality on insured's body at the time of medical examination but the insured also cannot be left unblemished for not giving this information of said swelling to the panel doctor concerned. It appears beyond natural human conduct and behavior that the complainant's wife having some deformity or abnormality like some swelling in the body from last 3 to 4 years would not consult any doctor to get the problem diagnosed and any advice towards treatment. The respondent have not disputed about the genuineness of the claim amount except concealment of material facts.

Hence, the respondent Max Bupa Health Insurance Co.Ltd. is directed to settle and make payment of 50% of claim amount as an ex-gratia to the complainant Mr. R.K.Judah within 15 days from the date of receipt of acceptance letter of the complainant failing which it will attract 9% simple interest p.a. from date of this order to the date of actual payment. In the result, the complaint is allowed in part to the extent of above amount only.

Mr. Rajesh Bhavnani .....Complainant

V/s

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

Order No. IO/BHP/A/GI/0125/2014-2015
Case No : GI/NIA/1111/66

Award

Brief Background:

The complainant's wife Smt. Bhavika Bhavnani and daughter Ku.Soumya Bhavnani were covered under group mediclaim policy bearing no. 121400/34/10/87/00000378. The complainant had taken the said policy as employee of L.I.C. of India which was issued by the respondent. He had preferred three mediclaim for Rs. 35,104/-, Rs. 24,735/- and Rs.1,490/- towards treatment cost of his wife and one for Rs.1,422/- towards treatment cost of his daughter before the respondent but the respondent has not settled his claims despite of his several reminders.

The complainant has not filed the copy of above policy document rather has filed copy of policy no. 121400/34/09/12/00000329 for period 01.04.2009 to 31.03.2010. However there is no dispute of coverage under group mediclaim policy by respondent.

The insurers in their SCN have stated that the complainant had preferred two claims on 25.05.2009 for the period 10.02.2009 to 18.02.2009 and 12.03.2009 to 13.03.2009 for Rs. 35,104/- i.e. after 52 days which was a violation of the policy condition no. 5.4 and after clarification from complainant, the claim was found admissible

only for Rs.1,250/- as all the expenses pertains to pre and post natal which were not covered under the scope of the policy and after receipt of proper discharge voucher, the payment was released in favour of LIC on 05.08.2010 and complainant had preferred a claim for Rs.35,537.72/- on 23.10.2009 covering above two mentioned treatment in a single claim form and the respondent had settled the claim for Rs. 26,952/- and paid on 18.12.2009 after receipt of proper discharge voucher and it is further contended that due to shifting of their office, the claim folder of Rs. 1,422/- was not traceable at their end and they are sure that this petty claim was already paid and give assurance that as soon as they get this folder, they will provide payment particulars.

For the sake of natural hearing was held at Gwalior camp office. Both the parties were present and were heard. The complainant narrated the facts as mentioned in the complaint and admitted about settlement of claims and payment thereunder. The insurer's representative has narrated the versions made in the SCN and laid emphasis that all the 4 claims made by the complainant has been settled and payment was released for accordingly after receipt of proper discharge boucher but claim folder of Rs,.1422/- was not traceable though the same was already paid.

<u>Findings & Decision:</u> I have gone through the material placed on the record and submissions made by both the parties. From the SCN, it is observed that all the claims except Rs. 1,422/- has already been paid but the payment details were not furnished for the claim amount of Rs.1,422/-. From the SCN and submissions made on behalf of respondent company, it is observed that all the claims expect Rs. 1422/- have been paid and the payment detail for Rs.1422/- has not been furnished. The complainant has not disputed

about the above submission made on behalf of respondent company regarding settlement of the claims and payment there under as per policy documents.

Hence, under aforesaid facts and circumstances, material on record, submissions made, the respondent The New India Assurance company is directed to make payment of Rs.1,422/- towards claim of the complainant if not paid earlier within 15 days from date of receipt of acceptance letter of the complainant under intimation to this office. In the result, the complaint is partly allowed for Rs. 1,422/- only.

Dated at Bhopal on 19th day of February, 2015

Mr.Rajesh Bhavnani

.....Complainant

V/s

New India Assurance Co. Ltd.

.....Respondent

Order No. IO/BHP/A/GI/0078/2014-2015
Case No : GI/NIA/1302/60

Award

Brief Background:

The complainant's daughter Ku.Soumya Bhavnani was covered under group mediclaim policy bearing no. 120700/34/11/05/00000001 (policy year 2011-2012) and the complainant had taken the said policy as employee of L.I.C. of India which was issued by the respondent. He had preferred a mediclaim for Rs. 6,462/- towards

treatment cost of his daughter before the respondent but the respondent partially settled his claim for Rs. 4,462/- only on 01.12.2011 which was short by Rs.2,000/- the cost of injections and medicines post hospitalization. He also approached the General Manager, Bhopal of respondent company but no reply was given. Being aggrieved from the action of respondent, the complainant approached this forum for redressal of his complaint.

For the sake of natural hearing was held on 27.11.2014 at Gwalior camp office. Both the parties were present and were heard. The complainant has conceded that he has not filed the P-II and P-III as well as copy of policy document as required for processing his complaint. The insurer's representative has also admitted that SCN has not been filed.

Findings & Decision:

I have gone through the material placed on the record and submissions made by both the parties. From the record, it is apparent that the complainant has failed to file the required P-II & P-III form and copy of policy document within stipulated period after registering of the complaint on 17.09.2012 as such the case cannot be further processed and it appears that due to oversight, the case was fixed for hearing. Moreover, the matter has already been settled partially as admitted by both the parties.

Hence, under these circumstances, the complaint is liable for dismissal. In the result, the complaint stands dismissed.

Dated at Bhopal on 01st day December, 2014

Mr. Rajesh

Jaiswal……Complainant

V/s

United India Insurance Co. Ltd.
……Respondent

Order No. IO/BHP/A/GI/0059/2014-2015
Case No. GI/UII/1002/112

Award

Brief Background:

The complainant had taken a Individual Health Insurance policy bearing no.191301 /48/08/97/00001503 for the period 15.01.2009 to 14.01.2009 covering himself, his wife and one son Mast. Priyank, daughter Ku. Parul & Ku. Priya for the sum assured Rs. 50,000/- for each person covered which was issued by the respondent company subject to terms & condition. It is further said that his daughter ku. Priya Jaiswal was admitted in Dr.Hardia Eye Hospital, Indore for treatment of her eye disease on 27.07.2009 and was discharged on 28.07.2009 after giving required treatment. Thereafter, he lodged the claim for Rs.17089/- towards treatment of his daughter but no action was taken and his claim was not considered. Being aggrieved by the action of respondent company, the complainant approached this forum for relief of making payment of Rs. 17089/- towards treatment cost.

The insurer in their Self Contained Note dated 28.04.2010 have admitted about the issuance of said policy covering the family members of the policy holder including Ku.Priya Jaiswal and they have also mentioned about undergoing laser surgery in Dr.Kishan Eye Care and laser surgery centre on 27.07.2009 of her eye and

about discharge on 28.07.2009 and have contended that their TPA had repudiated the claim under exclusion clause 4.3 of the policy.

The complainant as well as insurer's representative Mr. Ramkishan Bourasi were heard as mediation was failed. The complainant has reiterated the facts as mentioned in the complaint and laid emphasis that the vision was having dot-dot in the eyes and there was retinal disease and there was puncture in the eyes and for which laser operation and required treatment was given to his daughter and for which he incurred the above amount and prayed to allow his claim. On the other hand the insurer's representative has refuted the contention of complainant and laid emphasis that claim is not payable under clause 4.3 of the policy document as it was cosmetic treatment and correction of eye sight.

FINDINGS AND DECISION:

I have carefully gone through the material on the record and submissions made by both the parties. From perusal of the discharge card it is apparent that Ku. Priya Jaiswal the daughter of the complainant undergone treatment in Dr.Hardia Eye hospital Indore where Dr.Kishan B.Verma, Eye laser and lasik specialist, conducted the surgery (Argon Laser Selective and Focal Photocoagulation) and treatment was given in the said hospital as appears from the receipt dated 28.07.2009 issued by the Dr.Kishan B.Verma. The certificate dated 22.10.2009 issued by Dr.Kishan B.Verma also clearly shows that the procedure done to Ku.Priya Jaiswal on 27.07.2009 was argon laser treatment for retina disease and this was not a cosmetic procedure. The provisions of clause 4.3 of the policy document provided exclusion for cosmetic or aesthetic treatment of any description, plastic surgery, vaccination or inoculation or change of life only and does not exclude the laser

surgery of eye on account of any eye disease. From the medical documents, it is apparent that Ku.Priya Jaiswal was suffering from some retinal disease for which the aforesaid required surgery was done by laser and treatment was given. The repudiation letter dated 20.10.2009 of the TPA contains about clause 4.5 also for rejecting the claim but clause 4.5 of the exclusion clause relates to only dental treatment and surgery of any kind unless requiring hospitalization and does not exclude the treatment of aforesaid ailment of eye. Moreover, the TPA of the respondent company have already allowed the claim found as admissible for amounting Rs.10,999/- of other daughter Parul for the ailment diagnosed as bluming of vision and the insurer's representative have also furnished calculation chart for Rs.10,299/- if claim is found payable. Thus, I find force in the contention of complainant and respondent is liable to make payment of the admissible amount towards treatment cost under the policy document.

Hence, under the aforesaid facts,circumstances and material available on the record and policy terms & conditions, I am of the considered view that the decision taken by the TPA/ respondent for repudiating the claim in view of the exclusion clause 4.3 of the policy document is not justified and is not sustainable in law. Hence, the complainant is entitled for the admissible amount only towards treatment of his daughter Ku.Priya Jaiswal under the policy document.

Hence, the respondent United India Insurance Co.Ltd. is directed to make payment of admissible amount to the complainant towards treatment cost of his daughter within 15 days from the date of receipt of acceptance letter of the complainant failing which it will attract 9% simple interest p.a. from date of this order to date of

actual payment. In the result, complaint is allowed to the extent of admissible amount only.

Dated at Bhopal on 21st day of October, 2014

Mr. Rajnish Halen

.....Complainant

V/s

National Insurance Co. Ltd.

.....Respondent

Order No. IO/BHP/A/GI/0147/2014-2015
Case No. BHP-G-048-1314-0648

Brief Background:

The complainant had taken a Hospitalisation Benefit Policy bearing no. 320102/48/12/8500002284 for sum insured Rs. 5, 00,000/- for the period 27/11/2012 to 26/11/2013 covering himself and his family member. He preferred a mediclaim of Rs. 26,166/- towards treatment cost of his son Master Vedant Halen who had met with an accident but the TPA has settled his claim only for Rs.23,301/- after deducting Rs.2,865/-. Thereafter, he represents his claim towards payment of balance amount Rs.2,865/- before the TPA and respondent company but no reply was given.

The insurer in their SCN have stated that the claim has been approved and paid for an amount of Rs. 23,301/- as per duly consented discharge voucher and deductions were categorically specified and by their TPA which are logically convincing as per

policy terms & conditions and admissible claim had already been accepted by them.

For the sake of natural justice, hearing was held at Bhopal Office. The complainant was absent and has filed written submission narrating the facts about deductions asserting as not justified as and prayed to allow his claim. The insurer's representative was present and was heard who has taken the stand as mentioned in the SCN.

FINDINGS & DECISION:

I have gone through the material placed on the record and submissions made. From close perusal of the record, it is apparent that the amount of Rs. 23,301/- was only found payable as per policy terms and conditions and the amount deducted were in accordance with the plicy terms & conditions. The TPA of the company have also given details about the deductions as per policy terms & conditions and have specifically mentioned that the cost of IIF machine for Rs.2,000/- was deducted on the ground that all instrument rental charges have already been approved under package for minor procedure in private ward worth Rs.17,950/- (included under O.T. Charges). The complainant has executed the discharge voucher on 11.06.2013 accepting the payment of said amount Rs.23,301/- in full satisfaction and final settlement of all claims present or future and has not mentioned on the discharge voucher about making any protest for accepting the said amount. I find no discrepancy towards the deduction made in the claimed amount of the bills as the deductions were made in accordance with the terms & conditions of the policy document. I find substance in the contention of insurer's representative. In these circumstances, the respondent is not liable to make payment of the balance amount as prayed for.

Under the aforesaid facts & circumstances, material on record and submissions made and policy terms & conditions, I am, therefore of the considered view that the action/ decision of the respondent company to not considering the balance amount of claim is perfectly justified and is sustainable. Hence, the complainant is not entitled for the claim as prayed for. In the result, the complaint is dismissed being devoid of any merit.

Dated at Bhopal on 10th day of March, 2015

Mr.Rakesh Kumar Dumpalwar
.....Complainant

V/s

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

Order No. IO/BHP/A/GI/0092/2014-2015
Case No : GI/NIA/1108/44

Brief Background:

The complainant had taken a group mediclaim policy bearing no. 121400/34/10/87/00000378 as an employee of L.I.C. of India and beneficiary covering his mother also for the period 01.04.2010 to 31.03.2011 which was issued by the respondent subject to terms & conditions. It is further said that he lodged the claim before the TPA towards treatment cost amounting Rs.21,333.41 as mentioned in claim form only for hospitalization of his mother Mrs. Leelabai Dumpalwar in Swaraj Hospital, Nasik but his claim was rejected

under clause 2.1 (a) and (b) of the policy terms & conditions. Being aggrieved from the action of the respondent, the complainant approached this forum for the relief of making payment of Rs.21,244/- as mentioned in his letter dated 21.06.2010 and the claim amount has not been mentioned in the complaint as well as P-II form.

The insurer in their reply/SCN dated 12.09.2011 have taken the plea that the Swaraj Hospital was having 10 Beds and the certificate of registration of Swaraj Hospital had expired on 31.03.2010 and as per policy condition no.2.1, the hospital should either be registered with local authorities or should have atleast 15 inpatient beds and for class C cities, bed be reduced to 10 and the complainant had submitted receipt of Rs.10,000/- issued by Dr.Yogesh Goswami whereas the treatment was carried out at Swaraj Hospital and in investigation, it was found that the said hospital has been closed down and another hospital name Sarvodaya Hospital has been started since 1st December 2010 as such the claim was repudiated.

For the sake of natural justice, hearing was held at Bhopal office. Both the parties were heard as mediation was failed. The complainant has reiterated the versions made in the complaint and P-II form and laid emphasis that the registration of the hospital was renewed for the year 2010-2011 and registration fees was also deposited and has claimed Rs.21,244/- towards treatment cost of his mother. On the other hand, the insurer's representative has stated that the registration of the hospital was expired and the hospital was having only 10 beds and receipt of Rs.10,000/- was given by the Dr.Goswami and not by the concerned hospital. So, the claim was repudiated.

Findings & Decision:

I have gone through the material placed on the record and submissions made by both the parties. From the perusal of the terms & conditions of the policy document of group mediclaim insurance policy under which the complainant's mother also a beneficiary, it is apparent that as per clause 2.1 the concern hospital or nursing home must have been registered with the local authorities and it should have 15 inpatient beds and class C towns the condition of no. of beds has been reduced to 10. The respondent company has not challenged the status of the Nasik City as class C city town. The copy of receipt book no. 3094 issued by Nasik Mahanagarpalika shows about deposit of the fee for renewal of the hospital for the year 2010-2011 and the certificates issued by Dr.Yogesh Goswami on 30.05.2011 also show that the hospital registration has been renewed for the period 20010-2011 and fees has been paid accordingly and the insurer's representative has not challenged the genuineness of said certificates. The respondent company has also not challenged about the hospitalization and treatment of mother of the complainant during the period 09.06.2010 to 14.06.2010 as mentioned in claim form. The complainant has not brought on record the copy of the discharge card. Thus, it is established that the said hospital was registered at the time of hospitalization of the complainant's mother after renewal of the registration which was the major objection for repudiation of the claim. So, I do not find any force in the contention of the insurer's representative. In these circumstances, the respondent company is liable to pay the admissible amount towards claimed amount as per policy terms & conditions.

Under the aforesaid facts & circumstances and material on the record, I am therefore of the view that the decision of repudiation of the claim by the respondent company is not justified and is not sustainable, hence the complainant is entitled for the admissible amount towards the claim made as per policy terms & condition.

Hence, the respondent The New India Assurance Co. Ltd. is directed to pay the admissible amount towards the claim made of the complainant after reviewing the claim as per terms & conditions of the policy document within 15 days from date of receipt of acceptance letter of the complainant failing which it will attract simple interest of 9% p.a. from date of this order to the date of actual payment. In the result, the complaint is allowed to the extent of admissible amount only.

Dated at Bhopal on 23rd day of December, 2014

Mr. Ranchhod Malani
.....Complainant

V/s

The New India Assurance Co. Ltd.,
Ujjain.....Respondent

Order No.: IO/BHP/A/GI/0127/2014-2015 Case No.: BHP-G-049-1415-0107

Mr. Ranchhod Malani (hereinafter called Complainant) has taken a Mediclaim Insurance Policy No. 450203/34/12/0100000032 for the period 5.7.2012 to 4. 7.2013 for Sum Insured of Rs. 1,00,000/- each

for self and his wife from The New India Assurance Co. Ltd., Ujjain (hereinafter called Respondent).

As per the Complainant his wife Smt. Meera Malani was disgnosed with Diabetic Maculopathy with Abscess over back. She was admitted at Indubai Memorial Hospital at Nagda for 2 days from 6.10.2012 to 8.10.2012 and lateron admitted in Total Hospital, Indore from 29.10.12 to 2.11.12. A claim for Rs. 57152/- submitted to the TPA of the Insurance Company which was settled for Rs. 41776/- For remaining amount of Rs. 15376/- the TPA given the reason that as per policy condition OT charges and injection Avastin to treat diabetic complication on eyes amounting to Rs. 14000/- is not covered. He clarified to the TPA that his wife was suffering from T2DM with diabetic retinopathy which is different from ARMD and or choroidal Neo vascular membrance but his request was not entertained. Hence he approached this forum for his balance amount of Rs. 15376/- with interest.

The Respondent in its reply-dated 18.12.14 stated that in the captioned matter the Complainant wife Smt. Meera Malani was disgnosed with Diabetic Maculopathy with Abscess over back. She was admitted at Indubai Memorial Hospital at Nagda for 2 days from 6.10.2012 to 8.10.2012 and lateron admitted in Total Hospital, Indore from 29.10.12 to 2.11.12. He preferred a claim for Rs. 15376/- as Rs. 14000/- towards intra vertenal injection and other deductions for which details was not given. It confirmed that company has already informed to the complainant about the amendment in the policy conditions with original policy but he refused that no policy conditions were given to him.

FINDINGS & DECISION:

I have gone through the materials on record and submissions made during hearing and my observations are summarized below.

The Mediclaim Policy No. 450203/34/12/0100000032 for the period 5.7.2012 to 4. 7.2013 issued to the complainant is of Mediclaim Policy 2007 and there is no reference of treating ARMD the drugs like avastin or lucentis or Macular given. The Respondent vide its SCN dated 8.12.14 submitted that Rs. 14000/- were deducted towards intra vertenal injection and the details of Rs. 1376/- was not furnished even at the time of hearing. The complainant also refused to receive any changes in policy conditions as said in SCN.

This forum observed that the Respondent failed to submit any written statement or produce any opinion from an expert in their defence. Moreover, an internal administrative instruction cannot form part of the policy condition and hence cannot be made operative unilaterally without informing the insured. Therefore the decision of the respondent to repudiate the partial settlement of claim set aside.

The Respondent is directed to review & settle the claim as per policy conditions of Mediclaim Policy 2007 issued to the complainant and inform this forum within 15 days of the action taken by them.
Dated at Indore, this 25th Day of February 2015.

Mr. Shantilal Mehta ……. Complainant

V/s

United India Insurance Co.Ltd… ……. Respondent

Order No.IO/BHP/A/GI/0083/2014-2015 Case No.: BHP-G-051-1314-0650

Brief Background

The complainant Mr. Shantilal Mehta was covered under a Group Mediclaim Policy bearing No. 190300/48/11/41/00004079 for the period of 23.03.2012 to 22.03.2013 which was issued by the respondent company. It is further said that he was admitted in CHL Hospital, Indore from 14.01.2013 to 18.01.2013. He submitted all the documents after treatment for claim of Rs.63,670/- under aforesaid policy to the TPA but his claim was not settled even after approaching higher authorities. Being aggrieved from the action of the respondent, the complainant approached this forum for relief of making payment of Rs. 63,670/- as mentioned in the complaint.

The insurer in their SCN dated 10.12.2013 have stated that the complainant was hospitalized on 14.01.2013 at CHL Hospital Indore for the treatment of Type II DM/HTV/ Nephropathy /BOO. Choletithiasis/ Hypothysoidism/ Severe LV Dysfunction EF:20/LBBA/ complete Heart Block. It is further said that while taking first Insurance policy, he was not disclosed anything in proposal form about any illness or disease. So, due to non disclosure of material facts and non receipt of required documents, the claim was repudiated under the policy exclusion clause no.4.1.

For sake of natural justice, hearing was held at Bhopal office. The complainant did not appear. The insurer's representative Mr.K.K.Shete was present and was heard. Insurer's representative stated that complainant has filed a Writ Petition /4668/2014 in High Court of Jabalpur, Indore bench on same subject matter. So the case is not maintainable in this forum under RPG Rules,1998.

Findings & Decision:

I have gone through the material available on the record and submissions made by insurer's representative.
Since the complainant has filed a Writ Petition no.4668/2014 in High Court of Jabalpur, Indore bench on the same subject matter as admitted in his petition on 25.11.2014. Hence, as per RPG Rules, 1998 section 13(3)(c), such a complaint cannot be further processed by this forum and is liable for dismissal as not maintainable. In the result, the complaint stands dismissed.
Dated at BHOPAL on 9th day of December, 2014

Mrs. Shobha Chitnis
.....Complainant

V/s

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

Order No. IO/BHP/A/GI/0150/2014-2015 Case No.BHP-G-050-1314-0706

Mrs. Shobha Chitnis (hereinafter called Complainant) obtained a PNB-Oriental Royal Mediclaim Policy bearing no.

151200/48/2013/150127 for sum insured Rs. 5.00,000/- for the period 03.03.2013 to midnight of 02.03.2014 covering himself and his family members from The Oriental Insurance Co. Ltd., (hereinafter called Respondent).

As per the Complaint she hospitalized in Rajas Eye and Retina Research Centre, Indore for the treatment of DV in left eye. She preferred a claim for Rs.37401/- but the respondent deducted an amount of Rs.3500/- under various heads. Being aggrieved with the decision of the Respondent, he approached this forum for justice.

The complaint was registered and prescribed forms were issued. Replies were received from both the parties.

The Respondent vide its SCN contended that the Insured has submitted the claim papers for getting cataract operation amounting Rs.37859/- and their TPA MD India has paid claim for Rs.34359/- by deducting Rs.1000/- for Assistant Surgeon for Cataract Surgery which is not payable as per policy terms and conditions no. 3.12 as the cataract operation is performed by an eye surgeon individually which does not require any assistance and Rs.2500/- for phacoemulsification machine charge which is also not payable which is already included in OT charges.

<u>Observations:</u>

I have gone through the materials on record and submissions made during hearing and my observations are summarized below.

I found that an amount of Rs. 1000/- has been deducted on account of Asstt. Surgeon fee and Rs. 2500/- as Phacoemulsification machine charge. It is quite natural that a Cataract operation is performed by the Surgeon individually and machine charges are also

not payable as it comes under Operation Theatre charges. I found that the deductions made by the Respondent are genuine and there is no scope to interfere in the matter. The complaint is hereby dismissed without any relief.

Dated at Bhopal on 10th day of March, 2015

Mr. Shranik Lal Jain ..... Complainant

V/s

Orinental Insurance Co.Ltd. .....Respondent

Order No. IO/BHP/A/GI/0067/2014-2015
Case No. GI/OIC/1112/69

Award

Brief Background:

This complaint has been filed by the complainant Mr. Shranik Lal Jain for the relief of making payment of Rs.75,000/- towards his treatment cost.

The case of complainant in short is that he had taken a mediclaim policy bearing no.151401/48/2011/7186 from the period 15.03.2011 to 14.03.2012 for sum assured Rs.75,000/-from the respondent company. It is further said that prior to that, he was continuously with National Insurance Co.Ltd. since last 6 to 7 years without break. It is also said that he was hospitalized on 24.03.2011 to 11.04.2011 due to illness HTN, Liver, Abscess/ Ischaemia. Thereafter, he lodged a claim for Rs.75,000/- towards his treatment

cost before the respondent company but the respondent did not consider his claim and treated him as a new policy holder and not considered the old continuity with National Insurance Co.Ltd. Being aggrieved by the action of respondent company, the complainant approached this forum for relief of making payment of Rs.75,000/- towards his treatment cost.

The insurer in their reply dated 07.02.2012 contended that the insured had taken individual mediclaim policy first time and submitted only two renewal policy from National Insurace Co. and as per policy conditions, there was exclusion clause 4.1 which provides that the continuity of the policy will be maintained if the policy was taken by their company. As such, the policy taken from the previous insurer namely National Insurance Co. can not be considered for the continuity of the policy and have further contended that the claim of liver disease is not covered as per policy clause 4.2 and 4.3. So, the claim was repudiated.

For the sake of natural justice, hearing was held at Indore office. The complainant did not appear. The insurer's representative Mr. Murli Arora is present who narrated the facts as mentioned in the SCN and has also stated that the complainant has already died in year 2013. On perusal of record, it transpires that the complainant has already been died but no legal representative has came forward during proceeding of this case after death of the complainant for further proceeding and even on the date of hearing.

Hence, in view of the fact that the complainant has died and no LR has been brought on record after death of the complainant to proceed further before hearing and even today at the date of

hearing. So, this case cannot be processed further. Hence under the circumstances this complaint is closed.

Dated at Bhopal on 29 th day of October, 2014

Mrs. Shubhangi Sonaikar…….

…….Complainant

V/s

National Insurance Co. Ltd.

…….Respondent

Order No. IO/BHP/A/GI/0082/2014-2015
Case No : BHP-G-048-1415-0045

Brief Background:

The complainant' husband Mr. Avinash Sonaikar was covered under a mediclaim policy bearing no. 320200/48/11/8500001632 for the period 13.02.2012 to 12.02.2013 for sum assured Rs.1,00,000/- which was issued by the respondent company. It is further said that her husband was admitted in National Hospital Bhopal on 19.01.2013. Thereafter, she lodged two claim for Rs.46,016/- and Rs.15,415/- respectively on 25.01.2013 & 22.03.2013 for hospitalization and post hospitalization before the respondent company but neither the claim was settled nor any reply was received even after continuous follow up. Only oral information was given from the office that disease of your husband was related to alcohol and letter was sent on your address. When she had demanded information through RTI on 04.09.2013, then she received a letter on January,2014 from respondent company about rejection of her claim on 12.08.2013 and no policy terms & condition

was given to her. Being aggrieved from the action of the respondent, the complainant approached this forum for relief of making payment of her claim Rs.46,016/- and Rs.15,415/- towards treatment cost of her husband.

The insurer in their reply/SCN dated 01.07.2014 have stated that as per discharge card patient was admitted with K/C/O HTN C CLD C early hepatic encephalopathy since 2008 and policy inception date was 13.02.2011. So, disease comes under pre-existing. Therefore, the claim was not admissible under clause 4.1 and have further stated that the matter was reviewed by TPA and the company was informed that as per discharge card, the patient was admitted with K/C/O HTN C CLD C early hepatic encephalopathy since 2008 and policy inception date is 13.02.2008 and patient was a case of alcoholic liver disease as per prescription of Dr. R.K.Jain dated 03.12.2012 and 03.01.2013 and Dr. Sanjay Kumar dated 19.01.2013, so the claim is not admissible under clause 4.8 of the policy document and have also stated that matter was reviewed on the basis of information by the family members that Mr. Avinash has never consumed alcohol and claim was found not admissible on above grounds and have also stated that matter was reviewed many times but on the basis of reply of TPA, they agreed with the recommendation of the TPA and repudiated the claim under exclusion no.4.8 and communicated the same to the insured by registered letter but insured informed that no letter was received. Then, again a copy of letter was sent by speed post on the same address which was returned undelivered and again the matter was placed with DCRC for review who agreed with the repudiation and the decision was conveyed to the insured through courier which was returned with the remarked "locked, returned" and on the filing of

RTI application by the insured, they again sent the information on the same address and it was delivered to her. The respondent have also stated that another representation dated 24.03.2014 along with certificate from Dr.Sanjay Kumar has been sent mentioning therein that "as per his record, he had not been taking alcohol and cause of this liver disease is cryptogenic and one of his earlier papers somebody made a diagnosis of ALD and hence his junior resident has copied the same diagnosis but on confirmation his alcohol intake was not to be significant and the representation was sent to TPA through regional office for opinion and matter was again reviewed who opined that it is a case of alcoholic liver disease and certificate was given by Dr.Sanjay Kumar is after thought and cannot be considerd and patient was also advised tablet "Librium" which is used in alcoholic liver disease as such the claim is not admissible under clause 4.8 of the policy document.

The complainant as well as insurer's representative Mr.H.P.Singh was heard as mediation failed. The complainant has reiterated the facts as mentioned in the complaint and stated that her husband was treated for liver disease and has never taken alcohol but her claim as made was rejected and the information of rejection was only sent after filing RTI and the treating doctor has also given certificate about not taking alcohol. On the other hand, the insurer's representative refuted her contention and laid emphasis that the two prescriptions brought on record of Dr.R.K.Jain clearly show the history of ALD from 2008 before inception of the policy and the policy is continued from year 2008 and under exclusion clause 4.8 the claim is not payable.

Findings & Decision:

I have gone through the material placed on the record, written statement of the complainant and submissions made by insurer's representative and policy terms & conditions. As per exclusion no. 4.8 "the company is not liable to make any payment under the policy in respect of any expenses what so ever incurred by any insured person in connection with Convalescence, general debility, run-down condition or rest cure, congenial external disease or defects or anomalies, Sterility, infertility, venereal disease, intentional self injury and use of intoxication drugs/alcohol". The record shows that policy was taken in February 2008 which was continued till 12.02.2013. The two prescription dated 03.12.2012 and dated 03.01.2013 of Dr.R.K.Jain of the insured Mr.Avinash Soniaker clearly shows that in the history, the ALD since 2008 with weight loss and weakness and disturb sleep has been clearly mentioned who is professor of Gastro enterology, dept. of medicine of Gandhi Medical Collage, Bhopal and consultant of Hon'ble Chief Minister of Madhya Pradesh while the prescription of Dr. Sanjay Kumar, the treating doctor during hospitalization in National Hospital, Bhopal after admission on 19.01.2013 and discharge on 23.01.2013 shows KCO HTN with CLD with early hepatic encephalopathy and as per medical literature brought on record, the cause of encephalopathy has been shown due to alcohol intoxication also apart from other reasons. The complainant has brought on record a certificate dated 22.03.2014 of Dr.Sanjay Kumar who has mentioned that "as per his record, he has not been taking alcohol and cause of this liver disease is cryptogenic. In one of his earlier papers somebody made a diagnosis of ALD & hence his junior resident has copied the same diagnosis. But on confirmation his alcohol intake was not found to be

significant" but the complainant has not filed any supporting pathological report to show that alcohol intake was not significant. The above certificate certainly appears to be afterthought about above fact of not taking alcohol which is not a cogent evidence to dislodge the history mentioned in the prescription of the Dr.R.K.Jain about ALD since 2008 as it was recorded on the basis of patient's information. Thus it is established that the patient was suffering from Alcoholic Liver Disease since 2008 at the time of inception of first policy and during hospitalization period which was under the coverage period of the policy from 13.02.2012 to 12.02.2013 as. So, he is expected to place correct facts before the consulting doctor R.K.Jain in year 2008 for proper treatment of his ailment. I do not find any substance in the contention of the complainant and provisions of exclusion clause 4.8 are fully applicable to the facts of this case. In these circumstances the respondent is not liable to make payment of the claim as made.

Under the aforesaid facts & circumstances, material on record and submissions made and policy terms & conditions, I am, therefore of the considered view that the decision of the respondent company to repudiate the claim under clause 4.8 is perfectly justified and does not warrant any interference by this authority. Hence the complainant is not entitled for the claim as prayed for. In the result, the complaint is dismissed being devoid of any merit.

Dated at Bhopal on 8th day of December, 2014

Mrs. Snehlata Jain

……Complainant

V/s

New India Assurance Co.Ltd.
……Respondent

Order No. IO/BHP/A/GI/0091/2014-2015
Case No. GI/NIA/1106/25

Award

Brief Background:

The complainant's husband Anil Jain was covered under Janta Mediclaim policy bearing no.450200/34/10/14/00000618 for S.A. Rs. 50,000/- for the period 25.08.2010 to 24.08.2011 which was issued by respondent company. It is further said that in the month of August last year, the ailment of cancer was detected and during treatment he died on 23.09.2010 in Mumbai. Thereafter, she lodged the claim towards treatment cost of the hospitalization before the respondent company but no reply was given nor her claim was settled. Being aggrieved from the action of the respondent company, the complainant approached this forum for relief of making payment of Rs.1,16,010/-.

The insurer in their SCN dated 19.06.2013 have stated that their TPA requested the complainant for submission of some required document for settlement of the claim as Mr.Jain was diagnosed for

CA stomach and admitted twice from 4th to 8th September, 2010 and 15th to 23rd September, 2010 and sum insured for him was Rs.50,000/- and cumulative bonus Rs.12,750/- but since the required documents were was not made available. So, the claim was closed.

For the sake of natural justice, hearing was held at Bhopal office. The complainant did not appear . The insurer's representative Mr. Ramesh Gajrani was present who was heard as mediation could not be done due to absence of complainant. The insurer's representative has submitted that the claim has been settled and settled amount Rs.62,750/- has been paid to the complainant through cheque no. 142275 dated 07.12.2011 and has also filed claims payment statement. A letter has also been sent by some Sharad Kothari that the claim was related to his cousin brother Anil Jain after his death which has been settled.

FINDINGS AND DECISION:

I have carefully gone through the material on the record and submissions made. From the claims payment statement submitted by the insurer's representative, it is apparent that the settled amount Rs.62,750/- has been paid to the complainant through cheque no. 142275 dated 07.12.2011 and information has also been given on behalf of complainant that claim has been settled. Since the claim has been settled and payment of settled amount Rs.62,750/- has been made which is the sum insured and cumulative bonus. Hence, in these circumstances, the complaint is liable for dismissal. In the result, this case stands dismissed.

Dated at Bhopal on 23rd day of December, 2014

Mr. Sohanlal Jain .....Complainant

V/s

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

Order No. IO/BHP/A/GI/0057/2014-2015
Case No. GI/NIA/1005/19

Brief Background:

The complainant had taken a Mediclaim policy bearing no. 451300/34/07/11/00002989 for the period 18.03.2008 to 17.03.2009 for the sum assured Rs.25,000/-+75,000/- covering himself, his wife Smt.Pratibha Jain and three dependent sons which was issued by the respondent company. It is further said that his wife Smt. Pratibha Jain, insured beneficiary was hospitalized and underwent treatment in Curewell Hospital, Indore and information was given to company and TPA and lodged six claims for Rs.22,486.00 for the period 31.07.2008 to 05.08.2008, Rs.16,651/- for 21.08.2008 to 22.08.200,8 Rs.15,151/- for 11.09.2008 to 12.09.2008, Rs.15153.00 for 02.10.2008 to 03.10.2008, Rs.15,460.00 for 23.10.2008 to 24.10.2008 and Rs.16,927/- for 13.11.08 to 14.11.2008 but company has made payments for amounting Rs. 16280/-, 16,160/-, 10,345/-, 14,951/- and 15,216/- respectively in month of October,2008 to February, 2009 through cheques. The respondent company did not give any details of payment related to particular claim and he sent several letters to the respondent company but no reply was given and in this way against

total amount of Rs. 101828/- he received only Rs.72,952/- having a balance of Rs.28,876/- as un paid. Being aggrieved by the action of respondent company, the complainant approached this forum for relief of making payment of claim amounting Rs.28,000/- .

The respondent company have not submitted the self contained note rather have sent a letter dated 02.06.2010 mentioning therein that the claim of complainant was settled by the TPA and paid file was available with them and the request was made to provide them the paid/ settled claim file for sending brief note.

For the sake of natural justice, hearing was held at Bhopal office. The complainant did not appear. The complainant's son as his representative Mr. Rohit Khatod as well as the insurer's representative Mr. Praveen Potdar were heard as mediation could not be done due to absence of the complainant. The complainant's representative reiterated the versions made in complaint and P-II form and has admitted that his five claims from Sr.No. 1 to 5 as mentioned in complaint have been settled and payment has been made through cheques and has no objection for five claims which have been settled as per admissible amount but the sixth claim made for Rs.16,927/- as mentioned at Sr.no.6 of the complaint for the hospitalization period dated 13.11.08 to 14.11.2008 towards treatment of his insured mother has yet not been paid and no reply has been given by the respondent company regarding non payment of the aforesaid claim amount and prayed to allow the amount of the sixth claim. On the other hand, the insurer's representative has stated that the insured was suffering from cancer and chemo was going on and five claims as stated have been settled and paid but

the sixth claim is not admissible as per provisions of clause 5.5 and 6.0 (c) of the policy terms & conditions.

FINDINGS AND DECISION:

I have carefully gone through the material on the record and submissions made by both the parties. Admittedly, the above policy was issued to the complainant covering his wife also. There is no dispute for undergoing treatment during the aforesaid period in the hospital. It is also admitted position that the five claims as made from Sr.no. 1 to 5 has been settled and admissible amount has been paid as per policy document. It is also admitted fact that the sixth claim as mentioned at Sr.no.6 of complaint amounting Rs. 16,927/- for hospitalization period from 13.11.2008 to 14.11.2008 has not been paid to the complainant and no reasons have been shown for non payment of the same except the verbal assertion of the insurer's representative that the said claim was not admissible under clause 5.5 and clause 6.0(c). The clause 5.5 deals with fraud, misrepresentation and concealment but the respondent company could not prove any such ground to disallow the said claim. The clause 6.0 (c) provides that the enhanced sum insured will not be available for an illness, disease, injury already contracted under the preceding policy period but the respondent company also failed to bring the claim under the purview of clause 6.0 (c) as five claims for the treatment of the ailment of the complainant's wife have already been settled and paid. The respondent company have not filed any self contained note to deny the admissibility of the sixth claim as stated above. I do not find any reason for not considering and making payment for settlement of the sixth claim for amounting Rs.16,927/- as mentioned at Sr.no.6 of the complaint for the hospitalization period 13.11.2008 to 14.11.2008 inspite of

submitting the claim form, bills and receipts to the TPA of the company. Hence, in the circumstances, the respondent is liable to make payment of admissible amount of the sixth claim of the complainant towards treatment of his wife in accordance with the policy document.

Hence, keeping in view the entire facts and circumstances and material available on the record and policy terms & conditions, I am of the considered view that the action of the respondent for not considering and settling the sixth claim as mentioned at Sr.no. 6 of the complaint for amounting Rs.16,927/- towards treatment cost of complainant's wife is not proper and justified is not sustainable in law. Hence, the complainant is entitled for the admissible amount against his sixth claim amounting Rs. 16,927/- only and cannot get the balance amount as claimed on the basis of his making no objection against the payments already made for five claims.

Hence, the respondent The New India Assurance Co.Ltd. is directed to settle and make payment of admissible amount against the sixth claim for amounting Rs.16,927/- (Sixteen Thousand Nine Hundred Twenty Seven) only towards treatment of complainant's wife under the policy document within 15 days from date of receipt of acceptance letter of the complainant failing which it will attract simple interest of 9% from date of this order to the date of actual payment. In the result, the complaint is allowed to the extent of admissible amount.

Dated at Bhopal on 07th day of October, 2014

Mr. S.S.Dwivedi

……Complainant

V/s

New India Assurance Company Ltd……Respondent

Order No. IO/BHP/A/GI/0103/2014-2015
Case No. GI/NIA/1105/09

Award

Brief Background:

Being aggrieved by the action/ decision of the respondent company, the complainant Mr. S.S.Dwivedi as a beneficiary/ insured under Group Mediclaim (Tailor made) insurance policy no. 121400/34/10/87/00000378 for the period 01.04.2010 to 31.03.2011issued for employees and their dependent including retired employees of LIC approached this forum for redressal of his grievance towards making payment of Rs. 8,458/- for undergoing treatment of his wife Kalpana Dwivedi for bleeding before delivery in during period of hospitalization in Ashish Hospital Jabalpur from 12.05.2010 to 15.05.2010 and post hospitalization with cost and mental agony.

The respondent in their reply/ SCN have taken the plea that as per investigation reports and hospitals record there was no accident/ incident which led to medical treatment requiring anti natal curation and it was the case of voluntary medical termination of pregnancy

which was not covered under the policy as such the claim was closed as no claim.

The complainant was absent. The insurer's representative was present who was heard who has taken the stand as made in the SCN and laid emphasis that there was no accident which requires admission and treatment and only anti natal curation which was not covered under the policy document and the voluntary medical termination of pregnancy is also not covered under the policy so the claim is not payable.

FINDINGS & DECISION:

I have gone through the material placed on the record and submission made. From perusal of the discharge ticket (xerox copy) issued by Ashish hospital of the patient Smt.Kalpana Dubey wife of the complainant clearly shows that in the diagnosis column ANC three and half month has been mentioned and amenorrhoea three and half month is also been mentioned and in condition on admission BPV one month has been mentioned and investigation USG OBS single live foetus was seen and the required treatment was given about ANC and the complainant has clearly mentioned that a son was born on 03.10.2010 by cesarean in the Jamdar hospital and treatment was done on the advice of the doctor for bleeding before delivery and not for abortion rather to save the pregnancy. As per policy condition 4.11 the claim towards voluntary medical termination of pregnancy has been excluded, so it has no relevance if the birth of the child in the month of October, 2010 is taken into consideration as per oral submission of the complainant though no document has been filed showing the birth of the son. The sub clause 5.13 of the policy conditions clearly provides that pre natal and post natal expenses are not covered for maternity and

pregnancy related claims, only expenses pertaining to the confinement period in the hospital is payable. The complainant has also not taken the ground that hospitalization was done due to sustaining any injury on account of any accident which required anti natal curation. Though, the respondent company has brought on record the investigation report of Dr. R.K.Tiwari who is retired Dy.Director (Vety) and not of any allopathic doctor which is a fallacy and cannot be considered to decide the claim as not relevant rather the dispute of claim has been considered on the basis of discharge ticket and material on record. Since, it has been established from the discharge ticket that treatment was given for diagnosed ANC of three and half months and amenorrhoea three and half month BPV from one month which is not covered under the policy terms & conditions, so the expenses incurred and claim for post hospitalization also cannot be considered due to the above exclusion. In these circumstances, the respondent company is not liable to make payment of amount as claimed.

Under the aforesaid facts & circumstances, material on record and submissions made and policy terms & conditions, I am therefore of the view that the decision of the respondent company for not considering the claim and making the claim as no claim under policy terms & conditions is perfectly justified and is sustainable. Hence, the complainant is not entitled for the relief as prayed for. In the result, the complaint stands dismissed accordingly.

Dated at Bhopal on 13th day of January, 2015

Mr. S.S.

Vijayvargiya……Complainant

V/s

United India Insurance Co. Ltd.
……Respondent

Order No. IO/BHP/A/GI/0122/2014-2015
Case No.GI/UII/1106/27

Award

Brief Background:

The complainant covered under Group Mediclaim policy bearing no. 190300/48/10/41/00000715 for the period from 29.06.2010 to 28.06.2011 which was issued by the respondent company. He preferred mediclaim for Rs.21, 572/- and 12,868/- for pre & post hospitalization towards his treatment but no reply was given nor payment was made till date. He made representation before the higher authorities of the respondent but his claim was not

considered. Being aggrieved by the action of TPA/respondent Company the complainant approached this forum for the relief of making payment of his claim of Rs.34, 440/- with interest and cost.

The insurer in their reply have asserted that the condition 4.1 and 4.2 will not be applicable as insured has submitted previous policies but condition no. 4.10 of the policy is still applicable, so they are unable to settle the claim.

both the parties were heard as mediation failed. The complainant has narrated the facts as mentioned in the complaint that he had policies since 2005 from National Insurance Co. and policies from 20.06.2009 of the respondent company which were continued and his claim was rejected under clause 4.1, 4.2 and 4.10 on the other hand the insurer's representative has submitted that SCN could not be filed but as per reply filed today the provisions of clause 4.10 is applicable in this case so the claim is not payable.

FINDINGS & DECISION:

I have gone through the material placed on the record and submissions made. Clause 4.10 of the policy terms and conditions clearly provides that charges incurred at hospital or nursing home primarily diagnosis. X-Ray or laboratory examination or other diagnostic studies not consistent with or incidental to the diagnosis and treatment of positive existence of presence of any ailment, sickness or injury for which confinement is required at hospital/nursing home. From perusal of the discharge summery it is apparent that the complainant was admitted in the Rajshree Hospital, Indore with H/o proximally progressing pain in lift lower limb since last two months and swelling in left inguinal fold and patient was put on antihypertensive and oral anticoagulant therapy and he was fully investigated to rule out pancreatic or other

malignancy. The several invoice of the said hospital clearly shows about several pathological test like ANCA and APTT (activated partial thromboplastin time etc.) which are not at all connected with the ailment complaint of pain in left lower limb and the oral medication given do not appear to be consistent with the aforesaid ailment of pain of lower limb. Thus it is establish that the complainant was admitted only for thorough investigation to rule out pancreatic or other malignancy and mostly the diagnostic test was done for diagnosis of other ailment which certainly attracts the provisions of clause 4.10 of the policy terms and conditions. In these circumstances the respondent company is not liable to make payment of the claim as prayed for.

Under the aforesaid facts & circumstances, material on record and submissions made, I am therefore of the view that the action/decision of the respondent company for not considering the claim made by the complainant towards his treatment cost is justified and is sustainable under the policy document. Hence the complainant not entitle for the relief as prayed for. In the result the complaint stands dismissed.

Dated at Bhopal on 18th day of February, 2015

Mr. Subhash Porwal

……Complainant

V/s

United India Insurance Co. Ltd. …
……Respondent

Order No. IO/BHP/A/GI/0119/2014-2015
Case No. GI/UII/1108/42

Award

Brief Background:

This complaint has been filed on behalf of Mr. Subhash Porwal by Mr. Ajit Kumar Jain. The case of complainant in short is that, Mr. Subhash Porwal was covered under a Group Mediclaim (Tailor Made) policy bearing no. 191302/48/10/41/00000237 for the period 28/04/2010 to midnight of 27/04/2011 alongwith his wife. It is further said that the complainant's wife Smt. Renu Porwal was admitted in Dr. Hardia Eye Hospital, Indore on 07/06/2010 and discharged on 08/06/2010. It is alleged that complainant had submitted all the necessary documents towards claim for treatment cost of his wife in the office of TPA of the respondent but they did not give the response till now. Being aggrieved by the action of the respondent company, the complainant approached this forum for the relief of making payment of Rs. 26,100/- towards treatment cost of his wife.

The respondent have contended in their SCN the complainant's wife was hospitalized from for laser surgery of her eye which was done for removal of spectacles and as per terms and conditions of the policy it fall under cosmetic surgery, hence claim was repudiated.

The complainant did not appear and nor file any written submission. The insurer's representative was heard who has taken the stand as mentioned in reply/SCN and laid emphasis that this complaint has been filed and signed by Mr. Ajit Kumar Jain on behalf of Mr. Subhash Porwal and Mr. Ajit Kumar Jain has also signed on P-II and P-III form and Mr. Ajit Kumar Jain is not policy holder rather the policy is in name of Subhash Porwal in which his wife has been

covered and the said surgery was the cosmetic surgery, so it was not covered under the policy, so the claim was repudiate and prayed to dismiss the complaint.

FINDINGS & DECISION:

I have gone through the material placed on the record and submission made. From perusal of the claim form, it transpires that the complainant's wife was hospitalized from 07/06/2010 to 08/06/2010 for Excimec laser operation of eye but nothing has been mentioned on the Discharge card of about performing the above said operation of Eye as the column of treatment is totally blank. Moreover, the first prescription of the doctor concerned has also not been filed on behalf of complainant. As per exclusion clause 4.5 the cosmetic treatment of any description is not payable. No document has been filed by the complainant about specific ailment of eye for which said laser operation was advised. So, the above laser operation can be treated as cosmetic surgery which is not covered under the policy document. Apart from it, it is apparent from the complaint and P-Ii form itself that this complaint has been filed by Mr. Ajit Kumar Jain duly signed by him and not by Mr. Subhash Porwal who is beneficiary/ insured along with his wife under the said group mediclaim policy. So, the complaint is also not maintainable under the provisions of RPG Rules, 1998. In these circumstances the respondent is not liable to make payment of the claim as made.

Under the aforesaid facts & circumstances, material on record and submission made and policy terms & conditions, I am, therefore

of the considered view that the action/ decision of the respondent company to repudiate the claim is perfectly justified and is sustainable and the complaint is not maintainable. Hence, the complainant is not entitled for the claim as prayed for. In the result, the complaint stands dismiss accordingly.

Dated at Bhopal on 16th day of February, 2015

Mr. Sudhir Jain.....Complainant

V/s

National Insurance Company Ltd.....Respondent

Order No. IO/BHP/A/GI/102/2014-2015
Case No. GI/NIC/1302/56

Award

Brief Background:

Being aggrieved by the action/ decision of the respondent company, the complainant Mr. Sudhir Jain as a policyholder under Hospitalization Benefit Policy bearing no. 320100/48/10/8500002941 for the period 29.01.2011 to mid night of 28.01.2012 covering himself, his wife and sons and daughter approached this forum for redressal of his grievance towards making payment of Rs. 17,703/- for undergoing treatment of his wife Sapna Jain for left lateral epicondylytis during period of hospitalization in

Vishesh Hospital Indore from 13.12.2011 to 14.12.2011 and pre and post hospitalization.

The respondent in their reply/ SCN have taken the plea that the claim was handled by their TPA and after seeking advice of their panel doctor K.G.Agrawal, claim was repudiated on the ground that it was OPD procedure and hospitalization was not required and time consumed in the procedure was about 5-10 minutes and OPD procedure was converted into a 24 hours admission in this case.

. Both the parties were heard as mediation was failed. The complainant reiterated the facts as mentioned in the complaint and stated that injection was given in OPD on 13.12.2011 and the patient was kept under observation as per doctor's certificate and prayed to allow the claim. The insurer's representative has taken the stand as made in the SCN and laid emphasis that it was OPD procedure and hospitalization was not required but it was converted as inpatient in hospital for more than 24 hours, so the claim is not payable.

<u>FINDINGS & DECISION:</u>

I have gone through the material placed on the record and submission made. From perusal of the discharge summary, it appears that the wife of complainant was admitted on 13.12.2011 and discharged on 14.12.2011 and no time of admission and discharge has been mentioned and 'intra articular injection' was given on 13.12.2011 by Dr.Anant Jinsiwale of vishesh hospital, Indore for complaint of pain in left side elbow with swelling since one year which was diagnosed as RA with Fibro Myalgia and some medicines were also advised at the time of discharge. The certificate dated 08.05.2012 issued by the said doctor shows that the patient

was asked to get admitted in hospital to watch after injection on 13.12.2011 while the claim was already repudiated vide letter dated 27.02.2012, so the above certificate is after thought and to show the requirement of hospitalization. The panel doctor of the respondent company has also opined that the said injection was an OPD procedure and hospitalization was not at all required. Thus, it is established from the material available on the record that the procedure adopted for treatment of the diagnosed ailment of the complainant's wife by giving injection and advising for oral medication was certainly an OPD procedure and the hospitalization was not required. The concerned doctor has also mentioned that the patient was kept to watch after injection. In these circumstances, the respondent is not liable to make payment of the claim as made by the complainant.

Under the aforesaid facts & circumstances, material on record and submissions made and policy terms & conditions, I am therefore of the view that the decision of the respondent company to repudiate the claim under policy terms & conditions is perfectly justified and is sustainable. Hence, the complainant is not entitled for the relief as prayed for. In the result, the complaint stands dismissed accordingly.

Dated at Bhopal on 13th day of January, 2015

Mrs. Usha

Bai.....Complainant

V/s

The Oriental Insurance Co. Ltd.

.....Respondent

Order No. IO/BHP/A/GI/0172/2014-2015
Case No. BHP-G-050-1314-0691

Brief Background:

The complainant had taken an Individual Mediclaim Policy bearing no. 151100/48/2012/5795 as a beneficiary for sum insured Rs. 50,000/- for the period 29/09/2011 to midnight of 28/09/2012 from the respondent company. It is further said that she underwent treatment in the Curewell hospital from 26.11.2011 to 08.01.2009. Thereafter, she lodged the claim before the respondent's TPA M/s M.D.India Health Care Services, Indore on 07/12/2011 and has submitted all the necessary documents which was not considered and claim was not paid nor any reply was given to her. Being aggrieved by the action of the respondent company, the complainant approached this forum for redressal of her grievance towards making payment of Rs.6,322/- as treatment cost as mentioned in P-II form.

After registration of the complaint, the complainant submitted prescribed forms duly signed by him and but the respondent had not submitted SCN/reply rather has brought on record copy of letter dated 01.05.2013 only on date of hearing mentioning therein that the claim has been closed as requites documents were not provided inspite of ADR dated 27.12.2011 and 05.01.2012 viz attested photo copy of indoor case papers, patient health history/personal information/ preoperative anesthesia information alongwith day to day treatment chart with daily doctors visit notes. The non filing of

SCN clearly reflects the gross negligence of the respondent company.

The complainant did not appear but has sent the written submission. The representative of respondent company was heard who stated that the case was closed due to non furnishing of the required medical documents and claim is not payable.

FINDINGS & DECISION:

I have gone through the material placed on the record and submission made. The discharge card (xerox copy) shows about the date of admission of the complainant on 26.11.2011 and discharged on 30.11.2011 from the Curewell Hospital Pvt.Ltd., Indore and the said discharge card also shows treatment undergone by the complainant in the said hospital for the diagnosed ailment. The OPD form dated 26.11.2011 also shows about the requirement of admission of the patient in the said hospital. The pathological reports available on the record shows about investigation. From the letter dated 01.05.2013, it appears that the claim has been closed due to non compliance of the required medical documents by the insured i.e. attested photo copy of indoor case papers, patient health history/personal information/ preoperative anesthesia information alongwith day to day treatment chart with daily doctors visit notes while the complainant has clearly mentioned in her written

submission dated 04.12.2014 that she has submitted all the requisite documents related to her claim to the respondent's office vide her letter date 13.12.2013, 31.01.2014 and 10.04.2014 and all the claim formalities completed by her, it is clear that the claim has been closed due to non submission of some documents which does not appear to be just and proper as the complainant has already submitted the requisite documents before the respondent. In these circumstances the respondent is liable to settle the claim after reopen/ review the claim of the complainant on the basis of documents already submitted or on submission of required documents if not submitted earlier.

Hence, the respondent Oriental Insurance Co.Ltd. is directed to reopen/review and settle the claim of the complainant on the basis of documents already submitted or on submission of required documents if not submitted earlier in accordance with the terms & condition of the policy document within one month from the date of receipt of this order under intimation to the complainant and to this forum. In the result, the complaint is allowed to the extent of above observation.

Dated at Bhopal on 19th day of March, 2015

Mrs. Chandrika Lokwani

……Complainant

V/s

HDFC Ergo General Insurance Co.Ltd.
……Respondent

Order No. IO/BHP/A/GI/0090/2014-2015 Case No. BHP-G-018-1415-0043

Brief Background:

The complainant's husband Shri Nutan Kumar Lokwani was covered under Sarva Suraksha Advantage policy bearing no.51435123 under critical illness also for S.A. Rs. 15,00,000/- for the 07.01.2013 to 06.01.2014 which was issued by respondent company in lieu of a loan provided by HDFC Bank. It is further said that the husband of the complainant Late Nutan Kumar Lokwani passed away due to heart attack after 10 months of inception of the policy. Thereafter, the complainant lodged the claim of critical illness which was for Rs.15,00,000/- under the policy document but claim was not considered on the ground that it was necessary that the patient should survive for 30 days from the date of the of ailment of heart attack while as per medical record, her husband was alive for 45 days.

The insurer in their SCN the insurer have stated that in death summary prepared by the LBS Hospital, it has been mentioned that the insured was treated for palpitation and HTN on 15.09.2013 where after he came for follow up on 21.09.2013 for same complaints and was treated with antihypertensive drugs. He was admitted on 21.10.2013 with Myocardial infarction, CHB and cardiogenic shock and was also declared dead on the same day. As per death summary, the insured was being treated for palpitation and hypertension prior to 21.10.2013 and not myocardial infarction. In fact, Myocardial infarction occurred on 21.10.2013. Hence, the claim was repudiated as per policy terms and conditions section 1 critical illness.

FINDINGS AND DECISION:

From the death summary of the diseased patient Mr.Nutan Kumar, it is apparent that the patient came on follow up on 21.09.2013 for same complaint and treated with anti-hypertensive drugs as he had palpitation and HTN on 15.09.2013 and was treated accordingly and he was admitted to LBS on 21.10.2013 with Myocardial infarction, CHB and cardiogenic shock at 10.30 pm and his condition was deteriorated and patient was declared dead on 21.10.2013 at 11.45pm in LBS hospital. The prescription dated 15.09.2013 also shows only HTN and complaint of headache and ECG was advised by

Dr.G.C.Goutam and the Eco report only shows trivial MR on the basis of test conducted on 03.10.2013 and nothing has been mentioned about Myocardial infarction and concentric LVH has been mentioned and doctor has not shown any co-relation with the LVH and Trivial MR with the ailment of Myocardial infarction which was developed only on 21.10.2013 due to which death was caused. The section-1 critical illness of terms & conditions clearly provides that if the insured person named in the scheduled is diagnosed as suffering from a critical illness which first occurs or manifests itself during the policy period and the insured survived for the minimum period of 30 days from the date of diagnosis, the company shall pay critical illness benefit as shown in the schedule and in the critical illness coverage, the first heart attack (Myocardial infarction) has been mentioned and the ailment of HTN as well as palpitation has not been covered under the term critical illness and only CAD requiring surgery has been mentioned apart from Myocardial infarction but as per medical science, the ailment of HTN is said to be related with the ailment of Myocardial infarction. The condition of survival for minimum of 30 days from the date of diagnosis of critical illness is certainly a stringent condition which cannot be diluted by this forum but the factum of HTN and palpitation cannot be lost sight off for being a reason of heart attack (Myocardial infarction) though not incorporated in critical illness coverage. The respondent company has also failed to show that there was no link of HTN and palpitation for which the patient was treated before the heart attack (Myocardial infarction) which caused his death. So, in these circumstances and keeping in view the above deliberations, I arrive at the conclusion that the complainant deserves a reasonable amount of ex-gratia under the provision of Rule 18 of RPG rules 1998.

Dated at Bhopal on 22nd day of December, 2014

Mr. Keshav Goel .....Complainant

V/s

Bajaj Allianze General Insurance Co.Ltd.....Respondent

Order No. IO/BHP/A/GI/0068/2014-2015
Case No. GI/BAG/1010/85

Award

Brief Background:

The complainant had taken a policy bearing no.OG-09/2001/6401/00491272 under plan Accident & Home cover for the period of 15.02.2009 to 14.02.2010 for sum assured 10,000/- as a member of Reliance Loyalty & Analytics Ltd. the proposer which was issued by the respondent company. It is further said that the complainant undergone treatment in the Vishesh Hospital, Indore from 11.12.2009 to 17.12.2009. He lodged his claim for Lumber Slip Disk due to slip on floor accidently due to wrong posture of his body before the respondent company but his claim was repudiated on the ground that the injury was not accidental rather it was known disease prior to the accident. Being aggrieved by the action of respondent company, the complainant approached this forum for relief of Rs.33702/- as actual expenses though the covered amount under the policy was Rs.10,000/-.

The insurer in their Self Contained Note dated 18.02.2011 have admitted about the issuance of the above policy under accident and home cover policy subject to terms & conditions and have contended that on verification of all the documents, it was revealed that the complainant was hospitalized for the treatment of acute extruded lumber disk with acute coronary syndrome and was known to be suffering from lumber and cervical spondylosis while as per policy document it extents coverage only for expenses incurred on inpatient arising out of accident and only in case of accidental bodily injury and hospitalization for a minimum period of 24 hours the

reimbursement is made upto a maximum sum insured as per schedule and further contended that as per history mentioned in the document dated 11.12.2009 of the Vishesh Hospital, it is very well established that the diagnosis of the complainant can never be amounted to accident as such the claim was repudiated.

For the sake of natural justice, hearing was held. The complainant did not appear. The insurer's representative Mr. Sujeet Sahu was heard as mediation could not be done due to absence of complainant who submitted that claim is not payable as the treatment was not taken in the hospital due to any accident and there is no mention of any accident in the medical history at the time of admission of the complainant in the said hospital and is a known case of CAD.

FINDINGS AND DECISION:

I have carefully gone through the material on the record and submission made. On perusal of the MRI of Lumbo Sacral Spine of the complainant the Osteophytes were found in lumber vertebra and degenerated L5,S1 disk show large posterocentral and left peracentral exclusion the extruded disk fragment and the lumber spondylosis was found in impression and MRI of Cervico –Dorsal Spine shows cervical spondylosis and above both the ailments are auto immune disease. The discharge summary also does not show that due to any accident i.e. slip on the floor, the above lumber and cervical spondylosis were caused. The clause 3 of the policy terms & conditions clearly provides that only in case of hospitalization for minimum period of 24 hours on the advice of a doctor because of accidental bodily injury sustained during the policy period, the reimbursement will be made. The complainant has failed to establish that the diagnosed ailment of lumber & cervical spondylosis and

treatment of chest discomfort for which most of the medicines were given was taken only on account of accident. Thus, I find substance in the insurer's representative. The complainant has also not filed the copy of representation made to grievance cell of company before filing this complaint which is a serious infirmity. From the medical documents, it is established that the complainant was suffering from lumber & cervical spondylosis and CAD from before and were not the cause of any accident.

Hence, under the aforesaid facts, circumstances and material available on the record and policy terms & conditions, I am of the view that decision of the respondent company to repudiate the claim is perfectly justified. Hence the complainant is not entitled for the relief as prayed for. In the result, the complaint stands dismissed being devoid of any merit.

Mr. M. S. Jadaun …….

…….Complainant

V/s

The New India Assurance Co. Ltd.
…….Respondent

Order No. IO/BHP/A/GI/0158/2014-2015 Case No. BHP-G-049-1314-0672

<u>Brief Background:</u>

The complainant as a development officer of LIC of India was covered under Group Mediclaim policy bearing no.120700/34/13/05/00000001 for sum insured Rs. 1,10,000/- for the period 01.04.2013 to 31.03.2014 which was issued by the

respondent company to the LIC of India as insured for their employees and their dependents. He was admitted in Vasan Eye Care Hospital, Indore for the treatment of left eye subhyaloid haemorrhage. He preferred a claim for Rs.13,200/- which was repudiated by the respondent under policy condition 9.20.

FINDINGS AND DECISION:

I have carefully gone through the material on the record and submissions made by insurer' representative. The discharge summary shows the date of admission 27.06.2013 and the complainant was diagnosed to have left eye subhyaloid haemorrhage and was undergone intravitreal injection Bivacizumab under guarded visual prognosis for the same. Clause 9.20 of the policy conditions provides that all treatments like age related mascular degeneration (ARMD) and or Choroidal Neo Vascular Membrance done by administration of Lucentis/Avantis/Macugen/Avastin and other related drugs as intravertal injection are excluded under this policy. Since, the above ailment in the eye was age related macular degeneration for which the said intravertal injection was given towards treatment of the diagnosed ailment in the eye which is excluded under clause 9.20 of the policy document. Hence, I find substance in the contention of insurer's representative. Hence, in these circumstances, the respondent is not liable to pay the claimed amount under as per the clause 9.20 of the above policy document. Hence, the complainant is not entitled for the relief as prayed. In the result, the complaint stands dismissed.

Dated at Bhopal on 18th March, 2015

Mr. Pawan Jain
…….Complainant

V/s

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

Order No. IO/BHP/A/GI/0167/2014-2015 Case No.GI/SHI/1302/63

Brief Background:

The complainant had taken a Family Health Optima Insurance Policy bearing no. P/201114/01/2012/004399 for floater sum insured Rs.2,00,000/- for the period 10.12.2011 to 09.12.2012 covering himself and his family members from Respondent. It is further said that the Complainant was hospitalized in Curewell Hospital, Indore and Muljibhai Patel Neurological Hospital, Nadiad for the treatment of Chronic Kidney disease. He preferred a claim for Rs.40,414/- and Rs.20,000/- respectively which was repudiated on the ground that the patient was suffered from obstructive uropathy. The complainant said that obstructive uropathy was cured before 10 years and there were no symptoms of obstructive uropathy.

The Respondent vide its SCN have contended that the complainant was diagnosed as Chronic Kidney disease stage V, second degree Chronic Reflux Nephropathy, Severe Hypertension. As per discharge summary he gives history of left flank pain 10 years ago, found to have left lower urteric obstruction for which open surgery was done. It is further reiterated that CKD is a pre-existing condition much prior to inception of the policy on 10.12.2010 and the present

admission is for a complication of this PED. Hence, the claim was repudiated under condition No. 7 of the insurance policy.

<u>Findings & Decision:</u>

I have gone through the material on record and submissions made by both the parties.

From the proposal form placed on record it is clear that the complainant has written his condition as good health and there were no any disease at the time of taking the insurance policy in December, 2010. The complainant was admitted in curewell hospital from 14.8.12 to 17.8.12 for the treatment of CKD i.e. Chronic Kidney Disease) stage V, second degree chronic reflux nephropathy, severe hypertension. Again he was admitted in Muljibhai Patel Neurological Hospital, Naidad from 18.8.12 to 21.8.12 for CKD Stage-V and as per discharge summary the patient was having a history of left flank pain 10 years back and found to have left lower urteric obstruction for which open surgery was done, no stone. Patient was asymptomatic for last 9 years. In my opinion CKD develops gradually over a period of years and in this case, the cause is hypertension as well as the obstructive urinary disease which is so far advanced as to cause a non functioning left kidney in addition, the recurrent LUTS since one year contributed to the rapid failure of the left kidney. I have also gone through the certificate of Dr. S. Suresh Sankar, Group Medical Director about insured patient that the kidney disease is clearly a long standing disease and prior to policy initiation in December 2010 i.e. pre existing condition. As per policy condition No. 7, the complainant is not entitled to get any claim from the Respondent due to mis-representation of facts about his pre-existing disease at the time of taking policy.

Under the aforesaid facts & circumstances, material on record, I am therefore of the view that the decision/action of the respondent for not considering the claim of the complainant as per policy document is perfectly justified and is sustainable. Hence, the complainant is not entitled for the relief as prayed for. In the result, the complaint stands dismissed accordingly.

Dated at Bhopal on 19th day of March, 2015

Mr. Suresh Handiekar……Complainant

V/s

United India Insurance Co. Ltd. ……Respondent

Order No. IO/BHP/A/GI/0140/2014-2015
Case No. GI/UII/1208/31

Brief Background:

The complainant was covered under a Group Mediclaim Policy bearing no. 190300/48/11/41/00002477 for sum insured Rs. 5, 00,000/- for the period 29/10/2011 to 28/10/2012 with his wife Smt. Asha. It is further said that He preferred a mediclaim on

13.03.2012 for Rs.31,748/- and on 02.04.2012 for Rs.30,325/- towards treatment cost of his wife before the MedSave (TPA) but his claim was rejected on the ground of pre-existing disease. Being aggrieved by the action of the respondent company, the complainant approached this forum for redressal of his grievance towards payment of Rs.62,073/- (31,748/- + 30,325/-) with interest.

The insurer in their SCN have stated that the insured opted for Bank Insurer's policy being Account Holder of Canara Bank, Palasia Branch, Indore for sum assured of Rs.5 lacs. The claims were preferred by the insured for the treatment of Ca Breast Cancer for Smt.Asha which were rejected by the authorized TPA. It is further stated that the main issued involved was admissibility of claim preferred by the insured for the existing illness i.e CA Breast, detected in the year 1995 before taking the policy and the first policy issued by United India Insurance Co. form period 29.10.2009 to 28.10.2010 which should have been taken after the expiry of policy no. 151301/48/2010/00626 i.e w.e.f. 20.05.2010 to 19.05.2011 for sum insured of Rs.1.50 lacs only. As per exclusion clause 4.1 of the policy " All disease/ injuries which are pre-existing when the cover incepts for the first time. For the purpose of applying this condition, the date of inception of the initial Mediclaim Policy taken from any of the Indian Insurance companies shall be taken, provided the renewals have been continuous and without any break. However, this exclusion will be deleted after 3 consecutive claim free policy years." No claim is admissible under exclusion no. 4.1 stated above, since, the policy was issued by this company in the year 2009-10 was fresh policy and the cliam was preferred by the insured within 3 years.

FINDINGS & DECISION:

I have gone through the material placed on the record and submissions made by both the parties. From close perusal of the record, it is apparent that

I find substance in the contention of insurer's representative. In these circumstances, the respondent is not liable to make payment as prayed for.

Under the aforesaid facts & circumstances, material on record and submissions made and policy terms & conditions, I am, therefore of the considered view that the action/ decision of the respondent company to rejecting the claim is perfectly justified and is sustainable. Hence, the complainant is not entitled for the claim as prayed for. In the result, the complaint is dismissed being devoid of any merit.

Dated at Bhopal on 9th day of March, 2015

BHUBANESWAR OMBUDSMAN CENTER--------MEDICLAIM

COMPLAINT NO-14-004-1161

Smt. Sarojini Sahu

Vrs

United India Insurance Co. Ltd., New Delhi DO XI

Award Dated 25th Day of Nov., 2014

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

Brief case of the Complainant is that she is covered under Group Mediclaim Scheme 2012 meant for retired employees of SAIL. Unfortunately on 24.09.2012 she got admitted to Kalinga Hospital, Bhubaneswar for her treatment under Neurologist Mr. A.K. Mohapatra and was discharged on 28.09.2012 after necessary treatment. She spent a sum of Rs. 18,000/- in all. Subsequently she submitted all the relevant papers to MD India Healthcare Service being the TPA and lodged a health-claim. There has been unreasonable delay in settlement of the claim. So the Complainant approached this forum.

The OP files SCN stating that the Complainant was hospitalized for rheumatoid arthritis and admitted with complaints of pain in right leg, which was managed on oral analgesics. Actually it did not

require hospitalisation and could have been managed as an out-patient. So the claim was rightly repudiated by OP as per clause 9.7 of the group insurance scheme.

At the time of hearing the Complainant states that she was suffering from rheumatoid arthritis and PIVD. In November 2011 she got operated. Subsequently she suffered from severe pain in her waist. So as per doctor's advice she was hospitalized from 24.09.2012 to 28.09.2012 at Kalinga Hospital and received treatment as an in-door patient. MRI of dorsal spine was done. After discharge she lodged a claim, but it was rejected by the insurer. According to the representative of the OP, hospitalisation was not at all necessary in the present case. The treatment should have been in the OPD. So the OP rightly rejected the claim.

It is quite apparent from the Discharge Summary that the Complainant was hospitalized for rheumatoid arthritis and PIVD (Post operation status, being operated in November, 2011). The patient complained that pain was radiating to right leg. So during hospitalisation MRI of dorsal spine was made and medicines were given to the patient. Obviously this investigation through MRI and prescriptions of medicines could have been well made as an out-patient. Hospitalisation of the patient was absolutely not necessary.

Clause 9 of Group Mediclaim Scheme ,2012 enshrines important exclusions. As per sub-clause 7 of clause 9 the hospitalisation charges in which radiological/ laboratory investigations, other diagnostic studies have been carried out which are not consistent with or incidental to the diagnosis of treatment or positive existence or presence of any ailment, sickness or injury for which confinement at any hospital/Nursing Home has taken place are excluded. Here in this case the patient got admitted to the hospital for the disease of rheumatoid arthritis. The investigations made during hospitalization was neither consistent with nor incidental to the diagnosis of treatment of positive existence or presence of any other ailment. She was initially a rheumatoid arthritis patient and received treatment as such during her entire period of hospitalisation. It could have been easily made as an out-patient without any sort of hospitalisation. So the OP has rightly rejected the claim of the Complainant. Thus I find no infirmity in the action taken by the OP. Hence it is ordered that the complaint being devoid of any merit is dismissed.

BHUBANESWAR OMBUDSMAN CENTER

COMPLAINT NO- BHU-G-049-1314-1237

Shri Ghanashyam Panda

Vrs

The New India Assurance Company Ltd.

Award Dated 16th Day of Feb., 2015

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

In short, the case of the Complainant is that he was insured under Group Mediclaim policy for Club Member Agents with the OP through LIC of India. The Complainant met with an accident and underwent treatment at MKCG Medical College, Berhampur. He submitted the claim form and the treatment papers in the office of LIC, Berhampur which was forwarded to the TPA, Medi Assist India Pvt. Ltd., Mumbai. In spite of his repeated requests and follow up action, his claim was not settled by the OP. So the Complainant approached this forum.

Despite notice, the OP does not file any Counter/SCN.

In the meanwhile the Complainant intimates this forum that he has received the claim amount on 01.01.2014. At the same time he requests this forum to close the complaint. In such circumstances there is no good reason to go deep in to the matter. Since the grievance of the Complainant has already been redressed, the present complaint deserves dismissal. Hence it is ordered that the complaint being already redressed is hereby dismissed.

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BHUBANESWAR OMBUDSMAN CENTER

COMPLAINT NO-11-005-1105

Sri Esety Anip Kumar

Vrs

Oriental Insurance Co.Ltd.,

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

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

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

At the time of hearing, the Complainant reiterates that he submitted all the papers relating to his both eye operations to the TPA. Subsequently on his query he came to know that some papers were wanting in respect of his right eye operation and for that reason his claim was repudiated. Immediately he submitted the required papers and in spite of that he could not get his claim for his right eye operation.

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

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

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BHUBANESWAR OMBUDSMAN CENTER
COMPLAINT NO- BHU-G-038-1314-1302
Sri Saidutta Mishra
Vrs
Royal Sundaram Alliance Insurance Co.Ltd., Chennai,

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

Brief case of the Complainant is that his father Late Mahesh Prasad Mishra had a mediclaim policy from the OP. The expiry date of the policy was 07.04.2013. His father issued a cheque dated 16.04.2013 for Rs.3859/- being the premium amount which was received by the OP. Unfortunately, in the mean time his father expired on 23.04.2013. The Op informed vide their letter dt.23.04.2013 that the actual premium amount for the above policy was Rs.3930/- and as such there was a shortfall of Rs.71/-. So it asked for payment of the shortfall amount within 7 days, lest the amount already received would be returned back. Since Late Mahesh Prasad Mishra died in the mean time the Complainant requested the OP to return the amount paid by him along with interest but the OP turned deaf ear. Finding no alternative the Complainant approached this forum.

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

In consonance with the intimation of the OP, the Complainant sent an information to this forum that he had received the disputed amount of Rs. 3859/- by cheque no.310930 dated 03.03.2014 from the OP. At the same time he expressed his intention to drop the complaint. Here in this case the only grievance of the Complainant was to get back the premium amount of Rs.3859/- paid to the OP by

his deceased father. Since he has got back the amount, his grievance has already been redressed. In the circumstance the complaint is liable to be dismissed. Hence it is ordered that the complaint being already redressed is hereby dismissed.

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

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

It is said by the Complainant that he took Star Senior Citizens' Red Carpet Insurance Policy for his mother Smt. Gayatri Tikmani from the OP for a sum Insured of Rs.1,00,000/- for the period from 10.03.2010 to 09.03.2011 which was subsequently renewed for the period from 10.03.2011 to 09.03.2012. Since Smt. Gayatri Tikmani aged about 68 years was suffering from breast cancer at her right breast, she received medical treatment at Panda Curie Cancer Hospital, Cuttack and Hemalata Hospital, Bhubaneswar. In the treatment the Complainant spent a sum of around Rs.2,00,000/-. However after submission of claim regarding treatment expenditure the OP wrongly repudiated it. For this the Complainant approached this forum in Complaint no 14-017-0923 and got a favourable award on 22.11.2012. Then he received a part of his claim amounting to Rs. 20,160/- from the OP which overlooked the other bills amounting to Rs. 1,30,883/-. Under such contingency the Complainant approached this forum again.

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

At the time of hearing the Complainant openly declares that he has received a further sum of Rs.35,924/- from the OP, apart from his previous receipt of Rs.20,160/-. On a bare calculation his total receipt comes to Rs. 56,084/- as against his entire claim. However he makes it clear he has not verified the terms and conditions of the insurance contract nor can he say in which way he is entitled to the claimed amount. One Mr. Rajendra Sarangi, Consultant appears on

behalf of the OP. He says with force that the OP has already made payment as per the terms and conditions of the contract and there is nothing outstanding to be paid to the Complainant.

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

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

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BHUBANESWAR OMBUDSMAN CENTER

COMPLAINT NO- 11-002-1118

Sri Dinabandhu Mishra

Vrs

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

Award

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

Brief case of the Complainant is that he along with his spouse was having Senior Citizens' Mediclaim Policy from the OP since last 19 years without having any claim. In the year 2010 he renewed the aforesaid policy related to the period from 27.12.2010 to 26.12.2011. Due to cardiac ailment, his wife Manjula Mishra was hospitalized at Aditya Catre Hospital from 10.05.2011 to 14.05.2011. As against a total hospital bill of Rs.3,42,353.00, the OP paid

Rs.83,000.00 only. The Complainant found that he was entitled to get a further sum of Rs.57,000/- along with interest. So he approached this forum by lodging this complaint.

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

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

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

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BHUBANESWAR OMBUDSMAN CENTER

COMPLAINT NO- 11-011-1112

Sri Sumanta Kumar Jena

Vrs

Bajaj Allianz General Insurance Co. Ltd., Bhubaneswar,

Award

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

Sans unnecessary details, the case of the Complainant is that he was having health insurance from the OP since last four years. In July 2012, he sustained left knee fracture due to fall. After necessary medical aid he continued to have pain in his left knee. So on 21.08.2012, he went to Apollo Hospital and consulted with the doctor who advised him to get admitted to the hospital for investigation and treatment. Accordingly the Complainant got admitted to the hospital to conduct MRI on his left knee on 21.08.2012 and approached OP for cashless facility. Unfortunately even after lapse of twenty hours, no approval came from the OP for rendering cashless facility. As the Complainant was then not having much money to meet the medical expenses to conduct the MRI, he was compelled to leave the hospital after settling the hospital bill. He got discharged from the hospital on 22.08.2012. Then he applied to OP for reimbursement of the hospital expenses. But the OP repudiated the claim by letter dated 20.10.2012. Finding no alternative the Complainant approached this forum.

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

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

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

was administered on the patient.

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

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

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BHUBANESWAR OMBUDSMAN CENTER

COMPLAINT NO- 14-003-1116

Sri Bibhuti Bhusan Senapati

Vrs

National Insurance Co. Ltd., Mumbai DO VII.

Award

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

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

The OP took the plea that the Complainant submitted claim along with relevant documents on 22.06.2012 in respect of cataract operation dated 10.04.2012. Although there was a delay of 73 days in submission of claim with documents, the Complainant could not

show any valid reason for the same. So the TPA repudiated the claim as per Clause 5.3 of the policy.

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

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

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

Here in this case there is no dispute that the Complainant did not receive the policy bond till 21.05.2012 when a duplicate policy was issued to him. This fact becomes apparent from the photo-copy of the duplicate bond. No doubt Santoshi Senapati, wife of the Complainant underwent cataract operation on 10.04.2012. She was hospitalized and discharged on the same date. In absence of policy bond the Complainant waited till 21.05.2012 and after receipt of the duplicate policy, he submitted all the relevant papers on 09.06.2012. The TPA, Heritage Health Pvt. Ltd. sent those papers to the OP and the same appears to have been received by the OP in its Mumbai office on 22.06.2012. Since the present claim arises out of the terms and conditions of the policy bond, the duplicate of which was issued to the Complainant only on 21.05.2012, it cannot be said that there was any sort of negligence or latches on his part by submitting claim in June, 2012. Even if for the sake of argument it is conceded that there has been some sort of delay, then in absence of any trace of negligence it can be condoned as the reason shown appears to be satisfactory.

Further the SCN indicates that the claim was repudiated by the TPA as per clause 5.3 of the policy. As I feel it is not a sound practice. The policy forms a contract between the insured and the insurer. So the repudiation, if made, is to be done by the insurer, not by the TPA which acts as an intermediary. In case of any grievance, it is the insurer which has to take a final decision. However having

regard to the entire facts and circumstances of the case, the claim of the Complainant rightly deserves condonation. Hence it is ordered that the complaint is allowed. The OP is hereby directed to settle the claim of the Complainant without least delay.

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BHUBANESWAR OMBUDSMAN CENTER

COMPLAINT NO- 11-002-1108

Ms. Rupa Kanungo

Vrs

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

Award

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

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

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

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

On a minute scrutiny of the hospital bill it is seen that the hospital has charged room rent of Rs. 7700/- for two days including the charges for ICU for one day. As per clause 2.1 and 2.2 of the

Mediclaim Policy, where the sum insured is Rs.200000/-, the Complainant is entitled to get Room and ICU charges of Rs. 6,000/- during those two days of hospitalisation, instead of Rs.4,000/- as earlier calculated by the OP.

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

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BHUBANESWAR OMBUDSMAN CENTER

COMPLAINT NO- 11-003-1124

Sri Vinay Kumar Choudhary

Vrs

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

Award

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

Brief case of the Complainant is that he took a Health Insurance policy from the OP for the period from 31.03.2012 to 30.03.2013 for Rs.5,00,000. While the said policy was effective, the Complainant fell ill and consulted Apollo Hospital, Bhubaneswar, Aditya Care Hospital, Bhubaneswar and Apollo Hospital, Chennai for

treatment. Then he submitted his claim alongwith all relevant papers before the OP which repudiated the same. Finding no alternative the Complainant approached this forum.

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

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

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

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

Now let us concentrate on the Discharge Summary granted by Apollo Hospital, Chennai. It finds mentioned History of Present illness of the patient, Clinical examination, Course in the hospital & Discussion and lastly, Advice on discharge. The third heading "Course in the Hospital & Discussion" seems to be pertinent. It does not emit any scent of ailment and active treatment, although the Complainant reiterates that he received treatment for urine infection. Routine examination of urine & stool found to be normal. Urine culture shows growth of E-Coli. Opinion of the doctor was taken regarding urinary tract infection. The doctor advised watchful

wait and against use of antibiotics. The entire course taken in the hospital does not give any scent regarding ailment in urinary tract of the patient requiring hospitalisation and active line of treatment in that respect. As it appears the Discharge Summary indicates a series of diagnostic and investigative processes and nothing more. To add to it the Complainant himself openly declares in this forum that no disease was detected in him.

Of course it is true that the Complainant submits photo-copy of a bunch of medical papers for verification of this forum. But all of them are found to be of Out-patient Department of the hospital, where there is no question of any hospitalisation. In absence of hospitalisation policy coverage is not attracted. So all those medical papers are of no help for the purpose of this medi-claim. In the circumstances it can be safely held that there is no trace of any disease in the Complainant requiring hospitalisation and active line of treatment. The consultations made at Apollo Hospital and Aditya Care, Bhubaneswar and hospitalisation at Apollo Hospital Chennai was clearly for diagnostic & investigative purpose, the expenses of which is boldly excluded by the terms and conditions of the policy. As such the medi-claim of the Complainant is neither sustainable nor payable by the OP. Hence it is ordered that the complaint being devoid of any merit is hereby dismissed.

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BHUBANESWAR OMBUDSMAN CENTER

COMPLAINT NO-11-004-1133

Mr. Pramod Kumar Dash

Vrs

United India Insurance Co. Ltd., Bhubaneswar

Award

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

In short the case of the Complainant is that in the year 2011 he took a mediclaim insurance policy from the OP for a sum insured of Rs. 1,50,000/-. Unfortunately due to sudden onset of neck pain and brain seizure he was hospitalized in Kar Clinic & Hospital, Bhubaneswar during the coverage period and spent a total sum of Rs.22,153.00 in the treatment. Then he submitted all relevant documents to the OP and raised the health-claim. But the OP paid Rs.12,430/- only and did not pay the rest. Being aggrieved the Complainant approached this forum by filing the complaint.

The OP filed a Self Contained Note stating that the health claim of the Complainant had been duly processed as per the terms & conditions of the insurance policy. Since the Complainant availed a room with rent higher than the entitled category, the charges

payable under 1.2 C & D shall be limited to the rate applicable to the entitled category. Accordingly he is entitled to get 3/8th of the total claim under the heads of Surgeon's fee, Investigation charges and miscellaneous charges. However, the OP makes it clear that the above condition is not applicable to expenses related to medicines, drugs and implants.

At the time of hearing before this forum the Complainant says that the OP wrongly deducted Rs.9723/- from his claimed amount. So he prays that he may be allowed whatever he is genuinely entitled to receive as per the terms and conditions of the policy. According to the representative of the OP the calculation has been made as per note appended to clause 1 of the Terms & conditions of the Health Insurance Policy-Group. He admits that during course of calculation some mistakes have inadvertently crept into. But the OP is ready and willing to pay whatever permissible under the policy clause.

As per clause 1.2, the company will pay through TPA to the hospital/ nursing home or insured person the room, boarding and nursing expenses not exceeding 1% of the sum insured per day or the actual amount whichever is less. This includes nursing care and similar expenses. ICU expenses are payable not exceeding 2% of the sum insured per day or actual amount whichever is less. Note appended to the said clause makes it clear that the amount payable under clause 1.2 C & D shall be at the rate applicable to the entitled room category. In case the insured opts for a room with rent higher than the entitled category as in clause 1.2 A, the charges payable under 1. 2 C& D shall be limited to the charges applicable to the entitled category. However this will not be applicable in respect of medicines, drugs and implants. Keeping in view these relevant terms & conditions of the health policy, the claim of the Complainant is analised.

As it appears, the Complainant was hospitalized and submitted all the connected bills showing expenditure of a total sum of Rs.22,153/- under different heads. The OP claims to have analysed the Bills as per the terms & conditions of the policy and settled the claim at Rs.12429.60. The entire analysis has been reflected in a piece of paper attached to the SCN. On a careful scrutiny of the same it is found that each head of expenditure has been shown under 4 different columns – Net Bill amount, Deducted amount, Payable amount and Reason for deduction. Mistakes are quite apparent in the calculation or analysis of Bill No. M 5, M 6 and M 8. The amounts shown under the column of Deducted amount in respect of those three bills should have taken the corresponding place under the column Payable Amount and vice versa. Due to these mistakes

the Complainant has been paid less.

It should be kept in mind that the Complainant opted room having rent of Rs.2400/- per day and he paid Rs. 4800/- during hospitalisation. As per clause 2.1 A, he is entitled to get room expenses including nursing care of Rs.3000/- . Since his entitlement per day in respect of room expenses is Rs.1500 /- and since because he opted a room of rent of Rs. 2400/- per day the expenses under clause 1.2 C & D payable in the ratio of 5:8. But this ratio is not applicable to expenses made in medicines, drugs & implants. Computed on this basis the Complainant is entitled to get in respect of bill no. M 5, 6 & 8 the amount being calculated and shown under the column Deducted amount of the Calculation Sheet attached to SCN. Instead of 3/8th of the relevant expenses made in respect of Bill no. M 6 & 8, the Complainant is entitled to get 5/8th. Since Bill no. M 5 relates to expenditure under the head of medicines, the entire sum excluding cost of inadmissible drugs would be payable to the Complainant. Those mistakes need be rectified by the OP and the total amount arrived at by such rectification be paid to the Complainant. Hence it is ordered that the complaint is allowed in part. The OP is hereby directed to settle the claim as per the observation made above without least delay.

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BHUBANESWAR OMBUDSMAN CENTER

COMPLAINT NO-11-017-1139

Mr. Nilasaila Nayak

Vrs

Star Health and Allied Insurance Co. Ltd.

Award Dated 30th Day of Oct., 2014

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

The case of the Complainant in a nut shell is that on 31.03.2012, he took a family optima health Insurance policy from the OP and during the coverage period he had undergone bye pass surgery and valve replacement in Asian Heart Institute and Research Centre Pvt. Ltd., Mumbai. The matter was duly intimated to the OP and subsequently he submitted all the relevant papers to raise a Health- claim. Unfortunately, the OP rejected the Health claim on the ground that existence of breathlessness in the complainant for last two years clearly indicated misrepresentation/non-disclosure of material facts. Finding no alternative the complainant approached this forum for redressal.

The OP filed Self Contained Note stating therein that the patient had chief complain of breathlessness since two years. He had symptoms of heart disease and was undergoing routine health check-up. He was a chronic smoker, alcoholic and tobacco chewer. In spite of that the insured-complainant did not disclose his health details in the proposal form which amounted to misrepresentation/non-disclosure of material facts. As per clause 7 of the Health policy, the company shall not be liable to make any payment in respect of any claim if such claim is in any manner fraudulent or supported by any fraudulent means or device, misrepresentation whether by insured person or any other person acting on his behalf. Accordingly, the claim of the complainant being tainted with misrepresentation was rightly rejected.

At the time of hearing before this Forum, the complainant physically appears and states that under compulsion he has filed a case in connection with present matter before the District Consumer Disputes Redressal Forum, Cuttack. He adds that he did so, as many months elapsed after filing of this complaint, only to safe guard his interest in the said claim. According to the representative of OP the present matter has been carried to DCDRF, Cuttack in complaint no.216/2013 and as such the present proceeding is not maintainable in accordance with the provision of Redressal of Public Grievance Rules, 1998. He submits a photocopy of the notice served by DCDRF, Cuttack.

Admittedly, in connection with the present matter the complainant has taken shelter in the DCDRF, Cuttack and has initiated CC no.

216/2013 which is pending. Now the complaint filed here is governed by the RPG Rules,1998. Rule 13(3)(c) reads as follows:-

> ***"No complaint to ombudsman shall lie unless:-***
> ***x x x x x the complaint is not on the same subject matter, for which any proceedings before any Court or Consumer Forum or Arbitrator is pending or were so earlier,"***

In view of the express provision contained in Rule 13(3)(c) of RPG Rules, 1998, the present complaint, as rightly submitted on behalf of the OP, is not maintainable. Since the complaint is not maintainable as per rules, any elaborate analysis on the subject matter of the grievance seems to be redundant. Hence it is ordered that the complaint being not maintainable is hereby dismissed.

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BHUBANESWAR OMBUDSMAN CENTER
COMPLAINT NO-11-002-1136
Sri Madan Mohan Mohanty
Vrs
The New India Insurance Co. Ltd., Cuttack Branch Office
Award Dated 31st Day of Oct., 2014

This is a complaint against partial repudiation of health-claim by the O P-the Insurer.

Brief case of the Complainant is that his wife took a mediclaim policy for Rs.1,00,000/- and unfortunately during the policy period she underwent a surgery on her right palm and lodged a claim for Rs.14,838/-. The OP settled the amount at Rs.6202/- after deducting arbitrarily substantial amount from the health-claim, chiefly, on the ground of "as per entitled room category". Even the cost of the medicines used at the hospital was disallowed for want of details. In such circumstances the Complainant approached this forum for redressal of his grievance.

The OP files SCN and took a positive plea that as per clause 2.1 of the relevant policy the insured is entitled to room, boarding and nursing expenses not exceeding 1% of the sum insured per day or actual, whichever is less. As per Note 1 under the said clause the charges payable under clause 2.3 and 2.4 shall be at a rate applicable to entitled room category. In the present case sum insured being Rs.1,00,000/- eligible room expense is Rs.1,000/- per

day. Since the insured paid room rent of Rs.2,400/- for one day exceeding the eligible amount of Rs. 1,000/- per day, the expenditures incurred under clause 2.3 and 2.4 are affected by a reduction of (1400/2400x100=) 58.33%. So the OP emphasizes that the claim has been settled as per the terms and conditions of the policy.

At the time of hearing before this forum the complainant remains absent. The representative of the OP appeared and stated that the claim has been settled as per the terms and conditions of the policy. However, if any fault is detected, then the OP is ready and willing to abide by the Award passed by this Forum .

Here the main plank of attack is on the mode of settlement. The Complainant basically challenges the action of the OP and alleges that in absence of any specific provision in Mediclaim policy (2007), it has arbitrarily and whimsically deducted a major portion of the claim on the ground of 'entitled room category'. A photocopy of the Mediclaim Policy(2007) being filed on behalf OP is readily available in the file and thoroughly examined.

Clause 1 of the said policy deals with coverage and clause 2 specifies the expenses which are reimbursable under the policy. A note has been appended just below clause 2.6. The clause 2 alongwith note is pertinent for determination of the present controversy.

It is quite apparent from Note-1 that the entitled room category for an insured is 1% of the sum insured. It being so, in the present case the insured is eligible for room expenses of Rs.1000/- per day, as the sum insured is Rs.1,00,000/-. But the said note does not make any clear provision to deal with the expenses coming under clause 2.3 and 2.4. The note simply says that the charges payable under 2.3 and 2.4 shall be limited to the charges applicable to the entitled category. It does not convey any clear mode of limiting the charges coming under clauses 2.3 and 2.4. In a haphazard attempt to patch up such lacunae the representative of OP procures an IN-door Rate chart from Kar Clinic & Hospital, Bhubaneswar and files the same. On a minute scrutiny of the said Rate chart it is found that it does not include any rate for the present entitled category of Rs.1000/- per day. Thus the said Rate chart is considered to be of no use.

The SCN is attached with a calculation sheet. Keeping in view the relevant terms and conditions of the policy as discussed above, when this calculation sheet is taken in to consideration it becomes abundantly clear that the Complainant is entitled to get Room rent of Rs.1000/- only for one day hospitalisation. Since nursing charges are included in the room expenses as per 2.1, the insured is not

entitled to get extra nursing charges. The OP has rightly deducted consumable of Rs.100/-, as it does not find place in the policy condition and medicine charges of Rs.70/- for want of advice. But it cannot make any deductions from the fees of Surgeon, Asst. surgeon and anaesthetist, medical equipment charges, OT charges and medicines supplied by the hospital. Since those charges very well come under clause 2.3 and 2.4 the Complainant, in absence of any specific norm to be applied to the entitled category, is entitled to get the same in entirety. The OP cannot limit those charges arbitrarily nor can it deduct a major portion of the claim whimisically. Hence it is ordered that the complaint is allowed in part. The OP is hereby directed to settle the claim as per the observations made above without least delay.

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BHUBANESWAR OMBUDSMAN CENTER

COMPLAINT NO-14-004-1147

Sri Debabrata Moharana

Vrs

United India Insurance Co. Ltd., Cuttack Br. Office

Award Dated 2nd Day of Dec., 2014

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

The case of the Complainant in short is that he renewed his Family Medicare Policy from the OP in the year 2011 and unfortunately in the month of November, 2011 he fell ill and consulted with the doctor. The doctor found problem in his kidney and started necessary medication. As the disease could not be cured, the Complainant had to undergo kidney transplantation. But he was not allowed to avail cash less facility and hence, he spent a total sum of Rs.3,20,000/- in the transplantation and treatment. After discharge from the hospital he lodged a claim with the OP and submitted all the relevant papers through the TPA which clarified his doubt as to pre-existence of his disease after referring the consulting doctor Bibekanada Panda on the assistance of the Complainant. Inspite of that the OP turned a deaf ear to the entreaties of the Complainant and did not settle the claim lodged by him. Under such contingency the Complainant approached this forum.

The OP files SCN stating that the Complainant is covered under Family Medicare Policy and in order to process his claim the TPA asked for first prescription and investigation report regarding first

detection of chronic renal failure and first Discharge Certificate regarding Haemodialysis taken. In response prescriptions dated 03.11.2011, 02.01.2012 and 02.02.2012 of the consulting doctor were submitted. The insured was asked to submit all the prescriptions and Investigation reports before 03.11.2011 and the TPA sought certificate from the treating doctor as to probable duration of the disease CKD, as noted in the first prescription. But no supporting investigation reports in respect of the clinical findings noted in the prescription was made available nor the doctor confirmed in writing about it and previous treatment details. However there was overwriting in the first prescription. The second and third prescriptions contain deletion of findings/instructions. The treating doctor did not confirm in writing the reason for deletion. The further case of the OP is that the TPA reviewed the letter dated 17.09.2012 of the doctor, which stated that the CKD was first detected on 03.11.2011. Since the first prescription of dated 03.11.2011 contained report of increased urea and creatinine as written by the doctor, the blood report must have been prescribed by some other doctor. Therefore, the insured was asked to provide all the prescriptions and investigation reports before 03.11.2011. But no reply was received from the complainant in spite of several requests. So the insured was informed on 31.01.2013 regarding inadmissibility of the claim as per terms & conditions of the policy.

At the time of hearing before this forum the Complainant physically appears and states that in November 2011 he became ill and consulted with Dr. B.N. Das. As his feet were swelling, the doctor gave some medicines and advised for creatinine and urea test. After seeing the test report Mr. Das advised the Complainant to consult a nephrologist. So the Complainant contacted Doctor Mr. B.N. Panda who found problem in kidney and started treatment. When after treatment the disease could not be cured, in March 2012 Mr. Panda advised for kidney transplant. The package for the said transplantation was less at Kalinga Hospital than Apollo Hospital. So the Complainant was hospitalized at Kalinga Hospital on 19.03.2012 for kidney transplantation and he remained there till 02.04.2012. His sister donated kidney. Although he lodged a claim before the insurer and submitted all necessary papers, it was arbitrarily repudiated.

The representative of the OP stated that the Complainant did not submit any clarification as regards first occurrence of disease even after repeated requests. The claim form submitted by him is found silent on this score. He did not submit convincing doctor's prescription, rather he adopted fraudulent means by overwriting /tampering prescriptions. As per him, the prescription dated 03.11.2011 of the Doctor Mr. B.N. Panda clearly reflects that it bases

upon certain previous tests being advised by certain doctor. The Complainant does not furnish the connected prescription/adviced paper. The entire situation indicates pre-existence of the disease. Thus the OP rightly repudiated the claim.

As it appears, the Complainant has submitted photocopies of some prescriptions and medical bills at the time of lodging complaint before this forum. At the time of hearing he does not file any paper. Subsequently on the next day of hearing, i.e. on 19.11.2014 he files a bunch of medical papers. Again on 01.12.2014 he files a prescription dated 27.10.2011 of the doctor Mr. Shribatsa Dash of Bhubaneswar. In fact this prescription has no relevance as the Complainant reiterates that in November 2011 he fell ill and consulted with a doctor Mr B N Panda.

A great deal of emphasis is laid on the first prescription of the doctor Mr. B.N. Panda which is minutely examined. No doubt the name of the Complainant finds place there. The contents of the said prescription reflect that the doctor diagnosed the disease of the Complainant as CKD- V (Chronic Kidney Disease – Stage - 5) and HTN (Hypertension) and prescribed some medicines as mentioned therein. In the left hand side of the prescription the doctor has noted result of test regarding creatinine, urea etc. Clearly on the basis of those tests as advised by certain doctor, Mr. B.N. Panda diagnosed the diseases as reflected in his prescription. But to my utter surprise the advice of the doctor and the test reports upon which the first prescription is based are missing. It is the positive case of the OP that in spite of repeated requests the Complainant did not submit either the previous doctor's advice or the test reports.

It may here be noted that one partially illegible photocopy dated 02.11.2011 of a patholab at Baramunda, Bhubaneswar is filed from the side of the Complainant. It relates to testing of urea and creatinine. The most interesting fact is that the data as reflected in the pathology report dated 02.11.2011 does not tally with those mentioned in the left hand side of the first prescription. Obviously, that pathological report cannot be the basis of the first prescription. Of course it is true that the doctor has struck out certain portions of prescriptions dated 02.01.2012 and 02.02.2012. But those strikings have been duly initialed.

At this juncture it seems useful to disclose that CKD occurs when one suffers from gradual and usually permanent loss of kidney function over time. This happens gradually and usually over months to years. CKD is divided in to five stages of increasing severity. In fact we are here concerned with stage V- CKD as diagnosed in the case of the Complainant. Stage V - CKD is also referred to as Kidney failure, i.e. end stage of kidney disease wherein there is total loss of

kidney function. Most individuals in this stage of kidney disease need dialysis or transplantation to stay alive. Although CKD sometimes results from primary diseases of kidneys themselves, the measure causes are diabetes and high blood pressure.

In the present situation the TPA as well as the OP requested the Complainant to submit all the supporting papers of the first prescription. Also the terms & conditions of the Family Medicare Policy cast a duty in that regard on the insured. I do not understand what prevented the Complainant to produce all the supporting documents which are seemed to very much necessary for the processing of the claim. Non-submission of supporting documents and submission of inconsistent materials go to show that the Complainant does not come up with clean hands. The photocopy of the claim form as filed from the side of the Complainant is seen to be partially left blank. It is not intelligible as to why the Complainant did not choose to furnish 4th and 5th information in the claim form which relate to nature of illness/disease and date of its first detection.

In the result this forum comes to an irresistible conclusion that the Complainant has utterly failed to submit all the supporting documents necessary for the processing of the claim and thereby he has violated the terms & conditions of the policy. So he is not entitled to get the benefit under the policy. Hence it is ordered that the complaint being devoid of any merit is dismissed.

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BHUBANESWAR OMBUDSMAN CENTER

COMPLAINT NO-11-005-1178

Shri Bijaya Prasada Mohanty

Vrs

Oriental Insurance Co. Ltd., Cuttack

Award Dated 26th Day of Dec., 2014

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

Brief case of the Complainant is that he took a Mediclaim policy from the OP covering himself and his wife. During the period his wife underwent treatment at Aswini Hospital, Cuttack and he spent a sum of Rs.2840.00 in the treatment. Subsequently he lodged a claim and submitted all relevant papers. But the OP repudiated his claim. So the Complainant approached this forum.

The OP files SCN stating that wife of the Complainant got admitted in the casualty department of Aswini Hospital, Cuttack as an out-patient due to complaint of HTN and discharged from the hospital on the same day. Since the treatment was received in out-

patient department, the case came under exclusion clause no. 4.23 of the policy condition. Further it is made clear that Individual Mediclaim Insurance policy was only admissible for hospitalisation and not for out- patient treatment. The further plea of the OP is that since the wife of the Complainant received treatment for 3 hours in the casualty department, she cannot be treated as an inpatient which means treatment in hospital for minimum 24 hours after admission. So the OP rightly repudiated the claim.

At the time of hearing the Complainant physically appears and states that his wife suffered from hypertension and was hospitalized in Aswini Hospital for giving intra-venous fluid. She remained in the hospital from 8PM to 11 PM and then she was discharged. The Complainant incurred a medical expenditure of Rs. 2500.00 approximately and he lodged a claim with the OP. Unfortunately the officers of the OP not only rejected the claim but also showed bad behavior. All his representations were replied with a changed stand from time to time. However, none appears on behalf of the OP.

Admittedly, the wife of the Complainant got admitted in to casualty department of Aswini Hospital, Cuttack and received treatment for three hours and was discharged from the hospital on the very same day. A photocopy of the terms and conditions of Medicalim Insurance policy (Individual) as filed by the Complainant is readily available in the file for reference. Clause 1 clearly indicates that if during the policy period any insured person shall contact any disease or suffer from any illness and if such disease shall require to incur hospitalisation expenses as an in-patient, then the company would pay the same to the insured person. The word in-patient has not been defined. As per English lexicon, In-patient is a person who stays in a hospital while receiving treatment. But out-patient is a person who goes to the hospital for treatment and does not stay there. Clause 2.3 runs under the head hospitalisation period. As per the said clause, expenses on hospitalisation is admissible if hospitalisation is for a minimum period of 24 hours. Sub-clause A, B and C lay down the specific circumstances where this time limit will not apply. But the note appended to the said clause 2.3 makes it clear that procedures/treatments usually done in out patient department are not payable. To my utter surprise, the policy does not specify which are out-patient departments. Keeping the policy conditions in view, let us switch over to the facts and circumstances of the present case.

The wife of the Complainant got admitted in to the casualty and received treatment continuously for three hours. Then she was discharged. The certificate issued by Aswini Hospital goes to show that the patient was not needed to stay hospitalized overnight and

as such she was discharged after receiving treatment in the casualty. Manifestly, the Complainant's wife did not stay in a ward or in a room of the hospital in order to receive treatment. She went to the hospital, got admitted to the casualty, received necessary treatment and then was discharged as her stay was not necessary. Obviously she received treatment as an out-patient. So the medical expenses incurred by the Complainant in rendering her treatment fails to attract clause 1 of the Mediclaim Insurance Policy (Individual). When the medical expenses incurred by the Complainant does not come within the purview of clause 1, the OP is no way liable to pay the same. However the plea of the OP taken in the SCN that in-patient means hospitalisation for a minimum period of 24 hours and treatment in casualty department can not be treated as an in-patient treatment, can not be countenanced. Such plea neither assumes support from the policy conditions nor does primafacie appear to be correct. Had the Complainant's wife got admitted in to the hospital and stayed there before or after receiving treatment in the casualty then she would have been definitely treated as an in-patient. Since the wife of the Complainant was discharged from the hospital soon after treatment and did not stay in the hospital for taking treatment, the Complainant 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-11-004-1196

Shri Kishore Kumar Naik

Vrs

United India Insurance Co. Ltd., Balasore Branch

Award Dated 30th Day of Dec., 2014

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

Brief case of the Complainant is that he has taken Health Insurance Policy covering his wife and children from the OP continuously for 5 yrs. The sum insured for his wife was Rs.50,000/- initially and continued as such for three policy years. In the 4th policy year the said sum was enhanced to Rs.1,00,000/- and continued as such in the 5th policy year. Unfortunately, in the 5th policy year the wife of the Complainant underwent hysterectomy operation and subsequently the Complainant submitted medical bills amounting Rs.32,156.28 and lodged a claim before the insurer which was settled bt the TPA for Rs.13278/-. As per him, he is entitled to

get 25% of the sum insured i.e. Rs.25,000/- or actual expenses, whichever is less, as per the policy conditions. In this regard the Complainant made several approach to the OP, but in vain. Being frustrated in his attempt, he approached this forum.

The OP files SCN stating that the claim for hysterectomy operation is payable if the policy is continuously renewed for more than two years subject to actual expenses or 25% of the sum insured whichever is less. Therefore claim is payable only on the sum insured two years back i.e. on the sum insured on 3rd policy year which is Rs.50,000/-. This being so the claim was settled. The OP reiterates that the above settlement is as per policy conditions and admits continuity as well as renewal of relevant policy for five continuous policy years.

At the time of hearing the Complainant physically appears and states whatever he has averred in his complaint petition. According to the representative of the OP, the present case very well comes within the clause 4.3 read with clause 5.13 of the policy conditions. Since there is an exclusion of two years for the disease, the sum insured two years back would be taken into consideration at the time of health claim settlement. As such the settlement is in accordance with policy conditions and the Complainant is not entitled to get any thing more. The OP submits a photo-copy of policy condition for perusal. However, he fails to say if the Complainant's wife was subjected to any medical examination when she sought for enhancement in the sum insured.

Now the only controversy arises for consideration, particularly when the Complainant claims to be entitled to get 25% of the sum insured Rs.1,00,000/-., i.e. Rs.25,000/- as per policy condition. So a fair and equitable decision on this sole question would end the entire controversy.

As per clause 1.3, of the health insurance prospectus-Gold which contains the detailed policy conditions, expenses in respect of cataract, hernia, hysterectomy are limited to actual expenses or 25% of the sum insured whichever is less, per surgery.

Clause 4.3 deals with Exclusions. As per the said clause during the first two years of the operation of the policy, the expenses on treatment of diseases including hysterectomy are not payable. But to my utter surprise this is no body's case and hence clause 4.3 does not come in to play at all. The photocopy of policy condition as submitted by OP's representative contains clause 5.13 which deals with provision for enhancement of sum insured. After a careful scrutiny of clause 5.13 and clause 4.3 it is found that neither of these two clauses of the policy condition supports the plea of the OP. More clearly, those two clauses do not make any provision to the

effect that the medi-claim is payable on the sum insured two years back, as averred by the OP. Thus the procedure adopted by the OP in the settlement of the Complainant's claim is thoroughly wrong, erroneous and baseless.

Now it is abundantly clear from the policy conditions that the Complainant is entitled to get expenses in respect of his wife's hysterectomy operation to the extent as indicated in the clause 1.3. In fact he is entitled to get actual expenses or 25% of sum insured, i.e. Rs.1,00,000/-, whichever is less. Since the sum insured in the fifth policy year for Complainant's wife was Rs. 1,00,000/-, the OP cannot arbitrarily treat the sum insured as Rs.50,000/-. Such a course is vulnerable and is not based upon any sound principle. Hence it is ordered that the complaint is allowed. The OP is hereby directed to settle the claim of the Complainant in the manner as indicated above.

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BHUBANESWAR OMBUDSMAN CENTER

COMPLAINT NO-11-004-1227

Shri Baman Kishore Sahu

Vrs

United India Insurance Co. Ltd., Bhubaneswar

Award Dated 30th Day of Jan., 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 in the year 2006 he took a Mediclaim policy from the OP with Sum Insured of Rs.50000/- and continued to renew the same from year to year. During the policy year 2012-2013 he enhanced the Sum Insured to Rs.100000/- undergone for Cataract surgery of his right eye. He spent a sum of Rs.24000/- as medical expenses and then he lodged a claim and submitted all relevant papers. Unfortunately, the OP settled his claim for Rs.12500/- and paid the same. But it did not pay the balance amount of Rs.11500/- for which the complainant is entitled. Hence he approached this Forum for Redressal.

The OP files SCN stating that Hospitalisation benefits on Cataract per surgery is limited to actual expenses or 25% of the Sum Insured whichever is less (as per Condition no.1.2.1). As per exclusion Clause 4.3, expenses on Cataract is not payable for the first two years of the policy. As per the renewal clause 12.2, notwithstanding enhancement of Sum Insured, for claims arising in respect of ailments, disease or injury contacted or suffered during the preceding policy period, liability of the Company shall be to the extent of the sum insured under the policy in force at the time when it was contacted or suffered. This being so the complainant is

entitled to medical expenses @ 25% of the SI of Rs.50000/- (in the policy taken before two years), i.e.; Rs.12500/-.

At the time of hearing the complainant repeats what he has averred in his complainant petition. According to the representative of the OP the SI was enhanced from Rs.50000/- to Rs.100000/- for the policy year2012-13. The Cataract may have developed 5 to 7 years before. So the complainant is entitled to get medical expenses on the previous SI of Rs.50000/- as per the policy conditions and not on the SI of Rs.100000/- as claimed.

Photocopy of the policy terms and condition is gone through as the controversy is entirely dependent upon the same. It is true that Exclusions Clause no. 4.3 makes it clear that during the first two years of the operation of the policy, the expenses on the treatment of Cataract are not payable. But this clause does not come into play as the complainant took policy in the year 2006 and continued to renew it till the year 2012 and as because his Cataract operation was done during the 7th policy period. Further, according to the Renewal Clause 12.2, liability of the Company shall be to the extent of the SI under the policy in force at the time when the disease was contacted or suffered. But in the present case there is absolutely no definite material that the Cataract was contacted or suffered before 7th policy period which commenced on 11.08.2012 and continued till 10.08.2013. In the absence of it the OP cannot superfluously say that the Cataract may have developed during 5 to 7 years before.

Since the operation was made during 7th policy period with SI of Rs.100000/-, the complainant is entitled to the actual expenses or 25% of the SI i.e.; Rs.100000/-, whichever is less. Hence it is ordered that the complaint is allowed. The OP is hereby directed to settle the claim of the Complainant in the manner as indicated above, without any further delay.

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BHUBANESWAR OMBUDSMAN CENTER

COMPLAINT NO- BHU-G-044-1314-1236

Sri Ram Charan Mishra

Vrs

Star Health & Allied Insurance Co. Ltd.

Award Dated 18th Day of Feb., 2015

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

Brief case of the complainant is that the Complainant took a health insurance policy for his wife from the OP after undergoing medical check-up. As she was suffering from hernia and hypertension, the said diseases were stated as pre-existing in the policy. The Complainant's wife complained of pain in her shoulder

and spine. She consulted the doctor at Apollo Hospital and was diagnosed with the disease of osteoporosis. As per advice of the doctor, she was infused with zolandranate injection in the outdoor resulting in a severe reaction due to which, she had stomach pain. Since the symptoms did not subside, she was taken to Apollo Hospital, Bhubaneswar where she was admitted in the gastroenterology department. As the ailment was a complication of osteoporosis necessitating hospitalization, he preferred a claim with the OP which rejected it on the grounds that the disease was a complication of hernia which was a Pre-existing disease (PED) and for osteoporosis, the nature of treatment would require out-patient treatment only and hospitalization was absolutely not necessary. So the Complainant took shelter under this forum for redressal.

The OP files SCN stating that the insured is a known case of incisional hernia (post operative), low back ache and osteoporosis. On 25.02.2012, she had abdominal pain and was found to have sub acute intestinal obstruction which was managed conservatively. The Ultra Sound shows right iliac fosa anterior abdominal wall hernia containing non-dilated small bubble loops. The insured states that the pain started after injection Zolendranate taken for osteoporosis. But as per expert surgeon's opinion, injection Zolendranate cannot cause pain in abdomen. The pain is due to incisional hernia causing sub acute intestinal obstruction. This has been confirmed by ultra sound. Since hernia is a pre-existing disease with the insured, the claim was rightly rejected as per Exclusion no.1 of the policy.

At the time of hearing the Complainant physically appears further adding that as she was treated for complications of osteoporosis and not for hernia, he is entitled to get the claim. The representative of the OP appears and states that the patient was treated for hernia which is a pre-existing disease in her and comes under exclusion no.1. The OP has rightly rejected the claim as the stipulated 48 months have not elapsed since inception of the policy to cover the PED.

The policy in question is a new one with specific pre-existing diseases with the insured. So the PEDs and their complications are excluded from the scope of policy coverage. It appears from the photocopy of the Discharge Summary that the wife of the Complainant was hospitalized and was diagnosed with incisional hernia, sub acute intestinal obstruction improved with conservative treatment and osteoporosis. The Discharge Summary openly reflects that there was no known drug allergies. It clearly finds mentioned that even though the patient was a known case of incisional hernia, LBA, osteoporosis, she was presented with complain of abdominal pain. She was found to have sub-acute obstruction which was

managed conservatively. She improved and hence discharged in a stable condition. Since hernia and its complications are excluded from policy coverage and since because the sub-acute obstruction is nothing but a complication of incisional hernia, the complainant is not entitled to the medical expenses. Record lacks any expert/medical opinion supporting the plea of the Complainant that administration of zolandronate inj. for osteoporosis led to such complications thereby necessitating hospitalisation of the patient. 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-051-1314-1255
Sri Girija Nandan Mohanty
Vrs
United India Insurance Co. Ltd., Hyderabad

Award Dated 27th Day of Feb., 2015

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

Sans unnecessary details, the case of the complainant is that he himself and his wife Mrs.Geeta Mohanty both were covered under AB Aarogyadaan Medical policy issued by OP. Unfortunately the wife of the complainant was hospitalized at Apollo Hospital, Bhubaneswar. She was also further hospitalized at AIIMS, New Delhi. At the time of discharge from Apollo Hospital the authority collected Rs 4423/- from the complainant as co-payment against cashless treatment. Even on 14.08.2012 he had to pay Rs 350/- for check up of his wife. So he lodged a claim for the expenditure incurred in making co-payment and check up fee at Apollo Hospital, Bhubaneswar. But OP rejected said claim arbitrarily. Finding no alternative the complainant approached this forum for Redressal.

The OP files SCN stating that the expenditure incurred at Apollo Hospital, Bhubaneswar is primarily for Diagnosis and not followed by active line of treatment. So it is not payable as per Exclusion Clause 4.10 of policy.

At the time of hearing the complainant physically appears and states that he has in the meanwhile received medical expenses incurred at New Delhi for the treatment of his wife after deduction of 20% towards co-payment. But he has not received the medical

expenses of Rs.20767.37 made at Apollo Hospital, Bhubaneswar, even though there was active line of treatment of his wife there. Sri Prafulla Chandra Majhi, Dy.Manager appears on behalf of OP. According to him, there was no active line of treatment at Apollo Hospital, Bhubaneswar and hence OP rightly rejected the claim of the complainant.

Photo-copies of Discharge Summary and policy terms and conditions are examined and it appears from the Discharge Summary that Mrs Geeta Mohanty was admitted with unsteady gait, with difficulty in walking and associated with difficulty in speech. MRI of Brain was done and she was diagnosed with Olivo Ponto Cerebellar degeneration. She was managed conservatively and then discharged in stable condition. Obviously, the treatment is investigative. The Discharge Summary does not emit any scent of active line of treatment.

Clause 4 of the policy condition deals with exclusions. As per clause 4.10, charges incurred at hospital or Nursing Home primarily for diagnosis, X-Ray or Laboratory examinations or other Diagnostic studies not consistent with or incidental to the diagnosis and treatment of positive existence or presence of any ailment, sickness or injury, for which confinement is required in hospital/nursing home are excluded from the liability of the Company. In view of the said clause the OP is rightly not liable to pay the expenditures incurred by the complainant at Appolo Hospital, Bhubaneswar. This being so, the claim of the complainant deserves dismissal. 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-051-1314-1256
Sri Girija Nandan Mohanty
Vrs
United India Insurance Co. Ltd., Hyderabad
Award Dated 27th Day of Feb., 2015

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

In brevity, the case of the complainant is that he has taken AB Arogyadan Mediclaim insurance policy for self and his wife from OP. Unfortunately he got admitted into Hospital for Papilloma surgery and was hospitalized there for 3 days. At the time of discharge the hospital authorities collected a sum of Rs.7100/- from him through

inflated bills. The complainant intimated the matter to the OP, but of no avail. So he approached this forum for Redressal.

The OP files SCN stating that the grievance of the complainant is neither clear nor supported by bills, prescriptions etc. of the Hospital. In absence of the same his grievance cannot be resolved.

At the time of hearing, the complainant appears and states that he had to pay Rs.7100/- as the hospital authorities in collusion with the TPA gave an inflated Bill with respect to his hospitalisation. So he is entitled to get the same from the OP. According to the representative of the OP, the complainant has submitted no relevant medical papers, Bills etc and as such no decision could be taken by the OP.

The OP issued authorisation letter to the Hospital for treatment of the complainant and as a guarantee of payment of Rs.35502/- to the hospital after collecting 20% of the final amount towards co-payment from the complainant after deducting the non-payable items. Photocopy of the final bill filed from the side of the complainant indicates net service charges of Rs.35502/- from the side of Hospital. Obviously the complainant has to pay 20% i.e.; Rs.7100/- towards co-payment which is in consonance with the policy conditions. Record lacks any material to the effect that the Hospital issued an inflated bill as alleged by the complainant.

In the present context the OP reiterates that the claim of the complainant is not supported by the prescriptions and bills of the hospital. If actually the complainant has any other hospital prescriptions, bills etc. with him, then he has to submit the same before the OP thereby enabling it to resolve the claim at its end. On failure of the complainant to do the same within a reasonable time it would be deemed that he has nothing of the sort attracting settlement. Hence it is ordered that the OP is hereby directed to settle the claim of the complainant in the manner as indicated above. The complaint is, thus, disposed of.

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BHUBANESWAR OMBUDSMAN CENTER

COMPLAINT NO- BHU-G-044-1314-1303

Sri Laxmidhar Subudhi

Vrs

Star Health & Allied Insurance Co. Ltd.

Award Dated 9th Day of Mar., 2015

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

Brief case of the Complainant is that he has taken one Medi Classic Health Insurance Policy (Individual) from the OP covering his daughter and wife. His daughter was admitted to Woodland Multispeciality Hospital, Kolkata for 2 days for treatment of sudden blackout. She also consulted the doctors at Asian Institute of Gastroenterology, Hyderabad for further treatment. The Complainant submitted the bills for Rs.26,282/- alongwith other required documents to the OP for settlement of the claim, but in vain. So he approached this forum for Redressal.

The OP intimates this forum that the claim has been settled by it for Rs.18,208/- in full and final settlement as agreed by the Complainant.

Despite notice, the Complainant did not appear for hearing. The Consultant appears on behalf of the OP and states that on 11.04.2014, the Complainant agreed for settlement at Rs.18,208/- and the said amount was paid by the OP vide Demand Draft dated 05.04.2014. So the case may be closed.

OP has submitted the photocopies of the Discharge Voucher and DD dated 05.04.2014 issued by Standard Chartered Bank, showing acceptance of the claim amount by the Complainant. Since the grievance of the Complainant has already been redressed, the present complaint deserves dismissal. Hence it is ordered that the complaint being already redressed, is hereby dismissed.

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BHUBANESWAR OMBUDSMAN CENTER

COMPLAINT NO- BHU-G-031-1314-1252

Sri Nilamadhab Nanda

Vrs

Max Bupa Health Insurance Co. Ltd.

Award Dated 16th Day of Mar., 2015

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

Brief case of the Complainant is that he took a health insurance policy from OP in the name of his father who fell suddenly ill with a complain of blood in urine and was taken to Apollo Hospital, Bhubaneswar where he was admitted in the emergency ward and subsequently admitted as an indoor patient. The doctors diagnosed the problem as gross hematuria in the right kidney and advised to go for removal of kidney. After taking a second opinion from another doctor outside the hospital, the Complainant decided not to opt for the surgery and got his father discharged. Since his request for cashless settlement was not considered, he paid the bill of the hospital and preferred a claim with the OP. But the OP rejected the claim on the ground that Complainant had not declared his father suffering from blood pressure and diabetes. The Complainant reiterates that he had made such declarations while taking the policy. He conveyed it to OP, which did not respond. So the Complainant took shelter of this forum.

The OP files SCN stating that the insured approached it vide telesales of 29.03.2013. On 14.04.2013, insured was admitted at Apollo Hospital and was discharged on 16.04.2013. He underwent minimal invasive surgery named Right laparoscopic Radical Nephrectomy for treatment of Gross Hematuria with right loin pain. Insured applied for reimbursement on 17.04.2013 towards hospitalization expenses. The company conducted investigation and during the process asked the treating doctor and the insured to fill up a set of questionnaires in relation to the medical claim. As per answers to the questionnaires submitted by the Complainant, the insured was suffering from hypertension since 6 months. Thus prior to taking the policy the insured was suffering from hypertension but it was not disclosed to the tele-sales counselor. The treating doctor has submitted in his questionnaire that Mr. Nilamadhab Nanda had undergone prostrate surgery in the year 2007 in Kalinga Hospital and was a known case of diabetes and hypertension. But in the

Information Summary Sheet the question relating to any surgery during the past 7 years, was answered in the negative by the Complainant. The Information Summary Sheet was given to the Complainant at the inception of the policy. Since Information Summary Sheet is a part and parcel of the terms and conditions of the policy, the claim was rejected due to suppression of material facts regarding the hypertension, diabetes and prostrate surgery.

At the time of hearing the Complainant's father appears and submits what is already stated in the complaint petition and further states that he has never undergone prostrate surgery nor has he hypertension. His disease of diabetes has been disclosed in the policy. Long back in the year 1987, there was a plastic surgery in his left leg. He has submitted all the papers and is entitled to the claim. The representative of the OP appears and submits that as per the treating doctor the insured was a known case of hypertension and diabetes and underwent prostrate surgery in the year 2007 at Kalinga Hospital. Due to suppression of material facts, the OP has rightly rejected the claim.

As it appears from the documents, the complainant had disclosed the existence of diabetes while taking the policy. The other Enclosure which is answered by Sritam Nanda, son of the Insured has nothing to do with the health condition of the Insured as the questionnaire relates to his own wherein, he has answered that he suffers from blood pressure since six months. Enclosure C happens to be the questionnaires answered by the treating doctor which discloses that prostrate in 2007(Kalinga Hospital). There is no definite medical data from which, the insurer astonishingly infers that the Insured underwent prostrate surgery in 2007 at Kalinga Hospital. I do not understand what for such an inference is drawn even though the answer does not specifically reflect so and lacks definite medical data regarding surgery in Kalinga Hospital. In such circumstances the rejection of claim by OP, appears to be inappropriate. No other ground for rejection has been pleaded in the SCN. Since the Complainant incurred medical expenditure for the hospitalisation of his father (Insured) during the policy term, the OP is liable to pay him as per policy condition. Hence it is ordered that the complaint is allowed. The OP is hereby directed to settle the claim of the Complainant soon.

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BHUBANESWAR OMBUDSMAN CENTER
COMPLAINT NO - BHU-G-044-1314-1304
Smt. Bijaya Laxmi Nanda
Vrs
Star Health & Allied Insurance Co. Ltd.

Award Dated 16th Day of Mar., 2015

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

The case of the complainant sans unnecessary details is that she has taken one Star Senior Citizen Red Carpet Insurance Policy from the OP and the sum insured is Rs.2,00,000/-. The Complainant was admitted in Apollo Hospital, Bhubaneswar for surgery on both knees and in the process she incurred an expenditure of Rs. 3,59,527/- which was much above the insured amount. But the OP paid Rs.82,000/- only as cashless settlement to the hospital. After discharge from the hospital, she wrote the insurer to pay the balance amount of Rs. 1,18,000/- but the OP paid a deaf ear to her request. So she approached this forum for redressal.

The OP files SCN stating that it has paid Rs.82,000/- as cashless settlement to the hospital. On receipt of the claim papers from the Complainant, it has settled a further amount of Rs.32,800/- as per terms & conditions of the policy. The claim amount of Rs.164000/- was calculated taking in to account various sub-limits as per the terms and conditions of the policy and thereafter Rs. 49,200/- was deducted towards Exclusion No. 5. After considering the cashless settlement amount, the balance amount of Rs. 32,800/- was paid through DD no. 47703 dated 14.02.2014.

At the time of hearing, the Complainant physically appears and submits that in the present policy, the sum insured is Rs.2,00,000/-. Accordingly the OP's office assured her to pay the said amount. Unfortunately OP gave her only Rs.1,14,800/-. So she claims for the balance amount of Rs.85,200/-. OP's Consultant appears and states that the Complainant has received Rs.1,14,800/- as per the policy conditions.

Photocopy of the policy document is readily available in the file. I have elaborately gone through the same. This is Senior Citizen's Red Carpet Insurance Policy and includes a table containing diseases and limit of company's liability.

As it appears, the OP has adopted right procedure in accordance with the terms and conditions of the policy and has settled the claim of the Complainant. In the process of such settlement, it has paid Rs.82,000/- to the treating hospital and a sum of Rs.32,800/- to the Complainant through demand draft. This

fact has been openly admitted by the insured. Now it is fallacious to hold that one is entitled to get the sum insured in case of each and every claim, as pleaded by the Complainant. Neither the policy nor the conditions agreed upon supports this contention. In fact I find no infirmity in the settlement arrived at by the OP. The Complainant is not entitled to get anything more from the Insurer. Hence it is ordered that the complaint being devoid of any merit, is hereby dismissed.

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BHUBANESWAR OMBUDSMAN CENTER
COMPLAINT NO- BHU-G-050-1314-1313
Sri Niranjan Kar
Vrs
The Oriental Insurance Co. Ltd., Bhubaneswar.

Award Dated 16th Day of Mar., 2015

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

Brief case of the Complainant is that he took Individual Mediclaim Policy from the OP for himself and his wife since 2006 and continued to renew it till 2014. Initially the sum insured was Rs.1,50,000/-. During the policy period 2012-13 the sum insured was enhanced to Rs.3,00,000/- and it continued during the policy period 13-14. Complainant's wife underwent Knee Replacement surgery. For her treatment he incurred an expenditure of more than Rs.3,00,000/- but the OP settled the claim for Rs.1,50,000/- only by interpreting the terms & conditions of the policy in a wrong way and restricting the sum insured at Rs.1,50,000/- instead of Rs.3,00,000. He explained the OP that when he had knee replacement surgery in January, 2013, the TPA had paid Rs.1,00,000/- at the first instance but after protest, paid Rs.1,00,000/- more. But the OP did not accept his contention. 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 with sum insured of Rs. 1,50,000/- for the years 2008-09, 2009-10 and 2010-11. The sum insured was enhanced to Rs.2,50,000/- in 2011-12 and to Rs. 3,00,000/- in 2012-13 and renewed for the same sum insured in 2013-14. The Complainant lodged claim for treatment of left knee of his wife Mrs. Chandrika Kar on 25.11.2013 and TPA settled the claim for Rs. 23,389/-. Again for the Left Knee Joint Replacement TPA settled the claim for Rs. 1,26,611/- after deducting the previous claim amount from the entitled sum insured of Rs. 1,50,000/ -. As

per the exclusions 4.3(xxiii) & (xxiv), Joint Replacement due to degenerative conditions and age related osteoarthritis and osteoporosis has 4 years waiting period. Clause 8 of the policy terms and conditions states that if the policy is to be renewed for enhanced sum insured then restrictions as applicable to a fresh policy (condition 4.1,4.2 & 4.3) will apply to additional sum insured as if a separate policy has been issued for the difference. Hence enhanced sum insured has a waiting period of 4 years. The treatment was done in the year 2013-14. Hence the sum insured applicable for the knee replacement surgery would be 4 years prior to it i.e. 2009-10. The sum insured was Rs.1,50,000/- then and the same was rightly paid .

At the time of hearing before this forum the Complainant appears and states what is already stated in the claim petition. According to the representative of the OP the case very well comes within the purview of policy condition no. 8(C) read with 4.3. Although the operation took place in the policy year 2013-14 when sum insured was Rs.3 lakhs, the Complainant was entitled to get as per sum insured 4 years back. So OP rightly paid Rs.1.5 lakhs.

Admittedly, the knee joint replacement of Complainant's wife was done during policy year 2013-14 when the sum insured was Rs.3,00,000/-. There is no dispute that the sum insured in the previous policy years were Rs.3,00,000/- in 2012-13, Rs.2,50,000/- in 2011-12, Rs.1,50,000/- in 2010-11 and Rs.1,50,000/- during 2009-10. At this juncture let us now switch over to the policy conditions so as to reach a definite conclusion on the controversy.

Clause 8 deals with renewal of policy. As per clause 8 (c), 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. Clause 4.3 includes a table containing a series of diseases and the corresponding waiting periods as per which Joint replacement and age related osteo-arthiritis and osteoporosis are having waiting period is 4 years. On a conjoint reading of clause 8 (c) and 4.3, it is quite clear that in order to get the claim for the said disease at the enhanced rate of sum insured at Rs.3,00,000/- the Complainant has to wait till the policy year 2016-17 as the SI was enhanced to the said sum in the year 2012-13. But in the present case the knee replacement was done during the policy period 2013-14. Obviously the Complainant is entitled to get claim at the rate of sum insured during the policy year 2009-10 when the sum insured was Rs.1,50,000/-. I find absolutely no infirmity in the mode adopted by OP in settling the Complainant's claim. Since his claim has been settled in the light of sum insured 4 years back, the

Complainant is not entitled to get anything more. 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-038-1314-1308

Sri Manas Dehury

Vrs

Royal Sundaram Alliance Insurance Co. Ltd.

Award Dated 23rd Day of Mar., 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 a nut shell is that in the year 2013 he took a Family Health Protector Policy from OP. Suddenly, his wife fell ill and was admitted to Panda Nursing Home, Dhenkanal. He intimated the matter to the Insurer and subsequently a claim was lodged with all the papers and documents. Unfortunately the OP rejected the claim on the ground of fraud. Finding no alternative the Complainant approached this forum for Redressal.

The OP files SCN stating that the policy in question covers the Complainant and his family. After getting claim intimation the Investigator conducted discreet investigation and found many discrepancies in the Complainant's claim. As per the Investigator, at the time of his first visit the hospital authorities did not make the In-patient register available. On the next day it was found that the name of the Complainant's wife had been deliberately entered into the In-patient Register. Also it was seen that the date of discharge and diagnosis had not been mentioned in the register. All these facts and circumstances indicated that the Complainant stage managed the alleged hospitalization with intent to make unlawful gain from the insurer. So the OP rejected the claim of the Complainant on the ground of fraud.

At the time of hearing the Complainant appears and states that his wife Anupama Dehury was hospitalized at Panda Nursing Home for complicated malaria. He spent Rs.43,042/- in the treatment. But OP erroneously rejected the claim on the ground of fraud. In fact he is entitled to get the claim. According to the representative of the OP, the name of the Complainant's wife was interpolated subsequently in the In-patient Register by practising fraud. So OP rightly rejected the claim. He submits a photocopy of relevant portion of the in-patient register for perusal.

After a careful scrutiny of the photocopy of in-patient register as submitted on behalf of OP, it is found that the name of Complainant's wife appears there and her date of admission is as per

the claim made by the Complainant. It reveals that she was hospitalized for 10 days and her disease was diagnosed as complicated malaria. 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. Also there is no definite material before this forum to infer practice of fraud by the Complainant. Thus the plea advanced by the OP finds no leg to stand.

Admittedly, the policy in question covers the Complainant and his family. There is also no dispute that his wife was hospitalized in Panda Nursing Home, Dhenkanal during the policy period for treatment of complicated malaria. So the OP is liable to pay the reasonable hospitalization expenses incurred by the Complainant, as per the terms and conditions of the policy. It cannot escape liability on a fragile ground. Hence it is ordered that the complaint is allowed. The OP is hereby directed to settle the claim of the Complainant soon.

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BHUBANESWAR OMBUDSMAN CENTER

COMPLAINT NO- BHU-G-044-1314-1273

Sri Debasis Tarasia

Vrs

Star Health & Allied Insurance Co. Ltd.

Award Dated 23rd Day of Mar., 2015

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

Brief case of the complainant is that he has taken one Star Senior Citizen Red Carpet Insurance Policy for his mother who was admitted in Hospital for Acute Coronary Syndrome, Inferior Latemi and was discharged after angioplasty and implant of two stents. The total treatment bill was Rs.3,71,941. But the OP made a cashless settlement for Rs.1,05,000/- and the Complainant paid the balance amount. The policy document states that for cardio vascular diseases, the limit of company's liability is Rs.1,50,000/- and hence the Complainant lodged a claim for Rs.45,000/- with the OP which rejected his claim. However under the same policy, his mother was operated for cataract right eye. Out of the total claim amount of Rs.20,000/-, the OP had paid Rs.15,000/- as per limit of the company's liability mentioned in the policy. Being aggrieved by such arbitrary action of the OP, the Complainant approached this forum.

The OP files SCN stating that it has paid Rs.1,05,000/- as cashless settlement to the hospital as per the conditions of the policy. The claim amount was calculated taking in to account all the sub limits and co-payment factor as mentioned in the policy. However, on a further examination, the claims team of the OP found that the total payable amount was Rs.1,62,000/- and after taking into account co-payment of 30% on the admissible amount, i.e, on Rs.1,62,000/-, the net payable amount comes to Rs.1,13,400/-. Since Rs.1,05,000/- has already been paid to the hospital as cashless settlement, the OP is ready to pay the balance amount of Rs.8,400/- to the Complainant.

At the time of hearing, the Complainant appears and submits that his total medical expenses were more than Rs. 3 lacs. However, as per the policy condition the maximum limit for the operation is Rs.1,50,000/- but he has received Rs.1,05,000/- only. So he is entitled for a further sum of Rs.45,000/-. The representative of the OP appears and states that the Complainant has received Rs.1,05,000/- as cashless settlement and is entitled for a further sum of Rs.8,400/-. A detailed calculation sheet has been produced to that effect. As per the exclusion no.5, the Complainant has to pay 30% of the eligible claim.

In the relevant Insurance Policy document, the limits of different charges have been indicated on the face of the policy along with certain exclusions. As per Exclusion clause 5 of the policy, the company shall not be liable to make any payments in connection with 50% of each and every claim arising out of all pre-existing diseases and 30% in all other claims which are to be borne by the insured.

During hearing the Complainant submits a brochure with regard to the Policy wherein the scheme of co-payment as provided in the exclusion clause 5 of the policy have been well defined. According to it, co-payment is required to be made 50% of eligible claim applicable for pre-existing diseases /condition and 30% of eligible claim applicable for all other claims. There is no ambiguity on the point.

Here in this case a detailed calculation sheet has been appended on behalf of OP to the SCN. The Complainant has also submitted photocopies of the bills and money receipts regarding the expenditure incurred by him. On a minute scrutiny of the available papers, it is found that the total eligible claim is Rs.1,62,000/- as rightly calculated on behalf of OP. This eligible amount has been rightly arrived at after taking into all expenses as permissible under the policy. Now the insured has to pay 30% of the eligible claim as per exclusion clause no.5. On a bare calculation the insured has to

bear Rs.48,600/-. Subtracting the amount from the eligible claim, the Complainant is entitled to get Rs.8,400/- as he had already availed cashless facility for Rs.1,05,000/- being facilitated by the insurer. Hence it is ordered that the complaint is allowed to the extent as indicated above. The OP is hereby directed to settle the claim of the Complainant accordingly.

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BHUBANESWAR OMBUDSMAN CENTER

COMPLAINT NO- BHU-G-044-1314-1292

Sri Hari Shankar Jena

Vrs

Star Health & Allied Insurance Co. Ltd.

Award Dated 23rd Day of Mar., 2015

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

Brief case of the Complainant is that he had taken from the OP one Family Health Optima Insurance Policy and during the policy period he felt exhaustion and tiredness while walking for long distance. So he consulted doctor at Narayana Hrudayalay Hospital, Bangalore. After all the required tests, doctor advised him to go for heart surgery. Before admission to the hospital, he applied for cashless settlement to the OP which denied it. Then the Complainant was admitted to the hospital for heart surgery first from 14.09.2011 to 05.10.2011 and secondly, from 23.10.2011 to 14.12.2011. Subsequently, he submitted all the required documents and lodged a claim with the OP. As the settlement was delayed, he sent several reminders to it but in vain. Being aggrieved, he took shelter of this forum for redressal.

The OP files SCN stating that the Complainant claimed in the 10th month of taking the insurance policy. He was treated from 14.09.2011 to 05.10.2011 at Narayan Hrudayalay, Bangalore and the diagnosis was Takyaslu Aorto Arteritis, Ascending Aorta and Proximal Arch Aneurysm and severe Aortic Regurgitation. Initially the insured was admitted to Sathyasai Institute of Higher Medical Sciences, Anantpur on 29.04.2011 and was discharged on 18.05.2011. As per the said institute, the insured had past medical history as dyspnea on exertion since one year, i.e. prior to inception of the Star Health Insurance Policy. In such circumstances the OP rejected the claim as it falls under Exclusion no.1.

At the time of hearing before this forum the Complainat remains absent despite notice. According to the representative of the OP, the insured had history of dyspnea since one year..i.e., prior to taking the policy. Since the disease was pre-existing, the OP rightly rejected the claim as per exclusion no.1.

Photocopies of the policy document and the report granted by Sri Sthyasai Institute of Higher Medical Sciences, Anantpur are readily available in the file. I have elaborately gone through the same. As per the policy document, the Insurer will pay to the insured the hospitalization expenses incurred by him, if during the policy period he/she contacts any disease or suffers from any illness or sustain any bodily injury through accident requiring hospitalization, subject to the terms conditions exclusions and definitions contained in the policy. As per exclusion clause no.1 the company shall not be liable to make any payment under the policy in respect of any expenses whatsoever incurred by any insured person 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. Pre-existing disease means any ailment or any injury or related condition for which the insured had signs or symptoms and/or was diagnosed and/or received medical advice/treatment within 48 months prior to insured's first policy with the company.

The report of Sri Sathyasai Institute reveals that the Complainant made his first visit on 11.04.2011. Then he got admitted into the said institute on 29.04.2011 and was discharged on 18.05.2011. The diagnosis was inflammatory arteritis with aortic route dilation with severe AR. The document clearly indicates history of dyspnea on exertion, palpitations, backache since one year. The present policy is a new one and its date of inception is 14.12.2010. Obviously, dyspnea is pre-existing disease and clearly comes within the fold of exclusion clause no.1. Thus the OP is not liable to pay the hospitalization expenses as per the policy conditions. 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-049-1314-1281

Sri Mukesh Agarwal

Vrs

The New India Insurance Co. Ltd., Rourkela Branch Office.

Award Dated 24th Day of Mar., 2015

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

Brief case of the Complainant is that he took a Family Floater Mediclaim with the OP covering the hospitalization expenses of himself and his family for a sum insured of Rs.2,00,000/-. During the currency of the policy, Complainant's wife was treated in Kolkata by incurring an expenditure of Rs. 76,427/- and he claimed for the same. But the OP settled the claim at Rs.37,858/-after deducting a

substantial amount from the health-claim. The Complainant gathered from the TPA that Rs.35,000/- was deducted towards surgeon's fees as he had paid the amount by cash. He explained that the surgeon did not accept cheque payment and for releasing the patient he was compelled to pay cash, but the OP did not pay any heed to his request. In such circumstances the Complainant approached this forum for redressal of his grievance.

The OP files SCN stating that Complainant's claim was settled for Rs. 37,858/- as per the terms and conditions of the policy. The major deduction for which the Complainant has filed this complaint relates to a deduction of Rs.35,000/- as per Note 3 b (under clause 2.6) of the policy which mandates that 'Fees paid in cash will be reimbursed up to a limit of Rs.10,000/- only, provided the surgeon/anaesthetist provides a numbered bill. So the OP emphasizes that the claim has been settled as per the terms and conditions of the policy.

At the time of hearing before this forum the complainant remains absent. According to the representative of the OP, as per the Note 3(b) of clause 2.6 of the terms and conditions of the policy, the Complainant is entitled to Rs.10,000/- only. The OP has already paid the said amount on 26.09.2013. So he is not entitled to get anything more.

A photocopy of the Mediclaim Policy (2007) being filed on behalf OP is elaborately gone through same. Clause 2 specifies the expenses which are reimbursable under the policy. A Note has been appended just below clause 2.6. Relevant portions of the note which seems to be pertinent for determination of the present controversy is extracted hereunder :

"Note 2.-No payment shall be made under 2.3 other than as part of the hospitalization bill.

Note 3.b - Fees paid in cash will be reimbursed up to a limit of Rs.10,000/- only, provided the surgeon/anaesthetist provides a numbered bill."

The Complainant has not filed the Bills and Money Receipts regarding the treatment. However OP has filed photocopies of the nursing home bill and surgeon's receipt. The receipt no. 539, dated 22.04.13 issued by Dr.(Mrs.) Supriya Khetan shows payment of Rs. 45,000/- towards fees for surgical team including the anesthetist and post operative visits. Photocopy of the Bill cum receipt of Srijoni Healing Home shows that Rs. 17,355/- was paid to the Nursing Home towards Bed charges, OT charges and OT and ward items. It is quite apparent from Note-2 that no payment shall be made under 2.3 other than as part of the hospitalization bill. Note 2.3 pertain to the fees of surgeon, anesthetist, medical practitioner, consultant and

specialist. Obviously as seen from the bills and receipts mentioned above, the fees towards the surgeon and anesthetist does not form part of the hospitalization bill. Complainant has stated that the surgeon's fees was paid by cash. So as per the Note 3 b of the terms & conditions of the policy, the OP has rightly paid Rs.10,000/- and I do not find any infirmity in the mode of settlement. Hence it is ordered that the complaint is dismissed being devoid of any merit.

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BHUBANESWAR OMBUDSMAN CENTER

COMPLAINT NO- BHU-G-051-1314-1267

Shri Bishnu Charan Panigrahi

Vrs

United India Insurance Co. Ltd., Puri Branch Office

Award Dated 27th Day of Mar., 2015

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

Brief case of the Complainant is that he took an Individual Health Insurance Policy-2010 from the OP and was unfortunately hospitalized during the policy period. The disease was diagnosed as Hyponatremia. He is suffering from blood pressure and diabetes. For the treatment, he incurred an expenditure of Rs. 28,879/- and lodged a claim with the OP for reimbursement. But the TPA rejected his claim on the ground that the patient was suffering from diabetes mellitus since 15 years and as per the clause no.4.1 of the policy the claim was not admissible. The Complainant explained that the disease Hyponatremia has no relation with diabetes and can manifest on any person but the OP paid a deaf ear to his request. So he approached this forum by lodging this complaint.

The OP files SCN stating that the Complainant was covered under Individual Health Insurance Policy (Sr. Citizen) and underwent treatment for Hyponatremia (Diuretics Induced), hypertension and diabetes mellitus. The insured has taken his first policy in 2002 and subsequently renewed without break till 2007-08. After a break of nearly two years, he took the policy from 05.08.2010 to 04.08.2011 and renewed till 04.08.2012. Thus the policy taken for the year 2010-11 was considered as a fresh policy for application of pre-existing exclusion clause 4.1. for all subsequent policies renewed without any break. Insured-patient was a known case of diabetes and hypertension and was suffering from those diseases since last 15 years. In the discharge summary the diagnosis was Hyponatremia (Diuretics induced), Hypertension and diabetes mellitus. Diuretics are medicines used to treat hypertension. As Hyponatremia was directly caused due to Diuretics, used to treat the insured's state of hypertension, the claim was

found to be inadmissible as per pre-existing disease exclusion clause no.4.1 of the policy.

At the time of hearing before this forum the representative of the Complainant states that there was a gap in insurance from 2008 to 2010 and averred what is already stated in his complaint petition. According to the representative of the OP, the insured suffered from hyponetramia due to use of diuretics for hypertension. As such hypertension was pre-existing. As per exclusion clause 4.1, OP rightly rejected the claim.

Admittedly, the Complainant took the first policy from OP for the period from 16.11.2002 and continued to renew the policy till 04.08.2012 only with a gap of two years from 2008 to 2010. I have elaborately gone through the photocopy of the relevant policy condition which is readily available in the file, as the OP rejected the claim of the Complainant under exclusion clause 4.1 treating the disease hypertension as pre-existing.

It may here be noted that no definite material has been placed before this forum to the effect that the Complainant has been suffering from hypertension since last 15 years. It appears from the photocopy of the Discharge Summary that during the period of hospitalization the disease of the Complainant was diagnosed as hyponetramia (diuretics induced), hypertension and diabetes mellitus. It is well known that hyponetramia is a condition that occurs when sodium concentration in blood is abnormally low. Diuretics is commonly known as water pills. For hypertension diuretics is administered so as to get rid of unneeded water and salt through urine. Hyponetramia is an occasional but potentially fatal complication of diuretic therapy. However one cannot jump over to a sudden conclusion on the basis of disease diagnosed to be hyponetramia (diuretics induced), as it has happened in the instant case that the patient was suffering from hypertension since a long period thereby attracting the pre-existing condition under the policy.

The pre-existing condition/disease has been well defined under clause 3.10 of the policy. As per the said clause, pre-existing condition/disease is any condition, ailment or injury or related condition for which insured person had signs or symptoms, and/or were diagnosed, and/or received medical advice or treatment within 48 months prior to his/her first policy with the company. Further exclusion clause 4.1 envisages that the company shall not be liable to make any payment under the policy in respect of any expenses incurred by any insured persons in connection with or in respect of any pre-existing condition as defined in the policy until 48 months of continuous coverage of such insured person have elapsed since inception of his/her first policy with the company.

In the case in hand the Complainant took first policy on 16.11.2002. So after a continuous coverage of 48 months till 15.11.2006, he becomes entitled to get medical expenses from OP in respect of even any pre-existing disease. Since the claim relates to the period from 30.04.2012 to 03.05.2012, exclusion clause 4.1 does not come into play. The Complainant is very much entitled to get the medical expenses during the said period and the OP is liable to pay the same to him. The rejection of claim by the Insurer is thoroughly wrong and erroneous. Hence it is ordered that the complaint is allowed. The OP is hereby directed to settle the claim of the Complainant without least delay.

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BHUBANESWAR OMBUDSMAN CENTER

COMPLAINT NO- BHU-G-048-1314-1268

Shri Pramod Kumar Agarwal

Vrs

National Insurance Co. Ltd., Cuttack DO I

Award Dated 31st Day of Mar., 2015

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

In brevity, the case of the Complainant is that he took a Parivar Mediclaim Policy from the OP for himself and his family since 2009 and in the yr 2012-13 his son was admitted for surgery for pilonidal sinus at Sri Ram Chandra Hospital, Chennai. At the time of admission the Complainant applied for cashless settlement. But the TPA delayed in giving approval for the same. Hence the Complainant deposited Rs.40,000/- in cash as advance. Again at the time of discharge he paid the balance amount to facilitate discharge of his son. He spent a total sum of Rs.63,809/- in the treatment and lodged a claim with the TPA. But it paid him Rs.678/- only thereby rejecting the balance amount of Rs. 63,131/- on the ground of deduction as PPN. The Complainant is neither aware of PPN nor it forms a part of the policy terms & conditions. So he approached this forum for redressal.

The OP files SCN stating that the Complainant's son was treated in the Sri Ram Chandra Hospital, Chennai which was a PPN (Preferred Provider Network). The TPA has entered into an agreement with the hospital and has settled the cashless claim for Rs.32,322/- . Subsequently an amount of Rs.678/- was paid to the Complainant being the balance amount of the claim. PPN is an arrangement by four public sector insurance companies to provide

cashless facility through the TPAs for settling claims under health insurance policies only for treatment at PPN hospitals at the agreed package rates for specified treatments. In the present case the hospital is a PPN hospital and the total allowable amount for the said disease is agreed at Rs.33,000/- .

At the time of hearing the Complainant physically appears and states that totally he has received Rs.33,000/- including cashless benefit and reimbursement. Actually he spent Rs.63,879/- in the treatment at the hospital. He was quite ignorant about the PPN system. It was neither included in the contract nor intimated to him before. So he is entitled to get the entire expenditure incurred by him. According to the representative of the OP there was an understanding between all public sector general insurance companies on the one part and some hospitals (Network Hospitals) on the other regarding package system in respect of specified diseases. He submits relevant papers for perusal. Complainant is entitled to Rs.33,000/- and the same has already been paid. He further submitted that he can not show any proof that the fact of PPN was intimated to the Complainant.

Copy of Parivar Mediclaim Policy is readily available in the file and elaborately delved into. As per the said policy the Insurer undertakes to pay the insured the hospitalization expenses for medical/surgical treatments at any nursing home/hospital in India as an inpatient, if such expenses are reasonably and necessarily incurred as per the schedule, but not exceeding the sum insured in aggregate. The policy does not include the so-called PPN arrangement. It is said that PPN is an arrangement by four public sector companies to provide cashless facility through the TPAs. But this arrangement has neither been included in the policy nor is there any scent of intimation regarding it to the insured. A totally foreign concept has usurped into the insurance transaction which is not appropriate. Since the insured is ignorant about the said arrangement, the insurer cannot thrust it upon him.

It is needless to mention here that the Complainant has incurred a total expenditure of Rs.63,809/- in the hospitalization of his son who is covered under the policy. He has also submitted relevant papers regarding medical expenses. Now it is incumbent upon the insurer to process those papers in accordance with the provisions of the policy and make payment. It cannot limit the expenditure under the new PPN concept. The Complainant openly admits to have received Rs.33,000/- including cashless benefit. After deducting the amount already paid, the OP is liable to pay the balance, if any, to the Complainant after duly processing his papers as per the terms & conditions of the relevant policy. Hence it is

ordered that the complaint is allowed. The OP is hereby directed to settle the claim of the Complainant in the manner as indicated above.

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BHUBANESWAR OMBUDSMAN CENTER
COMPLAINT NO- BHU-G-051-1314-1275
Shri Surajit Roy Chowdhury
Vrs
United India Insurance Co. Ltd.

Award Dated 31st Day of Mar., 2015

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

Brief case of the Complainant is that he took a Mediclaim Policy from the OP for himself and his wife. Unfortunately, the Complainant was hospitalized with severe carbuncle and diabetes being in a semi-conscious stage. He was discharged after operation on his back and thereafter underwent post operative treatment at home. He incurred an expenditure of Rs.1,14,000/- for his treatment. As Kalinga Hospital was not a network hospital he submitted all the required documents to the TPA for reimbursement. On 02.08.2012 when the Complainant enquired about the claim, TPA advised him to submit the In-door case papers. So he deposited the requisite fees with the hospital and requested the superintendent to send the case papers to the TPA as the hospital authorities did not hand over the same to him. However, the Complainant was informed by the OP that his claim was rejected for want of case papers. So he approached this forum.

The OP files SCN stating that the Complainant has taken treatment at Kalinga Hospital, Bhubaneswar for multiple carbuncles with diabetes mellitus. Total claimed amount was Rs.1,00,000/- . On receipt of the claim documents from the insured, it asked for the case papers for processing the claim. As the required document was not received, the claim was closed on 05.02.2012.

At the time of hearing before this forum the Complainant states that he was hospitalized at Kalinga Hospital for treatment of carbuncle and diabetes mellitus. He submitted all the papers and claimed for Rs.1,00,000 for which he was eligible. But OP arbitrarily closed his claim. He undertakes to submit all the relevant papers including in-door papers and declaration to the effect that he has not taken the claimed amount from any other source, positively within 3 days hence. According to the representative of the OP, the claim was closed for want of in-door case papers and submits that if the

Complainant submits all the required documents along with an affidavit that he has not taken any reimbursement in respect of the claimed amount from any other source, then the claim would be processed and settled within 4 weeks positively.

Evidently, the claim was closed due to non-receipt of the indoor case papers by the TPA. However, the Complainant is now ready to submit the required documents within 3 days to the OP. Similarly OP has undertaken to process the claim within 4 weeks after receipt of the documents. As both the parties have mutually agreed, there is no need to delve further deep in to the matter. Hence it is ordered that the OP is hereby directed to settle the claim of the Complainant in the manner as indicated above.

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CHANDIGARH OMBUDSMAN CENTER

CASE NO. CHD-G-051-1415-0493

Ashok Kumar Sud Vs. United India Insurance Company

ORDER DATED: 12th January, 2015

Medi-claim

FACTS: This complaint was filed about settlement of a medi-claim by the Company for an inadequate amount. The insured was covered for a sum insured of Rs. 1,50,000/- under the policy, whereas a sum of Rs. 1,75,000/- was incurred on a surgical treatment and its claim was settled by the Company for Rs. 1,05,000/- only.

FINDINGS: It was found that a specific clause of policy provided that in case of major surgeries, a payment will be restricted to actual expenses incurred or maximum amount of 70% of sum insured under the policy. Hence, a claim was settled by the Company for Rs. 1,05,000/-.

DECISION: The decision of the Company to settle a claim restricting its liability as per terms and conditions of the policy was held justified. However, in view of a separate provision of policy about admissibility of payment of pre and post hospitalization expenses, that too up- to actual expenses or a maximum of 10% of sum

insured, insured was advised to prefer a claim for the reimbursement of pre and post hospitalization expenses, incurred if any.

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CHANDIGARH OMBUDSMAN CENTER

CASE NO. CHD-G-051-1415-0537

Ravi Garg Vs. United India Insurance Company

ORDER DATED: 4th March, 2015

FACTS: This complaint was filed about denial of a medi-claim by the Company on the ground of hospital not meeting a policy condition about '15 beds'. After receiving grievous injuries in an accident, insured was hospitalized in a specialist medical Institute of plastic surgery, wherein a claim for the reimbursement of Rs. 63,276/-, spent on a treatment, was declined by the Company.

FINDINGS: It was found that before obtaining a surgical treatment insured was given medical attention elsewhere. Infact he had met with a road accident and from the spot of accident Police Control van had brought him to Govt. Medical College and Hospital. But, after finding profuse bleeding and apprehending future permanent damage to his injured hand, he was referred to PGI for an urgent surgery. Alternatively, he was advised to visit nearest Tri-Institute as any delay could hamper movement of hand.

DECISION: The decision of the Company to deny a claim under specific policy clause about either registration of a hospital with the local authorities or meeting a criteria, stipulating 15 beds in an urban centre' was held unjustified because a treatment was obtained in emergency and hospital was fully equipped for the particular treatment.

CHANDIGARH OMBUDSMAN CENTER

CASE NO. CHD-G-044-1415-0571

Gaurav Garg Vs. Star Health Insurance Company

ORDER DATED: 23rd Feb., 2015

Medi-claim

FACTS: This complaint was filed about denial of a hospitalization claim by the Company on the ground of treatment of a pre-existing problem. It was pleaded that insured had a fall from stairs at home, resulting in his becoming unconscious. Thereafter, he was carried by other family members to a nearby hospital in an emergency. But, Company had declined to pay a claim for the reimbursement of treatment expenses on the ground of absence of trauma in 'MRI' report.

FINDINGS: It was found that a policy was obtained for the first time for a period from 26.04.2014 to 25.04.2015. Then, within 5 months from the commencement of risk, a claim was lodged about a treatment of 'prolapsed intervertebral disc'.

DECISION: The decision of the Company to decline a claim on the ground of a pre-existing condition was held justified because insured could not confirm any insurance for the previous period and treatment was about PIVD, which is progressive and degenerative in nature. Moreover, 'discharge summary' clearly mentioned about chronic low back-ache problem.

CHANDIGARH OMBUDSMAN CENTER

CASE NO. CHD-G-048-1415-0698

M. C. Singla Vs. National Insurance Company

ORDER DATED: 23rd March, 2015

MEDI-CLAIM

FACTS: This complaint was filed about settlement of a hospitalization claim for an inadequate amount. A sum of Rs. 1,83,811/- was spent on a treatment, out of which Rs. 64,120/- was paid by one insurance Company under its individual medi-claim policy for Rs. 1,00,000/-. Then, the balance amount of Rs.1,19,691/- was claimed under a second policy of another Insurance Company providing coverage to the extent of Rs. 3,00,000/-. But, the latter company paid only Rs. 30,000/-. Hence, balance amount, paid from pocket, was claimed by the complainant.

FINDINGS: The second policy of another insurance company was a tailor-made group medi-claim arrangement to cover a large number of retired employees of a bank under varying slabs of sum insured. In this context, MOU signed between the bank and insurance company laid down special terms and conditions of the insurance owing to subsidized premium. It was specifically provided that under the particular slab of sum insured, maximum of Rs. 30,000/- is payable i. r. o. non-surgical in-door hospitalization expenses.

DECISION: The decision of the Company to restrict a payment as per the special terms and conditions of a group policy was considered justified. It was held that there is a merit in the contention of the Company that individual health policy and a group medi-claim policy can't be viewed at par with each other owing to different terms and conditions and structure of charged premium.

OFFICE OF INSURANCE OMBUDSMAN ,DELHI

Case No.GI/NIA/295/12
In the matter of Sh. Rajesh Gupta
Vs
New India Assurance Company Ltd.

Policy No. 312300/34/11/00000615.

Date of Award 21.01.2015

1. **This is a complaint filed by Sh. Rajesh Gupta (herein after referred to as the complainant) against the decision of New India Assurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to non- settlement of full claim amount under Mediclaim.**

2. **The Complainant had alleged that his wife was diagnosed with cancer in August, 2009 and various claims were lodged by him. Insurance Company settled the claims after deducting 25% of claim on account of co-payment clause which resulted in short payment of Rs. 57810/- . Complainant was never told about co-payment clause nor was it mentioned in the policy.**

3. **The Insurance Company reiterated vide its letter dated 17.01.2013 that complainant has been taking the policy for last several years but in 2009 policy was renewed 20 days advance with 50% C.B. before due date and claim was reported in previous policy after the renewals so premium could not be loaded for claim. Against the renewal policy for the period 22.09.09 to 21.09.10 complainant had taken claims amounting Rs. 3.92, 822/- against the S.I. of Rs 3 Lacs thereby disbursement of Rs. 92.822/- in excess was made. Insurance Company had stated that a recovery was due from the complainant for Rs. 92.822/-+ 1371/- (short premium for 25% loading to be charged on premium). Complainant was well aware about the policy terms and conditions as on renewal in 2010 he had paid 100% loading applicable on the**

basis of 85% claim ratio with 20% as copayment. Insurance Company had already paid his various claims and there is recovery due on the part of complainant for excess payment made and loading on premium/ short premium.

4. **I heard both the sides, the complainant as well as the insurance company. I find that insurance company had settled the claim after deducting 25% of claim on account of co-payment resulted in short payment of Rs. 57,810, whereas complainant was never told about co-payment clause nor was it mentioned in the policy. The fact was not refuted by the insurance company. I therefore conclude that there was deficiency in service on part of the insurance company. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 57,810/- to the complainant.**

OFFICE OF INSURANCE OMBUDSMAN ,DELHI

Case No.GI/NIA/365/12

In the matter of Sh. R.K. Wadhawan.

Vs

New India Assurance Company Ltd.

Date of Award 21.01.2015.

Policy No. 311502/34/11/01/00001494.

1. **This is a complaint filed by Sh. R.K. Wadhawan (herein after referred to as the complainant) against the decision of New India Assurance Company Ltd. (herein after referred to as respondent Insurance Company) alleging non-settlement of mediclaim.**

2. **The complainant had alleged that he had a Medicalim Insurance from New India Assurance Co. Ltd since last 15 years. Complainant's wife was suffering from Hepatitis- C and underwent treatment at Institute of Liver and Biliary sciences. He had filed two mediclaim of Rs. 3, 74,401/- in July 12 and again on 23.04.13. He had submitted all the relevant**

documents. TPA had settled only Rs. 1, 70,234/- out of claimed amount of Rs. 3, 74,401/-. Complainant had not received payment of approved claims also. Complainant had sought relief of payment of approved claims as well as damages of Rs. 10 Lacs and action against TPA.

3. **The insurance company reiterated the written submissions vide letter dated 15.12.2014 that complainant had lodged 18 claims under the policy, out of which 8 claims were paid. Claims non-payable as per clause 3.4 Albumin infusion is not covered under day care procedure. Claims of Rs. 27,219 and Rs.4, 871/- were closed due to non-submission of deficient document.**

4. **I heard both the sides, the complainant as well as the insurance company. I find that complainant had lodged various claims under the policy. Insurance company had already settled 8 claims out of 18 claims as per terms and conditions of the policy. Claims were closed due to non-submission of original documents by the insured. During the personal hearing complainant had opined that original bills were lost by him, therefore duplicate bills were taken from the hospital on 03.06.2014 and were submitted to TPA along with affidavit. Accordingly an Award is passed with the direction to the insurance company to make the payment to the complainant subject to submission of the required documents.**

OFFICE OF INSURANCE OMBUDSMAN ,DELHI

Case No.GI/NIA/270/12.
In the matter of Sh. Umesh Mittal.

Vs
New India Assurance Company Ltd.

Date of Award 27.01.2015.

Policy No.: 320301/34/10/13/0000900.

1. **This is a complaint filed by Sh. Umesh Mittal (herein after referred to as the complainant) against the decision of New India Assurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to non settlement of Mediclaim.**

2. **The complainant had alleged that his wife underwent ear surgery from St. Stephen Hospital on 24.3.11. He preferred a claim for hospitalization under medical policy no. 3201301/34/10/13/00900 obtained from New India from 24/8/10 to 23/8/2011. He submitted all claim documents to TPA who rejected the claim on the ground of 2 years exclusion clause. Complainant provided previous Insurance details to the Insurance Company. He was insured with United Insurance from 23.08.09 to 22.08.2009 and from 23.8.2009 to 22.8.201, he took medical Insurance from Bharti AXA.**

3. **The insurance company stated that patient was covered under New India Family Floater Mediclaim Policy since 24.08.2010 (Ist year running policy) and the disease Chronic Otitis Media (Benign Ent Disorders) is an exclusion for first two years of the mediclaim policy as per clause 4.3 (3) which reads as "From the time of inception of the cover, the policy will not cover the following diseases/ailment/condition for the duration shown below, this exclusion will be deleted after the duration shown,**

provided, the policy had been continuously renewed with our company without any break".

4. **I heard both the sides, the complainant as well as the insurance company. During the course of hearing, the insurance company assured to settle the case within 10 days subject to submission of required documents. The settlement has not been done as yet. Accordingly an Award is passed with the direction to the insurance company to make the payment to the complainant subject to submission of the required documents.**

OFFICE OF INSURANCE OMBUDSMAN ,DELHI

Case No.GI/NIC/277/12.
In the matter of Ms. Neelam Dua.
Vs
National Insurance Company Ltd.

Date of Award 27.01.2015.

Policy No. : 360500/48/10/8500000418.

1. **Ms. Neelam Dua (herein after referred to as the complainant) had filed the complaint against the decision of National Insurance Company Ltd. (herein after referred to as respondent Insurance Company) alleging non-settlement of mediclaim.**

2. **The complainant had alleged that she was admitted in Sir Ganga Ram Hospital from 16.05.2012 to 18.05.2012 with diagnosis of suspected seizure disorder. The cashless facility was denied by TPA. She underwent investigations during hospitalization and was discharged with advices of epilepsy medicine by Sr. consultant Dr. S. Kalra, Neuro Consultant. But her cashless claim was denied on the ground of hospitalization only for investigation and evaluation.**

3. **The insurance company vide its letter dated 12.11.2012 submitted that patient had no complaints upon admission and was admitted on 16.05.2012 for investigation purpose. She had episode of becoming unconscious at home on 05.05.2012 and was admitted on 16.05.2012 for investigation purpose. Therefore as per clause 4.10- "expenses incurred primarily for evaluation/ diagnostic purposes not followed by active treatment during hospitalization" claim becomes non-payable. Claim file was also reviewed by RCC of the company, who opined that as per clause 4.10 of mediclaim policy, claim is non-payable.**

4. **I heard both the sides, the complainant as well as the insurance company. I find that expenses incurred for diagnostic evaluation were denied as per clause 4.10 which reads as "Expenses incurred primarily for evaluation/ diagnostic purposes not followed by active treatment during hospitalization". I find that patient was discharged with advices of medicines. Accordingly an Award is passed with the direction to the insurance company to allow only the expenses incurred for active treatment during hospitalization to the complainant.**

OFFICE OF INSURANCE OMBUDSMAN ,DELHI

Case No.GI/NIC/232/12.
In the matter of Ms. Shashi Dhingra.
Vs
National Insurance Co. Ltd.

Date of Award 27.01.2015

Policy No. : 354301/48/11/85-351.

1. **This is a complaint filed by Smt. Shashi Dhingra (herein after referred to as the complainant) against the decision of National Insurance Company Ltd. (herein after referred to as respondent Insurance Company)**

relating to delay in settlement of mediclaim and deficiency in service of Insurance Company.

2. **The Complainant had alleged that she has been paying regular premium for mediclaim Insurance since 2001. This complaint pertains to delay in reimbursement, deficiency in service, piece meal objections and mental agony. Objections/queries pertaining to claim were raised in piece-meal and the claims were settled late as well as cashless card issued after 42 days.**

3. **The Company reiterated the written submissions. Company stated that claims were settled after taking clarifications from the insured on queries raised by TPA. Due to delay in submission of discharge vouchers by the insured, claims were settled late.**

4. **I heard both the sides, the complainant as well as the Insurance Company. I find that although the claims were settled but chart provided by complainant shows that there was an inordinate delay in reimbursement of claims. The company could not show that delay was also on the part of the complainant in providing the vouchers. He was a long standing customer of National Insurance Company. There was deficiency in service on the part of Insurance Company. Therefore an ex-gratia payment of Rs.20,000/- is hereby granted to the complainant. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 20,000/- to the complainant.**

OFFICE OF INSURANCE OMBUDSMAN ,DELHI

Case No.GI/NIA/359/12.

In the matter of Smt. Kamlesh Johar.

Vs

New India Assurance Company Ltd.

Date of Award 28.01.2015

Policy No. : 32350/43/41/10/100000805.

1. **This is a complaint filed by Smt. Kamlesh Johar (herein after referred to as the complainant) against the decision of New India Assurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to inadequate settlement of Mediclaim.**

2. **The Complainant had alleged that she was admitted in Kalra Hospital for the period 03.03.12 to 06.03.12 with c/o severe pain in chest with restlessness and diaphoresis. She was diagnosed as CAD, LV dysfunction, acute coronary syndrome, UTI, non critical CAD, Pangartritis with small hiatus hernia. She had taken Mediclaim Insurance since 2002 with S.I. Rs 50,000/- with 30% CB. She had lodged claim first time. Hospital expenses were settled on cashless basis but pre and post hospitalization expenses were not settled by the company. The reimbursement claim was repudiated by TPA on grounds of fraudulent practice by the hospital as per clause 5.5**

3. **The Insurance Company vide letter dated 15.05.13 had reiterated that hospital had submitted papers to TPA for reimbursement of Rs. 52,621/- (expenses incurred by hospital). TPA had asked hospital to provide tariff rates for room rent in which patient was admitted. On scrutiny the tariff rate for room rent in which patient was admitted was Rs. 4100/- per day for deluxe room and 7100/- per day for Heart command (Suit Room) whereas in the bill hospital charged only 1000/- & 2000/- respectively. As per policy condition 2.3 linking charges applicable to Doctor's fee and other charges shall be applicable to entitled room category. Since the**

hospital had charged room rent as per the patients eligibility i.e. 1% of S.I. instead of tariff rates for room, this amount was fraud on the part of hospital. Hence claim was repudiated as per policy clause 5.5 states fraud.

4. **I heard both the sides, the complainant as well as the insurance company. I find that hospital expenses were settled on cashless basis, but pre- post hospitalization expenses were denied. Insurance company had repudiated the base case, therefore pre and post charges could not be settled. I find that base case was denied due to fraudulent practices of the hospital, hence in my opinion complainant is not liable to be penalized for mal practices of hospital. I direct the insurance company to settle the claim as admissible. Accordingly an Award is passed with the direction to the insurance company to settle the claim as admissible to the complainant.**

OFFICE OF INSURANCE OMBUDSMAN ,DELHI

Case No.GI/NIC/381/12.
In the matter of Smt. Sanchita Dey.
Vs
National Insurance Company Ltd.

Date of Award 28.01.2015

Policy No.: 360900/46/10/850000190.

1. **This is a complaint filed by Smt. Sanchita Dey (herein after referred to as the complainant) against the decision of National Insurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to non settlement of Mediclaim.**

2. **The complainant had alleged that her spouse was covered under two group mediclaims policies issued by National Insurance through Employer. One GMP was taken by Lease Plan India PVT. LTD. Second GMP was taken by M/S Alpha Technical Service PVT. LTD. Complainant's spouse was**

admitted to Max Super Speciality Hospital from 12/04/2011 to 19/04/2011 for UGI bleed cirrhosis and passed away. A claim of Rs. 5,27,054/- was lodged with TPA of second policy (354900/46/10/850000077) and another claim amounting Rs. 5,27,054/- was lodged with TPA of first policy. A claim of Rs. 1,82,000/- was approved by TPA of 2nd policy but rejected by TPA of first policy as per exclusion clause 4.8 (disease related to alcoholic intake). Complainant had alleged that deceased used to drink alcohol only in remote past. He was covered under policy for past 5 years, and even the claim has been approved by same insurer.

3. **TPA of the Insurance Company had investigated the hospital record and found that patient had a history of chronic alcoholism and as per the medical literature it is well established that cirrhosis of liver & UGI bleed and other hepatitis has a close proximity with history of alcohol and claim was repudiated under exclusion clause 4.8.**

4. **I heard both the sides, the complainant as well as the Insurance Company. Complainant was covered under two group mediclaim policies issued by National Ins. Co. Ltd. One claim for the same illness was allowed by one TPA under one group mediclaim policy whereas another claim for the same illness was denied by the other TPA. Insurance company could not prove why the claim was denied. Therefore, an Award is passed with the direction to the insurance company to settle the claim.**

OFFICE OF INSURANCE OMBUDSMAN ,DELHI

Case No.GI/NIC/324/12.
In the matter of Sh. Ram Prasad.
Vs
National Insurance Company Ltd.

Date of Award 28.01.2015

Policy No.: 360700/48/11/85/4457.

1. **This is a complaint filed by Sh. Ram Prasad (herein after referred to as the complainant) against the decision of National Insurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to non settlement of Mediclaim.**

2. **The Complainant had alleged that he was admitted in Apollo hospital with complaint of pain and difficulty in walking. He was diagnosed as a case of coronary artery double vessel disease. His Left artery was blocked. He underwent Angiography which revealed double vessel disease PTA with stenting to pudendal artery was done on 23.09.2012. He lodged a mediclaim and submitted all the documents to TPA. The claim was closed as "No claim" on account of pre-existing disease.**

3. **The company had stated that the claim was closed as "No claim" on account of pre-existing disease. The claim for double vessel disease was lodged within first year of policy. The discharge summary revealed that complainant was suffering from chest pain for last two years. Hence claim was closed as "No Claim" as per policy clause No- 4.1 which states that pre-existing ailments will be covered after 4 continuous claim free policy years.**

4. **I heard both the sides the complainant as well as the Insurance Company. I find that the Insurance Company could not show any supportive documents to show that the patient had undergone any treatment for his Pudendal Artery before,**

in the past two years. It was diagnosed only at the time of hospitalization on 22.09.2012. It cannot be considered a case of pre-existing disease. The insurance company is directed to settle the claim. Accordingly an Award is passed with the direction to the insurance company to reimburse the amount as admissible to the complainant.

OFFICE OF INSURANCE OMBUDSMAN ,DELHI

Case No.GI/STAR/316/12
In the matter of Mrs. Indu Sood
Vs
Star Health & Allied Insurance Co. Ltd.

Date of Award 29.01.2015

Policy No. P/161100/01/2012/000842

1. **This is a complaint filed by Mrs. Indu Sood (herein after referred to as the complainant) against the decision of Star Health & Allied Insurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to non-settlement of Mediclaim.**

2. **The Complainant had alleged that her husband was hospitalized in Fortis Hospital on 06.03.2012 and was diagnosed as RV Dysfunction, severe PAH, Cardiogenic shock , CLD and Portal HTN and died on 13.3.12. A claim amounting to Rs. 2, 60,000 was filed by complainant,which was rejected on the ground of pre-existing disease. Complainant had further stated that her husband was suffering from CLD & TB (Brain Abscess) in 2008, which was cured. They took Mediclaim Insurance from Star Health from 26.04.2008 onward but forgot to declare the disease which was fully cured, and had no bearing in the present ailment.**

3. **The Insurance Company had repudiated the claim on the ground that complainant had not disclosed the medical history at the time of inception of the policy which amounts to**

misrepresentation of material facts. From the medical certificate and record it was observed that insured had chronic liver disease and tuberculosis since 2008 which was prior to inception of policy taken by insured.

4. **I heard both the sides, the complainant as well as the insurance company. The case was rejected on the basis of non-disclosure of Chronic Liver Disease & TB (Brain Abscess) in 2008. The patient was admitted with severe RV Dysfunction and severe PAH and subsequently had Cardiogenic shock. The cause of death was not attributed to brain abscess or chronic liver disease. As per doctor's certificate cause was Cardiac Arrest. Accordingly an Award is passed with the direction to the insurance company to settle the claim as admissible to the complainant.**

OFFICE OF INSURANCE OMBUDSMAN ,DELHI

Case No.GI/NIC/280/12.
In the matter of Ms. Kanak Jain.
Vs
National Insurance Company Ltd.

Date of Award 29.01.2015

Policy No. : 351600/48/11/85/00000267.

1. **Ms. Kanak Jain (herein after referred to as the complainant) had filed the complaint against the decision of National Insurance Company Ltd. (herein after referred to as respondent Insurance Company) alleging inadequate settlement of mediclaim.**

2. **The complainant had alleged that insurance company had approved cashless settlement of Rs. 25,000/- against claimed amount of Rs. 32,000/- and reasons for deduction were not given. As regards pre-post expenses TPA had settled Rs. 12,138/- out of Rs. 13,970/-. The Complainant had sent**

various reminders for settlement of balance amount. He approached to this forum for release of balanced amount.

3. **The Insurance Company had submitted the claim settlement details along with reasons for deductions made vide letter dated 29.07.2013. The claim was settled as per T&C of the policy subject to availability of sum insured and deduction for room rent, TDS and other tests were made in cashless settlement. As regards reimbursement claim deductions were made for non submission of two reports dated 16.01.2012 for an amount of Rs. 1,200/- & 600/-.**

4. **I heard the company. The complainant was absent and none represented on her behalf. During the course of hearing, the company clarified that they had settled as per T&C of the policy and Rs. 1800/- would be given on submission of two reports. Accordingly an Award is passed with the direction to the insurance company to make the balance payment to the complainant subject to submission of the required documents.**

OFFICE OF INSURANCE OMBUDSMAN ,DELHI

Case No.GI/NIA/260/12.
In the matter of Mr. Nalin Goel.
Vs
New India Assurance Company Ltd.

Date of Award 29.01.2015

Policy No.: 310100/34/10/11/00001580.

1. **This is a complaint filed by Ms. Nalin Goel (herein after referred to as the complainant) against the decision of New India Assurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to non- settlement of Mediclaim.**

2. **The Complainant had alleged that he had taken a mediclaim policy from United since 2006 and after 4 year continuous**

running of policy. He renewed it from New India in the 5 the year. He had a brain Seizure on 21.09.2011 and was admitted in Santom Hospital from 21.09.2011 to 25.09.2011. TPA denied cashless facility on the basis that insured was a diagnosed case of NCC, Seizure GTCS and this ailment falls under first 2 years exclusion clause. Complainant had submitted previous insurance policies issued by united insurance company to establish the fact that he was continuously insured under mediclaim policies without break and his claim should not be treated under fresh insurance. On the basis of submission of all necessary papers insurance company directed TPA to reconsider the claim but it was repudiated.

3. **No written submission were received from the insurance company.**

4. **I heard both the sides, the complainant as well as the insurance company. I find that complainant had submitted copies of previous insurance to prove continuity of insurance. Insurance company sought another date because of lack of papers on 05.11.2014 but neither have they submitted any reply nor were presented during the hearing on 20.01.2015. Accordingly an Award is passed with the direction to the insurance company to settle the claim of the complainant as admissible.**

OFFICE OF INSURANCE OMBUDSMAN ,DELHI

Max Bupa/194/12.

In the matter of Sh. Rinchen Lepcha

Vs

Max Bupa General Insurance Co. Ltd.

Date of Award 30.01.2015

Policy No.: 30008282201101.

1. **This is a complaint filed by Sh. Rinchen Lapcha (herein after referred to as the complainant) against the decision of Max Bupa General Insurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to inadequate settlement of Mediclaim.**

2. **The complainant had alleged that his Wife was hospitalized at Puspawati Singhania Research Institute from 02.02.11 to 06.02.11 for pain in abdomen SAIO, FUC of Intestinal Tuberculosis. Cashless facility was denied by TPA. Complainant had submitted all the documents for taking reimbursement and followed up the case. Subsequently case was investigated by Insurance Company personnel who assured him that claim would be clear in 2-3 days. But on 03.02.12 claim was rejected without specifying reasons for rejection. Through tele-communication he came to know later that claim was rejected due to pre-existing disease i.e. tuberculosis that she was suffering from the last 2 years.**
   Complainant sent a legal notice to Insurance Company on 24.02.12 stating that the hospitalization was due to irritable Bowel Syndrome or acute enteric infection and not because of tuberculosis as claimed by Insurer. Insurance Company replied the legal notice sent by the complainant and reiterated the fact that claims were not payable on ground of pre-existing disease.

3. **As per the written submission of Insurance Company dated 22.3.12 to legal adviser of insured, it had been stated that**

complainant had approached the insurer through tele sales channel for buying health insurance. Based on the information provided policy was issued. Complainant had a long standing problem of intestinal TB which was not disclosed by proposer at the time of applying for the policy. The discharge summary revealed that the insured was being treated as follow up case for intestinal TB. This material fact was not shared by proposer. Pre-authorization was obtained by concealment of material facts. CT scan report dated 22.10.10 has not been provided. Selective documents were provided by the insured to hide the duration of ailment.

4. **I heard both the sides, the complainant as well as the insurance company. Insurance company had repudiated the claim due to non-disclosure of pre-existing ailment i.e. Intestinal Tuberculosis at the time of taking the policy. This material fact was revealed to the insurance company from the discharge summary. Complainant had stated that hospitalization was due to Acute Enteric Infection and not due to Tuberculosis. I find from the treating doctor's certificate dated 24.02.2012 that there was no evidence of active Tuberculosis in the patient at the time of hospitalization. She was treated for irritable Bowel Syndrome or Acute Enteric Infection. Accordingly an award is passed with the direction to the insurance company to settle the claim as admissible to the complainant.**

OFFICE OF INSURANCE OMBUDSMAN ,DELHI

Case No.GI/NIA/261/12
In the matter of Smt. Veena Karkara
Vs
New India Assurance Company Ltd.

Date of Award 30.01.2015

Policy No. : 310401/34/11/01/0000008 &

31040134120100000004

1. **This is a complaint filed by Smt. Veena Karkara (herein after referred to as the complainant) against the decision of New India Assurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to non-settlement of mediclaim.**

2. **The Complainant had alleged that her husband was an ex-employee of New India. He took VRS from Company in the year 2002 and since than his wife was continuity renewing the policy. His husband was suffering from chronic liver cirrhosis from last 6 years. He was hospitalized in Shanti Gopal Hospital in 2009 for liver cirrhosis which was settled by Insurance Company. He was again hospitalized in 2012 in the same hospital and was treated by same doctor (Dr. Sanjay Garg) but the claim was repudiated by the company on the ground that he was an alcoholic and ailment caused due to alcohol is not payable under the policy. Complainant admits the fact that he was a social drinker.**

3. **No written submission were received from the insurance company.**

4. **I heard both the sides, the complainant as well as the insurance company. No written submissions were submitted by the insurance company. The claim was repudiated on the ground that diseases caused due to alcohol intake are not**

payable under the policy. Complainant had stated that deceased was an occasional drinker only. Insurance company did not prove to the contrary. I find from the treating doctor's certificate dated 30.06.2012 that although the patient was suffering from CLD, he used to take alcohol occasionally which was not sufficient to cause Liver Disease. The cause of death was Cardiac Arrest. Accordingly an award is passed with the direction to the insurance company to settle the claims as admissible to the complainant.

OFFICE OF INSURANCE OMBUDSMAN ,DELHI

Case No.GI/Max Bupa/167/12.
In the matter of Sh. Rana Kumar.
Vs
Max Bupa General Insurance Co. Ltd.

Date of Award 30.01.2015

Policy No.: 30084742201200.

1. **This is a complaint filed by Sh. Rana Kumar (herein after referred to as the complainant) against the decision of Max Bupa General Insurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to inadequate settlement of Mediclaim.**

2. **The complainant had alleged about the claim of his 4 yrs Son Mr. Aryan Paul who was admitted in Fortis Hospital for treatment of Septic Arthritis Left Hip Joint for the period 07.06.2012 to 09.06.2012 was rejected by TPA.**

3. **The Insurance Company reiterated vide written submission dated 20.09.2012 that insured had taken mediclaim policy on 12.03.2012 under Portability benefit scheme. As per portability guidelines, a cashless pre authorization for a sum of Rs. 18,550/- was submitted by the insured for the treatment of Septic Arthritis Left Hip Joint. TPA rejected the pre-**

authorization request on the ground that as per exclusion clause 4. There is a specific waiting period of 24 months for ailemnts like Osteoarthritis, Arthritis, Govt, Rheumatism, Spondylosis, Spondylitis, Intevertebral Disc Prolapse.

4. **I heard both the sides, the complainant as well as the Insurance Company. Complainant had stated that it is a Septic Arthritis which is different from normal Arthritis. I find from the doctor's certificate which revealed that patient was admitted in emergency condition. Emergency definition of policy condition No.9 states that "Emergency means a severe illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a doctor to prevent death or serious long term impairment of the insured person's health". The patient was admitted for Septic Arthritis which is life threatening and admitted in emergency. Therefore, an award is passed with the direction to the insurance company to settle the claim as admissible to the complainant.**

OFFICE OF INSURANCE OMBUDSMAN ,DELHI

Case No.GI/NIA/228/13
In the matter of Sh. Krishan Kr. Batra.
Vs
New India Assurance Company Ltd.

Date of Award 02.02.2015

Policy No.: 31040134110100001207.

1. **This is a complaint filed by Sh. Krishan Batra (herein after referred to as the complainant) against the decision of New India Assurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to inadequate settlement of Mediclaim.**

2. **The complainant had alleged that he was admitted at Sir Ganga Ram Hospital from 26.09.2012 to 01.10.2012 with complaint of fever since 15 days. He was diagnosed as a case of diabetes with HTN with Cholecystitis, and on investigations, LFT report was found deranged. Diabetes was already incorporated in the policy under pre-existing disease column.**

   Complainant had alleged that he had taken mediclaim insurance since 1998 without break for Sum Insured 1.5 lacs. He enhanced the sum insured upto 2.5 lacs w.e.f 04.03.2011 and at that time he was not intimated that old sum insured will be applicable for room rent, doctor's visit and other charges. The deductions made by company in proportionate to sum insured were unjustified.

3. **The Insurance Company had stated that claim had been settled for Rs.23, 052/- against claimed amount Rs. 59,733/-. Deductions were made for excess room rent, consultations fee, and other charges as per clause 2.4 and 2.3 of policy which state that charges payable shall be at the rate applicable to the entitled room category.**

4. **I heard both the sides, the complainant as well as the Insurance Company. Complainant had stated that company had given policy but not the terms and conditions of the policy at the time of enhancing the policy in 2011. Insurance company could not show the relevant policy, nor could show their terms and conditions which were made known to the insured. I find that Insurance Company could not show any capping on room rent, Doctor's visits & Lab charges. Accordingly, an award is passed with the direction to the Insurance Company to reimburse the remaining amount for room rent, doctor's visit charges and lab charges as payable to the complainant.**

OFFICE OF INSURANCE OMBUDSMAN ,DELHI

Case No.GI/RGI/172/13.
In the matter of Mr. Sachchida Nand Jha.
Vs
Reliance General Insurance Co. Ltd.

Date of Award 02.02.2015

Policy No. : 1301712825000723.

1. **This is a complaint filed by Mr. Sachchida Nand Jha (herein after referred to as the complainant) against the decision of Reliance General Insurance Co. Ltd. (herein after referred to as respondent Insurance Company) relating to non-settlement of mediclaim.**

2. **The complainant had alleged that he had taken a mediclaim policy bearing no-1301712825000723 from Reliance Genera Insurance Company for the period 10/12/2012 to 09/12/2013. Complainant's wife was admitted at Holy Family hospital for the period 30/10/2012 to 04/11/2012 with c/o pain in abdomen. She was diagnosed with previous LSCS with P/H/O left Donar Nephrectomy with Anemia. Claim was rejected on the ground that ailment was due to previous**

caesarian delivery done on 01/06/2012 and expenses related to delivery and caesarian were not covered.

3. **The Insurance Company had stated that insured was hospitalized from 30/10/2012 to 04.11.2012 at Holy Family Hospital with complaint of pain in Abdomen and had history of caesarian delivery and was a case of Donor Nephrectomy. As per treating doctor's certificate and discharge summary, during Laparoscopy Dense adhesion were found between omentum and previous caesarian scar revealed that ailment was related to previous caesarian and as per policy clause 6 , expenses related to delivery and caesarian are not covered, hence claim was repudiated.**

4. **I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing, the insurance company could not prove conclusively that pain was because of adhesion to the anterior abdominal wall over previous caesarian scar . I find that doctor's certificate clearly state that adhesion may have formed following previous surgery. It does not categorically say that the pain was because of the adhesion. Accordingly an Award is passed with the direction to the Insurance Company to refund the claimed amount as admissible to the complainant.**

OFFICE OF INSURANCE OMBUDSMAN ,DELHI

Case No.GI/NIA/230/13.
In the matter of Sh. Manoj Kr. Jain.
Vs
New India Assurance Company Ltd.

Date of Award 02.02.2015

Policy No. : 32350034103000000126.

1. **This is a complaint filed by Sh. Manoj Kumar Jain (herein after referred to as the complainant) against the decision of New India Assurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to non-settlement of Mediclaim.**

2. **The complainant had filed a complaint for non-settlement of claim for his son who suffered injuries in the school. He had submitted all the relevant documents to TPA, but Insurance Company did not settle the claim.**

3. **The Insurance Company reiterated the written submissions vide letter dated 16.01.2015 that TPA had written various letters to the insured for submission of original discharge summary, original final bill of hospital, original prescriptions and break up of medicine bills. Due to non submission of requisite documents by the insured, the claim was closed as NO CLAIM.**

4. **I heard the Insurance Company. The complainant was absent and none represented on his behalf. During the course of hearing, the Insurance Company stated that complainant had not submitted the required documents, so claim was closed as NO CLAIM. Accordingly an Award is passed with the direction to the insurance company to settle the claim as admissible to the complainant subject to submission of the required documents.**

OFFICE OF INSURANCE OMBUDSMAN ,DELHI

Case No.GI/Star/129/13.

In the matter of Sh. V.N Sharma.

Vs

Star Health And Allied Insurance Company Ltd.

Date of Award 05.02.2015

Policy No. : P/161100/01/2013/005003.

1. **Sh. V.N Sharma (herein after referred to as the complainant) had filed the complaint against the decision of Star Health and Allied Insurance Company Ltd. (herein after referred to as respondent Insurance Company) alleging inadequate settlement of mediclaim.**

2. **The complainant had alleged that his wife was admitted at Anand Nursing Home with complaint of retention of Urine, DM & sleep Apnoea for the period 09.01.2013 to 14.01.2013. He had lodged a claim for Rs. 94,566/- out of which Rs. 23,555/- had been paid by the Company and Rs. 57,525/- were deducted which was illegal and unjustified.**
   Complainant had alleged that as per treating Dr's opinion prolonged Sleep Apnoea could be life threatening, so CPAP machine was life saving machine for the patient. He had sought relief of Rs. 57,525/- being deducted by Insurance Company.

3. **The Company reiterated the written submissions. The patient was admitted with diagnosis of Retention of Urine, dm, Sleep Apnoea, Bilateral Nasal Polyp. She was a known case of DM/HTN/Cervical spondylitis /fracture Spine in 2011. CPAP is a supporting device offered to the patient to be used at home to improve the breathing. It was similar to nebulizer, aerosol or nasal sprays. It was not covered under the policy. Expenses for the supporting device are not payable under exclusion No. 10 of the policy.**

4. **I heard both the sides, the complainant as well as the Insurance Company. during the course of haering complainant stated that prolonged sleep Apnoea could be life threatening so CPAP machine was life saving machine for his wife. He had also submitted a consumer court decision in favor of same illness. From the treating doctor's opinion I find that sleep disorder if not treated early may turn out to be life threatening. Accordingly an Award is passed with the direction to the Insurance Company to make payment for expenses incurred for CPAP machine.**

OFFICE OF INSURANCE OMBUDSMAN ,DELHI

Case No.GI/Star/262/13.
In the matter of Sh. Nishant Chaudhary.
Vs
Star Health And Allied Insurance Company Ltd.

Date of Award 06.02.2015

Policy No. : P/161100/01/2013/013519.

1. **Sh. Nishant Chaudhary had filed the complaint (herein after referred to as the complainant) against the decision of Star Health and Allied Insurance Company Ltd. (herein after referred to as respondent Insurance Company) alleging mediclaim.**

2. **The complainant had alleged that his wife was hospitalized at St. Stephen Hospital for the period 31.08.2013 to 03.09.2013 for treatment of Vitamin B12 deficiency and the insurance company had rejected his claim on the ground that ailment was about general debility, Anxiety and B12 deficiency could be treated on OPD bares, hence, claim was not admissible.**

3. **The company reiterated the written submissions. The insurance company had re examined the case and had observed that insured patient was diagnosed with B12 deficiency which is general debility. As per exclusion clause no. 10 of Policy Company was not liable to make any payment in respect o any expense incurred by the insured for treatment of general debility, hence claim had been repudiated.**

4. **I heard both the sides, the complainant as well as the Insurance Company. I find that the Insurance Company had repudiated the claim on the basis of exclusion clause No-10 of the policy which reads as Company was not liable to make any payment in respect o any expense incurred by the insured for treatment of general debility. I direct the Insurance Company**

to allow hospitalization charges only. Accordingly an Award is passed with the direction to the Insurance Company to allow only the expenses incurred during hospitalization.

OFFICE OF INSURANCE OMBUDSMAN ,DELHI

Case No.GI/OIC/114/13
In the matter of Sh. Harish Garg.
Vs
Oriental Insurance Company Ltd.

Date of Award 25.02.2015

Policy No. : 272102/48/2012/1360.

1. **This is a complaint filed by Sh. Harish Garg (herein after referred to as the complainant) against the decision of Oriental Insurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to non settlement of mediclaim of his mother.**

2. **The complainant has alleged that insured/claimant had continuous policies from 2009. His mother was hospitalized in 2012.**

3. **The Insurance Company reiterated their written submissions stating that they rejected the claim citing break in continuity of policy in the year in the 2010-2011.**

4. **I heard the complainant. No one was present from the Insurance Company. I find that complainant has had policies from Oriental Insurance since 2009. Even though there is a change from Group medical policy to Family floater policy, the Insurance Company is the same and the gap is also of only fourteen days, which the complainant stated was only because Insurance Company gave late. The Company representative did not attend the hearing, nor submitted the SCN inspite of follow up. I find there is deficiency in service. Even if there was a gap**

of 14 days since the Insurance Company was the same they cannot disallow the claim only because of clause 4.3. Accordingly an Award is passed with the direction to the Insurance Company examine the case and settle the claim as admissible.

OFFICE OF INSURANCE OMBUDSMAN ,DELHI

Case No.GI/UII/42/13.
In the matter of Sh. Ranjit Kumar Mittal.
Vs
United India Insurance Company Ltd.

Date of Award 25.02.2015

Policy No. : 041300/48/11/06/00000850.

1. **This is a complaint filed by Sh. Ranjit Kumar Mittal (herein after referred to as the complainant) against the decision of United India Insurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to non-settlement of Mediclaim .**

2. **The complainant alleged that his wife was admitted in Tirath Ram Shah Charitable Hospital from 15.06.2012 to 16.06.2012 for the treatment of Uterine Bleeding with Mild Hypertension. He had submitted all the necessary papers of the claim to the TPA/ Insurance Company for reimbursement of Rs. 12002/- but the Insurance Company had denied the claim on the ground of pre-existing disease. He had sought the relief of Rs. 12002/- from this forum.**

3. **The Insurance Company vide its letter dated 21.09.2012 had rejected the claim on the ground of pre-existing disease. There is a break of three months in renewal of insurance for the period 2010-2011. The policy in which the claim is preferred is**

considered as a fresh policy where the exclusion clause 4.1 is applicable for pre-existing disease.

4. **I heard both the sides, the complainant as well as the Insurance Company. The complainant has given particulars of policy no- 060400/48/10/41/2794 issued by the United India Insurance for period from 09.04.2010 to 08.04.2011. He has also given copy of Bank Pass Book showing debit of Rs. 11020/- in favour of Inshant Health Care on 13.04.2010, but could not show that premium had been passed on to the Company. However, Insurance Company could not refute the policy no- 060400/48/10/41/2794 nor have they submitted their SCN till date inspite of several reminders. I feel there is a deficiency in service on the part of the Insurance Company. Accordingly an Award is passed with the direction to the Insurance to pay the claim to the complainant.**

OFFICE OF INSURANCE OMBUDSMAN ,DELHI

Case No.GI/OIC/205/13
In the matter of Mrs. Preeti Lohia
Vs
Oriental Insurance Company Ltd.

Date of Award 25.02.2015

Policy No. : 215100/48/2013/3190.

1. **This is a complaint filed by Mrs. Preeti Lohia (herein after referred to as the complainant) against the decision of Oriental Insurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to non settlement of mediclaim of her husband Sh. M.M Lohia.**

2. **Mr. M.M. Lohia, representative of complainant, alleged that he had initially taken mediclaim policy of Oriental Insurance Company from 12.10.2010. It was renewed without any break in 2011. In 2012, cheque dated 10.10.2012 for Rs. 19116/- was issued for renewal of the policy. This cheque was**

dishonored due to insufficiency of funds. The next two days being non-working days of the Insurance Company intimation regarding this was received by the insured on 15.10.12. A fresh DD for Rs. 19116/- along with cash of Rs. 91/- totaling to Rs. 19207/- was promptly deposited on the same day. A forwarding letter was also submitted along with the DD requesting continuity of the policy after condoning the break. No proposal form was filled up as it was renewal of the earlier policy. Insurer also charged loading premium of Rs.814 /- on the basis of claim in the previous policy thus implying that it was renewal of previous policy with continuity benefits. There was no communication received by the insured that the policy issued was a fresh one and not a renewal of the previous one. The insured was hospitalized from 08.03.2013 to 10.03.2013 for left lower Uretic Calculus at Max Hospital. He submitted all documents for reimbursement of expenses of Rs. 80725/- incurred for this treatment. He has come to this forum with request to settle his mediclaim of Rs.80725/-. Insured has also submitted copy of IRDA circular dated 31.03.2009 and extract of IRDA handbook on Health Insurance which allows for condonation of delay in renewal within 15 days of expiry date so that insured persons are treated as continuously covered in terms of continuity benefits such as waiting periods and coverage of pre-existing diseases. IRDA instructions do not mention any basis of differentiating delay on account of dishonor of cheque due to insufficiency of funds or otherwise. Complainant has also submitted awards of various Ombudsman across the country to substantiate his contention. The awards attached are dated 14.05.2007, 24.05.2007, 18.07.2007, 24.07.2007 and 25.10.2007.

3. **The Insurance Company/TPA has rejected the claim under exclusion clause no-4.3 of the policy which excludes treatment of calculus during the first two years of inception of policy and the insured's policy was in the first year of running. In reference to the complainant's broker's letter dated 05.04.2013, the insurer vide their letter dated 09.04.2013 had clarified that "This policy cannot be continued and fresh policy**

will be issued as premium cheque got bounced due to insufficient funds by the banker which is a cognizable offence under Negotiable Instruments Act. The policy stands cancelled ab-initio due to non-receipt of consideration and the company is not on risk nor any claim shall be entertained". Insurance Company reiterated their decision vide their letter dated 15.05.2013 mail dated 25.06.2013 that "The dishonor of cheque due to insufficient fund is a cognizable offence under NIA and no activity which is unlawful can be condoned. Thus the break in insurance due to cancellation of policy on account of insufficient funds cannot be condoned and policy taken thereafter would be treated as fresh".

4. **I heard both the sides. The complainant represented by her husband Mr. M.M Lohia as well as the Insurance Company. The Company policy does not allow condonation of delay since the cheque was dishonoured due to insufficient funds -which is a cognizable offence. Insurance Company states that the policy was treated as void abinitio and policy issued for 2012-2013 to be treated as fresh policy. If 2012-13 policy is to be treated as fresh policy then premium charged should have been Rs. 18292/-. If Insurance Company's response is to be accepted, why was "earlier-claim" loading charged? Considering that 13th and 14th were Saturday/Sunday, break of 3 days could have been condoned even as per IRDA circular in this regard, however since dishonor was due to insufficient funds, we may not condone the delay, but an ex-gratia payment can be allowed. Accordingly an Award is passed with the direction to the Insurance Company to make an ex-gratia payment equivalent to refund of premiums paid after 2011-12.**

OFFICE OF INSURANCE OMBUDSMAN ,DELHI

No.GI/NIC/209/13
In the matter of Sh. Rajiv Shukla
Vs
National Insurance Company Ltd.

Date of Award 27.02.2015

Policy No. : 351804/48/12/8500001787.

1. **This is a complaint filed by Sh. Rajiv Shukla (herein after referred to as the complainant) against the decision of National Insurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to non settlement of mediclaim.**

2. **The Complainant had alleged that he had lodged a claim for accidental injury (fracture of left Ankle). The Insurance Company had not settled the claim.**

3. **The Insurance Company had repudiated the claim on the ground that treatment was taken as an outpatient and individual mediclaim policy does not cover the expenses incurred on treatment taken in OPD without hospitalization as per preamble of the policy.**

4. **I heard both the sides, the complainant was represented by his father, as well as the Insurance Company. During the course of hearing, the complainant stated that Company had not paid any hospital expenses. The Insurance Company stated that the claim was not payable as treatment taken on OPD basis is not covered under the scope of policy. In my considered view fracture does not need any hospitalization. Accordingly an Award is passed with the direction to the Insurance Company to settle the claim.**

OFFICE OF INSURANCE OMBUDSMAN ,DELHI

Case No.GI/NIA/228/13
In the matter of Sh. Krishan Kr. Batra.
Vs
New India Assurance Company Ltd.

Date of Award 02.02.2015

Policy No.: 31040134110100001207.

5. **This is a complaint filed by Sh. Krishan Batra (herein after referred to as the complainant) against the decision of New India Assurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to inadequate settlement of Mediclaim.**

6. **The complainant had alleged that he was admitted at Sir Ganga Ram Hospital from 26.09.2012 to 01.10.2012 with complaint of fever since 15 days. He was diagnosed as a case of diabetes with HTN with Cholecystitis, and on investigations, LFT report was found deranged. Diabetes was already incorporated in the policy under pre-existing disease column.**

   Complainant had alleged that he had taken mediclaim insurance since 1998 without break for Sum Insured 1.5 lacs. He enhanced the sum insured upto 2.5 lacs w.e.f 04.03.2011 and at that time he was not intimated that old sum insured will be applicable for room rent, doctor's visit and other charges. The deductions made by company in proportionate to sum insured were unjustified.

7. **The Insurance Company had stated that claim had been settled for Rs.23, 052/- against claimed amount Rs. 59,733/-. Deductions were made for excess room rent, consultations fee, and other charges as per clause 2.4 and 2.3 of policy which state that charges payable shall be at the rate applicable to the entitled room category.**

8. **I heard both the sides, the complainant as well as the Insurance Company. Complainant had stated that company had given policy but not the terms and conditions of the policy at the time of enhancing the policy in 2011. Insurance company could not show the relevant policy, nor could show their terms and conditions which were made known to the insured. I find that Insurance Company could not show any capping on room rent, Doctor's visits & Lab charges. Accordingly, an award is passed with the direction to the Insurance Company to reimburse the remaining amount for room rent, doctor's visit charges and lab charges as payable to the complainant.**

OFFICE OF INSURANCE OMBUDSMAN ,DELHI

Case No.GI/RGI/172/13.
In the matter of Mr. Sachchida Nand Jha.
Vs
Reliance General Insurance Co. Ltd.

Date of Award 02.02.2015

Policy No. : 1301712825000723.

5. **This is a complaint filed by Mr. Sachchida Nand Jha (herein after referred to as the complainant) against the decision of Reliance General Insurance Co. Ltd. (herein after referred to as respondent Insurance Company) relating to non-settlement of mediclaim.**

6. **The complainant had alleged that he had taken a mediclaim policy bearing no-1301712825000723 from Reliance Genera Insurance Company for the period 10/12/2012 to 09/12/2013. Complainant's wife was admitted at Holy Family hospital for the period 30/10/2012 to 04/11/2012 with c/o pain in abdomen. She was diagnosed with previous LSCS with P/H/O left Donar Nephrectomy with Anemia. Claim was rejected on the ground that ailment was due to previous**

caesarian delivery done on 01/06/2012 and expenses related to delivery and caesarian were not covered.

7. **The Insurance Company had stated that insured was hospitalized from 30/10/2012 to 04.11.2012 at Holy Family Hospital with complaint of pain in Abdomen and had history of caesarian delivery and was a case of Donor Nephrectomy. As per treating doctor's certificate and discharge summary, during Laparoscopy Dense adhesion were found between omentum and previous caesarian scar revealed that ailment was related to previous caesarian and as per policy clause 6 , expenses related to delivery and caesarian are not covered, hence claim was repudiated.**

8. **I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing, the insurance company could not prove conclusively that pain was because of adhesion to the anterior abdominal wall over previous caesarian scar . I find that doctor's certificate clearly state that adhesion may have formed following previous surgery. It does not categorically say that the pain was because of the adhesion. Accordingly an Award is passed with the direction to the Insurance Company to refund the claimed amount as admissible to the complainant.**

OFFICE OF INSURANCE OMBUDSMAN ,DELHI

Case No.GI/NIA/230/13.
In the matter of Sh. Manoj Kr. Jain.
Vs
New India Assurance Company Ltd.

Date of Award 02.02.2015

Policy No. : 32350034103000000126.

5. **This is a complaint filed by Sh. Manoj Kumar Jain (herein after referred to as the complainant) against the decision of New India Assurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to non-settlement of Mediclaim.**

6. **The complainant had filed a complaint for non-settlement of claim for his son who suffered injuries in the school. He had submitted all the relevant documents to TPA, but Insurance Company did not settle the claim.**

7. **The Insurance Company reiterated the written submissions vide letter dated 16.01.2015 that TPA had written various letters to the insured for submission of original discharge summary, original final bill of hospital, original prescriptions and break up of medicine bills. Due to non submission of requisite documents by the insured, the claim was closed as NO CLAIM.**

8. **I heard the Insurance Company. The complainant was absent and none represented on his behalf. During the course of hearing, the Insurance Company stated that complainant had not submitted the required documents, so claim was closed as NO CLAIM. Accordingly an Award is passed with the direction to the insurance company to settle the claim as admissible to the complainant subject to submission of the required documents.**

OFFICE OF INSURANCE OMBUDSMAN ,DELHI

Case No.GI/Star/129/13.
In the matter of Sh. V.N Sharma.

Vs
Star Health And Allied Insurance Company Ltd.

Date of Award 05.02.2015

Policy No. : P/161100/01/2013/005003.

1. **Sh. V.N Sharma (herein after referred to as the complainant) had filed the complaint against the decision of Star Health and Allied Insurance Company Ltd. (herein after referred to as respondent Insurance Company) alleging inadequate settlement of mediclaim.**

2. **The complainant had alleged that his wife was admitted at Anand Nursing Home with complaint of retention of Urine, DM & sleep Apnoea for the period 09.01.2013 to 14.01.2013. He had lodged a claim for Rs. 94,566/- out of which Rs. 23,555/- had been paid by the Company and Rs. 57,525/- were deducted which was illegal and unjustified.**
   Complainant had alleged that as per treating Dr's opinion prolonged Sleep Apnoea could be life threatening, so CPAP machine was life saving machine for the patient. He had sought relief of Rs. 57,525/- being deducted by Insurance Company.

3. **The Company reiterated the written submissions. The patient was admitted with diagnosis of Retention of Urine, dm, Sleep Apnoea, Bilateral Nasal Polyp. She was a known case of DM/HTN/Cervical spondylitis /fracture Spine in 2011. CPAP is a supporting device offered to the patient to be used at home to improve the breathing. It was similar to nebulizer, aerosol or nasal sprays. It was not covered under the policy. Expenses for the supporting device are not payable under exclusion No. 10 of the policy.**

4. **I heard both the sides, the complainant as well as the Insurance Company. during the course of haering complainant stated that prolonged sleep Apnoea could be life threatening so CPAP machine was life saving machine for his wife. He had also submitted a consumer court decision in favor of same illness. From the treating doctor's opinion I find that sleep disorder if not treated early may turn out to be life threatening. Accordingly an Award is passed with the direction to the Insurance Company to make payment for expenses incurred for CPAP machine.**

OFFICE OF INSURANCE OMBUDSMAN ,DELHI

Case No.GI/Star/262/13.

In the matter of Sh. Nishant Chaudhary.
Vs
Star Health And Allied Insurance Company Ltd.

Date of Award 10.02.2015

Policy No. : P/161100/01/2013/013519.

5. **Sh. Nishant Chaudhary had filed the complaint (herein after referred to as the complainant) against the decision of Star Health and Allied Insurance Company Ltd. (herein after referred to as respondent Insurance Company) alleging Non settlement of mediclaim.**

6. **The complainant had alleged that his wife was hospitalized at St. Stephen Hospital for the period 31.08.2013 to 03.09.2013 for treatment of Vitamin B12 deficiency. The Insurance Company had rejected the claim on the ground that ailment was about general debility, Anxiety and B12 deficiency. The patient could be treated on OPD basis, hence claim was not admissible.**

7. **The company reiterated the written submissions. The insurance company had stated that insured patient was diagnosed with B12 deficiency which is general debility and could be managed on OPD basis, hence repudiated the claim as per exclusion clause No. 10 of Policy, which reads as " The Company shall not be liable to make any payments under this policy in respect of any expenses what so ever incurred by any insured person in connection with or in respect of Convalescence, general debility, mental disorder, Run-down condition or rest cure, congenital external disease or defects or anomalies, sterility, veneral disease, international self injury and use of intoxicating drugs/alcohol".**

8. **I heard both the sides, the complainant as well as the Insurance Company. I find that the Insurance Company had repudiated the claim due to fact that patient was admitted for B12 deficiency which falls under general debility and could be treated on OPD basis. The treatment is given by the doctor, and the patient has no say in the line of treatment. Active line of treatment can only be arrived at after investigations. I find that complainant's wife was admitted on the advice of the doctor. The hospitalization expenses therefore are liable to be reimbursed to the complainant. Accordingly an Award is passed with the direction to the Insurance Company to allow only the expenses incurred during hospitalization.**

OFFICE OF INSURANCE OMBUDSMAN ,DELHI

Case No.GI/NIC/90/13.

In the matter of Mr. Chander Prakash Pahwa.
Vs
National Insurance Company Ltd.

Date of Award 06.02.2015

Policy No. : 360701/48/11/85-4165.

1. **Mr. Chander Prakash Pahwa (herein after referred to as the complainant) had filed the complaint against the decision of National Insurance Company Ltd. (herein after referred to as respondent Insurance Company) alleging non-settlement of mediclaim.**

2. **Complainant had taken a mediclaim policy bearing no-360701/48/11/8500004165 valid from 18-03-2012 to 17-03-2013 wife of complainant was suffering from chronic Ischaeimic foci. A claim of RS. 52384/- was made under the said policy by the Complainant for expenses incurred by him for treatment of his wife when she was hospitalized at Artemis Medicare Services for the period 23/03/12 to 26/03/12.**

The Insurance Company had rejected the cashless as well as reimbursement claim on the ground of pre-existing of disease under policy clause-4.1. Being aggrieved with the decision of the Insurance company he had filed a complaint to this forum and sought relief of Rs. 52384/- & 50000/- towards harassment.

3. **Insurance company had repudiated the claim on the ground that claim was reported in the 2nd year of insurance policy.The patient had history of chronic infarct-ischemic foci which was revealed from MRI report, hence makes the disease pre-existing . Therefore claim was repudiated as per exclusion clause 4.1 of insurance policy, which states that " pre-existing diseases are covered after 4 continuous claim free policy year".**

4. **I heard both the sides, the complainant as well as the Insurance Company. The Insurance Company had repudiated the claim on the ground of pre-existing disease as the claim was reported in 2nd running year of the policy. The Complainant had a fall and was taken to the hospital. Ischemic Foci was detected in bilateral cerebral hemispheres from MRI report. I find that the disease was discovered for the first time at the time of hospitalization hence does not make it pre-existing. The Insurance Company also could not supplement their contentions of pre-existing disease by way of previous treatments or hospitalization for the same. Therefore Insurance Company is directed to settle the claim as admissible. Accordingly an Award is passed with the direction to the insurance company to settle the claim as admissible to the complainant.**

Case No.GI/NIC/31/13/&88/13.

In the matter of Mr. Mahesh Chawla
Vs
National Insurance Company Ltd.

Date of Award 10.02.2015

Policy No. : 361800/48/10/8500002451.

1. **Mr. Mahesh Chawla (herein after referred to as the complainant) had filed the complaint against the decision of National Insurance Company Ltd. (herein after referred to as respondent Insurance Company) alleging non-settlement of mediclaim.**

2. **Complainant had lodged a Mediclaim for reimbursement of expenses incurred for treatment of fissure in Anus during hospitalization for the period 27.12.2011 to 29.12.2011 at Action Medical Institute. The claim was closed as no claim.**

3. **The Company reiterated their written submission dated 20.06.2013. The Insurance Company had stated that fistula in Anus was not covered during the first two years of inception of policy, hence claim was repudiated as per terms and conditions of the policy under clause No.4.3 of Parivar Mediclaim policy.**

4. **I heard both the sides, the complainant as well as the Insurance Company. Complainant had stated that he underwent two operations on 25.11.2011 and 27.12.2011. He had an ischiorectal fossa abscess for which he was operated on 25.11.2011. The treating Doctor had confirmed that he developed fistula in anus following ischiorectal abscess drainage which was related to the same ailment which he was operated on 25.11.2011 and hence, operated for fistula in anus on 27.12.2011. I hold that in the light of the doctors certificate the claim is reimbursable. Accordingly an Award is passed with the direction to the insurance company to settle the claim as admissible to the complainant.**

case No.GI/NIC/191/13.
In the matter of Sh. J.P. Singhal
Vs
New India Assurance Company Ltd.

Date of Award 10.02.2015

Policy No. : 12070034120500000003.

1. **Sh. J.P Singhal had filed the complaint (herein after referred to as the complainant) against the decision of New India Assurance Company Ltd. (herein after referred to as respondent Insurance Company) alleging in adequate settlement of mediclaim.**

2. **The complainant had alleged that he lodged a mediclaim through LIC for Rs. 1,62,482/- out of which insurance company had paid Rs. 61,961/- and 7393/- but rejected Rs. 93,127/- on account of deduction made for room rent and other items as per terms and conditions of policy. Complainant had alleged that to minimize the expenses to the insurance company he had opted for a package from Max Hospital and there was no condition under the policy which restrict per day room charges, payable by insurance company.**

3. **The Insurance company had reiterated vide written submission dated 22.10.2014 that complainant had taken two health policies, one from Citi Bank for sum insured 5 lacs and 2nd from New India Assurance for sum insured 3 lacs. He preferred a claim of Rs. 5,89,587/- from Citi bank for his treatment at Max Health Care Hospital from 07.06.2012 to 10-06-12 and 15-06-2012 to 27-06.2012. Citi bank had reimbursed Rs. 4,27,106/- and for balance amount of Rs. 1,62,481/- he lodged a claim under LIC Mediclaim policy. Insurance Company had obtained bifurcation of package from Max Hospital and had settled Rs.69,354/- for expenses incurred on medicines and difference of room rent, but deducted excessive room rent paid by complainant for staying in a suite consisting of two rooms with all modern amenities for patient and his attendant.**

Insurance company had obtained a single room basis schedule and paid room rent accordingly.

4. **I heard both the sides, the complainant as well as the Insurance Company. The Insurance Company had settled the claim after considering the deduction for items not payable under the policy. The panel doctor has visited to the hospital and in his investigation report he had submitted that he could not visit the room but got only a schedule for the room. Insurance company had obtained a single room basis schedule and paid room rent accordingly. I find that policy does not show any capping on the room rent. I also find that the complainant had received some reimbursement from Citi bank. The Insurance Company is directed to refund the difference of room rent subject to breakup of claim received by complainant from Citi bank to be provided by the complainant. Accordingly an Award is passed with the direction to the insurance company to settle the claim as admissible to the complainant on receipt of the necessary documents from the complainant.**

Case No.GI/Reliance/26/13
In the matter of Sh. Sneh Prabha Singh
Vs
Reliance General Insurance Company Ltd.

Date of Award 13.02.2015

Policy No. : 1302522817000002.

1. **Smt. Sneh Prabha Singh had filed the complaint (herein after referred to as the complainant) against the decision of Reliance General Health Insurance Company Ltd. (herein after referred to as respondent Insurance Company) alleging in adequate settlement of mediclaim.**

2. **The complainant had alleged that she had taken Reliance Health Care Travel Insurance Policy Bearing No.**

1302522817000002, for travel to UPTON, USA between 11.4.2012 to 09.10.2012. She was hospitalized there from 27.07.2012 to 29.07.2012due to acute pain in abdomen and chest associated with shortness of breath. Insurance company had settled $ 574302 out of claimed amount of $ 1400203. The expenses related to Cardiac, DM, & HTN ailment had been deducted. She had no Cardiac history.

3. **The Insurance company had stated that insured was admitted in hospital on the complaint of upper abdominal epigastric pain and chest pain associated with shortness of breath. Insured had similar severe pains before due to Gastro esophageal reflux. That the insured had not disclosed her past medical history at the time of taking policy. That the insured was given line of treatment only towards GERD-gastro esophageal reflux syndrome. There was no final diagnosis. Insured was evaluated for possible coronary ailment for chest pain which was negative. No treatment for the same was given. The insured submitted a bill of $14002 on account of her treatment at the hospital and the Company had approved $ 5743 as per the terms and conditions of the policy.**

4. **I heard both the sides, the complainant as well as the Insurance Company. The Insurance Company had settled the claim for gastric reflux only. The Expenses related to Cardiac, DM & HTN ailment had been deducted due to the fact that complainant had not disclosed in the proposal- form her past medical history at the time of taking policy. The Insurance Company could not show the proposal form which was mandatory to be filled by the insured. I find that the treating doctor had conducted the investigations/test to rule out the possibility of heart attack. Any active line of treatment could be done only after investigations. It was only after diagnostic tests, it was confirmed that patient was suffering from gastric reflux only. Therefore Insurance Company is directed to settle the claim as admissible Accordingly an Award is passed with the direction to the insurance company to settle the claim as admissible to the complainant.**

No.GI/NIC/138/13
In the matter of Sh. Dani Ram Sharma
Vs
National Insurance Company Ltd.

Date of Award 16.02.2015

Policy No. : 361000/48/12/8500002622.

1. **Sh. Dani Ram Sharma had filed the complaint (herein after referred to as the complainant) against the decision of National Insurance Company Ltd. (herein after referred to as respondent Insurance Company) alleging not settlement of mediclaim.**

2. **The complainant had alleged that he was admitted in Jaipur Golden hospital from 6-12-12 to 11-12-12 with complaint of Rt. Ankle fracture caused by road accident. Cashless claim was not settled by TPA. He had submitted all the documents and had submitted reply to all the queries raised by the TPA. The claim was closed as 'No Claim'.**

3. **Insurance Company had raised some queries like – Dr. Certificate who attended the patient first in hospital, Dr. Prescription advising admission, bank details etc. and had sent various reminders for necessary compliance. Due to non satisfactory reply from the complainant. The Insurance Company had closed the claim as 'No Claim'.**

4. **I heard both the sides, the complainant as well as the Insurance Company. After repeated reminders, again the representative of the company gave self contained note only at the time of hearing by hand. I find that the Insurance Company had closed the file as 'No Claim' due to non submission of required documents on the part of the complainant. Insurance Company is directed to settled the claim as admissible after submission of required documents by the complainant. Accordingly an Award is passed with the direction to the insurance company to settle the claim as admissible to the complainant subject to submission of documents by the complainant.**

Case No.GI/Star/39/13
In the matter of Sh. Rajender
Vs
Star Health & Allied Insurance Co. Ltd.

Date of Award 16.02.2015

Policy No. : P/16118/01/2013/000371

1. **Sh. Rajender had filed the complaint (herein after referred to as the complainant) against the decision of Star Health & Allied Insurance Co. Ltd. (herein after referred to as respondent Insurance Company) alleging non settlement of Mediclaim.**

2. **The complainant had alleged that he was hospitalized in Sunder L al Jain hospital for chest pain and ghabrahat on 24.06.2012. His claim was repudiated by the company as per exclusion clause No.12/13 of the policy.**

3. **The Insurance Company had submitted their written submission dated 22.07.2013. The Company had stated that the insured was admitted in Sunderlal Jain Hospital, on 24.06.2012 and discharged on 26.06.2012. CAG was done which revealed normal coronaries. No details of treatment given for the chest pain were available. He has been detected to be a diabetic since at the time of discharges. Coronary Angiography is a purely diagnostic and investigative technique done to detect cardiac disease. No heart disease was detected. The claim had been rejected under Exclusion Clause No. 12/13 of the policy which states that "The company shall not be liable to make any payment for expenses incurred at Hospitals primarily for Diagnostic, X-Ray-Laboratory Examinations not consistent with or incidental to the diagnosis and treatment of the positive existence of any ailment".**

4. **I heard both the sides, the complainant as well as the Insurance Company. The complainant was admitted with complaint of chest pain and ghabrahat. CAG was done which revealed normal Coronaries. The company had stated that CAG is a diagnostic and investigative technique to detect cardiac disease. Complainant was admitted for diagnostic purpose. No disease was detected and no details of treatment were**

available, hence claim was repudiated as per policy clause No. 12/13. I find that active line of treatment could be done only after investigations. The treating doctor had conducted the investigation to rule out the possibility of heart disease. Therefore Insurance Company is directed to settle the claim only for hospitalization expenses. Accordingly an Award is passed with the direction to the insurance company to settle the claim as admissible to the complainant.

Case No.GI/NIC/32/13
In the matter of Sh. Sanjay Garg
Vs
National Insurance Company Ltd.

Date of Award 17.02.2015

Policy No. 360400/48/11/8500001253.

1. **This is a complaint filed by Sh. Sanjay Garg (herein after referred to as the complainant) against the decision of National Insurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to non settlement of mediclaim.**

2. **Complainant's father had taken mediclaim Insurance from NIC since 2002. He was admitted to Bhagwati Hospital on 15.04.2012 with complaint of weakness accompanied by weight loss & decreased oral intake since 15 days and slurring of speech with breathing difficulty for 1-2 days. He was diagnosed as a case of bronchopasm with Hypothyroidism. He was discharged on 16.04.2012 on request. Cashless request was denied by TPA on the ground that "Psychiatric & Psychosomatic Disorders and other complications were not covered under the policy. He was again hospitalization to Max SSH hospital and discharged on 03.05.2012. The reimbursement claim was again denied on the ground that individual mediclaim policy does not cover the expenses on treatment of Psychiatric & Psychosomatic disorder as per exclusion clause 4.8.**

3. **Insurance Company reiterated their letter dated 19.08.2013 that Complainant was hospitalized at Max hospital with complaints of generalized weakness, weight loss and decreased oral intake for 15 days, disorientation 1 to 2 days. He was**

diagnosed as a known case of psychosis and was on Lithium since 20 years. Earlier he had been admitted in Bhagwati Hospital where reports suggested increased TLC & deranged Renal function. He had a past h/o of hypothyroidism, diagnosed as a case of renal failure, acute Lithium Toxicity and sepres for 20 years. Based on TPA's doctor A.K. Batra's report dated 08.08.2013, Lithium Toxicity does lead to deranged Renal functions, Thyroid and Electrolyte imbalance leading to dehydration. Since the claim pertains to management of Lithium Toxicity & its effects arising as a complication of prolonged treatment of chronic psychosis. The policy does not cover expenses on treatment of Psychiatric & Psychosomatic disorders. Hence claim was not admissible as per exclusion clause No. 4.8.

4. **I heard both the sides, the complainant as well as the Insurance Company. The complainant had sought relief for hospitalization expenses incurred for treatment taken for management for slurring of speech, breathing difficulty, disorientation and decreased oral intake. Insurance Company had stated that the claim pertains to management of Lithium Toxicity and its effects arising as a complication of prolonged treatment of chronic psychosis .Individual Mediclaim Policy does not cover expenses on treatment of Psychiatric & Psychosomatic disorders. Hence the claim was repudiated as per exclusion clause No.4.8 of the policy. I find that complainant is a policy holder since 2002 and had been continuously paying the premium and this was his first claim. I find that although documentary evidence shows that he suffered from side-effects of Lithium, it was not conclusively proved either by the doctors or the Insurance Company that the present case was of the Lithium Toxicity. Accordingly an Award is passed with the direction to the insurance company to pay Ex-gratia amount of Rs. 30000/- to the complainant.**

Case No.GI/NIA/208/12
In the matter of Sh. Jai Gopal Abrol.
Vs
New India Assurance Company Ltd.

Date of Order 21.01.2015

Policy No. : 311502/34/09/11/00003007.

1. **This is a complaint filed by Sh. Jai Gopal Abrol (herein after referred to as the complainant) against the decision of New India Assurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to inadequate settlement of mediclaim.**

2. **The Complainant had alleged that a claim was filed by him for hospitalization at AIIMS. Raksha TPA made a part payment of the claim. Expenses of MRI, Radiotherapy and some medicines were not paid in absence of MRI film and ambiguity in prescription. Complainant had already replied all the queries raised by TPA but difference in claim amount was not settled.**

3. **Insurance Company had reiterated vide letter dated 07.11.14 that complainant had taken a mediclaim policy valid from 19.03.2010 to 18.03.2011. The complainant made a claim for Rs. 31,887/-, out of which Rs. 21,616/- were approved and Rs. 10, 271/- had been deducted due to non-submission of some documents. Subsequently an amount of Rs 9300/- was settled on production of bills. Only Rs 971/- was deducted due to the fact that bill was not in the name of insured.**

4. **I heard the complainant as well as the Insurance Company. I find that insurance company had already settled the claim as per terms and conditions of the policy, therefore I find no reason to interfere with the decision of the Insurance Company. Accordingly the complaint filed by the complainant is hereby dismissed.**

Case No.GI/NIA/348/12
In the matter of Sh. Varun Vij.
Vs
New India Assurance Company Ltd.

Date of Order 21.01.2015

Policy No. : 311502/34/10/11/1420.

1. **This is a complaint filed by Sh. Varun Vij (herein after referred to as the complainant) against the decision of New India Assurance Company Ltd. (herein after referred to as respondent Insurance Company) alleging inadequate settlement of mediclaim.**

2. **The complainant had alleged that he had taken mediclaim insurance for S.I. Rs 2 Lacs and had earned 60% cumulative bonus upto 2008. He had enhanced the S.I. upto 5 lacs under the policy on 25.08.2008 (renewal). He was admitted in Apollo Hospital for the period 18.07.2011 to 23.07.2011 for treatment of intermittent claudication and was treated with stenting of left SFA and Rt. SFA. His mediclaim was settled on the basis of old S.I. i.e. (Rs.2 Lacs+60% CB). He alleged that his disease was not pre-existing. It was diagnosed in 2011; hence claim should be settled on enhanced S.I.**

3. **The Insurance company reviewed the matter and submitted written submission vide letter dated 12.12.2014 after the hearing. The original sum insured of Rs. 2,00,000/- + 80,000(CB) was taken for claim under policy no-311502/34/10/11/00001420 as the insured was diagnosed for HTN, CAD, PAD and treated for intermittent claudication and stenting of left SFA & right . SFA. The insured has exhausted the original S.I of Rs. 2.8 Lacs and sum insured which was enhanced on 2008 could not be considered due to pre-existing disease as per policy condition 6.0(d). Enhancement of sum insured is subject to the restriction under condition no-4.1(pre-existing disease/condition benefits will not be available for any conditions (s) as defined in the policy,**

until 48 months of continuous coverage had elapsed, since inception of the first policy), 4.2, and 4.3 of mediclaim policy.

4. **I heard the complainant as well as the company. I find that complainant's mediclaim was settled on the basis of old sum insured i.e. 2 lacs+ 80,000/- (CB) due to pre-existing disease which was fully exhausted. As per renewal of policy clause 6.0 (d) terms and conditions which states that if the policy is to be renewed for 'enhanced Sum insured then the restrictions i.e. 4.1, 4.2 & 4.3 will apply to additional Sum insured as if it is a new policy. I find no reason to interfere with the decision of the insurance company. Accordingly the complaint filed by the complainant is hereby dismissed.**

Case No.GI/NIC/323/12.
In the matter of Smt. Devika Manchanda.
Vs
National Insurance Company Ltd.

Date of Order 21.01.2015

Policy No. : 360203/48/10/8500001978.

1. **Sh. Jitin Batra (herein after referred to as the complainant) on behalf of Ms. Devika Manchanda had filed the complaint against the decision of National Insurance Company Ltd. (herein after referred to as respondent Insurance Company) alleging non-settlement of mediclaim.**

2. **The complainant had alleged that Ms. Devika Manchanda had taken mediclaim insurance policy from National Insurance Company w.e.f. 01.11.2010. She was hospitalized in Feb'2012and again in May'2012. Cashless approval was denied by TPA on the ground that expenses related to DM & HTN were not covered for first two year of the policy. She had applied for reimbursement of expenses incurred during hospitalization.**

She submitted all the relevant documents but insurance company did not settle the claim.

3. **The insurance company reiterated the written submissions. Insurance company had closed the case as no claim vide letter dated 31.05.2012 due to non-compliance of requisite formalities from insured and expenses on HT& DM were not covered during first two years of policy.**

4. **I heard the Company. The complainant was absent and none represented on her behalf. I find that the claim was denied under the exclusion clause as DM and HTN were not covered for the first two years 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 dismissed.**

Case No.GI/NIC/100/12.
In the matter of Sh. Bal Kishan Goyal.
Vs
National Insurance Company Ltd.

Date of Order 23.01.2015

Policy No. : 360701/48/11/8500000644.

1. **This is a complaint filed by Mr. Bal Kishan Goyal (herein after referred to as the complainant) against the decision of National Insurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to inadequate settlement of mediclaim.**

2. **The complainant had alleged that he had taken a Parivar mediclaim policy of Rs.2 Lacs. His wife had been hospitalized for cancer treatment on various dates. Insurance company had partially settled the claim.**

3. **The company had reiterated the written submissions dated 19.07.2012 stating that as per policy terms & conditions "total expenses incurred for any illness is limited to 50% of overall**

sum insured per family. In the instant case the total sum insured available (SI – Rs. 2Lacs, 50% Rs. 1 Lacs) had been exhausted. Two claims for the amount of Rs. 1 Lac have already been paid by the TPA & hence no further payment can be made. The complainant had also been informed in this regard by the company vide letter dated 27.06.2012. Regional claims committee had reviewed the case and stated that as the illness was with a gap of 8 days, hence it was considered continuous illness, the liability was 50% of SI, hence no further amount was payable under the policy.

4. **I heard the insurance company. The complainant was absent. I find that the company had settled the claim as per terms and conditions of the policy. I therefore find 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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Case No.GI/NIA/308/12
In the matter of Sh. Kanwaljeet Singh
Vs
New India Assurance Company Ltd.

Date of Order 27.01.2015

Policy No. : 310300/34/08/11/00001623.

1. **This is a complaint filed by Sh. Kanwaljeet Singh (herein after referred to as the complainant) against the decision of New India Assurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to non settlement of Mediclaim.**

2. **The complainant had alleged that his Son was hospitalized for the period 18.09.2009 to 20.09.2009 at Batra Hospital. The claim was repudiated by insurance company on the ground of pre-existing of disease. He had further alleged that insurance company had paid the earlier claims of same disease.**

3. **The insurance company had stated that the insured did not disclose any previous policy/coverage that was taken in the name of his son (Master Amandeep Singh) with New India Assurance Co. Limited and had taken a fresh policy from New India Assurance Co. Limited with malafide intention and got the sum insured revised from Rs.1 Lac to Rs.3 Lac. The claim was repudiated on the grounds of pre-existing disease as was evident from the discharge summary of M/S Batra Hospital.**
   The claim was also reviewed by the medical board of the company, which opined that "claim was not payable as per terms and conditions of the policy, as it was in the first year of the policy and child was having Nephrotic Syndrome on Steroids since 2.5 years of age, It was a pre-existing disease, hence claim was not payable".

4. **I heard both the sides, the complainant as well as the insurance company. Insurance company was advised to submit the SCN on location of the file which was submitted on 13.11.2014. I find that claim for previous hospitalization (03.08.2009 to 14.08.2009) was rejected by the company. Insured concealed the material facts about pre-existence of disease. I therefore find no reason to interfere with the decision of the Insurance Company. Accordingly the complaint filed by the complainant is hereby dismissed.**

Case No.GI/RSA/144/12
In the matter of Sh. Sunny Babbar
Vs
Royal Sundaram Alliance Insurance Co. Ltd.

Date of Order 27.01.2015

Policy No. : CDA0002546000100.

1. **This is a complaint filed by Sh. Sunny Babbar (herein after referred to as the complainant) against the decision of Royal Sundaram Alliance Insurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to inadequate settlement of mediclaim.**

2. **The Complainant had lodged a Mediclaim under Cash plus Insurance Plan of Royal Sundaram amounting to Rs. 17,270 for his surgery for fistula in anus with Insurance Company. His claim had been rejected by the Company on the ground that fistula in anus is not payable under the policy exclusion clause.**

3. **The Insurance Company reiterated the written submission dated 21.11.12. The company stated that complainant had taken a Hospital cash policy for the first time valid from 25.10.10 to 24.10.11. He was admitted at Saryodaya Hospital and Research Center from 03.12.10 to 06.12.10 for treatment of Fistula ailment. He was suffering from this ailment since 02.07.10 before taking the policy as admitted by the complainant himself and certified by the treating doctor. Therefore claim was inadmissible as per policy clause which reads as "During the first year of the operation of the respective certificate of insurance the treatment of Cataract, Benign Prostatic Hypertrophy, Hysterectomy for Menorrhagia or Fibromyoma, Hernia, Hydrocele, Congenital Internal Diseases, Fistula in Anus, Piles and Sinusitis are not payable."**

I heard both the sides, the complainant as well as the insurance company. I find that he was suffering from this ailment since 02.07.2010 prior to inception of the policy. Insurance company had repudiated the claim as per terms and conditions of the policy. I therefore find no reason to interfere with the decision of the Insurance Company. Accordingly the complaint filed by the complainant is hereby dismissed.

Case No.GI/NIA/264/12
In the matter of Sh. Sunil Kumar
Vs
New India Assurance Company Ltd.

Date of Order 28.01.2015

Policy No.: 312302/34/10/13/00001078.

1. **This is a complaint filed by Sh. Sunil Kumar (herein after referred to as the complainant) against the decision of New India Assurance Company Ltd. (herein after referred to as respondent Insurance Company) regarding non- settlement of Mediclaim.**

2. **The complainant had alleged that his son was hospitalized in Dr. B.D. Attam Hospital for treatment of high grade fever and vomiting for the period 4.11.11 to 09.11.11. Complainant had submitted all the relevant papers to TPA but the claim was repudiated.**

3. **The Insurance Company submitted that they had repudiated the claim on the ground that insured was suffering from high grade fever but at the time of admission he had fever 99.8 F which could be managed on OPD basis. All indoor papers were managed by a single staff which was practically not possible as single staff cannot be available round the clock. There was also no record of any visit conducted by treating doctor.**

4. **I heard both the sides, the complainant as well as the insurance company. I find that company had repudiated the claim on the basis that the patient had fever 99.8 F. All indoor papers were managed by a single staff which is practically not possible as single staff cannot be available round the clock and there was no record of any visit conducted by treating doctor. The complainant did not prove to the contrary. Therefore, I find no reason to interfere with the decision of the Insurance**

Company. Accordingly the complaint filed by the complainant is hereby dismissed.

Case No.GI/NIA/349/12
In the matter of Sh. Vinod Virmani.
Vs
New India Assurance Company Ltd.

Date of Order 29.01.2015

Policy No. 310604/34/12/03-11.

1. **This is a complaint filed by Sh. Vinod Virmani (herein after referred to as the complainant) against the decision of New India Assurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to non- settlement of Mediclaim.**

2. **The Complainant had alleged that he had taken floater mediclaim policy from New India Assurance Co. Ltd.. He had an history of HT, CAD and underwent PTCA/ STENT to LAD in 2010. He was admitted to Escort Hospital on 08.05.12 with complaint of chest pain radiating to left arm. He underwent some test and discharged on next day i.e. 09.05.12. The claim was rejected on the ground that hospitalization was less than 24 hours and for evaluation only.**

3. **The Insurance Company reiterated their letter dated 09.01.13 that complainant was hospitalized for less than 24 hrs. TMT was done in the hospital and report was negative. The claim was closed as no claim due to the reason that hospitalization was less than 24 hours and for pre-evaluation only. The claim was placed before the medical board for opinion which was re-confirmed the decision that claim was not payable as per policy clause 3.4 which reads as "hospitalization means admission in any hospital/ Nursing Home in India upon the**

written advice of a medical practioner for a minimum period of 24 consecutive hours" and hence repudiation justified.

4. **I heard the complainant. The insurance company was absent. From the discharge summary, it is revealed that complainant was admitted on 09.05.2012 and discharged on the same day which proves that hospitalization was less than 24 hours. I therefore find no reason to interfere with the decision of the Insurance Company. Accordingly the complaint filed by the complainant is hereby dismissed.**

Case No.GI/NIC/235/12
In the matter of Smt. Parminder Kaur.
Vs
National General Insurance Co. Ltd.

Date of Order 29.01.2015

Policy No. : 354500/48/09/85-1689.

1. **This is a complaint filed by Smt. Parminder Kaur (herein after referred to as the complainant) against the decision of National Insurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to non- settlement of Mediclaim.**

2. **The Complainant had alleged that she was covered under Family Floater mediclaim policy with National from 03.03.10 to 02.03.11. she was advised medical examination by panel doctor of Australia Embassy during medical examination while she had applied for a Visa abroad. She consulted the doctor in Sir Ganga Ram Hospital and was hospitalized for 9 days. He reported the claim to Insurance Company and submitted all the relevant documents. Insurance Company had rejected the claim on account of pre-existing disease as per clause 4.1 of the policy. The condition was first pointed out during the visa**

formalities. The disease was detected after 7 months of taking insurance, it was not pre-existing.

3. **The Company reiterated their written submissions. Based on Investigation reports submitted and investigation done by Insurer's panel doctor, the said hospitalization was done for management of off and on fever, acute cough, body ache, weakness, chest pain and diagnosed case of allergic-broncho-pulmonary with history of Rhinisinositis. Medical reports during visa also revealed that complainant was having parenchymal consolidation in left lower and outer cardiac region and radiology report showed Asymmetry of breast shadows, since hospitalization was for management of pre-existing disease (Allergic Bruncho Pulmonary Aspergilosis and its complication) the claim stands repudiated and was informed to insured.**

4. **I heard both the sides, the complainant as well as the Insurance Company. The complainant was represented by her Sister-in-Law. From the investigation report of Company's panel doctor, it seems that the disease was advanced and pre-existing. Complainant had a history of Allergic Rhinitis, Peripheral Eosinophillici and developed fever off and on followed by Pleuretic Chest Pain and Productive Cough. Therefore the claim was rightly repudiated by the insurance company. I therefore find no reason to interfere with the decision of the Insurance Company. Accordingly the complaint filed by the complainant is hereby dismissed.**

Case No.GI/NIC/326/12
In the matter of Sh. Anjeev Gupta
Vs
National Insurance Company Ltd.

Date of Order 29.01.2015

Policy No.: 360501/48/11/8500000155.

1. **This is a complaint filed by Sh. Ram Prasad (herein after referred to as the complainant) against the decision of National Insurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to non settlement of Mediclaim.**

2. **The Complainant had alleged that he had taken mediclaim policy from National Insurance Company from April 2005-06 & 2006-07. He switched from National to United Insurance from 09/04/2007 to 08/04/2010. He again switched from United to National Insurance. He lodged a mediclaim with National Insurance on 06/07/2011. He submitted all the documents to Safe way TPA. The claim was not settled by TPA due to non continuation of Insurance from National Insurance.**

3. **The Insurance Company had submitted vide letter dated 16/12/2014 that insured had taken mediclaim insurance from National for the period 08/04/2011 to 07/04/2012. A claim was lodged for hospitalization at Medanta on 01/07/2011 for ENT disorder. The ailment is covered after 2 years of the policy inception. Insurance company had asked for previous Insurance history but complainant could only provide TPA cards for United India Insurance showing the last policy validity up to 08/04/2010, which was not adequate for the purpose, hence claim was repudiated under exclusion clause 4.3.**

4. **I heard both the sides, the complainant as well as the insurance company. Complainant had not submitted the**

copies of previous policies to prove continuity. He could produce only TPA cards showing validity upto 08.04.2010. The National Insurance policy would then be treated as a fresh policy from 08.04.2011 to 07.04.2012. Hence the two year cap for ENT disorder as per terms and conditions of the policy was applicable. Therefore I see no reason to interfere with the decision of the Insurance Company. Accordingly the complaint filed by the complainant is hereby dismissed.

Case No.GI/NIC/321/12.
In the matter of Mr. Yog Raj Mahajan.
Vs
National Insurance Company Ltd.

Date of Order 29.01.2015

Policy No. : 360902/48/12/8500000468.

1. **Sh. Yog Raj Mahajan (herein after referred to as the complainant) had filed the complaint against the decision of National Insurance Company Ltd. (herein after referred to as respondent Insurance Company) alleging non-settlement of mediclaim.**

2. **The complainant had alleged in his letter dated 25.09.2012 that he had taken a mediclaim policy from National Insurance Company since 20 years and was renewing it continuously. The movement of his right hand stopped suddenly. The MRI revealed tear in Ligament of Right Shoulder. The Doctor suggested operation which had the 60% success rate. Physiotherapy was undertaken which did not improve much. He took Ayurvedic treatment from Ayurveda Kendra from 17.05.2012 to 27.05.2012. He submitted all the bills to TPA Medi Assist, who rejected the claim under exclusion No-4.24 of the policy which states that massages/steam bath/surothara palika ayurvedic treatment are not payable.**

3. **The Insurance Company reiterated their letter dated 07.01.2013 that insured was admitted in Ayurveda Kendra on 17.05.2012 for**

frozen shoulder. The claim was rejected under exclusion clause No-4.24 of policy which states that massages/steam bath/ surothara and alike Ayurvedic treatment are not payable.

4. **I heard the company. The complainant was absent and none represented on his behalf. The complainant had requested for hearing on merits. I find that Ayurveda treatment was not allowed on the basis of exclusion clause No-4.24 of policy which states that massages/steam bath/ surothara and like Ayurvedic treatment are not payable, hence claim was rejected by the insurance company. Therefore I see no reason to interfere with the decision of the Insurance Company. Accordingly the complaint filed by the complainant is hereby dismissed.**

Case No.GI/NIA/236/13.
In the matter of Sh. Sumeet Abrol.
Vs
New India Assurance Company Ltd.

Date of Order 03.02.2015.

Policy No. : 311502/34/11/03/00000473.

1. **This is a complaint filed by Sh. Sumeet Abrol (herein after referred to as the complainant) against the decision of New India Assurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to inadequate settlement of mediclaim.**

2. **The Complainant had lodged a claim for Rs. 3,85,778/- for expenses incurred in surgery of his son in July'12. TPA had settled Rs. 69,034/-, after deducting the major amount of Rs. 3,00,000/- paid directly by the complainant to Dr. Johri towards consultation charges other than the surgery expenses of the hospital and his surgery fee as per hospital's bill. Later on after vigorous follow up by the complainant, TPA had paid Rs. 67,500/- towards surgeon's fee. Complainant had alleged that as per policy Terms and Conditions, surgeon's fee payable should be 25% of S.I. i.e. Rs.1,25,000/- (25% of Rs.**

5,00000/-), hence he sought relief for balance amount from this forum.

3. **The Insurance Company had submitted vide its letters dated 09.01.2015 & 23.01.2015 that insured was hospitalized for the period 16.05.2012 to 22.05.2012 in Leelawati Hospital, Mumbai. The total expenses incurred for the treatment was Rs. 5,41,798/- out of which, Rs. 1,56,020/- had been claimed from Bharti Axa General Insurance. A claim for reimbursement of Rs. 3,85,778/- was lodged with New India Assurance including three lacs as surgeon's fee. As regard surgeon fee insurance company had paid Rs.112500/- as per policy condition 2.0 (Note 3) which states that the reasonable and customary and medically necessary surgeon fee and Aneasthetist fee would be reimbursed limited to maximum of 25% of sum insured. Condition No 2.10(b) states that " Persons paying Zone II premium but availing treatment in Zone I will have to bear 10% as co-payment for each admissible claim". So, the net surgeon fee paid was Rs.1,12,500/- from the remaining amount of. Rs. 85,778/- net amount paid was Rs. 76,704/- after considering following deductions.**

(Not Payable)

- **Rs.4523 - consumable charges**
- **Rs.2000 - Ambulance charges**
- **Rs.200 - Warming Blanket**
- **Rs. 780 - Patient name not mentioned in the bill**
- **Rs.71 - Urine pot**
- **Rs.7670 - 10% Zone wise deduction**
- **Rs.1500 - Ambulance charges**

4. **I heard both the sides, the complainant as well as the Insurance Company. Insurance Company was advised to submit the details of deductions , including deductions for Zone category. Complainant was also advised to submit the details of claimed amount received from Bharti Axa General Insurance Company for same illness to avoid double payment. The Insurance Company vide e-mail dated 23.01.2015 has stated that the complainant had taken policy in Zone II and**

availed treatment in Zone I and as per Condition No. 2.10(b) which states that "Persons paying Zone II premium but availing treatment in Zone I will have to bear 10% as co-payment for each admissible claim". Hence 10% was deducted as per Terms and Condition of the policy. I find no infirmity in the order of the Insurance Company to that effect. Accordingly the complaint filed by the complainant is hereby dismissed.

Case No.GI/NIC/91/13.
In the matter of Mr. Raj Kumar Kalra.
Vs
National Insurance Company Ltd.

Date of Order 03.02.2015.

Policy No. : 350300/48/11/85-1944.

1. **Sh. Raj Kumar Kalra (herein after referred to as the complainant) had filed the complaint against the decision of National Insurance Company Ltd. (herein after referred to as respondent Insurance Company) alleging non-settlement of mediclaim.**

2. **The Complainant had alleged that he had taken a mediclaim policy bearing no-360300/48/11/8500001944 from National for the period 28/01/2012 to 27/01/2013. He was admitted at Delhi Heart & Lung Institute for the period 02/06/2012 to 05/06/2012 with complaint of severe Cardiac Attack. Claim was rejected on the ground that claim was lodged on 4th running year of policy and falls under exclusion clause 4.1 of pre-existing disease.**

3. **The Insurance Company reiterated the written submissions dated 19/08/2013 that policy incepted from 28/01/2009 and pre-existing diseases could be covered after continuous running of policy for 48 months without break. Since claim was lodged under 4th year of the policy for a disease which was pre-existing. The claim was not admissible under policy clause 4.1.**

4. **I heard both the sides, the complainant as well as the Insurance Company. Policy incepted from 28.01.2009 and in the proposal form submitted by the insured it was clearly mentioned that insured had a history of Heart Disease since 1999. The policy was taken in 2009 and the claim was lodged in the 4th year. As per policy conditions pre –existing diseases are covered under the policy after continuous policy for 48 months without break. The judgments/ citations given by him do not cover his case as in those cases patient was not aware of the disease or the Insurance Company failed to establish that complainant was having a Heart Disease. In this case insured was aware of the pre-existing disease and Heart Disease was mentioned in the policy under details of pre-existing disease/illness column since inception of the policy. Therefore Insurance Company had rightly repudiated the claim. I find no reason to interfere with the decision of the Insurance Company. Accordingly the complaint filed by the complainant is hereby dismissed.**

Case No.GI/NIC/30/13.
In the matter of Mr. Sunil Moza.
Vs
National Insurance Company Ltd.

Date of Order 05.02.2015

Policy No. : 354301/48/12/8500004062.

1. **Sh. Sunil Moza (herein after referred to as the complainant) had filed the complaint against the decision of National Insurance Company Ltd. (herein after referred to as respondent Insurance Company) alleging inadequate settlement of mediclaim.**

2. **The complainant had taken Varishtha Mediclaim policy from National Insurance Company bearing policy no-354301/48/12/8500004062. He was diagnosed with enlarged prostate. He had taken initial authorization for Rs.40, 000/- from TPA before getting admitted to R.G Stone for the period**

06.02.2013 to 11/02/13. At the time of discharge TPA refused to settle Rs.40,000/- and sent approval for Rs. 20,000/- which was again reduced to Rs. 18,000/- due to cap of Rs. 18,000/- as per policy terms and condition of the policy.

3. **The Insurance Company reiterated vide their letter dated 12.08.2013 that a cashless request was received by TPA and a tentative amount of Rs. 40,000/- was sanctioned to the hospital as a pre-authorizing amount based on information available. The amount granted was on estimated basis and finally an amount of Rs. 18,000/- was passed as per policy terms and condition.**

4. **I heard both the sides, the complainant as well as the Insurance Company. I find that Insurance Company had settled the claim in accordance with terms and condition of the policy. Therefore, I find no reason to interfere with the decision of the Insurance Company. Accordingly the complaint filed by the complainant is hereby dismissed.**

Case No.GI/NIC/98/13.
In the matter of Mr. Paresh H. Shah.
Vs
National Insurance Company Ltd.

Date of Order 05.02.2015

Policy No. : 10030047109690000891.

1. **Sh. Paresh H. Shah (herein after referred to as the complainant) had filed the complaint against the decision of National Insurance Company Ltd. (herein after referred to as respondent Insurance Company) alleging non-settlement of mediclaim.**

2. **The complainant had alleged that his son expired due to an accident, when he was flying newly manufactured Air Craft. He**

along with his other flying crew died in that flight. The claim was lodged under JPA policy. The claim was rejected by the company on the ground that payment of compensation in respect of death while in service on duty with any armed force was not admissible under the policy.

3. **The Insurance company reiterated their written submissions dated 01-02-2013 that claim had been repudiated on 18-04-2012 under the provision No-2(e) of policy which states that the "Company shall not be liable under this policy for payment of compensation in respect of death/permanent total disablement of the Insured person on duty with any armed force".**

4. **I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing, Insurance Company had stated that in the proposal form the complainant had mentioned only 'Service' not armed forces. I find that as per terms and conditions of the policy Company is not liable to pay any claim if the insured person was on duty with any armed force. I find that the complainant had not disclosed that he was in armed forces at the time of taking the policy. the term 'Service' does not cover 'Armed services' Company had rightly repudiated the claim in accordance with the terms and condition of the policy. Therefore, I find no reason to interfere with the decision of the Insurance Company. Accordingly the complaint filed by the complainant is hereby dismissed.**

Case No.GI/NIC/04/13.
In the matter of Mr. Anil Kumar.
Vs
National Insurance Company Ltd.

Date of Order 05.02.2015

Policy No. : 360501/48/11/8500002421.

1. **Sh. Anil Kumar (herein after referred to as the complainant) had filed the complaint against the decision of National Insurance Company Ltd. (herein after referred to as respondent Insurance Company) alleging non-settlement of mediclaim.**

2. **The complainant had alleged that he had taken a mediclaim insurance policy from National Insurance Company valid from 01.09.2011 to 31.08.2012. Earlier he had taken insurance from Apollo Munich. His wife was admitted in RG Urology & Laparoscopy Hospital from 12.02.2012 to 14.02.2012 for treatment of Inguinal Hernia. All the papers were submitted to TPA, but claim was denied on the ground that claim falls under "the specified period of waiting".**

3. **The Insurance Company submitted that TPA had considered the policy as fresh (1st year) hence claim was denied as it falls under waiting period as per policy terms and condition.**

4. **I heard both the sides, the complainant as well as the Insurance Company. Complainant could not prove continuity in insurance policy. The claim was rightly rejected by the Insurance Company as being 1st year, and the said disease fell under the waiting period as per the terms and conditions of the policy. Accordingly the complaint filed by the complainant is hereby dismissed.**

Case No.GI/NIC/03/13.
In the matter of Mr. Surinder Gupta.
Vs
National Insurance Company Ltd.

Date of Order 05.02.2015

Policy No. : 361003/48/11/8500001506.

1. **Sh. Surinder Gupta (herein after referred to as the complainant) had filed the complaint against the decision of National Insurance Company Ltd. (herein after referred to as respondent Insurance Company) alleging inadequate settlement of mediclaim.**

2. **The complainant had alleged that he had taken mediclaim insurance for past ten years. His wife was admitted at Apollo Munich Hospital for the period 17.06.2012 to 20.06.2012 for treatment of Fibroid Uterus. He lodged a claim for reimbursement of Rs. 1, 75,000/- to TPA of the Company. Initially TPA had settled the claim for Rs.1, 72,292/- and informed him that payment shall be transferred through NEFT, but only Rs. 95,000/- was credited to his account. When he enquired the reason for deductions, TPA stated that reasonable and customary expenses to treat the condition for which the insured was hospitalized were paid.**

3. **The Insurance Company reiterated the written submission dated 15.02.2012 that patient was diagnosed as a case of Fibroid Uterus with Endo Metriosis and underwent LAVH+BSO. For the treatment of said disease they had package between 80,750/- to Rs. 95,000/- with major prominent hospitals in Delhi. Claim was settled as per terms and condition of the policy which states that "company will pay the amount of such expenses as are reasonably and necessarily incurred".**

4. **I heard both the sides, the complainant as well as the insurance company. I find that Insurance Company had**

already paid Rs. 95,000/- as reasonably and necessarily incurred charges as per terms and conditions of the policy. Therefore, I find no reason to interfere with the decision of the Insurance Company. Accordingly the complaint filed by the complainant is hereby dismissed.

Case No.GI/NIA/248/13.
In the matter of Sh. Girish Chandra Upadhyay.
Vs
New India Assurance Company Ltd.

Date of Order 05.02.2015

Policy No. : 31230034091100001565.

1. **Sh. Girish Chandra Upadhyay (herein after referred to as the complainant) had filed the complaint against the decision of New India Assurance Company Ltd. (herein after referred to as respondent Insurance Company) alleging inadequate settlement of mediclaim.**

2. **The Complainant had lodged a claim of Rs. 37,884/- for expenses incurred in surgery of his daughter (3 years) for enlarged Adenoids at Max Hospital on 18/01/2013. TPA had given pre-approval of Rs. 35,000/- but settled the claim of Rs. 15,757/- . Baby was covered under individual mediclaim policy period from 05/01/2011-12 for sum insured One Lakh. In the year 2012-13 S.I. was enhanced to 2 lacs. On renewal he had switched over to family floater policy with sum insured 5 lacs. Claim was lodged on 3rd year of policy. Insurance company had settled the claim on previous sum insured of Rs. 1 lac. Complainant sought relief for balance amount.**

3. **The Insurance Company had stated vide letter dated 13.01.2015 that name of baby was added in the policy first time in 2010-2011 as she was born in that year. Company has provided insurance details as under:-**

(PERIOD)	(SUM INSURED)
2010-11	1 Lac
2011-12	1 Lac
2012-13	2 Lac
2013-14	5 Lac (floater policy)

The claim was lodged within 13 days of renewal as S.I increased from 2 lacs to 5 lacs. As per terms and conditions of the policy the disease was not covered upto 2 years, therefore claim was settled as per policy which was in force two years ago.

4. **I heard both the sides, the complainant as well as the Insurance Company. I find that name of the baby was added in the policy for the first time in the policy period 2010-11. Policy was renewed with enhanced sum insured. Claim was lodged within 13 days of renewal with enhanced sum insured. As per policy terms and conditions the disease was not covered up to 2 years hence company had settled the claim on the basis of policy which was in force two years ago. Therefore, I find no reason to interfere with the decision of the Insurance Company. Accordingly the complaint filed by the complainant is hereby dismissed.**

Case No.GI/NIC/69/13.
In the matter of Mr. Shiv Kumar Dhir.
Vs
National Insurance Company Ltd.

Date of Order 05.02.2015

Policy No. : 360300/31/11/6300006959.

1. **Sh. Shiv Kumar Dhir (herein after referred to as the complainant) had filed the complaint against the decision of National Insurance Company Ltd. (herein after referred to as respondent Insurance Company) alleging non- settlement of mediclaim.**

2. **The Complainant had alleged that he had taken a "Motor Insurance Policy No. 360300/31/11/6300006959" from National Insurance Company to cover vehicle no. DL-1V-A-7407 (commercial vehicle). The vehicle met with an accident on 15/07/2012 and reported to the Company on 20.07.2012. He had further alleged that he had already submitted the reason for delay in intimation but Insurance Company had deducted 25% of claimed amount.**

3. **The Insurance Company had offered the settlement of claim on non-standard basis (75% of admissible amount) due to delay in intimation by 5 days hence spot survey could not be arranged.**

4. **I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing, complainant stated that delay in intimation to the Insurance Company was due to the reason that he was away to Amarnath from 13.07.2012 to 19.07.2012 and reported to the Company on 20.07.2012. He also showed copy of PNR No- 6EJDTDBD and 6EDP5BI of Indigo Airlines to prove his submissions. I hereby condone the delay and direct the Insurance Company to decide the case on merits. Accordingly an Award is passed with the direction to the insurance company to settle the claim as admissible.**

Case No.GI/NIA/127/13.
In the matter of Sh. Ashutosh Singhal.
Vs
New India Assurance Company Ltd.

Date of Order 06.01.2015

Policy No. : 323503/34/09/13/00000664.

1. **This is a complaint filed by Sh. Ashutosh Singhal (herein after referred to as the complainant) against the decision of New India Assurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to non- settlement of mediclaim.**

2. **The complainant had alleged that he was admitted in Sri Balaji Action Medical Institute during the period 11/11/2010 to 13/11/2010 with complaint of Ghabrahat and Breathing problem. He was kept in heart command on observation and Angiography was done which was necessary as per treating Doctor's certificate. Insurance Company had repudiated the claim under exclusion clause 4.3 of the policy. He had sought a relief of Rs. 28,145/-.**

3. **The Insurance Company had not submitted any reply.**

4. **I heard both the sides, the complainant as well as the Insurance Company. The Company had repudiated the claim under exclusion clause 4.3 of the policy and on forms of diagnostic treatment only. I find that Company had rightly repudiated the claim as per terms and conditions of the policy. Therefore, I find no reason to interfere with the decision of the Insurance Company. Accordingly the complaint filed by the complainant is hereby dismissed.**

Case No.GI/RSA/267/12
In the matter of Smt. Nandita Hazra.
Vs
Royal Sundaram Alliance Insurance Company Ltd.

Date of Order 30.01.2015

Policy No. : H000/5533000/107.

1. **This is a complaint filed by Smt. Nandita Hazra (herein after referred to as the complainant) against the decision of Royal Sundaram Alliance Insurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to non settlement of mediclaim.**

2. **The complainant had alleged that she had taken a mediclaim policy bearing no-H000/5533000/107 for the period commencing from 27.12.2010 to 26.12.2011 with S.I Rs.3 Lacs + 90,000/- C.B. She made a claim under the said policy for expenses incurred for treatment of Prilateral Oesteoarthritis of both knees for the period 23.08.2011 to 01.09.2011 hospitalized at Max Hospital. Due to non-settlement of cashless claim, complainant had applied for reimbursement of expenses amounting Rs.5,36,219. Complainant had received Rs.2,04,282/- from the employer of her spouse who was a retired govt. servant. Complainant had requested the insurance company to settle the balance amount. A claim of Rs. 1,50,000/- had been settled by insurance company due to a cap of sub-limit as per policy T&C. complainant had alleged that claim should be settled as per S.I under the policy.**

3. **Insurance company had reiterated vide letter dated 30.01.2013 that complainant claimed Rs. 5, 36,219/-. She got a sum of Rs.2, 04,282/- from UP Govt. with regard to claim being made there. Insurance company had paid a sum of Rs. 1, 50,000/- as the policy provided for a sub-limit of Rs. 1,50,000/- for the claims related to Knee replacement, which says " Treatment for knee/ hip joint replacement, all cancer, Renal failure- sub limit per claim 50% of S.I subject to maximum of Rs. 1.5 Lac.**

4. **I heard both the sides, the complainant as well as the Insurance Company. Insurance company had paid a sum of 1,50,000/- due to a cap of sub limit as per policy Terms and Conditions subject to maximum of Rs.1.5 Lac. Therefore I find no reason to interfere with the decision of the Insurance Company. Accordingly the complaint filed by the complainant is hereby dismissed.**

Case No.GI/NIC/182/13
In the matter of Sh.Ashok Mittal
Vs
National Insurance Company Ltd.

Date of Order 02.03.2015

Policy No. 354500481185000001231 &

354500/48/12/85000836.

1. **This is a complaint filed by Sh.Ashok Mittal (herein after referred to as the complainant) against the decision of National Insurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to in adequate settlement of mediclaim.**

2. **The Complainant had alleged that two claims were lodged by him under policy No. 354500481185000001231 and 354500/48/12/85000836 respectively. The Insurance Company had settled the claims amounting to Rs. 1,25,000/- under policy No. 354500481185000001231 and 1,50,000/- under policy No. 354500/48/12/85000836. Complainant had alleged that Insurance Company had settled the claim on 50% of liability of sum insured. He had stated that the clause of 50% liability under policy was no applicable in his case. He sought relief of Rs. 30,000/- and Rs. 1,50,000/-.**

3. **The Insurance Company reiterated their written submission dated 29/01/2015 and 19/02/2015. The company had paid claim of Rs. 1,25,000/- under parivar mediclaim policy No. 354500481185000001231 and disallowed Rs. 30,000/- for non**

submission of original payment receipt at the time of discharge. Another claim of Rs. 1,50,000/- was paid under policy No. 354500/48/12/85000836. Both the claims were settled as per terms and conditions of parivar mediclaim policy which states that "Company's liability would arise if the treatment of disease or injury contracted/suffered is incepted during the policy period. Total expenses incurred for anyone illness is limited to 50% of the sum insured per family. Company's liability in respect of all claims admitted during the period of insurance shall not exceed the sum insured mentioned in the schedule". Company agreed to settle balance amount of Rs. 25000/- under policy No. 354500481185000001231 on submission of original payment receipt.

4. **I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing, the complainant stated that Insurance Company had partially settled the claims under both the policies. The Insurance Company had stated that as per policy condition No-3.0, Company's liability in respect of claims admitted during the period of insurance shall be limited to 50% of the sum insured per family. The claims had already been paid as per terms & condition of the policy except Rs, 25000/- due to non submission of payment receipt. The Complainant had stated that since it is a long time the hospital may not be in a position to give a duplicate receipt. I direct the Insurance Company to accept the bill if receipt is not available with complainant. Accordingly an Award is passed with the direction to the Insurance Company to pay balance amount of Rs.25000/- to the complainant.**

Case No.GI/NIC/211/13
In the matter of Sh. Naresh Goel
Vs
National Insurance Company Ltd.

Date of Order 04.03.2015

Policy No. : 350601/48/09/8500000544 &

35601/48/10/8500000721.

1. **This is a complaint filed by Sh. Naresh Goel (herein after referred to as the complainant) against the decision of National Insurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to non settlement of mediclaim.**

2. **The Complainant had alleged vide letter dated 09.08.2013 that he was hospitalized from 12.08.2010 to 28/08/2010. The hospitalization period was falling between two policies period bearing No. 350601/48/09/8500000544 & 35601/48/10/8500000721. The liability of the company under the expiring policy No. 35/544 was exhausted. The balance amount of claim should be paid under renewal policy No. 35601/48/10/8500000721 since he was admitted continuously for the same illness without break. The claim amount should be split between 2 policies. The complainant sought relief of balance amount of claim of Rs. 490691/- from renewed policy. The complainant vide letter dated 16.02.2015 has desired that as he is unable to come for personal hearing, case may be decided on merits.**

3. **The Insurance Company reiterated their written submission dated 18/02/2015. The Insurance Company stated that complaint had lodged various claims and all the claims had been settled as per terms and conditions of the policy. The insured had made a complaint to this forum for dispute of a claim for which date of admission to the hospital was under policy no. 350601/48/09/8500000544 and date of discharge was under**

renewed policy no. 35601/48/10/8500000721. The maximum liability under policy No. 35/544 was 5 lacs and it was exhausted. The balance amount of claim amounting to Rs. 49,069/- could not be considered under renewed policy No. 35601/48/10/8500000721. Insurance company had stated that as per policy clause 3.0 any one illness means continues period of illness. Once the claim is reported it is the claim of that particular year only and is payable from the S.I. of that particular years policy. Mediclaim Insurance is an annual contracts and timely renewal of mediclaim policy is advised only for the purpose of giving continuity benefit and Bonus and not for the purpose of recovery of balance of claim of previous year.

4. **I heard the Insurance Company, the complainant was absent and none represented on his behalf. The Insurance Company stated that all the claims under policy no- 350601/48/09/8500000544 valid from 26.08.2009 to 25.08.2010 had been settled as per terms and conditions of the policy. Liability under the said policy was 5 lacs which was exhausted hence, balance amount of Rs 49064/- could not be paid. I find that any one illness means continuous period of illness and it includes relapse within 105 days. This is as per policy conditions. Company's liability would arise if the treatment of disease suffered is incepted during the policy period. In this case the claim was originally arose in policy no-350601/48/09/8500000544 and not under policy no-35601/48/10/8500000721 hence balance claim amount could not be considered under the renewed policy no-35601/48/10/8500000721. The claim was rightly settled by the Insurance Company. I find no reason to interfere with the decision of the Insurance Company. Accordingly the complaint filed by the complainant is hereby disposed off.**

Case No.GI/NIC/153/13
In the matter of Sh.Vipin Kant Tuli.
Vs
National Insurance Company Ltd.

Date of Order 04.03.2015

Policy No. : 36080448108500003507.

1. **This is a complaint filed by Sh. Vipin Kant Tuli (herein after referred to as the complainant) against the decision of National Insurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to non settlement of mediclaim.**

2. **The Complainant had alleged that he was admitted in Mata Chanan Devi hospital from 18.11.2011 to 21.114.2011 with complaint of Hematemesis and Ghabrahat. He was diagnosed with upper GI bled, Hiatus Hernia with Barret's Ulcer. The claim was repudiated on the ground of pre existing of the disease since 2000.**

3. **The Insurance Company stated that complainant had taken Parivar mediclaim policy since 27.01.2000. He was admitted is Mata Chanan Devi hospital from 18.11.2011 to 21.114.2011 with complaint of Hematemesis and Ghabrahat. He was diagnosed with upper GI bled, Hiatus Hernia with Barret's Ulcer. That complainant had history of disease since 2000 revealed from the discharge summary and took treatment for the same. The claim was lodged in the 3rd year of the policy. Pre-existing illness was covered in the policy after 4 continuous claim free policy years as per exclusion clause No 4.1. Hence claim was not admissible as per T & C of the policy.**

4. **I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant stated that his claim was rejected on account of pre-existing of the disease. The complainant admitted that treatment was taken for the same disease in the year 2000 and he had fully recovered. The Insurance Company stated that the**

claim was lodged in the 3rd year of the policy. Pre-existing illness was covered in the policy after 4 continuous claim free policy years as per exclusion clause No 4.1. His claim arose in third year of the policy, hence claim was not admissible as per T & C of the policy. I find no reason to interfere with the decision of the Insurance Company. Accordingly the complaint filed by the complainant is hereby disposed off.

Case No.GI/NIA/162/13
In the matter of Sh. Desh Deep Sharma
Vs
New India Assurance Company Ltd.

Date of Order 10.02.2015

Policy No. : 31150334101100001285.

1. **This is a complaint filed by Sh. Desh Deep Sharma (herein after referred to as the complainant) against the decision of New India Assurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to non settlement of mediclaim.**

2. **Complainant had lodged a claim under ediclaim policy bearing no-31150334101100001285 valid from 20.09.2010 to 19.09.2010 for surgery of ureteric calculus. The cashless facility was denied by TPA due to non availability of proof of continuity of insurance.He had submitted all the documents but claim was not settled by the Company.**

3. **Insurance company vide mail dt. 22.12.2014 & 15.01.2015 had stated that Insured had taken mediclaim policy from New India with effect from Sep'2009. Prior to that he had taken mediclaim Insurance from Cholamandalam. The complainant was admitted in Khandelwal hospital on 05.08.2011. The claim was reported in the 2nd years of the policy. He was diagnosed as a case of Ureteric Calculus which falls under 2 years waiting period as per policy clause 4.3, hence claim was repudiated. Portability was effective from July'2011, therefore benefit of continuous insurance could not be given.**

4. **I heard the complainant as well as the Insurance Company. The claim was reported in the 2nd year of the Insurance. The disease falls under 2 year waiting period hence claim was repudiated by the Company as per exclusion clause No. 4.3 of the policy. Therefore I see no reason to interfere with the decision of the Company. Accordingly the complaint filed by the complainant is hereby dismissed.**

Case No.GI/NIC/60/13

In the matter of Sh. Surender Kumar Bhasin
Vs
National Insurance Company Ltd.

Date of Order 10.02.2015

Policy No. : 351700/46/11/8500000391.

1. **This is a complaint filed by Sh. Surender Kumar Bhasin (herein after referred to as the complainant) against the decision of National Insurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to non settlement of mediclaim.**

2. **The Complainant had alleged that his son was admitted at Delhi Psychiatry Centre with complaint of severe depression, lack of concentration, suicidal tendency and lack of orientation. The claim was repudiated by Insurance Company on the ground that disease falls under exclusion clause No. 4.8 of the policy.**

3. **Insurance Company reiterated their written submission dated 15.12.2014. The Insurance Company had stated that insured was covered under group mediclaim policy opted by Federation of Indian Export Organization. Patient was admitted in the hospital for the period 16.12.2012 to 27.12.2012 for treatment of Obsessive Compulsive Disorder falling under psychiatry disease. From the Discharge summary it was revealed that patient had suicidal tendencies and had severe depression. The claim was repudiated as per exclusion clause No. 4.8 of the**

policy which states that "Convalescence General debility 'Run Down' condition or rest cure, congenital external disease or defects or anomalies, sterility, infertility/sub fertility or assisted conception procedures, venereal disease. International self-injury, suicide, all psychiatric & psychosomatic disorders/ diseases, accidents due to misuse or abuse of drugs/alcohol or use of intoxicating substances are not covered under the scope of the policy ."

4. **I heard the complainant as well as the Insurance Company. The son of complainant was hospitalized for treatment of Obsessive Compulsive Disorder falling under psychiatric disease. He had suicidal tendencies and was under severe depression. The claim was repudiated by the Company as per policy clause No. 4.8 which states that all psychiatric & psychosomatic disorders are not covered under the policy. Therefore I see no reason to interfere with the decision of the Company. Accordingly the complaint filed by the complainant is hereby dismissed.**

No.GI/NIC/130/13

In the matter of Smt. Charanjeet Kumar

Vs

National Insurance Company Ltd.

Date of Order 13.02.2015

Policy No. : 360102/48/12/8500000453.

1. **Smt. Charanjeet Kumar had filed the complaint (herein after referred to as the complainant) against the decision of National Insurance Company Ltd. (herein after referred to as respondent Insurance Company) alleging inadequate settlement of mediclaim.**

2. **The complainant had alleged that he had taken a mediclaim policy bearing no-360102/48/12/850000453 from National Insurance Company. He was admitted at Medanta hospital from 28/07/12 to 30/07/12 for Angiography and stenting. He filed a claim for a sum of Rs. 343620/- out of which Rs. 86900/- was paid by TPA on cashless basis. The complainant had alleged that his ailment falls under critical illness and S.I. for critical illness was 2 lacs, therefore balance amount under the claim should be settled.**

3. **Insurance company had stated that complainant was covered under Varistha Mediclaim policy for S.I. 100000/- under mediclaim benefit section & Rs 200000/- for critical illness benefit. He was admitted at Medanta on 30-07-12 with diagnosis of Hypertension, Coronary Artery Disease, TVD, acute coronary syndrome. He was a known case of post op CABG in 1999 at Escort Hospital. He had complaints of chest heaviness and nausea and underwent Coronary Angiography with stenting on 28/07/12 at Medanta. Insurance company had settled the claim for Rs. 86,900/- under section I (mediclaim benefit section) Complainant had demanded Rs. 2 lacs under section II (critical illness). Company repudiated the II claim on the ground that although the Coronary artery surgery was covered under critical cover but was defined under Open Heart surgery whereas in the said case it was coronary stenting without any mention surgery, hence expenses on treatment of Angiography falls under exclusion clause 1.1.**

4. **I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing complainant stated that he was not given the policy terms and conditions. Insurance Company had submitted that policy was incepted from 11.05.2010 without declaring any pre existing disease. I find that he was aware of the terms and conditions as he had declared his pre-existing disease at the time of renewal of his policy. Complainant had taken Varistha Mediclaim for Senior Citizens covering two sections under the policy. Section I was for hospitalization expenses up to Sum Insured of 1 lac. and section II was for critical illness cover for sum Insured 2 lac. Insurance Company had already paid Rs. 86,900/- under section I. The complainant had demanded balance amount under policy section II. Insurance Company had stated that section II covers critical illness only and as per the policy definition critical illness means open chest coronary artery bypass graft (CABG). In the said case coronary stenting was done during angiography, hence claim was not tenable under section II of the policy. I find no reason to interfere with the decision of the Insurance Company. Accordingly the complaint filed by the complainant is hereby dismissed.**

Case No.GI/NIC/132/13

In the matter of Sh. Pankaj jain
Vs
National Insurance Company Ltd.

Date of Order 13.02.2015

Policy No. : 360900/48/11/8500002005 &36090048108500002319

1. **Sh. Pankaj jain had filed the complaint (herein after referred to as the complainant) against the decision of National Insurance Company Ltd. (herein after referred to as respondent Insurance Company) alleging inadequate settlement of mediclaim.**

2. **The complainant had taken a mediclaim policy bearing no-360900/48/10/8500002319 from National for the period 09/02/2011 to 08/02/2011 for 5 lacs. It was renewed vide policy No. 360900/48/11/8500002005 for the period 09/02/2012 to 08/02/2013.Complainant was admitted at Apollo hospital for the period 24/11/2011 to 14/04/2012 with diagnosis of Massive Rt. Thalamoganglionic Haematoma with Intraventricular Extension with Hyderocephalous.Cashless claim was denied on the ground that limit under the policy had already been exhausted under policy No.48/2313.Complainant agreed that limit under previous policy No 48/2319 had been exhausted, but liability under next policy No 48/2005 was still there and claim should be payable.**

3. **Insurance Company had denied cashless on the ground that complainant was admitted at Apollo hospital on 24/11/2011 during the tenure of policy No. 36090048108500002319 and as per condition No. 1.0 of Floater policy 50% of S.I can be given per illness, hence S.I. under the policy was already exhausted. Insurance company had reiterated vide letter dt. 05/11/2012 that policy No 360900/48/11/8500002005 covers hospitalization claims of Insured person during the policy period only. In the said case the claim was originally arose in the policy No. 48/2319 and not under policy No 48/2005 hence balance claim amount could not be considered under**

renewed policy No. 48/2005. The deduction for DM and HTN were made as per condition No.4.1.1. which states "Insured shall bear 10% of any admissible claim if he is suffering from either Diabetes or Hypertension, and 25% of the admissible of claim amount in case he is suffering from both Diabetes and Hypertension. This provision is applicable only for claims arising out of Diabetes and Hypertension".

4. **I heard both the sides, the complainant as well as the Insurance Company. The complainant was admitted continuously for the same illness without break and period of hospitalization falls between two policies bearing No. 360900/48/11/8500002005 &36090048108500002319. As per the policy condition no 1.0 Company's liability would arise if the treatment of disease suffered is incepted during the policy period. In the said case claim was originally aroused in the policy No. 36090048108500002319 in which company's liability was already exhausted since 50% of sum insured per illness per family was the maximum liability under the policy and same claim on the second policy could not be considered due to continuous admission for same illness without break. This is as per the policy conditions. I find that deduction for DM & HTN were made as per co-payment clause of policy. The claim was rightly settled as per terms and conditions of the policy. I find no reason to interfere with the decision of the Insurance Company. Accordingly the complaint filed by the complainant is hereby dismissed.**

Case No.GI/NIC/57/13
In the matter of Smt. Shubha Shukla
Vs
National Insurance Company Ltd.

Date of Order 13.02.2015

Policy No. : 351840/48/12/8500001787.

1. **Smt. Shubha_Shukla had filed the complaint (herein after referred to as the complainant) against the decision of National Insurance Company Ltd. (herein after referred to as respondent Insurance Company) alleging non settlement of mediclaim.**

2. **The complainant had alleged that she had taken a mediclaim insurance from National Insurance Company for a sum of Rs. 50,000/-. She was admitted to Ashirwad Hospital form 22.10.2012 to 25.10.2012 with pain in abdomen associated with body ache and weakness for 7 days. A claim was filed for reimbursement of expenses of hospitalization. Insurance Company had repudiated the Claim.**

3. **The Insurance company had reiterated its letter dated 31.07.2013, that complainant was diagnosed as a case of conversion disorder which falls under exclusion clause NO. 4.8 which states that " Convalescence general debility 'Run Down' condition or rest cure, congenital external disease or defects or anomalies, sterility, intertility/sub fertility or assisted conception procedures, venereal disease, intentional self-injury, suicide, all psychiatric & psychosomatic disorders/diseases, accidents dur to misuse or abuse of drugs/alcohol or use of intoxicating substances". Since the ailment was related to psychosomatic Disorder which has specific exclusion, claim was not tenable. Insurance Company had reviewed the case and medical opinion from Dr. R.K. Mahajan was sought who also reiterated that disease was related to psychosomatic Disorder and falls under exclusion clause No. 4.8, hence claim was not payable**

4. **I heard both the sides, the complainant as well as the Insurance Company. I find that the complainant was admitted for pain in abdomen body ache and weakness for 7 days abd discharged as 'Conversion Reaction' and as per panel Doctors report Conversion Reaction is Psychosomatic Disorder. The Insurance Company had repudiated the claim on account of exclusion clause No. 4.8 of the policy which states that Convalescence general debility 'Run Down' condition or rest cure, congenital external disease or defects or anomalies, sterility, infertility/sub fertility or assisted conception procedures, venereal disease, intentional self-injury, suicide, all psychiatric & psychosomatic disorders/diseases, accidents due to misuse or abuse of drugs/alcohol or use of intoxicating substances" falls beyond the scope of the policy. Company's decision was also supported by the panel doctor's opinion therefore I find no reason to interfere with the decision of the Insurance Company. Accordingly the complaint filed by the complainant is hereby dismissed.**

Case No.GI/NIA/236/13.
In the matter of Sh. Sumeet Abrol.
Vs
New India Assurance Company Ltd.
ORDER

(Under Rule 16 of the Redressal of Public Grievances Rules, 1998)

Date of Order 03.02.2015

Policy No. : 311502/34/11/03/00000473.

1. **This is a complaint filed by Sh. Sumeet Abrol (herein after referred to as the complainant) against the decision of New India Assurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to inadequate settlement of mediclaim.**

2. **The Complainant had lodged a claim for Rs. 3,85,778/- for expenses incurred in surgery of his son in July'12. TPA had settled Rs. 69,034/- against the claim, after deducting the major amount of Rs. 3,00,000/- paid directly to Dr. Johri towards consultation charges other than the surgery expenses of the hospital and his surgery fee as per hospital 's bill. Later on after vigorous follow up by the complainant, TPA had paid Rs. 67,500/- towards surgeon's fee. Complainant had alleged that as per policy Terms and Conditions, surgeon's fee payable should be 25% of S.I. i.e. Rs.1,25,000/- (25% of Rs. 5,00000/-), hence he sought relief for balance amount from this forum.**

3. **The Insurance Company had submitted vide its letters dated 09.01.2015 & 23.01.2015 that insured was hospitalized for the period 16.05.2012 to 22.05.2012 in Leelawati Hospital, Mumbai. The total expenses incurred for the treatment was Rs. 5,41,798, out of which, Rs. 1,56,020 had been claimed from Bharti Axa General Insurance. A claim for reimbursement of Rs. 3,85,778/- was lodged with New India Assurance including 3 lacs as surgeon fee. As regard surgeon fee insurance company had paid Rs.112500/- as per policy condition 2.0 (Note 3) which states that the reasonable and customary and**

medically necessary surgeon fee and anesthetist fee would be reimbursed limited to maximum of 25% of sum insured and 2.10 which states that 10% Zone wise deduction would be made if the policy was taken in Zone II and treatment was taken in Zone I (Mumbai). So, the net surgeon fee paid was Rs.1,12,500/-. From the remaining amount of. Rs. 85,778/- net amount paid was Rs. 76,704/- after considering following deductions.

(Not Payable)

- **Rs.4523 - consumable charges**
- **Rs.2000 - Ambulance charges**
- **Rs.200 - Warming Blanket**
- **Rs. 780 - Patient name not mentioned in the bill**
- **Rs.71 - Urine pot**
- **Rs.7670 - 10% Zone wise deduction**
- **Rs.1500 - Ambulance charges**

4. **I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing, Insurance Company was advised to submit the details of deductions , including deductions for zone category. Complainant was also advised to submit the details of claimed amount received from Bharti Axa General Insurance Company for some illness to avoid double payment. Complainant had not reverted back yet. From the mail reply sent by the Insurance Company it was revealed that Insurance Company had already settled the claim after considering the deductions applicable as per terms and condition of the policy. 10% zone wise deduction was made in the surgeon fee as the policy taken in Zone II and treatment was taken in Zone I (Mumbai). Therefore, I find no reason to interfere with the decision of the Insurance Company. Accordingly the complaint filed by the complainant is hereby dismissed.**

Case No.GI/NIC/91/13.
In the matter of Mr. Raj Kumar Kalra.
Vs
National Insurance Company Ltd.

Date of Order 03.02.2015

Policy No. : 350300/48/11/85-1944.

1. **Sh. Raj Kumar Kalra (herein after referred to as the complainant) had filed the complaint against the decision of National Insurance Company Ltd. (herein after referred to as respondent Insurance Company) alleging non-settlement of mediclaim.**

2. **The Complainant had alleged that he had taken a mediclaim policy bearing no-360300/48/11/8500001944 from National for the period 28/01/2012 to 27/01/2013. He was admitted at Delhi Heart & Lung Institute for the period 02/06/2012 to 05/06/2012 with complaint of severe Cardiac Attack. Claim was rejected on the ground that claim was lodged on 4th running year of policy and falls under exclusion clause 4.1 of pre-existing disease.**

3. **The Insurance Company reiterated the written submissions dated 19/08/2013 that policy incepted from 28/01/2009 and pre-existing diseases could be covered after continuous policy of 48 months without break, since claim was lodged under 4th year of the policy for a disease which was pre-existing, hence claim was not admissible under policy clause 4.1.**

4. **I heard both the sides, the complainant as well as the Insurance Company. Policy incepted from 28.01.2009 and in the proposal form submitted by the insured it was clearly mentioned that insured had a history of Heart Disease since 1999. As per policy exclusion clause 4.1 pre –existing diseases are covered under the policy after continuous policy for 48 months without break. Though the policy was renewed by complainant continuously but claim was lodged under 4th year of the policy, hence claim was not admissible. Complainant had also submitted various judgments wherein claims for pre-existing diseases were paid due to fact that either the person**

was suffering from the symptoms of any disease without the knowledge of the same or the Insurance Company failed to establish that complainant was having a Heart Disease. In this case insured was aware of the pre-existing disease and Heart Disease was mentioned in the policy under details of pre-existing disease/illness column since inception of the policy. therefore Insurance Company had rightly repudiated the claim. I find no reason to interfere with the decision of the Insurance Company. Accordingly the complaint filed by the complainant is hereby dismissed.

INSURANCE OMBUDSMAN

Guwahati Centre

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Complaint No. ;GUW-G-048-1415-0013

Dr. Pulin Baruah,------ Complainant

VS

National Insurance Co. Ltd., --------- Insurer

AWARD-20.03.2015

The complainant, Dr. Pulin Baruah has stated in his complaint dated 08.07.2014 that his daughter Ms. Priyakshee Baruah is covered under the mediclaim policy no. 200200/48/12/8500000939 issued by National Insurance Co. Ltd., Jorhat DO. His daughter was suddenly suffering from proteinuria on 05.11.2013 and admitted at Manipal Hospital on 15.11.2013 as per consulting doctor's advice and discharged on 16.11.2013

He lodged a claim for Rs.30469/= along with all relevant documents in connection with the above hospitalization to the insurance company for reimbursement. But despite of several reminders, the insurance company did not respond on the matter

After careful evaluation of the submission of the representative of the insurer and all the facts and circumstances of the case, it is opined that as per discharge summary it is amply clear that the hospitalization was done for the evaluation purpose and only renal biopsy was done. The course of the hospitalization was uneventful. The staying in the hospital was advised only for observation and not for any active line of treatment. However the insurance company should be more responsive and should act more sensitively while dealing the customer.

INSURANCE OMBUDSMAN
Guwahati Centre
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Complaint No. ;GUW-G-048-1415-0029

Shri Rajendra Changkakoty,---------- Complainant
VS
National Insurance Co. Ltd.,..... Insurer

AWARD-04.02.2015

The complainant, Shri Rajendra Changkakoty stated in his complaint agent urged upon him to take up and insurance policy under mediclaim scheme assuring him of various facilities and immunities to be enjoyed by him from time to time. Accordingly he took an Individual Mediclaim Policy during the year 2008 and he is continuing the policy without any break. He suddenly fell ill on 16.02.2014 and had to be admitted to the International Hospital, Guwahati for his sudden ailment. The complainant submitted the

claim amounting to Rs. 86380/= to the TPA M/s E-Meditek (TPA) Services. The insurance company vide their letter no. 200600/Tech/PKG/14/71 dt. 27.05.2014 informed him that his claim was rejected by the TPA.

After careful evaluation of all the facts and circumstances of the case, it is found that in the entire course of treatment protocol followed in the hospital there was no evidence of an active line of treatment. Also it is evident that the insurance company processed the claim appropriately i.e. as per terms and condition of the policy. Hence we may not call for a hearing, neither, there is a need for self-contained note being called for from the insurance company. The complaint does not merit consideration. The decision of the insurer is upheld and complaint is disposed of without any relief to the complainant.

INSURANCE OMBUDSMAN

Guwahati Centre

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Complaint No. ;GUW-G-048-1415-018 :

Mr. Umasaday Bhattacharjya ..... Complainant
VS
National Insurance Co. Ltd., ... Insurer

AWARD—20.03.2015

The Complainant in his complaint dt. 21.08.2014 stated that he submitted two nos. of claim bill along with requisite documents, on 15.04.2013 and 16.05.2013 respectively. But his claim was repudiated by the TPA of the insurance company on the

basis of the policy condition no. 4.10 stating that active line of treatment during hospitalization was not done

After careful evaluation of the submission of the representative of the insurer and all the facts and circumstances of the case, it is opined that as per discharge summary it is amply clear that the hospitalization was done for the evaluation purpose and only Flexible Cystoscopy done under LA. Therefore the decision of the insurance company hereby upheld and the complaint is dismissed without any relief to the complainant.

The complaint is dismissed accordingly.

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INSURANCE OMBUDSMAN
Guwahati Centre
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Complaint No. : GUW-G-051-1415-0010

Shri Vinod Jain,---------- Complainant -
vs
United India Insurance Co. Ltd.-------- Insurer

AWARD-18.03.2015

The complainant, Shri Vinod Jain in his complaint dt. 19.06.2014 stated about partial repudiation against policy no. 130300/48/06/00000144 with United India Insurance Co. Ltd. He received only Rs. 75000/= against his claim of Rs. 329477/= On enquiring with the insurance company vide his letter dt. 7.03.2014,

he received a reply that the TPA has settled the claim on the basis of pre-judgement worded as "presumed pre-existing disease"

After careful evaluation of all the facts and circumstances of the case, it is found that the insurance company has deducted Rs.13,293/- from the total claimed amount. Out of these deductions, an amount of Rs.11,053/- were deducted in different heads for staying in a room higher than the entitlement of the complainant in proportion to the entitled room category. The Insurer was directed vide our letter dated 29.12.2014 to submit evidence in support of their submission in the letter head of the hospital within 10 days of the receipt of the letter which they failed to submit. Since, the Insurer could not submit any such evidence of existence of such variable rates in the said hospital, onus of proof lies with the Insurer and in absence of such evidence, the Insurance Company is found liable to pay the claim.

In view of the above, the insurer is directed to settle and pay a further amount of Rs.11,053/- within 15 days from the date of receipt of this award alongwith the consent letter from the complainant under intimation to this forum.

Hyderabad Ombudsman Centre
Case No. L-036-1415-0283
Sri Ashok Kumar Motilal
Vs
Reliance Life Insurance Co Ltd
Award Dated : 21.11.2014

Mr. Ashok Kumar Motilal had filed a complaint stating that his claim for 'Medi-claim reimbursement' under the policy taken from Reliance Life Insurance Company was wrongly rejected by the insurer. Hence, he requested for settlement of the same.

I have carefully considered the written and oral submissions of both the parties and the documentary evidence adduced by the insurer. The policy was taken by the complainant commencing the risk from 20.12.2010; and the 'cataract operation for the left eye' was performed on him on 30.8.2013, which was beyond the period of 24 months of waiting period. Hence, the complainant was eligible for reimbursement of the medical expenses. During the hearing, the representatives of the insurer also have agreed to settle the claim of the complainant.

In view of what has been stated above, the insurer is directed to settle the claim of the complainant, in terms of the policy.

In the result, complaint is allowed.

Hyderabad Ombudsman Centre
Case No. L - 029 -1415 - 0070

Sri Nallamothu Radha Krishna
Vs
LI C of India, Nellore Division
Award Dated : 21.11.2014

Sri Nallamothu Radha Krishna filed a complaint stating that the medi-claim benefit on his own life policy was wrongly repudiated by LIC of India, Nellore Division. Hence, he requested for settlement of the claim.

I have carefully considered the written and oral submissions of both the parties and the documentary evidence adduced. The basic grievance under the complaint was against rejection of medi-claim benefits in terms of the policy. The reason given by the insurer for rejection of the claim was non-disclosure of pre-existing ailments. However, on reconsideration, the insurer has decided to settle the

claim after filing of this complaint. The fact remains that there was a long delay of more than 9 months in the settlement.

In the circumstances, in my considered view, it would be proper to award the complainant with suitable interest on the claim amount for the delay in settlement of the claim.

For the reasons stated hereinabove, since the claim of the complainant has since been settled by the insurer, I direct the insurer to pay the interest only on the amount of Rs. 1,23,750/- @ 9% per annum, from 01.01.2014 to 31.08.2014.

In the result, the complaint is allowed.

Hyderabad Ombudsman Centre
Case No. L-009-1415-0406

Mrs. Aruna
Vs
Birla Sunlife Insurance Co. Ltd.
Award Dated : 02.12.2014

Mrs. G. Aruna wife of Mr. G. Srinivas filed a complaint stating that the medical expenses reimbursement benefit under the policy taken from Birla Sun Life Insurance Company Limited was wrongly rejected by the insurer. Hence, she requested for settlement of the Medi-claim.

I have carefully considered all the written and oral submissions of both the parties and the documentary evidence adduced by them. It is evident from the Discharge Card dated 2.3.2014 of Shree Vijay Vithal Maternity and Nursing Home, Raichur that on 24.2.2014 the complainant was admitted into the hospital vide Indoor No. 12359. She was diagnosed to have 'TLH for DUB and Fibroid'. It was further stated there on that "Uterus bulky with posterior fundal fibroid'

bleeding minimal. Both ovaries/tubes were normal and retained uterus with cervix removed. Both the Operation and POP were uneventful. The patient condition on discharge was good". There was no noting that there was any malignancy. That being a benign condition, it was an excluded surgery as per the Policy terms and conditions. The policy Annexure 1 contained the list of covered surgeries "Grade 4 category and the covered surgeries: Serial No. 63 - Hysterectomy (abdominal/vaginal/ laparoscopic/ pan). This was excluded only when for benign conditions". The terms and conditions of the policy were very much explicit; and as such, the insurer cannot be compelled to act beyond the scope of the policy. Hence, I hold that rejection of claim of the complainant was in accordance with the terms of the contract, and decision of the insurer does not need any interference.

In view of the aforesaid reasons, the complaint is dismissed without any relief.

Hyderabad Ombudsman Centre
Case No. L - 006 -1415 – 0277

Sri G Viswanatha Reddy Gurunatha Reddy
Vs
Bajaj Allianz Life Insurance Co. Ltd.

Award Dated : 02.12.2014

Sri Vishwanath Reddy Gurunath Reddy Devanagaon filed a complaint stating that the 'critical illness benefit claim' under his own policy was wrongly repudiated by the Bajaj Allianz Life Insurance Co. Ltd. Hence, he requested for settlement of the said claim.

I have carefully considered all the written and oral submissions of both the parties and the documentary evidence adduced by them. It is evident from the Discharge summary dated 3.11.2013 of Vikram hospitals, Millers Road, Bengaluru pertaining to the life assured that his Motor power in all 4 limbs (Right & left) was 4/6 or 5/6 from C5 to C8. Thus it clearly confirms that the Motor power rating of the life assured was only Mild and not Severe. The rating was specified in the policy terms and as per Clause 11, the policy covers the risk for severe cases only which have rating of 0/6 – 2/6. Hence, I hold that the rejection of the claim of complainant was in accordance with the policy terms, and decision of the insurer does not need any interference.

In view of the aforesaid reasons, the complaint is dismissed without any relief.

Hyderabad Ombudsman Centre
Case No. L – 021 -1415 - 0412

Smt. Gangisetty Suguna
Vs
ICICI Prudential Life Insurance Co. Ltd

Award Dated : 08.12.2014

Smt. Gangishetty Suguna filed a complaint stating that reimbursement of hospitalization expenses was not settled by ICICI Prudential Life Insurance Company Limited, as per the policy conditions. Hence, she requested for settlement of the medical expenses.

I have carefully considered the written and oral submissions of both the parties and the documentary evidence adduced. The complainant was pleading that her hospitalisation was genuine and as such the claim filed with the insurer should have been settled as per the policy conditions. The insurer was contesting that the claim filed by the complainant was inflated; as such, they rejected the claim on the ground of deliberate attempt to defraud the insurer. It is observed from the evidence filed by the insurer in the form of 'Annexure-D', i.e. the bill issued by Sri Pooja Hospital, Khammam for a total amount of Rs. 45,244/- to the complainant that the hospital authorities had endorsed on a copy of it that "By mistake we charged more for Nursing Charges, i.e. nearly Rs. 1400/-". Based on that endorsement, the insurer was arguing that the amount claimed by the complainant was inflated. However, the insurer neither questioned her hospitalisation nor stated any amount that should have been the actual charges of hospitalisation. During the hearing also the insurer could not reply as to what amount should have been the actual expenses of her hospitalisation. As per the evidence filed by the insurer also the amount inflated was shown as Rs. 1400/- only whereas the total claim amount was Rs. 45,244/-. Hence, I hold that rejection of claim in toto is not in order. In my considered view, it would be proper to award the complainant with a reasonable amount, as reimbursement of medical expenses, as per the policy conditions.

In view of the aforesaid reasons, the insurer is directed to settle a lump sum amount of Rs. 35,000/- to the complainant, in full settlement of the claim, as per the policy conditions.

In result, the complaint is partly allowed.

Hyderabad Ombudsman Centre
Case No. L-017-1415-0372

Mr. B. Hanumantha Rao
Vs
Future Generali Life Insurance Co. Ltd.

Award Dated : 08.12.2014

Mr. B. Hanumantha Rao filed a complaint stating that the 'Critical Illness Benefit claim' under the policy taken from Future Generali Life Insurance Company Limited, was wrongly rejected by the insurer. Hence, he requested for settlement of the claim.

I have carefully considered the written and oral submissions of both the parties and the documentary evidence adduced. The complainant was pleading that on the date of proposal for insurance he was healthy; and he did not conceal any ailment. He had come to know of the ailment just 6 months prior to the date of his hospitalisation; as such, his claim was genuine and should have been settled by the insurer as per the policy conditions. The insurer was contesting that the complainant had deliberately concealed his ailments and obtained the policy; hence, the claim was not payable. As to the basis for suppression of material facts, the insurer had relied on the Discharge Summary dated 13.5.2013 under I.P. No. 136857 pertaining to the life assured, issued by Narayana Hrudayalaya Hospitals, Jeedimetla, Hyderabad. It was recorded on the said summary, under the column Chief Complaints, that the patient was having the complaint of Chest pain with shortness of breath since 2 years. However, nowhere it was recorded that he was diagnosed with the said ailments from such and such date and had taken treatment. During the hearing also, the insurer was specifically asked to furnish the evidence pertaining to the pre-

proposal illness of the life assured, but they failed to produce the same. When the claim of the life assured was rejected on the ground of concealment of pre-existing ailments, burden of proving that lies on the insurer. However, the insurer had failed to furnish the specific and contemporaneous evidence pertaining to pre-proposal illness of the life assured. Hence, I hold that the insurer had erred in concluding that the life assured had concealed his ill-health while obtaining the policy. Consequently, rejection of the claim of the complainant doesn't appear to be in order.

In view of the aforesaid reasons, the insurer is directed to settle the claim of the complainant, as per the policy conditions.

In result, the complaint is allowed.

Hyderabad Ombudsman Centre
Case No. L-021-1415-0252

Mrs. Smita Mukherjee
Vs
ICICI Prudential Life Insurance Co. Ltd.

Award Dated : 02.12.2014

Mrs. Smita Mukherjee filed a complaint stating that the claim for medical expenses reimbursement under her 'Hospital Care policy', taken from the ICICI Prudential Life Insurance Company Limited, was short settled. Hence, she requested for settlement of balance of the claim.

I have carefully considered all the written and oral submissions of both the parties and the documentary evidence adduced by them. It is evident from the Annexure 1 of policy conditions, under Serial No.12 i.e., "Bone (Lower Limb), Plates and Screws/Nails Removal"

was listed as Grade 1 Surgery. Accordingly the insurer had settled the claim of the complainant as per the terms of the policy. The allegation of the complainant that the insurer had short settlement the claim does not have any merit. The terms and conditions of the policy were very much explicit and as such the insurer cannot be compelled to act beyond the scope of the policy. Hence, I hold that the decision of the insurer in settlement of the claim for Rs. 17,000/- only was in accordance with the policy terms and conditions.

In view of the aforesaid reasons, decision of the insurer does not require any interference.

In result, the complaint is dismissed without any relief.

Hyderabad Ombudsman Centre
Case No. L - 029 -1415 – 487

Sri Dharam Kumar
Vs
L I C of India, Karimnagar DO

Award Dated : 29.12.2014

Sri Dharam Kumar filed a complaint stating that reimbursement of medical expenses, under the Mediclaim policy taken from LIC of India, was wrongly rejected by the insurer. Hence, he requested for settlement of the claim.

I have carefully considered all the written and oral submissions of both the parties and the documentary evidence adduced by them. It is evident from the discharge summary dated 25.02.2014 of KIMS Hospital, Secunderabad, pertaining to the complainant that the chief

complaint was noted as 'shortness of breath on exertion since 1 week', whereas the discharge summary of Apollo hospitals dated 15.03.2014 recorded the history of 'shortness of breath on and off since 10 years'. Though the recordings/notings on both the reports were contradictory, the insurer had relied on the record of Apollo hospitals and repudiated the claim. However, the insurer could not substantiate their stand of 'pre-existing ailment' with contemporaneous documentary evidence. Burden of proof lies on the insurer when the claim was rejected on the ground of 'non-disclosure of pre-existing ailments'. But the insurer, in the instant case, failed to furnish any documentary evidence supporting their stand. Hence, I hold that the insurer has erred in concluding that the insured had concealed his pre-existing ailments in his proposal. Consequently, rejection of claim of the complainant by the insurer was not in order.

In view of the aforesaid reasons, the insurer is directed to settle the eligible benefits in terms of the policy, to the complainant.

In result, the complaint is allowed.

Hyderabad Ombudsman Centre
Case No. L-041-1415-0781

Mrs. Gaddam Madhavi
Vs
SBI Life Insurance Co. Ltd.

Award Dated : 24.02.2015

Mrs. Gaddam Madhavi wife of Mr. G. Ramesh Babu filed a complaint stating that the medi-claim reimbursement under her own policy taken from SBI Life Insurance Co. Ltd. was wrongly

repudiated by the insurer. Hence, she requested for settlement of the Mediclaim.

I have carefully considered all the written and oral submissions of both the parties and the documentary evidence adduced by them. It is evident from the Discharge summary of Sri Pooja Hospitals, Khammam that the insured person was diagnosed as suffering with 'Acute Diarohoea'. She was in the hospital from 28.08.2014 to 02.09.2014. All other related medical papers, viz. investigations/tests and pharmacy bills clearly show that hospitalisation was genuine. The insurer rejected the mediclaim on technical ground of 'delay in intimation' citing the policy conditions.

Since the complainant had argued that she was completely down at the time of her hospitalisation and her husband was not present, and there was none-else who was capable of informing the insurer, in my considered opinion, the insurer should have allowed her claim by condoning the delay in intimation to them, considering the exceptional circumstances of the case.

In view of the aforesaid reasons, the insurer is directed to settle the claim of the complainant in terms of the policy, by condoning the delay in intimation, as a special case.

In result, the complaint is allowed.

Hyderabad Ombudsman Centre
Case No. L-029-1415-0500

Mr. A. Nagi Reddy
Vs
LIC of India, Kadapa Division

Award Dated : 30.03.2015

Mr. Aluri Nagi Reddy filed a complaint stating that the medical expenses reimbursement claim under the policy taken from LIC of India was wrongly rejected by the insurer. Hence, he requested for settlement of the claim.

I have carefully considered all the written and oral submissions of both the parties and the documentary evidence adduced by them. It is evident from the Discharge Summary dated 24.2.2012, issued by the Bangalore Baptist Hospital, Hebbal, Bangalore on the name of the complainant that under the column "Past History" it was stated that the complainant had been treated for 'right sided tubercular pleural effusion??? 5 years ago" and that he was a diabetic on OHA. Since the evidence furnished by the insurer confirmed the contentions of the insurer that the complainant had been treated for 'right sided tubercular pleural effusion 5 years ago', and nature of the ailment appears chronic in nature, I am inclined to believe the version of the insurer that the complainant had concealed the material fact, i.e. his previous medical treatment details, in the proposal for assurance and obtained the policy on wrong declarations.

The contract of insurance is one of 'utmost good faith' and both parties to the contract shall disclose all facts, whether material or not, in full, to the other. Since the life assured/complainant did not

disclose his correct "health condition and past medical treatment details" in his proposal for insurance, the insurer cannot be made liable to pay the assured amount.

In view of what has been stated above, I hold that the rejections of claims of the complainant for reimbursement of medical expenses were on valid grounds and the decision of insurer does not warrant any interference.

In result, the complaint is dismissed without any relief.

KOCHI

Award No. IO/KOC/A/GI/0050/2014-15

Complaint No. IO/KCH/GI/11-005-398/12-13

Award Passed on 09.10.2014

Sri. K.K. Kunjumohammed Vs. Oriental Insurance Co.Ltd.

Repudiation of Individual Mediclaim

The complainant had taken a Individual Health Insurance policy from the respondent insurer. The same is kept uptodate by paying the premiums in time The complainant's wife was hospitalized for ayurvedic treatment and submitted a claim for Rs.38,605/- to the respondent Insurer. It was rejected by the TPA stating that the hospital was not a Medical college hospital or Government hospital. Hence this complaint. Relief sought is for the full claim amount and compensation of Rs.38,605/-.

Respondent-Insurer to pay to the complainant the amount of admissible claim.

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Award No. IO/KOC/A/GI/0054/2014-15

Complaint No. IO/KCH/GI/14-005-438/12-13

Award Passed on 10.10.2014

Sri. P. Ramaswamy Pillai Vs. National Insurance Co.Ltd.

Repudiation of Individual Mediclaim

The complainant had taken a mediclaim policy from the respondent Insurer. His wife, who is also covered under the policy was hospitalized for 4 days from 01/12/2011 to 04/12/2011. During these four days she was subjected to various tests & procedures. She was referred to a higher centre for further evaluation and treatment. After the discharge, necessary claim papers were submitted to the TPA M/s. Medi Assist. However no reimbursement has been received till date. The respondent Insurer has vide their letters called for many clarification and information which was submitted, but the claim was not paid. Hence this complaint. Relief sought is for the full claim amount.

Respondent-Insurer to pay to the complainant claim amount (less the inadmissible).

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Award No. IO/KOC/A/GI/0055/2014-15

Complaint No. IO/KCH/GI/11-002-318/12-13

Award Passed on 10.10.2014

Smt. C. Saraswathy Vs. The New India Assurance Co.Ltd.

Repudiation of Individual Mediclaim

The complainant's husband had taken a Mediclaim policy from the Respondent Insurer in 2008. Since he was under treatment for diabetes for 10 years at the time of taking the policy he has disclosed the pre-existing illness in the proposal. He had to undergo detailed medical exam and also charged additional amounts before he was issued the policy. The deceased policyholder was admitted to the hospital a couple of times since January 2011 and he expired in July 2011. All the bills have been submitted to the respondent Insurer, however they have refused to pay the claim citing pre existing diseases not mentioned in the proposal. Hence this complaint. Relief sought is for the full claim amount.

Respondent-Insurer to pay to the complainant the admissible claim amount excluding all amounts incurred for dialysis and other inadmissible as per the policy conditions.

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Award No. IO/KOC/A/GI/0057/2014-15

Complaint No. IO/KCH/GI/11-017-450/12-13

Award Passed on 10.10.2014

Smt. Rajasree G.L Vs. Star Health & Allied Insurance Co.Ltd.

Repudiation of Individual Health Insurance claim

The complainant's father was covered under a health scheme from the Respondent-Insurer. He was hospitalized thrice during 2011 and preferred all the three claims with the Insurance Company and all of them were repudiated due to suppression of material facts at the time of taking the policy. Disputes regarding this could not be settled among themselves, a complaint was filed before the Hon'ble Ombudsman.

Since the company has settled the claim, the complaint is dismissed.

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Award No. IO/KOC/A/GI/0059/2014-15

Complaint No. IO/KCH/GI/11-003-403/12-13

Award Passed on 10.10.2014

Sri. K.M. Hashir Vs. National Insurance Co.Ltd.

Repudiation of Individual Mediclaim

The complainant had taken a mediclaim policy from the respondent Insurer. He is continuing the policy for the last 16 years with the same insurer. It is submitted that the complainant's daughter was hospitalized for one day in Kunhalu's Hopsital kochi, for severe back pain. He has spent a total of Rs. 9,903/- for the same. The claim form for the same was submitted to the respondent Insurer on 03/01/2012. On 12/04/2012, the insurer has vide their letter informed the complainant that the claim cannot be entertained. The reason cited for repudiation was clause 4.10 of the policy conditions, that no active line of treatment was taken. Appeal to the grievance

cell of the insurer has been rejected, hence this complaint. Relief sought is for full claim amount.

Respondent-Insurer to pay to the complainant the admissible claim.

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Award No. IO/KOC/A/GI/0061/2014-15

Complaint No. IO/KCH/GI/11-008-731/12-13

Award Passed on 16.10.2014

Sri. J. Narayana Pai & Smt. Sandhya Vs. Royal Sundaram Alliance Ins.Co. Ltd.

Repudiation of Individual Mediclaim

The complainants had a mediclaim policy from the respondent Insurer. The policy was taken from the year 2008 onwards and renewed every year. In the same fashion the policy was renewed from 04/09/2012 to 03/09/2013. On 30/08/2012, the complainants met with a road traffic accident at Quilandy, near Calicut and were rushed to Baby Memorial Hospital for immediate treatment. On 31/08/2012, they were discharged and re-admitted to Sree Sudheendra Medical Mission Hospital, Kochi where they had complete treatment and was discharged on 10/09/2012 (Total of 11 days hospitalization). On 20/09/2012 the claim was filed with the respondent Insurer. On 04/10/2012 the complainants have received a letter from the respondent Insurer which stated that a service provider has been appointed to collect additional medical records and it would take 21 working days to update final status. On 30/10/2012 a letter has been received from Chennai office of the respondent Insurer stating that the claim has been rejected. On 06/12/2012 after repeated follow-up with the insurer, an amount of Rs.60,000/- was settled (Rs30,000/- each). The complainants have spent Rs.1,98,000/- for the treatment of the two insured lives and only Rs.60,000/- has been paid by the insurer. Aggrieved with the response from the respondent Insurer this complaint has been filed. Relief sought is for the full benefits under the policy available with the complainants.Insurer to pay to the complainants the admissible claim under the hospital cash policy for the period of hospitalization from 30/08/2012 till 03/09/2012 and under Super Hospital Cash Plan from 04/09/2012 till discharge.

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Award No. IO/KOC/A/GI/0062/2014-15

Complaint No. IO/KCH/GI/13-008-538/13-14

Award Passed on 16.10.2014

Sri. J. Narayana Pai & Smt. Sandhya Vs. Royal Sundaram Alliance Ins.Co. Ltd.

Issue of Wrong policy

The complainants had a mediclaim policy from the respondent Insurer. The policy was taken from the year 2008 onwards and renewed every year. In the same fashion the policy was renewed from 04/09/2012 to 03/09/2013. On 30/08/2012, the complainants met with a road traffic accident at Quilandy, near Calicut and were rushed to Baby Memorial Hospital for immediate treatment. On 31/08/2012, they were discharged and readmitted to Sree Sudheendra Medical Mission Hospital, Kochi where they had complete treatment and was discharged on 10/09/2012(Total of 11 days hospitalization). On 20/09/2012 the claim was filed with the respondent Insurer. It has come to the knowledge that the premium was collected for Hospital Cash plan but for the year 2012-13 a Super Hospital cash policy was wrongly issued. Therefore in the next year (2013-14) renewal the company has issued the actual policy i.e., Hospital Cash policy. The complainants insist that he has got the same policy from 2008 onwards and it has been changed in the year 2013-14 only.

Insurer to collect the necessary requirements and issue the Super Hospital cash plan as requested by the complainant.

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Award No. IO/KOC/A/GI/0065/2014-15

Complaint No. IO/KCH/GI/11-002-368/12-13

Award Passed on 23.10.2014

Sri. Jacob Thomas Vs. The New India Assurance Co.Ltd.

Repudiation of Individual Mediclaim

The complainant had been taking mediclaim insurance from the Respondent-Insurer from March 2007. At the time of taking the policy, the health was completely normal. However, in March 2008, during hospitalization for fever, it was found that the sugar levels were not normal. This was declared to the Respondent-Insurer and an additional Rs.370/- was paid to cover the Diabetes Mellitus. After that, all claims for hospitalization were settled without any objection. The current claim is for Rs.15,267.55 for the year 2011-12 which has been rejected citing pre-existing illness. Hence this complaint.

Respondent-insurer to pay eligible claim to the nominee/ legal heir of the complainant.

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Award No. IO/KOC/A/GI/0079/2014-15

Complaint No. IO/KCH/GI/11-003-104/13-14

Award Passed on 27.10.2014

Dr C.I. Jolly Vs. National Insurance Co.Ltd.

Repudiation of Individual Mediclaim

The complainant has a mediclaim policy with the respondent insurer for more than 10 years. His wife is also covered under the said policy. His wife is undergoing treatment for Breast cancer and various claims have been made to the respondent Insurer. One particular claim for administering oral chemo therapy was repudiated by the respondent insurer citing exclusion Clause 2.6 of the policy. Hence this complaint.

Respondent-Insurer to pay the admissible amount under this claim as a special case .

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Award No. IO/KOC/A/GI/0080/2014-15

Complaint No. IO/KCH/GI/11-003-547/13-14

Award Passed on 27.10.2014

Sri. Anuraj P.V. Vs. National Insurance Co.Ltd.

Repudiation of Individual Mediclaim

The complainant has a mediclaim policy with the respondent insurer for many years. In the year 2012-13, there was some delay in the renewal of the policy and a break of 16 days has occurred between the policy dates. On a claim being submitted the complainant was informed that this was the first year since the policy incepted (due to the 16 day break) and the claim was for a pre existing disease and therefore repudiated. Appeals to the insurer were in vain. Hence this complaint.

Respondent-Insurer to pay the admissible amount under this claim as a special case .

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Award No. IO/KOC/A/GI/0081/2014-15

Complaint No. IO/KCH/GI/11-020-374/2012-13

Award Passed on 27.10.2014

Sri. N. Vasu, (h/o Late B Lathika) Vs. Universal Sompo General Insurance Co.Ltd.

Repudiation of Individual Mediclaim

The complainant was having mediclaim policy with the respondent insurer for many years (from 2009 onwards). In December 2011, she was hospitalized. The necessary claim papers were submitted on 09/01/2012. The claim was repudiated citing reason "non disclosure of pre-existing disease". As per the policy condition, pre-existing disease is defined as ailment for which insured has signs or symptoms within 36 months prior to the first policy. Considering that this policy is from 2009, there is no question on pre existing illness. No documents collected had any indication that the diseases were present prior to 03/12/2011, the date of first consultation.

Also the respondent Insurer could not prove how there was any pre-existing illness. Hence this complaint.

Respondent-insurer to pay eligible claim to the nominee/ legal heir of the complainant.

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Award No. IO/KOC/A/GI/0082/2014-15

Complaint No. IO/KCH/GI/11-004-327/12-13

Award Passed on 27.10.2014

Sri. K.V. Valsalan Vs. United India Insurance Co.Ltd.

Repudiation of Individual Health Insurance claim

The complainant has taken an Individual health Insurance Policy from the respondent insurer. His family was also covered under the policy. On 19/08/2010, his son developed left shoulder pain and was taken to hospital. X-ray was taken, but the doctor was not satisfied with the same and insisted that an MRI scan was necessary to diagnose the problem. The scan was taken and the doctor has prescribed medicines for the same. A claim was submitted but was repudiated by the respondent Insurer. Hence this complaint.

Respondent-Insurer to pay to the complainant the eligible claim.

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Award No. IO/KOC/A/GI/0085/2014-15

Complaint No. KOC-G-048-1415-0037

Award Passed on 27.10.2014

Sri. S. Purushothaman Nair Vs. National Insurance Co.Ltd.

Increase in Individual Mediclaim premium

The complainant has a mediclaim policy with the respondent insurer for many years. Until the year 2013-14 the premium paid was Rs.6,276/-, but for renewal for the year 2014-15, he has been asked to pay premium of over Rs.14,000/-. The complainant informs that the increase was not intimated to him in advance. He has represented the case with the company for sympathetic reconsideration of premium, but was not successful. Hence this complaint.

Respondent-Insurer to renew the policy for this current year (2014-15) at the same premium as for year 2013-14.

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Award No. IO/KOC/A/GI/0086/2014-15

Complaint No. IO/KCH/GI/11-004-729/12-13

Award Passed on 28.10.2014

Sri. P.T. Gangadharan Nair Vs. United India Insurance Co.Ltd.

Repudiation of Individual Mediclaim

The complainant has been insured under a mediclaim policy with the respondent insurer for many years (from 2001 onwards). A claim was submitted on 04/02/2012. The claim amount was Rs.9,184/-. The TPA (E-Meditek has been calling for documents and clarifications repeatedly. All possible documents have been submitted, so far the claim has not been paid. All appeals to the Insurer and the TPA have been in vain. Hence this complaint.

Respondent-Insurer to pay the admissible amount under this claim.

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Award No. IO/KOC/A/GI/0087/2014-15

Complaint No. IO/KCH/GI/11-004-532/12-13

Award Passed on 03.11.2014

Sri. Shibu Lonappan Vs. United India Insurance Co.Ltd.

Repudiation of Individual Mediclaim

The complainant has a mediclaim policy with the respondent. This policy was taken as a transfer from another insurer with whom the complainant had a policy for 3 previous years. The agent of the respondent Insurer has confirmed that the policy can be transferred and all benefits would still be payable and it would be treated as a continuation of the old policy only. Accordingly, all necessary forms to transfer this policy to the respondent Insure has been signed and submitted. A policy document was also obtained. On a claim made for wife's treatment, it was informed that this is the first year and pre existing illness would not be covered. Numerous appeals to the respondent Insurer detailing the facts were in vain. Hence this

complaint.Respondent-Insurer to pay the admissible amount under this claim.

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Award No. IO/KOC/A/GI/0088/2014-15

Complaint No. IO/KCH/GI/11-004-638/12-13

Award Passed on 03.11.2014

Sri. Teffy Kochumathew Vs. United India Insurance Co.Ltd.

Repudiation of Individual Mediclaim

The complainant has a mediclaim policy with the respondent. The period of coverage under the said policy is from 10/03/2011 to 09/03/2012. During the first week of March 2011, his daughter (who is also covered under the policy) was ill. After many visits to the doctor it was found that she was in need of an operation and the same was done in May 2011. Necessary claim forms were submitted to the respondent Insurer, which was repudiated by then stating that it was a "pre existing illness" and congenital in nature. Appeals to the insurer were in vain, hence this complaint.

Respondent-Insurer to pay the admissible amount under this claim.

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Award No. IO/KOC/A/GI/0089/2014-15

Complaint No. IO/KCH/GI/11-004-862/12-13

Award Passed on 03.11.2014

Sri. Joy Thomas Vs. United India Insurance Co.Ltd.

Repudiation of Family Medicare Insurance claim

The complainant has a family medicare policy with the respondent insurer since 2010. The complainant had a fall due to which he had to undergo knee replacement surgery. He has preferred a claim to the respondent insurer, but it was rejected by the TPA.

Respondent-Insurer to pay the admissible amount under this claim as a special case .

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Award No. IO/KOC/A/GI/0090/2014-15

Complaint No. IO/KCH/GI/11-003-950/12-13

Award Passed on 03.11.2014

Smt. N. B. Kamalam Vs. National Insurance Co.Ltd.

Repudiation of Individual Mediclaim

The complainant has a mediclaim policy with the respondent insurer . Her daughter underwent hospitalization and a claim was preferred with the respondent insurer .However the claim was repudiated citing, clause 4.1- pre-existing illnesses. Appeals to the respondent Insurer was in vain. Hence this complaint.

Respondent-Insurer to pay the admissible amount under this claim as a special case.

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Award No. IO/KOC/A/GI/0091/2014-15

Complaint No. IO/KCH/GI/11-005-438/13-14

Award Passed on 03.11.2014

Sri. P. Jerome Vs. Oriental Insurance Co.Ltd.

Repudiation of Individual Mediclaim claim

The complainant is a senior citizen has taken PNB-Oriental royal Mediclaim Policy from 2010 and has been renewing the same till date. He was hospitalized for 3 days in March 2013. The claim forms were submitted but was repudiated by the company informing that there was a break in the policy and hence the present policy would be treated as a new one in which the ailments were excluded for a period of two years from inception.

Respondent Insurer to pay admissible claim.

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Award No. IO/KOC/A/GI/0100/2014-15

Complaint No. IO/KCH/GI/11-014-687/2012-13

Award Passed on 07.11.2014

Sri. George Varghese Vs. Cholamandalam MS General Ins.Co.Ltd.

Repudiation of Health Insurance claim

The complainant had remitted the premiums for a health policy. He has submitted claims to the company through an executive of the Insurer in 2009 and 2010. Due to non receipt of the claim even after a long delay, enquiries were made with the Insurer. He came to understand that the claims were submitted to the office only after almost two years. This was not due to any fault of the complainant and the insurer has to pay the claims, which was repudiated by the insurer. Hence this complaint.

Complaint is dismissed.

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Award No. IO/KOC/A/GI/0102/2014-15

Complaint No. IO/KCH/GI/11-002-686/2012-13

Award Passed on 13.11.2014

Sri. Andrews Peter Vs. New India Assurance Co.Ltd.

Non-receipt of surrender value

The complainant had taken a Policy from the respondent insurer (policy No 76040148010056 issued on 11/03/2012). The complainant has requested for surrender of the policy. The request was denied, hence this complaint.

Since the proceeds have been credited directly to the bank account of the complainant on 20/12/2012, the complaint is dismissed.

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Award No. IO/KOC/A/GI/0103/2014-15

Complaint No. IO/KCH/GI/11-002-713/2012-13

Award Passed on 13.11.2014

Smt.Maya Muralidharan Vs. New India Assurance Co.Ltd.

Partial repudiation of mediclaim

The complainant was covered under Mediclaim policy No. 760403/34/11/06/00000029 for the period from 30.06.2011 to 29.06.2012. She was hospitalized at Mar Baselious Medical Mission Hospital, Kothamanagalam due to fever, cough and wheezing from18.05.2012 for 6 days. She was again admitted at Matha Hospital, Thellakom, Kottayam for the same disease from 25.05.2012 to 28.05.2012. She had also obtained ENT consultation during the second hospitalisation. Though she applied for Cashless facility the same was denied. After discharge from the hospital, she submitted claim for reimbursement of hospitalisation expenses of Rs.6,038/- and Rs.9,226/- respectively for the first and second hospitalisation. The Respondent-Insurer settled only Rs.4,987/-. Her request to the insurer for reconsideration of the claim was in vain. Hence this complaint. Relief sought is for the full claim amount.

Respondent-Insurer to pay eligible claim to the complainant for both hospitalizations.

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Award No. IO/KOC/A/GI/0105/2014-15

Complaint No. IO/KCH/GI/11-005-422/2012-13

Award Passed on 14.11.2014

Sri.P A Sinik Vs. Oriental Insurance Co.Ltd.

Repudiation of Individual Mediclaim

The complainant had a policy with the respondent Insurer for the period from 28/10/2011 to 27/10/2012. His wife and son were also covered under the policy. The complainant's wife was hospitalized from 23/01/2012 to 30/01/2012. The claim for the same was lodged immediately. The claim was repudiated citing

delay in intimation and pre-existing illness. Appeals were in vain. Hence this complaint.

Complaint is dismissed.

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Award No. IO/KOC/A/GI/0106/2014-15

Complaint No. IO/KCH/GI/11-002-545/2012-13

Award Passed on 14.11.2014

Sri.PD Jose Vs. New India Assurance Co.Ltd.

Repudiation of Individual mediclaim

The complainant had a policy with the respondent Insurer for 10 years taken through Citibank and his wife had undergone operation for multiple Myeloma of Uterus on 25/04/2012. The claim was submitted on 08/05/2012 and partial claim of Rs13000/- was received on 16/08/2012. The total hospital bills amounted to Rs 98,249/-. Appeals made to the Insurer have not yielded any response. Hence this complaint.

Respondent Insurer is directed to pay the balance claim of Rs.10,000/- with simple interest at the rate of 9% p.a. from the date of claim till the date of award.

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Award No. IO/KOC/A/GI/0107/2014-15

Complaint No. IO/KCH/GI/11-005-594/2012-13

Award Passed on 14.11.2014

Sri.P M Sebastian Vs. Oriental Insurance Co.Ltd.

Repudiation of Individual mediclaim

The complainant had a mediclaim policy with the respondent Insurer (policy No 440102/48/2012/2340 for the period 09/09/2011 to 08/09/2012).His wife was hospitalized in May 2012 and claim was submitted. The same was rejected by the respondent Insurer citing exclusion clause 4.12 of the policy (treatment traceable to pregnancy…..). The complainant submits that neither he nor his wife was aware of the condition of tubular pregnancy and only on hospitalization, they came to know about the same. The

operation was done to save the life of the complainant's wife as this condition was life threatening. Appeals to the Insurer were in vain, hence this complaint.

Respondent Insurer is directed to pay the admissible claim.

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Award No. IO/KOC/A/GI/0110/2014-15

Complaint No. IO/KCH/GI/11-003-968/2012-13

Award Passed on 19.11.2014

Sri. K.T. Abdulla Vs. National Insurance Co.Ltd.

Repudiation of Individual Mediclaim

the complainant and his family were covered under a medi-claim policy of the respondent insurance Company. A claim towards hospitalisation of his wife was preferred with the Insurance Company, which was repudiated by stating that the ailment does not come under the ambit of the policy, since it is a pre-existing disease. As the disputes regarding this could not be settled among themselves, a complaint was filed before this Forum.

Respondent-Insurance company to admit the eligible claim.

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Award No. IO/KOC/A/GI/0111/2014-15

Complaint No. IO/KCH/GI/11-003-254/2012-13

Award Passed on 19.11.2014

Sri. P Rajan Vs. National Insurance Co.Ltd.

Repudiation of Individual Medi-Claim

The complainant and his wife were covered under a medi-claim policy of the respondent Insurance Company. A claim towards hospitalization of his wife was preferred with the Insurance Company, which was repudiated by stating that the admission was not followed by any active line of treatment. As the disputes regarding this could not be settled among themselves, a complaint was filed before this Forum. Respondent Insurance Company to admit the eligible claim.

Award No. IO/KOC/A/GI/0112/2014-15

Complaint No. IO/KCH/GI/11-003-525/2013-14

Award Passed on 19.11.2014

Sri. K Sasi Vs. National Insurance Co.Ltd.

Repudiation of Individual Medi-Claim

The complainant was covered under a Medi-claim policy of the respondent Insurance Company. A claim towards hospitalization was preferred with the Insurance Company, which was repudiated by stating that the treatment was relating to infertility which is an excluded item under the policy. Since the disputes regarding this could not be settled among themselves, a complaint was filed before this Forum.

Respondent Insurance Company to admit the eligible claim.

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Award No. IO/KOC/A/GI/0113/2014-15

Complaint No. IO/KCH/GI/11-003-792/2013-14

Award Passed on 19.11.2014

Sri. T S Sivadasan Vs. National Insurance Co.Ltd.

Repudiation of individual mediClaim

The complainant and his family were covered under a medi-claim policy of the respondent Insurance Company. A claim towards hospitalization of his son was preferred with the Insurance Company, which was repudiated by stating that the ailment does not come under the ambit of the policy, since it is a pre-existing disease. As the disputes regarding this could not be settled among themselves, a complaint was filed before this Forum.

Respondent Insurance Company to admit the eligible claim.

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Award No. IO/KOC/A/GI/0117/2014-15

Complaint No. IO/KCH/GI/11-017-962/2012-13

Award Passed on 21.11.2014

Sri. Radhakrishnan Nair Vs. Star Health & Allied Insurance Co.Ltd.

Repudiation of Individual Mediclaim

The complainant has taken a mediclaim policy from the respondent Insurer. The complainants wife was admitted to the hospital on two occasions in May and June 2012. The claims were submitted and the insurer has paid the amount after deducting some amount from the total claim made. After three months of continuous treatment, his wife was advised by the treating doctors to undergo an MRI scan to evaluate the progress of the treatment. Accordingly the MRI was taken and a claim made to the respondent Insurer to the extent of Rs.9,698/- which was not paid.

Complaint is dismissed.

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Award No. IO/KOC/A/GI/0118/2014-15

Complaint No. IO/KCH/GI/11-017-620/2012-13

Award Passed on 21.11.2014

Smt. Kala Nair Vs. Star Health & Allied Insurance Co.Ltd.

Repudiation of Individual Mediclaim

The complainant has taken a family health optima policy from the respondent insurer. The entire family (including her husband and daughter) was hospitalized at the same time due to Hepatitis A infection. The hospitalization period was from 13/10/2011 till 27/10/2011. Since the whole family was in hospital, they were looking to the cashless benefit under their insurance policy. The respondent Insurer has not settled the full claim and the family was put to a lot of trouble trying to settle the hospital dues etc. An amount of Rs.44,545/- is still due from the respondent Insurer.

Respondent Insurer to pay all eligible claims under the policy with simple interest at 9%p.a. from the date of claim till the date of award.

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Award No. IO/KOC/A/GI/0119/2014-15

Complaint No. IO/KCH/GI/11-017-643/2012-13

Award Passed on 21.11.2014

Sri. Kuriakose Mathai Vs. Star Health & Allied Insurance Co.Ltd.

Repudiation of Individual Health claim

The complainant has taken a Family Optima Health Policy from the respondent Insurer. The complainant's wife and child are also covered under the same. There were two instances of hospitalization of the complainants son. Claim forms were submitted to the Insurer, but the claims have been repudiated. The letter sent to the grievance cell also did not provide any relief, hence this complaint.

Respondent Insurer to pay eligible amounts under the two claims.

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Award No. IO/KOC/A/GI/0121/2014-15

Complaint No. IO/KCH/GI/11-017-972/2012-13

Award Passed on 21.11.2014

Sri. V Pradeep Kumar Vs. Star Health & Allied Insurance Co.Ltd.

Repudiaiton of Individual Mediclaim

The complainant has taken a policy for his parents and in-laws from the respondent insurer from 12/2011. In April 2012, his mother in law complained of swelling on her breast and consulted the gynaecologist at PRS Hospital , Trivandrum. Subsequently a biopsy was conducted and an operation to remove lumps in her breast was done at the same hospital. She was under treatment and chemotherapy thereafter. The hospitalizations were intimated to the respondent insurer in time and all claim forms with the medical records submitted. However all claims were repudiated citing pre-existing illness. This was determined as the medical records mentioned the symptoms were present for 6 months, which meant that it was present before the policy incepted. Appeal to the grievance cell also did not yield any positive result, hence this complaint. Respondent Insurer to pay all eligible claims under the policy.

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Award No. IO/KOC/A/GI/0122/2014-15

Complaint No. IO/KCH/GI/11-017-279/2013-14

Award Passed on 21.11.2014

Sri. S Anas Vs. Star Health & Allied Insurance Co.Ltd.

Repudiation of Health Insurance claim

The complainant has taken a Family Optima Health Policy from the respondent Insurer. In June 2012 the complainants wife was admitted to SAT Hospital for severe respiratory problems .She was shifted to KIMS Hospital , Trivandrum due to the complications. Detailed investigations showed that she was having ovarian tumour and the respiratory problems were due to the pleural effusion from the tumour. Urgent ceaserian section was performed to take the baby out and also to remove the tumour. The tumour was found to be cancerous and chemotherapy was done at RCC, Trivandrum. The complainant's wife was again admitted to SK Hospital due to cerebral venous thrombosis. Claims were submitted to the insurer. The claims were repudiated stating that exclusion clause 14 is applicable (expenses relating to pregnancy/related treatments or complications arising from child birth). This complaint is filed due to the repudiation action.

Respondent Insurer to pay eligible amounts under the two claims.

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Award No. IO/KOC/A/GI/0123/2014-15

Complaint No. IO/KCH/GI/11-017-698/2013-14

Award Passed on 21.11.2014

Sri. P J Mathew Vs. Star Health & Allied Insurance Co.Ltd.

Repudiation of Health Insurance claim

The complainant has taken a Family Health Optima policy from the respondent Insurer for the last three years. The complainant is also an advisor of the company. For the year 2009-10, the complainant was a policyholder with another insurer, however, agents of the respondent Insurer has induced him to shift to this company. The

policy is being continued from 2010 onwards. In June 2013, wife of complainant was hospitalized and claims were submitted. However the claim was repudiated. Appeals to the insurer have not yielded any result. Hence this complaint.

Respondent Insurer to pay eligible amount.

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Award No. IO/KOC/A/GI/0124/2014-15

Complaint No. IO/KCH/GI/11-017-235/2013-14

Award Passed on 21.11.2014

Smt. Mangalam Chandragupthan Vs. Star Health & Allied Insurance Co.Ltd.

Repudiation of Individual Mediclaim

The complainant has taken a policy from the respondent Insurer from 04/2011. A claim was lodged on 10/10/2012 for hospitalization from 28/09/2012 to 05/12/2012. The treating doctor and the discharge summary certify that the conditions for hospitalizations are only three months old. The claim was repudiated on the ground that there was "pre existing illness" and "suppression of material information". Appeals to reconsider the claim did not yield any result, hence this complaint.

Respondent Insurer to pay eligible claim.

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Award No. IO/KOC/A/GI/0125/2014-15

Complaint No. IO/KCH/GI/11-004-818/13-14

Award Passed on 28.11.2014

Sri. A. S. Joseph Vs. United India Insurance Co. Ltd.

Partial Repudiation of Individual mediclaim

The complainant was covered under a medi-claim scheme of the respondent Insurance Company. He was hospitalized in February, 2013. He preferred a claim towards reimbursement of hospitalization expenses. Due to delay in settlement of claim, a complaint was filed before this Forum.

Respondent Insurance Company has acted as per the terms and conditions of the policy in admitting the claim and it has properly narrated and clarified everything in detail during the hearing session, the complainant's demand for balance amount is devoid of merits and not admissible.

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Award No. IO/KOC/A/GI/0126/2014-15

Complaint No. IO/KCH/GI/11-004-752/12-13

Award Passed on 28.11.2014

Sri. A. K. Jayaprakash Vs. United India Insurance Co. Ltd.

Repudiation of Individual Mediclaim

The complainant and his family were covered under a medi-claim policy of the respondent Insurance Company. His wife was hospitalized in 10/2011 and a claim towards the same had been submitted to the TPA of the Insurer. Due to non receipt of claim amount, follow-up was done with the TPA and they informed that no claim forms were received by them in connection with the treatment of his wife. Since the dispute was not resolved amicably, a complaint was filed before this Forum. Respondent insurer to pay the admissible claim after collecting certified copies of Bills, discharge summary etc.

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Award No. IO/KOC/A/GI/0129/2014-15

Complaint No. IO/KCH/GI/11-004-743/13-14

Award Passed on 28.11.2014

Smt. K. Fathima Vs. United India Insurance Co. Ltd.

Repudiation of individual mediclaim

The complainant was covered under a medi-claim policy of the respondent Insurer. She was hospitalized in 4/2012, for which a claim was preferred with the respondent insurance company. The claim was repudiated by the company stating that the ailment did not require any hospitalization. The dispute regarding this could not be settled among themselves, a complaint was filed before this Forum. Complaint is dismissed.

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Award No. IO/KOC/A/GI/0130/2014-15

Complaint No. IO/KCH/GI/11-004-368/2013-14

Award Passed on 28.11.2014

Sri. C. V. Joy Vs. United India Insurance Co Ltd

Repudiation of mediclaim

The complainant, who along with his family is covered under the mediclaim policy issued by the respondent Insurer, filed a claim for his child's operation (umbilical Hernia). The hospitalization period was from 02/12/2012 to 05/12/2012. This was repudiated by the respondent Insurer stating that the same was congenital and not covered under the scope of the policy.

Respondent Insurer to pay the eligible amount under the claim along with simple interest at 9% p.a. from date of complaint (20/09/2013) till date of award(28.11.2014).

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Award No. IO/KOC/A/GI/0136/2014-15

Complaint No. IO/KCH/GI/11-004-501/2013-14

Award Passed on 28.11.2014

Sri. T. S. Mohanan Vs. United India Insurance Co. Ltd.

Repudiation of Individual Mediclaim

The complainant, who along with his family is covered under the mediclaim policy issued by the respondent Insurer, filed a claim for his wife's treatment from 18/12/2012 to 21/12/2012 at Westfort Hospital. The claim was repudiated stating that the treatment could have been taken on OPD basis and there was no necessity for admission. A certificate from the treating doctor was produced to the respondent Insurer which stated the reason for hospitalization and the fact that the decision regarding hospitalization is under the purview of the treating doctor. Appeals were in vain, hence this complaint.Respondent Insurer to pay the eligible amount under the claim along with simple interest.

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Award No. IO/KOC/A/GI/0137/2014-15

Complaint No. IO/KCH/GI/11-005-738/2013-14

Award Passed on 28.11.2014

Sri. T. S. Sreenivasan Vs. Oriental Insurance Co. Ltd.

Repudiation of individual mediclaim

The complainant, who is covered under the mediclaim policy submitted a claim on his wife's life for hospitalization from 28/03/2013 to 15/04/2013 at Sreedhareeyam Ayurvedic Hospital. The claim was repudiated vide Clause no 2.1 of the policy. The complainant states that the contention of the insurer is not correct as the hospital is fully accredited and has all the necessary approvals. Appeals to the Insurer has not borne fruit, hence this complaint.

Respondent-Insurer to make payment of eligible claim.

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Award No. IO/KOC/A/GI/0144/2014-15

Complaint No. IO/KCH/GI/14-004-659/2012-13

Award Passed on 03.12.2014

Sri. M Abdul Gafoor Vs. The United India Insurance Co. Ltd.

Repudiation of Individual mediclaim

The complainant had taken a Medi-claim policy from the respondent Insurer which covered his father also. Both the complainant and his father were hospitalized in May, 2010. Claims were preferred with the TPA of the Insurer with all the required documents. However, the claims have not been settled. The dispute regarding this could not be resolved, a complaint was filed before this Forum.

Respondent-Insurer to admit the eligible claim.

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Award No. IO/KOC/A/GI/0146/2014-15

Complaint No. KOC-G-044-1415-0003

Award Passed on 03.12.2014

Sri. S Byju Vs. Star Health & Allied Insurance Co.Ltd.

Repudiation of individual mediclaim

The complainant has taken a Basic floater Star health mediclaim Policy from the respondent Insurer with a coverage of Rs.3,00,000/-. In January 2013, the complainant suffered heart pain and was admitted to two hospitals, ie, Upasana Hospital and for further investigations in NIMS Hospital. The admission was intimated to the respondent insurer. The insurer has assured that the claim would be sanctioned soon. However vide letter dated 29/08/2013, it was informed that the claims were repudiated. Appeal was preferred, which was not positively considered, hence this complaint.

Respondent Insurer to pay Rs1,00,000/- as Ex-Gratia.

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Award No. IO/KOC/A/GI/0147/2014-15

Complaint No. IO/KCH/GI/11-017-132/13-14

Award Passed on 03.12.2014

Sri. Jojo K Jose Vs. Star Health & Allied Insurance Co.Ltd.

Delay in settlement of individual mediclaim

The complainant was offered a Medi-claim policy by the Respondent-Insurer for a sum assured of Rs. 4 Lakhs at a premium of Rs.9,758/-. Later on, a policy was issued for a sum assured of Rs. 2 Lakhs, contrary to the promise. He approached the Insurer for cancellation and refund of premium which was not allowed instantly but later on acceded. However, his request for interest on delayed settlement and loss of rebate towards income tax, was not acceded to by the Company. Since the dispute regarding this could not be resolved among them, a complaint was filed before this Forum.

Complaint is dismissed.

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Award No. IO/KOC/A/GI/0152/2014-15

Complaint No. IO/KCH/GI/11-004-739/2012-13

Award Passed on 04.12.2014

Sri. N. Seshadri Vs. United India Insurance Co. Ltd.

Repudiation of Individual Mediclaim

the complainant and his wife were covered under a Medi-claim Policy of the respondent Insurance Company. The complainant's wife was hospitalized in 10/2009 and a claim was preferred for reimbursement of expenses towards hospitalization which was rejected by the Insurer. Disputes regarding this could not be resolved among them, a complaint was filed before this Forum.

Respondent insurer to pay to the Complainant the admissible claim amount.

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Award No. IO/KOC/A/GI/0154/2014-15

Complaint No. IO/KCH/GI/13-005-125/13-14

Award Passed on 05.12.2014

Dr. P Ajit Prasanth Vs. Oriental Insurance Co. Ltd.

Repudiation of Individual Mediclaim

The complainant has taken a Happy Family Floater policy from the respondent Insurer from 2009 onwards. The complainant has received a letter from the insurer that the policy cannot be renewed henceforth because the complainant has claimed the full sum insured. Appeals were not considered favourably and hence this complaint.

Complaint is dismissed.

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Award No. IO/KOC/A/GI/0162/2014-15

Complaint No. IO/KCH/GI/11-005-836/2012-13

Award Passed on 10.12.2014

Smt. A N Kamalamma Vs. Oriental Insurance Co. Ltd.

Repudiation of individual mediclaim

The complainant was covered under a mediclaim policy taken from the respondent Insurer. She was hospitalized in 03/2012. A claim was preferred which was rejected. Her appeals to the higher offices of the insurer did not evoke any positive response, hence this complaint.

Complaint is dismissed.

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Award No. IO/KOC/A/GI/0163/2014-15

Complaint No. IO/KCH/GI/11-005-667/2012-13

Award Passed on 10.12.2014

Sri. K G Thomas Vs. Oriental Insurance Co. Ltd.

Repudiation of Individual mediclaim

The complainant who is covered under the mediclaim policy had submitted a claim for cataract operation of Smt Selvy Thomas who is also covered under the policy. The claim was rejected, hence this complaint.

Complaint is dismissed.

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Award No. IO/KOC/A/GI/0165/2014-15

Complaint No. IO/KCH/GI/13-004-901/2012-13

Award Passed on 10.12.2014

Sri. V C Baby Vs. United India Insurance Co. Ltd.

Non-renewal of Individual mediclaim policy

The complainant has availed of a mediclaim policy through the State Bank Of Travancore who had an offer for all their savings account holders. The premium was being automatically deducted from the savings bank account held with the bank. During regular updation of the passbook the complainant has come to know that the premium has not been deducted in 11/2012. On an enquiry with the bank, he was informed that the scheme was closed by the respondent Insurer. This fact was not informed to the policyholder either orally or in writing. On contacting the respondent Insurer, it was informed that since 15 days are over from expiry of the policy, nothing can be done. Appeals to the grievance cell did not elicit any positive response, hence this complaint.

Complaint is dismissed.

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Award No. IO/KOC/A/GI/0166/2014-15

Complaint No. IO/KCH/GI/11-004-621/2012-13

Award Passed on 10.12.2014

Sri. T V Chandran Vs. United India Insurance Co. Ltd.

Repudiation of individual mediclaim

The complainant and his wife were covered under the AB Arogyadaan Mediclaim policy of the respondent Insurance Company. The complainant's wife was admitted in an Ayurveda Hospital from 09/11/2010 to 18/11/2010. A claim was preferred for reimbursement of expenses towards hospitalization which was rejected as per exclusion clause 4.13 of Terms and conditions of the policy. The dispute regarding this could not be resolved among them, a complaint was filed before this Forum.Respondent insurer to pay to the Complainant the admissible claim amount.

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Award No. IO/KOC/A/GI/0170/2014-15

Complaint No. IO/KCH/GI/11-002-853/2012-13

Award Passed on 10.12.2014

Sri. Alroy Aloysius Vs. New India Assurance Co. Ltd.

Repudiation of individual mediclaim

The complainant was covered under a Medi-claim Policy of the respondent Insurance Company. The complainant was hospitalized in 10/2012 and a claim was preferred for reimbursement of expenses towards hospitalization which was partially settled by the Insurer. Disputes regarding this could not be resolved among them, a complaint was filed before this Forum.

Respondent insurer to pay the Complainant the disallowed proportionate charges.

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Award No. IO/KOC/A/GI/0173/2014-15

Complaint No. IO/KCH/GI/11-005-59/2013-14

Award Passed on 10.12.2014

Sri. M K Natarajan Nair Vs. Oriental Insurance Co. Ltd.

Repudiation of individual mediclaim

The complainant was covered under a Medi-claim Policy of the respondent Insurance Company. The complainant was hospitalized in 12/2012 and a claim was preferred for reimbursement of expenses towards hospitalization which was rejected by the Insurer. Disputes regarding this could not be resolved among them, a complaint was filed before this Forum.

Respondent insurer to pay to the Complainant the admissible claim amount.

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Award No. IO/KOC/A/GI/0176/2014-15

Complaint No. IO/KCH/GI/11-003-612/2012-13

Award Passed on 11.12.2014

Sri. G K Prakash Vs. National Insurance Co. Ltd.

Repudiation of individual mediclaim

The complainant was covered under a Medi-claim Policy of the respondent Insurance Company. The complainant was treated for Diabetic Retinopathy and a claim was preferred for reimbursement of expenses towards laser treatment which was repudiated by the Insurer. Disputes regarding this could not be resolved among them, a complaint was filed before this Forum.

Respondent Insurer to pay the complainant the eligible amount of claim.

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Award No. IO/KOC/A/GI/0178/2014-15

Complaint No. IO/KCH/GI/11-004-826/2012-13

Award Passed on 11.12.2014

Sri. Paul Varkey Vs. United India Insurance Co. Ltd.

Repudiation of individual medi claim

The complainant and his family were covered under a Medi-claim Policy of the respondent Insurance Company. The complainant's daughter was hospitalized in 09/2012 and a claim was preferred for reimbursement of expenses towards hospitalization which was partially settled by the Insurer. Disputes regarding this could not be resolved among them, a complaint was filed before this Forum.

Respondent insurer to pay the Complainant the disallowed proportionate charges.

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Award No. IO/KOC/A/GI/0179/2014-15

Complaint No. IO/KCH/GI/14-004-704/2012-13

Award Passed on 11.12.2014

Sri. G.Ajith Kumar Vs. United India Insurance Co. Ltd.

Repudiation of individual medi claim

the complainant and his family were covered under a Medi-claim Policy of the respondent Insurance Company. The complainant's wife was hospitalized in 05/2012 and a claim was preferred for reimbursement of expenses towards hospitalization which was repudiated by the Insurer. Disputes regarding this could not be resolved among them, a complaint was filed before this Forum.

Respondent Insurer to pay the complainant the eligible amount of claim.

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Award No. IO/KOC/A/GI/0191/2014-15

Complaint No. IO/KCH/GI/11-005-210/13-14

Award Passed on 17.12.2014

Sri. G A Vareed Vs. Oriental Insurance Co. Ltd.

Repudiation of individual medi claim

The complainant who has taken a mediclaim policy from the respondent Insurer submitted a claim for his father's hospitalization for liver ailments from 19/11/2012 to 22/11/2012, which was rejected by the respondent Insurer. The repudiation of claim was done as per Clause No 4.8 of the policy. Aggrieved by this, complaint has been preferred.

Complaint is dismissed.

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Award No. IO/KOC/A/GI/0193/2014-15

Complaint No. IO/KCH/GI/11-005-522/13-14

Award Passed on 17.12.2014

Sri. T P Varghese Vs. Oriental Insurance Co. Ltd.

Repudiation of individual mediclaim

The complainant who is covered under the mediclaim policy submitted a claim for his wife's hospitalization for acute migraine+DM+HTN from 19/04/2013 to 20/04/2013, which was rejected by the respondent Insurer. The repudiation of claim was done as per Clause No 4.10 of the policy. Aggrieved by this, complaint has been preferred.

Respondent Insurer to pay the eligible claim.

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Award No. IO/KOC/A/GI/0194/2014-15

Complaint No. KOC-G-049-1415-0187

Award Passed on 17.12.2014

Sri. P. Gangadharan Vs. New India Assurance Co. Ltd.

Repudiation of individual mediclaim

The complainant who is covered under the mediclaim policy submitted a claim for his own hospitalization from 14/06/2014 to 16/06/2014, which was rejected by the respondent Insurer. The partial repudiation of claim was done as per Clause No 3.37 of the policy. Aggrieved by this, complaint has been preferred.

Complaint is dismissed..

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Award No. IO/KOC/A/GI/0200/2014-15

Complaint No. IO/KCH/GI/13-003-418/13-14

Award Passed on 18.12.2014

Sri. K M Karunan Vs. National Insurance Co. Ltd.

Non-renewal of individual mediclaim policies

The complainant and his family members were covered under a Medi-claim Policy of the respondent Insurance Company introduced in association with Vijaya Bank. The Son of the complainant was deleted from the policy with an assurance that he can take a fresh policy with continuity benefits. Later, these benefits were denied. Disputes regarding this could not be resolved among them, a complaint was filed before this Forum.

Complaint is dismissed.

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Award No. IO/KOC/A/GI/0202/2014-15

Complaint No. IO/KCH/GI/11-002-861/2012-13

Award Passed on 18.12.2014

Sri. S.B.K Menon Vs. New India Assurance Co. Ltd.

Refund of additional premium-individual mediclaim

The complainant and his wife were covered lifelong under the Senior Citizens'Unit plan (SCUP) which was jointly offered by the above insurer and UTI, since 1999 onwards. Later they applied for a medi-claim insurance offered to senior citizens by the insurer, in order to get an enhanced cover. However, on issue of the policy, he learnt that additional premium was charged in his wife's case and heart disease was excluded in his case. He requested for waiver of exclusions and refund of additional premium. The dispute regarding this could not be resolved among them, a complaint was filed before this Forum.

Respondent insurer to consider cover for heart disease also in the policy.

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Award No. IO/KOC/A/GI/0203/2014-15

Complaint No. IO/KCH/GI/11-003-453/13-14

Award Passed on 18.12.2014

Sri. M O Jaymes Vs. National Insurance Co. Ltd.

Repudiation of individual mediclaim

The complainant took a mediclaim policy from the respondent Insurer. A claim was submitted for hospitalization of his wife in 01/2012. The respondent Insurer has not settled the claim so far, hence the complaint.

Respondent Insurer to settle the eligible claim.

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Award No. IO/KOC/A/GI/0207/2014-15

Complaint No. IO/KCH/GI/11-005-237/13-14

Award Passed on 18.12.2014

Sri. T P Shibu Vs. Oriental Insurance Co. Ltd.

Repudiation of individual mediclaim

The complainant and his family members were covered under a Medi-claim Policy of the respondent Insurance Company. The father of the complainant was hospitalized and claim was preferred for reimbursement of expenses which was repudiated by the Insurer. Disputes regarding this could not be resolved among them, a complaint was filed before this Forum.

Respondent Insurer to pay the complainant a sum of Rs.5,000/- as ex-gratia.

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Award No. IO/KOC/A/GI/0208/2014-15

Complaint No. IO/KCH/GI/11-004-304/13-14

Award Passed on 18.12.2014

Sri. M D Abraham Vs. United India Insurance Co. Ltd.

Repudiation of individual mediclaim

The complainant has a mediclaim policy issued by the respondent Insurer. The complainant underwent cataract operation and the bills for Rs.24,309/- were sent to the insurer for the claim. However only Rs.19,416/- was received on settlement. Hence this complaint, to obtain the full claim amount.

Complaint is dismissed.

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Award No. IO/KOC/A/GI/0211/2014-15

Complaint No. IO/KCH/GI/11-017-199/13-14

Award Passed on 18.12.2014

Sri. Imthy Keloth Vs. Star Health & Allied Ins.Co.Ltd.

Repudiation of individual mediclaim

The complainant was covered under a Medi-claim Policy of the respondent Insurance Company. The complainant was hospitalized in 05/2012 and a claim was preferred for reimbursement of expenses towards hospitalization which was repudiated by the Insurer. Disputes regarding this could not be resolved among them, a complaint was filed before this Forum.

Complaint is dismissed.

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Award No. IO/KOC/A/GI/0213/2014-15

Complaint No. IO/KCH/GI/11-017-447/13-14

Award Passed on 26.12.2014

Smt. Alphonsa Gracy Varghese Vs. Star Health & Allied Insurance Co.Ltd.

Repudiation of health insurance claim

The complainant had taken a health policy from the respondent Insurer. The complainant was hospitalized from 21/01/2013 to 04/02/2013 and a claim was made for Rs.45,990/- out of which the insurer had sanctioned an amount of Rs.23,900/-. On a request to revise the amount, the insurer informed that the claim has been closed, hence this complaint.

Respondent Insurer to settle the claim for Rs.30,000/- to the complainant.

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Award No. IO/KOC/A/GI/0214/2014-15

Complaint No. IO/KCH/GI/11-023-140/13-14

Award Passed on 31.12.2014

Sri. Kurian Jose Vs. Max Bupa Health Insurance Co.Ltd.

Repudiation of health insurance claim

The complainant and his family members were covered under a Health policy of the respondent Insurance Company, since January, 2012. Prior to January, 2012, they had Health policies from National Insurance and New India Assurance Co.Ltd. As Max Bupa Health Insurance Company had offered to upgrade their coverage with continuity, they had opted to take policy from them. His daughter-in-law was hospitalized in October, 2012, for an operation at Lourdes Hospital, Ernakulam. He preferred a claim towards reimbursement of hospitalization expenses which had been rejected by the respondent Insurer by citing pre-existing ailments. Subsequently, the complainant approached the Grievance cell of the Insurance Company for a reconsideration of the matter which also did not yield any result. Respondent insurer to pay the admissible claim amount.

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Award No. IO/KOC/A/GI/0215/2014-15

Complaint No. KOC-G-051-1415-0027

Award Passed on 31.12.2014

Sri. Satheesh S. Vs. United India Insurance Co. Ltd.

Repudiation of individual mediclaim

The complainant and his family members were covered under a Medi-claim Policy of the respondent Insurance Company introduced in association with Syndicate Bank. The Son of the complainant was hospitalized and claim was preferred for reimbursement of expenses which was repudiated by the Insurer. Disputes regarding this could not be resolved among them, a complaint was filed before this Forum.

Respondent-Insurer to pay an amount of Rs.15,000/- (Rupees Fifteen Thousand only) as Ex-Gratia to the complainant.

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Award No. IO/KOC/A/GI/0219/2014-15

Complaint No. IO/KCH/GI/11-002-961/2012-13

Award Passed on 05.01.2015

Smt. Jubily Josy Vs. United India Insurance Co. Ltd.

Repudiation of individual mediclaim

The complainant had taken a mediclaim policy from the respondent Insurer (policy no 100200/48/11/97/00001963). The complainant was hospitalised and had submitted a claim to the insurer to the tune of Rs.67,727/-. The insurer has paid only Rs.12,500/-, i.e., 25% of the insured amount without assigning any reasons. The insurer has also not reconsidered the case on appeal, hence this complaint.

Respondent Insurer to pay an amount of Rs.10,000/- (Rupees Ten Thousand only) as Ex-Gratia.

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Award No. IO/KOC/A/GI/0220/2014-15

Complaint No. IO/KCH/GI/11-004-45/2013-14

Award Passed on 05.01.2015

Sri. S. Venkitaraman Vs. United India Insurance Co. Ltd.

Partial repudiation of individual medi claim

The complainant is covered under a mediclaim policy taken by his son from the respondent Insurer (policy no 101300/48/11/97/00001148). The complainant was hospitalised for ayurvedic treatment in 05/2012 and had submitted a claim to the insurer to the tune of Rs.52,794.20. The insurer has repudiated the claim as the treatment was not taken in a Government Hospital or Medical College. The insurer has also not reconsidered the case on appeal , hence this complaint.

Respondent Insurer to pay an amount of Rs.25,000/- (Rupees Twenty Five Thousand only) as Ex-Gratia.

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Award No. IO/KOC/A/GI/0224/2014-15

Complaint No. IO/KCH/GI/11-023-1029-13-14

Award Passed on 09.01.2015

Sri. Denny Paul Vs. Max Bupa Health Insurance Co.Ltd.

Repudiation of Individual mediclaim

The complainant had a valid mediclaim policy issued on 14/09/2012. The policyholder was informed that it would cover all diseases except those mentioned in the 9th page. The complainant had heart surgery in 03/2013 and spent a considerable amount. A claim was filed which was rejected. Hence this complaint.

Complaint is dismissed.

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Award No. IO/KOC/A/GI/0227/2014-15

Complaint No. IO/KCH/GI/11-005-095/13-14

Award Passed on 09.01.2015

Sri. A Induchoodan Vs. Oriental Insurance Co. Ltd.

Repudiation of individual mediclaim

The complainant had a valid mediclaim policy. The policyholder's wife was hospitalized for some days in 09/2012. The Insurer has not paid the claim, hence this complaint.

Complaint is dismissed.

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Award No. IO/KOC/A/GI/0229/2014-15

Complaint No. IO/KCH/GI/11-004-703/2012-13

Award Passed on 09.01.2015

Sri.Sambhu Babu Vs. United India Insurance Co. Ltd.

Repudiation of individual mediclaim

The complainant had a policy with the respondent Insurer. He was hospitalised in 12/2011. A claim was preferred which was partially repudiated. An appeal to the Insurer was made on 21/09/2012 which was turned down, hence this complaint.

Respondent Insurer to pay the balance claim to the complainant along with simple interest of 9% p.a..

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Award No. IO/KOC/A/GI/0230/2014-15

Complaint No. IO/KCH/GI/11-003-484/13-14

Award Passed on 09.01.2015

Sri. N P Baji Vs. National Insurance Co. Ltd.

Repudiation of individual mediclaim

The complainant is the holder of a mediclaim policy valid from 21/08/2012 to 20/08/2013. In 03/2013 the complainant's wife was hospitalized for some days. Soon after, a claim was preferred which was repudiated, hence this complaint.

Complaint is dismissed.

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Award No. IO/KOC/A/GI/0231/2014-15

Complaint No. IO/KCH/GI/11-002-531/13-14

Award Passed on 09.01.2015

Smt. Mercy Francis Vs. New India Assurance Co. Ltd.

Repudiation of Individual mediclaim

The complainant is the holder of a mediclaim policy. On 16/04/2013 she had a fall from upstairs and sustained injury to her uterus. There was bleeding and the complainant was hospitalized for treatment. The complainant was discharged after 12 days and a claim was preferred to the respondent Insurer. The TPA has rejected the claim stating that the present claim has been excluded for the first two years from date of inception. The insured submitted that the current treatment is taken after a fall down the stairs and there is no waiting period for accidental hospitalization. Hence the claim should be paid in full.

Complaint is dismissed.

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Award No. IO/KOC/A/GI/0232/2014-15

Complaint No. IO/KCH/GI/11-003-863/2012-13

Award Passed on 09.01.2015

Sri. C.M. George Vs. National Insurance Co. Ltd.

Repudiation of Individual mediclaim

The complainant is the holder of a mediclaim policy valid from 08/11/2010 to 07/11/2011. The complainant's daughter was hospitalized for some days in 04/2011. Soon after, a claim was preferred which was repudiated, hence this complaint.

Complaint is dismissed.

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Award No. IO/KOC/A/GI/0235/2014-15

Complaint No. IO/KCH/GI/11-003-754/13-14

Award Passed on 13.01.2015

Sri. C. K. Krishnan Vs. National Insurance Co. Ltd.

Partial repudiation of Individual mediclaim

The complainant is holding a valid mediclaim insurance policy with the respondent Insurer. The complainant was hospitalised in 05/2013 and a claim was preferred. The claim was only partially settled. Appeals to the insurer did not yield any positive results, hence this complaint.

Respondent Insurer to pay the eligible claim to the complainant.

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Award No. IO/KOC/A/GI/0236/2014-15

Complaint No. IO/KCH/GI/11-003-171/13-14

Award Passed on 13.01.2015

Sri. K E Yesudas Vs. The National Insurance Co. Ltd.

Repudiation of individual mediclaim

The complainant is holding a valid mediclaim insurance policy with the respondent Insurer. He preferred a claim for hospitalisation of his wife. This claim was repudiated against which he has preferred appeal. The appeal did not have any positive result and hence this complaint.

Respondent Insurer to pay the eligible claim to the complainant with interest @9% p.a. from the date of claim to the date of payment and cost of Rs.2000/-

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Award No. IO/KOC/A/GI/0237/2014-15

Complaint No. IO/KCH/GI/11-002-456/13-14

Award Passed on 13.01.2015

Sri. S Radhakrishnan Vs. The New India Assurance Co. Ltd.

Repudiation of individual mediclaim

The complainant had a valid mediclaim policy from the respondent insurer. The policy was taken through Citibank. In 2012 the complainant's wife who is co-beneficiary fell ill and was diagnosed as having malignant growth in uterus. She underwent surgery and also 6 cycles of chemotherapy. Four claims were made.

Complaint is dismissed.

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Award No. IO/KOC/A/GI/0242/2014-15

Complaint No. IO/KCH/GI/11-004-68/13-14

Award Passed on 13.01.2015

Sri. M. F. Jinze Vs. United India Insurance Co. Ltd.

Repudiation of Individual Mediclaim

The complainant had a valid mediclaim policy. The policyholder's wife was hospitalized for some days in 05/2012. The Insurer has not paid the claim, hence this complaint.

Complaint is dismissed.

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Award No. IO/KOC/A/GI/0243/2014-15

Complaint No. IO/KCH/GI/11-004-135/13-14

Award Passed on 13.01.2015

Smt. A Malini POA holder of Smt. I Sarada Vs. United India Insurance Co. Ltd.

Partial repudiation of individual medi claim

The complainant is the Power of Attorney holder of Sri Sivaraman Nair who had a mediclaim policy valid from 05/07/2011 to 04/07/2012. The policyholder's wife was hospitalized for some days in 05/2012 for Byepass surgery. The Insurer has paid cashless benefit for Rs.50,000/- only. The complaint is now seeking the disallowed amount also.

Complaint is dismissed.

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Award No. IO/KOC/A/GI/0244/2014-15

Complaint No. IO/KCH/GI/11-004-389/13-14

Award Passed on 13.01.2015

Smt. Thankamma Mathew (w/o Late George Mathew) Vs. United India Insurance Co. Ltd.

Partial repudiation of Individual mediclaim

The complainant is the holder of a mediclaim policy with the respondent Insurer since 1998. It is submitted that a claim for Rs.21,060.63 towards treatment at Lissie Hospital was only partly allowed by the Insurer. An amount of Rs.1,400/- was disallowed. The complainant further went to the insurer for renewal of the policy along with enhancement of Sum Insured, the Branch Manager was not willing to increase the same. At the same time a clause was added to the effect that "existing illness not covered for enhanced Sum Insured". It is stated that this clause is unwarranted and unnecessary. Since the grievance cell has not given any reply, this complaint has been preferred seeking relief to grant the disallowed amount of Rs.1,400/-, issue instructions to Branch Manager for increasing the sum insured and to delete the clause which was incorporated in the policy document.

Complaint is dismissed.

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Award No. IO/KOC/A/GI/0246/2014-15

Complaint No. IO/KCH/GI/11-004-316/13-14

Sri. C.P. Mathew Vs. United India Insurance Co. Ltd.

Repudiation of individual mediclaim

The complainant is holding a valid mediclaim insurance policy with the respondent Insurer. He underwent Ayurvedic treatment for carpel tunnel syndrome and a claim was preferred. This claim was repudiated against which he has preferred appeal. The appeal did not have any positive result and hence this complaint.

Respondent Insurer to pay the claim to the complainant.

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Award No. IO/KOC/A/GI/0247/2014-15

Complaint No. IO/KCH/GI/11-004-57/13-14

Award Passed on 13.01.2015

Sri. Biju George Vs. United India Insurance Co. Ltd.

Repudiation of Individual mediclaim

The complainant had a policy with the respondent Insurer. His father was hospitalised in 12/2012 and a claim was preferred with the insurer who has partially repudiated the claim. Appeals given were in vain, hence this complaint.

Respondent Insurer to pay the balance claim (disallowance for charges under 1.2 (C &D) to the complainant.

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Award No. IO/KOC/A/GI/0248/2014-15

Complaint No. IO/KCH/GI/11-003-387/2012-13

Award Passed on 21.01.2015

Sri. Ashly George Vs. National Insurance Co. Ltd.

Repudiaiton of individual mediclaim

The complainant was covered under a Mediclaim policy of the respondent Insurance Company. He was admitted in a Hospital from 01/07/2011 to 05/07/2011, due to an accidental fall and undergone a surgery on the right knee. A claim was preferred for reimbursement of expenses towards hospitalization which was rejected by the Insurer on the ground of suppression and misrepresentation of material facts. The dispute regarding this could not be resolved among them, a complaint was filed before this Forum.

Respondent insurer to pay the eligible amount of claim to the complainant.

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Award No. IO/KOC/A/GI/0249/2014-15

Complaint No. IO/KCH/GI/11-003-331/13-14

Award Passed on 21.01.2015

Smt. Jaya Chacko Cheriyan Vs. National Insurance Co. Ltd.

Repudiaiton of Individual mediclaim

The complainant and her husband were covered under a Mediclaim policy of the respondent Insurance Company. The complainant's husband was admitted in a Hospital from 07/11/2012 to 12/11/2012. A claim was preferred for reimbursement of expenses towards hospitalization which was rejected as per exclusion clause 4.3 (First year exclusion) of Terms and conditions of the policy. The dispute regarding this could not be resolved among them, a complaint was filed before this Forum.

Respondent insurer to pay to the Complainant the admissible claim amount.

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Award No. IO/KOC/A/GI/0250/2014-15

Complaint No. IO/KCH/GI/11-003-367/13-14

Award Passed on 21.01.2015

Sri. V. Parameswaran Pillai Vs. National Insurance Co. Ltd.

Repudiaiton of individual mediclaim

The complainant was covered under a Mediclaim policy of the respondent Insurance Company. The complainant was admitted in a Hospital from 12/02/2013 to 15/02/2013. A claim was preferred for reimbursement of expenses towards hospitalization which was rejected by stating that 'admitted for Health check-up not covered under this policy'. The dispute regarding this could not be resolved among them, a complaint was filed before this Forum.

Respondent insurer to pay to the Complainant the admissible claim amount.

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Award No. IO/KOC/A/GI/0251/2014-15

Complaint No. IO/KCH/GI/11-003-632/12-13

Award Passed on 21.01.2015

Sri. K. G. Prakash Vs. National Insurance Co. Ltd.

Repudiaiton of individual mediclaim

The complainant and his wife were covered under a Mediclaim policy of the respondent Insurance Company. The complainant's wife was admitted in a Hospital from 31/10/2011 to 02/11/2011. A claim was preferred for reimbursement of expenses towards hospitalization which was partially rejected. The dispute regarding this could not be resolved among them, a complaint was filed before this Forum.

Complaint is dismissed.

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Award No. IO/KOC/A/GI/0252/2014-15

Complaint No. KOC-G-049-1415-0092

Award Passed on 21.01.2015

Sri. K. Radhakrishnan Vs. New India Assurance Co.Ltd.

Partial repudiation of individual mediclaim

The complainant's wife was covered under a Good Health policy. A claim for Rs.1,66,036/- was preferred for hospitalization from 01/07/2010 to 03/07/2010 when she had undergone PTCA with stenting. The Insurer has first settled around Rs. 1 Lakh and later, after many representations another amount of around Rs.31,000/- was paid. Now seeking the balance of the claim. Written representations to the insurer did not yield any positive result, hence this complaint.

Complaint is dismissed.

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Award No. IO/KOC/A/GI/0254/2014-15

Complaint No. KOC-G-051-1415-0232

Award Passed on 21.01.2015

Sri. K. Gopi Vs. United India Insurance Co. Ltd.

Repudiation of individual mediclaim

The complainant was covered under the AB Arogyadan Policy issued by the Hyderabad Office of the respondent Insurer. The complainant has undergone hospitalization at the Sri Chitra Tirunal Institute of Medical Sciences Trivandrum and submitted a claim for the same. The TPA has requested more documents to substantiate the claim. The complainant has requested the hospital for the documents and all available papers were submitted to the TPA. The claim was repudiated, hence this complaint. Appeals to consider the claim with available papers were in vain. Now seeking relief of Rs.26,000/- paid to the hospital.

Respondent Insurer to pay an amount of Rs.26,000/-.

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Award No. IO/KOC/A/GI/0255/2014-15

Complaint No. KOC-G-050-1415-0238

Award Passed on 21.01.2015

Sri. K. Rajappan Thampan Vs. Oriental Insurance Co. Ltd.

Partial repudiation of indidual mediclaim

Sri R Padmaraj is covered under mediclaim policy since 2003. He has preferred a claim for hospitalisation for near silent heart and ventilator support for 10 days. The complainant has a history of Asthma since childhood which was disclosed while availing the insurance. However, an amount of Rs.75,000/- alone was paid as against the Insurers amount of Rs. 4 Lakh. Appeal to the insurer was in vain, hence this complaint by Sri K Rajappan Thampan (power of Attorney holder).

Complaint is dismissed.

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Award No. IO/KOC/A/GI/0256/2014-15

Complaint No. KOC-G-050-1415-0119

Award Passed on 21.01.2015

Smt. Jessy Chacko Vs. Oriental Insurance Co. Ltd.

Repudiation of individual mediclaim

The complainant's husband was covered under a mediclaim scheme. He was hospitalized for treatment for cancer in 2011 and claims were preferred. Two cheques in favour of her husband was received, which was returned as her husband had already expired by then. The necessary documentation was also given like indemnity bond, death certificate etc. Appeals to the Insurer to pay the claims were not successful, hence the complaint.

Respondent Insurer to pay the balance claim of Rs.4,381/- with simple interest 9% p.a. from the date of claim till date of award and simple interest @ 9% on Rs.39,702/- for delayed payment from date of claim till date of payment(16.10.2014).

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Award No. IO/KOC/A/GI/0260/2014-15

Complaint No. IO/KCH/GI/11-005-994/12-13

Award Passed on 21.01.2015

Sri. S. Sunilkumar Vs. Oriental Insurance Co. Ltd.

Repudiation of individual mediclaim

The complainant and his family were covered under a medi-claim policy of the respondent Insurance Company. His son was hospitalized in December, 2012 and undergone a surgery. He preferred a claim towards reimbursement of hospitalization expenses which has been rejected by the insurer stating that the surgery was for 'Çongenital external disease' and hence no claim is payable. Subsequently, the complainant approached the Grievance cell of the Insurance Company for a reconsideration of the claim which was also in vain. Hence, he filed a petition before this Forum.

Respondent Insurer to pay the eligible claim to the complainant.

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Award No. IO/KOC/A/GI/0261/2014-15

Complaint No. IO/KCH/GI/11-005-936/12-13

Award Passed on 21.01.2015

Sri. P. Padmadas Vs. Oriental Insurance Co. Ltd.

Repudiation of individual mediclaim

The complainant and his family were covered under a medi-claim policy of the respondent Insurance Company. He was hospitalized in November, 2012 and preferred a claim towards reimbursement of hospitalization expenses which had been settled partially. Subsequently, the complainant approached the Grievance cell of the Insurance Company for a reconsideration of the claim which was also in vain. Hence, he filed a petition before this Forum.

Respondent Insurer to pay the eligible claim to the complainant.

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Award No. IO/KOC/A/GI/0265/2014-15

Complaint No. IO/KCH/GI/11-004-928/2012-13

Award Passed on 23.01.2015

Sri. C.V. Arun Vs. United India Insurance Co. Ltd.

Dispute in new policy terms of health policy

The complainant had taken a family health policy on the recommendation of SBT, Statue Branch under the SBT Unihealth Policy) for the period from 02/09/2011 to 01/09/2012 and paid only Rs1341/- as premium. In 08/2012 when the complainant approached for renewal of the policy the insurer informed that the tie-up with SBT was no longer in place and had an option to take a new policy by paying a premium of Rs. 2,466/-. Three things gave a lot of mental agony to the complainant i.e, loss of NCB, the increase in premium and loss in seniority. In fact, some claims made in 2012 were rejected due to loss of seniority alone. Despite appealing to the concerned authorities no action was forthcoming, hence this complaint.

Complaint is dismissed.

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Award No. IO/KOC/A/GI/0266/2014-15

Complaint No. KOC-G-050-1415-0131

Award Passed on 02.02.2015

Sri. Anil D Vs. The Oriental Insurance Co. Ltd.

Repudiation of individual mediclaim

The complainant along with his parents are covered under a Happy Family Floater policy issued by the respondent Insurer. The complainant's father had undergone treatment at various eye hospitals at Bangalore. However, all claims submitted have been rejected by the insurer citing the reason that the treatment could be done as OPD procedure and did not require admission. Appeals were also turned down, hence this complaint.

Respondent Insurer to pay the eligible claim with cost of Rs. 5,000/- to the complainant.

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Award No. IO/KOC/A/GI/0269/2014-15

Complaint No. KOC-G-051-1415-0110

Award Passed on 02.02.2015

Smt. Rajlaxmi R Nair Vs. United India Insurance Co. Ltd.

Repudiation of individual mediclaim

The complainant is the holder of a mediclaim policy from the insurer (policy no 020100/48/10/97/00013563 for the period 08/02/2011 to 07/02/2012). A claim was preferred for hospitalisation of her daughter from 01/02/2012 to 04/02/2012. The claim was intimated while submitting the forms on 15/02/2012. Being uneducated and due to the fact that her husband was also away at the native place, the complainant was not aware that she had to intimate the claim within 24 hours. The claim was rejected due to the fact that it was intimated late. Appeal to the Insurer was in vain, hence this complaint.

Respondent Insurer to settle the eligible claim of the complainant.

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Award No. IO/KOC/A/GI/0270/2014-15

Complaint No. IO/KCH/GI/11-017-158/13-14

Award Passed on 02.02.2015

Sri. O Rajindran Vs. Star Health & Allied Ins.Co. Ltd.

Repudiation of individual mediclaim

The complainant is the holder of a mediclaim policy with the respondent Insurer (No P/181200/01/2012/005418 for the period 06/07/2011 to 05/07/2012). The insured was diagnosed with CAD and HTN and was admitted to AIMS Hospital, Kochi on 17/06/2012. A claim was preferred for the hospitalisation which was repudiated by the insurer citing "suppression of material facts and pre-existing diseases". The complainant submits before this Forum that he does not have any pre-existing illness nor has made any suppression of facts while availing the Insurance. The complainant states that the "pre-existing diseases and suppression of facts" are being alleged by insurer only to avert their liability on the claim. This complaint has now been filed seeking the full claim of Rs.3,88,913/- with 10% interest.

Respondent Insurer to refund the premium paid for 2013-14 under the policy to the complainant.

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Award No. IO/KOC/A/GI/0271/2014-15

Complaint No. IO/KCH/GI/11-003-642/2012-13

Award Passed on 02.02.2015

Sri. T Jayakrishnan Vs. National Insurance Co. Ltd.

Repudiation of individual mediclaim

The complainant is the holder of a mediclaim policy with the respondent Insurer (570704/48/11/8500000586). On 27/03/2012, due to total lack of equilibrium in standing posture, the complainant was admitted to the hospital for an extensive check-up to further confirm the treating doctors diagnosis of "Ataxia". Different tests were conducted and it was found that the complainant was suffering from "infarcts in the Thalmus and corona

radiate" and also Vitamin B-12 deficiency and hypertension. The complainant was discharged on 04/04/2012 and a claim was preferred with the insurer. After about 75 days after lodging the claim, a letter was received to the effect that the claim has been repudiated as the policy exclusion no 4. 3 states that the insurer shall not be liable for any expenses for Hypertension for the first two policy years. Appeals to the Insurer were in vain, hence this complaint.

Respondent Insurer to settle the eligible claim of the complainant.

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Award No. IO/KOC/A/GI/0273/2014-15

Complaint No. IO/KCH/GI/11-017-658/13-14

Award Passed on 03.02.2015

Sri. P L Thomas Vs. Star Health & Allied Ins.Co. Ltd.

Repudiation of individual mediclaim

The complainant was holding a policy from the respondent Insurer (no P/181216/01/2012/001688 for the period from 04/09/2012 to 03/09/2013). The complainant's mother was admitted to the hospital on 02/05/2013 due to Hematoma in the subdural part of the brain, found during the investigations. Surgery was done and she was discharged from the hospital. The claim forms were submitted. The respondent Insurer has rejected the claim citing pre existing illness. A clarification from the treating doctor was submitted which stated that the duration of hematoma was not longer than 3 months but the insurer refused to reconsider the case, hence this complaint.

Complaint is dismissed.

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Award No. IO/KOC/A/GI/0274/2014-15

Complaint No. IO/KCH/GI/11-017-1000/13-14

Award Passed on 03.02.2015

Smt. Ajitha K Vs. Star Health & Allied Ins.Co. Ltd.

Repudiation of individual mediclaim

The complainant was holding a policy from the respondent Insurer (no P/181311/01/2013/009196). The complainant was hospitalized in 09/2013 and a claim was preferred thereafter. The insurer has rejected the claim citing Exclusion No 10 of the policy. Appeals were not considered by the insurer, hence this complaint

Respondent insurer reconsidered and settled the claim. Complaint is dismissed.

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Award No. IO/KOC/A/GI/0275/2014-15

Complaint No. KOC-G-044-1415-0052

Award Passed on 03.02.2015

Sri. Narendranathan P Vs. Star Health & Allied Ins.Co. Ltd.

Repudiation of individual mediclaim

The complainant was holding a policy from the respondent Insurer (no P/181300/01/2014/006129 for the period 09/03/2014 to 08/03/2015, Sum insured Rs. 1 Lakh). The complainant's wife was hospitalized in 03/2014 for aortic valve replacement and a claim was preferred thereafter. The hospital has asked to pay the difference between the estimated cost and the sum insured under the policy as an advance approval has been received from the insurance company. However on discharge it is found that the insurer has approved only Rs.17,684/-. The complainant, a senior citizen, was put to great difficulty in making the payment and following up with the insurer to settle the full claim.

Respondent insurer reconsidered and settled the claim. Complaint is dismissed.

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Award No. IO/KOC/A/GI/0277/2014-15

Complaint No. KOC-G-050-1415-0120

Award Passed on 03.02.2015

Sri. Anil Kumar A.M Vs. Oriental Insurance Co. Ltd.

Repudiation of individual mediclaim

The complainant is the holder of a mediclaim policy from the insurer (policy no 441000/48/2013/1451). Four Claims were preferred with the Insurer for hospitalisation to do treatment for the eye (administering Lucentis injection). The claims were rejected, hence this complaint.

Respondent Insurer to pay the eligible claim to the complainant.

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Award No. IO/KOC/A/GI/0279/2014-15

Complaint No. IO/KCH/GI/11-004-721/12-13

Award Passed on 03.02.2015

Sri. K M Gangadharan Vs. United India Insurance Co. Ltd.

Repudiation of individual mediclaim

The complainant is the holder of a mediclaim policy from the insurer (policy no 100300/48/21/97/00002290 for the period 17/01/2012 to 16/01/2013). The complainant was under treatment for multiple myeloma and had submitted many claims to the insurer. Some of the claims were settled, some were not. Appeal to the insurer has not borne any fruit, hence this complaint.

Complainant has filed a complaint in CDRF and hence dismissed.

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Award No. IO/KOC/A/GI/0280/2014-15

Complaint No. IO/KCH/GI/11-004-461/13-14

Award Passed on 05.02.2015

Sri. B. Anil Kumar Vs. United India Insurance Co. Ltd.

Repudiation of individual mediclaim

The complainant is the holder of a mediclaim policy from the insurer (policy no 101786/48/12/97/00000099). The complainant was holding a health policy of New India Assurance since 2006. In 2011 he was induced to shift to the respondent Insurer as he was promised all benefits as a continuation of the old policy. On transfer the Sum Insured was also increased to Rs. 1 lakh. The policy was again renewed for 2012. In 11/2012, the complainant was hospitalised and advised to undergo surgery. Accordingly he was hospitalised from 25/11/2012 and discharged on 29/11/2012. The necessary claim papers were submitted but despite the repeated follow-up only a partial settlement of claim was made citing the two year exclusion period for pre-existing diseases. Since the waiting period exclusion is not applicable in this case, the full claim has to be paid with interest for delayed payment.

Complaint is dismissed.

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Award No. IO/KOC/A/GI/0281/2014-15

Complaint No. IO/KCH/GI/11-008-201/13-14

Award Passed on 05.02.2015

Sri. T M Michael Vs. Royal Sundaram Alliance Ins.Co.Ltd

Partial repudiation of individual mediclaim

The complainant has taken a policy from the respondent insurer for the period from 12/05/2012 to 11/05/2013 (Medisafe and the policy was renewed for last seven years No HS 000 22551000 107). Another policy (hospital benefit plus) also was there with no SL000 4068 7000 102. The complainant underwent cataract surgery. Cataract surgery was undergone in 01/2013 and a claim preferred under both policies for an amount of Rs.22,049/-. There was one more hospitalization for the same problem in 02/2013 and all documents were submitted for the claim. The total claim now came to Rs.64,052.86. The respondent insurer has replied that cataract surgery does not warrant more than one day. The respondent insurer has paid a total of Rs.9,500/- only against a claim of Rs.64,052.86. Both policies have run for more than one year and hence the exclusion due to duration does not apply. The first hospitalization was for treatment and the second for surgery and the hospitalization was for more than 24 hours. There is no exclusions for any of this treatment. This complaint is filed seeking the full claim amount.

Complaint is dismissed.

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Award No. IO/KOC/A/GI/0282/2014-15

Complaint No. IO/KCH/GI/11-012-764/13-14

Award Passed on 05.02.2015

Sri. M P Narayanan Vs. ICICI Lombard General Ins.Co.Ltd.

Repudiation of individual mediclaim

The complainant had taken a mediclaim policy from the respondent Insurer. The complainant was hospitalised in 01/2012. A claim was

preferred, which was repudiated by the insurer. Appeal was given to the insurer which was turned down, hence this complaint.

Complaint is dismissed.

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Award No. IO/KOC/A/GI/0283/2014-15

Complaint No. KOC-G-050-1415-0190

Award Passed on 05.02.2015

Sri. Aditya Rajnarayan Vs. Oriental Insurance Co. Ltd.

Repudiation of individual mediclaim

The complainant is covered under a mediclaim policy from the respondent Insurer. The complainant was hospitalised for surgery in 04/2014. The surgery was done on an emergency basis as the complainant developed breathlessness. The policy commenced from 02/2013. A claim was made for the hospitalisation which was turned down by the insurer. Appeals did not prove fruitful, hence this complaint seeking the full claim amount.

Respondent-Insurer to pay to the complainant the eligible claim.

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Award No. IO/KOC/A/GI/0286/2014-15

Complaint No. IO/KCH/GI/14-004-396/13-14

Award Passed on 06.02.2015

Sri. Koshy Joseph Vs. United India Insurance Co. Ltd.

Repudiation of individual mediclaim

The complainant had a mediclaim policy with the respondent Insurer for more than two decades and was getting good service from them. However after appointment of TPA's by the insurer, claims were being repudiated. Some claims are still pending and complaint filed seeking speedy settlement of the same.

Complainant to submit the full details of claims which have been repudiated/ not received and the respondent insurer to process & settle the eligible claims, if any.

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Award No. IO/KOC/A/GI/0292/2014-15

Complaint No. IO/KCH/GI/11-005-694/13-14

Award Passed on 12.02.2015

Smt. Sangeetha Renjith Vs. Oriental Insurance Co. Ltd.

Repudiation of individual mediclaim

The complainant's father was covered under a mediclaim policy with the above insurer. He was hospitalised in 07/2011 and expired on 24/07/2011. A claim was preferred by the nominee ie. his wife Smt.Sarasamma. Despite follow-up, no reply was received from the insurer, hence this complaint.

Respondent-Insurer to pay to the complainant the eligible claim under the policy provided the full details of the claim are provided to the respondent Insurer.

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Award No. IO/KOC/A/GI/0293/2014-15

Complaint No. IO/KCH/GI/11-005-670/13-14

Award Passed on 12.02.2015

Sri. K A Sainuddin Vs. Oriental Insurance Co. Ltd.

Repudiation of individual mediclaim

The complainant is covered under an Individual mediclaim policy. The complainant had submitted two claims to the insurer for hospitalisation and both were rejected. The rejection letter informed him to contact this Forum for any further grievance redressal, hence this complaint.

Respondent-Insurer to pay to the complainant the eligible claim.

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Award No. IO/KOC/A/GI/0296/2014-15

Complaint No. IO/KCH/GI/11-010-973/13-14

Award Passed on 16.02.2015

Sri. A K Sivan Vs. IFFCO-TOKIO Genl. Insc. Co. Ltd.

Repudiation of individual mediclaim

The complainant had taken a family health policy from the respondent insurer. A claim was submitted for hospitalisation of self for heart ailments and angioplasty which was rejected by the insurer, hence this complaint.

Complaint is dismissed.

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Award No. IO/KOC/A/GI/0298/2014-15

Complaint No. IO/KCH/GI/11-004-404/13-14

Award Passed on 16.02.2015

Smt. M Sowmya Vs. United India Insurance Co. Ltd.

Partial repudiation of Individual mediclaim

The complainant was covered under a Mediclaim policy of the respondent Insurance Company. The complainant was admitted in an Ayurveda Hospital from 07/06/2012 to 29/06/2012 for the treatment of Vathavyadhi. A claim was preferred for reimbursement of expenses towards hospitalization which was partially settled by the insurer. The dispute regarding this could not be resolved among them, a complaint was filed before this Forum.

Respondent insurer to pay Rs.10,000/- (Rupees ten thousand only) as ex-gratia.

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Award No. IO/KOC/A/GI/0300/2014-15

Complaint No. IO/KCH/GI/11-011-466/13-14

Award Passed on 16.02.2015

Sri. Nivin Hubert alias Neven Vs. Bajaj Allianz General Insc Co. Ltd.,

Non-renewal of Individual mediclaim policy

The complainant had taken a mediclaim policy from the respondent insurer from 02/2007. The complainant was admitted to Lakeshore Hospital in 05/2011. Even though the policy was valid on that date, the insurer has rejected the claim made. To the complainant's surprise, the respondent insurer has issued notice for cancellation /non renewal of the policy. The complainant has vide letter dated 15/06/2011 requested the coverage to be continued, however this request was not acceded to. This complaint is filed seeking relief of 1) declaration of repudiation/cancellation of mediclaim policy no OG-11-1602-8401-00000454 issued to the complainant as illegal 2) to direct the respondent to renew the mediclaim policy and 3) to pay Rs.5 lakhs as compensation for the cancellation.

Complaint is dismissed.

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Award No. IO/KOC/A/GI/0301/2014-15

Complaint No. IO/KCH/GI/11-013-520/13-14

Award Passed on 16.02.2015

Sri. Gopakumar Kesavan Vs. ICICI Lombard General Ins.Co.Ltd.

Partial repudiation of health insurance claim

The complainant had taken a health policy from the respondent insurer for the period 04/07/2012 to 03/07/2013. A claim was preferred under the policy for hospitalisation in 01/2013. Despite several follow-ups & mails there was no response from the insurer. Finally in 09/2013 the insurer has informed that they are looking into the matter, hence this complaint.

Complaint is dismissed.

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Award No. IO/KOC/A/GI/0302/2014-15

Complaint No. IO/KCH/GI/11-003-332/13-14

Award Passed on 23.02.2015

Smt. Jancy Varghese Vs. National Insurance Co. Ltd.

Repudiation of individual mediclaim

the complainant and his family were covered under a Med-claim policy of the respondent Insurance Company. The complainant's husband was hospitalized in September,2011. A claim was preferred for reimbursement of expenses towards hospitalization which was not yet considered for payment. The dispute regarding this could not be resolved among them, a complaint was filed before this Forum.

Respondent insurer to pay the eligible claim amount.

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Award No. IO/KOC/A/GI/0304/2014-15

Complaint No. IO/KCH/GI/11-004-556/13-14

Award Passed on 23.02.2015

Sri. M N Sasi Vs. United India Insurance Co. Ltd.

Repudiation of individual mediclaim

The complainant and his family were covered under a family Medicare policy of the respondent Insurance Company. His wife was admitted in a Hospital from 21/11/2012 to 27/11/2012, due to bilateral ovarian cancer. A claim was preferred for reimbursement of expenses towards hospitalization which was rejected by the Insurer on the ground of pre-existing ailment. The dispute regarding this could not be resolved among them, a complaint was filed before this Forum.

Pay the eligible amount of claim to the complainant.

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Award No. IO/KOC/A/GI/0306/2014-15

Complaint No. KOC-G-050-1415-0223

Award Passed on 23.02.2015

Sri. Umesh Shetty K Vs. Oriental Insurance Co. Ltd.

Repudiation of individual mediclaim

The complainant and his family were covered under a medi-claim, Happy Family Floater Policy of the respondent Insurance Company. His daughter had undergone an eye surgery. A claim was preferred for reimbursement of expenses towards hospitalization which was rejected by the Insurer stating that the surgery was for correction of eye sight. The dispute regarding this could not be resolved among them, a complaint was filed before this Forum.

Pay the eligible amount of claim to the complainant, after submitting the requirements as required.

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Award No. IO/KOC/A/GI/0308/2014-15

Complaint No. IO/KCH/GI/11-017-383/13-14

Award Passed on 23.02.2015

Sri. Lal Sreedhar Vs. Star Health & Allied Ins.Co. Ltd.

Repudiation of individual mediclaim

The complainant and his family were covered under a Medi-claim policy (Family Health Optima Insurance Policy) of the respondent Insurance Company. The complainant's wife was hospitalized in March, 2012. A claim was preferred for reimbursement of expenses towards hospitalization which was repudiated by the insurer on the ground of pre-existing disease. The dispute regarding this could not be resolved among them, a complaint was filed before this Forum.

Respondent insurer to pay the eligible claim amount.

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Award No. IO/KOC/A/GI/0309/2014-15

Complaint No. IO/KCH/GI/11-002-983/13-14

Award Passed on 25.02.2015

Sri. R Vinodkumar Vs. New India Assurance Co. Ltd.

Partial repudiation of individual mediclaim

The complainant is the holder of policy no 760405341325000002 81 with the respondent insurer. A claim was made for Hysterectomy procedure for the complainant's wife and the insurer has reimbursed an amount of Rs.35,038/- only as against the expenses incurred of over Rs.1 lakh. Appeal to insurer was rejected, hence this complaint.

Complaint is dismissed.

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Award No. IO/KOC/A/GI/0311/2014-15

Complaint No. IO/KCH./GI/11-017-386/13-14

Award Passed on 25.02.2015

Sri. K Subhashchandran Vs. Star Health & Allied Ins.Co. Ltd.

Repudiation of individual mediclaim

The complainant had a policy with the New India Assurance Co Ltd for an insured sum of Rs.1 lakh with effect from 23/04/2009. The policy was renewed for two more years. Before the renewal due 23/04/2012, the complainant understands from some advertisements that the policy offered by the respondent insurer is better and an agent from the insurer approached giving full details of the scheme. Consequently, the complainant opted for a policy with the respondent insurer with effect from 20/04/2012. The complainant was hospitalised in 09/2012 for treatment of prostate problems and allied ailments. The hospitalisation was informed to the insurer. The cashless facility was denied citing first year exclusion. It was also informed that the present hospitalisation for a pre-existing ailment. The complainant has not shown pre-existing diseases while joining the scheme. A letter was sent to the respondent insurer informing that this was not a new policy and that

the old policy was held with another insurer for 3 years and this has to be treated as porting of policy. The claim has therefore, to be allowed in full.

Complaint is dismissed.

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Award No. IO/KOC/A/GI/0312/2014-15

Complaint No. KOC-G-044-1415-0139

Award Passed on 25.02.2015

Sri. K.V. Velayudhan Nair Vs. Star Health & Allied Ins.Co. Ltd.

Repudiation of individual mediclaim

The complainant was the holder of policy No P/141111/01/2013/006750 for the period 15/11/2012 to 14/11/2013 with an insurance cover of Rs.1 lakh from the respondent insurer. On 10/06/2013 the complainant was hospitalised in SDM Ayurveda hospital, Udipi for Treatment of some ear related ailments and was discharged on 26/06/2013. The claim for Rs.15,018/- was preferred and on 16/09/2013 an amount of Rs.3,755/- was directly credited to the bank account of the complainant. In 09/2013 there was another admission to the same hospital. Necessary claim forms were submitted and again an amount of Rs.3,100/- was credited to the SB account. As per the clause no 3(20) of the Mediclassic policy, Non allopathic medicines are covered upto 25% of the sum insured during the policy period. As per the stated condition the claim is payable in full and mail letters were sent to the grievance officer, no satisfactory reply was received, hence this complaint seeking full claim amount.

Complaint is dismissed.

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Award No. IO/KOC/A/GI/0317/2014-15

Complaint No. IO/KCH/GI/11-004-1077/13-14

Award Passed on 25.02.2015

Smt. V P Geethakutty Vs. United India Insurance Co. Ltd.

Partial repudiation of individual mediclaim

The complainant had a Family Medicare policy taken from the respondent insurer. The complainant was hospitalised in 10/2013 and a claim was preferred with the insurer. The claim was only partially settled and an appeal was filed against the same. The appeal also was turned down, hence this complaint.

Complaint is dismissed.

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Award No. IO/KOC/A/GI/0318/2014-15

Complaint No. KOC-G-051-1415-0240

Award Passed on 25.02.2015

Smt. Annie Pious Vs. United India Insurance Co. Ltd.

Partial repudiation of individual mediclaim

The complainant is the holder of policy no 100904/48/13/06/00000552 with the respondent insurer. A claim was made for Hysterectomy procedure for self and the insurer has reimbursed an amount of Rs.12,500/- only as against the expenses incurred of over Rs.36,000/. Appeal was rejected, hence this complaint.

Complaint is dismissed.

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Award No. IO/KOC/A/GI/0319/2014-15

Complaint No. IO/KCH/GI/11-017-181/13-14

Award Passed on 26.02.2015

Sri. K P Rajeev Vs. Star Health & Allied Ins.Co. Ltd.

Repudiation of individual mediclaim

The complainant took a Family health optima policy from the respondent insurer valid for the period 28/04/2011 to 27/04/2012. This was renewed for the second year 2012-13 also. The complainant was admitted to Lissie Hospital due to heart ailments and necessary surgery was done. A claim was preferred which was rejected by the insurer citing suppression of material facts i.e, the pre-existing diseases had not been disclosed while availing the policy. It is submitted that the repudiation is illegal, incorrect and improper as the finding is not supported by any evidence, not a speaking order, there was no suppression at the time of taking the policy, the complainant had no previous history of diagnosis of heart or related ailments leading to heart disease. Moreover to suppress such information, the complainant had to suffer ailments earlier, which was not so. Hence this complaint, seeking relief for the full eligible claim with interest at 18%.

Insurer to pay an ex-gratia of Rs.50,000/- (Rupees Fifty thousand only).

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Award No. IO/KOC/A/GI/0323/2014-15

Complaint No. IO/KCH/GI/11-004-409/13-14

Award Passed on 26.02.2015

Sri. C R Gopalakrishnan Nair Vs. United India Insurance Co. Ltd.

Repudiation of Individual Mediclaim

The complainant was covered under a Mediclaim policy of the respondent Insurance Company. A claim was preferred for reimbursement of expenses towards 'INTRAVITREAL AVASTIN ADMINISTRATION' which was rejected by the Insurer on the ground

of hospitalization for less than 24 hours. The dispute regarding this could not be resolved among them, a complaint was filed before this Forum.

Pay the eligible amount of claim to the complainant.

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Award No. IO/KOC/A/GI/0325/2014-15

Complaint No. IO/KCH/GI/11-011-43/2013-14

Award Passed on 27.02.2015

Sri. C.P.Jaleel Vs. Bajaj Allianz General Insc Co. Ltd.,

Repudiation of individual mediclaim

The complainant, was covered under a Health policy of the respondent Insurance Company. He was hospitalized in Ocober, 2011 for the treatment of 'Coronary Artery Disease'. 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.

Pay the eligible amount of claim to the complainant.

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Award No. IO/KOC/A/GI/0326/2014-15

Complaint No. io/kch/gi/11-004-646/13-14

Award Passed on 27.02.2015

Sri. K R Lawrence Vs. United India Insurance Co. Ltd.

Repudiation of individual mediclaim

The complainant and his family were covered under a Medi-claim policy of the respondent Insurance Company. His daughter was hospitalized in January, 2013 for the treatment of fibroid in uterus. 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.

Pay the eligible amount of claim to the complainant.

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Award No. IO/KOC/A/GI/0328/2014-15

Complaint No. IO/KCH/GI/11-005-105/13-14

Award Passed on 27.02.2015

Smt. Pushpalatha S Pai Vs. Oriental Insurance Co. Ltd.

Repudiation of individual mediclaim

The complainant and her husband were covered under the PNB-Oriental Medi-claim policy. The complainant's husband was admitted in a Hospital from 14/10/2012 to 23/10/2012, for the treatment of urinary infection. 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.

Complaint is dismissed.

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Award No. IO/KOC/A/GI/0329/2014-15

Complaint No. IO/KCH/GI/11-005-684/13-14

Award Passed on 27.02.2015

Sri. Shahul Hameed Moopan Vs. Oriental Insurance Co. Ltd.

Repudiation of Individual mediclaim

The complainant and his family were covered under a Medi-claim policy of the respondent Insurance Company. His son was hospitalized in May, 2012 for the treatment of eye. 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.

Pay the eligible amount of claim to the complainant.

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Award No. IO/KOC/A/GI/0330/2014-15

Complaint No. IO/KCH/GI/11-003-656/13-14

Award Passed on 27.02.2015

Smt. Mary Thomas (Legal Heir of Late Smt. Elizabeth Mathew) Vs. National Insurance Co. Ltd.

Repudiation of individual mediclaim

The complainant was covered under a Medi-claim policy of the respondent Insurance Company. She was hospitalized in March, 2012 for the treatment of 'CARCINO OVARY'. A claim was preferred for reimbursement of expenses towards hospitalization which was partially settled by the Insurer. The dispute regarding this could not be resolved among them, a complaint was filed before this Forum.

Pay the eligible amount of claim, Rs. 2 Lakhs being the Sum Insured, subject to policy conditions, to the complainant.

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Award No. IO/KOC/A/GI/0332/2014-15

Complaint No. IO/KCH/GI/11-003-802/13-14

Award Passed on 27.02.2015

Sri. M S Udayabhanu Vs. National Insurance Co. Ltd.

Repudiation of individual mediclaim

The complainant and his family were covered under a Mediclaim policy of the respondent Insurance Company. His wife was admitted in a Hospital from 08/03/2013 to 12/03/2013 for the treatment of severe headache. A claim was preferred for reimbursement of expenses towards hospitalization which was rejected by the Insurer as there was no active line of treatment. The dispute regarding this could not be resolved among them, a complaint was filed before this Forum.

Pay the eligible amount of claim to the complainant.

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Award No. IO/KOC/A/GI/0333/2014-15

Complaint No. IO/KCH/GI/11-003-819/13-14

Award Passed on 27.02.2015

Smt. K V Sherly Vs. National Insurance Co. Ltd.

Repudiation of individual mediclaim

The complainant was covered under a Mediclaim policy of the respondent Insurance Company. She was hospitalized in July, 2013, for the treatment of respiratory infection. A claim was preferred for reimbursement of expenses towards hospitalization which was rejected by the Insurer stating that there was no active line of treatment. The dispute regarding this could not be resolved among them, a complaint was filed before this Forum.

Pay the eligible amount of claim to the complainant.

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Award No. IO/KOC/A/GI/0334/2014-15

Complaint No. IO/KCH/GI/11-003-888/13-14

Award Passed on 27.02.2015

Sri. B Vijayakumar Vs. National Insurance Co. Ltd.

Repudiation of individual mediclaim

The complainant was covered under a Mediclaim policy of the respondent Insurance Company. He was hospitalized in August, 2013, for the treatment of injuries caused due to an accident. A claim was preferred for reimbursement of expenses towards hospitalization which was rejected by the Insurer stating that there was no active line of treatment. The dispute regarding this could not be resolved among them, a complaint was filed before this Forum.

Pay the eligible amount of claim to the complainant.

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Award No. IO/KOC/A/GI/0335/2014-15

Complaint No. IO/KCH/GI/11-003-892/13-14

Award Passed on 27.02.2015

Sri. Augustine Albert Vs. National Insurance Co. Ltd.

Repudiation of individual mediclaim

The complainant and his family were covered under a Medi-claim policy of the respondent Insurance Company. His sister was hospitalized in November, 2012 for the treatment of Chronic Obstructive Pulmonary Disease. A claim was preferred for reimbursement of expenses towards hospitalization which was rejected by the Insurer stating that the ailment was pre-existing one. The dispute regarding this could not be resolved among them, a complaint was filed before this Forum.

Pay the eligible amount of claim to the complainant.

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Award No. IO/KOC/A/GI/0336/2014-15

Complaint No. IO/KCH/GI/11-002-845/13-14

Award Passed on 27.02.2015

Sri. A. A Abdul Basheer Vs. National Insurance Co. Ltd.

Repudiation of individual mediclaim

The complainant, was covered under a Medi-claim policy of the respondent Insurance Company. He was hospitalized in September, 2013 for the treatment of 'LIPOMA EXICISION' 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.

Pay the eligible amount of claim to the complainant.

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Award No. IO/KOC/A/GI/0339/2014-15

Complaint No. IO/KCH/GI/11-017-363/13-14

Award Passed on 27.02.2015

Sri. P Anil Kumar Vs. Star Health & Allied Ins.Co. Ltd.

Repudiation of individual mediclaim

The complainant and his family were covered under a Mediclaim policy of the respondent Insurance Company. A claim was preferred for reimbursement of expenses towards hospitalization of his daughter which was rejected by the Insurer on the ground of pre-existing illness. The dispute regarding this could not be resolved among them, a complaint was filed before this Forum.

Pay the eligible amount of claim to the complainant.

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Award No. IO/KOC/A/GI/0341/2014-15

Complaint No. IO/KCH/GI/11-017-1007/13-14

Award Passed on 03.03.2015

Sri. R Rajesh Vs. Star Health & Allied Ins.Co. Ltd.

Repudiation of individual mediclaim

The complainant's father was insured under a policy taken in 05/2010. The insured was hospitalised in 06/2013 due to acute hematoma sustained in an accidental fall. A claim was filed with the respondent insurer, which was denied due to "suppression of material facts". In the proposal the complainant's father has declared that he is a diabetic and the rest of the ailments are after the date of inception of the policy. The claim was for hematoma and for the other diseases. This complaint is filed seeking full relief.

Respondent insurer to refund the premiums paid by the proposer.

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Award No. IO/KOC/A/GI/0343/2014-15

Complaint No. IO/KCH/GI/11-003-1014/13-14

Award Passed on 03.03.2015

Sri. C G Varghese Vs. National Insurance Co. Ltd.

Repudiation of individual mediclaim

The complainant had taken an Individual Mediclaim policy from the respondent insurer covering self and his wife. The complainant's wife was hospitalised in Medical Trust Hospital for which claim was preferred with the insurer for an amount of Rs.1,05,261.59. The claim was settled by the insurer for an amount of Rs.76,600/- which is less than the total claimed of Rs.1,05,261.59. This complaint has been filed seeking full relief for the claim.

Complaint is dismissed.

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Award No. IO/KOC/A/GI/0344/2014-15

Complaint No. IO/KCH/GI/11-003-1074/13-14

Award Passed on 03.03.2015

Sri. S.Ramesh Shenoy Vs. National Insurance Co. Ltd.

Repudiation of individual mediclaim

The complainant had taken an Individual Mediclaim policy from the respondent insurer covering self and his wife. The complainant's wife was hospitalised in Akshaya Hospital, Kochi and also Amritha Hospital, Edapally for which claim was preferred with the insurer for an amount of Rs.10,635/- and Rs.84,733/-. The claim was settled by the insurer for an amount of Rs.60,400/- which is less than the total claimed of Rs.95,368/-. This complaint has been filed seeking full relief for the claim.

Complaint is dismissed.

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Award No. IO/KOC/A/GI/0345/2014-15

Complaint No. IO/KCH/GI/11-003-1016/13-14

Award Passed on 03.03.2015

Smt. P T Rosy Vs. National Insurance Co. Ltd.

Repudiation of individual mediclaim

The complainant had taken a Varishta Mediclaim policy from the respondent insurer to take care of her medical expenses. A claim was preferred which was turned down by the insurer stating that there was no need for hospitalisation as only routine investigations were done. The complainant submits that she was in no condition to go home and hence the doctor has admitted her in the hospital. The claim is genuine and the insurer has to pay the amounts.

The insurer to settle the room rent under the claim which was repudiated.

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Award No. IO/KOC/A/GI/0347/2014-15

Complaint No. IO/KCH/GI/11-004-705/13-14

Award Passed on 04.03.2015

Sri. N. H. Anwar Sadath Vs. United India Ins.Co.Ltd.

Repudiation of individual mediclaim

The complainant and his family were covered under a Mediclaim policy of the respondent Insurance Company. He was admitted in a Hospital from 29/04/2013 to 30/04/2013 for the treatment of severe back-pain. A claim was preferred for reimbursement of expenses towards hospitalization which was rejected by the Insurer. The dispute regarding this could not be resolved among them, a complaint was filed before this Forum.

Respondent Insurer to pay to the complainant, the eligible amount of claim.

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Award No. IO/KOC/A/GI/0348/2014-15

Complaint No. IO/KCH/GI/11-004-730/13-14

Award Passed on 04.03.2015

Sri. C. J. John Vs. United India Ins.Co.Ltd.

Repudiation of individual mediclaim

The complainant and his wife were covered under a Mediclaim policy of the respondent Insurance Company. His wife was admitted in a Hospital from 11/02/2012 to 13/02/2012 for the treatment of head ache. A claim was preferred for reimbursement of expenses towards hospitalization which was rejected by the Insurer. The dispute regarding this could not be resolved among them, a complaint was filed before this Forum.

Respondent Insurer to pay to the complainant, the eligible amount of claim.

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Award No. IO/KOC/A/GI/0350/2014-15

Complaint No. IO/KCH/GI/11-004-744/13-14

Award Passed on 04.03.2015

Adv. Soly Baby Vs. United India Ins.Co.Ltd.

Repudiation of individual mediclaim

The complainant and her daughter were covered under a Family Medi-care policy of the respondent Insurance Company. Her daughter was admitted in a Hospital from 21/05/2012 to 23/05/2012 for the treatment of Head ache and fever. A claim was preferred for reimbursement of expenses towards hospitalization which was rejected by the Insurer. The dispute regarding this could not be resolved among them, a complaint was filed before this Forum.

Respondent Insurer to pay to the complainant, the eligible amount of claim.

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Award No. IO/KOC/A/GI/0351/2014-15

Complaint No. IO/KCH/GI/11-004-487/13-14

Award Passed on 04.03.2015

Sri. Anu S kadayathu Vs. United India Insurance Co. Ltd.

Repudiation of individual mediclaim

The complainant and his family were covered under a Medi-claim policy of the respondent Insurance Company. His father was admitted in a Hospital from 16/01/2013 to 26/01/2013 for the treatment of non healing ulcer of right toe. A claim was preferred for reimbursement of expenses towards hospitalization which was rejected by the Insurer. The dispute regarding this could not be resolved among them, a complaint was filed before this Forum.

Respondent Insurer to pay to the complainant, the eligible amount of claim.

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Award No. IO/KOC/A/GI/0352/2014-15

Complaint No. IO/KCH/GI/11-004-1066/13-14

Award Passed on 04.03.2015

Sri. K. Gireesan Vs. United India Ins.Co.Ltd.

Repudiation of individual mediclaim

The complainant was covered under a Medi-claim policy of the respondent Insurance Company. He was admitted in a Hospital from 25/06/2013 to 28/06/2013 for the treatment of kidney stone. A claim was preferred for reimbursement of expenses towards hospitalization which was partially settled by the Insurer. The dispute regarding this could not be resolved among them, a complaint was filed before this Forum.

Respondent Insurer to pay to the complainant, the disallowed proportionate expenses (other than room rent).

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Award No. IO/KOC/A/GI/0354/2014-15

Complaint No. IO/KCH/GI/11-004-768/13-14

Award Passed on 04.03.2015

Sri. M. X. Antony Vs. United India Ins.Co.Ltd.

Repudiation of individual Health claim

The complainant and his family were covered under Individual Health Insurance policy of the respondent Insurance Company. His daughter was admitted in a Hospital from 02/09/2013 to 04/09/2013, for the treatment of ADENOID HYPERTROPHY. A claim was preferred for reimbursement of expenses towards hospitalization which was partially settled by the Insurer. The dispute regarding this could not be resolved among them, a complaint was filed before this Forum.

Respondent Insurer to pay to the complainant, the disallowed portion of expenses (except room rent).

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Award No. IO/KOC/A/GI/0355/2014-15

Complaint No. IO/KCH/GI/11-004-927/13-14

Award Passed on 04.03.2015

Sri. M. I. Tomy Vs. United India Ins.Co.Ltd.

Repudiation of individual mediclaim

the complainant and his family were covered under a Mediclaim policy of the respondent Insurance Company. His wife was admitted in a Hospital from 06/08/2013 to 10/08/2013 for the treatment of Head ache and vertigo. A claim was preferred for reimbursement of expenses towards hospitalization which was rejected by the Insurer. The dispute regarding this could not be resolved among them, a complaint was filed before this Forum.

Respondent Insurer to pay to the complainant, the eligible amount of claim.

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Award No. IO/KOC/A/GI/0356/2014-15

Complaint No. IO/KCH/GI/11-004-867/13-14

Award Passed on 04.03.2015

Smt. M. Sowmya Vs. United India Ins.Co.Ltd.

Repudiation of individual mediclaim

The complainant was covered under a Mediclaim policy of the respondent Insurance Company. She was admitted in an Ayurveda Hospital from 20/05/2013 to 10/06/2013. A claim was preferred for reimbursement of expenses towards hospitalization which was rejected as per exclusion clause 2.1 NB of Terms and conditions of the policy. The dispute regarding this could not be resolved among them, a complaint was filed before this Forum.

Respondent insurer to pay to the Complainant 50% of the admissible claim amount.

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Award No. IO/KOC/A/GI/0358/2014-15

Complaint No. IO/KCH/GI/11-004-543/13-14

Award Passed on 10.03.2015

Sri. Baby Kurian Vs. United India Insurance Co. Ltd.

Partial Repudiation of individual mediclaim

The complainant and his wife were covered under a Medi-claim policy of the respondent Insurance Company. His wife, Smt. Jaya Baby was hospitalized from 11/02/2013 to 12/02/2013 and underwent Hysterectomy. A claim was preferred for reimbursement of expenses towards hospitalization which was partially settled by the Insurer. The dispute regarding this could not be resolved among them, a complaint was filed before this Forum.

The demand for more amount than as stated in the terms and conditions of the policy is unjustifiable and hence dismissed.

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Award No. IO/KOC/A/GI/0359/2014-15

Complaint No. IO/KCH/GI/11-004-651/13-14

Award Passed on 10.03.2015

Sri. Baby P Kurian Vs. United India Ins.Co.Ltd.

Partial Repudiation of individual mediclaim

The complainant and his wife were covered under a Medi-claim policy of the respondent Insurance Company. He was admitted in a Hospital from 02/08/2013 to 05/08/2013 and undergone a surgery on the right knee. A claim was preferred for reimbursement of expenses towards hospitalization which was partially settled by the Insurer. The dispute regarding this could not be resolved among them, a complaint was filed before this Forum.

Respondent insurer to pay the disallowed portion of expenses to the complainant

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Award No. IO/KOC/A/GI/0360/2014-15

Complaint No. IO/KCH/GI/11-012-809/13-14

Award Passed on 10.03.2015

Sri. V V Mohammed Ali Vs. ICICI Lombard General Ins.Co.Ltd.

Repudiation of individual mediclaim

The complainant and his wife were covered under a Medi-claim policy of the respondent Insurance Company. His wife was admitted in a Hospital from 17/07/2013 to 20/07/2013 for the treatment of Osteoarthritis. 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.

Respondent insurer to pay 50% of the admissible claim to the complainant.

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Award No. IO/KOC/A/GI/0361/2014-15

Complaint No. KOC-G-044-1415-0130

Award Passed on 10.03.2015

Smt. Gisha Vinod Vs. Star Health & Allied Ins.Co. Ltd.

Repudiation of individual health claim

The complainant had taken a health policy from the respondent insurer in 08/2011. The complainant had undergone Breast surgery in 06/2009 and the same was disclosed while availing the policy. However instead of Mastectomy, it was printed as Hysterectomy as pre-existing disease. Since the complainant was not aware of the technicality involved, this was not pointed out to the insurer on receipt of the policy document. In 04/2014 a claim was submitted to the insurer for a PET scan undergone to check a lesion in the liver which is not pre-existing, however the insurer has rejected the claim citing "pre-existing disease" and "suppression of material facts". Representations were given along with the treating doctor's certificate, which the insurer has not acknowledged with the result that the claim was again rejected. There is no reason why the complainant should disclose that she has undergone hysterectomy when she has not and maybe, would have to undergo at a later stage in life. The interchange in the words are a genuine mistake and there is no reason why the insurer should deny the claim for a mistake. This complaint is filed seeking the full claim and compensation of not less than Rs. 2 lakhs.

Respondent insurer to settle 50% of the eligible claim.

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Award No. IO/KOC/A/GI/0362/2014-15

Complaint No. IO/KCH/GI/11-017-616/13-14

Award Passed on 10.03.2015

Sri. K A sajeev Vs. Star Health & Allied Ins.Co. Ltd.

Repudiation of individual health insurance claim

The complainant has a health policy covering himself and family (P/181211/01/2013/008630). A claim was filed for reimbursement of hospitalisation expenses of his wife, who underwent treatment at San Joe Hospital from 22/08/2013 to

28/08/2013. Despite follow-up, the claim was not settled. The Insurer has rejected the claim citing pre-existing disease. Appeal to the insurer was in vain, hence this complaint.

Respondent insurer to settle the eligible claim on receipt of all requirements.

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Award No. IO/KOC/A/GI/0363/2014-15

Complaint No. KOC-G-050-1415-0236

Award Passed on 10.03.2015

Sri. Martin T. V. Vs. Oriental Insurance Co. Ltd.

Repudiation of individual mediclaim

The complainant has a mediclaim policy with the respondent insurer (No 441502/48/2014/929). A claim was submitted for hospitalisation of his wife which was not settled by the respondent insurer. His appeal to the insurer did not yield any result, hence this complaint seeking full relief.

Respondent insurer to make payment of eligible claim amount as per the Sum Insured limits applicable for the policy year.

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Award No. IO/KOC/A/GI/0364/2014-15

Complaint No. IO/KCH/GI/11-005-872/13-14

Award Passed on 10.03.2015

Smt. R. V. Sudha Bai Vs. Oriental Insurance Co. Ltd.

Repudiation of individual mediclaim

The complainant has a mediclaim policy with the respondent insurer (No 441201/002/95). The complainant was diagnosed with osteoporosis and treatment was taken at KIMS hospital, Trivandrum. All necessary papers were submitted to the insurer, but the claim was denied. The first reason for denial was that the treatment was less than 24 hours, on pointing out that there was no minimum stated in the policy the respondent insurer informed that the disease was not covered under the policy, when it was pointed that there was no such exclusion in the policy, the insurer came up with the

reason that there was no hospitalisation at all. This complaint is filed seeking full relief with respect to the claim.

Complaint is dismissed.

MUMBAI Ombudsman Centre

Complaint No. GI- 447 of 2012-2013
Award No. A/319/2014-15

The complainant lodged a claim was lodged on the Company for treatment of macular hole. Of the amount of Rs.57480, the same was settled for an amount of Rs.31184 and the balance amount of Rs.26266 was denied and this said amount was towards purchase of face down positioning support recovery system. The Company contended that this was a durable medical equipment which was not covered under the policy. During the hearing, the complainant emphasized that this equipment was a must for the recovery and the Company was asked to get a medical opinion for the same. macular hole surgery involves use of c3f8 gas which requires strict prone position for adequate and effective tamponade. The device aids in making the patient more comfortable during the prone position thus ensuring better compliance. Though it is not used by everyone due to cost constraints, it is definitely useful for the patient."

As confirmed by the doctor c3f8 meaning perfluoropropane gas is injected intravitreously for sealing of the macular hole and after the said surgery, the patient needs to be in prone position for

completing/aiding of the healing. The equipment purchased by the complainant helps in making the patient comfortable whilst maintaining such prone position. It is not part of the treatment to be mandatorily used by all patients but a gadget which can be bought by patients who can afford it for their comfort. Treatment/healing is possible despite the gadget too albeit with some amount of discomfort.

The eye surgeon too has opined on the same lines. Such gadgets are beyond the scope of the mediclaim policy and the decision of the Company of the Company was upheld.

BEFORE THE INSURANCE OMBUDSMAN
(MAHARASHTRA & GOA)
MUMBAI
Complaint No. GI- 544 of 2042-2015
Award No. IO/MUM/A/GI -284 /2014-2015
Complainant: Shri Jay Mathuria
Respondent: The New India Assurance Co.Ltd

Complainant, Shri Jay Mathuria was covered along with his family under the mediclaim policy of The New India Assurance Co.Ltd vide policy bearing number 140103/34/09/11/00003438, valid for the period 5.2.2010 to 4.2.2011. From the submitted policy copies it is noted that the sum insured has been enhanced over a period of time and the first policy was incepted in the year 2000.

Claim arose under the policy when Smt.Vaishali Mathuria, wife of the complainant got admitted to Bombay Hospital & Research Centre on 22.6.2010 to 16.7.2010 for renal problem and underwent kidney transplantation. The claim was settled for the basic sum insured under the policy and the enhanced sum insured was denied contending that the claimed illness was pre-existing for the enhanced sum insured which was not acceptable to the complainant and he approached this forum for redressal.

During the hearing, the Company obtained an independent opinion dated 15.4.2014 from one Dr.Sharad Sheth, consulting nephrologist who has opined that based on the available information, it was not possible to come to any conclusion about the pre-existence of the disease and that de novo glomerulonephritis can progress to CKD and ESRD in a span of more than three m As per medical websites, Glomerulonephritis refers to an inflammation of the glomerulus, which is the unit involved in filtration in the kidney. This inflammation typically results in one or both of the nephrotic or nephritic syndromes. Glomerulonephritis may be temporary and reversible, or it may get worse. Progressive glomerulonephritis may lead to Chronic kidney failure, reduced kidney function and end-stage kidney disease. As rightly pointed out by Dr.Sheth, the type of GN which the insured was suffering from is

not known as there are no medical papers pertaining to that episode. However, from the write up above, it looks like the insured suffered from progressive GN as she was lead to chronic kidney disease subsequently because the probability of an otherwise healthy 40 years old individual becoming an ESRD or CKD patient is very lean in the absence of other co-morbidities.

The treating doctor, Dr.Billa has also issued another certificate dated 6.10.2010 stating that the End stage kidney disease of the insured could be related to the primary GN which she suffered in 1999.

The contention of the complainant that the kidney disease was of acute onset cannot be accepted in the absence of documentary evidence to prove the same. On the contrary, there is medical evidence to suggest that she was having underlying conditions which can lead to CKD and the same is not refuted either by Dr.Sheth (as he has stated that some type of GN can progress to ESRD) or her treating doctor, Dr.Billa. In her case, it can only be concluded that the GN suffered by her has nevertheless lead her to ESRD over a period of time.

Hence the stand of the Company was sustained.

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Complaint No. GI- 1152 of 2012-2013
Award No. IO/MUM/A/GI/A/743 /2012-2013

Complainant was covered along with his family consisting of his wife and son under the mediclaim policy 2007 of the within mentioned Company vide policy bearing number 15360034110100002113 for a sum insured of Rs.5 lacs each. The said policy was valid for the period 2.9.2011 to 1.9.2012 and from the submitted copy, it is observed that the policy was incepted for the first time in the year 2003.

Claim arose under the policy when baby Shaunak Mishra, son of the complainant got admitted to KEM hospital from 26.4.2012 to 30.4.2012 and underwent surgery for cleft palate. When the claim was preferred on the Company, the same was denied by them contending that the problem for which the child was operated was a congenital external disease which was an exclusion under 4.4.6 of the policy. This being not acceptable to the complainant, he represented to the forum for redressal.

During the hearing, the complainant submitted that he had obtained an opinion from his treating doctor, Dr.Avinash Deodhar clarifying that according to the doctor the said defect of the child was an

internal deformity which was corrected by cleft palate repair surgery but the Company did not take cognizance of the same.

The company on the other hand countered this with an independent opinion stating as follows: " This boy who was operated for his cleft palate had his symptoms such as nasal regurgitation, difficulty in swallowing milk since his birth. This has been stated by his patents while giving history to the doctors attending him. He was diagnosed as a case of cleft palate and was operated...parents of the patient knew that the child had problem of swallowing and regurgitation from birth, they knew that there was some abnormality with the child since birth i.e the problem was congenital.."

The forum observed during the hearing that the said doctor, Dr.Karandikar had not clearly stated whether the defect was external and accessible without any intervention of instruments and hence a detailed clarification on that count should be sought by the Company from the said doctor. A direction was given that the clarification so obtained should reach the forum on or before 15.10.2014. The opinion along with the clarification of the doctor was received by the forum and the doctor has elaborated thus: " ...This patient suffered from his birth and had all the pertaining signs and symptoms of cleft palate – a hole or effect in hard palate ad his parents were advised to treat him with surgery for the same. This

condition... occurs due to failure of fusion of 2 parts of hard palate during development of the baby mother's womb. This condition is present since birth and as it is in the mouth, it can be palpated of felt by finger easily as well as seen easily by anybody with the naked eyes..."

As the said definition was conforming to the definitions given by the Regulator for congenital external anamoly, the stand of the Company was upheld.

Award dated 9.12.2014.

Complaint No. GI- 882 of 2014-2015
Award No. IO/MUM/A/GI/A/798/14-15
Complainant: Smt Mayurika Ajmera
Respondent: Bajaj Allianz Gen.Ins Co.Ltd

Complainant, Smt Mayurika Ajmera was covered along with her husband, Shri Virendra Ajmera under the mediclaim policy of the within mentioned Company vide policy bearing number OG-11-1901-8416-00000874 for a floating sum insured of Rs.10 lacs with a deductible per claim of Rs.3 lacs. The said policy was valid for the period 14.3.2011 to 13.3.2012. From the submitted documents it is observed that the policy was incepted for the first time in March 2011.

Claim arose under the policy when Shri Virendra Ajmera, husband of the complainant got admitted initially to Babsaheb Gawde hospital on 18.9.2012 for complaints of retrosternal chest pain with palpitation, perspiration and mild breathlessness. The hospital found anterolateral changes in the ECG, thrombolysed him and transferred him to Kokilaben hospital on 19.9.2012 for further management. However, not responding to the treatment given, the insured unfortunately expired on 7.10.2012.

The claim when lodged on the Company was denied by them under the ground of pre-existing ground of hypertension.

During the hearing, the complainant vehemently denied that the insured was hypertensive since last ten years and emphasized that he was diagnosed to be suffering from the same only from February

2011 and hence she was advised to submit copies of past medical papers of the insured if any.

Accordingly, the complainant submitted a copy of the discharge card of Jewel hospital for the period 14.6.2010 to 4.7.2010 where the insured was diagnosed to be suffering abdominal and mediastinal tuberculosis with granular hepatitis with renal insufficiency and hyper protenemia. In the past history column, it is recorded as "no h/o DM/IHD/HTN, no h/o of asthma/tuberculosis in the past.."

The death summary issued by Kokilaben hospital for the period 19.9.2012 to 7.10.2012 is as follows: " This 55 years old male patient known case of hypertension on Losar, Pulmonary Koch's, chronic bronchitis presented to KDAH with anterior wall myocardial infarction with LVF received Elaxim outside. Patient was put on NIV and continued with decongestive measures. His Echo showed EF of 25%. Once stabilized, CAG was done which showed TVD. In view of recent MI surgery (CABG) was advised after internal….shifted to wards on 25.9.2012. On 27.9.2012, cough with haemoptysis with mild breathlessness, so Intensivist's and Pulmonologist's opinion was taken. HRCT done showed extensive ground glass opacities with consolidation with alveolar hemorrhage. Background of pulmonary edema, spuatum c/s sent. On 28.9.2012, became very breathless so shifted to ICU again NIV given. He became hypotensive, decreased urine output – needed diuretic infusion. Troponin – I came positive. BNP increased and inotropic support added, Patient was intubated and ventilatory support was given. Later IABP support was also added. Patient was covered with antibiotics as per sputum c/s report. Patient gradually worsened and MODS set in. On 7.10.2012, had cardiac arrest, Patient could not be revived. Patient declared dead on 7.10.2012 at 4.25 p.m."

In the instant case, the deterioration of the insured occurred more because of underlying lung problem than heart problem. The imaging of the lungs continuously showed ground glass opacity. Generally ground glass opacity occurs due to infectious processes (usually opportunistic) like chronic interstitial diseases, acute alveolar diseases and other causes. In his case, the complainant was already a known case of abdominal and mediastinal (pulmonary) Koch's and hence a very likely target for opportunistic infections. Though his initial problem for which he was admitted was heart ailments, after being thrombolysed, he was stable. In fact on 27.9.2012, his trouble started by way of cough with hemoptysis (meaning coughing up blood) and pulmonary edema and breathlessness. If we examine the blood investigations of the insured, it can be seen that his hemoglobin and hematocrit values were very low and gradually declining and the cause of which can be

attributed to the alveolar hemorrhage (means bleeding from the lungs). Generally, rise in enzyme Troponin I indicates heart problem but can also be an indication in non cardiac problems such as pulmonary embolism or COPD. In the insured's case, he was having bronchitis and also alveolar hemorrhage which could have caused an elevation in Troponin I. Hence there are reasonable grounds to believe that the death was caused because of lungs disorder. Even the cause of death certificate states pulmonary edema and bronchitis to be the causative factors in addition to the heart problem for his death. Hence, the question whether the hypertension was pre-existing or otherwise is not relevant in deciding this claim.

However, it is noted by the forum that the admission to Jewel hospital in June 2010 and the resultant diagnosis has not been disclosed by the complainant in the proposal form. Abdominal and mediastinal Koch's are serious disorders which should have been disclosed by the complainant at the time of taking the policy in March 2011. The complainant has also confirmed that the policy with New India which was valid since long and was still continued in her name after the unfortunate demise of her husband and that they had also received a claim of Rs.2.10 lacs for the same admission/claim. This being so, the policy of Bajaj Allianz can only be treated as a fresh policy for additional sum insured of Rs.10 lacs and cannot be treated as continuity of New India policy because that policy is still in force and the complainant has not migrated to this present insurance after discontinuing the same. The validity of the writing of Bajaj Allianz that their policy is in continuity with the New India Assurance policy is not clear to me and the reasons are best known to them. Nevertheless, no credit can be given for the coverage of New India as this policy is a fresh one for additional sum insured and there is definite non disclosure of material facts by way of withholding information regarding the diagnosis of abdominal and mediastinal Koch's (which are pertinent to the cause of present day ailment and resultant of the insured) whilst taking the present policy. That the ailments for which the insured was admitted and which was the cause of his untimely demise was both pre-existing and non disclosed by the complainant is evident.

Hence the stand of the Company was upheld although for different reasons.

BEFORE THE INSURANCE OMBUDSMAN
(MAHARASHTRA & GOA)
MUMBAI

Complaint No. GI-418/2012-2013
Award No. IO/MUM/A/GI- /2014-15
Complainant: Smt. Lily Golwalla
Respondent: United India Insurance Co. Ltd.

Complainant Smt. Lily Golwalla was covered under Individual Mediclaim Policy No.022000/48/10/20/00002704 for the period 11.02.2011 to 10.02.2012 for Sum Insured of Rs. 2,00,000/- with 50% C.B., issued by United India Insurance Co. Ltd.

In July 2011, Smt. Golwalla was detected of Cancer of the pancreas and was operated for the same at Jaslok Hospital. Out of the total expenses of Rs.8,34,000/- incurred for the same, she received an amount of Rs.5 lacs under the Group Insurance policy held by her daughter as an employee of EXIM Bank. For the balance amount, she lodged a claim under her policy with 'United India'; however the claim was not settled by the Company.

Insurance Company contended that the policy issued to Smt. Golwalla carried a permanent exclusion for "Any expenses arising out of Cancer of kidney alongwith any complications arising therefrom and all kidney diseases". Since the insured was treated for Solitary Metastases to Pancreas from Renal Cell Carcinoma, the claim stood inadmissible as per the Exclusion mentioned on her policy.

Smt. Golwalla argued that she suffered from cancer of the kidney and had undergone left radical nephrectomy 25 years back after which she had no health problems till the present treatment which was for cancer of pancreas and was in no way connected to her previous ailment. She also pointed out that she had not lodged a single claim and this was her first claim under the policy in all these years.

The case was examined by the Forum. As per information available from various internet sites, Renal cell carcinomas (RCCs) account for 2% of all cancers and have a predilection to metastasize to rare locations, including the pancreas. RCC is the most common primary tumor leading to solitary pancreatic metastasis. Although the majority of metastases occur within 3 years of radical nephrectomy, the appearance of metastatic disease many years after nephrectomy is a well-known feature of RCC. Since most pancreatic

metastases are asymptomatic, routine long-term radiologic surveillance is necessary.

Also, the Discharge Summary of the hospital mentioned the diagnosis as "Solitary Metastases to Pancreas from Renal Cell Carcinoma" which implies that the present ailment was a complication of the Kidney Cancer suffered by her. In view of the same, the decision of the Insurance Company to repudiate the claim based on the Exclusion mentioned on the policy, cannot technically be faulted with.

At the same time, the fact cannot be totally overlooked that Smt. Golwalla is continuously insured under the Mediclaim policy of the Company since the year 1988 without any claim until the present one. Also, it needs to be taken into account that while the revised Health Insurance Policy introduced by the Company covers all pre-existing diseases after completion of 48 months of continuous coverage, the said benefit is not available to the persons insured under the old Mediclaim policy where pre-existing diseases are excluded permanently from the scope of the policy, irrespective of their uninterrupted long coverage. It is not even known whether Smt. Golwalla, being a senior citizen at the time of introduction of the revised policy, was given an option to go in for the revised policy or not. In view of the same taking into consideration the long-term association of Smt. Golwalla with the Company coupled with a good claim experience, the Forum is of the opinion that it would be in the interest of justice to allow her some relief on ex-gratia basis. Under the circumstances, the decision of the Company is intervened by the following Order.

ORDER

United India Insurance Co. Ltd. is directed to pay to Smt. Lily Golwalla an amount equivalent to 50% of the Sum Insured alongwith C.B. available under the policy, on ex-gratia basis against the claim lodged by her for her hospitalization at Jaslok Hospital from 17.07.2011 to 10.08.2011 for the treatment of Cancer of the pancreas There is no order for any other relief. The case is disposed of accordingly.

Complaint No. GI- 776(2013-2014)

Complainant: Smt. Sarita Rao
v/s.
Respondent: Star Health and Allied Insurance Company Ltd

Mrs. Sarita Rao was covered under Diabetes Safe Insurance policy and Family Health Optima Insurance policy issued by Star Health and Allied Insurance Company Ltd. She was admitted to Acharya Nursing Home, Kalyan from 08.03.2013 to 14.03.2013 with diagnosis of boil in her right thigh. After she was discharged from the hospital, when she preferred the claim to the insurer, it was rejected on the grounds that ailment suffered by her does not fall under three complications of diabetes covered under her Diabetes Safe policy and present ailment is complication of pre-existing disease i.e. Diabetes Mellitus.

Aggrieved by their decision, Mrs. Sarita Rao approached the Office of Insurance.Ombudsman seeking intervention in the matter of settlement of her claim.

After perusal of the records parties to dispute were called for hearing.

Star Health and Allied Insurance Company Ltd was represented by Dr. Arvind Thakkar. He stated that Diabetic Safe Insurance policy covers Diabetic Retinopathy, Diabetic Nephropathy and Diabetic Foot Ulcer requiring micro vascular surgery. He added that Mrs.Sarita Rao was diagnosed of Carbuncle on thigh which does not fall under any of the above 3 complications. Hence claim was rejected under Diabetic Safe policy. Since the ailment suffered by the complainant is complication of pre-existing disease i.e. Diabetes Mellitus and a period of 48 months had not elapsed since inception of the policy, claim was rejected under Family Health Optima policy.

Ombudsman asked Dr. Thakkar whether diabetes is the only cause of carbuncle, to which Dr. Thakkar replied that it is complication of Diabetes Mellitus.

Smt. Sarita Rao stated that she has obtained Certificate from her treating doctor, Dr. Nitin Zabak wherein he has stated that Carbuncle is an acute infective disease which can also be seen in patients other than those suffering from Diabetes. Dr. Thakkar

remarked that he is not in possession of the copy of the said certificate and requested the forum to grant him 10 days time to get expert opinion on this issue. The forum handed over the copy of the above certificate to Dr. Thakkar.

On hearing the deposition of both the parties to dispute, Ombudsman directed the company to get expert opinion on the issue whether ailment (Carbuncle) suffered by the complainant is only due to Diabetes Mellitus and inform their final stand to the forum within 10 days.

On 05.01.2015, the forum received a copy of letter dated 24.12.2014 sent by the company to the complainant stating that they have reviewed the case and has decided to settle the claim for Rs. 34,311/-.

Complaint No. GI- 260 (2013-2014)

Complainant: Shri Shivcharan Wagh
v/s.
Respondent: United India Insurance Co.Ltd

Mr. Shivcharan Wagh was covered under Group Mediclaim Policy no. 030400/48/09/41/00003041 taken by Medicare Service Club issued by United India Insurance Co.Ltd. In the first week of August, 2010 he received a letter from Medicare Service Club asking him to pay Rs. 17090/- and submit the enrollment form though he was already insured with UIIC since 10 years. Unfortunately on 21.08.2010, he suffered from hyponatermia and was confined to indoor treatment in S.L. Raheja Hospital for few days .After he was discharged from the hospital, he contacted the Medicare Service Club official in 11/2010 as to why he is required to submit the enrollment form which is supposed to be filled by the prospective customer. But the officials did not entertain his call. Thereafter he sent the cheque and the necessary papers to Medicare Service Club which was returned back to him stating that UIIC is not ready to accept his renewal request due to delay in submission.

Aggrieved by their decision, Mr.Shivcharan Wagh approached the Office of Insurance Ombudsman seeking intervention in the matter of renewal of his policy.

After perusal of the records parties to dispute were called for hearing.

The complainant Mr. Shivcharan Wagh along with his wife Mrs. Swati Wagh appeared and deposed before the Ombudsman. He stated that he along with his wife and daughter were covered under mediclaim policy with UIIC. He had paid a premium of Rs. 12851/- for period of from 01.03.2010 to 28.02.2011. He added that he had taken the policy on the basis of advertisement that there would be no medical test and premium will be debited from BOB credit card. He stated he was covered with UIIC since 10 years. When the Medicare Services Club returned his renewal cheque, he submitted all the necessary papers and cheque to United India Insurance Co.Ltd as was directed by UIIC official in churchgate. However he did not get any positive response from them and his policy was cancelled. He wrote several email to Grievance department of UIIC but they did not respond to those emails. He pleaded that since he had paid the premium till 02/2011, it was wrong on the part of the company to cancel the policy before its completion.
United India Insurance Co.Ltd was represented by Ms.S. Dharmambal and Ms. Harsha Mamtora. Ms. Dharmabal submitted that since they did not get necessary documents from the concerned Kolkata office for deposition, they requested Ombudsman to grant 3 weeks time to give their observations.

On hearing the deposition of both the parties to dispute, it is observed that Mr. Shivcharan Wagh was covered under Group Mediclaim policy issued by United India Insurance Co. Ltd and serviced by Medicare Service Club for period from 01.03.2010 to 28.02.2011. In August 2010, the complainant received letter from Medicare Service Club asking him to submit the proposal form along with premium amount for conversion of his Group Mediclaim to Individual Mediclaim policy. However his policy was discontinued from 01.10.2010 since he had delayed in submitting the proposal form along with premium cheque to the insurer due to his ill health. Inspite of his repeated followup with the insurance company asking for reason for discontinuing his policy, the insurance company did not give him any satisfactory reply. Since the policy was valid as on the date of submission of cheque on 09.11.2010, the company is directed to send their observation within 3 weeks, as to why they did not act on it and accept his request for policy conversion from Group Mediclaim to Individual Mediclaim.

On 12.12.2014, the forum received letter dated 11.12.2014 from UIIC stating the following: " The complainant was covered under GMP taken by Medicare Service Club.. The policy no. 03040048094100003041 was valid from 01.07.2009 to 30.06.2010. The policy expired on 30.06.32010 and as per Corporate decision not to continue the policies with the non employer-employee relationship that policy was not renewed from 01.07.2010 and the insured persons were given opportunity to migrate to Individual Health Insurance policies with a time from 19.11.2010.

Accordingly, notice was sent by Medicare Service Club to all Individual member for migrating their Health Insurance coverage to Individual policies and a letter to this effect was also sent to Mr. Wagh , the complainant on 05.08.2010 vide mentioning premium payable for coverage. That letter was received by Mr. Wagh on 06.08.2010 but after a long period of time premium cheque was sent to Medicare Service Club and the same was received by MSC on 30.11.2010. Since continuity of coverage cannot be given after 19.11.2010, we had refused to accept the premium after stipulated time frame and the cheque was returned to the complainant on 09.12.2010.

The complainant's statement that amount of premium was paid till 28.02.2011 and the policy was terminated on 02.12.2010 is not true. In fact the premium for the group policy was paid by Medicare Service club for a period from 01.07.2009 to 30.06.2010 after collecting subscription from individual member of the club. Presumably the date mentioned i.e. 28.02.2011 by the complainant is validity of membership with Medicare Service club and the amount paid to Medicare Service Club towards membership subscription. In fact he has not paid any money to Insurance Company.

The complainant has made On-line complaint to our Customer Care department and after reviving the matter they had closed the Online compliance by giving reply to the complainant. It is not true that the policy was cancelled before expiry of the terms. Allegation made by complainant that the policy was valid till 28.02.2011 is not correct at all. The policy issued by us is in the name of ANZ Card-holders expired on 30.06.2010 and thereafter it was not renewed. Hence alleged policy/Insurance coverage was not in existence."

The entire documents submitted to the forum are taken on record. Let us find out whether there is any merit in the complaint of Mr. Shivcharan Wagh:-

1) **As per copy of the policy no. 030400/ 48/ 09 41/ 00003041, it is observed that the period of insurance is from 01.07.2009 to 30.06.2010.**
2) **The complainant has submitted Certificate from Ms. Sunita Banerjee, Manager Relationship of Medicare Service Club which states "This is to certify that Mr. Shivcharan Wagh has opted for Group Medical Plan (Membership no. BOBMPOOO526A) of Medicare Service Club under Group Medsiclaim policy issued by United India Insurance Company Ltd. The present Master policy no. is 0300/48/09/41/00003041 is for coverage of Rs. 3 Lakhs for Mr. Shivcharan Wagh and his family and he has paid a consolidated amount of Rs. 12851/- for the period from 01.03.2010 to 28.02.2011 towards renewal of this Membership." Thus the Membership period of Mr. Wagh with Medicare Service Club is from 01.03.2010 to 28.02.2011 which was wrongly alleged by him to be insurance policy period .**
3) **On 05.08.2010, MedicareService Club sent a letter to the complainant asking him to send the enrolment form along with premium cheque before 31.08.2010 for migrating to Individual /Family Floater plan of United India Insurance Co.Ltd. The letter also clearly states that if they do not receive any communication from the complainant within 31.08.2010, then his policy will be cancelled from 1.10.2010.The complainant during the course of hearing has also accepted that he received the above mentioned letter in the first week of August.**
4) **Medicare Services had asked for extension in the time period from UIIC since it was difficult for them to inform all the members PAN India and then get the policy migrated into individual policies with the expiry of the card member policies. UIIC extended time limit till 19.11.2010.**
5) **The complainant had submitted the renewal premium cheque to Medicare Service Club on 30.11.2010.**
6) **Medicare Service Club vide letter dated 02.12.2010 returned the premium cheque to the complainant stating that UIIC was not accepting any premium as it was received beyond the stipulated date.**

Thus it is observed that the period of Group Insurance policy where in Mr. Wagh was covered ended on 30.06.2010. However UIIC gave an option to the policyholders to migrate to Individual policies along

with continuity benefits by submitting the necessary enrollment form and premium by 19.11.2010. Unfortuntaely Mr. Wagh submitted the same on 30.11.2010 which was much beyond the time frame originally given to him. Under these circumstances, the decision of the company to deny the request of the complainant to migrate into Individual policy is in order and the forum do not find any valid reason to intervene with the same.

Complaint No. GI- 803 (2012-2013)
Complainant: Ms. Suhasini Sharma
v/s.
Respondent: Bajaj Allianz General Insurance Company Ltd

Ms. Suhasini Sharma was covered under Individual Health Guard Policy number OG-12-1907-8401-00000224 issued by Bajaj Allianz Life Insurance Company Ltd. On 03.05.2012 Mrs. Suhasini Sharma was admitted to Saraswati Hospital as she was diagnosed with Malarial Fever with gastro enteritis. When she lodged the claim with the insurer it was repudiated on the grounds that there were discrepancies in the various hospital reports /records.

Aggrieved by their decision, Ms. Suhasini Sharma approached the Office of Insurance Ombudsman seeking intervention in the matter of settlement of her claim.

After perusal of the records parties to dispute were called for

hearing.

Bajaj Allianz General Insurance Company Ltd was represented by Mr. Sandip Jadhav and Dr. Rashmi Sachdev. Dr. Rashmi Sachdev stated that the claim under policy no. OG-12-1907-8401-00000224 was repudiated stating the reason as 'Fraud' as per Condition D7 of the policy. The decision to repudiate was arrived on the basis of investigation which revealed the following:-

1) **Verification of the claimant could not be conducted as the claimant was out of town as confirmed by Claimant's father.**
2) **Verification of treating Doctor Mr. Prakash Khetani could not be conducted as the hospital refused to co-operate.**
3) **Verification of Hospital Bills could not be conducted as the hospital refused to show IP register.**

4) **Verification of Pharmacy Register book maintained by the Hospital could not be conducted as the hospital refused to co-operate. In fact the hospital does not have license to sell the medicines.**
5) **Dr. Rajesh, owner of the hospital provided the certified copy of Invalid Hospital Registration Certificate but failed to inform whether he had applied for renewal or not.**
6) **Certain contradictions were noticed in the statements of Mr. Rajendra Sharma and Hospital Authorities like as per the statement of Mr. Rajendra , patient was admitted in General Ward wherein Doctor's Charge is Rs. 300/- but they have been charged with Rs.700/- as Doctor's Fees. In addition to this, bed charges in General Ward is Rs. 250/-as verbally confirmed by the claimant's father and Hospital Authorities but in the final bill, it shows that insured has been charged Rs.1000/- as bed charges.**
7) **The investigator requested Dr. Rajesh to show in-house Saraswati Diagnostic Centre from where lab testing has been done but he refused and informed that there is no in-house lab and all test has been conducted from other lab-whose details he refused to divulge.**
8) **Who has signed as witness on admission form is not known to the father of the patient.**
9) **The signature of the patient in Admission form and claim form differs from the signature in NEFT form and PAN card.**
10) **The doctor provided certified copy of ICP papers to the investigators wherein following discrepancies were noted:-**
    - **No IP number is mentioned on admission form.**
    - **No time of discharge is mentioned on admission form.**
    - **2 antibiotic injections , Injection Otron (to stop vomiting),3 calpol tablets and cyclopean tab (for abdominal pain) were given to the patient every day till the date of discharge though she was not febrile and no complaints of pain in abdomen were recorded in ICP .**

Ombudsman asked Mr. Rajendra Sharma that since they stay in Kamothe, Navi Mumbai then why his daughter was admitted to Saraswati Hospital in Govandi, to this he stated that there is no hospital in Kamothe which is in the network of the insurer. Since they also have house in Govandi and Saraswati hospital is one of the Network Hospital of the insurer, they got her admitted to this hospital.

The forum observed that company has not mentioned in their written statement that Saraswati Hospital is in their Network Hospital.

Ombudsman remarked that since the said hospital is in the panel of the insurer and the same was recommended by the insurer to the policyholders through their websites, now they cannot allege that the hospital is not providing them with requisite information and that cannot be ground for repudiation of claim. As far as faulty line of treatment and discrepancies noticed in the various reports/hospital papers, the insurer should have got the same clarified from the hospital authorities and in case the hospital did not co-operate necessary action should have been taken.
The company was directed to provide reasons as why they are not able to get the relevant information from the hospital authorities, though it is one of their Network. Since the company has also alleged that the claim is fabricated then what action has been taken against the hospital. The insurance company was required to submit their observations within 7 working days.

The forum directed the Complainant to get signature verification of Ms. Suhasini Sharma from the Bank where she is holding an account along with copy of pass book and submit the same within 7 working days. The complainant submitted the same on 10.10.2014.
On 4th November,2014 the forum received email from the company stating that " We are able to trace Dr. Khetani at Mahaveer Hospital, Govandi after a hunt in various hospitals of Chembur and Govandi. On going through the hospitalization documents, Dr. Khetani verbally confirmed that he have not seen the patient. He was not ready to mention anything on this letter head or stamp paper. He asked to prepare Questionnaire for the same and he will give the answer in Yes/No format with his signature and stamp. He mentioned "No" for the questions whether the handwriting and signature is of Dr. Khetani on hospitalization documents. He requested to deny the claim based on the same. Further he was not ready to write anything against the hospital citing reason that he shares very good relations with the hospital since past 15 years."
The Questionnaire for Treating Doctor signed by Dr. Prakash Khetani

is reproduced below:-

Answer

"1) Do you visit or have consultation at Saraswati Hospital,Govandi?

Yes

2) Do the clinical notes of hospitalization Indoor Case paper of Miss

Suhasini

Sharma bears your handwriting?

No

3) Does the Indoor case papers of Miss Suhashini bears your

signature? No

4) Have you treated Miss Suhashini Sharma on IPD basis at

Saraswati Hospital from 03.05.2012 to 10.05.2012

NA

5) Do you agree that your name has been misused by hospital in said

case ? NA"

On 24th November, 2014, Bajaj Allianz General Insurance Company Ltd sent an email stating that they have de –paneled Saraswati Hospital on 05.11.2014.

The entire documents submitted to the forum and deposition of both the parties to dispute is taken on record. It is observed that the company officials deposed that they were not able to conduct verification of treating doctor, Dr.Prakash Khetani and also of the hospital bills as the hospital authorities refused to co-operate with them. Though the insurance company noticed that Dr. Rajesh had provided them with Invalid Hospital Registration Certificate and there were many inconsistencies in various hospital bills and ICP papers, they failed to take any action against the hospital. It was the duty of the insurer to investigate whether such incidences had

repeatedly occurred in the said hospital or it was first instance since this hospital was in their Network group and accordingly action should have been taken to avoid such incidences in future. Instead, on the basis of above findings the insurer simply repudiated the claim under condition D7
which states that " If you make or progress any claim knowing it to be false or fraudulent in any way, then this policy will be void and all claims or payments due under it shall be lost and the premium paid shall be forfeited ." Since the name of Saraswati Hospital, Govandi was published in various documents and their website by the insurer, it implies that they have recommended this hospital to the insured who can approach for treatment and be assured that claim will be settled. Though Saraswati Hospital is PPN hospital, the forum has observed that there are glaring anomalies which are difficult to ignore. It is observed that Hospital records are not properly maintained .i.e. there is no mention of IP number in the admission form, time of discharge of the insured from the hospital is not mentioned and the line of treatment given is not consistent with the ailment diagnosed. On going through the hospital documents, it establishes that Ms. Suhasini had fever since 2-3 days, shivering, nausea+++, vomiting -4 times, pain in abdomen. However the complainant has not informed us what treatment she had taken prior to getting admitted in the hospital nor is the same mentioned in the hospital records. Also documents evidencing post- hospitalization followup are also not submitted. It is also noticed from the questionnaire signed by Dr. Khetani that he has not clarified whether his name is being misused by the hospital in the said case. Instead he has stated that he shares good relations with the hospital authorities for past 15 years.

From the above documents produced at this Forum, the material facts are contradicting in nature. To resolve a dispute of this nature where contradictory statements are placed, will involve detailed investigations, including cross examination of the Doctors who recorded the above noting. This Forum with a limited jurisdiction is not empowered to summon the hospital & Doctors which could not be held in the summary proceedings under the provision of the RPG Rules 1998. In view of this, the complaint is dismissed at this Forum with a liberty to the claimant to approach any other appropriate Forum for resolving her dispute.

Complaint No: GI/100/2012-13
Award No: IO/MUM/A/GI- /2013-14
Complainant : Mr Kamlesh T Doshi
Respondent : The New India Assurance Co.Ltd.

Master Darshan Doshi nephew of Mr Kamlesh T Doshi is covered under Individual Mediclaim Policy No:110900/34/10/11/00006661 for a sum insured of Rs. one lac. Master Darshan was first admitted to Sanjivani Hospital from 22.12.2010 to 23.12.2010 and then to Shubham Hospital from 23.12.2010 to 01.01.2011 for communicated displaced of patella and lodged a claim of Rs.122786/-. He had a history of Road Traffic Accident by Motor bike at around 11.30 pm. While he was walking on the road he was knocked down by a motor cycle. The Company repudiated the above claim as the complainant did not provide a copy of MLC/FIR in spite of repeated reminders. Sanjivani Hospital had informed Virar Police station of the incidence in which the injuries were sustained. FIR was not done.

The Forum asked the complainant about the case. The complainant submitted that Master Darshan was knocked down by a scooter on 22.12.2010 around 11.30 pm and the public on the road had admitted him to Sanjivani Hospital Virar and later on the next day they shifted him to Shubham Hospital for further treatment. Sanjivani Hospital had informed the police authorities about the accident.

The Forum asked the Company the reason for their denial. The Company submitted that as there was no FIR and MLC and therefore they repudiated the above claim.

Under the circumstances the Forum observes that though there was no FIR/MLC the hospital authorities have informed the Police and thereafter the Police has not made any visit to the hospital. The Forum therefore directed the Company to honour the above claim for the admissible expenses and inform the payment particulars to this Forum within a period of ten days. Both the Company and complainant agreed for the same.

ORDER

The New India Assurance Co.Ltd. to comply with the directions given as above. There is no order for any other relief. The case is disposed of accordingly.

BEFORE THE INSURANCE OMBUDSMAN
(MAHARASHTRA & GOA)
MUMBAI

Complaint No. GI-1861 of 2011-12
Award No. IO/MUM/A/GI /2014-2015
Complainant : Shri. Pradeep Vyas/Shri. Hemant Vyas
Respondent : The Oriental Insurance Co. Ltd.

Late Shri. Pradeep Vyas was covered under Group Mediclaim Family Floater Policy bearing No.112200/48/2011/2210 (Platinum) issued by The Oriental Insurance Co. Ltd. for the period 25.2.2011 to 24.2.2012 for Floater Sum Insured of Rs.2,00,000/-. Shri. Pradeep Vyas was admitted to Unique Hospital & Polyclinic on 10.10.2011 and thereafter on 18.10.2011 was shifted to Kokilaben Dhirubhai Ambani Hospital. Whilst undergoing the treatment he died in the Hospital on 19.10.2011. As per medical certificate issued by Hospital, the cause of death was Cardiogenic shock with Sepsis-Acute on chronic Pancreatitis-Chronic Liver Disease-Inferior Vena Cava Thrombosis. When a claim for Rs.2,20,400/- was preferred under the Policy, TPA of the Insurance Company repudiated it stating that patient was alcoholic and hence this claim is not admissible as per exclusion clause 4.8 of the Policy which excludes ailments arising out of the use of intoxicating drugs/alcohol. After perusal of the records parties to the dispute were called for hearing on 10.3.2014.

The claim has been repudiated by the Company based on the history of "chronic alcoholic" as recorded in the hospital/medicalpapers. Complainant's representative however contended that his brother used to consume alcohol occasionally and he was not a chronic alcoholic.

Pancreatitis means inflammation of the Pancreas. Alcohol consumption is the common cause of Pancreatitis. Chronic pancreatitis is a long-standing inflammation of the pancreas that

alters the organ's normal structure and functions. It is usually the result of longstanding damage to the pancreas from alcohol ingestion. It is also possible for patients with chronic pancreatitis to have episodes of acute pancreatitis. In about 80 percent of the cases, acute pancreatitis is caused by gallstones and alcohol ingestion. Acute Pancreatitis is suspected when patient has symptoms and has risk factors such as alcohol ingestion or gall stone disease. Localized complications include fluid collections, pancreatic pseudocysts, pancreatic necrosis and infectious pancreatic necrosis. Alcohol consumption is the commonest risk factor to cause chronic liver disease. Infection and Thrombosis of blood vessels are the complication of Acute Pancreatitis.

In the instant case, Kokilaben Dhribhai Ambani Hospital has certified the cause of death as cardiogenic shock with sepsis due to Acute on Pancreatitis and Chronic Liver Disease. It is noted that Shri. Vyas had history of long standing alcohol consumption as the hospital/medical papers submitted before the Forum have clearly mentioned that Shri. Pradeep Vyas was a "chronic alcoholic since 15 years". As examined above alcohol ingestion is the common cause for both Pancreatitis and chronic liver disease. Viewed in this context, Company's decision to reject the claim under exclusion 4.8 based on the history recorded in the hospital papers, cannot be faulted with.

ORDER

The complaint of Shri. PradeepVyas/Shri. Hemant Vyas against The Oriental Insurance Co. Ltd. on account of repudiation of a claim lodged in respect of hospitalization at Unique Hospital & Polyclinic and Kokilaben Dhirubhai Ambani Hospital from 10.10.2011 to 19.10.2011 does not sustain. The case is disposed of accordingly.

BEFORE THE INSURANCE OMBUDSMAN
(MAHARASHTRA & GOA)
MUMBAI

Complaint No. GI-1581/2012-2013
Award No. IO/MUM/A/GI- /2014-15
Complainant: Shri Falgun Anil Kanani
Respondent: United India Insurance Company Ltd.

Complainant Shri Falgun Kanani was covered under Individual Health Insurance Policy No.021400/48/12/97/00000236 for the period 18.04.2012 to 17.04.2013 for Sum Insured Rs.5,00,000/-, issued by United India Insurance Co. Ltd. Shri Kanani experienced severe pain in neck and both shoulders for which he took some conservative treatment which did not give much relief. Hence he underwent investigations and after an MRI, was detected as suffering from Arnold Chiari Malformation Type I for which he underwent a surgery at Hinduja Hospital in June 2012. A claim lodged under the Health Policy for the same was rejected by the Company citing Exclusion Clause 4.1 of the policy which excludes all External & Internal Congenital diseases. Shri Falgun argued that though his ailment was congenital i.e. present since birth, he was not aware of the same until the age of 30. Further clause 3.10 of the policy provides for covering even pre-existing diseases after completion of a period of 4 years of continuous renewal whereas his policy had run continuoulsy for more than 10 years. He also pointed out that other policies issued by the same Insurance Company have a provision for coverage of internal congenital disease after a specific period while the terms and conditions of his policy were restrictive to that effect.

As per information available, Chiari malformations, types I-IV, refer to a spectrum of congenital hindbrain abnormalities affecting the structural relationships between the cerebellum, brainstem, the upper cervical cord, and the bony cranial base. It can cause headaches, fatigue, muscle weakness in the head and face, difficulty swallowing, dizziness, nausea, impaired coordination, and, in severe cases, paralysis. The scale of severity is rated as Type I - IV, with IV being the most severe. Types III and IV are very rare. Type I is a congenital malformation and is generally asymptomatic during childhood, but often manifests with headaches and cerebellar symptoms. This type is difficult to diagnose and treat.

From the above it is clear that Arnold Chiari Malformation Type I suffered by the complainant is a congenital disease. Clause 4.1 of the Individual Health Insurance Policy permanently excludes all internal and external congenital diseases from the scope of the policy. Though the Forum is able to appreciate the case of the complainant in expecting the Insurer to settle the claim in view of the fact that even pre-existing diseases are covered after 48 months of continuous coverage, Health Insurance policy is an annual contract and whenever any dispute arises it is settled based on the terms and conditions of the policy under which a claim has arisen. It is to be borne in mind that this Forum has the inherent limitations in going beyond the provisions of the policy contract and the Forum examines cases in detail to see whether there is any breach of policy provisions while denying a claim and cannot grossly overlook the terms and conditions clearly spelt out in the policy and also approved by the IRDA. Under the facts and circumstances of the case, repudiation of the claim by the Company not being adversarial to the policy terms and conditions, cannot be faulted with.

ORDER

The claim of Shri Falgun Anil Kanani for reimbursement of expenses incurred for his hospitalization at P.D. Hinduja Hospital from 19.06.2012 to 25.06.2012 for the treatment of Arnold Chiari Malformation Type I with Syringomyelia C1-D1 is not sustainable. The case is disposed of accordingly.

BEFORE THE INSURANCE OMBUDSMAN
(MAHARASHTRA & GOA)
MUMBAI

Complaint No.GI-762 of 2012-2013

Award No.IO/MUM/A/GI- /2014-15
Complainant : Shri. Anuj Bhatia
Respondent : ICICI Lombard General Insurance Co. Ltd.

Complainant's spouse Smt. Alka Bhatia was covered under Home Safe Plus – Secure Mind Policy bearing No.4065/ICICI-HSP/1904607/00/000 issued by ICICI Lombard General Insurance Co. Ltd. for Sum Insured of Rs.29,10,000/- (Section I) for the period 24.6.2009 to 23.6.2014. Complainant approached this Forum with a complaint against repudiation by the Insurance Company of a claim under the Policy. The records were perused and parties to the complaint were heard during the personal hearing which was held on 21.7.2014

The analysis of the entire case reveals that as per medical papers on record, Smt. Bhatia was diagnosed to have Left Lung Collapse. Insurance Company took a stand that there has been no loss suffered by the insured as per the 9 major medical illness and procedures defined and covered under the Policy. Company repudiated the claim on the ground that ailment suffered by Smt. Bhatia i.e. Collapse Lung – left due to Bronchiectasis falls outside the purview of nine major medical illnesses and procedures defined and covered under the Policy as there is no evidence of major Organ Transplant. Complainant however is of a view that his wife suffered from irreversible left lung failure; however the lung transplant is not possible in India as the cost of the same is very high and there is a huge shortage of lung donors.

It should however be noted that the disputes in this Forum are resolved based on the terms and conditions of the Policy. In the instant case, under Section I, the Insurance Company has listed out 9 specific major illness and procedures as Insured Events which are covered under the Policy. Further, each Insured Event is specifically defined under the Policy and the "Major Organ Transplant" is one of the 9 listed Insured Events under the Policy. Major Organ Transplant is defined as the receipt of a transplant of one of the whole human organs viz. heart, lung liver, pancreas or kidney as a result of irreversible end stage failure of the respective organ. In

the instant case, there is no doubt that Smt. Bhatia suffered from irreversible left lung failure. However, she was not treated by way of Lung Transplant. As the medical condition suffered by Smt. Bhatia and the treatment underwent by her falls outside the purview of nine major medical illnesses/Insured Events, Insurance Co. rejected the claim. The decision of the Insurance Company which is based on policy terms & conditions is found to be correct and hence cannot be faulted.

Whilst on the issue it is also noted that as per P-II form, the complainant has sought compensation of Rs.29,10,000/- which is the Sum Insured available under the Policy under Section I. The RPG Rule 16(2) states that – The Ombudsman shall not award any compensation in excess of which is necessary to cover the loss suffered by the complainant as a direct consequence of the insured perils, or for an amount not exceeding rupees twenty lacs (including ex-gratia and other expenses), whichever is lower. Under the circumstances, since the compensation sought by the complainant exceeds the limit of Rs.20 lacs, on this count also, the complaint stands non-sustainable in this Forum.

ORDER

The claim of Shri. Anuj Bhatia in respect of loss suffered by him due to his wife's Left Lung Collapse is not sustainable. The case is disposed of accordingly.

BEFORE THE INSURANCE OMBUDSMAN
(MAHARASHTRA & GOA)
MUMBAI

Complaint No.GI-102/2012-2013
Award No.IO/MUM/A/ GI- /2014-2015
Complainant : Shri. B. Bhadran
Respondent : United India Insurance Co. Ltd.

Shri. B. Bhadran along with his wife Smt. L. Sanumathi Amma and son Shri. Hridesh Bhadran was covered under Individual Health Insurance Policy bearing No. 120100/48/08/97/00014896 issued by United India Insurance Co. Ltd. for the period 22.2.2009 to 21.2.2010. Shri. Bhadran approached this Forum with a complaint against the Insurance Company about non-settlement of the claim lodged in respect of his son's hospitalisation in Lifeline General Hospital from 13.9.2009 to 26.9.2009. Records were perused and parties to the complaint were called for the personal hearing on 6.5.2014.

Shri. Bhadran submitted that his son's platelet counts were drastically dropped down, he was having high grade fever with chills, hence on 13.9.2009 he was taken to Life Line Hospital. In the hospital one Dr. Trimukhe was specially called by him from Criti Care Hospital to treat his son. He further mentioned that his son could not get any relief in the hospital and hence discharge was taken from the hospital and the further treatment was taken at Kerala. He said that if the Company was knowing that the hospital where his son was admitted was not registered, then how the Insurance Company has settled his second claim of the same hospital.

On behalf of Insurance Company it was contended that on receipt of claim documents, their Office had appointed M/s Hi Tech Medical Services to investigate into the claim and their investigator had observed the following discrepancies – 1) The hospital was not registered with the local authorities and minimum of 15 beds' criteria was not fulfilled, 2) The address on the bill of the hospital and in the discharge card was different, 3) The IPD register, bill book and ICP were not available with the hospital, 4) Daily entries by the doctors/consultants were not available in the papers submitted to the Company, 5) Some of the medicine bills did not bear the name of the patient. He further mentioned that Dr. Babu of Lifeline Hospital has given his explanation on the above points in

writing vide his letter dated 29.12.2009. In view of various anomalies/discrepancies/irregularities noted by them, the Company repudiated the claim.

On scrutiny of the entire case, this Forum also noted the following discrepancies :

1) **During hearing complainant admitted that his son was hospitalized at 8 o'clock in the night on 13.9.2009, whereas hospital paper has noted the time of admission as 9.30 a.m. on 13.9.2009.**
2) **The scrutiny of the copy of Indoor case papers reveals that except for medication details, nothing has been mentioned therein. The important details such as recording of daily visits of the doctors, doctor's advices and remarks, health status of the patient are missing. Moreover, Dr. Babu has confirmed in writing that daily entries by the consultant are not mentioned. However, in the bill, the hospital has charged Rs.20,000/- towards consultant's 20 visits and Rs.14,000/- towards RMO's 28 visits. Dr. Babu has further confirmed that bill book is not traceable bearing serial no.5048 and old IPD register is in the stores which bears the patient's name.**
3) **As per Tem./Pulse/Resp. chart of the hospital the patient had fever of 102 degree only on two days and he had no temperature above 101 degree during his entire stay in hospital. Moreover, from 22.9.2009 till 26.9.2009, his temperature reading was 98 degree. Also, the date wise noting in the indoor case papers are missing and no fresh findings were noted warranting hospitalization.**
4) **As per discharge card of the hospital, Shri. Hridesh had complaints of fever, generalized weakness, vomiting since 3 days and on admission; however during hearing complainant admitted that prior to his admission in the hospital, he had not taken any treatment from any other doctor.**
5) **During hearing complainant mentioned that in the hospital one Dr. Trimukhe was specially called by him from Criti Care Hospital to treat his son. However, the same has not been substantiated by documentary evidence as the hospital papers has no mention about daily entries of the consultant.**

Thus, apparently, major discrepancies are noted in the documents submitted in support of the claim and also as pointed out by the Insurance Company. Further, the complainant/hospital has failed to substantiate the genuineness of the admission in the hospital with documentary evidence. Under the circumstances, the Forum does not find any fault with the decision of the Company to

reject the claim in the present circumstances and the said decision is upheld.

As regards complainant's contention of admissibility of claim based on the settlement of the subsequent claim by the TPA, in a similar case, it is be to appreciated that such decisions are not binding on this Forum.

O R D E R

The claim of Shri. B. Bhadran in respect of hospitalisation of his son Shri. Hridesh Bhadran in Lifeline General Hospital from 13.9.2009 to 26.9.2009 for the complaints of Enteric Fever + Malarial Fever + Leukopenia is not tenable. The case is disposed of accordingly and the same stands closed at this Forum.

BEFORE THE INSURANCE OMBUDSMAN
(MAHARASHTRA & GOA)
MUMBAI

Complaint No. GI-1049/2012-2013
Award No. IO/MUM/A/GI- /2014-15
Complainant: Shri Nagin Parekh
Respondent: The Oriental Insurance Company Ltd.

Shri Nagin Parekh was covered under Individual Mediclaim Policy for the period 15.06.2011 to 14.06.2012 for Sum Insured Rs.5,00,000/-, issued by Oriental Insurance Co. Ltd. On 01.01.2012, while Shri Parekh alongwith his wife and other members had gone for Hot Air Balloon ride, there was an accident resulting into injuries to some of the members including himself. He sustained fracture to his foot for which he was treated at the hospital. A claim lodged under the policy for the same was denied by the Insurance Company under Clause 4.20 stating that the accident was a result of his participation in a hazardous activity. He argued that the activity of Hot Air ballooning cannot be treated as a "hazardous activity" as compared with motor racing, scuba diving, hand gliding as the passenger does not have any role in the operation of the Hot Air Balloon which is operated by a pilot and co-pilot and he was only taking a joy ride therein which cannot be termed as "participation". Moreover, the activity is approved by Gujarat State Tourism. He also mentioned that the claim of one of his co-passengers who was also injured at the time, was passed by the same TPA on behalf of some

other Insurance Company, so how can the same activity be termed as 'hazardous' for one person and not for the other.

The issue whether hot air balloon flights can be termed as a "hazardous activity" was examined by the Forum. Hot air balloons operate on the very basic scientific principle that hot air rises. Many people practice ballooning as a sport, and some people also enjoy it as a relaxing recreational activity. Each balloon has a large bag called an envelope, attached to a sturdy gondola or wicker basket. In order to get enough lift, the air in the bag is heated with the assistance of a flame. As the air heats up, the balloon rises. The pilot can control the ascent by opening a valve to let air off, causing the balloon to drop again. When the flight is over, the pilot slowly lets out enough air to allow the balloon to drop to the ground. Being non-powered there is little steering capability for these craft, leaving them almost entirely at the mercy of winds. During the flight, the pilot's only ability to steer the balloon is the ability to climb or descend into wind currents going different directions. Control over ascent and descent is vital, and possible, but when it comes to velocity and direction, the huge balloon and its crew are utterly at the mercy of capricious winds. It is only by the use of these winds that a balloonist can "steer" his craft. Like hand gliders and kites, hot air balloons travel with the wind. The weather is the most important concern in hot air balloon safety. The National Transportation Safety Board, the U.S. agency that investigates accidents for the Federal Aviation Administration, has looked into a number of hot air balloon accidents. Most, but not all, of the accidents they investigated were caused by bad weather. The dangers of the sport include excessive (vertical or horizontal) speed during landing, mid-air collisions that may collapse the balloon, and colliding with high voltage power lines. It is the last of these, contact with power lines, that poses the greatest danger. Fires are not common, but often lead to explosions because of the close access to propane. There is anecdotal evidence to suggest that where these larger balloons are used without a rigorous licensing regime, the accident rate is many times higher than those in the more developed aviation environments. There is no body dealing with air ballooning regulations globally. Researchers have analyzed crash data for different modes of air travel and have found that the minimal regulations for hot air balloon rides may be making the tours more dangerous. The researchers specifically blame the lack of regulation covering these flights and suggest that extra safety measures, such as cushioned basket bottoms and restraints could save lives in the event of a crash.

In India, hot air ballooning is still in its nascent stage though it is slowly gaining popularity within the fraternity of adventure sports lovers. Balloonists claim that such accidents/fatalities are rare and that their sport is not particularly dangerous. Pilots say they can even be landed if they run out of fuel. But when one hits a power line, the result is almost always tragic. Hot air balloon rides are thrilling and beautiful, but not without risk. The study published in the journal Aviation, Space and Environmental Medicine, examines the number of injuries and death associated with hot air balloon crashes from 2000 to 2011. Researchers found that over this time span, there were 78 hot air balloon tour crashes, with 518 occupants being affected by the crashes. More than 80% of these crashes resulted in at least one serious injury or fatality. Most injuries sustained by passengers were broken leg bones. Most crashes occurred when the hot air balloon was landing with 65% of them involving hard landings. Collisions with power lines, trees, buildings and the ground accounted for 50% of all the serious injuries and all of the fatalities found in the study.

All the above information goes to show that Hot Air Ballooning is a hazardous activity. In the instant case also, the accident has taken place while the balloon was landing when due to the impact of hard landing, the pilot and co-pilot were thrown out as narrated by the complainant and the balloon again started rising in the air and had to be controlled by the occupants with great difficulty. Modern training systems and balloon technology mean that it is relatively uncommon for people to be injured in a hot air balloon accident but ballooning will always be an adventure and like all adventures carries a level of risk which cannot be equated with the risks/accidents involved in normal routine day-to-day activities as contemplated to be covered under an ordinary Mediclaim policy. The fact that it has been approved by the State Tourism does not necessarily imply that it will stand covered under the Mediclaim policy. As regards the complainant's argument that the claim of one of his co-passengers injured in the same accident has been paid by another Insurance Company, the reasons for the same are not known to the Forum and it may be noted that such decisions are not binding on this Forum.In view of the above observations, the decision of the Insurance Company to repudiate the claim being based on policy terms and conditions, was found to be in order.

ORDER

The complaint of Shri Nagin Parekh against non-settlement by The Oriental Insurance Co. Ltd. of a claim lodged under the above-mentioned Mediclaim policy for his hospitalization for Fracuture of

Calcaneum and Talus sustained by him due to an accident while undertaking a ride in Hot Air Balloon on 01.01.2012, does not sustain. The case is disposed of accordingly.

BEFORE THE INSURANCE OMBUDSMAN
(MAHARASHTRA & GOA)
MUMBAI

Complaint No. GI-2388/2012-2013
Award No. IO/MUM/A/GI- /2014-15
Complainant: Shri Javedshabbirali Dawoodani
Respondent: National Insurance Co. Ltd.

Shri Javedshabbirali Dawoodani alongwith his family members was covered under Individual Mediclaim Policy No. 261400/48/11/8500008552 for the period 16.01.2012 to 15.01.2013 for Sum Insured of Rs.1,00,000/- each for himself, his spouse and his two sons and Rs.50,000/- for his daughter, issued by National Insurance Co. Ltd. Shri Dawoodani approached this Forum with a complaint against rejection by the Insurance Company of a claim lodged under the policy for the admission of his wife Smt. Salma Dawoodani to Prince Aly Khan Hospital from 20.06.2012 to 23.06.2012 for Lap. Incisional Hernia Repair.

It was contended on behalf of the Insurance Company that the patient had history of three surgeries of LSCS in the past, last being 6 years back and the hernia had developed at the site of the operation scar; hence the proximate cause of the current disease is Maternity/surgery for pregnancy and child-birth which is excluded under Clause 4.12 of the policy. The Company also forwarded opinion obtained from Dr. Girish G. Lad, M.S. which confirmed that the Multiple Incisional Hernia is a sequence of multiple (3) Caesarian Sections that Smt. Salma Dawoodani underwent (LSCS) within 6 years. The Complainant, on the other hand, felt that hernia is a separate development and should not be linked to her pregnancy after a duration of 6 years from the last surgery for child-birth.

On scrutiny of the documents produced on record, it is observed that Smt. Salma Dawoodani was admitted to Prince Aly Khan Hospital on 20.06.2012 precisely for incisional hernia repair with complaints of swelling/mass around incision since 2 years with the swelling increasing and pain around mass since 10 days. Analysis of the case revealed that in fact there are quite a few fall outs of pregnancy and child birth like severe infections, eclampsia,

absence or delayed lactation etc. which would be excluded as arising out of same generic condition. In the instant case the very fact that there were 3 caesarian sections for delivery even if the last one was 6 years back, it would easily mean that the abdominal wall was sufficiently weakened and thinned. While any abdominal surgery is always a provocation for developing into a potential hernia, Caesarian section is distinctly a trigger and a pre-disposing factor for incisional and umbilical hernia. In fact, the very expression of "swelling around the Incision" would mean that herniation was due to the incision which occurs usually with abdominal exploration. This is very commonly experienced by ladies following caesarian section. It is well known that a considerable time period may elapse after the primary surgery before an incisional hernia develops (if at all). In the instant case, it was visible since last 2 years.

In view of clear explanation in the hospital records about the nature, extent and cause of hernia due to past incisions coupled with the medical opinion obtained from a specialist doctor confirming the said fact, repudiation of the claim by the Company as per Exclusion Clause 4.12 of the policy cannot be faulted with.

ORDER

The claim of Shri Javedshabbirali for reimbursement of expenses incurred for the hospitalization of his wife Smt. Salma Dawoodani at Prince Aly Khan Hospital from 20.06.2012 to 23.06.2012 for Lap. Incisional Hernia Repair is not tenable. The case is disposed of accordingly.

THE INSURANCE OMBUDSMAN
(MAHARASHTRA & GOA)
MUMBAI

Complaint No.GI-1301 of 2012-2013
Award No.IO/MUM/A/GI /2014-2015
Complainant : Shri Bharat Bhiwapurkar
Respondent : Star Health & Allied Insurance Co. Ltd.

Smt. Rajashree Bhiwapurkar, spouse of the complainant, who was insured with Star Health And Allied Insurance Co. Ltd. under Policy No. P/171115/01/2012/009026 issued for the period 30.9.2011 to 29.9.2012 for Floater Sum Insured of Rs.3,00,000/- was hospitalized in Kaushalya Medical Foundation Trust Hospital from 11.9.2012 to 18.9.2012 with complaints of pain in abdomen with Lt. complicated ovarian cyst with abdominal distention and

underwent Explaratory Laparotomy with (Lt) Oopherectomy with Adhesiolysis & Cystoscopy Bil. DJ Stenting. When complainant preferred a claim for Rs.1,49,843/- under the policy, Insurance Company repudiated the claim under pre-existing ailment clause and also stating that the pre-existing disease was not disclosed by the insured at the time of inception of the Policy.

Parties to the dispute were heard on 18th July, 2014. It was observed that the subject claim was reported on the first year of the policy. Company took a stand that insured had ovarian cyst removed in 2006 and had undergone hysterectomy with Right Oppherectomy in 2010 which falls prior to first incept of the Policy. The recurrent ovarian cyst is a complication of the ovarian cyst which was removed in 2006 and the present ailment is a complication of pre-existing disease and hence would fall under pre-existing ailment clause. Complainant however has contested that his wife underwent the present surgery after 66 months from the date of her previous Cystectomy surgery and also the treating doctor of his wife has certified that the present ailment is not a complication of pre-existing disease.

Analysis of the case revealed that Smt. Bhiwapurkar had history of Lap. Cystectomy done in 2006 and Total Abdominal Hystectomy with ® Oopherectomy in 2010. It appears that the complainant has not provided all the medical papers to the Forum. Whilst the medical papers of the year 2006 have been submitted to the Forum, the medical papers for the year 2010 have not been submitted by the complainant to this Forum for the reasons best known to him. Further, as per records, Smt. Bhiwapurkar underwent sonography on 3.9.2012 on the advices of Dr. R.H. Tanna; however the consultation paper of Dr. R.H. Tanna has not been submitted to the Forum. Although, it is a fact that the surgery for left ovarian cyst (Lt. Oopherectomy) was done after a period of 6 years from the date of earlier cystectomy surgery, but in absence of complete medical papers including that of the surgeries done in the year 2010, the complainant's contention that the current ailment is not a complication of pre-existing disease is not fully substantiated. Further, Smt. Bhiwapurkar also underwent the procedure of Adhesiolysis. In the "Operation Record, it is mentioned as – The abdominal cavity full of adhesions (omental dense), bowel & bladder adhesions. Typically, patients who have had any past surgical procedure in the abdominal, rectal or vaginal area can develop pelvic adhesions. In the instant case, Smt. Bhiwapurkar had history of past surgical procedures and that may be the risk factor to cause abdominal adhesions.

As regards the issue of non-disclosure of pre-existing ailment/surgeries, it should be noted by the complainant that any ailment, surgery – major or minor, whether material to the risk or not, should be disclosed to the Insurance Company. In the instant case, Smt. Bhiwapurkar had past history of ovarian cyst/fibroid uterus/Cystectomy, Hysterectomy with Right Oophrectomy. The surgeries underwent by her was an important intervention in her health status and hence it should have been clearly disclosed by the complainant in the proposal form submitted to M/s Star Health. Since the pre-existing ailment and episodes of previous surgeries were not disclosed to the Insurance Company, it constitutes non-disclosure material to the contract irrespective of the fact whether it was material to the cause of loss/claim. Considering that Star Health was not provided with an opportunity to take appropriate underwriting decisions at the time of accepting the proposal, it would constitute non disclosure for which their rejection is in order.

O R D E R

The complaint of Shri. Bharat Bhiwapurkar with regard to repudiation of claim lodged by him in respect of hospitalisation of his wife Smt. Rajashree Bhiwapurkar in Kaushalya Medical Foundation Trust Hospital from 11.9.2012 to 18.9.2012 for Explaratory Laparotomy with (Lt) Oopherectomy with Adhesiolysis & Cystoscopy Bil. DJ Stenting is not sustainable. The case is disposed of accordingly and the same stands closed at this Forum.

BEFORE THE INSURANCE OMBUDSMAN
(MAHARASHTRA & GOA)
MUMBAI

Complaint No. GI-924/2012-2013
Award No. IO/MUM/A/GI- /2014-15
Complainant: Shri Deepak Nilkanth
Respondent: The New India Assurance Co. Ltd.

Shri. Deepak Nilkanth was covered under Mediclaim Policy 2007 bearing No. 13100034110100000831 issued by The New India Assurance Co. Ltd. for the period 26.5.2011 to 25.5.2012 for Sum Insured of Rs.3,00,000/- 10% CB. Shri. Nilkanth underwent L5-S1 Microendoscopic Dissectomy for the complaints of L4-L5 Disc with Neurological Deficit in Saifee Hospital where he was hospitalized from 24.8.2011 to 26.8.2011. A claim lodged under the policy for the said hospitalizaion was repudiated by the Insurance Company. Aggrieved by the decision of the Company, Shri Nilkanth approached this Forum for settlement of the claim.

Records were perused and parties to the dispute were called for personal hearing on 13.6.2014. The claim for the above hospitalisation has been reported on the third year of the Policy. Insurance Company has rejected the claim under clause 4.3 which states that the Age Related Osteoarthritis has a waiting period of four years. During hearing, Complainant drew the attention of the Forum to a certificate issued by his treating doctor stating that Mr. Deepak Pandharinath Nilkanth was operated for acute on chronic prolapsed intervertebral disc. The complainant is a of a view of that the ailment suffered by him would fall under "Prolapse Inter Vertenbral Disc" which has a waiting period of two years.

Dr. Mukesh of TPA submitted that the MRI done immediately prior to hospitalisation, clearly indicates that the ailment suffered by the complainant was degenerative in nature. Due to degeneration, weakening takes place in a central part of the disc and because of pressure, central part of the disc gets prolapsed and it pressurizes the spinal cord and nerve root and results in radiculopathy, causing back pain. He stated that the ailment suffered by the patient was degenerative osteoarthritis which thereafter results in Prolapsed Intervertebral Disc.

In the light of the deposition made by Dr. Mukesh of TPA and the certificate issued by the treating doctor of the hospital, the Company was directed to seek an independent opinion from Orthopaedic doctor, as to whether the ailment suffered by the

complainant would fall under the category of "Age related Osteoarthritis" or "Prolapse Inter Vertebral Disc" and re-examine the case in the light of the said opinion and revert back to this Forum.

In response, Insurance Company submitted their reply with a copy of opinion obtained by them from Dr. Ashith Rao, MS, Orth., D.Orth. Dr. Ashith Rao opined as under : "I have examined the reports and discharge card of Mr. Deepak Nilkanth. The X-ray report – a degenerative condition. The MRI revealed Multiple level disc dessication, focal disc protrusion at L1-2. Disc protrusion with annular tear at L4-5with compression of L-4 root with min compression on L5. Disc protrusion is diffusely seen in L5L1with S1 root on the Rt. Side compressed. All these findings suggest a degenerative disc changes in L1L2L3L4& L5. S1 spacer Disc herniation at 3 levels suggests canal compromise and early spinal canal stenosis. These are c/f signs of age-related degenerative disc disease". Company re-iterated their decision by stating that degenerative disc disease is nothing but age related osteoarthritis and hence falls under clause 4.3 No.22 which attracts a waiting period of four years.

The Policy has a waiting period of four years for "Age Related Osteoarthritis". Osteoarthritis (OA) also known as degenerative arthritis or degenerative joint disease or osteoarthrosis, is a group of mechanical abnormalities involving degradation of joints, including articular cartilage and subchondral bone. OA commonly affects the hands, feet, spine, and the large weight bearing joints, such as the hips and knees, although in theory, any joint in the body can be affected. In the instant case, going by the finding of X-ray report and opinion given by Dr. Rao, the ailment would technically fall under the category "Age Related Osteoarthritis" which has a waiting period of four years.

This Forum however further observed that Policy has a waiting period of two years for "Prolapse Intervertebral Disc unless arising from accident". However, there is no clarity as to whether PID arising from degenerative conditions also would have waiting period of two years or the same would automatically fall under the category of "Age Related Osteoarthritis". Thus, in absence of any such specification in the Policy clause, there is a scope for different interpretations. The Forum strongly feels that the same ailment should not attract two different waiting period under two different headings. Thus, the clause – "waiting period of two years for Prolapse Intervertebral Disc unless arising from accident" is too vague. The terms and conditions attached to the Policy document should be very specific and it should not mislead or be likely to mislead by ambiguity. It is strongly felt that there is indeed an

ambiguity in the in the policy as regards the waiting period for "PID", leaving scope for interpretation.

In the instant case, claim reported by the complainant is related to PID; however the same has been certified by the Specialist doctor as age related degenerative disc disease. Thus, in view of the ambiguity in the policy wording as pointed out above and to strike a reasonable balance, I would like to award 50% of the admissible expenses to the complainant to resolve the dispute in the present case.

O R D E R

The New India Assurance Co. Ltd is directed to pay 50% of the admissible expenses to the complainant in respect of expenses incurred by on his hospitalisation in Saifee Hospital from 24.8.2011 to 26.8.2011 for L4-L5 Disc with Neurological Deficit. There is no order for any other relief. The case is disposed of accordingly.

BEFORE THE INSURANCE OMBUDSMAN
(MAHARASHTRA & GOA)
MUMBAI

Complaint No. GI-1017/2013-2014
Award No. IO/MUM/A/GI- /2014-15
Complainant: Shri Shevgoor S. Kamath
Respondent: The New India Assurance Company Ltd.

Shri Shevgoor S. Kamath was covered under Individual Mediclaim Policy No.111200/34/11/01/00015776 for the period 29.03.2012 to 28.03.2013 for Sum Insured Rs.3,00,000/-, issued by The New India Assurance Co. Ltd. Shri Kamath approached this Forum with a complaint against rejection by the Insurance Company of a claim lodged under the policy for the treatment of Multiple Myeloma taken by him at S.L. Raheja Hospital, Mumbai on 25.02.2013.

Records were perused and a joint hearing of the parties to the dispute was held on 01.08.2014. On scrutiny of the documents produced on record coupled with the depositions of the parties, it is observed that Shri S.S. Kamath was diagnosed as suffering from Multiple Myeloma and has been receiving treatment for the same

since March 2011 by way of chemotherapy and Radiation therlapy. After the conclusion of 1st stage of radiation treatment in October 2012, he was started on oral medicine treatment for six months from November 2012 and in between, had to be evaluated for post-radiation progress. The Insurance Company settled the claims lodged under the policy for chemotherapy and radiation treatment undergone by him while the claim for expenses of the progress evaluation undergone by him on 25.02.2013 was denied by the Company stating that it was an OPD consultation and did not fall within the time-limit prescribed under the policy for post-hospitalization treatment. The complainant argued that the progress evaluation was part of the continuing treatment and was not for evaluation of a new sickness and when the Company has paid all the claims for the treatment taken by him previously and subseqent to the said claim, denial of the subject claim relying on changed policy terms and conditions was not justified.

On an analysis of the case, it is noted that the Mediclaim policy basically grants reimbursement of hospitalisation expenses with a certain restriction on the period of hospitalization viz. one month pre-hospitalisation period, the period of actual hospitalization and a post-hospitalization period of two months from the date of discharge. And in all these cases, the basic criterion of "hosptialisation" as such is not compromised but only relaxation of minimum period of 24 hours' hospitalisation is granted for specific treatments listed under clause 3.4 of the policy in view of lesser time taken now for the treatments as compared to earlier times due to advancement of medical science. The said list includes Parenteral Chemotherapy and Radiotherapy and accordingly the Company has settled the claims of the complainant for these treatments undergone by him from time to time. As regards the claim for progress evaluation done on 25.02.2013 however, it is seen that there was no indoor confinement in the hospital as the same was done on OPD basis. Moreover, it was merely a follow-up consultation and not for direct treatment per se. Also, it did not fall within the period of 60 days following main hospitalization to qualify reimbursement under the head "post-hospitalization expenses" under the policy. Hence the claim could not be admitted under the policy and denial of the claim by the Company was done as per policy terms and conditions. Only if the claim is admissible, the expenses falling under various heads listed under the policy viz. Room, Boarding, Nursing expenses, Surgeon, Aneshtetist, Consultant, Specialists fees, etc. would be payable. The complainant's argument that the policy terms and conditions were revised at the time of renewal due to which his claim stood denied,

is not correct as the condition of 30 day's pre-hospitalization and 60 days' post hospitalization cover was very much there since the introduction of Mediclaim policy. Besides, it should be noted that Mediclaim policy is an annual contract and whenever any dispute arises it is settled based on the terms & conditions of the policy under which a claim has arisen.

It is admitted that the treatment of Cancer and similar other critical ailments require continued medical treatment entailing high expenditure but admissibility of these expenses is subject to the policy terms and conditions. It is to be borne in mind that this Forum has the inherent limitations in going beyond the provisions of the policy contract and the Forum examines cases in detail to see whether there is any breach of policy provisions while denying a claim and cannot grossly overlook the terms and conditions clearly spelt out in the policy and also approved by the IRDA. Under the facts and circumstances of the case, repudiation of the claim by the Company not being adversarial to the policy terms and conditions, I do not find any valid ground to intervene with the decision of the Insurance Company in the matter and hence no relief can be granted to the complainant.

ORDER

The complaint of Shri Shevgoor S. Kamath against The New India Assurance Co. Ltd. in respect of repudiation of the claim lodged for post-radiation progress evaluation undergone by him at S.L. Raheja Hospital on 25.02.2013, does not sustain. The case is disposed of accordingly.

BEFORE THE INSURANCE OMBUDSMAN
(MAHARASHTRA & GOA)
MUMBAI

Complaint No.GI-867 of 2012-2013
Award No.IO/MUM/A/ GI /2014-15
Complainant : Shri. Anupam Jasani
Respondent : The New India Assurance Company Limited

Shri. Anupam Jasani who was covered under Mediclaim Policy (2007) No.14200034110100006927 issued by The New India Assurance Co. Ltd. for the period 12.10.2011 TO 11.10.2012 for Sum Insured of Rs.3,00,000/- 30% CB, was hospitalized in Bhatia Hospital from 23.5.2012 to 26.5.2012 where he was diagnosed to have Anxiety with Depression with Diabetes. When the claim of Rs.48,373/- was reported under the policy towards reimbursement

of the expenses incurred on this hospitalization, TPA of the Insurance Company rejected the claim stating that expenses related to psychiatric disorders are not payable as per exclusion clause 4.4.6 of the Policy. Being aggrieved, complainant approached this Forum for redressal of his grievance. Records were perused and both the parties were called for personal hearing on 19.8.2014.

Complainant contended that mild anxiety or temporary depression should not be considered as psychiatric disorders as it is a temporary phenomenon and can be sorted out. He also pointed out that his blood sugar reading on 23.5.2012 and 25.5.2012 was very high and the treatment of diabetes has been completely ignored by the Company. Further, the haemoglobin level was low and required treatment for the same.

The Forum analyzed the case. In the instant case, in the indoor case papers of the hospital, it is clearly recorded that the complainant had complaints of – restlessness, disturbed sleep, increased thinking, depression, decreased confidence and s.i. and the final diagnosis made by the hospital was Anxiety with Depression. During hospitalisation, Shri. Jasani was treated with antidepressant medications and on discharge also he was advised to continue the same. The further scrutiny of the papers do not indicate any treatment for physiological illness which needed confinement barring diabetes, for which he was treated, which would not have warranted the hospitalisation in isolation.

The term psychiatric disorder means a mental disorder or illness that interferes with the way a person behaves, interacts with others, and functions in daily life. Mental disorders are generally defined by a combination of how a person feels, acts, thinks or perceives. Depression is a common feature of mental illness, whatever its nature and origin. When a person suffers from depression, it interferes with his daily life and causes pain for both him and those who care about him. Whatever the symptoms, depression is different from normal sadness in that it engulfs a person's day-to-day life, interfering with his ability to work, study, eat, sleep, and have fun. Depression can make people feel profoundly discouraged, helpless, and hopeless. Depression and anxiety might seem like opposites, but they often go together. Medications are used to treat the symptoms of mental disorders such as schizophrenia, depression, bipolar disorder and anxiety disorders.

The policy on which the claim is lodged carries a specific clause to exclude the expenses incurred on Psychiatric disorders. It should be appreciated that the disputes in this Forum are resolved based on

the terms and conditions of the policy on which the claim is preferred. As the Psychiatric disorder is a permanent exclusion under the Policy, Insurance Company rejected the claim, which appears to be in order. As regards the issue of diabetes, it is noted that Shri. Jasani was treated for the same only with oral medication and for diabetes per se, there was no need for hospitalisation.

Under the circumstances this Forum does not find any valid ground to intervene with the decision of the Insurance Co.

ORDER

The complaint of Shri. Anupam Jasani against The New India Assurance Co. Ltd. in respect of repudiation of his claim lodged towards his hospitalization in Bhatia Hospital from 23.5.2012 to 26.5.2012 for Anxiety with Depression with Diabetes is not sustainable. The case stands closed at this Forum.

BEFORE THE INSURANCE OMBUDSMAN
(MAHARASHTRA & GOA)
MUMBAI

Complaint No. GI-2019/2012-2013
Award No. IO/MUM/A/GI- /2014-15
Complainant: Shri Tayebali Egmail Patrawala
Respondent: The New India Assurance Company Ltd.

Complainant Shri Tayebali Patrawala was covered under Individual Mediclaim Policy No.111200/34/11/01/00005018 for the period 24.08.2011 to 23.08.2012 for Sum Insured Rs.5,00,000/- plus C.B. Rs.95,000/-, issued by The New India Assurance Co. Ltd. Shri Patrawala was insured with the Company continuously since the year 2000. He lodged a claim under the above-mentioned policy for his hospitalization in June 2012 for the treatment of acute coronary syndrome. The hospital papers mentioned his past history as "Morbid obesity – B. wt. 124 kg. - k/c/o DM since 5 years on OHA. Habits – Smoking 10-12/day & occ. Whisky/vodka since 10-12 years". Based on the said history, the claim was denied by the Insurance Company stating that morbid obesity and habits of

tobacco, occasional drinking are the major causes of the present ailment.

The insured argued that he suffered from and was treated for heart ailment and not for obesity and also produced a certificate from his treating doctor denying the history of smoking and drinking. In this connection, it may be stated that the history narrated before the doctor either by the patient or his/her representative is his or her own statement and hence cannot be totally overlooked. Every body would like to give exact narration to the doctor so as to enable him to make proper judgement with all the facts put before him so as to enable him to arrive at a correct diagnosis and adopt a proper line of treatment. In the face of patient's or his representative's own submission and admission which is received through the hospital papers, such certificates produced after rejection of claim would be deemed as an after-thought and cannot be accepted.

Further, it is a well established fact in Medical Science that Smoking is a major risk factor for heart disease. Smoking harms nearly every organ in the body, including the heart, blood vessels, lungs, eyes, mouth, reproductive organs, bones, bladder, and digestive organs. Any amount of smoking, even light smoking or occasional smoking, damages the heart and blood vessels. For some people, such as women who use birth control pills and people who have diabetes, smoking poses an even greater risk to the heart and blood vessels. When combined with other risk factors—such as unhealthy blood cholesterol levels, high blood pressure, and overweight or obesity—smoking further raises the risk of heart disease. Smoking also is a major risk factor for peripheral arterial disease (P.A.D.). P.A.D. is a condition in which plaque builds up in the arteries that carry blood to the head, organs, and limbs. Coronary heart disease (CHD) occurs if plaque builds up in the coronary (heart) arteries. Over time, CHD can lead to chest pain, heart attack, heart failure, arrhythmias, or even death.

In view of the afore-mentioned information, Shri Patrawala being a k/c/o morbid obesity and diabetes, the contention of the Company that these factors coupled with his habits of smoking and occasional drinking could have led to his heart ailment cannot therefore be set aside. Clause 4.4.6 of the Individual Mediclaim Policy excludes payment of any medical expenses incurred for treatment of an ailment arising out of use of intoxicating drugs/alcohol/ tobacco. In the facts and circumstances of the case, the decision of the Company to repudiate the claim being based on policy terms and conditions cannot be faulted with.

ORDER

The claim of Shri Tayebali Patrawala for reimbursement of expenses incurred for his hospitalization at Prince Aly Khan Hospital from 25.06.2012 to 27.06.2012 for the treatment of Acute Coronary Syndrome is not sustainable. The case is disposed of accordingly.

Complaint No. GI- 1657of 2012-2013
Award No. IO/MUM/A/ 497/2014-2015

Complainant, approached the Forum with a complaint against New India Assurance Company Limited in the matter of non-settlement of his wife's claim amounting to Rs. 95,000/- lodged under Policy No. 131500/34/11/002/12702 for treatment of Infraumbilical Hernia taken at Kirit Nursing Home.

In the case on hand, the admission of the Insured to the hospital was for treatment of Infraumbilica Hernia which is no doubt a complication of Obesity as treating doctor himself has mentioned in his certificate that Hernia was due to fat and medical papers reveal that she was Obese (+).

The Insurance company's interpretation of clause 4.4.6 is that the policy excludes treatment of obesity and complication of obesity." However, it is not properly worded to give such an indication, as the said clause can also be interpreted to exclude obesity treatment (i.e. weight loss treatment/bariatric surgery etc.) and complications arising out of it. Hence, the Forum is constrained to hold the view that there was obvious ambiguity in the policy condition.

In the instant case, the insured underwent surgery for repair of umbilical hernia and not any weight loss treatment and therefore the present claim will not fit into the said exclusion.

If it was the intention of the Insurer to exclude obesity, its complications and also its treatment, then it should have been properly worded leaving no room for any misconception. The company's intention would have come out clearly had the exclusion been worded as follows - "Obesity and its complications and all Treatments arising out of the same."

The Forum feels that the terms and conditions attached to the policy document should be very specific and there should not be any ambiguity. Although it is a fact that the ailment for which the complainant was hospitalized was due to obesity, but in view of the

ambiguity in the policy wording as pointed out above, I would like to award 50% of the admissible expenses to the complainant to resolve the dispute in the present case keeping in mind the fact that the Policy has been drafted by the Insurer.

Complaint No. GI-1382(2012-2013)
Complainant: Mrs.Amita Bhave
Vs
Respondent: The New India Assurance Co. Ltd.,

Mrs. Amita Bhave, her mother Mrs. Sudha Shevade and her son Master Sahil Bhave were covered under policy number 12050034110100000023 issued by The New India Assurance Co. Ltd. Mrs. Sudha Shevade took treatment for Right Subretinal Hemorrhage at Wavikar Eye Institute on 19.07.2012 . When she preferred the claim, it was rejected on the grounds that treatment given is OP based treatment and Lucentis injection is excluded under Mediclaim policy norms.

Not satisfied with their decision, Mrs. Amita Bhave approached the Office of Insurance Ombudsman for redressal of their grievance and requested that claim be settled.
After perusal of the records, parties to dispute were called for hearing.

The New India Assurance Co. Ltd., was represented by Mr. Ganesh Swaminathan – Regional Manager and Mr. Duttatreya Pandey- AO. . Mr. Ganesh Swaminathan stated that since treatment given is OPD based and there is specific exclusion in the policy for treatment of Lucentis injection, the claim was repudiated accordingly. Mrs Amita stated that as per the policy issued to her, there is no such exclusion. Ombudsman directed Mr. Ganesh Swaminathan to go through the policy terms and conditions issued to the insured. On going through the copy of policy terms and conditions issued to the insured, Mr. Ganesh stated that last page wherein the said exclusion clause is included is not to be found.

Ombudsman directed the complainant to submit all the policy documents pertaining to any year before and one year after the claim period along with terms and conditions if available with her within 10 days to this forum.

On 27.02.2015, the forum received letter dated 26.02.2015 from the company stating the following:
"The insurer feel obligated to present the following:

a) **Mediclaim 2007 Bilingual which specially excludes Age Related Macular Degeneration under clause 6(g)**
b) **Copy of Mediclaim Policy 2012 issued to Mrs. Amita Bhave, Policy no. 12050034132500000019 valid from 15.03.2014 to 14.03.2015 which excluded Age Related Macular Degeneration under clause 4.4.22.**

The insurers would further like to submit that a copy of the policy is available to all freely on the link http://newindia.co.in/downloads/MediclaimPolicy-2007.pdf, wherein Age Related Macular Degeneration has been excluded. Mediclaim Policy 2012 may be perused at the link http://newindia.co.in/downloads/Mediclaim-2012-Policy.pdf wherein Age Related Macular Degeneration has been excluded under clause 4.4.22.It is further submitted that the aforesaid internet links do not require any special permission or access and can be perused by all."

On 03.03.2015, the forum received email from Mrs. Amita Bhave stating the following:
"With reference to your request, I do not have policy documents of earlier or next year available with me. However please note that the policy documents relevant for the year of complaint along with all other supporting have been already submitted to your office."

The entire documents submitted to this forum and deposition of both the parties to dispute is taken on record. On going through the policy terms and conditions, it is observed that Clause 6(g) states "All treatments like Age Related Macular Degeneration (ARMD) and or Chorodial Neo Vascular Membrane done by administration of Lucentis/ Avantis/ Macugen and other related drugs as intravetral injection, Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP) and Hyperberic Oxygen Therapy are excluded under this policy."

From the above it is evident that the rejection of claim by the company is as per policy terms and conditions.

Complaint No. GI- 2152 (2012-2013)

Complainant: Shri Ashok Kumar
v/s.
Respondent: The New India Assurance Co. Ltd.,

Mr. Ashok Kumar was covered under mediclaim policy no. 140501/34/10/03/00020007 issued by The New India Assurance Co. Ltd. He was admitted to Alliance Hospital, Nallasopara on 19.08.2011 to 25.08.2011 with diagnosis of GI Bleed with acalculus cholecystitis with septicemia .When he lodged the claim with the insurer for Rs. 67580/- , it was repudiated on the grounds that ailment suffered by him was due to intake of alcohol. This not being acceptable to him, Mr. Ashok Kumar represented his complaint but the company upheld their stand of settlement.

Records were perused and parties to the dispute were called for a personal hearing. Mr.Ashok Kumar stated that he used to take alcohol but occasionally. Before his admission to the hospital, he had taken alcohol for the last time on 21.05.2011. He stated that he had submitted certificate from the doctor stating that the current illness is not related to intake of alcohol.

The New India Assurance Co. Ltd., was represented by Mr. Vijay Bavighar Asst. Manager who was accompanied by Dr. Nilesh-TPA . Mr. Vijay stated when the company received claim intimation from the complainant they investigated the case and it came to light that the complainant was occasional alcohol drinker. As GI Bleed (erosive gastritis) was result of alcohol consumption, claim was repudiated under clause 4.4.6. Dr. Nilesh stated that USG shows liver dysfunction and pathological reports shows rise in Alkaline phosphate and diffuse duodenum which are signs of alcoholism. The forum asked the doctor whether alcoholism is the single cause of liver dysfunction and rise in alkaline phosphate; to this Dr. Nilesh replied negatively and stated that basically this happens because of liver disease.

Ombudsman asked the company officials whether calculus cholecystitis has nexus to alcoholism and what treatment was given to the patient for this ailment, to this Dr. Nilesh stated that acalculus cholecystitis is an infective process and not related to alcoholism

and the complainant was given several antibiotics to treat this disease.

Ombudsman also raised the query to the company officials whether occasional intake of alcohol causes gastritis and whether they have taken any expert opinion on this issue, to this Dr. Nilesh replied negatively.

However Dr. Nilesh brought to the notice of the forum that Certificate dated 19.10.2011 is signed by some other doctor on behalf of the treating doctor, Dr. Sunil Apotikar. Ombudsman remarked that such certificate cannot be taken as authentic evidence in this forum.

<u>Directions given by the forum :-</u> The company and the complainant were directed to comply with the following requirements within 10 working days

1) **Since company has not produced enough cogent evidence that occasional alcoholism can cause GI Bleed (erosive gastritis), the company was directed to obtain medical opinion from an independent Gastroenterologist and inform their final decision to the forum.**
2) **The complainant was also directed to obtain clarification from the treating doctor regarding cause for this ailment i.e. GI Bleed (erosive gastritis).**

On 14.10.2014, the forum received letter dated 14.10.2014 from the complainant wherein he had attached letter dated 10.10.2014 given by Dr. Sunil Apotikar which states " This is to inform that Mr. Ashok Kumar was admitted at Alliance Hospital on 19.08.2011 and was diagnosed with upper GI bleed due to erosive gastritis due to hyperacidity and acalculus cholecystits . The above illness was not due to alcoholism."

On 29.10.2014, the forum received email from the company where medical opinion of Dr. C. Vasudev , M.D., D.M. (Gastro) of Seven Hills was also attached which states that " Ashok Kumar , 38 year male admitted at Alliance Hospital in August 2011 had severe erosive and Duodenitis resulting in GI Bleed along with acalculus cholecystitis with deranged liver function tests was unlikely due to alcohol. LFT abnormalities can't be explained by occasional alcoholism and the whole picture of Clinical history, lab investigation reports are suggestive of some viral etiology. An alkaline phosphate never rises because of alcoholism. GGT rises due to alcoholism".

The entire documents submitted to the forum are taken on record. It is observed that Mr. Ashok Kumar was admitted to Alliance Hospital on 19.08.2011 with diagnosis of GI Bleed (erosive gastritis) with acalculus cholecystitis . History and examination sheet shows "Patient admitted with c/o fever intermittent, gradually ↑in the evening since 9-10 days. Yellowish discoloration of skin, 3- 4 episodes of vomiting, Malena 2 episodes, No DM/ HT, IHD, Pt. alcoholic – occasional intake." To the question no. 6 (1) in the Pre- Authorization form which relates to personal history of alcoholism/ smoking/ Tobacco Chewing /Gutka/ Drugs, Mr. Ashok had answered that he occasionally used to take alcohol but has not consumed since 2 months. The contention of the company is that GI Bleed (erosive gastritis) was due to alcohol consumption and hence they repudiated the claim under clause 4.4.6 which states that claims arising as a result of use of intoxicating drugs/ alcohol are excluded. The crux of the issue is that whether GI Bleed (erosive gastritis) in case of Mr. Ashok Kumar was the result of occasional Alcohol consumption. Dr. C. Vasudev , M.D., D.M. (Gastro) of Seven Hills had opined that in case of Mr. Ashok Kumar severe erosive and Duodenitis resulting in GI Bleed along with acalculus cholecystitis with deranged liver function tests was unlikely due to alcohol. He has also stated that abnormalities in Liver Function Test cannot be due to occasional alcoholism. The contention of Dr. Nilesh (TPA) that rise in Alkaline phosphate as per Liver Profile test dated 19.08.2011 is suggestive of alcoholism is totally not accepted by Dr. Vasudev who opines that alkaline phosphate never rises because of alcoholism. In case if GGT (Gamma-glutamyl transpeptidase) would have be done, it would have indicated the presence of alcohol which unfortunately was not done during his hospitalization. The Clinical history and lab investigation reports are suggestive of some viral etiology and not due to alcoholism. Also the treating doctor has certified vide letter dated 10.10.2014, that cause of Erosive Gastritis in case of Mr. Ashok Kumar is due to hyperacidity and acalculus cholesystitis .

From the above, it is established that current ailment of the complainant was not due to alcoholism. Also the insurer has not be able to prove with concrete evidence that Erosive Gastritis suffered by Mr. Ashok Kumar was result of alcoholism and hence scales are tiled in favour of the complainant

Complaint No. GI-09 (2013-2014)
Complainant: Smt. Chhaya Mody
v/s.
Respondent: United India Insurance Co.Ltd

Mrs Chhaya Mody was covered under Individual Health Insurance policy no. 0204004811970013201 for sum assured of Rs. 7 lakhs issued by United India Insurance Co.Ltd. Mrs. Chhaya Mody was admitted to Beramji's Hospital, Girgaum from 24.09.2012 to 05.10.2012 with diagnosis Osteoarthritis of Knee with Spondylosis of spine .When she lodged the claim with the insurer, it was repudiated on the grounds that hospitalization was not justified as treatment given to her could have been taken on OPD basis.
Aggrieved by their decision, Mrs. Chhaya Mody approached the Office of Insurance Ombudsman seeking intervention in the matter of settlement of her claim.

On hearing the deposition from both the parties to dispute, Ombudsman observed that the complainant had lodged similar complaint with the forum, complaint no. being GI: 108 (13-14) under which the company has honoured the claim.
The company was directed to give its observations as to why claim has been rejected for Mrs. Chhaya's hospitalization when they had settled similar complaint of her husband.
On 05.12.2014, the forum received letter dated 02.12.2014 from the insurer stating that Mr. Bharat Mody was under Lumbar Treatment which is an IPD procedure and has to be done in hospital under the supervision of treating doctors whereas conservative treatment was given to his wife without use of such traction.
The entire documents submitted to the forum are taken on record. It is observed from the discharge summary of Beramji Hospital where Mrs Chhaya, was admitted from 24.09.2012 to 05.10.2012, that she had complaints of severe pain in knees since 6 months causing difficulty to stand /walk more than 5-7 mins, inability to climb more than 3-4 steps, walking with limping gait resulting in pain in back since 2-3 months. It is observed that her vitals were normal throughout her stay in the hospital from 24.09.2012 to 05.10.2012. The presenting symptoms do not show any emergency warranting immediate hospitalization. The discharge summary establishes that she was treated with Tab. Powergesic, TENS on knees, ULTRA on knees, Antiplast on knees, TENS on back, TENS on both legs, and

ULTRA on back which are all OPD procedure. The husband of the complainant i.e. Mr. Bharat Mody has deposed that his wife was only given treatment form morning 9.00a.m. to 12.00 noon. To Q.9. of the Medical Certificate which is to be filled by the doctor which states "Nature of surgery /treatment given for present ailment, Dr. R. Bermaji has answered "Conservative treatment with intensive physiotherapy." Thus from the above , it is observed that there is no justifiable ground to contravene the decision of the insurer that hospitalization in case of Mr. Chhaya Mody was not required and it was an OPD procedure which was converted to IPD.
As far as claim settlement of Mr. Bharat Mody is concerned, it is observed that he was treated with Lumbar Traction which requires hospitalization necessitating supervision of treating doctors.
Hence the forum does not find any reason to intervene with the decision of the company in denying claim to Mrs. Chhaya Mody.
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Complaint No. GI – 404 (2012 – 2013)
Complainant: Shri Kaippilly Satheesan
V/s
Respondent : The New India Assurance Co. Ltd.,

Mr.Satheesan Kaippilly was covered under mediclaim policy no. 140500/34/10/11/00002816 from The New India Assurance Co. Ltd. In the year 2008 he suffered from hearing loss for which he took allopathic and homeopathic treatment. Since these treatments did not produce any positive results, he approached Sreedhareeyam Ayurvedic Eye Hospital and Research Centre where the doctors advised him to get admitted from 04.05.2011 to 16.05.2011.When he preferred the claim with the insurer, it was repudiated on the grounds that treatment taken by him did not warrant hospitalization.

The entire documents submitted to this forum are taken on record. It is observed from the Discharge Summary of Sreedhareeyam Ayurvedic Eye Hospital where Mr. Satheesan K.M. was admitted on 04.05.2011 that he was diagnosed of Badiriyam/SNHL i.e. hearing loss in both the ears. There are certain discrepancies that are observed by this forum which are presented below:

- **Letter dated 24.11.2014 submitted by Sreedhareeyam Centre states the following: "Sub: Discrepancies in Final Bill and in the Discharge Summary:……Sorry for discrepancies. As**

regards the scan image of initial case papers, clinical summary, we are not able to provide it, as it is against our principle. The patient came on 04.05.2011 with symptoms of loss of hearing on both ears since 2008. He consulted elsewhere and took medicines and had no improvements. He had severe headache frequently during work. He was admitted here on 04.05.2011 for specific Ayurvedic treatment viz Abhyangam , Karnapooranam, Kizhiswedam, Lepanam, Sirodhara etc. He was discharged on 16.05.2011." However IPD papers dated 04.05.2011 shows that he was discharged on 17.05.2011.

- **As per discharge bill, Karnapooram was done 8 times, Lepanam –Karna was done 7 times, Kizhiswedham – Karna was done 13 times, Dhoopanam was done 23 times, whereas as per IPD Karnapooram was done 3 times , Lepanam –Karna was done 6 times, Kizhiswedham – Karna was done 12 times, Dhoopanam was done 11 times.**
- **IPD papers do not show any treatment being given on 16.05.2011 whereas course of treatment shown in discharge summary shows that he was treated with Kizhiswedham – Karna, Dhoopanam, Karnapooram and Lepam. Though vide letter dated 24.11.2014, the Dr. Johnnykutty Varughese has regretted for the discrepancies in the Final bill and the summary but it is observed that the hospital authorities have not shared the entire case papers i.e. initial case papers, clinical summary to prove their contention that details of treatment shown in Discharge Summary is true.**
- **It is observed from the IPD that the complainant was treated with Karnapooram, Lepanam –Karna, Kizhiswedham – Karna, Dhoopanam, Sirodhara, Sarvanga Abhyangam only on 12.05.2011 and 13.05.2011. In all other days, it was combination of 3-4 treatments. Also many of these treatments can be synchronized and hence the entire treatment per day would not be extended for more than 3-4 hours per day which could have been possible on OPD basis.**
- **From the above it is established that Sreedhareeyam Ayurvedic Eye Hospital do not maintain the records properly for the reasons best known to them and the contention of the company that discharge bill was exaggerated with increase in no. of treatments to prove that hospitalization was required in case of Mr. Kaippilly Satheesan cannot be completely ruled out.**

Thus from the above it is difficult to contravene the contention of the company that treatment taken by Mr. Kaippilly Satheesan could have been taken on OPD basis and the forum does not have any reason to

interfere in the decision of the company to repudiate the claim. If the Award is not acceptable to the complainant, he is at liberty to approach any other appropriate forum for redressal of his grievance.

Complaint No. GI-1812 (2013-2014)

Complainant: Mrs. Nisha Kurup
v/s.
Respondent: The New India Assurance Co. Ltd.,

Mrs. Nisha Kurup was covered under Mediclaim policy 2007, policy no. being 140104/34/11/01/00005454 for sum insured of Rs. 3,00,000/- issued by The New India Assurance Co. Ltd. She underwent Myomectomy with Ovarian cystectomy on 01.08.2012 at Sanjeevani Maternity and General Nursing Home. When she preferred the claim, it was rejected on the grounds that she had taken treatment for infertility which is excluded as per policy terms and conditions.

Aggrieved by their decision, Mrs. Nisha Kurup approached the Office of Insurance Ombudsman seeking intervention in the matter of settlement of her claim.

The entire documents submitted to the forum and deposition of both the parties to dispute is taken on record. On scrutiny of the available documents, the following observations are made by the forum:-

1) **As deposed by Mrs. Nisha Kurup, she first consulted Dr. Meera Agarwal on 10.07.2012 for menstrual pain and bleeding. However the consultation sheet of the same date shows that her Menstrual history as '3-4/28 days, Reg' which is normal for a woman aged 37 years and there is no mention of menstrual pain and bleeding as deposed by the complainant during hearing. At the same time, it is observed that Dr. Meera Agarwal has noted "Not taken any treatment so far. Wants to conceive" which implies that she had consulted the doctor as she was planning for a child.**
2) **After 7 days , she consulted Dr. Krishna of Pooja Hospital and the consultation sheet dated 17.07.2012 shows "Planning for a kid, married since 1 year; M.H- 3-4 d/28-32 days , Moderate flow, painless." Even in this consultation sheet the doctor has not mentioned anything about menstrual pain and bleeding.**
3) **The complainant during the course of hearing had stated that Dr. Krishna had informed her that she had small fibroid in her uterus which did not require any immediate surgery. The Report of USG**

Pelvis dated 16.07.2012 also establishes that she had a tiny fibroid measuring 1.8x1.4cm and 3.0x 2.5 cm cyst in her right ovary. Generally, in such situation the patients go in for conservative treatment and oral medication since it is not accompanied with menorrhagia and will prefer to wait for few months to see the results rather than immediately undergoing laparoscopic myomectomy and ovarian cystectomy as seen in case of Mrs. Nisha Kurup. It is also observed that doctors recommend myomectomy as a procedure to restore fertility in women with fibroids.

4) **The Certificate dated 03.01.2014 given by Dr. Ameet Patki of Fertility Associates stating that Mrs. Nisha Kurup had consulted in the month of July 2012 for severe menorrhagia and Dysmenorrhea cannot be accepted as her first consultation on 10.07.2012 and second consultation on 17.07.2012 with two different gynecologist showed normal menstruation cycle with moderate flow and there is no mention of patient suffering from menorrhagia and Dysmenorrhea in any of these consultation sheets.**

From the above it cannot be ruled out that Mrs. Nisha did not consult the gynecologist for conception and infertility treatment and the doctors advised her to undergo various tests, which revealed that she was suffering from Fibroids in Uterus and Endometriotic cyst in Right Ovary for which she underwent treatment. Under these circumstances, it is difficult to contravene the contention of the company that treatment taken by Mrs. Nisha Kurup i.e. Diagnostic Hysteroscopy, Myomectomy with ovarian cystectomy was for infertility and the forum does not find any reason to interfere in the decision of the company to repudiate the claim.

Complaint No. GI-141(2014-2015)

Complainant: Mr. Naleen Khatau
v/s.
Respondent: The New India Assurance Co. Ltd.,

Mr. Naleen Khatau was covered under Mediclaim Policy no.111200341201000021 72 for a period from 09.06.2012 to 08.06.2013 for sum insured of Rs. 1,00,000/-.He was admitted to Ramkrishna Mission Hospital from 02.06.2013 to 03.06.2013 and thereafter to Kokilaben Dhirubhai Ambani Hospital from 03.06.2013 to 07.06.2013 for treatment of Myocardial Infarction. When he

preferred the claim, it was repudiated on the grounds that his current ailment is direct complication of his smoking habits.

Aggrieved by their decision, Mr. Naleen Khatau approached the Office of Insurance Ombudsman seeking intervention in the matter of settlement of his claim.

After perusal of the records parties to dispute were called for hearing. The complainant Mr.Naleen Khatau along with his son Mr. Hardik appeared and deposed before the Ombudsman. He stated that as per policy clause use of tobacco leading to cancer is excluded and in his case he had suffered from Myocardial Infarction for which he was hospitalized. Hence rejection of claim is not justified.

The New India Assurance Co. Ltd., was represented by Mr. Hitendra Patel- Deputy Manager and Dr. Preeti – TPA. Mr. Patel stated that Mr. Naleen Khatau was admitted to Ramkrishna Mission Hospital from 02.06.2013 to 03.06.2013 with c/o of chest pain. He was then shifted to Kokilaben Dhirubhai Ambani Hospital from 03.06.2013 to 07.06.2013 for treatment of Myocardial Infarction. On going through the hospital records, they found that claimant was chronic smoker and present ailment was direct complication of smoking. He read clause 4.4.6 under which the claim was rejected.

Ombudsman observed that the said clause states that use of Tobacco leading to cancer is excluded whereas no where in the policy there is any exclusion relating to use of tobacco leading to Myocardial Infarction.

On hearing the deposition of both the parties to dispute, the forum directed the company to re-examine the case in light of the above observation of the forum and convey their final stand within 7 working days.

On 27. 02.2015, the forum received letter dated 26.02.2015 from the insurer which states "As per the observation from the indoor case paper, insured is a chain smoker (10-12 cigars per day). Insured is having family history of hypertension and Ischemic Heart Disease. Inspite of that, he was smoking cigarettes which are bodily injury or sickness due to willful or deliberate exposure to danger, intentional self-inflicted injury arising out of non-adherence to any medical advice. This falls under permanent exclusion for any medical

expenses incurred under Permanent Exclusion Clause 4.4.7 and 4.4.6."

The entire documents submitted to this forum and deposition of both the parties to dispute is taken on record. It is observed from the Discharge Certificate of Ramkrishna Mission Hospital that Mr. Naleen Khatau was admitted on 02.06.2013 with complaints of Chest pain , retrosternal pain with h/o profuse swelling . The case papers of the same hospital shows that the patient is chain smoker and is in the habit of taking 10-12 cigarettes per day. The Discharge Summary of Kokilaben Hospital where the insured was admitted from 03.06.2013 to 07.06.2013 shows that he was diagnosed with Anteroseptal MI, Thrombolysed with STK, PTCA-LAD was done.

The claim preferred by the complainant has been repudiated by the company under clause 4.4.6 as is evident from the repudiation letter dated 23.01.2014. Clause 4.4.6 is reproduced below:-:
"Convalescence, general debility, Run –down condition or rest cure, obesity treatment and its complications, congenital external diseases/defects or anomalies, treatment relating to all psychiatric and psychosomatic disorders, infertility , sterility, use of intoxicating drugs/alcohol, use of tobacco leading to cancer are excluded."
It is confirmed that Mr. Naleen Khatau was in the habit of smoking cigarettes as revealed from the case papers of the hospital where he was admitted. The insured has also not denied this fact during the course of hearing. However it is observed that clause 4.4.6 does not exclude claims arising due to use of tobacco leading to Myocardial Infarction. Thus rejection of claim of Mr. Naleen Khatau under the above exclusion clause is not as per policy terms and conditions.

The company vide letter dated 26.02.2015 has stated that claim has also been rejected under clause 4.4.7. The forum is surprised to note that the company could not decide about the grounds of rejection before calling up their final decision to the beneficiary. Only after the hearing at the forum, the company is referring to the clause which very clearly shows that company do not know the reasons for which the claim should be repudiated. Moreover it should also be known to the company that no new grounds for repudiating /rejecting the claim can be taken subsequently other than those mentioned in the rejection/repudiation letter.

Under these circumstances, the scales are tilted in the favour of the complainant

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Complaint No. GI- 95 (2014-2015)

Complainant: Mrs. Rupali Nawadkar
v/s.
Respondent: The New India Assurance Co. Ltd.,

Mrs. Rupali Nawadkar was covered under Group Mediclaim policy issued to M/s Maxx Moblink Pvt Ltd by The New India Assurance Co. Ltd. She gave birth to baby boy on 16.09.2013 but since the baby was born under extreme premature conditions, he had to be shifted to NICU at Neo Plus Children Hospital. However the baby expired on 23.09.2013. When she preferred the claim to the insurer, the company settled the claim pertaining to the Maternity Expenses and rejected the claim relating to treatment taken by her child.

Aggrieved by their decision, Mrs. Rupali Nawadkar approached the Office of Insurance Ombudsman seeking intervention in the matter of settlement of her claim.

After perusal of the records parties to dispute were called for hearing .

The complainant Mrs. Rupali Nawadkar appeared and deposed before the Ombudsman. She stated that her company had requested the insurer to deduct the premium pertaining to her child from the CD account maintained by them and pay the claim amount but the insurer and the TPA were not ready to accept it.

The New India Assurance Co. Ltd. was represented by Mr. G.M. Dave-AO. He submitted that Mrs. Rupali Nawadkar was covered under Tailormade Floater Group Mediclaim policy wherein Maternity Cover and Baby Day One cover was available. The policy clauses very clearly state that Mid Term Additions are allowed under the policy only for newly wed spouse and newly born children only on receipt of complete and full premium. When claim under the policy was received for Maternity Benefit and treatment taken by her new born

child, the company settled the claim pertaining to the Maternity expenses. However since no premium was charged for the new born child, the question of admitting liability does not arise. Also the insured had not send any intimation informing the birth of new born child. He defended the decision of the company.

On hearing the deposition of both the parties to dispute, Ombudsman directed the complainant to submit all the documents pertaining to communication between the company and the insurer/TPA relating to deduction of the premium pertaining to her child from CD account and settlement of claim amount within 7 working days.
On 03.03.2015, the forum received letter from the complainant wherein she had attached the following :

1) **Email exchanged between the insurer and her company official, wherein the insurer has stated that CD account balance as on 26.02.2015 was Rs. 4243/-**
2) **Email dated 01.02.2014 sent by Ms. Sonali Raizada HR- General Manager of Maxx Moblink Pvt Ltd to The New India Assurance Co. Ltd., for deducting applicable premium for new born baby of Mrs Rupali.**

The entire documents submitted to this forum and deposition of both the parties to dispute is taken on record. Mrs. Rupali was covered under Tailormade Floater Group Mediclaim policy which provides Maternity Benefit and Baby Day One cover. The Additional Clauses under the policy states that the newly born would be covered only on receipt of complete and full premium. Mrs. Rupali was admitted on 14.09.2013 to Health Hi- Tech Orthopaedic and Surgical Hospital and on 16.09.2013 she gave birth to baby boy. Since the birth of the baby took place within 6 months of pregnancy, the baby was very weak due to which he had to be shifted to NICU at Neo Plus Children Hospital. Inspite of the best efforts of the doctors, the baby could not survive long and expired on 23.09.2013. She submitted all the claim documents to TPA and they have confirmed that the same is received by them on 07.10.2013. The company settled the claim pertaining to Maternity Benefit but rejected the claim pertaining to the new born baby. The contention of the company was that they had not received any intimation about the birth of the child nor any necessary additional premium was received to cover him, hence they are not liable for claim settlement pertaining to the new born. However the company should understand that Mrs. Rupali was admitted under emergency conditions to the hospital and the birth of

the child was under extreme premature conditions. In such situation the full focus of the mother and other family members would be on the child. Also for a mother to lose her child within 8 days of its birth is too taxing , both emotionally and physically and in such situation to expect her to inform the insurer/ TPA about the child birth seems to be too demanding. Inspite of this, it should be appreciated that she had submitted all claim requirements within 30 days of her discharge from the hospital as stipulated in the policy terms and conditions. The forum is also of the opinion that since there was sufficient amount in the CD account of the company and the employer of the insured had also requested the insurer in February 2014 to debit the premium pertaining to the child and settle the claim amount, the insurance company as a special case should have considered the request.

Under these circumstances, The New India Assurance Co. Ltd., is directed to debit the necessary premium pertaining to the deceased child of Mrs.Rupali Nawadkar and pay the hospitalization claim for his admission to Neoplus Children Hospital from 16.09.2013 to 23.09.2013.

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Office of The Insurance Ombudsman, Pune.

1. **CR Deshpande Vrs National Insurance Co. Ltd.**

The Insured was covered under Group MediClaim policy of the Respondent, initially for 1 lac. The Sum Insured was later on enhanced to 5 lacs. The insured had a past history of HTN. Due to Heart attack he was hospitalised for treatment and Angioplasty was performed. The Insured developed Pulmonary Haemorrhage, post angioplasty treatment. The Doctors suggested treatment of Pulmonary Haemorrhage by a recently developed and very effective line of treatment, known as "Extra Corporeal Membrane Oxygenation". The Insured had incurred expenses to the tune of 14.45 lacs. The Claim was partially settled for Rs. 1 lac on the grounds of PED. The enhanced cover was considered as a new policy and hence the settlement was restricted to Rs. 1 lac only.
The respondent failed to prove any nexus between HTN and the Pulmonary Haemorrhage and could not establish that the HTN was the sole & direct cause of Pulmonary Haemorrhage. The repudiation

letter referred three clauses for disallowing major part of the Claim, but only one clause was correctly invoked, while the two other clauses were inapplicable in the case. The Forum considered that referring and invoking inapplicable clauses in the repudiation letter is an act of misleading the Insured. Last but not the least, was a fact that the policy document did not contain any condition that the enhancement of the cover will be treated as a fresh policy. The insured cannot be allowed to be taken for a ride by the Insurers for any omission on their part in the policy terms and conditions governing the contract. The Forum directed to pay balance sum insured of 4 lacs with 9% interest.

Sonali Shete Vrs Oriental Insurance Co. Ltd.

The Insured was covered for 15 lacs under Group Personal accident policy with the Respondent. The Insured fell from the fifth floor at 05.45 AM and succumbed to the injuries in the Hospital. The Claim is payable if the incidence is purely an Accident and not admissible for intentional self injury or suicide. The Respondent investigated the matter and inferred that the incidence was an act of suicide. Accordingly, the claim was repudiated.
It was observed that the height of the parapet wall & the iron railing was 4 feet & 9 inches. Falling accidently from such a barricaded balcony is not possible under normal circumstances. The PM report denies intake of any intoxicating substance by the DLA.
Initially, it was submitted by the wife of the deceased (Claimant) that the Insured fell while watering the plants but later on it was stated that he fell while exercising in the balcony. It is pertinent to note that neither anything that was used for watering the plants nor the equipments used for exercise were found in the balcony. The exact place from where the deceased fell, was not certain. The neighbours state the place of incidence as 'Balcony' whereas the Police reports mention the same as 'Staircase'.
The Respondent had requested the claimant to submit the call details of the deceased but the same were not provided to the Respondent. The statements of the other residents of the building were same in verbatim and hence can be considered as signed on a

pre written letter. Most importantly, none of them was a eye witness to the incidence.
The various police reports also fail to negate the possibility of suicide, though, the Police authorities had requested the Sub Divisional Magistrate to issue Death Summary as "Death due to Accident". The Police considered the death as an Accidental death without ruling out that it could be a Suicide also. However, all the circumstantial evidences converge towards treating the incidence as "suicide" only. The Forum deemed it quite appropriate that for granting any benefit under contract of Insurance, the cause of action leading to the loss, should be established beyond doubt. In the instant case, the cover was for the death due to accident only and the accidental death was not proved beyond doubt. Hence the Forum upheld the decision of the Respondent to repudiate the claim.

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Vaibhav Wagholikar vrs New India Insc. Co. Ltd.

The insured was covered under two policies- Mediclaim 2007 for Rs. 1 lac and Senior Citizen's Red Carpet Insurance for 1.5 lacs. The claimant was diagnosed with Prostate Cancer and Operated for Laproscopic Radical Prostatoctomy. His claim for Rs. 152086/- was Partially settled under Mediclaim 2007 policy for Rs. 71664/- and the balance was rejected under the second policy. The plea was for settlement of balance amount of Rs. 81952/- under Sr. Citizen's Policy.
As per the Respondent, the disease being a critical illness & Pre existing is not covered under Sr. Citizen's Red Carpet Insurance policy even after two claim free years.
The literature on the Web site of the Respondent highlighting the salient features of the Sr. Citizen's policy has no mention about exclusion of PED even after two claim free years. Doctor has certified that the ailment is not a Critical illness. Critical Illness is not defined in the policy document. The exclusion clause was not interpreted correctly. The first part of the exclusion clause 4.1 specifically states that "Pre existing diseases/Condition: All diseases/injuries, which are pre existing when the cover incepts for

the first time. However, they will be covered on completion of 18 claim free months of insurance" and hence the claim becomes admissible, even if , the disease was pre existing after 18 claim free months. The second part of the clause states that " Dialysis, Chemotherapy & Radiotherapy for diseases including Critical Illnesses, existing prior to the date of commencement of this policy are excluded, even after two claim free years". The current treatment does not fall within the purview of this exclusion clause as the policy schedule dealing with max. Charges include the disease 'Postrate' and hence the claim becomes admissible.

The policy is meant for Senior Citizens and is very attractively named as 'Red Carpet Insurance'. But the policy T&Cs, are framed in such a way that mostly all old age ailments/diseases are excluded even after the two claim free years, or the risk is deferred on the pretext of Pre existing disease. Interestingly, as per the literature on the web site "pregnancy & child birth" is excluded for senior citizens. The Complaint was admitted & the Respondent was directed to make payment of Rs. 80442/-.