Mr. Kamlesh N Patel V/S Iffco-Tokio Genl. Insurance Co. Ltd.

Complaint No.: AHD-G-023-1617-1511

Policy No.: 52646045

Date of Award : 12/04/2017

The Complainant's wife was first consulted on 04/08/2016 for knee pain and was admitted to Saviour Annexe Hospital for the treatment of Osteoarthritis of right knee joint and had incurred an expense of Rs.2,06,474/-. The claim was repudiated on the ground of Non-Disclosure of Material Fact. Complainant and his family was initially insured with New India Assurance Company Ltd. since the year 2000 and switched over to Iffco-Tokio General Insurance Co.Ltd under portability from 01/07/2015.

The Insurance Company had repudiated the claim stating that the patient was having history of hypertension since 10 years which was prior to policy inception (Portability) date, and the same was not disclosed in proposal form at the time of portability. The complainant agreed that his wife was suffering from BP since 10 years, but there is no nexus between BP and Knee Replacement. His claim was wrongly repudiated.

Respondent argued that as per consultation paper of Dr.Shilpa Toshniwal, patient had history of hypertension since 10 years. The same was not disclosed in the proposal form while taking policy / portability. Hence, this was "breach of trust and disclosure to information norm". Said claim was rejected due to NON-DISCLOSURE of past ailment and NOT FOR PRE-EXISTING DISEASE.

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. There is no nexus between BP & knee replacement. The Complaint was admitted

Taking into account the facts & circumstances, the Respondent is hereby directed to pay Rs.2,06,474/- to the Complainant.

Mr. Rajendra Singh Jain V/s The National Insurance Co. Ltd.

Complaint Ref No.AHD-G-48-1617-1483

Policy No. : 310304/48/15/8500036923

Date of Award : 12/04/2017

The Complainant's wife Mrs. Santosh, aged 71 years was insured since March, 2007 under Baroda Health Policy of The National Insurance Co.Ltd. She was hospitalized to Apollo Hospital, Chennai for Laparoscopic Single anastomosis gastric bypass surgery and Umbilical hernia repair, and incurred an expense of Rs.3,79,935/-. The claim was repudiated by the Respondent stating clause No. 4.6 Cosmetic, plastic Surgery, Sex Change was excluded.

Complainant's wife had 157 cms height, 63.4 kg weight, non-alcoholic & nonsmoker, non-obese had a BMI value of 25.7. She had a history of uncontrolled Diabetes Mellitus & was under treatment at Military Hospital Vadodra. She was diagnosed to be suffering from Metabolic Syndrome with Hypertension, Obstructive Sleep Apnea, Hypothyroidism, Dyslipidemia, and umbilical Hernia by Apollo Hospital, Chennai. Doctor opined that a "life-saving Laparoscopic Single Anastomosis Gastric Bypass Surgery" was required as medical necessity. Surgical operation was done as a last resort to sustain patient's life. Hospital Discharge Summary & other reports did not indicate any evidence to prove that the Gastrectomy Surgery undergone by the

patient (with HbA1C – 9.5 & TSH – 7.64 and Metabolic Syndrome) was in the nature of cosmetic surgery. Surgery to save life was not excluded in the policy.

The respondent stated that the claim was for the treatment of Metabolic Syndrome, diabetes Mellitus (uncontrolled), hypertension, obstructive sleep apnea, hypothyroidism, dyslipidemia, umbilical hernia. It was found from the claim & medical documents that the said complaint was due to obesity and the claim was payable only if the patient were morbidly obese (BMI > 40). For insured with BMI < 40 it would be treated as a cosmetic procedure and patient's BMI was 25.7, hence not payable as per policy clause No.4.6 and treatment undergone by the patient was not "Life threatening" and was a laparoscopic single anastomosis gastric bypass which meant bariatric surgery which was not covered as per clause No.4.6 of Baroda Health Policy.

As per Discharge Summary the insured was admitted to Apollo Hospital with complaints of Diabetes Mellitus (on medication-duration 10 years), hypertension (duration 3-4 years), and hypothyroidism. Diagnosed with Metabolic Syndrome, Diabetes Mellitus (uncontrolled), Hypertension, Obstructive Sleep Apnea, Hypothyroidism, Dyslipidemia, and Umbilical Hernia, she was admitted for laparoscopic single gastric bypass surgery and umbilical hernia repair. All the complaints were prime facie related to Obesity, and **there was no exclusion for obesity in policy condition.**

Taking into account the facts & circumstances, the Respondent is hereby directed to pay Rs.3,59,986/- to the Complainant.

Mr. Pradeep Badgujar V/s Royal Sundaram General Insu. Co. Ltd.
Complaint Ref No. : AHD-G-038-1718-0033
Policy No. : HS00011939000111
Date of Award : 06/06/2017

The Complainant and his family were insured with respondent and daughter-in-law of complainant had given birth to a child. Her medical expense on the child birth was denied by the Respondent citing policy clause D-4: Treatment arising from or traceable to pregnancy/childbirth was excluded from the scope of the policy.

The Insurance Company had not played its role and declared the Terms and Conditions in advance. The reason given by company that for denial of the claim that it was as per Terms and Conditions was not correct hence the contract was Null & Void. The T & C became void-ab-initio and hence the claim was payable to him.

The Respondent representative submitted that the claim was excluded as per the Terms and Conditions of the Medisafe Policy, Exclusion clause D-4.

The complainant accepted that he had received the terms and conditions along with the policy document, and he said that generally nobody read and simply file the terms and conditions of the policy. Merely stating that he had not read the terms and conditions of the policy or he was not aware of a particular condition clause of the policy did not entitle him for the benefit which are denied in the policy. In both the Insurance companies, the exclusion clause clearly stated that the claim related to pregnancy / childbirth was out of the scope of the policy. In view of the aforesaid facts complaint failed to succeed.

Taking into account the facts & circumstances and the submission made by both the parties to the complaint during the personal hearing, the Respondent's decision to repudiate the claim was upheld. The complaint, thus, needed no intervention, hence Dismissed.

Mr. Suryakant C Shah V/s The New India Assurance Co. Ltd.
Complaint No. AHD-G-049-1718-0013
Policy No. : 220200/34/16/25/00003616
Date of Award : 05/06/2017

The Complainant was diagnosed with Lower Esophagus Stricture. For surgery incurred total expense of Rs.30,001/-. The claim was repudiated by the Respondent for the reason that the admission was less than 24 hours.

The illness requires Gastroscopy & Balloon Dilatation with General Anesthesia his chief complaint was dysphagia. In past respondent had allowed medical reimbursement for similar disease and treatment from same hospital under Day Care with discharge less than 24 hours.

From claim documents it was observed that the patient was admitted for less than 24 hours, also said disease was not listed under daycare treatment; hence the claim was not admissible as per policy clause 2.16.1.

Earlier three claims were settled by Insurance Company for the same treatment in the same hospital. In clause 2.16.1 it was mentioned that admission in a hospital for a minimum period of twenty four In-patient Care consecutive hours except for specified procedures / treatments, where such admission could be for a period of less than twenty four consecutive hours-(6) Dilatation & Curettage was mentioned, hence hospitalization for more than 24 hours was not required and the claim was wrongly repudiated. In view of the above, the complaint was admitted.

Taking into account the facts & circumstances and the submissions made by both the parties to the complaint during the personal hearing, the Respondent is hereby directed to pay Rs.30,001/- to the complainant.

Ms. Deepa K Sheth V/s The New India Assurance Co. Ltd.
Complaint Ref No.AHD-G-49-1718-0023
Policy No. : 21120634162500000126
Date of Award : 05/06/2017

The Complainant was diagnosed with Morbid Obesity and incurred an expense of Rs.2,69,500/-. Claim was repudiated by respondent stating clause No. 4.4.6.1 "treatment of obesity & its complications was excluded from the scope of policy".

The Complainant was insured since last 7 years. She was suffering from Progressive weight gain, snoring, Backache, and hospitalized to Asian Bariatric Hospital. Since last 7 years, neither the agent nor the insurance company had informed him about the Terms and Conditions of the policy. He had not asked for the copy of the Terms and Conditions of the policy as he never felt the need.

The complainant was having Progressive Complications arising out of Obesity such as overweight, snoring, Backache. He had at the age of 44 years, weight 114 kgs, height 158 cms and BMI 45.670 (Excess weight 51.590 kgs), progressive weight gain since 3 years for which surgery/procedure for Laparoscopic Sleeve Gastrectomy done. As per policy Clause No.4.4.6.1, obesity treatment and its complication was not payable.

All the complaints were prime facie related to Obesity. 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 was the proximate cause and which has caused other co-morbidities. He 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.

Mrs. Varshaben H Mehta V/s The United India Insurance Co. Ltd
Complaint Ref No.AHD-G-051-1718-0045
Policy No.: 0662002816P104474690
Date of Award : 05/06/2017

The Complainant was insured with the Senior Citizens-Individual Health Insurance Policy-97 since last 5 years. Complainant was hospitalized for the treatment of Mix Cataract (Left Eye). Against the claim of Rs.62,227/-, the Respondent had settled Rs.32,927/- and disallowed Rs.29,300/- citing reasonable and customary clause.

Complainant was argued that It was a mental harassment to a senior citizen.

The balance amount was not payable as it was above Customary and reasonably charges. The claimant was 68 years old and a housewife so what could be the utility of the high advanced lens (Multifocal lens) instead of monofocal lens, for such a person. The policy grants coverage for the treatment which was reasonably required and not granted any betterment. The expenses are to be reimbursed for the treatment of affected disease (cataract) and not for improvement of eye sight.

The respondent had not proved how the amount deducted from the claim was unreasonable. The Customary and reasonable charges change with passing of time and with improvement of technologies and facilities. Since the cataract 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 the lens cannot be considered as unreasonable. As per IRDA circular, Reasonable and customary charges are 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. 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 was entitled for relief. The Complaint was admitted.

Taking into account the facts & circumstances, the Respondent is hereby directed to pay Rs.23,323/- to the Complainant.

Mr. Manubhai A Damani V/s Iffco-Tokio General Insurance Co. Ltd.
Complaint Ref No. : AHD-G-023-1718-0135
Policy No. : 52580892
Date of Award : 13/07/2017

The Complainant's wife was admitted to Kiran Surgical Hospital, Surat for the treatment of Pelvic Inflammatory Disease with GB Stones and D.M. He had incurred an expense of Rs.62,107/-. His claim was repudiated on the ground of Non-Disclosure of Material Fact.

The Complainant and his family were initially insured with Star Health and Allied Insu. Co. Ltd. since the year 2011 and switched over to Iffco-Tokio General Insurance Co.Ltd under portability with endorsement "Notwithstanding anything contained to the contrary, it is hereby declared and agreed that Family Portability is Applicable. Her illness was managed surgically and underwent procedure of Total Laparoscopic Hysterectomy and Cholecystectomy. The insurer had repudiated claim stating non-disclosure of material fact. Complainant had submitted a certificate of treating doctor that patient was suffering from continuous menses since about one month and operated for TLH in emergency, but the insurer says that the illness was since 8-9 months.

Patient was taking treatment on OPD basis. Evident history falls prior to policy inception and while opting the portability benefit. The claimant had not disclosed about past medical history, the material facts in the proposal form, which was a breach of contract therefore the claim does not sustain under "General Condition No.49 Disclosure to information norm".

The complainant and his son had signed a written statement that she was suffering from abdominal pain and irregular menses since 8-9 months. The statement given by complainant and his son was in third party handwriting. In discharge card there was no history of any illness. The impugned policy was ported from Star Health General Insurance Co. Ltd. to the respondent Insurance Company. All the accrued benefits (since 2011) under old policies 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.62,107/- to the Complainant.

Mr. Deepak H Sheth V/s The National Insurance Co. Ltd.
Complaint Ref No. : AHD-G-048-1718-0128
Policy No. : 30210148168500000443
Date of Award : 21/06/2017

The Complainant's daughter was admitted to Parekhs Hospital, Ahmedabad for treatment of Infective Hepatitis and incurred an expense of Rs.37,516/-. Claim was partially settled for Rs.26,937/-. Deduction of Rs.10,579/- was made under reasonable & customary clause.

The complainant had appealed to the Regional Office of the Insurer against the deduction, but no reply was received from them.

The claim was partially settled under policy clause, Reasonable & Customary clause 3.30. and annexure-ii of policy. Maximum Rs.1500/- per visit, per day was payable and for 4 days stay a

sum of Rs.1500 x 4 = Rs.6,000/- was allowed. He was asked to submit the Annexure-ii, he could not produce the same. In answer to a question, whether the Hospital was in PPN list, he replied that he does not know. The Representative was asked whether the Complainant was supplied with the list of PPN Hospital to which he replied in negative.

The Regional Office of insurance company had not given any reply to appeal. Partially settled the claim stating the usual, customary necessary charges as per PPN hospital, was paid to the insured. Hospital being Network Hospital, Insurance Company should have inquired with the hospital the reason for higher charges of visit. It was not done by the insurer. The respondent could not produce any list of allowable and non-allowable items hence the deduction was not proper. Also deduction of Visit charges under reasonable and customary charges was incorrect as there is no ceiling on visit charges in the Terms & Conditions of the policy. Hence it is payable. In view of the forgoing, the complaint is admitted.

Mr. Harendrasinh D Raulji V/s The New India Assurance Co. Ltd.
Complaint Ref No. : AHD-G-049-1718-0143
Policy No. : 220603/34/15/25/00000595
Date of Award : 13/07/2017

The Complainant and his family member were insured since the year 2008. The Complainant was hospitalized in Kokilaben Dhirubhai Ambani Hospital, Mumbai, diagnosed with Right ICA – Supraclinoid segment aneurysm treated with flow diverter and coils and Endovascular coiling done and incurred an expenses of Rs.3,05,000/-. The respondent insurance company settled the claim for Rs.1,00,000/- after deducting Rs.2,05,000/-.

The sum insured was enhanced from 1 lac to 3 lac from 07/04/2016 and the hospitalization was from 27/10/2016. The claim was partially settled stating policy clause 4.1 enhanced sum insured shall be applicable only after lapse of 48 months from its date of enhancement for any pre-existing condition / disease. In the year 2013-14 a claim of Head Injury was approved by the insurance company. He argued that past illness (2013-14) and current illness has no relation and it is not a pre-existing disease.

As per clause 2.8 of policy, in case of change in sum insured during uninterrupted continuous coverage, the Lowest Sum Insured shall be reckoned for determining continuous coverage. The applicable sum insured as per terms of the policy was considered as Rs.1,00,000/- and accordingly the deduction was made under policy clause No. 4.1 & 2.8.

In the year 2013-14 the claimant had head injury and was diagnosed with CL# middle third clavicle left with soft tissue inter position with cerebral conclusion and treatment done under general anesthesia, open reduction and internal fixation with 10 holes clavicle locking plate done left side with clavicle brace given. As per opinion of Expert (DMR-LIC of India), there is no relation of previous head injury and present treatment. So, there is no nexus. Therefore the clause of pre-existing disease 4.1 & 2.8 are not applicable. Respondent could not submit any documentary proof / expert opinion regarding nexus between both treatments. In view of the foregoing the complaint is admitted.

In view of the foregoing, the Forum, hereby, directs the Respondent to pay Rs.2,05,000/- to the Complainant.

Mr. Jagdishchandra R Pandya V/s The New India Assurance Co. Ltd.
Complaint Ref No. : AHD-G-049-1718-0153
Policy No. : 21040034162500002872
Date of Award : 13/07/2017

The Complainant had complaint of LUTS, admitted to Fusion Kidney Institute, Ahmedabad for treatment of Adenocarcinoma Prostate and incurred an expense of Rs.2,35,000/-. The claim was partially settled for Rs.93,200/-. Deduction of Rs.1,42,340/- was made citing Policy clause No. 2.21 Reasonable & Customary.

The Complainant and his family were insured since 13 years. He had consulted Uro-physician of Fusion Hospital, Ahmedabad, for surgery (Radical Prostatectomy). The Insurance company had deducted Rs.95,400/- Surgeon charges, Rs. 15,000/- Operation Theater Charges and Rs.30,737/- Pharmacy Charges as well as Rs.814/- was deducted from Anesthesia charges citing Reasonable & Customary payable.

The respondent could not submit the fee charged by similarly facilitated hospitals from the geographical area where the Insured had undergone for treatment. The Fusion Kidney Institute was not in PPN list, hence higher rate of PPN Hospital List, (Sterling Hospital's rate was Rs.93,200/-) was sanctioned which was justified. Respondent had submitted copy of a chart (3 pages) of Grade-room wise surgical charges-Fusion Kidney institute-Ahmedabad.

In absence of any rate charts comparative for same treatment in same or similar geographical area, the conclusion arrived by the respondent was arbitrary and abuse of process of law. The hospital bill was for Rs.1,75,100/-. As per Fusion Kidney Institute rate chart the payable amount comes to Rs.1,11,050/- against hospital bill of Rs.1,75,100/-. The respondent had paid a sum of Rs.93,200/- treating it as package of the operation. Hence balance amount of Rs.17,850/- was payable under hospital bill claim. Balance claim of Rs.60,094/- pertain to pre/post medicine and pathology charges was out-standing as requirements were pending Since copies of all bills and expenses details are not available with the Forum, so it is not possible to calculate the payable amount. Therefore, the respondent is directed to settle pre/post medicine & pathology expenses as per Terms and Conditions of the policy. In view of the forgoing, the complaint was admitted.

The Forum, hereby, directs the Respondent to pay Rs.17,850/-. The Forum further directs the respondent to settle the remaining claims of Rs.60,094/- as per Terms and Conditions of the policy.

Mr. Manish Popatlal Patel V/s The Oriental Insurance Co. Ltd.
Complaint Ref No. : AHD-G-050-1718-0188
Policy No. : 141500/48/2017/97
Date of Award : 14/07/2017

The Complainant was diagnosed with hernia and taken treatment in Valu Hospital, Ahmedabad. Against total expense of Rs.46,693/-, Respondent had settled the claim for Rs.17,343/- & disallowed the balance claim of Rs.29,350/- citing that the claimant opted for higher room rent

The Complainant was insured since the year 2009 had enhanced the sum insured from Rs.50,000/- to 1 lac from 03/04/2016. The insurance company had allowed only Rs.500/- against Rs.2000/-from room rent. The insurer had taken the base of room rent and deducted proportionally from OT Charges, Surgeon Charges, Anesthesia charges and Investigation charges. The insurance company had never informed him orally or in writing about the change in conditions.

It was first year of enhanced sum insured of 1 lac. The claimant was eligible for room rent of Rs.500/- only and other expenses related to surgeon, anesthetist etc would be as per entitled room category. The Complainant opted for room with a rent of Rs.2000/-. hence Rs.1,500/- was deducted from Room rent & Nursing charges and other charges deducted proportionately as per entitled room category as per Policy Clause No. 4.3, 1.2-A-a-b-Note (c & d). In reply to a question, whether the respondent would submit the entitled charges of the surgeon etc as per entitled category of room with charges of Rs.500/- per day, he assured to submit the same but it was not submitted by him even after reminders. Respondent could not submit even Self Contained Note during hearing.

The Respondent had not submitted the Self Contained Note. Respondent had assured that they will submit the entitled charges of the surgeon etc as per entitled category of room with charges of Rs.500/- per day, but they failed to submit the same. The Terms and Conditions of policy do not authorize the insurer to deduct all other charges (except medicine) proportionately. It authorizes to allow other expenses as per entitled class. The insurer has not done any exercise to find out the eligibility of other expenses as per entitled class. In view of the above, the complaint is admitted.

In view of the foregoing, the Forum, hereby, directs the Respondent to pay Rs.27,750/- to the Complainant.

Case of:-Dr. Revtiram K. Boriker v/s The Oriental Insurance Co. Ltd.

Complaint REF:No. AHD-G-050-1718-0189

Date Of Award:22/06/2017 **Policy No. 141100/48/2016/15180**

The Complainant and his wife were insured with Mediclaim Insurance policy issued by the Oriental Insurance company Ltd for Sum Insured of Rs.1,50,000/-. The complainant had enhanced the Individual Sum Insured from Rs: 75000/- to Sum Insured Rs:150000/- on 20.12.2015. The Complainant's wife was admitted to Sterling hospitals from 04.11.2016 to 07.11.2016 for the treatment of Angiography + PTCA. On discharge from the hospital the Complainant had filed claims for Rs. 359481/-. The Respondent had settled Rs. 75000/- as clause No. 4.3 Enhancement of Sum Insured read with clause no. 4.1 & 4.2. Hypertension and DM is excluded for 24 months to be considered for the purpose of additional enhanced Sum Insured.

The Complainant's wife had Hypertension since 1 ½ years and Diabetes Mellitus Since 4-5 years as per case summary of sterling hospital. As per note below clause 4.3 on enhancement of S.I. exclusions 4.1, 4.2 and 4.3 would apply write the additional S.I. There is waiting period for 2 years. Though heart attack was sudden, unforeseen & involuntary event but it was not caused by external, visible & violet means, hence it is not an accident, as contended by the complainant. So, heart attack is not an accident in terms of definition 2.1 of the policy terms & conditions. Before enhancement of sum insured, the sum insured was Rs: 75000. Additional enhanced sum insured of Rs: 75000 shall have waiting period of 2 yrs for treatment relating to Hypertension and Diabetes Mellitus. 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.**

Case of- Mr. Bhavin S. Dave Vs The Oriental Insurance Co. Ltd.

Complaint Ref No.AHD-G-050-1718-0216

Date Of Award:22/06/2017 **Policy No. 141100/48/2017/4671**

The Complainant's father was insured with Mediclaim Insurance Policy (Individual) issued by The Oriental Insurance Company Ltd for a Sum Insured of Rs. 1,50,000/-. The Complainant's father Mr. Shirishbhai was hospitalized at Dr. Talati's Eye Hospital, Ahmedabad on 14.12.2016 and was treated with Right Eye Intra vitreal Inj. Avastin and was discharged on the same day. The complainant submitted claim of Rs. 25,372/- to the respondent. The Respondent had rejected the Insured's claim under Clause No. 2.3 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.

It could be found from the reason for repudiation that the insurer would have settled the claim if the treatment necessitated hospitalization and procedure involved required specialized infrastructure/facilities available in the hospital and technological advancement reduced the hospitalisation period. The subject treatment required specialised infrastructure like sterile condition and Operation Theater. The treatment is an advancement of the technology where the ailment is treated within 24 hours of hospitalization.

ARMD/ Intra vitreal Avastin injection treatment was not excluded in the said policy.

The Consultation Charge of Rs. 600/- and expenses of Rs.2500/- incurred for O.C.T. done on 10.10.2016 were prior to 30 days and hence not payable.

In view of the foregoing, the complaint is 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 make payment of Rs. 22,272/- to the complainant being full and final settlement of the claim***

In Case of- Rajesh G. Patel Vs The United India Insurance Company Ltd.
Complaint Ref No.AHD-G-051-1718-0148 & 149

Date of Awrad: 21/06/2017 **Policy No. 0603002815P113741505**

The Complainant was insured with Individual Health Policy issued by United India Insurance Company Ltd for a Sum Insured of Rs.2,50,000/-. The Complainant was hospitalized at Nishant Eye Hospital Laser Center Anand on 20.01.2017 for the treatment of Cataract in Both Eye. Against the claim of Rs. 74390/- & 74381/- the Respondent had settled Rs.30000/- in both case and disallowed Rs.44390/- & 44381/-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.44390/- & 44381/-.

It is observed from the records that the Operation charges, OT Charges had been deducted on the basis of customary and reasonable charges. The Customary and reasonableness of charges change with passing of time and with improvement of technologies and facilities. Treatments considered, a few years back as cosmetic and exotic were 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 to restore to its normalcy. The cost of the Implant charges could not be considered as unreasonable.

As per IRDA circular, 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 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 paid a sum of Rs: 23500/- on 13/12/2017. Again the company had paid a sum of Rs: 6500/- on 25.04.2017 but no explanation has been submitted as to on which grounds/reasonable further an amount of Rs; 6500/- was calculated and paid. The insurer had

agreed to pay further Rs: 6140/-(Pharmacy, Nursing & Anesthetics charges), vide their Self Contained Note. The forum is unable to understand how a insurer of repute is paying the claim amount. It seems that on every appeal the amount payable is increased by the company without any justification. It is contended by the respondent alive of the insurer that cost of multifocal lens is not payable, only the cost of monofocal lens is payable. It is further argued that multifocal lens is used for betterment of eye vision, any expenses for betterment of vision is not allowed. Nowhere in the terms and conditions it was mentioned that cost of Multifocal eye lens is not payable. The respondent has compared the cost of multifocal lens with monofocal lens in the name of reasonable and customary charges payment. For arriving at the cost of lens the respondent has considered the cost of monofocal lens wherein the insured was implanted multifocal lens. The respondent has compared the non comparable items whereas the reasonable and customary charges condition state "Reasonable and Customary charges means the charges supplies, which are the standard charges for the standard charges for the specific provider and consistant with the prevailing charges in the geographical area or identical or similar services, taking into account the nature of illness/injury involved". There is specific limit for payment of cataract in terms and conditions of the policy. Policy conditions 1.2.1 says "Expenses in respect of cataract will be restricted in case of cataract as "Actual expenses or 25% of the Sum Insured whichever is less. When there is one restriction available how the company can put another restriction under reasonable and customary clause. The company is restricting the payment of monofocal lens to every insured person irrespective of the sum insured. How the company can restrict the claim payment for monofocal lens only, when it is not mentioned in the terms and conditions of the policy and that to when claim amount is restricted to 25% of the SA or actual expenses whichever is less. The Forum is of the opinion that the respondent is not making the claim payment based on the terms and conditions of the policy but on whims and fancies of the person deciding the claim payable amount. As per clause 1.2.1 (A) the claimant is entitle for payment of 25% of the SA or actual expenses. In this case SA is 2.5 lac and 25 % of this comes out to be Rs.62,500/- The actual expenses of the complainant is Rs.74,410/-, therefore the claim payable comes out to be Rs.62,500/-.

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 the remaining amount of Rs.32500/- in both case to the Complainant.**

Case of- Mr. N.K.Tiwari Vs The New India Assurance Company Ltd.

Complaint Ref No.AHD-G-49-1718-0223

Date Of Award: 22/06/2017 **Policy no. 21020034152500002352**

The Complainant aged 60 years was insured with New Mediclaim policy issued by the New India Assurance Company Ltd for a Sum Insured of Rs.5,00,000/- with CB Rs.45000/-. The Complainant was hospitalized in Nanavati Super Specialty Hospital from 11.04.2016 to 14.04.2016 for the treatment of Acute Inferior Wall MI, PAMI+HTN+DM. Against the claim of Rs. 447996/-, the Respondent had settled Rs.2,60,320/-. The contention of the Complainant was that the Respondent had disallowed Rs.187676/- citing PPN agreement. The Insured had approached the Forum for redressal of his grievance and settlement of the balance claim amount.

The Complainant was hospitalised in emergency condition. He suffered heart attack in aeroplane. He was treated in hospital of airport authority then he was shifted to the Nanavati Hospital, Mumbai. He had not taken any special service from the hospital. Sum Assured amount Rs: 5 lakhs with NCB Rs: 0.45 Lakhs in subject policy. 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 had enquired with the hospital as to why the hospital had charged excess amount. The hospital authority had informed insurer that the patient did not mention about his medical insurance policy, so he was charged at normal rates. The insured stated that he was never given list of PPN hospital & he was not in a position to give the details of insurance policy, as he was admitted in emergency condition, even then he had mentioned the hospital officials about his medical policy. Had the hospital been provided with mediclaim policy, they would have charged at PPN rates. The TPA and insurer can take up this issue with the hospital now. The insured should not suffer for this reason. Had the insured been admitted in Non PPN hospital, he would have been reimbursed full amount subject to small deductions as he has not taken any special services & he was admitted in ICU for the whole period in hospital within his entitled limit. He was entitled for Rs: 10000/- per day (2% of SA) in ICU whereas he was charged Rs: 6600/- per day for his stay in ICU. The complainant was eligible for balance amount after deduction of Rs:750/- Admission Charges and Care Hygienic charges Rs: 1350/-.

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.1,85,576/- 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.

In The Matter of:-Ms Kalpana M. Chudgar v/s National Insurance Co. Ltd.

Complaint REF:No. AHD-G-049-1718-0193

Award Date: 14/07/2017 Policy No: 21020034150100012971, 21020034160100004598,

The Complainant was admitted to Dr Sharad Oza's hospital from 23.11.2016 to 27.11.2016 for the surgery of Restro Knee. On discharge from the hospital the Complainant had filed a claim for Rs.360497/-. This claim was settled for Rs 176921/-. The respondent company had deducted the charges as per the reasonable and customary charges as per policy condition 3.29.

The pattern of surgeon fee charged by Dr Sharad Oza was analysed. It was found that where the patient has no insurance policy or has insurance policy but the Sum Assured is small, he charges his fee varying from Rs 75000/- to Rs 130000/-. In this case it is Rs 230000/-. As the Sum Assured increases, his fees also increases. The reason for huge variation is best known to Dr Oza.

In the subject case the Respondent has settled surgeon fee Rs 90000/- against the claimed amount of Rs 230000/-.

Some information of previous cases regarding surgeon fees charged by the doctor was provided by the respondent insurance company. Some information was available with this forum in some other complaints. An analysis was made by this forum. It is kept on record. As per the average, the maximum amount of Rs 150000/- was payable as surgeon fee. **The respondent was directed to pay the balance amount of Rs 60000/- (above the amount of Rs 90000/-).**

In The Matter of:-Mr Rajesh K Lalka v/s Oriental Insurance Co. Ltd.

Complaint REF:No. AHD-G-050-1718-0232

Award Date: 14/07/2017 Policy No: 171101/48/2017/2112

The complainant was covered under mediclaim policy issued by Oriental Insurance Co Ltd. Complainant was hospitalized for the treatment of Left Large Renal pelvis calculus during 03/02/2017 to 06/02/2017. His claim for Rs 88014/= was settled for Rs 43602/=.

The company had deducted the charges as per the The Charge schedule as decided by the Baroda Nephro Urological Association which was issued two years back dated 01/02/2015. It was not updated after the said date. The room category was not mentioned in the chart schedule. The proportionate

deduction of 52.63% was not justified. The policy condition also does not authorize the deduction on proportionate basis.

The deductions of Rs 1800/- towards ICU charges deductions, Rs 71/- towards Hospital services and Rs 908/- towards Misc Charges is in order.

The respondent had deducted Rs 44412/-. Out of this, the deduction of Rs 2779/= is in order.

The balance amount of Rs 41633/= is payable to the insured.

The respondent was directed to pay the amount of Rs 41633/-.

In the matter of

Mrs. Jyoti D. Sanghvi
Vs
Apollo Munich Health Insc. Co. Ltd.
Complaint Ref. No. AHD-G-003-1617-1551

Date of Award : 13.04.2017 **Policy No**120100/12001/2015/A0004932/148

The Complainant's wife was hospitalized with complaint of Loose stool, Nausea, vomiting and abdominal pain. She was discharged on 25.08.2016 after the treatment. The complainant had lodged a claim for Rs.32,446/-/- with the respondent. The respondent had repudiated the claim citing to Incorrect/wrong declaration of good health.

The Complainant was hospitalized for the treatment of Acute Gastroenteritis which had no relevance to Gout. The confirmation sought under declaration clause was on any major disease/disorder/ailment or deformity suffered during last 5 years. As at the date of proposal, the Gout was not a major disease in the insured, the insured and the proposer had not suppressed material fact required for underwriting the proposal. In view of the foregoing, the complaint was admitted.

In the matter of
Mrs. Jyoti D. Sanghvi
Vs.
Apollo Munich Health Insc. Co. Ltd.
Complaint Ref. No. AHD-G-003-1617-1551

Date of Award : 12.04.2017 Policy No 1804002814P109553366

The Complainant was hospitalized to Banker's Retina Clinic & Laser Centre, Ahmedabad on 31.12.2015 for Vitrectomy Surgery in Right Eye and was discharged on the same day. The complainant had lodged a claim for Rs.59,102/- with the respondent Insurance Company. The respondent insurance company had paid Rs.50135/- after disallowing Rs.8,787/-. The deduction of Rs.787/- was as per Non-Payable Items List of IRDAI and hence, in order. The deduction of Instrument charges of Rs.8,000/- (not payable as OT charges already paid) the treating doctor had clarified that the charge was for disposable endolaser probe used in operation. Hence, the same was payable. In view of the foregoing the complaint was admitted.

In the matter of

Mr. Mayank N. Shukla

Vs.

The Oriental Insurance Co. Ltd., Ahmedabad

Date of Award : 13.04.2017 **Policy No**141300/48/2015/5325

The Complainant was hospitalized to SAL Hospital, Ahmedabad on 08.06.2016, diagnosed Acute anterior wall MI, Cardiac arrest and Coronary artery disease – LV Dysfunction, PAMI to LAD done and was discharged on 13.06.2016. The complainant had lodged a claim for Rs.4,53,179/- with the respondent Insurance Company. The respondent insurance company had paid Rs.2,99,291/- after disallowing Rs.1,53,888/-. The respondent had not considered the detailed explanation given by the RMO and Treating Doctor of the hospital regarding the critical condition of the patient and treatment given. Instead, the Respondent had deducted the claim amount considering the PPN Rate approved for treatment under normal condition of the patient.
The Complainant was hospitalized under critical condition, he was unconscious for three days and treatment was given accordingly. The Respondent had not considered this aspect while settling the claim. The respondent had agreed that as per the Tripartite Agreement, the PPN Hospital was supposed to carry out entire treatment within agreed rate, irrespective of surgical

approach and complications. The Tripartite agreement existed between the Insurer, Hospitals and the TPA. The Insured is not a party to the agreement. He was not provided with the copy of the agreement, the rate chart on the types of surgeries. In absence of the access to the PPN agreement, the Insured was at a loss to understand and know the pre-fixed rates of treatments. The deduction of the claim was incorrect. In view of the foregoing the complaint was admitted.

In the matter of

Mr. Vijay G. Shah

Vs.

The United India Insc. Co.,Ltd., Ahmedabad

Date of Award : 13.04.2017 **Policy No** 0603002815P111502412

Complaint Ref. No. AHD-G-051-1617-1559

The Complainant's son Mr. Akshay Shah was hospitalized to Maa Nursing Home and Netra Jyoti Eyecare Centre, Mumbai on 07.06.2016, diagnosed both eyes Asthenopia , operated for Both eyes Cornea reshaping surgery under standby anesthesia and was discharged on the same day. The complainant had lodged a claim for Rs.54,019/- with the respondent Insurance Company. The respondent insurance company had repudiated the claim under Exclusion Clause No. 4.6 b of the Policy. The Complainant stated that patient had pus in both the eyes and the operation was carried out for the same. As per the certificate dated 7th June 2016 of treating doctor Dr. Jugal P. Shah of Maa Nursing Home and Netra Jyoti Eyecare Centre, " the patient was suffering from recurrent redness pain and watering due to contact lenses since 8 – 9 months in both the eyes. He had spectacle power of – Right eye -9.50 and Left eye -9.25. Due to his intolerance to contact lenses and spectacles, he was advised both eyes cornea reshaping surgery which will not only alleviate his symptoms, prevent further visual deterioration, but also help him to see better. " Due to high refractive error, the patient was almost blind without spectacles or contact lenses. The eyes cornea reshaping surgery was carried out to get rid of the suffering from recurrent redness pain and watering due to contact lenses. This cannot be considered cosmetic or aesthetic treatment for correction of eyesight.

In view of the foregoing the complaint was admitted.

In the matter of

Mr. Hardik Chauhan

Vs.

The United India Insurance Co. Ltd.

Date of Award : 13.04.2017 **Policy No**022000/42/14/00000099

The complainant had an accidental fall while walking on 09.04.2015 and was hospitalized to Zenith Hospital, Mumbai on 09.04.2015 for operation of right hip fracture on 10.04.2015 and was discharged on 15.04.2015. The complainant had lodged a claim for Rs. 2,62,627- being weekly compensation and medical expenses under PA Policy with the respondent Insurance Company. The respondent insurance company had paid Rs.33,536/-. The person having Muscular Dystrophy since 9 years would be exposed to more accidental injuries and delayed recovery in fractured bones. Muscular dystrophy is a group of disorders characterized by a progressive loss of muscle mass and consequent loss of strength. The treating doctor through his Certificate dated 03.07.2015, stating the dates of two surgeries viz. 14.04.2015 and 07.07.2015, had stated that the patient was diagnosed with severe osteoporosis and would require at least 6 month for bone building. He had advised rest till 07.12.2015 for the patient. **The certificate dated 03.07.2015 stated that the surgery was performed on 07.07.2015. The certificate was not acceptable to the Forum in view of the discrepancy in the date of the certificate and the date of second surgery.** The medical papers related to the second surgery dated 07.07.2015 was also not made available to determine whether the surgery was a fall out of the accident or why the second surgery was required. The complainant had not produced any medical treatment papers to assess the number of days/months he was bed ridden. The term required for settlement of PA claim was that the patient should have been bed ridden due to an accidental injury. There was no document to establish the number of days the patient was bed ridden. The Insurer had offered six plus six week compensation in view of the complainant's severe osteoporosis. Since he had an apprehension that he may get injured further in a chaotic life of Mumbai, he had not joined his office. Had he been offered the job in Gandhinagar/Ahmedabad, he would have taken up the job. Considering all the aspects, the Forum felt that weekly compensation for 12 week was fair and reasonable. Accordingly, the Respondent is directed to pay Rs.33,536/- (weekly compensation for 6 weeks @ Rs.3992/- per week and medical expenses of Rs.9582/-

In view of the foregoing the complaint is admitted.

In the matter of

Mr. Jahidhusen Saiyad

Vs

Star Health & Allied Insurance Co. Ltd.

Date of Award : 05.06.2017 **Policy No** P17220012017001079

Complaint Ref No.AHD-G-044-1718-0030

The Complainant was hospitalized at Jivandeep Hospital, Dholka from 20.12.2016 to 23.12.2016 for the treatment of Large Pituitary Macro-Adenoma & Compression of Optic Chasmal and then transferred to Brain & Spine Care Hospital from 23.12.2016 to 27.12.2016 for surgery of Trans Nasal Pituitary Tumor Excision and Septoplasty. The complainant had submitted a claim for Rs.34,042/- for first hospitalization and Rs. 1,50,292/- for subsequent hospitalization to the respondent. The Respondent had rejected the Insured's both claims under Condition No. 8 of the policyThe complainant was having mediclaim policy with Oriental Insurance Co. since for the 2014 and ported his mediclaim policy to Star Health Insurance on 21.08.2016. The complainant was not having any problem in eye earlier and had neither got treated nor lodged any claim with earlier insurer. The medical team of the respondent opined based on MRI Report that the complainant was having this disease prior to inception of their policy and it was not disclosed. The respondent had not produced any document proving that the insured patient had taken any medical treatment for the disease, establishing that he was aware of the disease and had concealed the same while porting the policy to the respondent. The claim of Rs.1,50,292/- for hospitalization from 23.12.2016 to 27.12.2016 for surgery of Trans Nasal Pituitary Tumor Excision and Septoplasty was payable.

The complaint was admitted.

In the matter of

Mrs. Mona S. Desai

V/s

he New India Assurance Co. Ltd.

Complaint Ref No.AHD-G-049-1718-0115

Date of Award : 05.06.2017 **Policy No**22030034152500004512

The Complainant's son Mr. Dheer Noal was hospitalized at Surekha Arthroscopy Arthroplasty Institutefrom 22.06.2016 to 23.06.2016 for the surgery of Arthroscopy Acl reconstruction Rt. Knee. The complainant submitted claim of Rs. 99,172/- to the respondent. The Respondent had settled the claim for Rs.63,915/- after deducting Rs.35,257The Complainant had opted for higher category room against the entitlement room rent of 1% of sum insured. Hence Respondent has made deduction as per policy clause 3.1(a) which was correct. Expenses incurred prior to 30 days of hospital were not payable as per the terms and conditions of the policy. Hence deduction of Rs.500/- being consultation charge of Surekha Arthroscopy Arthroplasty Institute as per Receipt No.2768 dated 09.03.2016 was not payable. The deduction of amount at Sl. No. 1, 2, 3 and 4 being cost of items not payable as per IRDAI Non Payable items list was in order.

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

In the matter of

Mr. Deepak Kumar P. Shah

v/s

Oriental Insurance Co. Ltd.

Complaint Ref No.AHD-G-50-1718-0036

Date of Award :05.06.2017 **Policy No** 144000/48/2017/6254

The Complainant's father Mr.Dipak Kumar P. Shah was hospitalized at Phaco Emulsification & Laser Centere, Ahmedabad on 27.08.2016 for Right Eye Cataract surgery. The complainant had submitted claim for Rs. 56,339/- to the respondent. The Respondent had settled the claim for Rs.34,217 after deducting Rs.22,122/- citing Reasonable & Customary charges. The claim

settlement letter dated 19.09.2016 was incorrect. The claim settlement letter stated the claim amount as Rs.82,889/-. The insurer was advised to be cautious in drafting the letter and write the true and correct facts in their communication to the insured. The complainant had submitted a blank claim form to the insurer. The Respondent's Self Contained Note stated the claim amount as Rs.56,062/-. The copy of the bills submitted to the Forum showed the total amount spent as Rs.55,838/-. The complainant in his complaint appeal letter had mentioned the amount of claim as Rs.52,000/-. Neither the Respondent nor the Complainant had bothered to present the correct amount of claim. The Forum had proceeded to consider the claim amount based on the bills submitted before us. The company and the complainant were cautioned to present correct facts before the Forum. The respondent had deducted Rs.500/- being expenses incurred before 30 days of hospitalization was as per policy terms and in order. As regards the deduction of of Rs.17,820/- being the difference of cost of unifocal lens and toric lens of Alcon (SN6AT4); nowhere in the policy terms, the limit of lens charges was described. The complainant had submitted letter from treating doctor mentioning the need of toric lens. Hence, the total cost of IOL Rs.26,550/- is allowed. In view of the foregoing, the complaint was admitted.

In the matter of

Ms. Geetaben G. Zala

Vs

United India Insurance Co. Ltd.

Complaint Ref No.AHD-G-51-1718-0009

Date of Award : 21.06.2016 Pol.No. 0603002814P104461624

The Complainant was hospitalized at Pramukh Orthopedic Hospital from 17.08.2015 to 22.08.2015 for repair of her left knee. The Respondent had rejected the Insured's claim for Rs. 2,08,890/- under clause 3.39 of the policy. The Respondent's representative in reply to a question whether the impugned "restoknee", the treatment was unproven or experimental, answered that their in-house doctor had called it so, hence they 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 under T. & C. of policy from reimbursement, he answered that there was no such clause in the terms and conditions of the policy. he Respondent had not proved the subject treatment was not based on established medical practice in India. The respondent as well as other companies have paid the claims for treatment under Restoknee procedure. Taking into account the facts and submissions by both the parties, the complainant was eligible for reimbursement of expenses restricted to 70% of the sum insured i.e. Rs.1,75,000/- as per the policy condition no.1.2.1. The complaint was admitted.

In the matter of

Mrs. Chandrika D. Vyas

V/s

The United India Insurance Co. Ltd.

Complaint Ref No.AHD-G-051-1718-0124

Date of Award : 05.06.2017 Policy No 120200/28/16/PI/03582322

The Complainant had undergone Dental Treatment on 28.07.2016 at Om Dental Clinic, Rajkot. The complainant submitted a claim for Rs. 7,640/- to the respondent. The Respondent had settled the claim for Rs.2,940/- after deducting Rs.4,700/-. As per the policy terms and conditions, Dental Root Canal Surgery was covered. The treating doctor is competent to decide whether protective cover (crown) would be required or not. The insured is 60 years old senior citizen, it is normally believed, the root canal procedure without crown would not be sufficient to protect the affected tooth. Hence, the treating Doctor put crown on the affected tooth to protect tooth from further damage and help restore proper chewing function. Thus, the cost of crown is payable. Scaling Treatment taken by the complainant was not related to Dental Root Canal Surgery done and hence, not payable. In view of the foregoing, the Respondent is directed to pay Rs. 3,000/- for Crown and Consultation Fee of Rs.100/-. The complaint is admitted.

In the matter of

Mr. Nitin S. Shah

Vs.

The Oriental Insurance Co. Ltd.

Complaint Ref. No. AHD-G-050-1718-0147

Date of Award : 13/07/2017 Policy No141601/48/2016/7505

The Complainant was hospitalized to Long Life Hospital, Ahmedabad on 11.07.2016, diagnosed to have Ca. Prostate primarily treated and discharged on 15.07.2016. He was hospitalized to Muljibhai Patel Urololgical Hospital, Nadiad on 08.08.2016, diagnosed Adenolcarcinoma Prostate and was treated with Robot assisted Radical Prostatectomy (B/L nerve sparing) and discharged on 16.08.2016. The complainant had lodged a claim for Rs/- Rs.7,49,537/-with the respondent Insurance Company. The respondent insurance company had paid Rs. 3,81,170/- after disallowing Rs.3,68,367/-. As per policy terms and conditions, there is no restriction for Robotic Surgery. The Insurer didn't

contend on the Item of Implant Charges Rs 205000/- and OT Charges Rs 125900/-. The representative of the insurer has agreed to pay these two charges. Both the parties agreed upon the proportionate deductions of Room charges, visiting charges, pathology charges, Pharmacy charges, nursing charges, surgeon charges, investigation charges anesthesia charges and cardiology charges as per entitle room category. The insured has also agreed for Rs 330900/- as balance payment receivable under the impugned claim. In view of the foregoing the complaint was admitted.

In the matter of

Mr. Kunal D. Shah

Vs.

The Oriental Insurance Co. , Ltd.

Complaint Ref. No. AHD-G-050-1718-0182

Date of Award : 13.07.2017 Policy No 5630000/48/2016/507

The Complainant's mother Mrs. Jyotee was hospitalized to Zydus Hospital for C.K.D. Maintenance hemodialysis on various dates. The complainant had lodged a claim for Rs.65,620/- (Claim No. HI-OIC-000178213) and Rs. 38119 (Claim No.HI-OIX-000199285) with the respondent Insurance Company. The respondent insurance company had repudiated the claim stating that "the patient is K/C/O CKD since 2004 and on continuous dialysis since 1 year. Hence present claim is repudiated as per policy terms and condition." As per the policy terms, all the pre-existing disease are covered from day one. The complainant had lodged three claims out of which one claim No. HI-OIX-000179310 FOR Rs. 27,356/- was settled by the insurer. Hence, there was no reason for the insurer to repudiate remaining two claims of the similar treatment. In view of the foregoing the complaint was admitted.

In the matter of

Mr. Bhavin S. Dave

Vs

The Oriental Insurance Co. Ltd

Complaint Ref No.AHD-G-050-1718-0216

Date of Award : 14.07.2017 Policy No 141100/48/2017/4671

The Complainant's father Mr. Shirishbhai was hospitalized at Dr. Talati's Eye Hospital, Ahmedabad on 14.12.2016 and was treated with Right Eye Intra vitreal Inj. Avastin and was discharged on the same day. The complainant submitted claim of Rs. 25,372/- to the respondent. The Respondent had rejected the Insured's claim under Clause No. 2.3 of the policy. The condition number 2.3 (c) further provides that

"This condition of minimum 24 hours Hospitalization will also not apply provided, medical treatment and/or surgical procedure is undertaken under General or Local Anesthesia in a hospital/day care centre in less tjhan 24 hours because of technological advancement, and which would have otherwise required a hospitalization of more than 24 hours. The subject treatment required specialized infrastructure like sterile condition and Operation Theater. The treatment is an advancement of the technology where the ailment is treated within 24 hours of hospitalization. ARMD/ Intra vitreal Avastin injection treatment was not excluded in the said policy. In view of the foregoing, the complaint is admitted.

In the matter of

Ms.Sudha P Shah

Vs.

he United India Insc. Co. Ltd. Baroda

Complaint Ref. No. AHD-G-051-1718-0137

Date of Award 21.06.2017 Policy No1804002814P11355633

The Complainant was hospitalized to Raghudeep Eye Hospital, Ahmedabad on 28.04.2016 for Vitrectomy Surgery in Right Eye cataract surgery with laser assisted Phaco and implantation of Intra ocular lens under topical anesthesia and was discharged on the same day. The complainant had lodged a claim for Rs.85,720/- with the respondent Insurance Company. The respondent

insurance company had paid Rs.40,000/- after disallowing Rs.45,720/-. There was no policy condition restricting maximum amount payable under cataract surgery. The respondent had not produced any other rate chart for comparison of rates prevailing in the same geographical area of the Hospital where the complainant had taken treatment and had arrived at the reasonableness of the expenses without comparison of the rates. The deduction of full Surgeon Fees of Rs.37,500/- and medication charges of Rs.8,220/- was not correct and hence, both these amounts were payable. In view of the foregoing the complaint was admitted.

In the case of Khyatyi N. Shah v/s ICICI Lombard General Insu. Co.ltd.

ComplaintRef:No.AHD-G-020-1617-1491

Award Date:13.04.2017 **Policy No.4015/116140992/00/000**

Mediclaim for treatment of Pathologic Myopia for(eye surgery) for Rs.122095/- was rejected under the reason exclusions for corrective surgery for refractive error. The complainant could establish that pathologic myopia was treated with implantation of Collamer Lens and it was to treat the deteriorating eye sight. It was not the correction of refrective error. The respondent treated it as LASIK surgery and excluded the reimbursement of claim.The respondent could not clarify whether implantation of Collamer Lens was included in LASIK treatment.

The complainant was awarded with Rs.122095/-.

In the case of Sandeep M. Thacker v/s The national Ins.co.ltd.

Complaint Ref: No.AHD-G-048-1617-1454

Mediclaim for cataract surgery was partially settled after deduction of Rs.42440/- towards customary and reasonable charges. The claim was settled on the basis of internal guidelines issued by the insurance company. The complainant argued that he was not informed about the restrictions placed by the company in respect of cataract surgery. The policy conditions did not mention any such restrictions. The complainant's contention was upheld and insurer's action to restrict claim amount was held unjust and unilateral.

The complainant was awarded Rs.42440/-.

In the case of Mr. Dipak Dadhania v/s Star Health and Allied Ins.co.ltd.

Complaint Ref: No.AHD-G-044-1718-0119

Award Date:05.06.2017 **policy No. P171220/01/2016/001714**

Mediclaim for treatment of up[per respiratory tract infection was repudiated by the insure on the ground of claim being fraudulent.The insurer argued that there was absence of pre & post hospitalization treatment. The line of treatment adopted was such that it could have been treated on outdoor basis. Except fever no other complaint was recorded in the treatment papers and discharge summary. All the investigation reports were normal. The complainant had submitted as many as 11 vclaims during 2013 to 2017 and all pertained either to treatment of upper respiratory tract infection or acute gestro enteritis. Therefore,under condition 8 of policy the claim was reje cted as being fraudulent. Insurer's repudiation was upheld.

The complaint failed to succeed.

In the case of Mr. Dipak Dadhania v/s Star Health and Allied Ins.co.ltd.

Complaint Ref: No.AHD-G-044-1718-0116

Award Date:05.06.2017 **policy No. P171220/01/2017/001726**

Mediclaim for treatment of up[per respiratory tract infection was repudiated by the insure on the ground of claim being fraudulent.The insurer argued that there was absence of pre & post hospitalization treatment. The line of treatment adopted was such that it could have been treated on outdoor basis. Except fever no other complaint was recorded in the treatment papers and discharge summary. All the investigation reports were normal. The complainant had submitted as many as 11 vclaims during 2013 to 2017 and all pertained either to treatment of upper respiratory tract infection or acute gestro enteritis. Therefore,under condition 8 of policy the claim was reje cted as being fraudulent. Insurer's repudiation was upheld.

The complaint failed to succeed.

In the case of Ruchit H. Shah v/s The New India Assurance co. ltd.

Complaint Ref: No.AHD-G-049-1718-0035

Award Date:05.06.2017 **Policy No.210402/34/16/25/00002180**

Mediclaim for cataract surgery for Rs.48251/- was settled for Rs.24000/- as per restrictive clause applied by the insurer. The complainant argued that his policy had incepted in the year 2000. He was not intimated about the imposition of clause restricting the reimbursement of cataract surgery to Rs.24000/- for each eye. The insurer submitted that till the year 2013 "mediclaim policy 2007" was issued without any restriction on claim amount. Thereafter the

policy was renewed as "New Mediclaim Policy 2012." The cpomplainant argued that policy did not contained any restrictive clause. But the insurer submitted the proposal form signed by the complainant which mentioned restrictive clause. The insurer's action was upheld.

The complainant failed to succeed.

In the case of Virbhadra Trivedi v/s The Oriental Insurance co.ltd.

Complaint Ref:No.AHD-G-050-1718-0026

Award Date:05.06.2017 **Policy No. 141200/48/2016/23260**

Mediclaim for treatment of COPD Post circulation stroke was rejected on the ground that the patient was treated for pre existing disease According to the insurer the insured person was suffering from breathing problem since 2 to 2.5 years. The complainant submitted that according to the certificate given by the treating doctor the patient was suffering from breathing problem since 1.5 years before 02.09.2016. he submitted that the policy had incepted in the November,2013 i.e. 2 years and 10 months before and therefore the insurer was not correct in pleading the pre existence of the breathing problem. The complainant's contention was upheld.

The complainant was awarded Rs.1,73,090/-.

In the case of Milan.g.Desai v/s The New India Assurance co.ltd.

Complaint No.AHD-G049-1718-0018

Award Date:05.06.2017 **Policy No.22030034160100002133**

Mediclaim for treatment of menopausal bleeding, Gall Stone and laparoscopic cholecystectomy was partially settled after deductions made towards non payable items like Registration Fees,service charges, non medical charges as per the terms of the policy. These deductions were upheld.doctor fees,anesthesia charges,surgeons FeesLab.Charges,O T Charges and doctor visit charges wer not properly derived. As per policy condition 2.1 ratio of eligible room rent ot actual room rent paid was to be applied for derivation of eligible proportion of above mentioned expenses. But the insure had added nursing charges to room rent for deriving this proportion Resultanatly the insurer took 60% as proportionate charges instead of 65.2017%.

The complainant was awarded Rs.6984/-

In the case of Mahendrabhai M. Patel v/s Religare Health Ins.co.ltd.

Complaint RefNo.AHD-G037-1718-0006

Award Date:05.06.2017 **policy No.10016538**

Mediclaim for treatment of viral fever and diabetes was repudiated on the ground of non disclosure of pre existing disease. The insurer submitted fasting blood sugar report and ppblood sugar report dated 11.12.2012 nof the complainant stating abnormal reading as 158-FBS & 214-PPBS. The policy had incepted in the year 2013 and the proposal papers for this insurance did not contained thois material information. The complainant was also prescribed tablate "Glimisave" for treatment of diabetes.The prescriptionwsa also submitted by the insurer. The Claim was repudiated and policy was cancelled under clause 6.1for non disclosure of material facts.

The complaint failked to succeed.

In the case of Jabraram Mali v/s The Oriental Ins. Co. ltd.

Complaint Ref:No.AHD-G050-1718-0230

Award Date:14.07.2017 **Policy No.131100/48/2013/21370**

Mediclaim for treatment of Dermatitis and Ulcer of left foot ankle was rejected on the ground that the the claim was fraudulent. The insurer submitted that the doctor had treated the patient conservatively and that he had no clinic in the city of Ahmedabad. Both these contentions were refuted by the complainant stating that the treating doctor had gone out of station for few months during which the insurer had taken a view that the clinic was closed. The treating doctor also had furnished proof in the form of municipal certificate about having his clinis=c at the address given by him. The respondent insurer did not appear in the hearing to defend the case.

The complainant was awarded Rs.50695/-

In the case of Anjankumar V. Vyas v/s The National Insurance Co. Ltd.

ComplainantRef:No.AHD-G048-1718-0164-0163

Award Date:13.07.2017 **Policy No.30010048168500006023**

The claim for cataract was settled for lesser amount and deductions were made towards reasonable & customary charges. The insurer argued that the deductions were made under policy clause 3.29. under this clause the insurer settles claim on the basis of rates prevailent in the same geographical area where the treating hospital us situated. Unfortunately the insurer did not produce any rate chart for the subject treatment. Therefore the deductions were not found just to the Forum and the insurer was directed to pay the same.

Rs.33893/- for left eye &Rs.31244/- for the right eye were awarded.

In the case of Sunil R. Patel v/s The Oriental Ins.Co. Ltd.

Complaint Ref:No. AHD-G-050-1718-0129

Award Date:13.07.2017 **Policy No.141102/48/2017/1652**

Mediclaim for treatment of vertigo-vestibular Neuronitis was rejected by the insurer was rejected on the ground of exclusion clause 4.3 for Ear disorders as per policy conditions. The complainant argued that he suffered from vertigo and it was not an ailment of ear. The insurer submitted that the ailment which the complainant suffered was vestibular Neuronitis. The treating doctor had certified it to be vestibular neuronitis. And insurer had obtained opinion of their medical refree also according to which vestibular neuronitis was benign ENT disorder. The repudiation was upheld.

The complaint failed to succeed.

In the case of Mr. Dinesh R. Gurjar v/s Iffco Tokio General Ins. Co. Ltd.

Complaint Ref.No.AHD-G-023-1718-0181

Award Date: 13.07.2017 **Policy No.52600101**

Mediclaim for treatment of retention of urine and abdominal pain was rejected on the ground that the complainant had been suffering from the same ailment prior to the inception of the policy with the insurer.the policy had first incepted with other insurer since 09.03.2010 it continued with them till 08.03.2016. It was then ported to the present respondent insurer company w.e.f. 09.03.2016.The present treatment started with first consultationON 25.05.2016. Therewas a typographical error in the case paper. History of one month was erroneously written as 1 year and this led the insurer to to infer that the illness was preexisting and it was not disclosed at the time of porting the policy. The treating doctor had already corrected this mistake in the case paper and duly attested the copy of the case paper. He submitted that in view of the certified correction of the case paper the insurer's plea for non disclosure was not tenable. The complainant 's stand was upheld.

The complainant was awarded Rs.60166/-

Date of Award: 05.06.2017
Group: Mediclaim
Pol.No. 10082447
Complainant No. AHD-G-037-1718-0012
Complainant: Mr. Manish S. Mehta Vs. Religare health Ins. Co. Ltd.

The Complainant was admitted to Smit surgical Hospital, Surat on 14.04.2016 for MIPH/Stepllar Haemorrhoidectomy and discharged on 15.04.2016. His claim for Rs.53,895/- was repudiated by the Respondent on the ground of non disclosure of Haemorrhoids before the commencement of the policy. Aggrieved by the decision of the Respondent he had submitted his case before the Forum for settlement of his claim.

The representative of the Respondent had stated that the Complainant was suffering from Haemorrhoids before start of the policy and he had not disclosed this fact at the time of taking insurance. Therefore the claim was repudiated as per policy clause no. 1.22 – Disclosure to Information Norm – means the policy shall be void and all premium paid thereon shall be forfeited to the company, in the event of misrepresentation, mis-description or non disclosure of any material fact.

The point to be considered was whether the Complainant had suppressed the material fact of his old disease Haemorrhoids/piles at the time of taking insurance with the Respondent company.

1. The Complainant had submitted the certificate dated 24.05.2016 of treating doctor Dr. Hitesh D. Shah M.S. where in he had mentioned that the Complainant was consulted by him on 12.04.2016. He had mentioned that there was H/o recurrent attacks of pain and bleeding P/R for last 6 months only. The patient had mentioned that he had one day mild attack of bleeding P/R 2 ½ years ago. After that it was asymptomatic and recurrent attack of bleeding started during the last 6 months only.
2. The Complainant was holding the policy of the Respondent since 16.03.2014 . As he had not taken any treatment of the Haemorrhoids/piles before first consultation with Dr. Hitesh Shah on 12.04.2016 the question of nondisclosure of the disease does not arise as the Complainant was holding the policy since 16.03.2014 continuously without break. The Respondent had not produced any other medical treatment documents of the insured on piles, the Respondent's contention that the Insured was suffering from piles for the past 2 to 2 ½ years was not acceptable. Mere mention of a happening (piles) in the medical case paper did not prove that the insured had piles as on the date of proposal. The Respondent had failed to prove and establish its contention – the reason for rejection of a claim.
3. In view of the above facts and submission by both the parties the complaint had been admitted.

Date of Award: 13.04.2017
Group:Mediclaim
Pol.No. 301200/48/14/85000210012
Complaint No. AHD-G-048-1617-1445
Complainant : Mr.Santosh T. Motwani Vs. The National Ins. Co. Ltd.

The complainant was admitted to Kaizen Hospital, Ahmedabad on 04.03.2016 for the treatment of Gastritis, Duodenitis, and Hiatus Hernia and discharged on 06.03.2016. He was again admitted to the same hospital on 07.03.2016 for the treatment of Acute Intestinal proximal small bowel (jejunum). On 09.03.2016 Laproscopic Adhesiolysis and on 12.03.2016 Laparotomy with jejuna resection anastomosis surgeries were performed. The Complainant was discharged on 24.03.2017. After the treatment, the Complainant had submitted the claim for Rs. 4,36,151/- which was settled by the TPA for Rs.1,42,500/-. The Complainant had sought relief of Rs.2,10,000/-.

The point to be considered was whether the partial settlement of the claim stating that the Mesenteric Ischemia was on account of long standing IHD?
Based on the documents submitted and the arguments made during the hearing, the following points emerged which were pertinent to decide the case.

1) The complainant was admitted at Kaizen Hospital from 04.03.2016 to 24.03.2016 for the treatment of acute intestinal obstruction, ischemic proximal small bowel (jejunum). As per the discharge summary, the patient was a known case of HTN for four years and was on medication namely, tab Monotrate 10, Tab UDP AT, Tab Ecosprin 75, Asthalin 2 mg.

2) On 08.03.2016 the patient had complained chest pain. Hence, an E.C.G. report was taken which showed ventricular premature contraction. His case was referred to Dr. Hitesh Patel, Intensivist. On his advise 2D Echo was carried out by Dr. Hasit Joshi (Cardiologist) s/o – LVEF 60%, creatine 1.4 so inj. mucomix was given and CT abdomen was done s/o Diffuse circumferential homogeneously enhancing wall thickening involving the mid end distal jejunal loops with fat stranding and haziness involving surrounding mesentery.

3) It was evident from the treatment taken at the Kaizen Hospital that the Complainant was suffering from the I.H.D. since last four years and was taking medicines for the treatment of the disease, as per the discharge summary. However, surprisingly the complainant's prostate discharge summery did not mention about his IHD in the patient's medical history column.

4) The letter submitted by the Complainant from the Kaizen Hospital mentioned that there was no direct correlation between I.H.D., Asthma and Ischemic bowel disease. However, the patient suffering from HTN and IHD and ischemic proximal small bowel could be due to insufficient blood supply.

5) The Respondent had submitted the opinion of Dr. Bhauman P. Maniar M.S. who vide his letter dated 10.08.2016 had stated that the patient as mentioned in discharged summary was a known case of IHD and Mesenteric Ischemia was a similar condition of abdomen. He had not expressed any opinion but had stated that the claim be not paid. He had not opined and proved with medical documents that the disease was due to 4 year old IHD. The so called opinion was not an opinion at all. There was nothing mentioned about the co-relation between the IHD and the acute intestinal obstruction, ischemic proximal small bowel or otherwise.

6) Further, the evidence submitted by the Respondent from the google search regarding the Mesentric Ischemia also failed to prove that the disease was the sole cause of the IHD. The google search produced by the Respondent stated that there existed other reasons for the disease. The representative, a medical doctor by profession was also not able to prove that IHD was the alone cause of the subject disease. He merely submitted that IHD could be one of the causes for the subject treatment.

7) The Respondent, thus, had failed to establish that the Mesentric Ischemia was the sole cause of the IHD. Therefore, the criteria of considering the sum insured as at before four years for calculation of the claim settlement was found to be incorrect.

8) The complaint was admitted.

Date of Award: 18.05.2017
Group: Mediclaim
Pol. No. 301800/48/16/8500004634
Complaint No. AHD-G-048-1718-0074/0120
Mr. Sureshbhai M. Shah Vs. National Ins. Co. Ltd.

The Complainant's wife Mrs Ramila S. Shah had undergone Right Eye cataract operation at Eye Global Hospital on 09.08.2016 with implantation of intraocular lens using Phacoemulsification technique. The Complainant had lodged the claim for Rs.34,798/- out of which the respondent had settled the claim for Rs.24,798/- after deduction of Rs. 10,000/- citing Reasonable & Customary Charges Clause.

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.10,000/- 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.

Date of Award: 13.07.2017
Group: Mediclaim
Pol.No. 30180048158500009301
Complaint No. AHD-G-048-1718-0138
Complainant: Mr. Harinkumar M. Shah Vs. National Ins. Co. Ltd.

The Complainant was admitted at Shreeji Multispeciality Hospital, Ahmedabad on 23.06.2016 for treatment of megalobastic anaemia, Hyperurecemia and 2nd degree piles and discharged on 28.06.2016. He had lodged the claim for Rs.37,480/- which was partially settled for Rs.22,243/- after deduction of Rs.15,237/- as per terms and conditions of the policy.
The amount of Rs. 9,000/- had been claimed towards room and nursing charges for 6 days. As per terms and conditions of the policy clause No. 2.1 – Room and Nursing charges @ 1% of sum assured are payable. The sum assured under the policy was Rs. 1,27,500/- (including CB of Rs. 27,500/-). Therefore the eligible amount was Rs.7,650/- (1275x6). The Respondent had correctly allowed Rs.7,650/- after deduction of Rs.1,350/- from the claimed amount.
The remaining amount deducted by the Company was Rs.13,887/- for which the reason for deduction was cited as 'Medicine charges' (Levoflox Inf. Rs. 129/- not payable out of Rs.259/- & Magnex IV/IMV not payable). On asking the clarification of this deduction the representative answered that it was as per the bill details of TPA attached and the medicines were tonic and not related to the disease of the Complainant. He could not prove that the deduction was as per the terms and conditions of the policy.
On google search we found that Levoflox Inf. and Magnex IV/IMV medicines were not tonic but were used to treat bacterial infections. Neomol IV contains paracetamol used as pain killer and for fever. Therefore the deduction of Rs.13,887/- was not made correctly by the Respondent.
In view of the above facts and submissions made by both the parties the Complaint had been admitted.

Date of Award: 13.07.2017
Group: Mediclaim
Pol. No. 604200501510001499
Complaint No. AHD-G-048-1718-0142
Complainant: Mr. Alkesh M. Shah Vs. National Ins. Co. Ltd.

The Complainant is a member of Group Policy issued to Shree Vallabh Vishvavihar Educational & Charitable Trust by The National Insurance Co. Ltd. under Policy No.604200501510001499. The Complainant was admitted at HCG Hospitals, Ahmedabad on 28.10.2016 with complaints of alleged history of Road Traffic Accident due to two wheeler, hit him on left leg on 28.10.2016 at 4.30 pm and he sustained injury on left foot. After discharge he submitted the claim file for Rs.1,00,086/- out of which Rs. 59067/- was paid and Rs. 41,019/- was deducted by the Company under various heads of account.

1. The Complainant was not provided the terms and conditions of the policy by the Respondent.

2. Except the deduction of Rs.8654/- towards Service Charges (As Service charges are levied by hospital), Rs.350/- Admission Charges (Admission Charges are not payable), Rs.3,000/- towards the visit charge (Claimed as per hospital bill dt. 30.10.2016 Rs.6,000/- less charges allowed by Ins. Co. Rs.3,000/-), Rs.3,000/- towards emergency visit charge on 01.11.2016 (Claimed Rs.5,000/- less charges allowed by Ins. Co. Rs.2,000/-) and 20% co-payment, the representative

of the Respondent had failed to prove the justification of all other deductions made by the Company.

3. In view of the facts and submissions made by both the parties the Complaint was admitted.

Date of Award: 14.07.2017
Group: Mediclaim
Pol. No. 30180048468500002179
Complaint No. AHD-G-048-1718-0214/215
Complainant: Mr. Mukesh J. Shah Vs. National Ins. Co. Ltd.

The complainant was admitted at Sanidhya Eye Hospital, Ahmedabad on 28.09.2016 for Right Eye cataract operation and was discharged on the same day. He had submitted the claim for Rs. 37,000/- which was partially settled by the Respondent for Rs.24,750/- after deduction of Rs.12,250/- as per guidelines of their higher office.

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 Respondent company could not prove that the reasonable and customary charges for cataract operation was Rs.24,750/- and excess of Rs.12,250/- incurred by the complainant was unreasonable and not customary. The insurer has not provided what is the standard charges of the specific hospital for cataract surgery and how it is not consistent with the charges of other similarly facilitated hospital for cataract surgery in the same geographical area . No comparison has been made by the respondent.
The representative of the Respondent could not explain how the higher authority of the Company had fixed the charges of Rs.24,000/- for cataract operation.
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.

Date of Award: 14.07.2017
Group: Mediclaim
Pol. No. 30180048468500002179
Complaint No. AHD-G-048-1718-0214/215
Complainant: Mr. Mukesh J. Shah Vs. National Ins. Co. Ltd.

The complainant was admitted at Sanidhya Eye Hospital, Ahmedabad on 28.09.2016 for Right Eye cataract operation and was discharged on the same day. He had submitted the claim for Rs. 37,000/- which was partially settled by the Respondent for Rs.24,750/- after deduction of Rs.12,250/- as per guidelines of their higher office.

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 Respondent company could not prove that the reasonable and customary charges for cataract operation was Rs.24,750/- and excess of Rs.12,250/- incurred by the complainant was unreasonable and not customary. The insurer has not provided what is the standard charges of the specific hospital for cataract surgery and how it is not consistent with the charges of other similarly facilitated hospital for cataract surgery in the same geographical area . No comparison has been made by the respondent.
The representative of the Respondent could not explain how the higher authority of the Company had fixed the charges of Rs.24,000/- for cataract operation.
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.

Date of Award: 13.07.2017
Group: Mediclaim
Pol. No. 22150234150100000602
Complaint No. AHD-G-049-1718-0173
Complainant: Mr. Burhani A. Chunawala

The Complainant's daughter Ms. Fatema B. Chunawala was admitted at Baroda Laproscopy Hospital, Vadodara for treatment of Hiatus Hernia with reflux Oesophagitis. She was discharged on 09.08.2016 after operation of Laproscopic Nissan's Fundoplication. The claim for Rs.1,11,704/- was submitted by the Complainant. The Respondent had partially admitted the claim for Rs.72,023/- after deduction of Rs.39,681/- under reasonable and customary charges and not payable items

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 Laparoscopic Nissan's Fundoplication operation in the geographical area. The representative of the Respondent had provided one list of Baroda Surgeon's Association charging for various surgeries. As per this list the charges for Strangulated Hernia Resection Anastomosis + Repair was shown as SM-2 and operation charges for SM-2 for Special Room was Rs.60,000/-. The President of the Baroda Surgeon's Association was Dr. Pankaj Khandelwal who was also treating doctor under this case. The operation charge taken by the Baroda Laproscopic hospital was also Rs.60,000/-. No excess operation charge was taken by the hospital, over and above the Baroda Surgeons Association's list. Hence the representative of the Respondent failed to prove that the charges charged by the hospital was not reasonable.
The Insurance company could not prove that deduction of Rs.38,750/- was the reasonable and customary charges for Laprascopic Nissan's Fundoplication surgery in the hospital, where the complainant's daughter was operated and it was consistent with the charge for similar surgery in similarly placed hospital in geographical area.

The deduction of Rs. 931/- towards not payable items was found correct as per policy condition. In view of the above facts and submissions made by both the parties the Complaint had been admitted.

Date of Award: 05.06.2017
Group: Mediclaim
Pol. No. 14400048201710262
Complaint No. AHD-G-050-1718-0032
Mr. Bhikhubhai R. Patel Vs. Oriental Ins. Co. Ltd.

The complainant was admitted at Sal Hospitals, Ahmedabad on 29.08.2016 with complaint of chest pain and ghabraman and discharged on 30.08.2016 after treatment. He was hypertensive and diabetic. He was diagnosed for coronary Artery Disease – Double vessel disease. Angioplasty with stenting to LAD and LCX was done. The complainant had submitted the claim for Rs.3,29,860/- which was repudiated by the Respondent citing policy clause No. 4.1 " Any pre existing health condition or disease or ailment are excluded upto three years of the policy." Since he had renewed his policy on 04.08.2015 after the break of one month, so the policy was considered as fresh and he had mentioned in his declaration form that he was suffering from hypertension and cancer. Therefore, the claim was repudiated by the company.

The date of collection of premium due 04.07.2015 for the year 2015-16, was 03.08.2015 as mentioned in the certificate issued by the collecting Agent , Punjab National Bank, Sola Road Ahmedabad. The premium was remitted within grace period of 30 days, therefore, the Complainant was eligible for continuity of the policy for the year 2015-16.

The Complainant was holding the policy with the Respondent since 04.07.2013 without break, the reason for repudiation cited by the Respondent as per terms and condition under clause No.4.1 regarding pre-existing health condition was not tenable. The disease and the treatment had happened after the two year waiting period.

The Complainant had claimed the amount of Rs.3,29,860.13 including post hospitalisation bills for Rs.4,012.63 (beyond 60 days of hospitalisation). The bills included receipts of medicines purchased beyond 60 days for Rs.3212.63 and consultation fee Rs.800/- done on 11.11.2016. Since the amount payable on post hospitalisation was upto 60 days only as per the terms and conditions, Rs.4012.63 was not payable. Hence the amount of claim payable would be Rs.3,25,847.50

In view of the documents and submissions by both the parties the Complaint was admitted.

Date of Award: 14.07.2017
Group: Mediclaim
Pol.No. 1723004820171534
Complaint No. AHD-G-050-1718-0194-95-96-97
Complainant: Mr. M.Hanif A. Kadva Vs. Oriental Ins. Co. Ltd.

The Complainant's wife Mrs. Madinaben was admitted at Desai Eye Institute & Research Centre, Vadodara on 15.11.2016 for her Right Eye Cataract Operation and discharged on the same day. The Complainant lodged the claim for Rs. 38,256/- with the Respondent. His claim was partially settled for Rs. 24,000/- and he was paid Rs. 21,600/- after deduction of Rs.2,400/- as co-payment and Rs.14,256/- was deducted toward reasonable and customary charges.

i) The respondent insurance company has submitted that Desai Eye Institute and Research Centre has charged a sum of Rs.3,27,805/- in seven cases. These cases were also settled by the respondent. The average of charges for eye cataract operation of these cases comes to Rs.46,829/-. The insured was also treated for cataract operation in the same hospital and in none of his four cases (two for himself and two for his wife) the "Desai Eye Institute and Research Centre" has charges more than Rs.46,.929/-. So the rate of eye cataract surgery for the specific provider is not excessive as compared to charges in other cases.

The Insurance company could not prove that deduction of Rs.14,256/- was reasonable and customary for cataract surgery in the hospital, where the complainant's wife was operated and it was not consistent with the charge for similar surgery in similarly placed hospital in same geographical area.

ii) In view of the facts and submissions made by both the parties, the Complaint was admitted. The Complainant was entitled to receive the claim for Rs.38,256/- less 10% co-payment = Rs.34,430/-. After deduction of Rs. 21,600/-, amount paid by the Respondent, the balance amount payable would be Rs.12,830/-.

Date of Award: 13.04.2017
Group: Mediclaim
Pol. No. 1801022816P105092049
Complaint No. AHD-G-051-1617-1481/1479
Complainant: Mr. Bharatbhai M. Vyas Vs. The United India Ins. Co. Ltd.

The Complainant was admitted to Jethwa Eye Hospital, Anand on 22.10.2016 for Left Eye Cataract surgery & discharged on the same day. His claim for medical expenses of Rs.92,100/- was partially settled for Rs.28,000/-. Deduction of Rs.64,100/- was made citing Reasonable & Customary Charges clause of the policy.

iii) There was a capping / ceiling for payment of cataract surgery under the policy conditions no. 1.2.1 – "Expenses in respect of Cataract, Hernia, Hysterectomy will be restricted to actual expenses incurred or 25% of the sum insured whichever is less, per surgery."

iv) No exercise for arriving at reasonable and customary charges has been made by the insurer. The insurer cannot restrict the claim at PPN rate with specific type of lens. Whether the cost of Toric lens is inflated, the insurer has not proved. When there is a specific clause for cataract surgery in the policy conditions, the general clause will not be applicable. Settlement

of claims on the basis of internal guidelines, which is not a part of terms and conditions of policy, is not proper.

v) The sum insured under the policy in question was Rs. 3,25,000/-. Hence as per the policy conditions no. 1.2.1 the complainant was eligible for Rs. 81,250/- for cataract surgery. He should, therefore, be paid the difference of Rs.53,250/-.
In view of the forgoing, the complaint was admitted.

Date of Award: 13.04.2017
Group: Mediclaim
Policy No.1805002815P104782306
Complainant No. AHD-G-051-1617-1530
Complainant: Mrs. Ritaben M. Trivedi Vs. The United India Insurance Co. Ltd.

The Complainant was insured with Individual Health Insurance Policy issued by United India Insurance Company Ltd for a Sum Insured of Rs.2,50,000/-. The Complainant was hospitalized at Pramukh Orthopedic Hospital from 06.05.2016 to 16.05.2016 for repair of her left knee. The Respondent had rejected the Insured's claim for Rs.2,46,516/- under clause 4.15 of the policy.

1. The Respondent's representative in reply to a question whether the impugned "restoknee" treatment was unproven or experimental, answered that their in-house doctor had called it so, hence they 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.
2. The Respondent had not proved the subject treatment was not based on established medical practice in India.
3. The Respondent had settled the claim for same treatment given by the same Hospital in favour of the claimant Mr. Ghanshyambhai Sharma, Claim No.92764037 on 17.08.2016 for Rs.2,27,838/- and not raised any question in terms of clause no 4.15 of the policy terms and condition.
4. We had sent an e-mail to United India Insurance Co., Ahmedabad on 7th June, 2017 requesting for confirmation of payment made under Policy No. 070300/28/15/P1/15167369 for treatment of Restoknee, followed by reminder email on 12th June and 19th June, 2017. However, we have not received confirmation of payment from the insurance company. In absence of their reply, it is presumed that the company had earlier made payment for operation made by Restoknee procedure. The proof of settlement of the claim as submitted by the Complainant, is accepted.
5. The respondent could not prove that the treatment Restoknee was unproven till today. Sufficient time was given to the insurer to do so.
6. The respondent as well as other insurance companies have paid the claims for treatment under Restoknee procedure.
7. As per the policy condition No. 1.2.1 – " Expenses in respect of the Major Surgeries which include cardiac surgery, brain tumor surgeries, pace maker implantation for sick sinus syndrome, cancer surgeries, hip, knee, joint replacement surgery, organ

transplant, will be restricted to actual expenses incurred or 70% of the sum insured whichever is less.

8. Taking into account the facts and submissions by both the parties, the complainant was eligible for reimbursement of expenses restricted to 70% of the sum insured i.e. Rs.1,75,000/- as per the policy condition no.1.2.1.

9. In view of the foregoing, the complaint was admitted.

In the matter of

Case of: Mr. Chandresh M. Nasit

V/s. The Oriental Ins. Co. Ltd., Ahmedabad

Complaint Ref. No. AHD-G-050-1617-1437

Award Date: 12/04/2017
Policy No. 143691/48/2016/1998

The Complainant and his family members were insured for Sum Insured of Rs.2,00,000/- under Happy Family Floater Policy with The Oriental Insurance Company Ltd. The Complainant's father Mr. Madhubhai Nasit, aged 54 years was hospitalized to Shri Aashapuira Maa Jain Hospital & Shri Mehta & smt. Sanghvi Eye Foundation Hospital, Ahmedabad on 03.10.2016 for operation of Right Eye Cataract by phaco-emulsification method with implantation of injuctable foldable lens in Rt.eye surgery and discharged on the same day. The complainant had lodged a claim for Rs.21,908/- with the respondent Insurance Company. The respondent insurance company had paid Rs.15,559/- after disallowing Rs.6,349/-.

A) As regards the deduction of Rs.4,600/- from IOL bill, the complainant had submitted a copy of Bill No.2397 dated 03.10.2016 for Rs.14,600/-. The Respondent had deducted Rs.4,600/- without producing any proof to prove that the cost of it was on higher side.

B) The respondent had correctly deducted Rs.2,189/- towards 10% Co-payment and Rs.20/- Misc. Charges which were not payable as –per policy terms and conditions.

C) In view of the foregoing the complaint was admitted AND ***the Respondent is hereby directed to make payment of Rs.4,140/- to the complainant.***

In the matter of

Case of: Mr. Mafatlal C. Shah

V/s. United India Ins. Co. Ltd., Ahmedabad

Complaint Ref. No. AHD-G-051-1617-1441

Award Date: 12/04/2017
Policy No. 181400/28/16/P/106206318

Mrs. Jayshriben M. Shah, aged 70 years, spouse of the Complainant was insured for Sum Insured of Rs.3,00,000/- under Individual Mediclaim Policy with United India Insurance Company Ltd. She was admitted to Kadam Eye Lasik Central, Vadodara on 26.11.2016 for Right Eye Cataract surgery and discharged on the same day. Her claim for medical expenses of Rs.36,779 was partially settled with Rs.24,000/- after deduction of Rs.12,779/- citing Reasonable and Customary Charges clause of the policy.

A) The respondent had not produced any rate chart 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 without comparison of the rates.

B) The complainant had submitted a copy of Bill No.18454 dated 26.11.2016 for Rs.16,750/-. The respondent had deducted Rs.12,779/- towards Lens charges under " Reasonable and Customary Charges" without producing any evidence for the same. The same was wrongly deducted.

C) Deduction of Rs.164/- towards Non-medical Charges was not payable as per the terms of the policy.

D) In view of the foregoing the complaint was admitted AND ***the Respondent is hereby directed to make payment of Rs 12,615/- to the complainant.***

In the matter of

Case of: Mr. Mafatlal C. Shah

V/s. United India Ins. Co. Ltd., Ahmedabad

Complaint Ref. No. AHD-G-051-1617-1452

Award Date: 12/04/2017
Policy No. 181400/28/16/P/106206318

Mrs. Jayshriben M. Shah, aged 70 years, spouse of the Complainant was insured for Sum Insured of Rs.3,00,000/- under Individual Mediclaim Policy with United India Insurance Company Ltd. She was admitted to Kadam Eye Lasik Central, Vadodara on 06.12.2016 for Left Eye Cataract surgery and discharged on the same day. Her claim for medical expenses of Rs.36,313/- was partially settled with Rs.24,000/- as per deduction of Rs.12,313/- citing Reasonable and Customary Charges clause of the policy.

A) The respondent had not produced any rate chart 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 without comparison of the rates.

B) The complainant had submitted a copy of Bill No.19186 dated 06.12.2016 for Rs.16,750/-. The respondent had deducted Rs.12,313/- towards Lens charges under " Reasonable and Customary Charges" without producing any evidence for the same. The same was wrongly deducted.

C) Deduction of Rs.164/- towards Non-medical Charges was not payable as per the terms of the policy.

In view of the foregoing the complaint was admitted AND ***the Respondent is hereby directed to make payment of Rs 12,149/- to the complainant.***

In the matter of

Case of:- Mr. Yashwant C. Soni

V/s The National Insurance Co. Ltd.

Complaint No. AHD-G-048-1617-1459

Award Date: 12/04/2017
Policy No. 302201/48/15/8500004826

The Complainant Mr. Yashwant C. Soni was admitted to Life Care Institute of Medical Sciences & Research Hospital, Ahmedabad for treatment of Coronary disease. He was discharged on 16/09/2015. The complainant had claimed total expense of Rs.5,75,740/-. His claim was settled for Rs.2,83,410/- (Cashless Facility) + Rs.13,380/- (Pre-Post hospitalization) , total amounting to Rs.2,92,330. The remaining claim of Rs.2,83,410/- was rejected by the Respondent citing Policy Clause No. 3.26

i) In the discharge summary of the Life Care Institute of Medical Sciences & Research Hospital ,Ahmedabad Effort Engina + CAD-DVD =successful PTCA stenting to LCx done on 10/06/2016 and successful PTCA stenting to LAD & POBA of D1 & Septal done using drug eluting balloon on 13/06/2016 + stress induced.

ii) The complainant had claimed Rs.5,75,740/-, and the Insurance company had settled total amount of Rs.2,92,330/- through cashless/reimbursement.

iii) The complainant had not received the policy terms and conditions.

iv) As per Policy Terms & Condition 3.26 read as :

“Preferred provider network (PPN) means a network of hospitals which have agreed to a packaged pricing for certain procedures for the insured person. The list is available with the company/TPA and subject to amendment from time to time . Reimbursement of expenses incurred in PPN for procedures (as listed under PPN package) shall be subject to the rates applicable to PPN package pricing”.

v) The Respondent had failed to provide any justification in support of the deduction of Rs.2,07,670/-/- made from the claim amount.

vi) In view of the aforesaid facts the complainant was admitted AND **the Respondent was directed to settle the balance claim amount of Rs 2,07,670/- to the Complainant.**

In the matter of

Case of: Mr. Dharmesh V. Gandhi

Vs. The New India Assurance Co. Ltd.

Complaint No. AHD-G-049-1617-1518

Award Date: 20/04/2017
Policy No. 230101/34/15/01/00003238

The Complainant's son Shri Harshil, aged 19 years was insured under Mediclaim Policy 2007 from 26/02/2016 to 25/02/2017 issued by The New India Assurance Co. Ltd. The Insured was admitted to Dr. Setul Shah's (M.S.- Ortho) Hospital, Surat on 01/07/2016 for the treatment of Prolapsed Intervertebral disc lesion L4-5 / L5-S1 and discharged on 07/07/2016. The Company had rejected his claim under the policy clause No.3.9.

a. On 01/07/2016, the complainant was admitted for the treatment of L4_L5 Prolapsed Intervertebral Disc and treated Parenteral in Analgesics, electro physiotherapy and Pelvic traction round the clock.

b. The Insurer had not disputed the ailment/injury and the electro physio therapy, pelvic traction, medicines injections.

c. The Respondent had repudiated the claim stating that thes OPD based treatment was converted to hospitalization.

d. The Respondent had rejected the claim stating that there was no active treatment or operative treatment but only conservative treatment was given. However the policy condition did not carry any such clause mentioned by the Respondent in its rejection letter. The patient was treated with electro physiotherapy and traction (pelvic) and administered with medicines/injections and the patient got cured of his ailment/injury. Active treatment was not defined in the policy. The dictionary defines active treatment as treatment directed immediately to cure of the disease or injury. The Insurer had not visited / examined the Insurer in the hospital to know the gravity of the injury.

e. The Company had hence wrongly repudiated the claim.

f. Expenses incurred under bill No.1607100252 for Rs.1,700/- (Rs.500/- + Rs.1200/-) was not related to the subject treatment and bill no. 40160300683 for Rs.1,420/- was related to expenses incurred on treatment of disease before 30 days from the date of hospitalization. Hence, Rs.3,120/- was not payable from the claim amount.

g. In view of the foregoing the complaint was admitted AND **hearing the Respondent is hereby directed to settle the balance claim amount of Rs 39,159/-to the Complainant.**

In the matter of

Case of: Mrs. Ritaben G. Shah

V/S The Oriental Insurance Co. Ltd.

Complaint No. AHD-G-050-1617-1553

Award Date: 13/04/2017
Policy No. 242500/48/2016/825

The complainant Mrs. Ritaben Shah, aged 54 years, and her family were insured for Sum Insured of Rs.4,00,000/- under Group Mediclaim Policy with Oriental Insurance Company Ltd. She was admitted to Welcare Hospital, Vadodara on 06/12/2015 for O.A. of Left Knee surgery and discharged on 10/12/2015. Her claim for medical expenses of Rs.1,83,550/- was repudiated by the respondent citing stop loss clause of 105% in the policy.

1) The claim was correctly rejected by the Respondent under stop loss clause of 105%.

In view of the foregoing the complaint failed to succeed.

In the matter of

Case of: Mr. Deepak

V/S. Jariwala V/s The Oriental Insurance Co. Ltd.

Complaint No.: AHD-G-050-1617-1561

Award Date: 24/04/2017
Policy No. 131100/48/2015/15606

The complainant Mr. Deepak V. Jariwala aged 67 years and his spouse were insured for Sum Insured of Rs.4,00,000/- each under Individual Mediclaim Policy with Oriental Insurance Company Ltd. He was admitted to Saviour Annexe Hospital, Ahmedabad on 17/06/2015 for Bil TKR surgery and discharged on 22/06/2015. His claim on medical expenses of Rs.4,00,022 was partially settled for Rs.3,58,767/-. Deduction of Rs.41,255/- was made from the claim citing GIPSA package.

2) The treatment package was for Rs.3,70,000/-. The cashless amount sanctioned by the respondent was for Rs.3,40,000/-.

3) The claim was rejected partially for Rs.40,500/- by the Respondent. The home visit charges (Rs.10,500/-) and non-payable Non-medical items (Rs.755/-) were correctly deducted as per policy terms and conditions.

4) The complainant was insured for Rs.4,00,000/- The Complainant had availed the Package for Rs.3,70,000/- which he was entitled for. The Respondent's mere statement that the Insured had preferred a package for Rs.3,40,000/- initially, did not restrain the Insured from claiming the package for Rs.3,70,000/- The medical papers and papers issued by the hospital showed that the complainant had availed a package for Rs.3,70,000/-. The respondent failed to prove that the Insured had not availed the package for Rs.3,70,000/-

5) The complaint was admitted AND the respondent is hereby directed to pay Rs.30,000/- to the complainant.

In the matter of

Case of: Mr. Govindbhai R. Prajapati

vs. HDFC Gen. Ins.Co. Ltd., Ahmedbad

Complaint Ref. No. AHD-G-027-1718-0011

Award Date: 05/06/2017
Policy No. 316108000638170000

The Complainant and his family members were insured for Sum Insured Rs.3,00,000/- under HDFC Ergo Gen. Ins. Co. Ltd. (Formerly L & T Gen. Insurance Co. Ltd.). The Complainant's daughter Ms.Nisha, aged 12 years was hospitalized at Shashvat Child Care Hospital, Ahmedabad on 24.10.2016 for the treatment of extreme abdominal pain and vomiting. She was diagnosed with Vasico Urinary Reflux Secondary to Calculus + Enteritis and was discharged on 26/10/2016. The complainant's claim for Rs.10,343/- was repudiated by the Respondent.

The Insured was detected to have calculi of 3 – 4 mm in the first year of the policy. The patient had fever, abdominal pain, vomiting etc. which were due to the presence of calculi in the urinary tract. The policy clause No. D – 3 exclusion provided for a waiting period of 2 years in the case of calculus and its complication. The patient was administered with

Tablets- Dolo 650, Emeset, Taxim & injections Emeset, Rantac, Buscogast, Pan 40, and Dynapur etc. These medicines were antibiotic and to reduce the swelling and pain in the abdomen caused by the calculus. The calculus of 4 mm usually gets itself thrown out of the body along with urine. The reports proved that there was calculus in the patient. The pain in the abdomen was due to the presence of the calculus which the doctor had diagnosed and had mentioned in the discharge summary. Since the exclusion clause of the policy provided for payment on the treatment of calculus and its complications after 2 years, the Insurer had applied the clause correctly and rejected the claim.

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

In the matter of

Case of: Mr. Ashokbhai K. Hirpara

Vs. The Iffco – Tokyo Gen. Ins. Co. Ltd.

Complaint No. AHD-G-023-1617-0038

Award Date: 05/06/2017
Policy No. 52586666

The Complainant and his wife were insured for Sum Insured Rs.5,00,000/- under Family Health Protector policy with Iffco-Tokio General Insurance Company Ltd. The Complainant was hospitalized to Ranchhodrai Eye Clinic, Ahmedabad on 30.03.2016 for operation of Left Eye Cataract and was discharged on the same day. The complainant had lodged a claim for Rs.30,468/- with the respondent Insurance Company. The respondent insurance company had repudiated the claim citing General policy condition No.49.

a. Complainant had no trace of cataract at the time of proposal for portability, so he had not mentioned it in the proposal form dated 16/02/2016.

b. It was found that the proposal was filled up by the agent and had wrongly guided the Insured to shift the policy to the Respondent. As it was evident that had the Insured been made aware that he would not get the claim on his medical treatment (cataract) he would not have ported the policy and would have continued with his previous insurer. The policy porting process started before 45 days from the date of commencement of the policy with the Respondent. The Discharge Summary stated that the Insured stated to have

diminished vision before 2 months that was roughly during the period of portability process. More ever, the Respondent did not have a clear proof to show the exact date of onset of cataract in the Insured. With the policy having ported to the Respondent, all the benefits flow to the Insured. In this case, the Insured had not taken any treatment on cataract as on the date of proposal for porting of the policy. Thus, it was wrong on the part of the Respondent to deny the claim under the pretext of suppression of material fact.

In view of the foregoing the complaint is admitted and **hearing the Respondent is hereby directed to settle the claim amount of Rs. 30,468/- to the Complainant and take necessary action against the Agent, if any.**

In the matter of

Case of: Mr. Prakash R. Mehta

V/s. The Oriental Ins. Co. Ltd., Ahmedabad

Complaint Ref. No. AHD-G-050-1718-0050

Award Date: 05/06/2017
Policy No. 141600/48/2017/1393

The Complainant's spouse was covered under Happy Family Floater-2015 policy of The Oriental Insurance Co. Ltd. The complainant's spouse Mrs.Daxaben, aged 61 years was hospitalized in Medilink Hospital & Research Centre Pvt. Ltd., Ahmedabad on 27/06/2016 and 19/07/2016 for Chemotherapy (CA Breast Adjuvant) and discharged on the same day. The complainant had incurred a total expenses of Rs.1,41,323/- which was repudiated by the Insurer stating that the patient was admitted with k/c/o CA Breast and treated with Chemotherapy, and claim for adjutant chemotherapy (trastuzumab) was not payable under clause 2.3. Aggrieved by the decision, he had represented to the higher office of the Respondent. Dissatisfied with higher office's decision, he had approached the Forum for settlement of his claim.

i) The total expenses was for Rs.1,41,323/-

ii) The Insured had a Sum Insured of Rs.2,00,000/-. The Insurer had settled Rs.1,38,562/- in favour of the complainant in the impugned policy year in various other claims. Thus, a Sum Insured of Rs.61,438/- was left for claim reimbursement. The subject claims were for Rs.1,41,323/-, the Insured was entitled for the available Sum Insured of Rs.61,438/-.

iii) The policy has provided for deduction of 10% Co-payment i.e. 10% of the claim amount payable would be borne by the policy holder.

iv) The patient had appeared in person before the Forum.

v) With the advancement of medical technology the treatment on various disease which needed hospitalization for more than 24 hours had been reduced to few hours. Chemotherapy and injections for the treatment of cancer are not like any other treatment like vaccination or anti rabis shots. This treatment needs a special care and attention of the oncologist, hematologist etc.

vi) The Respondent had, therefore wrongly denied the hospitalization aspect. The policy provides for reimbursement on the chemotherapy and the injections given to treat cancer under clause 1.2 (iv) of the policy. In the subject case, the Respondent had denied the cost of injection on the ground that hospitalization was not necessary for taking this injection.

vii) The insured was admitted to the hospital for few hours only. Hence, the question of hospitalization, Room charges etc. did not arise at all. The Respondent had erred in arriving the conclusion and denied the claim.

viii) In view of the above the complainant is admitted and the respondentent **is hereby directed to settle the claim amount of Rs.55,294/- to the Complainant**

In the matter of

Case of: - Mr. Jayantilal R. Modi

V/S The New India Assurance Co. Ltd.

Complaint No.: AHD-G-049-1718-0121

Date: 05/06/2017

Policy No.211502/34/15/01/00000191

The complainant Mr. Jayantilal Modi was admitted to Sterling Hospitals, Ahmedabad on 11/03/2016 for Brain surgery & discharged on 15/03/2016. The complainant had incurred an expense of Rs.1,25,250/-. His claim was partially settled on 29/04/2016 for Rs.58,786/-. Deduction of Rs.66,464/- was made citing - Proportionate deduction as per clause No.2.1, 2.3, 2.4 Note.1

vi) The insured is insured under Mediclaim policy 2007 which restricts the amounts payable under 2.3 & 2.4 as under :

“ The amounts payable under 2.3 & 2.4 shall be at the rate applicable to the entitled room category. In case insured opts for room with higher than the entitled under clause 2.1, the

charges payable under 2.3 & 2.4 shall be limited to the charges applicable to the entitled category".

It, nowhere, says that the amounts payable under 2.3 & 2.4 shall be reduced proportionately. The insurer has not made any exercise to ascertain the amounts payable under 2.3 & 2.4 for the entitled category and has reduced these expenses proportionately. It is not justified.

(ii) Deduction on account of room rent, ICU charges, non-medical items and service charges are justified.

(iii) The proportionate deduction of Rs.44,874/- on account amounts payable under 2.3 & 2.4 for Surgeons, Anesthetist, consultant charges etc. are not justified.

(iv) In view of the aforesaid facts, the complaint is admitted and the respondentent **is hereby directed to settle the claim amount of Rs.44,874/- to the Complainant.**

In the matter of

Case of: Mr. Vijay M. Thakkar

vs. Oriental Insurance Co. Ltd., Ahmedbad

Complaint Ref. No. AHD-G-050-1718-0125

Date: 05/06/2017

Policy No. 141200/48/2015/27051

The Complainant and his wife were insured for Sum Insured Rs.5,00,000/- under Oriental Bank Mediclaim policy with Oriental Insurance Company Ltd. The Complainant's spouse Mrs. Himansi was hospitalized to Raghudeep Eye Hospital, Ahmedabad on 08.12.2015 for operation of Right Eye Cataract and discharged on the same day. The complainant had lodged a claim for Rs.1,19,000/- with the respondent Insurance Company. The respondent insurance company had paid Rs.18,000/- after disallowing Rs.1,01,000/-.

A) The Complainant had enclosed copies of the claim settlement letters of (1) Panchal Dhananjay B – Insured with Oriental Ins. Co. Ltd. Claim No. HI-OIC-000080029 –

settlement amount of Rs.38,206/- on 30/11/2015. (2) Joshi Jyotsanaben V. – Insured with Oriental Ins. Co. Ltd., Claim No. MDI2965073 – settlement of Rs.24,000/- as proofs. He had written to the company stating that the company had settled the claim that had arisen from the same company.

B) The respondent had not produced any other rate chart for comparison of rates prevailing in the same geographical area of the Hospital where the complainant had taken treatment and had arrived at the reasonableness of the expenses without comparison of the rates.

C) As regards the deduction of operation charges of Rs.44,400/-; 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.

D) The respondent had deducted Rs.1,600/- Consultant Charges and Rs.55,000/- Pharmacy charges under " Reasonable and Customary Charges" without producing any evidence for the same.

E) The amount of Rs.145/- Gloves charges was not payable.

F) There is no ceiling on amount payable for eye cataract surgery in the policy.

G) In view of the foregoing the complaint is admitted and the respondentent **is hereby directed to settle the claim amount of Rs.1,00,855/- to the Complainant.**

In the matter of

Case of: Mr. Vijay M. Thakkar

vs. Oriental Insurance Co. Ltd., Ahmedbad

Complaint Ref. No. AHD-G-050-1718-0126

Date: 05/06/2017

Policy No. 141200/48/2015/27051

The Complainant and his wife were insured for Sum Insured Rs.5,00,000/- under Oriental Bank Mediclaim policy with Oriental Insurance Company Ltd. The Complainant's spouse Mrs.Himansi was hospitalized to Raghudeep Eye Hospital, Ahmedabad on 22.12.2015 for operation of Left Eye Cataract and discharged on the same day. The complainant had

lodged a claim for Rs.1,19,000/- with the respondent Insurance Company. The respondent insurance company had paid Rs.18,000/- after disallowing Rs.1,01,000/-.

A) The Complainant had enclosed copies of the claim settlement letters of (1) Panchal Dhananjay B – Insured with Oriental Ins. Co. Ltd. Claim No. HI-OIC-000080029 – settlement amount of Rs.38,206/- on 30/11/2015. (2) Joshi Jyotsanaben V. – Insured with Oriental Ins. Co. Ltd., Claim No. MDI2965073 – settlement of Rs.24,000/- as proofs. He had written to the company stating that the company had settled the claim that had arisen from the same company.

B) The respondent had not produced any other rate chart for comparison of rates prevailing in the same geographical area of the Hospital where the complainant had taken treatment and had arrived at the reasonableness of the expenses without comparison of the rates.

C) As regards the deduction of operation charges of Rs.49,800/-; 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.

D) The respondent had deducted Rs.2,800/- Consultant Charges, Rs.500/- Hospital charges and Rs.47,900/- Pharmacy charges under " Reasonable and Customary Charges" without producing any evidence for the same.

E) The amount of Rs.145/- Gloves charges was not payable.

F) There is no ceiling on amount payable for Eye Cataract Surgery in the policy.

G) In view of the foregoing the complaint is admitted and the respondentent **is hereby directed to settle the claim amount of Rs.1,00,855/- to the Complainant.**

In the matter of

Case of: Mr. Maheshbhai C. Raval V/s. Religare Health Ins. Co. Ltd.

Complaint No. AHD-G-037-1718-0139

Date: 14/07/2017

Policy No. 10634109

The Complainant Mr. Maheshbhai, aged 51 years was insured with his spouse under Religare Health Insurance Policy for the period from 01/05/2016 to 30/04/2019 by the

Religare Health Insurance Co. Ltd. The Insured was admitted to Stavya Spine Hospital, Ahmedabad on 17/10/2016 for the surgery of D9, D10, D11, D12, and L1 – Stenosis with Myelopathy (Compression of Spinal Cord) and discharged on 21/10/2016. The Company had rejected his claim under "General Condition No. 6.1 "Disclosure to information norm" of the policy. Unsatisfied with the rejection of the claim he had approached the Forum for redressal of his complaint.

a. The Complainant had ported his policy from The National Insurance Company Limited on 01.05.2016. He was insured with National Insurance Co.Ltd continuously since 30/05/2012.

b. On 17/10/2016, the complainant was admitted for the surgery of D9, D10, D11, D12, and L1 – Stenosis with Myelopathy (Compression of Spinal Cord).

c. The Respondent had repudiated the claim on the basis of Non-disclosure of material fact. However, they could not produce any proof that the insured was suffering from diabetes and taking treatment for the same. Its duration is varying in different papers submitted by the complainant.

d. The claim was for the surgery of spine, and the respondent had repudiated the claim on the bases of non disclosure of diabetes. Surgery of spine has no nexus with diabetes millities.

e. In reply to a question, had the insured declared his diabetes in portability proposal form, would the respondent have declined to issue the policy or otherwise, he could not reply.

f. It was observed by the Forum that the proposal form was filled up in the handwriting of third person.

In view of the foregoing the complaint is admitted and the respondentent **is hereby directed to settle the claim amount of Rs.1,65,031/- to the Complainant.**

In the matter of

Case of: Mr. Dilipkumar C. Shah
V/s. The Iffco – Tokyo Gen. Ins.
Complaint No. AHD-G-023-1718-0198

Date: 14/07/2017

Policy No. 52520067

The Complainant Mr. Dilipkumar C. Shah, aged 54 years was insured under Family Health Protector Policy for the period from 13/09/2015 to 12/09/2016 by the Iffco-Tokio General Insurance Co. Ltd. He had Hypertension for 1 year and is diabetic also. He had complaint of heaviness of chest on and off, on exertion since last 3 months. CAG was done on 21/12/2015 by Dr. Hemang Baxi, which was suggestive of CAD-TVD and advised him for CABG. As advised by the doctor the Insured was admitted to CIMS Hospital, Ahmedabad on 23/12/2016 , he underwent Coronary Artery Bypass grafting and was discharged on 29/12/2015. The Company had rejected his claim under "General Condition No. 49 "Disclosure of information norm" of the policy. Unsatisfied with the rejection of the claim he had approached the Forum for redressal of his complaint.

h. The Complainant had ported his policy from Reliance General Insurance Company Limited since 13.09.2015.

i. On 21/12/2015, the complainant was admitted for the surgery of CABG.

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

k. The Respondent had repudiated the claim on the basis of Non-disclosure of material fact. The previous history of Hypertension since 1 year and Diabetic was not declared in the proposal form, at the time of porting the policy.

l. During the hearing the complainant had agreed that he had ported the policy from Reliance Gen. 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 non-disclosure of the material fact also affects the underwriting of proposal form.

m. In the mail dated 28/05/2016 addressed to Mr. K. Srinivasa Gowda, Chairman by the complainant has stated that – The repudiation is unfair and untenable for the following reasons: point no. (2) & (3) which are read as under:

No. **"(2) As on the date of porting the insurance or the date on which signed the form given by your officials to me I was not suffering from hypertension to my knowledge.** Hence there is no misrepresentation or mis-description or non-disclosure of any material fact. The hospital officials have filled up the history details probably on oral information given by some friend / relative who does not know full and correct information. (3) **The proposal form is filled up by your officials in their handwriting.** Blame / responsibility for any error/ omissions / mistake / wrong statement/ wrong description / mis-description/misrepresentation/non-disclosure lies on the head of your officials and not me".

It was confirmed by the insured during the course of hearing the history of hypertension since 1 year and DM was reported to doctor by son of insured. Hence it cannot be taken as incorrect. The disease for which the insured was treated is complication of hypertension & DM.

n. 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).

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

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

In the matter of

Case of: Mrs. Vijayaben L. Paschal V/s. The Iffco – Tokyo Gen. Ins. Co. Ltd.

Complaint No. AHD-G-023-1718-0212

Date: 14/07/2017

Policy No. 52578183

The Complainant Mrs. Vijayaben, aged 58 years was insured under Health Protector Policy for the period from 02/02/2016 to 01/02/2017 by the Iffco-Tokio General Insurance Co. Ltd. The Insured was admitted to Sardar Patel Hospital, Ahmedabad on 14/11/2016 for the surgery of Radial head excision and ligation of fracture coronoid on rt. side and was discharged on 16/11/2016. The Company had rejected his claim under "General Condition No. 49 "Disclosure of information norm" of the policy. Unsatisfied with the rejection of the claim, she had approached the Forum for redressal of her complaint.

a. The proposal was not in vernacular language. It is in English language. The agent filled up the proposal and the complainant had signed the proposal in Gujarati.

b. On 14/11/2016, the complainant was admitted for the surgery of Radial head excision and ligation of fracture coronoid on Rt. Side.

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

d. The Respondent had repudiated the claim on the basis of Non-disclosure of material fact. The previous history of Hypertension, Diabetes since 5 years was not declared in the proposal form, at the time of porting the policy.

e. During the hearing the representative of the complainant had confirmed that she had HTN & DM since 5 years.

f. The insured had signed the proposal form in Gujarati & proposal form is in English.

g. The Respondent had failed to provide the underwriting guidelines before Forum to ascertain whether the policy could have been issued to the insured if she would have declared the history of HTN & DM since 5 years.

h. The disease for which the insured was treated has no nexus with HTN & DM. The insured was treated for accidental injury/fracture.

i. The amount of Rs.200/- for Medical Record, is not payable.

10) In view of the foregoing, the complaint is admitted and the respondentent **is hereby directed to settle the claim amount of Rs.51,237/- to the Complainant.**

In the matter of

Case of: Mr. Hardik R. Hakani V/s. The Iffco – Tokyo Gen. Ins. Co. Ltd.

Complaint No. AHD-G-023-1718-0217

Date:14/07/2017

Policy No.52598141

The Complainant Mr. Hardik Hakani, aged 31 years was insured under Swasthaya Kavach (Family Health) Policy for the period from 31/03/2016 to 30/03/2017 with Iffco-Tokio General Insurance Co. Ltd. The Insured was admitted to Star Hospital, Ahmedabad on 19/10/2016 for the treatment of fever , severe headache, body ache, nausea since 4-5 days. He was diagnosed Pyrexia with left Maxillary Sinusitis. His claim was repudiated by the Respondent citing policy

condition as it was not – "Medically Necessary" in terms of Definition 12. Unsatisfied with the rejection of the claim he had approached the Forum for redressal of his complaint.

a. As per submissions of the respondent, the treatment could have been on Out Door Patient, and Hospitalization was not required.

b. The patient had been under treatment of a physician before the hospitalization for 4-5 days. He had temperature and got treated, cured and discharged.

c. The patient could not decide which type of treatment was to be taken. It was the doctor who decided the line of the treatment. After examining the state of health of the patient and on the basis of the reports, the doctor had advised for admission.

4) The Respondent had repudiated the claim on the basis of policy conditions. Definition No.12 "Medically Necessary", which is not justified.

5) The company had wrongly applied the Definition No.12 and rejected the claim.

6) Amount of Rs.100/- under bill No.J/063 dtd. 26/10/2016, Rs.2950/- Vedant Hospital and Rs.300/- bill no. 91 dated 17/11/2016 were not payable, as the insured had not submitted the bills.

7) In view of the foregoing, the complaint is admitted and the respondent **is hereby directed to settle the claim amount of Rs.29,900/- to the Complainant.**

In the matter of

Case of: Mr. Jaimin J. Patel v/s The Oriental Insurance Co. Ltd.

Complaint Ref. No.: AHD-G-050-1718-0228

Date: 22/06/2017

Policy No.143600/48/2015/1216

1. Mrs. Mayuriben, spouse of the complainant Mr.Jaiminkumar, aged 23 years was insured under Happy Family Floater Policy since 20/08/2013. She was admitted to Raghudeep Eye Hospital, Ahmedabad twice for Rt. Eye –Intravitreal Injection Accenreix surgery as she was diagnosed with CNVM in Rt. Eye. She had undergone Intravitreal Injection Accentrix surgery on 12/08/2015 and 14/09/2015. On discharge from the hospital, the Complainant had filed two claims aggregating to Rs.50,225/- with the Insurer. The Respondent had repudiated the claim citing exclusions – OPD based treatment.

2. The Respondent had denied the claim on the ground that the hospitalization was for "less than 24 hours. Treatment was unproven and it could have been taken on OPD basis.
3. 2. The ground taken by the insurer is very casual. Administration of Accentrix injection is termed as "unproven". It is not clear whether the insurer has denied the claim as the treatment was unproven or hospitalization was less than 24 hours.
4. 3. It is noted that the Insurer had listed 26 types of disease under the day care procedure / treatment. It is also noted that in olden days these 26 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 impugned surgery could be carried out in short time extending to few hours. Eye surgery is covered under clause 2.3 A (iv) and there is no precondition of hospitalization for more than 24 hours.
5. 4. 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.
6. 5. 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.
7. 6. 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.
8. 7. The Respondent has not been able to prove that the surgeries performed by Dr. Abhay Vasavada, & administration of Accentrix injection is "unproven". The pharmacy company has manufactured the injection, it is sufficient to prove that such injection is proven cure of a disease.
9. As per policy condition under Silver plan 10% Co-pay deducted from admissible amount.
10) Complaint is admitted and the insurer is directed to pay the admissible claim after deducting co-pay of 10%.

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 the claim amount Rs. 45,203/- to the Insured.

In the matter of

Case of: Mr. Jignesh M. Upadhyay

Vs. The Oriental Insurance Co. Ltd., Ahmedabad

Complaint Ref No. AHD-G-050-1718-0233

Date: 22/06/2017

Policy No.143190/48/2016/1585

The Complainant's father Mr. Mahendrakumar, aged 57 years was covered under Happy Family Floater Policy issued by The Oriental Insurance Company Ltd for Sum Insured of Rs 7 lakh. He was hospitalized from 12.04.2016 to 14.04.2016 in Shivam Hospital situated at Himmatnagar for surgical treatment of Fistula in ano with piles. The complainant's claim for Rs.23130/- was rejected by the Respondent on the ground that the treating physician was not a Medical Practioner as defined in the policy condition as he was qualified in Ayurvedic Medicine and had given allopathic treatment. Aggrieved by the rejection of the claim the complainant had approached the Forum.

The complainant had taken surgical treatment as indoor patient from Dr. Kuryant M. Goswami, BAMS (Proctologist) M.D.(TM) qualified in Indian system of medicine.

b) In the subject case the treating physician Dr.Kuryant M. Goswami is a post graduate (MD.TM Proctology) with registration No. 150931

c)The Registered Medical Practioner Act 1963(A) categorically stated:"A qualified registered Ayurveda Medical Practitioner is legally allowed to provide Allopathic treatment".

Upon asking this question, the representative of insurer stated as follows.

"Since the insured has submitted that Doctor was specialized in this area – "Ksharsutra" and provided certificate of Gujarat Ayurved Authority, we shall admit the claim as per policy terms and conditions & Co-payment".

There is no co-payment in the impugned policy.

(e) Therefore the complaint is admitted and the Respondent is hereby directed to pay the claim amount Rs. 23,130/- to the Insured.

In the matter of

Case of: Mr. Indubhai C. Shah

v/s. The New India Assurance Co. Ltd., Ahmedbad

Complaint Ref. No. AHD-G-049-1718-0234

Date: 14/07/2017
Policy No.210402/34/15/04/00000049

The Complainant and his family were insured for Sum Insured Rs.5,00,000/- under New India Flexi Floater Group Mediclaim Policy issued to Bhagyodaya Co-operative Bank Ltd. by The New India Assurance Company Ltd. The Complainant's spouse Mrs. Suhasiniben Shah was hospitalized to Het Eye Care Hospital, Ahmedabad on 21.07.2016 for operation of Rt. Eye Cataract and was discharged on the same day. The complainant had lodged a claim for Rs.35,000/- with the respondent Insurance Company. The respondent insurance company had settled Rs.18,000/- after disallowing Rs.17,000/-. The complainant had not received the payment of Rs.18,000/- and complaint for full amount of Rs.35,000/-.

A) The Respondent had disallowed Rs.17,000/- out of total claim of Rs.35,000/- from complainant's claim under policy clause – Reasonable & Customary charges.
B) The Respondent had been settled for Rs.18,000/- against the amount claimed for Rs.35,000/- towards medical expenses incurred for treatment of Rt. Eye Cataract under UTR No. CITIN16678444653 dated 19/08/2016 from bank, The Bhagyodaya Co-Operative Bank Ltd.
C) The Respondent had submitted the PPN rate charges, as a proof of settling the amount of Rs.18,000/-.
D) As per Point No. 12 of Annexure-1 forming part of the policy, deduction of Rs.17,000/- was in order.
G) In view of the foregoing the complaint failed to succeed.

Complaint No: BNG-G-049-1617-0785

Case of: SHRI SANJAY BALAKRISHNA V/s THE NEW INDIA ASSURANCE CO LTD

Date of Award: 8th May, 2017

Repudiation of claim for infusion of Alzumab injection – No hospitalisation – DISMISSED.

The claim for infusion of Alzumab injection was rejected as it was an OPD procedure and did not warrant hospitalisation. The Complainant earlier 13 claims were settled and 14th claim compromised while ending before this Forum. The Respondent Insurer contended that the earlier claim settlements were by TPA and was made inadvertently. The Respondent Insurers' submission was accepted and this Forum opined that the inadvertent settlement cannot be a precedent and hence, the complaint was DISMISSED.

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Complaint No: BNG-G-044-1617-0748

Case of Shri K T MOHAMED YOUSUFF V/s STAR HEALTH & ALLIED INS CO LTD

Date of Award: 8th May, 2017

Repudiation of claim for non-disclosure of material facts – DISMISSED.

The dispute was with regard to repudiation of the claim for treatment of right Knee Osteoarthritis. The Respondent Insurer contended that this was an exclusion for 2 years as per policy. The Complainant requested for consideration as he had completed 1 year and 9 months. As the repudiation was as per the terms and condition of policy and hence, the Complaint was DISMISSED.

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Complaint No: BNG-G-049-1617-0860

Case of SHRI C. BALASUBRAMANIAN V/s THE NEW INDIA ASSURANCE CO LTD

Date of Award: 8th May, 2017

Short settlement of Mediclaim – DISMISSED.

The dispute was with regard to reduction of claim amount. The Respondent Insurer had partly disallowed charges towards Diagnostic Charges, Surgical Charges, Consultant Charges and other charges. The Complainant contended that the said charges remain same irrespective of category of room. The Insured person had availed room with rent more than his eligibility and hence, the said charges were proportionately reduced. The

said reduction was in accordance with the policy terms and conditions. Hence, complaint was DISMISSED.

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Complaint No: BNG-G-044-1617-0795

Case of: Shri JAGANNATH HG V/s STAR HEALTH & ALLIED INSURANCE CO LTD

Date of Award: 8th May, 2017

Repudiation of claim for non-disclosure of material facts – DISMISSED.

The dispute was repudiation of claim as per policy conditions for non-disclosure of material facts/pre-existing ailments at the time of proposal. The Complainant had disclosed the Heart related problem to the agent, but as advised by the agent he had mentioned only BP as pre-existing disease. The Complainant presumed that the Respondent Insurer had taken the pre-existing illness into account. The patient had a past history of ischemic heart disease and underwent PTCA to RCA in 2004, which was prior to inception of the policy.

The Forum concluded that the repudiation of claim was as per policy conditions.

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Generic Contingency Policy

Complaint No: BNG-G-005-1617-0791

Case of: Shri MANOJ KUMAR PANDEY V/s BAJAJ ALLIANZ GENL INS CO LTD

Date of Award: 8th May, 2017

Short Settlement of claim – Compromised

The Complainant was for short settlement of the claim. Sum Insured was enhanced from 2014. The Respondent Insurer settled the claim stating that the disease for which the patient was hospitalised was existing prior to enhancement. Upon mediation of this Forum, the inadvertent mistake in the date of laboratory report was accepted by the Respondent Insurer and they settled the balance amount.

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Complaint No: BNG-G-037-1617-0759

Case of Shri JOHN BOSCO V/s RELIGARE HEALTH INSURANCE CO LTD

Date of Award: 9th May, 2017

Repudiation of claim and forfeiture of premium – Claim repudiation upheld but ordered to refund premium.

The dispute was repudiation of claim as per policy conditions for non-disclosure of material facts/pre-existing ailments at the time of proposal. The Complainant was hospitalised during 2nd year of policy for chest pain.

As per hospital records, the patient was a known case of hypertension and diabetes mellitus since 2 years. The statements are recorded in the hospital as stated by the patient or his close relatives and hence, credence has to be given to the recording of the said statements. The repudiation of claim was as per policy conditions.

However, this Forum was not inclined to accept the forfeiture of the premium as the suppression of the policy makes the policy void *and* no liability attaches to the Respondent. The Respondent Insurer was directed to refund the premium.

Hence, complaint was partially allowed.

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Complaint No: BNG-G-037-1617-0848

Case of Shri GANESH KALLIDIL V/s RELIGARE HEALTH INSURANCE CO LTD

Date of Award: 9th May, 2017

Repudiation of claim for non-disclosure of material facts – DISMISSED.

The dispute was repudiation of claim for non-disclosure of material facts/pre-existing ailments at the time of proposal. The Complainant was hospitalised during 3rd year of policy and underwent percutaneous transluminal coronary angioplasty. As per hospital records the Complainant was a known case of Hypertension for the last five years i.e., before inception of the policy. The statements were recorded in the hospital as stated by the patient or his close relatives and hence, credence has to be given to the recording of the said statements.

The repudiation of claim was as per policy conditions hence, the complaint was Dismissed.

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Complaint No: BNG-G-050-1718-0032

Case of: SHRI BALAJI K V/s ORIENTAL INSURANCE COMPANY LIMITED

Date of Award: 10thMay, 2017

Disallowance of Laboratory Tests –Disallowed by Insurer as not related to Illness - ALLOWED.

The Complainant was hospitalised for Dengue Fever tested for TSH and HBAIC by the hospital and as these were not connected to diagnosis of dengue and the Respondent Insurer had disallowed the said charges. As these laboratory tests were conducted at the instance of the hospital and not at the request of the claimant, The Respondent Insurer was directed to settle the claim.

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Complaint No: BNG-G-051-1617-0746
Case of: SHRI KRISHAN KAPURV/s UNITED INDIAINSURANCE CO LTD

Date of Award: 11th May, 2017
Repudiation of claim for non-disclosure of material facts – DISMISSED.

The complaint emanated from repudiation of the health claim on the ground of suppression of pre-existing condition while proposing for insurance. It was admitted that the Insured person had a Super Top up Medicare Policy, was hospitalised for Brain Tumour and claim under the normal policy was paid as per its coverage leaving out a substantial balance amount and therefore, the claim under this Top Up had been filed.

The Complainant disputed the interpretation of the definition of the Pre-existing disease. The Respondent Insurer by documentary evidence submitted that the patient had recurrence of glioma for which he had been on palliative care and had symptomatic seizures for which he was on multiple anticonvulsants.

Therefore, the contention of the Complainant that his father did not have any kind of treatment was untenable and hence, the claim falls under exclusion 4.1 of the Policy. Under the circumstance, the Forum had no opportunity to intervene in favour of the Complainant and the complaint was DISMISSED.

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Mediclassic Insurance Policy (Individual)
Case of: SHRI VISHWAMURTHY A V/s STAR HEALTH & ALLIED INS CO LTD
Complaint No: BNG-G-044-1617-0773

Date of Award: 8th May, 2017
Repudiation of claim for non-disclosure of pre-existing diseases – Upheld

This complaint was for repudiation of the claim for non-disclosure of pre-existing disease of Rheumatoid Arthritis. The Complainant contended that the patient was diagnosed with the said complaint much after the commencement of the policy.

After careful scrutiny of documents on record the Forum found that the patient was suffering from Rheumatoid Arthritis since 5-6 years at some places and 4 years at certain places.

The remarks of physiotherapist refusing to provide physiotherapy considering the permanent deformity of finger joints & toe, ankylosed joints and also immobilisation of the

joints, which goes to say about the intensity of the problem and the duration was most likely to be a long standing one.

Even after considering the least duration of Arthritis of 4 years, the duration precedes the commencement of the Policy and hence, it could be safely concluded that it was existing prior to taking the first Policy and was also undisclosed in the relevant Proposal Form.

Therefore, the Forum had no opportunity interfere the decision of the Respondent Insurer.

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Family Health Optima Insurance Plan
Case of: SHRI V S JYOTHIMURUGAN V/s STAR HEALTH & ALLIED INS CO LTD
Complaint No: BNG-G-044-1617-0870

Date of Award: 8th May, 2017
Repudiation for non-disclosure of Pre-existing Disease – Upheld.

Pre-authorisation was denied and claim was also repudiated by the Respondent Insurer stating that the Insured failed to disclose about bilateral sacrolitis, which she was suffering from at the time of taking the insurance.

The Complainant contended that the Insured person was not on DEMARDs, as opined by the Respondent Insurer in their cashless pre-authorisation denial and repudiation of the claim and policy cancellation was unjustified. The Insured patient represented that she was suffering from back pain since 2012 and was advised for a test HLA B27 to diagnose Ankalysing Spondylitis and the said test done in 2014 indicated 'negative'.
The Respondent Insurer's representative submitted that the patient was granted insurance after undergoing Pre-Medical Examination and the kind of tests that were done viz., Serum Creatinine and USB which would not indicate the complete health of the insured person and it is incumbent upon the Insured to disclose all the information, which the Insured himself/herself could be aware of and the contract would be finalised based on the disclosures made in the proposal form.

On careful scrutiny of MRI Lumbar Spine Without Contrast dated 27.02.2013, it was opined that "Features are consistent with sequelae of bilateral sacroilitis" and had history of Low Back Pain since 3 years (as per Discharge Summary of CMC, Vellore dated 18.12.2016) but the same were not disclosed in the proposal form whilst taking the first policy form the Respondent Insurer from 17.11.2014, which amounted to non-disclosure of material facts. Hence, the complaint was Dismissed.

*****

Senior Citizen Red Carpet Health Insurance Policy
Case of: Shri SHIVAKUMAR KB V/s STAR HEALTH & ALLIED INS CO LTD
Complaint No: BNG-G-044-1617-0845

Date of Award: 8th May, 2017

Repudiation for non-disclosure of Pre-existing Disease – Dismissed

It was a denial of a medi-claim on the grounds of non-disclosure of pre-existing diseases of bronchial asthma and hypertension in the proposal form.

During the Personal Hearing, the Representative of the Respondent Insurer submitted that the process of claim settlement was initiated recently but the Complainant has not provided his consent for the said claim settlement, which was considered at 30% co-pay, as per the terms and conditions of the policy and hence, the claim payment could not be effected.

The Complainant had expressed his consent for the said settlement but sought for the revival of the cancelled Policy. The Representative of the Respondent Insurer offered to revive the cancelled policy. The Complainant had, however, expressed his deep anguish over the delayed initiation of the process of settlement, which was after 1 ½ years.

The Forum, on careful scrutiny of the documents on record, has observed no undue delay in process of the claim (the claim denial was made within 38 days of its submission and grievance reply was within 3 days), which would not warrant any interference of the Forum for awarding compensation.

The Forum considered the cancellation of the Policy as a harsh decision and advised the Respondent Insurer to arrange for revival of the cancelled Policy with stipulations, if required.

Therefore, the Forum had no opportunity to interfere with the decision of the Respondent Insurer.

*****

Family Health Optima Insurance Plan

Case of: SMT R J SOMALEKA V/s STAR HEALTH & ALLIED INSURANCE CO LTD
Complaint No: BNG-G-044-1617-0780

Date of Award: 8th May, 2017

Repudiation of claim for non-completion of waiting period – Upheld

The complaint was for repudiation of the claim for non-completion of the waiting period for the said disease.

On careful scrutiny of the Hospital Records, it was observed that the Insured patient was diagnosed as suffering from inter-alia Gross Right Hydronephrosis due to PUJ Obstruction and Hypertension. On further scrutiny of the Policy issued to the

Complainant, the expenses incurred in respect of 'all obstructive-uropathies' were excluded during the first 2 years of the insurance of the policy [exclusion no. 3 (2) and the present policy being 2nd year of insurance. The claim fell within the aforesaid exclusion hence the Forum upheld the decision of the R/I.

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Optima Restore Floater

Case of Shri M GOVINDARAJU V/s APOLLO MUNICH HEALTH INS CO LTD
Complaint No: BNG-G-003-1617-0863

Date of Award: 9th May, 2017

Repudiation of claim for non-disclosure of PED - Allowed

This complaint emanated from the repudiation of his claim and his daughter and cancellation of policy for non-disclosure of pre-existing disease. The Complainant represented to the Respondent Insurer that the Policy was provided to him by their Agent after his medical consultation in 2013, with an assurance that all claims would be paid, as he was not suffering from any disease.

The Forum, upon close scrutiny of the medical records and investigation reports, it was observed that the Complainant was suffering from IHD – ACS Unstable Angina and Mild Coronary Artery Disease, which was prior to the inception of the Policy. The same was not disclosed at the policy inception stage, which amounts to non-disclosure of material facts. Though the present claim of Complainant had no nexus with the pre-existing disease, his argument was untenable as the claim denial was on the grounds of non-disclosure of pre-existing Disease.

Therefore, the Forum had no opportunity interfere the decision of the Respondent Insurer.

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Health Suraksha Policy – Gold Plan
Case of: Shri RAVI SRINIVASDHULE V/s HDFC ERGO GENERAL INS CO LTD
Complaint No: BNG-G-003-1718-003

Date of Award: 9th May, 2017

Repudiation for non-disclosure of Pre-existing Diseases – Upheld

The Complaint arose out of the repudiation of the claim for non-disclosure of pre-existing diseases. The Complainant represented to the Respondent Insurer stating that he disclosed the said ailments during tele-talk.

The Complainant submitted that he was in a pre-diabetic stage (Borderline DM) at the time of taking the Policy and hence, he stated that he was not suffering from Diabetic Mellitus, during the sales canvassing. He further submitted that the Diabetic Mellitus has no nexus with the Heart ailment, for which the claim was raised.

During the Personal Hearing, the representative of the Respondent Insurer informed that the Policy was sold online and played the audio of the conversation the sales executive of the Respondent Insurer had with the Complainant, wherein he had specifically informed that he was not suffering from Hypertension and Diabetic Mellitus.

It was evident from the medical records of 2014, the Complainant was suffering from DM II and Acute Coronary Syndrome and Acute Anterior Wall, Myocardial Infarction which was prior to taking his policy and the Complainant failed to disclose during the policy sales stage, which amounted to non-disclosure of material facts.

Hence, the action of the Respondent Insurer was found to be in order.

*****

Optima Restore Floater Policy
Case of: Shri VENKATESWARAN M V/s APOLLO MUNICH HEALTH INS CO LTD
Complaint No: BNG-G-003-1617-0745

Date of Award: 9th May, 2017.

Repudiation for non-disclosure of PED - Dismissed

The complaint emanated from the repudiation of the claim of the Complainant's daughter for non-disclosure of the pre-existing disease, Autism Spectrum Disorder. The Complainant contended that the said illness had no nexus with the present complaint and which was supported by a Certificate from the treating doctor that the said disorder itself was not illness and hence, it did not amount to non-disclosure.

The Forum, after careful scrutiny of the Proposal Form, observed that there was no specific question relating to the particular disorder and hence, the Insured was absolved from disclosing the said disorder.

Further, the medical write-up submitted by the Respondent Insurer states that the persons suffering from ASD are more prone to seizures, than the normal children. Since all the ASD children are not likely to suffer from seizures, only the likelihood being more compared to normal children, this Forum was inclined to give the benefit of doubt and provide relief to the Complainant.

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Complaint No: BNG-G-031-1617-0842

Case of: SMT PHILOMENA PERISV/s MAX BUPA HEALTH INS CO LTD

Date of Award: 12th May, 2017

Repudiation of claim for non-disclosure of material facts & cancellation of Policy – Partially Allowed.

The complaint emanates from repudiation of the claim for knee replacement and cancellation of the policy on the ground of non-disclosure of Pre-existing disease after porting of the policy to the respondent for better service. As the repudiation of claim was on the grounds of non-disclosure of pre-existing ailments, the Forum had no opportunity to intervene in favour of the complainant.

As regards, the cancellation of policy on the ground of misrepresentation, the contract gets void from inception i.e., ab-initio and hence, the Forum felt that there was no obligation of the Respondent Insurer under a void contact and therefore, had no reason to withhold the consideration paid for such a contract and directed the Respondent Insurer to refund the Premium.

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Complaint No: BNG-G-031-1617-0710

Case of: Smt. S.K.SUMAV/s MAX BUPA HEALTH INSURANCE CO LTD

Date of Award: 12th May, 2017

Repudiation of claim for non-disclosure of material facts - Partially Allowed.

The complaint emanated from repudiation of the claim fornon-disclosure of Pre-existing disease after porting of the policy to the respondent for better service. The claim was for reimbursement of hospitalisation expenses for the surgery of Hysterectomy. The Complainant contended that she had continuous insurance before porting to the aboveinsurer. As there was continuity in insurance, the Complainant believed that the rejection of the claim was not justified.

This Forum directed the Respondent Insurer to consider the claim restricting the sum Insured to the previous policy. Hence, the complaint was PARTIALLY ALLOWED.

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Complaint No: BNG-G-044-1617-0810

Case of: Smt. MEENA GUPTAV/s STAR HEALTH & ALLIED INS CO LTD

Date of Award: 12th May, 2017

Repudiation of claim for non-disclosure of material facts -Allowed.

It was a complaint against the denial of health insurance claim on the ground of misrepresentation and non-disclosure of material facts. The Complainant had continuous

insurance and was ported to the above Respondent Insurer. The Complainant produced a copy of the proposal wherein he had declared all pre-existing diseases. The Respondent Insurer contended that the Complainant had produced a different proposal at the time of obtaining the policy, but failed to produce the proposal in original.
As the Respondent Insurer had failed to establish his contention of non-disclosure and suppression of material fact, the decision of the Respondent Insurer of repudiation of the claim was not sustainable and the Complaint was ALLOWED.

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Complaint No: BNG-G-031-1617-0713
Case of: SHRI HOMBE GOWDA R V/s MAX BUPA HEALTH INS CO LTD

Date of Award: 12th May, 2017
Repudiation of claim for non-disclosure of material facts -Allowed.

It was a complaint against the denial of health insurance claim on the ground of misrepresentation and non-disclosure of material facts. The Complainant had continuous insurance and was ported to the above Respondent Insurer. The Respondent Insurer had relied on the Declaration by one of the brother of the patient corroborating the pre-existence of the diseases.

This Forum drew the attention to the Respondent Insurer about the discrepancy in the said certificate and the Respondent Insurer having convinced agreed to review their decision and to settle the claim. The Forum appreciated the gesture of the Respondent Insurer.

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COMPLAINT NO- BHU-G-044-1718-0002
Mr.Chittaranjan Behera
Vrs
Star Health And Allied Insurance Co. Ltd.,
Award Dated 25th Day of May, 2017

Brief Facts of the Case:- Cause of Complaint: The complainant had applied for a health insurance through 5paisa.com and accordingly his bank account was debited Rs.4370/-. But Star Health Company declined to issue the policy and assured to refund the deposit. But till now the Company has not made a refund and when the complainant approached it again with Bank statement the Company refused to pay any more on the plea that the amount had already been paid to the bank account. Under such circumstances he approached this Forum for Redressal.

On the other hand, the Insurance Company did not file SCN despite notice.

Result of hearing with both parties(Observations & Conclusion)

I have elaborately gone through all the papers placed before this Forum. The advance premium receipt No. 11-01/1272029512 dated 08.08.2016 issued in favour of the complainant by the Insurer confirms receipt of premium of Rs.4370/- by the Insurer for an online health policy. The payment of premium appears to have been debited from the complainant's savings bank account of Bank of India, Badagada Branch. Subsequently, as issuance of the policy was declined the complainant requested the Insurer to refund the deposit premium . He also submitted Bank Statement for the period from 01.08.2016 to18.04.2017 which did not reveal credit of Rs.4370/-during the period. This is unfair on the part of the Insurer not to refund the deposit premium immediately after declining to issue the policy. The Insurer neither filed SCN nor attended the hearing in spite of notice. As such, the Insurer is hereby directed to release the amount of Rs.4370/- to the complainant towards refund of the deposit premium as early as possible.

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COMPLAINT NO- BHU-G-048-1718-0006
Mr. Subhash Chandra Mohanty
Vr
National Insurance Co. Ltd.
Award Dated 7th Day of June, 2017

Brief Facts of the Case: The complainant took a BOI Swathya Bima Policy from the above Insurer for the period from 28.03.2015 to 27.03.2016 covering himself, his wife and two daughters with a Sum Insured of Rs.5,00.000/-. Unfortunately, his wife died during hospitalization on 07.08.2015 at KIMS Hospital, Bhubaneswar. He lodged a claim with the Insurer and submitted all relevant documents. He pursued the claim, but the Insurer repudiated it. Under such circumstances he approached this Forum for Redressal.

On the other hand, the Insurer filed SCN and pleaded that the wife of the complainant was hypertensive and was under medication as reflected in the discharge summary for previous hospitalization in KIMS Hospital from 02.11.2009 to 10.11.2009. As the disease was pre-existing the claim was repudiated under exclusion clause no.4.1.

Result of hearing with both parties(Observations & Conclusion)

I have elaborately gone through the papers placed before this Forum. As it appears, the patient first admitted in the KIMS Hospital, Bhubaneswar from 24.06.2015 to 09.07.2015 and received treatment for **HTN induced stroke in right hemisphere** as reflected in the discharge summary. She was again hospitalized on 17.07.2015 for **Septic Shock with MOF, OLD CVA, HTN and T2DM** and unfortunately, expired on 07.08.2015 while undergoing treatment. The death certificate issued by the hospital reveals the cause of death as above. The Insurer submitted a discharge summary for hospitalization period of the same person from 02.11.2009 to 10.11.2009 which suggests treatment for **Post Diarrhoeal ARF with Tremulousness** and categorically declares that the patient is **not a known case of DM/HTN**. This document does not support the plea of the Insurer that the patient was hypertensive during the aforesaid period of treatment. So, the decision of the Insurer that HTN was pre-existing does not hold good. As the complainant's wife was hospitalized during the policy period and he incurred substantial medical expenditure, the Insurer is liable to pay the loss under the policy. In the result the Insurer is herby directed to settle the claim and release an appropriate amount as per policy terms and conditions to the complainant as early as possible.

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COMPLAINT NO- BHU-G-003-1718-0066
Mr T. L. Lodhania
Vrs
Apollo Munich Health Insurance Co. Ltd.
Award Dated 13th Day of July, 2017

Brief Facts of the Case: Cause of Complaint: The complainant took anasy Health Floater Standard policy from the Insurer and renewed it from 23.11.2015 to 22.11.2016 covering himself and his wife for a floater Sum Insured of Rs. 4,00,000/- plus Cumulatative bonus of Rs.80,000/-. Unfortunately, his wife was admitted in the Sukhayu Ayurveda, Jaipur, Rajasthan from 15.07.2016 to 12 08.2016 for treatment. The complainant intimated the Insurer about the admission immediately and submitted all relevant papers for reimbursement of the claim. But the Insurer rejected the claim on ground that the treatment can be managed on OPD basis. In such circumstances he approached this Forum for Redressal.

On the other hand, the Insurer filed SCN and pleaded that the procedure undergone by the patient could have been done on OPD basis as the treatment does not require hospitalization. Further, the Insurer defined the details of the procedure of the treatment and claimed that Sukhayu Ayurveda, Jaipur, is neither a Govt. Hospital nor a NABH accredited hospital for ayush benefit. As such, the Insurer rejected the claim.

Result of hearing with both parties(Observations & Conclusion)

I have elaborately gone through all the papers placed before this Forum. As it appears, the complainant's wife was admitted in Sukhayu Ayurveda, Jaipur, Rajasthan for ayurveda treatment of back ache & pain and incurred substantial medical expenditure for the same. As per clause 1.h of the policy conditions ayurveda treatment hospitalization benefit is admissible only when the treatment is availed in a Govt. Hospital or any institution recognized by government or accredited to QCI/NABH. But, the complainant failed to produce any evidence to prove that Sukhayu Ayurveda ,Jaipur, Rajasthan , where his wife underwent treatment , is a Govt. hospital or a recognized hospital of QCI/NABH. Although, the treatment was taken during the policy period , liability under the policy for reimbursement of medical expenditure is not admissible due to non compliance of policy condition no. 1h. In such circumstances intervention in the decision of the Insurer is not warranted.

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COMPLAINT NO- BHU-G-037-1718-0049
Mr Biswajit Mishra
vrs
Religare Health Insurance CO. Ltd.
Award Dated 12th Day of July, 2017

Brief Facts of the Case::

The complainant took a CARE health policy from the Insurer covering his mother for the period from 10.01.2014 to 09.01.2017 with Sum Insured of Rs.5,00,000/-. Unfortunately, she was admitted in Jagannath Hospital, Bhubaneswar from 16.04.2016 to 18.04.2016 for treatment of acute abdomen pain. She was referred to Kalinga Hospital following respiratory complication where she remained hospitalised from 18.04.2016 to 25.04.2016 and underwent treatment for acute pancreatitis. The complainant incurred medical expenditure of Rs.1,89,782/- and submitted all relevant papers before the Insurer for settlement of the claim. But the Insurer rejected the claim arbitrarily. Under such circumstances he approached this Forum for Redressal.

On the other hand, the Insurer did not file any SCN but by an E-mail dated 03.07.2017 communicated its willingness to settle the claim for Rs.18,493/- and Rs.1,31,606/- as per policy terms and conditions. It further conveyed its willingness to reinstate the policy on receipt of premium from the complainant.

Result of hearing with both parties(Observations & Conclusion)

I have elaborately gone through all the papers placed before this Forum. As it appears, the complainant's mother was first hospitalized at Jagannath Hospital for treatment of acute abdomen pain and following further respiratory complication she was referred to Kalinga Hospital where she remained hospitalized from 18.04.2016 to 25.04.2016 and underwent treatment for acute pancreatitis. As a claim was raised, the Insurer rejected the claim on grounds that the insured person was having hypertension at the time of taking policy which is revealed from the discharge summary granted by Kalinga Hospital. Since, this pre existing ailment was not disclosed it violated the policy condition of non-disclosure of material fact. Subsequently, the complainant produced a certificate from Dr.B B Binakar, Consultant Cardiologist which declares that she was diagnosed with HTN 1st time only on10.08.2014. But, during the course of hearing the Insurer openly declares to settle the claim for Rs.1,50,099/- and reinstate the policy on receipt of the appropriate premium. Since the Insurer has admitted liability under the policy it is no more required to go deep in to the merit of the case and ,as such, the Insurer is hereby directed to release the above amount of claim in favour of the complainant at the earliest with simultaneous reinstatement of the policy after collecting appropriate premium from the complainant..In the circumstances no interest nor penalty for harassment as claimed is payable.

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COMPLAINT NO- BHU-G-044-1718-0068
Mrs. Lopamudra Mullick
Vrs
Star Health And Allied Insurance Co. Ltd.
Award Dated 13th Day of July, 2017

Brief Facts of the Case:

The complainant was covered under a health insurance policy taken by her husband for the period from 30.11.2015 to 29.11.2016 for a floater sum insured of Rs.3,75,000/-. Unfortunately, she was hospitalized in Apollo Hospital, Bhubaneswar on 29.11.2016 due to accidental corrosive acid poisoning. The Insurer, to her surprise denied cashless hospitalization. After discharge from the hospital she raised a claim for reimbursement of medical expenditure, but the Insurer rejected the claim on ground of intentional self injury. Under such circumstances, she approached this Forum for Redressal.

On the other hand, the Insurer filed SCN and pleaded that the complainant was hospitalized due to accidental corrosive acid poisoning, NJFT for feeding purpose. As per verification report of Apollo Hospital and OP register case sheet, the present admission and treatment was for corrosive acid poisoning due to intentional self injury. Therefore, the claim was rejected as per exclusion clause no. 6 of the policy conditions.

Result of hearing with both parties(Observations & Conclusion):

I have elaborately gone through all the papers placed before this Forum. Admittedly, the complainant was hospitalized first in Capital Hospital and then in Apollo Hospital due to consumption of battery acid. Here a grave allegation is made by the Insurer that the complainant took battery acid with an intent to cause self injury(suicidal attempt) as reported in the investigation report which reveals verification of in-patient case sheets of Apollo Hospital and the investigator's discussion with people in her work place. But, the Insurer utterly fails to provide any concrete proof to show that the act of the complainant was an attempt of suicide. Had it been a case of suicidal attempt by the complainant, then the local police must have initiated criminal action against her. But there appears no scent of it. Rather the discharge summary of Capital Hospital reveals acid poisoning and that of Apollo Hospital specifically discloses accidental corrosive acid poisoning. Therefore, the suicide attempt theory of the Insurer does not hold good. Obviously, the liability of the Insurer arises under the policy for reimbursement of medical expenditure incurred by the complainant. Thus, the Insure is directed to settle the claim as per policy terms and conditions and release the payment at an early date. In the circumstances no interest as claimed is payable.

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COMPLAINT NO- BHU-G-044-1718-0068
Mr Piyush More
Vrs
Star Health and Allied Insurance Co. Ltd.
Award Dated 14th Day of July, 2017

Brief Facts of the Case:

The complainant took a Family Health Optima Insurance Plan from the Insurer covering himself, his wife and daughter for a sum insured of Rs.3,00,000/-. This policy was valid since 2008 and transferred to the present Insurer under portability. Unfortunately, the complainant was admitted at Dr. Mohan Diabetic Centre, Chennai on 08.06.2016 for treatment. His request for cashless treatment was rejected by the Insurer. Later, after discharge from the hospital he lodged a claim for reimbursement of Rs.49,005/- and submitted all relevant papers before the Insurer but it repudiated the claim. Under such circumstances, he approached this Forum for Redressal.

On the other hand, the Insurer filed SCN and pleaded that as per discharge summary dated 12.08.2016 issued by the hospital the patient was having secondary diabetes due to chronic pancreatitis. Further, as revealed from the cashless request of the hospital the complainant was suffering from Pancreatitis from 2005. Therefore, the condition no. 8 of the policy in regard to misrepresentation/ non-disclosure was violated and accordingly the claim was rejected.

Result of hearing with both parties(Observations & Conclusion)

I have elaborately gone through all the papers/documents placed before this Forum. As it appears, the complainant had taken the health policy with the present Insurer from 2011 under portability and continued to renew it till 2017. It is found from the proposal submitted in 2011 that the complainant had disclosed himself to be having diabetes. He admits in his complaint petition to have suffered from temporary inflammation in pancreas in 2005 and underwent OPD treatment and never suffered from the same disease again. The Insurer insists this to be a major non-disclosure and contends that it should have been disclosed in the column of the proposal form meant for 'any other problem'. However, it is observed from the proposal form that there is no specific column for disclosure of pancreatitis or any other disease for which OPD treatment was done in respect of the proposer. More so, in the instant case the discharge summary granted by the hospital even though diagnosed secondary diabetes due to chronic pancreatitis, nowhere declares the same to be related to any previous occurrence. Therefore, the contention of non-disclosure by the Insurer does not hold good and as such, the liability of the Insurer arises under the policy contract. In view of the above the Insurer is hereby directed to settle the claim as per policy terms and conditions and pay appropriate amount to the complainant. The Insurer is further directed to restore coverage of the complainant under the policy forthwith.

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Case no. CHD-G-048-1617-0672
In the matter of Ms Bhawna Puri Vs National Insurance Company Ltd.

ORDER DATED 17.04.2017 (Mediclaim)

FACTS: On 18.11.2016 Ms Bhawna Puri filed a complaint against National Insurance Company Ltd. about the repudiation of her mediclaim. She was insured under Policy No. 421200/48/15/850000290. The complainant was diagnosed of lump in bilateral accessory breast for which excision of bilateral axillaries breast was done. The claim was repudiated by invoking condition no. 4.3 of the policy which excluded the coverage of genioto urinary system during the first two years of mediclaim policy. Breast was treated to be a part of genioto urinary system.

FINDINGS: The complainant during the second year of policy was diagnosed of lump in the bilateral accessory breast and underwent excision of bilateral axillaries of breast. The claim was refused on the grounds that the breast was female genital organ and therefore, the treatment or surgeries were excluded during the first two years of policy under condition 4.3. The insurer further stated that as per World Health Organization's (WHO) definition breast was part of genioto urinary system and therefore excluded from coverage for the first two years of policy. Since this was second year's policy, the claim was repudiated.

DECISION: The complainant was diagnosed with lump in breast. The claim was denied on the grounds that the breast is part of genioto urinary system and there was two years waiting period for the treatment of genital organs. It was also submitted that WHO has defined the breast as a genital organ. No documentary evidence was produced to substantiate the submission of insurer. Even search on internet did not help as in none of the details available; breast was included in the list of female genital organs. Otherwise also under common parlance and understanding breast is not considered as part of female genital organ or part of reproductive system.

Accordingly the claimant was held entitled to admissible claim as per terms and conditions of the policy.

SHRI. B.N.MISHRA, INSURANCE OMBUDSMAN
TAMIL NADU AND PONDICHERRY
Mr K Mohanankrishnan Vs M/S The Oriental Insurance Co. Ltd
Complaint No. CHN-G-050-1617-0611
Award No: IO/CHN/A/GI/0001/2017-2018

The complainant was covered under his employer's Group Mediclaim. His father was hospitalized at Apollo Hospital Chennai on 18/01/2016 to undergo CABG surgery and cashless approval was given for Rs 150000. But subsequently, TPA withdrew the cashless approval stating that the corporate limit under the policy had exhausted. Then the complainant took up the matter with the insurer. Since there was no response, the matter was escalated to the grievance. Grievance cell had informed that the policy was subject to 90% stoploss clause and the balance left to reach the 90% loss level was only Rs 89564. Hence his claim could be considered for Rs.89564/- only subject to submission of bills/claim papers. Not satisfied with the reply from the grievance, the complainant approached this forum.

It was observed that the corporate limit under the policy was exhausted the TPA withdrew the cashless approval accorded for Rs150000 which is as per policy condition which reads as under:

> "It is hereby declared and agreed that when the claims paid exceeds 90% of premium at any time during the currency of the policy, the policy stands automatically cancelled."

Total premium received by respondent insurer was Rs 798963 and 90% of it works out to Rs 719066. Total claims paid under the policy, (before this claim) was Rs629502. So the balance available was only Rs89564.

Hence the insurer's action of restricting the claim to Rs89564 was as per policy condition. The complainant's argument that M/s Sriyah insurance Brokers, through whom the insurance was arranged, was not aware of the 90% stop loss clause, will not hold good since the policy has been handed over to the insured through them only.

Taking into account the facts & circumstances of the case and the submissions made by both the parties during the course of hearing, the insurer is directed to settle the claim upto Rs89564 along with interest at a rate 2% above the bank rate prevalent at the beginning of the previous financial year, in favour of the insured, subject to other terms and conditions and deductibles under the policy, if any. Thus the complaint is partly **Admitted**.

SHRI. B.N.MISHRA, INSURANCE OMBUDSMAN
TAMIL NADU AND PONDICHERRY
Mr Dev Kumar Nahar Vs M/S The Oriental Insurance Co. Ltd
Complaint No. CHN-G-050-1617-0627
Award No: IO/CHN/A/GI/0002/2017-2018

The complainant has insured himself, his wife, daughter, father & mother under Group Mediclaim Policy through Jain International Organization with the respondent insurance company. On 09/02/2016, the complainant's mother was admitted to Apollo Hospital Chennai with complaints of blood vomiting. During the course of her treatment; she died on 24/02/2016. The complainant preferred a claim for Rs14,30,000 which was denied by the respondent insurer since the hospitalization occurred on 09/02/2016, where as the policy commenced only on 16/02/2016. The representative of the complainant contended that the premium was actually paid to JIO on 25/12/2015. Inspite of this the insurer had repudiated the claim. Not satisfied with the denial of claim, the complainant approached Grievance cell, however, he did not get any reply from them. Hence the complainant has approached this forum.

The Forum observed that the respondent insurer's repudiation of the claim on the ground that the hospitalization occurred prior to the commencement of the policy is in order. The complainant's argument was that he had remitted the premium amount to Jain International organization as early on 25/12/2015 and hence the claim had to be considered. This argument will not hold good since the premium was not remitted to the respondent insurer on 25/12/2015 by JIO. Hence the repudiation of claim by the insurer is as per the policy condition.

Taking into account the facts & circumstances of the case and the submissions made during the course of hearing by both the parties, the Forum is of the view that the repudiation of the claim by the insurer is in order and does not warrant any interference in the hands of the Ombudsman.
Thus the complaint is treated as **Dismissed and closed.**

SHRI. B.N.MISHRA, INSURANCE OMBUDSMAN
TAMIL NADU AND PONDICHERRY
Mr Sumermal Dugar Vs M/S The Oriental Insurance Co. Ltd
Complaint No. CHN-G-050-1617-0681
Award No: IO/CHN/A/GI/0003/2017-2018

The complainant Mr Sumermal Dugar availed health Insurance for self and his wife through M/s Jain International Organization. On 07/08/2016 the complainant was admitted to Apollo Hospital Chennai for treatment of Diabetes Mellitus, Systemic hypertension, haemeatemesis and melena and incurred an amount of Rs 182,529/- and preferred a claim. Health India TPA repudiated the claim on the grounds that the patient is a known case of Hypertension since 20 years and the current treatment is related to the existing ailment. The matter was escalated to grievance cell on 22/09/2016. It was again concurred with repudiation stating that the current treatment was a continuous treatment of earlier treatment for HTN.

Respondent insurer repudiated the complainant's claim of Rs 182529 since the current treatment is a pre planned treatment and is a continuous treatment of earlier treatment undergone for hypertension, diabetes, Parkinson's disease and coronary artery disease and that this treatment could not be brought under the head pre existing disease. Further, there is also non disclosure of material fact of complainant about the continuous and ongoing treatment prior to taking this insurance.

The copy of the enrolment form provided by the complainant, during the hearing showed that there was no provision for the complainant to disclose PED. In the absence of provision for declaring PED in the enrolment form, insurer can't invoke the non disclosure of PED clause to repudiate the claim. Further, PED is covered under the policy.

The insurer failed to provide the copy of the enrolment form submitted by the insured to the broker, as contended. Under this circumstance, the insurer is directed to settle the claim for Rs.182529/- less deductible, along with interest at a rate 2% above the bank rate prevalent at the beginning of the previous financial year, as per the terms and conditions and deductibles of the policy.

Thus the complaint is **Allowed**.

OMBUDSMAN – SHRI B N MISHRA

Mr Nadar Anand S Vs Star Health and Allied Insurance Co. Ltd

COMPLAINT REF: NO: CHN-G-044-1617-0616

Award No: IO/CHN/A/GI/0005/2017-2018

The complainant had paid health insurance premium of Rs5147 & Rs5095 for his mother and father respectively, through online, to Star Health Insurance on 28/04/2016. Policy No P/700002/01/2017/007607 was generated for his mother Mrs Annamani S Nadar with policy period from 29/04/2016-28/04/2017, and was delivered to the complainant. But no policy was generated by the respondent insurer in respect of the complainant's father Mr. Shunmughadurai Nadar for whom a premium of Rs5095 was paid. Complainant was not informed about the non issuance of policy in respect of his father. Meanwhile on 25/11/2016, the complainant's father met with an accident and was hospitalized. He incurred a medical expenditure of Rs 44,300/-. He sought the policy details from the insurer for availing the claim. But to his surprise, he was informed by the grievance cell that proposal in respect his father the proposal was declined by their medical team, considering his high risk profile and refund of premium was initiated and that the premium amount paid would be credited to his account shortly. On 05/12/2016, after a gap of more than 7 months, premium amount of Rs5095 was credited to his account. Not satisfied with grievance reply, the complainant approached this forum vide letter dt10/02/2017.

Insurer didn't act on the proposal submitted online along with payment of premium on 28/04/2016 by the complainant, until 25/11/2016, when the complainant approached the insurer for preferring an accident claim in respect of his father. Regulations 4(6) of IRDA Protection of Policyholders' Interest Regulations, 2002 states that "Proposals shall be processed by insurer with speed and efficiency and all decisions thereof shall be communicated by it in writing within a reasonable period not exceeding 15 days from receipt of proposals by the insurer".

The insurer retained the premium of Rs5095 and no communication was sent to the complainant till 05/12/2016, as required under the above mentioned regulations. In view of the above the Forum is of the opinion that the accident claim on 25/11/2016 is payable, and subject to the co-pay clause of 30% for

accident claims under the Senior Red Carpet Insurance Policy, which was proposed by the complainant in respect of his father.

Thus the complaint is **Allowed.**

OMBUDSMAN – SHRI B N MISHRA
Mr T K Ganesan Vs Star Health and Allied Insurance Co. Ltd
Complaint Ref: NO: CHN-G-044-1617-0697
Award No: IO/CHN/A/GI/0006/2017-18

The complainant's wife had ported her health insurance policy from ICICI Lombard to Star health in the year 2016. She had policy with ICICI Lombard from 2014 and the current policy with Star health is in its 3rd year. The request for cashless authorization for breast cancer surgery was rejected on the grounds of non disclosure of material information relating to health conditions at the time of porting. Then the insured preferred reimbursement claim and the same was rejected by the insurer as per policy condition No. 8 which deals about non settlement of claim in case of fraudulent means or device, misrepresentation in any manner whether by the insured person or by any other person acting on his behalf.

The insurer rejected the claim based on the Amma Health Check up report dated 27/8/2016 wherein BIRADS 4 indicating left carcinoma of breast and Osteopenia of right hip was mentioned therein and that the said information was not disclosed in the proposal at the time of porting. Besides as per policy condition No. 15 which deals about cancellation clause. Under this clause the policy was cancelled. However, prior notice of 30 days as required under the policy condition was not given and the entire premium of Rs13858 was refunded. The grievance cell also rejected the appeal from the complainant.

The dispute involved here is whether the signature in the porting form and proposal form is that of the insured or a forged one. If it is insured's signature then repudiation by insurer is in order and if it is not then the repudiation is not in order. Since this forum is not the competent authority to verify whether the signature in the documents which forms the basis of contract based on which the claim was repudiated by the insurer, is a forged one or not.

As per condition no. 15 of the policy, policy can be cancelled only after giving 30 days of prior notice, in case of non disclosure of material fact. But the policy was cancelled on 01/02/2017 without giving any 30 days notice and thus the cancellation was not as per policy condition.

It is of the view that this forum is not the competent authority to verify the authenticity of the signature of the insured in the Proposal and Porting form, which was relied upon by the insurer at the time of claim repudiation

Thus the complaint is **Dismissed.**

OMBUDSMAN – SHRI B N MISHRA
Case of Mr Akbar Yusuf Bhai Vs The New India Assurance Co. Ltd.
Complaint Ref: NO: CHN-G-049-1617-0691
Award No: IO/CHN/A/GI/0007/2017-18

The complaint was made regarding short settlement of hospitalization expenses, incurred on his wife, who has been covered under New India mediclaim policy. The claim is for Bilateral Total Knee Replacement (TKR) at Fortis Malar Hospital and the amount incurred is Rs 521546. The respondent insurer has accorded cashless approval of Rs 125000 only. TKR has a waiting period of 48 months, as per clause 4.3.2 which reads as, "Unless the insured person has continuous coverage in excess of forty eight months with us, the expenses related to treatment of Joint Replacement due to Degenerative condition and age related Osteoarthritis & Osteoporosis are not payable."

Any enhanced sum insured after the inception of the policy will be subjected to the exclusion clause as per clause 5.11 which states as, "In respect of any enhancement of Sum Insured, exclusions 4.1, 4.2 & 4.3 would apply to the additional sum insured from such date."

As per clause 4.3.2 & 5.11 the cashless approval was restricted by the insurer's TPA, since the sum insured of the complainant's wife, 48 months prior to the current hospitalization is Rs 125000, under the policy 71260034110100002452 with the policy period 19/03/2012-18/03/2013. Sum Insured was enhanced to Rs300000 on 19/03/2013 and this sum insured has not completed 48 months as on 04/12/2016.

It is observed that the respondent insurer's action of restricting the sum insured to Rs125000, being the sum insured 48 months prior to hospitalization is in order and in line with the Policy clause no 4.3.2 & 5.11 as stated earlier.

Since the claim amount exceeded the sum insured, the insured is eligible for the cumulative bonus of Rs.25000/- accrued under the policy. The insurer expressed to the Forum, their willingness to pay Rs.25000/-. Hence the insurer is directed to pay Rs25000 being the cumulative bonus amount, along with interest at a rate 2% above the bank rate prevalent at the beginning of the previous financial year.

Thus the complaint is **partly admitted.**

OMBUDSMAN – SHRI B N MISHRA

Case of Ms Amrita Ripendran Vs Apollo Munich Health Insurance Co. Ltd

Complaint Ref: NO: CHN-G-003-1617-0674

Award No: IO/CHN/A/GI/0009/2017-18

The complainant's hospitalization claim for Rs 86732 towards expenses for treatment of seizure disorder, fore head Trifoliate Laceration and nasal bone fracture at Apollo Hospital Chennai, was rejected by the insurer on the grounds on non disclosure at the time of inception of the policy**.**

Section VI.J. of the policy terms and conditions reads as under:

" If at the time of issuance of Policy or during continuation of the Policy, the information provided to us in the proposal form or otherwise, by You or the Insured Person or anyone acting on behalf of You or an Insured Person is found to be incorrect, incomplete, suppressed or not disclosed, willfully or otherwise, the Policy shall be:

• Cancelled *ab initio* from the inception date or the renewal date (as the case may be), or the Policy may be modified by Us, at our sole discretion, upon 30 day notice by sending an endorsement to Your address shown in the Schedule without refunding the Premium amount; and

• The claim under such Policy if any, shall be rejected/repudiated forthwith."

The policy was cancelled invoking the above clause.

The respondent insurer repudiated the complainant's claim, on the grounds of non- disclosure of material fact i.e about seizure disorder in the year 2004, while availing this insurance. The fact that this was not disclosed was proved by respondent insurer, by submitting the copy of the proposal wherein seizure episode was not mentioned. Hence insurer's action of rejecting the claim as per policy condition VI.J is in order.

Taking into account the facts & circumstances of the case and the submissions made during the course of hearing, it is proved that the rejection of claim by insurer is in order and that there is no scope for reviewing the claim. Hence, the insurance Ombudsman is not inclined to interfere in the decision of the insurer.

Thus the complaint is **Dismissed.**

OMBUDSMAN – SHRI B N MISHRA
Case of Mr G Mathivanan Vs Tata AIG General Insurance Co. Ltd
Complaint Ref: NO: CHN-G-047-1617-0640
Award No: IO/CHN/A/GI/0010/2017-18

The complainant's wife had availed health Insurance covering self and her son. On 04/08/2016 complainant's wife was hospitalised for treatment of LA Myxoma and incurred medical expenditure of Rs 316875. She preferred claim a restricting the claim amount to sum insured of Rs200000. Initially cashless approval was granted for Rs 60000, but later the same was denied and withdrawn on the grounds that the said illness falls under two years waiting period clause of the policy. The claim for reimbursement was also repudiated by the insurer stating that LA Myxoma excision is excluded as per section 3 clause (C) of the policy. Clause C.i of the Section 3 reads as under:

"C)The illnesses and treatments listed below will be covered subject to a waiting period of 2 years as long as in the third policy year the insured person has been insured under an Mediprime policy continuously and without any break:
i) Illnesses: arthritis if non infective; calculus diseases of gall bladder and urogenital system; cataract; fissure/fistula in anus, hemorrhoids, pilonidal sinus, gastric and duodenal ulcers; gout and rheumatism; **internal tumors**, cysts, nodules, polyps including breast lumps (each of any kind **unless malignant**).....

It was observed that the insurer repudiated the claim under clause 3.c.i of the policy. The treatment undergone was for excision of LA Myxoma, which is an internal tumor. Non malignant internal tumor falls under exclusion clause 3.c.i of the policy. As per histopathology report, LA Myxoma for which surgery was undergone was non malignant.

The attending surgeon's certificate also did not categorically state that it is a malignant tumor. As per records available, LA Myxoma is a benign tumor, Hence the repudiation of claim by insurer is in order.

Thus the complaint is **Dismissed and closed.**

OMBUDSMAN – SHRI B N MISHRA
Case of Ms Kavitha Sreedhar Vs United India Insurance Co. Ltd
Complaint Ref: NO: CHN-G-051-1617-0604
Award No: IO/CHN/A/GI/0011/2017-18

The complainant's claim of Rs 53,773 towards adjuvant medication of Trastuzumab under daycare procedure at Kumaran Hospitals Chennai has been denied by the respondent insurer. The reason stated is that Trastuzumab is a monoclonanl antibody and not a chemotherapeutic drug. The policy covers only chemotherapy under daycare procedure. Complainant further stated that the insurer had earlier reimbursed, 16 times for the same treatment (adjuvant medication of Trastuzumab) of daycare procedure. Trastuzumab is an administration of hormonal injection which prevents recurrence of cancer. Hence the complainant prayed that denial of the same treatment under the pretext of a internal circular issued by their office is not fair and the claim has to be honoured by the insurer.

Respondent insurer repudiated the complainant's claim based on an internal circular issued by the company. Rejection by insurer is not supported by policy terms and conditions. Hence repudiation by insurer is not in order and the insurer is directed to settle the claim for Rs 53773, along with interest at a rate 2% above the bank rate prevalent at the beginning of the previous financial year,

in favour of the insured subject to other terms and conditions and deductibles under the policy if any.

Thus the complaint is **Allowed**.

OMBUDSMAN – SHRI B N MISHRA
Case of Mr V C Mukundarajan Vs United India Insurance Co. Ltd
Complaint Ref: NO: CHN-G-051-1617-0652
` Award No: IO/CHN/A/GI/0012/2017-18

The complainant's pre hospitalization expenses of Rs 5996 subsequent to surgery of cataract of right eye was settled for Rs496 only and thus short settled. The reason quoted by insurer in their SCN is that Pre hospitalization claim of Rs5500 was denied since the supporting investigation report was not submitted by the insured. The complainant stated that he was entitled upto Rs40000 for cataract surgery. Hence balance amount of Rs5500 has to be paid to him by the insurer. Complainant took up the matter with grievance vide letter dt 03/01/2017 and insurer vide letter dt 03/02/2017 stated that the claim was settled for Rs31000. Not satisfied with the grievance dept's reply, complainant has approached this forum.

Complainant's pre hospitalization claim of Rs5500 was denied by the insurer since complainant didn't submit the supporting optical biometric report and that they are prepared to pay on submission of the report.

The insurer is directed to settle the claim for Rs 5500, along with interest at a rate 2% above the bank rate prevalent at the beginning of the previous financial year, subject to submission of supporting Optical Biometric Report, in favour of the insured subject to other terms and conditions and deductibles under the policy if any.

Thus the complaint is **Allowed**.

OMBUDSMAN – SHRI B N MISHRA

Case of Mrs. Rajeswari Muralidharan Vs The Oriental Insurance Co. Ltd.

Complaint Ref: NO: CHN-G-050-1617-0583

Award No: IO/CHN/A/GI/0013/2017-18

The complainant was covered under health insurance since 2008. On 16/04/2016, she was hospitalised for Infected Sebaceous Cyst at Mehta's hospital. Under local anesthesia, she had undergone the sebaceous cyst excision procedure. The treatment was done on day care basis. Her claim for Rs. 16,300/- has been rejected by the insurer under clause 2.3 which states that expenses for hospitalisation were admissible only if hospitalisation was for a minimum period of 24 hours. However, under clause 2.3(A) exemptions to this 24 hours clause for 26 ailments are listed, however the procedure "sebaceous cyst excision" is not included in the said list. Under clause 2.3(C) of the policy the need for minimum of 24 hours hospitalisation is not applicable, provided, where medical treatment, and/ or surgical procedure is (i) undertaken under General Anesthesia in a hospital/day care centre which is less than 24 hours because of technological advancement and (ii) which would have otherwise required a hospitalisation of more than 24 hours. Further in a note under the said policy condition it is stated that "Procedures/ treatments usually done in outpatient department are not payable under the policy even if converted to day care surgery / procedure or as in patient in the hospital for more than 24 hours".

During the hearing, the complainant submitted a copy of policy terms and conditions downloaded from the website of the insurer with ref no: UIN: IRDA/NL-HLT/OIC/P-H/V.II/448/14-15 2014-15. As per this document, the list of Day care procedures / surgeries are stated wherein under serial "E" on "Operations on the skin & subcutaneous tissues" with details of Serial No. 32, which deals with Incision of a pilonidal sinus, Serial No. 33, Free skin transplantation, donor site, Serial No. 34, Revision of skin plasty and Serial No. 35, Simple restoration of surface continuity of the skin and subcutaneous tissues is included. The complainant expressed that as per the above conditions her ailment is covered under the list of day care procedures allowed under the policy.

However, the insurer's representative informed that there was no change in the policy terms and conditions till 2015-16 and that the copy of policy terms and conditions submitted by him to the Forum is alone applicable to the claim in dispute. Though the complainant had informed the Forum that she was not given the policy terms and conditions, it was not her original plea.

The complainant in her letter to the grievance cell of the insurer had stated that she was staying close to the hospital and she could rush to the hospital in an emergency, hence she did not get admitted. In addition she also thought paying Rs. 3000/- plus room rent just to claim the insurance was a criminal and avoidable expenditure. The Forum appreciates the complainant's intention to be reasonable and she behaved as if she was uninsured in reducing the expenses.

On scrutiny of the product terms and conditions placed in the IRDAI's website, it was observed that the insurer had filed a new terms and conditions under reference Mediclaim Insurance Policy (Individual) UIN: IRDA/NL-HLT/OIC/P-H/V.II/448/14-15 to the IRDAI for approval and the same was approved only in the year 2016-17 which came into effect from October 2016. However, the complainant's policy expired on 26/06/2016 and subsequently the policy was not renewed. Hence the new policy terms and conditions 2.11 and the list of Day Care procedures under serial "E" are not applicable to the present claim in dispute.

Hence Insurance Ombudsman was of the view that the insurer had rightly rejected the claim under clause 2.3. Thus the complaint is **Dismissed.**

OMBUDSMAN – SHRI B N MISHRA
Case of Mr. S Ashok Kumar Vs National Insurance Co. Ltd.
Complaint Ref: NO: CHN-G-048-1617-0591
Award No: IO/CHN/A/GI/0014/2017-18

The complainant was covered along with three of his family members under mediclaim from 15/05/2015 to 14/05/2016 and after gap of 10 days it was again renewed from 25/05/2016 to 24/05/2017. The sum insured for the complainant is Rs. 5 Lakhs. On 21/09/2016, the complainant was hospitalised at Billroth hospital, Chennai during 21/09/2016 to 29/09/2016 for treatment of Coronary Artery Disease (CAD) – Chronic stable angina class III, Systemic Hypertension (SHT). He had incurred hospital expense of RS, 4,00,000/- and when he submitted the claim, it was rejected by the insurer. The exclusion clause No. 4.1 was quoted as the reason for repudiation of claim which reads as, "All pre-existing diseases (PED) when the cover incepts for the first time until 48 months of continuous coverage has elapsed. Any complication arising from pre-existing ailments/disease /injury will be considered as a part of the pre-existing health conditions or disease."

It was observed that the policy was first issued for the period from 15/05/2016 to 14/05/2016. After 10 days break-in period, it was renewed from 25/05/2016 to 24/05/2017. The complainant was hospitalised on 29/09/2017 and as per the discharge summary under previous medical information, Hypertension was mentioned as pre-existing for one year. It means, one year period starts from September 2016, but the policy was in force from May 2016. That is nearly 4 months after the renewal of policy, after a break-in insurance. The Proposal form was obtained on 15th May 2015, and the complainant had not given details of any exiting ailments.

The insurer in their claim repudiation letter dated 05/12/2016 and the grievance cell reply dated 25/01/2017 had mentioned the repudiation under clause 4.1 whereas in the Self contained Note the reason for repudiation was as under specific clause relating to waiting period of two years period for the Hypertension and related complications. This is clearly stated in the terms and conditions of the policy, but the insurer had not mentioned the relevant clause 4.3(ii)(m) in their repudiation letter.

Though the discharge summary describes Hypertension is for one year, it still falls within the waiting period of 24 months as per clause 4.3(ii)(m).

Thus the complaint is **Dismissed.**

OMBUDSMAN – SHRI B N MISHRA
Case of Mr. H Jeelani Vs Apollo Munich Health Insurance Co. Ltd.
Complaint Ref: NO: CHN-G-003-1617-0590
Award No: IO/CHN/A/GI/0017/2017-18

The complainant is the husband of the insured. The insured Mrs Mubeena and her son Feroz Mohd. were covered under health insurance of Universal Sompo 20/08/2009. Then it was switched over to Apollo Munich by portability from 05/08/2013 and it is being renewed till date. The present sum insured is Rs. 2,00,000/- with cumulative bonus of Rs. 60,000/-. Mrs Mubeena was hospitalised at Vijaya Medical & Educational Trust, Chennai during 07/10/2016 to 08/10/2016 for Left ear central perforation and she had undergone the procedure of Mastoidectomy with tympanoplasty. Her request for cashless

treatment was rejected and subsequently on discharge from the hospital, her claim for reimbursement also was rejected. The reason for repudiation was due to Non-disclosure and concealment of facts.

It was observed that the insurer was asked to send their SCN within 10 days vide our letter dated 02/02/2017, but it was received by only on 03/04/2017. The insurer is hereby advised to the SCN at the earliest. The claim was repudiated under a wrong general conditions section no VI (J) instead of Condition no VII (j). The policy was first incepted in 2009 and ported to the present insurer in August 2013. In the previous policy copies, no pre-existing disease/s was mentioned. The copy of the proposal submitted with the present insurer duly signed by the complainant as the proposer. The proposer's spouse and child alone were included in the proposal. For a question on Diseases of the Ear/Nose/Throat/Teeth/Eye (please mention Dioptres in case of refractory error) under the heading "Medical and Life style information", question No. 6(ix), the proposer had given responses as "NO."

Further observed that the insurer submitted letter of the attending specialist Dr. Gananathan at Vijaya Health Centre wherein he had stated that the patient had consulted him only on 29/09/2016 and not before that. It means the patient had consulted the doctor seven days prior to the admission to the hospital. Hence the complainant version of not having consulted any doctors in the previous years is acceptable. Thus the question of non disclosure of the past history does not arise.

Also, the insurer in their SCN has referred to the investigation done and to the response to the questionnaire wherein to a question the insured has responded that ""From at the age of 8 the pain was there. But it comes once in 2 years". However, no copy of the questionnaire was submitted to the Forum and the insurer submitted a report in the name of "Apollo Munich SKD Health Allied Services – Final Report" typed in a plain paper. The report does not contain the name of the investigating officer and is unsigned. At the end of the report under

the column “Final Recommendation”, it is mentioned as “Rejection PED, Complaints since childhood and aggravated since 3 months. Insured stated from the age of 8 the pain was present but it comes once in two years.” The recommendation has no meaning and has no validity. It was also observed that the insurer invoked the cancellation clause and cancelled the policy which is not in order as the repudiation of claim is not correct.

Hence, the insurer is directed to settle the claim (including post hospitalisation), subject to other terms and conditions of the policy, along with interest as mentioned in the Insurance Ombudsman Rules, 2017. The insurer is also directed to reinstate the insurance cover.

Thus the complaint is **Allowed.**

OMBUDSMAN – SHRI B N MISHRA
Case of Mr. D Venkataraman Vs The Naional Insurance Co. Ltd.
Complaint Ref: NO: CHN-G-048-1617-0641
Award No: IO/CHN/A/GI/0018/2017-18

The complainant is having mediclaim insurance for self and spouse since 2008. He stated that earlier on 27/06/2016, he had undergone a Cataract surgery for his left eye at Dr. Mohan’s Diabetes specialties centre, for which the TPA M/s. Mediassist had settled Rs. 40,900/- as against the claim amount of Rs. 50,000/- . He further stated that again in October 2016, he underwent Cataract surgery for his Right eye for which he had incurred expenses of Rs. 52,765/-. The claim was settled for Rs. 28,524/- only. The reason for short settlement of claim was application of Reasonable and Customary charges”” as per policy condition No 3.29.

It is observed that no limit has been fixed/specified in the policy/terms and conditions for the Cataract Surgery. However the insurer had arrived at Rs. 26,500/- stating that the prevailing amount in other leading hospitals in

Chennai. They have also restricted the claim amount to Rs. 26,500/- based the operative clause of the policy which states that "the company will pay to the hospital or reimburse the insured person, the amount of such expenses described below, **reasonably, customarily and necessarily incurred** .....during the policy period". The term Reasonable and customary charges have been defined under definition section of policy.

The complainant was explained about the policy terms and conditions with regard to reimbursement of pre-hospitalisation and post-hospitalisation. Hence the amount of Rs. 5090/- is not payable. With regard to medical bills for Rs. 690/-, the complainant was not sure of having the prescriptions/ bills. Otherwise no additional amount becomes payable.

The complainant had submitted letter dated 30/06/2017 after the hearing, requesting the Forum to condone the delay in submission of bills. As per insurer's version, no bills were rejected for delay in submission. Only those amount spent prior to 30 days of hospitalization was disallowed under Pre Hospitalisation, as per policy terms and conditions.

It was also stated by the insurer's representative, that the previous claim for Cataract surgery was inadvertently settled for Rs. 40,900/-, by the TPA for which recovery procedure is under process. Hence the complainant was advised that any wrong payment made inadvertently cannot be taken as a case of precedence.

Under these circumstances, the insurer was directed to settle the claim of Rs.690/- on production of prescriptions/bills by the complainant.

Thus the complaint is **Allowed** in part.

OMBUDSMAN – SHRI B N MISHRA
Case of Mr. CV Ramanathan Vs The Naional Insurance Co. Ltd.
Complaint Ref: NO: CHN-G-048-1617-0682
Award No: IO/CHN/A/GI/0019/2017-18

The complainant had a mediclaim policy covering self and spouse since 15th November 1997. He was hospitalized on three occasions for Carcinoma Lung with progression of brain metastases. The period of first hospitalization was from 10/09/2016 to 16/09/2016, the second one from 03/10/2016 to 07/10/2016 and thirdly one from 07/11/2016 to 16/11/2016. When he raised the claim for reimbursement of the total amount spent towards treatment of Rs. 4,87,737/-, he was settled only Rs. 1,67,047/- after disallowing Rs. 3,20,687/-. He appealed to the grievance cell of the insurer and as he was not satisfied with grievance cell reply. Hence he approached this Forum.

It was observed that the major amount disallowed under 2nd claim was discussed during the hearing. The complainant's representative was quite co-operative and understanding. The insurer in their grievance reply dated 23/01/2017 had elaborated clearly about the application of clause 3.3 i.e. "**Any one illness**", which means a continuous period of illness including relapse within 45 days from the date of last consultation with the hospital/nursing home where treatment was undertaken. Once it was explained to the complainant's representative, she was enlightened, and got convinced immediately. Had the insurer/TPA explained in their first letter itself, the complaint would not have arisen and the complainant would not have taken so much efforts and time in getting her grievance redressed for the last 6 months.

The insurer/TPA was advised to take more care in future in writing to the insured in case of short settlement / rejection of the claim.

Thus the complaint is **Dismissed**.

OMBUDSMAN – SHRI B N MISHRA
Case of Mr. B Senthil Kumar Vs National Insurance Co. Ltd.
Complaint Ref: NO: CHN-G-048-1617-0618
Award No: IO/CHN/A/GI/0020/2017-18

This policy was issued to the Bank of India account holders. The complainant's 18 years old daughter was hospitalised at Vasanthi Orthopaedic hospital, Chennai during 13/06/2016 to 18/06/2016 with history of abnormal gait associated with pain over both legs. She had undergone surgery for deformity correction and LCP fixation left distal femur. When the complainant submitted a claim for Rs. 1,90,000/-, it was rejected. The insurer's rejection letter stating that treatment of Bilateral Genu Varus Deformity stands repudiated for the following reason, "Treatment related to External Congenital are not payable, as per clause No. 4.9 – General Debility, external congenital anamoly: convalescence, general debility, run down condition or rest cure, external congenital anamoly". The grievance cell of the insurer justified the rejection referring to the discharge summary wherein it was stated that the patient was having abnormal gait/bow legs from her childhood. Hence the complainant had approached this Forum.

As per discharge summary, the 18 years old insured patient was hospitalised with history of abnormal gait associated pain over both legs. She had complaint of bow legs both sides **SINCE CHILDHOOD** associated with difficulty in doing her day to day activities. It was diagnosed as Bilateral Genu Varus Deformity and the procedure she had undergone was Deformity correction and LCP fixation – Left distal femur (Fixator assisted deformity correction)

The medical dictionary defines the ailment as, "a childhood deformity, developing gradually in which the knees are together or "knock" in walking and the ankles are far apart.

As per the medical literature downloaded from the website: https://www.hxbenefit.com/genu-varum.html, the definition of Bilateral Genu Varus Deformity, "It is a medical condition in which the knees of an affected individual are wide apart, while the ankles and feet are together when he/she stands up. This type of physical deformity is considered to be normal among children below 18 years of age. The condition can worsen due to excessive walking". The literature also states that this medical condition generally affects infants between 1-2 years of age.

Further, during the hearing, the insurer's representative had confirmed that they relied on the discharge summary, which states that the ailment existed since childhood and that she had no medical paper to prove that the deformity was congenital. She was asked to differentiate the terms "Since childhood" and 'Congenital", for which she had no answer. As per medical dictionary, the ailment Genu Varus Deformity is a childhood deformity, developing gradually in which the knees are together or "knock" in walking and the ankles are far apart. If it is from childhood, it could have happened any time after the child was born, but not by birth. Hence the insurer could not prove that the insured person had this complaint by birth.

Thus the complaint is **Allowed.**

OMBUDSMAN – SHRI B N MISHRA

Case of S. Asim Basha Vs ICICI Lombard General Insurance Co. Ltd.

Complaint Ref: NO: CHN-G-020-1617-0617

Award No: IO/CHN/A/GI/0021/2017-18

The complainant is having medical insurance since 2009 covering self. He is having annual sum insured of Rs. 3,00,000/- and additional sum insured of Rs. 1,50,000/-. He was hospitalized at Dr. Agarwal's Eye Hospital on 17/09/2016 and discharged on 18/09/2016. He was diagnosed for Right eye Dislocated IOL. When he submitted claim for Rs. 52,000/-for reimbursement, it was rejected by the insurer referring to the Part III, schedule I of the policy terms and conditions which states about Incontestability and Duty of Disclosure and the policy was also cancelled subsequently. It was alleged that the complainant is a known case of Diabetes and Hypertension prior to inception of the policy.

The insurer had initially rejected the cashless on the ground that the complainant was a known case of DM & HT prior to policy inception which amounts to mis-representation, mis-description or non-disclosure. Subsequently the claim was also repudiated for the same reason quoting a document dated 24/12/2008 alleged to have been submitted by the complainant that the patient was a known case of DM.

The fact remains that the complainant's representative also agreed that his father is a diabetics and it was informed to the agent at the time of proposal. Also it was the complainant's son who had signed the proposal and not his father. To his surprise, from the copy of proposal submitted by the insurer to the Forum it was found that the proposal contained the name and signature of his father, which the complainant stated to have been forged. It was cross verified with the signature in the complaint and Annexure VI and were found to be different. Also from the policy it was observed that the proposer was Mr. SA Syed Nabil Basha, the complainant's son.

Further, the insurer's representative did not produce the proof of having delivered the copy of proposal along with the policy in the year 2009, as promised. Hence the rejection of the claim on the grounds by the insurer on the grounds of non disclosure of material facts in the proposal could not be substantiated.

Under the circumstances, the insurer is hereby directed to settle the claim Rs. 20,000/- as per the amount fixed for Cataract under clause Extension HC 15: Sub limits on Medical expenses/ illness/ surgeries procedures, to the complainant. Thus the complaint treated as **Allowed.**

OMBUDSMAN – SHRI B N MISHRA
Case of Mr. AR Kalyana Sundaram Vs New India Assurance Co. Ltd.
Complaint Ref: NO: CHN-G-049-1617-0603
Award No: IO/CHN/A/GI/0022/2017-18

The complainant's family is covered by the group mediclaim of LIC employees. His wife was hospitalized at PSG Hospital, Coimbatore and had undergone surgery for Uterus Prolapse, cystocele. Out of the total claim of Rs. 69,911/-, he was settled Rs. 59,573/- disallowing Rs. 10,338/-. But the complainant had claimed for Rs. 7,964/- being the balance amount to be settled. His appeal to the grievance cell was not replied.

The TPA in their settlement letter and the insurer in their SCN have given the detailed head-wise amount of allowed/disallowed supported by the list of 199 items which are not payable.

The various amount disallowed were under the heads of food charges not meant for patient (2366), non medical items. Some of operation theatre expenses were billed separately, but the TPA had mentioned it as part of theatre charges.

During the hearing it was observed that the disallowed amounts were discussed itemwise and accordingly some of the amounts become payable. The insurer's representative and the TPA were willing to pay a sum of Rs. 6991/-, subject to submission of bills by the complainant.

Thus the complaint is **Allowed.**

OMBUDSMAN – SHRI B N MISHRA

Case of Mr. AR Kalyana Sundaram Vs New India Assurance Co. Ltd.

Complaint Ref: NO: CHN-G-051-1617-0675

Award No: IO/CHN/A/GI/0023/2017-18

The insured, his family and dependant parents were covered under Arokya Raksha Policy since 2008, which was renewed continuously without any break. The sum insured under the current policy is Rs. 2,00,000/-. The insured's/Complainant's mother was admitted into Dr. V.Seshaiah Diabetic centre from 17/01/2017 to 20/01/2017 with complaints of illness, inability to walk and uncontrollable urine flow. The claim was submitted to the insurer for reimbursement of medical expenses for Rs.50,320/-. However the claim was rejected by insurer stating that the treatment did not warrant hospitalization. They referred to Exclusion clause 4.11 of the policy which reads as under:

" Charges incurred at hospital/nursing home primarily for diagnostic x ray/ laboratory examinations or other diagnostic studies not consistent with /incidental to the diagnosis and treatment of positive existence of presence of any ailment, sickness or injury, for which confinement is required at a Nursing home/Hospital". The Complainant registered a grievance with respondent insurer. Insurer vide letter dt 24/02/2017 reiterated the earlier decision of repudiation. Not satisfied with grievance's response the complainant has approached this forum now for settlement of his claim.

The Complainant's claim of Rs 50320 was rejected by respondent insurer under clause 4.11 of the policy, as they were of the view that the admission was essentially for diagnostic purpose only. The insurer's argument that admission was not warranted and could have been managed as outpatient can't be accepted. The insured person is a lady aged 64 years and was suffering from uncontrollable urine outflow. Hence admission was definitely warranted. It is quite possible that having got admitted into the hospital, several other tests not related to the current condition for which hospitalization was necessitated, might have been performed. Hence, during hearing, the insurer/TPA was asked to provide the expenses exclusively for the condition which necessitated hospitalization. The insurer/TPA responded and informed that an amount as Rs 27000/- could be paid. Hence the insurer is directed to settle the claim for Rs 27000/- along with interest stated under Insurance Ombudsman Rules, 2017, subject to other terms and conditions and deductibles under the policy if any.

Thus the complaint is partly **Allowed**.

OMBUDSMAN – SHRI B N MISHRA

Case of Mr. T.Sairam Subramanian Vs Cigna TTK Health Insurance Co. Ltd.,

Complaint Ref: NO: CHN-G-053-1617-0576

Award No: IO/CHN/A/GI/0024/2017-18

The complainant and his family members were covered under mediclaim policy with Apollo Munich Health Insurance service from 2009. The said insurance was duly ported to Cigna TTK in the year 2016. The sum insured under the policy was Rs.5.50 lacs (family floater). The complainant's wife was admitted into Apollo 1st Med Hospitals from 02/10/2016 to 06/10/2016 with diagnosis of AUB and was performed LAVH with conservation of both ovaries. The claim for expenses incurred towards treatment to the extent of Rs.1,76,609/- was submitted to the insurer. The claim was rejected by insurer under Duty of Disclosure clause VIII.1 and the relevant portion reads as under:

"The policy shall be null and void and no benefit shall be payable in the event of untrue or incorrect statements, misrepresentation, misdescription or non disclosure of any material particulars in the proposal form."

Since the insured didn't disclose the insured person having menorrhagia and D&C prior to portability with Cigna. Complainant represented to the grievance. Insurer reiterated the earlier decision of repudiation and terminated the policy without giving 15 days notice as mandated under Cancellation clause VIII.16. Not satisfied with grievance's decision, the complainant approached this forum now for settlement of his claim.

The complainant's claim was rejected on the grounds that the insured person was having Menorrhagia (abnormal uterine bleeding) and undergone D&C earlier and the same was not disclosed while porting and thus there is suppression of material fact. However, abnormal uterine bleeding and undergoing D&C are not uncommon and these are not material facts to be disclosed while availing health policy. The policy was ported from Apollo Munich and the respondent insurer could have easily got those details from the previous insurer as required under the Porting guidelines. More over there is a waiting period of only two years for hysterectomy for menorrhagia under Two Year Waiting Period Clause V.3. Since the policy is a ported one and the first policy started in 2009 and now the policy is in its 7th year, repudiation of the claim by respondent insurer is not in order. Consequently, cancellation of the policy by the insurer is not justified.

Hence the insurer is directed to settle the claim as per policy terms and conditions and restore the policy with all continuity of benefits.

Thus the complaint is **Allowed**

In the matter of Ms. Rekha Jindal V/s The New India Assurance Company Ltd.

1. Ms. Rekha Jindal has made a complaint to this office of Insurance Ombudsman on 27.04.2017 against the New India Assurance Company Ltd. regarding rejection of her medi- claim under policy number 31090034162800000327.

2. The Insurance Company justified the rejection of her medi- claim under policy exclusion clause 2.15, which excludes hospitalization for less than 24 consecutive hours except some specified treatments. The patient was admitted for injection methylprednisolone/pamidronate and this procedure can be done on OPD basis.

3. On scrutiny of papers, Hon'ble Insurance Ombudsman found that the patient was admitted in hospital on 16.03.2016 at 12.12 PM and was discharged on 17.03.2016 at 1.00 PM, which confirms that the requirement of policy condition with regard to the hospitalization for 24 consecutive hours was fulfilled and substantiated. Further the treating doctor of Indian Spinal Injuries had also certified that in order to infuse the injection Pamidronate 60 mg, the admission was essential. Accordingly, the said claim was found admissible, and the Insurance Company was directed to settle the said claim as per the entitlement within the scope of policy terms and conditions. The Insurance Company was further directed to implement the Award, dated 19.05.2017, within 30 days on receipt of the same.

4. There is no further relief to be granted to the complainant.

5. Hence, the complaint is disposed off accordingly. Copies of the Order to both the parties have been delivered.

In the matter of Mr. Vasdev Dhingra V/s The New India Assurance Company Ltd.

1. Mr. Vasdev Dhingra has made a complaint to this office of Insurance Ombudsman on 06.04.2017 against The New India Assurance Company Ltd. alleging inadequate settlement of his medi- claim under policy number 31230234152800000752.

2. The Insurance Company justified the settlement of claim on the basis of Sum Insured of Rs.2 lakh in the year 2011, i.e. sum insured in 4 years back policy, as they had considered the disease under treatment as PED (Pre-existing disease).

3. On scrutiny of papers, Hon'ble Insurance Ombudsman found that the Insurance Company had failed to substantiate their contention of Pre-existing disease through cogent and reliable documents. On the basis of lab report, the treating doctor had issued a letter, dated 29.07.2016, certifying that the disease Endometriosis was not because of T.B., and not related to the past A.T.T. treatment. Thus, the said claim does not come under pre-existing clause, and the Insurance Company was directed, vide Award dated 11.05.2017, to settle the said claim as per the entitlement within the scope of policy terms and conditions and pay the remaining amount of claim within 30 days from the date of receipt of the Award.

4. There is no further relief to be granted to the complainant. Hence, the complaint is disposed off accordingly. Copies of the Order to both the parties have been delivered.

In the matter of Mr. Avijit Bhattacharya V/s New India Assurance Company Ltd.

1. Mr. Avijit Bhattacharya has made a complaint to this office of Insurance Ombudsman on 25.04.2017 against New India Assurance Company Ltd. alleging non- settlement of his Medi-claim under policy number 32030134152500001125.

2. The complainant complained Insurance Company took 5 months for a reply to the complainant and rejected the claim on the grounds of delay of 10 days in submission of documents

3. The Insurance Company had rejected the claim. The TPA had stated in their email that insured has delayed in submission of the claim papers by 10 days, however, the claim was medically found admissible within the ambit of policy terms and conditions, subject to approval of competent Authority for condoning the delay as detailed above.

4. On scrutiny of the papers, Hon'ble Insurance Ombudsman found that the claim papers were found medically admissible within the scope of policy terms and conditions as commented by the Vipul Medcorp of New India Assurance Company Ltd. vide email dated 20.03.2017 The delay of 10 days in submission of the claim documents might have been condoned, as the reason for delay was provided, and TPA sought approval from the Insurance Company to condone the delay. The Insurance Company during the personal hearing also could not substantiate as to why the delay was not condoned. The Insurance Company themselves took five months to repudiate the claim. The delay of 10 days is therefore condoned. Accordingly, the Insurance Company was directed, vide Award dated 04.07.2017, to settle the claim as per the terms and conditions of policy within 30 days on receipt of the Award. There is no further relief to be granted to the complainant.

5. Hence, the complaint is disposed off accordingly. Copies of the Order to both the parties have been delivered.

In the matter of Mr. K.K. Aggarwal V/s The New India Assurance Co. Ltd.

1. Mr. K.K. Aggarwal has made a complaint to this office of Insurance Ombudsman on 03.05.2017 against New India Assurance Company Ltd. under policy number 31250034162500000949, alleging non-settlement of his Medi-claim.

2. The complainant had purchased New India medi- claim policy-2012 for the period 14.09.2016 to 13.09.2017 in continuity since 14.09.2000 for sum insured of Rs. 8,00,000/-. The complainant was hospitalized on 26.08.2015 for the treatment of Bilateral Pulmonary Artery Embolism, crohn's disease etc. The Insurance Company had rejected the claim on the ground that the crohn's disease is a genetic disorder. During the course of hearing the complainant had reiterated that the Insurance Company had previously settled a claim for the same disease in the month of Aug. 2015, and this time, they had rejected his claim wrongly.

3. The Insurance Company had rejected the claim of the complainant on the grounds that the crohn's disease is a genetic disorder. Further the company had also stated that Injection Remicade is not payable on day care basis, as hospitalization was done only for administration of this Injection, whereas it does not require 24 hours admission.

4. On scrutiny of papers and presentations from both sides during the course of hearing, Hon'b'le Insurance Ombudsman found that the first two paid claims, which the complainant referred, were not related to the present disease. The complainant had also submitted a Certificate of Dr. Vineet Ahuja, Professor, Department of Gastroenterology and Human Nutrition, AIIMS, clarifying that Inflammatory Bowel Disease (ulcerative colitis, crohn's Disease) is not primarily genetic Disorder. The policy conditions do not specify any exclusion for Crohn's disease as a genetic disorder, nor is there any mention of the disease being listed as genetic disorder as per the company's manual. It thus has no substance to the policy, issued to the insured. Accordingly, the Insurance Company was directed to treat the claim as admissible and settle the claim as per policy terms and conditions within 30 days from the date of receipt of the Award

5. There is no further relief to be granted to the complainant. Hence, the complaint is disposed off accordingly. Copies of the Order to both the parties have been delivered.

In the matter of Mr. Ram Sojan v. Bharti Axa General Insurance Company Ltd.

1. Mr. Ram Sojan has made a complaint to this office of Insurance Ombudsman on 16.05.2017 against Bharti Axa General Insurance Company Ltd. , alleging wrong rejection of his Medi-claim under policy number BIH/ Q0096360/41/12

2. The Insurance Company justified the rejection of his medi- claim under policy exclusion clause 7.1 and 7.6, which excludes Misrepresentation of material facts , and fraudulent claim. They reiterated during hearing that there was Misrepresentation of material facts with regard to hospitalization, Age of the patient, expiry of the registration of hospital etc., which led to rejection of claim.

3. On scrutiny of papers and presentations from both sides during the course of hearing, Hon'ble Insurance Ombudsman found that the Insurance company could not prove the misrepresentation of facts with regard to hospitalization in private Room, and that Room No. 202/2 was not a private room. Room No. 202/2 indicates that there was provision of 2 patients in the private room, and the insured complainant did not charge more than the hospital bill. The complainant cannot be held responsible for expiry of the registration of the hospital, or discrepancy in age of patient on the bills and reports of hospital and diagnostic lab, as both were beyond his control. Hence Insurer's objections on hospitalization treatment in private room, discrepancy in age of the patient, expiry of the registration of hospital etc are not acceptable and justified. Hence, the claim is admissible under policy terms and conditions. Accordingly, the Insurance Company was directed to treat the claim as admissible and settle the claim as per policy terms and conditions within 30 days from the date of receipt of the Award. There is no further relief to be granted to the complainant.

4. Hence, the complaint is disposed off accordingly. Copies of the Order to both the parties have been delivered.

In the matter of Mr. Narendra Bansal
Vs
Oriental Insurance Company Ltd.

1. Mr. Narendra Bansal (herein after referred to as the complainant) had filed the complaint against the decision of Oriental Insurance Company Ltd. (herein after referred to as respondent Insurance Company) alleging inadequate settlement of mediclaim. The complainant also stated that he was not aware of terms and conditions of GIPSA package since terms and conditions of policy were not supplied to him at the time of dispatch of policy. He also submitted that his pre & post hospitalization bill was also not settled by the Insurance Company.

2. The Insurance Company reiterated in the hearing that the claim of the complainant was settled as per GIPSA agreement.

3. After hearing both the sides and perusal of record, we found that the complainant was admitted in the hospital on 16.12.16 and diagnosed as acute coronary syndrome and he underwent surgery for coronary angiography on 16.12.16 and we find that no terms and conditions of GIPSA agreement were supplied to the complainant and hence we direct the Insurance Company to settled the admissible claim of the complainant as per terms and conditions of policy and also settle the pre and post hospitalization claim of the complainant.

4. There is no further relief to be granted to the complainant.

5. Hence, the complaint is disposed off.

6. Copies of the order to both the parties have been delivered.

In the matter of Mr. Trilok Chand Sapra
Vs
National Insurance Company Ltd.

1. The complainant alleged that his wife had undergone Cataract Eye surgery. The Insurance Company had paid Rs. 34,902/- against the claimed amount of Rs. 92,852/- inspite of sending non-acceptance advice to the Company. She sought relief of Rs. 57,950/- from this forum.

2. The Insurance Company reiterated that the insured patient has undergone Femto laser assisted cataract surgery + PCIOL at Centre for sight and a reimbursement claim for Rs. 92,852/- was submitted. TPA did not receive any cashless request from the hospital or the insured against this hospitalization. The hospitalization claim has been settled by TPA for Rs. 34,000/- under reasonable and customary charges clause of National Mediclaim Policy. As per TPA, the patient underwent laser assisted cataract surgery however MICS is a widely acceptable procedure costing 34,000/- under GIPSA package PPN agreed upon package rate hence balance is disallowed under reasonable and customary charges clause of NMP. In addition, as recommended by the TPA, Rs. 350/- may be further allowed to the insured under the head of 'pre-hospitalization expenses'.

3. During the course of personal hearing the complainant stated that his wife had undergone Femto cataract surgery for Right Eye on 05.11.2014 and Insurance Company had paid Rs. 99,776/- but Insurance Company had denied the Femto procedure for left eye surgery done on 05.11.2016. On perusal of papers on record and submissions during hearing I find that Insurance Company had paid the charges for Femto cataract surgery done for right eye in the year 2014, therefore I direct the Insurance Company to pay the charges for same procedure for left eye also. **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**.

In the matter of Ms. Kulvinder Kaur
Vs
National Insurance Company Ltd.

1. The complainant alleged that she was admitted in BLK from 11.08.2016 to 14.08.2016 with complaint of episode of giddiness, generalized weakness for further evaluation and management. The Insurance Company had rejected the claim on the ground that admission was for investigation & evaluation purpose only. He sought relief of Rs. 70,711/- from this forum.

2. The Insurance Company had rejected the claim on the ground that the patient was admitted for investigation purpose as per discharge summary. No active line of treatment was given. All the reports were normal. Hence claim was denied under clause no. 4.19 which states "Diagnostic and evaluation purpose where such diagnosis and evaluation can be carried out as outpatient procedure and the condition of the patient does not require hospitalization."

3. During the course of personal hearing the complainant stated that his mother was hospitalized in emergency from 11.08.2016 to 14.08.2016. On perusal of papers on record I find that patient was admitted in emergency. However the discharge summary revealed that the patient was admitted with complaint of giddiness, generalized weakness and syncope. The admission was for further evaluation and management. However the patient was admitted only on the doctor's advice. **Accordingly an award is passed with the direction to the Insurance Company to pay ICU charges and room rent as per terms and conditions of the policy to the complainant.**

In the matter of Mr. Hisham Mundol
Vs
Max Bupa Health Insurance Company Ltd.

1. The complainant alleged that he had taken a health insurance policy in the year 2012 which was continuously renewed. The complainant was facing progressive swelling in front of the neck in the year 2014 for which he had undergone thyroidectomy on 15.05.2014 and follow up treatment was taken but he did not claim. He was again hospitalized for a period of 3 days from 21.12.2015 to 23.12.2015. He had submitted a claim for reimbursement of Rs. 83,915/- which was rejected on the ground of non-disclosure of pre-existing illness at the time of obtaining insurance.

2. The Insurance Company reiterated that during claim processing it has been observed that patient had complaints of progressive swelling in front of neck which was detected 10 years back. The pre-existing illness/medical condition was not disclosed at the time of taking policy, hence as per policy condition no. 3 (def. 14) claim was rejected due to non-disclosure of material facts at the inception of policy.

3. I heard both the sides, the Complainant as well as the Insurance Company. During the course of personal hearing the complainant agreed that he had swelling in thyroid and on medication till 2014. On perusal of papers on record and submissions during personal hearing I find that thyroid lump was detected 1.5 years ago as revealed from prescription of Dr. Deepak Sarin, Medanta hospital, dated 12.05.2014 which was prior to policy inception (05.02.2013) and complainant had not disclosed the pre-existing illness at the time of taking policy, hence Insurance Company had rejected the claim due to non-disclosure of material information. As per Supreme Court judgment it is obligatory for the proposer to disclose the material facts at the time of filling the proposal form. The Insurance Company is not liable to pay the expenses in case of non-disclosure of material information. Therefore, I see no reason to interfere with the decision of the Insurance Company. **Accordingly the complaint filed by the complainant is hereby dismissed.**

In the matter of Mr. P.V. BhimaRao
Vs
National Insurance Company Ltd.

1. The complainant alleged that he was hospitalized at Metro hospital from 10.02.2016 to 12.02.2016 at the advice of doctor. He was diagnosed with coronary artery disease. He underwent Coronary Angiography and PTCA with stenting. The cashless claim was not approved so he had applied for reimbursement of Rs. 3,61,537/- from Insurance Company. The claim was rejected by the company on the ground that illness was pre-existing.

2. The Insurance Company had repudiated the claim vide repudiation letter dated 12.09.2016 on account of pre-existence of disease prior to policy inception and as per terms and conditions of the policy pre-existing disease were excluded for 4 years from the scope of policy.

3. During the course of personal hearing the complainant stated that he was not suffering from BP for 4 years. There was no pre-existing disease at the time of taking policy. There was a mistake made by attendant identified himself as complainant's son that patient was suffering from HTN for last four year, whereas HTN was detected only 3-4 months back of heart disease. The Insurance Company reiterated that disease was pre-existing hence claim was rejected under policy condition 4.1 which states that PED will be covered after 48 months of continuous coverage of policy. On perusal of papers on record and deposition made during hearing, I find that complainant was suffering from HTN for 3 months and recent ASMI as revealed from prescription dated 05.02.2016 of Dr. Ashwini Joshi, who referred him to Metro Hospital. Moreover the discharge summary dated 02.02.2016 of Metro Heart Institute revealed No past history of HTN.

During hearing Insurance Company was asked to produce documents regarding pre-existing disease within 10 days. No further documentary evidence has been submitted by the Insurance Company. The Insurance Company could not substantiate that disease was pre-existing, hence I direct the Insurance Company 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 and pay the admissible claim amount to the complainant.**

COMPLAINT REF:NO: GUW-G-048-1617-0073 (Awarded : 26/04/2017)

Mrs.Vinita Jain V/S The National Insurance Co. Ltd.

Patient suffering from **Intermenstrual bleeding** (IMB) was advised a variety of tests leading to Hysteroscopy which by itself is a diagnostic process according to Insurer and that too in a known case of 'fibroid uterus'. The daycare list of surgeries does not include Hysteroscopy (a test/diagnostic procedure for infertility) and not admissible as per policy. Insurer went on to reiterate "infertility treatment is not admissible as per Policy terms & conditions.

Having taken into account facts & circumstances of the case and the submissions made by both the parties during the course of hearing and on careful perusal of all available documents including the Policy Conditions, Clauses, Sub-Clauses, following salient points emerged worth consideration:

a) Claim was preferred for hysteroscopy, which is an INVESTIGATIVE PROCEDURE and NOT ADMISSIBLE unless followed by a CURATIVE

   TREATMENT/SURGERY like MYOMECTOMY, which was not done in the instant Case;

b) The Insurer, *prima facie*, is also guilty of inept and inappropriate handling of the case inasmuch as the Repudiation Letter dated 12/06/2015 under the signature of the then Divisional Manager, failed to quote the correct clauses and ground for rejection – which, however, DOES NOT RENDER THE CLAIM ADMISSIBLE.

Complaint is therefore treated as DISMISEED AND CLOSED without any relief to the Complainant, who is however allowed leave of approaching any other forum of law.

COMPLAINT REF:NO: GUW-G-051-1718-0001 (Order dated 30/05/2017)

Jayanta Borooah V/S The United India Insurance Co. Ltd.

After taking into account facts & circumstances of the case and the submissions (oral & documentary) made by both the parties during the course of hearing, salient points worth consideration are as under:

a) Whereas the claim occurred during the currency of a Policy with a Sum Insured of Rs. 500000/-, the Insurer settled the

   Claim on the basis of a Policy effective from 2012 with a

   Sum Insured of Rs. 275000/-;

b) The Complainant insisted that the basis of settlement should have been on the basis of the Sum Insured of Rs. 500000/- (effective from 04/09/2015) and that the revised Sum Insured ought not to have attracted afresh the Exclusion clause 4.1;

c) However, condition No. 5.12 of the Policy stipulates:

ENHANCEMENT OF SUM INSURED 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".

In view of the foregoing the decision of the Respondent's settlement of the claim the way they did is upheld with no relief to the Complainant and the Complaint is dismissed from this Forum.

Hence, the complaint is treated as CLOSED.

COMPLAINT REF:NO: GUW-G-007-1718-0015 (Order dated 29/06/2017)

Borun Jyoti Dutta V/S Bharti AXA General Insurance Co.Ltd.

Case of Reimbursement Claim under Smart Health Insurance Policy; PART of which was paid (36090/-) BUT Lump Sum amount was denied which according to complainant is payable BUT according to Respondent/Insurer is NOT payable.

After taking into account facts & circumstances of the case and the submissions (oral & documentary) made by both the parties during the course of hearing and before, this Forum is of the considered opinion that the

decision of the Respondent to repudiate the Lump Sum portion of the claim on the ground that CVA (Cardio Vascular Attack) 'was not fit to come under the definition of Critical Illness according to terms & conditions of the Policy issued' is fair and justified.

Moreover, the Complainant despite requests from this Office (over phone, by emails/letter) chose to skip the 'hearing' and authorized a person, who neither had a clue to the nitty-gritty of the scope & ambit of the Policy with reference to the illness nor was he in possession of any additional treatment-related papers other than the ones already submitted. On the basis of the available documents, CVA – in the instant case – fails to qualify as a Critical Illness according to relevant terms & conditions of the Policy.

Such being the circumstances we find no reason to interfere with the decision taken by the Respondent. The complaint is thus treated as dismissed and closed without any relief.

Complaint No. I.O.(HYD) G -11.037.0057 / 2017-18

Mrs. Saroj Jain VS. Religare Health Insurance Company Ltd.

Award No. I.O. (HYD)/A/GI/0006/ 2017-18 Dt. 11.08.2017 **INDIVIDUAL MEDICLAIM**

FACTS

The complainant, Mrs. Saroj Jain was covered under Health Insurance Policy (Care Plan) taken by her husband with the insurer from 06.10.2016 to 05.10.2017 for a floater SI of Rs. 4 Lacs. She underwent treatment in Star Hospitals, Hyderabad from 23.01.2017 to 28.01.2017 for bilateral total knee replacement. She filed reimbursement claim for Rs.3,95,000/-. The insurer rejected the claim stating that disease was pre-existing prior to the inception date of policy with the company and hence waiting period of 4 years apply.

FINDINGS

The complainant stated that she had walking difficulty, pain in knee joints and tingling sensation in her both lower limbs since a year on and off. Due to non-specific and mild symptoms, she was treated with analgesic and supplements by her son, who is a doctor. She further stated that later on the symptoms increased and she consulted a doctor during December 2016 and he evaluated her and diagnosed her ailment as 'osteoarthritis of both knee joints'. Thereafter, she underwent bilateral knee replacement surgery in Star Hospitals, Hyderabad from 23.01.2017 to 28.01.2017. The claim preferred by her for Rs.3,95,000/- was rejected by the insurer attributing pre-existence of the disease, prior to inception of the policy with them. She contended that her disease was diagnosed during last week of December 2016 but to why it was classified as pre-existing disease by the insurer was not known. The insurer submitted that the claim was investigated and during the investigation it was confirmed that the insured person had knee pain since one year and this fact was not disclosed to the respondent company at the time of porting the policy. Thus, there is concealment of material facts on the part of the complainant and hence it is a clear non-disclosure. The insurer further submitted that the claim of the complainant was erroneously repudiated on the ground of 4 years waiting period clause for PED instead of Non-disclosure of material facts/information.

DECISION

The present policy was underwritten under portability norms, porting from Star health Insurance company and the policy schedule confirms that the date of first enrolment was 07.09.2011 with Star Health with SI of Rs. 2 Lacs and cumulative bonus of Rs.30,000/-. The present policy is proposed for Rs.4 Lacs. The insurer produced a letter dated 26.07.2017 addressed to the Insurance Ombudsman from the Head Underwriter to the effect that the Religare Health Ins. Co. would not issue the policy if any proposal is received with declaration of knee pain since one year. On perusal of the proposal it is observed that/no question had been asked as to whether the proposer suffered from knee pain and if so the duration. In the absence of such question in the proposal, we are at a loss to understand how the head u/w can give such a undertaking that declaration of knee pain would not entitle the proposer the insurance coverage. Since the present policy was underwritten under Portability norms the waiting period clause shall apply from the inception of the original/ported policy. Realizing this perhaps the insurer has changed the ground of the rejection after filing of the case with this Forum. Thus, the insurer is not justified in denying the subject the claim. The insurer is advised to settle the claim to the extent of porting policy SI of Rs. 2 Lacs with accrued cumulative bonus of Rs.30,000/- along with interest in terms of Rule 17 (7) of Insurance Ombudsman Rules, 2017.

Complaint No. I.O.(HYD) G -11.018.0051 / 2017-18

Mr. K. Srinivasa Rao VS. HDFC ERGO Gen. Insurance Company Ltd.

Award No. I.O. (HYD)/A/GI/0007/ 2017-18 Dt. 11.08.2017 **INDIVIDUAL MEDICLAIM**

FACTS

The complainant, Sri K. Srinivasa Rao had availed cover under Health Suraksha Policy (Silver Plan) of the respondent insurer from 19.10.2012 for a SI of Rs.3 Lacs. The policy was continuously renewed up to 26.10.2018. During the 2016-17 policy period he suffered from 'Osteo-arthritis of bilateral knee' and underwent bilateral total knee replacement surgery in Land mark Hospitals, Hyderabad from 09.09.2016 to 13.09.2016. He preferred the claim for reimbursement of treatment expenses. The insurer rejected the claim stating that there was non-disclosure of previous medical history/conditions.

FINDINGS

The complainant stated that he had joint pains since 2 years only but it was wrongly recorded as 8 years by the hospital authorities and issued certificate confirming the same. It was not accepted by the insurer and the claim was rejected. The insurer contended that as per the discharge summary of the hospital, it was noted that the insured person was presented with *"complaints of bilateral knee joint pains since 3 years, pain severe 2 years, pain on walking, long standing and affecting daily activity. Patient apparently asymptomatic 3 years back, lateral developed bilateral*

knee joint pains." It was further noted from physiotherapy assessment sheet *"pain in both legs for 4 years aggravated from 1 year affecting activities of daily living".* An investigator was deputed to verify the records and he collected a discharge summary from the hospital which shows the duration of symptoms of the insured person is since 8 years and severe since 2 years where as the discharge summary submitted by the complainant shows the story of 3 years only. As per the documents collected by the investigator, the claim has found to be misrepresented. Hence, the claim was repudiated under Section 10j of the policy.

DECISION

The insurer repudiated the reimbursement claim on the ground that two sets of discharge summary copies are available. On a query by the insurer with regard to duration of illness as 8 years in one set and 2 years in another set, the attending doctor certified that there was typing error in the discharge summary and exact duration of illness was 2 years and not 8 years. The physiotherapist assessment form of Land Mark Hospitals cites the duration of illness as 4 years. Since the claim arose during 4th year of the policy and physiotherapy assessment form cites the illness as 4 years it is concluded that the complainant was suffering from the disease for the past 4 years, if not 8 years. However, since there was no continuous Policy coverage for past four years, the claim is not admissible and the insurer's decision in repudiating the liability is upheld.

Complaint No. I.O.(HYD) G -11.018.0016 / 2017-18

Mr. KHK Satya Prakash VS. HDFC ERGO Gen. Insurance Company Ltd.

Award No. I.O. (HYD)/A/GI/0008/ 2017-18 Dt. 11.08.2017 **INDIVIDUAL MEDICLAIM**

FACTS

Smt. K. Baby Sarojini had availed cover under Health Suraksha Policy (Silver Plan) of the insurer and proposed herself and her husband from 08.09.2012 for a SI of Rs.5 Lacs through tele-marketing. The policy was continuously renewed since then. During the 2016-17 policy period she suffered from fever with chills, rigors, myalgia and low backache and underwent Ayush treatment from 27.11.2016 to 10.12.2016 and preferred the claim. The insurer rejected the claim stating that there was non-disclosure of previous medical history/conditions. Sri K.H.K. Sathya Prakash, son of the insured represented to the insurer to review the decision but in vain.

FINDINGS

The insurer rejected the claim stating that there was non-disclosure of previous medical history/conditions of diabetes and hypothyroidism. The complainant submitted that his father had given the information to the extent he had understood the language of the tele-caller of the insurer. He had furnished a caesarian delivery detail which was happened very long ago. The complainant further stated that his father could not follow the accent and speed of the person who made a call for verification of the details and so he could not give other details. The complainant contended that it was informed that all pre-existing diseases are covered after 4 years of coverage and as to why the claim was rejected by the insurer on the ground of non-disclosure when a claim was filed during 5th year policy. The insurer contended that the initial assessment sheet revealed that the complainant's mother had DM type II from 10 years, Hypothyroidism for 10 years and ?CAD. This medical history was not disclosed while purchasing the policy with the company. Hence, the cashless and reimbursement claims were rejected for non-disclosure of material facts.

DECISION

The policy was obtained through tele-marketing and no hard copy of the proposal signed by the insured was submitted. The insurer submitted a audio recording in telugu of the tele-proposal wherein the caller elicited the information of health complaints, surgery and accident like for which the complainant's father confirmed that he had not undergone any surgery but his wife had caesarian when the child was born way back in 1993. No specific questions were asked as to whether the proposed persons are suffering from Hypertension, Diabetes, Thyroidism as is being elicited from the hard copy of the proposal form due to which the proposer cannot be blamed for the suppression of the previous ailments/conditions. Since the insurer failed to substantiate that there is fraudulent intention of the insured in suppressing the material information, the insurer is not justified in rejecting the claim. Complaint is allowed.

Complaint No. I.O.(HYD) G -11.037.0040 / 2017-18

Mr. K. Thirupathi Reddy VS. Religare Health Insurance Company Ltd.

Award No. I.O. (HYD)/A/GI/0009/ 2017-18 Dt. 11.08.2017 **INDIVIDUAL MEDICLAIM**

FACTS

The complainant, Sri K. Thirupathi Reddy insured himself and his daughter under an Health Insurance Policy with the respondent insurer from 23.08.2015 to 22.08.2018 (3 years) for a floater

SI of Rs. 10 Lacs. He underwent treatment in Apollo Hospitals, Hyderabad from 09.01.2017 to 12.01.2017 for intestinal obstruction. The insurer rejected the claim stating that there was non-disclosure of material facts, i.e. history of Chronic Myeloid Leukemia (CML-2009). He represented to the insurer to review the decision stating that he had disclosed the medical history to the agent and there was manipulation in the proposal.

FINDINGS

The complainant submitted that he had taken Health Insurance Policy with the present insurer under portability from ICICI Lombard by submitting a proposal on 18.08.2015. He was subjected to pre-medical tests also. The complainant stated that he had verified the policy only after receipt of rejection letter from the insurer and noted that his signature was forged by some officials of the insurer under 'Health & Lifestyle information' who had modified the information. The signature on the second page of the proposal was completely different from his signature and it could be easily identified. The insurer contended that the complainant is a known case of CML from 2009 and even in the cases of portability, the proposer is supposed to fill a proposal form and the new insurance company has a right to underwrite the proposal as per their underwriting practice. The respondent company, in good faith, believed the disclosures made by the complainant in the proposal form and thereby issued the policy. Had the correct health status of the proposed life to be insured been disclosed at the time of inception of the policy the company would not have issued the policy. Hence, the claim was rejected.

DECISION

The insurer obtained documents to the effect that he is suffering from CML since 2009, but the insured doesn't deny that he is suffering. The insurer states that there is no correction in the proposal form where details of treatment for past 48 months were elicited wherein categorical 'NO' was stated by the proposer. This itself shows that the proposer was concealing the material information. During the hearing the representative of the insurer produced copy of policy schedule issued by M/s ICICI Lombard GIC from whom the policy was ported to Religare. On perusal of the policy schedule the pre-existing diseases were mentioned as 'NONE' which confirms that he had not disclosed his medical history pertaining to the year 2009 (CML) to the previous insurer even though the policy was taken from ICICI during 2011. The Forum is convinced that the complainant insured did not honestly declare his health condition to both the insurers. Hence, the insurer is well within its right as per the policy to deny any liability.

Complaint No. I.O.(HYD) G -11.018.0089 / 2017-18

Mr. A. Vidyasagar Kumar VS. HDFC ERGO Gen. Insurance Company Ltd.

Award No. I.O. (HYD)/A/GI/0010/ 2017-18 Dt. 11.08.2017 **INDIVIDUAL**

MEDICLAIM

FACTS

The complainant, Sri A. Vidyasagar Kumar had availed cover under Health Suraksha Policy (Silver Plan) of the respondent insurer and insured himself and his spouse and children from 17.09.2011 for a SI of Rs.2 Lacs. The policy was continuously renewed since then up to 16.09.2017. During the 2016-17 policy period he suffered from vision problem and underwent Cataract surgery in his both eyes on 3.12.2016 & 4.2.2017 and preferred claims for Rs.78,000/-. The insurer rejected the claim stating that there was non-disclosure of previous medical history/condition of hypertension which was prior to inception of policy with the company, i.e. from 2008 year.

FINDINGS

The complainant contended that his cataract was not due to hypertension and it was induced by steroid drug used for control of conjunctivitis. In spite of submitting documentary evidence, the claim was not reviewed by the insurer favorably. He further contended that he preferred the claim during the 6th year policy and after 4 years of continuous coverage all pre-existing diseases were automatically covered under health insurance policies, the rejection of the claim on the ground of non-disclosure of hypertension was not in order. The insurer contended that the complainant was using Aten 25mg every day and this information was not disclosed at the time of tele-proposal. There was non-disclosure of previous health condition of hypertension. The insurer further submitted that as per policy terms and conditions Section 9 – Exclusion A iii "48 months waiting period for all Pre-Existing conditions declared and or accepted at the time of application". But nothing was disclosed by the complainant at the time of tele-proposal. Hence, it was a clear case of non-disclosure of material fact relating to PED hence, the claims were declined under Section 10 r ii of policy.

DECISION

The insurer solely relied on non-declaration of hypertension suffered during 2008, for rejection of the claim, which is arbitrary and against the spirit of pre-existing disease exclusion. The insurer also did not produce any evidence to prove that this hypertension is the sole cause for cataract. The medical literature submitted by the insurer states that hypertension increases risk of cataract but not the sole cause for cataract. In fact, the medical record submitted by the insured clearly prove that till 2015, i.e. till 4 years after inception of the policy, the insured's eye sight was normal and the surgery was necessitated due to usage of steroids for treatment of eye infection.

Moreover, as per the policy the waiting period for cataract is two years and he renewed the policy continuously without any break for the past 5 years from 2011. The complaint is allowed.

Complaint No. I.O.(HYD) G -11.053.0013 / 2017-18

Mr. Jasti Srinivasa Rao VS. Cigna TTK health Insurance Company Ltd.

Award No. I.O. (HYD)/A/GI/0011/ 2017-18 Dt. 11.08.2017 **INDIVIDUAL**

MEDICLAIM

FACTS

The complainant, Sri Jasti Srinivasa Rao covered under Pro-Health Plus Insurance Policy issued by the insurer for a SI of Rs. 5.50Lacs from 27.09.2016 to 26.09.2018 (2 years). Due to bike skid on 04.11.2016 he sustained fracture to his right leg. He underwent treatment for the same in M/s Sunrise Hospitals, Hyderabad from 04.11.2016 to 09.11.2016 and preferred claim for the incurred expenses of Rs.87,750/- The insurer rejected the claim alleging that there was fraud and concealment of facts.

FINDINGS

The insurer submitted that the reports / records obtained during investigation from Sunrise diagnostics convey different facts and it is abundantly clear that the said reports pertain to a period prior to 4th November 2016 and also prior to purchase of the insurance policy. The injury was sustained prior to inception of the policy and the complainant made an attempt to make a false claim with fraudulent intention to gain benefit out of the policy. Hence, the claim of the complainant was rejected under clause VIII.24 - Fraudulent claims.

DECISION

The insured sustained injury on 08.08.2016 as evident from the x-ray report of M/s Sunrise Diagnostics and also another X-ray report dated 06.10.2016. The policy was taken on 27.09.2016 and a claim was preferred for alleged accident on 04.11.2016 and x-ray reports were submitted. The hospital bills and discharge summary bears UHID No.51744 and IP No.2016008902 with the date of admission as 04.11.2016. Whereas, one x-ray report dated 08.08.2016, obtained by the investigator of the insurer, wherein the UHID number was mentioned as 51744 tallied with UHID no. & IP No. mentioned in the discharge summary which confirms that the accident took place on 08.08.2016. However, the X-ray report submitted by the insured for the alleged accident on 04.11.2016 bears UHID No. 54845 which does not belong to the insured UHID. The insurer should have clearly spelt out these discrepancies with evidence in their repudiation letter. But unfortunately no such mention was made. However, the insurer could prove with documentary evidence that the present claim was for the treatment taken for an accident that occurred prior

to the date of commencement of the insurance policy. Hence, the complaint requires no intervention by this Forum.

Complaint No. I.O.(HYD) G -11.053.0013 / 2017-18

Mr. Jasti Srinivasa Rao VS. Cigna TTK health Insurance Company Ltd.

Award No. I.O. (HYD)/A/GI/0011/ 2017-18 Dt. 11.08.2017 **INDIVIDUAL**

MEDICLAIM

FACTS

The complainant, Sri Jasti Srinivasa Rao covered under Pro-Health Plus Insurance Policy issued by the insurer for a SI of Rs. 5.50Lacs from 27.09.2016 to 26.09.2018 (2 years). Due to bike skid on 04.11.2016 he sustained fracture to his right leg. He underwent treatment for the same in M/s Sunrise Hospitals, Hyderabad from 04.11.2016 to 09.11.2016 and preferred claim for the incurred expenses of Rs.87,750/- The insurer rejected the claim alleging that there was fraud and concealment of facts.

FINDINGS

The insurer submitted that the reports / records obtained during investigation from Sunrise diagnostics convey different facts and it is abundantly clear that the said reports pertain to a period prior to 4th November 2016 and also prior to purchase of the insurance policy. The injury was sustained prior to inception of the policy and the complainant made an attempt to make a false claim with fraudulent intention to gain benefit out of the policy. Hence, the claim of the complainant was rejected under clause VIII.24 - Fraudulent claims.

DECISION

The insured sustained injury on 08.08.2016 as evident from the x-ray report of M/s Sunrise Diagnostics and also another X-ray report dated 06.10.2016. The policy was taken on 27.09.2016 and a claim was preferred for alleged accident on 04.11.2016 and x-ray reports were submitted. The hospital bills and discharge summary bears UHID No.51744 and IP No.2016008902 with the date of admission as 04.11.2016. Whereas, one x-ray report dated 08.08.2016, obtained by the investigator of the insurer, wherein the UHID number was mentioned as 51744 tallied with UHID no. & IP No. mentioned in the discharge summary which confirms that the accident took place on 08.08.2016. However, the X-ray report submitted by the insured for the alleged accident on 04.11.2016 bears UHID No. 54845 which does not belong to the insured UHID. The insurer should have clearly spelt out these discrepancies with evidence in their repudiation letter. But unfortunately no such mention was made. However, the insurer could prove with documentary

evidence that the present claim was for the treatment taken for an accident that occurred prior to the date of commencement of the insurance policy. Hence, the complaint requires no intervention by this Forum.

Complaint No. I.O.(HYD) G -11.051.0079 / 2017-18

Mr. Om Prakash Garg VS. United India Insurance Company Ltd.

Award No. I.O. (HYD)/A/GI/0015/ 2017-18 Dt. 11.08.2017 **INDIVIDUAL**

MEDICLAIM

FACTS

The complainant, Sri Om Prakash Garg insured himself and his wife under Individual health Insurance policy with the insurer from 21.08.2000 and it was renewed continuously since then till date. The insured person Smt. Sharada Garg was suffering from Breast Cancer and it was detected 7 years back. She was under treatment for the same. The treating doctor advised her to take injection Xgeva SC periodically. Her claims for cost of injections undertaken in M/s Omega Hospitals, Hyderabad was repudiated by the insurer alleging that they do not fall under the scope of the policy.

FINDINGS

The complainant stated that earlier the doctor advised his wife to take injection Zoldonate UMS IV and the claims preferred by him for administration of the injection were paid by the TPA/Insurer. The doctor now changed the injection to Xgeva SC and three claims preferred by him were rejected by the insurer stating that it does not fall under day care treatment and treated it as out-patient department treatment. The insurer rejected the claim as they are not falling under day care procedures.

DECISION

The main issue for consideration is whether the insurer is justified in rejecting a claim for reimbursement of injection expenses on the ground that no hospitalization took place for more than 24 hours. The insurer vide their rejection letter dt. 11.4.2017 relied on definition 2.3.1 which states that procedures/ treatments usually done in outpatient department are not payable under the policy. The insured is a cancer patient and getting reimbursement of the injection administered previously in the same hospital. On perusal of the earlier reimbursement papers, it was noted that the injection was IV administered whereas the present injection for which reimbursement was rejected was not IV administered. The medical literature downloaded from internet on administration of injection Xgeva states that it is to be administered subcutaneously and not through IV. Insurer is justified in repudiating the liability.

Complaint No. I.O.(HYD) G -11.044.0006 / 2017-18

Mrs. R. Jhansi Laxmi Bai VS. Star Health & Allied Insurance Company Ltd.

Award No. I.O. (HYD)/A/GI/0018/ 2017-18 Dt. 11.08.2017 **INDIVIDUAL**

MEDICLAIM

FACTS

The complainant, Smt. R. Jhansi Laxmi Bai, opted coverage under Sr. Citizens Red Carpet Health Insurance Policy on 29.03.2013 for a SI of Rs. One Lac and it was renewed with enhanced SI of Rs.2 Lacs from 29.03.2014 to till date. She suffered from heart disease and underwent coronary angiogram on 26.11.2015 and it revealed CAG-Double Vessel Disease. She underwent PTCA Stent in MaxCure Hospital from 19.04.2016 to 20.04.2016 and preferred the reimbursement claim. The insurer rejected the claim on the ground that there was suppression of previous surgical medical history – Left Carotid Endarterectomy in 2012.

FINDINGS

The complainant stated that she was subjected to Medical Examination by insurer and after getting satisfactory report only she was given coverage under the policy. She stated that she had disclosed to the Sales Manager at the time of the proposal her medical history and he had obtained blank signature on the proposal form and it was signed by her trusting him that he would fill-up the form with all the disclosed information to him. The policy was cancelled during 4th year of her coverage and thereby she lost her continuous benefits and it is a great injustice done to a senior citizen. The insurer contended that the insured patient had past history of Carotid Endarterectomy (11.08.2012) Post CAG-DVD (2012) prior to the policy inception date. The complainant had not disclosed about her past medical history in the proposal form which amounts to misrepresentation / non disclosure.

DECISION

Insurer rejected the claim for non disclosure of health condition. The present claim for which reimbursement is sought relates to the previous ailment. Even though the complainant states that they had disclosed their health condition to the Agent before the proposal, no evidence was produced by them. Hence the insurer is justified in rejecting the claim.

Complaint No. I.O.(HYD) G -11.044.0093 / 2017-18

Mrs. T.M.Mangalam VS. Star Health & Allied Insurance Company Ltd.

Award No. I.O. (HYD)/A/GI/0019/ 2017-18 Dt. 11.08.2017 **INDIVIDUAL**

MEDICLAIM

FACTS

The complainant, Smt. T.M. Mangalam was covered with the respondent insurer under the Sr. Citizens Red Carpet health Ins. Policy from 2012 year and the policy was continuously renewed till date. As per the complaint filed, during the Policy period from 25.04.2016 to 24.04.2017 for a SI of Rs. 3.00 Lacs, she underwent Total Knee Replacement surgery at Sunshine Hospitals, Secunderabad from 12.12.2016 to 15.12.2016 and preferred the reimbursement claim for hospitalization expenses incurred of Rs.2,40,000/-. The insurer rejected the claim stating that there was no-disclosure of past medical history of Wegener's Granulomatosis suffered by the complainant prior to the inception of the policy with the company.

FINDINGS

The claim preferred by the complainant during the 5th year policy was rejected by the insurer alleging misrepresentation/non-disclosure of material fact about her previous medical history of Wegener's Granulomatosis (WG). The complainant contended that she was diagnosed a decade back and it was completely cured and she was leading a normal life and she was not on any medication**.** She had forgotten about the said illness and so she could not declare it at the time of her proposal. The insurer submitted that Wegener's granulomatosis appears to develop by inflammation-causing event triggers an abnormal reaction from the Immune System is a life threatening disorder that restricts the blood flow and oxygen to several organs, including lungs, kidneys and upper respiratory tract. The discharge summary of Sunshine Hospitals clearly stated that the insured patient is a k/c/o of WG since 11 years. It confirmed that the insured patient is a k/c/o WG prior to the inception of the policy and the same was not disclosed in the proposal. Hence, the claim was repudiated under condition No. 9 of the policy. Further, as per condition No. 13 of the policy, the policy was also cancelled.

DECISION

On perusal of the claim documents it is noted that Osteoarthritis claim was reported in the 5th year of the policy with the present insurer and the insurer repudiated the claim on the ground that the proposer did not disclose 11 year old Wegner's Granulostomatosis disease in the proposal. On perusal of the proposal copy, medical history was elicited in two ways. *Has the person/s suffered from any disease/illness or sustained any injury or disability due to accident involving hospitalization? If yes give full details in appropriate columns. Mere dash is not sufficient. - 1. Preceding 12 months from the date of proposal and 2. Beyond 12 months from the date of*

*proposal without specifying upper limit of period of illness if any. I*n the present case, the insured was affected with WG 11 years ago. The medical history questionnaire in the proposal is not clear as to whether the proposer need to declare all diseases or diseases for which hospitalization took place. The representative of the insurer confirmed that the proposal form was revised in 2013 with more clarity and the present proposal pertains to the year 2012. The representative of the insurer was asked to produce any evidence in confirmation of their ground of repudiation that the insured person was hospitalized for WG 11 years ago for which the insurer replied in the negative and reaffirmed that except the noting in the hospital records there was no other evidence. It is also noted from the records that the present hospitalization for which reimbursement is claimed is for knee replacement surgery and except stating that WG affects all the organs, no conclusive proof was produced by the insurer that WG would definitely lead to 'osteoarthritis'. In view of this the forum is inclined to give the benefit of doubt to the complainant and the complaint is allowed.

Complaint No. I.O.(HYD) G -11.044.0047 / 2017-18

Mr . S. Rajesh Kumar VS. Star Health & Allied Insurance Company Ltd.

Award No. I.O. (HYD)/A/GI/0020/ 2017-18 Dt. 11.08.2017 **INDIVIDUAL**

MEDICLAIM

FACTS

Sri S. Rajesh Kumar insured himself, his wife and daughter under the respondent insurer's Family Health Optima Insurance Policy on 04.02.2014 for a floater SI of Rs. 3 Lacs. The policy was renewed continuously without any break. During the 3rd year policy period, from 04.02.2016 to 03.02.2017, insured daughter Ms. Mohita R was admitted in M/s NEO BBC Hospital, Vidyanagar, Hyderabad from 20.12.2016 to 24.12.2016 for Pyrexia. The hospital raised final bill for Rs.37556/- and the insurer approved cashless treatment for Rs.32,086/-. The balance amount of Rs.5100/- was paid by him. The complainant alleged that the insurer settled the bill without analyzing the claim.

FINDINGS

The complainant alleged that some of the services billed by the hospital were not utilized by them and the hospital collected extra money from him. The insurer submitted that the claim was processed and approved only after proper verification of the documents filed by the hospital in terms of the policy**.** The hospital raised pre-authorization request for cashless facility and it was approved for Rs.32,086/- as against the claim of Rs.37556/- after deducting Rs.5470/-. Registration chages, duty doctor, pulse oxymeter, infusion pump and service charges are not payable hence deducted. As per circular of Directorate General of Health Services dated 30.08.2016 the test charges for dengue antibodies was restricted to Rs.600/-. - Hence, Rs. 1000/- was deducted. The expenses towards gloves is not payable – Hence, Rs.120/- was deducted.

DECISION

The complaint is for short settlement of claim by Rs. 5140/- while admitting that the cash less approval was given for Rs. 32,086/-. The details of deductions were explained to the complainant. But the complainant objected to the charges levied viz., Pulse Oximeter was not used and Infusion pump was also not used. The complainant was expressing his dissatisfaction. We found that the insurer sufficiently explained all the details to the complainant and we do not see any deficiency in the service rendered by the respondent insurer. Hence the complaint is dismissed.

Complaint No. I.O.(HYD) G -11.044.0078 / 2017-18

Mrs. Manga Devi VS. Star Health & Allied Insurance Company Ltd.

Award No. I.O. (HYD)/A/GI/0023/ 2017-18 Dt. 11.08.2017 **INDIVIDUAL**

MEDICLAIM

FACTS

The complainant, Smt. D. Manga Devi insured herself, her husband and daughter under insurer's Star Comprehensive Insurance Policy from 30.03.2016 to 29.03.2017 for a floater SI of Rs. 25.00 Lacs. She underwent surgical intervention of L5 S1 for 'Spondylolisthesis' and filed claim for Rs.4,78,378/-. The insurer rejected the claim stating that there was non-disclosure of previous medical history. She represented to the insurer to review the decision stating that she obtained policy under portability norms and she had earlier coverage with a PSU insurer since 2007.

FINDINGS

The complainant contended that she did not have severe back pain at the time of her porting the policy to the Star Health Insurer and stated that the policy issued to her covered all PEDs and hence rejection of the claim is not justified. The insurer contended that the insured person had L5S1 Spondylolithesis for the past 4 years which was prior to the inception of the policy with the company. Further, MRI films dated 03.12.2016 suggestive of long standing disc disease prior to their policy. Insurer further stated that they have obtained a Specialist medical opinion from Dr. B. Pasupathy, Consultant Orthopaedic Surgeon who opined that as per MRI report Grade 3 Spondylolisthesis of Lytic type at L5-S1 level is not possible to exist for 5 months duration. It was a long standing disease. Hence, the claim was repudiated.

DECISION

The insurer rejected the claim based on the duration of illness recorded by the doctor on the claim form that the insured patient suffered from the present ailment since past 4 years. But in the other hospital documents, like the internal case sheet papers, discharge summary, the duration of ailment was recorded as 5 months at many places. In fact the same doctor while making noting

in ICP, mentioned the duration as 5 months only. Since the insurer is not satisfied with the stray remark in the claim form they have obtained specialist opinion from Dr. B. Pasupathy who opined that it is not possible to have L5-S1 level Grade III Spondylosis in 5 months duration. This is a policy ported from United India Insurance Co. and the last policy number of United India was also recorded on the policy. The present policy also contains continuity benefits applicable wherein the PEDs are stated as covered. Since the Apollo Hospital record show that the insured person had L5-S1 Spondylisthesis for past 4 years the present claim has to be restricted to the sum insured available four years before the first inception policy with the present insurer, i.e. Rs. 3 Lacs. Since the total claim amount exceeds the SI available under 2013-14 year policy, the insurer is directed to settle the claim for Rs.3 Lacs and interest in terms of Rule 17 (7) of Ins. Ombd., Rules, 2017.

Complaint No. I.O.(HYD) G -11.031.0072 / 2017-18

Mr. V. Thirupathi Reddy VS. Max Bupa Health Ins. Company Ltd.

Award No. I.O. (HYD)/A/GI/0025/ 2017-18 Dt. 11.08.2017 **INDIVIDUAL MEDICLAIM**

FACTS

The complainant, Sri V. Thirupathi Reddy insured himself and spouse under the respondent Insurer's Family First health Insurance Policy from 24.06.2015 to 23.06.2016, for a floater SI of Rs. 7 Lacs. The insured person, Smt. Vijayalaxmi suffered from severe back pain and had undergone surgical management in SKS Neuro Polytrauma Hospital, Hyderabad from 29.02.2016 to 11.03.2016. The insurer initially approved cashless treatment request for Rs.70,000/- but on submission of final bill it was rejected on the ground that the insured patient was suffering from the ailment prior to the inception of the policy. The reimbursement claim was also rejected on the same ground.

FINDINGS

The insurer submitted that on the perusal of claim documents it was noted that the insured patient was suffering from back pain since a year which falls prior to policy period and it was not disclosed at the time of taking the policy with the company. As per the consultation papers dated 18.02.2016, the insured person consulted a doctor and it was recorded based on MRI findings that she had L5 problem since one year. It established that the insured person underwent MRI a year prior to 18.02.2016, i.e. around 4 months prior to policy issuance by the company. The information regarding the MRI and L5 finding was not disclosed in the proposal form. The insurer referred to point No.6 "Medical History" of the proposal form wherein it was specifically asked under Question No.2 that "Whether the last 7 years have you been to a hospital

for an operation / and or an investigation (e.g. scan, x-ray, biopsy or blood tests)" and the complainant was under obligation to inform the company about the MRI so conducted but failed to do so. Thus, the material information was not disclosed and the disease was pre-existing prior to the inception of the policy. Hence, the claim was repudiated.

DECISION

The crux of the complaint is that whether the exclusion cited by the insurer applies to the present claim or not. The insurer could produce documentary evidence from the Yashoda Hospital consultation slip dated 18.02.2016 wherein it was stated that MRI (Spine) was taken one year ago and it was not disclosed in the relevant column of the proposal and the hospitalization claim related to the treatment of Lumbar Canal Stenosis only. When enquired about the same the complainant pleaded that he was not aware and his wife had visited the hospital along with his brother-in-law and he was not aware whether MRI was taken or not. Thus it was quite evident that the insured did not declare the previous illness in the proposal thereby the denying the insurer opportunity to take a considered decision. Hence, the insurer is justified in repudiation of the claim.

Complaint No. I.O.(HYD) G -11.044.0070 / 2017-18

Mr. U. Venkateswara Rao VS. Star Health & Allied Insurance Company Ltd.

Award No. I.O. (HYD)/A/GI/0026/ 2017-18 Dt. 11.08.2017 **INDIVIDUAL MEDICLAIM**

FACTS

Sri U. Venkateswara Rao insured himself, his wife and two daughters under the respondent insurer's Family Health Optima Insurance Policy on 29.07.2015 for a floater SI of Rs. 3 Lacs. The policy was renewed for a further period from 29.07.2016 to 28.07.2017. He met with a road accident on 28.01.2017 and sustained blunt injury to his chest which resulted in multiple rib bones fracture. He was admitted in Xenia Hospitals, Hyderabad from 28.01.2017 to 07.02.2017 for treatment of fractured rib bones. He preferred reimbursement claim on rejection of cashless treatment request for Rs.1,20,000/-. The insurer rejected the claim stating that there was non-disclosure of previous medical history.

FINDINGS

The complainant contended that at the time of taking the policy he had informed the agent about his proposed surgery for mitral valve replacement. But the agent not informed the same. At the time of renewal also this fact was informed and the insurer hiked the premium and issued the policy with exclusion of cover for heart diseases. When he filed his claim for accidental injuries, the same was rejected and policy was cancelled by the insurer. The insurer rejected the claim stating that the insured is a k/c/o rheumatic heart disease and it was not disclosed. He had not given factual information in the proposal form. Hence the claim was declined and policy was cancelled.

DECISION

The Insurer had repudiated the claim for reimbursement of hospital expenses due to a road accident on the ground that his previous ailment of heart surgery was not disclosed. The complainant explained that since his hospitalization was not claimed from the insurer he did not informed as per the advice of his agent. On perusal of the papers it is noted that the present claim for which reimbursement is sought is for road accident which is no way related to previous illness. The insurer is not justified in rejecting the claim and the complaint is allowed with a direction to the insurer to settle the claim for Rs. 117278/- as per their working sheet submitted by them during the hearing along with interest in terms of Rule 17 (7) of Insurance Ombudsman Rules, 2017.

Complaint No. I.O.(HYD) G -11.020.0035 / 2017-18

Mrs. R.L. Suverchela Devi VS. ICICI Lombard Gen. Insurance Company Ltd.

Award No. I.O. (HYD)/A/GI/0034/ 2017-18 Dt. 11.08.2017 **INDIVIDUAL**

MEDICLAIM

FACTS

The complainant, Smt. R.L. Suverchala Devi insured herself, her spouse and son under Health Protect Plus policy of the respondent insurer from 12.12.2013 and it was renewed further till date. During the policy period from 12.12.2015 to 11.12.2016, the complainant's husband Sri T. Venkata Subba Rao was hospitalized for abscess in abdominal wall in M/s KGH The Family Hospital, Malakpet, Hyderabad from 09.11.2016 to 11.11.2016. She preferred the claim for reimbursement of hospitalization expenses of Rs. 37,772/-. The insurer rejected the claim stating that there was non-disclosure of previous health conditions of her husband, i.e. diabetes.

FINDINGS

The complainant contended that her husband met with accident during 2012 year and there was amputation of left leg below the knee. At that time only her husband's diabetes and hypertension were diagnosed. This medical history was briefed to the agent of the insurer at the time of proposal and signed blank proposal. The mistakes in the policy names etc. were taken up by her and she filed another proposal by incorporating medical history of her husband for passing rectification endorsement. The insurer issued endorsement. The claim was rejected on the ground of non-disclosure of diabetes and renewal policy cancelled. The insurer submitted that at the time of purchasing the policy the previous medical history/condition was not mentioned/disclosed by the complainant at all. Later also the complainant approached the company for endorsement in proposer name and at that time also she did not request or enquire about the non-mentioning of her husband's previous medical history/conditions. Subsequent to the rejection of her claim for non-disclosure, the complainant approached the Company with another proposal form, which she claimed to have filled and signed by her, that she had disclosed her husband's previous medical condition of diabetes. However, on perusal of the proposal form it was noted that the alleged proposal does not bear any serial number printed on it. The proposal originally submitted bears printed serial number of 0258034. Since the insured had not disclosed the material facts, the company was devoid of an opportunity to assess its risk before issuance of the policy.

DECISION

The complainant produced a copy of endorsement dated 09.1.2014 having rectified the proposer name. Admittedly endorsement was passed based on the revised proposal only wherein the PED was declared. Thus, the insured cannot be blamed for suppression of health conditions and the insurer is not justified in repudiating the claim and cancelling the policy. While allowing the complaint, the insurer is directed to restore the policy and renewal as per the revised proposal submitted by the insured. The complaint is allowed for Rs. 29576/- along with interest in terms of Rule 17 (7) of Insurance Ombudsman Rules, 2017.

Complaint No. I.O.(HYD) G -11.020.0081 / 2017-18

Mr. Osahan Narinder Singh VS. ICICI Lombard Gen. Insurance Company Ltd.

Award No. I.O. (HYD)/A/GI/0038/ 2017-18 Dt. 11.08.2017 **INDIVIDUAL**

MEDICLAIM

FACTS

The complainant, Sri Osahan Narinder Singh insured himself and his son under insurer's health insurance Policy from 30.09.2016 for a floater SI of Rs. 10 Lacs. As per the complaint filed, the complainant met with a road accident on 15.03.2017 and sustained injury to his left knee. He underwent Arthroscopy + TBW (Circlage) at Apollo Hospitals, Hyderabad from 15.03.2017 to 17.03.2017 and incurred Rs.1,35,000/- for the treatment. On rejection of cashless treatment request he filed reimbursement claim and it was also rejected on the same ground, i.e. non-disclosure of hypertension.

FINDINGS

The complainant had undergone knee Arthroscopy Patella surgery. The pre-authorization request for cashless treatment was rejected on the ground that he had hypertension before inception of the policy and it was not disclosed at the time of proposal. Complainant submitted doctor certificate confirming that he did not have any hypertension. The insurer submitted that the claim of the complainant was further reviewed and it was approved by the competent authority to settle the claim at Rs.1,33,891/- as against the claim filed for Rs.1,37,400/- after deduction of non-medical expenses.

DECISION

The complainant represented that the insurer did not entertain his claim for pre & post hospitalization expenses. The amount advised as settled after the filing of complaint with the Ombudsman office did not include pre& post hospitalization claim. He also stated that his policy was cancelled. Since, the hospitalization claim was settled by the insurer, pre & post hospitalization expenses claim filed if any needs to be admitted by the insurer. During the hearing the complainant also stated that his policy was cancelled. Since the policy was cancelled arbitrarily the insurer is directed to restore the policy up to its expiry date, i.e. 29.09.2017.

Complaint No. I.O.(HYD) G -11.050.0057 / 2017-18

Mrs. Lalitha Lakshminarayanan VS. The Oriental Insurance Company Ltd.

Award No. I.O. (HYD)/A/GI/0039/ 2017-18 Dt. 11.08.2017 **INDIVIDUAL MEDICLAIM**

FACTS

The complainant, Smt. L. Lalitha was insured under Individual Mediclaim Policy of the respondent insurer from 15.06.2016 to 14.06.2017 for a SI of Rs. One lac. As per the complaint filed, she underwent cataract eye surgery for her left eye and preferred the claim for Rs. 22,888/-. The insurer settled the claim for Rs.10858/- and declined the claim for balance amount Rs. 10,030/- on the plea that she availed a room higher than her entitlement.

FINDINGS

The claim was restricted on the ground that she availed higher category room than her entitlement. The complainant stated that she had obtained a letter from the hospital that they have charged her room rent @ Rs.1000/- per day for 3 days. The SI under current year policy was @ Rs.1,00,000/- and her entitlement is Rs.1000/- per day. But TPA calculated the admissible amount taking the room rent at Rs.500/- per day by taking the period of stay in the hospital as 2 days. The insurer submitted that the complainant was covered under Individual Mediclaim Policy up to 2016 policy year for a SI of Rs.50,000/- and it was enhanced to Rs. One Lac from 15.06.2016 to 14.06.2017. She filed a claim for Rs. 22,888/- towards reimbursement of cataract surgery expenses. The TPA processed the claim and paid the eligible amount of Rs.10,858/- to the complainant on 27.02.2017. As per the claim documents filed by the complainant, it was observed that the complainant availed a room higher than her entitlement, i.e. her entitlement is Rs.500/- per day whereas she availed a room for Rs.1500/- per day. Hence, in terms of policy conditions 2.4 A (b) the claim proportionately reduced.

DECISION

The complaint is for short settlement of Mediclaim since the insured stayed in a room more than his entitled category. The insured renewed the policy with the enhanced Si of Rs.1 Lac from Rs.50,000/-. Since all the exclusions and waiting period apply afresh to the enhanced SI, the room rent and other charges were proportionately reduced. This Forum ascertained that the hospital where the complainant had undergone cataract surgery was an empanelled hospital by the insurer and the agreed PPN package rate for cataract surgery is Rs.18,000/-. The complainant contended that if they have gone for cashless treatment the insurer would have approved the same but since

they have gone for the reimbursement, the claim was reduced. The complainant further stated that the insurer revised the minimum sum insured from Rs.50,000/- to Rs. One Lac due to the changed regulations and hence the claim needs to be calculated by taking the revised SI. Since the incurred expenditure is more than the PPN package rate the claim can be paid up to the PPN package rate of Rs.18,000/-. Thus the difference of Rs. 7142/- is allowed to be paid to the insured along with interest in terms of Rule 17 (7) of Insurance Ombudsman Rules, 2017.

Complaint No. I.O.(HYD) G -11.044.0097 / 2017-18

Mrs. M. Veenayashree VS. Star Health & Allied Insurance Company Ltd.

Award No. I.O. (HYD)/A/GI/0041/ 2017-18 Dt. 11.08.2017 **INDIVIDUAL**

MEDICLAIM

FACTS

The complainant, Smt. M. Veenayashree insured herself, her husband and two sons under insurer's Family Health Optima Insurance Policy from 09.04.2016 to 08.04.2017 for a floater SI of Rs. 5.00 Lacs. As per the complaint filed, she underwent surgical intervention for hernia at Dr. Shantabai Nursing Home, Hyderabad from 01.08.2016 and was discharged on 04.08.2016 and filed claim for Rs.1,64,162/-. The Respondent insurer stated that the proposer failed to give correct information in the proposal form under Health History against specific questions that–(1) Have you consulted/taken treatment/been admitted for any illness/ diseases/ injury/ surgery – If yes since when – Insured answered 'NO' – 3(i) Have you ever suffered or suffering from any of the following – any gynecological disorder such as DUB, Fibroid uterus, Ovarian cyst or have you undergone cesarean/hysterectomy – If yes since when – Insured answered 'NO'. This amounts to non-disclosure of material facts. The insured/proposer earlier taken cover with Apollo Munich Health Ins. Co. from 09.04.2015 to 08.04.2016 and at the time of porting to our company he had not disclosed the medical history of the insured patient and it amounts mis-representation of material facts. Hence, as per condition No. 8 of the policy, the claim was repudiated.

FINDINGS

After filing the complaint by the complainant, the insurer further reviewed the claim and reprocessed it and approved the claim for Rs. 1,20,000/-. This Forum contacted the complainant and he had accepted the settled amount and requested to close the complaint.

DECISION

The complaint is treated as allowed.

Complaint No. I.O.(HYD) G -11.031.0052 / 2017-18

Mr. K. Ravikanth Reddy VS. Max Bupa Health Insurance Company Ltd.

Award No. I.O. (HYD)/A/GI/0042/ 2017-18 Dt. 11.08.2017 **INDIVIDUAL MEDICLAIM**

FACTS

The complainant, Sri K. Ravikanth Reddy insured himself, spouse and mother under respondent Insurer's Family First health Insurance Policy from 06.06.2014, for a floater SI of Rs. 30 lacs and it was renewed continuously till date. As per the complaint filed, during 2016-17 policy period, he met with road accident on 03.01.2017 and was admitted in Apollo Hospitals, Hyderabad on 04.01.2017. He underwent laprotomy and diaphragmatic hernia re3pair for traumatic diaphragmatic rupture and plastic surgery for lacerated wound of right forearm. Again he underwent open reduction internal fixation for acromioclavicular disruption on 28.01.2017. The insurer rejected the cashless treatment for both the hospitalizations on the ground that he was under the influence of alcohol at the time of accident and history asthama was not disclosed. The reimbursement claims were also rejected on the same ground. The complainant submitted that he had taken up the matter with the insurer to review the decision by submitting treating doctors' confirmation that he was not under the influence of any alcohol or he had any symptoms of asthama.

FINDINGS

After filing the complaint by the complainant, the insurer further reviewed the claim and reprocessed it and approved the claim bearing No. 232055 for Rs. 9,85,941/- and claim No. 232896 for Rs. 1,08,290/- This Forum contacted the complainant and he had accepted the settled amount and requested to close the complaint.

DECISION

The complaint is treated as allowed.

Complaint No. I.O.(HYD) G -11.031.0052 / 2017-18

Mr. K. Ravikanth Reddy VS. Max Bupa Health Insurance Company Ltd.

Award No. I.O. (HYD)/A/GI/0042/ 2017-18 Dt. 11.08.2017 **INDIVIDUAL MEDICLAIM**

FACTS

The complainant, Sri K. Ravikanth Reddy insured himself, spouse and mother under respondent Insurer's Family First health Insurance Policy from 06.06.2014, for a floater SI of Rs. 30 lacs and it was renewed continuously till date. As per the complaint filed, during 2016-17 policy period, he met with road accident on 03.01.2017 and was admitted in Apollo Hospitals, Hyderabad on 04.01.2017. He underwent laprotomy and diaphragmatic hernia re3pair for traumatic diaphragmatic rupture and plastic surgery for lacerated wound of right forearm. Again he underwent open reduction internal fixation for acromioclavicular disruption on 28.01.2017. The insurer rejected the cashless treatment for both the hospitalizations on the ground that he was under the influence of alcohol at the time of accident and history asthama was not disclosed. The reimbursement claims were also rejected on the same ground. The complainant submitted that he had taken up the matter with the insurer to review the decision by submitting treating doctors' confirmation that he was not under the influence of any alcohol or he had any symptoms of asthama.

FINDINGS

After filing the complaint by the complainant, the insurer further reviewed the claim and reprocessed it and approved the claim bearing No. 232055 for Rs. 9,85,941/- and claim No. 232896 for Rs. 1,08,290/- This Forum contacted the complainant and he had accepted the settled amount and requested to close the complaint.

DECISION

The complaint is treated as allowed.

Mr. SUDHIR NAIR Vs The New India Assurance Company Ltd.
(Mediclaim) Date of award: 27.07.2017

The complainant alleged that he was covered under a Family Floater mediclaim policy for Sum Insured of Rs. 3 lacs since 2002. The first claim in the month of February 2017, relating to Hernia operation, conducted at KIMS Hospital Trivandrum, was submitted for settlement of Rs.81484/- but the insurance company had paid a sum of Rs. 27243/- only. The Insurance Company stated that the insured opted for a sum insured of Rs. 3 lac and the eligible room/boarding/ICU and nursing charges rent for his SI was Rs. 3000/-and Rs. 6000/- respectively (i.e. 1% and 2% of the sum insured). The clause further specifies that in case the expenses exceed the above limits, the reimbursement of all other other expenses incurred at the hospital with the exception of cost of medicines, shall be effected in the same proportion as the admissible rate per day of the room rent/ICU charges. Hence the company had rightly settled the claim.

During hearing, the complainant reiterated as above and added that he had not received policy terms & conditions along with the policy inspite of repeated requests. He submitted that the room above his eligibility was allotted due to non availability of room. The complainant submitted a mail from the KIMS hospital informing that in his case investigation and procedure was not separately billed, hence question of hiking the hospitalization bill due to availment of an Executive Room does not arise. He further added that the only differential expenses reflected in the hospitaliastion bill is the rate difference between eligible room rent and the executive room rent alongwith its nursing charges availed. From the facts it was clear that except nursing charges, no other charges had been linked and proportionately hiked as per excecutive room charges which was clearly mentioned in the hospital mail as well. In view of all the facts it was a**warded that the Insurance Company shall settle the claim of the complainant as admissible.**

. Chiranji Lal Kala Vs The Oriental Insurance Company Ltd.
Mr. Mukul Shewaramani Vs Max Bupa Health Ins Co Ltd
(Mediclaim) date of Award: 27.05.2017

The complainant alleged that his son was admitted in hospital on 01.10.2016 due to ERYTHROCYTOSIS TO R/O POLYCYTHEMIAVERA and in the course of treatment he underwent various tests, including BONE MARROW and he was transfused 6 units blood as well. The complainant submitted all the relevant documents for reimbursement of his claim but the insurance company denied the claim stating that admission was primarily for investigation and evaluation purpose. Hence the claim is denied as per clause 4c, (vii)

convalescence and Rehabilition, supervision or any other purpose other than for eligible treatment…….

During the course of personal hearing, the complainant submitted that the patient was admitted on doctor's advice whereas the insurance company stated that the reimbursement of medical expenses was not made as hospitalization was done for diagnostic purpose only. It was observed that the patient was admitted only on doctor's advice. The disease ERYTHROCYTOSIS TO R/O POLYCYTHEMIAVERA i.e.greatly increased red blood cells and may be treated by bloodletting hence the procedure of treatment could be done at the hospital only. Hence it was observed that the hospitalization was not for evaluation and diagnostic purpose only and the patient had undergone treatment at the hospital for the said disease. An **award is passed with the direction to the Insurance Company to settle the claim of the complainant as admissible.**

Award No. IO/KOC/A/GI/0053/2017-2018

Complaint No. KOC-G-051-1718-0106

Award passed on : 16.06.2017

Mr. Alexander Oommen Vs The United India Insurance Co. Ltd.

Delay in payment of claim under health insurance

The Complainant is covered under a Medi-claim policy of the respondent Insurer. He was hospitalized during 20th to 22nd October 2016 for the treatment of his ailment. A claim for reimbursement of expenses for Rs.12619/- towards hospitalization was preferred with the TPA, which has not been settled till date. He appealed to the Insurer for settlement 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 plus interest since No reply/repudiation received from the TPA/Insured.

Decision : pay hospital charges.

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Award No. IO/KOC/A/GI/0047/2017-2018

Complaint No. KOC-G-051-1718-0099

Award passed on : 16.06.2017

Mr. P Venugopalan Vs The United India Insurance Co. Ltd.

Delay in settlement of health claim

Complainant and his family were covered under the health policy of the respondent Insurer from 17.06.2016.He had taken health policy from Oriental Insurance Co. Ltd. From 17.06.2014 to 16.06.2016 and thereafter ported to the present Insurer. His wife was admitted in the hospital on 28th October 2016 due to chest pain and underwent Coronary Angiogram on 7th November 2016. She was diagnosed with a "Myocardial Bridging in Mid Lad". The doctor advised further medication only and his wife was discharged on the very next day. He raised claim under the policy for the reimbursement. The TPA had sought some clarifications which were readily provided. However the claim was not settled. He approached the Grievance cell of the company, but they have not given any reply. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : dismissed.

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Award No. IO/KOC/A/GI/0051/2017-2018

Complaint No. KOC-G-051-1718-0088

Award passed on : 16.06.2017

Mr. T Venugopala Menon Vs The United India Insurance Co. Ltd.

Delay in settlement of medi claim

Complainant and his family were covered under the health policy of the respondent Insurer. He had submitted 2 claims of his wife Mrs. Maya Menon, who underwent eye injections for her Left eye at L V Prasad Eye Institute & Research Centre, at Banjara Hills, Hyderabad during September 2016 to January 2017. The First Bill was for Rs.27000/- and second Bill for Rs.26599/-. He raised claim with the Insurance Company for the reimbursement which was not settled till date. He approached the Grievance cell of the company, but they have not given any satisfactory reply. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : pay both claims.

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Award No. IO/KOC/A/GI/0022/2017-2018

Complaint No. KOC-G-018-1718-0057

Award passed on : 15.06.2017

Mr. Vinod P.P Vs HDFC ERGO General Insurance Company Ltd.

Dispute in payment of claim mediclaim

The complainant and his family are covered under a Medi-claim policy of the respondent insurer. His wife was hospitalized on 31/01/2017 for the treatment of back pain and discharged on 03/02/2017. He preferred a claim of Rs.8400/- from the Insurer which had been denied stating that more documents are to be produced. The insurer also states that the hospitalisation was not required for the aforesaid ailment. He made appeal 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 balance amount of the claim.

Decision : pay Rs.5,519.00.

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Award No. IO/KOC/A/GI/0048/2017-2018

Complaint No. KOC-G-051-1718-0063

Award passed on : 16.06.2017

Mr. Paulson T.M Vs The United India Insurance Co. Ltd.

Dispute in settlement of Cashless payment in health Insurance

The Complainant's wife was covered under the health policy of the respondent Insurer. She was admitted in the hospital and undergone Hysterectomy. He raised a claim from the Insurance Company for the reimbursement, but the company rejected the claim stating that ailment was pre-existing at the time of proposal and as per Policy Exclusion Clause 4.1, the claim is not payable. Actually, the present ailment was not pre-existing and he approached the Grievance cell of the company, but they have not given satisfactory reply. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim

Decision : dismissed.

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Award No. IO/KOC/A/GI/0057/2017-2018

Complaint No. KOC-G-051-1718-0025

Award passed on : 16.06.2017

Mr. Madhusoodanan Nair Vs The United India Insurance Co. Ltd.

Dispute on partial settlement of health claim

Complainant and his family including his blind brother were covered under the health policy of the respondent Insurer. His Brother, Mr. G Unnikrishnan was admitted in the hospital for Kidney ailment on 14.02.2016 and was discharged on 17.03.2016. He preferred a claim of Rs.1,32,097/- from the respondent Insurer, which was partially settled for Rs.92108/-. The Insurance company disallowed Rs.39989/- without assigning any reason. Further, he had submitted another claim of Rs. 78811/- to his employer Bank (Syndicate Bank), to get reimbursement from his employer bank, towards the treatment of his brother undertaken during 26.09.2015 to 09.10.2015. The aforesaid Medical Bill of Rs.78811/- was wrongly forwarded by the bank to the TPA along with his claim papers pertaining to Rs.1,32,097/-. The TPA has not returned the wrongly forwarded bills to them, in spite of repeated requests were made. Now, the Insurance TPA/company is liable to comply his two requirements; to reimburse the balance amount of the claim of Rs.39,989/-, and to return the bills of Rs.78811/- wrongly received by the TPA, or to reimburse the amount. He approached the Grievance cell of the company, but no satisfactory reply received. Hence, he seeks direction from this Forum to direct the Insurance Company to reimburse the balance amount of the claim and reimbursement towards the lost bills at TPA's end.

Decision : dismissed.

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Award No. IO/KOC/A/GI/0035/2017-2018

Complaint No. KOC-G-050-1718-0111

Award passed on : 16.06.2017

Mr. Jayarajan C Vs The Oriental Insurance Co. Ltd.

Partial repudiation of mediclaim

The complainant had a valid Health policy with the respondent Insurer (No 441003/48/2017/1313). After discharge from hospital, claim for reimbursement (of Rs.81527/-) was preferred with the Insurer with regard to hospitalization for treatment of injury due to accident. Claim was partially settled for Rs.25812/- and the balance amount of Rs.55715/- was denied. Since there were no vacant rooms in his entitled category he had taken an A.C. room. Therefore, the partial denial is unjust and the reason given by the Insurer was unacceptable. Hence this complaint seeking immediate settlement of balance claim amount.

Decision : dismissed.

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Award No. IO/KOC/A/GI/0029/2017-2018

Complaint No. KOC-G-044-1718-0047

Award passed on : 16.06.2017

Mr. Anil Kumar I Vs Star Health and Allied Insurance Co. Ltd.

Partial repudiation of health insurance claim

The complainant had a valid Health policy with the respondent Insurer(No P/181111/01/2017/003348). Cashless claim preferred was denied without attributing any cogent reason. After discharge from hospital, claim for reimbursement (of Rs129108/-)was preferred with the Insurer with regard to hospitalization of the complainant for treatment of ACL injury Lt Knee from 23.09.2016 to 26.09.2016 at Cosmopolitan Hospital, Trivandrum . Claim was partially settled for Rs86365/- and the Insurer refuses to settle the balance amount of Rs42743/-. The partial denial is unjust and the reason given by the Insurer for partial repudiation is unacceptable. Hence this complaint seeking settlement of balance claim amount of Rs.42,473/-.

Decision : dismissed.

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Award No. IO/KOC/A/GI/0064/2017-2018

Complaint No. KOC-G-044-1718-0075

Award passed on : 16.06.2017

Mr. N C Kurien Vs STAR HEALTH AND ALLIED INS. CO. LTD.

Partial repudiation of health insurance claim

Complainant was covered under the health policy of the respondent Insurer since 2010. He had an Abcess on his Right Leg (Thigh) and under one treatment in the hospital on 21.11.2016. He raised claim for Rs.12500/- from the Insurance company for the reimbursement, but the company settled the claim for Rs.9308/-, partially by deducting Rs.7338/- from two bills pertaining to MRI and CT Scan. He approached the Grievance cell of the company, but they have not given any satisfactory reply. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : pay Rs.3,200/-.

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Award No. IO/KOC/A/GI/0030/2017-2018

Complaint No. KOC-G-044-1718-0105

Award passed on : 16.06.2017

Mr. Tenju George Vs STAR HEALTH AND ALLIED INS. CO. LTD.

Partial repudiation of individual mediclaim

The Complainant's wife was covered under a Medi-claim policy of the respondent Insurer. She was hospitalized on 27.07.2016 for the treatment of her right side chest pain and undergone surgery procedure of Diaphral repair and Hysterectomy. A claim for reimbursement of Rs. 3,21,158/- towards hospitalization expenses was preferred with the Insurer, which has been settled partially for Rs.2,51,630/-(248880+2750). The Insurance company has to settle the balance amount since the sum insured under the policy was Rs.3,75,000/-. She appealed to the Grievance Cell of the Insurer for settlement of the claim, for which no satisfactory reply has been received. Hence, she filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : pay Rs.10,065/-.

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Award No. IO/KOC/A/GI/0040/2017-2018

Complaint No. KOC-G-048-1718-0103

Award passed on : 16.06.2017

Mr. Jacob Varkey Vs The National Insurance Co. Ltd.

Partial repudiation of individual mediclaim

Complainant was covered under the health policy of the respondent Insurer for the last 17 years with the full coverage of Medical Insurance of Rs.1 Lakh, Critical-Sum Insured of Rs.2 Lakh and No Claim Bonus of Rs.15,000/-. He was admitted in the hospital on 02.12.2016 with Critical condition of severe heart attack having breathing difficulty, vomiting and in an unconscious state. He underwent Angioplasty using Imported Stents. After discharge on 13.12.2016, he raised a claim under the policy for the reimbursement of hospital bill of Rs.2,99,967/- where as the Insurance company had reimbursed Rs.56,876/- only which work out only 19 % of the eligible claim. He approached the Grievance cell of the company, but they have not given any satisfactory reply. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the balance amount of the eligible claim.

Decision : dismissed.

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Award No. IO/KOC/A/GI/0049/2017-2018

Complaint No. KOC-G-051-1718-0124

Award passed on : 16.06.2017

Mr. C R Binoy Vs The United India Insurance Co. Ltd.

Partial repudiation of individual mediclaim

The complainant's wife was covered under a Medi-claim policy of the respondent insurer. She was hospitalized and undergone Laparoscopic Hysterectomy due to presence of Multiple Fibroid. Out of total claim of Rs.1,61,000/-, the Insurer has admitted the claim only for Rs.50,000/-. On appeal to the Insurer, he was informed that "as per policy condition the amount payable for Hysterectomy is restricted to actual expenses incurred or 25% of Sum Insured whichever is less. 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 : dismissed.

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Award No. IO/KOC/A/GI/0056/2017-2018

Complaint No. KOC-G-051-1718-0040

Award passed on : 16.06.2017

Mr. S Jahangeer Vs The United India Insurance Co. Ltd.

Partial repudiation of individual mediclaim

Complainant's wife was covered under a health policy of the respondent Insurer. She was admitted in KIMS Hospital on 27th October 2016 and discharged on 2nd November 2016 after undergoing Hysterectomy and surgery for hernia. The total expense incurred to this effect was Rs.1,65,426/- where as an amount of Rs.1,15,000/- was allowed by the Insurance company. On enquiry, the CPIO states that "it is found that as Smt. Shyla had undergone Hernia & Hysterectomy which were done simultaneously, the theatre and anaesthesia charges can't be paid separate. The other tariff rates agreed with hospital is enclosed for our reference which is self explanatory". In the tariff details it was mentioned that "the two procedures undergone simultaneously. One procedure Hernia approved in full Executive Suite AC Charges Rs.65000/-. Second procedure Hysterectomy paid half of Rs.100000/-, Rs.50000/-. Since both procedures are undergone simultaneously, the theatre and anaesthesia charges can't be paid separate. Kindly advice". The hospital had levied two anaesthesia charges as per the item no.12&13 of Bill. The subject matter was taken up with the hospital authorities for clarification. According to verbal clarification given by them, the surgeries were carried out by two separate departments and anaesthetists were engaged independently by each department. Hence one theatre charge and two Anaesthetist charges were levied. Even, if the claim was restricted to one Anaesthetist charge, he should have been paid Rs, 157215/- (Rs.165426-8300). But he was paid only Rs,115000/-. Further, there is no justification for restricting the charge of Hysterectomy by 50%. Further, the policy Enclosure 1 reads as "the restrictions imposed under clause 1.2.1 is not applicable for the CAN MEDICLAIM policy". In other words, he must have been paid the actual expenses incurred of Rs.165426/-The decision of the Insurance Company is not in conformity with the terms and conditions of the policy and action of the Insurance company is in breach of IRDA regulations. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim and compensation there on.

Decision : dismissed.

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Award No. IO/KOC/A/GI/0058/2017-2018

Complaint No. KOC-G-048-1718-0122

Award passed on : 16.06.2017

Ms. Beena Anil Tharakan Vs The National Insurance Co. Ltd.

Partial repudiation of individual mediclaim

The complainant was covered under a Medi-claim policy of the respondent insurer. She was hospitalized and undergone Angioplasty due to Unstable Block. Out of total claim of Rs.1,71,000/-, she is eligible for Rs.1,27,000/- However, the Insurer has admitted the claim only for Rs.60,110/-. She is eligible for the balance amount Rs.66890/-. Since, she was not a diabetic patient prior to present hopsitalization she made an appeal to the Insurance company along with a treating doctor's certificate confirming the same. Being not satisfied with the reply, she filed a complaint before this Forum, seeking direction to the Insurer for admission of balance amount of the claim.

Decision : consider SA plus cumulative bonus and release payment.

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Award No. IO/KOC/A/GI/0063/2017-2018

Complaint No. KOC-G-050-1718-0113

Award passed on : 16.06.2017

Mr. T J Joshy Vs The Oriental Insurance Co. Ltd.

Partial repudiation of individual mediclaim

The complainant had a valid Health policy with the respondent Insurer (No 440205/48/2016/4458). He was admitted in the hospital on 10th May 2016 with the complaint of lesion over left lateral border of tongue. After discharge from hospital, claim for reimbursement of Rs. 232000/- was preferred with the Insurer which was partially settled for Rs. 100000/- and the Insurer refuses to settle the balance amount stating that the ailment was pre-existing. Actually, the present ailment was not pre-existing and therefore, the partial denial is unjust and the reason given by the Insurer is unacceptable. Hence this complaint seeking immediate settlement of balance claim amount.

Decision : reword the claim and release eligible amount.

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Award No. IO/KOC/A/GI/0009/2017-2018

Complaint No. KOC-G-050-1718-0006

Award passed on : 20.04.2017

Mrs. Cicily Joseph Vs The Oriental Insurance Co. Ltd.

Partial Repudiation of claim under Mediclaim policy

The complainant had a valid Mediclaim with the respondent Insurer(No 441503/18/2016/1246). A claim for of Rs124815/- was preferred with the Insurer with regard to hospitalization of her Husband Sri. Joseph P.T. for treatment of Hypothyroidism/CAD from 10/11/2016 to 12/11/2016 at Trichur Heart Hospital. The Insurer has partially settled the claim for Rs.50,000/- . The Insurer had forced the complainant to increase the Sum Insured to Rs.1lakh stating that it was the minimum and hence increased premium was paid. Partial settlement to the extent of Rs50,000/- is unjust. Appeal made to insurer was rejected. Hence this complaint seeking immediate settlement of claim amount .

Decision : dismissed.

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Award No. IO/KOC/A/GI/0001/2017-2018

Complaint No. KOC-G-044-1718-0009

Award passed on : 20.04.2017

Mrs. B. Girija Vs Star Health and Allied Insurance Co. Ltd.

Repudiation of claim under a health policy

Complainant is covered under a health policy of the respondent Insurer. She was terribly sick in Baroda and came by flight to Chennai to meet the correct doctor. As per the treating doctor's advice, she was immediately admitted in the hospital for Investigation and there on treatment as Inpatient. She preferred a claim from the respondent Insurer which was denied by stating that there was no active line of treatment and admission was primarily for investigation and evaluation purpose. The treatment taken is as per the advice of the doctor to treat the illness. 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 : to pay eligible claim.

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Award No. IO/KOC/A/GI/0002/2017-2018

Complaint No. KOC-G-044-1718-0012

Award passed on : 20.04.2017

Dr. Reghunandanan V Vs Star Health and Allied Insurance Co. Ltd.

Repudiation of claim under a health policy

The complainant had a valid Health policy(senior citizens red carpet) with the respondent Insurer(No P/181211/01/2017/003581). A claim was preferred with the Insurer with regard to hospitalization (Ayurvedic treatment) of the complainant for treatment of VathaVyadhi from 18.01.2017 to 24.01.2017 at Kottakal Arya Vaidya Sala, Kochi. Claim was denied stating as per Exclusion Clause 19 of the Policy , claims are not payable for Non Allopathic treatment. Complainant submits that most other mediclaim policies pay for ayurvedic treatment and hence her claim also may be allowed.

Decision : dismissed.

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Award No. IO/KOC/A/GI/0066/2017-2018

Complaint No. KOC-G-044-1718-0005

Award passed on : 16.06.2017

Dr. K. Jayaprakash Vs Star Health and Allied Insurance Co. Ltd.

Repudiation of claim under a health policy

The complainant had a valid Health policy with the respondent Insurer (No. P/181113/01/2017/000657). After discharge from hospital, claim for reimbursement (of Rs75870/-)was preferred with the Insurer with regard to hospitalization of the complainant for treatment of Cholelithiasis, Hypertension, Diabetes Mellitus, Dyslipedimia from 11.12.2016 to 13.12.2016 at Aster Medicity, Kochi as Cashless claim preferred was denied without attributing any cogent reason. The claim was denied stating that treatment of ailments of Gall Bladder had an exclusion of two years from policy inception (the policy was in the second year). The denial is unjust as the operation was a life saving one (certificate from doctor that clinical situation warranted urgent surgical intervention) and the two year exclusion clause cannot be applied in this case. Hence this complaint seeking immediate settlement of claim amount.

Decision : dismissed.

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Award No. IO/KOC/A/GI/0003/2017-2018

Complaint No. KOC-G-049-1718-0007

Award passed on : 20.04.2017

Mr. Subeesh K.U Vs The New India Assurance Co. Ltd.

Repudiation of claim under a mediclaim policy

The complainant had a valid Mediclaim policy with the respondent Insurer(No 76030434152800000086). A claim was preferred with the Insurer with regard to hospitalization of the complainants wife for treatment of uncontrolled bleeding at Coop Hospital , Irinjalakuda . The patient has undergone laparoscopic sterilization and D&C on 22.11.2016. A claim preferred with the insurer was repudiated citing reason that the claim was pregnancy related which falls outside the purview of the policy as per provision 4.4.13 of the policy. The grievance cell has considered the appeal made by complainant but reiterated Insurer's decision to repudiate. Hence this complaint seeking immediate settlement of claim amount

Decision : dismissed.

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Award No. IO/KOC/A/GI/0006/2017-2018

Complaint No. KOC-G-051-1718-0002

Award passed on : 20.04.2017

Mr. Varghese V Joseph Vs The United India Insurance Co. Ltd.

Repudiation of claim under a mediclaim policy

The Complainant and his wife are covered under a health policy of the respondent Insurer. His wife was admitted at SNA Ayurveda Nursing Home during June 2016 and claim for Rs.50109/- was submitted for reimbursement. The Insurance Company denied the claim stating that the Ayurvedic treatments are excluded under the policy as per clause 3.3, whereas no such clause is seen in the policy. Therefore, he is eligible for the claim. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : pay eligible claim.

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Award No. IO/KOC/A/GI/0008/2017-2018

Complaint No. KOC-G-051-1718-0011

Award passed on : 20.04.2017

Mr. Varghese Elias Vs The United India Insurance Co. Ltd.

Repudiation of claim under a mediclaim policy

Complainant is covered under the health policy of the respondent Insurer. He has been under treatment for Keratoconus since October 2011 and has been undergone for surgery in December 2011 from Narayana Nethralaya, Bangalore. In, 2016, Implantation of contact lens (IPCL) has been done. Further to the treatment, he was having dual vision and the doctor has recommended to undergo Eye Correction(Squint Surgery) which has started from his eye correction. He preferred a claim for the expenses incurred for the Squint Surgery from the respondent Insurer, which was denied by stating that the Cosmetic Surgery is not covered under the policy. He approached the Grievance cell of the company, but they have reiterated their earlier stand. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : pay eligible claim.

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Award No. IO/KOC/A/GI/0010/2017-2018

Complaint No. KOC-G-048-1718-0021

Award passed on : 20.04.2017

Mr. P.K. Sukumaran Vs The National Insurance Co. Ltd.

Repudiation of claim under a mediclaim policy

Complainant's wife is covered under a health policy of the respondent Insurer. She was hospitalised and preferred a claim from the respondent Insurer which was denied by them stating that there was no active line of treatment. She was admitted in the hospital under ENT Department on 05/12/2016 with history of on and off right ear numbness for 6 months. She had solitary thyroid nodule. Neurosurgery consultation was done for her suboccipital pain. She had undergone CT and MRI as per the treating doctor's advice. CT CVj reported as having mobile AAD with dystopic os odontoideum and dorsal angulation of dens with impingement of cervico medullary junction and bilateral horn cell hyper intensity at this level. The treating doctor advised her to undergo surgery which she could not do immediately due to financial difficulty and requested for the discharge from the hospital fully depending upon usage of Cervical Collar. As per the treating doctor's advice only she has undergone CT, MRI during the course of hospitalisation. Therefore, the reason given by the Insurance Company to reject the claim would not sustain. The decision of the Insurer is unjustifiable. Hence, she filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : to pay hospitalisation charges.

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Award No. IO/KOC/A/GI/0011/2017-2018

Complaint No. KOC-G-048-1718-0014

Award passed on : 20.04.2017

Mr. Abdul Jabbar K.I Vs The National Insurance Co. Ltd.

Repudiation of claim under a mediclaim policy

Complainant was covered under a health policy of the respondent insurer for the last 10 years continuously. On 03.09.2016 he fell unconscious and was taken to hospital and got treated. He preferred a claim for Rs.18647/- from the respondent insurer which was denied by stating that as per policy clause 4.19, the claim was not payable. The decision of the Insurance company is not tenable. He approached the Grievance cell of the company, but they have reiterated their earlier stand. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : to pay hospitalisation charges.

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Award No. IO/KOC/A/GI/0014/2017-2018

Complaint No. KOC-G-051-1718-0018

Award passed on : 20.04.2017

Mrs. Thara Thomas Vs The United India Insurance Co. Ltd.

Repudiation of claim under a mediclaim policy

Complainant is covered under a health policy of the respondent Insurer. She was admitted in the hospital due to an accident and preferred a claim from the respondent Insurer. The Insurer denied the claim stating that there was no active line of treatment during course of hospitalisation. Insurance company has overlooked "LOC stage of patient, IVF, injections, neuro observations, wound dressing" etc. mentioned in the medical records. The decision of the Insurer is unjustifiable. Hence, she filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : pay eligible claim.

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Award No. IO/KOC/A/GI/0015/2017-2018

Complaint No. KOC-G-048-1718-0003

Award passed on : 20.04.2017

Mr. Aby Abraham Vs The National Insurance Co. Ltd.

Repudiation of claim under a mediclaim policy

Complainant's wife is covered under a health policy of the respondent Insurer. She undergone a surgery as per the advice of the treating doctor. He preferred a claim from the respondent Insurer which was denied by stating that the cosmetic surgery is an exclusion under the policy. Actually, the surgery(excision of bilateral axillary accessory breast) she underwent is preventive surgery against cancer which has been authenticated and proved by many medical experts in fields of Gynaecology and Oncology over the years. The Insurance company repudiated the claim referring the Policy Exclusion clause 4.6. However, the same clause provides the expenses that may be necessitated due to illness/ disease/injury in any case is admissible. Only due to recurring illness and constant pain, she was admitted in the hospital and surgery done, which was not at all considered while processing the 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 : admit the claim.

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Award No. IO/KOC/A/GI/0016/2017-2018

Complaint No. KOC-G-049-1718-0004

Award passed on : 20.04.2017

Mr. Jacob Mathew Vs The New India Assurance Co. Ltd.

Repudiation of claim under a mediclaim policy

Complainant's wife is covered under Two Mediclaim policies of National Insurance Company and New India Insurance company. She was diagnosed in the hospital and undergone treatment for Idiopathic Mesenteric Scleritis. The total Hospital Expenses Incurred was Rs.1,78,189/-. The National Insurance Company has paid Rs.82,000/- on the basis of the sum insured of Rs.1,00,000/-, under their Policy. Complainant preferred a claim from New Indai Assuarance company for the balance amount of the claim. New India rejected his claim stating that as per Policy condition 4.3.1(1); during the first 2 years of policy, expenses on treatment of all internal benign tumours, cysts,polyps of any kind, including benign breast lumps, not payable. The treatment his wife undergone was not any of the aforesaid ailment. Therefore, his claim is payable.

Decision : dismissed.

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Award No. IO/KOC/A/GI/0017/2017-2018

Complaint No. KOC-G-051-1718-0016

Award passed on : 20.04.2017

Mr. Umesh C.V Vs The United India Insurance Co. Ltd.

Repudiation of claim under a mediclaim policy

Complainat's wife Mrs. Vidya is covered under the health policy of the respondent Insurer. She was suffering from Thyroid Cancer. She was admitted in the Hospital on 26.03.2016 and discharged on 28.03.2016. after proper treatment. Subsequently, he raised a claim with the Insurance company for the reimbursement of the expenses incurred by her at hospital, but the company rejected the claim for the reason, that Oral Chemotherapy is not payable as per policy terms and conditions and it is not covered under day care procedure also and is covered under Post hospitalization Expenses. His wife was in feeble physical condition and as per the doctor advise only she got admitted. Again on 03.12.2016 she was admitted to hospital for continued treatment and discharged on 05.12.2016. Subsequently again he submitted fresh claim and the Insurer did not respond to the same. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : pay the eligible claim.

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Award No. IO/KOC/A/GI/0018/2017-2018

Complaint No. KOC-G-050-1718-0019

Award passed on : 20.04.2017

Mr. George Alookaran Vs The Oriental Insurance Co. Ltd.

Repudiation of claim under a mediclaim policy

Complainant is covered under the health policy of the respondent Insurer. He was admitted in the Amala Hospital on 12th May 2016 and discharged on 14th May 2016 for the treatment of Dysponea on exertion. He was admitted for Coronary Angiogram. During the course of hospitalisation CAD/ SVD was detected. PTCA with DES to LAD done on 12/05/2016. He preferred a claim for the reimbursement from the respondent Insurer, since the Cashless facility was denied. The Insurance company has not taken any decision in this regard. He has given clarification to the company that earlier on 11/3/2016 he had undergone TMT and Ultrasound test from Co-op Hospital, Irinjalakuda and the reports were negative. The present Dischrge summary also indicate that earlier TMT was Negative. Even after the lapse of 9 months, the insurance company has neither settled the claim nor repudiated the same. He approached the Grievance cell of the company as per the advice of the office of Insurance Ombudsman. On 30.11.2016, but the Grievance Cell of the Insurer replied him that " the matter is being attended by taking up with our concerned office and you will be hearing from us shortly". But, till date no decision has been taken by the Insurance Company. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim and to compensate for his mental agony.

Decision : pay eligible amount.

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Award No. IO/KOC/A/GI/0026/2017-2018

Complaint No. KOC-G-031-1718-0110

Award passed on : 15.06.2017

Mr. Salim M Vs MAX BUPA HEALTH INSURANCE CO.LTD

Repudiation of health insurance claim

The Complainant and his family were covered under a Medi-claim policy of the respondent Insurer since in the year 2015. His wife was admitted at Medical College Hospital Trivandrum for the Cardiac related issues. A claim for reimbursement of expenses of Rs.1,69,271/- towards hospitalization preferred with the TPA/Insurer has been rejected stating the reason that, Insured had diabetes which was not disclosed at the time of inception of policy. Actually, he had disclosed all the medical history of his family members including the Diabetic history of his wife to the then relationship manager. Moreover, the present claim was submitted with regard to Cardiac issue which is not at all related to diabetic. He appealed to the Insurer for settlement 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 : pay Rs.1,69,271.00.

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Award No. IO/KOC/A/GI/0027/2017-2018

Complaint No. KOC-G-044-1718-0085

Award passed on : 16.06.2017

Mr. Antony K.T Vs STAR HEALTH AND ALLIED INS. CO. LTD.

Repudiation of health insurance claim

Complainant and his family were covered under the health policy of the respondent Insurer since June 2012. His wife was admitted in the hospital for the tyreatment of her ailment. He raised a first ever claim under the policy for the reimbursement which was not settled till date. Further the Insurance company has Cancelled the Policy cover of his wife and refunded a premium of Rs.2627/-.He approached the Grievance cell of the company, but they have not given any satisfactory reply. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : dismissed.

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Award No. IO/KOC/A/GI/0028/2017-2018

Complaint No. KOC-G-044-1718-0030

Award passed on : 16.06.2017

Mr. T.D. James Vs Star Health and Allied Insurance Co. Ltd.

Repudiation of health insurance claim

Complainant was covered under a health policy of the respondent Insurer since 13.05.2015. He was admitted in the Hospital on 13.11.2016 for the treatment of illness related to liver. Subsequently, he raised a claim with the Insurance company for the reimbursement of the expenses incurred by him at hospital, but the company rejected the claim for the reason that the disease treated was pre-existing one. He was never hospitalised or had taken treatment in the last 20years. During 1996, he was hospitalised for a week in the hospital for treating Hepatitis-B, which was completely cured and never hospitalised before or after that. So, the reasons raised to repudiate the claim are totally wrong and unjustifiable. He approached the Grievance cell of the company, but they have reiterated their earlier stand. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : dismissed.

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Award No. IO/KOC/A/GI/0036/2017-2018

Complaint No. KOC-G-050-1718-0032

Award passed on : 16.06.2017

Mr. Niju John Vs The Oriental Insurance Co. Ltd.

Repudiation of health insurance claim

Complainant's father was covered under a health policy of the respondent Insurer. He was admitted at Divakaran Vaidyar Memorial Ayurvedic Research Centre on 08.08.2016 for the treatment of back bone. Subsequently, he raised a claim with the Insurance Company for the reimbursement of the expenses incurred by him at hospital, but the company rejected the claim on flimsy grounds. He approached the Grievance cell of the company, but they have not given satisfactory reply. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : dismissed.

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Award No. IO/KOC/A/GI/0044/2017-2018

Complaint No. KOC-G-048-1718-0039

Award passed on : 16.06.2017

Mr. John George Vs The National Insurance Co. Ltd.

Repudiation of health insurance claim

Complainant was covered under a health policy of the respondent Insurer. He was admitted in the hospital on 28.04.2016, due to severe pain in lower abdomen, and was diagnosed with Carcinoma in colon. He had submitted 2 claims which were not settled by the Insurance Company. The Insurance Company had also failed to renew his policy in spite of remitting the premium promptly. He approached Hon'ble Ombudsman against non-renewal of policy 2016-17 and against the repudiation of claims. The Hon'ble Ombudsman vide award dated 25.08.2016 in complaint no.KOC-G-048-1617-0229 declared that 'even though the necessary premium has been paid, Insurance company has not issued policy and settled his pending claim. The Insurance company has to settle his claim immediately. The present position is that since he recurrently undergoes medical treatment for his disease, he is issued with medical bills by the hospital. The Medical Bills for the amounts of Rs.1,64,476.64 dt. 29.06.2016, Rs.1,91,412.70 dt. 14.07.2016, Rs. 1,53,603.00 dt. 21.07.2016, Rs.1,63,602.29 dt. 08.08.2016 are pending for settlement. He approached the Grievance cell of the company, but they have not responded. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : settle claim and grant insurance without break.

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Award No. IO/KOC/A/GI/0059/2017-2018

Complaint No. KOC-G-049-1718-0035

Award passed on : 16.06.2017

Mr. N Damodaran Nair Vs The New India Assurance Co. Ltd.

Repudiation of health insurance claim

The Complainant is covered under a Medi-claim policy of the respondent Insurer. He was admitted at Chaithanya Eye Hospital on 30.03.2016 and underwent Intravitreal Pharmacotherapy – Ozurdex (Dexamethasone Injection). A claim for reimbursement of expenses towards the treatment preferred with the TPA/Insurer has been rejected quoting policy clause 2.11. Earlier, similar 3 claims had been reimbursed by the Insurance company. Further, the Honourable Insurance Ombudsman also had directed the Insurer on 17.04.2012, to settle a similar claim filed by Sri. V.V.Giri, (former information commissioner). The argument by the Insurance Company in the present case is also contradictory since they find Cataract operation eligible for reimbursement which is absolutely age related. He appealed to the Insurer for settlement 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 : admit the claim.

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Award No. IO/KOC/A/GI/0065/2017-2018

Complaint No. KOC-G-044-1718-0089

Award passed on : 16.06.2017

Mr. Subhash K Ouseph Vs STAR HEALTH AND ALLIED INS. CO. LTD.

Repudiation of health insurance claim

Complainant and his family were covered under the health policy of the respondent Insurer for the last 5 years. His son was admitted in the hospital and underwent Surgical Reduction Mamoplasty to correct the abnormality. He raised a first ever claim under the policy for the reimbursement which was denied stating that the treatment undergone was Cosmetic, which is an exclusion under the policy. He approached the Grievance cell of the company, but they have not given any satisfactory reply. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : pay eligible claim.

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Award No. IO/KOC/A/GI/0067/2017-2018

Complaint No. KOC-G-044-1718-0042

Award passed on : 16.06.2017

Mr. Ajin C S Vs Star Health and Allied Insurance Co. Ltd.

Repudiation of health insurance claim

The complainant had a valid Health policy (senior citizens red carpet) with the respondent Insurer (No P/181100/01/2017/006169) with effect from10.10.2012. A claim was preferred with the Insurer with regard to hospitalization of the complainant's mother for treatment of Thyroid CA? From – 13.10.2016 to 18.10.2016 at KIMS Hospital, Trivandrum. Cashless claim preferred was denied without attributing any cogent reason despite repeated appeals. On the advice of the Insurer, the claim of Rs. 63915/-was preferred on reimbursement basis. No reply was received from the Insurer and on a personal visit to the insurer, it was found that the policy was cancelled and claim repudiated due to non disclosure of material facts. The claim repudiation as informed by the insurer was made as the insured had H/o Thyroid CA since 2012 which was not disclosed when the policy incepted in 10/2012. The complainant avers that he has seen a stall of the insurer in the hospital during his mothers surgery in 2012 and was persuaded to take a policy. The forms were filled up with the help of the sales manager and all the pertinent facts were disclosed to the manager while filling up the form. The action of the Insurer in repudiating the claim is unjust especially after collecting premiums for five years. Hence this complaint seeking immediate settlement of claim amount.

Decision : dismissed.

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Award No. IO/KOC/A/GI/0074/2017-2018

Complaint No. KOC-G-044-1718-0114

Award passed on : 19.06.2017

Mr. Asif Rahiman Vs STAR HEALTH AND ALLIED INS. CO. LTD.

Repudiation of health insurance claim

The complainant/insured, Mr. Abdurahiman had a valid Health policy with the respondent Insurer (P/181321/01/2017/001022). He was admitted in the hospital and undergone Angioplasty. A claim for reimbursement of expenses towards hospitalization preferred with the TPA/Insurer has been rejected stating the reason that the Insured had Kidney ailment which was not disclosed at the time of inception of policy. Actually, the complainant was not diagnosed with any Kidney Disease at the time of taking the policy for the first time and he did not undergo any treatment for the same. Earlier, the Insurance Company had approved Angioplasty for cashless claim, but the doctor postponed the surgery due to suspected complication to carry out the angioplasty on him at that stage. As per the suggestion from the treating doctor he consulted nephrologists in the same hospital. The complainant understands that the grounds of the insurer's denial were the consulting notes of the nephrologists who had made an assumption that the patient might have kidney disease in the past. But, it was just an assumption from the doctor and there was no substantial Medical documentation or evidence to support this statement. He was not aware of any such disease in the past or was not diagnosed with any such disease during the time of taking the policy for the first time. Hence, he was not in a position to disclose a disease which he is not aware of or which was not diagnosed previously or at the time of first taking the policy. Therefore, there was no ground to deny the claim. Hence, this complaint, seeking direction to the insurer for immediate settlement of claim.

Decision : admit claim and settle eligible amount.

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Award No. IO/KOC/A/GI/0042/2017-2018

Complaint No. KOC-G-048-1718-0090

Award passed on : 16.06.2017

Ms. Vinitha K G Vs The National Insurance Co. Ltd.

Repudiation of Individual Mediclaim

The complainant was covered under a Medi-claim policy of the respondent insurer for the first time on16.02.2016 with Sum Insured of Rs.5,00,000/-. She was admitted in the hospital for the period from 19.01.2017 to 28.01.2017 and 01.02.2017 to 16.02.2017 for the treatment of her ailment due to mass lesion in the lower LS spine L5-S1 with thecal sac compression. During admission she underwent L4 L5 Laminectomy and tumour excision etc. She was readmitted on 01.02.2017 for surgical site infection and underwent secondary suturing under GA. She preferred 2 claims in respect of aforesaid treatment from the Insurer which were denied stating that the treatment taken was for Pre-existing Disease. Actually, by the first week of June 2016 she started suffering from constipation and back ache. In the moth of August 2016 she also started suffering from urinary retention. Due to the aforesaid problem, in the month of December 2016, she underwent treatment in an Ayurvedic hospital. Since there was no relief she started taking treatment from Urologist, Ortho and finally Neurologist (spine). MRI was done on 04.01.2017 which indicated the reason for the present ailment. Till such time she was not aware of any disease and the treating doctor had certified and substantiated the same. However, the Insurance Company reiterated their earlier stand and the claims were not settled. She made appeal to the Grievance Cell of the Insurer, but no satisfactory reply has been received. Hence, she filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : pay the claim.

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Award No. IO/KOC/A/GI/0043/2017-2018

Complaint No. KOC-G-048-1718-0100

Award passed on : 16.06.2017

Mr. Arun A Vs The National Insurance Co. Ltd.

Repudiation of Individual Mediclaim

Complainant was covered under the health policy of the respondent Insurer. He was admitted in the hospital on 28.02.2017 due to severe illness. He raised a claim under the policy for the Cashless which was denied stating that pre-existing disease are not covered. The TPA had denied Cashless overlooking the fact that the Inception policy from 2012. According to TPA, the Policy commencement was since 2013 which was wrong. Later, on 24th April 2017, the TPA reimbursed the claim. He had to borrow the money for making payment at the hospital, in spite of his eligibility for Cashless claim facility. He had to face harassment and bear with highly disturbing and distressing experience from the TPA for which Insurance Company is liable. Hence, the Insurance Company has to compensate him by paying 13 % interest on the claim amount which he was forced to borrow to remit the same to hospital. Hence, he filed a complaint before this Forum, seeking direction to Insurance company to pay 13 % interest and such other compensation.

Decision : dismissed.

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Award No. IO/KOC/A/GI/0050/2017-2018

Complaint No. KOC-G-051-1718-0081

Award passed on : 16.06.2017

Mr. Vasudevan P Vs The United India Insurance Co. Ltd.

Repudiation of Individual Mediclaim

Complainant and his family were covered under the health policy of the respondent Insurer for a Sum Insured of Rs.4 Lakh (Rs. 2 Lakh each for complainant and his spouse). His wife was under treatment from the Regional Cancer Centre, Trivandrum for Occult Primary- Breast Carcinoma, resulting in malignant blockade in the right auxiliary lymph node. After a course of Chemo Therapy followed by surgery & radiation, she was on prolonged hormone therapy based on biopsy results. Recently, based on a pet scan and CT scan made for assessment, the treating Doctor has introduced an injection FULVENAT 5oomg. In the ongoing treatment, from Dec'16, she was given the injections on 24/12 /16, 7/1/17, 21/1 /17 & 18/2/17 and to be continued for next few months. These injections are given at the RCC Hospital itself and though, as per the pre fixed schedule, each time after specific, pre appointed review check up of the doctor & the medicines released from the hospital pharmacy against prescriptions made after each check up, the injection is given by the hospital nurse only against specific authorization by the doctor after the review examination. Therefore it should be considered as a part of the hospitalization expenditure. The claims in respect of theses scans, lab charges and the injections are denied by the TPA treating them as domiciliary treatment despite the above explanation. He was unaware of the policy terms and conditions. However it was his understanding that in the case of Carcinoma treatment, chemo therapy, radiation etc are to be treated & approved as a part of the hospitalization. And the injection FULVENAT might be treated as hospitalization treatment just like chemotherapy, as it was done in the hospital. Since, the domiciliary treatment benefit had been exhausted; the aforesaid injection is to be considered as of chemotherapeutic value and to be settled under hospitalisation limit. Therefore, under the previous policy and present policy after deducting the domiciliary treatment claim he would be eligible for additional limit

of Rs.1,22,000/- and Rs.1,60,000/- respectively. He approached the Grievance cell of the company to consider the aforesaid injection under hospitalisation benefit just like Chemotherapy, but in vain. Hence, he filed a complaint before this Forum, seeking direction to the Insurer to admit claim under hospitalisation.

Decision : dismissed.

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Award No. IO/KOC/A/GI/0020/2017-2018

Complaint No. KOC-G-005-1718-0068

Award passed on : 15.06.2017

Mr. Peter P Kuriakose Vs Bajaj Allianz General Insc Co. Ltd.,

Repudiation of Medi Claim

Complainant was covered under Health insurance of the respondent Insurer with effect from 27.04.2016. He was admitted in the hospital on 25/07/2016 with diagnosis of CAD with Active Inferior Wall Infraction and treated for the same. The Insurance Company repudiated the claim stating that the CAD is a complication of Hypertension, DM, Dyslipidemia which was pre-existing prior to proposing for Insurance. Actually he was not having any previous history of CAD and a certificate in this regard was submitted to the Insurer. Complainant approached the Grievance cell of the company, but they have not given satisfactory reply. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : dismissed.

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Award No. IO/KOC/A/GI/0023/2017-2018

Complaint No. KOC-G-018-1718-0071

Award passed on : 15.06.2017

Mr. Manoj sunny Vs HDFC ERGO General Insurance Company Ltd.

Repudiation of Medi Claim

Complainant was covered under Health insurance of the respondent Insurer with effect from 10.06.2013. He had health Insurance for the last 8 years- earlier with New India Insurance Company. He was admitted in the hospital on 05/12/2016 for the treatment Osteoarthritis of knee, cervical intra-vertebral Disc prolapsed with Radiculopathy. The Insurance Company repudiated the claim stating that he is a known case of Asthma before the inception of the policy and he was having history of Asthma since Childhood and he had not disclosed the ailment while purchasing the policy and there was non-disclosure of material fact. Actually, he came to know from his parents that he had Asthma when he was 3-4 years old and he had mentioned it to the treating doctor during his present treatment. He was not under treatment or any sort of medication for Asthma. He had sent a letter from the doctor in this regard. It was impossible to get a first consultation certificate for something that happened 46 years back. It is not reasonable to expect by the insurance company from a proposer/Insured, to explain all his childhood illness while proposing for Insurance at the age of 46. The treating doctor has given clarification that he had Asthma only in childhood and never had relapse or exacerbations thereafter. While repudiating the Claim the Insurance Company added one word very conveniently – "since" – when they made a statement that "there is a history of Asthma since childhood"- it is a manipulated statement just to reject the claim. Complainant approached the Grievance cell of the company, but they have not given satisfactory reply. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : pay Rs.72,446.00.

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Award No. IO/KOC/A/GI/0025/2017-2018

Complaint No. KOC-G-018-1718-0056

Award passed on : 15.06.2017

Ms. Maya Varghese Vs HDFC ERGO General Insurance Company Ltd.

Repudiation of Medi Claim

Complainant's husband was covered under Health insurance of the respondent Insurer with effect from 06.12.2016. He was admitted in the hospital on 20/02/2017 with diagnosis of Transient Ischemic Attack, Hypertension and treated for the same. The Insurance Company repudiated the claim stating that the Hypertension was pre-existing for 3 months prior to proposing for Insurance on06/12/2016. Actually he was not having any ailment other than a dislocation of his right hand due to an accident happened in 2016. He was covered under the health policy for the Last 16 years. Even though, last year he had Medical Coverage of SBI, no claim has been made under the policy. HDFC ERGO representatives forced to change the policy from SBI to HDFC ERGO and now they are repudiating the claim without any valid reasons. Complainant approached the Grievance cell of the company, but they have not given satisfactory reply. Hence, she filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : dismissed.

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Award No. IO/KOC/A/GI/0031/2017-2018

Complaint No. KOC-G-012-1718-0098

Award passed on : 16.06.2017

Ms. Valsala V Nair Vs Cholamandalam MS Gen. Insu.Co. Ltd

Repudiation of Medi Claim

Complainant was covered under the health policy of the respondent Insurer. She was admitted in the hospital on 06.08.2016 with severe cough and fever and associated infection and discharged on 11.08.2016. She raised a claim under the policy for the reimbursement, which was denied. He approached the Grievance cell of the company, but they have not given any satisfactory reply. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : dismissed.

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Award No. IO/KOC/A/GI/0032/2017-2018

Complaint No. KOC-G-020-1718-0117

Award passed on : 16.06.2017

Mr. R Sreenivasan Vs ICICI LOMBARD GENERAL INSURANCE CO.LTD.

Repudiation of Medi Claim

The complainant had a valid Health policy with the respondent Insurer No 4128i/Ihpr/103670688/01/000). He was admitted in the Medical College hospital on 19th November 2016 as he slipped from the staircase and fell down, causing external injury to the head. After stich and sechwar was administered to curtail the bleeding and was discharged and advised to take rest. On 20th he was having internal pain and was referred to Amritha Institute of Medical Science for further treatment at Nuero Surgery Department from 20.11.2016 to 05.01.2017. Thereafter he was admitted at Physiotherapy Department till 09.01.2017. A claim for reimbursement of Rs. 6,93,050/- was preferred with the Insurer which was denied stating the Non-disclosure of pre-existing ailment and citing permanent exclusion clause pertaining to alcohol consumption.. Actually, the present ailment was not pre-existing and therefore, the denial is unjust and the reason given by the Insurer is unacceptable. Hence this complaint seeking immediate settlement of balance claim amount.

Decision : dismissed.

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Award No. IO/KOC/A/GI/0033/2017-2018

Complaint No. KOC-G-049-1718-0031

Award passed on : 16.06.2017

Mr. Mahesh Kumar Mintri Vs The New India Assurance Co. Ltd.

Repudiation of Medi Claim

Complainant was covered under a health policy of the respondent Insurer. He was admitted in the hospital due to sleepiness and head ache since 1 month. He had history of Cardiomyopathy since last 1 ½ years. He raised a claim with the Insurance Company for the reimbursement of the expenses incurred by him at hospital, but the company rejected the claim quoting the clause 4.4.11 and 4.4.15 of the policy. He approached the Grievance cell of the company, but they have not given reply. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : dismissed.

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Award No. IO/KOC/A/GI/0037/2017-2018

Complaint No. KOC-G-050-1718-0119

Award passed on : 16.06.2017

Mr. George Elias Vs The Oriental Insurance Co. Ltd.

Repudiation of Medi Claim

The complainant had a valid Health policy with the respondent Insurer (No 441800/48/2017/458). He was admitted in the hospital on 05/11/2016 for Cataract Surgery. He preferred a claim from the respondent Insurer which was denied stating the reason that the policy was not issued on Portability terms and hence two year exclusion clause would be applicable. Actually, he had continuous health Insurance coverage for over a decade. He had opted for porting the policy and submitted the proposal well in time (i.e. before 45 days of the expiry of the policy) along with the previous policies for 4 years to OIC in may 2015. Later, he was asked to remit the premium in the third week of June 2015 and the first policy was issued from 20.06.2015. He was not informed at that time that the continuity benefit under portability was not given to him. By doing so, he was denied the opportunity to renew the policy with his previous Insurer with continuous coverage. The Insurance company had asked the proof of previous Insurance policies along with Mediclaim proposal with the intention to provide portability. Even if the claim dates are not obtained from the previous Insurer within the stipulated time, the parting insurance company is permitted to issue policy with portability benefits. From the aforesaid facts, it is clear that the Insurance Company issued the policy with the intention of portability benefits and denying the claim now is against natural justice. Hence, this complaint seeking immediate settlement of the claim.

Decision : dismissed.

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Award No. IO/KOC/A/GI/0038/2017-2018

Complaint No. KOC-G-050-1718-0109

Award passed on : 16.06.2017

Mr. VARGHESE C.A Vs The Oriental Insurance Co. Ltd.

Repudiation of Medi Claim

The Complainant is covered under a Medi-claim policy of the respondent Insurer. He was admitted at St. James Hospital (Ayurveda) subsequently at Aiswarya Hospital for the treatment of Lumbar Spondylosis & Sciatica during the period 13th to 29th June 2016. A claim for reimbursement of expenses towards hospitalization preferred with the TPA/Insurer has been rejected. He appealed to the Insurer for settlement 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 : dismissed.

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Award No. IO/KOC/A/GI/0039/2017-2018

Complaint No. KOC-G-050-1718-0076

Award passed on : 16.06.2017

Mr. Sivaraman P Vs The Oriental Insurance Co. Ltd.

Repudiation of Medi Claim

Complainant was covered under the health policy of the respondent Insurer from. He was admitted in the hospital and undergone Cataract surgery for his both eyes. He raised a claim for Rs.57435/- with the Insurance company for the reimbursement, but the company rejected the claim citing Policy Clause 4.2 (vii). He could not find out any such clause in the policy. Further, he came to know in respect of one Sri. Radhakrishnan P.P, who availed the policy subsequent to him (in August 2015) got his claim fully settled towards the Cataract surgery he underwent on 29.09.2016. Both of them were holding the policy with same scope of cover under same terms and conditions of the policy. He approached the Grievance cell of the company, but they have not given satisfactory reply. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : dismissed.

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Award No. IO/KOC/A/GI/0052/2017-2018

Complaint No. KOC-G-051-1718-0065

Award passed on : 16.06.2017

Mr. Johny P J Vs The United India Insurance Co. Ltd.

Repudiation of Medi Claim

Complainant was covered under the health policy of the respondent Insurer in the year 2015 (present Policy No.100901/28/15P1/15725911) for a Sum Insured of Rs.1 Lakh. He was admitted in the hospital during the period from 05.02.2017 to 17.02.2017and undergone treatment for 'sub-epidermal bullous disorder', 'linear IGA dermatitis' at Amala Cancer hospital for the first time. He raised a claim with the Insurance Company for the reimbursement, but the company rejected the claim stating that ailment was pre-existing at the time of proposal and as per Policy Exclusion, the claim is not payable. Earlier, he had suffered from Coronary Artery Disease during the period from 23/5/2015 to 01/6/2015, which was not settled initially by the Insurance company and the Hon'ble Insurance Ombudsman found that CAD was not pre-existing and had allowed the claim vide Award No. IO/KOC/A/GI/0484/2015-16. Actually, the present ailment was not pre-existing and he approached the Grievance cell of the company, but they have not given satisfactory reply. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : pay Rs.12,690.00.

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Award No. IO/KOC/A/GI/0054/2017-2018

Complaint No. KOC-G-051-1718-0048

Award passed on : 16.06.2017

Mr. Anil M George Vs The United India Insurance Co. Ltd.

Repudiation of Medi Claim

Complainant's Child Joel George(15) was covered under the health policy of the respondent Insurer. The Child had undergone the treatment of 'intermittent Exotropia'. The Insurance Company denied the claim stating that the treatment was for corrections of Squint eye which was cosmetic in nature and was excluded from the scope of the policy vide Clause no. 4.6(b). The treating doctor has given clarification that the correction of eye is not cosmetic in nature. 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 : pay eligible claim.

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Award No. IO/KOC/A/GI/0055/2017-2018

Complaint No. KOC-G-051-1718-0069

Award passed on : 16.06.2017

Mr. Nibu Baby Vs The United India Insurance Co. Ltd.

Repudiation of Medi Claim

Complainant and family were covered under a health policy of the respondent Insurer. His mother was admitted in the hospital for treatment of her illness as per the Doctor's advice. He preferred a claim for Rs.25,160.00 from the respondent Insurer which was denied citing Policy clause 4.11 and stating that there was no active line of treatment and admission was primarily for investigation and evaluation purpose. The treatment taken is as per the advice of the doctor to treat the illness. 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 : pay hospital exp other than evaluation charges.

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Award No. IO/KOC/A/GI/0061/2017-2018

Complaint No. KOC-G-049-1718-0097

Award passed on : 16.06.2017

Mr. Vinish V Nair Vs The New India Assurance Co. Ltd.

Repudiation of Medi Claim

Complainant was covered under the health policy of the respondent Insurer. He was admitted in the hospital on 06.01.2017 with severe abdominal pain. The Treatment and Investigations were conducted during the course of hospitalization and incurred expenses of Rs.9535/-. He preferred a claim under the policy for reimbursement, which was denied by the Insurer stating that the claim was not payable as per the policy condition No. 4.4.11. He approached the Grievance cell of the company, but they have not given any satisfactory reply. Hence, he filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : pay hospitalisation charges.

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Award No. IO/KOC/A/GI/0075/2017-2018

Complaint No. KOC-G-050-1718-0094

Award passed on : 26.06.2017

Mrs. Valsamma Thampi Vs The Oriental Insurance Co. Ltd.

Repudiation of Medi Claim

Complainant and her family were covered under the health policy of the respondent Insurer since 2011 through Punjab National Bank. She was admitted in the hospital in March 2016 due to neck and back pain. She raised a claim under the policy for the reimbursement of Rs.17725/- which was denied stating that the disease was in existence since 3 & 6 years. The treating doctor clearly stated in the discharge summary that the disease exists since last 3 months. Even if the disease was in existence exceeding 3 months, as alleged by the Insurance Company, the claim is payable since the policy was in existence from 2011. Further, she was eligible for continuity even if the policy was not renewed within 30 days of expiry of the previous policy term. She approached the Grievance cell of the company, but they have not given any satisfactory reply. Hence, she filed a complaint before this Forum, seeking direction to the Insurer for admission of the claim.

Decision : dismissed.

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Case No. 049-1617-0664
Vinod Kumar Maskara
Vs
The New India Assurance Co. Ltd.

Award Dated 27/04/2017

Complainant's wife underwent Total knee replacement being diagnosed with Osteoartharitis Left Knee. Claim for Rs.2,10,530.54 , including Pre & Post Hospitalization Expenses , was partially settled for Rs.1,72,596/- while proportionate deductions were made as the patient had availed higher room category in line with Clause 3.1C & Clause 3.1D of the New Mediclaim Policy 2012 . It is opined that such proportionate reduction of liability based on room rent can only be legitimate in case the concerned Hospital follow Graded Tariff Structure. In this case it is not applicable as Belle Vue Clinic , Kolkata had not implemented graded tariff structure . The Complaint was allowed and Respondent directed to pay Rs.22,397/- in respect of Proportionate deductions effected along with unpaid residual Doctor's Fee.

Case No. 049-1617-0683
Anup Kumar Jhunjhunwala
Vs
The New India Assurance Co. Ltd.

Award Dated 27/04/2017

Complainant's son underwent ORIF Left Scaphoid procedure being diagnosed with Fracture Left Scaphoid . Claim for Rs.1,09,636.84 , including Pre & Post Hospitalization Expenses , was partially settled for Rs.57,821/- while proportionate deductions were made as the patient had availed higher room category in line with Clause 3.1C & Clause 3.1D of the New Mediclaim Policy 2012 . It is opined that such proportionate reduction of liability based on room rent can only be legitimate in case the concerned Hospital follow Graded Tariff Structure. In this case it is not applicable as Belle Vue Clinic , Kolkata had not implemented graded tariff structure . The Complaint was allowed and Respondent directed to pay Rs.38,036/- in respect of Proportionate deductions effected along with unpaid residual Doctor's Fee.

Case No. 050-1617-0703
Dulal Kumar Biswas
Vs
The Oriental Insurance Co. Ltd.

Award Dated 27/04/2017

Complainant underwent Total knee replacement being diagnosed with B/L Knee Osteoarthritis. Cashless Sanction for Rs.1,25,000/- was granted while residual Claim , including Pre & Post Hospitalization expenses , was disallowed . Repudiation was effected in line with the Policy T&C limiting the applicable SI to Rs.1,25,000/- as enhanced SI was subject to Exclusion Clause 4.2(xxii) . The ailment had a waiting period of 3 years with the enhancement in the 3rd year of operation. While adjudicating the case , the fact that Complainant was left with only 3 months to complete the mandatory 3 years waiting period and moreover that the Complaint could have waited for further 3 months and thereafter planned the procedure was given due weightage. The Complaint was allowed on Exgratia basis and Respondent directed to pay 50% of the residual Claim of Rs.1,73,053/- less inadmissible expenses.

Case No. 050-1617-0718
Bimal Kumar Basu
Vs
The Oriental Insurance Co. Ltd.

Award Dated 27/04/2017

Complainant was administered Intra Vitreal injection Accentrix 0.05 ml in left eye being diagnosed with OS-CME & DME. The Hospitalization claim for Rs.27,742/- was repudiated vide Clause 4.20 stating that the injection Accentrix could have been administered on OPD basis. It is observed from the Discharge Certificate that it was a case of Cystoid Macular Edema & Diabetic Macular Oedema of Left eye duly treated with Inj. Intravitreal Accentrix under Topical Anaesthesia . It is also opined that the treatment is not an OPD procedure as OT facilities had to be used in order to prevent further infection . The Complaint was allowed and Respondent directed to pay Rs.27,742/- less inadmissible expenses towards full and final settlement of the Claim.

Case No. 049-1617-0732
Nilanjan Chaudhuri
Vs
The New India Assurance Co. Ltd.

Award Dated 27/04/2017

Complainant underwent CABG & RSVG procedure being diagnosed with Severe Triple Vessel Disease with Class-III Angina . Cashless Sanction for Rs.1,00,000/- was granted while residual Claim , including Pre & Post Hospitalization expenses , was disallowed . Repudiation was effected in line with the Policy T&C limiting the applicable SI to Rs.1,00,000/- as enhanced SI was subject to Exclusion Clause 4.1 the patient being a known case of SOB. The said pre-existing ailment had a waiting period of 4 years . While the exclusion clause is applicable , the SI has been inadvertently taken as Rs.1,00,000/- while excluding applicable Cumulative Bonus which has accrued to Rs.41,750/- . The Complaint was allowed and Respondent directed to pay Rs.41,750/- less any inadmissible expenses towards full and final settlement of the Claim.

Case No. 050-1617-0656
Swapan Chakraborty
Vs
The Oriental Insurance Co. Ltd.

Award Dated 18/05/2017

Complainant's wife underwent Laparoscopic Cholecystectomy operation being diagnosed with Cholelithiasis. Hospitalization Claim for Rs.60,445/- including Pre & Post Expenses , was partially settled for Rs.34,254/- after applying PPN limits. Cashless Sanction was not granted as per PPN guidelines. While the Hospital was not enrolled in the PPN category yet the Insurance Company wrongfully settled the reimbursement Claim on PPN basis. It is opined that residual Hospital Claim Amount deducted beyond PPN limits is payable to the Complainant . The Complaint was allowed and Respondent directed to pay Rs.21,564/- towards full and final settlement of the Claim.

Case No. 053-1617-0661
Nirmal Bera
Vs
Cigna TTK Health Insurance Co. Ltd

Award Dated 18/05/2017

Complainant was mis-sold a Health Insurance Policy by the agents of M/s AB Insurance Brokers Pvt. Ltd. while promising refund of whole premium amount of his previous Exide Life Insurance Policies. Complainant represented to the insurance company for refund of entire premium amount paid for the health policy while cancelling the policy , although original Policy document has not been received by him. Being beyond the free look period , refund of entire premium was not permissible as per Clause VIII.15 of the Policy T&C , the policy document being claimed to have been delivered to the Insured dated 27/09/2016 . However the Insurance Company has offered 50% Refund of Premium as per Policy T&C . It is opined that there is gross aberration in the Underwriting prudency practiced by the Insurance Company under reference . In the said case the Complainant is a worker in a Gold shop with limited income. He has been mislead by the Broker to procure a Health Policy covering self and his wife for an SI of Rs.10,00,000/- without giving due consideration to his Age , Social Status and meagre Income. Taking into cognizance the bad precedent set by the Insurance Company/Intermediary in Gross Misselling of Insurance product it is suggested that the Health Policy be treated as Deemed Cancelled Ab Initio by the Insurance Company with immediate refund of Total Premium paid. The Complaint was allowed and the Respondent directed to refund the entire premium collected against the Policy.

Case No. 053-1617-0702
Partha Chatterjee
Vs
Cigna TTK Health Insurance Co. Ltd

Award Dated 18/05/2017

Complainant was mis-sold two nos. Health Insurance Policy and 2 nos. Accident Insurance Policy by the agents of M/s AB Insurance Brokers Pvt. Ltd. while false fully promising recovery of Surrender Value in respect of running Life Insurance Policy bearing no. 02278166 issued by M/s Exide Life Insurance Co. Realizing that he was cheated , Complainant requested for cancellation of all the policy . As per Policy T&C , 50% refund of premium against both the Health policy was credited while in respect of the Lifestyle Protection – Accident insurance policy 100% & 85% refund of premium was credited resp. It is opined that there is gross aberration in the Underwriting

prudency practiced by the Insurance Company under reference . In the said case the Complainant is a Gynaecologist in the Govt. Health Dept. with ample Medical & Accident coverage for self & spouse under the West Bengal Health Scheme. Taking into cognizance the facts in their totality , it is suggested that the two Health Policy & Accident Policy bearing no. LTPRAC010133518 be treated as Deemed Cancelled Ab Initio by the Insurance Company with immediate refund of Total Premium paid. The Complaint was allowed and the Respondent directed to refund the entire premium collected against all the three Policy.

Case No. 031-1617-0669
S K Chakrabarty
Vs
Max Bupa Health Insurance Co. Ltd.

Award Dated 18/05/2017

Complainant's wife underwent Total Left knee replacement surgery following accidental slipping. He lodged a claim for Rs.2,78,729/- for reimbursement having been denied Cashless sanction. Insurance Company repudiated the Claim stating that the ailment was Pre-existing , requiring mandatory 24 months waiting period for due coverage. Close scrutiny of Discharge Summary revealed that the patient had history of Left knee pain for last 10 years along with Left shoulder pain while Right knee total replacement surgery was done in the year 2013. All these material facts were not disclosed at the Inception of the Policy. Hence the decision of the Respondent was upheld with no relief to the Complainant.

Case No. 031-1617-0704
Basant Parekh
Vs
Max Bupa Health Insurance Co. Ltd.

Award Dated 18/05/2017

Complainant's son being an acute Leukemia patient was admitted to Tata Medical Centre for various periods . His son's eligibility of Rs.20 Lakhs under the FamilyFirst Silver 5 Lacs + 15 Lacs Policy for the period 19/09/2015 to 18/09/2016 got exhausted resulting in repudiation of his various Claims lodged for the Hospitalization period 15/08/2016 to 22/09/2016 . Since the said period of Hospitalization spilled over to the next Policy Period , Complainant had claimed for proportionate reimbursement which was initially disallowed by the Insurance Company. Insurance

Company thereafter offered a settlement of Rs.1,32,416/- while considering only the expenses for the respective four days less Inadmissible expenses. Insurance Company was advised to settle subsequent Claim of Rs.15,622/- & Rs.39,154/- under Claim ID 219140 & 216570 resp. for the overlapping period in a similar manner. Hence the Complaint was allowed .

Case No. 048-1617-0681
Arindam Das
Vs
The National Insurance Co. Ltd.

Award Dated 18/05/2017

Complainant's daughter , suffering from Alternate Exotropia , was operated in both eyes for LR REC 5.5 under GA. Claim , including Pre & Post Hospitalization Expenses, was repudiated on grounds that treatment was towards external congenital anomaly (Exclusion Clause 4.5). That the disease has manifested from early childhood with its initial detection when the patient was 2 to 2½ years of age was substantiated by doctor's prescription . As per Medical Science there are two types of Exotropia viz. a) Alternating Exotropia or Intermittent Exotropia which occurs from time to time & b) Constant Exotropia is permanent in nature . Exotropia can be by birth or early infancy while Congenital Exotropia i.e by birth is more unusual .The onus of proving that the anomaly existed by birth lies with the Insurance Company which they have not done . The Complaint was allowed and the Respondent directed to pay Rs.25,207/- towards full and final settlement of the Claim.

Case No. 048-1617-0708
Kaushik Das
Vs
The National Insurance Co. Ltd.

Award Dated 18/05/2017

Complainant's son , was Hospitalized having suffered head injury due to an accidental fall . Claim , including Pre & Post Hospitalization Expenses , for Rs.60,336/- was lodged . The MLC report has mention of Complainant's son being highly intoxicated prior to the fall. Being treatment arising out of head injury under the influence of intoxicating substances the claim was repudiated as per Exclusion clause 4.21 . Taking cognizance of the Medicolegal case Report of the Hospital the decision of the Respondent was upheld with no relief to the Complainant.

Case No. 049-1617-0678

Asoke Kumar Guha
Vs
The New India Assurance Company Ltd.

Award Dated 18/05/2017

Complainant was administered Intra Vitreal injection Accentrix 0.05 ml , under Topical Anaesthesia , in right eye being diagnosed with Infero Temporal Branch Retinal Vein Thrombosis (BRVO). The Hospitalization claim was repudiated vide Clause 2.16.1 & 4.4.22 , stating that the injection could have been administered on OPD basis being not an approved day care procedure. As per Medical Science , Branch Retinal Vein Thrombosis (BRVO) , Central Retinal Vein Thrombosis (CRVO) & Hemi Retinal Vein Thrombosis (HRVO) are different forms of Retinal Vein Occlusions with side effects of Macular Edema while Age related Macular Degeneration (ARMD) is a separate ailment which also leads to Macular Edema . Hence it is opined that treatment was undertaken for BRVO and not ARMD. It is also opined that the treatment is not an OPD procedure as OT facilities had to be used in order to prevent further infection . The Complaint was allowed and Respondent directed to pay Rs.30,788/- towards full and final settlement of the Claim.

Case No. 049-1617-0679
Arindam Das
Vs
The National Insurance Co. Ltd.

Award Dated 18/05/2017

Complainant was administered Intra Vitreal injection Accentrix 0.05 ml , under Topical Anaesthesia , in right eye being diagnosed with Infero Temporal Branch Retinal Vein Thrombosis (BRVO). The Hospitalization claim was repudiated vide Clause 2.16.1 & 4.4.22 , stating that the injection could have been administered on OPD basis being not an approved day care procedure. As per Medical Science , Branch Retinal Vein Thrombosis (BRVO) , Central Retinal Vein Thrombosis (CRVO) & Hemi Retinal Vein Thrombosis (HRVO) are different forms of Retinal Vein Occlusions with side effects of Macular Edema while Age related Macular Degeneration (ARMD) is a separate ailment which also leads to Macular Edema . Hence it is opined that treatment was undertaken for BRVO and not ARMD. It is also opined that the treatment is not an OPD procedure as OT facilities had to be used in order to prevent further infection . The Complaint

was allowed and Respondent directed to pay Rs.31,105/- towards full and final settlement of the Claim.

Case No. 049-1617-0680
Asoke Kumar Guha
Vs
The New India Assurance Company Ltd.

Award Dated 18/05/2017

Complainant was administered Intra Vitreal injection Accentrix 0.05 ml , under Topical Anaesthesia , in right eye being diagnosed with Infero Temporal Branch Retinal Vein Thrombosis (BRVO). Cost of the Intra-vitreal Injection was disallowed while proportionate deduction was effected on account of excess room rent availed. As per Medical Science , Branch Retinal Vein Thrombosis (BRVO) , Central Retinal Vein Thrombosis (CRVO) & Hemi Retinal Vein Thrombosis (HRVO) are different forms of Retinal Vein Occlusions with side effects of Macular Edema while Age related Macular Degeneration (ARMD) is a separate ailment which also leads to Macular Edema . Hence it is opined that treatment was undertaken for BRVO and not ARMD. It is further opined that proportionate reduction of liability based on room rent can only be legitimate in case the concerned Hospital follow Graded Tariff Structure. In this case it is not applicable as Apollo Hospital , Kolkata had not implemented graded tariff structure . The Complaint was allowed and Respondent directed to pay Rs.19,788/- (Rs.18,042/- being cost of Intra vitreal Injection plus Rs.1,746/- being proportionate deduction)

Case No. 049-1617-0739
Subrata Basak
Vs
The New India Assurance Company Ltd.

Award Dated 19/05/2017

Complainant's son was diagnosed with Refractive error in both eyes. Because of difficulty of vision thru glasses and being intolerant to contact lenses his son was advised Laser Refractive Surgery in both eyes which he underwent . Reimbursement Claim , including Pre & Post expenses , was repudiated as per Exclusion clause 4.4.2(b) of the Policy being treatment towards correction of eye sight which is not payable. Treatment towards refractive error correction being correction of eyesight is cosmetic in nature and beyond scope of the Policy coverage. However if such

treatment is undertaken to arrest the alarming change in power of the eyes which if not done may lead to permanent damage of the eyes then it defies the inner meaning of cosmetic correction. Complainant submitted papers certifying only mild myopia . The decision of the Respondent was upheld with no relief to the Complainant.

Case No. 048-1617-0821
Debasish Datta
Vs
The National Insurance Co. Ltd.

Award Dated 12/06/2017

Complainant was treated conservatively being diagnosed with Hypothyroidism , Bifascicular block , Fatty Liver , Mild post protusion of C6 – C7 disc , compromising anterior thecal sac & mild bilateral neural foranimal stenosis to exerting nerve root compression . Hospitalization claim was repudiated as per Exclusion Clause 4.19 having undergone various Diagnostic evaluation & investigations without any active line of treatment . Close scrutiny of documents revealed that conservative management involving some Diagnostic & Evaluation was done during Claimant's entire stay in Hospital which could have been avoided and done on OPD basis. The decision of the Respondent was upheld with no relief to the Complainant.

Case No. 048-1617-0825
Pranab Khemka
Vs
The National Insurance Co. Ltd.

Award Dated 12/06/2017

Complainant's wife , a patient of Carcinoma right breast since year 2013 , has received 6 cycles of injectible Chemotherapy from a Cancer Centre . Subsequently she underwent Oral Chemotherapy under the advise of Medical Superintendent of the Cancer Centre . He submitted claims towards oral chemo including testing undergone for reimbursement. Insurance company has observed that the patient had refused injectible Chemo Therapy planned formal . She was taking Oral Chemo at home which is not covered under the Policy vide Exclusion Clause 4.20 . That the cancer patient has undergone Chemotherapy , a valid day care procedure , is not fake . Further Insurance Company has repudiated all the claims while applying Exclusion Clause 4.20 which states that Treatment in convalescent home / hospital , health hydro / nature care clinic and similar establishments is beyond scope of the Policy . Since the present treatment of Cancer Chemotherapy is not in the category of convalescent home or convalescent hospital the

application of Clause 4.20 is not valid. The Complaint was allowed and the Respondent was directed to pay Rs.50,445/- less inadmissible expenses , if any.

Case No. 050-1617-0828
Shib Sankar Nandy
Vs
The Oriental Insurance Co. Ltd.

Award Dated 12/06/2017

Complainant was diagnosed with Acute tremor right sided limbs (normal MR) , Hypercholesterolaemia & Grade I DD with Trivial TR having past history of HTN , Dyslipidaemia & treated conservatively. He lodged a claim , including Pre & Post Expenses, which was repudiated as per Exclusion Clause 4.10 having undergone various Diagnostic evaluation & investigations without any active line of treatment . It is observed that the Complainant had suffered Loss of Consciousness . Due to medical emergency and upon the advise of the treating doctor he was admitted to SICU of a reputed Hospital . The said doctor has justified the Hospitalization as he was envisaging occurrence of any major Cardio Vascular event subsequent to the onset of LOC . The Complaint was allowed and the Respondent was directed to pay Rs.50,000/- less inadmissible expenses , if any.

Case No. 044-1617-0836
Sudeb Rudra
Vs
Star Health & Allied Insurance Co. Ltd.

Award Dated 12/06/2017

Complainant was diagnosed with Urosepsis & Prostate megaly and was treated actively . Reimbursement claim was repudiated vide Policy Condition no. 9 as the past medical history of Vasculitic Neuropathy in the year 2009 , CAD - undergoing PTCA and stent to LAD in March,2003 was not disclosed . The said policy was also cancelled on the ground of non-disclosure of material facts vide policy condition no. 13. Complainant has submitted that all pre existing diseases are covered after four years , as per IRDA guidelines , while his policy is in the fifth year of coverage. The complainant has also represented that the present treatment is not related with his past medical history and hence his claim cannot be repudiated on that ground. It is opined that non-

disclosure of PED was inadvertently made , attributed to in-efficiency of the servicing Agent. Further PED - Vasculitic Neuropathy (year 2009) has not been proved while no complications of PED – CAD (year 2003) has been reported with no claims having been lodged since policy inception , the policy being in force for fifth consecutive year . Further the present claim towards treatment of Urosepsis & Prostate megaly has nothing to do with CAD . The Complaint was allowed and the Respondent was directed to pay Rs.1,30,337/- less inadmissible expenses , if any.

Case No. 044-1617-0807

Rabindranath Dutta
Vs
Star Health & Allied Insurance Co. Ltd.

Award Dated 12/06/2017

Complainant was mis-sold a Health Insurance Policy by an agent with the false assurance of full health coverage of any disease on immediate basis although he had declared T2DM , HT as pre-existing ailment . Understanding from Customer Care of the Insurance Company that no coverage shall be entertained in the first year of the Policy he requested for cancellation of the Policy with full refund of premium . As per Policy condition no. 13 the said Policy was cancelled by the Insurance Company and an amount of Rs.6,483/- vide NEFT towards premium on short period rate was refunded . It is opined that there is gross aberration in the Underwriting prudency practiced by the Insurance Company . In the said case Complainant was wrongfully assured full coverage of all diseases on immediate basis . That the Policy document was actually received by the Complainant could not be substantiated by the Insurance Company , having not submitted proof of delivery of the Policy document . It is observed that the Intermediaries of the said Insurance Company are deliberately killing the free look period. Taking into cognizance the bad precedent set by the Insurance Company/Intermediary in Gross Misselling of Insurance product it is suggested that the Health Policy be treated as Deemed Cancelled Ab Initio by the Insurance Company with immediate refund of Total Premium paid. The Complaint was allowed and the Respondent directed to refund the entire premium collected against the Policy.

Case No. 053-1617-0835
Sarmistha Sanyal
Vs
Cigna TTK Health Insurance Co. Ltd

Award Dated 12/06/2017

Complainant was mis-sold 4 nos. Health Insurance Policy by the agents of M/s India Infoline Insurance Brokers Ltd. while promising refund of Dead fund of previous Life Insurance Policies. Realizing that she was cheated she placed a complaint with the Electronic Complex Police Station at Salt Lake . Complainant represented to the insurance company for refund of entire premium amount paid for the four health policy while cancelling all the policy. Subsequently she had received 75% refund of premium paid against Policy Nos. PROHLT010253821 & PROHLT010235826 while 62.5% refund of premium was received in respect of Policy no. PROHLT010100304. However Health Insurance Policy with Plan ProHealth - Plus bearing no. PROHLT010123829 was not cancelled and refund of full premium amounting to Rs.24,000/- was denied by the Insurance Company. It is opined that there is gross aberration in the Underwriting prudency practiced by the Insurance Company under reference . In the said case Complainant submitted that her family has been sufficiently covered under Health Insurance Policy since Year 2002. Taking into cognizance the bad precedent set by the Insurance Company/Intermediary in Gross Misselling of Insurance product it is suggested that the Health Policy be treated as Deemed Cancelled Ab Initio by the Insurance Company with immediate refund of Total Premium paid. The Complaint was allowed and the Respondent directed to refund the entire premium collected against the Policy.

Case No. 053-1617-0734
Dindayal De
Vs
Cigna TTK Health Insurance Co. Ltd

Award Dated 12/06/2017

Complainant was twice administered Intra Vitreal injection Accentrix 0.05 ml , under Topical Anaesthesia , in right eye being diagnosed with Sup. Temporal Branch Retinal Vein Thrombosis (ST-BRVO) with Macular Edema . The Hospitalization claim was repudiated vide Section IX.17 , stating that the injection could have been administered on OPD basis being not an approved day care procedure. It is opined that Intra-vitreal injection is administered in O.T in order to prevent Infection which is quite common in OPD procedures. The Complaint was allowed and Respondent directed to pay Rs.53,974/- towards full and final settlement of the Claim.

Case No. 053-1617-0742
Subir Prasad Chattopadhyay
Vs
Cigna TTK Health Insurance Co. Ltd

Award Dated 12/06/2017

Complainant was mis-sold 5 nos. Health Insurance Policy by an agent of M/s AB Insurance Brokers Pvt. Limited Realizing that he was cheated , he represented to the insurance company for refund of entire premium amount paid viz. Rs.4,34,675/- (18,240/- + 50,237/- + 1,32,150/- + 1,35,298/- + 98,750/-) while cancelling all the five policy . He has also filed a complaint with the appropriate Police station. Insurance Company has stated that Complainant had requested for cancellation of the first 2 policies after passage of 8 months from the inception of the policy period. As regards other three Health Insurance Policy bearing nos. PROHLR350003814 , PROHLR350153987 & PROHLR350153910 , since no records of issuance of such policies could be traced in their database Complainant was requested to share premium amount , payment proof with documents . The first two Policy being mis-sold and cancellation requested by the Complainant, Insurance Company is required to Refund the Premium. However in respect of other three no. standalone Health Insurance Policy , which are being disowned by the Insurance Company , Complaint has not only failed to substantiate Payment of Premium to the Insurance Company but is unable to submit Policy documents. In such a scenario further investigation is required. The Forum , being bound by jurisdiction , is not in a position to adjudicate the Complaint in respect of the three no. standalone Health Insurance Policy. The Complaint is partly allowed while the Respondent is directed to refund Rs.68,477/- towards Premium collected in respect of the first two policy . In respect of other three no. standalone Health Insurance Policy claimed to bear Nos. PROHLR350003814 , PROHLR350153987 & PROHLR350153910 , the Complaint is being set aside for future reference to appropriate Forum .

Case No. 031-1617-0716
Prabha Khemka
Vs
Max Bupa Health Insurance Co. Ltd.

Award Dated 12/06/2017

Complainant was covered under the Companion Policy being ported from National Insurance Co. Ltd . She was diagnosed with Polycystic right Ovary / Left and underwent procedure Left sided ovarian Cystectomy and Right sided Ovarian drilling under GA. Hospitalization Claim , including Pre & Post Expenses , was repudiated on grounds of Non-disclosure of Rhinorrhoea Surgery performed 4-5 years back. Insurance Company had sent an exclusion letter proposing exclusion for PRE-EXISTING : Other Disorder of nose and nasal sinuses endorsement in the said Policy which was not accepted by the Insured. Hence the policy was cancelled . Scrutiny of documents revealed that there was continuous coverage since Year 2012 with National Insurance Co. Ltd. with portability accepted by present Insurance company. Portability being carrying forward of all credits accumulated in the earlier Coverage should not come in the way of present Claim

settlement. Further Rhinorrhoea ailment cannot be considered material to the Claim. Insurance Company has now reviewed their decision of repudiation in the right perspective while offering a settlement of Rs.62,543/- effecting deduction of Rs.1,690/- towards inadmissible expenses. The Complaint stands allowed .

Case No. 031-1617-0796
Sankar Chakrabarty
Vs
Max Bupa Health Insurance Co. Ltd.

Award Dated 12/06/2017

Complainant's wife met with an accident by overstepping into the bathroom . She was diagnosed with Acute L.B.P following fall . He lodged a claim , including Pre & Post Expenses, which was repudiated as per Exclusion Clause 4e (vii) , the patient having undergone various Diagnostic evaluation & investigations without any active line of treatment . Due to medical emergency and upon the advise of the local doctor Complainant's wife she was admitted to hospital . Insurance Company has now reviewed their decision of repudiation in the right perspective while offering a settlement of Rs.22,685/- effecting deduction of Rs.2,500/- towards Ambulance charges & Rs.138/- towards inadmissible expenses. The Complaint stands allowed.

Case No. 031-1617-0662
Shalini Bhotika
Vs
Max Bupa Health Insurance Co. Ltd.

Award Dated 12/06/2017

Complainant submitted a Pre-Authorization request towards treatment of her husband at B M Birla Heart Research Institute , Kolkata for Rs.25,900/- which was denied by the Insurance Company on grounds that the patient had history of HTN since 1997 which was not disclosed at the time of inception of the said Policy. That the Discharge Summary inadvertently endorsed history of HTN since 1997 was substantiated by the declaration of treating consultant Dr. Tarun Kumar Praharaj of B M Birla Heart Research Institute , Kolkata & Dr. Bhaskar Bikash Pal of Apex General Hospital , Kolkata . Complainant also argued that if the history of HTN was since 1997 and her husband presently being 38 years old then he must have had HTN at the young age of 18 which is absurd. Against all this justification put forth by the Complainant , the Insurance Company further cancelled their policy . In light of the fact that Insurance Company has settled a Claim for Rs.90,000/- during July,2016 , they could have overlooked the present HTN anomaly and sanctioned the Pre-Auth keeping in mind that the Complainant had been with them since Year 2012. It is unfortunate that the Complainant has suffered irrecoverable human loss. Insurance Company has now reviewed their decision of denial of Pre-Auth and cancellation of

Policy in the right perspective while offering the Complainant to Lodge the Hospitalization Claim in respect of the cancelled Pre-Authorisation request. The Complaint stands allowed.

Case No. 035-1617-0808
Rajesh Kumar Shaw
Vs
Reliance General Insurance Co. Ltd.

Award Dated 12/06/2017

Complainant's wife was treated for LRTI & Radiculopathy. He lodged a claim for Rs.30,929/- which was repudiated on grounds that the date of admission to Hospital does not fall in policy commencement period . Complainant has argued that Insurance Company has delayed issuance of New Policy with all Portabilty benefits while the Proposal Form & Cheque was submitted dated 18/06/2016. Scrutiny of documents revealed that the Complainant had applied for Porting prior to the expiry of Reliance Healthgain Plan viz. before 09/06/2017. A Policy under Reliance Healthwise Plan effective 22/06/2016 with full Portability benefits was issued. As per Portability rules , Insurance Company is required to port to new Plan without any break . Therefore it is concluded that the Complainant is entitled to the Claim under reference. The Complaint stands allowed while Respondent was directed to pay Rs.30,929/- less inadmissible expenses .

Case No. 038-1718-0006
Raj Kumar Bachar
Vs
Royal Sundaram Alliance Insurance Co. Ltd.

Award Dated 12/06/2017

Complainant's wife was Hospitalized being diagnosed with Renal failure – CKD V D . She was again hospitalized being treated for AV Fistula creation. She was subsequently hospitalized for treatment of sudden onset of breathlessness & underwent active medical treatment being diagnosed with CKD & Lower Respiratory Tract Infection. He lodged a claim for Rs.1,51,358/- , including Pre & Post Hospitalization Expenses , in respect of the first Hospitalization . He lodged another Claim for Rs.15,000/- in respect of the second Hospitalization . Finally he lodged another Claim for Rs.97,250/- , including Pre & Post Hospitalization Expenses , in respect of the third & final Hospitalization. As per findings from the Discharge Summary & Claim documents the patient is a known case of Chronic Kidney Disease arising out of direct complication of accelerated phase of Hypertension existing since 2013. As HTN ailment was pre-existing at inception of the policy , mandatory 48 months waiting period for due coverage is required. The policy being in the third year , the Claims were rightly repudiated . However it is also true that Chronic Renal Failure treatment has mandatory waiting period of 24 months. The Complainant stands allowed and Respondent was directed to pay Rs. 3,01,120/- less any inadmissible expenses.

Case No. 038-1718-0069
Sushim Chandra Chakraborty
Vs
Royal Sundaram Alliance Insurance Co. Ltd.

Award Dated 11/07/2017

Complainant underwent Left Eye Cataract under LA . During - Hospitalization Expenses for Rs.17,500/- was settled on cashless basis for Rs.7,500/- . Supplementary Claim , in respect of Pre & Post Hospitalization expenses , for Rs.9,248/- , was denied on grounds of Sublimits being exhausted. It is opined that the clause sub-limiting Expenses to Rs.7,500/- in respect of Cataract procedure is applicable for During – Hospitalization expenses only. Subject to availability of sufficient Sum Insured + Cumulative Bonus , both Pre & Post Hospital expenses are reimbursable . The Complaint being allowed , Respondent was directed to pay Rs.9,248/- less any inadmissible expenses.

Case No. 051-1718-0008
Gautam Basu
Vs
The United India Insurance Co. Ltd.

Award Dated 11/07/2017

Complainant's wife was Hospitalized having been diagnosed with Left sudden Sensorineural Hearing Loss.. Medical Treatment was done by applying Left Intratympanic injection of Dexamethasone . Hospitalization Claim for Rs.22,366/- , including Pre & Post expenses , was repudiated applying Exclusion Clause 2.1 as stipulations in respect of minimum 24 hours period of admission in hospital as inpatient was not complied. Intra Tympanic injection of steroid is carried out under Topical Phenol Anesthesia applied to the Eardrum , hence cannot be an OPD procedure. The Complaint being allowed , Respondent was directed to pay Rs.22,366/- less inadmissible expenses.

Case No. 048-1718-0009
Shyamal Kanti Sen
Vs
The National Insurance Co. Ltd.

Award Dated 11/07/2017

Complainant underwent cataract operation (Phaco+Fold) for right eye . Cashless sanction for Rs.21,000/- , being PPN limits for the said procedure considering SI to be Rs.2,00,000/- was approved. Further Pre & Post Hospitalization Claim was settled for Rs.1,969/- with the residual amount of Rs.9,250/- deducted due to PPN limits having exceeded. From the discharge summary it is observed that although the undergone procedure of Phaco - Cataract is listed under PPN

Package yet the Final Bill of Rs.30,250/- raised by the Hospital Authority exceeds the PPN limit of Rs.21,000/- being the All inclusive charges stipulated jointly by the Insurance Company & the Hospital Authority for the said procedure . It is unjust to use Annexure-C as commitment by the patient party to pay hospital expenses over and above the PPN rate. Patient party had signed the Annexure-C only to enable completion of the Procedure by the Hospital within stipulated time frame on one hand while expecting reimbursement of the excess amount over and above the PPN rate by the Insurance Company on the other hand. By charging in excess of the PPN rate the Hospital authority has violated the agreement . The Complaint is allowed while the Respondent was directed to pay Rs.9,250/- towards full & final settlement of the claim.

Case No. 053-1718-0025
Nilanjan Gupta
Vs
Cigna TTK Health Insurance Co. Ltd.

Award Dated 11/07/2017

Complainant was mis-sold by the agents of M/s AB Insurance Brokers Pvt. Limited one ProHealth - Protect Insurance Policy and one Lifestyle Protection – Accident insurance policy while falsefully promising recovery of Surrender value of a Life Policy procured from Exide Life Insurance Company . Realizing that he was cheated , Complainant requested for cancellation of both the policy desiring refund of total premium. As per Policy T&C , 75% refund of premium has been proposed in respect of both the policy . It is opined that there is gross aberration in the Underwriting prudency practiced by the Insurance Company . In the said case Complainant submitted that he being a South Eastern Railway Employee and his wife being a Nurse at S.S.K.M Government Hospital sufficient Health coverage exists for their family. Taking into cognizance the bad precedent set by the Insurance Company/Intermediary in Gross Misselling of Insurance product it is suggested that the Health Policy & the Accident Policy be treated as Deemed Cancelled Ab Initio by the Insurance Company with immediate refund of Total Premium paid. The Complaint was allowed .

Case No. 053-1718-0046
Gouri Basu
Vs
Cigna TTK Health Insurance Co. Ltd.

Award Dated 11/07/2017

Complainant was mis-sold by an Intermediary of the Insurance Company one ProHealth - Accumulate Insurance Policy while falsefully promising recovery of Premium paid under Sampurna Sambriddi Life Policy and Premium paid under Reliance Life Policy . Realizing that she was cheated , Complainant requested for cancellation of the policy after expiry of free look period desiring refund of total premium . As per Policy T&C , 50% refund of premium has been proposed in respect of the said policy . It is opined that there is gross aberration in the

Underwriting prudency practiced by the Insurance Company . In the said case Complainant being a retired State Bank of India officer is sufficiently & reasonably covered under their mandatory Group Health Scheme offered by United India Insurance Co. Ltd. vide UHID No. UIIC.00014550684. Taking into cognizance the bad precedent set by the Insurance Company/Intermediary in Gross Misselling of Insurance product it is suggested that the Health Policy be treated as Deemed Cancelled Ab Initio by the Insurance Company with immediate refund of Total Premium paid. The Complaint was allowed.

Case No. 048-1718-0018
Malabika Basu
Vs
The National Insurance Co. Ltd.

Award Dated 11/07/2017

Complainant was hospitalized being diagnosed with Impacted Fracture of Left neck Femur . Being less than 24 hours Hospitalization , Insurance Company repudiated the Claim as per Exclusion Clause 3.12 . It is opined that the patient was admitted to Purnam Medicare Hospital dated 19/12/2016 at 11:07:00 AM and actually discharged dated 20/12/2016 some time after 11:19:46 AM when the Final Invoice cum Receipt was issued . Hence the minimum period of consecutive 24 hours stay as Inpatient in Hospital stipulation has been complied . The Complaint stands allowed while the Respondent was directed to pay Rs. 22,806/- Claim Amount less any inadmissible expenses.

Case No. 048-1718-0028
Ashok Santra
Vs
The National Insurance Co. Ltd.

Award Dated 11/07/2017

Complainant was Hospitalized while undergoing cataract operation (Phaco+IOL) for right eye dated 28/01/2017 and for Left eye dated 11/02/2017 . Both the Claims , including Pre & Post expenses , aggregating to Rs.1,13,000/- was settled on cashless basis for Rs.48,000/- while disallowing cost of Multifocal lens being Rs.65,000/- . As per Insurance Company , claims with respect to cataract operation should be restricted to monofocal lens , being necessary & reasonable . It is opined that Policy Terms & Conditions do not exclude reimbursement of cost of multi focal lens so long sufficient Sum Insured + Cumulative Bonus is available under the Policy . Further usage of multi focal lens has been recommended by the attending Consultant and any vision correction resulting from technological advancement are incidental benefits . Needless to mention that Internal Circulars cannot override Policy Terms & Conditions. The Complaint stands allowed while the Respondent was directed to pay Rs.65,000/- less any inadmissible expenses .

Case No. 050-1718-0043
Asit Baran Ray
Vs
The Oriental Insurance Co. Ltd.

Award Dated 11/07/2017

Complainant was administered Intra-vitreal Injection Accentrix in right eye , under Topical Anaesthesia , towards treatment of Macular Branch Retinal Vein Thrombosis (BRVO) . Hospitalization Claim was repudiated on grounds that the procedure Accentrix Injection could be done on an OPD basis vide clause 4.19 . It is opined that the treatment is not an OPD procedure as OT facilities had to be used in order to prevent further infection . It would be worthwhile to note that the Insurance contract under reference has no Exclusion clause with respect to Age Related Macular Oedema treatment . The Complaint stands allowed while the Respondent was directed to pay Rs.24,600/- less any inadmissible expenses .

Case No. 049-1718-0053
Rabindranath Das
Vs
The New India Assurance Company Ltd.

Award Dated 19/07/2017

Complainant underwent non-invasive treatment named Enhanced External Counter Pulsation – EECP (35 sittings) and Bio Chemical Angioplasty - BCA (20 infusion) at Saaol Heart Center , New Delhi under the supervision of Dr. Bimal Chhajer , an Ex. Consultant of AIIMS . Hospitalization claim for Rs.1,39,560/- was repudiated under Clause 4.4.19 as Bio Chemical Angioplasty was an unproven treatment , not recognized by MCI . Further the Policy T&C excludes EECP treatment as per Clause 4.4.22 . It is observed that the Policy Terms & Conditions of the product explicitly prohibits any treatment which is in the experimental stage and not recognized by the Medical Council of India (Exclusion Clause 4.4.19) , while EECP Therapy is explicitly excluded under Clause 4.4.22. Hence the Decision of the Respondent upheld without any relief to the Complainant.

Case No. 044-1718-0189
Kalyani Mitra
Vs
Star Health & Allied Insurance Co. Ltd.

Award Dated 19/07/2017

Complainant underwent Permanent Pacemaker (VVI) implantation having been diagnosed with Bifascicular Block with Recurrent Syncope . Cashless sanction was approved for Rs.39,000/- only /- as per 50% Co-pay Clause in a case of PED while applying Sub-limits. . Supp. reimbursement Claim for Rs.59,385/- including Pre & Post Expenses over and above the Cashless sanction was

considered for Rs.1,173/- which was not accepted . Now the Insurance Company has considered the claim deduction on 30% Co-pay basis (Condition 4[5]) while treating the claim not as PED and applying Sub-limits Clause 1A , 1B , 1C & 1D . As per Condition-1F , Pre-Hospitalization expenses of Rs.1,487/- is beyond the scope of the Policy . The Complaint has been redressed as the Claim has been settled in full & final with additional disbursement of Rs.16,773/- up to the satisfaction of the Complainant . Hence the Complainant has been Closed.

Case No. 048-1617-0731
Manjulika Kusari
Vs
The National Insurance Co. Ltd.

Award Dated 27/04/2017

Complainant had submitted a premium Cheque drawn on BOI-Rashbehari Avenue for renewal of her coverage under BOI-– National Swastya Bima Policy. The renewed Policy Bond was sent to her by end Dec'2015. Meanwhile she was hospitalized for treatment of Shortness of breath & Chest pain . Two Claims , including pre & post Hospitalization expenses , for Rs.17,674/- & Rs.6,303/- resp. was submitted . As Premium Cheque was dishonoured vide bank's advice dated 19/12/2015 due to account blocked situation , Policy was cancelled ab initio . Being breach of section 64VB of Insurance Act , the insurance company is not in a position to reimburse the Claim and allow continuation of coverage . It is opined that Insurance Company is primarily responsible for not intimating to his valued customer about the cheque being dishonoured and subsequent cancellation of Policy. Further Bank Of India - Rashbehari Avenue Branch , the principal Banker under the Bank Assurance Contract , has defaulted. Needless to mention that they are favoured with a reasonable Corporate Agent Commission in lieu of the expected Service. Bank's default has not only caused damage & mental agony to the Insured but has resulted in loss to the Insurance Company. Insurance Company may wish to take up the matter with the Banking Ombudsman . The Complaint was allowed while the Respondent was directed to pay Rs.23,977/- aggregate Claim Amount and reinstate the cancelled Policy with full continuity benefits.

Case No. 048-1617-0829
Rahul Chakrabarty
Vs
The National Insurance Co. Ltd.

Award Dated 12/06/2017

Complainant was covered under the BOI National Swasthya Bima Policy with Floater SI of Rs1,00,000/- duly enhanced to Rs.2,00,000/- effective 24/01/2015. He was hospitalized & treated for Coronary Artery disease with PTCA stenting of OM1 . Cashless Sanction for Rs.1,00,000/- was granted while residual Claim for Rs.87,614/- , including Pre & Post expenses was disallowed citing Exclusion Clause 4.1/4.2/4.3 applicability on the enhanced portion of the SI , the Insured patient being a known case of Coronary Artery disease since 2009. It is opined that enhanced SI has specific waiting periods before it could be considered for Claim settlement.

In this case the enhanced SI was subject to Exclusion Clause 4.1 as Insured patient was a known case of Coronary Artery disease having a waiting period of 3 years . In the said case the enhanced SI is in the second year of applicability. Hence the Decision of the Respondent upheld without any relief to the Complainant.

Case No. 048-1718-0002
Onkar Nath Ray
Vs
The National Insurance Co. Ltd.

Award Dated 12/06/2017

Complainant had taken BOI – National Swasthya Bima Policy with inception coverage being 23/05/2012. His wife was suffering from existence of Soft Tissue Lesion in Left side of Pelvis involving the GUT and underwent Laparoscopic excision of nodule on GUT wall under GA . Reimbursement Claim for Rs.85,499/- , including Pre & Post Hospitalization expenses was repudiated on grounds of non-disclosure of TAH + BSO done in 2011 for granulose cell tumour of the ovary prior to inception of Policy . Close scrutiny of documents revealed that patient had undergone TAH + BSO in the year 2011 for granulose cell tumour of the ovary and thereafter Coverage was incepted dated 23/05/2012 . Further the Discharge summary reveals that Soft tissue Lesion in left side of pelvis involving the GUT was noticed in a post TAH+BSO procedure done in 2011 for which Laparoscopic excision became necessary. It is opined that suppression of material facts ie. undergoing TAH + BSO in the year 2011 is wilful and tantamounts to violation of Policy T&C . The Insurance Company has rightfully denied the Claim and as a good will gesture desisted from cancelling the Policy . Hence the Decision of the Respondent upheld without any relief to the Complainant.

DATE OF AWARD :- 27th day of April 2017

COMPLAINT REF: KOL-G-051-1617-0670

CASE OF SHRI ACHIN MUKHERJEE
VS
UNITED INDIA INSURANCE COMPANY LIMITED

Breif facts of the case:-

The complainant, Shri Achin Mukherjee has stated that he was suffering from left eye problem and as per advice of the doctor he was admitted in Fortis Hospital & Kidney Institute, Kolkata where intravitreal injection accentrix was administered in his left eye and was discharged on the same day, but the said claim repudiated by the insurance co.under clause 2.1 of the Policy.

Ombudsman Award/recommendation:-

Intravitreal injection accentrix were administered in the left eye. Accentrix Injection contains Rainibizumab as an active ingredient. Accentrix Injection works by stopping abnormal blood vessel growth and leakage in the eye. The RISK Intravitreal injection Accentrix include .
*Pain, *retinal tear/ detachment*Infection*loss of vision*Loss of the eye (from severe infection *Increase IOP with damage to optic nerve((steroids), * need for surgery (to address some of the complications above) , * stroke / Heart attack.In view of the above Intravitreal injection Accentrix should be done in the OT under strict ascetic condition therefore, Anaesthesis , OT, and strict Aseptic condition were necessary in the Indian condition and these are available in a good Hospital.Therefore repudiation of this hospitalization claim by the insurer was unjustified and the same is set aside

COMPLAINT NO. : KOL-G-038-1617- 0728
DATE OF AWARD : 28-04-2017

SHRI SUSHIM KUMAR CHAKRABORTY
Vs.
ROYAL SUNDARAM GENERAL INSURANCE COMPANY LTD.

BRIEF FACT OF THE CASE –

The complainant lodged a claim of Rs.6482/- towards Pre + Post hospitalisation expenses in connection with his medical claim for Cataract treatment. The complainant has been covered under Royal Sundaram Family Health Floater Policy for a sum insured of Rs.1 lakh. The complainant was paid Rs.900/- only for Pre and Post hospitalisation expenses out of a total bill for Rs.6482/-. The complainant represented that the sub-limit is applicable for hospitalization expenses only and not for pre and post hospitalization expenses.

INSURER'S SUBMISSION –

The insurer submitted that as per policy terms and conditions under cataract claim maximum 8% of sum insured is payable. The Insurer made cashless payment for Rs.8000/- to the nursing home. It is 8% of the sum insured maximum payable for this disease. After that the complainant submitted claim for Rs.6482/- towards re-imbursement of pre and post hospitalisation expenses. The insurance company paid Rs.900/- as full and final settlement which is 8% of the C.B.

AWARD -

During the hearing it has been observed that the policy clause under the head "Expenses covered under the policy" has defined pre and post hospitalisation expenses separately and the amount incurred under this head is payable only through re-imbursement mode. Hence Pre and post hospitalisation expenses is an additional amount payable in addition to hospitalisation claim and the limit of 8% would not apply.

The insurer is directed to pay the balance amount of the pre and post hospitalization expenses subject to deduction of non-admissible amount.

DATE OF AWARD :- 27th day of April 2017
COMPLAINT REF: KOL-G-050-1617-0655

CASE OF SHRI JAGANNATH SARDAR
VS
THE ORIENTAL INSURANCE COMPANY LIMITED

Brief facts of the case:-

The complainant, Shri Jagannath Sardar has stated that his wife Smt. Sefali Sardar was suffering from painful swelling left sided vulvul area for last 5 to 6 days and was admitted in Sri Aurobindo Seva Kendra, Kolkata on 06.07.2016 where she underwent an operation under general Anaesthesia on the same day and was discharged on 08.07.2016. As per discharge summary the diagnosis of the disease was 'left sided barthalin cyst', the Insurance co repudiated the said claim under 4.3 of the policy , which states that surgery to genitor urinary system is not payable up to two years since inception of the policy.

Ombudsman Award/recommendation:-

The blocked gland is called a Bartholin gland cyst (Sometimes it's called a Bartholin duct cyst.) These cysts can range in size from a pea to a large marble. They usually grow slowly. If the Bartholin gland or duct gets infected, it's called a Bartholin gland abscess.Bartholin gland cysts are often small and painless. Some go away without treatment. But if you have symptoms, you might want treatment. If the cyst is infected, you will need treatment.

Genitourinary is a word that refers to the urinary and genitalorgans.Urology is the branch of medicine concerned with the urinary tract in both genders and the genital tract of the reproductive system in males. Nephrology is the branch of medicine concerned with the kidney.

In this case the disease of BARTHALIN CYST relates to Genitourinary disease thus repudiation made by the insurance co under clause 4.3 of the policy is justified.

DATE OF AWARD :- 23/06/2017
COMPLAINT REF: KOL-G-023-1617-0804

CASE OF Mr. Mafizuddin Sarkar
VS
Iffco-Tokio General Insurance Co. Ltd (Kolkata0

Breif facts of the case:-

The complainant, Sri Mr. Hafizuddin Sarkar, has stated that his wife Mrs. Rowsonara Sarkar was admitted to Burdwan Nursing Home,Burdwan with a history of Menorrhagia, diagnosed with fibroid uterus and inflamed appendix , managed surgically with total Abdominal Hysterectomy with bilateral Salpingoophorectomy and Appendicectomy under GA. He submitted a total hospitalization claim an amount of Rs. 52779.00/- to the Insurance co, but the Insurance co repudiated the said claim on the ground of clause 49 of "general definition" of FHP i.e non disclosure, incorrect statement, misrepresentation of material fact.

Ombudsman Award/recommendation:-

The complainant had given the declaration to the Insurance Co. on 15/12/2015, but the disease4 was detected after the declaration made to the insurance Co., declaration made to the insurance co on 15/12/2015 in regard to her pre-existing disease /medical history of the patient, but the disease was detected on 25/12/2015. The patient diagnosed with fibroid uterus and inflamed appendix, managed surgically with total Abdominal Hysterectomy with bilateral Salpingo-oophorectomy and Appendicectomy under GA, which has no relation with Hypertension, hypothyroidism and Manorrhagia., Considering the fact as stated above Non disclosure of Material fact (Pre-exiting disease) could not be established in this case , thus "non disclosure, incorrect statement, misrepresentation of material fact" as per clause 49 of the Policy is not established in this case. Thus repudiation made by the insurance co under the above clause is unjustified and set aside.

OFFICE OF INSURANCE OMBUDSMAN

MUMBAI & GOA

METROPOLITAN REGION EXCLUDING

(Under Rule No. 16/17 of the Redressal of Public Grievances Rules,1998)

Brief Facts of the Case :

Ms U wife of Mr P is covered under the Group Mediclaim Policy for the policy period from 31.03.2016 to 30.03.2017 and was admitted at Hospital from 26.12.2016 to 30.12.2016 for non functioning pituitary macroadenoma and Transnasal Transsphenoidal Hypophysectomy endoscopic (pituitary tumor excision) done on 27.12.2016. Total claim amount of Rs.236788/- was lodged with the Company and the Company settled the claim for Rs.72750/- and deducted Rs.164038/- as disease sub limit exhausted and they are disorders of nose and nasal sinuses. The complainant has represented in his written statement that he is not agreeable with the decision of the Company.

Observations :

The Forum observes in this case that Company has very casually deducted major amount of claim on the ground that their disease sub limit got exhausted and they are disorders of nose and nasal sinuses without examining the case in detail. The Forum notes that this surgery was not a stand alone septoplasty but it was performed by Transnasal Endoscopic approach the endoscopic septoplasty with fess in order to give access to pituitary fossa and therefore Company's denial of Rs.164038/- on the ground that septoplasty is excluded is not justifiable and the Company was directed to settle the balance admissible claim amount and submit the payment particulars to the Forum within a period of one day. Accordingly the Company has calculated the balance admissible claim amount as Rs.153668/- after deducting non medicals.

Dated: 28.07.2017

Brief Facts of the Case :

Mr S is covered under the above Group Mediclaim Policy and he underwent treatment for left eye Retinal Venous Occlussion by administering anti veg injections under local anesthesia (Accentrix, Avastin) since 2015 at regular intervals. The complainant had submitted Xerox copies of the hospital papers to the Company and the TPA had advised him that this claim will not be paid as there is no admission in the hospital and it is also not listed in their day care list of the policy. The complainant has represented in his written statement that he is not agreeable with the decision of the Company.

Observations/Conclusion

The facts that have been brought to the notice of the Forum clearly indicate that this procedure is an advancement of medical technology where minimum of 24 hours of hospitalization is not required.

Based on the deposition of the complainants, the forum notes that the treatment is a prolonged one wherein depending upon the prognosis the patient has to be administered more number of injections. Looking at the treatment undertaken by the complainant, the Forum finds that the doctors have been administering Avastin injections, which is cheaper than Lucentis and the criteria for choosing Avastin over Lucentis is not clear. Various Certificates issued by the Eye specialists indicate **divided opinion** amongst the doctors regarding the procedure being an inpatient or outpatient one.

The Forum observes in this case that this procedure is not a surgical intervention but is to be carried out in Operation theatre to maintain a sterile environment. The Forum is 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 bears a part of the expenses. Accordingly, taking a practical view of the facts of the case, which have been brought to the notice of this Form, the Forum has come to the conclusion that the cost of the treatment is to be shared equally between the complainant and the Company.

Under the circumstances the Company was directed to settle the claim for 50% of the admissible expenses subject to submission of original claim documents by the complainant and then submit the payment particulars to the Forum.

Dated: 28.07.2017

Brief Facts of the Case :

Mr D father of Mr R is covered under the above policy with effect from 16.11.2012 and he was admitted at Hospital on 19th August,2016 with complaints of swelling in left testis with diagnosis of Torsion of testis (left) and Orchidectomy done for which cashless request was denied by the Company. Patient was a known case of Coronary Artery Disease and was admitted at Care Hospital on 01.02.2010 which is prior to inception of policy and the same was not disclosed in the Proposal form. The Company has repudiated the claim on the ground of Non disclosure and also terminated the policy vide letter dated 22nd August,2016. The complainant has represented in his written statement that he is not agreeable with the decision of the Company.

Observations/Conclusion

The Forum observed in this case that insured was covered under the above policy since 2012 and underwent Orchidectomy (torsion of left testis) on 19th August,2016. Patient was a known case of Coronary Artery Disease since 2010 and the same was not disclosed in the Proposal form. The Forum notes that as insurance is based on the principle of utmost good faith the insured should have declared his health history at the time of commencement of insurance. However the complainant's contention was that he had disclosed his father's hypertension in the Proposal form but as regards CAD since his father was treated with medicines only during his hospitalization of 2010 he has not disclosed. Though there is a Non disclosure on the part of the complainant by not disclosing patient's history of CAD of 2010 in the Proposal form, it is also to be noted that patient's current ailment for which he was admitted is not related to the patient's health history.

The Forum observes that **this policy has a waiting period of 36 months for all pre existing conditions declared and/or accepted at the time of application. Coverage under the policy for any past illness/condition or surgery is subject to the same being declared at the time of application and accepted by us without any exclusion.** However in this case the complainant has not declared his pre existing disease CAD but the ailment for which he underwent treatment is not related to the pre existing disease and this claim arose in the fourth year of insurance and therefore Company's total denial of above claim on the ground of Non disclosure and subsequent cancellation of policy is not justifiable and therefore the Company is directed to settle the above claim for 50% of the admissible amount and also to reinstate the policy as per norms by collecting appropriate premium from the insured.

Dated: 27.08.2017

Brief Facts of the Case :

Ms N is insured under the Health Policy along with her family and her son Mr S was admitted at Hospital from 11.11.2016 to 12.11.2016 for cut over left fore arm with knife where primary closure of wound was done and then started pain, swelling and tenseness of left fore arm and again admitted at Hospital from 19.11.2016 to 22.11.2016 for further management. The Company has repudiated both the claims on the ground that it is a self inflicted injury and hence not payable as per Policy Clause of the above policy which reads as under :

"Treatment of obesity, general debility, convalescence, run down condition or rest cure, congenital external disease/illness or defects or anomalies, sterility, venereal disease or intentional self injury and use of intoxicating drugs/alcohol". The complainant has submitted in her written statement that she is not agreeable with the decision of the Company.

Observations/Conclusion

Thus the Forum came to the conclusion that Company's denial of above two claims on the ground of Policy Clause 3 Sub Clause 10 of the policy stating that this is a self inflicted injury is not justifiable as this is an accidental injury while cutting fruits. The Company was therefore directed to calculate the admissible amount after deducting non medicals if any in both the claims and submit the same to the Forum. Accordingly the Company has calculated the admissible claim amount as Rs.18300/- for the first claim and Rs.159588/- for the second claim totaling to Rs.177888/-.

Dated: 28.08.2017

Brief Facts of the Case :

Ms A is covered under the above Policy and was admitted at Hospital for Gall bladder surgery from 04.10.2016 to 09.10.2016 and lodged total claim of Rs.160618/- and the Company has settled the claim for Rs.92060/- and deducted the balance amount as the insured has opted for higher room rent and the Surgeon fees and Anesthetist fees amounting to Rs.70000/- were paid separately by cheque and the Company has paid Rs.20000/- only as per Policy Clause no 3.9 which reads as **"No payment shall be made for any Hospitalization expenses incurred, unless they form part of the Hospital Bill. However the bills raised by Surgeon, Anesthetist directly and not included in the Hospital Bill shall be paid provided a numbered bill is produced in support thereof, for an amount not exceeding Rs.Ten thousand, where such payment is made in cash and for an amount not exceeding Rs Twenty Thousand, where such payment is made by cheque."** The complainant has submitted that she is not agreeable with the decision of the Company.

Observations :

The Forum observes in this case that insured has opted for higher room rent and the Company has not examined the room rates of other hospitals for Rs.3000/- in the nearby vicinity and therefore Company's proportionate deduction is not sustainable and the Company was also directed to settle the doctor charges and anesthesia charges by applying Customary and Reasonability Clause and submit the calculations accordingly within a period of one working day. Accordingly the Company has submitted the balance amount payable as Rs.32476/- vide their email and we find the same in order.

Dated: 28.08.2017

Brief Facts of the Case :

Ms K is covered under the above policy and was admitted at Hospital from 03.08.2015 to 05.08.2015 and underwent Angioplasty and lodged a total claim of Rs.709271/-. The complainant is also insured under Individual Mediclaim Policy of M/s B for a sum insured of Rs.500000/- and this Company has settled the claim for Rs.432703/- as the sum insured under this policy is exhausted. The complainant has claimed balance claim amount of Rs.276568/- under Super Top Up Policy and the Company has settled the claim for Rs.198016/- after deducting Rs.500000/- towards threshold limit and Rs.11255/- towards Non payable items (Pre post expenses). The complainant has represented in her written statement that she is not agreeable with the decision of the Company.

Observations/Conclusion

The Forum observes in this case that complainant is insured under two policies one Individual Mediclaim Policy for a sum insured of Rs.500000/- of M/s B and second from M/s T Super Top Up Policy for a sum insured of Rs.500000/- with a threshold limit of Rs.500000/-. Insured has lodged a total claim of Rs.709271/- first with M/s B and this Company has settled this claim for Rs.432703/- as the sum insured under this policy is exhausted. The balance claim of Rs.276568/- is lodged under Super Top Up Policy and under this Policy the Respondent has settled the claim for Rs.198016/- after deducting threshold limit of Rs.500000/- and Rs.11255/- (non payables including pre and post expenses).

The Forum observes that the policy conditions is silent about the coverage of pre and post hospitalization expenses and it is also noted that there is no specific exclusion stating that pre and post hospitalization expenses are not payable. Thus deduction towards pre and post hospitalization expenses is not justifiable and the Company is directed to settle the same. As regards deduction towards non medicals is not sustainable as the claim was first submitted to M/s B and they have already deducted certain amount as non medicals and therefore the Company is directed to settle the balance amount of Rs.11255/-.

Dated: 29.08.2017

Brief Facts of the Case :

Ms P wife of Mr R was admitted at Hospital from 16.11.2016 to 19th November,2016 for treatment of Ademomyosis with Fibroids uterus and underwent hysterectomy. Total cashless request for Rs.225000/- was sent and the Company sanctioned only Rs.120000/- as the limit for hysterectomy under twin sharing is only Rs.120000/-. Balance amount was claimed under reimbursement claim where the same was repudiated under Policy Exclusion Clause which says **"Unproven/Experimental Treatment"** (Robotic charges). The complainant has submitted in his written statement that he is not agreeable with the decision of the Company.

Observations/Conclusion

The Forum observed in this case the patient underwent hystrectomy (Robotic assisted) as per Doctor's advise. It is noted by the Forum that the above exclusion does not talk about Robotic equipment or Robotic charges and this equipment is actually operated by a Surgeon and it is also noted that there is no specific exclusion or capping in the above policy for Robotic surgery and this is a well approved procedure. Therefore Company's denial of Robotic charges on the ground of Policy Exclusion Clause is not sustainable and the Company is directed to settle the Robotic Charges of Rs.105000/-. The Company agreed for the same.

Dated: 29.08.2017

Brief Facts of the Case :

Mr J is covered under the above Group Mediclaim Policy issued to M/s T along with his dependents. Ms K mother of Mr was hospitalized for chemotherapy treatment for Left Breast Cancer on different dates in 2016. From the medical records it was revealed that patient is a known case of cancer and was taking treatment before inception of the policy. Therefore the Company has repudiated the claim on the ground of Pre existing clause and Non disclosure. The complainant has submitted in his written statement that he is not agreeable with the decision of the Company.

Observations/Conclusion

On perusal of the documents produced on record, it is observed that Ms Kwas hospitalized for chemotherapy treatment for Breast Cancer on different dates in 2016 and as per hospital records she is a known case of cancer and was under treatment even before commencement of the policy. However the said fact was not disclosed to the Respondent while obtaining the policy. Thus there was non disclosure of material fact on the part of the insured. This establishes that the insurance was taken with an intention of taking benefit under the policy for a known disease which is against the basic principle of insurance. At

the same time it is also observed that the policy issued by the Respondent clearly states that pre existing diseases are covered from day one. Clause of the Policy defines **"Pre existing Health condition/Disease" as "any ailment/disease/injuries that the person is suffering from (treated/untreated, declared or not declared in the Proposal form) while taking the policy for the first time".** From this it can be inferred that while waiving off the exclusion for pre existing disease, the Company has also waived off the disclosure of the same by stating "treated/untreated, declared or not declared in the proposal form". Therefore denial of the claim now on the ground of Non disclosure of Pre existing appears to be contradictory to the policy wordings. Also from the copy of the proposal form supposed to be filled in by the proposers to be submitted to Group (as exhibited by the complainant during the personal hearing), it is observed that there is no column asking for details of any pre existing diseases. It is not known on what basis Group mention these details in the list of members submitted to the Respondent while forwarding the proposal and the Respondent accepts the same as NIL PED for all the members without scrutiny.

This reflects the casual attitude of the Respondent in underwriting the proposal for which they should now own up responsibility. Furthermore it has also been brought to the notice of the Forum that the Respondent has paid the earlier claims of Ms K for the same ailment for which the Respondent submitted during the hearing that they had paid the same erroneously. In view of the aforesaid observations, repudiation of the present claims on the ground of Pre existing and Non disclosure of material fact is not sustainable and the Respondent is directed to settle the above chemotherapy claims for the admissible amount and submit the payment particulars to the Forum.

Dated: 29.08.2017

Brief Facts of the Case :

Dr M is covered under the above policy and she underwent treatment for chemotherapy (Breast Cancer) by administering Injection Zoledronic at Hospital on 12th November,2016 and injection Herceptin was given on 22nd October,2016. The Company has repudiated these two claims on the ground of Policy Clause which reads as **"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 hours 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 complainant has submitted in her written statement that she is not agreeable with the decision of the Company.

Observations/Conclusion

The Company was therefore directed to clarify whether they have paid stand alone Injection Zoledronic and Injection Herceptin claims and submit the same to the Forum with their final decision on the above two claims immediately. Accordingly the Company has sent a mail stating that they have paid earlier

standalone injection claims. The Company has worked out the admissible amount payable for these two claims as Rs.72029/- plus Rs.65380/- totaling to Rs.137409/-.

The Forum notes in this case that the complainant is undergoing treatment for Breast Cancer since 2015 and the Company has also settled similar standalone claims for administration of Injection Zoledronic earlier except these two claims. Therefore rejection of these two claims on the ground of Policy Clause less than 24 hours is not sustainable and the Company is directed to settle the above two claims for Rs.137409/- and submit the payment particulars to the Forum.

Dated: 29.08.2017

Brief Facts of the Case :

Mr R husband of Ms U is insured under the above policy and was admitted at Hospital from 20.07.2016 to 25.07.2016 for treatment of Left Lobe Pneumonia. As per hospital indoor case papers Mr R is a known case of HIV and Anti Retroviral therapy with hyperpyrexia. The Company has taken medical opinion which reads as " **left lower lobe pneumonia is attributable to his ongoing HIV infection, despite normal CD4 count".** Therefore Company has repudiated the claim on the ground of Policy Exclusion Clause which reads as **"Sexually Transmitted Diseases, any condition directly or indirectly caused to or associated with Human T Cell Lymphotropic Virus Tuype III (HTLB-III) or lymphadenopathy Associated Virus (LAV) or the Mutants Derivative of Variation Deficiency Syndrome or any syndrome or condition of a similar kind commonly referred to as AIDS"**. The complainant has represented in her written statement that she is not agreeable with the decision of the Company.

Observations/Conclusion

The Forum observes in this case that patient was admitted with complaints of fever, high grade since five days and was diagnosed as Hyperpyrexia with Lower Lobe Pneumonia. Patient is a known case of Retro Viral Disease (HIV) since ten years. The Company has repudiated the above claim by taking medical opinion which states that insured's pneumonia is attributable to his HIV positive status despite normal CD4 count. The Forum notes that HIV patient's level of immunity is low compared to others. However the fact also cannot be ignored in this case that the insured has claimed for the first time since 2006 although he has history of HIV since ten years and the line of treatment underwent by the patient during hospitalization is purely for pneumonia and not associated with HIV. Hence the Company's stand of repudiation of above claim on the ground of Policy Exclusion Clause is not sustainable and the Company is directed to settle the above claim for the admissible expenses. Accordingly the Company calculated the admissible amount as Rs.38860/-.

Dated: 29.08.2017

Brief Facts of the Case :

Mr T is covered under Group Mediclaim Policy issued to E. Mr T was admitted at Hospital from 21.12.2015 to 31.12.2015 for Carcinoma of Tongue. Patient had history of chewing tobacco from 6 years. The Company repudiated the claim on the ground of Policy Exclusion Clause which reads as under :

"Medical treatment following use of intoxicating drugs and alcohol or drug abuse, solvent abuse or any addiction on medical condition resulting from relating to such abuse or addiction". The complainant has represented in his written statement that he is not agreeable with the decision of the Company.

Observations/Conclusion

The Forum observes in this case that the complainant (expired two days back) was diagnosed as Tongue Cancer (Stage IVA) during the hospitalization period from 21.12.2015 to 31.12.2015 at Hospital. As per indoor case papers of the hospital patient had history of tobacco chewing since six years around 5 packets daily. However subsequently the complainant has submitted a letter from treating doctor which states that complainant had stopped tobacco chewing since six years. The said letter was provided by the doctor on the request of the complainant for insurance purpose which is clearly mentioned in the letter. The Forum notes that cousin of the complainant has submitted Judgement copy of Consumer Court during the hearing which states that Cancer can occur due to causes other than chewing tobacco.

The Forum observes that though there are many causes for Carcinoma of tongue other than chewing of tobacco, the fact that chewing of tobacco is one of the major cause for tongue cancer cannot be ignored as far as this case is concerned. The Forum notes that Company has obtained independent medical opinion from an Oncologist Dr S which reads as under :

"As per indoor case papers of Hospital patient Mr T was chewing tobacco for six years daily five packets. There is a strong causal relation/association between tobacco chewing habit and carcinoma of tongue."

Therefore Company's repudiation of above claim on the ground of Policy Exclusion Clause cannot be faulted with. The Forum do not find any ground to intervene with the same and pass the following Order.

The complaint of Mr T against B in respect of repudiation of his hospitalization claim from 21.12.2015 to 31.12.2015 for Carcinoma of Tongue does not sustain. The case is disposed of accordingly.

If this Award is not acceptable to the complainant, he is at liberty to approach any other Forum, as he may deem fit.

02.04.2017

Brief Facts of the Case :

Ms M is covered under Group Health Insurance Policy for the policy period from 31.10.2015 to 30.10.2016. The complainant had filed claim for reimbursement of expenses incurred for aesthenopia of both eyes. On investigation it was observed that complainant underwent Lasik surgery at Nursing Home for both her eyes on 6th August,2016. The complainant has lodged total claim of Rs.80663/- and the Company repudiated the claim on the ground of Policy Exclusion Clause No which reads as :

"Lasik Surgery, Septioplasty, infertility & Related ailments including male sterility, treatment on trial/experimental basis, Admin/Registration/Services/Misc.Charges/Expenses on fitting of Prosthesis. Any device/instrument/machine contributing /replacing the function of an organ, Hotler monitoring are outside the scope of the policy."

Observations/Conclusion

The Forum observes in this case that Ms M underwent Lasik Surgery (aesthenopia) of both eyes on 6th August,2016 at Nursing Home and the Company has repudiated the above claim as Lasik surgery is specifically excluded under the above Group Policy. However, the Forum notes that the terms and conditions attached with the Identity card of the customer is not complete and there is a foot note written in small which reads **"Please approach the insurance company Call Centre for further details of the policy terms and condition".** The Company should take a serious note of this and the complete terms and conditions of the policy should be shared to all members of the group. The Forum notes that Company has taken a confirmation from Jain International Organization vide their letter dated 28th February,2016 which reads as **"We reiterate that all the members are aware of the terms and conditions of the policy and have taken the policy after accepting the same".** However has not shared this information (policy terms and conditions) to their members. Therefore Company's repudiation of above claim on the ground of Policy Exclusion No which specifically excludes Lasik Surgery is sustained. The Forum do not find any ground to intervene with the same and pass the following Order.

The complaint of Ms M against I in respect of repudiation of her hospitalization expenses incurred for aesthenopia of both her eyes at Nursing Home and on 6th August,2016 does not sustain. The case is disposed of accordingly.

If this Award is not acceptable to the complainant, she is at liberty to approach any other Forum, as she may deem fit.

02.04.2017

Brief Facts of the Case : Complainant was admitted to hospital from 26.02.2016 to 27.02.2016 and again from 29.02.2016 to 01.03.2016 and thereafter to another hospital from 25.03.2016 to 28.03.2016 for the treatment of Calculus of Kidney and Ureter. While the first claim was settled by the Respondent, the 2nd and 3rd claims were repudiated since it was noticed that the claimant had h/o HBSAG since 5 years which fact was not disclosed while taking the policy.

Observations/Conclusion of the Forum: The complainant had ported his policy from his previous insurance company in the year 2014. The subject claims were lodged in the second renewal of the policy with the second insurer. The Discharge Summary of the first hospital mentions that the patient was a known case of HBSAG since 5 yrs. The complainant claims that the history was recorded wrongly in the hospital records. In that case, if there was any error in the hospital notings, the complainant/his relatives should have got the same rectified immediately. The history of 11 months mentioned in the records of the second hospital was after denial of the cashless claim for the first hospitalization and hence there appears to be substance in the Respondent's contention that it could be an after-thought. Although the treating doctor at the second hospital has issued a certificate stating that his condition of HBsAg positive is not a cause for ureteric calculus, nevertheless the fact remains that the said history was not disclosed while opting for the policy with the Respondent. This was an important health condition which ought to have been disclosed while proposing for insurance to enable the insurers to evaluate the risk in its proper perspective. Insurance contracts are governed by the principle of utmost good faith which requires both parties of the insurance contract to deal in good faith and in particular it imparts on the proposer a duty to disclose all material facts which relate to the risk to be covered. Failure on the part of the complainant to mention these facts to the Insurance Company certainly amounts to non-disclosure/ suppression of material information entitling the Company to deny liability arising under the policy even though this information may or may not be related to the claim/s lodged subsequently. Under the facts and circumstances of the case, the decision of the Respondent to repudiate the claim on the ground of non-disclosure of material information, cannot be faulted with and the complaint lodged against the Respondent does not sustain.

Dated: 12.05.2017

Brief Facts of the Case : Complainant's son aged 5 months was admitted to Hospital from 13.06.2016 to 22.06.2016 and operated for Ventricular Septal Defect. Respondent denied the claim for the said hospitalization citing Clause 4.8 of the policy which excludes congenital diseases from the scope of the policy. Complainant argued that the antenatal Anomaly scan as well as fetal growth Scan done at the Hospital did not reveal any abnormality, especially no cardiac abnormality and hence the ailment suffered by his son was not congenital.

Forum's observations/Conclusion: The hospital discharge card mentions diagnosis as ACHD. The Paediatric Echocardiography and Colour Doppler Study also mentions Impression : Congenital heart defect. Clause 4.8 of the Family Floater Policy permanently excludes all internal and external congenital diseases from the scope of the policy. Even as per the revised policy, claims for congenital internal diseases are covered only after a Waiting period of two years while the subject claim has been lodged in the first year of the policy. Under the facts and circumstances of the case, repudiation of the claim by the Respondent being in accordance to the policy terms and conditions, the Forum does not find any valid ground to intervene with the decision of the Respondent in the matter and hence no relief can be granted to the complainant.

Dated: 15.06.2017

Brief Facts of the Case : Complainant's mother-in-law was suffering from Liver Cirrhosis and in January 2016 she was advised by the doctor to get registered for a liver transplant. In June 2016 she was admitted to the Hospital and underwent surgery for Deceased Donor Liver Transplantation. The claim lodged under the policy was closed without giving any reason. Complainant argued that the policy covered pre-existing diseases and hence denial of the claim by the Company was not justified.

Forum's Observations/Conclusion : As per Discharge Summary, the patient was a k/c/o non-alcoholic steolohepatitis (NASH) related Chronic Liver patient with Portal hypertension. She had undergone CT abdomen on 03.11.2015 which showed chronic liver disease with portal HTN. From this it is evident that the disease for which the insured was treated was pre-existing to the inception of the policy in February 2016. Also the complainant had knowledge of the fact that the patient would require a surgery for liver transplant; however the said fact was not disclosed to the Insurance Company while proposing for insurance. Besides, the mandated insurance broker of the insured JIO group had given details of members which showed that the said patient had NIL pre-existing disease. This establishes that the insurance was taken by the complainant with an intention to defraud the Company as rightly pointed out by the Respondent, for taking benefit under the policy for a pre-planned surgery, which is against the basic principle of insurance. One of the fundamental tenets of insurance is that insurance policies provide coverage against fortuitous losses. A fortuitous loss is a loss that occurs at a time and in such a way that

an insured cannot be held to have anticipated. Although the policy covers pre-existing diseases, a fortuity requirement ensures that one cannot insure against an event that is certain to take place as insurance is supposed to provide cover for a contingency i.e. for an unforeseen event. It is against public policy to insure a certainty as opposed to a risk. Insurance Companies are custodians of public money and hence such fraudulent practices cannot be encouraged. Hence the complaint does not sustain. At the same time, it is also expected of the Insurance Companies to exercise utmost care at the underwriting stage itself to eliminate such groups formed with a fraudulent intention to derive undue benefits from the policies. The Company should also take steps to lodge police complaints against such miscreants with a view to curb such practices against the society.

Dated: 20.06.2017

Brief Facts of the Case : Complainant was admitted to Hospital from 07.06.2016 to 09.06.2016 for the treatment of Right Maxilla Recurrent Ameloblastoma. Respondent rejected the claim for the same stating that dental treatment which is not directly attributable to accident/injury is not payable as per Exclusion Clause 4.5 under the policy. Complainant argued that it was not a dental treatment but the treatment was for a tumor in the jaw which was life threatening. She produced a certificate from her treating doctor wherein the doctor has stated that the treatment was for tumor in the jaw and consisted of resection of bone. She pointed out that she underwent the same treatment in 2006 and all the medical expenses were paid by the Company at that time. She added that she was insured with the Company since the year 1998 and these were the only two claims lodged by her in all these years.

Forum's Observations/Conclusion : The complainant has produced a certificate from treating doctor stating that the patient was diagnosed as a case of Ameloblastoma which is a benign odontogenic neoplasm (tumor) with high propensity of recurrence. This is not a developmental disorder of the pulp, but a benign neoplasm which requires surgical treatment under general anesthesia in the operation theatre set up. In the above view the patient has gone under appropriate treatment by oral and maxilla facial surgeon. The Respondent has not produced any opinion from a specialist to counter the said argument. Therefore, it would not be correct to say that the treatment undergone by the complainant was a dental treatment as it was not a treatment taken for routine dental problems or for maintenance purpose. The procedure was necessitated due to formation of a cyst which is a much severe problem and for that matter, a cyst can develop in any part of the body which is payable under the policy. Besides, in the instant case, the policy has run for nearly 20 years with only one claim for the same ailment lodged in all these years and as stated by the complainant, the earlier claim for the same treatment lodged in the year 2006 was settled by the Respondent. Therefore there is no reason why the subject claim should now be denied by them. The decision of the Respondent therefore does not sustain and the Respondent is directed to settle the claim for the admissible expenses of Rs.1,38,428/- in favour of the complainant, towards full and final settlement of the complaint.

Dated: 23.06.2017

Brief Facts of the Case : Complainant's wife was admitted to Nursing Home from 01.08.2016 to 02.08.2016 and underwent Excision of Bilateral Axillary fat deposits. Respondent repudiated the claim stating that the treatment was done for cosmetic purpose not payable as per Clause no. 4.4.2(b) of the policy.

Forum's Observations/Conclusion : On perusal of the documents produced on record it was observed that the insured had developed lumps in her arm pits which were painful for which she consulted a physician; however her complaints did not subside despite taking medication. She then consulted the Surgeon who advised her to go in for a surgery considering the possibility that the lumps could later on turn to be cancerous. In such a situation, no person would take the risk of going against a doctor's advice. The treating doctor has even issued a certificate stating the lumps carried chance of neoplasia in future (liposarcoma). The Respondent has not produced any evidence to substantiate their stand that the surgery was performed for cosmetic purpose. The decision of the Respondent therefore cannot be sustained and the Respondent is directed to settle the claim for the admissible expenses of Rs.32,101/- in favour of the complainant, towards full and final settlement of the complaint.

Dated: 27.07.2017

Brief Facts of the Case : Complainant's brother was admitted to Hospital from 27.12.2016 to 31.12.2016 with diagnosis of Ca Right Lateral Border of Tongue and underwent Hemiglossectomy for the same. Respondent repudiated the claim for the said hospitalization on the ground that the insured had history of tobacco chewing and as per policy terms and conditions, use of tobacco leading to cancer is excluded from the scope of the policy. Complainant submitted that in the hospital, her brother was asked about his habits when he mentioned that he used to chew tobacco in the past during his young age but had stopped since many years. Complainant pleaded that cancer can be caused due to various factors and is not necessarily caused due to tobacco.

Forum's Observations/Conclusion : Although the complainant claims that her brother quit use of tobacco many years back, the hospital papers clearly record him as "Tobacco chewer – stopped since 2 months". As per available information tobacco chewing and smoking are the most important oral cavity and oropharyngeal cancer risk factors. Mouth cancer is largely a lifestyle disease, meaning that the majority of cases are related to tobacco and alcohol use. Cigarette, cigar and pipe smoking are the main forms of tobacco use in many parts of the world. However, the traditional habits in some cultures of chewing tobacco, betel quid, gutkha and paan are particularly dangerous. Approximately 90% of the people with mouth cancer are tobacco users. Those who both drink and smoke have a 15 times greater risk of developing mouth cancer than others. Even the past history of tobacco chewing would be a pre-disposing factor, as the cells in the lining of the oral cavity would have been damaged because of the long standing habit and even with withdrawal at a later date, it might reach a dreaded point. Respondent has also produced an opinion from an oncologist stating that this cancer is related to tobacco chewing i.e. tobacco chewing is the direct cause of malignant neoplasm of tongue. Clause 4.21 of the policy excludes

reimbursement of expenses under the policy for treatments arising out illness/disease/injury due to misuse or abuse of drugs/alcohol or use of intoxicating substances. In view of the above, repudiation of the claim by the Insurance Company being as per policy terms and conditions, is found to be in order.

Dated: 11.08.2017

Brief Facts of the Case : Complainant's wife sustained Femur Fracture due to fall on 06.06.2016 and was admitted to Hospital for treatment. Respondent repudiated the claim stating that she had past history of Rheumatoid arthritis which was not disclosed at the time of inception of the policy. Complainant argued that his wife fell down on the road due to an accidental slip which was the proximate cause of her hospitalization. The Insurance Company was unnecessarily linking the same with her past disease which was already cured 7-8 years back and had no relationship with the present accident. It was contended on behalf of the Respondent that Rheumatoid arthritis is an Auto immune disease which is a declined risk as per the Company's underwriting guidelines and had the insured declared her past history, the policy would not have been issued at all.

Observations/Conclusion of the Forum: The hospital papers clearly mention that Ms. Snehal Mokle was a k/c/o Rheumatoid Arthritis since 8 years. This was an important health condition which ought to have been declared by her at the time of proposing for a health insurance policy to enable the insurer to evaluate the risk in its proper perspective and decide about acceptance or otherwise of the same. The proposal form contains a specific question eliciting information whether the proposer has ever suffered from any disease of bones/joints to which she had replied in the negative. This certainly amounts to non-disclosure of material fact on the part of the insured and therefore the decision of the Respondent to deny the claim cannot technically be faulted with. However, at the same time it is also noted that the hospital papers also mention that the patient was not on any continuing treatment for RA. The complainant has also produced a certificate from the doctor who had treated the patient for RA 7-8 years back, which states that she was on treatment for the same only for two months after which she was totally asymptomatic. Besides, the present claim has arisen out of an accident. Hence taking a considerate view of the situation, the Forum is of the opinion that the claim may be allowed to the extent of 50% of the admissible amount, to resolve the dispute in the present case. The Respondent is directed to reinstate the subject policy and pay an amount of Rs.1,12,544/- (50% of the admissible claim) in favour of the complainant, towards full and final settlement of the complaint.

Dated: 18.08.2017

Brief Facts of the Case : Complainant's new-born son was admitted to Children's Hospital, from 16.12.2015 to 27.12.2015 and operated for Hydrocephalus right side. A claim lodged for the same was repudiated by the Insurance Company stating that the treatment was for external congenital disease excluded from the scope of the policy. Complainant argued that as per certificate issued by the Neonatal & Pediatric surgeon who has treated his son, Hydrocephalus is an internal congenital disease.

Forum's Observations/Conclusion : On scrutiny of the documents produced on record coupled with the depositions of both the parties, it is observed that the complainant's son born on 16.12.15 was diagnosed with congenital hydrocephalous during an USG done prior to his birth and was operated with shunt insertion for the same on the third day after his birth. **Hydrocephalus** is a condition in which there is an accumulation of cerebrospinal fluid (CSF) within the brain. This typically causes increased pressure inside the skull. An unusually large head is the main sign of congenital hydrocephalus. In the instant case also, the head circumference of the baby at birth was noticeably more than the normal size. Thus, the abnormality was visible and hence the Respondent's contention that it was an external congenital anomaly cannot be faulted with. The policy issued to the complainant covers only internal congenital diseases and hence the decision of the Respondent to repudiate the claim being as per policy terms and conditions, does not call for any intervention.

Dated: 23.08.2017

Brief Facts of the Case : Complainant was admitted to Hospital from 31.07.2015 to 11.08.2015 for the treatment of Spinal disorder. Respondent repudiated the claim on the ground that as per policy clause 4.1 (b)(i)(l) there is a Waiting Period of 24 months for any claim for or arising out of Spinal Disorders. Complainant submitted that the Insurance Co. pointed out that the cervical spine MRI showed degeneration in the adjacent discs which implied that he was suffering from a spinal disorder. However, he never had any problems related to spine in the past and the injury to the spine was caused only due to the accidental fall which necessitated a life-saving surgery without which he would have been left paralysed for life. Thus he was treated for an accidental cervical spinal injury and not for a chronic spinal disorder which had a waiting period of two years.

Forum's Observations/Conclusion : The matter was referred for expert medical opinion of a Consulting Orthopedic Surgeon, who after reviewing the reports of the patient, was of the opinion that this is acute-on-chronic cervical myelopathy involving C4-5, C5-6. The fall resulted in acute symptoms which required surgical intervention. From this, it is evident that although the complainant was suffering from spinal disorder, the surgery was necessitated due to the acute pain resulting from the fall which was the proximate cause of hospitalization. The decision of the Respondent therefore to deny the claim by invoking the policy clause relating to Waiting period for Spinal disorders, is not justified and cannot be

sustained. The Respondent is directed to pay an amount of Rs.4,80,115/- less non-medical expenses, if any in favour of the complainant, towards full and final settlement of the complaint.

Dated: 28.08.2017

Brief Facts of the Case : Complainant lodged two claims, one under Major Medical Illness Section and another under Personal Accident Section of the policy in respect of death of her husband due to Dengue. The claims were repudiated on the ground that the ailment suffered by the insured did not fall within the policy purview. Complainant submitted that while taking the home loan, her husband was advised to take a life policy for which they were made to pay a premium of Rs.66,000/-; however ultimately he was given Home Suraksha Policy which is meant to cover the house taken on loan. Thus they were issued a wrong policy in place of a life cover and now the Company was denying the death claim of her husband stating that the cause of his death was not covered under the policy. She argued that dengue is caused by mosquito-bite which is also an "accident" as held by the Hon'ble National Commission in its recent judgement.

It was contended on behalf of the Respondent that the judgement of the Hon'ble National Commission referred to by the complainant could not be applied in the instant case as in that particular case the term "accident" was not defined under the policy and hence the Forum proceeded to define the said term with the definition available in the Oxford Dictionary whereas in the present case, the policy wordings clearly define the terms "Accident" as well as "Personal Accident" and the cause of insured's death did not fit within the said terms.

Forum's Observations/Conclusion : In the instant case, the ailment viz. Dengue which led to the death of the insured, is not covered under Major Medical Illness & Procedures section of the policy. The death was also not due to "accident" as defined under the policy issued to him. Hence repudiation of the claim being in accordance with the policy terms and conditions, the decision of the Respondent cannot be faulted with. However, in this context the Forum would like to place its observations on record. The instant policy was specifically taken as a security against the loan taken for housing purpose. The object of availing any Insurance Policy is that the need for which the required cover is sought should be fulfilled by the Policy which is sold. Whenever a policy is sold as collateral to a mortgage loan taken from the Bank, it should cover all the eventualities so that in the event of a death, the appropriate benefits are derived by the nominees of the deceased insured. Any sale of a policy which is sold to cover a mortgage loan, if it does not conform to this criterion, has to be taken as a "wrong sale". In the opinion of the forum, the insured should have been sold a simple term Insurance Policy or Decreasing Mortgage Redemption Policy and this cover could have been given at a low premium for the entire mortgage term. Unfortunately, the intermediary of the Insurance Co. sold a policy which was not meant for this mortgage cover and as the death occurred out of an ailment not covered under the policy, the Insurance Company rejected the claim

based on the policy conditions. Whilst the Forum does not want to fault the decision of the Insurance Company to repudiate the claim, we cannot but refrain from making an observation that the Insurance Company is at fault in selling a Policy which did not meet the purpose for which it was sold. This action of the Company is not fair as it goes against the fundamental principle of need-based selling. In view of such mis-selling by the intermediary of the Company, it would only be in order that the Company owns up responsibility and refunds the premium amount to the complainant to meet the ends of justice.The Respondent is directed to refund the premium amount of Rs.57,248/- to the complainant. There is no order for any other relief.

Dated: 29.08.2017

Brief facts of the case:

The complainant was admitted to hospital on 31.03.2016 and 01.04.2016 for treatment of left eye Macular Edema and treated with Intravitreal Injection Accentrix. He preferred a claim with the Insurance Co for total Rs.27,235/- but the same was rejected on the grounds that the administering of the injection is an OPD procedure. He cited the precedent from Ombudsman Ahmedabad Award No.11-002-0265-10 in favour of the aggrieved part in the similar case. He has attached literature from Novartis Pharma AG Basel, Switzerland suggesting the administration of the injection should be carried out under aseptic condition and that is not available under OPD. He has requested the Insurance Company to detail him specificallym under which clause of the policy, the administration of Accentrix is not covered.

Forum's observations :

The Forum observed that the complainant was treated for Macular Edema which is age related for which Injection.Accentrix was administered. The same is specifically excluded under the terms and conditions of the policy. In view of the same, denial of the present claim by the Respondent under clause 2.3 (a) which excludes expenses on hospitalization for less than 24 hours cannot be faulted with and the Forum does not find any valid reason to intervene with the decision of the Respondent, consequently no relief can be granted to the complainant.

Dated: 30.06.2017

Brief Facts of the Case :

The complainant underwent treatment for right lower third molar extraction at a dental clinic from 24.05.2016 and discharged on 42.05.2016 He did not require 24 hours hospitalization. He preferred a claim with the Insurance Co. which was repudiated under Clause 4.7 .

Forum's observations :

The Forum observed that the procedure is done on OPD basis by a dentist in a dental clinic under local anesthesia. The procedure was not done in OT and by a dental surgeon hence it does not fall under the definition of dental surgery. The complainant has undergone only tooth extraction which is not a surgery. The Respondent has repudiated the claim under exclusion clause 4.7 which clearly

states that dental treatment or surgery of any kind unless requiring hospitalization. The Forum noted that the claim has been rejected in consonance with the agreed terms of the policy which disallows any claim under dental treatment or surgery which does not require hospitalization. Hence the Forum does not find any valid reason to intervene in the decision of the Respondent, consequently no relief can be granted to the complainant.

Dated: 27.04.2017

Brief Facts of the Case :

The complainant was admitted to hospital from 29.05.2016 to 30.05.2016 to undergo laser piles surgery. He preferred a claim with the Insurance Company for Rs.90,000/- which was repudiated on the grounds of non disclosure/misrepresentation of piles. They alleged that his illness was more than 6 months old.

Forum's observations/conclusions:

The Forum questioned the Respondent whether the claim history was obtained from the earlier insurer and if not, why they had ported the policy and penalized the complainant. The complainant was covered for 5 years with another Insurance Co. for sum insured of Rs. 10 lacs and had he continued with the old policy he would have got the full claim. On the Respondent's remark that the complainant had not disclosed his illness in the proposal form, the Forum pointed out that no credence could be given to it since the questions in their proposal form are not specific. The Forum further stated that when a policy is ported the Insurance Co. is duty bound to get all information from the earlier insurer. The existing benefits of earlier policy cannot be denied. Moreover, the onset of piles is 6 months which the complainant has even declared and the same is mentioned in the hospital discharge summary. The denial on this ground was not justifiable.

On the basis of the above, the Respondent is directed to pay the admissible claim to the complainant.

Dated: 27.04.2017

Brief Facts of the Case :

The complainant had complaints of intermenstrual bleeding due to endometrial poly and underwent hysteroscopy polypectomy D & C on 01.06.2016 for the same. She preferred a claim with the Insurance Co. which was repudiated on grounds of non disclosure of material facts.

Forum's observations:

The Forum observed that there was non disclosure of D & C done in 2013 for menorrhagia. In the proposal form, under the head `**Medical History'**, the complainant has answered in the negative for the questions regarding previous hospitalization and consultation. The Forum clarified to the complainant that on the ground of non disclosure of previous ailment, the present hospitalization claim would not be payable. However, if the complainant gave his consent for applying pre-existing condition as mentioned by the Respondent, then the waiting period of 4 years would be applied from the inception of the policy, i.e. 2014. The Forum informed the complainant that it would give directions to the Respondent to reinstate the policy with the requisite premium with continuity benefits but with application of exclusion of the pre-existing condition. The complainant agreed to continue the policy. On the basis of the above, the Respondent is directed to reinstate the policy of the complainant with exclusion of pre-existing condition. Hence the Respondent's decision is intervened by the following Order:

Dated: 27.04.2017

Brief Facts of the Case :

The complainant, 90 years old was admitted to a Eye Hospital on 24.06.2016 for treatment of right eye with Injection Avastin. He preferred a claim with the Insurance Co for Rs. 8,900/- which was repudiated by them on the grounds of less than 24 hours hospitalization.

Forum Observations :

The Forum scrutinized all the documents submitted to its Office and observed that although 24 hours hospitalization is not required in such treatments because of advancement of medical technology, the injection is required to be administered in the operation theatre under sterile environment. Also, this treatment is prolonged and repetitive in nature. Therefore, taking a practical, thoughtful and considerate view of the facts, the Forum decides that it would be reasonable that the complainant bears a part of the expenses and accordingly concludes that the admissible expense of such treatment is to be shared equally between the complainant and the Respondent. In view of repeated course of treatment, having already decided vide earlier Awards passed in regard to the similar treatment undergone by the complainant, the Forum agrees that the same extent of sharing the admissible expense is admissible.

Dated: 30.06.2017

Brief Facts of the Case :

The complainant's wife was admitted to a hospital from 12.04.2016 and discharged on the same day for the procedure of L3-L4-5 disc prolapsed. He preferred a claim with the Insurance Co. which was rejected on grounds of less than 24 hours hospitalization.

Forum's observations :

The complainant informed the Forum that his claim was repudiated citing clause 2.16.1 on the grounds of less than 24 hours hospitalization. He brought it to the notice of the TPA and the Insurance Co. that his policy did not have the above clause; they subsequently rejected it under clause 3.4. When the Forum questioned the Insurance Co. about this lapse, they expressed their ignorance about the same and pointed out that the repudiation letter was sent by the TPA and not by them. On this the Forum questioned the Insurance Co. whether the letter is directly sent to the complainant and not routed through them. The Insurance Co. replied that they did not send the repudiation letter to the complainant. They referred to the repudiation letter citing clause 3.4 and hence the Forum pointed out why such an error was committed by them. The Forum, hence, on the account of the error on their part regarding the repudiation clause, directed the Insurance Co. to pay to the complainant the admissible expenses amounting to Rs. 17,622/-, as calculated.

Dated: 23.05.2017

Brief Facts of the Case :

The complainant's father was admitted to a Ayruvedic Medical College Hospital from 11.07.16 to 25.07.2016 for treatment of cervical spondylosis. She preferred a claim with the Ins.Co. for Rs. 35,415/- which was repudiated on the grounds of clause No.2.1, "In case ayurvedic/homeopathies/unani treatment, hospitalization expenses are admissible only when the treatment is taken as in-patient in a government hospital/medical college hospital."

Forum's observations :

The Forum observed that when the earlier two claims have been processed and settled by the same TPA why the present claim cannot be settled. The contention that the earlier claims were paid erroneously was not acceptable to the Forum. Moreover, the claim has been repudiated on the ground that "ayurvedic treatment taken as in patient in a government hospital/medical college hospital" is only payable whereas it is observed by the Forum that the complainant's father had taken treatment in an ayurvedic medical college. The Forum instructed the Respondent to verify from the TPA about the details of the earlier payments made to the complainant for the treatment taken in the same hospital and inform the Forum. The Respondent responded via email and confirmed about the two claim payments made to the complainant. On the basis of the above, it would be in order to allow the present claim also.

Dated: 22.06.2017

Brief Facts of the Case :

The complainant was admitted in a hospital on 29.12.2015 and was operated on 30.12.2015 for short tongue/tongue tie. He preferred a claim with the Insurance Co. but the same was rejected on the grounds of congenital external anomaly. He submitted that he faced difficulty in tongue movement for the past 2-3 years. He visited a local hospital on 19.10.2015 and was diagnosed with short tongue/tongue tie. The doctors there advised him surgery as the only option to correct the anomaly. He took second opinion from a doctor who confirmed tongue tie laser operation and accordingly he was admitted in BCJ Hospital on 29.12.2015 and was operated on 30.12.2015. He preferred a claim with the Insurance Co. but the same was rejected on the grounds of congenital external anomaly. He argued that he experienced difficulty in pronouncing words since 2-3 years only and it was not since birth.

Forum's observations/conclusions :

The Forum noted that tongue-tie or also known as ankyloglossia is a congenital anomaly which is acquired from the family tree. This condition has been reported to be running from the family and is considered more prevalent in males than in females. It has also been reported that this congenital problem is from the mother's inadequacies when pregnant with the child. Tongue tie is basically described as the decrease in size of the tongue tip which results in its decrease in mobility. It is also described as partial fusion of the tip of the tongue and the floor of the mouth. Because of this congenital anomaly, there is affectation of the lingual frenulum that movement limitation of the tongue progresses. The only alteration is that there is still part of the frenulum, but it is abnormally short. This restriction then results in the condition tongue-tie which is basically a literal description of the oral problem. The Forum observed that there were no medical morbidities or etiological factors in the clinical history that would have been responsible for tongue-tie. The clinical diagnosis was tongue-tie (Ankyloglossia) that necessitated surgical release for mobility and speech. The abovestated clearly points out that the ailment was present since birth to qualify as congenital. In view of the same, denial of the present claim by the Respondent under clause 4.5 which excludes congenital external anomalies cannot be faulted with and the Forum does not find any valid reason to intervene with the decision of the Respondent, consequently no relief can be granted to the complainant.

Dated: 14.06.2017

Brief Facts of the Case:

The complainant was admitted in hospital on 06.08.2016 with the complaint of Lesion over floor of mouth on left side and procedure of Biopsy was performed under local anesthesia and discharged on the same day. He lodged a claim amounting to Rs.14541/-to the Company which was rejected under exclusion clause2.16.1 of the policy stating that hospitalization benefits are admissible only if hospitalization is for a minimum period of 24 hours.

Observations/Conclusion:

In view of the above and deposition made by both the parties, the Forum observed that the patient is suffering with tongue cancer. He was operated for the same on 02.01.2013 followed by radiotherapy and was advised for regular checkup. During checkup only the Doctor found an ulcer on his tongue on same place where he was operated for cancer and advised him to go for biopsy. The Forum also observed that biopsy was necessary to diagnose that the existence of ulcer on tongue may be because of recurrence of cancer. Hence, the stand of the Company to reject the claim under exclusion clause No.2.16.1 of the policy is not justified.

Dated: 27.07.2017

Brief Facts of the Case:

The insured was admitted in hospital with complaint of chest discomfort for the period from 01.07.2016 to 01.08.2016. She was diagnosed with acute vertigo, diabetes mellitus, Renal insufficiency and osteo arthritis of both knees. She was treated with oral medicines and physiotherapy was given to her during hospitalization. She lodged a claim for Rs.149593/-which was denied by the Company saying that hospitalization was for investigations purpose only. The complainant submitted that the patient was admitted in the hospital for chest discomfort only but during hospitalization she was attended by ENT specialist Doctor and investigated and diagnosed with acute vertigo. After all investigations she was diagnosed with the above ailments and therefore she was treated for the same.

Observations/Conclusion:

Taking into account all the facts and submission made by both the parties the Forum observed that hospitalization was for chest discomfort and cause of the ailment can be diagnosed after investigation only for the further treatment. During hospitalization she underwent various investigations and diagnosed with the above ailments and treated for the same with oral medicines and even physiotherapy was given to the patient during entire hospitalization. Hence, the stand of Respondent to repudiate the claim under clause 4.11 – "Hospitalization for evaluation purpose-not payable" is not justified. Therefore, the Forum directed the Respondent to calculate the claim for payable claim amount to the insured.

Dated: 08.08.2017

Brief Facts of the Case:

The Insured was treated for Left Great toe Nail removal in hospital on 05.07.2016 on OPD basis. She lodged a claim for Rs.25086/- which was repudiated on the ground that the said procedure is not listed in day-care procedure of the policy. Hospitalization benefits are admissible subject to hospitalization for a minimum period of 24 hours as per policy clause 2.17.

Observations/Conclusion:

Taking into account the facts and circumstances of the case and deposition made by the complainant the Forum observed that the insured aged 75 years needs some extra care while passing through such a critical procedure of nail removal. The procedure was done in a day-care-center under anesthesia, which does not require hospitalization due to advanced technology. Hence, the decision of the company is intervened by the order that the company is directed to settle the claim for Rs.25086/-in favour of the complainant, towards full and final settlement of the complaint.

Dated: 27.07.2017

Brief Facts of the Case :

The complainant was covered for a sum insured of Rs.2,00,000/-+Rs.1,00,000/-cumulative bonus. He has ported policy for the period from 24.03.2016 to 23.03.2017 to the company B from the company A, where he was covered since last 4 years. He was hospitalized for Left Eye Cataract in Hospital on 14.04.2016 and submitted a claim for Rs.45,491/-which was repudiated by the company B on the ground that the Client was suffering with dimness of vision at the time of porting policy and he has not disclosed the material facts in the proposal form dated 16.03.2016, which is a breach of Contract.

Observations/Conclusion

The Forum observes in this case that the complainant was covered with the Company A since 4 years and ported his policy to the Company B from the fifth year. The complainant is entitled for all the continuity benefits in his current policy with company B. While filling the proposal form, the complainant was not aware of the exact cause of decrease in vision and submitted that it was not such a serious ailment as to be disclosed in the proposal form. He came to know about the ailment only when he consulted the Doctor at in hospital on 23.03.2016.It is unfortunate to find that the Company has denied the claim on such flimsy grounds of " case of decreased vision since 15-20 days" when the policy was ported with continuity benefits of 4 years.

Therefore Company's stand of denial of above claim under policy "Definition of word No.49" disclosure to information norm is not sustainable and the Company is directed to settle the claim for the admissible

claim amount with interest @ 1% above bank rate from one month after submission of final claim documents till the date of payment.

Dated: 23.05.2017

Brief Facts of the Case:

The complainant Mr. Nilesh Sinha boarded a local train on 22.12.2015 at Andheri station after which he found that his mobile was missing from his pocket. He lodged a claim under the policy for Rs.72000/- which was rejected by the Respondent under exclusion clause 7.1 of the policy which reads "Loss such as: Lost, forgotten, misplaced, left unattended, fallen and any loss under mysterious circumstances."

Observations/Conclusion:

The Forum observed that the Company is least bothered about their case. The Company has proved their irresponsibility by not sending the written statement as well consent letter to the Forum. Hence, the Forum could not know what was the defence of the Company.

However, the Forum analyzed the case independently based on available papers and observed that insured's mobile handset was stolen fom his trouser pocket on 22.12.2015 while boarding the train from Andheri station which he came to know after boarding the train. It is noted by the Forum that in this case the Company has not called for the Police Final Investigation Report. The Company has repudiated the above claim on the ground of Policy Clause (mysterious disappearance) is not sustainable as in Form 2A submitted by the complainant duly attested by Andheri Police Station which mentions the FIR number also clearly states that the mobile handset was stolen. Hence, the Company is directed to settle the above claim deducting special excess of Rs.500/-against total claim.

Dated:10.08.2017

Brief Facts of the Case:

The insured was operated for Right Eye cataract at Eye Hospital on 28.03.2015 & Left Eye cataract on 30.03.2015. He lodged a total claim for Rs.100000/-which was settled for Rs.48000/-deducting Rs.52000/-. The complainant submitted that he has a long-standing association with the Respondent as he is holding policy since 1998. He also submitted that as he is holding very old policy which should not have any capping limit. He stated that he is not aware of revision of old policy to New mediclaim policy, as his policy servicing is provided by his agent who collects premium cheque from him and renew the policy. He did not agreed with the deduction and approached the Forum for justice in his case.

Observations/Conclusion:

The Forum asked the Respondent whether they have obtained consent letter from the insured at the time of revision of Old Mediclaim poicy to New Mediclaim 2012 policy. The answer was they will find out from their office records and submit the same within short period. Accordingly, the Respondent while their email dated 14.08.2017 & 18.08.2017 have submitted policy copy of Mediclaim policy 2007 stating that the same is approved for renewal under New Mediclaim 2012 policy by Ex-Development Officer.

In view of the above the Forum observed that the Respondent has not complied with the procedure of obtaing consent letter from the insured before renewing the Old Mediclaim policy under New Mediclaim 2012 policy and hence, the current cataract claim cannot be settled as per capping limit for cataract under condition of New Mediclaim 2012 policy. The stand of Respondent of settling cataract claim as per capping limit of cataract is not justified.

Dated: 10.08.2017

Brief Facts of the Case:

The complainant is covered under the Insurance Company for sum insured of Rs.2,00,000/- for the period from 23.07.2015 to 22.07.2016 with the inception of 23.12.2003 with sum insured of Rs.50,000/- and it was increased upto Rs.2,00,000/- from 2010.. Policy was continuously renewed upto 2014. But, for the renewal of 23.12.2014, the insured had submitted the premium cheque No.101485 for Rs.9259/- six days before the renewal date of 22.12.2014. After six months the insured received a letter from the Company that his cheque was bounced due to insufficient fund with the Bank.. The insured approached the bank but bank informed that the cheque was not presented at all, so the question of clearance does not arise. The insured had approached Divisional office of the Respondent, but uncleared cheque was not shown to him. He was informed by the Company that his poicy would be renewed with continuity benefit but without cumulative bonus. But, policy was renewed for the period from 23.07.2015 to 22.07.2016 with inception of 23.07.2015

The insured was hospitalized in the Hospital from 30.06.2016 to 05.07.2016 for Ureteric Calculi in known case of Diabetes Mellitus & Hypertension. The insured lodged the claim for Rs.2,00,000/-. The Company repudiated the claim as the inception date of the above policy is 23.07.2015 i.e. policy is in its 1st year. As per policy terms & conditions, Ureteric Calculi ailment has a waiting period of 2 years. Hence the claim was repudiated under clause 4.3.1.

Observations/Conclusion :

On scrutiny of the claim papers, correspondence attached by the Company and deposition made by both the parties during hearingthe Forum observed that the complainant had submitted a post dated cheque bearing date 03.01.2015. The company could not establish as to when they have deposited the cheque in the Bank and when the Bank had sent back the dishonoured cheque. The company Head Office had called for the explanation of the Divisional Office for the delay in not communicating the insured from the date of the receipt of the dishonoured cheque till July 2015. So it clearly proves that there has been deficiency in service by the company without any fault of the insured.

The Representative of the company could not explain as to why a post dated cheque of the insured should be dishonoured when sufficient fund was there in the Bank Account of the insured.

Hence, there is no justification by the Respondent not to give the continuity Benefit and apply the Exclusion Clause No.4.3.1 taking this as a new policy.. In fact from the correspondence between their offices, it was also seen that their Divisional Office had recommended for approval of continuity benefit to their higher office. Therefore, the complainant is eligible for all the continuity benefits

& the complaint is tenable. Therefore, the company is directed to settle the claim for Rs.2,00,000/- in favour of the complainant, towards full and final settlement of the complaint.

Dated: 23.05.2017

Brief facts of the case:

The complainant's insured son underwent surgical treatment for Myopia in both eyes. The insured person underwent implantable Collamer Lens surgery for the right eye on 27th July, 2016 and on the left eye on 3rd August, 2016. The complainant lodged claim with the Company for reimbursement of medical expeses of Rs. 2,01,851/-. The Company repudiated the claim contending that as per exclusion clause in the Policy, the treatment/charges incurred towards change of life of any description was not payable. The Company also submitted that ICL implantation too, was not covered in the Policy.

Observations/Conclusion of the Forum:

The Forum observed that Company's contention that the claim was related to expenses incurred for change of life, cannot be justified since the surgery was performed for correction of refractive error, i.e. Myopia. The Discharge summary of the hospital also mentioned diagnosis as High Myopia. The submitted medical papers mentioned that the insured person had complaint of severe itching, burning, severe eyestrain in both eyes. There was serious complications in vision of the eyes. To address the above conditions and the imbalance in the refractive error between the two eyes he was adivsed by the treating

doctor for Toric Phakic in both eyes. However, the Company denied the admissibility of the treatment of the ailment under the Policy. But, the Forum observes that the Company could not refer or quote any specific exclusion mentioning that the treatment for correction of vision was not covered in the Policy. At the same time, Forum also observes that the amount claimed for such treatment was on quite a higher side. The Forum opines that while the ailment and its treament cannot be denied under the Policy, the Company should workout for a reasonable expenses in such treatment. The Forum directed the Company to consider the claim for customary and reasonable amount for such surgery. Accordingly, the Company agreed to process and settled the claim.

Dated: 25.04.2017

Brief Facts of the Case :

The complainant was covered for the period from 09.11.2015 to 08.11.2016 for sum insured of Rs. 5,00,000/-. She was hospitalised from 07.03.2016 to 10.03.2016 with Diagnosis of LV Dysfunction, DM and HTN for which conservative management was done. The complainant incurred medical expenses for Rs. 1,78,465/- and lodged claim with the Company for reimbursement under the Policy. The Company repudiated the claim stating that as per treating doctor the patient was having cardiomyopathy since 2007, and it was not disclosed at the time of initiation of the Policy in the year of 2009. Although the complainant has submitted a certificate from the doctor stating that the present illness was not related to the 2007 disease, the complainant is not relieved from the onus of declaring of all material facts at the time of taking of insurance.

Observations/Conclusion:

The Forum observed that the Policy was incepted in 2009, and hence,the insurance coverage was continued since last eight years. The Forum enquired from the Company whether claim was repudiated on the ground of Pre Existing Disease. The Forum was mindful of the concerns that since pre existing disease had a waiting period of four years and whereafter the same was covered, why the same would not be considered in present case where the insurance was incepted eight years ago with history of no claim. The Forum also asked the Company to differentiate between 'Pre Existing Disease' condition and 'Non disclosure of material fact'. Also, how both can affect differently to a particular medical condition. The Company accepted that virtually both the conditions represent the same health situation and lead to same consequences. Then it was evident that insured person's obscure health condition had no direct bearing to the prognosis of the present claim.

At the same time the complainant also cannot be relieved of the onus of declaration of health conditions in toto without any exception or omission.

In veiw of the long history of claim free eight policy years and inadvertent omission on the part of the complainant, the Forum is inclined to observe that both the parties should bear part of the expenses involved in the claim, and share it equally between them.

Dated: 27.04.2017

Brief Facts of the Case :

The complainant was covered for the period from 08.09.2014 to 07.09.2015 for sum insured of Rs. 2,00,000/-. She underwent Mastectomy Surgery on 14.03.2012 for the treatment of cancer of the left breast. After the surgery she was advised by the doctor to undergo hormonal therapy as a mild chemotherapy for the next five years. The Company settled the claims for the treatment and subsequent therapy/treatment even taken on day care basis on number of occasions. Suddenly Company stopped settling claims for such subequent therapy/treatment taken on day care basis, invoking the condition of minimum 24 hours hospitalisation. The complainant has submitted the details of similar claims approved on earlier occasions.

Observations/Conclusion

The Forum observed that one can never be sure about recurrence of such dreaded ailment and therefore, after surgery/major procedure in the hospital regular check up becomes integral part of the treatment. The complainant and his spouse, who underwent treatment, both are senior citizens of around eighty years of age. Because of the seriousness of the life threatning ailment and considering their higher age the Forum asked the Company to consider all the hospital check up claims submitted so far. The Company submitted that the claims for which complaint have been lodged in the Forum are for Rs. 22,034 and Rs. 24,368/-, totalling to Rs. 46,402/-. The Forum directed the Company to pay the complainant Rs.46,402/- for which the complaint lodged complaint with the Forum. The complainant has submitted that one more claim, pertaining to the date 19.10.2016 has also occured after lodging complaint with the Forum. The Forum directed the Company to consider the third claim also of similar nature.

Dated: 31.05.2017

Brief Facts of the Case：

The complainant was covered vide Mediclaim Policy , for sum insured of Rs.3,00,000/-. She was hospitalised from 09.01.2016 to 14.01.2016 with complaint of b 12 and vitamin d deficiency and severe backache and was treated with oral medication only. Since no active line of treatment was required to be administered in the hospital the claim was repudiated under Clause 2.16.1, which says that procedure/treatment usually done in outpatient department are not payable under the Policy even if converted as an inpatient in the hospital for more than 24 consecutive hours.

Observations/Conclusion:

On perusal of the documents submitted and personal depostion of the parties concerned to the dispute, the Forum observed that the complainant was admitted in the hospital with complaint of burning sensation in stomach due to which her appetite got decreased and she was having vitamin B12 & Vitamin D deficiency which required IV Parental fluids administration and injection Eldervit on IPD basis. Therefore, except administering IV fluid, other symptoms and complications could have been managed as Outdoor Patient Department, and for that reason, hospitalisation was not required. As such, the Forum opines that in veiw of IV fluid administration and associated weakness with other symptoms, two days hospitalisation was sufficient to take care of the ailment in the hospital. The Forum, therefore, opines that the complainant should be allowed for two days hospitalisation expenses for reimbursement under the Policy.

Dated: 30.06.2017

Brief facts of the case:

The complainant was hospitalised in on 21.05.2016 with complaint of Acute depression. He was treated in the hospital and was discharged from there on 24.05.2016. The complainant was diagnosed in the hospital as Acute Depression in K/C/O XDR Tuberculosis. The complainant lodged claim for reimbursement of medical expenses of Rs. 42,487/-. The Company repudiated the claim stating that all psychiatric and psychosomatic disorders were not covered under the Policy and therefore, as per Clause No. 4.9 of the Policy, the claim was repudaited. The complainant was covered vide Group Mediclaim Policy for sum insured of Rs.5,00,000/- for policy the period from 01.08.2015 to 31.07.2016.

Observations/Conclusion of the Forum:

The Forum observed that though the discharge summary of the hospital mentioned that the insured person was a known case of Acute depression in XDR Tuberculosis the Company did not submit any document showing or confirming that the insured person was treated exclusively for psychiatric ailment. Therefore, the Forum directed the Company to settle the claim of the complainant and inform the Forum the approved claim amount within a week.

Dated: 27.07.2017

Brief facts of the case:

The complainant's vehicle met with scratch damage and he lodged claim with the Company. The Company deputed surveryor for survey and to assess the loss. The surveyor mentioned in his report that the damage/scratches to the IV body panels on Right Front door, Dicky Asy and left rear door were due to malicious and hence the same was assessed. However, all other body panels were having existing impact damage/scratches which were fabricated with fresh malicious scratches over and above. Hence frunt bumper, Rh/Fr Fender, Rh/rear door, Rh/quatrter panel, rear Bumper Ih/quarter panel, Lh/front door, Ih/front fender damages are denied. The surveyor assessed the liability of Rs. 13,000/- in respect of the relevent damage. The complainant did not agree with the contention of the Company and approched this Forum for redressal of his grievance.

Observations/Conclusion of the Forum

The Forum observed that insured vehicle, Tata Indigo Manza Aura Safire, bearing registration no. MH02BZ59956, was covered vide Policy No. VPN0026394000101 for the period from 23.11.2015 to 22.11.2016 for Insured's Declared Value of Rs. 3,62,250/-. It was Private Car Package Policy covering legal liability towards third party and own damage of the vehicle. The complainant lodged claim for repairing expenses for scratch damage sustained by his vehicle. The Company deputed their surveyor for surevey and to assess the loss. Based on surveyor's report the Company admitted repairing claim for damage occurred to 3 nos. of panel against claim lodged for 9 no. of panels. The Company contended that scratch damages sustained in the remaining 6 nos. of panels were old and impact damages and therefore, were disallowed. The Forum wanted to know from the Company whether there was any specific exclusion in the Policy which deterred them to consider old scratch damage and also the impact damage. The Company replied in negative and could not furnish or provide any such specific exclusion In the Policy. In view of the above, The Forum is of the opinion that there was no justification in admitting only selective no. of damage claims of similar nature. Since scratch damage and impact damge were not excluded in the Policy the Forum consideres such damages very much within the policy coverage. In veiw of the above, the Company is directed to settle the claim in full, i.e. without any omission of the reported losses.

Dated: 29.08.2017

(a) CASE OF MR. SHRI NIWAS GOEL V/S ORIENTAL INSURANCE COMPANY LTD.

(Hearing dated: 20.06.2017)

The complainant has stated that his wife was diagnosed with cataract in her left eye and the attending doctor suggested her to go for cataract operation with Multi focal IOL (Intra Ocular Lens) Implant. Accordingly, she was admitted in the Hospital and the surgery was conducted on the same day. The insurer had however, reimbursed him only Rs. 24000/- against his total expenses of Rs. 43148/-. The complainant stated that he was unable to understand the reason of partial payment as it was nowhere mentioned in the policy document that the insured was not entitled for multi focal lens or surgery through advanced technique; hence, the balance amount should be reimbursed by the Insurance Company. The insurer stated that in PPN (preferred provider Network) framework, the TPA had procedure/operation

wise package rates for treatment in hospitals enrolled under PPN. In the instant case, the insured opted to avail treatment in Non-PPN hospital, hence, the cost of treatment was reimbursed to the claimant based upon the package rates at par with PPN hospitals in terms of condition no. 1.2 of the policy which stipulates reimbursement of reasonable and customary charges. The insurer however admitted that there was no clause in the policy restricting use of multi-focal lens, if the entire expenses were within sum insured under the policy. On perusal of the terms and conditions of the policy, it is observed that the terms and conditions of the policy do not restrict treatment through advanced technique or use of advanced version of lenses. So long as the treatment and use of a particular lens is not barred under the terms of the policy and the claim remains under sum insured, there is no reason, the insurer should deny the claim. Hence, the insurer was directed to reimburse the amount deducted by them.

(b) CASE OF MR. SURENDER SINGH SIROHI V/S NATIONAL INSURANCE CO. LTD.

(Hearing dated: 06.09.2017)

The complainant was admitted in a reputed Hospital for treatment of low grade fever which was running for the last 15 days and high PSA. He had incurred an expenditure of Rs. 2, 20,577/- but the Insurer had approved the claim only for Rs. 77774/- after making various deductions including a sum of Rs. 93820/- being cost of three tests namely Whole body PET Scan, CT Chest and Pro-biopsy (urology) stating that the tests were not relevant to the illness/diagnosis, hence, were not required. The complainant argued that the insurer had erroneously disallowed the said expenses as the attending doctor had given in writing that all the tests were necessary and were done as a part of protocol for the treatment of Pyrexia of Unknown Origin, a disease which is normally difficult to diagnose. The TPA stated that the attending doctor had performed Needle biopsy to rule out cancer which confirmed that the disease was only in benign stage and no malignancy was found but the said three diagnostic tests were still conducted without any need, hence, expenses incurred for these tests were deducted from the claim. During the personal hearing, the insurer was asked to clarify whether an insurance company could question the line of treatment including requirement of various diagnostic tests advised by the attending doctor of a reputed hospital. The insurer could not give a satisfactory reply. It is an established fact that an attending doctor is the best judge to decide line of treatment and requirement of various diagnostic tests for a patient and not a TPA who forms his opinion only on the basis of documents. Keeping in view the above, the deduction made by the insurer on account of the three diagnostic tests, was not justified and insurer was directed to pay the admissible claim to the complainant.