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SYNOPSES OF AWARDS 2008-09

Half Year: OCT 2008 TO MAR 2009

3. GENERAL=MEDICLAIM

Award dated 07-10-2008

Case No.11-002-0114-09

Mr.Sanjiv I Shah Vs. New India Assurance Co.Ltd.

Mediclaim Policy

The Claim lodged for reimbursement of hospital expenses for Ventral Hernia which was repudiated on the grounds of exclusion clause being pre-existing ailment.

The documents on record and hearing of the parties, it was revealed that the Insured had history of two Laparoscopic Caesarian Sections (LSCS) in 1992 whereas the policy was incepted from 2001 confirmed that operation preceded the inception of policy.

Complainant pleaded that there was no problem in last 16 years of LSCS as such cannot be treated as pre-existing. The operating Surgeon confirmed that the Hernia is not the outcome of LSCS but company's Medical Referee opined otherwise. The Ventral Hernia generally occur due to prior surgical operation thus the repudiation was justified and complaint was succeed.

Award dated 08-10-2008

Case No.11-002-0022-09

Mr.Bhavanishankar R.Oza Vs. New India Assurance Co.Ltd.

Mediclaim Policy

Claim for reimbursement of hospitalization expenses lodged and was repudiated on the ground that claims occurred within 30 days of inception of policy. This exclusion does not apply if in the opinion of panel of Medical Practitioners constituted by company for the purpose, the insured person could have known of the existence of disease or any

symptoms or complaint thereof at the time of making proposal to company and the insured had not taken consultation, treatment or medication in r/o hospitalization for which claim has been lodged under policy prior to taking insurance.

Before insurance the insured was medically examined by panel doctor and there was no past history of any disease then only mediclaim insurance was granted by the company.

In this case of acute appendicitis and complainant could not wait for completing 30 days. Respondent's plea that it is a case of pre-existing disease is ruled out, the complaint succeeds on merit.

Respondent was directed to settle the claim.

Award dated 15-10-2008

Case No. 11-004-0126-09

Mr.Prakashbhai I. Jambudi Vs. United India Insurance Co.Ltd.

Mediclaim Policy

The claim papers was not submitted within 30 days as per rules hence Respondent invoked clause No.5.4 for repudiation under time limit.

On examination of documents and hearing of the parties, it was revealed that the claim papers after post hospitalization treatment were submitted in given time frame of 60 days.

The Respondent was directed to entertain the claim and settle for Rs.38,311/-.

Award dated 15-10-2008

Case No.11-003-0125-09

Mr.Pravinchandra P.Joshi Vs. National Insurance Co.Ltd.

Mediclaim policy

The claim was partially settled by the Respondent.

Documents on record read with pleading of the parties it was revealed that patient was treated for Inguinal Hernia and Stone in Bladder and Respondent treated both the operations treating as one, as the same were done under single anesthesia.

On analysis of the two operations it was revealed that on trifurcation of the operation done by different surgeon though under single anesthesia the complainant is rightful for getting prorate reimbursement excluding common expenses for the different operation.

Thus complaint partially succeeded and Respondent was directed to settle the claim for difference of amount as prorate basis for Rs.8,220/-.

Award dated 16-10-2008

Case No.11-002-0118-09

Mr.Dipak K. Patel Vs. New India Assurance Co.Ltd.

Mediclaim for hospitalization for acute Gastroenteritis was repudiated under 4.1 Clause defining ailment as pre-existing.

The documents on record read with pleading the parties revealed as one letter of the attending doctor that IBS > 20 years has recurrent episodes of acute exacerbation at the time of colonoscopy. The Complainant submitted that insured has no history of IBS and that insurance cover is since December 1989 and enjoys 50% C.B. Had there been severe illness insured would have preferred treatment rather than waiting for such long period. There were previous 18 claim free years.

Clause 4.1 (Pre-existing ailment) also an analysis proved that the gastroenteritis is not pre-existing as last 18 years were claim free years. Thus complaint succeeded and Respondent was directed to settle claim.

Award dated 16-10-2008

Case No.11-004-0147-09

Mrs.Rekhaben R.Solanki Vs. United India Insurance Co.Ltd.

Medi guard Policy

The claim for hospitalization reimbursement under medi guard policy was repudiated on the grounds that the surgery was OPD process and hospitalization was not required.

The Insured was suffering from cystic swelling on left wrist slowly increasing. The surgery was performed (excision) under field block.

The medical referee's opinion was no hospitalization required as it can be OPD process. The attending surgeon's statement that surgical operation means manual or operative procedure for correction of deformities and defects, repair of injuries, diagnosis and cure of disease, relief of suffering and prolongation of life.

Thus the operation was within the purview of terms and condition of policy.

The repudiation was set aside and Respondent was directed to settle the claim.

Award dated 22-10-2008

Case No.11-004-0153-09

Mrs. Rupal J.Sharedalal Vs. United India Insurance Co.Ltd.

Mediclaim against reimbursement of Hospitalization was partially settled approx. to 50% of S.I. under clause 1.2 being Cancer as major surgery restricting benefit to 70% or Rs. 2 Lacks whichever is less.

The documents revealed that subject clause D specifically mentions expenses for Chemotherapy for restriction for Cancer surgery.

In the subject claim the chemotherapy does not involve surgery from the limit for Sum Insured is not justifiable.

The Respondent was directed to settle the claim for balance Rs.2 Lacs.

Award dated 27-10-2008

Case No.11-004-0154-09

Mr.Bipin V.Desai Vs. United India Insurance Co.Ltd.

Mediclaim for hospitalization reimbursement for major disease was partially settled for 70% of Sum Insured.

The material on record and pleading of the parties revealed that the insured was operated for Recurrent Intra abdominal Liposarcoma which was cancer surgery and treated as major disease and the terms and condition of policy restricts the reimbursement to 70% of S.I.

The Complainant's pleading that the Surgery was for removal of fat and not cancer since Liposarcoma is defined as malignancy fat the Respondent's plea is justified and case was dismissed.

Award dated 27-10-2008

Case No.11-003-0162-09

Mr.Gautam K.Shah Vs. National Insurance Co.Ltd.

Mediclaim policy was being renewed for past several years and maximum CB @ 50% of S.I was accrued under the policy. However in the year 2005-06 there was claim which exceeded the basic S.I and part of C.B was reimbursed under are such claim.

In successive year of removal as per the policy condition the C.B could have been accumulated @ 40% instead of 50% as earlier year are claim was reimbursed.

However the Respondent deducted further amount equal to claim paid which was in excess of basic S.I but within accumulated C.B.

Since there is no such rule to deduct beyond 10% of Basic S.A. towards C.B, the complaint succeeded and Respondent was directed to give CB @ 40% of basic S.I.

Award dated 27-10-2008

Case No.11-004-0155-09

Mr. Rajesh J.Mehta Vs. United India Insurance Co.Ltd.

Individual Health Policy claim.

The Claim lodged for reimbursement of hospitalization was partially settled.

The documents on record and parties pleading revealed that claims was settled for 70% of S.I. as the ailment amounting to major disease restricts the claim to 70% or 2 lacks whichever is less.

On examination it was found that the insured was denied reimbursement for chemotherapy.

Since the subject claim did not involve surgery as defined in Clause 2.2 and expenses are for chemotherapy only the imposition of clause for cancer surgery is incorrect as such repudiation is not justified.

The Respondent was directed to settle the claim for balance amount.

Award dated 27-10-2008

Case No.11-002-0113-09

Mr. Niranjan B. Mehta Vs. New India Assurance Co.Ltd.

Mediclaim lodged for reimbursement of hospital expenses for RT Upper LID Sebaceous Cyst was repudiated by the Respondent under exclusion clause 2.3 which states that minimum hospitalization required is less than 24 Hrs.

The Complainant pleaded that since it was eye surgery the clause 2.3 is not operative. The medical referee of Respondent stated that this is minor surgery performed under local anesthesia thus the patient can go home directly after operation.

It was revealed after analysis of the case that surgery was an exclusion and the cyst was on upper eyelid and not eye. Further more being minor surgery the patient was discharged within 3 hrs.

The case was dismissed on the repudiation was justified.

Award dated 27-10-2008

Case No.11-005-0138-09

Mr.Devendra C.Doshi Vs. Oriental Insurance Co.Ltd.

Mediclaim for surgery for Rt. eye Cataract of insured was partially settled under plea that expenses shown are very high and not reasonable.

On mediation of this forum the Respondent agreed for Rs.10,000/- which was accepted by the complainant and case was disposed under mutual resolution of both the parties.

Award dated 27-10-2008

Case No.11-005-137-09

Mr.Bhagvatiprasad M.Patel Vs. Oriental Insurance Co.Ltd.

The mediclaim for Ayurvedic Doctor's treatment was repudiated under clause 3.3, stating that Ayurvedic Doctor was given allopathic treatment.

The complainant underwent surgery for piles where the treating physician was qualified for Ayurvedic treatment.

Respondent pleaded that the doctor was not medical practitioner as per the definition, as he was not qualified for allopathic practice.

The prospectus define Medical Practitioner means person who holds Degree/Diploma of recognized institution and a registered by medical council of respective state in India would include physical surgeon and specialist to which Respondent could not justify.

As the clause No.3.3 was misquoted as contained in prospectus for detriment, the repudiation fails.

The Respondent was directed to settle the claim.

Award dated 27-10-2008

Case No.11-002-163-09

Mr.Kamalashanker R. Pathak Vs. New India Assurance Co.Ltd.

Mediclaim for acute bronchitis and septicemia was repudiated invoking clause 4.8.

On mediation of this Forum, the Respondent offered Rs.20,000/- which was accepted by complainant.

The case was mutually resolved and disposed.

Award dated 27-10-2008

Case No.11-002-0117-09

Mr.M.H.Vadiwala Vs. New India Assurance Co.Ltd.

Mediclaim was repudiated invoking clause 4.1 which excludes pre-existing disease.

The documents on record revealed that the policy initially incepted since 01-03-2002.

The Complainant was admitted in 2007 for treatment of Emphysematous Polynephritis with multi Organs failure + DM + IHD.

The discharge summary of Apollo Hospital confirmed CABG was done in 2001.

This history contributes the present treatment under pre-existing disease and invoking exclusion under clause 4.1 is justified.

The case was dismissed.

Award dated 04-11-2008

Case No. 11-002-0149-09

Shi Labhubhai M. Pandav Vs. New India Assurance Co.Ltd.

Mediclaim Policy

Claim lodged for treatment expenses of Intrno+Externo Piles was repudiated by the Respondent on the ground that the treatment taken from a Private Ayurvedic Hospital is not eligible to get reimbursement of hospital expenses.

As per terms and conditions of the policy, the Ayurvedic treatment, hospitalization expenses are admissible up to 25% of Sum Insured when the treatment is taken from a Government Hospital/Medical College Hospital.

Therefore Respondent's decision to repudiate the claim is upheld without any relief to the complainant.

Award dated 05-11-2008

Case No. 11-004-0157-09

Smt. Sonalben A. Mistry Vs. United India Insurance Co.Ltd.

Cradle Care Policy

The complainant was delivered a female child with certain disorders viz. Rt. incomplete cleft lip with septicemia and was treated for the same at Sterling hospital and Poojan Child Hospital. Claim lodged for reimbursement of hospital expenses was denied by the Respondent on the ground that the treatment for the child was primarily in respect of preterm care and septicemia which is an infective condition.

The policy covers defect/deformity/malformation/congenital abnormality. The claim for pre-term care or treatment of infection is not payable. It was the contention of the Respondent that as per the preamble of the policy, the company agrees to pay the sum insured in the event of the expectant mother (who is the insured under this policy) delivering a child with defect as mentioned above of any kind whatsoever. In the present case the new born baby was not suffering any kind of defect and hence her hospitalization is not covered under the policy. Therefore the claim is inadmissible.

Award dated 05-11-2008

Case No.11-002-104-09

Mr.Kiran J Shah Vs. New India Assurance Co.Ltd.

Mediclaim Policy

Complainant lodged a claim for the expenses of Hiatus Hernia Surgery were partially settled by the Respondent. The reason for deduction of claim on the ground that the disease is pre-existing. Policy incepted in 2002 and has been renewed in continuation up to 2008. Respondent's plea to deduct a sum of Rs.19,314/- is not justified.

On mediation of this forum, the Respondent offered to pay an amount of Rs.17,500/- which was accepted by the complainant. Therefore, no formal award was made in this case.

Award dated 05-11-2008

Case No. 14-002-00145-09

Mr.P.S. Patel Vs. New India Assurance Co.Ltd.

Health Plus Medical Expenses Policy

Complainant's son was hospitalized for Rt. Ear surgery at Dr. S.K.Bhansali Hospital and claim was repudiated by the Respondent on the ground of Pre-existing disease.

The policy was incepted from 1-06-2005 and first consultation for treatment was on 15-02-2006. As per doctor's opinion the insured was suffering from Traumatic injury with deafness in right ear for 6 months.

The insured's mother stated that the insured had traumatic perforation. The opinion of Dr. Parikh is vague and he seems to oblivious of the noting of Dr. S. K. Bhansali, as per history we go back by 6 months, it will be 15-08-2005 and commencement of risk from 01-06-2005. So, question of pre-existing disease does not arise.

The Respondent was directed to settle the claim.

Award dated 06-11- 2008

Case No. 11-004-0129-09

Mr. Pravin M. Thakkar Vs. United India Insurance Co.Ltd.

Medi Guard Policy

Claim for hospitalization expenses of the Complainant's wife was repudiated by the Respondent due to various deficiencies. The Respondent found discrepancies in the treatment papers, medical bills, X-ray reports, Physiotherapy report, date of intimation and date of admission etc.

During the Hearing Complainant proved through documentary evidence that the insured met with an accident on 30-05-2007 injuring left Knee point. This is corroborated by the hospital records, dates of consultations, Certificate of treating doctors, X-ray Report, MRI Report, Proof of Surgery etc.

Respondent failed their relevance for repudiating the claim while making submission during the hearing. Therefore it is established beyond any doubt that the Respondent had repudiated the claim on frivolous allegations and material on record does not support the grounds for repudiation.

Respondent is directed to settle admissible amount as full and final
settlement of the subject claim.

Award dated 07-11-2008

Case No.11-004-0108-09

Mr. Dinesh V.Vaja Vs. United India Insurance Co.Ltd.

Individual Mediclaim Policy

Complainant had taken treatment for Hip replacement in the year of 2003 and claim lodged by the complainant was in 2005. Respondent repudiated the claim by invoking Exclusion Clause 7.2 of Mediclaim policy states that- "Final Claim along with Hospital Receipted Bill/Cash Memos Claim Forms and list of the documents as listed in the claim form etc. should be submitted to the company within 30 days from the date of completion of treatment".

The treatment was only for two days. Since, the bills submitted for the claim by the complainant did not show any treatment given after February 2004, it means that in the subject hospitalization, the claim had been delayed in its lodgment in late 2005. It is a case where records show exorbitant delay in lodgment of the claim followed by casualness in submission of the Claim and absence of any reason for exercising

discretionary relation in condoning the manifest violation of Clause 7.2 of Mediclaim Policy by the Respondent.

Therefore the case was dismissed.

Award dated 10-11-2008

Case No.11-003-095-09

Mr. Narendra D. Shah Vs. National Insurance Co.Ltd.

Mediclaim Policy

Claim lodged for expenses of Surgical removal of teeth of the insured was repudiated by the Respondent.

Repudiation had been effected invoking clause 4.7 on the ground that the claim did not comply with requirements with regard to hospitalization. Dental treatment is excluded items under the benefits of the policy.

The treatment took place at Dr.S.K.Devan's Nursing Home. As per the certificate of the treating doctor, he carried out surgical removal of teeth on the patient under general anesthesia which is reportedly equipped for oral and Facio- Macio-Maxillary surgery.

Since the surgery was necessary due to disease and which required hospitalization, expenses incurred for it are therefore admissible as per terms and conditions of the policy. The charges for preparation of fixed prosthesis are not covered under the scheme so the complaint partially succeeds.

Award dated 10-11-2008

Case No.11-004-0130-09

Mr. Jafarali J. Panjwani Vs. United India Insurance Co.Ltd.

Mediclaim Policy

Hospitalization expenses repudiated by the Respondent invoking Exclusion Clause 5.4 which states - "All supporting documents relating to claim should be submitted within 30 days from the date of discharge from hospital.

Respondent submitted that the claim papers were submitted very late means 5 – 6 months later from discharge from hospital and without any convincing reason for this inordinate delay on the part of the complainant.

It needs to be pointed out that even if one does not take strict literal application of clause there are infirmities in lodgment of claim which make it justified not to pay as the delay had not been marginal but exceeding 5 months while the hospitalization was just for a few days.

The complainant has not brought to notice the reasons for delay to submit the claim papers, the delay is inordinate. The Respondent has not exercised discretionary relaxation in condoning the violation of clause 5.4.

Therefore claim was dismissed.

Award dated 11-11-2008

Case No. 14-005-150-09

Mr. Ramesh N. Trivedi Vs. Oriental Insurance Co.Ltd.

Mediclaim Policy

The insured member was hospitalized for Parastomal Hernia and claim was lodged for expenses of hospitalization was repudiated by the Respondent on the grounds that the disease was outcome of previous operation and was pre-existing prior to inception of policy.

The complainant pleaded that the insured member had Cancer rectum and operated in 2001 and operation of Parastomal Hernia in 2006 which is not related with Cancer as such the repudiation on the grounds of pre-existing disease is not correct.

The operating Surgeon confirmed the present operation was performed to repair defect of Parastoma at the side of Parastomal opining. This infers that this was complication subsequent to operation for previous Cancer Rectum.

In view of this Claim was repudiated.

Award dated 11-11-2008

Case No. 14-003-0158-09

Mr. Ritesh S. Shah Vs. National Insurance Co.Ltd.

Mediclaim Policy

Complainant's son had taken treatment for dog biting on OPD basis at Yugum Hospital. Claim repudiated by the Respondent on condition 3.11 which state that minimum period of stay in Hospital shall be 24 hours except disease mentioned in 2.6. The dog bite treatment is not fall under clause 2.6. So treatment on OPD basis is not covered and case was dismissed.

Award dated 12-11-2008

Case No. 11-010-103-09

Mr. Jignesh J Dhruv Vs. IFFCO TOKYO Gen. Ins.Co. Ltd.

Individual Medishield Policy

Complainant's wife had hospitalized for treatment of Myelodysplastic syndrome with anemia and diarrhea and claimed for expenses were repudiated by the Respondent by invoking pre-existing condition.

Policy was incepted on 25-01-2006 and treating doctor certified that the insured had anemia off and on for over past 10 years. Due to anemia the patient is vulnerable to other disease.

The Respondent has also focused on the fact that the complainant had not reported about anemia in the proposal form in the proposal form. History record shows that she had anemia in 1996 and 2001 which was prior to inception of the policy.

There is suppression of material facts which is against principle of Uberima fides which is centre point of all insurance contracts. Therefore claim is dismissed.

Award dated 14-11-2008

Case No.11-004-0140-09

Shri Shaileshbhai T. Gandhi Vs. United India Insurance Co.Ltd.

Mediclaim Policy

The Complainant had lodged claim for treatment of his wife on three occasion at various hospitals at Rajkot for the treatment of Hypertension, Diabetes, Rhino Cerebral with Type-II D.M, Aspergillus, Septicemia etc.

Respondent referred the case to their Medical referee and opined that the insured was a known case of Type-II Diabetes Mellitus since last 7 years and Hypertension since last 2 years. Therefore the claim has repudiated on the ground of exclusion clause 4.1 as pre-existing disease.

In the investigation report it was found that she had Meningitis, Tuberculosis, Fungal. She was later died because of Fungal Meningitis with D.M., H.T and Septicemia.

So far as opinion of Medical Referee of the Respondent and treating doctors certificate concerned the insured was a well known case of diabetes for the last 7 years, hence the repudiation of claim by the Respondent is justified as per terms and conditions of the policy.

Therefore claim is dismissed.

Award dated 18-11-2008

Case No. 11-00232-159-09

Mr. Pramukhlal N. Shah Vs. New India Assurance Co.Ltd.

Mediclaim Policy

The Complainant was admitted at Anand Nursing Home, Baroda in the month of November 2006 for the treatment of Chest pain, Hypertension with IHD and Anemia. Claim was repudiated by the Respondent alleging that the disease was pre-existing prior to inception of policy.

Respondent submitted that the inception of the policy was 2002 but the same was renewed in the year of 2006. Thus the policy has not been renewed in continuation.

As per papers on record history of disease goes as far back as 16-12-1998. So the disease was pre-existing prior to the inception of policy and repudiation of claim is justified.

Therefore case is dismissed.

Award dated 19-11-2008

Case No. 11-02-0078-09

Mr. Govindram T Kukreja Vs. The New India Assurance Co.Ltd.

Mediclaim Policy

Complainant's Son Vimalkumar was admitted at Goyal Nursing Home, Bhavnagar for treatment of Vascular Headache with vomiting and investigations like MRI- Brain, CBC, ESR, RBS, CREATININE, SGPT, TISH, URINE etc. were done and oral drugs were given.

Claim repudiated by the Respondent on the grounds that the hospitalization was for observation and investigation purpose only invoking clause 4.19 of the Policy condition.

On perusal of hospital records, it is proved that the insured was admitted for observation and investigation as is corroborated by the discharge papers.

Thus Respondent's decision to repudiate the claim is justified and case dismissed.

Award dated 20-11-2008

Case No.11-004-0128-09

Mr. Dinesh M Vora Vs. United India Insurance Co.Ltd.

Mediclaim Policy

Complainant had lodged claim for expenses of Hospitalization & treatment for Bilateral Otosclerosis with mixed hearing loss.

Claim repudiated by the Respondent by invoking exclusion clause 4.1 of Mediclaim policy which excludes payment for all diseases/injuries which are pre-existing when the cover incepts for first time.

The Policy incepted in 2003 and operation done in 2007. The complainant earlier operated in 2006 for similar problem and expenses reimbursed by the Respondent.

In the present case claim denied by the Respondent on opinion of Medical Referees of the Respondent that the disease is chronic and since last 7-8 years, claim is not payable hence file closed as 'No Claim'. The expenses incurred to the treatment is Rs.58,148/-.

The Respondent is failed to prove the past history or any documentary evidence to deny the present claim as pre-existing disease.

Therefore Respondent's decision to repudiate the claim is set aside and directed to pay admissible amount to the complainant.

Award dated 25-11-2008

Case No.11-002-121-09

Mr. Chandubhai C Patel Vs. The New India Assurance Co.Ltd.

Mediclaim Policy

The Complainant's son was admitted at Matru Hospital for treatment of Viral Hepatitis from 13-02-2007 to 15-02-2007. As per the record first consultation paper was submitted on 31-03-2007 and hospitalization took place from 12-02-2007 to 15-02-2007. Hospitalization always follows the first consultation. Further, treating doctor has confirmed in writing to Respondent that treatment papers of patient named Master Hiren C Patel does not contains his signature.

The Respondent has repudiated claim invoking policy condition 5.7 i.e. claim is fraudulent. Taking into consideration documents on record, facts and circumstances of the case and policy condition the Respondent's decision to repudiate the claim is in order and case dismissed.

Award dated 25-11-2008

Case No.21-001-0084-09

Smt. Hemlata M Chhara Vs. LIC of India

Life Insurance Policy

Late Manoj J Chhara held a Policy for Sum Insured Rs.5.00 Lacs. Death claim lodged by Nominee and wife of the DLA was repudiated by the Respondent on the ground that deceased had not disclosed correct income in proposal. Further, he had no regular income and had habit of consuming alcohol which later on resulted into death. This fact not disclosed in the proposal in-spite of several reminders.

It has been find that No evidence submitted by Sr. Branch Manager of LIC that DLA was in the habit of drinking alcohol or chewing tobacco. The investigation report confirms that DLA had an income of Rs.5,000/- per month so meager to finance insurance for Rs.5.00 lacs but the respondent did not question about income and occupation of DLA at the time of granting insurance. The Respondent has failed to prove deliberate misstatement in proposal in respect of income, occupation and habit of consuming alcohol and tobacco. There is no documentary evidence to support ground of repudiation of claims. So Respondent's decision to repudiate the claim is set aside and directed to settle the claim.

Award dated 26-11-2008

Case No.11-002-0167-09

Mr. Bansilal V.Chandel Vs. The New India Assurance Co.Ltd.

Mediclaim Policy

The Complainant's wife was underwent a surgery of Hysterectomy and claim lodged by the complainant.

Respondent has repudiated the claim under policy condition 4.1 as pre-existing disease. The insured was illiterate and Medical Referee of

the Respondent made false statement about her health history as she was suffering Pelvic Inflammatory disease for the last 4-5 years and was taking treatment from various hospitals under Thumb impression of the insured.

During the hearing Complainant declared this fact and Respondent failed to prove any other evidence of the previous treatment.

Therefore Respondent's decision to repudiate the claim is set aside and directed to settle the claim.

Award dated 26-11-2008

Case No.11-002-0185-09

Mr. Bababhai J Prajapati Vs. The New India Assurance Co.Ltd.

Mediclaim Policy

Complainant's wife was hospitalized for treatment of Osteoarthritis and claim was lodged for Rs.69,250/-. The Insured had policy for S.I Rs. 50,000/- which was renewed with increase of S.I Rs.50,000/-(Total Rs.1.00 Lac) as per revised Mediclaim Policy 2007.

TPA settled the claim for Rs.50,000/- as per old policy conditions and disallowed Rs.19,950/- as per exclusion clause 4.3 of the policy.

Complainant's request that the insured was treated for Osteoarthritis and total expenses incurred were Rs.1,20,098/-, at least Rs. 50,00/- should be paid as the Sum Insured under the policy is Rs. One lac.

Respondent submitted that TPA settled subject claim for sum insured of Rs.50,000 + 10% C.B but complainant confirmed that the C.B of Rs.5,000/- is not received till date. As per old policy conditions Complainant is eligible to get C.B of Rs. 5,000/- and Respondent is advised to reopen the case and pay Rs.5000/- as full and final settlement of the claim.

Award dated 27-11-2008

Case No.11-002-00172-09

Mr. Dinesh M. Patel Vs. The New India Assurance Co.Ltd.

Mediclaim Policy

Claim lodged by the Complainant for reimbursement of hospitalization expenses of his wife, was repudiated by the Respondent.

Repudiation was on the ground of Policy Condition 4.1 as pre-existing disease when the cover incept for the first time.

As per the discharge summary of the hospital, history of HTN is since 40 years while policy was incepted in 2002.

The Complainant submitted an affidavit to hospital on the basis of which the treating doctor certified the history of HTN is 4 years instead of 40 years. The history of hypertension as recorded in the hospital records is not contradicted and the Respondent's decision to repudiate the claim is vindicated. Therefore the case is dismissed.

Award dated 27-11-2008

Case No.11-002-0190-09

Mrs. Priyamvada P Surani Vs. The New India Assurance Co.Ltd.

Mediclaim Policy

Complainant admitted at Apollo hospital and was diagnosed prolapsed Intervertibral Disc and claim lodged for reimbursement of hospitalization expenses was repudiated by the Respondent.

Respondent submitted that the hospitalization was for investigation purpose only, as nowhere in hospital papers recorded that surgery is required. Therefore claim repudiated by invoking clause 4.10 of the policy.

Complainant admitted at hospital for Lumber Canal Stenosis and PID, as per hospital record, this was known at the time of admission itself for which a treating doctor issued a certificate.

Respondent's contention that hospitalization for investigative and diagnostic purpose is simply an excuse to avoid payment of claim.

Therefore Respondent's decision to repudiate the claim is set aside and directed to pay claim amount with interest as per IRDA Rules.

Award dated 28-11-2008

Case No.11-009-143-09

Mr.Kanaiyalal B Bhavsar Vs. Reliance General Insurance Co.Ltd.

Mediclaim Policy

The Complainant aged 48 years serving at Saraspur Nagrik Co-op Bank as a cashier was treated for Acute C.V Stoke and claim lodged for reimbursement of expenses was repudiated by the Respondent.

Repudiation had been effected by invoking Policy Exclusion 10 and 18 which interalia state that the company shall not be liable to make any payment for any claim directly or indirectly caused for treatment of Congenital external/internal disease/illness or defects or anomalies, sterility, venereal disease or intentional self injury and use of intoxicating drugs or alcohol. Respondent pleaded that the claim repudiated under clause 10 and clause 18 which excludes "treatment for alcoholism" and "alcohol or drug abuse" respectively.

The complainant has himself admitted the use of alcohol occasionally and chewing tobacco in limited quantity. Discharge summary from hospitals and treating doctor's certificates prove the claimant had history of HTN for three years.

Respondent has not given any conclusive evidence to prove the nexus between consumption of alcohol, the claimant became illness. Therefore Respondent's decision to repudiate the claim is set aside and directed to settle the claim.

Award dated 28-11-2008

Case No.11-003-0177-09

Mr. Parth Dineshbhai Shah Vs. National Insurance Co.Ltd.

Mediclaim Policy

Claim lodged for reimbursement of hospitalization expenses for the treatment of Calculus disease and Pancreatic was repudiated by the Respondent by invoking Policy clause 4.3 which states that the treatment for various illness/diseases are not payable for first two years of the policy. The above treatment was within 2 years and not covered under the policy.

In the Discharge Summary issued by the treating doctor specifically stated as Pancreatitis + GB Stone and treated conservatively through oral medicines.

Complainant appears to be an after thought to get full Medical reimbursement of the expenses incurred by the complainant which is not fair. The forum desires to follow the golden rule of average and considering hospitalization for two ailments it will be in order that the Respondent reimburses the expenses accordingly.

Therefore directed to pay 50% of the admissible amount.

Award dated 27-11-2008

Case No.11-002-0165-09

Miss. Bijal K Patel Vs. The New India Assurance Co.Ltd.

Mediclaim Policy

Claim lodged for reimbursement of hospitalization for treatment of Urinary Track Infection was repudiated by the Respondent.

Repudiation is on the basis of opinion of Panel doctor of the Respondent that the insured suffered from severe menorrhagia leading to anemia and claim is not admissible under exclusion clause 4.3.

Going through the treating doctor's certificate, it is established that the complainant had undergone treatment for three different diseases-DOB, PID and UTI in addition to anemia due to Menorrhagia which alone is excluded as per Clause 4.3.

Since Menorrhagia is one of the many disease for which insured was treated in all fairness she deserves reimbursement of an amount slightly more than what has been suggested by Respondent's Medical Referee.

The Complainant is eligible to get expenses of about 40% of charges as per the Respondent's own Medical Referee and hence to deny the entire amount of claim is not justified.

Therefore, Respondent's decision to repudiate the claim is set aside and directed to pay 50% of the claimed amount within 15 days.

Award dated 01-12-2008

Case No.11-005-0026-09

Mr.Chandrakant M Babariya Vs. The Oriental Insurance Co. Ltd.

Mediclaim Policy

Claim lodged for hospitalization expenses for the treatment of Chronic Kidney disease requiring renal replacement therapy or transplant of Complainant's wife was repudiated by the Respondent.

Repudiation had been effected on the ground of Policy Condition 4.1 as Pre-existing disease. She was hospitalized for treatment of HT, C&F, Hypothyroidism, IHD since 6-8 years and history of HBP since 15 years. The Respondent had taken opinion of Medical Referee Dr. Dumra. Respondent failed to produce the Proposal to prove non-disclosure of Material facts. There is no specific date showing when H.T and medicine started. The history of H.T since 15 years not supported by any evidence.

Therefore Respondent's decision to repudiate the claim is set aside and directed to settle the claim.

Award dated 02-12-2008

Case No. 14-002-0069-09

Mrs. Sarojben S. Patel Vs. The New India Assurance Co. Ltd.

Mediclaim Policy

Claim lodged for treatment of primary pulmonary Hypertension of Complainant's husband was repudiated by the Respondent.

TPA had called various requirements from the Claimant to consider the settlement of the subject claim like – to prove duration of illness, Investigation report, Previous consultation and treatment papers, details of stem cell therapy, No. of Oxygen Cylinders used and payment details.

Claimant replied that her husband was under treatment of the same disease since 2005 and claim amount of Rs.15,861/- was already paid by the Respondent hence previous records are already with the Respondent, she does not have any papers and her husband has expired.

The insured had expired, considering the circumstances of the case, the information supplied by the claimant and material on record the treatment and hospitalization is justified.

Thus the Respondent's decision to repudiate the claim not based on reason as the grounds given for repudiation are very flimsy and the Forum directed the Respondent to settle the claim.

Award dated 11-12-2008

Case No.11-003-0200-09

Mr. Ashokkumar C.Modi Vs. National Insurance Co. Ltd.

Mediclaim Policy

Claim lodged for treatment of Dilation of Urethra by catheterization was repudiated by the Respondent on the ground of Pre-existing disease.

The insured had policy with United India Insurance Co. in the year of 1998 which was rolled over into Mediclaim policy with National Insurance Co. The Policy with National Insurance Co. was not renewed in continuation in the year of 2002 when policy was renewed for the

period from 03-11-2002 to 02-11-2003 while first policy in the year 1999 was for the period 11-10-1999 to 10-10-2000.

There is discrepancy in the duration of the policy as stated by Insured and history of disease stricture Urethra since 1998 is confirmed by consulting doctor and policy was incepted in the year 1999.

The Respondent had repudiated the claim under policy clause 3.5 is also nexus between the previous dilation in 1998 and subsequent treatment is upheld and case dismissed.

Award dated 15-12-2008

Case No.11-004-0156-09

Dr. Yashesh S. Anantani Vs. United India Insurance Co.Ltd.

Mediclaim Policy

Claim lodged for the expenses of complainant's wife Total Knee Replacement was repudiated by the Respondent by invoking exclusion clause 4.1 which excludes pre-existing at the time of taking the Mediclaim policy.

As per discharge summary of Apollo Hospital, history of illness mentioned as 15 years where as Insured had declared pain in right knee since 1 year. Insured did not disclose this material fact while taking the mediclaim insurance policy. Thus Respondent's decision to repudiate the claim is upheld and case is dismissed.

Award dated 16-12-2008

Case No.11-005-0207-09

Mr. Arun R Paunikar Vs. The Oriental Insurance Co.Ltd.

Mediclaim Policy

The Complainant's wife had reptured Ectopic Pregnancy and a laparoscopic operation was performed to save her life.

Respondent has repudiated the claim under exclusion clause 4.12 of the Mediclaim policy. The treatment given is arising from and traceable to pregnancy. Thus although child birth or caesarian was not

the occasioned and the Respondent's decision is correct as per the terms of the policy. Therefore case is dismissed.

Award dated 16-12-2008

Case No.11-02-0079-09

Mr. Balchandra H Gajjar Vs. The New India Assurance Co.Ltd.

Mediclaim Policy

Claim lodged for the expenses of treatment for Heart disease at Banker's Heart Institute, Vadodara was repudiated by the Respondent.

Repudiation was on the ground of Pre-existing disease under Exclusion Clause 4.1 of the Mediclaim Policy.

As per the information provided by the claimant, the policy incepted in 1999 and he had undergone CABG, as heart disease treatment at Apollo Hospital, Madras in 1992 and again treated in 2001.

As per the medical case summary of Banker's Heart Institute, history of CABG in 1992 and patient had undergone CAG at BHIRC on 19-04-2001 and present disease also related to previous problem.

Under this circumstances, it is established beyond doubt that the insured was suffering from heart disease at the time of inception of the policy so Respondent's decision to repudiate the claim is upheld and case is dismissed.

Award dated 17-12-2008

Case No. 11-004-0184-09

Mr. D.C.Limbachiya Vs. United India Insurance Co.Ltd.

Health Insurance Policy

Claim lodged for treatment of Hysterectomy operation and expenses incurred for Rs.34,271/- was partially settled by the Respondent by Rs.10,000/-.

The insured covered Health Insurance Policy (Gold) and expenses in respect of the Hysterectomy are restricted to the 20% of S.I or maximum of Rs.50,000/- whichever is less. Sum Insured of the Complainant's policy was Rs.50,000/-. Therefore Respondent has paid Rs.10,000/- as per terms and conditions of the policy. So Respondent's decision is justified and case is dismissed.

Award dated 23-12-2008

Case No. 11-005-0209-09

Mrs. Dharmisthaben A Trivedi Vs. Oriental Insurance Co.Ltd.

Mediclaim Policy

Claim lodged for treatment expenses of complainant's husband was repudiated by the Respondent.

Repudiation was on the ground of exclusion clause 1.1 of the policy. The Respondent's contention that the treatment given was on OPD procedure is not correct as treating doctor clarified and explained in details.

Considering the certificate of treating doctors and prescription for medicines and advice of emergency operation, hospitalization was necessary and Respondent's decision set aside and directed to settle the claim.

Award dated 24-12-2008

Case No. 11-005-0175-09

Mr. Indravadan G. Dave Vs. Oriental Insurance Co. Ltd.

Mediclaim Policy

Claim lodged for treatment expenses of Complainant's daughter was repudiated by the Respondent.

Repudiation was by invoking clause 4.8 of the policy. The attending physician confirmed that the insured was suffering from Schizophrenia symptoms for 2 months before admission for Schizophrenia- Residual. The treatment papers also confirmed that

during hospitalization, treatment was given for Psychiatric Disorders. Since the Schizophrenia is classified as Psychiatric disorder/disease, hospitalization expenses for it are excluded from the purview of the policy.

Therefore case was dismissed.

Award dated 24-12-2008

Case No. 11-09-0174-09

Mr.Jignesh J Thakkar Vs. Reliance General Insurance Co.Ltd.

Mediclaim Policy

Claim lodged for treatment expenses of Complainant's wife was repudiated by the Respondent by invoking clause 1 of Mediclaim Policy as pre-existing disease.

From the case papers and certificate of treating doctor, it is proved that duration of the treatment is 8 months. Policy incepted in the year of 2001 and renewed up to 2006 with Oriental Insurance Co., thereafter the policy was converted to New India Assurance Co.Ltd. and lastly policy renewed with Reliance General Insurance Co. in the year of 2007-2008.

The informative material mention under heading what does the policy not cover that any disease contracted during the first 30 days of inception of the policy. This exclusion will not be applicable for roll over cases and renewals. So the claim is not tenable because the subject claim attracts exclusion clause 1 of the policy.

Therefore, Respondent's decision upheld and case was dismissed.

Award dated 26-12-2008

Case No.11-002-0178-09

Mr. Ileshkumar L Dave Vs. The New India Assurance Co.Ltd.

Mediclaim Policy

The insured while playing was injured resulting in the swelling of the scrotum and as per the medical opinion he was operated. Claim lodged for the treatment expenses was repudiated by the Respondent.

Repudiation was on the ground of Exclusion Clause 4.8 of the mediclaim Policy which states as Congenital External Disease is not payable as per clause 4.8.

The operating surgeon in his discharge summary recorded that the insured is 4 years old, had swelling of right side of scrotum, of one month duration which was painful, doubtful history of injury while playing.

The Respondent had not examined the case history sheet carefully and relied on the opinion of treating doctor who's certificate bears only the rubber stamp of the doctor and is not signed by him.

Looking to the discussions and materials on record, the Respondent's decision to repudiate the claim is set aside and directed to settle the claim as admissible amount.

Award dated 29th December 2008

Case No.11-002-0203-09

Mr. Hasmukhbhai G. Patel Vs. The New India Assurance Co.Ltd.

Mediclaim Policy

Claim lodged for reimbursement of expenses of treatment for Major Depression of complainant's wife was repudiated by the Respondent.

Repudiation was on the ground of Policy Clause 4.4-6 which states the treatment for Psychiatric and Psychosomatic disorders is not payable.

Complainant disagreed with the Respondent stating that he holds the mediclaim policy since 2002 and was renewed without break with revised rules on 17-04-2008. The Respondent obtained the revised proposal excludes treatment relating psychiatric disorders.

Therefore Respondent's decision is justified and case was dismissed.

Award dated 30-12-2008

Case No.14-002-0216-09

Mr. Kisorbhai N Pathak Vs. The New India Assurance Co.Ltd.

Mediclaim Policy

Claim lodged by the complainant for expenses of cataract operation of his wife was repudiated by the Respondent on the ground of late submission of claim papers.

The Complainant informed to the Respondent in writing that he had lost the original claim papers in AMTS bus and submitted duplicate papers to the Assistant Manager of the Respondent's office, which is not acceptable by the Respondent.

The forum realized the inability of submission of original claim papers by the complainant and directed the Respondent to consider the claim for admissible amount treating that the original papers have been lost and condoning the delay in submission of original papers.

Award dated 30-12-2008

Case No. 11-002-0208-09

Mr. Nimesh U. Shah Vs. The New India Assurance Co.Ltd.

Mediclaim Policy

Claim lodged by the complainant for short receipt of claim amount. The deduction made by the Respondent according to Policy Clause 2.1.

As per Policy provisions, 2% of S.I should be payable together for Room Charges and Nursing charges per day but in this case post hospitalization, Nursing charges are not payable.

Complainant claimed for short payment of Rs.9564/-. As per terms and conditions of the policy, complainant is eligible to get Rs.700/- instead of Rs.9,564/-. Thus, complaint partially succeeds.

Award dated 30-12-2008

Case No.11-009-181-09

Mr. Pankajkumar M Chauhan Vs. Reliance General Insurance Co.Ltd.

Health Wise Mediclaim Policy

Claim lodged by the Complainant was repudiated by the Respondent under exclusion clause 2 stating that the illness was contracted within 30 days from the date of inception of policy.

Respondent pleaded that first consultation of the complainant was on 30-09-2007 with history of pain from 23-09-2007 and inception of policy was on 25-08-2007 i.e., within 30 days from the date of inception of policy is excluded under clause 2 and hence repudiation is justified.

Repudiation is only on the basis of first consultation date, there is no other documentary/conclusive evidence to prove that the disease was contracted within 30 days from the date of inception of policy.

Thus, Respondent's decision is set aside and directed to pay admissible amount.

Award dated 30-12-2008

Case No.11-002-0225-09

Mr. Satish D. Parmar Vs. The New India Assurance Co.Ltd.

Mediclaim Policy

Claim lodged for treatment expenses of the Complainant's son was repudiated by the Respondent.

According to treating doctors opinion and available records, the minimum period of 24 Hrs hospitalization was not required and claim was repudiated. Thus the case was dismissed.

Award dated 30-12-2008

Case No. 11-002-0218-09

Smt. Sushilaben D. Chotaliya Vs. The New India Assurance Co.Ltd.

Mediclaim Policy

Claim lodged for hospitalization expenses was partially settled by the Respondent.

Partial settlement of claim by invoking exclusion clause 4.3 states that "Osteoarthritis is not payable up to 4 year from the date of enhanced sum insured".

The insured was hospitalized for treatment of Osteoarthritis Knee by Total Knee Replacement and claim lodged for 1,58,933/- was settled by TPA for Rs.60,000/- as per new policy conditions under exclusion clause 4.3.

The deduction of claim is justified and case was dismissed.

Award dated 30-12-2008

Case No.11-003-0226-09

Mr. D. A Patel Vs. National Insurance Co.Ltd.

Mediclaim Policy

The Respondent has deducted doctors' 3 visit charges for 36 hrs hospitalization, they have charged 5 visit charges @ Rs.400/- per visit.

On mediation of this forum, Respondent agreed to allow one more visit charges which was agreed by the complainant and no formal award was made.

Award dated 30-12-2008

Case No. 11-002-0206-09

Smt. Jyotiben Shah Vs. The New India Assurance Co. Ltd.

Mediclaim Policy

Dental treatment expenses claimed by the complainant were repudiated by the Respondent by invoking exclusion clause 2.1 of the Mediclaim policy.

On referring the treatment records and doctor's certificate, it is proved that the treatment was taken on the basis of OPD and case does not qualify for reimbursement and repudiation of the Respondent is justified.

Thus case was dismissed.

Award dated 30-12-2008

Case No.11-002-0195-09

Mr. Trikamdas N. Delvadia Vs. The New India Assurance Co. Ltd.

Mediclaim Policy

Claim lodged for hospitalization expenses was repudiated by the Respondent on the ground of late submission of claim papers by invoking exclusion clause 5.4 of the mediclaim policy.

Hospitalization was for accidental head injury sustained in a Road Traffic Accident. As per the prospectus of above Insurance Co., the final claim along with all necessary treatment records should be submitted to the insurer within 30 days from the date of completion of treatment. The Policy provides for post hospitalization expenses up to 60 days from the date of discharge from hospital.

Complainant submitted a medical certificate which states that he was under treatment for six months but there is no other evidence of treatment.

Therefore Respondent's decision to repudiate the claim for delay in submission of papers is justified and case was dismissed.

Award dated 31-12-2008

Case No. 11-004-0193-09

Mr. Sanjaykumar B Bohra Vs. United India Insurance Co. Ltd.

Mediclaim Policy

Claim for hospitalization expenses of complainant's wife was repudiated by the Respondent by invoking exclusion clause 4.1 of the mediclaim policy as pre-existing disease.

Insured covered under mediclaim policy since December 2001 and operated for kidney on 2000 which is justified as pre-existing disease and Respondent's decision is upheld. Thus case was dismissed.

Award dated 31-12-2008

Case No. 11-008-0189-09

Ms. Avani H Panchal Vs. Royal Sundaram Alliance Insurance Co.Ltd.

Mediclaim Policy

Claim lodged for treatment of the complainant was repudiated by the Respondent on the ground of treating doctor was not qualified.

The Investigation report of the TPA shows that Laboratory tests done by the complainant from Biotech Lab. was found closed since two to three months.

As per terms of Policy condition, the Medical Practitioner must be Physician, Specialist or Surgeon. In the subject case one hospital run by Dr. P. S. Yadav, RMP (Registered Medical Practitioner) by using the name, registration number and stamp of another M.B.B.S doctor. Mediclaim form completed by Dr. P.S. Yadav is not qualified and repudiation is justified. Thus case was dismissed.

Award dated 06-01-2009

Case No.11-004-0215-09

Mr. Dinesh J Makwana Vs. United India Insurance Co.Ltd.

Mediclaim Policy

The treatment for oral chemotherapy was repudiated by the Respondent by invoking exclusion clause that there was no hospitalization in subject claim.

The principle and rule though correct asking for hospitalization as the basic condition it is for ascertaining the treatment is given by qualified doctors with infrastructure facility.

In case of oral chemotherapy though given under medical supervision the hospitalization is not required as the patient is not kept under treatment or observation.

The Respondent's decision to repudiate the claim was set aside as the medical sciences are making advancement for betterment of the patient only in lesser difficulties/pains etc as such in view of the cost involved for dreaded disease the exception of hospitalization is required.

Award dated 15-01-2009

Case No.11-002-0219-09

Mr. S.M.Bhatt Vs. The New India Assurance Co.Ltd.

Mediclaim Policy

The Claim for Cardiac Stroke (C.V Stroke) and H.T was repudiated on exclusion clause of pre-existing disease.

The pleading of the parties revealed that the inception of cover is since 1997 and the complainant has taken treatment for D.M + HTN+CV stroke since 1999 which was not disclosed in the proposal form as such amounts to non-disclosure of fact in inception.

The Respondent however could not produce proposal form to confirm if the material is disclosed or otherwise as a proof of non-disclosure.

The conclusive proof was not submitted by the Respondent hence the complaint succeeded and the award was given directing Respondent to settle the claim.

Award dated 16-01-2009

Case No. 11-009-0254-09

Mrs. Pragna K Barot Vs. Reliance General Insurance Co.Ltd.

Mediclaim Policy

The claim for treatment of Incisional Hernia was repudiated as it was due to complication of operation done prior to inception of policy.

The Respondent proved that the insured underwent Tubal Ligation Operation two years back before inception of the policy and the hernia was the complication of this prior operation and repudiation was as per the terms and conditions of the policy.

The complaint was dismissed.

Award dated 20-01-2009

Case No.11-003-0246-09

Mr. Nanalal H. Jhaveri Vs. National Insurance Co.Ltd.

Mediclaim Policy

The claim for treatment for DM-II and CRF, HBP was repudiated by the Respondent informing that same was pre-existing.

As per the discharge summary of hospital, the insured was suffering HBP and DM since 15 years and policy incepted since 12 years.

The documents on record proved that the patient was brought to hospital in unconscious state and was unable to speak. The history given was by relatives on approximation as exact details have not known to the informant.

The Respondent's information was on the basis of noting of hospital but could not produce conclusive evidence to substantiate their stand.

The award given was directing the Respondent to settle the claim for admissible amount.

Award dated 21-01-2009

Case No.11-002-0171-09

Smt. Roopali B Rao Vs. The New India Assurance Co.Ltd.

Mediclaim Policy

The claim was repudiated on the grounds of exclusion clause as the patient had Cirrhosis of lever due to Chronic Alcoholism.

The Complainant's pleading was that cirrhosis of lever is not due to alcoholism but due to other reason also like infection of lever, Wilson's disease, inherited disease etc.

The Respondent proved that the hospital records and special facts conducted in the case confirm their stand.

Though the attending physician could not opined as to how the CL was developed, the habit of alcohol consumption proved for repudiation.

Thus the complaint was dismissed.

Award dated 21-01-2009

Case No.11-004-0251-09

Mr. Deepakbhai B Patel Vs. United India Insurance Co. Ltd.

Mediclaim Policy

The mediclaim was repudiated for late submission as per exclusion clause on the claim was not submitted in 30 days.

The Respondent proved that claim papers were submitted after 4 months without any convincing reason for delay.

The claim papers were submitted by complainant through agent cannot be the reason for consideration.

Thus the complaint was dismissed.

Award dated 27-01-2009

Case No. 11-005-0210-09

Mr. Rajendrabhai C Dani Vs. Oriental Insurance Co.Ltd.

Mediclaim Policy

The claim for incisional hernia was repudiated as the same was due to earlier operation for LSCS which is excluded as per policy terms and condition.

The Respondent proved that the earlier operation for LSCS done in 1983 had led to the hernia in 2008.

The incisional hernia means hernia developed from Scar of previous surgery. This is always associated with previous surgery.

Thus the complaint was dismissed.

Award dated 28-01-2009

Case No.11-002-0211-09

Mr. V.C. Chhabada Vs. The New India Assurance Co.Ltd.

Mediclaim Policy

Partial repudiation of claim for Kidney Transplant of the complainant.

The claim was for settlement of claim as per extended S.I Rs.3,00,000/- + C.B. The Respondent's pleading was for Rs.20,000/- S.I + C.B Rs.4,000/- (Total Rs.24,000/-).

The analysis of material on record shows Rs.20,000/-S.I in the year 2000 and was increased from time to time in 2002-03.2006-07, 2007-08 and 2008-09 coming up to Rs.3,00,000/- S.I. The insured was diagnosed Renal Disease in the year 2002

as such it was no pre-existing as 20-02-2002 the date of increase of S.I from Rs.20,000/- to Rs.45,000/- and thus can become pre-existing for subsequent increase in S.I.

Thus Rs.45,000/- be treated as S.I and award given directing Respondent to settle for Rs.45,000/-+C.B.

Award dated 27-01-2009

Case No. 11-09-0249-09

Mr. Mukesh K. Patel Vs. Reliance General Insurance Co. Ltd.

Mediclaim Policy

The claim for hospitalization was repudiated invoking exclusion clause for pre-existing disease.

The Complainant was earlier insured with New India Assurance Co. from 2001 to 2005. However due to operative canvassing by the agent, same was switched was to Reliance Genl. Insurance Co. from 2007-08.

The complainant was hospitalized for hysterectomy in April 2008. The discharge summary reflected that ovarian cyst was for the period prior to the policy with Reliance General Insurance Co. Ltd. This was proved by the Respondent as per documents confirming pre-existence of disease.

Thus the complaint was dismissed.

Award dated 28-01-2009

Case No.11-002-0164-09

Mr. Navinchandra Vyas Vs. The New India Assurance Co. Ltd.

Mediclaim Policy

The insured member was admitted for heart ailment but the claim was repudiated as the insured was having history of HTN

which was treated as pre-existing disease prior to policy inception.

The documents and pleading revealed that the policy incepted in 2001. The admission was for hemorrhage of the patient was not due to HTN but was due to aneurysm.

Thus pre-existing HTN as per Respondent could not be proved as the ailment was due to aneurysm, Complaint succeeded.

The Respondent was directed to settle the claim.

Award dated 27-01-2009

Case No.11-005-0243-09

Mr. Darshit H Majmudar Vs. Oriental Insurance Co.Ltd.

Mediclaim Policy

The Claim for operation for Piles in Ano was done by Ayurvedic Surgeon. The operation was for piles done by K.S. Application under General Anesthesia.

The exclusion clause however stated that Massages, stream bathing, shirodhara and alike treatment caused under Ayuvedic treatment by K.S. Application under General Anesthesia was not included in above Ayurvedic Treatment and Respondent's policy did not exclude K.S. Application treatment.

The Respondent was directed to settle the claim.

Award dated 29-01-2009

Case No.11-003-0205-09

Mr. Suresh K Modi Vs. National Insurance Co.Ltd.

Mediclaim Policy

The claim was repudiated on the basis of late submission of claim papers beyond 30 days as per policy condition.

The examination of papers revealed that the complainant had taken Radiotherapy. The complainant submitted that he lost documents during shifting of house. The fact was admitted by Respondent.

The complainants submission that original records are not provided by the hospital was agreed that the claim was to be submitted on copies only.

Thus, the complaint succeeds and Respondent was directed to settle the claim.

Award dated 29-01-2009

Case No. 11-004-0245-09

Mr. Chetankumar R. Patel Vs. United India Insurance Co.Ltd.

Mediclaim Policy

Claim lodged for treatment of Oral Chemotherapy for Cancer Colon was repudiated as there was no hospitalization by the Respondent as per their exclusion clause of non hospitalization.

The views taken in the case that the hospitalization is required for medical supervision and other infrastructure. Due to medical advancement to relieve the patient from pains etc. oral Chemotherapy is adopted though the same is costly.

The claim was succeeded on this grounds as the claim settlement to relief of dreaded disease for unfortunate victims. The policy clause does not exclude oral chemotherapy.

Respondent was directed to settle the claim.

Award dated 29-01-2009

Case No.11-005-0213-09

Mr. Sudhir S Goel Vs. Oriental Insurance Co.Ltd.

Mediclaim Policy

Claim for treatment of Coronary Artery Disease (CAD) was partially repudiated on the grounds of

The documents revealed that claim was for Rs.3,47,000/- against S.I. Rs.2.50 Lacs. The Respondent considered claim for Rs. 1.50 Lacs prior to increase by invoking clause 4.1 of pre-existing condition and clause 4.2 and 4.3 limiting the S.I prior to increase on S.I.

The mediclaim incepted on 1998 and renewed continuously for 10 years. This was first claim. While increase in S.I no medical report was obtained by Respondent. The claim falls when S.I. was increased and renewed policy does not show any exclusion.

The complaint thus succeeded and Respondent was directed to settle the claim for Rs.2.50 Lacs.

Award dated 30-01-2009

Case No.11-010-259-09

Mr. Manishkumar V. Panchani Vs. IFFCO TOKIYO Gen.Ins.Co.Ltd.

Mediquard Policy

The claim for treatment was repudiated for the reason that name of the Insured was not recorded in the Indoor Patient Register of the hospital which was viewed as fraudulent act.

The discharge card proved that the insured patient was in the hospital in specified period. Treatment papers and admission card proves the admission in the hospital.

Thus the repudiation was proved to be on wrong grounds and directed the Respondent to settle the claim.

Award dated 30-01-2009

Case No. 11-005-0222-09

Mr. Dilipkumar T. Kiri Vs. The Oriental Insurance Co.Ltd.

Mediclaim Policy

The claim for treatment for HTN of the insured consequent to accidental fall. Thus the hospitalization was due to accidental fall and is excluded from payment as per policy. Though the policy was incepted 8 years back has been renewed in claim.

On examination it was observed that in 2008 there was break of 16 days and parents was included subsequent to this by way of endorsement.

Since the insured being in first year of policy due to gap and the insured was admitted in lock in period (within 30 days of policy), the repudiation of claim is justified.

The complaint was dismissed.

Award dated 30-01-2009

Case No.11-008-0252-09

Mr. Kirit N. Raval Vs. Royal Sundaram Alliance Insurance Co.Ltd.

Mediclaim Policy

The cataract of the insured was repudiated clarifying it as Congenital Internal Disease.

During hearing with documents on record it was revealed that the policy was incepted in 2007 and with 2 years waiting period for cataract surgery there was excluded as per policy condition.

Since the policy conditions are clear and unambiguous the claim does not stand for admission.

The complaint was dismissed.

Award dated 30-01-2009

Case No.11-002-0212-09

Mr. Harshad B Satwara Vs. The New India Assurance Co.Ltd.

Mediclaim Policy

The insured's claim for treatment for Acute Low Back prolepses disc L-4.5 was admitted on 22-10-2007 and discharged on 24-10-2007. MRI was done and complete rest was suggested with epidural injection at an interval of 3 weeks.

However the Respondent treated the case on OPD as no hospitalization was required.

It was observed that complainant was admitted as per the advice of doctor and treatment involved complete bet rest/traction/injectables and rest can be treated on post hospitalization treatment.

The complaint succeeded on merit and Respondent was directed to settle the admissible claim.

Award dated 30-01-2009

Case No.11-005-0236-09

Mr.Balmukund N. Nagori Vs. Oriental Insurance Co.Ltd.

Mediclaim Policy

A claim for treatment for BPH with retention of Urine was partially settled.

The Respondent submitted that the insured raised the cover to Rs. 1 Lakh through Vax Assurance at the time of renewal with gap of 13 days. The increase made at 68 years of age which resulted as policy is in 1 year renewal and as per policy condition only 10% S.I is payable.

On examination it was viewed that policy is renewed in chain and S.I. was increased from Rs.25,000/- to Rs.1 Lakh since the benefit of renewal is available for original S.I. Rs.25,000/- with C.B Rs.2,500/- the claim should have been passed for Rs.27,500/-.

The Respondent was directed to settle the claim accordingly.

Award dated 30-01-2009

Case No.12-012-0241-09

Mr. Lalit Soni Vs. ICICI Lombard General Insurance Co.Ltd.

Health Insurance Policy

This is a case of telemarketing where the insurance cover was granted on telephonic contract.

The complainant pleaded that during the conversation they promises about the deduction of premium were made though the credit card however they blocked the amount and deducted the amount disproportionately. On cancellation of policy also the policy refund was as per terms and conditions only.

The complaint was thus dismissed.

Award dated 30-01-2009

Case No.11-003-0227-09

Mrs. Kokilaben K Shah Vs. National Insurance Co.Ltd.

Mediclaim Policy

Claim for hospitalization was repudiated as per clause 4.3, treating the policy as a fresh policy. The expenses for cataract during first two years of policy was not covered as per policy conditions.

It was revealed that policy was incepted from 2002 and was renewed 1 day late (instead of 5-9-2007 it was renewed from 6-9-2007). The cheque for renewal was received by the Respondent on 6-9-2007, but the cheque dated 4-9-2007 was sent to Respondent and Respondent is having discretion to condone delay up to 7 days.

As there was no rational in not treating it as continuous policy on the side of Respondent though the gap is only one day the Respondent was directed to treat this as continuous policy renewal and settle the claim.

Award dated 13-02-2009

Case No.11-004-0280-09

Mr. Dhirajlal P Soni Vs. United India Insurance Co.Ltd.

Individual Health Insurance Policy

Claim repudiated due to late submission by 42 days from the date of discharge as against the required time limit of 7 days.

As the reason for delay at the hands of the complainant was apparently convincing and on mediation of this forum the Respondent agreed to settle the claim

for

Rs. 3,490/- in full and final settlement to which the complainant agreed and joint resolution was signed by both the parties.

Award dated 16-02-2009

Case No. 11-002-0233-09

Mr. Bhagvatiprasad B Jani Vs. The New India Assurance Co. Ltd.

Mediclaim Policy

Claim for Rs.19,932/- against hospitalization for Myocardial Infarction was repudiated on the grounds of exclusion clause which do not allow claim under treatment for ailment following or arising hypertension.

The pleading of the parties and documents on record revealed that the policy was incepted in 2000 for S.I of Rs.25,000/- but was increased. The policy excludes the treatment arising from or out of H.T and the complainant was diagnosed for AMI (Acute Myocardial Infarction) which -------- H.T.

The complaint was dismissed.

Award dated 17-02-2009

Case No. 11-004-0287-09

Mr. Narendrakumar M Gangey Vs. United India Insurance Co.Ltd.

Mediclaim Policy

Claim lodged for operation for removal of calycen/stone was repudiated for late submission of claim papers by 16 days.

The documents and submission of parties revealed that the hospitalization from 17-07-2008 to 22-07-2008 was over but post hospitalization for drainage of urine bag and dressing

continued subsequently which should have been treated on post hospitalization treatment. Thus the submission of claim papers after bill and fitness certificate was well within the time schedule as such the Respondent is required to pay claim.

Respondent was directed to settle the claim.

Award dated 20-02-2009

Case No.11-010-0237-09

Mr. Anubhai Morbhai Vekariya Vs. IFFCO TOKIYO Gen.Ins. Co.Ltd.

Mediclaim Policy

Claim was repudiated on the basis of pre-existing disease.

The policy incepted from 16-08-2005 and was defaulted in renewal and took policy from IFFCO TOKYO from 8-9-2006 (other insurer).

The hospital documents proved that the complainant was earlier hospitalized for acute hepatitis on 1-9-2006 to 8-9-2006 which established that the ailment clarified as pre-existing and was found correct.

Thus case was dismissed.

Award dated 20-02-2009

Case No.11-005-0301-09

Mrs. Hansaben N. Patel Vs. Oriental Insurance Co.Ltd.

Mediclaim Policy

A claim for Rs.8,906/- for treatment of LRTI (Lower Respiratory Tract Infection) and bronchitis was repudiated on the basis of history given by the treating doctor.

However on mediation both the parties consented for settlement for 75% of claim.

The case was disposed on compromise.

Award dated 20-02-2009

Case No.11-005-0274-09

Mr. Vaikunth G. Bhatt Vs. Oriental Insurance Co.Ltd.

Mediclaim Policy

A Claim for Genito Urinary System was repudiated as the clause of minimum waiting period of 2 years.

Since the policy was incepted within the specified period of Exclusion clause the Respondent was justified in repudiation.

The case was thus dismissed.

Award dated 24-02-2009

Case No.11-009-0278-09

Mr. Bhupatsinh G. Soni Vs. The Reliance General Insurance Co.Ltd.

Mediclaim Policy

Claim for Perianal abscess was repudiated on the grounds of pre-existing disease.

The complainant switched over from New India Assurance Co. to Reliance from 16-08-2007. Thus after date of de-terrifying in 2006 the continuity benefit taken in Feb.2006 was thus cleared as pre-existing and the Respondent's decision to repudiate the claim was justified and case was dismissed.

Award dated 24-02-2009

Case No. 11-009-0204-09

Smt. Gitaben J Prajapati Vs. Reliance General Insurance Co.Ltd.

Health Wise Policy

Claim for reimbursement of hospital expenses was repudiated on the grounds of Pre-existing disease.

The complainant was admitted and treated for abdominal pain, bleeding and general weakness. Sonography revealed that on focal adenomyosis and patient was operated for vaginal hysterectomy on 29-08-2007.

Respondent's plea was that policy incepted on 26-07-2007 is treated as fresh policy but not supported by material evidence as excessive bleeding and pain are only symptoms.

As the policy was switched over from National Insurance Co. Ltd to Reliance w.e.f. 26-07-2007. History recorded for ailment was for 3/4 months which are symptoms and not disease. No doctor was aware about focal adenomyosis in uterine wall hence cannot be cleared as pre-existing.

The Respondent was directed to settle the claim keeping aside repudiation.

Award dated 24-02-2009

Case No. 11-005-0260-09

Mr. Prahladbhai P. Patel Vs. The Oriental Insurance Co. Ltd.

Mediclaim Policy

Claim for hospitalization for Kidney Transplant for donation was clarified as Donor Nepharectomy which is not covered in mediclaim policy.

The policy condition for Donation of Kidney is payable only when the limits of mediclaim of the recipient patient and not payable to Donor's mediclaim policy is upheld.

The complaint thus was dismissed.

Award dated 24-02-2009

Case No. 11-005-0279-09

Mrs. Sonalben V. Joshi Vs. The Oriental Insurance Co.Ltd.

Mediclaim Policy

Claim was repudiated as it was pre-existing. On the plea that insured was Anemia since last 10 years.

The Respondent though proved that the insured was anemia, it cannot be clarified as disease. In this case anemia was due to iron deficiency and no nexus with Anterior wall Ischemia.

The Respondent was directed to settle claim, setting aside repudiation.

Award dated 24-02-2009

Case No.11-002-0229-09

Mr. Rajesh M Jain Vs. The New India Assurance Co. Ltd.

Mediclaim Policy

Claim was repudiated alleging that use of tobacco leading to Cancer.

The insured was admitted for treatment of Carcinoma Lt. Upper Alveolus with history as Ex-smoker/Ex- tobacco chewer.

In the case the duration of smoking and chewing is not mentioned. The hospital did not certify that cancer was due to smoking or chewing of tobacco and cancer attribute other reason also. There was no question in proposal form whether the insured is tobacco chewer or smoker.

Thus repudiation is not justified. Respondent was directed to settle the claim setting aside the repudiation.

Award dated 25-02-2009

Case No.11-004-0288-09

Mr. G.J.Sheth Vs. United India Insurance Co.Ltd.

Mediclaim Policy

Claim was repudiated on the grounds that the documents are not submitted in specified time limit.

The insured was admitted between 9-6-2008 to 15-06-2008. The fitness certificate was given by attending doctor on 30-06-2008. The claim was submitted on 11-07-2008.

After going through the entire happenings the benefit of condonation of 7 days (14-07-2008) the papers were well within condonation period (submission on 11-7-2008). Thus the repudiation was not justified.

Respondent was directed to settle the claim setting aside repudiation.

Award dated 25-02-2009

Case No. 11-004-0298-09

Mr. Naishadh V. Bhatt Vs. United India Insurance Co.Ltd.

Mediclaim Policy

Claim for hospitalization and treatment of heart disease was repudiated on the grounds of exclusion clause of same treatment.

The documents on record and pleading of the parties it was revealed that the insured had history of diabetes and closure of ASD. This ailments were declared by the insured and also were excluded from the policy cover with specific mention.

Since it was proved that the exclusion was correctly recorded and informed to the complainant in policy schedule the case was dismissed.

Award dated 25-02-2009

Case No. 11-002-0303-09

Mr. Jayesh H. Nagori Vs. New India Assurance Co.Ltd.

Mediclaim Policy

Claim for hospitalization for Cancer treatment was repudiated on the grounds of exclusion clause of tobacco chewing leading to cancer.

The documents revealed that the insured was tobacco chewer and diagnosed for the same on endoscopies.

The complainant pleaded that the policy cover incepted 18 years earlier and from 2007 onwards only this exclusion was mentioned in renewed policy.

The judgment of Hon. High Court of Gujarat under LPA No.1029 of 2003 etc. and SCA No.9425 of 2002 dated 12-12-2003 indicated that the cover for diseases which was not excluded earlier in first year of cover would continue even in subsequent renewals if the renewal premiums are paid in time.

In this case the renewal was continuous and also that Respondent did not prove that tobacco chewing leads to cancer. The Respondent was directed to settle the claim keeping aside the repudiation.

Award dated 26-02-2009

Case No. 11-005-0263-09

Mr. Pravinkumar S. Joshi Vs. Oriental Insurance Co.Ltd.

Mediclaim Policy

The mediclaim was repudiated on the grounds of pre-existing disease prior to inception of policy.

The documents on record confirmed that the complainant lodged claim for Ischemic Heart Disease but the

person was having interior wall myocardial infarction with B.P since last 20 years and diabetes for 2 years whereas the inception of policy is from 15-05-2005.

The complaint was dismissed.

Award dated 26-02-2009

Case No. 11-004-0281-09

Mr. Hareshbhai Thakor Vs. United India Insurance Co. Ltd.

Mediclaim Policy

Mediclaim lodged for ailment of severe chest pain – Angina pain and High B.P was repudiated on the grounds that only oral treatment was given and hospitalization was less than 24 hours (on the basis of hospital summary). However, since the Respondent did not submit Self Contained Note to support its stand nor any documentary evidence was submitted for more than one month till hearing- the forum opined that Respondents grounds for rejection is not tenable and there is nothing on record to justify rejection of claim.

The Respondent was directed to settle the claim within 15 days.

Award dated 26-02-2009

Case No. 11-002-0294-09

Mr. J.S. Mehta Vs. The New India Assurance Co.Ltd.

Janata Mediclaim Policy

Claim for treatment of accidental injury for Rs.46,463/- was settled only for Rs. 10,000/- and balance was not paid.

The documents revealed that maximum permissible amount as per policy condition is Rs.10,000/- only. But

on examination it was found that limit for Arthroscopy under schedule 2.9 is Rs.10,800/- as such balance Rs.800/- still becomes payable.

Respondent was directed to settle balance amount of Rs.800/-.

Award dated 26-02-2009

Case No. 11-09-0300-09

Mr. Rajnikant A. Patel Vs. Reliance General Insurance Co.Ltd.

Health Wise Policy

Claim against the treatment of Pulmonary Koch and Typhoid for Rs.17,517/- was repudiated on the grounds of fraudulent claim.

The documents on record revealed that TPA's remarks of noticing certain irregularity on claim papers scrutiny was observed besides the information given by insured.

The Respondent had made vague statement without mentioning specific irregularity or discrepancy in the report. They have not questioned date of admission and date of discharge and also not disputed about cash receipt issued by hospital and chemist and no discrepancy was pointed out. The investigator submitted questionnaire for insured which was filled in by him and signed and sealed which alleges about discrepancies in vague nature. Complainant agreed that he signed the questionnaire but comments were written by investigator who informed him that this will enable the payment of claim.

Thus the Respondent was directed to settle for admissible amount.

Award dated 26-02-2009

Case No. 11-002-0319-09

Mr. Shailesh I Patel Vs. The New India Assurance Co.Ltd.

Mediclaim Policy

Claim for hospitalization and treatment expenses of operation for Umbilical Hernia was repudiated on the grounds that it was incisional hernia due to previous history of hysterectomy as per the opinion of medical referee of the Respondent.

The documents however revealed that the operating doctor certified that the hernia is Umbilical hernia and not incisional are due to hysterectomy.

Since the Respondents pleading is not supported by medical science and in adults too much abdominal pressure may cause umbilical hernia may be due to ability, heavy lifting and multiple pregnancies etc. thus the complaint succeeded.

The Respondent was directed to settle the claim.

Award dated 04-03-2009

Case No. 11-002-0283-09

Mr. G.K.Agrawal Vs. The New India Assurance Co.Ltd.

Mediclaim Policy

Mr. G.K.Agrawal lodged claim for hospitalization of insured wife for ventral hernia was repudiated on the grounds of pre-existing disease.

The documents revealed that the insured had undergone abdominal hysterectomy 10 years earlier and the ventral hernia is the cause of this earlier operation as this operation was earlier to inception of the present policy and

amounts to pre-existing exclusion where the Respondent was justified.

The complaint was dismissed.

Award dated 04-03-2009

Case No. 11-009-0290-09

Mrs. Raxaben R. Prajapati Vs. Reliance General Insurance Co.Ltd.

Mediclaim Policy

Claim lodged for hospitalization for Mitral Valve prolapsed and Anginal pain + anemia. There was no past history. The claim was repudiated on the basis of pre-existing on the grounds of letter obtained from the complainant that she was taking medicine for the ailment.

However the Respondent's medical referee could not prove/submit any evidence as to when the tablet was started. Thus the medical referee's inference about pre-existing hypertension could not be proved. The Complainant denied that she submitted any letter and agreed that the letter written by medical referee was signed by her on his insistence.

As Respondent failed to justify the repudiation on the grounds of non-disclosure of facts the Respondent was directed to settle the claim.

Award dated 12-03-2009

Case No.11-017-0307-09

Mr. Rakeshkumar N.Shah Vs. Star Health & Allied Insurance Co.Ltd.

Star Health Policy

The claim for treatment expense of diabetics and bronchitis was repudiated on the grounds of pre-existing disease.

The complainant had insurance with United India Insurance Co. Ltd since 2002 and switched over to Star Health & Allied Insurance Co. in 2007 without break.

The Respondent's plea that the policy be treated as fresh policy is not tenable because they were aware of earlier insurance since 2002. The Respondent was responsible to make the complainant aware about the consequences being fresh policy and can not absolve themselves from liability that of non-disclosure on previous insurance with United India Insurance was known to them.

The Respondent was directed to settle the claim.

Award dated 13-03-2009

Case No.11-003-0277-09

Mr. Biran N. Shah Vs. The National Insurance Co.Ltd.

Mediclaim Policy

The Claim lodged for hospitalization of the Insured for cancer for oral chemotherapy was repudiated as there was no hospitalization.

Since due to medical advancement the chemotherapy can be administered orally which relatively reduce his pain and patient has to be taken as per with that of earlier methodology for the dreaded disease like cancer and in such case the 24 hours of hospitalization should be ignored.

On this ground the Respondent was directed to settle the claim.

Award dated 17-03-2009

Case No. 11-004-0314-09

Mr. Soy P. Itty Vs. United India Insurance Co.Ltd.

Individual Health Insurance Policy

Claim for hospitalization for Depression Episode was repudiated by Respondent on the grounds of "No justification for hospitalization".

The documents on records proved that for depression treatment the hospitalization is not required which was as per terms and conditions of policy clause, there was no advice for qualified medical practitioner.

The claim was dismissed.

Award dated 16-03-2009

Case No. 11-002-0318-09

Mr. Rasikbhai M Patel Vs. The New India Assurance Co.Ltd.

Mediclaim Policy

Claim for hospitalization expenses was settled for lesser amount than the claimed amount.

The documents revealed that as per the related clause 2.1, 2.3 and 2.4 the hospitalization expenses are reimbursed in relation to Sum Insured and has fixed percentage with the Sum Insured category.

The examination of records proved that the Respondent was justified in correct reimbursement.

The complaint was dismissed.

Award dated 16-03-2009

Case No. 11-003-0297-09

Mr. Manish B. Shah Vs. National Insurance Co. Ltd.

Mediclaim Policy

Claim lodged for expense of hospitalization for the insured was repudiated on the grounds of hospitalization for diagnostic purpose and not for treatment.

The documents on record and pleading of the parties revealed that the insured was admitted in Orthopedic Hospital after falling down from scooter and having severe back pain and was not able to sit and stand. The diagnosis was Compression fracture of D-12 Vertebra with Ligamental injury and was treated accordingly.

Thus it was apparent that hospitalization due to accident was essential and not diagnostic.

The Respondent was directed to settle claim keeping aside repudiation.

Award dated 16-03-2009

Case No.11-004-0250-09

Mr. Dhiren I Shah Vs. United India Insurance Co. Ltd.

Mediclaim Policy

Claim for hospitalization expenses was partially settled in relation to % of Sum Insured.

The documents revealed that the claim was settled as per the copying of payable amount which relates to 20% of Sum Insured and since it was correctly paid as per the terms and conditions of the policy, the complaint was dismissed.

Award dated 17-03-2009

Case No.11-09-0309-09

Ms. Veena A. Almal Vs. Reliance General Insurance Co.Ltd.

Mediclaim Policy

Claim was repudiated on the grounds that the ailment was pre-existing.

The documents revealed that the insured was treated for Mesh repair of Umbilical Hernia after the hysterectomy fibroid uterus. However the -------- of the insured confirmed with the operating surgeon's report that Sonography detected infra umbilical midline incisional hernia was not due to earlier hysterectomy as such Repudiation was unjustified.

Respondent was directed to settle the claim keeping aside the repudiation.

Award dated 17-03-2009

Case No.11-002-0295-09

Mr. Bhavya A Shah Vs. The New India Assurance Co. Ltd.

Mediclaim Policy

Claim for hospitalization expense was partially settled disallowing Rs.10,030/-.

The claim for accidental fall resulting in fracture of leg and wrist. The policy terms and condition given exact amount payable under various heads and accordingly the amount paid was correct.

The complaint was dismissed.

Award dated 18-03-2009

Case No. 11-005-0267-09

Mr. Jashvant R.Gajjar Vs. The Oriental Insurance Co.Ltd.

Mediclaim Policy

Claim lodged for hospitalization expenses of the insured was repudiated on the grounds of exclusion of

treatment of hysterectomy due to any clause (No.2-1-3 of policy).

The documents on record and pleading revealed that the policy was renewed continuously without break and there was no evidence on record that the Respondent informed about change in policy about this ailment exclusion nor asked for consent when the terms and conditions were changed from 2007.

Thus the repudiation was not commit because they have ignored the fact of surgery of various cyst and this was not excluded in policy as this was confused with hysterectomy.

The Respondent was directed to settle the claim keeping aside repudiation.

Award dated 18-03-2009

Case No. 11-004-0311-09

Mr. Manish A Raval Vs. United India Insurance Co.Ltd.

Mediclaim Policy

Claim lodged for hospitalization expenses for treatment arising from traceable to pregnancy including Caesarian Section was repudiated.

The documents revealed that as per exclusion clause No.4.12 imposed when the insured complained abdominal pain suspected due to Kidney disorder. The papers revealed that past LSCS sepsis with acute renal failure. The insured developed High B.P in 6th month of Pregnancy.

The nephrologists opined that thrombophlebitis (vein inflammation) relating to blood clot of ovarian vein.

It was confirmed that Repudiation ground of pregnancy is not correct as the actual cause was for Acute

Renal Failure due to thrombophlebitis and has no nexus with pregnancy.

Thus Respondent was directed to settle the claim.

Award dated 18-03-2009

Case No. 11-002-0324-09

Mr. Akshay H Patel Vs. The New India Assurance Co.Ltd.

Mediclaim Policy

Claim lodged for expenses for hospitalization of the insured for Cystic Lesion Rt. Mandible was repudiated under exclusion clause of Dental Treatment.

The documents on record and pleading of parties revealed that as per opinion of Dental Surgeon that Cystic Lesion of Right Angle of Mandible is not related to Dental treatment. Cystic Lesion is usually benign but can be locally aggressive and destructive and has to be removed Surgically.

The Respondent hence directed to set aside the repudiation and settle the claim.

Award dated 18-03-2009

Case No. 11-002-0333-09

Mr. Jagdish P Dave Vs. The New India Assurance Co.Ltd.

Mediclaim Policy

Claim lodged for Hospitalization expenses of the insured for IHD (Ischemic Heart Disease) was repudiated on the grounds of pre-existing disease under its exclusion clause.

The documents and pleading of the parties revealed that the insured was suffering from coronary Artery disease

with HT & DM since 6 to 7 years which was prior to the inception of the policy.

The discharge summary of the hospital confirmed the ailments were pre-existing and complainant did not challenged the same.

Thus the repudiation was justified and complaint was dismissed.

Award dated 19-03-2009

Case No. 11-004-0308-09

Mr. Natvarlal C. Vyas Vs. United India Insurance Co.Ltd.

Mediclaim Policy

Claim lodged for hospitalization expenses was repudiated by the Respondent.

The documents on records and pleading of the parties revealed that the claim for Non Hodgkins Lymphoma Brain treatment claim was submitted late by 114 days. The analysis of the case proved that the insured was admitted in different spells for 9 times with gaps in between which was involved chemotherapy. The fitness certificate by attending doctor was on 17-11-2008 after which the claim was submitted which was well within the time limit.

The Respondent was directed to settle the claim keeping aside the repudiation.

Award dated 20-03-2009

Case No.11-005-0328-09

Mr. Nareshkumar A. Modi Vs. Oriental Insurance Co.Ltd.

Mediclaim Policy

TTD claim for Accidental treatment was repudiated on the grounds that TTD for 4 weeks was not due to accident but because of inflammation with roater cuff intact.

The documents revealed that the insured was continued to perform his normal duties in days which claimed for TTD and was after 5 months of the accident of lifting goods at work places.

It was established that the injury/accident was not sole and direct cause for TTD as such the Repudiation was justified and case was dismissed.

Award dated 25-03-2009

Case No. 11-002-0339-09

Mr. Rajenikant B Rashiya Vs. The New India Assurance Co.Ltd.

Mediclaim Policy

The insured's claim for hospitalization expenses was settled for the lesser amount than that of claimed amount.

The documents revealed that the Respondent had curtailed the amount under each head such as Room/Nursing charge, O.T charge Medicine etc which was as per the Sum Insured.

The complainant's plea that the charges were standard as per the hospital was ruled out by Respondent's pleading that the mediclaim after 2007 ----- expressly mentioned that they have kept capping of expenses based on Sum Insured which is 1% of S.I and has been duly informed to the insured in the policy terms and conditions on the basis of which it was found that repudiation is justified.

Case was dismissed.

Award dated 26-03-2009

Case No.11-002-0335-09

Mr. S.C. Shah Vs. The New India Assurance Co.Ltd.

Mediclaim Policy

The mediclaim for hospitalization expenses was repudiated on the grounds of treatment arising out of traceable pregnancy, childbirth, miscarriage etc. as per exclusion clause 4.12.

The documents on record and pleading of the parties revealed that the insured was admitted for operation of Para Umbilical Hernia and Respondents submission was that there was previous surgery of LSCS and the hernia is out come of earlier surgery.

Since it was established, on the basis of attending surgeon, that the hernia was Para Umbilical Hernia, clarifies the doubts and being reliable the repudiation on the basis of previous surgery was ruled out.

The Respondent was directed to settle the claim.

Award dated 27-03-2009

Case No. 11-004-0326-09

Mr. Manoj Y Acharya Vs. United India Insurance Co.Ltd.

Mediclaim Policy

Claim was repudiated on the grounds of exclusion for treatment of traceable pregnancy etc.

The documents revealed that treatment for Endometriosis i.e. presence of tissues inside Uterus and has no relation with earlier LSCS which was the grounds for repudiation.

The Surgeons opinion being more reliable the repudiation was set aside and directed for settlement of claim.

Award dated 27-03-2009

Case No. 11-003-0292-09

Mr. Rajesh Natwarlal Purohit Vs. The National Insurance Co. Ltd.

Mediclaim Policy

The claim for hospitalization expenses was repudiated on the grounds of late submission as per exclusion clause.

The documents revealed that insured was admitted for Hypogastric pain and Haematuria + dislodgment of Urethral stone but the intimation was not given in 7 days as there was no one at home.

The complainant was residing in remote and small village in Rajasthan besides the fact that he was not provided with terms and conditions of the policy. Secondly the delay was of 12 days as against 7 days which is marginal and condonable by Respondent.

The Respondent was directed to settle the claim.

Award dated 30-03-2009

Case No. 11-005-0304-09

Mr. Anantrai V Sanghvi Vs. Oriental Insurance Co.Ltd.

Individual Mediclaim Policy

Claim for hospitalization expenses was repudiated on the grounds of exclusion clause 4.8 for that ailment.

The documents and pleading revealed that the insured was admitted for treatment of chronic Laxative abuse, Mild renal impairment and Chronic Malabsorption. This ailment

is related to general debility, Run-down and Psychiatric disorder.

As per the exclusion clause the Respondent repudiated the claim was justified.

The case was dismissed.

Award dated 30-03-2009

Case No. 14-003-0331-09

Mr. B.D. Modi Vs. National Insurance Co. Ltd.

Mediclaim Policy

Claim for hospitalization expenses was repudiated on the grounds of pre-existing disease.

The documents and pleadings revealed that the claim was for treatment of acute backache with history of Stress pain and treated forL-2- L-3, L-3-L-4 and L-5 S1 Intervertrebral discs and policy incepted from 1994.

The Respondent's plea that the backache was prior to 1994 did not support any documentary evidence hence the repudiation was not justified.

The Respondent was directed to settle the claim.

Award dated 30-03-2009

Case No. 11-002-0352-09

Mr. Parag M Parikh Vs. The New India Assurance Co. Ltd.

Mediclaim Policy

The claim was repudiated on the grounds of Clause 2.3 that minimum hospitalization of 24 hours was not required and patient could have been treated on OPD basis.

The documents revealed that the patient was admitted for right foot abscess for 1 day as it was accompanied with

edema and pain and could not be treated on OPD basis with surgery and general anesthesia.

Thus the repudiation was not justified and Respondent was directed to settle the claim.

Award dated 30-03-2009

Case No. 11-003-0329-09

Mrs. Sadgunaben P Shah Vs. National Insurance Co. Ltd.

Mediclaim Policy

Claim was repudiated on the grounds of exclusion clause for surgery of Gall Bladder and bile duct under Clause No.4.3.

The documents revealed that the insured was treated for acute acalculus cholesystitis with peritonitis which relates to surgery of Gall Bladder.

Since the Respondent's pleading of exclusion clause in policy terms and conditions was justified, the case was dismissed.

Award dated 30-03-2009

Case No. 11-002-0320-09

Mr. H. I. Mistry Vs. The New India Assurance Co. Ltd.

Mediclaim Policy

Mediclaim was repudiated on the grounds of exclusion clause for pre-existing disease and cover is not for treatment of Cataract, Benign prostate Hypertrophy, Hysterectomy for menorrhagia or Fibromyoma, Hernia, Hydrocele, congenital internal disease, defect and related disorders in the first year as per the terms and conditions of the policy.

The documents revealed that the insured was hospitalized for Urogenital system disorder which were excluded for first three years of policy inception.

The repudiation was justified hence case was dismissed.

Award dated 30-03-2009

Case No. 11-002-0330-09

Mr. M.B.Shah Vs. The New India Assurance Co. Ltd.

Individual Mediclaim Policy

Claim was partially settled disallowing total claimed amount as per the terms and condition of policy for dental treatment.

The documents and pleading revealed that insured suffered head injury with CLW on lip which had to be stitched which required some time to heal. Thus, prior application of clause of the policy is rather harsh.

The Respondent's offer of 1/3 claim amount was set aside and directed them to settle the claim for full amount.

Award dated 30-03-2009

Case No.11-004-0334-09

Mrs. Dinbalaben Shodhan Vs. United India Insurance Co. Ltd.

Mediclaim Policy

The claim was repudiated for treatment of Chemotherapy for Cancer of Prostate of the Insured on the grounds under clause 1.1 that Chemotherapy/Radiotherapy when oral will be treated as OPD treatment.

Since it was found that Respondent had not examined the papers carefully and allegated that treatment did not

require hospitalization and that there was evidence to confirm that chemotherapy was administered in the clinic under supervision of doctor, it became evident that Repudiation was not justified.

The Respondent was directed to settle claim keeping aside repudiation.

Award dated 30-03-2009

Case No. 11-002-0332-09

Mr. Dhaval B Shah Vs. The New India Assurance Co. Ltd.

Mediclaim Policy

Claim was repudiated on the grounds of Medical Circular disallowing the treatment for Hairline Stress/Fracture as per clause 3.4.

The documents and pleading in the subject case revealed that insured met with accident resulting into Hairline fracture of Tibia but the allegation of Respondent about exclusion was not supported by any clause under Mediclaim policy 2007. The clause 3.4 was misquoted as the said clause refers to waiver of minimum hospitalization condition.

The Respondent's repudiation was totally on wrong interpretation of clause 3.4 hence was directed to settle claim.

Award dated 30-03-2009

Case No. 11-005-0327-09

Mr. Shaileshkumar G. Joshi Vs. Oriental Insurance Co. Ltd.

Mediclaim Policy

The mediclaim submitted was not settled in-spite of completing requirements.

The documents and pleading of the parties revealed that the insured was suffering from rhinorrhea (running nose with nasal discharge) since 5 years prior to inception of the policy. The Surgical operation of Rhinorrhea was DNS confirming that ailment pre-existed the subject policy amounting to exclusion of disease.

Since, sufficiently proved that the ailment pre-existed the case was dismissed.

Award dated 31-03-2009

Case No. 11-004-0358-09

Mr. Jasmin C. Pandya Vs. United India Insurance Co. Ltd.

Mediclaim Policy

Claim lodged for treatment for two days but the claim was repudiated as there was no intimation in 24 hours and no submission of claim within 15 days of discharge as per clause No.5.3 and 5.4.

The documents and pleading revealed that the intimation was given to TPA but Respondent could not prove that it was given late. As regards claim papers, the insured was prescribed medicine for 5 days after discharge to declare fit.

Thus the actual delay was not 29 days as Respondent stated but was for 25 days instead of required 15 days time from which can be viewed on marginal delay when read with insured's claim free 4-5 years prior to claim.

The Respondent was directed to settle the claim keeping aside the repudiation.

Award dated 31-03-2009

Case No. 14-002-0350-09

Mr. Joheri H. Sadanpurwala Vs. The New India Assurance Co. Ltd.

Mediclaim Policy

Claim lodged was repudiated as the claim was not submitted in 7 days which was admitted by both the parties.

However on mediation by the forum the Respondent agreed for 75% of claim for which complainant consented and case was resolved.

Award dated 31-03-2009

Case No. 11-002-0359-09

Mr. Farokh K Gazdar Vs. The New India Assurance Co. Ltd.

Mediclaim Policy

The mediclaim lodged for Rs.68,329/- for seizure episode was rejected on the grounds of pre-existing disease.

The documents and pleading of the parties revealed that insured was polio affected aged 72 years where the exclusion clause was mentioned for polio related disease.

However the insured was found unconscious in his house with probable cause of seizure episode not amounting to febrile convulsion (which occur in young children).

The discharge card mention treatment for hemiparesis past infective which is due to muscular weakness in one part of body.

Thus allegations of Respondent that pre-existing hemiparesis is not established as it is not disease but condition of body as such Repudiation becomes unjustified.

The Respondent was directed to settle claim.

Award dated 31-03-2009

Case No. 14-004-0362-09

Mr. Viththalbhai R. Shah Vs. United India Insurance Co. Ltd.

Individual Health Insurance Policy

Claim lodged for insured's treatment of abdominal pain expenses was neither settled nor any requirement called for, for longer time.

The documents and pleading revealed that insured was operated for hysterectomy was amounting to late submission of claim even without supporting evidence nor replying the insured.

Respondent was directed to settle the claim.

Award dated 31-03-2009

Case No. 11-004-0344-09

Mr.Kaumud C. Christian Vs. United India Insurance Co. Ltd.

Individual Mediclaim Policy

The mediclaim lodged for reimbursement of expenses was repudiated on the grounds of late submission of claim under clause 5.4.

The documents revealed that complainant submitted claim papers in time but does not have proof of acknowledgement of receipt of papers by TPA.

Respondent was willing to consider condoning the delay but wanted original claim papers.

As the complainant did not have any proof of submission of papers in the prescribed time limit the Repudiation was justified. However, since Respondent was agreeable to condone delay but required original papers the dispute could be resolved at their level.

The case was disposed.

Award dated 31-03-2009

Case No. 11-002-0361-09

Mr. Sureshkumar S. Kothari Vs. The New India Assurance Co. Ltd.

Mediclaim Policy

Claim lodged was repudiated on the grounds of Clause ----- as the hospitalization was not required for severe backache.

The documents revealed that the insured was diagnosed for L-4,5 and L-5-S-I disc annular tear and root compression (from MRI).

Treatment given was oral medicines and injection but treating doctor's opinion is non acceptable as he is qualified surgeon than panel doctor's opinion. Thus the repudiation is not justifiable.

Respondent was directed to settle claim.

Award dated 31-03-2009

Case No. 11-010-0247-09

Mr. Lalit N. Shahani Vs. IFFCO TOKIO General Insurance Co. Ltd.

Individual Medishield Policy

Claim lodged for Kidney disease was repudiated on the grounds of exclusion of genetic disorder.

The documents and pleading after its analysis revealed that the case of Chronic Kidney disease stage-5 and there was no Alports syndrome (as pleaded by Respondent). Genetic disorder is disease that is caused by abnormality in individual's DNA. The complainant was not admitted for any genetic disorder but evaluation of kidney transplant, which

is not excluded from provision of policy. Repudiation not justified.

The Respondent was directed to settle the claim.

Award dated 31-03-2009

Case No. 11-005-0346-09

Mr. Babubhai M. Patel Vs. Oriental Insurance Co. Ltd.

Mediclaim Policy

Claim lodged for expenses of Cataract operation was repudiated by invoking exclusion clause 4.3.

The documents and pleading of the parties revealed that the complainant and insured member were admitted for Rt. eye mature Cataract surgery and also irreducible Ventral Hernia.

It was established that there was break of one month in renewal of policy and the exclusion of both the diseases under clause 4.3 become applicable.

The Respondent was justified in repudiation of claim as such case was dismissed.

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Award dated 31-03-2009

Case No. 14-002-0354-09

Mr. Dilip C Kharidiya Vs. The New India Assurance Co. Ltd.

Individual Mediclaim Policy

Claim lodged for treatment expenses for accidental injury was partially settled on the grounds of the reimbursement on the count of injury due to accident was excluded as per policy terms and condition.

The documents confirmed that Respondent has settled the claim beyond the terms and condition and settlement was correct.

The case was dismissed.

Award dated 31-03-2009

Case No. 11-004-0345-09

Mr. P. K. Shah Vs. United India Insurance Co. Ltd.

Mediclaim Policy

Claim lodged for hospitalization expenses of the Insured was repudiated on the grounds of late submission by 28 days as against 7 days without convincing reasons.

The forum was of the opinion that the delay is not inordinate in view of the reason given and hence Respondent also agreed for settlement.

The case was disposed on mediation.

Award dated 31-03-2009

Case No. 11-002-0363- 09

Ms. Suvarnaben A Parikh Vs. The New India Assurance Co. Ltd.

Mediclaim Policy

Claim lodged was partially settled on the grounds of capping of the reimbursement as per policy clause related to Sum Insured.

The documents revealed that the mediclaim reimbursement is related to Sum Insured on % basis mentioned in the policy clause 2.1, 2.3 and 2.4 under various heads.

Thus calculation of Respondent were in accordance with policy condition except Inward investigation charges where Rs.450/- was wrongly deducted.

The Respondent was directed to settle claim for balance Rs.450/-.

Award dated 31-03-2009

Case No. 11-002-0265-09

Mr. Manoj P Bhatt Vs. The New India Assurance Co. Ltd.

Mediclaim Policy

Claim lodged was repudiated on the grounds of Clause No.4.10, 5.4 and 5.7 alleging that Indore case papers were not made available, which are overwritten and manipulated.

On analysis of papers and pleading it was established that there are infirmities in lodgment of claim whereby the repudiation is justified.

Case was dismissed.

BHOPAL

BHOPAL OMBUDSMAN CENTRE

Case No.: GI/ITG/0708/60

Shri Mr. Ambika Tiwari V/s Iffco Tokio Gen. Insurance Co.

Order No.: BPL/GI/0708/25 dtd. 22.10.2008

Brief Backgrounda

Mr.Ambika Tiwarihad insured under Medishield Policy No.31/IGM/05-06/52034601 for the period 01/12/2006 to 30/11/2007 for Sum Insured Rs. 20000/- from M/s Iffco Kotkio Gneral Insurance Co. Kolkata

He was suffering from Infective Hepatitis with Jaundice (Piliya) and was admitted in Madan Mahal Hospital, Jabalpur for the period from 28.2.2007 to 3.3.2007 where exp. for Rs. 12777.00 and submitted to Insurance Co. but till date the Claim is rejected by TPA vide their letter dated. 23.7.2007. The Respondent in its reply stated that - the requisite documents are not submitted by complainant for processing the claim

but in spite of repeated request from the TPA, the insured failed to submit the documents. Hence the TPA has no other option but to close the claim.

Observation

There was no doubt that the Insured was suffering from Infective Hepatitis with Jaundice (piliya) as confirmed from the prescription/discharge ticket of Madan Mahal Hospital which also certified by previous attending Dr. Shushil Kalley in his Certificate cum Receipt dated 27.2.2007 As per the Whole Abdomen Sonography report dtd. 28.2.2007 of Dr. H.C.Dube, MBBS, DMRD Radiologist & Sinologist, the Liver shows Mild Enlargement and the Hospitalization was as per the advices of Dr. H.R.Lodh of Madan Mahal Hospital. The Respondent through M/s Golden Multi Services Club Ltd. Vide their letter dated. 3.4.2007 & 11.5.2007 asked the Insured to submit the various documents along with the USG plates of Whole abdomen (performed by Madan Mahal X-ray & Sonography center done on 28.2.2007 & 10.3.2007) & Registration No. of Nursing home. The complainant during hearing agreed that the USG plates could not be provided by him due to the same has not provided by Center to him and also that the same is not possible at present being the same plates can be arranged at the time of Investigation only. He also explained that he was unaware that the same will be the requirement of Insurance Co. for Claim. However, the disease of Infective Hepatitis with Jaundice is quite evident from various documents of attending doctors for which the complainant was hospitalized & incurred the necessary Medical Expenses. Since, the disease is ascertained even without the plates which not provided by Hospital/radiologist can not prejudice the admissibility of Claim. However, the Insured is also agreed to submit all other Claim related documents to Insurance Co.

Decision:

In view of the circumstances stated above, the decision of the Respondent to No Claim/non payment of Claim is unfair and unjust. Hence, directed Respondent to settle the claim for Rs. 12777.00 within 15 days on receipt of claim required documents from the Complainant (waiving the requirement of USG plates & Registration of Nursing Home) as also committed by both party during hearing.

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BHOPAL OMBUDSMAN CENTRE
Case No.: GI/UII/0708/56
Shri S.K.Dubey . V/sUnited India Assurance Co. Ltd.,.
Order No.: BPL/GI/0809/26 DTD. 22.10.2008

Brief Background

Mr. S.K.Dubey and his wife Smt. Rajni Dubey were covered under Mediclaim policy No. 191100/48/07/97/00000318 for S.I of Rs. 75000/- for the period 13.11.2007 to 12.11.08 from United India Assurance Co. Ltd.,

As per the Complainant he himself admitted in Akshyay Hospital Bhopal for the period 24.01.08 to 29.01.08 for the treatment of heart disease. He was taking mediclaim policy since 13.11.06 without any break. After the treatment of his present ailment, but the claim was settled for Rs. 8129.00 as against claim for Rs. 31195.00 after deducting Rs. 23066.00. The Respondent in its reply stated that the Complainant had preferred a claim for the hospitalization from 24.01.08 to 29.01.08 for Rs. 31195.00 for heart disease and that the S.I. under the Policy is only for Rs. 75000.00 for the policy period 13.11.2007 to 12.11.2008. As per Policy condition 1.2(D) it is specifically mentioned that for major surgery-Angioplasty 70% of Sum Insured will be payable and as the first claim relating to heart disease surgery for the admission date 26.11.2007 was paid for Rs. 44371.00 as such in this head balance amount left was for only Rs. 8129.00 which is paid to Complainant for the admission dated 24.1.08 to 29.1.08 and also that the they have settled the claim as per the specific conditions laid down under condition No. 1.2 (d) hence, as such no deficiency has been observed in the settlement of claim by them. Respondent also submitted Policy documents, TPA letter dated. 15.9.08 & Agent's Statement in support of defense.

Observations:

The Policy copy given to Complainant does not contain the above-mentioned conditions. Only premium receipt & two-paged policy without any clause & conditions were given to complainant. On going through the Policy copies submitted by Complainant & Insurance Co. & found that the policy copy provided to Complainant contains no Conditions of 70% restriction of S.I. Moreover, On going through the both Claim documents and found that there is no specific treatment for Major Surgery-Angioplasty in any claim for which the condition of 70% is applied by Insurance Co. As per Summary at Discharge by Akshay Hospital for the hospitalization 26.11.2007 to 3.12.2007 the Main Complaints were – Chest pain, Suffocation & Ghabrahat, Dizziness, Breathlessness while 2nd claim for the period from

24.1.08 to 29.1.08 was for also for Main complaint of Chest pain. In both hospitalization there is no Major surgery-Angioplasty done as clearly evident from the discharge ticket of both hospitalization. On asking the above both questions (Policy clauses & Nature of disease/treatment) from respondents during hearing, he could not deny &/or submitted any substantial information..

Decision:

In view of the circumstances stated above, It is found that the decision of the Respondent to deduct Rs. 22524.00 being maximum restriction of 70% on S.I. is unfair and unjust. Since neither the abovementioned policy condition was provided to Complainant nor the condition applies to both claims, hence, the Respondent is directed to settle the balance claimed amount for Rs. 22524.00 as per medical claim form/papers submitted by the Complainant.

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BHOPAL OMBUDSMAN CENTRE

Case No.: GI/OIC/0408/02

Shri K.C. Rathore V/s Oriental Insurance Co. Ltd.,

Order No.: BPL/GI/0809/27 dated 23.10.2008

Brief Background

Mr. K.C. Rathore and his wife Smt. Shakuntala Rathore were covered under Mediclaim policy No. 151200/07/00000539 for S.I of Rs. 200000.00 for the period 16.03.2007 to 15.03.08 from Oriental Insurance Co. Ltd., Bhopal.

As per the Complainant he was admitted Wockhardt Hospital, Mumbai for the period 20.09.2007 to 21.09.08 for the treatment of persistent pain in abdomen, severe at times & irregular bowels habits. He was taking mediclaim policy since 16.3.2005 without any break. After the treatment of his present ailment, he preferred a claim with M/s E-meditek Solutions Limited, (the TPA of Respondent) for Rs. 18355/- which has been disapproved by TPA vide their letter dated. 30.11.2007 stating that " As case of sigmoid colon carcinoma arises from Feb. 2006 so our liability of this disease is restricted for Rs. 1.06 lakh as per Sum Insured of Policy period of 2005-06.

Observations:

There was no dispute that the Complainant was covered under the above-mentioned policy. Moreover, on going through the Claim documents it was found that there was no doubt that the Insured was admitted in Wockhardt Hospital for the period from 20.09.2007 to

21.09.2007 for persistent pain in abdomen, severe at times & irregular bowels habits where he was treated properly and incurred the expenses for Rs. 18350.00 The Discharge summary also clearly mention that there is no evidence of recurrence, no significant medical or surgical illness in the past. During hearing the respondent representative did not furnish any defense & explained his inability to submit anything because the claim file is not received to them from TPA and requested for giving further chance to submit the claim note. Further on the contrary the Complainant justified his claim by explaining that the above claim was for a fresh illness & not due to pre/post surgery & reoccurrence for which he has already been reimbursed hence, there is no question of exhausting S.I. in previous claim/Policy.

Decision:

In view of the circumstances stated above, the attitude, neglecting exercise of TPA and the decision of the Respondent to reject the Claim found unfair and unjust. Hence, the Respondent is directed to settle the claim amount for Rs. 18093.00 as found payable from the medical claim form/papers and Bills submitted by the Complainant.

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BHOPAL OMBUDSMAN CENTRE
Case No.: GI/NIA/0808/63
Shri D.K.Jain V/s The New India Assurance Co. Ltd.,Indore
Order No.: BPL/GI/0809/32 Date of Order:- 12/11/2008

Brief Background

Mr.Dinesh Kumar Jain and his Mother Smt. Pushpa Jain were covered under Mediclaim policy No. 450800/48/06/20/00000992 for S.I of Rs. 35000.00 for the period 07/08/2006 to 06.08.07 from The New India Assurance Co. Ltd Indore

As per the Complainant, her Mother was admitted in Suyash Hospitals Pvt. Ltd., Indore on 06.10.2006 and was discharged on 8.10.2006 and further admitted on 8.10.2006 at CHL Apollo Hospital and discharged on 10/10/2006. He submitted all the required documents to TPA for the settlement of Claim. On 29.01.07 he received a letter from TPA for the submission of more documents, which also submitted by him, but on 28.2.2008 he received a letter from T.P.A mentioning that the case has been rejected due to non-submission of documents.

As per self contained note of Respondent, the patient is a known case of hypertension since 2003 and the member was admitted to K.D.Care hospital on 11.7.2004 with the complaint of acute heart attach prior taking the policy. Now to process this claim they required “Claim

settlement data in 2004" and CT report, which are not submitted by complainant hence, the claim is rejected by their T.P.A.

Observations:

There was no dispute that the Complainant was covered under the above-mentioned policy. On going through the Claim documents it is found that Smt. Pushpa jain was admitted in Suyash Hospital for the period from 6.10.2006 to 8.10.2006 and in CHL Apollo Hospital for the period from 8.10.2006 to 10.10.2006 where she paid Rs. 10910/- and Rs. 19359/- respectively (total amount Rs. 30269/-) for her treatment. The only dispute was for non submission of documents as required by T.P.A. vide their letter dated 5.11.2007. Whereby they required "Claim Settlement Data in 2004" only and no other documents were required. On asking from the Respondent, he described that the above Insurance Policy is continuously renewed by us since 2001 without any break. Similarly, on asking from the Respondent that for what purpose this Claim settlement Data in 2004 was asked by TPA from the Complainant when this claim pertains to Oct. 2006 and the patient is continuously insured since year 2001 by your Company, but he could explain except that it is required by T.P.A. On asking from Respondent about the payable claim amount for subjected both Hospitalization claim, he replied that Rs. 623/- are deductible under the policy conditions.

Decision:-

Under the circumstances explained above, the decision of rejection the claim for the wants of documents i.e. Claim settlement Data in 2004 **is not just & fair** because the said documents are not under the control of Complainant as the claim settlement exercise are done by the Insurance Co. Secondly, the current Policy is a Renewal of Insurance since year 2001, hence, the above requirement found not relevant to this claim, where, sufficient sum Insured i.e. Rs. 35000.00 is available under the policy, Therefore, the Respondent is directed to settle the claim for Rs. 29646/-

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BHOPAL OMBUDSMAN CENTRE
Case No.: GI/RSI /0908/68
Shri Dilip Dev V/s The Royal Sundaram Alliance Insurance Co.
Order No.: BPL/GI/0809/34 Date of Order:- 05/12/2008

Brief Background

Mr. Dilip Dev was covered under Mediclaim policy No. HS00008480000103 for S.I of Rs. 150000/- and Rs. 22500/- cumulative Bonus for the period from 18/06/2007 to 17/06/2008 covered by The Royal Sundram Alliance Insurance Co. Ltd. Co. Ltd., Chennai

As per the Complainant, he was admitted in Indraprastha Apollo Hospitals Delhi on 25.07.2007 and was discharged on 02.08.2007 for heart disease where he spent Rs.223423.00 for the surgery and the claim was lodged with the Respondent but the Respondent Repudiated the claim vide their letter dated 11.10.2007 stating that he suffered from hypertension for the last 07/08 year and also that the present illness is a complication of hypertension and the same is out of the scope of the cover and also that the fact of hypertension was not revealed to them when the insurance was proposed to them in the year 2004 hence there is a suppression of material fact also hence, the claim is not payable.

As per self contained note of Respondent, their TPA Medicare Services Pvt. Ltd., opined that the claim is inadmissible and not payable as the present illness is a complication of hypertension which is pre-existing and further the concentric LVH detected in the echo shows that the hypertension was pre-existing for a long time and also from the Adult In-patient History and Physical record dated 25.7.2007 the complainant was suffering from "Hypertension" for the past 7 to 8 years. Respondent further stated in self contained note that the complainant had deliberately concealed relevant facts of Hypertension even before the inception of policy which comes under the category of clause 6, Misdescription. Further respondent also stated that as per TPA Medicare Services Pvt. Ltd. has stated that the admissible amount is only Rs. 100000.00 and the said sum is the opposite party's maximum liability under the insurance policy if at all the claim is liable to be paid.

Observations:

There was only dispute for the period of Hypertension as pre-existing disease and non-disclosure of above facts. On asking from Respondent about the documents in support of their conclusion for Hypertension since Last 7-8 year. Respondent showed the Adult-in-Patient History & Physical Record of Indraprastha Apollo Hospital dated 25.7.2007, the same was shown to complainant who challenged the period of Hypertension mentioned in above record and emphasized that the period

of hypertension is mentioned as 7-8 Months and not 7-8 year and also stated that the period is wrongly interpreted by Respondent. The forum examined the above Adult In-Patient History and physical Record of Indraprastha Apollo Hospitals dated 25.7.2007 and observed that there is no crystal clear reading of duration of HTN. The duration period in the above document is in short and not in full words i.e. for year it is mentioned as yr or for month it is written as m. The short wording of period is not clearly readable as yr or as m. In other words, it looks as yr and m as well. On viewing through the magnifying glass it observed to be m and not yr. On asking from the Respondent whether he can say that it is clearly a word of year and not as month, he could not confirm that it can be a year only. On further asking from respondent whether they are having any other documents to prove that the Hypertension is since 7-8 years, he denied for it. Further he was also asked whether the above ambiguity in period is got checked/verified from Hospital records by them, he replied in negative. On the other hand the complainant reiterated that he is a patient of Hypertension since last 7 to 8 month only and the same is wrongly interpreted by the respondent. He also showed the letter dated 14.11.2007 written to Hospital by him for the above discrepancy. This Forum also gone through the Discharge Summary of Indraprastha Apollo Hospitals and found that the Status of Diagnoses for Hypertension is mentioned as **CURRENT**. Similarly, the respondent was asked to produce the Proposal form obtained from complainant at the first inception of policy to check about the disclosure or non-disclosure of policy but the same was not produced by respondent and replied that they are not having that document. The complainant explained that there was no proposal form obtained by respondent from him and the business was booked over phone, moreover, he questioned to respondent that how the Hypertension is considered as non-disclosure when the same was not asked to him.

Under the circumstances explained above, the decision of Repudiation of Claim by Respondent found not just & fair as the Respondent is failed to substantiate the period of hypertension as 7-8 year, simultaneously, the non-disclosure of Hypertension as material fact is also not substantiated by them by not producing the Proposal Form, whereas the Discharge summary of Hospital which is duly issued & signed by Hospital Authorities clearly states that the status of hypertension is CURRENT, therefore, the Respondent is directed to settle claim and pay the Admissible claim amount under the scope of Policy.

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Order No.: BPL/GI/0809/35 Date of Order: - 17/12/2008

Brief Background

Mr. Anand Kedia was covered under Reliance Health wise Policy No. 282510077293 for S.I of Rs. 500000/- for the period from 14/09/2007 to 13/09/2008 covered by The Reliance General Insurance, Indore

As per the Complainant, he was continuously covered under Mediclaim Policies since 9/2/2005 without any break starting with National Insurance Co. up to 8/2/2007 and from 9/2/2007 to 8/2/2008 with Iffko Tokyo and with Reliance General Insurance from 14/9/2007 to 13/9/2008 and also stated that In Dec. 2007 he came to know that the swelling above his groin since 4-5 months is due to Hernia and Doctor advised him for the Surgery. The date of Surgery was fixed initially on 4th Feb. at Breach Candy but by the hospital, the date was postponed and finally surgery was done on 11/2/2008 at Breach candy Hospital, Mumbai where an amount of Rs. 193435/- was incurred. TPA of respondent M/s Medi Assist India Pvt. Ltd. stating that the claim is not admissible due to Policy clause No. 1, which states that pre-existing illness is not covered, denied the claim. The complainant also mentioned that Policy condition no. 1 i.e. Pre-existing disease is not applicable in this case being he is having Mediclaim Policies since 1994. Moreover, the complainant also explained that under Policy condition clause No. 3 which states that within the first year from inception of this policy expenses will not be payable for various diseases including Hernia but this exclusion does not apply for Insured having any Health Insurance Policy in India at least for 1 year prior to taking this policy as well as for subsequent renewals with the Company without a break, in this case he was having continuous cover since 9/2/2005.

Observations & Decision:

There was dispute for the pre-existing disease as on the date of inception of Insurance with Reliance General Insurance and previous Insurance Policies with other Insurance companies. The complainant produced policy exclusion condition No. 3 i.e. this condition for Hernia is not applicable as he is having Health Insurance Policies since 9/2/2005 in India and also reiterated that the hernia disease was only diagnosed in Dec. 2007. Complainant also reiterated that his claim is well payable in the light of Policy condition No. 3. On asking from Respondent about the Policy condition No. 3 as shown by Complainant, the respondent after reading Carefully could not deny the fact of the coverage available for Hernia disease during first year in the policy being continuously Health Insurance policies obtained by claimanant since 9/2/2005 but also emphasized that the continuous Insurance Policies are not obtained from their Company i.e. Reliance General Insurance, hence, the above disease

was considered as pre-existing by Reliance. On asking specifically whether the above claim for Hernia is admissible or not in the light of Policy condition No. 3 and previous Insurance Polices with different Insurer, respondent narrated that the condition suggests that the claim may be admissible but the claim is denied on the basis of pre-existing disease. Respondent in support of their decision of denial the claim submitted no documents/evidence. Similarly, on asking from respondent about any Medical/Health check-up reports etc. were obtained from complainant at the time of Insurance of this Policy, it is replied that the same are not obtained from complainant. This forum gone through the Policy condition No.3 as produced by complainant and observed that the condition speaks: "Expenses incurred on treatment of following diseases, illness, injury with the first year from the inception of this policy, will not be payable - Cataract, Benign Prostatic Hypertrophy, Myomectomy, Hysterectomy or Menorrhagia or Fibromyoma unless because of Malignance, Dilation, Hernia, Hydrocele, Congenital Internal Disease etc. - This exclusion doesn't apply for Insured/Insured person having **any** health insurance policy in India at least for 1 year prior to taking this policy as well as for subsequent renewals with the Company without a break". I also gone through the previous Insurance policies submitted by complainant in support of this claim and found that the Health Insurance Policies were obtained for the period from 9/2/2005 to 8/2/2007 from National Insurance Co. while from 9/2/2007 to 8/2/2008 from Iffko Tokyo General Insurance and from 14/9/2007 to 13/9/2008 from Reliance General Insurance Co. without break. The respondent while asking to substantiate the decision of denial the claim particularly in the light of above two evidences i.e. previous Policies and condition No. 3 as produced by complainant, the respondent could not substantiate neither through statement nor through any document. It was also found that the complainant was suffering from the specific disease of Hernia and the policy condition No.3 specifically relaxed for Hernia during occurrence of first year if the complainant having ANY Health Insurance Policy in INDIA for 1 year prior to taking this Policy, then the plea for other condition i.e. pre-existing disease in the matter of Hernia observed not relevant. It is also found that in the wording of condition No. 3 the Policy means **any Policy** in India and the complainant is continuously covered since 9/2/2005 under the Health Insurance Policies in India, off course with different Insurers, prior to this policy. Therefore, the Respondent directed to settle the claim and pay the Admissible claim amount under the scope of Policy.

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BHOPAL OMBUDSMAN CENTRE

Case No.: GI/OIC/1208/86

Shri Deepak Jain V/s Oriental Insurancer Co. Ltd.,.DO.-II, Indore

Order No.: BPL/GI/0809/47 Date of Order :- 31.03.2009

Brief Background

Mr. Deepak Jain, and his wife Smt. Manju and son were covered under Mediclaim policy No. 151208/08/00000854 for S.I of Rs. 100000.00 each for the period 19.6.2007 to 16.03.2008 from Oriental Insurance Co. Ltd., D.O.II, Indore

As per the Complainant he was continuously Insured with the Respondent under Mediclaim Policy since 2004 and the premium cheque was for Rs. 5565/- was given to respondent on 12.6.2008 for the renewal of Previous policy which was due on 14.6.2008 but the same was dishonored by Bank due to insufficient balance in the Bank account causing cheque returned by Bank without payment to Respondent. During this period he was compelled to go to Ajmer due to death in relation and after coming back, on receipt of intimation from Respondent he deposited cash premium along with Bank charges for Rs. 150/- for the Insurance of his Medilcaim policy. Later on, he suffered heart disease on 28.6.2007 and was admitted in Hospitals for the period from 28.6.07 to 30.6.07, 30.6.07 to 3.7.2007 and finally at CHL Apollo Hospital, Indore for the period from 17.7.07 to 24.7.07 and incurred total expenses for Rs. 162606/- Then, he preferred claim to the T.P.A. of respondent but the same is not settled by them and finally his claim is rejected.

As per self contained note the Respondent described that the complainant had renewed his Mediclaim Policy tendering Premium through Cheque and the policy No. 48/2008/792 for the period from 14.6.07 to 13.6.08 was issued but the Cheque was dishonored due to insufficient fund in the account of policy holder, hence, the policy was cancelled since inception. Later on the complainant submitted a Fresh Proposal for which a new Policy No. 48/2008/854 was issued for the period from 19.6.2007 to 18.6.2008. The T.P.A. Repudiated the subject claim on the ground that the Policy holder had suffered the disease within first 30 days of the commencement of the Policy which comes under the exclusion clause No. 4.2 of policy condition.

Observations:

There was only matter of dispute for Fresh Insurance or Renewal of previous Insurance due to Break in Insurance for 5 days. On going through the Policies and other documents produced by both the parties it was observed that the insurance was due for renewal on 14.6.2007 for which the premium for Rs. 5565/- was paid by complainant through Cheque No. 042302 dtd. 12.6.2007 which was dishonored by Bank for the reason of “Insufficient Fund”. Accordingly, the policy was cancelled

abintio by Respondent and was informed to complainant in writing also specifically mentioning that the company is not on Risk nor any claim will be entertained for the cancelled policy and also that further, cover shall commence from the time of receipt of fresh remittance of Rs. 5565/- including bank charges of Rs. 100/- consequently, the complainant approached Respondent on 19.6.2008 for the Insurance of Mediclaim and deposited Rs. 5565/- for premium and in consideration thereof, the respondent issued fresh Policy for the period from 14.00 Hrs. of 19.6.2007 to 18.6.2008. During hearing the complainant reiterated that it is a continuous Insurance of previous Policy because the Proposal form was not obtained by respondent, in response thereof the Respondent produced Proposal Form and explained that this fresh Insurance was given after obtainment of **Proposal form** and declaration form duly signed by Complainant. The copy of proposal form as produced by respondent was shown to complainant where he denied for his signature available in the Proposal form by saying that these are not his signatures. On going personally through the signatures available on the proposal form and the signatures available in the various so many documents (submitted by complainant to this forum in support of this complainant) and observed that the signatures are almost similar. On asking from the Respondent about the guidelines circular dated 3.7.2000 as submitted by complainant for Grace period for renewal of Mediclaim Policy. The respondent described that these are the old internal guidelines for the policy issued in the year 2000 and since then, the entire Mediclaim policy has been revised moreover, the authority to condone the delay is vested in RM/AGM in charge only on the reasons which are beyond the control of Insured and the same should be justifiable and acceptable to the competent authority only. In this case the reason of delay as "Insufficient Fund" found not justifiable and acceptable to the competent authority hence the same is not condoned.

In view of the circumstances stated above the decision of repudiation of Mediclaim on the grounds mentioned above is Just & Fair because the above Insurance found to be a Fresh Insurance and not in continuation of previous Insurance due to dishonourement of Premium cheque for the reason of "Insufficient Fund" while disease suffered by the complainant during first 30 days of the commencement of Policy No. 151208/48/2008/854 which are specifically excluded under the Policy condition, therefore, found no reason to interfere with the decision taken by the Respondent. The complaint is dismissed without any relief.

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Shri Prasanna Kumar Jain V/s The Royal Sundaram Alliance Insurance Co. Order No.: BPL/GI/0809/50 Date of Order:- 31/03/2009

Brief Background

Mr. Prasanna Kumar Jain was covered under Mediclaim Health Shield Insurance policy/certificate No. HS00072786000102 for S.I of Rs. 100000/- for the period from 20.06.2008 to 19.06.2009 and Hospital cash Insurance Policies No. HCSBIL0012/CS00080429000101 for daily benefit Rs. 2500/- for the period 23.8.08 to 22.8.09 and SCSBIL003 For daily Benefit Rs.1000/- for the period from 31.8.08 to 30.08.09 and SN00000176000100 for daily cash benefit for Rs. 1000/- for the period from 19.2.08 to 18.2.09 by The Royal Sundaram Alliance Insurance Co. Ltd., Chennai

As per the Complainant, he was admitted in City Hospital; Bhopal on 6.10.2008 due to sudden severe bleeding from Nose (Nasal cavity) and after various investigations, the treatment was given and remained hospitalized up to 11.10.2008. In the meantime the respondent was informed and the representative of respondent visited Hospital and the Cash less facility for Rs. 14500/- for the above treatment was sanctioned by the T.P.A. of Respondent. On discharge from the Hospital the remaining Medical expenses for Rs.2716/- and the Daily cash benefits available under other Policies for Rs. 37000/- (total for Rs. 39716/-) was preferred but the same are not paid even after the regular follow-ups/reminders but instead of settlement of claim the Policies are cancelled w.e.f. 18.9.2008 stating that the " Policy shall be void and all premium paid hereon shall be forfeited to the company in the even of mis-representation, misdescription or non-disclosure of any material fact" by sending letter bearing date of 18.9.2008 through postal Department which are received on **27.10.08** while the seal of postal department on the envelope bears date as 15.10.2008

As per self contained note of Respondent the complainant had taken various health policies to deceive this Insurance Company by making fictitious claim at regular intervals and also that the entire family members of the complainant got themselves hospitalized and underwent treatment within short span of time which found to be made by fraudulent means to gain unlawfully accordingly the claims are repudiated and policies are cancelled.

Observations:

There was no dispute that the complainant was admitted in the City Hospital, Bhopal on 06.10.2008 to 11.10.2008 for the treatment of Hemorrhage from Nose (Nose Bleed) where an amount of 16389/- was

incurred for treatment. Similarly, there was also no doubt as regards Daily cash benefits available under the other Policies. The only dispute was for validity of the Policies i.e. whether as on the date of 6.10.2008 (i.e. the hospitalization period) they were in force or cancelled?

During hearing on asking from the respondent to submit the evidence of cancellation of Policy and also the date of dispatching the Intimation letter for the cancellation of Policies to complainant, it was explained that the same exercise was done at our Chennai Office and presently he has nothing to show the same and reiterated that the Policies are cancelled due to Previous claims lodged by complainant are observed to be fake &/ or inflated &/or manipulated hence, the policies are cancelled. Similarly, on asking from the respondent, if the policies were cancelled w.e.f. 18.9.2008 as mentioned in the letters, then, why the Cash Less Facility for Rs. 14500/- against the Claim for the above period was sanctioned on 10/11.10.2008 He could not explained the reason. During hearing the complainant described that the respondent has re-instated his Policy No. HCSBIL0003 certificate No. CS00004465000103 on 6.11.2008 w.e.f. 31.8.2008 valid for the period from 31.8.2008 to 30.08.2009 by debiting premium for Rs. 2933/- on 5.11.2008. The Endorsement No. 002 to this effect is also produced by Complainant. On going through the Envelops through which the aforesaid intimation letter for the cancellation of Policies dated 18.9.2008 is said to be sent by respondent it was observed that the seal contains dated 15.10.2008 which is received by complainant on 27.10.2008

Under the circumstances explained above, the complainant found well entitled for the Medical expenses and Daily cash benefits available under the abovementioned Policies because as per the above mentioned documents produced by complainant before this forum it reveals that the Policies was well in force as on the claim period i.e. 6.10.2008 to 11.10.2008 while the respondent failed to prove that the polices was cancelled on 18.9.2008 moreover, the same was intimated to complainant on 15.10.2008 i.e. after the claim period which was received by complainant on 27.10.2008, therefore, the respondent is directed pay the claim for Rs. 29616/- as found payable as per the claim documents submitted by complainant.

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BHOPAL OMBUDSMAN CENTRE
Case No.: GI/RGI/0109/92
Shri Satish Agarwal V/s Reliance General Insurance Co. Ltd., Indore
Order No.: BPL/GI/08-09/49 Date of Order:- 31/03/2009

Brief Background

Mr. Satish Agrawal had obtained Mediclaim Policy No. 282520093558 from Reliance Gen. Insurance Co. Ltd. for the period 03.07.2007 to 02.07.2009 covering his family members including his wife Meena Agarwal for S.I. Rs. 1,00,000/- each along with Recovery Benefit for Rs. 10000/-

As per the Complainant his wife Mrs. Meena Agarwal was hospitalized in Suyash Hospital, Indore for the period from 26.05.08 to 10.06.2008 and claim was preferred to respondent for Rs. 43780/- where an amount of Rs. 33529/- is paid to him but the amount for Rs. 10000/-for **recovery benefit** was not paid.

Observations:

There was no dispute that the Complainant's wife Mrs. Meena Agarwal was covered under the above-mentioned policy. On going through the Hospital documents , It found that the complainant's wife was admitted in the Hospital for the period from 26.5.2008 to 10.06.2008 and the respondent settled the partial claim for Rs. 33529/- for the treatment expenses during above mentioned hospitalization period but the claim for Rs. 10000/- for Recovery benefit was not paid. On going through the Policy and clause it was observed that the policy covers the Recovery Benefit for Rs. 10000/- when the Hospitalization for treatment of disease/illness/injury for a period of 10 days or more. On asking from the Respondent why the above benefit was not paid to complainant when the same are payable under the scope of Policy, the respondent explained that as per the nature of treatment given by hospital it was for Oral medicines where the hospitalization for more than 3 days was not required hence, the T.P.A. did not consider the above benefit payable. On asking from the respondent whether the Policy contains such kind of conditions, it is explained that there is no such kind of restriction in the policy conditions.

In view of the circumstances stated above, the decision for non payment of Rs. 10000/- being Recovery Benefit by the respondent is not just & Fair because the same is well covered under the policy and the complainant is well entitled for the same, hence, the decision taken by respondent is set aside and directed to pay Rs. 10000/- to complainant.

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BHOPAL OMBUDSMAN CENTRE

Case No.: GI/UII/0109/94

Mr. R.S. Rajpal V/s United India Insurance Co. Ltd

Order No.: BPL/GI/08-09/45 Date of Order:- 17/03/2009

Brief Background

Mr. R.S. Rajpal informed that he had obtained Mediclaim policy No. 191301/48/07/97/00001248 for the period from 29.11.2007 to 28.11.2008 from United India Insurance Co. Ltd., Dewas under which claim was lodged for the treatment of his wife Smt. Indrajeet with the Respondent.

As per the Complainant his was hospitalized in Choithram Hospital & Research Centre, Indore for the period 30.03.08 to 05.04.08 for Uterine Fibroid. The complainant preferred a claim for Rs. 31328/- with the TPA of the Respondent which was paid only for Rs. 24205/- after deducting Rs. 7123/- on various heads.

The Respondent in its reply-dated 27.02.09 stated that the Complainant had lodged a claim for Rs. 31328/- for the treatment of his wife Smt. Indrajeet Kaur for Abdomen Hysterectomy to their TPA M/s Medsave Health Care. After scrutinizing the papers the TPA settled the claim for Rs. 24205/- after deducting Rs. 7123/-

Observations:

There was no dispute that the Complainant was covered under the above-mentioned policy. At the time of hearing the Respondent committed the mistake of its TPA for wrong deductions of medical bills. It justified that the amount for Administrative expenses for Rs. 150/- and Service Charges for Rs. 1256/- totaling Rs. 1406/- is not payable and the rest amount of Rs. 5717/- is payable under terms & conditions of the policy.

Decision:-

In view of the circumstances stated above, the decision of the Respondent to deduct the claim amount found unfair and unjust. Hence, the Respondent is directed to settle the claim admissible for Rs. 5717/- as per medical papers submitted by the Complainant.

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BHUBANESWAR

MEDICAL/MEDICLAIM POLICY (Ind)

BHUBANESWAR OMBUDSMAN CENTER

Complaint No.11-002-0299
Sri Basudev Panda

Vrs
New India Assurance Co. Ltd., Cuttack D.O-II

Award dated 4th November, 2008

The Complainant was covered under L.I.C Staff Group Mediclaim Policy issued by New India Assurance Co. Ltd., Mumbai. Wife of the complainant was operated for cataract and spent Rs. 12509.00 where as the insurance company settled the claim for Rs. 10000.00.

Hon'ble Ombudsman heard the case on 18.08.2008 where both parties were present. After hearing both parties and perusing the documents Hon'ble Ombudsman directed insurance company to take steps to consider the claim afresh and take decision within one month from the date of receipt of this order.

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MEDICAL/MEDICLAIM POLICY (Ind)

BHUBANESWAR OMBUDSMAN CENTER

Complaint No.14-002-0329
Sri Brajendu Bhusan Das
Vrs
New India Assurance Co. Ltd., Mangalabag Branch.

Award dated 26th November, 2008

Complainant had taken a mediclaim policy with New India Assurance Co for self and wife. His wife was admitted to Sun Clinic and the claim for Rs 3545 was not entertained by the insurance company on the ground that the treatment was for a pre-existing ailment..

Hon'ble Ombudsman heard the case on 18.08.2008 where both parties were present. After hearing both parties and perusing the documents Hon'ble Ombudsman held that there is insufficient grounds to establish pre-existence of the disease and hence allowed the complaint and directed insurance company to pay the claim within one month of receipt of consent letter.

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MEDICAL/MEDICLAIM POLICY (Ind)

BHUBANESWAR OMBUDSMAN CENTER

Complaint No.11-002-0435
Dr Ananta Prasad Panda

Vrs
New India Assurance Co. Ltd., Link Road Br, Cuttack

Award dated 29th December, 2008

Complainant had taken a mediclaim policy with New India Assurance Co. Ltd. and within the policy period undergone bypass surgery at Apolo hospital. His claim was repudiated by insurance company on the ground that the treatment was for a pre-existing disease.

Hon'ble Ombudsman heard the case on 17.07.2008 and 2.12.2008 where both parties were present. After hearing both sides and perusing the documents Hon'ble Ombudsman held that the insurance company is not able to produce the proposal form of 1999, where in the complainant has pleaded to disclose the ailment before policy was incepted. Since no document in lieu of proposal form to establish the pre-existance of the ailment treated could be produced by inurer ,the order repudiation was not justified and insurance company is directed to settle the claim within a month of receipt of consent letter.

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MEDICAL/MEDICLAIM POLICY (Ind)

BHUBANESWAR OMBUDSMAN CENTER

Complaint No.14-008-0297
Sri Soumya Ranjan Padhy

Vrs
Royal Sundaram Alliance Insurance Co Ltd
Chennai Branch

Award Dated 03 February,2009

Complainant had taken a Hospital Cash Plan insurance policy with Royal Sundaram Alliance Insurance Co. Ltd., for himself and his family and within the policy period was hospitalised for chronic renal disorder. His claim was repudiated by insurance company on the ground that the treatment was for a pre-existing disease.

Hon'ble Ombudsman heard the case on 19.08.2008 where both parties were present. After hearing both sides and perusing the documents, including a clarification letter from Kalinga Hospital, Hon'ble Ombudsman held that the insurance company is not able to establish the pre-existence of the ailment treated except for the opinion of its legal executive and set aside the decision of repudiation and directed insurance company to pay Rs 9000/- to complainant within a month of receipt of consent letter.

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MEDICAL/MEDICLAIM POLICY (Ind)

BHUBANESWAR OMBUDSMAN CENTER

Complaint No.11-012-0333
Sri Bimal Kumar sarkar
Vrs
ICICI Lombard General Insurance Co Ltd
Mumbai Branch

Award Dated 01 January,2009

Complainant had taken a Health Care Family Plan Policy of ICICI Lombard General Insurance Co Ltd for 2 years through his credit card with monthly instalment of Rs 636/- to be debited to the card A/C. But entire premium of Rs 13,500/-with added interest was charged to him through the credit card A/C. After several rounds of protest the premium of Rs 13,500/- was refunded but the period of policy was not amended to commence on 28.06.2006, ie the date of regularisation of the premium.

Hon'ble Ombudsman heard the case on 19.08.2008 where the complainant was only present. The insurance company neither attended hearing nor sent any self contained

note to explain his stand. Hon'ble Ombudsman there fore directed the insurance company to issue the policy with effect from 28.07.2005 to 27.07.2007.

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MEDICAL/MEDICLAIM POLICY (Ind)

BHUBANESWAR OMBUDSMAN CENTER

Complaint No.11-002-0473

Sri Dhananjay Pattnaik
Vrs
New India Assurance Co. Ltd., Link Road Branch, Cuttack

Award dated 04th February,2009

Complainant had taken a Mediclaim policy with New India Assurance Co. Ltd .Complainant spent Rs10036/- for treatment of his eye which Insurance company did not pay on the grounds that the expenses were for out door treatment and are not covered by the policy .

Hon'ble Ombudsman heard the case on 20.01.2009, where both parties were present. After hearing both parties and perusing the documents , Hon'ble Ombudsman held that the expenses were for out door treatment, which in strict terms of policy are not payable, but the complainant being honest has not got himself admitted ,which he could have done and claimed for his hospital stay as well. There fore directed the insurance company to pay an ex-gratia of Rs 4000/- to the complainant within one month of receipt of the consent letter.

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MEDICAL/MEDICLAIM POLICY (Ind)

BHUBANESWAR OMBUDSMAN CENTER

Complaint No.11-004-0410
Sri Tapan Kumar Sarkar
Vrs
United India Insurance Co. Ltd., Hyderabad DO- IV

Award dated 25 February, 2009

Complainant had taken a Mediclaim Policy with United India Insurance Company Ltd. He was hospitalised for chest pain and breathing problem. After discharge he preferred a claim on the insurance company, which was repudiated on the grounds that the disease treated was pre existing.

Hon'ble Ombudsman heard the case on 04.12.2008 where both parties were present. On perusal of documents produced by both sides and listening to their arguments, Hon'ble Ombudsman held that the complainant has disclosed to be a known case of diabetes in his proposal when he took the insurance for the first time and was not aware of hypertension and directed insurance company to settle the claim within one month of receipt of consent letter.

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MEDICAL/MEDICLAIM POLICY (Ind)

BHUBANESWAR OMBUDSMAN CENTER

Complaint No.11-011-0417
Sri Devashis Das
Vrs
Bajaj Allianz General Insurance Co. Ltd., Bhubaneswar Branch

Award dated 03 March, 2009

Complainant had taken a Hospital Cash Policy with Bajaj Allianz General Insurance Company Ltd and was treated for Pneumonia at Unit IV, Govt Hospital during the currency of policy. Company has not settled the claim, even though all documents have been submitted.

Hon'ble Ombudsman heard the case on 04.12.2008 where complainant was absent. On perusal of documents produced by both sides, Hon'ble Ombudsman held that the insurance company has not produced either the investigation report or the statement of the treating doctor, which form the basis of repudiation of the claim. No other additional evidence in support of their repudiation of claim was produced during hearing. Hence allowed the complaint and directed Insurance Company to settle the claim within 30 days of receipt of the consent letter.

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MEDICAL/MEDICLAIM POLICY (Ind)

BHUBANESWAR OMBUDSMAN CENTER

Complaint No.11-005-0553

Sri Biranchi Narayan Dash
Vrs
Reliance General Insurance Co. Ltd., Mumbai

Award dated 17th March 2009

Complainant had taken a Health wise policy from Reliance General Insurance Co. Ltd., Mumbai for self, wife & daughter. His wife met with an accident and was treated for fractured knee. A claim for Rs75,450/- was preferred and Insurance Company paid Rs29028/- only.

Hon'ble Ombudsman heard the case on 17.03.2009 where Insurer remained absent despite advance intimation. After hearing the complainant, Hon'ble Ombudsman directed the Insurance Company to settle the claimed amount or inform the complainant detail reasons for settlement at a lower amount within a month of this order. The complaint disposed accordingly

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MEDICAL/MEDICLAIM POLICY (Ind)

BHUBANESWAR OMBUDSMAN CENTER

Complaint No.12-004-0439

Sri Sandip Mohanty
Vrs
United India Insurance Co. Ltd., Link Road Branch

Award dated 13Th March, 2009

Complainant had taken a Health Shield Policy with United India Insurance Company Ltd for self and wife. His wife was admitted to a hospital from 09.06.2005 to 16.06.2005.He

had lodged a claim with Insurance Company. While he claimed for Rs165496/-, Insurance Company settled it for Rs 120000/-.

Hon'ble Ombudsman heard the case on 04.12.2008 where complainant was absent. After hearing the Insurance Company and perusing the documents, Ombudsman held that the complaint does not have any merits considering the loading factor on the basis of premium paid and amount settled and hence dismissed the complaint accordingly.

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MEDICAL/MEDICLAIM POLICY (Ind)

BHUBANESWAR OMBUDSMAN CENTER

Complaint No.11-004-0508

Sri Madhusudan jena

Vrs

United India Insurance Co. Ltd., Mancheswar Branch

Award dated 17Th March, 2009

Complainant had taken a Mediclaim Insurance Policy with United India Insurance Company Ltd for his wife through his employer. He preferred a claim, which was settled at a lower amount than claimed.

Hon'ble Ombudsman heard the case on 17th March 2009, where both sides were present. Insurance Company during hearing produced copy of order of Consumer Dispute Redressal Forum, Khurda, where a complaint was filed against them for same subject. As per RPG Rule 1998, complaint was dismissed.

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MEDICAL/MEDICLAIM POLICY (Ind)

BHUBANESWAR OMBUDSMAN CENTER

Complaint No.11-002-0394

Sri Sarada Prasad Das

Vrs

New India Assurance Co. Ltd., Jajpur Road DO

Award dated 30Th March, 2009

Complainant had taken a Mediclaim Insurance Policy with New India Assurance Company Ltd and after a check up at High Tech Hospital for heart ailment, took treatment at R N Tagore Hospital, Kolkata. He preferred a claim for Rs 1,05,000/-for the treatment. His claim was repudiated on the grounds that the ailment was a congenital internal disease and out side scope of policy.

Hon'ble Ombudsman heard the case on 02.12.2008, where both sides were present. On the basis of self contained note of Insurance Company and the discharge summery of the treating hospital , Hon'ble Ombudsman set aside the decision of repudiation by Insurance Company and directed to settle the claim on the basis of bills and cash memos submitted by the claimant within one month of receipt of consent letter.

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CHANDIGARH

Chandigarh Ombudsman Centre

CASE NO. GIC/323/NIC/14/09

Manohar Lal Nagpal Vs. National Insurance Co. Ltd.

Order dated 07.11.08 **MEDICLAIM**

FACTS: Sh. Manohar Lal Nagpal had taken a mediclaim policy No. 404000/48/06/8500000414 for the period 30.08.06 to 29.08.07 covering himself and his wife for sum insured of Rs. 1.00 lakh each. On 09.12.2006, he felt some uneasiness and consulted the family doctor. The doctor gave him some medicine, after examination. On 13.12.2006, he was admitted in Apollo Hospital, Ludhiana. He was hospitalized from 13.12.06 to 26.12.06. He submitted all the claim papers but till date his claim has not been settled in spite of several reminders. Parties were called for hearing on 16.10.08 at Chandigarh.

FINDINGS: During the course of hearing the insurer clarified that the date of commencement of the policy is 30.08.2005. This was the second year of the policy. At

the time of filling up the proposal form, the insured stated that he was hypertensive as given in a medical report but he was recommended fit for taking the policy. The TPA had gone by this record and recommended repudiation of the claim. On a query, whether discharge summary was available, the insurer replied in the affirmative. On a query, whether the repudiation of the claim was intimated to the complainant, the insurer replied in the negative.

DECISION: Held that in the discharge summary which is the most authentic document regarding the treatment of the patient, there is no history of hypertension and diabetes mentioned. Moreover, in my opinion, hypertension is a state of being and cannot be treated as a specific disease. Almost 2 years have lapsed and the decision had not been communicated to the complainant. This, in my view, is a deficiency of service. Giving the benefit of doubt to the complainant regarding pre-existing disease, I am of the opinion that since no preexisting disease has been mentioned in the discharge summary, the claim is payable. It is hereby ordered that the admissible amount of claim should be paid by the insurer to the complainant.

Chandigarh Ombudsman Centre

CASE NO. GIC/375/UII/14/09

Seema Rani Vs. United India Insurance Co. Ltd.

Order dated 18.11.08 **MEDICLAIM**

FACTS: Smt. Seema Rani and her son Prerit were insured by United India Insurance Co. Ltd. for the period 23.10.2007 to 22.10.2008. His son remained hospitalized in Mehak Hospital, Faridabad from 24.12.07 to 27.12.07 for which she incurred an expenditure of Rs. 7404/- All the papers were submitted in time to the TPA, M/s E-Meditek Solutions Ltd. However, the amount of claim had not been paid so far. Parties were called for hearing on 18.11.08 at New Delhi.

FINDINGS: During the course of hearing the insurer clarified that there was some doubt about the bonafides of the claim as Mehak Hospital had been closed some time back.

DECISION: Held that on going through the papers very carefully. There are four other complaints which are similar to this case. These are

1. M/s Kalyani [Complaint No. GIC/371/REL/14/09]
2. Sh. Dharam Raj [Complaint No. GIC/372/REL/14/09]
3. Sh. Satish Kumar Fogaat [Complaint No. GIC/373/UII/14/09]
4. Sh. Dev Raj [Complaint No. GIC/376/UII/14/09]

All these complaints have been written by one person only and got signed by the complainant. All the complaints were written on 31.07.2008. In all these complaints, the treatment was taken from Mehak Hospital. In all these complaints, the diagnosis is acute gastro enteritis with shock and the course in the hospital is the same treatment with antibiotics and analgesic etc. While the duration of stay in the hospital and the treatment are almost the same, the amounts of claims are different by different complainants. Taking the above factors into consideration, I am of the opinion that the bonafides of these five claims are not justified and the complaints need to be dismissed straight away without any further action on the part of the insurer. This complaint is accordingly dismissed.

Chandigarh Ombudsman Centre

CASE NO. GIC/402/UII/11/08

Raj Kumar Vs. United India Insurance Co.

Order dated 15.12.08 **MEDICLAIM**

FACTS: Shri Raj Kumar stated that he along with his wife and two kids was insured by the D.O. II Ludhiana under their Mediclaim Policy No. 200800/48/612/000806 since 2005. His wife suffered from some pain of the stomach. She was taken to the Apollo Hospital where the doctors diagnosed the disease as hernia and operated upon her. All the papers and medical bills amounting to Rs. 107914/- were submitted with the company. The claim was, however, rejected on the grounds that

this disease was related to pregnancy. It was stated by the complainant that this was incorrect, their last child was born on 18.06.2002 and she had not experience any problem after that. Parties were called for hearing on 15.12.2008 at Ludhiana.

FINDINGS: During the course of hearing the insurer stated that as per Medical opinion, incisional hernia was related to child birth and as per Exclusion clause 4.12 of terms and conditions of the policy, the same was not payable.

DECISION: Held that the child birth 5 years old and it should not be the cause of incisional hernia after 5 years. The repudiation of the claim is not in order. The claim is payable. It is hereby ordered that the admissible amount of claim should be paid by the insurer to the complainant by 10.01.2009 under intimation to this office..

Chandigarh Ombudsman Centre

CASE NO. GIC/388/NIC/11/09

N.K. Vasudeva Vs. National Insurance Co. Ltd.

Order dated 24.12.08 **MEDICLAIM**

FACTS: Sh. N.K. Vasudeva had taken a mediclaim policy no. 420102/48/07/8500000268 for the period 25.01.08 to 24.01.09 covering himself and his family members. As per the complainant, he is taking mediclaim policy regularly for last 7-8 years from the same insurer without any break. On the night of 15th July 2008, he felt uneasy and breathing problem. The doctor was called at home and after check-up, the doctor referred him to Fortis Hospital. The ambulance was called and he was admitted in Fortis at the night of 15th July 2008 and discharged on 16.07.2008. He lodged a claim on

19.07.08 with TPA for Rs. 31191/-. Initially the TPA informed that his policy has not been enrolled. Now he understood from TPA that his claim is not payable. The TPA vide letter dt. 30.08.08 addressed to insurer has stated that since the hospitalization was less than 24 hours, hence in terms of policy condition No. 2.6, the claim is not payable. Parties were called for hearing on 24.12.08 at Chandigarh.

FINDINGS: During the course of hearing the insurer clarified that the hospitalization for less than 24 hours as the complainant was admitted in 16.07.08 00.50 hrs. and discharged on 16.07.08 at 14.30 hrs. During the hospitalization only tests were conducted which turned out to be normal. Hence the claim was not payable as per exclusion clause 2.6 of the terms and conditions of the policy for hospitalization less than 24 hours.

DECISION: Held that the contention of the insurer that the claim was not payable in view of the hospitalization being less than 24 hours is justified as per terms and conditions of the policy. The repudiation of the claim is, therefore, in order. No further action is called for. The complainant is dismissed.

Chandigarh Ombudsman Centre

CASE NO. GIC/424/NIC/11/09

Brij Mohan Vs. National Insurance Co. Ltd.

Order dated 23.01.09 **MEDICLAIM**

FACTS: Sh. Brij Mohan had taken a mediclaim insurance policy bearing No. 361101/48/07/8500004744 covering himself. On 25.05.2008, the insured become sick and was hospitalized in Sharma Nursing Home which was near to his house. He submitted the bills to TPA M/s Vipul Medicorp. On regularly contacting with TPA, he could not get any suitable reply. However, he was later on informed that his claim will be settled by the insurer. On 18.08.2008, he was informed by the insurer vide its letter dt. 18.08.08 that since the treatment has been taken in Sharma Nursing Home which is not in the list of 64 hospitals effective on policy w.e.f. 01.11.2007, his claim is not admissible and claim file has been closed as No Claim. The insured has also stated that he is taking this policy regularly for the last 4 years. Parties were called for hearing on 23.01.2009 at New Delhi.

FINDINGS: During the course of hearing the insurer clarified the position by stating that the hospital was not on the panel of there approved hospitals. Hence the claim was repudiated.

DECISION: Held that the terms and conditions of the policy do not mention that treatment should be taken from a hospital which is on the panel of the insurer. The only condition given in terms and conditions of the policy is that the hospital should be either 15 bedded or should be under a registered medical practitioner. In view of the above, the repudiation of the claim on the ground of hospital not being on the panel of insurer is not in order. The claim is payable subject to Sharma Nursing Home fulfilling the criteria given in the terms and conditions of the policy and bonafides about the genuineness of the claim. It is hereby ordered that the admissible amount of claim should be paid by the insurer to the complainant by 15.02.2009 under intimation to this office.

Chandigarh Ombudsman Centre

CASE NO. GIC/541/UII/14/08

Raj Kumar Vs. United India Insurance Co. Ltd.

Order dated 10.02.09 **MEDICLAIM**

FACTS: Sh. Raj Kumar had taken a mediclaim policy No. 200603/48/08/9700000090 for the period 02.09.08 to 01.09.2009 covering himself. He got treatment from CMC Ludhiana and was hospitalized from 30.10.08 to 10.11.08. He has mediclaim policy since 2000. He submitted his medical bills for Rs. 42578/- to the insurer / TPA. However, his claim had not been settled as yet. Parties were called for hearing on 10.02.2009 at Ludhiana.

FINDINGS: During the course of hearing the insurer clarified the position by stating that at the time of cashless application, it was mentioned that the patient has diabetes since 1998. Hence it was treated as a pre-existing disease. On a query, whether discharge summary was available, the insurer replied in the affirmative.

DECISION: Held that on going the through the discharge summary carefully, there is no mention of history of diabetes in the discharge summary and no record of any treatment since 1998 for diabetes. Therefore, the benefit of doubt goes to the complainant. The repudiation of the claim is, therefore, not in order. The claim is payable. It is hereby ordered that the admissible amount of claim should be paid by the insurer to the complainant.

Chandigarh Ombudsman Centre

CASE NO. GIC/546/Reliance/11/09

Ram Gopal Setia Vs Reliance Gen. Insurance Co. Ltd.

Order dated 12.02.09 **MEDICLAIM**

FACTS: Sh. Ram Gopal Setia had purchased one PNB Arogya Shree Insurance Policy no. 900126283000001 from Reliance General Insurance Co. Ltd through Punjab National Bank for the period 19.03.07 to 18.03.08. His wife, Smt. Kanchan got treatment in Indra Prastha Apollo Hospital, New Delhi and the complainant had spent a sum of Rs. 2,74,662/- on the treatment. All the claim documents were submitted to M/S Paramount Health Services Pvt. Ltd, TPA for settlement of claim. But the TPA vide letter dated 28.07.08 denied the claim on the ground that the disease was pre-existing. Parties were called for hearing on 12.02.09.

FINDINGS: During the course of hearing the insurer clarified that the treatment was for valve replacement in the heart. The problem of valve is congenital disease. As per exclusion clause 4.10 of the terms and conditions of the policy, all congenital diseases either internal or external are not covered for claiming the reimbursement.

DECISION: Held that the contention of the insurer that the disease was congenital and the claim is not payable is justified. The repudiation of the claim is, therefore, in order. No further action is called for. The complainant is dismissed.

CHENNAI

Office of Insurance Ombudsman, Chennai
Complaint No.IO(CHN) 11.05.1101/2008 – 09
Mrs. Aartai Roy
vs
The Oriental Insurance Co. Ltd
Award No.IO (CHN)/G/050/2008 – 09 dated 20/10/2008

The Complainant and her son were covered under the mediclaim policy of Oriental Insurance Co . without break from 1997. The insured was hospitalized for heart problem and her claim was rejected by the insurer on the grounds of pre existing ailments. The insurer contend that the insured was suffering from diabetes mellitus for 10 years and this had not been revealed at the time of taking the policy.
The present claim had arisen in Nov.2004 i.e. in the 8th policy year. Although the actual date of occurrence of the diseases of diabetes and hypertension are not available, there is no document to prove that the complainant had deliberately withheld the information regarding the existence of the diseases. Even if the insured had been aware of diseases, it is seen that the treatment is for implantation of pacemaker and not for controlling or managing diabetes or hypertension per se. Though diabetes and hypertension does predispose a person to ailments relating to heart as well as several other organs, it cannot be concluded that all such persons will definitely require implantation of a pacemaker.
Hence ,the decision of the insurer to reject the claim in the absence of clinching evidence like indoor case sheets, prescriptions or other records are not justified. The insurer was directed to settle the claim subject to other terms and conditions of the policy.
Complaint **was allowed.**

INSURANCE OMBUDSMAN, CHENNAI

Complaint No.IO(CHN) 11.04.1120/ 2008-09

Mr. Bhikam Chand Jain
Vs
United India Insurance Co. Ltd,

AWARD No. 51 / 2008-09 dated 24/10/2008

The complainant and his family were covered under Individual Mediclaim. His wife was hospitalized for Disc Prolapse and the TPA settled the claim on cashless facility. Subsequently, she took post hospitalization treatment and submitted the bills for Rs.14,541/- to the TPA. But the same was not settled because TPA contended that they had not received the bills..

The case came up for hearing on 19/08/2008.

Documents such as correspondence exchanged between the complainant and insurer and TPA were also perused. On perusal of the documents, it was seen that TPA had called for duplicate or Xerox copies of the bills sent to them. Further, the insured also did not have proof of sending the bills like postal receipt, courier receipt etc. It is observed that the stand of the TPA/insurer in calling for the copies of the documents is not unreasonable. At the hearing, the insured was informed that he could submit either copies of bills or certificates for the same in respect of the two major amounts, which were observed to have been paid to reputed hospitals in the City. For reasons best known to the complainant, no such effort seems to have been made either as soon as the TPA/insurer informed the same to him or even after being advised by the Forum.

The insurance policy being a contract, the duty is cast on the insured to make available to the insurer all records like original bills, receipts and other documents and he shall also give the TPA/insurer such additional information and assistance as they may require in dealing with the claim. In the present case, the insurer has settled the hospitalisation claim of Rs 16,394/- where the diagnosis was "L5-S1 Disc prolapse with hypothyroidism". The post hospitalisation claim is for Rs 14,541/-. It was seen that the insurer has settled the hospitalisation claim under "cashless" facility and therefore there is no deficiency in service. It is seen that the TPA has asked the insured to submit only duplicate copies. But the complainant did not avail of this opportunity. Sufficient opportunity was given to the insured to submit at least some proof with regard to the amount of claim. The insured has not submitted any proof in support of the expenses incurred for which the reimbursement had been sought. Hence the insurer had no option but to reject the claim since relevant bills were not submitted to

them. Held decision of the insurer in rejecting the claim for non-submission of the bills cannot be faulted.

The complaint was dismissed.

Office of Insurance Ombudsman, Chennai

Complaint No.IO(CHN) 11.04.1131/2008 – 09
Mrs. C. Manonmani
Vs
United India Insurance Co. Ltd
Award No. 052 dated 24/10/2008

The complainant and her spouse were covered under the mediclaim policy issued by the insurer continuously for four years. During the policy period the insured was diagnosed with heart problems and had not opted for heart surgery. Instead she underwent EECP treatment, which did not involve any invasive treatment.The insurer rejected the claim on the ground that the EECP therapy is not covered under the mediclaim scheme of the Company.

It is found that EECP treatment given to the insured was a non-invasive procedure and involved sittings of about an hour each on 35 different dates. Hospitalisation in such a case is also not warranted. On comparing the two discharge summaries and on scrutiny of the bills, it appears that the contention of the insurer that the second discharge summary has been furnished so as to make the claim payable as a case of hospitalisation by showing the insured as being admitted and discharged on difference dates is true. The contention of the insured that, claims in respect of the same treatment, had been settled by other insurance companies and therefore United India should settle the claim is not acceptable. Terms and conditions of group policies are different from those given to individuals. Insurance market in India has been opened up and companies have been given the freedom to file and use policies. Uniformity in policy conditions has given way to tailor made policies. As such, mediclaim policies given to groups of employees of software companies or credit card holders cannot be compared to those issued to individuals.Since the proposed treatment was not an emergency but a planned one, the insured had ample time to inform the TPA about the proposed treatment and ascertain its admissibility. Hence,the decision of the insurer to reject the claim is in order and the complaint is dismissed.

Office of Insurance Ombudsman, Chennai
Complaint No.IO(CHN) 11.12.1175/2008 – 09
Mr. A. Venkatesh Babu
Vs
ICICI Lombard General Insurance Co. Ltd
Award No.IO (CHN)/G/053/2008 – 09 dated 24/10/2008

The Complainant had taken a health insurance policy for his family including his wife and two sons with the insurer. During the policy period, insured's son was hospitalized for treatment of high fever. After discharge from the hospital, the insured settled the bill for Rs.25,695/- and the same was reimbursed to the insured by the hospital. After one year, the insured received information from the hospital requesting him to pay the amount since the insurer had subsequently declined the claim based on the remark in the discharge summary that the baby is a "known wheezier for the past one year".

It is not possible to totally ignore the treatment given to the child during the hospitalisation and the advice at the time of discharge. Most of the medicines prescribed are for treatment of respiratory ailments. Although the treating doctor has certified that the child did not have a recurrent history of wheeze and the noting in the discharge summary is in error, it is seen that the certificate has been obtained only after dispute arose regarding the admissibility of the claim. If the complainant had got the discharge summary rectified on his own because it contained a factually incorrect assessment of the health of his child and the same had been done before the repudiation of the claim, it would have been more authentic. Hence, taking all the above into account an amount of Rs.15,000/- is awarded as Ex-gratia**.**

Office of Insurance Ombudsman, Chennai
Complaint No.IO(CHN) 11.03.1179/2008 – 09
Mrs. Luxmi B Nair Vs
National Insurance Co. Ltd
Award No. 054 dated 24/10/2008

The Complainant had Mediclaim insurance policy since 5 years and renewing the same without break. In December 2007, she started having complaints of pain in the knees, elbows and joints

and legs. She took ayurvedic treatment and filed a claim with the insurer. The claim was rejected by the insurer quoting clause 4.24 wherein Shirodhara and like treatment were disallowed.

The point to reckoned is whether the treatment undertaken by the insured falls under the exclusions of the policy.

The insured was admitted as an in patient in the hospital and both oral and intensive therapy were given. The patient was feeling better at the time of discharge and prescribed medicines on discharge. Under intensive therapy there is a mention about Sirodhara with Dhanwanthri thailam for 5 days. The diagnosis is mentioned as Vatha Raktha.

The insurer has rightly rejected the claim as per the revised policy exclusions relating to Srodhara. But, the medical bills and discharge summary indicate that Surodhara is only a part of the treatment and the entire treatment was not only Surodhara but other treatment which were not excluded. Since exclusion pertains to Surodhara and the likes only, the other treatment taken which are borderline were not conclusively proved by insurer as falling under exclusions of the policy. An amount of Rs.10,000/- is awarded as Ex-gratia.

Office of Insurance Ombudsman, Chennai
Complaint No.IO(CHN) 11.04.1219/2008 – 09
Mr. P.R. Raman
Vs
United India Insurance Co. Ltd
Award No. 055 dated 24/10/2008

The complainant Mr P R Raman and his family had been covered under Mediclaim Insurance policy of the insurer. In October 2007, his wife Mrs. Priya Raman was hospitalized for high fever. During hospitalization, she was kept in the ICU under observation and medicines were administered. The claim was rejected on the grounds that the claim was made for high-grade fever during pregnancy, which is not covered as per the policy.

It is a fact that under the individual mediclaim policy, there is no coverage for maternity related expenses. But, in the present case, the admission to the hospital was for treatment of the high fever, other wise there is no need for hospitalization. As confirmed by the complainant at the hearing, the insured has been having regular

check ups and keeping normal health and the hospitalization was not resorted to for carrying out any tests. While we may agree with the view of the insurer that fever can be treated as out patient, the condition of the patient at the time of admission is to be considered. The clinical history states that the patient had a history of high fever, vomiting and severe body pain. Such condition could warrant hospitalization even in a normal person and the authority to take a decision on the need for hospitalization is the attending or treating doctor. And it is also seen that the diagnosis is "High Fever" and the reference only refers to the patient and her state of pregnancy. Nothing in the diagnosis points to the fact that her maternity condition was treated. Besides, nothing in the policy states that an insured person, who is pregnant, will not be covered during the period of her pregnancy for any illness whatsoever. As such, the repudiation of the claim in full as unjustified and Rs.3,000/- awarded as **Ex-Gratia**.

Chennai Ombudsman Centre
Case No.IO(CHN) 11.08.1224/2008 – 09
Mr.K.V.B. Prasad
Vs
Royal Sundaram Alliance Insurance Co. Ltd
Award No.061 dated 10/11/2008

The Complainant was covered under the Health Shield Insurance Policy of the insurer. The insured was hospitalized and

underwent Coronary Artery Bypass Graft Surgery on 29.11.2007. The insured filed a claim with the insurer and the same was rejected on the ground that the ailment related to pre existing diabetes.

It is seen that as per the discharge summary the insured was having diabetes for a considerably long time, 20 years. The probability of such a person contracting coronary artery disease is more in such cases. Diabetes need not be the only reason for CABG but the long duration of the disease must have contributed to his health condition. Onus lies on the insured to disclose his correct state of health which he failed. The contention of the insurer that pre existing diabetes is responsible for the onset of the heart disease was not disproved by the insured. Hence, the decision of the insurer to decline the claim on the basis of pre-existing conditions is in order and the complaint is dismissed.

Chennai Ombudsman Centre

Case No.IO(CHN) 11.12.1110/2009 – 10
Mr. P. Aruldhas
Vs
ICICI Lombard Gen. Ins. Co. Ltd
Award No.065 dated 28/11/2008

The Complainant had taken a two year mediclaim policy from the insurer. He underwent CABG surgery and filed a claim with the insurer. Despite furnishing all relevant documents and clarifications, the insurer had not settled his claim.

The complainant cannot expect the insurer to reimburse the expenses for CABG surgery of a triple vessel disease within 120 days of inception of policy. Though insured was not having any symptoms, such a serious condition might have been the result of conditions, which gradually developed prior to taking the policy. Besides, both hospitals in various

records, have stated that both diabetes and hypertension were recently diagnosed. The insured has claimed that he did not have prior consultation papers whereas the insurer has been insisting for the same to deal with the claim. If indeed the diagnosis was done recently, the relevant papers should have been readily available. Although the complainant has claimed Rs 2.00 lacs under the policy; Rupees One lakh has been reimbursed by his employer. Taking into account the above and to render justice to both the parties, an amount of Rs 50,000/- is awarded as Ex-Gratia **and the Complaint is partly allowed.**

Chennai Ombudsman Centre

Complaint No.IO (CHN) 11.05.1236 / 2008-09

Mrs. Vasanthi Ravichander

Vs

The Oriental Insurance Co. Ltd

AWARD No. 067 dated 10/12/2008

The Complainant was covered under group Mediclaim policy of the Oriental Insurance Company issued to her employer for a sum insured of Rs.50,000/- for the period 21/06/2007 to 20/06/2008. The insured was hospitalized from 30/04/08 to 3/05/2008 for Bilateral Fibrocystic Breast Disease and underwent bilateral wide excision. Her claim for Rs 48,785/- was repudiated on the grounds of 'Pre-existing disease' under clause 4.1.

The insurer stated that the policy had incepted on 21/06/2007 and the complainant had been hospitalized on 30/04/2008 . She had undergone surgery on the same day. Their TPA had repudiated the claim under the clause pre-existing disease.

The case thus came up for hearing on 15/10/2008. Documents such as policy copy, proposal form and self-declaration dated 21/6/2007,

Cytology Report, Histopathology Report, Discharge Summary were scrutinized.

The claim has arisen in April 2008, which is with 10 months of inception of policy in June 2007.Considering the size of the masses the growth of the cysts would have been over a long period of time and could not have developed suddenly and as per Exclusion 4.1 which is in force from Sept. 2006 onwards, decision to repudiate could not be faulted.

However, no records like indoor case papers have been produced to confirm the actual onset of the disease or the symptoms was before the inception of policy 10 months ago. Therefore awarded a sum of Rs 25,000/- as Ex-Gratia**.**

Chennai Ombudsman Centre

Complaint No.IO(CHN) 11.04.1227 / 2008-09

Mr. R. Rajappa
Vs
The United India Insurance Co. Ltd

AWARD No 071 dated 26/12/2008

The Complainant Mr R. Rajappa was covered under Individual Health Insurance policy of United India Insurance Co. Ltd for a sum insured of Rs1,50,000/-. He was hospitalized on 09/02/08 and underwent treatment for SUBFOVEAL CHOROIDAL NEOVASCULAR MEMBRANE in the right eye and lodged a claim for Rs.1,82,815/-. The insurer rejected the claim on the grounds of pre existing condition and age related degenerative disorder.

The insurer stated policy been incepted two years earlier and insured preferred a claim for photodynamic therapy that he underwent. The claim was rejected since ailment was due to age related degenerative disorder and pre-existing in nature.

The case thus came up for hearing on 15/10/2008.

Both parties were heard and documents such as Proposal form, Policy copy, Discharge Summary and Case Summary of Sankara Nethralaya, Attending doctor certificate were perused. As per the case summary and the treating doctors certificate, submitted after the claim was repudiated, the complainant has been taking treatment from June 2004 at Shankar Nethralaya. In 2004, intraocular lens implant had been in place in both eyes. The case summary dated 17/03/08 given by the same doctor however mentions that the insured consulted them on 19/06/2004 with the complaint of diminution of vision in the left eye since the last 20 years. Expert opinion was obtained due to the contradiction in the case sheet and treating doctor's opinion the opinion of an independent specialist was obtained who opined that the insured should have degenerated disease of both the eyes in 2004 itself as recorded by the hospital authorities. The preexistence of the eye ailment having been established, the decision of the insurer to repudiate the claim was upheld.

The complaint is dismissed.

Chennai Ombudsman Centre
Complaint No.IO (CHN) 11.04.1250 / 2008-09
Mrs. P.Vijaya Krishnakumar
Vs
United India Insurance Co. Ltd
AWARD No. 072 dated 29/12/2008

The Complainant, Mrs. P.Vijaya Krishnakumar was covered under mediclaim policy of the United India Insurance Co. Ltd for the period from 07/06/2007 to 06/06/2008 for a sum insured of Rs 50,000/-. She was hospitalized for hysterectomy along with surgery for umbilical Hernia and Sebaceous Cyst. The claim of the insured was rejected by the insurer on the grounds of exclusions of certain conditions during the first two years of the policy.

The insurer contended that the claim is under the first year of their policy whereas as per their individual mediclaim policy terms and conditions the treatment of menorrhagia, hernia and other related disorders are not payable in the first two years of policy commencement. The case thus came up for hearing on 23/10/2008.

After hearing both the parties and the TPA documents such as Discharge summary, Hospital record, Proposal Form, Policy copy and Clause 4.3 were perused. It was seen that as per the terms and conditions, certain diseases /conditions occurring during the first two years of the taking of the cover are excluded under condition 4.3 of the policy. Since insured's hysterectomy and other surgeries falls under the scope of the specific exclusion and insurer could establish pre existing illness. Decision of insurer to repudiate was upheld.

The complaint was dismissed**.**

Chennai Ombudsman Centre

Complaint No.IO(CHN) 11.04.1254 / 2008-09

Mr. C. Unnikrishnan
Vs
United India Insurance Co. Ltd
AWARD No. 073 dated 29/12/2008

The Complainant and his family were covered under individual medicalim policy of United India Insurance Co. Ltd from 2001 onwards for a sum insured was Rs 25,000/-. His wife, was hospitalized for fibroids in the uterus and she underwent diagnostic Laproscopy and then it was converted to laparatomy and hysterectomy/Bilateral salphingo-Oopherectomy. He preferred a claim for Rs 23,188/- which was rejected on the ground that the patient was admitted for treatment of Menorrhagia but underwent Medical Termination of Pregnancy and Family Planning Surgery,

which are excluded under the policy .Although the hospital had issued a revised discharge summary with correct details his claim was not considered.

The insurer stated that the claim was not supported by valid documents and no prescriptions/reports were submitted by the insured. As per discharge summary, the patient was admitted for menorrhagia but underwent MTP and no indication of diagnostic Laportomy was available. Further they stated that the complainant has claimed for Hysterectomy. The MTP and family planning are exclusion under the policy. Revised discharge summary, which did not mention of MTP and family planning was not substantiated by records in the hospital.

The case thus came up for hearing on 17/11/2008.

After hearing the parties, records such as the policy copy with exclusion clauses 4.12 and 4.3, the two materially different Discharge Summaries from the same hospital, Histopathology Report, Indoor case papers, Operation notes were examined.It was seen that the primary reason for the admission of Mrs Pushpa was due to the fact that she was into the second month of her pregnancy and had opted for voluntary termination of pregnancy. The decision of insurer to repudiate the claim was upheld.

The complaint was dismissed.

Chennai Ombudsman Centre

Complaint No.IO(CHN) 11.03.1284 / 2008-09

Mr. M.V. Vaidyanathan
Vs
The National Insurance Co. Ltd
AWARD No. 074 dated 30/12/2008

The Complainant, Mr. M.V. Vaidyanathan was covered under individual mediclaim policy of M/s National Insurance Company Ltd. from 2002 onwards for a sum insured of Rs.2,00,000/-. He was hospitalized for by-pass surgery during April 2007 and incurred an amount of Rs

2,61,591/-. The insurer rejected the claim on the ground that the insured was suffering from the ailments prior to taking the policy and the claim falls under "pre-existing disease" exclusion 4.1. of the policy.
The case thus came up for hearing on 19/11/2008.
After hearing the parties, documents such as Proposal form**,** Discharge Summary were perused. It was observed that as per the Discharge summary,the insured had undergone coronary angiogram on 22/01/1997, which had revealed double vessel block and he had been on medical management. But on 19/06/2002, the insured had submitted a proposal form and taken a mediclaim policy without disclosing the true and factual position regarding his health. It was therefore established that the insured was diagnosed to be having double vessel disease in 1997. The present claim by the complainant is towards treatment of the very same health condition, which existed in him prior to taking the insurance policy. Hence, the decision of the insurer in rejecting the claim on the grounds of pre existing condition **was upheld.**
The complaint is dismissed.

Chennai Ombudsman Centre

Complaint No.IO (CHN) 11.05.1255 / 2008-09

Mr. M. Srinivasan
Vs
United India Insurance Co. Ltd

AWARD No. IO 076 dated 31/12/2008

The Complainant his wife and two children were covered under mediclaim policy of United India Insurance Co. Ltd. during the period 15/12/2007 to 14/12/2008 for sum insured of Rs 50,000/- each for the husband and wife and Rs 20,000/- each in respect of the children. The complainant's wife Mrs.Shanthi underwent Appendectomy and correction of bilateral uterus. The insured lodged a claim for Rs 70,574/- and the insurer restricted the claim to Rs 10,000/- only, as per the revised terms of the policy.
The insurer contended that they had settled the claim for Rs 10,000/-, which is 20% of the sum insured payable as per terms and conditions of the policy for the surgery undergone by Mrs Shanthi.
The case thus came up for hearing on 19/11/2008.
After hearing the parties, documents such as Discharge Summary, Policy copy along with Health Insurance Policy – Gold - Prospectus, Claim form and Histopathology were perused.

The patient was hospitalized and hysterectomy was performed.But since appendix was inflamed they proceeded with appendectomy. It was seen that there were apparent contradictions in the Discharge summary also. However, as per the Gold policy, under Sec 4.3, Hysterectomy for menorrhagia or Fibromyoma are exclusions for the first two years under the policy. It was seen that the insurer has paid Rs 10,000/- that is 20 % of the sum insured for the hysterectomy as per the old policy although as per the Gold policy, it is "Two Year exclusion". Decision of insurer to restrict the claim to 20 % of sum insured was upheld.

The Complaint was dismissed.

Chennai Ombudsman Centre

Complaint No.IO(CHN) 11.03.1302 / 2008-09

Dr. L. Ganapathy
Vs
National Insurance Co. Ltd,

AWARD No. 077 dated 31/12/2008

The Complainant Dr. L. Ganapathy and his wife were covered under individual mediclaim policy of the National Insurance Co. Ltd continuously since 2000. On 14/06/07, the wife of the complainant was operated for Left Ovarian Cyst at Joseph's Nursing home. The insured's claim of Rs.36,250/- was rejected on the grounds of pre existing condition

The insurer contended that there was a medical certificate stating that the patient had a history of left ovarian cystectomy in 1994. As per insurer's panel doctor's opinion, the present ailment is due to the complication of pre existing ailment in 1994. Hence, the insurer/TPA had rejected the claim under condition 4.1 relating to pre existing diseases.

The case thus came up for hearing on 21/11/2008.

After hearing the parties, documents such as the Proposal form, Discharge Summary , Ultrasonography reports dated 09/07/94 and 12/06/2007,Medical opinion etc were perused.In the scan report dated 9/07/1994 it is seen to be stated therein that "Left Ovary shows a cyst". But Mrs Mahalakshmi did not state anything about the left ovarian cyst or the operation to the same in the proposal form in 2000 whereas full details had been furnished regarding the uterus and cyst in right ovary which had been removed. The insurer has rejected the claim on the grounds of condition No.4.1 of the mediclaim policy. The insurer's contention is that the surgery carried out in 1994 is the root cause of the present cyst formation which required operation under hospitalization. But it is seen that the insured had declared the surgery she underwent in the proposal submitted at the commencement of the policy in 2000 and the insurer had not expressly excluded the same from the scope of the policy. Since the insured had declared her health status, the option was available to the insurer to call for additional tests or documents before accepting the proposal. The impression created is that since the cyst is completely cured, the insurer might not have thought it necessary to exclude the same. The present cyst has formed after a gap of more than 6 to 7 years and during the intervening period scan reports taken during some of the years mention normal study. Held that the decision of the insurer to reject the claim in full is untenable and awarded a sum of Rs 15,000/- as Ex-Gratia.

Chennai Ombudsman Centre

Complaint No.IO(CHN) 11.03. 1294/ 2008-09

Mr. Vinu Nayar Vs The National Insurance Co. Ltd

AWARD No. 079 dated 13/01/2009

The Complainant, Mr. Vinu Nayar had covered his mother under Mediclaim Insurance Policy of the National Insurance Co. Ltd for the past 15 years. During the policy year

2007-2008, his mother was treated for Osteoarthritis by Rotational Field Quantum Magnetic Resonance procedure (RFQMR). The insured's claim of Rs.90,000/- was rejected by the insurer on the grounds that the treatment given was an unproven, outpatient procedure and does not fall under the purview of the policy

The insurer had stated that as per the opinion of their Panel Doctor, the insured's treatment was an unproven procedure and not falling under hospitalization, was an outpatient procedure and the treatment was not recognized by the Medical Council of India.

The case thus came up for hearing on 21/11/2008.

After hearing the parties and records such as terms and conditions of the relevant policy, Insurer's repudiation letter, Treatment Summary of SBF Health Care ,proposal form, Write up on Rotational field quantum magnetic resonance in treatment of osteoarthritis of the knee joint, Copy of Award of the Hon'ble Insurance Ombudsman of Chandigarh dated 9th March 2007 were scrutinized.

It was found that the insured has been suffering from Osteoarthritis and the disease was at Stage III which required knee replacement as opined by the specialists at Apollo Hospitals and the cost of the surgery would have been Rs.1.5 lacs. Considering the age of the insured, the insured had opted RFQMR treatment which is a non invasive method of treatment at SBF Healthcare Pvt. Ltd. The said treatment centre is also yet to get approval of Medical Council of India. The treatment was taken on outpatient basis. RFQMR has not been included in the list of treatments for which the 24 hours hospitalisation has been waived. On scrutiny of the Order of the Hon'ble Insurance Ombudsman Chandigarh, it was observed that there are vital differences on many points of fact including the type of policy which was not the regular 'mediclaim policy'. As such it could not be a precedent.

It was held that the treatment received by the insured does not fall within the scope of the policy conditions and no facts have emerged which warrant interference by the insurance ombudsman in the decision of the insurer to repudiate the claim.

The Complaint was **dismissed**.

Chennai Ombudsman Centre

Complaint No.IO(CHN) 11.02.1316 / 2008-09

Dr. B. Subramani

Vs

The New India Assurance Co. Ltd

AWARD No. 82 dated 29/01/2009

The Complainant's father was covered under Individual Mediclaim Insurance policy for a sum insured of Rs.1,00,000/-. Shri S Bagawatheeswaran was hospitalized during the policy period for Chronic Obstructive Pulmonary Disease. The Insured claimed an amount of Rs 83,455/- towards hospitalization. The claim was rejected by the insurer on the grounds of pre existing disease.

The insurer contended that as per their controlling office and as confirmed by the investigation report, the present ailment is due to pre existing disease/condition only.

The case was heard on 19/12/2008.

After hearing the parties, documents such as Policy copy, Discharge Summary of the hospitals, Repudiation letter of insurer, Proposal Forms, Requests for cashless facility etc were perused.

It was seen the insured had made five hospitalization claims in the past and the same had been settled by the insurer. During the various admissions to hospital, the insured had been giving different versions regarding his pre existing diseases condition. The insured had submitted proposals at the time of first coverage and subsequent renewal after a break wherein he had not disclosed any past history of diseases, operations, accidents, investigations which came to light during hospitalization at a later date. Only under the current hospitalization, the insurer/TPA was able to correlate and find out that the insured was giving different versions regarding his pre existing disease condition. The independent expert opinion points to pre existing nature of airway disease and cardiac ailment resulting from pre existing hypertension.

It was been conclusively established by insurer through investigation and also through expert doctor's opinion that the claimant was suffering from hypertension since 32 years and allergic bronchitis since 10 years.

The Complaint was dismissed.

Chennai Ombudsman Centre

Complaint No.IO(CHN) 11.04.1374 / 2008-09

Mr. H. Selvamuthu Kumaran
Vs
United India Insurance Co. Ltd.,
AWARD No. 084 dated 31/01/2009

The Complainant and his family were insured for a sum insured of Rs.1,00,000/-.The wife of the complainant was hospitalized for Umbilical Hernia Tissue Repair with onlay mesh and recurrent Incisional Hernia. The complainant lodged the claim for Rs.38,489/- & Rs.50,897/-. Both claims were rejected.

The insurer contended that the insured had hernia repair along with maternity during the 2006 and the claim was rejected orally only without any written communication. In the second case, during 2008, the insurer rejected the claim of Incisional hernia on the grounds of pre existing disease.

1. **The case thus came up for hearing on 18/12/2008.**
   a) **After hearing the parties to the dispute, records such as Policy copy for the relevant years, Discharge Summary for both the hospitalisations, Claim forms, TPA notes and repudiation letter.**

b) The point to be considered was whether the rejection of the claim for Hernia repair treated along with maternity during 2006 and rejection of recurrent incisional hernia in 2008 as a pre existing condition were in order.

2. **After hearing the parties and perusal of the records, it is found that**

   - **The insured was hospitalized for LSCS with sterilization and Umblical Hernia Repair during 29/10/2006 to 18/11/2006.**
   - **The insured was again hospitalized for recurrent incisional hernia/mesh repair and excision of ? desmoid tumor.**
   - **The coverage under 2006 policy excludes maternity related expenses.**
   - **Both the policies are continued without any break**

3. The insured underwent surgical procedure of LSCS with sterilization and umbilical hernia repair tissue repair with onlay mesh during the policy period in 2006. Sufficient coverage was available and sum insured was adequate. Though maternity and sterilization were not covered under the policy, the insurer/TPA have casually dealt with the claim for umbilical hernia and rejected the same as a consequence of maternity. As per the policy, it was continuous since 2004 and hernia is an exclusion during the first year of the policy only and not during 2006 when the insured has completed the waiting period of one year. The insurer has not even cared to send a letter in writing explaining the reasons for rejection. Merely noting on the claims information sheet and informing the insured orally can not be taken as providing customer service.

4. **The surgical procedure during 2008 for recurrent** incisional hernia/mesh repair & excision of? desmoid tumor-anterior abdominal wall **was also rejected under the 2008 policy of the same insurer on the grounds of pre existing condition. The insurer states that the reason for the rejection of the claim was that they thought**

that the policy was a first year policy and as per the terms of the policy exclusion they had dealt with the claim. They further added that, had they known about the continuity of the policy without break, they could have dealt with the claim differently. The insured also had a duty to disclose the correct state of health whenever the policy is renewed in a different office though the policy is a continuous renewal without any break. The insured has also stated that since it was a group policy, the insurer had not taken any proposal and merely took the name, age details only at the time of renewal of the insurance and not sought any other specific information.

5. **In these circumstances, it is found after the details available as above, the insurer's rejection of the claim of 2006 for incisional hernia as maternity related is not justified as this condition has nothing to do with maternity. If anything it was an attempt not to re-open the abdomen a second time. In the claim of 2008 also, since the policy continuity was not known to the insurer, they thought that the claim had happened during the first year of the policy and rejected Recurrent incisional hernia/mesh repair & excision of ? desmoid tumor-anterior abdominal wall under first year exclusion. But since it has been established that the insured was covered by the same insurer from 2004 without a break, the insurer should have considered the claim.**

6. **In view of the above facts, the decision of the insurer to repudiate both the claims namely in the years 2006 & 2008 needs intervention at the hands of the Ombudsman as the reasons adduced in both these cases for rejection of the claims are not justified. It is however observed that in the first claim out of the entire expenses for hospitalisation of Rs 37,015/-, Rs 29,800/- is being claimed as relating to hernia which is unreasonable. It is observed that the entire period of hospitalisation of 21 days and related expenses (of which the expenses of maternity and**

sterilisation are not payable) have been entirely attributed to hernia which is not acceptable. The stand of the insurer that the admission was primarily for maternity is justified and it is noted that procedure was LSCS and not a normal delivery. Further sterlisation has also been performed. Both these procedures are exclusions under the policy. As regards the second claim it is observed that bills as early as 04/09/2006 are included whereas the policy was incepted only on 08/01/2007. Besides, surgery was performed only on 10/02/2008. Also no complications have been recorded in the discharge summary which warranted hospitalisation up to 21/02/2008.

7. **As such I award a sum of Rs** 15,000/- **(Rupees Fifteen thousand only) towards the hernia surgery and a sum of** Rs. 25,000/- **(Rupees Twenty five thousand only) for hernia repair to be paid by the respective insurers as** Ex-Gratia under Rule 18 of Redressal of Public Grievance Rules, 1998**.**

8. **The complaint is partly allowed as** Ex-Gratia.

9. **The attention of the Complainant and the Insurer is hereby invited to the following provisions of Redressal of Public Grievances Rules, 1998:**

   a) **According to Rule 16(5) of Redressal of Public Grievance Rules, 1998, the complainant shall furnish to the insurer <u>within a period of one month</u> from the date of receipt of this Award, a letter of acceptance that the Award is in full and final settlement of his claim.**

   b) **As per Rule 16(6) of the said rules the Insurer shall comply with the Award <u>within 15 days</u> of the receipt of the acceptance letter of the Complainant and <u>shall intimate the compliance to the Ombudsman</u>.**

c) **According to Rule 17 of the said Rules if the Complainant does not intimate his acceptance of the Award under Rule 16(5), the Award may not be implemented by the Insurance Company.**

Dated at Chennai this 29th day of January 2009

(K. SRIDHAR)
INSURANCE OMBUDSMAN
CHENNAI

THE INSURANCE OMBUDSMAN, CHENNAI
Complaint No.IO(CHN) 11.02. 1256 / 2008-09
AWARD No. IO (CHN)/G/ 088 /2008-09 dated 30/01/2009

Mr. R. Sudarsanan Vs The New India Assurance Co. Ltd

Mr R Sudarsanan and his wife were covered under Individual Health Insurance policy of The New India Assurance Co. Ltd. Mrs. S. Rukmani, was hospitalized and underwent surgery for Hernia. The insured submitted the claim to the insurer for Rs 22,037/-.

The insurer rejected the claim on the ground that the insured was having the policy since 18/04/2005 but swelling in the lower abdomen was traced to 1995 and was therefore preexisting prior to taking the policy for the first time and as such was an exclusion under clause 4.1 of the policy.

The case was heard on 16/12/2008.

After hearing the parties, documents such as Lab Report, Sonography, Policy copy, Discharge Summary, Repudiation letter were perused.

As per discharge summary, the complaint of swelling in lower abdomen was existing since 12 years, soon after operation of laporoscopic cholesystectomy in 1995. At the time of taking the policy the complainant's wife had been medically examined. During the examination also, it was disclosed that she had undergone a laparoscopic Cholecystectomy in 1995. It was observed that as per the policy issued to the insured, hernia is first year exclusion and claim has come in the second year. It was held that neither the Insurer nor the TPA could prove with clinching evidence that hernia was existing for the past 12 years by way of documentary evidence like case sheets, consultations /treatment taken in this connection. No record was produced to establish hernia was present in 1995. No attempt had been made to obtain the indoor case sheets or seek clarification from either the attending doctor or the insured herself. Since neither party could establish their contention with clinching evidence, insurer was directed to pay a sum of Rs.12,000/- as Ex-Gratia as per Rule 18 of Redressal of Public Grievance Rules, 1998.

The complaint was partly **allowed as Ex Gratia.**

Chennai Ombudsman Centre

Complaint No.IO(CHN) 11.02. 1256 / 2008-09

Mr. R. Sudarsanan

Vs

The New India Assurance Co. Ltd

AWARD No. 088 2008-09 dated 30/01/2009

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The complaint was partly allowed as Ex Gratia.

Chennai Ombudsman Centre

Complaint No.IO(CHN) 11.08.1375 / 2008-09
AWARD No. IO (CHN)/G/ 090 /2008-09 dated 30/01/2009

Mr. S. Kumar Vs Royal Sundaram Alliance Insurance Co. Ltd

The Complainant was covered under Health Forever Insurance policy of the M/s Royal Sundaram Alliance Insurance Co. Ltd for a sum insured of Rs.1,00,000/- during 2008-09. The complainant was hospitalized for Left Renal Calculi – Left PCNL/ICL and claimed an amount of Rs 51,469/- towards hospitalization. His claim was rejected by the insurer on the grounds of pre existing disease.

The insurer stated that the ultra sound report of the insured showed renal calculi with a stone of 16mm size in the pelviuretic junction which cannot develop over a period of 16 months and was pre-existing. Hence they had rejected the claim on the grounds of pre existing nature of the disease suffered by the insured.

The case was heard on 19/12/2008.

After hearing the parties, records such as Policy copy, terms and conditions, Statement of expenses for the hospitalization, Repudiation letters of TPA and insurer, scrutinized. The recording of the pre sale telemarketing was also heard.

The repudiation of the claim had been on the ground that the renal calculus was a pre existing disease. But the insurer could not exactly establish, with any clinching evidence like prior consultations, prescriptions or even any scientific data that the fact that the renal calculus had developed prior to the commencement of policy 16 months earlier. The insured too could not establish with any medical records that the renal calculus developed only after the commencement of the policy. Taking into account, that the patient was asymptomatic and below 40 years and there is no clinching evidence regarding the date of formation

of the condition an amount of Rs 30,000/- was awarded as Ex-Gratia under Rule 18 of Redressal of Public Grievance Rules, 1998.

The complaint was partly allowed as Ex-Gratia .

Chennai Ombudsman Centre

Complaint No.IO(CHN) 11.03. 1314/ 2008-09
AWARD No. IO (CHN)/G/ 092 /2008-09 dated 25/02/2009

Mrs. Poorni Venkataraman Vs The National Insurance Co. Ltd

The Complainant's family was covered under Mediclaim Insurance Policy of the National Insurance Co. Ltd. During the policy period, the complainant's son undertook Ayurvedic treatment at JM Kerala Aayurveda SpecialityCentre or shoulder injury and made a claim for about for Rs 15,000/- which was rejected.

The insurer stated that they had rejected the claim because the clinic where the patient received inpatient treatment did not qualify as a hospital as defined in Condition 2.4 of the policy which contained the requirements for an institution to qualify as a 'Hospital'. Besides, treatment given was an exclusion under Condition 4.24 of the policy by which "massages/steambath /Surodhara and alike Ayurvedic treatment" are excluded. Further the treatment given also did not warrant inpatient stay.

The case thus came up for hearing on 16/12/2008.

After hearing the parties, documents such the mediclaim policy and its terms and conditions, Discharge Summary and Bill of JM Kerala Aayurveda Speciality Centre, Bill of Kumaran Hospital were perused. It was observed that the patient had taken Ayurveda treatment at Kumaran Hospital. Professional processing of claims is a necessity to distinguish whether the treatment given was for "wellness or illness" and necessary for the ailment reported. In such cases, it would be necessary for the TPA/insurer to obtain the opinion on treatments and claims from medical practioners qualified under this system of medicine.However the insured also cannot plead just ignorance before getting treated in the Hospital since the contract

of insurance entered into with the insurer is based on the principle of utmost good faith. Since the treatment was a planned one and not any medical emergency, the necessary clarification regarding policy terms and conditions could have been got from the insurer/TPA. Held that though the payment of full claim to the insured is not justified, the insurer can partially compensate the medical expenses. An Exgratia amount of Rs.8,000/- was awarded under Rule 18 of Redressal of Public Grievance Rules, 1998. No amount is allowed towards interest and mental agony.
The complaint was partly allowed as Exgratia**.**

Chennai Ombudsman Centre

Complaint No.IO(CHN) 11.12. 1365/ 2008-09
AWARD No. IO (CHN)/G/ 094/2008-09 dated 25/02/2009

Mrs.S. Hemalatha Vs ICICI Lombard General Insce. Co. Ltd

The Complainant had taken a Health Care Policy covering her parents from 22.12.2007. After 7 months, in the first week of July 2008, suddenly her mother complained of numbness in her right leg. Thereafter her mother had undergone surgery for Arnald Chiari Malformation and submitted the claim for Rs 92,529/-.
The insurer/TPA rejected the claim on the grounds that the 'present ailment is congenital internal illness' and falls under exclusion 3.4 (iii) of the policy.
The complainant was heard on 23/12/2008 the insurer was heard on 9/01/2009.
After hearing the parties documents such as Mediclaim policy along with terms and conditions, Report of Department of Radiology , Case History and Discharge Summary, Claim form, Write up on ACM and treating doctor's opinion were perused.
Since it is an accepted medical fact that Arnold Chiari malformation is a congenital defect but the treating doctor had opined other wise, the matter was referred to a Specialist for expert opinion. It has been clarified that the malformation is congenital. The late onset of

the symptoms does not rule out congenital cause. All literature in medicals journals pertaining to the above disease only mentions a congenital etiology.

It was held that the rejection of the claim by the insurer on the grounds of pre-existing ailments (congenital) under Permanent Exclusion Clause 3.4 of their policy cannot be faulted.

The Complaint was dismissed.

Chennai Ombudsman Centre

Complaint No.IO(CHN) 11.02. 1410/ 2008-09
AWARD No. IO (CHN)/G/ 096/2008-09 dated 25/02/2009

Mr. Kastoor Chand B. Jain Vs The New India Assurance Co. Ltd

The Complainant Mr Kastoor Chand B Jain and his family members were covered under a Mediclaim Policy continuously for 8 years. During the policy period 2008-09, the insured preferred a claim for Rs 94,000/- for treatment of 'Myopia and Astigmatism for both eyes' (i.e implantation of intra Occular Contact Lens) for his son. The complainant has contended that the treating doctors have diagnosed this case as a case requiring contact lens for treatment of the condition.

Claim was repudiated the claim on the grounds that the claim falls under the clause 4.4.2 which states exclusion of expenses towards "Circumcision, Cosmetic or aesthetic treatment, Plastic Surgery unless required to treat injury or illness.

The case thus came up for hearing on 28/01/2009.

After hearing the parties, documents such as policy copy along with terms and conditions, Discharge summary, Medical opinion of treating doctor, opinion of TPA doctor were perused.

It was seen that the insured's son was admitted at the hospital on 01/04/2008 and eye surgery was carried out for right eye and on 02/04/08 for the left eye. The diagnosis was Myopia and Astigmatism both the eyes. Since patient had been unable to

tolerate regular contact lens since 2-3 months duration implantation of intra ocular contact lens in both the eyes was done. A reading of the policy terms and conditions clearly indicates that the policy cover only medical treatments and procedures undertaken for purely therapeutic purposes. The treating doctor's certificate does not talk of any medical complication or ailment, which made the surgical correction necessary. Held that repudiation was in order.

The Complaint was dismissed.

Chennai Ombudsman Centre
Case No.IO(CHN) 11.03.1411/2008 – 09
Mr. T.V. Thiagarajan
vs
National Insurance Co. Ltd
Award No.101 dated 20/03/2009

The Complainant had been covered under Mediclaim policy of the insurer continuously since 2002. The complainant was hospitalized and operated for heart block and preferred a claim with the insurer. The insurer rejected the claim on the grounds of pre existing diseases.

The point to be considered is whether the rejection of the claim by the insurer on the grounds of pre existing condition is in order.

Since the insured was ex employee of CLRI, his employer had paid a sum of Rs 2,37,804/- out of the total expenses of Rs.3,30,183/-. The insured has claimed for the difference amount of Rs.92,379/- from the insurer. The TPA had not allowed the cash less facility based on the noting in the pre authorization form that the insured had previous history of hypertension.

The insurer/TPA have not obtained the case sheets to prove their contention of pre existing hypertension before taking the policy for the first time by the insured. There is one document that states the presence of hypertension for twenty years and the other document in which no reference to hypertension is made. Although the preexistence of hypertension does pre dispose a person to heart ailments, it cannot be established that it was the sole cause for heart disease in the complainant.

A sum of Rs. 50,000/- is awarded as Ex-Gratia **and the complaint is partly allowed**.

Chennai Ombudsman Centre
Case No.IO(CHN) 11.04.1473/2008 – 09
Mr. L. Sivakumar
vs
United India Insurance Co. Ltd
Award No.102 dated 20/03/2009

The Complainant was covered under medicalim policy of the insurer for a sum insured of Rs.1,50,000/-. He was having the policy continuously from 01/07/2004 to 30/06/2007. During the renewal of 2007-08, he had not renewed the policy on time. Instead he had renewed it from 09/08/2007. The insured was hospitalized for CABG during February 2008 and submitted claim to the insurer for reimbursement. The insurer rejected his claim on the grounds that the hospitalization was for a pre existing ailment.

The point to be considered is whether the rejection of the claim by the insurer on the grounds of pre existing disease exclusion as per the policy terms 4.1 is in order.

The policy for the period 2007-08 was renewed with a break period of 38 days i.e. from 09/08/2007. Since the policy was renewed with a break and claim for CABG was made after six months

of renewal after the break, the TPA treated it as a fresh policy, they in their judgment had concluded that the disease might not have contracted after taking the current year's policy but might have been present well before obtaining the policy. Since the policy has been renewed with a break period of 38 days, the insurer had to treat the policy of 2007-08 as a fresh policy as per the guidelines of the Company.

In these circumstances, the decision of the insurer to reject the claim on the grounds of pre existing disease exclusion treating the renewal of the policy as a fresh one is in order and the Complaint is dismissed.

Chennai Ombudsman Centre
Case No.IO(CHN) 11.02.1425/2008 – 09

Mr. R. Vijayakumar
vs
The New India Assurance Co. Ltd

Award No.105 dated 20/03/2009

The family of the Complainant, was covered under Mediclaim Insurance policy of the insurer. Due to change of minimum sum insured under the policy for the year 2007-08, the insurer had renewed the policy for a sum insured of Rs.1,00,000/- each. For the hospitalization of 2008-09, even though the sum insured was increased to Rs.1 lac, the insurer chose to settle Rs.50,000/- only on the grounds that the increased sum insured is not eligible for an already existing ailments as per the terms of the policy.

The patient was a known case of Acute Myeloid Leukemia-M4, had developed other complications like Marrow aplasia and breathing difficulty. All of these were treated unsuccessfully until the death of the patient. Hospitalization in such serious ailments are dealt with by having different approaches involving treatment methods,

special procedures etc. and has to be seen as an extra ordinary situation as distinct from a mere medical management of a blood cancer patient.

Though policy conditions provide for paying claims upto the limits of the previous sum insured relating to pre existing ailments and not the benefits of increased sum insured, the action of the insurer needs to be little more practical keeping with the sum insured under the present policy involving the claim. It is pertinent that the insurer had insisted on the increase of sum insured, even though they had already settled a major claim. But at the same time, the complainant cannot claim that he is eligible for the entire enhanced sum insured for a pre-existing disease. In the circumstances, an amount of Rs.25,000/- is awarded as Ex-Gratia.

Chennai Ombudsman Centre
Case No.IO(CHN) 11.02.1446/2008 – 09
Mrs. Lakshmi Kameswaran
vs
The New India Assurance Co. Ltd
Award No.106 dated 25/03/2009

The Complainant is covered under the mediclaim policy. She preferred a claim for Incisional Hernia with the insurer and the Insurer/TPA repudiated the same. The TPA stated in their letters that she had history of laparoscoic cholecystectomy in 2000 and now Hernia was developed at that previous laparascopic site. So current illness is taken as the complication of previous surgery and the claim was repudiated under clause 4.1 dealing with pre existing disease.

The point to be considered is whether the rejection of the claim on the grounds that the present condition is due to the

complication of surgery performed during 2000 and falls under condition No. 4.1 relating to exclusions is in order.

It has been established by the insurer with clinching evidence that the complainant had undergone laparoscopic cholecystectomy in 2000 and the same had not been disclosed in the proposal form. The "revised discharge summary' submitted by the complainant has been disowned by the treating doctor. Hence, the insurer/TPA' s stand of rejection of the claim is in order and the Complaint is dismissed.

Chennai Ombudsman Centre

Case No.IO(CHN) 11.02.1412 / 2008-09
Mrs. K.G. Lakshmi
Vs
The New India Assurance Co. Ltd
AWARD No.109/2008-09

The Complainant and her family have been covered under the Mediclaim policy of the insurer. They had preferred three claims on behalf of her late husband. The insurer settled only a part of the claim on the ground that the enhanced sum insured was not applicable to the three claims as the ailment for which the claims were made, was under the definition of pre existing diseases. The complainant contended that the treatment was necessitated for a combination of various ailments including T.B. Further this specific exclusion pertaining to the enhanced sum insured was not incorporated in the policy schedule.

The discharge summary at Coimbatore reveals that the person was diagnosed and treated for diabetes, as well as "Deep vein thrombosis (DVT), lumboscaral radiculopathy with hypotonic bladder with borderline impaired GTT". Because the patient is a known case of one major ailment, the insurer is not justified in considering all

treatment given to be clubbed as treatment of the original ailment. In case of chronic diseases, the effect of medication may lead to further complications. At NIMHANS, the insured was diagnosed to be suffering from another ailment 'Cauda Equina Lesion (LtRt) Tubercular Etiology'. All these diseases having been diagnosed for the first time in 2007, cannot be considered as preexisting when the sum insured had been increased in Oct 2005. Expenses to all these diseases should not be treated as relating to the preexisting diseases. These expenses which are not related to the pre-existing ailments should have been viewed as separate and not to be clubbed with the pre existing ailments. The insured already suffering from a major ailment and under medication, susceptibility to other ailments are high. This will lead to frequent hospitalization and should not be taken as compulsive claimer. Hence an amount of Rs.25,000/- is awarded as Ex-Gratia and the complaint is partly allowed.

Chennai Ombudsman Centre

Case No.IO(CHN) 11.05.1468 / 2008-09
Mr. S. Sreenivasan
Vs
Oriental Insurance Co. Ltd
AWARD No.111/2008-09

The Complainant and his spouse have been covered under the Mediclaim policy of the insurer. He was hospitalized and treated under the Ayurvedic system of medicine, for Sandhigatavatham. He submitted the treatment bills for reimbursement. The insurer rejected his claim on the grounds that the treatment was not taken at the Government Medical College hospital as per the policy terms**.**

A reading of Exclusion clause 2.1 **indicates that the policy intends to cover hospitalization under Ayuvedic system of medicine, the only pre condition being that the treatment should be taken at a well established medical institution. They have prescribed that the**

treatment is to be taken as an inpatient at a Government Hospital/Medical College Hospital. The clause does not restrict the treatment to Government institutions alone. It extends to both Government and private Medical College Hospitals also where the facilities/infrastructure is sufficient enough to take care of the treatment requirement of the insured. The clause should have been interpreted in the spirit in which it was introduced.

The second ground of repudiation is in respect of treatment which falls under exclusion 4.24. The hospital in which the treatment was taken is a well known hospital with high standards and the treatment followed is strictly as per the Ayurvedic System. An amount of Rs.25,000/- is awarded as Ex-gratia and the complaint is partly allowed.

Chennai Ombudsman Centre

Case No.IO(CHN) 11.12.1424 / 2008-09
Mrs. V. Pushpalatha
Vs
ICICI General Insurance Co. Ltd
AWARD No.113/2008-09

The complainant' spouse was covered under the mediclaim insurance policy of the insurer . He was hospitalized for Acute pulmonary Embolism Right Lower limb DVT. The insurer has rejected the claim on the grounds that the claim had occurred within 30 days of commencement of the cover, which is an exclusion under the policy.

The insured had no previous policy. This policy obtained from the insurer is the first year of the policy. The policy was taken from 11/06/2008 and hospitalization happened on 20/06/2008 after ten days of taking the insurance coverage. As per the policy, "medical charges incurred within 30 days of inception date of the policy except those that are incurred as a result of bodily injury caused by an accident. This exclusion doesn't apply for subsequent

renewal with the company without a break." **This clearly mention that hospitalization is not covered within 30 days of inception of the cover except in cases where hospitalization is required as a result of an accident. Hence as per the terms and conditions of the policy, the rejection of the claim by the insurer is in order and the complaint is dismissed.**

As regards refund of premium on cancellation the same is effected from the date of inception of the cover, and since no claim has been entertained, the insurer is directed to refund the premium in full, as if no cover was attached.

Chennai Ombudsman Centre

Case No.IO(CHN) 11.04.1472 / 2008-09
Mr.T. Namachivayam
Vs
United India Insurance Co. Ltd
AWARD No.116/2008-09

The Complainant had been taking mediclaim insurance cover from 2005 without break. During the policy period 2005-06, he was hospitalized for cardiac problem. The insurer rejected his claim of Rs.1,20,000/-. However, even after that, he was renewing the policy continuously. He was hospitalized on 22/03/2008 for chest pain and was treated as an inpatient till 29/03/2008 and claimed Rs.30,960/-. The insurer rejected the claim on the grounds that the hospitalization arose due to pre-existing ailments.

The point to be considered is whether the rejection of the claim by the insurer on the grounds of pre existing ailments exclusion of the policy is in order.

The insured had a history of diabetes and hypertension as well as heart ailment before the inception of the policy. The insurer

has been able to establish that the insured had suffered from heart ailment in 2004 of which he had been aware and also availed of treatment for which the stent had been placed, whereas the insurance policy was incepted for the first time in 2005. As such, the stand of the insurer in rejecting the claim under condition 4.1. of the mediclaim policy is in order and the Complaint is dismissed.

Chennai Ombudsman Centre

Case No.IO(CHN) 11.04.1556 / 2008-09
Mr.B. Lalchand
Vs
United India Insurance Co. Ltd
AWARD No.116/2008-09 dated 31/03/09

The Complainant and his family were covered under the mediclaim policy of the insurer. During the policy period , on a visit to Mumbai , he experienced high BP and chest pain. He was hospitalized and CT Angio gram was taken, high BP and chest pain were controlled after treatment. His claim was rejected by the insurer on the ground that the treatment could have been taken as an outpatient without hospitalization.

The point to be considered is whether the action of the insurer rejecting the claim on the grounds that non requirement of hospitalization and pre existing disease exclusion is in order.

The treating doctor is the best judge to decide whether the tests are to be taken under his supervision or the same may be done as an outpatient procedure. Once admitted to a hospital, the treating doctors at the hospital decide about the course of treatment to be given, diagnostic tests to be taken etc. and on these matters, the patient has little say. The complainant was already on treatment and unless there was any significant development he would not have been admitted. Although some of

the tests may have been in the nature of routine evaluation, to set aside the whole hospitalization as unwarranted, is not justified and an amount of Rs.30,000/- is awarded as Ex-Gratia and the complaint is partly allowed.

Chennai Ombudsman Centre

Case No.IO(CHN) 11.03.1521 / 2008-09
Mr.Jayantilal H. Shah
Vs
National Insurance Co. Ltd
Award No.118/2008-09 dated 31/03/09

The Complainant and his wife, were covered under a mediclaim policy of the insurer. During the policy period, his wife underwent cataract surgery for the right eye **and claimed Rs.49,000/- with the insurer, but the insurer restricted the claim to Rs.14,000/- only, on the grounds that the policy would pay only reasonable expenses.**

The point to be considered is whether the action of the insurer restricting the claim to Rs.14,000/- even though Rs.49,000/- were incurred on the grounds that only reasonable and necessary expenses is payable, is in order.

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The insured had undergone cataract surgery in the left eye just prior to the present surgery. At that time, the lens implanted was also similar ie. 'imported foldable intraocular Re-zoom Multifocal lens'. Therefore the fact that one eye already had the advanced lens would have necessitated the implanting the same kind of lens in the other eye as well. To this extent, the complainant would not have been in a position to go in any other type of lens. Taking into account that the left eye glass was a multifocal one and the other eye can not have a dissimilar one, the restriction of the claim to Rs.14,000/- only, ie the cost of ordinary lens, is

not fair and an amount of Rs.15,000/- is awarded as Ex-gratia in addition to the sum of Rs 14,000/- already paid and the complaint is partly allowed.

Chennai Ombudsman Centre

Case No.IO(CHN) 11.02.1438 / 2008-09
Dr. Haja Kamal
Vs
The New India Assurance Co. Ltd
Award No.119/2008-09 dated 31/03/09

The complainant and his wife were covered under Mediclaim policy of the insurer. The hospitalization claim of the insured was rejected by the insurer under Clause 4.1 exclusion of pre existing diseases.

The point to be considered is whether the rejection of the claim by the insurer on the grounds of pre existing condition is in order.

It is found that the insured had long standing adverse medical history of 1.Coronary Artery disease 2. Dilated Cardiomyopathy 3. Diabetes mellitus 4. Diabetic Nephropathy 5.Hypothyroidism 6.Bronchial Asthma. If there were errors in the medical records, the complainant could have got the matter sorted out from the hospital authorities since the insured has been consistently treated by very reputed cardiologists of the city. On the other hand, it is seen that, the hospital authorities have deliberately not filled in the data relating to the duration of diabetes, heart disease and bronchial asthma. The contention of the complainant that the Supreme Court has held that preexisting diseases should not be disallowed is not relevant to this case. The decision does not refer to diseases contracted by any person, even before he takes a policy for the first time. In the disputed claim in 2007, unfortunately all the seven ailments are preexisting. Although most insurers are deleting

the exclusion clause in cases where there are 4 illness free years, it is observed that this benefit will not be applicable to the insured since she has been quite hospitalized regularly. The complainant has preferred another claim under the policy period 2008-09 relating to 1.acute left ventricle failure, 2.Hyponatremia 4.Coronary Artery disease 3. Dilated Cardiomyopathy 4. Diabetes mellitus 5. Diabetic Nephropathy 6 Bronchial Asthma and 7. Hypothyroidism which has also been repudiated as preexisting diseases. The complaint is dismissed.

Chennai Ombudsman Centre

Case No.IO(CHN) 11.04.1570 / 2008-09
Mrs. Sai Subha Karthik
Vs
United India Insurance Co. Ltd
Award No.120/2008-09 dated 31/03/09

The complainant stated that she had been taking insurance cover since Feb 2006. She has not declared any pre existing ailment at the time of taking the policy. She was hospitalized for Mitral Valve Prolapse Syndrome and her claim was rejected by the insurer under Mediclaim clause 4.1 relating to exclusion of expenses towards congenital internal illness. The insurer has since settled the hospitalisation claim before the hearing. The issue now is whether the action of the insurer rejecting part of the claim on the grounds of non-submission of prescriptions for availing ECG test and medicine and also cost of medicine purchased for the period beyond 60 days, is in order.

It is seen that some amounts have been disallowed due to non submission of prescription as well as exceeding of 60 days post hospitalisation duration is justified keeping in line with the policy terms. Several claims under the policy of the insured as well as other persons covered under the policy have been settled in the normal course in the past and cashless authorization had also been given. It is also observed that the complainants are well educated and well aware of the terms and conditions of the policy. As such

there is no deficiency in service on the part of the insurer and the TPA. Hence, the complaint is dismissed.

Chennai Ombudsman Centre

Case No.IO(CHN) 11.04.1460 / 2008-09
Mr. Ponnu Seshan
Vs
United India Insurance Co. Ltd
Award No.121/2008-09 dated 31/03/09

The Complainant, had taken an individual mediclaim policy from the insurer with Gold Policy conditions. During the policy period , the insured underwent Lasik surgery for correction of Myopia in both the eyes. The insurer rejected his claim on the grounds that the surgical procedure is an exclusion as per condition 4.5 of the policy.

The point to be considered is whether the action of the insurer rejecting the claim under condition 4.5 of the policy is in order.

The complainant had submitted the treating doctor's certificate as well as the other relevant reports. It is seen that the correction required by the complainant at the time the decision to go in for surgery was made was (-) 7.5 in right eye and (-) 6 in the left eye and not as claimed by the complainant at the hearing. The mediclaim guidelines of the insurer provides for allowing the lasik surgery in case the correction is (-) 7 and above, when it becomes a therapeutic necessity. As such the rejection of claim in total by the insurer is not justified. The complainant, also cannot claim for reimbursement of surgical expenses for both the eyes as correction for the left eye is only (-) 6. To render justice to both the parties to the dispute, an amount of Rs.15,000/- **is awarded as** Ex-gratia **and the** complaint is partly allowed.

Chennai Ombudsman Centre

Case No.IO(CHN) 11.02.143760 / 2008-09
Mrs. Chandra Krishnan
Vs
The New India Assurance Co. Ltd
Award No.122/2008-09 dated 31/03/09

Mrs Chandra Krishnan was covered under the mediclaim policy of the insurer. During the policy period, the insured was initially hospitalized at Kaliappa Hospital and later shifted to Harvey Hospital, Chennai where she underwent angiogram and PTCA stenting. Initially the TPA authorized cashless facility at Harvey hospital on request but later withdrew it because the discharge summary at Kaliappa Hospital stated that the patient was suffering from hypertension since 30 years. In the discharge summary of Harvey Hospital hypertension was stated to be "since six months only". The complainant contended that the recording in the first hospital was an error and although they tried to get the hospital to rectify their records, they had refused to do so. Based on the earlier discharge summary, the insurer rejected the claim under condition No.4.1 of the mediclaim policy. The point to be considered is whether the action of the insurer rejecting the claim on the grounds of pre existing diseases is in order.

The insurer could not conclusively establish the presence of pre existing hypertension prior to inception of the policy for the first time. The complainant has established that she was suffering from osteo arthritis much before the inception of the policy but has not declared this in the proposal form. Although she has not proved the onset of hypertension or the fact that she did not have hypertension, benefit of doubt is given to the complainant. But since insurance contracts are contracts of utmost good faith, the insured also have got a duty to inform the hospital the correct information regarding their health and confirm/recheck with them whether only the right details are recorded. Hence, the

decision of the insurer to reject the claim in its entirety is too harsh and to render justice to both the parties to the dispute, an amount of Rs.30,000/- is awarded as Ex-gratia and the complaint is partly allowed.

Chennai Ombudsman Centre

Case No.IO(CHN) 11.02.1528 / 2008-09
Mrs. R. Padmini Devi
Vs
The New India Assurance Co. Ltd
Award No.124/2008-09 dated 31/03/09

The Complainant had been covered, along with her husband under the mediclaim policy of the insurer. She was hospitalized for severe vertigo and vomiting on and discharged. After discharge, she submitted all the papers to TPA for reimbursement of hospitalization expenses. But they repudiated the claim without proper investigations, giddiness pain, vomiting subsided.

The point to be considered is whether the action of the insurer rejecting the claim , on the grounds that there was no active line of treatment taken based on the investigative reports, is in order.

It is found that the complainant was hospitalized with complaints of vomiting, giddiness and she could not get up from bed even. Judging by the condition of the patient, the treating doctor had decided to commence the treatment after obtaining the results of the diagnostic tests. The scan report revealed mastoiditis and on treatment giddiness pain, vomiting subsided. The TPA note states that the claim was rejected since no active line of treatment carried out based on the investigative reports. The medication and line of treatment in this case is to bring down the giddiness, pain and vomiting. The treating doctor after thorough examination of the reports only administered the medicines so that the symptoms started subsiding. In the instant case, the treating

doctor only was convinced that taking of such tests were essential to treat the condition. The insurer is directed to process and settle the claim as per the other terms and conditions of the policy and the complaint is allowed**.**

Chennai Ombudsman Centre

Case No.IO(CHN) 11.02.1582 / 2008-09
Mr. A. Palaniappan
Vs
The New India Assurance Co. Ltd
Award No.125/2008-09 dated 31/03/09

The Complainant had insured his father and other family members under Janata Mediclaim policy of the insurer. During the policy period, his father was hospitalized for treatment of chest pain. The insured's claim was partly settled towards angiogram only, without giving any details and disallowed the remaining amount. Insured was informed that the claim settlement was as per the policy terms and conditions.

The point to be considered is whether the action of the insurer rejecting the claim on the grounds that only angiogram expenses are payable and other treatment expenses are not payable as per policy terms is in order.

The policy provides for further treatment when a diagnostic procedure is positive and the attending doctors have decided that medical management is the best option and administered the relevant medicines since the patient was admitted to the hospital after sudden heart failure. Based on the condition of the patient the doctors have extended the hospitalization for the patient to stabilize and at the time of discharge have advised regular medicines to be taken and periodical review. The stand of the TPA/insurer in considering the treatment for heart failure after

the patient was shifted from one hospital to another , as a simple case of angiogram is not justified.

Hence, the decision of the insurer to reject a part of hospitalization expenses shall not be considered as Angiography under sec 2.10 but as 'Hospitalisation Expenses for medical/surgical treatment at Nursing homes/Hospital in India as envisaged in the preamble of the policy. The insurer is directed to process and settle the claim as per the other terms and conditions of the policy and the complaint is allowed.

Chennai Ombudsman Centre

Case No.IO(CHN) 11.03.1476 / 2008-09
Mr.V. Shanmugasundaram
Vs
National Insurance Co. Ltd
Award No.127/2008-09 dated 31/03/09

The Complainant and his wife were covered under a Mediclaim policy of the insurer. During the policy year 2008-09 the sum insured was Rs.1,00,000/- and cumulative bonus earned was Rs.30,000/-. During this policy period, the insured was hospitalized for coronary angiogram and underwent arotic valve replacement. Her claim was rejected by the insurer on the grounds of pre existing diseases.

The point to be considered is whether the action of the insurer rejecting the claim on the grounds of pre existing diseases is in order.

From the records available, the complainant's spouse has not established that she was diagnosed with aortic valve stenosis only in 2005 with any documentary evidence. The insurer has also not established that the insured was suffering from Aortic Valve Stenosis from 1995. In the circumstances, to meet the ends of

justice to both parties to the dispute, a sum of of Rs.25,000/- is awarded as Ex Gratia **and the** complaint is partly allowed.

Chennai Ombudsman Centre

Case No.IO(CHN) 11.02.1568 / 2008-09
Mr.Sardarmal Chordia
Vs
The New India Assurance Co. Ltd
Award No.129/2008-09 dated 31/03/09

The Complainant and his family were covered under the mediclaim policy of the insurer. During the policy period, the insured underwent treatment for coronary artery disease. The TPA authorized only Rs.1.00 lac and insured's request for remaining amount of Rs.82,500/- was neither approved for payment nor was any clarification given for not considering the same.

The point to be considered is whether the action of the insurer in restricting the claim to the original sum insured on the grounds that the complainant is not eligible for the benefit of increase of sum insured prior to surgery is in order.

As per the policy terms, the enhanced sum insured is considered as being a fresh insurance and the cumulative bonus is also differently shown for the previous sum insured as well as the enhanced sum insured. Further, the insurer also came forward to pay the cumulative bonus earned under the pre enhanced sum insured amounting to Rs.30,000/- for the present hospitalization which had not been allowed by the TPA earlier. In the circumstances, the action of the insurer to restrict the claim to pre enhanced limit of expenses cannot be faulted and the complaint is dismissed.

DELHI

Mediclaim
Case No. GI/236/NIC/08
In the matter of Shri Sushil Kumar Lal
Vs

National Insurance Company Limited

AWARD dated 31.10.2008

Shri Sushil Kumar Lal has lodged a complaint with this forum on 03.08.2008 that he had taken a mediclaim policy No.360102/48/07/8500002139 from the National Insurance Company Limited for Rs. Two lakh and Rs. One lakh policy each for his wife and his daughter in January,2008 and previous policy was Rs. One lakh each with no claim bonus issued by the Company. Meanwhile he had got some heart problem and gone to hospital. It was discovered by doctors of Metro Heart Hospital at Noida on 25.02.2008 that he was having unstable Angina pain and he need angiography and angioplasty. He went through all those process suggested by the doctors which costed him Rs.1,51,357/-. He had submitted his total medical bills of Rs.1,51,357/- on 10.03.2008 with the Company for settlement. But the Insurance Company has paid him Rs.1,00,000/- only against his claim of Rs.1,51,357/-. After three months of harassment, the company forced him to accept Rs.1,00,000/- only which is not fair. He had taken up the matter with the Regional Office but he has not received any reply. He requested the Forum that the balance amount may be paid.

At the time of hearing, Shri Sushil Kumar Lal informed the Forum that he had taken a mediclaim policy from the company on 01.02.2007 which was subsequently renewed on time wherein he had increased the sum insured from Rs.1,00,000/- to Rs.2,00,000/-. He was admitted in Metro Hospital on 25.02.2008 and discharged on 27.02.2008 and the Insurance Company has paid him Rs.1,00,000/- against his claim for Rs.1,51,357/- thereby the Insurance Company has not paid him the full amount. Since he was having a policy for Rs.2,00,000/- he requested the forum that the balance amount of Rs.51357/- may be paid.

The representative of the Insurance Company informed the Forum that Shri Sushil Kumar Lal had taken a mediclaim policy for Rs.1,00,000/- on 01.02.2007 and subsequently in the following year he has increased the sum insured to Rs.2,00,000/-. Since the claim has arisen within 25 days of the renewal of the policy, the insured was aware that he was suffering from heart ailment and accordingly had got the sum insured

increased. Further, he had also not availed the Cashless Facility as he has mentioned that he has borrowed money and it would have been prudent for him to avail the cashless facility and not to go for reimbursement. The mediclaim policy has a capping on Room Rent, Nursing Expenses and Doctors fees and medicines. Taking these factors into consideration, they had paid Rs.1,00,000/- sum insured of previous year's policy. They have therefore, rightly settled the claim.

After hearing both the parties and on examination of the documents submitted, it is observed that Shri Sushil Kumar Lal had taken a mediclaim policy No. 360102/48/07/8500002139 from the National Insurance Company Limited. On renewal of the policy, he had increased the sum insured from Rs.1,00,000/- to Rs.2,00,000/- for himself and Rs.1,00,000/-each for his wife and his daughter. He was admitted in Metro Hospital, Noida on 25.02.2007 where he was diagnosed for Coronary Artery disease and unstable angina. He has lodged a claim for Rs.1,51,357/- with the Insurance Company and the Company has settled the claim for Rs.1,00,000/-. Shri Lal requested the Forum that the balance amount be paid to him. The Insurance Company has mentioned that due to a capping on Room Rent, Nursing Expenses and Doctors fees and medicines, the amount payable would be Rs.1,19,250/- and since he was admitted in the hospital within 25 days of renewal of the policy they have considered the sum insured of Rs.1,00,000/- and had paid this amount. The Insurance Company has nowhere able to establish that the disease occurred prior to increase in sum insured therefore in my opinion Shri Sushil Kumar Lal should have been paid a sum of Rs.,119,050/- after taking into consideration the capping of sum in the Room Rent, ICU Unit, Doctors Fees and other expenses.

I, therefore, pass the Award that Shri Sushil Kumar Lal be paid balance amount of Rs.19050/-.

Mediclaim Policy

Case No. GI/262/NIC/08
In the matter of Shri Sri Dutt Bhardwaj
Vs

National Insurance Company Limited

AWARD dated 24.11.2008

Shri Sri Dutt Bhardwaj has lodged a complaint with this Forum on 17.09.2008 that he has taken a mediclaim policy No.8500000767 with the National Insurance Company Limited. He has been insuring with the Company since 03.08.2000 and he has been paying annual premium without break. He had never made any claim under the policy. He fell ill due to Jaundice and admitted in Batra Hospital and Medical Research Centre, New Delhi on 23.07.2007. In spite of cashless hospitalization facility, he was forced to make payments in the hospital which caused him great inconvenience during his illness. The Insurance company reimbursed him only Rs.51121/- out of the total hospital bill of Rs.103245/- on 07.05.2008. He made several requests to the Senior Branch Manager, Divisional Manager, Deputy General Manager and Chairman cum Managing Director of the Company but they paid no heed to his requests. He had spent lot of money on postage, D/D for RTI etc. He is a pensioner and senior citizen, hence cannot afford it. He requested the Forum that the balance amount of his claim be paid.

At the time of hearing, Shri Sri Dutt Bhardwaj informed the Forum that he was admitted in Batra Hospital on 23.07.2007 and was discharged on 07.08.2007. The admission in the hospital was because of Jaundice and it has no correlation with MVR for which he had undergone treatment in August,2000. As he is hail and hearty and there is no problem of any heart disease and was treated for Jaundice, he should be paid his full amount of claim.

The representative of the Insurance Company informed the Forum that Shri Sri Dutt Bhardwaj has been insured with them since 03.08.2000 and immediately after 7 days of the inception of the policy, he was admitted for Mitral Valve replacement. They had referred the matter to the panel doctor who has mentioned in his report that the policy does not cover treatment of pre-existing disease and complications thereof. Such expenses incurred due to treatment of Rheumatic Heart Disease, Mitral Valve could not be admissible. He has recommended 50% of the claim amount since the treatment was for Hepatitis B & C diagnosed during the current hospitalization and complication of regular intake of Ecospin and Aciform (Anticoagulants). They have, therefore, released 50% of the claim amount.

After hearing both the parties and on examination of the documents submitted, it is observed that Shri Sri Dutt Bhardwaj had taken a mediclaim policy from the National Insurance Company Limited. The Insurance Company has paid 50% of the claim amount based on the advice of their panel doctor to segregate the expenses incurred by the claimant for treatment of Hepatitis B & C and the pre-existing problems or complications of follow up treatment of MVR due to anticoagulants intake. Hence 50% of the payable expenses may be disallowed. On examination of the discharge summary, it is observed that Shri Sri Dutt Bhardwaj was diagnosed for Hepatitis B & C. The In house doctor of the Insurance Company has disallowed 50% of the payable claim amount as he has mentioned that the existing problem/complication due to follow up treatment of MVR due to anticoagulants intake. However, I observe that Shri Sri Dutt Bhardwaj has been renewing his mediclaim policy in continuation and has never claimed for any disease as a result of MVR treatment. As per the opinion of the in house doctor of the Insurance Company, the claim pertains to management of Hepatitis B & C diagnosed during the current hospitalization and it is very difficult to segregate the expenses incurred by the claimant for treatment of Hepatitis B & C and the pre-existing problems of follow up treatment of MVR due to anticoagulants intake. It is a well known fact that doctors normally do not prescribe medicines knowing the medical history of the patient which will have side effects and the contention of the in-house doctor that the present hospitalization is as a result of anticoagulant. I do not agree as it has been 7 years since Shri Sri Dutt Bhardwaj had the problem of MVR and the medicine to react at this late stage. I am, therefore, not in agreement with the decision of the in house doctor of the Insurance Company that the claim should be paid 50% of the claim amount.

Keeping in view the above facts, I pass the Award that Shri Sri Dutt Bhardwaj be paid balance 50% of his claim amount.

Mediclaim Policy

Case No. GI/264/Chola/08
In the matter of Shri Raje Singh Rawat
Vs

Cholamandalam MS General Insurance Company Limited

AWARD dated 28.11.2008

Shri Raje Singh Rawat has lodged a complaint with this forum on 26.09.2008 that he had taken a mediclaim policy from Cholamandalam MS General Insurance Company Limited. His wife Smt.Kusum Rawat caught by viral fever in September,2007 and the fever was so severe that she was advised for hospitalization. She therefore admitted in Holi Family Hospital for a week and it was detected that she has sinusitis complain and was medicated for viral fever as well as sinusitis. The medical expenses incurred by him were fully reimbursed. However, the sinusitis problem still persist and has been advised a surgery. He contacted Paramount health Services TPA for the Insurance Company who assured him a full reimbursement of surgical and medical expenses. She was admitted for surgery but due to low TLC count detected in her blood sample, the surgery was postponed. He has submitted all her medical bills and doctors prescriptions but to his dismay, the Company turned down his claim giving a reason that no reimbursement is proposed in a sinusitis case. He requested the Forum that his claim be paid.

At the time of hearing, Shri Raje Singh Rawat reiterated the details of his claim as mentioned in his complaint letter dated 26.09.2008. He further informed that the operation of his wife for sinusitis could not be performed because of low TLC count in the blood sample. The Insurance Company has repudiated the claim which is not justified. Had his wife not been having very low TLC before performing the operation, she would have undergone the same and the rejection of the claim by the Insurance Company is not fair and reasonable.

The representative of the Insurance Company informed the Forum that Smt. Kusum Rawat was admitted in Holi Family Hospital on 17.03.2008 to 19.03.2008 for mouth breathing, headache, and recurrent sneezing. She was diagnosed as deviated nasal septum with rhino sinusitis. As per the discharge summary, patient was not given any active medical management necessitating hospitalization. As per the Group Health Policy issued to M/S.Outlook Group, under Exclusion 24 : any congenital (Internal or External) disease are not covered under the policy and they have therefore rightly repudiated the claim.

After hearing both the parties and on examination of the documents submitted, it is observed that Shri Raje Singh Rawat was covered under Group Health Policy issued to M/S.Outlook Group. His wife was hospitalized in Holi Family Hospital on 17.03.2008 with complaints of mouth breathing, headache, and recurrent sneezing. The Insurance Company has repudiated the claim under Exclusion 24 of the policy that any congenital (internal or external) disease is not covered. DNS is a congenital disease, pre-disposing to sinusitis. The patient has no past history of trauma; hence DNS should be congenital only. The investigations for present ailment could be done under OPD basis as surgery was post-poned and only investigations, evaluation was done during hospital stay. The illness of Sphenoidal sinusitis appears to have been diagnosed on CT PNS examination in July 2007. No mention of the detection of DNS has been made in the report of CT PNS which is written in the discharge summary.

Definition of DNS : The Nasal septum is the structure, which normally divides the nasal cavity in to two halves. Sometimes the septum is so deformed that air passage is blocked in one or both nostrils. This condition is known as Deviated Nasal Septum(DNS).

Etiology of DNS : DNS is either present from birth or occurs due to damage to the nose as a result of trauma to the face sustained in a fight or a fall.

Definition of Congenital : The term "congenital" refers to conditions existing at and usually before, birth referring to conditions that are present at birth, regardless of their causation.

It appears that she was hospitalized from 17.03.2008 to 19.03.2008 for planned surgery. Only pre-operative investigations were carried out, bur surgery was post-poned due to unexplained reasons. All this pre-op workup could have been carried out in OPD and the insured person could have been hospitalized for planned surgery only if found fit for surgery after pre-operative workup.

From the foregoing it is clear that Deviated Nasal Septum (DNS) would not fall under the terms of congenital disease and it could have also been due to as a result of trauma to the face sustained injuries. IN my opinion, the claim is payable.

I, therefore, pass the Award that Cholamandalam MS General Insurance Company Limited should pay Rs.9908/- to Shri Raje Singh Rawat.

Mediclaim Policy

Case No. GI/212/RSA/08
In the matter of Ms.Arpana Caur
Vs

Royal Sundaram Alliance Insurance Company Limited

ORDER dated 05.12.2008

Ms. Arpana Caur has lodged the complaint with this forum 14-07-08 that she had taken mediclaim policy No. HJ00006184000100 from Royal Sundaram Alliance Insurance Company Ltd in November, 2006 for a sum assured of Rs.200000/-. Premium was paid along with lipid profile, that is comprehensive blood, urine, stool and ECG etc. as per their requirements. All these test were clear and the insurance company insured her after receiving the report of all these test. They issued her the policy. Unfortunately, she had a certain heart stroke on 15.03.2007 and had to undergo bypass surgery. As advised by Max Hospital Cardiologist Specialist, Dr.Ashok Seth, who sent her to the heart specialist of Escorts Dr. Naresh Trehan who operated her. Though she paid Rs.2,45,876/- for the operation, but she expected the insurance company to pay her at least insured sum of Rs.2,00,000/-. She has submitted the claim papers on 02.07.2007 and also explained the reasons for the late submission which was due to major shuffling in Escorts, in which Dr. Naresh Trehan had joined Apollo Hospital. This Escorts Hospital fiasco was known to every human being of India because of the dispute between the Escorts management and Dr. Naresh Trehan made headlines in every National newspaper for weeks. She could not get their papers from Escorts on time which leads to the delay in submitting their bills. On 01.08.2007, she received a rude letter from Insurance Company rejecting her claim. They tried to fabricate the facts and made superficial by alleging that insured person has diabetes, Hypertension and heart condition at the time of getting insured. If there was any slightest trace of Diabetes and her heart was known to get stroke why there was no indication of either of these in comprehensive lipid profile test and ECG test and why In God's name did the Insurance Company

insured the diabetic and heart patient? The Company cannot fabricate colossal lies to avoid saying her, her just dues. Despite of her requesting them to reopen the case and submitting the duplicate copy of lipid profile and ECG report and previous mediclaim report in which it was mentioned that no mediclaim had ever been taken from Insurance Company and hence she demanded strong action against their fraudulent practice and their ugly lies and excuse. She requested the Forum that her claim be paid.

At the time of hearing Ms. Arpana Caur informed the Forum that she had undergone a comprehensive blood, urine, stool and ECG tests as per the Company's requirements and had submitted the same to the Insurance Company she has produced a copy of the reports issued by Medical Diagnostic Centre, Hauz Khaz, New Delhi issued on 02.09.2006. According to the report she was a Healthy lady and did not suffer from any disease like Hypertension and Diabetes. She further mentioned that she had been taking mediclaim policy from one of the nationalized Insurance Company. Since she was traveling for quite sometime, the policy could not be renewed in time and as such she took the policy from Royal Sundaram Alliance Insurance Co. Ltd. She also explained the delay in submission of her claim because of the change in management at Escorts Hospital as per the report submitted; prior taking the policy she did not show any adverse medical health problem. She therefore requested the Forum that her claim may be paid.

The representative of the Insurance Company informed the Forum that as per the Discharge Summary dated 20.03.2007 of Escorts Hospital wherein it is mentioned that the patient (Ms. Arpana Caur) was suffering from depression, Hypertension in the year 2006 which is prior to the inception of the above said policy. Critical triple vessel disease along with CAD cannot develop within 3 months from the inception of the policy. Since the disease was pre-existing, they had rightly repudiated the claim.

Ms. Arpana Caur who was admitted in Escorts Hospital, New Delhi on 15.03.2007 as Hypertension, non-diabetic with positive family history of CAD, Hypertension and depression 6 months ago. She develop chest pain on 14.03.2007 with chocking for which she was admitted on local hospital; where angiography was done which revealed left main (70%) with double vessel disease. For which she had not

preferred any claim. However, she was later admitted in Escorts Hospital on 15.03.2007 where she underwent OPCAB on 16.03.2008 and she preferred a claim with Royal Sundaram Alliance Insurance Co. and the same was rejected by them on the ground that she was a suffering from Hypertension and Diabetes which she was not and her claim has therefore wrongly been repudiated.

On examination of the papers submitted and after hearing both the parties it is observed that Ms. Arpana Caur had taken a mediclaim policy from Royal Sundaram Alliance Insurance Co. Ltd. She was admitted in Max Devki Devi Heart and Vascular Institute, New Delhi on 14.03.2007 under the care of Dr. Ashok Seth as Hypertension, Non Diabetic with positive family history of Ischemic Heart Disease, C/o resent onset angina and palpitation for two hours prior to admission. She also had mild chest discomfort and suffocation a day back for which TMT was done in a private hospital, the report of which is not available. She was brought to emergency for revaluation and management. On admission her pulse was 78 bpm and BP of 150/90 mmhg with precordial auscultation and systemic examination unremarkable. She was investigated with hemogram, serum biochemistry, APTT, PT, HIV, HBSAg, LFT, lipid profile, cardiac enzymes, Trop-T and underwent Coronary angiography and diagnosed as a case of CAD with left main with double vessel disease (LAD Ostial 95% and LCx 90%) with LVEF of 65% with Hypertension. She was advised early CABG and discharged on request on 15.03.2007 with advice as per discharge summary. No claim was lodged with the Insurance Company for this Hospitalization. She has further submitted that she was perfectly healthy person, swimmer and walker and had a sudden heart attack in March 2007. If Hypertension is diagnosed, it means high BP which can happen to any one at any time. However, the exact duration of Hypertension has not been given. Further this is a case of hospitalization for the management of a hypertensive with h/o depression six months ago, in case of chocking sensation and chest discomfort for one month on medical therapy and develop mild chest discomfort and suffocation with resent onset angina and palpitation acute onset investigated and diagnosed as CAD, double vessel disease with EF of 65% with hypertension managed conservatively initially followed by OPCAB x 3 (LIMA to LAD, RSVG to OM1 and OM2) the investigation done and treatment given was relevant and consistent with the diagnosis/ illness.

Considering the below mentioned facts I am of the opinion

1 The hospitalization is for the management of CAD and unstable angina with Double vessel disease which was not pre-existing.

2 Hypertension appears to be pre-existing in all the probabilities.

3 CAD is not a complication of hypertension ; however, the risk of developing CAD in a hypertensive person are 2-3 times more as compared to a non-hypertensive person

4 During first year of the policy issued by Royal Sundaram Alliance Insurance Co. Ltd. The expenses on the treatment of any heart, kidney and circulatory disorders are not payable for all insured persons suffering from hypertension/ diabetes mellitus and the claim has been lodged in the first year of the policy coverage.

In view of the Policy conditions that Ms. Arpana Caur was a patient of hypertension and the claim being lodged in the first year of the Policy treatment for heart disease is not payable and accordingly in my opinion the claim of Ms. Arpana Caur is not payable.

I, therefore, uphold the decision of the Royal Sundaram Alliance Insurance Company.

Mediclaim Policy

Case No. GI/271/NIC/08
In the matter of Shri R.K. Malhotra
Vs

National Insurance Company Limited

AWARD dated 19.12.2008

Shri R.K. Malhotra has lodged a complaint with this Forum on 13.05.2008 that he has been insured under mediclaim policy No.351800/48/06/8500001615 issued by the National Insurance Company Limited for the period 25.02.2007 to 24.02.2008. He had lodged a claim on 21.02.2008 with the company for Rs.42, 640/-. He has been informed

by the company vide their letter dated 15.04.2008 that the claim is not admissible and stands rejected. He has checked up the status of such claims in the past and has found that different consumer courts/forums have upheld the rights of the insured and different insurance companies have been advised to reimburse the claim amount. He has enclosed photocopies of the judgments given by consumer orders/media reports giving details of such cases against (i) Case No.2153/99 Oriental Insurance Company Limited Vs.Anurag Chawla in Consumer Court of Tis Hazari, Delhi (ii) New India Assurance Company Limited Vs. Shiv Rupramka, Order given by Justice J.D.Kapoor of State Consumer Commission. He requested the Forum that his claim may be paid.

At the time of hearing, Shri R.K.Malhotra, informed the Forum that he was suffering from excessive sleepiness in day, snoring and morning headache. He got himself examined as an OPD patient with Safdarjung Hospital, New Delhi. Later he was advised by Dr.J.C.Suri, to be admitted in the hospital. He was admitted in the hospital on 07.02.2008 and discharged on 08.02.2008 where PSG was done. He was issued a certificate by Dr.J.C.Suri that he was suffering from obesity with Sleep Apnea Syndrome with Chronic Hypoxic respiratory failure. He was recommended CPAP (Constant Positive Airway Pressure). He therefore, as per the advised of the Doctor, purchased CPAP machine for which he has paid a sum of Rs.42640/-. He requested the Forum that his claim be paid.

The representative of the Insurance Company informed the Forum that as per the mediclaim insurance policy Clause 4.16, CPAP machine is clearly excluded and as such, the claim is not payable. The forum enquired from the representative of the Insurance Company when did the company revise the terms and conditions of the policy, the representative of the company informed that the same were revised from 01.01.2005. The Forum further enquired whether he has any evidence to show that the terms and conditions of the Individual Mediclaim policy has changed from 01.01.2005, the representative of the company was not able to produce any documentary evidence. He, however, insisted that the claim is not payable under clause 4.16 of the policy.

After hearing both the parties and on examination of the documents submitted, it is observed that Shri R.K.Malhotra has lodged a claim for payment towards CPAP machine

after he was hospitalized at Safdarjung Hospital where he was diagnosed for Sleep Apnea Syndrome with Chronic Hypoxic respiratory failure. He has accordingly purchased the CPAP machine for which he has preferred a claim with the Insurance Company. The Insurance Company has repudiated the claim as per condition 4.16 of the policy. At the time of hearing, the representative of the Insurance Company has not been able to substantiate that the revised mediclaim policy came into effect from 01.01.2005. This Forum has been advised by the representative of the Insurance Company in another case that that the terms and conditions were revised with effect from 01.04.2007. Since the mediclaim policy of Shri R.K.Malhotra commenced from 25.02.2007, as such the earlier terms and conditions were applicable which did not specifically exclude payment for CPAP machine. Further as per clause 1.2(d) of the policy, " Cost of pacemaker, artificial Limbs and Cost of Organs and similar expenses" (earlier policy terms and conditions prior to 1st April, 2007) the cost of CPAP machine would fall under the category of "similar expenses". In view of the foregoing, I am of the opinion that the cost of CPAP machine should be paid to Shri R.K.Malhotra.

I, therefore, pass the Award that Shri R.K.Malhotra be paid Rs.42640/- towards the cost of CPAP machine.

Mediclaim Policy

Case No. GI/256/UII/08
In the matter of Shri Ravinder Kumar Vs

United India Insurance Company Limited

ORDER dated 30.03.2009

Shri Ravinder Kumar has lodged a complaint for the reason that his mediclaim has not yet been settled by the United India Insurance Company Limited. He as per his claim fell from the stairs and suffered facial injuries and therefore, was admitted in ABHI Hospital and Trauma Centre on 14.01.2008 and was discharged on 17.01.2008. The surveyor and loss assessor Shri K.K.Sharma in his Investigation Report dated 03.10.2008 writes that he had personally visited the insured's residence where the house owner has confirmed that Shri Ravinder Kumar has left the house (Shri K.K.Sharma has not

mentioned the date of his visit but it may be sometime in the early part of May, 2008). Subsequent to his visit, he has written letter on 20.05.2008 requesting the insured to produce the details and to show him the cut sign over his fact. In the absence of any response from Shri Ravinder Kumar, he visited the hospital and his report shows that hospital was not cooperative. Finally, he has given his opinion as follows:

"On going through thorough observation of the documents and circumstance, I am of the opinion that the insured has tried to hide the fact, after long reminder he does not want to show me the cut sign, it means the claim is fake."

So far the claim has not been disposed of either way by the Insurance Company.

On verification, it is found that Notices which have been sent by this Office to the insured returned undelivered with the postal remarks that this gentleman does not live at the address given on the envelope. On two occasions, the letters have bounced back.

At the time of hearing, the representative of the Insurance Company showed me the letter sent by them to Shri Ravinder Kumar and the acknowledgement for receipt of the envelop by the post office is available on records.

I feel, it will be presumptuous to conclude that Shri Ravinder Kumar is deliberately non-cooperative with the Insurance Company. The letters sent from the office of Insurance Ombudsman to Shri Ravinder Kumar fixing the date of hearing also returned undelivered with the postman's remark that he is not staying at the address. There is no reason why Shri Ravinder Kumar should be deliberately refusing to receive the letters specially from the Office of Insurance Ombudsman whom he has approached for relief. I do not see why the investigator could not make a second visit to the address. In any case, so far, there is no record that the Insurance Company has settled the claim either way. The investigation report is merely a recommendation to the Insurance Company which has not yet been considered or decided upon.

Considering the circumstances, I am of the opinion that the Insurance Company should try to locate Shri Ravinder Kumar at his old address if he is there or ascertain the

new address by local enquiries and dispose of the case after giving him reasonable opportunity of being heard. This is a situation where no reasonable opportunity given of being heard has been given to Shri Ravinder Kumar and the investigator has been rather presumptive in his conclusion without appropriate basis. This is a violation of natural justice.

Accordingly, the Insurance Company is directed to dispose of the claim of Shri Ravinder Kumar by 15.05.2009 after locating him as per the directions above and giving him an opportunity of being heard.

Mediclaim Policy

Case No. GI/293/OIC/08
In the matter of Shri Anil Bansal Vs

Oriental Insurance Company Limited

ORDER dated 31.03.2009

Shri Anil Bansal has taken a mediclaim policy No.271400/48/2008/1592 from the Oriental Insurance Company Limited. He was admitted in Sir Ganga Ram Hospital on 22.11.2007 and was discharged on 23.11.2007. The claim for expenditure incurred during hospitalization has been rejected by the Insurance Company on the ground that there is no active treatment for any specific treatment or ailment and Shri Bansal was admitted only for the purpose of investigation.

Before me, it is submitted by the representative of the Insurance Company that in terms of Para 4.10 of the policy, the claim is not entertainable unless there is active treatment. On the other hand, Shri Bansal argued that he is a policyholder for the last 10 years and he was suffering from Nocturnal Seizures with Osteoporosis for which various tests were undertaken in the hospital. A total expenditure of Rs.35000/- was claimed by the insured. He refers to the prescriptions of Dr.Anshu Rohatgi of Sir Ganga Ram Hospital dated 15.11.2007 and 22.11.2007 wherein he was advised admission. Shri Bansal submitted that it is not for fun that anybody is admitted to the hospital. The

representative of the Insurance Company reiterated his arguments that there is no active treatment and, therefore, Para 4.10 of the policy applies.

I have considered the submissions of the complainant as well as the Insurance Company. I find in the discharge summary there is no detail of any active treatment. At the time of discharge, the patient has been advised one Tab.Eptoin 100 mg, thrice daily. Hospitalization was not for any acute symptoms of Nocturnal Seizures or Osteoporosis. The period of hospitalization was just for one day. In absence of any material in the discharge summary is not possible to hold that there was indeed any active treatment. Apparently, Shri Anil Bansal got admitted only for a day to get all the investigations done. TPA as well as Dr.Vipin Gupta who is on the panel of the Insurance Company suggested repudiation of the claim.

Considering the fact that there is no material fact that Shri Anil Bansal was given any active treatment in the hospital, I am of the opinion that the Insurance Company was justified in rejecting the claim of Shri Anil Bansal.

Mediclaim Policy

Case No.GI/219/UII/08

In the matter of Dr. Om Prakash Kocher
Vs
United India Insurance Company Limited.

AWARD dated 13.10.2008

Dr. O.P. Kocher had lodged a complaint with this Forum on 28.04.2008 that his ex-employers SAIL India had taken a mediclaim Policy from United India Insurance Co. Ltd., New Delhi. He underwent Cytotron Treatment at the centre for Joint Rejuvenation at New Delhi from 29.12.2007 and 18.012008 without hospitalization, for osteo-arthritis of both knee joints, as advised by orthopaedic surgeon, Dr. Prashant Bajpai of the Centre. As no hospitalization was required for this treatment and this is the only reason given by the Company for non-payment of his claim for Rs.1 Lakh only. He had orally as well as in writing requested the Company for review their decision but he was orally informed of the rejection of his claim on 25.04.2008. He addressed the letter to the Grievance

Redressal Officer, informing him of the second rejection of his claim and of his decision to take up the matter at the highest level of justice. In this connection he pointed out that the same treatment i.e. Cytotron Treatment was given to two osteo-arthritis patients of Ludhiana. The mediclaim for the treatment was objected by the United India Insurance Co. Ltd. on the ground of Non- hospitalization. The claimant went to Hon'ble Insurance Ombudsman of Chandigarh who advised the Insurance Company to pay the claim and copy of his Order was enclosed. He has therefore requested the Forum that his claim may be paid.

At the time of hearing Dr. Om Prakash Kocher was represented by her daughter Ms. Shalini Gulati who informed the Forum that her father Dr. O.P. Kocher was an employee of Sail India and was covered under the policy issued by United India Insurance Co. Ltd. She had mentioned that United India Insurance Co. has repudiated the claim of her father who had undergone Cytotron treatment for Osteo-Arthritis of both knee joints as advised by their Orthopaedic Surgeon, the basis of rejection by the Insurance Company was "no hospitalization was required". However, in similar cases, Hon'ble Ombudsman of Chandigarh had approved of claim where Cytotron Treatment was performed and he had passed an Order on 09.03.2007 against United India Insurance Co. Ltd. She further contested that Cytotron treatment can not be termed as alternative therapy because traditional forms of medicine in our country have been Ayurveda and Unani having being practiced since centuries. By reasoning all allopathic medicine being recent in invention becomes alternative therapy, then why is Company providing compensation in those cases. IMC i.e. Indian Medical Council is not a body to approve/disapprove ant treatment modality. It is a body that governs medical ethics and code of conduct of doctors in India but is not a regulatory body or approving authority for medical treatments or drugs in the market. Unfortunately, there is no regulatory body in India for approving or disapproving a medical a device. The laws of USFDA are not applicable to India. The Cytotron Machine is manufactured and used under International certifications like: ISO 9001:2000, 13485: 2003. The safety standards for the machine have been met by the International Commission for Non-lonizing Radiations. Further she has supported her arguments by a note submitted by her on 08.10.2008.

At the time of hearing the Forum inquired from Ms. Shalini Gulati that whether her father was admitted in the Hospital since the claim has been repudiated by the Insurance Company that there was no hospitalization, and if she had gone through the judgement of Hon'ble Ombudsman of Chandigarh it was very clearly mentioned that in the case of Somnath Gupta Vs. United India Insurance Co. Ltd. that the patient was hospitalized for two days. She informed the Forum that her father was not admitted in the hospital. However, when treatment such as Dialysis, Chemotherapy, Cataract and Microsurgery is taken in the hospital/ Nursing Home and the insured is discharged on the same day, the treatment to be taken under hospitalization benefit section. The usage of the term "such as" clearly implies the inclusion of any other such treatment modalities using highly advanced medical techniques, such as the Cytotron therapy undertaken by the complainant and radiotherapy both of which involve the use of multi frequency electro-magnetic radiations, the difference being in the range of the frequencies being used, therapy qualifying for compensation as the others. She therefore informed the Forum that this is a clear case where the Insurance Company should honour the claim in view of the facts mentioned above.

The representative of the Insurance Company informed the Forum that they had rejected the claim on the grounds that there was no hospitalization. The view was with held not only by the panel of doctors at Delhi but they had referred, the matter to their Head Office who has upheld their decision. Further, the "Rejuvenation Center" does not fall within the definition of the hospital that it is neither registered nor it comes under the definition of hospital as mentioned in the policy. They therefore informed the Forum that they have rightly rejected the claim.

After hearing both the parties and on examination of the documents submitted it is observed that Dr. O.P. Kocher had undergone Cytotron treatment at New Delhi from 29.12.2007 to 18.01.2008 without hospitalization, for osteo-arthritis of both knee joints, as advised by orthopedic surgeon. The Insurance Company has repudiated the claim on the grounds that there was no hospitalization required. Dr. Kocher has cited the decision of Hon'ble Ombudsman of Chandigarh wherein in the case of Somnath Gupta vs. United India Insurance Co. Ltd. the Forum had passed an Order that the claim may be paid since there was hospitalization of the patient for two days in the hospital. As such according to

me the case is not identical and I may further advise that each Ombudsman functions independently. However, I wish to state that Dr. O.P. Kocher has mentioned that as per the policy effective from 01.01.2008, the claim was payable. I would wish to clarify that the policy for the year 01.01.2007 to 31.12.2007 is to respond in this case since Dr. Kocher was admitted from 29.12.2007 to 18.01.2008. I have examined the policy covering this period and would like to mention that United India Insurance Co. Ltd. have repudiated the claim on the grounds that there was no hospitalization. One may refer to the definition "6" of the policy Note 1 which mentions "when treatment such as Dialysis, Chemotherapy, Cataract and Microsurgery is taken in the hospital/ Nursing Home and the insured is discharged on the same day, the treatment to be taken under hospitalization benefit section. The usage of the term "Such as" clearly implies the inclusion of any other such treatment which may be developed from time to time and Cytotron therapy would fall under this defination according to me, since it involves use of multi frequency electro-magnetic radiations. It is not necessary with the advancement of modern day medical science where by 24 hour hospitalization may be required and the Insurance Companies are aware of such like situations and therefore in Note 1 of the policy they have dispensened with the stipulation of 24 hours of hospitalization and in this case also no hospitalization was required and the Insurance Company has therefore wrongly repudiated the claim. The objection raised by the Insurance Company that this "Rejuvenation Center" where the treatment was under taken does not qualify within the definition of hospitalization as mentioned in the policy; the representative of the Insurance Company has not produced any evidence showing therein that it was not registered nor it did not have the infrastructural facility as mentioned in the policy were such hospitals which are not registered have to meet such requirements as it should be having 15 beds, operation theatre, qualifying nursing staff and qualified doctors. As such there objection does not hold good. I, therefore pass an Award that Dr. O. P. Kocher be paid for the treatment of his both knee joints by "Cytotron Treatment" which he had undergone at Rejuvenation Center at 19/32, West Punjabi Bagh, New Delhi from 29.12.2007 to 18.01.2008.

Mediclaim Policy

Case No.GI/209/NIA/08

In the matter of Shri A.K. Pandey Vs
The New India Assurance Company Limited.

ORDER dated 24.12.2008

Shri A.K. Pandey had lodged a complaint with this Forum on 26.05.2008 that he was insured with New India Assurance Co. Ltd. since 1996. He was admitted in S R Kalla Memorial Gastro & General Hospital on 18.10.2007 and discharged on 20.10.2007. He had submitted a claim for Rs.12130/- which was repudiated by the Insurance Company on 19.11.2007 on the grounds that the treatment could have been done on OPD basis as no positive existence of any disease and the same was not payable under clause 4.10 of the policy.

At the time of hearing on 10.11.2007 Shri A.K. Pandey informed the Forum that the Insurance Company had paid for earlier hospitalization for the same disease as such hearing was adjourned since Shri Pandey did not have the relevant papers. On 15.12.2008 Shri A.K. Pandey submitted the papers when he was hospitalized on 10.01.2006 and the Insurance Company have paid the claim for Rs.9000/-.

The representative of the Insurance Company informed the Forum that Shri A.K. Pandey was admitted with history of abscess and ? mole like nodular swelling on right forehead along with pain and persistent low grade fever, whereas admission on 18.10.2007 was for abnormal movement of left upper arm. The diseases in both the cases are different and as such Shri A.K. Pandey's contention that earlier claim having been paid has no relevance with the present case for which the complaint has been filed. They have therefore rightly repudiated the claim on the grounds that Shri A.K. Pandey underwent investigation which included routine biochemistry, X Ray Chest, Sonography of whole abdomen, Dengue ab test, CT Scan head and ECG. A neurology opinion was also taken. He was not given any treatment during the hospital stay and the discharge medicines prescribed were purchased by him on 22.10.2007. Further, no investigation was done to label him as a case of APD. The admission is not advised and the insured did not require any admission as such they have rightly repudiated the claim under clause 4.10 of the policy.

After hearing both the parties and on examination of the documents submitted Shri A.K. Pandey was admitted in S R Kalla Memorial Gastro & General Hospital on 18.10.2007 and discharged on 20.10.2007 with the complaints of Abnormal movement of left upper arm. The Insurance Company has repudiated the claim on the grounds that during the hospitalization diagnostic procedures are done and treated conservatively and orally treatment could be done on OPD basis and no positive existence of any disease, hence as per clause 4.10 of the policy the claim was not payable. On going through the discharge summary of Shri A.K. Pandey he was admitted in S R Kalla Memorial Gastro & General Hospital as a case of abnormal movement of left upper arm. He was seen and investigated and diagnosed as a case of Acid Peptic disease and anxiety neurosis. He was allegedly managed conservatively with symptomatic treatment and was discharged after recovery with follow up advice and rest. As per discharge summary it is clear that insured is admitted only for investigation of the symptoms which could have been done as OPD basis. No treatment of any kind as would have been given to indoor patients normally was given to him. As such considering all facts and observations that the claim of Shri A.K. Pandey has rightly been repudiated by the Insurance Company under clause 4.10 of the policy, since the hospitalization was only for investigation which could have been done as a OPD patient.

GUWAHATI

GUWAHATI OMBUDSMAN CENTRE
Complaint No. 11-003-0112/08-09

Mr. Bisanong Singpho
- Vs -
The National Insurance Co. Ltd.

Award dated : 20.02.2009

The Complainant was holding mediclaim policy for his wife Mrs. Khako Singpho under National Insurance Co. Ltd. with Sum Assured of Rs.1,00,000/- for the period 01.10.2004 to 30.09.2005. The Insured was admitted in the Rontix Hospital on 24.05.2005 and treated there. The Complainant had

accordingly lodged the claim before the Insurer seeking reimbursement of the expenses incurred in connection with her treatment but the Insurer has repudiated the claim on the ground that her ailments, during the treatment period, was diagnosed to be "Alcoholic Pancreatitis with RT. Lower Zone" which is found to be not covered as per policy condition . Being aggrieved, the Complainant has approached this forum for redressal.

The Insurer has contended that the Exclusion Clause contained in Clause 4.8 of the mediclaim policy discloses that the Insurance Company shall not be liable to make any payment under the policy in respect of any expenses whatsoever incurred by any Insured person in connection with or in respect of :-

> "4.8 - Convalescence, general debility, 'Run-down' condition or rest cure, congenital external disease or defects or anomalies, sterility, venereal disease, intentional self injury and use of intoxicating drugs / alcohol."

The Insurer pleaded that since Khako Singpho was treated for such ailments in the Rontix Hospital during the period from 24.05.2005 to 29.05.2005, there appears to be no liability of the Insurance Company to make any payment in reimbursement of the expenses incurred in connection with her treatment. The Insurance Company has accordingly repudiated the claim. The Complainant has also not denied about furnishing such findings by the treating Hospital but contended that the Rontix Hospital Authority, Margherita noted the above diagnosis, out of grudge, as he had shifted his wife from that Hospital to Sristi Hospital & Research Centre and according to him, the Rontix Hospital could not give proper treatment. The Complainant has also produced another certificate dated 01.12.2005 from one Dr. A. AL Hydari who stated that Mrs. Khako Singpho had no evidence of any Alcohol related disorder when she was under his treatment. This certificate dated 01.12.2005 was procured long after his claim was repudiated by the TPA. The Complainant has also failed to establish any proof of issuing false certificate by the Rontix Hospital, out of grudge.

From the policy conditions, it becomes clear that the insurance coverage is not there for treatment of alcohol related problems as per exclusion clause No. 4.8 and hence the complaint is dismissed.

Guwahati Ombudsman Centre
Case No.11/003/0050/08-09
Mr. Indar Chand Ajitsaria
-Vs-
National Insurance Co. Ltd.

Award dated = 13.10.2008

Smt. Gita Devi Ajitsaria, wife of the Complainant, was an insured under "Hospitalization and Domiciliary Hospitalization Benefit Policy" for the period 09.01.2007 to 08.01.2008. The Insured expired at Bellevue Clinic, Kolkata on 03.02.2007 due to "Shock with multi organ failure and the antecedent cause was (i) Sepsis and (ii) CVA – hemorrhage. The claim for Rs.5,89,338.25 lodged with the Insurer through TPA – Medsave Healthcare Ltd. was repudiated on the ground that the patient was hypertensive since last 10 years, CABG done in July, 2000 and hence the disease becomes pre-existing.

During the course of hearing, it is stated by the representative of the Insurer that the Insured procured the above mediclaim policy originally in the year 1986 and renewed the policy since then covering the period upto 04.01.2002. According to the representative of the Insurer, there was a gap of 5 days in renewing the policy after 04.01.2002 and the subsequent renewal was done only w.e.f. 09.01.2002 for the subsequent period. In case of such a break, the Insurer treated the policy as a fresh one meaning thereby covering the risks afresh since 09.01.2002 only ignoring previous policy coverage. However, the representative of the Insurer has not been able to produce any document or rule in support of the contention. The documents produced by the Complainant shows that he had tendered the renewal premium for renewal of the policy for subsequent year vide Cheque No. 018446 dated 04.01.2002 for Rs.12,517/- while the previous policy was in force till that date. Although the said Cheque was received before expiry of the term of the previous policy but the Insurer, instead of renewing the policy, returned the same to the Insured, after retaining the Cheque for 3 days asking her to submit some documents mentioned in the letter within 3 days from 07.01.2002. The Insured submitted all the required documents and tendered the aforesaid Cheque for renewing the policy again and the policy was accordingly renewed giving effect from 09.01.2002. Thus, the gap of 5 days in renewing the policy was caused by the Insurer and not due to the fault of the Insured who appears to have tendered the premium Cheque well ahead before the renewal date. When the Insured was having the above policy continuously since 1986 and the gap was also not caused due to her fault, hence it can be taken to be a policy continuously being renewed. The Insurer considered the statement in the Discharge Certificate, wherein it was stated that the Insured was suffering since 10 years which was pre-existing but the policy being continuing since 1986.

The repudiation of the claim on the ground of pre-existing clause was not in order. The claim was payable. Hence, ordered that the admissible amount should be paid.

Guwahati Ombudsman Centre
Case No.11/005/0096/08-09
Mr. Pankaj Kr. Saikia
-Vs-
The Oriental Insurance Co. Ltd.

Policy No. 321201/2007/1729

Award dated = 10.11.2008

Mr. Pankaj Kr. Saikia and his family members were covered under the above Mediclaim policy taken from the above Insurer which was originally procured with effect from 21.03.2006 and renewed upto 20.03.2008. His daughter was an Insured was admitted in the Apollo First Med Hospital at Chennai on 25.10.2007 wherein "Electro Cautery" was done due to "Warts" (a skin problem in her hand). A claim was lodged before the Insurer but the claim was repudiated on the ground of pre-existing disease. Being aggrieved, the Complainant approached this forum for redressal.

The Insurer has contended in their "Self Contained Note" that the date of inception of the policy is from 21.03.2006. The Ist prescription dated 03.09.2006 contained "Warts and Electrocautery" was done. Insurer submitted that Multiple Warts in different sites cannot develop within 6 months of inception of policy, and hence the disease is long standing and is considered as pre-existing.

On scrutiny, it is revealed that the 1st prescription dated 03.09.2006 that the Doctor had diagnosed the disease to be "Warts" and did "Electrocautery" on the effected portion. The Insured was shown to the Doctor on 03.09.2006 for the first time for treatment. The 1st prescription failed to disclose appearing such disease since long. The discharge summary of the Apollo First Med Hospital, Chennai also proves that the Insured was admitted in the said Hospital on 25.10.2007 and surgery was done on that day adopting "Electrocautery Procedure" for the treatment of such Multiple Viral Warts. She was discharged on the following day. That was done after a year from first detection. There is nothing on record to disclose about existence of the said disease prior to inception of the policy on 21.03.2006 and the disease was detected within the policy period.

Held that the repudiation of the claim by the Insurer / TPA on the ground of pre-existing disease was not in order. Repudiation was set-aside and Insurer was asked to settle the claim.

GUWAHATI OMBUDSMAN CENTRE
Complaint No. 11-008-0095/08-09

Mr. Prabhat Kr. Kedia
- Vs -
The Royal Sundaram Alliance Ins. Co. Ltd.

Award dated : 22.12.2008

The Complainant was an insured under a "Health Shield Insurance Policy" for the period from 13.09.2007 to 12.09.2008. The Insured was admitted in the Hospital

on 22.05.2008 for treatment of "Avascular Necrosis of right femoral head" The Complainant thereafter submitted a claim seeking re-imbursement of the expenses incurred in the hospitalization and treatment and submitted all the relevant documents but the Insurer has repudiated the claim. Being aggrieved, the Complainant approached this Authority for redressal.

On a perusal of the copy of repudiation letter dated 09.07.2008, it appears that the Insurer has repudiated the claim on the ground that his hospitalization during the above period was for treatment of "Avascular Necrosis of right femoral head" which is a complication of previous fracture sustained prior to the inception of the policy and treatment was taken for a pre-existing medical conditions is outside the scope of the policy.

It is revealed that the Complainant sustained a Trochantric fracture in April, 2005 which, according to the Complainant, was cured after due treatment. He thereafter felt hip pain in July, 2007 and consulted Orthopedic Surgeons and ultimately took treatment through Hospitalization during the period from 22.05.2008 to 03.06.2008 and the claim in question was submitted. The attending Doctor has submitted in the Health Shield Claim Form in Column No.4 that the Complainant started suffering for the disease since 22.06.2007 and thereafter he was admitted in the Hospital on 22.05.2008. The disease for which he was admitted and treated was diagnosed to be "Avascular Necrosis of right femoral head". In answer to Column No. 10, the attending Doctor reported the previous medical history of the patient as "Trochantric Fracture right hip in 2005, operated with DHS, pain and limping pains two years latter". In answer to Column No. 11, the said attending Doctor, in answer to the query whether the ailment diagnosed as above was a complication of a pre-existing disease or condition or not, observed the disease "may be related to trochantric fracture". In the certificate dated 05.08.2008, the said Doctor further clarified that the Complainant developed "Avascular Necrosis of right femoral head" on which he had sustained a Trochantric Fracture earlier which had been fixed by a DHS plate and "Avascular Necrosis of right femoral head" may occur in rare condition. He has not ruled out the possibility of developing "Avascular Necrosis of right femoral head" on that part of his body wherein he had sustained trochntric fracture earlier. The Insurer as well as their panel doctors have also considered the disease for which he was treated in the Hospital, to be due to "trachantric fracture sustained in the year 2005". The policy was taken after sustaining the above fracture and since the claim lodged for treatment of a complication of the earlier fracture, the Insurer has repudiated the claim keeping in view the Exclusion Clause under the policy. Hence, the decision of the Insurer cannot be said to be improper / unjustified in view of the facts and circumstances available before us.

In view of the above facts and circumstances, the complaint is dismissed.

KOCHI

Complaint No.IO/KCH/GI/11-005-332/2008-09

Smt.A.N.Kamalamma
Vs
The Oriental Insurance Co.Ltd.

AWARD DATED 13.01.2009

The complainant was covered by a mediclaim policy during the period 28.03.2007 to 27.03.2008. During the currency of policy, she was admitted in hospital and was treated for Irritable Bowel Syndrome [IBS]. The claim was repudiated on the ground that there was no active line of treatment which requires hospitalization and also the treatment was for depression which is not covered under the policy.

The hospital reports produced show that she was admitted on 20.03.2007 and treatment commenced on 20.03.2008 itself. Blood, stool and urine tests were also done and discharged on 22.03.2008. Reports of gastro duodenoscopy done on 21.08.2007 was also produced which shows that she was having hernia. The discharge bills show that medicines were given during hospitalization. Hence it is clear that there was treatment from hospital and started immediately after admission and continued even after discharge. The fact that she had undergone some tests also does not mean that the hospitalization was only for investigation. Hence repudiation on the ground will not stand.

Another reason for repudiation is that there was treatment for depression. But it is noted that the insured was treated by a Physician and not by a Psychiatrist. No psychiatric or psychological treatment was given during hospitalization and even after discharge, treatment was only for IBS and GRED. Of course, depressive illness was also there. Depression need not always be connected with psychiatry. On account of IBS also, depression may develop. On account of gravity of illness, one may become depressed. Anyhow she has not subjected to any psychiatric treatment. Hence repudiation on this ground also is not sustainable. Hence an award is passed directing the insurer to pay the eligible amount of Rs.3,000/- together with interest at 8% p.a. from the date of claim till payment and a cost of Rs.500/-.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-004-336/2008-09

Shri Antony Leon
Vs
United India Insurance Co.Ltd.

AWARD DATED 16.02.2009

The complainant is having a mediclaim policy since 19.02.2003. During the currency of the 2008 policy, he was admitted in Amrita Institute of Medical Sciences and Research Centre [AIMS] from 19.06.2008 to 22.06.2008 and treated for CAD. The claim was repudiated on the ground that the illness was pre-existing. In the discharge summary, it is stated that in 1998, he had acute coronary syndrome. In the treating doctor's certificate also, it is so stated. Hence CAD has to be taken as a pre-existing illness. However, as per condition of the policy, the condition of pre-existing illness will not apply if there is a claim free period of 3 years. The insured was having mediclaim policy continuously since 2003. As there is a claim free period of more than 3 years, exclusion condition Cl.4.1 will not apply. Hence the insured is eligible for the claim amount. As the hospital expenses is more than the sum assured of Rs.50,000/-, an award is passed for payment of insured sum of Rs.50,000/- with 8% interest p.a. from the date of claim till payment and a cost of Rs.1,000/-.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-003-179/2008-09

Shri Baby Abraham
Vs
National Insurance Co.Ltd.

AWARD DATED 07.11.2008

The complainant has been covered by a mediclaim policy since 2000. As he suffered severe back pain, he was hospitalized at Varma Medical Clinic from 26.12.2007 to 31.12.2007. The claim was repudiated on the ground that there was no active line of treatment and hospitalization was only for diagnostic purpose. It was submitted by the complainant that he was suffering from back pin for quite a long time. He was advised admission in the hospital and undergo MRI scan. Only on the advice of treating doctor, he got admitted in the hospital.

The repudiation was made invoking Cls.4.10 and.4.14 of policy conditions. On going through the records produced, it looks that the admission was mainly for taking MRI scan. No specific treatment was given, apart from oral tablets and injection. MRI report also shows 'normal study'. After MRI scan, he was advised to continue the medicines prescribed earlier. Hence it looks that admission is only for the purpose of scanning and there was no specific treatment except giving some tablets and injection. Policy condition is very

specific that such hospitalization is not covered under the policy. The repudiation is, therefore, correct and complaint is **DISMISSED.**

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-003-161/2008-09

Shri Biji V.Easo
Vs
National Insurance Co.Ltd.

AWARD DATED 28.10.2008

The complainant is having a mediclaim insurance policy with National Insurance Co.Ltd. since 26.11.2004 for a sum assured of Rs.1,00,000/-. The sum assured was enhanced to Rs.2,00,000/- at the time of renewal w.e.f. 26.11.2007. On 27.11.2007, he was hospitalized o account of myocardial infarction and incurred hospital expenses of Rs.1,89,998/-. TPA allowed only Rs.1,00,000/- being the sum assured under pre-revised policy, repudiating the claim under enhanced sum assured, invoking Cl.4.2 of policy conditions. Cl.5.12 deals with enhancement of sum assured. It only says that continuing and recurrent nature of diseases/complaints which the insured has suffered, will be excluded from the scope of cover as far as enhancement of sum assured is concerned. The definite case is that he suffered a myocardial infarction only on 27.11.2007. There is no case that before that, he had any such ailments. Hence he is eligible for benefits under enhanced sum assured even if the hospitalization is on the very next day of enhancement of sum assured.

As per policy condition, there is restriction under each head of expenses. Room rent is limited to 1% of sum assured or Rs.5,000/-. But he has claimed only Rs.3,950/- which was allowed by the insurer in full. Surgeon, Anesthetic and Consultation fee is limited to 25% of sum assured. He claimed only Rs.1,250/- which was allowed by the insurer in full. OT charges was limited to 50% of sum assured. The amount claimed is Rs.1,77,000/-. This amount has to be limited to Rs.1,00,000/- only, being 50% of sum assured. In total, the insured is entitled for an amount of Rs.1,05,150/- and an award is, therefore, passed directing the insurer to pay the amount of Rs.1,05,150/- with interest @ 8% p.a. and a cost of Rs.1,000/-.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-008-211/2008-09

Shri G.Satheesh Kumar
Vs
Royal Sundaram Alliance Insurance Co.Ltd.

AWARD DATED 13.11.2008

The complainant was issued with a health Shield Policy of Royal Sundaram Alliance Insurance Co.Ltd. for a sum of Rs.1,00,000/- covering the period 10.03.2007 to 09.03.2008. In October 2007, the complainant sought treatment from Amrita Institute of Medical Sciences for nasal bleeding. On 29.11.2007, nasal growth was removed and biopsy was taken. An open surgery was done on 18.12.2007. The claim was repudiated on the ground that the illness was a pre-existing one.

The contention of the insurance company is that the patient was admitted in the hospital with complaint of nasal bleeding. As per hospital records produced, he was having complaint of nasal bleeding for 6 months prior to 28.11.2007. That means he was having the symptoms of disease within 2 months of taking policy. As per expert medical opinion received by the insurer from Dr.Rajender Kumar, it takes several months, certainly more than 2 months, to develop the illness to such a stage. Hence the illness is pre-existing one and hence, they are not liable to honour the claim. However, according to the opinion of the treating doctor, it is possible that the symptoms may develop within 2 months. As there are two contradictory opinion, one from the treating doctor and the other, from a doctor who gave his opinion just by going through the medical report, opinion of treating doctor is to be taken into confidence. It is also to be noted that Dr.Rajender Kumar has only stated that the symptoms will not develop within 2 months. But he didn't say within how many months the symptoms will set in. Hence the opinion is only a vague one. But the treating doctor specifically states that the symptoms will develop within 2 months. Hence by no strategy of imagination, it can be said that the insurance company has failed to prove that the disease is a pre-existing one. Another contention of the insurance company is that as per disclaimer clause, complaint must be lodged before the Ombudsman within 3 months of repudiation. Here in this case, the complaint is lodged after 6 months of repudiation. But the insurer had preferred an appeal on 15.07.2008 which was replied by the insurer on 04.08.2008. The complaint is, therefore, within 3 months of final repudiation. An award is, therefore, passed directing the insurer to pay the sum assured of Rs.1,00,000/- with interest @ 8% p.a. and a cost of Rs.1,000/-.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-004-349/2008-09

George Emmanuel
Vs
United India Insurance Co.Ltd.

AWARD DATED 16.02.2009

The complainant and his wife wee covered under an Individual Health Insurance Policy for the period 21.10.2007 to 20.10.2008. In June 2008, the complainant's wife had undergone hysterectomy in respect of which a claim was laid for Rs.49,189/-. But he was allowed only Rs.10,000/- as there is special restriction of 20% of sum assured for hysterectomy.

It was submitted on behalf of the complainant that there is dispute only with regard to restriction of 20% of SA for hysterectomy. Earlier there was no such restriction and the restriction was imposed in 2007 revival, without the consent of the policyholder. Also the restriction is 20% or maximum Rs.50,000/- and hence, he is eligible for claim up to Rs.50,000/-, as there is no clause such as 'whichever is less'.

Insurance is only for a specific period. Some additional benefits are given in case of renewal without any break. On issuing a new policy on renewal, the benefit will be that available under renewed policy only. Hence the terms and condition of the policy issued in 2007 need only be looked into. As per this policy, expenses for hysterectomy is limited to 20% of SA, maximum Rs.50,000/-. The contention of the complainant is that, as the term 'whichever is less' is not shown in the restrictive clause, he is eligible up to Rs.50,000/-. But it is relevant to note that Rs.50,000/- is qualified by the word 'maximum'. It also comes under the caption 'restrictions'. Hence the only interpretation possible is that the amount is 20% of sum insured which may go up to Rs.50,000/-. Hence the liability of the insurer is only Rs.10,000/- and complaint is, therefore, DISMISSED.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-005-247/2008-09

Smt.Jainy Thomas
Vs
The Oriental Insurance Co.Ltd.

AWARD DATED 02.12.2008

The complainant is having a mediclaim policy with Oriental Insurance Co.Ltd. since 30.11.2006. Before that, she was having insurance with ICICI Lombard. During the currency of policy issued on 30.11.2006, she was admitted in Laxmi Hospital for hysterectomy. The claim was repudiated by the insurer on the ground that hysterectomy was not covered during the first two years of policy. The contention of insured is that, though the policy with Oriental Insurance Co.Ltd. incepted only on 30.11.2006, she was having mediclaim insurance policy for the previous two years also with ICICI Lombard Insurance Co. As there is insurance coverage continuously for 3 years, the two year exclusion clause is not applicable to her. The clause 4.1 of policy conditions state that date of inception of mediclaim policy taken from Oriental Insurance Co.Ltd. alone shall be considered, provided the renewal has been continuous and without any break. Here the policy was taken from Oriental Insurance Co.Ltd. on 30.11.2006 and hospitalization was from 11.02.2008 to 21.02.2008. As per policy condition 4.1, insurance taken from Oriental Insurance Co.Ltd. alone will be considered for determining the policy period. As per policy condition, hysterectomy is not covered during the first two years of policy. As the hospitalization was within 2 years of inception, the claim will not sustain and the complaint is, therefore, **DISMISSED.**

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-004-330/2008-09

Shri K.K.Sibi
Vs
United India Insurance Co.Ltd.

AWARD DATED 06.01.2009

The complainant is covered under a mediclaim policy since 2002. On 01.04.2008, he was admitted in Medical Trust hospital and was discharged on 02.04.2008 advising bed rest.

The claim was repudiated on the ground that there was no active line of treatment and hospitalization was only for investigation, which is not covered under Cl.4.10 of policy condition. The contention of the complainant is that as hospitalization was done under the advice of treating doctor and he is eligible for the claimed amount.

As per the discharge summary, diagnosis is back pain. On clinical examination, vitals were found stable. It is stated "treated symptomatically" and discharged advising bed rest and prescribing tablets in the condition in which he was admitted. Hence it is evident that he was admitted only for investigation and no active line of treatment, which justifies hospitalization, was given. Cl.4.10 of policy condition is very specific that such hospitalisation is not covered under the policy. The complaint is devoid of any merits and hence **DISMISSED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/15-009-421/2008-09

Shri K.P.Ravi
Vs
Reliance General Insurance Co.Ltd.

AWARD DATED 26.03.2009

The complainant was issued with a mediclaim policy covering himself and his wife & children for the period 12.7.2006 to 11.07.2007. After expiry, a further policy was issued w.e.f. 02.08.2007. On 20.12.2007, the complainant's wife underwent a fibroid surgery and the claim was repudiated on the ground that there is a break on renewing the policy and hence, the surgery comes under first policy year which is excluded from the scope of the policy, as per policy condition Cl.4.3. It was submitted by the complainant that he has presented the cheque for revival well before the due date and also it was noted in the policy document that the cheque was received by them on 10.07.2007. Hence the policy is a continuous one w.e.f. 12.7.2006 and treatment is in the second policy year and as such, he is eligible for reimbursement.

On scrutiny of file, it can be seen that the cheque was received by the insurer on 10.07.2007 and this was mentioned in the policy document itself. It was submitted by the insurer that the cheque was a post dated one and the date as noted in the policy document, as the date of receipt of cheque as 10.07.2007 is a system error and the policy actually commenced only on 02.08.2007. They have also produced copy of a proposal form which shows the date of commencement as 02.08.2007. But the complainant has stated that he has not submitted such a proposal form and the signature is not that of his. On verifying, it can be seen that the proposal was signed by someone else and also there are so many correction in the date. It looks that the proposal is a subsequent manipulation. It is curious to note that the proposal is undated. Also for the purpose of renewal, such a proposal form is not required. Hence the period given in the proposal cannot be relied upon and it is to be taken that the cheque was given on 10.07.2007 as noted in the policy document. This being the case,

it is a continuation of previous policy and surgery is in the second policy year. An award is, therefore, passed directing the insurer to pay the claim amount of Rs.52,526/- with 8% interest and a cost of Rs.1,000/-.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-004-321/2008-09

Kurian Isac
Vs
United India Insurance Co.Ltd.

AWARD DATED 22.01.2009

The complainant has been holding a mediclaim policy for the last 10 years and the same was revived on 22.09.2007 in continuation of earlier policies. On 09.05.2008, his wife was admitted in Sunrise Hospital and after hysterectomy, she was discharged on 11.05.2008. A claim was raised for an amount of Rs.54,983/-, but the insurer allowed only Rs.10,000/- as, as per revised policy condition, the expenses for hysterectomy was limited to 20% of the sum assured. In the complaint, it is stated that he was holding the policy continuously for the last 10 years and he was not aware of the new restrictive conditions imposed. The new changes were made unilaterally by the insurance company without his consent and hence, he is eligible for full amount.

Earlier policy was for a sum assured of Rs.35,000/-. At the time of revival in 2007, certain changes were made. Minimum sum assured was increased to Rs.50,000/-. The differentiation between old policy and new policy was indicated in the policy itself by saying that the complainant and his wife were under Gold Policy and their children under Platinum Policy. Such a differentiation was not there in the old policy. This classification itself shows that the revised policy is a new one with new terms & conditions. It is also admitted that alongwith the policy, policy conditions were issued. If it was a renewal of old policy, new policy conditions would not have been issued. Hence there is sufficient indication that renewed policy is a new type, different from the one issued earlier. As per conditions of the revised policy, expenses for hysterectomy was limited to 20% of sum assured, i.e., Rs.10,000/-. As the insurance company has already paid the eligible amount, the complaint stands DISMISSED.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-003-154/2008-09

Smt.Lilly Varghese
Vs
National Insurance Co. Ltd.

AWARD DATED 29.09.2008

The complainant was covered under a mediclaim policy renewed upto 19.04.2008. She was admitted in PVS Hospital from 14.4.2008 to 18.4.2008 with the complaint of urgency with urge incontinence as to which a claim of Rs.3,729.30 was preferred. The claim was repudiated on the ground that there was no active line of treatment and hospitalization was only for evaluation and investigation, which could have been done on an out-patient basis. It was submitted on behalf of the complainant that she was admitted in the hospital as per advice of expert doctors. During the days of hospitalization, several tests were conducted and medicines were prescribed. Hospital records produced shows that there was only conservative treatment. There was no significant past history. On examination, no serious abnormality was also detected. She was discharged prescribing only 2 types of tablets. The bill produced shows that during hospitalization also, only two types of capsules and tablets were given. As per Cl.4.10 of policy conditions, expenses incurred primarily for evaluation/diagnosis purpose not followed by active treatment during hospitalization is not covered under the policy. As the policy condition is very specific about its exclusion clause, the insurance company has no liability to make any payment and the complaint is, therefore, dismissed.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-004-322/2008-09

Smt.Mary Chakku
Vs
United India Insurance Co.Ltd.

AWARD DATED 22.01.2009

The complainant was holding a mediclaim policy of United India Insurance Co.Ltd. covering the period 17.02.2007 to 16.02.2008. In june 2007, she fell ill on account of viral fever and was admitted at St.James Hospital and treated for 5 days. Her claim for reimbursement of hospital expenses was repudiated on the ground that the treatment can be taken on an OP basis. Though the claim was repudiated, neither the Insurance company nor the TPA has produced any records to substantiate their stand. However, the complainant has produced a certificate from the treating doctor certifying that the patient

required admission in view of high fever and vomiting which require IV injection. The repudiation letter also says that the treatment was for viral fever. IV Injection cannot be taken on OP basis. As the certificate is supported by reason, it is to be held that repudiation is faulty. An award is, therefore, passed directing the insurer to pay the amount of Rs.1,478/- with 8% interest p.a. and a cost of Rs.200/-.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-008-175/2008-09

Shri M.S.Netaji
Vs
Royal Sundaram Alliance Insurance Co.Ltd.

AWARD DATED 28.10.2008

The complainant and his family members were covered by Health Shield Policy of Royal Sundaram Alliance Ins.Co.Ltd. While the policy was in force, he was hospitalized on 18.01.2008 for Ischemic Heart Disease and was discharged on 31.01.2008. His claim was repudiated on the ground that at the time of taking policy, he was a diabetic and this existing illness led to the present illness. The decision of insurer was mainly based on blood sugar report dated 28.02.2006 which shows FBS reading as 122 mg/dl and PPBS reading 146 mg/dl which is beyond the normal reading. Clause D of policy condition deals with exclusions which say that if a person having pre-existing hypertension, diabetes, suffers any heart disease and incurs treatment for the same, that will not be covered under the policy. The diagnosis made at the hospital is Ischemic Heart disease, angina, hypertension and diabetes. The last report dated 28.02.2006 shows that he was diabetic since 2006. Hence the policy excludes any heart disease. The contention of the insured is that the insurance company relied on a report 1 ½ years before taking the policy, but all the test results after taking the policy shows normal reading and hence, he is eligible for insurance coverage. But it is to be noted that policy condition is very specific that if a person having diabetes and later become heart patient, the policy will not cover the same. He was diagnosed to have diabetes during the hospital treatment. His blood sugar was tested regularly and intermittently only to see whether the sugar level is under control. By the mere reason that his sugar level was within normal limit, it cannot be said that he is not diabetic. It only means that blood sugar is controlled due to medication. Hence the repudiation is correct and is to be upheld. The complaint is, therefore, **DISMISSED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-004-335/2008-09

Murali Madhavan K.
Vs
United India Insurance Co.Ltd.

AWARD DATED 28.01.2009

The complainant was issued with a mediclaim policy on 20.05.2007. During the currency of the policy, he was hospitalized in AIMS on 13.01.2008 and was discharged on 15.01.2008. The claim was repudiated on the ground that there was no active line of treatment from the hospital and hospitalization was only for evaluation. The insured consulted the hospital with a history of hearing loss. From the hospital records produced, it seems that the insured was hospitalized for investigation and evaluation. No active line of treatment was given. MRI scan was done to rule out intracranial anomalies. He also underwent audiometry and tympanometry tests. But no abnormalities were observed during these tests. In the discharge summary, doctor has clearly mentioned that he was hospitalized for investigation and evaluation. After discharge, he was prescribed some vitamin tablets only. No treatment was given from the hospital. Hence it looks that the hospitalization was only for evaluation and investigation which is not covered under the policy. The complaint is, therefore, **DISMISSED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/14-003-268/2008-09

Shri N.A.Varghese
Vs
National Insurance Co.Ltd.

AWARD DATED 18.12.2008

Deceased Sunil Varghese was covered under a mediclaim policy from 17.11.2006 to 16.11.2007. On 05.07.2007, he was admitted in Sree Sudheendra Medical Mission Hospital and there, he was referred to Medical Trust Hospital on 19.07.2007. He expired on 24.07.2007. The claim was repudiated on the ground that the hospitalization was for a pre-existing illness. The earlier policy, which lapsed on 25.09.2006, was revived on 17.11.2006. Hence policy commenced on 17.11.2006 is to be treated as a new policy. In the hospital records produced, it is shown as a known case of Wegners Granulomattosis. In the death summary issued from Medical Trust Hospital, diagnosis made is Wegners Granulomattosis with CNS since October 2005. Also, as per medical

reports of Sree Sudheendra Medical Mission Hospital and Medical Trust Hospital, the insured was suffering from polyarthritis since 2002. Hence it is a clear that the hospitalization was for a pre-existing disease, which is not covered under the policy. The complaint is, therefore, **DISMISSED.**

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-003-210/2008-09

Shri J.Nandikeswaran
Vs
National Insurance Co.Ltd.

AWARD DATED 11.11.2008

While holding Bank of India Swasthya Beema Policy, which commenced on 15.02.2008, the complainant's wife, Smt.Pratibha was admitted at Holy Cross Hospital, Kottiyam and treated for CSOM of left ear. The claim was repudiated by the insurer on the ground that the illness, for which treatment was taken, was existing at the time of taking policy. As per Cl.4.1 of policy, all pre-existing diseases are excluded from the benefit of policy. The complainant had stated that the illness has started only after taking policy. As per hospital records produced, the insured first consulted a doctor on 28.02.2008 i.e., after taking policy. She approached the doctor with the complaint of left ear discharge for one year. The claim was also for the treatment of the same illness. During the course of hearing, it was submitted that the insured was taking treatment for this illness for about one year from local doctors and only as per the advice of treating doctor, she got admitted at Holy Cross Hospital for surgery. From this, it is clear that the treatment is taken for a pre-existing disease for which no claim is sustainable and the complaint is, therefore, **DISMISSED.**

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-005-275/2008-09

Shri P.A.Niju
Vs
The Oriental Insurance Co.Ltd.

AWARD DATED 19.12.2008

The complainant and his family members were covered under a mediclaim policy since 27.01.2008. His son was admitted in the hospital on 04.03.2008 and was discharged on 05.03.2008 for constipation. The claim was repudiated invoking exclusion Cl.4.10 of policy condition. The claim was repudiated on the ground that there was no active line of treatment from hospital and hospitalisation was only for investigation. But the condition of the complainant is that he was admitted only as per advice of a specialist doctor. Hence he is eligible for claim amount.

The patient was admitted on 04.03.2008, as ayurvedic treatment was ineffective. He was admitted on 04.03.2008 evening. The patient was kept under fasting till next day morning and he was taken to the theatre for check up at 11:00 am on 05.03.2008. The report was obtained at 05.:30 PM and was discharged then itself prescribing milk of magnesia and advising to take soft food. From the hospital report, it looks that the hospitalization is merely for investigation and there was no active line of treatment. The complainant also admitted that there was no treatment from the hospital, except check up. The exclusion clause 4.10 is very specific that such hospitalization is not covered under the policy. The complaint is, therefore, **DISMISSED.**

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-004-291/2008-09

P.G.Shajan
Vs
United India Insurance Co.Ltd.

AWARD DATED 22.01.2009

The complainant and his family members were covered by a health policy since 16.08.2004, and it was renewed from 16.08.2007 to 15.08.2008. On 13.08.2007, the complainant's daughter, Ms.Anu Mary Shajan, was hospitalized and was discharged on 10.09.2007. The insurance company allowed only balance sum assured upto 15.08.2007. Though the policy was revived in full after 15.08.2007, the sum assured under the revised policy was not paid, as the disease has contracted during the previous policy year. The complainant is claiming full reimbursement as he has renewed the policy after 15.08.2007 in time.

As per policy condition, insurer promises to reimburse hospital expenses in respect of any disease contracted during the policy period. Policy condition further says that occurrence of a disease after a lapse of 105 days will be considered as fresh illness for the purpose of policy. So as per terms and conditions of policy, if a disease is contracted during the currency of a policy and treatment continued even after policy period, the payment will be made up to the sum assured under a policy. The illness is contracted during the currency of earlier policy, the amount to be paid is out of sum assured of that policy period. Even though that illness continues, it is not the one contracted during the subsequent policy. Here in this case, the illness contracted

during the policy period ended on 15.08.2007 and hence the claim will be paid out of sum assured available up to 15.08.2007 only. For a disease contracted during the currency of a policy amount cannot be given out of sum assured of the subsequent policy. Hence the repudiation is correct and the complaint is **DISMISSED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-004-165/2008-09

Shri P.O.George
Vs
United India Insurance Co.Ltd.

AWARD DATED 14.09.2008

The complainant and his wife are covered by Mediclaim policy since 2007. During the currency of policy, his wife was admitted in hospital from 20.11.2007 to 23.11.2007 for knee pain with effusion of joint. The claim was repudiated on the ground that the entire treatment could be done on an OPD basis and as such, this treatment is not covered under the policy. It was submitted by the insurer that during the period of hospitalization, only some oral medicines were given which would have been done on an OPD basis. On going through the hospital records produced, it can be seen that apart from administration of medicines, knee aspiration was also done. After that compression bandage was applied. Physiotherapy was also done. Aspiration is sucking a fluid with a device. It looks that there is difficulty in walking also during the course of treatment. The treatment was painful too. For such treatment, hospitalization is reasonably required. Hence it cannot be said that such treatment was one which do not require hospitalization. The repudiation is, therefore, set aside and an award is passed directing the insurer to pay the amount of Rs.1,150/- with interest at 8% p.a. and cost of Rs.250/-.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/14-003-391/2008-09

Shri Rajesh Methil
Vs
National Insurance Co.Ltd.

AWARD DATED 19.02.2009

The complainant and his wife were covered under a mediclaim policy for the period 01.01.2007 to 31.12.2007. The complainant's wife was subjected to laproscopic myomectomy for uterine fibroid and for that, he raised a claim which was repudiated by the insurer. The claim was repudiated on the ground that during the 1st year of the policy, cystic ovarian disease is not covered. The insured earlier had the policy from 02.12.2005 to 01.12.2006. Since the policy was not renewed in time, a fresh policy was taken w.e.f. 01.01.2007. Hence the policy is to be taken as a new policy only with date of commencement 01.01.2007.

The surgery is for removal of uterine fibroid. Hence it is a surgery conducted in genitor urinary system. As per policy condition, such treatment is excluded for the first two policy years. Even if the policy is taken as a continuation of the earlier policy, the treatment falls within 2 years of taking the policy, which is excluded as per policy condition. Hence the repudiation is to be upheld and the complaint stands **DISMISSED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/14-003-086/2008-09

Shri N.Retnakaran
Vs
National Insurance Co. Ltd.

AWARD DATED 25.09.2008

The complainant has been covered under a mediclaim policy since 22.4.2005. In the year 2007, he has been hospitalized on 3 occasions and 3 claims for reimbursement were made before the insurer. As the claims were not paid by the insurance company, he approached the Forum for justice. During the course of hearing and in the self contained note, it was submitted by the insurer that they have settled the first 2 claims and the 3rd claim was disallowed as the hospitalization was only for investigation and there was no active line of treatment. However, the complainant has stated that he had not received any payment from the insurance company.

As the insured had not received the cheques said to have been sent by the insurer in respect of first 2 claims, they have issued a fresh cheque for Rs.7,353/- on 18.09.2008. In respect of first claim, an amount of Rs.80/- for X-ray charges was deducted from claim amount. The insured is eligible for this amount also. Similarly, in the second claim, an amount of Rs.169/- was deducted as cost of medicines for treatment of diabetes. This amount was disallowed as if diabetes is a pre-existing disease. But no proof was produced to show that diabetes is pre-

existing. The complainant has stated that diabetes was diagnosed only in 2007. Hence he is eligible for this amount also. The claim for the third hospitalization was repudiated in full stating the reason that there was no active line of treatment from the hospital. That conclusion was arrived at presumably on the basis of discharge bills which only take in medicine charges of Rs.191.36. But it looks that immediately on admission, medicines were prescribed and the patient has purchased the same. On 5.3.2007, the date of admission, medicines were purchased 6 times. On 6.3.2007 also, medicines were prescribed and purchased. All these purchases were made from the dispensary of the very same hospital. Hence it cannot be said that there was no active treatment from the hospital. Of course, while admitting for active treatment, some investigations were also done. Hence it cannot be said that the admission was merely for investigation. An award is, therefore, passed directing the insurer to pay the eligible amount of Rs.9,295/- with 8% interest and a cost of Rs.1,000/-. Rs.7,353/- said to have been paid on 18.09.2008 is to be adjusted from this amount.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-002-144/2008-09

Shri Roy Varghese
Vs
The New India Assurance Co.Ltd.

AWARD DATED 29.10.2008

The complainant and his family members were covered under a mediclaim insurance scheme for several years. At the time of revival on 11.06.2006, the sum assured in respect of the complainant was enhanced to Rs.1,25,000/- from Rs.1,00,000/-. He had already earned a no-claim bonus of Rs.20,000/-. He had undergone a bypass surgery on 22.05.2007 and claimed an expense of Rs.1,56,371/-. Insurer allowed only Rs.1,20,000/- being the sum assured and no claim bonus before enhancement, on the ground that at the time of enhancement, he was a heart patient. The insured had stated that at the time of enhancement of sum assured, he was not aware that he was heart patient. The heart disease was detected only on 16.4.2007 while taking TMT. As per hospital record also, previous history is shown as one month only and hence, he is eligible for enhanced sum assured also.

In the hospital records produced, it is stated that he was not a known diabetic and there was no history of MI in the past. He was treated for triple vessel disease CABG. The treating doctor has given a certificate dated 26.09.2007 stating that the history of hypertension and hyperlipidemia does not mean established CAD, though they are risk factors. So to say that he had CAD at the

time when he developed hypertension is not correct. He might have sumptom, but it was detected only by TMT on 16.04.2007. From the certificate, it looks that the heart disease and dislipidemia are not CAD, though it may be a risk factor. But policy do not exclude risk factors. It exclude only pre-existing diseases. There is no case that there were any symptoms to the knowledge of the complainant. As per Cl.4.2, if the insured would not have known the existence of any disease, the exclusion will not apply. Hence the insurer cannot deny coverage for enhanced sum assured. An award is, therefore, passed for the enhanced sum assured of Rs.25,000/- with interest @ 8% p.a. and a cost of Rs.500/-.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-003-426/2008-09

Shri S.Sreejith
Vs
National Insurance Co.Ltd.

AWARD DATED 05.03.2009

The complainant is having individual mediclaim policy with National Insurance Co.Ltd. since 31.01.2006 without any break. On 19.06.2008, he was admitted in Amrita Institute of Medical Sciences and Research Centre and treated for idiopathic PAH, Moderate RV dysfunction, etc. The claim for reimbursement of expenses was repudiated on the ground that the treatment was for a pre-existing illness which is not covered under Exclusion Cl.4.1 of policy condition.

The repudiation is only on the ground that as per hospital records, he was suffering from dyspnoea for 2 ½ years before admission in AIMS on 19.06.2008, As the policy was taken only on 31.01.2006, the ailment was there at the time of taking policy and hence it is pre-existing. However, it was submitted by the complainant that the illness was first diagnosed only in 2007 and some bystander might have given wrong information at the time of admission.

As per Mosbys Medical Dictionary, dyspnoea is stated as shortness of breath or difficulty in breathing and that may be caused due to certain heart condition, strenuous exercise or anxiety. Hence dyspnoea is only a symptom following out of other condition. Even anxiety may cause dyspnoea. What is stated in the medical report is that he has been experiencing dyspnoea on exertion since 2 ½ years. Hence it is clear that though he was having dyspnoea, it was only on exertion. Only on instances of exertion, dyspnoea was occurring. Hence it is not on account of any condition of heart but only due to exertion. It cannot be said to be an illness. Also on a previous occasion, he has been admitted at Sree Chitra from 12.05.2007 to 15.05.2007. In the hospital reports, nothing has been said about dyspnoea. History of dyspnoea is only shown as2 ½ years. It is only an approximation. On account of this approximation, there is difference of only one month, as policy commenced on 31.01.2006. So the advantage of doubt must be given to the insured. Hence it is not proper to deny the benefit under the policy. An award is, therefore, passed directing the insurer to pay the claimed amount of Rs.19,713/- with 8% interest and cost of Rs.1,000/-.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-002-183/2008-09

Smt.Srikala Thirumeni
Vs
The New India Assurance Co.Ltd.

AWARD DATED 29.10.2008

The complainant was having a policy with The New India Assurance Co.Ltd. since 2001. At the time of renewal in 2007, the insurance company revised the plan prescribing a minimum sum assured and also imposing some restrictions for Ayurvedic treatment. Her claim for ayurvedic treatment at Amrita Hospital was repudiated on the ground that as per revised policy condition, ayurvedic treatment is covered only if taken in a Govt.hospital. It was submitted by the insured that she was not aware of such condition. Previously, such a condition was not incorporated in the policy. The original policy issued in 2001 covers ayurvedic treatment without any restriction. It was submitted by the insurance company that the new policy issued while revising in 2007 was issued with some restrictive condition. The new condition and premium chart was given to the insured at the time of renewal. New Janata Mediclaim Policy was issued only with the consent of the insured. As per new policy condition, ayurvedic treatment is covered only when taken in a Govt.hospital. As the policy condition is very specific about the exclusion clause and the treatment is taken from a private hospital, there is no reason to interfere with the decision of insurer and complaint is, therefore, **DISMISSED.**

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-004-435/2008-09

Shri T.P.Vijayakumar
Vs
United India Insurance Co.Ltd.

AWARD DATED 27.03.2009

The complainant had insured his vehicle bearing No.KL-35-9560 for an IDV of Rs.4,27,500/- under a package policy. The vehicle met with an accident and got damaged. The surveyor assessed the loss to Rs.2,49,500/- and wreck value as Rs.1,77,500/-. But the insured was not willing to accept the settlement on salvage basis and he is insisting on total loss basis and he is insisting on the IDV of Rs.4,27,500/-. It was submitted by the insurer that the claimant has already admitted the settlement on

salvage basis and only after getting his consent, they have proceeded with the settlement of claim. As the salvage is not kept properly, some items might have been lost by theft. As the salvage is under the custody of dealer who is an agent of the insured, they are not responsible for loss by theft, etc. The insured has submitted that at the time of signing consent for settlement on salvage basis, he was bedridden and was not in a position to understand what is there in the agreement.

Admittedly, the vehicle was insured for an IDV of Rs.4,27,500/-. Now the factum remains that the total amount receivable by the insured on total loss basis is Rs.4,27,500/- after deducting the salvage and policy excess. The wreck value is assessed by the surveyor. The dispute is only regarding the assessment made. As per policy condition, the insurer is liable to pay the entire loss and also eligible to get back the wreck. The survey report would contain what all items are contained in the wreck and the value of each item. Hence it is proper to pass an award directing the insurer to pay the loss assessed after deducting the value of wreck parts not entrusted with the insurer. This amount will carry interest @ 8% interest p.a. till the date of payment.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-003-293/2008-09

Shri Thomas John
Vs
National Insurance Co.Ltd.

AWARD DATED 27.01.2009

The complainant was holding mediclaim policy with National Insurance Co.Ltd. covering himself and his family members for a sum assured of Rs.25,000/-. At the time of renewal for the period 02.05.2007 to 01.05.2008, minimum sum assured was fixed as Rs.50,000/-. From 05.09.2007 to 19.09.2007, he had undergone a hip surgery and raised a claim for Rs.1,90,146/-. The TPA allowed only Rs.30,000/- being the sum assured under pre-renewal policy and bonus earned under the same. The complaint was filed to get full sum assured of Rs.50,000/- and bonus of Rs.5,000/-.

He was first admitted at City Hospital and Research Centre, Mangalore and during this period, he was taken Yenepoya Hospital for surgery and after surgery, he was brought back to City Hospital. The contention of the insurer is that as he was admitted in 2 different hospitals at the same time, the expenses at Yenepoya Hospital is not payable. But it is to be noted that he was taken to Yenepoya Hospital only for surgery at the instance of City Hospital, and after surgery, he was brought back to City Hospital. Hence as he was admitted at Yenepoya Hospital for the purpose of surgery and that too, at the instance of City Hospital, the expenses incurred at this hospital are also payable.

Another contention of the TPA is that the sum assured was enhanced to Rs.50,000/- from the earlier sum assured of Rs.25,000/-. As the illness has started during previous policy

period, only SA before renewal with bonus accrued i.e., Rs.30,000/- only is payable. But it is to be noted that the SA was increased to Rs.50,000/- at the instance of the insurer. The insured was not in a position to renew the policy for the earlier sum assured of Rs.25,000/-, as minimum SA was enhanced by the insurer. Hence the contention of the insurer that only pre-renewal SA is payable also is not standing. Hence the complainant is eligible for the full sum assured of Rs.50,000/- and bonus of Rs.5,000/-. However, as per policy condition, restrictions are there for each head such as doctor's fee, room rent, etc. Applying these restrictions, the insured is eligible to get an amount of Rs.47,370/-. As Rs.30,000/- stands already paid, an award is passed for the balance amount of Rs.17,370/- with interest @ 8% p.a. and a cost of Rs.1,000/-.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-003-269/2008-09

Shri Tony Antony
Vs
National Insurance Co.Ltd.

AWARD DATED 31.12.2008

During the period 27.10.2007 to 26.10.2008, the complainant was covered under mediclaim policy of National Insurance Co.Ltd. for a sum of Rs.20,000/-. On 07.02.2008, he was admitted to Elite Mission Hospital, Koorkkencherry and after various tests, he was discharged on 08.02.2008. The claim was repudiated on the ground that there was no active line of treatment from the hospital and hospitalization was merely for investigation, which was excluded as per Cl.4.10 of policy conditions. Hospital records produced show that he first consulted the doctor on 05.02.2008. As Crohn's disease was suspected, he was admitted on 07.02.2008 and various tests such as serology, immunology, etc., were conducted. MDCECT of abdomen was also done. There is nothing in the hospital bill to show that treatment was given in the hospital. During the tests also, no serious ailments was diagnosed. The complainant also has no case that he had undergone any treatment from hospital. It looks that the hospitalization was merely for investigation, which is not covered under the policy. The complaint is, therefore, DISMISSED.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-004-166/2008-09

Shri T.V.Varghese
Vs
United India Insurance Co.Ltd.

AWARD DATED 23.10.2008

The complainant is covered by a mediclaim policy of United India Insurance Co.Ltd. During the currency of the policy, he was admitted in St.Joseph's Hospital, Manjummelon 30.09.2007. As his condition worsened, he got discharged on 1.10.2007 and got admitted in MAJ Hospital and continued treatment up to 08.10.2007. His claim was repudiated as immediate notice was not given to the TPA. The contention of Insurance Company is that as per policy condition 5.3, immediate notice must be given to TPA which enables them to verify the genuineness of the claim and also to negotiate with the hospital authorities. As there are chances of escalation and manipulation by the hospital, immediate notice is a must to enforce strict control on claim management. However, it was submitted by the insured that immediate notice could not be given as he was seriously ill and his wife, being an illiterate, it was not possible to give immediate notice.

Policy condition 5.3 states that immediate notice must be given to insurer. In extreme cases, this condition may be waived where under, the circumstances in which the insured was placed, it was not possible for him to give such notice. He was admitted at St.Joseph's Hospital on 30.09.2007. As his condition worsened, he got discharged and got admitted at MAJ Hospital on 01.10.2007. From this, it is clear that he was not in a condition to give immediate notice. It looks that he had complained of urinary calculus, which is a highly painful ailment. The complainant had stated that his wife alone was there in the house to assist him and she, being illiterate, it was not possible for him to give notice. From the above discussion, it looks that this is a fit case for condoning the delay in submitting the claim. An award is, therefore, passed directing the insurer to pay the claimed amount of Rs.4,853/- with interest @ 8% p.a. and a cost of Rs.500/-.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-005-351/2008-09

Shri V.K.Antony
Vs
The Oriental Insurance Co.Ltd.

AWARD DATED 20.01.2009

The complainant, Shri V.K.Antony, and his wife are covered under a mediclaim policy since 2002. Shri Antony was admitted in hospital for dental treatment on 3 occassions, but only part of a bill for one admission was allowed by the insurer and other claims were repudiated. His wife was also admitted from 24.04.2008 to 25.04.2008 for dental treatment. The bill for this treatment and 2 other bills for post hospitalization expenses were also repudiated by the insurer.

In the complaint, it is stated that on feeling complaint to his gums, Shri Antony consulted 2 or 3 doctors and he was found suffering from periodontitis. He was advised to undergo surgery as it will effect decay of gum. As it was not possible to conduct surgery at one stage, it was done in 3 stages on 13.02.2008, 12.03.2008 and 09.04.2008 and claimed an expense of Rs.7,014/-. He was allowed only Rs.303/- being the hospital charges and medicine charges. The balance amount of Rs.6,711/- was disallowed on the ground that the treatment was of a cosmetic nature and also, it can be done on an OP basis. But it is to be noted that in the hospital records, the diagnosis is shown as Chronic Periodontitis with bleeding pockets. What is excluded as per policy condition is cosmetic, corrective or aesthetic treatment. Any dental treatment caused due to injury or illness is payable. Here the surgery was done for a condition arisen out of illness. Flap surgery is done for treatment of a condition caused due to illness. Hence it cannot be said that it is cosmetic or aesthetic surgery. Another cause of repudiation is that the treatment can be done on an OP basis. But it is to be noted that the insurer has allowed part of the bill. From the above, it is clear that the insurer is satisfied that the hospitalization is necessary. Hence repudiation is to be revoked.

The claim in respect of his wife was disallowed on the ground that the treatment can be done on an OPD basis. It looks that no dental procedure was done at the hospital. She was admitted on 24.04.2008 and discharged on 25.04.2008. No treatment was given except for medical attention and also some tests were done. As this can be done on an OPD basis, the repudiation is to be upheld. As hospital expenses are not payable, post hospitalization expenses also are not payable.

An award is, therefore, passed directing the insurer to pay an amount of Rs.6,681/- with interest @ 8% p.a. and a cost of Rs.600/-.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-004-153/2008-09

Shri V.L.Joseph
Vs
United India Insurance Co.Ltd.

AWARD DATED 30.09.2008

The complainant is covered under a mediclaim policy since 2004. On 2.1.2007, he was taken to Karothukuzhi Hospital due to chest pain and then he was referred to Lissie Hospital, where he was admitted and treated up to 9.1.2007 diagnosing heart disease. The claim for sum assured of Rs.25,000/- was repudiated by the insurer invoking Cl.4.1 of policy condition on the ground that he was hypertensive.

The decision of insurer to repudiate the claim was mainly based on the hospital record which stated that he was hypertensive for 8 years. But it was stated by the insured that he never had hypertension and he has not taken any medicines for hypertension before undergoing treatment for heart disease in 2007. It is relevant to note that in the hospital records also, it is not stated that he was taking treatment for hypertension. It merely states that he is hypertensive for 8 years. Even if it is assumed that he is hypertensive, it cannot be taken as pre-existing disease, as the present treatment is not for hypertension, but for heart disease. Of course, hypertension may be a risk factor for CAD, but as per policy condition, only the pre-existing diseases are excluded and not the risk factor. Of course, during hospitalization, medicines might have been given for containing hypertension also. But he had incurred an expenditure of more than one lakh and the sum assured is of Rs.25,000/-. In the self contained note also, there is no case that hypertension is a pre-existing disease, but it is described only as a pre-disposing factor. As the pre-disposing factors are not excluded as per policy condition, the insured is eligible to get the claim amount. An award is, therefore, passed directing the insurer to pay the amount of Rs.25,000/- with 8% interest and a cost of Rs.1,000/-.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI.

Complaint No.IO/KCH/GI/11-005-136/2008-09

V.Raju

Vs
The Oriental Insurance Co.Ltd.

Award Dated 26.09.2008

The complainant and his family members were covered under a mediclaim policy of The Oriental Insurance Co.Ltd. The complainant's daughter was admitted and treated in Benziger Hospital for 5 days from 14.12.2007 incurring an expense of Rs.7,549/-. But they allowed only Rs.5,000/-. As per Cl.1.2[a] of policy condition, eligible amount of reimbursement under the head of room boarding and nursing expenses is only Rs.5,000/- per day or 1% of the SA whichever is less. As the policy was for a sum assured of Rs.50,000/-, the complainant is eligible for only Rs.500/- per day under the head room, boarding and nursing expenses. The insurance company allowed that much amount and only the balance amount is disallowed. As the insurer has allowed the maximum payable as per policy condition, the complainant is not eligible to get any more amount and the compliant is therefore DISMISSED.

KOLKATA

Medical/Mediclaim Policy

Kolkata Ombudsman Centre
Case No. 613/14/003/NL/01/2007-08
Shri Sanjoy Kumar Chatterjee
Vs.
National Insurance Company Ltd.

Order Dated : 28.11.2008
Facts & Submissions :

This petition was in respect of delay in settlement of a claim under Individual Mediclaim Insurance Policy issued by National Insurance Company Ltd.

The petitioner, Shri Sanjoy Kumar Chatterjee stated that he along with wife was covered by a Mediclaim Policy from 29.01.2007 to 28.01.2008. His wife Smt. Parijat Chatterjee was hospitalized on 23.07.2007 and diagnosed there upto 24.07.2007 for excision of biopsy done under LA. He lodged a claim for Rs.2,556/- to the insurance company which was not paid in spite of repeated requests. Therefore, he approached this forum for redressal of his grievance seeking monetary relief of Rs.2,556/-.

The insurance company in their self-contained note stated that the claim was repudiated by their TPA on the ground that the excision done as an OPD in lieu of hospitalization. The claim had been disallowed under policy clause 4.10 in respect of any expenses whatsoever incurred by the insured person in connection with or in respect of charges incurred at hospital or nursing home primarily for diagnostic X-Ray or Laboratory examinations not consistent with or incidental to

the diagnosis and treatment of the positive existence or presence of any ailment, sickness or injury, for which confinement was required at a Hosptial/ Nursing Home.

Decision :

This complaint had to deal with on ex-parte basis as the complainant did not attend the hearing.

As the insurance company had finally directed the TPA to settle the claim as per the original advice of the doctor for admission to the hospital, it was felt that the same would have been paid immediately. However, the insurance company was directed by the Hon'ble Ombudsman to pay and settle the claim immediately.

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Kolkata Ombudsman Centre
Case No. 077/11/002/NL/05/2008-09
Shri Seth Prasad Shaw
Vs.
The New India Assurance Co. Ltd.

Order Dated : 31.10.2008
Facts & Submissions :

This petition was against repudiation of claim under Individual Mediclaim Policy issued by The New India Assurance Company Ltd. on the ground that that the disease contracted within 30 days of inception of policy i.e. exclusion clause no. 4.3.

The petitioner Shri Seth Prasad Shaw stated that he along with his family members was covered by a Mediclaim policy for the period 09.07.2007 to 08.07.2008. His wife Smt. Rita Shaw underwent cataract operation on 12.07.2007 and he lodged a claim for Rs.24,500/- with the insurance company which was repudiated by the TPA of the insurance company under exclusion clause 4.2 and 4.3 of the policy. He represented against the decision of the insurance company and requested for reconsideration of his claim but his appeal was not considered by them. Therefore, he approached this forum for redressal of his grievance seeking monetary relief of Rs.24,500/-.

The insurance company in their self-contained note dated 09.07.2008 stated that Smt. Rita Shaw was admitted in B.B.Eye Foundation, Kolkata for urgent Phaco operation on left eye. The disease detected as per Discharge Summary was Traumatic Cataract. As per policy condition 4.3 during the first year of the insurance cover the expenses on treatment of disease such as cataract was not payable.

Decision:

On going through Butterworths Medical Dictionary, it was found that Traumatic cataract meant cataract that arose due to a wound or injury. In this case it was clear that the patient's suffered an injury and due to which the eye lens was disturbed and an operation was necessitated. There was no cataract existing in the eye and therefore, it was an operation of eye to improve the vision after injury.

Hon'ble Ombudsman did not agree with the arguments set forth by the insurance company with regard to repudiation of the claim as the policy exclusion clause 4.2 & 4.3 could not be invoked as the patient underwent an eye surgery due to an injury. "Cataract per se" which naturally occurred was excluded in the first year of the policy and not a *"Traumatic Cataract"*. Therefore, he directed the insurance company to pay and settle y the claim.

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Kolkata Ombudsman Centre
Case No. 081/14/003/NL/05/2008-09
Smt. Smriti Bhattacharya (Misra)
Vs.
National Insurance Company Ltd.

Order Dated : 16.10.2008
Facts & Submissions :

This petition was against delay in settlement of claim under Individual Mediclaim Policy issued by National Insurance Company Limited.

The petitioner Smt. Smriti Bhattacharya (Mishra) stated that she along with her son was covered under mediclaim insurance policy from 06.03.2002 which was renewed upto 05.03.2009. In the year 2006 she and her husband took separate policies for income tax purpose. Her son Shri Souratirtha Misra was hospitalized in Apollo Gleneagles Hospital from 27.03.2005 to 03.04.2005. They diagnosed the disease as Jejunal resection. In the 5th year of the policy he was again admitted in Jaslok Hospital and Research Centre, Mumbai and Smt. Motiben B.Dalvi Hospital, Mumbai for treatment of abdominal Pain. On 31.10.2006 a claim for Rs.1,00,092/- was lodged to the TPA of the insurance company M/s MdIndia Healthcare Services (P) Ltd. The TPA of the insurance company wanted previous history of treatment and also entire case papers and day to day treatment chart which she could not submit and clarified why those papers could not be submitted. In spite of repeated requests the payment was not received by her. Therefore after 1 year 4 months she approached this forum for redressal of her grievance seeking monetary relief of Rs.1,00,092/-.

The insurance did not provide any self-contained note, as sought.

Decision :

Since the grievance of the complainant had been satisfactorily redressed, it was felt that no further intervention called for in this case. However, the complainant had the right to revert back to this forum if she did not receive the claim cheque before 31.10.2008, as directed by the Hon'ble Ombudsman.

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Kolkata Ombudsman Centre
Case No. 089/11/008/NL/05/2008-09
Shri Barun Kanti Saha
Vs.
Royal Sundaram Alliance Insurance Co. Ltd.

Order Dated : 16.10.2008
Facts & Submissions :

This petition was in respect of repudiation of a claim on the ground that cataract was not payable during the first two years of the policy under Health Shield Insurance policy.

The petitioner, Shri Barun Kanti Saha stated that he took a Health Shield Insurance Policy from Royal Sundaram Alliance Insurance Company Ltd. for the period 19.10.2006 to 18.10.2007. He was hospitalized for cataract operation in Disha Eye Hospitals & research Centre Pvt. Ltd. Barrackpore, Kolkata on 03.08.2007 and released on the same day. He lodged a claim for Rs.12,800/- to the insurance company but the claim was repudiated by the insurance company on the ground that cataract was not payable during first two years of the operation of the policy. He represented to the insurance company stating that he was covered with various insurance companies without any break but the insurance company clarified vide their letter dated 03.12.2007 that other companies policies could not be treated as renewal policy as per their policy terms and conditions. The insurance company reviewed the claim and reiterated their earlier decision of repudiation. Being aggrieved, the complainant approached this forum for redressal of his grievance seeking monetary relief of Rs.12,800/-

The insurance company in their self-contained note stated that the insured had claimed the expenses for cataract surgery which took place on 03.08.2007. The insurance company repudiated the claim by invoking 2 years exclusion clause.

Decision :

It was clear that the insured was having policy since 16.11.2003 without a break. However, he changed the company from The New India Assurance Company to the Oriental Insurance Company Ltd. and later to Royal Sundaram Alliance Insurance Company Limited. The insured should not be denied the benefits that had been accrued under the policy. Hon'ble Ombudsman did not agree with the arguments of the insurance company that the policy taken from their company was a fresh policy. Therefore, Hon'ble Ombudsman held that the policy was continuous one and directed the insurance company to pay the claim as per policy terms and conditions.

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Kolkata Ombudsman Centre

Case No. 090/14/003/NL/05/2008-09
Shri Sankar Prosad Ghosh
Vs.
National Insurance Company Ltd.

Order Dated : 23.10.2008
Facts & Submissions :

This petition was against delay in settlement of claim under Individual Mediclaim Policy issued by National Insurance Company Limited.

The petitioner, Shri Sankar Prosad Ghosh stated that he along with his wife were covered under a mediclaim policy for the period 18.02.2006 to 17.02.2007. Previous policy was valid upto 17.02.2006. His wife Smt. Jharna Ghosh was hospitalized in Rabindra Nath Tagore International Institute of Cardiac Sciences from 04.02.2007 to 06.02.2007 for complaint of chest pain and she was diagnosed as Triple Vessel Coronary Artery disease. She underwent angiogram on 05.02.2007 and he submitted a claim for Rs.31,610/- with the TPA of the insurance company on 07.02.2007. In spite of repeated requests the claim was not settled. Being aggrieved by the delay he approached this forum for redressal of his grievance seeking monetary relief of Rs.31,610/-.

The insurance company did not provide any self-contained after repeated reminders.

Decision:

On going through the records that a diagnosis had been made, investigations and tests had been done to confirm such diagnosis and a conservative treatment followed. Therefore, it was clear that the policy condition 4.10 as was existed in February 2002 should be applicable and the insurance company was not correct in invoking the policy condition 4.10. Hon'ble Ombudsman stated that the reasons advanced in the internal correspondence as per the letter dated 19.09.2008 for repudiation of the claim as untenable. He directed the insurance company to pay the claims as per the policy terms and conditions

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Kolkata Ombudsman Centre
Case No. 092/11/003/NL/05/2008-09
Shri Rabindra Nath Bhattacharjee
Vs.
National Insurance Company Ltd.

Order Dated : 16.10.2008
Facts & Submissions :

This petition was against repudiation of claim under Individual Mediclaim Policy issued by National Insurance Company Limited as the illness fell under first year policy as per exclusion clause 4.3 of the policy.

The petitioner Shri Rabindra Nath Bhattacharjee stated that he along with his family members was covered under policy for the period 01.06.2007 to 31.05.2007. As his wife Smt. Susmita Bhattacharjee felt acute pain in her left Arm, Dr. T.K.Biswas suggested operation of infected Sebaceous Cyst. Accordingly she was hospitalized in Spondon Diagnostic & Nursing Home from 16.08.2007 to 18.08.2007. He submitted a claim for Rs.5,358/- to the TPA of the insurance company, but the same was repudiated by them on the ground of first year exclusion (4.3). He represented to the insurance company for reconsidering their decision which was not considered by the insurance company. Being aggrieved, the complainant approached this forum for redressal of his grievance seeking monetary relief of Rs.5,358/-.

The insurance company did not provide any after repeated reminders.

Decision ::

On going through the policy condition 4.3 it was clear that any benign lump or growth was not covered within first two years of the policy period. Here it was a clear case of a cyst in the left arm of the patient. Therefore, it had been correctly treated as benign growth in any part of the body and the insurance company was correct in deciding that the claim was not payable. Here repudiation had not been done on the basis of pre-existing clause but only on the basis of 4.3 being an exclusion clause.

Hon'ble Ombudsman upheld the decision of repudiation of the insurance company.

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Kolkata Ombudsman Centre
Case No. 097/11/008/NL/05/2008-09
Shri Sundeep Agarwal
Vs.
Royal Sundaram Alliance Insurance Co. Ltd.

Order Dated : 16.10.2008
Facts & Submissions :

This petition was in respect of repudiation a claim on the ground of 'pre-existing' disease under Health Shield Insurance policy issued by Royal Sundaram Alliance Insurance Company Ltd.

The petitioner Shri Sundeep Agarwal stated that he along with his wife was covered under Policy for the period from 30.07.2007 to 29.07.2008. His wife Smt. Shilpa Agarwal was hospitalized in Belle Vue Clinic from 17.02.2008 to 21.02.2008 for treatment of heavy continuous menstrual bleeding. She had Laparoscopic Myomectomy followed by removal of specimen by Morcelation. She was diagnosed with heavy continuous bleeding due to Fibroid uterus. He lodged a claim for Rs.47,194/- which was repudiated by the insurance company stating that the fibroid was bigger it had developed before the inception of the policy. The complainant contended that they were not aware of the existence of fibroid. Only during the pregnancy test it was detected in the USG. More over his wife was covered under a mediclaim policy with United India Insurance Co. Ltd. from 30.07.2005 to 29.07.2006. If the policy was renewed from 29.07.2006 the policy would have been for 3 years. He also stated that maternity claim was settled on 05.09.2007 and only during pregnancy fibroid was detected. He represented to the insurance company but they did not consider the same. Therefore, he approached this forum for redressal of his grievance seeking monetary compensation of Rs.47,194/- plus damages for Rs.5,000/-.

According to the self-contained note the insured was having the policy for the period 30.07.2007 to 29.07.2008. A claim was made for Laparoscopic Myomectomy for the period 17.02.2008 to 21.02.2008. Based on the opinion of the panel doctor the insurance company repudiated the claim.

Decision :

It was found that the insured was having the policy from 30.07.2003 to 29.07.2006 and it was renewed with Royal Sundaram later on. Hon'ble Ombudsman did not find any reason how the insurance company treated the disease as pre-existing with the panel doctor's opinion clearly stated that multiple fibroids could not develop over 5 months duration. The operation was done in February 2008 on the report of USG dated 15.12.2006 i.e., nearly after one year. Even if it was considered the date of existence of sub serous fibroids from 15.12.2006, 5 months period which was only an estimate fell in July 2006. Apart from this a mediclaim policy was taken by the insured from United India Insurance Company Ltd. for the period 30.07.2005 to 29.07.2006. Under no stretch of imagination the fibroid detected in December 2006 could be treated as pre-existing. The whole interpretation was based on surmises and not on any irrefutable evidence.

Hon'ble Ombudsman held that the reasons given by the insurance company for taking a decision of repudiation were untenable. Therefore, he held that the claim was payable. Hence, he directed the insurance company to pay the claim as per the policy terms and conditions.

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Kolkata Ombudsman Centre
Case No. 102/11/003/NL/05/2008-0909
Shri Abhijit Kundu
Vs.
National Insurance Company Ltd.

Order Dated : 23.10.2008
Facts & Submissions :

This petition was against repudiation of claim under Individual Mediclaim Policy issued by National Insurance Company Limited as per exclusion clause 4.10 of the policy that the treatment taken in the hospital for investigation purpose only.

The petitioner Shri Abhijit Kundu stated that he along with his wife were covered under policy for the period 24.10.2006 to 23.10.2007 (previous policy renewed upto 23.10.2006). His wife Smt. Mithu Kundu was hospitalized in AMRI Hospital on 31.07.2007 with acute pain in lower abdomen and discharged on 05.08.2007. The final diagnosis was acute pain abdomen (Right iliac fossa region). He submitted a claim for Rs.21,544/- to the insurance company which was repudiated by the TPA of the insurance company on the ground that the hospitalization was done for investigation purpose only. He represented to the insurance company for review of their decision, but his appeal was not considered by them. Being aggrieved, the complainant approached this forum for redressal of his grievance seeking monetary relief of Rs.21,544/-.

According to the self-contained note they repudiated the claim by invoking the exclusion clause No. 4.10.

Decision:

On going through the treatment summary it was found that diagnosis was acute pain in the abdomen (right iliac fossa region) and they conducted tests and investigations with regard to the same and treated the patient conservatively. Therefore, according to them exclusion clause 4.10 as was existed before the inception of the policy should apply. According to that policy condition after diagnosis was made any investigations and tests conducted to confirm the diagnosis and treated would not fall under the exclusion clause 4.10 Therefore, Hon'ble Ombudsman of the firm opinion that the reasons given by the insurance company in taking the decision of repudiation were not tenable. Hence, Hon'ble Ombudsman was directed the insurance company to pay and settle the claim as per the policy terms and conditions.

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Kolkata Ombudsman Centre
Case No. 220/11/005/NL/06/2008-09
Smt. Anjana Chanda
Vs.
The Oriental Insurance Company Ltd..

Order Dated : 28.11.2008
Facts & Submissions :

This petition was against repudiation of claim under Individual Mediclaim Policy issued by the Oriental Insurance Company Ltd. on the ground of "pre-existing" disease as per Exclusion Clause No.4.1 of the policy.

The petitioner, Smt. Anjana Chanda stated that she was covered under Group Mediclaim policy No. 311603/2007/639 for the period 31.07.2006 to 30.07.2007. She was hospitalized in ILS Multispeciality Clinic, Kolkata from 26.05.2007 to 27.05.2007 for treatment of Menopausal Bleeding for 6 days and Fibroid Uterus. She lodged a claim for Rs.15,038/- with the insurance company on 12.07.2007 but the same was repudiated by the insurance company on the ground of pre-existing disease as per exclusion clause 4.1 of the policy. She had also stated that she was insured with NICL by an individual mediclaim policy for 15 years for Rs.1,12,800/- (including 50% C.B), and this fact was intimated to the insurance company. The TPA informed that this was a non-disclosure as she already had a policy. She represented to the insurance company for reconsideration of her claim but the same was not considered. Hence she approached this forum for redressal of her grievance seeking monetary compensation of Rs.4,296/- considering ratable proportion of total amount of policy.

The insurance company in their self-contained note dated 30.10.2008 stated that since this was first year policy with the Oriental Insurance Company Ltd. and as they did not have any knowledge about the policy with National Insurance Company Ltd., it was treated as first year policy and repudiated the same. They also explained that the policy with National was still being renewed and so their policy could not be treated as a continuous policy. However, if it was treated as a continuous policy, then the amount for which the policy was taken from them was an additional sum insured.

Contribution Clause of the policy, according to the insurer was applicable when the claim was admissible in both policies. They contended that since the claim was not admissible under their policy, the question of applying Contribution Clause did not arise.

Decision:

Keeping in view the exception to the policy condition 4.2 and 4.3 that policy should be treated as continuous policy, Hon'ble Ombudsman was of the opinion that the policy taken with Oriental Insurance Company Ltd. was deemed to be continuous policy that had been existed with National Insurance Company Limited. Therefore, the policy condition 4.3 could no more be invoked. However, the offer of pro-rata basis payment was acceptable as it was only the ratio between total cover under National Insurance Company Ltd and total cover under the Oriental Insurance Company Ltd. as both were parallel insurance contracts taken by the insured. Therefore, he directed the Insurance Company Ltd. to pay the pro-rata amount of Rs.4,296/- (Four thousand two hundred ninety six) only as policy condition 4..3 was no more operative.

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Kolkata Ombudsman Centre
Case No. 221/11/005/NL/06/2008-09
Shri Sanjay Sutradhar
Vs.
The Oriental Insurance Company Ltd.

Order Dated : 21.11.2008
Facts & Submissions :

This petition was against repudiation of claim under Individual Mediclaim Policy issued by the Oriental Insurance Company Ltd. on the ground of "pre-existing" disease as per exclusion clause 4.1 and congenital external disease 4.8 of the policy.

The petitioner Shri Sanjay Sutradhar stated that he along with his family members were covered for the period 27.11.2006 to 26.11.2007. His daughter Miss Shruti Sutradhar was hospitalized in National Institute of mental Health & Neuro Sciences, Bangalore from 13.04.2007 to 28.04.2007 for treatment of Epilepticus. He lodged a claim with the insurance company but the claim was repudiated by the TPA of the insurance company on the ground of pre-existing disease (4.1) and congenital external disease (4.8) of the policy. The complainant explained that the child did experience Febrile Convulsion at the age of 3 months whereas policy was taken at the age of 1 year 4 months but every Febrile Convulsion ultimately did not lead to Epilepticus. Many children all over world experienced convulsions at high temperature which subsided with age. Epilepticus could develop for some other problems later on. His appeal for reconsideration of his claim was not considered by the insurance company. Hence he approached this forum for redressal of his grievance seeking relief of Rs.20,329/-.

The insurance company in their self-contained note dt.13.10.2008 stated that they had agreed with the decision of the panel doctor and based on his opinion they repudiated the claim. In the Discharge Summary it was mentioned that the patient had a history of seizure since the age of 3 months.

Decision :

Hon'ble Ombudsman agreed with the arguments of the complainant with regard to the fact that Febrile Convulsion could not be treated as existence of disease called Epilepticus. However there was definitely suppression of material facts with regard to not mentioning of surgical procedure and therefore, there was suppression of material facts at the time of inception of the policy because of this non mentioning of surgical procedure the contract between insurance company and the insured was undermined the right to underwrite a premium payable was affected.

Hon'ble Ombudsman held that the terms of contract were vitiated due to suppression of material facts in the proposal form submitted before the inception of the policy. Therefore, he upheld the repudiation decision of the insurance company.

Kolkata Ombudsman Centre
Case No. 223/11/002/NL/06/2008-09
Sri Sankar Bagchi
Vs.
The New India Assurance Company Ltd.

Order Dated : 17.11.2008
Facts & Submissions :

This petition was against repudiation of a claim on the ground of "pre-existing" disease under exclusion clause 4.1 of the policy.

The petitioner, Shri Sankar Bagchi stated that his sister Miss Manu Bagchi was covered under policy for the period 21.05.2007 to 20.05.2008. His sister was hospitalized in Aparna Nursing Home, Kolkata from 02.01.2008 to 15.01.2008 for pain in abdomen. He lodged a claim for Rs.14,060/- with the insurance company which was repudiated by the TPA of the insurance company M/s Medicare TPA Services (I) Pvt. Ltd. on the ground of 'pre-existing' disease. He represented to the insurance company for review of the claim but his appeal was not considered by them. Therefore, he approached this forum for redressal of his grievance seeking relief of Rs.14,060/-.

The insurance company in their self-contained note dated 25.08.2008 made the following observations in respect of repudiation of the claim.

a) As per USG report, "Gall Bladder" was distended, thick-walled, multiple echogenic foci seen which could not develop within six and half month after taking 1st policy.
b) As per USG report Uterus was operated and ovaries would not be traced i.e., were operated before taking the policy but insured did not declare the same when taking the aforesaid policy.

Decision:

From the above it was clear that though there was no irrefutable proof of existence of gall bladder problem before the inception of the policy. However, it was clear that the proposer did not mention the surgical procedure with regard to uterus operation before the inception of the policy.

Therefore, it clearly proved that the insured did not mention the important information with regard to operation of the uterus and hence there was suppression of material fact in the proposal form. In the light of the above Hon'ble Ombudsman upheld the decision of repudiation.

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Kolkata Ombudsman Centre
Case No. 224/11/003/NL/06/2008-09
Smt. Minati Nandi
Vs.
National Insurance Company Ltd.

Order Dated : 28.11.2008
Facts & Submissions :

This petition was against repudiation of claim under Individual Mediclaim Policy issued by National Insurance Company Ltd. on the ground that the claim fell under the first year exclusion clause of the policy.

The petitioner Smt. Minati Nandi stated that she along with her son and daughter were covered under mediclaim policy No. 100300/48/06/8500003633 for the period 15.01.2007 to 14.01.2008. She was admitted in Medical College and Hospital, Kolkata on 19.02.2008 for treatment of Menorrhagia and operation was done on 21.02.2008. She lodged a claim for Rs.17,000/- with the insurance company which was repudiated by the insurance company on the ground of first year exclusion. She represented to the insurance company for reconsideration of her claim but the same was not considered by the insurance company. Therefore, she approached this forum for redressal of her grievance seeking relief of Rs.17,000/-

The insurance company did not send any self-contained, after repeated reminders.

DECISION:

The cashless facility was correctly denied as the operation of Menorrhagia was covered by the policy exclusion clause No. 4.3. However, the expenses for operation done on 21.02.2008 could not reimburse as there was no policy cover.

Hon'ble Ombudsman upheld the decision of repudiation.

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Kolkata Ombudsman Centre
Case No. 225/11/008/NL/06/2008-09
Shri Ravi Kant Poddar
Vs.
Royal Sundaram Alliance Insurance Co. Ltd.

Order Dated : 26.11.2008
Facts & Submissions :

This petition was in respect of repudiation a claim on the ground of pre-existing disease under Health Shield Insurance policy issued by Royal Sundaram Alliance Insurance Company Ltd.

The original petition was lodged by the petitioner with the Insurance Ombudsman, Uttar Pradesh & Uttaranchal and subsequently the same had been transferred to Insurance Ombudsman, Kolkata. The petitioner Shri Ravi Kant Poddar stated that he was covered under Health Shield Insurance policy for the period from 22.03.2007 to 21.03.2008. He was hospitalized from 03.12.2007 to 06.12.2007 with complaint of ulcer in left lateral aspect of tongue anteriorly in Prince Aly Khan Hospital. Glossectomy was done under G.A. He lodged a claim for Rs.74,520/- with the insurance company which was repudiated by the insurance company stating that Carcinoma of tongue could not develop within 8 months from the inception of the policy on 22.03.2007. Hence the claim was repudiated on the ground of pre-existing disease. He approached to the Office of Insurance Ombudsman, Uttar Pradesh & Uttaranchal who sent the file to us that Royal Sundaram Alliance Insurance Company Limited objected on the ground that the complainant was residing at Kolkata and the policy was not issued from any where in Uttar Pradesh or Uttaranchal. Therefore, the file was sent to this office. It was observed that in respect of his appeal for reconsideration of his claim but the insurance company did not take any favourable decision. Therefore, he approached Ombudsman Office for redressal of his grievance seeking monetary compensation of Rs.74,520/- plus post hospitalization expenses.

The insurance company in their self-contained note dated 28.05.2008 to the Office of the Insurance Ombudsman Lucknow had mentioned that 'squamous carcinoma of tongue' requiring wide Glossectomy could not develop over 8 months. Hence the claim was inadmissible and payable on the ground of pre-existing disease. Further a self-contained note was called for which was submitted on 17.11.2008.

Decision:

On going through the documents available it was found that the insurance company did not have irrefutable proof for existence of Carcinoma of the tongue before the inception of the policy. Obviously the disclaimer clause was not applicable as the petition has been filed before the Ombudsman within the time limit mentioned the disclaimer clause. As there is no irrefutable proof of existence to a disease or irrefutable proof that the patient was in the knowledge or not of the disease or symptoms before the inception of the policy, it was felt that that the arguments given by the insurance company for taking a decision of repudiation were not tenable.

Hon'ble Ombudsman directed the insurance company to pay the claim.

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Kolkata Ombudsman Centre
Case No. 226/11/002/NL/06/2008-09
Sri Kartik Sinha Ray
Vs.
The New India Assurance Company Ltd.

Order Dated : 28.11.2008
Facts & Submissions :

This petition was against repudiation of claim under Individual Mediclaim Policy issued by

The New India Assurance Company Ltd. under exclusion clause 4.7 of the policy.

The petitioner Shri Kartik Sinha Ray stated that he along with his wife was covered for the period 28.09.2007 to 27.09.2008. His wife Smt. Tripti Sinha Ray was hospitalized in Ballygunge Maternity & Nursing Home for surgical extraction of '6' under LA & conservative procedures to prevent Meslal & Distal migration of '5' & '7' done due to want of which patient would suffer from severe malocclusion in the lower jaw on right side leading to inefficient chewing & mastication for the period 16.10.2007 to 17.10.2007. He lodged a claim for Rs.18,800/- with the insurance company but his claim was repudiated by the TPA M/s Medicare TPA Services (I) Pvt. Ltd. with the remarks *"surgical extraction under local anesthesia does not require in house treatment and as per policy exclusion 4.7 this claim is not payable".* He represented to the insurance company for review of his claim but his appeal was not considered by them. Hence he approached this forum for redressal of his grievance without mentioning any quantum of relief in the 'P' form details.

The insurance company in their self-contained note dated 18.08.2008 stated that the surgeon fee for Rs.18,000/- paid to Dr. G.R.Ashok was not payable as receipt is on the letter head of Ramakrishna Dental Care & Research Centre Pvt. Ltd., whereas the patient got treated at Ballygunge Maternity & Nursing Home. As per the policy condition 2.3 surgeon fee must be included in the hospital bill and they were ready to settle the claim partially.

Decision:

It was clear that the insured was not in the knowledge that the policy condition had been changed for the first time and that the bill which was being enclosed along with the claim should be from the hospital wherein the surgery took place.

Keeping in view that the complainant was not in the knowledge that the policy condition had already been changed for the mediclaim cover period in which the claim arose and also keeping in view that the doctor had to necessarily issue a receipt only through his organization and treating the case as rarest of rare cases, Hon'ble Ombudsman proposed to give benefit of doubt to the complainant.

Therefore, he directed the insurance company to pay the claim.

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Kolkata Ombudsman Centre
Case No. 240/14/003/NL/06/2008-09
Shri Omprakash Roy
Vs.
National Insurance Company Ltd.

Order Dated : 28.11.2008
Facts & Submissions :

This petition was in respect of delay in settlement of claim under Individual Mediclaim Insurance policy issued by National Insurance Company Ltd.

The petitioner, Shri Omprakash Roy stated that he along with his family members were covered under mediclaim policy for the period 24.03.2007 to 23.03.2008. His wife Smt. Sandhya Roy was hospitalized from 29.01.2008 to 30.12.2008 in AMRI, Kolkata with complaints of pain in both legs more in the left leg and short term loss of memory for 4 days. She lodged a claim for Rs.23,938/- with the TPA of the insurance company M/s MDIndia Health Care Services (P) Ltd. on 12.03.2008 but the claim was not paid. He wrote to the National Insurance Company, Midnapore Divisional Office and also to their Head Office at Kolkata for settlement of the claim but he did not receive any reply from them. Therefore, he approached this forum for redressal of his grievance seeking monetary compensation for Rs.23,938/-.

The insurance company did not provide any self-contained note, after repeated reminders.

Decision :

Since there was only a few minutes difference for reckoning it as one day, Hon'ble Ombudsmane directed the insurance company to settle the claim and pay the claim.

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Kolkata Ombudsman Centre
Case No. 247/11/005/NL/06/2008-09
Shri Sunil Kumar Jaiswal
Vs.
The Oriental Insurance Company Ltd.

Order Dated : 21.11.2008
Facts & Submissions :

This petition was in respect of partial repudiation of a claim under Individual Mediclaim Insurance Policy issued by The Oriental Insurance Company Ltd.

The petitioner Shri Sunil Kumar Jaiswal stated that he along with his family members were covered under a mediclaim policy for the period 15.09.2006 to 14.09.2007. He was hospitalized in Uma Medical Related Institute (P) Ltd., Kolkata from 19.05.2007 to 22.05.2007 with complaints of pain in leg and difficulty in walking. He lodged a claim for Rs.23,952/- but the claim was settled for Rs.3,600/-. He represented to the insurance company for the balance amount but the same was not paid. Hence, he approached this forum for redressal of his grievance seeking monetary relief of Rs.19,660/-.

The TPA of the insurance company M/s Heritage Health Services Pvt. Ltd. submitted the break-up of the expenses disallowed as under vide their letter dated 11.03.2008:-

"1. Rs.14,700/- on Bill No. 0 dated 22.07.2007 (Physiotherapist) for not Applicable Bills.
2. Rs.201.50 on Bill No. 9754 dated 08.07.2007 (Medicines by shop) for no prescription.
3. Rs.180/- on bill No. 103 dated 03.07.2007 (X-Ray) for referred by Homeopathy doctor – not payable.
4. Rs.1590/- on bill No. 102 dated 03.07.2007 (Laboratory) for referred by Homeopathy doctor – not payable.
5. Rs.1680/- on bill No. 102 dated 03.07.2007 (Biochemistry) for referred by Homeopathy doctor – not payable.
6. Rs.2000/- on bill No. 0 dated 10.06.2007 (Doctor/RMO/Duty Doctor) for paid for Homeopathy not payable."

Decision:

From the above details it could be seen that there was some confusion with regard to disallowance of some portion of expenditure claimed by the complainant. The insurance company was directed by the Hon'ble Ombudsman to verify as per their policy conditions for the policy period 15.09.2006 to 14.09.2007, whether the claim expenses were reimbursable. If so, they are directed to reconsider the claim and pay the amount as per the policy terms and conditions.

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SYNOPSIS OF FOURTH QUARTER STARTING FROM JANUARY 2009 – MARCH 2009 PERTAINING TO AWARD/RECOMMENDATION/ORDER AGAINST NON-LIFE CASES PASSED BY HON'BLE OMBUDSMAN, KOLKATA

Medical/Mediclaim Policy

Kolkata Ombudsman Centre
Case No. 281/11/002/NL/07/2008-2009
Shri Palash Kumar Mukherjee
Vs.

The New India Assurance Co. Ltd.

Order Dated : 05.01.2009

Facts & Submissions :

This complaint was filed against repudiation of a claim on the ground that the subject claim arose within 4 days from the date of inception of the policy under Mediclaim Insurance Policy.

The petitioner, Shri Palash Kumar Mukherjee stated that he was having a Mediclaim Insurance Policy with the New India Assurance Co. Ltd. covering self and spouse with Sum Insured of 95,000/- and Rs.45,000/- respectively for the period 16.07.2007 to 15.07.2008. He also stated that he was a member of Group Mediclaim Hospitalization Benefit Scheme till 31.8.07 which was taken by his employer for its retired employees from United India Insurance Co. Ltd. Suddenly he felt chest pain on 18.7.2007 and as per Dr.'s advice dt.20.7.2007, he underwent Angioplasty on 30.7.2007. After completion of treatment he applied for reimbursement of Medical Expenses, but the same was denied by the TPA of the Insurance Company vide their letter dt.27.11.2007 on the ground that the policy was treated as a new policy and onset of the disease was within 4 days from the date of inception of the policy.

The insurance company stated that he was admitted at Rabindranath Tagore International Institute of Cardiac Sciences on 20.7.07 for Coronary Angiogram and on 29.7.08 for Coronary Artery Disease and was discharged on 21.7.07 and 2.8.07 respectively. He submitted all the documents for reimbursement. On scrutiny, it was found that the declaration made by the Insured at the time of taking the policy from the New India Assurance Co. Ltd that previously he was covered by a Group Mediclaim Policy with United India Insurance Co. Ltd. which he did not disclose and thus there had been breach of the doctrine of utmost good faith. The insurance company on the other hand issued an Individual Mediclaim policy for the period 16.7.07 to 15.7.08 with an Endorsement on 26.7.2007 mentioning that the subject policy would be treated as New Policy, as there was a break in continuation. They also reiterated their stand that the TPA had rightly repudiated the claim as the same being under a fresh policy and onset of the disease was within 4 days from the inception of the policy.

Decision :

On going through the facts as mentioned above, it was clear that the policy was incepted from 16.7.2007 and continuity of the policy could not be granted as the Group Mediclaim Policy held between the United Bank of India and the United Insurance Co. Ltd. was terminated w.e.f. 1.4.2007.

Hon'ble Ombudsman felt that the insurance company was correct in repudiating the claim.

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Kolkata Ombudsman Centre
Case No. 257/11/005/NL/07/2008-09
Shri Ramesh Kumar Sureka
Vs.
The Oriental Insurance Co. Ltd.

Order Dated : 09.01.2009

Facts & Submissions :

This complaint was filed against repudiation of claim on the ground that the disease was excluded in the first year and first two years of insurance which fell under Exclusion Clause No. 4.3 of the Mediclaim Insurance policy.

The petitioner, Shri Ramesh Kumar Surekha stated that his wife Smt. Susma Surekha was covered by a Mediclaim Policy. She underwent a surgery on 13.06.2007 and lodged claim on 23.06.2007 along with all the relevant documents for reimbursement after completion of her treatment. The claim was repudiated on the ground that the subject disease had already been excluded in the first year and first two years of insurance under Clause No.4.3 of the Mediclaim Policy. He represented against the decision of the insurance company. In the year 2002-03 there was a break in continuation of the policy by 25 days due to change in code of the agent. After that the said policy was continued as usual upto 2005-06 without any break. Again in the year 2006-07 there was a break in continuation of the policy by 4 days. Otherwise the said policy was a continuous one. He issued the cheque to the agent's representative on 20.11.2006. He was not informed about delay in depositing the same. Further, the complainant stated that if it was a new policy, the company should have sought fresh proposal form and Medical Certificate from him. He further represented his case citing the above stated points to the Manager, Grievance Cell of the Insurance Company on 17.01.2008, but of no avail.

The Insurance Company stated that based on the decision of repudiation made by their TPA, they repudiated the claim. They opined that the subject claim fell under exclusion clause No.4.3 which stated that the disease was excluded in the first year and first two years from first commencement of risk of the policy. Since there was a gap in continuation of policy under Policy by 4 days for the period from 24.11.2006 to 23.11.2007, the same would be considered as 1st year policy. Therefore, the disease 'MENORRHAGIA' was excluded from the scope of cover in the first and two years from the scope of cover under Policy condition No.4.3.

Decision :

Merely, because of break of 4 days the insured should not lose all the benefits available for continuous policy, keeping in view of very short span of delay, Hon'ble Ombudsamn

condoned the same and treated the policy as being existed continuously. Hon'ble Ombudsman directed the Insurance Company to settle the claim as the break in continuation of the policy had already been condoned without precedence in future.

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Kolkata Ombudsman Centre
Case No. 381/11/003/NL/08/2008-2009
Smt. Shyamali Sarkar
Vs.
National Insurance Co. Ltd.

Order Dated : 20.01.2009

Facts & Submissions :

This complaint has been filed against repudiation of claim under Individual Mediclaim Insurance policy.

The petitioner, Smt. Shyamali Sarkar stated that since 24.9.2001 she was having a Mediclaim Policy alongwith her husband and daughter with National Insurance Co. Ltd. and the said policy was renewed upto 22.9.2008 without any interruption. In the year 2005, she switched over from National Insurance Co. Ltd. to United India Insurance Co.Ltd. for a period of one year from 23.09.2005 to 30.08.2006 under a tailor-made Group Medical Policy. The said policy was issued for a lesser period of 23 days with an exorbitant premium charged by the United India. Due to such anomaly, she again switched over to National Insurance Co. Ltd. D. O. XII, w.e.f. 23.9.2006 for an Individual Mediclaim Policy for a period of one year. By that time her husband was hospitalized at AMRI Hospital on 5.5.2007 as per advice of the attending physician. He was discharged on 13.6.2007 with a treatment expense of Rs.2,68,640/-. As per request of the complainant the hospitalization expenses had been reduced to Rs.1,78,020/- by the hospital authority. Therefore, she submitted the claim of her husband for Rs.1,78,020/- for reimbursement to the insurance company. But the insurance company repudiated the claim on the ground of pre-existing disease under Exclusion Clause No.4.1 and the subject policy under which the claim arose had been treated as fresh policy with a gap of 23 days in continuation of earlier policy.

The Insurance Company in their self-contained note dt.28.11.2008 stated that the complainant submitted a proposal form for having a Mediclaim policy on 30.8.2006. On the basis of such proposal form the insurance company issued the policy to her and the spouse and daughter for the period 23.09.2006 to 22.09.2007. The Mediclaim Policy was renewed after a gap of 23 days. They also stated that the patient was a known case of ankylosing spondylosis. He had been treated conservatively for his abdominal distension. Various relevant investigations had been done such as St X-ray abdomen, USG, CT Scan abdomen during the present hospitalization which was according to them was related to a pre-existing disease. The insurance company also stated that the subject claim was repudiated on the ground that there was a gap of 23 days in continuity of the policy. Any break in policy would generally entail a policy to be treated as fresh policy and therefore would attract Exclusion Clause No.4.1 of the policy conditions.

Decision :

On going through the records, Hon'ble Ombudsman felt that this was a fit case for condonation of delay of 23 days. However, the proposal form was a paramount document to underwrite the policy and therefore, non-mentioning of previous ailments or previous claims would vitiate the contract. However, there was no intimation or records from where it could be ascertained that the

diseases had existed prior to 24.09.2001 when the original Mediclaim Policy was taken with the Oriental Insurance Co. Ltd. However, the Discharge Summary indicated that the patient was a known case of Abdominal Distension and for Rectal Piles.

Non-mentioning of any health problems and claims made previously, in the proposal form would definitely make the contract void. He agreed with the decision of repudiation made by the insurance company.

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Kolkata Ombudsman Centre
Case No. 358/11/002/NL/08/2008-09
Shri Mohan Lal Puri
Vs.
The New India Assurance Co. Ltd.

Order Dated : 06.02.2009

Facts & Submissions :

This complaint was filed against repudiation of a claim on the ground that damage indicated on Echocardiogram could not occur in a span of one year under Mediclaim Insurance Policy.

The petitioner, Shri Mohan Lal Puri stated that he was having a Mediclaim Insurance Policy with the New India Assurance Co. Ltd. for the period 02.11.2007 to 01.11.2008 covering self, spouse and two sons. He further stated that his wife Smt. Sudha Puri was hospitalized at B.M. Birla Research Centre on 8th January, 2008 with Chest pain (retrosternal) for 20 hours and diagnosed there and she was discharged on 16.01.2008. He submitted a claim for Rs.76,085/- on her wife's behalf on 29.02.2008 for reimbursement. The insurance company repudiated the claim on the ground that the ailment indicated on Echocardiogram could not occur within a span of one year. He represented against the decision of the insurance company on 19.5.2008 against repudiation of the claim.

The insurance company stated that the complainant was covered under an individual mediclaim policy consisting of self, spouse and two sons for the 1st time since inception starting from 2.11.2006 to 1.11.2007. During the second year of policy his wife, Smt. Sudha Puri got admitted at B. M. Birla Heart Research Centre with chest pain and diagnosed there. During the course of her treatment it was found that she was a known patient of Hypertension for 1 year which was not declared in the proposal form. Echo report also revealed that she had LVEF of 55%. On the basis of doctor's report they repudiated the claim as pre-existing disease which attracted policy exclusion clause no.4.1.

Decision :

According to Hon'ble Ombudsman the insurance company was unable to adduce irrefutable proof that the patient was having a disease, before inception of the policy. The hypertension and LVEF were only symptoms of the disease and that too had been found to be in existence for one year only and therefore, the same could not be treated as pre-existing disease before inception of the policy as the policy was more than one year old.

Hon’ble Ombudsman opined that the claim was exigible and therefore, he directed the insurance company to pay the claim within the frame work of the terms and conditions of the policy.

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Kolkata Ombudsman Centre
Case No. 403/11/002/NL/08/2008-09
SHRI JIM EDWARD D'CRUZ
Vs.
The New India Assurance Co. Ltd.

Order Dated : 12.02.2009

Facts & Submissions :

This complaint was filed against partial settlement claim under Mediclaim Insurance Policy issued by the New India Assurance Co. Ltd., Howrah Division.

The petitioner, SHRI JIM EDWARD D'CRUZ stated that he was having a Mediclaim Insurance Policy with the New India Assurance Co. Ltd. for the period 9.11.2007 to 8.11.2008 covering self, spouse and daughter. He further stated that his wife, Smt. Eileen D'cruz underwent cataract operation in the right eye at Samariton Clinic (P) Ltd. on 31.12.2007. Immediately after completion of operation the complainant paid an amount of Rs.17,000/- in cash to Dr.Vijay Pahwa, the attending surgeon. To this effect a bill was issued for Rs.17,000/- as professional charges. The next day i. e. 1.1.2008 the patient was released from the said clinic and he had to pay Rs.4,633/- as nursing charges to the hospital authorities. A claim for Rs.22,353.75 for reimbursement was received by the insurance authorities on 04.02.2008. The TPA of the insurance company settled the claim only for Rs.7,518/- and disallowed Rs.14,000/- as surgeon's fees.

The insurance company stated that the complainant had lodged a claim for Rs.22,354/- for hospitalization of his wife as she underwent cataract operation of her Rt. Eye at Samariton Clinic (P) Ltd. on 01.01.2008. The TPA had considered and settled the claim for Rs.7,518/-. The insurance company also provided the break-up against deductions made by them to the insured. In all they deducted Rs.14,836 from the total claim amount of Rs.22,354/-.

Decision :

On going through the doctor's bill given in the letter pad, Hon'ble Ombudsman found that the complainant had paid Rs.17,000/- which included Rs.14,000/- as doctor's fees, Rs.1,000/- as anaesthesia charges and Rs.2,000/- as miscellaneous charges. However, he found from the break-up that had already been settled included anaesthesia charges and miscellaneous charges, only doctor's fees was not allowed. He did not find any logic when the new condition was introduced in August, 2007 had to be applied, why only doctor's fee was disallowed.

However, keeping in view the new policy condition and that the complainant was not aware of the change in the Mediclaim Policy, agreeing with the decision of repudiation by the insurance company, he proposed to deal with the matter on ex-gratia basis to meet the ends of justice. Therefore, as a rarest of the rare cases, he directed the insurance company to pay ex-gratia of Rs.14,000/- which would meet the ends of justice.

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Kolkata Ombudsman Centre
Case No. 336/14/003/NL/07/2008-09
Shri Pradip Chakraborti
Vs.
National Insurance Company Ltd.

Order Dated : 09.03.2009
Facts & Submissions :

This petition was in respect of delay in settlement of claim under Individual Mediclaim Policy issued by National Insurance Company Limited.

The petitioner, Shri Pradip Chakraborty stated that he had a mediclaim policy of National Insurance Company Ltd. for the period 02.08.2006 to 01.08.2007. He was admitted in Kurji Holy Family Hospital, Patna, Bihar on 03.10.2006 to remove implant in right elbow and operated upon on the next day and he was released on 08.10.2006 from the hospital. He preferred his claim with the said insurance company on 06.11.2006 and his claim is still lying with the insurance company. He repeatedly visited the office of the insurance company and followed up over phone but of no avail. On 25.04.2007 he was told that the cheque was despatched from Hyderabad but local office had not received. On 27.08.2007 he had directly contacted FHPL – Hyderabad office and enquired about the status of his claim when he was informed that the payment was pending for release of fund from insurance company. He had also taken up the matter with the Sr. Divisional Manager of National Insurance Company Ltd. and lastly it was revealed that NICL had failed to update his policy number to FHPL and the claim was processed with a policy number that was not valid although all his correspondences were referring actual policy number and his claim remained unsettled.

The insurance company did not provide the self contained note.

DECISION:

As the representative of the insurance company did not attend, Hon'ble Ombudsman proposed to deal with the matter on ex-parte basis.

Purely for the mistake committed by the insurance company, the complainant should not suffer. Irrespective of the fact that the correct policy number quoted or not Hon'ble Ombudsman directed the insurance company to settle and pay the claim as per policy terms and condition and also would pay penal interest @ 2% above the prevailing bank rate from the date of settlement of claim to the date of issue of cheque.

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Kolkata Ombudsman Centre
Case No. 423/11/002/NL/09/2008-09
Shri Abhijit Banerjee
Vs.
The New India Assurance Co. Ltd

Order Dated : 13.03.2009
Facts & Submissions :

This petition was against partial repudiation of claim under Janata Mediclaim Policy issued by the New India Assurance Company Ltd.

The petitioner Shri Abhijit Banerjee stated that he along with his family members were covered under the said policy for the period 14.01.2008 to 13.01.2009. He met with an accident on 27.02.2008 following which his left index finger was surgically amputed at AMRI Hospitals, Kolkata on 17.02.2008 and released on 18.02.2008. He submitted a claim for Rs.22,177/- on 02.04.2008 to the TPA of the insurance company , but the said claim had been settled by the said TPA on 14.05.2008 for Rs.14,772/- deducting Rs.7,405/-. He lodged another claim for Rs.8,000/- on 12.06.2008 towards cost of artificial limbs which was repudiated by the TPA of the insurance company on 14.08.2008. He represented to the insurance company on 26.05.2008 and 03.09.2008 for payment of the above claims but his appeal was not considered.

The insurance company stated that the surgery was treated as intermediate surgery and accordingly the amounts that had to be payable were allowed. Accordingly, they had not paid an amount of Rs.2,766/-. An amount of Rs.8,000/- was not paid by invoking policy condition 4.4.4 as the complainant got an external prosthetic devices for his finger which was amputed.

DECISION:

As the representative of the insurance company did not attend, Hon'ble Ombudsman proposed to deal with the matter on ex-parte basis.

The complainant had produced a Hospital Bill No.IPCS 38311 issued by AMRI Hospitals wherein it was mentioned that major OT2 was booked for the complainant for operation. Hon'ble Ombudsman was satisfied with the explanation given by the complainant that surgery undertaken had to be categorized as a major surgery and therefore amounts that had been deducted for

Anesthetist, Surgeon fees and O.T charges should be reimbursed. This amount was Rs.2,700/-. In short the total amount of Rs.2,766/- should be reimbursed as the same is to be treated as major surgery and not intermediate surgery.

With regard to the second claim of Rs.8,000/-, he tend to agree with the decision of the insurance company that the complainant had purchased an external prosthetic device for his finger which had been amputed. The condition 4.4.4 had been correctly invoked as the prosthetic finger could not be treated as replacement of limbs. As the limbs were defined only as the two legs and two hands, therefore, the insurance company was directed to pay an amount of Rs.2,766/- (Rupees Two Thousand Sixty Six) only as mentioned above as per terms and conditions of the policy.

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LUCKNOW

Lucknow Ombudsman Centre
Case No.G-39/11/11/08-09
Shri.Inderjit Salwan
Vs
Bajaj Allianz General Insurance Co. Ltd..

Award Dated : 19.12.2008
Complaint filed against Bajaj Allianz General Insurance Co. Ltd. by Shri.Inderjit Salwan in respect of rejecting his claim for treatment of his wife.

Facts : Shri.Inderjit Salwan, had taken a Mediguard policy for self and wife with Bajaj Allianz General Insurance Co. Ltd. for the period 1.12.06 to 30.11.07. His wife underwent an operation for Hysterectomy for fibroid uterus at BEAMS Hospital on 13.1.08. She was further treated in Ganga Ram Hospital from 25.1.08 for acute pulmonary edema. The total bill submitted by the insured was Rs.2,37,110/-. The claim was settled for Rs.66548/- but the balance of Rs.170562/- was repudiated on the ground that the said treatment is for hysterectomy which is an exception under the policy during the first 2 years of the policy. Aggrieved with the decision of the insurer the claimant approached this forum giving rise to the complaint.

Findings : On careful examination of all the documents the forum found that the insured has been taking the above policy for the periods:13.7.03 to 12.7.04; 13.7.04 to 1.7.05; 13.7.05 to 12.7.06. However there was a break of about 5 months between 12.7.06 and the date of renewal of the policy i.e.1.12.06. Therefore as per insurance practice the policy should be considered as a fresh policy from 1.12.06. As such the policy excludes treatment for hysterectomy during the first two years of the policy. However the insured has submitted that he had not renewed the policy due to some impending dispute about a claim and after the matter was subsequently sorted out; he renewed the policy resulting in

this long gap. Apart from the above the insured had produced an e-mail wherein he had requested the company clearly mentioning the policy details and the nature of operation to be performed, to inform him the formalities to be completed to get cashless treatment. To this the company has responded that the cashless facility will not be available at BEAMS but asked him to settle the bill and submit the claim for reimbursement without mentioning the policy condition which misled the insured that the claim will be reimbursed.

Decision: Held that the policy will be considered as a fresh policy and treatment of hysterectomy is therefore an exception as per policy condition. As such the claim is not tenable. However, the communication in which the company had assured him that the claim will be reimbursed has made the insured erroneously believe that the claim would be payable. Had he been informed at that time itself about the policy condition he would have been prepared because as an ordinary man we cannot expect him to be aware of this exclusion. Therefore in view of the above circumstances, the insured was awarded an EX-gratia of Rs.50,000/-.

Lucknow Ombudsman Centre
Case No.G-47/11/04/08-09
Shri.Rajesh Lal
Vs
United India Insurance Co. Ltd..

Award Dated : 2.1.2009

Complaint filed against United India Insurance Co. Ltd. by Shri.Rajesh Lal in respect of repudiation of his Mediclaim in respect of treatment of his wife.

Facts : Shri.Rajesh Lal, had taken a mediclaim policy for self and wife with United India Insurance Co. Ltd. for the period 4.9.06 to 3.9.07. His wife had developed osteoarthritis for which she was treated at Cartigen Health Care Pvt. Ltd. Bangalore from 16.1.07 to 5.2.07. The total cost of the treatment had come to Rs.1,20,000/-. The respondent through its TPA repudiated the claim on the ground that the treatment is on outpatient basis and it was taken in a clinic not fulfilling the criteria for hospital as per policy condition. Aggrieved with the decision of the insurer the claimant approached this forum giving rise to the complaint.

Findings : On careful examination of all the documents the forum found that the insured has been taking the above policy since last six years. The treatment of PFQMR was taken in Cartigen Health Care Pvt. Ltd. Bangalore. The respondent had relied on a circular issued by their Regional office wherein it was clarified that the said treatment does not require inpatient admission into a hospital. On going through the clause 2.1 of the policy it is clear that the above treatment centre does not fulfill the criteria for hospital. Even as per records the above health care is not registered either as a nursing home or hospital. However the insured had produced a letter addressed to the TPA wherein he had elaborated the proposed nature of treatment and details of Cartigen Health Care Pvt. Ltd.

Bangalore and sought their advice about the above treatment and whether it could be covered under the policy coverage. This fact has been confirmed by the Divisional office of the company also. But when the insured did not receive any advice from the TPA he went ahead with the treatment.

Decision: Held that the treatment undertaken by the wife of the complainant does not fall within the coverage of mediclaim policy. However, the circumstances in which the insured went ahead to undergo treatment shows negligence on the part of the TPA. Had the TPA given advises to the insured in time probably he would not have entailed the above expenditure. After the treatment when the bill is submitted, the decision of the TPA to repudiate the claim is unfortunate. Therefore in view of the above circumstances, the insured was awarded an EX-gratia of Rs.60,000/-.

MUMBAI

MUMBAI OMBUDSMAN CENTRE

Complaint No. GI – 685 of 2008-2009
Award No. IO/MUM/A/ 434 /2008-2009
Complainant: Shri Achut Parsharam Kakirde
VS.
Respondent: National Insurance Company Limited

AWARD DATED 24.02.2009

Shri Achut Parsharam Kakirde was covered under a mediclaim Policy No.250300/48/04/8504763 taken from National Insurance Company Ltd. for the period 04.02.2005 to 03.02.2006 for sum insured Rs.50,000/- with cumulative bonus of Rs.5,000/-. The inception of the policy with the Insurer was from 2003. Shri Kakirde was was hospitalized at Dr. Chandorkar Hospital from 09.01.2006 to 12.01.2006 for Left Inguina Hernia. He preferred a claim with the Company for Rs.21,655/- which was repudiated by the TPA, E-Medilink Solutions Ltd. vide their letter dated 21.07.2006. under clause 4.1 as pre-existing disease.

The documents produced at this Forum have been examined. Shri A.P. Kakirde had taken a mediclaim policy for sum insured Rs.50,000/- from 09.01.2001 to 08.01.2002 with The New India Assurance Company Limited and continued the policy till 08.01.2003. Thereafter, he took a mediclaim policy from National Insurance Co. Ltd. for sum insured Rs.50,000/- for the period 03.02.2003 to 02.02.2004. He was hospitalized in Dr. Chandorkar Hospital from 09.01.2006 to 12.01.2006 for Left Inguina Hernia. He submitted a claim to the company for the said hospitalization. The TPA repudiated the claim stating that as per the discharge card of Dr. Chandorkar Hospital, he was diagnosed as left inguinal recurrent hernia and under went left inguinal hernioplasty. As per the history notes, he was operated for bilateral hernia on 16.01.2001. At that time he was covered under New India Insurance Individual Mediclaim policy and the policy

period was from 09.01.2001 to 08.01.2002. He later shifted to National Insurance Company from 03.02.2003 (date of inception). According to them there was gap of 1 year and 1 month. However, on producing the copy of policy document for the period 09.01.2002 to 08.01.2003, it is found that there is a gap of 25 days between the renewals of his policy with National Insurance Co. Ltd. In addition the National Insurance Company has not condoned the gap and considered the policy as a fresh insurance. Shri Kakirde was hospitalized for left inguinal hernia, which was diagnosed and treated on 16.01.2001. During the hearing, Shri Karkirde also admitted that he had undergone bilateral hernia on 16.01.2001. Hence the present hospitalization for Left Inguinal Hernia from 09.01.2006 to 12.01.2006 was considered as pre-existing disease and the claim was repudiated by the Company under Exclusion Clause 4.1 of the policy terms and conditions.

Under the facts and circumstances of the case and under the policy terms and conditions, the rejection of the claim under Exclusion Clause 4.1 by National Insurance Company Ltd. is tenable.

MUMBAI OMBUDSMAN CENTRE

Complaint No. GI – 689 of 2007-2008
Award No. IO/MUM/A/ 457/2008-2009
Complainant: Dinesh H. Shah
VS.
Respondent: The Oriental Insurance Company Limited

AWARD DATED 9.3.2009

Shri Haribhai Shah was covered under a Mediclaim Policy The exclusion under the policy was for Pre existing disease "Byepass Surgery". The policy period was from 22.07.2006 to 21.07.2007. The inception of the policy with the Company was from 2001. Earlier he was insured with United India Insurance Co. Ltd. with cumulative bonus of Rs.7,750/-. Shri Haribhai Shah had earlier undergone Bypass Surgery in the year 1997. He was hospitalized in Bharatiya Arogya Nidhi Hospital from 28.01.2007 to 05.02.2007 and the diagnosis was Left MCA Acute Infarct. He lodged a claim forRs.63,973/- with the Insurer which was repudiated by the TPA, stating that the present claim is for Left MCA

Acute Infarct and all ailments relating to Bypass surgery are excluded from the scope of the policy As all ailments relating to bypass surgery are excluded from the scope of the policy, the present ailment is one of the complications of the earlier bypass surgery and the claim is also not admissible as per terms and conditions of the policy.

As the present ailment is one of the complications of the earlier Bypass surgery performed in 1997, the claim is also not admissible as per terms and conditions of the policy. The pathology which caused cardiac disease and Bypass surgery was done is same for Left MCA Infarct. Also Left MCA Acute Infarct is one of the complications of old cardiac ailment. As Bypass surgery and its complications are also excluded, hence the claim is not admissible as per exclusion clause 4.1 pre-existing diseases. Shri Haribhai Shah was covered under the good health policy from 2004 where all pre-existing diseases were covered if there were no claims for 4 years without any break in renewal of the policy. However, the good health policy was discontinued in 2006 and he renewed his policy under the individual mediclaim policy. The Insurance Company may be technically correct in repudiating the claim but looking at the age of the Insured i.e. 82+ years and his policy is with the Company from 2001 with cumulative bonus of Rs.87,750/- for the policy year 22.07.2006 to 21.07.2007, I am inclined to grant him an ex-gratia payment of Rs.30,000/- for the present hospitalization. However, this payment should not be taken as a precedent to any claim in future, under the exclusion of ailments mentioned in the policy bond.

MUMBAI OMBUDSMAN CENTRE

Complaint No. GI - 656 of 2008-2009
Award No. IO/MUM/A/ 455 /2008-2009
Complainant : Mariya Saifuddin Molai
V/s
Respondent : The New India Assurance Company Limited, DO 142000.

AWARD DATED 09.03.2009

Shri Saifuddin A. Molai alongwith his wife Smt. Mariya S. Molai and children were insured under mediclaim policy issued by The New India Assurance Company Limited from 09.12.2007 to 08.12.2008 He was insured for Rs.1.00 lac with 20% cumulative bonus. The inception of the policy was from 09.12.2003. Shri Saifuddin A. Molai was admitted to Mediheights Healthcare Pvt. Ltd. on 27.07.2008 at 6.30 P.M. with complaints of severe abdominal pain. He was later transferred to Bharatiya Arogya Nidhi Hospital on the same day i.e. on 27.07.2008 at 10.00 P.M.. He expired on 28.07.2007 at 11.00 A.M.. The Cause of Death was Acute Pancreatitis Sepsis related Multi Organ Failure. The Company repudiated the claim invoking clause 4.4.6. stating that the cause of death was acute pancreatitis sepsis related MOF. They stated that as per the indoor case papers, patient is chronic alcoholic with k/c/o HTN, this claim stands non payable under clause 4.4.6 – "General debility, congenital external disease, sterility, use of intoxicating drugs/alcohol".

On going through the documents submitted at this Forum, Shri Saifuddin Molai was first admitted to Mediheights Healthcare Pvt. Ltd. on 27.07.2008 at 7.00 P.M. On admission the notes and treatment sheet of the hospital states c/o severe abdominal pain. Since yesterday, multiple episodes of vomiting – radiation to the back. H/o chronic alcohol consumption. He was discharged on the same day at 10.30 P.M. and was shifted to Bharatiya Arogya Nidhi Hospital from Mediheight Hospital and on admission the symptoms noted was Acute Renal Failure with Septicemia due to Pancreatitis with acute respiratory failure k/c/o chronic ALD and polycythamid O/E breathlessness . Put on respirator. The past history mentioned is H/o alcohol and tobacco. The treatment

sheet of the hospital dated 27.07.2008 at 10.30 P.M. recorded by Dr. Nilesh states 51 yr. old male brought by relatives with cardiac ambulance transferred from Mediheights Hospital – presented with acute renal failure, septicemia due to pancreatitis – details not available. GP done 6 months back. Check up shows infection in pancreas. Chronic alcoholic as well as tobacco chewer. K/c/o HTN on Tab Amplopin 5 mg. B.P. not recordable. On 28.07.2008 he was seen by Dr. Samir Pandya and had recorded as 51 yr male – Alcoholic liver disease with pancreatitis with Septicemia with ARF. No urine output. The patient was under the treatment of Dr. S. Parikh and other doctors. The patient was attended by various doctors with the same observations. From both the hospital papers it is clear that patient was a chronic alcoholic and in the habit of chewing tobacco. Shri Molai had a cardiac arrest on 28.07.2008 at 10.40 p.m. and he expired on 28.07.2008 at 11.00 A.M. The cause of death noted as Acute pancreatic sepsis related and multiorgan failure, but the cause of death is not mentioned due to cardiac arrest only.

Let us examine the cause of Pancreatitis. According to the Medical Guide Report "Alcohol abuse and gallstones are the two main causes of pancreatitis". The symptoms of pancreatitis is the pain is usually centered in the upper middle or upper left part of the abdomen. The pain may feel as if it radiates through to the back. They have trouble breathing and are given oxygen."

It is evident from the medical papers that the patient was alcoholic. The cause of death as reported in the Municipal Death Certificate was due to Acute Pancreatitis and sepsis related multi organ failure. The patient had undergone an electrocardiogram on 26.07.2008 i.e. one day before hospitalization in Mediheights Hospital. The Report was mentioned as "WNL" (Within Normal Limit)". The Company has rejected the claim based on the history that the patient was chronic alcoholic. The history noted in the hospital just can't be set aside, as it is given for the better management of the disease. In mediclaim policy it is not necessary to prove the reason for pancreatitis. Therefore the contention of the complainant that there are many reasons for pancreatitis, other than alcohol, is not tenable. However, the present treatment is not directly related to alcohol, in view of the above, it will be appropriate to allow 80% of the admissible expenses to settle the dispute in the present case.

MUMBAI OMBUDSMAN CENTRE
Complaint No.GI-469 of 2008-2009
Award No.IO/MUM/A/ 490 /2008-2009
Complainant : Shri Dhiren Mull
V/s.
Respondent : The New India Assurance Co. Ltd.

AWARD DATED 26.03.2009

Shri Dhiren Mull was covered under the mediclaim Policy for sum insured Rs.5 lakhs, issued by The New India Assurance Co. Ltd.. He was first covered under the Goodhealth policy from The New India Assurance Company Limited from 01.08.1999. The Policy was converted to Individual Mediclaim Policy from 01.08.2007 under the same Insurer. He had preferred a claim for Rs.23,000/- for Right Eye Vitreous Hemorrhage undergone on 15.11.2007 at Bombay City Eye Institute & Research Centre. TPA repudiated the claim stating that in the present claim as per the OPD letter of Bombay City Eye Institute the history of Diabetes Mellitus and Hypertension is mentioned as 10 years. As DM and HT is a direct proximate cause for the present ailment and both falls prior to inception of policy, hence this ailment is prior to inception of policy and therefore pre-existing, they have repudiated the claim under clause 4.1 of the policy exclusions.

As advised by Ombudsman during the hearing Shri Dhirem Mull produced on certain medical reports that were taken on 12.01.2002 before his cataract operation in 2002. As per the FBS report his Sugar Count on fasting was normal. His PLBS was however above the normal range. During the hearing Shri Dhiren Mull admitted that he came to know about his diabetes only during this time when he underwent his first cataract operation in 2002.

The documents produced at this Forum have been perused. The inception of the policy with The New India Assurance Company Limited was from 01.08.1999 under a Group policy. It was later converted to an individual policy from 01.08.2006 with the same Insurer. The complainant during the hearing stated that the Insurer had settled two earlier claims. He produced as evidence the claim settlement advice. The 1st claim was settled on 19.04.2002 for Rs.31,380/- and the 2nd claim was settled on 30.01.2007 for Rs.39,450/-. Both the claims were settled for Cataract Operation. He underwent Right Eye Vitrectomy and Endolaser Surgery on 15.11.2007 at Bombay City Eye Institute & Research Centre. He submitted a claim for the said surgery for which the TPA repudiated the claim stating that as per the OPD letter dated 31.03.2008 of the said hospital he was having history of Diabetes Mellitus and Hypertention since 10 years and therefore the ailments were pre-existing and falls prior to inception of the policy and therefore was non payable under clause 4.1 of the policy terms and conditions. It is well known that before any surgery certain medical reports are obtained and the Complainant has also provided evidence that the Company has settled two earlier claims for Cataract Operations. During the hearing, the representative of the Company has stated that as the policy was converted from Group mediclaim policy to Individual mediclaim policy from 2007, the policy is treated as a fresh policy. However, according to an internal circular of the Company, the policy is to be treated in continuity in respect of policy condition 4.1. However, this circular does not mention any retrospective date or prospective date. Since the policy has been continued since 1999 with the same Company, the benefit of the continuity of the policy should be given to the Insured. In the facts of the case, the repudiation of claim by the Insurer is not tenable.

MUMBAI OMBUDSMAN OFFICE
Complaint No. GI-490 (08-09)
Award No. IO/MUM/A / 439 / 2008-2009
Complainant: Smt. Abhilasha R. Shah
V/s.
Respondent: The National Insurance Co. Ltd., DO 260500

AWARD DATED 25.02.2009

Smt. Abhilasha R. Shah had submitted a claim to The National Insurance Co. Ltd. for the hospitalization of her husband Shri Ravindra Natwarlal Shah at Harkissondas Hospital from 07.12.2006 to 15.12.2006. He expired on 15.12.2006. The policy period was from 25.04.2006 to 24.04.2007. The complainant preferred a claim for Rs.2,40,309/-. After much follow-up with the Insurer and complaint made to IRDA, the Company settled the claim by making a payment of Rs.1,87,448/- as the Company had received documents for Rs.2,31,127/- only. They deducted an amount of Rs.43,229/- as Bulk Medicine, Rs.100/- as Registration fees and Rs.350/- as Miscellaneous. Her dispute with the Company was the quantum of claim settlement.

The National Insurance Co. Ltd. sent a letter dated 18.02.2009 to this Forum informing that the hospital bill only has been settled by TPA deducting certain amounts where the bills were not available. The Complainant has also vide his letter dated 20.02.2009, submitted copies of documents and the copies of hospital treatment papers.

It is clear that the TPA had lost the original documents and after obtaining the duplicate copies of the documents, the amount of Rs.1,87,448/- was settled after deducting the above amount of Rs.52,659/-. Even though the complainant had submitted all the original

documents immediately for settlement of claim, but the claim was not settled in time. He had also approached the IRDA for their intervention in the matter and finally had to approach this Forum for justice. The bulk medicine bill was raised by the hospital and had the TPA asked for the details, the complainant would have provided the details. Now after the lapse of more than two years, there is no point in asking the details from the Hospital. The complainant had also submitted the indoor case papers where the medicines have been prescribed. In view of the above, the company should pay the amount of Rs.52,659/- to the complainant without raising any further query. There is inordinate delay in claim payment and therefore the Insurer to pay the interest for delayed settlement of the claim from one month after submission of claim papers i.e. 09.01.2007 to the date of payment of the claim amount at the rate of 8% per annum simple interest.

MUMBAI OMBUDSMAN CENTRE

Complaint No. GI – 593 of 2008-2009
Award No. IO/MUM/A/ 426 /2008-2009
Complainant: Mrs. Judith C. D'Souza
VS.
Respondent: Royal Sundaram Alliance Insurance Company Ltd.

AWARD DATED 17.02.2009

Mrs. Judith C. D'Souza and her son Mr. Jonathan Albert D'Souza were covered under a Health Shield Double Protect Insurance Policy bearing No. HE00106677000100 taken from Royal Sundaram Alliance Insurance Co. Ltd. for sum insured Rs.2.00 lakhs each. The policy period is from 03.03.2007 to 02.03.2009. Mr. Jonathan Albert D'Souza was hospitalized at P.D. Hinduja Hospital from 13.07.2008 to 16.07.2008 for treatment of "Bilateral Maxillary and Ethmoidal Sinusitis". Mrs. Judith

D'Souza preferred a claim to the Company for Rs.41,193.74 which was repudiated vide their letter dated 22.09.2008 under clause 2 – Two Year Exclusions.

The documents produced at this Forum have been examined. According to the Discharge Summary of Hinduja Hospital it is mentioned B/L sinonasal polyporis, c/o nasal block, headache, h/o nasal Sx. The Department of Imaging signed by Dr. Asif A. Monin, MD and Dr. Sanjay N. Jain, MD, mentions the clinical profile as Headache. The CT: Paranasal Sinuses (Coronal) (Plan) "Inflammatory soft tissue is seen in both maxillary and ethmoid sinuses. Frontal and sphenoid sinuses reveal no focal muscosal abnormality. Both osteomeatal complexes are normal. Bony nasal septum is in midline. Middle Inferior turbinates appear normal. There are no Haller cells or concha bullosa. Superior, inferior oblique fissures, clinoid process and optic canals are normal. The bony walls of orbits and paranasal sinuses are intact including lamina papyraceae. Orbital fissures appear normal. The Impresssion : Findings are suggestive of Bilateral Maxillary & Ethmoidal Sinusitis.

The Company rejected the claim as the patient got admitted for sinus with nasal polyp which is not covered during the first two years of operation of the policy.

The policy commenced from 03.03.2007. As the hospitalization was from 13.07.2008 to 16.07.2008 for Bilateral Maxillary and Ethmoidal Sinusitis, which is excluded in the Two Year Exclusions clause of policy terms and conditions, the claim was rejected as it was outside the scope and purview of the policy. The claim was denied.

MUMBAI OMBUDSMAN CENTRE

Complaint No. GI – 667 of 2008-2009
Award No. IO/MUM/A/ 416/2008-2009
Complainant: Smt. Hirani Daulat
VS.
Respondent: The New India Assurance Co.Ltd., D.O. 141600

AWARD DATED 11.02.2009

Smt. Hirani Daulat was covered under a mediclaim Policy from The New India Assurance Co. Ltd. for sum insured Rs.50,000/- with cumulative bonus of Rs.5,000/-. The policy period is from 01.01.2007 to 31.12.2007. The inception of the policy according to the Insurer was from 2002. Smt. Hirani Daulat was hospitalized at Holy Family Hospital from 03.10.2007 to 03.01.2008 for IHD with OA Right Knee with Electrolyte Imbalance with UTI. She preferred a claim with the Company for Rs.1,80,000/- which was repudiated by the TPA, Paramount Health Services Pvt. Ltd. vide their letter dated 11.03.2008 under clause 4.1 as pre-existing disease.

The documents produced at this Forum have been examined. Mrs. Hirani Daulat was first covered under Tailor made Annual Group Hospitalization Policy for sum insured Rs.50,000/- from 01.01.1999 where all pre-existing diseases were covered. In 2001 she was hospitalized in Holy Family Hospital from 17.10.2001 to 08.11.2001 with diagnosis given in the discharge card as Neurogenic Bladder (Need Urodynamic studies). Operation (if any) – is given as OA Right knees – need replacement. This claim was paid by the Company. There was also a claim submitted in 2002 for which Expert Medico legal Consultancy was sought in which it is mentioned that "The major symptom for which the claimant was admitted was inability to walk due to severe osteoarthritis with sinusitis, which was confirmed on investigation done.", this claim was settled by New India Assurance Company Ltd. for Rs.44,484/-.

The Group policy was thereafter converted to Individual Hospitalization and Domiciliary Hospitalization Benefit Policy for the period 01.01.2003 to 31.12.2003 and was taken from National Insurance Co. Ltd. The policy from 01.01.2005 was shifted to New India Assurance Co. Ltd.. Under the Individual

Mediclaim policy for Rs.50,000/- with standard terms, conditions and exclusions. The complainant was hospitalized in Holy Family Hospital from 03.10.2007 to 03.01.2008 with diagnosis of IHD/Right OA Knee, electrolyte imbalance UTI. She submitted a claim for her above hospitalization to the Company which was rejected on the grounds as she was suffering from IHD since 6 years and Osteoarthritis since 2001 and underwent surgical operation for neurogenic bladder in 2001, in view of the said ailments and as they were pre-existing, the claim was rejected under exclusion clause 4.1 of the policy terms and conditions.

The terms and conditions under the group mediclaim policy and individual medical policy are different. In the group mediclaim policies the pre-existing diseases might have been covered but in this individual mediclaim policy, pre-existing diseases are not covered. As the policy was converted to individual mediclaim policy in 2002, hence the claim is not admissible as per exclusion clause 4.1 of the policy which excludes pre-existing ailments and its complications. The Insurance Company may be technically correct in repudiating the claim but looking at the age of the Insured i.e. 82+ years and in 1999 the same Insurance company covered the above Insured with a Tailor Made Annual Group Hospitalization policy for sum insured Rs.50,000/- and paid a claim for a similar hospitalization. From the papers and record it is not clear whether the pre-existing ailments were covered or not. When the policy was converted to Individual medical policy, no exclusion was put when they were very much aware of the hospitalization of 2001. In the facts and circumstances, the rejection of this claim under the pretext of exclusion 4.1 is not justified and

the total rejection is set aside and 80% of the expenses of the sum Insured under the policy was awarded.

MUMBAI OMBUDSMAN CENTRE
Complaint No.GI-694 of 2008-2009
Award No.IO/MUM/A/ 422 /2008-2009
Complainant : Shri Sadanand Gangadhar Naik
V/s.
Respondent : United India Insurance Company Ltd.

AWARD DATED 16.02.2009

Shri Sadanand Gangadhar Naik alongwith his wife Smt. Geeta Naik was covered under the mediclaim policy No.120500/48/06/20/00000290 from 26.08.2006 to 25.08.2007 for sum insured Rs.1.5 lakhs each. The TPA repudiated the claim under pre existing condition clause 4.1.

On analysis of the documents Smt. Geeta Naik was admitted to Vintage Hospital, Panaji, Goa, from on 01.12.2006 to 05.1.2006. The diagnosis given was "Severe Mirtral Stenosis, Rheumatic heart disease". The History stated was – c/o high grade fever : 3 days, H/o productive cough, H/o dypspnoea, breathlessness. She was shifted on 05.12.2006 from Vintage Hospital to Apollo Victor Hospital on 05.12.2006 for further management. As per the Discharge Summary of Apollo Hospital, the diagnosis stated are – "Rheumatic Heart Disease, Severe Mitral Stenosis, Severe Pulmonary Hypertension, Percutaneous Balloon Mitral Valvotomy Performed". The History stated was "Patient was admitted at a private hospital on 01.12.2006 with history of fever and breathlessness of 4 days duration. She was diagnosed to have moderately severe mitral stenosis with respiratory tract infection with pulmonary edema. She was referred here for further management. No history of diabetes mellitus or hypertension". The course in the hospital is mentioned as "Patient underwent emergency percutaneous balloon mitral valvotomy on 05.12.2006. Post procedure echo revealed mitral value area of 1.8 cm^2.

The Insurer repudiated the claim stating that the t hospitalization is for the management of an ailment which is related to a pre-existing condition clause 4.1 based on the opinion of the cardiologist. As per the history noted in the discharge card. there is no mention that the disease was pre-existing. No where in the record/documents produced at this Forum, date or year is given when the Insured had this ailment. The TPA had called for the previous treatment papers but the complainant has denied of having taken treatment. In the absence of any such evidence, the case was referred to a

renowned cardiologist Shri P. Seshagiri Rao of Hyderabad and based on his findings the TPA doctors arrived at the conclusion of pre-existing disease. It is unfortunate that when the complaint had approached the Insurance Company, they have not looked into the grievance properly by going into the details. Even during the hearing it was informed that once the case is rejected by the TPA, they can't do any thing, as the claims are decided by the TPA. I hope the Head Office/RM will take appropriate steps to ensure that the Grievance Cell of the Company looks into such cases abinitio before the complainant approaches the Ombudsman. The complainant has requested to look into the case from clause 4.2 Note (b) where it was stated that insured has not consulted any Doctor or taken any treatment or medication for the current problem of hospitalization before the inception of the policy, the clause 4.1 will not be applicable. Here it is to be noted that in this note there is an "AND" between the two conditions. In 4.2 Note (a) and (b) are both to be satisfied and since the TPA's medical team did not agree to it, it is not fully satisfied. However, as the ailment and its symptoms were not known to the insured and in rheumatic heart disease very often the symptoms are not readily noticeable, the complainant should get some benefit of doubt. The company except for the opinion from the consultant has not produced any documents for pre-existing disease. Under the circumstances, to strike a balance, it will be appropriate to allow 75% of the claim on ex-gratia basis.

MUMBAI OMBUDSMAN CENTRE
Complaint No. GI-728 of 2008-2009
Award No. IO/MUM/A / 489 / 2008-2009
Complainant: Shri Tarsemlal Saini
V/s.
Respondent: The National Insurance Co. Ltd., D.O. 253500.

AWARD DATED 26.03.2009

Shri Tarsemlal Saini had a mediclaim Policy from National Insurance Co. Ltd. for the period 29.10.2007 to 28.10.2008 for Sum Insured Rs.2.00 lakhs with C.B. Rs.35,000/-. He was admitted in Shushrusha Heartcare Centre for the period 14.12.2007 to 22.12.2007 for Angina Pectoris. His total hospitalization expenses for the treatment of the problem was Rs.4,78,506/-. He preferred a claim to the Company for Rs.2,35,000/- i.e. the sum insured and the cumulative bonus. The Company paid Rs.1,46,900/- directly to the hospital as cashless. His dispute with the Company was for the balance payment.

The Company sent their letter dated 19th March, 2009 addressed to this forum as also copy of letter dated 23.03.2009, addressed to Shri Tarsemlal Saini. From the said letters it is noted that the payment of Rs.1,46,900 made to the insured, Shri Tarsemlal Saini under cashless hospitalization is very much in order as it is confirming to the terms, conditions and exclusions of the standard mediclaim policy. They have instructed the TPA to release only balance of Rs.200/- to the insured as shown below:-

Total Sum Insured under the Policy No. : Rs.2,00,000/-

Cumulative Bonus : Rs. 35,000/-

Total available Sum Insured for claim : Rs.2,35,000/-

	Room Rent – Maximum	Doctors' fees	Others Maximum	Total

	25% of SI (1% of SI per day)	Maximum 25% of SI	50% of SI	
Amounts Claimed	Rs.15,300/-	Rs.14,300/-	Rs.4,06,046/-	Rs.4,35,646/-
Paid by Company	Rs.15,300/-	Rs.14,300	Rs.1,17,300/-	Rs.1,46,300/-
Amount Allowed	Rs.15,300/-	Rs.14,300	Rs.1,17,500/- *	Rs.1,47,100/-

*Amount payable under head is 50% of Rs.2,35,000/- i.e. Rs.1,17,500 - hence a balance of Rs.200/- is due to the insured.

Let us examine the terms and conditions of the policy. As per policy condition 1.0 it states:

> In the event of any claim becoming admissible under this scheme, the company will pay to the insured person the amount of such expenses as would fall under different heads mentioned below and as are reasonably and necessarily incurred thereof by or on behalf of such Insured Person but not exceeding the Sum Insured in aggregate mentioned in the Schedule hereto.
>
> A. Room, Boarding, Nursing expenses as provided by the Hospital / Nursing Home. Room Rent Limit: 1% of Sum Insured per day subject to maximum of Rs.5,000/-. If admitted in IC unit: - 2% of Sum Insured per day subject to maximum of Rs.10,000/-. Overall limit under this head; 25% of Sum Insured per illness.
> B. Surgeon, Anesthetist Medical Practitioner, Consultants Specialist fees. Maximum limit per illness – 25% of Sum Insured.

C. Anesthesia, Blood Oxygen, OT charges, Surgical appliances, Medicines, drugs, Diagnostic Material and X-Ray, Dialysis, Chemotherapy, Radiotherapy, cost of pacemaker, artificial limbs and cost of stent and implant. Maximum limit per illness – 50% of Sum Insured.

As per facts of the case and on the basis of the above Policy Condition the Insurance Company has made the payment of Rs.1,46,900/- to the Insured. The balance amount of Rs.200/- is only payable.

MUMBAI OMBUDSMAN CENTRE
Complaint No. GI-762 of 2008-2009
Award No. IO/MUM/A /479/ 2008-2009
Complainant: Smt. Snehalata Wagh
V/s.
Respondent: The New India Assurance Company Limited

AWARD DATED 19.03.2009

Smt. Snehalata Wagh has a Goodhealth Policy from The New India Assurance Company Limited for the period 01.12.2007 to 20.11.2008 for Sum Insured Rs.2.00 lakhs with C.B. Rs.2,500/- with endorsement of Hospital Cash cover limit per day as Rs.400 with maximum No. of days 15. Her earlier policy for the period 01.12.2006 to 30.11.2007 was with sum insured Rs.50,000/-. The inception of the policy was from 2004. She was hospitalized in P.D. Hinduja National Hospital & Medical Research Centre for the periods 23.08.2008 to 02.09.2008 and 04.09.2008 to 23.09.2008 and diagnosed for Left Renal Mass/Left RCC with Partial Nephropathy. The insured had claimed Rs.1,60,488 towards the first hospitalization and Rs.1,03,407 towards the second hospitalization (total amounting to Rs.2,63,895). She preferred a claim to the Company for the enhanced sum insured. The Company sent her three cheques for Rs.50,000/-, Rs.4,200/- and Rs.1,800/-. According to the Company, as per the Discharge Summary, the insured was suffering from the said ailment from the year 2007, hence as per policy clause No.6.3 the TPA M/s TTK Healthcare TPA Pvt Ltd. have restricted the claim amount to Rs.50,000/- which was the sum insured opted by the insured during the year 2007. They stated that the sum insured under the current policy is Rs.2.00 lacs but for the first 11 months of the year 2007, the sum insured was Rs.50,000/- only. Based on the previous sum insured the claim was settled.

Condition 6.3 states

If the policy is to be renewed for enhanced sum insured, as a continuation of the earlier policy either with the Company or any other insurance company in India, the increased benefits are not applicable for those illnesses / diseases /

disabilities contracted / suffered during the previous policy periods, and in such cases the claim if any arises for the said illness / diseases / disability, if admitted, shall be processed subject to the Sum Insured limits applicable for the relevant previous policy period and not on the increased Sum Insured limits."

Smt. Wagh during the period 01.12.2006 to 30.11.2007 was having the Goodhealth Policy for Sum Insured for Rs.50,000/-. The next policy year she renewed her policy for an enhanced sum insured for Rs.2.00 lacs. She was hospitalized during the period February 2007. Though she submitted a claim during the next policy year with enhanced sum insured, the Company settled the claim for Rs.50,000/- with Rs.4,200/- and Rs.1,800 towards hospital cash benefit. A total of Rs.56,000/- was settled. The increased benefits are not applicable for her pre-existing ailments which she was hospitalized for in February 2007. The claim has been processed subject to the Sum Insured limits applicable for the relevant previous policy period and not on the increased Sum Insured limits.

In the facts of the case, the repudiation of claim by the Insurer for the enhanced sum assured is justified as per terms and conditions of the policy.