MEDI CLAIM

In The Matter of:-Sh. Mansaji B. Prajapati v/s Star Health And Allied Insurance Co. Ltd.

Complaint REF:No. AHD-G-044-1617-0079

Award Date: 28.06.2016 **Policy No: P/171014/01/2015/003519**

The Complainant was admitted to Bodyline hospital from 21.09.2015 to 22.09.2015 for the surgery of Lt. big lower ureteric stone & Rt. Two renal stones. On discharge from the hospital the Complainant had filed a claim for Rs.50556 /-. (Rs. 35000/- claim was approved as cashless).The Respondent has repudiated the claim vide their letter dated 30.11.2015 stating that as per policy condition maximum claim amount was approved as cashless.

Policy condition schedule of benefits clearly mentioned that limit of company's liability during one policy period i.e.(09.10.2014 to 08.10.2015) for major surgeries was maximum Rs. 35000/- reimbursable but there is no clause in policy schedule which stated that pre and post Medical expenses are also included in the major surgery limit. On the other hand, there is separate clause according to which pre & post hospitalisation are also payable. It clearly shows that pre & post hospitalisation expenses are payable in addition to fixed sum payable on a/c of major surgeries.

In the subject case the Respondent has settled maximum Rs. 35000/- as cashless benefit. In view of the terms and condition of the policy Respondent has failed to prove that pre & post expenses are included in the limit.

In view of the above the complaint deduction made by Respondent towards pre & post Medical expenses is wrong.. **, the Respondent is hereby directed to pay a sum of Rs. 14,990/- in addition to the amount already paid to the Complainant.**

In The Matter Of:- Sh. Mahendra J. Dave V/s Respondent: - The National Insurance Co.

Complaint No. AHD-G-048-1617-0082

Award Date: 27.06.2016 **Policy No: 301000/48/14/85/00004852**

The Complainant was covered under Mediclaim Policy issued by The National Insurance Company Ltd. The Complainant was hospitalized at Malavia Eye Hospital on 22.10.2015 and

29.10.2015 for Left Eye and Right Eye Cataract surgeries with Intraocular Lens (IOL). Against the claim of Rs. 48,000/-, the Respondent had settled the claim for Rs. 36,000/- and the balance amount for Rs.12,000/- was deducted citing reasonable clause. Unsatisfied with decision of the Respondent the Insured had approached the Forum for redressal of his grievance and settlement of the claim.

It is seen that the deductions done by the TPA towards other charges are liable but additional Rs: 3850*2 disallow as under usual & customary for cataract Max payable is not allowable. It is also seen that from the two hospitalizations for the same surgery the deductions are same. For eg. Room rent as per 1.2 (a) he is eligible for 1% of Sum Insured i.e. Rs.1500/-. In both surgery the Complainant was reimbursed Rs. 200/- was paid stating that it is a Day care procedure.. As per IRDA circular dated 20.02.2013 on "standardization in health insurance" Reasonable charges means the "charges for services or supplied which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness/injury". Further, on deductions under reasonable and customary expenses, the Respondent had not produced rate charts of other hospitals in and around the geographical area where the Complainant was hospitalized.".The Respondent's stated that Insurance Co. have tie-up with hospital at Ahmedabad city under preferred provider network, and also stated that in Bhavnagar Akshardeep Eye Hospital and Clear Eye Hospital Pvt. Ltd. are also agree for Rs:18,000/- per Eye cataract surgery. The Respondent had refused reimbursement on a bill for Rs. 6000/- expense incurred during the hospitalization for both eye cataract surgery stating that the payment was not possible to pay other charges of Hospital bill was not given. The Complainant had submitted a copy of this bill along with other papers to the Forum.In view of the foregoing, the complainant is entitled for relief. T**he Respondent is hereby directed to pay a sum of Rs. 7,700/- in addition to the amount already paid to the Complainant.**

In The Matter of :-Mr. Mahendra P. Vyas Vs The National Insurance Company Ltd.

Complaint No. AHD-G-048-1617-0168

Award Date: 27.06.2016 **Policy No: 302100/48/15/85/00000233**

The Complainant along with his wife was insured under Mediclaim Policy issued by the National Insurance Company Ltd. Smt Niruben Vyas, wife of the Complainant was hospitalized at GuruKrupa Hospital from 09.06.2015 to 10.06.2015. She was diagnosed with Acute infract in

Left fronto temporo parietal lobe. She was then later admitted to V.S.Hospital Ahmedabad. The Insurer rejected her claim under clause Nos. 4.1 of the mediclaim policy. Not satisfied with decision of the Respondent the Insured had approached the Forum for redressal of his grievance and settlement of the claim.

The clause 4.1 states as "No claim will be payable under this Policy for the following: Treatment of any Pre-existing condition/diseases until 36 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" . The Forum had weighed the nexus between the Lymphoma and CVA. The Dr's. certificate also indicated the nexus as "Infract is a necroed Segment resulted from arterial supply blockage here middle cerebral artery was blocked due to Lymphoma tumor infiltration". The reason for repudiation of the claim was found to be valid and it is justified in the light of clause 4.1 (Pre-exiting disease). **The complaint stands dismissed**

Mr. Jayendra P. Shah Vs The New India Assurance Company Ltd.
Complaint No. AHD-G-49-1617-0196

Award Date: 01.07.2016 **Policy No: 220300/34/14/01/00005630**

The Complainant alongwith his family members was insured under the Mediclaim Policy 2007 issued by the New India Assurance Company Ltd. He had approached the Forum against non-settlement of his hospitalisation claim for the period from 23.09.2015 to 26.09.2015 at Nimish Nurshing Home for Acute Gastritis & Viral fever. The Company had rejected the claim stating clause 3.13 of the mediclaim policy.

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 having been attached to the Schedule. The criterion of minimum number of in-patient beds was not informed to the Complainant.

In view of the above the complaint is admitted. **The Respondent is hereby directed to pay Rs: 11,047/- to the Complainant.**

In Case of Mr. Hashmukh V. Patel Vs The Oriental Insurance Co. Ltd

Complaint Ref No.AHD-G-051-1617-0202

Award Date: 01.07.2016 **Policy No: 141102/48/2016/1965**

The Complainant along with his family members was insured under Individual Medi Claim Policy issued by the Oriental Insurance Company Ltd. The Complainant, was hospitalized at Bhatia

Hospitals, Mumbai from 07.09.2015 to 09.09.2015 for right elbow Synovitis and further management. Against a claim for Rs. 1,72,146/-, the Insurer had paid Rs: 75,000/- citing clause No. 4.3 and clause No.7. As per Clause 4.3 certain diseases are covered after waiting period mentioned against them. In this case " Non infective Arthritis is covered after 2 years. Clause-7 is on restriction on enhance sum insured on renewed. It is applicable on clause 4.1 (Pre-Existing), 4.2 (Waiting period 30 days) & 4.3. If sum insured on renewed, then clause 4.1,4.2 & 4.3 shall apply in relation to enhanced sum assured. According to the insurer " Synovitis" is a type of Non infective Arthritis and it is pre existing disease. So the Insurer has applied clause 7 and restricted the sum insured at Rs: 75,000/-.

The Respondent had partialy repudiated the claim without seeking any clarification of synovitis is infective or non infective Arthritis. As per the terms conditions of the policy, the decision of the Respondent to Partially repudiate the claim was not in order. The insurer has neither been able to prove that Synovitis/Arthritis was Pre-exiting nor did it have any proof that it was non-infective Arthritis. The Respondent fails to succeed. T**he Respondent is hereby directed to pay Rs: 97,147/- to the insured, as addition as settlement of claim.**

In The Case of:-Sh. Naresh L. Shah v/s The United India Insurance Co. Ltd.

Complaint REF:No. AHD-G-051-1617-0203

Award Date: 01.07.2016 Policy No:06200/28/14/P/11/1680089

The Complainant's was admitted to 3rd Eye Clinic, Ahmedabad on 23.12.2015 for the treatment of decreased vision in the left eye. He was diagnosed with fresh subretinal haemorrhage suggestive of recurrence of ARMD. On discharge from the hospital, the Complainant had filed a claim for Rs. 12,390/- with the Insurer. The Respondent disallowed the claim of Rs.12,390/- stating as day care treatment and no surgery was involved and not required 24 hrs Hospitalisation.

In the subject case, the doctor had advised intravitreal injection under sterile conditions which has been carried out. Clause No.2 states "The treatment is undertaken under general or local Anesthesia in a Hospital/Day care center is less than 24 hours". Moreover, the TPA has recommended for repudiation of the claim on the basis of their internal circular of insurer vide: UIIC ARO/HEALTH/2009/3151. This is not proper, A claim can not be repudiated unilaterally on the basis internal modification unless it is made a part & parcel of the terms & conditions of the policy. The Complaint is therefore allowed. **The Respondent is hereby directed to pay Rs. 12,390/- to the Insured, as full and final settlement of the claim.**

In Ths Case of Mr. Sunil J. Kayasth Vs. The New India Assurance Co. Ltd

Complaint Ref No.AHD-G-049-1617-0278

Award Date: 23.08.2016 **Policy No 23030034120300001136**

The Complainant along with his family members was insured under Family Floater Mediclaim Policy issued by The New India Assurance Co. Ltd. The Insured was covered under the policy from the year 2000. The Complainant was admitted to Global Hospital & Research Center-Mumbai from 27.08.2013 to 31.08.2013 for the treatment of Revision surgery and placement of Dental Implement. The Company had rejected the claim under clause No.4.4.5 (All types of Dental treatments except arising out of an accident) of policy terms and conditions. Aggrieved by the decision, the complainant had approached the Forum for redressal of his grievance.

The Dental Implant was necessary to restore his ability to swallow food which was affecting his quality of life and nutrition and subject surgery was not a cosmetic surgery.As per policy condition clause 4.4.5 expenses arising out of all types of Dental treatments except arising out of an accident were not reimbursable.The complainant's lower front jaw and a teeth were surgically removed to treat his mouth cancer. The reconstruction job could not be carried out as the doctor then felt that his jow bone was too thin for the reconstruction. He had been consulting various doctors for the reconstruction since then. The Representative during the hearing had agreed that the claim on reconstruction of the jaws and teeth would have been reimbursed had it been done at the time of surgery for removal of the cancer in his mouth. The insured had difficulty in swallowing food and had been staying indoor due to the cut open jaw and teeth. The clause restrains dental treatment. Understandably, the dental treatment included damaged tooth, cavities, worn tooth enamel, fillings, gum diseases, fractured teeth, exposed roots, root canalling, teeth whitening, tooth erosion, cosmetic dental work etc. In the subject treatment the surgical removal of the jaw and the teeth was due to cancer and it was as good as an accident. The complainant, even after the subject surgery, had not regained his original or near original face or appearance. It appeared as if he had met with an accident and had the surgery done. The usual dental surgeries do not disfigure the face of the patient. The company had struck to the exclusion clause mechanically. In view of the foregoing, the complainant is entitled for relief. **The Respondent is hereby directed to pay a sum of Rs. 3,29,135/- to the Complainant as settlement of claim.**

In The Case of Mr. Vinod Goyal Vs The New India Insurance Co. Ltd

Complaint Ref No.AHD-G-049-1617-0309

Award Date: 23.08.2016 Policy No 22150034142500000089

The Complainant was insured for S. I. of Rs:350000/- under New mediclaim-2012 issued by The New India Insurance Company Ltd. The complainant was admitted to Nistha Retina Center on 18/08/2014 (one day) for treatment of Sublevel Neovascular Membrane in Right Eye and Lucentis Injection was administered for three times (on 18/08/2014, 18/09/2014 and 17/10/2014) within 60 days from the discharge from the Hospital. When a claim for Rs. 69864/- was preferred, the Company rejected the claim under clause 2.16.1 of the mediclaim policy. Aggrieved by the decision, the complainant approached the Forum for redressal of his grievance.

The policy did not specifically exclude reimbursement on the treatment for injection Avastin/Lucentis/Macugen. Internal circular, if not in corporate in policy, can not be basis for repudiation of claim. The respondent can not repudiate any claim on the basis of condition not mentioned in terms & condition of policy. In view of this the complaint was admitted. **, the Respondent is hereby directed to pay Rs: 64,865/- to the insured.**

In The Case of Mr. Sagar C.Gosalia Vs. The Oriental Insurance Co. Ltd

Complaint Ref No.AHD-G-050-1617-0235-236

Award Date: 22.08.2016 Policy No 141200/48/2015/1316

The Complainant's wife, her dependent parents and her son were insured under Happy Family Floater Policy issued by the Oriental Insurance Co. Ltd. The Insured was insured under the policy from 12/04/2011. The Insured was admitted to Radhe Hospital on 03/02/2015. The Company had rejected the claim under clause 4 (Exclusion 4.1- Pre-existing Health condition) of policy terms and conditions. Aggrieved by the decision, the complainant had approached the Forum for redressal of his grievance.

The policy had not run and completed four years for the Insured to avail the benefit beyond the exclusion clause of the policy. The Clause No. 4.1 excluded reimbursement on claim arising out of pre-existing disease for four years. The patient died due to " Terminal cardio respiratory arrest with acute on chronic renal failure in known case of I.H.D/L V H/ Hypertension

PVD". The exclusion condition on pre-existing disease included disease like renal, Ichemia-HBP, etc. The Insured's claim would have been reimbursed had the subject medical treatment been taken after two more months. However, the policy clause excluded the reimbursement of medical expenses in the subject ailments for 4 years. The company has correctly applied the pre-existing clause and rejected the claim. In view of the above, the compliant failed to succeed.

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.

Complainant: - Sh. Rakesh V. Patel V/s Respondent: - The Oriental Insurance Co.

Complaint No. AHD-G-050-1617-0251

Award Date: 22.08.2016 Policy No 143600/48/2016/1818

The Complainant alongwith his family was insured with Happy Family Floater Policy issued by the Oriental Insurance Company Ltd. The Complainant's mother Smt. Manjulaben was hospitalized at Phaco Emulsification & Laser Center Ahmedabad on 21.12.2015 for Left Eye Cataract surgery with Intraocular Lens (IOL).Against a claim of Rs. 45690/-, the Respondent had settled the claim for Rs. 18,000/- and the balance amount of Rs.27, 690/- was deducted citing reasonable clause. Unsatisfied with decision of the Respondent the Insured had approached the Forum for redressal of his grievance and settlement of the claim.

No exercise has been done to find out a). The cost of treatment on cataract surgery carried out in other similarly facilitated hospitals from the same area. b). The standard cost of such surgeries in the said hospital. The action of the Respondent to settle the partially was arbitrary and not as per the terms & conditions of the policy. In view of the foregoing, the complainant is entitled for relief. **The Respondent is hereby directed to pay a sum of Rs. 27,690/- in addition to the amount already paid to the Complianant.**

Case of Mr. Baldevbhai K maheriya Vs The Oriental Insurance Co. Ltd

Complaint Ref No.AHD-G-050-1617-0267

Award Date: 22.08.2016 **Policy No 141102/48/2014/10886**

The Complainant along with his wife was insured under Happy Family Floater policy issued by the Oriental Insurance Company Ltd. The Complainant, was hospitalized at Smit Hospital from 11.12.2014 to 17.12.2014 for Multiple thrombi involving descending thoracic and upper abdominal aorta with complete occlusion of left renal artery with HT and first time detected Diabetes mellitus. The complainant had lodged a claim for Rs: 65,797/-. The respondent had repudiated claim under clause-4.3 certain diseases are covered after waiting period mentioned against them. In this case " Hypertension and Diabetes" was covered after 2 years. The Insured was hospitalized for the treatment of various dieses but not for the treatment of HTN or DM or of complications of HTN or DM. HTN and DM were detected recently during the treatment of other health related complications. The rejection of the claim was incorrect. As per the terms conditions of the policy, the decision of the Respondent to repudiate the claim was not in order. The Compliant was admitted. **The Respondent is hereby directed to pay Rs: 65,797/- to the insured, as full and final settlement of claim.**

In The Case of:-Sh. Vijay M. Patel v/s Future Generali Insurance Co. Ltd.

Complaint REF:No. AHD-G-016-1617-0261

Award Date: 22.08.2016 **Policy** No **2015-V3950010-FPV**

The Complainant's car, had met with an accident on 14.11.2015. His claim on repair of his car for Rs.26,303/- was declined by the Insurer stating that the Complainant had not disclosed the earlier claim details in proposal forms at the time of purchase of the policy. The complainant had insurance policies from Future Generali India Insurance Co. Ltd. He had approached the Forum for redressal of his grievance.

The Complainant's car, had met with an accident on 14.11.2015. His claim on repair of his car for Rs.26,303/- was declined by the Insurer stating that the Complainant had not disclosed the earlier claim details in proposal forms at the time of purchase of the policy. The complainant had insurance policies from Future Generali India Insurance Co. Ltd. He had approached the Forum for redressal of his grievance.

Case of Mr. Krunal D. Vyas Vs. The Oriental Insurance Co. Ltd.

Complaint Ref. No. AHD-G-050-1617-0463

Award Date: 19.09.2016 Policy No 141100/48/2016/3219

The Complainant alongwith his family was insured with Happy Family Floater Policy issued by the Oriental Insurance Company Ltd. The Complainant's father Shri Dipakbhai N. Vyas was hospitalized at Vardan Eye Hospital, Nirmay Nagar, Ahmedabad on 13.06.2015 for Left Eye Cataract surgery with Intraocular Lens (IOL). Against a claim of Rs. 36,632/-, the Respondent had settled the claim for Rs. 23,969/- and the amount of Rs: 10,000/- from the balance of Rs.12,663/- was deducted citing reasonable clause. Unsatisfied with decision of the Respondent the Insured had approached the Forum for redressal of his grievance and settlement of the claim.

No exercise has been done to find out a). The cost of treatment on cataract surgery carried out in other similarly facilitated hospitals from the same area. b). The standard cost of such surgeries in the said hospital. The action of the Respondent to settle the partially was arbitrary and not as per the terms & conditions of the policy. The Respondent had failed to prove the unreasonableness of the fees charged by the hospital. In view of the foregoing, the complainant was entitled for relief. **As the Respondent failed to establish reasonable, valid and justifiable reason for the deductions they have made from their Insured's claim, the Respondent is hereby directed to pay a sum of Rs. 9,000/-(Rs: 10000-10% of Rs: 10000/- for co-payment) in addition to the amount already paid to the Complainant.**

Case of Mr. Mineshkumar K. Shah Vs. National Insurance Co. Ltd.

Complaint Ref No: AHD-G-048-1617-0432

Award Date: 20.09.2016 Policy No 301800/48/14/85/000/16836

The Complainant was admitted at Brahma Ayurved multi specialty Hospital from 28/09/2015 to 29/09/2015 for treatment of Acute on chronic Fissure in anal with sentinel

tag, Spasmodic Anal sphincter, Fissure fistula, Anal cystitis papillitis. The Complainant had incurred total expense of Rs.32,800/-. His claim was repudiated by the Respondent citing Policy Clause No. 4.16- the treatment was given in a combination of Ayurvedic and Allopathic treatments by an Ayurvedic Doctor but treatment other than Allopathic System of Medicine was excluded as per terms and condition of the policy.

The Representative of the Respondent had submitted Terms and Condition of the policy to the Forum which did not carry Clause No. 3.15 & 4.16 cited by the TPA in the repudiation letter. The clauses cited for rejection were nonexistent in the terms & condition of the policy. The representative also agreed with the finding. This proved the Respondent carelessness and casualness in rejecting or attending to the claim of the Insured. The repudiation letter has been signed by TPA, not by the insurer. The Respondent had not submitted the SCN giving pera wise comments on the complaint and their say in the matter. In view of the above, the compliant was admitted on its merits.T***he Respondent is hereby directed to make payment of Rs. 32,800/- to the complainant being full and final settlement of the claim.***

Case of Mr. Ramesh Nambiar Vs. The New India Insurance Co. Ltd.

Complaint Ref. No. AHD-G-049-1617-0488 & 627

Award Date: 20.09.2016 Policy No 220300/24/14/25/00006351

The Complainant along with his family members was insured under the New Mediclaim Policy-2012 issued by the New India Insurance Company Ltd. He had approached the Forum against non-settlement of claim on hospitalization of his Wife Mrs. Sujatha Nambiar. The period of hospitalization was from 31/10/2015 to 03/11/2015. at Nand Hospital, Vadodra for treatment of Dengue Fever with Thrombocytopenia.. He had incurred total expense of Rs.17943/- his claim was repudiated on 21/02/2016 by Vipul MedCorp TPA citing Policy Clause No. 2.15 – Hospital/Nursing Home (criteria of minimum beds). He had written to the insurance company and received a reply dtd. 04/04/2016 stating that the claim was not payable as per the terms and conditions of the Policy. Aggrieved by the decision of the Respondent, the Insured had approached the Forum for redressal of his grievance and settlement of the claim.

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. The hospital started having 15 beds in the hospital since opening of the hospital.The treating Doctor has given full bifurcation of beds position in the hospital. TPA investigation reports did not give correct facts on the No. of beds in the hospital. Hence, the complainant was entitled for relief. The complaint was admitted. **T*he Respondent is hereby directed to make payment of Rs. 17,943/- to the complainant being full and final settlement of the claim.***

Smt. Geetaben P Patel Vs. The New India Insurance Co. Ltd.

Complaint Ref No: AHD-G-049-1617-0531

Award Date: 07.12.2016 Policy No 23080234142500000190

The Complainant alongwith her husband and son was insured with The New India Assurance Co Ltd. The Complainant was admitted to Shreyas Ano-Rectal Hospital from 26/07/2015 to 27/07/2015 for the treatment of Laser fistulectomy with Ksharsutra ligation & barron band application under spinal anesthesia. On discharge from the hospital the Complainant had filed a claim for Rs.74060/- The Respondent had repudiated the claim vide their letter dated 03.09.2015 under clause Nos. 2.15 & 2.26.

As per policy condition No. 3.5 “Expenses incurred for Ayurvedic/Homeopathic/ Unani treatment are admissible up to 25% of the S.I. provided the treatment for illness or injury is taken in a government hospital or in any institute recognized by government and /or accredited by quality council of India/National accreditation board on health, excluding centers for spas, massage and health rejuvenation procedures.”
In view of the foregoing, the complainant was entitled for relief 25% of Sum Insured as per policy clause No. 3.5.

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of personal hearing, the Respondent is hereby directed to pay Rs. 50000/-.

In The Case of:-Sh. Vijay M. Patel v/s Future Generali Insurance Co. Ltd.

Complaint REF:No. AHD-G-016-1617-0261

Award Date: 22.08.2016 Policy No 2015-V3950010-FPV

The Complainant's car, had met with an accident on 14.11.2015. His claim on repair of his car for Rs.26,303/- was declined by the Insurer stating that the Complainant had not disclosed the earlier claim details in proposal forms at the time of purchase of the policy. The complainant had insurance policies from Future Generali India Insurance Co. Ltd. He had approached the Forum for redressal of his grievance.

The Complainant's car, had met with an accident on 14.11.2015. His claim on repair of his car for Rs.26,303/- was declined by the Insurer stating that the Complainant had not disclosed the earlier claim details in proposal forms at the time of purchase of the policy. The complainant had insurance policies from Future Generali India Insurance Co. Ltd. He had approached the Forum for redressal of his grievance.

Case of Mr. Krunal D. Vyas Vs. The Oriental Insurance Co. Ltd.

Complaint Ref. No. AHD-G-050-1617-0463

Award Date: 19.09.2016 Policy No 141100/48/2016/3219

The Complainant alongwith his family was insured with Happy Family Floater Policy issued by the Oriental Insurance Company Ltd. The Complainant's father Shri Dipakbhai N. Vyas was hospitalized at Vardan Eye Hospital, Nirmay Nagar, Ahmedabad on 13.06.2015 for Left Eye Cataract surgery with Intraocular Lens (IOL). Against a claim of Rs. 36,632/-, the Respondent had settled the claim for Rs. 23,969/- and the amount of Rs: 10,000/- from the balance of Rs.12,663/- was deducted citing reasonable clause. Unsatisfied with decision of the Respondent the Insured had approached the Forum for redressal of his grievance and settlement of the claim.

No exercise has been done to find out a). The cost of treatment on cataract surgery carried out in other similarly facilitated hospitals from the same area.

b). The standard cost of such surgeries in the said hospital. The action of the Respondent to settle the partially was arbitrary and not as per the terms & conditions of the policy. The Respondent had failed to prove the unreasonableness of the fees charged by the hospital. In view of the foregoing, the complainant was entitled for relief. **As the Respondent failed to establish reasonable, valid and justifiable reason for the deductions they have made from their Insured's claim, the Respondent is hereby directed to pay a sum of Rs. 9,000/-(Rs: 10000-10% of Rs: 10000/- for co-payment) in addition to the amount already paid to the Complainant.**

Case of Mr. Mineshkumar K. Shah Vs. National Insurance Co. Ltd.

Complaint Ref No: AHD-G-048-1617-0432

Award Date: 20.09.2016 Policy No 301800/48/14/85/000/16836

The Complainant was admitted at Brahma Ayurved multi specialty Hospital from 28/09/2015 to 29/09/2015 for treatment of Acute on chronic Fissure in anal with sentinel tag, Spasmodic Anal sphincter, Fissure fistula, Anal cystitis papillitis. The Complainant had incurred total expense of Rs.32,800/-. His claim was repudiated by the Respondent citing Policy Clause No. 4.16- the treatment was given in a combination of Ayurvedic and Allopathic treatments by an Ayurvedic Doctor but treatment other than Allopathic System of Medicine was excluded as per terms and condition of the policy.

The Representative of the Respondent had submitted Terms and Condition of the policy to the Forum which did not carry Clause No. 3.15 & 4.16 cited by the TPA in the repudiation letter. The clauses cited for rejection were nonexistent in the terms & condition of the policy. The representative also agreed with the finding. This proved the Respondent carelessness and casualness in rejecting or attending to the claim of the Insured. The repudiation letter has been signed by TPA, not by the insurer. The Respondent had not submitted the SCN giving pera wise comments on the complaint and their say in the matter. In view of the above, the compliant was admitted on its merits.T***he Respondent is hereby directed to make payment of Rs. 32,800/- to the complainant being full and final settlement of the claim.***

Case of Mr. Ramesh Nambiar Vs. The New India Insurance Co. Ltd.

Complaint Ref. No. AHD-G-049-1617-0488 & 627

Award Date: 20.09.2016 Policy No 220300/24/14/25/00006351

The Complainant along with his family members was insured under the New Mediclaim Policy-2012 issued by the New India Insurance Company Ltd. He had approached the Forum against non-settlement of claim on hospitalization of his Wife Mrs. Sujatha Nambiar. The period of hospitalization was from 31/10/2015 to 03/11/2015. at Nand Hospital, Vadodra for treatment of Dengue Fever with Thrombocytopenia.. He had incurred total expense of Rs.17943/- his claim was repudiated on 21/02/2016 by Vipul MedCorp TPA citing Policy Clause No. 2.15 – Hospital/Nursing Home (criteria of minimum beds). He had written to the insurance company and received a reply dtd. 04/04/2016 stating that the claim was not payable as per the terms and conditions of the Policy. Aggrieved by the decision of the Respondent, the Insured had approached the Forum for redressal of his grievance and settlement of the claim.

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. The hospital started having 15 beds in the hospital since opening of the hospital.The treating Doctor has given full bifurcation of beds position in the hospital. TPA investigation reports did not give correct facts on the No. of beds in the hospital. Hence, the complainant was entitled for relief. The complaint was admitted. ***The Respondent is hereby directed to make payment of Rs. 17,943/- to the complainant being full and final settlement of the claim.***

Smt. Geetaben P Patel Vs. The New India Insurance Co. Ltd.

Complaint Ref No: AHD-G-049-1617-0531

Award Date: 07.12.2016 Policy No 23080234142500000190

The Complainant alongwith her husband and son was insured with The New India Assurance Co Ltd. The Complainant was admitted to Shreyas Ano-Rectal Hospital from

26/07/2015 to 27/07/2015 for the treatment of Laser fistulectomy with Ksharsutra ligation & barron band application under spinal anesthesia. On discharge from the hospital the Complainant had filed a claim for Rs.74060/- The Respondent had repudiated the claim vide their letter dated 03.09.2015 under clause Nos. 2.15 & 2.26.

As per policy condition No. 3.5 “Expenses incurred for Ayurvedic/Homeopathic/ Unani treatment are admissible up to 25% of the S.I. provided the treatment for illness or injury is taken in a government hospital or in any institute recognized by government and /or accredited by quality council of India/National accreditation board on health, excluding centers for spas, massage and health rejuvenation procedures.”
In view of the foregoing, the complainant was entitled for relief 25% of Sum Insured as per policy clause No. 3.5.

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of personal hearing, the Respondent is hereby directed to pay Rs. 50000/-.

Case of- Mr. Bhaskar A Patel Vs The National Insurance Company Ltd.
Complaint Ref No.AHD-G-048-1617-0745 & 1060
Award Date: 22.12.2016 Policy No 11700/48/14/8500010508

The Complainant was insured with National Mediclaim Policy issued by the National Insurance Company Ltd for a Sum Insured of Rs.5,00,000/-. The Complainant was hospitalized at Jain Eye Associates High Tech Phaco Surgi Center Vadodara on 21.08.2015 for the treatment of Cataract and Retina surgery in the right eye. Against the claim of Rs. 53322/-, the Respondent had settled Rs.24,000/- and disallowed Rs.29322/- under reasonable and customary clause of the policy. Dissatisfied with decision of the Respondent, the Insured had approached the Forum for redressal of his grievance and settlement of the claim for an amount of Rs.29322/-.

As per IRDA circular, Reasonable and customary charges means the charges for services or supplied, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness/injury involved. Here the

Respondent also failed to submit the said rate chart of other hospital in and around the geographical area where the Insured was hospitalized. In absence of any rate charts or specifically pointing out the grounds for deductions towards the above mentioned charges, the Complainant was entitled for the balance amount of Rs. 29322/-. **The Respondent is hereby directed to pay Rs.29322/- to the Complainant.**

Mr. Ritesh Chauhan Vs ICICI Lombard General Insurance Company Ltd.

Complaint Ref No.AHD-G-020-1617-0797

Award Date: 23.12.2016 Policy No 28i/HPR/97692749/00/000

The Complainant's wife was insured with the Health care Policy issued by the ICICI Lombard General Insurance Company Ltd for a Sum Insured of Rs.3,00,000/-. The Complainant's wife was hospitalized at H C G Multi Specialty Hospitals from 07.04.2016 to 12/04/2016 for the treatment of Accelerated hypertension, angina, and obesity with Vitamin D deficiency. Against the claim of Rs. 1,08,799/-, the Respondent had settled Rs.97590/- and disallowed Rs.9391/- as hospital service charges, admission-cashless procedure charges, and Rs.858/- as other than medicine consumable items was not payable. Unsatisfied with decision of the Respondent, the Insured had approached the Forum for redressal of his grievance and settlement of the claim for an amount of Rs.11209/-.

It was seen from the records that the Service/Admission and Pharmacy charges were not payable items hence deductible as per clause No..xxxvii of the terms and condition of the policy. The Respondent was ready to pay Rs: 960/- cost of the pathology charges against submission of its reports. The deductions were as per the terms and conditions of the policy. The compliant had no merit and failed to succeed. **In view of the facts and circumstance, the decision of the Respondent needed no interference. The Complaint was dismissed.**

Case of:- Mr.Jamnadas J. Faldu Vs Religare Health Insurance Co. Ltd

Complaint No. AHD-G-037-1617-0794

Award Date: 23.12.2016 Policy No 1041340

The Complainant was insured with Care- Health Policy issued by the Religare Health Insurance Company Ltd from 19.10.2015 to 18.10.2016 for a sum insured of Rs. 3,00,000/-. The Complainant was hospitalized at Shivani Hospital for Left eye cataract surgery from 10.12.2015 to 11.12.2015. When a claim was filed for reimbursement, the Company rejected the claim mentioning clause 6.1 of the policy terms and condition "Non disclosure of Material facts at the time of portability" in the year 2013. Aggrieved by the decision he had approached the Forum for redressal.

The Respondent had repudiated the claim on the basis of Clause No.1.51 Pre-existing disease. As per the Clause any treatment taken for pre existing disease within 48 months of the first policy issued by the Company was not payable. The complaint was failed to succeed. In view of the facts and circumstance, the decision of the Respondent needs no interference. The Complaint is dismissed.

MEDI CLAIM

Case of- Mr. Nirmal R Thakkar Vs The National Insurance Company Ltd.
Complaint Ref No.AHD-G-048-1617-0710

Award Date: 22.12.2016 Policy No 300703/81/15/8500003554

The Complainant was insured with the National Mediclaim Policy issued by the National Insurance Company Ltd for a Sum Insured of Rs.4,00,000/-. The Complainant was hospitalized at Raghudeep Eye Hospital on 08.04.2016 for the treatment of Cataract and Proliferative Diabetic Retinopathy surgery in his right eye. Against the claim of Rs. 1,11,360/-, the Respondent had settled Rs.24,676/- and disallowed Rs.86,684/- citing reasonable and customary clause of the policy condition. Unsatisfied with decision of the Respondent, the Insured had approached the Forum for redressal of his grievance and settlement of the claim for the balance amount of Rs.86,684/-.

The Complainant was operated not only for cataract-Right eye but also for treatment of proliferative diabetic retinopathy. In absence of any rate charts or specifically pointing out the grounds for deductions towards the above mentioned charges, the Complainant was entitled for the balance amount of Rs. 86684/- .The complaint was thus admitted. The Complainant was operated not only for cataract-Right eye but also for treatment of proliferative diabetic retinopathy. In absence of any rate charts or specifically pointing out the grounds for deductions towards the above mentioned charges, the Complainant was entitled for the balance amount of Rs.

86684/- . The complaint was thus admitted. **Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of the personal hearing, the Respondent is hereby directed to pay Rs.86684/- to the Complainant.**

MEDICLAIM

Case of- Mr. Mahendra Desai Vs National Insurance Company Ltd.
Complaint Ref No.AHD-G-48-1617-0785
Award Date: 22.12.2016 Policy No 301200/48/15/8500012488

The Complainant aged 66 years was insured with National mediclaim policy issued by the National Insurance Company Ltd for a Sum Insured of Rs.3,50,000/- with CB Rs.175000/-. The Complainant was hospitalized from 27.05.2016 to 31.05.2016 for the treatment of Acute Inferior Wall MI Complicated with Ventricular Tachycardia, PTCA+HTN+DM. Against the claim of Rs. 3,58,691/-, the Respondent had remitted Rs.2,75,400/- as cashless settlement. The contention of the Complainant was that the Respondent had disallowed Rs.83,291/- citing PPN agreement. The Insured had approached the Forum for redressal of his grievance and settlement of the balance claim amount.

The hospital had wrongly collected excess amount Rs: 83291/- as the medical expenses from the Insured. The Company had failed to Question the hospital & the TPA for the excess charge collected form the Insured. The Respondent has to remember that they are holding the public money as the trustee of the fund. The complaint was admitted on its merits. **Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of the hearing, the Respondent is hereby directed to pay Rs. 83291/- to the Complainant, as the hospital has charged this amount in excess of the amount agreed under PPN agreement and the complainant has actually paid it to the hospital.**

MEDI CLAIM

Case of- Mr. Mahendra S Vyas Vs United India Insurance Company Ltd.
Complaint Ref No.AHD-G-051-1617-0791

Award Date: 23.12.2016 **Policy No 06202002814P111179707**

The Complainant was insured with Individual Mediclaim Policy issued by the United India Insurance Company Ltd for a Sum Insured of Rs.2,00,000/-. The Complainant was hospitalized at Raghudeep Eye Hospital Ahmedabad on 08.03.2016 for the treatment of Cataract surgery in his right eye. Against the claim of Rs. 86921/-, the Respondent had settled Rs.63321/- and disallowed Rs.23600/- citing reasonable and customary clause as per the policy condition.

Unsatisfied with decision of the Respondent, the Insured had approached the Forum for redressal of his grievance and settlement of the claim for the balance amount of Rs.23600/-.

In absence of any rate charts or specifically pointing out the grounds for deductions towards the Lens charges, the Complainant was entitled for the amount of Rs. 22900/-. As the bill for Rs: 700/- being consultation charges beyond the pre-existing expenses period, it was not payable. The complaint was thus admitted.

MEDI CALIM

Case of:-Mr. Narendra M. Sanghvi v/s New India Assurance Co. Ltd.

Complaint REF:No. AHD-G-049-11617-0879

Award Date: 24.01.2017 Policy No 21040034142800001466

The Complainant and his wife were insured with the Floater Mediclaim policy issued by the New India Assurance Company Ltd for a Floater Sum Insured of Rs.5,00,000/-. The complainant had enhanced the Individual Sum Insured from Rs:100000/- to Floater Sum Insured Rs:500000/- on 27.03.2015. The Complainant's wife was admitted to Zydus hospitals from 06.12.2015 to 11.01.2016 for the treatment of SAH with mid brain bleed + Hypertension. On discharge from the hospital the Complainant had filed claims for Rs. 500000/-. The Respondent had deducted Rs. 400000/- under clause No. 5.11 Enhancement of Sum Insured read with clause no. 4.3.1. Hypertension though detected first time is excluded for 24 months to be considered for the purpose of additional enhanced Sum Insured. Before enhancement of sum insured, the sum insured was Rs: 1 lakh. Additional enhanced sum insured of Rs: 4 lakh shall have waiting period of 2 yrs for treatment relating to Hypertension as provided under clause 5.11 read with 4.3.1. The sum insured was taken correctly. The compliant had no merit and failed to succeed. **In view of the foregoing the decision of the Respondent needs no intervention. The complaint stands dismissed.**

MEDICLAIM

Case of- Mrs. Falguni A Gandhi Vs The New India Assurance Company Ltd

Complaint Ref No.AHD-G-049-1617-1164

Award Date: 08.02.2017 Policy No 230110034152800002031

The Complainant was insured with a New India Floater Mediclaim Policy issued by the New India Assurance Company Ltd. The Complainant's son was hospitalized at Anand Hospital from

20/07/2016 to 27/07/2016 for Eosinophilie Enteritis. When a claim was lodged, the Company repudiated the claim on 30.09.2016 citing clause 4.1 (Pre-Existing Diesease) of the policy terms and conditions. Aggrieved by the decision, she had appealed to the Grievance Cell and dissatisfied with their decision, she had approached the Forum for redressal of her grievance.

The Insurance Company has not been able to prove that the Complainant was suffering from Eosinophilie Enteritis since 2 years. The whole confusion had arisen because in first consultation letter it was written as "Eosinophilie Enteritis since 2 years", which was later on clarified by the same doctor. The Complainant's son was diagnosed to have ulcerative prostatic after biopsy and colonoscopy report. It was not a pre-existing disease as per definition of P.E.D. The Complainant had not suppressed any material fact. The claim had been wrongly repudiated. The Insured was treated for Ulcerative Prostatic, which was not a pre-existing disease. The decision taken by the Insurance Company was found incorrect. The Complainant was entitled for relief and his complaint was admitted. **Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of hearing, the Respondent is hereby directed to pay Rs: 54696/- to Complainant.**

MEDI CLAIM

Case of- Mrs. Dikshita A Gandhi Vs United India Insurance Company Ltd.
Complaint Ref No.AHD-G-051-1617-1113 & 1331
Award Date: 07.02.2017 Policy No 1803002815P110870399

The Complainant and his wife were insured with Individual Health Policy issued by United India Insurance Company Ltd for a Sum Insured of Rs.3,00,000/-. The Complainant's wife was hospitalized at I Care Hospital & Phaco Center Vadodara on 12.08.2016 for the treatment of Cataract in Right Eye. Against the claim of Rs. 58000/-, the Respondent had settled Rs.24,000/- and disallowed Rs.34000/- citing reasonable and customary clause of the policy. Dissatisfied with decision of the Respondent, the Insured had approached the Forum for redressal of his grievance and settlement of the claim for an amount of Rs.34000/-.

In absence of any rate charts or specifically pointing out the grounds for deductions towards the above mentioned charges, the Complainant was entitled for the balance amount of Rs. 34000/- . The complaint was thus admitted. **Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of the personal hearing, the Respondent is hereby directed to pay to the Complainant.**

MEDI CLAIM

Case of- Mr. Sureshchandra Gheewala Vs The National Insurance Company Ltd.

Complaint Ref No.AHD-G-048-1617-1096

Award Date: 07.02.2017 **Policy No 300703/48/15/8500004198**

The Complainant was insured with National Mediclaim Policy issued by the National Insurance Company Ltd for a Sum Insured of Rs.75,000/-. The Complainant was hospitalized at Ami Eye Hospital High Tech Phaco & Laser Center Patan on 03.11.2015 for the treatment of Cataract surgery in the left eye. Against the claim of Rs. 31175/-, the Respondent had settled Rs.23575/- and disallowed Rs.7600/- under reasonable and customary clause of the policy. Dissatisfied with decision of the Respondent, the Insured had approached the Forum for redressal of his grievance and settlement of the claim for an amount of Rs.7600/-.

In absence of any rate charts or specifically pointing out the grounds for deductions towards the above mentioned charges, the Complainant was entitled for the balance amount of Rs. 7500/- . The complaint was thus admitted. **Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of the personal hearing, the Respondent is hereby directed to pay Rs.7500/- to the Complainant.**

MEDI CALIM

Case of:- Mr. Rakesh H Patel V/S New India Assurance Co. Ltd.

Complaint No.: AHD-G-049-1617-1085

Award Date: 06.02.2017 **Policy No 21020534152800000918**

The complainant's wife Mrs. Kaminiben was admitted to Stavya Spine Hospital, Ahmedabad on 27/03/2016 for the treatment of L5-S1 Listhesis & discharged on 31/03/2016. He had incurred an expense of Rs.1,64,536/-. His claim was partially settled for Rs.1,52,536/- unsatisfied with the settlement, he had approached the Forum for payment of balance amount.

The respondent agreed that if the amount of Rs.12,000/- was included in operation charges, it was payable. The doctor had clarified that IITV & Monitor were essential for the surgery SS. In view of the aforesaid facts the complaint was allowed. **The Forum, hereby, directs the Respondent to pay Rs.12,000/- to the Complainant.**

MEDI CLAIM

Case of:-Shri D.C.Gandhi v/s The New India Assurance Co. Ltd.

Complaint Ref. No.: AHD-G-049-1617-1098

Award Date: 07.02.2017 **Policy No 21040034142500005098**

The complainant and his wife were insured under New Mediclaim-2012 Policy. The Complainant aged 68 years was admitted to Netralaya the eye associates Ahmedabad on 30/03/2015 for Right eye treatment as he was diagnosed with Severe Non-Proliferative Diabetic Retinopathy with Cystoids Macular Edemas (CME). He had intravitreal anti VEGF procedure (procedure in operating theatre) in right eye. On discharge from the hospital, the Complainant had filed a claim for Rs.38274/- with the Insurer. The Respondent had repudiated the claim citing Exclusions, Condition of the policy, No. 2.11 and later on under condition No.4.4.23.

As the Insurer had stated that the hospitalization was not necessary in the treatment of the Insured, the dispute apparently was hospitalization v/s treatment on OPD basis. He was operated for intravitreal Anti VEGF Surgery. Due to advanced technology, more than 24 hours hospitalization was not required. Also there was no exclusion clause in policy on Intravitreal surgery. The clause applied for rejection of the claim, did not restrain the reimbursement either. The Insured was justified in claiming the relief. The complaint was thus admitted. **Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of hearing, the Respondent is hearing, the Respondent is hereby directed to pay Rs. 38,274/- to the Insured.**

MEDI CLAIM

Case of- Mr. Kirtikumar P. Patel Vs The National Insurance Company Ltd.
Complaint Ref No.AHD-G-048-1617-1218 & 1220
Award Date: 20.02.2017 **Policy No 302101/48/15/8500006702**

The Complainant and his wife were insured with Parivar Mediclaim Policy issued by The National Insurance Company Ltd for a Sum Insured of Rs.2,00,000/-. The Complainant was hospitalized at Ranchhodrai Eye Clinic Ahmedabad on 16.08.2016 for the treatment of Cataract in Right Eye. Against the claim of Rs. 30476/-, the Respondent had settled Rs.24,476/- and disallowed Rs.6000/- citing reasonable and customary clause of the policy. Dissatisfied with decision of the Respondent, the Insured had approached the Forum for redressal of his grievance and settlement of the claim for balance amount of Rs.6000/-.

As per IRDA circular, Reasonable and customary charges means the charges for services or supplied, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness/injury involved. Here the Respondent also failed to submit the said rate chart of other hospital in and around the geographical area where the Insured was hospitalized.

The Insured had produced a receipt for the lens costing Rs: 14000/- used in the rectification of the cataract. The company had not produced any comparative rate charges. In absence of any rate charts, the Complainant was entitled for the balance amount in both case.The complaint was thus admitted.

MEDI CLAIM

Case of- Mr. Indravadan N. Shah Vs The New India Assurance Co.Ltd
Complaint Ref No.AHD-G-049-1617-1186
Award Date: 20.02.2017 Policy No 22220034152500000174

The Complainant alongwith his wife were covered under New Mediclaim-2012 issued by The New India Assurance Company Ltd. The Complainant's wife was hospitalized at Arinant Clinic for surgery of OA big toe MP Joint Right side from 13.08.2015 to 14.08.2015. When a claim for Rs. 26444/-was filed, the Company repudiated the claim citing clause 2.15 of the policy terms and conditions regarding number of beds. Aggrieved by the decision of the Respondent, the Insured had approached the Forum for redressal of his grievance and settlement of the claim.

Since the policy terms and condition was clear and as per the doctor's certificate, the number of beds were 5 in his clinic, repudiation by the Respondent under clause 2.15 was in order. The complaint failed to succeed.

MEDI CALIM

Complainant: Mrs. Urvi D. Dani V/s The New India Assurance Co. Ltd

Complaint No. AHD-G-049-1617-1197

Award Date: 20.02.2017 Policy No 21020434152800000106

The Complainant along with her husband was covered under New India Floater Mediclaim Policy issued by the New India Assurance Company Ltd. The Complainant was admitted to Sannidhya Maternity & Multi-specialty Hospital from 10.06.2016 to 14.06.2016 for treatment of Adherent Placenta, Retained Products. When the complainant had submitted a claim for Rs. 43364/-, the Respondent rejected the claim under policy clause 4.4.13- maternity expenses, treatment arising from or traceable to pregnancy was not payable. Dissatisfied with the decision of the Respondent, she had approached the Forum.

It was observed that the repudiation of the claim was under policy clause 4.4.13 of the policy. In the subject treatment, there was a miscarriage. Some conceptions were left out in the patient.

She was treated for the miscarriage. It was not Ectopic pregnancy. The clause No. 4.4.13 provided for the treatment of Ectopic pregnancy and not for the treatment of miscarriage. The Respondent had correctly rejected the claim as per the relevant clause of the policy. In view of the foregoing, the complaint failed to succeed. **Taking into account facts and circumstances of the case, material on record, findings as at above, the Respondent's decision to repudiate the claim was upheld without any relief to the Complainant.**

MEDI CALIM

Case of- Mr. Riddhish J Parikh Vs United India Insurance Company Ltd.
Complaint Ref No.AHD-G-051-1617-1324
Award Date: 21.02.2017 **Policy No 1814002815P113665697**

The Complainant was insured with Individual Health Policy issued by the United India Insurance Company Ltd Baroda for a Sum Insured of Rs.3,00,000/-. The Complainant was hospitalized at Jain Eye Associates Hi-Tech Phaco Surgi center-Baroda on 16.09.2016 for the treatment of Cataract surgery in his Left eye. Against the claim of Rs. 47600/-, the Respondent had settled Rs.24000/- as Cashless Claim and disallowed Rs.23600/- citing reasonable and customary clause as per the policy condition. Unsatisfied with decision of the Respondent, the Insured had approached the Forum for redressal of his grievance and settlement of the claim for the balance amount of Rs.23600/-.

As per the Clause No.1.2.1 of terms and condition of the policy, reimbursement on the expenses incurred in respect of the Cataract surgery was restricted to 25% of the Sum Insured or Actual expenses whichever less. The Sum Insured was Rs: 300000/- and 25% of the Sum Insured was Rs:75000/-. The Insured had incurred an expense of Rs: 47600/- towards the treatment of his cataract. It is well within the admissible limit. In view of the aforesaid facts the complaint was allowed.

MEDI CLAIM

Case of- Mr. Bipinchandra A Patel Vs United India Insurance Company Ltd.
Complaint Ref No.AHD-G-051-1617-1364
Award Date: 21.03.2017 **Policy No 1804002816P100999433**

The Complainant was insured with Individual Health Policy issued by the United India Insurance Company Ltd Baroda for a Sum Insured of Rs.2,75,000/-. The Complainant was hospitalized at Ami surgical hospital -Baroda from 20.07.2016 to 21.07.2016 for the treatment of right inguinal Hernia . Against the claim of Rs. 52571/-, the Respondent had settled Rs.31708/- and disallowed Rs.20863/- citing reasonable and customary clause and other clause as per the

policy condition. Unsatisfied with decision of the Respondent, the Insured had approached the Forum for redressal of his grievance and settlement of his balance claim.

As per the Clause No.1.2.1 of terms and condition of the policy, reimbursement on the expenses incurred in respect of the Cataract surgery was restricted to 25% of the Sum Insured or Actual expenses whichever less. The Sum Insured was Rs: 275000/- and 25% of the Sum Insured was Rs:68750/-. The Insured had incurred an expense of Rs: 52571/- towards the treatment of Hernia. It is well within the admissible limit. In view of the aforesaid facts the complaint was allowed.

MEDI CALIM

Case of:- Mr. Vishal A Doshi V/S Iffco-Tokio General Insurance Co. Ltd.

Complaint No.: AHD-G-023-1617-1379

Award Date: 21.03.2017 **Policy No 52520372**

The Complainant's wife Smt. Swetaben, aged 35 years was admitted to Mayflower Women's Hospital, Ahmedabad on 10/08/2016 for Laparoscopic Hysterectomy, Bilateral Ovarian Cystectomy, with Bilateral Salpingectomy and discharged on 12/08/2016. He had incurred an expense of Rs.121439/-. His claim was repudiated on the ground "Non-Disclosure of Material Fact."

Appendectomy done in 2008 & LSCS done in the year 2010 are not pre-existing disease for the policy issued in Sept-2015 as these were done before 48 months of issuance of the impugned policy. The complaint was admitted.

MEDICLAIM

In the matter of
Mr. Rudresh P. Pandya
Vs.
The New India Assurance Company Ltd.
Complaint Ref. No.AHD-G-049-1617-0753

Award Date: 23/01/2017
Policy No. 210200/34/15/04/00000001

Smt. Kinjal R. Pandya had the insurance policy from The New India Assurance Co. Ltd. since the year 2014-15. The Insured was admitted to the Gayatri hospital, Gandhinagar on 09/05/2015 for the treatment of Lt. Tubal Ectopic Pregnancy and discharged on 11/05/2015.

The Respondent had rejected her claim of Rs.29, 642/- citing Policy Clause No. 4.4.13 “Maternity Expenses, except abdominal operation for extra uterine pregnancy (Ectopic Pregnancy), which is proved by submission of ultra Sonographic Report and Certification by Gynecologist that it is life threatening”. Unsatisfied with the rejection she had approached the Forum for Redressal of her grievance.

The treating Dr. Ratnesh Patel had clarified that the surgery was necessary to save the life of the patient and had certified that it was an Ectopic pregnancy.

The Complainant had submitted USG report of pelvis which confirmed mass lesion.

Respondent had asked for the Biopsy report which was not prescribed in the terms and conditions of the policy.

It was observed that the Insurer and its doctor had demanded a report which the policy clause did not provided for. The requirement for the biopsy report was in contravention of the terms of the policy and was unwarranted.

The point to be noted was that even if the growth in the tube was considered as mass lesion, it needed to be medically treated and the claim in such case was payable.

In other words the treatment and claim on ectopic pregnancy or mass lesion was payable.

The Respondent and its doctor without application of their mind and prudence had preferred to deny the claim. The rejection of the claim was incorrect. The denial of the rightful claim was highly arbitrary and against the PPHI Rules, 2002. In view of the above facts, the complaint was admitted to the claim amount of Rs. 29,642/-.

In the matter of
Mr. Nimesh R. Shah
Vs.
The Oriental Insurance Company Ltd.
Complaint Ref. No.AHD-G-050-1617-0769

Award Date: 23/01/2017
Policy No: 141100/48/2016/14760

Mrs. Nita Nimesh Shah, the health insurance policy holder of Oriental Insurance Co. Ltd., was diagnosed with Cirrhosis of liver, SLE & Hepatitis Genotype – 1 in the year 2003. She

had taken treatment from Shrey Hospitals Pvt. Ltd., Ahmedabad from 10/02/2016 to 11/02/2016. The Insured had incurred total expense of Rs.1, 14, 962/= The Respondent had rejected her claim citing Policy Clause No. 4.10 “Expenses incurred for evaluation / diagnostic purposes.”

The complainant’s claim for Rs.1,67,868/- on similar procedure was settled in the year 2004.

Since the discharge from the hospital in the year 2004, the patient had been under medication (Interferra Pegasys injections).

With the availability of new medicine Sofocure I in the year 2016, a set of medical tests were carried out before the prescription of the medicine.

The tablet ‘Sofocure I’ had been prescribed for 6 months. The medicine is used with other antiviral medicines to treat chronic Hepatitis C infection in adults.

Tab Sofocure L like the previous medicine had to be consumed over a long period or till the disease was cured. There may be more new medicines manufactured or alternate medicines available to control the disease in future.

The medication was a continuation of the treatment for the existing disease and not a treatment on new found disease.

There was no hospitalization to treat any disease. The hospitalization was to evaluate the suitability of the new medicine to the patient.

The Forum had not examined the correctness and relevance of the year 2004 claim settlement. The subject claim was like a post hospitalization claim on a continued treatment for the past 12 years.

The Respondent had correctly denied the claim as per the terms and conditions of the policy.

In view of the foregoing, the complaint failed to succeed.

In the matter of
Mr. Karimbhai K. Dhanani
Vs.
The Oriental Insurance Company Ltd.
Complaint Ref. No.AHD-G-050-1617-0793

Award Date: 23/01/2017
Policy No: 141701/48/2015/4914

Smt. Sonalben K. Dhanani had the insurance policy from Oriental Insurance Co. Ltd since the year 2011-12. She was diagnosed with Anemia + Bronchitis and was admitted to

Sharda Hospital on 04/03/2016 and discharged on 07/03/2016 after treatment. The Respondent had rejected her claim of Rs.15, 520/- citing Clause No. 4.8 of the Policy. She had approached the Forum as her claim was not paid.

As per the discharge card the patient had fever, cough, vomiting and weakness."

The treating Dr. M. A. Thakkar had mentioned in his letter dated 24/06/2016 that the patient was evaluated for fever and was found to be anemic subsequently. The Patient was treated for Bronchitis, fever, Gastritis and Anemia; and not "Anemia" alone.

The respondent had contended that as per the discharge summary that the patient was admitted in hospital on 04/03/2016 and discharged on 07/03/2016 after the treatment for Anemia + Bronchitis.

The Respondent had mentioned in their Self Contained Note that the insured was admitted to the hospital on 04/03/2016 for the treatment of iron deficiency anemia. The certificate of treating doctor showed the exact cause for Anemia as 'severe Iron deficiency Anemia', which was excluded in policy clause No. 4.8. However, there was no word 'anemia' found in the exclusion clause. He also submitted Dr. S. J. Dumra's expert opinion, and stated that the prescribed medicines did not reflect treatment for bronchitis. Only vitamin & nutritional supplements were prescribed for the patient.

The insured was treated with intravenous fluids, injection Antibiotics, Multivitamins and Iron. It was observed that the treatment was mostly in the nature to cure anemia. The Respondent had not considered the treatment given to cure Bronchitis. Clause 4.8 under which the claim was rejected did not carry the word anemia. The respondent failed to conclusively prove that the Insured was treated for her general debility as it had repudiated the claim stating that the patient was treated for anemia which was not in the policy clause 4.8. The Complainant was entitled for relief. Out of Rs.2550/- under head Disposables + Miscellaneous-Inu, the amount of Rs.12/- for Micro Tape was not payable.Policy was issued under – Silver Plan with 10% Co. Pay. The claim amount was Rs.15,520/-. After deducting of Rs.12/-(Non-payable item) and Rs.1551/- (10% Co-payment), Rs.13,957/- was payable.

In view of the above facts, the complaint was admitted to the claim amount of Rs.13,957/-.

In the matter of
Mr. Jayantilal R. Shah
Vs.
Star Health & Allied Insurance Company Ltd.
Complaint Ref. No.AHD-G-044-1617-0869

Award Date: 24/01/2017
Policy No: P/171200/01/2015/003415

The Complainant was insured under Sr. Citizens Red Carpet Insurance Policy from 02/03/2015 to 01/03/2016 issued by the Star Health & Allied Insurance Co. Ltd. The Insured was admitted to Guru Krupa Hospital on 05/02/2016 and Discharged on 13/02/2016. The Company had rejected his claim and cancelled his policy under Clause 7 and Clause No.11.

The Complainant stated that he had taken the first time policy in the year 2013. He told that the co.'s agent had not mentioned the previous history of the disease in the proposal form. The Complainant was admitted in the year 2008 in Sterling Hospital for CV Stroke – Cerebro Vascular Stroke – Vertebro basilar infarct .On 05/02/2016 the complainant was admitted for Koch's Pulmonary Effusion.

As per the underwriting manual produced by the Insurer, had the Insured declared the CVS, the Insurer would not have issued the policy at all. The documents produced before the Forum established the suppression of material facts required for underwriting the proposal. The Respondent had repudiated the claim on the basis of Non-disclosure of material fact. The previous disease history of 2008 was not declared at the time of taking the policy. The Respondent had told that there were 5 questions in the proposal form related to previous history of any disease, the complainant had replied in negative to all the 5 questions. One of the diseases was CVA.

The Respondent had correctly cancelled the said policy on 29/08/2016 and refunded the premium amounting to Rs.9,681/-. The company has correctly applied the non-disclosure clause and rejected the claim. In view of the above, the complaint failed to succeed.

In the matter of
Mr. Ashwinbhai T. Limbadia
Vs.
The New India Assurancwe Company Ltd.
Complaint Ref. No.AHD-G-049-1617-0909

Award Date: 24/01/2017
Policy No: 210600/34/14/25/00000942

The Complainant had Mediclaim policy with The United India Insurance Company Ltd. since 11.08.2009 to 10/08/2013 and subsequently ported to the New India Assurance Co. Ltd. from 11/08/2013 insuring himself, his wife and two children. The Complainant's wife Mrs. Naliniben was hospitalized in Anand Multi Speciality Hospitals Pvt. Ltd., Ahmedabad on 23.07.2015 for

operation of Incisional Hernia and was discharged on 28.07.2015. The complainant lodged a claim for Rs.76,037/- with the respondent Insurance Company. The respondent insurance company paid Rs.46,265/- after deducting Rs.29,772/-.

The Insured initially had the policy from United India Insurance Co. Ltd. since 11.08.2009 for S.I. of Rs.1,25,000/-.The policy was ported to the respondent w.e.f. 11.08.2013 with S.I. of Rs.3,00,000/-. The claim had arisen in the 2nd year of the policy. There was a waiting period of 24 months in the policy. Since the policy was ported , the Respondant had accordingly given the benefit of waiting period. However, there was no Clause in the policy which restricted the S.I. to S.I. of a particular year, in the case of enhancement of Sum Insured.

The Respondent's reasoning that the Insured had undergone LSCS in 1984 & 1991 and the happening of the hernia in 2015 was due to pre-existing disease was highly incorrect as it had happened after 24 years. The Respondent had accepted the ported policy with all benefits of the previous policy. The application of various clauses in deducting the claim was arbitrary and incorrect. The Insured was entitled for the reimbursement of the mediclaim The Respondent had failed to prove the unreasonableness of the charges and the fees paid by the Insured.

In view of the foregoing the complaint was admitted to the claim amount of Rs.29,000/-.

In the matter of
Mr. Rajendra D. Parikh
Vs.
United India Insurance Company Ltd.
Complaint Ref. No.AHD-G-051-1617-0931

Award Date: 24/01/2017
Policy No: 180300/28/15/P/104083039

The Complainant Mr. Rajendra Parikh, aged 84 years, was insured with United India Insurance Co. Ltd. for a Sum Insured of Rs.4,50,000/- with CB of Rs.1,57,500/-. He was admitted to Medanta – The Medicity Hospital in Gurgaon, Haryana on 12/04/2016 for the treatment of Hematuria. Against the claim of Rs.2,21,720/-, the Respondent had remitted Rs.1,08, 960/- to the Insured The Complainant had approached the Forum for redressal of his grievance and settlement of the balance claim amount.

The Insured was having the policy since the year 2004 as per policy schedule.

The Sum Assured was Rs:4.50 lakhs with NCB of Rs: 1.57,500/- in the subject policy. The total S.I. for claim purpose was Rs.6,07,500/-. The Insured was not made aware of the PPN agreement with the hospital. It was seen that the Respondent had settled Rs 4,93,082/- and disallowed the balance claim of Rs.1,14,418/- stating PPN agreement with the hospital. The Complainant had not taken any special service from the hospital.

The PPN agreement existed between TPA, Hospital and company. The Hospital, a party to the PPN agreement, had charged excess amount, contravening the PPN agreement.

The Respondent and the TPA had not enquired with the hospital as to why the hospital had charged excess amount. It is noted from the discharge summary that the complainant was admitted in hospital for 8 days. The rate applicable for Turp is Rs.80,000/- for 1-2 days hospitalization. The complainant was not admitted for TURP. The Respondent has not considered the other disease, which were managed by the hospital during hospitalization. It has mechanically applied PPN rate for TURP whereas the respondent should have considered control and management of other disease also.

In view of the facts and circumstances the complaint was admitted to the claim amount of Rs.1,14,418/-.

.

In the matter of
Mr. Manih A. Rana
Vs.
United India Insurance Company Ltd.
Complaint Ref. No.AHD-G-051-1617-1022

Award Date: 06/02/2017
Policy No: 180800/28/15/P/103790229

The complainant's father Mr. Arvindbhai was admitted to Metas Adventis Hospital, Surat on 15/04/2016 for the treatment of Severe Ileo Colitis & discharged on 21/04/2016. The complainant had incurred an expense of Rs.84,091/-. His claim was partially settled for Rs.65,935/- after deduction of Rs.18,156/- citing Admission charges, Investigation/Lab charges, procedure charges, service charges and consulting charges.

The complainant had not provided copies of the reports advised by the BHMS doctor to the Forum. Hence, its requirement and utility for the treatment was not known. Hence, the reimbursement on the same could not be awarded.

Similarly, the complainant had not provided the receipts of the expenses incurred on procedure charges and the visiting consultant charges. Hence, these amounts were also not considered.

In view of the above facts, the complaint failed to succeed.

In the matter of
Mr. Jayesh A. Mehta
Vs.
The New India Assurance Company Ltd.
Complaint Ref. No.AHD-G-049-1617-1045

Award Date: 06/02/2017
Policy No: 230400/34/15/25/00005856

The Complainant and his family members were insured with New Medicare 2012 Mediclaim policy issued by The New India Assurance Company Ltd. The Complainant's wife was hospitalized in Kidney Care Urological hospital on 11/03/2016 for the treatment of Acute Uretic Stone and discharged on 12/03/2016. Since the complainant's claim for Rs. 51,158/- was rejected under Clause No.2.15, he had moved the Forum for justice.

The Complainant had provided a Certificate dated NIL from the Kidney Care Urological Hospital wherein, it was stated that the hospital had various wards with 15 beds rooms-wise.

The complainant enclosing a copy of the claim settlement letter of Shri Ashokkumar N. Parekh, claim No. HI-NIA-000135864(0) dated 18/04/2016, as an example and proof, had written to the company stating that the company had settled the claim that had arisen from the same hospital.

The Respondent neither had responded to the letter nor made any statement in the SCN or mentioned before the Forum during the hearing.

It proved that the Respondent had settled the claim of at least 2 patients of this hospital whose hospitalization period was during or around the complainant's hospitalization duration.

The Respondent had failed to prove their point of contention that there was less than 15 beds in the hospital.

The claim settlement of other two patients of the same hospital contradicted the complainant's claim being rejected.

The amount of Registration charges Rs.100/- + Linen Charges – Rs.200/- + Gloves –Rs.254/- + Betadin – Rs.106/- = Total Rs. 660/- were non-payable items.

In view of the facts and circumstances the complaint was admitted to the claim amount of Rs.50,498/-.

In the matter of
Mr. Vijaykumar Gupta
Vs.
United India Insurance Company Ltd.
Complaint Ref. No.AHD-G-051-1617-1066 / 1067 / 1068

Award Date: 06/02/2017
Policy No: 060400/28/14/P/109567898
& Pol. No. 060400/48/15/P/113082409

The complainant Mr.Vijaykumar, aged 70 years was insured under Family Medicare Policy 2014. He was admitted to Rising Retina Clinic, Ahmedabad thrice for Left eye - OS Intravitreal Lucentis surgery as he was diagnosed with OS: Hemi Central Retinal Vein Occlusion + OS Cystoid Macular Edema. He had undergone intravitreal Lucentis surgery on 16/01/2016, 13/02/2016 and 15/03/2016. On discharge from the hospital, the Complainant had filed three separate claims aggregating to Rs.85,770/- with the insurer. The Respondent had repudiated the claim citing Exclusions: Condition No.2 – Definitionss.2.3 – OPD based treatment.

The Respondent, citing “less than 24 hours hospitalization” clause, had denied the claim.

The Respondent had not assigned any other reason for the rejection of the claim. It meant the claim was payable had the hospitalization been for more than 24 hours.

It was seen that the Insurer had listed 34 types of disease under the day care procedure / treatment. It was also found that in olden days these 34 diseases needed hospitalization for more than 24 hours. Similarly, the subject treatment also needed hospitalization for more than 24 hours. However, with the advancement of medical technology and new medical inventions the surgery could be carried out in short time extending to few hours. The Company needed to update its list of day care treatment with the subject treatment as well.

Retinal vein occlusions (RVOs) are the second most common type of retinal vascular disorder after diabetic retinal disease. They can occur at almost any age (although typically in middle to later years - most in those aged over 65 years) and their severity ranges from asymptomatic to a painful eye with severe visual impairment.

Retinal vein occlusion is one of the most common causes of sudden painless unilateral loss of vision. Loss of vision is usually secondary to macular edema.

The treatment had to be carried out with local anesthesia in sterile conditioned Operation Theater under aseptic precaution by a specialist. The treatment needed specialized doctor. The subject treatment could not be carried out like other OPD treatments.

Based on the deposition of the parties to the complaint, the Forum noted that the treatment was a prolonged one, depending on the prognosis, the patient had to be administered with more number of injections. Looking at the treatment under taken by the complaint, the Forum found that the doctor had administered Lucentis injections, which was costlier than Avastin. The criterion for choosing Lucentis over Avastin was not clear. There's divided opinion amongst the doctors regarding the patients, undergoing the procedure, being considered as inpatient or outpatient case.

Though the Forum was also able to appreciate the case of the complainant in expecting the Insurer to settle the claims in as much as the treatment being a prolonged one and repetitive in nature, but for the reasons stated above, it would be reasonable that the complainant bore a part of the expenses. Accordingly, taking a practical view of the facts of the case, which had been brought to the notice of the Forum, the Forum had come to the conclusion that the cost of the treatment be shared equally between the complainant and the Company.

In view of the facts and circumstances the complaint was admitted to the claim amount of Rs.42,885/- being 50% of the total claim amount to the complainant.

In the matter of
Mr. Rakesh H. Shah
Vs.
The New India Assurance Company Ltd.
Complaint Ref. No.AHD-G-049-1617-1080

Award Date: 06/02/2017
Policy No: 210200/34/15/28/00000174

The complainant's wife Mrs. B. R. Shah, aged 41 years old was admitted to Spine Hospital, Ahmedabad on 26/11/2015 for the treatment of prolapsed inter-vertebral disc C6-C7 & discharged on 29/11/2015. His claim for Rs.1,04,503/- was partially settled with Rs.52, 632/- after deductions of Rs.51, 871/- citing clause Nos. 5.11, 2.1, 2.3, 2.4.

The Insured had ported her policy before two years from other insurer. The SI then was Rs.1,00,000/-. The Respondent had correctly given the benefits of the portability as it had considered the claim that had arisen within two years from the date of the ported

policy. The subject policy had a waiting period of 24 months to cover the subject disease.

The guideline No.12 of the IRDAI circular dated 09.09.2011 on health insurance portability clearly provides for the SI to be considered in such ported policies. Accordingly, the Insurer had applied the SI of Rs.1,00.000/- while considering the claim.

The next point to be considered was whether the deduction of the claim in proportion to the room rent was correct? The Respondent could not answer the question whether it had sought the fee charged by the hospital in cases where it charged Rs.1000/- as the room rent.

The Representative was asked to get the quotation from the doctor on the fee charged by him presuming that the patient was hospitalized in a room with rent of Rs.1000/-.

The doctor had given a fee structure item wise for Rs.55,000/- (with room rent Rs.1000/) and Rs.69,500/- (with room rent of Rs.3000/-). Thus, there was a difference of Rs.15,000/-in the hospital charges which is not payable.

Thus, from the total expense of Rs.1,04,503/- Various expenses, amounting to Rs.1,775/- was not payable, as per the terms and conditions of the policy (Rs. 400/- for Other Hospital Bill, Rs.575/- Non-pharmacy charges and Rs.800/- beyond post limit charges).

The balance amount payable was worked out as under:

Amount claimed	Rs.1,04,503/-
SI considered	Rs.1,00,000/-
Less	
Not payable items	Rs.1,775/-
Not payable as per room rent	Rs.15,000/-
Already paid by the Insurer	Rs.52,632/-
Balance payable	**Rs.35,096/-**

The complainant was thus entitled for further sum of Rs.35,096/-

The Respondent was advised to provide a copy of the terms and conditions to the Complainant.

In view of the facts and circumstances the complaint was admitted to the claim amount of Rs.35,096/- to the complainant.

In the matter of
Mr. Himanshu Patel
Vs.
The Oriental Insurance Company Ltd.
Complaint Ref. No.AHD-G-050-1617-1054

Award Date: 06/02/2017
Policy No: 142606/48/2016/1446

Mr. Narendrakumar Patel, aged 60 years, father of the complainant was admitted to Raghudeep Eye Hospital, Ahmedabad on 02/06/2016 for Right Eye Cataract surgery and discharged on the same day. His claim for medical expenses of Rs.1,06,940/- was partially settled with Rs.54,810/- after deduction of Rs.52,130/- citing Reasonable and Customary Charges/Non-medical expenses/Femtolaser related charges and Maximum Surgeon charges. He had approached the Forum for settlement of full claim.

The patient had flat eye requiring a different treatment than the regular lens and treatment.
The settlement letter of the complainant's eye treatment cannot be taken into account for comparison as the nature, extent; gravity of cataract etc. would be different for his father's case which was not known to the Forum.
The patient in the subject complaint was the father of the complainant.
As per IRDAI circular on standardization in health insurance, reasonable and customary charges meant 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.
The Insurance company could not prove that Rs.52,130/- was the unreasonable and non-customary charges for cataract surgery in the hospital (where the complainant's father was operated), and it was consistent with the charge for similar surgery in similarly placed hospital in the geographical area.
There was no capping / ceiling for payment of cataract surgery under the policy.
The Respondent had failed to prove that the charges were unreasonable.
Deduction of Rs.251/- towards Non-medical Charges was found to be in order as per the

terms of the policy.

In view of the foregoing the complaint was admitted to the claim amount of Rs.51,879/-.

In the matter of
Mr. Himanshu Patel
Vs.
The Oriental Insurance Company Ltd.
Complaint Ref. No.AHD-G-050-1617-1055

Award Date: 06/02/2017
Policy No: 142606/48/2016/1446

Mr. Narendrakumar Patel, aged 60 years, father of the complainant, was admitted to Raghudeep Eye Hospital, Ahmedabad on 13/06/2016 for Lt. Eye Cataract surgery & discharged on the same day. His claim for medical expenses of Rs.1, 05,720/- was partially settled with Rs.51,590/-. Deduction of Rs.54,130/- was made citing Reasonable & Customary Charges/Non-medical expenses/Femtolaser related charges and Maximum Surgeon charges. He had approached the Forum for settlement of full claim.

The patient had flat eye requiring a different treatment than the regular lens and treatment.
The settlement letter of the complainant's eye treatment cannot be taken into account for comparison as the nature, extent; gravity of cataract etc. would be different for his father's case which was not known to the Forum.
The patient in the subject complaint was the father of the complainant.
As per IRDAI circular on standardization in health insurance, reasonable and customary charges meant 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.
The Insurance company could not prove that Rs.54,130/- was the unreasonable and non-customary charges for cataract surgery in the hospital (where the complainant's father was operated), and it was consistent with the charge for similar surgery in similarly placed hospital in the geographical area.
There was no capping / ceiling for payment of cataract surgery under the policy.
The Respondent had failed to prove that the charges were unreasonable.
Deduction of Rs.251/- towards Non-medical Charges was found to be in order as per the

terms of the policy.

In view of the foregoing the complaint was admitted to the claim amount of Rs.53,879/-.

In the matter of
Mr. Pramesh T. Shah
Vs.
The National Insurance Company Ltd.
Complaint Ref. No.AHD-G-048-1617-1114

Award Date: 07/02/2017
Policy No: 301900/48/15/85/00001221

The Complainant was admitted to Akshar Eye Hospital, Ahmedabad on 12.03.2016 for Rt eye Cataract surgery. On discharge from the hospital, the Complainant had filed a claim for Rs.30, 622/- The Respondent had rejected Rs.8,685/- being OT Charges & Surgeon charges under customary & reasonable charges.

The Respondent had disallowed Rs 8,685/- out the total claim of Rs.30, 622/- from complainant's claims under policy clause No. 6.42 - customary & reasonable 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. In the subject case the Respondent had not provided any rate list from similar hospitals in the geographical area.

The Respondent had failed to provide any justification in support of the deduction of Rs.8,685/-/- made from the claim amount. He had also confirmed that there was no capping in cataract claim in policy.

The Respondent had also not justified deduction for Rs.8, 685/- under OT & Surgeon Charges.

Under the circumstances the deduction was arbitrary. The Complainant was entitled for relief. The Forum had reworked the claim payment including the OT &Surgeon charges.Accordingly,Rs.8, 685 /- being the balance claim amount was payable.

In view of the foregoing the complaint was admitted to the claim amount of Rs.8,685/-.

In the matter of
Mr. Ramnikbhai S. Virpara

Vs.
Iffco-Tokio General Insurance Company Ltd.
Complaint Ref. No.AHD-G-023-1617-1144

Award Date: 07/02/2017
Policy No: 52625656

The Complainant's son Shri Avinash, aged 24 years was insured under Swasthaya Kavach (Family Health) Policy for the period from 28/05/2016 to 27/05/2017 by the Iffco-Tokio General Insurance Co. Ltd. The Insured was admitted to Sankalp Spine Hospital, Ahmedabad on 28/06/2016 for the treatment of L4-L5 Prolapsed Inter-vertebral disc and discharged on 29/06/2016. The Company had rejected his claim under Clause 4 of the policy. Unsatisfied with the rejection of the claim he had approached the Forum for redressal of his complaint.

The Complainant had ported his policy from National Insurance Co. Ltd. since 28.05.2014.

The complainant was paid with the claim amount of Rs.55,848/- on 20/05/2013 by the National Insurance Co. for the treatment of L2-L3 prolapsed disc.

The Complainant had not mentioned his son's medical history pertaining to the year 2013 in the proposal form in the year 2014.

During the year 2015, the Complainant's son was admitted in Giriraj Orthopedic Hospital for PCKG-05-SURG-00-1 general surgery. While considering the claim in the year 2015 it was found that in discharge summary the medical history of the year 2013 was not mentioned by the hospital. Hence the claim was settled without any question for Rs.20,800/-.

On 28/06/2016, the complainant was admitted for the treatment of L4-L5 Prolapsed Inter-vertebral Disc. The medical papers of the year 2016 mentioned the treatment of L2-L3 Prolapsed Disc in the year 2013.

The documents produced before the Forum established the suppression of material facts required for underwriting the proposal.

The subject medical condition was directly related to the treatment taken in the previous policies with National Ins. Co. Ltd.

The Respondent had repudiated the claim on the basis of Non-disclosure of material fact. The previous surgical history of 3 years was not declared in the proposal form, at the time of porting the policy.

During the hearing the complainant had agreed that he had taken the claim from National Ins. Co. Ltd. The same was also not disclosed in the proposal form, this was breach of basic Principle of Insurance – "Utmost Good Faith".

The complainant was duty bound to disclose the medical history in the proposal form. The complainant taking a shelter under the fact that previous claim was settled hence the subject claim should also be settled was incorrect (as the claim then was settled without the knowledge of the treatment undergone by the Insured).

The company had correctly applied the non-disclosure clause and rejected the claim.

In view of the foregoing the complaint failed to succeed.

In the matter of
Mr. Dhiresh T. Shah
Vs.
The National Insurance Company Ltd.
Complaint Ref. No.AHD-G-048-1617-1173

Award Date: 20/02/2017
Policy No: 302100/48/12/85/00005689

The Complainant and his spouse were insured for Sum Insured of Rs.2,00,000/- each under National Mediclaim Policy with The National Insurance Company Ltd. The Complainant was hospitalized to Raghudeep Eye Hospital, Ahmedabad on 08.11.2013 for operation of Right Eye Cataract surgery with implantation of intra ocular lens and discharged on the same day. The complainant had lodged a claim for Rs.1,24,700/- with the respondent Insurance Company. The respondent insurance company had paid Rs.59,799/- after disallowing Rs.64,700/-.

The respondent had produced Dr. Piyush Shah's opinion for comparison of rates prevailing in the same geographical area of the Hospital where the complainant had taken treatment. It had arrived at the reasonableness of the expenses deducted with comparison of the rates Ahmedabad City..

As regards the deduction of operation charges of Rs.12,000/-; nowhere in the policy terms, the limit of the operation charges was described. The Operation/Surgeon Charges may vary as per the skill, experience and expertise of the treating doctor. The representative could not prove that the Operation charge was unreasonable.

As regards the deduction of Rs.24,000/- from IOL bill, the complainant had submitted a copy of Bill No.216/8544 dated 08.11.2013 for Rs.40,000/-. The Respondent had deducted Rs.24,000/- without producing any proof to prove that the cost of it was on higher side.

The respondent had deducted Rs.26,000/- towards Lens soft fit + Rs.1,700/- O.T. charges under " Reasonable and Customary Charges" without producing any evidence for the same. The respondent had deducted Rs.201/- correctly as not payable medicines charges

In view of the foregoing the complaint was admitted and hereby directed to make payment of Rs.63,700/- to the complainant.

In the matter of
Mr.s. Palkaben M. Parmar
Vs.
The National Insurance Company Ltd.
Complaint Ref. No.AHD-G-048-1617-1279

Award Date: 20/03/2017
Policy No: 301800/48/16/85/00009270

The Complainant and her family members were insured with National Mediclaim Policy for sum insured of Rs.1,00,000/- from The National Insurance Co. Ltd. The complainant's son Master Yax, aged 8 years was hospitalized to Aditi Children Hospital and Neonatal Care, Ahmedabad on 06.10.2016 and was treated for Dengue fever and discharged on 12.10.2016. The complainant had submitted a claim for Rs.22,427/-. The respondent insurance company had rejected the claim citing the reason; claim had arisen during the break of insurance period. The complainant being aggrieved with the rejection of the claim had approached the Forum for settlement of full claim amount.

The complainant had paid the premium on 03/10/2016 to the corporate agent, the bank, for coverage of the insured – i.e. from 05/10/2016 to 04/10/2017. She had submitted the proof for payment for the insurance.

The insurer had issued the policy for the period from 13/10/2016 to 12/10/2017 instead of 05/10/2016 to 04/10/2017 as it had received the premium on 13/10/2016.

There existed a MOU between the Corporate agent (Bank of Baroda) and the Respondent. The Insurance Corporate agent being a bank is governed by the IRDAI Rules / Regulations and RBI Rules.

The Corporate agent was duty bound to remit the premium and submit the proposal papers collected from the policy holders to the Insurer on the same day or on the next day Since, it was a renewal of the policy, the collection of the renewal premium at the hands of the Corporate agent is considered as premium received at the end of the Insurer. Invoking Sec. 64 VB of the Insurance Act and denying the claim of the insured who had renewed the policy before lapsation of the was sheer absurdness. The Corporate agent represented

the Respondent. The Respondent could not absolve of its obligations to the Insured. The Insured by paying the premium to the agent before the expiry of the policy had established and expressed her desire to keep the policy continually in force. The Insurer has to prevail upon the Corporate agent to implement and act upon the laid Rules, Regulation & Acts like remitting the premium to the Insurer immediately on receipt of the premium. The Insurer had failed to play its role in bringing the Corporate agent to books. The Insured had performed her part – paying the premium in time. The Respondent had erred by denying the claim. The Respondent had wrongly denied the claim.

In view of the foregoing the complaint was admitted and the respondent is hereby directed to pay Rs.22,427/- to the complainant and treat the policy as continuous with effect from 05/10/2016.

In the matter of
Mrs. Rashmita H. Patel
Vs.
The New India Assurance Company Ltd.
Complaint Ref. No.AHD-G-049-1617-1299

Award Date: 20/02/2017
Policy No: 201402/34/16/25/00000559

The Complainant, aged 53 years, was insured for Sum Insured of Rs.1,00,000/- under New Mediclaim 2012 Policy with The New India Assurance Company Ltd. The Complainant was hospitalized to Life Care Institute of Medical Sciences & Research Hospital, Ahmedabad on 12.08.2016 for operation of Right Supraclavicular Lymphnode Excision and discharged on 13/08/2016. The complainant had lodged a claim for Rs.32,199/- with the respondent Insurance Company. The respondent had paid Rs.17,744/- after disallowing Rs.14,455/-.

The respondent had produced the proposal form along with proof of date of dispatch of the policy. As per the policy condition no. 3.1 the deduction made by the insurer was in order. As regards the deduction of operation charges of Rs.8,667/-; Anesthetic Charges Rs. 1334/-, O.T. Charges Rs.1334/- and Pathology charges Rs.1000/- were as per policy clause 3.1. The respondent had deducted Rs.2000/- being room charges The complainant was entitled for Rs.1,000/- per day towards Room + Nursing Charges being 1 % of Sum Insured of Rs.1,00,000/-.The complainant had claimed

Rs.3000/- towards room and nursing charges. The deduction was correct. Amount of Rs.120/- being cost of non-payable pharmacy charges was deducted correctly.

In view of the foregoing the complaint failed to succeed.

In the matter of
Mr. Mukesh J. Mistry
Vs.
The New India Assurance Company Ltd.
Complaint Ref. No.AHD-G-049-1617-1318

Award Date: 20/02/2017
Policy No: 220300/34/15/01/00002621

The Complainant and his wife were insured with Mediclaim Policy 2007 for sum insured of Rs.2,00,000/- (each) from The New India Assurance Company Ltd. The Complainant's wife was hospitalized to Advance Orthopedic Management Centre Hospital, Vadodara on 19.06.2016, treated for Acute Lumbar Spondylosis and discharged on 24.06.2016. The complainant had submitted claim for Rs.22,466/-. The respondent insurance company had repudiated the claim under policy clause No. 3.13. The complainant had approached the Forum for settlement of the claim amount.

The complainant had provided the copy of Registration Certificate from the Advance Orthopedic Management Centre Hospital, Vadodara validated up to 31/03/2017.

The Complainant had enclosed copies of the claim settlement letters of (1) Pushpaben Patel –Insured with United India Ins. Co. Ltd., Claim No.MDI5-0028074961- settlement amount of Rs.84,644/- on 21/06/2016.(2) Mr. Snehalkumar Pancholi – Insured with Bajaj Allianz Gen. Ins. Co. Ltd., Claim ID No. 1073599 – settlement of Rs.21670/- as proofs. He had written to the company stating that the company had settled the claim that had arisen from the same hospital. The Respondent neither had respondent to the letter nor made any statement in the SCN or mention before the Forum during the hearing. The Respondent stated that its investigators found less than 15 beds. However the Respondent was unable to state the no. of beds found in the hospital. The Representative was unable to produce the investigation report. Hences, it had failed to prove their point of contention that there was less than 15 beds in the hospital. The claim settlement of other two patients of the same hospital contradicted the complainant's claim being rejected.

In view of the facts mentioned above, the complaint was admitted and the Respondent was directed to settle the balance claim amount of Rs.22,466/- to the complainant.

In the matter of
Mrs. Jyostsana A. Thaker
Vs.
United India Company Ltd.
Complaint Ref. No.AHD-G-051-1617-1183

Award Date: 21/02/2017
Policy No: 180601/28/15/P/102337292

The Complainant, aged 80 years had insured for Sum Insured Rs.2,75,000/- under Individual Mediclaim Policy with United India Insurance Company Ltd. The Complainant was hospitalized to Samvid Retina Clinic & Laser Centre, Vadodara on 14.08.2015 for surgery of Right Eye Retina Problem and discharged on the same day. The complainant had lodged, a claim for Rs.36,350/- with the respondent Insurance Company. The respondent insurance company had repudiated the claim citing Exclusions: condition 4.19.

The Respondent had cited less than 24 hours hospitalization clause and denied the

claim. It was seen that the insurer had listed 34 types of disease under the day care procedure / treatment. It was also found that in olden days these 34 diseases needed

Hospitalization for more than 24 hours. Similarly, the subject treatment too needed hospitalization for more than 24 hours in earlier days. Due to technical advancement, it can be done in less than 24 hours. The Day Care treatment has been defined in the policy as under in clause 3.11.

Clause – "3.11" - "Day Care treatment means the medical treatment and/or surgical procedure which is –(i) Undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hrs because of technological and (ii) which would have otherwise required a hospitalization of more than 24 hours. Treatment normally taken on an out-patient basis is not included in the scope of this definition".

The treatment had to be carried out in Operation Theater with sterile condition and by a specialized doctor. These injections / treatment are not similar to other OPD treatment.

The complainant had submitted the proof of her previous claims for her similar treatment on her left eye settlement details:

a. File No.20140506B007R2B7527 - Rs.21750/- 10/07/2014

b. File No 20140602B007R2B7921 - Rs.13150/- 10/07/2014

c. File No.20140709B007R2B8464 - Rs.13150/- 19/07/2014

d. File No.20140903B007R2B9371 - Rs. 12000/- 24/09/2014

e. File No.20141225B007R2B11318 - Rs.12000/- 06/01/2015

The Respondent could not explain the reason for rejection of the claim on similar treatment on the patient's right eye. The complainant was entitled for relief.

In view of the foregoing the complaint was admitted, the Respondent was hereby directed to make payment of Rs.36,350/- to the complainant being full and final settlement of the claim.

In the matter of
Mrs. Jyostsana A. Thaker
Vs.
United India Company Ltd.
Complaint Ref. No.AHD-G-051-1617-1184

Award Date: 21/02/2017
Policy No: 180601/28/15/P/102337292

The Complainant, aged 80 years had insured for Sum Insured Rs.2,75,000/- under Individual Mediclaim Policy with United India Insurance Company Ltd. The Complainant was hospitalized to Samvid Retina Clinic & Laser Centre, Vadodara 18.02.2016 for surgery of Right Eye Retina Problem and discharged on the same day. The complainant had lodged, a claim for Rs.29,850/- with the respondent Insurance company. The respondent insurance company had repudiated the claim citing Exclusions: condition 4.19.

The Respondent had cited less than 24 hours hospitalization clause and denied the claim. It was seen that the insurer had listed 34 types of disease under the day care procedure / treatment. It was also found that in olden days these 34 diseases needed

hospitalization for more than 24 hours. Similarly, the subject treatment too needed hospitalization for more than 24 hours in earlier days. Due to technical advancement, it

can be done in less than 24 hours. The Day Care treatment has been defined in the policy as under in clause 3.11.

Clause – "3.11" - "Day Care treatment means the medical treatment and/or surgical procedure which is –(i) Undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hrs because of technological and (ii) which would have otherwise required a hospitalization of more than 24 hours. Treatment normally taken on an out-patient basis is not included in the scope of this definition".

The treatment had to be carried out in Operation Theater with sterile condition and by a specialized doctor. These injections / treatment are not similar to other OPD treatment.

The complainant had submitted the proof of her previous claims for her similar treatment on her left eye settlement details:

a. File No.20140506B007R2B7527 - Rs.21750/- 10/07/2014

b. File No 20140602B007R2B7921 - Rs.13150/- 10/07/2014

c. File No.20140709B007R2B8464 - Rs.13150/- 19/07/2014

d. File No.20140903B007R2B9371 - Rs. 12000/- 24/09/2014

e. File No.20141225B007R2B11318 - Rs.12000/- 06/01/2015

The Respondent could not explain the reason for rejection of the claim on similar treatment on the patient's right eye. The complainant was entitled for relief.

In view of the foregoing the complaint was admitted, the Respondent was hereby directed to make payment of Rs.29,850/- to the complainant being full and final settlement of the claim.

In the matter of
Mrs. Jyostsana A. Thaker
Vs.
United India Company Ltd.
Complaint Ref. No.AHD-G-051-1617-1185

Award Date: 21/02/2017
Policy No: 180601/28/15/P/102337292

The Complainant, aged 80 years had insured for Sum Insured Rs.2,75,000/- under Individual Mediclaim Policy with United India Insurance Company Ltd. The Complainant was hospitalized to Samvid Retina Clinic & Laser Centre, Vadodara 03.11.2015 for surgery of Lt Eye Retina Problem and discharged on the same day. The complainant had lodged, a claim for Rs.12,000/- with the respondent Insurance company. The respondent insurance company had repudiated the claim citing Exclusions: condition 4.19.

The Respondent had cited less than 24 hours hospitalization clause and denied the

Claim. It was seen that the insurer had listed 34 types of disease under the day care procedure / treatment. It was also found that in olden days these 34 diseases needed

hospitalization for more than 24 hours. Similarly, the subject treatment too needed hospitalization for more than 24 hours in earlier days. Due to technical advancement, it can be done in less than 24 hours. The Day Care treatment has been defined in the policy as under in clause 3.11.

Clause – "3.11" - "Day Care treatment means the medical treatment and/or surgical procedure which is –(i) Undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hrs because of technological and (ii) which would have otherwise required a hospitalization of more than 24 hours. Treatment normally taken on an out-patient basis is not included in the scope of this definition".

The treatment had to be carried out in Operation Theater with sterile condition and by a specialized doctor. These injections / treatment are not similar to other OPD treatment.

The complainant had submitted the proof of her previous claims for her similar treatment on her left eye settlement details:

a. File No.20140506B007R2B7527 - Rs.21750/- 10/07/2014

b. File No 20140602B007R2B7921 - Rs.13150/- 10/07/2014

c. File No.20140709B007R2B8464 - Rs.13150/- 19/07/2014

d. File No.20140903B007R2B9371 - Rs. 12000/- 24/09/2014

e. File No.20141225B007R2B11318 - Rs.12000/- 06/01/2015

The Respondent could not explain the reason for rejection of the claim on similar treatment on the patient's left eye. The complainant was entitled for relief.

In view of the foregoing the complaint was admitted, the Respondent was hereby directed to make payment of Rs.12,000/- to the complainant being full and final settlement of the claim.

In the matter of
Mrs. Jyostsana A. Thaker
Vs.
United India Company Ltd.
Complaint Ref. No.AHD-G-051-1617-1187

Award Date: 21/02/2017
Policy No: 180601/28/15/P/102337292

The Complainant, aged 80 years had insured for Sum Insured Rs.2,75,000/- under Individual Mediclaim Policy with United India Insurance Company Ltd. The Complainant was hospitalized to Samvid Retina Clinic & Laser Centre, Vadodara 14.10.2015 for surgery of Right Eye Retina Problem and discharged on the same day. The complainant had lodged, a claim for Rs.29,850/- with the respondent Insurance Company. The respondent insurance company had repudiated the claim citing Exclusions: condition 4.19.

The Respondent had cited less than 24 hours hospitalization clause and denied the Claim. It was seen that the insurer had listed 34 types of disease under the day care procedure / treatment. It was also found that in olden days these 34 diseases needed hospitalization for more than 24 hours. Similarly, the subject treatment too needed hospitalization for more than 24 hours in earlier days. Due to technical advancement, it can be done in less than 24 hours. The Day Care treatment has been defined in the policy as under in clause 3.11.

Clause – "3.11" - "Day Care treatment means the medical treatment and/or surgical procedure which is –(i) Undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hrs because of technological and (ii) which would have otherwise required a hospitalization of more than 24 hours. Treatment normally taken on an out-patient basis is not included in the scope of this definition".

The treatment had to be carried out in Operation Theater with sterile condition and by a specialized doctor. These injections / treatment are not similar to other OPD treatment.

The complainant had submitted the proof of her previous claims for her similar treatment on her left eye settlement details:

a. File No.20140506B007R2B7527 - Rs.21750/- 10/07/2014

b. File No 20140602B007R2B7921 - Rs.13150/- 10/07/2014

c. File No.20140709B007R2B8464 - Rs.13150/- 19/07/2014

d. File No.20140903B007R2B9371 - Rs. 12000/- 24/09/2014

e. File No.20141225B007R2B11318 - Rs.12000/- 06/01/2015

The Respondent could not explain the reason for rejection of the claim on similar treatment on the patient's right eye. The complainant was entitled for relief.

In view of the foregoing the complaint was admitted, the Respondent was hereby directed to make payment of Rs.29,850/- to the complainant being full and final settlement of the claim.

In the matter of
Mr. Paresh C. Manek
Vs.
HDFC General Insurance Company Ltd.
Complaint Ref. No.AHD-G-018-1617-1201

Award Date: 21/02/2017
Policy No: 2952201133885100-2825

The Complainant, aged 36 years, was insured with HDFC Ergo Gen. Ins. Co. Ltd. for the period from 28/07/2015 to 27/07/2017.The Complainant was admitted to Urocare Hospital Rajkot, on 23/09/2016 for operation of Right Ureteric Calculus and discharged on 26/09/2016.The respondent had repudiated her total claim of Rs.59,879/-. Being aggrieved by the repudiation of the claim he had approached the Forum to get claim amount of Rs.59,879/-.

The Complainant was admitted in Urocare Hospital, Rajkot for the period from 23.09.16 to 26.09.16. He was operated for Rt. Ureteric Calculus. The Complainant had lodged a claim for Rs 59,879/- The respondent had repudiated the claim.

The Respondent Co. had provided the Terms and Condition of the policy. As per section 9.a.ii a and 9.a.ii.b of policy, a waiting period of 2 years was applicable for the said ailment and procedure. The subject Rt. Ureteric Calculus surgery took place within 2 year of the Commencement of the policy. The rejection of the claim was correct.

In view of the foregoing the complaint failed to succeed,

In the matter of
Mr. Dhaval S. Sheth
Vs.
The New India Assurance Company Ltd.
Complaint Ref. No.AHD-G-049-1617-1153

Award Date: 20/03/2017
Policy No. 230300/34/14/01/00008200

The Complainant and his family members were insured with Medi-claim Policy 2007 issued by The New India Assurance Company Ltd. The Complainant's wife Mrs. Roopalben, aged 43 years was hospitalized in Surat Institute of Digestive Sciences hospital on 15/02/2016 for the treatment of Celiac disease + Muscular Backache + Cryptogenic Cirrhosis and discharged on 18/02/2016. Since the complainant's claim for Rs.32,329/- was rejected under Clause No.4.4.16, he had moved the Forum for justice.

The claim attracted clause 6.0 Renewal clause of the policy which restricted the Sum Insured to Rs.2,50,000/- plus CB of Rs.52,500/- as the available SI to consider the claim. The clause read as "if the policy is to be renewed for enhanced sum insured, then the restriction i.e. 4.1, 4.2 & 4.3 will apply to additional sum insured as if it is a new policy". Clause 4.1 dealt with pre-existing disease, 4.2 dealt with 30 days waiting period and 4.3 dealt with waiting period for specified disease, ailments, and conditions. The Forum noted that it had heard his other complaint and awarded a relief for Rs.50,834/-. The insured had already exhausted the Sum Insured in the policy year 2015-2016. Hence, there was no possibility of any further relief. The complaint failed to succeed.

In view of the submission of the parties during the course of hearing and the documents made available to the Forum, the complaint stands dismissed.

In the matter of
Mr. Dhaval S. Sheth
Vs.
The New India Assurance Company Ltd.
Complaint Ref. No.AHD-G-049-1617-1154

Award Date: 20/03/2017
Policy No. 230300/34/14/01/00008200

The Complainant and his family members were insured with Medi-claim Policy 2007 issued by The New India Assurance Company Ltd. The Complainant's wife Mrs. Roopalben, aged 43 years was hospitalized in Global hospital on 08/01/2016 for the treatment of stomach related disease and discharged on 22/01/2016. Since the complainant's claim for Rs.3,98,261/- was rejected under Clause No.4.4.16, he had moved the Forum for justice.

The Discharge Summary in its diagnosis described the history along with the subject disease, the treating doctor had certified that none of the disease viz. celiac sprue disease + autoimmune hepatitis + chronic liver disease, was a genetic disorder. The complainant had written in her appeal to Grievance Cell of the Respondent that treatment was not given for the treatment of any Genetic Disorder. Even then the respondent had repudiated the claim without examining any medical opinion / papers given by the treating hospital.
Celiac Sprue is a genetic disorder. Other disease was complications of Celiac Sprue. The treatment given was not only for the Celiac Sprue but also for the complications. The policy restrained payment of Genetic disorder but not on its complications. The complainant had earlier settled the claim on the treatment in the same policy year. The, insurer citing its internal guidelines had denied the subject claim. The internal guidelines were not part of the policy terms and conditions. The Celiac disease is genetic, which fell under exclusion clause. Since treatment was also given for the complications of the celiac disorder and other diseases which were not excluded, the complainant is entitled for relief. The insured had Sum Insured of Rs.2,50,000/- plus CB of Rs.52,500/-. The Insurer had settled Rs.2,51,666/- in favour of the

complainant in the impugned policy year. Thus, a Sum Insured of Rs.50,834/- was left for claim reimbursement. The subject claim was for Rs.3,98,261/- on the treatment of excluded and not excluded treatments. The Insured was entitled for the available Sum Insuredddd of Rs.50,834/-

.The claim was admitted in view of the foregoing facts and the Respondent was directed to settle the balance claim amount of Rs.50,834/- to the complainant.

In the matter of
Mr. Dhaval S. Sheth
Vs.
The New India Assurance Company Ltd.
Complaint Ref. No.AHD-G-049-1617-1155

Award Date: 20/03/2017
Policy No. 230300/34/15/01/00006256

The Complainant and his family members were insured with Medi-claim Policy 2007 issued by The New India Assurance Company Ltd. The Complainant's wife Mrs. Roopalben, aged 44 years was hospitalized in Surat Institute of Digestive Sciences hospital on 23/05/2016 for the treatment of Autoimmune Hepatitis-CLD + Coeliac Sprue and discharged on 02/06/2016. Since the complainant's claim for Rs.2,43,293/- was rejected under Clause No.4.4.16, he had moved the Forum for justice.

The Discharge Summary, in its diagnosis column, described the history along with the subject disease. The treating doctor had certified that none of the disease viz. Autoimmune Hepatitis-CLD, which was not genetic disorder. The complainant had written in his appeal to Grievance Cell of the Respondent that treatment was not given for any Genetic Disorder. Even then the respondent had repudiated the claim without examining any medical opinion / papers given by the treating hospitals.

Celiac Sprue is a genetic disorder. Other disease were complications of Celiac Sprue. The policy restrained payment of Genetic disorder but not on its complications. The complainant had earlier settled the claim on the treatment of Menorrhagia, Cryptogenic, Cirrhosis of Liver with Pht. Celiac Sprue and Dysfunction Uterine Bleeding + Autoimmune Hepatitis + Rt. Lower limb Deep Vein, thrombosis in the previous policy year. The insurer citing its internal guidelines had denied the subject claim. The representative had stated that their internal guidelines (not part of the policy terms and conditions) had identified celiac disorder as genetic. The Celiac disorder, a genetic disorder, fell under the exclusion clause. Treatment was also given for the complications of celiac disorder and other disease which were not excluded. The Sum insured of the policy was Rs.5,00,000/-. The policy clause No. 6 restricted the sum insured to Rs.2,50,000/-. The clause read as "if the policy is to be renewed for enhanced sum insured,

then the restriction i.e. 4.1, 4.2 & 4.3 will apply to additional sum insured as if it is a new policy". Clause 4.1 dealt with pre-existing disease, 4.2 dealt with 30 days waiting period and 4.3 dealt with waiting period for specified disease, ailments and conditions. There was no CB available in the policy as it was exhausted in the previous year policy after settlement of the claims. The Insurer had settled Rs.1,84,995/- as claim in the subject policy year. Thus, a Sum Insured of Rs.65,005/- was left for claim reimbursement. The claim was admitted in view of the foregoing facts, the Respondent was directed to settle the balance claim amount of Rs.65,005/- to the Complainant.

In the matter of
Mr. Ramzanbhai Y. Sanghriyat
Vs.
Religare Health Insurance Company Ltd.
Complaint Ref. No.AHD-G-037-1617-1169

Award Date: 21/03/2017
Policy No. 10087119

The Complainant Mr.Ramzanbhai, aged 38 years was insured with Religare Health Insurance Co.Ltd. under Group Care (Scheme 2- IIB). He was admitted to Anas Medical Nursing Home, Ahmedabad on 12/10/2016 for the treatment of Fever and discharged on 14/10/2016. He had incurred a total expense of Rs.20,018/-. His claim was repudiated by the Respondent citing Policy clause Nos.3.2.1 Annexure B (71), "the hospitalization was not justified". Aggrieved with the rejection of the claim the complainant had approached the Forum for Redressal of his grievance.

As per submission of the respondent, the treatment could have been on Out Door Patient (OPD basis), and Hospitalization was not required.

The facts of the complaint failed before CDRF, Palwal was different from the facts of present case. In the present case the insured was having fever for a few days prior to hospitalization. He had symptoms of vomiting and nausea. His " test for Dengue fever" was done on 11/10/2016, which was positive . Thus he was admitted on 12/10/2016 on the advice of qualified physician and substantial amount (Rs.4,468/-) was spent on medicines.

The submission of representative of Religare Health Insurance Co. Ltd. that no test for dengue was done is not correct.

In view of the above, the complaint was admitted, the Respondent was directed to settle the balance claim amount of Rs.20,018/- to the complainant.

In the matter of
Mrs. Nilaben J. Shah
Vs.
The New India Assurance Company Ltd.
Complaint Ref. No.AHD-G-049-1617-1388

Award Date: 21/03/2017
Policy No. 4015/11542965700000

The Complainant, aged 72 years, was insured with ICICI Lombard Gen. Ins. Co. Ltd. for the period from 31/03/2016 to 30/03/2017.The Complainant was admitted to Parekh Hospital Ahmedabad, on 27/06/2016 for operation OA of Rt. Knee and discharged on 30/06/2016.The respondent had repudiated her total claim of Rs.1,29,600/-.Being aggrieved by the repudiation of the claim he had approached the Forum to get her claim amount of Rs.1,29,600/-.

The Complainant was admitted in Parekh Hospital, Ahmedabad for the period from 27/06/16 to 30/06/16. She was operated for Rt. TKR. The Complainant had lodged a claim for Rs 1,29,600/- The respondent had repudiated the claim.

The Respondent Co. had provided the Terms and Condition of the policy. As per policy terms and condition, a waiting period of 1 year was applicable for the said ailment and procedure.

The subject Rt. TKR surgery took place within 1 year of the Commencement of the policy.
The rejection of the claim was correct.

In view of the foregoing the complaint failed to succeed, the Respondent needed no intervention. The complaint was dismissed.

In the matter of
Mr. Harisinh S. Rathod
Vs.
Iffco-Tokio General Insurance Company Ltd.
Complaint Ref. No.AHD-G-023-1617-1376

Award Date: 21/03/2017
Policy No. 52689676

The Complainant Shri Harisinh Rathod, aged 57 years was insured under Family Health Protector Policy for the period from 15/10/2016 to 14/10/2017 by the Iffco-Tokio General Insurance Co. Ltd. The Insured was admitted to Zydus Hospitals & Healthcare Research Pvt. Ltd., Ahmedabad on 03/12/2016 for the treatment of Excision biopsy – Left (level 4) par jugular node and discharged on 04/12/2016 and second time admitted in HCG Cancer Centre on 17/12/2016 for the treatment of Classical Hodgkin's Lymphoma (Chemotherapy first cycle day 1).The Company had rejected his total claims amounting to Rs.98,975/- under General Condition No. 49 & 15(a) of the FHP policy. Unsatisfied with the rejection of the claim he had approached the Forum for redressal of his complaint.

MEDICLAIM

In the matter of
Mr. Rudresh P. Pandya
Vs.
The New India Assurance Company Ltd.
Complaint Ref. No.AHD-G-049-1617-0753

Award Date: 23/01/2017
Policy No. 210200/34/15/04/00000001

Smt. Kinjal R. Pandya had the insurance policy from The New India Assurance Co. Ltd. since the year 2014-15. The Insured was admitted to the Gayatri hospital, Gandhinagar on 09/05/2015 for the treatment of Lt. Tubal Ectopic Pregnancy and discharged on 11/05/2015. The Respondent had rejected her claim of Rs.29, 642/- citing Policy Clause No. 4.4.13 "Maternity Expenses, except abdominal operation for extra uterine pregnancy (Ectopic Pregnancy), which is proved by submission of ultra Sonographic Report and Certification by Gynecologist that it is life threatening". Unsatisfied with the rejection she had approached the Forum for Redressal of her grievance.

The treating Dr. Ratnesh Patel had clarified that the surgery was necessary to save the life of the patient and had certified that it was an Ectopic pregnancy.
The Complainant had submitted USG report of pelvis which confirmed mass lesion.
Respondent had asked for the Biopsy report which was not prescribed in the terms and conditions of the policy.

It was observed that the Insurer and its doctor had demanded a report which the policy clause did not provided for. The requirement for the biopsy report was in contravention of the terms of the policy and was unwarranted.

The point to be noted was that even if the growth in the tube was considered as mass lesion, it needed to be medically treated and the claim in such case was payable.

In other words the treatment and claim on ectopic pregnancy or mass lesion was payable.

The Respondent and its doctor without application of their mind and prudence had preferred to deny the claim. The rejection of the claim was incorrect. The denial of the rightful claim was highly arbitrary and against the PPHI Rules, 2002. In view of the above facts, the complaint was admitted to the claim amount of Rs. 29,642/-.

In the matter of
Mr. Nimesh R. Shah
Vs.
The Oriental Insurance Company Ltd.
Complaint Ref. No.AHD-G-050-1617-0769

Award Date: 23/01/2017
Policy No: 141100/48/2016/14760

Mrs. Nita Nimesh Shah, the health insurance policy holder of Oriental Insurance Co. Ltd., was diagnosed with Cirrhosis of liver, SLE & Hepatitis Genotype – 1 in the year 2003. She had taken treatment from Shrey Hospitals Pvt. Ltd., Ahmedabad from 10/02/2016 to 11/02/2016. The Insured had incurred total expense of Rs.1, 14, 962/= The Respondent had rejected her claim citing Policy Clause No. 4.10 “Expenses incurred for evaluation / diagnostic purposes.”

The complainant’s claim for Rs.1,67,868/- on similar procedure was settled in the year 2004.

Since the discharge from the hospital in the year 2004, the patient had been under medication (Interferra Pegasys injections).

With the availability of new medicine Sofocure I in the year 2016, a set of medical tests were carried out before the prescription of the medicine.

The tablet ‘Sofocure I’ had been prescribed for 6 months. The medicine is used with other antiviral medicines to treat chronic Hepatitis C infection in adults.

Tab Sofocure L like the previous medicine had to be consumed over a long period or till the disease was cured. There may be more new medicines manufactured or alternate medicines available to control the disease in future.

The medication was a continuation of the treatment for the existing disease and not a treatment on new found disease.

There was no hospitalization to treat any disease. The hospitalization was to evaluate the suitability of the new medicine to the patient.

The Forum had not examined the correctness and relevance of the year 2004 claim settlement. The subject claim was like a post hospitalization claim on a continued treatment for the past 12 years.

The Respondent had correctly denied the claim as per the terms and conditions of the policy.

In view of the foregoing, the complaint failed to succeed.

In the matter of
Mr. Karimbhai K. Dhanani
Vs.
The Oriental Insurance Company Ltd.
Complaint Ref. No.AHD-G-050-1617-0793

Award Date: 23/01/2017
Policy No: 141701/48/2015/4914

Smt. Sonalben K. Dhanani had the insurance policy from Oriental Insurance Co. Ltd since the year 2011-12. She was diagnosed with Anemia + Bronchitis and was admitted to Sharda Hospital on 04/03/2016 and discharged on 07/03/2016 after treatment. The Respondent had rejected her claim of Rs.15, 520/- citing Clause No. 4.8 of the Policy. She had approached the Forum as her claim was not paid.

As per the discharge card the patient had fever, cough, vomiting and weakness.”

The treating Dr. M. A. Thakkar had mentioned in his letter dated 24/06/2016 that the patient was evaluated for fever and was found to be anemic subsequently. The Patient was treated for Bronchitis, fever, Gastritis and Anemia; and not “Anemia” alone.

The respondent had contended that as per the discharge summary that the patient was admitted in hospital on 04/03/2016 and discharged on 07/03/2016 after the treatment for Anemia + Bronchitis.

The Respondent had mentioned in their Self Contained Note that the insured was admitted to the hospital on 04/03/2016 for the treatment of iron deficiency anemia. The certificate of treating doctor showed the exact cause for Anemia as 'severe Iron deficiency Anemia', which was excluded in policy clause No. 4.8. However, there was no word 'anemia' found in the exclusion clause. He also submitted Dr. S. J. Dumra's expert opinion, and stated that the prescribed medicines did not reflect treatment for bronchitis. Only vitamin & nutritional supplements were prescribed for the patient.

The insured was treated with intravenous fluids, injection Antibiotics, Multivitamins and Iron. It was observed that the treatment was mostly in the nature to cure anemia. The Respondent had not considered the treatment given to cure Bronchitis. Clause 4.8 under which the claim was rejected did not carry the word anemia. The respondent failed to conclusively prove that the Insured was treated for her general debility as it had repudiated the claim stating that the patient was treated for anemia which was not in the policy clause 4.8. The Complainant was entitled for relief. Out of Rs.2550/- under head Disposables + Miscellaneous-Inu, the amount of Rs.12/- for Micro Tape was not payable.Policy was issued under – Silver Plan with 10% Co. Pay. The claim amount was Rs.15,520/-. After deducting of Rs.12/-(Non-payable item) and Rs.1551/- (10% Co-payment), Rs.13,957/- was payable.

In view of the above facts, the complaint was admitted to the claim amount of Rs.13,957/-.

In the matter of
Mr. Jayantilal R. Shah
Vs.
Star Health & Allied Insurance Company Ltd.
Complaint Ref. No.AHD-G-044-1617-0869

Award Date: 24/01/2017
Policy No: P/171200/01/2015/003415

The Complainant was insured under Sr. Citizens Red Carpet Insurance Policy from 02/03/2015 to 01/03/2016 issued by the Star Health & Allied Insurance Co. Ltd. The Insured was admitted to Guru Krupa Hospital on 05/02/2016 and Discharged on 13/02/2016. The Company had rejected his claim and cancelled his policy under Clause 7 and Clause No.11.

The Complainant stated that he had taken the first time policy in the year 2013. He told that the co.'s agent had not mentioned the previous history of the disease in the proposal form. The Complainant was admitted in the year 2008 in Sterling Hospital for CV Stroke – Cerebro Vascular Stroke – Vertebro basilar infarct .On 05/02/2016 the complainant was admitted for Koch's Pulmonary Effusion.

As per the underwriting manual produced by the Insurer, had the Insured declared the CVS, the Insurer would not have issued the policy at all. The documents produced before the Forum established the suppression of material facts required for underwriting the proposal. The Respondent had repudiated the claim on the basis of Non-disclosure of material fact. The previous disease history of 2008 was not declared at the time of taking the policy. The Respondent had told that there were 5 questions in the proposal form related to previous history of any disease, the complainant had replied in negative to all the 5 questions. One of the diseases was CVA.

The Respondent had correctly cancelled the said policy on 29/08/2016 and refunded the premium amounting to Rs.9,681/-. The company has correctly applied the non-disclosure clause and rejected the claim. In view of the above, the complaint failed to succeed.

In the matter of
Mr. Ashwinbhai T. Limbadia
Vs.
The New India Assurancwe Company Ltd.
Complaint Ref. No.AHD-G-049-1617-0909

Award Date: 24/01/2017
Policy No: 210600/34/14/25/00000942

The Complainant had Mediclaim policy with The United India Insurance Company Ltd. since 11.08.2009 to 10/08/2013 and subsequently ported to the New India Assurance Co. Ltd. from 11/08/2013 insuring himself, his wife and two children. The Complainant's wife Mrs. Naliniben was hospitalized in Anand Multi Speciality Hospitals Pvt. Ltd., Ahmedabad on 23.07.2015 for operation of Incisional Hernia and was discharged on 28.07.2015. The complainant lodged a claim for Rs.76,037/- with the respondent Insurance Company. The respondent insurance company paid Rs.46,265/- after deducting Rs.29,772/-.

The Insured initially had the policy from United India Insurance Co. Ltd. since 11.08.2009 for S.I. of Rs.1,25,000/-.The policy was ported to the respondent w.e.f. 11.08.2013 with S.I. of Rs.3,00,000/-. The claim had arisen in the 2nd year of the policy. There was a waiting period of

24 months in the policy. Since the policy was ported , the Respondant had accordingly given the benefit of waiting period. However, there was no Clause in the policy which restricted the S.I. to S.I. of a particular year, in the case of enhancement of Sum Insured.

The Respondent's reasoning that the Insured had undergone LSCS in 1984 & 1991 and the happening of the hernia in 2015 was due to pre-existing disease was highly incorrect as it had happened after 24 years. The Respondent had accepted the ported policy with all benefits of the previous policy. The application of various clauses in deducting the claim was arbitrary and incorrect. The Insured was entitled for the reimbursement of the mediclaim The Respondent had failed to prove the unreasonableness of the charges and the fees paid by the Insured.

In view of the foregoing the complaint was admitted to the claim amount of Rs.29,000/-.

In the matter of
Mr. Rajendra D. Parikh
Vs.
United India Insurance Company Ltd.
Complaint Ref. No.AHD-G-051-1617-0931

Award Date: 24/01/2017
Policy No: 180300/28/15/P/104083039

The Complainant Mr. Rajendra Parikh, aged 84 years, was insured with United India Insurance Co. Ltd. for a Sum Insured of Rs.4,50,000/- with CB of Rs.1,57,500/-. He was admitted to Medanta – The Medicity Hospital in Gurgaon, Haryana on 12/04/2016 for the treatment of Hematuria. Against the claim of Rs.2,21,720/-, the Respondent had remitted Rs.1,08, 960/- to the Insured The Complainant had approached the Forum for redressal of his grievance and settlement of the balance claim amount.

The Insured was having the policy since the year 2004 as per policy schedule.

The Sum Assured was Rs:4.50 lakhs with NCB of Rs: 1.57,500/- in the subject policy. The total S.I. for claim purpose was Rs.6,07,500/-. The Insured was not made aware of the PPN agreement with the hospital. It was seen that the Respondent had settled Rs 4,93,082/- and disallowed the balance claim of Rs.1,14,418/- stating PPN agreement with the hospital. The Complainant had not taken any special service from the hospital.

The PPN agreement existed between TPA, Hospital and company. The Hospital, a party to the PPN agreement, had charged excess amount, contravening the PPN agreement.

The Respondent and the TPA had not enquired with the hospital as to why the hospital had charged excess amount. It is noted from the discharge summary that the complainant was admitted in hospital for 8 days. The rate applicable for Turp is Rs.80,000/- for 1-2 days hospitalization. The complainant was not admitted for TURP. The Respondent has not considered the other disease, which were managed by the hospital during hospitalization. It has mechanically applied PPN rate for TURP whereas the respondent should have considered control and management of other disease also.

In view of the facts and circumstances the complaint was admitted to the claim amount of Rs.1,14,418/-.

.

In the matter of
Mr. Manih A. Rana
Vs.
United India Insurance Company Ltd.
Complaint Ref. No.AHD-G-051-1617-1022

Award Date: 06/02/2017
Policy No: 180800/28/15/P/103790229

The complainant's father Mr. Arvindbhai was admitted to Metas Adventis Hospital, Surat on 15/04/2016 for the treatment of Severe Ileo Colitis & discharged on 21/04/2016. The complainant had incurred an expense of Rs.84,091/-. His claim was partially settled for Rs.65,935/- after deduction of Rs.18,156/- citing Admission charges, Investigation/Lab charges, procedure charges, service charges and consulting charges.

The complainant had not provided copies of the reports advised by the BHMS doctor to the Forum. Hence, its requirement and utility for the treatment was not known. Hence, the reimbursement on the same could not be awarded.

Similarly, the complainant had not provided the receipts of the expenses incurred on procedure charges and the visiting consultant charges. Hence, these amounts were also not considered.

In view of the above facts, the complaint failed to succeed.

In the matter of
Mr. Jayesh A. Mehta
Vs.
The New India Assurance Company Ltd.
Complaint Ref. No.AHD-G-049-1617-1045

Award Date: 06/02/2017
Policy No: 230400/34/15/25/00005856

The Complainant and his family members were insured with New Medicare 2012 Mediclaim policy issued by The New India Assurance Company Ltd. The Complainant's wife was hospitalized in Kidney Care Urological hospital on 11/03/2016 for the treatment of Acute Uretic Stone and discharged on 12/03/2016. Since the complainant's claim for Rs. 51,158/- was rejected under Clause No.2.15, he had moved the Forum for justice.

The Complainant had provided a Certificate dated NIL from the Kidney Care Urological Hospital wherein, it was stated that the hospital had various wards with 15 beds rooms-wise.

The complainant enclosing a copy of the claim settlement letter of Shri Ashokkumar N. Parekh, claim No. HI-NIA-000135864(0) dated 18/04/2016, as an example and proof, had written to the company stating that the company had settled the claim that had arisen from the same hospital.

The Respondent neither had responded to the letter nor made any statement in the SCN or mentioned before the Forum during the hearing.

It proved that the Respondent had settled the claim of at least 2 patients of this hospital whose hospitalization period was during or around the complainant's hospitalization duration.

The Respondent had failed to prove their point of contention that there was less than 15 beds in the hospital.

The claim settlement of other two patients of the same hospital contradicted the complainant's claim being rejected.

The amount of Registration charges Rs.100/- + Linen Charges – Rs.200/- + Gloves –Rs.254/- + Betadin – Rs.106/- = Total Rs. 660/- were non-payable items.

In view of the facts and circumstances the complaint was admitted to the claim amount of Rs.50,498/-.

In the matter of
Mr. Vijaykumar Gupta
Vs.
United India Insurance Company Ltd.
Complaint Ref. No.AHD-G-051-1617-1066 / 1067 / 1068

Award Date: 06/02/2017
Policy No: 060400/28/14/P/109567898
& Pol. No. 060400/48/15/P/113082409

The complainant Mr.Vijaykumar, aged 70 years was insured under Family Medicare Policy 2014. He was admitted to Rising Retina Clinic, Ahmedabad thrice for Left eye - OS Intravitreal Lucentis surgery as he was diagnosed with OS: Hemi Central Retinal Vein Occlusion + OS Cystoid Macular Edema. He had undergone intravitreal Lucentis surgery on 16/01/2016, 13/02/2016 and 15/03/2016. On discharge from the hospital, the Complainant had filed three separate claims aggregating to Rs.85,770/- with the insurer. The Respondent had repudiated the claim citing Exclusions: Condition No.2 – Definitionss.2.3 – OPD based treatment.
The Respondent, citing "less than 24 hours hospitalization" clause, had denied the claim.
The Respondent had not assigned any other reason for the rejection of the claim. It meant the claim was payable had the hospitalization been for more than 24 hours.
It was seen that the Insurer had listed 34 types of disease under the day care procedure / treatment. It was also found that in olden days these 34 diseases needed hospitalization for more than 24 hours. Similarly, the subject treatment also needed hospitalization for more than 24 hours. However, with the advancement of medical technology and new medical inventions the surgery could be carried out in short time extending to few hours. The Company needed to update its list of day care treatment with the subject treatment as well.

Retinal vein occlusions (RVOs) are the second most common type of retinal vascular disorder after diabetic retinal disease. They can occur at almost any age (although typically in middle to later years - most in those aged over 65 years) and their severity ranges from asymptomatic to a painful eye with severe visual impairment.

Retinal vein occlusion is one of the most common causes of sudden painless unilateral loss of vision. Loss of vision is usually secondary to macular edema.

The treatment had to be carried out with local anesthesia in sterile conditioned Operation Theater under aseptic precaution by a specialist. The treatment needed specialized doctor. The subject treatment could not be carried out like other OPD treatments.
Based on the deposition of the parties to the complaint, the Forum noted that the treatment was a prolonged one, depending on the prognosis, the patient had to be administered with more number of injections. Looking at the treatment under taken by the complaint, the Forum found that the doctor had administered Lucentis injections, which was costlier than Avastin. The criterion for choosing Lucentis over Avastin was not clear. There's divided opinion amongst the doctors regarding the patients, undergoing the procedure, being considered as inpatient or outpatient case.

Though the Forum was also able to appreciate the case of the complainant in expecting the Insurer to settle the claims in as much as the treatment being a prolonged one and repetitive in nature, but for the reasons stated above, it would be reasonable that the complainant bore a part of the expenses. Accordingly, taking a practical view of the facts of the case, which had been brought to the notice of the Forum, the Forum had come to the conclusion that the cost of the treatment be shared equally between the complainant and the Company.

In view of the facts and circumstances the complaint was admitted to the claim amount of Rs.42,885/- being 50% of the total claim amount to the complainant.

In the matter of
Mr. Rakesh H. Shah
Vs.
The New India Assurance Company Ltd.
Complaint Ref. No.AHD-G-049-1617-1080

Award Date: 06/02/2017
Policy No: 210200/34/15/28/00000174

The complainant's wife Mrs. B. R. Shah, aged 41 years old was admitted to Spine Hospital, Ahmedabad on 26/11/2015 for the treatment of prolapsed inter-vertebral disc C6-C7 & discharged on 29/11/2015. His claim for Rs.1,04,503/- was partially settled with Rs.52, 632/- after deductions of Rs.51, 871/- citing clause Nos. 5.11, 2.1, 2.3, 2.4.

The Insured had ported her policy before two years from other insurer. The SI then was Rs.1,00,000/-. The Respondent had correctly given the benefits of the portability as it had considered the claim that had arisen within two years from the date of the ported policy. The subject policy had a waiting period of 24 months to cover the subject disease.

The guideline No.12 of the IRDAI circular dated 09.09.2011 on health insurance portability clearly provides for the SI to be considered in such ported policies. Accordingly, the Insurer had applied the SI of Rs.1,00.000/- while considering the claim.

The next point to be considered was whether the deduction of the claim in proportion to the room rent was correct? The Respondent could not answer the question whether it had sought the fee charged by the hospital in cases where it charged Rs.1000/- as the room rent.

The Representative was asked to get the quotation from the doctor on the fee charged by him presuming that the patient was hospitalized in a room with rent of Rs.1000/-.

The doctor had given a fee structure item wise for Rs.55,000/- (with room rent Rs.1000/) and Rs.69,500/- (with room rent of Rs.3000/-). Thus, there was a difference of Rs.15,000/-in the hospital charges which is not payable.

Thus, from the total expense of Rs.1,04,503/- Various expenses, amounting to Rs.1,775/- was not payable, as per the terms and conditions of the policy (Rs. 400/- for Other Hospital Bill, Rs.575/- Non-pharmacy charges and Rs.800/- beyond post limit charges).

The balance amount payable was worked out as under:

Amount claimed	Rs.1,04,503/-
SI considered	Rs.1,00,000/-
Less	
Not payable items	Rs.1,775/-
Not payable as per room rent	Rs.15,000/-
Already paid by the Insurer	Rs.52,632/-
Balance payable	**Rs.35,096/-**

The complainant was thus entitled for further sum of Rs.35,096/-

The Respondent was advised to provide a copy of the terms and conditions to the Complainant.

In view of the facts and circumstances the complaint was admitted to the claim amount of Rs.35,096/- to the complainant.

In the matter of
Mr. Himanshu Patel
Vs.
The Oriental Insurance Company Ltd.
Complaint Ref. No.AHD-G-050-1617-1054

Award Date: 06/02/2017
Policy No: 142606/48/2016/1446

Mr. Narendrakumar Patel, aged 60 years, father of the complainant was admitted to Raghudeep Eye Hospital, Ahmedabad on 02/06/2016 for Right Eye Cataract surgery and discharged on the same day. His claim for medical expenses of Rs.1,06,940/- was partially

settled with Rs.54,810/- after deduction of Rs.52,130/- citing Reasonable and Customary Charges/Non-medical expenses/Femtolaser related charges and Maximum Surgeon charges. He had approached the Forum for settlement of full claim.

The patient had flat eye requiring a different treatment than the regular lens and treatment.
The settlement letter of the complainant's eye treatment cannot be taken into account for comparison as the nature, extent; gravity of cataract etc. would be different for his father's case which was not known to the Forum.
The patient in the subject complaint was the father of the complainant.
As per IRDAI circular on standardization in health insurance, reasonable and customary charges meant 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.
The Insurance company could not prove that Rs.52,130/- was the unreasonable and non-customary charges for cataract surgery in the hospital (where the complainant's father was operated), and it was consistent with the charge for similar surgery in similarly placed hospital in the geographical area.
There was no capping / ceiling for payment of cataract surgery under the policy.
The Respondent had failed to prove that the charges were unreasonable.
Deduction of Rs.251/- towards Non-medical Charges was found to be in order as per the terms of the policy.

In view of the foregoing the complaint was admitted to the claim amount of Rs.51,879/-.

In the matter of
Mr. Himanshu Patel
Vs.
The Oriental Insurance Company Ltd.
Complaint Ref. No.AHD-G-050-1617-1055

Award Date: 06/02/2017
Policy No: 142606/48/2016/1446

Mr. Narendrakumar Patel, aged 60 years, father of the complainant, was admitted to Raghudeep Eye Hospital, Ahmedabad on 13/06/2016 for Lt. Eye Cataract surgery & discharged on the same day. His claim for medical expenses of Rs.1, 05,720/- was partially settled with Rs.51,590/-. Deduction of Rs.54,130/- was made citing Reasonable

& Customary Charges/Non-medical expenses/Femtolaser related charges and Maximum Surgeon charges. He had approached the Forum for settlement of full claim.

The patient had flat eye requiring a different treatment than the regular lens and treatment.
The settlement letter of the complainant's eye treatment cannot be taken into account for comparison as the nature, extent; gravity of cataract etc. would be different for his father's case which was not known to the Forum.
The patient in the subject complaint was the father of the complainant.
As per IRDAI circular on standardization in health insurance, reasonable and customary charges meant 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.
The Insurance company could not prove that Rs.54,130/- was the unreasonable and non-customary charges for cataract surgery in the hospital (where the complainant's father was operated), and it was consistent with the charge for similar surgery in similarly placed hospital in the geographical area.
There was no capping / ceiling for payment of cataract surgery under the policy.
The Respondent had failed to prove that the charges were unreasonable.
Deduction of Rs.251/- towards Non-medical Charges was found to be in order as per the terms of the policy.

In view of the foregoing the complaint was admitted to the claim amount of Rs.53,879/-.

In the matter of
Mr. Pramesh T. Shah
Vs.
The National Insurance Company Ltd.
Complaint Ref. No.AHD-G-048-1617-1114

Award Date: 07/02/2017
Policy No: 301900/48/15/85/00001221

The Complainant was admitted to Akshar Eye Hospital, Ahmedabad on 12.03.2016 for Rt eye Cataract surgery. On discharge from the hospital, the Complainant had filed a claim for Rs.30,

622/- The Respondent had rejected Rs.8,685/- being OT Charges & Surgeon charges under customary & reasonable charges.

The Respondent had disallowed Rs 8,685/- out the total claim of Rs.30, 622/- from complainant's claims under policy clause No. 6.42 - customary & reasonable 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. In the subject case the Respondent had not provided any rate list from similar hospitals in the geographical area.

The Respondent had failed to provide any justification in support of the deduction of Rs.8,685/-/- made from the claim amount. He had also confirmed that there was no capping in cataract claim in policy.

The Respondent had also not justified deduction for Rs.8, 685/- under OT & Surgeon Charges.

Under the circumstances the deduction was arbitrary. The Complainant was entitled for relief. The Forum had reworked the claim payment including the OT &Surgeon charges.Accordingly,Rs.8, 685 /- being the balance claim amount was payable.

In view of the foregoing the complaint was admitted to the claim amount of Rs.8,685/-.

In the matter of
Mr. Ramnikbhai S. Virpara
Vs.
Iffco-Tokio General Insurance Company Ltd.
Complaint Ref. No.AHD-G-023-1617-1144

Award Date: 07/02/2017
Policy No: 52625656

The Complainant's son Shri Avinash, aged 24 years was insured under Swasthaya Kavach (Family Health) Policy for the period from 28/05/2016 to 27/05/2017 by the Iffco-Tokio General Insurance Co. Ltd. The Insured was admitted to Sankalp Spine Hospital, Ahmedabad on 28/06/2016 for the treatment of L4-L5 Prolapsed Inter-vertebral disc and discharged on 29/06/2016. The Company had rejected his claim under Clause 4 of the policy. Unsatisfied with the rejection of the claim he had approached the Forum for redressal of his complaint.

The Complainant had ported his policy from National Insurance Co. Ltd. since 28.05.2014.

The complainant was paid with the claim amount of Rs.55,848/- on 20/05/2013 by the National Insurance Co. for the treatment of L2-L3 prolapsed disc.

The Complainant had not mentioned his son's medical history pertaining to the year 2013 in the proposal form in the year 2014.

During the year 2015, the Complainant's son was admitted in Giriraj Orthopedic Hospital for PCKG-05-SURG-00-1 general surgery. While considering the claim in the year 2015 it was found that in discharge summary the medical history of the year 2013 was not mentioned by the hospital. Hence the claim was settled without any question for Rs.20,800/-.

On 28/06/2016, the complainant was admitted for the treatment of L4-L5 Prolapsed Inter-vertebral Disc. The medical papers of the year 2016 mentioned the treatment of L2-L3 Prolapsed Disc in the year 2013.

The documents produced before the Forum established the suppression of material facts required for underwriting the proposal.

The subject medical condition was directly related to the treatment taken in the previous policies with National Ins. Co. Ltd.

The Respondent had repudiated the claim on the basis of Non-disclosure of material fact. The previous surgical history of 3 years was not declared in the proposal form, at the time of porting the policy.

During the hearing the complainant had agreed that he had taken the claim from National Ins. Co. Ltd. The same was also not disclosed in the proposal form, this was breach of basic Principle of Insurance – "Utmost Good Faith".

The complainant was duty bound to disclose the medical history in the proposal form. The complainant taking a shelter under the fact that previous claim was settled hence the subject claim should also be settled was incorrect (as the claim then was settled without the knowledge of the treatment undergone by the Insured).

The company had correctly applied the non-disclosure clause and rejected the claim.

In view of the foregoing the complaint failed to succeed.

In the matter of
Mr. Dhiresh T. Shah
Vs.
The National Insurance Company Ltd.
Complaint Ref. No.AHD-G-048-1617-1173

Award Date: 20/02/2017

Policy No: 302100/48/12/85/00005689

The Complainant and his spouse were insured for Sum Insured of Rs.2,00,000/- each under National Mediclaim Policy with The National Insurance Company Ltd. The Complainant was hospitalized to Raghudeep Eye Hospital, Ahmedabad on 08.11.2013 for operation of Right Eye Cataract surgery with implantation of intra ocular lens and discharged on the same day. The complainant had lodged a claim for Rs.1,24,700/- with the respondent Insurance Company. The respondent insurance company had paid Rs.59,799/- after disallowing Rs.64,700/-.

The respondent had produced Dr. Piyush Shah's opinion for comparison of rates prevailing in the same geographical area of the Hospital where the complainant had taken treatment. It had arrived at the reasonableness of the expenses deducted with comparison of the rates Ahmedabad City..

As regards the deduction of operation charges of Rs.12,000/-; nowhere in the policy terms, the limit of the operation charges was described. The Operation/Surgeon Charges may vary as per the skill, experience and expertise of the treating doctor. The representative could not prove that the Operation charge was unreasonable.

As regards the deduction of Rs.24,000/- from IOL bill, the complainant had submitted a copy of Bill No.216/8544 dated 08.11.2013 for Rs.40,000/-. The Respondent had deducted Rs.24,000/- without producing any proof to prove that the cost of it was on higher side.

The respondent had deducted Rs.26,000/- towards Lens soft fit + Rs.1,700/- O.T. charges under " Reasonable and Customary Charges" without producing any evidence for the same. The respondent had deducted Rs.201/- correctly as not payable medicines charges

In view of the foregoing the complaint was admitted and hereby directed to make payment of Rs.63,700/- to the complainant.

In the matter of
Mr.s. Palkaben M. Parmar
Vs.
The National Insurance Company Ltd.
Complaint Ref. No.AHD-G-048-1617-1279

Award Date: 20/03/2017
Policy No: 301800/48/16/85/00009270

The Complainant and her family members were insured with National Mediclaim Policy for sum insured of Rs.1,00,000/- from The National Insurance Co. Ltd. The complainant's son Master Yax, aged 8 years was hospitalized to Aditi Children Hospital and Neonatal Care, Ahmedabad on 06.10.2016 and was treated for Dengue fever and discharged on 12.10.2016. The complainant had submitted a claim for Rs.22,427/-. The respondent insurance company had rejected the claim citing the reason; claim had arisen during the break of insurance period. The complainant being aggrieved with the rejection of the claim had approached the Forum for settlement of full claim amount.

The complainant had paid the premium on 03/10/2016 to the corporate agent, the bank, for coverage of the insured – i.e. from 05/10/2016 to 04/10/2017. She had submitted the proof for payment for the insurance.

The insurer had issued the policy for the period from 13/10/2016 to 12/10/2017 instead of 05/10/2016 to 04/10/2017 as it had received the premium on 13/10/2016.

There existed a MOU between the Corporate agent (Bank of Baroda) and the Respondent. The Insurance Corporate agent being a bank is governed by the IRDAI Rules / Regulations and RBI Rules.

The Corporate agent was duty bound to remit the premium and submit the proposal papers collected from the policy holders to the Insurer on the same day or on the next day Since, it was a renewal of the policy, the collection of the renewal premium at the hands of the Corporate agent is considered as premium received at the end of the Insurer. Invoking Sec. 64 VB of the Insurance Act and denying the claim of the insured who had renewed the policy before lapsation of the was sheer absurdness. The Corporate agent represented the Respondent. The Respondent could not absolve of its obligations to the Insured. The Insured by paying the premium to the agent before the expiry of the policy had established and expressed her desire to keep the policy continually in force. The Insurer has to prevail upon the Corporate agent to implement and act upon the laid Rules, Regulation & Acts like remitting the premium to the Insurer immediately on receipt of the premium. The Insurer had failed to play its role in bringing the Corporate agent to books. The Insured had performed her part – paying the premium in time. The Respondent had erred by denying the claim. The Respondent had wrongly denied the claim.

In view of the foregoing the complaint was admitted and the respondent is hereby directed to pay Rs.22,427/- to the complainant and treat the policy as continuous with effect from 05/10/2016.

In the matter of
Mrs. Rashmita H. Patel
Vs.
The New India Assurance Company Ltd.
Complaint Ref. No.AHD-G-049-1617-1299

Award Date: 20/02/2017
Policy No: 201402/34/16/25/00000559

The Complainant, aged 53 years, was insured for Sum Insured of Rs.1,00,000/- under New Mediclaim 2012 Policy with The New India Assurance Company Ltd. The Complainant was hospitalized to Life Care Institute of Medical Sciences & Research Hospital, Ahmedabad on 12.08.2016 for operation of Right Supraclavicular Lymphnode Excision and discharged on 13/08/2016. The complainant had lodged a claim for Rs.32,199/- with the respondent Insurance Company. The respondent had paid Rs.17,744/- after disallowing Rs.14,455/-.

The respondent had produced the proposal form along with proof of date of dispatch of the policy. As per the policy condition no. 3.1 the deduction made by the insurer was in order. As regards the deduction of operation charges of Rs.8,667/-; Anesthetic Charges Rs. 1334/-, O.T. Charges Rs.1334/- and Pathology charges Rs.1000/- were as per policy clause 3.1. The respondent had deducted Rs.2000/- being room charges The complainant was entitled for Rs.1,000/- per day towards Room + Nursing Charges being 1 % of Sum Insured of Rs.1,00,000/-.The complainant had claimed Rs.3000/- towards room and nursing charges. The deduction was correct. Amount of Rs.120/- being cost of non-payable pharmacy charges was deducted correctly.

In view of the foregoing the complaint failed to succeed.

In the matter of
Mr. Mukesh J. Mistry
Vs.
The New India Assurance Company Ltd.
Complaint Ref. No.AHD-G-049-1617-1318

Award Date: 20/02/2017
Policy No: 220300/34/15/01/00002621

The Complainant and his wife were insured with Mediclaim Policy 2007 for sum insured of Rs.2,00,000/- (each) from The New India Assurance Company Ltd. The Complainant's

wife was hospitalized to Advance Orthopedic Management Centre Hospital, Vadodara on 19.06.2016, treated for Acute Lumbar Spondylosis and discharged on 24.06.2016. The complainant had submitted claim for Rs.22,466/-. The respondent insurance company had repudiated the claim under policy clause No. 3.13. The complainant had approached the Forum for settlement of the claim amount.

The complainant had provided the copy of Registration Certificate from the Advance Orthopedic Management Centre Hospital, Vadodara validated up to 31/03/2017.

The Complainant had enclosed copies of the claim settlement letters of (1) Pushpaben Patel –Insured with United India Ins. Co. Ltd., Claim No.MDI5-0028074961- settlement amount of Rs.84,644/- on 21/06/2016.(2) Mr. Snehalkumar Pancholi – Insured with Bajaj Allianz Gen. Ins. Co. Ltd., Claim ID No. 1073599 – settlement of Rs.21670/- as proofs. He had written to the company stating that the company had settled the claim that had arisen from the same hospital. The Respondent neither had respondent to the letter nor made any statement in the SCN or mention before the Forum during the hearing. The Respondent stated that its investigators found less than 15 beds. However the Respondent was unable to state the no. of beds found in the hospital. The Representative was unable to produce the investigation report. Hences, it had failed to prove their point of contention that there was less than 15 beds in the hospital. The claim settlement of other two patients of the same hospital contradicted the complainant's claim being rejected.

In view of the facts mentioned above, the complaint was admitted and the Respondent was directed to settle the balance claim amount of Rs.22,466/- to the complainant.

In the matter of
Mrs. Jyostsana A. Thaker
Vs.
United India Company Ltd.
Complaint Ref. No.AHD-G-051-1617-1183

Award Date: 21/02/2017
Policy No: 180601/28/15/P/102337292

The Complainant, aged 80 years had insured for Sum Insured Rs.2,75,000/- under Individual Mediclaim Policy with United India Insurance Company Ltd. The Complainant was hospitalized to Samvid Retina Clinic & Laser Centre, Vadodara on 14.08.2015 for surgery of Right Eye Retina Problem and discharged on the same day. The complainant had lodged, a claim for Rs.36,350/- with the respondent Insurance

Company. The respondent insurance company had repudiated the claim citing Exclusions: condition 4.19.

The Respondent had cited less than 24 hours hospitalization clause and denied the

claim. It was seen that the insurer had listed 34 types of disease under the day care procedure / treatment. It was also found that in olden days these 34 diseases needed

Hospitalization for more than 24 hours. Similarly, the subject treatment too needed hospitalization for more than 24 hours in earlier days. Due to technical advancement, it can be done in less than 24 hours. The Day Care treatment has been defined in the policy as under in clause 3.11.

Clause – "3.11" - "Day Care treatment means the medical treatment and/or surgical procedure which is –(i) Undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hrs because of technological and (ii) which would have otherwise required a hospitalization of more than 24 hours. Treatment normally taken on an out-patient basis is not included in the scope of this definition".

The treatment had to be carried out in Operation Theater with sterile condition and by a specialized doctor. These injections / treatment are not similar to other OPD treatment.

The complainant had submitted the proof of her previous claims for her similar treatment on her left eye settlement details:

a. File No.20140506B007R2B7527 - Rs.21750/- 10/07/2014

b. File No 20140602B007R2B7921 - Rs.13150/- 10/07/2014

c. File No.20140709B007R2B8464 - Rs.13150/- 19/07/2014

d. File No.20140903B007R2B9371 - Rs. 12000/- 24/09/2014

e. File No.20141225B007R2B11318 - Rs.12000/- 06/01/2015

The Respondent could not explain the reason for rejection of the claim on similar treatment on the patient's right eye. The complainant was entitled for relief.

In view of the foregoing the complaint was admitted, the Respondent was hereby directed to make payment of Rs.36,350/- to the complainant being full and final settlement of the claim.

In the matter of
Mrs. Jyostsana A. Thaker
Vs.
United India Company Ltd.
Complaint Ref. No.AHD-G-051-1617-1184

Award Date: 21/02/2017
Policy No: 180601/28/15/P/102337292

The Complainant, aged 80 years had insured for Sum Insured Rs.2,75,000/- under Individual Mediclaim Policy with United India Insurance Company Ltd. The Complainant was hospitalized to Samvid Retina Clinic & Laser Centre, Vadodara 18.02.2016 for surgery of Right Eye Retina Problem and discharged on the same day. The complainant had lodged, a claim for Rs.29,850/- with the respondent Insurance company. The respondent insurance company had repudiated the claim citing Exclusions: condition 4.19.

The Respondent had cited less than 24 hours hospitalization clause and denied the claim. It was seen that the insurer had listed 34 types of disease under the day care procedure / treatment. It was also found that in olden days these 34 diseases needed

hospitalization for more than 24 hours. Similarly, the subject treatment too needed hospitalization for more than 24 hours in earlier days. Due to technical advancement, it can be done in less than 24 hours. The Day Care treatment has been defined in the policy as under in clause 3.11.

Clause – "3.11" - "Day Care treatment means the medical treatment and/or surgical procedure which is –(i) Undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hrs because of technological and (ii) which would have otherwise required a hospitalization of more than 24 hours. Treatment normally taken on an out-patient basis is not included in the scope of this definition".

The treatment had to be carried out in Operation Theater with sterile condition and by a specialized doctor. These injections / treatment are not similar to other OPD treatment.

The complainant had submitted the proof of her previous claims for her similar treatment on her left eye settlement details:

a. File No.20140506B007R2B7527 - Rs.21750/- 10/07/2014

b. File No 20140602B007R2B7921 - Rs.13150/- 10/07/2014

c. File No.20140709B007R2B8464 - Rs.13150/- 19/07/2014

d. File No.20140903B007R2B9371 - Rs. 12000/- 24/09/2014

e. File No.20141225B007R2B11318 - Rs.12000/- 06/01/2015

The Respondent could not explain the reason for rejection of the claim on similar treatment on the patient's right eye. The complainant was entitled for relief.

In view of the foregoing the complaint was admitted, the Respondent was hereby directed to make payment of Rs.29,850/- to the complainant being full and final settlement of the claim.

In the matter of
Mrs. Jyostsana A. Thaker
Vs.
United India Company Ltd.
Complaint Ref. No.AHD-G-051-1617-1185

Award Date: 21/02/2017
Policy No: 180601/28/15/P/102337292

The Complainant, aged 80 years had insured for Sum Insured Rs.2,75,000/- under Individual Mediclaim Policy with United India Insurance Company Ltd. The Complainant was hospitalized to Samvid Retina Clinic & Laser Centre, Vadodara 03.11.2015 for surgery of Lt Eye Retina Problem and discharged on the same day. The complainant had lodged, a claim for Rs.12,000/- with the respondent Insurance company. The respondent insurance company had repudiated the claim citing Exclusions: condition 4.19.

The Respondent had cited less than 24 hours hospitalization clause and denied the

Claim. It was seen that the insurer had listed 34 types of disease under the day care procedure / treatment. It was also found that in olden days these 34 diseases needed

hospitalization for more than 24 hours. Similarly, the subject treatment too needed hospitalization for more than 24 hours in earlier days. Due to technical advancement, it can be done in less than 24 hours. The Day Care treatment has been defined in the policy as under in clause 3.11.

Clause – "3.11" - "Day Care treatment means the medical treatment and/or surgical procedure which is –(i) Undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hrs because of technological and (ii) which would have otherwise required a hospitalization of more than 24 hours. Treatment normally taken on an out-patient basis is not included in the scope of this definition".

The treatment had to be carried out in Operation Theater with sterile condition and by a specialized doctor. These injections / treatment are not similar to other OPD treatment.

The complainant had submitted the proof of her previous claims for her similar treatment on her left eye settlement details:

a. File No.20140506B007R2B7527 - Rs.21750/- 10/07/2014

b. File No 20140602B007R2B7921 - Rs.13150/- 10/07/2014

c. File No.20140709B007R2B8464 - Rs.13150/- 19/07/2014

d. File No.20140903B007R2B9371 - Rs. 12000/- 24/09/2014

e. File No.20141225B007R2B11318 - Rs.12000/- 06/01/2015

The Respondent could not explain the reason for rejection of the claim on similar treatment on the patient's left eye. The complainant was entitled for relief.

In view of the foregoing the complaint was admitted, the Respondent was hereby directed to make payment of Rs.12,000/- to the complainant being full and final settlement of the claim.

In the matter of
Mrs. Jyostsana A. Thaker
Vs.
United India Company Ltd.
Complaint Ref. No.AHD-G-051-1617-1187

Award Date: 21/02/2017
Policy No: 180601/28/15/P/102337292

The Complainant, aged 80 years had insured for Sum Insured Rs.2,75,000/- under Individual Mediclaim Policy with United India Insurance Company Ltd. The Complainant was hospitalized to Samvid Retina Clinic & Laser Centre, Vadodara 14.10.2015 for surgery of Right Eye Retina Problem and discharged on the same day. The complainant had lodged, a claim for Rs.29,850/- with the respondent Insurance Company. The respondent insurance company had repudiated the claim citing Exclusions: condition 4.19.

The Respondent had cited less than 24 hours hospitalization clause and denied the Claim. It was seen that the insurer had listed 34 types of disease under the day care procedure / treatment. It was also found that in olden days these 34 diseases needed hospitalization for more than 24 hours. Similarly, the subject treatment too needed hospitalization for more than 24 hours in earlier days. Due to technical advancement, it can be done in less than 24 hours. The Day Care treatment has been defined in the policy as under in clause 3.11.

Clause – "3.11" - "Day Care treatment means the medical treatment and/or surgical procedure which is –(i) Undertaken under General or Local Anesthesia in a hospital/day care centre in less than 24 hrs because of technological and (ii) which would have otherwise required a hospitalization of more than 24 hours. Treatment normally taken on an out-patient basis is not included in the scope of this definition".

The treatment had to be carried out in Operation Theater with sterile condition and by a specialized doctor. These injections / treatment are not similar to other OPD treatment.

The complainant had submitted the proof of her previous claims for her similar treatment on her left eye settlement details:

a. File No.20140506B007R2B7527 - Rs.21750/- 10/07/2014

b. File No 20140602B007R2B7921 - Rs.13150/- 10/07/2014

c. File No.20140709B007R2B8464 - Rs.13150/- 19/07/2014

d. File No.20140903B007R2B9371 - Rs. 12000/- 24/09/2014

e. File No.20141225B007R2B11318 - Rs.12000/- 06/01/2015

The Respondent could not explain the reason for rejection of the claim on similar treatment on the patient's right eye. The complainant was entitled for relief.

In view of the foregoing the complaint was admitted, the Respondent was hereby directed to make payment of Rs.29,850/- to the complainant being full and final settlement of the claim.

In the matter of
Mr. Paresh C. Manek
Vs.
HDFC General Insurance Company Ltd.
Complaint Ref. No.AHD-G-018-1617-1201

Award Date: 21/02/2017
Policy No: 2952201133885100-2825

The Complainant, aged 36 years, was insured with HDFC Ergo Gen. Ins. Co. Ltd. for the period from 28/07/2015 to 27/07/2017.The Complainant was admitted to Urocare Hospital Rajkot, on 23/09/2016 for operation of Right Ureteric Calculus and discharged on 26/09/2016.The respondent had repudiated her total claim of Rs.59,879/-. Being aggrieved by the repudiation of the claim he had approached the Forum to get claim amount of Rs.59,879/-.

The Complainant was admitted in Urocare Hospital, Rajkot for the period from 23.09.16 to 26.09.16. He was operated for Rt. Ureteric Calculus. The Complainant had lodged a claim for Rs 59,879/- The respondent had repudiated the claim.

The Respondent Co. had provided the Terms and Condition of the policy. As per section 9.a.ii a and 9.a.ii.b of policy, a waiting period of 2 years was applicable for the said ailment and procedure. The subject Rt. Ureteric Calculus surgery took place within 2 year of the Commencement of the policy. The rejection of the claim was correct.

In view of the foregoing the complaint failed to succeed,

In the matter of
Mr. Dhaval S. Sheth

Vs.
The New India Assurance Company Ltd.
Complaint Ref. No.AHD-G-049-1617-1153

Award Date: 20/03/2017
Policy No. 230300/34/14/01/00008200

The Complainant and his family members were insured with Medi-claim Policy 2007 issued by The New India Assurance Company Ltd. The Complainant's wife Mrs. Roopalben, aged 43 years was hospitalized in Surat Institute of Digestive Sciences hospital on 15/02/2016 for the treatment of Celiac disease + Muscular Backache + Cryptogenic Cirrhosis and discharged on 18/02/2016. Since the complainant's claim for Rs.32,329/- was rejected under Clause No.4.4.16, he had moved the Forum for justice.

The claim attracted clause 6.0 Renewal clause of the policy which restricted the Sum Insured to Rs.2,50,000/- plus CB of Rs.52,500/- as the available SI to consider the claim. The clause read as "if the policy is to be renewed for enhanced sum insured, then the restriction i.e. 4.1, 4.2 & 4.3 will apply to additional sum insured as if it is a new policy". Clause 4.1 dealt with pre-existing disease, 4.2 dealt with 30 days waiting period and 4.3 dealt with waiting period for specified disease, ailments, and conditions. The Forum noted that it had heard his other complaint and awarded a relief for Rs.50,834/-. The insured had already exhausted the Sum Insured in the policy year 2015-2016. Hence, there was no possibility of any further relief. The complaint failed to succeed.

In view of the submission of the parties during the course of hearing and the documents made available to the Forum, the complaint stands dismissed.

In the matter of
Mr. Dhaval S. Sheth
Vs.
The New India Assurance Company Ltd.
Complaint Ref. No.AHD-G-049-1617-1154

Award Date: 20/03/2017
Policy No. 230300/34/14/01/00008200

The Complainant and his family members were insured with Medi-claim Policy 2007 issued by The New India Assurance Company Ltd. The Complainant's wife Mrs. Roopalben, aged 43 years was hospitalized in Global hospital on 08/01/2016 for the treatment of stomach related

disease and discharged on 22/01/2016. Since the complainant's claim for Rs.3,98,261/- was rejected under Clause No.4.4.16, he had moved the Forum for justice.

The Discharge Summary in its diagnosis described the history along with the subject disease, the treating doctor had certified that none of the disease viz. celiac sprue disease + autoimmune hepatitis + chronic liver disease, was a genetic disorder. The complainant had written in her appeal to Grievance Cell of the Respondent that treatment was not given for the treatment of any Genetic Disorder. Even then the respondent had repudiated the claim without examining any medical opinion / papers given by the treating hospital.

Celiac Sprue is a genetic disorder. Other disease was complications of Celiac Sprue. The treatment given was not only for the Celiac Sprue but also for the complications. The policy restrained payment of Genetic disorder but not on its complications. The complainant had earlier settled the claim on the treatment in the same policy year. The, insurer citing its internal guidelines had denied the subject claim. The internal guidelines were not part of the policy terms and conditions. The Celiac disease is genetic, which fell under exclusion clause. Since treatment was also given for the complications of the celiac disorder and other diseases which were not excluded, the complainant is entitled for relief. The insured had Sum Insured of Rs.2,50,000/- plus CB of Rs.52,500/-. The Insurer had settled Rs.2,51,666/- in favour of the

complainant in the impugned policy year. Thus, a Sum Insured of Rs.50,834/- was left for claim reimbursement. The subject claim was for Rs.3,98,261/- on the treatment of excluded and not excluded treatments. The Insured was entitled for the available Sum Insuredddd of Rs.50,834/- .The claim was admitted in view of the foregoing facts and the Respondent was directed to settle the balance claim amount of Rs.50,834/- to the complainant.

In the matter of
Mr. Dhaval S. Sheth
Vs.
The New India Assurance Company Ltd.
Complaint Ref. No.AHD-G-049-1617-1155

Award Date: 20/03/2017
Policy No. 230300/34/15/01/00006256

The Complainant and his family members were insured with Medi-claim Policy 2007 issued by The New India Assurance Company Ltd. The Complainant's wife Mrs. Roopalben, aged 44 years was hospitalized in Surat Institute of Digestive Sciences hospital on 23/05/2016 for the treatment of Autoimmune Hepatitis-CLD + Coeliac Sprue and discharged on 02/06/2016. Since the complainant's claim for Rs.2,43,293/- was rejected under Clause No.4.4.16, he had moved the Forum for justice.

The Discharge Summary, in its diagnosis column, described the history along with the subject disease. The treating doctor had certified that none of the disease viz. Autoimmune Hepatitis-CLD, which was not genetic disorder. The complainant had written in his appeal to Grievance Cell of the Respondent that treatment was not given for any Genetic Disorder. Even then the respondent had repudiated the claim without examining any medical opinion / papers given by the treating hospitals.

Celiac Sprue is a genetic disorder. Other disease were complications of Celiac Sprue. The policy restrained payment of Genetic disorder but not on its complications. The complainant had earlier settled the claim on the treatment of Menorrhagia, Cryptogenic, Cirrhosis of Liver with Pht. Celiac Sprue and Dysfunction Uterine Bleeding + Autoimmune Hepatitis + Rt. Lower limb Deep Vein, thrombosis in the previous policy year. The insurer citing its internal guidelines had denied the subject claim. The representative had stated that their internal guidelines (not part of the policy terms and conditions) had identified celiac disorder as genetic. The Celiac disorder, a genetic disorder, fell under the exclusion clause. Treatment was also given for the complications of celiac disorder and other disease which were not excluded. The Sum insured of the policy was Rs.5,00,000/-. The policy clause No. 6 restricted the sum insured to Rs.2,50,000/-. The clause read as "if the policy is to be renewed for enhanced sum insured, then the restriction i.e. 4.1, 4.2 & 4.3 will apply to additional sum insured as if it is a new policy". Clause 4.1 dealt with pre-existing disease, 4.2 dealt with 30 days waiting period and 4.3 dealt with waiting period for specified disease, ailments and conditions. There was no CB available in the policy as it was exhausted in the previous year policy after settlement of the claims. The Insurer had settled Rs.1,84,995/- as claim in the subject policy year. Thus, a Sum Insured of Rs.65,005/- was left for claim reimbursement. The claim was admitted in view of the foregoing facts, the Respondent was directed to settle the balance claim amount of Rs.65,005/- to the Complainant.

In the matter of
Mr. Ramzanbhai Y. Sanghriyat
Vs.

Religare Health Insurance Company Ltd.
Complaint Ref. No.AHD-G-037-1617-1169

Award Date: 21/03/2017
Policy No. 10087119

The Complainant Mr.Ramzanbhai, aged 38 years was insured with Religare Health Insurance Co.Ltd. under Group Care (Scheme 2- IIB). He was admitted to Anas Medical Nursing Home, Ahmedabad on 12/10/2016 for the treatment of Fever and discharged on 14/10/2016. He had incurred a total expense of Rs.20,018/-. His claim was repudiated by the Respondent citing Policy clause Nos.3.2.1 Annexure B (71), "the hospitalization was not justified". Aggrieved with the rejection of the claim the complainant had approached the Forum for Redressal of his grievance.

As per submission of the respondent, the treatment could have been on Out Door Patient (OPD basis), and Hospitalization was not required.

The facts of the complaint failed before CDRF, Palwal was different from the facts of present case. In the present case the insured was having fever for a few days prior to hospitalization. He had symptoms of vomiting and nausea. His " test for Dengue fever" was done on 11/10/2016, which was positive . Thus he was admitted on 12/10/2016 on the advice of qualified physician and substantial amount (Rs.4,468/-) was spent on medicines.

The submission of representative of Religare Health Insurance Co. Ltd. that no test for dengue was done is not correct.

In view of the above, the complaint was admitted, the Respondent was directed to settle the balance claim amount of Rs.20,018/- to the complainant.

In the matter of
Mrs. Nilaben J. Shah
Vs.
The New India Assurance Company Ltd.
Complaint Ref. No.AHD-G-049-1617-1388

Award Date: 21/03/2017
Policy No. 4015/11542965700000

The Complainant, aged 72 years, was insured with ICICI Lombard Gen. Ins. Co. Ltd. for the period from 31/03/2016 to 30/03/2017.The Complainant was admitted to Parekh Hospital Ahmedabad, on 27/06/2016 for operation OA of Rt. Knee and discharged on 30/06/2016.The respondent had repudiated her total claim of Rs.1,29,600/-.Being aggrieved by the repudiation of the claim he had approached the Forum to get her claim amount of Rs.1,29,600/-.

The Complainant was admitted in Parekh Hospital, Ahmedabad for the period from 27/06/16 to 30/06/16. She was operated for Rt. TKR. The Complainant had lodged a claim for Rs 1,29,600/- The respondent had repudiated the claim.

The Respondent Co. had provided the Terms and Condition of the policy. As per policy terms and condition, a waiting period of 1 year was applicable for the said ailment and procedure.

The subject Rt. TKR surgery took place within 1 year of the Commencement of the policy.
The rejection of the claim was correct.

In view of the foregoing the complaint failed to succeed, the Respondent needed no intervention. The complaint was dismissed.

In the matter of
Mr. Harisinh S. Rathod
Vs.
Iffco-Tokio General Insurance Company Ltd.
Complaint Ref. No.AHD-G-023-1617-1376

Award Date: 21/03/2017
Policy No. 52689676

The Complainant Shri Harisinh Rathod, aged 57 years was insured under Family Health Protector Policy for the period from 15/10/2016 to 14/10/2017 by the Iffco-Tokio General Insurance Co. Ltd. The Insured was admitted to Zydus Hospitals & Healthcare Research Pvt. Ltd., Ahmedabad on 03/12/2016 for the treatment of Excision biopsy – Left (level 4) par jugular node and discharged on 04/12/2016 and second time admitted in HCG Cancer Centre on 17/12/2016 for the treatment of Classical Hodgkin's Lymphoma (Chemotherapy first cycle day 1).The Company had rejected his total claims amounting to Rs.98,975/- under General

Condition No. 49 & 15(a) of the FHP policy. Unsatisfied with the rejection of the claim he had approached the Forum for redressal of his complaint.

MEDICLAIM

Case of:-Smt Nisha S Deo v/s Star Health & Allied nsurance Co. Ltd.

Complaint Ref No. : AHD-G-044-1617-0023
Policy No.: P/171200/01/2016/000569

Date of Award : 29/06/2016

The Complainant was diagnosed with High Grade Fever with rigors associated with body ache & weakness. The Complainant had incurred total expenses of Rs.36,023/-. The Respondent had partially settled the claim for Rs.20,181/-. The Complainant had asked for reimbursement of Rs.14,580/- as it represented charges for carrying out various investigations on the advice of treating physician. The deduction on account of it, was unwarranted.

The amount deducted Rs. 14,580/- was towards investigation carried out on the advice of the treating doctor and was arbitrarily deducted. The doctor had clarified the need for carrying out the said investigations. He requested the Forum to get his legitimate claimed amount paid.

As per respondent the claimed amount was deducted for investigation carried out which were not necessary & had no relevance with the ailment for which the Complainant was hospitalized. Therefore, the deduction was correct.

The investigations were carried out on the advice of the doctor & not at the wish of the Insured. The treating doctor had mentioned in the treatment sheet carry out various tests. The treating doctor was the best judge after assessing the progress of the Patient as to what investigations are to be carried out. Hence, the same were payable. The doctor had clarified vide his certificate that the patient had Pyrexia of unknown origin & her routine reports were normal & still she had fever during her stay. So she was advised detailed investigation to find out cause of Pyrexia. The Respondent should have sought further clarification from the treating doctor if they

had doubts instead they denied the claim arbitrarily. In view of the aforesaid facts the Complaint is admitted.

The Forum, hereby, directs the Respondent to pay Rs.14,580/- to the Complainant.

Case of:- Mrs. Dipti Devani V/S Star Health & Allied Insurance Co. Ltd.

Complaint No.: AHD-G-044-1617-1301
Policy No. P/171216/01/2015/004478

Date of Award : 21/03/2017

The Complainant Mrs. Dipti, aged 34 years was admitted to Parikh Orthopedic Hospital, Ahmedabad on 16/06/2015 for the treatment of Left Knee ACL and MM tear and discharged on 18/06/2015. She had incurred an expense of Rs.1,05,000/-. Her claim was repudiated on the ground of Non-Disclosure of Material Fact.

The Complainant and her family was initially insured with New India Assurance Company Ltd. since the year 2000-2001 and switched over to Star Health and Allied Insurance Co.Ltd under portability from 08/03/2015 with continuity Benefits as per policy endorsement. On 31/03/2015 while was washing clothes she slipped and got injured in her left leg. On the same day they had consulted Dr.Ashok, Sardar Hospital, Ahmedabad. The doctor had advised for X-ray of Left Knee-AP/Lat as she had pain and swelling in left knee. The doctor had advised Q-drill and SOS MRI gave some medicine and advised to consult after 8 days. After some time she had pain in left leg hence on 16/06/2015 they had consulted Dr. Yogesh Parikh Orthopedic Hospital, Ahmedabad. She was diagnosed with Left Knee ACL and MM Tear. The doctor had advised for surgery hence she was admitted to hospital on 16/06/2015 and discharged on 18/06/2015. Surgery was done for Arthroscopic reconstruction of ACL. She had incurred an expense of Rs.1,05,000/-. The Insurance Company had repudiated her claim stating that MRI showed degenerative changes. As per discharge summary injury of knee 4/12 swelling and pain persists i.e. the patient had the ailment for the past 4 months i.e. from February 2015 which was prior to policy inception. At the time of portability, it was not disclosed. As per complainant, her leg was injured only on 31/03/2015, before that she had no complaint in her health and she had not taken any treatment. Her claim was wrongly

repudiated. The Complainant requested the Forum that her claim was genuine; hence, she should be paid claim amount.

As per respondent, based on proposal form, they had assessed & underwritten the risk and issued a policy on 08/03/2015 with portability benefits as per IRDA guidelines. As per discharge summary of the Parikh Hospital and the clarification furnished by the treating doctor during the course of their internal verification that the insured patient had injury knee 4/12 swelling and pain persisted, i.e. the patient had the aid ailment for the past 4 months, i.e. from February 2015, which was prior to the policy. At the time of portability, the insured did not disclose the said medical history/health details in proposal form and other document which amounts to misrepresentation / non-disclosure of material facts. As per condition No.7 of the policy, "If there was any misrepresentation / non-disclosure of material facts whether by the insured person or any other person action on his behalf, the company was not liable to make any payment in respect of any claim". Hence the claim was repudiated on said ground.

The complainant and her family were insured since the year 2000. The Insured had opted for portability and the policy was issued on 08/03/2015. The incident of injury occurred on 31/03/2015 (i.e. after issuance of the policy) and as per consultation paper of Dr.Ashok, Sardar Hospital, there was no past history of pain or swelling. On 16/06/2015 the Operating Surgeon had mentioned history of pain and swelling since 4 months, which was in February,2015. The respondent had repudiated the claim on the basis of history mentioned by the operating surgeon but could not produce any proof of treatment / medication prior to inception of policy. The impugned policy was ported from New India Assurance Co. Ltd. to the respondent Insurance Company. All the accrued benefits (since 2000-2001) under old polices for 15 years are available to the insured. The complainant was entitled for relief. The Complaint was admitted

Taking into account the facts & circumstances, the Respondent is hereby directed to pay Rs.1,05,000/- to the Complainant.

Case of:- Mr. Kanak B Zala V/S Iffco-Tokio General Insurance Co. Ltd.

Complaint No.: AHD-G-020-1617-1221
Policy No, : 52643734

Date of Award : 20/03/2017

The Complainant's wife Smt. Hemlata, aged 50 years was admitted to Urvashi Maternity and Nursing Home, Ahmedabad on 04/07/2016 for the treatment of Veginal Hysterectomy and discharged on 09/07/2016. He had incurred an expense of Rs.62,144/-. His claim was repudiated on the ground of Non-Disclosure of Material Fact.

As per complainant, his family was initially insured with Oriental General Insurance Company Ltd. The policy was due for renewal from 19/06/2016. Before the renewal date, the agent had informed him that if he chose to port his policy to Iffco-Tokyo Insurance Company he would get more insurance benefits. The agent had confirmed during the proposal stage that his wife's gynecological disease would also be covered in new policy. As per the advice of the agent, he had handed over a blank cheque to the agent. He had consulted the doctor on 23/06/2016 for his wife's health problem. As per prescription, the patient was having history of menorrhagia, burning micturition since 15 days. As per doctor's advice she was admitted to the hospital on 04/07/2016 and after taking treatment of Vaginal Hysterectomy, she was discharged on 09/07/2016. He had incurred an expense of Rs.62,144/-. The Insurance Company had repudiated his claim stating that the patient was suffering from gynecological problems prior to the date of the policy and the ailment was not declared in proposal form while opting the portability of the policy. The complainant had added that he had not signed any proposal form for portability of the policy. The original proposal form was submitted by the respondent during the hearing wherein the signature was checked. It was found that the signature on the proposal form was forged. It was also observed that the date of proposal was 06/06/2016, the policy was issued on 19/06/2016 and the patient had consulted the doctor on 23/06/2016 i.e. after issuance of the policy. However, the history diagnosis of the disease dated prior to inception of the policy. The Complainant requested the Forum that his claim was genuine; hence, he should be paid claim amount.

As per respondent, they had received duly filled/signed proposal form from the client / representative of the client on 06/06/2016. Based on proposal form, they had assessed & underwritten the risk and issued a policy on 19/06/2016 with portability

benefits as per IRDA guidelines. The proposal form was signed on 06/06/2016, As per doctor's consultation dated 23/06/2016, that patient was having history of menorrhagia, burning maturation since 15 days. The insured had not intimated the insurance company about the illness before the commencement of policy which was required to be done as per declaration clause mentioned in proposal form. Hence the claim was repudiated on said ground.

The complainant had not signed the proposal for portability of his policy. Thus, evidently the declarations regarding his status of health were not made by the Insured. The proposal was signed on 06/06/2016, and the policy was issued on 19/06/2016. The first consultation of complainant's wife was done on 23/06/2016 i.e. after issuance of the policy. However, history of the health complaint dated prior to the date of issuance of the policy. It was observed from the medical papers of the Insured patient that she had the gynecology issue before the policy commenced. Moreover, hysterectomy in a patient is not carried out with complainant of menorrhagia for 15 days. As per declaration clause mentioned in proposal form, "I/We further declare that I/We will notify in writing any change occurring in the occupation or general health of the life to be insured/proposer after the proposal form has been submitted but before communication of the risk acceptance by the company". The proposal was signed on 06/06/2016, and policy was issued on 19/06/2016. As per doctor's consultation dated 23/06/2016, the patient was having history of menorrhagia, burning maturation since 15 days (i.e. 08/06/2016), which falls prior to issuance of the policy, and the same was not intimated to Insurance Company by insured. The complainant had not disclosed the material facts in proposal form. Also he had not intimated to Insurer for any change occurring in general health. The Forum was not convinced with the complainant's submission on the medical history of the insured. The complaint failed to succeed.

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

Case of: Mr. Prakash K Vijayan V/s The Oriental Insurance Co. Ltd

Complaint Ref No.AHD-G-050-1617-1280
Policy No. 171600/48/2016/9511

Date of Award : 20/03/2017

The Complainant was insured under PNB Oriental Royal Mediclaim Policy since 01/09/2014 with The Oriental Insurance Co.Ltd. The Complainant Mr. Prakash, aged 41 years was diagnosed with Epidural Granulation, C6-7 with PIVD C4-5 with cord compression. He had claimed Rs.2,19,253/- His claim was rejected under clause No. 4.2(xx) the expenses on treatment of surgery for prolapsed inter vertebral disk unless arising from accident for specified period of two years are not payable. Aggrieved by the decision, the complainant represented to the Insured and not satisfied by their decision he had approached the Forum for redressal of his grievance.

The representative of the complainant stated that Mr. Prakash had neck pains in May, 2016. He went to the Orthopedic Surgeon who started treating him for spondylosis. However, his condition worsened and he began to fall down suddenly and lost control of his limbs. He underwent MRI of spine. He was diagnosed with Tuberculosis and underwent surgery in VINS Hospital, Vadora. He added that the surgery and subsequent treatment, medication, physiotherapy etc was necessitated due to his primary disease, spine Tuberculosis. After discharge, he submitted a claim of Rs.2,19,253/- which was wrongly rejected by the respondent stating that the claim attracted exclusion clause No.4.2(xx). He requested the Forum that his claim was genuine, hence, he should be paid full amount.

As per Respondent the rejection under clause 4.2(xx) was in order. From the documents submitted for the subject claim, it was observed that the patient was diagnosed with epidural granulation C6-7 with PIVD (Prolapsed Inter Vertebral Disk) C4-5 with cord compression. The claim was rejected as per policy Exclusions clause.

The complainant was having the policy since 01/09/2014. The hospitalization, during July 2016, was in the second year of the policy. The exclusion clause No.4.2 (xx) provides for a waiting period of 2 years from the inception of the policy on the treatment of Prolapsed Inter-Vertebral Disk. The treatment of PIVD had attracted the exclusion clause. The Insurer had rejected the claim correctly. The complaint hence, failed to succeed.

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

Case of:- Mr. Paresh R Pandya V/S The The New India Assurance Co. Ltd.

Complaint No.: AHD-G-049-1617-1180

Policy No. : 21250034150600000102

Date of Award : 20/02/2017

The Complainant was hospitalized for the treatment of injury sustained in an accident and discharged on 14/08/2016. He had incurred an expense of Rs.54,110/- . His claim was partially settled for Rs.34,270/- after deduction of Rs.19,840/- citing Policy Terms and Conditions.

The Complainant was slipped down while driving his Activa Scooter and sustained injury in his right hand. He had consulted Doctor, who had advised him surgery as there was a fracture in his right hand wrist. He was admitted in hospital on 12/08/2016; the surgery was done on same day and discharged from the hospital on 14/08/2016. He put-up the claim. On 22/09/2016 he had received a message on his mobile that an amount of Rs.34,270/- was credited in his Bank Account. He inquired with the insurance company and demanded full details of claim payment and deduction, as his claim was for higher amount. He wrote letter to Higher Office of Insurance Company stating that the Amount of Rs.34,270/- was not agreeable to him. However, the Regional Office had sent claim settlement statement in reply to his appeal. He argued that he had incurred an expense of Rs.60,518/- as the Insurance company had wrongly deducted Rs.19,840/- citing Policy Terms and conditions. He requested the Forum that his claim was genuine hence he should be paid the balance amount of Rs,19,840/-

As per respondent, the claim was partially settled under policy Terms and Condition of Janta Mediclaim Policy. Regional Office had sent the detailed settlement statement to the claimant. The partial settlement was as per Terms and Conditions of the subject policy.

It was noted that Rs.8,600/- was short paid by the Respondent. The complainant had not submitted post-hospitalization claim bills and receipts neither to the Insurer not to the Forum. Hence, the question of considering the post hospitalization claim does not arise. The complaint was admitted.

The Forum, hereby, directs the Respondent to pay Rs.8,600/- to the Complainant in full and final settlement of the claim.

Case of- Mr. Monish D Modi V/s The New India Assurance Co. Ltd.

Complaint Ref No.AHD-G-49-1617-1199

Policy No. 21010034150100007688
Date of Award. : 23/01/2017

The Complainant Mr. Manish, aged 52 years was insured under Mediclaim Policy-2007, issued by the New India Assurance Co.Ltd. Complainant was hospitalized to Asian Bariatric Hospital, Ahmedabad for the treatment of Sleep Apnea Disorder. He had incurred an expense of Rs.5,96,449/-. His claim was repudiated by the insurance company stating clause No. 4.4.6 treatment of obesity &/or its complications was excluded from the scope of policy. Aggrieved by the decision, he had appealed to the Regional Office. Unsatisfied with their decision he had approached the Forum for Redressal of his complaint.

The Complainant was insured with the insurance company since the year 2006. He was suffering from Sleep Apnea; his heart was working up to 55% to 60% of its capacity. He was not getting the Oxygen at its required level, hence the organs were not working properly and he suffered from Diabetes, Gout, Blood Pressure, Hyper Acidity etc. He was admitted for the treatment of Sleep Apnea Disorder and to cure the said disease Obesity treatment was compulsory. He added that he was on high risk of Sleep Apnea treatment, which was not detected on time. He was admitted to Asian Bariatric Hospital. He was diagnosed with 1) Pure Hypercholesterolemia (E78.0), 2) Chronic gout (M1A), 3) Essential (primary) hypertension (l10), 4) Mild LV dysfunction, 5) Diabetes mellitus due to underlying condition (E08), 6) Overweight and obesity (E66) and underwent Obesity surgery as the treatment. His claim of Rs.5,96,449/- was repudiated by the insurance company citing exclusion clause 4.4.6. He had submitted copies of three awards issued by Ombudsman, Ahmedabad, one award issued by Ombudsman, Delhi, and an order issued by Consumer Redressal Forum, Ahmedabad. It was observed from these awards/orders that the point of contest was whether the surgery was for cosmetic enhancement? The Awards/Orders had spelt that the Bariatic Surgery was lifesaving and not a cosmetic surgery and hence the awards/orders were in favor of the complainant. He claimed that the treatment was done to save his life hence his claim should be considered favorably.

As per Respondent, from the Discharge Summary it was observed that the complainant was having Progressive Complications arising out of Obesity such as Pure Hypercholesterolemia, Chronic Gout, Essential Hypertension, Mild LV Dysfunction, Diabetes Mellitus, over weight and obesity. The complainant had stated in his complaint that he was suffering from Sleep Apnea, but the same was not mentioned in Final Diagnosis Summery of Asian Bariatrics. Nevertheless, sleep apnea itself was a complication of obesity. From Discharge Summary it was also observed the patient had complaints of Progressive weight gain since last 5 years. As per Clinical Examination the 167 cms heighted patient weighed 103.300 kgs with body mass index of 37.040 kg/sq.mt. The BMI were categorized as normal from 20-25 kg/sq.mt over weight from 25-30 kg/sq.mt., Obese 30 kg/sq.mt and greater & Morbid or extreme obesity from 40 kg/sq.mt and greater. The respondent had produced a letter (opinion) dated 24/09/2016 issued by Dr.Ajit H Shah (MS, Surgeon, Ahmedabad) whereby he had opined that "as per medical reports, IP was operated for obesity. According to mediclaim policy clause 4.4.6, claim for obesity treatment and its complication was excluded. So in his opinion, the said claim was not admissible." He concluded that at RO Level, the Insurance Company had diligently gone through all the case papers, opinions of TPA, referred opinion of MS Surgeon and then reached at a conclusion that the claim repudiation was in order.

As per Discharge Summary the insured was admitted in Asian Bariatric with complaints of Progressive Weight Gain since last 5 years Snoring, Daytime Sleepiness. (No history of knee, back pain). Provisional Diagnosis: Overweight and Obesity. All the complaints were prime facie related to Obesity. Undoubtedly, obesity is a serious health condition that can interfere with basic physical functions such as breathing or walking. Those who are obese are at greater risk for illnesses including diabetes, high blood pressure, sleep apnea, gastro-esophageal reflux disease (GERD), gallstones, osteoarthritis, heart disease and cancer. **The patient had undergone investigations such as Body Composition Analysis, Muscle Fat Analysis, Obesity Diagnosis, and Exercise Planner. All the pathological test reports were substantiating that the insured had undergone this surgery primarily to get treated for obesity which is the proximate cause and which has caused other co-morbidities.** The Insured was treated with Laparoscopic mini Gastric Bypass as he was diagnosed with Pure Hypercholesterolemia, Chronic

gout, Essential Hypertension, Mild LV dysfunction, Diabetes mellitus due to underlying condition, over weight and Obesity. In view of aforesaid, it was proved that the insured had undergone obesity treatment and its complication which were excluded under terms and conditions of the policy. The complaint failed to succeed.

In view of the facts and circumstances, the Respondent's decision to repudiate the claim was upheld. The Complaint, thus, needed no intervention, hence, Dismissed.

Mr. Yogeshbhai B Patel V/S The National Insurance Co. Ltd.

Complaint No.: AHD-G-048-1617-1300
Policy No. 301800/48/15/8500013359
Date of Award : 20/02/2017

The Complainant's wife Smt. Heena, aged 37 years had pain in abdomen and heavy bleeds during menstruation since 3-4 months and was admitted for treatment of Fibroid Uterus and Adenomyosis and discharged after Total hysterectomy. He had incurred an expense of Rs.75,136/-. His claim was partially settled for Rs.59,518/-. Deduction of Rs.15,618/- was made citing Policy clause Reasonable & Customary.

As per complainant his wife was diagnosed with Fibroid Uterus + Adenomyosis and underwent Total Laparoscopic Hysterectomy and Adenomyolysis. He had incurred an expense of Rs.75,136/-. The Insurance Company had wrongly deducted some amount citing Reasonable & Customary payable. The complainant had appealed to higher office against the repudiation letter of TPA, and in reply the Respondent had replied that they had again reviewed the file and it was observed that the claim was paid as per Norms of the company. The Complainant requested the Forum that his claim was genuine, hence, he should be paid the balance amount.

As per respondent, the claim was partially settled under policy clause, Reasonable & Customary. He was asked to submit the fee charged by similarly facilitated hospitals from the geographical area where the Insured had undergone for treatment. The representative had submitted a list of charges which was prepared by TPA (Anmol Medicare Insurance (TPA) Ltd). and was not on the Letter Head of the concerned Hospitals. Three types of charges (Amount) were mentioned but the details like what was included in the said charges etc were not mentioned. He added that the partial settlement was done considering the package of other hospital as most reasonable and it was justified.

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 submitted a rate list (In Excel Format), which was prepared by TPA. The list of charges did not show that what was included in the package. Also it was not on Letter Head of concern Hospitals. The Higher Authority of the Insurance company had reviewed the claim and replied that the amount Rs.59,518/- was paid as per Norms of the Company. The Insurance company had deducted total Rs.15,618/- however the complainant had sought for payment of Rs. 15,000/-. The Respondent had failed to prove that the medical expenses were unreasonable. In view of the forgoing, the complaint was admitted.

The Forum, hereby, directs the Respondent to pay Rs.15,000./- to the Complainant in full and final settlement of the claim.

Case of : Mr. Pankaj C Sheth V/s. The Oriental Insurance Co.Ltd.

Complaint Ref No. : AHD-G-050-1617-1120

Policy No. 171391/48/2016/2624

Date of Award : 07/02/2017

The complainant Mr.Pankaj Sheth, aged 59 years was insured under the Mediclaim Policy issued by The Oriental Insurance Company Ltd. He was hospitalized for the treatment of Tendoachilles Rupture. He had incurred total expense of Rs.66,853/- His claim was repudiated citing minimum 15 beds criteria. He had approached the Forum against non-settlement of claim on hospitalization.

As per complainant, they were insured with the insurance company since last 15 years. He alleged that the Insurance Company and the TPA had harassed a senior citizen, a lot. He had been paying the Insurance Premium of the subject Policy since long time with a hope to get protected against any unforeseen hospitalization expenses. His claim was repudiated stating a reason that the hospital where the treatment was taken did not fulfill the 15 beds criteria. He argued that the Insurance Company had never informed him about the said condition. He never had received any Terms and Conditions of the policy. In reply to a question, whether he had ever demanded the Terms & Conditions of the policy, he replied in negative. The surgery

was planned and had informed the Insurance Company before the hospitalization. But, the respondent had not informed or cautioned him about 15 beds criteria. He submitted a certificate issued by Medical Officer of Health, Vadora Municipal Corporation, whereby it had been certified that the Clinic was registered with Vadodra Municipal Corporation as “Hospital” and had been authorized to carry on the said Medical Facility (The medical facility has been registered under various provisions). He argued that his claim was wrongly repudiated. The complainant had appealed many times through mail from August-2016 to October-2016 to various higher-ups, but not received any reply from them. In reply to another question, he replied that he had not counted the Number of beds in the hospital as he did not feel the necessity of it then. He requested the Forum for settlement of his claim.

The Insurance Company had not submitted the Self Contained Note despite the Notice to the Insurer well in advance. The representative of the Respondent too remained absent.

As the Respondent had not responded to the complainant’s claim or his letters, the claimant had got the Draft Repudiation letter printed from the TPA’s site (online).

“The claim was rejected under clause 2.16 of the policy on 15 beds criteria”. The hospital did not have minimum 15 beds. The Respondent’s Self Contained Note or the Representative was not present to explain the dispute on the 15 beds aspect. In absence of the defense, The Forum had to accept the arguments and submissions of the complainant and proceed to decide the complaint.

The claimant had intimated the Insurance Company prior to hospitalization. The complainant was insured for 15 years, had never been informed about minimum 15 beds criteria and was not aware about the terms and conditions of the Insurance Company. The claim was lodged on 06/05/2016. The Repudiation Letter was not sent by the Insurance Company. Reply of Appeal was not given by the Respondent. The Respondent had not submitted The Self Contained Note, and representative was absent. Form “C” (Certificate of Registration) of the hospital was submitted by the complainant, The certificate stated that Arihant Clinic to be registered with Vadodra Municipal Corporation as “Hospital” and has been authorized to carry on the said Medical Facility (which has been registered under various provision of 1) Gujarat (Bombay) Nursing Home Registration Act,1949, 2)G(B) PMC Act,1949, 3)

PC & PNDT Act,1994, 4) Birth & Death Registration Act,1969. The claimant had also submitted the Registration Certificate of Establishment under The Bombay Shops & Establishments Acts, 1948. The complaint was admitted, and decided ex-parte. (No representation and no Self Contained note submitted by the Respondent).

In view of aforesaid facts, the Respondent is directed to Pay Rs.66,853/- to the complainant.

Case of:- Mr. Ramesh R Sharma V/s The National Insurance Co. Ltd.

Complaint No. AHD-G-048-1617-1093
Policy No. 301800/48/14/85/00013889

Date of Award : 07/02/2017

The Complainant's wife Mrs. Ushadevi, aged 46 years was diagnosed with L03.8-Cellulitis of other sites. The complainant had incurred total expense of Rs.26,809/-. His claim was partially settled for Rs.10,431/-by the Respondent citing reasonable and day care treatment. Aggrieved with the partial rejection of the claim, the complainant had approached the Forum for Redressal of his grievance.

As per Complainant, his family was insured since last 10 to 15 years with National Insurance. His wife had some complaint of back pain/swelling was diagnosed with L03.8-Cellulitis of other sites. As per the doctor's advice she was hospitalized on 07/11/2015 for surgery and was operated on 08/11/2015. She was discharged on 09/11/2015 and advised to follow-up as OPD patient. He argued that the respondent had arbitrarily deducted Rs.16,378/- from the claim. He requested the Forum to get his legitimate claim paid.

As per Respondent, the Complainant had undergone treatment for sebaceous cyst on upper back. This treatment could have been taken in OPD (Day care) & Hospitalization was not required. Therefore, the deduction considering the day care treatment and reasonableness of the cost was correct as per Terms and Conditions-List of Day care treatment. The respondent was not able to explain the prudence on the decision to partial rejection the claim. As per submission of the respondent, the complainant's wife was admitted for treatment of sebaceous cyst on upper back.

She was diagnosed with Cellulites of other sites. The treatment could had been taken in Out Patient Department (OPD), and Hospitalization was not required. Hence, the claim was settled on the ground of Day Care Charges. The Patient was 46 years old. As per doctor's advice she was admitted for treatment and surgery. It was the treating doctor who took a decision on the course of treatment including hospitalization. The Respondent failed to prove that there was 'No need for hospitalization" with proper reasoning. Except deduction of Rs.309/- towards Nursing charges (as included in Room Charges and maximum payable Rs.2,000/-) and Rs.569/- towards medicine charges (Bandage, Gloves, Butadiene, Sterillium) all other deduction was not correct. In view of the above, the complaint was admitted.

In view of the foregoing, the Forum, hereby, directs the Respondent to Pay Rs.15,500/- to the complainant.

Case of:-Mr.Mohamedsadiq A Pathan v/s Royal Sundaram Gen. Ins. Co. Ltd.

Complaint Ref No.: AHD-G-038-1617-1017
Policy No. FHG000833000100

Date of Award : 25/01/2017

The Complainant's son Azeemkhan, Aged 18 years was diagnosed with Dengue fever with Thrombocytopenia. He was admitted in the hospital and incurred an expense of Rs.34,478/-. The Respondent had repudiated the claim stating discrepancies in Inpatient Case Papers.

The respondent had called for some explanation from claimant which was submitted by him. The queries were as under :

1) Medicines shown as administered prior to admission:
2) Vital shown as observed post discharge of patient:
3) The Indore Case Paper (ICP) are written in one single stretch continuously:
4) Sub-normal temperature noted on the day of discharge:

Complainant had given detailed clarification for said queries. He added that he has incurred the expense of Rs.34,478/- for treatment of his son. The Complainant requested the Forum to get his legitimate claim of Rs.34,478/-.

As per respondent, there were gross discrepancies and contradictions in the medical records which cast serious doubt on the genuineness of the hospitalization. The hospital records, which indicated towards fabrication of the medical documents for the purpose of unlawful gain from insurance.

In the Indoor Case Papers, it was mentioned that medicines were given at 08.00 **am** on the date of admission, wherein the in-patient admission only happened at 07.00 **pm**. Further, on the date of discharge, the discharge happened at 10.50 **am** whereas the indoor case papers showed administration of medicines at 10.00 **pm**. The temperature and pulse noting were written in a single stretch in the same handwriting however the signature was different. Also the same document showed temperature and pulse noting at 12.00 in the noon, whereas discharge occurred at 10.50 am. She added that temperature at the time of discharge shows sub-normal at 96.6 degrees and low pulse, however in spite of the same, patient supposedly was discharged from hospital and further despite the abnormal reading of temperature and pulse, nowhere was it mentioned that the patient was discharged on request against advice. The above indicate that the hospitalization records were prepared hastily in order to prefer a claim, though the patient had not received any treatment on in-patient basis. The complainant had not properly explained the discrepancies.

The Respondent failed to prove that the bills / receipts, pathological reports, Indoor Case Papers were false. The Respondent should have obtained clarification from the hospital authority instead they chose to repudiate the claim by pointing out some mistake here and there. At the time of admission and at the time of discharge some discrepancies were found in timing and medication, except this, the respondent could not prove that the patient had not received treatment on in-patient basis. The Insurance Company failed to prove the fraud. In view of the above, the complaint was admitted.

In view of the foregoing, the Forum, hereby, directs the Respondent to pay Rs. 34,478/- to the Complainant.

Case of:- Mr. Kanubhai D Sanghani V/s The National Insurance Co. Ltd.

Complaint No. AHD-G-048-1617-1035
Policy No. 300503/48/16/8500000021
Date of Award : 25/01/2017

The Complainant's wife Mrs.Savitaben, Aged 55 years was admitted for Double Valve Replacement. The complainant had claimed total expense of Rs.5,24,273/-. The claim was rejected by the Respondent citing Policy Clause No. 4.2.

As per Complainant, his wife was admitted to CIMS Hospital, Ahmedabad for treatment of Moderate Mitral Valve Regurgitation, moderately Severe Aortic Regurgitation, mild Aortic Stenosis. The respondent had repudiated the claim stating that as per claim form the patient was suffering from the disease since last 25 days, thus the illness / disease was within the first 30 days of the commencement of the policy, hence the claim was repudiated. He added that there was no history of the same but she was suffering from breathlessness since 10 to 15 days. He added that on 14/05/2016 she consulted Dr.J.S.Shukal, at Veraval who had referred them to consult CIMS Hospital, Ahmedabad, and they consulted the doctor on same day. The policy had commenced from 05/04/2016 and the hospitalization was from 24/05/2016. There was a gap of 50 days from the date of policy to date of hospitalization. He contended that even if 15 days were to be counted for the complaint of breathlessness, then also there was 35 days left from the date of taking the insurance. He added that the insurance company had reckoned the days of disease to happen as 25 days. The repudiation of the claim was illegal. The Complainant requested the Forum to get their claim paid.

As per Respondent, the Insured was insured for the first time from 05/04/2016 only. As per claim form, the patient had breathlessness since 25 days. The complainant had primarily consulted a doctor at Veraval who had advised them to consult CIMS hospital. On advise of CIMS hospital, 2D Echo color Doppler was done on 14/04/2016 and was detected with Severe MR first time, Mild Calcify AS, Moderate AR and first time detected Rheumatic Heart Disease. Thus the illness / disease was contracted within the first 30 days of the commencement of the policy. Hence, repudiation was done under policy condition No. 4.2.

The complainant and his family was Insured with said Insurer since 05/04/2016 only. This was the first policy from the said Insurer. As per Discharge summary, the claimant's wife was hospitalized from 24/05/2016 to 01/06/2016 with complain of breathlessness since 10-15 days. 2D ECO was done on the advice of Dr.Bhavesh Thakkar on 14/04/2016 and she was diagnosed Severe MR, Mild Calcify AS, Moderate AR, which fell within 30 days from the inception of the policy. As the

disease was contracted by the insured within 30 days from Date of Commencement of the policy, it attracted clause 4.2. The Respondent had rejected the claim correctly. The complaint failed to succeed.

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

Case of- Mr. Jayantilal B Patel V/s The Oriental Insurance Co.Ltd.

Complaint Ref No.AHD-G-050-1617-0933
Policy No. 142700/48/2016/611

Date of Award : 25/01/2017

The Complainant Mr. Jayantilal, Aged 71 years was insured since last 15 years with the Individual Mediclaim Policy issued by The Oriental Insurance Company Ltd. for a Sum Insured of Rs.2,50,000/-. The Complainant was hospitalized for Left and Right Eye Cataract and IOL. Against the claim of Rs.1,18,061/-, the Respondent had settled Rs.64,061/- and disallowed Rs.54,000/- under reasonable and customary clause, the Insured had approached the Forum.

As per the representative of complainant, Mr. Jayantilal was the holder of the Individual Mediclaim Policy for a sum insured of Rs. 2.5 lacs. He was having some problem in his eyes he had consulted eye specialist. After the surgery of left and right eye on alternate days, when he preferred the claim of Rs.1,18,061 for both eyes, the Respondent had settled part of the claim. He had made an appeal to Grievance Department of the Insurance Company. The Heritage Health TPA Pvt. Ltd. had settled Rs.64,061/- and deducted Surgeon Fees Rs. 14,000/- also Deducted Implants charges Rs.40,000/- under policy condition No.3.12. His contention was that the deduction of Rs.54,000/- was not proper. He requested the Forum to get his balance claim to be paid.

As per the Respondent, the claim was settled for Rs. 64,061/- and deducted Rs.54,000/- as per policy terms and condition No.3.12. Rs.14,000/- Surgeon Fees and Rs.40,000/- Implant charges was not payable as it was above Customary and Reasonably charges by that amount. In reply to a question whether they had

provided list of charges of various operations to the insured, he replied in negative. In reply to another question whether the decision of TPA had been reviewed by Higher Authority, he replied in negative and said that no complaint was received by them.

The Instrument / Implant Charges and Surgeon Fees have been deducted on the basis of customary and reasonable charges. The Customary and reasonable charges change with passing of time and with improvement of technologies and facilities. Since the cataract and retina operation was primarily to improve the eye sight and restore it to its normalcy, the use of the lens was appropriate to bring back the normalcy to the vision. The doctor's surgery charges and the actual cost of IOL charges cannot be considered as unreasonable.

As per IRDA circular, Reasonable and customary 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 involved. Here the Respondent also failed to submit the said rate chart of other hospital in and around the geographical area where the Insured was hospitalized.

The Respondent had failed to prove that the medical expenses were unreasonable. In absence of any rate charts comparative for same treatment in same or similar geographical area, the conclusion arrived by the respondent is arbitrary and abuse of process of law. The Complainant is entitled for the balance amount of Rs. 54,000/- The Complaint was admitted.

Taking into account the facts & circumstances the Respondent is hereby directed to pay Rs.54,000/- to the Complainant in full and final settlement of his claim.

Case of:- Mrs. Kalpnaben J. Shah V/s The New India Assurance Co. Ltd.

Complaint No. AHD-G-049-1617-0919
Policy No. 210600/34/15/25/00001955

Date of Award : 25/01/2017

The Complainant's son Mr. Alay J Shah, Aged 21 years was admitted for the treatment of Septicemiac Shock and expired on next day. The complainant had claimed total expense of Rs.32,000/-. The claim was rejected by the Respondent stating Hospital was Black Listed.

As per Complainant, her son (Late) Shri Alay was admitted to Shri Bharti Vallabh Hospital, Ahmadabad, as he had complaint gasping of respiration, unconsciousness, pulselessness, high grade fever and was diagnosed to have Septicemiac shock. He was admitted on 17/05/2016 and expired on 18/05/2016. She added that her son was in critical condition on 17/05/2016 and they had taken him to nearby hospital in an emergency. They are insured with the insurance company since the year 2014, but the insured had never informed them about the black listed hospitals. They only came to know vide the repudiation letter where in the insurance company had mentioned the Circular No. HO/Health/DL/2015/IBD: Admin/416/07 the names of the Black Listed Hospitals. She added that she was not aware that the hospital where her son was admitted in an emergency was in black list of the Insurance Company. The repudiation of the claim was totally unfair. The Complainant requested the Forum to get her legitimate claim paid.

The Respondent's representative submitted that the Insured was admitted to Shree Bharti Vallabh Hospital, Ahmadabad. The patient was diagnosed with Septicemiac Shock. The Patient was treated conservatively and expired on 18/05/2016. The said hospital was in their black listed hospital hence the claim was not payable as per Circular No. HO/Health/DL/2015/IBD: Admin/416/07. Hence, repudiation was as per rules of the Insurance Company.

The complainant and her family were insured with said Insurer since the year 2014. The claimant's son was hospitalized on 17/5/2016 and expired on 18/05/2016. He was hospitalized in an emergency condition. The Respondent had never informed the insured about the Black Listed Hospitals or provided the list of black listed hospitals. The complainant had no scope to know about the hospital being black listed. Moreover the hospitalization was done in an emergency situation. The patient too expired due to his critical condition on the very next day. The Insurer need to be humane an sympathetic in such situations. The complaint was admitted.

In view of the facts and circumstances, the Forum directs the Respondent to pay Rs.32,000/- to the Complainant.

1.

In the Matter of

Mr. Mitesh S. Desai

v/s

The United India Insurance Co. Ltd.

Complaint No.AAHD-G-051-1617-0036

Medilaim for surgical treatment of bone fracture(ulna) was partly repudiated on the ground of anesthetic fee bill was not included in the hospital bill. The complainant argued that the anesthetic was called at his instance and therefore the bill was paid by him. The medicines required for administering anesthesia were provided by the hospital from their on hand stock. Hence, the cost was included in the hospital bill. The anesthesia was required for nailing of the fractured bone. The complaint was admitted and Rs.6800/- awarded to complainant.

2.

In the matter of

Mr. Pravinchandra C. Patel

v/s

Max Bupa Health Insurance Co. Ltd.

Complainant:AHD-G-031-1617-0021

Mediclaim for the treatment of Acute Entritis was repudiated on the groung of being a fraudulent claim as the date of admission and time were altered. The treating doctor confirmed that the changes were bonafide and the date of other reports were in keeping with the alterations.Also only one document had been corrected whereas other documents were intact and they confirmed that the alterations were genuine. The respondenr could not prove the fraud.The complaint was admitted and awarded Rs.7125/-.

3.

In the matter of

Mr.Siddhrth J. Shah

v/s

The oriental Insurance Co. Ltd.

Complainant:AHD-G-050-1617-0027

Mediclaim for the treatment of Entric Fever was partly repudiated on the ground that charges for unnecessary and irrelevant pathological tests like colonoscopy, CT&USG Abdomen, Anestetist charges and emergency charges were not payable.According to the respondent this was a case of planned hospitalization.The patient was kept in the doctors cabin for the first two days. Colonoscopy was done after the date of discharge.Hence charges for two days special room stay ,charges for colonoscopy and emergency charges were disallowed. Ct& Usg abdomen allowed.Complaint was partly admitted Rs.10000/- awarded to the complainant.

4

In the matter of

Mr. Nathalal A. Nageshree

v/s

National Insurance Co. Ltd.

Complaint:AHD-G-048-1617-0047

Mediclaim for surgical treatment of compression of Finger was partly repudiated on the ground of reasonable and customery expenses.The respondent did not produce the details of reasonable rates prevailing in the area where the complainant had taken treatment.The policy did not contained any condition in respect of the rate to be used for the surgery performed without which it was difficult to arrive at reasonable charges.However non medical charges were disallowed and award for Rs.11200/- was made to the complainant.

5.

In the matter of

Mr. Niranjan J. \Shah

V/s

The New India Assurance Co.Ltd.

Complainant:AHD-G-049-1617-0035

Mediclaim for the treatment of eye using drugs like Avastin or Macugen and other related drugs(ozurdex) was rejected on the ground of age related disease. The patient was treated for central retinal vein occlusion. The disease was categorized as age related macular degeneration and therefore rejected. Cogisance of patient's age(38) was taken and complainant was admitted. Awarded Rs.63636/- to complainant.

6.

In the matter of

Mr.Rajendrabhai J. Zaveri

v/s

National Insurance Co. Ltd.

Complaint:AHD-G-048-1617-0048

Mediclaim for treatment of enlargement of prostate was partly repudiated to the extent of the amount which exceeded the package amount by Rs.17156/-and by Rs,1424/- towards expenses incurred thirty days before the hospitalization. The complainant submitted that he was not aware about package charges. The respondent had not informed the same to him. The respondent did not appear in the hearing to contest the repudiation.Rs.17156/-allowed. Rs.1424/- disallowed.

7.

In the matter of

Mr. Chaturbhai P. Patel

v/s

National Insurance Co. Ltd.

Complaint: AHD-G-048-1617-0077

Mediclaim for treatment of Ureteric Renal Stone was partly repudiated on the ground of reasonable and customary charges. The respondent could not produce the rates for the similar treatment prevailing in the area where the treatment was taken by the complainant as required by IRDAI. The complaint was admitted and Rs.41102/- awarded to the complainant.

8.

In the matter of

Mr. Dipesh S. Thakkar

v/s

The Oriental Insurance Co.

Complaint:AHD-G-050-1617-0357

Mediclaim of Rs.374500/- for Bariatric surgery was rejected on the ground that treatment for obesity and its complications were excluded from the coverage under the policy. The complainant had cited awards from other ombudsman favoring claim for similar treatment. But it was held that the treatment was given for complexities associated with obesity and the complaint was dismissed.

9.

In the matter of

Mr. Kirit P. Mehta

v/s

National Insurance Co. Ltd.

Mediclim for cataract surgery was partly repudiated on the ground of reasonable and customary charges. . The respondent could not produce the rates for the similar treatment prevailing in the area where the treatment was taken by the complainant as required by IRDAI. The complaint was admitted and Rs.14100/- awarded to the complainant.

10.

In the matter of

Mr. Himmatbhai K. Patel

v/s

United insurance Co. Ltd.

Complaint:AHD-G-051-1617-0311

Reimbursement of mediclaim for hysterectomy was restricted to 25% of the sum insured as per policy condition. The partial repudiation was upheld as it was within policy terms and condition. The complaint was dismissed.

11.

In the matter of

Mr. Hardik A. Shah

v/s

ICICI Lombard General Insurance Co.

Complaint:AHD-G-020-1617-0301

Mediclaim for treatment of Hip Replacement was rejected by the Insurer on the ground that Joint replacement during the first policy year was excluded as per the terms and conditions of the group mediclaim policy issued to the members of the Jain International Organisation. The complainant argued that only knee replacement was excluded as per the brochure shown to him. The respondent refuted issuance of any such brochure by them. As per the policy terms joint replacement was excluded in the first policy year and therefore their repudiation was correct. The forum uhheld the repudiation and dismissed the complaint.

12.

In the matter of

Mr. Vipul B. Patel

v/s

The Appolo Mnich Health Insurance Co. Ltd.

Complaint:AHD-G-003-1617-0293

Mediclaim for treatment was rejected and policy was cancelled on the ground of misrepresention of material facts at the time of proposal. The bills submitted under the subject cclaim were handwritten and their bill Nos. were not consistent with the date of bills. The patient's husband has shown his occupation as 'computer Business" whereas he was a laboratory Technician and had his own pathology laboratory wherefrom the investigation reports in the subject claim were issued. Blood pressure reading throught the treatment was 120/80 which was unrealistic.The respondent had done investigation and the indoor treatment

papers and charts were prepared at the time. The claim did not appear to be genuine to the forum. The complaint was dismissed.

13.

In the matter of

Mr. Suresh A. Prajapati

v/s

National Insurance Co. Ltd.

Complaint;AHD-G-048-1617-0279

Mediclaim for surgical treatment of right eye external angular dermoid was rejected on the ground of it being congenital external disease which was excluded under policy condition. The expert opinion of the ophthalmologist was relied upon and the complaint was dismissed.

14.

In the matter of

Mr. Sandip J. Patel

v/s

The New India Assurance Co. Ltd.

Complaint:AHD-G-049-1617-0263

In this case Temporary total disability was already paid under personal Accident policy but Death claim was rejected on the ground that the insured died after expiry of one calendar year from the date of accident. The death claim under P.A. policy becomes payable only if the death occurs within one year from the date of accident due to the accidental injury as a sole and direct cause of the death. The repudiation of death claim was upheld.

15.

In the matter of

Ms. Nazareen Wadia

v/s

Future Generali India Insurance Co. Ltd.

Complaint:AHD-G-016-1617-0237

Mediclaim for treatment of (1) Functunal Endoscopic Surgery (2) DNS Septoplasty(3)Hypertrophied Turbinates-urbinectomy was partially

Repudiated on the ground that clause III-28 excluded surgery to correct deviated septum and hypertrophied turbinate.The doctor had given bill for all the three conditions mentioned above without any bifurcation of charfes foe each treatment separately. The respondent had curtailed 25% of the total bill as an alternate measure on practical basis. The Forum upheld the stand taken by the insurer and dismissed the complaint.

16.

In the matter of

Mr. Dilip C. Gidwani

v/s

Oriental Insurance Co. Ltd.

Complaint:AHD-G-050-1617-0228

Mediclaim for chronic kidney disease, psychosis, megalobolastic anemia and hypothyroidism was totally rejected on the ground that exclusion clause 4.8 of the policy excluded the treatment for psychiatric and psychometric disorders. The forum took a view that the insurer were not right in not paying the cost of the treatment other than psychiatric disorder. The complaint was partly admitted and Rs.15885/- was awarded to the complainant for the treatment of chronic kidney disease, megalobolastic anemia and hypothyroidism.

17.

In the matter of

Mr. Natvarlal A. Soni

v/s

National Insurance Co. Ltd.

Complaint:AHD-G-048-1617-0784

Mediclim for cataract surgery was partly repudiated on the ground of reasonable and customary charges. . The respondent could not produce the rates for the similar treatment prevailing in the area where the treatment was taken by the complainant as required by IRDAI. The complaint was admitted and Rs.14142/- awarded to the complainant.

18.

In the matter of

Mr. Rakeshkumar D. Parikh

v/s

Oriental Insurance Co. Ltd.

Complaint:AHD-G-050-1617-0833

Mediclaim for surgical treatment of Hernia was repudiated on the ground that the hospital did not fulfill the criteria laid down by IRDAI. As per IRDAI 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 1000000 and at teast 15 in-patient beds in all other places.” In this case the hospital had only 5 in-patient beds and therefore the claim was rejected. The stand taken by insurer was upheld by the Forum and complaint was dismissed

19.

In the matter of

Mr. Darpan G. Shah

v/s

National Insurance Co. Ltd.

Complaint:AHD-G-048-1617-0858

Mediclaim for treatment of abscess on forearm was partly repudiated.The insurer argued that the said treatment was a day care treatment and claim was paid on that basis. There was a ceiling on the expenses incurred for day care procedure. Against this the complainant submitted

that according to the policy condition 25% of the sum insured is to be paid on any single event of treatment . He also arugued that he had preffered hospital treatment as per the advice of the treating doctor and therefore the insistence for daycare procedure should not become the point for repudiation. The complaint was admitted and Rs.15702/- was awarded.

20.

In the matter of

Mrs. Pragnaben D. Raval

v/s

National Insurance Co. Ltd.

Complaint:AHD-G-048-1617-0774

Mediclim for cataract surgery was partly repudiated on the ground of reasonable and customary charges. . The respondent could not produce the rates for the similar treatment prevailing in the area where the treatment was taken by the complainant as required by IRDAI. The complaint was admitted and Rs.24227/- awarded to the complainant.

21.

In the matter of

Mrs. Pragnaben D. Raval

v/s

National Insurance Co. Ltd.

Complaint:AHD-G-048-1617-0729

Mediclim for cataract surgery was partly repudiated on the ground of reasonable and customary charges. . The respondent could not produce the rates for the similar treatment prevailing in the area where the treatment was taken by the complainant as required by IRDAI. The complaint was admitted and Rs.25170/- awarded to the complainant.

22.

In the matter of

Mr. Sujit A. Shah

v/s

Appolo Munich Health Insurance Co. Ltd.

Complaint:AHD-G-003-1617-0207

Mediclaim for treatment of cancer of Buccal Mucosa was repudiated on the ground of suppression of material facts in the proposal form at the time of porting the policy in the year 2015. The complainant had mediclaim policy with New india Assurance Co. since 2012. It was ported to Appolo Munich Health Insurance Co. w.e.f.11.02.2015. The complainant had taken treatment in the year 2014 for “Proliferative Verrucous Hyperplacia” and this was not mentioned in the proposal form at the time of porting the policy.

23.

In the matter of

Mr. Maheshbhai D. Thakkar

v/s

Oriental Insurance Co.Ltd.

Complaint:AHD-G-050-1617-0086

Mediclaim for the treatment of ulcer in leg was partly repudiated. This was a group mediclaim policy covering preexisting disease. Policy conditions restricted the reimbursement to 60% of the amount of claim which arised after 6 months but before 1 year from inception of the policy. The subject treatment was taken in the 11th month of the policy. The insurer had also deducted certain amounts by imposing ceiling on room charges, surgeon,anesthetist, medical practitioner, consultants specialist fees, doctor visit fee. But he could not show the policy conditions to substantiate it. The complaint was admitted and 60% of the total claim amount was awarded to the complainant.

24.

In the matter of

Mr. Niranjan A.Thakkar

v/s

Oriental Insurance Co. Ltd.

Complaint:AHD-G-050-1617-0140

Mediclaim for the treatment of cardio vascular stroke was repudiated on the ground that no active line of treatment was adopted during hospitalization. The complainant pleaded that he had suddenly developed difficulty in speech,word finding and paraphonia and was taken to the hospital where he was put under the treatment of Neurophysician and was treated there for two days.He was diognised as having CV stroke LT parietal Occipital Region with thrombus. The respondent argued that intravenous treatment was not administered. Only oral medication was given. The Forum held that exclusion clause does not make a mention of intravenous treatment. The policy condition also did not define Active Line of Treatment. In the subject case sympyoms, tests, and diagnosis of disease and the administration of the medicines formed the active line of treatment. The patient was relieved of his health problem. Thus the respondent had erred in arriving at the decision of repudiation. Complaint was admitted and Rs28905/- awarded to the complainant.

25.

In the matter of

Arvindbhai J. Raval

v/s

National Insurance Co. Ltd.

Complaint:AHD-G-048-1617-0145

Insured’s Bank of india Swasthya Bima Policy was issued for the period 01.07.2014 to 30.06.2015 was due for renewal on 01.07.2015. Insured’s request for renewal with payorder was received by the Insurer on 07.09.2015. i.e. 67 days after expiry of the policy.The policy being a tie-up policy with the BOI , The bank was asked for the reasons for delay in debiting the insured’ A/C. The bank informed that the insured’s consent was received late. The insured informed that no consent was obtained in the earlier years. Had the bank informed him earlier

he would not have hesitated for the same. Hence, the bank had defaulted for which heshould not be punished and continuity should be granted to his health policy. The Forum intervened and asked the insurer to grant continuity within 30 days.

26.

In the matter of

Mr.Rameshchandra B. Pandya

v/s

United India Insurance Co. Ltd.

Complaint:AHD-G-051-1617-0520

Mediclaim for treatment of breathlessness with altered sensorium was repudiated on the ground of treatment having incepted before the commencement of the policy. In this case the mediclaim was lodged by a retired employee of Bank of India. The premium was deducted by the bank but it was remitted to the insurer through NEFT transaction on 05.11.2015. Hence, the cover started w.e.f.05.11.2015. The hospitalization started on 03.11.2015. Moreover the name of Mr R. B. Pandya was covered from 17.11.2015 as the bank had sent the request for addition of retirees on 17.11.2015. The forum held that the patient was not covered under the policy at the time of hospitalization and hence, the complaint was dismissed.

27.

In the matter of

Mr. Tushar S. Shah

v/s

Bazaz Allianz General Insurance Co. Ltd.

Complaint:AHD-G-005-1617-0563

The claim for theft of car was repudiated on the ground of intimation to rhe Insurer was given as late as 64 days. The insured argued that he was not aware about the rule for immediate intimation.he told that time had elapsed in obtaining FIR and RTO papers. The respondent submitted judgement of National Consumer Dispute Redressal Commission New Delhi F.A. No. 321 of 2005 New India V/S Trilokchand Jain. It stated that any delay in FIR and in intimation to the insurer could be fatal as it could hamper the investigation process. The complaint was dismissed.

28.

In the matter of

Mr. Hiren R. Dave

v/s

Oriental Insurance Co. Ltd.

Complaint:AHD-G-050-1617-0608

Mediclaim was repudiated on the ground that the nature of treatment was Nutritional Deficiency. Policy conditions excluded any treatment for convalescence debility or rest cure.The complainant argued that the insured was admitted to the hospital on the advice of the doctor and had taken the treatment suggested by him. Ultimately it was heald by the Forum that hospitalization charges only be paid and medicine charges be disallowed.Rs 2100/- was awarded.

29.

In the matter of

Mr. Bhavesh A. Panchal

v/s

Oriental Insurance Co. Ltd.

Complaint:AHD-G-050-1617-0670

Mediclaim for treatment of Pneumonia and Severe Septicemia was repudiated on the ground of pre-existing disease. The respondent argued that their investigator had inquired with the brother of the complainant according to which the patient was suffering from the ailment since last two years. The complainant refuted this and informed that his father was suffering from the ailment since two months and not since two years. The respondent could not produce any evidence to substantiate their argument with actual evidence to prove preexistence of the ailment. The complaint was admitted and complainant was awarded Rs.95990/-.

30.

In the matter of

Mr. Bhavesh A. Panchal

v/s

Oriental Insurance Co. Ltd.

Complaint:AHD-G-050-1617-0670

Mediclaim for treatment of Pneumonia and Severe Septicemia was repudiated on the ground of pre-existing disease. The respondent argued that their investigator had inquired with the brother of the complainant according to which the patient was suffering from the ailment since last two years. The complainant refuted this and informed that his father was suffering from the ailment since two months and not since two years. The respondent could not produce any evidence to substantiate their argument with actual evidence to prove preexistence of the ailment. The complaint was admitted and complainant was awarded Rs.55086/-.

31.

In the matter of

Amrutlal K. Patel

v/s

National Insurance Co.

Complaint:AHD-G-048-1617-0677

Mediclaim for the treatment of lower esophegal varices was repudiated on the ground of preexisting disease. According to the respondent the insured had the history of the disease since two years. The cover incepted thereafter. Hence, the claim was not payable for a preexisting disease. The repudiation was upheld. The complaint was dismissed.

32.

In the matter of

Jayshreeben I Patel

v/s

Oriental Insurance Co. Ltd.

Complaint:AHD-G-050-1617-0689

Claim for indemnification of loss and damage caused to A.C. and T.V. due to high voltage surge under House Holder Package Policy was partially repudiated. The surveyor had assessed the damage on total loss basis. For T.V. Rs.8000/- and for A.C. Rs.12000/-. The respondent admitted only Rs.10000/- but he could not any reasoning for that. The complaint was admitted and complainant was awarded Rs.20000/-.

33.

In the matter of

Omkarsinh D. Mahida

v/s

National Insurance Co. Ltd.

Complaint:AHD-G-049-1617-0611

Mediclim for treatment of radio frequency ablation of long vain lower limb with foam scelerotherapy was partly repudiated on the ground of reasonable and customary charges. . The respondent could not produce the rates for the similar treatment prevailing in the area where the treatment was taken by the complainant as required by IRDAI. The complaint was admitted and Rs.25763/- awarded to the complainant.

34.

In the matter of

Mrs. Renu S. Dhavan

v/s

New India Assurance Co. Ltd.

Complaint:AHD-G-049-1617-070

Mediclaim for the treatment of progressive weight gain, Knee and backpain snoring Obstructive sleep apnea, recurrent UTI-surgical treatment called Laproscopic Bended Roux En Y Gastric Bypass procedure was repudiated on the ground that treatment for obesity and its complication was not payable under the terms of the policy. The complainant cited circular from Govt. of india,Health Ministry mentioning tht expenses for treatment of Obesity was payable. But the Forum held that the said treatment is categorically excluded from the scope of the policy cover. Hence, the complaint was dismissed.

35.

In the matter of

Mr. Nikhilray M. Bhatt

v/s

Tata AIG General Insurance Co. Ltd.

Complaint:AHD-G-047-1617-0629

Claim for reimbursement of medical expenses for treatment of Deep Vain Thrombosis under Travel Insurance policy was repudiated on the ground that extension of the policy was obtained by making a false declaration about health. The complainant had taken treatment for deep venous thrombosis of lower limb on 04.01.2016. At the time of extending his policy from

07.01.2016 to26.01.2016 he did not disclosed the treatment taken on 04.01.2016.Hence, his claim for next treatment of the same ailmemt from 12.01.2016 to 25.01.2016 was repudiated.The Forum upheld the repudiation and dismissed the complaint.

36.

In the matter of

Mr. Pareshkumar c. Bagadia

v/s

Oriental Insurance Co. Ltd.

Complaint:AHD-G-050-1617-0632

Mediclaim for post hospitalisation treatment of iron deficiency was repudiated stating that treatment for nutritional deficiency was excluded from under the policy. The complainant argued that after hysterectomy the patient was required intravenous iron supplements and it was part of the original treatment given during hospitalization. The complainant's stand was found to be just and the complaint was admitted. Awarded Rs.23400/-

37.

In the matter of

Mr. Subhaschandra C. Shah

v/s

Oriental Insurance Co. Ltd.

Complaint:AHD-G-050-1617-0651

Mediclaim for treatment of Intra Vitereal Lucentis procedure was repudiated on the ground that the treatment could have been given on outdoor basis.To support this view, the respondent also argued that no operation theatre charges or admission fee, Room chrges etc were levied. The Forum took in to account the fact that due to advancement of medical facility and technologies this treatment could be completed within few hours, which took days in hospital earlier. Hence the claim was payable. The complaint was admitted and Rs.25000/- awarded.

38.

In the matter of

Mr. Subhaschandra C. Shah

v/s

Oriental Insurance Co. Ltd.

Complaint:AHD-G-050-1617-0652

Mediclaim for treatment of Intra Vitereal Lucentis procedure was repudiated on the ground that the treatment could have been given on outdoor basis.To support this view, the respondent also argued that no operation theatre charges or admission fee, Room chrges etc were levied. The Forum took in to account the fact that due to advancement of medical facility and technologies this treatment could be completed within few hours, which took days in hospital earlier. Hence the claim was payable. The complaint was admitted and Rs.29000/- awarded.

39.

In the matter of

Mr. Subhaschandra C. Shah

v/s

Oriental Insurance Co. Ltd.

Complaint:AHD-G-050-1617-0650

Mediclaim for treatment of Intra Vitereal Lucentis procedure was repudiated on the ground that the treatment could have been given on outdoor basis.To support this view, the respondent also argued that no operation theatre charges or admission fee, Room chrges etc were levied. The Forum took in to account the fact that due to advancement of medical facility and technologies this treatment could be completed within few hours, which took days in hospital earlier. Hence the claim was payable. The complaint was admitted and Rs.25000/- awarded.

40.

In the matter of

Mr. Harishbhai C. Shah

v/s

National Insurance Co. Ltd.

Complaint:AHD-G-048-1617-0708

Mediclim for treatment of radio frequency ablation of long vain lower limb with foam scelerotherapy was partly repudiated on the ground of reasonable and customary charges. . The respondent could not produce the rates for the similar treatment prevailing in the area where the treatment was taken by the complainant as required by IRDAI. The complaint was admitted and Rs.41100/- awarded to the complainant.

41.

In the matter of

Mr. Brijeshkumar J Shah

v/s

ICICI Lombard General Insurance Co. Ltd.

Complaint:AHD-G-020-1617-0647

Payment of Mediclaim for treatment of knee replacemrnt under a group mediclaim policy issued to Jain Inernational Organisation covering their members and their families was restricted to Rs.125000/- by the respondent insurer company as per the terms of the policy. The complainant did not agree to this ststing that the advertisement given by the J I O did not mentioned any such restriction. The respondent argued that the the terms of the policy were given to the master policy holder,J I O, and that included the aforesaid restriction. The respondent disowned the advertisement given by the J I O . However, this restriction did not apply to pre and post hospitalization expenses. Rs.5414/- awarded to the complainant towards pre and post hospitalization expenses.

42.

In the matter of

Mr. Pravin P Mehta

V/S

The Oriental Insurance Co. Ltd.

Mediclaim for treatment of heat stroke was not being attended to by the respondent. In the hearing the respondent argued that treatment included medication for pre existing cellulities of the scar of previous operation and therefore the claim was not payable. The complainant argued that he was admitted for treatment of heat stroke with high grade fever and only on the date of discharge oral antibiotics were prescribed for an oozing scar of previous operation. It was feld by the Forum that the treatment included both the ailments and it was not possible to bifurcate

the treatment expenses. Ultimately, the Rs.9603/- were awarded to the complainant being 805 of amount claimed.

43.

In the matter of

Mrs. Sangeeta M Patel

V/S

Religare Health Insurance Co. Ltd.

Mediclaim for treatment of heart attack was declined by the respondent under policy clause 2.1(E)(III) which excluded treatment of other Acute Coronary Syndromes where there was no characteristic ECG changes and elevation of specific enzymes from the benefit of critical illness.The stand taken by the respondent was upheld as though the insured person had expired with history of chest pain and hypertention, there was no ST changes and specific enzymes level was not raised.no post mortem was done to prove the cause of death. The complainant was dismissed.

In the matter of

Mr. Sujit A. Shah

V/S

The Appolo Munich Health Insurance Co. Ltd.

45.

In the matter of

Mr. Niraj A Naik

V/S

The New India Assurance Co. Ltd.

Mediclaim for surgical treatment of Excision of anterior abdominal wall was declined as per policy condition 4.3 which excluded the said ailment during the first 24 months of the policy. In the present the treatment was taken within the second year. The repudiation was upheld and complaint was dismissed.

46.

In the matter of

Mr. Niranjan K. Trivedi

V/S

The National Insurance Co. Ltd.

Mediclaim for treatment of Diastolic HF,UTI, AKI was partially settled for Rs.100361/- after deduction of Rs.14534/- towards Customary and reasonable charges. As per IRDA cicular dated 20.02.2013,Reasonable charge meant"The charges for services or supplies which are the standard charges for the specific provider and consistent with the prevailing charge in the geographical area for identical or similar services, taking into account the nature of the illness/ injury". In the present case the respondent could not provide any analysis or comparisan

Chart for deduction of consultation charges for Rs.10000/-.The same amount was awarded.

47.

In the matter of

Mr. Hirenkumar M. Prajapati

V/S

The Oriental Insurance Co. Ltd.

Mediclaim for treatment of accidental bone fracture was rejected by the respondent on the ground of misrepresentation of material fact in the claim form. There was difference in the dates of admission to the hospital. The case was not reported to policy. The Forum held that the the insured person had fallen down from the two wheeler and sustained bone injuries. He was first admitted to a Govt. hospital and then taken to the Private Orthopadec hospital. The nature of accident does not necessitate police complainant. Other evidences in the case papers do not confirm any material misrepresentation. The repudiation was not upheld and complainant was awarded the claim.

48.

In the matter of

Mrs. Kumudben V. Kachiwala

V/S

Max Bupa Health Insurance Co. Ltd.

Mediclaim for treatment of Right Breast cancer was rejected by the respondent on the ground of misrepresentation about preexistence of Diabetes for more than 10 years at the time of taking the policy. The insured person was suffering from diabetes since 16 years which was revealed from the treatment papers of the present treatment. As per insurers guidelines proposals with history of diabetes and hypertention for more than 10 years were liable to be declined. In view of this the complaint was dismissed.

49.

In the matter of

Mr. Navnitbhai M. Gandhi

V/S

The United India insurance Co. Ltd.

Mediclaim for treatment of hernia was partly repudiated on the ground of customary and reasonable clause. The complainant argued that he was not informed about any such restrictions and the respondent had unilaterally imposed it. The respondent replied that they had decided the reasonable charges according to the rates fixed by the Association of Surgeons of Baroda. The Forum held that the deduction was not justified. Rs.21875/- was awarded to the complainant.

50.

In the matter of

Mr. Sagar D. Sutaria

V/S

The Religare Health Insurance Co. Ltd.

Mediclaim for treatment of appendectomy was rejected on the ground of suppression of material facts regarding pre existing ailments. The insured person was suffering from Hypertention and epilepsy prior to date of proposal for the insurance. The information in the treatment papers of the present claim proved that the respondents contention was tenable and corroborated with evidence. The precedents of other cases were also cited in support of repudiation. The complaint was dismissed.

51.

In the matter of

Mr. Harkishan Mohata

V/S

The Iffco-Tokio General Insurance Co. Ltd.

Mediclaim for the treatment of cervical pain was rejected by the respondent on the ground that the past history of treatment taken for the same ailment was not disclosed at the time of porting the policy from previous insurer. The proposal(English Language Version) form was not filled by the policyholder himself and it was signed in Hindi. Again the policy was continuous. The present insure had failed to check up previous claim history at the time of allowing the porting of the policy. Therefore the complaint was admitted and Rs.9302/- was awarded.

52.

In the matter of

Mr. Anilkumar J. Vyas

V/S

The Max Bupa Health Insurance Co. Ltd.

Mediclaim for treatment of left foot ankle drop injury was declined and the policy was cancelled on the ground of non disclosure of information. The complainant pleaded that he had not suppressed any information in the proposal form. The relavant questioned asked about any disease or injury or treatment oe investigation reports within the last seven years at the time of ptaking the insurance .the insurance was taken in the year 2013. The insured person had taken treatment way back in the year 1995. The reply to the questionasked was not misrepresented. The complainant's stand was found justified to the Forum and Rs.91318/- was awarded.

53.

In the matter of

Mr. Ketanbhai B. Vekadiya

V/S

Universal Sompo General Insurance Co. Ltd.

Mediclaim for surgical treatment of piles was rejected in terms of policy clause 14 which excluded allopathic treatment. The Claim was justified by the forum on the following ground. The respondent did not take cognizance of regulation 5(1) of the IRDA(Health Insurance)Regulations,2013 in updating their policy conditions.This regulation extended the coverage to the non allopathic treatment also. In the present case the treating doctor also had submitted that aurvedic doctors are also allowed to administer allopathic treatment as per Reifstered Medical Practitioner Act 1963(A). The complaint was admitted by the Forum and Rs.23190/- was awarded.

56.

In the matter of

Mr. Natvarlal j. Acharya

V/S

The New India Assurance Co. Ltd.

Mediclaim for coronary artery disease was partially repudiated on the ground of reasonable and customary charges. The patient was treated with Bioabsorbabale stent cost of which was higher by Rs.65000/- than drug eluting stent which are generally used in this type of treatment.

As per IRDA cicular dated 20.02.2013,Reasonable charge meant"The charges for services or supplies which are the standard charges for the specific provider and consistent with the prevailing charge in the geographical area for identical or similar services, taking into account the nature of the illness/ injury". In the present case the respondent could not provide any comparisan chart for deduction of stent charges of Rs.65000/-. The repudiation was not found justified.The award was made for Rs.65000/-.

57.

In the matter of

Mr. Ravi k. Brahmbhatt

V/S

Bajaj Allianz General Insurance Co. Ltd.

Cliam for motor own damage was rejected by the respondent on the ground of absence of privit of insurance contract between the purchaser of the car and insurer. The other reason was lack of insurable interest in the object of the insurance as the vehicle was not transferred in the name of the purchaser on the date of accident. As per complainant thecar was purchased on 16.04.2016 and met with an accident on the same day. The intimation of accident was given to the Insurer on 18.04.2016 and the complainant had applied for the transfer of insurance on 19.05.2016. The insurer denied the transfer insurance on a damaged vehicle.The claim was rejected fro the aforesaid reasons.The complainant pleaded that he was about to initiate the process of RTO transfer,but the accident occurred on the same day leaving no time for him to complete the process.The respondent pleaded that the consent of the seller of the vehicle was not submitted with the transfer intimation. Moreover it was observed that the Auto Consultant had given the receipt of the sale transaction on 11.04.2016. Hence, the complaint was dismissed.

58.

In the matter of

Dr. Lalitshankar Joshi

V/S

The Oriental Insurance Co. Ltd.

Mediclaim for treatment of grade III hemorrhoids was partly repudiated.Deduction of Rs.8624/- was made.Rs.4500/- towards higher room category,Rs.800/- towards non-submission of investigation reports. It was held t insurer was right in deducting the claim amount except Rs.2005/- deducted towards Co-Payment. Rs.2005/- was awarded with 9% interest.

59.

In the matter of

Mr. Alkeshsinh J. Sengar

V/S

The United Insurance Co. Ltd.

Mediclaim for treatment of incisional hernia on the spot of old incision of appendectomy was rejected on the ground that the claim for treatment of pre existing ailment was excluded within the first four years of the policy as per policy conditions. The treating doctor had certified that present treatment was for hernia not for appendix.The Forum held that hernia was not pre existing and therefore the repudiation was not correct. Rs.22500/- was awarded.

60.

In the matter of

Mr.Divyakant A. Shah

V/S

The United India Insurance Co. Ltd.

Mediclaim for the surgical treatment of appendicitis was partially repudiated by the respondent ounder policy clause for reasonable and customary charges. The respondent argued that association of surgeons at Baroda have fixed the rates for various surgical procedures and allied aspects of surgery. The respondent informed that they had settled the claim on the basis of rates fixed by ASSOCIATION OF SURGEONS OF BARODA. The Forum held that it was a n unilateral action on the part of the insurer to have applied such rates arbitrarily without informing the policyholder.Moreover the respondent had not questioned the treating doctors for charging rates higher than the rates decided by the surgeon association. The partial repudiation was not correct and award for Rs.221026/- was made.

61.

In the matter of

Mr. Sanjay V. Ganatra

V/S

The New India Assurance Co. Ltd.

Mediclaim for treatment of umbilical hernia was repudiated on the ground that claim for treatment of obesity related ailments was excluded under terms of the policy. The respondent had taken a view that obesity had the chance to induce hernia.However he could not prove weather obesity was the cause of hernia in the subject case. The treating doctor had opined that in this case hernia was not induced by obesity. The Forum also took thasame stand and awarded Rs.41830/- to the complainant.

62.

In the matter of

Mr. Sujit A. Shah

V/S

The Appolo Munich Health Insurance Co. Ltd.

Mediclaim for treatment of cancer of buccal mucosa was repudiated on the ground of suppression of material facts regarding past treatment of proliferative verrucous hyperplacia at the time of portability. The respondent's argument was not found tenable as the respondent had not checked the claim history of the insured person with the previous insurer. Moreover the application for portability was not made within the stipulated time by the complainant and yet it was accepted by the respondent and it showed that respondent had taken care while granting portability. It was wrong to punish the insured person for the suppression.The complainant was awrded Rs.317929/-

63.

In the matter of

Mrs. Jyotsana s. Shah

V/S

The New India Assurance Co. Ltd.

Mediclaim for hip replacement was partially repudiated on the ground of reasonable and customary charges. The policy conditions provided that amount payable under clause 2.3 and 2.4 shall be at the rate applicable to the entitled room category. In case insured opts for the room with rent higher than the entitled category as under clause 2.1, the charges payable under 2.3 and 2.4 shall be limited to the charges applicable to the entitled room category. The respondent had taken calculated the eligible amounts on proportionate basis which was wrong. The deductions made were found to be incorrect and award for Rs.25196/- was declared.

MEDICLAIM

In the matter of
Shri Deepak R Baldi
Vs
The New India Assurance Co. Ltd
Complaint Ref No.AHD-G-049-1516-0885

Award Date: 18.04.2016

Policy No: 212200/34/15/25/00000456

The Complainant alongwith his family members was insured with the Mediclaim Policy 2012 issued by the New India Assurance Company Ltd. Ms. Disha Baldi, daughter of the Complainant, was hospitalized from 19.06.2015 to 20.06.2015 at Shree Bharti Vallabh Hospital for Adenoid enlargement and Adenotonsillectomy was done. The TPA vide their letter dated 10.01.2016 rejected the claim stating that the hospital was black listed. The Complainant stated that he was not aware that Shree Bharti Vallabh Hospital was under Declined List of the Hospitals. He said he was not informed by the Company or the Hospital about the declined list. He said after lot of follow-up/reminders, the Company rejected the claim on 10.01.2016. He had filed his claim on 23rd June,2015. The representative of the Insured stated Shree Bharti Vallabh Hospital was not under the declined list of hospital. He stated that as per the Agent the list of declined list was not provided to the Insured. He said that the Insured had taken treatment from Dr. C.S. Kabra and the doctor had utilized Shree Bharti Vallabh hospital for treating the patient. On the basis of this fact the claim was admissible which was also informed to the TPA as the name of the hospital was not mentioned in the January, 2015 circular.The Registration No. of Shree Bharti Vallabh Hospital was 031201033 dated 17th March, 2012 and the certificate was issued on 26th March, 2012 which was valid till 31st March, 2016.A circular letter of the Respondent Ref: HO/Health/DL/2015/IBD: Admn/416/07 dated 9th January, 2015 attached a revised list of 28 hospitals and asked all the operating offices to attach the clause with the policy. However, in this case, the policy was renewed on 05.06.2015 and the company had not sent the list of declined hospital along with the policy schedule. Even at the time of intimation of hospitalisation, the TPA /Insured did not inform the Insured about the declined list of hospital.The claim was filed on 23.06.2015 by the Complainant. The Company repudiated the claim on 10.01.2016. It had taken more than six months for the Respondent to state that the hospital was delisted in the list of hospitals. The Respondent had violated the provisions of the Protection of the Policyholders' Interest Rules, 2002. Shree Bharti Vallabh hospital was not in

the list of the delisted hospitals. The claim amount if admissible was worked out by the Respondent as Rs. 48,428/-.

The complaint was admitted for Rs. 48,428

In the matter of
Shri Chetan R Shah
Vs.
The New India Assurance Co. Ltd.
Complaint Ref No.AHD-G-49-1516-0902

Award Date: 18.04.2016

Policy No: 210402/34/14/25/00002065

The Complainant alongwith his family members was insured under Mediclaim Policy 2012 issued by the New India Assurance Company Ltd. He was insured since the year 2002. The Sum Insured under the said policy was for Rs. 2,00,000/-/ The Complainant was hospitalized at Dr. Ajay Munshi's surgical Nursing Home from 08.06.2015 to 09.06.2015 for Left Uretric Colic. When Claim for Rs.12088 was lodged, the TPA had paid Rs. 6458/-. On the Complainant's representation, the TPA settled Rs. 2018/-. The TPA had deducted the amount under proportionate deduction as per Sum Insured. The Complainant's argument was that he was having the mediclaim policy since the year 2002. He had increased the Sum Insured in the year 2013 to Rs. 2 lacs. He said that at the time of his hospitalisation in the year 2015, his Sum Insured was Rs.2,00,000/-. As against his claim of Rs. 12,088/-, the Company had settled Rs.8,476/- only. He prayed for the balance amount deducted by the Company.

It was seen from the records that the Insured was having policy from the year 2002. The Sum Insured was increased in the year 2013-14 from Rs. 1.50 lacs to Rs. 2 lacs. The Complainant was admitted to the hospital in the policy year 2014-15 with Sum Insured of Rs. 2 lacs. The Respondent had deducted the above charges restricting to the Sum Insured of Rs. 1.50 lacs. However, from the terms and conditions of Mediclaim Policy 2012 provided to the Forum there was no mention of any such restrictions of Enhanced Sum Insured. Hence the Complainant was entitled for reimbursement with full sum Insured of Rs. 2,00,000/- as the base for calculation of his claim.

In view of the facts and circumstances, the complaint was admitted to the balance amount of Rs.3612/-.

In the matter of
Mr.Tribhuvanbhai D Patel
Vs.
The National Insurance Company Ltd
Complaint Ref No.AHD-G-48-1516-0870

Award Date: 19.04.2016

Policy No:300703/48/15/8500003913

The Complainant was insured with National Mediclaim Policy issued by the National Insurance Company Ltd. Mrs. Pushpaben T Patel, wife of the Complainant ,was hospitalized to

Jain Eye Associates on 16.10.2015 for Right Eye Phaco Emulsification with Fodable IQ Lens. Against the claim of Rs. 47879/-, the Respondent had settled the claim for Rs.19000 and the balance amount for Rs.28879/- was deducted citing Authorised Limit exhausted. The deductions were done on the basis of 'Authorized limit exhausted' which was not in order.The Representative was not able to give any justifiable reason for the deductions. The Information about the PPN hospital and the rates were not informed to the Complainant which the representative also agreed.

The duty of the Insurer was that the Insured should have been informed about the rates of the PPN hospital. Under the agreement between the Insurer and the hospitals (PPN), the rates for treatment of various diseases were fixed. The Insured was to be treated "Cashless" for the specified diseases mentioned in the agreement. However, the Hospital under PPN, instead of cashless treatment had overcharged the Insured. The Insurer had deducted the excess amount from the Insured's claim citing 'Reasonable and Customary' clause. The Insurer instead of taking up the matter with the hospital, had penalized the Insured.

In view of the facts and circumstances the complaint was admitted to the claim amount of Rs.28,879/-.

In the matter of
Mr.Tribhuvanbhai D Patel
Vs.
The National Insurance Company Ltd
Complaint Ref No.AHD-G-48-1516-0871

Award Date: 19.04.2016

Policy No:300703/48/15/8500003913

The Complainant was insured with National Mediclaim Policy issued by the National Insurance Company Ltd. Mrs. Pushpaben T Patel, wife of the Complainant was hospitalized to Jain Eye Associates on 30.10.2015 for Left Eye Phaco Emulsification with Fodable IQ. Against the claim of Rs. 48,084/-, the Respondent had settled the claim for Rs.23084 and the balance amount for Rs.25000/- was deducted citing Reasonable and Customary clause.Based on the hearing and the records submitted, it was noted that The deductions were done on the basis of 'Reasonable and Customary charges'.The Respondent had deducted the excess amount from the Insured's claim citing 'Reasonable and Customary' clause. The Insurer instead of taking up the matter with the hospital, had penalized the Insured. The Insured had failed to obtain the reasonableness of the expenses.

In view of the foregoing, the complainant is entitled for relief for Rs.25,000

In the matter of
Shri Navinchandra S Solanki
Vs.
The National Insurance Company Ltd
Complaint Ref No.AHD-G-48-1516-0892

Award Date: 19.04.2016

Policy No: 300900/48/14/8500011999

The Complainant was insured under National Swasthya Bima Policy issued by the National Insurance Company Ltd. The Complainant was hospitalized to Vision Eye Care on 14.09.2015 for Left Eye Cataract surgery. Against a claim of Rs. 32000/-, the Respondent had settled the claim for Rs.18,000/- and the balance amount of Rs.14000/- was deducted citing Reasonable & Customary clause. The Complainant stated that his treating doctor, Dr. Rajesh

Shah had informed him that the cost of the operation was Rs. 27,000/- and he had to bear the extra charges as the Insurance company would be reimbursing only 90% of the claim amount. He said the file was prepared by the Dr. Rajesh Shah and information regarding hospitalisation to the TPA was also done by him. He also stated that the bill for Rs. 32,000/- included the medicines and the lens used. He said deduction by the TPA was not correct. He was ready to bear the difference of Rs. 5000/- which the doctor had informed him. But when he received the amount much less than what he had expected, he represented and came to this Forum for balance claim amount.

As per IRDA circular dated 20.02.2013 on "standardization in health insurance" the Respondent had not produced rate charts of other hospitals in and around the geographical area where the Complainant was hospitalized.The Complainant had produced a price list given to him by Dr. Rajesh Shah, of Vision eye care where the price for the cataract surgery was mentioned as Rs. 27,000/-. The basis for deduction of claim amount by the Respondent was not in order. As the Complainant was aware of the PPN rates well before the surgery, and the doctor had informed him the cost towards the surgery would be Rs. 27,000/-, it would be appropriate to settle the claim for Rs. 27,000/-.

In view of the facts and circumstances, the Complainant is entitled for the balance amount of Rs. 9000/- over and above the claim amount of Rs. 18,000/-.

In the matter of
Ms.Ranjanben Prajapati
Vs
The Oriental Insurance Company Ltd
Complaint Ref No.AHD-G-50-1516-0893

Award Date: 22.04.2016

Policy No: 141100/48/2015/5297

The Complainant was insured under Happy Family floater policy issued by the Oriental Insurance Company Ltd. The Complainant was hospitalized at Ashirvad Orthopaedic and Medical Hospital from 19.03.2015 to 22.03.2015 and again from 17.04.2015 to 20.04.2015 for Severe neck pain + Left UL tingling/Numbness with burning pain. When claims were filed on 23.04.2015 and 29.04.2015, the Respondent closed the file on the basis of delay in intimation and non submission of hospital papers. Based on the hearing and the records submitted, it was noted that The Complainant was hospitalized at Ashirvad Orthopaedic and Medical Hospital from 19.03.2015 to 22.03.2015 and again from 17.04.2015 to 20.04.2015 for Severe neck pain + Left UL tingling/Numbness with burning pain. Since there was no mention of the disease in the Discharge Summary, the Forum felt it necessary to seek the opinion of an Expert, i.e. an Orthopedic Doctor. Accordingly, a medical opinion was sought from Dr. Mukesh S Shah, M.S. (Ortho-Surgeon), Regn.No.G 2080, on the papers submitted to the Forum. **Final diagnosis from reports stated – Multiple Cx spine disc lesion with cervical spondylosis with Mild Carpal Tunnel Syndrome (left) side.**

The Respondent could have sought an opinion from their doctor or an independent doctor and arrived at a conclusion on the nature of disease. By sticking to their decision not to settle the claim and keep calling for the requirement which the treating doctor had refused to part with, the Respondent had exhibited their casual and callous approach toward their own Insured. In the subject complaint the helpless Insured had been driven to the Forum unnecessarily.

The Complainant is entitled for relief and his complaint stands admitted for Rs.15,808

In the matter of
Smt Sushilaben B Gheewala
Vs.
National Insurance Co. Ltd

Complaint Ref No.AHD-G-48-1617-0073

Award Date: 23.05.2016

Policy No: 300703/48/15/8500004616

The Complainant was covered under National Mediclaim Policy issued by the National Insurance Company Ltd for a Sum Insured of Rs.1,75,000/-. The Complainant was hospitalized at Ami Eye Hospital, Patan on 05.01.2016 for right eye cataract surgery with Phaco surgery with imported Foldable IOL Implantation under Topical anesthesia. Against the claim of Rs. 63,652/-, the Respondent had settled Rs.22452/-, and Rs.41200/- was deducted citing Reasonable and Customary clause No.3.29 of the policyIt is seen that the Sum Insured of the Complainant was Rs.1,75,000/-.The room rent as per terms and conditions was 1% of the basis sum insured which comes to Rs.1750 and the company had allowed only Rs. 1000/-. Thus Rs. 750 becomes payable. In respect of OT charges, Investigation charges Instrument charges, Operation charges were deducted under 'Reasonable and Customary charges' clause. The representative had failed to establish and justify the deductions.

No policy terms and conditions were given to the Insured.

In view of the foregoing, the Complainant was entitled for partial settlement of Rs. 39,850/-.

In the matter of
Shri Nirav A Parikh
Vs.
National Insurance Co. Ltd.

Complaint Ref No.AHD-G-048-1617-0034

Award Date: 23.05.2016

Policy No: 300703/48/15/850006936

The Complainant alongwith his family was insured under National Mediclaim Policy issued by National Insurance Company Ltd. Smt Mitalben, wife of the Complainant, was hospitalized at Bharti Hospital from 10.10.2015 to 12.10.2015 for Vaginal, Hysterectomy with Bilateral Oophorectomy. When claim for Rs.74,665/- was lodged, the Company paid Rs.56775/- and disallowed Rs. 17890/- under 'reasonable and customary charges' clause of the policyThe deduction by the Respondent towards non–medical items amount to Rs. 680 was in order. The deduction of Rs. 1500 for left breast mammography was disallowed stating that it was not related to the current disease. The Insured had taken treatment for right breast cancer alongwith the hysterectomy and bilateral oophorectomy. Hence, the deductions stating that it was not related to the current disease by the Respondent shows callous attitude towards the Insured. The Respondent failed to submit their Self Contained Note in time. The SCN was sent through mail received on the date of hearing without any signature by any Officer of the Respondent.

In view of the facts and circumstances, the Complainant is entitled for relief to the amount of Rs.17,210/-.

In the matter of
Smt Jayshree B Shah
Vs.
The New India Assurance Co. Ltd.
Complaint Ref No.AHD-G-49-1617-0010

Award Date: 24.05.2016

Policy No: 23080034142500002349

The Complainant was covered under the New Mediclaim 2012 issued by the New India Assurance Company Ltd for a Sum Insured of Rs.1,00,000. The Complainant was hospitalized at Smt R.B.Shah Mahavir Super Speciality Hospital, from 22.09.2015 to 24.09.2015 for Mustard flap cover for right intaorbital region Against the claim of Rs. 40,272/-, the Respondent had settled Rs.29004/-, and Rs.11268/- was deducted without citing any reasons.

The representative of the Respondent appeared and stated that they were ready to pay the amount of Rs.7432/- deducted out of OT charges. Other charges being non-medical and not payable as per Terms and Conditions of the policy, the deductions were in order.

It is seen that the Sum Insured of the Complainant was Rs.1,05,000/-. The Respondent had not given any clarifications to the Complainant for the deductions made by them. However, the Respondent in their Self Contained Note alongwith the annexures has submitted to the Forum the clarifications for the deductions made.The deductions towards non-medical items, service charges and registration charges are not payable as per the terms and conditions of the policy.The Respondent had deducted an amount of Rs. 7432/- out of OT charge being 25% of surgeon charge under the 'Customary and Reasonable clause'. They have however, failed to establish and justify the deductions so made.

Since the representative of the Respondent has agreed to pay the amount of Rs. 7432/- during the hearing, the case is disposed of accordingly.

In the matter of
Shri Harsukh V Patel
Vs
United India Insurance Co. Ltd.
Complaint Ref No.AHD-G-51-1617-0009

Award Date: 29.06.2016

Policy No: 067700/28/15/P/10/6383085

The Complainant was covered under Individual Health Policy issued by the United India Insurance Company Ltd for a Sum Insured of Rs.2,00,000. The Complainant was hospitalized at Apoorva diagnostic centre from 12.12.2015 to 13.12.2015 for Hemorrhoids + Fissure. Against the claim of Rs. 35,039/-, the Respondent had settled Rs.7439/- and Rs. 27,600/- was disallowed stating bill other than hospital bill and Admission charges not payable. Unsatisfied with decision of the Respondent, the Insured had approached the Forum for redressal of his grievance and settlement of the balance claim.

From the submissions made by both the parties and the documents submitted on record it was noted that there were two deductions:

(i) Rs. 27500 towards surgeon charges with remark Bill other than hospital bill not payable
(ii) Rs. 100 Admission charges

i) The admission charge was not payable as per the terms and conditions.

ii) In respect of the surgeon charges in the discharge bill of the hospital it was mentioned that Surgeon's fee of Rs.27,500/- was paid separately vide bill No. 804 dated 12.12.2015. Both the bills were examined by the Forum. It was seen that the name of the hospital appears in the bill. However, the note 2 under condition No. 1.2 (c) Surgeon Anesthetist, Medical Practitioner, Consultants, Specialists Fee states " No payment shall be made under 1.2(c) other than as part of the hospitalisation bill.

iii) The Company had rejected the claim stating that the Surgeon's fee did not form part of the hospital bill. But the clause mentioned about the **hospitalization bill.** The Surgeon charges were incurred during the hospitalization. The Respondent had erred by using the term "Hospital bill" instead of "Hospitalization bill". The Respondent had deducted the amount arbitrarily.

In view of the foregoing, the Complaint was admitted and was directed to pay Rs.27,500/-

In the matter of

Smt Kalpana G Pancholi
Vs.
Max Bupa Health Insurance Co. Ltd

Award Date: 28.06.2016

Policy No: 30306885

The Complainant was insured under the Health Companion Policy issued by the Max Bupa Health Insurance Company Ltd. The complainant was hospitalized at Shubhechha Multispeciality Hospital from 14.01.2016 to 20.01.2016 for "Medial compartment Osteoarthritis of the Left Knee Joints". The claim was rejected by the Company on the ground of non-disclosure of HTN and wrong disclosure of height and weight in the proposal form. Aggrieved by the decision, he had appealed to the Grievance Cell and not satisfied with their decision she had approached the Forum for redressal.

From the submissions of both the parties and the documents submitted it was observed that the Insured was operated for Medial Compartment Osteoarthritis of the left knee joints. The Insured was having policy from the year 2008 with Oriental Insurance Company and from the year 2014 the policy was ported to the Respondent.The Respondent had conducted medical examination of the Complainant and had issued the policy. The Medical examination report stated height as 156 cms and weight as 72 Kgs.

The OPD paper of Shubhechha Multispecialty Hospital dated 09.01.2016 dated H/o HT – 2 years on medication. Further HTN had no nexus with the Osteotomy of left knee treatment. The Forum felt that the Respondent's disowning its liability to pay the Insured on the claim was wrong.

Thus, the complaint was allowed.

In the matter of- Shri Rajendra H Gehani
Vs
Royal Sundaram Alliance Insurance Co.Ltd

Complaint Ref No.AHD-G-38-1617-0091

Award Date: 29.06.2016

Policy No: FGH0004046000102

The Complainant alongwith his wife was insured with the Family Good Health Insurance Policy issued by Royal Sundaram Alliance Insurance Company Ltd. Smt Swapanaben Gehani, wife of the Complainant, was admitted to Shalby hospital from 23.07.2015 to 28.07.2015 for total knee replacement in both the legs. The TPA had sanctioned Rs. 3,00,000/- as authorized limit for cashless. However, the Complainant could not avail cashless facility, as its sanction was received after discharge. On discharge from the hospital, the Complainant had filed a claim for Rs.4,53,450/-. The Respondent had repudiated the claim stating that the claim had arisen within 4 years from the date of commencement of the policy out of pre-existing disease.

From the submissions made by both the parties and the documents submitted on record it was noted that The Insured had bought the policy during the period 10.06.2013 to 09.06.2014 from the Respondent. The hospitalization for total knee replacement from 23.07.2015 to 28.07.2015 was in the third year of the policy. The manifestation of the disease requiring Total Knee Replacement does not happen in short time. However, there was no record to prove by the Respondent that the disease was pre-existing. They had only taken an expert opinion of their panel doctor.The policy terms and conditions clearly stated that knee/hip joint replacement was covered after 2 years of the policy. The Respondent had approved the cashless and the TPA had given their approval for claim settlement on 02.09.2015.
In absence of any proof that the ailment was pre-existing, the decision of the Respondent to repudiate the claim was incorrect.

The complaint was entitled for Rs. 3,25,000 + interest from 02.09.2015 till the date of the payment.

In the matter of
Shri Kanaiyalal M Patel
Vs
National Insurance Co. Ltd

Complaint Ref No.AHD-G-48-1617-0200

Award Date: 27.06.2016

Policy No: 310300/48/15/85/00009430

The Complainant was insured under Baroda Health Policy for a Sum Insured of Rs.2,50,000 issued by the National Insurance Company Ltd. Smt Bhanuben Patel, wife of the Complainant was hospitalized at Venus Super Specialty Hospital from 29.01.2016 to 04.02.2016 for L4 L5 canal stenosis with degenerative grade I spondylosis.

Against the claim of Rs. 2,21,609/-, the Respondent had settled it at Rs.1,00,000/- and Rs. 1,21,609 was disallowed stating that the restricted sum insured exhausted.The claim has arisen in the fifth year of the policy. The consultation paper dated 18.01.2016 of Dr. Rakeshkumar C Luhana, Consultant Neurosurgeon and spine specialist stated :

" c/o low back pain (L) L/L pain – 8 years -Increased since 2 months"

The policy had run continuously for 4 years and the pre-existing ailment gets covered after continuous period of 36 months of the policy, In absence of any specific exclusion restricting the claim payment to Sum Insured at any previous year was incorrect and wrong.

The Complainant was entitled for relief to the extent of Sum Insured of Rs. 2.50 lacs.

In the matter of
Smt Indiraben K Vasani
Vs.
Oriental Insurance Co. Ltd
Complaint Ref No.AHD-G-50-1617-095 & 096

Award Date: 05.07.2016

Policy No: 131100/48/2012/11865

The Complainant was insured under the Group Mediclaim Master Policy No.131100/48/2012/11865 and certificate No.159/12/05/23551 issued by the Oriental Insurance Company Ltd, Divisional 20, Andheri for the period 01.06.2012 to 23.12.2012. The complainant was hospitalized at Siddhi Vinayak Hospital from 07.10.2012 to 12.10.2012 for Right total knee replacement and from 14.12.2012 to 18.12.2012 for Left Total Knee Replacement. All the documents were forwarded but the claim was not settled. Hence aggrieved, she approached the Forum for settlement of her claim. From the documents submitted it is observed that The Insured was covered under the Group Mediclaim Tailormade Master Policy No.131100/48/2012/11865 issued by Divisional Office NO. 20, Andheri for the period from 01.06.2012 to 23.12.2012 issued to Shree Visha Shrimali, 108 Jain Charitable Sanstha. The Insured was operated for Right and Left side total knee replacement on 08.10.2012 and 15.12.2012 respectively. The Sum Insured under the family floater policy was Rs. 5,00,000/-. A sheet attached to the schedule of the policy stated that Pre-existing diseases were covered after 4 months waiting period for fresh member. Premium of Rs. 69,000/- was paid though Vax Assurance and Solutions (P) Ltd on 16.06.2012 for proposal of Platinum.It is not clear how policy for duration of less than one year was issued to the Insured. Since the Company had taken the premium and issued policy for the same they cannot avoid payment at the time of claim.The annexure attached to the policy showed a ceiling for joint replacement to the tune of Rs. 1.50 lacs under the said policy. During the hearing it was explained to the Insured that an amount of Rs. 1.50 lac would be payable. As the Complainant had agreed for settlement of claim at Rs. 1,50,000/- the complaint is allowed to the extent of the amount mentioned in attachment of the policy schedule. No co-payment would arise as the age of the Insured was 63 years at the time of hospitalization. The complaint was admitted for Rs. 1,50,000/-

In the matter of Shri Harsukh V Patel
Vs
United India Insurance Co. Ltd.
Complaint Ref No.AHD-G-51-1617-0009

Award Date: 29.06.2016

Policy No: 067700/28/15/P/10/6383085

The Complainant was covered under Individual Health Policy issued by the United India Insurance Company Ltd for a Sum Insured of Rs.2,00,000. The Complainant was hospitalized

at Apoorva diagnostic centre from 12.12.2015 to 13.12.2015 for Hemorrhoids + Fissure. Against the claim of Rs. 35,039/-, the Respondent had settled Rs.7439/- and Rs. 27,600/- was disallowed stating bill other than hospital bill and Admission charges not payable.

From the submissions made by both the parties and the documents submitted on record it was noted that there were two deductions: Rs. 27500 towards surgeon charges with remark Bill other than hospital bill not payable. Rs. 100 Admission charges. The admission charge was not payable as per the terms and conditions. In respect of the surgeon charges in the discharge bill of the hospital it was mentioned that Surgeon's fee of Rs.27,500/- was paid separately vide bill No. 804 dated 12.12.2015. Both the bills were examined by the Forum. It was seen that the name of the hospital appears in the bill. However, the note 2 under condition No. 1.2 (c) Surgeon Anesthetist, Medical Practitioner, Consultants, Specialists Fee states " No payment shall be made under 1.2(c) other than as part of the hospitalisation bill. The Company had rejected the claim stating that the Surgeon's fee did not form part of the hospital bill. But the clause mentioned about the **hospitalization bill.** The Surgeon charges were incurred during the hospitalization. The Respondent had erred by using the term "Hospital bill" instead of "Hospitalization bill". The Respondent had deducted the amount arbitrarily.

In view of the foregoing, the Complaint was admitted for Rs. 27,500/-

In the matter of Shri Ramanbhai R Patel
Vs.
Bajaj Allianz General Insurance Company
Complaint Ref No.AHD-G-005-1617-0169

Award Date: 28.06.2016
Policy No: OG-16-2214-9910-00000112

The Complainant was insured with Travel Age Elite Gold Policy w.e.f. 27.07.2015 to 22.01.2016 for Sum Insured of 2,00,000 USD. The Complainant was hospitalized at University Hospitals of Leicester NHS Trust from 24.09.2015 to 28.09.2015 for Malaena and was diagnosed with severe oesophagitis with deep ulceration. When a claim was preferred the Company rejected the claim for non-disclosure of pre-existing disease in the proposal form. They invoked clause No.2.4 and 2.4.12 of the policy. Unsatisfied with decision of the Respondent, the Insured had approached the Forum for redressal of his grievance and settlement of the claim.

From the submissions made by both the parties and the documents submitted on record it was noted that The Respondent had repudiated the claim stating that the Complainant had past medical history of Myocardial Infarction which was not disclosed in the proposal form by the Complainant while applying for the insurance. The Complainant was admitted for the treatment of Malaena and was diagnosed with severe oesophagitis during his stay with deep ulceration in London on 24.09.2015. The Complainant had undergone Angiography and was prescribed Asprin and Clopidogrel for blood thinning. The current admission to the hospital was the complication of these two tablets which the Complainant was taking. The medicines were discontinued and the Complainant was advised to stop those medicines. The complainant had not disclosed his medication in the proposal form.The Complainant had not disputed his medical history. Merely stating that the Complainant had disclosed his health condition and medication to the Agent does not support the Complainant's plea for the claim. The policy was purchased on 24.07.2015 and the Complainant flew on 27.07.2015. Especially in view of the medication,

the Complainant should have taken ample care in disclosing the material facts required for the underwriting of the proposal. The Complainant cannot feign ignorance on disclosure of his health condition. The Complainant was an Ex-banker, he had filled up the claim form in English. These proved that he had the knowledge of English. The Complainant also did not dispute this fact.

Considering the above facts it is clear that the proposer had failed to act in utmost good faith & suppressed the material facts regarding past medical history.

In view of the facts and circumstance, the decision of the Respondent needs no interference. The Complaint is dismissed.

In the matter of
Ms. Jignasha J Shah
Vs

Respondent - Universal Sompo General Insurance Co. Ltd
Complaint No. AHD-G-052-1617-0206

Award Date: 01.07.2016

Policy No: 28255546275600000

The Complainant alongwith her family was insured under the Complete Healthcare Insurance issued by Universal Sompo General Insurance Company Ltd from 30.09.2015 to 29.09.2016. Shri Jiteshkumar N Shah, husband of the Complainant was hospitalized for Coronary Angiography on 11.12.2016 and from 14.02.2016 to 22.02.2016 for CABG. During the hospitalization, the cashless facility was not provided. When claim was filed for reimbursement, the Company rejected the claim on the basis of non-disclosure of diabetes in the proposal form. From the submissions made by both the parties and the documents submitted on record it was noted that the policy was continuous from the year 2002. The Policy was with Oriental Insurance from the year 2002 till the year 2007. Then from the year 2008 till 2014 it was with United India Insurance Company. The policy was ported in 2014 with Star Health and in the year 2015 it was ported with the Respondent. it is seen that the policy is continuous from the year 2002 and the policy was ported with the Respondent. As per IRDA guideline dated 20.02.2013 regarding standard definitions of terminology used in health insurance policies states “Portability means the right accorded to an individual health insurance policy holder (including family cover) to transfer the credit gained by the insured for pre-existing conditions and the time bound exclusions if the policyholder chooses to switch from one insurer to another Insurer or from one plan to another plan of the same insurer, provided the previous policy has been maintained without any break”.

Here the policy was without break. As the Insured had her policy ported , all the benefits, therefore, got carried forward to the ported policy. The Respondent had repudiated the claim on the basis of non-disclosure of material fact. It is seen that the Proposal Form was signed by the Complainant in Gujarati and no Official had countersigned under the vernacular declaration nor the Declaration of the Agent was given by the Agent which meant that the legal document was not explained to her.

In view of the facts and circumstances, the decision of the Respondent in disowning its liability to pay the claim was wrong.

Thus, the complaint was allowed for Rs. 3,00,000/-

In the matter of-
Mr. Shalin K Shah
Vs

The National Insurance Company Ltd

Complaint Ref No.AHD-G-48-1617-0222

Date of the Award: 22.08.2016
Policy No. 311300/48/14/8500006686

The Complainant alongwith his family members was insured under Baroda Health Policy issued by the National Insurance Company Ltd. Master Valey Shah, son of the Complainant was hospitalized to Shlok Medical and Heart Hospital from 24.08.2015 to 25.08.2015 for Dengue fever. The Respondent had repudiated the claim of Rs.10,530/- citing clause 4.10 and additional condition no. 2 of the mediclaim policy. Dissatisfied with decision of the Respondent the Insured had approached the Forum for redressal of his grievance and settlement of the claim. The Complainant deposed that his son had fever for one week prior to the hospitalization. He had continuous fever, vomiting and red spot on his body. As his fever was not subsiding, he was admitted to the hospital and tests were done and it was revealed that he had dengue. He said that his son was studying in Ahmedabad and on the advice of the doctor he was admitted to the hospital at Ahmedabad. He was told that the doctor was correct authority in deciding the course of treatment and discharge. Post discharge the patient had improved with his health hence his comments on the number of platelets had no relevance. Similarly that since the policy did not restrain the Insured to purchase policy from a particular branch office or take medical treatment in a particular hospital, his statement were meaningless and was advised to restrict himself to the point of contention. Since the patient had shown improvement after the treatment, the decision of the company that hospitalization was not warranted was not in order.The Respondent had exhibited their casual and callous approach toward their own Insured. In the subject complaint the helpless Insured had been driven to the Forum unnecessarily.

The Complainant is entitled for relief and his complaint stands admitted for Rs.10,530.

In the matter of
Mr. Mehul R Sheth
Vs
IFFCO TOKIO General Insurance Co. Ltd

Complaint Ref No.AHD-G-023-1617-257

Date of the Award: 22.08.2016
Policy No: 52391488

The Complainant was insured under Swasthya Kavach, Family Health Policy issued by the Iffco Tokio General Insurance Company Ltd. The Complainant was hospitalized in Global Hospital, Mumbai from 27.04.2015 to 09.05.2015 and then shifted to HCG Hospital, Bhavnagar from 10.05.2015 to 29.05.2015 and from 04.06.2015 to 11.06.2015. He was later hospitalized to Sterling hospital, Ahmedabad during the period from 11.06.2015 to 23.06.2015 for Acute biliary pancreatitis. For 4 hospitalizations, claim amounting to Rs.6,20,836/- was submitted to the Respondent and the Respondent had settled the claim for Rs.2,00,000/- deducting Rs.4,20,836/- citing General condition No. 23 on portability and the waiting period of enhanced sum insured. Dissatisfied with decision of the Respondent the Insured had approached the Forum for redressal of his grievance and settlement of the claim.

It was brought to his notice that the final diagnosis as per the Sterling hospital papers was Acute necrotizing pancreatitis and not choletithiasis. The cause of pancreatitis as per the doctor was idiopathic i.e. unknown. The representative of the Respondent stated that in the hospital discharge summary of first two hospitalization the treatment of cholelithiasis was mentioned, hence sum assured was restricted to Rs. 2 lacs. He was informed that the Insured

had undergone treatment for pancreatitis in the last hospitalisation and as there was no exclusion or restriction on the claim that had arisen due to the treatment of Acute biliary pancreatitis, the claim was to be considered under the third hospitalization to which the representative of the Insurer agreed.

From the submissions of both the parties and the documents submitted it was observed that in respect of 1st claim, only non payable medical items of Rs.6489/- were deducted. The balance claim was paid. Hence no interference is required in respect of hospitalization during 27.04.2015 to 09.05.2015 in Global Hospital, Mumbai. The deduction of Rs. 6489/- is as per Terms and Conditions of the policy.

In view of the facts and circumstance, the decision of the Respondent needs no interference. The Complaint is dismissed.

In the matter of
Mr. Mehul R Sheth
Vs.
IFFCO TOKIO General Insurance Co. Ltd

Complaint Ref No.AHD-G-023-1617-258

Date of the Award:26.08.2016

Policy No. 52391488

The Complainant was insured under Swasthya Kavach, Family Health Policy issued by the Iffco Tokio General Insurance Company Ltd. The Complainant was hospitalized in Global Hospital, Mumbai from 27.04.2015 to 09.05.2015 and then shifted to HCG Hospital, Bhavnagar from 10.05.2015 to 29.05.2015 and from 04.06.2015 to 11.06.2015. He was later hospitalized to Sterling hospital, Ahmedabad during the period from 11.06.2015 to 23.06.2015 for Acute biliary pancreatitis. For 4 hospitalizations, claim amounting to Rs.6,20,836/- was submitted to the Respondent and the Respondent had settled the claim for Rs.2,00,000/- deducting Rs.4,20,836/- citing General condition No. 23 on portability and the waiting period of enhanced sum insured. Dissatisfied with decision of the Respondent the Insured had approached the Forum for redressal of his grievance and settlement of the claim.

In respect of first two hospitalizations, the sum assured would be taken as Rs. 2 lac only as there was treatment of cholelithiasis for which there is fresh waiting period of 2 years in respect of enhanced sum assured in respect of expenses relating to hospitalization on account of cholelithiasis. The sum assured was increased to Rs. 5 lacs from Rs. 2 lacs in the current policy period, thus the fresh waiting period of 2 years for cholelithiasis would apply. Hence, only the difference between previous sum assured (Rs. 2 lacs) and Rs. 1,31,998 paid under first claim is payable. The Respondent has rightly paid the balance sum of Rs. 68,002/-. Hence no interference in the decision of Insurer is needed in respect of second claim for the treatment in HCG Hospital, Bhavnagar. The complaint is dismissed without any relief.

In the matter of
Mr. Mehul R Sheth
Vs.
IFFCO TOKIO General Insurance Co. Ltd

Complaint Ref No.AHD-G-023-1617-259

Date of the Award:26.08.2016

Policy No. 52391488

The Complainant was insured under Swasthya Kavach, Family Health Policy issued by the Iffco Tokio General Insurance Company Ltd. The Complainant was hospitalized in Global Hospital, Mumbai from 27.04.2015 to 09.05.2015 and then shifted to HCG Hospital, Bhavnagar from 10.05.2015 to 29.05.2015 and from 04.06.2015 to 11.06.2015. He was later hospitalized to Sterling hospital, Ahmedabad during the period from 11.06.2015 to 23.06.2015 for Acute biliary pancreatitis. For 4 hospitalizations, claim amounting to Rs.6,20,836/- was submitted to the Respondent and the Respondent had settled the claim for Rs.2,00,000/- deducting Rs.4,20,836/- citing General condition No. 23 on portability and the waiting period of enhanced sum insured. Dissatisfied with decision of the Respondent the Insured had approached the Forum for redressal of his grievance and settlement of the claim.

It was brought to his notice that the final diagnosis as per the Sterling hospital papers was Acute necrotizing pancreatitis and not choletithiasis. The cause of pancreatitis as per the doctor was idiopathic i.e. unknown. The representative of the Respondent stated that in the hospital discharge summary of first two hospitalization the treatment of cholelithiasis was mentioned, hence sum assured was restricted to Rs. 2 lacs. He was informed that the Insured had undergone treatment for pancreatitis in the last hospitalisation and as there was no exclusion or restriction on the claim that had arisen due to the treatment of Acute biliary pancreatitis, the claim was to be considered under the third hospitalization

It is seen from the records that the Respondent had rejected the claim towards hospitalization at Sterling Hospital where the final diagnosis was Acute necrotizing pancreatitis. There is no exclusion or restriction on sum assured on account of expense relating to Acute biliary pancreatitis. There is no waiting period for pancreatitis. The cause of pancreatitis as per the doctor was idiopathic i.e. unknown. The Sum Assured for this disease would be Rs. 5 lacs. Out of which Rs. 2 lacs have been paid. Balance sum assured of R. 3 lacs is still available to the complainant for treatment of necrotizing pancreatitis. The representative of the Insurer has also agreed to pay expenses on account of necrotizing pancreatitis.

The total claim amount towards hospitalization at Sterling hospital was Rs.4,62,077/- out of which Rs. 2,37,000/- was paid by other Insurance Company. This information was neither given by the Insured nor by the Insurance Company during the hearing. On a query regarding non payable items to be deducted for the hospitalization at Sterling hospital, the Respondent vide their e-mail dated 24.08.2016 had informed the Forum that an amount of Rs. 2,37,000/- was paid by another Insurer and non medical items amounted to Rs. 6426 /-. The Complainant had claimed for balance amount of Rs. 2,25,077/- for the hospitalization at Sterling. The same was also confirmed by the Complainant over telephone.

In view of the facts and circumstances, the complainant was entitled for the balance relief of Rs. 2,18,651 after deduction of non-medical items, incurred towards the hospitalization at Sterling hospital.

In the matter of Mr.Javedbhai I Mansuri
Vs
Bajaj Allianz General Insurance Co.Ltd
Complaint No. AHD-G-005-1617-0299

Date of the Award: 23.08.2016
Policy No: OG-16-2206-1802-00000408

The Complainant had taken a “2 Wheeler Package Policy” from the Respondent for the period from 17.12.2015 to 16.12.2016 to cover his Hero Moto Corp Splender Pro for IDV value of Rs. 40,000/- bearing registration no.GJ22E9509. The said vehicle was stolen from the parking place near his friend’s residence on 13.01.2016. The theft claim filed by the Complainant, was rejected by the Insurer on the ground that there was delay in intimation to the police as well as to the Insurer. Aggrieved with it, the Complainant is before this Forum. The Insured had taken the policy from the Respondent for his Hero Moto Corp Splendor Pro for the period from 17.12.2015 to 16.12.2016. The Vehicle was stolen on 13.01.2016 during the currency of the

policy. The Insured had intimated the loss of his vehicle to the Insurance Company after 22 days of the loss of the vehicle. The FIR was lodged on 25.01.2016 by a third person i.e. after 13 days of the theft, when his vehicle (3rd person's vehicle) was also stolen from the same place. The Insured did not provide the 2nd original key which raised doubt about the authenticity of the theft of the vehicle, over and above the delayed intimation. The Insured had not complied with the terms and conditions of the policy.
In view of the facts and circumstances, the Complaint failed to succeed.

In the matter of Mr. Ashok Bansal
Vs
United India Insurance Co.Ltd
Complaint No. AHD-G-051-1617-0308

Date of the Award: 24.08.2016
Policy No. 180400/48/12/97/00007263

The Complainant had a policy from United India Insurance Company Ltd since the year 2001. The Complainant was hospitalized at Baroda Health Institute for Angioplasty for the period from 13.12.2013 to 16.12.2013. When a claim for Rs.2,67,550/- was filed, the Company settled Rs. 1,40,000/-. He was informed that it was Gold health Insurance policy and restriction of 70% of Sum Insured for major surgery was applied, while there was no restriction under the Platinum policy. He claimed his Individual Mediclaim Policy was converted to Individual Health Insurance Policy-2010 without his knowledge. He represented to the Company for conversion of his Gold policy to Platinum policy from the year 2008 so that the monetary loss caused to him during his claim for his hospitalization in December, 2013 could be restored.

Not receiving any favourable response, the Complainant had approached the Forum. The Complainant was having Individual Mediclaim Policy from the year 2001. The policy was converted to Individual Health Policy covering himself and his wife under Gold policy from the year 2008-09.The conversion of policy from Platinum to Gold was per the General Administrative guidelines of the Company duly approved by IRDAI under 'File and Use' procedure. As per the administrative guidelines provided by the Respondent, the Complainant could be insured under the Gold policy only as the age of the Insured at the time of conversion was around 46 years. As per the Individual Health Policy (Gold), condition No.1.2.1 the reimbursement of claim to the extent of 70% of Sum Insured by the Respondent was in order. The decision of the Company to convert to Gold Category policy was as per the guidelines which was done in 2008 and the policy was continuously renewed thereafter. The Complainant had called the policy in question after renewing the policy for the last 7 -8 years which cannot be intervened. The Complaint is dismissed.

In the matter of
Mr.Indravadan P Patel
Vs
The Oriental Insurance Co. Ltd

Complaint Ref No.AHD-G-50-1617-347

Date of the Award: 26.08.2016
Policy No: 143190482016566

The Complainant alongwith his family was insured under Happy Family Floater Policy issued by the Oriental Insurance Company Ltd. Mrs.Nilam Patel, wife of the Complainant was admitted to Stavya Spine Hospital and Research Institute from 25.08.2015 to 29.08.2015 for L4-5 TLIF (Transforaminal Lumbar Interbody Fusion). When a claim was filed, the company repudiated the claim stating that as the Insured was admitted for treatment of obesity and /or its

complications which was excluded from the scope of the policy, the claim was not payable. Not satisfied with their decision he had approached the Forum for redressal.

The Complainant was having the policy from the year 2009. The Insured was included in the policy from the year 2011 after her marriage. No proposal form was filled in. No medical examination was carried out during inclusion of the Insured. It is proved that the Insured was hospitalized for treatment of lower back pain and not obesity. Here the hospitalization was not for obesity. The Respondent had preferred to repudiate the claim only because there was mention of obesity in consultation papers with least regard to the ailment for which the insured had undergone the treatment. The Respondent had rejected the claim without going into the cause for hospitalization. No treatment for obesity or its complications was given in the hospital. The weight of the Insured had not gone down. The patient is still obese. Hence it is proved that the hospitalisation and the treatment was done to reduce the pain and not to reduce obesity.

In view of the facts and circumstances, The complaint is admitted for Rs.1,57,319.

In the matter of Mr.Vinod N Patel

Vs

Respondent - The Oriental Insurance Co. Ltd

Complaint No. AHD-G-050-1617-0365

Date of the Award: 24.08.2016
Policy No. 171301/48/2016/03990

The Complainant alongwith his family was insured under the Happy Family Floater Policy issued by the Oriental Insurance Company Ltd from 13.09.2015 to 12.09.2016 for a sum insured of Rs. 4,00,000/-. Mrs.Vaishali P Patel, wife of the Complainant was hospitalized at Siddhi Surgical Hospital for Fissure in Anus from 28.11.2015 to 30.11.201516. When a claim was filed for reimbursement, the Company rejected the claim on the basis of clause 4.3 being first year From the submissions made by both the parties and the documents submitted on record it was noted that the policy was continuous from the year 2012. The Policy was with Oriental Insurance from the year 2012 to the year 2014. As per IRDA guideline dated 20.02.2013 regarding standard definitions of terminology used in health insurance policies states “Portability means the right accorded to an individual health insurance policy holder (including family cover) to transfer the credit gained by the insured for pre-existing conditions and the time bound exclusions if the policyholder chooses to switch from one insurer to another Insurer or from one plan to another plan of the same insurer, provided the previous policy has been maintained without any break”. Here the Insured was having continuous cover. However, at the time of taking the policy from the Oriental during the period 2015-16 the policy was not ported thus he lost the benefit of portability. The contention the Respondent was that the Agent had filled up the form and he was not aware of the same which cannot be considered.

As the policy was a fresh policy, the decision of the Respondent to repudiate the claim under clause 4.3 is in order.

In view of the facts and circumstance, the decision of the Respondent needs no interference. The Complaint is dismissed.

In the matter of
Shri Rameschandra S Gheewala

Vs.
The National Insurance Co.Ltd

Complaint Ref No.AHD-G-48-1617-0331

Date of Award: 24.08.2016
Policy No: 300703/48/15/8500004619

The Complainant was insured under National Mediclaim Policy issued by the National Insurance Company Ltd. The Complainant was hospitalized to Anosurge Hospital and Research Private Limited, Patan from 02.03.2016 to 10.03.2016 for the treatment of Tendon repair on the right side of the heel. Against a claim of Rs. 91,141/-, the Respondent had settled the claim for Rs.72,521/- and the balance amount of Rs.18,620/- was deducted citing Reasonable & Customary clause. Unsatisfied with decision of the Respondent the Insured had approached the Forum for redressal of his grievance and settlement of the claim. From the submissions of both the parties and the documents submitted, it is observed that The Respondent did not produce any rate chart from other hospitals for comparison of reasonableness of the charges collected by the hospital where the Insured had undertaken the surgery. They had produced only one rate chart of the Sterling hospital of Ahmedabad which was under their PPN. The Respondent failed to do any exercise on the reasonable and customary charges. The basis for deduction of claim amount thus was not in order. This Forum is of the opinion that PPN rates cannot be blanketly taken as reasonable and customary charges as it is an agreed rate between two persons. Retail price and whole sale price cannot be the same. The Insured is giving business to the PPN hospital and it is in a better position to bargain than an individual.The Respondent failed to prove the unreasonableness of the expenses of Rs. 18,500/-.

In view of the facts and circumstances, the Complainant was entitled for the balance amount of Rs. 18500/- .

In the matter of
Mr. Bhikhaji N Dabhi
Vs
The Oriental Insurance Co.Ltd

Complaint No. AHD-G-050-1617-0379

Date of Award: 26.08.2016
Policy No. 14601/31/2015/6965

The Complainant had purchased a “Private Car Package policy” from The Oriental Insurance Company Ltd with an IDV of Rs. 4,88,400/-.The vehicle bearing no. GJ-01 KS 1570 had met with an accident on 01.02.2015 at about 11.45 p.m. near Sumerpur Police Station. When a claim was filed by the Complainant for Rs, 2,47,800/-, the Respondent settled the claim for Rs. 1,87,000/-.

Aggrieved by the decision of the Respondent, the Complainant had represented his grievance and on not receiving any favourable decision, the Complainant had approached the Forum for redressal of his grievance and settlement of his claim.

From the submissions made by both the parties and the documents submitted on record it was noted that The Company had settled Rs. 187,000/-. The Complainant had signed the discharge voucher in full and final settlement and also submitted a letter to the Respondent stating that the he did not have any objection for the assessment done.In view of the discharge given by the Complainant in full and final settlement, the Insurer’s decision is upheld, while

doing so I am supported by the decision of NCDRC New Delhi in the case of Ankur Surana V/s United India Insurance Co. Ltd. In revision petition no. 2031 of 2012 wherein it was held that the petitioner cannot be permitted to approach consumer forum for the balance amount treating the payment as only part payment against the claim unless he establishes that he accepted the amount under undue influence, misrepresentation or fraud played by the insurance company.The NCDRC while passing the order in revision petition no. 2031 of 2012, relied upon the judgement of Apex Court in the case of United India Insurance Co. Ltd. V/s Ajmer Singh Cotton & General mills and ors.[(1999)6 SCC 400].
The decision of the Respondent is upheld.

In the matter of Mr. Vizak B Ankleshwaria
Vs
United India Insurance Co. Ltd.
Complaint Ref No.AHD-G-51-1617-0428

Date of Award: 20.09.2016
Policy No. 1806012814P110873784

The Complainant was covered under Individual Health Policy issued by the United India Insurance Company Ltd for a Sum Insured of Rs.5,00,000/-.The Complainant was hospitalized at Bombay City Eye Institute and Research Centre on 21.09.2015 for left eye cataract surgery with Intra Ocular Lens Implantation. Against the claim of Rs.1,00,787/-,the Respondent had settled it at Rs.33,030/- and balance of Rs.67,757/-was deducted citing Reasonable and Customary clause of the policy. Unsatisfied with the decision of the Respondent, the Insured had approached the Forum for redressal of his grievance and settlement of the claim.
From the submissions made by both the parties and the documents submitted on record it was noted that the deduction was done under clause 'Reasonable and Customary clause' charges.
The amounts broadly disallowed by the Respondent are as under:

1. It was seen from the records that the claim towards Medicines, OT Charges, Surgeon/Operation charges and Laboratory charges were disallowed on the basis of Reasonable and Customary charges.
2. The Respondent did not produce any rate chart from other hospitals for comparison of reasonableness of the charges collected by the hospital where the Insured had undertaken the surgery. The deductions in respect of above charges were done by the Respondent under 'Customary and Reasonable charges' clause without providing any standard fees charged by the specific provider which were inconsistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness/injury involved.
3. The policy stated that 25% of the sum insured was payable in case of cataract surgery. The Sum Insured was Rs. 5,00,000 and the limit comes to Rs.1,25,000/-. The cost of cataract surgery was Rs. 1,00,787/- which was within the limit of 25% of the sum insured.
   In view of the foregoing, the Complainant was entitled for balance claim of Rs. 67757/-.

In the matter of Mrs. Hemaxiben R Shah
Vs.
United India Insurance Co. Ltd.
Complaint Ref No.AHD-G-51-1617-0417

Date of Award: 19.09.2016

Policy No. 180400/28/14/P/10/50/63323

The Complainant was insured with Individual Health Insurance Policy issued by United India Insurance Company Ltd for a Sum Insured of Rs.1,50,000/-. The Complainant was hospitalized at Pramukh Orthopaedic Hospital from 29.05.2015 to 03.06.2015 for Restoknee surgery (left). When a claim for Rs.1,52,035/- was filed the Respondent had rejected the claim under clause 3.39 of the policy. Unsatisfied with decision of the Respondent, the Insured had approached the Forum for redressal of her grievance and settlement of the claim.

From the submissions made by both the parties and the documents submitted on record it was noted that: The Complainant was having the policy since the year 2007.The Complainant was admitted to the hospital for osteoarthritis of left knee and had undergone restoknee surgery.Cuts were made near the joints over the bone and then the joint was realigned and brace was applied. The Complainant had pain prior to the hospitalization she was not able to do her daily chorus. After the treatment the ailment was cured and she was able to do her daily work.

The Respondent's representative, in reply to a question on their claiming the treatment to be unproved or experimental, answered that their in-house doctor had called it so hence had repudiated the claim. He answered that he had no proof to claim the medical treatment carried out was unproven or experimental. In reply to another question whether expenses on such treatment was excluded from reimbursement he answered that there was no such clause in the Terms and conditions of the policy. The Company had not proved the subject treatment was not based on established medical practice in India.

In view of the foregoing, the Complainant was entitled for the claim amount of Rs.1,50,000

In the matter of Mr. Suryakant M Patel
Vs.
United India Insurance Co. Ltd.
Complaint Ref No.AHD-G-51-1617-0469

Date of Award:20.09.2016
Policy No. 181300/48/14/97/00004396

The Complainant was covered under Individual Health Policy -2010 issued by the United India Insurance Company Ltd for a Sum Insured of Rs.3,00,000/-. The Complainant was hospitalized at Tanmay Hospital from 14.09.2015 to 16.09.2015 for right direct hernia with divartication of racti. Against the claim of Rs. 177916.28, the Respondent had settled Rs.75,000/- citing the policy condition as 25% of the Sum Insured is payable in respect of Hernia surgery. Unsatisfied with decision of the Respondent, the Insured had approached the Forum for redressal of his grievance and settlement of the claim.

From the submissions made by both the parties and the documents submitted on record it was noted that the Insured was having the policy since 2001. The deduction was done under clause 1.2.1 in respect of illnesses restricted towards Hernia It was seen from the records that hospitalization was for right direct hernia with divartication of racti. Under coverage 1.2.1 expenses in respect of hernia was restricted to 25% of the Sum Insured or actual expenses which ever is less. Accordingly, the Respondent had made the payment of Rs. 75,000/- being 25% of Sum Insured Rs. 3,00,000/-. Medically Diastasis Recti also referred to as Divarication of Recti or Rectus Distension is not a hernia, though hernia and diastasis recti can co-exist. Since there were two operations one for hernia and another for divartication of recti, two meshes were fixed, two surgeries in one operation was carried out, the basis for restriction of claim amounting to 25% in respect of hernia was not in order.

In view of the foregoing, the Complainant is entitled for an amount of expenses related to Diastasis of recti. The Respondent is hereby directed to pay balance claim amount of Rs. 102916/-

In the matter of Shri Hitesh B Soni
Vs
The Oriental Insurance Co. Ltd

Complaint Ref No.AHD-G-50-1617-462

Date of Award: 21.09.2016

Policy No. 1416014820163752

The Complainant alongwith his family was insured under the Mediclaim Insurance Policy (Individual) issued by the Oriental Insurance Company Ltd. Smt Aartiben Soni, wife of the Complainant was hospitalized at Gujarat Pet CT Centre, Samved Hospital on 11.02.2016 for chemotherapy. The Respondent had partially settled the claim stating that some documents were not received. He submitted all the policy documents but still the claim was pending. He had approached the Forum for redressal.The Complainant had stated that against his claim for Rs.45236/- the Company had paid only Rs. 6914/- and not settled Rs.38322/-. He said initially the company stated that due to late submission of the claim it was not payable. He said that after he approached Bima Lokpal, he had come to know that due to non-submission of film, the claim was not payable. He was ready to produce the film. He said that the Company had harassed him a lot. He pleaded that his wife was under the treatment of cancer and was at the final stage. He was under tension and the attitude of the TPA and the company towards him had only aggravated the condition. He pleaded for settlement of his claim and also requested for timely settlement of claims in future which he would be filing. The Insurer's representative stated that the claim was rejected on the basis of non-submission of certain documents. It was brought to her notice that the dispute was for hospitalization on 10.02.2016. She said that the Company was ready to settle the claim for Rs. 19,350/- being the cost of x-ray and Pet scan on production of film. She further stated that the medicines upto 60 days post –hospitalisation was payable as per policy terms and conditions.

Since the representative of the Respondent had agreed for settlement for Rs. 19350/- the complaint is disposed off.

In the matter of
Shri Ashwin Gajjar
Vs.
The National Insurance Company Ltd

Complaint Ref No.AHD-G-48-1617-0385

Date of Award:20.09.2016

Policy No. 301800/48/15/8500003791

The Complainant alongwith his wife was insured under National Mediclaim Policy issued by the National Insurance Company Ltd. Smt Meenaben A Gajjar wife of the Complainant, was hospitalized to Shri Sardar Patel Hospital from 14.11.2015 to 17.11.2015 for Menorrhagia + Interain Fibroid. Against a claim of Rs. 79,022/-, the Respondent had settled the claim for

Rs.50,829/- and the balance amount of Rs.28,193/- was deducted citing Reasonable & Customary clause, non-medical items and Pre-hospitalisation exceeding 30 days. Dissatisfied with decision of the Respondent the Insured had approached the Forum for redressal of his grievance and settlement of the claim. It was seen from the records that the Medicines and investigation charges, registration charges, non medical items amounting to Rs. 3393/- were disallowed correctly as per the terms and conditions of the policy. The deductions of Rs.20,000 was done on the basis of Reasonable and Customary charges and Rs. 4800 was towards visit charges of the Physician. The Respondent did not produce any rate chart from other hospitals for comparison of the reasonableness of the charges collected by the hospital where the Insured had undertaken the surgery. The deductions in respect of O.T. charges, and the Professional charges were made under 'Customary and Reasonable charges' clause without providing any standard fees charged by the specific provider which were inconsistent 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 failed to prove the unreasonableness of the expenses of Rs. 24,800/-.In view of the facts and circumstances, the Complainant was entitled for the balance amount of Rs. 24,800/- .

In the matter of
Mr. Hardik J Kachhia
Vs
The New India Assurance Co.Ltd
Complaint Ref No.AHD-G-49-1617-0486

Date of Award: 20.09.2016
Policy No. 22030034142500004796

The Complainant alongwith his family members was covered under New Mediclaim-2012 issued by The New India Assurance Company Ltd. Kumari Prachi Kachhia, daughter of the Complainant was hospitalized at Neel Surgical hospital for Children for Left Vulval Abcess from 10.08.2015 to 11.08.2015. When a claim for Rs. 21,129/-was filed, the Company repudiated the claim citing clause 2.15 of the policy terms and conditions. Aggrieved by the decision of the Respondent, the Insured had approached the Forum for redressal of his grievance and settlement of the claim. From the submissions made by both the parties and the documents submitted on record it was noted that :

The Complainant was covered with the Respondent from the year 2003 and the Insured was covered from the year 2014.The Insured was hospitalized at Neel Surgical hospital for left Vulval Abcess. The Bio Medical Waste (BMW) authorization certificate issued by Gujarat Pollution Control Board, Gandhinagar, which was issued on 18.08.2015 and valid upto 10.03.2017 stated that the hospital was having 7 beds before expansion and the authorization was granted for 15 number of beds .As per the Hospital visit form dated 10.07.2015 submitted by the TPA M/s Vipul MedCorp stated that the number of beds as on 10.07.2015 was 10. The number of beds as per the certificate issued by the Hospital on their letter head and signed by the doctor stated that the number of beds have been increased from 12 to 15 beds from 07.10.2015.The hospitalization was on 10.08.2015. The advertisement for the criteria of number of beds was given in the newspaper in the month of June, 2015 and the hospitalization was in the month of August,2015.Since the policy terms and condition was clear and as per the doctor's certificate, the number of beds have been increased from 12 to 15 beds from 07.10.2015, repudiation by the Respondent under clause 2.15 was in order.

Case of- Mr. Narsinhdas Vs. National Insurance Co. Ltd.
Complaint Ref No.AHD-G-48-1617-0441

Date of Award:20.09.2016
Policy No. 30180048148500008664

The Complainant alongwith his wife was covered under National Mediclaim Policy issued by The National Insurance Company Ltd for a Sum Insured of Rs.50,000/-. Smt Shardaben N Shah, wife of the Complainant was hospitalized at Pain Care Clinic from 17.09.2015 to 18.09.2015 for low Back pain with left LL Radiculopathy for Caudal neuroplasty. A claim was filed for Rs.20,813/-. The Company repudiated the claim stating that the patient was given epidural injection which was not payable as per the recent guidelines of the Head Office of National Insurance Company. Aggrieved by the decision of the Respondent, the Insured had approached the Forum for redressal of his grievance and settlement of the claim.
From the submissions made by both the parties and the documents submitted on record it was noted that :The Complainant was covered under the National Mediclaim policy since 21.09.2002 for a Sum Insured of Rs.50,000/-.The Insured was hospitalized for low back pain with Lt LL radiculopathy. The Age of the Insured was 80 years. Local anesthesia was given. A dye was injected under continuous fluoroscopy to check. Caudal neuroplasty was performed.The TPA had consulted their panel doctor and they had given their decision based on the recent guidelines of the Head Office of National Insurance Company that the cost of the epidural injection was not reimbursable.In this case as the patient was old aged, hospitalization was required and the terms and conditions of the policy did not exclude epidural injection. The guidelines issued by the Head Office was not submitted to the Forum alongwith their Self Contained Note. As there was no exclusion for epidural injection in the policy terms and conditions, the decision of the Respondent to reject the claim was not in order.
In view of the foregoing, the Complainant was entitled for claim.

In the matter of-Mr. Jaykumar Maherchandani
Vs
Star Union Dai-ichi-Life Ins. Co. Ltd.

Complaint Ref No.AHD-L-045-1617-0392

Date of Award: 21.09.2016
Policy No. GT001014

Smt. Kavita Govindram Maherchandani, the DLA had purchased a Star Union Dia-Ichi's Group Term Insurance Scheme on 16.02.2015 under Master Policy No. GT001014 through Bank of India, Bandra (E).The DLA had expired on 01.01.2016 due to Swine Flu. When a claim was filed by the Complainant, who is the nominee under the policy, the Respondent vide their letter dated 22.02.2016 repudiated the claim on the grounds of suppression of material information. They refunded the premium of Rs. 6,370.83 paid by the DLA. Aggrieved by their decision, the Complainant represented to the Company and not receiving any favorable decision he had approached the Forum.

Based on oral submissions of the parties, read along with documents on record it is observed that The department of Microbiology BJ Medical College, Ahmedabad vide their test report dated 29.12.2015 has confirmed that the Test Result was positive of H1N1 (Novel) Swine Flu virus. The cause of death of the Complainant was due to Swine Flu which was not disputed by

the Respondent.The Respondent had issued Insurance to 52 years female without any medical examination.The health and personal declaration was signed wherein it was declared that she was in good health and free from disease of disability or symptoms thereof (relating to condition other than to minor impairments such as colds or flu). I have never had a heart condition, a stroke, paralysis cancer, kidney failure, liver failure, mental illness, HIV infection or AIDS…"This health declaration was material fact. It is to be noted that the 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 DLA while proposing for insurance. When information on a specific aspect is asked for in the Proposal form, the Life Assured is under a solemn obligation to make a true and full disclosure of the information on the subject which is well within his or her knowledge. The available evidences with the Respondent categorically prove that the Proposer at the time of making the statement had suppressed facts about her health.

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

In the matter of

Mr. Vipul Gurjar

Vs.

National Insurance Co. Ltd.

Complaint Ref No.AHD-G-048-1617-529

Date of Award: 25.10.2016

Policy No: 311400/48/14/8500008716

The Complainant alongwith his family members was covered under National Mediclaim Policy issued by The National Insurance Company Ltd for a Sum Insured of Rs.2,00,000/-. The Complainant was hospitalized at Narayana Ayurveda Chikitsalayam Amrithakripa from 07.11.2015 to 14.11.2015 for low and mid back pain. When a claim was filed for Rs.20,469/-, the Company rejected the claim citing clause 3.17 of the policy. He represented to the Company stating that he was hospitalized for the same ailment two years back and the company had settled his claim. Not receiving any favourable response, he had approached the Forum for settlement of his claim amount.

Based on the submissions and records it was observed that the Company had settled the claims in the year 2013 and 2014 for the same ailment which the representative of the Respondent also agreed that the ailment was same and the treatment was taken in Ayurvedic Hospital. It was also found that there was no change in the terms and conditions of the policy. He was asked to whether he would consider settling the claim for the treatment of sacroilitis to which he said he had no authority for the same.Since the ailment and the treatment were the same as those in the years 2013 & 2014 the complaint was admitted for Rs. 20469/-

In the matter of
Mr. Rajendrakumar Natvarlal Gangadiya
Vs.
Star Health and Allied Ins Co. Ltd.

Complaint Ref No.AHD-G-044-1617-0626

Date of Award:09.11.2016
Policy No: P/171221012016001790

The Complainant alongwith his wife was covered under Star Comprehensive Insurance Policy issued by Star Health and Allied Insurance Company Ltd. for a Sum Insured of Rs.5,00,000/- with exclusion clause on Pre-existing disease. Smt Anilaben R Gangadiya, wife of the Complainant was hospitalized at Sterling Hospital from 18.11.2015 to 24.11.2015 for " recently detected Rheumatic Heart Disease with Severe Mitral Stenosis AF with fast venticular rate in k/c/o Diabetes Mellitus Hypertension". When a claim was filed, the Company had rejected the claim under condition No. 9 of the policy non disclosure and concealment of facts (Rheumatic Heart Disease, diabetes mellitus and Hypertension). The policy was cancelled under condition no. 14 and the premium was refunded. As his representation to the grievance department was not heard, he had approached the Forum.It was observed that the Complainant had taken the policy in the year 2013 with sum insured of Rs. 3 lakh and subsequently increased to Rs. 5 lakh in 2015-16.Medical tests were carried out by the Respondent and the policy was issued with exclusion clause" treatment of diseases related to Cardio Vascular System". The Insurer had vested their decision on the noting of the HTN. DM and RHD in the indoor case papers. They did not have any proof or supporting documents to prove the same. The proposal form was silent. But the Respondent had taken medical examination and issued the policy with exclusion clause thus it was proved that the disease pre-existed and the policy had attracted the waiting period on pre-existing disease. The Respondent had rejected the claim under condition 9 citing non-disclosure and fraud and cancelled the policy of the Insured and refunded the premium amount of the Insured Smt Anilaben Gagadiya and continued the policy of Shri Rajendra N Gagadiya .Middle cerebral artery (MCA) stroke describes the sudden onset of focal neurologic deficit resulting from brain infarction or ischemia in the territory supplied by the MCA. The MCA is by far the largest cerebral artery and is the vessel most commonly affected by cerebrovascular accident. The complainant had requested to consider and take the facts mentioned in the Discharge Summary into account. Thus, the existence of the DM and HTN in the Insured for the last 3 years was reckoned to November, 2012 which was before the commencement of the policy (08.10.2013). The undeclared pre-existing HTN and DM devoid the Insured/Complainant from claiming the reimbursement on the subject claim. Thus, the Respondent's decision to reject the claim needed no intervention. The Respondent had issued policy to the husband of the Insured with exclusion of disease related to HTN, DM and CVS. Similarly, the Insurer should continue the risk (the policy) of the Insured, Smt Anilaben Gagadiya with exclusion of DM, HTN and CVS.

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of personal hearing, the decision of the Respondent to reject the claim needed no intervention. However, the Respondent is hereby directed to reinstate the policy with all benefits as it would have continued before the cancellation of the policy with exclusion of diseases arising out of HTN, DM and CVS for 4 years from the commencement of the policy

In the matter of
Mrs. Roopkosha G Mehta
Vs
National Insurance Company Ltd.
Complaint Ref No.AHD-G-48-1617-586

Date of Award: 07.11.2016

Policy No: 300900/48/14/8500011916

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.5,00,000/-. Shri Ghanshyam V Mehta, husband of the Complainant was hospitalized on 20.08.2015 for left eye cataract surgery at Modi Eye Care Centre. Against the claim of Rs. 35,495/-, the Respondent had settled Rs.18,000/- without citing any reason for deduction. The Insured had approached the Forum for redressal of her grievance and settlement of the balance claim amount.
From the submissions made by both the parties and the documents submitted on record it was noted that the Respondent had paid Rs. 18,000/- as reasonable and customary charges. How Rs. 18,000/- was reasonable has not been explained to the Complainant nor to the Forum. The Respondent did not produce any rate chart from other hospitals for comparison on reasonableness of the charges collected by the hospital where the Insured had undergone the surgery. The deductions in respect of above charges were done by the Respondent under 'Customary and Reasonable charges' clause without providing any standard fees charged by the specific provider which were inconsistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness/injury involved. Respondent had not provided any rate list of similar hospitals & their charges for cataract operation in the geographical area.As required under the IRDA guidelines, the Respondent had failed to submit the said rate chart of other hospitals in and around the geographical area where the Insured was hospitalized, the basis for deduction of claim amount thus was not in order.

In view of the foregoing, the Complainant was entitled for balance claim amount of Rs. 17,4954/-towards the left eye cataract surgery.

In the matter of
Mrs. Roopkosha G Mehta
Vs National Insurance Company Ltd.
Complaint Ref No.AHD-G-48-1617-587

Date of Award: 8.11.2016

Policy No: 300900/48/14/8500011916

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.5,00,000/-. Shri Ghanshyam V Mehta, husband of the Complainant was hospitalized on 12.02.2016 for right eye cataract surgery at Modi Eye Care Centre. Against the claim of Rs. 35,000/-, the Respondent had settled Rs.18,000/- without citing any reasons for deduction.The Insured had approached the Forum for redressal of her grievance and settlement of the balance claim amount. From the submissions made by both the parties and the documents submitted on record it was noted that the Respondent had paid Rs. 18,000/- as reasonable and customary charges. How Rs. 18,000/- was reasonable has not been explained to the Complainant nor to the Forum. The Respondent did not produce any rate chart from other hospitals for comparison

on reasonableness of the charges collected by the hospital where the Insured had undergone the surgery. The deductions in respect of above charges were done by the Respondent under 'Customary and Reasonable charges' clause without providing any standard fees charged by the specific provider which were inconsistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness/injury involved. Respondent had not provided any rate list of similar hospitals & their charges for cataract operation in the geographical area.As required under the IRDA guidelines, the Respondent had failed to submit the said rate chart of other hospitals in and around the geographical area where the Insured was hospitalized, the basis for deduction of claim amount thus was not in order

In view of the foregoing, the Complainant was entitled for balance claim of Rs. 17,000 towards right eye cataract.

In the matter of
Mrs. Roopkosha G Mehta
Vs National Insurance Company Ltd.
Complaint Ref No.AHD-G-48-1617-590

Date of Award:08.11.2016
Policy No: 300900/48/14/8500011916

The Complainant was covered under BOI National Swasthya Bima Policy issued by the National Insurance Company Ltd for a Sum Insured of Rs.5,00,000/-. The Complainant was hospitalized from 24.09.2015 to 28.09.2015 for right knee replacement. Against the claim of Rs. 2,17,824/-, the Respondent had settled Rs.1,85,000/- as cashless and settled Rs.14,832/- after filing the claim papers on post hospitalization claim. The contention of the Complainant was that the Respondent had disallowed Rs.17,992 without citing any reason for deduction. He had represented to the Grievance cell and on not receiving any response from the Company, the Insured had approached the Forum for redressal of her grievance and settlement of the balance claim amount.

From the submissions made by both the parties and the documents submitted on record it was noted that The Insured was having the policy since the year 2011 as reported by the Complainant . It was seen that the Respondent had settled Rs.1,85,000/-as cashless and on filing the balance claim amount of Rs. 32,824/- the Respondent had settled Rs.14,832/- and disallowed Rs.17,992/- as the Insured had selected better quality implant which was not covered under the PPN agreement with the hospital. The Insured was aware of the PPN agreement with the hospital. As a prudent customer, he was aware that as per the PPN rate the charges for knee replacement was Rs. 1,85,000/- which was paid by the Respondent. Any excess amount paid would be the responsibility of the Insured as the Insurance Company indemnified the loss. In view of the above, as the Complainant was aware of the PPN Network and the amount reimbursable, the balance amount towards the Implant cost was not payable.

In view of the above facts and circumstances, the complaint fails to succeed.

In the matter of

Mr. Nilkanth J Patel

Vs.

National Insurance Co. Ltd.

Complaint Ref No.AHD-G-48-1617-556

Date of Award: 26.10.2016
Policy No. 302201/48/14/8500001693

The Complainant alongwith his family was covered under National Mediclaim Policy issued by The National Insurance Company Ltd for a Sum Insured of Rs.5,00,000/-. The Complainant was hospitalized at Aashray Medical Hospital from 21.03.2015 to 25.03.2015 for D.M.H.T/Generalized weakness with vertigo. A claim was filed for Rs.22,167/-. The Company rejected the claim under exclusion clause 4.5 of the policy General Debility, Run down condition. The Complainant's plea for settlement of his claim to the Company was not heard. Hence, he had approached the Forum for settlement of his claim amount.

Based on the records and submission it was found that the Complainant was suffering from Thalessemia minor as per the records and doctor's certificate dated 15.06.2015. The Insurer had settled the claim on the treatment of the same disease in the last year. The Company had not taken any corrective action against the TPA. The Company had also quoted wrong clause while repudiating the claim and had not bothered to rectify the mistake even at grievance redressal stage at its Regional Office level.

In view of the facts and circumstances, invoking condition no. 3 of the policy terms and condition was not correct. The Complainant was entitled for claim. Accordingly, the Complaint filed by the Complainant is admitted for Rs.22,167/-.

In the matter of

Mrs Dahiben G Goswami

Vs

The New India Assurance Co. Ltd.

Complaint Ref No.AHD-G-049-1617-570

Date of Award:25.10.2016
Policy No: 21150042140100000250

Mr. Vasantgiri Gandagiri Goswami, the deceased life Insured had taken a Personal Accident Insurance from the New India Assurance Company Ltd for a sum insured of Rs. 3,00,000/-.

The complainant, nominee under the policy, had preferred a claim to the Company. The Respondent after investigation had repudiated the claim on the ground of fraudulent statement invoking condition No. 3 of the Personal Accident Insurance Policy. Aggrieved by their decision, the Complainant represented to the Company and on not receiving any favorable decision she had approached the Forum.

(i) Based on the records and submission it was clear that the income of the DLA was Rs.3500/- p.m.

(ii) The Employer had given a certificate stating that the Deceased Life Insured's Income was Rs. 3500/- p.m. Entries for Rs. 3500/- p.m. were found in the bank pass book of the DLA. The Complainant had stated that the DLA was the sole bread earner and used to do other jobs and would earn around Rs.10,000/- p.m. The Forum believed that even with the low cost of living it would not be possible for any person to survive with monthly income of Rs. 3500/- p.m. The DLA had to feed himself and his mother as well.

(iii) The Forum had examined the documents submitted by the parties to the dispute. Against a column on annual income of the DLA, in the proposal form, the amount was overwritten as Rs. 8000/-. The Respondent had not sought counter signature on the corrected monthly income though the proposal was signed by the DLA. Copy of the proposal was also not sent to the DLA.

(iv) In reply to a question as to what would have been the Sum Insured had the DLA's income was stated as Rs.3500 p.m. the representative replied that the amount would be Rs. 1,84,000/-(3500 x24 months and Maximum Sum Insured Rs. 1,00,000/- as per the terms and conditions of the policy was payable).

(v) The Complainant, thus, was entitled for relief. The Complaint was admitted to the extent of Rs. 1,84,000/-.

In the matter of
Mr. Karan Singh Jain
V/s
The Oriental Insurance Company Ltd.
Complaint Ref No.AHD-G-050-1617-0604

Date of Award:11.11.2016
Policy No: 242202/48/2015/1732

The Complainant alongwith his wife was covered under PNB Oriental Royal Mediclaim Policy issued by the Oriental Insurance Company Ltd. for a Sum Insured of Rs.5,00,000/-. the Complainant was hospitalized at Hemato Oncology Clinic on various dates for treatment of Multiple Myeloma IGG Kappa. When a claim was filed, the Company settled some claim and rejected nearly 20 claims on subsequent similar treatments. He had appealed to the Company and dissatisfied with their decision he had approached the Forum.It was observed that the Complainant had taken the policy in the year 2011.The Complainant was hospitalized 20 times every week for chemotherapy to treat multiple myeloma. He was administered Inj Bortezomib, Inj Dexona 20 mg and Inj. Zoletrust 4 mg Borteszomib is used to treat people with multiple myeloma (a type of cancer of the bone marrow) who have already been treated with atleast one other medication. Bortezomib is also used to treat people with mantle lymphoma (a fast growing cancer that begins in the cells of the immune system) who have already been treated with at least one other medication. Bortezomib is in a class of medications called antineiplastic agents works by killing cancer cells. The re-review of the claim was not done by any independent Competent doctor. The chemotherapy kills good cells alongwith cancerous cells. The Immunomodulator drugs induces, enhances or suppresses an immune response. It has fewer side effects than the existing drugs, including less potential for creating resistance in microbial diseases. Cell based Immunotherapies are effective for some cancers. Immune effector cells work together to defend the body against cancer by targeting abnormal antigens expressed on the surface of the tumor cells. Thus, the Immunomodulator drugs are used in cancer patients alongwith chemotherapy to enhance the immune system of the patient. The policy had not excluded these payments. The Respondent had rejected the claim stating that the treatment did not fall under hospitalization clause. The Forum felt that since The re-review

was not done by an independent doctor with equivalent or higher medical degree as that of the treating doctor.The policy provided reimbursement on chemotherapy.Immunomodulator drugs are administered after chemotherapy to boost the Immune system and in cancer patients alone.

The Complainant was entitled for relief. The Complaint was admitted for Rs.1,50,144/-

In the matter of
Mr. Karan Singh Jain
V/s
The Oriental Insurance Company Ltd.

Complaint Ref No.AHD-G-050-1617-0605

Date of Award:11.11.2016
Policy No: 242202/48/2016/1868

The Complainant alongwith his wife was covered under PNB Oriental Royal Mediclaim Policy issued by the Oriental Insurance Company Ltd. for a Sum Insured of Rs.5,00,000/-. the Complainant was hospitalized at Hemato Oncology Clinic on various dates for treatment of Multiple Myeloma IGG Kappa. When a claim was filed, the Company settled some claim and rejected nearly 20 claims for which he appealed to the Company and dissatisfied with their decision approached the Forum.It was observed that the Complainant had taken the policy in the year 2011.The Complainant was hospitalized 20 times every week for chemotherapy to treat multiple myeloma.He was administered Inj Bortezomib, Inj Dexona 20 mg and Inj. Zoletrust 4 mg. Borteszomib is used to treat people with multiple myeloma (a type of cancer of the bone marrow) who have already been treated with atleast one other medication. Bortezomib is also used to treat people with mantle lymphoma (a fast growing cancer that begins in the cells of the immune system) who have already been treated with at least one other medication. Bortezomib is in a class of medications called antineiplastic agents works by killing cancer cells. The re-review of the claim was not done by any independent Competent doctor. The chemotherapy kills good cells alongwith cancerous cells. The Immunomodulator drugs induces, enhances or suppresses an immune response. It has fewer side effects than the existing drugs, including less potential for creating resistance in microbial diseases. Cell based Immunotherapies are effective for some cancers. Immune effector cells work together to defend the body against cancer by targeting abnormal antigens expressed on the surface of the tumor cells. Thus, the Immunomodulator drugs are used in cancer patients alongwith chemotherapy to enhance the immune system of the patient. The policy had not excluded these payments. The Respondent had rejected the claim stating that the treatment did not fall under hospitalization clause. The Forum felt that since The re-review was not done by an independent doctor with equivalent or higher medical degree as that of the treating doctor. The policy provided reimbursement on chemotherapy. Immunomodulator drugs are administered after chemotherapy to boost the Immune system and in cancer patients alone.

The Complainant was entitled for relief. The Complaint was admitted for Rs.60,472/-

In the matter of
Mr. Jagrut Vadilal Balu
Vs
The Oriental Insurance Company Ltd.
Complaint Ref No.AHD-G-050-1617-0658

Date of Award:11.11.2016
Policy No: 131100/48/2014/20118

The Complainant along with his family member was insured with a Happy Family Floater Policy issued by the Oriental Insurance Company Ltd. Shri Badarmal Vadilal Balu, father of the Complainant was hospitalized at HCG Hospital from 26.12.2014 to 29.12.2014 for Breathlessness, CRF, Hypertension and Type II Diabetes. When a claim was lodged, the TPA had asked for previous policy documents which the Complainant had complied with. The claim was repudiated on 05.03.2015 invoking clause 4.1 of the policy terms and conditions. Aggrieved by the decision, he had appealed to the Grievance Cell and on not receiving any reply he had approached the Forum for redressal of his grievance.From the documents submitted and the submissions made during the hearing it is observed that the Insured was having policies from the year 2009. The hospitalization was in the month of December, 2014. The Complainant had produced the copies of the policy documents. The policy document pertaining to 2013 -2014 showed that the certificate was issued by Trisure Health Care Trust, Mumbai and insured with the Oriental Insurance Company Ltd, Andheri, Mumbai.The Discharge records stated that the Insured was admitted to the hospital for Breathlessness, CRF, hypertension, Type II diabetes and was suffering from hypertension and DM since 7-8 years. The Respondent had stated that the policies since the year 2011 were under Group Mediclaim Claim (GMC) policies . The Complainant stated that he was not provided with the terms and conditions to know the details. The Respondent did not provide the terms and conditions of the GMC policies to the Forum as well. Hence it was not possible to understand the exclusions in the GMC policies under such circumstances, the benefit of doubt should be given to the Insured.

The complaint was admitted for Rs.29,299

In the matter of
Mr. Amrutlal Kantilal Patel
Vs
The National Insurance Co. Ltd
Complaint Ref No.AHD-G-48-1617-0683

Date of Award:08.11.2016
Policy No: 3020048/15/8500009323
18. Brief facts of the case
The Complainant alongwith his wife was covered under Baroda Health Policy issued by The National Insurance Company Ltd for a Sum Insured of Rs.2,00,000/-. Mrs. Kailashben A Patel, wife of the Complainant was hospitalized at Pain Care Clinic from 07.01.2016 to 08.01.2016 for the treatment of low Back pain with B/L L5-S1 Facet Joint Arthropathy with B/L L5 Radiculopathy. A claim was filed for Rs.60,577/-. The Company repudiated the claim stating that the medical expenses on epidural injection was not payable as per their recent guidelines from their Head Office. Aggrieved by the decision of the Respondent, the Insured had approached the Forum for redressal of his grievance and settlement of the claim. From the submissions made by both the parties and the documents submitted on record it was noted that :The

Insured was hospitalized for low back pain with B/L L4,L5, S1 Radiofrequency Neurolysis of medial branch of spinal nerves with caudal neuroplasty. The age of the Insured was 70 years. The patient was old aged. The treating doctor had decided on the hospitalization considering his patient's age and health condition. The terms and conditions of the policy did not exclude epidural injection. The guidelines issued by the Head Office was not submitted to the Forum alongwith their Self Contained Note. As there was no exclusion for epidural injection in the policy terms and conditions, the decision of the Respondent to reject the claim was not in order.However, from the documents submitted it is seen that the hospital charges were Rs. 50,000 and the medicine bill and pathology bills submitted were around for Rs.10,577/- . There was one bill for Rs. 4500/- of Sanya Diagnostics dated 13.06.2015 which was prior to 30 days of pre-hospitalisation which was not payable as per the terms and conditions of the policy. The Complainant had lodged claim for Rs. 60,577/-.

In view of the foregoing, the Complainant was entitled for the admissible claim amount. The complaint was admitted for Rs.56057

In the matter of
Mr. Pranlal B Shah
Vs
The New India Assurance Company Ltd.

Complaint Ref No.AHD-G-049-1617-0644

Date of Award:08.11.2016

Policy No: 21250134140100001093

The Complainant alongwith his wife was insured under the Mediclaim Policy 2007 (Hospitalisation Benefit Policy) issued by the New India Assurance Company Ltd. Smt Vimlaben Shah, wife of the Complainant was hospitalized from 06.11.2015 to 08.11.2015 for Acute onset –Delirium. When a claim for Rs. 33,771/- was filed, the company rejected the claim under clause 4.46 stating that treatment for psychiatric illness was not payable. It was seen that the policy was from 28.03.2015 for Sum Insured of Rs. 1,00,000/-.The Insured was admitted to the Shiv Hospital for Acute Onset- Delirium? Metabolic ? Infective. In the Discharge summary the Insured was asked to follow up after 10 days (sos follow up with neurophysician.) If the ill health condition continued.The age of the Insured was 80 years. In absence of the representation, proposal form, medical examiner's report at the time of proposal, the Forum was at a loss to know the circumstances especially the health condition of the policyholder under which the policy was issued to a proponent aged around 80 years for Sum Insured of Rs. 1,00,000. The underwriting norms were also unknown. Here the Insured, 80 years of age was admitted for Infective delirium and had consulted a neurologist and not a psychiatrist. Hence the Respondent's stand of repudiation on the ground of psychiatric illness is not tenable.

Since the treatment was not for psychiatric illness the Forum felt it appropriate to consider the claim of the Complainant. The complaint was admitted for Rs. 33,771

In the matter of
Mr. Pravin A Patel
V/s
The Oriental Insurance Company Ltd.

Complaint Ref No.AHD-G-050-1617-0706

Date of Award: 10.11.2016
Policy No: 1412004820164148

The Complainant along with his family was insured under Individual Mediclaim Policy issued by the Oriental Insurance Company Ltd. Ms. Ankita Patel, daughter of the Complainant was hospitalized at Asian Bariatrics from 07.12.2015 to 11.12.2015 for Metabolic syndrome with final diagnosis as Diabetes Mellitus and Morbid (severe) obesity. She had undergone Laparoscopic Banded Sleeve Gastrectomy. The claim was rejected under clause 4.19 of the policy. From the submissions of both the parties and the documents submitted it was observed that:The Insured was operated for Sleeve Gastrectomy for morbid obesity. The weight of the Insured was 126.600 kgs and BMI was 49.450. The two discharge summaries were provided. In one Discharge Summary the provisional diagnosis was morbid obesity and in another it was mentioned as metabolic syndrome. On a query to the Complainant about two discharge summaries he said that he was advised as to he may not get claim on the ground of morbid obesity and hence metabolic syndrome was given. However, in both the discharge summaries morbid obesity was mentioned. The Insured had submitted a copy of Award issued by this Forum and also a judgement passed by the Consumer Forum in the year 2010 and 2012 respectively where the decision was in the favour of the complainant. It is to be noted that these cases are different. In one case the claim was rejected by the company stating that it was a cosmetic surgery, and as Bariatic surgery was not cosmetic it was awarded in favour of the complainant as per the terms and conditions of the policy by the Insurance Ombudsman, Gujarat. In another case, the award was given in favour of the Complainant by the District Consumer Redressal Forum, Ahmedabad on the ground that the terms and conditions mentioned in the old policy at the time of taking the policy for the first time would be applicable. Subsequent modification in the Terms and conditions of the policy would not apply. I do not agree with the views taken by the District Consumer Forum, Ahmedabad because the policy is renewed annually. After expiry of a year, new contract is issued. The terms and conditions mentioned in the old contract cease to exist. The terms and conditions mentioned in the new renewed policy shall apply in this case. The new terms and conditions was never objected by the Insured. The policy terms and conditions issued to the Complainant for the year 2015-16 by the Respondent where clause 4.19 reads as "**Treatment of obesity or condition arising there from (including morbid obesity) and any other weight control programme services or supplies etc"** are excluded under the policy terms and conditions

Therefore, as per the policy terms and conditions issued by the Respondent for the current hospitalisation, excluded obesity treatment and its complications, the decision of the Company not to pay the claim was in order. The complaint failed to succeed.

In the matter of

Ms Rekha A Dalal

Vs

The New India Assurance Co. Ltd

Complaint Ref No.AHD-G-049-1617-0676

Date of Award:10.11.2016

Policy No: 221500/34/15/01/00005005

The Complainant was covered under Mediclaim Policy 2007 (Hospitalisation benefit Policy) issued by the New India Assurance Company Ltd. Smt The Complainant was hospitalized at Vadodara Institute of Neurological Sciences from 04.03.2016 to 05.03.2016 for Right lower limb (knee) pain under Evaluation. DM, CVA : Right Hemiparesis (Left Thalamic infarction). She was managed conservatively. When a claim was filed for Rs. 47,068 the company repudiated the claim under clause 3.14.1 and 4.4.11. Unsatisfied with the decision of the Respondent, the Complainant had approached the Forum for redressal of his grievance and settlement of the claim. Based on the hearing and the records submitted, it was noted that

(i) The Complainant was having severe pain in the back and knee and was not able to stand up from her sitting position. She had history of old stroke.During the hospitalization she was managed conservatively. The clause 3.14.1 where minimum period of 24 hours is not applicable as the admission was on 04.03.2016 at 16.22 hours and discharged on 05.03.2016 at 18.00 hours. In respect of clause 4.4.11, the tests done were consistent with the ailment she was suffering. A certificate from Dr. Mihir J Acharya, MD, DM (Neurology) dated 28.04.2016 stated that "Mrs. Rekha Dalal presented with on 03 March 2016 with acute onset weakness + Alaxia since she was a known case of CVA + DM- Plan was to rule out new neurological deficit. Recurrent CVA with GB syndrome – All relevant tests done for Neurological- were negative and orthopedic pathology was found and she was hence referred to the Ortho surgeon. In her case admission was necessary for evaluation of the pathology- which could have escalated and worsened".

(ii) There is an advice from the doctor, Dr. Mihir J Acharya, MD DM Neurology for admission for Cavda Equina Syndrome and also to consider LMN Syndrome , Cervical cord Pahtology.The treating doctor evaluates his patients with various reports to diagnose the exact nature of disease. The doctor takes a decision on the hospitalization of the patient considering the gravity, pain and condition of his patient. Various medical tests were carried out and the disease was diagnosed as ortho issue. It was not that the diagnosis was carried out and the patient was found to be perfectly alright.

The treatment carried out in the hospital were consistent to the illness which the Complainant had suffered though there was no operations and was managed conservatively, the Rejection of the claim under clause 3.14.1 and 4.4.11 is not in order.

The complaint was admitted for Rs.46,391.

In the matter of

Mr. Chetan Chokshi

Vs

The New India Assurance Co. Ltd

Complaint Ref No.AHD-G-049-1617-0674

Date of Award: 11.11.2016

Policy No: 22030034152500000725

The Complainant alongwith his wife was insured under the New Mediclaim 2012 Policy issued by the New India Assurance Company Ltd. The Complainant was hospitalized at Shastri Maharaj Hospital from 16.11.2015 to 18.11.2015. The TPA had rejected the claim stating that there was a difference of age by 5 years of the Insured in the policy. The age of the Insured was shown as 58 years in the policy whereas the correct age as per the Identity proof submitted by the Complainant comes out to be 63 years. They cited clause 5.8 of the mediclaim policy. Based on the hearing and the records submitted, it was noted that The Insured was continuously covered under Mediclaim policy since the year 2001.The Respondent failed to produce the age proof submitted during the year 2001.In absence of this, it is difficult to ascertain how this mistake has happened. Who has done it? Whether the complainant submitted wrong age proof or there was typographical mistake committed by the Insurer.The Complainant had lodged claims during the year 2007 and 2008 which were honoured by the Insurer. The age difference issue was not raised at that time.

i) The Respondent had corrected the age and issued a fresh policy with higher premium for the period 14.05.2016 to 13.05.2017. While accepting the premium for 2016-17 they have also recovered a sum of Rs.7600 on account of premium loading for age difference from the year 2001.The Respondent has not cancelled the policy but renewed the policy from 14.05.2016 to 13.05.2017 by charging revised of premium of Rs. 26,498/- on account of increase in age.The Insured had paid the premium of Rs. 16,414/- for the policy period 14.05.2015 to 13.05.2016.

ii) The Insured had failed to state the correct age and the Insurer had failed to produce the age proof submitted at the time of first proposal in the year 2001. The Insurer had renewed the policy by charging extra premium which showed that the Insured was insurable. The Insured had collected the loading of premium on account of difference in age for previous years.

iii) The claim was repudiated under clause 5.8 by the Respondent. Total Repudiation of the claim on the basis of understatement of 5 years age is not justified, even after accepting the difference of premium from the year 2001. The Insured has taken a stand that there was breach of principle of Utmost Good Faith which was base of the Insurance law. This is not correct when the Insured had already collected extra premium for the age difference from the year 2001.The Respondent is hereby directed to settle the claim upto reduced Sum Insured of Rs.1,90,000/-. However, the total claim of the Complainant is Rs. 1,74,246/- and is within the reduced Sum Insured. The Complainant is entitled for the admissible claim amount. The Complaint is thus disposed off.

In the matter of
Mr.Kishor Malaviya
Vs.
Star Health and Allied Ins Co. Ltd.

Complaint Ref No.AHD-G-044-1617-0695

Date of Award: 09.11.2016
Policy No: P/171213/01/2016/001799

The complainant alongwith his family was covered under Family Health Optima Insurance Plan issued by Star Health and Allied Insurance Company Ltd. for basic floater Sum Insured of Rs.3,00,000/-. Ms. Sonal K Malaviya, daughter of the Complainant was hospitalized at Angel Hospital from 03.03.2016 to 08.03.2016 for enteric fever. When a claim was filed, the Company had rejected the claim under condition No. 8 of the policy "claim by fraudulent means and misrepresentation". The policy was cancelled and the premium of Rs.3,257/- was refunded. It was observed that the Complainant had taken the policy in the year 2013. As per discharge summary of the hospital the insured was admitted to the hospital on 03.03.2016 at 8:05:09 p.m.At the time of admission the insured was suffering from fever since ten days. She had symptoms of nausea, vomiting, headache, bodyache, mild abdominal pain. The temperature was recorded as 103.9 F . The Investigation report of the Respondent stated that on 04.03.2016 the patient was found in the hospital at 12.30 p.m. At the same time the letter dated 14.05.2016 to the Complainant mentioned that the Insured was present in the Institute for exams from 3rd to 8th March, 2016. The contradiction was not explained by the Representative. The Complainant had submitted a lab report dated 27.02.2016. However, the Respondent had ignored this and stated that no papers pertaining to prior hospitalization were produced to them.

(i) If there was no hospitalization and treatment carried out, then the question that arose was why would the complainant have informed the Respondent about the hospitalization and requested for permission to leave hospital to appear for the exams. In light of above it is clear that hospitalization was there and the treatment was taken for typhoid during the period 03.03.2016 to 08.03.2016 and from 12.03.2016 to 15.03.2016. Since the claim filed at the Forum was for the period 03.03.2016 to 08.03.2016, the claim is admitted for said period. The Respondent vide letter dated 13.07.2016 had cancelled the policy on the ground of pre-existing diseases and refunded Rs.3257/- which was not in order.

In view of the above facts, the complainant is entitled for claim of Rs. 36793/- and reinstatement of the policy.

In the matter of
Mr. Kailash Chand Jain
Vs
The Oriental Insurance Company Ltd.
Complaint Ref No.AHD-G-50-1617-0709

Date of Award:23.12.2016

Policy No: 144000/48/2016/16193

The Complainant was covered under the PNB Oriental Royal Mediclaim Policy issued by the Oriental Insurance Company Ltd for a Sum Insured of Rs.4,00,000/-. The Complainant was hospitalized at Raghudeep Eye Hospital on 20.10.2015 for right eye Cataract surgery + Uveitis. Against the claim of Rs. 70,632/-, the Respondent had settled Rs.18,000/- and disallowed Rs.52,632/- citing reasonable and customary clause as per the preamble of the policy condition. Unsatisfied with the decision of the Respondent, the Insured had approached the Forum.From the submissions made by both the parties and the documents submitted on record it was noted that the surgery charges, pharmacy and medicine charges have been deducted on the basis of customary and reasonable charges. The Respondent had used this clause as a blanket instrument. The Customary and reasonableness charges changes with passing of time and with

the improvement of technologies and facilities. Whatever was considered a few years back as cosmetic and exotic is today accepted as reasonable and customary in many fields including medical science and related expenses. Since the cataract and retina operation was primarily to improve the eye sight and restore normalcy, to the vision, the payments made towards surgery charges and pharmacy charges cannot be considered as unreasonable.

The Complainant had undergone cataract and Uveitis. Uveitis is the inflammation of the uvea and the Respondent had rejected the claim for the retina surgery without any base. The deduction of discount of Rs. 10,000/- was given to the Insured and the Complainant had not claimed the same for reimbursement. The Respondent had deducted the amount of Rs. 10,000 arbitrarily.

In absence of any rate charts or specifically pointing out the grounds for deductions towards the above mentioned charges, the Complainant was entitled for the balance amount of Rs. 52,632/- .

In the matter of
Mr. Sandip Amartlal Shah
Vs
National Insurance Company Ltd.
Complaint Ref No.AHD-G-48-1617-0728

Date of Award:23.12.2016
Policy No: 301800/48/15/85000005190

The Complainant was covered under National Mediclaim Policy issued by the National Insurance Company Ltd. The Complainant was hospitalized at Dr. Rajendra C Patel Orthopedic Nursing Home from 26.04.2016 to 29.04.2016 for fracture of left forearm. Against the claim of Rs. 51717, the Respondent had settled Rs.42082 and disallowed Rs.9635/- under reasonable and customary policy condition. Disatisfied with decision of the Respondent, the Insured had approached the Forum for redressal of his grievance and settlement of the claim for an amount of Rs.9635 + 2220 being the cost of medicines post hospitalization.

From the submissions made by both the parties and the documents submitted on record it was noted that:The post hospitalization bills were for Rs. 2660/- out of which Rs. 400 was paid by the Respondent and Rs.2260 was for the external durable devises which was not payable and the same was agreed by the Complainant during the hearing. Here the Respondent failed to submit the said rate chart of other hospital in and around the geographical area where the Insured was hospitalized. In absence of any rate charts or specifically pointing out the grounds for deductions towards the above mentioned charges, the Complainant was entitled for the balance amount of Rs. 8500/-.

PROCEEDINGS BEFORE THE INSURANCE OMBUDSMAN,
State of Gujarat and Union Territories of Dadra, Nagar Haveli and Daman & Diu
(Under Rule No: 15 (1) / 16 of The Redressal of Public Grievances Rules, 1998)

Ombudsman: Shri N.P.Bhagat
Case of- Mr. Jethabhai B Patel Vs National Insurance Company Ltd.
Complaint Ref No.AHD-G-48-1617-0714

Date of Award:23.12.2016
Policy No: 31700/48/14/8500013442

The Complainant was covered under BOI National Swasthya Bima Policy issued by the National Insurance Company Ltd for a Sum Insured of Rs.5,00,000/-. The Complainant was hospitalized at Bhailal Amin General Hospital from 06.11.2015 to 10.11.2015 for chronic cholestatic Liver Disease with subacute Bacterial Peritonitis. Against the claim of Rs. 1,68,136/-, the Respondent had settled Rs.1,45,614 and disallowed Rs.22,522/- stating as per the policy condition. Unsatisfied with decision of the Respondent, the Insured had approached the Forum for redressal of his grievance and settlement of his balance claim amount. The point to be considered was whether the deductions of Rs. 22522 under various heads was in order ?
From the submissions made by both the parties and the documents submitted on record it was noted that The main contention of the Complainant was for the Service charges, Pharmacy charges amounting to Rs. **17372/-.** The Forum had collected the details of the accommodation charges from the Bhailal Amin General Hospital through E-mail. The hospital had clarified that the Accommodation charges included Theraputic Diet charges, Linen charges, Nursing charges and IC Monitoring charges.

(i) As per the policy condition and as correctly quoted by the Complainant the Service charge was not payable if nursing charges was included in accommodation charges.
(ii) The details of the Pharmacy charges provided by the Insurer showed that the expenses were not payable as per the list of excluded expenses attached to the policy. The expenses related to Diabetes Mellitus was permanently excluded from the policy. Hence expenses like RBS, Accucheck medicines related to diabetes were not payable. The exclusion list stated that the cost of cotton, needle syringe was payable if there was no dressing charges collected. Here as there was no surgery, dressing charges were not collected hence the amount becomes payable.

Thus the complainant was entitled to get relief for Rs. 2845/- under claim No.*111111500210.*

In the matter of
Mr. Nitin S Vyas
Vs
United India Insurance Company Ltd.
Complaint Ref No.AHD-G-51-1617-0789

Date of Award:23.12.2016
Policy No: 0602002814P110941963

The Complainant was covered under the Health Insurance Gold Policy issued by the United India Insurance for a Sum Insured of Rs.5,00,000/-. The Complainant was hospitalized at Raghudeep Eye Hospital on 08.03.2016 for cataract operation in the right eye. Against the claim of Rs. 92,635/-, the Respondent had settled Rs.48639/- and disallowed Rs.43996/- under reasonable and customary clause as per the preamble of the policy condition. Disatisfied with decision of the Respondent, the Insured had approached the Forum for redressal of his grievance and settlement of the claim for an amount of Rs. 43996/-.
From the submissions made by both the parties and the documents submitted on record it was noted It was seen that main deduction was under medicines and surgeon operation charges.
The deductions towards non-medical items for Rs. 387 are in order. The claim towards cost of stent and implants for Rs. 6000/- as claimed by the Respondent that it was calculated twice is not in order The policy condition NO. 1.2.1(a) for cataract surgery mentioned that actual

expenses or 25%of the SI whichever less was payable. In the subject complaint the Complainant had a policy for SI RS. 5,00,000/- and he was entitled for 25% of Sum Insured i.e. Rs. 125000/- against the claim amount of Rs. 92,635/- for the surgery. The Respondent had failed to prove any justification in support of deduction made from claim amount.Therefore the complaint was allowed for Rs.43609

In the matter of
Mr. Mahendra B Chelani
Vs
The Oriental Insurance Company Ltd
Complaint Ref No.AHD-G-050-1617-0871

Date of Award:25.01.2017
Policy No: 141200/48/2015/37301

The Complainant was insured with a Happy Family Floater Policy issued by the Oriental Insurance Company Ltd. The Complainant was hospitalized at U.N.Mehta Hospital from 06.12.2015 to 09.12.2015 for PTCA to LAD and RCA (PDA). When a claim was lodged, the Company repudiated the claim on 11.03.2016 invoking clause 4.1 of the policy terms and conditions.From the documents submitted and the submissions made during the hearing it was observed that the hospitalization was in the month of December, 2015.The Discharge records stated that the provisional diagnosis as DM –II with HTN with EA with CAD-DVD S/P PTCA→ LAD PTCA → PDA. **Percutaneous transluminal coronary angioplasty (PTCA) is a minimally invasive procedure to open up blocked coronary arteries, allowing blood to circulate unobstructed to the heart muscle.** The Insured was having hypertension since long was evident, and the current ailment occurring due to 7-8 months of hypertension was not convincing and acceptable. His first consultation sheet dated 21.11.2015 wherein it was stated that HTN (7-8 years) on medicine cannot be ignored.The Complainant could not produce first consultation papers wherein he was prescribed with the medicines for HTN/DM. This document would have proved whether HTN was existing for 7-8 months or 7 to 8 years.

(i) In view of the facts and circumstances since the policy was in 4th year and exclusion clause gets deleted after continuous coverage of 4 years, the decision taken by the Insurance Company was found to be correct. The complaint failed to succeed.

In the matter of
Mr. Jayesh Kantilal Shah
V/s
The Oriental Insurance Company Ltd.
Complaint Ref No.AHD-G-050-1617-0890

Date of Award:25.01.2017
Policy No: 141200/48/2015/35929

The Complainant along with his family was insured under the Happy Family Floater Policy issued by the Oriental Insurance Company Ltd. Ms. Archana J Shah, wife of the Complainant was hospitalized at Asian Bariatrics from 01.09.2015 to 04.09.2015 for Laparoscopic Sleeve Gastrectomy. The claim was rejected under clause 4.17 of the policy. Aggrieved by the

decision, he had appealed to the Grievance Cell and not satisfied with their decision he had approached the Forum for redressal. From the submissions of both the parties and the documents submitted it was observed that the clause 4.17 of the policy excluded reimbursement on "**Treatment of obesity or condition arising there from (including morbid obesity) and any other weight control programme services or supplies etc"** .The Insured had undergone Sleeve Gastrectomy. The diagnosis and the treatment was to cure morbid obesity.

The decision of the Company not to pay the claim was in order. The complaint failed to succeed.

In the matter of
Mr. Yogeshkumar V Bhat
Vs
National Insurance Company Ltd.
Complaint Ref No.AHD-G-48-1617-0918

Date of Award: 25.01.2017

Policy No: 302101/48/16/8500001882

The Complainant was covered under Parivar Mediclaim Policy issued by the National Insurance Company Ltd. The Complainant was hospitalized at Fusion Kidney Institute from 17.07.2016 to 21.07.2016 for Visual Internal Urethrotomy (VIU) + Transurethral Resection of the Prostate (TURP) +CIRCUMCISION. Against the claim of Rs. 99438/-, the Respondent had settled Rs.78593/- and disallowed Rs.20845/- under reasonable and customary policy condition. Dissatisfied with decision of the Respondent, the Insured had approached the Forum for redressal of his grievance and settlement of the claim for an amount of Rs.20,845/-. From the submissions made by both the parties and the documents submitted on record it was noted that the claim was rejected under reasonable and customary clause. The patient aged 64 years was admitted in a special room and had undergone three surgeries i.e. VIU + TURP+CIRCUMCISION. The rate table prepared by the TPA of the Company was submitted by the Respondent. The rates were for Economy room, twin sharing and single sharing charges and for the two surgeries i.e TURP and Circumcision. The rates submitted by the Respondent were not considered by the Forum as it was not certified by the hospitals. It was merely a statement of the T.P.A. not corroborated by evidence. Moreover, TPA has not considered the charges for VIU. The decision of the TPA and the Respondent to settle Rs. 78,593/- was incorrect and arbitrary. The Complainant was entitled for the balance claim amount after deduction of the non-payable amounts like registration, admission charges and non-medical items. The complaint was admitted for balance of Rs.20,500.

In the matter of

Mr.Saransh T Shah

Vs

ICICI Lombard General Insurance Co.Ltd

Complaint Ref No.AHD-G-020-1617-0988

Date of Award:25.01.2017

Policy No: 3005/2010750881/80/00000031638

The Complainant had taken a “Motor Two Wheeler Policy” insuring his Activa Honda Motorcycle for IDV value of Rs. 40,000/- bearing registration No.GJ01-SU-2098 from the Respondent for the period from 16.12.2015 to 15.12.2016. The said vehicle was stolen on 19.02.2016 from the parking place where his wife worked. The theft claim filed by the Complainant, was rejected by the Insurer vide letter dated 07.07.2016 on the ground that there were contradictory statements in respect of availability of the key. Aggrieved with it, the Complainant had approached the Forum. From the submissions of both the parties and the documents submitted it was noted that the Insured’s Activa Honda Motorcycle for IDV value of Rs. 40,000/- was stolen on 19.02.2016 during the currency of the policy.The Final report was dated 31.03.2016 issued by the police stated that the vehicle could not be located. The Affidavit given by Mr. Sharansh T Shah stated that the key of the vehicle was lost 2 months before the vehicle got stolen on 19.02.2016. This information was not given to the police or the Insurance Company then.The Complainant was unable to explain the circumstances under which the key was lost, why no police complaint or FIR was lodged. The Forum was not convinced with the explanation of the complainant. With the key being left in the ignition slot or lost by the Insured , there was all possibility for the thief to steal the vehicle very easily. In view of the facts and circumstances, it was clear that the Insured as a Prudent person ought to have taken care of the vehicle as the terms and conditions of the policy issued stated that the Insured shall take all reasonable steps to safeguard the vehicle from loss or damage. Hence the decision taken be the Respondent as per the terms and conditions of the policy was in order. The Complaint failed to succeed.

In the matter of

Mr. Nayan K Shah

Vs

United India Insurance Co. Ltd.

Complaint Ref No.AHD-G-051-1617-0932

Date of Award:07.02.2017

Policy No: 0605002814P102695699

The Complainant alongwith his family was insured under the Individual Health Policy issued by the United India Insurance Company Ltd. The Smt Binal N Shah, wife of the Complainant had consulted Dr. Ramesh G Shah for Left thigh abscess. The doctor had removed the abscess on 21.06.2015. When a claim was filed by the Insured, the Respondent rejected the claim citing condition 3.14, 2.1 and 5.3 of the policy. Not satisfied with the decision of the Respondent the Insured had approached the Forum for redressal of his grievance and settlement of the claim.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. The Insured had undergone removal of abscess in left thigh on 21.06.2015.The doctor vide his certificate dated 01.10.2016, has certified that Mrs. Binal N Shah was brought to his clinic on 21.06.2015 at 11.30 a.m. incision and drainage of abscess was done. He stated that she was relieved from the hospital after 2 hours of rest.The contention of the company was that the Insured had taken treatment on OPD basis on 21.06.2015 for removal of abscess of thigh. The case was not under OPD or hospitalization but was under the

day care treatment. The policy terms and conditions provided for less than 24 hours hospitalization in cases like“ incision and drainage of abscess” (Sr. No. 15). The day care treatment was payable if anesthesia was given. The Respondent had not enquired with the hospital to find out whether the surgery was carried out without anesthesia. The Complainant had stated that his wife was administered with local anesthesia.

In view of the foregoing the complaint was admitted for Rs.7085/-

In the matter of

Ms.Sapana R Shah

Vs

CIGNA TTK Health Insurance Co. Ltd.

Complaint Ref No.AHD-G-053-1617-1030

Date of Award:09.02.2017
Policy No: PROHLT010173766

The Complainant was insured under the Cigna TTK Pro Health Insurance Policy issued by Cigna TTK Pro Health Insurance Co. Ltd.for the period from 23.02.2016 to 21.02.2017. The Complainant had undergone Right Eye cataract surgery on 19.05.2016. When a claim for Rs.106298 was filed by the Insured, the Respondent settled Rs.30,000/- and disallowed Rs.76298 citing reasonable and customary charges. Based on the oral submissions of the parties read along with documents on record made available to this Forum, the amount disallowed were Non medical items of Rs. 175 and service charges of Rs. 3736 /-were not payable as per the terms and conditions of the policy. A discount of Rs. 10,000/- was received by the Complainant since she was a doctor by profession. The Insured was having a Pro Health Plus policy for a Sum Insured of Rs. 10,00,000. She had undergone cataract surgery in the right eye on 04.07.2016 and for the left eye on 11.11.2016.The Femtosecond Laser assisted cataract surgery justification given by the doctor dated 04.07.2016 stated that (LENSX) is the latest in cataract surgery techniques and allows precise outcomes alongwith reducing the risk factor during cataract surgery. This procedure is not for cosmetic purpose. It is meant to provide better safety and better results during cataract surgery. Moreover, the company had settled the claim of the Complainant on her left eye rgery on 22.11.2016 which was done after the right eye surgery. The deduction done by the Respondent was illogical and irrational. Since there was no capping or restriction for cataract surgery reducing the amount arbitrarily by the Respondent was not in order.

In view of the foregoing, the Complainant was entitled for the balance claim amount of Rs.62,387/-

In the matter of
Mr. Chandrakumar Banshiwala
Vs
The Oriental Insurance Co.Ltd.

Complaint Ref No.AHD-G-48-1617-1058

Date of Award:07.02.2017
Policy No: 141500/48/2016/10145

The Complainant alongwith his family was insured under the Happy Family Floater Policy issued by the Oriental Insurance Company Ltd. Mrs. Kamlaben Banshiwala, mother of the Complainant was hospitalized from 20.12.2015 to 25.12.2015 for Bilateral Pneumonitis + CCF due to severe anemia + septicemia. When he had filed a claim for Rs.47,695/- with the Oriental Insurance Company, the company vide their letter dated 23.03.2016 repudiated the claim stating that as the Insured was diagnosed as Bilateral Pneumonitis + CCF due to severe anemia + septicemia, the claim was not payable as per policy condition 4.8. Based on the submission of parties as at above and materials made available to this Forum, the following points emerge which are pertinent to decide the case. As per discharge summary of the hospital the Insured was hospitalized on 20.12.2015 with complaint of fever 100 degree, Breathlessness, bodyache , vertigo. She was administered with injections and IV fluids during the hospitalization.The treating doctor vide a certificate dated 11.04.2016 had stated that the Bilateral pneumonitis with septicemia to be an infectious and acute condition. Congestive cardiac failure and severe anemia which produces cardiac failure is an absolute indication for hospitalization and needs attention for rapid correction of anemia. The Respondent has rejected the claim invoking clause 4.8 The treatment was for pneumonitis with congestive cardiac failure. However the treating doctor in the discharge summary stated that it was due to anemia. With the setting right of the anemic condition the patient had shown improvement in her health. The Medical opinion given by Dr. Sohansingh J Durma, MD stated that the Insured was admitted for Bilateral pneumonitis + Congestive Cardiac failure due to severe anemia + Septicemia which falls under the rundown condition and general debility of the policy terms and condition.

In view of the foregoing the complaint failed to succeed.

In the matter of
Mrs. Damyantiben K Shah
Vs
The New India Assurance Co.Ltd
Complaint Ref No.AHD-G-049-1617-1084

Date of Award: 09.02.2017
Policy No: 220600/34/14/01/00000302

The Complainant was covered under the Mediclaim Policy-2007 issued by The New India Assurance Company Ltd. The Complainant was hospitalized at City Heart Centre from 17.04.2015 to 23.04.2015 for Acute LVF, DM in a known case of Valvular Heart Disease. When a claim was filed, the Company repudiated the claim citing clause 3.13 of the policy terms and conditions. Aggrieved by the decision of the Respondent, the Insured had approached the Forum for redressal of her grievance and settlement of the claim. From the submissions made by both the parties and the documents submitted on record it was noted that the Complainant was covered with the Respondent from 26.10.1997.The Insured was hospitalized at City Heart Centre for Acute LVF, DM in a known case of Valvular Heart Disease from 17.04.2015 to 23.04.2015.City Heart Centre was registered under Bombay Shops and Establishment Act, 1948**.** 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 had not followed the minimum criteria of the number of beds at the time of admission to the hospital.The Respondent repudiated the claim without seeking any clarification on the number of beds in the hospital.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 23.04.2015 i.e. before the date of advertisement.In view of the above the complaint is admitted for Rs. 36120.

In the matter of

Mr. Mukesh P Pathak

Vs.

National Insurance Co. Ltd.

Complaint Ref No.AHD-G-48-1617-1092

Date of Award:08.02.2017

Policy No: 30190048158500004898

The Complainant was covered under National Mediclaim Policy issued by the National Insurance Company Ltd for a Sum Insured of Rs.1,50,000. The Complainant was hospitalized at Parth Eye Hospital, on 08.03.2016 for Left eye cataract surgery with CE Phaco Against a claim of Rs 41153/- the Respondent had settled Rs.24000/- and deducted Rs.17153/- citing Reasonable and Customary clause of the policy. Unsatisfied with decision of the Respondent, the Insured had approached the Forum for redressal of her grievance and settlement of the claim. From the submissions made by both the parties and the documents submitted on record it was noted that the deduction was done under 'Reasonable and Customary clause' charges. It was seen that the Sum Insured of the Complainant was Rs.1,50,000/-.The room rent reimbursable as per terms and conditions was 1% of the basic sum insured . The room rent of Rs. 1000/- was totally disallowed. The representative could not explain the total deduction on the room rent. The deductions from OT charges, Investigation charges Instrument charges, Operation charges etc were under 'Reasonable and Customary charges' clause. The representative had failed to establish and justify the deductions. Moreover, the company had settled the claim of the Complainant on his right eye surgery which was done 3 months before the disputed surgery. The deduction done by the Respondent was illogical and irrational. Since there was no capping or restriction for cataract surgery reducing the amount arbitrarily by the Respondent was not in order.

In view of the foregoing, the Complainant was entitled for the balance claim amount of Rs.17153.

In the matter of

Mr. Atmaram M Prajapati

Vs

Iffco Tokio General Insurance Co.Ltd

Complaint Ref No.AHD-G-023-1617-1128

Date of Award:09.02.2017
Policy No: 52641383

The Complainant alongwith his wife was insured under the Family Health Protector Policy issued by the IFFCO Tokio General Insurance Company Ltd. The Complainant was hospitalized at Amdavad Eye Laser Hospitals Pvt. Ltd on 14.07.2016 for Left Eye Cataract surgery. The Respondent rejected the claim citing condition 49 and 15(a) of the policy. Not satisfied with the decision of the Respondent the Insured had approached the Forum for redressal of his grievance and settlement of the claim. Based on the oral submissions of the parties read along with documents on record made available to this Forum, the following points emerged which were pertinent to decide the case The policy was ported from the Oriental Insurance Company Ltd and the the claim had arisen in the 3rd year of the policy.The proposal form to question no. 13 (xiii) diseases of the nose/ear/throat/Teeth/Eye and any ailment/injury/sickness for which underwent treatment or undergoing/contemplating under medical history column of the proposal form at the time of policy (dated 23.05.2016) the Insured had answered in negative. It was noted that the first consultation sheet dated 08.07.2016 stated that he had diminished vision in both eyes since one month which dated back to 08.06.2016 after the proposal date and before commencement of the policy.The stand taken by the Company stating that the Insured had signed the declaration is not correct as the signature of the Complainant is available at the place where the witness is given to sign. Hence the proposal form itself was void and the declaration cannot be treated as declaration given by the proposer.The Respondent had failed to prove that the disease had pre-existed prior to the initial proposal. The Insured had his policy ported from the Oriental Insurance Company Ltd. All benefits, therefore, got carried forward to the ported policy. Thus, the benefit in the subject complaint gets covered in the ported policy with the Respondent. The agent had filled up the form for the Insured. The Respondent had not collected the data on pre-existing disease & the claim paid on the hospitalization if any, of the Insured. The Respondent was contented with the sale of the policy. Mere stating that the Insured had not declared the disease did not convince the Forum to let the Insured forego the portability and the continuity benefit available under the policy. Thus, the complaint was allowed for Rs.24,600

In the matter of
Mrs.Parul G Shah
V/s
The New India Assurance Company Ltd.

Complaint Ref No.AHD-G-049-1617-1148

Date of Award:09.02.2017
Policy No: 201500341501000005006

The Complainant alongwith her husband was covered under the Mediclaim Policy 2007 issued by the New India Assurance Company Ltd. for a Sum Insured of Rs.5,00,000/-. Shri Girish P Shah was treated at Hemato Oncology Clinic on various dates for Multiple Myeloma. When a claim was filed for the treatment carried out for the period June to July, 2016, the Company rejected the claim under clause 3.14.1.It was observed that the Insured was administered Inj Bortezomib. A certificate from the treating doctor, Dr. Jigar G Patel of Hemato Oncology Clinic stated that the Insured was a case of multiple myeloma. He was on RVD Protocol Post transplant. He was given injection Bortezomib. Borteszomib is used to treat people with multiple myeloma (a type of cancer of the bone marrow). There was no doubt that the Insured was given chemotherapy treatment. The parenteral chemotherapy was payable as per the Clause 3.14.1 Here the chemotherapy treatment was given and the Company had taken a stand that as the certificate given by the doctor stated that it was on OPD basis the claim was denied. The Respondent had paid to the Insured for the similar claim earlier also. The attitude of the Respondent towards the Insured on the basis of a word OPD was very casual and insensitive. The Regional Office of the Respondent should have reviewed the case on the basis of certificate provided by the Insured, which the Respondent failed to do. In view of the facts and circumstances, the complaint was admitted alongwith 9% p.a. and recovered from the TPA and erring Officials on the 50-50% basis.

Case of Mr. Vinodbhai B Bhavsar
Vs.
The National Insurance Co. Ltd
Complaint Ref No.AHD-G-48-1617-1172

Date of Award: 20.02.2017
Policy No: 302101/48/15/8500015578

The Complainant alongwith his wife was covered under Baroda Health Policy issued by The National Insurance Company Ltd for a Sum Insured of Rs.5,00,000/-. The policy was taken for the first time on 25.03.2016. The Complainant was hospitalized at Shalby hospital on 25.04.2016 for Culprit RCA occlusion and was advised PAMI of RCA. He had undergone angiography and Percutaneous Transluminal Coronary Angioplasty (PTCA). The Company repudiated the claim stating that the disease seemed to be contracted within 30 days from the inception of the policy, which was not covered under clause 4.2. Aggrieved by the decision of the Respondent, the Insured had approached the Forum for redressal of his grievance and settlement of the claim.

From the submissions made by both the parties and the documents submitted on record it as noted that the Insured was hospitalized on 25.04.2016 for Culprit RCA occlusion and had

undergone angiography and PTCA .There was Peri Procedure complication.The age of the Insured was 60 years at the time of taking the policy and no medical examination was done by the Respondent.The policy was taken on 25.03.2016 at 14.00 hours . The Complainant was hospitalized on 25.04.2016. The hospital records stated the onset of chest pain was at 5.a.m. on 25.04.2016. The hospitalization was on the 31st day of taking the policy.The opinion of the panel doctor Dr. Piyush Shah stated that on admission ECG showed Lt ventricular hypertrophy which occurs commonly in patients of chronic hypertension. This indicates that problem could have been an old health issue. But there was no other proof to substantiate that the pain or the symptoms had started before 25.04.2016.As claim under the policy is payable after 30 days from the inception of the policy, the repudiation by the Respondent on the ground of 4.2 is not tenable.

In view of the foregoing, the Complainant is entitled for the admissible claim amount. The complaint is admitted.

In the matter of
Mr. Jigish J Patel
Vs
National Insurance Company Ltd.
Complaint Ref No.AHD-G-48-1617-1269

Date of Award:21.02.2017

Policy No: 301800/48/16/85/00006257

The Complainant was covered under National Mediclaim Policy issued by the National Insurance Company Ltd. The Complainant was hospitalized at Ashray Clinic under the care of Dr. Bhupesh D Shah on 20.08.2016 for Varocose Vein (Left side). Against the claim of Rs.66177/-, the Respondent had settled Rs.42572/- and disallowed Rs.23605/- Dissatisfied with decision of the Respondent, the Insured had approached the Forum for redressal of his grievance and settlement of the claim of Rs.23605/-. From the submissions made by both the parties and the documents submitted on record the Respondent had settled the claim on the basis of PPN hospital rates. While the insured was not hospitalized in PPN hospital. In absence of any rate charts or specifically pointing out the grounds for deductions towards the operation charges, the Complainant was entitled for the balance amount of Rs. 22800/-.

In the matter of
Mr. Prabhubhai B Patel
Vs
National Insurance Company Ltd.
Complaint Ref No.AHD-G-48-1617-1312

Date of Award: 21.02.2017

Policy No: 302101/48/15/85/00007665

The Complainant was covered under National Mediclaim Policy issued by the National Insurance Company Ltd. The Complainant was hospitalized at NETR Eye Care Clinic on 13.05.2016 for Right Eye Cataract surgery. Against the claim of Rs.39272/-, the Respondent had settled Rs.24372/- and disallowed Rs.14900/- citing reasonable and customary clause of the policy. Dissatisfied with the decision of the Respondent, the Insured had approached the Forum for redressal of his grievance and payment of the balance claim.

From the submissions made by both the parties and the documents submitted on record, the deductions under reasonable and customary charges were payable. The cost of phaco blade as per IRDAI guidelines surgical blades are payable under OT charges and not payable separately. Since the Phaco Blade was charged separately under the drugs charges the claim for the same was not payable. In absence of any rate charts or specifically pointing out the grounds for deductions towards the operation charges, Investigation charges, O.T.charges, the Complainant was entitled for the balance amount of Rs. 12500/- .

In the matter of
Mr. Prabhubhai B Patel
Vs
National Insurance Company Ltd.
Complaint Ref No.AHD-G-48-1617-1313

Date of Award:21.02.2017

Policy No: 302101/48/15/85/00007665

The Complainant was covered under National Mediclaim Policy issued by the National Insurance Company Ltd. The Complainant was hospitalized at NETR Eye Care Clinic on 24.05.2016 for Left Eye Cataract surgery. Against the claim of Rs.37950/-, the Respondent had settled Rs.24050/- and disallowed Rs.13900/- citing reasonable and customary clause of the policy. Dissatisfied with decision of the Respondent, the Insured had approached the Forum for redressal of his grievance and settlement of the claim.
From the submissions made by both the parties and the documents submitted on record, the deductions under reasonable and customary charges were payable. The cost of phaco blade as per IRDAI guidelines surgical blades are payable under OT charges and not payable separately. Since the Phaco Blade was charged separately under the drugs charges the claim for the same was not payable. In absence of any rate charts or specifically pointing out the grounds for deductions towards the operation charges, Investigation charges, O.T.charges, the Complainant was entitled for the balance amount of Rs. 11500/- .

PA Accident Policy

In the matter of

Mr. Paresh R Pandya

Vs.

The New India Assurance Co. Ltd.

Complaint Ref. No. AHD-G-049-1617-1260

Date of Award: 21.02.2017

Policy No: 212500/42/16/01/00000025

The Complainant had a PA Accident Policy issued by The New India Assurance Co. Ltd., It was reported by him that he had the policy since last 20 years. On 09.08.2016 he slipped from his activa scooter (as per complaint it was 09.09.2016) and had fractured his

right wrist. He was operated on 12.08.2016. He had approached the Forum for release of Rs 5600/- as the insurer had settled only Rs.11200/- being 8 weeks compensation instead of 12 weeks compensation as claimed by him.The point to be considered was whether the part payment of the PA Claim was correct? Based on the submission of parties as above and the material made available to this Forum, the following points emerged which were pertinent to decide the case.The treating doctor in his certificate dated 29.09.16 had certified that Mr.Paresh Ramniklal Pandya was under his treatment for fractured lower end (Rt) radius and operated on 12.08.2016. He required physiotherapy at physiotherapy clinic for mobilization of wrist joint, radio-ulnar joint and grip strengthening exercises in the post operative period. He would require rest for about twelve weeks.The Insured was immobile from 09.08.2016. The Complainant had submitted final bill for physiotherapy done on 29.10.2016 .The advice given by the treating doctor, Dr. Paresh R Nanda of Param Hospital was gradual mobilization except wrist and elbow and shoulder which meant full mobilization was not there on 29.08.2016. Hence the Company's stand of payment only till 29.08.2016 was not in order. The Complainant had taken physiotherapy till 29.10.2016

In view of the foregoing the complaint was admitted till 29.10.2016 i.e for 11 weeks.
The Claim was admitted for Rs.4200/-

In the matter of
Mr. Sanjay M Shah
Vs
The Oriental Insurance Company Ltd.

Complaint Ref No.AHD-G-050-1617-1290

Date of Award: 22.02.2017

Policy No: 141100/48/2016/12689

The Complainant was covered under Parivar Mediclaim Policy issued by the National Insurance Company Ltd. The Complainant was hospitalized at Shri Jalaram Surgical Hospital from 27.02.2016 to 29.02.2016 for Para-umbilical hernia. Against the claim of Rs.86789/-, the Respondent had settled Rs.71284/- and disallowed Rs.15505/- citing reasonable and customary clause of the policy. Dissatisfied with decision of the Respondent, the Insured had approached the Forum for redressal of his grievance and requested for settlement of his balance claim amount. From the submissions made by both the parties and the documents submitted on record the The deduction of Surgeon charges by the Respondent was on the basis of reasonable and customary. In absence of any rate charts or specifically pointing out the grounds for deductions towards the above mentioned charges, the Complainant was entitled for the balance amount of Rs. 15,000/- .

In the matter of

Mr.Suresh Giri

Vs

Bharti Axa General Insurance Co.Ltd

Complaint No. AHD-G-007-1617-1264

Date of Award: 21.02.2017
Policy No: FPV/S8519906/2C/09/003511

The Complainant had purchased a "Private Car Comprehensive Insurance Policy from Bharti Axa General Insurance Company Ltd with an IDV of Rs. 4,30,000/-.The vehicle bearing no. GJ-06FC6341 had met with an accident due to heavy traffic on 21.12.2016 when he was driving back from his office to his residence. His submission was that the car got hit from back and the rear bumper alongwith the left side of the front bumper was damaged. When a claim was filed by the Complainant the Respondent had not settled the damages of the front bumper of the car. Hence he had approached the Forum for redressal of his grievance. From the submissions made by both the parties and the documents submitted on record it was noted that the front left side rear bumper of the vehicle was scratched. The damages were evident from the photographs submitted by the Respondent. Some of the damages were old and not related to the subject accident.The Respondent had paid Rs. 7177/- for the damages, on 25.01.2017, that were tallied with the cause of loss.The estimate cost given by the Down Town Garage for the front bumper was Rs.1800 with screws worth Rs. 79. The representative of the Respondent agreed to settle an amount of Rs. 2000/-

The Forum felt that the amount of Rs. 2000/- offered by the Respondent to repair the left front of the bumper and fix the lock of the bumper was in order.

In the matter of

Mr. Manojkumar Babulal Panchiwala

Vs.

National Insurance Co. Ltd.

Complaint Ref No.AHD-G-48-1617-1333

Date of Award: 22.03.2017
Policy No: 300705/48/15/85/00001229

The Complainant was covered under Baroda Health Policy issued by the National Insurance Company Ltd for a Sum Insured of Rs.5,00,000. The Complainant was hospitalized at Banker's Retina Clinic and Laser Centre on 16.08.2016 for right eye Vitrectomy surgery. Against a claim of Rs 47371/- the Respondent had settled Rs.22,171/- and deducted Rs.25,200/- citing Reasonable and Customary clause of the policy. Unsatisfied with decision of the Respondent, the Insured had approached the Forum for redressal of her grievance and settlement of the claim.

From the submissions made by both the parties and the documents submitted on record it was noted that the deduction was done under 'Reasonable and Customary clause' charges. The deductions from Surgeon's charges, OT charges, Lab charges were under 'Reasonable and Customary charges' clause. The representative had failed to establish and justify the deductions. The Treating doctor had given a certificate stating that Vitrectomy surgery was crucial and sight saving surgery which required specialty surgeon skill as well as instrumental

handling skills for this crucial surgery. The surgery took around 3 hours to complete hence an Assistance surgeon charge of Rs. 5000/- was also included. Since the Lab investigations were required before the surgery, the same was done before pre-operation.
In view of the foregoing, the Complainant was entitled for the balance claim amount. Of Rs. 25,200/-

In the matter of
Mrs. Bhavisha Jyotish Parikh
Vs
The Oriental Insurance Company Ltd
Complaint Ref No.AHD-G-050-1617-1387

Date of Award:22.03.2017
Policy No: 171601/48/2016/7487

The Complainant alongwith his family was insured with a Happy Family Floater Policy issued by the Oriental Insurance Company Ltd for a sum insured of Rs. 1,50,000/- The Complainant was hospitalized at Smt R.B.Shah Mahavir Super Specialty Hospital from 20.06.2016 to 23.06.2016 for right side lower ureteric calculus with obstructive Uropathy. She had undergone surgery for Right URS and DJ Stenting under General Anesthesia. When a claim was filed by the Complainant for Rs. 1,32,015 the Respondent had rejected the claim invoking clause 4.1 i.e. pre-existing disease and clause 5.14 for misrepresentation. From the documents submitted and the submissions made during the hearing it was observed that The continuous policy was from the year 2013 **. The waiting period for calculus is 2 years.** Since the representative was not able to prove with the treatment papers that the Insured was under continuous treatment for calculus prior to inception of the policy, rejection of the claim under pre-existing clause was not correct.

The complaint is admitted for an admissible claim amount

In the matter of
Mr. Rahul Bhavishi
Vs
National Insurance Company Ltd
Complaint Ref No.AHD-G-48-1617-1375

Date of Award: 21.03.2017
Policy No: 301700/48/15/8500000557
The Complainant was covered under National Mediclaim Policy issued by the National Insurance Company Ltd. Smt Subidha R Bavishi, wife of the Complainant was hospitalized at Dastur Hospital from 23.12.2015 to 26.12.2015 for Para-umbilical hernia. Against the claim of Rs.66879, the Respondent had settled Rs.45781/- and disallowed Rs.21098/- citing policy condition 2.2 of the policy. Dissatisfied with decision of the Respondent, the Insured had approached the Forum for redressal of his grievance and settlement of the balance claim of Rs.21098.
From the submissions made by both the parties and the documents submitted on record As per clause 2.2 in respect of Medical Practitioner's fees Surgeon, Anaesthetist, medical practitioner, consultants, specialists fees the maximum limit for any one illness payable was 25% of the sum insured.Here the Respondent stated that the Sum Insured and the Cumulative Bonus worked out to Rs.1,87,500/- hence 25% under item no. 2 and 3 was Rs.46875 against the claim

amount of Rs. 47,000.In view of the facts and circumstances, the Complainant was entitled for the balance amount of Rs. 20875/-

In the matter of
Mr. Bhupendra L Shah
Vs
The Oriental Insurance Company Ltd
Complaint Ref No.AHD-G-050-1617-1356

Date of Award:24.03.2017
Policy No: 141600/48/2012/1164

The Complainant was insured with a PA Individual Policy Schedule issued by the Oriental Insurance Company Ltd. Smt Bhavnaben Shah, wife of the Complainant was hospitalized at Parimal Multispeciality Hospital from 22.04.2012 to 26.04.2012 for lateral malleolus non-union and medial malleolus right ankle re-fracture. When she had filed a Personal Accident claim for 12 weeks the Company rejected the claim stating that the injury was the same injury which she had sustained in the year 2011. Aggrieved by the decision, he had appealed to the Grievance Cell and dissatisfied with their decision, he had approached the Forum for redressal of his grievance.From the documents submitted and the submissions made during the hearing it was observed that The Insured was hospitalized at Parimal Multispeciality hospital for Lateral malleolus non-union # medual malleolus right ankle- refracture.

(i) The first consultation sheet dated 11.04.2012 stated case of pain the right ankle inability to work. History of fall while walking at home. On examination of right knee it was found tenderness over lateral and medical malleolus. Edema++. Fracture of lateral malleolus –non-union, fracture with medial malleolus with varius deformity. Move of ankle painful. Synovitis present.

(ii) Synovitis is a condition characterized by inflammation of the soft tissue lining the ankle joint capsule known as the synovioum with subsequent ankle swelling, pain and stiffness. There was no physiotherapy treatment undertaken or any follow up cases after the surgery. The blood sugar noted in the consultation sheet was PPBS 237 and FBS 173 which was on higher side. Due to the diabetic condition of the patient the healing of the earlier injury took longer time. There was no x-ray reports to substantiate that the injury was a fresh one.

(iii) The opinion given by the Dr. Hardik J Shah stating that the fracture was a complication of an old fracture and not an accident is in order.

(iv) In view of the facts and circumstances the case is dismissed.

In the matter of
Mr. Kishor M Senjliya
Vs.
Star Health and Allied Ins Co. Ltd.

Complaint Ref No.AHD-G-044-1617-1238

Date of Award: 23.03.2017
Policy No: P/171216/01/2015/004921

The Complainant alongwith his family was covered under the Family Health Optima Insurance Plan issued by the Star Health and Allied Insurance Company Ltd. for a Sum Insured of Rs.3,00,000/-. Master Dhruv, son of the Complainant was hospitalized at Gajera Children Hospital from 22.02.2016 to 25.02.2016 for LRTI with R/o Malaria. When a claim was filed, the Company had rejected the claim under condition No. 8 of the policy. The Respondent also cancelled the renewed policy citing condition no. 15. and the premium was refunded. As his representation to the grievance department was not heard, he had approached the Forum. From the facts and circumstances it was evident that there was hospitalization and there was no dispute on the same. Investigation of the hospital not carried out by the Respondent for inflated bill and the difference in the serial nos being manual error.The payment receipt towards hospitalization was only Rs. 19,500 for both the kids and the representative of the Respondent had agreed for payment of Rs.19518

The complaint is disposed off.

In the matter of
Mr. Kishor M Senjliya
Vs.
Star Health and Allied Ins Co. Ltd.

Complaint Ref No.AHD-G-044-1617-1239

Date of Award: 23.03.2017

Policy No: P/171216/01/2015/004921

The Complainant alongwith his family was covered under the Family Health Optima Insurance Plan issued by the Star Health and Allied Insurance Company Ltd. for a Sum Insured of Rs.3,00,000/-. Kum Ruhi, daughter of the Complainant was hospitalized at Gajera Children Hospital from 22.02.2016 to 25.02.2016 for Septicaema with GE. When a claim was filed, the Company had rejected the claim under condition No. 8 of the policy. The Respondent also cancelled the renewed policy citing condition no. 15. and the premium was refunded. As his representation to the grievance department was not heard, he had approached the Forum. To a question whether there was any dispute in hospitalization, the representative answered in negative. Since it was seen that there was no doubt for the admission to the hospital and the treatment taken, the representative was asked whether he would consider to settle the impugned bill for half of Rs. 19500/- which was paid by the Complainant for one kid towards hospitalization expenses plus pharmacy and investigation charges. The representative of the Respondent agreed for the same. However to calculate the medicines and the lab charges he required billing sheet from the Company.

Pursuant to the hearing the billing sheet was received and the representative agreed for payment of Rs. 16052.

Since the Respondent had agreed for payment of Rs.16052/- the complaint is disposed off.

Group : mediclaim

Complaint No. : AHD-G-048-1617-1259

Complainant : Mr. pritesh D. Shah V/s. National Ins. Co. Ltd.

Policy No. 30180048148500017757

Date of Award : 20.03.2017

The complainant's mother aged 64 years was admitted to Saviour Hospital on 28/02/2016 and was diagnosed with Acute Gastroenteritis in known case of Post Kidney Transplantation. She was discharged from there on 04/03/2016. She was then admitted to Sterling Hospital on 08/03/2016 for further treatment. There she died on 17/03/2016. The complainant had submitted the claim for Rs.3,05,578/- which was rejected by the Respondent as per policy condition no. 4.1 – All pre-existing disease when the cover incepts for the first time until 36 months of continuous coverage has elapsed. Any complication arising from pre existing ailment/disease/injuries will be considered as a part of the pre-existing health condition or disease.

The renal transplantation of the patient was done in the year 2013. She was admitted to Saviiour Hospital from 28.02.2016 to 04.03.2016 and dignosed for Acute Gastro Enteritis in Known case of post kidney transplantation where the Claim amount was Rs.95600/- She was again admitted to Sterling Hospital from 08.03.2016 to17.03.2017 and was diagnosed for Weakness under investigation, Hypertension, Diabetes Mellitus, Ischemic heart disease, post renal transplant. Patient was admitted in Sterling Hospital for further medical management. The patient could not revive and was declared dead on 17.03.2016. The claim amount of Sterling Hospital was Rs. 2,09,978/-. The patient was given treatment for Acute Gastro Enteritis at Saviour Hospital from 28.02.2016 to 04.03.2016. Nowhere in the discharge summary of Saviour Hospital it was mentioned that any treatment due to renal transplant was given to the patient. The Wikipedia article on Gastroenteritis explained that the disease could occur due to infections by viruses, bacteria, parasites, and fungus. It was not mentioned that it could occur due to renal transplant. It was clear from the biochemical report that there was a damage in kidney function gradually due to other organs failure on account of her deteriorating health conditions.

In view of the facts and documentary evidences submitted by both the parties it was concluded that the entire treatment was given to treat Acute Gastro Enteritis in both the Hospitals and the patient collapsed due to multifailure organs on 17.03.2016. The first claim on treatment of Acute Gastro Enteritis was also settled by the Respondent. Therefore the complaint was admitted for Rs.3,05,578/-.

Group : Mediclaim
Complaint No. : AHD-G-048-1617-1321
Complainant : Mr. Harish V. Mankodi V/s. National Ins. Co. Ltd.
Policy No. 31030048158500004265
Date of Award : 20.02.2017

The complainant's wife Smt. Varshaben was admitted to Kailash Hospital on 25/09/2015 with the complaint of Acute onset of breathlessness and dry cough for 4-5 days and discharged on 01/10/2015. The complainant's claim for Rs.35,970/- which was partially settled for Rs.25,213/- by the Insurer after deduction of Rs. 10,757/- as non-payable items.

It was observed from the documents submitted by both the parties that following charges were payable but the Insurer had wrongly deducted from the claim.

1) Rs. 7,000/- deducted towards pulse oxymeter charges was actually for Oxygen charges as per the Hospital bill dated 01/10/2015. Hence it was payable.
2) Rs. 1,050/- deducted towards Monitor charges was not excluded under policy terms and conditions, hence it was payable.
3) Rs.1,127/- deducted towards "Continue bill counted by client" was not correct as the complainant had submitted separate bills. However the total of bill no.18798 dated 01/10/2015 was 1025/-. Hence Rs.1025/- was payable under this item.
4) The total amount incorrectly deducted by the Insurer was Rs.9,075/- as mentioned in item Nos.1,2 and 3 as above.
5) In view of the aforesaid facts and submissions by both the parties, the complaint was admitted for Rs.9,075/-.

Group : Mediclaim
Complaint No. : AHD-G-048-1617-1311
Complainant : Mr. H.T.Menghani V/s. National Ins. Co. Ltd.
Policy No. 3802014614850000142
Date of Award : 20.03.2017

The Complainant was admitted to Apollo Hospitals, Gandhinagar on 21/11/2014, diagnosed with Left Pelvic Uretric mass (Transitional Cell Carcinoma) treated and discharged on 27/11/2014. He had lodged a claim for Rs.1,95,874/- which was repudiated by the company for the reason - as per policy clause No.V – Cancer will be covered after two years from the date of the policy with Hriday Credit Co-Operative Society Ltd. and no continuity benefit will be counted. Aggrieved with the decision of the Insurance Company the Complainant had requested the Forum to get his claim for Rs. 1,95,874/-.

The Complainant was having the policy from the Insurer since the year 2012 through different intermediaries. The Insurer did not have such exclusion clause in the previous policy of 2012. The Insurer had imposed the exclusion clause in the subject policy. If the Respondent happened to impose more exclusion clauses in the policies to come, the complainant will be at loss all the while. The representative was asked to submit copy of the product approval on the subject plan given by I.R.D.A. The representative stated that the policy conditions were decided by the company in consultation with the intermediaries. The Forum had asked the Respondent to submit such papers from I.R.D.A. which empowered the Respondent to decide the terms and conditions of the policy. The Respondent could not submit the desired papers till the date of issuance of the award.

The complainant was holding the policy of the Respondent since 07.09.2012. He was hospitalized on 21.11.2014 that was in the third policy year. Therefore he was eligible for payment of his claim.

The Complainant was admitted for rs.1,95,874/-.

Group : Mediclaim

Complaint No. : AHD-G-023-1617-1315

Complainant : Aruna Deepakkumar Banker

Policy No. 52580264

Date of Award : 23.02.2017

The Complainant's son Master Vihan aged 4 years was admitted to Tapan Hospital, Ahmedabad on 15/07/2016 with the diagnosis of Right Inguinal Hernia and underwent Inguinal Hernia repair. He was discharged on 16/07/2016 in a stable condition. The complainant had lodged the claim for Rs.36,099/-which was repudiated by the Insurance Co. stating that the disease was congenital in nature in 4 years young child which fell under exclusion no.9 of the policy conditions. Aggrieved with the decision of the Insurance Co. the Complainant has approached the Forum and urged to help her to get the claim amount.

20. <u>Conclusion :</u>

Meaning of the word "congenital" as per Black's Medical Dictionary is " Congenital deformities, disease, etc. are those which are either present at birth, or which, being transmitted direct from the parents, show themselves some time after birth. Under this case the disease hernia was not present at birth, if it was there it could have been treated immediately after birth. Also it was not transmitted from the parents because this disease was not transmittable from one person to another.

As per Vaginal process from Wikipedia : There is the potential for an indirect inguinal hernia to develop, although not all people with a patent vaginal process will develop one. The more patent the vaginal the more likely the patient is to develop a hernia.

However, the hernia had happened because of the vaginal process, the hernia sooner or later was evident to happen. Although the hernia was not congenital, there was all the conducive chances to happen which was congenital and it had happened.

In view of the above fact the complaint failed to succeed.

Group : Mediclaim
Complaint No. : AHD-G-051-1617-1138
Complainant : mr. A. A. Gandhok V/s. United India Insurance Co. Ltd.
Policy No. 1814002815P109717713
Date of Award : 09.02.2017

The Complainant's wife Mrs Manjeet Kaur was admitted to Navjeevan Nursing Home , Vadodara on 21-04-2016 with severe pain in left side area of Trigeminal N distribution. As her pain continued she was referred to Dr. Anupam desai (ENT) but there was no apparent ENT cause for her pain. She was, then, referred to Dental Surgeon for his opinion but no active dental problem was diagnosed. Her WBC was rising so she was treated with higher antibiotics from 25-04-2016 and discharged on 27-04-2016. The patient was diagnosed with left TM joint inflammation-URI- with severe neurotic pain. Her claim for Rs.40,701/- was rejected by the Insurer stating that it was the treatment of her dental disease.

The complainant's wife Mrs. Manjeet Kaur was admitted with complaint of left side jaw pain since 5-6 days severe during chewing. On investigations her WBC counts were found high and i/v antibiotics in form of Augmentin was started. She was referred to ENT, but there was no apparent ENT cause for her pain, so she was referred to Dental Surgeon for his opinion but no active dental problem could be found out. Her WBC were rising so she was treated with higher antibiotics from 25-04-2016 and was discharged on 27-04-2016, when her pain reduced and WBC counts came back to normal.

The Respondent had repudiated the claim under policy condition clause No. 4.8- Exclusions- Dental treatment or surgery of any kind unless necessitated by accident and requiring hospitalization.

The respondent had mentioned in rejection letter dated 10-06-2016 that the insured had under gone dental treatment which was not directly attributable to any accident/injury, hence claim was repudiated as per policy conditions Clause No.4.8

However the radiological investigation report dated 22/04/2016 stated MRI brain-Mild Diffuse Atrophy with few chronic Ischemic Foci in both frontal white matter. 22/04/2016- Orthopantomogram- Rt.Upper and Rt. & Lt. Lower Last Molars have been extracted. Left upper –Last Molar is impacted.

The term dental includes jaw and teeth , and treatment of jaw and teeth is dental treatment. Most common dental treatments are filling and repairs, root canal, dental crowns, bridges and implants, extraction and teeth whitening. The representative had failed to explain as to how the treatment was classified as dental treatment.

It could be found from the radiological report and discharge summary that the treatment was related to inflammation of nerves.

In view of above facts the complaint was admitted for Rs.40,701/-.

Group : Mediclaim
Complaint No. : AHD-G-051-1617-1042
Complainant : Mr. Anant N. Mehta V/s. United India Insurance Co. Ltd.
Policy No. ; 1803002815P11546968
Date of Award : 06.02.2017

The Complainant had taken treatment for Lt. Eye Cataract on 30.08.2016 at Roshani Eye Hospital. He had submitted a claim for Rs. 35970/. which was settled for Rs. 24000/-after deduction of Rs. 11,970/- stating reason reasonably & customary charges clause also that any expenses incurred for pre and post hospitalization beyond 30 days and 60 days respectively were not payable. Unsatisfied with the deduction from his claim he had approached the Forum.

The point to be considered was whether the deduction of Rs.11,970/- citing unreasonableness of the charges pre and post expenses beyond 30 and 60 days respectively from the date of surgery was correct?

As required under the IRDA circular on standardization in health insurance. The Respondent had not gathered the fees charged by various hospitals on the surgery of cataract before the claim was partially settled. Further, the skill, expertise etc. of the doctors differ from one another and fees charged by them, consequently differs.

The Respondent had failed to satisfy how the TPA had arrived at the reasonable charges. The TPA/Respondent had not provided the standard charges for cataract surgery and prevailing charges in the similar geographical area for identical or similar services. No documentary evidence to substantiate their contention was produced before the Forum.

The respondent could not provide any analysis or comparison chart for deductions made under Cataract surgery charges,

The deduction of Rs. 1,560- pre and post expenses beyond 30 days and 60 days respectively from the date of surgery under policy clause No. 3.30 & 3.31 was in order. Amount deducted Rs. 10410/- under policy clause 3.33 ‘Reasonable and Customary Charges.was not justified. Hence amount payable was Rs.10,410/-.

In view of the foregoing, the complaint was entitled for relief and therefore, the complaint was admitted for Rs.10,410/-.

Group : Mediclaim
Complaint No. : AHD-G-050-1617-1019
Complainant : Mr. Abhijit G. Thokdiwala V/s. Oriental Insurance Co. Ltd.
Policy No. 17210048201515675
Date of Award : 07.02.2017

The Complainant's father Mr Girish C. Thokdiwala was admitted to Bavin Eye Hospital, Surat on 03-11-2015 at 10.30 for right eye cataract by phacoemulsification with (+22.50 D) foldable IOL Implantation and discharged on 03-11-2015 at 12.30. The Complainant's claim for Rs.53377/- was partially settled with Rs.36100/- after deduction of Rs.17277/- citing policy condition No. 4.6

The complainant's father Mr. Girish C. Thokdiwala had undergone cataract operation. As per operating doctor Dr. Bhavin Jariwala's letter dated 23-05-2016 addressed to the Branch Manager, Oriental Insurance Co. Ltd. the patient was implanted with a monofocal lense (IOL) which was wrongly considered as expenses of luxury or cosmetic by insurance company. The lenses used corrected only distance vision and the patient had to wear glasses after the surgery.

The bills of more than 30 days prior to admission in hospital on 03-11-2015 for Rs. 1727/- and Admission fee of Rs. 50/- were disallowed correctly.

There is no capping in the policy terms and conditions on claim amount payable for cataract operation.

In view of the above the complaint was admitted for Rs.15,500/-.

Group : Vehicle
Complaint No. : AHD-G-050-1617-0894
Complainant : mr. Mafatbhai K. Bharwad V/s. Oriental Ins. Co. Ltd.
Policy No. 170011/31/2015/9194
Date of Award : 24.01.2017

The Complainant Mr.Mafatbhai Karsanbhai Bharwad had purchased a “Private Car –Packa Policy- Zone B Insurance Policy” for Vehicle No. GJ-06-HD-5670 from The Oriental Inuran Co. Ltd with IDV of Rs.1006526/-. The complainant was driving his insured vehicle towar Vadodara with the Insured car from Village Punjera on 19/07/2015 and the accident to place. The front RH tyre of the Insured Vehicle got burst he lost the control on the vehicle a it heavily dashed with road side tree and damage took place. The complainant had claim for Rs.1006526/- from the Insurance Company as there was a total loss to the car.T insured car had capacity of five persons, while at the time of accident seven persons we travelling in the car.

The insurer had offered Rs.675279/- against the total loss on non standard basis consideri the value of vehicle as 901706/- as assessed by the surveyor.

. The IDV of the insured vehicle was Rs.1006526/-. The accident took place on 19/07/20 during the policy period. The insured vehicle had seating capacity of five persons while at t time of accident seven persons were travelling in the car. The complainant had claimed t amount of Rs.1006526/- as total loss of his car. As per the report of respondent’s survey M/s. Z.A. Amiri, net liability of the respondent after disposal of salvage w/o R.C. w Rs.800705/- against which the respondent had approved the claim for Rs. 675279/- on to loss non standard basis. The recoverable salvage value was Rs.1,00,000/- as per Insuran Company’s surveyor The Forum expressed the view that the offer of Rs.6,75,279/- w reasonable and correct. It further observed that the respondent may retain the salvage a pay Rs.7,75,279/- as final settlement. Both the Complainant and the Respondent had agre to settle the claim for Rs.7,75,279/- during the hearing.

:laim

No. AHD-G-049-1617-0957

: Mr. Vipul T. Patel V/s. New India Assurance Co. Ltd.

)20234152800001379

l : 24.01.2017

ıntʼs wife Mrs. Mittal Patel was admitted to Vinayak Hospital with complaint of ıausea, vomiting and giddiness. She was diagnosed to suffer from systemic lupus (SLE), Nephritis since 4-5 years. His claim for Rs.47,456.98 was rejected by the lence, he has approached the Forum for Redressal of his grievance.

ıntʼs wife Mrs Miittal Patel was suffering from pyrexia with neutropenia in k/c/o erythematosus (S.L.E.) & nephritis since 4-5 years.

ıt had contended that both Pyrexia and Neutropenia were complications of long ɔpressive therapy with tablet Azoran and it fell under genetic disorder and rred towards genetic disorder were not payable as per the terms and conditions under clause no.4.4.16. In support of their contention they had attached the S.L.E from web md.com. However, the literature submitted by the Respondent did :. as a genetic disease. The same was confirmed by the representative of the ; well.

ɔ had made a Google search and found that the risk of developing S.L.E. was at genetic, but it was a complex genetic illness with no clear Mendelian pattern of ıe disease tends to occur in families. Siblings of SLE patients have a risk of ut 2%.

: all the documents submitted by the Respondent it was found that both the emic Lupus Erythematosus & Nephritis were not genetic disorder.

ıt failed to prove its reason for repudiation (genetic disorder) of the Insured's ɔmplainant was hence entitled for relief. The complaint was admitted for

Group : Mediclaim
Complaint no. ; AHD-G-049-1617-0892
Complainant : Mr. Rajnikant S. Vadnagra
Policy No. 21010034150100001440
Date of Award : 07.02.2017

The complainant Mr. Rajnikant S. Vadnagra had lodged a medi-claim on his right knee replacement for Rs. 49278/-. Out of total claim amount , the Respondent had settled an amount of Rs.4,793/- and deducted balance amount of R. 44,485/-. Reason for deduction was shown as ; Co-Payment of other TPA not payable.

The claim was rejected partially by the Respondent and Rs. Rs.44,485/- was deducted as co-payment as per the internal guide lines of the Respondent Co.

As per IRDA guide lines and policy clause 3.7 – A Co-payment is a cost sharing requirement under a health insurance policy that provides that the insured will bear a specified percentage of the admissible claim amount. A co-payment does not reduce the sum assured.

As per policy clause no.5.6(2)- If the amount to be claimed exceeds the sum insured under a single policy after considering the deductibles or co-pay, the insured person shall have the right to choose insurers by whom the claim to be settled. In such cases, the insurer may settle the claim with contribution clause.

The amount of Rs.44,485/- deducted as co-payment by other Insurer was not the co-payment for the Respondent. The complainant had submitted the claim for his balance amount.

Similar co-payment was settled by the same TPA on the claim of his wife for Rs.57,296/- under policy no. 210100/34/13/01/00001825 in F.Y. 2013-2014.

In view of the above facts and submissions the complaint was fit for admission for Rs.44,485/-.

ıp: Mediclaim
ıplaint No. AHD-G-037-1617-0934
ıplainant : Mr. Viral Hasmukhbhai Shah
:y No. : 10092290
ve of Award : 24.01.2017

›mplainant's daughter Ms. Hetvi aged 6 yrs. was admitted at Mody Hospital, Rajkot from 2016 to 09/04/2016 as she was diagnosed with Obsructive Sleep Apnea and underwent adenoidectomy. The respondent has rejected the claim citing clause 4.3(a) (ix) – nent exclusions of the policy..

tvi Shah was admitted at Mody Hospital, Rajkot for Obstructive Sleep Apnea. She was d with tonsiloadenoidectomy.

spondent had rejected the claim under clause No.4.3(a)(ix) i.e. Permanent Exclusions by any treatment related to sleep disorder or sleep apnea syndrome was excluded from im purview of the policy..

ver, the root cause of the disease of the insured was enlarged tonsils and adenoids. She ot able to sleep due to this illness. Sleep disturbance was not the disease but it was a of the disease of enlarged tonsils and adenoids which was cured by the surgery.

eatment of enlarged tonsils and adenoids was not included under the 'Permanent sion' clause under the Terms and Conditions of the policy.

›mplaint was admitted on merits of the case for Rs.43256.64

Group : Mediclaim
Complaint No. : AHD-G-051-1617-1150
Complainant : Mr. Arvindbhai C Patel V/s. United India Insurance Co. Ltd.
Policy No. : 1804002815P113247867
Date of Award : 07.02.2017

The Complainant Mr. Arvindbhai C. Patel was admitted with Gall bladder stone. He under went Laparoscopic Cholecystectomy with adhesiolysis on 10-09-2016. The Complainant submitted the claim for Rs. 1,00,010/- and was partially settled after deducting Rs. 13,832/- towards reasonable and customary expenses.

The claim was partially rejected for Rs. 13,832/- The amount deducted was from Surgeon Fee of Rs. 8,865/- and Operation Theatre charges of Rs.4,967/-. The deductions were made under section 3.33 of the policy conditions – Reasonable and Customary Charges- Reasonable and customary 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 services, taking into account the nature of illness/injury involved.

However, the Respondent had not submitted any list of comparative charges of the same treatment in the geographical area of the hospital.

Since there was no submission of any document related to justification of the deduction made by the respondent, the Compliant was admitted for Rs.13,832/-.

Group : Mediclaim
Complaint No. : AHD-G-048-1617-1036
Complainant : Mr. Kanaiyalal N. Raval V/s. National Insurance Co. Ltd.
Policy No. 31170048158500001043
Date of Award : 07.02.2017

The Complainant was admitted to Subhechha Hospital Vadodara for Acute Lower Lim Venous Thrombosis from 05/04/2016 to 14/04/2016. The complainant had claimed th bill for Rs. 78874/-. Against 10 days of stay, the bill for only 4 days was paid i.e. Rs 41071/- against the total claim of Rs.78874/-. The claim of Rs.37803/- was disallowe stating the reason that last 6 days of stay was not justified medically.

The Complainant was admitted to Subhechha Hospital Vadodara for treatment of Acut Lower Limb Venous Thrombosis from 05/04/2016. During the course of treatmer suddenly in early morning on 11/04/2016 the blindness in his Right Eye was observed Immediately the Eye Specialist was contacted by the Hospital authority and treatment o right eye was started alongwith the treatment of Acute Lower Limb Venous Thrombosis However there was no mention of eye treatment in the Discharge summary given by th hospital. But the hospital authority had issued a separate letter dated 21/04/2016 to th complainant in which they had mentioned that the extended stay in the hospital was du to sudden development of Right Eye Retinal Hemorrhage and total loss of vision.

In view of sudden development of eye disease during the stay in hospital for treatment o Acute Lower Limb Venous Thrombosis, the complainant had to stay for some more day in hospital. The stay was required for medical management of the illness suffered b the complainant. The said period was prescribed by the hospital authority.

The Respondent had not caused any enquiry with the treating doctor regarding the eye treatment and as to why it was not mentioned in the Discharge Summary.

The charges of Rs. 36060/-, deducted by the respondent are payable.

The Complaint was admitted for Rs.36,060/- in view of the above observations and submissions.

Group : mediclaim

Complaint No. : AHD-G-048-1617-0920

Complainant : Mr. Natwarlal A. Soni Vs. N.I.C.

Policy No. 31170048158500000976

Date of Award ; 09.02.2017

The Complainant's wife Smt Pravinaben N. Soni was admitted to M.M.Chokshi Medical Centre, Vadodara on 19/01/2016 for Left Eye Cataract surgery & was discharged on 19/01/2016. He had incurred an expense of Rs.37285/-. His claim was partially settled for Rs.24000/-. Deduction of Rs.13285/- was made citing the policy terms & conditions,- 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.

The insurance company had not given any proper and detailed reply in its Self Contained Note. The Self Contained Note in the nature of fill in the blanks form, was very casual. The Respondent failed to prove how the deductions made by them were not reasonable expenses. The Forum has noted that there was an unnecessary delay in settlement of a senior citizen's Mediclaim.

In view of the forgoing, the complaint was admitted for Rs.13,285/-.

oup : Mediclaim
mplaint No. : AHD-G-049-1617-0872
mplainant : Mr. Vijay C. Bhatt V/s. Natiional Insurance Co. Ltd.
licy No. : 30190048158500002619
te of Award : 07.02.2017

e Complainant was admitted to Krishna Shalby Hospital on 25/11/2015 and underwent procedure called PAMI (POMA) to RCA (Heavy Calcification) PCI (DES) to LDA successfully done. He was discharged on 28/11/2015 with haemodynamically stable condition. He had submitted the claim for Rs.1,85,406/- out of which Rs. 75,000/- was settled mentioning the condition that only 50% of Sum Insured was payable for Old AWMI, Acute IWMI, DM, HTN, Severe LVD, Severe TVD.

e Respondent had not called for the claim history while underwriting the proposal for insurance at the time of porting to the respondent company and policy was issued in continuity of the previous policy of United India Insurance Co. The policy year 2013-2014 onwards the over all sum assured of the complainant and his wife was Rs.3,00,000/- for the policies issued by the Respondent Co.

e Respondent had taken into consideration Rs. 1,50,000/- sum insured of the United India Ins. Co.'s policy of 2012-13 and settled the claim for Rs. 75,000/- at 50% of the SI.

ere was no policy clause in the subject policy which restricted the Sum Insured to the policies issued by previous insurer.

the overall sum assured of the policy of 2013-14 onwards of the Respondent Co. was Rs. 3,00,000/-, the complainant should be paid Rs.1,50,000/-, the 50% of SI Rs. 3,00,000/- overall SI of policy of the year 2015-16.

view of above fact and submissions the complaint was admitted for Rs.75,000/-.

Group : Mediclaim
Complaint No : AHD-G-048-1617-0865
Complainant : Mr. Chandulal N. Mistry V/s. National Insurance Co. Ltd.
Policy No. 30210048148500006969
Date of Award : 07.02.2017

The Complainant's wife Mrs. Shilaben C. Mistry was admitted to ECLC Eye Hospital, Ahmedabad on 24/12/2015 for Left Eye Cataract surgery & discharged on the same day. His claim for medical expenses of Rs.33,148/ was partially settled for Rs.24,148/-. Deduction of Rs.9,000/- was made citing Reasonable & Customary Charges as per the policy terms & conditions,

As per IRDAI circular on standardization in health insurance, reasonable and customary charges meant 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. The Insurance company could not prove that deduction of Rs.9,000/- was the reasonable and customary charges for cataract surgery in the hospital, where the complainant's wife was operated and it was consistent with the charge for similar surgery in similarly placed hospital in geographical area. There is no capping / ceiling for payment of cataract surgery under the policy conditions. The Respondent had failed to prove that the charges claimed were unreasonable.

In view of the forgoing, the complaint was admitted for Rs.9,000/-.

Group : Mediclaim
Complaint No. AHD-G-018-1617-0866
Complainant : Mrs. Sonal Parag Mehta V/s. HDFC Ergo General Ins. Co. ltd.
Policy No. 29522006994588022825
Date of Award : 07.02.2017

The Complainant Mrs.Sonal P. Mehta was admitted to Siddhi Surgical Hospital, Vadodara, and operated for Vaginal PAN Hysterectomy. She was admitted to the hospital on 18.03.2016 and discharged on 23.03.2016. She claimed the amount of Rs. 69169.55 towards her treatment expenses. Her claim was repudiated by the Respondent stating that there was a gap in the renewal of her policy from 07.03.2016 to 19.03.2016

The complainant's husband was informed about renewal of her policy and suggested for a separate policy for her major daughter which he agreed. An SMS was sent to the complainant on 20.02.2016 for maintaining sufficient balance in her credit card account as the bank was to debit the amount of renewal premium from her account. The complainant did not bother about the renewal premium deduction from her credit card account till 18.03.2016 i.e. date of admission to the hospital. The complainant came to know about the lapsed condition of her policy, only when her husband informed the respondent of her admission to hospital on 18.03.2016. The complainant had renewed her policy on 19.03.2016. The complainant did not take due care to verify whether renewal premium for policy was debited from her credit card account, also there was no proof as to assurance given by the executive of the Respondent Company to renew her policy retrospectively during the grace period.
In view of the above facts the complaint failed to succeed.

Group : Mediclaim
Complaint No. : AHD-G-005-1617-1327
Complainant : Mr. Ankit K. Patel
Policy No. OG-162202841700003568
Date of Award : 20.03.2017

The Complainant was admitted to Sterling Hospital on 31.05.2016 with complaint of sudden onset of right side (upper limb + lower limb) weakness, difficulty in walking and holding objects since one month, MRI Cervical Spine showed C3-4-5 compression with myelopathy. Surgery of C3-4-5 laminectomy was done and he was discharged on 06.06.2016 in stable hemodynamic condition. The Complainant had lodged the claim for Rs.1,63,415/-. His claim was repudiated by the Respondent for the reason that the policy did not extend coverage for any expenses incurred on prolapsed Intervertebral Disc (PIVD) during the first four years. Aggrieved with the decision of the Respondent the Complainant had approached the Forum to get his claim settled.

i)The Complainant was diagnosed with C3-4-5 compression with myelopathy and had undergone C3-4-5 laminectomy . His claim was rejected under Exclusions clause C3 (during the first four consecutive annual periods) “Surgery for prolapsed inter vertebral disc unless necessitated due to an accident” ii)As per MRI Report of the Complainant : (a)Posterior prostrusion of C4-C5 Intervertebral disc causing compression over ventral aspect of cervical dural theca,bilateral exiting C5 nerve roots and underlying spinal cord. (b)Posterior difuse prostrusion of C5-C6 Intervertrebral disc causing compression over ventral aspect of dural theca, bilateral exting C6 nerve root and mild compression over spinal cord. (c)Posterior bulging of C3-C4 intervertebral disc (propensity left side)causing mild compression over ventral aspect of dural theca and left exiting nerve root.

The MRI report clearly showed that the Surgery was for prolapsed intervertrebral disc which did not occur due to any accident and the policy was in the second year. The claim was repudiated by the Respondent as per policy clause C3 (Exclusions) correctly.

There was no need to intervene into the decision of the Respondent.

Group : Mediclaim
Complaint No. AHD-G-049-1617-1348
Complainant : Mr. Dilip R. Gupta V/s. New India Assurance Co. Ltd.
Policy No. 111900341505
Date of Award : 20.03.2017

The Complainant's wife Mrs. Poonam D. Gupta was admitted to Gulati Nursing Home Infertility Centre at Gorakhpur (U.P.) from 03.09.2016 to 04.09.2016 for treatment of Primary Infertility. The Complainant had lodged a claim for Rs.41,284/- which was repudiated by the Respondent citing policy exclusion clause No. 4.4.6.1. Aggrieved by the decision of the Respondent the Complainant had approached the Forum to get his claim settled.

21. <u>Conclusion :</u>

As per Discharge Card of the Gulati Nursing Home and Infertility Centre the Insured Mrs. Poonam Gupta had been treated for Primary Infertility with. Diagnostic Laproscopy and the medicines were also prescribed.

The treatment taken for the Infertility fell under – exclusion clause no.4.4.6.1 of the policy.

In view of the facts and submissions by both the parties, the Complaint was dismissed.

Group : Mediclaim

Complaint No. : AHD-G-048-1617-1384

Complainant : Mr. Manojbhai Ankleshwaria V/s. National Insurance CO. Ltd.

Policy No. 30190048158500005942

Date of Award : 20.03.2017

The Complainant's wife Mrs. Meena M. Ankleshwaria was admitted to Cure Sight Laser Centre, Ahmedabad on 24/10/2015 for Left Eye Cataract surgery & discharged on the same day. His claim for medical expenses of Rs.70,000/- was partially settled for Rs.24,000/-. Deduction of Rs46,000/- was made citing Reasonable & Customary Charges as per the policy terms & conditions. Aggrieved by the decision of the Insurance Company the complainant had approached the Forum with a plea to get his claim settled.

As per IRDAI circular on standardization in health insurance, reasonable and customary charges meant 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.

- The Insurance company could not prove that deduction of Rs.46,000/- was the reasonable and customary charges for cataract surgery in the hospital, where the complainant's wife was operated and it was consistent with the charge for similar surgery in similarly placed hospital in geographical area.

There was no capping / ceiling for payment of cataract surgery under the policy conditions.

- The Respondent's view, as stated in their internal guidelines, for reimbursing the insured as per the package rate/conventional treatment using mono-focal lens, was not in conformity with the policy provisions of paying/reimbursing the reasonable cost of treatment.
- The Respondent had failed to prove that the charges claimed were unreasonable.

In view of the forgoing, the complaint was admitted for Rs.46,000/-.

OMBUDSMAN CENTRE, BENGALURU
INDIVIDUAL MEDICLAIM POLICY

Complaint No: BNG-G-044-1617-0406

Case of: Shri SOMASEKAR R v/s STAR HEALTH AND ALLIED INSURANCECOMPANY LIMITED

Date of Award: 10th January, 2017

Repudiation for non-disclosure of Pre-existing Disease - Upheld

The Complainant had hospitalisation at Goa following a fall and was diagnosed as suffering from cervical cord injury and subsequently he had further hospitalisation at Bangalore also for the said complaint along with Oesophageal Perforation.

The Respondent Insurer repudiated both the claims on the ground that the Insured person had hospitalisation prior to inception of the policy for treatment of right vestibular schwannoma and underwent Right Retromastord Suboccipital Cramectomy, which was not disclosed at the time of taking the Policy which amounted to misrepresentation/non-disclosure of material facts and invoked the policy condition to repudiate the claim. Despite taking up with the Grievance cell, the claim remained unsettled.

The Complainant pleaded that he does not understand English and the proposal form was filled by the Agent and he had just affixed his signature and therefore he could not be held responsible for the non-disclosure of material information.

This Forum, however, opines that the submission of the signed proposal form seeking insurance tantamount to action being done with his knowledge/understanding and consent. As sufficient evidence was placed before the Forum to its satisfaction that the decision of the Respondent was as per the terms of the policy, the Forum found no reason to intervene in favour of the Complainant.

Hence, the Complaint was **Disposed of** accordingly.

*****

Complaint No: BNG-G-044-1617-0458

Case of: MR. GANGADHAR BA V/s STAR HEALTH AND ALLIED INSURANCECOMPANY LIMITED

Date of Award: 10th January, 2017

The Insured was hospitalised and underwent a surgery. The certificate issued by the treating hospital as to the duration of the illness was tampered/manipulated and hence, the same was not accepted by the Respondent Insurer, even though the hospital confirmed the changes by issuing fresh certificates. The Respondent Insurer rejected the claim on the ground of non-disclosure of pre-existing disease and the Grievance Cell also upheld the rejection of the claim.

This Forum observed that -

- The swelling was gradual and attained to the present stage over a period of time and hence, the Insured Patient would have had symptoms and knowledge thereof.
- The alterations made in the certificate of Clinic as to the duration of the illness, did not seem to be accidental.

- The claim occurred within the waiting period for Pre-existing Diseases.

Hence, the decision of the Respondent Insurer in repudiating the claim was in consonance with the terms and conditions of the policy and did not warrant any interference at the hands of the Ombudsman.

******

Complaint No: BNG-G-044-1617-0464

Case of Shri. NATESH H S V/s STAR HEALTH AND ALLIED INSURANCECOMPANY LIMITED

Date of Award: 11th January, 2017

The Complainant underwent Lt. URS + Stone Retrieval + B/L 6/26 DJ Stenting under GA. Prior to porting to the present Insurer, the Complainant had insurance with another Insurer since 2011. The Respondent Insurer repudiated the claim stating that whilst porting to their Company, the proposer did not disclose about having symptomatic Psoriatic Arthritis with skin Psoriatic Spondylitis. Representation to the Grievance Cell also did not yield any relief to the Complainant. Hence, he approached this Forum.

The Forum observed that the claim was under a ported policy and if he had continued with the previous Insurer, his claim would have been entertained. If a claim under the ported policy suffered from the same latches as to pre-existing diseases treating it as a fresh policy, then the very intention of the Regulator to allow porting was certainly defeated. As the claim, would have been payable under the previous policy, it merited payment under the ported policy as well. The Respondent Insurer had definitely not acted judiciously in repudiating the claim.

******

Complaint No: BNG-G-050-1617-0504

Between Shri. VICKY G LAKHANI v/s THE ORIENTAL INSURANCE COMPANY LIMITED

Date of Award: 11.01.2017.

Condonation of delay for renewal – Dismissed.

The Complainant renewed the policy after a delay of 32 days. The Respondent Insurer treated this as a fresh policy and delay was not condoned. As a result, the claim preferred was rejected treating the same as pre-existing disease.

The grace period for the delay in renewing the Policy, as allowed by the IRDA, was 30 days and in the instant case, it exceeded such grace period. Hence, the present illness was treated as a pre-existing disease and the same would stand covered only after 4 years of continuous insurance.

The Form was of the opinion that the discretion of waiving the additional delay beyond the grace period allowed by the Regulator rests solely with the Respondent Insurer and was beyond the preview of this Forum.

The complaint was **Dismissed.**

*****

Complaint No: BNG-G-044-1617-0459

Case of: SHRI N VENKATESH v/s STAR HEALTH & ALLIED INSURANCE COMPANY LIMITED

Date of Award: 11th January, 2017

Repudiation for non-disclosure of Pre-existing Disease - Upheld

The Complainant, during the currency of the Policy was hospitalised and was diagnosed to be suffering from Severe Anaemia, Acute Coronary Syndrome, Acute Pulmonary Edema and Multi Vessel Disease. The claim was rejected on the grounds non-disclosure of pre-existing illness of Chronic liver disease with portal hypertension with oesophageal varices, at the time of proposing the insurance.

However, the Complainant contended that the policy was continuously renewed since its inception and at the time of taking the Policy, he had Diabetes only which he had been duly disclosed in the proposal form and the same was reflected in the policy also. But he did not suffer from any Liver diseases or Hypertension, as mentioned by the Insurer.

The Respondent Insurer submitted that the Insured suppressed his pre-medical condition in the Proposal form and the rejection of the claim was justified.

The Respondent Insurer had produced evidences before the Forum to its satisfaction that indeed there had been a deliberate suppression of information which is material to the underwriting of the policy and therefore, the Forum was of the opinion that the Respondent was well within its right to absolve itself from any liability under the Policy and the Forum had no intention to interfere with the decision of the Respondent.

*****

Complaint No: BNG-G-051-1617-0451

Case of: Shri. V ROHIT RAMANUJAM v/s UNITED INDIA INSURANCE COMPANY LIMITED

Date of Award: 11th January, 2017

Repudiation for non-disclosure of Pre-existing Disease - Upheld

Wife of the Complainant underwent Laparoscopic Myomectomy under GA for Fibroid Uterus (Multiple Fibroids) 24 weeks' size. Upon repudiation of the claim by the Respondent Insurer on the pretext of pre-existing condition, the Complainant contended that it was a sudden onset and before surgery she had enquired with the TPA about the admissibility of the claim and only after getting an assurance from the TPA that the claim would be admissible, she preferred the claim.

The Respondent Insurer submitted that the Insured person had fibroid uterus since 4-5 months prior to the admission into the hospital, which was prior to taking the first policy. Hence, the present illness was treated as a Pre-existing disease/illness and the same was covered after 48 months of continuous insurance, whereas the present claim arose in the first policy period.

This Forum concurred with the decision of the Respondent Insurer and did not require any interference at the hands of the Ombudsman.

*****

Complaint No: **BNG-G-031-1617-0405**

Between Smt. DEVAYA KALIANDA ARATI Vs MAX BUPA HEALTH INSURANCE Co. Ltd

Date of Award : 11.01.2017

Repudiation of claim – Amicably settled.

The Complainant had obtained the policy after undergoing medical test. Subsequently also, she underwent two medical check-ups and no adverse findings were noticed about her health. Her claim for hospitalisation was denied by the Insurer for non-disclosure while proposing for the policy and the policy was also terminated.

The Forum negotiated with the Respondent Insurer and they offered to settle the claim before the commencement of the hearing and the Complainant also consented for the same.

Hence, the complaint was accordingly treated **as Closed** and Personal Hearing was **cancelled.**

****

Complaint No: BNG-G-007-1617- 0452

Between Shri. Arpit Saurabh v/s Bharti AXA General Insurance Company Limited

Date of Award: 11.01.2017

Repudiation of claim - Upheld

The Complainant's wife was treated at the Hospital on OPD basis. Though she was suggested admission into the Hospital took the treatment in emergency ward and requested to consider the claim under Domiciliary Hospitalisation.

The claim was repudiated by the Respondent Insurer as the duration of hospitalisation was less than 24 hours and thus it was not fulfilling the criteria of 'Hospitalisation.' Also the treatment was not listed under the day care category and also didn't fall under Domiciliary Hospitalisation.

The reason for not taking admission into the Hospital was the personal problem and also would not satisfy the criteria of Domiciliary Hospitalisation.

The complaint was **dismissed and treated as closed**.

*****

Complaint No: BNG-G-051-1617-0498

Case of: SHRI A THYAGARAJ V/s UNITED INDIA INSURANCE COMPANY LIMITED

Date of Award: 12th January, 2017

Non-condonation of delay beyond permissible/grace period - Upheld

The Complainant had hospitalisations on 4 occasions and the diagnosis in the final hospitalisation was Recurrent SAIO – Managed conservatively, Periampullary Carcinoma – S/P Whipple Surgery and Tumor Recurrence at Lower CBD with Retroperitoneal Node Metastasis. Upon repudiation of the claim by the Respondent Insurer, the Complainant contended that despite there was delay of 46 days, nothing prohibits the Respondent Insurer to condone such delay despite it exceeded the permissible delay of 30 days for renewal, the agent failed to discharge his duties, as laid by IRDA, by not intimating about the renewal and not ensuring the renewal and also there was lapse on the part of the Respondent Insurer in not intimating about the black listing of the Agent, who serviced previously.

The Respondent Insurer submitted that the present policy was renewed after a gap of 45 days of expiry of previous policy. While renewing the said policy, the complainant was informed that since there was a gap of 45 days from the date of expiry of previous policy, the present policy would be treated as a fresh policy and no benefits of old policy would accrue to this policy since it was being renewed after the permissible/grace period of 30 days. However, he renewed the policy.

The Forum found that the Respondent could not be compelled under the contract or under any guideline of the Regulator and the Forum found no fault on the part of the Respondent regarding its decision to issue a fresh policy. So far as the repudiation of the claim was concerned, the decision was also as per the policy terms, since it was a new policy and the disease being a pre-existing one. Regarding the alleged deficiency in the service of the agent and his alleged black listing by the Respondent, no evidence had been adduced. Therefore, the Forum had no opportunity to intervene on behalf of the Complainant.

*****

Complaint No: BNG-G-031-1617-0453

Between PAPANASAM SAMBAMOORTHY SRIRAM v/s MAX BUPA HEALTH INSURANCE COMPANY LIMITED

Date of Award: 13.01.2017

Cancellation of Policy–Compromised.

Respondent Insurer repudiated the claim on the ground of PED and cancelled the policy. The Complainant represented that the cancellation of policy was unjustified and particularly coverage in respect of his wife and son. He further, represented that he did not question repudiation upon knowing his ineligibility of the claim for non-completion of 48 months. He sought for continuation of the Policy or refund of premium.

With the intervention of this Forum, the Respondent Insurer refunded the premium and the claimant had confirmed receipt of the same.

Thus, the complaint was treated as **COMPROMISED AND CLOSED.**

****

Complaint No: BNG-G-023-1617-0525

Between Dr. PANNEER SELVAM V/s IFFCO-TOKIO GENERAL INSURANCE COMPANY LIMITED

Date of Award: 13.01.2017.

Repudiation of claim – Pre-Existing - Allowed

The Insured person was hospitalised for complaints of severe low backache following a fall resulting in blunt injury to her lower back.

The Respondent Insurer repudiated the claim as it had arisen in the 1st year of the Policy. The Respondent Insurer contended that the patient had pre-existing low backache since 5 years and was under medication on Calcium supplements but the same was not disclosed.

This Forum observed that the patient was administered only Shelcal which was only a supplement and there was no evidence that the illness was pre-existing.

Hence, the complaint was **Allowed.**

****

Complaint No: BNG-G-044-1617-0540

Between Shri KESHAV MALLYA v/s STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED

Date of Award: 13.01.2017.

REPUDIATION OFCLAIM – SUPPRESSION OF MATERIAL FACT - Dismissed.

The Complainant preferred a hospitalisation claim during 1st year of policy stating that the disease was detected a few months after the inception of the policy. Claim was repudiated for non-disclosure of pre-existing illness.

The Respondent Insurer contended that the hospitalisation was within the waiting period of 30 days from the inception of the Policy and hence, not payable. The patient had not disclosed existing ailments in the proposal and hence, Policy was also cancelled and the premium was refunded.

The Respondent Insurer had produced evidences before the Forum to its satisfaction that indeed there had been a deliberate suppression of information, and therefore, the Forum had no intention to interfere with the decision of the Respondent.

Hence, the complaint was **Dismissed**.

****

Complaint No: BNG-G-037-1617-0462

Case of: SHRI VINOD KUMAR R V/s RELIGARE HEALTH INSURANCE COMPANY LIMITED

Date of Award: 13th February, 2017

Repudiation of claim – Compromised.

The Complainant along with his mother was covered under the policy taken by his Employer.
Complainant's mother was hospitalised for acute gastroenteritis and diarrhoea and cashless claim was rejected on the grounds that the admission was primarily for investigation and evaluation. Reimbursement claim was also rejected stating that the ailment did not require hospitalisation and could have been managed on OPD basis.

Despite the Complainant took up with the Respondent Insurer stating that upon the advice of the medical practitioner, she was hospitalised and since she was also considered to be a high risk considering her age and her other complaints of thyroid, diabetes and hypertension. However, his claim was not settled. Aggrieved with the non-settlement of his claim, the Complainant approached this Forum.

In view of the mediation of this Forum, the Respondent Insurer offered to settle the claim and the Complainant had consented for the same and conveyed us his consent to close the Complaint.

Hence, the Personal Hearing was **cancelled** and the Complaint was treated **as Closed.**

*****

Complaint No: BNG-G-044-1617-0631

Case of SHRI UDAY KRISHNA YALAMARTHY V/s STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED

Date of Award: 22nd Day of February, 2017

Repudiation for non-disclosure of pre-existing disease - Compromised

The Policy, under which the Complainant's father was covered, had waiver of 30 days waiting period, 1st and 2nd year exclusions and coverage for all Pre-existing diseases. Before porting to the present Insurer, he had insurance with another Insurer since 09.06.2008.

For hospitalisation of the Insured Person, Cashless and reimbursement claims were rejected by the Respondent Insurer on the ground of non-disclosure of CAG done in 2011, (which showed Coronary Artery Diseases - SVD), whilst porting to the Present Insurer. Aggrieved with the non-settlement of his father's claim, the Complainant approached this Forum.

In view of the mediation of this Forum, before the scheduled hearing, the Respondent Insurer agreed to settle the claim (on submission of all documents) as per the terms and conditions of the Policy including the co-pay @ 30% and the Complainant conveyed his consent for such settlement.

The Respondent Insurer was advised to settle the claim, as agreed upon.

Hence, the Personal Hearing was cancelled and the Complaint was treated **as Closed.**

*****

Complaint No: BNG-G-044-1617-0620

Case of: SHRI B H HAKKI V/s STAR HEALTH AND ALLIEDINSURANCE COMPANY LIMITED

Date of Award: 27th February, 2017

Non-disclosure of Pre-existing Disease – Compromised

Cashless pre-authorisation and claim were denied by the Respondent Insurer on the grounds of non-disclosure of PTCA done in 2000 and the policy was also cancelled.

The Complainant contended that he had PTCA about 16 years before this insurance and he had no signs and symptoms existed at the time of signing up the proposal form and all Diseases existed within 48 months of commencement of the first policy were only to be disclosed. Further, his first claim for his hospitalisation at Dharwad was settled, despite disclosing the complete PCTA details. He, therefore, requested the Respondent Insurer to settle the present claim and do away with the cancellation of the Policy.

Upon mediation of this Forum, the Respondent Insurer agreed to settle the claim and continue the Policy. The Complainant consented for such proposal.

Hence, the Complaint was treated **as Closed** and the Personal Hearing was cancelled.

*****

Complaint No: BNG-G-050-1617-0712

Case of SHRI MANJUNATH N V/s ORIENTAL INSURANCE COMPANY LIMITED

Date of Award: 28th February, 2017

Delay in settlement of the claim – Compromised

Before undergoing the cataract operation, the Complainant approached TPA for cashless settlement. Since there was no response, the Complainant underwent with the said cataract procedure, as scheduled and preferred a claim but his was not settled. In view of the long delay, the Complainant approached the Grievance Cell of the Respondent Insurer, which also remained un-replied to. Hence, he sought the intervention of this Forum.

Upon persuasion of this Forum, before the scheduled Hearing, the Respondent Insurer settled the claim as per the terms and conditions of the policy and the Complainant confirmed the receipt of the claim payment and he consented for closing the Complaint.

Hence, the Complaint was treated **as Closed** and the Personal Hearing was cancelled.

*****

Complaint No: BNG-G-018-1617-0623

Case of SHRI SURESH KUMAR R V/s HDFC ERGO GENERAL INSURANCE COMPANY LIMITED

Date of Award: 1st March, 2017

Repudiation for non-disclosure of pre-existing disease - Compromised

The claim of the Complainant for treatment of Dorsal Space Abscess of Left Foot was repudiated by the Respondent Insurer on the grounds of non-disclosure of pre-existing Disease. In spite of taking up with

the Grievance Cell of the Respondent Insurer, the claim was not settled. Aggrieved with such non-settlement of his claim, he approached this Forum.

Before the scheduled Personal Hearing, a compromise was reached between both the parties that the Respondent Insured would settle his claim.

The Respondent Insurer was therefore advised to settle the claim as per the assurance given to the Complainant and this Forum. The Complainant communicated to this Forum about the withdrawal of his complaint.

Hence, the Complaint was treated **as Closed** and the Personal Hearing was cancelled.

*****

Complaint No: BNG-G-020-1617-0465

Case of MS. HEMALATHA D MANAE v/s ICICI LOMBARD GENERAL INSURANCE COMPANY LIMITED

Date of Award: 1st March, 2017

Denial of Health Claim – Disallowed.

Husband of the Complainant obtained Policy No. (1) 4128i/IHIR/88266944/00/000 - effective from 01.02.2008 and (2) 4113i/XOL/100603478/00/000 - effective from 23.03.2015.

The Insured person was hospitalised on 4 occasions in the same hospital and was diagnosed as suffering from Hypertension, Diabetes Mellitus, Anemia with Hypoprotenemia, Chronic Liver Disease (HBsAg Positive State) and Hyperkalemia with severe Acidosis and had another hospitalisation in a different hospital till his death. All the claims were repudiated by the Respondent Insurer on the grounds of non-disclosure of pre-existing disease of Diabetes Mellitus.

The Complainant contended that her husband was not suffering from Diabetes Mellitus prior to taking his first policy in 2008 and the same was not disclosed by her and her husband, who was not in a position to talk. She wondered how the hospital records were showing the duration of the Diabetes without being informed. Further, she sought for a copy of the Proposal Form submitted while taking the first policy in 2008 but the same was not made available to her.

The Respondent Insurer submitted that the claim records revealed that he was also suffering from Diabetes Mellitus, Positive for Hepatitis B Virus (since 2001), Chronic Liver Disease as well as past Kidney problems. As per the independent medical opinion dated 29.12.2016, chronic alcohol use and Hepatitis B virus are known to cause acute as well as chronic liver disease. Further, long standing diabetes can lead to kidney disease including chronic kidney failure with hyperkalemia. Policy termination was also advised.

From the analysis, the Forum observed that both the policies were covering all the hospitalisations and the policy under which the claim was preferred, was obtained in the year 2008. The audio recording of telesales made available during the hearing which was pertaining to the policy obtained in 2015 and not

to the policy of 2008. They further failed to submit the proposal form obtained for the Policy in which the claim was made. As the Respondent Insurer had failed to provide appropriate supporting documents/recordings pertaining to their repudiation, the Forum was inclined to give the benefit doubt to the Insured and would like the claim to be settled.

*****

Complaint No: BNG-G-044-1617-0536

Case of: SHRI SURESH B N V/s STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED

Date of Award: 28th February, 2017

Repudiation of claim for non-disclosure of Pre-existing Disease - Compromised

Wife the Complainant was hospitalised for a complaint of swelling in the neck since 4 years and was diagnosed as suffering from Papillary CA Thyroid. The Respondent Insurer repudiated the claim for non-disclosure of Pre-existing diseases, whilst porting into their Company. Aggrieved with the non-settlement of the claim, the Complainant approached this Forum and the Complaint was scheduled for a Personal Hearing.

In view of the mediation of this Forum, the Respondent Insurer agreed to settle the claim before the scheduled hearing and the Complainant conveyed his consent for such settlement.

Hence, the Complaint was treated **as Closed** and the Personal Hearing was cancelled.

*****

Complaint No: BNG-G-044-1617-0539

Case of SMT. GOWRI RAMESH V/s STAR HEALTH & ALLIED INSURANCE COMPANY LIMITED

Date of Award: 1st March, 2017

Repudiation of Claim for Laparoscopic Banded TYGB for Morbid Obesity and its co-morbidities – Upheld.

The Complainant had his continuous insurance from the present Respondent Insurer from 14.08.2013 till date. Earlier, he had insurance from Royal Sundarm from 14.08.2008 till he ported to the present insurer.

Insured Person, Smt. Gowri Ramesh R was admitted into Hospital with a history k/c/o Hypothroidism since 15 years and on Tab. Thyronorm (125 mcg-OTPD), had h/o started gaining weight since 15 years, snoring (+), Excessive day time sleeping, Lcthorgy (+), h/o OSA+ and k/c/o Type II DM (recently detected) and was diagnosed as Morbid Obesity, Type II DM, OSA and Hypothyroidism and underwent Laparoscopic Banded TYGB. The claim was repudiated by the Respondent Insurer stating that the said surgery falls under the exclusions of the Policy. The Complainant contended that the patient had the above co-morbidities and the Doctor suggested (certificate submitted) for undergoing the prescribed surgery/treatment to avoid further complications, which were life threatening and not for the purpose of weight reduction.

The Respondent Insurer submitted that the Complainant ported to their Policy on 14.08.2013 but failed to disclose her medical condition. The Insured Person had hospitalisation for treatment of Morbid Obesity, Diabetics Mellitus, Hypothyroidism and OSA and underwent Laparoscopic Banded TYGB for Morbid Obesity i.e., surgery for weight loss and the same was not payable as per Exclusion No. 11 of the Policy.

The Forum among all the papers and documents takes into cognizance the certificate of Dr. M Ramesh which clearly indicated that the patient was suffering from Morbid Obesity along with several co-morbities like hypo thyroidism, Type II DM, Bilateral knee joint pain, exertional dysponea and OSA. The Doctor's certificate categorically stated that the patient underwent the aforesaid procedure for reduction of her weight which would resolve the co-morbidities referred as life threatening co-morbidities. The Forum also examined the Policy terms and conditions exclusively pertaining to this specific condition of the Insured Person and there was an exclusion of the Policy which specifically excluded the expenses incurred on weight control services including surgical procedures for treatment of obesity, medical treatment for weight control, treatment for metabolic, genetic and endocrine disorders". The exclusion was categorical and left no scope. The Doctor certificate clearly stated the laparoscopic RYGB was for reduction of weight but of course also for the resolution of the above mentioned life threatening co-morbid conditions. As the procedure undergone by the Insured Person was primarily excluded under the Policy, any other benefits arising out of such procedure would not make the process qualify the payment under the policy.

Therefore, the repudiation of the claim done by the Insurer was in order and required no interference at the hands of the Ombudsman

*****

Complaint No: BNG-G-044-1617-0668

Case of: SHRI ANANTHANARAYAN RAMAN IYER v/s STAR HEALTH AND ALLIED INSURANCE CO LTD

Date of award: 3rd March, 2017

Repudiation of claim for non-disclosure – Upheld

Insured Person was hospitalised for complaints of breathlessness and uneasiness. Cashless and reimbursement claim (made in 3rd Policy Period) was denied by the Respondent Insurer on the grounds of non-disclosure of pre-existing disease of CAD – Triple Vessel Disease and of undergoing CABG. The Complainant contended that whilst issuing the first policy, the tele-caller enquired about the existing disease and accordingly the information about the condition of diabetes since 15 years, was disclosed and the same was reflected on the policy. However, no question was raised about other complications and hence, he did not provide any further information. He also took up with the Insurance Company stating that CABG (non-disclosed ailment) had no nexus with the present treatment of diabetic nephropathy and cancellation of policy was unjustified.

The Respondent Insurer submitted that the prescription submitted pertaining to the year 2012 disclosed that the patient had a history of Coronary Artery Disease – Triple Vessel disease and underwent CABG (more than 20 years back) and was a k/c/o Diabetic Nephropathy and Diabetic Retinopathy and the same was not disclosed which amounts to breach of 'utmost good faith' and hence the claim was rejected.

The Forum heard the audio in the CD and observed that the proposal was completed by a well versed person who had not disclosed the vital information about the pre-existing condition of the Insured Person, even though he was aware of the same, which amounted to mis-representation/non-disclosure of material fact and invoked the policy condition.

Hence, the claim repudiation was found to be in order and did not require interference at the hands of the Ombudsman.

*****

Complain no: BNG-G-050-1617-0673

Case of: SHRI RANGANATH K HERKAL V/s THE ORIENTAL INSURANCE COMPANY LIMITED

Date of Award: 3rd March, 2017

Rejection of eye treatment - Upheld

The Complainant was administered with Intravitreal Accentrix injection for the diagnosis of Infero Temporal Branch Retinal Vein Occlusion with Cystoid Macular Edema. But, neither the TPA nor the Respondent Insurer responded to the Complainant settled his claims. In view of the delay, the Complainant approached this Forum.

The Respondent Insurer submitted that the duration of stay in the Hospital was less than 24 hours, and the same could have been managed on OPD basis and did not require any hospitalization and was not payable as per policy conditions.

Since this specific procedure neither satisfied the mandatory hospitalisation of a minimum of 24 hours nor being found in the list of Day Care Procedures where such 24 hours mandatory hospitalisation was waived, the Forum was unable to intervene on behalf of the Complainant.

*****

*****

Complaint No: **BNG-G-044-1617-0621**

Between SHRI VISHWANAG HIREMATH V/s STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED

Date of Award: 01.03.2017

Repudiation of Mediclaim – Non-disclosure of facts - Disallowed.

Complainant was hospitalised for the injury sustained in a road accident during the currency of policy and was contended that this hospitalisation has nothing to do with the earlier illness. The fact that his father had giddiness during 2008, was prescribed medicine and had clot of blood was not disputed.

The Insured that to a specific query in the proposal as to whether the insured person suffered from / are is suffering from CVA / Brain Stroke**,** was answered as negative. The Forum was of the opinion that the Complainant had mis-represented the fact of suffering from major illness and obtained the Policy.

The Forum did not want to interfere with the decision taken by the Respondent Insurer in repudiating the claim of the Complainant as per the terms and conditions of policy and the complaint was disposed of.

Hence, the Complaint was **Disallowed.**

****

Complaint No: **BNG-G-007-1617-0506**

Between: Smt. MANISHA GUPTA Vs BHARTI AXA GENERAL INSURANCE COMPANY LIMITED

Date of Award: 01.03.2017

Repudiation for non-disclosure of Pre-existing Disease – Compromised.

The Complainant had continuous health insurance since 2011. Her claim for hospitalisation was repudiated on the grounds of non-disclosure of pre-existing medical condition. She contended that that the papers relating to her previous health condition were submitted to the Respondent Insurer and they obtained a special permission from their higher offices for accepting the said proposal that it was their responsibility to ensure proper and complete filling up the proposal.

During the Personal Hearing, the Respondent Insurer offered to settle the claim and to renew the Policy and the Complainant agreed for the same.

Hence, the complaint was accordingly treated as **Closed.**

****

Complaint No: **BNG-G-037-1617-0555**

Between SHRI VINOD C Vs RELIGARE HEALTH INSURANCE COMPANY LIMITED

Date of Award: 01.03.2017

Repudiation for non-disclosure of Pre-existing Disease – Upheld.

The claim was repudiated on the ground of suppression of pre-existing disease of Diabetes Mellitus. The Respondent Insurer contended that as per the Hospital records, the claimant had undergone PTCA, had

'DM 4 years'. The Discharge Certificate of the same Hospital stated that the patient was a diabetic and another statement which contradicted the former. Therefore, Discharge Certificate could not be taken as an evidence. The Claimant had come up with a clarification issued by the same Hospital where he was treated, stating that the hospital records erroneously mentioned that he was diabetic since 4 years but confirmed it as 18 months duration on examination of other records.

Under the circumstances, the Forum was inclined to accept the clarification of a reputable institution and give the benefit of doubt to the Complainant Insured.

Hence, the Complaint was **ALLOWED.**

****

Complaint No: **BNG-G-037-1617-0571**

Between SHRI AMAR CHANDWANI Vs RELIGARE HEALTH INSURANCE COMPANY LIMITED

Date of Award: 01.03.2017

Repudiation of Mediclaim – Pre-existing Disease - Upheld

The Complainant was admitted into hospital for removal of earlier inserted implant from the elbow, was denied by the Respondent Insurer on the grounds of non-disclosure of material fact and non-completion of waiting period for PED.

The repudiation of the claim pertained to pre-existing disease that the insured suffered from. The insured had informed the Respondent Insurer about a fracture he suffered but did not specifically mention that screws had been implanted surgically on the broken arm to fix it. The claim was for reimbursement of expenses incurred for the removal of such screws implanted. The injury occurred long before the policy was availed and the removals of screws were only related to that injury. Therefore, under a new policy any injury/disease which had occurred prior to the inception of the policy would not be covered as per the policy terms. Therefore, the Forum had no opportunity to intervene in favour of the Complainant.

Hence, the Complaint was **DISMISSED.**

****

Complaint No: BNG-G-044-1617-0675

Between SHRI GOPAL B RAICHUR V/s STAR HEALTH AND ALLIED INSURANCE COMPANY LIMITED

Date of Award: 01.03.2017

Repudiation of Mediclaim – Pre-existing Disease - Disallowed.

The claim had been filed under a specially designed Senior Citizen Policy with exclusive terms and conditions. The policy among other things excluded any claim pertaining to a pre-existing disease in the 1st year of the Policy. The Complainant, as per the records available with the Forum, had undergone

treatment for the same ailment (for which the claim has been filed) 1 month prior to the commencement of the policy The doctor's certificate and hospital records were absolutely clear that the patient's ailment was but a continuation of the previous ailment and its treatment. Under the circumstances, the Forum had no opportunity to intervene in favour of the complainant.

Hence, the Complaint was **Disallowed.**

*****

Complaint No: BNG-G-044-1617-618

Case of: SMT. MALINI V/s STAR HEALTH & ALLIED INSURANCE COMPANY LIMITED

Date of Award: 1st March, 2017

Repudiation of Mediclaim – Partially Allowed.

The Complainant's husband was inter-alia covered since 2010 continuously without break of Insurance. The Respondent Insurer rejected the hospitalisation claim of the Insured person for complaints of loose stools & decreased in urine output and was a k/c/o Decompensated Chronic Liver Disease (DCLD) with portal hypertension with (R) LL Cellulitis and Spontaneous Bacterial peritonitis (SBP). The rejection was for non-disclosure of a pre-existing disease. The Insured Person died during the course of the hospitalisation. Despite she took up with the Insurer that he gave up alcohol consumption since 2005, her claim was not honoured. She further added that her husband's earlier claim in 2014 was repudiated and the Insurer, by then, was aware of her husband's health condition and could have stopped collecting premium, if no claim could to be entertained, considering his health condition.

The Respondent Insurer submitted that he was a known case of Chronic Alcoholic Liver Disease since 16 years, which was prior to taking the first policy in 2010 and the discharge summary of the present hospitalisation confirmed that he was a k/c/o Alcoholic Liver Disease with Alcoholic hepatitis which was a result of alcohol intake, which was not covered under the Policy.

After careful scrutiny of the Discharge Summary for his hospitalisation during October, 2015, it was observed that the Insured was a chronic alcoholic since 16 years (by then) with an intake of about 180 ml per day and also a chronic tobacco chewer and smoker, since his childhood and was diagnosed as suffering from Chronic Alcoholic Liver Disease (alcoholic hepatitis) (Cirrhosis with portal HTN). Thus, the records confirm that the hospitalisation was on account of alcohol consumption and tobacco chewing, which is specifically excluded under the policy and hence, the denial of the claim was in order. Non-disclosure of his previous health condition also merits repudiation of the claim as such non-disclosure is much relevant for the subject claim.

Further, Progress Report of the same hospital dated 16.10.2009 confirms that he started taking alcohol again, which rendered the Complainant's statement that he gave up alcohol consumption since 2005, as incorrect. Thus, the repudiation of the claim was found to be in order and requires interference in the hands of the Ombudsman.

On critical scrutiny of the proposal form, the Forum observed that the said proposal form was signed *'on behalf of the Insured'* and not *'by the Insured.'* Therefore, the Insurer was found to be guilty of accepting such proposal and thus the contract which was based on the said proposal form, was rendered void, since inception of the policy.

*****

Complaint No: **BNG-G-050-1617-0617**

Between Shri. C N ANANTHARAM V/s THE ORIENTAL INSURANCE COMPANY LIMITED

Date of Award: 03.03.2017

Short settlement of Mediclaim - Partly Allowed

The dispute pertains to reduction of the amount reimbursed by the Insurer against the claimed amount. The Forum analysed the different heads under which the claim amount had been reduced. The Forum found that the Respondent Insurer's decision regarding the reduction of Anaesthesia charges, Surgeon fees and assistant charges under the pretext of Customary and reasonable charges, had not been explained appropriately. The Forum did not concur with the submission of the Respondent Insurer that they have considered the overall charges for similar procedure in Network hospitals Therefore, the Forum directed the Respondent Insurer to reimburse these amounts.

However, the Forum was of the opinion that any specific deduction should be logical and in consonance with the terms of the Policy.

Hence, the Complaint was **Partly Allowed.**

****

Complaint No: **BNG-G-050-1617-0676**

Between SHRI MAHENDRA M BAFNA V/s THE ORIENTAL INSURANCE COMPANY LIMITED

Date of Award: 03.03.2017

Repudiation of Mediclaim - Dismissed

The Complainant was covered under an Individual Mediclaim policy since 2008 and during the currency of the policy, she underwent re-suturing of abdominal wound gape. The Complainant pleaded that the re-suturing was independent of the earlier procedure and therefore his claim was payable under the policy.

The Respondent Insurer stating it to be maternity related complications, an exclusion under the Policy repudiated the said hospitalisation claim on the grounds that the treatment taken was a complication of maternity, which was excluded in the Policy vide exclusion no. 4.12.

As the policy specifically categorically excluded any treatment arising from or traceable to pregnancy, child birth, miscarriage, abortion or complications any of these. The particular procedure of re-suturing was found to be a complication of the incision made during hysterotomy. As the decision of the Respondent Insurer was as per the terms of the policy, this Forum found no reason to intervene on behalf of the Complainant.

Hence, the Complaint was **Dismissed.**

****

Complaint No: **BNG-G-020-1617-0574**

Between SHRI HAJI ISHAQ SAIT v/s ICICI LOMBARD GENERAL INSURANCE COMPANY LIMITED

Date of Award: 03.03.2017

Partial settlement of claim – Allowed

It was a case of partial settlement of the claim for hospitalisation during the currency of the policy for treatment of Type II DM, HTN and cellulitis to his right leg and his claim was settled for a meagre amount. Respondent Insurer contended that they informed the Complainant that he opted for Sub-limit 'A' at the time of inception and the claim was settled, as per the policy terms and conditions.

The basic dispute pertains to the applicability of Extension HC 28 which reads as 'All Medical Expenses for any treatment not involving surgery/medical procedure.' to the hospitalisation in question and as well the Tele-caller did not inform about the 'Sub-limit A'. During personal hearing it was confirmed to have informed at the time of soliciting the proposal application of sub-section 'A' for the claims.

However, considering the subject hospitalization for 11 days and the treatment being provided, this Forum was of considered opinion that the subject treatment fell under healthcare, which was defined as a medical procedure and hence, it would not fall under Extension HC 28. The Respondent Insurer was advised to settle the claim as per the terms and conditions of the Policy, save Extension HC 28.

Hence, the Complaint was **Allowed**.

****

Complaint No: **BNG-G-044-1617-0631**

Between SHRI SRIKAR RAI Vs STAT HEALTH & ALLIED INSURANCE COMPANY LIMITED

Date of Award**: 03.03.2017**

Repudiation of claim - Disallowed

The patient underwent D & C in the year 2013.The policy was obtained in the year 2015 and as per the request of the Complainant**,** the policy was cancelled and the premium was refunded. The repudiation of claim was on the ground of non-disclosure of material information and the present illness did not complete the waiting period.

The Forum observed from the Proposal Form that the details of previous D & C was not disclosed and to a specific query which was relevant to this claim was stated as 'NA'. However, the records which were prior to commencement of the first policy, had indicated that she had the illness related to 'Uterus' prior to taking the policy but the same were not disclosed in the proposal form which was a non-disclosure of pre-existing disease.

Hence, the Complaint was **Disallowed.**

****

Complaint No: **BNG-G-044-1617-0633**

Between SMT. RAVANAMMA N V/s STAR HEALTH AND ALLIED INSURANCECOMPANY LIMITED

Date of Award : 03.03.2017

Repudiation of claim for non-disclosure - Dismissed

During the currency of the Policy, the Complainant was hospitalised for treatment and the claim was repudiated on the grounds of non-disclosure of pre-existing disease. It was contended that the proposal was not filled by her and she had just signed the papers.

The Respondent Insurer submitted that the Insured Patient was treated in the same hospital during 2010 but the same was not disclosed while taking the first policy, which amounts to non-disclosure of material facts.

This Forum also observed that with regard to a specific query in the proposal which was relevant to this claim was answered as negative. Further, considering her job profile, the Forum was not inclined to accept her version of Proposal Form being filled by the Agent of the Respondent Insurer and the same was signed without looking into details. Under the circumstances, the Forum found no opportunity to intervene in the matter.

Hence, the Complaint was **Dismissed.**

****

Complaint No: BNG-G-044-1617-0743

Case of: SHRI ANUP JOSE A V/s STAR HEALTH AND ALLIED INSURANCECOMPANY LIMITED

Date of Award: 31st March, 2017

Non-extension of waiting period of previous policy – Dismissed.

The complaint arose out of the repudiation of the claims on the ground that the surgeries of cataract and Inguinal Hernia Rt, which the Complainant underwent, were within the waiting period for such diseases.

The Complainant contended that prior to taking the present policy, the Insured person was covered under a group policy and the credit for duration of such group policy should be extended to him.

On careful examination of the documents on record, the complaint and the response of the Insurer, the Forum decided to dispense with the necessity of personal hearing and decide the case.

On scrutiny of the Regulator's guidelines, it was observed that the benefit of waiting period of group policy shall not accrue to an individual policy taken with a different Respondent Insurer. Therefore, the said surgeries would fall within the stipulated waiting periods thereof.

Hence, the complaint was D**isallowed.**

*****

Complaint No: BNG-G-051-1617-0604

Case of: SHRI GEORGE JOSEPH V/s UNITED INDIA INSURANCE COMPANY LIMITED

Date Award: 3rd March, 2017

Rejection of administration of an injection to eye – Upheld.

The wife of the Complainant was administered with Intravitreal Ozurdex Implantation under local anaesthesia for a diagnosis of non-infectious Posterior Uveitis for her right eye. The Respondent Insurer repudiated the claim stating no hospitalisation was involved and also the said procedure was not enlisted in the Day Care Procedures. The Complainant pleaded before this Forum that the he had been continuing this insurance with the present insurer since 22 years continuously and earlier 2 claims for the same procedure were settled. He further went on to explain that the present treatment involved an administration of injection into the eye under local anaesthesia and the patients were allowed to go home in almost all eye procedures including Cataract, which was allowed under the policy even though, the said cataract procedure did not involve 24 hours hospitalisation.

The Respondent Insurer's Representative submitted that the earlier claims were for the same procedure, settled by them by oversight and maintained their earlier stand.

On a careful scrutiny of the papers on record and submissions made, the Forum observed that the said procedure did not satisfy the definition of the hospitalisation as it did not involve hospitalisation for a minimum period of 24 hours and further it did not figure in the procedures listed out in Day Care Procedures. Considering the foregoing and also the admission of Respondent Insurer about settlement of 2 previous similar claims by mistake, the action of the Respondent Insurer in repudiating the claim was found to be in order. Moreover, an erroneous payment would not justify settlement of another subsequent claim.

*****

Complaint No: BNG-G-044-1617-0709

Case of: DR. GNANESH B N V/s STAR HEALTH AND ALLIED INSURANCECOMPANY LIMITED

Date of Award: 31st March, 2017

Repudiation for non-disclosure of pre-existing Disease – Upheld

The Complaint was filed for repudiation of claim for the non-disclosure of the pre-existing disease.

The Complainant contended that health reports were taken for obtaining visa for going abroad based and he was hale and healthy based on such reports and such reports were taken a little before the commencement of the first policy. Further, he started taking medicine in the year 2015 when his creatinine levels shot up from 4.00 to 12.00 and not from the time of taking the policy.

On a careful examination of the documents on record, the Forum decided to dispense with the necessity of holding personal hearing of the parties.

The Respondent Insurer submitted a copy of DMSA Scan Report which revealed that the right kidney functioning was at ≥ 95% and that of the left kidney was at ≤ 5%, which was prior to taking his first policy. It was also noticed from the documents that about a week later after taking the policy, the Complainant had a complete/comprehensive check-up and was diagnosed as suffering from CKD and HTN and was prescribed suitable diet and 4 gms. salt and his serum creatinine levels were @2.00 mg/dl, which exceeded the permissible upper limit of 1.5 mg/dl.

In the light of the above, it was but obvious that the Complainant's diseases were pre-existing which the Complainant Insured was aware of, but did not declare thereby justifying the application of the exclusions under the policy. Moreover, his contention that he was unaware of the illness, therefore, holds no water and the Respondent was well within its right to cancel the policy.

*****

Complaint No: BNG-G-050-1617-602

Case of: SHRI JOY JOSEPH V/s THE ORIENTAL INSURANCE COMPANY LIMITED

Date of Award: 31st March, 2017

Denial for Pre-existing condition – Dismissed

The Complainant's wife had hospitalisation for complaints of generalised weakness for 1 month and was diagnosed as suffering from Pancytopenia with Vitamin B12 deficiency.

The Respondent Insurer repudiated the claim stating it to be a known case of 'easy fatiquibility" since 2-3 months and had 'postural giddiness' since a few months which was a possible symptom for anaemia and hence it was a pre-existing disease and had fallen under exclusion of the policy.

The Complainant represented that the Anemia was noticed a month before hospitalisation and a certificate of a treating doctor confirmed the same.

The Forum found the documents on record to be sufficient for its decision and therefore, the necessity of holding personal hearing was dispensed with.

The Forum observed that there was no sufficient record on file to confirm that the patient had the complaints prior to commencement of the policy. Further, the Forum also feels that the posterior giddiness of few months need not be construed as necessarily prior to thirty days after the commencement of the policy. Under the circumstances, the Forum giving the benefit of doubt to the Complainant, conceded to the version of the Complainant that the disease was contacted after 30 days of the commencement of the Policy.

The Complaint was **Disposed of** accordingly.

*****

Complaint No: BNG-G-035-1617-0698

Case of: SHRI RAMASUBRAMANIAN S V/s RELIGARE HEALTH INSURANCE COMPANY LIMITED

Date of Award: 31st March, 2017

Partial repudiation of Claim under exclusions of the Policy – Upheld.

The Complaint arose out of the partial repudiation of claim under an Overseas Health Insurance, for reimbursement of expenses incurred for Physiotherapy, Shoulder Immobiliser, medical bills and expenses incurred in India for follow-up treatment. The Respondent Insurer contended that they were not payable as per the terms and conditions of the Policy.

On careful examination of the documents on record, the complaint and the response of the Respondent Insurer, the Forum decided to dispense with the necessity of holding a personal hearing.

On scrutiny of the documents and policy exclusions nos.2.1.3 (xvi), 2.1.5 (IV) & 3 (m) submitted by the Respondent Insurer, the Forum observed that the non-payment of Physiotherapy Charges, Shoulder Immobiliser Charges, medical bills and expenses incurred in India for follow-up treatment were in tune with the Policy issued.

Hence, the Complaint was **Dismissed.**

*****

Bhopal Ombudsman Centre

Case no. BHP-G-051-1617-0112

Mr.Anil Kakar

V/s

United India Insurance Co.Ltd.,Bhopal

Date of Award:05/10/2016

Facts:

The complainant was admitted in Matashree Netralaya, Bhopal for treatment of Left Eye diagnosed as BRVO with Macular Odema. Thereafter he lodged the claim with Respondent Company for reimbursement of expenses Rs.29,388/- incurred by him. Respondent company repudiated the claim on the grounds of exclusion of policy clause no.4.18.

Findings and Decision:

The complainant argued that during first and second quarter of 2015 the company has already paid for the same treatment. However, the complainant is about 63 years old and is administered I/V accentrix injection on regular basis. This injection is given for the treatment of Choroidal Neovascular Membrane which is age related macular degeneration. The same is categorically excluded under clause 4.18 of the terms & condition of the policy. The repudiation is proper.

In view of all these facts and circumstances, I feel it just, fair & equitable to dismiss the complaint as not justifiable.

Case No. BHP-G-020-1617-0101

Mr.Surendra Kumar Jain

V/s

ICICI Lombard General Ins.Co.Ltd., Bhopal

Date of award:05/10/2016

Facts:

The insured Mrs Shanti Devi was hospitalized at Shalby Hospital Indore from 30/06/2016 to 01/07/2016 for cardiac treatment, thereafter, she was admitted in Krishna Institute of Medical Sciences, Hyderabad on 09/7/2016 for heart surgery diagnosed as CAB. Complainant applied through hospital for cash less facility on 09/07/2016 which was denied on the grounds of pre-existing disease i.e. PTCA done in the year 2004.

The SCN is submitted by the Respondent Company stated that the insured had taken cardiac treatment (PTCA) on 20/12/2004 at Escort Heart Hospital ,Faridabad and also known case of DM ,hypertension as per past history recorded by this hospital. Since the proposer had not disclosed this pre-existing disease at the time of insurance and also given negative reply recorded in CD, submitted by the respondent company.

Findings and Decision:

During hearing, it is observed that the cash less facility was denied by the respondent and complainant never submitted any claim. The respondent company had no opportunity to decide the claim. The complaint is premature.

In view of all these facts and circumstances, I feel it just, fair & equitable to dismiss the complaint as premature.

Case No. BHP-G-051-1617-0103

Mrs. Madhu Tanvar

V/S

United India Insurance Company Ltd. Indore.

Date of award:07/10/2016

Facts:

Complainant was covered under mediclaim policy issued by the respondent. It is further said that complainant was suffering from abdominal pain, loose motion, vomiting since 2-3 days therefore, she was hospitalised wef 19/07/2015 to 21/07/2015 at Arpan Hospital, Indore. During the hospitalization Acute Gastro Enteritis was diagnosed. After discharge complainant has filed claim on 13/08/2015, for reimbursement of incurred amount with the respondent company but Respondent insurance company repudiated her claim on the ground of late submission of claim papers.

Finding and Decision:

The complainant stated that she was hospitalized from 19.07.2015 to 21.07.2015 and rest advised by the doctors. The claim was filed on 13.08.2015. The complainant's husband is no more. Considering the explanation of delay is reasonable. The repudiation nearly on the ground of delayed submission is not proper.

In view of these facts and circumstances, I feel it just fair and equitable to award that respondent shall consider the claim filed by the complainant and pay the allowable sum as per the terms and conditions of the policy to the complainant as full and final settlement of the grievance complaint.

Case no. BHP-G-003-1617-0086

Ms. Sapna Mangal

V/S

Apollo Munich Health Insurance Company Ltd. Indore.

Date of Award:10/10/2016

Facts:

The complainant was suffering from on / off fever, abdominal pain, loose stool on / off last 15 days and therefore, admitted in Medi-Square Hospital Indore, from 18/08/2015 to 21/08/2015, in which various medical tests like Australia Antigen Test, Blood, Sonography were conducted. In the Sonography report suggested to assess chronic liver disease for confirmation of Hepatitis C ailment. Finally Hepatitis- C was confirmed by the SRL Diagnostics Test Report dated 01/09/2015.Treating Dr.B.S.Thakur Cosmos Gastro & Path Lab. Indore, has given a certificate stating that complainant was diagnosed Chronic Hepatitis "C" related to Chronic Liver Disease and advised treatment for 12 weeks. After discharge she has filed 6 claim cases for reimbursement of medical expenses with the respondent company for Rs.3,25,544/- out of which Rs.1,61,313/- has been paid. Thus complainant has filed complaint for balance amount.

The respondent in their SCN stated that the claim of Complainant's / Insured,s was diagnosed Acute gastroenteritis with Acute abdomen pain and was admitted for the management of chronic liver disease. After discharge she filed 6 claims for reimbursement. After processing of all claims,2 claims were settled which were admissible and remaining claims were repudiated which were not related to the said ailment.

Finding and Decision:

During the time of hearing it was observed that As per medical literature Hepatitis -C is a liver disease caused by the Hepatitis- C virus, the virus can cause both acute and chronic hepatitis infection, Symptoms may exhibit fever, fatigue, decreased appetite, abdominal pain, dark urine etc. During hospitalization Hepatitis Markers- (BY CLIA) test was conducted on 20/08/2015. This was found positive and acute HCV infection was diagnosed. It was also indicative of Hepatitis " C" ailment. Therefore the patient was advised for further tests and as per test report dated 01/09/2015 Hepatitis " C" was confirmed. Obviously all the symptoms necessitating hospitalization were caused by Hepatitis-C which was detected on 20.08.2015 during

hospitalization and confirmed on 01.09.2015. In the meantime the patient was discharged from the hospital on 21/08/2015. Further all the claims are within 90 days of the hospitalization and respondent insurance company has already settled some of these claims and paid the amount incurred to the complainant. There is no reason to allow some of these claims and repudiating others on the ground that the bills are not related to main claim.In fact, all the expenses for consultation, investigations and medicines are related to main ailment and are within 90 days after discharge from the hospital and are, therefore, payable under policy coverage i.e. expenses incurred after post hospitalization.

In view of these facts and circumstances, I feel it just fair and equitable to award that the respondent Apollo Munich Health Insurance Co. Ltd. shall consider all the mediclaim claims filed by the complainant and pay the allowable sum as per the terms and conditions of the policy to the complainant as full and final settlement of the grievance complaint.

Case no. BHP-G-050-1617-0114

Mr.Pradeep Pipaliya

V/s

Oriental Insurance Co.Ltd., Indore

Date of award:27/10/2016

Facts:

The son of complainant Mr.Ketav Pipaliya hospitalized at Arpan Hospital & Research Centre Indore, for the period 09/10/2015 to 13/10/2015 for treatment of Dengue Fever. Complainant had lodged the claim with Respondent Company for reimbursement of the expenses Rs.25,057/- incurred by him. Respondent company had settled claim for Rs.20,211/- after deduction of Rs.2,600/- towards registration charges Rs.100/- and higher amount paid to doctor's visits Rs.2,500/- as per discharge voucher cum consent letter of respondent company.

The SCN is submitted by the Respondent Company during hearing and stated that the TPA settled the claim as per the conditions of policy of Customary and reasonable charges.

Findings and Decision:

The only dispute is regarding doctor's visit charges @ Rs.1500/- per visit and the amount allowed by respondent @ Rs.1000/- per visit for total five visit.As per TPA's letter dated

22.09.2016, the amount has been restricted under Reasonable & Customary clause after comparing the visiting charges of some other hospitals at Indore. However, the respondent company failed to produce the details of doctor's visiting charges prevalent in these hospitals. Under these circumstances, it cannot be said that the amount has been disallowed on reasonable grounds.

In view of these facts and circumstances, I feel it just fair and equitable to award that the Respondent insurance company should allow the claim of the complainant for Rs.2500/- (less 10% to be born by the insured) and shall pay Rs.2,250/- to the complainant as per Terms & Conditions of the policy as full and final settlement of the grievance complaint.

Case no.27/10/2016

Mr. Harpal Singh

V/S

Oriental Insurance Co. Ltd. Indore

Date of Award:27/10/2016

Facts:

It is pertinent to mention material facts about the issuance of the insurance policies. Insured was taking regular policy from the Respondent insurance company since 2009. It is further stated by the complainant that he had no complaint of Diabetes or Hypertension till 2013, suddenly he developed chest pain in Aug.2015 and Angioplasty was performed on 31/08/2015 at Mohak Hi-Tech Specility Hospital, Indore. Thereafter, Claim was lodged for reimbursement of incurred amount but respondent company has repudiated the claim stating that said ailment is excluded for 4 years from the policy coverage under exclusion clause 4.1 of the policy.

The respondent have filed their SCN / reply contended that complainant was suffering from Diabetes Mellitus for the last 20 years and also he is hypertensive for the last one year which is one of complication of CAD. As the policy is running in 4th year and claim is filed within 4 year which is excluded under T & C of policy. As per medical history the claim is not admissible under general terms and conditions 4.1of the policy.

Findings and Decision:

The Complainant is having mediclaim policy continuously since 27.01.2012. The respondent repudiated the claim on the ground that as per prescription of Dr.Siddhant Jain dated 25.08.2015

the patient was a known case of DM for last 20 years and the same was not disclosed at the time of taking a policy. The complainant produced a prescription dated 10.06.2013 from Dr. B. Rajpurohit as per which his sugar level was quite high and even after taking medicines for six months, the sugar level was more or less same. The prescription in no way support complainant's case. Another letter dated 18.01.2016 from Dr.Siddhant Jain was submitted by the complainant. As per this letter, DM Type II was wrongly written as for 20 years instead of 2 years. The handwriting in prescription dated 25.08.2015 and letter dated 18.01.2016 are obviously of different persons. The letter dated 18.01.2016 cannot be relied on because of so many inconsistencies including the fact that it is signed by Dr.W.Biswas.

In view of these circumstances, this forum is of the view that the repudiation is proper and does not call for any interference. Hence, complaint stands dismissed.

Case no. BHP-G-048-1617-0115

Mrs.Sudha Jaithliya

V/s

National Insurance Co.Ltd.,Indore

Date of Award:03/11/2016

Facts:

The complainant was hospitalized from 19/04/2016 to 24/04/2016 in Breach Candy Hospital Trust, Mumbai for the treatment of Inter vertebral disorders /HNP L4-L5 with LCS. She underwent Laminotomy and lodged a claim for reimbursement of incurred expenses Rs.4,11,204/- but TPA paid only Rs.1,46,880/- after deduction of Rs.2,64,324/- vide settlement letter dt.12/07/2016.

The Respondent company in their SCN stated that the insured had taken the treatment from non-network hospital which has charged much more then charged by the hospitals under their network GIPSA PPN. Therefore, respondent company allowed the rates as per GIPSA PPN and also as per terms and conditions of the policy.

Findings and Decision:

The complainant was treated for Inter vertebral disorders /HNP L4-L5 at Breach Candy Hospital, Mumbai. At the time of enrolment of policy, the respondent company had provided the list of

hospital under GIPSA PPN at Indore. As per this, the approved rates for the relevant treatment vary from Rs.1,02,000/- to Rs.1,22,400/-. The Respondent company taking reference to clause 3.29 of reasonable & customary charges, have restricted the payable amount to Rs.1,22,400/- + 10% for non PPN facilities+10% for other complication. It has accordingly paid Rs.1,46,880/-, which appears to be reasonable under the circumstances.

In view of all these facts and circumstances, I feel it just, fair & equitable to dismiss the complaint as not justifiable. A copy of the award may be sent to the Complainant and the Respondent Insurance Company for information.

Case no. BHP-G-049-1617-0119

Ms. Trilochan Kour

V/S

The New India Assurance Co. Ltd. Bhopal.

Date of award:03/11/2016

Facts:

The complaint's husband and his family was covered under mediclaim policy since 2009 issued by the Respondent company. It is stated that her husband was admitted in the Peoples Hospital, Bhopal from 30/12/2015 to 11/01/2016 for the treatment of liver ailment, he expired during hospitalization. Respondent company has repudiated the claim, stating that patient was admitted for alcohol liver disease and treatment related to chronic alcohol consumption is excluded from the scope of the policy. Hence, claim is not admissible under exclusion 4.4.6.1 of the policy.

During the time of hearing respondent's representative have explained and submitted OPD records along with USG reports which clearly exhibit Patient is chronic alcoholic since childhood, therefore, fatty liver shows chronic liver disease.

Finding and Decision:

The claim was repudiated by the respondent company in view of clause 4.4.6.1, as per which illness/injury caused by use of intoxicating drug/alcohol is excluded. Repudiation is well based.

In view of all these facts and circumstances, I feel it just, fair & equitable to dismiss the complaint as not justifiable.

Case no. BHP-G-044-1617-0122

Mr.Pawan Nalotia

V/S

Star Health and Allied Insurance Co.Ltd.,

Date of Award:17/11/2016

Facts:

The complainant Mr. Pawan Nalotia has got Family floater mediclaim policy renewed from the same insurance company M/s Star Health and Allied Insurance Co.Ltd.,Bilaspur for the period 31/08/2016 to 30/08/2017 for the same sum insured Rs.5,00,000/- and paid renewal premium Rs.29,199/- and got their renewal policy no.P/201311/01/2017/000421. The complainant was disagree for enhancement of premium due to change of age band ie 36-45 to 46-50, as the age of (oldest one) Mr. Pawan Nalotia, insured was 46 years and 9 months.

SCN submitted by the respondent company with supporting documents stated that this is the renewal of previous year policy no.P/201311/01/2016/000290 which was issued for the period 31/08/2015 to 30/08/2016 , where the premium was charged Rs.16,410/- plus service tax Rs.2,297/- total Rs.18,707/- as the age of (oldest one) insured, Mr.Pawan Nalotia was 45 years and 9 months, therefore , the premium of age band 36-45 was charged but at the time of renewal of this policy the age of insured (oldest one) was 46 years and 9 months i.e. completed 46 years hence the premium of next age band 46-50 was applicable and accordingly, the renewal notice was issued on 03/07/2016 i.e. well before, around 2 months of renewal and enhanced premium was demanded. It is also stated that the brochure of this policy was also given to the insured which also clearly showing the premium based on age band wise. The respondent company in support of their practice submitted the approval of IRDA under file and use regulations. Gazette of India: Extraordinary IRDA Notification dt.12/07/2016 part III-sec.4 at sl.no.7 Principles of Pricing of Health Insurance Products (a) The Premium for a health insurance policy shall be based on, (i) "for individual policies, the completed age of the prospect on the date of inception of the policy or **on the date of its renewal".** The respondent company contended that renewal premium was rightly charged as applicable for the respective age band and there is no excess charged.

Findings and Decision:

As per IRDA guide lines, premium for Health Insurance Policy is to be based on age of insured. In this case at the time of entry, the age of Mr. Pawan Nalotia was in 36 - 45 years bracket. In the current year, he falls in the next bracket as he has already completed 46 years. Accordingly the premium has rightly been enhanced. In view of all these facts and circumstances, I feel it just, fair & equitable to dismiss the complaint as not justifiable.

Case no. BHP-G-044-1617-0121

Mr. Anil Kumar Rai

V/S

Star Health & Allied Insurance Co. Ltd.,C.G.

Date of Award:28/11/2016

Facts:

The son of the complainant was suffering from broncho pneumonia. Therefore, admitted for further management from18/10/2015 to 20/10/2015 at J L N hospital and Reserch Centre, Bhilai. During hospitalization Broncho Pneumonia was diagnosed. The claim was rejected by the respondent stating that as per medical record dated 24/02/2015 insured's child is a case of prematurity polycythemia neonatal seizure and sepsis at birth which is prior to inception of mediclaim policy i.e. 27/03/2015. The SCN / reply has been filed by the respondent company stated that they have rejected the claim as per the Condition No.8 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 claim.

Findings and Decision:

During the course of hearing, it emerge that the newly born baby was suffering from MIAF and had also suffered seizure episode during first week after the date of delivery. These problems were not disclosed in the proposal form submitted by the complainant. The mediclaim has been rightly repudiated by the respondent. In view of all these facts and circumstances, I feel it just, fair & equitable to dismiss the complaint as not justifiable

Case no. BHP-G-048-1617-0152

Ms. Snehlata Jain

V/S

National Insurance Co. Ltd. Jabalpur

Date of award:08/12/2016

Facts:

The complainant stated that she was suffering from pain in cervical collar region, therefore she underwent for hospitalization. Cervical Spondylolisthesis with Rediculopathy was diagnosed and she was admitted from 25/11/2015 to 26/011/2015 at Best Super Specialty Hospital, Jabalpur. The respondent company repudiated the claim stating that admission of patient was primarily for investigation and evaluation purpose, there was no active treatment given during hospitalization. Hence, claim is not admissible under exclusion 4.10 and 4.13 of the policy.

Findings and Decision:

After going through the discharge certificate, it is seen that the patient was admitted only for diagnostic & evaluation purpose. Claim has been rightly repudiated by the respondent.

In view of all these facts and circumstances, I feel it just, fair & equitable to dismiss the complaint as not justifiable.

Case no. BHP-G-050-1617-0125

Mr. Prabhat Mittal

V/S

Oriental Insurance Co. Ltd. Satna.

Date of Award: 08/12/2016

Facts:

Complainant has stated that her husband was suffering from brain ailment and admitted in Neuro surgery Dept. from 25/07/2016 to 31/07/2016 at Bombay Hospital, Mumbai and

underwent for further management, later he was admitted at Tata Memorial Hospital where he died on 27/06/2013. Respondent company has repudiated the claim stating that due to Non-compliance of the requirement of TPA claim file has been closed. Respondent insurance company have filed their SCN / reply and contended that after issuance of various reminders on 10/04/2014, 17/05/2014 and 29/05/2014 for compliance of the requirements of the claim, but insured did not complied the requirements till date. Hence the file is closed.

Findings and Decision:

Complete details have been submitted by the complainant to the respondent's Satna Office vide letter dated 07.06.2016. The copy of the reply have also been emailed to the TPA. Since all the required details and explanation for delay etc. has been submitted by the complainant to the Satna Office of the respondent, there is no reason for further delaying the matter. The delay in filing the claim and papers have been satisfactorily explained by the complainant. The matter is quit old and the complainant is not in a position to resubmit original paper at this juncture. In case of doubt, the respondent should make proper verification through TPA and the claim should be settled without any further delay.

In view of these facts and circumstances, I feel it just fair and equitable to award that the company shall consider the claim filed by the complainant and workout the amount payable as per terms & conditions of the policy and same shall be paid to the complainant as full and final settlement of the grievance complaint.

CASE OF Mr. Amit Kumar Saraf V/S Star Health & Allied Insurance Co. Ltd..

COMPLAINT NO :BHP-G-044-1617-0186 AWARD NO: IO/BHP/A/GI/0090/2016-2017

Date of Award 20th March 2017

Brief Facts of the Case:

Respondent company has rejected the claim stating that as per medical record dated 13/01/2015 insured child is case of prematurity polycythemia, encephalopathy, syndromic diagnosis PDA with ASD which is prior to inception of mediclaim policy.

Decision

The complainant was taking regular policy since 03.11.2012 from the same respondent company and the child was covered on 6th November 2014. The respondent company. has repudiated the claim due to non-disclosure of material facts that the insured child has case of

prematurity polycythemia, encephalopathy, syndromic diagnosis PDA with ASD which is prior to inception of mediclaim policy.

The complainant was having the policy from the respondent company since 2012 and the child was covered on 6th November 2014 and non-disclosure detected on 20th November 2014 which is not applicable.

Accordingly, an award is passed with the direction to the Respondent Insurance Company to settle the claim of the complainant as admissible.

CASE OF Mrs. Aarti Shrivastava V/S Oriental Insurance Co.Ltd.

COMPLAINT NO:BHP-G-050-1617-0162 AWARD NO: IO/BHP/A/GI/0071/2016-2017

Date of Award 20/03/2017

Brief Facts of the Case:

The respondent stated that the patient was admitted with case of hypertension, posterior circulation stroke, right hemiplegia for which medical management was done during hospitalization. patient is a known case of hypertension since 2012 which is a risk factor for occurrence of current disease. So, on account for misrepresentation of material facts the claim was repudiated under policy exclusion clause 4.1 and 5.8.

Result of hearing with both parties (Observations and Conclusion)

It was a sudden onset of hypertension, the neighbor admitted. Insurance company stated that HTN was prior to policy inception as mentioned in the initial evaluation(history) report of Bansal Hospital dt.28/09/2015, HTN since 2012.

Complainant produced copy of one letter dt.13/10/2015 of Bansal Hospital in response to denial of claim by the respondent company that there was no history of HTN/DM/Asthma. Since this letter was issued subsequently which can only be relied if supported by an affidavit of hospital.

The affidavit not produced from Bansal Hospital it is established that disease was pre-existing

In view of all these facts and circumstances, complaint stands dismissed.

CASE OF Mr. Arun Kr. Bhuraria V/S Oriental Insurance Co.Ltd.

COMPLAINT NO:BHP-G-050-1617-0151 AWARD NO: IO/BHP/A/GI/0066/2016-2017

Brief Facts of the Case:

The complainant was covered under above captioned policy issued by respondent company. complainant lodged claim of Rs.24,919/-/- but respondent company paid only Rs.21,569/-

Result of hearing with both parties(Observations & Conclusion)

After hearing both the parties, the respondent company was directed to give copies of deductions done to the complainant.

In view of all these facts and circumstances, I feel it just, fair & equitable to dismiss the complaint as not justifiable.

CASE OF Mrs. Asha Bansal V/S Oriental Insurance Co.Ltd.

COMPLAINT NO: BHP-G-050-1617-0141 AWARD NO: IO/BHP/A/GI/0069 2016-2017

Date of Award 20/03/2017

Brief of the case:-

The complainant is taking policy since 2011 to 2017 without break. She was admitted for CAD. But her claim was repudiated under exclusion 4.1 &4.2.

Result of hearing with both parties(Observations & Conclusion)

The Insured was covered under Happy Family floater policy since 2011 to 2017 and shifted to PNB –Oriental Royal Mediclaim and continuously renewed upto 2017. These policies were issued by same respondent company i.e. Oriental Insurance Company.

Respondent company stated that they have not told the complainant regarding continuity or otherwise.

In view of these facts and circumstances, I feel it just fair and equitable to award that the company shall pay the admissible amount as per terms and conditions of the policy to the complainant as full and final settlement of the grievance complaint.

CASE OF Mr.Mr.Chanchal Kumar Gupta V/S Oriental Insurance Co.Ltd.,

COMPLAINT NO: BHP-G-050-1617-0178 AWARD NO: IO/BHP/A/GI/ 0084 /2016-2017

Date of Award 20/03/2017

Brief of the case:-

The complainant is taking policy since 10/08/2011 to 09/08/2016 without break. His wife was suffering from recurrent right lower ureteric stricture and hospitalized in Bombay hospital. Claim was lodged for Rs.7,18,714/- out of which Rs.50,067/- was paid.

Result of hearing with both parties (Observations and Conclusion)

I heard the complainant and respondent both. The Complainant denied of congenital disease and added that respondent company had paid in 2015 for same illness. The doctor also certified in Sept'2015 that it is not congenital. Respondent Insurance Company reiterated the same.

Since the illness was not congenital as certified by doctor in September'2015. Moreover respondent company had also paid claim for same disease in the year 2015.

Therefore, an Award is passed with the direction to the Insurance Company to pay the claim amount to the Complainant as admissible.

CASE OF Mr. Daulal Gupta V/s Oriental Insu.Co. Ltd., Indore

COMPLAINT NO: BHP-G-050-1617-0142 AWARD NO: IO/BHP/A/GI/0081/2016-17

Date of Award 20/03/2017

Brief Facts of the Case: The complainant and his wife has undergone for hospitalized for the Angioplasty (CAD). The claim lodged with respondent company through TPA, Rs.3,52,468/- who has settled claim for Rs.1,50,000/- as per sum insured in the policy of 2012-13.

Result of hearing with both parties (Observations and Conclusion)

I heard the complainant and respondent both. Complainant stated that he is short paid Rs.2,02,468/-. The Respondent Insurance company stated that they have paid the sum insured of previous policy of year 2012-13 Rs.1,50,000/-,i.e. the policy before enhancement. As the discharge summary does not indicate any PED and also TPA both shows no PED, Therefore, I

direct the Insurance company to settle the claim of the complainant as admissible treating the sum insured Rs.5,00,000/- and not Rs.1,50,000/-. Accordingly an Award is passed with the direction to the Insurance Company to settle the claim of balance amount to the Complainant as admissible.

CASE OF Mrs.Deepa Singh V/S Oriental Insurance Co.Ltd.,

COMPLAINT NO:BHP-G-050-1617-0122 AWARD NO:IO/BHP/A/GI/0088 /2016-2017

Date of Award 20/03/2017

Brief Facts of the Case:

The complainant was admitted in the Indian Red cross Hospital and Diagnostic Centre Bhopal for the period 02/11/2014 to 07/11/2014 for the treatment of diagnosed as pyrexia suspected Dengue.. She also visited Government Jai Prakash Hospital 1250, Bhopal as referred by Red cross for Dengue test , the report st.07/11/2014 confirmed the Dengue.

Respondent company stated that the hospitalization is not justified , no record of daily treatment and temperature chart, Dengue profile etc not shown to the investigator by the hospital, therefore, claim is repudiated under policy condition clause no.5.8.

Result of hearing with both parties (Observations and Conclusion)

There was no hospital daily chart and could not show IPD admission records and treatment. Insurance company stated that due to no IPD record and no dengue profile, hence repudiated the claim

Since no admission advice, no treatment record, IPD papers and dengue profile submitted, the claim is rightly rejected by the respondent company.

In view of all these facts and circumstances, complaint stands dismissed.

CASE OF Mr.Dinesh Sachdeva V/S Oriental Insurance Co.Ltd.,Indore

COMPLAINT NO:BHP-G-050-1617-0192 AWARD NO:IO/BHP/A/GI/0085 /2016-2017

Date of Award 20/03/2017

Brief Facts of the Case:

.Complainants father was hospitalized the treatment diagnosed as AWMI with HTN and DM. Complainant lodged claim with the respondent company, which were repudiated on the grounds of violation of policy condition and clause4.1 i.e. pre-existing disease, since the disease was from 1&1/2 years prior to the treatment and four years were not completed.

Result of hearing with both parties (Observations and Conclusion)

I heard the complainant and respondent both. The complainant stated that no past history of illness he is suffered only after inception of policy. Insurance company could not prove pre-existing disease. Therefore, I direct the Insurance company to settle the claim of the complainant as admissible. Accordingly an Award is passed with the direction to the Insurance Company to settle the claim of the Complainant as admissible.

CASE OF Mr. Gajraj Singh Parmar V/S United India Insurance Company Ltd. .

COMPLAINT NO :BHP-G-050-1617-0171 AWARD NO: IO/BHP/A/GI/0078 /2016-2017

Date of Award 20/03/2017

Brief Facts of the Case:

complainant's mother was suffering from back pain radiating left leg therefore admitted for further management at Swami Vivekanand Regional Spine Centre, Bhopal during hospitalization Left L-5 root compression was diagnosed and Microdecompression surgery was performed.

But the claim was repudiated stating that **Claim is preferred in second year of the policy, and current ailment is covered in 3rd year of the policy.**

Result of hearing with both parties(Observations & Conclusion)

The complainant family members were covered under group medical policy for the period of more than 5 years issued by the respondent company to M.s HEG ltd upto December 2014. Later in December 2015, the policy was converted into Individual family floater with the same respondent,. During the hearing, the complainant also played recording of the conversations held between complainant and the Branch Manager of the respondent company Mr. Navneet

Chikrasal who has argued that continuity benefit was not given after 2015 in writing to the individual and the company's circular also not made available to the individuals. He also submitted that there are several cases of similar nature and advised to approach the ombudsman office for relief.

After going through the material placed on the record, alongwith policy copies and submission made by the complainant. I find that internal circulars may be bending on the Insurance company but as the insured is not aware of such guidelines he cannot be penalized for the same. Accordingly an Award is passed with the direction to the Respondent Insurance Company to settle the claim of the complainant as admissible.

CASE OF Mr. Harish Sachdeva V/S Oriental Insurance Co. Ltd. Indore.
COMPLAINT NO:BHP-G-050-1617-0194 AWARD NO:IO/BHP/A/GI/0092/2016-2017
Date of Award 20/03/2017

Brief Facts of the Case: Complainant is regularly taking insurance policy since 14/09/2010 his further was suffering with H/O heaviness in chest and ghabrahat, breathlessness. Therefore admitted For further medical management

first policy was taken in the year 2010 for the Sum Insure of Rs.50,000/- which was enhanced in the year 2013 for a Sum Insured of Rs. 1,00,000/- and hospitalization was wef.15/10/2015 to 19/10/2015. It is also admitted by the complainant that policy was renewed by enhancing sum insured in the year 2013-2014 PTCA was done. Respondent insurance company's representative has confirmed that they have paid Rs.50,000/- towards final settlement of the claim as per T & C of the policy.

Result of hearing with both parties(Observations & Conclusion)

Hence, under the aforesaid facts and circumstances and policy terms and conditions, the 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 being devoid of any merit.

CASE OF Mr. Nagindas Vora V/S Oriental Insurance Co. Ltd. Indore.

COMPLAINT NO:BHP-G-050-1617-0182 AWARD NO:IO/BHP/A/GI/00 /2016-2017

Date of Award 20/03/2017

Brief Facts of the Case: Complainant was suffering from Mild URI, Cough, and General weakness since 15 days. he was hospitalized for further management of ailment but his claim was not settled on the ground that admission of patient was primarily for investigation and evaluation purpose, there was no active treatment given during hospitalization.

. The complainant stated that no reply was received from the company since 20.10.2015 even RTI application was filed is not replied.

Result of hearing with both parties(Observations & Conclusion)

Under the aforesaid facts, circumstances and policy documents and material on record, I am of the considered view that decision / action of the respondent company is not justified.

Hence, I feel it just fair and equitable to award that the company shall pay Rs.37,837/- with 9% interest from the date it was due i.e. from 16.11.2015 till the date of payment to the complainant as full and final settlement of the grievance complaint.

CASE OF Mr. Nirupam Bhuraria V/S Oriental Insurance Co.Ltd.

COMPLAINT NO:BHP-G-050-1617-0151 AWARD NO: IO/BHP/A/GI/0067 /2016-2017

Date of Award 20/03/2017

Brief Facts of the Case:

Complainant's mother was hospitalized for the period 21.01.2016 to 23.01.2016 in Dr.A.Ramachandran's, Chennai. After that complainant lodged claim of Rs.25,250/- but respondent company paid only Rs.19,967/-

Result of hearing with both parties(Observations & Conclusion)

After hearing both the parties, the respondent company was directed to give copies of deductions done to the complainant.

In view of all these facts and circumstances, I feel it just, fair & equitable to dismiss the complaint as not justifiable. A copy of the award may be sent to the complainant and the Respondent Insurance Company for information.

CASE OF Mrs. Pushpa Devi Kansal V/S Oriental Insurance Co.Ltd.

COMPLAINT NO: BHP-G-050-1617-0154 AWARD NO: IO/BHP/A/GI/0076 /2016-2017

Date of Award 20/03/2017

Brief Facts of the Case:

It is stated by the complainant that her husband was hospitalized for the period 01.12.2013 to 02.01.2014 in Bombay Hospital, Indore due to brain hemorrhage.

Respondent has repudiated on the ground that insured is very old and known case of hypertension , diabetic and operated case of subdural hematoma due to this the complainant had vertigo and unconsciousness. The proximate cause is not accidental which is not covered in the definition of accident of PA policy

Result of hearing with the parties (Observations & conclusion)

It is noted that the respondent company rejected the claim merely on the basis of some of his doctor Hansmukh Gandhi, who was not treating doctor, therefore, it is clear that the complainant sustained injury due to fallen, which is an accident. Disability certificate issued by Medical board Indore dt.08/08/2014 also certify that Mr.Vishwanath Kansal is totally bed ridden and physically disabled and has 60% permanent disability, asked to further examine after 2 years.

As per the coverage of policy Table III benefits were given and this is case of minimum temporary total disablement for two years . As per coverage at serial number 6 of Table III TTD @1% of CSI upto 104 weeks is covered, subject to Capital sum insured i.e. Rs.One Lakh.

In view of these facts and circumstances, I feel it just fair and equitable to award that the company shall pay Rs.1,00,000/-(Rupees One Lakh) to the complainant as full and final settlement of the grievance complaint.

CASE OF Dr. R.K.Gupta V/S Star Health & Allied Insurance Co.Ltd., Indore.

COMPLAINT NO :BHP-G-044-1617-0128 AWARD NO: IO/BHP/A/GI/0068/2016-2017

Date 20/03/2017

Brief Facts of the Case:

As per discharge summary the complainant was suffering from Coronary artery Disease, HTN, Hypothyroidism, Therefore, admitted for further management. During hospitalization Bypass surgery was done .

But respondent has settled the claim for Rs.1,80,000/- only and representation for balance amount was rejected on the ground that under package policy only 80% is payable under clause No.17 of the policy.

Result of hearing with both parties(Observations & Conclusion)

During the time of hearing respondents representative has stated that claim was settled in the absence of final breakup of the payments and as now the complainant has submitted copy of final breakup of Rs.2,17,067/- the respondents has agreed to settle the balance amount on its merit to the complainant.

In view of these facts and circumstances, the Star Health and Allied Insurance Co. has agreed during the time of hearing to pay the admissible balance amount to the complainant.

Accordingly, an award is passed with the direction to the Respondent Insurance Company to settle the claim of the complainant as admissible as per terms and conditions of the policy.

CASE OF Mr.Rajesh Kumar Jain V/s Oriental Insurance Co.Ltd.,

COMPLAINT NO: BHP-G-050-1617-0177 AWARD NO: IO/BHP/A/GI/0083 /2016-2017

Date of Award 20/03/2017

Brief Facts of the Case:

Complainant was having policy since 11/08/2010 from same Insurer without break, since last 5 years. The complainant' wife was hospitalized for cataract surgery. The respondent company has neither responded nor settled the claim

Result of hearing with both parties(Observations & Conclusion)

After hearing both the parties and in view of all these facts and circumstances, I feel that the complainant was not informed regarding changes under the policy. The IRDA Guidelines also provide categorically that any changes in the policy conditiond be made known to the insured. The respondent company is hereby directed to pay the claim amount with 9% rate of interest from the date of filing of claim i.e. 08/03/2016 with the respondent company till date of payment.

CASE OF Mr.Ram Babu Bansal V/S Oriental Insurance Co.Ltd.

COMPLAINT NO: BHP-G-050-1617-0170 AWARD NO: IO/BHP/A/GI/ 0093/2016-2017

Date of Award 20/03/2017

Brief Facts of the Case:

The complainant and his family are insured by respondent company since 2011 to 2017 without break continuous for 7 years. Complainant was hospitalized for the treatment of Lumbar canal stenosis. which was repudiated by the respondent on the ground of exclusion 4.1 & 4.2.

Result of hearing with both parties(Observations & Conclusion)

The Insured was covered under Happy Family floater policy since 2011 to 2017 and shifted to PNB –Oriental Royal Mediclaim and continuously renewed upto 2017. These policies were issued by same respondent company ie. Oriental Insurance Company.

Respondent company stated that they have not told the complainant regarding continuity or otherwise.

In view of these facts and circumstances, I feel it just fair and equitable to award that the company shall pay the admissible amount as per terms and conditions of the policy to the complainant as full and final settlement of the grievance complaint.

CASE OF Mr.S.N.Saboo V/S Oriental Insurance Co.Ltd.,

COMPLAINT NO:BHP-G-050-1617-0118 AWARD NO:IO/BHP/A/GI/0080 /2016-2017

Date of Award 20/03/2017

Brief Facts of the Case: The complainant was admitted in the Medicare Hospital & Research Centre ,Indore for the period 17/11/2015 to 19/11/2015 for the **surgery of LAP Hernioplasty** . Claimed for Rs.87,732/- out of which Rs.30,400/- paid. OT and medicines charges were not paid.

Result of hearing with both parties (Observations and Conclusion)

I observed that the respondent company has short paid Rs.37,337/-. The Respondent Insurance company stated that they have paid as per GIPSA-PPN rates but could not show the name of hospital where treatment taken is covered under GIPSA-PPN. Therefore, I direct the Insurance company to settle the claim of the complainant as admissible. Accordingly an Award is passed with the direction to the Insurance Company to settle the claim of the Complainant as admissible.

CASE OF Mrs.Seema Singh V/s Bharti Axa Gen.Ins.Co.Ltd.,

COMPLAINT NO: BHP-G-007-1617-0176 AWARD NO: IO/BHP/A/GI/0089/2016-2017

Date of Award 20/03/2017

Brief Facts of the Case:

Complainant stated he is taking regular policy since last 5 years. His wife was suffering from problem of dizziness, ghabrahat sleeplessness etc, consulted Bansal Hospital , Bhopal in OPD on 03/09/2016, thereafter she went to Breach candy Hospital,Mumbai, where she was admitted for the period 10/09/2016 to 11/09/2016 and again for the period 14/09/2016 to 16/09/2016 , where the disease was finally diagnosed as “Wide neck left paraophthalmic curvilinear aneurysm of left ICA”-flow diverter stening done.

Result of hearing with both parties(Observations & Conclusion)

None appeared on behalf of respondent company. The complainant informed during the hearing and submitted an e-mail from respondent company that they are ready to settle the claim, Hence the complaint was closed.

CASE OF Mr.Shivkant Choubey V/S Oriental Insurance Co.Ltd.,Bhopal

COMPLAINT NO:BHP-G-050-1617-0204 AWARD NO:IO/BHP/A/GI/0087/2016-2017

Date of Award 20/03/2017

Brief Facts of the Case:

Complainant was hospitalized in Retina Specialty Hospital, Indore, 7 times between 26/10.2015 to 08/04/2016 every time discharged on next day, for the treatment of disease diagnosed as Active CNVM/ IPCV ,problem in retina of right eye. Complainant lodged claim with respondent company which were denied on the grounds that this treatment can be given in OPD for which hospitalization were not required.

respondent company has stated that the patient was admitted for Right eye CNVM for which intravitreal injection Accentrix was given. This procedure can be given on OPD basis. Hence hospitalization is not justified and therefore the claim repudiated under policy exclusion clause 1.0.

Result of hearing with both parties(Observations & Conclusion)

The complaint is related to the patient administered Acentrix but rejected treating is as ARMD. On going the documents submitted by both the parties and hearings , I found that the Injection Accentrix was administered to patient . the respondent insurance company has given two repudiation letters dated 13/06/2016 & 06/07/2016 given different reasons for rejection.

Once the insurance company had rejected the claim on one ground, subsequently they cannot change the ground of rejection I find the injection Accentrix is administered in aseptic sterile condition in operation theater and due to advancement in technology, hospitalization for 24 hours is not necessary. Hence, the Insurance Company is liable to settle the claim and directed to pay admissible amount to the insured as per terms and conditions of the policy.

CASE OF Mr. Suresh Vednere V/S Oriental Insurance Co. Ltd., Indore.

COMPLAINT NO :BHP-G-050-1617-0199 AWARD NO: IO/BHP/A/GI/0077/2016-2017

Date of Award 20/03/2017

Brief Facts of the Case:

Complainant's wife was admitted in the ICU for 5 days and later 2 days in normal room during the hospitalization she expired. claim was filed for Rs.1,11,127/- out of which Rs.87283/- was paid by the respondent. Now the complainant has filed claim for balance amount of Rs.23844

Respondent has contended that Indore city comes under GIPSA PPN package guidelines accordingly claim has been settled as per prevailing rates in Indore. In support respondent has submitted photocopy of Notice to public by public sector Insurance Companies in which they have published list of authorized 21 hospitals at Indore.

Result of hearing with both parties(Observations & Conclusion)

Under the above circumstances and from the perusal of the GIPSA PPN Guidelines material on record, and Gokuldas Heart hospital medical records it is not disputed that complainant has taken treatment at Gokuldas hospital. It is apparent that the respondent has processed and settled the claim as per GIPSA PPN guidelines. The complainant has taken treatment at Gokuldas heart hospital which does not falls under GIPSA PPN hospital list and therefore, GIPSA PPN guidelines is not applicable in this particular case.

Accordingly, an award is passed with the direction to the Respondent Insurance Company to settle the claim of the complainant as admissible.

CASE OF Mrs. Ankita Tripathi V/S United India Insurance Company Ltd.

COMPLAINT NO :BHP-G-051-1617-0147 AWARD NO: IO/BHP/A/GI/0079 /2016-2017

Date of Award 21/03/2017

Brief Facts of the Case: Complainant was suffering from high myopia with job profile of using computers for more than 10 hours per day. She was persistently having problem due to

Minification and constricted field of vision, hence medical surgery was suggested and therefore she has undergone Lasik surgery of both the eyes.

Respondent insurance company repudiated her claim on the ground that claim pertains to myopic correction and is Non-admissible as per terms & conditions4.2 (c) of the policy

Result of hearing with both parties(Observations & Conclusion)

The complainant submitted that respondent has neither settled their claim nor returned their original treatment medical records. I have gone through the material placed on the record and submission made by the complainant and according to doctor's certificate and discharge summary, the procedure undergone by the patient was not cosmetic surgery. Hence the claim is payable.The respondent company was not present during the hearing to produce any document to show the policy conditions.

Accordingly, an award is passed with the direction to the Respondent Insurance Company to settle the claim of the complainant as admissible.

CASE OF Mr.Chandmal Malani V/s The New India Assurance Co.Ltd.,

COMPLAINT NO:BHP-G-049-1617-0153 AWARD NO:IO/BHP/A/GI/0082 /2016-2017

Date of Award 21/03/2017

Brief Facts of the Case. Insured person was admitted in Indubhai Parekh Memorial Hospital,Nagda for the disease diagnosed as ILD with Hypothyroidism with Hypertension. Her claim was rejected

Result of hearing with both parties (Observations & Conclusion)

The complaint stated that his wife was admitted for 24 hours and treatment given by the hospital accordingly. The Respondent Insurance Company stated that there was no active line of treatment, only diagnostic and investigations done.

Since the admission in the hospital was on doctor's advice and given IV's i.e. active line of treatment. Therefore, the claims stands payable.

Accordingly an Award is passed with the direction to the Insurance Company to settle the claim of the Complainant as admissible.

CASE OF Mr.Sanjay Saboo V/S Apollo Munich Health Ins. Co.Ltd.,Indore

COMPLAINT NO:BHP-G-003-1617-0136 AWARD NO:IO/BHP/A/GI/0097 /2016-2017

Date of Award 21/03/2017

Brief Facts of the Case:

Complainant was covered under Health Insurance policy issued by respondent company .Complainant was hospitalized (this is continuous renewal since 2012-13) for the illness diagnosed as Coronary Artery disease-Acute Anterior wall Myocardial infraction. The claim was lodged for payment of sum insured Rs.3,00,000/- as a lump sum towards Critical illness benefit. The claim was rejected by the respondent company on the ground of second time illness which is excluded as per policy condition Sec.4 a)I,ii and Sec.VIII Def.12.

Result of hearing with the parties (observations & Conclusion)

The complainant stated that he had the insurance policy since the year 2012 and admitted for CAD for second time on 07/06/2016 and angioplasty was done and all criteria of critical illness was fulfilled. The respondent company stated that the claim for critical illness was denied since the procedure done is PTCA which does not fall under the Critical illness clause. Also, as per discharge summary insured had similar episode 3 years ago, hence this is not the first time insured had heart attack and is not covered under specified clause. The criteria for critical illness is not fulfilled as the criteria defined in the policy. Hence, the claim was rejected under section IV 4 (a) and section VIII def.12 of the policy. In view of all these facts and circumstances, complaint stands dismissed.

CASE OF Mr.Dheeraj Arora V/s The United India Insurance Co.Ltd.,

COMPLAINT NO:BHP-G-051-1617-0163 AWARD NO:IO/BHP/A/GI/0064/2016-2017

Date of Award 21/03/2017

Brief Facts of the Case:

Complainant and his family were insured under Mediclaim policy issued by the respondent company. The father of complainant was hospitalized for cataract operation. Claim lodged with the respondent for Rs.18,445/- out of which Rs.5,685/- had been approved which is not accepted by the complainant.

Result of hearing with both parties (Observations and Conclusion)

As both the parties complainant as well as respondent company are absent , therefore, the complaint is dismissed in default and closed.

CASE OF Mr. Harish Chourasia V/S Chola MS Gen. Insurance Co. Ltd. Bhopal.
COMPLAINT NO:BHP-G-012-1617-0135 AWARD NO:IO/BHP/A/GI/0075/2016-2017
Date of Award 21/03/2017

Brief Facts of the Case: Complainant felt sudden onset burning in chest and severe perspiration & ghabrahat, breathlessness since 2 hours therefore admitted at Bansal Hospital, Bhopal and during hospitalization on further medical management it was diagnosed that patient is K/C of IHD / Post PTCA/ and DM/HTN since 2002 and angiography was performed and patient was treated with medication.

Result of hearing with both parties(Observations & Conclusion)

During the hearing the complainant stated that he was not admitted for Hypertension or Diabetes but for angiography. As per the discharge summary issued by Bansal Hospital Bhopal the complainant is a known case of DM & HTN since 2002, which was not disclosed during the time of filling the proposal form hence the respondent company has repudiated the claim on the ground of non disclosure of material facts.

Hence, under the aforesaid facts and circumstances and policy terms and conditions, the respondent is not liable to make the payment of any amount as claimed by the complainant. Hence, the complaint stands dismissed being devoid of any merit.

CASE OF Mr.Gaurav Sharma V/S Bharti AXA General Insurance Co.Ltd.

COMPLAINT NO: BHP-G-007-1617-0172 AWARD NO: IO/BHP/A/GI/0065//2016-2017

Date of Award 21/03/2017

Brief Facts of the Case: Complainant was admitted for the treatment of disease diagnosed as Entric Fever. Claim lodged for reimbursement of amount incurred with respondent company on the ground having misrepresentation and fraudulent activity.

Result of hearing with both parties (Observations & Conclusion)

As both the parties complainant as well as respondent company were absent, therefore, the complaint is dismissed in default and closed.

CASE OF Mr. Kailash Chandra Agrawal V/S United India l Insurance Co. Ltd. Indore.

COMPLAINT NO :BHP-G-051-1617-0133 AWARD NO: IO/BHP/A/GI/0073 /2016-2017

Date of Award 21/03/2017

Brief Facts of the Case:

Complainant sustained fracture due accidental injuries and during hospitalization Right platting under brachial block was performed and after discharge he has preferred claim for reimbursement of medical expenses with the respondent company for Rs.917221/- out of which Rs.51852/- has been paid on 08/07/2016 as per policy clause 1.2 C. A separate receipt of Rs.35000/- towards Doctors fees is not allowed because that is not included in the hospital bill.

Result of hearing with both parties(Observations & Conclusion)

I find that the policy condition clearly states that final bill other than as part of the hospitalization bill is not payable. In the instant case the surgeon bill is not part of the hospitalization bill. Hence not payable.

Hence, the complaint stands dismissed being devoid of any merit.

CASE OF Mr. Rajan Saxena V/S Universal Sompo Gen. Insurance Company Ltd.

COMPLAINT NO :BHP-G-052-1617-0140 AWARD NO: IO/BHP/A/GI/0097 /2016-2017

Date of Award21/03/2017

Brief Facts of the Case: Complainant's wife was suffering from injury in left knee and therefore was hospitalised at Ashadeep Hospital, Raipur. Respondent insurance company repudiated his claim on the ground of delay of 310 days in submission of claim papers.

Result of hearing with both parties(Observations & Conclusion)

During the hearing, the complainant has submitted that the respondent insurance company kept asking for the documents in the piecemeal manner and as the complainant's wife is a cancer patient therefore lots of treatment papers are with them, the said papers inadvertently mis-placed in the cancer treatment papers. During the current treatment he found the concerned documents and applied for reimbursement in March2016.

I find that from April2016 till four/six month after that the Insurance company kept asking for the relevant documents in a piecemeal manner. Thereby adding to the delay in settling the claim. Under PPHI 2002. If the reason for declining the claim was "delay" then the Insurance company should have rejected the same in March2016. I therefore condone the delay and direct the Insurance company to reimburse the as per terms and conditions of the policy.

CASE OF Mr.Murlidhar Neema V/S National Insurance Co.Ltd.,

COMPLAINT NO:BHP-G-050-1617-0148 AWARD NO:IO/BHP/A/GI/0070 /2016-2017

Date 21/03/2017

Brief Facts of the Case: The The complainant was admitted for the operation of cataract with corneal Astigmatism of left Eye. lodged claim for Rs.34,630/-, out of which a sum of Rs.18,080/- was approved.

Respondent insurance company contended that the claim is settled as per GIPSA package and reasonable and customary charges and a sum of Rs.16,550/- is deducted being excess amount claimed.

Result of hearing with the parties (observations & Conclusion)

The complainant was unable to attend the hearing which was informed to us vide his letter dt. 17.03.2017. The Insurance Company respondent was not present in the hearing. From the documents on record it is clear that the deduction were made by the Respondent company on the basis of GIPSA PPN, which was not known to the complainant.

In view of all these facts and circumstances, the award is passed to pay by the respondent company to the complainant as amount of Rs. 16550/- being deducted from the total amount claimed.

CASE OF Mrs. Rama Rawat V/S United India Insurance Co.Ltd.,
COMPLAINT NO:BHP-G-051-1617-0144 AWARD NO:IO/BHP/A/GI/0091/2016-2017

Brief Facts of the Case: The complainant has stated that she was suffering from Cataract disease in her both the eyes and was admitted in Rohit eye Hospital Indore on 06/09/2016 and on 19/09/2016 for cataract surgery of both the eyes. Respondent has settled only for Rs.21,600/-. for each eyes.

Result of hearing with both parties (Observations & Conclusion)

During the hearing the complainant was not present and the respondent company has stated that insured has under gone for cataract surgery which comes under the United India GIPSA PPN network hospital. Accordingly claim has been settled and respondent has clarified to the complaint vide letter dated 20/10/2016 in this regardas hence no further balance amount as claimed by the complainant is payable. **Hence, the complaint stands dismissed being devoid of any merit.**

DATE: 01.02.2017

In the matter of Mr. Naresh Kumar
Vs
ICICI Lombard General Insurance Company Ltd. (New Delhi)

1.The Complainant had purchased ICICI Lombard Complete Health Insurance Policy for family for sum Insured of Rs. 3 lac. The policy was renewed with continuity benefits w.e.f. 09/05/2013 Mrs. Santosh wife of the complainant was hospitalized on 29/07/2016 to 31/07/2016 with diagnosed of Renal calculi. The Complainant raised a claim for reimbursement pre and post hospitalization expenses for an amount of Rs, 37,414/- which the company had rejected as the claim was not related to diagnose & of main claim.

2.The Insurance Company had rejected the claim which was not related to main claim and the as the claim raised for pre and post hospitation for treatment ailment other then the main diagnosed hospitalization claim.

3.The bills for pre-post hospitalization not related to main diagnosed calculus of kidney and ureter. However from the consultation papers it was observed that insured had visited the hospital for general consultation for syringomas, melasma (skin related), Dysmenorrhea, Perinea pain and Anal Fissure. Therefore, the Company considered expenses incurred by insured towards main aliment hospitalization and settled the claim for an amount of Rs. 2182/- only.

4.I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant had pleaded before the forum that the Insurance Company had settled a claim for Rs. 2182/- out of total bill for Rs. 37,441/-. The complainant repeatedly requested Insurance Company to return the unsettled bills. The company failed to provide the unsettled bills to him, thereby preventing the complainant to claim from his other health Insurance Policy.There has been considerable delay to seek claim under the policy of the other Insurance Company. The representative of Insurance Company had also agreed during the course of hearing that they had failed to return the unsettled bills of complainant in time. In view of the above, the Insurance Company was found deficient in providing services to the complainant as per the IRDA guidelines related to Protection of Policy holder-Interest. The insured has suffered due to no fault of his. Accordingly, the Insurance Company is directed to settle claim as admissible.

DATE: 23.02.2017

In the matter of Mr. N.K Chopra
Vs
The New India Assurance Company Ltd. (New Delhi)

1. The Complainant had purchased New Mediclaim 2012 Insurance Policy from New India Assurance Company Ltd. w.e.f. 22.08.2016 to 21.08.2017 for self and spouse for sum Insured of Rs. 3 lac each person with policy inception date of 2000. The complainant was hospitalized in Medanta the medicity Hospital On 02.02.2015 with date of discharge on 07.02.2015 having been diagnosed for Aden carcinoma recto sigmoid in known case of ulcerative colitis. The complainant was again hospitalized on 04-06-2015 for chemotherapy in day care and the procedure was repeated on regular intervals. The Complainant had stated that the Insurance Company is not providing the details of the payment released by them against the bills raised. The complainant is seeking details of grounds and base for the deductions made by the Insurance Company. The complainant had also stated that the Insurance Company never provided copy of Terms & Conditions though the policy was in continuity since 1985.

2. The self contained note is provided by Insurance Company, which states that an amount of Rs. 77,742/- have been paid by them out of Rs. 1,42,514/-. Rs. 56,096/- have been deducted due to the room rent entitlement as per the sum insured applicable to the policy.

3. I heard both the sides the complainant as well as the Insurance Company. During the course of hearing the complainant had reiterated that the Insurance Company had not provided the details of the claims paid by them. The complainant had also stated that the Company is not furnishing the details of deductions and the reason for the same. The representative of Insurance Company had pleaded that the claim settlement was made as per policy terms and conditions. The Company had made available the brief details of the claim paid during the course of hearing and copy of same was handed over to the representative of complainant. On scrutiny of papers and on the basis of the detailed hearing from both sides, I find that the Insurance Company failed to provide the details of deduction and its reasons to the complainant. Accordingly, the Insurance Company is directed to settle the remaining claims as per the

terms and conditions of the policy and provide complete details about the deductions alongwith reasons for the same, to the complainant after making payment of claim. The Insurance Company is also directed to return the original test reports of the case after making payment of claim, for further treatment of the complainant which are necessitated and compulsorily required to ascertain the status of illness. **Accordingly, the complaint of the complainant is disposed off.**

DATE: 31-01-2017

In the matter of Mrs. Neerja Gupta
Vs
The New India Assurance Company Ltd. (New Delhi)

1. The Complainant had purchased a Mediclaim Insurance Policy from New India Assurance Company. Ltd. for self, spouse and a son for S.I. of Rs. 3 lac in/continuity with inception year of 2005. The Complainant was hospitalized on 11.05.2015 for treatment of Both Knee Replacement and after the Knee's surgery the complainant was having no pain in knee. On 22.07.2016, the complainant fell down on the floor while walking in the morning and feeling pain in right Knee and had consultation with physician, who suggested surgery of right knee. The complainant had been hospitalized again on 27.07.2016 and undergone surgery of right Knee and raised a claim for cashless settlement, which was settled on the basis of sum insured applicable on 4 years previous policy which was for Rs. 1.75 lac. The complainant had pleaded that it was an accidental injury which attracts the current year policy sum insured of Rs. 3 lac. The complainant had sought relief from the forum for balance amount of Rs. 1.25 lac.

2. The Insurance Company had stated that the complainant had a fall on 22/07/2016 at home due to a slip on floor. Thereafter, patient had complaints of pain and instability in right Knee and underwent Surgery for Revision TKR in right knee on 28th July,2016, which was not very severe one as patient had waited for 6-7 days prior to admission. The company had further contended that, in case there was no surgery (TKR) done previously, the condition of the insured would not have been such, which would have required the revision of TKR. The proximate cause for the hospitalization was the one-year-old TKR surgery done on the right knee due to the degenerative condition of the knees of the patient as past history shows in discharge surgery that patient was suffering from parkinsonism for 2 years.

3. I heard both the sides, the complainant as well as Insurance Company. During the Course of hearing the complainant had stated that the Revised TKR done on 22.07.2016 was due to fall which was an accidental case and for the current policy year sum insured should be considered, whereas the Insurance Company had settled the claim as per the sum insured applicable to 4 years previous policy. The representative of Insurance Company had reiterated that the insured undergone for both knee replacement surgery on 11.05.2015. The complainant fell down on 22.07.2016 and the doctor advised for revision of TKR in right Knee, which was done on 28.07.2016. As per the discharge summary (Procedure and Surgery) Stage- 1 Revision TKR right done on 28.07.2016 under S.A. If there were no surgery (TKR) was done previously, the condition of the insured would not have been such, which would have required the revision TKR. The proximate cause for hospitalization was the one-year-old TKR surgery done on the right Knee and the inability incurred in the Knee due to the displacement/disturbance of the implant from its fixed position.

4. On scrutiny of papers, I find that the Insurance Company had correctly settled the claim on the basis of sum Insured of 4 years previous policy as the treatment of Revision of TKR in right Knee was a follow up case of Right Knee TKR done on 11.05.2015 admitted with complaint of pain, difficulty in walking and instability over right Knee following a history of fall on 22.07.2016, currently was admitted for further evaluation and treatment, Accordingly, I uphold the decision of Insurance Company for settling the claim as the treatment taken was for pre-existing disease which falls under Policy clause No. 4.1 quote to : "Treatment of any Pre-Existing Condition/Disease, until 48 months of continuous coverage of such Insured person have elapsed, from the date of inception of his/her first policy with us as mentimed in the schedule" I see no reason to interfere in the decision of Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

DATE: 09.02.2017

In the matter of Mr. YagyaDutt
Vs
The New India Assurance Company Ltd. (New Delhi)

1. The complainant had purchased Mediclaim Insurance policy from New India Assurance Company Ltd. for coverage of self, spouse and a daughter for S-I. ofRs. 5 lac on floater basis. The Complainant was hospitalized 3 times for the treatment of Ankylosing spondylitis. A bill was raised for reimbursement for an amount of Rs. 1,34,791/- which was rejected by Insurance Company on the grounds that treatment could be taken on OPD basis. The complainant has sought relief of balance amount from this forum.

2. The Insurance Company had repudiated the claim on the grounds that the administration of Injection Remicade could be managed on OPD basis.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant had pleaded that in all 3 claims have been preferred by him for hospitalization for treatment of same ailment out of which 2 claims had already been settled by the Insurance Company, whereas the 3rd claim was rejected by them on the grounds that the treatment was not covered under the list of permissible day care procedures listed under the policy. OPD treatment converted into IPD was also not admissible. The representative of Insurance Company had reiterated that the hospitalization of the insured was for administration of injection Remicade which could be managed on O.P.D. basis. Therefore, the claim was repudiated as the treatment was not covered under the list of permissible day care procedures listed under the policy. OPD treatment converted into IPD was also not admissible.

4. I find that the Insurance Company had already settled 2 claims of complainant of same nature for infusion of Injection Remicade. The treatment for 3rd claim pertaining to the hospitalization for the period 16.06.2016 to17.06.2016 was availed on the advices of treating Doctor forinfusion of Injection Remicade, which was denied by the Insurance Company. As per the discharge summary of hospitalization claim of 13.04.2016 wherein the patient was advised to review after 8 weeks for infusion of Reimicade. Since 2 claim had already been settled by the Insurance Company for the same treatment the 3rd claim, which was for infusion of Injection Reimicade as had been done in previous 2 paid claims of the complainant can not be denied. In view of above facts, it was observed that claim was admissible within the ambit of policy coverage. Accordingly an Award is passed and Insurance Company is directed to settle the claim as per the terms and conditions of the policy.

DATE: 19.01.2017

In the matter of Ms. SunitaBhushan

Vs

ICICI Lombard General Company Ltd. (Mumbai)

1. The Complainant was Debit Card holder of ICICI bearing No. 4704560314066113 thereby insured for personal Accident cover linked to Salary Account No. 031401553568 under Master Policy of the ICICI Lombard General Insurance Company. Ltd. A claim was reported under the master policy No. 4049/84291225/00/000 for the death of the husband of complainant who was covered for Personal Accident risk being ICICI Privilege debit Card holder of card No. 4704560314066113 Valid upto 04/13 to 03/23. The Insurance Company had rejected the claim saying that the card was not Active as per the policy T&C as the insurance cover was available only for the Active Cards. The Complainant is seeking relief from the forum.

2. The Insurance Company had repudiated, the claim vide letter dated 11.05.2016 saying that the insured died on 07.10.2014 and as per the confirmation received from ICICI Bank Ltd. the card through which the claim got registered was inactive for more than 30 days prior to date of death. Hence the claim war inadmissible. The policy exclusion clause says "Active card will be defined as those on which there is a retail transaction of Rs. 499/- in last 30 days prior to the date of loss.

3. I heard both sides, the complainant as well as the Insurance Company. During the course of hearing the representative of complainant had stated that the Insurance Company had asked the complainant to comply with the formalities and it took about one year to complete the documents like police report, post mortem report, Viscera report, final report of police, Indemnity bond on stamp papers and undertaking on non-Judicial papers. The complainant's representative pleaded that the Insurance Company had rejected the claim after getting all the formalities completed with a plea that the debit card was inactive and the benefits of insurance are available only on the "Active Cards whenever retail transactions of Rs. 199/- made in last 30 days prior to the date of loss".

4. The representative of the Insurance Company had stated that as per the policy terms and conditions item "C" the insurance coverage was valid on Active cards only, where as the card in which claim reported was found inactive as no retail transaction was carried out in last 30 days prior to the date of loss.

5. Accordingly, I uphold the decision of Insurance Company for repudiation of claim on the grounds of the Debit Card was not Active as no retail transaction was done during the last 30 days prior to the date of loss, which falls under the exclusion clause of the Insurance policy. Therefore, in view of the above, the complaint of the complainant is disposed off.

DATE: 23.01.2017

In the matter of Mr. R.R Iyer
Vs
The New India Assurance Company Ltd. (New Delhi)

1. The complainant had purchased health Insurance Policy from New India Assurance for self & spouse for Sum Insured of Rs. 20,0000/- each in continuity since 1995. The Complainantwas hospitalized on 11.07.2016 in the BLK Super Specialty Hospital fortransfusion of 2 unit of blood and four injections of Reditux which took 4-5 hours for administration. The complainant applied for cashless treatment which was rejected by the TPA saying that "The Hospitalization was only for Injection Reditux, which was not payable hence rejected." The Complainant was given Reditux Injections on 21st July, 2016, 29th July 2016 and on 5th August, 2016 but the Insurance Company denied for all 4 Cycles of hospitalizations for administration of Reditux injections as per the advices of treating Doctor. The treating Doctor had also issued a certificate which reads as "This is to state that Mr. R.R Iyer, MRD No.459463, is suffering from Lympho-Plasmacytic lymphoma. This is a type low grade cancer. The treatment for this disease is Rituximab Therapy (targeted Chemotherapy) and is given as 6-8 hours infusion under medical supervision and for this he requires admission for one day for each cycle of Rituximab therapy. He was planned for 4 cycles of Rituximab Therapy. In due course, he may need blood product support till he responds to the treatment."

2. The Insurance Company had rejected the claim Vide letter dated. 29.07.2016 saying that Hospitalization was only for injection Reditux (Rituximab) Not payable hence rejected.

3. I heard both sides, the complainant as well as the Insurance Company. During the course of hearing, the complainant had stated that the contention of Insurance Company for repudiation of claim was absolutely wrong on the grounds that "the hospitalization was only for Injection Reditux, which was not payable hence rejected". The Complainant had further stated that treating Doctor had issued certificate saying that "The complainant was suffering from Lympho-Plasmacytic lymphoma, which is a type of low grade cancer." As per the opinion obtained by the Insurance Company from Adroit Consultancy vide report ref. No. ACM/211114/2016 date. 29/12/2016 it was revealed from the clinical facts of the case that "the complainant was admitted and treated in BLK Hospital for the treatment of B Cell lymphoma. He was given Injection Rituxamib as a part of chemotherapy."

4. The representative of Insurance Company has contended that the claim was not payable as the hospitalization was only for injection Reditux (Rituximab) not payable hence rejected.

5. On scrutiny of papers, I find that the investigator deputed by the Insurance Company had categorically stated that the patient was given Injection Rituxamib as a part of chemotherapy and the opinion of the investigator further states that the Injection is always given slowly intravenously under observation and to be given with anti allergic medications before starting the Injection drip, as it can otherwise lead to life threatening complication. Even in the opinion of Insurance Company's investigator M/S. Adroit consultant, the claim was admissible. The certificate of Dr. Dharma Choudhary of Deptt of Hemato-oncology of BLK Superspeciality Hospital also endorse that the Rituximab Injection is given as 6-8 hours infusion under medical supervision which requires admission for one day for each cycle of Rituximab therapy. In view of the above, I find that the claim is admissible. Accordingly. the Insurance Company is directed to settle the claim as per terms and conations of policy.

DATE: 21.02.2017

In the matter of Mr. Ashok Kumar Bhateja
Vs
The New India Assurance Company Ltd. (New Delhi)

1. The Complainant had purchased a Mediclaim policy for family i.e. self, spouse and daughter and a son with inception date of 27.12.2010. The Daughter of complainant Ms. Anjali received injuries in leg due to fall in garden and got fractured her leg. The insured was hospitalized at J.K Hospital, JanakPuri, New Delhi-110058 on 30.05.2015 and discharged on same day. The Insurance Company had closed the claim file on the grounds of delay in submission of documents (seeking reasons to clarify the delay of 5 days for late submission). The complainant had raised claim bill for Rs. 1,9690/- out of which Rs. 13,947/- were deducted as "not payable" and claim was settled for Rs. 5,743/- only. Hence the Complainant was seeking relief from the forum for the payment of balance amount of Rs. 5,743/-

2. The Insurance Company had settled the claim for Rs 5,743/-. The deductions for an amount of Rs. 13,947/- were made as per the policy conditions.
3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant had pleaded that Insurance Company through their TPA, E-Meditek (TPA) Service Ltd. had conveyed their decision vide letter date 02.09.2015 saying that the claim was marked "No claim" on account of 5 days late submission of documents. The Insurance Company had rejected the claim on the grounds of 5 days late submission of documents, with provision of waiver of delay from Insurance Company. On scrutiny of the papers, I find that the representative of Insurance Company had failed to submit their view point and also did not provide self contained note in their defence. Therefore, the Insurance Company is directed to condone the delay and settle the claim for admissible amount as per terms & conditions of the Insurance Company.**Accordingly, an Award is passed with directions to the Insurance Company to settle the claim as admissible as per the terms and conditions of the policy.**

DATE: 17.03.2017

In the matter of Mr. I. S. Arora
Vs
The New India Assurance Company Ltd.

1. The complainant had purchased a New Mediclaim 2012 policy from New India Assurance Company Ltd. for coverage of sum insured of Rs. 3 lac for self and Rs. 2 lac for spouse. The complainant was hospitalized on 31/08/2016 diagnosed CAD-AWMI. The complainant lodged two claims for reimbursement for Rs. 2,75,875/- which was settled for Rs. 2,25,104/- (Rs. 50,775/- being non-payable amount were deducted) towards hospitalization at Sir Ganga Ram Hospital. The other claim was for hospitalization at Ashlok Hospital one day prior to the admission at Ganga Ram Hospital on 30.08.2016. The complainant is seeking relief from the forum Rs. 8,700/- of Ashlok Hospital and Rs. 50,775/- of Sir Ganga Ram Hospital.

2. The Insurance Company had settled the claim as per the policy terms and conditions related to GIPSA package (agreed rates) for hospitalization claim of Sir Ganga Ram Hospital. The claim for Ashlok Hospital was settled excluding room rent charges as admission was for less than 24 Hours, however, other expenses for medications etc. paid considering the same as pre-hospitalization of the claim of Sir Ganga Ram Hospital.
3. I heard both sides, the complainant as well as the Insurance Company. During the course of hearing the representative of the Insurance Company had reiterated that the claim related to hospitalization at Ganga Ram Hospital was settled on basis of GIPSA package agreed between the Insurance Company, Hospital and TPA. The second claim of Hospitalization at Ashlok Hospital was settled for the expenses incurred other than Room rent charges treating it as pre-hospitalization claim on the grounds the duration was short of 24 hours stay at hospital thus not qualifying the requirement of hospitalization. The Insurance Company stated during the course of hearing that the complainant was informed about the GIPSA PACKAGE at the time complainant applied for the cashless Authorization for treatment.

   On scrutiny of the papers, I find that the complainant had submitted two claims i.e. first claim for hospitalization at Ashlok Hospital on 30.08.2016 for an amount of Rs. 23893/- out of which Rs. 15103/- were settled deducting Rs. 8700/- towards recovery room charges. The second claim was for Hospitalization at Sir Ganga Ram Hospital for Rs. 275875/- which was settled by Insurance Company for Rs. 225100/- as per the GIPSA Package. I observed that the complainant was not informed prior to hospitalization about the GIPSA Package. With regard to second claim for hospitalization at Ashlok hospital, it is observed that the patient was kept in recovery room under observation which form the part of treatment. Thus recovery room charges are also found admissible. **Accordingly, the Insurance Company is directed to settle first claim as per policy condition without considering the capping of GIPSA Package. The Insurance Company is also directed to settle the second claim of Ashlok hospital in full alongwith the recovery room charges of Rs. 8700/- within 30 days of receipt of the Award.**

DATE: 23.02.2017

In the matter of Mr. Vinod Gupta
Vs
Cigna TTK Health Insurance Company Ltd.

1. The complainant had purchased a mediclaim policy from Cigna TTK Health Insurance Company Ltd. for self and spouse for sum insured of Rs. 5,50,000/- in the year 2014 for the period 18.06.2014 to 17.06.2015 which was renewed continuously till 17.06.2017. The said policy was transferred under portability from National Insurance Company Ltd. in the year 2014 having continuity since 2009 as intimated by the complainant after carrying out all the test before shifting the policy under portability. The complaint was hospitalized at Sir Ganga Ram Hospital from 07.11.2016 to 12.11.2016 and incurred an expenses for Rs. 3,97,320/- as per the claim form. The Insurance Company had rejected the claim on the grounds of non-disclosure of material facts.
2. The Insurance Company had rejected the claim on the grounds that the complainant had not disclosed the existing disease i.e. Bipolar disorder since 1994, in view of the same there was suppression of material fact. Claim was therefore not admissible under the clause related to non-disclosure-VIII-I-duty of disclosure which reads as "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, claim form declaration, medical history on the claim form and connected documents, or any material information having been withheld by your or any one acting on your behalf, under this policy. You further understand and agree that we may at our sole discretion cancel the policy and the premium paid shall be forfeited to us."

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant had pleaded that the insurance policy was purchased on 18.06.2014 to 17.06.2015 which was renewed upto 17.06.2017. The policy was shifted from the National Insurance Company under portability in the year 2014 with continuity since 2009 after getting all the test done before the shifting of policy under portability. The complainant had pleaded that the policy was shifted under portability after satisfying from the test reports of tests conducted prior to issuing the policy.

   The representative of the Insurance Company had stated that the claim was rejected on the grounds that the complainant had not disclosed the disease i.e. Bipolar disorder, which was diagnosed in 1994. The Non disclosure and suppression of material facts had attracted breach of the policy condition as per clause-VIII-I-duty of disclosure, which reads as " 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, claim form declaration, medical history on the claim form and connected documents, or any material information having been withheld by your or any one acting on your behalf, under this policy".

   On scrutiny of papers, I find that the Insurance Company had failed to prove through cogent and reliable documents which shows that the complainant was on medications for the treatment of Bipolar disorder which was considered as pre-existing disease. Therefore, the contention of Insurance

Company regarding pre-existing disease is ruled out. Accordingly, the Insurance Company is directed to treat the claim as admissible and settle the same as per the terms and condition of the policy. **Accordingly, an Award is passed with directions to the Insurance Company to settle the claim as admissible as per the terms and conditions of the policy.**

DATE: 14.03.2017

In the matter of Mr. Himanshu Saxena
Vs
HDFC Ergo General Insurance Company Ltd.

1. The complainant had purchased a health insurance policy from HDFC Ergo GIC Ltd. for self and spouse for Rs. 4 lac as family floater Dr. Garima Sachdev Saxena was hospitalized in Sir Ganga Ram Hospital on 05.04.2016 with complaint of renal allograft recipient on 06.04.2016 having basic disease of Hypertension.

2. The Insurance Company had repudiated the claim on the grounds that the patient was admitted on 05.04.2016 with the diagnosis of renal allograft recipient, ABO incomplete RAR and was managed surgically with renal transplant recipient surgery (which is genitourinary surgery). As per section 9A IIB of policy waiting period of 2 years is applicable on any Genitourinary surgery. As the date of first inception of policy is 29.09.2014. The policy was in 2nd year. Hence the claim was repudiated under the above mentioned section of the 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 stated that the disease/ailment of CKD is not excluded from the scope of converge whereas the renal transplant is not covered as alleged by the Insurance company. The representative of Insurance Company had reiterated that as per section 9(A) (ii) (b) of the policy a waiting period of 2 years is applicable for any Genitourinary Surgery. As the date of first inception of policy is 29.09.2014, the policy is in second year. Hence the claim was repudiated under the above mentioned section of the policy terms and conditions.

4. On scrutiny of the papers, I find that the disease/aliment of CKD i.e. renal transplant is not excluded under the scope of policy coverage. The contention of the Insurance Company also does not medically substantiate the evidence for proving that the disease i.e. renal transplant was caused mainly and unilaterally due to the failure of genito urinary system. Accordingly, the Insurance Company is directed to treat the claim as admissible and settle the claim as per the terms and

conditions of Insurance Policy. **Accordingly the complaint filed by the complainant is hereby disposed off at the forum.**

DATE: 14.03.2017

In the matter of Ms. Priya Rawat
Vs
HDFC Ergo General Insurance Company Ltd.

1. The complainant had purchased a critical illness policy from HDFC Ergo GIC Ltd. for 15 lac sum insured. The complainant was hospitalized on 13.03.2016 in Rajiv Gandhi Cancer Instt. and Research Centre, where she underwent total thyroidectomy + Centre Compartment Clearance+ Right functional Neck Dissection (II-IV) + Left Functional Neck Dissection (level-II-V) on 14.03.2016.

2. The Insurance Company had repudiated the claim vide letter dated 16.05.2016 on the grounds of pre-existing disease as the insured was diagnosed with papilliarycarcinoma of thyroid on 27.02.2016. The date of inception of policy was 16.07.2015 and patient had complaint of enlargement of thyroid gland since 6 months as per consultation paper dated 21.12.2015 which falls prior to policy inception date therefore the condition/ailment is pre-existing in nature. The

Insurance Company had repudiated claim under purview of section 5 definition -19 of policy terms and condition.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the representative of complainant had pleaded that the Insurance Company had rejected the claim on the grounds of pre-existing disease of enlargement of thyroid glands since six months as indicated in the prescription dated 21.12.2015 of consulting Dr. ManojAgarwal.The complainant's representative had further added that the insured was in family way and every months some test were carried out as advised by the consulting doctor.The routine tests related to thyroid had been done but the treatmentwas never initiated prior to Dec, 2015.

   The representative of the Insurance Company had reiterated that insured was diagnosed with papillary carcinoma of Thyroid on 27.02.2016. The date of policy inception was 16.07.2015 and the patient had complaints of enlargement of thyroid gland since 6 months as per consultation paper dated 21.12.2015 which falls prior to policy inception date, therefore the condition/ailment was pre-existing in nature. The Insurance Company had rejected the claim by invoking the policy condition as per section 5 definition 19 of the policy terms and conditions.

   On scrutiny of papers, I find that the Insurance Company was unable to produce reliable and cogent evidence to prove the pre-existing disease as the company failed to show any documents which could prove that the complainant was under medication for the treatment related to thyroid prior to Dec, 2015. Accordingly, I conclusively arrive at decision that the claim was admissible and the Insurance Company to settle the claim as per the terms and conditions of the policy.**Accordingly an award is passed with the direction to the Insurance Company to settle the claim as per terms and conditions of the policy and pay the admissible amount to the complainant.**

DATE: 27.03.2017

In the matter of Mrs. Sangeeta Aggarwal
Vs
New India Assurance Company Ltd.

1. The complainant had purchased a mediclaim Insurance policy from New India Assurance Company Ltd. for sum insured of Rs. 2.5 lac with inception date of 21.11.2006. The complainant was hospitalized on 02.09.2016 with complaints of both knee isolated medical compartment osteoarthritis. A surgery was carried out for both knee Asthroscopic debridement and high tibial osteotomy of right knee under spinal anesthesia under G.A. The complainant had submitted a claim for reimbursement of claim for Rs. 3 lac whereas Insurance Company had settled bill for Rs. 1,99,000/- only, saying that except medicine bills all other expenses were considered and paid 1/3rd of the actual amount being proportionate to the room rent entitlement. The complainant had sought for the relief from the forum.

2. The Insurance Company had settled the claim as per the room rent applicable in the policy and all other expenses except the medicine bills had been paid in proportion to the room rent entitlement as per the 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 was absent as the complainant had given a written letter dated 20.02.2017 saying that she has not yet recovered from the leg injury and her relatives also not available to attend the hearing at the forum. The complainant had given consent to proceed in the hearing in her absence. The representative of Insurance Company had stated that the complainant had undergone treatment of surgery of both knee isolated medical compartment osteoarthritis on 02.09.2016. The Insurance Company had settle the claim on the basis of sum insured @ 2.50 lac and the room rent category and other linked expenses were considered accordingly. The claim was settled as per room rent category and the other expenses other than medicines were linked to room rent category and settled the expenses proportionately.

   On scrutiny of the papers, I find that the complainant had undergone knee surgery on 02.09.2016. The Insurance Company had settled the claim considering the sum insured of Rs. 2.5 lakhs instead of Rs. 3 lakhs due to policy condition no. 4.3.2 which states that enhanced sum insured will be applicable after 4 years of continuous coverage. I find that surgery was performed within 3 years of enhancement of sum insured, therefore sum insured applicable was restricted to Rs. 2.5 lakhs and accordingly maximum payable room rent was Rs. 2,500/- per day. The claim was settled as per eligible room rent category as per clause no. 3.1. Hence, claim was settled as per terms and conditions of the policy. **Accordingly the complaint filed by the complainant is hereby dismissed**

DATE: 17.03.2017

In the matter of Ms. Anjali Jain
Vs
New India Assurance Company Ltd.

1. The complainant had purchased a mediclaim insurance policy from New India Assurance Company Ltd. for self and 2 children for sum insured of 3 lac each person with inception date of 21.03.2001. The complainant was admitted in Rajiv Gandhi Cancer Instt. and Research Centre on 05.11.2015 with ailment of metastatic net pancreas stage-IV Grade-I and treated on sandostatin LAR having co-morbidity of HTN and Hypothyroidism. The complainant had stated that he had undergone for a preventive Health checkup at Paras Hospital gurgaon on 21.10.2015 and the tests revealed numerous and large lesions. The test of CT scan, chromogranin-A, liver biopsy were done and it was found positive for malignant cello and was diagnosed stage-IV pancreas cancer spread over the entire liver. The medical oncologist of Rajiv Gandhi Cancer Instt. suggested for chemotherapy and planned for sandostatin LAR based chemotherapy. Their treatment plan was for chemoplan of inj. Sandostatin 30mg deep IMQ4 weekly. The complainant had sought second opinion from AIIMS hospital, N. Delhi and as per their advices the same cancer treatment was continued at AIIMS, where the day care admission was done for chemotherapy and sandostatin 30mg administered and the claims were settled. The complainant had also stated that sandostatin 30mg based chemotherapy is administered intramuscular (I/M) which is covered under parenteal chemotherapy as per the policy condition of the Insurance Company.
2. The insurance company had rejected the claim on the ground that the patient was diagnosed as metastatic pancreas and admitted at AIIMS for administration of Inj. Sandostatin (hormone Drugs). Since this was not a chemotherapy agent and not included in approved day care procedure list of policy hence admission for its standalone administration is not admissible.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant had stated that the patient/insured had undergone for a preventive health check up on 21.10.2015 and the tests revealed numerous large lesions. The test of CT scan, chromogranin –A and liver biopsy were done which revealed positive for malignant

cells and diagnosed stage-IV pancreas cancer spread over the entire liver. The Oncologist of Rajiv Gandhi Cancer Instt. had suggested for chemotherapy and planned for the sandostatin LAR based chemotherapy. The treatment was planned for chemoplan of Inj. Sandostatin weekly. The complainant had sought 2nd opinion from AIIMS, N. Delhi where the day care admission was given and chemotherapy was given through sandostatin 30 mg based chemo administered for which claim was settled by the Insurance Company. The complainant also pleaded that sendostatin 30 mg chemotherapy was administered intramuscular (I/M), which is covered under parenteral chemotherapy as per the terms and conditions of Insurance Policy. The representative of the Insurance Company reiterated that the treatment not covered under parenteral chemotherapy. The Insurance Company had repudiated the claim on the grounds that the Sandostatin is not a chemotherapy agent and not included in approved day care procedures list of policy hence admission for its standalone administration is not admissible.

On scrutiny of the papers, I find that patient was admitted in AIIMS at the advice of the Doctor and underwent chemotherapy under day care procedures. The Insurance Company had rejected the claim on the ground that administration of Injection Sandostatin (hormone drug) was not a chemotherapy agent and not covered under parentralchemotherapy. However the certificate dated 22.08.2016 of Dr. Alok Gupta, Max Health Care shows that the treatment was a part of chemotherapy and injection Sandostatin was give intramuscular. I find that treatment given to the patient falls under specified procedures and is included in approved day care procedure list of the policy i.e. parenteral chemotherapy which is an Intravenous (I.V) therapy and administration of Injection intramuscular. Hence the claim falls within the scope of Insurance Company policy. Insurance Company is directed to pay the claim as admissible. **Accordingly, The Insurance Company is directed to treat claim as admissible and settle the claim as per terms & conditions of the complainant.**

DATE: 16.03.2017

In the matter of Mr. Sanjeev Kumar

Vs

The New India Assurance Company Ltd. (New Delhi)

1. The complainant had purchased a Health Insurance Policy (Floater) from New India Assurance Company Ltd. for the period of 10.07.2015 to 09.07.2016 for coverage of self, spouse and 3 children for sum insured of Rs. 5 lac. The complainant was hospitalized on 15.01.2015 and discharged on 19.01.2015 for the treatment of illness diagnosed as ACID PEPTIC DISEASE WITH CHRONIC KIDNEY DISEASE, Hypertension. The complainant had stated that the treating Doctor had wrongly mentioned on his prescription that the complainant was suffering from disease for 2-3 years instead of 2 to 3 months. Later the same doctor issued a certificate that the total duration of hypertension was 1½ years only.
2. The Insurance Company had vide their letter dated 25.11.2016 rejected the claim as non-tenable being a pre-existing disease.

3. I heard both the sides the complainant as well as the Insurance Company. During the course of hearing the complainant had pleaded that the Insurance policy was purchased on 10.07.2015 having continuity since 10.07.2013 and the hospitalization was on 04.04.2016, hence the claim

was not falling under PED. The representative of Insurance Company had reiterated that the insured was a known case of HTN since Nov. 2013 and was a chronic ethanolic. The Insurance Company further added that the ailment of the insured falls under the pre-existing disease under the exclusion clause no. 4.1 as the complainant had purchased the Insurance Policy in 2013. Therefore, the claim was repudiated as per policy clause No. 4.1. being pre-existing disease and under clause No. 4.4.6.1 which excludes the intentional self-injury and illness or injury caused by the use of intoxicating drugs/alcohol.

On scrutiny of the papers, I find that the Insurance Company failed to prove the disease as pre-existing as they were unable to provide any cogent and reliable document to prove that the complainant was suffering from CKD prior to inception date of Insurance policy. The treating Doctors, Dr. Anil Kumar Gulia and Dr. Dinesh Khullar have issued certificates on 05.04.2016 and 21.04.2016 that the complainant was suffering from HTN for the last 1½ years only, whereas the policy was in force for 3 years. I find that the claim does not fall within the ambit of policy exclusion of 4.1 and 4.4.6.1. Hence the Insurance Company is directed to treat the claim as admissible and settle the claim as per terms and conditions of the policy with the period of 30 day of receipt of the Award. **Accordingly an award is passed with the direction to the Insurance Company to settle the claim as per terms and conditions of the policy and pay the admissible amount to the complainant.**

DATE: 16.03.2017

In the matter of Mr. Ankur Gupta
Vs
The New India Assurance Company Ltd.

1. The complainant had purchased a New Mediclaim-2012 policy from New India Assurance Company Ltd. for sum insured of Rs. 5 lac. The complainant was also entitled for cumulative Bonus for Rs. 50000/- as an additional sum insured over and above the basic sum insured. The complainant was hospitalized on 29.04.2016 as was diagnosed comminuted fracture left distal end radius as the complainant had a history of fall from chair 2 days prior to admission in hospital. The complainant had incurred total expenses of Rs. 54403/- towards the hospitalization expenses but the Insurance Company had settled claim for Rs. 30328/- thereby deducting an amount of Rs. 24075/-. The complainant sought relief from the forum.

2. The Insurance Company had settled the claim excluding the home visit charges of physiotherapist and the non-payable items. The Insurance Company had stated in email dated 22.11.2016 that the Physiotherapy charges are settle @ 50% i.e. Rs. 4,050/-, Rs. 4,050/- and Rs. 12,000/- against the bills of Rs. 8,100/-, Rs. 8,100/- and Rs. 24,000/-.
3. During the course of hearing the Insurance Company failed to represent its case as no representative attended the hearing. The Insurance Company had also not provided any Self Contained Note to the forum. However the hearing took place and the complainant was heard. The complainant had pleaded that the Insurance Company had settled the claim for physiotherapy charges @ 50% of the bills for Rs. 8,100/-, Rs. 8,100/- and Rs. 24,000/- and paid Rs. 4,050/-, Rs.4,050/- and Rs. 12,000/- only. The complainant stated that the treating Doctor Dr. Pradeep Sharma, MS (Ortho) Director and HOD of BLK Memorial Hospital had advised on 29.08.2016 for domiciliary physiotherapy for 60 sessions as the complainant was unable to visit Physio Centre at hospital. Since the representative of Insurance Company was absent, the case was dealt on merits of the case.

   On scrutiny of the papers, I find that the claim is admissible according to the policy terms and conditions and as per the post hospitalization medical expenses clause No. 2.33 which reads as "Medical expenses incurred immediately after the insured person is discharged from the Hospital provide that (i) such medical expenses are incurred for the same condition for which the insured person's hospitalization was required." The treating Doctor, Dr. Pradeep Sharma, MS (Ortho) Director and HOD had also advised the complainant on 29.08.2016 for domiciliary physiotherapy for 60 sessions as the complainant was unable to visit Physio Centre at hospital. The Insurance Company failed to show any conditions excluding the physiotherapy charges for home visit within the 60 days period for post hospitalization. In view of the cited circumstances, the Insurance Company is directed to settle the claim for the balance amount of physiotherapy charges as per the terms and conditions of the policy. **Accordingly an award is passed with the direction to pay the**

remaining amount of physiotherapy charges as per the terms and condition of the policy to the complainant.

DATE: 24.11.2016

In the matter of Mr. Shakti Manchanda
Vs
The National Insurance Co. Ltd. (New Delhi)

1. The complainant alleged that he had taken his mediclaim policy since 2010 from National Insurance Co. Ltd. for his family He further alleged that from 21/12/13 To 28/01/14 his father was admitted in the hospital for various times for renal transplantion, as advised by the Dr. of Medica Superspeciality Hospital. Hence on 27/12/13, he was admitted in the Hospital and Renal transplantion surgery (Recipient) OT Note was done on 28/12/13. He underwent the surgery of left GIBSINCISION alongwith the other treatment in the hospital and he was discharged from the hospital on 04/01/14, but his claim was repudiated by the Ins. Co. on the ground of PED, before taking the Policy.

2. The Ins. Co. reiterated vide its letter dated 19/10/15 that the patient was covered under Policy No. 351800/46/13/8500001516 for treatment at Medica Superspeciality hospital from dated 21/12/13, whereas his policy was since 20/05/10 and as per Dr. Prescription the Patient was K/C/O DM from 5 To 6 years (known PED) whereas policy was in 4th year, hence claim was denied under clause 4.1 (All Diseases/Injuries which were Pre-Existing, when the cover was incepted for the first time. However, those Diseases will be covered after 4 year continuous claim free policy years. The Ins. Co. further stated that for the purpose of applying this conditions, the period under mediclaim Policy taken from National Insurance Co. only will be considered. Hence, claim was denied by them.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of personal hearing the complainant contended that two claims were paid by the Insurance Company for treatment taken in September, 2012 but claim for renal transplant in December, 2013 was rejected by the company.

   Insurance Company reiterated that policy incepted from 20-05-2010. The insured patient underwent renal transplant on 28-12-13. The insured was covered under Tailor-Made mediclaim policy exclusively for the investors of Bajaj Capital. As per tailor-made policy major organ transplants like kidney was covered after 4 continuous claim free policy years. The policy in question was in 3rd year, hence claim was not admissible.

   On perusal of papers on record, I find that complainant's father was covered under Tailor-made mediclaim policy incepted from 20-05-2010. He underwent renal transplant on 28-12-2013. Earlier two claims in September, 2012 were paid by the Company one of which was for cardiac disease and other one was for dialysis. The Insurance Company had submitted during hearing that claim was wrongly settled on cashless basis. As per terms and conditions of the policy major organ transplant like kidney transplant was covered after 4 continuous claim free policy years, hence Insurance Company had rightly rejected the claim. I uphold the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

DATE: 30.01.2017

In the matter of Mr. Dinesh Sharma

Vs

IFFCO-Tokio General Insurance Company Ltd.

1. The complainant had taken his Mediclaim policy from IFFCO Tokio General Insurance Company Ltd. on 29-11-2015 after porting from United India Insurance Company Ltd. The complainant alleged that his wife was admitted in the hospital on 03-05-2016 for the complainant of continuous bleeding per vaginumandlater her case was dignosed as abnormal Uterine Bleeding with poorlyDifferentiatedTumour of uterus with sarcomatous changes associated with cholelithiases. She underwent the surgery for laparoscopic redical Hysterectomy with B/L salpingo-oophorectomy alongwith the other surgeries related to her disease. But her claim was denied by the Insurance Company on the ground that she had not declared her disease at the time of taking the policy from the Insurance Company.
2. The Insurance Company vide its letter dated 23-06-2016 reiterated that as per OPD document of DR. PunitaBhardwajMD (Gynaecology) of Sir Ganga Ram Hospital, Delhi dated 01-05-2016, it was observed that the patient had the history of Irreguler Bleeding per Vaginum since 03 years, which was prior to taking the policy from them. Hence, claim was denied as per policy conditions and the policy of the complainant was also cancelled in accordance with the clause 49 of policy which is with regard to cancellation of policy norm, in case of non-disclosure of disease.

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 ported his policy from United India Insurance Company Ltd. on 29.11.15 and his wife was admitted in the hospital on 03.05.2016 but his claim was denied by the Insurance Company.

   The Insurance Company stated during the personal hearing that the complainant had ported his policy with their Company on 29.11.15 but the patient was suffering from the disease since 03 years, which fact was not declared in the proposal form at the time of porting the policy.

   After hearing both the sides and perusal of record, I find that the complainant had ported his policy on 29.11.15.His wife was admitted in the hospital on 03.05.16 for the complaint of irregular bleeding but her claim was denied by the Company on the ground that the patient was suffering from her disease since 03 years. I find that in the discharge summary of Sir Ganga Ram Hospital, which was prepared at the time of admitting the patient in the hospital by the treating doctor that there was no mention that the patient was suffering from the disease since 03 years. The Insurance Company could not produce any documentary evidence toestablish that the patient

was suffering from the disease since 03 years. Therefore, I direct the Insurance Company to settle the claim of the complainant as admissible. **Accordingly an Award is passed with the direction to the Insurance Company to settle the claim of the complainant as admissible.**

DATE: 30.01.2017

In the matter of Mr. Sonu Jain
Vs
Reliance General Insurance Company Ltd.

1. The complainant alleged that he had taken a Health Insurance policy No. 1315352812000030 w.e.f. 01-08-2015 to 31-07-2016 for his family from Reliance General Insurance Company Ltd. He further alleged that his son on 27-11-2015 was admitted in the hospital for the complainant of Acute retention of urine since one day and later his case was diagnosed as phimosis with AUR and was discharged from the Hospital on the same day but his claim was denied by the Insurance Company on the ground that the disease of his son was since birth.

2. The Insurance Company vide their letter dated 14-12-2015 reiterated that as per the submitted documents the claim if for phimosis in a case of 3 years male child (Tigut prepuce since birth) and the patient was admitted for surgical management.The Insurance Company also stated that as the ailment being a congenital External Anamoly and hence the claim of the patient was repudiated by them.

3. I heard the complainant, but the Insurance Company was absent during the course of hearing. The complainant stated that his claim was not settled by the Insurance Company. I find that the son of the complainant was admitted in the hospital on 27.11.15 for the complaints of acute retention of urine since one day but his claim was denied by the Company on the ground that the ailment of the patient was a congenital external anomaly. I find from the discharge summary of Khandel-wal Hospital and Urology Centre, that the patient was admitted in the hospital on 27.11.15 for the complaints of acute retention of urine since one day and later his case was diagnosed as Phimosis with AUR, but it was no-where mentioned in the discharge summary that the disease of the patient was since birth.

There was no documentary proof to establish that the patient was suffering from the disease since birth. Therefore, I direct the Insurance Company to settle the claim of the complainant as admissible. **Accordingly an Award is passed with the direction to the Insurance Company to settle the claim of the complainant as admissible.**

DATE: 27.01.2017

In the matter of Mr. Vikas
Vs
IFFCO-Tokio General Insurance Company Ltd.

1. The complainant alleged his family was covered under Group Mediclaim policy no. 52478715. He further alleged that his wife was admitted in the Hospital on 22-03-2016 and female baby was born by LSCS and was discharged from hospital on 25-03-2016 but her claim was denied by the Insurance Company on the ground that baby care was excluded from the scope of group mediclaim policy.

2. The Insurance Company vide its letter dated 30-06-2016 reiterated that as per submitted documents it was revealed that the present Hospitalization was for investigation and

observation only followed by no active line of treatment.Newly born baby was kept in ICU for observation after birth and latershiftedto mothers side next date. The Insurance Company also stated in SCN sent through mail dated 28-12-2016 that baby care was excluded from the scope of policy coverage and the patient had also not sustained any injury or contracted any disease, hence the claim was repudiated by them.

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 in the hospital and a female baby was born by LSCS, but her claim was not settled by the Insurance Company.

   The Insurance Company during the personal hearing stated that the baby care was excluded from the scope of policy since the patient had also not sustained any injury or contracted any disease. Hence, claim was denied by them.

   After hearing both the sides and perusal of record placed before me, I find that the patient was admitted in the hospital on 22.03.2016 and a female baby was born by LSCS. The Apgar score of baby was 8/9/9 after birth and kept in NICU for observation. The baby was hospitalized for further treatment in the hospital which was necessary for the welfare of baby. Next day the baby was shifted to the mother's side. Accordingly I direct the Insurance Company to settle the claim of the complainant after adjusting Co-Payment clause, as per policy condition. **Accordingly an Award is passed with the direction to the Insurance Company to settle the claim of the complainant as admissible.**

DATE: 30.01.2017

In the matter of Ms. PremaRawat
Vs
IFFCO-Tokio General Insurance Company Ltd.

1. The complainant alleged that he had taken a motor Insurance policy no. 9695877 for his vehicle from IFFCO-Tokio General Insurance Company Ltd. During the currency period of policy, his vehicle met with the accidents twice but neither the Insurance Company had settled his claim nor informed him the status of claims.

2. The Insurance Company vide its mail had required certain copies of documents from the complainant which was not submitted to the Insurance Company, as per record available and the claim was not settled by the Insurance Company.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing, the complainant stated that neither the Insurance Company had settled his claims nor informed the status of his claims.

   The Insurance Company during the personal hearing stated that they had written a letter dated 15.04.16 for some clarification in the bills from the complainant but the complainant had not submitted the compliance to the Insurance Company.

   After hearing both the sides and perusal of record placed before me, I find that the Insurance Company had required certain bills/ cash memos of the damaged (in accident)parts but the same bills were not submitted to the Insurance Company by the complainant. Therefore, I direct the Insurance Company to settle the claims of the complainant as admissible on submission of the relevant documents. **Accordingly an Award is passed with the direction to the Insurance Company to settle the claim of the complainant as admissible.**

DATE: 30.01.2017

In the matter of Mr. T. P Sharma
Vs
Oriental Insurance Company Ltd.

1. The complainant alleged that he had taken a policy no. 214500/31/2016/8963 w.e.f. 22-01-2016 to 21-01-2017 from Oriental Insurance Company Ltd. for his vehicle. He also stated that on 28-01-2016 his vehicle was stolen and later the vehicle was recovered and he had taken the possession of his vehicle from the police Authority. He further stated that some parts of vehicle were missing/damaged at the time of taking delivery from police Authority. But the Insurance Company had not considered same parts in their approval such as CNG kit, stereo, bumper assembly stabilizer and wind strip etc., apart from the replacement of tyres which were damaged and the payment of crane charges. Insurance company had approved the claim of Rs. 22,700/- only after deduction of policy clause.

2. The Insurance Company vide its mail dated 01-07-2016 reiterated that the claim of the complainant was approved for Rs. 22,700/- after deduction of policy clause, as per the survey report of the surveyor and discharge voucher was sent to the insured for making payment, which he did not submit.

3. I heard the complainant during the course of hearing Insurance Company was absent from the hearing. During the hearing, the complainant admitted that out of the total parts such as Tyre, CNG kit, Stereo wind-strips and bumper assembly were later allowed by the Insurance Company. The remaining parts such as stabilizer assembly and payment for crane, were not allowed by the company.

   After hearing the complainant and perusal of record placed before me, I find the vehicle of the complainant was stolen on 28-01-2016 and later the vehicle was recovered. But after taking the possession of vehicle by the complainant some parts such as CNG kit, stereo, bumper assembly stabilizer and wind-strips etc. apart from the replacements of tyres and payment for crane expenses were not considered by the Insurance Company at the time of settlement of claim of the complainant. However, some parts such as CNG kit, stereo, wind-strips and bumper assembly were later allowed by the Insurance Company. The Insurance Company is directed to allow the replacement of stabilizer assembly and crane expenses to the complainant on receipt of cash memo/bill from the complainant.**Accordingly an Award is passed with the direction to the Insurance Company to settle the claimandpay the expenses for stabilizer assembly and crane expenses, as admissible.**

DATE: 03.03.2017

In the matter of Mr. Azad Gautam
Vs
Oriental Insurance Company Ltd.

1. The complainant alleged that he had taken a personal accident policy no. 271900/48/2016/3408 w.e.f. 16.10.2015 to 15.10.2016 from Oriental Insurance Company Ltd. The complainant also alleged that on 04.11.2015 he met with the accident and Dr. had advised him rest upto 13.12.2015. But Insurance Company had not settled his claim adequately and no claim approval letter was given by the Insurance Company.

2. The Insurance Company had not submitted any Self Contained Note or any relevant documents.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant stated that his claim for medical expenses under P.A. policy was not settled by the Insurance Company and he had already submitted bills to the Insurance Company.
   The Insurance Company reiterated that the complainant had not submitted original bills of medical expenses inspite of the letter sent to the complainant.
   On perusal of claim papers placed on record, I find that the complainant had not submitted original bills of medical expenses and in the absence of the same Insurance Company could not settle the claim of medical expenses under P.A. policy. However, the claim for weekly benefit of the complainant had already been settled by the Insurance Company. The Insurance Company is directed to settle the claim on receipt of the original bills of medical expenses from the complainant. **Accordingly an Award is passed with the direction to the Insurance Company to settle the claim of the complainant as admissible.**

DATE: 23.03.2017

In the matter of Mr. Sanjeev Aggarwal
Vs
Oriental Insurance Company Ltd.

1. The complainant alleged that he had taken a Happy Family Floater Policy w.e.f. 30.03.2013 to 29.03.2014 for his family from Oriental Insurance Company. He renewed his policy w.e.f. 15.04.2014 to 14.04.2015 after a gap of 15 days and he could not condone the gap from the Competent Authority. However, he had renewed his current policy w.e.f. 15.04.2016 to 14.04.2017 for his family. He further alleged that on 21.06.2016 he was admitted in the Hospital for the complaints of seasonal Asthmatic Bronchitis associated with moderate grade fever and also with the complaints of cough and shortness of breath and later his case was diagnosed as lower Respiratory Tract Infection – Acute Bronchitis. But his claim was denied by the Insurance Company on the ground that his gap of 15 days in renewal of policy between the year 2013-14 and 2014-15 was not condoned by the Competent Authority and record of his illness of Bronchial Asthma was not provided to the Insurance Company.
2. The Insurance Company vide its letter dated 03.08.2016 reiterated that the complainant had not condoned the gap of 15 days in the renewal of policies for the year 2013-14 and 2014-15 by the Competent Authority. The Insurance Company also stated that the complainant had also not provided the record of his disease of Bronchial Asthma and also not submitted the claim documents, as required to the Insurance Company. Hence, his claim was denied by them.

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 in the hospital for the complainants of seasonal asthmatic bronchitis and later he was diagnosed as Lower Respiratory Tract Infection-Acute Bronchitis. The complainant also stated that he could not condone the gap of 15 days in renewal between the policies of the year 2013-14 and 2014-15 from the Insurance Company and accordingly his claim was denied by the Insurance Company.

   The Insurance Company in the personal hearing stated that the complainant had not applied for the condonation of gap in the renewal of policies and also had not provided the required documents hence his claim was denied by them.

   After hearing both the sides and perusal of record placed before me, I find that complainant had taken mediclaim policy for the period 30.03.2013 to 29.03.2014 which was renewed on 15.04.2014 to 14.04.2015 after a gap of 15 days and subsequently renewal in time every year. A claim was lodged on 4th year running policy (15.04.2016 – 14.04.2017) for hospitalization during the period 21.06.2016

to 24.06.2016 for treatment of Acute Bronchitis. The Insurance Company had rejected the claim due to non-submissions of record of bronchial Asthma and on the ground that insured had not applied to condone the gap of 15 days in renewal of first year policy (30.03.2013 to 29.03.2014). I condone the gap of 15 days in renewal of first year policy (30.03.2013 to 29.03.2014). The claim was lodged on 4th year running policy (15.04.2016 to 14.04.2017) and Insurance Company could not substantiate that disease was pre-existing. Hence Insurance Company is directed to settle the claim as admissible. **Accordingly, I direct the complainant to submit the required documents to the Insurance Company and Insurance Company to settle the claim of the complainant as admissible.**

DATE: 31.01.2017

In the matter of Mr. NatwarHari Sharma
Vs
Apollo Munich Health Insurance Company Ltd.

1. The complainant alleged that he had health Insurance policy with Apollo Munich Health Insurance Company since 2013. It was ported (transferred) from Star Health Insurance with whom he was having policy since 2010. He was admitted in Max health care on 27-09-2016 and diagnosed as a case of Paraumbilical Hernia with obstructive changes and was told to get it operated by Max SuperSpecialtyHospital. Before operating the attending doctor asked for any heart-related concern and he told that he had some problem at the age of 14 related to heart. He had submitted all the necessary papers of the claim for reimbursement of Rs. 1,56,139/- but the Insurance Company had denied the claim on the ground of non-disclosure and concealment of material facts and policy was also terminated on the said ground. He had sought the relief of Rs. 1,56,139/- from this forum.
2. The Insurance Company vide its letter dated 30-09-2016 had rejected the claim on the ground that the medical history details of Rheumatic heart disease at the age of 14 years was not revealed in the proposal form while taking the policy. Hence, the policy is cancelled and claim is repudiated due to non-disclosure and concealment of material facts under section VII (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 complainant had reiterated the same. The Insurance Company had stated that the claim was rejected on the ground that the medical history details of Rheumatic heart disease at the age of 14 years was not revealed in the proposal form while taking the policy. Hence, the claim was repudiated due to non-disclosure and concealment of material facts under section VII (J) of the policy.

   On perusal of the claim papers placed on record and submissions made during the hearing, I find that Mr. Natwar Hari Sharma was admitted in Max Health care on 27-09-2016 and diagnosed as a case of Paraumbilical Hernia with obstructive changes. The Insurance Company had rejected the claim on the

ground that medical history details of Rheumatic Heart Disease at the age of 14 years was not revealed in the proposal form while taking the policy in June, 2013. Hence, the claim was repudiated due to non-disclosure and concealment of material facts under section VII (J) and policy was also cancelled abinitio. During the hearing the complainant had stated that Rheumatic Heart Disease was diagnosed at the age of 14 years (around 25 years back) and was fully cured. He does not have any record of the said disease. The Insurance Company had failed to prove that the complainant had undergone any treatment of RHD or he was on medication for the said disease before taking the policy. Merely because the patient was diagnosed as a case of RHD at the age of 14 years (around 25 years back) and was fully cured, it cannot be assumed that he was suffering from RHD since prior to purchase of the Insurance policy. The Insurance Company could not prove their contention with cogent and reliable documents that the insured had concealed the material facts at the time of purchasing the policy. Hence, I hold the Insurance Company is liable to settle the claim as per terms and conditions of the policy. Further the Insurance Company is directed to renew/restore the policy. **Accordingly an award is passed with the direction to the Insurance Company to settle the claim as per terms and conditions of the policy and pay the admissible amount to the complainant.**

DATE: 23-01-2017

In the matter of Ms. Meera Rani Verma
Vs
The United India Insurance Company Ltd.

1.The complainant had alleged that she got acupuncture treatment from 21-02-2016 to 09-07-2016 at Indraprastha Apollo Hospital, Delhi. She had submitted all the necessary papers of the claim to the Heritage TPA (Pvt.) Ltd. on 08-08-2016 for reimbursement of Rs. 58,800/- but they had rejected the claim on the ground of claim papers late submitted. She had sought the relief of Rs. 58,800/- from this forum.

2.The Insurance Company vide its Self-Contained Note (SCN) dated 13-01-2017 had submitted that the claim was rejected on the ground that acupuncture treatment is not covered under the policy. As per additional condition No. 2 of part-I of the policy schedule applicable to retirees employees of State Bank of Bikaner & Jaipur which states no expenses related to domiciliary/OPD treatment is payable.

3.I heard both the sides the representative of 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 Mrs. Meera Rani Verma had taken the acupuncture treatment for osteoarthritis which is not covered under OPD treatment. As per additional condition No. 2 of part-I of the policy schedule applicable to retirees employees of State Bank of Bikaner & Jaipur which states no expenses related to domiciliary/OPD treatment is payable.

4.On perusal of the claim papers placed on record and submissions made during the hearing, I find that the patient Mrs. Meera Rani had taken the acupuncture treatment for osteoarthritis from Dr. Raj Kumar. The complainant had submitted only hand written bills on letter head of Dr. Raj Kumar, no admission card, treatment details and discharge summary were provided neither to the TPA/Insurance Company nor to the forum for necessary perusal. During the hearing the Insurance Company had stated that as per policy additional condition No. 2 applicable to retirees employees of State Bank of Bikaner & Jaipur "no expenses related to domiciliary/OPD treatment" is payable. Since the patient was treated as an OPD, the claim was not payable under policy clause No. 2.Hence, I find no reason to interfere with the decision of Insurance Company and uphold the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

DATE: 23.01.2017

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

1. The complainant alleged that he was admitted in National Heart Institute from 11-04-2016 to 15-04-2016 and diagnosed as a case of Pseudo Pancreatic cyst. During hospitalization cystogastrostomy procedure was done under G.A. He had submitted all the necessary papers of the claim for reimbursement of Rs. 69,202/- to the Insurance Company but the company had denied the claim on the ground that he was consuming alcohol/drugs and due to this reason the said disease was developed. He had sought the relief of Rs. 69,202/- from this forum.

2. The Insurance Company vide its letter dated 03-08-2016 had rejected the claim on the ground that the submitted claim was for treatment of large Pseudo Pancreatic cyst which is a consequence/complication of Alcohol/drug intake. Treatment related to Alcoholabuse/substance abuse is excluded in the policy, hence claim was repudiated under Section V C (IV) 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 reiterated the same. The Insurance Company had stated that the claim was rejected on the ground that the submitted claim was for treatment of large Pseudo Pancreatic cyst which is a consequence/complication of Alcohol/drug intake. Treatment related to Alcohol abuse/substance abuse in excluded in the policy, hence claim was repudiated under V C (IV) of the policy.

On perusal of the claim papers placed on record and submissions made during the hearing I find that Mr. SandeepVerma was admitted in National Heart Institute from 11-04-2016 to 15-

04-2016 and diagnosed as a case of Pseudo Pancreatic Cyst. The Insurance Company had rejected the claim on the ground that the submitted claim was for treatment of large Pseudo Pancreatic cyst which is a consequence/complication of Alcohol/drug intake. Treatment related to Alcohol abuse/substance abuse is excluded in the policy, hence claim was repudiated under V C (IV) of the policy. As per medical record submitted it was evident that as per consultation paper dated 30-10-2014 of Dr. AmitabhaDutta, Indraprastha Apollo Hospital the patient was a known case of Chronic Liver Disease and Ethanol (Alcohol) and as per consultation paper dated 16-01-2016 of Dr. AnupamZutshi the patient is a known case of Type II DM, CLD and history of Alcohol. Treatment related to Alcohol abuse/substance abuse is excluded in the policy under Section V C-(IV), hence Insurance Company had rightly rejected the claim and I find no reason to interfere with the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

DATE: 23-01-2017

In the matter of Mr. Kamal Kishore Aggarwal
Vs
Apollo Munich Health Insurance Company Ltd.

1. The complainant alleged that he was admitted in Fortis Escorts Hospital, New Delhi on 08-07-2016 for the treatment of Liver cirrhosis and for endoscopic viraceal ligation and UGI Endoscopy procedures to be performed including different test & MRIs. He was discharged on the same day as his recovery was fast and the condition was stable. He had incurred Rs. 32,485/- towards the treatment and submitted all the necessary papers of the claim to the

Insurance Company for reimbursement of Rs. 32,485/- but the company had denied the claim on the ground of "non-hospitalization of more than 24 hours". He had sought the relief of Rs. 32,485/- from this forum.

2. The Insurance Company vide its letter dated 08-09-2016 had rejected the claim on the ground that the submitted claim was for management of an ailment which was done on out-patient basis without any hospitalization.OPD treatment is excluded from the scope of coverage in the policy, hence claim was repudiated under Section-VIII Def. 23 of the policy.
3. I heard both the sides the son of the complainant and the Insurance Company. During the course of hearing the representative of the complainant had reiterated the same. The Insurance Company had stated that the claim was for the management of Liver cirrhosis with portal hypertension and the patient had undergone endoscopic litigation which was done on out-patient basis without any hospitalization. OPD treatment is excluded from the scope of coverage in the policy, hence the claim was repudiated under policy clause section-VIII, Def 23 i.e.Hospitalization or Hospitalized-means admission in a Hospital for a minimum of 24 in patient care consecutive hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.

   On perusal of the claim papers placed on record and submissions made during the hearing, I find that Mr. Kamal Kishore Aggarwal had taken the OPD treatment in fortis Escorts hospital, Delhi on 08-09-2016for the management of Liver cirrhosis with portal hypertension and undergone endoscopic ligation. The Insurance Company had rejected the claim as the procedure/treatment taken by the patient does not fall under the OPD/day care procedure as per the terms and conditions of the policy. I find that since the endoscopic treatment does not fall under the OPD/day care procedure under the policy, the Insurance Company had rightly rejected the claim under section-VIII Def. 23 and I find no reason to interfere with the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

DATE: 24-01-2017

In the matter of Mr. HarbansLal
Vs
The United India Insurance Company Ltd.

1.The complainant had alleged that he was admitted in Dr. R.P. Centre, AIIMS, Delhi on 16-03-2016 and 02-05-2016 and diagnosed as B/E CDR. He was given injection Lucentis in the operation theater of casualityDeptt. of RP Centre, AIIMS. He had incurred Rs. 40,066/- (Rs. 21,687 + Rs.18,379) and submitted all the necessary papers of the claim to the Insurance Company for reimbursement of Rs. 40,066/- but the company had rejected the claim on the ground that hospitalization of 24 hours was not done and the treatment is not covered in day care procedure. He had sought the relief of Rs. 40,066/- from this forum.

2.The Insurance Company vide its letter dated 03-08-2016 had rejected the claim on the ground that injection Lucentis givenin this case and the said procedure is not enlisted in day care procedure, hence this claim is not payable as per policy clause 3.15 i.e. admission in a hospital/Nursing home for a minimum period of 24 in patient care consecutive hours except for specified procedure/treatment, where such admission could be for a period of less than 24 consecutive hours.

3.I heard both the sides the son of the complainant as well as the Insurance Company. During the course of hearing the complainant had alleged the same. The Insurance Company had stated that the claim was rejected on the ground that the complainant Mr. HarbansLal was treated in OPD (out-patient Deptt.) of AIIMS and injectionLucentis were administered. The said procedure is not enlisted in day care procedure list, hence the claim was not payable as per policy clause 3.15 i.e. admission in a hospital/Nursing Home for a minimum period of 24 in patient care consecutive hours except for specified procedure/treatment, where such admission could be for a period of less than 24 consecutive hours.

4.On perusal of the claim papers placed on record and submissions made during the hearing, I find that Mr. HarbansLal was treated at Dr. R. P. Centre, AIIMS, Delhi on 16-03-2016 and 02-05-2016 and diagnosed as B/E CDR. During the treatment injection Lucentis was administered to the patient under operation theatre OT. The complainant had submitted that the injection "Lucentis" was given in operation theatre under Sterile conditions and before the injection Lucentis was given, the angiography of both the eyes and O.C.T was done at the hospital. Since the patient was treated in hospital and injection Lucentis was administered in operation theatre (OT) under sterile conditions, and the said procedure is also not specifically excluded in the policy issued to the complainant, 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.**

DATE: 23.02.2017

In the matter of Mr. Mritunjay Bhattacharya
Vs
The United India Insurance Company Ltd. (New Delhi)

1. The complainant alleged that his father Dr. A.K. Bhattacharya was admitted in Sir Ganga Ram Hospital from 12.11.2014 to 14.11.2014 and diagnosed as a case of Lumbar canal stenosis L4-5 with Right L5 Radiculitis. He had submitted all the duplicate medical papers of the claim to the Insurance Company for reimbursement of Rs. 1,74,690/-. The original claim papers were lost by him and the intimation to the policy station, BarakhambaRoad, New Delhi was given on 09.11.2015 in this regard. The Insurance Company had rejected the claim on the ground that original claim papers were not submitted for settlement of the claim. He had sought the relief of Rs. 1,74,690/- from this forum.

2. The Insurance Company TPA vide its letter dated 19.02.2016 and 01.12.2016 had rejected the claim under policy clause No. 5.6. which states that the Insuredperson shall obtain and furnish to the TPA with all original bills, receipts and other documents, upon which a claim is based and shall also give the TPA/Company such additional information and assistance as the TPA/ Company may require in dealing with the claim.Since the Insured had submitted the duplicate papers, hence claim was repudiated under policy clause 5.6.

3. I heard both thesides, 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 there was a delayed intimation and the Insured had submitted duplicate claim papers, hence claim was rejected.

On perusal of the claim papers placed on record and submission made during the hearing I find that Dr. A.K. Bhattacharya was admitted in Sir Ganga Ram Hospital from 12.11.2014 to 14.11.2014 and diagnosed as a case of Lumbar Canal stenosis L4-5 with Right L5 Radiculitis. The complainant had stated that original claim papers were lost from Himalaya House, K.G. Marg, New Delhi, and he had lodged a complaint in this regard with Police Station Barakhamba Road, New Delhi on 19.11.2014. He had submitted duplicate papers of the claim to the Insurance Company for settlement of the claim but the company had denied the claim under policy condition 5.6 which states "The insured person shall obtain and furnish to the TPA with all the original bills receipts and other documents upon which a claim is based and shall also give the TPA/Company such additional information and assistance as the TPA/Company may require in dealing with the claim. During the hearing the representative of Insurance Company had stated that there was also a delay on the part of insured in intimation of claim and submission of claim documents to the Insurance Company. But the contention of the insurer do not hold any merits as the final reply letter dated 01.12.2016 sent by unicustomer care department, Regional Office, Chennai to the insured had specifically mentioned that the claim was repudiated only under policy condition 5.6 and not on the ground of delayed intimation and delayed submission of documents. The Insurance Company in its Self Contained Note (SCN) dated 06.02.2017 had mentioned that M/s Vidal Health, the TPA vide their letter dated 19.02.2016 had informed the insured about the repudiation of the claim but on perusal of the said letter it is found that the same had been written to only the Divisional Manager of United India Insurance Company Ltd. and not to the Insured. Hence, Insurance Company is hereby directed to settle the claim on the basis of duplicate papers submitted by the insured after obtaining the affidavit from the insured that his original medical papers were lost and he had not taken the said claim from any other Insurance Company/ Institution by using the said original medical papers.**Accordingly an award is passed with the directions to the Insurance Company to settle the claim on merits and pay the admissible amount as per terms and conditions of the policy to the complainant.**

DATE: 31.03.2017

In the matter of Mr. Ravi Shankar Gupta
Vs
United India Insurance Company Ltd.

1. The complainant had alleged that his wife was admitted in Max Health Care Super Specialty Hospital from 23.06.2016 to 28.06.2016 and diagnosed as a case of Acute Chest infection with sepsis. The reason for admission was complaints of fever, breathlessness, and cough with expectoration, breathing difficulty since 7-8 days and a known case of Allergic Bronchopulmonary Aspergillosis (ABPA). He had incurred Rs. 57,115/- towards the treatment of his wife whereas he had received the cashless approval of Rs. 31,293/- only. The claim amount of Rs. 25,822/- was deducted under room, rent category as the sum insured of the year 2005 was taken for room rent entitlement (1% of Rs. 1,50,000/-). He had the sum insured of Rs. 5,00,000/- under the policy since 2014 and the claim should have been settled according to the sum insured of Rs. 5,00,000/-. He has sought the relief of Rs. 25,822/- from this forum.
2. The TPA vide its email dated 12.01.2017 had apprised the insured that she has history of Asthma since 8-10 years and 10 years back her sum insured was Rs. 1,50,000/-, so as per policy clause 5.12 (enhancement of sum insured) liability of insurer on this particular disease is restricted on 2005 sum insured which was Rs. 1,50,000/- and as per policy clause 1.2 insured was entitled for room rent per day of Rs. 1,500/- (1% of applicable sum insured), but insured availed room of Rs. 3,500/- day, hence excess room rent per day were deducted and in the same proportion charges from other heads were also deducted except medicines and consumable.

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 accordingly to terms and conditions of the policy. The patient Mrs. Sudha Gupta Was admitted in Max Healthcare Super Specialty Hospital on 23.06.2016 with diagnosis of Acute Chest infection with sepsis and a known case of Allergic Bronchopulmonary Aspergillosis (ABPA). As per medical record the patient had a history of Asthama Since 8-10 years. Under the circumstances, the disease suffered lies in policy period 2004-05 and the sum insured in that policy was Rs. 1,50,000/- only. The sum insured of the policy during whose period the disease was first contracted i.e. policy for 2004-05 was Rs. 1.5 lakh only and accordingly the claim was settled as per the policy terms and conditions no. 5.12 i.e. Enhance of sum insured i.e. – "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. Any such request for enhancement must be accompanied by a declaration that the insured or any other insured person in respect of whom such enhancement is sought is not aware of any symptoms or other indications that may give rise to a claim under the policy. the company require such insured person to undergo a medical examination to enable the company to take a decision on accepting the request of the insured for enhancement in the Sum Insured." An amount of Rs. 31,293/- was paid to the complainant against a claim amount of Rs. 57,114/- as per policy terms and conditions.

On perusal of the claim papers placed on record and submissions made during the hearing, I find to the patient Mrs. Sudha Gupta was admitted in Max Healthcare Super Specialty Hospital from 23.06.2016 to 28.06.2016 and diagnosed as a case of Acute Chest infection with Sepsis and a known case of ABPA. As per medical record produced by the Insurance Company the patient had a past history of Asthama since 8-10 years and the working diagnosed was Lower Respiratony Tract Infection (LRTI). Hence, the disease suffered pertains to policy period 2004-05 and the sum insured in that policy was Rs. 1.5 lakhs (P. No. 040400/48/04/00461 from 03.08.2004 to 02.08.2005). As per policy clause 5.12 – "Enhancement of sum insured" as mentioned above, the claim would be settled according to the sum insured the policy during which period the disease was first contracted. The patient had a past history of Asthama since 08-10 years, hence the sum insured Rs. 1.5 lakh of 2004-05 was considered for settlement of the claim by the company. Hence, 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 is disposed off.**

DATE: 14.03.2017

In the matter of Mr. Omkar Nath Sharma
Vs
United India Insurance Company Ltd.

1. The complainant alleged that he was admitted in Fortis Escorts, Hospital, Faridabad from 20.10.2015 to 24.10.2015 and diagnosed as a case of accelerated hypertension coronary artery disease, double vessel disease, old cerebrovascular accident, parkinsonism, hypovitaminosis-D, acute kidney injury. He had submitted all the necessary papers of the claim to the Insurance Company for reimbursement of Rs. 43,229/- but the company had settled the claim only for Rs. 19,575/-. He had sought the relief of Rs. 23,672/- balance amount of claim from this forum.

2. The Insurance Company vide its email dated 05.12.2016 had informed the insured that amount of Rs. 19,757/- was paid on 18.10.2016 through NEFT.

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 as per policy clause 1.2 (A to D). The TPA M/s Vipul Medcorp had paid Rs. 19,757/- on 18.10.2016 and Rs. 3,054/- on 19.12.2016. thus total Rs. 22,811/- was paid to the Insured. As per policy clause 1.2A insured's entitlement of Room Rent is Rs. 1,000/- per day but he opted the Room rent for Rs. 2,700/- per day hence difference on room rent and other expenses as mentioned in 1.2 C and D (Doctor's consultation charges and investigation charges) according to entitled room rent category had been disallowed as per policy provision stated on Note after clause 1.2 of policy.

On perusal of the claim papers placed on record and submissions made during the hearing I find that the TPA M/s Vipul Medcorp had paid the claim amount Rs. 22,811/- to the insured and deductions were made as per policy clause 1.2 (A to D). Since the claim was paid according to policy terms and conditions, I find no reason to interfere with the decision of the Insurance Company. **Accordingly, the complaint filed by the complainant is disposed off.**

DATE: 15.03.2017

In the matter of Mr. Balvinder Ralhan
Vs
United India Insurance Company Ltd.

1. The complainant had alleged that his son Mr. Prabhat Ralhan had met with an accident on 13.04.2016 at Bangalore (Karnatka) and was admitted in Sparsh Hospital, Bangalore. In the hospital it was found that during the accident he had his front upper tooth broken and the adjoining teeth were also affected and there was facial injury also. He got stitches at his chin and few stitches under the lips also. Suitable treatment was given by the hospital at that time. He was also advised to go for further treatment of tooth implant under the supervision of MDS doctor. After completing his studies his son came back to Delhi and he was taken to Dr. Manu Modi on 02.06.2016 for teeth relating treatment and he had undergone treatment for tooth implant and other allied treatment of his other teeth. He had incurred Rs. 1,20,625/- towards the treatment. The Insurance Company had denied the claim on the ground that the treatment was taken on OPD basis and as per policy terms the dental treatment is not payable unless arising due to an accident and requiring hospitalization. He had sought the relief of Rs. 1,20,625/- plus 18% interest from the date of lodge till its realization.
2. The TPA M/s M. D. India Health Care services (TPA) Pvt. Ltd. vide letter dated 03.09.2016 had rejected the claim on the ground that OPD treatment is not payable and dental treatment unless necessitated by accident and require hospitalization is not payable. Hence, claim was rejected under policy clause no. 4.5 "dental treatment of surgery of any kind unless necessitated by accident and requiring hospitalization" and clause 2.1 no. "Procedure/treatment usually done on out-patient basis are not payable under the policy even if converted as in-patient in the hospital for more than 24 hours or carried out in day care centre."

3. I heard both the sides the representative of complainant as well as Insurance Company. During the hearing the representative of the complainant had reiterated the same. The Insurance Company had stated that the said claim was rejected under policy clause 4.5 which states that dental treatment or surgery of any kind unless necessitated by accident and requiring hospitalization. Since the patient Mr. Prabhat Ralhan had taken the dental treatment on OPD basis, hence claim was not payable under policy clause 4.5 and policy clause 2.1 i.e. procedure/treatment usually done on out-patient basis are not payable under the policy even if converted as an in-patient in the hospital for more than 24 hours or carried out in day care centres.

   On perusal of the claim papers placed on record and submissions made during the hearing I find that Mr. Prabhat Ralhan had met with an accident on 13.04.2016 at Bangalore and had undergone for tooth implant and other allied treatment of his other teeth on OPD basis. As per policy clause 4.5 of the policy the dental treatment is payable only if dental treatment or surgery of any kind unless necessitated by accident and requiring hospitalization. Since, the patient Mr. Prabhat Ralhan had taken the dental treatment on OPD basis which was not payable according to policy clause 4.5 and policy clause 2.1procedure/treatment usually done on out-patient basis are not payable under the policy even if converted as an in-patient in the hospital for more than 24 hours or carried out in day care centres. Hence, I uphold the decision of the Insurance Company and find no reason to interfere with the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

DATE: 14.03.2017

In the matter of Mr. Uday Pathak
Vs
United India Insurance Company Ltd.

1. The complainant alleged that his son Mr. Rudravir Pathak was admitted in Sir Ganga Ram Hospital from 10.11.2016 to 12.11.2016 and diagnosed as a case of Adenotonsillar Hypertrophy. Her son was operated for Adenoids and Tonsil removal. During operation the doctor prescribed using the coblation technique. The total bill amount was Rs. 1,05,228/- but the TPA M/s Vipul Medcorp had sanctioned the cashless claim only for Rs. 32,000/- on the ground that the procedure is covered under GIPSA PPN package of Rs. 32,000/-. He had sought the relief of Rs. 73,228/- from this forum.

2. The Insurance Company vide its email dated 09.12.2016 had informed the insured that the cashless approval for Rs. 32,000/- was as per GIPSA PPN package. The coblation tonsillectomy, and coblation Adenoidectomy is not payable as it is an advanced medical treatment/ technique and in such cases the company's liability is to be restricted to the cost of conventional treatment expenses i.e. Adenotonsillectomy.
3. I heard the Insurance Company. The complainant vide his letter dated 16.02.2017 had informed that he was unable to attend the hearing and the case may kindly be decided on the basis of written submission and documents filed by him. The complainant had submitted that he had not been informed by the Insurance Company about GIPSA Package nor is there anymention in the policy terms and conditions. The representative of the Insurance Company had agreed that there was no mention of GIPSA Package in the policy.

   On perusal of the claim papers placed on record and submissions made during the hearing, I find that details of GIPSA Package are not incorporated in the policy, the said facts had also been admitted by the representative of the Insurance Company. Hence, in the absence of such condition, I direct the Insurance

Company to settle the claim and pay the remaining amount as admissible to the complainant. **Accordingly an Award is passed with the direction to the Insurance Company to settle the claim of the complainant and pay the remaining amount as admissible to the complainant.**

DATE: 20.03.2017

In the matter of Mr. Vishnu Bansal
Vs
United India Insurance Company Ltd.

1. The complainant alleged that her mother was admitted in Rajiv Gandhi Cancer Institute and Research Centre from 29.06.2016 to 04.07.2016 and diagnosed as a case of Carcinoma Cervix. During hospitalization Robotic Radical Hysterectomy surgery was performed. She had submitted all the necessary papers of the claim to the Insurance Company for reimbursement of Rs. 4 lakhs (approx.) including robotic surgery cost Rs. 1.80 lakhs but the Insurance Company had denied the claim on the ground that the charges of robotic surgery are not payable under policy terms and conditions. She is ready to accept the amount of other expenses except robotic surgery. She had requested to settle her claim by deducting the robotic surgery charges which comes to Rs. 2 lakh (approx).
2. The Insurance Company vide its letter dated 23.01.2017 had rejected the claim on the ground that the patient Ms. Vidhya Devi Bansal was diagnosed as Carcinoma Cervix and admitted for Robotic Redial Hysterectomy which is not payable.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant had reiterated the same. The Insurance Company had stated that the claim was rejected vide rejection letter dated 23.01.2017 on the ground that the patient was diagnosed as carcinoma cervix and admitted for Robotic Radical Hysterectomy which is not payable. Hence, the claim has been rejected as No Claim.

   On perusal of the claim papers placed on record and submissions made during the hearing I find that Mrs. Vidya Devi Bansal was admitted in Rajiv Gandhi Cancer Institute and Reach Centre from 29.06.2016 to 04.07.2016 and diagnosed as a case of carcinoma cervix. During hospitalization Robotic Radical Hysterectomy (Type-III RH with B/L PLND) under G.A. was done. The Insurance Company had rejected the claim vide letter dated 23.01.2017 on the ground that the treatment of Robotic Radical Hysterectomy was not payable under the policy. The Insurance Company had submitted the Self Contained Note (SCN) on 14.03.2017 and changed the ground of rejection of the claim under the said SCN. As per Self Contained Note the claim was not payable under policy clause 4.3. i.e. "During the first two years of the operation of the policy, the expenses on treatment of disease such as Cataract, Benign Prostatic Hyperthrophy, Hysterectomy for Menorrhagia or Fibromyoma, Hernia, Hydrocele, Congenital internal disease, Fistula in Anus, Piles, Sinusitisand related disorder, Gall bladder Stone removal, Gout & Rheumatism, Calculus disease are not payable." Once the claim had been rejected and the insured had been informed about the rejection and the ground of rejection of the claim, the Insurance Company subsequently cannot change the stand of ground of rejection of claim before the forum. The plea of Insurance Company can not be accepted that the claim was not payable under policy exclusion clause 4.3. As per definition of surgery or surgical procedure under policy –"Surgery or surgical procedure means manual and/or operative procedure(s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of disease, relief of suffering or prolongation of life, performed in a hospital or day care centre by a Medical Practitioner." I find that there is no exclusion clause regarding the robotic surgery. 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 as per terms and conditions of the policy and pay the admissible amount to the complainant.**

DATE: 27.03.2017

In the matter of Ms. Monica Singhal
Vs
Apollo Munich Health Insurance Company Ltd.

1. The complainant alleged that she was admitted in Fortis Escorts, Faridabad from 13.02.2016 to 15.02.2016 and diagnosed as a case of Acute Relapse of Multiple Sclerosis and Hypovitaminosis-D. She had submitted all the necessary papers of the claim for reimbursement of Rs. 74,735/- to the Insurance Company but company had rejected her claim on the ground of non-disclosure and concealment of material facts and the policy was also terminated. She had sought the relief of Rs. 74,735/-and restoration of her policy from this forum.

2. The Insurance Company vide its letter dated 30.03.2016 had rejected the claim on the ground of non-disclosure and concealment of facts under Section-VI (J) of the policy terms and conditions. The medical history details of Acute relapse of Multiple Sclerosis was not revealed while taking the policy in the proposal form. The policy was also terminated on the said 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 had reiterated the same. The Insurance Company had stated that the claim was rejected on the ground of non-disclosure of material facts under section- VI (J) of the policy terms and conditions. The medical history details of Acute Relapse of multiple Sclerosis was not revealed in the proposal form while taking the policy. The policy was also terminated on the said ground of concealment of material facts.

   On perusal of the claim papers placed on record and submissions made during the hearing I find that the patient Mrs. Monica Singhal was admitted in Fortis Escorts Hospital from 13.02.2016 to 15.02.2016 and diagnosed as a case of Acute Relapse of Multiple Sclerosis, Hypovitaminous-D. The medical details/discharge summary dated 04.01.2013 of Indraprastha Apollo Hospital had revealed that the patient was suffering from multiple demyelinating plaques in brain and corpus callosum and she was admitted for further management. But the said facts was not revealed by the insured at the time of taking the policy (P. No. 110101/11121/6000119687 from 30.08.2013 to 29.08.2014). The medical history details of Acute Relapse of Multiple Sclerosis was not disclosed by the insured in proposal form dated 30.08.2013 under column No. 6-Medical and Life style information, hence the Insurance Company had rightly rejected the claim under policy clause section-VI (J) i.e. non-disclosure and concealment of material facts. I find no reason to interfere with the decision of the Insurance Company. Further during the hearing the complainant had stated that the Insurance Company had also terminated the policy on the ground of non-disclosure and concealment of material facts. The Insurance Company had agreed to restore the policy for the family with continuity benefits as per underwriting guidelines of the company by excluding the name of the complainant Mrs. Monica Singhal from the policy. Hence, I direct the Insurance Company to restore the policy with continuity

benefits as per underwriting guidelines of the company by excluding the name of Mrs. Monica Singhal from the policy. **Accordingly the complaint filed by the complainant is hereby dismissed.**

DATE: 10.03.2017

In the matter of Mr. R. P. Chopra
Vs
United India Insurance Company Ltd.

1. The complainant alleged that he was suffering from a common Skin Cancer "Basal Cell Carcinoma (Nose)" which is truly invasive and malignant in nature and attacks face specially near nasal Skin and eye lids. For its treatment he got himself admitted to Medanta Hospital, Gurgaon on 27.04.2015 for surgery. There was bulge in the region of upper part of the nose. SSG over forehead well healed and secondary/third surgery for correction of the bulge can be done, if desired. He had incurred Rs. 5,94,151/- towards treatment and submitted all the necessary papers of the claim for reimbursement of Rs. 5,94,151/- but the TPA M/s E-Meditek had paid only Rs. 1,75,168/-. He had sought the relief of Rs. 4,18,983/- from this forum.

2. The Insurance Company vide its SCN dated 08.03.2017 had stated that three claim were settled and deductions were made as per policy terms and conditions. The details of 03 paid claims are as under:-

    1. Claim no. 122041505381 (Hospitalization period 27.04.2015 to 29.04.2015) amount claimed – Rs. 1,52,968/- amount settled Rs. 1,14,661/-.

    2. Claim no. 122051503925 (Hospitalization period 25.05.2015 to 26.05.2015) amount claimed Rs. 53,604/- amount settled Rs. 28,117/-.

    3. Claim no. 122051503925 (Extension claim) Bills received Rs. 32.252/- amount settled Rs. 3,555/-.

    For rest of the claims the insured had not submitted any claim papers for settlement.

5.I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the Insurance Company had stated that three claims of the insured amounting to Rs. 1,46,333/- (Rs. 1,14,661/- + Rs. 28,117/- + Rs. 3,555/-) were paid as per terms and conditions of the policy and no further claim is pending for settlement with them. The sum insured under the policy was Rs. 2 lakh (P. No. 2219002814P108867937 from 29.01.2015 to 28.01.2016) and there was a balance left for Rs. 53,667/- (Rs. 2,00,000 - Rs. 1,46,333) under the said policy. the Insurance Company is ready to settle the claim to the extent of sum insured left under the policy if the insured would submit the claim papers for the treatment taken during the said policy period. Hence, the complainant is directed to submit the claim papers for the remaining claims to the Insurance Company for settlement of the claim on its merits as per terms and conditions of the policy.**Accordingly the complaint filed by the complainant is hereby disposed off.**

DATE: 18-01-2017

In the matter of Mr. Krishan Kumar Goyal
Vs
The National InsuranceCompany Ltd.(New Delhi)

1. The complainant alleged that he was hospitalized at Apollo hospital for the period 24/10/2015 to 28-10-2015with complainant of high grade fever. The claim was settled for an amount of Rs. 58920/- on cashless basis against final bill of Rs. 80807/- leaving an unpaid balance of Rs. 21,887/-. Subsequently he had submitted all the relevant documents for reimbursement of pre/post hospitalization and balance of cashless claim.The Insurance Company had paid Rs. 6496/- only leaving an unpaid amount of Rs. 14,617/- He sought relief of Rs. 14,617/- + Rs. 25000/- (compensation) from this forum.

2. The Insurance Company vide SCN dated 11-01-2017 reiterated that TPA received cashless request from Apollo hospital for an amount of Rs. 80,807/- which was initially settled for an amount of Rs. 58,920/- as per bill submitted and as per policy terms and condition. Subsequently after discharge from hospital, insured submitted claim for an amount of Rs. 31,113/- towards post hospitalization and balance amount under cashless request. After thorough examination of his claim TPA settled for an amount of Rs. 6,496/- after making deductions of Rs. 24,617/- (Rs. 21,887/- excess room rent & proportionate deduction + 2730/- not related to the diagnosis).

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of personal hearing the complainant had alleged the same. The Insurance Company could not

show any counter documentary proof or reason for deduction of Rs. 14,617/- from claimed amount.

On perusal of papers on record I find that patient was admitted for chikungunya and cellulitis as revealed from discharge summary dated 28-10-2015 of Apollo hospital. The Insurance Company had considered only chikungunya and not cellulitis and has deducted Rs. 14,617/- under heads miscellaneous charges, medicines and consultation not related to diagnosis. The Insurance Company could not substantiate the reason for deductions made under the claim. There was deficiency on the part of the Insurance Company. The Insurance Company is directed to pay the remaining Rs. 14,617/-. **Accordingly an award is passed with the directions to the Insurance Company to pay the remaining amount to the complainant.**

DATE: 18.01.2017

In the matter of Ms. SudeshKamra

Vs

The National Insurance Company Ltd. (New Delhi)

1. The complainant alleged that she was admitted in the hospital for a period from 22/06/2016 to 28/06/2016 for treatment of fracture shaft Femur. She was advised physiotherapy. She had submitted all the relevant papers of the claim for reimbursement of Rs. 57645/- but Insurance Company had paid Rs. 19395/- only. Physiotherapy charges of Rs. 36750/- were disallowed on the ground that exercises advised by the physiotherapist could have been done by attendant.

2. The Insurance Company vide SCN dated 28-12-2016 reiterated that claim was rightly settled as per the policy. Home visit charges during pre and post hospitalization fall under exclusion as per clause No. 4.28, hence Rs. 1500/- were disallowed and Rs. 36750/- were disallowed since physiotherapy charges were not justified. The exercises advised by the physiotherapist could have been done at home by attendant.

3. I heard both the sides, the Complainant as well as the Insurance Company. During the course of person hearing the complainant stated that his mother was 75 years old. She was taken to home in ambulance after discharge. She was advised physiotherapy at home at the time of discharge. She can not go to hospital for physiotherapy. The Insurance Company reiterated as above.

   On perusal of papers on record I find that complainant's mother had undergone surgery for fracture shaft femur. Doctor had advised physiotherapy for 2 months at the time of discharge. The patient could not be taken to the hospital daily for physiotherapy; hence physiotherapy was done at home. The policy exclusion Clause "4.28 Home visit charges" excluded home visit charges during pre and post hospitalization period of doctor, attendant and nurse. It does not exclude home visit charges for physiotherapist. Hence Insurance Company is directed to pay post-operative physiotherapy charges for 2 months. **Accordingly an award is passed with the direction to the Insurance Company to settle the claim and pay post-operative physiotherapy charges for 2 monthsto the complainant as per terms and conditions of the policy.**

DATE: 18-01-2017

In the matter of Mr. Pradeep Kumar Pawar
Vs
The National Insurance Company Ltd. (New Delhi)

1. The complainant alleged that he was hospitalized at SAAOL hospital for the period 17/02/2016 to 28/03/2016 for treatment of Coronary Artery Disease by natural By pass therapy. During hospitalizations period only 3-4 hours of daily hospitalizations was required per shift in day case. He had submitted all the relevant papers of the claim for reimbursement of Rs.1,27,500/- but the claim was repudiated by the Insurance Company.

2. The Insurance Company reiterated that insured patient had taken 35 sittings for Natural Bypass and 20 settings for Biochemical Angioplasty for coronary artery disease carried out in SAAOL (Science and Art Of Living) for a period of 17/02/2016 to 28/03/2016. As per clause No. 4.18 of T&C of the policy Insurance Company was not liable to make any payment in respect of any expenses incurred in respect of OPD treatment – Hence claim was rejected.
3. I heard both the sides the complainant as well as the Insurance Company. During hearing, it emerged that the complainant had undergone "Enhanced External Counter Pulsation (EECP) and Bio-Chemical Angioplasty (BCA)" from 17-05-2016 to 28-03-2016. The claim was denied on the ground that the bio-chemical angioplasty was non-conventional therapy and the other ground was that it was a day care process not listed in the policy. The treatment is regularly being given at "SAAOL HEART CENTER" by trained doctors from AIIMS, Delhi. The treatment is cheaper and safer from the conventional angioplasty. It is in no way a day care process and required hospitalization for no. of days 40 to 45 days sitting are required with medicines and special equipment. Scores of patients are successfully availing this treatment all over India.

5. In view of these facts and circumstances and advancement of technology, I feel it just, fair and equitable to award that the case of the complainant for an amount of Rs. 1,27,500/- should be processed and settled as per terms and conditions of the policy. **Accordingly an award is passed with the direction to the Insurance Company to settle the claim and pay the admissible amount to the complainant as per terms and conditions of the policy**.

DATE: 25-01-2017

In the matter of Mr. Neeraj Kumar
Vs
Max Bupa Health Insurance Company Ltd. (New Delhi)

1. The complainant alleged that he was admitted in SR MALIK Hospital for the period 27-09-2016 to 03-10-2016 with complaints of high fever, vomiting and loose motion and was diagnosed as a case of viral fever and UTI. He had submitted all the relevant claim papers to the company for reimbursement of Rs. 52,649/-, "The claim was rejected on the ground that misrepresentation of facts were revealed in the claim documents."

2. The Insurance Company had rejected the claim vide letter dated 30-11-2016 on the ground that as per the submitted documents and investigation done by the Company, misrepresentation of facts was found between the hospital and insured with claim documents.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of personal hearing the complainant stated that cashless claim was approval earlier but denied later. He had answered all the questions raised by agent.

   The Insurance Company reiterated that on investigation of claim it was observed that complainant had availed three claim after every three months for the same illness. He had not declared previous claims during the inception of the policy. The complainant had tampered the claim documents.

   On perusal of papers on record I find that Insurance Company had already paid two claims to the complainant. The issue of non-disclosure if any could have been raised during settlement of first claim. The Insurance Company could not substantiate any documentary proof of tampering of documents by the complainant. Therefore I uphold that Insurance Company is liable to settle the claim. **Accordingly an award is passed with the direction to the Insurance Company to settle the claim as per terms and conditions of the policy and pay the admissible amount to the complainant.**

DATE:18-01-2017

In the matter of Ms. Manju Gupta
Vs
The National Insurance Company Ltd. (New Delhi)

1. The complainant alleged that she had been suffering from Parkinsonism disease for last three years and was on medication. On the night of 04-07-2016, she had accidently taken wrong medicine (Alprazolam) and became unconscious. She was taken to the Hospital immediately and discharged same day. The Insurance Company had denied the claim due to the reason that period of hospitalization was less than 24 hours. She sought relief of Rs. 29,384/- from this forum.

2. The Insurance Company vide letter dated 03-10-2016 had rejected the claim on the ground that period of hospitalization was less than 24 hours for disease other than covered under the policy.
3. I heard boththe sides, the complainant as well as the Insurance Company. During the course of hearing the Insurance Company reiterated as above. On perusal of papers on record, I find that patient was hospitalized on 04/07/2016 at 2.45 am and discharged same day in the evening. The duration of hospitalization was less than 24 hours, hence claim was rejected by the Company under Clause No. 3.12 of policy Terms and Conditions which states that minimum period of hospitalization should be 24 consecutive hours. Therefore I see no reason to interfere with the decision of the Company. **Accordingly the complaint filed by the complainant is hereby dismissed**

DATE: 20-01-2017

In the matter of Ms. Urmila Devi
Vs
Star Health And Allied Insurance Company Ltd. (New Delhi)

1. The complainant alleged that she slipped from the stairs at home on 15-12-2014. He was diagnosed collapse Fracture D12 Body and was admitted in the hospital at doctor's advice for the period 23-12-2014 to 01-01-2015 for surgery. The cashless claim was denied. She had submitted all the relevant documents for reimbursement of Rs. 2,59,397/- vide letter dated 20-01-2015 but claim was rejected on the ground that disease was pre-existing.

2. The Insurance Company had rejected the claim due to non-disclosure of material fact i.e. existence of pre-existing disease and policy was cancelled on pro-rata basis for remaining period of policy.
3. I heard both the sides the complainant as well as the Insurance Company. During hearing, the complainant contended that claim was lodged in 01/01/2015 and Insurance Company had rejected the claim in 20/04/2015. Subsequently he wrote in 26/05/2015 for continuation of Insurance but Insurance Company did not respond.

   On perusal of papers on record and submissions made during hearing it emerged thatInsurance Company reviewed the case only after complaint was lodged in Insurance Ombudsman and agreed to settle the claim and renew the policy with exclusion. Insurance Company could not show any response to the letter dated 20/05/2015 and could not substantiate with documentary proof as to why after 1 year Insurance Company agreed to settle the claim and renew the policy with exclusion.

   Insurance Company is directed to settle the claim and renew the policy from current date subject to deposition of premium along with continuity benefits; however Insurance Company is not liable for any liability during the uncovered period. **Accordingly the complaint filed by the complainant is hereby disposed off.**

DATE: 18.01.2017

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

1. The complainant alleged that he had taken a mediclaim policy no. 360801/48/15/8500003482 w.e.f. 13.09.15 to 12.09.16 for his family from National Insurance Company Ltd. He also stated that on 06.05.16 he was admitted in the hospital for the complaints of gradually increasing B/L groin swellings for the last 06 months and later his case was diagnosed as Right and Left inguinal hernia associated with phimosis due to balanopasthitis and was discharged from hospital on 09.05.16 but his claim was not settled by the Company adequately.

2. The Insurance Company vide its letter dated 21.06.16 reiterated that the patient was hospitalizated at National Heart Institute from 06-05-2016 to 09-05-2016 with diagnosis of Right Obstructed Inguinal Hernia. The Insurance Company had settled the claim for Rs.87007/- as against the estimate of Rs. 1,44,941 as per terms and conditions of the policy.The available room rent limit was Rs. 5000/- per day, hence proportionate deductions were made is Dr's free, investigation charges, non-payable items etc.

3. I heard both the sides, the Complainant as well as the Insurance Company. During the course of personal hearing the complainant pleaded that he was not aware of GIPSA Package and sough reimbursement of surgery charges deducted by the company under GIPSA Package. The Insurance Company reiterated that procedure cost Rs. 93210/- as per

agreed package rates at ShriMool Chand hospital was paid to the insured and balance amount was disallowed under reasonable and customary clause.

On perusal of papers on record and submissions made during hearing I find that surgery charges were paid as per agreed package rates of Mool Chand hospital. The Insurance Company had paid Rs. 93210/- against incurred/claimed amount of Rs. 141840/-. The GIPSA Package rates were not known to the complainant before surgery. The Insurance Company can not restrict the liability to the amount comparing with other hospitals in the vicinity of the hospital where the complainant had undergone for treatment without having it made noun to the complainant. As per terms and conditions of the policy there was no capping for surgery. Hence Insurance Company is directed to pay the balance amount of surgery charges. **Accordingly an award is passed with the direction to pay the remaining amount of surgery charges after deducting excess room rent, Drs Fee, consumables etc**.

DATE: 18-01-2017

In the matter of Mrs. SarojBirla
Vs
National Insurance Company Ltd.

1. The complainant alleged that he had taken a mediclaim policy no. 360801/48/14/8500005014 w.e.f. 12.01.15 to 11.01.16 for her family. She further stated that on 12.10.15 she was admitted in the Hospital with complaints of pain in abdomen,

recurrent vomiting since morning and not able to pass factus and later her case was diagnosed as acute intestinal and obstruction secondary to band and was discharged from hospital on 21.10.15 but her claim was not settled adequately by the Insurance Company.

2. The Insurance Company vide SCN dated 12-01-2017 reiterated thatthe patient was hospitalized at Pentamed from 12-10-2015 to 21-10-2016 with diagnosis of Acute IntestinalObstruction
Secondary to Band. The claimant was covered under National Mediclaim policy with sum insured of Rs. 200000/- + Cumulative Bonus Rs. 45500/-. In this case the sum insured was considered Rs. 1lac + Cumulative Bonus Rs. 45500/- for the year 2011 to 2012 since the patient was already on treatment in the same year. The claim was settled for Rs. 1,02,404/- after deduction of Rs. 59,672/-. (Rs. 28,540/- - excess room rent. + Rs. 31,132/- Maximum limit of OT.) Medicines and investigations 50% of total sum insured has exhausted.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of personal hearing the complainant had alleged the same. The Insurance Company reiterated that insured had undergone a surgery in the year 2011 and second surgery in 2015 was resultant of the first surgery, hence Sum Insured in the year 2011 was considered for settlement of claim and claim was settled as per terms and conditions of the policy.

On perusal of papers on record and submissions made during hearing I find that the patient was diagnosed as a case of Acute Intestinal Obstruction Secondary to Band as revealed from the discharge summary dated 21-10-2015. Sum Insured of the policy in the year 2011 was Rs. 1Lac + Cumulative Bonus Rs. 45,500/-. The complainant was already on treatment in the year 2011 and second surgery in 2015 was necessitated of the first surgery performed in 2011. The Insurance Company had already settled the claim taking into consideration the sum insured in the year 2011. Therefore I uphold the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby dismissed**

DATE: 16.02.2017

In the matter of Mr. HargobindAgarwal
Vs
The National Insurance Company Ltd. (New Delhi)

1. The complainant alleged that his son aged 39 yrs. was admitted at Fortis hospital on 30.12.2015 and expired on 31.12.2015. The earlier three claims lodged between the period 04.11.2015 to 24.12.2015 were partially settled by the company. The current claim amounting Rs. 2,67,211/- was rejected by Vipul TPA. He managed to condone Rs. 1,02,000/- from the final bill with the help of a MLA and paid Rs. 1,65,000/- to the hospital to get the body of his son released from the hospital. Subsequently he filed the complaint to the Grievance cell to the company vide letter dated 24-10-2016 and also lodged a complaint with this forum and sought relief of Rs. 1,65,000/-.
2. The Insurance Company vide SCN dated 08-02-2017 reiterated that complainant had taken Parivarmediclaim policy for sum insured of Rs. 4,00,000/- for the period 29-09-2015 to 28-09-2016. The insured lodged a claim for dengue fever in Nov 2015 which was approval for Rs. 31,979/- subsequently another claim lodged in Nov 2015 was also approval for Rs. 1,07,053/-. The third claim lodged in Dec 2015 for treatment of CVA was settled for Rs. 35,000/-. The current claim lodged in Dec 2015 was rejected. The IPD record dated 30-12-2015 and discharge summary revealed that patient had history of fever on or before 30-09-2015 (inception of policy). Since insured was covered under ParivarMediclaim policy from 29-09-2015 to 28-09-2016, the disease falls during the 30 days from the inception of the policy, hence cashless facility for Rs. 1,71,260/- was reject under policy clause 4.2.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant reiterated as above. The representative of Insurance Company stated that insured lodged three claims for recurrent illness relapsed within 45 days of hospitalization, hence considered as one illness and claims were paid as per sub-limit clause 2 (c) which states that total expenses incurred for anyone illness is limited to 50/- of sum insured. On perusal of papers on record and submissions during hearing, I find that complainant's son had taken ParivarMediclaim policy for sum insured of Rs. 4,00,000/- for the period 29.09.2015 to 28.09.2016. The Insurance Company had already paid 3 claims for admissions in the hospital between 04.11.2015 to 24.12.2015. The Insurance Company had treated all the claims as one illness and rejected the 4th claim on the ground that illness was contracted during the 30 days from the inception of the policy. In the instant case complainant's son was admitted in Fortis hospital on 30.12.2015 and

expired on 31.12.2015. The death certificate revealed the cause of death was septic shock with multi organ failure with myositis with CVA with history of dengue fever. In view of the cause of death mentioned in the death summary; admission for current illness cannot be treated as one illness. The Insurance Company also agreed that current illness cannot be treated as one illness. Therefore, I direct the Insurance Company to pay the claim as admissible after deduction of non-payable items as per terms and conditions of the policy. **Accordingly an award is passed with the direction to the Insurance Company to settle the claim as per terms and conditions of the policy and pay the admissible amount to the complainant.**

DATE: 28.02.2017

In the matter of Mr. Vikas Kumar
Vs
The National Insurance Company Ltd. (New Delhi)

1. The complainant alleged that he underwent surgery for ureteric calculus at Bansal Hospital on 02.07.2016. He had applied a claim for reimbursement of Rs. 55620/-. The Insurance Company had paid Rs. 29991/-. He sought relief of Rs. 27120/- from this forum.

   The Insurance Company vide mail reply dated 07.11.2016 informed to the complainant that patient was hospitalized at Bansal hospital which was not listed in PPN. The insured underwent URSL.For this treatment the hospital had billed for Rs. 55620/-. The same treatment cost Rs. 24000/- as per agreed PPN package rates at Aakash Hospital, located in same geographical area and similar facility available, hence rates prevailing in Aakash Hospital have been taken into account and accordingly claim was settled for Rs. 29991/- [Procedure charges Rs. 24000/- + CT Scan Rs. 4500/- and Pre-post HospitalizatonRs. 1491/-].

2. I heard both the sides, the complainant as well as the Insurance Company. During the course of personal hearing the complainant contended that the earlier claim for treatment from the same hospital was paid to him. The TPA had not taken any consent and transferred Rs. 29991/- in his account against claimed amount of Rs. 55620/-.

The Insurance Company reiterated that consent was taken from the insured. The insured had changed the policy. Previous claim was under individual mediclaim policy and current claim falls under ParivarMediclaim policy.

On perusal of papers on record and submissions during hearing I find that insured had switched from individual mediclaim policy to ParivarMediclaim policy w.e.f 01.08.2014. The previous claim arose on 08.07.2015, also falls under the same policy condition i.e. Parivarmediclaim. The Insurance Company had paid the previous claim without mention of PPN Package rating. Insured was not made known about PPN pricing before hospitalization. The complainant had raised the query vide mail dated 05.11.2016 to know the reason for disallowed amount, at that time he was informed about PPN package pricing. In view of the above, Insurance Company is directed to pay the balance amount to the complainant. **Accordingly an award is passed with the direction to the Insurance Company to pay the claim for balance amount to the complainant.**

DATE: 10.03.2017

In the matter of Mr. Suresh Kumar Sharma
Vs
The National Insurance Company Ltd. (New Delhi)

1. The complainant alleged that he was covered under VaristhaMediclaim policy for the period 20.01.2013 to 20.01.2015 with sum insured of Rs. 1 lac (Medical) and Rs. 2 lac (Critical illness). He switched from VaristhaMediclaim to National Mediclaim on 20.01.2015 and enhanced the sum insured from Rs. 1 lac to Rs. 2 lac. He was hospitalized at Maharaja Agrasen Hospital from 24.02.2015 to 26.02.2015 with diagnosis of CAD-unstable Angina. He had lodged a claim for reimbursement of Rs. 2,92,000/- which was rejected by the Company.

2. The Insurance Company vide its letter dated 06.03.17 reiterated that the insured was hospitalized from 24.02.2015 to 26.02.2015 with diagnosis Coronary Artery Disease-Unstable angina and underwent Coronary angiography which revealed single vessel disease followed by stenting. The insured was non case of hypertension at the inception of policy.

   The present claim falls under National Mediclaim policy and as per its terms and conditions, pre-existing diseases and its complications are excluded from scope of policy until 48 months of continuous coverage has elapsed. Insured being in 3rd year of insurance and disease was pre-existing hence, the claim was repudiated under policy clause no. 4.1.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of personal hearing the Insurance Company reiterated as above. The complainant argued that he had not signed the proposal forum. The complainant was shown the copy of proposal form during the hearing. He denied his signature on the proposal form.

   On the basis of submissions during hearing and perusal of papers on record I find that the complainant has denied his signature on the proposal form. Hence, it is a case of fraud/forgery of signature.Therefore this complaint is out of purview of this forum as per RPG Rules 1998 12(1).**Accordingly the complaint filed by the complainant is hereby dismissed**.

DATE: 01.03.2017

In the matter of Mr. Tarandeep Singh
Vs
Max Bupa General Insurance Company Ltd. (New Delhi)

1. The complainant alleged that his mother was hospitalized at Max health care on 10.12.2015 and was discharged on 23.12.2015 on LAMA She passed may away in 2015. The cashless claim was rejected due to non-renewal of policy for the period 28.07.2015 to 27.07.2016. The complainant further alleged that policy was taken w.e.f 28.07.2011 and was subsequently renewal till 27.07.2015.He could not renew the policy on due datei.e on 27.07.2015 as he was out of Delhi.So the Insurance Company had extended the period of renewal till 26.08.2015 at his request. The complainant had issued a cheque dated 06.09.2015 for Rs. 77840/- which could not be received by agent on 08.09.2015. During the admission of his mother (10.12.2015-23.12.2015) he came to know that the policy was not renewed, hence claim was rejected by the company. The complainant alleged that Insurance Company never informed him that policy could not be renewed nor returned the cheque. He sought relief of Rs. 11,02,790/- from this forum.
2. The Insurance Company vide email dated 22.12.2015 had replied to the complaint that Insurance Company had not received any cheque towards the renewal of policy no. 30045142201403. As the policy had been lapsed on 27.07.2015 and insured could not renewed the policy during grace period i.e. 26.08.2015, hence the claim for hospitalization in Dec, 2015 could not be entertained.

3. I heard both the sides, the complainant as well as the Insurance Company. The complainant stated that he gave a cheque dated 06.09.2015 for renewal of policy which was not debited from his account.The Insurance Company reiterated that no cheque was received hence there was no policy at the time of hospitalization.

   On perusal of papers on record I find that policy has been lapsed on 27.07.2015 and insured could not renew the policy during grace period of 1 month i.e. 26.08.2015. Although zerox copy of the cheque dated 06.09.2015 shown by the complainant showedthe receipt of thechequeon 08.09.2015 (after grace period) but the cheque was not debited from the complainant's account, hence no policy was in existence at the time of hospitalization. Therefore there was no liability at the part of Insurance Company.**Accordingly the complaint filed by the complainant is hereby dismissed.**

DATE: 02.03.2017

In the matter of Mr. Pradeep Kumar

Vs

Max Bupa General Insurance Company Ltd. (New Delhi)

1. The complainant alleged that he was hospitalized at Kalra Hospital from 21.082016 to 24.08.2016. He had lodged a claim for reimbursement of Rs. 45000/- from Max Bupa Company, but Insurance Company had rejected the claim. He sought relief of Rs. 45000/- interest from this forum.

2. The complaint was admitted at Kalra Hospital for the period 21.08.2016 to 24.08.2016 with complaints of high Grade Fever, extreme weakness and not able to stand.He was diagnosed with Fever with thrombocytopenia, chikangunia serology positive. During claim verification done by Insurance Company, gross discrepancy and misrepresentation of facts were noticed in hospital documents. However as per investigation report chikangunia and degue was negative. Insured temperature was normal after 22.08.2016 also there was no sign of thrombocytopenia as platelet count was more than 1 lac.Hospitalization was not justified as diagnosis was different as per ICP and investigation report. Hence claim was denied on the basis of diagnosis not supported by investigation report.
3. I heard both the sides, the complainant as well as the Insurance Company. During the course of personal hearing, the complainant reiterated as above. The Insurance Company stated that there was discrepancy in ICP and final diagnosis. As per investigation reports dated 21.08.2016 chikangunia and dengue were negative but as per discharge summary patient was diagnosed with chikangunia with thrombocytopenia.

   On perusal of papers on record and submissions during hearing I find that although there was discrepancy between final diagnosis and investigation reports of the complainant, but the patient was admitted and discharged at the advice of the doctor. 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 per terms and conditions of the policy and pay the admissible amount to the complainant.**

DATE: 01.03.2017

In the matter of Mr. Ravinder Kumar
Vs
Religare Health Insurance Company Ltd.

1. The complainant alleged that he was admitted in Metro Hospital for the period 13.09.2016 to 15.09.2016 with complaints of breathlessness, cough and fever for last 5-7 days. He was diagnosed with Acute LRTIC (Lower Respiratory Tract Infection). The pre-authorization approval for cashless hospitalization was declined by the insured stating the reason that "Admission for investigation and evaluation is not payable. All the vitals are normal and investigation within normal limits". Subsequently he had applied the claim for reimbursement of hospitalization expenses which was again rejected. He sought relief of Rs. 50747/- + interest from this forum.

2. The Insurance Company vide SCN dated 24.02.2017 reiterated that the patient presented to the hospital with complaints of breathlessness cough and fever for last 5-7 days. The patient was diagnosed for acute LRTI. However all vital parameters were normal through his hospitalization. It was observed that almost 95% of the cost involved during hospital stay was towards non-medicinal expenses. The complainant was admitted in conducting various medical investigations. The investigations could have been done in OPD basis, hence claim was rejected as per clause 4.3 (A)(1) Annexure C (71)Hospitalization for investigation and evaluation.
3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant reiterated as above. The Insurance Company reiterated that complainant was admitted for investigation and evaluation only. All vitals were normal. There was no clinical features that necessitated hospitalization. The investigations could have been done on OPD basis.

On perusal of papers on record I find that complainant was admitted with complaint of breathlessness, cough and fever for last 5-7 days. He was diagnosed acute LRTC, (Respiratory tract Infection). All vital parameters and investigations were normal throughout the hospitalization. Since the complainant was admitted at the advice of the doctor, the Insurance Company is directed to pay hospitalization charges only (no diagnostic test and evaluation).**Accordingly an award is passed with the direction to the Insurance Company to pay charges for hospitalization expenses to the complainant.**

DATE: 01.03.2017

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

1. The complainant alleged that his wife was hospitalized at Indian Spinal Injuries Center from 31.01.2016 to 02.02.2016. She was diagnosed with L2-L3 degenerative disc disease. The pre-authorization of cashless hospitalization was declined. Subsequently he filed a claim for reimbursement of Rs. 57,000/- which was rejected with the reason that Admission for investigation and evaluation was not covered under policy terms and condition.

2. The Insurance Company vide SCN dated 24.02.17 reiterated that insured patient was hospitalized at Indian Spinal Injuries Center from 31.01.2016 to 02.02.2016. As per discharge summary the patient had complaints of pain moderate in intensity. She was diagnosed withL2-3 degenerative disease. She was advised conservative treatment.All other investigations which were not related to illness were also within normal limits. The treatment can be given on OPD basis and does not require hospitalization. Hence claim was rejected as per clause no. 4.3 of policy terms and conditions which state that "Admission for investigation and evaluation as is not covered".
3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant reiterated as above. The Insurance Company stated that insured patient had consulted in OPD on 30.01.2016 as per initial assessment form and was advised to be admitted for evaluation purposes. According to discharge summary the patient had complaints of pain moderate in intensity and she was advised conservative management. The treatment can be given in OPD basis and does not require hospitalization. Admission for evaluation purpose is not covered as per policy condition no 4.3. Hence claim was rejected.

   On perusal of papers on record I find that complainant's wife was admitted in the hospital for evaluation purpose as revealed from "Initial Assessment form" dated 30.01.2016. The patient was hospitalized on next day and underwent various investigations. Since the patient was hospitalized for evaluation at the advice of the doctor, I direct the Insurance Company to pay charges for hospitalization only (not diagnostic test and evaluation).**Accordingly an award is passed with the direction to the Insurance Company to pay charges for hospitalization expenses to the complainant.**

DATE: 01.03.2017

In the matter of Mr. Shabbir Ahmed
Vs
The National Insurance Company Ltd. (New Delhi)

1. The complainant alleged that his son was hospitalized at VIMHANS hospital from 28.07.2016 to 06.08.2016 for treatment of Paranoid Schizophrenia. He lodged a claim for reimbursement of Rs. 70,000/- but Insurance Company had rejected the claim on the ground that illness falls under Psychiatric disorder which falls under exclusion clause No. 4.10.

2. The Insurance Company vide SCN dated 17.02.2017 reiterated that insured lodged a claim for reimbursement of hospitalization and port hospitalization expenses ofRs. 67,932/- incurred towards treatment of his son during hospitalization at VIMHANS Hospital for the period 28.02.2016 to 06.08.2016. He was diagnosed as a case of Paranoid Schizophrenia and treated conservatively.The Insurance Company had rejected the claim vide letter dated 01.12.2016 under clause No-4.10 which states that Treatment for all Psychiatric and Psychosomatic disorders/disease falls under exclusion.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the Insurance Company reiterated that disease falls under Psychiatric disorders which is not covered under policy. I find that complainant's son was hospitalized at VIMHANS hospital with complaints of suspiciousness, fearfulness hearing voices, poor self-care, social withdrawal, from last 1 year. He was diagnosed as Paranoid Schizophrenia which is a chronic mental disorder and not covered under policy coverage as per policy condition no. 4 which states that treatment for all Psychiatric and Psychosomatic disorder/ disease falls under exclusion. Hence I uphold the decision of the Insurance Company.**Accordingly the complaint filed by the complainant is hereby dismissed.**

DATE: 01.03.2017

In the matter of Ms. Urmila Gupta
Vs
The National Insurance Company Ltd. (New Delhi)

1. The complainant alleged that she had undergone Laser Cataract Surgery for both eyes on 03.12.2015 and 10.12.2015 at "Centre for Sight". The claim was lodged with The National Insurance Company for Rs. 104585/- and for Rs. 89509/- respectively in Jan 16. The Insurance Company had approved an amount of Rs.68,000/- only for both the eyes as against the total bill of Rs. 1,94,094/- as per reasonable and customary clause No-3.29 of policy terms and conditions. She sought relief of Rs. 1.94.094/- + interest from this forum.

2. The Insurance Company vide SCN dated 17.02.2017 reiterated that insured patient had undergone Femto Assisted Micro Incision cataract surgery of both eyes and raised claim of Rs. 1,94,094/-. The Insurance Company had approved the claim for Rs. 68000/- for both the eyes keeping in view the reasonable and customary clause No-3.29 and informed to the insured vide letter dated 23.03.2016. But the insured did not accept approval of Rs. 68,000/-. Subsequently claim was reviewed by regional committee and claim approval was found in order.
   The Insurance Company further submitted that Insurance is a common pool created by premium from many policy holders to pay the claims of a few. This pool is to be utilized for paying the reasonable cost of treatment which is medically necessary to help the insured to recover from illness. Hence, advanced procedures do not fall under reasonable and customary clause, since many existing procedures provide the same result.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant reiterated as above. The Insurance Company reiterated that the complainant had opted Non-TPA policy, therefore there was no communication of customary and reasonable clause prior to the surgery.

I find that the complainant had undergone cataract eye surgery at the hospital as per her choice. The Insurance Company failed to convey to the complainant the admissible maximum amount before undergoing for operation/ hospitalization. As per terms and conditions of the policy there was no capping for cataract eye surgery. Hence, Insurance Company is directed to settle the claim for balance amount.**Accordingly an award is passed with the direction to the Insurance Company to pay the claim for balance amount to the complainant in addition to earlier approval.**

DATE: 25.01.2017

In the matter of Mr. Bijendra Singh
Vs
Star Health and Allied Insurance Company Ltd.

1. The complainant alleged that he had lodged two claims for himself and his son for reimbursement of expenses incurred during hospitalization at Saroj Hospital from 11.01.2015 to 15.01.2015 (for himself) Sunrise Hospital from 20.02.2016 to 22.02.2016 (for his Son). Both claims were rejected on the ground of non-disclosure of material facts. He sought relief of Rs. 43,969/- from this forum.

2. The Insurance Company reiterated vide SCN date 27.03.2017 that the insured.The insured patient, Master. TanavSingh, was admitted at Sunrise Hospital, Rohini-Delhi on 20.02.2017 and discharged on 22.02.2016. As per Discharge Summary, the insured patient was diagnosed as Developmental Delay with Seizure Disorder with Microcephaly.As per the treating doctor the insured was on Anticonvulsant treatment which was not declared the claim was rejected on
ground of non-disclosure of material fact and hence, the policy in respect of Master. TANAV SINGH stands cancelled with effect from 11.05.2016 due to non-disclosure of PED-SEIZURE DISORDER, DEVELEPMENTAL DELAY, MICROCEPHALY as per Condition No. 8. In consequence thereof a refund of premium amounting to Rs. 1603/- was allowed and the fresh policy was issued to the rest of the family members.

3. I heard the Insurance Company, the complainant was absent. The case was taken upon merits. During the course of personal hearing, the Insurance Company submitted that it was a case of non-disclosure, therefore they had cancelled the policy for Master Tanav and continued for the family.

   On perusal of papers on record I find that the complainant had not disclosed the material facts i.e. pre-existence of the disease-seizure disorder, developmental delay microcephaly in case of Master Tanav in the proposal form at the time of taking the policy. Hence Insurance Company had rejected the claim under policy condition no. 8. In view of the above, I see no reason to interfere. **Accordingly the complaint filed by the complainant is hereby dismissed**

4.

DATE: 30.03.2017

In the matter of Mr. Inder Kumar Sharma
Vs
Max BupaHealth Insurance Company Ltd.

1. The complainant had taken mediclaim policy from Max Bupaw.e.f 23.11.2014 with disclosure of DM same was recorded in the Insurance certificate. The complainant was admitted in BLK Super Specialty Hospital on 03.10.2016 with complaint of high grade fever and breathing difficulty. the complainant had submitted a claim vide letter dated 14.11.2016 for reimbursement of Rs. 3,63,140/-. The Insurance Company had rejected the claim on the ground of non-disclosure of pre-existing medical condition.

2. The Insurance Company reiterated that as per submitted documents and claim investigation it was found that the patient was suffering from H/O COPD since 8 years and HT since 12 years. The pre-existing medical condition was not disclosed at the time of taking policy. Hence claim was rejected 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 complainant submitted a letter from the hospital to show that duration past history of DM, HT and COPD was 3 months instead of 10 years. The Insurance Company reiterated as above.
   On perusal of papers on record and submissions during hearing I find that Dr's Certificate is not signed or authenticated nor counter signed by the MS of the Hospital. I direct the Insurance Company to reinstate the policy by excluding HTN, DM and COPD alongwith its co-morbidies. **Accordingly, the complaint of the complainant is disposed off.**

DATE: 30.03.2017

In the matter of Mr. Mayank C Chopra
Vs
The National Insurance Company Ltd. (New Delhi)

1. The complainant alleged that he was admitted at Jaipur Golden Hospital on advice of Doctor/rheumatologist from 18.07.2016 to 19.07.2016 with complaint of back pain with stiffness on and off. He had filed a claim for reimbursement of Rs. 1,03,754/- which was rejected by the company under clause 4.19, on grounds that patient was admitted for diagnostic and evaluation purpose.

2. The Insurance Company reiterated that on scrutiny the documents by medical experts it was observed that patient was admitted for administration of injections and during hospitalization no active treatment was given. The treatment can be carried out on OPD basis. Hence, claim was repudiated under policy clause 4.19 which states that "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."

3. I heard both the sides, the complainant (representative by his father) as well as the Insurance Company. during the course of personal hearing the complainant stated that his son was admitted in the hospital for administration injection Ramicade through i/v fluids. Admission was not for diagnostic of evaluation purpose. Even Drs Certificate submitted also showed endorsement by the doctor on cashless request the need for hospitalization. The Insurance Company reiterated that hospitalization was not required. The treatment can be carried out as out patient procedure.
   On perusal of papers on record I find the patient was admitted with complaint of back pain with stiffness. He was administered Ramicade injection and solumedrol injection through IV infusion. The complainant also submitted the cashless request wherein the

doctor had endorsed that "Ramicade injection is an ANTI-TNT AGENT needs to be given by I/V infusion over several hours with close monitoring during and after infusion. Inappropriate infusion speed/ lax monitoring can result in cytokine storm, cardiovascular collapse and even death can only be given by I/V infusion after hospitalization." It is also noticed that the Insurance Company had applied a wrong clause 4.20 in the repudiation letter. In view of the above Insurance Company is directed to pay 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 as per terms and conditions of the policy**.

DATE: 31.03.2017

In the matter of Mr. Praveen Kumar Goyal
Vs
The National Insurance Company Ltd. (New Delhi)

1. The complainant alleged that his wife was admitted at Sanjivani Nursing Home for the period 19.08.2016 to 23.08.2016 and underwent Vaginal Hysterectomy. The Insurance Company had paid Rs. 29,867/- only against the claimed amount of Rs. 79,297/-. The nursing home had charged Rs. 70,375/- for vaginal hysterectomy, however the same procedure costs Rs. 23,400/- as per Vinayak Hospital in the same geographical area approved under GIPSA Package. Hence Rs. 46,975/- was deducted under reasonable and customary clause which was not accepted by the complainant.

2. The Insurance Company had settled the claim as per terms and conditions of the policy. The sum insured under the policy was Rs. 3 lacs hence available room rent limit was Rs. 3,000/- per days (1% of sum insured per day including nursing), however the insured had opted a room rent of Rs. 3,400/- per day + Rs. 250/- (nursing). Hence claim was settled as per room rent liability and proportionate deductions in Drs. Fee and other charges were made. The cost of Hysterectomy was Rs. 23,400/- in Vinayak Hospital which is in the near proximity to Sanjivani Nursing Home and approved under GIPSA Package, hence the cost of Hysterectomy was paid as per reasonable and customary clause.
3. I heard both the sides, the complainant as well as the Insurance Company. During the course of personal hearing the complainant stated that he was not told about the package rates of the PPN hospital. The Insurance Company reiterated as above.

   On perusal of papers on record I find that the Insurance Company had settled the claim was as per PPN pricing rates approved by GIPSA. The complainant was not made known the procedure pricing rates nor the GIPSA package pricing list was mentioned in the policy. Therefore Insurance Company is directed to pay the claim as per the expenses incurred for hospital at Sanjivan Nursing Home. **Accordingly an award is passed with the direction to the Insurance Company to settle the claim and pay the as per the expenses incurred for hospitalization at Sanjivan Nursing Home as per terms and conditions of the policy**.

DATE: 30.03.2017

In the matter of Mr. Dinesh Kumar
Vs
The National Insurance Company Ltd. (New Delhi)

1. The complainant alleged that his daughter was admitted in Ganga Ram hospital with complaints of unsteadiness in walking. She was given tablet Dianax and was counselled by experts for corrective measures. The claim of Rs. 1,28,173/- was rejected by the company for the reason that only investigations were done and no active line of treatment was given.

2. The Insurance Company reiterated that as per final bill and other documents the insured patient was admitted complaints of unsteadiness in walking which was sudden in onset, non progressive, and get settled on its own with no aggravating or relieving factor. She admitted in Sir Ganga Ram Hospital for further evaluation and management. Only investigations were done and no active line of treatment was followed. More over investigation did not bring out any positive bindings. Hence claim was rejected by the company under policy clause 4.10.

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 had difficulty is walking, hence admitted in the hospital for evaluation and management. The Insurance Company reiterated as above.
   On perusal of papers on record I find that patient was admitted at the advice of the Doctor. However the discharge summary revealed that the patient was admitted with complaints of unsteadiness in walking which was sudden in onset, non progressive. The admission was for evaluation and management, however the patient was admitted only on the doctor's advice. In view of the above I direct the Insurance Company to pay the room rent and medicine expenses. **Accordingly an award is passed with the direction to the Insurance Company to pay the room rent (for hospitalization from 09.06.2015 to 13.06.2015) and medicine expenses as per terms and conditions of the policy and pay the admissible amount to the complainant.**

DATE: 31.03.2017

In the matter of Mr. S. K. Arora
Vs
The National Insurance Company Ltd. (New Delhi)

1. The complainant alleged that he had taken mediclaim policy since 2010 from National Insurance Company Ltd. There was a gap of 40 days in renewal of policy in the year 2014. The officials of the company convinced him that late renewal payment will not affect the continuity benefit and previous policy no was mentioned on renewal policy. He lodged a claim for reimbursement of Rs. 60,511/- for the expenses incurred during hospitalization from 13.07.2016 to 16.07.2016 at MGS hospital. The claim was rejected on the ground that HTN and DM were pre-existing and would be covered after 4 years of continuous coverage of policy.

2. The Insurance Company had repudiated the claim on the ground that insured had a history HTN and DM for 3 years and policy was running in the 3rd year. Hence as per policy clause 4.1 pre-existing disease is covered after 4 years of continuous coverage of policy.
3. I heard both the sides the complainant as well as the Insurance Company. during the course of personal hearing the complaint stated that he had taken mediclaim policy since 2010. For renewal of policy in the year 2014, he had given the cheque to the agent who did not deposit in time, so there was a delay of 39 days in renewal of policy. The Insurance Company assured that continuity benefit will be given and old policy no was mentioned on the renewal policy. The Insurance Company reiterated that there was a delay of 39 days in renewal of policy. The insured had not given any application for condoning the delay.

   On perusal of papers on record I find that there was a delay of 39 days in renewal of policy in the year 2014, hence Insurance Company had treated the Insurance as fresh and accordingly did not settle the claim as the claim was lodged on 3rd year policy. However the Insurance Company had not informed the procedure for condoning the delay at the time of renewing the policy in 2014 after a gap of 39 days. I condone the delay. Insurance Company is directed to pay 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 as per terms and conditions of the policy**.

DATE: 10.03.2017

In the matter of Mrs. PremwatiGarg
Vs
Star Health And Allied Insurance Company Ltd.

1. The complainant alleged that she was admitted in Springdale Medical Centre for the period 16.04.2015 to 20.04.2015 and was diagnosed with DM, HTN and acute Gastro Entritis. She had lodged a claim for reimbursement of Rs. 40399/- which was rejected on the ground of non-disclosure of pre-existing disease.

2. The Insurance Company reiterated that the insured was admitted in Spring Meadows Hospital Pvt. Ltd. On 16.04.2015 and discharged on 20.04.2015. As per discharge summary, the diagnosis was DM (Diabetes Mellitus) /HT (Hypertension) with Age (Acute Gastric Enteritis) with internal bleeding (drug induced).During claim investigation it was observed the insured was a case of paraparesis and was on Tab. Ecosprin which states that the insured was suffering from CVA and under gone PTCA.The patient had a history of spine surgery 22 years back and fissurectomy 3 year back, history ofDiabetes and HTN for the past 2 years which were prior to inception of the policy (14.06.2013). Further as per the indoor case records of the hospital patient was a K/C/O post PTCA and old CVA.The pre-existing medical condition was not disclosed in the proposal form. Hence claim was rejected due to mis-representation/non-disclosure of material facts.
3. I heard boththesides, the complainant (represented by her Son) as well as the Insurance Company. During the course of personal hearing the complainant stated that policy incepted in June, 2013. He had informed to the agent about her previous illness. The Insurance Company reiterated as above.

   On perusal of papers on record and submissions during hearing I find that complainant had a history of CVA and under gone PTCA. The patient had a history of spine surgery 22 years back and fissurectomy 3 year back, history of Diabetes and HTN for the past 2 years as revealed from discharge summary dated 20.04.2015 of Springdales Medical Centre.The pre-existing medical condition was not disclosed in the proposal form, hence claim was rejected due to mis-representation/non-disclosure of material facts.As per Supreme Court Judgment the Insurance Company is not liable to pay any expenses in case of non-disclosure of material facts at the time of taking the policy. Therefore, I uphold the decision of the Insurance Company.**Accordingly the complaint filed by the complainant is hereby dismissed.**

DATE: 15.03.2017

In the matter of Mr. Narender Singh
Vs
Max BupaHealth Insurance Company Ltd.

1. The complainant alleged that his wife was admitted in Lokpriya Nursing Home 10.06.2016 to 11.06.2016. She was diagnosed with Abdominal ligation. He had lodged a claim for reimbursement of Rs. 18720/- which was rejected by the company on the ground that treatment falls under permanent exclusion.

2. The Insurance Company reiterated that the complainant submitted claim bearing no. 200156 with respect to the insured's admission in LOKPRIYA NURSING HOME from 10.06.2016 to 11.06.2016. The said admission was for treatment of ABDOMINAL LIGATION. Tubal Ligation/ Abdominal Ligation or Tubectomy is a surgical procedure for sterilization in which a woman's fallopian tubes are clamped and blocked or severed and sealed, either of which prevents eggs from reaching the uterus for implantation. The treatment taken by the insured patient falls under permanent exclusion as per clause no. 4e xxi 1 "(Reproductive medicine- Birth control and Assisted reproduction) – Any type of contraception, sterilization, termination of pregnancy or family planning are not covered." Hence claim was denied.
3. I heard both the sides, the complainant as well as the Insurance Company. During the course of personal hearing the complainant reiterated as above. The Insurance Company stated that admission was for treatment of ABDOMINAL LIGATION which is a surgical procedure for sterilization. The treatment taken by the insured patient falls under permanent exclusion as per clause no. 4e xxi 1 "(Reproductive medicine- Birth control and Assisted reproduction) – Any type of contraception, sterilization, termination of pregnancy or family planning are not covered." Hence claim was denied.

   On perusal of papers on record I find that Tubal Ligation/ Abdominal Ligation or Tubectomy is a surgical procedure for sterilization. The treatment taken by the insured patient falls under permanent exclusion as per clause no. 4e xxi 1 "(Reproductive medicine- Birth control and Assisted reproduction) – Any type of contraception, sterilization, termination of pregnancy or family planning are not covered." Hence claim was denied. Therefore, I do not find any reason to interfere with the decision of the Insurance Company.**Accordingly the complaint filed by the complainant is hereby dismissed.**

DATE: 15.03.2017

In the matter of Mr. Surya Narayan
Vs
ReligareHealth Insurance Company Ltd.

1. The complainant alleged that his wife was admitted in BLK hospital for the period 25.06.2016 to 26.06.2016. She was diagnosed Endometrial Curettings. The Insurance Company had rejected the claim on the ground of non-disclosure of pre-existing ailments at time of proposal.

2. The Insurance Company reiterated that insured patient was hospitalized at B. L. Kapur Hospital from 25.06.2016 till 26.06.2016 and from 22.08.2016 to 25.08.2016 for treatment of post-menopausal bleeding. In light of the documents submitted by the insured (i.e. Drs certificate dated 22.02.93 of Pant Hospital, OPD consultation sheet dated 19.04.93 of Pant Hospital, and pre-operative evaluation sheet dated 16.06.2016 of B. L. Kapur Hospital.) it was observed that patient was suffering from RHD and had undergone Balloon Mitral Volvotomy (BMV). The pre-existing medical condition was not disclosed at the time of taking the policy. Hence claim was rejected by the company due to non-disclosure of material facts at the time of taking the policy. The Insurance Company had cancelled the policy and premium had already been refunded to the complainant.
3. I heard both sides, the complainant as well as the Insurance Company. During the course of personal hearing the complainant contended that current treatment was not related to heart problem, therefore claim should be payable. The Insurance Company reiterated as above.

   On perusal of papers on record I find that patient was suffering from RHD and had undergone Balloon Mitral Volvotomy (BMV) as revealed from Drs. Certificate dated 22.02.93 and OPD consultation sheet dated 19.04.93 of Pant Hospital, and pre-operative evaluation sheet dated 16.06.2016 of B. L. Kapur Hospital. The pre-existing medical condition was not disclosed at the time of policy inception hence claim was rejected as per policy clause 4 (a) due to non-disclosure of material facts. As per Supreme Court Judgment Insurance Company is not liable to pay any expensesin case of non-disclosure of material facts. Therefore I uphold the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby dismissed and Insurance Company is directed to restore the policy for other family members already covered in the policy**.

DATE: 10.03.2017

In the matter of Mr. PuneetAggarwal
Vs
Max BupaHealth Insurance Company Ltd.

1. The complainant alleged that he was insured since last 10 years. He had ported the policy to Max Bupa on 29.09.2015.His wife was hospitalized at Max health care from 13.10.2016 to 18.10.2016 with complaints of continue bleeding for 15 days. Her claim was rejected by the company on the ground that illness was pre-existing and not disclosed at the inception of policy.

2. The Insurance Company reiterated that as per submitted documents and claim investigation it was found that patient was suffering from severe heavy bleeding since 2½ years, is a known case of HTN and on medication since 8 years, and also known case of hypothyroidism and on medicine since 3 years and underwent appendicectomy 10 yearsago. The pre-existing medical condition was not disclosed at the time of policy inception hence claim was rejected as per policy clause 4 (a) due to 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 complainant stated that he had ported the policy from United Insurance to Max Bupa. He had informed the previous illness to the agent. The agent had filled the form. The Insurance Company had cancelled the policy but had not refunded the premium. The Insurance Company reiterated as above.

   On perusal of papers on record I find that patient was suffering from severe heavy bleeding since 2½ years, is a non-case of HTN and on medication since 8 years, and also known case of hypothyroidism and on medicine since 3 years and underwent appendicectomy 10 years ago,asrevealed from the discharge summary dated 18.10.2016 of Max Health Care. The pre-existing medical condition was not disclosed at the time of policy inception hence claim was rejected as per policy clause 4 (a) due to non-disclosure of material facts.As per Supreme Court Judgment Insurance Company is not liable to pay any expensesin case of non-disclosure of material facts. Therefore I uphold the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby dismissed and Insurance Company is directed to refund the premium to the complainant**.

DATE: 21.10.2016

In the matter of Sh. N.B Sharma
Vs
New India Assurance Company Ltd.

1. The complainant is covered under group medical policy obtained by his Employer (LIC) from New India Assurance Company Ltd. The complainant's wife was treated for Brain Hemorrhage at Sir Ganga Ram Hospital from 31.03.2015 to 7.05.2015. The Insurance Company had settled expenses of Rs. 6,67,650/- against claimed amount of Rs. 6,87,002/- . Post hospitalization amount of Rs. 1,10,000/- was deducted towards payment made to nurses on the ground that payments receipt for domestic nursing charges were not in order. He sought relief of Rs 1,10,000 /- from this forum.

2. The Insurance Company had stated in the self contained note that there was discrepancy in the bill number and date. The matter was investigated. The investigation report reveals that the nursing bureau did not exist and receipt was not in order. Therefore the Insurance Company had deducted the amount of Rs. 1,10,000/- out of total amount of claim for Rs. 6,67,650/-.
3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant had pleaded that a private nurse was hired through St. Marry's Nursing Bureau (Regd.) to
look after his wife at residence. The complainant had further stated that the qualified nurse was engaged for which the nursing Bureau charged Rs. 1, 10,000/- for 02 months (Rs. 5, 5,000/- per month) and he also produced the bills in support of his contention. The representative of Insurance Company had settled the
claim for post hospitalization treatment deducting the charges of Rs. 1,10,000/- towards nursing care charges at home . The Insurance Company contended that the bills produced for domestic care were improper and that they had investigated the matter, which revealed that the nursing bureau was not registered. It was also revealed during the investigations that St. Marry's Nursing Bureau was not operative from the address given in bills.
In view of the submissions and on scrutiny of the documents available, I find that the nurses who rendered the service through the Nursing Bureau have been paid by Mr. Abin, Manager of Bureau as confirmed by Mrs. Sunita, nurse vide statement dated 29.02.16. The Insurance Company had also confirmed vide email dated 06.10.2016 that they will obtain an affidavit from the complainant regarding the payment of Rs. 1,10,000/- in support of the services taken by him from Mr. Abin. It is observed that the Insurance Company requires an affidavit from the complainant to consider the claim for the nursing charges in dispute, which otherwise deemed tenable. In view of the circumstances, the Insurance Company is directed to settle the claim for Nursing Charges after the complainant submits the affidavit to the Insurance Company. **Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant as admissible as per terms and conditions of the policy.**

DATE: 03.10.2016

In the matter of Sh. Satyaban Sen
Vs
New India Assurance Company Ltd.

1. The complainant alleged that he had purchased a good health policy from New India Assurance in 2007 for S.I. of Rs. 1 Lac which was renewed in 2009 for S.I. of Rs. 1.5 Lac. The policy had been continuously renewed by the New India Assurance Company Ltd. since 2007 till 2015, without any remarks indicating the pre-existing disease. The complainant had availed a claim during 2008 for Right UL Pneumonitis, HTN and COPD. In the Year 2013 the S.I. was increased to Rs. 2.5 Lac. The complainant had been hospitalized from 26.07.15 to 07.08.2015 with following diagnosis for the treatment of Right LL Pneumonitis. The complainant had stated that the TPA had settled the claim on the basis of S.I. of Rs. 1.5 Lac+20% bonus i.e. Rs. 1.8 Lac instead of Rs. 2.5 Lac + 20% bonus i.e. Rs. 3 Lac applicable in current year policy.

2. The Insurance Company had settled the claim on S.I. of Rs. 1.5 Lac pertaining to the year 2009 to 2012 (having waiting period of 4 years) as the disease was previously contracted in the year 2008 when the sum insured was Rs. 01 Lac.

3. I heard both the sides, the complainant as well as the Insurance Company. The complainant had pleaded during the course of hearing that the Insurance Company had wrongly settled the claim

considering the ailment as pre-existing and taken the S.I. of 04 years back when it was Rs 1.5 Lac + 20% bonus i.e.
Rs. 30,000/- totaling to Rs. 1.8 Lac. The complainant had preferred a claim for right UL pnuemonitis, HTN and COPD in the year 2008, which was settled by the Insurance Company. The complainant got the sum insured enhanced to Rs. 2.5 Lac in the year 2013. A claim was reported in the year 2015 for the treatment of Right LL pneumonitis which was settled on the basis of pre-enhanced sum insured of Rs. 1.5 Lac pertaining to the year 2012.

The representative of the Insurance Company had contended that the pneumonitis was a pre-existing disease as the complainant suffered from the disease in 2008 and claim was settled on the basis of sum insured prior to enhancement of S.I. in lieu of 04 years waiting period when sum insured was Rs. 1.5 Lac. The claim for consideration of the increased S.I. was rejected as per the policy condition no. 3.5 –"change in plan/increase in sum insured" i.e. any increase in sum insured/plan change shall attract clauses relating to waiting period and pre-existing diseases.

The complainant had a history of mediclaim insurance with New India Assurance Company Ltd. as detailed below:

Years	Sum Insured
2007-2008	01 Lac
2009-2012	1.5 Lac
2013-2016	2.5 Lac

In the light of the above clause, the claim does not fall within the exclusion clause of 3.5 as the case neither falls under waiting period clause nor is a pre-existing disease, as the Insurance Company had already settled a claim for the pneumonitis in 2008 in the Ist year of inception of the policy of complainant. The Insurance Company in the continuous renewals since2007- 08 had never mentioned any restrictive PED. Therefore, since the disease is not a pre-existing one as per the definitions of the policy, the current sum insured is admissible for the treatment of pneumonitis. The Insurance Company could not prove with cogent and reliable documents that the ailment for which the patient was treated falls under pre-existing or waiting period clause. **Accordingly an award is passed with the direction to the Insurance Company to settle the loss on the basis of current year policy sum insured i.e. 2.5 Lac + 20% C.B.**

DATE: 07.10.2016

In the matter of Mr. Sumeet Chopra
Vs
CIGNA TTK Health Insurance Company Ltd.

1. The complainant alleged that his son Mr. Sumer Chopra was hospitalized at Global Hospital, Mumbai from 13.07.16 to 15.07.16 with complaint of vomiting and chest pain. He was

diagnosed with Reflux esophagistis (GERD). The cashless claim was rejected and later on reimbursement claim was also rejected on the ground of high probability of present ailment being a complication of alcoholism. He further alleged that his son was non alcoholic and there was no medical report to prove that ailment was related to alcohol abuse. He sought relief of Rs. 54,406/- from this forum.

2. The Insurance Company vide mail dated 15.07.16 had rejected the claim on the ground of high probability of present ailment being a complication of alcoholism. The injury/ ailment occurring due to alcohol abuse were not payable as per the policy sub-limits and liability could not be ascertained under non-disclosure of the ailment at the time of inception of claim.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant had reiterated that his son Mr. Sumer Chopra, age 20 years was insured previously with Bajaj Allianz since 2010 and portability have been shifted the insurance with CIGNA TTK Pro Health Insurance with effect from 15.11.2015. The complainant had further stated that his son Sumer Chopra was pursuing studies for graduation at Mumbai staying independently for 02 years. He was admitted to Global Hospital-Super Specialty and transplant Centre, Parel Mumbai on 13.07.16 having a complaint of vomiting (black) and chest pain. The Insurance Company had rejected the claim.

The representative of the Insurance Company had contended that the patient was having chest heaviness since 04 days had such episodes intermittently since 02 years and during the time of shifting the policy from Bajaj Allianz under portability of insurance, the proposer had not disclosed the facts as this was a Ist year insurance policy with Cigna TTK. The Insurance Company had further stated that as the pre-existing ailment was not declared by the insured /complainant during the inception of the policy, the claim was repudiated and policy was terminated in view of the "non-disclosure of chest heaviness and pain intermittently since 02 years " as mentioned in the discharge summary submitted by complainant. The Insurance Company had invoked the policy condition no. VIII i.e. "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, claim for declaration, medical history on the claim form and connected documents, or any material information having been withheld by you or any one acting on your behalf, under this policy."

On scrutiny of the documents placed on record, I find that the Insurance company had failed to establish the case of alcoholism or of any pre-existing disease from which the patient had suffered and treated in the light of report of the treating Dr. Vaishali Salao, ICU Incharge of the Hospital, who clearly reported that "the complainant presenting symptomatology are in no way connected to his very occasional alcohol intake." In view of the fact the Insurance Company could not substantiate their contention. **Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant as admissible.**

DATE: 07.10.2016

In the matter of Mr. Rajesh Kumar
Vs
Apollo Munich Health Insurance Company Ltd.

1. The complainant alleged that he was admitted in Sri Balaji Action Medical Institute, Delhi from 04.03.16 to 08.03.16 and diagnosed as a case of acute pancreatitis with the chief complaints of pain in abdomen (epigastrium region) and vomiting. He had submitted all the necessary papers of the claim to the Insurance Company for reimbursement of Rs. 60,000/- but the Company had denied the claim on the ground that treatment related to alcohol abuse is excluded in the policy. He had sought the relief of Rs. 60,000/- from this forum.

2. The Insurance Company had rejected the claim under policy clause VI C (iv). The submitted claim was for the treatment of acute pancreatitis which is a consequence/complication of alcohol intake. Treatment related to alcohol abuse is excluded in the policy under section VI C (iv).
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 Sri Balaji Action Medical Institute, Delhi from 04.03.16 to 08.03.16 and diagnosed as a case of acute pancreatitis with the chief complaints of pain in abdomen (epigastrium region) and vomiting. The Insurance Company had denied the claim on the ground that treatment related to alcohol abuse was excluded in the policy.

   The Insurance Company had stated that the submitted claim was for the treatment of acute pancreatitis which is a consequence/complication of alcohol intake. Treatment related to alcohol abuse is excluded in the policy under section VI c (iv) i.e. "substance abuse and de-addiction programs: abuse or the consequences of the abuse of intoxicants or hallucinogenic substances such as intoxicating drugs and
   alcohol, including smoking cessation programs and the treatment of nicotine addiction or any other substance abuse treatment or services or supplies." Hence claim was repudiated.

   On perusal of the claim papers placed on record and submissions made during the hearing, I find that Mr. Rajesh Kumar was admitted in Sri Balaji Action Medical Institute, Delhi from 04.03.16 to 08.03.16 and diagnosed as a case of acute pancreatitis with the chief complaints of pain in abdomen (epigastrium region) and vomiting. As per in-patient history sheet of patient

Mr. Rajesh Kumar dated 04.03.16 issued by the Action Balaji Medical Institute the patient had a history of chronic alcoholic and known case of DM and HTN. As per medical literature available the most common cause of acute pancreatitis is alcohol consumption. In the said claim of complainant no stone was found in gall bladder except history of chronic alcoholic as noted in IPD papers. Since the submitted claim was for the treatment of acute pancreatitis which was a consequence/complication of alcohol consumption as the patient had a history of chronic alcoholic which was excluded under policy section VI c (iv) i.e. "substance abuse and de-addiction programs: abuse or the consequences of the abuse of intoxicants or hallucinogenic substances such as intoxicating drugs and alcohol, including smoking cessation programs and the treatment of nicotine addiction or any other substance abuse treatment or services or supplies" hence Insurance Company had rightly rejected the claim and I find no reason to interfere with the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

DATE: 17.10.16.

In the matter of Mr. Puneet Sharma
Vs
Apollo Munich Health Insurance Company Ltd.

1. The complainant alleged that his wife Mrs. Kalpana Sharma was admitted in AIIMS from 13.10.15 to 17.10.15 and from 03.05.16 to 14.05.16 and diagnosed as a case of right frontal AVM and subsequently underwent decompressive craniectomy for cranioplasty. He had submitted all the necessary papers of the claims to the Insurance Company for reimbursement of Rs. 6,90,822/- but the Company had rejected the claims on the ground that the disease arterioveneous malformation (AVM) falls under the category of congenital defect/anomalies. He further stated that the Insurance Company had earlier paid three claims for the same disease. He had sought the relief of Rs. 6,90,822/- from this forum.

2. The Insurance Company vide its letter dated 09.06.2016 had rejected the claim under policy clause V C- Viii (K) congenital defects/anomalies. As per documents submitted, the insured was admitted for treatment of atriovenous malformation which falls under category of congenital defects/anomalies. Evaluation and treatment related to a condition which is present since birth 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 complainant had reiterated the same. The Insurance Company had stated that Mrs. Kaplana Sharma was diagnosed as a case of right frontal arterioveneous malformation (AVM) and underwent decompressive craniectomy for carnioplasty. As per documents submitted the patient was treated for AVM which falls under the category of congenital defects/ anomalies, hence not payable under policy exclusion clause sec 4e (vi) i.e. congenital external or internal disease are not covered. Evaluation and treatment related to a condition which is present since birth had been excluded in the policy. They had further stated that three claims for the said disease were inadvertently paid earlier to the complainant.

   On perusal of claim papers placed on record and submission made during the hearing, I find that the patient Mrs. Kalpana Sharma was admitted in AIIMS from 13.10.15 to 17.10.15 and from 03.05.16 to 14.05.16 and diagnosed as a case of right frontal AVM and subsequently underwent decompressive craniectomy for cranioplasty. As per medical literature available the disease arteriovenous malformation (AVM) is a congenital disorder (one present at birth) of blood vessels in the brain, brainstem or spinal cord that is characterized by a complex, tangled web of abnormal arteries and veins connected by one or more fistulas (abnormal communications). As per policy exclusion clause section 4 (e-vi) congenital external or internal diseases are not covered. Since the patient Mrs. Kalpana Sharma was suffering from right frontal arteriovenous malformation (AVM) which is congenital disorder and excluded under the policy. Therefore, I uphold the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

DATE: 17.10.16

In the matter of Ms. Shashi Gupta
Vs
United India Insurance Company Ltd.

1. The complainant alleged that her daughter Dr. Aparna Gupta was admitted in Fortis Hospital, Vasant Kunj, New Delhi from 25.09.15 because of Dengue fever and she expired on 27.09.2015. She had submitted all the necessary papers of the claim to the TPA/Insurance Company for reimbursement of Rs. 1,54,109/- but the Company had rejected the claim on the ground that daughter cover is available upto the age of 25 years or till the girl gets married or gets employment whichever occurs earlier without age restriction. Her daughter was married in 2009 but she was staying with her soon after the marriage because of divorce case filed by in-laws in Agra Court which was going on even now. Her daughter was unemployed and 100% dependent on her. She had sought the relief of Rs. 1,54,109/- alongwith 18% interest and Rs. 1,00,000/- as damages for mental harassment.

2. The Insurance Company vide its letter dated 26.02.2016 had rejected the claim on the ground that Dr. Aparna Gupta (patient) aged 34 years was a married daughter of Mrs. Shashi Gupta who was covered under the above policy as dependent daughter on the basis of the mis- description provided by the insured in the proposal form. But as per definition of dependent in the policy, married daughter could not have been covered in the policy. The policy definition says: "dependent children age: for daughters, cover is available upto the age of 25 years, or till the girl gets married or gets employment whichever occurs earlier without age restriction. "As per the documents available in the file, it is an admitted fact that a divorce proceeding was pending at the time of death of Dr. Aparna Gupta. Dr. Aparna Gupta could not have been dependent on the insured during the pendency of divorce proceedings." Hence 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 reiterated the same. The Insurance Company had stated that the claim was rejected on the ground that Dr. Aparna Gupta (patient) aged 34 years was a married daughter of Mrs. Shashi Gupta who was covered under the above –said policy as dependent daughter on the basis of mis-description provided by the insured in the proposal form. As per the policy terms and conditions the definition of dependent children age: for daughters, cover is available upto the age of 25 years or till the girl gets married or gets employment whichever occurs earlier without age restriction. For the dependent male children cover is restricted upto the age of 21 years or till he gets employment or his marriage whichever is earlier. Hence the said claim was not payable under the policy.

On perusal of claim papers placed on record and submissions made during the hearing I find that Dr. Aparna Gupta was covered under the policy (No. 0405002815P102895513 from 19.06.15 to 18.06.16). As per proposal form dated 18.06.14 submitted by the proposer Smt. Shashi Gupta to the Insurance Company, the age of the Dr. Aparna Gupta was 34 years (DOB- 30.10.1980) and she was dependent on her. As per the documents available a divorce proceeding was pending at the time of death of Dr. Aparna Gupta. As per policy terms and conditions the definition of dependent children age: for daughters, cover is available upto the age of 25 years or till the girl gets married or gets employment whichever occurs earlier without age restriction. For the dependent male children cover is restricted upto the age of 21 years or till he gets employment or his marriage whichever is earlier. The claim was thus not admissible under the policy clause "Dependent children Age" as Dr. Aparna Gupta, aged 34 years was a married daughter and divorce proceeding was pending at the time of her death. Hence, the Insurance Company had rightly rejected the claim and I find no reason to interfere with the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

DATE: 17.10.2016

In the matter of Mr. Sumit Kapoor
Vs
United India Insurance Company Ltd.

1. The complainant alleged that he was admitted in Max Health Care Hospital three times from 26.12.15 to 30.12.15, 18.01.2016 to 22.01.16 and 10.02.16 to 14.02.16 and diagnosed as a case of mediastinal germ cell tumor. During hospitalization 03 cycles of chemotherapy was done. He had submitted all the necessary papers of the claim for reimbursement of Rs. 2,59,570/- to the Insurance Company but the Company had denied the claim on the ground that the disease falls under genetic disorder which is a exclusion under the policy. He had sought the relief of Rs. 2,59,570/- from this forum.

2. The Insurance Company vide its letter dated 21.07.16 had rejected the claim on the ground that genetic disorders and stem cell implantation/surgery is not covered under policy exclusion clause no. 4.17. As per medical literature the defective genes are CGB, AFP, APAF-1, CGA, ERBB-2, CGB-7, CGBS and these causes mediastinal germ cell tumour which comes under genetic disorder. Hence, claim is not payable.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant had reiterated the same. The Insurance Company had stated that the claim was rejected on the ground that genetic disorder and stem cell implantation/surgery was not covered under policy exclusion clause no. 4.17. The mediastinal germ tumour comes under genetic disorder. Hence, claim was not payable.

   On perusal of the claim papers placed on record and submissions made during the hearing, I find that Mr. Sumit Kapoor was admitted in Max Health Care Hospital three times from 26.12.15 to 30.12.15, 18.01.2016 to 22.01.16 and 10.02.16 to 14.02.16 and diagnosed as a case of mediastinal germ cell tumor. During hospitalization 03 cycles of chemotherapy was done. The Insurance Company had rejected the claim under policy clause 4.17 which states that genetic disorder and stem cell implantation/ surgery was not covered under the policy. The Insurance Company had not filed the self contained note and relevant papers of the case before the forum to substantiate their contention that disease mediastinal germ cell tumor falls under genetic disorder. In discharge summary there was no mention that disease mediastinal germ cell tumor pertains to genetic disorder. The complainant had also submitted a certificate dated 31.12.15 from the treating doctor Randeep Singh, Max Health Care which states that disease mediastinal germ cell tumor cannot be attributed to any congenital or inherited genetic cause. The Insurance Company could not conclusively prove with cogent and reliable documents that the mediestinal germ cell tumor disease falls under genetic disorder. 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 as admissible.**

DATE: 15.11.2016

In the matter of Mr. Sachin Vasudeva
Vs
United India Insurance Company Ltd.

1. The complainant alleged that his son Mr. Soham Vasudeva was admitted in Cosmos Institute of Mental Health & Behavioral Science from 09.11.2015 to 09.01.2016 and diagnosed as a case of Moderate Depressive Episode with Somatic Symptoms. The treatment given to his son during stay at the hospital was mood stabilizers, anti-depressants and other therapy. He had submitted all the necessary papers of the claim to the Insurance Company for reimbursement of Rs. 6,75,000/- but the Company had denied the claim under policy clause No.4.6 psychiatric disorder. He had sought the relief of Rs. 6,75,000/-from this forum. He had further stated that a claim for psychiatric disorder was settled by the Company in the year 2009-10 for his wife under policy no. 040903/48/07/97/1470 and at that point of time there was no exclusion clause for treatment of psychiatric disorder. The said exclusion had been incorporated subsequently under the policy without informing him and was a unilateral act which was in violation of the IRDA guidelines.

2. The Insurance Company vide its email dated 16.06.2016 had rejected the claim on the ground that as per opinion of the panel doctor of TPA, they observe that he was admitted in COSMOS Institute of Mental Health & Behavioral Sciences New Delhi. A-12 year old patient with complaints of Academic decline, social withdrawal, Impulsitivity, excessive Internet use, pervasive sadness diagnosed as a case of Moderate depressive episode with somatic episode, conduct disorder confined to family context treated conservatively. The claim was not payable as per policy clause No. 4.6 which states Convalescence, General debility, run down condition or rest cure, obesity treatment and its complications including morbid obesity, Congenital external disease/ defects or anomalies, treatment relating to all psychiatric and psychosomatic disorders, infertility, sterility, Veneral disease, intentional self injury and use of intoxication drugs/alcohol are not covered under the policy.

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 denied under policy clause 4.6 which states Convalescence, General debility, run down condition or rest cure, obesity treatment and its complications including morbid obesity, Congenital external disease/ defects or anomalies, treatment relating to all psychiatric and psychosomatic disorders, infertility, sterility, Veneral disease, intentional self injury and use of intoxication drugs/alcohol are not covered under the policy.

   On perusal of the claim papers placed on record and submission made during the hearing, I find that Mr. Soham Vasudeva was admitted in Cosmos institute of Mental Health and Behavioral science from 09.11.2015 to 09.01.2016 and diagnosed as a case of Moderate Depressive Episode with somatic Symptoms. The complainant had alleged that the exclusion of treatment relating to all psychiatric and psychosomatic disorder was incorporated subsequently in the policy (No.040101/48/11/97/0002987 from 24.01.2012 to 23.01.2013) and there was no such exclusion under the policy before 2012. He had further stated that a claim for psychiatric disorder was settled by the Insurance Company in the year 2009-10 for

his wife and at that point of time there was no exclusion clause in the policy for treatment of psychiatric disorder. The said exclusion had been incorporated subsequently under the policy without informing him and is a unilateral act which is in violation of the IRDAI guidelines. As per policy clause is 12(1) "Important Notice" and IRDAI guidelines "File and use procedure for health Insurance products" the company may revise any of the terms, conditions and exceptions of this insurance including the premium payable on renewal in accordance with the guidelines/rules framed by the Insurance Regulatory and Development Authority (IRDA) and inform the policy holder of such changes at least three months before the revision are to take effect. Therefore the Insurance Company had failed to comply their own condition as they could not prove conclusively that the Insured was informed about such changes atleast 03 months prior to the date when such revision or modification came into effect. Hence, 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 as per terms and conditions of the policy**.

DATE: 18.11.2016

In the matter of Mr. Kamal Singh
Vs
United India Insurance Company Ltd.

1. The complainant alleged that his wife was admitted in Singhal Hospital, Sadh Nagar, Palam Colony, New Delhi for 05.04.2016 to 08.04.16 and diagnosed as a case of fever with rigor, Burning Micturition, pain lower abdomen. He had submitted all the necessary papers of the claim to the Insurance Company for reimbursement of Rs. 39,961/- but the company had denied the claim on the ground that charges incurred at hospital were primarily for diagnosis, x-ray or laboratory examination etc. not consistent with or incidental to the diagnosis and treatment. He had sought the relief of Rs. 39,961/- from this forum.

2. The Insurance Company vide its letter dated 23.05.2016 had rejected the claim under policy exclusion clause No. 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 or positive existence of presence of any ailment, sickness or injury for which confinement is required at a Hospital/Nursing Home."

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 claim was rejected under policy clause 4.11 which states that charges incurred at Hospital or Nursing Home primarily for diagnosis X-ray or Laboratory examinations or other diagnostic studies not consistent with or incidental to the diagnosis and treatment of positive existence of presence of any ailment, sickness or injury, for which confinement is required at a Hospital/Nursing Home. Mrs. Nisha was hospitalized on 05.04.2016 UTI with DNS with sinusitis with allergy. She was discharge on 08.04.2016. On scrutiny of the claim papers it was observed by the TPA that the lab Investigation reports were inconsistent to the diagnosis and the patient was admitted for

observation purpose and there was no other therapeutic treatment, was done. On perusal of the claim papers placed on record and submissions made during the hearing, I find that Mrs. Nisha was admitted in Singhal Hospital from 05.04.2016 to 08.04.2016 and diagnosed as a case of UTI with DNS with sinusitis with allergy. During the hearing the complainant had alleged that his wife was hospitalized on the advice of treating doctor as she was suffering from fever with pain in lower abdomen. The company had alleged that the investigation reports were inconsistent to the diagnosis. I find that the complainant was hospitalized in the hospital on the advice of treating doctor and the treatment given during hospitalization was found in active line and managed/followed with injectible, IV fluids and necessary diagnostic and evaluation corroborated with the treatment given to the patient. The Insurance Company could not prove as to why hospitalization was not necessary. Hence, I hold that the Insurance Company is liable to settle the claim**. Accordingly an award is passed with the directions to the Insurance Company to settle the claim as per terms and conditions of the policy and pay the admissible amount to the complainant.**

DATE: 27.10.2016

In the matter of Mohd. Shakeel Saifi
Vs
Apollo Munich Health Insurance Company Ltd.

1. The complainant alleged that his wife Ms. Shayana Shakeel was suffering from severe eye problems since last 02 years. She was admitted in Sharp Sight Centre on 28.04.2016 and 03.05.2016 and diagnosed as early contract. During hospitalization surgery of clear lens extraction with multifocal lens in both the eyes was done. He had incurred Rs. 87000/- towards the surgery of both the eyes and filed the necessary papers of the claim for reimbursement. But the Insurance Company had rejected the claim on the ground that the said treatment falls under cosmetic surgery, hence not payable under the policy.

2. The Insurance Company vide its letter dated 15.06.2016 had rejected the claim on the ground that the submitted claim is for correction of refractive error. Treatment for correction of refractive error is specifically excluded in the policy. Hence the claim was rejected under section VI C vi of the policy i.e. any kind of cosmetic surgery is excluded in the policy.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant had alleged that his wife was admitted in a Sharp Sight Centre on 28.04.16 and 03.05.16 and diagnosed as a case of high myopia in both the eyes. During hospitalization surgery of clear lens extraction with multifocal lens in both the eyes were done. The Insurance Company had rejected the claim on the ground that treatment for correction of refractive error is specifically excluded in the policy under section VI C (vi).

The Insurance Company had stated that the submitted claim was for correction of refractive error. Treatment for correction of refractive error is specifically excluded under the policy. The claim was rejected under section VI C-vi which states that treatment for correction of eye sight due to refractive error is excluded under the policy.

On perusal of the claim papers placed on record and submissions made during the hearing, I find that Mrs. Shayana Shakal was admitted in Sharp Sight Centre on 28.04.16 and 03.05.16 and diagnosed as a case of High Myopia in both the eyes. During hospitalization surgery of clear lens extraction with multifocal lens in both the eyes were done. The Insurance Company had rejected the claim on the ground that treatment for correction of refractive error is excluded under the policy under section VI C-(vi) which states that treatment for correction of eye sight due to refractive error is not payable under the policy. Since the treatment taken by Mrs. Shayana Shakeel falls under the exclusion clause of the policy, I find that the Insurance Company had rightly rejected the claim and I find no reason to interfere with the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

DATE: 23.12.2016

In the matter of Mr. Trebawan Nath Jaggi
Vs
United India Insurance Company Ltd.

1. The complainant alleged that he is a patient of Prostate Cancer, undergoing treatment at Apollo Hospital, New Delhi. This treatment required hospitalization on 01.04.16 and 31.05.16. As per policy clause no. 2, reimbursement of expenses are payable even when the hospitalization is less than 24 hours in 34 listed cases of ailments and treatments amongst which prostate ailment at Sr. no 29 is one of them. His prostate cancer treatment is continuing and his subsequent claims of reimbursement of expenses of hospitalization less than 24 hours on 01.08.16, 01.09.16, 03.10.16 and 03.11.16 are lying pending with the TPA. He had requested to settle his all these claims and pay him the admissible amount.

2. The Insurance Company vide its letter at 19.08.16 has rejected the claim on the ground that as per discharge summary, Mr. Trebhawan Nath Jaggi is suffering from Metastatic Carcinoma Prostate and was started on Androgen Deprivation therapy and admitted for bisphosponate therapy. The Bisphophonates are given to prevent bone fracture and bone pain in Cancer Prostate patients with bony metastasis. It is not a chemotherapeutic agent. This administration of Bisphosphonates is not mentioned in the list of Day Care procedures mentioned in clause 2 of policy. As per policy this procedure is not included in day care list and hospitalization less than 24 hours is not payable as per policy clause 3.16- i.e. hospitalization means admission in a hospital/nursing home for a minimum period of 24 in-patient care consecutive hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours.

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 Mr. Trebhawan Nath Jaggi was treated for Bisphosphonate therapy. As per medical opinion obtained by them Bisphosphonate was not a chemotherapeutic agent but was given to prevent bone fracture and bone pain in prostate cancer patient with bony metastasis. As per policy clause no. 02 this procedure (treatment by bisphosphonate) is not included in day care list and hospitalization for less than 24 hours is not payable as per policy clause 3.16, hence, claim was rejected accordingly.**

On perusal of the claim papers placed on record and submissions made during the hearing, I find that Mr. Trebhawan Nath Jaggi was a known case of NHL (treated) and was diagnosed as carcinoma prostate (metastatic). He was started on androgen deprivation therapy and presently admitted for bisphosphonate therapy. As per policy clause 02 the time limit of hospitalization for minimum period of 24 hours is not applied for the treatment of prostate, but on perusal of discharge summary the patient was admitted for bisphophonate therapy which was given to prevent bone fracture and bone pain in cancer prostate patient. It was not a chemotherapeutic agent and the said procedure (treatment of bisphosphenate) is not included in day care list under policy clause no. 02 i.e. expenses on hospitalization for minimum period of 24 hours are admissible. However, this time limit is not applied to specific treatment as mentioned in the list under policy clause no. 02. Hence, the Insurance Company had rejected the claim under policy clause no. 02 and I find no reason to interfere with the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

DATE: 14.12.2016

In the matter of Ms. Renu Kapoor
Vs
United India Insurance Company Ltd.

1. The complainant alleged that she had been insured with United India Insurance Company Ltd. for more than 20 years. She had a heart attack on 13-08-2016 and was rushed to Sir Ganga Ram Hospital. She was admitted in Sir Ganga Ram Hospital from 13-08-2016 to 16-

08-2016 and diagnosed as a case of coronary artery disease and primary PTCA + Stent to proximal LAD was done on 14-08-2016. She had submitted all the necessary papers of the claim to the TPA M/s E-Meditek for reimbursement of Rs. 3,16,879/- but the TPA had settled the claim only for Rs. 2,25,100/-. She had sought the relief of Rs. 91,779/- being difference of amount from this forum.

2. The TPA E-Meditek vide its email dated 06-09-2016 had informed that the claim was settled as per GIPSA Package. The PAC was given as per GIPSA Package for CAG and PTCA (Rs. 107100+Cost of stent as per reasonable rate i.e. Rs. 1,18,000). Thus total amount paid to the insured was Rs. 2,25,100/-.
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 he had not been informed by the Insurance Company about GIPSA package nor did the Insurance Company provide him the terms

   and conditions of the policy. The representative of the Insurance Company had agreed that there is no mention of GIPSA package in the policy.

   On perusal of the claim papers placed on record and submission made during the hearing, I find that details of GIPSA package was not incorporated in policy, the said fact had also been admitted by the representative of the Insurance Company. Hence, in the absence of such condition, I direct the Insurance Company to settle the claim and pay the remaining amount as admissible to the complainant. **Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant and pay the remaining amount as admissible.**

DATE: 21.10.2016

In the matter of Mr. Ravinder Singh
Vs
National Insurance Company Ltd.

1. The complainant alleged that he had taken a motor insurance policy no. 360703/31/14/6390006570 for his vehicle w.e.f 28.03.2015 to 27.03.2016 from National Insurance Company Ltd. He further alleged that on 10.09.2015 his vehicle was totally damaged due to fire. But the Insurance Company had settled his claim of vehicle on cash loss repair basis for Rs. 11, 09,523/-. The complainant also stated that the IDV of his vehicle was Rs. 23, 00,000/-. He is requesting for higher assessment of loss of his vehicle on the basis of revised estimates of Rs. 19, 96,343/- on total loss basis, but an amount of Rs. 1,55,000/- of revised estimates was not considered by the Insurance Company.

2. The Insurance Company reiterated vide its letter dated 18.03.2016 that the request of complainant could not be accepted on total loss basis, in view of the policy conditions as regard to settlement of claim on the repair basis loss 64.08% was well within the stipulated limit of 75% of the IDV as per the provision of policy conditions as was assessed by the surveyor. The settlement of loss was allowed accordingly.

3. I heard both the sides, the complainant as well as the Insurance Company. The complainant stated that the vehicle was a total loss. As per revised estimate of Tata Motors cost of repair of the vehicle was

   Rs. 19,96,343/- which was more than 75% of IDV of the vehicle (Rs. 23,00,000/-). The surveyor had manipulated the report and did not include parts worth Rs. 55000/- in the assessment. Had the surveyor included the parts amounting to Rs. 1,55,000/- the cost of repairs exceeds 75% of the IDV. He also showed list of items allowed by Tata Motors.

   The Insurance Company reiterated that insured was interested to settle the claim on total loss basis. Pursuant to meeting held between the insured, surveyor and higher officials, revised estimated from authorized dealer (Tata Motors) was taken which was amounting to Rs. 19,96,343/-. The surveyor had assessed the net repair liability which was amounting to Rs. 17,09,293/-. As per policy condition constructive total loss was allowed only when vehicle is

beyond repair or cost of replacement exceeds 75% the IDV. In the instant case cost of repair was less than 75% of the IDV (Rs. 37,000/-) hence claim was considered on cash less basis. As per policy condition IMT 23 cost of tyres was not covered but that too was allowed by the surveyor.

On perusal of papers on record, I find that estimate of Tata Motors was Rs. 19, 96,343/-. The surveyor had assessed the net repair liability Rs. 17, 09,293/- and cash loss repair liability Rs. 11,09,523/- (in case insured did not repair the vehicle). The surveyor had allowed Rs. 37000/- for 2 tyres which was not covered/ payable as per policy condition. During the course of hearing the Insurance Company was asked to submit clarification on number of parts which were not included in assessment report of surveyor but included in the estimate. Based on the clarification received from the Insurance Company, I find that surveyor had considered the major assemblies i.e. complete front axle along with its fittings, engine assembly complete, gear box assembly complete, cowl assembly complete and chassis frame complete. The complainant had submitted a list of 55 parts of Rs. 1,55,000/- which were not considered by the surveyor. As per clarification obtained from Insurance Company regarding the missing items the surveyor had submitted that parts mentioned at S.I. No. 1, 8 -11, 17, 23-25, 28, 31, 35-38, 46, 47 and 54 were already allowed by the surveyor in complete assembly Items no. 40, 41 &55 were not payable being cause of accident and some small items (consumables) were not considered by the surveyor Items no. 3-7, 18-21, 29,30 and 43 were not affected.

I find that after including the cost of small items amounting Rs. 3,000/- (after depreciation) the net repair liability was less than 75%of IDV of the vehicle. Hence I direct the Insurance Company to settle the claim on repair basis or cash loss repair basis and in addition to that pay cost of small items not considered by the surveyor. **Accordingly the complaint filed by the complainant is hereby disposed off.**

DATE: 03.10.2016

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

1. The complainant stated that he had taken a Mediclaim policy no. 361500/48/15/8500000526 w.e.f. 16.05.2015 to 15.05.2016 for his family. He further stated that on 11.03.2016 his wife was admitted in the hospital for the complaint of shortness of breath and palpitation and her illness was diagnosed as CAD- single vessel disease, associated with PTCA and stent to proximal LAD (absorb 3.0x18 mm) and normal LV function (LVEF- 63%, hypothyroidism and cervical spondylosis. He raised bill for Rs. 3,98,850/- but his bill was approved for Rs. 2,14,550/-. He sought the relief amount of Rs. 1,84,000/- from this forum.

2. The Insurance Company had submitted vide their self contained note thereby stated that the Saket City Hospital is a unit of GM Modi Hospital, the said hospital is approved as an PPN

hospital with pre-decided package rates. The complainant was provided cashless facility to the tune of Rs. 2,14,550/- as detailed below:

- package for angioplasty- Rs.1,00,000/-
- other associated cost- Rs.1,14,550/-
- total – Rs. 2,14,550/-

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/TPA had not mentioned the complete details of deductions in the pre-authorized approval letter, while giving approval of the claim. During the course of hearing, the Insurance Company stated that the claim was settled as per pre-decided package of GIPSA and they had also mentioned this condition in their policy clause 3.23 with regard to preferred provider Network (PPN) which confirmed that a fixed pre-decided package of claim shall be paid, in case of claim lodged with the Insurance Company.

On perusal of records placed before me, I find as per policy clause 3.23 which reads as " a preferred provider network (PPN) 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 Package) shall be subject to the rates applicable to PPN Package pricing." And also in "re-authorization letter" vide reference claim control no. NI-3-174283/2 dated 16.03.2016 issued by Alankit Health Care TPA Ltd. in column- Special remark- "it is mentioned that maximum as per GIPSA, PPN Rate including cost of implant and submission of original bill with sticker. No further grant and no reimbursement allowed." I find that the claim is rightly settled by the Insurance Company. Hence, I do not find any reason to interfere with the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

DATE: 07.10.2016

In the matter of Sh. Jugjeev Singh Sarna
Vs
National Insurance Company Ltd.

1. The complainant alleged that he had taken a personal Accident policy No. 360303/42/13/8100000/165 w.e.f 16.06.13 to 15.06.2014. He further alleged that on 09.06.2014 he sustained injury but his claim was rejected by the Insurance Company on the ground that the injury was not due to accident.

2. The Insurance Company reiterated vide their mail dated 19.09.2016 that insured alleged that he had a fall on 09.06.14 from stairs and claimed weekly compensation along with medical extension benefit under personal accident policy. The insured was suffering from deformity of spine/ prolapsed disc before he had a fall. The treating doctor had confirmed that patient had chronic disc problem which was not related to fall. Since the injury was not sustained due to accident. Hence, the claim was rejected by them.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant contended that he had a fall at home due to which he developed acute lumbar pain and numbness in leg. He was advised bed rest. His fall was not due to prolapsed disc.

   The Insurance Company reiterated that as per treating doctor's certificate dated 21.01.15 there was "No accident" and patient had a history of prolapsed disc which was not related to fall. Initially the insured was advised bed rest for 15 days due to accidental fall but the rest period was prolonged due to prolapsed disc which existed prior to fall.

   On perusal of papers on record, I find that the complainant had preferred a claim under personal accident policy for compensation of weekly benefits. The complainant alleged he had a fall at home due to which he sustained injury and was advised bed rest. However on scrutiny of medical certificate dated 21.01.15 and 29.04.15 and e-mail dated 11.07.15 and 06.10.15 of treating doctor Nitiraj Oberoi it is observed that treating doctor had clearly mentioned vide email dated 06.10.15 addressed to Insurance Company that "patient was suffering from a slip disc of the lumbar spine before he had fall, after the fall his back ache
   and leg pain increased but Prolapsed disc was not related to fall." I find that the complainant was advised bed rest and domiciliary physiotherapy for 15 days as revealed from OPD consultation dated 13.06.2014 of Dr. Anshu Rohatgi. Therefore Insurance Company is directed to pay weekly benefits compensation for 15 days. **Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant as admissible.**

DATE: 03.10.2016

In the matter of Sh. Ravinder Nath Sharma
Vs
Max Bupa Health Insurance Company Ltd.

1. The Complainant alleged that he had ported his mediclaim policy from Apollo Munich to Max Bupa Health Insurance Company Ltd. in the year 2012-2013. He further alleged that on 10.02.2016 he was admitted in the hospital for the complaints of cheek swelling for the last 02 months and had a history of reduced mouth opening since 02 months. After findings his case was diagnosed as carcinoma left alveolus. He underwent surgery of mouth on 11.02.2016 under G.A. He was discharged from Hospital on 22.02.2016 but his claim was denied by the Insurance Company on the ground of chewing tobacco, which he had not declared at the time of taking the policy.

2. The Insurance Company reiterated vide self contained note dated 14.09.2016 that as per pre-operative notes by hospital it was found that patient had a history of tobacco chewing and alcohol since 03 years.
   Hence accordingly the claim was rejected as per policy clause 4(e) (i) i.e. treatment related to addictive conditions and disorders or from any kind of substance abuse or misuse 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 stated that he had not the habit of tobacco chewing. The Insurance Company stated that the complainant had the history of tobacco chewing and alcohol

since 03 years. Apart from this, the complainant was also suffering from HTN since 06 years as per the records of hospital.

On perusal of papers on record, I find that in pre-authorization mandatory form, prepared by Dr. Mudil Aggarwal, the complainant had admitted that he was suffering from hypertension. Besides this, in pre-operative evaluation record (prepared by Dr. Vivek Varshney on 12.02.16) and investigation report of hospital, the complainant had a history of HTN since 06 years and he was on regular esomax-2.5 mg tablet daily. As per pre-operative questionnaire format of hospital, at sr. no. 12 the complainant had admitted that he had the history of smoking and tobacco chewing. And also at sr. no. 18 of pre-operative questionnaire, the complainant had also admitted that he had the habit of alcohol consuming since 03 years. In post-operative report, the complainant on 12.02.2016 had admitted that he was suffering from HTN since 02 years. Based on these factual admissions, I find that the Insurance Company had rightly denied the claim. 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.**

DATE: 03.10.2016

In the matter of Sh. Dushyant Sharma
Vs
Max Bupa Health Insurance Company Ltd.

1. The Complainant alleged that he had taken mediclaim policy for his family since 2010-11 from Oriental Insurance Company Ltd. and he ported this policy with Max Bupa Health Insurance Company Ltd. in the year 2015-16. He further alleged that on 18.04.2016 he was admitted in the hospital for the complaint of right flank pain since one day with fever, nausea and abnormal bowel habits and his case diagnosed as a right proximal ureteric calculus with left renal calculus. He underwent the surgery of cystoscopy, bilateral RIRS and bilateral DJ stenting done under GA on 18.04.2016 and was discharged on 19.04.2016 from the hospital but his claim was denied by the Insurance Company on the ground of PED and non-disclosure of material facts from policy inception date.

2. The Insurance Company reiterated vide their letter dated 07.06.2016 that as per submitted documents and investigations done by them it was revealed that the patient was suffering from stone problem recently
since 3-4 years back and kidney calculus surgery 8-9 years back which falls prior to policy inception dated which confirmed condition of PED and non-disclosure also. Hence they had repudiated the claim as per clause 4(a) 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 not suffering from any disease, prior to taking the Insurance policy. He also stated that my wife had submitted in the hospital before treatment that I was taking homeopathy treatment for kidney stone.

   The Insurance Company stated that the complainant was suffering from stone problem since 3-4 years back and kidney calculus surgery 8-9 years back which had fallen prior to policy inception and had confirmed the condition of PED and non-disclosure since the complainant had not declared his disease in the proposal form at the time of porting his policy with them.

   On perusal of papers on record, I find that in the ultrasound report of Dr. Abishek Gupta, the complainant was suffering from left kidney calculus of six 11.3mm at lower calyx. As per investigation reports of hospital it was revealed that the complainant had renal disease haematuria and was suffering from stone problem since 3-4 years. He was also admitted in the hospital and underwent kidney stone surgery 8-9 years back. It was a case of non-disclosure. Hence I do not find any reason to interfere with the decision of the Insurance Company. However, I direct the Insurance Company to continue the policy of the complainant with the exclusion of present hospitalization disease and its co-morbidities. **Accordingly the complaint filed by the complainant is hereby disposed off.**

DATE: 05.10.2016

In the matter of Ms. Swati Verma
Vs
Max Bupa Health Insurance Company Ltd.

1. The complainant alleged that she had taken a meidiclaim policy no. 30242684201502 w.e.f. 06.08.2015 to 05.08.2016 from Max Bupa Health Insurance Company Ltd. She further alleged that on 05.09.2015 she was admitted in the hospital but the claim was denied by the Company on the ground that there was gross discrepancy between the hospital records and claim documents.

2. The Insurance Company reiterated vide their letter dated 29.12.2015 that as per the submitted documents and investigations done by them, it was found that gross discrepancy between the hospital records and claim documents. Hence, as per policy clause 5(e) claim falls under misrepresentation of facts. Also patient going home during hospitalization. Hence hospitalization was not justified. Accordingly, the claim was repudiated by them.
3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant stated that she was admitted in the hospital from 05.09.2015 till 11.09.2015 for the treatment of her urinary tract infection. She left the hospital for a couple of nights with the consent of hospital since the water supply in the bathroom of her allotted room was contaminated and muddy. She also stated that at the time of hospitalization she was not suffering from the disease of kidney stone.

   The Insurance Company stated that the complainant had left the hospital for a couple of nights during her hospitalization. Hence, her admission in the hospital was not justified. They also stated that the complainant was suffering from kidney stone since two years.

   On perusal of papers on record, I find that the complainant had left the hospital with the proper consent of hospital because the water supply of her bathroom was contaminated and muddy.

The treating Dr. Ankur Gupta of the complainant had also written to claim department of Insurance Company vide hospital letter dated 16.12.15 that the patient had left the hospital for two nights with their consent due to the problem of water supply in the bathroom of the patient and no other room was available in the hospital where she could have been shifted. She was allowed to go home after administering all the medicines and antibiotics for that day. However, she was advised to come back early in the morning the next day so that all the medicines could be administered on scheduled time. The treating Dr. had also informed the Insurance Company that the hospitalization of the complainant w.e.f. 05.09.2015 to 11.09.2015 was absolutely essential for the treatment. The Insurance Company could not establish with any reliable documents that the patient was suffering from kidney stone since 02 years. Accordingly, I direct the Insurance Company to settle the admissible claim of the complainant only for the days she was hospitalized and OPD expenses, if any, 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 admissible.**

DATE: 03.10.2016

In the matter of Mr. Ravinder Singh Jaryal
Vs
Max Bupa Health Insurance Company Ltd.

1. The complainant alleged that he had taken a meidiclaim policy no. 30177392 from Max Bupa Health Insurance Company Ltd. for his family. His wife was hospitalized from 19.12.15 to 29.12.15 and was discharged on 29.12.2015 but the claim was denied by the Company on the

ground of non-disclosure of material facts at the time of taking insurance. The complainant also stated that he had declared his illness in the proposal form submitted to the Insurance Company.

2. The Insurance Company reiterated vide their mail dated 09.12.2016 that the patient had a history of diabetes mellitus since past 25 years and was on medication for the last 05 years and also had a history of stone 10 years which falls prior to taking the policy. Hence claim was denied by them.
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 declared his disease in the proposal form stating that he was on medication since 05 years.

   The Insurance Company stated that the patient had a history of diabetes mellitus since past 25 years and was on medication since 05 years and also had a history of renal stone 10 years back but he had not disclosed his illness in the proposal form at the time of insurance.

   On perusal of papers placed on record, I find that in investigation report of hospital it was revealed that the patient was suffering from diabetes since 25 years and was on insulin but he had disclosed his disease only as 05 years at the time of taking the policy. The patient was also operated for kidney stone 10 years ago.
   Apart from this the complainant had also admitted on 08.01.2015 in "self declaration of the insured form" which is mandatory to be filled by the complainant to the hospital before surgery that he was suffering from diabetes since15 -20 years and was also operated for kidney stone 10 years back in Kartik Nursing Home, Janakpuri. Hence, I do not find any reason to interfere with the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

DATE: 21.10.2016

In the matter of Mr. Raman Aggarwal
Vs
Star Health and Allied Insurance Company Ltd.

1. The complainant had purchased a Star Health "Family Health Optima Insurance Plan" on 22.10.2013 and renewed the policy continuously till 21.10.16. The Insurance Company had issued the first year policy after medical examination of the proposer and that time no pre-existing disease was detected. The complainant's mother had been hospitalized on 30.06.2016 and underwent PTCA using xience prime stent in OM was diagnosed as CAD, CAG single vessel disease. The claim filed by the complainant had been rejected by the Insurance Company.

2. The Insurance Company had submitted self contained note stated that the cardiovascular system diseases are excluded from the coverage since the inception of policy i.e. from 2013 itself. The disease was found P.E.D. on the basis of medical examination i.e. "ECG Report". The Insurance Company had rejected the claim saying that "treatment of disease related to cardiovascular system is an endorsed PED in the policy and is not payable for 48 months from the inception of the policy.

3. I heard both the sides, the complainant as well as the Insurance Company. The complainant reiterated during the course of hearing that before inception of Ist year policy in the year 2013 the Insurance Company had conducted health check up through their panel doctor and the medical report was furnished to the Insurance Company without any adverse remarks. The panel doctor had very clearly stated in the medical report that in his opinion no adverse remarks related to any pre-existing disease were incorporated in the policy. The complainant further contended that in response to special examination conducted for the "cardiovascular system" the panel doctor had mentioned in his report that the CVS was found "Normal". The complainant had also pleaded that in the medical examination report of the panel doctor of Insurance Company, it was mentioned that the proposer Mrs. Pushpa was not suffering from any of the disease such as DM/HTN/Orthopes/CVA/Neurodogic/Heart disease/mental illness/renal disease/cancer/others

The representative of Insurance Company had contended that the treatment of diseases related to cardiovascular system was an endorsed PED in the policy hence the disease is not payable for 48 months from the inception of the policy. The Insurance Company had further stated that the exclusions of disease related to CVS was endorsed in the policy since inception on the basis of Electrocardiogram report of medical examination conducted prior to inception of policy wherein impression was observed as indicated "RBBB".

On scrutiny of the papers submitted on record, I find that the pre-insurance medical report was the base of endorsing the policy with exclusions of diseases related to CVS. It is observed from the medical examination report of the panel doctor that the cardiovascular system was "Normal' as per the report of "Examination of System". There was no pre-existing disease found as per the opinion of medical examiner as reported in the medical examination report of the panel doctor. It was also mentioned in the medical report that no pre-existing disease of the person to be insured was to be incorporated in the policy. In view of the above facts, I find that the Company had failed to establish that there was any cogent and sufficient evidence for declaring the cardiovascular disease as pre-existing disease. Therefore, the Insurance Company is directed to settle the claim as per the 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 admissible.**

DATE: 07.10.2016

In the matter of Mr. Gurinder Singh
Vs
Religare Health Insurance Company Ltd.

1. The complainant alleged that agent of Religare Health Insurance Company Ltd. had misled/ misguided him. The term and conditions of Religare Health Care Freedom were entirely different from what was told by the agent, so he had approached the Insurance Company for cancellation of policy. The Insurance Company had cancelled the policy and refunded Rs. 17389/- out of total premium of Rs. 69557/-. He sought the relief for balance amount of premium retained by the Company.

2. The Insurance Company reiterated vide self contained note dated 14.09.16 that on receipt of request from the complainant on 07.03.2016 for cancellation of the policy no. 10450001, the Insurance Company had cancel the policy and refunded the premium on short scale basis for the unutilized period of sum insured as per the 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 pleaded that the agent of the Insurance Company had mis-led/mis-guided his father Sh. Sujeet Singh (age 82 years) and sold 08 policies for life and

one of mediclaim. The terms and conditions of policies were different from what was told by agents, so he approached to all the Insurance Company for cancellation of policies. Most of the Insurance Company of life denied to cancel the policy as freelook period was over. The Religare Insurance Company had cancelled the policy but refunded only Rs. 17389/- out of paid premium of Rs. 69,557/- he pleaded for refund of balance amount of premium.

The Insurance Company reiterated that the complainant had approached to cancel the policy after 04 months form the inception of the policy. The insurance was cancelled and 25% premium was refunded under clause 7.11 of terms and conditions of the policy.

I find that complainant's father had taken the health policy from Religare Insurance Company in November 2015 at the age of 80years. The agents had sold him various policy (08 life and 01 mediclaim) as revealed from annexure attached with the complainant dated 10.08.2016. The complainant had approached the Religare Health Insurance Company on 24.03.16 for cancellation of the policy after lapse of 04 months from the inception of the policy (14.11.2015). Since no claim been reported under the policy, the insurance was cancelled by the Company at the request of the insured and 25 % of premium was refunded as per clause no. 7.11 (cancellation and termination). I see no reason to interfere with the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

DATE: 07.10.2016

In the matter of Mr. Ravish Sareen
Vs
Star Health and Allied Insurance Company Ltd.

4. The complainant had purchased a Star Super Surplus Insurance Policy of Star Health and Allied Insurance Company Ltd. for the period 2015-16 which was a renewal of the same Company for previous year's policies for the year 2012-13, 2013-14 and 2014-15. The complainant had applied for reimbursement of claim under the policy which the Insurance Company had rejected.

5. The Insurance Company had rejected the claim on ground of pre-existing disease prior to obtaining the policy from Star Health and Allied Insurance Company Ltd. as the patient was a known case of chronic kidney disease. The Insurance Company reiterated that the claim was rejected as per policy terms and conditions no. 08 which read as "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 for claim.

6. I heard both the sides, the complainant (represented by his father) as well as the Insurance Company. During the course of hearing the complainant's father Mr. K.D. Sareen had pleaded that the Insurance Company had wrongly rejected the claims for the year 2014-15 amounting to Rs. 210389/- and Rs. 146302/- as the disease contacted in 2014 only.

   The representative of the Insurance Company had stated that the complainant was suffering from the disease CKD since 2009, which was not disclosed in proposal form submitted at the inception of the policy, therefore, the claim was rejected as per policy condition no. 08 of the policy.

   On scrutiny of the papers placed on record, I find that as per the Medical Certificate issued by the treating doctor of Columbia Asia hospital it revealed that the complainant was suffering from ESRD since 2009.
   The complainant had been insured under medical insurance policy from Star Health and Allied Insurance Company Ltd. since 02 Feb, 2012 onward resting with the last year policy for 2015-16 which was cancelled by the Insurance Company on 29.11.15 through an endorsement dated 23.11.15 due to non-disclosure of PED-CKD. Since it was a case of breach of policy condition no. 08 i.e. misrepresentation/non-declaration of material facts with regard to pre-existing disease i.e. CKD, conclusively I uphold the decision of the Insurance Company. 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.**

DATE: 22.11.2016

In the matter of Mr. Parveen Kucchal
Vs
National Insurance Company Ltd.

1. The complainant alleged that he had taken his mediclaim policy from National Insurance Company Ltd. bearing no360801/48/15/8500002883 w.e.f . 14.08.15 to 13.08.16. He further alleged that on 26.08.2015, he was admitted in the hospital for the complaints of high grade fever associated with mild cough and recurrent vomiting and later his illness was diagnosed as acute dengue fever and was discharged from hospital on 02.09.15 but his claim was denied by the Company on the ground of violation of policy conditions by the complainant.

2. The Insurance Company vide its letter dated 06.11.2015 reiterated that the claim of the complainant was repudiated since he had not submitted the required documents despite several reminders and also the claim was closed on account of violation of policy conditions by the complainant. As per self contained note dated 05.08.2016, the complainant had not submitted previous policies of United India Insurance Company Ltd. and his current policy is commencing from 14.08.2015 and the complainant admitted in the hospital on 26.08.15 hence disease contracted in first 30 days of insurance cover and claim was denied under clause 4.2 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 reiterated that complainant had taken Baroda Health policy for himself and his family for the period 14.08.2015 to 13.08.2016. Prior to his insurance complainant had taken mediclaim coverage from United Insurance w.e.f. 21.07.2014 to 20.07.2015. The claim arosed during first 30 days of commencement of policy. As per exclusion clause 4.2 of the policy expenses incurred on treatment of any disease contracted during first 30 days of insurance cover were not payable, hence claim was rejected. I rely upon the judgment of the District Consumer Forum that "In our considered opinion when a snake bites a person, it is an accident. On this analogy we do not find any difference between the death caused by a snake bite and the death caused by the bite of malaria parasite provided there should be a proof to that fact". In the instant case, although

not a death case, but complainant's son was treated for dengue which is because of mosquito bite. The analogy remains the same hence claim is admissible treating it as an accident during first 30 days of Insurance cover. 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 of the complainant as admissible.**

DATE: 09.11.2016

In the matter of Mr. Inder Sain
Vs
Star Health and Allied Insurance Company Ltd.

1. The complainant alleged that he had purchased Health Insurance Policy on 09.12.2014 from Star Health and Allied Insurance Company Ltd. The complainant had started problem in abdomen. He consulted doctor as the problem was getting severe day by day. Lastly he was diagnosed cancer in March 2015. The complainant was hospitalized on 23.09.15 in Medanta The Medicity (unit of Global Health Pvt. Ld.) Gurgaon and was diagnosed Retroperitoneal

Liposarcoma. The complainant had pleaded that the cashless claim submitted for reimbursement was also denied by the Insurance Company on the ground of their findings that the disease was present prior to inception of the medical insurance policy. The complainant had approached the forum with the contention that the disease had contracted later after the inception of policy. The complainant is seeking relief from the forum.

2. The Insurance Company had rejected the claim that their medical team had gone through the case and found that as per the CT abdomen report dated 19.03.2015 it was a huge bilobed liposarcoma of size 50* 50 cm displacing the left kidney cranially and small intestine anteriorly and protruding through meso sigmoid into right iliac fossa and also extending into left inguinal canal and severally engulfing the ureter. The medical team arrived at the opinion that the tumor was present at inception of the medical insurance policy, in view of the same, the claim was repudiated.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant had stated that he was hospitalized on 29.03.2015 in Medanta Hospital for treatment of cancer diagnosed in March, 2015. The complainant pleaded that the insurance policy was purchased in December, 2014 and the detection of disease cancer was in the month of March, 2015. The representative of the Insurance Company had stated that as per the casualty card dated 'NIL' issued by Sir Ganga Ram Hospital the duration of painful swelling in left groin was overwritten as 2 months. The Insurance Company further added that as per the investigation report submitted by their investigator, no casualty card is being kept in hospital records unless patient is admitted in the hospital. The report further stated that as per the soft copy of the casualty card the patient was visited hospital on 18.03.2015 with the complaints of swelling in left groin for the past 2 and a half months. As per the investigation report, the patient had taken consultation from Fortis Hospital on 19.03.2015, Mohanty Surgical Centre and Nursing Home on 19.03.2015, Dr. Rudraprasad Acharya of Max Hospital, Salimar Bagh on 19.03.2015, Artimes Hospital on 23.03.2015, Dr. B R Ambedkar sans than Rotary Cancer Centre and Hospital on 25.03.2015, finally visited Medanta Hospital, where surgery was done on 30.03.2015. On Scrutiny of papers, I find that the Insurance Company failed to establish the existence of the disease Liposarcoma prior to inception of the policy, as the investigation report was made the base for repudiation of the claim, which had not been conclusively documented the evidences to prove the existence of PED. In view of the circumstances stated above and in the absence of cogent and reliable documentary evidences to prove the disease as pre-existing. I find that the claim is admissible. **Accordingly the Insurance Company is directed to settle the claim.**

DATE: 07.10.2016

In the matter of Ms. Savita Chawla
Vs
Oriental Insurance Company Ltd.

1. The complainant alleged that she was admitted in Saroj Hospital, Rohini, Delhi from 13.12.14 to 15.12.14 and diagnosed as a case of large irreducible umbilical hernia with DM/HTN with obesity. She had applied for cashless facility which was denied by the TPA E-Meditek. She had submitted all the necessary papers of the claim to the TPA for reimbursement of Rs. 84,953/- but the TPA had denied her claim on the ground that treatment of obesity or condition arising therefrom (including morbid obesity) and any other weight control programme is not payable under the policy. She had sought the relief of Rs. 84,953/- from this forum.

2. The TPA E-Meditek vide its letter dated 14.03.2015 had rejected the claim on the ground that the Company shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any insured person in connection with or in respect of (4.17) which states that "treatment of obesity or condition arising therefrom (including morbid obesity) and any other weight control programme, services or supplies etc. are not payable." The patient was admitted in Saroj Super Hospital with complaints of swelling paraumbillical region since 2 years, diagnosed as large irreducible umbilical hernia with diabetes/hypertension with obesity and underwent partial omentectomy with hernioplasty with umbillicolectomy under SA on 13.12.2014. The claimed amount of Rs. 84953/- as per investigation and documentation, patient admitted with history of swelling paraumbillical region since 02 years, umbilical hernia could be a complication of obesity, hence 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 wife Mrs. Savita Chawla was admitted in Saroj Hospital, Rohini, Delhi from
13.12.14 to 15.12.14 and diagnosed as a case of large irreducible umbilical hernia with DM/HTN with obesity. During the hospitalization she had undergone omentectomy with hernioplasty with umblicolectomy under SA on 13.12.2014. The Insurance Company had rejected the claim on the ground that treatment of obesity or condition arising therefrom (including morbid obesity) and any other weight control programme is not payable under the policy.

   The Insurance Company had stated that the claim was rejected under policy exclusion clause 4.17 which states that "treatment of obesity or condition arising therefrom (including morbid obesity) and any other weight control programme, services or supplies etc. are not payable." The patient was admitted in Saroj Super Hospital with complaints of swelling paraumbillical region since 2 years, diagnosed as large irreducible umbilical hernia with diabetes/hypertension with obesity underwent partial omentectomy with hernioplasty with

umbillicolectomy under SA on 13.12.2014. Umbilical hernia could be a complication of obesity, hence not payable under the policy.

On perusal of the claim papers placed on record and submissions made during the hearing, I find that Mrs. Savita Chawla was admitted in Saroj Hospital, Rohini, Delhi from 13.12.14 to 15.12.14 and diagnosed as a case of large irreducible umbilical hernia with DM/HTN with obesity. She had undergone omentectomy with hernioplasty with umblicolectomy under SA on 13.12.2014. As per medical literature available an umbilical hernia in adults usually occurs when there is pressure is put on a weak section of the stomach muscles due to being overweight or obese. The Insurance Company had rejected the claim under policy clause 4.17 which states "treatment of obesity or condition arising therefrom (including morbid obesity) and any other weight control programme, services or supplies etc. are not payable." since the patient Mrs. Savita Chawla underwent partial omentectomy with hernioplasty with umbillicalectomy under SA on 13.12.14 which was arising out of obesity and excluded under the policy clause 4.17, hence Insurance Company had rightly rejected the claim. I find no reason to interfere with the decision of Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

DATE: 17.10.2016

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

1. The complainant had alleged that his father was admitted in Action Medical Institute from 06.11.15 to 09.11.15 and diagnosed as a case of CAD-Acute Coronary Syndrome, Chronic obstructive pulmonary disease (COPD). He was taken up for CAG on 06.11.15 which showed single vessel disease. PTCA+Xience Prime –Prox and Mid LAD were done successfully. He had applied for cashless facility but the TPA had sanctioned the amount only Rs. 75,000/- whereas the total expenditure was Rs. 2,06,379/-. He had sought the relief of Rs. 1,31,379/- from this forum.

2. The Insurance Company vide their letter dated 14.12.2015 had informed the complainant that the patient was suffering from hypertension and COPD for 28 years as revealed from the discharge summary. Since the CAD is listed complication of hypertension under policy exclusion clause 4.1, the applicable sum insured was considered for the period 2011 - 2012. As per the available information the maximum available limit of S.I. Rs. 75,000/- had already exhausted during the settlement of cashless claim of the hospitalization from 06.11.15 to 09.11.15. Hence the claim is not admissible.

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 Mr. Mukesh Sharma was suffering from hypertension and COPD for 28 years as revealed from cardiac evaluation form dated 06.11.12015 Sri Balaji Action Medical Institute. Since the CAD was listed complication of hypertension under policy exclusion clause 4.1 "pre-existing disease", hence the applicable S.I. i.e. Rs. 75,000/- was considered for the period 2011-12 (P.No. 272600/48/2012/3090 from 24.09.11 to 23.09.12 and the claim was paid accordingly.

On perusal of the claim papers placed on record and submissions made during the hearing, I find that Mr. Mukesh Sharma was admitted in Sri Balaji Action Medical Institute from 06.11.15 to 09.11.15 and diagnosed as a case of CAD, Acute Coronary Syndrome and COPD (Chronic Obstructive Pulmonary Disease). During hospitalization PTCA + Xience Prime-Prox and Mid LAD was done successfully. As per cardiac evaluation form dated 06.11.15 Sri Balaji Action Medical Institute the patient was a known case of COPD and HTN since 28 years. In cashless request form also which was duly signed by the Insured Mr. Karan Sharma, the patient Mr. Mukesh Sharma was having a history of HTN (hypertension) since 28 years. As per policy clause no. 7 (c) Renewal of policy which states "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) and for a disease/ailment/injury for which treatment had been taken in the earlier policy period, the enhanced sum insured will be applicable only after four continuous renewal with the increased sum insured. The S.I. under the policy for 2011-12 (P.No. 272600/48/2012/3090 from 24.09.2011 to 23.09.2012) was Rs. 75,000/- which was subsequently enhanced to Rs. 5,00,000/- under P.No. 272600/48/2014/2125 from 24.09.2013 to 23.09.2014 and further enhanced to Rs. 6,00,000/- under P.No. 272600/48/2015/2041 from 24.09.14 to 23.09.15. the claim arose under P. No. 272600/48/2016/2199 from 30.09.15 to 29.09.16, sum insured Rs. 6,00,000/-, hence as per policy clause 7(c) "Renewal of policy", the enhanced S.I. will be applicable only after four continuous renewals with the increased sum insured. Hence, Insurance Company had rightly settled the claim considering the S.I. Rs. 75,000/- for the period 2011-12 (P.No. 272600/48/2012/3090 from 24.09.11 to 23.09.12) as the patient was suffering from COPD and HTN for 28 years before 06.11.15. I find no reason to interfere with the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

DATE: 18.10.2016

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

1. The complainant alleged that he had taken a Family Floater Mediclaim Policy in the year 2012 covering his family for the sum insured of Rs. 10 Lacs. His wife and his two daughters were covered under the above-said policy. His daughter Ms. Sasha Gambhir was admitted in Primus Super Speciality Hospital from 24.02.2016 to 02.03.2016 and diagnosed as a case of adolescent idiopathic left thora columbar progressive scoliosis with the chief complaints progressive increasing deformity of back. Posterior instrumentation (TS-L3) + Porte's osteotomy (T11-L1) spine surgery under GA was done on 25.02.2016. He had submitted all the necessary papers of the claim to the TPA M/s Vipul MedCorp (TA) Pvt. Ltd. for reimbursement of Rs. 7,81,168/- but the TPA/Insurance Company had denied the claim on the ground of pre-existing disease and non-disclosure of material facts. He had sought the relief of Rs. 7,81,168/- from this forum.

2. The Insurance Company vide its letter dated 20.05.2016 had rejected the claim on the ground of pre-existing disease and non-disclosure of material facts at the time of taking the policy. As per investigation in the case the hospital record showed that the patient Ms. Sasha Gambhir was admitted due to progressively increasing deformity in the back which was first noticed in the year 2009. The insured had taken the first policy with Oriental Insurance Company w.e.f. 17.09.2012 to 16.09.2013 vide policy no. 272100/48/2013/1186. This tantamount to the pre-existing disease and excluded under policy clause 4.1
   secondly on going through the proposal form submitted by the insured at the inception of the policy, there was no mention of any injury of any spinal disorder or any ailment to Ms. Sasha Gambhir which also tantamount to non-disclosure of material facts. Hence the claim was not admissible and repudiated under policy clause 4.1, 5.9 and 5.10 of 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 had reiterated the same. The Insurance Company had stated that the claim was rejected on the
   ground of pre-existing disease and non-disclosure of material facts at the time of taking the policy. As per investigation in the case the hospital record showed that the patient Ms. Sasha Gambhir was admitted due to progressively increasing deformity in the back which was first noticed in the year 2009. The insured had taken the first policy with Oriental Insurance Company w.e.f. 17.09.2012 to 16.09.2013 vide policy no. 272100/48/2013/1186. This tantamount to the pre-existing disease and excluded under policy clause 4.1 secondly on going through the proposal form submitted by the insured at the inception of the policy, there was no mention of any injury of any spinal disorder or any ailment to Ms. Sasha Gambhir which also tantamount to non-disclosure of material facts. Hence the claim was not admissible and repudiated under policy clause 4.1, 5.9 and 5.10 of Happy Family Floater Policy. At the time of claim the policy was running in the fourth year (P.No. 272100/48/2016/739 from 17.09.15 to 16.09.16).

On perusal of the claim papers placed on record and submissions made during the hearing, I find that Ms. Sasha Gambhir aged 20 years was admitted in Primus Super Speciality Hospital from 24.02.16 to 02.03.16 and diagnosed as a case of adolescent idiopathic left thoracolumabar progressive scoliosis. The history of present illness was progressively increasing deformity of back. During hospitalization posterior instrumentation +Ponte's osteotomy under G.A. was done on 25.02.16. As per IPD papers dated 24.02.16 Primus Super Speciality Hospital deformity of back was first noticed in the year 2009 and doctor had prescribed the boston milwaukee brace to support the parts of the body in correct position, hence the disease was pre-existing as the policy in which the said claim lodged was running in the fourth year. The first policy was taken by the insured in the year 2012 (P.No. 272100/48/2013/1186 from (17.09.12 to 16.09.13) and the disease deformity of back pertains to the year 2009, hence falls under pre-existing disease. As per exclusion clause 4.1: 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 from), 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. Further the proposer Mr. Naresh Kumar Gambhir had not disclosed the said disease in proposal form under column 6 "personal history of the insured person" which tantamount to non-disclosure of material facts. Hence, in view of the above facts I find that Insurance Company had rightly rejected the claim under policy clause pre-existing disease and non-disclosure/ concealment of material facts in the proposal form. I find no reason to interfere with the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby disposed off.**

DATE: 28.11.2016

In the matter of Ms. Renu Chanana
Vs
IFFCO Tokio General Insurance Company Ltd.

1. The complainant alleged that he had taken a mediclaim policy from IFFCO Tokio General Insurance Company Ltd. for her family on 09.08.13 after porting from National Insurance Company Ltd. She further alleged that her husband was admitted in the hospital on 24.02.2016 for the complaints of cough with expectoration, restless and breathlessness for last 2-3 days which increased in severity and later the illness was diagnosed as congestive heart failure and coronary artery disease. He underwent coronary angiography followed by coronary angioplasty and later he was declared dead on 05.03.2016. But his claim was denied by the Insurance Company on the ground that the disease of hypertension was not declared at the time of taking the policy.

2. The Insurance Company vides its letter dated 16.08.2016 reiterated that as per certificate of Dr. J.P.S. Sawhney of Sir Ganga Ram Hospital dated 16.04.2016, it was clearly affirmed and illustrated that the patient had a history of hypertension since 6-7 years (prior to taking the policy) which was not declared at the time of taking the policy. Hence claim was repudiated by them. The Insurance Company also stated that on receipt of representation on 30.06.2016 stating that the patient had a history of hypertension since 6 to 7 months instead of 6-7 years the consultation papers of 6-7 months treatment of the patient were required from the complainant

for reviewing the matter, but as per record available the same documents were not submitted to the Insurance Company.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing, the complainant stated that his claim was rejected by the Insurance Company on the ground of Non-disclosure of Hypertension at the time of porting the policy with their Insurance Company which was since 6-7 months instead of 6-7 years, and was mentioned wrongly by the hospital and necessary clarification was sought from the attending Dr. of Hospital vide certificate dated 16-06-2016 by the complainant. The complainant also stated that the PTCA was done in 2015, instead of 2013, as mentioned wrongly by the hospital and Insurance Company had also settled similar claim of his disease in 2015.

4. During the personal hearing the Insurance Company stated that they had repudiated the claim of the complainant since the patient had the disease of Hypertension since 6-7 years. However, at the request of the complainant that the patient was suffering from this disease since 6-7 months, as per clarification sought from the attending Dr. vide certificate dated 16-06-2016 by the complainant. The Insurance Company also stated that they had required the consultation papers of attending Dr. of 6-7 months, when the first disease of Hypertension was occurred for reviewing their decision but the same documents were not submitted to the Insurance Company by the complainant.

5. After hearing both the sides, the complainant as well as the Insurance Company and perusal of record placed before me. The complainant was directed to submit the clarification of PTCA, which was done in 2015 instead of 2013, which he letter submitted from the attending vide certificate dt. 26-10-2016, which shows PTCA was done in 2015 instead of 2013 the complainant had also submitted payment voucher of his similar claim paid in june-2015 in the office, which indicates that his claim of similar disease was settled by the Insurance Company in 2015 and Insurance Company in response to this, had stated vide letter dated 10-11-2016 that the claim of the complainant was paid wrongly and human error can never he treated as standard practice. The complainant was also directed to submit the first consultation treatment papers of 6-7 months to Insurance Company, which he had not submitted inspite of directions given to the complainant. I find as per certificate of attending Dr. J.P.S. summery dated 16-06-2016 of Sir Ganga Ram Hospital stating they the patient had the history of Hypertension since 6-7 months from the date of admission of 24-02-2016, however, the discharge summery of june-2015 , which was 9 months prior to the admission, confirms that the patient was Hypentensive. The Cashless Request Form of the complainant. submitted by the Hospital also indicates that the patient had the history of Hypertension and heart diseases since one year from the time of admission i.e. 24-02-2016 Apart from this, as per Pentamed Hospital letter dated 06-06-2015, prepared by Dr. R. Gupta, it is clearly mentioned that the patient was a known case of Hyprtension, whereas the exact history of ailment was not mentioned anywhere on the documents. So, it clearly shows that prior to inception of policy, the patient had the history of

Hypertension, which was not disclosed in the proposal form at the time of porting the policy. Accordingly, I do not find any reason in interfering with the decision of Insurance Company in repudiating the claim. **Accordingly the complaint filed by the complainant is hereby disposed off.**

DATE: 20.10.2016

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

1. The complainant alleged that he was admitted in Fortis Hospital, Vasant Kunj, Delhi from 09.01.2016 to 12.01.2016 and diagnosed as a case of Syncope Recurrent, hyponatremia and LRTI with Bronchitis. The present illness was two episodes of fall at home followed by unconsciousness lasted 30-40 seconds regained spontaneously 01 episode and fever and cough for 3-4 days. He had submitted all the necessary papers of the claim for reimbursement of Rs. 54817/- but the Insurance Company had denied the claim on the ground of pre-existing disease and the admission was evaluation/diagnostic purpose which was not followed by active line of treatment for the ailment during the hospitalization period.

2. The Insurance Company vide its letter dated 20.04.2016 had rejected the claim under policy exclusion clause 4.1 and 4.10 of the policy. The presenting complaints of the patient were 2 episodes of all at home followed by unconsciousness for 30-40 seconds regained spontaneously. As per the details patient was not unconscious at the time of admission. The records also revealed that the patient is a known case of
pertension from 10 years. All the details clearly indicate that no active line of management was done. Therefore, this ailment is concluded as a pre-existing disease/ailment and for evaluation/ diagnostic purposes which is not followed by active treatment for the ailment during the hospitalized period.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing, the complainant had reiterated the same. The Insurance Company had also reiterated the same that the ailment for which the patient was treated falls under pre-existing disease and the hospitalization was only for
evaluation/ diagnostic purposes which was not followed by active line of treatment. Hence, claim was not payable.

   On perusal of the claim papers placed on record and submissions made during the hearing, I find that Mr. Sudhir Kumar Singh was admitted in Fortis Hospital from 09.01.2016 to 12.01.2016 and diagnosed as a case of Syncope Recurrent, hyponatremia and LRTI with Bronchitis. The present illness was two episodes of fall at home followed by unconsciousness lasted 30-40 seconds regained spontaneously 01 episode and fever cough for last 03-04 days. As per investigation conducted by the TPA the patient had a history of blood pressure since 08-09

years and this was the first time, nothing in the past. The Insurance Company had rejected the claim under policy clause "pre-existing disease" as the patient was a know case of hypertension since last 10 years and secondly the hospitalization was for evaluation/diagnostic purpose which was not followed by active line of treatment for the ailment.

On perusal of discharge summary placed on record it is found that the patient was diagnosed as a case of Syncope Recurrent, hyponatremia and LRTI with Bronchitis and the chief complaints were fever and cough for 03-04 days. During hospitalization the patient was managed conservatively with IV fluids, IV antibiotics and other supportive medications. During the hearing the complainant had stated that he was admitted in the hospital on the advice of treating doctor as he was seriously ill at that time. He had also produced /submitted the treating Dr. Renu Achtani certificate dated 23.04.2016 that hyponatremia is known to cause serious complication like seizures, coma etc and this is treated with IV fluids as in-patient and the patient is still under constant supervision of treating doctor.

The Insurance Company could not prove that the disease hyponatremia is caused due to hypertension. Hence, in view of the above facts, I hold that the Insurance Company is liable to settle the claim and pay for hospitalization and treatment expenses thereof. However treatment expenses related to hypertension are not payable as the patient had a history of the same since 8-9 years and falls under pre-existing disease. **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.**

DATE: 14.12.2016

In the matter of Mr. P. R. Khanna
Vs
Oriental Insurance Company Ltd.

1. The complainant alleged that he had been insured under Oriental mediclaim policy for the last 25 years without break. Last year he received a letter from their Head Office to increase the sum insured to Rs. 10 lacs, but when he approached the policy issuing office they refused to do so. He had taken up the matter with the CMD of the Company but no replied was received so far. Further in the month of May, 2016 his wife Mrs. Kiran Khanna who is also insured for the last 25 years had to undergo the treatment of "Left Nephrolithiasis" for which surgery was done at Apollo Hospital. The hospital raised a bill of Rs. 2,93,302/- but the TPA E-Meditek had approved the amount only for Rs. 90,650/-. There was a difference of Rs. 2,02,652/-. The sum insured under the policy was Rs. 4.5 lacs. On being asked from the Insurance Company about deduction of the claim amount, they had told that the claim was settled as per GIPSA Package. He had sought the relief of Rs.

2,02,652/- being difference of amount and for increasing the sum insured under the policy to Rs. 10 Lakhs.

2. The TPA M/s E-meditek vide its email dated 15-07-2016 had informed that the claim was settled as per GIPSA Package and Rs. 90,650/- was paid to the insured.
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 had alleged that he had not been informed by the Insurance Company about GIPSA package nor did the Insurance Company provide him the terms and conditions of the policy. The representative of the Insurance Company had agreed that there is no mention of GIPAS package in the policy.

On perusal of the claim papers placed on record and submission made during the hearing, I find that details of GIPSA package was not incorporated in policy, the said fact had also been admitted by the representative of the Insurance Company. Hence, in the absence of such condition, I direct the Insurance Company to settle the claim and pay the remaining amount as admissible to the complainant. **Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant and pay the remaining amount as admissible.**

DATE: 28.02.2017

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

1. The complainant alleged that he had taken a mediclaim policy no. 272400/48/2016/2342 w.e.f. 29.05.15 to 28.05.2016 for his family from Oriental Insurance Company Ltd. The complainant also alleged that on 25.11.2015 he was admitted in the hospital for the complaints of chest discomfort associated with uneasiness radiating to both arms for last 02 days. He underwent coronary angiography which revealed double vessel disease. Subsequently he underwent PTCA with stent to MID LCX and later he was diagnosed as acute coronary syndrome, CAG-double vessel disease and PTCA with stent to MID LCX. He was discharged from hospital on 27.11.2015 but his claim was rejected by the Insurance Company on the ground that his disease was a case of varicose veins.

2. The Insurance Company vide its letter dated 28.06.2016 reiterated that on scrutiny of documents, it was revealed that the disease of the complainant was a case of varicose veins and also overweight. Varicose veins is the pre-disposing factor in this case and is known case from 40 years and hence concluded as a

sequel of pre-existing disease/ailment and the policy of the complainant was since 2014. Accordingly the claim was repudiated by the Insurance Company.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant stated that varicose veins have no co-relation with myocardial infarction and only on the basis of frivolous reasons his claim was denied by the Insurance Company.

   The Insurance Company during the personal hearing reiterated that varicose veins is the pre-disposing factor and is a known case from 40 years and accordingly this ailment is concluded as a pre-existing disease of the complainant and accordingly the claim was repudiated by them.
   After hearing both the sides, the complainant as well as the Insurance Company and after perusal of record placed, I find that claim of the complainant was denied by the Insurance Company due to pre-existing disease of varicose veins based on the recommendations of TPA. The copy of the letter dated 30.03.16 of Dr. (Col.) Viney Jetley (DM Cardiologist) of Fortis Hospital submitted by the complainant during hearing confirms that the varicose veins have no co-relation with Myocardial Infarction. There is also no mention of pre-existing disease of Varicose Veins in the discharge summary of Fortis Escorts Hospital issued during the admission of the complainant in the hospital. I find that the Insurance Company could not substantiate their case with any reliable documents to establish that varicose veins are the causative risk factors of Myocardial Infarction. Hence the 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 of the complainant as admissible.**

DATE: 03.03.2017

In the matter of Mr. Azad Gautam
Vs
Oriental Insurance Company Ltd.

1. The complainant alleged that he had taken a personal accident policy no. 271900/48/2016/3408 w.e.f. 16.10.15 to 15.10.16 from Oriental Insurance Company Ltd. The complainant also alleged that on 04.11.2015 he met with the accident and Dr. had advised him rest upto 13.12.2015. But Insurance Company had not settled his claim adequately and no claim approval letter was given by the Insurance Company.

2. The Insurance Company had not submitted any self contained note or any relevant documents.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant stated that his claim for mediclaim expenses under P.A. policy was not settled by the Insurance Company and he had already submitted bills to the Insurance Company.

   The Insurance Company reiterated that the complainant had not submitted original bills of medical expenses inspite of the letter sent to the complainant.
   On perusal of claim papers placed on record, I find that the Insurance Company stated that the complainant had not submitted original bills of medical expenses and in the absence of the same they could not settle the claim of medical expenses under P.A. policy. However, the claim for weekly benefit of the complainant had already been settled by the Insurance Company who met with the accident on 04.11.15. The Insurance Company is directed to settle the claim on receipt of the original bills of medical expenses from the complainant. **Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant as admissible.**

DATE: 06.03.2017

In the matter of Mr. Sandeep Taluja
Vs
Royal Sundaram General Insurance Company Ltd.

1. The complainant alleged that he had taken a mediclaim policy for his family bearing no. 0005756000106 w.e.f. 19.12.15 to 18.12.16 from Royal Sundaram General Insurance Company Ltd. The complainant also alleged that his wife was admitted in hospital on 29.08.2016 for the complaints of Menorrhagia for 02 months with heavy menstrual flow since 8-9 months and she underwent the surgery for Laparoscopic hysterectomy + B/L salpingectomy B/L ovarian conservation and her case was diagnosed as large fibroid uterus in Menorrhagia and she was discharged from Hospital on 01.09.2016. The complainant also further alleged that subsequently her wife was again hospitalized twice in the hospital on 04.09.2016 for the complaints of enteric fever and was discharged on 09.09.2016. And on

10.09.2016 for the complaints of viral fever on enteric and was discharged from hospital on 14.09.16. The complainant also stated that he is taking his Insurance Policy regularly since 2009. But the claim of his wife was denied by the Insurance Company on the ground that fraudulent means were adopted in lodging the claim.

2. The Insurance Company vide its letter dated 04.11.16 and 12.11.16 reiterated that after investigation it was observed that record submitted by the complainant to the Insurance Company were fabricated for making fraudulent claim using fraudulent means to make unlawful gain and accordingly the claim was rejected and policy was also cancelled by them. However, a claim for Rs. 1500/- was settled by the Insurance Company towards daily benefit clause as per policy terms and conditions.

3. I heard both the sides, the complainant as well as the Insurance Company. The complainant during the course of hearing stated that she was hospitalized in the hospital twice for the complaints of enteric fever. First time she was hospitalized on 04.09.2016 and was discharged on 09.09.2016 and second time she was hospitalized on 10.09.2016 and discharged on 14.09.2016 but her claim was denied by the Insurance Company.

   The Insurance Company during the personal hearing stated that the claim of the complainant was rejected by them after investigation since fabricated record was submitted by the complainant for making fraudulent claim adopting fraudulent means to make unlawful gain.

   After hearing both the sides and perusal of record placed before me, I find from the record of hospital submitted by the Insurance Company alongwith the self contained note dated 20.02.2017 that the patient was admitted on 04.09.2016 but the vitals were normal and only one spike of fever was there in the hospital record and no recommendation for admission in the hospital by the treating doctor was found and after discharge from hospital on 09.09.2016 suddenly again the complainant was admitted on 10.09.2016. No proper Dr. Notes of treatment are available in the hospital record. The patient was admitted in room no. 03 during admission on 10.09.2016 and the another patient namely Nikunj Garg was also found in the same room between 08.09.16 to 11.09.16 while the complainant was discharged on 14.09.16 from room no. 03 as per hospital record submitted by the Insurance Company. Besides this, as per record, the hospital was registered with 07 beds and out of that too, 05 beds were operational only but IPD is showing 15 patients were admitted in the hospital. I find that the matter was investigated by the Insurance Company and claim was repudiated accordingly but no speaking order of repudiation of claim was given by the Insurance Company to the complainant. Neither necessary clarification on the lapses was sought from the hospital nor from the complainant. Accordingly, Insurance Company is directed to issue speaking order of repudiation of claim to the complainant and after on receipt necessary clarifications from the complainant to decide the matter accordingly at their end. The complaint stands closed at this office. **Accordingly the complaint filed by the complainant is hereby disposed off.**

DATE: 27.03.2017

In the matter of Ms. Bhajana Devi
Vs
Oriental Insurance Company Ltd.

1. The complainant alleged that she had taken a mediclaim policy no. 272900/48/2014/8316 w.e.f. 03.09.13 to 02.09.14 from Oriental Insurance Company Ltd. She also alleged that on 20.05.14 she slipped in her house and had fracture and admitted in the Government Hospital w.e.f. 20.05.14 to 16.06.14 but she did not claim medical expenses from the Insurance Company. The complainant further stated that she renewed her policy no. 272900/48/2015/12375 w.e.f. 20.10.14 to 19.10.15 (after a gap of 47 days) and on 01.09.2015, she again slipped in her house and again admitted in the hospital for the complaint of pain, difficulty in hip movement and loose implant and her case was diagnosed as loose implant with fracture w.e.f. 01.09.2015 to 10.09.2015 but her claim was denied by the Insurance Company on the ground of pre-existing disease.

2. The Insurance Company reiterated that on perusal of claim documents it was observed that the patient was admitted as a case of loose implant with fracture neck femur right and underwent renewal of the
implant for the same. The patient had the history of fracture ST right femur and was admitted from 20.0514 to 16.06.15 and the present admission is directly related to the ailment from which the patient was suffering prior to the inception of the policy. Hence the present claim was falling under exclusion for pre-existing disease and was denied by the Insurance Company.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing, the complainant agreed that there was a gap of 47 days in the renewal of his policies for the year 2013-14 and 2014-15 since he could not renew his policy in time. He also admitted that initially her mother was slipped on 20.05.14 in the house and admitted till 16.06.14 in the government hospital and implant was done after operation.

   The Insurance Company during the personal hearing stated that there was a gap of 47 days in both the policies of the complainant for the year 2013-14 and 2014-15. The Insurance Company also reiterated that the renewal of the policy was effected w.e.f. 20.10.14 to 19.10.15 and the complainant had slipped on 01.09.15 and the present admission was directly related to the ailment for which the patient was suffering since 20.05.14 which was prior to the inception of policy. Hence, the claim of the complainant had fallen under exclusion clause of pre-existing disease and was accordingly denied by them.

After hearing both the sides and perusal of record placed before me, I find that the complainant had taken mediclaim policy for the period 03.09.13 to 02.09.14 which was subsequently renewed after a gap of 47 days i.e. from 20.10.14 to 19.10.15. The complainant slipped and fell on 20.05.14 and undergone surgery for fracture to insert implant (during the first policy period). The complainant again slipped and fell on 01.09.15 and got admitted from 01.09.15 to 10.09.15 and diagnosed loose implant with fracture. The Insurance Company had rejected the claim on the ground that present ailment was related to old injury and there was a gap of 47 days in renewal of policy (03.09.13 to 02.09.14). I condone the delay of 47 days , hence claim is payable. Therefore, Insurance Company is directed to settle the claim as admissible as per terms and conditions of the policy. **Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant as admissible.**

DATE: 14.03.2017

In the matter of Ms. Sugandh Tibrewal
Vs
Oriental Insurance Company Ltd.

1. The complainant alleged that she is renewing her mediclaim policy regularly since 2012. She also alleged that her father was admitted in the hospital on 26.07.16 for the complaints of breathlessness, swelling all over the body and gross fluid over load since 10 days and he was diagnosed as CKD- with DM with hypothdyrodism and was discharged from hospital on 01.08.16 but the claim of her father was denied on the ground of pre-existing disease of the patient. The complainant also stated that the diabetic history of her father is since 2-3 years which is after taking the policy.

2. The Insurance Company vide its letter dated 01.08.2016 reiterated that the claim of the patient was denied on the ground of pre-existing disease of the patient and hence was not payable as per exclusion 4.1 of policy. Accordingly, claim of the complainant was rejected by them.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing, the complainant stated her father was not suffering from any disease prior to taking his

   Insurance Policy from the Insurance Company. The complainant also further stated that as per the certificate issued by Dr. Neeru P. Aggarwal confirms that the complaints Pulmonary Edema, Fluid overload and Hypoalbuminemia for which he was admitted in the hospital were not related to diabetes directly.

   The Insurance Company during the personal hearing stated that the claim of the patient was denied by them since he was suffering from DM-2 and CKD prior to taking the Insurance Policy from them. Hence, his claim was denied by them.

   After hearing both the sides and perusal of record placed before me, I find that the complainant had taken the mediclaim policy since 2012 regularly. As per the discharge summary of Pushpanjali Medical Centre, issued by the hospital at the time of admission of the patient in the hospital shows that the patient was admitted in the hospital for the complaints of breathlessness, swelling all over the body, associated with Gross Fluid over load for the last 10 days and later the case was diagnosed as CKD with DM and hypothyroidism. In discharge summary there is no-mention that the patient was suffering from the disease before 2012. I find from the prescription dated 26.07.16 of Dr. Neeru P. Aggarwal that at the time of admission of patient in the hospital in history column, it was shown that the patient was suffering from T2-DM Hypothyroidism and CKD V for the last 2-3 years only. As per certificate Ref.No. PMC/E. Cert/16/38 dated 04.08.2016 issued by Dr. Neeru Aggarwal, the treating Dr. of Pushpanjali Hospital which states that although the patient had diabetes but his prevailing diseases were not related to diabetes directly. Besides this, as per the out-patient prescription dated 25.07.2016, issued before admission of patient in the hospital by Dr. J.M. Dua of Apollo Indraprastha Hospital shows that the patient was suffering from DM II since 2014 and Hypothyroidism since 2013, i.e. after taking the Insurance policies from the Insurance Company. I find that the Insurance Company could not substantiate with any reliable document to establish that the patient was suffering from the diseases prior to taking the Insurance Policy. **Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant as admissible.**

DATE: 15.03.2017

In the matter of Mr. Jatin Arora
Vs
Oriental Insurance Company Ltd.

1. The complainant alleged that his previous policy no. 271601/48/2015/4092 was commencing from 27.12.2014 to 26.12.15 and he renewed his policy bearing no. 271601/48/2016/4340 w.e.f. 04.01.2016 to 03.01.2017 (after a gap of 07 days). He further alleged that his wife was admitted in the hospital for the complaints of cough and fever, associated with breathlessness but her claim was denied on the ground that illness/ disease contracted in first 30 days.

2. The Insurance Company vide its letter dated 08.08.2016 reiterated that as there is a gap of 07 days between the policy no. 271601/48/2015/4092 and 271601/48/2016/4340 but the competent authority had not condoned this gap of 07 days. Hence, the claim falls in first 30 days of the commencement of policy treating the policy as fresh, therefore the claim denied under condition 4.3 of policy

3. I heard the Insurance Company. The complainant was absent during the course of hearing. The Insurance Company in the hearing stated that in renewal of both the policies of the complainant there was a gap of 07 days. The gap in renewal was not condoned by them since the complainant had not applied for the condonation.
   After hearing the Insurance Company and perusal of record placed before me, I find that the previous policy no. 271601/48/2015/4092 of the complainant commenced from 27.12.14 to 26.12.15 and the same policy was renewed w.e.f. 04.01.16 to 03.01.2017 (pol. no. 271601/48/2016/4340) after a gap of 17 days. The Insurance Company during the hearing could not show any renewal notice to establish that they had invited the renewal premium from the complainant in time. I find that the claim of the complainant was otherwise payable if there was no gap in both the policies. After perusal of record placed before me, I condone the gap of 07 days in both the policies and 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 of the complainant as admissible.**

DATE: 31.03.2017

In the matter of Ms. Usha Chadha
Vs
Oriental Insurance Company Ltd.

1. The complainant alleged that she is taking her mediclaim policy since 20 years from Oriental Insurance Company Ltd. She had taken her current policy no. 215600/48/2016/2129 w.e.f. 31.08.2015 to 30.08.2016 for her family. She further stated that on 25.06.2016 she was admitted in the hospital for the complaints of pain and swelling in the multiple joints. O/e right elbow and right knee joints were swollen with effusion. She was diagnosed as seropositive rheumatoid arthritis. During treatment she was given injection methylprednisolone+ intra articular injection in the hospital and was discharged from hospital on 27.06.2016. But her claim was denied by the Insurance Company on the ground that her admission in the hospital was not justified for the above treatment. The complainant also stated that her previous claim for the same treatment was also disallowed by the Insurance Company.

2. The Insurance Company vide its letter dated 15.09.2016 reiterated that the patient was admitted in Indian Spinal Injuries Centre on 25.06.2016. She was diagnosed as case of Rheumatoid Arthritis and underwent infusion of injection methylprednisolone+Intra Articular injections and discharged on 27.06.2016. Hospitalization for this injection was not justified and this procedure

was not covered in Day-Care treatment. The treatment could have been done on OPD basis. Hence, claim was denied by them.

3. After hearing both the sides, the complainant as well as the Insurance Company during the hearing, the complainant state that my wife was hospitalized in the hospital on the advice of Doctor for 3 days and she was diagnosed as Seropositive Rheumatioid Arthritis but her claim was denied by the Insurance Company.

   During the personal hearing the Insurance Company stated that the disease of the patient was not covered under day care treatment. Hence the claim was denied by them.

   After hearing both the sides the complainant as well as the Insurance Company and perusal of record placed before me. I find that the wife of the complainant was admitted in the hospital w.e.f 25.06.2016 to 27.06.2016 for the complaint of pain and swelling in the multiple joints and her o/e right elbow and right knee joints were swollen with effusion and later she was diagnosed as Seropositive Rheumatioid Arthritis. As per discharge summary she underwent several test and necessary injections were given in the hospital. The certificate dated 27.06.2016 of the treating Doctor confirms that the admission of the patient in the hospital was necessary as the administered injections required monitoring and it was a active line of treatment in the hospital. **Accordingly an Award is passed with the direction to the Insurance Company to settle the claim on merits and pay the admissible claim amount as per Terms and Conditions of the policy to the complainant.**

DATE: 27.03.2017

In the matter of Ms. Poonam Dora
Vs
Oriental Insurance Company Ltd.

1. The complainant alleged that he is renewing his Mediclaim policy regularly since 2006 for his family from Oriental Insurance Company. The current policy no. 272900/48/2016/11353 was renewed w.e.f. 12.09.2015 to 11.09.2016. He further alleged that on 21.12.2015 his wife was admitted in the Hospital for the complaints of difficulty in breathing on exertion associated with nausea since 5 days. The patient had also history of decreased urine output since 2 days and history of pedal edema since one month later her case was diagnosed as Ankylosing Spondylitis obstructive sleep Apnoea Type II Respiratory Failure, Morbid obesity and Cholelithiasis. But his claim was denied by the Insurance Company on the ground of pre-existing disease and morbid obesity which was not covered under the policy.

2. The Insurance Company vide its letter dated 29.09.2016 reiterated that on scrutiny of claim documents it was found that the patient was a case of ankyolysing spondylitis OSA with Type-2 resp failure. And from documents it is noted that patient is a known case of hypertension, ankyolysing spondylitis, OSA with type-2 resp failure, morbid obesity,
cholelithiasis Insurance Company also stated that OSA with respiratory failure type, its underlying cause is morbid obesity and obesity was not covered under policy clause 4.16. Hence the claim was denied accordingly.

3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing the complainant stated that her husband was admitted in the hospital for the complaints of difficulty in breathing of exertion associated with nauseas since 05 days. The complainant also stated that the patient was not suffering from obesity and he had not taken the treatment for the same.

   The Insurance Company during the personal hearing stated that the diseases of the patient were arisen from morbid obesity which was not covered under the policy. Hence, the claim was denied by them.

   I heard both the sides and perusal of record placed before me, I find that the patient was admitted in the hospital on 21.12.2015 for the complaints of difficulty in breathing and nausea since 05 days and later her case was diagnosed as Ankylosing Spondylitis obstructive sleep Aponea Type II Respiratory Failure. I find a certificate dated 12.07.16, issued by Dr. Ambuj Garg the treating doctor of the patient of Sir Ganga Ram Hospital who stated that the patient was admitted in the hospital for the treatment of Respiratory distress, acute kidney injury and Type II Respiratory failure. He also stated that no treatment for obesity was given to the patient during hospitalization. I also find that Insurance Company during hearing could not substantiate with any reliable documents to establish that the diseases of the patient were arisen from Morbid Obesity. **Accordingly an award is passed with the direction to the Insurance Company to settle the claim of the complainant as admissible.**

DATE: 31.03.2017

In the matter of Mr. Parveen Kumar Mehta
Vs
SBI General Insurance Company Ltd.

1. The complainant alleged that he and his wife were covered under Group Mediclaim policy no. 150057-0000-01 w.e.f 12.06.2016 to 11.06.2017. He further alleged that he had taken treatment from hospital w.e.f 17.09.2016 to 19.06.2016 and his wife also taken w.e.f 18.09.2016 to 20.09.2016 for the complaints of fever with joints pains (uninvestigated chikungunia) but there claims were not settle by the Insurance Company on the ground that the hospital from where they had taken treatment was not a Registered Hospital.

2. The Insurance Company vide their letter dated 07.11.2016 and 09.11.2016 stated that the mediclaims of Mr. Parveen Kumar Mehta and Mrs. Indra Mehta were denied by them since the hospital where they had taken treatment was not a Registered and had not complied the definition of Hospital/ Nursing Home. Hence, their claims were denied by them. As per SCN dated 22.03.2017 which shows that the patient were not admitted in the Hospital and they had taken treatment only between from 10.00 AM to 8.00 PM daily. The Hospital was also for day care treatment only.
3. I heard both the sides, the complainant as well as the Insurance Company. During the course of hearing, the complainant admitted that Sanjeevan Medicare Centre was not a Registered Hospital and was only providing day care treatment to the patients. He also stated the saving of life was more important than selection of treatment centre and therefore he was admitted in the SMC.

   The Insurance Company during the personal hearing stated that they had denied the claims of the patients since the Hospital was not Registered as per terms and conditions of policy and they had taken treatment only in day care from 10.00 AM to 8.00 PM on daily basis.

4. After hearing both the sides, and perusal of record placed before me, I find that as per discharge summary of hospital Mr. Parveen Kumar Mehta and his wife Mrs. Indra

Mehta had taken treatment in Sanjeevan Medicare Centre (SMC) from 17.09.2016 to 19.06.2016 between 10.00 AM to 8.00 PM on daily basis and 18.09.2016 to 20.09.2016 between 10.00 AM to 8.00 PM on daily basis respectively for the complaints of fever with Severe Joints pains Chikunguniya (un-investigated). As per letter dated 04.10.2016 of SMC written by Doctor O.P. Yadav to Raksha TPA Pvt. Ltd. confirms that SMC where both the patients had taken treatment was not a hospital but was providing only day care treatment to the patients. I find from the discharge summary of hospital that the patients were under treatment from 10.00 AM to 8.00 PM on daily basis for 3 days and hence there was no admission of the patients in the hospital, thus falling out of the scope of policy coverage. Therefore, I see no reason to interfere with the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby dismissed**

Pankaj Kumar Dugar **Max Bupa Health Ins Co.**

V/s

(Non Settlement of Medi-claim)

The complainant was having Health Companion Medi-claim Insurance Policy from the respondent Co. bearing no. 30408510201500 for the period 16/03/15 to 15/03/16 for SI Rs.3 lakhs. Wife of complainant Mrs. Neetu Dugar – also insured under the policy, was admitted in EHCC Hospital from 29/02/16 to 02/03/16 for hysterectomy due to fibroid uterus & paid Rs.81,378/- to the hospital for treatment. The insurer in its reply/SCN submitted that the claim was declined on the ground of non-disclosure of material facts. The patient was having Polymenorrhagia & menorrhagia since last 5-6 years, which was prior to inception of the policy.

During hearing it emerged that the complainant was having medi-claim policy with United India Insurance Company since the year 2007. The same was ported to the respondent company w.e.f 16-03-2015. On 04-02-2016 complainant's wife Mrs. Neetu Dugar consulted Dr. Shashi Gupta (Senior Gynecologist of SMS Medical College, Jaipur) with complaint of intermenstral bleeding for 2-3 days, with a remark that the problem is recurring for almost one year. Finally Mrs. Neetu Dugar underwent hysterectomy operation at EHCC Eternal Hospital, Jaipur from 29-02-2016 to 02-03-2016. At the time of admission on 29-02-2016, it was mentioned in the case history that the patient was admitted with the history of poly metrorrhagia and menorrhagia from 5-6 years. The respondent company repudiated the claim, mentioning past history and taking of tablet Eltroxin 50mcg daily. The complainant submitted a certificate from EHCC Eternal Hospital, mentioning therein that the comment at the time of admission was "inter- menstral bleeding for 2-3 days & spotting for 15 days" was for 5-6 months and wrongly mentioned as 5-6 years, earlier. There was no evidence anywhere, to suggest that the patient was

having any serious problem or taking Eltroxin tablet prior to 08-02-2016. The changes made by EHCC Hospital from 5-6 years to 5-6 months go well with the comments made by Dr. Shashi Gupta on 08-02-2016 (for one year). Such a situation could not have continued for 5-6 years without being attended to. The loose comment "for one year" made by Dr. Shashi Gupta cannot be strictly taken as referring to H/o exactly one year. The policy was ported on 16-03-2015 and the comment was made on 08-02-2016 i.e. 10 months and 23 days after the DOC. The repudiation of the claim was not proper.

In view of these facts and circumstances, it was awarded that the respondent company Max Bupa Health Insurance Company Ltd. shall consider the medi-claim of Rs.81378/- and pay allowable sum as per T&C of the policy. This will be as full and final settlement of the grievance/ complaint.

Award No. IO/KOC/A/GI/0167/2015-16

Complaint No. KOC-G-003-1617-0413

Award passed on : 21.12.2016

Mrs. P. Ammukutty Vs Apollo Munich Health Ins.

Repudiation of claim under health policy

The Complainant has taken a Health Insurance policy from Apollo Munich Health Insurance. The Policy commenced 26th August 2015. On 5th and 11th June 2016 Mrs. Ammukutty was hospitalized and treated for Hyper Esnophiliic Syndrome. The Respondent insurer rejected the claim giving reason of suppression of material fact that her ailment history of Osteoarthritis of both knee and the surgery conducted for knee replacement there on were not informed to the insurer while submitting the proposal form. According to the insured, the present hospitalization is not for osteoarthritis, hence, she is eligible for the claim. The matter was represented to the Grievance cell of the insurer, but in vain. Hence, she filed a complaint before this Forum.

Decision : The complaint is dismissed.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0168/2015-16

Complaint No. KOC-G-003-1617-0359

Award passed on : 21.12.2016

Mr. Sadanandan. K.R Vs Apollo Munich Health Ins.

Repudiation of claim under a health policy

The Complainant and his family are covered under a Medi-claim policy of the respondent Insurer. His wife was hospitalized on 18/04/2016 for the treatment of "Multi Nodular Goitre", underwent surgery and discharged on 20/04/2016. He submitted that the cashless facility was denied by the Insurer. The claim was denied on the ground that there was a passing remark in discharge summary about Past history of Asthma, DM& HTN. As a routine procedure hospital Nursing staff erroneously recorded in the chart as 'Asthma for 05 years'. Whereas the insured does not have symptom nor she has taken treatment for the same. The first policy is incepted 4 years back and renewed continuously. The complainant's wife never had undergone any treatment for Asthma, HT or DM. The claim has been denied by stating that the required documents, to process the claim, have not been received by them despite several reminders. The insurer was insisting for the documents of treatment taken for the aforesaid alleged ailments (Asthma) for which his wife has never undergone any treatment. He appealed to the Grievance Cell of the Insurer for a review of the claim, for which the reply was not satisfactory. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim

Decision : The Respondent insurer is directed to Settle the claim within 15 days.

$$$$$$$

Award No. IO/KOC/A/GI/0169/2015-16

Complaint No. KOC-G-003-1617-0334

Award passed on : 21.12.2016

Mr. Tomy Eapen Vs Apollo Munich Health Ins.

Denial of claim under a Health Insurance policy

The Complainant is covered under a Health policy of the respondent Insurer (Policy No 120100/12001/ 2015/A004932/094). He was hospitalized on 27/07/2016 for the treatment of 'Pneumonia' and discharged on 04/08/2016. Though he made a cashless claim before the Insurer, they declined his claim reserving his right to claim for reimbursement. A claim for reimbursement of expenses towards hospitalization was preferred with the Insurer, which has been denied by stating that concealment of facts at the time of taking the policy. The aforesaid reason given by the insurer is not justifiable since it has been stated in the proposal form that he has to disclose only a major operation which took place within 5 years prior to the date of taking policy. In fact, the surgery was done in 2009. The Policy was taken in February, 2015. As such he is not bound to reveal the fact of Angioplasty as it took place before February, 2010. He appealed to the Grievance Cell of the Insurer for a review of the claim, for which no reply was received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim along with interest.

Decision : The Respondent insurer is directed to reinstate the policy.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0170/2015-16

Complaint No. KOC-G-003-1617-0361

Award passed on : 21.12.2016

Mr. V. Vijayakumar Vs Apollo Munich Health Ins.

Repudiation of claim under a health policy

The Complainant is covered under the Easy Health Group Insurance Policy of the respondent Insurer. He underwent Medical treatment in connection with Pulmonary Tuberculosis, Hyponatremia, Type-2 DM etc. After treatment, he has submitted the claim to the respondent insurer for reimbursement of Medical expenses with all required documents on 19/04/2016. But the Company has not yet reimbursed the medical expenses and is evading the claim without assigning any valid reason. He appealed to the Grievance Cell of the Insurer also for the settlement of the claim, for which no response has been received. Hence, he filed a complaint before this forum, seeking direction to the Insurer for admission of the claim.

Decision : The complaint is dismissed.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0171/2015-16

Complaint No. KOC-G-003-1617-0381

Award passed on : 21.12.2016

Mr. Madhu A.N Vs Apollo Munich Health Ins.

Repudiation of claim under a health policy

The Complainant and his family are covered under a Medi-claim policy of the respondent Insurer. His wife was hospitalized for a day for the treatment of 'LEG PAIN' and discharged. A claim for reimbursement of expenses towards hospitalization was preferred with the Insurer, which has been denied by stating that "EVALUATIONS AS SUCH WERE NOT FOLLOWED BY ANY ACTIVE LINE OF TREATMENT OTHER THAN ORAL MEDICINES''. He appealed to the Grievance Cell of the Insurer for a review of the claim, for which the reply was not satisfactory. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The Respondent insurer is directed to Pay the amount.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0172/2015-16

Complaint No. KOC-G-003-1617-0414

Award passed on : 21.12.2016

Mr. SURESH NAMBIAR Vs Apollo Munich Health Ins.

repudiation of claim under mediclaim policy

The complainant's daughter, Ms. Sanvy (8) is covered under a Health policy of the respondent insurer, which was renewed continuously for the last 3 years. She was hospitalized and underwent "Tympanoplasty" surgery. A claim towards reimbursement of expenses towards hospitalization was preferred with the Insurer, which has been denied by the insurer, even though the ear related surgery is covered after 2 years of policy period, mentioning the reason that the disease was prevailing prior to commencement of insurance policy and the past history of the ailment was not declared while proposing for Insurance. The complainant's daughter, when she was 4 years old had a discharge from her left ear due to cold. They consulted a pediatrician who prescribed antibiotics and the discharge from the ear stopped. She had similar instances once or twice a year, and whenever that happens they follow the same routine of visiting a pediatrician and taking the antibiotics to correct the problem. Few months back she faced the same problem and they decided to consult an ENT Surgeon and he advised endoscopy of the left year. As per the investigation report, the ear drum is damaged 70% due to infection. The doctor advised Tympanoplasty surgery to fill the hole in the ear drum. The insurer rejects the claim by insisting to provide any investigation report of past 4 years. There were only two OPD consultations done. The complainant did not keep the OPD bills because he never thought in future his daughter will have to undergo ear surgery and he may have to produce those bills to the insurer. He appealed to the Grievance Cell of the Insurer but no satisfactory reply has been received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim without further delay.

Decision : The Respondent insurer is directed to Pay eligible claim.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0173/2015-16

Complaint No. KOC-G-003-1617-0425

Award passed on : 21.12.2016

Mr. Bineshkumar Vs Apollo Munich Health Ins.

Repudiation of health insurance claim

The Complainant and his family are covered under a Medi-claim policy of the respondent Insurer. His wife was hospitalized at Sree Sankara Ayurveda Hospital on 03/06/2016 for the severe back pain and discharged on 26/06/2016. She had undergone MRI Scan and treated with Ayurvedic medicine. A claim for reimbursement of expenses towards hospitalization was preferred with the Insurer, which has been denied by stating that the management of an ailment which was done on Outpatient basis without any hospitalisation is not covered under the policy. The insured has sent hospital records to substantiate that his wife's treatment was on inpatient basis and appealed to the Grievance Cell of the Insurer for settlement of the claim, for which same reply was received that the treatment was on OPD basis,. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The Respondent insurer is directed to Pay eligible claim.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0176/2015-16

Complaint No. KOC-G-053-1617-0368

Award passed on : 22.12.2016

Mr. Sebastian Jacob T.G & Mrs. Rency Vs Cigna TTK Health Insurance Company Limited

Repudiation of accident claims under a health policy

The complainant and his wife are covered under a "Family Health Cash Basic Plan" of the respondent Insurer with an assurance of reimbursement of Medical Bills and other allied payments. On 30/01/2016, both of them met with a road accident and admitted to the nearby hospital for more than 25 days and advised further 3 months bed rest. He preferred 2 claims with the respondent Insurer along with necessary required documents within the time limit. But to his surprise, both the claims were rejected under policy Clause as Fraudulent Claims. They appealed to the Grievance Cell of the Insurer for a review of both the claims, but no response was there, till date. Hence, he filed a complaint before this forum, seeking direction to the Insurer for admission of both claims along with interest, cost and compensation.

Decision : The complaint is dismissed.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0177/2015-16

Complaint No. KOC-G-003-1617-0278

Award passed on : 22.12.2016

Mr. Sahadevan Vs Apollo Munich Health Ins.

Repudiation of claim under a health policy

The Complainant is covered under a Medi-claim policy of the respondent Insurer (policy No 10006747055) . He was hospitalized on 30/03/2015 for the treatment of Acute Ischaemic stroke and discharged on 06/04/2015. A claim for reimbursement of expenses towards hospitalization was preferred with the Insurer, for which no reply has been received despite several follow-up. He appealed to the Grievance Cell of the Insurer for the settlement of the claim, for which also no response was there, even after 3 months of sending the representation. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for settlement of the claim without further delay.

Decision : The Respondent insurer is directed to Pay eligible amount.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0179/2015-16

Complaint No. KOC-G-053-1617-0354

Award passed on : 23.12.2016

Mr. Narayanan Namboothiri. V.R Vs Cigna TTK Health Insurance Company Limited

Repudiation of claim under a Health policy

The Complainant has taken a Health policy from the respondent Insurer after porting earlier policy of star Health Insurance Company Ltd. He had renewed the policies of Star Health for the previous 5 years without losing continuity benefit. The sixth Policy was renewed with the request of the insured by porting the star Health policy even prior to expiry of the same. The Star Health policy was to be expired on 17.12.2015. However, the renewal insurance premium has been paid to Cigna TTK prior to expiry date i.e; on 24/11/2015. The premium Cheque was encashed on 25/11/2015. The Insurer has wrongly issued a policy with effect from 07.01.2016 to 05.01.2017. He was hospitalized on 22/02/2016 for the treatment of 'pain left knee', underwent surgery and discharged on 25/02/2016. A claim for reimbursement of expenses towards hospitalization was preferred with the Insurer, which has been rejected by citing non disclosure of material facts at the time of taking the policy. Since, the policy premium has been remitted prior to expiry of the previous policy and ported the same, the insurer has to settle the claim. The Cigna TTK has cancelled the policy also. The insurer has to reinstate the policy. He appealed to the Grievance Cell of the Insurer for a review of the claim based on facts and also for re-instatement of the policy, for which no reply has been received so far. Hence, he filed a complaint before this forum, seeking direction to the Insurer for admission of the claim with interest and cost based on actual fact and also for re-instatement of the policy.

Decision : The complaint is dismissed & refund of premium.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0181/2015-16

Complaint No. KOC-G-031-1617-0289

Award passed on : 23.12.2016

Mr. G. Unnikrishnan Vs MAX BUPA HEALTH INSURANCE CO.LTD

Repudiation of claim under a health policy

The Complainant is covered under a Medi-claim policy(304600 56201500) of the respondent Insurer. He was hospitalized on 28/11/2015 for the treatment of CAD, undergone surgery and discharged on 30/11/2015. A claim for reimbursement of expenses towards hospitalization was preferred with the Insurer, which no reply has been received. He appealed to the Grievance Cell of the Insurer for admission of the claim, for which also no reply has been received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim along with 12% interest for the delay, from the date of claim.

Decision : The Respondent insurer is directed to Pay eligible claim.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0182/2015-16

Complaint No. KOC-G-044-1617-0424

Award passed on : 23.12.2016

Mr. M. Venugopal Vs STAR HEALTH AND ALLIED INS. CO. LTD.

Repudiation of health insurance claim

The Complainant is covered under a Medi-claim policy for senior citizens, of the respondent Insurer, covering the period 25.07.2015 to 24.07.2016. He was hospitalized on 23.12.2015 and discharged on 08.01.2016 for the treatment as detailed in discharge summary. A claim for reimbursement of expenses towards hospitalization was preferred with the Insurer. The insurer demanded some medical documents and in turn the insured submitted a detailed report from the treating doctor. The insurance company now wants him to obtain and submit documents for imaginary disease and admission from James Hospital during November 2007 (9 years ago). The insured aged 77 years, consider this demand to submit very old medical documents as harassment. He appealed to the Grievance Cell of the Insurer for the settlement of the claim, for which also no credible reply has been received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for settlement of the claim without further delay.

Decision : The Respondent insurer is directed to Co.advised to issue repudiation ltr. which is not yet recd by the complainant. case closed.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0184/2015-16

Complaint No. KOC-G-035-1617-0430

Award passed on : 23.12.2016

Mr. Pradip Nair Vs Reliance General Insurance Co. Ltd.

Repudiation of health insurance claim

The Complainant is a policy holder of Medi-claim ever since 2001 with the respondent Insurer. He was hospitalized on 04.04.2016 for the treatment of Congenital Bicuspid Aortic Valve'. He has undergone the Modified Bentalls Procedure with proximal arch replacement and graft was done due to the severe "calcification" of Bicuspid Aortic Valve. A claim for reimbursement of expenses towards hospitalization was preferred with the Insurer. The insurer rejected the claim stating that the congenital disease is not covered under the policy. The insured submits that the Calcification is not a congenital anomaly. It is entirely different ailment, which can occur in almost any part of the body. It is only because of calcification, which had occurred at the root of the Aortic-valve, the replacement surgery had to be done. The calcification was not pre-existing prior to inception of policy. So, he appealed to the Grievance Cell of the Insurer for the settlement of the claim, for which also no satisfactory reply was received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for settlement of the claim without further delay.

Decision : The complaint is dismissed.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0185/2015-16

Complaint No. KOC-G-047-1617-0297

Award passed on : 23.12.2016

Mr. A.M. Saji Vs Tata AIG General Insurance Co.Ltd.

Partial Repudiation of claim under a Mediclaim policy

The Complainant and his spouse are covered under a Health policy (No WF 002000000290)of the respondent Insurer, since 2011. He was hospitalized on 07/12/2015 for the treatment of CAD, undergone surgery and discharged on 11/12/2015. A claim for reimbursement of expenses towards hospitalization was preferred with the TPA of the Insurer, which has been partially settled for Rs,9000/-. He alleges that as per terms and conditions of the policy, he is entitled for Daily Hospital Cash and Cashless Hospitalisation. The insurance company has paid only Daily Hospital Cash and did not pay the Cashless Hospitalisation. The insurer has clearly stated that the " Cashless Hospitalisation" is covered under the policy. The insurance company has given in writing that "CASHLESS HOSPITALISATION" is covered. The annual Premium paid is Rs.38,944/-. According to the letter received from the insurer, in addition to Daily Hospital Cash, Cashless hospitalization is covered and in the policy in the claim procedure clause9, it is mentioned that to avail cashless hospitalization, the TPA is to be approached. He appealed to the Grievance Cell of the Insurer for a review of the balance amount of the claim, for which the reply was not satisfactory. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of Cashless Hospitalisation expenses.

Decision : The Respondent insurer is directed to pay room rent, ICU and ambulance charges.

$$$$$$$

Award No. IO/KOC/A/GI/0186/2015-16

Complaint No. KOC-G-031-1617-0390

Award passed on : 23.12.2016

Mr. Koshy Jacob Vs MAX BUPA HEALTH INSURANCE CO.LTD

Repudiation of claim under a health policy

The Complainant and his family are covered under a Medi-claim policy of the respondent Insurer. He was hospitalized on 25/06/2016 for the treatment of CAD, underwent surgery and discharged on 29/06/2016. Pre-authorization request for cashless treatment was denied, as they could not produce ID and Insurance card, before the Hospital authorities. He preferred a claim with the respondent Insurer along with necessary required documents, which was denied by stating that "CONCEALMENT OF MATERIAL FACTS, at the time of taking the policy and the Policy also cancelled. The complainant has not undergone Cronory Angography prior to the commencement of insurance, as claimed by the insurer and therefore there is no preexistence of illness/ medical conditions at the time applying for health insurance policy. His initial medical report was fully satisfied by the insurer and issued policy. Further, he submits that he has no variation levels for BP, Diabetic,HDL, Creatine. He appealed to the Grievance Cell of the Insurer for a review of the claim and restoration of the policy, for which the response was not satisfactory. Hence, he filed a complaint before this forum, seeking direction to the Insurer for admission of the claim, and restoration of the policy.

Decision : The Respondent insurer is directed to Reinstate policy and pay claim.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0187/2015-16

Complaint No. KOC-G-040-1617-0321

Award passed on : 23.12.2016

Mr. Raju. K.G Vs SBI General Insurance Co. Ltd

denial of claim under a mediclaim policy

The Complainant and his spouse are covered under a Group Mediclaim Master Policy (no 95000-0000-00: Certificate no.2331605-01) of the respondent Insurer. His wife was hospitalized on 17/01/2016 for the treatment of 'Left Adenexal Cyst', undergone surgery and discharged on 19/01/2016. A claim for reimbursement of expenses towards hospitalization was preferred with the TPA of the Insurer, which was denied by stating that the treatment was taken for a pre-existing disease, which comes under exclusion. According to the complainant, the treatment undergone by his wife is not excluded as per the policy terms. Prior to his retirement from service on 30.05.2013- he has taken coverage from Oriental Insurance Company which was valid till 30.05.2015. As per the advice of SBI Manager he has shifted the insurance coverage to SBI General Insurance Company much earlier to the renewal date. i.e; w.e.f.04.12.2014 and have completed 32 months coverage before admission in hospital. He appealed to the Grievance Cell of the Insurer for a review of the claim, for which the reply was not satisfactory. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The complaint is dismissed.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0189/2015-16

Complaint No. KOC-G-037-1617-0274

Award passed on : 23.12.2016

Mr. Rajesh V.R Vs Religare Health Ins. Co. Ltd.

Repudiation of claim under a health policy

The Complainant holds individual Health Insurance Plans (No 10446626) for his parents for a Sum insured of Rs.4,00,000/- His father was hospitalized for the treatment of an injury caused due to fall of a Jackfruit on his shoulder . A claim for reimbursement of expenses towards hospitalization was preferred with the Insurer, which has been denied by stating that as per Policy condition, 2 year waiting period since inception of the policy is required to consider the claim. He appealed to the Grievance Cell of the Insurer for review of the claim, as the treatment is caused by the accident, for which no satisfactory reply has been received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim, based on actual facts.

Decision : The Respondent insurer is directed to Reimburse expenses incurred.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0190/2015-16

Complaint No. KOC-G-050-1617-0279

Award passed on : 23.12.2016

Mr. K.J. Paul Vs The Oriental Insurance Co. Ltd.

Partial repudiation of claim under an Individual Mediclaim policy

The complainant and his family are covered under a Medi-claim policy (no 442600/48/2016/1822) of the respondent insurer. His wife was hospitalized on 06/06/2016 for the treatment of Fibroid Uterus, underwent hysterectomy and discharged on 11/06/2016. Out of total claim of Rs.41650/-, the Insurer has admitted the claim only for Rs.25813/- and the balance amount of Rs.15837/-had to be paid by him. On appeal to the Grievance Cell of the Insurer, he was informed that the treatment was taken since 16/02/2013 and the Sum Insured at that time was only Rs.50000/-, the room rent eligibility was only Rs.500/-per day (1% of the Sum Insured) and other expenses were proportionately reduced. Being not satisfied with the reply, he filed a complaint before this Forum, seeking direction to the Insurer for admission of balance amount of the claim.

Decision : The Respondent insurer is directed to Pay difference in eligible claim.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0191/2015-16

Complaint No. KOC-G-050-1617-0403

Award passed on : 23.12.2016

Mr. K Sathya Narayanan Vs The Oriental Insurance Co. Ltd.

Partial repudiation of individual mediclaim

The Complainant is covered under a Medi-claim policy of the respondent Insurer. He was hospitalized on 18/07/2016 for the treatment of "Neuro related disease'' and discharged on 25/07/2016. Again he was hospitalized on 20/09/2016 for close injury. The first claim was repudiated and for the second claim, Cashless facility was allowed by the TPA of the Insurer to the extent of Rs.37600/-. He preferred a claim for the balance amount with the respondent Insurer along with necessary required documents, for which no response was there, even after 2 months of submission of the claim. He appealed to the Grievance Cell of the Insurer for admission of balance amount of the claim, for which also no response was there even after the expiry of one month. Hence, he filed a complaint before this forum, seeking direction to the Insurer for admission of balance amount of the claim.

Decision : The complaint is dismissed.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0192/2015-16

Complaint No. KOC-G-050-1617-0277

Award passed on : 23.12.2016

Mr. Baby N.V Vs The Oriental Insurance Co. Ltd.

Repudiation of claim under an Individual Mediclaim policy

The complainant and his family are covered under a Medi-claim policy(No 440205/48/2016/4419) of the respondent insurer. His daughter was hospitalized on 16/06/2016 for the treatment of ''Pilonidal Sinus'', underwent surgery and discharged on 18/06/2016. Out of total claim of Rs.27216/-, the Insurer has admitted the claim only for Rs.12408/-. On appeal to the Grievance Cell of the Insurer, he was informed that the pre-enhanced Sum Insured was only Rs.50000/- the room rent eligibility was only Rs.500/-per day (1% of the Sum Insured) and other expenses were proportionately reduced. Being not satisfied with the reply, he filed a complaint before this Forum, seeking direction to the Insurer for admission of balance amount of the claim.

Decision : The complaint is dismissed.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0193/2015-16

Complaint No. KOC-G-050-1617-0305

Award passed on : 23.12.2016

Mrs. Bindu Madhuvanam Vs The Oriental Insurance Co. Ltd.

Repudiation of claim under a mediclaim policy

The Complainant and her family are covered under a Medi-claim policy (No 441003/48/2015/1598) of the respondent Insurer. Her daughter was hospitalized on 19/07/2015 for the treatment of 'Fever and abdominal pain' and undergone surgery and discharged on 24/07/2015. A claim for reimbursement of expenses towards hospitalization was preferred with the TPA of the Insurer, which has been repudiated by stating that the disease for which the treatment was taken is excluded from purview of the policy. He appealed to the Grievance Cell of the Insurer for a review of the claim, for which the reply was not satisfactory. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The complaint is dismissed.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0194/2015-16

Complaint No. KOC-G-050-1617-0431

Award passed on : 23.12.2016

Mr. Madhusudanan Vs The Oriental Insurance Co. Ltd.

Repudiation of Individual Mediclaim

The complainant is covered under a Mediclaim policy of the respondent insurer (No.440100/48/2016/2551). He has been admitted in the hospital and underwent treatment from 25.05.2016 to 26.05.2016. A claim towards reimbursement of expenses towards hospitalization was preferred with the Insurer, which has not been settled by giving flimsy reasons. He appealed to the Grievance Cell of the insurer but the reply received was not satisfactory. Hence, she filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim without further delay.

Decision : The Respondent insurer is directed to Pay eligible claim - paid Rs.11200/-.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0196/2015-16

Complaint No. KOC-G-051-1617-0349

Award passed on : 23.12.2016

Mr. Prasadh S Vs The United India Insurance Co. Ltd.

Partial Repudiation of claim under a Mediclaim policy

The Complainant is covered under a Medi-claim policy (No 100100/28/15/P1/10699221) of the respondent Insurer, since last 10 years. Initially, the Sum Insured was Rs.50,000/- and the same was enhanced to Rs.3 lakh in 2014. He was hospitalized in April, 2016 for the treatment of 'Subdural hematoma', underwent surgery and discharged. A claim for reimbursement of expenses towards hospitalization was preferred with the Insurer, which has been partially settled based on the pre-revised Sum insured. He appealed to the Grievance Cell of the Insurer for a review of the claim based on enhanced Sum Insured, for which no reply was received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim, based on enhanced Sum Insured

Decision : The Respondent insurer is directed to Pay eligible claim.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0197/2015-16

Complaint No. KOC-G-051-1617-0284

Award passed on : 23.12.2016

Mr. Sukumaran. P Vs The United India Insurance Co. Ltd.

Repudiation of claim under an Individual Mediclaim policy

The Complainant and his son are covered under a Medi-claim policy (No 10090 22815 SP 109914664) of the respondent Insurer. He was hospitalized on 09/02/2016 for the treatment of Cervical Spondylitis and discharged on 10/02/2016. A claim for reimbursement of expenses towards hospitalization was preferred with the TPA of the Insurer, which has been denied by stating that the hospitalization is for one day (less than 24 Hours) and there is no active line of treatment. He appealed to the Grievance Cell of the Insurer for a review of the claim, but in vain. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim

Decision : The Respondent insurer is directed to Pay hospitalisation charges.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0198/2015-16

Complaint No. KOC-G-051-1617-0330

Award passed on : 23.12.2016

Mr. Loui C.J Vs The United India Insurance Co. Ltd.

Repudiation of claim under a mediclaim policy

The Complainant and his family are covered under a Medi-claim policy (no KOC-UI-10593-0001411) of the respondent Insurer. His family met with a road accident in March, 2016. A claim for reimbursement of expenses towards hospitalization of his family was preferred with the TPA of the Insurer, out of which 2 cases were settled. But the claims of his 2 children were not yet settled. Further, another claim for the treatment of his son is also pending with the Insurer. He appealed to the Grievance Cell of the Insurer for the settlement of the claim, for which no reply was received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claims of his two children, without further delay.

Decision : The Respondent insurer is directed to Pay all claims.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0199/2015-16

Complaint No. KOC-G-051-1617-0399

Award passed on : 23.12.2016

Mrs. Linta Paul Defilen Louiz Vs The United India Insurance Co. Ltd.

repudiation of claim under mediclaim policy

The Complainant and her 2 children are covered under a Medi-claim policy of the respondent Insurer since, 2005. His son was hospitalized on 27/05/2016 for the treatment of fever. Even after 2 weeks, he could not be recovered from illness, referred to AIMS and admitted there from 03/06/2016 to 21/06/2016. A claim was preferred with the TPA of the Insurer, which was repudiated by stating that ''the disease was congenital one''. She appealed to the Grievance Cell of the Insurer for a review of the claim, but they concurred with the decision of the TPA. Hence, she filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The Respondent insurer is directed to Pay hospitalisation charges.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0200/2015-16

Complaint No. KOC-G-051-1617-0419

Award passed on : 23.12.2016

Mr. SANIL KUMAR. T.K. Vs The United India Insurance Co. Ltd.

Repudiation of health insurance claim

The complainant and his family are covered under a Medi-claim policy of the respondent insurer. His wife was hospitalized on 09/04/2016 for the treatment of Fibroid Uterus, underwent hysterectomy and discharged on 11/04/2016. Out of total claim of Rs.67326/-, the Insurer has admitted the claim only for Rs.20000/- and the balance amount of Rs.47326/-had to be paid by him. He appealed to the Grievance Cell of the Insurer, Being not satisfied with the reply, he filed a complaint before this Forum, seeking direction to the Insurer for admission of balance amount of the claim.

Decision : The Respondent insurer is directed to settle the claim.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0201/2015-16

Complaint No. KOC-G-051-1617-0331

Award passed on : 23.12.2016

Mrs. Santhakumari. P.K Vs The United India Insurance Co. Ltd.

Partial Repudiation of claim under a Mediclaim policy

The Complainant and his family are covered under a Health policy (No 010500 2016484 100000263484) of the respondent Insurer. The Policy has been renewed by increase in Sum insured year by year and the present cover is Rs.7 lakh. Her husband was hospitalized on 26/05/2016 for the treatment of 'breathing trouble' and discharged on 06/06/2016. A claim for reimbursement of expenses towards hospitalization was preferred with the TPA of the Insurer, which has been partially settled. On enquiry with the Insurer, she was informed that the sum Insured was restricted to Rs.1 lakh, while settling the claim. She appealed to the Grievance Cell of the Insurer for a review of the balance amount of the claim, for which the reply was not satisfactory. Hence, she filed a complaint before this Forum, seeking direction to the Insurer for admission of balance amount of the claim

Decision : The complaint is dismissed.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0202/2015-16

Complaint No. KOC-G-051-1617-0382

Award passed on : 23.12.2016

Mr. T.O. Mathew Vs The United India Insurance Co. Ltd.

Repudiation of claim under a mediclaim policy

The Complainant is covered under a Group Medi-claim Policy of the respondent Insurer, taken by his erstwhile employer, SAIL. He was hospitalized for the treatment of "Prostate Cancer'' and 5 claims were preferred with the TPA of the Insurer on various dates, all of them were repudiated by stating that "admission for injection ''Leuprolide'' is not justified as there is no active line of treatment during hospital stay. He appealed to the Grievance Cell of the Insurer for a review of all claims, for which the reply was not satisfactory. Hence, he filed a complaint before this forum, seeking direction to the Insurer for admission of all 5 claims.

Decision : The Respondent insurer is directed to Pay all claims.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0204/2015-16

Complaint No. KOC-G-051-1617-0357

Award passed on : 23.12.2016

Mr. Hariharaputhradas. M Vs The United India Insurance Co. Ltd.

Repudiation of claim under a mediclaim policy

The Complainant is covered under a Medi-guard policy of the respondent Insurer. He was hospitalized on 13/01/2016 for the treatment of head ache and neck pain and discharged on 15/01/2016. A claim for reimbursement of expenses towards hospitalization was preferred with the Insurer, which has been denied by stating that the admission is not justified. He appealed to the Grievance Cell of the Insurer for a review of the claim, for which no satisfactory reply was received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The Respondent insurer is directed to Admit claim.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0205/2015-16

Complaint No. KOC-G-051-1617-0380

Award passed on : 23.12.2016

Mr. C.P. George Vs The United India Insurance Co. Ltd.

Repudiation of claim under a mediclaim policy

The Complainant and his family are covered under a Medi-claim policy of the respondent Insurer. His wife was hospitalized for a day for the treatment of 'LEG PAIN' and discharged. The doctor has detected DISC Bulge as per MRI and recommended for surgery. Since the complainant's wife was not mentally prepared for the surgery she opted for Ayurvedic treatment in a nearby Ayurvedic Hospital. A claim for reimbursement of expenses towards hospitalization was preferred with the Insurer, which has been denied by stating that "EVALUATIONS AS SUCH WERE NOT FOLLOWED BY ANY ACTIVE LINE OF TREATMENT OTHER THAN ORAL MEDICINES''. He appealed to the Grievance Cell of the Insurer for a review of the claim, for which the reply was not satisfactory. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The Respondent insurer is directed to to pay the claim.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0206/2015-16

Complaint No. KOC-G-051-1617-0296

Award passed on : 23.12.2016

Mr. Damin John Vs The United India Insurance Co. Ltd.

Partial Repudiation of claim under an Individual Mediclaim policy

The complainant and his family are covered under a Medi-claim policy (No 1011812815 P 113720128) of the respondent insurer. His daughter was hospitalized on 15/05/2016 for the treatment of ''PUJ OBSTRUCTION'', underwent surgery and discharged on 21/05/2016. Out of total claim of Rs.170882/-, the TPA of the Insurer has admitted the claim only for Rs.56392/-. Initially for cashless claim, approval was given for Rs.61969/-. On enquiry with the TPA for the drastic reduction in eligible claim amount, he was informed that proportionate reduction has been made on treatment expenses in relation to eligible room rent. He says that the hospital is charging the expenses at the same rate whatever be the room rent. On appeal to the Grievance Cell of the Insurer, he was informed that the claim has been paid in full as per admissible category and also sent the Medi-claim computation sheet with details. Being not satisfied with the reply, he filed a complaint before this Forum, seeking direction to the Insurer for admission of balance amount of the claim.

Decision : The complaint is dismissed.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0207/2015-16

Complaint No. KOC-G-051-1617-0324

Award passed on : 23.12.2016

Mr. M.P. Unnikrishnan Vs The United India Insurance Co. Ltd.

Partial Repudiation of claim under a Mediclaim policy

The Complainant and his spouse are covered under a mediclaim policy(No 100104 2815 P 103360981) of the respondent Insurer. His wife was hospitalized on 11/06/2016 for the treatment of "Third Degree Haemorrhoids", underwent surgery and discharged on 16/06/2016. A claim for reimbursement of expenses towards hospitalization was preferred with the TPA of the Insurer, which has been partially settled for Rs.40,890/-. His claim bill was for Rs.99319/- On enquiry with the Insurer, he was informed that it is a proportionate deduction since the patient was admitted in a room with higher rent than the entitled category. He appealed to the Grievance Cell of the Insurer for a review of the balance amount of the claim, for which the reply was not satisfactory. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of balance amount of the claim.

Decision : The complaint is dismissed.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0208/2015-16

Complaint No. KOC-G-051-1617-0405

Award passed on : 23.12.2016

Mr. M.J. Sabu Vs The United India Insurance Co. Ltd.

Partial repudiation of health insurance claim

The Complainant is covered under a Medi-claim policy of the respondent Insurer. He was hospitalized on 21/03/2016 for the treatment of "left knee pain" and discharged on 23/03/2016. He preferred a claim with the respondent Insurer along with necessary required documents, which was partially settled. He appealed to the Grievance Cell of the Insurer for admission of balance amount of the claim, for which no response was there even after the expiry of one month. Hence, he filed a complaint before this forum, seeking direction to the Insurer for admission of balance amount of the claim

Decision : The complaint is dismissed.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0209/2015-16

Complaint No. KOC-G-051-1617-0371

Award passed on : 23.12.2016

Mr. Alby Peter Vs The United India Insurance Co. Ltd.

Repudiation of claim under a mediclaim policy

The Complainant and his spouse are covered under a Group Medi-claim Policy of the respondent Insurer, taken by his erstwhile employer. His wife was hospitalized on 04/03/2016 for the treatment of IVDP, T2DM etc and discharged on 09/03/2016. His request for cashless treatment was declined by the Insurer. After discharge from the Hospital, he preferred a claim with the TPA of the respondent Insurer with all required documents, but they denied the claim by stating that there is no active line of treatment and the admission is mainly for evaluation, which does not warrant hospitalization. He appealed to the Grievance Cell of the Insurer for a review of the claim, but their reply was not satisfactory. Hence, he filed a complaint before this forum, seeking direction to the Insurer for admission of the claim

Decision : The Respondent insurer is directed to Pay hospitalisation charges.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0210/2015-16

Complaint No. KOC-G-051-1617-0408

Award passed on : 23.12.2016

Mrs. K. C. Geetha Vs The United India Insurance Co. Ltd.

Repudiation of claim under health policy

Sri Saroj S/o the Complainant had an accident on 16th December 2013 and had treatment at the Sunrise Hospital and the insurer has settled the claim. In continuation of the treatment he has undergone dental treatment at Amrita Dental College from 12th to 19th June 2014. The second claim has not yet been settled. She appealed to the Grievance Cell of the Insurer for a review of the claim, for which they have not given a satisfactory reply. In this context, she filed a complaint before this Forum seeking direction to the insurer for admission of the claim of Rs.70800/-.

Decision : The Respondent insurer is directed to Pay the claim with penal interest.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0211/2015-16

Complaint No. KOC-G-051-1617-0317

Award passed on : 23.12.2016

Mr. Abdul Rasheed Vs The United India Insurance Co. Ltd.

Repudiation of claim under a mediclaim policy

The Complainant and his family are covered under a Medi-claim policy (No 10180 22816P 100110590) of the respondent Insurer. His wife was hospitalized on 01/08//2016 for the treatment of 'Multiple Sclerosis" and discharged on 02/08/2016. A claim for reimbursement of expenses towards hospitalization was preferred with the TPA of the Insurer, which has been partially settled based on pre-enhanced Sum Insured. He appealed to the Grievance Cell of the Insurer for a review of the balance claim, for which no reply has been received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the balance amount of the claim, based on the enhanced Sum Insured.

Decision : The complaint is dismissed.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0212/2015-16

Complaint No. KOC-G-051-1617-0333

Award passed on : 23.12.2016

Mr. Abith Harshan P Vs The United India Insurance Co. Ltd.

Repudiation of claim under a mediclaim policy

The complainant is covered under a Medi-claim policy (No 101400 2814 P 105752190) of the respondent Insurer. He was hospitalized on 09/10/2015 due to vomiting, body pain, head ache and fever in an emergency situation. He had intimated the Insurer about the hospitalization, but they have denied cashless scheme. After discharge from the hospital, he preferred a claim for reimbursement of expenses towards hospitalization, which was denied by stating that the admission and evaluations as such were not followed by any active line of treatment. He appealed to the grievance cell of the Insurer, but in vain. Hence this Complaint was filed before this Forum.

Decision : The Respondent insurer is directed to Pay the claim.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0213/2015-16

Complaint No. KOC-G-044-1617-0275

Award passed on : 23.12.2016

Mr. Edayath Ravi Vs STAR HEALTH AND ALLIED INS. CO. LTD.

Repudiation of claim under a health policy

The Complainant is covered under a Senior Citizen Red Carpet policy (no P/700002/01/2016/044047) of the respondent Insurer- Star Health &Allied Insurance co. He was hospitalized on 07/06/2016 for the treatment of Small Vessel Disease of Brain and discharged on 10/06/2016. A claim for reimbursement of expenses towards hospitalization was preferred with the Insurer, which has been denied by alleging the non disclosure of material facts, at the time of taking the policy. The complainant had not filled up any proposal form or signed the same while proposing for Insurance. He had declared previous Medical History to the agent while he approached for canvassing the Medical insurance. The agent has asked only past 3 years Medical History of the complainant. Further, the present ailment has nothing to do with his previous medical history. Against the repudiation of claim, he approached grievance cell of the company, but no satisfactory reply was received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim or else cancels the policy and return the premium paid there on.

Decision : The complaint is dismissed.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0214/2015-16

Complaint No. KOC-G-044-1617-0369

Award passed on : 23.12.2016

Mr. K.J. Philip Vs STAR HEALTH AND ALLIED INS. CO. LTD.

Denial of Insurance for complainants wife and denial of Sum insured

The Complainant and his spouse are covered under a 'Senior citizen Red carpet Insurance Policy' of the respondent Insurer, since 04/07/2013. His wife was hospitalized on 27/04/2015 and underwent "Urinary Bladder Prolapse" repair surgery. A claim for reimbursement of expenses towards hospitalization was preferred with the Insurer, which has been first denied by stating that the Insured had suppressed the material facts at the time of taking the policy and later admitted and paid the claim. His request for enhancement of the Sum Insured from 2 Lakh to 3 Lakh was declined. Further, while renewing the policy in 2016, the name of his wife is excluded from the Policy.The reason given by the insured is suppression of material fact/ Non disclosure of of Pre-existing disease of CA Endometrium three years back. However, this same objection of suppression of material fact is proved to have been cleared by admitting his wife's claim during 2015, which was initially objected to for the same reason. Her insurance was also renewed for the next year without any objection. Therefore, the same reason is irrelevant and invalid for denying insurance in subsequent years. He appealed to the Grievance Cell of the Insurer to accept enhancement of Sum Insured and include his wife in the policy, but in vain. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for inclusion of his wife's name in the policy and also to enhance the Sum Insured, as requested.

Decision : The Respondent insurer is directed to Renew policy.

$$$$$$$

Award No. IO/KOC/A/GI/0215/2015-16

Complaint No. KOC-G-044-1617-0319

Award passed on : 23.12.2016

Mr. C.O. George Vs STAR HEALTH AND ALLIED INS. CO. LTD.

Denial of claim under a Health Insurance policy

The Complainant is covered under a Health policy (No P/181315/01/2016/001413) of the respondent Insurer. He was hospitalized on 17/05/2016 for the treatment of 'Osteo Arthritis', underwent surgery and discharged. A claim for reimbursement of expenses towards hospitalization was preferred with the TPA of the Insurer, which has been partially settled. Out of total claim for Rs.293725/-, the Insurer has settled only Rs.2 lacs. Due to oversight, the duration of illness was wrongly recorded as 2 years instead of 1 year in the medical records of MIMS, Calicut, Kerala, which resulted in partial repudiation of his claim. Subsequently, after denial of a part of claim, he represented to the Grievance cell of Insurance company with a clarification from the treated doctor who has certified that " The duration of illness was wrongly recorded as 2 years on 17.5.2016. But as per the previous Medical records from WIMS hospital, Wayanad reveals that patient was suffering from same illness for last one year only." But, the insurer reiterated their earlier stand and did not settle the balance amount payable of Rs.93,725 only. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of balance amount of the claim

Decision : The Respondent insurer is directed to consider balance amount of claim on submission of affidavi.

$$$$$$$

Award No. IO/KOC/A/GI/0216/2015-16

Complaint No. KOC-G-044-1617-0376

Award passed on : 23.12.2016

Mr. George Sebastian Vs STAR HEALTH AND ALLIED INS. CO. LTD.

Repudiaion of claim under a health policy

The Complainant is covered under a Medi-claim policy of the respondent Insurer. He was hospitalized on 13/04/2016 for the treatment of NODULAR GOITRE, underwent surgery and discharged on 15/04/2016. A claim for reimbursement of expenses towards hospitalization was preferred with the Insurer, which has been denied by stating that "suppression of material fact of previous health related facts suffered before the date of inception of the policy makes the policy contract 'Void ab initio'". The insured had explained to the Insurance agent about his heart ailment, Blood Pressure, Cholestrol etc while proposing for Insurance. The insurance agent has not given much importance to his disclosure and stated that, since the policy pertains to Senior citizen the medical reports are not relevant. Further, the present treatment does not pertain to his pre-existing ailment, i.e; Thyroid ailment. He appealed to the Grievance Cell of the Insurer for a review of the claim, for which no satisfactory reply was received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The complaint is dismissed.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0217/2015-16

Complaint No. KOC-G-044-1617-0323

Award passed on : 23.12.2016

Mr. Suresh Kumar. A Vs STAR HEALTH AND ALLIED INS. CO. LTD.

Denial of claim under a Health Insurance policy

The Complainant and his family are covered under a Medi-claim policy (no P/181119/01/2016/005533) of the respondent Insurer. His wife was hospitalized on 12/05/2016 for the treatment of CHRONIC SUPPORTIVE OTITIS MEDIA (Lt) EAR, underwent surgery and discharged on 19/05/2016. A claim for reimbursement of expenses towards hospitalization was preferred with the Insurer, which has been denied by stating that "there is concealment of facts" at the time of taking the policy. The Insurer says that while taking the policy, the Insured has not revealed the previous health complaints and obtaining a policy without disclosing the full facts on health of a person would make the insurance policy "void ab initio". The complainant submits that after the treatment, the temporary illness of his wife was cured in 2003-04. The ear discharge is not a severe illness and is also not a repeated or hereditary one. Hence, the already cured illness about 12 years back could not be construed as Pre-existing disease. Similarly,the 'non-disclosure' of treatment taken about 8 years back due to ear discharge should not be construed as suppression of fact. Highlighting the above points, he appealed to the Grievance Cell of the Insurer for a review of the claim, for which the reply was not satisfactory. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The Respondent insurer is directed to reinstate policy excluding wife.

$$$$$$$

Award No. IO/KOC/A/GI/0218/2015-16

Complaint No. KOC-G-044-1617-0348

Award passed on : 23.12.2016

Mrs. Jiji Mammen Vs STAR HEALTH AND ALLIED INS. CO. LTD.

Denial of claim under a Health Insurance policy

The Complainant and his spouse are covered under a Medi-claim policy (No P/181212/01/2014/002352) of the respondent Insurer. He was hospitalized on 07/04/2015 for the treatment of Discoid Lupus Erthematosus, Lower Respiratory Tract Infections, and referred to Christian Medical College, Vellore. The complainant is diagnosed positive for Blood Cancer and is undergoing treatment at CMC Vellore. A claim for reimbursement of expenses towards hospitalization was preferred with the Insurer, which has been denied by stating that the Insured had suppressed the material facts at the time of taking the policy. Further, they cancelled the policy also citing suppression of material facts. The complainant submitted that the so called suppressed disease was diagnosed during January, 2015, while the Insurance Policy is in force. He appealed to the Grievance Cell of the Insurer for a review of the claim and reinstatement of the policy, for which no reply was received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim and also for reinstatement of the policy

Decision : The Respondent insurer is directed to reinstate policy with exclusions.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0219/2015-16

Complaint No. KOC-G-044-1617-0420

Award passed on : 23.12.2016

Mr. I.K. Mukundan Vs STAR HEALTH AND ALLIED INS. CO. LTD.

Repudiation of health insurance claim

The Complainant is covered under a Medi-claim policy of the respondent Insurer. He was hospitalized on 08/08/2015 for the treatment of Chest infection, high fever, and cough. A claim for reimbursement of expenses towards hospitalization was preferred with the Insurer, which has been denied by stating that he had heart disease earlier. The insured submitted that on 05.02.2013 due to an accident he was hospitalised and when the ECG was taken there was slight variation in his heart beats. Thereafter as per the advice of the doctor, Angiogram was taken and confirmed it as negative. During the present hospitalisation for chest congestion his bystander informed about the angiogram done earlier. In present hospitalisation record, the doctor has mentioned only about angiogram and nothing reported about existence of heart ailment. The insurer fully relied on this casual remark and rejected the claim without substantiating with medical records. The rejection of claim is on flimsy grounds. He appealed to the Grievance Cell of the Insurer for settlement of the claim, for which no favourable response has been received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The complaint is dismissed.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0220/2015-16

Complaint No. KOC-G-044-1617-0400

Award passed on : 23.12.2016

Mr. C. Radhakrishna Pillai Vs STAR HEALTH AND ALLIED INS. CO. LTD.

repudiation of claim under mediclaim policy

The Complainant and his family are covered under a Medi-claim policy of the respondent Insurer. He was hospitalized on 07/12/2015 to 11/12/2015 for the treatment of 'right flank pain and recurrent Urinary Tract Infection'. Pre-authorization request for cashless treatment was denied. He preferred a claim with the respondent Insurer along with necessary required documents, which was denied by stating that "CONCEALMENT OF MATERIAL FACTS, at the time of taking the policy. The respondent Insurer has not only denied the claim but cancelled the original Policy also and issued a new Policy deleting his name from it. On 1st NOVEMBER 2013 he and his family has taken the medical policy after a detailed Medical check- up at a hospital directed by the company. All of their existing body conditions and treatment of diabetes which were undergoing by himself and his Right Flank Pain and nature of job/ field work were also told to the doctor who examined him. His diabetic label and Urea creatinine level were also investigated. His creatinine level at the time was 0.6 mg%. The doctor who examined was of the opinion that there is nothing abnormal in his kidney/Urinary system. The right flank pain is insignificant and may be due to his nature of work and daily travelling of 100 KM. After the medical examination, the policy was issued on 01.11.2013. The policy was renewed up to 31/10/2016, continuously. In April 2015, he was admitted to for the treatment of PYUREA. The bill amount was reimbursed by the insurer subject to certain limitations. In December 2015, he was admitted to hospital for the evaluation right flank pain and recurrent Urinary tract Infection. The doctor who examined at the hospital reported to the Insurance Company for Cashless facility for the treatment with his Provisional diagnosis- Urinary Tuberculosis. The provisional finding of the doctor was wrong which was proved in the course of evaluation and treatment. The Insurance company refused to settle the claim, cancelled his insurance cover, deleted his name and issued a new Family insurance policy giving reason that "The treatment is for Urinary tuberculosis-Chronic renal disease prior to the inception of the policy and non-disclosed during the inception of policy''. Due to heavy mental stress he suffered heart attack on April 2016 night and was admitted in emergency department of the hospital. Angiogram was done on 17/4/2106, due to which he failed to submit his appeal to this forum. He appealed to the Grievance Cell of the Insurer for a review of the claim and also for reinstatement of the policy, but the response was not satisfactory. Hence, he filed a

complaint before this forum, seeking direction to the Insurer for admission of the claim and also for the reinstatement of the policy.

Decision : The Respondent insurer is directed to Reinstate policy excluding kidney ailments and consider claim.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0221/2015-16

Complaint No. KOC-G-044-1617-0391

Award passed on : 23.12.2016

Mr. Sivadasan Pillai Vs STAR HEALTH AND ALLIED INS. CO. LTD.

Repudiation of claim under a health policy

The complainant is covered under a Senior Citizen's Medi-claim Policy of the respondent insurer. He was hospitalized on 14/02/2016 for the treatment of CAD, LRTI & Diabetic Mellitus and discharged on 22/02/2016. A claim was preferred with the Insurer, which has been repudiated by stating that "the patient had not revealed the previous health complaints in the proposal form which made the policy void ab initio". The insurer alleges that the insured had undergone treatment for RBBB on 31.1.2014. According to the insured, he has under gone ECG test on 31.1.2014 in the OP department of the Hospital.. However, after the test the doctor has not prescribed any medicine. Even though he is a Diabetes Mellitus patient, he was never treated or taken any medicine prior to the present hospitalisation. Hence, taking refuge under "pre-existing disease clause" by the insurance company could not be justified. He appealed to the grievance cell of the Insurer for a review of the claim, but their reply was not satisfactory and was requested to approach this Forum for a resolution. Hence, he filed a complaint before this forum, seeking direction to the Insurer for admission of the claim.

Decision : The Respondent insurer is directed to Pay the eligible claim.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0222/2015-16

Complaint No. KOC-G-044-1617-0396

Award passed on : 23.12.2016

Mrs. Meera Vs STAR HEALTH AND ALLIED INS. CO. LTD.

repudiation of claim under mediclaim policy

The Complainant is covered under a Medi-claim policy of the respondent Insurer. She was hospitalized on 18/07/2016 for the treatment of ''Knee replacement'' underwent surgery and discharged on 25/07/2016. She preferred a claim with the respondent Insurer along with necessary required documents, which was denied by stating that "SUPPRESSION OF MATERIAL FACTS', 'at the time of taking the policy. She says that at the time of taking the policy, the agent had asked only regarding heart, sugar, pressure etc and her knee was in perfect condition at that time. She has never thought that the knee surgery undergone by her 13 years back and cured thereon is any way relevant to her proposal for insurance. She appealed to the Grievance Cell of the Insurer for a review of the claim, but the response was to approach this Forum. Hence, she filed a complaint before this forum, seeking direction to the Insurer for admission of the claim.

Decision : The Respondent insurer is directed to Claim settled for 75000/-.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0223/2015-16

Complaint No. KOC-G-049-1617-0322

Award passed on : 23.12.2016

Mr. E. Suresh Babu Vs The New India Assurance Co. Ltd.

Repudiation of claim under a mediclaim policy

The Complainant and his family are covered under a Medi-claim policy(No 760600/34/15/25/00000332) of the respondent Insurer. His son was hospitalized on 19/02/2016 for the treatment of 'Painful Gynaecomastia', underwent surgery and discharged on 21/02/2016. A claim for reimbursement of expenses towards hospitalization was preferred with the TPA of the Insurer, which has been denied by stating that the treatment undergone is cosmetic and not payable under clause 4.4.2 of the policy. He appealed to the Grievance Cell of the Insurer for a review of the claim, for which no reply has been received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim

Decision : The Respondent insurer is directed to Pay eligible claim.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0224/2015-16

Complaint No. KOC-G-049-1617-0426

Award passed on : 23.12.2016

Mr. Mohanlal Suda Vs The New India Assurance Co. Ltd.

Repudiation of Individual Mediclaim

The Complainant and his family are covered under a Medi-claim Policy No.761001/34/15/28/00000498) of the respondent Insurer. His son was hospitalized on 19/05/2016 for the treatment of 'Gynaecomastia', at Specialist Cosmetic Centre, underwent surgery and discharged on 20/05/2016. A claim for reimbursement of expenses towards hospitalization was preferred with the TPA of the Insurer, which has been denied by stating that the treatment undergone is cosmetic and not payable under clause 4.4.2 of the policy. His son was suffering from mental agony because of aforesaid ailment and the treatment is not for beautification. He appealed to the Grievance Cell of the Insurer for a review of the claim, for which no reply has been received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim

Decision : The Respondent insurer is directed to Admit the claim.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0227/2015-16

Complaint No. KOC-G-049-1617-0332

Award passed on : 23.12.2016

Mr. V.V. Surendran Vs The New India Assurance Co. Ltd.

Repudiation of claim under a mediclaim policy

The complainant and his family are covered under a Group Insurance Scheme (No 120700/34/15/04/00000008) of the respondent Insurer, taken by his employer. He had submitted a claim towards his eye treatment, with the TPA of the Insurer, which has been denied stating that "administration of Intravitreal Accentrix injection" falls outside the scope of the policy and not payable. Intravitreal Injection was administered specially on the advice of the doctor as a treatment for Diabetic Retinopathy. It was taken in a surgery room with the accompaniment of all procedures similar to a surgical operation. Due to the advancement of technology, it is more safe and effective than operation, as suggested by the doctor. Hon'ble Ombudsman vide award No.IO/KOC/A/G0052/2016-17 dt 27/5/2016, upheld his grievance on rejection of an earlier claim during 2015-16 under claim No.KOC-1215-CL-0005335 of similar kind of treatment. The present one is a booster to the earlier treatmernt. He appealed to the Grievance cell of the Insurer for a review of the claim, for which no response was received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim, based on actual facts.

Decision : The Respondent insurer is directed to Pay eligible claim.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0228/2015-16

Complaint No. KOC-G-049-1617-0288

Award passed on : 23.12.2016

Mr. K.K. Gopalakrishnan Nair Vs The New India Assurance Co. Ltd.

Partial repudiation of claim under an Individual Mediclaim policy

The Complainant and his spouse are covered under a Medi-claim policy of the respondent Insurer. He was hospitalized on 21/03/2016 for the treatment of his disease, undergone surgery and discharged on 28/03/2016. A claim for reimbursement of expenses towards hospitalization was preferred with the TPA of the Insurer, which has been partially settled. He alleges that as per terms and conditions of the policy, he is entitled to get full re-imbursement and what is done by the company is against the conditions of the policy. He appealed to the Grievance Cell of the Insurer for a review of the claim, for which no reply has been received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of balance amount of the claim

Decision : The complaint is dismissed.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0229/2015-16

Complaint No. KOC-G-049-1617-0316

Award passed on : 23.12.2016

Mr. M.V. Abraham Vs The New India Assurance Co. Ltd.

Repudiation of claim under a mediclaim policy

The Complainant and his family are covered under a Medi-claim policy (No 76100 23415 2500000523) of the respondent Insurer. He was hospitalized on 03/03/2016 for the treatment of 'Severe Head Ache' and discharged on 04/03/2016. A claim for reimbursement of expenses towards hospitalization was preferred with the TPA of the Insurer, which has been repudiated by stating that the there is 'no positive existence of any disease which needs hospitalization'. He appealed to the Grievance Cell of the Insurer for a review of the claim, for which no reply has been received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The Respondent insurer is directed to Pay the hospitalisation charges.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0230/2015-16

Complaint No. KOC-G-049-1617-0358

Award passed on : 23.12.2016

Mr. K. Gopinathan Nambiar Vs The New India Assurance Co. Ltd.

Partial Repudiation of claim under a Mediclaim policy

The Complainant and his spouse are covered under a Group Medi-claim Insurance policy of the respondent Insurer. His wife was hospitalized on 01/04/2015 for the treatment of VERTIGO, HTN &DYSLIPDEMIA and discharged on 02/04/2015. A claim for reimbursement of expenses towards hospitalization was preferred with the TPA of the Insurer, which has been partially settled by stating that 'admission was for evaluation' only. He appealed to the Grievance Cell of the Insurer for a review of the balance amount of the claim, for which the reply was not satisfactory. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of balance amount of the claim.

Decision : The Respondent insurer is directed to Pay the hospitalisation charges.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0231/2015-16

Complaint No. KOC-G-049-1617-0306

Award passed on : 23.12.2016

Mr. Joy P.J Vs The New India Assurance Co. Ltd.

Partial Repudiation of claim under a Mediclaim policy

The Complainant and his spouse are covered under a Mediclaim policy (No 760701834/16/00000007) of the respondent Insurer. His wife was hospitalized on 28/05/2016 for the treatment of irregular bleeding and undergone surgery and discharged on29/05/2016. A claim for reimbursement of expenses towards hospitalization was preferred with the TPA of the Insurer, which has been partially settled. On enquiry with the Insurer, he was informed that it is a proportionate deduction since the patient was admitted in a room with higher rent than the entitled category. The Hospital has given a clarification that the charges of hospital under various heads are not categorized in proportion to Hospital rent. The insured appealed to the Grievance Cell of the Insurer for a review of the balance amount of the claim, for which the reply was not satisfactory. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of balance amount of the claim.

Decision : The complaint is dismissed.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0232/2015-16

Complaint No. KOC-G-049-1617-0347

Award passed on : 23.12.2016

Mr. Mathew. N.V Vs The New India Assurance Co. Ltd.

Repudiation of claim under a mediclaim policy

The Complainant is covered under a Medi-claim policy (No 761002341 52800000361) of the respondent Insurer. He was hospitalized on 11/05/2016 for the treatment of 'Fracture of both bones', underwent surgery and discharged on 16/05/2016. A claim for reimbursement of expenses towards hospitalization was preferred with the Insurer, which has been denied by stating that the Insured was under influence of alcohol during Road Traffic Accident and the injury caused by the use of intoxicating alcohol is permanently excluded from claim, under exclusion clause 4.4.6.1. He appealed to the Grievance Cell of the Insurer for a review of the claim, for which no satisfactory reply was received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The Respondent insurer is directed to Pay the eligible claim.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0235/2015-16

Complaint No. KOC-G-048-1617-0318

Award passed on : 23.12.2016

Mr. Velayudhan P.P Vs The National Insurance Co. Ltd.

Repudiation of claim under a mediclaim policy

The Complainant is covered under a Medi-claim policy of the respondent Insurer. He was hospitalized on 12/04/2016 for the treatment of 'Shoulder pain' and discharged on 15/04/2016. A claim for reimbursement of expenses towards the treatment was preferred with the Insurer, which has been denied by stating that 'the need for hospitalization is not justified'. He appealed to the Grievance Cell of the Insurer for admission of the claim, for which no reply has been received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The Respondent insurer is directed to Pay the claim.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0236/2015-16

Complaint No. KOC-G-048-1617-0273

Award passed on : 23.12.2016

Mrs. Annakuty Chacko Vs The National Insurance Co. Ltd.

Repudiation of claim under an Individual Mediclaim policy

The Complainant is covered under a Medi-claim policy (no 571000/48/15/8500002045) of the respondent Insurer. She was hospitalized on 08/03/2016 for the treatment of DM, Hypothyroidism etc. and discharged on 10/03/2016. A claim for reimbursement of expenses towards hospitalization was preferred with the Insurer, which has been denied by stating that admission and evaluations were not followed by any active line of treatment. She appealed to the Grievance Cell of the Insurer for settlement of the claim, for which no response has been received. Hence, she filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The Respondent insurer is directed to Pay the claim.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0237/2015-16

Complaint No. KOC-G-048-1617-0411

Award passed on : 23.12.2016

Mr. T.C. VARGHESE Vs The National Insurance Co. Ltd.

Repudiation of claim under health policy

The Complainant holds Family Health Insurance policy named as "National Mediclaim", covering him and his family members with Sum Insured of Rs.50,000/- each. The Policy was running for the second year from inception. The Present Policy period is from 29/04/2015 to 28/04/2016. He was hospitalized on 09/03/2016 due to chest pain and underwent an emergency angioplasty. The claim was repudiated by the insurer by giving reason that the hypertension related disease was coming under the two years waiting period. Since he was not a Hypertension patient at the time of joining the policy, he appealed to the Grievance Cell of the Insurer for review of the claim, for which no satisfactory reply has been received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim, based on actual facts.

Decision : The Respondent insurer is directed to Pay eligible claim.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0238/2015-16

Complaint No. KOC-G-048-1617-0335

Award passed on : 23.12.2016

Mr. Mathew N Poulose Vs The National Insurance Co. Ltd.

denial of cashless and subsequent claim under a mediclaim policy

The Complainant is covered under a Medi-claim policy(No 571001/48/15/8500001454) of the respondent Insurer. He was hospitalized on 17/06/2016 for the treatment of 'Precordial Discomfort', underwent some laboratory tests and discharged on 18/06/2016. Though he made a cashless claim before the Insurer, they declined his claim reserving his right to claim for reimbursement. A claim for reimbursement of expenses towards hospitalization was preferred with the Insurer, which has been denied by stating that no medications were prescribed during the stay at Hospital and only evaluation was done. He appealed to the Grievance Cell of the Insurer for a review of the claim, for which no reply was received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim along with interest

Decision : The Respondent insurer is directed to Pay post hospitalisation expenses.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0239/2015-16

Complaint No. KOC-G-050-1617-0559

Award passed on : 20.02.2017

VARGHESE C.A Vs The Oriental Insurance Co. Ltd.

Repudiation of Medi Claim

The Complainant's son is covered under a Health policy of the respondent Insurer. He was admitted in the hospital for treatment and discharged. A claim for reimbursement of expenses towards hospitalization was preferred with the Insurer, which has been denied by stating flimsy reasons. He appealed to the Grievance Cell of the Insurer for a review of the claim, for which no satisfactory reply was received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim

Decision : The complaint is dismissed.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0241/2015-16

Complaint No. KOC-G-038-1617-0451

Award passed on : 20.02.2017

Mr. Abdulla Koya Vs ROYAL SUNDARAM ALLIANCE INSURANCE COMPANY LIMITED

Repudiation of health insurance claim

The complainant and his wife are covered under the Hospital Cash Insurance Policy of the Insurer for the last six years, without making any claims except in the current period. In the current policy period, i.e on 7th year of policy, the complainant had made a claim for prostrate and bladder stone removal and the insurer has settled the claim for Rs 14000.00 towards the hospitalisation of 7 days at the rate of Rs.2000.00 per day. During the pre-surgery check up, the treating doctor advised to consult with a cardiologist after convalescing from post surgery period. Accordingly, he consulted a cardiologist who advised 9 Days hospitalised treatment for heart ailment which he underwent from 12.05.2016 to20.05.2016. The present claim which pertains to the same is rejected by the insurer on the ground that HTN was pre-existing the policy inception and the Cardiac Disease is a complication of pre-existing Hypertension and therefore the ailment falls under the permanent exclusion as per the clause no.1 of the policy. The insured was a HTN patient for the last 30 to 35 Years and while taking the policy. The insurer has not asked any question on health condition or history or family history. There was no proposal form for the policy. This policy is taken and is continuously renewed by Visa Credit Card through credit card billing. The doctor's certificate clearly says the chest pain stated one week back. Further, the policy inception was more than 6 years prior to the inception of the policy. Hence, rejection of claim on the ground that the HTN was pre-existing would not sustain especially when there is no non-disclosure. He appealed to the Grievance Cell of the Insurer for review of the claim, for which no satisfactory reply has been received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim, based on actual facts.

Decision : The Respondent insurer is directed to Pay eligible claim.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0242/2015-16

Complaint No. KOC-G-003-1617-0527

Award passed on : 21.02.2017

Mr. SREEDHARAN O.K Vs Apollo Munich Health Ins.

Repudiation of health insurance claim

The complainant, a senior citizen (70) is covered under a Health policy through Canara Bank with effect from 06.12.2014 and renewed the same up to 05.12.16, of the respondent insurer. According to him he is an illiterate carpenter and is not aware of details of policy conditions. He preferred a claim for reimbursement of medical expenses for the surgery undergone in hospital for the period 10.07.2016 to 13.07.2016 in connection with Bilateral Hydrocele. The insurer denied the reimbursement of the claim amount. The insurer rejected the claim for the reason that "the medical history details of enlarged prostrate prior to policy inception is not revealed while taking the policy in the proposal form. Hence the claim is repudiated due to incorrect good health declaration". Actually, on 31.07.2008 i.e. 6 ½ years prior to the inception of policy, he has undergone ultra sound abdomen which revealed "Prostrate is enlarged and shows homogenous echogenicity". He is not advised nor has undergone any kind of treatment for next 6 ½ years. So, the alleged non disclosure of treatment/past history as a reason to repudiate the claim, would not sustain.

Decision : The Respondent insurer is directed to Pay both eligible claim.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0243/2015-16

Complaint No. KOC-G-003-1617-0546

Award passed on : 21.02.2017

Mr. Gimty George Vs Apollo Munich Health Ins.

Repudiation of health insurance claim

The complainant's wife is covered under a health policy of the Insurer. She was admitted in the hospital with complaints of fever with chills and leg pain. She had difficulty in walking and history of loss of weight of 10kg in last 3 months. The treating doctor advised admission in the hospital to undergo investigation and treatment. After investigation she was found to be suffering from Tuberculosis of (rt) Sacrilia Vein and oral Medicine started. The treating doctor advised that when they start Anti- TB medicines patient needs close observation of 8-10 days to see the side effects of the drugs. She had no option other than to agree with the doctor's advice. However, the insurer has rejected the claim stating that there was no active line of treatment. So, He appealed to the Grievance Cell of the Insurer for a review of the claim, for which no satisfactory reply was received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim with all other benefits.

Decision : The Respondent insurer is directed to Pay eligible claim.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0244/2015-16

Complaint No. KOC-G-018-1617-0482

Award passed on : 21.02.2017

Mr. Davies K.J Vs HDFC ERGO General Insurance Company Ltd.

Repudiation of health insurance claim

The complainant is a policy holder Medical Insurance of the respondent insurer since 2010. On 13th March 2015 he was admitted in the hospital due to Acute Bronchitis and discharged on 16.03.2015. From 10/07/2015 to 18/07/2015 he had 3 admissions due to pyrexia, viral fever, Bronchopneumonia, delirium and transplant graft dysfunction caused by temporary withdrawal of immunosuppression due to Acute Maloyed Leukemia and back on maintenance hemodialysis. He preferred the claim for reimbursement which was denied because of history of renal disorder since 2001. While proposing for insurance the insurance authority called over phone and informed him that call is being recorded as evidence of his declaration. He has informed the caller that he had renal transplant in 2001, nine years back. Till the time of proposal he hadn't any significant complaints and as per medical conditions a transplant person is no more a patient, a normal person after a successful renal transplant. In 2014 he had developed graft dysfunction caused by temporary withdrawal of immunosuppression necessitated because he develop Acute Meloyed Leukemia, for which he was on maintenance Chemotherapy. The Insurer alleges that the there is non-disclosure of material fact as he suppressed the knowledge of renal disorder. The renal transplant was disclosed by him during the call-recording by the insurance authorities. The present renal disorder had developed in 2014, four years after the commencement of policy. So, the denial of his claims could not be justified. He appealed to the Grievance Cell of the Insurer but no satisfactory reply has been received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim and revival of his policy.

Decision : The Respondent insurer is directed to Pay eligible claim.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0245/2015-16

Complaint No. KOC-G-018-1617-0555

Award passed on : 21.02.2017

Mr. SREENARAYANAN M Vs HDFC ERGO General Insurance Company Ltd.

Repudiation of health insurance claim

The complainant holds a valid Health Suraksha Policy of the respondent Insurer with effect from 27.10.2009. The aforesaid policy was renewed continuously and under the current policy he preferred a claim in respect of his hospital admission and treatment of Degenerative Lumbar Spondylosis with extrusion and superior migration L3-L4 disc. The Insurer denied the cashless claim stating that he had failed to disclose the existence of the disease DVT. The insurance company sought to terminate the insurance policy by claiming that he had failed to disclose the existence Vericose Vein at the time of taking the policy. Varicose vein and DVT (Deep Vein Thrombosis) are different medical condition/diseases. Varicose Veins is a medical condition in which the veins have become enlarged and twisted. DVT is the formation of a blood clot predominantly in the legs. Further, the degenerative disease is totally unconnected to the disease of DVT. He had undergone medical check up for availing the insurance policy and the insurer is well aware of his health status. He had taken the policy after disclosing all the details and health history over phone. No Proposal Form was taken from him at the time proposing for insurance. He placed reliance on the judgement of the National Consumer Disputes Redressal Forum in the case of New India Assuarance Co. Ltd. v Rajeev Agarwal & Anr, decided on 29th June 2015. The Insurance Company is under obligation to produce sufficient evidence to support their allegation that he had deliberately/ intentionally suppressed the fact that he was suffering from DVT. The Insurance Company by failing to produce the necessary documents to show that he had intentionally subscribed the policy to get wrongful gain cannot be allowed to take undue advantage of their own mistakes. He appealed to the Grievance Cell of the Insurer for a review of the claim, for which no satisfactory reply was received. Hence, he filed a

complaint before this Forum, seeking direction to the Insurer for admission of the claim with all other benefits.

Decision : The Respondent insurer is directed to Pay eligible claim and renew the policy.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0249/2015-16

Complaint No. KOC-G-023-1617-0470

Award passed on : 21.02.2017

Mr. MARTIN K.J Vs IFFCO-TOKIO Genl. Insc. Co. Ltd.

Repudiation of health insurance claim

The complainant's wife is covered under a Health policy of the respondent insurer, since 01/07/2015. Subsequently the policy was renewed for one more year. She was hospitalized due to Budd Chiary Syndrome from 26/07/2016 to 01/08/2016 and from 28/08/2016 to 05/09/2016. The claim towards reimbursement of expenses towards hospitalization was preferred with the Insurer, which was denied by the insurer since the Hypothyroidism was not disclosed at time of proposal. The insured was diagnosed with Hypothyroidism 4 years ago after the birth of their first child and normalised without taking any medicine. On 27/02/2016, problem of Hypothyroidism was detected and she was advised to take medicine. She has been taking medicine from February 2016. She is not suppose to declare the Hypothyroidism at the time of proposing insurance as his wife was never under the treatment for the same, prior to inception of the policy. On 18/07/2016 his wife had consulted a doctor for treating her sneezing problem started a few days ago and told the doctor about this hypothyroidism when she was asked to tell about her past physical problem. Moreover Hypothyroidism is not a cause for the present ailment. He appealed to the Grievance Cell of the Insurer but no satisfactory reply has been received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim without further delay.

Decision : The Respondent insurer is directed to Pay eligible claim.

$$$$$$$

Award No. IO/KOC/A/GI/0250/2015-16

Complaint No. KOC-G-047-1617-0500

Award passed on : 21.02.2017

Mr. N S DEV Vs Tata AIG General Insurance Co.Ltd.

Repudiation of health insurance claim

The complainant is holding a valid Hospital cash policy with the respondent Insurer since 2010 which has cumulative benefits @ 5% is added on in case of each claim free year. There has been no claim from 2012 onwards. The complainants wife was admitted to Sree Agasthya Medical Centre , Kochi on 10.10.2016 for treatment of back pain and related ailments. The Insurer was intimated and claim registered. The patient was discharged on 03.11.2016 and claim forms were received by the Insurer on 04.11.2016. Instead of settling the claim, the Insurer has called for non existent documents, even sent a representative to physically check at the hospital and at the insured's house. Complaints were escalated through the proper channel for which a response was received on 30.11.2016 intimating settlement of Rs. 46000.00(23 days *2000). Another complaint was preferred regarding the cumulative benefit for which the Insurer has quoted IRDA circulars and insisted that Cumulative Benefits cannot be given as per the circular. However the complainant submits that the IRDA Health Regulations 2013 does not invalidate any earlier benefits. Moreover the Health Regulations notified on 12.07.2016 also does not bar giving cumulative benefits. The complainant has not received any communication regarding change in policy condition throughout these years. Hence the cumulative bonus should be rightly paid.

Decision : The Respondent insurer is directed to Pay Rs.9200/-.

$$$$$$$

Award No. IO/KOC/A/GI/0252/2015-16

Complaint No. KOC-G-051-1617-0522

Award passed on : 22.02.2017

Mr. RAJU T L Vs The United India Insurance Co. Ltd.

Repudiation of Medi Claim

The complainant holds a valid mediclaim policy from the respondent Insurer His wife (also covered under the policy) underwent hysterectomy operation necessitated due to onset of cancer and a claim (of Rs65720.00)was made with the insurer. The Insurer has paid an amount of Rs40000.00 and rejected the balance claim stating that only an amount of Rs40000.00 is payable. The treating doctor's certificate showing that the hysterectomy was done only due to the Cancer of the ovary was also submitted to the insurer to prove that this was not a regular hysterectomy operation but one done to save the life of a patient. This was not considered and the partial repudiation was reiterated. Hence this complaint is filed seeking the Insurer to pay the entire claim as the complainant is in financial difficulties due to the ongoing treatments for cancer

Decision : The complaint is dismissed.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0253/2015-16

Complaint No. KOC-G-051-1617-0574

Award passed on : 22.02.2017

SUGUNA N Vs The United India Insurance Co. Ltd.

Repudiation of Medi Claim

The complainant is covered under a mediclaim policy of the respondent insurer for the last 9 years. There was a delay for renewal of policy during the year 2013 for 134 days. It was due to non-receipt of insurance renewal intimation from the insurer. On 23/03/2016 she was admitted in the hospital for Total knee replacement surgery of both legs and preferred a claim with TPA. Her claim was denied stating that "Unless the insured has 48 months of continuous coverage, the expenses related treatment of Joint Replacement due to Degenerative Condition and age related Osteoarthritis & Osteoporosis are not payable." She could not renew the policy on due date in 2013, as the insurance company failed to issue the renewal notice in time. She is not responsible for the lapse of renewal of policy and her claim should be settled by the insurer. She appealed to the Grievance Cell of the Insurer for a review of the claim, for which no satisfactory reply was received. Hence, she filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The complaint is dismissed.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0254/2015-16

Complaint No. KOC-G-051-1617-0397

Award passed on : 22.02.2017

Mr. S. Gopalakrishnan Vs The United India Insurance Co. Ltd.

repudiation of claim under mediclaim policy

The Complainant and his Spouse are covered under a Medi-claim policy of the respondent Insurer. His wife was hospitalized on 02/04/2016 for Orthopedic treatment and discharged on 03/04/2016. A claim for reimbursement of expenses towards hospitalization was preferred with the Insurer, which has been denied by stating Clause 2.1 of the policy, which states that "procedures/treatments 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 or carried out in Day care Centres". He appealed to the Grievance Cell of the Insurer for a review of the claim, for which the reply was not satisfactory. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The Respondent insurer is directed to Pay eligible claim.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0255/2015-16

Complaint No. KOC-G-051-1617-0436

Award passed on : 22.02.2017

Mr. P.S.PEETHAMBARAN Vs The United India Insurance Co. Ltd.

Repudiation of Individual Mediclaim

The Complainant has taken a Family Medicare Policy for the first time on 19.03.2015 and renewed the same for the period 19.03.2016 to 18.03.2017. He was admitted to hospital on 22.06.2016 and discharged on 28.06.26 for the treatment of Vesical Calculus. A claim for reimbursement of expenses towards hospitalization was preferred with the Insurer, which has been denied by stating that first 2 years of policy Calculus disease are not covered as per exclusion clause 4.3 of the policy and his policy has completed 1 year 3 months only while he was admitted to hospital. As per the aforesaid clause "Unless the Insured has 24 months of continuous coverage" certain disease are not covered. The insured submits that the policy coverage is in existence from 19.03.2015 to 18.03.2017 continuously and that he is eligible for the claim since he has 24 months continuous coverage, even though the treatment has been taken on 15th month. He appealed to the Grievance Cell of the Insurer for review of the claim, quoting the Clause from the policy, for which no reply has been received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim, based on actual facts.

Decision : The complaint is dismissed.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0257/2015-16

Complaint No. KOC-G-051-1617-0455

Award passed on : 22.02.2017

Mr. Lawrence Johnson Veliyil Vs The United India Insurance Co. Ltd.

Repudiation of health insurance claim

The complainant is covered under a Health policy of the respondent insurer. He was hospitalized due to subluxation of left joint shoulder due to a fall at home and underwent shoulder strapping. A claim towards reimbursement of expenses towards hospitalization was preferred with the Insurer, which has been denied by the insurer by mentioning that he had undergone the shoulder strapping without anaesthesia which does not necessitate inpatient care nor is listed in day care list and as per policy condition 1.1 hospitalisation not justified and 3.1 it is not covered under day care list. The observation of insurer is not correct as he was on sedation for more than three hours and was totally unconscious while undergoing shoulder strapping procedure. Further, after strapping he was not physically fit to be taken to home other than treating as patient. He appealed to the Grievance Cell of the Insurer to reconsider the claim, but in vain. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The Respondent insurer is directed to Pay eligible claim.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0258/2015-16

Complaint No. KOC-G-051-1617-0472

Award passed on : 22.02.2017

Mr. M.P.MOHANAN Vs The United India Insurance Co. Ltd.

Delay in settlement of claim

The Complainant is covered under a Medi-claim Policy of the respondent Insurer. His was admitted in the Nirmala hospital and Amrita hospital in the month of February and June 2016, respectively. After discharge from the Hospital, he preferred a claim with the TPA of the respondent Insurer with all required documents, but till date the claims were not settled. He appealed to the Grievance Cell of the Insurer for settling the claim, but they have not bothered even to reply his Grievance. Hence, he filed a complaint before this forum, seeking direction to the Insurer for admission of both the claims.

Decision : The Respondent insurer is directed to Pay eligible claim.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0259/2015-16

Complaint No. KOC-G-051-1617-0497

Award passed on : 22.02.2017

Mrs. Ponnamma Mani Vs The United India Insurance Co. Ltd.

Repudiation of Medi Claim

The complainant is covered under a valid mediclaim policy from the respondent Insurer. The complainant suffers from chronic back and leg pain since 2011 and due to the pain being unbearable, doctors consultation was taken on 07.04.2016 where, after a scan the doctors have advised an epidural injection to be taken to reduce and manage the pain. Since the pain became worse, the insured agreed to undergo the injection and was admitted to the hospital on 02.05.2016. The procedure was done on the same day and discharged on the next day as the doctors had recommended 24 hours observation for pain reduction after the injection. Since there appeared to be no relief even after the injection, discharge was allowed. A claim (of Rs23469.00) was made to the Insurer for reimbursement which has been denied i.e. no reply has been received. Representations to Insurer remains unanswered, hence this complaint, as she has already spent a huge amount of over Rs23000.00.

Decision : The Respondent insurer is directed to Pay eligible claim.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0260/2015-16

Complaint No. KOC-G-051-1617-0499

Award passed on : 22.02.2017

Mrs. Mary jacob Vs The United India Insurance Co. Ltd.

Partial repudiation of health insurance claim

The complainant is covered under a health Insurance policy with the respondent insurer. The Sum Insured was enhanced to Rs1lakh during 2014. However no mention of the enhancement is shown in the policy terms and conditions. Since OPD treatment for knee pain did not yield any relief, the doctors have suggested total Knee replacement. On doctors advice the complainant was admitted for the Knee Replacement surgery on 22.04.2016 and discharged on 30.04.2016. The total expenses for the procedure including hospital stay came to Rs 5.51 lac. The TPA has extended cashless facility to the extent of Rs35000.00 only considering the earlier Sum Insured of Rs50000.00.

Decision : The Respondent insurer is directed to Pay Rs.35000/- towards balance amt of claim.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0261/2015-16

Complaint No. KOC-G-051-1617-0502

Award passed on : 22.02.2017

Mr. JOSHY XAVIER Vs The United India Insurance Co. Ltd.

Repudiation of Medi Claim

The complainant is holding a valid mediclaim policy from the respondent Insurer. His son aged 13 years was admitted to Rajagiri Hospital, due to acute wheezing, constant cough and cold and tiredness. The insured was admitted for three days from 30.06.2016 to 02.07.2016 and was discharged under the advice to review after 1 week in pediatric OPD and 2 months in endocrinology OPD with T4/TSH results. At the time of admission a request was submitted for cashless claim which was turned down by the TPA. After settling the Hospital bills on discharge, a claim was preferred with the insurer which was also turned down stating that no hospitalisation was required and only OPD treatment was necessary. Since both the complainant and his wife are working , they preferred OPD treatment , but the patient was admitted on the doctors advice necessitating taking leave from work place also. The amount claimed is only Rs11961.00 and the eligible claim may be reimbursed as it is genuine.

Decision : The Respondent insurer is directed to Pay eligible claim.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0262/2015-16

Complaint No. KOC-G-051-1617-0554

Award passed on : 22.02.2017

Mr. V.C. VARGHESE Vs The United India Insurance Co. Ltd.

Repudiation of health insurance claim

Complainant is covered under a mediclaim policy of the respondent Insurer. He preferred a claim for Rs.15,070.00 from the Insurance company. He succeeded in getting his claim approved times previously for same treatment. He availed 4 injections around each eye (total 8) under aseptic precautions in operation theatre. Since it is allergy prone drug, need hospital admission also. He appealed to the Grievance Cell of the Insurer for a review of the claim, for which no satisfactory reply was received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The Respondent insurer is directed to Pay eligible claim.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0263/2015-16

Complaint No. KOC-G-051-1617-0473

Award passed on : 22.02.2017

Mr. Mahesh U Vs The United India Insurance Co. Ltd.

Repudiation of health insurance claim

The complainant and his family are covered under a Group Insurance Scheme of the respondent Insurer, taken by his employer. His father is a prostate cancer patient and had submitted a claim towards Medicine and physiotherapy treatment of his father, which has been denied by the insurer stating that "OPD treatment is not payable - hormonal therapy given (Injection Lupried) which does not comes under the purview of day care list". He appealed to the Grievance cell of the Insurer for a review of the claim, for which reply was not satisfactory. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim, based on actual facts.

Decision : The Respondent insurer is directed to Pay claim considering injections as day care procedure.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0264/2015-16

Complaint No. KOC-G-031-1617-0444

Award passed on : 22.02.2017

Mr. Dixon Thekkemuriyil Philip Vs MAX BUPA HEALTH INSURANCE CO.LTD

Repudiation of health insurance claim

Complainant and his family are covered under a health policy of the respondent insurer for the last 5 years. In July 2013 his wife was admitted in the hospital and the claim was denied by the insurance company. Now, the insurer denies the renewal of policy. He and his family had undergone medical checkup while proposing for insurance, 5 years back. The insurer should have rejected the proposal at that time itself. At least he should have saved the premium for 5 year policy cover. The claim rejected in 2013 was also on flimsy ground. The reason given for repudiation was that " the patient was admitted for oral treatment, evaluation and investigation, thus hospitalization is not justified and the patient could have been managed on OPD Basis and also the patient had a similar episode 9 years back but it was not disclosed at the time of inception of policy thus denied for unjustified hospitalization and non-disclosure of material facts". As instructed by Max Bupa he moved his wife in an ambulance from the admitted hospital to network hospital over 2 hours journey to get the Insurance claim. Considering all above he is not at fault, and his policy is to be accepted for renewal since no other company is allowing to port as the insurer has cancelled the policy and the waiting period for all the benefits gone. He appealed to the Grievance Cell of the Insurer for renewing the policy with continuity of benefit, but their reply is not satisfactory. Hence, he filed a complaint before this forum, seeking direction to the Insurer for allowing the renewal of policy with continuity of benefits.

Decision : The Respondent insurer is directed to Pay Rs.11064/- and renew policy excluding child.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0265/2015-16

Complaint No. KOC-G-003-1617-0450

Award passed on : 22.02.2017

Mr. Johnson k.G Vs Apollo Munich Health Ins.

Repudiation of health insurance claim

The Complainant and his family are covered under a Health policy of the respondent Insurer. His wife was hospitalized on 12/08/2016 for the treatment of Carcinoma of Uterus, underwent surgery and discharged on 22/08/2016. A claim for reimbursement of expenses towards hospitalization was preferred with the Insurer, which has been denied by stating that non-disclosure of facts at the time of taking the policy. The premium towards insurance cover was debited by the Canara Bank while sanctioning a loan and he was not aware of any proposal/declaration and he came to know about insurance policy only after seeing the debited amount from his account. Hence, there is no non-disclosure of material fact. Further, there was no adverse affect due to fibroid uterus. Only during the present hospitalisation of his wife with the complaint of heavy bleeding, Carcinoma to Uterus was detected. He appealed to the Grievance Cell of the Insurer for a review of the claim, for which no satisfactory reply was received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim with all other benefits.

Decision : The Respondent insurer is directed to Pay eligible claim.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0266/2015-16

Complaint No. KOC-G-037-1617-0552

Award passed on : 22.02.2017

Mr. M.E. ELIAS Vs Religare Health Ins. Co. Ltd.

Repudiation of health insurance claim

The complainant is covered under tailor made Group Mediclaim policy of the respondent insurer which was arranged by his employer. The policy commenced with effect from18/03/2016. On 04/06/2016 he is admitted to hospital for the treatment of Sudden sensory neural hearing loss (SNHL)-right. Prior to hospitalisation he had enquired the admissibility of the claim and the insurer has confirmed the same. The treatment undergone in the MOSC medical college did not cure his ailment. So, he got admitted at Rajagiri Hopsital on 15/06/16 and undergone surgery. The application for cashless was rejected by the insurer stating that ENT Treatment is excluded from the scope of the coverage for the first two year of inception of policy. The insurance company has rejected his both claims stating the aforesaid reason. He was not aware of the said policy condition and the policy document given to him does not show the same. So, He appealed to the Grievance Cell of the Insurer for a review of the claim, for which no satisfactory reply was received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim with all other benefits.

Decision : The complaint is dismissed.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0267/2015-16

Complaint No. KOC-G-048-1617-0576

Award passed on : 22.02.2017

V.P. ISSAC Vs The National Insurance Co. Ltd.

Repudiation of health insurance claim

The complainant's wife was covered under a Mediclaim policy of the respondent insurer. On 04.07.2016, due to stomach ache, she consulted a Gastro Doctor and taken oral medication for a week. Since there was no relief, she was admitted to hospital on 11.07. 2016 due to severe Stomach ache. She has undergone colonoscopy and waited for biopsy report. After the receipt of Biopsy report the treating doctor prescribed medicines for oral medication. She preferred a claim with the insurer which was denied stating that there was no active line of treatment during hospitalization. The hospitalization was primarily for evaluation purpose is exclusion under the policy. The complainant appealed to the Grievance Cell of the Insurer for a review of the claim, for which no satisfactory reply was received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The Respondent insurer is directed to Pay the claim.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0268/2015-16

Complaint No. KOC-G-048-1617-0512

Award passed on : 22.02.2017

Mr. G.UNNIKRISHNAN Vs The National Insurance Co. Ltd.

Repudiation of Medi Claim

The complainant is covered under two Mediclaim policies of the respondent insurer for the sum insured of Rs. 50,000.00 and 2 Lakhs. The sum insured under the first policy (with sum insured of Rs.50,000.00) has been exhausted due to his accident claim in the month of November 2016. The second policy with sum insured of Rs.2 Lakh commenced for the first time with effect from 11.05.2016. After taking the second policy, he developed complaints of palpitation in June 2016 and had chest discomfort and breathlessness in July 2016. He underwent TMT and CAG which revealed Double Vessel Disease. He was advised CABG and surgery was conducted on15.07.2016. The Cashless claim was denied stating that "the treating doctor certifies that the patient to be hypertensive since six years". Subsequently, he submitted all his claim papers for reimbursement of the claim which was denied stating that they were unable to settle the claim based on terms and conditions of the Mediclaim policy and the claim is repudiated on the following reasons: "1. A case of heart failure, 2. Policy since 11.05.2016, as per submitted documents, h/o presenting complaints since 2 months., Hence the claim is not payable." The repudiation of claim is not justifiable as he had undergone a thorough medical checkup and the respondent issued the policy without any exclusion after being satisfied about his health condition. It was thereafter only he developed palpitation and discomforts. It was not pre-existing disease while taking the policy. He has not suppressed any material facts from the Insurer while taking the policy. He appealed to the Grievance Cell of the Insurer for a review of the claim, for which no reply has been received even after one month. Hence, he filed a complaint before this Forum to resolve the issue.

Decision : The complaint is dismissed.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0269/2015-16

Complaint No. KOC-G-051-1617-0536

Award passed on : 22.02.2017

Mrs. Stella Vs The United India Insurance Co. Ltd.

Repudiation of death claim under group policy

The complainant is the wife of deceased Sri Simon, a fisherman, who was a member of the Fishermans Welfare Fund Board. The members under the Board are covered by a Group Personal Accident Policy issued by the respondent Insurer. The insured went for fishing operations on 10.01.2014 and owning to the stress and strain of his job suffered chest pain. He was rushed to the nearest hospital wherein he was found dead on arrival. A police case was filed and post-mortem also conducted. The copies of the FIR, Post Mortem Report and death certificate have been produced as exhibits. A claim was filed with the respondent Insurer for allowing the death claim which was repudiated. The reason given by the Insurer was that "death due to heart attacks are not covered and heart attack is not an accident as defined in the MOU". This repudiation is unfair and therefore this complaint filed before this forum seeking justice. Copies of Government order dated 04.12.2009 and 12.12.2013 is also produced to clarify the stand that the claim is indeed payable. Moreover the heart attack is as a result of the stress & strain of the job and is therefore an accident which is clearly payable under the policy.

Decision : The complaint is dismissed.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0270/2015-16

Complaint No. KOC-G-051-1617-0514

Award passed on : 22.02.2017

Mrs. Sheeji alias Shiji Vs The United India Insurance Co. Ltd.

Repudiation of death claim under group policy

The complainant is the wife of deceased Sri Sudarsanan , a fisherman , who was a member of the Fishermans Welfare Fund Board. The members under the Board are covered by a Group Personal Accident Policy issued by the respondent Insurer. The insured went for fishing operations on 27.06.2013 and owning to the stress and strain of his job suffered a heart attack and fainted. He was rushed to the nearest hospital wherein he was found dead on arrival. A police case was filed and post-mortem also conducted. The copies of the FIR,Post Mortem Report and death certificate have been produced as exhibits. A claim was filed with the respondent Insurer for allowing the death claim which was repudiated . the reason given by the Insurer was that "death due to heart attacks are not covered and heart attack is not an accident as defined in the MOU". This repudiation is unfair and therefore this complaint filed before this forum seeking justice. Copies of Government order dated 04.12.2009 and 03.12.2011 is also produced to clarify the stand that the claim is indeed payable. Moreover the heart attack is as a result of the stress & strain of the job and is therefore an accident which is clearly payable under the policy.

Decision : The complaint is dismissed.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0271/2015-16

Complaint No. KOC-G-044-1617-0564

Award passed on : 22.02.2017

Shafi. A Vs STAR HEALTH AND ALLIED INS. CO. LTD.

Repudiation of health insurance claim

The complainant's father was admitted in the hospital due to weakness and diagnosed Hyponatremia which later induced seizure. He was admitted in ICU for few days and treated for Hyponatremia. He preferred a claim with the insurer and got rejected mentioning his father was already a seizure patient and that is not covered under the policy and also said this information hasn't revealed while issuing the policy. But, the insured had informed about this ailment while taking the policy, moreover he was not admitted for seizure treatment. It is the Hyponatremia which induced seizure and the hospital authorities has clearly mentioned in the report. The insurer is misleading the information as the report says and Hyponatremia seizure (which means Hyponatremia induced seizure) and the Insurer splits the word to Seizure/Hyponatremia. Complainant has struggled a lot for the money, more over the money, the mental stress and pain he went through is beyond words. He appealed to the Grievance Cell of the Insurer for a review of the claim, for which no satisfactory reply was received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim and compensation for the struggle he faced.

Decision : The complaint is dismissed.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0272/2015-16

Complaint No. KOC-G-044-1617-0561

Award passed on : 22.02.2017

JOB JOHN P Vs STAR HEALTH AND ALLIED INS. CO. LTD.

Repudiation of Medi Claim

The complainant is a Mediclaim Policy holder of the respondent insurer for the last 7 years. His daughter was admitted to hospital for the period 07.10.2016 to 15.10.2016 and 20.10.2016 to 28.10.2016 and undergone treatment. The application for Cashless and subsequently the request for reimbursement were rejected. He appealed to the Grievance Cell of the Insurer for a review of the claim, for which no satisfactory reply was received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.(scn not filed)

Decision : The Respondent insurer is directed to Pay eligible claim.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0273/2015-16

Complaint No. KOC-G-044-1617-0379

Award passed on : 22.02.2017

Mrs. Sajeena Beevi Vs STAR HEALTH AND ALLIED INS. CO. LTD.

Repudiation of claim under a health policy

The Complainant and his spouse are covered under a Medi-claim policy of the respondent insurer. Her husband was hospitalized for the treatment of CAD, underwent surgery and discharged. A claim for reimbursement of expenses towards hospitalization was preferred with the Insurer, which has been denied by stating that her husband was a diabetic patient with history of one year. The insurer repudiated the claim on the ground that, even though the present treatment is not for Diabetic, non- disclosure of pre-existence of DM at the time of proposing for insurance shall be taken as suppression of material fact. She appealed to the Grievance Cell of the Insurer for review of the claim based on actual facts, for which the reply was to approach this Forum. Hence, she filed a complaint before this forum, seeking direction to the Insurer for admission of the claim.

Decision : The Respondent insurer is directed to Pay eligible claim.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0274/2015-16

Complaint No. KOC-G-044-1617-0563

Award passed on : 22.02.2017

A. Yusuf Kunju Vs STAR HEALTH AND ALLIED INS. CO. LTD.

Partial repudiation of health insurance claim

The complainant is covered under Senior Citizen Red Carpet policy of the respondent Insurer. He was admitted in the hospital on 19/04/2016. He preferred a claim with the insurer. The insurer has settled his claim partially. The balance amount of Rs.3206.00 has not been reimbursed. He is eligible for the 70% of the claim amount. He appealed to the Grievance Cell of the Insurer for a review of the claim, for which no satisfactory reply was received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The Respondent insurer is directed to Pay difference in post hospitalisation expenses.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0276/2015-16

Complaint No. KOC-G-044-1617-0541

Award passed on : 22.02.2017

Mr. Daniel mathew Vs STAR HEALTH AND ALLIED INS. CO. LTD.

Repudiation of health insurance claim

The complainant holds a valid health policy from the respondent Insuer. The complainant was admitted with Phimosis with Balantitis, uncontrolled DM and UTI and the doctors have advised Circumcision as the only remedy for the same. Accordingly it was carried out and a claim was made to the Insurer. The Insurer has repudiated the claim citing Exclusion clause No 04 of the policy conditions wherein it was stated that claims made for circumcision is not payable. However as per Policy clause-04, there is exception for prevention of disease. As the circumcision is done for treating the ailment of acute difficulty of passing urine, Dysuria, Phymosis etc., denial of the claim by the insurer by misinterpreting the Clause, is not justifiable. He appealed to the Grievance Cell of the Insurer for a review of the balance amount of the claim, for which the reply was not satisfactory. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The Respondent insurer is directed to Pay eligible claim.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0277/2015-16

Complaint No. KOC-G-044-1617-0516

Award passed on : 22.02.2017

Mr. Siju Putheth Kuriakose Vs STAR HEALTH AND ALLIED INS. CO. LTD.

Repudiation of health insurance claim

The complainant is holding a valid Health policy from the respondent Insurer. The complainant's wife is also covered under the policy. The Insured Smt Manju Siju became pregnant and was under consultation at VMM Hospital, Perumbavoor wherein it was discovered that the BP reading was very high. Despite that no medications were taken; the readings were monitored with the help of an apparatus at home. On 09.04.2016, the reading again showed very high and immediate consultation was taken and medication was prescribed. The insured continued with treatment for hypertension and pregnancy in Rajagiri hospital. In August 2016 she was admitted to the Hospital due to high BP reading due to non availability of medicines prescribed for hypertension. Due to the condition called Pre Eclampsia doctors have carried out tests and for life saving measure of insured and baby carried out LSCS on 28.08.2016. On 01.09.2016 the complainant informed the respondent Insurer for cashless treatment which was rejected stating that there is a waiting period for pregnancy as shown in the policy document. All representations for consideration of the claim has been denied, hence this complaint seeking the full eligible claim and 12% interest from date of claim.

Decision : The complaint is dismissed.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0278/2015-16

Complaint No. KOC-G-044-1617-0567

Award passed on : 22.02.2017

Jacob Cherian Vs STAR HEALTH AND ALLIED INS. CO. LTD.

Repudiation of Medi Claim

Complainant is covered under health policy of the respondent Insurer. He was admitted in the hospital on 01.10.2016. After investigations and angiogram, agressive medication was administered and discharged on 04.10.2016He preferred a claim form the respondent Insurer which was denied by stating he had suppressed pre-existing disease known to him while he was proposing for Insurance. . Actually he was not a kidney patient while he proposed for insurance. To substantiate the same he has submitted Ultrasongraphy report dtd 11/12/2016 by Dr. Alex Ittyavirah M.D, one of the topmost medical practitioner of Trivandrum. He appealed to the Grievance Cell of the Insurer for a review of the claim, for which no satisfactory reply was received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The Respondent insurer is directed to Pay as admissible.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0279/2015-16

Complaint No. KOC-G-044-1617-0556

Award passed on : 22.02.2017

Ms. LALY K.V Vs STAR HEALTH AND ALLIED INS. CO. LTD.

Repudiation of health insurance claim

Complainant is a Mediclaim policy holder of the respondent insurer. She was admitted in the hospital for treatment on 14/6/2016 and 08/08/2016 due to the sudden chest pain and stroke, respectively. She claimed for Cashless and subsequently for reimbursement of her both claims. The Insurer has denied the claim alleging that she suppressed past history of 20 years of her ailment of MVP (Mitral Value Prolapsed), while proposing for insurance for the first time on 29th March2015. She denied having suppressed any material fact while taking the policy. She had no cardiac disease till this day. It was the mistake on the part of the hospital that she was suffering from MVP since 20 years of age. The complainant submits that while undergoing treatment in Out Patient Department in the hospital at Paramula on 01/02/2016 for head ache and dizziness, Dr Madhu expressed doubt about MVP without any clinical confirmation. During current treatment she told the treating doctor about the doubt regarding MVP. Dr.Cherian Koshi, Cardiologist after ECHO evaluation certified that she has no MVP since ECHO showed normal Cardiac Valves. She submitted to Insurer, the scanning report taken by Dr. Madhu and Dr. Koshy, which reveal her cardiac fitness. However, the insurer had not settled the genuine claim. Hence, she filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim with all other benefits and reinstatement of policy.

Decision : The complaint is dismissed and restoration of policy excluding MVP.

$$$$$$$

Award No. IO/KOC/A/GI/0280/2015-16

Complaint No. KOC-G-044-1617-0534

Award passed on : 22.02.2017

Mr. JAMES JOSEPH POOTHARA Vs STAR HEALTH AND ALLIED INS. CO. LTD.

Repudiation of health insurance claim

The complaint is insured under a Health Insurance policy from the respondent Insurer. A claim for reimbursement was made in 05/2015 of Rs. 69700.00 towards Chemotherapy expenses incurred by the complainant at Amritha Hospital kochi. The Insurer has informed that the claim is not payable as the ailment was not disclosed while taking the policy in 2012. The claim was repudiated. In the year 2009 whilst beeing abroad, and on vacation, he went for an executive Medical Check up at Amrita Hospital, there he was asked to take some medicines(tablets) for a cancer related disorder. He took the medicine for some months and later shown positive signs of recovery, there after he has stopped the Medicines completely. 4 years later, in 2012, he has taken the policy indicating only the known diseases which was BP, Diabetics, and something of minor nature. Diseases whichn did not bother him, like Elephantiasis'during his college days, Hepatitis during his foreign assignments, and similar diseases which was not bothering him, for which he was not taking any medication, was excluded whilst taking insurance policy. So is the case with the starting stage of Myeloma found in 2009 at Amrita Hospital was not mentioned. The aforesaid fact should not be construed as deliberate suppression of facts while taking the policy. A representation was made for reconsideration of the claim, but the Insurer has replied that since the original disease was not disclosed while taking the policy; the policy has been cancelled with effect from 12/2016. As a senior citizen, finding no other avenue for justice, this complaint has been filed seeking settlement of the eligible claim.

Decision : The complaint is dismissed.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0281/2015-16

Complaint No. KOC-G-044-1617-0383

Award passed on : 22.02.2017

Mr. Abdul Hameed Vs STAR HEALTH AND ALLIED INS. CO. LTD.

Repudiation of claim under a health policy

The Complainant and his family are covered under a "Family Health Optima Insurance Plan" of the respondent Insurer. He was hospitalized on 12/04/2016 for the treatment of "LARGE MNG'', underwent surgery and discharged on 16/04/2016. Pre-authorization request for cashless treatment was denied. He preferred a claim with the respondent Insurer along with necessary required documents, which was denied by stating that "SUPPRESSION OF MATERIAL FACTS', 'at the time of taking the policy. He appealed to the Grievance Cell of the Insurer for a review of the claim, but no response was there, till date. Hence, he filed a complaint before this forum, seeking direction to the Insurer for admission of the claim along with interest, cost and compensation.

Decision : The Respondent insurer is directed to Renew the policy excluding CAD and pay present claim.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0282/2015-16

Complaint No. KOC-G-044-1617-0577

Award passed on : 22.02.2017

ARUNAKUMARI RAJENDRAN Vs STAR HEALTH AND ALLIED INS. CO. LTD.

Partial repudiation of health insurance claim

The Complainant, Smt. Arunakumari Rajendran had enrolled a Senior Citizen Red Carpet Health Insurance Policy. She had recently undergone a total knee replacement surgery. The Total Hospital Bill was Rs.3,39,133.00. The total claim amount received against this policy was Rs.85200.00 only. The Sum Insured under the policy is Rs.2lakh. The explanation received from the insurance company is not satisfactory. She appealed to the Grievance Cell of the Insurer for a review of the claim, for which no satisfactory reply was received. Hence, she filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The complaint is dismissed.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0283/2015-16

Complaint No. KOC-G-044-1617-0568

Award passed on : 22.02.2017

Damodaran C Vs STAR HEALTH AND ALLIED INS. CO. LTD.

Repudiation of health insurance claim

The complainant, a senior citizen holds Health Insurance Policy for the fifth year. During the health check-up, prior to inception of policy, he mentioned about his Pre-existing disease to the Doctor and his report showing it, proves beyond doubt that he had no intention to hide anything. Even if there is any unintentional lapse on his part about the PED declaration, which he denies strongly, at the inception of policy, the issue renders redundant once the policy has completed one year as per the clause of the policy. The fact of the matter is that pre-existing disease is covered from the second year onwards. His policy is running for the fifth year by now. The Clause of PED is valid when the conditions mentioned within is true (in this case, the completion of one year) irrespective of other non-related issues are derived and attached by the company to make it null and void. The insurance company has done a great injustice to a senior citizen. He appealed to the Grievance Cell of the Insurer for a review of the claim, for which no satisfactory reply was received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The complaint is dismissed.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0284/2015-16

Complaint No. KOC-G-044-1617-0571

Award passed on : 22.02.2017

MOHAN THOMAS Vs STAR HEALTH AND ALLIED INS. CO. LTD.

Repudiation of Medi Claim

The complainant is a Health Insurance policy holder of the respondent insurer for the period 2016-17. He was admitted to hospital for the treatment of Liver Cirrhosis. He preferred a claim with the respondent insurer. The Insurer denied the claim stating that the Liver Cirrhosis is caused by alcohol consumption and the policy excludes the alcoholic related treatment. Actually he does not consume alcohol and the treating doctor opined that the lever cirrhosis is caused by the excess consumption of Non-vegetarian food. So, He appealed to the Grievance Cell of the Insurer for a review of the claim, for which no satisfactory reply was received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim with all other benefits.

Decision : The complaint is dismissed.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0285/2015-16

Complaint No. KOC-G-048-1617-0467

Award passed on : 22.02.2017

Ms. Rince Vijayan Vs The National Insurance Co. Ltd.

Repudiation of Individual Mediclaim

The Complainant is covered under a Medi-claim Policy of the respondent Insurer. She was admitted in Amrita hospital on 9th August 2016. Initially the Cashless was approved for Rs.10,000.00 and subsequently on the date of discharge the TPA disallowed the same. After discharge from the Hospital, she preferred a claim with the TPA of the respondent Insurer with all required documents, but till date the claims was not settled. She appealed to the Grievance Cell of the Insurer for settling the claim, but they have not bothered even to reply her Grievance. Hence, she filed a complaint before this forum, seeking direction to the Insurer for admission of the claim.

Decision : The Respondent insurer is directed to Pay the hospitalisation charges.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0286/2015-16

Complaint No. KOC-G-049-1617-0544

Award passed on : 22.02.2017

Mr. M. R. Raveendran Vs The New India Assurance Co. Ltd.

Repudiation of Individual Mediclaim

The complainant is an agent of LIC of India and is covered under the group Mediclaim policy. The complainant has undergone inpatient treatment from 04.12.2015 to 06.01.2016(34 days) at Vayanadan Adivasi Paramparya Chikitsalayam for Rheumatoid Arthritis, Osteoarthritis and back pain. A claim was preferred with the Insurer for an amount of Rs. 61,400.00. All the necessary bills and discharge summary was also submitted to the Insurer. However the claim has been turned down by the Insurer stating that there was no need for hospitalization for this line of treatment. Aggrieved by this decision this complaint has been filed seeking the full eligible claim to be reimbursed.

Decision : The Respondent insurer is directed to Pay 50% eligible claim amt.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0287/2015-16

Complaint No. KOC-G-049-1617-0285

Award passed on : 22.02.2017

Mr. P.V. Michael Vs The New India Assurance Co. Ltd.

Repudiation of claim under an Individual Mediclaim policy

The complainant and his spouse are covered under a Group Medi-claim policy (No 120700/34/15/04/00000006) of the respondent Insurer, taken by his employer for their retired employees/spouse. His wife had undergone GLAUCOMA TREATMENT on 16/12/2015 and a claim for reimbursement of expenses was preferred with the TPA of the Insurer, for which no response was there till date. He appealed to the Grievance Cell of the Insurer for admission of the claim without further delay, for which also no response, even after 2 months. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The complaint is dismissed.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0288/2015-16

Complaint No. KOC-G-049-1617-0387

Award passed on : 22.02.2017

Mr. V.M. Joseph Vs The New India Assurance Co. Ltd.

Repudiation of claim under a mediclaim policy

The Complainant and his family are covered under a "Family Floater Medi-claim Policy of the respondent Insurer. His wife was hospitalized on 21/07/2015 for the treatment of "migraine'' and discharged on 23/07/2015. He preferred a claim with the TPA of the respondent Insurer along with necessary required documents, which was denied by stating that "treatment related to Psychiatric and Psychosomatic disorders'' is not payable and there is no active line of treatment. As his wife was 60 years old woman presenting with chronic and sever migraine associated with Thyroid disorders, the hospital has done certain routine investigations including Neuro and Psychiatric consultations. It was an outcome of the investigation that a condition called 'Dystymia' was also diagnosed. The treated doctor has certified that the insured has no Psychiatric problem and substantiates that the present hospitalization is for treatment of Chronic head ache and not for evaluation purpose only. He appealed to the Grievance Cell of the Insurer for a review of the claim, but they also concurred with the decision of the TPA. Hence, he filed a complaint before this forum, seeking direction to the Insurer for admission of the claim amounting to Rs.15,107/- after deducting Rs.300/- towards Psychiatric Consultation charges.

Decision : The Respondent insurer is directed to Pay hospital charges.

$$$$$$$

Award No. IO/KOC/A/GI/0289/2015-16

Complaint No. KOC-G-049-1617-0434

Award passed on : 22.02.2017

Mr. Gopalan Thampi Vs The New India Assurance Co. Ltd.

Partial repudiation of individual mediclaim

The Complainant and his wife are covered under a Medi-claim policy for a sum insured of Rs. 1 Lakh each, of the respondent Insurer. His wife was admitted in KIMS HOSPITAL Hospital, Trivandrum and a claim for reimbursement of expenses towards the treatment was preferred with the Insurer, which has been partially settled. Out of total claim for Rs.92,252/-the TPA/Insurer has settled only Rs.52032/-. He appealed to the Grievance Cell of the Insurer for admission of balance amount of the claim, for which no reply has been received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of balance amount of the claim.

Decision : The complaint is dismissed.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0291/2015-16

Complaint No. KOC-G-049-1617-0458

Award passed on : 22.02.2017

Mr. GEORGE JOSEPH Vs The New India Assurance Co. Ltd.

Repudiation of Individual Mediclaim

The complainant is covered under a Group Mediclaim policy of the respondent insurer, New India Assuarance Co. Ltd. The insurer has rejected his claim for reimbursement of post hospitalization mentioning the reason that they had cancelled the policy with effect from 21.01.2016 as per advice of the South Indian Bank and all claims up to that date was processed by them. The Post Hospitalization treatment pertains to his admission to hospital for the period 05.12.2015 to 06.12.2015. He preferred a claim for reimbursement of hospital expenses and got settled. The Post hospitalization claim dated 08.12.2015 also settled by the insurer. However, the Post hospitalization bill dated 06.01.2016 for Rs.100,000/- has not been settled. On his follow up, the insurer has advised him to approach the SIB, to whom the balance premium has been refunded as per agreement between them during cancellation of policy after processing all pending claims by the insurer up to 21/01/2016. He approached the south Indian Bank, but no reply received till date. In this context, the insurer is bound to reimburse the the post hospitalization bill as the same is within the period of 60 days after discharge from the hospital and the bill date is before the cancellation date of the policy, that is 21.01.2016. As per the terms and conditions of the policy, post hospitalization expenses up to 60 days shall be reimbursed. So, the repudiation of claim is not justifiable.

Decision : The Respondent insurer is directed to Pay hospitalisation bills Rs.100102/-.

$$$$$$$

Award No. IO/KOC/A/GI/0292/2015-16

Complaint No. KOC-G-049-1617-0491

Award passed on : 22.02.2017

Mr. C.M. THOMAS Vs The New India Assurance Co. Ltd.

Repudiation of Medi Claim

The complainant is holding a valid mediclaim policy with the respondent Insurer since last 16 years. The complainant was admitted to Believers Church Medical College and underwent surgery and incurred an expense of Rs145678/-. The entire bills along with the claim forms were sent to the TPA for which no reply has been received so far. A letter addressed to the grievance redresser of the Insurer was also sent on 05.11.2016, for which, again there is no response. This complaint has been filed seeking the full reimbursement of the claim incurred.

Decision : The Respondent insurer is directed to Pay eligible claim.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0293/2015-16

Complaint No. KOC-G-049-1617-0493

Award passed on : 22.02.2017

Mr. M.G. SUNILKUMAR Vs The New India Assurance Co. Ltd.

Repudiation of health insurance claim

The complainant holds a valid mediclaim policy from the respondent Insurer. The complainant underwent treatment at Aravind Eye Hospital , Coimbatore and had submitted all the documents for reimbursement of the claim. However the claim has been rejected without any reason. . Representation to the grievance cell of the Insurer did not elicit any response hence this complaint.

Decision : The Respondent insurer is directed to Pay eligible claim.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0294/2015-16

Complaint No. KOC-G-049-1617-0518

Award passed on : 22.02.2017

Mrs. VIDHYA RAMAKRISHNAN Vs The New India Assurance Co. Ltd.

Partial repudiation of individual mediclaim

Complainant is a Mediclaim Policy holder of the respondent insurer. She had undergone laparoscopic hysterectomy in P.V.S Hospital, Kaloor, Ernakulam. She preferred a claim under the policy. Out of total claim of Rs.114852.00, the Insurer has admitted the claim only for Rs.63541.00 and the balance amount of Rs.51311/is to be reimbursed. She was informed by the TPA/Insurer that the room rent eligibility is only 1% of the Sum Insured and ICU Charges are limited to 2% of sum insured and she has opted higher room rent than entitled category. Therefore the room rent and other hospital charges have been reimbursed in proportion to the entitled room category. Actually, the hospital has not overcharged in proportion to the room rent. She was allotted an ordinary room without air-conditioning and within the limit specified. A certificate obtained from hospital substantiates the same. She appealed to the Grievance Cell of the Insurer for review of the claim, for which satisfactory reply has not been received. Hence, she filed a complaint before this Forum, seeking direction to the Insurer for admission of the balance claim, based on actual facts.

Decision : The complaint is dismissed.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0296/2015-16

Complaint No. KOC-G-049-1617-0531

Award passed on : 22.02.2017

Mr. R.K. PANKAJAKSHAN Vs The New India Assurance Co. Ltd.

Delay in payment of claim under health insurance

The complainant holding a valid Mediclaim policy from the respondent Insurer was admitted to the Hospital on 25.05.2016 and discharged on 30.05.2016 after undergoing urgent surgery for Prostrate & hernia. The documents for the pre & post hospitalization expenses (Rs.10056.00) were sent to the TPA . However the claim is yet to be settled despite taking up with both the TPA & the respondent Insurer. Hence this complaint is filed seeking a direction for payment of the entire claim.

Decision : The Respondent insurer is directed to Pay eligible claim.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0298/2015-16

Complaint No. KOC-G-050-1617-0344

Award passed on : 22.02.2017

Mr. K.P. Saleem Vs The Oriental Insurance Co. Ltd.

Repudiation of claim under a mediclaim policy

The Complainant is covered under a Medi-claim policy (No 442200/48/2016/1886) of the respondent Insurer. He was hospitalized on 05/03/2016 for the treatment of ''Right Renal Stone +Left Hydronephrosis'', underwent surgery and discharged on 15/03/2016. A claim for reimbursement of expenses towards hospitalization was preferred with the Insurer, which has been partially settled. He appealed to the Grievance Cell of the Insurer for a review of the balance claim, for which no reply was received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the balance amount of the Claim.

Decision : The complaint is dismissed.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0299/2015-16

Complaint No. KOC-G-050-1617-0461

Award passed on : 22.02.2017

Mr. RAPHY ANTO KATTUMATH Vs The Oriental Insurance Co. Ltd.

Repudiation of Medi Claim

The Complainant holds PNB-Oriental Mediclaim policy, for him and his family members. The hospitalisation claim submitted in March 2016 for the treatment of his son, Mr. Rosario Raphy was partially settled and the claim pertaining to hospitalisation in August 2016 for his another son, Mr. Clement Raphy was not settled till date inspite of several reminders. The reason given for the partial repudiation of the claim by the insurer is that, when his son was treated for the same ailment in February 2013, the sum insured under the policy was only Rs.1 lakh. Actually, the sum insured under the earlier policy period i.e. in February 2013 is Rs. 2 lakh. So, the partial repudiation on this ground would not sustain. Similarly, the Insurer is holding back the settlement of the claim of Mr. Clement Raphy without assigning any reason. He appealed to the Grievance Cell of the Insurer for review of the claim, for which no satisfactory reply has been received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim, based on actual facts.

Decision : The complaint is Disposed off.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0300/2015-16

Complaint No. KOC-G-050-1617-0524

Award passed on : 22.02.2017

Mr. BALACHANDRAN PILLAI Vs The Oriental Insurance Co. Ltd.

Repudiation of Medi Claim

The complainant is insured along with his spouse under the Oriental Royal mediclaim Policy. His wife underwent treatment since 25th July 2016 for heavy bleeding. However due to the situation worsening despite the medications prescribed, his wife Smt Beena had to be hospitalized on the 4th August and after undergoing various tests and treatment discharged on 6th August 2016. While in the Hospital, a claim was made for Cashless hospitalization which was turned down by the TPA. On discharge from the hospital a claim was made for reimbursement of the hospital bill which was also turned down hence this complaint seeking a direction to the Insurer to pay the entire claim.

Decision : The complaint is dismissed.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0301/2015-16

Complaint No. KOC-G-050-1617-0520

Award passed on : 22.02.2017

Ms. ANNAMMA SIMON Vs The Oriental Insurance Co. Ltd.

Repudiation of Medi Claim

The complainant is having a mediclaim policy with the respondent Insurer since several years. She has preferred a claim on 05.08.2016 for inpatient treatment at KA Samajam Hospital, Maradu, Kochi from 06.07.2016 to 29.07.2016 (24 days). The hospital is run under the direct supervision of PNNM Ayurveda Medical College Hospital, Shoranur. Even though the entire papers were submitted the claim was repudiated citing Policy condition 2.1 which stated that "Hospitalisation expenses are admissible only when the treatment is taken as inpatient in a Government/Medical College Hospital". Even though the issue was taken up with the grievance redressal cell of the Insurer, the response was the same, hence this complaint is filed seeking the entire, genuine claim amount.

Decision : The Respondent insurer is directed to Pay the claim.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0302/2015-16

Complaint No. KOC-G-050-1617-0519

Award passed on : 22.02.2017

Mr. SIMON JOHN Vs The Oriental Insurance Co. Ltd.

Repudiation of Individual Mediclaim

The complainant is having a mediclaim policy with the respondent Insurer since several years. He has preferred a claim on 05.08.2016 for inpatient treatment at KA Samajam Hospital, Maradu, Kochi from 10.07.2016 to 28.07.2016 (19 days). The hospital is run under the direct supervision of PNNM Ayurveda Medical College Hospital , Shoranur. Even though the entire papers were submitted the claim was repudiated citing Policy condition 2.1 which stated that "Hospitalisation expenses are admissible only when the treatment is taken as inpatient in a Government/Medical College Hospital". Even though the issue was taken up with the grievance redressal cell of the Insurer, the response was the same, hence this complaint is filed seeking the entire , genuine claim amount.

Decision : The Respondent insurer is directed to Pay the claim.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0303/2015-16

Complaint No. KOC-G-050-1617-0477

Award passed on : 22.02.2017

Mrs. Vijayakumari Vs The Oriental Insurance Co. Ltd.

Partial repudiation of individual mediclaim

The Complainant has been holding valid mediclaim policies from the respondent Insurer since 2007. The present Sum insured is Rs.2Lakhs. The complainant was admitted to Aster MIMS Hospital, Kottakkal on 31.01.2016 due to severe heart attack and underwent treatment. Bills to the tune of Rs1.6lakhs was submitted to the insurer for reimbursement (hospital Bill for Rs1.25 and the balance of post hospitalization Bills). However the Insurer has only paid Rs.90000.00 as cashless directly to hospital. On taking up the matter with the insurer for the balance reimbursement as the Sum Insured was Rs.2 Lakhs resulted in the Insurer paying an additional amount of Rs.9000.00. Further representations did not elicit any response from the Insurer, hence this complaint.

Decision : The complaint is Disposed off.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0305/2015-16

Complaint No. KOC-G-050-1617-0439

Award passed on : 22.02.2017

Mr. M K VARGHESE Vs The Oriental Insurance Co. Ltd.

Repudiation of Individual Mediclaim

The Complainant has taken a Health Insurance policy from Oriental Insurance Co. Ltd. The Policy commenced for the first time on 12/11/2013. On 14-06-2016 he was admitted at V.G.SARAF Hospital and treated for Chest pain. To undergo Angiogram he got admitted at Lissy Hospital on 03-07-2016 and on evaluation 3 blocks in heart was detected. The treating doctor advised surgery. To get a second opinion he got admitted at Rajagiri hospital on 10-07-2016 and as per the expert opinion of the treating doctor it was decided not to undergo surgery. Thereafter, he is undergoing E.E.C.P treatment at Indira Gandhi hospital. He was not aware of his heart disease till he was hospitalised due to chest pain. It is a common knowledge that anybody who crosses 70 years of age shall have life style ailments like high B.P, DM, High Cholestrol etc. The insurer has not asked him to undergo pre-enrolment medical test too. The Respondent insurer rejected the claim giving reason of suppression of material fact that his past medical history of Cardiac ailment, HTN, DM etc were not informed to the insurer during submission of proposal form on 12th November 2013. According to the insured, the present ailment was not pre-existing. So, he is eligible for the claim. The matter was represented to the Grievance cell of the insurer, but in vain. Hence, he filed a complaint before this Forum.

Decision : The Respondent insurer is directed to Pay the claim.

$$$$$$$

Award No. IO/KOC/A/GI/0307/2015-16

Complaint No. KOC-G-050-1617-0566

Award passed on : 22.02.2017

SURESH S Vs The Oriental Insurance Co. Ltd.

Repudiation of Medi Claim

The complainant's wife is covered under a mediclaim policy of the respondent insurer for a sum insured of Rs.50,000.00 since January 2011. The Sum Insured under the policy was enhanced from Rs.50,000.00 to 5 Lakh, while renewing the policy in January 2015. On 11.04.2016 she consulted a doctor for the treatment of her leg pain and as advised by the doctor she has undergone Ultrasound scan. As per the scan report an abdominal mass was detected and she got admitted in the hospital for the period from 25.04.2016 to 04.05.2016 to undergo surgery. The Biopsy report after the surgery confirmed her ailment as Cancer and she has undergone Chemotherapy form 13.06.16 to 03.10.16. Subsequently she has undergone radiation therapy from 07.11.2016 to 16.12.2016. The complainant preferred a claim for the present treatment. The Insurance company informed him that their limit of liability is restricted to the original sum insured of Rs.50,000.00only. Since the current sum insured is Rs.5Lakh and the present ailment was not pre-existing prior to enhancement of sum insured, his wife is eligible for the full reimbursement of her claim. He appealed to the Grievance Cell of the Insurer for a review of the claim, for which no satisfactory reply was received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The Respondent insurer is directed to Pay eligible claim.

$$$$$$$

Award No. IO/KOC/A/GI/0312/2015-16

Complaint No. KOC-G-044-1617-0466

Award passed on : 22.02.2017

Mr. ACHUTHANKUTTY.P Vs STAR HEALTH AND ALLIED INS. CO. LTD.

Delay in settlement of claim

The complainant is a senior citizen over 72, holding the Senior Citizens Red Carpet Policy over 5 years. According to him this is the first claim he ever put up that too on account of abrupt collapse at home and subsequent hospitalisation. All the documents required by the insurer have been submitted. The Insurer demanded the papers one after another and he found it difficult to fetch and submit the same in instalments. He submitted all documents required by the Insurer and Inspite of the aforesaid hardship he never got a response or an acknowledgement to his email messages and telephone calls. He addressed emails to Sr. GM of the insurer stating his grievance, but in vain. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim, based on actual facts.

Decision : The Respondent insurer is directed to Pay Rs.650/- towards post hospitalisation benefit.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0317/2015-16

Complaint No. KOC-G-048-1617-0560

Award passed on : 22.02.2017

Mrs. Geetha Aravindan Vs The National Insurance Co. Ltd.

Repudiation of Medi Claim

The complainant is a Mediclaim Policy holder of the respondent insurer. She was admitted to hospital on23.11.2015 and undergone treatment for severe vertigo and vomiting. She preferred a claim with the insurer which was rejected by stating that she has been taking medicines like tinnicar for tinnitus much before hospitalisation. The allegation of the aforesaid oral medication/treatment is baseless and her genuine claim has been rejected by the insurer on flimsy ground. She appealed to the Grievance Cell of the Insurer for a review of the claim, for which no satisfactory reply was received. Hence, she filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The Respondent insurer is directed to Pay the hospitalisation charges.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0319/2015-16

Complaint No. KOC-G-050-1617-0481

Award passed on : 22.02.2017

Mr. Sajith M.K Vs The Oriental Insurance Co. Ltd.

Partial repudiation of individual mediclaim

Complainant is a Mediclaim Policy holder of the respondent insurer. He underwent a surgery, Stapedotomy at Dr, Manoj's ENT centre Calicut. He preferred a claim under the policy. Out of total claim amount of Rs.74694.00, the Insurer has admitted the claim only for Rs.44743.00 and the balance amount of Rs.29951.00had to be reimbursed. He was informed by the TPA/Insurer that the room rent eligibility is only Rs.1000.00per day (1% of the Sum Insured) and therefore the room rent and other expenses were proportionately reduced. The hospital has not changed the treatment and procedural charges in proportion to the room rent and the total amount for surgery and other related expenses will be the same irrespective of the class of room. In the present case, the room rent charged is Rs. 1500.00 which is the lowest room rent prevailing in this hospital. The insurer should have cut short of excess amount of Room rent of Rs.500.00 only per day; Instead, insurer has deducted proportionately all other charges (except Medicines), which is quite illogical and unjustifiable. Further, Rs.2200.00 towards consumable & disposables and Rs.9000.00 in respect of Establishment charges were not reimbursed. On appeal to the Grievance Cell of the Insurer, Being not satisfied with the reply, he filed a complaint before this Forum, seeking direction to the Insurer for admission of balance amount of the claim.

Decision : The complaint is dismissed.

$$$$$$$

Award No. IO/KOC/A/GI/0320/2015-16

Complaint No. KOC-G-050-1617-0507

Award passed on : 22.02.2017

Mr. SHAJI N RAJ Vs The Oriental Insurance Co. Ltd.

Repudiation of Medi Claim

The complainant is holding a valid Mediclaim policy from the respondent Insurer . He has taken this from 2010 onwards. The complainants father (also covered under the policy) has undergone treatment for eye (intravitrial injection of Accentrix). A claim (of Rs31608.00) was submitted to the Insurer who has repudiated the claim citing Exclusion clause no 4.2 that such treatment is not covered under scope of policy. Representation to the Insurer against this decision did not bring forth any relief, hence this complaint has been preferred.

Decision : The Respondent insurer is directed to Pay the eligible claim.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0321/2015-16

Complaint No. KOC-G-050-1617-0521

Award passed on : 22.02.2017

Mrs. B. SUDHERMA Vs The Oriental Insurance Co. Ltd.

Partial repudiation of individual mediclaim

The complainant is covered under a mediclaim policy of the respondent insurer since the year 2000. The complainant was admitted to hospital from 16.02.2016 to 18.02.2016 and a claim was filed with the Insurer for reimbursement on 11.03.2016. The Insurer did not pay the claim. A further hospitalisation also happened for the same ailment from 18.05.2016 to 20.05.2016. All the original reports, discharge summary and the original bills based on which payments were made were sent by courier to the TPA on 07.06.2016. However the Insurer has finally sent a letter in 12/2016 that the claim is not payable as the original bills were not submitted. The complainant avers that the repudiation is not justifiable as the bills available with her were sent for claim reimbursement. Hence this complaint before this forum claiming the eligible benefits under the two claims.

Decision : The complaint is Disposed off.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0322/2015-16

Complaint No. KOC-G-050-1617-0464

Award passed on : 22.02.2017

Mr. SUMESH KUMAR M Vs The Oriental Insurance Co. Ltd.

Repudiation of health insurance claim

The Complainant is covered under a Medi-claim policy of the respondent Insurer. He was admitted in the hospital on12/08/2016 as he has suffered difficulty to walk or sit. A claim for reimbursement of expenses towards hospitalization was preferred with the TPA of the Insurer, which has been denied by stating that "the treatment undergone was conservative management doing physiotherapies and oral medication. The admission in the hospital was for management of ailment and there was no active line of treatment". He was admitted in the hospital as per the advice of the treating doctor. He appealed to the Grievance Cell of the Insurer for a review of the claim, for which no satisfactory reply has been received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The Respondent insurer is directed to Pay eligible claim.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0323/2015-16

Complaint No. KOC-G-050-1617-0465

Award passed on : 22.02.2017

Mr. SANKARANKUTTY.P Vs The Oriental Insurance Co. Ltd.

Repudiation of Individual Mediclaim

The Complainant and his family are covered under a Medi-claim policy of the respondent Insurer. He was hospitalized for 2 days for the treatment of Macular tributary vein occlusion, Multinodular goitre, Dyslipidemia, Old TIA and discharged. A claim for reimbursement of expenses towards hospitalization was preferred with the Insurer, which has been denied by stating that "Admission and evaluations as such were not followed by any active line of treatment''. He appealed to the Grievance Cell of the Insurer for a review of the claim, for which the reply was not satisfactory. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The Respondent insurer is directed to Pay eligible claim.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0324/2015-16

Complaint No. KOC-G-044-1617-0504

Award passed on : 22.02.2017

Mr. S. GOPINATHAN Vs STAR HEALTH AND ALLIED INS. CO. LTD.

Partial repudiation of health insurance claim

The complainant is a Senior citizen holding a valid Senior citizens Red Carpet Policy from the respondent Insurer. He was admitted on 06.07.2016 for removal of cyst and due to certain other complications had to stay in hospital till 25.07.2016. The entire expenses came to Rs. 4.75 lakhs and the Insurer has assessed the eligible claim to be Rs4,22,480.00 however only a reimbursement of Rs 96125.00 has been settled so far. The reduction from the eligible claim has been made as per the co payment clause which has not been properly explained by the agent. On obtaining the details of the settlement, it is seen that the claim has not been correctly settled hence the matter was again represented before the Insurer. A complaint was further preferred with the IRDA also. However no reply has been received so far. This complaint is filed seeking settlement of the claim as per the terms of the policy, compensation for delay in settling claim and reimbursement of expenses for taking up this complaint.

Decision : The Respondent insurer is directed to Insurer to pay Rs.103875/-.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0325/2015-16

Complaint No. KOC-G-044-1617-0459

Award passed on : 08.03.2017

Mrs. RASIABI Aboobacker Vs STAR HEALTH AND ALLIED INS. CO. LTD.

Partial repudiation of health insurance claim

The Complainant is covered under a Senior citizen red carpet Policy of the respondent Insurer, for the last 9 years. Her hospitalization claim to undergo a surgery for knee replacement due to Osteo-arthritis, as ligaments were irreparably damaged, was partially settled by the Insurer alleging that the ailment is a pre-existing disease. The Insurer has reimbursed only Rs.79,234.00 out of the total hospital bill of Rs.2,18,750.00. The insured further submitted that the Osteoarthritis for which the surgery has been done was not a pre-existing disease at the time of availing the policy. She was diagnosed for Osteoarthritis only in the year 2015 and there is a clear mention of it in the discharge summary. The medical report issued by Lakeshore Hospital in the year 2011 would show that she was not having Rheumatoid Arthritis also. So, the rejection of claim amount of Rs.1,39,246.00 is improper and illegal. She appealed to the Grievance cell of the insurer but the reply was not satisfactory. Hence, she filed a complaint before this forum, seeking direction to the Insurer for admission of balance amount also towards the claim.

Decision : The Respondent insurer is directed to pay the difference in eligible claim.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0326/2015-16

Complaint No. KOC-G-003-1617-0604

Award passed on : 27.03.2017

Mr. Jayaraj.G Vs Apollo Munich Health Ins.

Repudiation of Medi Claim

Complainant and his family are covered under the health Insurance policy of the respondent Insurer for Rs.5 Lac for the last 3years continuously. His wife was admitted in the hospital on 27.12.2016 and underwent excision biopsy for the cystic lesion in the maxilla under general anesthesia on 28.12.2016. He preferred a claim from the respondent Insurer which was denied stating that the Dental treatment is excluded under the policy. The medical records and discharge summary clearly establishes that the present claim is not for Dental Treatment. The Insurance Company has not gone through the Discharge Summary and other medical records while repudiating the claim. The Medical report from the treating surgeon, Biopsy Reports submitted by the doctor and discharge summary were submitted to the Insurer. He approached the Grievance cell of the company, but no satisfactory reply received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The Respondent insurer is directed to Pay eligible claim.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0327/2015-16

Complaint No. KOC-G-003-1617-0664

Award passed on : 27.03.2017

Mr. M. Gopinathan Nambiar Vs Apollo Munich Health Ins.

Repudiation of health insurance claim

The Complainant is covered under a Group Medi-claim Insurance policy of the respondent Insurer with effect from24.10.2015. Subsequently the policy was renewed up to 23.10.2016. On 05.01.2016 he underwent surgery for Left eye for Cataract. His claim for the same was repudiated by the Insurance Company by stating that he had not disclosed his history of surgery of Coronary artery bypass grafting at the time of submitting the proposal form and hence claim stands repudiated due to non-disclosure and concealment of facts as per policy terms and conditions. Complainant submitted that he had handed over the Discharge summary of his treatment at Amrita Hospital, Ernakulum in the year 2003 with respect to Coronary Artery Disease and after verifying the same at the time of filling the proposal, the agent of the insurance company has categorically informed him that the questionnaire in the proposal form sought for disclosure of treatment or surgery for internal organs that took place within 5 years from the date of proposal and not necessary to disclose any disease or treatment undertook beyond 5 years. In fact the proposal was filled up by the agent and he has only affixed signature. Hence, he had not suppressed any material fact. The Insurer has also cancelled his policy on 23.03.2016. He appealed to the Grievance Cell of the Insurer for a review of the balance amount of the claim, for which the reply was not satisfactory. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of balance amount of the claim.

Decision : The Respondent insurer is directed to Pay eligible claim.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0328/2015-16

Complaint No. KOC-G-038-1617-0657

Award passed on : 27.03.2017

Mr. Krishna Hari Vs Royal Sundaram Alliance Insurance Co. Ltd.

Repudiation of health insurance claim

Complainant and Ms. Pavithra Krishnan are covered under a health policy of the respondent Insurer. Ms. Pavithra Krishnan was admitted in the hospital for Laparoscopic Cholecystecomy. Complainant preferred a claim with the respondent Insurer which was denied by them stating that during the first year of the policy any expenses incurred towards the following disease/ surgical procedures are not covered “stones in the Urinary and Biliary systems”. Ms. Pavithra Krishnan was not suffering from the aforesaid ailment prior to the inception of policy. Despite her being an ideal candidate for an exception to the first year exclusion, she has been denied her claim. He approached the Grievance cell of the company, but no satisfactory reply received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The complaint is dismissed.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0330/2015-16

Complaint No. KOC-G-044-1617-0600

Award passed on : 27.03.2017

Mr. K.V. Asharaf Vs Star Health and Allied Ins. Co. Ltd.

Repudiation of health insurance claim

Complainant and his family are covered under the health policy of the respondent insurer since may 2010. His daughter was admitted in the hospital for the first time on 22.11.2014 due to sudden Vertigo. The insurer has settled 5 claims for the same ailment till May 2015. Subsequently, he preferred the sixth claim of Rs.2 Lakh from the Insurance Company which was rejected stating the Non-disclosure of material fact at the time of proposing Insurance. Later on, the insurer deleted his daughter from the coverage and refunded the premium in respect of the same. His daughter had suffered aforesaid ailment only in 2014, i.e. after 4 year of inception of policy. He appealed to the Grievance Cell of the Insurer for a review of the claim, for which Insurance Company did not give any reply. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The complaint is dismissed.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0331/2015-16

Complaint No. KOC-G-044-1617-0652

Award passed on : 27.03.2017

Mr. S. Rajendradas Vs Star Health and Allied Ins. Co. Ltd.

Repudiation of health insurance claim

Complainant is covered under a health Insurance policy of the respondent Insurer. He was admitted in the hospital and undergone a surgery. He preferred a claim from the respondent insurer. The denied the claim stating the reason that the he had not disclosed Pre-existing disease. Actually, he was not having any ailment while proposing for Insurance. In 2010, he had undergone surgery due to stomach pain after laparoscopic diagnosis. At that time, to rule out Crohn's disease, the doctor had advised laparoscopy. Subsequently, crohn's disease was ruled out. He has not undergone any treatment for aforesaid ailment. Hence, repudiation of claim regarding pre-existence of crohn's disease is unjustifiable. Even now he is ready to undergo any test to prove that he is not a crohn's disease patient. The medical record which the insurer used to repudiate his claim was submitted by him voluntarily. This proves that there is absolutely no intention of any mala fides on the part of him. He approached the Grievance cell of the company, but no satisfactory reply received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The complaint is dismissed.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0332/2015-16

Complaint No. KOC-G-044-1617-0661

Award passed on : 27.03.2017

Mrs. Sangeetha Anil Vs Star Health and Allied Ins. Co. Ltd.

Repudiation of health insurance claim

Complainant's son, Mr. Vignesh Anil was covered under a health Insurance policy of the respondent Insurer. He was admitted in the hospital for the treatment of an accident occurred while he was playing football on 05-05-2015. Complainant preferred a claim from the respondent Insurer which was denied stating that the treatment records reveal the history of alleged fall on January 2012, which was a pre-existing condition and to become eligible for the pre-existing ailment 48 months of continuous coverage have to be elapsed, and the insured has suppressed the material fact while proposing for Insurance which makes the policy void. Complainant agrees that it is true that her son had a small fall in January 2012 while parking a two wheeler and not from a running vehicle. He was never admitted in the hospital nor had any continuous treatment even for a week. Therefore there is no suppression of material fact nor pre-existing disease. She approached the grievance cell of the company, but no satisfactory reply received. It is understood that the Grievance cell of the Insurance Company does not consist a Medical practitioner, so, their decision is questionable. Hence, she filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The Respondent insurer is directed to Settle the claim.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0333/2015-16

Complaint No. KOC-G-044-1617-0595

Award passed on : 27.03.2017

Mrs. Aneyamma Varghese Vs Star Health and Allied Ins. Co. Ltd.

Repudiation of health insurance claim

The complainant and her husband are covered under a Health policy of the respondent Insurer. Her husband was treated in hospital for the treatment of Diabetes. She preferred a claim with the Insurer, which was denied by the respondents stating that the treatment was for Diabetes which is a pre-existing illness. Further the policy was cancelled by the respondent insurer stating there was suppression of pre-existing illness. She appealed to the Grievance Cell of the Insurer for a review of the claim, for which the reply was not satisfactory. Hence, she filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The Respondent insurer is directed to renew the policy for complainant & husband.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0334/2015-16

Complaint No. KOC-G-044-1617-0620

Award passed on : 27.03.2017

Mr. K Rajesh Kumar Vs Star Health and Allied Ins. Co. Ltd.

Repudiation of health insurance claim

Complainant's wife is covered under a Health Insurance Policy of the respondent Insurer. She had an accidental slip and fall in the kitchen one week earlier to the hospitalization at AKG Hospital, Kannur. As there was no relief with the treatment she has undergone surgery at KMC Hospital Manipal. Complainant preferred a claim with the respondent Insurer which was rejected on flimsy ground. He approached the Grievance cell of the company, but no satisfactory reply received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The complaint is dismissed.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0335/2015-16

Complaint No. KOC-G-044-1617-0679

Award passed on : 27.03.2017

Mr. M.R. Nelson Vs Star Health and Allied Ins. Co. Ltd.

Repudiation of Medi Claim

The complainant holding a valid Health insurance policy was hospitalised on 11.09.2016 at Gaurishankar Hospital , Kodungalloor due to chest pain. The complainant was discharged on 13.09.2016 after having settled a bill of almost Rs12000/-. A claim was preferred with the Insurer which has been rejected citing the reason that the ailment for which treatment was taken is listed under the two year exclusion clause. Appeal to the Insurer to settle the claim did not have any positive result, hence this complaint.

Decision : The complaint is dismissed.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0336/2015-16

Complaint No. KOC-G-044-1617-0585

Award passed on : 27.03.2017

Mr. K. Valsan Vs Star Health and Allied Ins. Co. Ltd.

Partial repudiation of health insurance claim

Complainant and his family is covered under the Health Policy Issued by the respondent Insurer. He was admitted in the hospital on 7th November 2016 for Rotator cuff repair surgery (Shoulder surgery). He was discharged from hospital on 10th November 2016 after surgery. The insured preferred a claim with the insurer for Rs.1,63,679.00, towards which the insurer has reimbursed only Rs.1,27,051.00. Further, his Physiotherapy bill was also not reimbursed. He has undergone physiotherapy for 3 months, as advised by the treating doctor. Therefore, the insurer has to reimburse the difference in hospitalisation claim and Physiotherapy bill. He appealed to the Grievance Cell of the Insurer for a review of the claim, for which Insurance company did not bother even to reply. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.(scn not filed).

Decision : The Respondent insurer is directed to Pay Rs.1800/- + 300/-.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0337/2015-16

Complaint No. KOC-G-044-1617-0649

Award passed on : 27.03.2017

Mr. Jesin K Jose Vs Star Health and Allied Ins. Co. Ltd.

Repudiation of health insurance claim

This is a complaint filed under Rule 12(1)b read along with Rule 13 of RPG Rules 1998. The complaint is Repudiation of health insurance claim. The complainant, Mr. Jesin K Jose is the policyholder. Before conducting hearing, the Insurance Company settled the case for an amount of Rs.25,000/- vide NEFT No.Q0123615 dated 23.03.2017 in full and final settlement of the claim and the complainant accepted it.

Decision : The complaint is Disposed off.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0338/2015-16

Complaint No. KOC-G-044-1617-0674

Award passed on : 27.03.2017

Mr. Sajeev A.K Vs Star Health and Allied Ins. Co. Ltd.

Repudiation of health insurance claim

The Complainant is covered under a Health policy of the respondent Insurer. He was hospitalized on 19/'01/2016 for the treatment of Kidney disease and renal transplant discharged on09/02/2016 . He preferred a claim with the Insurer, which was rejected stating that the policy does not extend coverage for any expenses related to pre-existing ailments. He appealed to the Grievance Cell of the Insurer for a review of the claim, for which the reply was not satisfactory. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The complaint is dismissed.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0339/2015-16

Complaint No. KOC-G-031-1617-0622

Award passed on : 27.03.2017

Ms. Ramani Prabhakaran Vs Max Bupa Health Insurance Co. Ltd.

Repudiation of health insurance claim

Complainant is covered under a health Insurance policy of the respondent Insurer. She was admitted in the hospital on 21/08/2016 and treated for Acute Heart failure. She never knew about her heart ailment till she was admitted in the hospital for the present treatment. No doctor has ever diagnosed with the above problem nor was she admitted in the hospital to take treatment for the same in the past. She approached the Grievance cell of the company, but no satisfactory reply received. Hence, she filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The Respondent insurer is directed to Settle the claim.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0340/2015-16

Complaint No. KOC-G-031-1617-0599

Award passed on : 27.03.2017

Ms. Anuja Kumari K.S Vs Max Bupa Health Insurance Co. Ltd.

Repudiation of health insurance claim

Complainant is covered under the Health Policy of the respondent Insurer, with effect from 29/03/2015. On 06/06/2015 she suffered ligament injury due to a slip fall and treated as out patient in the casuality ward of the Pushpagiri Hospital. Since there was no recovery, as per the doctor's advice MRI of Left Knee was taken on15/07/2015 from Pushpagiri hospital. She has undergone Op treatment at the same hospital up to 24/02/16. As there was no major relief from the OP Treatment she got admitted at Specialist Hospital for further treatment. She preferred a claim from the insurance company which was denied by the Insurer stating that as per medical records of the specialist hospital the past history of injury was mentioned as 8 months back i.e. prior to the commencement of policy. Only after receiving the said communication, she realised the error crept in the hospital records and approached the hospital to find out the reason for the error in their records. The Specialists hospital verified the records of Pushpagiri hospital and got convinced about the inadvertent error on their part and explained the same in the form of a certificate. To substantiate the actual date of slip fall she submitted the documents of Pushpagiri hospital, form where she had undergone OP treatment, to the insurer. But, the insurer did not bother to go through the same. She appealed to the Grievance Cell of the Insurer for a review of the claim, for which Insurance company did not give satisfactory reply. Hence, she filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The Respondent insurer is directed to Settle the claim.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0341/2015-16

Complaint No. KOC-G-031-1617-0590

Award passed on : 27.03.2017

Mr. Satheesh. P Vs Max Bupa Health Insurance Co. Ltd.

Repudiation of Medi Claim

Complainant is covered under a health policy of the respondent Insurer. He has undergone Angioplasty and preferred a claim for Rs.1,35,883/- from the respondent Insurer. After one and half year later, The Insurer denied the claim stating that non-disclosure of material fact while taking the policy and informed that they are terminating the policy. Actually, he has specifically indicated that he has been taking medicines for hypertension and cholesterol, to the doctor, who has done his medical examination. He appealed to the Grievance Cell of the Insurer for a review of the claim, for which Insurance company did not give satisfactory reply. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The Respondent insurer is directed to Settle the claim.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0342/2015-16

Complaint No. KOC-G-048-1617-0675

Award passed on : 27.03.2017

Mr. D.V. Sajeevan Vs The National Insurance Co. Ltd.

Repudiation of Medi Claim

The complainant's wife covered under a valid mediclaim policy was hospitalised from 05/09/2015 to 08/09/2015. On a request for cashless, no positive reply was received from the insurer or the insurance desk at the hospital and hence on discharge the entire amount was paid by the complainant. Actually, the insurer had approved a cashless limit of Rs. 5000/- which was not made known to the complainant or to the patient, nor was adjusted against the bill. However this fact came to the knowledge of the complainant in 2016 and a claim was made to the insurer in 11/2016. This was denied citing inordinate delay in submission of claim. Appeals were preferred which was turned down, hence this complaint seeking settlement of the full claim.

Decision : The Respondent insurer is directed to Partial Settlement.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0343/2015-16

Complaint No. KOC-G-048-1617-0669

Award passed on : 27.03.2017

Mr. Sali Mathew Vs The National Insurance Co. Ltd.

Repudiation of Medi Claim

Complainant and family are covered under a health policy of the respondent Insurer. His daughter was admitted in the hospital for treatment of wheeze. He preferred a claim from the respondent Insurer which was denied stating that "claim is denied on the ground that the patient had several admission for same ailment i.e, Broncho Pnewmonia and the history of wheez started at the age of 4 months. Hence as per policy exclusion clause all disease/injuries which are pre-existing when the cover incepts for the first time is excluded. However these disease will be covered after four continuous claim free policy years." But, the insurance company had settled similar claims earlier for the same treatment. He approached the Grievance cell of the company, but no satisfactory reply received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The Respondent insurer is directed to Settlement.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0344/2015-16

Complaint No. KOC-G-050-1617-0617

Award passed on : 27.03.2017

Mr. Sukumaran M.K Vs The Oriental Insurance Co. Ltd.

Repudiation of Medi Claim

Mr. M.K. Sukumaran (G) The Complainant and his family are covered under a Group Medi-claim policy of the respondent insurer, taken by his employer. He was hospitalized for the treatment of Type 2 DM during the period from 01/08/2016 to 04/08/2016. He preferred a claim with the TPA of the Insurer, which was denied by stating that the evaluation as such was not followed by any active line of treatment other than conservative regimen and admission for evaluation is exclusion as per Clause No.4.10 of the policy conditions. He appealed to the grievance Cell of the Insurer for a review of the claim, for which no reply has been received till date. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The Respondent insurer is directed to Settlement - Rs.4406/-.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0345/2015-16

Complaint No. KOC-G-049-1617-0668

Award passed on : 27.03.2017

Mr. Antony Sigbert Dcouto Vs The New India Assurance Co. Ltd.

Partial repudiation of individual mediclaim

The Complainant is covered under a Medi-claim policy of the respondent Insurer. He is undergoing "Haemodialysis" treatment at Medical Trust Hospital, Ernakulam and a claim for reimbursement of expenses towards the treatment was preferred with the Insurer, which has been partially settled. Out of total claim for Rs.64181/-the TPA/Insurer has settled only Rs.45000/-.He appealed to the Grievance Cell of the Insurer for admission of balance amount of the claim, for which no reply has been received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of balance amount of the claim.

Decision : The Respondent insurer is directed to Settlement.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0346/2015-16

Complaint No. KOC-G-049-1617-0587

Award passed on : 27.03.2017

Mr. Jins Jose Vs The New India Assurance Co. Ltd.

Repudiation of Medi Claim

Complainant and his family are covered under a family health policy. The policy covers maternity benefit and he preferred maternity claim of his wife from the respondent insurer. The insurer denied the claim stating that the claim in respect of delivery for only first two living children will be considered in respect of any one insured person covered under the policy. Those Insured person who are already having two or more living children will not be eligible for this benefit, even if they have not claimed for their earlier confinements. However, the same circular based on which the claim was repudiated clearly provides cover for the present maternity claim for the third child, because the earlier maternity of his wife was for twins. The circular reads as "However delivery of twins shall be treated as a Maternity claim for single child". He appealed to the Grievance Cell of the Insurer for a review of the claim, for which Insurance company did not bother even to reply. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The Respondent insurer is directed to Settlement.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0347/2015-16

Complaint No. KOC-G-049-1617-0634

Award passed on : 27.03.2017

Mr. George P.I Vs The New India Assurance Co. Ltd.

Repudiation of Medi Claim

The complainants wife covered under the family floater mediclaim policy was hospitalised for a minor surgery 09.09.2016.The insurer has denied cashless facility and complainant was asked to submit the bills for claim reimbursement. However even after submission of the documents, the claim was not paid. On persistent enquiries, the Insurer has settled the claim for Rs.12220/-. Repeated appeals for the payment of difference in amount did not bring any relief, hence this complaint seeking the settlement of the full claim made of Rs12469/- by reimbursing the balance amount with interest.

Decision : The complaint is dismissed.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0348/2015-16

Complaint No. KOC-G-044-1617-0581

Award passed on : 27.03.2017

Mrs. Preethi Reji Vs Star Health and Allied Ins. Co. Ltd.

Repudiation of health insurance claim

The complainant, Mrs Preeth Reji is covered under a health policy of the respondent Insurer. She is admitted to hospital and undergone surgery for the removal of Soft Tissue Tumor Right Upper Thigh. She preferred a claim with the insurer which was denied. The aforesaid ailment occurred suddenly and is not having any past history. She appealed to the Grievance Cell of the Insurer for a review of the claim, for which no satisfactory reply was received. Hence, she filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The complaint is dismissed.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0349/2015-16

Complaint No. KOC-G-050-1617-0683

Award passed on : 27.03.2017

Mr. Pradeep Manjali Vs The Oriental Insurance Co. Ltd.

Repudiation of Medi Claim

Complainant and his family are covered under Happy Family Floater Policy of the respondent Insurer. His son aged 5 years was admitted in the hospital for the difficulty in passing urine. The treating doctor advice his son underwent Circumcision. He preferred a claim from the respondent Insurer which was denied stating that as per policy exclusion clause 4.8, "congenital external disease or defects or anomalies" are excluded from the scope of the policy. Since the Circumcision has been to treat an ailment, the Insurance Company has to settle the claim of Rs.9162/-only. He approached the Grievance cell of the company, but no satisfactory reply received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the balance claim from the Buffer amount available for him.

Decision : The Respondent insurer is directed to Pay eligible claim.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0350/2015-16

Complaint No. KOC-G-049-1617-0616

Award passed on : 27.03.2017

Mrs. Lissie Renee Gloria Vs The New India Assurance Co. Ltd.

Repudiation of Medi Claim

Dr.Lissie Renee Gloria (G) The complainant and her spouse are covered under a Medi-claim policy of the respondent Insurer taken in 1999, for which no claim has been raised till 2015. Now, she is undergoing regular treatment for ARMD, since October, 2015. She submits that the illness requires regular check-up and treatment since it can progress to blindness as age advances. She preferred 5 claims with the TPA of the Insurer at frequent intervals, out of which 2 claims were rejected as NO claim. On an appeal to the Grievance Cell of the Insurer, she was informed that 4 claims were rejected as No claim and one claim for which the treatment was taken from "Sreedhareeyam Ayurvedic Hospital" for the period from 08/04/2016 to 22/04/2016, they sought the opinion of their Mumbai Office as the same number is allotted for 2 different claims by their office in Chennai. Being not satisfied with the reply, she filed a complaint before this Forum, seeking direction to the Insurer for admission of all the 4 claims.

Decision : The Respondent insurer is directed to Pay eligible claim.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0351/2015-16

Complaint No. KOC-G-049-1617-0629

Award passed on : 27.03.2017

Mr. P.R. Shaji Vs The New India Assurance Co. Ltd.

Repudiation of Medi Claim

The complainant and his family are covered under a Mediclaim policy of the respondent insurer. His wife had undergone treatment for ovary removal in the Lakeshore hospital and incurred hospital expenses of Rs.236738/-. He preferred a claim with respondent Insurer for the full amount of claim. The Insurer has paid only Rs.50,000/-. On enquiry the insurer stated that a waiting period of 24 months is to be completed to consider the enhanced sum insured of Rs.2.50 lac as he had enhanced the sum Insured from Rs.50,000/- to 3 lac. To complete 2 years of waiting period only 6 days were left. The Insurer had not explained the policy clause of 4.3.1(1) while he approached for enhancement of sum Insured. Partial repudiation of the claim due to the aforesaid reason is unjustifiable. He approached the Grievance cell of the company, but no satisfactory reply received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The complaint is dismissed.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0352/2015-16

Complaint No. KOC-G-049-1617-0655

Award passed on : 27.03.2017

Ms. T.R. Girijakumari Vs The New India Assurance Co. Ltd.

Repudiation of Medi Claim

The complainant holding a valid Insurance policy was hospitalised from 08.04.2016 to 11.04.2016 with complaints of increased burning sensation and numbness of bilateral feet and toes since two weeks. A claim for Rs48905/-was preferred which was denied stating that admission was for taking injections and it was not covered under day care procedures. Once again an appeal was made , however the claim was repudiated citing reason as “not listed under day care procedure”. Various representations were made to the regional office of the insurer as also the head office which was not responded to hence this complaint seeking the full claim and also the reasons for rejection of claim.

Decision : The Respondent insurer is directed to Pay eligible claim.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0353/2015-16

Complaint No. KOC-G-049-1617-0656

Award passed on : 27.03.2017

Mr. V. Gopalakrishna Pai Vs The New India Assurance Co. Ltd.

Repudiation of Medi Claim

Complainant is covered under a health policy of the respondent Insurer. He underwent Intravetrial Injection of Accentrix as a Day care procedure on 24.05.2016 and submitted his claim with the Insurer. Insurer denied the claim stating that as per Policy clause 4.4.23 treatment for age related Macular Degeneration (ARMD) is not covered under the policy as a day care procedure. He submitted a Medical certificate from the treating doctor, which confirms his diagnosis as "Severe Non-proliferative Diabetic retinopathy with clinically significant Macula Odema, superior retinal branch vein occlusion and epiretinal membrane (Rt eye)". The doctor confirmed that he is not a case of Age Realted Macular Degeneration. The Hon'ble Insurance Ombudman also had allowed his previous claims for the same Treatment he had undergone earlier. He approached the Grievance cell of the company, but no satisfactory reply received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The Respondent insurer is directed to Pay the claim.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0355/2015-16

Complaint No. KOC-G-049-1617-0605

Award passed on : 27.03.2017

Mr. P.J. Manuel Xavier Vs The New India Assurance Co. Ltd.

Partial repudiation of individual mediclaim

Complainant's wife is covered under a health Insurance policy of the respondent Insurer. She was admitted in the hospital for Total Knee Replacement. He preferred a claim from the respondent Insurer for Rs.269987/. The Insurance company has settled the claim for Rs.1,00,000/- only. The reason for deduction has not been informed to him. He approached the Grievance cell of the company, but no satisfactory reply received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the balance amount of the claim.

Decision : The complaint is dismissed.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0358/2015-16

Complaint No. KOC-G-050-1617-0621

Award passed on : 27.03.2017

Mr. Shazin K.I.M Vs The Oriental Insurance Co. Ltd.

Repudiation of Medi Claim

Complainant is covered under a Health Insurance policy of the respondent Insurer. He was admitted in the hospital for treatment of haemorrhoidsfrom 19.05.2016 to 25.05.2016. He preferred a claim with the respondent Insurer. They repudiated the claim on reason that there is a break of 45 days in Insurance coverage from the Employers Group Mediclaim Policy to the subject PNB-Oriental RMC Policy due to which the continuity of coverage was lost. Therefore, the present policy was treated as fresh one under which treatment for piles excluded for 2 years. Actually, the Accenture GMC policy was valid for the period from 17.10.2015 to 16.10.2016, unless it is cancelled. He was not informed by his previous employer regarding termination of Insurance coverage at the time of resignation on 31.12.2015. Hence, he believed that his policy might be in force even after his resignation. He came to know about termination of Insurance coverage only upon receipt of their relieving letter dated 22.01.2016, received by him on 29.01.2016. He has taken steps to renew the policy on 29.01.2016 itself. The present policy commenced with effect from15.02.2016. He approached the Grievance cell of the company, but no satisfactory reply received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The Respondent insurer is directed to Pay eligible claim.

$$$$$$$

Award No. IO/KOC/A/GI/0360/2015-16

Complaint No. KOC-G-048-1617-0631

Award passed on : 27.03.2017

Mr. Raphy Jose Pathadan Vs The National Insurance Co. Ltd.

Repudiation of Medi Claim

Complainant is covered under a health Insurance policy of the respondent Insurer. He was admitted in the hospital for his neck and body pain. He has undergone Physiotherapy. The Insurer has rejected his claim stating that "Physiotherapy is an OPD procedure and hospitalisation is not required. He approached the Grievance Cell of the company, but no satisfactory reply has been received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The Respondent insurer is directed to Pay the claim.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0361/2015-16

Complaint No. KOC-G-048-1617-0606

Award passed on : 27.03.2017

Mr. Stoney Olivero Vs The National Insurance Co. Ltd.

Repudiation of Medi Claim

Complainant's wife is covered under a health Insurance policy of the respondent Insurer. She was admitted in the hospital as per the treating doctor's advice for the treatment of pain in the neck, shoulder, and continuous giddiness. He preferred a claim from the respondent Insurer which was denied stating that the hospitalisation was not required for the present treatment. He approached the Grievance cell of the company, but no satisfactory reply received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The Respondent insurer is directed to Pay Hospitalisation charges.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0362/2015-16

Complaint No. KOC-G-044-1617-0632

Award passed on : 27.03.2017

Mr. R. Ramachandran Vs Star Health and Allied Ins. Co. Ltd.

Repudiation of health insurance claim

Complainant and his wife are covered under a health policy of the respondent Insurer. His wife has undergone surgery and preferred a claim from the respondent Insurer. The Insurance Company rejected the claim stating that "Dermoid Cyst" falls within the 2 year exclusion. The Insurance Company had settled for the treatment of same disease at Jubilee hospital on 30.08.2015 and 11.09.2015. He approached the Grievance cell of the company, but no satisfactory reply received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The complaint is dismissed.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0363/2015-16

Complaint No. KOC-G-044-1617-0666

Award passed on : 27.03.2017

Mr. K.Prabhakaran Vs Star Health and Allied Ins. Co. Ltd.

Partial repudiation of health insurance claim

The Complainant is covered under a Health policy of the respondent Insurer. He was treated on hospital for stapler haemorrhoidectomy & for Gastro problem. He preferred a claim from the respondent Insurer, which was settled without considering his treatment for Gastro problem in O.P DEPARTMENT. As per the conditions stipulated in the policy, he is eligible for Day care treatment for Gastro problems. He has submitted the medical reimbursement claim for Rs.6750/-in respect of Day care treatment for gastro problem since the same was not submitted by the hospital along with the claim for Stapler haemorrhoidectomy. He appealed to the Grievance Cell of the Insurer for a review of the claim, for which the reply was not satisfactory. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim of Rs.6750/- in respect of his OP treatment for Gastro problem.

Decision : The Respondent insurer is directed to Pay balance amount Rs.2600/-.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0364/2015-16

Complaint No. KOC-G-049-1617-0619

Award passed on : 27.03.2017

Mr. Mathew Jacob Vs The New India Assurance Co. Ltd.

Partial repudiation of individual mediclaim

Complainant is a policy holder of the respondent Insurer. He was admitted in the hospital in July 2016 and undergone Angioplasty. He preferred a claim for Rs. 71245/- from the respondent Insurer which was settled for Rs. 44008/- only. The Insurance company has not given the reason in detail for the deduction made from the claim amount. According to the policy document, except for the ceiling of 1% of the Insured sum on room rent, he is eligible for all the other expenses incurred during his hospital stay for surgery as well as pre-hospitalisation expenses. There is an outstanding claim amount of Rs.27237/- to be reimbursed by the Insurer. He appealed to the Grievance Cell of the Insurer for a review of the claim, for which Insurance company did not give satisfactory reply. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The complaint is dismissed.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0365/2015-16

Complaint No. KOC-G-049-1617-0651

Award passed on : 27.03.2017

Mr. N.M. Brahamanandan Vs The New India Assurance Co. Ltd.

Partial repudiation of individual mediclaim

Complainant is covered under a health Insurance Policy of the respondent Insurer. On 24.11.2016 he met with an accident and was admitted in the hospital for treatment. He preferred a claim for Rs.63524/- from the respondent Insurer for the reimbursement of hospital expenses. The Insurance Company has reimbursed only 50% of his claim stating that he has opted a Room of higher category than his eligibility limit of of 1% of Sum Insured. He had opted a higher category room since other category rooms were not available. He approached the Grievance cell of the company, but no satisfactory reply received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The complaint is dismissed.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0367/2015-16

Complaint No. KOC-G-051-1617-0615

Award passed on : 28.03.2017

Mr. Mathew T Sam Vs The United India Insurance Co. Ltd.

Repudiation of Medi Claim

Mr. Mathew T Sam.(G) the complainant and his family are covered under a Medi-care policy of the respondent Insurer, which had coverage till 28/03/2016. He was hospitalized from 22/01/2016 to 06/02/2016 for the treatment of acute cervical discomfort. He preferred a claim with the TPA of the Insurer, which was denied by stating that there was a delay of 91 days in submission of the claim and the reconsideration of the claim is subject to approval from the Insurance Company, once they receive explanation for delay from him. He appealed to the Grievance Cell of the Insurer for a review of the claim based on his explanation for the delay in submission, for which neither a reply nor the payment of the claim is made so far. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim, condoning the delay in submission of the claim.

Decision : The complaint is Disposed off.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0368/2015-16

Complaint No. KOC-G-051-1617-0612

Award passed on : 28.03.2017

Mr. Thomas Jacob Vs The United India Insurance Co. Ltd.

Repudiation of Medi Claim

Mr. Thomas Jacob(G), the complainant was covered under a Group Medi-claim policy of the respondent insurer, taken by his employer. He was hospitalized on 18/07/2016 for the treatment of ''URTICARIA'' and discharged on 20/07/2016. A claim for reimbursement of expenses towards hospitalization was preferred with the Insurer, which has been denied by stating that "the charges are not consistent with or incidental to the diagnosis and treatment of the ailment". He submits that the charges incurred at the Hospital, for tests and diagnostic studies are incidental to the diagnosis and treatment of the ailment and the respondent Insurer has not made any enquiry with the Doctor before arriving at a conclusion. He also submits that the reason cited for rejection of the claim is contrary to facts and not supported by reasons. His appeal to the Grievance Cell of the Insurer for a review of the claim was also in vain. Hence, a complaint was filed before this Forum to resolve the issue.

Decision : The Respondent insurer is directed to Settlement.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0370/2015-16

Complaint No. KOC-G-051-1617-0685

Award passed on : 28.03.2017

Mrs. Rossy C.V Vs The United India Insurance Co. Ltd.

Repudiation of death claim

Complainant's husband was covered under Group Personal Accident Insurance of the respondent Insurer which was sponsored by the Govt. of Kerala, under RSBY(Scheme). On 17th August 2011 her husband fell into a well and died due to drowning. Post-mortem Report clearly establishes the aforesaid fact. She submitted all relevant documents to the Insurer, but the claim has not been settled till date. Hence, she filed a complaint before this Forum, seeking direction to the Insurer for the payment of the claim.

Decision : The Respondent insurer is directed to Settlement.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0371/2015-16

Complaint No. KOC-G-050-1617-0614

Award passed on : 28.03.2017

Mr. M.P. Luka Vs The Oriental Insurance Co. Ltd.

Repudiation of Medi Claim

Mr. M.P. Luka (G) The complainant was covered under a Group Medi-claim policy of the National Insurance, taken by his employer in 2004 and continued up to 2015.From 1st January 2010, the Policy was continuously renewed up to 31.12.2015. In January, 2016, as per the advice of the employer, PNB Royal Medi-claim policy was availed from the Oriental Insurance Co. Ltd, for which the continuity benefit of earlier Group policy should have been allowed. He was hospitalized, for two spells from 28/03/2016 to 31/03/2016 and from 07/04/2016 to 12/04/2016. He preferred two claims which work out to be Rs.86891.07 from the respondent Insurer. These claims were repudiated by imposing exclusion Clause 4.3 (xix) & (xiii) of the policy conditions. The exclusion Clause 4.3 states that the expenses on treatment of Calculus diseases and Surgery for gallbladder and bile duct excluding malignancy for 2 years, come under Exclusion Clause 4.3. Since the claims were reported during the first year of the policy, Exclusion clause 4.3 is applicable. As he was a policy holder since 2004 and considering the genuine nature of the claim the Insurer has to settle the claim. He appealed to the Grievance cell of the Insurer for a review of the claim, but in vain. Hence, this complaint was filed.

Decision : The Respondent insurer is directed to Pay eligible claim.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0372/2015-16

Complaint No. KOC-G-050-1617-0681

Award passed on : 28.03.2017

Mr. Jose P Abraham Vs The Oriental Insurance Co. Ltd.

Partial repudiation of individual mediclaim

Complainant is covered for a Sum Insured of Rs.1.25 Lakh under a health Insurance Policy of the respondent Insurer for the policy period from 05.08.2015 to 04.08.2016. He was admitted in the hospital on 11.06.2016, for the treatment of Cardiac problem. He preferred a claim from the respondent Insurer. Insurance company has settled the claim for Rs.1 Lakh, even though he had submitted I.P bill for Rs.2,09,000/-. He is eligible for Rs.1.25 Lakh, maximum payable under the policy. The Insurance Company has not explained to him the reason for the deduction from his claim amount. He approached the Grievance cell of the company, but no reply was received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for the payment of balance amount of the claim.

Decision : The complaint is dismissed.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0373/2015-16

Complaint No. KOC-G-049-1617-0665

Award passed on : 28.03.2017

Mr. P.K. Balakrishnan Vs The New India Assurance Co. Ltd.

Partial repudiation of individual mediclaim

The 80 years old Complainant and his wife are covered under a Mediclaim policy of the respondent insurer. They were admitted for Ayurvedic treatment in Aryavaidya Chikitsalayam & Research Institute in Coimbatore. He preferred a claim for Rs.1,03,880/- from the respondent insurer. The Insurance company has reimbursed Rs.48219/- and the balance amount of Rs.55661/- was disallowed. The Insurer has reimbursed Doctor Charges, Medicines and Room rent. Their "Treatment Charge" (Rs.26290/-) was for Abhayangam, Enna kizhi, & Pizhichal which is not similar to naturopathy. Their "OTHER TREATMENT Charge" of Rs.12500/- is for eyes, ears, wounds etc. He approached the Grievance cell of the company, but no satisfactory reply received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The Respondent insurer is directed to Pay eligible claim.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0375/2015-16

Complaint No. KOC-G-044-1617-0594

Award passed on : 28.03.2017

Mr. Aneesh V.P. Vs Star Health and Allied Ins. Co. Ltd.

Repudiation of health insurance claim

Complainant's wife is covered under the Health Policy Issued by the respondent Insurer. She was admitted in the hospital on 2nd January 2017 due to miscarriage. He preferred a claim from the respondent Insurer which was rejected by them stating that the present claim is "outside the scope of the policy; maternity and related complications are not payable". He approached the Grievance Cell of the company to review the claim, explaining them that the miscarriage happens as part of some illness and not to be considered at par with Delivery and maternity, for which Insurance Company did not give a satisfactory reply. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.(scn not filed).

Decision : The complaint is dismissed.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0377/2015-16

Complaint No. KOC-G-049-1617-0654

Award passed on : 28.03.2017

Mrs. Seema Iqbal Vs The New India Assurance Co. Ltd.

Repudiation of Medi Claim

The complainants daughter is covered under the valid mediclaim policy held and was hospitalised for an emergency MTP(medical termination of pregnancy) due to fetal exencephaly, which left untreated could have led to intra uterine fetal demise and septicaemia endangering the mothers life. A claim for Rs42487/- was preferred which was denied by the Insurer citing clause 4.4.13(permanent exclusions for pregnancy related ailments). Appeal to the grievance cell also did not provide any relief hence this complaint seeking reimbursement of the full claim.

Decision : The Respondent insurer is directed to Pay eligible claim.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0378/2015-16

Complaint No. KOC-G-051-1617-0588

Award passed on : 28.03.2017

Mr. Mathew M.M Vs The United India Insurance Co. Ltd.

Repudiation of Medi Claim

Complainant and his family are covered under a Mediclaim policy of the respondent Insurer. His wife was admitted in the hospital with the complaint of stomach ache. He preferred a claim from the respondent insurer which was denied stating that the charges incurred at hospital primarily for diagnosis X-ray or Laboratory examinations not consistent with the diagnosis and treatment of positive existence of presence of any ailment, are not payable. After receiving the rejection letter from the insurer he approached the treating doctor and obtained a confirmatory certificate, affirming the admission & treatment, which is soundly proof enough to disallow the denial reasons of the Insurance Company. He appealed to the Grievance Cell of the Insurer for a review of the claim, for which Insurance company did not give any reply. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The Respondent insurer is directed to Pay except diagnostic exp.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0379/2015-16

Complaint No. KOC-G-051-1617-0633

Award passed on : 28.03.2017

Mr. Shaiju Poulose Vs The United India Insurance Co. Ltd.

Repudiation of Medi Claim

Complainant and his family are covered under a health Insurance policy of the respondent Insurer. His 1yr 7month old son was admitted in the hospital on 28/7/2016 for treating Urinary bladder. He preferred a claim from the respondent Insurer which was denied stating that the ailment was pre-existing prior to proposal of Insurance. His son was included in his renewal policy on11/03/2015. The ailment was detected on 26.11.2015. Hence, the ailment should not be considered as pre-existing one and his claim is admissible. He approached the Grievance cell of the company, but no satisfactory reply received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The complaint is dismissed.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0381/2015-16

Complaint No. KOC-G-051-1617-0592

Award passed on : 28.03.2017

Ms. Asha V Prince Vs The United India Insurance Co. Ltd.

Partial repudiation of individual mediclaim

Complainant is covered under the Mediclaim Policy of the respondent Insurer. In the month of February 2016, she was admitted in the hospital and undergone treatment. She preferred a claim for Rs.90,000/-(approximately) from the respondent Insurer which was settled partially. The insurance company has settled only 25% of the sum insured. Since this is a major surgery, Insurer has to settle 75% of the Sum Insured. She appealed to the Grievance Cell of the Insurer for a review of the claim, for which Insurance company did not give satisfactory reply. Hence, she filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The complaint is dismissed.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0382/2015-16

Complaint No. KOC-G-051-1617-0598

Award passed on : 28.03.2017

Mr. C.A. Jose Vs The United India Insurance Co. Ltd.

Repudiation of Medi Claim

Complainant and his family are covered with effect from 01.03.2016 under Arogya raksha Medical Insurance of the respondent Insurer. On 05.08.2016 he suffered severe chest pain and was admitted on emergency basis in C.C.U at Rajagiri Hospital. He was diagnosed as acute anterior wall non S T elevation M.I and underwent Coronary angiogram which revealed Single Vessel Disease for which P.T.C.A with stent to LAD (1 DES) was done. He incurred expenses of Rs.1,53,501/- for his aforesaid treatment. He preferred a claim from the respondent insurer which was not settled till date. He appealed to the Grievance Cell of the Insurer for a review of the claim, for which Insurance Company did not give reply. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The Respondent insurer is directed to Settlement.

$ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0383/2015-16

Complaint No. KOC-G-051-1617-0623

Award passed on : 28.03.2017

Mr. P.M. Jacob Vs The United India Insurance Co. Ltd.

Partial repudiation of health insurance claim

Complainant is covered under a Mediclaim policy of the respondent Insurer. The Insured was admitted for two days (27/9/2016 to 29/09/2016) and thus the room rent which is 1% of the Sum Insured of Rs. 1.25 lakh for two days will amount to Rs.2500/-. The amount allowed was only Rs.1250/- and proportionate deduction of 48% has been made in all other expenses. The Insurance company has not given the reason for the deduction of Rs.2253/- under the head "others". He approached the Grievance cell of the company, but no satisfactory reply received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The Respondent insurer is directed to Settlement.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0384/2015-16

Complaint No. KOC-G-051-1617-0646

Award passed on : 28.03.2017

Mr. M. Ramachandran Vs The United India Insurance Co. Ltd.

Partial repudiation of health insurance claim

Complainant is covered for Rs.5 Lakh under a health policy of the respondent Insurer. He has undergone a cataract surgery and preferred a claim for Rs.50,000/- from the respondent Insurer. The Insurance Company settled the claim partially for Rs.30,950/-. As per policy condition 1.2a, for Cataract, he is eligible for the actual expenses incurred or 25% of the sum Insured. Since, he is covered for a Sum insured of Rs.5 Lakh, he is eligible to get reimbursement of cataract claim up to Rs. 1,25,000/-. He approached the Grievance cell of the company, but no satisfactory reply received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The Respondent insurer is directed to Pay the claim.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0385/2015-16

Complaint No. KOC-G-051-1617-0642

Award passed on : 28.03.2017

Mr. C.K. Narayana Panicker Vs The United India Insurance Co. Ltd.

Partial repudiation of individual mediclaim

Complainant is covered under a health Insurance policy of the respondent Insurer. Being a Prostate Cancer patient he has to go for checkup/ Treatment/Medicnes regularly and the Medical Bills are submitted as per procedure. In earlier case the Hon'ble Insurance Ombudsman allowed such day care procedures. Even though, he is eligible up to 8 Lakh (Original 4Lakh + 4Lakh additional Insurance), his bills were not reimbursed on Day care basis. He approached the Grievance cell of the company, but no satisfactory reply received. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : The Respondent insurer is directed to Pay the claim.

$ $ $ $ $ $ $ $

Award No. IO/KOC/A/GI/0386/2015-16

Complaint No. KOC-G-050-1617-0680

Award passed on : 28.03.2017

Mr. Jailal M.R Vs The Oriental Insurance Co. Ltd.

Partial repudiation of individual mediclaim

Complainant and his family are covered under a health Insurance policy for the last 6 years for a Sum Insured of Rs.50,000/-. During the tenure of last 6 years he has not had any hospitalisation relating to heart disease nor has made any with the Insurer. On 19.01.2016 while renewing the policy, he has enhanced the S.I. to Rs.100,000/-.He developed intense chest pain all of a sudden at 3 a.m. on 31.08.2016 following which; he was rushed to the nearby hospital. The Diagnostic tests undergone there viz., ECG, Trop, Echo, CAG for the first time lead to the diagnosis of Single Vessel Disease necessitating emergency Primary PTCA following admission on 31.08.2016. He preferred a claim from the respondent Insurer which was settled for Rs.50,000/- against the hospitalisation bill of Rs.1,27,000/-, even though the S.I under the present policy Rs. 100,000/-. The Insurance company states the reason for the partial settlement as the disease was Diagnosed through CAG ON 31.03.2016 and the S.I. was enhanced to Rs.1 Lakh from 19.01.2016. As per terms and conditions of the policy, for enhanced S.I., all the terms and conditions of fresh policy applicable and pre-existing disease are exclusions for 4 years from the date of inception of the policy. In fact he underwent the CAG on31.08.2016 only and NOT on 31.03.2016. In the discharge summary CAG date was erroneously written as 31.03.2016. Subsequently, the hospital clarified that CAG date31.03.2016 was a clerical error and the actual date should have been 31.08.2016. Even hypothetically, going by the date 31.03.2016, he is eligible for the full Sum Insured of Rs. 1 Lakh as the CAG & DIAGNOSIS of SVD was made during currency of the current policy. The Symptoms of disease, the diagnostic tests, the disease was diagnosed as SVD- all took place around31.08.2016 which is good seven months after the commencement date of the renewal policy on 19.01.2016 with S.I. as 1 Lakh. Therefore he is

eligible for the balance amount of the claim. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission balance amount of the claim.

Decision : The complaint is dismissed.

$ $ $ $ $ $ $ $

MEDICLAIM

1. CASE OF KULDEEP SINGH BARTWAL V/S RELIGARE HEALTH INS. CO. LTD.

DATE OF AWARD 08.03.2017

- The complainant stated that he had purchased a Health Insurance Policy on 04.10.2015 for a sum insured of Rs.4 lakhs. In May, 2016, he was admitted in Dharamshila Hospital and Research Centre Delhi for the treatment of papillary CA Thyroid(Cancer) and had incurred a sum of Rs. 2,93.494/-. The Claim was repudiated by the insurance company stating that the insured was suffering from swelling of thyroid for the last eight months but the same was not declared in the proposal form submitted to the company on 30.09.2015.

- Both the parties appeared for personal hearing and reiterated their submissions

- The insured admitted that he was having slight swelling on the neck since June 2015 but he was not experiencing any physical discomfort due to the said swelling hence, he had not considered it worthwhile to mention in the proposal form.

- Later, some time in Nov.2015, a physician residing in his neighborhood incidentally observed it and advised him to get pathological investigation like thyroid test to rule out any remote possibility of any serious ailment. Accordingly, he underwent thyroid tests on 25.11.2015 and 4th March 2016 but nothing abnormal was detected. It was in fact for the first time in May 2016, that the swelling was diagnosed as a case of papillary carcinoma of thyroid, because had he been aware of cancerous growth at the time of proposal, he would not have waited for 6 months to initiate treatment as cancer is not only a serious problem but a life-threatening disease. Therefore, contention of the insurer that the insured was aware about the disease, was not correct.

- The statement of the insured supported by pathological test reports dated 25.11.2015 and 04.03.2016 appears convincing hence denial of the claim on the basis of non-disclosure of material facts was not justified.

- Taking into account the facts & circumstances of the case, an award was passed directing the insurance company to pay admissible amount of the claim on receipt of required documents

2. CASE OF MUKUL GODANI V/S STAR HEALTH AND ALLIED INSURANCE CO.LTD.

DATE OF AWARD 21.03.2017

- The complainant stated that he had purchased a Family Health Optima Plan from the insurer on 24.12.2015 for a sum insured of Rs. 5 lakhs. In March, 2016, his wife was admitted in Medanta Hospital for treatment of Metastatic Carcinoma but his claim was repudiated stating that the disease was pre-existing at the time of proposal and the same was not disclosed in the proposal form.

- The insurer stated that the patient was suffering from intermittent bleeding per rectum for the last one year and there was a large growth of sigmoid colon causing narrowing of lumen of anus and intermittent intestinal obstruction resulting in cancerous growth spreading to lungs and liver but the insured had not disclosed the same in the proposal form.

- During the hearing, the insured admitted that there was slight bleeding per rectum but only once during the last one year but she had not experienced any physical discomfort due to the said bleeding, hence, she had not considered it worthwhile to mention it in the proposal form. It was in fact for the first time in March 2016, that she felt discomfort due to passing of blood per rectum hence was advised detailed investigations by the doctors resulting in diagnosis of metastatic carcinoma.

- The main ground for suspicion that the insured had not disclosed the fact of her illness is bleeding per rectum – intermittent or otherwise. It is a known fact that the cause of bleeding may not always be colon cancer as it could be due to ulcer, piles, constipation or some other reason. The moot point here is whether the insured was aware of her disease and whether she had intentionally concealed it to reap the benefits of insurance. The possibility appears quite remote in as much as no sensible person would wait for three month to initiate treatment for cancer just to take benefit of insurance cover. The insurer has not been able to prove by way of any documentary evidence that the insured was aware of this problem at the time of proposal by producing any treatment or hospital records. Hence, the denial of claim by the insurer on the basis of non-disclosure of material facts was not justified. Taking into account the facts & circumstances of the case, an award was passed directing the insurance company to pay admissible amount of the claim on receipt of required documents.

3. CASE OF RICHA YADAV V/S NATIONAL INSURANCE COMPANY LTD.

DATE OF AWARD 13.12.2016

- The complainant has stated that her father Mr. Parvindra Singh Yadav had purchased a National Mediclaim policy on 05.10.2015 providing risk cover of Rs. 5 Lakhs to the family. In Jan. 2016, her father was admitted in Asian Bariatrics Hospital, Ahmedabad and had undergone two surgeries namely Cholecystectomy and Bariatric Surgery incurring an expenditure of Rs. 1083886/- as medical expenses and claim was lodged with the TPA who admitted partial claim in respect of surgery performed for Cholecystectomy only.

- In order to justify, she explained that her father was also suffering from Morbid obesity (weight 116.7 Kg, BMI 36.8) Hypertension/Diabetes Mellitus, Hernia and chronic pancreatitis and was regularly gaining weight which could have threatened his life. As the diseases had reached life threatening proportion, bariatric surgery was conducted as a lifesaving procedure and not as a cosmetic surgery to reduce weight. In support of her statement, she had also submitted a certificate to this effect issued by the attending doctor, the insurance company stated that Bariatric surgery whether life threatening or not was specifically excluded from the policy.

- Ongoing through terms and conditions of the policy, specifically exclusion under condition number 4.9 of the policy in respect of bariatric surgery, it was observed that the said exclusion has been inserted in the policy specifically to disallow expenses for Bariatric Surgery conducted preferably for cosmetic purpose for weight management while in the subject case, condition of the patient was different and had attained life threatening proportion. The condition apparently had deteriorated to the extent that had he not gone for the bariatric surgery, chances of his survival would have been at stake. Hence the procedure was conducted for saving life and not primarily for reduction of weight. In the nutshell, purpose and motive of a treatment/surgery is more important than the nomenclature hence claim for Bariatric surgery, as per his entitlement, need to be considered by the company. Accordingly, an award was passed directing the insurance company to reimburse expenses for Bariatric surgery as per his entitlement based on sum insured under the policy.