Individual Mediclaim Policy

Case No. BNG-G-003-1516-0409

Mr. Ravikumar P V/s Apollo Munich Health Insurance Company Limited

Date of Award – 5th January, 2016

The Complainant held an Individual Mediclaim Insurance Policy. During the currency of the Policy, the complainant was hospitalized in an Ayurvedic Hospital for complaints of pain in the lower back region radiating to the right leg and was diagnosed as suffering from Grudrasi (Ayurveda). Claim for hospitalization expenses was denied.

The Insurer repudiated the claim stating that the X-rays submitted were normal and did not indicate any fracture/infection and the treatment provided for spinal subluxation was merely for muscle strain/muscle stimulation which falls under (d) (xii) exclusion of the policy.

Based on the facts and circumstances of the case, documents made available by and submissions made by both the parties, it was concluded that the repudiation of the claim by the Insurer was justified and required no interference at the hands of this Forum.

Hence, the case was **Dismissed**.

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Diabetes Safe Insurance Policy

Case No. BNG-G-044-1516-0511

Dr. (Mrs.) Hema Sridhar V/s Star Health And Allied Insurance Company Limited

Date of Award – 19th January, 2016

The Complainant was a Diabetes Safe Insurance Policy holder uninterruptedly for 8 years. She was administered 12 injections as a part of treatment of Myeloma.

The Insurer repudiated the claim stating that the treatment was taken at home (Domiciliary treatment) and does not fall under in-patient treatment and day care procedures.

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of personal hearing, it was concluded that the decision of the Insurer in repudiating the claim was in order and does not require any interference.

Hence, the Complaint is **Dismissed**.

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Individual Mediclaim Insurance Policy

Case No. BNG-G-037-1516-0512

Ms. Vijayalakhsmi Kishore V/s Religere Health Insurance Company Limited

Date of Award – 19th January, 2016

During the 1stYear of the Policy, the Complainant was hospitalized and was diagnosed as suffering from LeucocytoclasticVascuiltis.

But, the Insurer repudiated the claim stating that the line of treatment was not in consistent with the diagnosis and unrelated investigations and consultations were carried out. Insurer reported to the Indian Medical Council about this irregularity.

Since the matter was pending before the Medical Council of India, which is Apex Body as far as medical profession is concerned, this compliant **does not fall within the scope of the functioning of the Insurance Ombudsman.**

Hence, the Complaint is **Disposed of**.

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Medi-Classic Insurance Policy (Individual)

Case No. BNG-G-044-1516-0593

Mr. Basavaraju v/s Star Health & Allied Insurance Company Limited

Date of Award – 16th February, 2016

The Complainant took a Mediclassic Insurance Policy (Individual) covering himself for the period from 05.03.2015 to 04.03.2016. During the currency of the policy, the insured was hospitalized for left ICA thrombosis. He pleaded that during 2014, he consulted for neurological problems and some tablets were prescribed but the treating doctor did not disclose the disease and he was not aware of any pre-existence medical condition.

Insurers submitted earlier treatment papers which confirms that the patient had suffered from Thrombos formation and ecosporin tablets were used for avoiding clotting of blood. They went to add that thrombosis leads to weakness of limbs and the current hospitalization of a repeat of the hospitalization which he had prior to taking the said policy. Further, the insured failed to disclose the earlier hospitalization at the time of taking the policy which amounts to non-disclosure of material fact and the claim merits repudiation.

It has been concluded that the decision of the Insurer in repudiating the claim is in order and as per terms and conditions of the Policy and **does not require any interference at the hands of this Forum.**

Hence, the Complaint is **Dismissed**.

Senior Citizens Red Carpet Insurance Policy

Case No. BNG-G-044-1516-0582

Mr. J Sathyanarayan v/s Star Health & Allied Insurance Company Limited

Date of Award – 16th February, 2016

The Complainant took a Senior Citizens Red Carpet Insurance Policy covering his father. During the currency of the 7th year of Insurance, the Insured Person (aged 72 years) was hospitalized for the complaints of abdominal bloating, early satiety and decreased appetite and was a known case of DM & HTN and on medication and was diagnosed with Intestinal Sysmotility, Parkinson plus syndrome, Diabetes Mellitus and Hypertension.

Insurer repudiated the claim stating that the patient had history of tremors and was diagnosed with Parkinson's disease since 20 years and the same was not disclosed while taking the first policy which amounts to non-disclosure of material information.

The complainant emphatically denied about suffering from the disease of Parkinson since 20 years since his father was a teacher by profession which required writing on the black board which was done without any problem and they could become aware of the existence of the Parkinson's disease during the current hospitalization only. Further, the patient was very keen on his good health, he used to undergo various medical tests and the same presented to the Forum.

The Forum directed the Insurance Company **to settle the claim** as per the terms and conditions of the Policy.

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Heartbeat Gold 05 lacs Insurance Certificate

Case No. BNG-G-031-1516-0542

Mr. Kiran G V/s Max Bupa Health Insurance Company Limited

Date of Award – 16th February, 2016

During the currency of the current policy, the Complainant had a fall from the stairs sustained injury to right shoulder dislocation reduced outside – III episode. He had similar episodes one year ago and reduction was done and was treated with sling for 3 weeks. This policy being first year of insurance.

The claim was denied by the Insurer stating that the complainant had history of Right Shoulder Injury 6 years back and he had the similar episode one year back and was treated with sling for 3 weeks. However, while taking the insurance, the complainant did not disclose previous health history which amounts to non-disclosure of material information/facts and the repudiation of claim was justified.

During the course of the Hearing, the Complainant informed that he had also filed a case in Consumer Redressal Forum for the compensation of the same claim.

It is concluded by the Forum that the complaint is beyond the scope of the functioning of the Insurance Ombudsman under Rule 13(3)(c) of the RPG Rules, 1998, wherein it is stated that "the complaint should not be on same subject matter, for which any proceedings before any Court or Consumer Forum or Arbitration is pending or were so earlier", and does not warrant any interference by this Forum.

Hence, the Complaint is **Dismissed**.
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ICICI Lombard Complete Health Insurance

Case No. BNG-G-020-1516-0581

Mr. Ravi Shankar S. Poll v/s ICICI Lombard General Insurance Company Limited

Date of Award – 16th February, 2016

The Complainant took the Policy 7 years ago through tele-sale and had been renewing without any break. During the currency of the present policy, the insured was hospitalized and was diagnosed with Right Upper ureteric Calculi and Cystoscopy + Right URS + Lithoclast + Righjt DJ Stenting was performed on him. He was suffering from HTN since 20 years but the same was not disclosed as he was advised by the sales tem not to disclose, if proper medication was taken and the same was under control. Treating Doctor certified that the HTN had no relevance to the present complaint. He preferred a claim for Rs. 1,61,694/-

The Insurer repudiated the claim on the ground of non-disclosure of material fact at the time of taking the first policy and the same was substantiated by playing pre-acceptance IVRS call through a pre-corded CD disc.

Through conciliation and mediation, the Insurers agreed to settle the claim for Rs. 74,695/- in full and final settlement of the claim and the Insured agreed for the same.

Accordingly, the case was **disposed of**.
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Senior Citizens Red Carpet Health Insurance Policy

Case No. BNG-G-044-1516-0639

Mrs. S G Saraladevi v/s Star Health & Allied Insurance Company Limited

Date of Award – 10th March, 2016

The Complainant along with her spousewas covered in the policy taken by her spouse. Policies were taken continuously since 2013. The Complainantsuffered pain in abdomen since 2 days prior to admission and progressed gradually. It was a sudden onset. She was admitted into an emergency ward and was discharged after 4 hours, carrying out the necessary investigations.

Insurer repudiated claim stating that the claim was not admissible unless the treatment was taken as an inpatient for more than 24 hours whereas in the instant case, the treatment was only for 4 hours and the same was also on outpatient basis.

The Complainant pleaded that recently the Sum Insured was enhanced and relevant premium was paid and sought for refunding of the same. Insurer agreed to refund, upon receipt of request for the same.

However, during the hearing, the Insurer agreed to pay Rs. 1,000/- towards consultation charges, as the same were payable since the same were incurred in a Net Work Hospital.

The Complaint is accordingly **disposed of**.
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Individual Care Health Insurance Policy

Case No. BNG-G-037-1516-0735

Mr. Paras Chand Jain v/s Religare Health Insurance Company Limited

Date of Award – 22nd March, 2016

The Complainant obtained a Policy in the year 2014 and renewed the same in the year 2015. During the currency of the 2nd year, the wife of the Complainant underwent a comprehensive health checkup and as part, TMT Report was positive which necessitated angiography test. The Discharge Summary stated that TMT positive for IndusibleIschemia CAG done on 23.12.2015 – CAD Triple Vessel, S/P PTCA + Stent to LAD to RCA normal LV systolic function was carried out. The Claim was rejected by the Insurer stating "non-disclosure of pre-existing disease ie., Angina Pectoris in 2013, which was present at the time of taking the policy. The Complainant submitted his justification that she was not suffering from any disease prior to present hospitalization. A Notarized Affidavit was also submitted to that effect. Further the gap between the ECG taken in India and in Singapore was hardly one month

Insurer submitted that the patient had undergone Heart Treatment in Tan Tock Seng Hospital, Singapore and was diagnosed with Angina Pectoris, Left-sided Chest – pain radiating to Left arm and generalized weakness and was prescribed medication for the chest discomfort. This aspect of hospitalization at Singapore and the relevant treatment taken and also the illness of Angio Petcoris which she suffered and the continuous medication she had been taking for the said illness, was not disclosed in the Proposal form at the time of inception of the first policy, which amounts to non-disclosure of material information and claim merits repudiation as per the term and conditions of the Policy.

This Forum concluded that the decision of the Insurer in repudiating the claim was in order and in consonance with the terms and conditions of the policy and **does not require any interference at the hands of the Ombudsman.**

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ICICI Lombard Complete Health Insurance

Case No. BNG-G-020-1516-0707

Mr. Elangovan T S v/s ICICI Lombard General Insurance Company Limited

Date of Award – 22nd March, 2016

The Insured along with spouse was covered since 2007 continuously. During the currency of the current policy, the insured was hospitalized for complaints of retrosternal chest pain since 5 days with peak pain on the previous day and was referred by another hospital giving him initial treatment. He was a known case of IHD-S/P PTCA with stent to LAD (2006), HTN &n DM on treatment. He diagnosed as suffering from IHD – Acute AWMI, CAG – Single Vessel Disease (28.10.2015) with patent LAD Stent, Successful Primary PTCA with stent to LAD (Promus Element) with IABP support done on 28.10.2015, S/P PTCA with stent to LAD (2006). Reduced LV Function, LVEF – 30%, Diabetes Mellitus, Hypertension, ?Cardioembolic Stroke – Recovered (VBI – AICA Territory). Cashless request and subsequent claim for reimbursement of expenses were denied by the Insurers on the ground of non-disclosure of the pre-existing diseases/illness.

Insurers pleaded that the Insured had a history of DM and HTN since 6 years and PTCA Percutaneous Transluminal Coronary Angioplasty was done in 2006,Single Vessel Disease (28.10.2015) with patent LAD Stent and was on continuous medication. However, the Insured did not disclose these pre-existing ailments in the proposal form, at the time of taking the first policy. They also played the audio of IVRS tele-recording carried out prior to the policy commencement and the tele-call confirms that he declared that he was healthy and did not disclose the above aspects ofpre-existing illness/medical condition. They drew reference of a case decided in National Consumer Commission Redressal (LIC of India and another v/s Smt. VimlaVerma) wherein it was held that the Insurance Contract are based on the principle of "Ubberima Fides" (Utmost Good Faith) and suppression of material information by the insure would amount to breach of contract which would justify repudiation of the claim by the Insurance Company. They also confirmed the refund of the premium of the current policy.

The Forum concluded that the Insurer's decision of repudiating the under the Policy is in consonance with the terms and conditions of the Policy and **does not warrant any any interference at the hands of the Ombudsman.**
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ICICI Lombard Complete Health Insurance

Case No. BNG-G-020-1516-0717

Mr. BrahmanandK v/s ICICI Lombard General Insurance Company Limited

Date of Award – 22nd March, 2016

The Complainant was holding the above policy covering himself and his spouse since 2012 continuously without any break of insurance. During the currency of the present policy, the spouse of the Insured was admitted into Hospital and was dignosed for Bilateral

Degenerative Osteoarthritis of Knee and underwent Bilateral Total Knee Replacement Surgery-Stryker Scorpio CR was done under epidural/spine anesthesia. The claim was rejected by the Insurer stating that the patient was suffering from HTN prior to commencement of the fir policy and the same was not disclosed in the proposal form.

Insurer contended that the Insured Person had history of both the knee problem (Arthritis) and was on continuous medication and also had history of HTN and was on mediation, before the commencement of the first policy and the same were not disclosed during the proposal period. This non-disclosure of material information renders the contract void. They drew reference of a case decided in National Consumer Commission Redressal (LIC of India and another v/s Smt. VimlaVerma) wherein it was held that the Insurance Contract are based on the principle of "Ubberima Fides" (Utmost Good Faith) and suppression of material information by the insure would amount to breach of contract which would justify repudiation of the claim by the Insurance Company.

The Forum concluded that even though the pre-existing disease of Hypertension does not have direct bearing on the current surgery, the decision of the Insurers to repudiate the claim is in order and justified, as 48 months have not elapsed since policy inception and the Discharge Summary states that "the patient suffered from significant antalgic gait due to severe osteoarthritis of both knees which had been significantly symptomatic for the past few years, was severely affecting her activities of daily living, sleep and walk for even a short distance…."

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PNB-Oriental Royal Mediclaim Policy

Case No. BNG-G-050-1516-0644

Mr. Satish Kumar K P v/s Oriental Insurance Company Limited

Date of Award – 22nd February, 2016

The Complainant was holding the said policy covering himself, spouse and dependent daughter. While he was renewing the Policy through online (using credit card), though his account was debited for the premium amount, he received an error message stating that the Policy could not be issued and was advised to visit local office and get the policy renewed and accordingly he got the policy renewed offline. Inspite of taking up his matter with the Insurance Company for refund of the premium paid for the on-line failed transaction, he could not get the same refunded and hence he approached this Forum.

Insurer submitted in their Self Contained Note that the premium was refunded but the same was after a lapse of 87 days.

The Insured informed that he was unable to attend the Hearing. Insurer contended that there was no facility in their software module to incorporate any charges/interest on account of delay in refund of online premium.

The Forum directed the Insurance Company to pay interest @ 6% for the delay of 87 days in refunding the premium.

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Individual Health Insurance Policy

Case No. BNG-G-051-1516-0635

Mr. Gopalakrishnan R v/s United India Insurance Company Limited

Date of Award – 10th March, 2016

The Complainant had obtained the Policy covering himself and his spouse and the policy being first year of insurance. During the currency of the policy, the Complainant had undergone OsteoArtjritis treatment of both of his knees. The X-ray taken during the treatment revealed that patient had arthritic changes in both knees and while Right Knee had Grade II changes and Left Knee with Grade III changes. He was advised treatment using Sequential Programmed Magnetic Field (SPMF Therapy) for 21 days consecutively. During the treatment, the affected joints were exposed to radiofrequency beams for 1 hour followed by physiotherapy for an hour and observation for one hour and thus total stay was for 3 hours for every visit. On the first day of the treatment, the patient was admitted for 8 hours for blood investigation, treatment, rehab exercises, pain management and observation.

The Insurer repudiated the claim stating that –

Exclusion Clause 4.19 and as per Exclusion Clause No. 3.14.
Minimum of 24 hours hospitalization is not fulfilled, as per Exclusion Clause No. 3.15
Unproven/experimental treatment as per Exclusion No. 3.39

During the personal hearing, the Insurer's representatives submitted that treatment of SPMF Therapy is similar to RFQMR, besides the grounds made for the repudiation of the claim. The Doctor of TPA submitted that the treatments viz., RFQMRand SPMF are **similar but not the same** and submitted the same in the form of an affidavit.

The Complainant submitted that SPMF Therapy is a modern non-surgical treatment to help regenerate worn out cartilage cell on the weight bearing knee joints. He quoted a judgment of National Consumer Disputes Redressal Commission wherein all the aspects of the present case were similar. While directing the Insurer to honour the claim, the Commission observed that the particular treatment viz., SPMF Therapy is not specifically excluded from the scope of the policy and further excluding the age related diseases in a policy issued to a senior citizen, amounts to unfair trade practice.

Forum observed that the Affidavit is submitted by a doctor on the rolls of TPA would be either directly or indirectly influenced by the decision of repudiation of claim done by his employer and SPMF therapy is not specifically excluded in the policy, a cue from the decision of NCDRC.

Accordingly, the complaint **is Disposed of**.

Family Floater Policy

Case No. BNG-G-050-1516-0395

Mr. Jeetendra Kumar B V/s The Oriental Insurance Company Limited

Date of Award – 5th January, 2016

The Complainant obtained a Happy Family Floater Policy covering his family members till 29.03.2015 since 2010 onwards, without any break of insurance.

One of the Insured Persons was hospitalized and was diagnosed to be suffering from Chronic Liver Disease (Compensated), S/P Traumatic Paraplegia, Fracture shaft of Femur (Lower 1/3), Chronic Constipation, Hemorrhoids, Diabetes Mellitus Type-2, and suspected AIN-NSAID related.

The claim of the Complainant was repudiated by the Insurer stating that the hospitalization expenses incurred were primarily for evaluation/diagnostic purposes with no active line of treatment, by invoking the exclusion of 4.11. The insurer relied on an independent medical opinion obtained by them which confirmed that the hospitalization was for constipation and the treatment/investigations carried out were of general in nature, in respect of her associated co-evaluation/diagnostic purposes not followed by any active line of treatment.

Based on the facts and circumstances of the case, documents made available by and submissions made by both the parties, it was concluded that the repudiation of the claim by the Insurer was justified and required no interference at the hands of this Forum.

Hence, the case was **Dismissed**.

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Optima Restore Floater (2 year)

Case No. BNG-G-003-1516-0430

Mr. Mehul Shah V/s Apollo Munich Health Insurance Company Limited

Date of Award – 22ndJanuary, 2016

The Insured Person was hospitalized and was diagnosed with Pelvic Abscess. The Discharge Summary stated that the patient had h/o Lap Cystectomy done 7 years back and h/o Endometriotic Right Ovarian Cyst. During hospitalization, doctors performed laparoscopic drainage of? Pelvic Abscess? Ovarian Abcess.

Insurer contended the patient was diagnosed to have a benign cyst and had undergone pelvic region abscess drainage on account of the infected cyst. The nursing records also confirmed the presence of an ovarian cyst and the pathological report findings declared the cyst to be benign. They further contended that the specific waiting period for the coverage of cyst was 2 years and in the instant case, it happened before the completion of 2 years and hence the claim was not admissible as per the terms, conditions and exclusions of the policy.

Based on the facts and circumstances of the case, documents submitted by both the parties and the submissions made during the Personal Hearing, it can be concluded that the Insured underwent treatment for benign cyst and pelvic ovarian abscess. As it was not possible to segregate the expenses, **it was prudent to allow payment of the claim to the extent of 50% of the total claim**, towards full and final settlement of the claim as per terms and conditions of the policy.

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Happy Family Floater Policy

Case No. BNG-G-050-1516-0580

Mr. Shivlal G V/s Oriental Insurance Company Limited

Date of Award – 26th February, 2016

The Complainant obtained above Insurance Policy covering himself, spouse and two dependent children. During the second year of the Policy, the complainant's wife was hospitalized for Right Upper Uretic Calculus and she underwent Right Uretholithotomy + DJ stenting.

Insurer repudiated the claim on the ground that Calculus Disorder is covered after two continuous policy renewals (4.3 & 4.1 of the Policy) whereas in the instant case, the claim occurred during the currency of the second year policy and hence the claim was inadmissible.

The decision of the insurer was in order and did not require any intervention at the hands of this Forum.
Hence, the Complaint is**Dismissed**.

****

Family Health Optima Insurance Plan

Case No. BNG-G-044-1516-0562

Mr. Ananth Kumar Diwakar v/s Star Health & Allied Insurance Company Limited

Date of Award – 16th February, 2016

The Complainant took the above policy (first policy) covering himself and his spouse for the period from 09.12.2014 to 08.12.2015. During the currency of the Policy, his spouse was admitted into Hospital in Mangalore and was diagnosed as suffering from Laprotomy (LP) Cystectomy and the same was removed through a surgery. The Complainant and his spouse were earlier covered under ManipalArogya Suraksha Schme since 01.09.2013 and hence the period of coverage under the said scheme should also be considered for application of any waiting period in the policy.

Insurer repudiated the claim stating that the current policy was the first insurance policy obtained from them and hence it would satisfy the waiting period applicable for the said disease/illness. The earlier coverage was under a scheme for development for Konkan's Community and the same was not considered as coverage provided by an Insurer,

registered and approved by IRDA. Further, it was submitted that Insurance Company under RPG Rules, 1998 means any Insurance Company who was given licence by IRDA to carry on any Life Insurance or General Insurance business and the same is not done in this case. Hence, the previous coverage would not reckon as Insurance for the purpose of application of waiting period.

This Forum concluded that the decision of the Insurer was in order and did not require any interference.
Hence, the Complaint is **Dismissed**.
****

Family First Silver 1 lac + 3 lacs Heartbeat Family First Insurance Policy

Case No. BNG-G-031-1516-0604

Mr. S SrinivasaReddy v/s Max Bupa Health Insurance Company Limited

Date of Award – 26th February, 2016

The Complainant took the above policy covering himself and his wife. During the currency of the Policy, the Complainant's wife was admitted into Hospital with Cervical OPLL with Comprehensive Myelopathy (Nurick grade2) with a past history showing that she was known case of Hypertension for the past 10 years and was on medication. She did not suffer from lower back ache either earlier to the surgery or after the surgery.

Insurer repudiated the claim stating that the insured did not declare the pre-existing condition of HTN in the proposal form which amounted to non-disclosure of material information/facts. All pre-existing diseases would not be covered until expiry of 48 months of continuous insurance for the plan obtained by the Insured. It was further ascertained that the patient had a past history of lower back-ache for the past 5/6 years and numbness of little finger since 6 months and the same was not disclosed in the Proposal Form.
However, the treating doctor issued a certificate stating the patient had no significant history of back plain which merit treatment.
In viewof the conflicting opinion, this Forum sought an independent medical opinion from a Senior Consultant Neurosurgeon who opined that "OPLL is a long standing condition (months to years), but aggravation may be of recent onset"
This Forum concluded that the current surgery was on account of pre-existing medical condition of Cervical Compressive Myelopathy, which was not disclosed at the time of filling the proposal form which had adverselyaffected the decision of the Insurer in writing the proposal and **the repudiation of the claim was in accordance with the terms and conditions of the Policy.**
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Happy Family Floater Policy

Case No. BNG-G-050-1516-0732

Mr. Deepak Kumar Jain v/s Oriental Insurance Company Limited

Date of Award – 22nd March, 2016

The Insured along with his spouse, Dependent Parents were covered under individual policies in 2009 and renewed in 2010 on the similar basis. However, during 2011, he renewed the policies under a Family Floater Policy for a Sum Insured of Rs. 4,00,000/-. During the year 2013, (5th year of first policy and 2nd year of enhanced sum insured policy), father of the Insured had hospitalization for chest discomfort and underwent Coronary Angiogram – Ostill LMCA Plaquing + Double vessel disease. The Insurers settled the claim under the initial sum insured of Rs. One lakh and not the enhanced sum insured of Rs. 4 lakhs.

Insurers submitted that the patient was a known case of HTN since 3 - 4 years and CAG is a direct complication of HTN and hence they restricted the settlement of claim to the sum insured of the first policy only. Waiting period of 4 years did not complete for pre-existing diseases under the enhanced sum insured Policy and hence the same was not considered. They drew the attention to Condition No. 7 (c) of the policy in this connection.

The Forum concluded that the decision of the Insurer was in accordance with the terms and conditions of the Policy **and does not require any interference at the hands of the Forum**.

Happy Family Floater Policy

Case No. BNG-G-031-1516-0691

Mr. SiddharthSekhar v/s Max Bupa Health Insurance Company Limited

Date of Award – 22nd March, 2016

The Complainant was covered under the policy taken by his son in the year 2014 and the same was renewed in 2015 also without any break. He underwent a general health check-up with cardiac symptoms and he would be to a diabetic and hypertensive patient since the last 10 years. Pre-authorization cashless requests were made which were denied. The Insurer subsequently serviced a notice of cancellation of the policy without any refund of premium. Agitating the cancellation of the policy, he reported the matter to this Forum.

The Insurers submitted that the Insured Person declared in the proposal form that he was suffering from Diabetes and accordingly the Policy was issued with the said PED. During the personal hearing, the representative of the Insurer submitted that during the 2nd pre-authorization cashless request, it was noticed from the papers submitted that the patient had history of 10 years old hypertension and cardiomyopathy. They also took a reference of a medical report of 2009 where Left Bundle Branch block were detected and cardio/ECG investigations were conducted but the same were not disclosed by the Insured. Therefore, a counter offer of policy with fresh terms and conditions was made by them to the Insured, which was not accepted by him within the stipulated time-frame and the Policy was cancelled as per Clause 3 and definition 14 of the Policy terms and conditions. (Clause 3 – Termination of policy giving 30 days prior written notice without refund of premium; Definition 14 – Disclosure to Information Norm)

This Forum observed that the decision of the Insurers to cancel the policy is consonance with their underwriting guidelines.

Family Health Optima-Accident Care Insurance Policy

Case No. BNG-G-044-1516-0633

Mr. Kumar H R v/s Star Health and Allied Insurance Company Limited

Date of Award – 16th February, 2016

The Complainant had taken the Policy covering himself, spouse and 3 dependent children. During the currency of the policy in the first year itself, the complainant was hospitalized for C5-C6 Spontaneous Epidural Hematoma. Insurer repudiated the claim stating that the treatment was taken for prolapse of intervetebral disease (joint disease) which falls within the exclusion of treatments for the first two years. The treating doctor certified that the bleeding was in the epidural space compressing the spinal cord and not a Joint Disease. Since the Insurer did not settle the claim even after submitting the certificate of the treating doctor, the Complainant approached this Forum for rendering justice.

Before the scheduled hearing, the Insurer settled the claim for Rs. 2,17,051/- as against the claim of Rs. 2,62,746/-. However, the Complainant insisted for attending the Hearing in view of short settlement of the claim.

During the Personal Hearing, the Insurer explained the deductions made from the claim amount (which were already mailed to the Complainant) and the same were found to be in consonance with the terms, conditions and exceptions of the Policy.
The Complaint is accordingly **Disposed**.
****

Happy Family Floater Policy

Case No. BNG-G-050-1516-0705

Ms.Roopa R v/s Oriental Insurance Company Limited

Date of Award – 22nd March, 2016

The Complainant had been taking the Policy continuously since 2011, covering herself, spouse and dependent son. When her husband offered to donate blood, pre-donation blood test was conducted and it was detected that he was been suffering from Chronic Hepatitis C. The medication which was advised had to be taken under the medical supervision, for about 4-6 hours.

The Insurer repudiated the claim stating that the administration of medicines was taken on OPD basis and also the same was not found in the enlisted Day Care Procedures of the Policy.

The Forum observed that the repudiation of the claim was as per the terms and conditions of the policy and **does not require any interference at the hands of this Forum**.
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HEALTH SYNOPSIS Oct'15 to March'16

Bhopal Ombudsman Centre

Case no. BHP-G-037-1516-0001

Mr. Maneesh Dabhade…….. ……Complainant

V/s

Religare Health Insurance Co Ltd……Respondent

Award dated:14/10/2015

Facts:

Claim repudiated by the respondent Insurance company on the grounds that Hospitalization was not required.

Finding & Facts:

As per the Complaint lodged, he was suffering from Dengue fever,So, he was hospitalized for necessary treatment at S.S. Hospital and Research Centre, Ujjain(MP) on 01/11/2014 and discharged on 05/11/2014. After discharge from the hospital, he preferred a claim for Rs.11,239/- to the respondent company towards his treatment cost but the respondent have rejected the claim on the ground that the hospitalization was not required.

The Respondent in their SCN/ reply have contended that complainant was admitted for the treatment of Dengue fever with Gastritis and Colitis in the said hospital and during review it was noticed that all the vitals of the complainant was normal, he was kept a febrile throughout hospitalization stay and platelet counts were also within the normal range i.e.151000, so it can be concluded that hospitalization was unwarranted and the patient could manage on OPD basis. So, the claim was repudiated.

On perusal of the discharge certificate of the patient as well as the prescription dated 01/11/2014 and Inpatient sheet it transpires that the complainant was admitted on 01/11/2014 in S.S.Hospital and Research centre, Ujjain and was advised for various test and investigations in view of suffering from fever with chills and body ache by the concerned doctor and after giving required treatment of diagnosed with Dengue fever with gastritis and colitis he was discharged on 05.11.2014. Serology test was also conducted Antigen was found positive and primary dengue virus infection is characterized by elevations in specific NS 1 antigen levels 0 to 9 days after the onset of symptoms, which generally persists upto 15 days and dengue virus causes dengue fever a severe flu-like illness. Igm antibodies are not detected until 5-10

days in case of primary dengue infection. Thus the diagnosis of the ailment of dengue fever also in the discharge certificate cannot be brushed aside on the basis of test report and the doctor is only competent to decide the hospitalization and required treatment keeping in view the physical condition prevailing at the time of admission.Therefore, I am 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 and conditions of the policy document.

Hence Respondent Insurane Company shall reimburse within 15 days from the receipt of acceptance letter of the complainant failing which it will attract simple interest of 9% p.a. from the date of this order to the date of actual payment. In the result, the complaint is allowed with above observation.

Case no. **BHP- G-050-1516-0006**

Mr. S.N. Sharma.....Complainant

V/s

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

Award dated:14/10/2015

Facts:

Treament of Obesity/ morbid obesity and any weight control treatment comes under exclusion no.4.17 of Mediclaim policy ,expenses repudiated by respondent company.

Finding & Decision:

The exclusion clause 4.17 of the concerned policy document clearly provides that the company shall not be liable to make any payment under the policy in respect of any expenses whatsoever incurred by the insured person in connection with or in respect of treatment of obesity or condition arising there from (including morbid obesity) and any other weight control programme, services or supplies etc. The discharge summary of the complainant issued by Asial Bariatrics and Cosmetics Pvt.Ltd. Ahmadabad clearly shows the diagnosis of the complainant "Morbid Obesity, Hypertension, DM, Sleep Apnoea and for treatment of the same, the procedure of LAPROSCOPIC ROUX EN Y GASTRIC BYPASS SURGERY was done and the said treatment of the diagnosed ailment particularly morbid obesity clearly comes under the exclusion clause 4.17 of the policy document. In these circumstances, the respondent is not liable to make payment of the claim as made by the complainant under the terms & conditions of the above concerned policy document.

Case no. BHP-G-020 -1516 -0004

Mr. Susheel Bapna …….. ……Complainant

V/s

ICICI Lombard General Insurance Co. Ltd……Respondent

Award dated:14/10/2015

Facts:

Mediclaim repudiated by respondent insurance company on the ground of non-disclosure of Pre-existing disease.

Findings & Decision:

From the perusal of the discharge summary of the patient it transpires that complainant was admitted on 11/10/2014 with the present complaints of Pain, Swelling, Tenderness in his perineal region since 5 days with history of fistulectomy done one and half month back in Medicap hospital, Indore by Dr.C.P.Kothari and due to present complication, he was admitted for further management and was diagnosed for Non healing anal wound with recurrent interspincetric fistula – HTN and surgery was done of lying open of fistula on 13.10.2014 and was discharged on 15.10.2014. *So far as said preexisting disease of HTN is concerned, in this present scenario, hypertension has become a life style disease and is easily controlled with conservative medicines* and there is no medical evidence/ medical literature on record on behalf of respondent to show that HTN was connected with Non healing anal wound with recurrent interspincetric fistula. *The respondent company have failed to show about furnishing the copy of proposal form to the complainant with the policy document to enable him to clarify about the entries regarding pre-existing disease and the proposal form contains the word NA only in the column of pre-existing illness.* For the sake of argument, if it was so, the company could have loaded the premium only.

Under the aforesaid facts and circumstances, material on record and submission made, I am of the considered 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 towards his treatment cost in accordance with the terms and conditions of the policy document.

Hence, the respondent ICICI Lombard General Insurance Co. Ltd is directed to review the claim and make payment of admissible amount to the complainant in accordance with the terms and condition of the policy within 15 days from the date of receipt of acceptance letter of the

complainant failing which it will attract simple interest of 9% p.a. from the date of this order to the date of actual payment.

Case no.BHP-G-050-1516-0059

Mr. Gheesalal Sharma .....Complainant

V/s

Oriental Insurance Co. Ltd.....Respondent

Award date: 14/10/2015

Facts:

Complainant underwent for cataract Operation / treatment at Rohit Eye Hospital, Indore on 20/11/2014 and incurred a sum of Rs.26,879/- towards medical treatment and after discharge from the hospital, he preferred a claim for Rs.26,879/- before the TPA/respondent but his claim settled only for Rs. 24,000/- after deducting Rs.2,879/-.

Findings & Decision :

The package of Rohit Eye Hospital itself shows package for cataract operation (MICS) as Rs.24,000/- and for Phac+cat as Rs.17,000/- and the discharge summary clearly shows that the said cataract operation was performed in Rohit Eye Hospital. It is clear from the record that the claim has been settled and paid for Rs.24,000/- after deducting Rs.2879/- as misc. charges towards full and final settlement which is quite reasonable and customary in accordance with the policy terms and conditions and agreed tariff in Indore. Hence respondent is not liable to make payment of balance amount as claimed by the complainant. The complaint is liable for dismissal. Hence, the complaint stands dismissed accordingly.

Case No. **BHP-G-003 -1516 -0042**

Mr. Jagdish Chawda..... .....Complainant

V/s

Apollo Munich Health Insurance Co.....Respondent

Award Dated :16/10/2015

Facts:
The case is pertaining to treatment of disease caused due to deficiency of vitamins B12 and Iron.Claimed amount was Rs.39,230/-.The respondent insurance company has rejected the claim, with the reasons, the need for hospitalization not established.

Findings & Decision:

I have gone through the material placed on record and submission made by both the parties. According to discharge summary, complainant was admitted and investigated and patient hadpancytopenia, liver enzymes were mildly raised, RFT was normal, Vitamin B12 was low, his serum ferritin was low normal, he supplemented with vitamin B12 and iron, he had persistent anemia bone marrow aspiration was done and report was awaited. There is no dispute about hospital treatment in view of the photocopies submitted by complainant pertains to Apollo hospital which is a reputed and well recognized medical institution. The doctor had advised him for hospitalization in view of his history of present illness and necessary treatment was given and all the medical treatments papers, discharge summary, test reports are on the record, which can not be ignored. It is the doctor only who can decide about hospitalization of the patient and required treatment after physical examination and body condition of the patient. The medical documents also shows that bone marrow aspiration was done which might be required to rule out the ailment of cancer in view of the prevailing physical condition of the patient. Clause VI-b of policy documents provides that vitamins and tonics unless certified to be required by the attending medical practitioner has been shown as exclusion. In the instant case all the medicines as well as vitamins as required for treatment of the patient has been given by the treating doctors of the said reputed hospital.

Hence, the Respondent Insurance Co is directed to review the claim and make payment of admissible amount to the complainant within15 days from date of receipt of acceptance letter of the complainant failing which it will attract simple interest of 9% p.a. from the date of this order to the date of actual payment.

Case no. **BHP-G-051 -1516 -0060**

Mr. Suresh Parikh..... .....Complainant

V/s

United India Insurance Co.....Respondent

Award dated:26/10/2015

Facts:

Post hospitalization claim rejected by respondent Insurance company on the ground of late submission of documents.

Findings & Decision :

There is no dispute about post hospitalization treatment in view of the photocopies submitted by complainant pertaining to month of July & August 2014 and date of discharge is 29/06/2014. From the perusal of the complaint, it is observed that cause of late submission was complainant's father's illness and no knowledge of stipulated period of post hospitalization and a death certificate dated 16/12/2014 MNC Indore of complainant's father late Tarachand Parikh has also been submitted in this connection which appears to be reasonable ground for delayed submission of said claim which should have been considered by the respondent in view of circular no. IRDA/HLTH/MISC/CIR/216/09/2011 dated 20.09.2011 and the delay should have been condoned.

Hence, the complainant is entitled for the admissible amount in accordance with the terms and conditions of the policy document condoning the delay of late submission of post hospitalization claim.

The respondent Insurance Company is directed to reopen the claim and pay within 15 days from the date of receipt of acceptance failing which 9% interest p.am shall also be paid from the date of order to date of payment.

Case no. . BHP-G-003-1516-0031

Ms.Ruksar Ansari .....Complainant V/s

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

Award dated:26/10/2015

Facts:

Claim under Mediclaim policy rejected by respondent insurance company on the grounds of exclusion of pre-existing disease for two years, whereas the disease "urogenital surgery" term is combination of two illnesses Urinary and Genital. Kidney treatment such as dialysis are payable since it is not surgery.Hence partly covered.

Finding & Decision:

From the perusal of discharge summary issued by Bombay Hospital, Indore, it transpires that complainant was admitted on 18/01/2014 for kidney transplantation and undergone surgery for kidney transplantation on 22/01/2014 and the patient was having CKD Stage V, HTN and was discharged on 03.02.2014. The record shows that her two claims were settled for for Rs.30,341/- in July 2013 and for Rs.1,04,771/- in March 2014 towards treatment cost. During third claim respondent have observed that complainant is suffering from Chronic Kidney Disease which is not covered due to waiting period of 2 years as per policy terms & conditions. In my opinion, CKD develops gradually over a period of years and in this case patient has undergone for treatment twice of the same ailment in July 2013, and in March 2014, I have also gone through the certificate dated 06/08/2014 of *Dr.O.P. Rathi who has opined that the renal surgery do not belong to category of urogenital surgery and it is a separate kind of surgery*. *According to the Butterworths Medical Dictionary, the Urogenital relates to the Urinary and genital organs* and kidney is a vital organ of urinary system and after combination with the reproductive system(genital system), it is known as Urogenital system. Complainant's kidney disease is clearly a long standing disease and prior to policy initiation. The medical documents clearly show about kidney transplantation on 22.01.2014 in the said hospital which certainly comes under the surgery of urogenital organs and there is a waiting period of two years for the illness/ treatment (surgery) of urogenital system under the provisions of section 4 (c) of the policy documents. Therefore decision of the respondent is partly justified with regard to rejection of the claim for kidney transplantation *but the claim towards expenses pertaining to dialysis and medicines charges if payable.* in view of earlier allowed claims should have been considered by the respondent except renal surgery and the insurer's representative has also assured to review the dialysis charges not related to kidney transplant surgery.

Under the aforesaid facts, circumstances and material on record and submissions made, I am of the considered view that the decision of the respondent company to reject the entire claim is not justified. Hence, the respondent Apollo Munich Health Insurance Co.Ltd. is directed to review the claim and make payment of the admissible amount towards dialysis procedure and also medicine charges if found payable under terms & conditions of 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 payment. In the result, the complaint is allowed in part with the above observation.

Case no. **BHP-G-051-1516-0072**

Mr. Rajneesh Vaid ……..Complainant

V/s

United India Insurance Co. Ltd.……Respondent

Award dated:26/10/2015

Facts:

Respondent Insurance Company rejected Mediclaim on the ground of late intimation .

FINDINGS & DECISION:

It is proved that the duration of treatment (from 14/08/2014 to 21/08/2014)is well covered in the policy. Now it is pertinent to mention here that complainant has submitted claim papers in a single lot amounting to Rs.50,029/- on 28/10/2014 (which is beyond stipulated time limit & without any explanation of delay. The complainant has not uttered about condo nation of delay by filing any application. The complainant has failed to show any cogent reason for lodging his claim after such a long delay of 86 days . In these circumstances, the respondent is not liable to make payment .

Under the aforesaid discussed facts and material available on the record, I am of the view that the decision of the respondent for not considering the claim of the complainant towards his treatment cost under policy condition 5.5 is perfectly justified and is sustainable in law and does not require any interference by this authority. Hence, the complainant is not entitled for the relief as prayed for. In the result, the complaint stands dismissed.

Case No. BHP- G-040-1516-0079

Mr. Lal Chand Jaiswar.....Complainant

V/s

SBI General Insurance Co. Ltd. ……Respondent

Award Dated:26/10/2015

Facts :

Claim of pre-existing disease under Health policy

Finding & Decision:

It is apparent that complainant was a known case of CAD, HTN on regular treatment. From the medical records it reveals that patient was suffering from various ailments such as CAD, HTN and was on regular treatment and he was admitted in the said hospital with complaint of sudden onset chakkar and was also diagnosed for the said

ailments and there is a question mark (?) about vertigo and the patient was also given medicines like Angispan, Clopitab, Losar, Revolo, Mactor, Etizola, etc. all pertaining to CAD,HTN. The admitting consultant was Dr.Khare Rajeev M.D. D.M (Cardiologist) which clearly shows that the complainant consulted the said cardiologist in view of his past history of CAD (attempted PTCA) and HTN due to sudden onset chakkar for further management and MRI and MRA of brain was found normal and he was managed conservatively with IV fluids with Tablet Angispan TR, losar etc. which are given for heart disease and hypertension. Thus, it is established that the complainant was given treatment towards heart disease and related complications and hypertension and clause 3 ix of the policy terms & conditions excludes the cover of treatment of hypertension, heart disease and related complications during first year from commencement of the policy. In these circumstance, respondent is not liable to make payment of the claim on the basis terms & conditions of the policy document.In the result, the complaint stands dismissed accordingly.

Case no.BHP-G-012-1516-0068

Mr. Ankit Sharma…. .....Complainant

V/s

Cholamandalam MS General Insurance Co. Ltd.....Respondent

Award dated:26/10/2015

Facts:

Claim was denied under general exclusion clause D3 for first two years as related to surgery of genito urinary system.

Findings & Decision:

The Complainant was going by his bicycle which hit by scooty driver and he sustained injury at perineal region. The FIR was lodged at Police Station Pardeshipura, Indore. He was examined in the clinic of Dr.Mukesh Chouhan who advised for leg, x-ray, blood test and sonography and in view of acute pain in his leg, stomach and below scrotal region. He was also examined in Life Line Hospital, Indore on the same day and was advised for admission and after making payment of the bills, he took discharge and came home but he was not feeling well and suffering from pain so, he was admitted in Bharat Memorial Hospital situated near his house where his treatment was started and due to severe pain on account of perineal abscess at the place of accident below scrotal region, his operation was performed on 06.04.2015 and was discharged on 10.04.2015 and after discharge, he submitted his claim to the respondent for reimbursement as per policy document which was repudiated on the ground general exclusion clause D-3.

The respondent had not filed any SCN/reply against the complaint. From the FIR, it is apparent that there was an accident of the complainant who was going by his bicycle and hit by a scooty driver. The medical document available on the record shows about his examination firstly on 03.04.2015 after accident by Dr.Mukesh Chouhan. The prescription of the said doctor clearly shows about injury in scrotal region also for which he was admitted in Life Line Hospital on the same day for taking proper treatment of the injuries sustained on account of said accident but took discharge due to some personal reason and again he was admitted in Bharat Memorial Hospital due to pain in perineal region and swelling where I & D was done of perineal abscess and required treatment was also given. There is no dispute about repudiation of his claim as appears from repudiation letter dated 26.05.2015 which reveals that the claim was denied under general exclusion clause D3 for first two years as related to surgery of genito urinary system but as per discharge card of the Bharat Memorial Hospital, the perineal abscess was

diagnosed and I & D was done. Thus, from the medical documents, it is clear that there was no surgery of genito urinary system of the complainant rather only I & D was done of perineal abscess which might be due to sustaining injury in scrotal region on account of the said accident. Since no SCN/reply against the facts made in the complaint, so it can be easily inferred that respondent have no defence for repudiation of the claim and the exclusion clause D3 as mentioned in the repudiation letter sent to the complainant is not at all applicable to the facts of this case. In these circumstances, the respondent company is liable to make payment of the amount .

Hence the respondent Insurance Co. is directed to pay the admissible amount of hospital confinement benefit towards complainant's treatment within 15 days from the 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.

Case no. BHP- G-044-1516-0019

Mr.Ritesh Gangwal …… ……..…….Complainant

V/s

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

Date of Award:26/10/2015

Facts:

Mediclaim repudiated by the respondent Insurance company on the ground of non-disclosure of material fact i.e.well known pre-existing disease. (but answer in irrelevant/confusing term)

Findings & Decision:

I have gone through the material placed on the record, submission made by both the parties and policy terms & conditions. The condition no.7 of the policy documents 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/ non disclosure whether by the insured person or any other person action on his behalf. The record shows that the complainant has declared himself during the time of filling of the proposal form under column 'h' SRS since 2005 and in his application, he has admitted that he is suffering from CKD since 2005 and he got kidney transplanted in the year 2006. *As per complainant's version in relation to word SRS is Severe Renal Syndrome*, it is related to CKD but he could not produce any medical literature in this regard while the respondent have submitted the *medical literature showing the full form of SRS as "Silver-Russell-Syndrome" which is disorders of growth and development of children*. The insurance contract is based on principles of utmost good faith and before entering into insurance contract it is the legal obligation of the insured to disclose all the material information related to subject matter of insurance, so that the insurer may get an opportunity to take decision for issuing the policy as proposed. If there is non-discloser with fraudulent intention, the insurance

contract becomes void. Thus, it is established from the material on the record that the complainant has not disclosed the said material fact of CKD/CRF and kidney transplant specifically in the proposal form (except the word SRS) for reasons best known to him but which can certainly be inferred as fraudulent intention. 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 considered view that the decision of the respondent company to repudiate all the claims as made by the complainant is perfectly justified and is sustainable in law. Hence, the complainant is not entitled for the relief as prayed for. In the result the complaint stands dismissed accordingly.

Case no. **BHP-G-012 -1516 -0089**

Mrs. Neelu Daga.....Complainant

V/s

Cholamandalam MS General Insurance Co.Ltd.....Respondent

Award dated: 29/10/2015

Facts:

Dental treatment claim rejected by the respondent insurance Company, though complainant sustained injuries in her mouth due to fallen down.

Finding & Decision:

The complainant fell down in the bathroom due to which she sustained mouth injury and consulted doctor who after examining advised for Hospitalization for surgery. The respondent company repudiated her claim on the ground that dental treatment is not under the scope of the policy under exclusion clause D-7.

The medical record shows that the patient came with complaint of erupting of teeth with severe pain, swelling and little bleeding in mouth and the treating Dr.Gorav Pratap Singh Gaharwar has confirmed vide his certificate dated 07/04/2015 that patient was admitted in the said Pushpanjali hospital on 05/03/2015 for suffering from mouth injury due to accidently fell down in her residence bathroom on 04/03/2015. The discharge summary of the said Puspanjali hospital also shows that the patient was finally diagnosed for bleeding and swelling of Ext^{n} Socket and patient was apprehensive and the required treatment was given in the said hospital during hospitalization and was discharged on 09.03.2015. The documents on record clearly show that the said injury was caused in the mouth due to accidently falling down in her residence. The respondent company have not filed SCN/reply against the assertions made in the complaint. There is only repudiation letter on the record, which shows that claim has been

repudiated on the ground that dental treatment is not under the scope of policy under exclusion clause D-7 but in the same letter, it has been clearly mentioned that no indemnity is available for claims arising out of or connected to any dental treatment unless it requires hospitalization is carried out under general anesthesia and the necessitated by illness or accidental bodily injury. All the medical record shows for her hospitalization for necessary treatment on the basis of diagnosis which cannot be ignored and respondent had repudiated the claim in a mechanical way .

Under the aforesaid facts and circumstances, material on record and submission made, I am of the considered view that the decision/action of the respondent company for repudiation of the claim is not justified and is not sustainable. Hence, the complainant is entitled for the admissible amount towards hospital confinement benefit in accordance with the terms and conditions of the policy document.

Hence, the respondent insurance Company is directed to make the payment of admissible amount to the complainant .Failing which it will attract simple interest of 9% p.a. from the date of this order to the date of actual payment.

Case no. BHP-G-049-1516-0049
Mr. Shailesh Tiwari .. ..Complainant
V/s
The New India Assurance Co.Ltd. .....Respondent
Award dated:30/10/2015

Facts:

Expenses without hospitalization under Mediclaim were rejected by respondent Insurance Company.

Findings and Decision:

It is said in the complaint that his wife has been suffering from cancer (Carcinoma Ovary) for which she has been undergoing treatment and follow up in TATA Memorial Hospital, Mumbai and regular tests were conducted from time to time by the doctors and all the medical bills were produced under the claim for Rs.18,924/- but paid only Rs.2,800/-

but his claim for pathological test were not considered on the ground that amount is not payable due to beyond pre and post hospitalization treatment.

The respondent have taken the plea in their SCN /reply that the wife of the complainant is suffering from cancer disease and bills for Rs.18,924/- was submitted out of which they have paid Rs.2800/- under clause C- Expense relating to diagnostic tests without

hospitalization and the remaining amount of Rs.16,124/- was not paid because there is no hospitalization.

Hence, the complainant is not entitled for the relief as prayed for except the amount towards sonography charges which has already been paid to the complainant. In the result, the complaint stands dismissed being devoid of any merit.

Case no. **BHP-G-048 -1516 -0101**

Mr. Navneet Patel….. ……Complainant

V/s

National Insurance Co. Ltd……Respondent

Award dated:16/11/2015

Facts:

Respondent Insurance Company settled cataract claim within the limit set by GIPSA packages and deducted excess amount.

Findings & Decision:

I have gone through the material placed on the record and submission made by the insurer's representative. The record shows that the claim has been settled by the TPA for Rs.24,909/- against Rs.30,909/- made by the complainant towards treatment for cataract operation. It appears from the record that the claim has been settled keeping in view the expenses which were reasonable and necessary as provided in the policy condition after comparing the charges of Cataract Operation with GIPSA packages. The policy condition Sec.4 of Sampurn Suraksha Bima with respect to mediclaim provides that "the company will pay to insured person the amount of such expenses as are reasonably and necessarily incurred in respect of the treatment taken in the hospital as an In-patient". Thus, it is clear from the material on the record that the claim has been properly settled for Rs.24,909/- as found reasonable and necessary under the policy condition keeping in view the GIPSA packages . The complaint is liable for dismissal. Hence, the complaint stands dismissed being devoid of any merit.

Case no. BHP-G-012-1516-0099

Mr. Hemant Joshi… ……Complainant

V/s

Cholamandalam MS General Insurance Co. Ltd.……Respondent

Award dated:17/11/2015

Facts:

Respondent Insurance company rejected the benefits of Hospitalization on the ground of manipulation of documents and concluded no hospitalization.

Findings & Decision:

I have gone through the material placed on the record and submission made by the complainant. From the perusal of admission / discharge record issued by City Hospital, Indore, it transpires that complainant was diagnosed for entric fever & malaria and was treated in the said hospital w.e.f. 12.06.2015 after admission and was discharged on 19.06.2015. The doctor's order sheets also show about providing required treatment for recovery of the diagnosed ailments during the hospitalization which is substantial proof of ailments and treatment in the said hospital w.e.f.12.06.2015 to 19.06.2015. The respondent company have repudiated the claim only on the ground that the submitted document are manipulated and fabricated without genuine hospitalization vide their letter dated 31.07.2015 but the respondent company have not filed the SCN/reply against the complaint about taking the said pleas and respondent have also failed to prove any manipulation or fabrication in the medical document submitted by the complainant, so the pleas taken by the respondent in the repudiation letter do not show any force for repudiating the claim towards hospital confinement benefit. The payment of Rs.24,520/- towards treatment cost in the said hospital during the aforesaid period by the Raksha TPA of the Oriental Insurance Co. also finds support from the document submitted by the complainant. In these circumstances, the respondent is liable to make payment of admissible amount towards hospital confinement benefit under the policy document.

Under the aforesaid facts & circumstances, material on record and submission made, I am of the considered view that the decision of the respondent company to repudiate the claim of the complainant is not just and proper and is not sustainable. Hence, the complainant is entitled for the admissible amount towards hospital confinement benefit under the policy document.

Case no. BHP-G-044-1516-0102

Mrs. Kulsum Bee …… ……..……..……Complainant

V/s

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

Award dated:17/11/2015

Facts:

Sum Insured enhanced in renewal policy but respondent insurance company considered previous sum insured on the grounds of waiting period of two years not crossed of revised sum insured.

Findings & Decision:

There is no dispute that the by-pass surgery of the complainant was conducted on 01.07.2015 after admission on 26.06.2015 in Shalby Hospitals, Jabalpur. It is also not in dispute that on the basis of representation made by the complainant after partial settlement of the claim on the ground of enhanced sum insured, Rs.50,000/- was paid to the complainant. It is also admitted by the complainant that policy was renewed by enhancing the sum insured for Rs.1,50,000/- in the year 2014-2015 and subsequent 2015-2016 during which the by-pass surgery was done and claim was made. The record shows that the claim has been made in the 2nd year of the policy taken under enhanced sum insured Rs.1,50,000/- The discharge summary of the complainant clearly shows that the complainant was diagnosed with Coronary Artery Disease- Multi-vessel disease and processor of CABG was performed and by-pass surgery was conducted. The policy document under which the claim has been made contains the condition that incase 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 and as per clause 8 of the policy terms and conditions. It is clear from medical record that the complainant was treated for CAD Since, the complainant has already been paid Rs.50,000/- after settlement of his claim taking into consideration of sum insured of previous policy as Rs.50,000/- which to my mind is perfectly justified and in accordance with terms and conditions of the policy documents and I do not find any cogent reason to interfere in the decision taken by the respondent company.

Case no. BHP-G-050-1516-0110

Mr. Rajeev Kumarr. Shrivastava

V/S

Oriental Insurance Co. Ltd. Indore

Award dated:21/12/2015

Facts Complainant has underwent treatment for diagnosed ailment of SRNVM with SR Fluid after being admitted on 01/05/2015 and was discharged on same day i.e.01/05/2015 and patient was kept in hospital on day care basis to look for any post injection problem arises(RE Intravitreal Injection). The treating Dr. Sachin Burhanpurkar has also certified that the disease was basically an age related problem called as ARMD. The complainant approached this forum due to refusal of his claim by respondent company on the ground that the hospitalization was less than 24 hours.

Respondent have filed the SCN contending therein that the claim has been repudiated due to breach of policy clause 2.3 as the period of hospitalization was less than 24 hours.

FINDINGS AND DECISION

The policy condition clause 2.3 clearly provides that expenses on hospitalization are admissible only if hospitalization is for a minimum period of 24 (Twenty Four) hours.The treating doctor confirmed that the desease was age related problem require day care treatment only.
Therefore, the decision taken by respondent company is correct and the complaint is stand dismissed.

Case no. BHP-G-050-1516-0137

Mr. Ajay Joshi

V/S

Oriental Insurance Co. Ltd.

Award dated:23/12/2015

Facts:

Claim was repudiated by the respondent insurance company on the ground of misrepresentation of the claim.

Findings & Decision:

Complainant was admitted on 28/06/2015 to 05/07/2015 in Charak Hospital, Indore due to suffering from high grade fever, chills, Abd. pain etc. and various investigation / pathological tests were conducted and require treatment was given. Thereafter, the claim towards treatment cost was lodged before the respondent company, but the same was repudiated on the ground that as per discharge card he was diagnosed for Enteric Fever but the IPD paper showed diagnosed case of Enteric Fever with Jaundice.
Respondent insurance company has filed the copy of SCN dated 11.12.2015 on date of hearing stating that insured has misrepresented the claim as per documents. Hence claim is repudiated.
Complainant has reiterated the facts as mentioned in the complaint and laid emphasis that in fact, concerning hospital has issued a certificate dated 01/10/2015 in which it has been admitted that due to duty doctor's mistake, the word Jaundice was not mentioned in the discharge card and the treating doctor who has issued the certificate on behalf of hospital has certified that complainant had Enteric Fever with Jaundice during the period of treatment.
The respondent company have simply taken the plea for repudiation on the ground of misrepresentation of the claim as per documents and have placed reliance by filing the copy of history sheet showing Enteric Fever with Jaundice as diagnosed and the copy of the discharge showing the diagnosis Enteric Fever and in this way, the respondent company have tried to show the misrepresentation.

It is apparent from the certificate dated 01.10.2015 issued by treating doctor Dr.Manish Bindal that due to duty doctor's mistake, in discharge card Jaundice word was not written and the complainant had Enteric fever with Jaundice which also finds support from the history sheet of the said hospital. So, non mentioning of the word Jaundice in the discharge card due to mistake of the doctor on duty cannot be ruled out and it was fault of the doctor not of the insured complainant, who was not at all concerned about writing of the discharge card and the said mistake cannot be treated as intentional and also cannot be attributed against the complainant.The respondent have

not challenged about the treatment given to the complainant in the said hospital during the said period for the ailments as diagnosed.

The respondent is hereby directed to pay the admissible amount to the insured complainant in accordance with the policy document as full and final settlement of the claim.

Case no. BHP-G-052-1516-0133

Mr. Anirudh Induria

V/S

Universal Sompo Gen. Insurance Co. Ltd.

Award dated:24/12/2015

Facts:

Respondent Insurance company repudiated claim on the ground of non-disclosure of material facts about past adverse medical history of break period in proposal form.

Findings & Decision:

The MDCT PNS CORONAL report dated 19/06/2105 issued by Dr.Rajesh Mehra of Venus MRI & MDCT Centre, Bhopal of the complainant on reference by Dr. Milind Kirtne and Discharge summary issued by Breach Candy Hospital Trust, Mumbai showing admission date 01.09.2015 and discharge date 03.09.2015 confirms that complainant was suffering from nasal blockage problem and was diagnosed deviated nasal septum + concha bullosa right as Bony spur was seen on left nasal cavity region since 19.06. 2015.

It is admitted fact that the above concerned policy was issued on the basis of fresh proposal form duly signed and submitted by the complainant after a break of almost 6 months subject to condition that 'No claim reimbursement for expenses incurred for hospitalization commencing during the period of break' will be made by the complainant.

From perusal of the proposal form ,it is apparent that the complainant has given answer as 'No' regarding the question no. 2 connected with any sickness or any medical complaint, regarding question no.12 connected with any complaint or tendency that may necessitate such consultation or treatment in the future and regarding final question connected with any additional facts or matter medical otherwise affecting or relevant to the proposed insurance (attach separate sheet if required) in the column of medical history, Thus, it is established that the complainant did not disclose the above material fact to get insurance cover for the said known ailment and has violated the principles of utmost good faith of insurance contract. So, I do not find any force in the contention of the complainant. Hence, the complainant is not entitled for the relief as prayed for.

Case No. BHP-G-050-1516-0140

Mr. Mahesh Chotrani

V/S

Oriental Insurance Co. Ltd. Bhopal

Award date:24/12/2015

Facts : Complainant was a mediclaim policy holder of the respondent for last 19 years and has filed photocopies of the policies since 23.03.2008 to 20.03.2015 in continuation, mean while he was suffering from progressive systematic sclerosis and non-healing ulcers of both legs, therefore he underwent for necessary treatment at DK'S Hospital, Bhopal wef 26/05/2015 to 28/05/2015 and the claim was lodged for reimbursement of treatment cost before the TPA Heritage Health of respondent company, but his claim was repudiated due to suspicion and doubt on account of various anomalies, during investigation.

Respondent insurance company have not submitted their SCN/ Reply against the complaint regarding claim made.

Complainant has reiterated the facts as mentioned in the complaint and stated that claim was repudiated as per investigation report and all the facts mentioned in the report is totally wrong and earlier claim for treatment of the same ailment was allowed by the respondent company and he has claimed reimbursement of treatment cost for the same disease which has been rejected without any proper reason and laid emphasis that treating doctor, Dr. Durgesh Khemchandani who has sent a letter dated 29/09/2015 to the respondent describing all the material facts about severity of the disease of the patient and giving required treatment .

Findings and Decision

The complainant was admitted on 26.05.2015 and discharged on 28.05.2015 and was given required treatment for diagnosed ailment of progressive systematic sclerosis etc. and in past illness, the same ailment has been mentioned as known case. The complainant had also earlier underwent treatment of same illness and was hospitalized for the period 26.05.2014 and discharged on 27.05.2014 at Central Hospital, Bhopal , the claim was reimbursed by the respondent company. The none filing of the SCN/ reply against the complainant clearly reflects that the respondent company have nothing to say against the case of complainant for seeking the said relief of reimbursement of treatment cost. Thus, it appears from the material on record, that the respondent company have repudiated the claim of the complainant in a mechanical way without giving any serious thought to the medical documents and without any cogent reasons which compelled the complainant to approach this forum. The respondent company have not furnished any calculation chart towards admissible amount, Taking into consideration the entire facts & circumstances of the case and the submissions made, material on record and policy terms & conditions, the respondent Oriental Insurance Company is hereby directed to pay the admissible amount in accordance with the terms & conditions of the policy document to the complainant as full and final settlement of the claim.

Hence, the complaint is Allowed for admissible amount only.

Case no. BHP-G-050-1516-0127

Mr. Ajay Sharma

V/S

Oriental Insurance Co. Ltd. Gwalior.

Award dated:24/12/2015

Facts:

Claim has been repudiated on the ground of non-disclosure of pre-existing diseases, by respondent Insurance Company.

Findings & Decision ;

The respondent insurance company have simply taken the plea for repudiation of the claim that patient was suffering from cataract since past 3 years which is prior to the inception of the policy, but in support, no medical document has been produced except the discharge summary in which the present illness has been mentioned as 3 years while the reissued discharge summary clearly shows that according to previous record the patient was seen first at Negi Eye Centre Noida on 15.07.2013, so, the cataract was considered from July,2013 but the respondent company did not accept the above reissued discharge summary which was issued by the same Dr.Manav Sethia of the same hospital treating it as revised document. It is well known that discharge summary is prepared by the doctor of the hospital concerned and not by the patient and the above reissued discharge summary showing the history of cataract from July, 2013 is based on the cogent supporting document dated 15.07.2013 which is the first prescription about consulting the Negi Eye Centre. So, the above reissued discharge summary should have been properly considered by the respondent about any discrepancy relating to the history of said illness. The first prescription does not show any previous history of ailment of cataract which reflects that the ailment of cataract was just started. the above reissued discharge summary cannot be dislodged and can be taken into consideration to decide the history of said ailment of cataract.

The respondent insurance company have filed copy of the terms and conditions of the policy. The exclusion 4.1 shows the specific ailment / disease / surgeries for specified periods are not payable if contracted during the currency of the policy. While going through the terms and conditions of the policy, under clause 4.1 in view of Cataract disease, the specified period is mentioned as 2 years under exclusion. This condition does not apply particularly in the said complaint as the inception date of the first policy was 06.03.2013 and operation was performed during hospitalization from 14.04.2015 to 15.04.2015 i.e. after two years of issuance of first policy.Respondent Insurance Company is hereby directed to be pay the admissible amount accordance with the terms & conditions of the policy document to the complainant as full and final settlement of the claim.

Case no. BHP-G-048-1516-0136

Mrs. Bhavna Banerjee

V/S

National Insurance Co. Ltd. Bhopal.

Date of Award:27/01/2016

Facts:

The Complainant was covered under concerned medi-claim policy of the respondent since 08/06/2012 till 08/06/2014 in continuation. She was operated due to severe backache with radiating pain to right lower limb for the two months starting December 25, 2014 (which was of sudden onset and severe in nature) not for just back ache. Thereafter she lodged the claim for reimbursement of the treatment cost which was repudiated by the respondent company on the ground of pre-existing disease which falls within exclusion no. 4.1 of Parivar Mediclaim policy.

Finding and Decision:

The prescription dated 29.12.2014 issued by Bone and Joint Clinic Bhopal clearly shows about on and off episodes of backache since 2004 of the complainant. The letter issued by Dr.Vikas Gupta of the BLK Hospital to the TPA

show that the said doctor treated the patient who has on and off back pain in 2004 and the disc prolapsed is recent as it was a completely excluded disc. The certificate dated 12.08.2015 which has been issued after issuance of repudiation letter dated 18.05.2015 shows that the doctor has opined that the episode of backache in past do not bear any relationship the present situation for which the complainant underwent surgery.

The letter of Dr. Mahesh Gupta, consultant orthopedic surgeon of Balaji fracture and general hospital who has given opinion in the case of the complainant to the respondent company shows that as patient has history of recurrent backache since 10 years and MRI report also suggestive of degenerative changes which is indicative of long standing backache which complicates in to disc protrusion. As per opinion of Dr. Protima Ramji, Manager-medical of TPA of the respondent company that as the complaints of backache are since 2004 and with time, this complaint aggravated with degenerated changes in spine.

Condition no. 4.1 of the exclusion clause of Parivar Mediclaim policy clearly provides that pre-existing disease when the cover incepts for the first time will be covered after four continues claim free policy years taken from the respondent company only.

The claim has been made in the third policy year. As per prescription dated 19.12.2014, it has been established that the patient had backache since 2004 which was not mentioned in the proposal form and the waiting period for pre-existing disease if any is four years from inception of the first policy.

From the close scanning of the material on record particularly medical opinions brought on record by both the parties, it appears me that opinions of various doctors are contradictory which requires evidence of independent expert medical opinion of the orthopedic side for deciding this case. This forum has got limited jurisdiction under 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 these circumstances, the complaint stands dismissed with liberty to the complainant to approach some other appropriate forum / court to resolve the subject matter of dispute.

Case No. BHP-G-044-1516-0128

Mr. Ranjan Somani

V/S

Star Health and Allied Insurance Co. Ltd. Ujjain.

Date of Award:29/01/2016

Facts:

The complainant was suffering from chest pain and he was admitted in Medanta Hospital, Indore on 10.02.2015 and underwent for Angiography and Adhoc PTCA with DES to RCA was done. He was discharged on 12.02.2015. Before it, he had complaint of chest pain on 08.02.2015 and consulted to local physician and ECG was done but no treatment paper and ECG of 08.02.2016 was given by Medanta Hospital. The complainant lodged the claim before the respondent company towards his treatment cost but his claim was rejected on the ground of non- submission of required documents of first consultation and ECG taken on 08.02.2015. The complainant approached this forum for relief of payment of treatment cost of Rs.1,36,678/-.

Findings & Decision

Both the parties have expressed their willingness for the resolution of the complaint through mediation. both the parties have 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.

The respondent Star Health and Allied Insurance Co. Ltd. is agreed to pay Rs.1,19,550/- (Rs.One Lakh Nineteen Thousand Five Hundred Fifty) only as admissible amount against the claimed amount to the complainant under the policy document. The complainant is also agreed for the same. The settlement has been done as full and final settlement of the above referred 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 and directed to the respondent company to pay the agreed amount Rs.1,19,550/- within 15 days from the date of receipt of acceptance letter from the complainant failing which it will attract 9% of simple Interest p.a. from date of this order till date of actual payment and submit compliance report to this office.

Case No. BHP-G-044-1516-0129

Mr.Kamal Kishore Parikh

V/S

Star Health and Allied Insurance Co. Ltd.

Award Date:29/01/2016

Facts:

The complainant underwent coronary artery bypass surgery on 14/04/2015 at SAL Hospital, Ahmadabad. Thereafter, he lodged the claim towards treatment cost for Rs. 1,81,179/- before the respondent but his claim was settled only for Rs.75,200/- on the ground of pre-existing disease.Respondent company have contended in the SCN/ Reply that Senior Citizen Red corporate policy was issued to the complainant subject to condition of 50% Co Payment for pre-existing disease @50% and have taken the plea that insured submitted the claim in 3rd year of the policy. The insured was admitted on 13.04.2015 and discharged on 21.04.2015 at SAL Hospital, Ahmadabad and was diagnosed as case of coronary artery disease-triple vessel disease and fail LV function-EF45-48% and CAG was done on 08.04.2015 which recommends CABG surgery and authorization was given for Rs.60,000/- towards cash less facility and also contended that insured had history of Diabetic Mellitus and Hypertension since 6-7 years which is prior to inception of the policy and the hospitalization for diabetic coronary arteries disease, so claim was approved for Rs.75,200/- in total under 50% copayment as per the terms and conditions of the policy as the insured has undergone treatment for pre-existing disease.

Findings and Decision:

The prescription of Dr. V. K. Rawat dated 03/04/2015 shows that patient was K/C of T2DM since 6 years as appears later on he has issued another medical certificate on 11/04/2015 mentioning that he diagnosed him as a case of T2 DM, HTN three months which reflects some discrepancy about the period of DM Type 2. I am unable to understand

that if it is taken that the period of T2 DM was mentioned as 6 months in prescription dated 03.04.2015 then what necessitated to the complainant to obtain a certificate on 11.04.2015 showing the diabetes, HTN from three months and the reasons behind this discrepancy are best known to the complainant.

The FVR dated 07.04.2015 submitted by the respondent after admission of the complainant in the CHL hospital shows about DM from 6 years and HTN from 6-7 years which was prepared during field visit made on behalf of respondent company and recorded on the basis of statement given by the complainant/patient during hospitalization.

As per medical literature submitted on the behalf of respondent clearly shows that coronary artery disease may be caused due to high BP (HTN) diabetes or insulin resistance, High cholesterol, Sedentary lifestyle. The complainant has been found as known case of DM 2/HTN which is the major cause for CAD which is not developed in short span rather due to long ailment of diabetes and HTN etc.

I have gone through the material on the record and submissions made by both the parties. Possibility of maintaining a very good health at the age of 60 years is doubtful in this polluted scenario and life style and therefore General Insurance Companies charge higher premium according to higher age group. In this specific case, respondent have issued Unique Senior Citizen Red Carpet Policy containing limit of Co-Pay of 50% in case of pre-existing disease and accordingly, the respondent company have paid Rs.75,200/- towards co payment in view of condition no.5 of co payment which clearly provides that this policy subject to co payment of 50% of each and every claim arising out of pre-existing diseases and 30% of each and every claim for all the other claims. The claim has been made in the third year of the policy. From the material on record, it can be easily inferred that the complainant had pre-existing disease of DM Type 2 and HTN at the time of issuance of policies which was the major factor for coronary artery disease. Thus I arrive at the conclusion that the claim has been settled in accordance with the terms and conditions of the policy documents.

Case no. BHP-G-044-1516-0167

Mr. Ketan Agrawal

V/S

Star Health and Allied Insurance Co. Ltd. Indore

Award date:29/01/2016

Facts:

The Complainant was covered under concerned mediclaim policy of the respondent company. He suffered from Acute Parenchymatous Tonsilitis, therefore, he was admitted for further management, therefore he underwent for necessary treatment at Greater Kailsh Hospital, Indore. wef 14/09/2015 to 18/09/2015 and the claim was lodged for reimbursement of treatment cost of Rs. 46,046/- before the TPA / respondent company but the respondent company settled his claim only for Rs.28,454/- without any cogent ground. The complainant approached this forum for relief of payment of balance amount.

Respondent insurance company have filed their reply mentioning therein about settlement of the claim, which has been finally settled on 07/01/2016.

Findings and Decision:

The insurer's representative has stated that respondent company have reviewed the claim and settled the claim for Rs.11,643/- As per the letter dated 14.01.2016, it is apparent that the respondent have settled the claim towards full and final settlement of the claim for Rs.11,643/- and payment has been made vide cheque No.146675 dated 07/01/2016 towards balance amount and complainant has also filed petition for withdrawal of the case due to settlement and payment of the claim.

Case no. BHP-G-051-1516-0166

Mr. Neelesh Gangwal

V/S

United India Insurance Co. Ltd. Indore.

Award date:29/01/2016

Facts: The complainant had taken a group mediclaim policy being an account holder of Bank of Maharashtra under which his wife was also covered. It is further said that before taking this policy the complainant, his wife and family members were covered under Family Health Optima Insurance Policy since 2010 from Star Health & Allied Insurance Co. and the complainant had applied under portability scheme of his previous policy in the United India Insurance Co.Ltd. which was made effective from 05.06.2014 vide receipt no. 190300/81/14/00000138 for the period 23.07.2014 to 22.07.2015 and policy was continued without break. It is further said that the complainant's wife Smt. Renu underwent for D&C on 23.12.2014 and he preferred claim to respondent on 30.12.2014 but TPA of the respondent company was demanding Continuity certificate under portability scheme**.** He made request before the respondent for issuing the same but no reply has been received in this regard.

Findings and Decision

After mediation, both the parties have 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 .

The respondent United India Insurance Co. Ltd. is agreed to pay the admissible amount only as per terms & conditions of policy document against the claimed amount to the complainant. The complainant is also agreed for the same. This settlement has been done as full and final settlement of the above referred grievance/complaint, accordingly the recommendation award is passed.

Case no. BHP-G-051-1516-0153

Mr. Arpan Kashyap

V/S

United India Insurance Co. Ltd. Indore

Date of award:02/02/2016

Facts:

The Complainant was an insured person under Group Medi-claim policy issued by the respondent for the accounts holders of Bank of Maharastra. Complainant had suffered from fever, vomiting, cold & cough, so he was admitted in Arpan Hospital, Indore on 21.03.2015 and discharged on 26.03.2015. Thereafter, he lodged the claim for reimbursement of treatment cost before the TPA Heritage Health/ respondent company for Rs.27, 630/- out of which respondent has settled the claim only for Rs.15147/-. The complainant has approached this forum for relief of payment of balance amount of his claim.

Respondent company in the SCN/ Reply have admitted that claim is genuine, hospitalization is confirmed and have taken the plea that need of hospitalization for 6 days for Cough is not justified according to ICP so out of total amount claimed Rs.27,630/- claim has been settled for Rs.15,147/-.

Findings and Decisions

The complainant has himself admitted during hearing that he has not lodged any complaint to the company after repudiation of the claim for redressal of his grievance and has also not made any representation before the grievance redressal office/ higher authority of the company and has directly filed this complaint before this forum as apparent from the record itself. Thus, it is established that the complainant has not complied with the mandatory requirements of provisions of RPG Rules, 1998 before filing the complaint in this forum, which touches the maintainability of the case under RPG Rules, 1998 as such the complaint is not maintainable under the provisions of RPG Rules, 1998. So, it is needless to analyze the other factual aspects of this case on the point of partial settlement. Hence , the complaint stands dismissed.

Case no. BHP-G-050-1516-0141

Mr. Ajay Jain

V/S

Oriental Insurance Co. Ltd. Indore.

Date of Award:04/02/2016

Facts:

The complainant's son was covered under concerned mediclaim policy of the respondent. He was admitted in Aditya Nursing Home on 24/07/2015 for treatment of Recurrent Tonsillitis with Enlarged Adenoids and discharged on 25/07/2015. Thereafter, complainant lodged the claim for Rs.35,311/- before the respondent for reimbursement of treatment cost but respondent settled the claim for Rs.29,259/-and remitted Rs.19,458/-.

Finding & Decision

Respondent company in the SCN /reply have contended that as per reasonability and customary clause amount payable for tonsillitis with enlarged adenoids is restricted to Rs.18700/-subject to 10% Co- Payment deduction as per silver plan. The respondent has not filed any cogent document to show the package of enlarged tonsillitis surgery for Rs.18,700/- only.

The respondent's representative has also agreed during the time of hearing that TPA has processed the claim for Rs.29,259/- and the same was conveyed to the complainant also, later on, the claim was settled for Rs.19458/- on 04/09/2015 and payment was made through NEFT.

The insurer's representative has not given any calculation chart for showing the admissible amount if found payable as per the terms and conditions of the policy document. Taking into consideration the entire facts & circumstances of the case and the submissions made, material on record and policy terms & conditions, I am of the view that the complainant is entitle for the balance admissible amount as per policy document. Hence, the respondent is hereby directed to pay the balance admissible amount in accordance with the terms & conditions of the policy document to the complainant as full and final settlement of the claim.

In the result, the complaint is Allowed for balance admissible amount only.

Case no. BHP-G-051-1516-0161

Mr. Sharad Dixit

V/S

United India Insurance Co. Ltd. Indore

Date of Award:22/02/2016

Facts:

The Complainant was covered under mediclaim policy of the respondent company. It was third renewal. The complainant had hospitalized for the treatment of T2 DM (Uncontrolled) Cellulitis Left Leg, at Balaji Hospital & Citizen Hospital, Indore from 23.05.2015 to 28.05.2015. The claim was lodged towards treatment cost for Rs.52,338/- before the respondent but his claim has been repudiated on the ground of Pre-existing disease of T2DM .while he suffered ailment of diabetes for the first time on 14.08.2013 and first policy was effective from 09/01/2013. Being aggrieved by the decision of respondent the complainant has approached this forum for payment of his claim.

Respondent insurance company have filed their SCN/ Reply contending therein that the reason for the repudiation is pre-existing disease not covered for the first three years from date of inception of the policy , claim was repudiated under clause 4.1 & 5.9 since three years not completed and insured had not disclosed as hemight have infected before commencement of first policy

Finding and Decisions

The respondent insurance company have repudiated the claim on the ground that the claim falls under Clause 4.1 and 5.9 of the policy. The exclusion clause 4.1 of the policy terms & condition clearly provides that any pre-existing condition as defined in the policy, until 48 months of continues coverage of such insured person has elapsed since inception of first policy with the company and 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 pre-existing conditions. The exclusion clause 5.9 provides that the policy shall be void and all premium paid hereon shall be forfeited to the company in the event of mis-representation, mis- description and nondisclosure of any material fact. The certificate dated 07/06/2015 issued by treating Dr.Sushil Joshi, MD shows that the insured patient Mr. Sharad Dixit was having T2DM since last one year as history given by patient himself but as per consultation prescription dated 14.08.2013 issued by Dr.Uttam Jain, clearly shows that blood sugar of the insured patient was 274 mgl and the patient was advised to take Glyciphage 500 before meal finding him patient of diabetes mellitus which was detected in pathological examination of blood. The sugar was also found present in urine examination of the said insured patient which reflects that the complainant insured had history of diabetes mellitus before inception of the policy as it cannot be developed within few months. Even if it is taken into consideration that the ailment of diabetes was detected on 14.08.2013 after passing of about 7 months from date of inception of the first policy even then it will attract the provisions of exclusion clause 4.1 of the policy document under which the waiting period is 48 months of continuous coverage and the company shall not be liable to make any payment for said pre-existing condition. Under the aforesaid facts, circumstances and material on record and submission made, I am of the considered view that the decision / action of the respondent company for repudiating the claim of the complainant is perfectly justified and is sustainable in law and does not require any interference by this authority. Hence, complainant is not entitled for relief as prayed for.

Case No. BHP-G-044-1516-0135

Mr. Santosh Kumar Makhija

V/S

Star Health and Allied Insurance Co. Ltd.

Date of Award:29/02/2016

Facts: The complainant was covered under mediclaim policy issued by the respondent company. The complainant was admitted in Chirayu Hospital for angiography and further management with k/c of CAD, AC IWMI where Coronary Artery Disease and Ac Inferior Wall MI,CAG-Triple Vessel Disease was diagnosed and angiography was performed during hospitalization period from 04/02/2015 to 07/02/2015. Later on, the complainant was admitted at Indraprastha Apollo Hospital, New Delhi on 10/02/2015 and underwent treatment (surgery) for the heart ailments as diagnosed and was discharged on 24/02/2015. Thereafter, he lodged the claim towards treatment cost for Rs.3,50,000/- before the respondent but his claim was repudiated on the ground of Pre-existing disease. Being aggrieved by the action of the respondent, the complainant approached this forum for relief of payment of treatment cost.

Respondent in the SCN / reply have contended that all the complications directly or indirectly related to the surgeries or procedures performed previously- disease of the kidney and urinary tract and their complication, treatment of disease related to Cardiovascular System, hypertension and its complications including target organ damage were incorporated as pre existing disease in the policy and have further contended that the insured reported

the claim in 2nd year of insurance of policy .His cashless treatment with respect to claim no. 252460/2015 was rejected on the grounds that the management related to CVS is not payable till 48 month of continuous coverage from the date of inception as CVS is declared as pre-existing disease. As such the claim was repudiated under exclusion no.1 of the policy .

The complainant has narrated the facts as mentioned in the complaint and stated that he had taken policy for 2013-14 and renewed for 2014-15 and in the proposal form, he had mentioned ' NO' about any ailment and also stated that his medical was done at the time of taking the policy and suddenly he suffered heart attack in Feb.2015 and took treatment and CABG was performed during hospitalization from 10.02.2015 to 24.02.2015 in Delhi Indraprasth hospital and before that angiography was done at Chirayu hospital but his claim was refused on the ground of PED. He has further stated that policy was not read over and relied on company's personnel and nothing was told to him about pre-existing disease .

Insurer's representative has taken the stand as made in the SCN and stated that medical was done before giving first policy in 2013 and some changes were found in ECG so it was excluded in policy document itself and even at the time of renewal of the policy also as PED for which waiting period is 48 months and also stated that it was not disclosed in proposal form .

Findings & Decisions

From perusal of the discharge card of Chirayu Hospital, Bhopal it is clear that the insured was obese patient, known case of coronary artery disease, Ac Inferior wall MI and was admitted for angiography and further management and angiography revealed triple vessel disease and was advised for CABG.

From perusal of the concerned policy document as well as previous policy of 2013-2014, it is apparent that both the policy documents itself shows the inclusion of pre-existing disease which are excluded like "all complication directly or indirectly related to the surgeries performed previously disease of the kidney & urinary tract & their complications and also treatment of diseases related to Cardiovascular system, Hypertension and its complications target organ damage.

The prescription of the complainant issued by Dr. Vijay Kumar Nandmer clearly shows that the complainant was having HTN with Obesity but in the proposal form (xerox copy the complainant has mentioned 'No' regarding the question that "have you consulted/ taken treatment/ been admitted for any illness/ disease/ injury" and has answered ' Yes' regarding the question " Are you in good health and free from physical or mental disease or infirmity". From perusal of the proposal form xerox copy, it is also apparent that the complainant has mentioned ' No' regarding details of drugs and medicines prescribed and period from which these drugs are taken while in the medical examination report issued by Dr.Anil Batra, MBBS,BMB on behalf of respondent company has clearly mentioned that the complainant is patient of HTN and was taking HTN medicine since last 20 years tablet ' Losar 4' and has also mentioned about renal stone surgery done in 1993 and the above medical examination report also contains the signature of the complainant on 12.09.2013 which has also been admitted by the complainant during hearing. It is admitted fact that claim has been made in 2nd year of the policy. Policy condition exclusion 1 clearly provides that the company shall not be liable to make any payment under the concerned policy in respect of any expenses what so

ever incurred by the insured person in connection with or in respect of pre existing diseases as defined in the policy until 48 consecutive months of continuous coverage has elapsed .

On perusal of the medical literature submitted on behalf of the respondent, it transpires that the coronary artery disease is thought to begin with damage or injury to the inner layer of a coronary artery and the damage may be caused by high blood pressure also. and it has been already established that the complainant was suffering from HTN for last 20 years and was taking medicine which has been excluded as PED in the policy document itself and the waiting period for the same is 48 months.

Thus, from the material on record, that the respondent company have rightly repudiated the claim on the basis of medical documentary evidence on record and as per policy terms and conditions with cogent reasons. The complaint stand dismissed.

Case no. BHP-G-012-1516-0190

Mr. Hemant Joshi

V/S

Cholamandalam MS Gen. Insurance Co. Ltd. Indore.

Date of Award:17/03/2016

Facts:

Complainant is covered under mediclaim policy issued by the respondent. He suffered from Urinary tract infection with fever therefore, he was hospitalized at Verma Nursing & Maternity Home, Indore w.e.f. 27/09/2015 to 04/10/2015 for further management. After discharge he lodged the claim for reimbursement of treatment cost before respondent, but his claim was repudiated under general condition 6.14 of the policy (documents submitted are manipulated / fabricated). Respondent insurance company have stated in the SCN / reply during the time of hearing that insured is habitual in taking claims and doing fraud to gain benefits of policy with wrongful activities and have also taken the plea that IPD no. 1358 has been repeated in IPD register as IPD no. 1358 which has been written in front of patient Hemant Joshi and also in front of patient Sunny Barade. As per IPD register the date of admission has been shown as 27.09.2015 and date of discharge as 29.09.2015 whereas documents produced by insured in the claim case shows date of discharge as 04.10.2015 which is not found mentioned anywhere in hospital records. No proper clinical notes was found maintained and bed head ticket also not available or provided during investigation and multiple and costly antibiotics prescribed only for UTI which is inadequate and not necessary for UTI. Bills and discharge are manipulated and fabricated as such the claim has been repudiated.

Findings & Decisions

The respondent insurance company have repudiated the claim on the ground that the claim falls under general condition 6.14 which reads as No indemnity is payable for claims directly or indirectly caused by false or fraudulent

manner abetting fraud against insurance company. This policy shall be null & void initio in relation to insured person.

Thus, in view of the material on record the genuineness of the entry made in the IPD register with regard to the name of complainant and discharge date becomes doubtful which can only be proved by examining the investigator Dr. Namrata Pawar who was authorized by the respondent to investigate the case and the veracity of the entries made also can be proved by examining the medical staff of the said hospital. The above issues involve in this case can only be decided by producing evidence by both the parties.This forum has got limited authorities under RPG Rules, 1998. It can only hear the parties at dispute without calling fresh witnesses, 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 subject matter of dispute, calling other witness may help in arriving at a just decision. Under these circumstances, the complaint stands dismissed with a liberty to the complainant to approach some other appropriate forum/court to resolve the subject matter of dispute.

Case No. BHP-G-051-1516-0173

Mr. Gajanan Jadhav

V/S

United India Insurance Co. Ltd. Indore.

Date of Award:17/03/2016

Facts:

Complainant was covered under Group mediclaim policy alongwith his family members issued by the respondent. The complainant /insured daughter was suffering from fever, bodyache, vomiting, ghabrahat, for which she was admitted in Arpan Hospital, Indore for the period 26/07/2015 to 28/07/2015 after treatment ,claim was lodged for reimbursement of treatment cost before the TPA / Respondent insurance company but his claim was refused on the ground that hospitalization was not needed. The complainant approached this forum for relief of payment of his claim.

Respondent company have not filed the SCN / reply. The complainant has reiterated the facts as mentioned in the complaint and stated that respondent neither responding nor settling the claim amount. He himself has collected claim status through Net web site.

Findings & Decisions

The claim status report shows that respondent insurance company have simply taken the plea for repudiation on the ground that hospitalization was not needed and the treatment taken can be received on OPD basis also.

The respondent have not challenged about the treatment given to the patient in the said hospital during the said period for the ailments as diagnosed.

On going through the repudiation details dated 17/08/2015, it appears that the anomalies shown in the letter are baseless allegations and unsupported by any document while the treating Dr. Asok Jain has clarified about the

seriousness of the disease which was found as severe in nature, so in this way, the hospitalization becomes necessary and justified.

The discharge summary of the complainant shows that the complainant was admitted on 26.07.2015 and discharged on 28.07.2015 and was given required treatment for diagnosed ailment is not disputed, and respondent have not challenged about the genuineness of treatment given.The insurer's representative has not given any calculation chart for showing the admissible amount if found payable as per the terms and conditions of the policy document. Taking into consideration the entire facts & circumstances of the case and the submissions made, material on record and policy terms & conditions, the respondent Oriental Insurance Company is hereby directed to pay the admissible amount in accordance with the terms & conditions of the policy document to the complainant as full and final settlement of the claim.Hence, the complaint is Allowed for admissible amount only.

Case no. BHP-G-049-1516-0152

Mr. Vijay Kumar Thethwar

V/S

The New India Assurance Co. Ltd. Raipur.

Date of Award:17/03/2016

Facts:

Complainant is an employee of LIC of India ,was covered under Group mediclaim policy taken by employer , was issued by the respondent. It is further said that his wife was suffering from Iron deficiency, anemia with UTI. Therefore she was hospitalized from 25/05/2015 to 27/05/2015 at Ramkrishna Care Hospital, Raipur. The complainant lodged the claim for reimbursement of treatment expenses for Rs.2550.84 which was settled for Rs.2099/- only by the respondent after deducting Rs.450/- on the ground that necessary X-ray report and Money receipt of doctor's fees was not available. The complainant approached this forum for relief of payment of balance amount of his claim.

Respondent insurance company have filed their SCN /reply contending therein that claim for Rs.10,401/- under additional payment for post hospitalization expenses have been settled for Rs.9,951/- and rest amount of Rs.450/- deducted is not payable due to following reasons. – a. Rs.250/- investigation reports (X ray) is not available, b. Rs.200/- authentic bill receipts (with printed bill no. and date) are not available.

Findings & Decisions

The respondent representative has admitted during the time of hearing that now respondent insurance company is ready to make payment of Rs.450/- which was deducted for want of authentic bills .

Case no. BHP-G-023-1516-0162

Mrs. Sandhya Singhai

V/S

IFFCO-TOKIO Gen. Insurance Co. Ltd.

Date of Award:22/03/2016

Facts:

Complainant was covered under mediclaim policy issued by the respondent. She underwent open mesh hernioplasty surgery on 08/07/2015 due to the disease diagnosed "Infra Umbilical Incisional Hernia". She lodged the claim for reimbursement of treatment cost before respondent company ,which was repudiated on the ground of "Exclusion no.12 .

Respondent insurance company have submitted their SCN/ Reply against the complaint . During the time of review by the Medical Team it was observed that Aetiology of the said ailment is history of lower segment Caesarean section done in 1992. As the hernia is incisional and herein incision refers to previous incision made in the abdominal wall, i.e. the scar left from a previous surgical operation of LSCS, therefore claim is not admissible, since it is complications of LSCS which is excluded under condition no.12.

Claim was repudiated by the respondent insurance company . Complainant's representative has reiterated that as mentioned in the complaint and stated that claim was repudiated is without going in to deep analysis of facts showing the grounds that ailment was complication of LSCS done in 1992 about 23years back and she was leading healthy life without any problem. Her husband also submitted the details of earlier two policies and argued that if she was having malafied intention to get insurance of known problem, she may lodge claim in first policy taken in year 2013.

Findings & Decisions

The respondent insurance company have repudiated the claim on the ground of exclusion 12 of the policy which reads as "what is not covered" Expenses on treatment arising from or traceable to pregnancy, childbirth, miscarriage, abortion or complications of any of these, including caesarean section and any infertility, sub fertility or assisted conception treatment." The complainant had history of LSCS (Lower segment caesarean section) in 1992. As per discharge card, the complainant was admitted in Shekhar Hospital ,Bhopal on 08/07/2015 and discharged on 12/07/2015 and the ailment diagnosed was "Infra Umbelical Incisional ernia" and she was operated on 08/07/2015 and relevant treatment was given for the diagnosed ailment.

The SCN shows that medical team has observed that aetiology of the ailment in this case is history of Lower segment Caesarean section done in past which has been confirmed vide letter dated 13/08/2015 of said hospital stating past illness and showing the cause of hernia as complications of LSCS done in1992 which is exclusion under clause 12 "what not covered".

Respondent Insurance company has also submitted photocopy of relevant pages of "A concise Textbook of Surgery". The relevant lines of page no.1119, reads as," INCISIONAL HERNIA (SYN.Ventral Hernia or Postoperative Hernia).

An incisional hernia is one which occurs through an acquired scar in the abdominal wall caused by a previous surgical operation or an accidental trauma. Scar tissue is inelastic and can be stretched easily if subjected to constant strain." Page no.1120 (v)"Certain incisions are more liable to cause incisional hernia e.g.midline infraumbilical Incision for caesarean section."

After going through the oral submission and documents submitted by both the parties and in view of above, I arrive at the conclusion that the Open mesh hernioplasty surgery is complications of LSCS which was done in 1992, and per terms and conditions of policy "what not covered under exclusion no.12" the claim has been rightly repudiated by the respondent insurance company.

Case no. BHP-G-050-1516-0154

Mr. Indra Mohan Bajaj

V/S

Oriental Insurance Co. Ltd. Harda.

Date of Award:22/03/2016

Facts:

Complainant was covered under concerned mediclaim policy issued by the respondent. The complainant was hospitalized wef.14/11/2014 to 20/11/2014 at Avanti hospital, Nagpur for Rotabblation + PTCA with 2 stents to LAD done on 15/11/2014. After discharge he lodged the claim for reimbursement, but his claim has not been settled till date . Respondent have stated in the SCN/ Reply that in spite of several written reminders by the TPA, the insured has not fulfilled the requirements as mentioned resulting in delay of settlement of claim. Claim was neither settled nor repudiated till date of filing complaint.

The insurer's representative has taken the stand as made in the SCN and stated that various reminders has been issued for submission of relevant documents in connection with claim but the same has not been complied with by the complainant.

Findings & Decisions

Complainant has failed to prove that he had complied the requirements of the claim. Since respondent company has also admitted that the claim is still pending and to be decided, therefore, it is a pre-mature case.

The complainant has not filed any representation to their grievance department of the respondent company in this regard and has directly filed this complaint before this forum. Thus, it is established that the complainant has not complied with the mandatory requirements of provisions of RPG Rules 1998 before filing complaint in this forum which touches the maintainability of the case under RPG Rules, 1998. As such, the complaint is not maintainable under the provisions of RPG Rules, 1998. So, it is needless to analyze the other factual aspect of this case on the point of settlement of the claim.

Case no. BHP-G-050-1516-0164

Mr. Vikas Verma

V/S

Oriental Insurance Co. Ltd. Indore.

Date of Award;25/03/2016

Facts:

The Complainant with his wife and dependent parents were covered under mediclaim policy issued by the respondent. The complainant's father hospitalized at Unique Super Specialty Centre, Indore from 28.05.2015 to 29/05/2016 where CAD / Angina was diagnosed and then he was shifted to Greater Kailash Hospital, Indore on 29/05/2015 till 01/06/2016 where CAD, SVD, and underwent Coronary Angiography and simple Angioplasty (PTCA). The claim was lodged for reimbursement of incurred amount but respondent company had repudiated the claim under exclusion No.4.1 'PED' of the policy because policy was running in 2nd year. So, the complainant approached this forum for relief of treatment cost.

Respondent insurance company have filed the SCN/reply stating therein that the policy inception date was 11.06.2013 and claim has been reported in 2nd year of policy and also contended that patient was treated for CAD/SVD/PTCA/STENT and coverage of disease as per policy is available from 5th year renewal ,without break. The respondent have also taken the plea that the patient was very well known that he was suffering from HTN & he might be arrested by cardiac or related disease, so he opted the policy and applied for claim ,therefore , as per the policy terms & condition no.4.1 & 4.3 the claim was repudiated.

Findings & Decisions

The Complainant has submitted copies of proposal forms dated 03/06/2013, which clearly shows that "NO" has been mentioned in the column of personal history about disease/ ailment ever suffered. While going through the discharge summary, it has been specifically mentioned under history of present illness that patient was non diabetic, normo tensive and the complaint was chest pain along with difficulty in breathing since morning and the same ailments have been confirmed through clinical case records.

The Respondent have not challenged about the treatment given to the complainant in the said hospital during the said period for the said ailment. It appears that ground of repudiation is baseless because Dr. Sanjay Gujrati, M. D. of Unique Super Specialty Centre, Indore has certified vide his certificate dated 22/06/2015 that patient was not having history of HTN/DM.

The respondent insurance company have filed copy of clinical notes during the time of hearing in which date is mentioned as 29/05/2014 instead of 29/05/2015, but at the same time, it was narrated by the complainant that before 29/05/2015, they have never consulted any hospital in this regard. It was the first instance when his father was admitted in the said hospitals for the said ailment. Treating Dr.Abhishek Gupta has also clarified vide certificated dated 18.03.2016 submitted after hearing about mentioning date 29/05/2014 that in hurry it was written as 29/05/2014 instead of 29/05/2015.

Thus, it appears from the material on record, that the respondent company have repudiated the claim of the complainant in a mechanical way without giving any serious thought to the medical documents and without any cogent reasons which compelled the complainant to approach this forum. The respondent company have not furnished any calculation chart towards admissible amount, if it is found payable.

In view of aforesaid facts, circumstances and material available on the record, I arrive at the conclusion that the respondent have repudiated the claim relying on the medical paper (clinical note) containing dated 29.05.2014 of Greater Kailash Hospital, Indore without verifying about taking treatment by the insured the complainant's father on 29.05.2014 in the said hospital, while the medical documents filed on behalf of complainant are connected from dated 28.05.2015 of Unique Super Specialty Centre, Indore and 29.05.2015 and onwards of Greater Kailash Hospital, Indore to show about first treatment after complaint of chest pain and breathing trouble to his father. Hence, the respondent The Oriental Insurance Company is directed to review the claim after verifying the authenticity of treatment date if any on 29.05.2014 and if it is found a clerical error, the claim should be settled and paid as per terms and condition of policy document within one month from date of receipt of this order under intimation to this office.

Case no. BHP-G-048-1516-0192

Mr. Devendra Pithadiya

V/S

National Insurance Co.Ltd.,Indore

Date of Award:25/03/2016

Facts:

The complaint is related with the cumulative Bonus earned and not included in sum insured while settling the claim amount.

Respondent company vide their SCN clarified that the Cumulative bonus 25% earned is reduced as penalty of late intimation of claims

The complainant was absent but has submitted written submission making request for payment of 25% extra amount giving reference of IRDA rules since his claims were settled very late and for endorsements of cumulative bonus in previous policies.

The insurer's representative has taken the stand as made in the SCN and laid emphasis that all six claims has been settled as per terms and conditions of the policy documents and settled amount has been paid through NEFT which has been accepted by the complainant also and also stated that cumulative bonus was not given after enhancement of sum insured and the cumulative bonus of Rs. 37,500/- was given on previous policy and 25% of the admissible amount was deducted due to delay in filing of claim and delay was condone by deduction of 25% and also stated that sum insured was exhausted.

Findings & Decisions

From perusal of the copy of complaint dated 15.01.2015 bearing case no. BHP-G-048-1415-0160, it transpires that the complainant has already made complaint with regard to four claims bearing file no. 14RBO9NAJ3030, 14RBO9NAJ3687,

15RBO9NAJ0171 and 15RBO9NAJ1954 which also find place in the instant complaint and has claimed different amounts by adding 25% additional amount which has been rejected in the name of delay condone. The basis of letter dated 09.06.2015, payment details and copy of withdrawal petition dated 26.05.2015 of the complainant mentioning about settlement of the claim by respondent but the complainant has not disclosed this important information in instant complaint which is serious concealment of the facts and kept this forum in dark. Since, the earlier complaint regarding four claims as mentioned above under the concerned policy was withdrawn by the complainant by mentioning the fact that his all claims has been settled by the respondent company and accordingly the complaint was dismissed by this forum on 16/06/2015 on the above ground. There is no provision for review of its Order/ Award already passed in any case under the RPG Rules, 1998 as re appreciation of the facts mentioned in the instant complaint will amount to review of the order and award passed regarding above mentioned four claims which have already been settled and paid. Hence, it is useless to discuss about the above mentioned four case which have already been decided. As regards for the remaining two cases mentioned for endorsements of cumulative bonus, I find that there is dispute of percentage of Cumulative bonus demanded by the complainant and granted by the respondent insurance company. so, both the demand of cumulative bonus and 25% extra due to delay of settlement of claims, are beyond the jurisdiction of this forum, hence the above prayer made in the complaint is not maintainable and cannot be considered in this case.

Lucknow Ombudsman Centre
Complaint No: LCK-G-044-1516-0098
Award No : IO/LCK/A/GI/110/2015-16
Mr. Ankit Srivastava Vs Star Health & Allied Insurance Co. Ltd.
Award Dated – 21.03.2016

Reason For Grievance – Repudiation of Claim

Summary of the case:

Name of the complainant:	Mr. Ankit Srivastava
Name of Policy holder:	Mr. Ankit Srivastava
Name of Insurance Co. (RIC):	Star Health & Allied Insurance Co. Ltd.
Policy No.:	P/231121/01/2015/000056 & P/231121/01/2016/0000176
Period of Insurance:	04.07.2014 to 03.07.2015 & 04.07.2015 to 03.07.2016
Type of Insurance:	**Health Insurance – Floater**
Sum Insured	Rs. 1,50,000/- in both the policy
Date of hearing:	14/03/2016

Facts: The complainant went for spinal surgery in year 2013 due to accident. The claim for this hospitalisation was paid by the RIC. Thereafter, the complainant had made two claims during the policy period 04/07/2014 to 03/07/2015

and also one more claim during the policy period 04/07/2015 to 03/07/2016 for the same injury. As per hospital discharge summaries in all aforesaid three hospitalisation, the complainant was treated by autologus bone marrow Stem cell / bone marrow cells transplantation. The claims were repudiated by the RIC under policy exclusion clause 3(19) which reads as under:-

3.The company shall not be liable to make any payments under this policy in respect of any expenses what so ever incurred by the insured person in connection with or in respect of:

19. Stem cell implantation and / or therapy

Findings: As per complainant's representative submission, all three hospitalisation were related to bone marrow transplant and not to stem cell implantation and/or therapy. He further argued that there was difference between "transplantation" & "implantation". The main differences were enumerated by him as follows:

(i) Transplants are biological tissues, which are used to replace the tissue or organ in the human. Implants are materials that are not alive.

(ii) Transplant needs immune suppression in donor, but implants do not need.

(iii) Transplant will work as an active tissue in the human, while implants are mechanical support to the organ function.

Thus it was not implantation. Doctor did not refer the procedure followed by him as "therapy" in discharge summary. Hence, repudiation of claims by RIC was not justified as per policy terms and conditions. The representative of RIC submitted that the treatment given in all three hospitalisation was stem cell implantation and/or therapy.

On perusal of documents submitted by both the parties, it was observed that the complainant was treated in all three hospitalisation by autologus bone marrow stem cell transplantation / autologus bone marrow cells transplantation through IV and CSF. It was not relevant to delve whether it was implantation or transplantation. As per medical literature/ English dictionary, therapy means treatment. The contention of representative of complainant that the treatment given was a transplant and not a therapy, was not correct. Bone marrow contains adult stem cells which are undifferentiated immature cells. When these cells are transplanted/implanted in any damaged organ, these cells are capable of regenerating damaged cells of that organ resulting into recovery of the illness. Hence, It definitely comes under therapy. Therapy is a wider term and includes any type of treatment. In this case, stem cells from bone marrow was put in injured part of spinal cord so that the stem cells of bone marrow could grow into cells of spinal cord and it is repaired. The patient was given stem cells therapy or treatment thus it comes under policy exclusions 3(19).

Decision/Award: In view of the above, this forum do not find any merit to intervene in the decision already taken by RIC.

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In the matter of Sh. Chandra Pal Singh
Vs
The Religare Health Insurance Company Ltd.

DATE: 26.11.2015

1. The complainant's daughter was hospitalized at Ansari Hospital from 25.04.15 to 26.04.15. She was diagnosed Polyarthralgia and foot corn (left). The excision of foot corn was done on 25.04.15. The complainant had filed a claim for reimbursement of Rs. 10,063/- which was rejected by the Company.

2. The Insurance Company reiterated that as per discharge summary the patient was admitted with complaints of multiple joint pains as knee pain, elbow pain, hip joint, weakness with corn in left foot. Further evaluation and management of joint pains was done. All vital parameters were normal. The excision of foot corn was done under local anesthesia. As per expert opinion sought by Insurance Company the excision of foot corn was a simple procedure. The hospitalization was not clinically required. All investigations were normal. No disease could be identified. The treatment could have been done on OPD basis. Hence claim was rejected under policy exclusion 3.2 sub clause (xxii) i.e. out- patient treatment).

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the Insurance Company reiterated that the patient was admitted for further evaluation and management of joint pains. The excision of foot corn was a minor surgery, done under local anesthesia. The hospitalization was not clinically required No disease could be identified and treatment could have been done on OPD basis. I find that the complaint's daughter was hospitalized for further evaluation and management of joint pain as revealed from the discharge summary. As per the Expert opinion of
   Dr. C.H. Asrani, dated 14.05.15 taken by the Insurance Company, the foot corn surgery was a minor surgery done under local anesthesia. There was no acute clinical feature that required either indoor investigation or management. The admission was primarily for investigation and evaluation. Therefore I uphold the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Sh. Sandeep Kumar Ragsania
Vs
The Religare Health Insurance Company Ltd.

DATE: 26.11.2015

1. The complainant's wife was admitted at Maharaja Agrasen Hospital from 09.05.15 to 13.05.15 with complaints of dizziness, vomiting, headache and ghabrahat. She was diagnosed acute vertigo and hypotension. The complainant had lodged a claim for reimbursement of Rs. 35,392/- which was rejected by the Insurance Company on the ground that admission for investigation and evaluation is not covered. He sought relief of Rs. 35,392/- from this forum.

2. The Insurance Company vide self contained note dated 15.10.15 reiterated that Health Policy was issued to the complainant for the period 27.07.14 to 26.07.15. The complainant's wife was admitted at Maharaja Agrasen Hospital from 09.05.15 to 13.05.15 with complaints of dizziness, vomiting, headache and ghabrahat. She was diagnosed as suffering from acute vertigo. On perusal of documents it was noted that admission was made primarily for investigation and evaluation of vertigo and to rule out the cause of vertigo. All the vitals of the patient were normal throughout hospitalization. As per "initial assessment sheet" a number of tests had been prescribed for the purpose of investigation i.e. CBC, LFT, ECG, RBST, urine culture, USG, MRI Brain, MRI Spine and other. All these investigations could have been done on OPD basis. Out of total bill of Rs. 35,392/-, bills for medicines was for Rs. 1872/- only. Therefore claim was declined under clause 4.3 A (1) read with Annexure C (71) of the policy terms and conditions i.e. Admission for Investigation and evaluation is not covered.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant stated that his wife was admitted for 05 days for treatment of Vertigo but the claim was rejected by the Company. The Insurance Company reiterated that patient was admitted for investigation and evaluation of vertigo. All the vitals of the patient were normal throughout hospitalization. As per initial assessment sheet dated 09.05.2015 a number of tests i.e. CBC, LFT, ECG, RBST, urine culture, USG, MRI brain, MRI Spine etc. had been prescribed. All these investigations could have been done on OPD basis. Therefore claim was declined under clause 4.3 A(1) C (71) of the policy terms and conditions i.e. "Admission for Investigation and evaluation is not covered." I find from the discharge summary that all routine investigations were done. The patient was admitted on 09.05.15 and discharged on 13.05.15. Since the patient was admitted on the advice of the doctor, the Insurance Company is directed to allow only hospitalization expenses for room rent as per terms

and conditions of the policy. **Accordingly the complaint filed by the complainant is hereby dismissed.**

In the matter of Sh. Sunny Arora
Vs
The Max Bupa Health Insurance Company Ltd.

DATE: 04.12.2015

1. The complainant alleged that he had taken "Heart Beat Gold" Health policy from 26.12.12 to 25.12.13 from Max Bupa Health Insurance Co. Ltd. The first claim in May, 2013 for the diagnosis of Acute Bronchitis was paid by the Insurance Company. However the subsequent claim for hospitalization at Ganga Ram Hospital for the period 16.02.15 to 19.02.15 was rejected by the Insurance Company on the ground of non-disclosure of material facts at the time of taking the policy. He sought the relief of Rs. 37,472/- from this forum.

2. The Insurance Company reiterated vide its self contained note dated 08.10.15 that the complainant had applied for cashless on 24.05.13 for the treatment of acute bronchitis which was approved and claim was paid since there was no history of previous illness. The complainant had applied for claim reimbursement of Rs. 37,472/- on 23.02.15 for his admission at Ganga Ram Hospital from 16.02.2015 to 19.02.15. At the time of admission the patient was diagnosed with HTN, DCMP (LVEF -25%), chronic kidney disease-V on CAPD, urinary tract infection and osteoarthritis. During investigation by the Insurance Company it was revealed that patient was admitted in Sir Ganga Ram Hospital from 19.12.11 to 27.12.11 and was diagnosed with CVA with left basal ganglia bleed with right hemiparasites with dysarthria, DM and renal failure. The policy was effective from December 2012. The complainant had not disclosed the material fact at the time of taking the policy, thus deprived the right of Insurance Company for proper underwriting. The claim was rejected under non-disclosure as per policy terms and conditions.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant stated that Heartbeat gold plan for Rs. 5 Lacs S.I. was taken for his father and mother in December, 2012. A claim of Rs. 1, 38,853/- in respect of his father was paid by the Company in May, 2013 for treatment of acute bronchitis. In April, 2014 his father had undergone annual health check up organized by Max Bupa Company and the reports were submitted to the Company. The current claim for hospitalization at Ganga Ram Hospital from 16.02.15 to 19.02.15 was rejected by the Company on account of non-disclosure of pre-existing disease. The Insurance Company reiterated that patient was earlier hospitalized at Sir Ganga Ram Hospital from 19.12.11 to 27.12.11 and was diagnosed with CVA with left basal ganglia bleed with right hemiparasites with dysarthria, DM and renal failure. The policy was effective from December 2012. The complainant had not disclosed the pre-existing disease at the time of taking the policy, thus claim was rejected under non-disclosure of material facts as per policy terms and conditions.

I find that the first claim for hospitalization in May, 2013 for the diagnosis of acute bronchitis was paid by the Insurance Company. No claim documents were available with the complainant so Insurance Company could not investigate further. The patient was admitted in Ganga Ram Hospital twice once in 19.12.11 to 27.12.11 and from 31.12.11 to 07.01.12. He was diagnosed with CVA with left basal ganglia bleed with right hemiparasites with dysarthria, DM and renal failure which was not disclosed at the time of taking the policy. These facts were not known to them in May 2013, therefore claim of that i.e. May period was paid. The policy is effective from 26.12.2012 whereas the admission at Ganga Ram Hospital from 19.12.2011 to 27.12.2011was prior to policy inception. The complainant had answered "No" to all the

questions asked under column 6 "Medical History" The claim for current hospitalization from 16.02.15 to 19.02.15 at Ganga Ram Hospital was rejected on the ground of non-disclosure of material information at the time of taking the policy. This was a case of non-disclosure. In the case of Satwant Kaur Sandhu Vs New India Assurance (2009) 8 SCC 316, the Hon'ble Supreme Court emphasized that it is obligatory at the part of the insured to disclose all the material facts at the time of taking the policy. The Insurance Company is not liable to make any payment in case of non-disclosure/misrepresentation of facts by the insured. The claim was rightly rejected by the Company under non-disclosure as per terms and conditions of the policy. The policy was cancelled by the Company. However I find that policy for both the insured's was cancelled. I direct the Insurance Company to renew the policy for Ms. Neelam Arora. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Ms. Shashi Dingra
Vs
The National Insurance Company Ltd.

DATE: 23.11.2015

1. The complainant alleged that she was admitted at Ganga Ram Hospital on 29.08.2013 and was given injection zolendronic acid for treatment of Osteoarthritis with Osteopenia. The complainant has submitted all the papers to the TPA for reimbursement of Rs. 25,833/-. The claim was rejected on the grounds that hospitalization was less than 24 hours. She sought the relief of Rs. 25,833/- from this forum.
2. The Insurance Company reiterated vide self contained note dated 16.10.15 that the patient was admitted on 29.08.13 at 11:44 am and discharged on the same date at 4:57 pm. The hospitalization was less than 24 hours. The patient was administered injection for osteoarthritis. The injection was administered over 30 minutes. It does not require prolonged monitoring and can be done on OPD basis. Hence the claim was rejected under clause no. 2.6 of the policy which states:

- Expenses of hospitalization for minimum period of 24 hours are admissible.
- Procedures/treatments usually done in out-patient department (OPD) are not payable under the policy even if converted to Day Care Surgery procedure or as in patient in hospital for more than 24 hours.

3. I heard both the sides, the complainant (represented by her husband) as well as the Insurance Company. During the course of hearing the Insurance Company reiterated that that the patient was admitted on 29.08.13 at 11:44 am and discharged on the same date at 4:57 pm. The hospitalization was less than 24 hours. The patient was administered injection for osteoarthritis. The injection was administered over 30 minutes; it does not require prolonged monitoring and can be done on OPD basis. Hence claim was rejected under clause no. 2.6 of the

policy which states: Expenses of hospitalization for minimum period of 24 hours are admissible. Procedures/treatments usually done in out-patient department (OPD) are not payable under the policy even if converted to Day Care Surgery procedure or as in patient in hospital for more than 24 hours. I find that the hospitalization was less than 24 hours and administration of injection for osteoarthritis was not covered in day procedure as per clause no. 2.6 of the policy. I find that the policy conditions very categorically stipulate that treatment for osteoarthritis is not covered as it hospitalization was less than 24 hours. Therefore, I see no reason to interfere with the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. Amit Mittal
Vs
The Max Bupa Health Insruance Company Ltd.

DATE: 30.12.2015

1. The complainant alleged that he had taken "Family First Silver Plan" health policy of Max Bupa w.e.f. March, 2013. He upgraded the policy to "Family First-Gold Plan" on subsequent renewal of the policy. As per Gold plan the maternity coverage was Rs. 50,000/-. The complainant alleged that the Insurance Company had paid Rs. 25000/- only whereas the policy was eligible for a sum of Rs. 50,000/- against maternity benefit section. He sought relief for Rs. 25,000/- from this forum.

2. The Insurance Company reiterated vide self contained note dated 09.10.15 that the complainant was issued a health insurance cover under product "Family First Silver" from 26.03.13 to 25.03.14. The complainant has ported his policy from health product "Family First Silver" to "Family First Gold" in the 2nd year and later got it renewed under Gold Plan itself. The claim was lodged in the 3rd year policy however, as per the maternity clause the insured should be insured for 2 consecutive years under same product and have paid 3 premiums for the same to avail benefits of upgraded product. However, in this case insured has paid only two premiums in the upgraded policy. Thus, the claim was paid as per the first policy terms and conditions under Silver Plan. As per clause no. 2.7 (1B) (b) i.e. "Maternity benefit cover will be available under the maternity benefit only after 24 months of continuous converge have elapsed since the inception of the first policy with the Company." The clause no. 5hii (2 &3) which states "portability benefit is available only upto the existing cover. If the proposed sum insured is higher than the sum insured under the expiring policy, waiting periods would be applied on the amount of proposed increase in sum insured only.

3. 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 paid Rs. 25000/-

only which was not acceptable to him. As per health product taken by him i.e. "Family first gold plan" the maximum liability under maternity benefits section was Rs. 50,000/-therefore Company should pay Rs. 50,000/- for maternity benefit coverage. The Insurance Company reiterated that the complainant had ported his policy from health product "Family First Silver" to "Family First Gold" in the 2nd year and later got it renewed under Gold Plan itself. The claim was lodged in 3rd year policy. As per the maternity clause the insured should be insured for 2 consecutive years under the same product. However, in this case insured had paid only 2 premiums in the upgraded policy. Thus the claim was paid as per the first policy terms and conditions under Silver Plan.

I find that the complainant had taken a health insurance cover under Company's product "Family First Silver" from 29.03.13 to 28.03.14. He had ported his policy from Silver Plan to Gold plan in the 2nd year (29.03.14 to 28.03.15) and later got it renewed under Gold Plan itself (29.03.15 to 28.03.16). I find that as per clause no. 2.7 (1B) maternity benefit clause –"Maternity benefit cover will be available only after 24 months of continuous coverage have elapsed since the inception of the first policy with the Company" and as per clause no. 5(h) ii(3) (internal portability clause) which states "portability benefit is available only upto the existing cover. If the proposed sum insured is higher than the sum insured under the expiring policy, waiting periods would be applied on the amount of proposed increase in sum insured only." In the instant case the complainant had filed the claim on 11.05.2015 after completion of 24 months of continuous coverage of first policy (29.03.2013-28.03.2014) and insured had upgraded the product only by paying higher premium but the S.I. under the expiring policy i.e. Silver Plan and new policy i.e. Gold Plan was same i.e. (Rs. 20 Lacs). As per portability guidelines waiting period is applicable on the enhanced S.I., however in the instant case there was no increase in S.I. hence no waiting period was to be applied for settlement of claim. The claim falls under the purview of policy condition no. 2.7 (1B) and 5(h) ii (2&3) and is admissible. Therefore I direct the Insurance Company to settle the claim as per "Family First Gold" policy. **Accordingly an Award is passed with the direction to the Insurance Company to settle the claim as admissible to the complainant.**

In the matter of Mr. Pankaj Gupta
Vs
The Max Bupa Health Insruance Company Ltd.

DATE: 28.10.2015

1.The complainant alleged that his wife (around 43 years of age) had heavy bleeding on 06.07.2015. She was taken to the nearest hospital in emergency. She was diagnosed as a case of incomplete abortion. The claim was rejected on the ground that maternity related charges were not covered under the policy.

2. The Insurance Company reiterated vide self contained note dated 16.09.15 that complainant is policy holder of Health Insurance since 14.03.2012 till 13.03.2016. He had applied for reimbursement of Rs. 61,720/- for treatment of his wife at W Hospital

from 06.07.2015 to 07.07.2015. She was diagnosed with G2 P1 L1 with incomplete abortion and had undergone surgery for the same. The patient was treated for abortion and during the hospitalization urine test was conducted for pregnancy which was positive. The claim was rejected under policy clause 3 (e) of permanent exclusion sub clause XXVII of heartbeat companion which states that Company is not liable to pay for "(A) Any type of contraception, sterilization, termination of pregnancy or family planning (b) treatment to assist reproduction, including IVF treatments (c) Any expenses incurred on treatment arising from or traceable to pregnancy (including voluntary termination of pregnancy, childbirth, miscarriage, abortion or complications of any of these, including cesarean section)".

3. I heard both the sides the complainant as well as the Insurance Company. During the course of hearing, the complainant stated that his wife was hospitalized in emergency condition. She was diagnosed with incomplete abortion. She underwent surgery for Dilation and evacuation. The complainant was not satisfied with the reason for rejection of the claim. He alleged that patient was hospitalized in emergency; the claim was only for expenses on emergency treatment and not for maternity or abortion, hence the claim should be paid. The claim was rejected on the ground that maternity related charges were not covered under the policy was incorrect. The Insurance Company reiterated that the patient was treated for abortion. During the hospitalization urine test conducted for pregnancy was positive. The claim was rejected under "Heartbeat companion" policy clause 3 (e) of permanent exclusion sub clause XXVII which states that the Company is not liable to pay for "(A) Any type of contraception, sterilization, termination of pregnancy or family planning (b) treatment to assist reproduction, including IVF treatments (c) Any expenses incurred on treatment arising from or traceable to pregnancy (including voluntary termination of pregnancy, childbirth, miscarriage, abortion or complications of any of these, including cesarean section)" is not payable as it is under exclusion. I find that the complainant's wife was admitted with complaint of heavy bleeding P/V and was diagnosed with incomplete abortion as is revealed from the discharge summary. I find from the complainant mail to GRO on 25.07.2015 of the Company that he informed the doctor that the patient felt big clots or masses with heavy bleeding. The pregnancy test was performed by the doctor was positive. The documentary evidence i.e. discharge summary and complainant's mail dated 25.07.2015 to GRO of the Company proves that the treatment was related to/complication of pregnancy. It is a fact that patient was admitted in emergency due to heavy bleeding. During the course of investigation and treatment it was discovered to be a case of incomplete abortion for which further treatment was given. It is clearly a case that falls under exclusion clause 3(e) xxvii of the policy. Therefore, I uphold the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. Om Prakash Swami
Vs
The New India Assurance Company Ltd.

DATE: 02.11.2015

1. The complainant alleged that he had taken a mediclaim policy of New India Assurance Company Ltd. since 1999. He lodged a claim for reimbursement of Rs. 32,404/- towards hospitalization for the period 02.05.2015 to 04.05.2015 at Metro Life Line Hospital and per-post hospitalization expenses. He alleged that Insurance Company had deducted Rs. 13,400/- towards pre-hospitalization expenses and Rs. 200/- towards post hospitalization expenses.

2. The Insurance Company reiterated its self contained note dated 17.09.15 that complainant was admitted with complaints of fever, headache and vomiting. He was diagnosed with acute gastritis. The claim for hospitalization expenses was settled as per terms and conditions of the policy. Prior to current hospitalization the patient had taken treatment for numbness in upper/lower limb on 03.04.2015 on OPD basis. The MRI (brain) and other investigations were done on 14.04.2015. The pre-hospitalization expenses towards investigation dated 03.04.2015 and 14.04.2015 were deducted as these were not related to current illness for which complainant was hospitalized. The Insurance Company agreed to pay R. 750/- (RMO Charges) and Rs. 200/- (post hospitalization expenses) on submission of supportive document by the insured.

3. 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 not allowed the pre-hospitalization expenses toward MRI (Brain). The Insurance Company reiterated that prior to current hospitalization patient had taken treatment for numbness in upper/lower limb on 03.04.2015 on OPD basis. The MRI (brain) and other investigations were done on 14.04.2015. The pre-hospitalization expenses towards investigation dated 03.04.2015 and 14.04.2015 was deducted as these were not related to current illness for which complainant was hospitalized. The complainant was advised to submit documents regarding pre-hospitalization treatment i.e. MRI (Brain) and reports of B12/D3. The complainant had submitted pre-hospitalization consultation of metro hospital along with MRI (brain) report dated 14.04.2015 and certificate dated 25.09.2015 obtained from the hospital where in it is mentioned that the attendant of the patient had not disclosed the history of previous treatment taken by the patient, hence the same was not mentioned in the history of patient. I find from the report of MRI and MRA (Brain) dated 14.04.2015 of SRL Diagnostics that patient had diffused cerebral atrophy with mild chronic ischemic changes. The current hospitalization was for treatment of acute gastritis. The pre-hospitalization treatment was for numbness in upper and lower limb for which

investigations i.e. vitamin B12, D3 and MRI (brain) was prescribed by the doctor on 03.04.2015 on OPD basis. The certificate date 25.09.2015 of metro hospital submitted by the complaint itself revealed that pre-hospitalization treatment was not informed by the attendant of the patient during current hospitalization, hence no treatment was given by the hospital for previous diagnosis. The Insurance Company had already paid the hospitalization expenses and not allowed the pre-hospitalization expenses incurred on MRI as these were not related to current illness for which complainant was hospitalized. The Insurance Company agreed to pay Rs. 750/- (RMO Charges) and Rs. 200/- (post hospitalization expenses) on submission of supportive document by the insured. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. Rajesh Goel
Vs
The Max Bupa Health Insruance Company Ltd.

DATE: 02.11.2015

1. The complainant had taken Mediclaim policy under portability guideline from Max Bupa from 30.05.2014, prior to that he was insured with New India Assurance Company for last 14 years. The complainant's son was diagnosed tumor in chest in July, 2014 and had a seizure on 20.07.2014. He was admitted in emergency in Medanta and was diagnosed as a case of primary Mediastinal B cell Lymphoma. The cashless was denied. He applied for reimbursement of Rs. 3, 12,491/- on 12.08.2014. The claim was rejected by the Company vide letter dated 24.09.2014 on the ground that patient had a history of pain in Neck and left shoulder since 03 months (April 2014) prior to policy inception and did not disclose the same in the proposal form at the time of taking the policy, hence the claim was declined for non-disclosure of material facts.

2. The Insurance Company vide Self Contained Note dated 21.09.2015 reiterated that the patient was admitted with complaints of pain in neck and left shoulder since three months (April 2014). He was diagnosed with Primary Mediastinal B cell Lymphoma and underwent Chemotherapies as per discharge summary. It was observed that the policy incepted from 30.05.2014, the first consultation dated 08.07.2014 revealed that doctor suspected mediastinal mass or TB. During investigation complainant has mentioned that symptoms of disease started in April, 2014 which was prior to policy inception and complainant did not disclose the material facts that insured was facing health issues prior
switching to policy. The insured had replied "No" to all the questions under medical history in the proposal form. Thus the claim was declined under policy clause non-disclosure of material information.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing, the complainant stated that Health Insurance policy was taken under portability guidelines from Max Bupa w.e.f. 30.05.2014. He had mediclaim Insurance policy from New India Assurance Company Ltd. since 2001. He switched over to Max Bupa on 30.05.2014. The current illness i.e. Lymphoma was diagnosed in July 2014. The Insurance Company reiterated that the patient was hospitalized on 20.07.2014 with complaints of neck and left shoulder pain since 3 months, dry cough since 2 months and had history of seizures followed by loss of consciousness for 3-4 minutes as revealed from the discharge summary. The patient was diagnosed with Lymphoma (localized disease). The first consultation sheet dated 08.07.2014 revealed that doctor suspected mediastinal mass or TB. During investigation the complainant himself had mentioned that symptoms of disease started

in April 2014 which was prior to policy inception. The complainant did not disclose the material fact that the insured was facing health issues prior switching to policy from New India to Max Bupa Health Insurance. Thus the claim was declined under policy clause No.5 non-disclosure of material information.

I find that the complainant had ported the mediclaim policy on 30.05.2014. The complainant's son was hospitalized for treatment of Lymphoma on 20.07.2014. The Discharge summary revealed that patient had history of neck and shoulders pain since 3 months, dry cough since 2 months and general tonic colonic seizures followed by unconsciousness for 3-4 minutes. The ortho consultation from fracture and orthopedic clinic dated 13.05.2014 and OPD consultation dated 08.07.2014 of Paras Hospital revealed that symptoms of disease started since 13.05.2014 prior switching the policy to Max Bupa on 30.05.2014. During investigations by the Insurance Company a questionnaire was filled by the patient wherein he himself had mentioned "signs and symptoms started in April 2014" whereas the policy was ported on 30.05.2014. The complainant did not disclose the material information at the time of filling the proposal form. As per portability guidelines the portability benefits are subjected to receipt and evaluation of portability form and proposal form by the Company. In the instant case the complainant had replied 'No' to all the questions under medical history in the proposal form. It is a case of non-disclosure. In the case of Satwant Kaur Sandhu Vs New India Assurance (2009) 8 SCC 316, the Hon'ble Supreme Court emphasized that it is obligatory on the part of the insured to disclose all the material information at the time of taking the policy as it is integral to the decision of granting policy. The Insurance Company is not liable to pay any expenses in case of non-disclosure of material information. Had the proposer disclosed in the proposal forum the health issues of his son and consultations taken from the doctor, this information would have influenced the decision of the insurer, as whether to reject the proposal being high risk or enhance the premium. By such non-disclosure the insurer was deprived of the opportunity to assess the case in totality. I see no reason to interfere with the decision of the Insurance Company. I uphold the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Sh. Fazal Ahmed
Vs
The Star Health & Allied Insurance Company Ltd.

DATE: 02.11.2015

1. The complainant alleged that he was admitted at Max Health Care on 15.03.2015 with complaints of severe shortness of breath with breathing difficulty and chest discomfort. He was diagnosed with Acute LVF (Left Ventricular Failure), Dilated Cardiomyopathy and severe LV dysfunction. The cashless claim was rejected, so he had submitted all the documents for reimbursement of expenses incurred at Max Hospital for the period 15.03.2015-20.03.2015. The claim was rejected by the Company on the ground of non-disclosure/misrepresentation of pre-existing medical condition i.e. pre-existing of Cholelithiasis and Gastritis at the time of taking the policy. He sought the relief for payment of claim and reinstatement of cancelled policy without any break.
2. The Insurance Company vide Self Contained Note dated 28.08.2015 received on 17.09.2015 reiterated that the complainant is a policy holder of Family Health Optima Insurance plan for the period 11.12.2014 to 10.12.2015. He had applied for a claim in the first year policy for hospitalization expenses incurred at Max Health Care for the period 15.03.2015 to 20.03.2015. The complainant was diagnosed with Acute LVF, Dilated Cardiomyopathy and severe LV dysfunction. The cashless claim was denied on the account of finding in reports of Echo and ECG which shows severe LV dysfunction and acute LVF which are long standing nature of diseases. Insured had submitted the

documents for reimbursement of claim. As per medical records i.e. OPD card of Rockland Hospital dated 09.04.2012 and gastro duodenoscopy report dated 12.04.2012 it was revealed that insured patient was an alcoholic and a case of Esophaghitis, LA Grade A, hiatus hernia with gastritis which were prior to inception of the policy. Thus claim was rejected as per policy condition no. 08 of the policy which states that "if there is any misrepresentation/non-disclosure of material facts whether by the insured person or any other person acting on his behalf, the Company is not liable to make any payment in respect of any claims."

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing, the complainant stated that he was admitted for chest discomfort for the first time. The proposal form was filled by the agent and he had informed the agent also. The Insurance Company reiterated that claim was rejected due to non-disclosure of material information at the time of taking the policy from 11.12.2014 to 10.12.2015. As per medical records i.e. OPD card of Rockland Hospital dated 09.04.2012 and gastro duodenoscopy report dated 12.04.2012 it was revealed that insured patient was an alcoholic and a case of Esophaghitis, LA Grade A, hiatus hernia with gastritis. This was prior to inception of the policy. Thus the claim was rejected as per policy condition no. 08 of the policy which states that "if there is any misrepresentation/non-disclosure of material facts whether by the insured person or any other person acting on his behalf, the Company is not liable to make any payment in respect of any claims." I find that the proposal form was duly signed by the Insured and he had marked 'NA' against all the questions (question no 1to 4) in the Health History Column of the proposal form. The policy incepted from 11.12.2014. In the instant case as per OPD Card of Rockland Hospital dated 09.04.2012 and gastro duodenoscopy report dated 12.04.2012, the complainant was suffering from Esophaghitis, LA Grade A, hiatus hernia with gastritis which was not disclosed in the proposal form. In the case of Satwant Kaur Sandhu Vs New India Assurance (2009) 8 SCC 316, the Hon'ble Supreme Court emphasized that it is obligatory for the proposer to disclose the material facts at the time of filling the proposal form. The Insurance Company is not liable to pay the expenses in case of non-disclosure of material information. Thus it was a case of non-disclosure. Therefore, I uphold the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Sh. Sham Sunder Behal
Vs
The Star Health & Allied Insurance Company Ltd.

DATE: 28.10.2015

1. The complainant is a policy holder of Senior Citizen Red Carpet Insurance from 2008 onward. He underwent knee replacement surgery at All India Institute of Medical Science on 29.10.2014. He had submitted all the papers for reimbursement of expenses incurred during the hospitalization for the period 29.10.2014 to 12.11.2014. The claim was rejected by the Company on the grounds of non-disclosure of material facts at the time of policy inception.

2. The Insurance Company vide Self Contained Note dated 31.08.2015 reiterated that the complainant had undergone knee replacement surgery on 29.10.2014. The claim was reported in the 7th year of the policy. As per discharge summary of AIIMS Hospital, patient had a history of DM, HTN (was under medication), history of CVA in the year 2002, and underwent angioplasty in the year 2007. As per the consultation records of AIIMS Hospital dated 13.09.2014, insured had complaint of pain in both knee since 20 years. Based on the medical history, the claim was rejected as per the condition no. 7 of the policy which states that "if there is any misrepresentation/non disclosure of material facts whether by the insured person or any other person acting on his behalf, the Company is not liable to make any payment in respect of any claims."

3. I heard both the sides, the complainant as well as the Insurance Company. I find that the claim for knee replacement surgery was rejected by the Company on the grounds of non-disclosure of material information by the complainant at the time of taking the policy in the year November 2007. As per discharge summary of AIIMS Hospital, patient had a history of DM, HTN (was under medication), history of CVA in the year 2002, underwent angioplasty in the year 2007. As per the consultation records of AIIMS Hospital dated 13.09.2014, insured had complaint of pain in both knee since 20 years. Based on the medical history, claim was rejected as per the condition no. 7 of the policy which states that "if there is any misrepresentation/non disclosure of material facts whether by the insured person or any other person acting on his behalf, the Company is not liable to make any payment in respect of any claims." In the case of Satwant Kaur Sandhu Vs New India Assurance (2009) 8 SCC 316, the Hon'ble Supreme Court emphasized that it is obligatory for the proposer to disclose the material facts at the time of filling the proposal form. The Insurance Company is not liable to pay the expenses in case of non-disclosure of material information. This was a case of non-disclosure. Hence the claim was rightly rejected by the Company as per terms and condition of the policy. The policy was cancelled by the Company and premium was refunded. However I find

that the complainant had taken Sr. Citizen Red Carpet Insurance since November 2007. Keeping mind the fact that the policy was in continuous from last 7 years, I direct the Insurance Company to renew the policy with permanent exclusion of Coronary Artery Disease and related complications including co-morbid conditions. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Sh. Ram Dhan Groh
Vs
The Religare Health Insurance Company Ltd.

DATE: 21.12.2015

1. The complainant alleged that the Insurance Company had rejected the claim for expenses incurred at Fortis hospital for treatment of Liver Abscess from 24.05.15 to 02.06.15. The claim was rejected on the grounds of non-disclosure of chronic alcoholic history in the medical examination form at the time of taking the policy. He sought relief of Rs. 2, 59,766/- from this forum.

2. The Insurance Company had informed to the complainant vide letter dated 25.06.15 that the claim was not payable as per clause no. 6.1 of the policy due to non-disclosure of chronic alcoholic history in the medical examination form during the pre-medical checkup at the time of taking the policy. The ICU admission form dated 24.05.15 of the patient revealed that he was chronic alcoholic. In the medical examination form under the heading "personal habits" the complainant had answered "No" against the question "Do you consume alcohol/smoking/tobacco? It was the duty of the insured to make correct disclosures at the time of taking the policy as it has direct bearing the medical underwriting of the Company. Therefore claim was denied due to non-disclosure of material facts as per clause 6.1 of the policy.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant stated that cashless claim was denied by the Insurance Company due to non-disclosure of alcoholic history. The Insurance Company reiterated that the Company had issued an initial authorization letter dated 27.05.5015 for an amount of Rs. 21,000/-, however upon receiving additional documents i.e. ICU admission form dated 24.05.15 it was found that complainant was chronic alcoholic, which was not disclosed at the time of taking the policy, hence cashless request was declined. In the medical examination form under the heading "personal habits" the complainant had answered "No" against the question "Do you consume alcohol/smoking/tobacco? It was

the duty of the insured to make correct disclosures at the time of taking the policy as it has direct bearing on the medical underwriting of the Company. Therefore claim was denied due to non-disclosure of material facts as per clause 6.1 of the policy.

I find from the discharge summary dated 02.06.2015 of Fortis Hospital that the patient was diagnosed with Liver Abscess. The ICU admission sheet dated 24.05.2015 of the patient revealed that he was chronic alcoholic. The complainant had not disclosed the material facts at the time of taking the policy. In the medical examination form dated 24.09.2013 duly signed by the insured, under heading "personal habits", the complainant had answered "No: against the question "Do you consume alcohol/smoking/tobacco?" It was a case of non-disclosure. In the case of Satwant Kaur Sandhu Vs New India Assurance (2009) 8 SCC 316, the Hon'ble Supreme Court emphasized that it is obligatory at the part of the insured to disclose all the material facts at the time of taking the policy. The Insurance Company is not liable to make any payment in case of non-disclosure/misrepresentation of facts by the insured. The claim was rightly rejected by the Company under non-disclosure as per terms and conditions of the policy. Therefore, I uphold the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Ms. Santosh Sharma
Vs
The Star Health and Allied Insurance Company Ltd.

DATE: 21.12.2015

1. The complainant alleged the Insurance Company had rejected the claim on the ground that the heart disease, DM and HTN was not disclosed at the time of filling the proposal form. The complainant had further alleged that fracture has got nothing to do with these diseases. She sought the relief for Rs. 1, 93,919/- from this forum.

2. The Insurance Company reiterated vide Self Contained Note dated 10.11.2015 that the complainant had taken Sr. Citizen Red Carpet Policy for the period 09.03.15 to 08.03.16. The complainant was admitted at Indian Spinal Injuries Centre from 27.05.15 to 30.05.15 for treatment of fracture. As per the submitted documents it was found that patient had history of DM for the past 7-8 years, ischemic heart disease, old IWMI-PTCA with stenting done on 28.11.13. She underwent CAG on 19.01.13 which revealed triple vessel disease. The complainant had not disclosed the medical history at the time of filling the proposal form. Hence the claim was rejected under policy condition no. 7 of the policy i.e. in case of non- disclosure of material facts by the insured. The Company is not liable to make any payment in respect of any claim.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant stated that current claim was for fracture which has no relation to Diabetes and heart disease. The Insurance Company reiterated that patient had history of DM for the past 7-8 years, ischemic heart disease, old IWMI-PTCA with stenting done on 28.11.13. She underwent CAG on 19.01.13 which revealed triple vessel disease. The complainant had not disclosed the medical history at the time of filling the proposal form. Hence the claim was rejected under policy condition no. 7 of the policy i.e. in case of non- disclosure of material facts by the insured.

On perusal of papers on record I find that the complainant had taken Senior Citizen Red Carpet policy for the period 09.03.15 to 08.03.16. The claim arose in the 3rd month of the insurance policy. The patient was hospitalized from 27.05.15 to 30.05.15 at Indian Spinal Injuries Centre with "fracture inter-trochanteric right." The discharge summary revealed that patient was a known case of DM and CAD. The progress notes dated 27.05.15 of Indian Spinal injuries centre clearly mentioned that patient had CAD in 1993 and stenting was also done. The patient had history of DM and was on medication. The pre-operative cardiac assessment form dated 27.05.15 revealed that patient had DM for the past 7-8 years, old IWMI-PTCA on 28.11.2003 and CAG on 19.01.2013 which revealed triple vessel disease. The patient had history of admission from 12.01.2013 to 21.01.2013 for LVF. All these findings confirm that the patient was having heart disease prior to taking the policy. At the time of inception of policy (9.03.15 to 08.03.16) the complainant had not disclosed the medical history in the proposal form.

I find that it is a case of non-disclosure of material facts. In the case of Satwant Kaur Sandhu Vs New India Assurance (2009) 8 SCC 316, the Hon'ble Supreme Court emphasized that it is obligatory at the part of the insured to disclose all the material facts at the time of taking the policy. The Insurance Company is not liable to make any payment in case of non-disclosure/misrepresentation of facts by the insured. The claim was rightly rejected by the Company under non-disclosure as per terms and conditions of the policy. Therefore, I uphold the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. Devender Budhiraja
Vs
The New India Assurance Company Ltd.

DATE: 12.01.2016

1. The complainant alleged that his mother was hospitalized at Max Hospital from 14.07.2014 to 19.07.2014. The Raksha TPA had paid Rs. 25565/- as cashless settlement against total bill for Rs. 88,831/-. The claim was settled as per S.I. of Rs. 1, 00,000/- instead of S.I. of Rs.3, 00,000/-. He sought the relief for Rs. 63,266/- from this forum.

2. The Insurance Company had reviewed the claim and informed to the complainant vide letter dated 04.02.15 that deductions made by TPA were in order. The complainant had not disclosed the long history of Hypertension at the time of enhancement of S.I. The S.I. was increased during the policy period i.e. 08.12.2013-07.12.2014 and claim was lodged in the same year i.e. on 14.07.14, hence the applicable S.I. was Rs. 1, 00,000/-.

3. I heard the complainant, the Insurance Company was absent, and no self contained note was submitted by the Company. During the course of hearing the complainant stated that no terms and condition were given to him. The claim for hospitalization of his mother at Max Hospital was settled on the basis of S.I. of Rs. 1,00,000 instead of Rs. 3,00,000/-. No form/declaration letter was asked to be filled by him at the time of enhancement of S.I. There was no communication from the Company regarding any disclosure to be made at the time of enhancement of S.I.

On perusal of documents placed on record I find that the mediclaim policy for family was taken by the complainant since 08.12.2010 which was renewed subsequently. The S.I. under the policy was enhanced from 1 Lac to 3 Lacs in the policy period 08.12.2013 to 07.12.2014 for the insured person Mrs. Sudershan. A claim arose in the same year i.e. on 14.07.2014 for Mrs. Sudershan at Max Hospital for the period 14.07.2014 to 19.07.2014. The TPA had settled the claim on the basis of previous S.I. i.e. Rs. 1, 00,000/- on the ground that the insured had not disclosed the long history of HTN at the time of enhancement of S.I., hence S.I. applicable was Rs. 1, 00,000/- only.

I find that Insurance Company had enhanced the S.I. without any medical checkup as per the Health Circular no. HO/Health/2013/JBD/ADMN/115 dated 10.09.2013. After introduction of mediclaim 2012 relaxation in enhancement of sum insured under "mediclaim 2012" was allowed under migration from mediclaim 2007 to mediclaim 2012. For over 65 years of age the enhancement of S.I. upto 3 Lacs was allowed without medical examination with only one hospitalization in preceeding 02 years subject to insured person not suffering from HTN, DM or any chronic illness/critical illness. In respect of any increase in S.I. exclusions 4.1, 4.2, 4.3 would apply to the additional S.I. as if a new policy. In the instant case the claim arose in the same year i.e. S.I. was enhanced on 08.12.2013 and claim arose on 14.07.2014 during the policy period. The complainant had long history of HTN prior to enhancement of S.I. As per policy condition i.e. exclusion no. 4.1 the pre-existing disease is covered after 48 months of continuous coverage. Hence enhanced S.I. would be applicable after 48 months of continuous coverage. Therefore I uphold the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. Vikas Jain
Vs
The Religare Health Insurance Company Ltd.
DATE: 06.01.2016

1. The complainant alleged that his wife underwent Laparoscopic Cholecystectomy on 02.06.2015 at RG Urology and Laparoscopy Hospital. He had lodged a claim for reimbursement of hospitalization expenses. The claim was rejected by the Insurance Company on the ground of non-disclosure of HTN and Thyroid at the time of taking the policy.
2. The Insurance Company had informed to the complainant vide letter dated 18.06.15 that the patient had Hypertension and Thyroid since 04 years (since 2011). The pre-existing ailments were not disclosed at the time of taking the policy; hence the claim was rejected under the policy clause Non-disclosure of material facts. The Insurance Company reiterated that as per discharge summary dated 04.06.15 the patient had history of HTN and Thyroid since 4 years (since 2011) and on regular medication for thyroid i.e. on tablet Thyronorm. The insured had not disclosed the correct information in the proposal form. He had answered "No" against the heading "Pre-Existing Disease Details" regarding Hypertension and other disease. Hence claim was rejected due to non-disclosure of material information as per clause 6.1 of the policy terms and conditions.

3. I heard both the sides, the complainant (represented by his brother-in-law) as well as the Insurance Company. During the course of hearing the complainant stated that doctor had wrongly written the history of Thyroid and HTN as 04 years instead of 04 months. The complainant had obtained a certificate from the hospital to the effect that period of Thyroid was wrongly mentioned as 04 years in the discharge summary and corrected discharge summary was provided to the Insurance Company. The Insurance Company reiterated that as per discharge summary dated 04.06.15 the patient had history of HTN and Thyroid since 4 years (since 2011) and on regular medication for thyroid i.e. on

tablet Thyronorm. The insured had not disclosed the correct information in the proposal form. He had answered "No" against the heading "Pre-Existing Disease Details" regarding Hypertension and other disease. Hence claim was rejected due to non-disclosure of material information as per clause 6.1 of the policy terms and conditions.

I find that a certificate dated NIL was issued by Dr. Ramandeep Singh to the effect that "period of thyroid was wrongly mentioned as 04 years in the discharge summary. Kindly correct it to 04 months." Subsequently a new discharge summary with corrected past history of Thyroid as 04 months was provided to the patient which was also unsigned.

A letter dated 26.11.2015 with subsequent reminder dated 28.12.2015 was written to Dr. Ramandeep Singh, RG stone Urology and Laparoscopy Hospital to give the rectified documents on affidavit. The hospital has not responded till date. I therefore do not take cognizance of the unsigned certificates given by the doctor.

I find from the original discharge summary dated 04.06.15 that patient had history of HTN and Thyroid since 04 years (2011) and on regular medication for thyroid i.e. on tablet Thyronorm. The insured had not disclosed the correct information in the proposal form. He had answered "No" against the pre-existing disease details in the proposal form. It was a case of non-disclosure. In the case of Satwant Kaur Sandhu Vs New India Assurance (2009) 8 SCC 316, the Hon'ble Supreme Court emphasized that it is obligatory for the proposer to disclose the material facts at the time of filling the proposal form. The Insurance Company is not liable to pay the expenses in case of non-disclosure of material information. Thus it was a case of non-disclosure. Therefore, I uphold the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. Gurvinder Singh Sawhney
Vs
The National Insurance Company Ltd.

DATE: 12.01.2016

1. The complainant alleged that Insurance Company had not settled the claim for hospitalization of his wife from 24.01.15 to 10.02.15 at Batra Hosptial. The claim was rejected under clause no. 4.1 of the policy. He sought the relief of Rs. 1, 74,000/- from this forum.

2. The Insurance Company reiterated vide its Self Contained Note dated 11.11.2015 that the complainant had taken mediclaim policy on 10.04.2012. The claim was lodged in the 3rd year of the policy for hospitalization at Batra Hospital from 24.01.2015 to 10.02.2015. As per discharge summary the complainant had history of HTN since 2010, diffuse Proliferative Glomerulonephritis since April, 2008. The pre-existing diseases were not disclosed in the proposal form. As per policy clause 4.1 "All the pre-existing diseases are covered after 48 months of continuous coverage of the policy." The claim was lodged in the 3rd year of the policy and the disease was existing prior to policy inception. Hence the claim was rejected.

3. 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 repudiated the claim for hospitalization at Batra Hospital from 24.01.15 to 10.02.15, however the earlier claim filed in March, 2013 was paid by the Company. The Insurance Company reiterated that as per discharge summary the complainant had

history of HTN since 2010, diffuse Proliferative Glomerulonephritis since April, 2008. The pre-existing diseases were not disclosed in the proposal form. As per policy clause 4.1 "All the pre-existing diseases are covered after 48 months of continuous coverage of the policy." The claim was lodged in the 3rd year of the policy and the disease was existing prior to policy inception. Hence the claim was rejected.

I find that the complainant had taken the mediclaim policy from National Insurance Company w.e.f. 10.04.2012. In the proposal form duly signed by the proposer, the insured had mentioned "No" against pre-existing disease column no. 07. The first claim was lodged by the complainant in March, 2013 for admission in Batra Hospital from 10.02.13 to 16.02.13 for treatment of acute Bronchitis, HTN and chest infection as revealed from the discharge summary dated 16.02.13 of Batra Hospital. The claim was paid by the Company after disallowing HTN related expenses. In the first claim expenses related to HTN were deducted as HTN was pre-existing but claim for Bronchitis was paid since as per record bronchitis was not pre-existing and as per policy clause pre-existing diseases are covered after 48 months of continuous coverage. Hence complainant's contention that first claim was settled but second claim was rejected is not justified.

The second claim was lodged for admission at Batra Hospital from 24.01.2015 to 10.02.2015. The Discharge summary revealed that patient had history of HTN since 2010, diffuse Proliferative Glomerulonephritis since April, 2008 which were prior to policy inception. The complainant had not disclosed the pre-existing disease in the proposal form. As per policy clause 4.1 "All the pre-existing diseases are covered after 48 months of continuous coverage of the policy." In the instant case the claim was lodged in the 3rd year of the policy and the diseases were existing prior to the policy inception. Hence the claim was rejected. Therefore, I uphold the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. Manoj Sharma
Vs
The Religare Health Insurance Company Ltd.

DATE: 04.12.2015

1. The complainant alleged that he had ported the Health Policy from ICICI in December, 2013. He had taken the Health Policy from ICICI since 2009. His daughter was hospitalized at Max Super Specialty Hospital from 21.07.15 to 22.07.15 for Adenotonsillectony. The claim was rejected on the ground that patient had seizure disorder before taking the policy and it was not disclosed at the time of taking the policy. He sought the relief of Rs. 1, 30,000/- from this forum.

2. The Insurance Company reiterated vide Self Contained Note dated 27.10.15 that the first claim for hospitalization at Fortis Hospital from 17.06.15 to 20.06.15 for treatment of Amoebiasis was paid by the Company in absence of any document and disclosures regarding the pre-existing disease. The patient was again hospitalized at Max Super Specialty Hospital for treatment of Chronic Sinusitis from 21.07.15 to 22.07.15. At the time of cashless request by the hospital, the Company came to know that the patient had a "previous undisclosed history of seizures since the age of 04 years and she was on Antiepileptic drugs till June 2013." The complainant had not disclosed the past medical history of patient in the proposal form, hence the claim was rejected as per clause 6.1 of the policy i.e. non-disclosure of material facts.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant stated that insurance policy was ported from ICICI Lombard to Religare health Insurance in December, 2013. He had taken the Health Policy from ICICI since 2009. His daughter was on Antiepileptic drugs till June, 2013. He himself had informed the doctor about antiepileptic drugs to the anesthesiast at the time of the operation. The Insurance Company reiterated that complaint had previous history of seizures since the age of 4 years and she was on epileptic drug till June 2013 as revealed from the pre-operative evaluation record dated 04.06.2015. This was not disclosed at the time of policy to Religare Health Policy. Hence the claim was rejected due to non-disclosure/suppression of material facts at the time of taking the policy.

I find that as per the records submitted before the Ombudsman the patient had history of seizure since the age of 04 years. She had multiple episodes of seizures and was on antiepileptic drugs till June 2013 as revealed from the pre-operative evaluation record dated 04.06.2015 of Max Hospital. As per underwriting guidelines of the Company if the complainant had made the disclosure of Epilepsy in the proposal form, the Insurance Company would have declined the proposal at the beginning itself. The complainant had answered "No" against the column of pre-existing disease details in the proposal form for all the family members. It is a case of non-disclosure.
In the case of Satwant Kaur Sandhu Vs New India Assurance (2009) 8 SCC 316, the Hon'ble Supreme Court emphasized that it is obligatory at the part of the insured to disclose all the material facts at the time of taking the policy. The Insurance Company is not liable to make any payment in case of non-disclosure/misrepresentation of facts by the insured. The claim was rightly rejected by the Company under non-disclosure as per terms and conditions of the policy. Therefore, I uphold the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. Krishan Kumar Goyal
Vs
The National Insurance Company Ltd.

DATE: 21.12.2015`

1. The complainant alleged that he preferred a claim for reimbursement of medical expenses incurred on the hospitalization of his son at Max Super Speciality Hospital for surgery being Adenotonsillectomy done on 06.01.2015. The Insurance Company had not remitted the full claimed amount of Rs. 57698/-. The Insurance Company had remitted a sum of Rs. 38000/-+ Rs. 3152/- (Pre and Post Hospitalization). The Insurance Company had disallowed Rs. 7766/- on account of expenses beyond 15 days from the date of hospitalization and Rs. 8780/- as Coblator not payable as per GIPSA package.

2. The Insurance Company had replied to the grievance of the complaint vide letter dated 28.07.15. The Insurance Company reiterated that the complainant had taken Parivar Mediclaim Policy and in the said policy the pre-hospitalization limit was 15 days and post hospitalization limit was 30 days. The bills amounting to Rs. 7766/- were disallowed on the ground that policy covers pre-hospitalization expenses upto 15 days from the date of hospitalization. The cost of Coblator of Rs. 8780/- was not payable as per GIPSA package.

3. 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 disallowed pre-hospitalization expenses beyond 15 days from the date of hospitalization and cost of Coblator. The Insurance Company reiterated that the complainant had taken the Parivar Mediclaim Policy. As per terms and conditions of the policy i.e. clause no. 3.4 medical expenses incurred during period upto 15 days prior to hospitalization will be considered as part of claim. The claim was paid as per GIPSA package. The cost of coblataor was not covered under GIPSA package.

I find from the inpatient bill summary dated 07.01.2015 of Max Health Care that Insurance Company had paid Rs. 38000/- for adenotonsillectomay as per GIPSA package and equipment charges i.e. coblator (Rs. 7500/-) as non payable items were not paid by the Insurance Company. However the details of coverage under GIPSA package were not described in the terms and conditions of the policy. No consent form was filled by the complainant before the surgery regarding maximum amount payable under GIPSA package. The Insurance Company could not prove that GIPSA package was known to the

complainant. Therefore Insurance Company is liable to pay expenses incurred for coblator. **Accordingly an award is passed with the direction to pay Rs. 7500/- towards expenses incurred on coblator.**

In the matter of Smt. Ram Sawari Dubey
Vs
The New India Assurance Company Ltd.

DATE: 14.01.2016

1. The complainant (represented by her son) alleged that she had taken mediclaim policy from New India Assurance Company with S.I. of Rs. 1 Lac since 2001. At the time of renewal in March, 2014 the S.I. was enhanced from 1 Lac to 3 Lac under policy period 15.03.14 to 14.03.15. The complainant was hospitalized at Fortis Hospital from 22.08.14 to 27.08.14. She underwent coronary angiography on 23.08.14 and diagnosed with hypertension, coronary artery disease, double vessel disease and sinus bradycardia. She underwent PTCA stenting. The cashless approval for Rs. 1Lac was given by the TPA and the enhanced S.I. of 3Lacs was not considered by the TPA. He sought relief for balance amount of claim from this forum.

2. The Insurance Company reiterated that the insured had taken the mediclaim policy for the last ten years for the sum insured Rs. 1 Lac only. After introduction of mediclaim 2012 relaxation in enhancement of sum insured under "mediclaim 2012" was allowed under migration from mediclaim 2007 to mediclaim 2012. For over 65 years of age the enhancement of S.I. upto 3 Lacs was allowed without medical examination with only one hospitalization in preceeding 02 years subject to insured person not suffering from HTN, DM or any chronic illness/critical illness. In respect of any increase in S.I. exclusions 4.1, 4.2, 4.3 would apply to the additional S.I. as if a new policy. At the time of renewal in March 2014 the S.I. was enhanced from 1 Lac to 3 Lacs under policy period 15.03.14 to 14.03.15. But in this case as per discharge summary submitted through Fortis Escorts dated 27.08.2014 "the patient is hypertensive." Hence, the TPA M/s E-Meditek had paid only maximum amount of Rs. 1 Lac under the claim.

3. I heard both the sides, the complainant (represented by her son) as well as the Insurance Company. During the course of hearing the complainant stated that mediclaim policy with S.I. of Rs. 1 Lac was running since 2001 from New India Assurance Company Ltd. At the time of renewal in March 2014 the S.I. was enhanced from 1 Lac to 3 Lacs under policy period 15.03.14 to 14.03.15.The claim was settled on the basis of previous S.I. of Rs. 1 Lac only. The complainant had submitted doctor's certificate dated 02.09.14 regarding no correlation between hypertension and coronary artery disease in case of Mrs. Ram Sawari Dubey. The Insurance Company reiterated that insured was hospitalized at Fortis Hospital from 22.08.14 to 27.08.14 and was diagnosed with HTN,

coronary artery disease, double vessel disease, PTCA stent and sinus Brady cardia. At the time of enhancement of S.I. from 1 Lac to 3 Lac the insured had not disclosed that she was hypertensive, hence claim was approved on the basis of previous S.I. of Rs. 1 Lac only.

At the time of enhancement of S.I. from 1 Lac to 3 Lac the Insurance Company had not taken any form from the insured regarding any disclosure/declaration of any pre-existing disease. As per doctor's certificate dated 02.09.14 of Dr. Anil Saxena of Fortis Hospital "Mrs. Ram Sawari Dubey was admitted to the hospital on 22.08.14 with brady cardia (heart rate of 38). Coronary angiography was done on 23.08.14 which revealed double vessel disease for which she underwent PTCA stenting on 28.08.2014. There was no correlation between hypertension and coronary artery disease in her case." The Insurance Company could not show that hypertension was the cause of Brady cardia and CAG. Therefore in my considered view and in view of the doctor's certificate the claim is admissible. **Accordingly an Award is passed with the direction to the Insurance Company to settle the claim as admissible to the complainant.**

In the matter of Sh. Deepak Kumar Bansal
Vs
The New India Assurance Company Ltd.

DATE:20.01.2016

1. The complainant alleged that his son was hospitalized at Saroj Super Specialty Hospital on 20.08.2015 for the treatment of acute intestinal obstruction-Meckels Diverticulum with Gangrenous ileum. The Insurance Company had approved cashless settlement on the basis of S.I. of Rs. 2 Lacs instead of S.I. of 3Lacs. The TPA had categorized the said illness as internal congenital disorders and as per policy condition no. 4.4.6.2 the congenital disorders are covered only after 48 months from the date of first policy. He sought relief for balance amount of claim from this forum.

2. The Insurance Company vide self contained note dated 26.11.2015 reiterated that the complainant had taken mediclaim policy from 16.12.11 to 15.12.12 with S.I. of Rs. 2 Lacs for his son Mr. Sahil Bansal. The S.I. was enhanced under policy period (16.12.14-15.12.15) from Rs. 2 Lacs to Rs. 3 Lacs and claim was filed in the same year hence the applicable S.I. was Rs. 2 Lacs. The complainant's son had acute intestinal obstruction-Meckels Diverticulum with Gangrenous ileum which was an internal congenital disorder. The TPA had allowed Rs. 1, 21,854/- from the total bill of Rs. 1, 41,263/- and disallowed the balance amount considering the S.I. Rs. 2 Lacs. As per clause no. 3.1 of the policy the entitlement for room rent was 1% of S.I. i.e.

Rs. 2, 00,000/- and all other charges have been deducted in proportion to the difference in room rent entitled category as per policy.

3. I heard both the sides, the complainant (represented by his brother) as well as the Insurance Company. During the course of hearing the complainant stated that master Sahil Bansal was hospitalized on 20.08.2015 at Saroj Hospital and underwent treatment for Gangrenous Meckel's with Gangrenous ileum. The Insurance Company had paid the claim on the basis of S.I. of Rs. 2Lacs instead of enhanced S.I. of Rs. 3 Lacs.
The Insurance Company had considered the disease as congenital disorder whereas the hospital had not mentioned on any document that disease was congenital. The Insurance Company reiterated that acute intestinal obstruction-Meckels Diverticulum with Gangrenous ileum falls under congenital internal disorder (Sl No 194-list of congenital disorder Health Manual). As per clause 4.4.6.2 "congenital disorder/anomalies are covered under the scope of cover of policy only after 24 months of continuous coverage". Thus the enhanced S.I. was not applicable.

On perusal of papers on record I find that SI was enhanced from 2 Lacs to 3 Lacs during the policy period 16.12.2014-15.12.15 under policy no. 31060034142500002305. The claim arose on 20.08.2015. The Insurance Company had settled the claim on the basis of earlier S.I. i.e. S.I. of 2 Lacs on the ground that -Meckels Diverticulum was a congenital disease and enhanced S.I. would be applicable after 24 months of continuous coverage. Although the discharge summary dated 28.08.2015 of Saroj Hospital does not mention that Meckels Diverticulum is a congenital disorder. As per medical literature "A Meckel's Diverticulum, a true congenital diverticulum is a slight bulge in the small intestine present at birth and a vestigial remnant of the omphalomesenteric duct resulting from the incomplete closure of the yolk stalk." In view of the above mentioned fact, I uphold the decision of the Insurance Company that the disease was a congenital disorder falling under clause 4.4.6.2 and enhanced S.I. covered only after 24 months of continuous coverage. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Sh. Anurag Chhiller
Vs
The Max Bupa Health Insurance Company Ltd.

DATE: 13.01.2016

1. The complainant alleged that he had taken a Health Policy (Family First Gold) from Max Bupa Health Insurance Company on 08.06.2015. His wife was hospitalized at Max Bupa Health Insurance Company from 14.06.2015 to 16.06.2015 with diagnosis of left tubal ectopic pregnancy. She underwent Laparoscopic Salpingectomy (abortion) on 15.06.2015. The claim was rejected on the grounds that ailment was pre-existing.

2. The Insurance Company reiterated that the discharge summary and documents submitted by the insured revealed that symptoms of the treated ailment existed prior to policy inception. The policy was taken from 08.06.2015. As per discharge summary patient has been symptomatic since 01.06.2015 which was prior to policy inception; however the same was not disclosed at the time of filling the proposal form. The insured had not disclosed the material facts at the time of taking the policy. Hence, the claim was repudiated under clause "Non disclosure" of material facts.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant stated that there was an emergency condition. She was diagnosed ectopic pregnancy which was life threatening, so doctor immediately admitted her and she was operated. Ectopic pregnancy was not known to them earlier at the time of taking insurance.

The Insurance Company reiterated that the discharge summary and documents submitted by the insured revealed that symptoms of the treated ailment existed prior to policy inception. The policy was taken from 08.06.2015. As per discharge summary patient has been symptomatic since 01.06.2015 which was prior to policy inception; however the same was not disclosed at the time of filling the proposal form. The insured had not

disclosed the material facts at the time of taking the policy. Hence, the claim was repudiated under clause "Non disclosure" of material facts.

On perusal of papers on record, I find that patient was diagnosed ectopic pregnancy on 14.06.2015 as revealed from the discharge summary dated 16.06.2015 of Max Hospital, ectopic pregnancy was life threatening; hence patient was operated immediately in an emergency condition. I find that insurance policy was taken on 08.06.2015. The ectopic pregnancy was not known at the time of taking the policy. Hence the claim is admissible. **Accordingly an Award is passed with the direction to the Insurance Company to settle the claim as admissible to the complainant.**

In the matter of Sh. Jatin Dhawan

Vs

The Max Bupa Health Insurance Company Ltd.

DATE: 21.01.2016

1. The complainant alleged that his father had taken Health policy from Max Bupa Health Insurance Company since 2011. A claim was lodged in 2013 for fracture which was paid by the Company. On 11.07.2014 his father had suffered brain hemorrhage and was hospitalized at Holy Family Hospital from 12.07.14 to 13.07.14. His father was shifted to Max Super Specialty Hospital on 13.07.14. The cashless approval was denied. Again his father was shifted to Ram Manohar Lohia Hospital from 21.07.2014 to 09.08.14. The claim was repudiated by the Company on the ground that the patient was suffering from Dementia since 4-5 years and same had not been disclosed at the time of taking the policy.

2. The Insurance Company vide letter dated 27.10.2014 had informed to the complainant that on investigation the case by the Company it was found that patient had history of Dementia since 4-5 years and CVA in 2006 prior to policy inception and the material facts were not disclosed in the proposal form at the time of taking the policy. Hence as per terms and conditions of the policy the claim was repudiated under clause "Non-disclosure" of material facts.

3. 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 rejected the claim on account of history of Dementia since 4-5 years and CVA in 2006 prior to policy inception. He further stated that his father never had CVA. The Dementia was detected only in 2012. The Insurance Company had already passed two claims in the year 2013. He had requested for the indoor case papers to be provided by the Insurance Company. His father passed away in August, 2014 and even after that Insurance Company had sent mail for renewal of policy.

The Insurance Company reiterated that death certificate was provided with the claim documents. The written communication from legal heirs regarding the death of insured was not communicated to the customer care team; hence renewal letter was issued as default reminder by the system. The policy was terminated on the expiry of policy period (16.02.15); the renewal notice was generated as default reminder but no premium was paid by the legal heirs after expiry of policy. The Insurance Company further stated that 02 claims were paid partially, since the duration of dementia was within the policy. However, in the current claims after knowing the duration of dementia since 4-5 years prior to policy inception and CVA in 2006, the claim was rejected on the ground of non-disclosure of material facts.

I find that inception date of mediclaim policy from Max Bupa was 17.02.2011.

Two claims were paid by the Company in the year 2013 for compression fracture and seizure. At that time it came to the knowledge of Insurance Company that insured had history of Dementia hence query was raised by the Company regarding duration of the Dementia in October, 2013. The complainant vide letter dated 23.11.13 addressed to claim department of Max Bupa informed that insured was suffering from Dementia since 2012. The duration of Dementia was within policy period hence question of non-disclosure did not arise and claims were settled. However during current claim the IPD record of Holy Family Hospital dated 12.07.14 revealed that insured had history of Dementia since 4-5 years (prior to policy) and CVA as per pre-operative evaluation record-neurosurgery dated13.07.14 the insured had history of CVA in 2006 which was questionable. However the

emergency paper of Holy Family Hospital revealed that patient had history of Dementia, seizure disorder, respiratory infection and Cerebrovascular accident (CVA). Hence complainant's contention that his father never had CVA is not correct. The complainant had not disclosed the pre-existing ailment in the proposal form. It was a case of non-disclosure.

In the case of Satwant Kaur Sandhu Vs New India Assurance (2009) 8 SCC 316, the Hon'ble Supreme Court emphasized that it is obligatory for the proposer to disclose the material facts at the time of filling the proposal form. The Insurance Company is not liable to pay the expenses in case of non-disclosure of material information. It was a case of non-disclosure. As regards the renewal notice sent by the Insurance Company after the death of the insured it was submitted by the Company that no communication was sent by the legal heirs to the customer care team regarding death of the insured, although the intimation was with the claim department, but claims and customer care were separate departments, hence the renewal notice was generated as default reminder by the system. But on perusal of record I find that no policy was issued after 16.02.15. Therefore, I uphold the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Sh. Krishan Chand Nasa
Vs
The Star Health and Allied Insurance Company Ltd.

DATE: 12.01.2016

1. The complainant alleged that he had taken a senior citizen Red Carpet Insurance Policy from Star Health on 24.04.2013. He was admitted at Janak Puri Super Speciality Hospital on 01.08.2015 with complaints of sudden onset of giddiness with blackening in front of eyes 2 episodes, pain abdomen and chest heaviness. The cashless approval was declined by the Company on the ground of non disclosure of DM, HTN and coronary artery disease at the time of taking the policy. The complainant sought relief of Rs. 45,000/- from this forum.

2. The Insurance Company vide self contained note dated 19.11.2015 reiterated that senior citizen red carpet policy was taken by the insured w.e.f. 24.04.2013. He had preferred a claim during the 3rd year of insurance policy. He was admitted on 01.08.2015 at Janakpuri Super Speciality Hospital and was diagnosed as a case of IHD with old IWMI with sinus brady cardia. On scrutiny of the submitted documents it was found that patient was a known case of DM, HTN and coronary artery disease since 3 years and on regular treatment, presented to cardiology OPD for routine follow up, which was prior to the policy inception. Hence claim was declined on the ground of non-disclosure of material facts under clause no. 07 of the policy. The policy was cancelled and premium was refunded to the insured.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant stated that he had no problem

before the inception of the policy, but the Insurance Company had declined the cashless approval on

the ground of non-disclosure of DM, HTN and coronary artery disease at the time of taking the policy. The Insurance Company reiterated that insured was a known case of DM, HTN and coronary artery disease prior of policy inception which was revealed from the OPD consultation dated 13.03.2014. The complainant did not disclose the previous medical condition at the time of taking the policy; hence claim was declined under policy clause non-disclosure of material facts.

I find that the complainant had taken the mediclaim policy on 24.04.2013 and claim arose in August, 2015 during the 3rd year of the policy. On perusal of papers placed on record I find from the discharge summary dated 01.08.2015 that complainant was a known case of DM, HTN and coronary artery disease since 03 years and was on regular treatment, and was presented to cardiology OPD for routine follow up on 13.03.2014 which was prior to the inception of policy i.e. 24.04.2013. The complainant had not disclosed the past medical history in the proposal form. It was a case of non-disclosure. In the case of Satwant Kaur Sandhu Vs New India Assurance (2009) 8 SCC 316, the Hon'ble Supreme Court emphasized that it is obligatory for the proposer to disclose the material facts at the time of filling the proposal form. The Insurance Company is not liable to pay the expenses in case of non-disclosure of material information. It was a case of non-disclosure. Therefore, I uphold the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Sh. Harish Bhalla
Vs
The New India Assurance Company Ltd.

DATE: 13.01.2016

1. The complainant alleged that he had taken a mediclaim Policy from 26.09.2014 to 25.09.2015. His wife was hospitalized in Sir Ganga Ram Hospital from 30.04.2015 to 05.05.2015 and was diagnosed as a case of UGI Bleed isolated gastric varices. The cashless approval was denied by Raksha TPA. He had filed a claim on reimbursement basis. The claim was rejected by the Company on the ground that the treatment was done for gastric varices i.e. ulcer, hence not payable as per exclusion clause no. 4.3.1 (9). The complainant had submitted a certificate dated 14.08.2015 from treating doctor stating that UGI bleed was due to fundal varices, not due to ulcer. The Insurance Company had again repudiated the claim on the ground of pre-existing disease i.e. patient had history of belching and heart burn since one year i.e. prior to the inception of the policy. The complainant sought relief of Rs. 1, 54,183/- from this forum.

2. The Insurance Company reiterated vide self contained note dated nil that the patient was admitted to Sir Ganga Ram Hospital on 30.04.2015 with complaint of recurrent episodes of hemetemesis and melena, similar history in the past (2 to 3 months back) patient had history of belching and heart burn. Upper GI endoscopy was done on 01.05.2015 which revealed isolated gastric varices with active spurt. Since the patient had a history of belching, heart burn since one year i.e. prior to the inception of the policy. The policy was in running in its first year the claim was repudiated as per clause 4.1 as per the policy terms, which excludes pre-existing ailments from the scope of cover of policy" after 48 months of continuous coverage of policy.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the Insurance Company reiterated that Patient had a history of belching and heart burn. Upper GI endoscopy was done on 01.05.2015 which revealed isolated gastric varices with active spurt. Since the patient had a history of belching and heart burn since one year i.e. prior to the inception of the policy. The policy was running in its first year the claim was repudiated as per clause 4.1 in the policy terms, which excludes pre-existing ailments from the scope of cover of policy" after 48 months of continuous coverage of policy.

I find from the discharge summary dated 05.05.2015 of Sir Ganga Ram Hospital that the patient was diagnosed with isolated gastric varices as revealed from UGI endoscopy dated 01.04.2015 and repeat UGI endoscopy dated 02.05.2015 revealed "fundal gastric varices, no blood in stomach, esophagus showed normal mucosa." Even the panel doctor of the Company Dr. Sanjiv Gupta vide report dated 19.08.2015 stated that UGI bleed was due to isolated fundal varices and not due to gastric ulcer and claim was within the purview of mediclaim policy terms and conditions. Although the patient had history of belching heart burn prior to the policy but current hospitalization was for UGI bleed due to isolated fundal varices and not due to gastric ulcer. Hence, in my considered view the claim is admissible. **Accordingly an Award is passed with the direction to the Insurance Company to settle the claim as admissible to the complainant.**

In the matter of Sh. Sunder Lal Goel
Vs
The New India Assurance Company Ltd.

DATE: 27.01.2016 .

1. The complainant alleged that Insurance Company had paid Rs. 7544/- only out of claimed amount of Rs. 15324/-. The Company had disallowed Rs. 7780/- stating the reason that "Diabetes related expenses are not payable as inconsistent with hospitalization." He sought relief for Rs. 7780/- from this forum.

2. The Insurance Company reiterated that complainant was hospitalized at Sant Parmanand Hospital from 12.06.2015 to 19.06.2015. He was diagnosed Pyrexia, Gastritis and dehydration. The TPA had paid Rs. 62,401/- on cashless basis to the hospital. Later on the insured had applied for reimbursement of Rs. 15,394/- (pre and post hospitalization), out of which Rs. 7544/- was paid and Rs. 7780/- towards expenses related to treatment of Diabetes wire not allowed as it was not consistent with the cause of hospitalization.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant stated that expenses on diabetes treatment taken post-hospitalization were not reimbursed by the Company. The Insurance Company reiterated that total expenses of hospitalization (pre-post) were paid as per terms and conditions of the policy. At the time of hospitalization no treatment was given for Diabetes, hence post hospitalization charges related to Diabetes were not paid.

I find that as per discharge summary of Sant Parmanand Hospital dated 19.06.2015 the patient was diagnosed with enteric fever with gastritis with dehydration. He had no history of Diabetes. The Insurance Company had already paid the hospitalization expenses pre and post expenses excluding post hospitalization expenses related to Diabetes. The Doctor's certificate dated 09.12.15 from the Sant Parmanand Hospital was contradictory to the discharge summary. The discharge summary dated19.06.15 revealed that patient was not a known case of Diabetes; whereas Dr's certificate dated 09.12.15 stated that patient was found to be Diabetic at admission.

I find that there is inconsistency in the Doctor's certificate. The Insurance Company had already paid the claim except expenses related to Diabetes, as it was not consistent with the cause of hospitalization. I uphold the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. N.S. Bhatnagar
Vs
The National Insurance Company Ltd.

DATE: 29.01.2016 .

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1. The complainant alleged that his wife underwent cataract eye surgery on 04.05.2015 at Sukhmai Hospital. The Insurance Company had paid Rs. 16507/- against the claimed amount of Rs. 40,028/- .

2. The Insurance Company reiterated vide self contained note date 22.12.2015 that wife of the complainant was admitted in Sukhmani Hospital on 04.05.15 for cataract surgery. The claim was reimbursed for Rs. 16,507/- as per clause 3.23 (PPN) which means "a network of hospitals which have agreed to a cashless packaged pricing for certain procedures for the insured person. The list is available with the Company/TPA and subject to amendment from time to time. Reimbursement of expenses incurred in PPN for the procedures (as listed under PPN package) shall be subject to the rates applicable to PPN package pricing."

The claim file was reviewed after receipt of Grievance and it was observed that as per registration cum admission form the complainant had mentioned cash against the column "insurance coverage", hence hospital had charged cash payment and claim was settled for Rs. 16507/- (Rs. 15000+ Rs. 1607/- pre and post expenses) as per agreed GIPSA PPN Package by the Sukhmani Hospital.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant stated that in the registration cum admission form he had mentioned cash, instead of cashless therefore Insurance Company had paid Rs. 16507/- on reimbursement basis out of claimed amount of Rs. 40,028/-.

The Insurance Company reiterated that in the registration cum admission form the complainant did not mention whether he was covered by the mediclaim insurance or not, he had mentioned cash in the column "insurance coverage", hence hospital had charged cash payment. The claim was paid as per agreed GIPSA package phaco surgery.

On perusal of papers on record, I find that the complainant had indeed mentioned cash in the column "insurance coverage". The complainant had not applied for cashless facility as confirmed by the Sukhmani Hospital via mail reply dated 09.07.15 to the TPA. The complainant had not informed the hospital of his being covered under mediclaim policy. The complainant had made full payment in cash to the hospital. The claim was reimbursed as per policy clause 3.23 as per rates applicable to PPN package pricing for cataract. The maximum liability limit for cataract surgery under GIPSA package was not mentioned in the policy clause. The policy clause 3.23 stated that (PPN) which mean "a network of hospitals which have agreed to a cashless packaged pricing for certain procedures for the insured person. The list is available with the Company/TPA and subject to amendment from time to time. Reimbursement of expenses incurred in PPN for the procedures (as listed under PPN package) shall be subject to the rates applicable to PPN package pricing."

I find that the complainant was never informed either by the Company/TPA that maximum limit for cataract surgery was Rs. 15000/- (as per agreed GIPSA package by Sukhmani Hospital) and expenses over and above the maximum limit would be borne by the insured. The Insurance Company could not substantiate that pricing list for GIPSA package was provided to the insured with policy. Therefore I direct the Insurance Company to settle the claim. **Accordingly an Award is passed with the direction to the Insurance Company to settle the claim of the complainant.**

In the matter of Mr. Bhim Sen Aggarwal
Vs
The National Insurance Company Ltd.

DATE: 27.01.2016

1. The complainant had submitted all the original documents to the TPA for reimbursement of Rs. 49,252/- towards hospitalization expenses incurred at Saket City Hospital for Treatment of Aortic Dissection from 12.01.2015 to 13.01.2015. The claim was not settled by the Company. He sought relief of Rs. 49,252/- from this forum.

2. The Insurance Company had not submitted any self contained note. The Discharge summary revealed that patient had history of Aortic Dissection - 2002 and have been on conservative medical therapy and follow up since 2002. He was diagnosed HTN, Aortic Dissection since 2002, Extension of Aortic Dissection of Type I (2009), Moderate AR, LVEF 40% CT Aorta 2012, repeat CT Aorta Coronary Angio on 12.01.2015. The patient

was admitted only for investigations which is not payable under clause no. 4.19 of the policy.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant stated that he was admitted for chest discomfort. The claim was not settled by the Company. The Insurance Company reiterated that claim was repudiated because the complainant was admitted for diagnostic and evaluation reasons and as per clause no. 4.19 of policy claim was not payable.

On perusal of the papers on record, I find that complainant was admitted with Retrosternal Discomfort lasting for 10-12 hours. The discharge summary clearly revealed that patient was a known case of HTN and history of aortic dissection 2002. He was on conservative medical therapy and follow up since 2002. The discharge summary was thoroughly evaluated for Aortic Dissection. He underwent repeat 2D Echo, CT Coronary Angio and Aortogram. There was no active line of treatment in the hospital. The patient was admitted for diagnostic and evaluation reasons. As per policy clause no. 4.19 which states "Diagnostic and evaluation purpose where such diagnosis and evaluation can be carried out as outpatient procedure and the condition of the patient does not require hospitalization." The claim was not admissible. Hence, I uphold the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. Atul Sanghi

Vs

The Religare Health Insurance Company Ltd.

DATE: 27.01.2016

1. The complainant alleged that he underwent Lasik surgery on 27.08.2015 at Vision Eye Centre for correction of eye sight (Myopia). The Insurance Company had not settled the claim till date. He sought relief of Rs. 91,952/- from this forum.

2. The Insurance Company reiterated vide self contained note dated 28.12.2015 that the complainant had filed a reimbursement claim for Lasik surgery for both eyes in Vision Eye Centre on 27.08.2015. As per clause 4.3 (a) (i) corrective surgery for refractive error is not payable. The consultation paper dated 03.08.2015 of Vision Eye Centre clearly revealed that patient "wants removal of glasses" and had been using glasses for a long time. Therefore it was a cosmetic and aesthetic surgery, hence falls under exclusion clause 4.3 (a) xii-aesthetic treatment and cosmetic treatment is not covered in the policy.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant agreed that he underwent Lasik surgery for removal of glasses. The Insurance Company reiterated that corrective surgery for refractive error is not covered under the terms and conditions of the policy clause 4.3(a) (i) and S.No.-67 of exclusion annexure "C". I find that as per clause no. 4.3 (a) (i) and 4.3 (a) (xii) of policy terms and conditions the corrective surgery for refractive error was not covered. The complainant agreed that he underwent Lasik for removal of glasses. Hence I uphold the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. Varun Gupta
Vs
The National Insurance Company Ltd.

DATE: 21.01.2016

1. The complainant alleged that he is a mediclaim policy holder with National Insurance since 2008. He had filed a claim for treatment taken at Vinayak Hospital for the period of 13.03.15 to 14.03.15 for Liposuction of Breast with Excision of B/L Lump with plastic repair of Nipple. The claim was rejected by the Company under clause 4.14 i.e. cosmetic surgery is not covered under the policy.

2. The Insurance Company reiterated vide self contained note dated 29.12.15 that Mr. Varun Gupta, 31 years old, male was admitted in Vinayak Hospital from 13.03.15 to 14.03.15 with complaints of Bilateral Gynaecomastia for which he underwent Bilateral Liposuction of Breast with Excision of Bilateral Lump with plastic repair of nipple. The discharge summary did not mention any other complaints like tenderness and pain. The surgery was done primarily for cosmetic reasons. As per technical opinion for gynaecomastia persisting beyond pubertal age, the line of treatment suggested includes hormonal replacement therapy. Hence claim was repudiated under clause 4.14 of National Mediclaim policy which excludes cosmetic, plastic surgery, sex change and hormone replacement.

3. I heard both the sides, the complainant (represented by his brother) as well as the Insurance Company. During the course of hearing the complainant's brother stated that Mr. Varun Gupta underwent surgery for Gynaecomastia, but the claim was rejected by Insurance Company on the ground that surgery was done for cosmetic reasons.

The Insurance Company reiterated that which he underwent Bilateral Liposuction of Breast with Excision of Bilateral Lump with plastic repair of nipple. The discharge summary did not mention any other complaints like tenderness and pain. The surgery was done primarily for cosmetic reasons. Hence claim was repudiated under clause 4.14 of National Mediclaim policy which excludes cosmetic, plastic surgery, sex change and hormone replacement.

I find that the complainant was diagnosed as having suffered from Bilateral Gynaecomastia. He was therefore, operated upon by way of Liposuction with excision and plastic repair of nipple. The discharge summary does not mention that surgery was conducted for the purpose of cosmetic or aesthetic treatment. There is no material on record to show that surgery was done primarily for cosmetic reasons. The Insurance Company contention that "since the discharge summary does not mention any other complaints like tenderness and pain, hence it seems that the surgery was done primarily

for cosmetic reasons" is not convincing and conclusive. As per Doctor's certificate dated 30.04.2015 of Vinayak Hospital it was clearly mentioned that "This is to certify that Mr. Varun Gupta 31 years, male, was operated by me for Bilateral Gynaecomastia. Bilateral Gynaecosmastia is a disease related to hormonal changes excess fat disposition and treat for removal of mammary gland. In this particular patient surgery was not done for Gynaecomastia"

As per medical literature/dictionary "Gynaecomastia is an abnormal enlargement of one or both breast in men. It may be caused by hormonal imbalance due to disturbance in Endocrine System that led to an increase in the ratio of Estrogen/androgens. Conservative management of Gynaecomastia is often appropriate as the condition commonly resolves on its own but if marked, may be corrected surgically for cosmetic or psychological reasons", hence in my considered view surgical removal of excess tissue is required not only for cosmetic reasons but more importantly for psychological reasons too. Hence claim is admissible. **Accordingly an Award is passed with the direction to the Insurance Company to settle the claim of the complainant.**

In the matter of Mr. Mohinder Singh Sahni
Vs
The New India Assurance Company Ltd.

DATE: 19.02.2016

1. The complainant alleged that he was admitted to Max Super Speciality Hospital on 31.08.2015 at 10:07a.m. for treatment of Myelodysplastic Syndrome-RARS and discharged on the same day at 22:01 p.m. He filed a claim for reimbursement of hospitalization expenses amounting to Rs. 74,337/- plus Rs. 1000/- as daily hospital cash benefit. The claim was rejected under clause no. 2.17 of the policy, being less than 24 hours of admission.

2. The Insurance Company vide its self contained note dated 03.02.2016 that the insured was covered under Good Health Mediclaim policy for the period 01.02.15 to 31.01.16. He was admitted in the hospital for myelodysplastic syndrome-PARS. He underwent blood transfusion. There was no other procedure carried out and no other illness identified. He was hospitalized for 12 hours. The claim was rejected as "not payable" under clause 2.17 which specifies minimum period of 24 hours of hospitalization for

eligibility of the claim. Since the blood transfusion was not a day care procedure, hence claim could not be considered under day care procedure too.

3. I heard both the sides, the complainant (represented by his employee) as well as the Insurance Company. During the course of hearing the Insurance Company reiterated that hospitalization was for 12 hours, hence claim was rejected as "not payable" under policy clause 2.17 which specifies the requirement of a minimum period of 24 hours of hospitalization. On perusal of papers on record, I find that mediclaim medical report (MMR) dated 07.09.2015 signed by Doctor Rahul Naithani clearly mentioned at serial no. 17 that hospitalization was required for blood transfusion. In my considered view due to technological advancement 24 hours hospitalization is not required for certain procedure. Hence 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.**

In the matter of Mr. Anuj Kansal
Vs
The Religare Health Insurance Company Ltd.

DATE: 25.02.2016

1. The complainant alleged that his mother Mrs. Madhu Kansal was hospitalized at Max Health Care form 20.09.15 to 25.09.15. She was diagnosed with Dengue Fever with Thrombocytopenia. The claim was rejected on the ground of non-disclosure of hypertension at the time of taking policy. He sought relief of Rs. 30,000/- from this forum.

2. The Insurance Company vide its self contained note dated 02.02.16 reiterated that Ms. Madhu Kansal was hospitalized for dengue fever in Max Super Speciality Hospital. As per the internal assessment sheet of Max Hospital, patient had a history of Hypertension since seven years and was on regular medication for the same. The discharge summary of Pushpanjali Hospital dated 08.02.13 submitted by the complainant himself clearly stated "To continue antihypertensive as before (tenormin - 25mg)". This proves that the patient had hypertension prior to the issuance of policy i.e. prior to (08.11.2013). However these medical conditions and treatment was not disclosed at the time of applying the policy. Hence claim was declined under clause 6.1 of the policy terms and conditions i.e. on ground of non-disclosure of material facts.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of personal hearing the Insurance Company reiterated that complainant had history of HTN, and was on medication prior to issuance of mediclaim policy which was not disclosed at the time of taking the policy. Hence claim was declined under clause 6.1 of policy terms and conditions i.e. non-disclosure of material facts.

On perusal of papers on record, I find that the complainant was admitted for treatment of Dengue fever which is covered under the purview of policy conditions. However the discharge summary of Pushpanjali Hospital dated 08.02.13 revealed that the complainant was on antihypertensive medicines and the claim was rejected by the Insurance Company on grounds of non-disclosure of history of HTN at the time of taking the policy. In my considered view HTN is a life style disease which is controllable with medicines. The Dengue fever has no relation with HTN. Hence Insurance Company is directed to pay the hospitalization expenses for treatment of Dengue fever and reinstate the policy with exclusion of HTN and its co-morbidity with increase of premium if required. **Accordingly an Award is passed with the direction to the Insurance Company to settle the claim of the complainant.**

In the matter of Mr. Rohit Gupta
Vs
The National Insurance Company Ltd.

DATE: 25.02.2016

1. The complainant alleged vide letter dated 11.09.2015 that he had taken a mediclaim policy valid from 30.01.15 to 29.01.16 from National Insurance Company for a S.I. of Rs. 2,00,000/-. He met with an accident on 21.04.15. He was hospitalized at Sant Parmanand Hospital from 21.04.15 to 29.04.15 with diagnosis of Poly Trauma with multiple fractures. The Insurance Company had rejected the claim on the ground that patient was under the influence of alcohol at the time of accident.

2. The Insurance Company reiterated vide letter dated 27.01.2016 that as per the MLC report dated 21.04.15 of Aruna Asaf Ali Government Hospital the patient was under the influence of alcohol at the time of incident. Hence violated the policy clause

no. 4.10 which states that "Expenses incurred on treatment arising out of injury due to abuse of alcohol are not covered."

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of personal hearing the Insurance Company reiterated that insured had violated that policy condition no. 4.10 which states that "Expenses incurred on treatment arising out of injury due to abuse of alcohol are not covered."

I find that the MLC report dated 21.04.2015 of Aruna Asaf Ali Government Hospital revealed "smell of alcohol" only. The Insurance Company could not prove that alcohol content was beyond the permissible limit. The Insurance Company could not submit any cogent reasons for denying the claim. Therefore I direct the Insurance Company to settle the claim as admissible. **Accordingly an Award is passed with the direction to the Insurance Company to settle the claim of the complainant.**

In the matter of Mr. P.K. Malhotra
Vs
The Star Health And Allied Insurance Company Ltd.

DATE: 23.02.2016

1. The complainant alleged that senior citizens Red Carpet Insurance Policy was taken for Mrs. Rekha Sharma by proposer Mr. P.K. Malhotra from Star Health and Allied Insurance on 31.12.2014. She had history of recurrent strokes/HTN which was disclosed at the time of taking the policy. The PED was not endorsed in the policy, so he had requested the Insurance Company vide mail correspondence dated 07.03.2015 and 13.03.15 to endorse the PED in the policy. Mrs. Rekha Sharma was hospitalized at Moolchand from 12.08.15 to 19.08.15 with diagnosis of Epileptics and Aspiration Preunomites. The claim was rejected and subsequently policy was cancelled by the Company on the ground of non-disclosure of PED, Recurrent stroke and HTN. He sought relief of Rs. 3, 95,836/- from this forum.

2. The Insurance Company reiterated vide its self contained note dated 09.02.16 that as per pre-authorization request of Moolchand Hospital, insured patient was a known case of hypertension and recurrent stroke for the past 3-4 years, which was prior to policy inception. At the time of inception of the policy i.e. from 31.12.2014 to 30.12.2015, insured had not disclosed the medical history in the

proposal form. The claim was reported on the Ist year policy period. The PED was not disclosed at the time of filling the proposal form. Hence claim was rejected under clause non-disclosure of material facts.

3. I heard both the sides, the complainant (represented by Mr. Rakesh Sharma) as well as the Insurance Company. During the course of hearing the complainant stated that he had informed the sales manager on 23.01.2015 and also mail was sent on 24.01.2015 for inclusion of PED in the policy schedule. But the claim for hospitalization at Moolchand from 12.08.15 to 19.08.15 was rejected by the Company on the grounds of non-disclosure of PED.

The Insurance Company reiterated that complainant had history of HTN and recurrent stroke prior to policy inception which was not disclosed in the proposal form at the time of taking policy. The modified policy document submitted by the complaint was fabricated. Any change in the policy is made by means of an endorsement. Stroke was an excluded risk which cannot be included in the policy as PED as per underwriting guidelines of the Company.

I find that complainant had taken Health policy w.e.f. 30.12.2014. He had not disclosed history of HTN and recurrent stroke in the proposal form at the time of taking the policy. The complainant had sent mails dated 23.02.2015 and 05.03.2015 to the Sales Manager for inclusion of PED. Subsequently policy was modified to include stroke by the agent which was not stamped and no endorsement No. was mentioned on the modified policy to the Insurance Company, therefore not acceptable. It was a case of non-disclosure. In the case of Satwant Kaur Sandhu Vs New India Assurance (2009) 8 SCC 316, the Hon'ble Supreme Court emphasized that it is obligatory for the proposer to disclose the material facts at the time of filling the proposal form. The Insurance Company is not liable to pay the expenses in case of non-disclosure of material information. Thus it was a case of non-disclosure. Therefore, I uphold the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. Vijay Kumar Malhotra
Vs
The Star Health And Allied Insurance Company Ltd.

DATE: 18.02.2016

1. The complainant had ported mediclaim insurance to Star Health and Allied Insurance Company from 01.03.15 to 29.02.16. Prior to that he was insured with Apollo Munich from 01.03.14 to 28.02.15 and New India Assurance Company from 29.02.12 to

28.02.14. The complainant alleged that his daughter (Bhaavya Malhotra) had undergone Hernia operation on 25.05.2015 at St. Stephen Hospital. The claim was rejected by Star Health and Allied Insurance Company on the ground that disease was prior to porting the policy and same had not been disclosed at the time of taking the policy.

2. The Insurance Company vide self contained note dated 09.02.16 reiterated that insured had taken mediclaim policy from Star Health w.e.f. 01.03.15 under portability. The insured had not disclosed PED in the proposal form and portability form; hence policy was issued without incorporating PED. The complainant had reported a claim for treatment of Hernia at St. Stephen Hospital. As per the findings of Ultra Sound report dated 13.12.2014, patient had possibility of right inguinal Hernia which was prior to policy inception from Star Health. The insured had not disclosed the material information in the proposal form/portability form. Hence claim was rejected under clause no. 08 "Non-disclosure of material facts."

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant stated that his mediclaim policy was running since 29.02.2012 which was ported to Apollo Munich and then to Star Health on 01.03.2015. At the time of taking the insurance from Star Health, agent was informed about the existing ailment i.e. Hernia and agent assured him that everything would be covered under the policy.

The Insurance Company reiterated that treatment of Hernia was taken on 13.12.12014 prior to policy issuance (09.03.2015). The complainant had not disclosed the material information in the portability/proposal form hence claim was rejected under policy clause no. 08 "Non-disclosure of material facts."

On perusal of the claim papers on record, I find that the complainant had taken the mediclaim policy from Star Health w.e.f. 01.03.2015 under portability. The complainant's daughter had undergone Hernia operation on 25.05.2015. The ultra sound report dated 13.12.2014 revealed that patient had possibility of inguinal Hernia which was prior to policy inception from Star health (01.03.2015). The complainant had not disclosed the existing disease in the portability form. In the case of Satwant Kaur Sandhu Vs New India Assurance (2009) 8 SCC 316, the Hon'ble Supreme Court emphasized that it is obligatory for the proposer to disclose the material facts at the time of filling the proposal form. The Insurance Company is not liable to pay the expenses in case of non-disclosure of material information. Thus it was a case of non-disclosure. Therefore, I uphold the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. Bidya Bhushan Prasad
Vs
The New India Assurance Company Ltd.

DATE: 19.02.2016

1. The complainant alleged that his wife was hospitalized at Ortho Point from 05.08.2015 to 06.08.2015. She was diagnosed with inflammatory polyarthritis, osteoporosis, secondary osteoarthritis and hypothyroidism. She had been given I.V. fluid injection in both knees. He had submitted all the documents to the TPA for reimbursement of Rs. 39627/- incurred during hospitalization. But the claim was not settled by TPA. He sought relief of Rs. 39,627/- from this forum.

2. The Insurance Company vide its email dated 11.02.16 informed that insured person (Meera Prasad) is covered under Good Health Mediclaim Policy for the period 01.05.15 to 30.04.16. She was admitted in the hospital for Inflammatory Polyarthritis, Osteoporosis, secondary OA and Hypothyroidism. She underwent Intra-articular injection (Zolendronic Acid) in both knees. Injection Zolendronic Acid is payable under day care for Multiple Myeloma, as an exception. In the instant case there was no other procedure carried out except Intra- articular injection and no other illness treated. Hence, the claim should be repudiated. However, the said case was closed as "No claim" due to non-submission of required documents by the complainant.

3. I heard the Insurance Company. The complainant had submitted his written submission dated 04.02.2016 and requested for decision on merits. The Insurance Company reiterated that additional documents regarding duration of arthritis and break up of bills were sought from the complainant and claim was closed as "No claim" due to non-compliance of submission of additional documents by the insured. The claim was not tenable as the intra- articular injection in knees was not covered under day care procedure.

On perusal of documents placed on record, I find that mediclaim medical report (MMR) dated 26.08.2015 signed by the doctor clearly mentioned that hospitalization was required. The patient was given for I.V. Fluid/Injection. The Insurance Company did not settle the claim and no response was given by the Company to the complainant. This shows the shoddy treatment meted out by Insurance Company. 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.**

In the matter of Mr. Hemant Singhal
Vs
The Religare Health Insurance Company Ltd.

DATE: 10.03.2016

1. The complainant alleged that he was hospitalized from 03.09.2015 to 06.09.2015 and from 23.09.15 to 29.09.15 at Life Line Hospital and at Maharaja Agrasen Hospital respectively. He underwent Angiography with stenting. Both claims were rejected by the Insurance Company on account of Non-disclosure of material facts/pre-existing ailment i.e. Hypertension at the time of taking policy.

2. The Insurance Company vides its Self Contained Note dated 10.02.16 submitted that a health policy was issued to Mr. Hemant Singhal w.e.f 22.08.2014 which was subsequently renewed. The Insurance Company received a cashless request for hospitalization of Mr. Hemant Singhal for acute coronary syndrome on 03.09.2015. The cashless was denied due to pre-existing nature of disease. The complaint filed a reimbursement claim. On scrutiny the documents it was observed that patient himself had given a signed statement declaring that he was suffering from HTN since 4-5 years and was on ayurvedic medication. Hence claim was rejected on the basis of clause 6.1 of the policy terms and conditions i.e. non-disclosure of pre-existing diseases. Subsequently another cashless claim request dated 25.09.2015 was made which was rejected for the same reason on 25.09.2015, since the patient was suffering from HTN, prior to policy inception which was not disclosed at the time to taking the policy.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant stated that he had no history of HTN or Diabetes. The Insurance Company reiterated that complainant was suffering from HTN since 4-5 years and was on ayurvedic medication which was not disclosed in the proposal form. Hence claim was rejected on the grounds of non-disclosure.

   On perusal of the papers on record, I find that the discharge summary dated 29.09.2015 of Maharaja Agrasen Hospital reveals that HTN and Diabetes were diagnosed on 03.09.2015. The self declaration dated 05.09.2015 of the complainant mention "I used to take ayurvedic medicine 4-5 years ago and B.P. was normal." The self declaration does not mean that he was on medication. The hospital treatment does not show any treatment for HTN. The Insurance Company could not show any medical record to prove that he was on medication for HTN prior to policy inception; HTN and Diabetes were diagnosed recently as per records available. Therefore Insurance Company is directed to settle the claim as admissible and reinstate

the policy. **Accordingly an Award is passed with the direction to the Insurance Company to settle the claim as admissible to the complainant.**

In the matter of Mr. Dhinender Sharma
Vs
The New India Assurance Company Ltd.

DATE: 25.02.2016

1. The complainant alleged that he had taken mediclaim policy no. 3104003414280000089 from New India Assurance Company Ltd. w.e.f. 10.11.14 to 09.11.2015. On 17.07.2015 his daughter Dhaani Sharma fell down on the floor and had some tongue injury which was later developed into cyst. She was admitted in Sir Ganga Ram Hospital on 11.08.2015 for the treatment of cyst on tongue. He had submitted all the documents to the TPA for reimbursement of Rs. 42,488/- incurred during hospitalization. But the claim was not settled by TPA. He sought the relief of Rs. 42,488/- from this forum.

2. The Insurance Company had rejected the claim vide letter dated 16.10.15 on the ground that the treatment of cyst falls under two years waiting period. The claim was lodged on 2nd year policy. Hence as per policy terms and conditions of the policy, the claim was repudiated.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of personal hearing the complainant stated that his daughter underwent excision of tongue cyst at Ganga Ram Hospital. The cyst was due to accidental fall of his daughter. The Insurance Company reiterated that the claim was filed in the 2nd year policy. The treatment of cyst falls under 2 years waiting period.

On perusal of claim papers on record, I find that discharge summary shows cyst since 15 days with no history of bleeding/pain over swelling and no mention of fall or reason thereof. The treatment of cyst falls under two year's waiting period as per terms and conditions of the policy. The claim arose on 2nd year policy, hence not admissible as per policy terms and conditions. Therefore, I see no reason to interfere with the decision of

the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. Gurcharan Singh
Vs
The Max Bupa Health Insurance Company Ltd.

DATE: 19.02.2016

1. The complainant alleged that he was hospitalized at Fortis Hospital from 01.08.2015 to 04.08.2015. He was diagnosed with Cirrhosis, (idiopathic) gastritis with GI bleed. The claim was rejected on the grounds that condition for which patient was treated falls under 2 years waiting period. The complainant had further alleged that Insurance Company had cited two different clauses for denial of claim. The Insurance Company had cited clause no. 3C.3 in the denial letter dated 08.12.15 and cited clause no. 4c.3 in the denial letter dated 06.10.15. He sought relief of Rs. 1, 12,128/- from this forum.
2. The Insurance Company vide self contained note dated 10.02.16 reiterated that insured had taken mediclaim policy w.e.f. 24.04.2015. He had reported a claim for hospitalization expenses incurred from 01.08.2015 to 04.08.2015 at Fortis Hospital. The complainant was diagnosed with cirrhosis (idiopathic) and erosive gastritis with GI bleed. As per the discharge summary patient had a past history of Pulmonary KOCH's received ATT for 9 months (5-6 years back) and off and on low BP since 5-6 years. During the said hospitalization the treatment was related to multiple erosions (gastric ulcers) and active ooze/bleed in stomach as per gastroduodenoscopy report. As per clause 3C.3 of the policy terms and conditions there was a waiting period of 24 months for said illness. There was clear non-disclosure of material facts by the insured that he had undergone Pulmonary Koch's treatment for 09 months (5-6 years back) and also that he had been suffering from Low B.P. The complainant had not disclosed the material facts in the proposal form. The claim had been declined as per clause no. 3C.3 of policy terms and conditions.
3. I heard both the sides, the complainant (represented by his Son-in-law) as well as the Insurance Company. During the course of hearing the representative of the complainant

stated that the complainant was suffering from GI bleed and treated for Cirrhosis during hospitalization at Fortis Hospital from 01.08.2015 to 04.08.2015 and subsequently he had consulted to ILBS on 10.08.2015 for further treatment of Cirrhosis. The Insurance Company reiterated that patient had multiple erosions (gastric ulcers) and active ooze/bleed in stomach as per gastroduodenoscopy report dated 01.08.2015 and treated for same. As per policy terms and conditions Gastric and Duodenal ulcers falls under specific waiting of 24 months as per clause 3C.3. Patient had not been treated for

Cirrhosis during hospitalization. The complainant had undergone Pulmonary Koch's treatment (5-6 years back), which was not disclosed at the time of taking policy.On perusal of the papers placed on record, I find that complainant was treated for erosive gastritis and on discharge on 04.08.2015 he was advised for review in Gastro OPD, the cirrhosis was symptomatic during said hospitalization (01.08.15- 04.08.15). Moreover the complainant had not disclosed past history of Pulmonary Koch's at the time of taking policy. In the case of Satwant Kaur Sandhu Vs New India Assurance (2009) 8 SCC 316, the Hon'ble Supreme Court emphasized that it is obligatory for the proposer to disclose the material facts at the time of filling the proposal form. The Insurance Company is not liable to pay the expenses in case of non-disclosure of material information. Thus it was a case of non-disclosure. However the condition (gastric ulcer) for which patient was treated during hospitalization falls under 24 months waiting period. He was treated for gastritis not cirrhosis as per the discharge summary. The cirrhosis was symptomatic. Therefore, I uphold the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. Indraneel Chatterjee
Vs
The New India Assurance Company Ltd.

DATE: 10.03.2016

1. The complainant alleged that he was admitted at Apollo Hospital from 30.10.15 to 01.11.15 with complaint of erectile dysfunction and lower urinary tract symptom. The pre-authorization of cashless hospitalization was rejected on the ground that infertility treatment was excluded under mediclaim policy. He had filed a reimbursement claim later, which was denied on the ground that the hospitalization was mainly for the investigation and evaluation purpose, which was not covered under policy condition no. 4.4.11. He sought the relief of Rs. 74,799/- from this forum.

2. The Insurance Company reiterated vide mail dated 01.03.2016 that the complainant was admitted in the hospital for erectile dysfunction and lower urinary tract symptom. He underwent cystoscopy + pipe test on 30.10.2015. The cashless request was denied on the ground that as policy clause 4.4.6 infertility treatment falls under permanent exclusion. The insured had submitted claim for reimbursement of Rs. 74799/-. On scrutiny the papers it was observed that during hospitalization at Apollo hospital from 30.10.15 to 01.11.15 only investigations were done to diagnose erectile dysfunction and results proved normal. There was no positive existence of any ailment, only medicines were given. No IV Fluid injection was given. No procedure was involved. Hence claim was repudiated under policy exclusion no. 4.4.11 which states "Diagnosis, X-Ray or laboratory examination not consistent with or incidental to the positive

existence and treatment of any ailment, sickness or injury, for which confinement is required at a hospital" are excluded.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant stated that claim was rejected twice on different grounds. The cashless claim was rejected on the ground that infertility treatment falls under policy exclusion clause and reimbursement claim was rejected on the ground that hospitalization was for only investigation and evaluation which is not payable. The Insurance Company reiterated that only investigations were done to diagnose erectile dysfunction and lower urinary tract symptom. Hence claim was rejected on the ground that infertility treatment falls under permanent exclusion as per clause 4.4.6 and hospitalization for diagnosis and evaluation purpose is not covered under policy as per exclusion clause 4.4.11.

On perusal of papers on record, I find that complainant was diagnosed recurrent lower urinary tract symptom with erectile dysfunction. He underwent cystoscopy for diagnostic and therapeutic purpose for recurrent urinary tract symptoms and PIPE test for ruling out any anatomic/vascular or neuro pathology resulting in erectile dysfunction. In PIPE test intra cavernosal injection was given. The discharge summary dated 01.11.15 of Apollo Hospital does not mention any infertility treatment. The patient was treated for lower urinary tract symptom and advised medicines on discharge. Hence Insurance Company contention that complainant was admitted only for investigations to diagnose erectile dysfunction could not be substantiated. There is no mention of infertility treatment, nor is it mentioned the erectile dysfunction results in infertility. 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.**

In the matter of Ms. Seema Gupta
Vs
The Star Health and Allied Insurance Company Ltd.

DATE: 10.03.2016

1. The complainant alleged that her husband late Sh. Ajay Kumar Gupta had taken a mediclaim policy no. P/201311/01/2014/000247 w.e.f. 17.01.2014 to 16.01.12015 from Star Health and Allied Insurance Company Ltd. She further alleged that her husband was admitted in the hospital for the treatment of Liver disease from 02.01.2015 to 21.02.2015. The claim was repudiated by the Insurance Company on grounds of non-disclosure of past medical history. She sought the relief of Rs. 328227/- from this forum.

2. The Insurance Company had repudiated the claim vide letter dated 13.05.2015 on the ground that as per discharge summary of the hospital the insured patient was a case of chronic liver disease-HBV related from 2000 and on treatment with tenofovir till February 2014, which was prior to inception of policy (17.01.2014) hence the claim was rejected by the Insurance Company under clause No. 07 i.e. non-disclosure of past medical history at the time of taking policy.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant stated that chronic liver disease was cured with medicines, hence it was not declared in the proposal form. The Insurance company reiterated that as per discharge summary of the hospital the insured patient was a case of chronic liver disease-HBV related from 2000 and on treatment with "tenofovir" till February 2014, which was prior to inception of policy (17.01.2014) hence the claim was rejected by the Insurance Company under clause No. 07 i.e. non-disclosure of past medical history at the time of taking policy.

On perusal of papers on record I find that discharge summary dated 21.02.2015 of All India Institute of Medical Sciences clearly revealed that patient was a follow up case of CLD HBV related failed interferon treatment in 2000 and on "tenofovir" since February, 2014. The past medical history was not disclosed at the time of taking the policy. In the case of Satwant Kaur Sandhu Vs New India Assurance (2009) 8 SCC 316, the Hon'ble Supreme Court emphasized that it is obligatory for the proposer to disclose the material facts at the time of filling the proposal form. The Insurance Company is not liable to pay the expenses in case of non-disclosure of material information. Thus it was a case of non-disclosure. Therefore, I uphold the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. Vipin Kumar Jain
Vs
The Religare Health Insurance Company Ltd.

DATE: 10.03.2016

1. The complainant alleged that he had taken a mediclaim insurance policy no. 10239702w.e.f. 05.05.2015 to 04.05.2016 from Religare Health Insurance Company Ltd. He further alleged that on 26.10.15 he was admitted in the Hospital for the treatment of Productive cough, difficulty in breathing, swelling in both legs. The Insurance Company had rejected the claim on account of non-disclosure of pre-existing disease (COPD) in the proposal form. He sought the relief of Rs. 47,000/- from this forum.

2. The Insurance Company reiterated vide self contained note dated 23.02.2016 that the complainant was hospitalized from 26.10.15 to 28.10.15 for treatment of acute exacerbation of chronic obstructive pulmonary disease (COPD) with lower respiratory tract infection (LRTI). The discharge summary revealed that complainant was a known case of COPD. As per the statement given by complainant's son on 28.10.2015 during claim verification process, patient was suffering from said illness for past one year. The claim was not payable as per policy clause no. 6.1 i.e. non-disclosure of material facts/pre-existing ailments at the time of proposal." The complainant had a history of COPD prior to policy. Hence the claim was rejected due to non-disclosure/concealment of material information.

3. I heard both the sides, the complainant (represented by his son) as well as the Insurance Company. During the course of hearing the complainant stated that he had taken mediclaim policy since 2008 from National Insurance Company which was ported to Religare Health Insurance Company in 2015. The Insurance Company reiterated that the complainant was a known case of COPD for past one year as per statement given by his son on 28.10.2015 during claim verification process. The complainant had history of COPD prior to policy; hence claim was rejected due to non-disclosure of material facts. I find from the discharge summary dated 28.10.15 of Pentamed Hospital that patient was a known case of COPD. As per the statement dated 28.10.15 duly signed by Mr. Mukul Jain, son of the complainant it was clearly mentioned that his father had swelling in both legs for past one year and he had not disclosed the COPD in the proposal form on the advice of his agent Mr. Ajay Kumar.
In the case of Satwant Kaur Sandhu Vs New India Assurance (2009) 8 SCC 316, the Hon'ble Supreme Court emphasized that it is obligatory for the proposer to disclose the material facts at the time of filling the proposal form. The Insurance Company is not liable to pay the expenses in case of non-disclosure of material information. Thus it was a case of non-disclosure. Therefore, I uphold the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. S.P.S. Chawla

Vs

The New India Assurance Company Ltd.

DATE: 14.03.2016

1. The complainant had taken a standard mediclaim policy with S.I. of Rs. 5, 00,000/- alongwith top up mediclaim policy valid from 06.04.2015 to 05.04.2016 upto S.I. of Rs. 15, 00,000/-. His wife was hospitalized at Fortis Hospital from 31.08.2015 to 05.09.2015 with diagnosis of uterine fibroid. She underwent laparotomy on 01.09.2015. He had preferred a claim for reimbursement of Rs. 5, 58,249/-. The Insurance Company had paid Rs. 1, 05,151/- only. He sought relief for balance amount of Rs. 4, 53,098/- along with interest.

2. The Insurance Company reiterated vide e-mail dated 26.02.2016 that complainant had taken standard mediclaim policy for himself and his family with S.I. of Rs. 5,00,000/- alongwith a top-up mediclaim policy upto S.I. Rs. 15, 00,000/- effective from 06.04.2015. A claim was lodged under standard mediclaim policy No. 323200341525000002 for insured person Mrs. Vandana Chawla. The S.I. under the policy was Rs. 5, 00,000/-, hence room rent eligibility was Rs. 5000/- per days (1% of S.I. Rs. 5, 00,000/-). The patient had taken a room of Rs. 43,000/- per day. Hence claim was settled as per room rent eligibility under the policy and proportionate deductions were made in other charges such as Dr's fee/surgeon fee/investigations etc.

3. I heard both the sides the complainant (represented by Mr. Mohan Kumar Nair) as well as the Insurance Company. During the course of hearing the complainant had stated that Insurance Company had not provided the detailed terms and conditions of policy since beginning and the breakup of expenses to be paid in the event of hospitalization. The Insurance Company stated that all the terms and condition are already endorsed on the policy, which was sent to the complainant and details of admissible expenses were also mentioned on the face of the policy. However, the Insurance Company is directed to provide break-up of claim paid/deductions made by the Insurance Company to the complainant and case to be settled accordingly. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. Rahul Kumar Mahindra
Vs
The Religare Health Insurance Company Ltd.

DATE: 21.03.2016

1. The complainant submitted that on 02.09.15, his mother was admitted in the hospital for the treatment of severe pain and vomiting. He had submitted all the documents to the Insurance Company but his claim was rejected by the Insurance Company. He sought the relief of Rs. 45857/- from this forum.

2. The Insurance Company vide its letter dated 26.10.2015 had rejected the claim on the ground that Investigation and Evaluations are not covered under the policy as per clause 4.3 (a) (i), read with annexure c (71). As per expert medical opinion it was outlined that patient was febrile (without temperature), B.P. was normal and symptoms of pain in abdomen, nausea, vomiting were present since the day of admission only. the patient underwent various evaluations like bone densitometry, KFT, blood sugar, LFT, various X rays, ultra-sound etc. these investigations could either be done on OPD basis or were not required at all given the symptoms. The cost of medicines was just Rs. 2718/-.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant stated that his mother was hospitalized for acute colitis.

   The Insurance Company reiterated that there was no OPD consultation prior to hospitalization patient was febrile (without temperature), B.P. was normal and symptoms of pain in abdomen, nausea, vomiting were present since the day of admission only.
   The patient underwent various evaluations like bone densitometry, KFT, blood sugar, LFT, various X rays, ultra-sound etc. these investigations could either be done on OPD basis or were not required at all given the symptoms.

   On perusal of the papers placed on record I find that patient was diagnosed with acute abdomen pain with lumbago as per discharge summary dated 05.9.15 of Kalra Hospital. The patient underwent various tests during hospitalization period from 02.09.15 to 05.09.15. As per policy clause 4.3 (a) (i) with Annexure c (71) hospitalization for investigations and evaluations are not covered under the policy. However, the patient was admitted to the hospital on the doctors' advice. Hence, I direct the Company to allow hospitalization charges only i.e. expenses incurred on room charges and medicines during hospitalization. **Accordingly an Award is passed with the direction to the Insurance Company to pay room charges and medicines to the complainant.**

In the matter of Mr. Sunil Kumar Bansal
Vs
The Religare Health Insurance Company Ltd.

DATE: 22.03.2016

1. The complainant alleged that on 13.11.2015 his wife Ms. Rekha Sharma was admitted in the hospital for treatment of CSF Rhinorrhea. He had submitted all the documents to the Insurance Company but claim was rejected on the ground of pre-existing disease i.e. DVT which was not disclosed at the time of taking policy.

2. The Insurance Company reiterated vide its self contained note dated 14.03.2016 that Health policy was issued to the complainant w.e.f. 09.10.2015. The complainant's wife was hospitalized for treatment of CSF Rhinorrhea (Nasal discharge) from 13.11.15 to 17.11.15. On investigation by the Company it was found that patient had history of deep vein thrombosis (DVT) since 7 years and was on treatment i.e. Tab Acitrom 4 mg. The Anesthesia record dated 13.11.2015 and certificate issued by Jaipur Golden Hospital clearly mentions that patient was a known case of DVT since 07 years, complainant's statement dated 10.11.2015 also revealed that patient had history of DVT from 10-12 years. MRI report dated 13.08.2007 and OPD treatment sheet dated 28.08.07 also corroborated that patient had history of DVT. Hence claim was rejected under policy clause no. 6.1 i.e. Non disclosure of material facts at the time of taking policy.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant stated that his wife had DVT since 2007 but it was cured with medicine and she was not on medication at the time of taking policy, hence same had not been declared in the proposal form.

The Insurance Company reiterated that as per medical reports placed on records i.e. Anesthesia report dated 13.11.2015, certificate issued by hospital, MRI report dated 13.08.2007, OPD treatment sheet dated 28.08.07 and complainant's statement dated 10.11.2015 all revealed that patient had history of Deep vein thrombosis (DVT) since 2007 and was on treatment-Tab Acitron 4 mg. The material information was not disclosed at the time of taking policy, hence claim was rejected under clause 6.1 i.e. Non-disclosure of material facts.

On perusal of papers paced on record, I find that anesthesia report dated 13.11. 2015 clearly states that patient was a known case of DVT since 2007, was on medication Tab Acitron 4 mg OD, stopped since 10-12 days only. The complainant's statement dated 10.11.2015 given during claim verification by Insurance Company revealed that patient

had history of DVT since 10-12 years. I find that the complainant had not disclosed the previous illness i.e. DVT in the proposal form. It was a case of non-disclosure. In the case of Satwant Kaur Sandhu Vs New India Assurance (2009) 8 SCC 316, the Hon'ble Supreme Court emphasized that it is obligatory for the proposer to disclose the material facts at the time of filling the proposal form. The Insurance Company is not liable to pay the expenses in case of non-disclosure of material information. Thus it was a case of non-disclosure. Therefore, I uphold the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. Inder Jeet Suri
Vs
The Max Bupa Health Insurance Company Ltd.

Date:21.03.2016

1. The complainant alleged that he had taken a Health insurance policy no. 30089255201503 valid from 29.03.15 to 28.03.2016 and during the currency of policy i.e. on 25.09.15 his wife was admitted to the hospital for the treatment of hypotension and decreased urine output. The claim was denied on the ground that disease was pre-existing which was not disclosed in the proposal form. He sought relief of Rs. 2, 13,413/-.

2. The Insurance Company reiterated vide self contained note dated 16.03.2016 that as per discharge summary patient had been suffering from same ailment LUTS since past 04 years and recurrent UTI since 5-6 years which was prior to policy inception (29.03.2012) and was not disclosed at the time of taking the policy. Hence the claim was repudiated under the suppression of the material facts.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant stated that his wife was admitted for treatment of low B.P. and decreased urine output. She was on medication for UTI off and on but she never suffered LUTS.

   The Insurance Company reiterated that insured patient was suffering from LUTS (lower urinary tract symptom) and UTI since 5-6 years prior to policy inception and was on medication off and on, and had not declared the same while taking the policy, hence claim was rejected under suppression/non- disclosure of material facts.

   On perusal of papers on record I find that patient was hospitalized from 25.09.15 to 30.09.15.The discharge summary dated 30.09.15 of Artemis Health Institute clearly revealed that patient had history of LUTS for past 04 years recurrent UTI for three years and was diagnosed Urosepsis, C/s E-coli, HTN, Hyperthyroidism. It was observed from

the hospital record that patient had history of UTI and this previous medical condition was not disclosed at the time of taking policy. It was a case of non-disclosure, therefore claim was declined and policy was also cancelled by the Company. In my considered view, hospitalization charges for room rent can be given. Therefore I direct the Insurance Company to pay the room rent charges for hospitalization and to re-instate the policy with the exclusion of UTI/loading of premium if any. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. Girish Gurnani
Vs
The TATA AIG General Insurance Company Ltd.

DATE: 29.03.2016

1. The complainant alleged that he had taken a motor policy no. 015533142400 w.e.f. 09.08.15 to 08.08.16. He further alleged that on 27.11.15 his car met with an accident and he had submitted estimate through the workshop for repair of his car. He demanded the replacement of parts such as control arm, wish bone, damper, front bumper (repair) and right fender (repair). He also alleged that the Insurance Company only allowed control arm repair, Complainant also demanded the replacement of other parts, which were necessary to repair but the Insurance Company had not responded/allowed.

2. The Insurance Company vide self contained note dated 10.03.2016 reiterated that the disallowed parts were not related to the accident. However, compressor was allowed as a good-will gesture. A claim of Rs. 1, 78,187/- was settled and paid to the credit of M/s Regent Garage Pvt. Ltd. (workshop). The Insured was telephonically informed about the settlement.

3. I heard both the sides, the complainant (represented by his father) as well as the Insurance Company. During the course of hearing the complainant contended that Insurance Company had allowed replacement of control arm, wish bone, damper and repair of right front suspension, but not allowed repair charges for front bumper, right fender and some other parts to be fitted on the left side of the car.

The Insurance Company reiterated that as per claim form submitted by the complainant "An innova hit from the rear side while taking a U-turn leading to busting of left suspension and internal damages." However as per survey report right front suspension was found damaged instead of left front suspension (as narrated in claim form) and damages to right fender and front bumper were not fresh and not in accordance to the cause of accident. As a good will gesture repair of front suspension was allowed and surveyor had assessed the loss to the tune of Rs. 1, 78,187/- excluding the old damages

and damages not related to the cause of accident. I find that Insurance Company had already settled the claim as per policy terms and conditions. The survey report dated 28.01.16 issued by M/s M.S. Uppal & Associates revealed that as per verification of the spot of accident vehicle went over the side pavement which was at left, however damages to suspension were right front side. Thus insured had concealed the facts. But as a good gesture Insurance Company had allowed the repairs of right front suspension also. Therefore I uphold the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Ms. Urmimala Dutt
Vs
The New India Assurance Company Ltd.

DATE: 28.03.2016

1. The complainant had taken a mediclaim policy no. 31150234142500002053 w.e.f. 17.02.15 to 16.02.16 and during the currency of the policy she preferred three claims of Rs. 45,545.18, Rs. 37856.87 and Rs. 39011.68 with the Insurance Company for the treatment of her eyes. She underwent intravitreal injection Lucentis, but claims were rejected on the ground that treatment was neither day care nor hospitalization hence falls beyond the scope of policy conditions.

2. The Insurance Company reiterated that the complainant had taken a mediclaim policy no. 31150234142500002053. The sum insured under the said policy was Rs. 500000/- and insured had accrued Rs. 73750/- as cumulative bonus buffer. The total sum Insured of Rs. 573750/- was available to insured under the said policy. The patient was treated for Choroidal neovascular membrane with right subfoveal SRF with administration of intravitreal injection, lucentis and three claims were lodged for Rs. 45,845 (24.08.15-24.08.15, Rs. 37857/- (09.12.15- 09.12.15) and Rs. 39011/- (17.10.15-17.10.15) respectively. The treatment was neither day care nor hospitalization, as per policy terms and conditions and OPD procedures are excluded from the scope of cover of policy, hence repudiated.

3. I heard both the sides, the complainant (represented by her husband) as well as the Insurance Company. During the course of personal hearing the complainant stated that she underwent Lucentis injection in the hospital under topical anesthesia. All the three claims for the said procedure were rejected by the Company and Grievance Redressal officer did not even bother to reply.

The Insurance Company reiterated that administration of intravitreal injection, lucentis was neither day care procedure nor hospitalization and OPD procedures are excluded from scope of cover as per terms and condition of policy. On perusal of papers placed on record I find that complainant underwent intravitreal Lucentis injection in the hospital under topical anesthesia as revealed from discharge summary of Max Health Care. The certificate dated 10.03.16 signed by treating Dr. Aparna Gupta, consultant vitreo-retina, Max hospital, clearly stated that "The condition suffered by the patient (choroidal Neovascularisation CNVM) is a disease of old age also called Age Related Macular Degeneration, but is likely to present early in young patients with high Myopia" In the instant case condition suffered by the patient falls under "Age Related Macular Degeneration" and there is specific clause (4.4.23) in the policy terms excluding treatment of Age related Macular degeneration. Therefore I uphold the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. Harish Sharma
Vs
The New India Assurance Company Ltd.

DATE: 21.03.2016

1. The complainant alleged that his wife was hospitalized for missed abortion from 31.05.2010 to 01.06.2010 at Narinder Mohan Hospital. She was also evaluated for TB-PCR and chromosomal analysis on 31.05.2010 and results were positive. The Insurance Company had partially settled the claim for Rs. 17226/- only as against claimed amount of Rs. 58610/-. The complainant had followed up regularly for balance amount of claim but the Insurance Company had not paid the expenses related to TB on the ground that "hospitalization was for missed abortion; hence expenses related to TB were not payable."

2. The Insurance Company vide mail dated 21.08.2014 had requested the insured to provide duplicate papers to review the case, since the claim file was not traceable. On the basis of photocopy of claim papers submitted by the complainant, the Insurance Company had reviewed the case and informed to the insured vide mail dated 17.03.2015 that

hospitalization was for missed abortion, hence expenses related to TB were not payable as per policy terms and conditions.

3. I heard both the sides, the complainant as well as the Insurance Company. I find that as per discharge summary of Narinder Mohan Hospital dated 31.05.10 patient was diagnosed with missed abortion but during the period of hospitalization (31.05.10-01.06.2010) patient was also evaluated for PCR-TB and chromosomal analysis of which the results were positive and the patient was treated for the same. It is noticed that the treatment for TB was given while the patient was in hospital. One cannot bifurcate the treatments as payable and non payable. Therefore I direct the Insurance Company to pay balance amount of claim as admissible. **Accordingly an Award is passed with the direction to the Insurance Company to settle the claim as admissible to the complainant.**

In the matter of Sh. Deepak Mathur
Vs
Apollo Munich Health Insurance Company Ltd.

DATE: 05.10.2015

1. The complainant alleged that he was admitted in Medanta Hospital from 17.09.13 to 19.09.2013 and diagnosed as Right Vocal Cord Polyp and procedure surgery was done on 18.09.2013 MLS (Laser assisted) under G.A. He had applied for cashless facility which was denied by the Insurance Company. He had filed all the necessary papers of the claim to the Insurance Company for reimbursement of Rs. 66456/- but the Insurance Company had denied the claim under "two years waiting period"

2. The Insurance Company vide its letter dated 12.10.2013 had rejected the claim under clause 4 (c) of the policy i.e. two years waiting period. The submitted claim is for illness which had a specific two years of waiting period as per the policy. The policy start date was 29.06.12 and claim arose in second year of policy i.e. 29.06.13 to 28.06.14. Hence, the claim is repudiated under section 4 (c) of the policy.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing, the Insurance Company had stated that the claim was rejected under exclusion clause Sec-4 c under "two years waiting period". As per claim papers

submitted by the insured, he was treated for the illness vocal cord polyp which has a specific two years of waiting period. The policy start date is 29.06.2012 and the claim was reported in 2nd year of policy on 17.09.2013. On perusal of the claim papers placed on record, I find that the Insurance Company had rightly rejected the claim under exclusion clause sec 4 (c) i.e. "two years waiting period". As per discharge summary the patient was treated for Right Vocal Cord polyp which is excluded for first 2 years of policy. The claim arose on 17.09.2013 when the policy was in the second year running (29.06.2012 to 28.06.2013 and 29.06.2013 to 28.06.2014), hence as per clause 4 (c) i.e. "two years waiting period" claim is not payable. I see no reason to interfere with the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Sh. Ravi Kumar
Vs
Apollo Munich Health Insurance Company Ltd.

DATE: 08.10.2015

1. The complainant alleged that his mother was admitted in Apollo Hospital Chennai from 09.04.2014 to 17.04.2014 and diagnosed as old Spinal instrumentation –PID L-4-L-5, L-5-S1 Radiculopathy left leg. During hospitalization surgery of Redo Implant Removal Spine + Posterior Decompression L-4 L-%, L-5 S1 Discectomy and Foraminotomy. The cashless facility was denied by the Insurance Company. The Company had closed the claim file as "No Claim" on the ground of non-submission of documents. He had sought the relief of Rs. 2, 30,216/- from this forum.

2. The Insurance Company vide its letter dated 30.04.2015 had rejected the claim on the ground non-disclosure of material facts as the patient Mrs. Asha Devi was a known case of Rheumatoid arthritis since 10 years, coronary artery disease since 2007, Intra-ventricular meningioma since 2007 and a known case of Diabetes Mellitus and Hypertension.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing, the Insurance Company had stated that the claim was rejected under non-disclosure of material facts as the patient Mrs. Asha Devi was a known case of Rheumatoid arthritis since 10 years, coronary artery disease since 2007, Intra-ventricular meningioma since 2007 and a known case of Diabetes Mellitus and Hypertension since 05 years. The said facts about the health condition of insured member were never disclosed to the Insurance Company at the time of application for health insurance coverage which was material to the Insurance Company from under writing perspective.

In view of the suppression of said material facts the policy was also terminated. They had further stated that earlier in discharge summary (DOA 09.04.2014 to DOD 15.04.2014) the history of DM and HTN was given as 05 years but later on it has been changed as 02 years. The policy no. 110100/11001/1000049226 was issued to the insured for the period of 20.10.2009 to 19.10.2010 and further renewed from 20.10.2010 to 19.10.2011 then from 29.10.2011 to 28.10.2013 and then from 29.10.2013 to 28.10.2015. On perusal of claim papers viz. discharge summary, proposal form placed on record, I find that the under proposal form dated 20.10.2009 column No. 6 "medical and life style information" (section A and section B) the disease which she ever suffered from/currently suffering was marked as "N". As per discharge summary of Apollo Hospital (DOA 09.04.2014) the patient Mrs. Asha Devi had a history of diabetes mellitus and hypertension since 05 years which was not disclosed at the time of taking the policy. As per case sheet of the patient, Ms. Asha Devi, provided by Insurance Company Family Health Plan (TPA) Ltd. the past history of the patient was shown DM, HTN since 05-06 years, CAD since 2007, RA since 10 years which was not revealed while taking the policy. The Insurance Company had rightly rejected the claim for non-disclosure of material facts. I see no reason to interfere with the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Smt. Santosh
Vs
Apollo Munich Health Insurance Company Ltd.

DATE: 06.10.2015

1. The complainant alleged that her son was admitted in Tirath Ram Shah Charitable Hospital from 06.12.2014 to 10.12.2014 and diagnosed as allergic bronchitis with chest infection. She had deposited all the necessary papers of the claim to the Insurance Company for reimbursement (Pre-+Post Hospital Expenses) of Rs. 73,656/- but the Insurance Company had not settled the claim so far. She had sought the relief of Rs. 73,656/- from this forum.

2. The Insurance Company vide its letter dated 17.03.2015 had rejected the claim on the grounds of pre-existing condition will not be covered until 36 months of continuous coverage with them, non-disclosure and concealment of material facts and as per submitted documents and case verification report, misrepresentation and discrepancy of the documents is found and case is fraudulent.

3. I heard both the sides, the complainant (represented by her brother) as well as the Insurance Company. During the course of hearing, the Insurance Company had stated that Mr. Arvind the insured person was admitted in Tirath Ram Shah Hospital from 06.12.2014 to 10.12.2014 for the treatment of allergic bronchitis with chest infection. The disease/symptoms of the said

disease were started in the year 2012. As per terms and conditions of the policy any pre-existing condition will not be covered until 36 months of continuous coverage with us. The medical history detail of Bronchitis was also not revealed in the proposal form while taking the policy. Hence the claim was repudiated under Sec-VI A (iii) which states that 36 months waiting period for all pre-existing conditions declared and/or accepted at the time of application and Sec-VII r (ii) i.e. " We may terminated this policy on grounds of misrepresentation, fraud non-disclosure of material facts or non-cooperation by the complainant or any insured person or anyone

action on the complainant behalf or on behalf of an insured person after 30 days of giving a notice and the Company would issue and sent an endorsement in this regard at the address shown in the schedule without refund of any premium. Further as per submitted documents and case verification report, misrepresentation and discrepancy of the documents was found and case was fraudulent. On perusal of the claim papers placed on record, I find that the policy no. 110100/11051/1000331103 was issued to the insured for the period of 08.10.2012 to 07.10.2013 which was further renewed from 01.11.2013 to 31.10.2014 (gap of 24 days) and then from 01.11.2014 to 31.10.2015 with P.NO. 110100/11051/1000331103-02. As per statement given by insured person Mr. Arvind and his father to the Insurance Company that Mr. Arvind was suffering from Asthma since 2012 and was also admitted in the hospital for the said treatment and he could not take the cashless facility as there was no mediclaim policy at that time. In proposal form submitted to the Insurance Company on 08.10.2012 he did not disclose the disease Asthma, Bronchitis or any other lung/respiratory disorder is under column no. 6(ii) i.e. medical and life style information. Further the pre-existing diseases are not covered until 36 months of continuous coverage with the Insurance Company. The disease of Asthma/Bronchitis was first detected in the year of 2012 before inception of the first policy i.e. 08.10.2012. As per investigation arranged/conducted by the Insurance Company it is found that some manipulation in the chemist bills submitted by the insured was found and bills were inflated to get higher amount from the Insurance Company which the complainant could not refute. There are overwriting on chemist's bills Kamal Chemist and cosmetics Sr. No. 11280 dated 05.01.2015 and Sr. No. 11446 dated 03.02.2015 which is on record. So, keeping in view all the above facts, I feel that the Insurance Company had rightly rejected the claim under pre-existing disease/condition (Sec-VI-A iii) under column 6 i.e. medical and life style information. (iii) Non-disclosure and concealment of material facts (Sec-VII r-ii), and misrepresentation and discrepancy of the documents found during investigation (Sec-VII-J). I see no reason to interfere with the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Sh. Gurmeet Singh
Vs
Apollo Munich Health Insurance Company Ltd.

DATE: 06.10.2015

1. The complainant alleged that his daughter was admitted in St. Stephen's Hospital from 12.05.2014 to 14.05.2014 and diagnosed as F/U/C/O Equinocavovarus foot right side. He had submitted all the necessary papers of the claim to the Insurance company for reimbursement of Rs. 31,641/- but the Insurance Company had denied the claim under clause "congenital defect/anomalies". He had sought the relief of Rs. 31641/- from this forum. His daughter was insured earlier with United India Insurance Company since 2004 and in 2012 the policy was taken from Apollo Munich under portability scheme.

2. The Insurance Company vide its letter dated 08.12.2014 had rejected the claim under policy clause 4 e (VI) under category of "congenital defect/anomalies". As per documents submitted the Insured was admitted for treatment of Equinocavovarus Foot right side which falls under category of congenital defect. Evaluation and treatment related to a condition which was present since birth and has been excluded in the policy.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the Insurance Company had stated that claim was rejected under policy clause 4e (VI) i.e. "Congenital defect/anomalies". As per documents submitted the insured was admitted for treatment of "Equinocavovarus Foot Right side" which falls under category of congenital defect/ anomalies. Evaluation and treatment related to a condition which is present since birth has been excluded in the policy." The complainant alleged that his daughter was not suffering from the said disease by birth, but they only came to know later of the disease. On perusal of claim papers placed on record I find that Insurance Company had rejected the claim under clause 4e (VI) i.e. "congenital defect/anomalies".
As per discharge summary the patient was facing difficulty in walking for 06 months and having alleged history of trauma while walking 10 months back. She had injury to great toe, so the patient used to walk with the foot in inwards position and developed the said complaints. The Insurance Company could not produce any medical report/documents to prove that the patient was having the said problem by birth. The Insurance Company could not substantiate their contention with cogent and reliable documents that the disease "Equinocavovarus Foot RT side" which the patient suffered, fell under exclusion clause 4 e (VI) i.e. "congenital defect/anomalies". Hence, I hold that the Insurance Company is liable to settle the claim. **Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant.**

In the matter of Sh. Mani Bhushan Singh
Vs
Apollo Munich Health Insurance Company Ltd.

DATE: 07.10.2015

1. The complainant alleged that he was admitted in Kalra Hospital from 06.02.2015 to 09.02.2015 and diagnosed as acute vertigo and seizure disorder. The cashless facility was denied by the Insurance Company vide its letter dated 09.02.2015. The Insurance Company had denied the claim on the ground of "admission was for Investigation and Evaluation of the ailment only". He had incurred Rs. 64,944/- towards treatment.

2. The Insurance Company vide its letter dated 14.03.2015 had rejected the claim under policy clause no. Sec-4e sub clause-xv of the policy which states that the claim is not payable if the patient was admitted in hospital primarily for Investigation and evaluation purpose of the ailment

3. I heard both the sides the complainant as well as the Insurance Company. During the course of hearing, the Insurance Company had stated that the claim was rejected under policy clause no. Sec-4e sub clause-xv which states that the claim is not payable if the patient was admitted in hospital primarily for investigation and evaluation purpose of the ailment. On perusal of the discharge summary/claim papers placed on record. I find that the patient was admitted in Kalra Hospital SRC NC from 06.02.2015 to 09.02.2015 and diagnosed as acute vertigo and Seizure Disorder with the chief complaints dizziness followed by loss of consciousness. The complainant had alleged that he was hospitalized on the advice of the treating doctor. I find that the Insurance Company had rejected for claim under clause Sec-4e sub-clause - xv which states that the claim is not payable if the patient was admitted in hospital primarily for investigation and evaluation purpose of the ailment. As the complainant was hospitalized only on the advice of the treating doctor and the treatment whether active or evaluation or investigative depends on the doctor. The fact is that he was admitted for 03 days; therefore the expenses incurred on hospitalization by the complainant should be paid. The Insurance Company could not substantiate their contention with cogent and reliable documents that patient was admitted in hospital primarily for investigation and evaluation purpose only and that there was no active line of treatment. The Insurance Company is directed to reimburse hospitalization charges. Investigation and diagnostic expenses are not payable as per terms and conditions of policy. The main treatment was CT scan, ECG, EEG which is investigation and evaluation is not payable. Hence, I hold that the Insurance Company is liable to settle the claim. **Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant.**

In the matter of Sh. Bharat Bhushan Sehgal
Vs
Apollo Munich Health Insurance Company Ltd.

DATE: 21.10.2015

1. The complainant alleged that he was admitted in Fortis Hospital, Gurgoan for the treatment of Femoro-femoral Crossover Graft Operation. The operation was done on 22.05.2014 for the said treatment. The Insurance Company had denied the cashless facility vide their letter dated 20.05.2014. he had submitted all the claim papers to the Insurance Company for reimbursement of Rs. 2,87,485/- but the Company had denied the claim on the ground of "he had not informed the Insurance Company at the time of taking the policy that he had a cancer in 2007". He had sought the relief of R.s 2, 87,485/- from this forum.

2. The Insurance Company vide its letter dated 10.10.14 had rejected the claim on the ground of "the medical history details of Non Hodgkin's Lymphoma, concentric left ventricular hypertrophy. Thickened and calcified aortic value and lymphadenopathy since 2007 is not revealed in the proposal form while taking the policy". Hence the claim is repudiated due to Non-disclosure and concealment of facts under section 5(U) of policy terms and conditions. The policy had also been cancelled vide letter dated 11.07.2014 on the ground of non-disclosure of material facts.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the Insurance Company had stated that the said claim was rejected under section 5(U) i.e. non-disclosure and concealment of material facts. The medical history details of Non Hodgkins Lymphoma, Concentric Left Ventricular Hypertrophy, Thickened and calcified Aortic valve and Lymphadenopathy since 2007 is not revealed in the proposal form while taking the policy. Hence the claim was repudiated due to non-disclosure and concealment of facts under section 5u of policy terms and conditions. The complainant alleged that he was admitted in Fortis Memorial Research Institute, Gurgaon from 20.05.2014 to 27.05.2014 and diagnosed as a case of critical limb ischemic. Femoro-femoral crossover graft was done under GA on 22.05.2014. The claim was denied on the ground that he had not informed the Insurance Company at the time of taking the policy that he was treated for cancer in the year 2007. His policy was also terminated by the Insurance Company on the ground of non-disclosure and concealment of material facts. On perusal of the claim papers placed on record, I find that the complainant Mr. Bharat Bhushan Sehgal was admitted in Fortis Memorial Research Institute, Gurgaon from 20.05.2014 to 27.05.2014 and diagnosed as a case of critical limb ischemia. Femoro-femoral crossover graft was done under GA on 22.05.2014. As per

discharge summary the complainant had a past history of hypertension for 03 years and lymphoma detected in 2007 (8 chemotherapy cycles taken) which was not disclosed by him in the proposal form dated 11.12.2013 under column 06 i.e. "Medical and Life style information" submitted to the Insurance Company. This is non-disclosure and concealment of material facts on the part of the complainant. Hence, I feel that the Insurance Company had rightly rejected the claim on the ground of non-disclosure and concealment of material facts on the part of the insured while taking the policy and terminated the policy under Sec-5U i.e. non-disclosure and concealment of material facts as per the policy terms and conditions. I see no reason to interfere with the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Sh. Pramod Kr. Jain
Vs
Oriental Insurance Company Ltd.

DATE: 21.10.2015

1. The complainant alleged that he was admitted in Maharaja Agrasen Hospital for the period of 24.10.2014 to 26.10.2014 and diagnosed as CAD-ACS. Coronary Angiography was done which revealed triple vessel disease for which PTCA+ICS_LAD &Ramos was done successfully. The cashless request was denied by the TPA. He had submitted all the necessary papers of the claim to the TPA/Insurance Company for reimbursement of Rs. 1,98,420/- but the Insurance Company had denied the claim under "two years waiting period" exclusion clause. He had sought the relief of Rs. 1, 98,420/- from this forum.

2. The Insurance Company vide its letter dated 01.12.2014 had rejected the claim under exclusion clause no. 4.2 i.e. "two years waiting period." The patient was diagnosed as CAD-ACS; the date of inception of the policy was 06.05.2013. The history of DM & HTN since 05 months, B.P. at the time of admission 190/94. Since there is a direct relation between HTN and CAD and there is an exclusion of 02 years for the treatment related to DM/HTN, hence the present claim is falling under exclusion and is not payable.

3. I heard both the sides the complainant (represented by his daughter) as well as the Insurance Company. During the course of hearing the Insurance Company had stated that the patient was admitted in Maharaja Agrasen Hospital from 24.10.2014 to 26.10.2014 and diagnosed as a case of CAD-ACS. Angiography was done which revealed triple vessel disease for which PTCA+ICS-LAD and Ramus was done successfully. The claim was rejected under policy exclusion clause 4.2 i.e. two years waiting period clause. The date of inception of the first policy was 06.05.2013 and the claim lodged by

the complainant was in the 2nd year of policy (No. 272900/48/2015/1151 from 06.05.2014 to 05.05.2015). The patient had a history of DM and HTN since 05 months; B.P. at the time of admission was 190/94. Since there is a direct co-relation between HTN and CAD which is excluded under the policy exclusion clause 4.2 Hypertension/
Diabetes and related disorder are excluded for first two years and the claim was reported under second year of policy. On perusal of the claim papers placed on record, I find that the patient was diagnosed as a case of CAD-ACS, Triple Vessel disease and PTCA+ICS-LAD was done which has a direct relation with HTN and CAD. The policy was in 2nd year (06.05.2013 to 05.05.2014 and 06.05.2014 to 05.05.2015). Hypertension/diabetes and related disorder are excluded for first two years under policy clause 4.2. The claim was reported under 2nd year of policy. I feel that the Insurance Company had rightly rejected the claim under policy exclusion clause 4.2 and I see no reason to interfere with the decision of Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. Arun Kumar Sharma
Vs
Oriental Insurance Company Ltd.

DATE: 12.11.2015

1. The complainant alleged that he was admitted in East West Medical Centre from 07.12.14 to 14.12.14 and diagnosed as Enteric fever UTI. He had submitted all the necessary paper of the claim to the TPA M.D. India for reimbursement of the claim amount of Rs. 66086/- but the Insurance Company had not settled the claim so far. He had sought the relief of Rs/ 71,554/- from this forum.

2. The Insurance Company vide its letter dated 09.04.2015 had rejected the claim on the ground that the claim had been submitted with fraudulent papers and reports for seeking reimbursement of a manipulated claim. The claim was repudiated on the basis of investigation done by the TPA and the Medical opinion given by the panel doctor of the Insurance Company that it is a cooked up case for the sake of reimbursement under Mediclaim Benefits. It is well supported with erratic line of treatment, without Medical justification viz. Lab and other relevant investigations and therefore not payable.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing, the Insurance Company had stated that the claim was rejected on the ground that the claim papers were fraudulent it was for seeking reimbursement of a manipulated claim. As per medical opinion of panel doctor Vinod Gandotra and investigation report of M/s Sharp Eye there was no admission of the patient Mr. Arun Kumar Sharma in the hospital. Dr. Hema Kapoor (Incharge of Hospital) had also confirmed the fact vide her certificate dated 09.07.2015 that Mr. Arun Kumar Sharma was "never admitted/treated in OPD in their hospital East West Medical Centre and all the documents submitted by the patient are fabricated."

On perusal of all the claim papers placed on record, I find that as per discharge summary the patient was admitted in East West Medical Centre from 07.12.2014 to 14.12.2014 diagnosed with enteric fever UTI and treated conservatively. As per investigation report and medical opinion submitted by the Insurance Company it is revealed that the said claim had been submitted by the insured with fraudulent papers and reports for seeking reimbursement of a manipulated claim. During the investigation also the Dr. Hema Kapoor (Incharge of hospital) had submitted that it was a fraud case and certified the same. I find that the Dr. Hema Kapoor (Incharge of hospital) has also given a certificate dated 09.07.2015 that the patient Mr. Arun Kumar Sharma was never admitted/ treated in OPD in their hospital and all the documents submitted by the patient were fabricated. Hence, keeping in view all the above facts, I hold that the Insurance Company had rightly rejected the claim on the ground that the claim had been submitted

with fraudulent papers for seeking reimbursement of a manipulated claim. I see no reason to interfere with the decision of Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. Jagjot Singh Sodhi
Vs
Oriental Insurance Company Ltd.

DATE: 09.11.2015

1. The complainant alleged that his mother was admitted in Mujlibhai Patel Urological Hospital from 04.11.14 to 07.11.14 and diagnosed as Left Renal Calculi. He had submitted all the necessary paper of the claim to the TPA Good Health TPA Services Ltd. for reimbursement of the claim amount of Rs. 1,09,800/- but the Insurance Company had denied the claim under clause no. 4.3 of the policy citing the reason that the claim was in the 2nd year of the policy. He was insured under the mediclaim policy Happy Floater Family with his parents as dependents since last 04 years (01.04.2011 to 17.04.2015). He had sought the relief balance amount of Rs. 1, 09,800/- from this forum.

2. The Insurance Company vide its self contained note dated 05.06.2015 had reiterated that the claim was rejected under exclusion clause no. 4.3 of the policy i.e. "two years waiting period clause". As per record the patient had policies since 2013 (policy period 18.04.13 to 17.04.14 and 18.04.14 to 17.04.15) i.e. the policy is in 2nd year. Copies of the previous year's policies (01.04.2011 to 31.03.2012 and 01.04.2012 to 31.03.2013) were not submitted by the insured. There was also a gap of 17 days between corporate policy and Happy Family Floater Policy and the gap was not condoned, because of which gap the benefit of continuation cannot be given from corporate policy to floater policy.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing, the Insurance Company had stated that the insured was suffering from Renal Calculi (Left). The disease renal calculus is not covered for the first two years of the policy exclusion clause 4.3. The complainant alleged that he had a mediclaim policy from the Oriental Insurance Company since 04 years and details are as under:

1. Policy number: 154400/46/11/8500000092 from 01.04.2011 to 31.03.2012
2. Policy number: 311800/48/2013/00073 from 01.04.2012 to 31.03.2013
3. Policy number: 311202/48/2014/194 from 18.04.2013 to 17.04.2014
4. Policy number: 272500/48/2015/274 from 18.04.2014 to 17.04.2015

He further stated that there was a gap of 17 days in reviewing the policy on 2013-14 (01.04.2012 to 31.03.2013 and 18.04.2013 to 17.04.2014). A grace period of 30 days in renewal of policy is provided in Health Regulation 2013. Had the delay of 17 days been

condoned by the Insurance Company his policy would have been in continuation since 01.04.2011 and the policy exclusion clause 4.3 "two year waiting period" would not have been applicable in his case. On perusal of the claim papers placed on record. I find that the insured was covered under mediclaim policy continuously since 01.04.2011 which was further renewed timely except in the year 2013-14. There was a gap of 17 days in renewal of the policy in 2013-14 (01.04.12 to 31.03.13) (18.04.2013 to 17.04.2014). As per Health Regulation 2013 a grace period of 30 days is given on renewal of the policy and the Insurance Company can suo motto condone the delay of 30 days but the Insurance Company failed to do so. Hence, I condone the delay of 17 days and restore the continuity benefits of the policy to 01.04.13-17.04.14 and direct the Insurance Company to settle the claim on its merits as clause 4.3 would not be applicable in the instant case of renal calculus. **Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant.**

In the matter of Ms. Manju Gupta
Vs
Bajaj Allianz General Insurance Company Ltd.

DATE: 30.11.2015

1. The complainant alleged she had filled up the proposal form no. 608/14 of Bajaj Allianz at the time of taking the Insurance Policy and furnished all material information required by them relating to her ill illness/disease/ailment up to the date of the proposal. She had not suppressed any material facts. But the Company had rejected her claim on the ground of "Non-disclosure of material information". She had sought the relief of Rs. 8.5 Lacs from this forum.

2. The Insurance Company vide its letter dated 23.01.2013 had rejected the claim on the ground that the ailment for which the patient was treated was "pre-existing" and was not payable under policy exclusion clause 2.4 and 2.4.12. The said exclusion states that any medical condition or complication arising from it which existed before the commencement of the policy period, or for which care, treatment or advice was sought, recommended by or received from a physician. Hence, the claim stands repudiated for "non-disclosure of material information" and/or under exclusion clauses as mentioned above. Earlier the complainant had filed the complaint before this office of the Insurance Ombudsman for Rs. 35 Lacs which was beyond the powers of Hon'ble Ombudsman. Now the complainant had filed the fresh complaint reducing the amount to Rs. 8.5 Lacs as she had requested the hospital for a massive discount and she had agreed for compensation of USD 13420 (approx. Rs. 8.5 Lacs)

3. I heard both the sides, the complainant (represented by her husband) as well as the Insurance Company. During the course of hearing, the Insurance Company had stated that the said claim was rejected under exclusion clause No. 2.4 and 2.4.12 of Travel Elite Gold policy. As per the medical record of West Hills Hospital the patient Mrs. Manju Gupta, Age 60 years was hospitalized from 03.10.2012 to 07.10.2012 and diagnosed with transient ischemic attack,

cerebro-vascular accidents (CVA) and hypertension. The primary diagnosis was TIA (Transient Ischemic attack) /CVA

(cerebro-vascular accidents) with other co-morbidity of hypertension. Strokes are strongly associated with hypertension mainly because hypertension is strongly associated with atheromatous deposits blocking or narrowing brain arteries, predisposing to local clot formation. This in itself mentions direct relation of CVA with hypertension. The complainant was on medication for hypertension in India as well. Hence, the present ailment was pre-existing in nature as the major complication of ailment existed before policy inception date. Hence, expenses are attributable to, arising from out of, traceable to and a complication of pre-existing disease (hypertension) thus not payable under policy exclusion clause 2.4 and 2.4.12 which states "the Company shall be under no liability to make payment hereunder in respect of any claim directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following: any medical condition or complication arising from it which existed before the commencement of the policy period, or for which care, treatment or advice was sought, recommended by or received from a Physician."

On perusal of claim papers placed on record, I find that the insured Mrs. Manju Gupta had taken a Travel Elite Gold Policy from 06.07.2012 to 02.11.2012 vide policy no.OG-13-1101-9910-00008405 from Bajaj Allianz General Insurance Company Ltd. The complainant was admitted in West Hills hospital when she was abroad from 03.10.2012 to 07.10.2012 with chief complaints of Headache, tingling in left arm with numbness, slurred speech and swelling in lip. She was diagnosed with Transient ischemic attack, cerebro-vasculer accident (CVA) with other co-morbidity of hypertension and treated for the same. As per discharge summary she had a past history of hypertension. Hence, claim falls under pre-existing disease/clause which is excluded under the Travel Elite Gold policy exclusion clause no. 2.4 and 2.4.12 which states "the Company shall be under no liability to make payment hereunder in respect of any claim directly or indirectly caused by, based on, arising out of or howsoever attributable to any of the following: any medical condition or complication arising from it which existed before the commencement of the policy period, or for which care, treatment or advice was sought, recommended by or received from a Physician."

Hence, I feel that the Insurance Company had rightly rejected the claim under pre-existing clause. I see no reason to interfere with the decision of Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. Ashok Kr. Sarin
Vs
United India Insurance Company Ltd.

DATE: 21.12.2015.

1. The complainant alleged he was under continuous mediclaim coverage from UIIC since 02.11.1991 without any break. He had lodged 03 claims with UIIC and all of these claims were for complications and disease which were contracted recently and which he had never had in past. Certificate from treating doctor was given to the TPA/Insurance Company but the Insurance Company was adamant on their stand that these

complications were the outcome of the problems which he had in the year 2003 and 2004 whereas since 2003-2004 till 2014 he had not taken a single claim from the Insurance Company. The Insurance Company had taken defense under the policy condition no. 5.12 i.e. S.I. increased during renewal of policy will be restricted for the ailments for which the claim is already taken. He had sought the relief of Rs. 1, 52,875/- from this forum. He had also requested that S.I. for the current year policy 2014 should be considered for settlement of these 03 claims. The S.I under the policy was Rs. 3.5 Lacs for the year 2013-14.

2. The Insurance Company vide its email dated 06.01.2015 had apprised the payment/settlement details of the 03 claims. As per claim papers the insured had history of renal transplantation in 2004 post PTCA 10 years back and HTN since 10 years i.e. 2004. So, the liability of the insurer restricted to the S.I. of Rs. 80,000/- which was in 2003-2004. The TPA had paid two claims either related to the treatment/complications of HTN/Post renal transplantation/Post PTCA and restricted the liability on S.I. Rs. 80,000/- under policy no. 040603/48/03/20/00000949 (02.11.03 to 01.11.04)

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the Insurance Company had stated that as per claim papers, the Insured had a history of renal transplantation in 2004, known case of CAD, PTCA was done 10 years ago and hypertension since 10 years i.e. 2004. The present complaint (Diarrhea, Black Stools etc.) was the side effects of the immunosuppressant, Capsule Neoral which the patient was taking. The said claim was restricted to the sum insured of policy of 2003-04 i.e. Rs. 80,000/-. The S.I. under the said policy was Rs. 80,000/-. The insured had lodged 03 claims under the policy no.040603/48/13/97/00001190, period of insurance 02.11.13 to 01.11.14 sum insured Rs. 3, 50,000/-. The claims were settled on the basis of S.I. available during 2003-04 i.e. Rs. 80,000/-as per policy condition no. 5.12 (enhancement of S.I.) which states "the insured may seek enhancement of sum insured in writing at or before payment of premium for renewal, which may be granted at the discretion of the Company. However, notwithstanding enhancement, for claims arising Hence, payment made to the insured was in order.

On perusal of the claim papers placed on record I find that the patient had a history of renal transplantation in 2004, Post PTCA 10 years back, and hypertension since 10 years i.e. 2004. The S.I. under the policy for 2003-04 was Rs. 80,000/- which was subsequently increased to Rs. 3.5 Lacs in the year 2013-14 (P.No. 40603/48/13/197/00001190) from 02.11.13 to 01.11.14). As per discharge summary of 03 claims submitted by the complainant the history of present illness was hypertension, abdomen pain, history of loose motions and loss of weight, multiple intestinal ulcers with CMV positive and diagnosed as post renal transplant with abdominal pain with diarrhea.

The complainant was prescribed Neoral which as per Wikipedia is an immunosuppressant, used for preventing the rejection of organ transplants (kidney, liver, and heart). The side effects of which are indicated as mild diarrhea; stomach discomfort; persistent diarrhea; severe or persistent headache or dizziness; shortness of breath.

The present complaints as per discharge summary were abdominal pain and diarrhea, difficulty in breathing tightness of the chest which is the side effects of the immunosuppressant's (capsule Neoral). The policy condition clearly state that in case claims arising in respect of ailment, disease or injury contracted or suffered during a preceding policy period, liability of the Company shall be only to the extent of the Sum insured under the policy in force at the time when it was contracted or suffered during the currency of such renewal policy or any subsequent renewal thereof. The claims were restricted to S.I. of 2003-04 i.e. Rs. 80,000/- and were settled accordingly. The third claim (16.08.2014-17.08.2014) was not paid by the Insurance Company as the S.I. of Rs. 80,000/- was exhausted in the 2 claims Rs. 42382/- and Rs. 37618/-. The S.I. of Rs. 3.5 Lacs was increased in the policy year 2013-14 (P. No. 40603/48/13/197/00001190) from 02.11.13 to 01.11.14). As the current illness for which the patient was treated were side effects of the medication taken for the illness for which he had been treated in the year 2003-04, S.I. for that period was considered for settlement of the claim. Although the certificate of Dr. Vinay Jetely dated 04.10.14 states that the present illness has no relation with the renal transplant history, however, the present symptoms were result of side effects of the immunosuppressant Neoral. The fact remains that the liability for pre-existing disease would be restricted to the S.I. of Rs. 80,000/- of 2003-04 which was existing since 2003-04. Hence, I find that the Insurance Company had rightly settled the claims as per S.I. for previous policy (2003-04) i.e. Rs. 80,000/- and I see no reason to interfere with the decision of Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. D.S. Anand
Vs
IFFCO Tokio General Insurance Company Ltd.

DATE: 05.10.2015

1. The complainant alleged that he had taken a travel Health Insurance Policy from IFFCO Tokio for his wife Mrs. Sunita Anand for the period of 04 months. They had gone to Los Angles on 13.06.2014 where his wife fell sick and was taken in emergency on 18.07.2014 to the nearest hospital i.e. Placentia Linda Hospital as she was detected with an E Coli infection after a day's bout of mild fever and vomiting. The infection spread throughout her body and in the process one of her knees got infected. She was operated on 22.07.2014. She stayed in the hospital from 18.07.2014 to 02.08.2014 and was discharged with orders of a follow on treatment with the home –health service. He had lodged a claim of USD 21512.19 with the Insurance Company but the Insurance Company had allowed only a sum of USD 2000 against the claim on the ground that the operation on the knee is a pre-existing ailment and thus disallowed. He sought the relief of USD 19512.19 from this forum.
2. The Insurance Company vide its self contained note dated 21.07.2015 had informed to the insured that the disease/ailment for which the patient was treated should be construed as a complication of pre-existing disease (Bilateral total knee replacement). As per policy (point no. 7) the policy excludes all category of pre-existing disease/ conditions excluding any life saving unforeseen emergency. The maximum benefit allowed in such a case will be upto USD Rs. 2000/-. The claim was settled as per policy terms and conditions.

3. I heard both the sides the complainant (represented by his daughter) as well as the Insurance Company. During the course of hearing, the Insurance Company had stated that Mrs. Sunita Anand, the Insured member had a past history of bilateral total knee replacement 09 months prior to her departure for USA. The Insured Member was hospitalized on 18.07.2014 at Placentia-Linda Hospital for the complaints of fever and chills with Right Knee Pain and diagnosed as a case "Septic Arthritis", this should be construed as a complication of pre-existing condition (Bilateral total knee replacement). As per Travel policy terms and condition No.7 the policy excludes all categories of pre-existing disease/conditions excluding any life saving unforeseen emergency measure or measures solely designed to relieve acute pain provided to the insured. As per terms and conditions of the policy they had paid USD 2000 to the insured. On perusal of the claim papers placed on record. I find that Mrs. Sunita Anand, the insured member had undergone both the knee replacements in October, 2013. She had gone to Los Angeles on 13.06.2014. On 18.07.2014 she was fell

sick and was taken in emergency to the nearest hospital Placentia-Linda hospital as she was detected with an E. coli infection after a day's bout of mild fever and vomiting. The infection spread throughout her body and in the process one of her knees got infected and incision and drainage to the knee was done on 20.07.2014. She was operated on 22.07.2014 revision polyethylene exchange alongwith revision of total knee replacement was done. The said complications of the pre-existing condition where prosthesis got infected and thus polyethylene covering alongwith revision knee replacement was done. Hence, claim falls under pre-existing disease and maximum benefits allowed under policy terms and conditions no. 7 under this head was USD 2000. Hence, the Insurance Company had rightly settled the claim and I see no reason to interfere with the decision of Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. Sandeep Kumar
Vs
Oriental Insurance Company Ltd.

DATE: 12.11.2015

1. The complainant alleged that he was admitted in Sanjeevani Specialty Hospital on 22.08.2014 as he was unconscious. He was discharged on the same day. He paid hospital charges of Rs. 13893/-. At the time of discharge the treating doctor advised him for treatment in Fortis Hospital and accordingly he was admitted there with severe headache and vomiting and giddiness. He had been admitted from 22.08.2014 to 04.09.2014 and diagnosed as "ACOM Aneurysm". He had submitted all the necessary papers of the claim to the TPA M/s Vipul Med. Corp. for reimbursement of Rs. 5, 69,948 but the Company had rejected the claim under two years waiting period clause (4.3) of the policy. He sought the relief of Rs. 5, 69,948/- from this forum.

2. The Insurance Company vide its self contained note dated 13.07.2015 reiterated that the claim was rejected under exclusion clause no. 4.3 i.e. "two year waiting period". The patient was a known case of hypertension for last one month. The insured was covered in first year policy. The present aliment was related to HTN and internal congenital in nature. Hence, claim was not admissible under clause 4.3 for HTN and internal congenital.

3. I heard both the sides, the complainant (represented by his brother) as well as the Insurance Company. During the course of hearing the Insurance Company had stated that the policy issued to the insured was in the first year. The patient was admitted at Fortis Hospital DLH from 22.08.2014 to 04.09.2014 and diagnosed with ACOM Aneurysm. The patient underwent Left peritoneal craniotomy with clipping of ACOM Aneurysm

under G.A. The patient was a known case of hypertension (Recently diagnosed) and this was a risk factor for the above ailment. The policy clause 4.3 (xvii) of Happy Family floater policy described that hypertension and its related complication is excluded for a period of 02 years. Hence, the claim was rejected. On perusal of the claim papers placed on record, I find that the patient was admitted in Fortis Hospital, Shalimar Bagh, New Delhi from 22.08.2014 to 04.09.2014 and diagnosed as case of ACOM Aneurysm and left peritoneal craniotomy with clipping of ACOM aneurysm done under GA on 23.08.2014. As per certificate dated 02.12.2014 issued by Dr. Prem Aggarwal, Sanjeevani Medical Research Centre (P) Ltd. the complainant Mr. Sandeep is a known case of hypertension for last 01 month. The policy issued to the insured was in the first year (P.No.271602/48/2014/3144 from 12.02.2014 to 11.02.2015). The claim arose on 22.08.2014. Hypertension and its related complication are excluded for a period of 2 years under policy clause 4.3 (xvii). Hence, I hold that the Insurance Company had rightly rejected the claim under "two year waiting period clause 4.3 (xvii)" of the policy. I see no reason to interfere with the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. Ashok Goel
Vs
Oriental Insurance Company Ltd.

DATE: 13.10.2015

1. The complainant alleged that he had taken the treatment in Jaipur Golden Hospital on 22.09.2014 as an OPD for infection in stomach. He had submitted all the necessary papers of the claim to the Insurance Company for reimbursement of claim amount of Rs. 22,534/- but the Company had rejected the claim on the ground he had taken a treatment as OPD basis and diagnostic purpose. He sought the relief of Rs. 22,500/- from this forum.

2. The Insurance Company vide its letter dated 26.12.2014 had repudiated the claim under policy terms and conditions no. 4.10, 3.5 and 4.20. As per papers submitted by the Insured TPA observe as per documents patient taken a treatment as OPD basis and diagnostic purpose.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the Insurance Company had stated that the claim was rejected on the ground that the patient had taken a treatment on OPD basis and diagnostic purpose. Hence, the claim was rejected as per policy terms and conditions under clause no. 4.10, 3.5 and 4.20. The complainant alleged that he was treated at Jaipur Golden Hospital from 22.09.2014 to 20.10.14 as an OPD for

infection in stomach and incurred Rs. 23,000/- towards treatment. On perusal of the claim papers placed on record, I find that the patient was not admitted in the hospital. He was treated as an OPD and according to his written submission also, he took the treatment at home. Under policy clause no. 3.5 i.e. "Hospital period which states the period for which an insured person is admitted in the hospital as inpatient and stays there for the sole purpose of receiving the necessary and reasonable treatment for the disease/ailment contracted/injuries sustained during the period of policy. The minimum period of stay shall be 24 hours" and the clause no. 4.10 which states "Expenses incurred at Hospital or Nursing Home primarily for evaluation/ diagnostic purposes which is not followed by active treatment for the ailment during the hospitalized period." The clause no. 4.20 which states "Any treatment required arising from insured's participation in any hazardous activity including but not limited to scuba diving, motor racing, parachuting, hang gliding, rock or mountain climbing etc unless specifically agreed by the Insurance Company is not applicable in the said case. The complainant had not produced the discharge summary for the said period (22.09.14 to 20.10.14) to substantiate that he was admitted in the hospital for the period of treatment taken by him. The complainant could not substantiate his claim with cogent and reliable documents. Hence the Insurance Company had rightly rejected the claim under said policy clauses 3.5 and 4.10 and I see no reason to interfere with the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. Nitin Gupta
Vs
Oriental Insurance Company Ltd.

DATE: 4.11.2015

1. The complainant alleged that he was admitted in Sir Ganga Ram Hospital from 09.01.15 to 14.01.2015 and from 24.01.2015 to 31.01.2015 and diagnosed as "Mediastinal lymphadenopathy/right hilar mass lesion occluding right middle bronchus with right lower lobe intra cavitatory? Mass." He was suffering from right lower chest pain. after discharge from the hospital he had submitted all the necessary papers of the claim to the TPA E-Meditek for reimbursement of claim amount but the claim was closed by the TPAS as "No Claim" on the ground of non-submission of necessary documents. He sought the relief of Rs. 2 Lacs from this forum.

2. The Insurance Company vide its letter dated 28.03.2015 had filed the claim as "No Claim" as the Insured had not completed the formalities/provided the necessary papers of the claim for processing and settlement of claim.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the Insurance Company had stated that the claim was closed as "No claim" due to non-submission of necessary documents by the Insured. They further stated that attested copies of indoor case papers with nursing chart of hospitalization are required to process the claim. Hence, the complainant is hereby directed to provide the medical test reports in support of final diagnosis to the Insurance Company and accordingly the Insurance Company is directed to settle the claim as per policy terms and conditions of the policy on receipt of the said documents. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. Mahendra Sen
Vs
Oriental Insurance Company Ltd.

DATE: 02.12.2015

1. The complainant alleged he had a multiple fracture in his left elbow in the month of August, 2003 and he was operated at Maharaja Agarsen Hospital, Delhi and the bone was put together using implant. He was re-operated in February, 2004, and the wire was removed after elbow bone had healed. However, after almost 10 years in September, 2013 he had pain in his left elbow again and he was operated for the same at Maharaja Agarsen Hospital. He claimed for reimbursement from the Insurance company and the Insurance Company had reimbursed the amount of Rs. 56,525/- and Rs. 51,165/- on 23.11.2013. He further stated that the infection in his left elbow re-occurred after a year 2014 and again hospitalized at Medanta Hospital from 23.09.2014 to 07.10.2014 and operated on 24.09.2014 for Osteomyelitis Distal Humerus with arthritis left elbow and treated to clean up the infection and debris. He had incurred Rs. 1,54,398/- (Rs. 93,823+Rs. 60,575) and submitted all the necessary papers for reimbursement of amount but the Insurance Company had denied the claim under pre-existing condition/ailment (clause 4.1). He had sought the relief of Rs. 1, 54,398/- from this forum.

2. The Insurance Company vide its letter dated 11.12.2014 had repudiated the claim under clause no. 4.1 under pre-existing disease. The patient was a post operative case of left elbow (2004-2013) and a known case of DM/HTN. The present ailment was found to be pre-existing disease as the patient was found to be pre-existing disease as the patient was previously operated in 2004 and also had history of DM/HTN and was falling under exclusion 4.1 of pre-existing disease.

3. I heard both the sides, the complainant as well as the Insurance Company. during the course of hearing the complainant alleged that he had a multiple fracture in his left elbow in the month of August, 2003 and he was operated at Maharaja Agarsen Hospital, Delhi and the bone was put together using implant (a wire) to support pieces of bones. He was then again operated in February, 2004, and the wire was removed after elbow bone had healed. However, after almost 10 years in September, 2013 he had pain in his left elbow again and he was operated for the same at Maharaja Agarsen Hospital. He further stated that the infection in his left elbow re-occurred after a year 2014 and again hospitalized at Medanta hospital from 23.09.2014 to 07.10.2014 and operated on 24.09.2014 for Osteomyelitis Distal Humerus with arthritis left elbow and treated to clean up the infection and debridement. He had submitted all the necessary papers for reimbursement of amount but the Insurance Company had denied the claim under pre-existing

condition/ailment. The Insurance Company had stated that the patient was a post operative case of left elbow (2004-2013) and a known case of DM/HTN. The present ailment was found to be pre-existing disease. The patient was previously operated in 2004 and also had history of DM/HTN. The exclusion clause states 4.1 that any ailment/disease which are pre-existing (treated/untreated, declared/not declared in the proposal form), in case of any of the insured person of the family, when the cover incepts for the first time, are excluded for such insured person up to 03 years of this policy being in force continuously." The first policy inception dated is 21.12.2011 and claim was reported in the 3rd year of policy (21.12.13 to 20.12.14). Hence, the said claim was repudiated. On perusal of the claim papers placed on record, I find that as per discharge summary of Medanta, the Medicity (DOA 23.09.14 DOD 07.10.14) the medical history and present complaints, the patient was a known case of DM, HTN. He was a post operated case of Left elbow (2004&2013), and presented with complaints of pain in left shoulder associated with swelling in left elbow since 01 week from the date of admission i.e. 23.09.14. He had a history of infection in left elbow. Surgery of Arthrotomy left elbow was done on 24.09.14 by Ortho team and Debridement and wound closer left elbow was done on 04.10.14. The present complaint of pain in left shoulder associated with swelling in left elbow was a recurrence of his old ailment for which he was treated earlier in the years 2004 and 2013, hence falls under pre-existing disease clause 4.1 which states that any ailment/disease which are pre-existing (treated/untreated, declared/not declared in the proposal form), in case of any of the insured person of the family, when the cover incepts for the first time, are excluded for such insured person up to 03 years of this policy being in force continuously." As per policy terms and conditions exclusion clause 4.1 three years waiting period is required to cover the pre-existing disease. The first policy inception date was 21.12.11 and the claim falls under policy no. 272900/48/2014/13085 from 21.12.13 to 20.12.14, which is running in 3rd year. Hence Insurance Company had rightly rejected the claim under exclusion clause 4.1 and I see no reason to interfere with the decision of Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. Puneet Manchanda
Vs
Oriental Insurance Company Ltd.

DATE: 12.11.2015

1. The complainant alleged his son was admitted in Fortis Hospital form 10.03.2014 to 11.03.2014 and diagnosed as Left (Palpable) undescended testis. He had submitted all the necessary papers of the claim to the TPA for reimbursement of Rs. 74,733/- but the Insurance Company had repudiated the claim on the ground that the disease for which the patient was treated comes under congenital external and internal disease. He had sought the relief of Rs. 74,733/- from this forum.

2. The Insurance Company vide its letter dated 08.01.2015 had repudiated the claim under exclusion clause no. 4.8 of the policy which states that convalescence, general debility, "run down" condition or rest cure, congenital external and internal diseases or defects or anomalies, sterility any fertility, sub-fertility or assisted. They had further stated that as per medical opinion of their panel doctor undescendent testis" is a congenital external disease and is not covered as per terms and conditions of the policy.

3. I heard both the sides the complainant as well as the Insurance Company. During the course of hearing the complainant alleged that his son Master Rian Manchanda was admitted in Fortis Hospital from 10.03.14 to 11.03.14 and diagnosed as a case of Left (palpable) undescended testis. He underwent left orchidopexy on 10.03.14. The Insurance Company had denied the claim on the ground that the disease for which the patient was treated comes under congenital external and internal disease. The Insurance Company had reiterated that the said claim was repudiated under exclusion clause 4.8 of the policy being the congenital external disease which states "Convalescence, general debility, "run down" condition or rest cure, congenital external and internal 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." As per medical opinion of Dr. Anil Bhatia their panel doctor undescendent testis is congenital external disease. On perusal of the claim papers placed on record, I find that Master Rian Manchanda aged 01 year 04 months was admitted in Fortis Escorts Heart Institute from 10.03.14 to 11.03.14 and diagnosed as a case of Left (Palpable) undescendent

testis and underwent left orchidopexy on 10.03.14. As per medical opinion of panel doctor of Insurance Company Dr. Anil Bhatia the undescendent testis are congenital external disease. In some cases the testis descends of its own upto certain age after birth and do not require surgery. But since the disease is congenital in nature and as per policy clause 4.8 it is not payable. I hold that the Insurance Company had rightly rejected the claim under policy exclusion 4.8 congenital external disease as the patient was suffering from left (palpable) undescended testis which came under congenital disease. I see no reason to interfere with the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. Deepak Gupta
Vs
Oriental Insurance Company Ltd.

DATE: 30.12.2015.

1. The complainant alleged that he had taken the Happy Family Floater Gold Plan Policy with add on Hardship Plan B. He had lodged claim under this clause for payment of 10% sum insured i.e. Rs. 10 Lacs on survival for 180 days after ESRD (End Stage Renal Disease) and the Insurance Company had paid him Rs. 1 Lac (10% of S.I. Rs. 10 Lacs) under Life Hardship survival benefit clause accordingly. But when he lodged second claim for 15% of S.I. i.e. Rs. 1, 50,000/- was denied. The ground to rejection of claim was that the S.I. of Rs. 4 Lacs at the time of hospitalization in December, 2007 will be taken to settle the claim. He had sought the relief of Rs. 1, 50,000/- from this forum.

2. The Insurance Company vide its letter email dated 24.04.2015 had clarified that the insured was first diagnosed and discharged from Hospital for ESRD in December, 2007. At the material time the S.I was Rs. 4 Lacs. Since the Insured had survived more that 270 days he was released Rs. 1 Lac (25 % of Survival benefits of S.I. Rs 4 Lacs). The benefit under this section shall be paid only once under this policy or subsequent renewable for the same disease for the same person. The amount paid to the Insured was in order and as per terms and conditions of the policy.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant had submitted that that he had taken the Happy Family Floater Gold Plan Policy with add on Hardship Plan B. He had lodged claim under this clause for payment of 10% sum insured i.e. Rs. 10 Lacs on survival for 180 days after ESRD (End Stage Renal Disease) and the Insurance Company had paid him Rs. 1 Lac (10% of S.I. Rs. 10 Lacs) under Life Hardship survival benefit clause accordingly. But when he lodged second claim for 15% of S.I. i.e. Rs. 1, 50,000/- was denied. The ground to rejection of claim was that the S.I. of
Rs. 4 Lacs at the time of hospitalization in December, 2007 will be taken to settle the claim. The Insurance Company had stated that the Insured Mr. Deepak Gupta was first diagnosed and discharged from Hospital for ESRD in December, 2007. At the material time the S.I. under the policy was Rs. 4 lacs. Since the insured survived for more than 270 days the amount of Rs. 1, 00,000/- (25% survival as per the Happy family floater policy the survival benefit is payable from (i) the first date of discharge from the hospital when diagnosed for ESRD (the first discharge date in case o more than one hospitalizations are involved) (ii) the benefit under this section shall be paid only once under this policy or subsequent renewals for the same disease for the same person. Based on the above two conditions the complainant had been released Rs. 100000/- towards 25% survival benefit and no further amount is payable to the complainant.

On perusal of all the claim papers placed on record I find that Mr. Deepak Gupta was admitted in Maharaja Agarasen Hospital from 20.09.2014 to 22.10.14 and diagnosed as a case of kidney disease. The Insured is covered under Happy Family Floater Policy (No. 214300/48/2014/5784

from 24.01.14 to 23.01.15) for sum insured of Rs. 10, 00,000/- with Gold Plan add on hardship Plan B. As per record the complainant was first diagnosed and discharged from hospital for end stage renal disease (ESRD) in December, 2007and at the material time the S.I. under the policy was Rs. 4 Lacs. As per policy clause 3.21 –Life Hardship Survival Benefit Plan-B the complainant was paid Rs. 1 Lac (25% of S.I. Rs. 4, 00,000/-) as he had survived for more than 270 days. As per said clause (i) the survival benefit is payable from the date of discharge from the hospital i.e. the first discharge date in case of more than one hospitalizations are involved. (ii) The benefit under this section shall be paid only once under this policy or subsequent renewals for the same disease for the same person. Since, the disease ESRD related to the year December, 2007, the S.I of Rs. 4 Lacs of the year 2007 would be considered for settlement of the claim according to terms and conditions of the policy. I see no reason to interfere with the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. Ramesh Kumar Mishra
Vs
Oriental Insurance Company Ltd.

DATE: 30.11.2015

1. The complainant alleged that his son had met with an accident and was admitted in emergency at Max Health Care on 28.01.2015 and diagnosed as Head Injury. He had incurred Rs. 25,000/- (approx) towards the treatment of his son but the Insurance Company had rejected the claim on the ground of patient was treated on OPD basis and as per terms and conditions of the policy OPD treatment was not payable. He had sought the relief of Rs. 25,000/- from this forum.

2. The Insurance Company vide its letter dated 16.03.2015 had rejected the claim on the ground that as per policy terms and conditions of the policy clause 4.20 which states the Company shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any insured person in connection with or in respect of i.e. "Out patient diagnostic, Medical or surgical procedures or treatment, non-prescribed drugs and medical supplies, hormone, replacement therapy, sex change or treatment which results from or is in any way related to sex change."The patient was treated on OPD basis and as per terms and conditions of the policy OPD treatment was not payable.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant alleged that his son Mr. Ankur Mishra had met with an accident on 28.01.15 and admitted in emergency at Max Health Care on 28.01.15 (16:36 P.M.) and discharged on the same day at 07:39 P.M. He had submitted the necessary papers of the claim for reimbursement to the Insurance Company but the Company had rejected the claim on the ground that the patient was treated on OPD basis

and as per terms and conditions of the policy OPD treatment was not payable. The Insurance Company had stated that the patient was admitted for the treatment of RTA with head injury and managed surgically by repair of the wound. As per claim documents it is observed that the patient was treated an OPD basis and as per policy terms and conditions OPD based treatment was not payable. Hence, the claim was repudiated under policy exclusion clause 4.20 which states the Company shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any insured person in connection with or in respect of i.e. "Out patient diagnostic, Medical or surgical procedures or treatment, non-prescribed drugs and medical supplies, hormone, replacement therapy, sex change or treatment which results from or is in any way related to sex change."

On perusal of the claim papers placed on record I find that Mr. Ankur Gupta was admitted in Max Health Care in emergency as he had met with an accident and suffered head injury. As per discharge slip of Hospital the patient Mr. Ankur Mishra was admitted on 28.01.15 at 16:36 P.M. and discharged on 28.01.15 at 07:39 P.M. hence, the contention of Insurance Company that the patient was treated on OPD basis is not correct and clause 4.20 referred by the Insurance Company would not be applicable. As per clause 2.3 (c) (i) and (iii) of the policy the condition of minimum 24 hours hospitalization shall not apply provided:

(i) The treatment is such that it necessitates hospitalization and the procedure involves specialized infrastructural facilities available only in hospitals,

BUT

(ii) Due to technological advances hospitalization is required for less than 24 hours.

Mr. Ankur Gupta had suffered head injury and was admitted in hospital on 28.01.2015 from 16:36 P.M. to 07:39 P.M. thus attracting 2.3 (c) (i) and (iii) of the policy terms and conditions. Hence, I hold the Insurance Company is liable to settle the claim. **Accordingly an award is passed with the direction to the Insurance Company to settle the claim and pay the admissible amount to the complainant.**

In the matter of Mr. Rohit Dalmia
Vs
Apollo Munich Health Insurance Company Ltd.

DATE: 21.12.2015

1. The complainant alleged that he was admitted in Max Super Specialty Hospital from 12.09.14 to 22.09.2014 and diagnosed as "sudden onset severe pain in neck and left arm". The cashless claim that was approved at the time of discharge was partial and he had to pay the balance payment of claim to the hospital. The reason for partial approval given by the TPA/Insurance Company was "patient was put on oral medication after 17.09.2014". He had sought the relief of Rs. 52,424/- from this forum.

2. The Insurance Company vide its letter dated 05.12.2014 had rejected the claim on the ground that the admission is for investigation and evaluation of the ailment only which is not covered under Sec VI C VIB of the policy.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant alleged that he was admitted in Max Super Speciality Hospital from 12.09.2014 to 22.09.2014 on sudden onset severe pain in neck and left arm. The cashless claim was approved at time of discharge was partial and he had to pay the balance payment of claim to the hospital. The reason for partial approval given by the TPA/Insurance Company was patient was put on oral medication after 17.09.2014. The Insurance Company had stated that the patient was only on oral medication post 17.09.2014 and the medication administered to the patient could be given without the necessity of hospitalization. Hence, the treatment after 17.09.2014 was disallowed.

On perusal of the claim papers placed on record, I find that Mr. Rohit Dalmia was admitted in Max Health Care Institute Ltd. form 12.09.2014 to 22.09.2014 and diagnosed as a case of sudden onset severe pain in neck and left arm. As per Dr. R. Maheswari certificate of Max Super Speciality dated 25.09.2014 the patient was admitted with acute cervical radiculopathy (left arm on 12.09.2014 and was treated conservatively. Till 19.09.2014 he was on injectables and oral therapy and on 20.9.2014 and 21.09.2014 was put on oral medication and was sent home on 22.09.2014 in stable condition. I observe that since the patient was on injectables and oral therapy till 19.09.2014 and required hospitalization the medical expenses should be allowed till such date and post hospitalize expenses for the treatment taken should also be allowed as per policy clause section I "inpatient benefits" sub-section-1 (c) "post hospitalization" which states medical expenses incurred in 90 days after the hospitalization. **Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant.**

In the matter of Mr. Pankaj Tuli
Vs
United India Insurance Company Ltd.

DATE: 21.12.2015

1. The complainant alleged that his son was admitted in Fortis Hospital from 29.08.14 to 30.08.2014 and diagnosed as "Thygroglossal Cyst" with Chief Complaints Neck Swelling (middling) for 8-9 months. He had submitted all the necessary papers of the claim to the Insurance Company for reimbursement of amount of Rs. 52,889/- but the Insurance Company had denied the claim under "congenital external disease". He had sought the relief of Rs. 52,889/- from this forum.

2. The Insurance Company vide its letter dated 28.07.15 that the claim was rejected under exclusion clause 4.8 which states that "convalescence, general debility rest cure, congenital external disease or defects or anomalies, sterility, infertility, intentional self-injury and use of intoxicating drugs/alcohol." Mr. Mayank Tuli was suffering from Thyroglossal cyst which is congenital (present by birth) defect.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant had stated that his son Mr. Mayank Tuli was admitted in Fortis Hospital from 29.08.2014 to 30.08.2014 and diagnosed as a case of Thyroglossal cyst. Surgery of Thyroglossal cyst excision was done in the hospital. The Insurance Company had denied the claim under exclusion clause congenital external disease. The Insurance Company had submitted that Mr. Mayank Tuli was suffering from some throat problem and after examination by Doctor on the basis of diagnostic reports it was come to know that the patient was suffering from Thyroglossal cyst which is congenital defect (present by birth). The claim falls under exclusion clause 4.8 of the policy which states that "convalescence, general debility rest cure, congenital external disease or defects or anomalies, sterility, infertility, intentional self-injury and use of intoxicating drugs/alcohol" hence not payable.

   On perusal of the claim papers placed on record I find that the patient Mr. Mayank Tuli was admitted in Fortis Hospital from 29.08.14 to 30.08.14 and diagnosed as a case of Thygroglossal cyst. Surgery of thyroglossal cyst excision was done in the hospital. The Insurance Company had rejected the claim on the ground that the disease falls under exclusion clause "congenital defect (present from birth) and submitted excerpts taken from Wikipedia "Thyroglossal cyst is a fibrous cyst that forms from a persistent thyroglossal duct. Thyroglossal cyst can be defined as an irregular neck mass or a lump which had developed from cells and tissues left over after the formation of the thyroid gland during developmental stages. Thryoglossal cysts are developed at

birth and can have much diagnosis procedure to establish the degree of the cyst. I find that the Insurance Company had rightly rejected the claim as the thyroglossal cyst is a congenital (present from birth) defect and is outside the scope of the policy. I see no reason to interfere with the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. Ravindra Prasad Mathur
Vs
United India Insurance Company Ltd.

DATE: 22.12.2015

1. The complainant alleged that he had a mediclaim policy for a S.I. of Rs. 5 Lacs for the period 16.03.14 to 15.03.15. On 21.04.14 he was admitted in Fortis Hospital for Coronary Angiography and stenting and discharged on 23.04.2014. The total expenses were Rs. 3, 51,200/- for which Rs. 3, 00,000/- claim was passed which he had accepted. He had submitted bills of Rs. 8007/- for pre & post-hospitalization treatment. But the Insurance Company had rejected his claim on the ground that he had already availed his S.I. limit i.e. Rs. 3 Lacs. He had sought the relief of Rs. 8007/- (pre & post hospitalization) from this forum.

2. The Insurance Company vide its letter dated 28.04.15 had informed to the Insured that he had already availed the sum insured limit of Rs. 3 Lacs. So, claim was not payable after exhausting the Rs. 3 Lacs limit.

3. I heard both the sides the complainant as well as the Insurance Company. During the course of hearing the complainant had alleged that he had a mediclaim policy for S.I. of Rs. 5 Lacs for the period of 16.03.2014 to 15.03.15. On 21.04.14 he was admitted in Fortis Hospital for coronary angiography and stenting. He was discharged on 23.04.2014. The Insurance Company had paid main hospitalization claim for Rs 3 Lacs on 04.06.14 but rejected the pre and post hospitalization claim of Rs. 8007/- as the S.I. of Rs. 3 Lacs was exhausted. The Insurance Company had stated that Mr. Ravinder Prasad Mathur was admitted at Escorts Hospital Institute and Research Centre Ltd., New Delhi from 21.04.2014 to 23.04.14. The diagnosis as per the discharge summary was CAD, Double vessel disease, post PCI stent to LAD-2012, TMT positive for RMI, CAG with PTCA+Stent. The main claim was settled under cashless scheme for Rs. 3 Lacs on 04.06.2014. The Insured had preferred post-hospitalization claim for Rs. 8007/- which was not payable as the S.I. of Rs. 3 Lacs was exhausted under main claim. The disease for which the patient had preferred the claim was a pre-existing disease as per discharge summary.
Therefore, the S.I. available under previous policy i.e. Rs. 3 Lacs was considered for the settlement of claim and not the S.I. i.e. Rs. 5 Lacs available under the current policy. Therefore, no amount was available for the settlement of the claim.

On perusal of the claim papers placed on record I find that the Insured had taken policy no. 040500/48/10/41/00005032 for the period of 16.03.11 to 15.03.12 for a S.I. of Rs. 3 Lacs and he opted to enhance the S.I. from 3 Lacs to Rs. 5 Lacs during the next renewal vide policy no. 040500/48/11/41/00005378 for the period 16.03.12 to 15.03.13. Since then the S.I. under the policy is continued to be Rs. 5 Lacs. The said claim falls under policy no. 040500/48/13/41/00005900 (16.03.14 to

15.03.15) for which the sum insured was Rs. 5 Lacs. As per discharge summary of Fortis Hospital the patient was admitted from 21.04.14 to 23.04.14 and diagnosed as a case of Coronary artery disease, Double vessel disease, Post PCI Stent to LAD- 2012, TMT-Positive for RMI, CAG: Patent stent LAD, RCA (P) and (D) 70%, LM (O) 40%- 21-04-2014, PTCA+Stent (Promus Element Plus x 2) to RCA (D) & (P)-21.04.2014. He is a known case of coronary artery disease-underwent coronary angiography which revealed double vessel disease and PCI stent to LAD in 2012. The patient underwent PTCA on 21.04.14 using (Promus Element Plus X2) stent in RCA (D) & (P). Since the disease for which the patient was treated was a pre-existing disease, therefore the S.I. available under previous policy (2011-12) i.e. Rs. 3 Lacs would be considered for the settlement of claim and not the S.I. of Rs. 5 Lacs available under current policy (2014-15) as per policy condition 4.1 which states " All diseases/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 three consecutive continuous claim free policy years, provided there was no hospitalization for the pre-existing ailment during these three years of insurance." Hence, I feel that the Insurance Company had rightly settled the claim according to terms and conditions of the policy and I see no reason to interfere with the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Ms. Alka Gupta
Vs
The Oriental Insurance Company Ltd.

DATE: 16.02.2016

1. The complainant alleged that her husband was admitted in Pushpawati Singhania Research Institute from 24.06.2014 to 01.07.14 and diagnosed as a case of chronic kidney disease-End Stage Renal Disease, Left AVF made on 27.06.2014, DM-Type II, Diabetic Retinopathy, Diabetic nephropathy, Hypertension. She had submitted the necessary papers of claim for reimbursement of Rs. 48,768/- to the Insurance Company but the Company had not settled the claim so far. Her husband had passed away on 26.07.15. She had sought the relief of Rs. 48,768/- from this forum.

2. The Insurance Company vide its self contained note dated 26.11.15 had submitted that all the claims of Mr. Arvind Gupta were settled and paid by the TPA by taking into consideration policy no. 272200/48/2010/2965 (23.09.09 to 22.09.10) said to be issued from the Divisional office-3, New Delhi. The said policy was submitted to TPA directly by Mr. Arvind Gupta. The policy was verified and found to be fake. The TPA M/s E-Meditek TPA-Services had also deposited the recovery in lieu of claims paid to Mr. Arvind Gupta.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant alleged that her husband was admitted in Pushpawati Singhania Research Institute from 24.06.2014 to 01.07.14 and diagnosed as a case of chronic kidney disease-End Stage Renal Disease, Left AVF made on 27.06.2014, DM-Type II, Diabetic Retinopathy, Diabetic nephropathy, Hypertension. Later on she had submitted three claims to the Insurance Company for dialysis which was taken at Jan Kalyan Health Care Centre and incurred Rs. 48768/- but the Company had not settle the claim so far. She had sought the relief of Rs. 48768/-. The Insurance Company vide its self contained note dated 26.11.15 had submitted that all the claims of Mr. Arvind Gupta were settled and paid by the TPA by taking into consideration policy no. 272200/48/2010/2965 (23.09.09 to 22.09.10) said to be issued from the Divisional office-3, New Delhi. The said policy was submitted to TPA directly by Mr. Arvind Gupta. The policy was verified and found to be fake. The TPA M/s E-Meditek TPA-Services had also deposited the recovery in lieu of claims paid to Mr. Arvind Gupta.

On perusal of the claim papers placed on record, I find that Mr. Arvind Gupta was admitted in Pushpawati Singhania Research Institute for liver, Renal and Digestive Disease from 24.06.14 to 01.07.14 and primary diagnosis as chronic kidney disease-end

stage renal disease, Left AVF made on 27.06.2014, DM-Type II, Diabetic Retinopathy, Diabetic nephropathy, Hypertension Thereafter dialysis was taken at Jan Kalyan Health Care Centre. The complainant had submitted three claims to the Insurance Company for dialysis which was amounting to Rs. 48768/-, but the Company had not reimbursed the claim amount nor did the Company reject the claim. I find that all the three claim of dialysis pertained to policy no. 272302/48/2015/1174 from 23.09.14 to 22.09.15 and not under the policy no. 272200/48/2010/2965 from 23.09.09 to 22.09.10 which the Company had claimed as fake policy. Since the policy under which claims arose (no. 272302/48/2015/1174 from 23.09.14 to 22.09.15) was in order and not disputed by the Insurance Company also, hence the Company is liable to settle the claim. **Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant.**

In the matter of Mr. Mahender Singh
Vs
The Apollo Munich Health Insurance Company Ltd.

DATE: 28.1.2016

1. The complainant alleged that he had submitted a cashless claim (Ref No. 181379) to Apollo Munich Health Insurance Company which was rejected by the Insurance Company due to non-disclosure of material facts. He had claimed cashless treatment for his knee surgery for which they are only considering portability form and confirmation call as evidence but not all the communication which took place while porting the policy. He had sought the relief for cashless claim of knee injury prescribed by the doctor.

2. The Insurance Company vide its letter dated 24.08.2015 had rejected the cashless request and cancelled the policy ab-initio/ from the date of renewal in view of non-disclosure of material facts (known case of ACL-Anterior Cruciate Ligament tear since 26.10.14) in the proposal form.

3. I heard both the sides, the complainant as well as the Insurance Company. The Insurance Company had stated that the Company is ready to consider the policy of the complainant however, the Company had only received cashless request. No treatment documents or reimbursement documents were submitted to process and settle the claim. Hence, the complainant is hereby directed to submit all the necessary papers of the claim

to the Insurance Company for processing and settling the claim and Insurance Company is directed to settle the claim on receipt of required documents. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Ms. Kritika Bhambani
Vs
The Bharti AXA General Insurance Company Ltd.

DATE: 11.02.2016

1. The complainant alleged that she had developed illness on 13.05.2015 and was diagnosed as ovarian tumor by the doctors at Fortis Memorial research Hospital, Gurgaon. She was admitted in Fortis Memorial Research Institute, Gurgaon from 09.06.15 to 13.06.2015 with the chief complaints of vomiting associated with pain abdomen last one month. She was diagnosed as a suspicious mucinous tumor ovary/pseudomyxoma. She had applied for cashless facility but the same was declined by the TPA E-Meditek. She had submitted all the necessary papers of the claim to the TPA/Insurance Company for reimbursement of Rs. 2,27,190/- but the Company had denied the claim on the ground of non-disclosure of material facts in proposal form. She had sought the relief of Rs. 2, 27,190/- from this forum.

2. The TPA E Meditek vide its letter dated 28.05.2015 had denied the cashless request of the insured and denied the claim on the ground that the patient Ms. Kritika Bhambani, 23 years old, female complaint of heaviness and pain in abdomen, vomiting and diagnosed left ovary tumor and planned for surgery on dated 01.06.2015. The policy inception date is 29.02.2012. As per submitted documents the patient had history of Intestinal obstruction in 2008-2010 and also took ATT on and off for 15 months. These past medical history facts were not disclosed in proposal form. Hence the claim was denied under section "General Condition" the duty of disclosure: the policy shall be null and void and no benefit shall be payable in the event of untrue or incorrect statements, misrepresentation, mis-description or non-disclosure of any material particulars in the proposal form, personal statement, declaration and connected documents, or any material information having been withheld, or a claim being
fraudulent or any fraudulent means or device being used by the insured/insured person or any one acting on his/their behalf to obtain a benefit under this policy.

3. I heard both the sides, the complainant (represented by her sister) as well as the Insurance Company. During the course of hearing Ms. Laveena Bareja sister of the complainant had alleged that her sister Kritika Bhambani was admitted in Fortis Memorial Research Institute, Gurgaon from 09.06.15 to 13.06.2015 with the chief complaints of vomiting associated with pain abdomen last one month. She was diagnosed as a suspicious mucinous tumor ovary/pseudomyxoma. She had applied for cashless facility but the same was declined by the TPA E-Meditek. She had submitted all the necessary papers of the claim to the TPA/Insurance Company for reimbursement of Rs. 2,27,190/- but the Company had denied the claim on the ground of non-disclosure of material facts in proposal form.

On perusal of the claim papers placed on record, I find that Ms. Kritika Bhambani was admitted in Fortis Memorial Research Institute, Gurgaon from 09.06.15 to 13.06.2015 and diagnosed as a case of

suspicious mucinous tumor ovary/pseudomyxoma with the chief complaints of vomiting associated with pain abdomen for last one month. Exploratory Laparotomy +excision of cystic wall + adhesiolysis + Left Salipingo –Oophorectomy was done under G.A. on 10.06.2015. As per certificate dated 27.05.15 issued by Dr. Rama Joshi, Fortis Memorial Research Institute the patient was treated for intestinal obstruction conservatively outside with ATT off and on since 2008 in OPD basis for 15 months. After that the patient was asymptomatic till 13.05.15. The said facts had not been revealed by the Insured in proposal form dated 25.02.2012 under column no. 01 "Have you or any of the Insured person(s) suffered/are suffering from any disease/illness?" and this tantamount to non-disclosure of material facts at the time of policy in 2012. There was a violation of policy terms and conditions no. 06 "General Condition" the duty of disclosure: the policy shall be null and void and no benefit shall be payable in the event of untrue or incorrect statements, misrepresentation, mis-description or non-disclosure of any material particulars in the proposal form. In the case of Satwant Kaur Sandhu Vs New India Assurance (2009) 8 SCC 316, the Hon'ble Supreme Court emphasized that it is obligatory for the proposer to disclose the material facts at the time of filling the proposal form. The Insurance Company is not liable to pay the expenses in case of non-disclosure of material information. Thus it was a case of non-disclosure. Therefore, I uphold the decision of the Insurance Company. I see no reason to interfere with the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. Sumit Gupta
Vs
The Apollo Munich Health Insurance Company Ltd.

DATE: 28.01.2016

1. The complainant alleged that his son was admitted in Max Health Care from 13.06.15 to 20.06.15 and diagnosed as a case of "bleeding meckels diverticulum." He had applied for cashless service but the same was denied by the Insurance Company. He had submitted all the necessary papers of the claim to the Insurance Company for reimbursement of Rs. 2,07,717/- but the Company had denied the claim on the ground that the disease for which the patient was treated fell under category of congenital defect/ anomalies. He had sought the relief of Rs. 2, 07,717/- alongwith Rs. 15 Lacs towards mental harassment.

2. The Insurance Company vide its letter dated 02.07.2015 had rejected the claim on the ground that the disease "bleeding meckels diverticulum" fell under the category of congenital defect/anomalies. Evaluation and treatment related to a condition which is present since birth has been excluded in the policy. The claim was repudiated under clause VI-CK of the policy.

3. I heard both the sides, the complainant as well as the Insurance Company. The complainant submitted that his son was admitted in Max Health Care from 13.06.15 to 20.06.15 and diagnosed as a case of "bleeding meckels diverticulum." The cashless service was denied by the Insurance Company. He had submitted all the necessary papers of the claim to the Insurance Company for reimbursement of Rs. 2,07,717/- but the Company had denied the claim on the ground that the disease for which the patient was treated fell under the category of congenital defect/ anomalies.

The Insurance Company had rejected the claim on the ground that the disease "bleeding meckels diverticulum" fell under the category of congenital defect/anomalies. Evaluation and treatment related to a condition which was present since birth has been excluded in the policy. The claim was repudiated under clause VI-CK of the policy.

I find that as per medical literature "A Meckel's Diverticulum, a true congenital diverticulum is a slight bulge in the small intestine present at birth and a vestigial remnant of the omphalomesenteric duct resulting from the incomplete closure of the yolk stalk. It is the most common malformation of the gastrointestinal tract and is present in approximately 2% of the population, with males more frequently experiencing symptoms." The majority of people with a Meckel's Diverticulum are asymptomatic. An asymptomatic Meckel's Diverticulum is called a silent Meckel's diverticulum. If symptoms do occur, they typically appear before the age of two years. In view of the above mentioned fact, I uphold the decision of the Insurance Company that the disease was a congenital disorder falling under the category of congenital defect/anomalies. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. Tarsem Singh
Vs
The ICICI Lombard General Insurance Company Ltd.

DATE: 11.02.2016

1. The complainant alleged that he was admitted in BLK Super Specialty Hospital from 09.05.15 to 13.05.15 and diagnosed as a case of uretheral tear with proximal penile uretheral stricture. The history of present complaint was post coital uretheral bleeding. He had submitted all the necessary papers of the claim for reimbursement of Rs. 68,650/- but the Insurance Company had denied his claim on the ground of non-disclosure of material facts. He had sought the relief of Rs. 68,650/- from this forum.

2. The Insurance Company vide its letter dated 18.06.2015 and 10.07.2015 had rejected the claim on the ground of non-disclosure of material facts in the proposal form while taking

the policy (as per part III, clause 1 of policy terms and conditions). The insured was suffering with diabetes and hypertension since 2008 and on regular treatment prior to policy commencement which he had not disclosed at the time of taking the policy. The policy of the Insured had also been cancelled on the ground of concealment of material facts.

3. I heard both the sides, the complainant as well as the Insurance company. During the course of hearing the complainant alleged that he was admitted in BLK Super Specialty Hospital from 09.05.15 to 13.05.15 and diagnosed as a case of uretheral tear with proximal penile uretheral stricture. The history of present complaint was post coital uretheral bleeding. He had submitted all the necessary papers of the claim for reimbursement of Rs. 68,650/- but the Insurance Company had denied his claim on the ground of non-disclosure of material facts.

The Insurance Company had stated that the claim was repudiated on the ground of non-disclosure of material facts in the proposal form while taking the policy (as per part III, clause 1 of policy terms and conditions). The insured was suffering with diabetes and hypertension since 2008 and on regular treatment prior to policy commencement.
The policy of the Insured had also been cancelled on the ground of concealment of material facts.

On perusal of the claim papers placed on record, I find that the patient Mr. Tarsem Singh was admitted in BLK Super Speciality Hospital from 09.05.2015 to 13.05.15 and diagnosed as a case of Urethral Tear with Proximal penile uretheral stricture. As per discharge summary the patient was a known case of DM Type II and Hypertension and as per self-declaration given by the complainant to the hospital on 11.05.15 he was suffering from hypertension and diabetes since 2008 and was on regular medication which was prior to taking the first policy (policy no. 4128i/HPR/83384068/00/000 from 15.10.2009 to 14.10.2010) and had not disclosed by the complainant while taking the policy in 2009. Now a day the disease like hypertension, diabetes etc are so common and are always controllable and unless and until patient had undergone long treatment including hypertension and remain in hospital for days and undergoes operation etc. in the near proximity of taking the policy cannot be accused of concealment of material facts. In the instant case the patient was treated for coital uretheral bleeding which is not related to HTN and DM. Hence Insurance Company is liable to settle the claim. The Insurance Company is hereby directed to restore the policy of the complainant with continuity benefit by incorporating the special exclusion clause for disease "DM II and Hypertension." **Accordingly an award is passed with the direction to the Insurance Company to settle the claim and pay the admissible amount to the complainant.**

In the matter of Mr. Sarfraz Shah
Vs
The Bajaj Allianz General Insurance Company Ltd.

DATE: 04.02.2016

1. The complainant alleged that his father was admitted in Max Hospital, Saket, New Delhi from 29.10.14 to 01.11.14 and diagnosed as a case of coronary artery disease, acute IWMI, CAG, double vessel disease, primary PTCA + stent, Hypertension. The S.I. under the policy was Rs. 2 Lacs but the Insurance Company had approved only Rs. 1 Lac against final bill of Rs. 2,95,646/-. The Insurance Company submitted that the patient was admitted for atherosclerotic cardiovascular disease and the policy opted by the Insured is Silver Health policy, in which this particular ailment has restriction of 50% as per policy terms and conditions and therefore. He had sought the relief of Rs. 1, 00,000/- from this forum.

2. The Insurance Company vide its email dated 11.11.2014 had informed to the complainant that the patient was admitted for atherosclerotic cardiovascular disease. The policy opted by the Insured was Silver Health Policy and the particular ailment was restricted to 50% of the limit of indemnity as per policy terms and conditions.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant had reiterated the same. The Insurance Company had stated that the claim was settled for Rs. 1, 00,000/- (50% of S.I. Rs. 2 Lacs) according to terms and condition no. 06 (i) of policy Basis of Claims payment "for any one pre-existing illness covered under this policy (if this policy is the renewal without break of an earlier Silver Health Policy issued by us and held for a continuous period of one year) will be restricted to 50% of the limit of indemnity." As per discharge summary of Max Health Care the patient Mr. Gulam Nabi Shah was admitted from 29.10.14 to 01.11.14 and diagnosed as a case of Coronary Artery disease, acute IWMI (29.10.14), CAG (double vessel disease), hypertension, DM (Type II). The patient was a known case of coronary artery disease and underwent for primary PTCA+Stent (Resolute integrity-2.50x22 mm) on 29.10.14. As per prescription of Vasan Eye Care dated 28.09.13 and pre-auth form (annexure B), the patient was a known case of HTN, Diabetes since 07 years. The policy in which claim arose was in 3rd year (P.No. OG-15-1104-8408-00000037(20.05.14 to 19.05.15), and there was a waiting period of 48 months for pre-existing disease, hence claim was rightly settled.

On perusal of claim papers placed on record, I find that the patient was a known case of Hypertension and DM (Type II). As per discharge summary of Max Health Care the

patient Mr. Gulam Nabi Shah was admitted form 29.10.14 to 01.11.14 and diagnosed as a case of coronary artery disease, acute IWMI, CAG, double vessel disease, primary PTCA + stent, Hypertension Coronary. Angiography was done on 29.10.14 and subsequently patient underwent primary PTCA+Stent (resolute Integrity-2.50x22mm) to LCX on 29.10.14. As per prescription of Vasan Eye Care Hospital dated 28.09.13 and pre-auth form (Annexure-B) produced by the Insurance Company the patient was having a history of Hypertension and DM (Type II) since 07 years which was pre-existing in nature at the time of taking the first policy (OG-12-1104-8408-00000041(19.05.11 to 18.05.12). Hence, the Insurance Company had settled the claim according to terms and conditions no. 6(i) of the policy which states Basis of Claims payment "for any one pre-existing illness covered under this policy (if this policy is the renewal without break of an earlier Silver Health Policy issued by us and held for a continuous period of one year) will be restricted to 50% of the limit of indemnity." I see no reason to interfere with the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. Raj Kumar
Vs
The Oriental Insurance Company Ltd.

DATE: 27.01.2016

1. The complainant alleged that his mother was admitted in Sir Ganga Ram Hospital from 08.03.14 to 12.03.14 for surgery of the brain. She was diagnosed as a case of Hunt and Hess Grade-1 subarachnoid hemorrhage with Acom Artery Aneurysm with the chief complaint of severe headache and vomiting. He had submitted all the necessary papers of the claim for reimbursement of claim amount but the Insurance Company had rejected the claim on the ground that the treatment was related to Hypertension which is not covered under first two years of policy.

2. The Insurance Company vide its letter dated 16.09.2014 had rejected the claim on the ground that the claim falls under exclusion clause 4.2 "two years waiting period." After investigation it was found that patient is a known case of HTN and present ailment was not payable in first two years of policy.

3. I heard both the sides, the complainant as well as the Insurance Company. The complainant alleged that his claim for his mother's hospitalization was not settled by the Insurance Company on the grounds that the present illness was related to hypertension which has a two years waiting period as per exclusion clause no. 4.2 of the policy. The Insurance Company submitted that the claim was denied on the

grounds that the patient was suffering from Hunt and Hess Grade-1 subarachnoid hemorrhage with Acom Artery Aneurysm with the chief complaint of severe headache and vomiting and this is related to Hypertension. The policy incepted on 07.08.2012 and the claim arose on 08.03.2014. The disease hypertension falls under the exclusion clause 4.2 "two years waiting period" of the policy and hence was denied.

I have considered the written and oral submission and on perusal of the documents, I find that certificate from the treating doctor Ajit Kumar Sinha dated 19.03.15 states that "Aneurysm bleed is never due to hypertension." The Insurance Company could not prove with any documentary evidence that the treatment undertaken by the complainant was related to HTN nor could rebut the doctor's certificate.

In view of the doctor's certificate on record, I uphold that the case is not related to HTN and therefore the exclusion clause 4.2 "two years waiting period" is not applicable. Hence the claim is admissible. **Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant.**

In the matter of Mr. Arun Gupta
Vs
The Oriental Insurance Company Ltd.

DATE: 15.01.2016

1. The complainant alleged that he was admitted in Sant Parmanand Hospital, Delhi from 27.06.14 to 04.07.14 and diagnosed as a case of Osteoarthritis. Bilateral Knees operation total knee replacement was done on 28.06.14. He had incurred Rs. 8, 62,980/- towards the treatment but the Insurance Company had allowed the claim only for Rs. 3, 90,000/- as cashless and rejected the balance amount of Rs. 4, 72,980/- on the ground that it was as per GIPSA package. He had sought the relief of Rs. 4, 72,980/- alongwith interest @ 18% for delay in settlement of claim from the date of discharge from the hospital and Rs. 50,000/- for the mental harassment suffered by him.

2. The TPA Park Mediclaim Pvt. Ltd. vide its letter dated 04.07.2014 had apprised that as per GIPSA package for the treatment of B/L TKR the amount of Rs. 3,90,000/- was allowed to the hospital as cashless approval.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant alleged that he was admitted in Sant Parmanand Hospital, Delhi from 27.06.14 to 04.07.14 and diagnosed as a case of Osteoarthritis Bilateral Knees. Operation of bilateral total knee replacement was done on 28.06.14. He had incurred Rs. 8, 62,980/- towards the treatment but the Insurance Company had

allowed the claim only for Rs. 3,90,000/- as cashless and rejected the balance amount of Rs. 4,72,980/- as per GIPSA package. The S.I. under the policy was Rs. 10 Lacs.

The Insurance Company had stated that claim was settled as per policy terms and conditions of Happy Family Floater Policy. The amount of Rs. 3, 90,000/- was allowed to the hospital as cashless approved as per GIPSA package for the treatment of B/L TKR.

On perusal of all the claim papers placed on record, I find that Mr. Arun Kumar Gupta was admitted in Delhi Institute of Trauma and Orthopedics, Sant Parmanand Hospital from 28.06.14 to 04.07.14 and diagnosed as a case of osteoarthritis bilateral knees. Operation of Bilateral total knee replacement was done on 28.06.14. The TPA M/s Park Mediclaim TPA (P) Ltd. had approved the amount of Rs. 3, 90,000/- as cashless under GIPSA package for (Single Room). As per TPA M/s Park Mediclaim TPA (P) Ltd. letters of 01.07.14 and 04.07.14 the cashless request was approved for Rs. 3.90 Lacs as per GIPSA Package. They had further advised to the hospital that hospital must collect the excess amount over and above the authorization amount from the concerned member before discharging from the hospital. Since the claim had been settled according to policy clause "Reasonable and necessary expenses" and as per GIPSA package agreed rates between Insurance Company and the hospital, I find that the Company had rightly settled the claim. I see no reason to interfere with the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. Manoj Goel
Vs
The Oriental Insurance Company Ltd.

DATE: 27.01.2016

1. The complainant alleged that his father was admitted in Maharaja Agarsen Hospital from 22.05.15 to 25.05.15 and diagnosed as a case of Acute Myocardial Infarction. He had applied for cashless facility but the same was denied by the Insurance Company. he had submitted all the necessary papers of the claim for reimbursement of Rs. 3,70,000/- but the Insurance Company had denied the claim on the ground of patient had a sugar and B.P. problem which is not covered under the first year of policy. His father had no sugar and B.P problem and had heart attack first time. He had sought the relief of Rs. 3, 70,000/- form this forum.

2. The Insurance Company vide its letter dated 07.08.2015 had rejected the claim on the ground that the patient was admitted as a case of coronary artery disease-acute inferior wall MI and underwent PTCA for the same. As per IPD record, it is noted that patient was a known case of DM/HTN. As this is the first year policy the present claim is falling under exclusion clause 4.2 (xviii) i.e. two years waiting periods.

3. I heard both the sides, the complainant as well as the Insurance Company. The complainant submitted that his father was admitted in the Hospital for treatment of Acute Myocardial Infarction. His cashless claim was denied on the grounds that patient had a sugar and B.P problem which is not covered under the exclusion clause 4.2 (xviii) i.e. two years waiting periods. The Insurance Company submitted that the patient had a history of D.M. and HTN. The policy 272900/48/2015/17077 was taken in from 12.01.2015 to 11.01.2016 and the claim arose on 22.05.15. They also pointed out that as per the indoor paper which shows that as per IPD records the patient was mentioned as case of DM/HTN which was later scratched. DM and CAD are related to each other and this is the first year of the policy and therefore falling under the exclusion clause 4.2 (xviii) i.e. two years waiting periods. The claim was denied.

On perusal of papers placed on record, I find from the initial assessment sheets of Maharaja Agarsen Hospital dated 22.05.15 the past medical history is shown as case of DM 2/HTN/TB, Asthama. The provisional diagnosis was also shown as HTN and DM 2 which writing seems to be scratched out. However, the daily record sheet dated 22.05.15 shows the diagnosis as CAD/DM, ACS and DVD even in the diet sheet the diagnosis is shown as DM/CAD. In view of the above findings I am of the view that the patient was suffering from DM and HTN prior to the hospitalization. As this is the first year policy the claim would be hit by the exclusion clause 4.2 (xviii) i.e. two years waiting period for the disease DM and HTN. The claim is therefore not payable. I see no reason to interfere with the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. Sunil Kumar Sharma
Vs
The Oriental Insurance Company Ltd.
DATE: 21.12.2015

1. The complainant alleged that he was admitted in East West Medical Centre from 09.11.14 to 22.11.14 for the treatment of high grade fever and pain in upper abdomen. He had incurred Rs. 1, 28,451/- towards the treatment and submitted all the necessary papers of the claim to the TPA for reimbursement of claim amount of Rs. 1, 28,451/- but the TPA had not settled the claim so far. He had sought the relief of Rs. 1, 28,451/- from this forum.
2. The Insurance Company had not submitted any Self Contained Note, but stated that the claim was rejected on grounds that fraudulent papers had been submitted to get the claim.
3. I heard both the sides the complainant (represented by his brother) as well as the Insurance Company. During the course of hearing the complainant submitted that he was admitted in East West Medical Centre from 09.11.14 to 22.11.14 for the treatment of high grade fever and pain in upper abdomen. He had incurred Rs. 1, 28,451/- towards the treatment and submitted all the necessary papers of the claim to the TPA/ Insurance Company for reimbursement of claim amount but the Company had not settled the claim so far. The Insurance Company stated that the claim was rejected on the ground that the Insured had submitted the fraudulent papers and reports for seeking reimbursement of a manipulated claim. As per Medical opinion of the panel doctor of Insurance Company, Dr. Vinod Gandotra dated 27.03.2015 the claim was not tenable under the policy and can be repudiated as per terms and conditions of individual mediclaim policy schedule on the ground of it being a cooked up case for the sake of reimbursement under mediclaim benefits. On perusal of claim papers placed on record, I find, that the patient Mr. Sunil Kr. Sharma was admitted in East West Medical Centre, Sector-14, GGN from 09.11.14 to 22.11.14 and diagnosed as a case of Acute Pancreatitis. He was treated conservatively for high grade fever and pain in upper abdomen. As per the medical report submitted by the panel doctor Mr. Vinod Gandotra the patient was treated for pancreatitis initially for 06 days in ICU and 08 days in ward. But none of the treatment papers supported the fact that patient remained in the ICU. In ICU very extensive vital charts on hourly basis Treatment Progress Report (TPR) and oxygen saturation chart with monitoring by a Sr. Doctor should be maintained which is done around the clock. In the instant case all the case sheets were prepared or filled up, by same/one person even TPR Chart/Nurses Daily record appears to be prepared, by the same person as the writing appears to be the same. Moreover, no details are

shown of medication and treatment, there are no signatures of the nurse in Nurse's daily record, sheet/TPR. Both the columns of medication and treatment and remarks are left blank in the treatment chart. As per the letter dated 13.08.2015 issued by Dr. H. Kapoor the original record has been misplaced. Further the said letter is a photocopy and not original. The letter dated 13.08.15 is also not certified by any HOD of the Hospital. The representative of the complainant (his brother) Mr. Dimple could not rebut the facts as pointed out to him. Hence, keeping in view all the above facts, I hold that the Insurance Company had rightly rejected the claim on the ground that the claim had been submitted with fraudulent papers for seeking reimbursement of a manipulated claim. I see no reason to interfere with the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. Jai Prakash
Vs
United India Insurance Company Ltd.

DATE: 04.12.2015

1. The complainant alleged that he was admitted in D.R. Maternity and Nursing Home from 20.11.14 to 22.11.14 for cyst surgery (dental). He had submitted all the necessary papers of the claim to the TPA/Insurance Company for reimbursement of Rs. 99,914/- but the Insurance Company had denied the claim on the ground of dental surgery/treatment of any kind unless necessitated by accident and requiring hospitalization is not payable. He had sought the relief of Rs. 99,914/- from this forum.

2. The Insurance Company vide its letter dated 13.07.15 had rejected the claim under exclusion clause no. 4.8 which states that "dental treatment of surgery of any kind unless necessitated by accident and requiring hospitalization" is not payable. The patient was treated for periapical abscess i.e. dental treatment which is not attributable to any accident/injury.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant had alleged that he was admitting in D.R. Maternity and Nursing home from 20.11.14 to 22.11.14 for dental surgery (cyst in the jaw). He had submitted all the necessary papers of the claim to the Insurance Company for reimbursement of claim of Rs. 99914/-. The Insurance Company had rejected the claim on the ground that the dental treatment/surgery of any kind unless necessitated by accident and requiring hospitalization is not payable. The Insurance Company had stated that the claim was repudiated under exclusion clause no. 4.8 which states "dental treatment of surgery of any kind unless necessitated by accident and

requiring hospitalization" is not payable. The patient took treatment in D.R. Maternity and Nursing Home on 20.11.14 to 22.11.14 for dental surgery which is not attributed to any accidental injury. The same is excluded from the scope of the policy.

On perusal of the claim papers placed on record I find that the patient was admitted in D.R. Maternity and Nursing Home from 20.11.14 to 22.11.14 for dental surgery. As per policy terms and condition the dental surgery/treatment (cyst in jaw of any kind) is not payable, unless necessitated by accident and requiring hospitalization. The complainant was treated for Dental cyst. I find that the Insurance Company had rightly rejected the claim as the same is excluded from the scope of the policy. I see no reason to interfere with the decision of Insurance Company. **Accordingly the complaint filed by the complainant is hereby dispose off.**

In the matter of Sh. Sushil Kr. Verma
Vs
Oriental Insurance Company Ltd.

DATE: 21.12.2015

1. The complainant alleged that he was admitted in Sri Balaji Action Medical Institute from 09.10.2014 to 10.10.2014 for the treatment of chest pain associated with sweating ghabrahat. He had submitted the entire necessary medical papers to the TPA/Insurance Company for reimbursement of Rs. 27136/- but the Insurance Company had denied the claim on the ground of admission was primarily for Evaluation/diagnostic purpose which is not followed by active treatment. He had sought the relief of Rs. 27136/- from this forum.

2. The Insurance Company reiterated vide its Self Contained Note dated 15.12.14 that the claim was rejected under exclusion clause 4.8 of the policy which states Group Mediclaim policy does not cover expenses incurred at Hospital or Nursing Home primarily for Evaluation/diagnostic purpose which is not followed by the active treatment for ailment. The patient was admitted in hospital as the case of "CAD" with Type II DM and was managed conservatively with oral tablets only.

3. I heard the complainant. The Insurance Company was absent on the date of hearing. During the course of hearing the complainant had alleged that he was admitted in Sri Balaji Action Medical Institute from 09.10.14 to 10.10.14 for the treatment of chest pain associated with sweating and ghabrahat. He was diagnosed as a case of CAD-Non critical and DM Type-II. The Insurance Company had denied the claim on the ground that admission was primarily for evaluation and diagnostic purpose which was not followed by active line of treatment. The Insurance Company vide its self contained note dated 26.08.2015 had stated that the claim was rejected under policy terms and conditions no. 4.8 which states Group Mediclaim policy does not cover expenses incurred at Hospital or Nursing Home primarily for Evaluation/diagnostic purpose which is not followed by the active treatment for ailment. The patient Mr. Sushil Kumar

Verma was admitted in Hospital from 09.10.14 to 10.10.14 and diagnosed as a case of CAD-Non Critical with DM Type-II. Treatment given to him was conservative and only oral tablets were given

to him. There was no active line of treatment and hospitalization was primarily for investigation and evaluation purpose. As per opinion of Dr. Vipin Gupta taken by the Insurance Company, there were some discrepancies in the claim i.e.

I) Insured as per IPD papers is noted to be having chest pain, sweating, ghabrahat, dysnoea on exertion for last 3 days. His Trop T test done was negative. Insured thus was not suffering from any critical CAD which warranted immediate hospitalization.

II) Insured during hospitalization had primarily undergone tests- TMT, Stress Echo etc, which could have been done on an OPD basis too.

III) Insured during hospitalization was administered only 5-6 oral tablets. No active treatment/invasive procedure done to justify hospitalization.

IV) Insured finally diagnosed as non critical CAD-no proper diagnosis, probably it was just an anxiety problem as mentioned at many places in IPD papers. He had undergone coronary angiography in the past which also was inconclusive for CAD.

On perusal of claim papers placed on record I find that the patient was diagnosed as a case of CAD-Non critical, Type-II DM. his stress ECO test done was found negative. The patient was admitted in hospital as the case of "CAD" with Type II DM and was managed conservatively with oral tablets only. He was given conservative treatment and was administered only oral medication. Hence, I find that the Insurance Company had rightly rejected the claim under policy clause 4.8 Group Mediclaim policy which does not cover expenses incurred at Hospital or Nursing Home primarily for Evaluation/diagnostic purpose which is not followed by the active treatment for ailment. I see no reason to interfere with the decision of Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Ms. Lali Gupta
Vs
The ICICI Lombard General Insurance Company Ltd.

Date:28.12.2015

1. The complainant alleged that she was suffering pain in left leg and admitted in Primus Super Speciality Hospital from 15.06.14 to 22.06.14 and diagnosed as Advanced Osteoarthiritis of Left knee. She was operated for left total knee replacement on 16.06.2014. She had submitted all the necessary papers of the claim to the Insurance Company for reimbursement of Rs. 3, 16,730/- but the Insurance Company had rejected the claim under "Non-disclosure of material facts". She had a mediclaim policy from ICICI Lombard from 2005 to 2014 and operated earlier also for Right knee replacement. She had sought the relief of Rs. 3, 16,730/- plus Rs. 50,000/- for mental agony.

2. The Insurance Company vide its letter dated 16.10.2014 had rejected the claim under part III clause (1) of policy schedule that as per document available the patient was a known case of osteoarthritis and undergone total knee replacement in 2004 which falls prior to policy inception and not declared during policy inception. Based on the documents submitted in support of the claim, the Insured was suffering prior to policy commencement. The Insured had not disclosed

the same at the time of commencement of the policy. Accordingly the claim was rejected and policy was also terminated.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant had reiterated that she was suffering from pain in left leg and admitted in Primus Super Speciality Hospital from 15.06.14 to 22.06.14 and diagnosed as a case of advanced osteoarthritis of left knee. Left total knee replacement was done on 16.06.14. The Insurance Company had rejected the claim on the ground of "Non-Disclosure of material facts". She had a mediclaim policy from ICICI Lombard from 2005 to 2014 and was operated earlier also in February, 2004 at Breach Candy Hospital, Mumbai for her right knee replacement. The Insurance Company had stated that the said claim was repudiated under Part-III clause (I) of policy schedule that the patient was a known case of Osteoarthritis and undergone total

knee replacement (Right) in 2004 which falls prior to policy inception and not declared during policy inception. The insured was suffering of the said disease prior to commencement of the policy. The insured had not disclosed the same at the time of taking the policy. Accordingly the claim was rejected and policy was also terminated due to non-disclosure of material facts.

On perusal of the claim papers placed on record, I find that the patient was suffering from pain in left leg and admitted in Primus Super Speciality Hospital from 15.06.14 to 22.06.14 and diagnosed as a case of Advance Osteoarthritis. Left Knee Replacement of total left knee was done on 16.06.2014 in Primus Super Speciality Hospital. As per history sheet of Primus Super Speciality Hospital and discharge summary of Breach Candy Hospital dated 08.02.2004, the patient had been operated earlier in February, 2004 for her right knee replacement which she had not disclosed in proposal form while taking the policy in the year 2005. In the proposal form dated 18.05.15 submitted by the Insured to the Insurance Company she had not disclosed her previous disease i.e. TKR (right) in February, 2004 which was a non-disclosure of material facts on the part of the Insured. Hence, I find that the Insurance Company had rightly rejected the claim under policy terms and conditions part III, clause (i) i.e. Incontestability and duty of disclosure which states "the policy shall be null and void and no benefit shall be payable in the event of untrue or incorrect statement, misrepresentation, mis description or non disclosure in any material particular in the proposal form, personal statement, declaration and connected documents or any material information having been withheld." I see no reason to interfere with the decision of the Insurance Company. Further the Insurance Company had also terminated the policy of the Insured. The Insurance Company is hereby directed to restore the said policy with special exclusion of the disease Osteoarthritis and its co-morbidities. **Accordingly an award is passed with the direction to the Insurance Company to restore the policy with special exclusion of Osteoarthritis (knee Problem).**

In the matter of Sh. Ramesh Chand Jain
Vs
The Oriental Insurance Co.Ltd.

DATE: 28.12.2015

1. The complainant alleged that he was admitted in Mittal Hospital and Research Centre, Ajmer (Rajasthan) from 12.04.2015 to 16.04.2015 and diagnosed as a case of CAD, Acute IWMI, and known case of HTN with the chief complaint of chest pain. The cashless facility was denied by the TPA/Insurance Company. He had submitted all the necessary papers of the claim for reimbursement of Rs. 1, 55,664/-+Rs. 5323/-(post-hospitalization bill) to the Insurance Company but the Company had denied the claim under "two years waiting period" clause. He had sought the relief of Rs. 1.60.987/- + 15% Interest.

2. The Insurance Company vide its letter dated 04.06.2015 had rejected the claim under exclusion clause 4.3 under two years waiting period clause. Mr Ramesh Chand Jain was hospitalized at Gheesibai Memorial Mittal Hospital from 12.04.2015 to16.04.2015 and diagnosed with coronary artery disease, acute inferior wall myocardial infarction and was underwent coronary angiography with angioplasty. As per the available information, the claimant was suffering from hypertension since 10 days. The claimant was covered under Happy Family Floater Policy since 26.07.2013 only. Happy Family Floater Policy does not cover the expenses on treatment of hypertension and its complication during first two years of operation of insurance cover vide exclusion clause 4.3. Hence the claim was not admissible.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant had alleged that he was admitted in Mittal Hosptial and Research Centre, Ajmer (Rajasthan) from 12.04.15 to 16.04.15 and diagnosed as a case of CAD, Acute IWMI, and known case of HTN with the chief complaint of chest pain. The Insurance Company had rejected the claim under two years waiting period clause of the policy. The Insurance Company had stated that Mr. Ramesh Chand Jain was hospitalized at Gheesibai Memorial Mittal Hospital from 12.04.2015 to16.04.2015 with diagnosis coronary artery disease, acute inferior wall myocardial infarction and was underwent coronary angiography with angioplasty. As per the discharge summary and information available the patient was suffering from hypertension since 10 days. The policy was in 2nd year and Happy Family Floater policy does not cover the expenses on treatment of hypertension and its complication during first two years of operation of insurance cover vide policy exclusion clause 4.3.

   On perusal of claim papers placed on record, I find that during hospitalization at Gheesibai Memorial Mittal Hospital the patient was diagnosed as a case of CAD, Acute

IWMI, and known case of HTN. He underwent for coronary angiography with angioplasty on 12.04.15. As per discharge summary dated 12.04.15 the patient was suffering from Hypertension since 10 days. The claimant is covered under Happy Family Floater policy since 26.07.13 only. The policy does not cover the expenses on treatment of hypertension and its complication during first 02 years of operation of insurance policy under policy exclusion clause 4.3. I find that the Insurance Company had rejected the claim under policy clause 4.3. I see no reason to interfere with the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Sh. Naresh Upadhyay
Vs
Oriental Insurance Company Ltd.

DATE: 15.01.2016

1. The complainant alleged that he was admitted in Saraswati Hospital and Cancer Care Centre from 02.04.2015 to 04.04.2015 and diagnosed as a case of LRTI. He was suffering from high grade fever and breathlessness. He had submitted all the necessary papers of the claim to the TPA M/s Good Health for reimbursement of the claim for Rs. 41,156/- but the Insurance Company had not settled his claim so far. He had sought the relief of Rs. 41,156/- from this forum.

2. The Insurance Company had submitted the self contained note and reiterated the same. The claim was rejected under policy clause 2.1 as the hospital was not registered and has 10 beds only.

3. I heard both the sides, the complainant as well as the Insurance Company. The complainant stated that he was not aware that Saraswati Hospital and Cancer Care Centre it was not a registered hospital. He was orally informed by the Insurance Company that claims of other cases have been settled by the Insurance Company. The Insurance Company was represented by Mr. Sunil Oberoi, A.O., who submitted the self contained note only during the hearing. The representative submitted that claim had been repudiated as the treatment had been taken in a non-registered hospital. The terms and conditions of the policy clearly state that treatment taken only in a registered hospital is covered/payable. As per policy terms and conditions no. 2.1 the

hospital does not fulfill the criteria of hospital/nursing home. The Hospital management had applied for registration since eight years but has not yet been registered. The complainant could not substantiate his contention that he was informed by the Insurance Company that claims arising of Saraswati Hospital are covered. The terms and conditions of policy no. 2.1 remain unfulfilled. I see no reason to interfere with the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.** However the Insurance Company is further advised to take note of the fact that the representative has again failed to submit the self contained note in time despite several reminders that Self Contained Note be submitted well in time.

In the matter of Sh. Jai Deo Bhardwaj
Vs
United India Insurance Company Ltd.

DATE: 13.01.2016

1. The complainant had alleged that his wife was admitted in Fortis hospital, Noida from 26.07.15 to 30.07.15 for operation of the uterus. He had health plan from HDFC Ergo vide policy no. 2825200425750000000 from 07.02.13 to 06.02.15. He had submitted all the necessary papers of the claim but the Insurance Company had denied the claim on the ground of pre-existing disease and treating the present policy as a fresh policy.

2. The Insurance Company vide its reply dated 20.10.2015 had repudiated the claim on the ground of pre-existing disease. Policy under reference had been treated as fresh policy since there was no request from the insured for portability from the previous Insurance Company.

3. I heard both the sides, the complainant as well as the Insurance Company. While reiterating his submission dated 30.10.2015, the complainant said that the agent himself had filled the proposal form, and therefore he should not be penalized for not

mentioning the previous policy details and deny him the benefits.
The Insurance Company stated that previous policy particulars had not been disclosed by the complainant, and nor had he applied for portability benefits, therefore current policy was treated as a fresh policy and claim was denied on the reason of it being a pre-existing disease.

The complainant had signed the proposal form, he could not provide any proof of having applied for portability which is mandatory for the portability benefits. Hence the current policy would be treated as a fresh policy. The disease uterine fibroid and menorrhagia has a "two year waiting period" as per clause 4.3. The claim arose in 26.07.15 i.e. within the first year of the policy. I see no reason to interfere with the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Sh. Abhisek Kumar
Vs
United India Insurance Company Ltd.

DATE: 29.01.2016

1. The complainant had alleged that he was admitted in Manglam Hospital, West Vinod Nagar, Delhi from 30.10.14 to 03.11.14 and diagnosed as a case of Enteric fever with Hepatitis. He had submitted all the necessary papers of the claim to the TPA/Insurance Company but the Insurance Company had rejected his claim on the ground that the claim papers were not found in order.

2. The Insurance Company vides its letter dated 11.05.2015 had rejected the claim on the ground of policy terms and conditions no. 5.7 of the policy which states "The Company shall not be liable to make any payment under this policy in respect of any claim if such claim be in any manner fraudulent or supported by any fraudulent means of device whether by the insured Person or by any other Person acting on his behalf." On the basis of investigation report the claim papers submitted by the Insured were not found in order and hence claim was rejected.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant alleged that he was admitted in Manglam Hospital, West Vinod Nagar, Delhi from 30.10.14 to 03.11.14 and diagnosed as a case of Enteric fever with Hepatitis. He had submitted all the necessary papers of the claim to the TPA/Insurance Company but the Insurance Company had rejected his claim on the ground that the claim papers were not found in order.

The Insurance Company had stated that the claim was rejected on the ground of policy terms and conditions no. 5.7 of the policy which states "the Company shall not be liable to make any payment under this policy in respect of any claim if such claim be in any manner fraudulent or supported by any fraudulent means of device whether by the insured Person or by any other Person acting on his behalf." M/s Medsave TPA
Healthcare had investigated the said case through their investigator and found the following discrepancies to quote:

- The patient did not co-operate with investigator in verifying the facts of the case.
- No purchase invoice was found with the hospital. Batch No. of medicine administered to the patient, was not in records with the hospital.
- No reason for Inj. Hepamerz administered was found as patient's LFT was within normal limits.

- Hospital has pharmacy but they have submitted the bills made on hospital letter head.On perusal of the claim papers placed on record, I find that the patient Mr. Abhishek Kumar was admitted in Manglam Hospital from 30.10.14 to 03.11.14 and diagnosed as a case of Enteric fever with Hepatitis. At the time of admission the patient's

temperature was 99° F with BP 110/80 and the patient was treated conservatively. The patient was admitted in hospital for 05 days but no treatment progress chart/report was prepared by the Nursing Staff/attending doctor. The bills of medicines and lab charges were found to be on the hospital letter head although the hospital has its own pharmacy. No purchase invoice was found with the hospital. Batch no. of medicine administered to the patient was not in records with the hospital. Further, it is also noticed that all the medical papers prepared in same handwriting. During the personal hearing the complainant could not refute the facts as pointed out to him and could not prove his case with cogent and reliable documents.

Hence, I find that the Insurance Company had rightly rejected the claim under policy clause 5.7 which states that no claim would be payable if found to be fraudulent. I see no reason to interfere with the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Sh. Markenday Mishra
Vs
Oriental Insurance Company Ltd.

DATE: 03.02.2016

1. The complainant had alleged that his wife was admitted in Fortis Hospital from 11.03.15 to 13.03.15 and diagnosed as a case of left tubal ectopic pregnancy with hemoperitoneum with severe anemia. He had availed the cashless facility from DHS-TPA (United India Insurance Company) under his Corporate HDFC Ergo Policy and the claim was settled by the TPA M/s Dedicated Health Care Services (TPA) Pvt. Ltd. after deducting the 20% co-payment and some additional medicine bills. So, he claimed the same from Oriental Insurance Company and submitted the documents to M/s Park TPA for reimbursement of Rs. 24,845/- but the claim was rejected on the ground that the Ectopic pregnancy was not covered under the Happy Family Floater Policy. He had sought the relief of Rs. 24,845/- from this forum.

2. The Insurance Company vides its email dated 29.06.15 had rejected the claim under policy exclusion clause 4.13 which states that "any treatment arising from or traceable to pregnancy, child birth, miscarriage, caesarean section, abortion or complications of any of these including changes in chronic condition as a result of pregnancy is not covered" hence, the expenses on treatment of Ectopic Pregnancy are not covered under the Happy Family Floater Policy.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant alleged that his wife was admitted in Fortis Hospital from 11.03.15 to 13.03.15 and diagnosed as a case of left tubal ectopic pregnancy with hemoperitoneum with severe anemia. He had availed the cashless facility from DHS-TPA (United India Insurance Company) under his Corporate HDFC Ergo Policy and the claim was settled by the TPA M/s Dedicated Health Care Services (TPA) Pvt. Ltd. after deducting the 20% co-payment and some additional medicine bills. So, he claimed the same from Oriental Insurance Company and submitted the documents to
M/s Park TPA for reimbursement of Rs. 24,845/- but the claim was rejected on the ground that the Ectopic pregnancy was not covered under the Happy Family Floater Policy.

The Insurance Company had rejected the claim under policy exclusion clause 4.13 which states that "any treatment arising from or traceable to pregnancy, child birth, miscarriage, caesarean section, abortion or complications of any of these including changes in chronic condition as a result of pregnancy is not covered" hence, the expenses on treatment of Ectopic Pregnancy were not covered under the Happy Family Floater Policy.

On perusal of claim papers placed on record, I find that Mrs. Kanak Lata was admitted in Fortis Hospital from 11.03.15 to 13.03.15 and diagnosed as a case of Left Tubal Ectopic Pregnancy with hemoperitoneum with severe anemia. During the admission she was treated for Lap drainage of Hemoperitoneum with Milking of Left tube under GA on 11.03.2015 per operative findings About 1.5 L of hemoperitoneum was present. Uterus was bulky in size. A 2cmX 2 cm subserous fibroid was present on the posterior uterine wait. Right tube and ovary were healthy. Tubal abortion with POCs protruding out of the left tube soon. Flimsy adhesions were present between anterior abdominal wall and omentum. Flimsy adhesions were present in the periheptaic area. The Insurance Company had rejected the claim under policy exclusion clause no. 4.13 which states that "any treatment arising from or traceable to pregnancy, child birth, miscarriage, caesarean section, abortion or complications of any of these including changes in chronic condition as a result of pregnancy is not covered." As per medical literature the term pregnancy means, a condition of having a growing foetus in the womb of the mother, however Ectopic Pregnancy is an illness which is a pathological and abnormal condition and would never result in child birth, it may be life threatening if unattended, hence requires hospitalization. The policy excludes only pregnancy resulting to childbirth, hence insurer erred in disallowing claim for Ectopic pregnancy under policy exclusion clause no. 4.13 As per discharge summary the patient was diagnosed as a case of Left Tubal Ectopic Pregnancy with hemoperitoneum with severe anemia and treated for Lap drainage of Hemoperitoneum with Milking of Left tube under GA and not for pregnancy, child birth, miscarriage. Hence, I hold that the Insurance Company is liable to settle the claim. **Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant.**

In the matter of Sh. M.L. Goyal
Vs
Oriental Insurance Company Ltd.

DATE: 06.01.2016

1. The complainant alleged that he had a mediclaim policy from Oriental Insurance Company for the past 4-5 years. During 2014-15 a policy was issued for the validity (from 08.04.14 to 07.04.15) through cheque. However, the said cheque was dishonored, resulting in cancellation of the policy. On receipt of information about the dishonor of the said cheque, he immediately deposited the cash with the Insurance Company to get the policy renewed. This resulted in alleged break of 07days (15.04.14 to 14.04.15). He was admitted in Sehgal News Hospital from 27.05.15 to 28.05.16 and then he was referred to Jaipur Golden Hospital and was hospitalized from 28.05.15 to 30.05.15. The Insurance Company had rejected the claim on the ground that the treatment of Hypertension and its complication CAD is not covered during first 02 years of the policy vide exclusion no. 4.3. The Insurance Company had treated the policy as fresh policy

since there was a break of 07 days on renewal of the policy. He had sought the relief of Rs. 2, 65,093/- from this forum.

2. The Insurance Company vide its letter dated 10.08.2015 and 20.08.2015 had rejected the claim under policy exclusion clause 4.3 of the policy which states that "policy does not cover the expenses incurred on treatment of hypertension and its complication (CAD) during first two years of insurance cover. There was a break of 07 days in renewal of the policy which was not condoned by the competent authority."

3. I heard both the sides, the complainant as well as the Insurance Company. The complainant reiterated his submissions mentioned above and stated that he has had the policy for the last 4-5 years. When he came to know of cheque dishonour he immediately paid cash. There was delay of only 07 days which may be condoned. Insurance Company also reiterated their submissions that claim had been denied under clause 4.3 of the policy which disallows expenses incurred on treatment of hypertension and CAD during first two years of insurance cover. Since there was a break of 07 days which had not been condoned by Competent Authority therefore the claim had been denied.

I find that the complainant has had this policy for more than 4-5 years. As per Health Regulation-2013 a grace period of 30 days is given on renewal of the policy and the Insurance Company can suo motto condone the delay of 07 days but the Insurance Company had failed to do so. Hence, I condone the delay of 07 days and restore the continuity benefits of the policy. In this case, the cheque had been paid well in time for renewal. The delay of 07 days happened only because of cheque dishonor, and the complainant had immediately paid cash and got the policy renewed. The delay of 07 days is hereby condoned. **Accordingly an award is passed with direction to the Insruance Company to condone the 07 days delay and settle the claim.**

In the matter of Sh. Surender Kumar
Vs
United India Insurance Company Ltd.

DATE: 30.12.2015

1. The complainant alleged that he was admitted in Paras Hospital, Gurgaon from 19.06.15 to 20.06.15 and diagnosed as a case of Left Chronic Suppurative Otitis Media. He was suffering from decreased hearing in left ear since 01 month. Initially the TPA M/s Paramount Health Services (TPA) Pvt. Ltd. had approved the cashless for Rs. 40,000/- on 15.06.2015 but when he was discharged from Hospital on 20.06.15 they had informed him that only Rs. 19,000/- had been approved. He had to make the payment of Rs. 30,000/- to the hospital from his own pocket. The total bill of the hospital was Rs. 49,000/-. He had submitted all the necessary papers of the claim to the TPA for reimbursement but the TPA/Insurance Company had not settled his claim so far. He had sought the relief of balance amount of claim from this forum.

2. The Insurance Company vides its email dated 06.08.2015 had apprised the Insured that as per Tailor Made Group Mediclaim Policy issued to M/s BPTP Limited, the sum insured is Rs. 3,00,000/- and in case of hospitalization the room rent entitlement is Rs. 3000/- per day where as the patient have opted a room rent category of Rs. 6750/- therefore the room rent is restricted to Rs. 3000/- per day and other expenses are paid as per reasonable and customary clause (Insurance Company's decision will be final) and the surgery performed in this case comes under Elective Surgery which attracts PPN Network rates. The package rate of Tympanoplasty is Rs.16000/- and for Mastoidectomy is Rs. 8000/- (surgery at same site so 50% was given) hence the total entitlement comes to Rs. 24000/-. There is an excess clause of Rs. 5000/- deductible in each and every claim therefore the total payable amount comes to Rs. 24000/--Rs. 5000/-=Rs. 19000/- which is already paid to the complainant.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the Insurance Company had informed that they had paid Rs. 19,000/- to the complainant and agreed to settle the claim according to terms and conditions no. 1.2 of Tailor Made Group Mediclaim Policy which states "In the event of any claim becoming admissible under this scheme, the Company will pay through TPA to the Hospital/ Nursing Home or Insured person the amount of such expenses as would fall under different heads mentioned below and as are reasonably and necessarily incurred thereof by or on behalf of such insured person but not exceeding the sum insured in aggregate mentioned in the schedule hereto:

A) Room, Boarding and Nursing expenses as provided by the Hospital/Nursing Home not exceeding 1% of the sum insured per day or the actual amount whichever is less. This also includes nursing care, RMO charges, IV Fluids/Blood transfusion/injection administration charges and similar expenses.

B) Intensive Care Unit (ICU) expenses not exceeding 2% of the sum insured per day or actual amount whichever is less.

C) Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialists Fees.

D) Anesthetic, Blood, Oxygen, Operation Theatre Charges, Surgical appliance, Medicines and Drugs, Dialysis, Chemotherapy, Radiotherapy, Cost of Artificial Limbs, cost of prosthetic devices implanted during surgical procedure like pacemaker, orthopedic implants, infra cardiac valve

replacements, vascular stents, relevant laboratory/diagnostic tests, X-ray and such similar expenses that are medically necessary.

E) Hospitalization expenses (excluding cost of organ) incurred for/by donor in respect of organ transplant to the insured.

1. The amount payable under 1.2 C&D above shall be at the rate applicable to the entitled room category. In case the insured person opts for a room with rent higher than the entitled category as in 1.2 A above, the charges payable under 1.2 C& D shall be limited to the charges applicable to the entitled category. This will not be applicable in respect of medicines and drugs and implants.
2. No payment shall be made under 1.2 C other than as part of the hospitalization bill.

Hence, Insurance Company is hereby directed to settle the claim as per policy terms and condition no. 1.2 and pay the difference of claim amount to the complainant.**Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Ms. Seema Kochhar
Vs
Oriental Insurance Company Ltd.

DATE: 13.01.2016

1. The complainant alleged that she had taken the mediclaim policy from New India Assurance Company Ltd. from 21.10.2011 to 20.10.2014. Thereafter, the policy was renewed with the Oriental Insurance Company from 10.10.2014 to 09.10.2015 and further renewed from 10.10.15 to 09.10.16. She was admitted in Columbia Asia Hospital, Gurgaon from 01.04.2015 to 03.04.15 and diagnosed as a case of Diabetes Mellitus, Syncope and Hyperglycemia without coma. The brief history of illness was giddiness, anxiety and fever since 1-2 days. She had submitted the claim papers to the Insurance Company for reimbursement of the claim for Rs. 33,570/- but the Insurance Company had denied the claim on the ground of "two years waiting period" clause of the policy. She had sought the relief of Rs. 33570/- from this forum.

2. The Insurance Company vides its letter dated 28.09.2015 had rejected the claim on the ground of policy exclusion clause no. 4.3 as the illness for which the patient was treated was not covered in the first two years of the policy. The policy issued by Oriental Insurance Company was in the first year policy which did not cover diabetes. As regard the previous mediclaim policies taken by the Insured from New India Assurance, the Insured had not declared the details of the previous policies in proposal form nor did the insured apply for portability before 45 days of the expiry of the previous policy.

3. I heard both the sides, the complainant as well as the Insurance Company. The complainant reiterated that she has been continuously covered since 2011 under the mediclaim policies. She was not aware of the portability clause. The Insurance Company

stated that complainant had not declared details of previous insurance and had neither applied for portability. Previously she was covered under mediclaim policy with NIA vide policy no. 31150334110300000175 from 21.10.11 to 20.10.12 which was subsequently renewed from 21.10.12 to 20.10.13 policy no. 31150334120300000125 and further renewed from 21.10.13 to 20.10.14 under policy no. 31150334132600000004. Thereafter he had taken the policy from Oriental Insurance Company Ltd. policy no. 215500/48/2015/4266 from 10.10.2014 to 09.10.15 and the same was treated as a fresh policy. The claim had been rejected under clause 4.3 as the illness for which the patient was treated was not covered in the first two years of the policy as per the terms and conditions of the policy. I see no reason to interfere with the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Ms. Priyanka Sharma
Vs
Oriental Insurance Company Ltd.

DATE: 28.01.2016

1. The complainant alleged that her father was admitted in Medanta the Medicity, Gurgaon from 10.01.15 to 14.01.15 and diagnosed as a case of Coronary artery disease (Double Vessel Disease), LV Dysfunction (EF-40%) Coronary angiography was done on 12.01.15 which revealed double vessel disease. Her father underwent for PTCA + Stent to LAD and LCX on 12.01.15. She had submitted all the necessary papers of the claim to the TPA M/s M.D. India Health Services for reimbursement of the claim amounting to Rs. 4, 53,112/- but the Insurance Company had denied the claim on the ground of pre-existing disease. She had sought the relief of Rs. 4, 53,112/- from this forum.

2. The Insurance Company vide its letter dated 31.03.2015 had repudiated the claim under policy exclusion clause 4.1 which states "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), in case of any of the insured person of the family, when the cover incepts for the first time, are excluded for such insured person upto 04 years of this policy being in force continuously." On perusal of the claim papers it has been observed that the current illness Awmi, Double Vessel disease is a complication of hypertension which was since 10 years whereas the policy was in 3rd year, hence it is a pre-existing disease and the claim is not payable.

3. I heard both the sides, the complainant (represented by her father) as well as the Insurance Company. The complainant submitted that she had taken a policy vide P.No. 214300/48/2014/6920 21.03.14 to 20.03.15**.** He was hospitalized for the treatment of CAD from 10.01.15 to 14.01.15. Despite submission of all the necessary papers to the TPA M/s M.D. India Health Services for reimbursement of the claim the Insurance Company denied the claim on the ground that the patient was suffering from Hypertension which is closely linked with CAD and hypertension was the pre-existing disease therefore hit by the exclusion clause 4.1. The Insurance Company reiterated its reasons for repudiating the claim under exclusion clause 4.1 which states "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), in case of any of the insured person of the family, when the cover incepts for the first time, are excluded for such insured person upto 04 years of this policy being in force continuously."

On perusal of the documents submitted on record, I find that the initial assessment and treatment record dated 10.01.15 reveals the reasons for admission of HTN/GRD and in the column of past medical history has been shown as HTN 10 years back. I find both these documents seem to have been modified subsequently as the word "one episode" on dated 10.01.15 and the word "Non" on dated 10.01.15 added in front of HTN are of a different ink. The doctor

certificate dated 12.01.15 i.e. after the date of admission clarifies that the patient had one episode of HTN 10 years back and that he was not on any anti hypertensive medicine and had no prior history of any DM 2 and heart disease. From the indoor treatment paper submitted by the Company I find that the patient was not treated for hypertension and diabetes. He had no history of heart disease as also supported by certificate given by the Vinayak Hospital dated 31.01.2015 I am of the opinion that the corrections made on the ICP were apparently made on the same day as the date of the operation. The claim is therefore payable. **Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant.**

In the matter of Sh. Ashok Kumar Jha
Vs
United India Insurance Company Ltd.

DATE: 11.02.2016

1. The complainant alleged that he was working with KEC International Ltd. and covered under the above-said policy with UIIC. He was suffering from CA colon (Cancer) since September, 2014 and underwent treatment with Indraprastha Apollo Hospital, Delhi. He was operated upon in last September and had 12 courses of chemotherapy. On the advices of his treating doctor he was admitted for PED and other investigation on 01.09.2015. He had incurred Rs. 48,678/- towards this medical treatment and submitted all the necessary papers of the claim for reimbursement of Rs. 48,678/- but the Insurance Company had denied the claim on the ground that the hospitalization was not required. He had sought the relief of Rs. 48,898/- from this forum.

2. The TPA M/s Medi Assist India (TPA) Pvt. Ltd. vide its email dated 12.10.15 had informed the Insured that the said claim is not payable as the hospitalization for the said disease was not justified for the given treatment and expenses for diagnostic purpose are not admissible, hence the claim was denied under clause 4.11of the policy which states "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 and 1.1 of the policy which states "Now this policy witnesses that subject to the terms, conditions, exclusions and definitions contained herein or endorsed, or otherwise expressed hereon the Company undertakes that if during the period stated in the Schedule or during the continuance of this policy by renewal any insured person shall contract any disease or suffer from any illness (hereinafter called Disease) or sustain any bodily injury through accident (hereinafter called Injury) and if such disease or injury shall require any such insured Person, upon the advice of a duly qualified Physician/Medical Specialist/Medical practitioner (hereinafter called Medical Practitioner) or of a duly qualified Surgeon

(hereinafter called Surgeon) to incur hospitalization/domiciliary hospitalization expenses for medical/surgical treatment at any Nursing home/hospital in India as herein defined (hereinafter called Hospital) as an inpatient, the Company will pay through TPA to the Hospital/ Nursing Home or Insured the amount of such expenses as are reasonably and necessarily incurred in respect thereof by or on behalf of such insured person but not exceeding the sum insured in aggregate in any one period of insurance stated in the schedule hereto." The patient is known case of adenomacarcinoma of colon with anemia and admitted for re-evaluation for follow up and had undergone PET CT investigation evaluation for the same.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant had reiterated the same. The Insurance Company had stated that the patient was admitted in Indraprastha Apollo Hospital on 01.09.15 for re-evaluation for follow up. During the hospital stay patient underwent PET CT scan which is diagnostic procedure and discharged on same day i.e. on 01 September, 2015. Hence claim cannot be considered for settlement under definition 1.1 and exclusion clause no. 4.11 of the policy which states "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 and 1.1 of the policy which states hospitalization expenses for medical/surgical treatment at any Nursing home/hospital in India as herein defined (hereinafter called Hospital) as an inpatient, the Company will pay through TPA to the Hospital/ Nursing Home or Insured the amount of such expenses as are reasonably and necessarily incurred in respect thereof by or on behalf of such insured person but not exceeding the sum insured in aggregate in any one period of insurance stated in the schedule hereto."

On perusal of the claim papers placed on record, I find that Mr. Ashok Kumar Jha was admitted in Indraprastha Apollo Hospital on 01.09.15 and diagnosed as a case of Adenocarcinoma colon (moderately differentiated) and after clinical evaluation the patient underwent for Postitron Emission Tomography (PET) and Computed Tomography (CT) and after investigation and evaluation (PET, CT) the medicine was also prescribed by the treating doctor. Hence the contention of the Insurance Company that the patient was admitted for re-evaluation and follow up only and that clause 4.11 i.e. would be applicable in the said case is not correct. The Insurance Company had also quoted policy clause 1.1 in its rejection letter but on perusal of the said clause I find that the clause 1.1 shall also not applicable in this case as the complainant was admitted in Indraprastha Apollo Hospital on 01.09.15 and underwent for PET CT after clinical evaluation. The Insurance Company could not prove its contention with cogent and

reliable documents that the patient was admitted for investigation and evaluation purpose only. Hence, I find that the Insurance Company is liable to settle the claim. **Accordingly an award is passed with the direction to the Insurance Company to settle the clam and pay the admissible amount to the complainant.**

In the matter of Mr. Jatinder Pal Singh Kohli
Vs
The United India Insurance Company Ltd.

DATE: 28.12.2015

1. The complainant alleged that he had applied for cashless authorization for his cataract RE treatment which was at Bharti Eye Foundation, East Patel Nagar, New Delhi, costing Rs. 1,25,000/- (Lensx Femto Laser Cataract Surgery) but the Insurance Company had only approved Rs. 24,000/- (for normal surgery) as against Rs. 1,25,000/- (Lensx Femto Laser Cataract Surgery). He had sought the relief of Rs. 1, 25,000/- for cashless authorization alongwith Rs. 25,000/- for mental harassment from this forum.

2. The TPA M/s Heritage Health TPA Pvt. Ltd, vide its email dated 20.08.2015 had allowed the cashless authorization for Rs. 24,000/- as per GIPSA package for MICS procedure.

3. I heard the complainant. The Insurance Company was absent on the day of hearing i.e. 16.11.15. During the course of hearing the complainant had alleged that he had applied for cashless authorization for the operation of cataract in Right Eye which was to be taken place at Bharti Eye Foundation, East Patel Nagar, New Delhi and costing Rs. 1,25,000/- (lensx Femto Laser Cataract Surgery) but the TPA M/s Heritage Health TPA (P) Ltd. vide its letter dated 20.08.2015 had allowed the cashless authorization for Rs. 24,000/- only as per GIPSA package for MICS procedure. He further submitted that he had not been informed by the Insurance Company at any point of time about GIPSA Package. The sum insured under the policy was Rs. 5.75 Lacs and as per terms and conditions of Health Insurance Policy-Gold Section 1.21 expenses in respect of limits per surgery for cataract, Hernia, hysterectomy is restricted to actual expenses incurred or 25 % of the sum insured whichever is less. As per this clause the maximum reimbursable amount comes out to Rs. 1,31,250/- Lacs of as per policy gold section clause hence he

was eligible for cashless approval of Rs. 1, 25,000/- as sought by him for the operation of cataract in right eye.

On perusal of the claim papers placed on record I find that the complainant had applied for cashless authorization for cataract surgery in right eye at Bharti Eye Foundation and costing Rs. 1, 25,000/- approx but the TPA M/s Heritage Health TPA (P) Ltd. vide its letter dated 20.08.15 had allowed the cashless authorization for Rs. 24,000/- only as per GIPSA package. On the date of hearing the Insurance Company was absent. The Insurance Company had also not filed the self contained note, or any other relevant papers of the case. As per terms and conditions of the Health Insurance Policy-Gold submitted by the complainant, the clause 1.21 states that expenses in respect of limits per surgery for cataract, hernia, hysterectomy is restricted to actual expenses incurred or 25% of the S.I. whichever is less. During the course of hearing the complainant had stated that he had not been informed by the Insurance Company about GIPSA package. Hence, I find that the claim be decided on actual expenses incurred or 25% of the S.I. whichever is less as mentioned in policy clause 1.21. Hence, insurance Company is hereby directed to allow the cashless authorization according to terms and conditions no. 1.21 of the Health Insurance Policy-Gold issued to the complainant. **Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant.**

In the matter of Sh. Baldev Singh
Vs
ICICI Lombard General Insurance Co.Ltd.

DATE: 01.01.2016

1. The complainant alleged that his motor cycle was stolen on 20.12.2014 from his residence. He had lodged the FIR No. 1175 dated 20.12.2014 at P.S. Neb Sarai, South Delhi in this regard and submitted all the necessary papers of the claim to the Insurance Company for settlement of claim but the Company had rejected the claim on the ground of reasonable steps to safeguard the vehicle from loss or damage was not taken by the insured. The IDV of vehicle was Rs. 30,765/-. He had sought the relief of Rs. 30,765/- from this forum.
2. The Insurance Company vide its letter dated 18.05.2015 had rejected the claim on the ground that the lock of the vehicle stolen was damaged and it could be started with any local key. This gross negligent act regarding vehicle (damage) lock led to the incidence of insured asset being stolen. This is violation of terms and condition of motor insurance policy no. 04 which states-The insured shall take all reasonable steps to safeguard the vehicle from loss or damage and to maintain it in efficient condition.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant alleged that his motor cycle was stolen on 20.12.14 from his residence. He had lodged the FIR no. 1175 dated 20.12.2014 at Police Station Neb Sarai, South Delhi and submitted all the necessary papers of the claim to the Insurance Company for settlement of claim. But the Insurance Company had rejected the claim on the ground of reasonable steps to safeguard the vehicle from loss or damage was not taken by the Insured as the lock of the stolen vehicle was damaged and could be started with any local key. The Insurance Company had stated that the complainant had given a statement at the time of claim that the lock of the vehicle was not in a proper condition and vehicle could be started with any other key also. It shows that the insured had not taken due and reasonable care to safeguard the vehicle as a result of which theft occurred. There is a violation of policy terms and conditions no. 04 which states that "The insured shall take all reasonable steps to safeguard the vehicle from loss or damage

and to maintain it in efficient condition and the Company shall have at all times free and full access to examine the vehicle or any part thereof or any driver or employee of the insured. In the event of any accident or breakdown, the vehicle shall not be left unattended without proper precautions being taken to prevent further damage or loss and if the vehicle be driven before the necessary repairs are effected any extension of the damage or any further damage to the vehicle shall be entirely at the insured's own risk."

On perusal of the claim papers placed on record, I find that the motor cycle of the complainant was stolen on 20.12.14 and in this regard he had lodged the FIR at Police Station, Neb Sarai, South Delhi on 20.12.2014. The Insured Mr. Baldev Singh on 31.12.2014 had given a statement to the Investigator M/s Alpha Risk Control Services that due to heavy use of the said vehicle from the last one and half year the lock condition of the vehicle was very bad. During the movement of the vehicle the key came outside the bike. The bike easily opens with any motor cycle key. After that the Insured was using the said vehicle with the 2nd Key. The Insured had lost his Ist key from his residence. The Insured was aware about the condition of lock but did not change the lock and was using the vehicle with the damaged lock which violates the condition no. 04 of the policy which states "The insured shall take all reasonable steps to safeguard the vehicle from loss or damage and to maintain it in efficient condition and the Company shall have at all times free and full access to examine the vehicle or any part thereof or any driver or employee of the insured. Hence I see no reason to interfere with the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Sh. Gaurav Aggarwal
Vs
Oriental Insurance Company Ltd.

DATE: 31.12.2015

1. The complainant alleged that his father was admitted in Institute of Liver and Biliary Science from 22.05.13 to 03.06.13 and diagnosed as a case of Chronic Calcific Pancreatitis, Post ERCP Pancreatitis (recovering), Micro perforation (contained, self resolved), T2DM, HTN, Hypothyroidism. ERCP for stone removal was done during hospitalization. He had submitted all the necessary papers of the claim to the Insurance Company for reimbursement of Rs. 1,91,039/- but the Company had rejected the claim under pre-existing clause 4.1 of the policy. He had sought the relief of Rs. 1, 91,039/- from this forum.

2. The Insurance Company vide its letter dated 30.09.2013 & 09.12.2014 had rejected the claim under pre-existing clause 4.1 of the policy. The patient was suffering from calcific pancreatitis with DM since 35 years and HTN since 07 years. The current policy was in 3rd year, so it was a case of pre-existing disease and therefore the said claim is not payable under policy clause 4.1 and 4.3 i.e. pre-existing disease and two years waiting period.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant had alleged that his father was admitted in Institute of Liver and Biliary Science from 22.05.13 to 03.06.13 and diagnosed as a case of chronic calcific pancreatitis, post ERCP Pancreatitis (recovering) microperforation and co morbidity: T&DM, HTN, Hypothyroidism. During hospitalization ERCP for stone removal was done. He had submitted all the necessary papers of the claim but the Insurance Company had rejected the claim under policy clause pre-existing disease. The Insurance Company had stated that the complainant Mr. Gaurav Aggarwal had taken the Mediclaim policy for self, wife and his child for the first time on 23.03.11 to 22.03.12 for a S.I. of Rs. 7 Lacs. Subsequently on renewal of the policy i.e. 23.03.12 to 22.03.13 he added his father namely Sh. D.P. Aggarwal. Thereafter, the Insured had further renewed the policy for the period of 23.03.13 to 22.03.14 for S.I. of Rs. 7 Lacs in which he lodged a claim for the treatment of his father Sh. D.P. Aggarwal for whom the policy was to be treated in the 2nd year. Sh. D.P. Aggarwal was admitted in Institute of Liver and Biliary Science Hospital on 22.05.13. As per policy exclusion clause 4.1 & 4.3 calcific pancreatitis disease is pre-existing disease, hence claim is not payable.

   On perusal of the claim papers placed on record, I find that patient Mr. D.P. Agarwal was admitted in Institute of Liver and Biliary Sciences, Vasant Kunj, New Delhi and

diagnosed as a case of chronic calcific pancreatitis, post ERCP Pancreattitis, Microperforation and co-morbidity T2DM, HTN Hypothyroidism.
As per discharge summary the ERCP for stone removal was done during hospitalization. The patient was a known case of Type-2 Diabetes Mellitus, Hypertension and hypothyroidism since many years. He was suffering from T2DM since last 33years, initially on oral drugs later on converted to insulin therapy. During one of his routine examination he was diagnosed to have calculus in main pancreatic duct and features of chronic pancreatitis. CECT abdomen showed large hyperdense intra ducal calculus (12.0 mm) in proximal MPD in head region with upstream dilated MPD (upto 9.0 mm). Since the patient was treated for ERCP for stone removal (calculus in main pancreatic duct) and known case of Type- 2DM (since last 33 years) Hypertension and hypothyroidism which is excluded under policy exclusion clause 4.1 and 4.3. The coverage of Sh. D.P. Agarwal was in the 2nd year (23.03.12 to 22.03.13, 23.03.13 to 22.03.14), therefore not payable.

As per policy exclusion clause no. 4.1 which states "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), in case of any of the insured person of the family, when the cover incepts for the first time, are excluded for such insured person upto 4 years of this policy being in force continuously and 4.3 which states "the expenses on treatment of Hypertension, Diabetes and calculus disease are not payable for first two years of the policy" since the policy/coverage of Mr. D.P. Aggarwal was in 2nd year of the policy (23.03.12 to 22.03.13, 23.03.13 to 22.03.14) and the disease calculus as mentioned in policy clause 4.3 (xix) would be covered only from 3rd year onward, hence I find that the Insurance Company had rightly rejected the claim and I see no reason to interfere with the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. Manoj Khandewal
Vs
Apollo Munich Health Insurance Company Ltd.

DATE: 12.01.2016

1. The complainant alleged that she was admitted in AIIMS from 09.02.0215 to 17.02.2015 and diagnosed as OART knee with Left TKR (total Knee replacement) IN SITU. She had submitted all the necessary papers of the claim to the Insurance Company but the Company had denied the claim under "Non- disclosure of material fact" clause. She had sought the relief of Rs. 1, 78,914/- from this forum.

2. The Insurance Company vide its letter dated 13.04.2015 had rejected the claim under Sec VII rii of policy terms and conditions. The medical history details of OA RT knee with LT TKR is not revealed while taking the policy in the proposal form. Hence, the claim is repudiated due to non-disclosure and concealment of material facts.

3. I heard both the sides, the complainant (represented by his son) as well as the Insurance Company. During the course of hearing the complainant alleged that his mother Mrs. Saroj Khandelwal was admitted in AIIMS from 09.02.15 to 17.02.15 and diagnosed as OA right knee with left total knee replacement in SITU. Total knee replacement (right) with it Patelloplasty was done on 11.02.15 under CSE. He had submitted all the necessary papers of the claim but the Insurance Company had rejected the claim and cancelled the policy under policy clause "Non-disclosure of material facts." The Insurance Company had stated that the medial history details of OA RT Knee with LT TKR (Total Knee Replacement) were not revealed in the proposal form while taking the policy. Hence, the claim was repudiated and policy was also cancelled ab-initio due to non-disclosure and concealment of material facts under Section VII-r (ii) of the policy terms and conditions which states "the policy can be terminated on grounds of misrepresentation, fraud, non-disclosure of material facts or non-cooperation."
   As per discharge summary dated 01.01.13 at AIIMS, New Delhi, the patient, Mrs. Saroj Khandelwal, was a case of pain in Left knee since 08 years and was also a known case of Hypertension and on medication which was not disclosed in the proposal form dated 27.01.2012 submitted by the proposer Mrs. Saroj Khandelwal to the Insurance Company.

   On perusal of the claim papers placed on record, I find that as per discharge summary of AIIMS, New Delhi the patient was admitted from 09.02.15 to 17.02.15 with a history of pain in Right knee since 1.5 years and pain occasional left knee – 02 years TKR. On 11.02.15 right TKR with left Patelloplasty was done by the doctor under CSE. It is also seen from the details of the discharge summary that Mrs. Saroj Khandelwal was admitted from 01.01.2013 to 11.01.2013 and had a history of pain in left knee since 08 years and left TKR was done on 02.01.2013. She was also a case of Hypertension and was on medication. I find that the complainant was also advised by the doctor of AIIMS Hospital on 03.09.2011 for TKR (Lt. side) which was prior to taking the policy in 2012 which makes the disease pre-existing as left TKR was done on 02.01.2013 but these material facts were not revealed by the proposer at the time of taking the policy in proposal form dated 27.01.2012 under column 06 i.e. Medical and Life Style Information which tantamount to non-disclosure concealment of material facts on the part of proposer Mrs. Saroj Khaelwal.

   The Insurance Company had rejected the claim on the ground of non-disclosure and concealment of material facts and cancelled the policy ab initio in consonance with section VII- r (ii) of the policy terms

and conditions. In the case of Satwant Kaur Sandhu Vs New India Assurance (2009) 8 SCC 316, the Hon'ble Supreme Court emphasized that it is obligatory for the proposer to disclose the material facts at the time of filling the proposal form. The Insurance Company is not liable to pay the expenses in case of non-disclosure of material information. Thus it was a case of non-disclosure. Therefore, I uphold the decision of the Insurance Company. I see no reason to interfere with the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Smt. Jatinder Kaur Bagga
Vs
The United India Insurance Company Ltd.

DATE: 05.01.2016

1. The complainant alleged that she holds a mediclaim policy no. 221605/48/10/06/0001794 with United India Insurance Company and since then her policy is continuously being renewed with them. She was having pain in her back for some time and after various consultations, she was admitted to AIIMS as per the advice of Dr. P.K. Julka-Professor, Department of Radiology and oncology at AIIMS. The cashless facility was denied by the TPA. She had filed the necessary papers of the claim for reimbursement of Rs. 2, 21,879/- + Rs. 1, 81,590/-but the Insurance Company had denied the claim. Since it was an ongoing treatment, she filed subsequent claims also but all those had been rejected by the Insurance Company on various pretexts or the other. She had sought the relief of Rs.403469/- (Rs. 2, 21,879 + Rs. 1, 81,590) from this forum.

2. The Insurance Company vide its letter dated 20.11.2014 had apprised the status of the claims (04) to the insured details are as under:-

1. **Claim No. 15866377**-Pre and post hospitalization limit 10% of S.I. had already been exhausted. Hence claim rejected.
2. **Claim No. 122081301045**-No Claim. Documents were not submitted.
3. **Claim No. 122081301037**- No Claim. The insured claimed for supplementary claim but main hospitalization claim was not reflecting in profile. All submitted documents were photo-copied. No originals were provided.
4. **Claim No. 122081301049**-No Claim-documents were not submitted

3. I heard both the sides, the complainant (represented by her husband) as well as the Insurance Company. During the course of hearing the complainant had alleged that his wife Mrs. Jatinder Kaur Bagga was having pain in her back for some time and after various consultations she was admitted to AIIMS as per the advice of Dr. P.K. Julka-Professor, Department of Radiology and Oncology at AIIMS. This was an ongoing treatment where injections are to be given under OPD.
He had filed the 04 claims with the Insurance Company but the Insurance Company had denied all the claims on one pretext or the other. All the relevant papers of the claims were submitted to Insurance Company/TPA but the Insurance Company had not settled the claims so far.

The Insurance Company had stated that the complainant had filed the 04 claims of his wife Smt. Jatiender Kaur Bagga for reimbursement, the status of which was apprised to the Insured vide their letter dated 20.11.2014 details of claims are as under:

1. **Claim No. 15866377- Hospitalization Period**: From June 02, 2011 to June 03, 2011-Pre and post hospitalization limit 10% of S.I. has already been exhausted. Hence claim rejected.
2. **Claim No. 122081301045- Hospitalization Period:** From March 22, 2012 to April 10, 2012 Claim- No Claim Documents were not submitted.
3. **Claim No. 122081301037- Hospitalization Period:** From May 30, 2012 to June 2, 2012- No Claim. The insured claimed for supplementary claim but main hospitalization claim was not reflecting in profile. All submitted documents were photo-copied. No originals were provided.
4. **Claim No. 122081301049- Hospitalization Period:** From 01.05.2012 to 01.05.2012No Claim-documents were not submitted

On perusal of the claim papers placed on record, I find that in claim no. 15866377 (Hospitalization Period from 02.06.2011 to 03.06.2011) all the expenses incurred by the Insured pertain to pre and post hospitalization and as per terms and conditions no. i.e. 1.2 G of the policy, the limit of pre and post hospitalization expenses is actual expenses incurred subject to maximum of 10% of S.I. whichever is less. The S.I. under the policy was Rs. 5 Lacs and the maximum eligibility under pre and post hospitalization would be Rs. 50,000/- which has already been exhausted. Hence, the claim was rejected. The three claims (No. 122081301045, 122081301037 and 122081301049) are pending for want of relevant documents. The Insurance Company would settle these claims on submission of the same.

Hence, the Insured is hereby directed to submit the required documents to the Insurance Company. The Insurance Company is hereby directed to settle the claims accordingly on receipt of the said documents. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. Raman Sethi
Vs
The Apollo Munich Health Insurance Company Ltd.

DATE: 05.01.2016

1. The complainant alleged that he had purchased a family floater policy of Apollo Munich in the year 2011 for a S.I. of Rs. 5 Lacs. It is a portability case from IFFCO Tokio. He had been regularly paying the premium since then and the policy had been continuously running without a break. His wife was admitted in Fortis La Famme Hospital from 16.02.2015 to 20.02.15 and diagnosed as a case of Adenomyosis with multiple uterine fibroids (Tumor). He had applied for cashless service but the Insurance Company had denied the same. He had submitted the necessary papers of the claim to Insurance Company for reimbursement of Rs. 4, 25,402/- but the Company had denied the claim on the ground of non-disclosure and concealment of material facts. He had sought the relief of Rs. 4, 25,402/- from this form.

2. The Insurance Company vide its letter dated 09.03.2015 had rejected the claim under section V (A) of policy terms and conditions i.e. non-disclosure of material facts. The medical history details of Adenomyosis and uterine fibroids were not revealed in

the proposal form while taking the policy. In their self contained note, Company stated that the patient is a known case of Adenomyosis and multiple Fibroids since 2007. She had also been re-treated with a Merina insertion done on 02.08.2013. This fact was not revealed before the inception of the policy and therefore claim was repudiated on account of non-disclosure.

3. I heard both the sides, the complainant (represented by his friend) as well as the Insurance Company. The complainant reiterated that the policy was taken because they were given to understand that all diseases were covered after 3 years of continuous policy running. Since the policy was taken in 2011 and claim arose in 2015 he expected the Company to pay the claim. The Company reiterated that patient was suffering from Adenomyosis and multiple fibroids since 2007 and the fact was not disclosed at time of

taking the policy. It was evident that policy holder was aware of the medical condition before policy commencement i.e. on 2011; however same was not declared to the Insurance Company. As per section VI (J): Non Disclosure or Misrepresentation: "If at the time of issuance of policy or during continuation of the policy, the information provided to us in the proposal form or otherwise, by you or the Insured person or anyone acting on behalf of you or an insured person is found to be incorrect, incomplete, suppressed or not disclosed, willfully or otherwise, the policy shall be:

- cancelled ab initio from the inception date or the renewal date (as the case may be), or the policy may be modified by us, at our sole discretion, upon 30 day notice by sending an endorsement to your address shown in the schedule without refunding the premium amount: and
- the claim under such policy if any, shall be rejected/repudiated forthwith.

Since the medical history details were not revealed by policy holder, the claim was repudiated by the Company under non-disclosure of material facts as per policy terms and conditions. In the case of Satwant Kaur Sandhu Vs New India Assurance (2009) 8 SCC 316, the Hon'ble Supreme Court emphasized that it is obligatory for the proposer to disclose the material facts at the time of filling the proposal form. The Insurance Company is not liable to pay the expenses in case of non-disclosure of material information. Thus it was a case of non-disclosure. Therefore, I uphold the decision of the Insurance Company. I therefore see no reason to interfere with the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby dismissed.**

In the matter of Sh. Rajendra Seksaria
Vs
The United India Insurance Company Ltd

DATE: 05.01.2016

1. The complainant alleged that he was continuously taking mediclaim policy from United India Insurance Company Ltd. since the year 1999 without any break. In the year 2013 he was admitted in Medanta Hospital from 04.02.13 to 11.02.13 for operation of both the knees. He had incurred Rs. 3,75,944/- towards treatment and submitted all the necessary papers of the claim to the TPA/Insurance Company for reimbursement but the Insurance Company had settled the claim for Rs. 3 Lacs only. He had sought the relief of Rs. 75,944/- from this forum.

2. The TPA Medi Assist India Pvt. Ltd. vide its letter dated 28.08.2014 had informed the insured that the sum insured in the year 2007 was Rs. 3.75 Lacs and according to United India Insurance Company policy clause 70% of S.I. is payable for total Knee Arthroplasty which they had already paid to hospital. Hence, the claim was denied and further no more enhancement of amount will be done.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant had alleged the he had a mediclaim policy from United India Insurance Company Ltd. since the year 1999 without any break. In the year 2013 under the above said policy he was admitted in Medanta Hospital from 04.02.13 to 11.02.13 for operation of both the knees. He had incurred Rs. 3,75,944/- towards treatment and submitted all the necessary papers of the claim to the TPA/Insurance Company for reimbursement but the Insurance Company had settled the claim for Rs. 3 Lacs only. The Insurance Company had stated that the payment of the claim was made according to terms and conditions of the policy issued to the Insured (P. No. 222700/48/11/20/00004251 from 30.03.12 to 29.03.13).

On perusal of the claim papers placed on record, I find that Mr. Rajendra Seksaria, the complainant was admitted in Medanta Medicity on 04.02.13 with the complaints of pain in both knees and was operated on 05.02.13. As per certificate issued by Dr. Ashok Raj Gopal, Medanta Hospital the patient was having pain in both his knees for the past 1.5 years. During the course of hearing the complainant had apprised that there was no capping of 70% of the S.I. under the Individual Mediclaim policy and no waiting period for advanced degenerative joint disease of knee. The Insurance Company could not refute statement of the complainant. The Insurance Company had not submitted the self contained note and other relevant papers of the case.

On perusal of the policy and terms and conditions of the Individual Mediclaim policy (No. 222700/48/11/20/00004251 from 30.03.12 to 29.03.13) submitted by the complainant, it is observed that there is no capping of 70% of S.I. and no waiting period

for advanced degenerative joint disease of knee. The S.I. under the said policy was Rs. 5, 62,200/- (S.I. Rs. 3, 75,000/- + cumulative bonus Rs. 1, 87,500/-). The Insurance Company had not tendered any relevant papers of the case/terms and conditions of the policy to prove their contention that the claim only 70% of S.I. was payable. The Insurance Company is hereby directed to settle the claim as per S.I. available under the policy (222700/48/11/20/00004251 from 30.03.12 to 29.03.13) as there is no capping of 70% of the S.I. and no waiting period for advanced degenerative joint disease. **Accordingly an award is passed with the directions to the Insurance Company to pay the balance amount of claim to the complainant.**

In the matter of Mr. Virender Kumar Sharma
Vs
The United India Insurance Company Ltd.

DATE: 07.01.2016

1. The complainant alleged that he was admitted in hospital for the operation of cataract. The total expenses incurred for the treatment was Rs. 95,000/- out of which the Insurance Company had paid only Rs. 34,000/-. He had sought the relief of Rs. 61,000/- from this forum.

2. The Insurance Company vide its letter dated 30.12.2014 had informed to the insured that the amount was paid as per policy clause 3.11 of the policy which states that the Insurance Company will pay the expenses of claim which are reasonably and necessarily incurred on the treatment. In this case the cataract surgery was done through Femto Procedure through laser which is restricted to the surgery of MICS procedure cost of Rs. 34,000/- which is agreed by all the major hospital comes under GIPSA Network hospital and have a package rate as defined.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant had alleged that he was admitted in hospital for the operation of cataract. The total expenses incurred for the treatment was Rs. 95,000/- out of which the Insurance Company had paid only Rs. 34,000/-. The Insurance Company had stated that the amount was paid as per policy clause 3.11 of the policy which states that the Insurance Company will pay the expenses of claim which are reasonably and necessarily incurred on the treatment. In this case the cataract surgery was done through Femto Procedure through laser which is restricted to the surgery of MICS procedure cost of Rs. 34,000/- which is agreed by all the major hospital comes under GIPSA Network hospital and have a package rate as defined.

On perusal of all the claim papers placed on record, I find that the complainant Mr. Virender Kumar Sharma was admitted in Centre for Sight Hospital for the operation of cataract and incurred Rs. 95,000/- towards the cataract surgery which was done through Femto Procedure through Laser. The Insurance Company had paid Rs. 34,000/- for MICS procedure which was agreed by all the major hospital under GIPSA Network Hospital. As per policy clause 3.25 of the policy which states "Preferred Provider Network means a network of hospitals which have agreed to a cashless packaged pricing for certain procedures for the insured person. Reimbursement of expenses incurred in PPN for the procedures (as listed under PPN package) shall be subject to the rates applicable to PPN packaged pricing." In this case the complainant had opted for Femto Laser in which case the liability was to be limited to the MICS procedure as per Corporate Management circular/guidelines Health Department. Hence, the Insurance Company had rightly settled the claim for Rs. 34,000/- under GIPSA package for MICS procedure. I see no reason to interfere with the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. Ashok Jain
Vs
The Oriental Insurance Company Ltd.

DATE: 06.01.2016

1. The complainant alleged that his wife was admitted in Max Hospital, Shalimar Bagh, Delhi from 29.12.14 to 01.01.15 and diagnosed as a case of loss of consciousness, cervical spondylosis with sinusitis, known case of hypertension. After completion of the treatment he had lodged two claims with the Insurance Company for reimbursement of Rs. 61,411/- (Rs. 54196/- + Rs. 7215/- post hospitalization). But the Insurance Company had denied the claim under clause 4.10 of the policy, saying only Investigations was done with no active line of management. Post-hospitalization claim was also rejected under clause 3.7 of the policy taking the view that main claim for Rs. 54,196/- had been denied. He had sought the relief of Rs. 61,411/- from this forum.

2. The Insurance Company vide its email dated 24.07.2015 had informed the insured that the claim was rejected under clause 4.10 of the policy "Investigation and evaluation and there was no active line of treatment." During admission, the patient underwent complete evaluation and as managed conservatively with oral medications as all the tests done showed normal results apart from insignificant findings as mentioned in diagnosis not related to presenting complaint. Post hospitalization claim of Rs. 7215/- was also rejected under clause 3.7 as the main claim had been denied.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant alleged the his wife was admitted in Max Hospital, Shalimar Bagh, Delhi from 29.12.14 to 01.01.15 and diagnosed as a case of loss of consciousness, cervical spondylosis with sinusitis, known case of hypertension. After completion of the treatment he had lodged two claims with the Insurance Company for reimbursement of Rs. 61,411/- (Rs. 54196/- + Rs. 7215/- post hospitalization). But the Insurance Company had denied the claim under clause 4.10 of the policy, saying only Investigations done with no active line of management. Post-hospitalization claim was also rejected under clause 3.7 of the policy taking the view that main claim for Rs. 54,196/- had been denied. The Insurance Company had stated that the claim was rejected under clause 4.10 of the policy "Investigation and evaluation and there was no active line of treatment." During admission, the patient underwent complete evaluation and as managed conservatively with oral medications as all the tests done showed normal results apart from insignificant findings as mentioned in diagnosis not related to present complaint. Post hospitalization claim of Rs. 7215/- was also rejected under clause 3.7 as the main claim had been denied.

On perusal of the claim papers placed on record, I find that Mrs. Veena Bansal was admitted in Max Health Care from 20.12.14 to 01.01.15 and diagnosed as a case of loss of consciousness, cervical spondylosis with sinusitis and known case of hypertension. As per discharge summary the patient was managed conservatively and required regular monitoring at hospital. During the course of hearing the complainant had stated that his wife was admitted in the hospital on the advices of the treating doctor. I find that the wife of the complainant was hospitalized on the advices of treating doctor; therefore hospitalization expenses incurred by the complainant should be paid by the Insurance Company. Diagnostic and other expenses are not payable. **Accordingly an award is passed with the direction to the Insurance Company to pay the hospital expenses to the complainant.**

In the matter of Mr. Anil Pandey
Vs
The Apollo Munich Health Insurance Company Ltd.

DATE: 07.01.2016

1. The complainant alleged that he was admitted in Medanta Hospital, Gurgaon from 07.01.15 to 12.01.15 and diagnosed as a case of Hypertension, Post EPS+RFA, Ventricular Tachycardia and surgery of ICD-D implantation was done on 09.01.15. He had applied for cashless service which was denied by the Insurance Company. He had submitted all the necessary papers of the claim to the Insurance Company for reimbursement but the Insurance Company had denied the claim on the ground of non-disclosure of material facts and policy was also terminated on this ground. He had sought the relief of Rs. 08 Lacs from this forum.

2. The Insurance Company vide its letter dated 09.01.15 had rejected the claim on the ground of non-disclosure of material facts at the time of taking the insurance policy. The Insured had a history of dilated cardiomyopathy, LV dysfunction and ventricular tachycardia in 2003. The policy of the insured was also terminated under Sec-07 (s) of the policy.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant had alleged that he was admitted in Medanta Hospital, Gurgaon from 07.01.15 to 12.01.15 and diagnosed as a case of Hypertension, Post EPS+RFA, Ventricular Tachycardia and surgery of ICD-D implantation was done on 09.01.15. He had applied for cashless service which was denied by the Insurance Company. He had submitted all the necessary papers of the claim to the Insurance Company for reimbursement but the Insurance Company had denied the claim on the ground of non-disclosure of material facts and policy was also terminated on this ground.

The Insurance Company had stated that they had rejected the claim on the ground of non-disclosure of material facts at the time of taking the insurance policy. The Insured had a history of dilated cardiomyopathy, LV dysfunction and ventricular tachycardia in 2003 which was not declared at the time of taking the policy. The policy of the insured was also terminated under Sec-07 (s) of the policy.

On perusal of the claim papers placed on record, I find that the patient was admitted in Medanta Hospital, Gurgaon from 07.01.15 to 12.01.15 and diagnosed as a case of Hypertension, post EPS+RFA, Venticular Tachycardia and Surgery of ICD-D implantation was done on 09.01.2015. As per certificate dated 08.01.2015 issued by Dr. Balbir Singh, Medanta Hospital, Mr. Anil Pandey "suffered from VT (RVOT VT) which was treated by RF Ablation at Batra Hospital and Medical Research Centre on 10.05.2003." These material facts had not been declared/revealed by the complainant in the proposal form dated 30.11.09 under column no. 06 i.e. medical and life style information while taking the policy.

Since the medical history details were not revealed by the policy holder the claim was repudiated by the Insurance Company under non-disclosure of material facts as per policy terms and conditions. In the case of Satwant Kaur Sandhu Vs New India Assurance (2009) 8 SCC 316, the Hon'ble Supreme Court emphasized that it is obligatory for the proposer to disclose the material facts at the time of filling the proposal form. The Insurance Company is not liable to pay the expenses in case of non-disclosure of material information. Thus it was a case of non-disclosure. Hence, the Insurance Company is not liable to pay the expenses in case of non-disclosure of material facts. Therefore, I uphold the decision of the Insurance Company and see no reason to interfere with the decision of the Insurance Company. Further, the Insurance Company had also terminated the policy of the Insured. The Insurance Company is hereby directed to restore the said policy with special exclusion of the disease Hypertension, Post EPS+RFA, Ventricular Tachycardia. **Accordingly an award is passed with the direction to the Insurance Company to restore the policy with the special exclusion of the disease Hypertension, Post EPS+RFA, Ventricular Tachycardia.**

In the matter of Mr. Naveen Jain
Vs
The Oriental Insurance Company Ltd.

DATE: 07.01.2016

1. The complainant alleged that he had a mediclaim policy from Oriental Insurance Company for the past 4-5 years. His last policy was issued on 21.07.14 (from 01.08.14 to 31.07.15), however the said policy was cancelled by the Insurance Company due to cheque dishonoured as there was an overwriting on the cheque. However, on receipt of the information about the cheque dishonoured he deposited the premium and Insurance Company had issued the fresh policy from 08.08.2014 to 07.08.2015. This resulted in break of 06 days. He had to hospitalize from 18.02.15 to 23.02.15 in Maharaja Agrasen Hospital, Punjabi Bagh, Delhi. He had submitted all the necessary papers of the claim for reimbursement of Rs. 29,863/- but the Insurance Company had denied the claim on the ground that the disease Hypertension is not covered "first two years of policy" (clause 4.3) and history of Alcoholism (clause 4.8). He had sought the relief of Rs. 29,863/- from this forum.

2. The Insurance Company vide its letter dated 28.09.15 had rejected the claim on the ground that there was a gap of 07 days in renewal of policy and the said policy (08.08.14 to 07.08.15) considered as a fresh policy. Expenses on treatment of HTN not covered during the first two years after inception of insurance policy (clause 4.3) and there was a history of Alcoholism of the patient (clause 4.8).

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant had alleged that he had a mediclaim policy from Oriental Insurance Company for the past 4-5 years. His last policy was issued on 21.07.14 (from 01.08.14 to 31.07.15), however the said policy was cancelled by the Insurance Company due to cheque dishonoured as there was an overwriting on the cheque. However, on receipt of the information about the cheque dishonoured he deposited the premium and Insurance Company had issued the fresh policy from 08.08.2014 to 07.08.2015. This resulted in break of 07 days. He had to hospitalize from 18.02.15 to 23.02.15 in Maharaja Agrasen Hospital, Punjabi Bagh, Delhi. He had submitted all the necessary papers of the claim for reimbursement of Rs. 29,863/- but the Insurance Company had denied the claim on the ground that the disease Hypertension is not covered "first two years of policy (clause 4.3) and history of Alcoholism (clause 4.8).

The Insurance Company had stated that the claim was rejected on the ground that due to cheque dishonoured there was a gap of 07 days in renewal of the policy and the said

policy (08.08.14 to 07.08.15) considered as a fresh policy. Expenses on treatment of HTN not covered during the first two years after inception of insurance policy (clause 4.3) and there was a history of Alcoholism of the patient (clause 4.8).

On perusal of the claim papers placed on record, I find that the Insured was having a mediclaim policy with the Oriental Insurance Company since 01.08.2011 which was continuously renewed up to 31.07.2014. When he applied for further renewal of the policy from 01.08.14 to 31.07.15, his premium cheque got dishonoured as there was an overwriting on the cheque and the Insurance Company had cancelled the policy accordingly. On receipt of the intimation about the cheque dishonoured he deposited the premium afresh and Insurance Company had issued the policy from 08.08.14 to 07.08.15 and this resulted in a break of 07 days in renewal of the policy. The Insurance Company had rejected the claim on the ground of there was a gap o 07 days in renewal of the policy treating the policy as a fresh policy. The Insurance Company had further stated that the expenses on treatment of HTN are not covered during the first 02 years after inception of policy (clause 4.3) and there was a history of Alcoholism of the patient (clause 4.8 of the policy). During the course of hearing the Insurance Company could not show/prove with any documents that the premium cheque was dishonoured. Had the delay of 07 days in renewal of the policy been condoned by the Insurance Company, his policy would have been in continuation since 01.08.2011 and clause 4.3 "02 years waiting period" would not have been applicable in the case. As per Health Regulation-2013 a grace period of 30 days is given on renewal of the policy and the Insurance Company can suo motto condone the delay of 07 days but the Insurance Company had failed to do so. Hence, I condone the delay of 07 days and restore the continuity benefits of the policy.

Further as regard there was a history of Alcoholism of the patient (clause 4.8) as narrated by the Insurance Company, there is no mention in discharge summary of Maharaja Agrasen Hospital (date of admission 18.02.15 DOD 23.02.15). The contention of Insurance Company in this regard is not supported by any documentary proof. The Insurance Company could not substantiate their contention with cogent and reliable documents that the patient had a history of alcoholism. Hence, I hold the Insurance Company is liable to settle the claim. **Accordingly an award is passed with the directions to the Insurance Company to reimburse the admissible claim amount to the complainant.**

In the matter of Mr. Ram Babu Garg
Vs
The United India Insurance Company Ltd.

DATE: 14.01.2016

1. The complainant alleged that he was admitted in Avantika Hospital from 29.10.14 to 03.11.14 and diagnosed as a case of chest infection with high grade fever. He had incurred Rs. 47,726/- towards the treatment and submitted the claim papers to the TPA/Insurance Company for reimbursement of Rs. 47,726/- but the Insurance Company had denied the claim on the ground that claim found to be fraudulent. He had sought the relief of Rs. 47,726/- from this forum.

2. The Insurance Company vide its email dated 15.06.2015 had informed the complainant that the claim was repudiated under clause no. 5.7 of the policy which defines "the Company shall not be liable to make any payment under this policy in respect of any claim if such claim be in any manner fraudulent of supported by any fraudulent means or device whether by the Insured person or by any other person acting on his behalf." As per investigative report purchase provided by the Hospital is not matching the batch number of medicine used during patient hospitalization.

3. I heard both the sides, the complainant (represented by his cousin) as well as the Insurance Company. During the course of hearing the complainant had alleged that he was admitted in Avantika Hospital from 29.10.14 to 03.11.14 and diagnosed as a case of chest infection with high grade fever. He had incurred Rs. 47,726/- towards the treatment and submitted the claim papers to the TPA/Insurance Company for reimbursement of Rs. 47,726/- but the Insurance Company had denied the claim on the ground that claim was found to be fraudulent. The Insurance Company had stated that the claim was repudiated under clause no. 5.7 of the policy which defines "the Company shall not be liable to make any payment under this policy in respect of any claim if such claim be in any manner fraudulent or supported by any fraudulent means or device whether by the Insured person or by any other person acting on his behalf." The Company had further stated that TPA-E-Meditek investigated the claim and noticed some discrepancies in the details of medicine used during the hospitalization as medicine did not match with the batch no. of the purchase bill provided by the hospital Avantika.

   On perusal of the claim papers placed on record, I find that Mr. Ram Babu Garg, the complainant was admitted in Avantika Hospital, Sector-2, Rohini, Delhi from 29.10.14 to 03.11.14 and diagnosed with a "chest infection with high grade fever and treated

conservatively." As per investigation report submitted by the TPA-E-Meditek it is revealed that the said claim had been submitted by the Insured with fraudulent papers and bills for seeking reimbursement of a manipulated claim. The purchase bills provided by the Avantika Hospital Dispensary did not match with batch no. and expiry date of the medicine used during the hospitalization. As per OPD prescription dated 26.10.14 of the Avantika Hospital the attending doctor found fever 99.8F, BP 110/74, Pulse 94/M and no severe abnormality was found. The complainant had not produced any test reports and other relevant papers of the treatment to prove his claim. The complainant could not rebut the facts as pointed out to him during the personal hearing. Hence, keeping in view these facts, I am of the considered view that the claim had been submitted with fraudulent papers for seeking reimbursement of a manipulated claim. I see no reason to interfere with the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Ms. Neeta Mangla
Vs
The Oriental Insurance Company Ltd.

DATE: 13.01.2016

1. The complainant alleged that she was admitted in Avantika Hospital from 16.11.14 to 21.11.14 for the treatment of high grade fever. She had submitted all the necessary papers of the claim for reimbursement of Rs. 41,211/- to the Insurance Company but the Company had denied the claim on the ground that the claim had been submitted with fraudulent papers and reports for reimbursement of a manipulated claim. She had sought the relief of Rs. 41,211/- from this forum.

2. The Insurance Company vide its letter dated 22.04.2015 had rejected the claim on the ground that the claim had been submitted with fraudulent papers and reports for seeking reimbursement of a manipulated claim. The Insurance Company had submitted the self contained note vide its letter dated 01.10.15 which states that as per ICPs and discharge summary it was found that no proper investigation was advised in OPD papers and ICPs. Final diagnoses were not confirmed by the treating doctor as per Investigation reports. These documents were fabricated for availing the benefits of health policy.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant alleged that she was admitted in Avantika Hospital from 16.11.14 to 21.11.14 for the treatment of high grade fever. She had submitted all the necessary papers of the claim for reimbursement of Rs. 41,211/- to the Insurance Company but the Company had denied the claim on the ground that the claim had been submitted with fraudulent papers and reports for reimbursement of a manipulated claim.

   The Insurance Company had stated that they had rejected claim on the ground that the claim was submitted with fraudulent papers and reports for seeking reimbursement of a manipulated claim. As per mediclaim opinion of their panel doctor Vinod Gandotra dated 27.03.2015 this is a fabricated case for the sake of reimbursement under mediclaim benefits. It is well supported with Erratic line of treatment without medical justification viz lab and other relevant investigations. No medical diagnosis could be made even after 05 days of hospitalization. To quote:

   - "Throughout her hospitalization, she was neither asked nor advised any chest specialist/physician opinion.
   - Chest X-ray film is there without mentioning name of the patient, date and age, which is the basics, nowadays, when it is done digitally, as happened in this case.
   - Patient remained in the hospital for 05 days but final diagnosis could not be made, medically. Simply it is mentioned, like a layman language-Chest infection with

high grade fever. Otherwise hospital is having computerized lab. Facilities, as per attached reports."

The Insurance Company had further stated that the case was further investigated by M/s Sharp Eye Investigation Service and as per their findings the medical documents submitted by the Insured are fabricated for availing the benefit of health policy. As per ICPs and discharge summary no proper investigations was advised on OPD paper and ICPs. Final diagnoses were not confirmed by the treating doctor as per investigation reports. On perusal of the claim papers placed on record, I find that as per discharge summary the patient Mrs. Neeta Mangla was admitted in Avantika Hospital, Rohini, Delhi from 16.11.14 to 21.11.14 and diagnosed as a case of chest infection with high grade fever and treated conservatively. As per the medical report submitted by the panel doctor Mr. Vinod Gandotra it is revealed that the said claim had been submitted by the Insured with fraudulent papers and reports for seeking reimbursement of a manipulated claim.

- Throughout her hospitalization, she was neither asked nor advised any chest specialist/physician opinion.
- Chest X-ray film is there without mentioning name of the patient, date and age, which is the basics, nowadays, when it is done digitally, as happened in this case.
- Patient remained in the hospital for 05 days but final diagnosis could not be made, medically. Simply it is mentioned, like a layman language-Chest infection with high grade fever. Otherwise hospital is having computerized lab. Facilities, as per attached reports.

As per ICPs and discharge summary no proper investigation was done. Final diagnoses were not confirmed by treating doctor. In the instant case no treatment progress report (TPR) and monitoring by a doctor was maintained. In the final bill of the hospital dated 21.11.14, the cost of medicines and expenses of X-ray/ultrasound ECG were also not charged from the patient. I find that:

- As per discharge summary the patient was suffering from high grade fever with chest infection but throughout her hospitalization, she was neither asked nor advised any chest specialist/physician opinion.
- The chemist bills Avantika Hospital Dispensary submitted by the complainant seem to be prepared in the same handwriting.
- No ICP papers (indoor case papers) or test reports for various tests conducted by the hospital were produced by the representative of the complainant to prove his claim during the personal hearings.

The complainant could not rebut the facts as pointed out to her. Hence, keeping in view all the above facts, I hold that the Insurance Company had rightly rejected the claim on the ground that the claim had been submitted with fraudulent papers for seeking reimbursement of a manipulated claim. I see no reason to interfere with the decision of

the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. Ravinder Singh Jolly
Vs
The United India Insurance Company Ltd.

DATE: 13.01.2016

1. The complainant alleged that he was admitted in Max Health Care Hospital from 16.04.14 to 20.04.14 and diagnosed as a case of "Morbid Obesity" and operated for Laparoscopic sleeve Gastrectomy on 17.04.14. He had incurred Rs. 3, 11,886/- towards the treatment and submitted all the necessary papers of the claim for reimbursement of Rs. 3, 11,886/- but the Insurance Company had not settled his claim so far. He had sought the relief of Rs. 3, 11,886/- from this forum.

2. The TPA-E-Meditek vide its letter dated 24.06.2014 had rejected the claim on the ground that as per policy terms and conditions cosmetic surgery/morbid obesity treatment was not payable. The claim falls under policy exclusion clause 4.5 which states "The Company shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any Insured Person in connection with or in respect of: circumcision unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to an accident (b) vaccination or inoculation or change of life or cosmetic or aesthetic treatment of any description (c) plastic surgery other than as may be necessitated due to an accident or as a part of any illness.

3. I heard both the sides, the complainant as well as the Insurance Company. The complainant submitted that his treatment for morbid obesity was not paid by the Insurance Company despite submission of all the relevant papers. The Insurance Company had stated that the claim was rejected under policy clause 4.5 which states that the treatment of cosmetic surgery/morbid obesity was not payable.

On perusal of the claim papers placed on record, I find that the patient Mr. Ravinder Singh was admitted in Max Health Care Hospital from 16.04.14 to 20.04.14 and diagnosed as a case of Morbid Obesity. He underwent Laparoscopic Sleeve Gastrectomy, a surgical procedure for treating morbid obesity on 17.04.14.

The complainant also produced the treating doctor's certificate from Max Health Care dated 22.04.14 which stated that Morbid Obesity "is a serious disease that may be associated with severe complications, many of which are life threatening. It is now worldwide that the best treatment option for morbid obesity is Bariatric surgery, wherein

Laparoscopic Sleeve Gastrectomy is a treatment option. Laparoscopic Sleeve Gastrectomy Surgery is a potentially lifesaving surgery and not a cosmetic surgery."

I find that Insurance Company had rejected the claim on the ground of exclusion clause 4.5(b). Now-a-days bariatric surgery is not a cosmetic weight loss procedure. It is a metabolic operation that involves cutting or bypassing parts of the stomach and intestine-to-control or even get rid of diabetes. The Centre Government Health Scheme CGHS are also reimbursing the expenses for the treatment of the said diseases. As per doctor's certificate from Max Health Care Laparoscopic Rouxen-y Gastric Bypass Surgery is a potentially lifesaving surgery and not a cosmetic surgery. Hence, I hold that the Insurance Company is liable to settle the claim. **Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant.**

In the matter of Mr. Manwar Singh
Vs
The Apollo Munich Health Insurance Company Ltd.

DATE: 16.02.2016

1. The complainant alleged that his wife was admitted in NH1 Hospital from 04.04.15 to 12.04.15 and diagnosed as a case of Rheumatic Heart Disease. She was operated for Mitral Valve Replacement on 06.04.2015. He had submitted all the necessary papers of the claim for reimbursement of Rs. 2, 58,621/- but the Insurance Company had rejected the claim on the ground of non-disclosure and concealment of material facts. The policy was also terminated by the Company on this ground. He had sought the relief of Rs. 2, 58,621/- from this forum.

2. The Insurance Company vide its letter dated 12.09.15 had rejected the claim on the ground that the medical history details of (Elevated FBS (fasting blood sugar) finding dated 28.12.2009 and Chest x-ray findings (enlargement of cardiac shadow and bronchovascular markings in both lungs fields) dated 29.12.2009) is not revealed in the proposal form while taking policy. Hence the claim is repudiated due to non disclosure and concealment of facts under Section VII r ii of policy terms and conditions.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant alleged that his wife was admitted in NH1 Hospital from 04.04.15 to 12.04.15 and diagnosed as a case of Rheumatic Heart Disease. She was operated for Mitral Valve Replacement on 06.04.2015. She had submitted all the necessary papers of the claim for reimbursement of Rs. 2, 58,621/- but the Insurance Company had rejected the claim on the ground of non-disclosure and concealment of material facts. The policy was also terminated by the Company on this ground.

The Insurance company had stated that the claim was rejected on the ground that the medical history details of (Elevated FBS (fasting blood sugar) finding dated 28.12.2009 and Chest x-ray findings (enlargement of cardiac shadow and bronchovascular markings in both lungs fields) dated 29.12.2009) is not revealed in the proposal form while taking policy. Hence the claim was repudiated due to non disclosure and concealment of facts under Section VII r ii of policy terms and conditions.

On perusal of the claim papers placed on record, I find that Mrs. Kamleshwari was admitted in National Heart Institute, East of Kailash, New Delhi from 04.04.15 to 12.04.15 and diagnosed as a case of Rheumatic Heart Disease, Post BMV (2010), Severe calcific mitral stenosis, Mild tricuspid regurgitation, Moderate PAH, NYHA Class III, Normal LV function and operation of Mitral Valve Replacement was performed on 06.04.2015. The medical history details of (Elevated fasting blood sugar) finding dated 28.12.2009 and chest x-ray findings (enlargement of cardiac shadow and bronchovascular markings in both lung field) dated 28.12.2009 was not revealed in the proposal form under column no. 6 i.e. Medical and Life style information while taking the first policy (p. no. 110100/11001/1000086459 from 27.05.10 to 26.05.11) which tantamount to non-disclosure of material facts on the part of the Insured.
In the case of Satwant Kaur Sandhu Vs New India Assurance (2009) 8 SCC 316, the Hon'ble Supreme Court emphasized that it is obligatory for the proposer to disclose the material facts at the time of filling the proposal form. The Insurance Company is not liable to pay the expenses in case of non-disclosure of material information. Thus it was a case of non-disclosure. Therefore, I uphold the decision of the Insurance Company. I see no reason to interfere with the decision of the Insurance Company. However, the Insurance Company is hereby directed to restore the policy of the complainant which was cancelled/ terminated earlier by excluding the Rheumatic Heart disease." **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. Raj Kumar Mittal
Vs
The IFFCO Tokio General Insurance Company Ltd.

DATE: 10.02.2016

1. The complainant alleged that he had lodged a claim with the Insurance Company for damage of windshield glass of his vehicle amounting to Rs. 6091/-. But the Insurance Company had denied the claim on the ground that no claim bonus was availed by the Insured for which he was not entitled to since there was a claim on the previous policy. But the Insurance Company had not mentioned the particulars of the policy and nature of the claim which was availed by him. He had sought the relief of Rs. 6091/- i.e. cost of the replacement of windshield glass to Rs. 50,000/- for mental agony and harassment.

2. The Insurance Company vide its letter dated 15.06.2015 had rejected the claim on the ground that no claim bonus had been availed by the Insured for which he was not entitled to since there was a claim on previous policy of the Insured. The same fact has not been disclosed and facts have been misrepresented while taking the insurance policy with them.

3. I heard both the sides, the complainant as well as the Insurance Company. The complainant submitted that his present claim was denied on the grounds that he had availed of No Claim Bonus despite having availed of claim in previous policy. The Insurance Company argued that the complainant had availed of No claim bonus but was not able to show the documents and the particulars of the policy and nature of claim availed by the complainant under the previous policy. I find that the complainant had been repeatedly approaching the Insurance Company for settlement of his claim but the Insurance Company had not responded. In view of the fact that the Insurance Company was unable to show any documentary proof with regard to their submission that No Claim Bonus had been availed by the complainant despite having availed of claim in previous policy. In the absence of submission of any cogent and documentary proof by the Insurance Company. I direct the Insurance Company to settle the motor claim of the complainant. **Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant.**

In the matter of Mrs. Chandra Primlani
Vs
The Oriental Insurance Company Ltd.

DATE: 27.01.2016

1. The complainant alleged that she was admitted in Medanta Global Health Pvt. Ltd., Defence Colony, New Delhi on 01.05.2015 for cataract surgery. The Hospital had charged Rs. 85,000/- for the surgery whereas the TPA M/s E-Meditek Health Services had approved Rs. 21,000/- only. She had contacted the Insurance Company for the difference in claim amount but till date she had not received any reply from them. She had sought the relief of Rs. 64,000/- from this forum.

2. The Insurance Company had submitted the self contained note vide dated 09.01.2016 which states that the Competent Authority of the TPA has approved the claim for Rs. 21,000/- only after adjusting the TDS @10% (i.e. 21,000-2,100= Rs. 18900/- only) subject to submission of all original investigation reports and documents at the time of final settlement by NEFT to Hospital as per the GIPSA package for "Cataract Surgery" which was also adopted by all the Hospital including Medanta The Medicity, Gurgaon.

3. I heard the Insurance Company. The complainant was absent during the hearing but submitted vide her letter dated 18.01.16 requested for decision on merits on the basis of records submissions. She requested Mrs. Chandra Primlani, the complainant, was admitted in Medanta Global Health Pvt. Ltd, Defence Colony, New Delhi on 01.05.2015 for cataract surgery. The Hospital had charged Rs. 85,000/- for the surgery whereas the TPA M/s E-Meditek Health Services had approved Rs. 21,000/- only. She had contacted the Insurance Company for the difference in claim amount but till date she had not received any reply from them.

The Insurance Company had stated that the TPA has approved the claim for Rs. 21,000/- only after adjusting the TDS @10% (i.e. 21,000-2,100= Rs. 18900/- only) subject to submission of all original investigation reports and documents at the time of final settlement by NEFT to Hospital as per the GIPSA package for "Cataract Surgery" which was also adopted by all the Hospital including Medanta The Medicity, Gurgaon.

On perusal of the claim papers placed on record, I find that the complainant Mrs. Chandra Primlani was admitted in Medanta, Global Health Pvt. Ltd. on 01.05.15 for cataract surgery of her Right Eye and incurred Rs. 85,000/- towards the treatment. But the Insurance Company had paid her only Rs. 21,000/- as per GIPSA package.

The complainant had submitted that she was not informed at any point of time by the Insurance Company about the GIPSA package nor was it mentioned in policy terms and conditions of the Mediclaim policy. The Insurance Company could not refute the charges and had agreed that there was no mention of GIPSA package in the terms and conditions of the mediclaim policy. Since the complainant was not informed about GIPSA package and there was also no mention of the same in the policy terms and conditions, the Insurance Company is liable to settle the claim as per terms and conditions of the policy. Hence Insurance Company is hereby directed to settle the claim as per terms and conditions of the policy and pay the remaining amount to the complainant. **Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant.**

In the matter of Mr. Yogesh Kumar
Vs
The Apollo Munich Health Insurance Company Ltd.

DATE: 08.02.2016

1. The complainant alleged that he was admitted in Holy Family Hospital from 24.04.15 to 27.04.15 with the complaints of joint pain and fever. He had submitted all the necessary papers of the claim to the Insurance Company for reimbursement of Rs. 31167/- but the Company had denied his claim on the ground that the need of hospitalization was not established. He had sought the relief of Rs. 31167/- from this forum.

2. The Insurance Company vide its letter dated 04.08.2015 had rejected the claim on the ground that as per submitted documents need of hospitalization was not established. Hence the claim was repudiated under sec-VI C, VI B of the policy.

3. I heard both the sides, the complainant as well as the Insurance Company. The complainant submitted that he was admitted in the hospital from 24.04.15 to 27.04.15 with the complaints of joint pain and fever. His claim had not been settled despite the fact that he had submitted all the necessary documents of the claim to the Company. The Insurance Company argued that the claim had been rejected under sec sec-VI C, VI B of the policy as the need of the hospitalization was not established. I find from the documents on record and certificate given by the doctor dated 15.07.2015

that the patient was brought in nearly hours on the night of 24.04.15 with severe joint pain and inability to move and was hospitalization was essential for such case. Since the patient was admitted on the advice of the doctor and the Company could not prove beyond doubt as to why hospitalization was not necessary, I direct the Insurance Company to settle the claim. **Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant.**

In the matter of Mr. Umesh Chhabra
Vs
The United India Insurance Company Ltd.

DATE: 10.02.2016

1. The complainant alleged that he was admitted in Sukhda Hospital on 14.08.2014 for operation of Cataract in Left Eye and underwent phacoemulisification with Toric IOL implant surgery on 14.08.14. He had submitted all the relevant papers to the TPA M/s MD India for reimbursement of Rs. 69655/- out of which the TPA had paid Rs. 48019/- only. The sum insured under the policy was Rs.6.5 Lacs and as per policy clause 1.2.1 the amount payable for cataract surgery restricted to "Actual Expenses incurred or 25% of S.I. whichever is less." Hence, he was eligible for Rs. 1, 62,500/- against which he was asking for Rs. 69,655/-. He had sought the relief of Rs. 21,636/- + Rs. 5,000/- towards harassment and mental agony.

2. The Insurance Company vide its letter dated 10.03.2015 had informed the Insured that the Toric Lens used for the cataract surgery comes under the cosmetic benefit category, hence not covered by the terms and conditions of the policy. The TPA had rightly settled the claim.

3. I heard both the sides, the complainant as well as the Insurance Company. The complainant submitted that the Insurance Company had not settled his mediclaim fully. He had undergone phacoemulisification with Toric IOL implant surgery on 14.08.14. His claim was denied on the ground that Toric lens used for the cataract surgery falls under the cosmetic surgery and therefore not covered under the policy conditions. The Insurance Company also submitted that the complainant had sought clarification under the RTI regarding inadequate claim settlement. In the reply dated 14.10.15 Insurance Company had informed the complainant that the amount payable in respect of cataract is "Actual Expenses incurred or 25% of S.I. whichever is less."

During the personal hearing the Insurance Company could not show the policy terms and conditions which show the "admissibility of multifocal (Acryl IQ toric SN6AT9 IOL)." Further Insurance Company stated that this (Toric Lens) is primarily a cosmetic benefit to eliminate the need of Spectacles which does not rule out the possibility of use of Toric lens being used as multifocal lens for medical necessity. However I find that a person having undergone a cataract surgery does not require spectacles. The Insurance Company is hereby directed to settle the mediclaim as per terms and conditions of policy no. 1.2.1 referred above including any expenses arising on post hospitalization. **Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant including any expenses arising on post hospitalization.**

In the matter of Mrs. Laxmi Devi
Vs
The Oriental Insurance Company Ltd.

DATE: 28.01.2016

1. The complainant alleged that she was admitted in Max Health Care Hospital from 17.07.15 to 21.07.15 and diagnosed as a case of painful opthamoplegia (Right Lateral Rectus Palsy) left frontal tuberculoma. She had submitted all the necessary papers of the claim to the TPA M/s Mediassist India for reimbursement of the claim but the Insurance Company had denied the claim on the ground that the policy is running in the 2nd year and the disease has a waiting period of 02 years.

2. The TPA M/s Medi Assist India vide its email dated 24.07.15 had informed to the Insured that the said claim is rejected on the ground that patient was diagnosed with cavernus thrombosis/Tolosa han's syndrome with high blood sugar level which could be the cause of the same. As the policy is in 2nd year and the disease has a waiting period of 02 years. Therefore the claim was denied.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the Insurance Company had stated that in this case the cashless facility was denied as the patient was diagnosed with

cavernus thrombosis/Tolosa han's syndrome with high blood sugar level which could be

the cause of the same. As the policy is in 2nd year and the disease has a waiting period of 02 years. They had further stated that the complainant had not submitted the claim papers so far to process and settle the claim.

On perusal of discharge summary of Max Health Care Hospital the patient Mrs. Laxmi Devi was admitted from 17.07.15 to 21.07.15 and diagnosed as a case of Painful Opthamoplegia (Right Lateral Rectus Palsy) Left Frontal Tuberculoma and the reason for admission was acute onset right hemicranial/temporal headache along with pain on eye movements and recurrent vomiting since 3 days. There is no mention in discharge summary that patient is a known case of diabetes, hence the policy clause "two years waiting period" would not be applicable as the patient was treated for acute onset right hemicranial/temporal headache along with pain on eye movements and recurrent vomiting and not for Diabetes. The Insurance Company is hereby directed to settle the claim as admissible on receipt of claim papers from the Insured. **Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant as admissible.**

In the matter of Mr. Sunil Khetarpal
Vs
The United India Insurance Company Ltd.

DATE: 21.01.2016

1. The complainant alleged that he was admitted in Action Cancer Hospital from 31.10.14 to 08.11.14 and diagnosed as a follow up case of Carcinoma right upper alveolus with second primary squamous cell carcinoma. He had incurred Rs. 4, 37,322/- towards the treatment and submitted all the necessary papers of the claim to the Insurance Company for reimbursement of Rs. 4,37,322/- but the Insurance Company had settled the claim only for Rs. 1 Lac considering the S.I. of earlier policy (2007-08). The S.I. under the current year policy was Rs. 5 Lacs. He had sought the relief of Rs. 3, 37,322/- (balance amount) alongwith Rs. 60,000/- towards mental agony. As per Discharge Summary dated 31.10.14 the patient had a past history of surgery and adjuvant radiotherapy for carcinoma right upper alveolus in 2010.

2. The Insurance Company had submitted the self contained note and reiterated the same.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant submitted that he was admitted in Action Cancer Hospital from 31.10.14 to 08.11.14 and diagnosed as a follow up case of Carcinoma right upper alveolus with second primary squamous cell carcinoma. He had incurred Rs. 4, 37,322/- towards the treatment and submitted all the necessary papers of the claim to the Insurance Company for reimbursement of Rs. 4,37,322/- but the Insurance Company had settled the claim only for Rs. 1 Lac considering the S.I. of earlier policy (2007-08). The S.I. under the current year policy was Rs. 5 Lacs. The insurance Company had stated that the Insured was admitted in hospital on 31.10.14 with diagnosis as a follow up case of carcinoma right upper alveolus with second primary squamous cell carcinoma right upper alveolus and underwent surgery for the same. The claim was settled for Rs. 1 Lac as per policy period 2007-08 as the disease pertained to the year 2008.

On perusal of the claim papers placed on record, I find that the complainant was admitted in Action Cancer Hospital from 31.10.14 to 08.11.14 and diagnosed as a follow up case of carcinoma right upper alveolus with second primary squamous cell carcinoma. As per discharge summary dated 31.10.14 the patient was having a history of surgery and adjuvant radiotherapy for carcinoma right upper alveolus in 2010. The complainant had apprised that he had been paid the claim in 2012 also for the same illness which had occurred in 2010 also according to S.I. Rs. 3 Lacs under policy for 2009-10. The disease pertains to the year 2010 and claim arose in February, 2010 and the Insured had taken the claim for the same disease in the year 2012 at the S.I. of Rs. 3 Lacs for the policy period 2009-10 (P.No. 222700/48/09/97/00001559 from 19.10.09 to 18.10.10). Hence, I hold that the Insurance Company is liable to settle the claim according to the S.I. of Rs. 3 Lacs for the policy period 2009-10 as per policy clause 5.12 i.e. enhancement of S.I. which states notwithstanding enhancement, for claims arising in respect of ailment, disease or injury contracted or suffered during a preceding policy period, liability of the Company shall be only to the extent of the Sum Insured under the policy in force at the time when it was contracted or suffered during the currency of such renewed policy or any subsequent renewal thereof." The Insurance Company is hereby directed to settle the claim considering the S.I. Rs. 3 Lacs as the disease occurred in the year 2010 and pay the balance amount as per policy terms and conditions of the policy. **Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant as per the correct sum insured i.e. Rs. 3 Lacs.**

In the matter of Sh. K.M. Agarwal

Vs

The United India Insurance Company Ltd.

DATE: 19.01.2016

1. The complainant alleged that his wife was admitted in Shalby Hospital, Ahmadabad on 26.03.2015 for surgery replacement of both the knee joints. She was operated on 27.03.2015 and discharged on 01.04.2015. He had a super top up policy with Threshold Limit of Rs. 5 lacs besides regular mediclaim policy. He had incurred Rs. 8,92,928/- towards treatment and submitted all the necessary papers of the claim for reimbursement of claim amount under super top up policy i.e. Rs. 3,92,628/- (Rs. 8,92,928-Rs. 5,00,000 threshold limit) out of which Insurance Company had paid only Rs. 40,000/-. He had sought the relief of Rs. 3, 52,628/- from this forum.

2. The Insurance Company vide its letter dated 11.08.2015 had informed the insured that the base claim was settled by Heritage TPA for an amount of Rs. 3.50 lacs against the total S.I. of Rs. 5 lacs on 70% basic limit for knee joint replacement claim as per policy operative clause 1.2.1. As per Shalby Hospital tariff the treatment of total knee replacement for both knees including cost of implant is provided in a package of Rs. 5.40 lacs, hence the Heritage TPA has approved an amount of Rs. 3.5 lacs which as per policy condition is in order. Second claim was preferred for the remaining amount of the package of Rs. 5.40 lacs under super top up policy and the amount was paid for Rs. 40,000/- in excess of Rs. 5 lacs which was also in order.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant alleged that his wife was admitted in Shalby Hospital, Ahmadabad on 26.03.2015 for surgery of both the knee joints. She was operated on 27.03.2015 and discharged on 01.04.2015. He had a super top up policy with Threshold Limit of Rs. 5 lacs besides regular mediclaim policy. He had incurred Rs. 8, 92,928/- towards treatment and submitted all the necessary papers of the claim for reimbursement of claim amount under super top up policy i.e. Rs. 3,92,628/- (Rs. 8,92,928-Rs. 5,00,000 threshold limit) out of which Insurance Company had paid only Rs. 40,000/-.

The Insurance Company had stated that the base/main claim was settled by Heritage TPA for an amount of Rs. 3.50 lacs against the total S.I. of Rs. 5 lacs on 70% basic limit for knee joint replacement claim as per policy operative clause 1.2.1 which states "the amount payable for major surgeries restricted to "Actual Expenses incurred or 70% of S.I. whichever is less." As per Shalby Hospital tariff the treatment of total knee replacement for both knees including cost of implant is provided in a package of Rs. 5.40 lacs, hence the Heritage TPA has approved an amount of Rs. 3.5 lacs which as per policy condition is in order. Second claim was preferred for the remaining amount of the package of Rs. 5.40 lacs under super top up policy and the amount was paid for Rs. 40,000/- in excess of Rs. 5 lacs which is also in order.

On perusal of the claim papers placed on record, I find that the main claim for TKR (Bilateral) was settled according to tariff rate of Shalby Hospital i.e. Rs. 5.40 Lacs. The S.I. under

the main policy was Rs. 5.40 Lacs and the liability for total knee replacement was restricted to 70% of S.I. i.e. Rs. 3, 50,000/- as per policy clause 1.21. Hence, the amount approved by the TPA under main policy was in order. The second claim for the said illness for the remaining amount of the package of Rs. 5.40 Lacs was preferred by the complainant under Super Top up Policy which has a threshold limit of S.I. of Rs. 5 Lacs. The claim amount over and above of Rs. 5 Lacs would be considered under this policy. The Insurance Company had paid Rs. 40, 0000/- in excess of Rs. 5, 00,000/- under this Super Top up Policy. I find that the Insurance Company had rightly settled the claim under both the policies. Hence I see no reason to interfere with the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. Ravinder Kumar Taneja
Vs
The United India Insurance Company Ltd.

DATE: 19.01.2016

1. The complainant alleged that he was hospitalized in Saroj Specialty Hospital at Rohini on 17.05.2015 and diagnosed with chest pain and Coronary angiography was done alongwith PTCA+Stenting to LAD. He had incurred expenditure of Rs. 2, 14,250/- towards treatment out of which Rs. 70,000/- was settled by the Insurance Company although. The sum insured under the policy was Rs. 5 Lacs. He had sought the relief of Rs. 1, 44,250/- from this forum.

2. The Insurance Company vide its email dated 08.06.2015 had informed the insured that the claim was settled as per S.I. available in the policy for the year 2001-02 as per the terms and conditions of the policy as the patient was suffering from IHD disease since last 13 years. The S.I. was Rs. 1 Lac during 2001-02 hence the claim was approved for Rs. 70,000/- (70% of S.I. Rs. 1 lac) as per major surgery restrictions as per clause 1.21 of the policy. The policy renewal clause 5.10.4 states "the insured may seek enhancement of Sum Insured in writing at or before payment of premium for renewal, which may be granted at the discretion of the Company. However, notwithstanding enhancement, for claims arising in respect of ailing, disease or injury contracted or suffered during a preceding policy, liability of the Company shall be only to the extent of the sum insured under the policy in force at the time when it was contracted or suffered."

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant had alleged that he was hospitalized in Saroj Specialty Hospital at Rohini on 17.05.2015 and diagnosed as chest pain and coronary angiography was done along with PTCA+Stenting to LAD. He had incurred Rs. 2, 14,250/- towards treatment out of which Rs. 70,000/- was settled by the Insurance Company although. The sum insured under the policy was Rs. 5 Lacs.

The Insurance Company had stated that the claim was settled as per S.I. available in the policy for the year 2001-02 as per the terms and conditions of the policy as the patient was suffering from IHD disease since last 13 years. The S.I. was Rs. 1 Lac during 2001-02 hence the claim was approved for Rs. 70,000/- (70% of S.I. Rs. 1 lac) as per major surgery restrictions. The policy renewal clause 5.10.4 states "the insured may seek enhancement of Sum Insured in writing at or before payment of premium for renewal, which may be granted at the discretion of the Company. However, notwithstanding enhancement, for claims arising in respect of ailing, disease or injury contracted or suffered during a preceding policy, liability of the Company shall be only to the extent of the sum insured under the policy in force at the time when it was contracted or suffered."

On perusal of the claim papers placed on record, I find that the complainant was hospitalized in Saroj Specialty Hospital at Rohini on 17.05.2015 and diagnosed as a case of Diabetes Mellitus, Hypertension, Coronary artery disease, Post PTCA, Acute Anterior Wall MI. Coronary angiography was done on 17.05.2015. Doctor had also advised for PTCA+ Stenting to LAD which was also done on same day. The Insurance Company had settled the claim as per S.I. available in the policy i.e. Rs. 1 Lac for the year 2001-02 as the patient was suffering from IHD disease since last 13 years but the Insurance Company had not provided any supporting documents in this regard to prove their contention. In the discharge summary of the patient there is no mention that the patient had a history of IHD since 13 years. The Insurance Company could not substantiate their contention with cogent and reliable documents that the Insured had a history of IHD since 13 years i.e. 2001-2002.

I find that the Insurance Company had wrongly settled the claim by taking the S.I. of Rs. 1, 00,000 for the year 2001-02. The patient was treated under policy no. 0404012814P103744416 from 07.09.14 to 06.09.15 and the S.I. Rs. 5 Lacs which should be considered for settlement of this claim. Hence, the Insurance Company is hereby directed to settle the claim on the basis of S.I. i.e. Rs. 5 Lacs under the policy for the period of 2014-15 as the disease detected and treated in the said policy period and pay the admissible amount to the complainant as per terms and conditions of the policy. **Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant as per the correct sum insured.**

In the matter of Sh. N.K. Jain

Vs

The United India Insurance Company Ltd.

DATE: 19.01.2016

1. The complainant alleged that he was admitted in Hospital Vardhman Nursing Home Pvt. Ltd. from 29.05.2014 to 01.06.2014 due to severe pain in his right shoulder for which he was under treatment since 01.05.2014 from Dr. Mayank Jain. He had incurred the following expenses towards the treatment:-

1.	Pre- hospitalization Expenses	Rs. 10,207.00 (01.05.2014 to 29.05.2014)
2.	Post hospitalization Expenses	Rs. 11,819.00 (02.06.2014 to 30.06.2014)
3.	Hospitalization Expenses	Rs. 24.699.00 (29.05.2014 to 01.06.2014)
		Rs. 46,725.00

He had submitted all the necessary papers of the claim to the Insurance Company for reimbursement of Rs. 46,725/- but the Insurance Company had denied the claim on the ground of pre-existing disease and that hospitalization for physiotherapy of shoulder was not warranted which could have been treated as an OPD patient. He had sought the relief of Rs. 46,725/- from this forum.

2. The Insurance Company vide its letter dated 22.01.2015 had rejected the claim on the ground of pre-existing disease (clause 4.1) and hospitalization for physiotherapy of shoulder was not warranted and could have been treated as an OPD patient. On the basis of documents provided by the patient, he was a known case of diabetes (DM) since long and it is a pre-existing in nature and falls under the policy terms and conditions exclusion No. 4.1 which states "All diseases/injuries which are pre-existing when the cover incepts of 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 03 consecutive continuous claim free policy years, provided there was no hospitalization for the pre-existing ailment during these 3 years of insurance." There was also a gap of 28 days in renewal of policy (2013-14).

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant had alleged that he was admitted in Hospital Vardhman Nursing Home Pvt. Ltd. from 29.05.2014 to 01.06.2014 due to severe pain in his right shoulder for which he was under treatment since 01.05.2014 from Dr. Mayank Jain. He had incurred the following expenses towards the treatment:-

1.	Pre- hospitalization Expenses	Rs. 10,207.00 (01.05.2014 to 29.05.2014)
2.	Post hospitalization Expenses	Rs. 11,819.00 (02.06.2014 to 30.06.2014)
3.	Hospitalization Expenses	Rs. 24.699.00 (29.05.2014 to 01.06.2014)
		Rs. 46,725.00

He had submitted all the necessary papers of the claim to the Insurance Company for reimbursement of Rs. 46,725/- but the Insurance Company had denied the claim on the ground of pre-existing disease and hospitalization for physiotherapy of shoulder was not warranted and could have been treated as an OPD patient.

The Insurance Company had rejected the claim on the ground of pre-existing disease (clause 4.1) and hospitalization for physiotherapy of shoulder was not warranted and could have been treated as an OPD patient. On the basis of documents provided by the patient, he was a known case of diabetes (DM) since long and it is a pre-existing in nature and falls under the policy terms and conditions exclusion No. 4.1 which states "All diseases/injuries which are pre-existing when the cover incepts of 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 03 consecutive continuous claim free policy years, provided there was no hospitalization for the pre-existing ailment during these 3 years of insurance." There was also a gap of 28 days in renewal of policy (2013-14).

On perusal of the claim papers placed on record, I find that the complainant was admitted in Vardhman Nursing Home from 29.05.14 to 01.06.14 and diagnosed as a case of Severe Periarthritis Right Shoulder with Global restriction of ROM with Diabetes Mellitus Type-2. The Insurance Company had rejected the claim under policy exclusion clause 4.1 i.e. any pre- existing condition (s) as defined in the policy until 36 months of continuous coverage of such insured person have elapsed, since inception of his/her first policy with the Company and also that there was a gap of 20 days in renewal of policy period (2013-14). The Insured had taken a Mediclaim policy no. 040500/48/12/41/00000350 from 01.05.2012 to 30.04.13 which was subsequently renewed vide policy no. 040500/48/13/41/0000551 from 01.05.13 to 30.04.14 and policy no. 040500/48/14/41/0000511 from 01.05.14 to 30.04.15. So, the contention of Insurance Company that there was a break of 28 days in the renewal is not correct. The policies were continuously renewed without any break. The complainant had alleged that he had taken the claim for the same illness in earlier also in 2013 and provided the NEFT payment details made by the Medsave Health Care (TPA). Since the Insurance Company had settled the claim for the same disease in earlier also in 2013, the Company is liable to

settle the present claim also. As per D/s of Karuna Hospital the patient was admitted from 01.10.13 to 04.10.13 for the treatment of spondylosis Lumber Spine with periarthritis Left shoulder. The patient was treated for pain in right shoulder which does not have any relation to the pre-existing disease diabetes (DM). The Insurance Company could not substantiate their contention with cogent and reliable documents that disease for which the patient was treated falls under pre-existing disease. **Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant.**

In the matter of Ms. Shabana Nargis
Vs
The United India Insurance Company Ltd.

DATE: 05.02.2016

1. The complainant alleged that she was covered under mediclaim policy of UIIC since 2008. Her current policy was from 18.06.2013 to 17.06.2014 with S.I. of Rs. 4 lacs, was a family floater policy. Renal Doppler was done on 31.08.2011 and kidney disease was detected. Her first dialysis was done on 30.05.2012. The TPA Vipul Medcorp Pvt. Ltd. restricted the S.I. Rs. 1.75 lacs as per earlier policy 2010-11 as she had been also detected with hypertension few months prior to CKD. The Insurance Company had considered the S.I. of earlier policy (2010-11) and not the eligible S.I. Rs. 4 lacs for family floater (2011-12). She had requested the Insurance Company to consider the claim on the basis of eligible S.I. of Rs. 4 lacs as the treatment was for CKD and not HTN. She had sought the relief of Rs. 2.25 lacs (Rs. 4 lacs-Rs. 1.75 lacs) from this forum.

2. As per TPA M/s Vipul Med Corp TPA (Pvt.) Ltd. letter dated 02.05.2014 the patient was suffering from chronic Renal failure and liability for the said disease was restricted to Rs. 1.5 lacs which has already been exhausted. Thus, the claim was not admissible.

3. I heard both the sides, the complainant (represented by her husband) as well as the Insurance Company. During the course of hearing the complainant alleged that she was covered under mediclaim policy of UIIC since 2008. Her current policy starts from (18.06.2013 to 17.06.2014) with S.I. of Rs. 4 lacs (family floater policy). Renal Doppler was done on 31.08.2011 and kidney disease was detected. Her first dialysis was done on 30.05.2012. The TPA Vipul Medcorp Pvt. Ltd. restricted the S.I. Rs. 1.75 lacs as per earlier policy 2010-11 as she had been detected with hypertension few months prior to CKD. The Insurance Company had considered the S.I. of earlier policy (2010-11) and not allowed eligible S.I. Rs. 4 lacs for family floater (2011-12). She had requested for considering the S.I. of Rs. 04 Lacs instead of S.I. of Rs. 1.75 Lacs, but the Insurance Company had not agreed.

The Insurance Company had stated that the patient was suffering from Chronic Renal failure and the liability for the said disease was restricted to Rs. 1.75 Lacs for the period 2010-11 in which it was detected which had already been exhausted.

On perusal of the claim papers, I find that the patient Mrs. Shabana Nargis was admitted in Pushpawati Singhania Research Institute for Liver, Renal and Digestive diseases from 30.05.2012 to 01.06.2012 and diagnosed as a case of HTN, CKD-ESRD, Azotemia (MHD initiated on 30.05.2012), Severe anemia and left AVF made under LA on 01.06.2012. As per discharge summary dated 30.05.2012 the patient was having a past history of known case of HTN one and a half years and was on regular treatment, cholecystectomy 12 years back, CKD-progressive rise in S.creatinine 01 year. The Insurance Company had settled the claim on the basis of S.I. Rs. 1.75 Lacs under policy no. 042301/48/10/97/00000677 from 18.06.10 to 17.06.11 as the disease CKD-progressive rise in S. Creatinine was one year old as per discharge summary dated 30.05.2012. Since the disease CKD arose in May, 2011, as per enhancement of S.I. clause 5.11which states "The insured may seek enhancement of Sum Insured in writing at or before payment of premium for renewal, which may be granted at the discretion of the Company. However, notwithstanding enhancement, for claims arising in respect of ailment, disease or injury contracted or suffered during a preceding policy period, liability of the Company shall be only to the extent of the Sum insured under the policy in force at the time when it was contracted or suffered during the currency of such renewed policy or any subsequent renewal thereof." The Insurance Company had settled the claim considering the S.I. of Rs. 1.75 Lacs under policy no. 042301/48/10/97/0000677 from 18.06.10 to 17.06.11 (as per discharge summary dated 30.05.2012) Puspawati Singhani Research Institute. The patient was on her own admission suffering from CKD detected in 2011 when the S.I. was Rs. 1.75 Lacs. Hence the claim is covered by the clause 5.1 which states that "any claims arising in respect of ailment, disease or injury contracted or suffered during a preceding policy period, liability of the Company shall be only to the extent of the Sum insured under the policy in force at the time when it was contracted or suffered during the currency of such renewed policy or any subsequent renewal thereof." In this case it was detected in 2011 so the Insurance Company has rightly restricted it to the period 2010-11 when S.I. was Rs. 1.75 Lacs I see no reason to interfere with the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Ms. Purnima Bhalla
Vs
United India Insurance Company Ltd.

DATE: 15.03.2016

1. The complainant had submitted that she was covered under the captioned mediclaim policy. She had 2 operations/hospitalization claims for Right Eye and left eye respectively, and paid Rs. 119500/- for each operation. The insurer had reimbursed her only Rs. 24,000/- per claim. The complainant had made representation to GRO, but no reply was received so far from the side of insurer. She sought the relief of Rs. 1, 89,000/- from this forum.

2. The Insurance Company had rejected the claim under the following clauses no. 3.2.3, 3.2.5 and 3.33 as under i.e. the treatment taken it should be medically necessary, treatment in a Network PPN Hospital and expenses incurred should be a reasonable and customary as standard charges applicable in the geographical area.

3. I heard both the sides, the complainant (represented by her employee) as well as the Insurance Company. During the course of hearing the complainant had stated that the Insurance Company did not inform her about the GIPSA package hence she was not aware of the GIPSA rates. Further it was stated that she had applied for cashless treatment which was denied by the Medanta hospital, Gurgaon. She was asked to submit the denial letter. The hospital refused to give the letter as the case was too old.

   Under the circumstances she had to undergo for eye operation on re-imbursement basis. The Insurance Company could not prove that the GIPSA packages were made known to the complainant in advance. The TPA also had not given any list or other documents to prove that GIPSA package was made known to the complainant. In view of this I hereby direct the Insurance Company to settle the claim and reimburse the admissible amount. **Accordingly an award is passed with the direction to the Insurance Company to settle the claim and pay the admissible amount as per policy terms and conditions to the complainant.**

In the matter of Mr. Danish Khan
Vs
Apollo Munich Health Insurance Company Ltd.

DATE: 10.03.2016

1. The complainant alleged that he was hospitalized at Max Hospital, Patparganj on 08.10.2015 with the complaint of acute pain in cervical along with left scapular margin with parasthesia of right upper limb (distal) and breathlessness and dizziness etc. He submitted that prior to this, he was admitted with same problems and reasons in September, 2015 at Kailash Hospital and that claim for Rs. 30,601/- was settled and paid by Insurance Company. Now when he got admitted in Max Hospital for almost same problems/treatment in October, 15 the claim stands rejected by the Company on illogical reasons. He sought the relief of Rs. 69,607/- only.

2. The Insurance Company had rejected the claim under section V-C and VIII-d saying that as per the documents submitted need for hospitalization was not established which indicates that hospitalization was primarily for evaluation and observation.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant alleged that he was admitted in Max Health Care Hospital Patparganj, New Delhi from 08.10.15 to 11.10.15 and diagnosed as a case of severe cervical radiculopathy, drug induced gastritis, spondyloarthropathy. He was suffering from severe pain in left iliac crest and pain in left leg, causing sleep disturbance and also repeated nausea and vomiting. He was admitted in hospital on the advice of the treating doctor.

   The Insurance Company had stated that the claim was rejected on the ground that need for hospitalization was not established as there was no active line of treatment given to the patient. The hospitalization was primarily for evaluation and observation.

   On perusal of the claim papers placed on record, I find that Mr. Danish Khan was admitted in Max Health Care Hospital from 08.10.15 to 11.10.15 and diagnosed as a case of severe cervical radiculopathy, drug induced gastritis, spondyloarthropathy. During personal hearing the complainant had apprised that at the time of admission he was suffering from acute pain in cervical along with left scapular margin with parasthesia of right upper limb (distal) and breathlessness and dizziness. He was admitted in hospital on the advice of the treating doctor. Since, the patient was suffering from severe pain in cervical along with left scapular margin along with parasthesia of right upper limb and also repeated nausea and vomiting and was managed with IV analgesics, IV antiemetic MRIC spine and LS spine with contrast were done, proper monitoring of the patient was

required during hospitalization. Hence, the contention of the Insurance Company that the said treatment could have been done on an outpatient basis without any hospitalization is not correct. The patient was admitted on the advice of the attending doctor and managed conservatively with support of IV fluids and other supportive treatment. MRIC spine and LS spine with contrast were also done during hospitalization. Hence, I hold that the Insurance Company is liable to settle the claim. **Accordingly an award is passed with the direction to the Insurance Company to settle the claim and pay the admissible amount as per policy terms and conditions to the complainant.**

In the matter of Ms. Sushmita Chandra
Vs
Apollo Munich Health Insurance Company Ltd.

DATE: 21.03.2016

1. The complainant alleged that claimant fell down from the Rickshaw and suffered soft tissue injury left leg and foot which resulted into cellulitis and wound infection. She was admitted in Max Hospital from 08.2.15 to 13.02.15 and diagnosed as a case of acute soft tissue infection and ulcer left leg and foot. She was admitted for debridement and skin grafting. She sought the relief of Rs. 1, 62,418/- from this forum.

2. The Insurance Company had rejected the claim stating that the claim was denied on account of Acute soft tissue infection and ulcer left leg and foot for the reasons mentioned below:

- The submitted claim fell under first 30 days waiting period clause of policy.
- The claim was repudiated under section 2B of the policy. As per the previous claim history before inception of the (within 30 days) which was for the debridement with fasciotomy (date of Surgery 18.12.2014). The policy inception was 16.01.2015

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the Insurance Company had contended that the claimant had a history of debridement and fasciotomy in December 2014 in the left leg as mentioned in

hospitalization records, and which was not disclosed at the inception of the policy i.e. 16.01.2015. The present illness was soft tissue injury left leg and foot, which resulted into cellullitis and wound infection and admitted for debridement and skin grafting. Hence the Insurance Company had rejected the claim on the grounds of pre-existing medical condition and concealment of material facts. I uphold the decision of the Insurance Company. I see no reason to interfere with the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. Neeraj Jain
Vs
Oriental Insurance Company Ltd.

DATE: 14.03.2016

1. The complainant alleged that he was hospitalized in Tirath Ram Shah Hospital on 16.07.15 to 17.07.15, 25.08.15 to 26.08.15, 06.10.2015 to 07.10.2015 and 19.11.15 to 20.11.15 for treatment of Hypogammaglobulinemia and paid bill for Rs. 2, 20,172/- which was denied by the Insurance Company under clause 2.3 i.e. "expenses on hospitalization are admissible only if hospitalization is for a minimum period of 24(twenty four) hours." The complainant had contended that the hospitalization is for more than 24 hours which is evident by discharge summary of Hospital. He sought the relief of Rs. 2, 20172/-.

2. The Insurance Company had repudiated the claim invoking the policy clause 2.3 saying that the given condition and management does not require hospitalization. The clause 2.3 speaks about the admissibility of claim only if hospitalization is for a minimum period of 24 hours.

3. I heard both the sides, the complainant (represented by his uncle) as well as the Insurance Company. During the course of hearing the complainant alleged that he was hospitalized in Tirath Ram Shah Hospital, Civil Line, Delhi four times for the treatment of Hypogammaglobulinemia with chronic diarrhoea with weight loss. He was treated for immunoglobulin infusion therapy. He had submitted all the necessary papers of the claim for reimbursement of Rs. 2,20,172/- to the TPA/Insurance Company but the Company had denied the claim on the ground that "expenses on hospitalization are admissible only if hospitalization is for a minimum period of 24(twenty four) hours."

The Insurance Company had stated that the claim were rejected under policy clause 2.3 "expenses on hospitalization are admissible only if hospitalization is for a minimum period of 24(twenty four) hours."

On perusal of the claim papers placed on record, I find that Mr. Neeraj Jain was admitted in Tirath Ram Shah Hospital on 16.07.15 to 17.07.15, 25.08.15 to 26.08.15, 06.10.2015 to 07.10.2015and 19.11.15 to 20.11.15 for treatment of immunoglobulin infusion therapy as he was suffering from Hypogammaglobulinemia with chronic diarrhoea with weight loss. As per patient bill (summary) provided by the hospital, the patient was admitted in hospital for more than 24 hours in all the four claims. Hence the contention of the Insurance Company that the patient had not been in hospital for a minimum period of 24 hours is not correct. As per certificate of attending Dr. D.K. Singh dated 18.11.2015 produced by the complainant, the treatment for the disease for which the patient Mr. Neeraj Jain was suffering can only be done in hospital under the supervision of qualified practitioner. During the personal hearing the complainant had also submitted that the Oriental Insurance Company had paid the claims for the said illness in the past also. The Insurance Company could not refute the charges made by the complainant. Hence, keeping in view all the above facts, I hold that the Insurance Company is liable to settle the claim. **Accordingly an award is passed with the direction to the Insurance Company to settle the claim and pay the admissible amount as per policy terms and conditions to the complainant.**

In the matter of Mr. Jai Bhagwan
Vs
The Apollo Munich Health Insurance Company Ltd.

DATE: 25.02.2016

1. The complainant alleged that he was admitted in Ayushman Hospital from 27.08.15 to 31.08.15 and diagnosed as a case of Dengue fever with acute gastritis. He had submitted all the necessary papers of the claim to the Insurance Company for reimbursement of Rs. 28,000/- but the Company had rejected the claim on the ground that hospitalization was not required. He had sought the relief of Rs. 28,000/- from this forum.

2. The Insurance Company vide its letter dated 30.10.15 had rejected the claim on the ground that submitted record does not validate the requirement of hospitalization. The claim was repudiated under Sec-V C (viib) of the policy.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant alleged that he was admitted in Ayushman Hospital from 27.08.15 to 31.08.15 and diagnosed as a case of Dengue fever with acute gastritis. He had submitted all the necessary papers of the claim to the Insurance Company for reimbursement of Rs. 28,000/- but the Company had rejected the claim on the ground that hospitalization was not required.

The Insurance Company had stated that the claim was rejected on the ground that as per submitted documents, the need for hospitalization was not established and treatment could have been done on an outpatient basis without any hospitalization. Hence, the claim was repudiated under Sec V c Viii b of the policy.

On perusal of the claim papers placed on record, I find that Mr. Jai Bhagwan was admitted in Ayushman Hospital from 27.08.15 to 31.08.15 and diagnosed as a case of Dengue fever with acute gastritis. During personal hearing the complainant had apprised that at the time of admission he was suffering from High Grade Fever (104° F) associated with nausea since 02 days with severe pain in abdomen and he was admitted in hospital on the advice of the doctor. Since the patient was suffering from Dengue fever (104° F) with severe pain in abdomen and platelet count was also 85,000 proper monitoring of the patient was required at hospital. Hence, the contention of Insurance Company that the said treatment could have been done on an outpatient basis without any hospitalization is not correct. The patient was admitted on the advice of the attending doctor and managed conservatively with support of IV antibiotics, antiemetic and other supportive treatment, platelet monitoring was also done during hospitalization. Hence, I hold that the Insurance Company is liable to settle the claim. **Accordingly an award is passed with the direction to the Insurance Company to settle the claim and pay the admissible amount as per policy terms and conditions to the complainant.**

In the matter of Mr. Akhil Dua
Vs
The Oriental Insurance Company Ltd.
DATE: 25.02.2016

1. The complainant alleged that his father was admitted in PGI Hospital, Chandigarh from 12.06.15 to 13.06.15 and 26.06.15 to 27.06.15 for the operation of both eyes. He had lodged the claim of Rs. 40,198/- with the Insurance Company but the Company had rejected the claim on the ground that the treatment given was only OPD treatment. He had sought the relief of Rs. 40,198/- from this forum.

2. The Insurance Company vide its letter dated 30.07.15 had rejected the claim on the ground that the patient was hospitalized from 12.06.15 to 13.06.15 and 26.06.15 to 27.06.15 as a case of clinically significant Macular Edema and was treated with injection Ozurdex. As administration of intravitreal injection which was considered an OPD procedure, the claim was not admissible.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant alleged that his father was admitted in PGI Hospital, Chandigarh from 12.06.15 to 13.06.15 and 26.06.15 to 27.06.15 for the operation of both eyes. He had lodged the claim of Rs. 40,198/- with the Insurance Company but the Company had rejected the claim on the ground that the treatment given was OPD treatment.

The Insurance Company had stated that during hospitalization at PGI hospital, Chandigarh, there was no active line of treatment, only injection ozurdex was administered to the patient which was considered an OPD procedure. Hence, the claim was not payable.

On perusal of the claim papers placed on record, I find that Mr. Parveen Dua was admitted in PGI Hospital, Chandigarh from 12.06.2015 to 13.06.2015 and 26.06.15 to 27.06.15 and diagnosed as a case of CSME (Left and Right Eye). During hospitalization injection "ozurdex" was administered to the patient. The complainant had submitted that his father was admitted in hospital on the advice of the attending doctor and the injection "ozurdex" was given in operation theatre under sterile conditions. Since the patient was admitted in hospital on the advice of the attending doctor as confirmed from treatment record produced by the complainant and injection ozurdex was administered in operation theatre (OT) under sterile conditions, I hold the Insurance Company is liable to settle the claim. **Accordingly an award is passed with the direction to the Insurance Company to**

settle the claim and pay the admissible amount as per policy terms and conditions to the complainant.

In the matter of Mr. D.K. Chauhan
Vs
The Oriental Insurance Company Ltd.

DATE: 25.02.2016

1. The complainant had alleged that he was admitted in Delhi Heart and Lung Institute on 03.10.15 with the complaint of chest pain/discomfort on exertion. Angioplasty was done for which the total bill was Rs. 3.5 Lacs (approx) but the Raksha TPA had approved Rs. 2.5 Lacs under cashless facility. His sum insured under the policy was Rs. 7 Lacs. He had sought the relief of Rs. 1 Lac from this forum.

2. The Insurance Company had submitted self contained and stated that the treatment taken was falling under pre-existing disease.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the Insurance Company was unable to establish pre-existing condition of complainant. Further the complainant submitted certificates/discharge summary of the Parmanand Hospital and Delhi Heart and Lungs Institute + Saket City Hospital which clearly shows that he was not a known case of hypertension.

In view of this, the Insurance Company is directed to settle the claim for balance amount of Rs. 1 Lac. **Accordingly an award is passed with the direction to the Insurance Company to settle the claim and pay the admissible amount as per policy terms and conditions to the complainant.**

In the matter of Mr. Akshay Ahuja
Vs
The Oriental Insurance Company Ltd.

DATE: 03.03.2016

1. The complainant alleged that he was admitted in Fortis Escorts Heart Institute from 01.01.15 to 05.01.15 and diagnosed as a case of Coronary Artery Disease, Acute Inferior Wall Myocardial Infarction/Stemi, CAG: Triple Vessel Disease, Left Dominant Circulation (01.01.2015), Primary PTCA + Stent to Distal LCx (01.01.2015) and PTCA+STENT to LAD (03.01.2015). The hospital has raised a bill of Rs. 5, 86,560/- but the Raksha TPA had approved the claim amount of Rs. 4,19,721/- after deducting an amount for the room rent as well as the value of stents as per GIPSA package. He had sought the relief of Rs. 1, 60,000/- from this forum towards the difference of amount of 2 stents.

2. The Raksha TPA vide its letter dated 05.01.2015 had informed that the amount of Rs. 4, 19,721/- was approved as per GIPSA package PPN tariff.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant had submitted a letter/email written by Shri Rajender Kumar, Divisional Manager of the Insurance Company saying that the deductions were not justified and he recommended for the release of balance amount payable under the claim. In view of above and since there was no such clause mentioned in the policy terms and conditions which indicates the payment of claim on GIPSA package rates agreed between Insurance Company and PPN Hospitals. It is matter of great concern when rates have been agreed by PPN Hospitals and Authorization letter was issued by the TPA on the basis of such rates, the Hospital should charge over and above the rates already agreed. In this case the Insurance Company had access to the hospitals and preventive measures must be taken in this regard so that unnecessary advantage is not taken by the hospitals.

In view of the above, I, hereby, direct the Insurance Company to settle the claim for balance amount of Rs. 1, 60,000/- towards the difference in cost of 2 stents and confirm the compliance to this office. **Accordingly an award is passed with the direction to the Insurance Company to settle the claim and pay the admissible amount to the complainant.**

In the matter of Mr. Kamal Kishore Jain
Vs
United India Insurance Company Ltd.

DATE: 29.03.2016

1. The complainant alleged that his wife had undergone cataract operation and incurred Rs. 87,500/- towards hospitalization expenses at an Empanelled Hospital. The TPA had settled a claim/reimbursed an amount of Rs. 30,600/- only, thereby short payment made for Rs. 56,900/- as per the GIPSA package agreed by the empanelled hospital. He sought the relief of Rs. 56,900/- as full and final settlement from this forum.

2. The Insurance Company reiterated that the insured himself was willing to go for Femto Laser Surgery which was not payable under reasonable and customary expenses clause of the policy. The claimant initially applied for "cashless" approval through the same hospital. Approval for cashless was given as per GIPSA guidelines. But the complainant did not avail cashless benefits under this claim. Therefore, the claim on reimbursement basis was settled on basis of policy terms and conditions i.e. reasonable and customary expenses clause of policy and GIPSA approved rates as the Hospital was on panel for GIPSA agreement.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant had contended that he had undergone for a cataract operation keeping in view the policy condition specifically mentioned on the face of the policy that 25% of S.I. will be the eligibility for the cataract treatment. The representative of the Insurance Company mentioned that the claim was settled on the basis of GIPSA agreement of PPN hospital. The Insurance Company could not explain as to why "25%" of S.I. would not be payable though it was mentioned specifically on the face of the policy under clause 1.2.1. Therefore, I direct the Insurance Company to settle the claim as per policy clause 1.2.1 i.e. actual expenses incurred or 25% of the S.I. whichever is less. **Accordingly an award is passed with the direction to the Insurance Company to settle the claim and pay the admissible amount to the complainant.**

In the matter of Mr. Kanhaiya Lal
Vs
HDFC ERGO General Insurance Company Ltd.

DATE: 21.03.2016

1. The complainant alleged that he was admitted in Bansal Hospital, Nangloi Delhi from 06.09.15 to 12.09.15 and diagnosed as a case of Gastroenteritis and colitis of unspecified origin. He had submitted all the necessary papers of the claim to the Insurance Company for reimbursement of Rs. 88,792/- but the Company had rejected the claim on the grounds of misrepresentation of material facts and the claim was found manipulated as fraudulent claim papers were submitted. He sought the relief of Rs. 1, 08,792/- with interest from this forum.

2. The Insurance Company reiterated vide its letter dated 29.12.2015 and 19.01.2016 had rejected the claim on the grounds of misrepresentation of material facts and as per the submitted documents by the Insured the claim was found to be manipulated. The claim was rejected under section 10J of the policy.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the Insurance Company had failed to establish the fraudulent nature of the claim. No documentary evidence was shown to prove manipulation. Further regarding obtaining a fresh additional policy for critical illness also found no relevance here. I find that there is no bar on taking any number of policies.

The Insurance Company could not show the relevance or otherwise of the critical illness policy and its impact on the current claim. Therefore, I direct the Insurance Company to settle the claim as per policy terms and conditions. **Accordingly an award is passed with the direction to the Insurance Company to settle the claim and pay the admissible amount to the complainant.**

In the matter of Mr. Rohit Kapur
Vs
Apollo Munich Health Insurance Company Ltd.

DATE: 15.03.2016

1. The complainant alleged that his daughter Ms. Shria Kapur was admitted in Sir Ganga Ram Hospital from 06.08.2015 to 07.08.2015 and diagnosed as a case of cervical mass operation of excision of soft tissue mass was done under GA on 06.08.2015. He had submitted all the necessary papers of the claim for reimbursement of Rs. 41,000/- to the Insurance Company but the Company had rejected the claim on the ground of non-disclosure of material facts at the time of taking the policy and terminated the policy also. He sought the relief of Rs. 41,000/- from this forum.

2. The Insurance Company vide its email dated 31.12.2015 had rejected the claim on the ground that the medical history details of Echogenic Kidneys (USG finding) since 2007, hypertension, obesity and concentric left ventricular hypertrophy was not revealed in the proposal form while taking the policy. Hence, the claim was rejected and policy was cancelled due to non-disclosure and concealment of material facts under section VI (J) of policy terms and conditions.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the Insurance Company reiterated the claim was rejected on the ground on non-disclosure of material facts regarding the congenital diseases the complainant daughter was suffering. Hence the claim was repudiated and the insurance policy of the family cancelled on account of concealment of material facts under section VI (J) of policy terms and conditions. The complainant had contended that on the advices of his insurance agent the insurance policy of the family was ported/ transferred to 2-3 companies, however the continuity was maintained. In response to this the Insurance Company submitted that while submitting the proposal form for the portability the pre-existing and congenital diseases were not disclosed thus were deprived to take suitable decision about acceptability of the policy with regard to chargeable premium and imposing of terms and conditions. To this effect the Insurance Company is correct. However Insurance Company is directed to provide with continuity insurance cover to

other family members. However, the cover may be provided to the daughter with suitable loading of premium or exclusions of the congenital diseases. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. Mukesh Kumar Jain
Vs
Oriental Insurance Company Ltd.

DATE: 03.03.2016

1. The complainant alleged that his son Mr. Akash Jain had undergone Bilateral Hip Salvage Surgery and a claim was lodged in December, 2014, which was rejected on ground that he had undergone psychiatric treatment which is exclusion under clause 4.8 of the policy as this ailment was a side effect of psychiatric treatment. The complainant had also provided the Dr's support letter which states that "there is no direct link between the psychiatric disorder or treatment with the fracture and non-union. The fracture and the non union are not a complication of his psychiatric condition." He sought the relief of Rs. 3,33,316/-

2. The Insurance Company reiterated vide letter dated 09.11.2015 had rejected the claim under the policy on the ground that the ailment was a side effect of psychiatric treatment as he was diagnosed as having obsessive compulsive neurosis and was put on psychiatric medicines in February, 2014, this was not payable as per exclusion clause 4.8 of the individual mediclaim policy.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the Insurance Company representative Sh. Jagdish Chand Suneja, Asstt. Manager, Oriental Insurance Company explained that the claim was rejected by the Company on the grounds that the complainant was under the psychiatric treatment and the present illness was the effect of the psychiatric medicines as he was diagnosed as having obsessive compulsive neurosis. In the month of April after a spasmodic episode he experienced pain in both hip joints and could not get up from bed or put weight on his lower limbs. Later X-ray was done which showed bilateral femoral neck fractures. Thus the claim was repudiated under the mediclaim policy exclusion clause no. 4.8 which states "Convalescence, general debility, "run down" condition or rest cure, congenital external and internal 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."

In reply to that the complainant pleaded that the treating Doctor Manoj Padman of Fortis Memorial Research Institute (Ms Orth, DNB Orth.) which clarifies that the "Patient had documented obsessive compulsive neurosis for which he had been on psychiatric treatment even before the fractures happened. There is no direct link between the psychiatric disorder or treatment with the fracture and non union. The fracture and the non-union are not a complication of his psychiatric condition." In order to arrive at conclusion the Insurance Company was questioned to signify the relevance between the psychiatric treatment and the vitamin D deficiency which they could not co-relate and justify. Under the circumstances I am of the opinion that the present ailment does not fall under the policy exclusion 4.8 of the individual mediclaim policy. Therefore, I hereby direct the Insurance Company to settle the claim as per the policy terms and conditions for the applicable sum insured. **Accordingly an award is passed with the direction to the Insurance Company to settle the claim and pay the admissible amount as per policy terms and conditions to the complainant.**

In the matter of Mr. Narender Kumar Verma
Vs
Apollo Munich Health Insurance Company Ltd.

DATE: 29.03.2016

1. The complainant alleged that his son was admitted in Max Health Care Hospital from 07.12.15 to 08.12.15 and diagnosed as a case of viral fever with artyhralgia. The cashless facility was denied by the Insurance Company. He had submitted all the necessary papers of the claim to the Insurance Company for reimbursement of Rs. 25,790/- but the Company had denied the claim under "two years waiting period" clause and also on the policy condition that the admission was for Investigation and Evaluation of the ailment only. He sought the relief of Rs. 25,790/- from this forum.

2. The Insurance Company vide its letter dated 19.01.2016 had rejected the claim on the following grounds:

- The submitted claim was for the illness which has a specific clause for two year(s) of waiting period as per the policy. The policy start date was 23 Feb 2015. Hence claim was repudiated under section V A (ii) of the policy.
- As per submitted documents, the admission was for Investigation and Evaluation of the ailment only.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the Insurance Company had contended that the policy had a specific clause for 2 years waiting period for the disease of Tonsillitis hence the claim was denied. The complainant had pleaded that no treatment for tonsillitis was taken by him as the discharge summary reveals diagnosis of pain in joints +fever+ sore throat. I find that in the initial assessment sheet dated 07.12.15 of Max Hospital it had been clearly indicated that the patient was being treated for acute follicular tonsillitis since 04.12.15 and was treated with the tab-augmentin-duo which created allergic reactions i.e. pain in the joints and fever. He was admitted in the hospital on 07.12.15 for the treatment of joint pain and fever. These were the consequential result of the tonsillitis and the medication received for it. Tonsillitis has a 2 years waiting period as per the policy terms and conditions. Therefore, I see no reason to interfere with the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. Raj Kumar Jaiswal
Vs
ICICI Lombard General Insurance Company Ltd.

DATE: 21.03.2016

1. The complainant alleged that he was continuously insured with ICICI Lombard General Insurance Company since 26.11.2009. He was admitted in Medanta the Medicity, Gurgaon from 30.06.2015 to 02.07.2015 and diagnosed as a case of hypertension, diabetes Mellitus (Type II), Coronary Artery Disease, Double vessel disease with patent stent in LAD/LCX. Coronary angiography was done on 30.06.2015 and coronary stenting (Resolute integrity and Promus element) to RCA & LCX was done on 30.06.2015. The cashless facility was denied by the Insurance Company. He had submitted all the necessary papers of the claim to the Insurance Company for reimbursement of Rs. 3,84,392/- but the Company had denied the claim on the ground of non-disclosure of material facts. He had sought the relief of Rs. 3, 84,392/- from this forum.
2. The Insurance Company vide its letter dated 19.08.2015 had rejected the claim and cancelled/terminated the policy also on the ground that it was noted from the discharge summary dated 06.08.2009 that the Insured was diagnosed with Diabetes and Coronary Artery disease and underwent PTCA which was not

disclosed at policy inception i.e. 26.11.2009. Hence, the claim was rejected under part-III of the schedule of the policy i.e. non –disclosure/misrepresented the material facts.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant alleged that he was admitted in Medanta the Medicity, Gurgaon from 30.06.2015 to 02.07.15 and diagnosed as a case of and diagnosed as a case of hypertension, diabetes Mellitus (Type II), Coronary Artery Disease, Double vessel

disease with patent stent in LAD/LCX. During hospitalization Coronary angiography was done and coronary stenting (Resolute integrity and Promus element) to RCA & LCX was done on 30.06.2015.the Insurance Company had denied his claim on the ground of non-disclosure of material facts.

The Insurance Company had stated that the claim was rejected on the ground of non-disclosure of material facts as it was noted from the discharge summary dated 06.08.2009 the patient was diagnosed with Diabetes and Coronary Artery disease and underwent PTCA double vessel disease on 02.08.2009 which was not disclosed at the time of taking the policy i.e. 26.11.2009. Hence, the claim was rejected under part-III of the schedule of the policy i.e. non –disclosure/misrepresented the material facts and policy was also terminated.

On perusal of the claim papers placed on record, i find that the patient was hospitalized from 30.06.15 to 02.07.15 at Medanta the Medicity, Gurgaon. During hospitalization Coronary angiography was done and coronary stenting (Resolute integrity and Promus element) to RCA & LCX was done on 30.06.2015. I find that as per discharge summary dated 06.08.2009 the patient was diagnosed with diabetes and CAD and underwent PTCA double vessel disease on 02.08.2009 which was not disclosed at the time of taking the policy i.e. 26.11.2009. This is a case of non-disclosure. In the case of Satwant Kaur Sandhu Vs New India Assurance (2009) 8 SCC 316, the Hon'ble Supreme Court emphasized that it is obligatory for the proposer to disclose the material facts at the time of filling the proposal form. The Insurance Company is not liable to pay the expenses in case of non-disclosure of material information. Therefore, I uphold the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Ms. Avanika Dedakia
Vs
Apollo Munich Health Insurance Company Ltd.

DATE: 16.03.2016

1. The complainant had obtained a Family Floater Policy from Apollo Munich in April, 2015 which was in continuity under the portability from Oriental Insurance Company (having 5 years old policy). In July, 2015 a claim arose for an eye operation of my wife under non-panelled Hospital. After a month, Apollo Munich had sent a letter thereby terminated the contrast of insurance of the policy on the grounds of Non-disclosure of Material facts. He further added that he disclosed all about his wife's feeling of uneasiness in her left eye and it might be possible that the agent did not mention it in the proposal form.

2. The Insurance Company had rejected the claim on the grounds that the medical history details of mass on left eye lower lid increasing rapidly in size since 6 months was not revealed in the proposal form while taking the insurance policy. Hence the claim was repudiated due to the non-disclosure and concealment of material facts under sec-5(U) of the policy terms and conditions. Further the Insurance Company gave 30 days notice for cancellation of policy in view of non-disclosure of material facts.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant alleged that his wife was admitted in Kiran Eye Care Centre, Delhi on 14.07.15 and diagnosed as a case of Left Eye Lower Lid mass increasing rapidly in size since 06 months. Left eye lower lid mass excision and lower lid reconstruction +LA was done on 1.07.15. The Insurance Company had rejected the claim on the ground of non-disclosure of material facts.

The Insurance Company had stated that the claim was repudiated on the ground that the medical history details of mass on left eye lower lid increasing rapidly in size since 6 months was not revealed in the proposal form while taking the insurance policy. Hence the claim was repudiated due to the non-disclosure and concealment of material facts under sec-5(U) of the policy terms and conditions. The policy was also terminated on the said ground.

On perusal of the claim papers placed on record, I find that Mrs. Avanika A Dedakia was admitted in Kiran Eye Care Centre, Delhi on 14.07.15 and diagnosed as a case of Left Eye Lower Lid mass. As per treatment details dated 06.07.15 she was suffering from the said disease since last 06 months which was not revealed in the proposal form while taking the policy i.e. 21.05.15. In the case of Satwant Kaur Sandhu Vs New India

Assurance (2009) 8 SCC 316, the Hon'ble Supreme Court emphasized that it is obligatory for the proposer to disclose the material facts at the time of filling the proposal form. The Insurance Company is not liable to pay the expenses in case of non-disclosure of material information. Thus it was a case of non-disclosure. Therefore, I uphold the decision of the Insurance Company. Further the Insurance Company is hereby directed to restore the policy with continuity benefits by excluding the said disease. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. Mandeep Arora
Vs
Oriental Insurance Company Ltd.

DATE: 15.03.2016

1. The complainant alleged that his mother Mrs. Jagdish Kaur was admitted in Vinayak Hospital for her inability to take any kind of food and profuse bleeding in urine and stool in February, 2015. The claim was not settled on the grounds that there was no active line of treatment given to the patient. The complainant had also made available Dr's support letter in this regard. He sought the relief of Rs. 67842/-.

2. The Insurance Company had reiterated vide email dated 11.06.2015 had upheld their decision given earlier. The claim was rejected under policy clause no. 4.11 which states that "expenses incurred at hospital for diagnostic purpose which is not followed by active line of treatment for the ailment during hospitalization period."

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant alleged that his mother Mrs. Jagdish Kaur was admitted in Vinayak Hospital, Derawal Nagar (Model Town) Delhi from 06.02.15 to 14.02.15 and diagnosed as a case of Iron Deficiency Anaemia with UTI with Hypothyroidism (GI Bleed/Hematuria). UGI Endoscopy was done on 12.02.2015. She was admitted in the hospital on the advice of the treating doctor.

The Insurance Company had stated that the claim was rejected under policy clause 4.11 which states that "expenses incurred at hospital for diagnostic purpose which is not followed by active line of treatment for the ailment during hospitalization period."

On perusal of the claim papers placed on record, I find that Mrs. Jagdish Kaur was admitted in Vinayak Hospital from 06.02.15 to 14.02.15 and diagnosed as a case of Iron

Deficiency Anaemia with UTI with Hypothyroidism (GI Bleed/Hematuria). UGI Endoscopy was done on 12.02.2015. During the personal hearing the complainant had apprised that his mother was admitted on the advice of the treating doctor and was managed with IV Fluids and other supportive treatment. Since, the patient was suffering from UTI with Hypothyroidism (GI Bleed/Hematuria) and was managed with IV Fluids as she was unable to take orally, the contention of the Insurance Company that the said treatment could have been done on an outpatient basis without any hospitalization and there was not active line of treatment is not correct. The attending doctor vide his certificate dated 09.05.15 had also clarified that admission is required in such type of disease. Hence, I hold that the Insurance Company is liable to settle the claim. **Accordingly an award is passed with the direction to the Insurance Company to settle the claim and pay the admissible amount to the complainant.**

In the matter of Mr. Surender Pal Arya
Vs
Apollo Munich Health Insurance Company Ltd.

DATE: 15.03.2016

1. The complainant alleged that he had taken a Mediclaim Insurance Policy from Apollo Munich since 05.03.2013 onwards. During 18.10.2015 to 22.10.2015, he was admitted in Maharaja Agrasen Hospital for the treatment related to typhoid fever. The TPA rejected the cashless approval and asked the complainant to file the complaint for reimbursement on the grounds that need for hospitalization was not established. Therefore, the claim was repudiated under section 6-C and Section-8-B of policy terms and conditions. He sought the relief of Rs. 26,656/- from this forum.

2. The Insurance Company had rejected the claim on the grounds that as per medical opinion and submitted documents, the need for hospitalization was not established. Hence the claim was repudiated under the condition no-6C and 8B of the policy.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant had alleged that he was admitted in Maharja Agrasen Hospital for the treatment of typhoid fever as per the advices of

treating/consulting doctor. The Insurance Company contended that the claim was repudiated on the ground that as per the medical opinion and submitted documents the need for hospitalization was not established. Therefore, the claim was repudiated under section 6-C and Section-8-B of policy terms and conditions.

I find that the complainant was advised by the Doctor for admission in hospital. The treatment was given from 18.10.2016 to 22.10.2016. These facts the Insurance Company also could not dispute. During the personal hearing the Insurance Company agreed to resolve the matter. Hence the Insurance Company is hereby directed to settle the claim and pay the admissible amount as per policy terms and conditions to the complainant. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Ms. Suman Arora
Vs
HDFC ERGO General Insurance Company Ltd.

DATE: 15.03.2016

1. The complainant alleged that she had taken a Health Suraksha Policy from HDFC ERGO General Insurance Company in continuity since 27.11.2010 onwards. On 11.01.2016 she got hospitalized in National Heart Institute, East of Kailash, New Delhi-65 with complaints of high fever from last few days alongwith chest congestion, cough and cold, breathlessness and severe headache. The claim was rejected by HDFC on the grounds of Non-disclosure of material facts (i.e. Haemorrhoids, since 10 years).

2. The Insurance Company had rejected the claim vide email dated 08.02.2016 invoking the policy exclusion under section 10rii, the Insurance Company had contended that "As per the document submitted, the patient was admitted on 11.01.2016 for the diagnosis of Haemorrhoids, LRTI and anaemia. The patient was a known case of Haemorrhoids before the first inception of the policy (27.11.2010). There was a history of Haemorrhoids for the last 10 years. It was further stated by Insurance Company that the Insured had not disclosed the ailment while purchasing the policy, thereby the complainant had concealed

the material facts. Hence the claim was denied under section 10Rii of policy terms and conditions.

3. I heard both the sides, the complainant (represented by her husband) as well as the Insurance Company. During the course of hearing the complainant explained that it was a single episode 10 years back wherein no active line of treatment of disease was taken by patient. I find that the Insurance Company failed to prove that after the episode of hospitalization for the treatment of Haemorrhoids 10 year's back the complainant was under regular treatment before the inception of the policy which can be established as pre-existing disease. In view of this, I hereby direct the Insurance Company to settle the claim of the complainant. **Accordingly an award is passed with the direction to the Insurance Company to settle the claim and pay the admissible amount as per policy terms and conditions to the complainant.**

In the matter of Mr. Pankaj Arora
Vs
United India Insurance Company Ltd.

DATE: 15.03.2016

1. The complainant alleged that his father was insured with United India Insurance Company since 2002 and the current policy number in which a claim was registered with the Company for treatment of Multiple Myeloma (Recurrence) post induction in Remission for peripheral antilogous STEM CELL TRANSPLANT at Sir Ganga Ram Hospital during 22.09.15 to 09.10.15. The complainant further stated that the TPA Vipul had informed him that if the treatment was decided to be done by any other method except using stem cells it would be payable. The complainant had been under the advices of treating doctor and taken treatment accordingly. The Insurance Company had settled partial claim for Rs. 17,438/- instead of actual claim of Rs. 6,82,750/-

2. The Insurance Company had rejected the claim vide self contained note dated 07.03.2016 wherein they had contended that the policy conditions were revised w.e.f. 01.08.2014 and the revised product was filed with IRDA for their further use. The Insurance Company further stated that an information sheet was sent alongwith the policy copy mentioning the revised terms and conditions so it was in the notice of the insured. It was also stated that in case the complainant was not interested in the product/policy, a free look period

for 15 days as per policy terms and conditions was available to him for cancellation or otherwise.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing, the complainant had pleaded that for last 13 years his insurance was being continuously renewed with the same insurer. The claims for blood cancer (bone marrow transplant) was lodged with the TPA Vipul Medcorp for pre-authorisation, which was approved for Rs. 1, 00,000/- and subsequently for another Rs. 40,000/- by the TPA. Finally only an amount of Rs. 17,438/- was approved by the TPA towards the cost of chemotherapy done by hospital excluding cost of treatment for stem cell implant.

The Insurance Company had submitted that there was exclusion under the policy for stem cell implants vide exclusion policy clause no. 4.17 and the customer was informed through the customer information sheet attached with the policy in which it was specifically mentioned about the exclusion. The Insurance Company further stated that there was a free look period available in the policy which provides the option cancel the policy to the insured which can be exercised within 15 days of the inception of the policy, if the terms and conditions are not acceptable.

In the given circumstances, I hereby direct the Insurance Company to settle the claim for other expenses including hospitalization except the pure cost of stem cell implant, which was agreeable to both the parties. **Accordingly an award is passed with the direction to the Insurance Company to settle the claim and pay the admissible amount as per policy terms and conditions to the complainant.**

In the matter of Mr. Naresh Nijhawan
Vs
Oriental Insurance Company Ltd.

DATE: 22.03.2016

1. The complainant alleged that his wife was admitted in St. Stephen's Hospital and diagnosed as a case of Hypersomnolence and high levels of Ammonia. He had submitted all the necessary papers of the claim to the Medi Assist India (TPA) Ltd. in the month of November, 2015 but the Insurance Company had rejected the claim on the ground that admission was only for Investigation and Evaluation purpose.

2. The Insurance Company had rejected the claim on the ground that the admission was only for Investigation and Evaluation purpose. The patient could have been treated on OPD basis.

3. I heard both sides the complainant as well as the Insurance Company. During the course of hearing the complainant alleged that his wife Mrs. Lovely Nijhawan was admitted twice in St. Stephen's Hospital, Delhi from 01.09.2015 to 04.09.2015 and 11.09.2015 to 14.09.2015 for the treatment of Hypersomnolence and high level of ammonia. He had submitted all the necessary papers of the claim to the TPA/Insurance Company but the claims were denied by the Insurance Company on the ground that admission was only for Investigation and Evaluation purpose.

The Insurance Company stated that the claim was rejected on the ground that patient was admitted for Investigation and Evaluation purpose and there was no active line of treatment during hospitalization.

On perusal of discharge summaries dated 04.09.2015 and 14.09.2015 I find that there was no active line of treatment given to the patient. The admission was only for investigation and evaluation purpose. Even the follow up advice was for further evaluation as per the discharge summary. Hence, I uphold the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. Subhash Gupta
Vs
Oriental Insurance Company Ltd.

DATE: 28.03.2016

1. The complainant alleged that he was admitted in Jeevan Nursing Home, Delhi on 15.04.15 and then he was referred to Max Hospital, Saket, Delhi where he was hospitalized from 15.04.15 to 17.04.15. The cashless approval was not given by the TPA but asked to submit the claim for reimbursement. He had submitted all the necessary papers of the claim for reimbursement of Rs. 76,966/- but the Company had approved the amount of Rs. 44,652/- only. The reasons for deduction given by the Insurance Company was that non-payable Items were not allowed and the deduction of 25% of the claim amount i.e. Rs. 14,550/- was because of PED (DM & HTN), since a gap of 15 days during renewal of the policy due to "cheque dishonoured" was not condoned.

2. The Park Mediclaim TPA (P) Ltd. vide its email dated 15.02.2016 had informed to the complainant that the subject claim was approved for Rs. 44,652/- as per terms and conditions of the policy. Out of total claim of Rs. 76,966/- the amount of Rs. 33314/- was disallowed on non-payable items and Rs. 14550/- (25%) was deducted on account of pre-existing disease DM and HTN since the patient was suffering from these disease DM and HTN for the last 02 years. There was a gap of 15 days in renewal of the policy due to cheque dishonoured.

3. I heard both the sides, the complainant (represented by his son) as well as the Insurance Company. The Insurance Company reiterated that the subject claim was approved for Rs. 44,652/- as per terms and conditions of the policy. Out of total claim of Rs. 76,966/- the amount of Rs. 33314/- was disallowed on non-payable items and Rs. 14550/- (25%) was deducted on account of pre-existing disease DM and HTN since the patient was suffering from these disease DM and HTN for the last 02 years. There was a gap of 15 days in renewal of the policy due to "cheque dishonoured."

On perusal of the claim papers placed on record, I find that the complainant Mr. Subhash Gupta was admitted in Jeevan Nursing Home, Delhi on 15.04.2015 and thereafter he was referred to Max Hospital, Saket, Delhi where he was hospitalized from 15.04.2015 to 17.04.2015. The Insurance Company had deducted Rs.14,550/- (25% of the claim amount) on account of pre-existing disease DM and HTN since the patient was suffering from these diseases DM and HTN for the last 2 years. There was a gap of 15 days in renewal of the policy due to cheque dishonoured. As per the provision of Health Regulation-2013 there was a grace period of 30 days to renew or continue a policy in force without loss of continuity benefits. Hence, the Insurance Company is hereby

directed to condone the delay of 15 days in renewing the policy (P.No.272400/48/2014/815 from 23.04.2013 to 22.04.2014) and pay the amount of Rs.14, 550/-(25%) which was deducted on account of pre-existing disease DM and HTN. **Accordingly an award is passed with the direction to the Insurance Company to settle the claim and pay the admissible amount as per policy terms and conditions to the complainant.**

In the matter of Ms. Sunita Aggarwal
Vs
United India Insurance Company Ltd.

DATE: 21.03.2016

1. The complainant alleged that she was admitted in Medanta Hospital from 15.12.15 to 16.12.15 and diagnosed as a case of Right adrenal lesion with? Fracture 11th rib, post left radical nephrectomy, and hypertension. But the Medsave Health Care (TPA) Ltd. had refused cashless facility on the plea that admission for test was not covered.

2. The Insurance Company had submitted self contained note dated 17.03.2016 that according to the TPA the patient was admitted in Medanta Hospital from 15.12.15 to 16.12.15 for "tests" only. The cashless facility was denied by the TPA on the plea that admission for test was not covered. Therefore the claim was rejected as per the policy terms and conditions under exclusion 4.11 which states "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. But the insured was advised to submit the papers for reimbursement which were not deposited yet by the complainant.

3. I heard both the sides, the complainant (represented by her husband) as well as the Insurance company. During the course of hearing the Insurance Company had apprised that cashless facility was denied and the Insured had not submitted the claim papers to the TPA for reimbursement. The complainant is directed to submit the claim

papers to the TPA/Insurer and Insurance Company is hereby directed to settle the claim on receipt of claim papers. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. Chunni Lal
Vs
Oriental Insurance Company Ltd.

DATE: 22.03.2016

1. The complainant alleged that he had taken a PNB-Oriental Royal Mediclaim policy from Oriental Insurance Company Ltd. A claim was reported under the said policy for the treatment of CAD+ ACS coronary angiography was done on 22.08.2015 at Maharaja Agrasen Hospital, Delhi. He sought the relief of Rs. 1, 54,630/- from this forum.

2. The Insurance Company repudiated the claim under policy exclusion no. 4.1 which was related to pre-existing disease. The Insurance Company had stated that the PTCA+ICS+LAD were done for treatment of single vessel disease. The policy inception date is 04.03.2015, hence policy is in the Ist year, which attracts the denial of claim under the policy exclusion clause no. 4.1 which states "The Company shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by insured person in connection with or in respect of pre-existing health condition or disease or ailment/injury (treated/untreated declared/undeclared in the proposal form), in case of any of the insured person of the family, when the cover incepts for the first time are excluded for such insured person upto 03 years of this policy being in force continuously.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the Insurance Company had reiterated that the policy inception date was 04.03.2015 and the complainant had undergone treatment of CAD+ACS coronary angiography on 22.08.2015 which revealed single vessel disease for which PTCA+ICS+LAD was done. The claim fell under clause 4.1 which states "The Company shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by insured person in connection with or in respect of pre-existing

health condition or disease or ailment/injury (treated/untreated declared/undeclared in the proposal form), in case of any of the insured person of the family, when the cover incepts for the first time are excluded for such insured person upto 03 years of this policy being in force continuously. In this case claim was raised in 1st year of the policy. In view of the given circumstances, I find no reason to interfere with the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Mr. Apjit Singh Ahluwalia
Vs
Oriental Insurance Company Ltd.

DATE:18.03.2016

1. The complainant alleged that he had taken a policy Individual Mediclaim from Oriental Insurance Company Ltd. w.e.f 27.11.2014 to 26.11.2015 which was a continuous renewal since 1995 onward from Oriental Insurance Company only. He was hospitalized during 05.08.2015 to 06.08.2015 at Indraprastha Apollo Hospital for the treatment of FUC of TCC bladder (gr-2) BPH having part of history of TURBT in 2007. The Insurance Company had rejected the claim this time for the treatment which they had been paying for the last 07 years including cashless approval last year. Further it was stated by complainant that he had undergone surgery for Bladder cancer (TCC bladder) on 24.10.2007 followed by the Chemotherapy. He had to undergo a procedure of Cystoscopy from January, 2008 to 2012 twice a year. Since 2013 it was reduced to once a year and all those procedures of cystoscopy were accepted and paid by Insurance Company. Now for same treatment the claim was rejected.

2. The Insurance Company vide had rejected the claim under policy exclusion 4.10 of Section-4 which says that "Expenses incurred at Hospital or Nursing Home primarily for evaluation/diagnostic purposes which is not followed by active treatment for the ailment during the hospitalization period."

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant had alleged that he was hospitalized from 05.08.15 to 06.08.15 at Indraprashtha Apollo Hospital for IAH for the procedure of cystoscopy and during the course of admission he underwent for cystoscopy + bladder biopsy done under LA on 05.08.15.

The Insurance Company had stated that the claim was rejected under policy condition no. 4.10 which states "expenses incurred at hospital or nursing home primarily for evaluation/diagnostic purposes which is not followed by active treatment for the ailment during the hospitalised period." The Insured was admitted in the hospital for preventive health check up for cystoscopy under local anaesthesia as a preventive measure only to overrule re-occurrence of same disease. The treatment was diagnostic and the hospitalization was also less than 24 hours.

On perusal of the claim papers placed on record, I find that the patient Mr. Apjit Singh was admitted in Indraprashtha Apollo Hospital from 05.08.15 to 06.08.15. As per discharge summary the patient was admitted to IAH for the procedure of cystoscopy and a follow up case of TCC bladder since 2007. Last cystoscopy was done in 2013 and during the hospitalization he underwent the procedure of cystoscopy+ bladder biopsy done under LA on 05.08.2015. Hence, there was no active line of treatment and the expenses incurred at Hospital or Nursing Home was primarily for evaluation/diagnostic purpose. I uphold the decision of the Insurance Company and see no reason to interfere with the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

In the matter of Sh. Rajesh Kumar
Vs
Oriental Insurance Company Ltd.

DATE: 28.03.2016

1. The complainant had purchased Happy Family Floater policy from Oriental Insurance Company. The complainant's wife was hospitalized in Max Hospital, Saket, New Delhi and applied for cashless approval. The Health India, TPA, had rejected the claim mentioning that case was related to the treatment of a congenital heart disease. The complainant submitted that the disease did not pertain to the congenital Heart Disease. He sought the relief of Rs. 68,359/- from this forum.

2. The Insurance Company had not submitted any self contained note and not given any response to client, however, TPA had informed the complainant that the disease for which treatment was taken was a congenital Heart Disease; hence the claim was not tenable.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the Insurance Company had reiterated their decision of repudiation of claim due to the policy exclusion of congenital disease. The complainant had insisted that the clarifications given by the treating doctor of Max Hospital through a certificate which

stated that "The current admission of the patient was for the case of chest discomfort and not related with congenital disease". On perusal of the claim papers placed on record, I find that Mrs. Payal was admitted in Max Health Care Hospital from 20.07.15 to 22.07.15 and diagnosed as a case of congenital heart disease, TOF with ASD aortic arch, post total correction (1982), acute chest pain with pre-syncope for evaluation, Marked sinus bradycardia, CAD-Acute coronary syndrome, LVEF- 40% and Left carpal tunnel syndrome. The brief clinical history of the patient was complaints of sudden onset left upper chest pain on 20.07.15, neck pain radiating to left hand, associated with numbness and tingling in left hand, vertigo, heaviness of head at the time of admission. The Insurance Company had rejected the claim under policy exclusion 4.8 which states "convalescence, general debility, "run down" condition or rest cure, congenital diseases or anomalies, sterility any 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." As per certificate of treating Dr. Anupam Goel dated 22.07.15 provided by the complainant, the current admission of the patient Mrs. Payal was for complaint of chest discomfort and pre-syncope which definitely need admission in emergency and was unrelated to congenital heart disease. Since the current admission of the patient was for chest discomfort, vertigo and heaviness of head as revealed from the discharge summary and doctor's certificate also states that the current ailment was not related to congenital heart disease, I uphold the exclusion clause 4.8 shall not be applicable in the said claim. Hence, the Insurance Company is liable to settle the claim **Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant and pay the admissible amount to him.**

In the matter of Ms. Bimla Jain

Vs

Oriental Insurance General Insurance Company Ltd.

DATE: 21.03.2016

1. The complainant has undergone for an eye operation for both eyes and have paid hospital bill for Rs. 41,201/- per eye at Ganga Ram Hospital, Rajendra Nagar, New Delhi, whereas the Insurance Company through their TPA have settled the claim for Rs. 48,000/- (Rs. 24,000/- each eye). The complainant sought relief of Rs. 34,402/- from this forum.

2. The Insurance Company submitted that they had settled the claim for MICS-Operation of both the eye Rs. 24,000/- each eye as per the GIPSA package rates approval for PPN Hospital.

3. I heard both the sides, the complainant as well as the Insurance Company. During the curse of hearing the complainant had alleged that she was admitted in Sir Ganga Ram Hospital, Delhi on 16.09.15 and 25.11.15 for cataract surgery of both the eyes. The hospital charged Rs. 82,402/- towards the said surgery but the TPA E-Meditek had sanctioned Rs. 48,000/- only under GIPSA package. She had sought the relief of Rs. 34,402/-. The Insurance Company had stated that the claim was settled as per GIPSA package rates approved for PPN Hospital.

   On perusal of the claim papers placed on record, I find that the patient Mrs. Bimla was admitted in Sir Ganga Ram Hospital on 16.09.15 and 25.11.15 for cataract surgery of both the eyes. During the personal hearing the complainant had apprised that she was not told about the said GIPSA package either by the Insurance Company or by the hospital. The Insurance Company could not prove that they had apprised the complainant about GIPSA package to the complainant. Hence, the Insurance Company is liable to pay the difference of amount to the complainant. **Accordingly an award is passed with the direction to the Insurance Company to settle the claim and pay the difference of amount of claim to the complainant.**

MEDICLAIM

In the matter of

Complainant Shri Manojkumar K Mistry

Vs

Bajaj Allianz General Insurance Co.Ltd

Award Date: *02.11.2016*
Policy No. OG-15-2201-8401-00003467

The Complainant alongwith his family members was insured under the Health Guard Policy issued by the Bajaj Allianz General Insurance Company Ltd. The Complainant was hospitalized from 08.02.2015 to 20.02.2015 at U.N. Mehta Institute of Cardiology and Research Centre for Aortic dissection. The company rejected the claim stating that the Insured had pre-existing Hypertension before 4-5 years prior to the purchase of the policy. History of HTN recorded were different at different places.

The Complainant had taken the policy from 2011 and the proposal form was without any date or period. The proposal form was signed in vernacular language and the proposal form did not have any column for vernacular declaration. The total expenses of the hospitalisation was around Rs.5 lacs and the Sum Insured of policy was for Rs. 1.50 lacs.The policy was in the 4th year. The repudiation was done under C-1 of the policy treating the disease as pre-existing disease. Here the Insured was hospitalized for Aortic dissection. Medically Aortic dissection occurs when a tear in the outer wall of the aorta causes blood to flow between the layers of the wall of the aorta, forcing the layers apart. Aortic dissection is more common with those with a history of high blood pressure a known thoracic aortic aneurysm.

The Insurer had repudiated the claim under clause C-1 which related to pre-existing condition. However, as per the Discharge Summary the diagnosis was Aortic dissection which was not pre-existing. It was noted that the policy was first time taken in the year 2011 and as per the Discharge summary the Complainant was suffering from HTN which is alleged to be not disclosed in the proposal form. However, the proposal form was signed without any date or period. The form was filled up by somebody else on his behalf and the signature was in vernacular language but no vernacular declaration was there in the proposal form.

Complaint admitted for Rs. 60,000/- on ex-gratia basis.

In the matter of

Shri Jitendra B Adhyaru

Vs.

United India Insurance Co. Ltd

Award Date:04.11.2015

Policy No. 181400/48/14/97/00000161

The Complainant alongwith his wife was insured under the Health Insurance Policy (Gold) issued by the United India Insurance Company Ltd. Smt Rekhaben, the wife of the Complainant, was hospitalized at Ami Surgical Hospital from 08.02.2015 to 17.02.2015 for the treatment of Incisional hernioplasty with adhesionolysis. When a claim for Rs. 1,48,186 was lodged, the TPA had settled Rs. 25,000 and deducted Rs.1,23,186 citing condition 4.3 of the policy.The Insurer's representative was asked to explain the basis of the settlement of the claim. The representative had referred to the policy condition under the subject policy where in under clause 1.2.1 the hospitalisation benefit for hernia was restricted to actual expenses incurred on 25% of the Sum Insured whichever was less. He had further explained that since the sum insured in 2012-13 was Rs. 1 lac, 25% of the sum insured was rightly paid .

In view of the foregoing there is no merit in the complaint.

The complaint is dismissed

In the matter of

Shri Chandrakant A Thakkar

Vs.

United India Insurance Co. Ltd.

Award Date:03.11.2015

Policy No. 06770028/14/P/1041/38926

The Complainant was insured under Individual Health Insurance Policy issued by the United India Insurance Company Ltd. The Complainant was hospitalized at Astha Eye Hospital on 27.02.2014 for Right Eye cataract surgery with Phaco-emulsification technique under local anesthesia with IOL implantation (Multifocal). When a claim for Rs. 55,794 was lodged, the TPA had settled Rs. 30,794 and deducted Rs. 25,000 under clause 3.33 .It was seen that the TPA had deducted the above amount based on reasonable and customary charges. However, they had not produced any rate charts of any other hospital in and around the geographical area where the Insured was hospitalized. The Insurer had earlier settled the claim on left eye treatment with multifocal lens. The operating surgeon had advised and felt the necessity to use multifocal lens in the treatment of the right eye. However, there is no bar to use of multifocal lens as per the policy terms. Moreover, the reasonable and necessary were not explained. The Representative when asked to reconsider the claim , refused to do so

In view of the foregoing the complaint is admitted for Rs. 25,000

In the matter of
Smt Indiraben A Desai
V/s
United India Insurance Co Ltd

Award Date: 04.11.2015

Policy No. 181301/48/14/32/00000374

The Complainant had taken a Householders Insurance Policy from United India Insurance Company Ltd for the period from 15.06.2014 to 14.06.2015. The Television set of “Philips” make Model No.32TA2800/98 with 32 inches screen size was damaged due to electrical problem. The same was informed to the Respondent on 08.11.2014 and a survey was carried out on 15.11.2014. Based on the survey report the Respondent settled the claim for Rs.4975. However, the Insured had not agreed to accept the amount and approached the Forum for redressal

From the submissions and the documents it was observed that the Insurer had offered an amount of Rs. 4975/- based on total loss basis. The surveyor M/s Mehul C Patel had also

assessed the loss on repair basis for Rs. 13,573/-. Moreover, as per the survey report the said TV was no more manufactured and under these circumstances it has to be taken as total loss. Condition No. 8 of the policy stated about the Indemnity wherein it was stated that the company in no case shall be bound to expend more in reinstatement than it would have cost to reinstate such property as it was at the time of occurrence of such loss or damage, nor more than the Sum Insured by the Company thereon.

The Insurer while conveying the approval of the claim has not stated any basis of the settlement. The equipment has become obsolete one and the survey report was also not clear. As such keeping in view the various difficulties involved in the assessment of the loss the

Complaint is admitted on Ex-gratia basis for Rs. 8000

In the matter of

Shri Chirag R Panchal

Vs

United India Insurance Company Ltd

Date of Award: 03.11.2015
Policy No. 060300/2814P/108999684

The Complainant along with his family was insured under Individual Health Insurance – Policy-issued by the United India Insurance Company Ltd. Master Vatsal C Panchal, the son of the complainant, was hospitalized at Sparsh Neonatal & Pediatric centre from 19.04.2015 to 21.04.2015 for Pustular Tonsillitis. When a claim was lodged with the Company for Rs. 6746, the TPA had settled the claim for Rs. 4346 and disallowed Rs. 2400 quoting clause 1.2. C of the terms and conditions of the policy . Based on the papers and documents it was noted that no policy condition was quoted in the claim settlement letter.The Complainant was asked to explain the reason for two separate bills with Receipt Nos as 18 and 49 with the same date when he stated that he had made a single payment to the hospital. He replied that he did not check the bills then and he was not aware of the reason for such discrepancy. He was told that if it was a mistake on the part of the hospital he being an Accountant should have taken up the issue with the hospital and not the Insurer.

Since the Respondent had settled the claim, complaint at this Forum stands closed. Hence, the complaint is treated as disposed off.

In the matter of

Shri Ajmer Nandal

Vs

Bajaj Allianz General Insurance Co.Ltd

Date of Award: 16.11.2015
Policy No. OG/15/2201/8402/00000002

The Complainant along with his wife was insured under the Group Mediclaim (Standard) Policy issued to Check Mate Services Pvt Ltd by Bajaj Allianz General Insurance Company Ltd. Smt Anju Nandal wife of the Complainant was hospitalized at Mor Hospital Rohtak, Haryana from 01.12.2014 to 09.12.2014 for disc problem. When a claim for Rs. 12,750/- was lodged with the Company, the TPA rejected the claim stating that no treatment was administered or any such investigative procedure was performed which supported the need for hospitalisation.

During the hearing the complainant was not present and the representative of the Respondent had appeared and submitted in writing that they had consulted their Head Office Team and were ready to settle the claim for Rs.12,750/-.

Since the Respondent had agreed for settlement of Rs. 12,750/- to the Complainant, the case is disposed off.

In the matter of

Shri Harshad K Shah

Vs

The New India Assurance Company Ltd

Date of Award: 18.11.2015
Policy No. 220600/34/13/01/00000206

The Complainant along with his wife was insured under the Mediclaim Policy issued by The New India Assurance Company Ltd. Smt Pratimaben H Shah, wife of the Complainant, was hospitalized at Dr. Bhavin J Patel on 11.06.2014 and 18.06.2014 for Proliferative Diabetic Retinopathy + Virtreous Heamorrhage in both eyes. She had undergone Vitrectomy + Endolaser under Local anesthesia in the Left Eye on 11.06.2014 and in the right eye on 18.06.2014. His claim for Rs. 90,150/- was rejected by the TPA stating that the copies of the policies were not provided to them for the year from 1999 to 2013. It was seen that repudiation was done under clause 5.5 of the policy " Non Disclosure of Material Facts". However, it was noted that the Insured had disclosed the existence of diabetes and had paid additional premium as well since the year 2001 as charged by the Respondent. Hence, the ground of repudiation stands proved wrong. Moreover, as per clause 4.1 the policy stated that "No claim would be payable under this Policy for the treatment of any Pre-existing condition/diseases until 48 months of continuous

coverage of such insured Peron have elapsed from the date of inception of his/her first policy with us as mentioned in the schedule" .Here the policy had run for more than15 years. The rejection of the claims, hence was not in order. The Company had a very casual insensitive approach despite the Insured being a senior citizen.

The complaint was admitted alongwith 9% interest.

In the matter of

Smt Shaila B Desai

Vs

United India Insurance Company Ltd

Date of Award: 18.11.2015

Policy No. 060500/48/13/97/00017712

The Complainant along with her husband was insured under Individual Health Insurance Policy-2010 issued by the United India Insurance Company Ltd from the year 2001. Shri Bharat M Shah husband of the Complainant was hospitalized at HCG Multispecialty hospital on 08.01.2015 where PTCA in LAD was done on 11.01.2015. Since he had an episode of VT (reverted by DC shock), the Insured was shifted to SAL Hospital on 11.01.2015. The Insured expired on 12.01.2015.Against a claim for Rs.3,46,452/-, the TPA had settled Rs. 2,42,588/- and deducted Rs. 1,03,864/-stating policy terms and conditions and PPN (Preferred Provider Network).

It was seen that the deductions for Rs. 94,216/- were under the PPN clause. The arrangement of PPN with the hospitals is between the Respondent and the Hospital.

In view of 70% clause, of the Sum Insured i.e. Rs. 4,25,000 which comes to 2,97,500/- becomes payable. The Respondent had settled only Rs.2,42,588/- Hence the complainant is eligible for payment of Rs.54,912/- which the Representative of the Respondent during the hearing had agreed to pay.

The complaint is admitted fpr Rs. 54,912 alongwith 9% interest and recover 50% of the amount from the TPA.

In the matter of

Case of-Shri Dhananjay Desai

v/s

The New India Assurance Co.Ltd.

Award Date: 06.11.2015.

Policy No. 210600/34/01/00002204

The Complainant along with his family was insured under Individual Mediclaim Policy issued by the New India Assurance Company Ltd. Smt Vaishalee Desai, wife of the complainant was hospitalized at Astha Hospital from 08.09.2014 to17.09.2014 for Post Sleeve Gastrectomy-Gastric Stricture. The claim was rejected under clause 4.4.6 being obesity and its complications. From the submissions of both the parties and the documents submitted it is observed that the Insured was operated for Sleeve Gastrectomy for morbid obesity. The treating doctor, Dr. Bhavin Patel in his certificate dated 01.08.2013 had certified that due to obesity the Insured was having problems like knee joint pain, inability to walk and hypertension. She was operated to improve her health related problems due to obesity."

The Insured had approached the treating doctor on 08.09.2014 where in it was recorded that the Insured was having vomiting since last 2-3 months. Past history of sleeve gastrectomy-before 1 year. History of weight loss and was advised operation laparoscopic seromyotomy. Medically, Laparoscopic gastric seromyotomy is used as an alternative procedure to resolve obstructive symptoms after sleeve gastrectomy. Here the Insured was having problems like vomiting etc which were the result of sleeve gastrectomy and the said operation was done to improve her health related problems due to obesity.

Therefore, as the policy terms and conditions excluded **obesity treatment and its complications, the decision of the Company not to pay the claim is in order.**

However, as no terms and conditions were provided to the Complainant and the Representative of the Insured was not able to produce any proof of dispatch of the terms and conditions, it has been decided by this Forum to pay an Ex-gratia amount of Rs. 45,000/- to meet the end of justice.

In the matter of

Smt Indiraben A Patel

v/s

The Oriental Insurance Co. Ltd.

Award Date.06.11.2015

Policy No: 311500/48/2013/11075/S

The Complainant along with his son was insured with a Policy "Health Insurance Cover-Standard" issued by the Oriental Insurance Company Ltd. The complainant was hospitalized at Shri Sardar Patel Hospital from 16.01.2014 to 22.01.2014 for Acute Cholecystitis and had under gone Cholecystectomy. When a claim was lodged the TPA had asked for requirements which the Insured had complied with. However, the case was closed on 31.03.2014 due to non submission of policy copy for the policy period 2011-12. During the hearing it is observed that the Insured was having policies from 2008. The hospitalisation was in the month of January, 2014. There is on record a sheet stating policy period 09.12.2011 to 08.12.2012 bearing policy no. 124500/48/2012/7624. The Complainant was asked to send the copy of the policy document pertaining to 2011- 2012 for which he had shown a certificate issue by Trisure Health Care Trust, Mumbai. The Respondent had informed to this Forum that the policy no. 124500/48/2012/7624 pertained to policy period 2012-13 and not 2011-12 as noted in the schedule issued by Trisure Healthcare Trust.However the Forum noted following points:

As per the closure letter dated 31st March, 2014 the only reason given for the closure of the claim was not providing the policy copy for the period 2011-12. No reason is given for asking this policy.

The claim had arisen under 2013-14 policy. The deficiency letter dated 29th March, 2014 had only asked for policy copy of 2011-12. There was a 7 days period given in the letter dated 29th March, 2014, yet the claim was closed on 31st March, 2014. Hence it is highly irregular and unfair.There is a document on the file stating as OIC policy no. 124500/48/2012/7624 being for the period 09.12.2011 to 08.12.2012 as renewal of policy no. OIC 24500/48/2011/5512. It was for the Insurer to verify this policy. Head Office of the Insurer vide letter No. CSD/3/167/2015 dated 16.03.2015 had acknowledged the grievance and had advised the concerned office to resolve. However, instead of resolution no reply was given. Even the SCN was not submitted meaning thereby the Insurer had no defence.

The Complaint is admitted for Rs. 90,000

In the matter of

Shri Chandrakant A Thakkar

Vs.

United India Insurance Co. Ltd.

Award Date.03.11.2015

Policy No: 06770028/14/P/1041/38926

The Complainant was insured under Individual Health Insurance Policy issued by the United India Insurance Company Ltd. The Complainant was hospitalized at Astha Eye Hospital on 27.02.2014 for Right Eye cataract surgery with Phaco-emulsification technique under local anesthesia with IOL implantation (Multifocal). When a claim for Rs. 55,794 was lodged, the TPA had settled Rs. 30,794 and deducted Rs. 25,000 under clause 3.33 i.e. Reasonable and customary clause

It was seen that the TPA had deducted the above amount based on reasonable and customary charges. However, they had not produced any rate charts of any other hospital in and around the geographical area where the Insured was hospitalized.

The Respondent had not verified with the service provider regarding reasonable charges and fees being collected by them.

As regards the deduction towards multifocal lens, the letter of settlement by E-Meditex simply stated that it was not payable as per reasonable and customary clause.. The Grievance cell's reply quoted condition 3.3. of the policy but had not confirmed the standard charges for the specific provider and prevailing charges in the geographical area for identical or similar services were verified or quoted in the letter to the Insurer. The Insurer's representative also agreed that there was no specific clause in the policy excluding the multi focal lens.

The Insurer had earlier settled the claim on left eye treatment with multifocal lens. The operating surgeon had advised and felt the necessity to use multifocal lens in the treatment of the right eye. However, there is no bar to use of multifocal lens as per the policy terms. Moreover, the reasonable and necessary were not explained.

The Representative when asked to reconsider the claim , refused to do so.

In view of the foregoing the complaint is admitted for Rs. 25,000/-.

In the matter of

Jitendra B Adhyaru

Vs.

United India Insurance Co. Ltd

Award Date.04.11.2015

Policy No: 181400/48/14/97/00000161

The Complainant alongwith his wife was insured under the Health Insurance Policy (Gold) issued by the United India Insurance Company Ltd. Smt Rekhaben, the wife of the Complainant, was hospitalized at Ami Surgical Hospital from 08.02.2015 to 17.02.2015 for the treatment of Incisional hernioplasty with adhesionolysis. When a claim for Rs. 1,48,186 was lodged, the TPA had settled Rs. 25,000 and deducted Rs.1,23,186 citing condition 4.3 of the policy . The representative had referred to the policy condition under the subject policy where in under clause 1.2.1 the hospitalisation benefit for hernia was restricted to actual expenses incurred on 25% of the Sum Insured whichever was less. He had further explained that since the sum insured in 2012-13 was Rs. 1 lac, 25% of the sum insured was rightly paid .

In view of the foregoing there is no merit in the complaint.

Taking into account the facts & circumstances the complaint is dismissed

In the matter of

In the matter of

Mr. Chetan R Shah

Vs

The National Insurance Company Ltd.

Award Date: 21.12.2015
Policy No : 301800/48/14/85/00000289

It was seen that the deductions were under the PPN clause and reasonable & customary charges. It is to be noted that the arrangement of PPN with the hospitals was between the Respondent and the Hospital. The said hospital did not fall under the PPN clause. Here the clause which would be applied was reasonable and customary charges which the Company had later on applied in reply to the Insured's appeal.
As per IRDA circular the TPA had merely quoted condition 3.24 of the policy but had not confirmed the standard charges for the specific provider and prevailing charges in the geographical area for identical or similar services.

In view of the foregoing the complaint is admitted for Rs. 34,772

In the matter of

Mrs Mridula Bharal

Vs.

Bajaj Allianz General Insurance Company Ltd.

Date of Award: 21.12.2015
Policy No. OG-14-2201-8408-000000204

The Complainant alongwith her husband was insured under the Silver Health (Senior Citizen) policy issued by the Bajaj Allianz General Insurance Company Ltd. The Complainant was hospitalized from 28.06.2014 to 03.07.2014 for severe abdominal pain at Bhailal Amin General Hospital. The final diagnosis was conversion reaction. When a claim for Rs. 32,178/- was filed, the company rejected the claim under clause C24 stating that treatment for any mental illness or psychiatric illness was not payable. Aggrieved by the decision of the TPA, the complainant represented alongwith a certificate from his treating doctor dated 10.11.2014 stating that the complainant was admitted for abdominal pain. During the course of Investigation and management of the abdominal pain a psychiatrist consultation was sought. She was not

admitted primarily for any psychiatric disorder at that time.It was seen that the discharge summary stated Final Diagnosis as Conversion Reaction Abdominal pain with HTN, DM. From the hospital papers it was seen that the Complainant was hospitalized for abdominal pain. She was examined by physician, surgeon, gastroenterologist and psychiatrist. The Respondent's contention that the Insured was treated by a psychiatrist, and as the policy excluded treatment for any mental or psychiatric illness, the claim was not payable.The Insured was treated for abdominal pain and during her treatment a psychiatrist was consulted and treatment for the same was also given. Since the treatment was not for psychiatrist treatment alone the Forum felt it appropriate to consider the claim for 50% of the claim amount.

The complaint was admitted for 50% of the claim amount.

In the matter of
Dr. Pradip J Jhala

Vs.

The New India Assurance Company Ltd.

Date of Award: 11.01.2016

Policy No. 220300/34/14/25/00010071

The Complainant alongwith his family members was insured under the Mediclaim Policy 2012 issued by the New India Assurance Company Ltd. Smt Nitiben Jhala, wife of the Complainant was hospitalized from 13.04.2015 to 14.04.2015 at Arthroplasty Institute Sports Medicine and Arthritis Clinic under the care of Dr. Manoj H Mehta. The Company rejected the claim citing clause 2.15 of the policy (hospital not registered under the clinical Establishment Act or did not have 15 beds. From the hospital records and other documents made available by both the parties, it was seen that the Insured was covered under the Mediclaim policy from year 2000 onwards. Surekha Arthroscopy and Arthoplasty Institute (SAAI) is registered under the Shops and Establishment Act, 1948.The Respondent has failed to prove that the terms and conditions were provided to the Complainant. In the absence of which the Complainant was not able to know the precautions she had to exercise while selecting the hospital.

The Complainant has also alleged that there were claims where the Respondent had made payment for the hospital with less than 15 beds. The Forum, therefore, asked for an affidavit from the Respondent to rule out the allegation made. The Representative of the Respondent submitted an affidavit on 11.01.2016 under which she had not given the specific information sought by the Forum. She had simply mentioned that as per the information and confirmation from their TPA, they were following the hospital criteria w.e.f. 01.01.2015. The Forum had specifically asked the representative to confirm in affidavit whether they had made any payment of claim where the beds in the hospital were less than 15 beds. There was no mention or

confirmation to that effect in the said affidavit which gives an understanding that the Respondent has indeed made payment in similar claims.

The complaint therefore is admitted on 50% of the claim amount on ex-gratia basis.

In the matter of Mr. Paresh Kumar A Dave

Vs.

The New India Assurance Company Ltd.

Date of Award: 22.12.2015

Policy No. 2301013414/2800002086

The Complainant alongwith his wife was insured under the Floater Mediclaim Policy issued by the New India Assurance Company Ltd. Smt Leena Dave, wife of the Complainant, was hospitalized at Dr. Mehta's Maternity Home from 14.02.2015 to 17.02.2015 for Chocolate cyst (Bilateral) adhenomyosis. The TPA had rejected the claim under clause 4.3.1.1.

The Forum had heard the submissions of both the parties and examined the hospital records and other documents made available to the Forum. It was seen that the Insured was covered under the New India Floater Mediclaim policy. The policy was taken by the Complainant from Religare Health Insurance for the first time in the year 2014. At the time of renewal the Complainant filled in fresh proposal form with previous policy details and the Respondent issued a policy for the period 2015-16. The claim had arisen in the 2nd year of the policy. The claim was rejected under clause 4.3.1.1 which states as under:

Hence the rejection by the Respondent was as per the exclusion clause.

However, it was noted that the Respondent had not sent the terms and conditions to the Insured and no repudiation letter was sent to the Complainant.. The Respondent was found to be deficient in rendering services to the Insured. The complainant was entitled for relief, thus,

The complaint stands admitted for 25% of the claim amount on ex-gratia basis.

In the matter of

Mr. Keyur J Patel

Vs.

The Oriental Insurance Company Ltd.

Date of Award: 18.01.2016

Policy No. 172300/48/2015/3394

The Complainant was insured under the Individual Mediclaim Policy issued by the Oriental Insurance Company Ltd. He had approached the Forum against non-settlement of his claim on his hospitalisation from 01.05.2015 to 06.05.2015 at Jaynil Hospital for Left lower ureteric calculus + coliky pain. The TPA had rejected the claim stating clause 2.1 and 4.3 of the mediclaim policy. The complainant alleged that the Insurance Company and the TPA had harassed him a lot. He stated that he was having the policy since the year 2005-06. Based on the oral submissions of the parties read along with documents on record it was seen that the Insured was covered with the Respondent from the year 2005. Jaynil hospital was registered under Bombay Shop and Establishment Act, 1948**.** A certificate issued by Gujarat Pollution Control Board, Gandhinagar submitted by the Complainant to this Forum stated that the hospital was having 15 beds.

The hospital was not registered under the Clinical Establishment (Registration and Regulation) Act, 2010 or under the enactments specified under the schedule of Section 56(1) of the said act and the number of beds at the time of admission to the hospital was 14.

The criteria of bed was not informed to the Complainant. The policy schedule was dispatched and no terms and conditions were given to the Complainant. The Policy Schedule was examined by the Forum. There was no indication of the terms and conditions being attached to the schedule Since the Respondent had not sent the terms and conditions of the policy to the Complainant he was at a loss to know the conditions on the minimum 15 beds clause. Moreover as the advertisement was given in the newspaper in the month of June, 2015 and the hospitalisation was in the month of May, there was no possibility of knowing the minimum bed criteria to the Insured. The Respondent instead of owning the responsibility had shirked it.

In view of the foregoing and the casual approach of the TPA and the Respondent the complainant was entitled for relief.

The complaint is admitted for full claim

In the matter of

Mr. Kushal S Rathod

Vs

The New India Assurance Co. Ltd

Date of Award: 01.02.2016

Policy No: 21020534140100000754

The Complainant alongwith his wife was insured under the Mediclaim Policy 2007 issued by the New India Assurance Company Ltd. The Complainant was hospitalized from 05.03.3015 to 07.03.2015 at Shree Bharti Vallabh Hospital for Acute Viral Fever with Thrombocytopenia, Dengue. The Company rejected the claim for Rs. 14710/- citing clause 3.2 of the policy. The complainant appeared and stated that he was not aware that Shree Bharti Vallabh Hospital was under Declined List of the Hospitals He said the intimation regarding his hospitalisation was given well in advance to the Company and to the TPA. However, no one from the Company informed him at that time that the said hospital was under declined list of hospitals. He pleaded for settlement of his claim. The Complainant is having the policy from 2002No terms and conditions or the list of de-listed hospitals were given alongwith the Policy schedule by the Respondent.

The Insured during the hearing had produced particulars of claim settled by the TPA MedSave India in the month of October, 2015 about the same hospital. To this, the representative of the Respondent stated that may be the TPA was not aware of the circular. She was informed that when the Company/TPA was not aware of the circular, how come you could expect that the Insured was aware of the declined list of hospital.

The claim was filed on 17.03.2015 by the Complainant. The Company repudiated the claim on 08.05.2015. To repudiate the claim by stating that the hospital was under de-listed hospital list should not have taken such a long period of nearly 2 months. Just to inform the Complainant that their claim was repudiated for the reason that they had taken treatment from a delisted hospital, the Respondent had taken an unreasonable long time.

Claim is admitted .

In the matter of
Mrs. Rasilaben C Kosambi
Vs
The National Insurance Company Ltd.

Date of Award: 01.02.2016

Policy No. 301200/48/14/85/00002413

The Complainant was insured under the Hospitalisation Benefit Policy issued by the National Insurance Company Ltd. The Complainant was admitted to Pulse ICCU and Hospital from 11.08.2014 to 16.08.2014 for alleged history of medicine consumption (overdose) and acute gasto-enteritis. The Company rejected the claim under clause 4.10 and 4.11 of the mediclaim policy. (wrongly typed as 4.21 in the repudiation letter). The Complainant's request to the Company for settlement of her claim was not acceded to. She had requested the Forum to consider her claim. The clause No. 4.10 of the mediclaim policy stated: The Company shall not be liable to make any payment under this Policy in respect of any expenses incurred in connection with or in respect of "Treatment for all psychiatric and psychosomatic disorders/diseases, intentional self –inflicted injury, attempted suicide"."Treatment arising out of illness/disease/injury/due to misuse or abuse of drugs/alcohol or use of intoxicating substances".

It is stated in the history given in the Discharge card that 56 years old female patient presented here with a history of consumption of 15-16 strips of Tab. Texidep(0.25) Tab Alprax x 10 Tab App.

The Complainant during the hearing also admitted that she had taken the overdose of the medicine due to depression.

` Hence, as per the terms and conditions of the policy, the decision of the Respondent to repudiate the claim was in order. The complaint fails to succeed.

In the matter of

Mr. Jaydipsingh P Chauhan

Vs

United India Insurance Co. Ltd

Date of Award: 01.02.2016

Policy No. 1804002815P101052197

The Complainant alongwith his family members was insured under the Individual Health Policy issued by the United India Insurance Company Ltd. The Complainant was hospitalized from 28.06.2015 to 01.07.2015 for Appendectomy. Against the claim for Rs. 87,296/-,the company had settled Rs. 71,396/- citing reasonable clause. Aggrieved by the decision of the TPA, the complainant represented and distressed by their decision he had approached the Forum for redressal of his grievance.

It was seen that the deductions were under reasonable & customary charges and based on the Surgeon's Association, Baroda.

It is to be noted that the arrangement of this is between the between the Respondent and the TPA. The Terms and conditions provided to the Complainant did not state that as per the Surgeon's Association the claim would be payable. The Insured had acted against the law.

The Company had quoted condition 3.34 (instead of 3.33) of the policy but had not confirmed the standard charges for the specific provider and prevailing charges in the geographical area for identical or similar services.

In view of the foregoing the complaint is admitted for an amount of Rs. 14000/-

In the matter of

Mr. Balvant Singh S Thakor

Vs

The Oriental Insurance Co. Ltd

Date of Award: 01.02.2016

Policy No. 141700/48/2015/14396

The Complainant alongwith his family members was insured under the Happy Family Floater Policy issued by the Oriental Insurance Company Ltd. Ms. Mayaben B Thakor, daughter of the Complainant, was hospitalized at Apollo Hospitals International Ltd, from 12.04.2015 to 15.04.2015 for acute abdomen pain and further management. The claim for Rs. 54,000 was rejected by the Company citing clause 4.3 (xix) of the policy stating that USG report showed mild hepatomegly and mild to moderate ascites sludge gall blader, right kidney showed mild hydroureteronephrosis to do distal obstruction. The clause 4.3 xix excluded calculus disease if contracted or manifested during the currency of the policy. The policy was in the 2nd year. USG report showed mild hepatomegly and mild to moderate ascites sludge gall bladder, right kidney showed mild, hydroureteronephrosis to do distal obstruction.

Hence, as per the terms and conditions of the policy, the decision of the Respondent to repudiate the claim was in order.

The complaint fails to succeed.

In the matter of

Mr. Pradip R Shah

Vs

The New India Assurance Co. Ltd

Date of Award:04.02.2016

Policy No. 22030034142500003190

The Complainant alongwith his family members was insured under New Mediclaim Policy 2012 issued by the New India Assurance Company Ltd. It is reported that the Insured was covered under the policy from 1998. Shri Ratilalbhai Shah, father of the Complainant was admitted to Shreeji Hospital from 13.03.2015 to 26.03.2015 for CV stroke (Hammorhagic) + Aspirated Pneumonia . The Company rejected the claim under clause 5.8 of the mediclaim policy citing non disclosure and concealment of facts (Hypertension + Diabetes). Aggrieved by the decision, the complainant had approached the Forum for redressal of his grievance.

The Insured was hospitalized for CV stroke (Hammorhagic) + Aspirated pneumonia. The hospital records showed that the Insured was a known case of DM and HTN since last 30 years. To which the Complainant had also not disputed. It is to be noted that Insurance contracts are contracts of 'Uberrima Fides' i.e. Utmost good faith and every fact of material must be disclosed, otherwise, there is a good ground for rescission of the Contract. The duty to disclose material facts has been violated in this case by the Insured while proposing for insurance.

The available evidences with the Respondent categorically prove that the Proposer at the time of making the statement had suppressed facts about his health, which were material to disclose. Hence the Respondent was within its rights to repudiate the Insurance Claims.

The complaint fails to succeed.

In the matter of

Mr. Haresh S Hukumtani

Vs

United India Insurance Co. Ltd

Date of Award:02.02.2016

Policy No. 060400/28/14/P/1026/45708

The Complainant was insured under the Individual Health Policy issued by United India Insurance Company Ltd. Shri Haresh S Hukumtani was admitted to Raghudeep Eye Hospital on 26.09.2014 and was administered Lucentis Intravitreal Injection in the right eye. The injection was administered due to Macular Edema. The Company rejected the claim under clause 2.3.1 of the mediclaim policy.It was observed that the Insured was administered Lucentis injection in the right eye and he was diagnosed to have macular edema in the right eye.The clause 2.3.1. quoted by the Company was wrong.The internal circular was issued in the year 2009 and the policy was issued on 22.07.2014. The policy did not specifically exclude reimbursement on the treatment for ARMD with injection Avastin/Lucentis/Macugen.

In view of this the complaint is admitted to the extent of his claim amount.

In the matter of

Mr. Mahesh G Parmar

Vs

TATA AIG General Insurance Co. Ltd

Date of Award:02.02.2016

Policy No. 2005537495

The Complainant alongwith his family members was insured under the Individual Mediclaim Policy issued by the TATA AIG General Insurance Company Ltd. The Complainant was hospitalized at Apollo Hospitals International Ltd, from 09.08.2015 to 17.08.2015 for left Renal colic. The claim for Rs. 38,872/- was rejected by the Company citing section 3 (c)(i) of the policy the disease was excluded from coverage for the first inception of the policy. It was seen that the claim was reported in the 1st year of the policy.Two claims for Jaundice and CLW nasal bridge were paid by the Company. Section 3 (c)(i) excluded payment towards calculus disease of gall bladder and urogenital system.The consultation sheet dated 08.08.2015 of Karnavati Super Specialty Hospital stated diagnosed upper uretic calci with renal colic. Since the policy is in the first year, the decision of the Respondent to repudiate the claim was in order.

The complaint fails to succeed.

In the matter of

Mrs Chhayaben J Kulkarni

Vs

The New India Assurance Co. Ltd

Date of Award: 02.02.2016

Policy No. 220300/34/14/01/00003747

The Complainant alongwith her family members was insured under the Mediclaim Policy 2007 issued by the New India Assurance Company Ltd. The Complainant was hospitalized from 11.11.2014 to 12.11.2014 at Desai Surgical and Eye Hospital Pvt. Ltd for right parital region head injury. The Company rejected the claim citing clause 4.4.11 of the policy.The Complainant is having the policy from 2007

1. The Discharge cards states : A k/c/o RTA at 5.45 p.m. on 11.11.2014 near her house. Head injury on right parital region. Patient oriented /conscious/follow verbal command.
2. Repudiation letter dated 23.02.2015 by the TPA stated that claim was not payable as per clause 4.4.11.The Respondent during the personal hearing stated that the patient could be managed on OPD basis and hospitalisation was not required. Further, as per indoor case papers admission time of 6.00 p.m. was corrected and in the discharge card discharge time of 8.00 p.m was corrected. Overwriting at both the places is evident and seems to have been done to make up minimum hospitalisation period of 24 hours so as to get claim under the policy.
3. The Insured during the hearing stated that he was not aware of the changes made in the timings. From the records, it was noted that the Insured had a fall and was treated for fracture and was kept in the hospital for observation due to head injury.
4. The Complainant did not reply to the questions on the discrepancy in the time of treatment, admission and discharge.In view of the unexplained discrepancy the Forum was constrained to believe that the case was cooked up for financial gain.

The complaint fails to succeed.

In the matter of

Mr. K. Sethumadhavan

Vs

The Oriental Insurance Co. Ltd

Date of Award: 04.02.2016
Policy No. 141700/48/2015/5864

The Complainant alongwith his wife was insured under Mediclaim Policy with the Oriental Insurance Company Ltd. Smt Indira Sethumadhavan, wife of the Complainant was admitted to Santhigiri Ayurveda Hospital and Research Institute from 03.08.2014 to 21.08.2014 for Galphasandhishoolam. She had undergone treatment for pain in her both knees and ankle joints. The Company rejected the claim under clause no. 2.1 of the mediclaim policy. Aggrieved by the decision, the Complainant had approached the Forum for redressal of his grievance.

The said treatment was not taken in a Government Hospital/Medical College Hospital though some tests were done from Santhigiri Siddha Medical College. It is registered under Kerala Registration Act.

Hence, as per the terms and conditions of the policy, the decision of the Respondent is in order. The complaint fails to succeed.

AWARD

Taking into account the facts & circumstances of the case and the submissions made by both the parties, no intervention at the hands of the Ombudsman is warranted & justified. Hence, the complaint is treated as disposed of.

In the matter of

Shri Mayank N Shah

Vs.

India First Insurance Co. Ltd.

Date of Award: 03.02.2016

Policy No. A 0148/10205364

The Complainant alongwith his family was insured under India First Money Back Health Insurance Plan issued by India First Insurance Company Ltd. Smt Sharmila M Shah, wife of the Complainant was hospitalized at Shubhechha Multispecialty Hospital and as approval for cashless benefit was not received even after waiting for long hours, she was shifted to Baroda Laparoscopy Hospital from 04.03.2015 to 06.03.2015 for Umbilical Hernia. Claims for Rs.1,11,380 was lodged. The Company paid Rs. 67,274/- and on representation, the Company again allowed Rs.16,818 i.e. (Rs. 84092) . He represented to the Company for non settlement of Rs. 27,291.From the submissions made by both the parties and the documents submitted on record, it was observed that as against the deduction of Rs. 27,291/-, a sum of Rs. 2,371 was payable in terms of the policy, and the remaining deductions made were as per the policy terms and conditions. He was told that the calculations were as per the policy conditions. However, he declared that he disagreed with the view and stated that he would drag the Company to Higher Courts. He was explained with his rights.

In view of the recalculation, the Complainant was entitled for Rs. 2371/-. The Complaint was admitted.

In the matter of

Shri Jugatran V Joshi

Vs. The New India Assurance Company Ltd

Date of Award:

Policy No. 22030034140100005211

The Complainant alongwith his wife was covered under Mediclaim Policy 2007 issued by the New India Assurance Company Ltd for a Sum Insured of Rs.3,00,000. Shri Jugatram V Joshi was hospitalized at Eye Hospital & Retinal Laser Centre from 25.05.2015 to 26.05.2015 for the treatment of . Glaucoma + Retinal breaks RE + Trab + Retinal laser. Against the claim of Rs. 29400, the Respondent had settled the claim for Rs.23,900/-, and the balance amount for Rs.5500/- was deducted citing clauses 3.35 of the policy.

The deduction for Rs. 1500/- by the Respondent for the dressing charges for post hospitalisation expenses, as the same was included in the final hospital bill, was in order.

The deduction of Rs.4000/- by the Respondent towards procedural charges citing customary and reasonable clause without providing the standard fees charged for the specific provider and not valid as the same was not a part of the policy terms and conditions.

In absence of any rate charts or specifically pointing out the grounds for deductions towards the above mentioned charges, the deductions made by the Respondent for Rs.4000/- was not in order.

In view of the above the complaint is partially admitted to Rs. 4000/-.

In the matter of

Mrs Lataben D Pandya

Vs

National Insurance Company Ltd.

Date of Award: 10.03.2016

Policy No. 302101/48/14/8500010198

The Complainant was insured under the National Mediclaim Policy issued by the National Insurance Company Ltd. The Complainant, was hospitalized at Live Well pain clinic from 06.08.2015 to 07.08.2015 for under C arm in Prone position. The TPA had rejected stating that hospitalisation was not required. They cited clause 4.18 and 4.19 of the mediclaim policy. Here in this case the age of the patient was 73 years and the hospitalisation was done under the advice of the doctor. Hence invoking the clause is not tenable .However, as the age of the Insured was declared lower than the age of the Insured which was evident from the policies submitted to the Forum.

The claim is considered on 50% basis on non-standard basis.

In the matter of

Shri Vasishtha P Patel

Vs.

United India Insurance Company Ltd

Date of Award:26.02.2016

Policy No. 0606002814p109360163

The Complainant alongwith his family members was covered under Individual Health Insurance Policy issued by United India Insurance Company Ltd. Smt Itishree, wife of the Complainant was hospitalized at HCG Multispeciality hospital from 30.06.2015 to 01.07.2015 for right hemithyroidectomy. Against the claim of Rs. 126883/-, the Respondent had settled the claim for Rs. 94184/-, and the balance amount for Rs.32699- was deducted citing clauses 3.33, 4.16 and 4.21. It was seen that the medicines purchased for Rs. 438 was supported by prescription and the deductions of Rs. 550 was not in order.

1. The contention of the Respondent was that the deductions of operation charges was deducted as per the schedule of charges quoted by the HCG hospital (valid upto 31.03.2016). It was seen that the rate quoted by the hospital for Surgeon charges for a special room was Rs. 41,250 against the amount of Rs. 54,000 charged by the hospital. The deduction of Rs. 12,750/- done by the TPA as per the schedule of charges was in order. The Complainant was asked to approach the Hospital authorities and seek refund of the extra amount charged by them. Hence, the deductions towards surgeon/operation charges needs no interference.

In view of the foregoing, the complainant is entitled for relief for Rs. 988/- .

In the matter

Of

Smt Devyaniben B Ankleshwaria

Vs.

National Insurance Co. Ltd.

Date of Award: 14.03.2016

Policy No. 311700/48/14/85/00010802

The Complainant alongwith her husband was covered under BOI National Swasthya Bima Policy issued by the National Insurance Company Ltd for a Sum Insured of Rs.4,00,000. Shri Bhupinkumar V Ankleshwaria, husband of the Complainant was hospitalized at Dipti Eye Hospital on 25.08.2015 for left eye cataract surgery with PCIOL (Phaco) under Local anesthesia. Against the claim of Rs. 34155/-, the Respondent had settled Rs.24,000/-, and Rs.10155/- was deducted citing Reasonable and Customary clause No.3.30 of the policy. It was noted that deduction for Rs. 10,155 by the Respondent was done under clause 3.30 reasonable and customary charges.

The Respondent though had deducted the claim citing Reasonable and customary clause, they have failed to establish and justify their deductions.

In view of the foregoing, the Complainant was entitled for relief. The complaint is admitted for Rs.10,155/-

In the matter of

Mr. Kamlesh P Desai

Vs

The New India Assurance Co. Ltd

Date of Award: 18.03.2016

Policy Nos. 221502234140100000835 and 2215234150100000739

The Complainant alongwith his wife was insured under Mediclaim Policy -2007 issued by the New India Assurance Company Ltd. The Complainant was hospitalized at Raghudeep Eye Hospital on 14.12.2015 and 25.08.2015 and had undergone cataract and Aniridia in left and right eye respectively. Against the claim of Rs. 1,20,203/- the Respondent had settled the claim for Rs. 48,000/- and the balance amount of Rs.72,203/- was disallowed citing clause 2.7 being the restriction on claim amount for cataract surgery and genetic disorder. Based on the oral submissions of the parties read along with documents on record made available to this Forum, the following points emerge which are pertinent to decide the case.There were two hospitalisations under two policies. The Respondent had paid Rs. 24,000/- towards cataract surgery which was as per the terms and conditions of the policy and the Complainant had agreed upon the same.The Respondent had rejected the claim stating that Aniridia is absence of the iris which is genetic.The certificate provided by the treating doctor dated 08.01.2016 stated that right eye cataract with highly pigmented iris. Therefore, aniridia ring was used to reduce glare. This means that Iris was present but it was highly pigmented. Iris Pigment is a rare condition which generally referred to as a congenital ectropion uveae. The search in Google on Aniridia stated it to be a genetic disorder.The Medical opinion submitted by the Respondent's doctor corroborated with the findings.

In view of the foregoing, the complaint fails to succeed.

In the matter of

Mrs. Monaben S Soni

Vs

The New India Assurance Company Ltd

Date of Award: 15.03.2016

Policy No. 21060634140300000008

The Complainant alongwith her family members was covered under Floater Mediclaim Policy 2007 issued by the New India Assurance Company Ltd for a Sum Insured of Rs.3,00,000. The Complainant was hospitalized from 09.07.2013 to 10.07.2013 at Aarogyam Specialty Hospital for Bilateral RIRS +Laser Litho + DJ stenting + RGP + Cystoscopy +Hysteroscopy + IUCD removal. Against the claim for Rs. 1,80,439, the Respondent had settled the claim for Rs.1,27,474/-, and the balance amount for Rs.52,965/- was deducted citing clauses 3.35 of the policy. Based on the hearing and the records submitted, it was noted that the deduction for Rs. 715/- by the Respondent for non-consumable was in order. However, the deduction of Rs.52,250/- by the Respondent citing customary and reasonable clause without providing the standard fees charged for the specific provider which was consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness/injury involved which was mandatory as per the IRDA guidelines is not tenable.

In absence of any rate charts or specifically pointing out the grounds for deductions towards the above mentioned charges, the deductions made by the Respondent for Rs.52,250/- was not in order.

In view of the above the complaint is admitted for Rs.52,250

In the matter of Mr. Nainesh M Patel
Vs
The Oriental Insurance Company Ltd.

Date of Award:16.03.2016

Policy No. 172300/48/2015/6018

The Complainant alongwith his family members was insured under the Happy Family floater Policy issued by the Oriental Insurance Company Ltd. He had approached the Forum against non-settlement of his claim on his wife's hospitalisation from 23.06.2015 to 26.06.2015 at Jaynil Hospital for Acute Calculus cholecystitis + UTI. The Company had rejected the claim stating clause 2.1 of the mediclaim policy. Based on the oral submissions of the parties read along with documents on record made available to this Forum it is seen that the Respondent repudiated the claim without seeking any clarification on the applicability of the Clinical Establishment Act from the authorities of Baroda Municipal Office.The Respondent could not prove that they had sent the terms & conditions of the policy to the Complainant. The criterion of minimum number of in-patient beds was not informed to the Complainant.

In view of the above the complaint is admitted.

In the matter of

Mrs. Alkaben H Thakkar

Vs

National Insurance Co. Ltd

Award Date: 17.03.2016

Policy No. 300703/48/15/8500003355

The Complainant alongwith her husband was covered under National Mediclaim issued by National Insurance Company Ltd. The Complainant was hospitalized from 22.09.2015 to 24.09.2015 at First Choice Vascular under the care of Dr. Malay D Patel, Vascular Surgeon and Endovascular specialist for Left leg Varicose veins. Against the claim of Rs. 83,574/- the Respondent had settled the claim for Rs. 65,310/- and the balance amount of Rs.18,264/- was disallowed citing the Reasonable and Customary charges clause of the policy. Based on the records it was noted that medicine charges for Rs. 1000/- for non-submission of bill and Rs. 214/- for consumables deducted by the Respondent was in order.The Respondent though had deducted the claim citing Reasonable and Customary Charges Clause, they had failed to establish and justify the deductions made by them.

The complaint is admitted for Rs. 17050/-

Date of Award: 06.11.2015

Complainant:- Smt. Indiraben A Soni V/s Respondent :- The Oriental Ins. Co. Ltd.

Complaint No. AHD-G-050-1516-0230

Repudiation of Mediclaim

The Complainant was diagnosed with Myocardial Infarction & D.M Type-2 & was admitted in Ayushi Family Care Hospital, Talod from 27.02.2014 to 05.03.2014 & Again on 07.03.2014 to 08.03.2014. Then she was again admitted in Apex Heart Institute, Ahmedabad from 08.03.2014 to 10.03.2014. She had incurred an expense of Rs.2,97240/-. The Respondent had repudiated her claim stating that she was having Hypertension since last 5 years. The Policy Clause cited by the Respondent was Exclusion Clause No.4-“The Company shall not be liable to make any payment under this policy in respect of any expenses of whatsoever incurred by any Insured Person in connection with or in respect of: Exclusion Clause No. 4.1-“Pre-existing health condition or disease or ailment/injuries: any ailment/disease/injuries/health condition which are pre-existing (treated/untreated, declared in the proposal form) in case of any of the insured of the family, when the cover incepts of the first time, are excluded for such insured up to 4 years of this policy being inforce continuously. For the purpose of applying this condition, the date of

inception of the policy taken from the Company, for each insured person of the family, shall be considered, provided the renewals have been continuous & without any break in period. This exclusion will also apply to any complications arising from pre-existing ailments/disease/injuries. Such complications shall be considered as a part of the pre-existing health conditions or disease."

It was no where mentioned in the medical papers of Ayushi Family Care Hospital, Talod that the Complainant was having Hypertension. In the medical papers of Apex Heart Institute, Ahmedabad it was mentioned that the Complainant was a known case of Hypertension but there was no mention about duration i.e since when. Dr. Tejas Patel had only mentioned in the Mediclaim Medical Report that the Complainant was having Hypertension since last 5 years. The Complainant had submitted Dr. Mahendra Patel, Ayush Family Care Hospital, Talod certificate stating that the Complainant was having Hypertension since last 5 months. It was also noted by the Forum that the Apex Heart Institute at one place had stated Hypertension as 5 years & at another place as 5 months. The Respondent had violated the guidelines laid down in Protection of Policyholders Interest Regulations, 2002 by not sending the terms & conditions of the policy along with the schedule of the policy & contradiction in the past history of the Insured the Forum is inclined to admit the complaint on Ex-gratia basis.

The directed the Respondent to pay Rs.50,000/- to the Complainant.

Date of Award: 06.11.2015

Complainant:- Shri Mehul V Patel V/s Respondent :- The Oriental Ins. Co. Ltd.

Complaint No. AHD-G-050-1516-0238

Repudiation of Mediclaim

The Complainant's father Shri Vishnubhai Patel was diagnosed with Metastatic RCC at right hilar mass with past history of Nephrectomy Adjuvant Chemotherapy. He was admitted in Sterling Hospitals, Ahmedabad on 01.05.2014. He was discharged on 11.05.2014 after treatment. The Complainant had incurred an expense of Rs.3,38,487/-. The Respondent had repudiated the claim citing Exclusion Policy Clause No. 4.1-"Pre-existing disease-current illness is since October 2010 & 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."The policy was in 4th year. The Clause No.4.1- "Pre-existing disease" was wrongly applied by the Respondent. The Insured was covered under the mediclam policy from 19.01.2010. He was diagnosed with Left Kidney Tumour on 13.10.2010. That was well after 9 months of taking the policy. The Respondent failed to prove that the Insured was having illness or was under treatment prior to taking of the policy. Therefore, the applicability of pre-existing disease clause does not arise. The Insured was insured with the Respondent since long. The Insured had shifted from Individual Mediclaim policy to Family Floater from 2011-12. As per Item No. 10

point 2 of IRDAI Circular Ref: IRDA/Health/HLT/Misc/Cir/209/09/2011 dated 09.09.2011 it is stated that "Individual members including the family members covered under any group health insurance policy of a non-life insurance company shall have the right to migrate from such a group policy to an Individual Health Policy or a Family Floater policy with the same Insurer. 1 year thereafter he shall be accorded the right mentioned in 10.1."The Insurer agreed before the Forum to settle a sum of Rs.50,000/-, as per the sum insured available under 2010-11 policy & as claimed by the Complainant.

The directed the Respondent to pay Rs.50,000/- to the Complainant with interest @ 2% over & above bank rate (PLR) prevailing on 01.04.2014, w.e.f from 17.07.2014 till the date of payment.

Date of Award: 05.11.2015

Complainant:- Smt. Induben D Umrigar V/s Respondent :- The Oriental Ins. Co. Ltd.

Complaint No. AHD-G-050-1516-0242

Repudiation of Mediclaim

The Complainant's daughter Anjali was diagnosed with Uterine Fibroids-for open Myomectomy. She was admitted in Ishaan Maternity Hospital, Surat on 05.06.2014. She was discharged on 07.06.2014 after treatment. The Complainant had incurred an expense of Rs.59,994/-. The Respondent had repudiated the claim citing Exclusion Policy Clause No. 2.1-"As per investigation report hospital was having less than 15 beds."

The Complainant, who is just 7th pass, was asked to confirm as to how many rooms/beds were in the hospital. She has stated that it was 15. As per the documents submitted to the TPA the Annexure-'A' issued by the attending Doctor under item 17 says number of beds in the Nursing Home/Hospital as 16. Moreover, he had given a certificate dated 11.07.2014 stating that numbers of beds were 16. In the investigation report dated 05.06.2014, conducted by the Respondent, does not contain specific information on how many beds hospital was having. It was vaguely mentioned as less than 15 beds. <u>This report nowhere says exact number of beds available in the hospital. The TPA/Insurer should have questioned to Doctor/Hospital through a letter to verify the actual number of beds.</u> The Representative of the Insurer agrees that no such steps were taken. However, he has produced another certificate dated 27.10.2015 issued by Dr. Prashant Jani wherein it is stated that this hospital is having 16 beds from 02.09.2015. In view of the forgoing, discrepancies were observed on both the sides. The Forum is inclined to consider the complaint on Ex-gratia basis.

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

Date of Award: 06.11.2015

Complainant:- Shri Nandkumar K Adhvaryu V/s Respondent :- The New India Assurance Co. Ltd.

Complaint No. AHD-G-049-1516-0247

Partial settlement of Mediclaim

The Complainant was diagnosed with Rt. Inguinal Hernia. He had taken treatment in Munshi Surgical Nursing Home, Ahmedabad. He was admitted to the hospital on 14.02.2015 & discharged on 15.02.2015. He had incurred total expense of Rs.57,426/-. His claim was repudiated by the Respondent citing Policy Clause No. 3.1-"Room, boarding & nursing expenses are provided by the hospital not exceeding 1% of the sum insured (without cumulative bonus) per day or actual, whichever is less." The reimbursement on Rt. Inguinal Hernia treatment had a waiting period of 2 years from the date of enhanced sum insured. Therefore, the applicable sum insured taken by the Respondent was Rs.1 lac & proportionate deductions were made.

The Insurer had referred to the proposal form without any date wherein sum insured selected to be 2 lacs & expiring policy stated to be on 21.09.2013. However, the Complainant denied the signature. He was asked to sign 2 places. His signatures were tallied with Form VI & the signature made on D.O item. It is clearly proved that signature were different. The Insurer's representative attention was also drawn policy copy wherein the date of inception, for continue coverage, mentioned as 2 lacs with effect 1999. In view of the above the Forum is inclined to admit the complaint on Ex-gratia basis.

The Forum directed the Respondent to pay Rs.20,000/- to the Complainant, on Ex-gratia basis.

Date of Award: 06.11.2015

Complainant:- Smt Shardaben S Agrawal V/s Respondent :- The National Ins. Co. Ltd.

Complaint No. AHD-G-048-1516-0253

Partial settlement of Mediclaim

The Complainant was diagnosed with Acute coronary syndrome, Anterior wall myocardial infarction, Right bundle branch block, Coronary Artery Disease: Double Vessel Disease, Severe LV dysfunction (EF: 30% on echo). She was admitted in Apex Heart Institute, Ahmedabad on 22.07.2014. She was discharged on 26.07.2014 after treatment. She had incurred an expense of Rs.4,53,635/-. The Respondent had repudiated the claim stating that the Critical Illness Cover fell outside the purview of the coverage & did not merit admission.

The Respondent had submitted the Varistha Mediclaim policy terms & conditions along with SCN wherein under Section-II Critical Illness Cover was defined & Angioplasty &/or any other Intra-arterial procedures are excluded. There was a cap of maximum, 20% of the Sum Insured, for the compensation for Coronary Artery Surgery under the policy. A maximum sum of Rs.40,000/- would have become payable had the claim not attracted the exclusion clause.

The claim is not payable as per Section-II- Critical Illness Cover: Definitions: Coronary Artery Surgery.However, in view of the deficiency in the services on the part of the Insurer like (1) delayed reply dated 22.06.2015 to the Complaint dated 05.03.2015 (2) not furnishing the copy of the proposal form, terms & conditions of the policy (3) violation of the provisions of the Protection of Policyholder's Interest Act, 2002, the Forum is inclined to admit the complaint as Ex-gratia.

The Forum directed the Respondent to pay Rs.20,000/- as Ex-gratia to the Complainant.

Date of Award: 06.11.2015

Complainant:- Shri Harivadan C Desai V/s Respondent :- The New India Assurance Co. Ltd.

Complaint No. AHD-G-049-1516-0255

Repudiation of Mediclaim

The Complainant was diagnosed with PDR with DM with Post Focal PHC. He was treated with PRP+ Intravitreal Anti VGF Injections Accentrix. He was admitted to Govind Clinic & Retinal Laser Centre, Vadodara on 09.01.2015, 19.01.2015 & 04.02.2015. He was discharged on the same day after treatment. He had incurred total expense of Rs.81,480/-. The Respondent had repudiated the claim stating that as per Mediclaim 2012 Policy only some of the eye surgeries listed in Policy Clause No.2.16.1 performed within less than 24 hours hospitalization were payable. Above treatments was not covered under Clause No.2.16.1. Hence, the claims were rejected.

The subject treatment does not fall under the listed eye surgery but it was performed to prevent permanent loss of sight as the Complainant was having complaint of diminishing vision. The Intravitreal Anti VEGF procedure can slow down the growth of abnormal blood vessels, vision loss & even reduce it. The Intravitreal Anti VEGF procedure was done in operation theatre. The Insured was hospitalized at the advice of the treating doctor as the doctor only can decide on the duration of hospitalization depending upon the gravity of the disease, age of the patient, health parameters of the patient etc. The patient has to act according to the advice from the treating doctor. The treatment does not fall within the scope of the policy the Forum was inclined to consider it under Clause No.2.11 on Ex-gratia basis.

The Forum directed the Respondent to pay Rs.20,000/- to the Complainant, as Ex-gratia.

Date of Award: 06.11.2015

Complainant:- Shri Sureshkumar Surana v/s Max Bupa Health Ins. Co. Ltd.

Complaint No. AHD-G-031-1516-0262

Repudiation of Mediclaim

The Complainant was diagnosed with Carpal Tunnel Syndrom & was admitted in Rajat Hospital, Surat on 27.11.2014. He was discharged on 28.11.2014 after treatment. He had incurred an expense of Rs.39,030/-. The Respondent had repudiated the claim stating the probable cause of the illness as Rhematoid Arthritis, as insured was a k/c/o it & the same was not disclosed at the time of taking the cover.

Rheumatoid Arthritis is not the only cause of Carpal Tunnel Syndrom. The Complainant had submitted the certificate of the treating Doctor confirming that Rheumatoid Arthritis was not the cause for Carpal Tunnel Syndrom. The Respondent had not proved the said certificate to be wrong or the disease was due to Rheumatoid Arthritis by obtaining an expert medical opinion from a doctor with same stature. The Respondent had also not submitted any proof to show that the Complainant was taking treatment of Rheumatoid Arthritis.

The Forum directed the Respondent to pay Rs.39,030/- to the Complainant.

Date of Award: 05.11.2015

Complainant:- Shri Bhagirath Buch v/s The New India Assurance Co. Ltd.

Complaint No. AHD-G-049-1516-0265

Partial settlement of Mediclaim

The Complainant's Son Parth was diagnosed with Rt. Ear Unsafe (Canal Down). He was admitted in Nene Clinic, Vadodara on 02.08.2015. He was discharged on 03.08.2014 after treatment. The Complainant had incurred total expense of Rs.53,379/-. The Respondent had partially settled Rs.21,338/- & deducted Rs.32,041/- reasoning that the Insured had opted room rent for higher category than what he was eligible for. Accordingly, all other charges were deducted proportionately. Rs.3,996/- was deducted towards ECG lead.

The Forum had verified the cash memo/receipt dated 03.08.2014 of Nene Clinic wherein it was specifically written as Special AC Room & charge @ Rs.3,000/- for the period from 02.08.2014 to 03.08.2014. Time of admission & discharge were not mentioned. Subsequently the Doctor had clarified the room rent as Rs.1,500/- X 2 days. The date of discharge on the discharge card, appeared to have been written not at the time of discharge. It showed discrepancy. The Complaint failed to succeed.

Date of Award: 05.11.2015

Complainant:- Shri Naranbhai J Patel v/s The New India Assurance Co. Ltd.

Complaint No. AHD-G-049-1516-0285

Repudiation of Mediclaim

The Complainant's spouse Shantaben had met with an accident. She was rushed to Navdeep Dental Clinic, Ahmedabad. She was diagnosed with hairline displaced # alveolar surface of maxilla right. She was operated for Intermaxillary fixation. The Complainant had incurred expense of Rs.34,000/-. The Respondent repudiated the subject claim mentioning Exclusion Clause No.4.4.5-" All types of dental treatments except arising out of an accident." in their repudiation. In their second letter, on representation to R.O the clause mentioned by the Respondent's T.P.A was 3.13-"Hospital should be registered under the clinical establishment having minimum beds." Another Clause cited in the said letter was Clause No.3.14.1- "Hospitalization means admission in a hospital for a minimum period of 24 in patient care consecutive hours except for specified procedures/treatments, where such admission could be period of less than 24 consecutive hours (Dental Surgery following an accident)."

As required by the terms & conditions of the policy to reimburse the dental treatment expenses, there was an accidental dental injury, hospitalization & treatment for less than 24 hours. Except the criteria on hospital. The Company could have gracefully waived the "hospital" clause & settled the claim. The Respondent had wrongly interpreted the clause & repudiated the claim. In view of the forgoing, the complaint is admitted on Ex-gratia basis.

The Forum directed the Respondent to pay Rs.20,000/- to the Complainant on Ex-gratia basis.

Date of Award: 06.11.2015

Complainant:- Shri Nikunj K Anandjiwala v/s The New India Assurance Co. Ltd.

Complaint No. AHD-G-049-1516-0287

Repudiation of Mediclaim

The Complainant's mother Shardaben was facing dimness in vision in left eye since one month. She was diagnosed with OS: Huge SRNV OU: Large Confluent Drusem++. She was admitted in Rising Ratina Clinic, Ahmedabad on 11.04.2013, 09.05.2013 & 09.01.2015. She was discharged on the same day after treatments. Avantis injections were given on 11.04.2013 & 09.05.2013. Intra Vitreal Lucentis surgery was done on 12.01.2015. The Complainant incurred expense of Rs.1,11,847/-. The Respondent repudiated the subject claim mentioning Exclusion Clause No.1 Note-5- "All treatments like Age Related Macular Degeneration (ARMD) &/or Choroidal Neo Vascular Membrance done by administration of Lucentis/ Avantis/ Macugen/ Avastin & other related drugs as intra vitreal injection, rotational field quantum magnetic

resonance, External Counter Pulsation & Hyperberic Oxygen Therapy are excluded under this policy".

Under the subsequent claims under policy No. 21020034130100020914 although the claim was rejected under Note 5 on page No.1 of the policy yet no terms & conditions of the policy were given to the Insured. As the Respondent had violated the guidelines laid down in Protection of Policyholders Interest Regulations, 2002 by not sending the terms & conditions of the policy along with the schedule of the policy the Forum is inclined to admit the complaint on Ex-gratia basis.

The Forum directed the Respondent to pay Rs.40,000/- to the Complainant, on Ex-gratia basis.

Date of Award: 04.11.2015

Complainant:- Shri Amrutlal D Nayi v/s Religare Health Ins. Co. Ltd.

Complaint No. AHD-G-037-1516-0290

Partial settlement of Mediclaim

The Complainant's Son Hardik was admitted in Siddhi Heart & Medical Hospital, Ahmedabad with a complaint of fever & abdominal pain. He was diagnosed with Hepatitis-E. He was admitted in the hospital from 31.03.2015 to 10.04.2015. The Complainant had incurred expense of Rs.45,478/-. The Respondent partially settled Rs.29471/- & deducted Rs.16,007/- mentioning Policy Clause No.1.54-"Reasonable & customary charges means the charges for services or supplies, which are the standard charges for the specific provider & consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of illness/injury involved."

The Respondent had not sought any clarification from the treating doctor especially when they happened to claim that there was no active line of treatment. The decision to decide on the active line of treatment was arbitrary & baseless. The Insured was in the hospital at the advice of the treating doctor it was not his will to stay in the hospital. On 07.04.2015 & 08.04.2015 the Insured had Right Hypochandriac pain. The Respondent should have assessed the same before making deductions. Further the Insured was having Anorexia since admission till discharge. In the progress record the treating doctor had mentioned in treatment column to continue the same treatment till the date of discharge. It was the doctor to decide on the continuity of the hospitalization considering the progress in the health of his patient. The Forum feels that the Respondent had arbitrarily made deductions without having diligent assessment of the mediclaim papers. The amount deducted under Room Charges for Rs.9,200/- & Consulting Fees for Rs.4000/- for balance 4 days becomes payable.

The Forum directed the Respondent to pay Rs.13,200/- to the Complainant.

Date of Award: 17.11.2015

Complainant:- Shri Harshit Vora v/s Apollo Munich Health Ins. Co. Ltd.

Complaint No. AHD-G-003-1516-0293

Repudiation of Mediclaim

The Complainant was admitted in Asian Bariatrics on 20.05.2015 with a complaint of Fever; on & off since 4 days, Headache, Pain in throat & difficulty in swallowing since 4 days. He was discharged from the hospital on 24.05.2015 after the treatment. The Complainant had incurred expense of Rs.43,900/-. The Respondent repudiated the claim mentioning that the medical papers submitted for the assessment of the claim does not justify hospitalization. The treatment could have been managed on OPD basis.

The treating Doctor confirmed in his certificate that the insured was admitted for Thrombocytopenia-deficiency of platelets in the blood. This causes bleeding into the tissues, bruising, and slow blood clotting after any injury. On the date of admission i.e 20.05.2015 the platelet count was 1,05,000. On 21.05.2015 the same was 95,000. It was quite obvious that when there is fall in the counts the Doctor will keep the patient under observation. Further fall in platelet counts could be fatal. The WBC count was 4,990 on 20.05.2015 & on 22.05.2015 the same was 4,050. It was diagnosed as Lymphocytosis along with Thrombocytopenia. The Respondent had not assessed the medical papers diligently.

The Complainant had submitted the progress note containing details of line of treatment. The Respondent had failed to prove medically that the admission under the subject claim was not required. In the consultation letter only the Complainant was advised CBC & admission.

The Forum directed the Respondent to pay Rs.43,140/- to the Complainant.

Date of Award: 17.11.2015

Complainant:- Smt. Jagrutiben M Pate l v/s The Oriental Ins. Co. Ltd.

Complaint No. AHD-G-050-1516-0306

Partial settlement of Mediclaim

The Complainant's father Late Shri Maheshbhai Patel was diagnosed with Cardiogenic Shock+ ARF+ Acute I/W MI+ Severe LV Dysfunction+ CAD (TVD) & was admitted in Life Care Institute of Medical Sciences & Research, Ahmedabad on 06.03.2015. He expired on 08.03.2015 after treatment. She had incurred an expense of Rs.1,49,392/-. The Respondent had deducted Rs.74,392/- under various heads. Rs.11,801/- was deducted as 10% Co-pay as per policy terms & condition. Rs.10,000/- was deducted towards IABP insertion charges not payable. Rs.31,214/-

as applicable Sum Insured was Rs.75,000/-. Rs.19,300/-not payable as considered two times. Rs. 2,077/- deducted as Non-medical items are not payable.

It was specifically mentioned in Happy Family Floater Policy Terms & Conditions under Important-7-Renewal of Policy: c) In case the policy is to be renewed for enhanced sum insured then the restrictions as applicable to a fresh policy (condition 4.1, 4.2 & 4.3 shall apply to additional sum insured) as if a separate policy has been issued for the difference. In case of increase in sum insured, treatment for pre-existing disease (after specified time) & for a disease/ailment/injury for which treatment has been taken in the earlier policy period, the enhanced sum insured will be applicable only after four continuous renewals with the increased sum insured. The sum insured was enhanced from Rs.75,000/- to Rs.2,50,000/- in the policy year 2012-13. As the Insured was having pre-existing disease the enhanced sum insured shall be applicable after 4 years. The Respondent has correctly paid the claim.

The Complaint was dismissed.

Date of Award: 16.11.2015

Complainant:- Shri Rajiv Sharma v/s The Oriental Ins. Co. Ltd.

Complaint No. AHD-G-050-1516-0312

Repudiation of Mediclaim

The Complainant was diagnosed with Right Frontal Cystic Brain Tumor & was admitted in Unique Hospital, Surat on 09.12.2013. He was discharged on 15.12.2013 after treatment. He had incurred an expense of Rs.1,00,707/-. The Respondent had repudiated his claim citing Policy Clause No. 4.1-"Any ailment, injuries/health condition which are pre-existing (treated/untreated declared/not declared in the proposal from) in case any of the person of the family when the cover incepts for the 1st time are excluded for such insured person up to 4 years of this policy being inforce continuously."

It wais quite clear from the records submitted that the Complainant's hospitalization had taken place within the waiting period of 4 years which has been specifically excluded under Clause No. 4.1 of the policy terms & conditions. The Respondent's repudiation of the claim was therefore as per the terms of the policy. In the consultation papers of Unique Hospital, Surat dated 03.12.2013 it was specifically mentioned that the Complainant was operated for Right Frontal Dermoid in 2008, which was also confirmed by the representative of the Complainant during the course of hearing. In the proposal form also the Complainant had not mentioned about his past medical/treatment details. In reply to Question B, on Personal History, the proponent had replied in negative.

The Complaint was dismissed.

Date of Award: 17.11.2015

Complainant:- Shri Niranjan Patel v/s The New India Assurance Co. Ltd.

Complaint No. AHD-G-049-1516-0322

Partial settlement of Mediclaim

The Complainant was diagnosed with CAD, Double Vessel Disease, Essential Hypertension, Type 2 D.M & Moderate LV Systolic Function. Coronary Angiography & Angioplasty was done. He was admitted in DDMM Heart Institute, Nadiad on 22.08.2014. He was discharged on 24.08.2014 after treatment. The Complainant had incurred an expense of Rs.2,81,816/-. The Respondent had settled his claim partially for Rs.1,00,000/-, equal to sum insured. The Respondent had not considered cumulative bonus as per policy terms & conditions.

It was specifically mentioned under the policy terms & conditions No.9-Cumulative Bonus-"Sum Insured under the policy shall be progressively increased by 5 % in respect of each claim free of insurance, subject to maximum accumulation of 10 claim free years of insurance. Accordingly, Rs.50,000/- cumulative bonus was accrued under the subject policy for 9 completed years. This includes 15% carried forward cumulative bonus under the policy with a maximum cap restricting cumulative bonus up to Rs.50,000/- for 10 claim free years.

The Forum directed the Respondent to pay Rs.50,000/- with interest @ 9% from the date of submission of claim forms till the date of payment of claim to the Complainant.

Date of Award: 25.11.2015

Complainant:- Shri Darshan Bhatt v/s The New India Assurance Co. Ltd.

Complaint No. AHD-G-049-1516-0335

Partial settlement of Mediclaim

The Complainant was diagnosed with mouth Cancer & was admitted in Super Surgical Hospital, Ahmedabad on 17.04.2015. He was discharged on 21.04.2015 after treatment. The Complainant had incurred an expense of Rs.1,15,529/-. The Respondent had settled his claim partially for Rs.68,969/- & deducted Rs.46,560/- from the claim. Rs.3,200/- was deducted towards Room charges as only 1% of sum insured was payable. Rs.655/- deducted towards Pharmacy Charges/Non-medical items. Rs.42,705/- was deducted proportionately from other charges as the Complainant had opted for higher room category. The SCN has mentioned that the Complainant had not considered Rs.11,400/- in the claim form. Therefore, the same has to be added to amount of relief sought.

The terms & conditions submitted by the Respondent's representative in the evening for the Mediclaim Policy (2007) did not contain specific mention of proportionate deduction for amount payable under policy clause No.2.3 & 2.4. In that case the Respondent's decision to deduct the

charges under the clause No.2.3 & 2.4 proportionately was arbitrary. Rs.11,400/- was payable to the Complainant as confirmed by the Respondent since the same was not included in the total of claim.

The Forum directed the Respondent to pay Rs.57,295/- to the Complainant.

Date of Award: 25.11.2015

Complainant:- Shri Kamlesh Kachhiya v/s The New India Assurance Co. Ltd.

Complaint No. AHD-G-049-1516-0343

Partial settlement of Mediclaim

The Complainant was diagnosed with Proliferative Diabetic Retinopathy & Clinically Significant Macular Edema & was admitted in Nishtha Retina Centre, Vadodara on 07.10.2014. He was discharged on 07.10.2014 after treatment. The Complainant had incurred an expense of Rs.79,470/-. The Respondent had settled his claim partially for Rs.50,276/-. The Respondent had considered claim amount Rs.77,998/- as per actual bills. Rs.22,080/- deducted towards Reaonable Customary Charges & Instrument Charges not payable, Rs.4,000/- ARMD treatment excluded, Rs.1,500/- towards Surgeon's charges under Customary & reasonable charges, Rs.142 towards Eye Drape charge not payable under non-medical items.

The Complainant had taken the treatment at the advice of the doctor. There must have been severity which could have lead Complainant to take such treatment at such an early age of 48 years. The Respondent had not enquired about the reason for hospitalization with the hospital. The Respondent's R.O had applied two clauses under the deduction of Rs.22,080/-. Firstly, clause No.3.35 was applied for Customary & Reasonable charges & another clause No.4.4.4 applied was for instrument charges. In SCN they had applied clause No.4.4.4 & 4.4.21-Non-medical Items. This really contradicts the decision of the Respondent. The policy did not restrain the Insured from claiming reimbursement in macular degeneration in younger people. The bill clearly carried the name of the patient; the Complainant. The Respondent did question the Doctor regarding the bill. The Respondent had applied exclusion clause No.4.4.23 for ARMD treatment. The policy did not restrain the Insured from claiming reimbursement in macular degeneration in younger people. ARMD usually occurred in people aged 50 years & above. The Respondent had deducted Rs.1,500/- towards Surgeon Charges & OT Charges giving reason only 25% of professional charges was payable as per Association Charge List. The list was not made known to the Complainant. The Administration charges of Rs.4,000/- was deducted towards Injection Avastin & other procedures performed thereafter. The deduction was effected as per the Respondent's guidelines to TPA. The Respondent had failed to establish what is reasonable & customary charges. The Respondent's action in partial settlement without proper evidence on the clause is against the provisions of the IRDAI circular dated 20.02.2013 on standardization in health insurance Reasonable Charges. In absence of any comparative rate charts 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 Forum directed the Respondent to pay Rs.27,580/- to the Complainant.

Date of Award: 22.12.2015

Complainant:- Shri Chander P Ruchwani v/s The Oriental Insurance Co. Ltd.

Complaint No. AHD-G-050-1516-0351

Repudiation of Mediclaim

The Complainant's son Shri Dipesh was diagnosed with Left Eye Choroidal Neovascular Membrane at the age of 21 years. Dr. Manish Nagpal advised him to undergo a procedure involving three Injections Intravitreal Accentrex spread over 3 months. He was admitted in Retina Foundation & Asopalav Eye Hospital, Ahmedabad on 13.02.2015, 13.03.2015 & 16.04.2015. He was discharged on 14.02.2015, 14.03.2015 & 17.04.2015 after treatment. The Complainant had incurred an expense of Rs.34,056/-, 30,238/- & 30,238/- amounting to Rs.94,532/-. The Respondent had repudiated his claims citing Policy Clause No. 4.23.

The Intravitreal procedure was done in operation theatre. The Insured was hospitalized at the advice of the treating doctor as the doctor can only decide on the duration of hospitalization depending upon the gravity of the disease, age of the patient, health parameters of the patient etc. The patient has to act according to the advice of the treating doctor. The Insured was aged just 21 years. The certificate of the treating doctor dated 17.04.2015 clearly highlights the importance & seriousness of the treatment. The above treatment was performed to prevent permanent loss of sight. Lucentis can slow down the growth of abnormal blood vessels, vision loss & even reduce it. 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 4.23 vitiates the very purpose of availing of the latest advanced technology.

The Forum directed the Respondent to pay Rs. 94,532/- to the Complainant.

Date of Award: 07.01.2016

Complainant:- Dr. Mayank J Trivedi v/s United India Insurance Co. Ltd.

Complaint No. AHD-G-051-1516-0354

Repudiation of Mediclaim

The Complainant had met with an accident. He was rushed to Vakade's Centre for Dental Excellence, Vadodara. He was diagnosed with Dentoalveolar Trauma. He was treated for Fracture of Mandible. The Complainant had incurred expense of Rs.35,104/-. The Respondent repudiated the subject claim mentioning Policy Definition Clause 3.14-Hospital/Nursing Home: A Hospital means any institution established for inpatient care and day care treatment of illness &/or injuries & which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration & Regulation) Act, 2010 or under the enactments specified under the Schedule of Section 56(1) of the said Act or complies with all minimum criteria as under-has qualified nursing staff under its employment round the clock- has at least 10 in-patient beds in towns having a population of less than 10 lacs & at least 15 in-patient beds in all other places- has qualified medical practitioner(s) in charge round the clock- has a fully equipped operation theatre of its own where surgical procedures are carried out-maintains daily records of patients & makes these accessible to the Insurance Company's authorized personnel.

On the advice of the Forum the Respondent's TPA again visited the clinic to investigate about the No. of beds in the clinic & registration. The receptionist of the clinic had informed him that the treating Doctor was out of country for 2-3 months. Further neither the TPA's representative was not allowed to take photographs of the clinic nor anybody attended to his queries. The TPA's Manager Jignesh Patel confirmed, vide his mail dated 01.01.2016, about their visit to the clinic & confirmed that no indoor facility was available in the clinic. They also had a doubt whether in-patient treatment was given to the Complainant as the clinic timings were 10.00 a.m to 6.00 p.m, whereas the Complainant was admitted on 06.04.2015 & discharged on 07.04.2015. They also observed that Civil Hospital was far of from the Vakad's Clinic where the treatment was taken. The subject clinic did not fulfill the required criteria of hospital under policy clause No.3.14. The Respondent had not disputed the treatment. However, since the Insured had to get the medical assistance in the clinic due to the accident (extra ordinary situation) & that the Civil Hospital personnel had advised him to consult a private hospital the Forum is inclined to grant relief on ex-gratia basis.

The Forum directed the Respondent to pay Rs.8,800/- (25% of the claim) on ex-gratia basis.

Date of Award: 07.01.2016

Complainant:- Shri Prashant Dave v/s The New India Assurance Co. Ltd.

Complaint No. AHD-G-049-1516-0358

Repudiation of Mediclaim

The Complainant was diagnosed with Morbid Obesity. He was hospitalized from 12.12.2014 to 15.12.2014 in Asian Bariatrics, Ahmedabad. Roux-En-Y Gastric Bypass Surgery was performed. The Complainant had incurred total expenses of Rs.2,80,000/-. The Respondent had rejected the claim citing Policy Clause No. 4.4.6.1 which dealt with various diseases including obesity treatment & its complications.

The Policy Terms & Conditions Clause No. 4-Exclusions-4.6 excluded obesity Related treatment. The primary diagnosis was morbid obesity. In the discharge summary it was categorically mentioned in the complaint portion that progressive weight gain long time & snoring. The Complainant was hospitalized for the treatment of Morbid Obesity. Apart from the opinion by the panel doctor there was no mentioned about treatment for diabetes in the discharge summary. The treating Dr. Sanjay Patoloia himself confirmed that the Insured needed to undergo Roux-En-Y Gastric Bypass Surgery. Medical Science confirms this surgery as weight loss surgery that reduces the size of the stomach to a small pouch-about the size of an egg. It is very clear in the subject claim that due to morbid obesity, the treatment was taken. However, as the terms & conditions were not provided to the Complainant the Forum asked the Respondent to review the claim, to which they had settled Rs.1,41,758/- & deducting other charges not payable due to higher room category & other charges deductible due to higher room availed then entitled category.

The amount paid by the Respondent of Rs.1,41,718/- was found in order.

Date of Award: 22.12.2015

Complainant:- Shri Manishkant Oza v/s The Oriental Insurance Co. Ltd.

Complaint No. AHD-G-050-1516-0359

Repudiation of Mediclaim

The Complainant's Daughter Kum. Yashasvi was diagnosed with Partial Seizures (?) Idiopathic. She was admitted in Zydus Hospital, Anand on 09.08.2013. She was discharged on 11.08.2013 after treatment. The Complainant had incurred an expense of Rs.20,273/-. The Respondent had repudiated his claims citing Policy Clause No. 4.1 which read as-"All Pre-existing Disease (whether treated/untreated, declared or not declared in the proposal form), which are excluded up to 48 months of the policy being in force. Pre-existing diseases shall be covered only after the policy has been continuously in force for 48 months."

The medical literature confirms that Hypocalcemia is the presence of low serum calcium levels in the blood. Supplementation of calcium & some form of vitamin D are given during the

treatment. From the version of the Complainant it was confirmed that Calcium Sandoz injections were given to the Insured while she had suffered from Hypocalcemia at her age of 5 months i.e before 10 years. She was cured of the deficiency. The human brain works by sending electrical signals through neurons, which are nerve cells. A seizure occurs when there is a surge in this electrical activity. This causes a host of physical symptoms, such as muscle contractions, visual disturbances & black outs. Seizures can affect entire brain. A partial seizure is when a seizure occurs in just one area. A partial seizure may occur for many reasons, including epilepsy, brain tumors or infections, heat stroke or low blood sugar. The doctor had certified that the earlier illness Hypocalcemia does not seem to have any correlation with the subject illness Partial Seizures. Earlier illness was due to deficiency in the calcium whereas the subject illness was related to surge in brain activity. The Respondent had not taken specific medical opinion from an expert to counter the treating doctor's certificate who was of the opinion that subject treatment had no correlation with the earlier one. The Respondent had also failed to prove that the partial seizure had correlation with the Hypocalcemia. The Respondent failed to prove that the Insured had the subject disease pre-existing before the commencement of the policy. The Insured was not under treatment or had taken any treatment related to Hypocalcemia after taking treatment before 10 years.

The Forum directed the Respondent to pay Rs. 20,273/- to the Complainant.

Date of Award: 23.12.2015

Complainant:- SMT. DAXA T SHAH V/S UNITED INDIA INSURANCE CO. LTD.

Complaint No. AHD-G-051-1516-0361

Partial settlement of Mediclaim

The Complainant was admitted in Eye Care Hospital, Ahmedabad on 12.05.2015 for Left Eye Cataract surgery & was discharged on the same day. She had incurred total expense of Rs.64,582/-. Her claim was partially settled for Rs.33,082/-. Deductions for Rs.31,500/- were made under the policy terms & conditions clause No.3.33- Reasonable & Customary Charges. The Complainant submitted that she was eligible for the claim of Rs.68,750/- as per Policy Condition No. 1.2.1-A , according to which reimbursement under Cataract Surgery expense could be made up to "25% of Sum Insured or actual expense whichever was less".

The Policy Terms & Conditions No. 1.2.1(a) clearly states that in case of Cataract Surgery "Actual expense incurred or 25% of the sum insured whichever is less is payable." In the subject policy, 25% of the sum insured (Rs.2,75,000/-) was Rs.68,750/-. The Complainant had incurred expense of Rs.64,582/-. There was no specific condition mentioned in the policy on the type, rate & quality of lenses to be used. Without any guidance or advice it would be difficult for an Insured to arrive at reasonable & customary charges for a surgery especially, when there is a specific mention of reimbursement under Cataract surgery in the terms & conditions of the policy itself. Therefore, the clause No. 4.6(b) was not tenable & was not conveyed to the

Complainant in the repudiation letter. The Respondent had not carried out survey for the charges levied by other hospitals for the same surgery in same geographical area to apply reasonable & customary charges clause. The Forum observed that when there was a specific clause on particular medical treatment, it gets invoked. It is really sad on the part the Respondent not to honour the terms & conditions of the subject policy framed by the Respondent.

The Forum directed the Respondent to pay Rs.31,500/- to the Complainant.

Date of Award: 23.12.2015

Complainant:- SHRI BUDDHIDHAN SOMPURA V/S STAR HEALTH & ALLIED INSU. CO. LTD.

Complaint No. AHD-G-044-1516-0364

Repudiation of Mediclaim

The Complainant was diagnosed with Bulbar Urethral Stricture with Distal Penile Urethral Stricture. He was admitted in Euro Care Clinic, Ahmedabad on 10.07.2014. He was discharged on 11.07.2013 after treatment. The Complainant had incurred an expense of Rs.26,958/-. The Respondent had repudiated his claims citing Policy Exclusion Clause No. 9 which read as-"The Company is not liable to make any payment in respect of any expenses incurred by the Insured person for treatment of congenital external defect/disorder."

The Respondent had claimed that the Insured had Hypospadias as a congenital defect. The medical literature states that Hypospadias is diagnosed during physical examination after the baby is born. In case Hypospadias is diagnosed & if it requires surgery the same is usually done when a boy is between the ages of 3-18 months old. Here in the subject claim the age of the Insured was 60 years. The treating doctor had already confirmed in his certificate that all Hypospadias are not congenital. It was acquired due to distal penile urethra stricture. During the hearing the Complainant was asked whether he was married which he confirmed and said he had 2 sons & a daughter. He added that he had problem in passing urine for quite some time. He said a surgery was carried out on him and he would require further surgery to rectify the problem. He mentioned that since the first claim was not settled he had deferred the further surgery which would involve transplanting nerve from other part of his body.

The Forum directed the Respondent to pay Rs. 26,958/- to the Complainant.

Date of Award: 22.12.2015

Complainant:- Shri Viral M Mehta v/s The New India Assurance Co. Ltd.

Complaint No. AHD-G-049-1516-0367

Repudiation of Mediclaim

The Complainant's Father Mansukhbhai was diagnosed with Acute Synovitis of Knee Joints & Lumbar Spondylosis. He was hospitalized from 19.11.2014 to 20.11.2014 in Sheth P.T Surat General Hospital, Surat. The Complainant had incurred total expenses of Rs.11,346/-. The Respondent had rejected the claim citing Policy Clause No.2.11- "hospitalization for less than 24 hours".

From the medical papers & the reports submitted it was clear that hospitalization of the Insured was done & the Respondent had no doubt on the hospitalization. The insured was taken to the hospital in the morning only. After carrying out necessary report the doctor arrived at a conclusion that the Insured needed to be admitted for further treatment. It was not the will of the Insured but at the advice of the doctor they acted. The pleading of the Complainant with the OPD consultation time & further course of treatment till the treatment on next day was convincing, reasonable & justified. The Respondent should have considered these facts & settled the claim.

The Forum directed the Respondent to pay Rs. 11,346/- to the Complainant.

Date of Award: 11.01.2016

Complainant:- Shri Dhaval B Parikh v/s The New India Assurance Co. Ltd.

Complaint No. AHD-G-049-1516-0369

Repudiation of Mediclaim

The Complainant's Son Mast. Karnav was diagnosed with Rectal Prolapse. He was hospitalized from 12.03.2015 to 14.03.2015 in Neel Surgical Hospital, Vadodara. The Complainant had incurred total expenses of Rs.33,723/-. The Respondent had rejected the claim citing Policy Clause No.3.13 which stated that the hospital should have at least 15 inpatient beds where the population of the town was 10 lacs & above, but the above named hospital had only 10 beds.

It is correct that the hospital is not registered under the Clinical Establishment (Registration & Regulation) Act, 2010 nor does it satisfy the criteria of the minimum number of 15 beds & thus do not fall within the definition of the term 'Hospital' as defined by IRDAI. From the medical papers & the reports submitted it was clear that hospitalization of the Insured was done & that there was no malafide intention on the part of the Complainant. The same was not disputed by the Respondent. The Respondent failed to prove that the terms & conditions were provided to

the Complainant. In the absence of the policy terms & conditions, the Insured would not be able to know the precautions he had to exercise while selecting the hospital. The Complainant also alleged that there are instances of claims having been paid by the Respondent under similar circumstances. The Forum therefore asked the Respondent to submit an affidavit to rule out the allegation made. The Respondent representative submitted the affidavit under which she had not given the specific information sought by the Forum. She had simply mentioned that as per the information & confirmation from their TPA they are following the hospital criteria w.e.f 01.01.2015. The Forum had specifically asked the representative to confirm in affidavit that whether they have made any payment under the claim where the beds in the hospital were less than 15 days. There was no mention or confirmation to that effect in the said affidavit. On the other hand, the said affidavit gave an understanding that the Respondent had, indeed, made payment of claim in similar circumstances.

The Forum directed the Respondent to pay Rs. 33,723/- to the Complainant.

Date of Award: 21.12.2015

Complainant:- Shri Dipakbhai M Parajapati v/s National Insurance Co. Ltd.

Complaint No. AHD-G-048-1516-0385

Partial settlement of Mediclaim

The Complainant was diagnosed with N49.2-Inflammatory disorder of Scortum & was admitted in Vadaj Surgical Nursing Home, Ahmedabad on 22.05.2015. He was discharged on 29.05.2014 after treatment. The Complainant had incurred an expense of Rs.51,548/-. The Respondent had settled his claim partially for Rs.43,540/-.

The Respondent had deducted Rs.7,500/- under the clause 3.29-Reasonable, Customary & Necessary Expenses. The terms & condition of the policy did not carry specific critical information on the extent the claim was payable. No investigation was carried out by the Respondent, regarding the reasonable rates charged by other hospitals with similar services in that geographical area, to prove that the treating hospital had charged excess fees. The Respondent had failed to establish what was reasonable & customary charges. The Respondent's action in partial settlement without proper evidence on the clause is against the provisions of the IRDAI circular dated 20.02.2013 on standardization in health insurance Reasonable Charges. In absence of any comparative rate charts, obtained from various hospitals with similarly facilitated hospitals in the vicinity of the hospital where the insured had undergone the medical treatment, the deduction from surgeon charges & OT charges caused merely on assumption or without any base is arbitrary.

The Forum directed the Respondent to pay Rs. 7,500/- to the Complainant.

Date of Award: 23.12.2015

Complainant:- SHRI CHANDRAKANTBHAI K SHAH V/S NATIONAL INSURANCE CO. LTD.

Complaint No. AHD-G-048-1516-0405

Repudiation of Mediclaim

The Complainant's spouse Smt. Mitaben was diagnosed with Neck pain & Right Renal Calculas. She was hospitalized from 13.04.2015 to 14.04.2015 in Shri Sardar Patel Hospital, Ahmedabad. The Complainant had incurred total expenses of Rs.28,571/-. The Respondent had rejected the claim citing Policy Clause No.4.19.

The Complainant had submitted the chart of line of treatment given to her. MRI or any other diagnosis becomes essential & necessary to find the exact cause of the illness. USG of Abdomen indicated the presence of renal stone. Medical papers also confirmed that the Insured had past history of surgery for cervical region femur. The Certificate issued by the Hospital, submitted by the Complainant during the hearing stated that the patient had severe pain, she was advised hospitalization, administered tablets, dynapar injection through IV on 12 hour basis and syrup citralca. Blood tests, USG and MRI were carried out to rule out recurrence of old disease and to find the cause of pain. She was advised for renal surgery for renal stone. Dynapar contains the active ingredient diclofenac; it is a non-steroidal anti-inflammatory that is used to treat pain, fever and swelling. The certificate cleared the fact that the patient was admitted to the hospital to detect the reason for pain and presence of renal stone was confirmed through the pathological tests. The patient had done the diagnosis, identified the health issue but did not undergo the surgery as advised by her doctor instead had preferred oral medicines. The medicines administered were pain relievers in nature which could have been consumed as out patient.

The decision of the Respondent needs no intervention.

Date of Award: 12.01.2016

Complainant:- SMT. Vasantiben Patel v/s National Insurance Co. Ltd.

Complaint No. AHD-G-048-1516-0433

Partial settlement of Mediclaim

The Complainant was admitted in Dr. Sharmeel S Gandhi Hospital, Ahmedabad for the surgery of Right Eye Cataract on 31.01.2015 & was discharged on the same day. She had incurred total expense of Rs.43,225/-. Her claim was partially settled for Rs.20,500/-. Rs.21,825/- was deducted from the claim stating that the said Dr. Sanjay Gandhi Hospital was a part of the GIPSA PPN. As per the MOU, the hospital was supposed to charge Rs.20,500/- & accordingly the amount was sanctioned by the TPA.

The treating Dr. Sharmeel Gandhi had given letter certifying that he was an independent practitioner having his own registered hospital. He further certified that he was not attached to any hospital or eye surgeon. He also confirmed that he had no agreement with any insurance company or TPA. Despite considering the treating doctor's certificate the Respondent had arbitrarily invoked wrong clause while repudiating the claim. The Respondent had entered in to an agreement with Dr. Sanjay Gandhi Hospital & not with Dr. Sharmeel Gandhi. The reasoning applied by the Respondent that the operation was carried out in the PPN hospital & same operation theatre was used does not stand good as both the doctors are carrying out the practice separately. The Customer was in no way responsible. Therefore the amount deducted Rs.21,825/- towards O.T charges, Operation Charges & Anesthesia charges was payable to the Complainant.

The Forum directed the Respondent to pay Rs. 21,825/- to the Complainant.

Date of Award: 07.01.2016

Complainant:- Shri Govind R Dulani v/s National Insurance Co. Ltd.

Complaint No. AHD-G-048-1516-0444

Partial settlement of Mediclaim

The Complainant was diagnosed with Retinal detachment in left eye & was admitted in Netralaya Hospital, Ahmedabad on 11.03.2015. He was discharged on 12.03.2015 after treatment. The Complainant had incurred an expense of Rs.53,463/-. The Respondent had settled his claim partially for Rs.41,963/-. Rs.8,500/- was deducted from Surgeon Charges & Rs.3,000/- deducted from O.T charges under Reasonable charges both under policy clause No.3.26.

The Respondent had deducted the amount of Rs.11,500/- under the clause 3.26-Reasonable charges. There is no specific mention on the amount payable/not payable for the subject treatments. 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 was levied by the hospital. The Respondent had failed to establish that the charges were unreasonable. The Respondent's action in partial settlement without proper evidence on the clause is against the provisions of the IRDAI circular dated 20.02.2013 on standardization in health insurance Reasonable Charges. In absence of any comparative rate charts obtained from various hospitals with similarly facilitated hospitals in the vicinity of the hospital where the insured had undergone the medical treatment, the deduction caused merely on assumption or without any base is arbitrary.

The Forum directed the Respondent to pay Rs. 11,500/- to the Complainant.

Date of Award: 07.01.2016

Complainant:- Shri Karsanbhai R Patel v/s National Insurance Co. Ltd.

Complaint No. AHD-G-048-1516-0446

Partial settlement of Mediclaim

The Complainant was diagnosed with Acute Appendicitis & was admitted in Sterling Hospital, Ahmedabad on 17.03.2015 night. He was discharged on 20.03.2015 after treatment. The Complainant had incurred an expense of Rs.1,00,570/-. The Respondent had settled his claim partially for Rs.40,700/-. The Complainant had sought relief for Rs.48,023/-. Rs.27,648 was deducted from Operation Charges under PPN Package, Rs.6,050/- deducted from O.T equipment charges & Rs.14,325/- deducted as Disposable Probes, Harmonic Scalpel & Image charges.

The Respondent failed to prove that a copy of list of PPN hospitals was given to the Complainant. The Complainant was not aware that the fees of Rs.40,700/- was to be paid for the Appendicitis to Sterling Hospital. The agreement was between Hospital & TPA. Neither the hospital nor the Respondent had brought the existence of the MOU on PPN hospitals to the knowledge of the Complainant. The hospital had violated the MOU & charged excess amount from the Complainant. The Customer in no way was responsible for such violation. The Forum gave an opportunity to the Respondent's representative & Shri Manoj Shah representing TPA to review the claim once again & arrive at an amicable figure acceptable to both the Complainant & the Respondent. The Respondent after reassessing the claim file agreed to settle total claim of Rs.75,000/- i.e balance Rs.34,300/- payable to the Complainant within 10 days from the receipt of the Award. The Complainant had also consented for the same.

The Forum directed the Respondent to pay Rs. 34,300/- to the Complainant as per their mutual agreement, post hearing.

Date of Award: 01.02.2016

Complainant:- Shri Viral H Ajmera v/s Bajaj Allianz General Insurance Co. Ltd.

Complaint No. AHD-G-005-1516-0455

Repudiation of Mediclaim

The Complainant was diagnosed with Chronic Otitis Media in left ear & was admitted in Vedant Hospital, Anand on 31.12.2014. He was discharged from the hospital on 01.01.2015 after treatment. The Complainant incurred an expense of Rs.40,819/-. The Respondent repudiated the claim on the ground of "Non-disclosure of ailment prior to the proposal form & Preamble".

The consultation paper of the hospital dated 26.11.2014 stated the 'case of left ear discharge with decreased hearing since 6 months'. In the discharge card, it was mentioned as since last 2

months. In the proposal form dated 07.10.2014, in reply to question No.24- "Do you or any of the family members to be covered have/had any health complaints in the past 4 years & have been taking treatment/hospitalization" the Complainant had answered in negative. The Consultation papers dated 26.11.2014 mentioned "c/o Left ear discharge with Left decreased hearing x6 months". The Respondent had not investigated the matter with Dr. Mehul S Patel about the exact duration of the illness- 2 months or 6 months, or 2 days. The Forum had contacted the treating doctor vide email dated 12.01.2016 & sought written confirmation, regarding the duration of discharge from the ear of the Complainant. The treating doctor vide his reply email dated 21.01.2016 had confirmed that the Complainant had mentioned about his Left Ear discharge as since 2 months during the consultation. With this the date of disease falls after the date of proposal.

The Forum directed the Respondent to pay the claim of Rs.40,819/- to the extent otherwise admissible under the Policy Terms & Conditions, to the Complainant.

Date of Award: 07.01.2016

Complainant:- Shri Rushin I Shah v/s National Insurance Co. Ltd.

Complaint No. AHD-G-048-1516-0461

Repudiation of Mediclaim

The Complainant was diagnosed with Chronic Pancretitis & was admitted in Kaizen Hospital, Ahmedabad on 08.04.2015. He was discharged on 09.04.2015 after treatment. The Complainant had incurred an expense of Rs.12,306/-. The Respondent had repudiated the subject claim citing Policy Clause No.3.12.

In the Inpatient Bill dated 09.04.2015 it was clearly mentioned D.O.A as 08.04.2015-21.28 & D.O.D as 09.04.2015-17.31. The Complainant himself had admitted that after carrying out various blood reports in the afternoon he had gone back to his home. As he fell ill & his health deteriorated in the evening he was advised to get admitted in the hospital. The Clause clearly warrants minimum 24 hours hospitalization & the respondent had rightly applied the same. However, if OPD timings are considered the treatment period covers hospitalization for more than 24 hours. Further, the Respondent had not disputed about the treatment of the Insured. There was no malafied intention of the Insured. He had asked for the discharge & was given. If he would have stayed for 4 hours more in the hospital the claim would have become payable.

The Forum directed the Respondent to pay Rs.6,150/- (50% of the claim) on ex-gratia basis.

Date of Award: 08.01.2016

Complainant:- Shri Mansukhbhai V Bhungani v/s The New India Assurance Co. Ltd.

Complaint No. AHD-G-049-1516-0471

Repudiation of Mediclaim

The Complainant was diagnosed with Endophthalmitis in left eye. He was hospitalized from 10.12.2014 to 11.12.2014 in Gadre Eye Care Centre, Rajkot. The Complainant had incurred total expenses of Rs.46,586/-. The Respondent had rejected the claim citing Policy Clause No.3.4.

There was no mention in the policy terms & condition that no reimbursement shall be made for complication arising from cataract surgery. Endophthalmitis was an inflammation of the internal coats of the eye. It was possible due to complication of cataract surgery, with possible loss of vision & the eye itself. Infectious etiology is the most common & various bacteria & fungi have been isolated as the cause of the Endophthalmitis as per medical literature. Here there was no fault on the part of the Complainant to go for the Surgery. The Respondent's representative had also produced newspaper cutting wherein precaution not taken by the doctors & hospitals led to blindness after cataract operation. This deficiency led to bacterial infection in eyes. This could be one of the reasons for the complication. The Complainant was not responsible for such negligence.

The Forum directed the Respondent to pay Rs. 46,586/- to the Complainant.

Date of Award: 07.01.2016

Complainant:- Shri Dilip V Parmar v/s The Oriental Insurance Co. Ltd.

Complaint No. AHD-G-050-1516-0486

Repudiation of Mediclaim

The Complainant's Smt Daxaben was diagnosed with Recurrent Parotid Tumor + Swelling over Right Dorsum of hand. She was admitted in Shubham Hospital, Ahmedabad on 04.09.2014. She was discharged on 08.09.2014 after treatment. The Complainant had incurred an expense of Rs.89,414/-. The Respondent had repudiated his claims citing Policy Clause No. 4.1 which read as-"All Pre-existing Disease (whether treated/untreated, declared or not declared in the proposal form), which are excluded up to 48 months of the policy being in force. Pre-existing diseases shall be covered only after the policy has been continuously in force for 48 months."

The Respondent failed to prove that the ailment existed when the policy was taken. The Insured was operated in the year 2000 & was fully cured. The biopsy report carried out in the year 2000 also confirmed that the tumor was fully cured. Further the treating Dr. Jayesh Prajapati , who was a MS-Onco Surgeon had given his certificate confirming that final histology report was

suggestive of new tumor pleomorphic adenoma second primary & not recurrent. The Dr. further submitted in his certificate that tumor in parotid did not occur after 12 years. The Dr. also opined that the Insured had undergone another surgery for pigmented lesion over dorsum of right hand, clinically which was highly suspicious of malignant lesion & risky of malignant transformation.

The Forum directed the Respondent to pay Rs. 85,589/- to the Complainant.

Date of Award: 18.01.2016

Complainant:- Shri Sandeep Trehan v/s Star Health & Allied Insurance Co. Ltd.

Complaint No. AHD-G-044-1516-0503

Repudiation of Mediclaim

The Complainant's daughter was diagnosed with Idiopathic Chondrolysis of Right Hip. She was hospitalized from 06.02.2015 to 14.02.2015 in Surya Child Care, Mumbai. The Complainant had incurred total expenses of Rs.5,48,272/-. Out of which the Complainant's employer's Insurer had paid Rs.1,23,272/-. He had lodged a claim for Rs.4,25,000/- with the Respondent. The Respondent settled the claim for Rs.8,025/- & the balance claim was repudiated stating "Bill towards Surgeon Fees did not form part of the hospital bills hence the amount charged towards Surgeon fee was disallowed."

The attending doctor had given the treatment to the Insured. The treatment had been given in the hospital by the doctor during the subject hospitalization period. The hospital had the knowledge of the fee charged by the doctor. The hospital had not objected to it. The doctor's fee/bill must have been collected at the cash counter of the hospital. It was not a bill other than the hospitalization & treatment given to the Insured. The Insured who had received the treatment merely had paid the bill as it was put to him. The Insurer being an institution should take up such matters with the hospital & the doctor for such bills as by means of separate bills tax evasion should not be involved. Further the Respondent had failed to establish that the surgery charges were unreasonable as he did not produce any comparative fee chart charged by similarly facilitated hospital in that vicinity of the hospital where the subject treatment had been carried out. The Forum also questioned the representative of the Respondent whether they have investigated what charges were charged by the treating doctor with other hospital where he gave his services for the same surgery. The representative replied in negative. The Respondent's action in partial settlement without proper evidence was against the provisions of the IRDAI circular dated 20.02.2013 on standardization in health insurance Reasonable Charges. The deduction caused merely on assumption or without any base is arbitrary.

The Forum directed the Respondent to pay Rs. 4,25,000/- to the Complainant.

Date of Award: 18.01.2016

Complainant:- Shri Suresh D Prajapati v/s United India Insurance Co. Ltd.

Complaint No. AHD-G-051-1516-0529

Partial Settlement of Mediclaim

The Complainant's wife Smt. Bhavnaben was diagnosed with CA Sigmoid Colon. She was admitted in Parekhs Hospital from 17.02.2015 to 25.02.2015. The Complainant had incurred total expense of Rs. 1,23,661/-. The Respondent settled Rs.61,548/- & deducted Rs.62,113/- citing Policy Clause No.1.2.1.

The Insured was admitted in Siddhi Vinayak Hospital, Ahmedabad thrice during the period from 01.12.2014 to 04.12.2014, from 26.12.2014 to 29.12.2014 & from 16.01.2015 to 19.01.2015 for the treatment of CA Rectum with Liver Metastasis. The treatment was for Cancer. The present treatment was also for cancer. It was specifically written in policy clause No.1.2.1 that the reimbursement of expenses for Cancer treatment would be restricted to 70% of the sum insured or actual expenses whichever was less. The Respondent had settled the claim by restricting the reimbursement up to 70% of the sum insured. Further Policy Clause No. 5.12 stated that- "The Insured may seek enhancement of sum insured in writing at or before…….the Company. However, …..for claims arising in respect of ailment, disease or injury contracted or suffered during a preceding policy period, liability of the Company shall be only to the extent of the sum insured under the policy in force at the time when it was contracted or suffered during the currency of such renewed policy or any subsequent renewal thereof". The Insured should have mentioned in the proposal form while enhancing the sum insured about the disease which she was suffering with (frequency of stool-liquid since last 4 months), which subsequently led to diagnosis of CA Sigmoid Colon. The Respondent might have adopted some other steps on deciding the sum insured enhancement proposal. The Insured had thus, suppressed material fact from the Respondent.

The Complaint failed to succeed.

Date of Award: 01.02.2016

Complainant:- Shri Mukesh Patel v/s The Oriental Insurance Co. Ltd.

Complaint No. AHD-G-050-1516-0557

Repudiation of Mediclaim

The Complainant was diagnosed with Acute Viral Hepatitis (HEV Positive). He had taken treatment in Jaynil Hospital, Vadodara. He was admitted in the hospital on 01.06.2015& discharged on 09.06.2015. He incurred expense of Rs.45,000/- approximately. His claim was repudiated by the Respondent citing Policy Clause No. 2.1.

The hospital was not registered under the Clinical Establishment (Registration and Regulation) Act, 2010 or under the enactments specified under the schedule of Section 56(1).The hospital did not have 15 beds. The criterion of minimum number of in-patient beds was not informed to the Complainant. The Complainant's son was admitted into the hospital on 01.06.2015 whereas the Respondent advertised the subject condition through newspapers on 28.06.2015. The policy schedule was dispatched with no terms and conditions attached thereto. The Policy Schedule was examined by the Forum. There was no indication of the terms and conditions being attached to the schedule. Without the T&C, the policy holder would not know the 15 beds' condition.

The Respondent was directed to settle the claim of Rs.44,000/- admissible as per the Terms & Conditions of the policy, towards full and final settlement of the claim.

Date of Award: 01.02.2016

Complainant:- Dr. Suresh Goyal v/s The Oriental Insurance Co. Ltd.

Complaint No. AHD-G-050-1516-0560

Repudiation of Mediclaim

The Complainant was diagnosed with Sarcoidosis, unspecified, Hypothyroid, Coronary Artery Disease, Essential (Primary) Hypertension, D.M & Morbid Obesity. He had taken treatment in Asian Bariatrics, Ahmedabad. He was admitted in the hospital on 03.10.2014 & was discharged on 06.10.2014. His claim was repudiated by the Respondent citing Policy Clause No. 4.19.

The Respondent had taken the expert opinion from a panel doctor who himself is Laproscopic Gastro Surgeon. The doctor had specifically confirmed that the treatment/surgery/procedure was for reduction in weight. The panel doctor had not mentioned in his opinion about the implication of diabetes in progressive weight gain at an advanced age.

The discharge summary of the hospital mentioned diagnosis of other ailments also. It was not only morbid obesity. The age of the Complainant was 66 years. The progressive weight gain was due to heavy Diabetes. The Complainant had submitted Hb1AC reports which clearly confirmed that the reading has gone down drastically to 6.4 on 11.12.2014, from 9.6 on 28.11.2013. In the subject claim the treatment was to control of diabetes which was evident from the reading of HbA1C. The same is admissible after 2 years as per the terms & conditions of the subject policy. From the above, an inference can be drawn that, in the subject claim the surgery was not for weight reduction but it was to control diabetes & other implications which have been proved. The Respondent has not produced the proposal form for verification. The Complainant has claimed that he had declared his 27 years old DM & HTN in the proposal form. The Complainant's weight as on the date of proposal could not be verified to rule out his body structure (morbid obesity) as on the date of proposal. The Respondent could not conclusively prove that the Insured was obese on the date of proposal & the subject complications arose due to the obesity. The Insured had been suffering from DM & HTN since 27 years & as it went

beyond control with insulin & medicine, the bariatric surgery had to be performed to save the life. The treatment at an age of 66 years had been done to control DM & HTN & not for the loss of weight.

The Forum directed the Respondent to pay the claim of Rs.2,61,200/- to the extent otherwise admissible under the Policy Terms & Conditions, to the Complainant.

Date of Award: 01.02.2016

Complainant:- Shri Jagmohan N Arora v/s The Oriental Insurance Co. Ltd.

Complaint No. AHD-G-050-1516-0566

Repudiation of Mediclaim

The Complainant was diagnosed with Left eye CRVO with Macular Edema. He had taken treatment in Raghudeep Eye Hospital, Ahmedabad. He was admitted &discharged from the hospital on 15.06.2015. He had incurred expense of Rs.27,406/-. His claim was repudiated by the Respondent citing Policy Clause No. 2.3 (c) which stated-"Procedures/treatment usually done in outpatient 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".

The Intravitreal procedure was done in operation theatre. The above treatment was performed to prevent permanent loss of sight. Lucentis could slow down the growth of abnormal blood vessels, vision loss & even reduce it. 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 2.3(C) vitiates the very purpose of availing of the latest advanced technology. The internal guidelines issued by the Respondent had no relevance as the said guidelines were not incorporated in the policy terms & conditions.

The Forum directed the Respondent to pay Rs. 27,406/- to the Complainant.

Date of Award: 03.02.2016

Complainant:- Shri Umesh Baraiya v/s The New India Assurance Co. Ltd.

Complaint No. AHD-G-049-1516-0574

Partial Settlement of Mediclaim

The Complainant was diagnosed with HT, DM, acute severe gastritis with? Cx Spondolysis with scapula dyskinosis. He had taken treatment in Life Line Multi-speciality Hospital, Surat. He was

admitted on 24.09.2014 & discharged from the hospital on 26.09.2014. The Complainant had incurred expense of Rs.11,136/-. The Respondent had deducted Rs.5,000/- & settled the claim for Rs.6,136/-. The Insured was entitled for the room rent of Rs.1000/-(including Nursing Charges), as his sum insured was Rs.1,00,000/- . He had availed a room including Nursing Charges with a rent of Rs.2,600/. Rs.1,600/- was deducted from room rent, as the same was in excess of entitled Room category of Rs.1,000/-. Rs.540/- was deducted from Laboratory Charges, Rs.327/- from Sonography charges & Rs.1308 from Doctor's visit charges. Rs.400/- was deducted as non-medical expenses (Glucometer Charges).

The terms & conditions for the Mediclaim Policy (2007) did not contain specific mention on proportionate deduction for amount payable under policy clause No.2.3 & 2.4. In that case the Respondent's decision to deduct the charges under the clause No.2.3 & 2.4 proportionately was arbitrary & incorrect. The charges deducted under the head laboratory, sonography & visit charges becomes payable. The deduction made for non-medical items was in order.

The Forum directed the Respondent to pay Rs.2,175/- to the Complainant.

Date of Award: 02.02.2016

Complainant:- Shri Gaurav B Gandhi v/s The New India Assurance Co. Ltd.

Complaint No. AHD-G-049-1516-0577

Repudiation of Mediclaim

The Complainant's mother Smt. Premilaben was diagnosed with Right Sialadenitis Sub Mandibular Salivary Gland. She had taken treatment in Siddhi Surgical Hospital, Vadodara. She was admitted on 09.04.2015 & discharged from the hospital on 11.04.2015. The Complainant had incurred expense of Rs.46,043/-. The Respondent had repudiated the claim citing Complainant's mother was treated did not fulfill requirements of Policy Condition No.3.13 to be considered as hospital under the policy. The hospital had 10 beds as per Claim Form Part-B whereas the same should have minimum 15 beds as per the policy.

It was correct that the hospital did not fulfill the criteria on minimum number of 15 beds & thus did not fall within the definition of the term 'Hospital' as defined by IRDAI. From the medical papers & the reports submitted it was clear that hospitalization of the Insured was done & that there was no malafide intention on the part of the Complainant. The same was accepted by the Respondent. The Respondent failed to prove that the terms & conditions were provided to the Complainant. In the absence of the policy terms & conditions, the Insured would not be able to know the precautions he had to exercise while selecting the hospital. The advertisement given by the Respondent was also after the date of hospitalization of the Complainant. The Representative of the Respondent admitted that till December, 2014 they used to entertain claim of hospital having less than minimum bed criteria. Since January, 2015 they have stopped entertaining such claims. When there was uproar against the decision of the 4 GIPSA Companies they decided to give advertisement in local newspaper. The Forum questioned how

the Insured will come to know that from January, 2015 such claim would not be entertained by the Respondent.

The Forum directed the Respondent to pay Rs. 46,043/- to the extent otherwise admissible under the Policy Terms & Conditions, to the Complainant.

Date of Award: 03.02.2016

Complainant:- Shri Shailesh H Patel v/s The Oriental Insurance Co. Ltd.

Complaint No. AHD-G-050-1516-0596

Partial Settlement of Mediclaim

The Complainant was diagnosed with Recurrent Lipoma in Suprasternal Notch & Benign Thyroid Cyst in Right Trancheo-oesophageal Groove. He had taken treatment in SAL Hospital, Ahmedabad. He was admitted on 24.02.2015 & discharged from the hospital on 25.02.2015. The Complainant had incurred expense of Rs.1,89,031/-. The Respondent had settled Rs.1,27,702 & deducted Rs.61,329/-. The deduction of Rs.20,000 from Surgeon's Charges & Rs.6,000/- from O.T Charges was made under the Reasonable Charges Clause of the policy. Service Charges Rs.20,223/- were deducted being not payable in terms of the policy. Rs.14,189/- deducted towards co-payment as per the terms & condition of the Silver Plan Happy Family Floater Policy. Rs.618/- was deducted towards Miscellaneous Charges. The Representative stated that the surgical charges tariff in respect of a Semi Special Room ranged from Rs.18,000-22,000 for Thyroglossal Cyst Surgery & they had made the payment taking average of the surgical charges.

The Complainant submitted letter dated 02.02.2016 issued by the R.M.O, SAL Hospital clarifying that there were two tumors of Suprasternal Notch & Right Tracheoesophageal Groove. The surgery of both Cardiac & Cancer lasted for 5-6 hours. Both the surgeries were performed separately & were unique. Therefore, the charges were quite reasonable. The Complainant also submitted the pathological reports also along with the certificate. The hospital certificate justifies the charges levied by them for the subject claim & hence, becomes payable. The deductions made by the Respondent towards Service Charge, Co-payment & Miscellaneous Charges were according to terms & conditions of the policy.

The Forum directed the Respondent to pay Rs. 26,000/- to the Complainant.

Date of Award: 02.02.2016

Complainant:- Shri Bipin D Shah v/s National Insurance Co. Ltd.

Complaint No. AHD-G-048-1516-0599

Partial Settlement of Mediclaim

The Complainant's spouse Smt. Shreyarthiben was diagnosed with Adenomyosis. She had taken treatment in EVA Women's Hospital & Endoscopy Centre, Ahmedabad. She was admitted on 28.05.2015 & discharged from the hospital on 30.05.2015. The Complainant had incurred expense of Rs.1,08,267/-. The Respondent had deducted Rs.34,751/- & settled the claim for Rs.73,516/-. The deduction of Rs.25,000 was out of the Surgeon's Charges & Rs.9,000/- from O.T Charges under the Reasonable & Customary Charges Clause. Further, Rs.751/- was deducted towards Miscellaneous Charges. The said deductions were made under policy clause No.3.29-"Reasonable charges means the charges for services or supplies, which are the standard charges for the specific provider & consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness/injury involved."

The Respondent had deducted Rs.34,000/- under the clause 3.29-Reasonable charges, without any specific information/basis of deduction. No survey 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 that the charges were unreasonable. The Respondent's action in partial settlement without proper evidence & valid proof was against the provisions of the IRDAI circular dated 20.02.2013 on standardization in health insurance Reasonable Charges. In the absence of any comparative rate charts of 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 basis was arbitrary & not justified. The deduction made of Rs.751/- by the Respondent under the head "miscellaneous charges not payable" was correct.

The Forum directed the Respondent to pay Rs. 34,000/- to the Complainant.

Date of Award: 02.02.2016

Complainant:- Ms. Darshana Chauhan v/s National Ins. Co. Ltd.

Complaint No. AHD-G-048-1516-0602

Repudiation of Mediclaim

The Complainant's father, Shri Ranjitbhai, was diagnosed with Ischemic Stroke Lt. Franto parital region-Lt. ICA occlusion/HTN with post stroke seizure. He had taken treatment in Sunshine Global Hospitals, Bharuch. He was admitted on 04.07.2014 & discharged from the hospital on

14.07.2014. The Complainant had incurred expense of Rs.71,811/-. The Respondent repudiated the claim citing Policy Clause No.4.1 namely, pre-existing diseases.

It was quite clear from the records submitted that the Complainant's hospitalization had taken place within the waiting period of 4 years which has been specifically excluded under Clause No. 4.1 of the policy terms & conditions. In the consultation papers of Sunshine Global Hospitals, Bharuch dated 04.07.2014 it was specifically mentioned that the Complainant was known case of hypertension since 10 years & was under treatment. Further, the treating Dr. Dhirajkumar Sathe also vide his medical certificate dated 11.07.2014 confirmed that the Insured was known case of hypertension since 10 years & was under treatment.

The Complaint was dismissed.

Date of Award: 03.02.2016

Complainant:- Shri Sarvadaman J Trivedi v/s United India Insurance Co. Ltd.

Complaint No. AHD-G-051-1516-0605

Partial Settlement of Mediclaim

The Complainant was diagnosed with Lt. Eye Retinal detachment. He had taken treatment in Nanavati Eye Hospital, Ahmedabad. He was admitted & discharged from the hospital on 21.07.2015. The Complainant had incurred expense of Rs.44,630/-. The Respondent had settled the claim for Rs.20,847 & disallowed the balance claim amount of Rs.23,783/-. The sum insured of the Complainant was Rs.50,000/- & he was entitled for the Room @1% of the sum insured i.e Rs.500/- day. The Complainant opted for room with a rent of Rs.1,000/-. Rs.500/- deducted towards excess room rent paid. Rs.21,725/- deducted proportionately as per entitled room category. Rs.1000/- deducted as medicine supply without drug license/tin number. Rs.558/- deducted as consulting letter was not attached.

The Forum had asked the Representative of the Respondent to confirm from the hospital about the minimum tariff of room. She was also asked to confirm whether the hospital charged according to room tariff. She was asked to submit the information by 03.02.2016 evening. The Representative confirmed vide email dated 03.02.2016 that their TPA had visited Nanavati Eye Hospital to verify the room category & the surgeon charges against the room category, but the hospital did not provide any tariff & the doctor verbally told that he charged the same surgeon fee for all room category. With this clarification it was proved that deduction made by the Respondent was arbitrary & whatever proportionate amount deducted towards higher room rent category were payable to the Complainant.

The Forum directed the Respondent to pay Rs.23,283/- to the Complainant.

Date of Award: 02.02.2016

Complainant:- Shri Amit Vadnagara v/s The New India Assurance Co. Ltd.

Complaint No. AHD-G-049-1516-0609

Repudiation of Mediclaim

The Complainant & his spouse underwent health check-up on 22.08.2015. They incurred an expense of Rs.5,400/-. Their claim was rejected stating that the policy had no provision for health check-up.

There was no provision under the New India Floater Mediclaim Policy for reimbursement of health check-up as claimed by the Complainant. The Respondent had rightly repudiated the subject claim. Every policy has its distinct features, & including the benefits & exclusions & its own terms & conditions. The benefits of the earlier policy cannot be extended to another policy. To avail the benefit of the subject claim, the Complainant should have renewed the policy under Mediclaim Policy 2012, as he had fulfilled the desired criteria for the subject claim.

The Complaint failed to succeed.

Date of Award: 03.02.2016

Complainant:- Smt. Durga C Solanki v/s The New India Assurance Co. Ltd.

Complaint No. AHD-G-049-1516-0615

Repudiation of Mediclaim

The Complainant was diagnosed with Neo Vascular Membrane in both eyes. She had taken the treatment in Samvid Retina Clinic & Laser Centre, Vadodara. She was admitted to the hospital on 01.12.2014& discharged on 02.12.2014. The Complainant had incurred expense of Rs.21,294/-. The Respondent had repudiated the claim citing Policy Clause No.4.4.23.

The age of the Complainant was 75 years & medical science had proved that diminishing in vision, at an advanced age, is the cause ARMD. The Policy Terms & Conditions Clause No. 4-Exclusions-4.23 clearly excluded Age Related Macular Diseases treatment.

The Complaint fails to succeed.

Date of Award: 03.02.2016

Complainant:- Smt. Durga C Solanki v/s The New India Assurance Co. Ltd.

Complaint No. AHD-G-049-1516-0616

Repudiation of Mediclaim

The Complainant was diagnosed with Neo Vascular Membrane in both eyes. She had taken the treatment in Samvid Retina Clinic & Laser Centre, Vadodara. She was admitted to the hospital on 31.12.2014 & discharged on 01.01.2015. The Complainant had incurred expense of Rs.13,000/-. The Respondent had repudiated the claim citing Policy Clause No.4.4.23 clearly excluded Age Related Macular Diseases treatment.

The age of the Complainant was 75 years & medical science had proved that diminishing in vision, at an advanced age, is the cause ARMD. The Policy Terms & Conditions Clause No. 4-Exclusions-4.23 clearly excluded Age Related Macular Diseases treatment.

The Complaint fails to succeed.

Date of Award: 22.02.2016

Complainant:- Shri Rameshbhai D Desai v/s National Insurance Co. Ltd.

Complaint No. AHD-G-048-1516-0617

Partial Settlement of Mediclaim

The Complainant was diagnosed with Coronary Artery Disease, Post PCI Status, Patent Stent, Normal LV Function (on Echo). He was hospitalized from 16.04.2015 to 17.04.2015 in Apex Heart Institute. The Complainant had incurred total expenses of Rs.2,51,028/-. The Respondent had settled only Rs.99,950/- & deducted Rs.1,51,078/- citing Policy Clause No.5.17 enhancement of sum insured would be treated as fresh & the exclusions under Clause No. 4.1, 4.2 & 4.3 will apply to incremental portion of the sum insured. The sum insured was Rs.1 Lac since the year 2003. In the policy year 2013 the sum insured was enhanced to Rs.2 Lacs & in the year 2014 it was further enhanced to Rs.3 Lacs. Hence, the enhanced sum insured during previous two years would not be available to the benefit of the Insured. So, the sum insured of Rs.1 Lac & Cumulative Bonus accumulated there on i.e Rs.30,000/- was considered for the subject claim & the claim was processed accordingly.

The Respondent has presented the TPA letter, dated 26.06.2015, wherein all the facts about the settlement were explained. The policy for the year 2013-14 showed sum insured as Rs.2 lacs whereas for the year 2006-07 the policy showed the sum insured as Rs.1 lac. The current policy showed the sum insured as Rs.3 lacs, which clearly showed that the sum insured was enhanced periodically. The Complainant was suffering from HBP, DM & Heart Disease since the year 2006 & as per the policy condition the enhancement of sum insured of Rs.1 Lac each,

in the year 2013 & 2014, are to be excluded while considering the claim. The Respondent had rightly considered Rs.1 Lac sum insured with Cumulative Bonus of Rs.30,000/-. The settlement made by the Respondent was also as per the terms & conditions of the policy.

The Complaint fails to succeed.

Date of Award: 23.02.2016

Complainant:- Shri Mahedra S Kothari v/s The New India Assurance Co. Ltd.

Complaint No. AHD-G-049-1516-0620

Partial Settlement of Mediclaim

The Complainant was admitted in Raghudeep Eye Hospital, Ahmedabad on 01.12.2014 for Left Eye Cataract surgery & was discharged on the same day. He had incurred total expense of Rs.65,000/-. His claim was partially settled for Rs.24,000/-. Deductions for Rs.41,000/- were made under the policy terms & conditions clause No.2.7- Limit on payment for Cataract: "Company's liability for payment of any claim relating to Cataract shall be limited to actual or maximum of Rs.24,000/-(inclusive of all charges, excluding service tax), for each eye, whichever is less." Accordingly, the payment of Rs.24,000/-, maximum permissible, was paid.

The Complainant was asked to produce original policy as received. He had showed the Schedule & the terms & conditions of the policy. His attention was drawn to the Condition No.2.7 of the policy wherein a limit of Rs.24,000/-was defined for the cataract surgery.The settlement of claim was done in accordance with the terms & conditions of the policy by the Respondent. Policy Clause No. 2.7 clearly specified the permissible ceiling of Actual or Maximum Rs.24,000/- inclusive of all charges whichever was less, for Cataract Surgery on each eye. All charges included cost of lens also.

The Complaint fails to succeed.

Date of Award: 26.02.2016

Complainant:- Ms. Anjuben M Sudani v/s Max Bupa Health Insurance Co. Ltd.

Complaint No. AHD-G-031-1516-0629

Repudiation of Mediclaim

The Complainant was diagnosed with Acute Entritis. She was hospitalized from 20.08.2015 to 20.08.2015 in Arogyam Hospital, Surat. The Complainant had incurred total expenses of Rs.13,855/-. The Respondent had rejected the claim citing Policy Annexure 3 Srl. No. 71. The

medical papers indicated that the patient could have been managed on OPD basis. The hospitalization was not justified.

As per the hospital prescription dated 20.08.2015, the Complainant was having abdominal pain, fever without rigour, body ache & weakness for 5 days, but in the history sheet dated 20.08.2015 it was mentioned as 3 days. The Complainant's representative was not able to explain the time of admission, room no. or any other details. Under the circumstances the claim seems to be manipulated, hence rejected.

The Complaint fails to succeed.

Date of Award: 26.02.2016

Complainant:- Ms. Anjuben M Sudani v/s Max Bupa Health Insurance Co. Ltd.

Complaint No. AHD-G-031-1516-0630

Repudiation of Mediclaim

The Complainant's daughter-in-law Mrs. Monika was diagnosed with Enteric Fever. She was hospitalized from 05.08.2015 to 06.08.2015 in Arogyam Hospital, Surat. The Complainant had incurred total expenses of Rs.12,368/-. The Respondent had rejected the claim stating the patient could have been managed on OPD basis, there was no need of hospitalisation. The medical papers indicated that the patient could have been managed on OPD basis. The hospitalization was not justified.

The patient was under treatment at home from 29.07.2015 & was diagnosed with suffering from Enteric Fever. However, she was admitted in the hospital on 05.08.2015 & discharged on 06.08.2015. One of the prescription dated 05.08.2015 states low grade fever at the same time the temperature was recorded as 100 degree ft on 05.08.2015. There was no recording of temperature & date in continuation sheet. Under the circumstances the claim seems to be manipulated, hence rejected.

The Complaint fails to succeed.

Date of Award: 22.02.2016

Complainant:- Shri Nareshkumar A Shah v/s The New India Assurance Co. Ltd.

Complaint No. AHD-G-049-1516-0633

Repudiation of Mediclaim

The Complainant was diagnosed with Morbid Obesity with D.M, HTN & Hyperlipedimia. He was admitted in Bopal Multispeciality Hospital, Ahmedabad on 20.02.2015 & was discharged on

24.02.2015 after the bariatric treatment. He had incurred total expense of Rs.2,30,000/-. His claim was repudiated by the Respondent citing Policy Clause No. 4.4.6- which dealt with various diseases including obesity treatment & its complications. He further submitted that the Complainant weighed 150 kg, 170 cm tall & his BMI was 51.9. The bariatric surgery was performed to reduce the weight & the same was not payable as per the policy terms & conditions.

It was very clear in the subject claim that due to morbid obesity, the treatment was taken & in view of excess calories the bariatric surgery was carried out. The literature submitted by the Complainant of Medical Council of India was for not to treat bariatric surgery as cosmetic surgery, whereas the policy clause No.4.4.6 specifically excluded any expenses related to treatment of obesity was not payable.

The Complaint fails to succeed.

Date of Award: 24.02.2016

Complainant:- Shri Hasmukh J Joshi v/s National Insurance Co. Ltd.

Complaint No. AHD-G-051-1516-0650

Partial Settlement of Mediclaim

The Complainant's spouse Mrs. Jyotiben was diagnosed with Paraumbilical Hernia+DM+HTN. She was hospitalized from 09.09.2015 to 16.09.2015 in Siddhi Vinayak Hospital, Ahmedabad. The Complainant had incurred total expenses of Rs.143,916/-. The Respondent had partially settled the claim for Rs.15,000/- only & deducted Rs.1,28,916/-. The Respondent had deducted the amount citing Policy Clause NO.1.2F- "Expenses in respect of Hernia Surgeries will be restricted to 15% of the Sum Insured subject to maximum of Rs.1,00,000/-." Further, the Representative submitted that under Family Medicare Policy the premium slabs had been changed w.e.f 01.08.2014 & accordingly Rs.12,446/- premium was charged.

The settlement of claim was done in accordance with the terms & conditions of the policy by the Respondent. Policy Clause No. 1.2F clearly specified the permissible ceiling of 15% of the sum insured i.e Rs.15,000/-, maximum Rs.1,00,000/-, for Hernia Surgery. The Respondent's representative was asked whether pre & post hospitalization expenses are covered under the policy, he agreed. However, the representative had no answer as to why it was not paid earlier. The Complainant was advised to submit the details of pre & post hospitalization expenses within a week to the Respondent.

The Respondent is hereby directed to settle the pre & post hospitalization expenses, as per the terms & conditions of the Family Medicare Policy 2014, on receipt of the details from the Complainant.

Date of Award: 25.02.2016

Complainant:- Shri Babubhai P Chaudhary v/s National Insurance Co. Ltd.

Complaint No. AHD-G-048-1516-0654

Partial Settlement of Mediclaim

The Complainant's spouse Mrs. Meenaben was diagnosed with Acute Gastroentetritis. She was hospitalized from 14.12.2014 to 14.12.2014 in Family Care Nursing Home, Ahmedabad. The Complainant had incurred total expenses of Rs.16,647/-. The Respondent had partially settled the claim for Rs.12,491/- & deducted Rs.4,156/-. The claim was repudiated after assessing the Insured's medical paper. The medical papers indicated that the patient could have been managed on OPD basis. The hospitalization was not justified.

Though the reports were carried out on the advice of the doctor & not at the wish of the Insured there was no mention of treatment or complaint regarding heart ailment. The reason for 2D Echo was unknown. The treating doctor had not mentioned in his consultation paper to carry out 2D Echo report. Hence, the same was not payable. The Respondent's representative was not able to explain the deductions made for Rs.700/-, Rs.286/- & Rs.170/-. She was asked to let know as to why in their settlement letter they had not mention about the particulars of amount deducted against claimed amount. She had no answer for it. Simply making mention of deduction under miscellaneous charge was not enough. The Doctor had specifically asked to carry out TSH report. Therefore, amount of Rs.700/-spent the by the Complainant was payable. The Respondent had wrongly deducted amount of Rs.286/- towards Miscellaneous Charges & Rs.170/- as follow up charges as the same could have been considered as post hospitalization expenses.

The Forum directed the Respondent to pay Rs.1,156/- to the Complainant.

Date of Award: 09.03.2016

Complainant:- Smt. Jyotiben M Desai v/s The New India Assurance Co. Ltd.

Complaint No. AHD-G-049-1516-0656

Partial Settlement of Mediclaim

The Complainant was diagnosed with 3rd degree Lt. Prolapse + Cystocele + Rectocele. She had taken treatment in Purnima Clinic, Surat. She was admitted in the hospital on 11.09.2015 & discharged on 14.09.2015. The Complainant had incurred expense of Rs.55,374/-. The Respondent had settled the claim for Rs.34,559/- & disallowed the balance claim amount of Rs.20,815/-. The Respondent had cited Policy Clause No. 2.1 which reads as- Room, boarding & nursing expenses as provided by the hospital not exceeding 1.0% of the Sum Insured (without Cumulative Bonus) per day or actual, whichever is less. Remark:- Reimbursement/payment of

Room, boarding & nursing expenses incurred at the Hospital shall not exceed 1% of the Sum Insured per day. In case of admission to Intensive Care Unit or Intensive Cardiac Care Unit, reimbursement or payment of such expenses shall not exceed 2% of the Sum Insured per day. In case of admission to a room/ICU/ICCU at rates exceeding the aforesaid limits, the reimbursement/payment of all other expenses incurred at the hospital, with the exception of cost of medicines, shall be effected in the same proportion as the admissible rate per day bears to the actual rate per day of room rent/ICU/ICCU charges.

The Respondent failed to prove that all other charges, deducted proportionately, were charged according to room rent by the hospital. The Complainant had actually paid the amount to the hospital. Had all other charges levied by the hospital, depending upon the room rent preferred by the Complainant, the applicability of the Note under Clause No.2 was apt. In absence of cogent evidence about other charges charged by the hospital according to room rent, the proportionate deductions of Rs.15,420/- made by the Respondent becomes payable. Deductions of Rs.600/- for room rent & Rs.1,800/- for Nursing Charges was in order. Rs.100/- Registration charge was not payable. Rs.130/- non-medical items not payable. Rs.2,540/- becomes payable as the Complainant had confirmed that she had submitted authentic bill receipts to the Respondent.

The Forum directed the Respondent to pay Rs.17,960/- to the Complainant.

Date of Award: 11.03.2016

Complainant:- Smt. Smita K Shah v/s United India Insurance Co. Ltd.

Complaint No. AHD-G-051-1516-0664

Partial Settlement of Mediclaim

The Complainant was diagnosed with Lt. L3-L4 PID. She had taken treatment in HCG Hospital, Ahmedabad. She was admitted in the hospital on 23.02.2015 & discharged on 25.02.2015. The Complainant had incurred expense of Rs.1,76,534/-. The Respondent had settled the claim for Rs.96,566 & disallowed the balance claim amount of Rs.79,968/-. As the Complainant had opted room higher than entitled category all other charges were proportionately deducted, as per Policy Clause No.1.2 C & D. Other deductions like Hospital Service Charge, Registration Charge, Consumables were deducted as the same were not payable as per the terms & conditions of the policy.

The Forum had asked the Representative of the Respondent to confirm from the hospital whether the hospital charged all other charges according to room tariff. She was asked to submit the findings by 11.03.2016 morning. The Representative confirmed vide email dated 11.03.2016 that the hospital charged other charges according to room category preferred by the Complainant. The Respondent had also submitted the rate charges of the HCG Multi Speciality Hospitals Tariff rates, along with mail, which confirmed that all other charges are charged according to room category. With the cogent evidence placed before the Forum the

proportionate deductions made by the Respondent toward Surgeon/Operation Charges, Consultant Charges, Diagnostic Material/ X-ray/ Laboratory/ Ultrasound/ CT Scan/ MRI was in order.

The decision of the Respondent needed no intervention.

Date of Award: 10.03.2016

Complainant:- Shri Kalpesh P Chhowala v/s The Oriental Insurance Co. Ltd.

Complaint No. AHD-G-050-1516-0683

Repudiation of Mediclaim

The Complainant's daughter Ms. Krupa was diagnosed with Malaria & Hepatitis. She had taken treatment in Hirani Children Hospital, Surat. She was admitted in the hospital on 26.08.2015 & discharged on 27.08.2015. He incurred expense of Rs.4,198/-. His claim was repudiated by the Respondent citing Policy Clause No. 2.1- the hospital where the Complainant's Daughter was treated was neither registered under the clinical establishment (Registration and Regulation) Act, 2010 nor had the minimum number of 15 in-patient beds as stipulated under the Policy Clause.

The treating Doctor S.A.Hirani had confirmed vide his certificate dated 30.09.2015 that his hospital was having 15 beds & is in existence since 1998. The Respondent had not produced cogent evidence which proves certificate to be wrong. From the medical papers & the reports submitted it was clear that hospitalization of the Insured was done & that there was no malafide intention on the part of the Complainant. The same was not disputed by the Respondent. The Respondent failed to prove that the terms & conditions were provided to the Complainant. In the absence of the policy terms & conditions, the Insured would not be able to know the precautions he had to exercise while selecting the hospital. The policy schedule was dispatched with no terms and conditions attached thereto. The Policy Schedule was examined by the Forum. There was no indication of the terms and conditions being attached to the schedule. Without the T&C, the policy holder would not know the 15 beds' condition.

The Forum directed the Respondent to pay Rs. 4,198/- to the Complainant.

Date of Award: 08.03.2016

Complainant:- Shri Ashokkumar K Patel v/s Cigna TTK Health Insurance Co. Ltd

Complaint No. AHD-G-053-1516-0688

Repudiation of Mediclaim

The Complainant's Son Shri Akshay was diagnosed with Right Eye Corneal Ectasia. He had taken treatment in Clear View Laser Centre, Ahmedabad. He was admitted & discharged from the hospital on 08.12.2015. He incurred expense of Rs.30,843/-. His claim was repudiated by the Respondent stating procedure was not covered under day care list.

The treating Doctor had clearly certified vide his certificate dated 28.12.2015 that the Complainant's Son was operated for Right Eye Corneal Ectasia. The medical literature states that Corneal Ectasia occurs when the inner layers of your cornea become weak, causing the cornea to change shape, protrude forward and distort your vision. It is important to understand that Corneal Ectasia is a serious condition that can cause permanent loss of vision if not treated, and may require a corneal transplant. It cannot be corrected with glasses. It further states that younger patients are at higher risk for Ectasia. The age of the Complainant's Son was young & it was necessary & at the advice of the Doctor they underwent for the surgery. The Respondent failed to prove that the subject surgery had no technological advancement & therefore cannot be covered under day care procedure. The representative should have obtained expert opinion about the treatment. When the Insurer repudiates a claim it must not be based on assumptions & presumptions but based on cogent evidence. The Insurer has failed to produce any evidence in support of their stand that there is no technological advancement in this procedure.

The Forum directed the Respondent to pay Rs.30,843/- to the Complainant.

Date of Award: 14.03.2016

Complainant:- Shri Kirit G Bosamiya V/S National Insurance Co. Ltd.

Complaint No. AHD-G-048-1516-0705

Partial Settlement of Mediclaim

The Complainant's spouse Smt. Shardaben was admitted in Maheshwari Eye Care Hospital, Rajkot on 04.08.2015 for Right Eye Cataract surgery & was discharged on 05.08.2015. She had incurred an expense of Rs.60,900/-. Her claim was partially settled for Rs.18,000/-. Again on 01.09.2015 she underwent Left Eye Cataract surgery & was discharged on 02.09.2015. She had incurred anotherl expense of Rs.60,900/-. Her claim was partially settled for Rs.18,000/-.

Deduction of Rs.42,900/- on each surgery was made citing the policy terms & conditions clause No.3.29- Reasonable & Customary Charges.

As per IRDAI circular on standardization in health insurance, reasonable charges means the charges for services or supplies which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar service, taking into account the nature of the illness/injury. But in the subject case the Respondent has not provided any rate list of similarly facilitated hospitals & their charges for cataract operation in the geographical area. There was no specific condition mentioned in the policy on the type, rate & quality of lenses to be used. Without any guidance or advice it would be difficult for an Insured to arrive at reasonable & customary charges for a surgery especially, when there is a specific mention of reimbursement under Cataract surgery in the terms & conditions of the policy itself. Therefore, the clause No. 4.6(b) was not tenable & was not conveyed to the Complainant in the repudiation letter.

The Forum directed the Respondent to pay Rs.85,800/- to the Complainant, under both claims.

Date of Award: 16.03.2016

Complainant:- Shri Rameshbhai N Patel v/s The Oriental Insurance Co. Ltd.

Complaint No. AHD-G-050-1516-0724

Repudiation of Mediclaim

The Complainant was diagnosed with Acute Gastroentritis, Severe Dehydration, Renal Dysfunction & Ketoacidosis. He had taken treatment in Jaynil Hospital, Vadodara. He was admitted in the hospital on 16.05.2015 & discharged on 20.05.2015. He incurred expense of Rs.27,080/-. His claim was repudiated by the Respondent citing Policy Clause No. 2.1- the hospital where the Complainant's Son was treated was neither registered under the clinical establishment (Registration and Regulation) Act, 2010 nor had the minimum number of 15 in-patient beds as stipulated under the Policy.

As per IRDA circular Ref: IRDA/HLT/REG/CIR/125/07/2013 dated 03.07.2013 "A hospital means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishment (Registration and Regulation)Act, 2010 or under the enactments specified under the schedule of section 56(1) of the said act or complies with all minimum criteria as- at least 10 in-patient beds in town having a population of less than 100000 and at least 15 in-patient beds in all other places". The Respondent repudiated the claim without seeking any clarification on the applicability of the Clinical Establishment Act from the authorities. The Respondent could not prove that they had sent the terms & conditions of the policy to the Complainant. The Complainant produced the Schedule of the Policy only. The Policy Schedule was examined by the Forum. There was no indication of the terms and conditions being attached to the

Schedule. The criterion of minimum number of in-patient beds was not informed to the Complainant. All the Public Sector General Insurance Companies in Baroda had given an advertisement in English & Gujarati news papers on 28.06.2015. The advertisement reiterated the definition of hospital as given under the IRDAI guidelines. The Complainant was hospitalized on 22.06.2015 i.e. before the date of advertisement.

The claim of Rs. 27,080/- was awarded to be paid by the Insurer to the Insured, towards full and final settlement of the claim.

Date of Award: 15.03.2016

Complainant:- Shri Girish M Patel v/s The New India Assurance Co. Ltd.

Complaint No. AHD-G-049-1516-0822

Partial Settlement of Mediclaim

The Complainant's Son Rinav was diagnosed with Acute LRTI + Bronchitis, as per doctor's diagnosis he had the symptoms of Swine Flu (H1N1). He had taken treatment in Sunshine Global Hospital, Vadodara. He was hospitalized from 24.02.2015 to 25.02.2015. He had claimed total expense of Rs.17,819/- . The Respondent had settled Rs.6,636/- partially stating Policy Terms & Condition No. 2.1: "Room rent, boarding & nursing expenses as provided by the Hospital/Nursing Home not exceeding 1% of Sum Insured (excluding cumulative bonus) per day/actual whichever is less, is reimbursable". The Sum Insured was Rs. 1 Lac & so eligible room charges was Rs. 1000/- per day as against Rs. 1,775/- per day (paid by the Complainant). As per policy condition Note No. 1 to Clause 2.3 & 2.4 the amount payable should be as per the entitled category. Accordingly, the deductions of other charges were made.

The contention of the Complainant that his Son was suspected to be Swine Flu patient & was admitted to Special Isolation Room, which had higher room rent than his entitled category, on the advice of the treating. So, the claim that all deductions made by the Respondent should be reimbursed does not stand because the Insured was suspected of Swine Flu but not diagnosed. The report of Swine Flu was also negative. In view of the above the deductions made by the Respondent were found to be in order of terms & conditions of the policy.

The decision of the Respondent needed no intervention.

Date of Award: 15.03.2016

Complainant:- Shri Manubhai K Parmar v/s National Insurance Co. Ltd.

Complaint No. AHD-G-048-1516-0828

Repudiation of Mediclaim

The Complainant's Son, Mast. Prakash had met with an accident on 01.10.2015. He had traumatic injury in his upper Anterior totally evclsion with widening anterior alvcolar socket with extra oral swelling & bleeding. He was treated in Mehta Dental Clinic, Vadodara. The Complainant had incurred an expense of Rs.22,990/-. The Respondent had repudiated his claim citing Policy Clause No. 3.24-"Out-patient treatment means treatment in which the Insured person visits a clinic/hospital or associated facility like a consultation room for diagnosis & treatment based on the advice of a medical practitioner & the Insured person is not admitted as a day care patient or in-patient" & 4.8-"Dental treatment or surgery which is a corrective, cosmetic or aesthetic procedure, including wear & tear, unless arising from an accident & requiring hospitalization for treatment".

Policy Exclusion Clause No.4.8 allowed reimbursement on dental treatment if it had arisen out of accidental injury & requiring hospitalization. Under the subject claim there was no hospitalization but accident was there. The treatment was given as day care treatment. The Complainant had carried out C.T scan of Brain on the date of accident. Though, there was no hospitalization but the Insured had sustained the injury & underwent the dental treatment. The Forum was inclined to grant relief on ex-gratia basis.

The Forum directed the Respondent to pay Rs. 11,500/- to the Complainant, 50% of claim amount on Ex-gratia basis.

Date of Award: 15.03.2016

Complainant:- Shri Gaurang D Soni V/S National Insurance Co. Ltd.

Complaint No. AHD-G-048-1516-0829

Repudiation of Mediclaim

The Complainant's mother Smt. Madhukantaben was diagnosed with Right Renal Stone. She was admitted in Arogyam Hospital, Ahmedabad on 13.06.2015 & was discharged on 15.06.2015. She had incurred total expense of Rs.1,06,734/-. Her claim was repudiated by the Respondent stating that her policy had expired on 12.12.2014 & the same was renewed from 10.06.2015 with a break of 6 months. The waiver was condoned by the Respondent with a condition to exclude disease/illness/accidents/injury which had already been suffered/contracted/sustained during the gap period & without enhancement of expiring sum

insured. The current disease was contracted during the gap period. The claim was, therefore, repudiated.

During the course of the hearing the Respondent's representative had confirmed that the Bank was allowed to deduct premiums on their behalf. The bank had confirmed through their certificate that the premium was deducted on 27.11.2014 & the Banker's cheque was prepared on the same day & sent to the Respondent. The Complainant was in no way responsible for break in the policy. He had regularly followed up with the bank & but with the Respondent. The Respondent should have empathetically looked in to the grievance of the Complainant & settled his claim. Rs.2,954/- deducted towards pre-hospitalization expenses exceeding 30 days was in order. Rs.6,305/- deducted towards medicine charges, (not permissible as per IRDAI guidelines) was in order. Rs.200/- deducted towards Miscellaneous Charges was in order. Rs.2,800/- deducted towards O.T charges was arbitrarily deducted by the Respondent. Rs.10,000/- deducted towards laser machine & Fiber charges by the Respondent as rental charges was arbitrary. The charges are payable as per IRDAI guidelines.

The Forum directed the Respondent to pay Rs.97,275/- to the Complainant.

Date of Award: 16.03.2016

Complainant:- Shri Nitinbhai S Shah v/s Oriental Insurance Co. Ltd.

Complaint No. AHD-G-050-1516-0836

Repudiation of Mediclaim

The Complainant's daughter, Ms. Dhwani was diagnosed with Left Eye Keratoconus. She had taken the treatment in Vasan Eye Care Hospital, Ahmedabad. She was admitted to the hospital & discharged on 02.07.2015. The Complainant had incurred expense of Rs.22,637/-. The Respondent had repudiated the claim citing Policy Clause No.4.13 & 2.13.

As per medical literature Keratoconus weakens the cornea of the eye causing the eye to bulge outwards & produces moderate to severe blurriness of vision. During the C3R procedure, the eye is impregnated with a riboflavin solution & exposed to ultra-high frequency light. C3R causes the collagen fibrils to thicken, stiffen & crosslink & re-attach to each other, making the cornea stronger & more stable thus convincingly halting the progression of the disease. This is a simple one time treatment that offers a permanent solution to Keratoconus. The TPA official confirmed that the Medical Council of India had approved this procedure. Further other Insurance Company had settled the claim raised with them. The treating doctor had certified, vide his letter dated nil, that the Insured had Keratoconus in both eyes. C3R surgery in left eye was performed on 02.07.2015. As regards the Policy Clause No. 2.3, 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. The Complainant had taken the treatment at the

advice of the doctor. The severity of Keratoconus had lead Complainant to undergo C3R surgery.

The Forum directed the Respondent to pay Rs.22,637/- to the Complainant.

Date of Award: 16.03.2016

Complainant:- Shri Jagdishbhai M Shah v/s The New India Assurance Co. Ltd.

Complaint No. AHD-G-049-1516-0840

Repudiation of Mediclaim

The Complainant was diagnosed with Right Eye BRVO(Branch Retinal Vein Occlusion). He had taken the treatment in Rising Retina Clinic, Ahmedabad. He was admitted to the hospital & discharged on 19.09.2015. The Complainant had incurred expense of Rs.29,500/-. The Respondent had repudiated the claim citing Policy Clause No.2.16.1 Note & 2.11. As per Policy Clause No. 2.16.1 - minimum 24 hours hospitalization was required & under Clause 4.4.23 treatment for Age Related Macular Degeneration was excluded.

The Respondent had not submitted the SCN, Policy Terms & Conditions of the subject policy & proposal of the Complainant for verification & examination. The Representative of the Respondent claimed that the Policy Terms & Conditions Clause No. 4-Exclusions-4.23 excluded Age Related Macular Diseases treatment. The Respondent failed to prove that BRVO in Right Eye was age related disease. The retina is the delicate light-sensitive membrane that lines the inside of the eye. Like the rest of the body, the retina has blood vessels that supply it with vital oxygen & nutrition. Arteries are the vessels carrying blood into the eye while veins carry blood out. The retinal arteries & veins criss-cross over each other at numerous locations in the retina. Rarely, at one of these crossing points, the thicker walled artery may compress the more fragile vein & lead to a partial obstruction. This is called a BRVO. The BRVOs are found commonly in patients whose blood vessel health is less than ideal. The factors those increase the risk of BRVO include High Cholestrol, overweight & especially high blood pressure. The treating doctor had certified, vide his letter dated 27.10.2015, that BRVO is not Age Related macular Degeneration. The Respondent should have obtained opinion of a doctor having same or higher stature to counter the certificate. The Respondent failed to do so. For Policy Clasue No. 2.16.1 Note & 2.11 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. The Complainant had taken the treatment at the advice of the doctor. There must have been severity which could have lead Complainant to take such treatment. During the hearing it was revealed that the terms & conditions given to the Complainant were of old policy. Policy conditions of New Mediclaim 2012 were not given.

The Forum directed the Respondent to pay Rs.29,500/- to the Complainant.

Date of Award: 16.03.2016

Complainant:- Shri Jagdishbhai M Shah v/s The New India Assurance Co. Ltd.

Complaint No. AHD-G-049-1516-0841

Partial Settlement of Mediclaim

The Complainant was diagnosed with Right Eye BRVO (Branch Retinal Vein Occlusion). He had taken the treatment in Rising Retina Clinic, Ahmedabad. He was admitted to the hospital & discharged on 15.10.2015. The Complainant had incurred expense of Rs.29,000/-. The Respondent had partially settled the claim for Rs.4,000/- & disallowed Rs.25,000/- citing Policy Clause No.4.4.23.

The Representative of the Respondent claimed that the Policy Terms & Conditions Clause No. 4-Exclusions-4.23 excluded Age Related Macular Diseases treatment. The Respondent failed to prove that BRVO in Right Eye was age related disease. The retina is the delicate light-sensitive membrane that lines the inside of the eye. Like the rest of the body, the retina has blood vessels that supply it with vital oxygen & nutrition. Arteries are the vessels carrying blood into the eye while veins carry blood out. The retinal arteries & veins criss-cross over each other at numerous locations in the retina. Rarely, at one of these crossing points, the thicker walled artery may compress the more fragile vein & lead to a partial obstruction. This is called a BRVO. The BRVOs are found commonly in patients whose blood vessel health is less than ideal. The factors those increase the risk of BRVO include High Cholestrol, overweight & especially high blood pressure. The treating doctor had certified, vide his letter dated 27.10.2015, that BRVO is not Age Related macular Degeneration. The Respondent should have obtained opinion of a doctor having same or higher stature to counter the certificate. The Respondent failed to do so. For Policy Clasue No. 2.16.1 Note & 2.11 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. The Complainant had taken the treatment at the advice of the doctor. There must have been severity which could have lead Complainant to take such treatment. During the hearing it was revealed that the terms & conditions given to the Complainant were of old policy. Policy conditions of New Mediclaim 2012 were not given.

The Forum directed the Respondent to pay Rs.25,000/- to the Complainant.

Date of Award - 18.03.2016

Case of:-Sh. Bhuvenesh Kumar Malik v/s New India Assurance Co. Ltd.
Complaint REF:No. AHD-G-049-1516-0713

The Complainant had BRVO in his left eye. The reason for BRVO was Hypertension. The complainant was admitted to Rising Retina Clinic on 22.07.2015 for the treatment. On discharge from the hospital, the Complainant filed a claim for Rs.29500/- The Respondent repudiated the claim vide their letter dated 15.09.2015 under clause No. 3.4 of the policy Terms & Conditions

The representative of the Respondent had stated that the complainant had ARMD and underwent intravertal injection of Lucentis in left eye on 22.07.2015 and discharged on the same day. Since 24 hours hospitalization was not completed, as per Policy condition No.3.4 and that the OPD treatment was also not covered, the claim was rejected. The copy of the Terms and conditions produced by the Complainant did not carry exclusion of BRVO/Lucentis/Aventis, etc. from the ambit of treatment and reimbursement thereon it. Therefore the complaint is allowed.

Date of Award : 18.03.2016

Case of:-Sh. Bhuvenesh Kumar Malik v/s New India Assurance Co. Ltd.
Complaint REF:No. AHD-G-049-1516-0716

The Complainant had BRVO in his left eye. The reason for BRVO was Hypertension. The complainant was admitted to Rising Retina Clinic on 16..09.2015 for the treatment. On discharge from the hospital, the Complainant filed a claim for Rs.58,793/-. The Respondent paid Rs.8,793/- towards Laser treatment expenses and denied Rs.50,000/- stating amount not payable under Clause No.3.4. The representative of the Respondent had stated that the complainant had ARMD and underwent intravertal injection of Lucentis in left eye on 22.07.2015 and discharged on the same day. Since 24 hours hospitalization was not completed, as per Policy condition No.3.4 and that the OPD treatment was also not covered, the claim was rejected. The copy of the Terms and conditions produced by the Complainant did not carry exclusion of BRVO/Lucentis/Aventis, etc. from the ambit of treatment and reimbursement thereon it. Therefore the complaint is allowed.

Date of Award : 09.03.2016

Case of Mr. Nimesh M. Gandhi Vs. The New India Assurance Co. Ltd., Baroda.
Complaint Ref No. AHD-G-049-1516-0659.

Shri Maheshbhai Gandhi was hospitalized from 18.06.2015 to 19.06.2015 for (BE) Cataract L>R (LE) Old Branch retinal Vein Occlusion. Insurance Company rejected the entire claim under Clause No. 2.15 of the Insurance Policy i.e. Hospital has less than 15 beds. Respondent

Insurance Company observed that the hospital is having less than 15 beds. Since this hospital does not fall under the definition of Hospital/Nursing Home, the claim is not payable under Clause No.2.15 of the insurance policy. As per the Policy Condition No. 2.16.1 & 2.16.2, Cataract operation was allowed as day care surgery and no hospitalization of minimum 24 hours was required for the same. The Complainant had also submitted an explanation letter dated 14.08.2015 issued by attending doctor confirming that patient was admitted for observation until 19.06.2015 since patient developed discomfort (Nausea & vomiting) after surgery and no charge is taken for stay. He had charged for day care treatment. The Respondent Company had not considered this aspect. The Insurance Company had wrongly applied the hospital clause and rejected the claim of a senior citizen in a very unethical manner applying policy condition in a stringent manner.. The complainant is entitled for relief. In view of the foregoing the complaint is admitted.

Date of Award : 10.03.2016

Case of Mr Shashikant J. Gandhi Vs. United India Insurance Co. Ltd
Complaint Ref No. AHD-G-051-1516-0661

The Complainant was hospitalized for the treatment of left eye CME (Cystoid Macular Oedema) - Left Eye and Surgery of Vitrectomy + Endolaser under LA – Left Eye was carried out. Respondent had rejected the claim under Exclusion Clause No. 4.19 of the Insurance Policy– "Treatment for Age Related Macular Degeneration (ARMD) treatments such as Rotational Field Quantum Magnetic Resonance (RFQMR), Enhanced External Counter Pulsation (EECP), etc." As per the treating doctor's certification (Dr. Bhavin . Patel) the patient had undertone left eye procedure i.e. intravertal avastin done under TA on 08.01.2015 and another procedure Vitractomy with Endo Laser photocoagulation on 21.07.2015. The first one being a treatment of AMD and hence, not payable and the complainant has not disputed / challenged this amount too. Whereas, second procedure done on 21.07.2015 is payable in view of the treating doctor's Certification which has not been rebutted by the Respondent Insurance Company through any expert opinion by documentary evidence. Thus, the amount of Rs.33,800/- is payable in the light of the abovementioned facts.

In view of the foregoing the complaint is admitted.

Date of Award : 18.03.2016

Case of Mr. Nimesh M. Gandhi Vs. The National Insurance Co. Ltd.,
Complaint Ref No. AHD-G-048-1516-0673.

The Complainant was hospitalized on 20.02.2015 for Cataract surgery on her Right Eye. The Insured had submitted claim papers for total claim of Rs. 90,530/- on 04.03.2015. The respondent had partially settled the claim for Rs.32,030/- and rejected Rs.58,500/- under reasonable and customary charges. Respondent Insurance Company, have deducted

Rs.29,300/- from Misc / lenses charges, Rs.4200/- from OT Charges and Rs.18000/- from Surgeon Charges as reasonable and customary charges payable under Clause 3.29 of the policy. However, the Respondent had not provided any proof or supporting papers to show that what they had paid was reasonable. Further, as stated by the Complainant that earlier, his wife had undergone retina surgery in the same eye and hence, cataract operation was required to be done by most competent doctor with latest technology available considering the past operation of the same eye. The deduction of the claim was, thus, arbitrary illegal and unethical. The complainant was entitled for relief. In view of the foregoing the complaint is admitted.

Date of Award : 18.03.2016

Complaint Ref No. AHD-G-044-1516-0676.

Case of Mr. Bhavik D. Pateli Vs. Star Health & Allied Insurance Co. Ltd.

The Complainant's wife Mrs Minaxiben D. Patel was hospitalized from 01.08.2013 to 03.08.2013 for Menorrhagia and TLH was done. Insured had submitted claim papers for total claim of Rs.94,410 /- but received reimbursement of Rs. 62,243/-. The respondent had partially rejected the claim stating "prevailing market rate".

Date of Award : 10.03.2016

Case of Mr Jignesh M. Vithlani V The United India Inc. Co. Ltd. Ahmedabad.

Complaint Ref No. AHD-G-051-1516-0681

The Complainant, along with his family members was insured under the Individual Insurance Health Policy issued by The United India Insurance Company Ltd for the period from 06.03.2015 to 05.03.2016 for Rs.3/- Lacs each for himself and his wife and Rs.1/- lac each for his two children. Insured had also taken Super Top Up Mediclaim Policy for himself and his wife for SI of Rs. 7/- lacs each for the period from 10.03.2015 to 09.03.2016 from The United India Insurance Company Ltd . Mr Jigneshbhai M. Vithalani was hospitalized on 27.06.2015, for Massive Hematohezia due to Large Bleeding Rectal Ulcer. Against the total claim of Rs.42,563/-, the Insurance Company had settled the claim for Rs.30,418/- deducting Rs.12,145/- under various terms and conditions of the Policy. Respondent Insurance Company can deduct proportionate room rent taking into account 1 % of basic sum insured as per policy condition. However, if they deduct operation charge and other charges in the same proportion, it is sheer injustice to the insured when respondent insurance company does not have confirmation of different rates of Operation and other Charges charged by concerned Hospital based on Room Rent. Although the Company may have acted as per policy condition, the disallowance is unethical and anti customer centric. In view of this, respondent Insurance Company is advised to pay Rs. 8,204/- after deducting Rs.3000/- being higher room rent and Rs. 941/ being Pharmacy Return amount. In view of the foregoing the complaint is admitted.

Date of Award : 10.03.2016

Case of Mr. Nimesh M. Gandhi Vs. The New India Assurance Co. Ltd., Baroda.
Complaint Ref No. AHD-G-049-1516-0687.

The Complainant was hospitalized for the period from 15.09.2015 to 21.09.2015 for Acute Dengue Fever. He had lodged a claim for Rs. 66,093/- with the Respondent. Insurance Company had settled the claim for Rs. 34,923/- deducting Rs.31,170/- under various heads, as per terms of Mediclaim Policy 2012. Respondent Insurance Company can deduct proportionate room rent taking into account 1 % of basic sum insured as per policy condition. However, if they deduct operation charge and other charges in the same proportion, it is sheer injustice to the insured when respondent insurance company does not have confirmation of different rates of Operation and other Charges charged by concerned Hospital based on Room Rent. Although the Company may have acted as per policy condition, the disallowance is unethical and anti customer centric. However, the respondent is given an opportunity to produce the differential rates from the Hospital immediately but not later than 15th March, 2016. Respondent Insurance Co. submitted Schedule of Rates of Bodyline Hospital vide letter dated 10.03.2016, according to which in some charges, there is no rate difference in Room Rent permissible to insured as 1% of sum insured and higher room rent opted by Complainant. Hence, Visiting Charges Rs.11285 + Pathology Charges Rs. 3403 +Ultrasound Charges Rs. 1198 + Cardiology Charges Rs 120 = Rs. 16006 are payable to` the insured. .Rest of the deductions made by respondent Insurance Company are in order. In view of the foregoing the complaint is admitted.

Date of Award : 08.03.2016

Case of Mr. Nimesh M. Gandhi Vs. The National Insurance Co. Ltd.,

Complaint Ref No. AHD-G-048-1516-0690.

The Complainant was hospitalized on 07.07.2015 for operation of Cataract of Left Eye. The Insured had submitted claim papers for total claim for Rs. 65,549/- on 21.07.2015. The Respondent settled the claim for Rs.18,000/- and rejected Rs47,549/- under internal circular.

The Respondent had rejected the claim under their internal circular which was not a part of the Policy. The Policy and its Terms and Conditions are the contract. There can not be any other conditions beyond the Policy. The deduction of the claim citing internal circular is arbitrary and unjust. The Insurer had contradicted their Repudiation letter with a different clause No. 3.29 for rejection in their SCN. In the SCN, they have stated that cost of lenses is much on the higher side whereas routine lenses which cost between Rs.8,000/- to Rs.10,000/- are used in cataract surgeries by ophthalmologist in a routine manner. Respondent has deducted Rs.34,200/- from lenses charges, Rs.9000/- from OT Charges and Rs.4349/- from Surgeon Charges as reasonable and customary charges payable under Clause 3.29 of the policy. However, the Respondent had not provided any proof or supporting papers to show that what they had paid

was reasonable. The complainant was entitled for relief. In view of the foregoing the complaint is admitted.

Date of Award : 16.03.2016

Case of Mr. Harshad P. Patel Vs. The Oriental Insurance Co. Ltd. Baroda
Complaint Ref No. AHD-G-050-1516-0694

The complainant's son was hospitalized on 24.04.2015 for treatment of Acute Viral Fever in Jaynil Hospital and was discharged on 29.04.2015. The Insured submitted claim for Rs. 26,758/-. The respondent insurance company rejected the claim under Clause No.2.1. Respondent told that the hospital where the Complainant was treated, neither was registered under the Clinical Establishment (Registration and Regulation) Act, 2010 nor the hospital had at least 15 in-patient beds as per IRDA guideline. So, the claim was correctly rejected under clause No. 2.1. As per IRDA circular Ref: IRDA/HLT/REG/CIR/125/07/2013 dated 03.07.2013 "A hospital means any institution established for in-patient care and day care treatment of illness and/or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishment (Registration and Regulation)Act, 2010 or under the enactments specified under the schedule of section 56(1) of the said act or complies with all minimum criteria as- at least 10 in-patient beds in town having a population of less than 100000 and at least 15 in-patient beds in all other places". The Respondent repudiated the claim without seeking any clarification on the applicability of the Clinical Establishment Act from the authorities. The Respondent could not prove that they had sent the terms & conditions of the policy to the Complainant. The Complainant produced the Schedule of the Policy only. The Policy Schedule was examined by the Forum. There was no indication of the terms and conditions being attached to the Schedule. The criterion of minimum number of in-patient beds was not informed to the Complainant.

All the Public Sector General Insurance Companies in Baroda had given an advertisement in English & Gujarati news papers on 28.06.2015. The advertisement reiterated the definition of hospital as given under the IRDAI guidelines. The Complainant was hospitalized on 22.06.2015 i.e. before the date of advertisement. In view of the above the complaint is admitted.

Date of Award : 16.03.2016

Case of Mrs. Jyotsanaben V. Patel Vs. Bajaj Allianz General Insc. Co.Ltd

Complaint Ref No. AHD-G-005-1516-0707

The Complainant and her son were insured under the Health Guard-Individual Policy issued by Bajaj Allianz General Insurance Co. Ltd., for the sum insured of Rs.3,00,000/- each. Complainant was hospitalized on 14.04.2015 for the treatment of Metabolic Syndrome and discharged on 16.04.2015. The Insured's claim for Rs. 3,92,560/- was rejected by the

Respondent on 07.05.2015 citing Exclusion Clause No. C26 - "We will also not pay claims arising out of or howsoever connected to the following : Weight management services and treatment related to weight reduction programmers including treatment of obesity." It was very clear that treatment of obesity is excluded from the scope of the Policy. Accordingly, the repudiation of the claim made by Respondent was in order.

In view of the foregoing the complaint fails to succeed.

Date of Award : 16.03.2016

Case of Mr. Santosh N. Kaka Vs The New India Assurance Co. Ltd.-Baroda.
Complaint Ref No. AHD-G-049-1516-0734.

The Complainant's daughter Ms. Disha Santosh Kaka was hospitalized on 11.04.2014 for Recurrence of Branchial Cyst, operated and discharged on 12.04.2014. Insured submitted claim papers for Rs.35,200/-. The Respondent had stated that the claim was payable after 48 months subject to 10 % of the average of the Sum Insured of last 4 years. The policy clause No. 4.4.6 submitted along with the complaint also confirms the claim payable . It was seen that the policy was incepted in the year 2004. The Complaint had submitted Statement of insurance policies, according to which the inception date of Policy was 28.03.2004 with continuous renewal till date of claim. Accordingly, the claim as per Clause No. 3.10 mentioned by respondent in their letter dated 31.08.2015 becomes payable. Thus, considering the average sum insured for last 4 years comes to Rs.2/- lacs and considering 10 % of average sum insured, Rs.20,000/- is payable. In view of the foregoing the complaint is admitted.

Date of Award : 14.03.2016

Case of Mr. Pravin K. Prajapati Vs. The National Insurance Co. Ltd. Ahmedabad.
Complaint Ref No. AHD-G-048-1516-0766

The Complainant was hospitalized on 10.08.2015 for operation of Cataract of Left Eye. The Insured submitted claim papers for reimbursement of Rs. 28,730/-. Against the total claim of Rs.28,730/-, the Insured received payment of Rs.22,230/- after deduction of Rs.6,500/- as more than the reasonable operation charges. During the personal hearing, complainant conveyed that he was having insurance policy since 12.08.2002. Though respondent insurance company deducted Rs.6,500/- towards reasonable charges for operation as per the condition No.3.29 of the Policy, no data of charges of cataract operation in the geographical area for identical or similar services was provided. Further, there was no confirmation that the relevant Hospital was PPN. Under these circumstances, there is no other alternative, but to accept the request of the complainant. In view of the foregoing, the complaint is admitted.

Date of Award : 16.03.2016

Case of Mr. Jayesh L. Gosai V/s The United India Insu. Co. Ltd. Ahmedaba

Complaint Ref No. AHD-G-051-1516-0811

The Complainant was hospitalized on 27.03.2015 for operation of Fistula. Insured submitted claim of Rs. 1,05,680/- against which the insured received payment off Rs.31,680/-, after deduction of Rs.74,000/-. The deduction of Rs.70,000/- being the cost of Anal Fistula plug was made as xerox copy of bill issued by the hospital was produced and Rs.4000/- being the Anesthetist fee was deducted citing Note No.2 to the Clause No.1.2 C.Complainant had already submitted Xerox of the original Hospital Bill dated 28.03.2015 for Rs.86,10/- wherein amount of Rs. 70,000/- for Anal Fistula Plug – 2 was clearly mentioned by the hospital. Further on demand for submission of original Purchase Bill for the said item, the insured had submitted Xerox copy of purchase bill for the said item with the name of Dr. Ashish A. Ganatra on the bill along with Doctor's letter confirming purchase of the same and regretting his inability to part with original bill being his record for tax purpose. Respondent has not accepted the letter of treating doctor and deducted Rs.70,000/- from the total claim amount of Rs.1,05,680/- . As the Doctor had purchased the material consumed in operation, it was his right to keep the original bill with him for his record. The respondent had not asked about the genuineness of the bill. Thus, the deduction of Rs.70,000/- made by respondent for non submission of original bill was wrong. The Anesthetist had charged Rs.4000/- for spinal anesthesia given for the treatment of the patient and during the hospitalisation. It was not for any other treatment and not a bill from any other hospital. The expenses incurred was during the hospitalization. The complaint was admitted.

Date of Award : 15.03.2016

Case of Mr. Jignesh A. Patel Vs. The New India Assu. Co. Ltd.- Ahmedabad.

Complaint Ref No. AHD-G-048-1516-0812

The Complainant's wife was hospitalized on 30.09.2015 and operated for Rt Total Lobectomy + Isthamectomy - Sub-thyroidectomy. The Insured submitted claim papers for a claim of Rs. 60,613/-against which the insured received payment of Rs.21,614/- after a deduction of Rs.38,999 being not payable as per the limit/sub-limits prescribed under the Policy Condition No. 2.10.

It was observed that in spite of the complainant having knowledge of the fact that he was covered under Janata Mediclaim Policy with the low premium amount, the insured was expecting no deduction though the maximum limit/sub-limits were explicitly mentioned in the terms and conditions of the Policy. Looking to the Clause No. 2.10 of the policy, there is capping in room charges, Operation Theatre charges, Surgeon charges, etc. Since the insured was covered under the Janta Mediclaim Policy under which capping under different Sections has been stipulated, deductions made in various charges as per Clause No. 2.10 by Respondent insurance company is in order.

In view of the foregoing the complain fails to succeed.

Date of Award : 25.03.2016

Case of Mr. Dilipsinh J. Parmar Vs The New India Assu. Co.Ltd.Ahmedabad.

Complaint Ref No. AHD-G-049-1516-0838

The complainant was hospitalized on 17.08.2015 for the treatment of Lt. Post parietal & high parietal infarct with megaloblastic changes with high homocysteine. He had submitted claim for Rs. 30,522. The claim was rejected by Respondent on 18.11.2015 under Exclusion Clause No. 4.4.6. In view of the arguments of complainant and respondent, the case papers were referred to DMR of LIC to give his opinion as to whether the hospitalization was due to general debility, "Run-down condition or rest cure" with particular reference to the diagnosis, Medicines, Treatments and various reports of the patient. The DMR opined on 23.03.2016 that the hospitalization was due to stroke in the brain & it was not due to general debility. In view of the foregoing, the complaint was admitted.

Date of Award : 17.03.2016

Case of:-Mr. Balvant S. Desai v/s ICICI Lombard Gen Ins. Co. Ltd.

Complaint REF:No. AHD-G-020-1516-0848

The complainant had purchased Travel Insurance Policy for their travel to their daughter's house in CA, USA. Their daughter's house at C.A. USA was burgled on 04.05.2015 & the Complainant lost his passport, Indian rupees, US dollars, Ornaments, credit cards, important documents & tickets to USA (to & fro). The complainant's son-in-law had filed a FIR on 05.05.2015 & intimated the burglary to the Respondent. The claim for emergency cash advance was rejected by the Respondent on 03.11.2015 stating that emergency cash advance was payable only as transactional service.

As per Policy the limit for reimbursement of actual expenses for obtaining duplicate passport was USD 300 with deductible USD 50 plus fixed sum of USD 50 towards any and all incidental expenses that would have been incurred by the insured in connection with obtaining the emergency certificate. Respondent has paid USD 206.20 based on actual receipts for obtaining new passport plus Incidental Expenses of USD 75 without supporting receipts. As regards the relief of US $ 1000, there was no request for transfer of fund from the complainant to the respondent. Hence the question on Cash Advance did not arise. The Respondent was correct in not paying the transactional cost to the complainant. In view of the foregoing the complaint fails to succeed.

Date of Award : 17.03.2016

Case of:-Mr. Balvant S. Desai v/s ICICI Lombard Gen Ins. Co. Ltd.

Complaint REF:No. AHD-G-020-1516-0849

The complainant had purchased Travel Insurance Policy for their travel to their daughter's house in CA, USA. Their daughter's house at C.A. USA was burgled on 04.05.2015 & the Complainant lost his passport, Indian rupees, US dollars, Ornaments, credit cards, important documents & tickets to USA (to & fro). The complainant's son-in-law had filed a FIR on 05.05.2015 & intimated the burglary to the Respondent. The claim for emergency cash advance was rejected by the Respondent on 03.11.2015 stating that emergency cash advance was payable only as transactional service.

As per Policy the limit for reimbursement of actual expenses for obtaining duplicate passport was USD 300 with deductible USD 50 plus fixed sum of USD 50 towards any and all incidental expenses that would have been incurred by the insured in connection with obtaining the emergency certificate. Respondent has paid USD 206.20 based on actual receipts for obtaining new passport plus Incidental Expenses of USD 75 without supporting receipts. As regards the relief of US $ 1000, there was no request for transfer of fund from the complainant to the respondent. Hence the question on Cash Advance did not arise. The Respondent was correct in not paying the transactional cost to the complainant. In view of the foregoing the complaint fails to succeed.

Date of Award : 15.03.2016

Date of Award:08.03.2016
Complaint No. AHD-G-048-1516-0679
In the matter of Mr. Bhupendra B Bhadiyadra Vs National

The Complainant was admitted to Perfect Lifecare Hospital from 24-12-14 to 27-12-14 for the treatment of Acute Interior Wall MI. After discharge from the hospital, the Complainant had filed a claim of Rs 21329 /-. The Respondent had repudiated the claim on the ground of clause No. 4.1 pre existing conditions not covered for first time until 36 months of continuous coverage has elapsed.

In the subject complaint, the claim under the policy with the Insurance Co. Ltd. had arisen after 3 years from the inception of the policy. Thus, the Respondent wrongly repudiated the claim.

The respondent had not proved the subject disease was due to HTN or DM. However it is a known fact that HTN and DM triggered heart disease.

Respondent had not submitted SCN and not justified the repudiation of the claim.

In view of the forgoing the claim is admissible

Date of Award -08.03.2016

Complaint No. AHD-G-048-1516-0686

The Complainant was admitted to Jain Eye Associate hospital 22-09-2015 for left eye cataract surgery. On discharge from the hospital the Complainant had filed a claim for Rs.49947/- The Respondent had deducted Rs.24228/- from the claims under Agreed Tariff Limit with Hospital

The Complainant had a policy for SI RS. 200000/- The copy of the agreement with Hospital was not given to the Inured alongwith Policy and he was entitled Rs. 24228/- which was deducted by the Respondent.

The Respondent had not informed to the Insured rate for Cataract Surgery decided by TPA and Network Hospital.

The same TPA Paramount Health had setteled claim for Rs. 45417/- for the same Hospital.

The Respondent had failed to prove any justification in support of deduction made from claim amount. When the agreement made with the Hospital was not known to the Insured the arbitrary deduction by the insurance company is not legally tenable.

Therefore the complaint is allowed.

Date of Award:09.03.2016

Complaint No. : AHD-G-049-1516-0674

The Complainant's mother Smt Rekhaben was admitted in Surgical Nursing Home, Ahmadabad on 16.01.2015 9.00 A.M. for excision of Corn on Rt. Foot & discharged on 17.01.2015 11.00 A.M.. He had incurred total expense of Rs.16716/-. His claim was repudiated onn the ground that excision of Corn can be done on OPD basis and do not justify Hospitalization.

The representative of Respondent was absent during the Hearing of the Complaint.

No Policy Terms and Conditions Provided by the Respondent.. Without any terms and Condition of the Policy it is very difficult to consider repudiation of Claim under policy Clause 2.3. The Respondent had not investigated before the repudiation of the Claim.

The Insured was around 60 years of age at the time of Surgery. The Insured's health and recovery condition after surgery were assessed by the Doctor and taken decision admission. The Complaint is admitted and the Respondent to pay Rs. 16716/- to the Complainant

Date of Award: 09.03.2016

Complaint No. AHD-G-049-1516-0692

The Complainant was admitted to Ami Surgical hospital from 09-07-2015 to 11-07-2015 for the treatment of Lt.Parotid Cyst and operated for Lt. Superficial Perotidectomy with Excision of the Cyst.. On discharge from the hospital the Complainant had filed a claim for Rs 71749/-. The Respondent had deducted Rs. 15113/- under Co's guidelines non payable

items and Expenses incurred before 30 days & after 60 days of Hospitalization. Respondent had settled the claim amount Rs. 56636/-The Respondent had disallowed Rs. 15113/- out the total claim of Rs. 71749

The Respondent had not disputed for agrred to amount Rs. 400/- and Rs. 1250/- as explained by respondent.Respondent has agreed to pay Rs. 6250/- Assistant Charges and Rs. 1512/- O.T. Charges Rs.1562/-(25 % of Rs. 6250).Total amount payable comes to Rs. 7812/-

The respondent and Complainant mutually agreed for settlement. In view of the above the complaint is admitted.

Date of Award:10.03.2016

Complaint No. AHD-G-5-051-1516-0662

The Complainant had taken treatment at Banker's Retina Clinic & Laser Centre Ahmadabad for the period 18-04-15 to 27-04-15 & 27-06-15 to 29-06-15 for Sub retinal hemorrhage in both Eyes with injection lucentis and discharged on the same day. After the discharge, the Complainant had filed a claim for Rs.88298/- & Rs. 71500/-. The claim was rejected by the Respondent under clause No. 2.3.1 "Procedures/Treatments usually done in Out Patient are not payable under the policy even if converted as In-Patient in the hospital for more than 24 hours.

The Respondent had stated in his letter dated 04/08/2015 & 22/06/2015 addressed to the Complainant that "as per the scope of the policy for treating the Sub retinal hemorrhage in both Eyes, the injection drug of Lucentis Surgery Laser surgery and administration of other related drugs is is an OPD treatment In the subject case, the doctor had advised hospitalization and the treatment had been carried out accordingly. The insurer cannot arbitrarily decide that this is necessarily an OPD protocol. There are any numbers of instances where injection likes Avastin, Lucentis etc. are given after admission as inpatients.

Since the patient was admitted as per Doctors directive, the Co. has to allow the claim on a non standard basis.

Therefore the complaint is allowed. The Respondent is hereby directed to pay Rs.1,25,000/- to the Complainant.

Date of Award 10.03.2016

Complaint Ref No.AHD-G-051-1516-0689

The Complainant alongwith his family members was insured under the Hospitalization Benefit Policy issued by the United Insurance Company Ltd.The Daughter of the Complainant was hospitalized to Synergy Neonatal & Pediatric Centre from 19.07.2015 to 23.07.2015 for High Grade Fever. Against the claim for Rs. 15298/- the company had settled Rs 11799/- citing clause.No. 1.2 C. Aggrieved by the decision of the TPA, the

complainant represented stating that Co. had wrongly deducted Amount Rs.3500/- The Company had disallowed the balance amount under clause of 1.2 C. Distressed by their decision he had approached the Forum for redressal of his grievance.

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". The Respondent had failed to verify with the service provider regarding reasonable charges and fees being collected by them. The TPA quoted condition 1.2 C of the policy

In view of the foregoing the complaint is admitted.

Date of Award:10.03.2016

Complaint No. AHD-G-50-1516-0672

The Complainant was admitted to ZYDUS Hospital, Ahmadabad from 30.04.2015 to 01.05.2015 with the history of Fever with Chills and Rigor He was diagnosed with Right Obstructive Pyonephrosis & operated for 30.04.2015 Cystoscopy + Rt. RGP & DJ Stenting. After his discharge from the hospital, he had filed a claim for Rs 52514 /- which was repudiated by the Respondent under clause No. 4.3 on the ground that the Surgery

of Genito-urinary system is not payable for 2 Years from inception of the Policy.

The repudiation of the claim by treating the procedure undergone by the Insured under the head "Surgery of genito Urinary System" is not Fully supported by any cogent medical evidence notwithstanding the medical opinion of Dr. Dinesh D. Patel. The matter is not completely free from doubt as to whether the procedure is surgery of genital Urinal Tract or not. Hence the claim is admitted on a non Standard Basis and Co. is directed to pay 50 % of the claim

In view of the forgoing the claim is admissible

Date of Award:`14.03.2016

Complaint No. AHD-G-048-1516-0780

The Complainant was admitted to Vasan eye care twice viz. 25.06.2015 & 27.06.2015 for the cataract surgery of both Eyes On discharge from the hospital the Complainant had filed two claims for Rs 42861/- & Rs.42304/- The Respondent had deducted Rs. 21861/- & Rs.21304/- respectively from both the claims as per PPN Network Hospital package on Cataract Surgery

The Respondent had failed to prove any justification in support of deduction made from the claim amount. The hospital irrespective of cashless or reimbursement mode of payment should not have charged more than the pre-fixed amount. In the subject claim, the Respondent instead of questioning the PPN hospital on the charges collected, contravening the PPN agreement, has preferred to deduct the claim amount.

The Insurer's practice of making deduction from the claim instead of questioning the PPN Hospital is unethical and against the interests of the Insured. At the same time Complaint should have got it confirmed from the Insurer as to why the Hospital was charging more than the PPN Hospital pricing. It would therefore meet the ends of justice if the difference is borne by the Insurer & the Insured in the ratio of 50:50.

The complaint was admitted.

Date:14.03.2016

Complaint No. AHD-G-048-1516-0809

The Insured was admitted to Dipti Eye Hospital on 28.07.2015 for Rt. eye cataract surgery. On discharge from the hospital the Complainant filed a claim for Rs. 34939/-. The Respondent deducted Rs. 10939/- from the claim under Reasonable & Customary clause.

The insured was not provided with the copy of the list of hospitals under PPN and Terms and Conditions of the policy. In absence of PPN & the Terms Conditions. The Insured did not have the Knowledge of the PPN hospitals & the Cost of the Cataract surgery.

In view of the forgoing, the complaint is admitted.

Date:14.03.2016

Complaint No. AHD-G-048-1516-0837

The Complainant's 13 years old Son Himanshu was admitted to Ankur Institute of Child Health from 09-10-15 to 20-10-15 for the treatment of Vomiting, Fever & diagnosed as Hyperammonemia, Dengue with warning sign I a patient of Urea Cycle disorder. On discharge from the hospital, the Complainant had filed a claim for Rs. 214098/- The Respondent had repudiated the claim under clause No. 4.4.16 (Genetic Disorder The boy was treated for multiple diseases like dengue, Epilepticas, Hyperammonemia. So the treatment was not only for Urea Cycle Disorder. The Respondent had claimed that the treatment was for Urea Cycle disorder and did not take note of dengue. The Complaint is admitted

Date of Award:15.03.2016

AHD-G-049-1516-0722

The Complainant was admitted to Add Care Hospital on 25.11.2015 to 26.11.2015 and operated for Lt. Inguinal Hernia. After the discharge, the Complainant had filed a claim for Rs. 50122/- & the Respondent had paid the claim for Rs. 48154/- after disallowed the amount of Rs. 1968/- with reasons that Amount payable not justified and amount paid for Gloves,Betadin,Sterilium,Gause not payable.

As per IRDA circular IRDA/HLT/CIR/036/02/2013 dated 20.02.2013 regarding Guidelines on standardization in Health Insurance and annexure IV, in this annexure

clearly mentioned that amount charged by the hospital is payable for the Razor, Betadin/Hydrogen Peroxide/ Spirit/Disinfectants/Listerine/Antiseptic mouth wash etc. were prescribed for the patient.
In the above cited case the Respondent had approved the claim amount Rs. 48154/- after deduction the amount (Rs50122-Rs.1968) of the hospital as per policy terms & conditions

the Forum admitted the complaint.

Date of Award:15.03.2016

Complaint No. AHD-G-049-1516-0839

The Complainant's Son Master Ayush was admitted to Chir Ayu Cildren hospital from 06.06.2015 to 12.06.2015 for the treatment of High grade Fever, loose motion,Vomiting. On discharge from the hospital, the Complainant had filed a claim for Rs.29451 /- The Respondent had repudiated the claim vide their letter dated 22.05.2015 under clause No. 3.13

The hospital where the Complainant's Son was treated has not covered under the definition of Hospital given as per IRDAI guideline.
The application of the Dr. Chauhan to Gujarat Pollution Control Board.showed the No. of beds as 15. Respondent had not sought clarification from the Authorities regarding the applicability of clinical establishment Act and had repudiated the claim.

In view of the above the complaint is admitted on Ex-Gratia basis

Date of Award:15.03.2016

Complaint No. AHD-G-049-1516-0814

The Complainant was admitted to Jivraj Mehta Smarak Health Foundation from 03.08.2015 to 05.08.2015 and PTCA + RCA were done. After the discharge, the Complainant had filed a Claim for Rs. 132039/-.The Respondent had paid Rs.83579/- after disallowing Rs. 48460/-

Major portion of amount deducted by the Insurer is justified. However the Respondent had made offer to settle the claim for Rs. 21,397/- (Emergency Charges Rs. 10000/- and O.T. Charges Rs. 11397/- after deduction of proportionate amount as per the room category under the Clause 3.1). The Forum allowed amount further Rs.810/-, Rs. 750/- and Rs.50/- for Consultant Visit, Consultant Charge, and RBS respectively.

In view of the above, the complaint is allowed.

Date of Award:16.03.2016

Complaint No. AHD-G-050-1516-0729

The Complainant was admitted to SALBY Hospital from 06.05.2015 to 17.05.2015 for the treatment of Temperoperital Hemorrhage. After discharge from the hospital, the Complainant had filed a claim for Rs. 251446/-. The Respondent had repudiated the claim under exclusion clause No. 4.2 (xvii) of the policy, waiting period 2 years for HTN, as the Complainant suffered from HTN since 2012 the year which was pre existing disease and it was excluded from the policy.

Respondent had shown a copy of the terms and conditions of the policy. Clause No. 4.2 excluded any pre-existing disease upto first 3 years, and clause No.4.2 (xvii) excluded reimbursement on expenses incurred on treatment of HTN for 2 year if contracted and or manifested during currency of the policy.

Discharge Summary of the Hospital showed the Patient as a k/c/o Diabetes Mellitus, Hypertension, and Ischemic Heart Disease. Mediclaim Medical Report showed previous history of disease of the patient as Engeoplasty, Diabetes and Blood Presser.

Medical literature states that if the HTN was controlled and treated it was not a risk factor at all. In the subject case the complainant was unable to submit any documents to prove that the HTN was the controlled with medicines.

In the proposal form in reply to past history on diseases like High B.P ,Heart Disease etc. it was answered in negative as " No "

The insured had a policy with Oriental Insurance Co. since 14.02.2012 while date of admission to Hospital was on 06.05.2015 i.e. after 3 years and 3 Month.

The complainant had not submitted copies of policy; portability forms filed up by him requesting the Respondent for continuity of the policy from the previous insurer.

In absence of the continuity the Respondent was not bound to extend the continuity Benefit Medical papers from Google search shows that 80% of cerebral hemorrhage patient had history of High Blood pressure.

In view of the above, the complaint fails to succeed.

Date of Award:16.03.2016

Complaint No. AHD-G-050-1516-0732

The Complainant's Son was admitted to Synergy Eye & ENT hospital from 08.05.2015 to 09.05.2015 for Chronic Tonsillitis with Adenoiditis. On discharge from the hospital, the Complainant had filed a claim for Rs.64009/-. The Respondent had deducted Rs. 30000/- under customary & reasonable charges and settled the balance claim amount.

The Respondent had disallowed Rs. 30000/- out the total claim of Rs. 64009/- from hospital bill, Rs. 30000/- was deducted from Surgeon Fees citing customary & reasonable charges that any other hospitals charged Rs. 20000/-in the same geographical area .

The Respondent had failed to prove any justification in support of the deduction made from the claim amount(Surgeon fees) Under the circumstances the deduction was

arbitrary. The Complainant was entitled for relief, In view of the above the complaint is admitted

The Respondent is directed to pay Rs. 30000/- to the Insured, as full and final settlement of the claim

Date of Award:17.03.2016

Complaint No. AHD-G-0490-1516-0853

The Complainant was admitted to Care & Cure Hospital from 20.05.15 to 21.05.15 for Laparoscopic Cystectomy. After discharge from the hospital, the Complainant had filed a claim for Rs. 33540/-/-. The Respondent had repudiated the claim under exclusion clause No. 4.3.1 of the policy, waiting period 2 years for Cyst.The Respondent had showed a copy of the terms and conditions of the policy clause No. 4.3.1 excluding reimbursement on expenses incurred on treatment of Cyst until 48 months of continuous coverage of such Insured person had elapsed, from date of inception of her first policy.Discharge Summary of the Hospital showed Patient Mrs. Priyanka was operated for Rt.side Ovarian Cyst .She had lower abdominal pain since 2 months and USG showed Rt.sided Ovarian cyst P/O Chocolate Cyst.The Respondent had correctly repudiated the claim under Cl. No. 4.3.1 as she was not covered continuously for two years.

The complaint fails to succeed.

Date of Award:15.03.2016

Complaint AHD-G-049-1516-0847

MS Harsha was admitted to Sanjivani hospital from 15.08.2015 to 21.08.2015 for the treatment of Acute Pancriatitis On discharge from the hospital the Complainant had filed a claim for Rs.20177/-. The Respondent had paid Rs. 15607

Withdrawn by Complainant.

Mediclaim

1. CASE OF MR AMIT KUMAR SHARMA VS APOLLO MUNICH HEALTH INSURANCE CO. LTD.

(Award dated : 06.05.2016)

- The daughter of the complainant was admitted in the hospital for Steroid resistant nephritic syndrome (SRNS)/B/L IJV Thrombosis with RA Clot/Ischemic stroke/left hemiparesis and discharged from the Hospital on 05/05/2015. The complainant lodged a claim of Rs. 17,834/- but the same was repudiated by the Company vide their letter dated 26.06.2015 on the ground of Non-disclosure of material facts at the time of issuing the policy.

- The complainant argued that the main purpose to buy the policy was health of his daughter who was suffering from nephritic syndrome since she was 1 ½ years old. The complainant was informed by the representative of the company that the disease of his daughter will be covered after three years from the date of purchasing the policy. The complainant and his family were continuously insured with the company for more than 4 years. As he had no intention of hiding the disease of his daughter and it was the main reason for buying the policy, the claim should be paid. The complainant also sought relief against cancellation of his policy of all four family members.

- The insurance company rejected the claim on the basis of the discharge summary which showed that the patient was a known case of SRNS since age of 1.5 years and Renal disease and this medical history was not revealed in the proposal form while taking the policy, thus resulting in non-disclosure of material facts. The action taken by the company for repudiation of the claim on the ground of non-disclosure of pre-existing disease is justified. However since the complainant does not appear to be familiar with the T&C of the policy and was misguided by the agent of the insurance company into purchasing the policy when he had voluntarily acknowledged that his daughter was a k/c/o SNRS hence some relief may be provided to the complainant in the form of refund of premium for the current year by the insurance company.

2. CASE OF MR HARINDER JARI VS MAX BUPA HEALTH INSURANCE CO. LTD.

(Award dated : 30.03.2016)

- The complainant was hospitalized for Coronary Artery Disease, Double vessel disease from 6.11.2013 to 13.11.2013. The claim was repudiated by the Insurance Company vide their letter dated 23.01.2014 on the ground of ***"Non-disclosure material facts. K/C/o Hernia 4-5 years not disclosed at the time of policy inception."***

- As per complainant, he had taken Health Insurance Policy from Max Bupa on 14.08.2012 and at the time of issuing policy, medical test e.g. blood, urine & complete physical examination was conducted by the company. At that time hernia was in an initial stage and as he did not have any problem due to the same, the same was not disclosed in the proposal form due to oversight. In Nov. 2013 when the complainant was hospitalized and lodged a claim with the company for reimbursement of medical expenses, and investigator from the insurance company got a questioner form filled by the complainant wherein he disclosed that he had Hernia since 4 to 5 years.

- On the basis of the investigation and questioner filled by the complainant the insurance company rejected the claim on the ground of non-disclosure of material facts i.e. Hernia was not disclosed in the proposal form.

- As per the complainant he had not provided details about hernia in the proposal form due to oversight and the same was unintentional. That he had no intention to conceal the fact of hernia as he had disclosed the same in the questioner at the time of inquiry. On going through the documents and oral submissions it was observed that there is no direct relation between the two disease hernia and Coronary Artery Disease, Double vessel disease for which he was hospitalized and undergone OPCABG. The insurance company had conducted medical test of the insured at the time of proposal and had issued the policy accordingly. In view of the above the decision of repudiation of claim is not justified. Accordingly an award is passed in favor of the complainant.

3. CASE OF MRS. LAXMI SINGH V/S STAR HEALTH GEN. INS. CO. LTD.

(Award dated : 16.03.2016)

- The complainant had taken a Mediclaim Policy No. **P/161212/01/2015/003500** for the period 08-12-2014 to 07-12-2015 for a basic floater sum insured of Rs. 200000/- to cover herself and her husband Sri Vijay Singh. Sri Vijay Singh was hospitalized at Tulsi Hospital, Meerut on 15/06/2015 and discharged on 21/06/2015. He was diagnosed with Chronic Osteomyelitis Right Femur, deformity right leg and COPD (Chronic Obstructive Pulmonary Disease). The Insurance Company rejected the cashless request of the insured and advised for submission of claim documents for reimbursement. The complainant submitted the documents on 4th July, 2015 for reimbursement but the Insurance Company rejected the claim on 21/07/2015 on the ground of misrepresentation / non – disclosure of material facts quoting violation of policy condition No. 7 which states "***that if there is any misrepresentation/non-disclosure of material facts whether by the insured person or any other person acting on his behalf, the company is not liable to make any payment in respect of any claim".***

- The complainant stated that ***as per policy bond paper column No. 2.0 and definition mentioned regarding pre-existing condition is somewhat means "any condition, ailment or injury or related condition(s) for which the insured person had signs or symptoms and/or was diagnosed and / or received medical advice/treatment within 48 months prior to the person's first policy with any Indian insurer".***

- The complainant further stated that her husband Mr. Vijay Singh was having some problem in his leg in the year 2004 and got operated after investigation and was treated. The complainant contended that they were having the insurance policy since 2010 and as per policy terms and conditions, a disease which is diagnosed within 48 months prior to the insured person's first policy, is considered as pre-existing disease and in that case they were legally entitled to receive entire claim amount.

- The insurance company rejected the claim on the ground that the patient was known case of Chronic Osteomyelitis and Ankylosis right hip since 2004 and he had not disclosed this in the proposal form when the policy was first taken in the year 2010. This amounted to misrepresentation/ non-disclosure of material facts. The complainant reiterated that the condition of pre-existing disease does not apply to treatment taken more than 48 months prior to inception of policy. Further the claim had also been lodged after more than 4 ½ years of inception of the policy.

- After hearing both the sides and based on the documents it is observed that the contention of the complainant is justified and they are entitled for reimbursement of the insurance claim.

4. CASE OF MRS. SEEMA BHATTER V/ S NEW INDIA ASSURANCE CO. LTD.

(Award dated : 02.03.2016)

- The complainant fell down from stairs on 07th April, 2015. She was hospitalized from 8.4.2015 to 10.4.2015. The patient was diagnosed with pain in B/L knee and treated with medicine and physiotherapy. The Insurance Company / TPA rejected the claim on the ground that the patient was treated with injection biovisc only during the hospitalization and the treatment given could be managed on OPD basis. The complainant contends that on the advice of doctor she was hospitalized and a doctor of a Government Hospital never asks for admission if treatment is possible in OPD. She has submitted a certificate from the treating doctor confirming her hospitalization and line of treatment

- The insurance company rejected her claim stating that it was found she was treated with injection BIOVISC which is used for Arthritis and it was not a treatment for current ailment. Hence current treatment neither falls under the definition of hospitalization nor can be considerd under day care list and claim was rejected as per clause 2.11 of Mediclaim Policy 2012 which states " Procedure/Treatment usually done in outpatient department are not payable under the policy even if converted as an in-patient in the hospital for more than 24 hours."

- It is found that the argument of insurance company stating that the injection BIOVISC is used for Arthritis case may be right but at the same time the discharge summary of hospital cannot be overlooked wherein it is clearly written that the Patient had a fall from stairs on 07-04-2015 and the treatment was given as per advice of doctor. Hence, taking into consideration the above facts, I hold that the insurance company is not justified in rejecting the claim.

1. **Vishnu Jangid v/s New India Assurance Co.**

The Complainant had Medi-claim Policy w.e.f.26.01.14 to 25.01.15 for SI Rs.2 Lacs. Policy first incepted from 26.01.11, so, the current policy was running into 4th year. Claimant preferred claim for hospitalization due to Aortic Dissection during May 2014 which was repudiated under exclusion 4.1 of the policy, citing that the complainant was having HTN since 3-4 years and the aortic dissection is related to hypertension. They further stated that pre- existing could be covered only after completion of 4 years.

During hearing it was observed that there was no evidence that the patient was suffering from hypertension prior to 26.01.11. Further there was no evidence that Acute Aortic dissection was due to hypertension.

It was awarded that the Company shall consider the claim up to SI Rs.2 Lacs as per T & C of the policy.

1. **PrabhuDyal v/s Star Health & Allied Insurance Co.**

The complainant preferred a claim for reimbursement of medical expenses of Rs.1,17.000/- forhospitalization at SAAOL Heart Center, Jaipur for treatment of TVD underMedi-claim Insurance Policy. The claim was repudiated citing that the patient had undergone Enhanced External Counter Pulsation (EECP) and Bio-Chemical Angioplasty (BCA) which was non- conventional and non proventherapy by the Cardiologist Society and hence non payable under T & C of the policy. Other ground of repudiation was that it was a day care process not listed in the Policy.

During hearing it emerged that the treatment is being given at SAAOL Heart Center by Doctors trained from AIIMS, Delhi. The treatment is cheaper &

saferas compared to conventional angioplasty. It is in no way a day care process and require hospital sittings for 40-45 dayswith medicines & special equipment. Scores of patient are successfully availing this treatment all over India.

An award was passed for Rs.1,17,646/-.

1. **AbhishekKhandelwal v/s Oriental Insurance Co.**

The Complainant obtained a Medi-claim policy from the respondent company for the period 25.03.2011 to 24.03.2012 for SI Rs. 4 Lac. He lodged a claim for his mother for Rs.1,77,324/- but the respondent company paid only Rs.90,000/-.

The insurer in its SCN submitted that the deductions were made by respondent company as per terms & conditions of the policy.

During hearing the respondent co. argued that the payment was made on the basis of S.I.of Rs.1 lac which existed four years back, as the disease was pre-existing. The treatment in this case was for 'Sleep apnea' and 'Pneumonia'. The company claimed that 'Sleep apnea' was due to 'Thyroid' problem, which was pre-existing. The company's SCN could not bring out any connection between 'Sleep apnea' and 'Thyroid'. Even pre-existence of 'Thyroid' problem was not established.

In view of these facts and circumstances, it was awarded that the company should settle the claim of the complainant on the basis of the current SI Rs.4 Lacs.

Case No.: CHD-G-020-1516-0695

In the matter of Mr. Kishore Kumar Sethi vs. ICICI Lombard General Insurance Co. Ltd.

ORDER DATED 14.03.2016 (Mediclaim)

Facts: On 03.12.2015 Mr Kishore Kumar Sethi filed a complaint against ICICI Lombard General Inasurance Company Limited about repudiation of mediclaim in respect of the treatment of his wife Mrs Rimi Sethi who was suffering from Pancreatic Cancer. She was insured under Health Care Plus (Top Up) Policy No. 4113i/XOL/86429025/00/000. The reason for repudiation was stated that the insured was suffering from hypertension and diabetes at the time of inception of the cover and the same was not disclosed in the proposal. Thus the claim was denied on the basis of non-disclosures of material facts. This was first year policy with ICICI Lombard.

FINDINGS: The Complainant was regularly insured for the last 8-9 years with Apollo Munich for a sum insured of rupees four lacs. Top Up cover for rupees ten lacs with an excess of 4 lacs was obtained from ICICI Lombard for the period from 09.01.2014 to 08.01.2015. The Insurer maintained that the insured did not disclose the material facts that she was suffering from hypertension and diabetes at the time of taking the insurance cover. Therefore, the claim was correctly denied and policy cancelled. On the other hand the insured submitted that full facts were disclosed at the time of taking the cover. Moreover there is no co-relation with the hypertension/ diabetes with the pancreatic cancer. No Policy documents were received by him.

DECISION: It was a case where the insured was taking regular policy from Apollo Munich for the las 8-10 years and took Health Care Plus cover (Top up) from ICICI Lombard for 10 lacs for the period from 9.01.2014 to 08.01.2015 (with an excess of 4 lacs). Insured was diagnosed and treated of Adenocarcinoma of head pancreas in Fortis Mohali/Lilawati Hospital Mumbai in November 2014. Claim has been rejected and policy cancelled on the basis of non disclosures of hypertension/ diabetes in the proposal form. Complainant states nothing was hidden. Moreover there is no relation between cancer and hypertension. Policy documents were also not received by him. Insurer insisted that policy kit was sent to him through courier. Insurer were asked to furnish the copy of forwarding letter etc through which the policy was sent. But despite giving sufficient time and also reminding them on phone, no proof of policy having been sent was submitted to this office. In the absence of this adverse inference was drawn against the insurer and it was held that policy kit was not sent to complaint. Therefore, denial of claim and cancellation of policy under the condition of policy which never reached the insured was held not in order.Therefore, insurer was directed to settle the claim as per terms and conditions of the policy and also restore the policy.

Case No: CHD-G-051-1516-0345

In the matter of Mr Mukesh Kumar Vs United India General Insurance Co Ltd

ORDER DATED: 30.03.2016 **(Mediclaim)**

FACTS: The complainant was insured with United India under Family Floater Medical Policy No. 2006032814P111200618 for the period from 30.03.2015 to 29.03.2016 for a sum insured of Rs.2.50 lakh. On 09.07.2015 he lodged the complaint with this office that his claim has been short paid. He was admitted in the hospital for treatment of knee pain. Hospital raised a bill for Rs.74, 043/- The Insurance Company settled it for Rs.27, 031/- . He further incurred Rs. 5, 700/- and 600/- on MRI and Doctor's fee. The unpaid amount of claim was Rs.53, 312/-.

FINDINGS: It was found that the Complainant had taken Family Floater Health Insurance Policy for the period from 30.03.2012 to 29.03.2013 for a sum insured of Rupees one lac, which was renewed for the period from 30.03.2013 to 29.03.2014. It was again renewed for the enhanced sum insured of Rs.2.50 lacs for the period from 30.03.2014 to 29.03.2015 and further renewed for the period from 30.03.2015 to 29.03.2016. The Insured was admitted in the hospital on 28.05.2015. While submitting a request for cashless authorization, the hospital stated that the Insured suffered injuries about one and a half years ago. Thus, it means that it was during the policy period of 30.03.2013 to 29.03.2014 when he had fallen and suffered knee injuries, which was directly linked with the current hospitalization. The sum insured under that policy was Rupees one lac only.

DECISION: Since the current hospitalization was directly in consequence of the injuries suffered by the insured when the sum insured was only one lakh and therefore, the decision of the Insurer to limit the liability to the extent of sum insured at the relevant time was found in order and complaint was dismissed.