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**AHMEDABAD**

**OFFICE OF THE INSURANCE OMBUDSMAN (GUJARAT)**

2nd Floor, Ambica House, Nr C.U. Shah College, Ashram Road, Ahmedabad-380014

Phone : 079-27546840, 27545441 Fax : 079-27546142

**Ahmedabad Ombudsman Centre**

Case No. 11-004-0367-09

Mr. Parag S. Shah V/s. United India Insurance Co.Ltd.

**Awarded Dated 29-04-2009**

Mediclaim

The complainant's claim was repudiated on the ground that as per policy clause 1.1 that treatment was not required hospitalization and it could have been given on OPD basis.

`The Insured was diagnosed for chronic HBV infection and advised by his Doctor for 48 injection of peginterfom. The Insured who admitted for 3 days on different dates for 25 hours and amount Rs.253594/- No Bills for 10 injections costing Rs.130000/- are submitted. The treatment papers of Dr.Nilay Mehta have not mentioned advice of Hospitalization exception 27-10-07. The complainant was afraid of the complication and even threat to his life because of adverse reaction of the injection. There is no case papers or record of the Hospital which confirms adverse reaction. The treatment was such as could be carried out on OPD basis. The decision of the Insurer to repudiate the claim was up held.

**Ahmedabad Ombudsman Centre**

Case No. 11-003-0386-09

Mr. Mayank K. Patwa V/s. National Insurance Co. Ltd.

**Awarded Dated 24-04-2009**

Mediclaim

The complainant lodged mediclaim for the treatment of his son Vivek who was admitted at Sterling Hospital on 23-08-07 for treatment of frequent loss of consciousness. He was discharged on 24-08-07.

The claim was repudiated by Respondent Insurance Co. on the ground that the hospitalization was not unjustified on the opinion of their medical Referee.

The decision of the insurer to repudiate the claim was upheld as the hospitalization was mainly for diagnostic purpose which could have been carried out without hospitalization as on OPD.

**Ahmedabad Ombudsman Centre**

Case No. 11-002-0370-09

Mrs.Anandiben M. Parmar V/s. The New India Assurance Co.Ltd.

**Award Dated 6-05-2009**

The complainant and his wife had lodged Mediclaim for Hiper cloradia, cold cough, fever and for his wife spinal cord and spondylitis at Jain Panch Karma Ayurvedic Hospital at Surat.

The respondent had repudiated claim under policy exclusion 4.24 stating that the company shall not be liable to make any payment for Ayurvedic treatment i.e. massage/steam-bath/Sirodhara and alike Ayurvedic treatment.

The policy condition is very specifically stated which was breached by the complainant to repudiate the claim was upheld.

**Ahmedabad Ombudsman Centre**

Case No. 11-003-0005-10

Mr.Pravinbhai R. Shah V/s. The National Assurance Co.Ltd.

**Awarded Dated 26-05-2009**

Mediclaim

Claim was repudiated on ground of breach of policy condition 4.1 is pre-existing disease. The complainant was hospitalized during the period from 3-10-07 to 04-10-07 and 7-12-07 to 9-12-07 for coronary Artery disease. Hospitals papers mentioned duration of illness as 6 and 10 months. The complainant had mediclaim policy with the New India Assurance Co. for the

period 2004 to 2007 and thereafter in the year of 2007 with the National Insurance Co. Ltd.

It was decided to uphold the decision taken by the Respondent as the policy was for the period 12-09-07 to 11-09-08 while the insured was suffering from heart disease for 6 and 10 months before the date of hospitalization viz. 3-10-07 and 7-12-07.

Case No. 14-004-0022-10

Mr.A. R. Shah V/s. United India Insurance Co.Ltd.

**Awarded Dated 26-05-2009**

Mediclaim

Repudiation of claim on the ground of late submission of claim papers. As per policy condition 5.4, the claim must be submitted to Insurer within 30 days from discharge from the Hospital. The complainant was discharged from Hospital on 20-11-07 while the claim papers were submitted on 15-04-08. There is delay of more than 4 months from the date of issue of fitness certificate 28-11-07. As such the decision of the Respondent to repudiate the claim was upheld.

**Ahmedabad Ombudsman Centre**

Case No. 11-004-0014-10

Mr.Prabhudas B. Patel V/s. United India Insurance Co.Ltd.

**Awarded Dated 27-05-2009**

Mediclaim

The subject claim for hospitalization during the period from 17-05-08 to 24-05-08 for surgery of incisional and umbilical Hernia. The consultation papers dated 15-05-08 of Deep Dhara Nursing Home show history of operation for Acid Peptic disease.

The claim was repudiated invoking policy clause 4.1 relating to all congenital disease (Internal and external) and pre-existing disease.

It was decided that the disease was not pre-existing because if it is was pre-existing, 30 years back complainant will not wait till 2008 from treatment.

Further, there is no nexus between Acid Peptic diseases for which the complainant was operated 30 years back and umbilical Hernia for which claim has filed.

The decision of repudiation of the claim was set aside and they were directed to pay claim for Rs.31, 670/-

**Ahmedabad Ombudsman Centre**

Case No. 11-004-0030-10

Mr.Indravadan A. Patel V/s. United India Insurance Co.Ltd.

**Awarded Dated 29-05-2009**

Mediclaim

Claim was repudiated on ground of pre-existing disease as complainant had mild left Flank Pain and passing gravel in urine every 1-2 years since 1983. The complainant had taken treatment for uretaric stone and related problems since 1983.

The complainant has argued that complication of previous treatment is not applicable as he had taken treatment and was cured of the problems. It was find that present claim of the insured was for treatment of left upper renal stone is complication of disease since 1983 that goes prior to the inception of the policy. As such the complainant failed to succeed and decision of the Respondent to repudiate the claim was upheld.

Case No. 11-002-0026-10

Mrs. Sangita K. Jain V/s. The New India Insurance Co.Ltd.

**Awarded Dated 27-05-2009**

Personal Accident Claim

Widow of late Keyur M. Jain lodged claim with the Respondent. The claim was repudiated on various grounds by Respondent stating that no inquest or PM was conducted. In absence of PM Report nexus between specific cause of death and accidental injuries caused not proved. The deceased was discharged from the hospital against medical advice and he was not given any treatment for 5 days before his death. Personal Accident Policy covers death due to accident.

There was on record that on 21-12-07, the deceased who was on Bicycle knocked down by unknown vehicle and FIR was made for the accident. He was immediately got treatment at civil hospital, Gandhinagar and thereafter for further treatment he was shifted to Apollo Hospital, Ahmedabad.

On going through the policy document and treatment papers it was held that though P.M. was not done but circumstantial evidence in the form of injuries recorded in hospital treatment paper is suffice to prove death because of accidental injuries.

The policy document given reference of clause 2 of Personal Accident Policy which is also applicable to motorcycle policy issued to deceased. It is stated that is necessary report of P.M. be furnished so it is not mandatory. As such the decision of the insurer to repudiate the claim was set aside and they were directed to pay claim amount Rs.1.00 lacs.

**Ahmedabad Ombudsman Centre**

Case No. 11-004-0356-09

Mr.Nitin J. Pandya V/s. United India Insurance Co.Ltd.

**Awarded Dated 29-05-2009**

Mediclaim

The insured Master Amit Padhiyar had received treatment for Chronic Superlative Obits Media (csom) on 4-4-08. The treating Dr.N.J.Shah has confirmed that the patient was suffering from the disease since more than 3 years i.e. prior to commencement of first policy effective from 30-06-05. The claim was repudiated by invoking exclusion clause 4.1 pre-existing disease excluded from policy cover. The history of the disease was approximately 1½ years, the insured first consulted for treatment on 30-11-07 and policy was incepted from 30-6-05.

As a result of mediation by this forum both the parties agreed for settlement for sum of Rs.13, 500/-

Case No. 14-002-0351-09

Mrs.Niranjanben K. Dave V/s. The New India Assurance Co.Ltd.

**Awarded Dated 09-07-2009**

Mediclaim

75% of the claimed amount paid by the Respondent by deducting 25% from total claim alleging incorrect information about age and withholding of material information while filling the proposal form.

Complainant's argument that deduction of Rs.34, 375/- is not reasonable as age might have been incorrectly entered due to typing or keying error. It was found that in Proposal form, age stated 66 years instead of 68 years. Respondent submitted proposal form and Pan card number for evidence. The Respondent has taken decision as per terms and conditions of the policy and declaration in proposal form and also as per their circular UNTB/2004-05/IBD/ADMN 323 dated 15-04-2007. For difference of 3 years age, --- penalty of difference in premium collected and settled claim up to 75% of claim amount.

There was suppression of material facts regarding age of the complainant which affect decision to accept proposal of enhance rate or decline the risk. Respondent's decision was upheld.

Case No. 11-004-0044-10

Mr.Suresh V. Pimple V/s. United India Insurance Co.Ltd.

**Awarded Dated 23-07-2009**

Mediclaim

Claim lodged by the Complainant for partial settlement of Cataract Surgery expenses for Rs.26,278/-as against Respondent paid for Rs.8,305/-. Deduction shown on the ground of limit of reimbursement of expenses to 10% of Sum Insured of Rs.25000/- whichever is less.

The Respondent's decision to partial payment of Rs.8,305/- is not justified as per new Mediclaim Policy terms and condition as complainant had renewed the old policy of the year 2006 with 15% CB on S.I of Rs.75000/-. However, Respondent is directed to pay deducted amount of Rs.17,973/- to the complainant.

**Ahmedabad Ombudsman Centre**

Case No. 11-008-0064-10

Mr.Mukeshkumar G. Patel V/s. Royal Sundaram Alliance Insurance Co.Ltd.

**Awarded Dated 23-07-2009**

Mediclaim

The Complainant has a Hospital Cash Insurance policy from the Respondent insurer which provides benefit for Rs.1500/- per day for the period of hospitalization. The claim was repudiated on ground that hospitalization and surgery done at hospital is not true. Further, insured had misrepresented to gain monetary benefits from the insurer.

Respondent has not given any evidence in support of its contention that the hospitalization and treatment is false and there was misrepresentation by the Complainant. The Complainant had insurance policy with United India and got reimbursement amount of Rs.36, 143/- against Rs.43, 691/-. So difference amount of Rs.7, 548/- require to be paid. It will be fair that the Respondent Insurer reimburse the amount of Rs.7, 548/-.

Case No. 11-002-0061-10

Mr.Viran A. Javeri V/s. The New India Assurance Co.Ltd.

**Awarded Dated 23-07-2009**

Mediclaim

Complaint lodged for short payment of Rs.29, 776/-. Claim paid by the Respondent on the basis of Old S.I of 50,000/- with CB Rs.25, 000/-. S.I increased by Rs.50, 000/- at the time of renewal of policy on 24-09-2007. The treatment papers show the history of mass in left breast since 2 months and history of HTN and diabetes. As per certificate produced by the Complainant, it was known case of left breast Lump with a history of one year.

Respondent had denied claim under policy clause 4.1 for increased sum insured which is upheld as the increased S.I is just like a fresh insurance and the revised conditions applicable to fresh insurance are operative for increased S.I.

Case No. 11-002-0037-10

Mr.Manish A. Shah V/s. The New India Assurance Co. Ltd.

**Awarded Dated 23-07-2009**

Mediclaim

Complainant's claim was repudiated by Respondent on the ground of policy clause 4.4-11, Expenses of diagnostic test, X-ray etc. not consistent with or incidental to the diagnosis of positive existence and treatment of ailment and under policy clause 4.4-6 treatment relating to all psychiatric and psychosomatic disorder is not covered.

It was finding that treatment was not for psychiatric disorder but it was a metabolic dementia due to deficiency of vitamin B-12. Respondent is directed to pay claim for Rs.16, 775/-.

**Award Dated 29-07-2009**

Group Mediclaim Policy

A Claim for reimbursement of hospitalization for accidental injury on 27-10-2008 was repudiated by the Respondent by invoking Clause 2.3 of the policy terms and conditions of the Group Mediclaim policy issued to LIC of India for their employees.

There must be minimum period of 24 hours for hospitalization except for specific treatment like dialysis, chemotherapy etc. Hospitalization was less than 24 hours as the insured admitted on 27-10-2008 at 1.30 pm and discharged on same day at 3.00 pm. Respondent's decision to repudiate the claim was upheld without any relief to the complainant.

**Ahmedabad Ombudsman Centre**

Case No. 11-009-0029-10

Mr. Kuldeep Solanki Vs. Reliance Gen. Insurance Co.Ltd.

**Award dated 30-07-2009**

Mediclaim

The Claim was repudiated on the grounds of Pre-existing disease and non disclosure of material information in the proposal form. Complainant had Mediastinal Mass since 6-12-2007 and had not taken any treatment for the same. Respondent produced indoor case papers of SAL Hospital which prove X-ray of chest dated 6-12-2007, showing a huge patch. The Complainant consulted Dr. Nandan M Parikh on 6-12-2009 and he was diagnosed and treated for left para cardiac consolidation. This information was not disclosed by the complainant in the proposal form. Therefore,

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

Case No.11-002-0062-10

Mr. Bharatbhai K. Dudhat Vs. The New India Assurance Co. Ltd.

**Award dated 14-08-2009**

Mediclaim Policy

Claim lodged by the Complainant for treatment of Angioplasty at Dhakaan Hospital, Rajkot was repudiated by the Respondent invoking clause 1 of the Mediclaim Policy which inter alia states that any hospitalization for pre-existing disease is excluded from the purview of the policy.

Complainant pleaded that, he consulted Dr. B.G. Saparia on 18-01-2008 with a complaint of chest pain which was a Fibro Muscular chest pain certified by treating doctor. The chest pain was not related with any heart problem.

The Respondent has not produced any concrete evidence to show that the disease for which the Complainant has hospitalized for pre-existing disease prior to inception of the policy. However, the Respondent is directed to pay a Sum of Rs.1, 31,770/- to the Complainant towards full and final settlement of the subject claim.

Case No.11-010-0140-10

Mr. Sanjeev Gupta Vs. The IFFCO TOKIO Gen. Ins. Co.Ltd.

**Award dated 26-08-2009**

Mediclaim Policy

Complainant was hospitalized on 25-02-09 for treatment of Acute Anteroseptal Myocardial Infarction, CAD and also diagnosis for Hypertension, Diabetes Mellitus at Sterling Hospital. Claim was repudiated by Respondent invoking exclusion clause 3 of the Mediclaim Policy i.e. misrepresentation, concealment of diabetes and hypertension which are known risk factor of heart ailment.

Complainant submitted that he had policy with National Insurance Co. since 03-06-2003 and it was renewed with the Respondent from 03-06-08 and benefit of cumulative also given, so it is not fresh policy.

The Respondent submitted that previous disease of diabetes and hypertension not shown in proposal form. It is established that insured has not disclosed the fact in proposal form so Respondent's decision to reject the claim is upheld.

Case No.11-003-0135-10

Shri Babubhai S. Patel Vs. National Insurance Co.

**Award dated 31-08-2009**

Mediclaim

Insured had taken treatment for right upper and left lower ureteric calculus was repudiated by invoking clause 4.3, expenses incurred for Genito-urinary system are excluded for first two years of the policy. Policy was incepted on 08-11-2007 and claim preferred in the second policy year.

The decision of the Respondent to repudiate the claim is upheld.

Case No.11-004-0131-10

Mr. Pulikotil S. Thomas Vs. United India Insurance C.Ltd.

**Award dated 31-08-2009**

Mediclaim

Mrs. Sushma Sebastin (Insured) had admitted for surgery of Hysterectomy for Fibroid in Uterus and claim was partially settled on the ground that the reimbursement of subject surgery is limited to 20% of Sum Insured as per rules of Golden Policy.

The Complainant submitted that surgery was not a simple case of hysterectomy and multiple ailments such as Rt. ovarian Cyst Fibroid Uterus and severe adhesiolysis which diseases are completely independent repairing treatment.

Respondent's Medical Referee's opinion that claims should be considered for Hysterectomy and Cystectomy. Since, Cystectomy involved Cystoscopy with

bilateral ureteric stenting to rule out injury to bladder and ureter, it will not fair to deny payment on this count.

Respondent is not justified in denying the claim for other procedures when hospital has charged 50% of the amount for the same which do not come under the limit for hysterectomy.

Therefore, Respondent is directed to pay 50% of the claimed amount of Rs.74,242/- to the Complainant.

Case No.11-004-0147-10

Arvindkumar V.Tripathi Vs. United India Insurance Co. Ltd.

**Award dated 31-08-2009**

Mediclaim

The claim was repudiated by invoking policy condition 5.4 i.e., claim intimation should be within 24 hours from the date of hospitalization. Complainant submitted that the claim intimated within two days i.e., late by one day which is not exorbitantly on higher side.

However, the Respondent's decision to reject the claim simply on the ground of late submission by one day is not justified and directed to pay claim amount to the complainant.

Case No.11-003-0112-10

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

**Award dated 31-08-2009**

Mediclaim Policy

Complainant's wife Smt. Hemlata was admitted in Shivam Surgical Hospital for removal of Cyst in Uterus. The doctor has issued certificate showing disease as Scar Endometriosis. The Complainant has stated that the disease is as a result of negligence of doctor who had treated during pregnancy. The doctor had not drained dark blood from Uterus which developed in Tumor.

The claim had been repudiated by invoking exclusion clause 4.12 of the Mediclaim policy which excludes the reimbursement of expenses on

treatment arising from or traceable to pregnancy (child birth including caesarean section, miscarriage, abortion or complication including changes in chronic conditions arising out of pregnancy and exclusion clause 10 of the Baroda Health Policy which excludes Treatment from or traceable to pregnancy (including) voluntary termination of pregnancy and child birth (including caesarean section and allied maternity benefits. Further, the respondent had repudiated claim due to pre-existing condition as caesarian operations 10 years back was revealed by case papers. The Respondent's Medical referee Dr. Kirit M Vadalia confirms that Laproctomy done on 2-10-08 for pelvic adhesion and scar endometriosis due to previous LSCS and Respondent's decision to repudiate the claim is justified.

**Ahmedabad Ombudsman Centre**

**Ahmedabad Ombudsman Centre**

Case No.11-002-0068-10

Mr. Hemant R. Marfatia Vs.

The New India Assurance Co. Ltd.

**Award dated 31-08-2009**

Mediclaim

Claim lodged by the Complainant for the expenses of Cataract Surgery was rejected by the Respondent invoking Policy clause 4.3 which stipulates that expenses incurred on treatment for cataract and age related eye ailments has a waiting period of two years from the date of inception of policy.

The policy was incepted in the year of 2007 for S.I. of Rs.1,50,000/-and renewed for second year for S.I. of Rs.1,00,000/-. The change in S.I is just like a fresh insurance and the revised conditions applicable to fresh insurance becomes operative to revised S.I when the premium for the same was paid. The cataract Surgery was done on 26-12-2008; however Respondent's decision to reject the claim is justified.

Case No.11-009-0113-10

Mr. Nimesh D. Patel Vs. Reliance Gen. Ins. Co. Limited

**Award dated 31-08-2009**

Mediclaim Complainant's wife Mrs. Hiralben Patel was admitted at Sardar Hospital, Ahmedabad on 03-11-2008 for treatment of acute fever with severe thrombocytopenia and discharged on 08-11-2008.

The claim had been repudiated by invoking policy condition 15 of health wise policy which states claim is fraudulent, false statement made in support of to get benefit under the policy. The Respondent had got the claim investigated through their investigator dated 16-03-2009 showing discrepancies observed in respect of diagnosis, duration of illness and hospitalization copy of questionnaire signed by Insured submitted with a request to substantiate the same. As per the investigation report, the insured was not admitted in the hospital and it is a fraudulent claim.

The Complainant did not submit any evidence to contradict the ground of repudiation of claim is incorrect. Repudiation based on fraud and proving a fraud require elaborate legal procedure calling for examination of documents, calling for witness etc. which is beyond the jurisdiction of this forum and complaint disputed with advise to Complainant.

Case No.11-002-0162-10

Mr. Dilipbhai A Patel Vs. The New India Assurance Co. Ltd.

**Award dated 10-09-2009**

Mediclaim

The Complainant had unbearable chest pain on 26-07-2008 and was admitted in Apollo Hospital, Ahmedabad. The claim was repudiated by invoking policy clause 4.1-11 which shows that hospitalization was not required as the subject treatment papers was diagnostic, X-ray or laboratory examination do not reflect positive existence and treatment of any ailment, sickness or injury for which confinement is required at Hospital.

From treatment papers, it is observed various diagnostic tests carried out did not reveal any positive existence of disease or ailment. There is no active treatment for any disease or ailment, so Respondent's decision to repudiate the claim is upheld.

Case No.11-004-0153-10

Mr. Indravadan N. Soni Vs. United India Insurance Co. Ltd.

**Award dated 10-09-2009**

Partial Settlement of Mediclaim

The Complainant had spent a total amount of Rs.2, 49,568/- towards treatment expenses of his wife for treatment of Glioblastoma Multiforme a most virulent form of brain cancer. Respondent settled by paying 2, 00,000/-under policy clause 1.1 & 1.2 and deducting an amount of Rs.49,568/-which is not agreeable to the Complainant and a case registered with this forum.

The insured was suffering from virulent brain cancer and the treatment was restricted to Radiotherapy and Chemotherapy and no surgery was involved, Clause 1.2 quoted by the Respondent relates to Cancer surgery and not to Radiotherapy and Chemotherapy. Since no surgery was involved and chemotherapy and Radiotherapy do not cap of 70% of Sum Insured and Rs.2.00 Lakhs maximum as per clause 1.2, Respondent is not justified in restricting the claim to 70% of the Sum Insured or Maximum Rs.2.00 Lacs.

Respondent to reject the claim on the ground that hospitalization was not required the treatment could have been given on OPD basis does not hold is not justified. Therefore Complainant succeeds and directed to pay remaining amount of Rs.49, 568/- to the Complainant.

Case No. 11-004-0156-10

Mrs. Jyoti H. Shah Vs. United India

**Award dated 16-09-2009**

**MEDICLAIM**

Complainant lodged a claim for Rs.19,071/- for treatment expenses of Chest Pain, Acute A.F and claim was partially settled by the Respondent invoking clause 4.14 of the Mediclaim Policy, any kind of service charges, surcharges, admission fees, registration charges levied by hospital are excluded. The Complainant was advance deposited Rs.9,500/- to the hospital which was adjusted by refund voucher No.0003643.

The Complainant had erroneously added the amount of advance also. The deduction of Rs.800/- for procedure and services charges and Rs.50/- towards Registration charges which are not payable as per terms of policy.

The Complainant realized his mistake and withdrawn his complaint, so no formal award is required to be issued.

Case No.11-005-0121-10

Mr. Rameshbhai D. Patel Vs. Oriental Insurance Co. Ltd.

**Award dated 17-09-2009**

Mediclaim Policy

Complainant filed a case for repudiation of claim towards the expenses of Cataract surgery. Respondent repudiated the claim invoking exclusion clause 4.3 which states that expenses on treatment of cataract will be covered after 2 years from the inception of the policy. Policy incepted on 20-08-2007 and hospitalized for surgery on 20-09-2008 that means second year of the policy. Hence the decision of the Respondent to repudiate the claim is justified.

Case No.11-002-0176-10

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

**Award dated 22-09-2009**

Mediclaim Policy

Claim lodged for treatment expenses of left tibia inter locked nailing and radius/ulna plating was partially settled by the Respondent in a manner not agreeable to the Complainant and a case filed with this forum.

Respondent submitted that they have deducted amount as per terms and condition of the policy clauses 2.1, 2.3 and 2.4.

Complainant submitted that hospital has charged 12% room rent as Nursing charges on total bill, O.T charges and doctor's visit charges. So room charges are within eligible limit @ Rs.1000/- per day.

The Respondent has erroneously clubbed Nursing care charges with room charges and incorrectly made deduction, it is established that Respondent's decision to deny the partial claim in terms of policy clause 2.1 to 2.4 is not justified and directed to pay an additional sum of Rs.38,804/- to the Complainant from the total deduction of Rs.50,954/-.

Case No.14-004-0180-10

Mr. Karsanbhai K Patel Vs. United India Insurance Co. Ltd.

**Award dated 30-09-2009**

Mediclaim Policy

Claim lodged towards hospitalization expenses of Complainant's wife was repudiated by the Respondent on the ground of Policy clause 5.3 and 5.4 i.e. late intimation and late submission of claim papers respectively.

Respondent stated that Insured had not given any intimation for admission of hospital within 24 hours and claim papers did not submit within 7 days of discharge from hospital.

Complainant stated that intimation for hospitalization was given by his son on 2nd day of hospitalization and he was told that the claim file can be submitted later on.

The policy condition stipulates that in case of Post hospitalization treatment (limited to 60 days) all claim documents should be submitted within 7 days after completion of such treatment. There are papers on record which shows that post hospitalization treatment lasted for 45 days after discharge and claim papers submitted well before the date of completion of Post hospitalization treatment.

Thus, Respondent's decision to reject the claim simply on the ground of late submission is not justified and directed to pay the claim amount to the Complainant.

Case No.11-002-0192-10

Mr. V.V. Patel Vs. The New India Assurance Co. Ltd.

**Award dated 30-09-2009**

Mediclaim Policy

Claim lodged for reimbursement of expenses for treatment of Acute Pancreatitis was repudiated by the Respondent invoking Clause 4.4-6 of the Policy condition on the ground that illness was due to consequently use of Alcohol. Hospital record also shows the Complainant's personal history 'use of alcohol' and alcohol account for 80%, patient admitted with acute pancreatitis while other causes include drugs and infections such as

mumps. So Respondent's decision to repudiate the claim is justified and claim upheld.

Case No.11-003-0181-10

Mr. Mahesh V. Jasani Vs. National Insurance Co. Ltd.

**Award dated 30-09-2009**

Mediclaim Policy

Claim lodged for reimbursement of expenses for treatment of the Complainant was repudiated by the Respondent invoking Clause 4.3 which excludes expenses incurred for treatment during first year of the Policy. The policy incepted in the year 2004 and the claim was preferred in the year 2008-09.

The Respondent submitted that their TPA processed the claim and repudiated the same invoking clause 4.8 and 4.10, but Respondent did not send any communication to the Complainant, conveying that the claim is repudiated in terms of clause 4.8 and 4.10.

As per Discharge Summary and hospital treatment records proves Complainant had sudden onset, uneasiness progressing to giddiness, headache, tingling at fingertips, gabhraman and weakness. Respondent has not produced any evidence to justify repudiation; hence it appears to be unreasonable and arbitrary.

Therefore complaint succeeds and Respondent is directed to pay claim amount as full and final settlement of the subject claim.

Case No. 11-003-0177-10

Mr.B.K. Joshi V/s. National Insurance Co. Ltd.

**Award dated 30-09-2009**

Delay in settlement of mediclaim :

The insured was hospitalized thrice during the currency of the policy. Three different claims were lodged with the respondent. The respondent stated that all the three claims were referred to their Mumbai Office. In-spite

of repeated reminders by the complainant, nothing was heard from the respondent and hence he preferred a petition to this office.

The Respondent had by referring the matter to their Mumbai Office accepted the receipt of three claims lodged by the complainant. The respondent had also not disputed the admission at hospital and expenses incurred on treatment of the insured.

It was concluded that there was a deficiency in service by the respondent by not taking any decision in settlement of claims for no reason, hence no ground for delaying the settlement of claims. Respondent was directed to pay total amount of all the three claims in full and final settlement of the Subject Claim.

The complaint was thus disposed off.

Case No. 11-002-0195-10

Mrs. Kumud J. Vaishnav V/s. The New India Assurance Co.Ltd.

**Award dated 30-09-2009**

Partial settlement of mediclaim :

The insured was hospitalized for the operation of Lt. Inguinal hernia. Claim lodged was partially settled by the Respondent deducting Rs. 7400/- invoking clause 2.1, 2.3 and 2.4 of revised mediclaim policy 2007 which restricts Room Nursing charges as 1% of Sum Insured and consultant, Surgeon, O.T. charges at the rate of applicable room category.

The Respondent had applied double standard for considering the claim as under:

1. Though in revised mediclaim policy, there was a waiting period of two years, ignoring this, settled the partial claim.
2. Room charges & surgeon's charges restricted as per terms and conditions of revised mediclaim policy.

The Respondent's decision to settle the claim partially was set aside and the respondent was directed to make payment of balance Rs. 7400/-

Thus the complaint was disposed off.

Case No. 11-004-0184-10

Mr. H. B. Dalal V/s. United India Insurance Co.Ltd.

**Award dated 30-09-2009**

Repudiation of mediclaim :

The insured was hospitalized in Orthopedic Surgeon's hospital because of injury sustained in a car accident. Two separate claims were lodged for the treatment underwent at two different hospitals.

The respondent repudiated the claims on the ground that claims were lodged late by 69 days after the stipulated time limit lay down as per terms and conditions of the subject policy.

The complainant submitted that because of marriage of his son and all the members of family were in state of trauma due to accident, claims were lodged late.

Based on the fact, findings and circumstances of the case, the respondent was directed to review the claim and pay 75% of the total admissible amount on non standard basis.

In the result the complaint partially succeeded.

Case No. 11-004-0194-10

Mr. Asfak K. Siddique V/s. United India Insurance Co.Ltd.

**Award dated 30-09-2009**

Repudiation of mediclaim:

The insured was hospitalized for high grade fever. Claim lodged for the reimbursement of hospital expenses were rejected by the respondent on the ground that there was delay in submission of the claim.

The complainant submitted that due to festive seasons of Diwali, claim file was submitted late by 10 days. It was observed that except delay in submission of claim papers there was no other infirmity in the claim.

Based on the facts and circumstances, material on record, the respondent was advised to review the case and pay the claim amount of Rs. 6230/- as full and final settlement of the claim.

The complaint, thus, succeeded.

Case No. 11-012-0160-10

Mrs. Premilaben B. Makwana V/s. ICICI Lombard Gen. Ins. Co. Ltd.

**Award dated 30-9-2009**

Delay in settlement of mediclaim :

The Insured was hospitalized for the treatment of Septal Ischomia and Lt. bundle branch block. Claim lodged by the complainant was not settled on the ground that additional documents required by the respondent were not submitted.

The complainant submitted that all documents pertaining to his hospitalization were submitted to the TPA along with claim file.

A close examination of the material on record showed that whatever case papers were submitted by the complainant were sufficient to take decision.

The Respondent's decision to close the file on a flimsy ground was not justified. The respondent was directed to pay claim amount of Rs. 7296/- in full and final settlement of the claim.

In the result, the complaint succeeded.

Case No. 11-008-0171-10

Mr. Ravindra Buch V/s. Royal Sundaram Alliance Insurance Co.Ltd.

**Award dated 16-09-2009**

Repudiation of mediclaim :

The insured was hospitalized for the surgery of Abdominal Soft Tissue Sarcoma. Claim was lodged for the reimbursement of expenses for hospitalization. The respondent had repudiated the claim invoking clause D alleging that the disease was pre-existing prior to the inception of the Policy.

The complainant pleaded that subject policy was taken through voice mail with commencement date as 18-7-08 when the insured was hale and healthy.

The respondent had their focus on letter dated 08-11-08 from their TPA stating that cashless was rejected in the case because C.T. Scan report

stated 1.9 x 1.5 cm. mass lesion which cannot develop over 3 months and was pre-existing.

It was observed on scrutiny of the papers that there was no medical consultation by the insured prior to 27-09-2008 and history given in the consultation paper does not go prior to the date of commencement i.e. 18-07-08.

The respondent had failed to produce sustainable documentary evidences to prove that the subject disease was existing prior to the inception of the policy hence decision of the respondent was not justified.

In the result, the complaint succeeds.

Case No. 11-002-0166-10

Mr. K. C. Palan V/s. The New India Assurance Co. Ltd.

**Award dated 17-9-2009**

Repudiation of mediclaim:

The insured was hospitalized and underwent two ureteric stone surgeries on 10-06-08 and 30-06-08. Claim lodged for the reimbursement of hospitalization expenses was rejected by the respondent invoking clause 4.3 which stipulates that expenses incurred on treatment for surgical operation for stones in urinary system has a waiting period of two years from the date of inception of the policy.

The complainant pleaded that his policy incepted on 12-03-07 and renewed in chain. At the time of renewal, there was no reference of revised terms and conditions hence terms and conditions of the first policy should prevail which had no waiting period for ureteric stone surgery.

From the material on record, fact and findings it was concluded that it was evident that at no point of time respondent communicated to the complainant that the renewal of the policy would be as per the new terms and conditions of mediclaim policy 2007. Respondent also did not send the terms and conditions of mediclaim policy 2007 with the policy document after renewal. Hence, there was violation of principles of utmost good faith, the basic of the Insurance Contract.

The respondent's decision was set aside and the respondent was directed to pay the admissible amount of the claim.

In the result, the complaint succeeded.

Case No. 11-003-0177-10

Mr.B.K. Joshi V/s. National Insurance Co. Ltd.

**Award dated 30-09-2009**

Delay in settlement of mediclaim :

The insured was hospitalized thrice during the currency of the policy. Three different claims were lodged with the respondent. The respondent stated that all the three claims were referred to their Mumbai Office. In-spite of repeated reminders by the complainant, nothing was heard from the respondent and hence he preferred a petition to this office.

The Respondent had by referring the matter to their Mumbai Office accepted the receipt of three claims lodged by the complainant. The respondent had also not disputed the admission at hospital and expenses incurred on treatment of the insured.

It was concluded that there was a deficiency in service by the respondent by not taking any decision in settlement of claims for no reason, hence no ground for delaying the settlement of claims. Respondent was directed to pay total amount of all the three claims in full and final settlement of the Subject Claim.

The complaint was thus disposed off.

Case No. 11-002-0195-10

Mrs. Kumud J. Vaishnav V/s. The New India Assurance Co.Ltd.

**Award dated 30-09-2009**

Partial settlement of mediclaim :

The insured was hospitalized for the operation of Lt. Inguinal hernia. Claim lodged was partially settled by the Respondent deducting Rs. 7400/- invoking clause 2.1, 2.3 and 2.4 of revised mediclaim policy 2007 which restricts Room Nursing charges as 1% of Sum Insured and consultant, Surgeon, O.T. charges at the rate of applicable room category.

The Respondent had applied double standard for considering the claim as under:

3. Though in revised mediclaim policy, there was a waiting period of two years, ignoring this, settled the partial claim.
4. Room charges & surgeon's charges restricted as per terms and conditions of revised mediclaim policy.

The Respondent's decision to settle the claim partially was set aside and the respondent was directed to make payment of balance Rs. 7400/-

Thus the complaint was disposed off.

Case No. 11-004-0184-10

Mr. H. B. Dalai V/s. United India Insurance Co.Ltd.

**Award dated 30-09-2009**

Repudiation of mediclaim :

The insured was hospitalized in Orthopedic Surgeon's hospital because of injury sustained in a car accident. Two separate claims were lodged for the treatment underwent at two different hospitals.

The respondent repudiated the claims on the ground that claims were lodged late by 69 days after the stipulated time limit lay down as per terms and conditions of the subject policy.

The complainant submitted that because of marriage of his son and all the members of family were in state of trauma due to accident, claims were lodged late.

Based on the fact, findings and circumstances of the case, the respondent was directed to review the claim and pay 75% of the total admissible amount on non standard basis.

In the result the complaint partially succeeded.

Case No. 11-004-0194-10

Mr. Asfak K. Siddique V/s. United India Insurance Co.Ltd.

**Award dated 30-09-2009**

Repudiation of mediclaim:

The insured was hospitalized for high grade fever. Claim lodged for the reimbursement of hospital expenses were rejected by the respondent on the ground that there was delay in submission of the claim.

The complainant submitted that due to festive seasons of Diwali, claim file was submitted late by 10 days. It was observed that except delay in submission of claim papers there was no other infirmity in the claim.

Based on the facts and circumstances, material on record, the respondent was advised to review the case and pay the claim amount of Rs. 6230/- as full and final settlement of the claim.

The complaint, thus, succeeded.

Case No. 11-012-0160-10

Mrs. Premilaben B. Makwana V/s. ICICI Lombard Gen. Ins. Co. Ltd.

**Award dated 30-9-2009**

Delay in settlement of mediclaim :

The Insured was hospitalized for the treatment of Septal Ischomia and Lt. bundle branch block. Claim lodged by the complainant was not settled on the ground that additional documents required by the respondent were not submitted.

The complainant submitted that all documents pertaining to his hospitalization were submitted to the TPA along with claim file.

A close examination of the material on record showed that whatever case papers were submitted by the complainant were sufficient to take decision.

The Respondent's decision to close the file on a flimsy ground was not justified. The respondent was directed to pay claim amount of Rs. 7296/- in full and final settlement of the claim.

In the result, the complaint succeeded.

Case No. 11-008-0171-10

Mr. Ravindra Buch V/s. Royal Sundaram Alliance Insurance Co.Ltd.

**Award dated 16-09-2009**

Repudiation of mediclaim :

The insured was hospitalized for the surgery of Abdominal Soft Tissue Sarcoma. Claim was lodged for the reimbursement of expenses for hospitalization. The respondent had repudiated the claim invoking clause D alleging that the disease was pre-existing prior to the inception of the Policy.

The complainant pleaded that subject policy was taken through voice mail with commencement date as 18-7-08 when the insured was hale and healthy.

The respondent had their focus on letter dated 08-11-08 from their TPA stating that cashless was rejected in the case because C.T. Scan report stated 1.9 x 1.5 cm. mass lesion which cannot develop over 3 months and was pre-existing.

It was observed on scrutiny of the papers that there was no medical consultation by the insured prior to 27-09-2008 and history given in the consultation paper does not go prior to the date of commencement i.e. 18-07-08.

The respondent had failed to produce sustainable documentary evidences to prove that the subject disease was existing prior to the inception of the policy hence decision of the respondent was not justified.

In the result, the complaint succeeds.

Case No. 11-002-0166-10

Mr. K. C. Palan V/s. The New India Assurance Co. Ltd.

**Award dated 17-9-2009**

Repudiation of mediclaim:

The insured was hospitalized and underwent two ureteric stone surgeries on 10-06-08 and 30-06-08. Claim lodged for the reimbursement of hospitalization expenses was rejected by the respondent invoking clause 4.3 which stipulates that expenses incurred on treatment for surgical operation for stones in urinary system has a waiting period of two years from the date of inception of the policy.

The complainant pleaded that his policy incepted on 12-03-07 and renewed in chain. At the time of renewal, there was no reference of revised terms and conditions hence terms and conditions of the first policy should prevail which had no waiting period for ureteric stone surgery.

From the material on record, fact and findings it was concluded that it was evident that at no point of time respondent communicated to the complainant that the renewal of the policy would be as per the new terms and conditions of mediclaim policy 2007. Respondent also did not send the terms and conditions of mediclaim policy 2007 with the policy document

after renewal. Hence, there was violation of principles of utmost good faith, the basic of the Insurance Contract.

The respondent's decision was set aside and the respondent was directed to pay the admissible amount of the claim.

In the result, the complaint succeeded.

Case No. 11-002-0055-10

Mr. Jitendra K. Shah V/s. The New India Assurance Co. Ltd.

**Award Dated 30-06-09**

Partial settlement of Mediclaim.

Mediclaim was lodged for Rs. 20950/- for hospital expenses and medicine bills. The Respondent offered Rs. 10475/- deducting Rs. 10475/- (Rs. 250/- room nursing charges + Rs. 10225/- consultant, surgeon, O.T. charges etc.) on the ground for excess of 1 % of Sum Insured as per terms and condition of the policy. The Complainant submitted that he had made payment as per the vouchers and bills submitted by the treating doctor.

The Respondent submitted that as per revised terms and condition of the policy, certain restrictions are put for room charges, surgeon's fees and diagnostic reports.

Since the old Sum Insured was Rs. 25000/- and total expenses were well within this limit, the complainant was entitled to the payment of full amount of Rs.20950/-

Thus the Respondent was not justified in applying two standards for the terms and condition under same policy. Hence, the decision of the Respondent to disallow Rs. 10475/- was set aside and directed to pay Rs.10475/-.

In the result the complaint succeeds.

Case No. 11-002-130-10

Mr. R.P. Pujara Vs. New India Assurance Co. Ltd.

**Recommendation dated 12-08-09**

Partial settlement of claim under Personal Accident Policy:

The Insured met with an accident. Claim for TTD was sought for 5 weeks as recommended by the treating Orthopedic by the Insured whereas the insurer offered TTD for 2 weeks.

During the course of hearing, both the parties mutually agreed for the conservation for 3½ weeks along with medical expenses of Rs.1100/- Total Rs.8600/- was mutually agreed and thus settlement was reached to this effect.

Case No. 11-002-0132-10

Mr. D.N.Patel Vs. New India Assurance Co. Ltd.

**Recommendation Dated 12-08-2009**

Partial Repudiation of Mediclaim :

The Insured was admitted for the surgery of Laproscopic Torsion of Tubal Hydrosalpinx. Claim was lodged for Rs.70728/-. The Insurer had offered Rs.35543/- partially settling the claim by invoking clause 2.1, 2.3, 2.4 and 4.3 of new terms and conditions, for the surgery of ovarian cyst, there is a waiting period of two years for the increased Sum Insured and hence they offered Sum Insured with Bonus.

As a result of mediclaim by this forum, the respondent and the complainant mutually agreed for a sum of Rs.42000 (Rs. S.I. + Rs.7000 C.B. as per old policies)

Thus settlement was reached to this effect.

Case No. 11-004-0131-10

Mr.Pulikottil S. Thomas Vs. United India Insurance Co. Ltd.

**Award Dated 31-08-2009.**

Partial settlement of Mediclaim.

The Insure was operated for subtotal Abdominal Hysterectomy, Rt. Ovarian Cystectomy, left salpingooperectomy and dense adhesiolysis. As against total expenses of Rs.80179/- the insurer partially settled the claim for Rs.20,000/- on the ground that the reimbursement of subject surgery of Hysterectomy for fibroid uterus is limited to 20% of Sum Insured as per the

rules of the Gold Policy and other surgical interventions are part of the hysterectomy surgery.

The Insurer produced opinion of their panel doctor in support of their decision who opined that because entire surgical procedure with minor encounters was for hysterectomy only. The insurer had rightly settled the claim for 20% of Sum Insured i.e. Rs.20, 000/-.

The Insured in support to her claim produced certificates of the operating surgeon and another Cynic Surgeon of Apollo Hospital who opined that subject surgery was not a simple hysterectomy but condense surgery which required assistance of urologist also and severe procedures were involved. They also stated that when several procedures are done in one sitting it is hospital's policy to change fully for major procedure and 50% charges for additional procedures.

To resolve the divergent view of the doctors of the insured and the insurer, this forum obtained an independent opinion of expert Gynecologist and laparoscopic surgeon and both opined that claim should be considered for Hysterectomy and Gystectomy.

On the basis of the above stated facts award was passed stating that 20% of Sum Insured applied by the insurer is justified for hysterectomy. The insurer was directed to pay 50% of total operation charges for other surgeries which do not come under the limit for hysterectomy.

Thus the complaint partially succeeds.

Case No. 11-002-0143-10

Shri V.G. Patel Vs. Reliance General Insurance Co. Ltd.

**Award Dated 31-08-2009**

Repudiation of Mediclaim.

The Insured had lodged claim for reimbursement of hospitalization expenses incurred for the operation of intestinal perforation after medical

Termination of pregnancy. The insurer had repudiated the claim invoking exclusion clause 6 of the Medical Policy which excludes pregnancy related complications as per the Health wise Policy. The insurer in their submission stated that the perforation of intestine was a complication during treatment of medical termination of pregnancy and had direct nexus with the MTP.

In order to arrive at the decision, this forum obtained combined opinion from Gynecologist and General Surgeon who confirmed that Intestinal perforation was due to erroneous MTP by the operating surgeon.

The Complainant also admitted in the representation made to the Respondent that the problem arose due to the error of the doctor who performed MTP.

On the basis of the above fact an award was passed to uphold the decision of the insurer to repudiate the claim.

The complaint, thus, disposed off.

Case No. 11-004-0146-10

Mr. N. J. Prajapati Vs. United India Insurance Co.Ltd.

**Award Dated 24-08-2009.**

Repudiation of Mediclaim.

The insured was suffering from tuberculosis and was taking post hospitalization treatment. The insurer repudiated the post hospitalization treatment claim on the ground of late submission of claim paper i.e. beyond stipulated time limit of 7 days after completion of the treatment.

While actually calculating the days for delayed submission, it came to 14 days. Taking ground that tuberculosis is a disease which requires lengthy treatment for getting cured and the insured was under treatment up to 30-03-09 before submitting claim papers on 2-4-09 which was within 7 days time.

The decision of the Insurer to repudiate the post hospitalization treatment claim was set aside and was directed to pay the admissible claim to the insured.

Case No. 11-004-0129-10

Mr.H.A.Desai Vs. United India Insurance Co. Ltd.

**Award Dated 14-08-2009.**

Repudiation of Mediclaim :

The Insured was hospitalized twice during the policy year for the treatment of unstable angina. Claim lodged for reimbursement of expenses for hospitalization was repudiated by the insurer treating the disease as pre-

existing which is excluded from the purview of the policy. The complainant submitted that the insured was never suffering from any heart disease or HBP or DM. Previously the respondent neither gave any written submission nor any supporting documents to show that the disease was pre-existing; Respondent did not submit evidence to justify their action of Repudiation of the claim.

Thus the decision of the Respondent is set aside.

Case No. 11-002-0120-10

Mr.Manish Verma Vs. The New India Assurance Co.Ltd.

**Award Dated 27-08-2009**

Repudiation of Group Mediclaim :

The Insured was hospitalized for delivery and a female child was delivered by LSCS operation at the end of 35 weeks pregnancy period. The complainant lodged claim for hospital expenses and bills for medicines. The insurer had repudiated the claim on the ground of clause No.5.16.2 of Group Mediclaim policy which excludes benefit to the policy holder during waiting period of nine months from the date of enrolment of the employee

In the scheme. The said clause reads as under:

> "A waiting period of nine months is applicable for payment of any claim relating to normal delivery or caesarean section of abdominal operation for extra uterine pregnancy. The waiting period may be relaxed, only in case of delivery miscarriage or abortion induced by accident or other medical emergency."

The complainant submitted that looking to the insured's condition, treating doctor decided for caesarean delivery, though the normal full confinement period was not over.

As per the certificate of the treating doctor, looking to the bad obstetric history, caesarean operation was done,

Because the operating Gynecologist had opined that because of bad obstetric history, caesarean operation was done before normal full confinement period was over this proved that there was a medical emergency.

So the decision of Respondent to repudiate the claim was set aside. In the result of complaint succeeds.

Case No. 11-002-0150-10

Mr. I.R. Krishnan Vs. The New Inkdia Assurance Co.Ltd.

**Award Dated 28-08-2009**

Partial settlement of Mediclaim :

The insured was operated for cataract in both the eyes on different dates falling under different policy years. The Insurer partially settled the claims for Rs.52500/- as against total expenses of Rs.69272/- disallowing Rs.17, 172/- on the ground that Rs.1750/- was Room and nursing charges hence it attracts restrictive clauses as per the new terms and conditions No.2.1, 2.3, 2.4, & Note 1 on it.

The Insured submitted that in PHACO type cataract operation there is no need for pre or p9st operational nursing assistance. He further argued that since there was no Room charges paid hence restrictive clauses are not applicable.

The treating surgeon clarified that amount charged as nursing charges was not nursing charges in the room but it is a part of operation theatre charges.

The subject policy has Sum Insured before increase is Rs.50, 000/- with added bonus, the complainant is entitled to the payment of alteration within limit of original sum Insured. On the basis of the above fact, the insurer was directed to make payment of Rs.17, 172/-

In the result, the complaint succeeded.

Case No. 11-008-0116-10

Mr.Minesh K.Modi Vs. Royal Sundaram Alliance Insurance Co. Ltd.

**Award Dated 11-08-2009**

Repudiation of mediclaim :

The insured was hospitalized at Shalby hospital, Ahmedabad from 24-05-09 to 30-05-09 for left knee replacement due to osteoarthritis. Claim lodged for expenses incurred on hospitalization was repudiated by the respondent

invoking clause of mediclaim policy which excludes benefit to the policy holder for pre-existing disease.

The policy was incepted with effect from16-03-07 and first consultation report stated that pain in left knee was for the last 3 years with the history of total knee replacement of right knee.

In claim form for cashless facility it was answered that date of illness was from last 3 years.

The respondent had informed the complainant about exclusions and important conditions of the policy on 16-03-07 itself.

It was evident that subject claim for hospitalization was not within the purview of terms and conditions of the policy and the repudiation of the claim by the respondent invoking the condition for pre-existing disease was justified.

In the result the complaint fails to succeed.

Case No. 11-005-119-10

Mr.Chirag N. Shah Vs. Oriental Insurance Co. Ltd.

**Award Dated 11-08-2009**

Repudiation of mediclaim :

The insured was hospitalized from 26-10-07 to 29-10-07 for the surgery of Acute Calculus Cholecystitis at Sterling Hospital, Ahmedabad. Claim lodged with the Respondent for Rs.135121/- was repudiated by invoking exclusion clause 4.3 of the mediclaim policy.

The complainant submitted that the respondent had wrongly repudiated the claim treating the disease falling under waiting period of two years though he had renewed his mediclaim policy in chain with national Insurance Co. and Oriental Insurance Co. So the ailment of the insured did not fall under clause 4.3 which stipulates waiting period of two year for calculus choleocystitis.

The Respondent submitted that the Subject Policy was a fresh policy taken from them. There was no continuity of renewal with them prior to 27-02-07. Since the policy was a de novo contract it had not earned cumulative Bonus.

It was justified that the claim for surgery of calculus choleocystitis was within period of two years from the date of inception of policy i.e. 27-02-07.

The Respondent was justified in rejecting the claim under clause 4.3 of the policies.

In the result, the complaint fails to succeed.

**Award dated 30.6.2009**

**Case No.11-002-0042-10**

**Mr.Arvind Vaghela Vs. New India Assurance Co.Ltd.**

Mediclaim Policy

Claim for hospitalization expenses was settled for lesser amount than the claimed amount for the reason prolonged stay at the hospital invoking clause 1 of terms and conditions of policy which interalia states that in the event of any claim becoming admissible under this Mediclaim policy the company will pay the reasonable and necessary incurred amount to the insured.

The Insured after operation was suffering from infection of wound for which drainage was carried out. She could not walk independently and required physiotherapy treatment and medical observation. The documents on record and hearing of the parties, it was revealed that Respondent while making arbitrary deduction for room charges and doctor's visit charges from the claim relied upon the opinion of a TPA.

The treating doctor has advised for the specific requirement of the subject case and he has given his rationale. In fact charges incurred are commensurate with the treatment given

The Respondent was directed to entertain the claim for full amount of claim fro room charges and doctor visit charges.

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**Award dated 25.06.2009**

**Case No.11-002-0053-10**

**Mr. Pravinchandra M Shah Vs. New India Assurance Co.Ltd.**

Mediclaim Policy

Claim for hospitalization expenses was the claim was partially settled by invoking policy exclusion Clause 4.3 in respect of increased Sum Insured. As per clause 4.3, Prolapse Inter Vertebral Disc unless arising from accident is excluded for first two years of policy.
The Policy was renewed in 2007 under revised conditions, the Sum Insured was increased for Rs.60, 000/- and the complainant had agreed to revisal terms and condition effective from 2007. Revised policy conditions would apply to increase Sum Insured. As per the revised terms and conditions, Prolapse Inter Vertebral Disc unless arising from accident was excluded for two years i.e. up to 2009. Hence reimbursement of expenses incurred on treatment of Backache (Left Lower limb Radiculopathy) would not become payable as far as the increased sum insured is covered The case was dismissed and the partial repudiation for increased SA was justified.

**Award dated 31.8.2009**

**Case No. 11-002-0068-10**

**Mr. Hemant Rajendra Marfatia Vs. New India Assurance Co.Ltd.**

Mediclaim Policy

The claim was repudiated by invoking Clause 4.3 which stipulates that expenses incurred on treatment for cataract and age related eye ailments has a waiting period of two years from the date of inception of the policy.
The policy was incepted on 19.1.2007 and renewed for second year for the period from 19.1.2008 to 18.1.2009. On renewal for the second year the complainant had decreased sum insured on his life from Rs. 1.50 lac to 1 Lac.

Both claims for right and left eye were preferred in the second year of policy on 15.03.2008 and 26.12.2008 respectively and as per terms and condition of the policy none of the claim is payable

The case was dismissed.

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**Award dated 30-07-2009**

**Case No.11-002-0109-10**

**Mr.Dhartiben K. Shah Vs. New India Assurance Co.Ltd.**

The Claim lodged for reimbursement of hospitalization was partially settled on the ground that they have considered the admissible amount as per the guideline of the company according to which:

The reasonable customary and necessary Surgeon fee and Anesthetist fee should be reimbursed limited to maximum of 25% of Sum Insured. The payment is to be reimbursed provided the Insured pays such fees through cheque and Surgeon/Anesthetists provides a numbered bill. Bill given on letterhead of the Surgeon/Anesthetists should not be entertained. Fees paid by cash may be entertained up to a limit of Rs.10,000/- only provided the Surgeon/Anesthetists provides a numbered bill.

The ceiling on reimbursement of Doctor/Surgeon charge paid in cash is, according to the internal instructions issued by the Respondent which are neither part of policy condition nor they were informed to the complainant. Insurance contracts are based on the principle of utmost good faith which is reciprocal, applicable to both the insurer and the insured. If insured is required to disclose material information for assessment of risk, it is equally obligatory on the part of the insurer to inform the insured whenever a change in terms and conditions of the policy affecting the benefit available is made.

Thus complaint succeeded and Respondent was directed to settle claim for deducted amount of Rs. 16500/.

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**Award dated 13-08-2009**

**Case No.11-002-0128-10**

**Ms.Kanchanben P Panchal Vs. New India Assurance Co.Ltd.**

Mediclaim Policy

The claim was repudiated by invoking Clause 4.3 which stipulates that expenses incurred on treatment for cataract and age related eye ailments has a waiting period of two years from the date of inception of the policy.

The initial sum insured under the policy was Rs.25, 000/- when the policy was incepted in 2002. The Sum Insured was increased from Rs.25, 000/- to Rs.1.00 Lac at the time of renewal for the period from 05-08-2008 to 04-08-2009 with 30% cumulative bonus (CB) on original Sum Insured of Rs.25, 000.

The claim lodged for right eye cataract surgery for an amount of Rs. 19579/- was settled by the Respondent for Rs. 13371/- for the balance of Sum insured of original Sum Insured of Rs.25, 000/- with 30% Bonus

thereon – Rs.7,500/-.( Rs. 19129 + 13371) = Rs. 32500/- because increase in sum insured was excluded as per clause 4.3

The increased Sum Insured of Rs.75, 000/- attracts the policy exclusion clause 4.3. Thus the decision of the Respondent to consider of payment of claim within the limit of original Sum Insured of Rs.25, 000/- along with bonus of Rs.7, 500/- is justified

The case was dismissed.

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**Award dated 26-08-2009**

**Case No.11-002-0144-10**

**Mr. Kalpesh Amulakhbhai Shah Vs. New India Assurance Co.Ltd.**

Mediclaim against reimbursement of Hospitalization was partially settled disallowing a total amount of Rs.16617/- under various heads like room charges, Consultant's fee, Surgeon's charges, Anesthetist charges, O.T. charges etc. as per terms and conditions of the policy and expenses related to hypertension is restricted for two years from the date of inception of policy clause 2.1 and 4.3.

The amount was disallowed due to the reason that insured had opted for a higher room rent than the entitled category as per policy terms and conditions 2.3, 2.4 and 2.6 note 1. They have taken the Sum Insured in respect of the insured as RS. 30000/ and accordingly worked out the amount payable.

The documents revealed that insured was suffering from Adenoid hyperplasia and Bilateral Sinus and not Hypertension.

The Sum Insured is Rs.1, 00,000/- with Cumulative Bonus of Rs.12, 000/-. Insured is having the insurance cover with the Respondent since 1997 continuously without any break.

The Respondent had not examined the case papers properly and has invoked clause 4.3 citing hypertension as the diagnosis for which there is a waiting period of two years. Respondent are oblivious of the fact that insured is a 11 year old child not suffering from hypertension but treated for adenoids and sinus. The deductions made out of claim amount are not justified because of the fact that insured was not suffering from hypertension which has a waiting period of two years, but adenoids and sinus.

The Respondent was directed to settle the claim for balance Rs.16617/.

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**Award dated 18-09-2009**

**Case No.11-002-0163-10**

**Mr. Jayntibhai M Patel Vs. New India Assurance Co.Ltd.**

Mediclaim for hospitalization reimbursement was repudiated invoking clause 4.4.11 of the Mediclaim policy on the ground that hospitalisation is not justified as no active line of treatment was given to the complainant during hospitalisation.

The material on record and pleading of the parties revealed that nature of treatment given was operation, I/V fluid, injection and oral treatment. The complainant underwent split thickness skin grafting surgery which is an active line of treatment.

Respondent's decision to repudiate the claim by invoking clause 4.4.11 is not justified.

The Respondent was directed to settle the claim.

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**Award dated 13-07-2009**

**Case No.11-003-0009-10**

**Mr.Ravindrakumar R Shah Vs. National Insurance Co.Ltd.**

Mediclaim lodged for reimbursement of hospital expenses was repudiated by invoking clause 4.1 which states that treatment for joint replacement due to degenerative conditions, age related osteoarthritis and osteoporosis are not payable for first four years of operation of the policy.

The policy was incepted from 07.03.2005 and continuously renewed without break The subject claim was preferred in the fourth policy year for the period from 7.3.2008 to 6.3.2009.The insured was treated for Rheumatoid Arthritis and underwent surgery for total knee joint replacement left on 18.7.2008 during the fourth year of the policy.

It was revealed after analysis of the case that surgery was exclusion.

The case was dismissed on the repudiation was justified.

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**Award dated 15-06-2009**

**Case No.11-003-0024-10**

**Mr. Vipulkumar K Patel Vs. National Insurance Co.Ltd.**

Individual Mediclaim Policy

The Complainant's wife was suffering from Bilateral breast abscess
The Claim lodged for reimbursement of hospitalization was on the ground of Exclusion Clause 4.12 "Treatment traceable to Pregnancy, childbirth".

Respondent contested that, it is a case of complication arising 'directly or indirectly' and traceable to the pregnancy, childbirth as the Bilateral Breast abscess developed one month after delivering a baby by the insured and considering it as pregnancy and maternity related complication.

The respondent had not taken any opinion from a medical expert or Medical referee and had considered the bilateral abscess as maternity related complication which does not find any mention in exclusion clause 4.12 or elsewhere in the terms and condition of the policy , the clause refers pregnancy and child birth and not maternity.

On examination of material on record it was found that Hospitalisation was for bilateral breast abscess which was as a result of infection and not due to pregnancy.

The Respondent was directed to settle the claim.

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**Award dated 27-07-2009**

**Case No.11-003-0107-10**

**Mr.Ramjibhai Mohanbhai Patel Vs. National Insurance Co.Ltd.**

The claim was repudiated invoking clause 2.6 of the Mediclaim policy on the ground that hospitalisation is not justified as complainant underwent surgery under local anesthesia which does not require hospitalisation for more than 24 hours

It observed from the treatment case papers that the treatment given to the Complainant was such which could have been given on OPD basis

Therefore the case was dismissed.

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**Award dated 31-08-2009**

**Case No.11-003-0135-10**

**Mr.Babubhai S Patel Vs. National Insurance Co.Ltd.**

The complainant's wife was treated for left lower ureteric calculus and underwent ureteroscopy.

The claim was repudiated by invoking Clause 4.3. As per clause 4.3, expenses incurred for Genito –urinary system are excluded for first two years of the policy. The claim was preferred in the second policy year.

Discharge summary of Devasya Hospital and certificates of the treating doctor D D Patel, confirmed that the insured had taken treatment for right upper and left lower ureteric calculus which is excluded as per clause 4.3 of the policy.

The case was dismissed.

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**Award dated 26-08-2009**

**Case No.11-003-0141-10**

**Mrs. Damyantiben P Gnandhi Vs. National Insurance Co.Ltd.**

The claim was settled for lesser amount than claimed disallowing amount under various heads like room charges, Consultant's fee, Surgeon's charges, Anesthetist charges, O.T. charges etc. as per terms and conditions of the policy.

The complainant was covered under the policy with a sum insured of Rs.1 lac/-since 2000. The Sum Insured was increased from Rs.1 lac to Rs. 3 lac with revised terms and conditions in 2007. The Complainant renewed the policy for the period from 13.12.2008 to 12.12.2009 for Sum Insured of Rs. 3 lac with total cumulative bonus of Rs. 35000/ (15% on original Sum Insured of Rs. 1 lac and 10 % on increased sum insured of Rs. 2 lac).

The Complainant' underwent total left knee replacement. Total hospitalisation expenses incurred were Rs. 132661/ after discount of Rs. 52500/ under the head surgeon's fee.

The TPA considered the Sum Insured as Rs. 115000/ and bifurcated expenses into three category with ceiling viz Room charges 1% of Sum Insured, Doctor, Anesthetic charges 25 % of Sum Insured and medicine, diagnostics and Implant charges 50 % of Sum insured as per revised policy terms and condition applicable with effect from the year 2007and paid settled the claim for Rs. 76042/-

Respondent admitted the claim as per the terms and conditions of the new policy. Whereas claim considered for original Sum Insured of Rs.1, 00,000/- with Cumulative Bonus of Rs.15, 000/-.

The revised policy condition was neither informed to the complainant by the Respondent nor was her consent obtained by the Respondent.

The policy with increased sum insured bears an endorsement that S.A. for knee and Hip joint is Rs. 100000/- for five years. So the respondent has to consider the claim for old sum insured and cumulative bonus thereon without applying new policy conditions.

Therefore the complaint succeeds partially.

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**Award dated 17-07-2009**

**Case No.11-004-0081-10**

**Mr.Amit Sevantilal Shah Vs. United India Insurance Co.Ltd.**

Claim was repudiated on the grounds that the claim was lodged without discharge summary from hospital and the discharge summary was submitted by the complainant after 78 days of discharge from hospital. The claim was repudiated invoking clause 5.4 of policy.

Complainant submitted that he was suffering from tuberculosis and due to his critical condition he was unable to submit the requirement and requested to waive the delay in submission of requirement.

The forum realized the inability of submission of requirement by the complainant and directed the Respondent to consider the claim for admissible amount.

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**Award dated 13-07-2009**

**Case No. 11-004-0088-10**

**Shri Rajesh C Shah vs. United India Insurance Co.Ltd.**

Mediclaim Policy

The insured underwent hysterectomy and lodged claim under the policy.

The claim was partially settled by invoking policy clause 1.2 which stipulates that the reimbursement of expenses incurred for Hysterectomy will be 20% of the Sum Insured or maximum Rs. 50000/- and pre and post hospitalization expenses shall be maximum 10% of Sum Insured

The claim was settled for a sum of Rs. 22067/- by the Respondent out of which Rs. 20000/ was towards hospitalisation expenses (20% of Sum Insured) while Rs. 2067/- was for pre and post hospitalisation expenses (10% of Sum Insured subject to actual expenses).

As per terms and conditions of the policy in case of hospitalisation for hysterectomy reimbursement of expenses is restricted to 20% of the Sum Insured and 10% of the Sum Insured towards pre and post hospitalisation expenses.

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

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**Award dated 17-09-2009**

**Case No. 11-005-0121-10**

**Shri. Rameshbhai D Patel Vs. Oriental Insurance Co.Ltd.**

Individual Mediclaim Policy

The claim was repudiated by invoking clause 4.3 which states that during the period of insurance cover, the expenses on treatment of Cataract are not payable for a specified period of two years if contracted and/or manifested during the currency of the policy

The complainant was covered under Mediclaim policy with United India Insurance Co. Ltd., Ahmedabad till 19-08-2007. At the time of renewal in August 2007, Complainant took a fresh policy from Oriental Insurance Co.Ltd. Under their Individual mediclaim Policy Plan for the period from 20.8.2007 to 19-08-2008.The policy with the respondent was

renewed without break for the second year for the period from 20.8.2008 to 19.08.2009. The subject claim was preferred in the second policy year for cataract.

The treatment was taken by the insured in the second policy year and this attracts exclusion clause 4.3. Which provides for 2 years waiting period before claim for cataract surgery can be entertained. Hence the decision of the Respondent to repudiate the claim is justified.

The case was dismissed.

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**Award dated 31-08-2009**

**Case No.11-005-0124-10**

**Mr. Bhupendra K Patel Vs. Oriental Insurance Co.Ltd.**

Mediclaim Policy

The Claim was repudiated by the Respondent invoking Exclusion Clause 4.19 of revised Mediclaim Policy which specifically excludes the claim for expenses incurred on treatment of obesity or condition arising there from including morbid obesity

The complainant was hospitalised for laparoscopic sleeve gastrectomy. Final diagnosis was morbid obesity. The complainant's surgeon had certified that the complainant was suffering from Morbid obesity for which bariatric surgery was performed.

As the claim was for treatment of Morbid Obesity which is excluded from the benefit of the policy as per clause 4.19 of the policy. The respondent's decision to repudiate the claim was justified.

The case was dismissed.

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**Award dated 13-07-2009**

**Case No. 11-009-0058-10**

**Mr.Ketan Vora Vs. Reliance Gen. Insurance Co.Ltd.**

Health wise Medical Policy

Complainant's wife was operated for vaginal Hysterectomy and claim was repudiated by the Respondent on the ground of Pre-existing disease.

The respondent had not produced any concrete documentary evidence to show that the disease for which insured was hospitalised pre-existed prior to inception of the policy. Hence repudiation of claim by the Respondent was not justified.

The Respondent was directed to settle the claim.

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**Award dated 29-07- 2009**

**Case No. 11-009-0101-10**

**Mr. Vishnubhai G Patel Vs. Reliance Gen. Insurance Co.Ltd**.

Mediclaim Policy

The complainant's wife was suffering from Squamous papilloma with areas of moderate dysplasia. She underwent Micro Laringeal surgery with laser under general anesthesia and lodged claim.

The claim was repudiated invoking clause 7 of the Mediclaim policy on the ground that all types of laser surgeries are excluded as per terms and conditions of policy.

On examination of the policy clause it was revealed that the respondent had wrongly interpreted wordings of the clause. The word used "Laser Surgery" in the clause prefixed with the word "Cost of Spectacles" and suffixed with the word "contact lenses" and it is all related to eye and ear only. There is no mention in the clause that all types of laser surgeries are permanently exclude from the policy benefits.

Since Repudiation had been made invoking clause 7 of the policy it is not tenable as the said clause is not applicable to the subject claim.

Respondent was directed to settle admissible amount of claim.

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**Award dated 23-09-2009**

**Case No.11-009-0196-10**

**Mr. Pratap Sevaram Mistry Vs. Reliance General Insurance Co.Ltd.**

Individual Mediclaim Policy

The claim had been repudiated on the grounds that many discrepancies were found during claim investigation thus claim was repudiated by invoking clause 15 of the RGIL policy.

On mediation of the Forum, the Respondent agreed to settle the claim for a sum of Rs.6500/- as full and final settlement of the claim to which the Complainant also agreed.

The case was disposed on compromise

**Award dated 17-07-2009**

**Case No.11-009-0375-09**

**Mr. Rajeshbahi B Ganhdhi Vs. Reliance Gen. Insurance Co. Ltd.**

Mediclaim Policy

The claim was repudiated on the ground that claim papers were submitted after more than 60 days from the date of discharge and Hospitalisation is not justified as complainant was treated on OPD Basis and claim is inadmissible as per clause 21 of Reliance Healthwise Policy. (RHWP).

Treatment papers bring out that the Complainant was treated on OPD basis. The complainant had also claimed for day care treatment expenses and not for the hospitalization expenses, claim papers were also submitted after a delay of over 60 days from the date of discharge from Hospital.

The complaint was dismissed.

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**Ahmedabad Ombudsman Centre**

**Award dated 19-09-2009**

**Case No. 14-004-0138-10**

**Mr. Sharadcahndra S Panchal Vs. United India Insurance Co.Ltd.**

Mediclaim Policy

After the hearing was concluded the complainant made a written submission that he is not satisfied with the hearing proceedings.

It was made clear that the forum within the parameters set by RPG Rules (1998) deals with complaints on a summary basis. Reliance is placed on the documentary materials submitted by both the parties and the RPG Rules do not even require any hearing to take plea. If the Complainant is not satisfied with the proceedings he is free to move any other forum / court as may consider fit.

It is pertinent to note that the award pronounced by this forum comes into force only after its unconditional acceptance by the Complainant, since the complainant had shown his dissatisfaction even before pronouncement of formal award by the forum; no order was desirable to be issued favoring either of the parties. Instead, the Complainant was advised to move any other Forums/Courts, as may be considered appropriate, for the purpose of the Redressal of his Complaint.

The complaint thus stands disposed.

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**Ahmedabad Ombudsman Centre**

**CASE NO. 11-004-0206-10**

**MR. D K PATEL V/S**

**THE NEW INDIA ASSURANCE CO.LTD.**

**Award Dated: 14-09-2009**

Repudiation of Mediclaim because of late submission of papers invoking clause 5.4 by the Respondent. Papers were examined and found 45 days late submitted by the complainant. It is also found that treatment was in continue and treated as post hospitalization treatment. For which as per terms and conditions of the Mediclaim policy up to 60 days post hospitalization expenses can be reimbursed. The Respondent was directed to pay the full claim amount.

**CASE NO. 11-009-0228-10**

**DR. HIREN PARIKH**

**V/S**

**RELIANCE GENERAL INSURANCE CO.LTD.**

**Award Dated: 29.09.2009**

Repudiation of Mediclaim. The Respondent rejected the claim because insured was admitted less than 24 hours. Complainant produce set of papers and reports, which prove that insured was admitted to the hospital for 10 days. The Respondent was directed to pay the admissible claim amount as per policy terms and conditions.

## BHUBANESHWAR

**C – MEDICAL/MEDICLAIM POLICY**

**(1)**

BHUBANESWAR OMBUDSMAN CENTER

Complaint No.11-008-0482

Dr Jitendra Kumar Panda

*Vrs*

Royal Sundaram Alliance Insurance Co. Ltd., Chennai

**Award dated 07 Apr 2009**

Complainant had availed Health Shield insurance for self and family from Royal Sundaram Insurance Co Ltd. He was admitted to Usthi Hospital, Bhubaneswar. A claim was lodged. Insurer repudiated the claim on the grounds that the hospitalisation was not required.

Hon'ble Ombudsman heard the case on 21.01.2009 where complainant was present but insurer remained absent inspite of advance notice. Hon'ble Ombudsman after hearing complainant and on perusing documents like clinical summery of treating Hospital and other treatment papers held that any prudent person with transient loss of consciousness would definitely get admitted if advised by any doctor to do so and hence set aside the repudiation decision and directed Insurance company to pay Rs 13,000/- within one month of receipt of consent letter.

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BHUBANESWAR OMBUDSMAN CENTER

Complaint No.11-003-0522

Sri Anil Kumar Narula

*Vrs*

National Insurance Co. Ltd., Cuttack DO-II

## Award dated 26th May 2009

Complainant had taken a Mediclaim Policy with National Insurance Company Ltd for himself and his family members. His wife was admitted to Appolo Hospital Bangalore and a claim was lodged. Insurer repudiated the claim on the grounds that the disease was pre existing and she is a patient for same ailment for last 20 years.

Hon'ble Ombudsman heard the case on 18.03.2009 where both sides were present. Hon'ble Ombudsman after hearing both sides and on perusing documents like clinical summery of Sagar Hospital and other treatment papers held that there is no document to prove that the low back pain was there for last 20 years, rather treating hospital has clarified in writing, 20 years to be wrongly written. Therefore he directed insurance company to pay the claim within 30 days of receipt of consent letter.

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## BHUBANESWAR OMBUDSMAN CENTER

## Complaint No.11-008-0509

## Sri Sanjay Choudhury

*Vrs*

## Royal Sundaram Alliance Insurance Co. Ltd., Bhubaneswar Branch

## Award dated 01 May 2009

Complainant had availed Health Shield insurance for self and family including parents from Royal Sundaram Insurance Co Ltd. He received all medical expenses for his mother, when she fell ill but was refused reimbursement for the similar expenses incurred for treatment of his father on the ground that the ailment treated was pre existing.

Hon'ble Ombudsman heard the case on 17.03.2009 where both parties were present. Hon'ble Ombudsman after hearing complainant and on perusing documents like clinical summery of treating Hospital and other treatment papers held that the discharge certificate produced earlier mentioned the existence of the disease for last 20 years by mistake, which has been clarified by the same hospital to be of 2 years only and there fore directed Insurance Company to pay Rs 39,866/- to the complainant.

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## BHUBANESWAR OMBUDSMAN CENTERc

## Complaint No.11-003-0537

Sri Debendra Kumar Sahu

*Vrs*

National Insurance Co. Ltd., Bhubaneswar DO-II

**Award dated 30th June 2009**

Complainant had taken a Mediclaim Policy with National Insurance Company Ltd for himself and his wife. His wife was admitted to Hospital and on discharge a claim was lodged. Insurer repudiated the claim on the grounds that the ailment treated for is not covered by the policy.

Hon'ble Ombudsman heard the case on 18.03.2009 where both sides were present. Hon'ble Ombudsman after hearing both sides and on perusing documents felt the necessity to refer the matter to a Medical Specialist, to which both sides agreed. The specialist opined that the patient was given conservative treatment for gall bladder but was not operated upon. Since there was no operation, the exclusion under the policy does not apply to this case and there fore directed insurer to pay the claim.

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BHUBANESWAR OMBUDSMAN CENTER

Complaint No.14-004-0552

Sri Arun Sutar

*Vrs*

United India Insurance Co. Ltd., Hyderabad DO IV

**Award dated 16Th June, 2009**

Complainant had taken a Mediclaim Insurance Policy for self and family with United India Insurance Company Ltd. Complainant was admitted at the Prince Alli Khan Hospital,Mumbai for treatment of Sub-mucous Fibrosis .Hon'ble Ombudsman heard the case on 17th March 2009, where both parties were present. After hearing both sides and perusing documents produced, held that the repudiation of the claim as a pre-existing condition is not proper as the complainant had renewed the policy with the same company since four years and even though the disease had occurred before one year, it can not be termed as pre-existing merely for change of policy.Hence ordered to pay the claimed amount within one month on receipt of the consent letter from the complainant

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# BHUBANESWAR OMBUDSMAN CENTER

## Complaint No.14-005-0561

## Sri Radha Mohan Jena

*Vrs*

## Oriental Insurance Co. Ltd., CDO-II, Bhubaneswar

**Award dated 07th July, 2009**

Complainant had taken a Mediclaim Policy with Oriental Insurance Company Ltd for himself and his wife. He was admitted to Hospital and on discharge lodged a claim. Insurer repudiated the claim on the grounds that the ailment treated for was pre existing.

Hon'ble Ombudsman heard the case on 12.05.2009 where both sides were present. Hon'ble Ombudsman after hearing both sides and on perusing the discharge summery of Kalinga Hospital held that it does not specify since when the complainant was suffering from hypertension. As complainant has produced the policies since 2004 with continuous renewal from the same insurer, the ailment treated cannot be called as preexisting and therefore directed insurer to pay the claim.

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# BHUBANESWAR OMBUDSMAN CENTER

## Complaint No.11-012-0573

## Smt Archana Somani

*Vrs*

## ICICI Lombard Gen Insurance Co Ltd. Bhubaneswar

**Award dated 24th August 2009**

Complainant had taken a Group Mediclaim Policy with ICICI Lombard Gen Insurance Co Ltd through Ragadi Co-operative Weavers' Society. Complainant has submitted all treatment papers for his hospitalization but Insurer has not settled the claim.

Hon'ble Ombudsman heard the case on 17.03.2009 where complainant was absent but Insurance Company was present, inspite of prior notice issued to both parties. Insurance company expressed that they are unable to settle the claim as the complainant has not submitted documents

to them. However complainant has submitted some documents to this forum. Therefore direction was given to the Insurance Company to settle the claim within 15 days of receipt of consent letter, as per documents submitted and complainant was directed to submit documents to insurance company within 15 days of receipt of this order.

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## BHUBANESWAR OMBUDSMAN CENTER

Complaint No.11-002-0569

Sri Biswanath Joshi

*Vrs*

New India Assurance Co. Ltd., Khurda Road Branch

**Award dated 05Th August, 2009**

Complainant had taken a Mediclaim Insurance Policy for self and spouse with New India Assurance Company Ltd. His spouse was admitted at the Udaybhanu Clinic, Cuttack for

an emergency operation. She was operated on 28.07.2006 and discharged on 06.08.06.A claim was lodged with insurer who has repudiated the same on grounds of late intimation.

Hon'ble Ombudsman heard the case on 21.07. 2009, in presence of both parties. After hearing both sides and perusing documents produced, held that the repudiation of the claim merely on grounds of late intimation ,where delay has been explained, is against natural justice and hence directed to pay the claim on the basis of bills and cash memos produced within one month of receipt of the consent letter from the complainant.

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## BHOPAL

**DEPTT.** **Mediclaim Policy**

**CATEGORY:** **Mediclaim Policy**

**SUB CATEGROY:** **Total Repudiation of Claim**

**Order No.: BPL/GI/0910/002** **Case No.: GI/RSI /0209/103**

**Dated 6th May, 2009**

**Shri Prasanna Kumar Jain & others**

**V/s**

**The Royal Sundaram Alliance Insurance Co. Ltd., Chennai**

## Brief Background

Mr. Prasanna Kumar Jain (hereinafter called Complainant) was covered along with his wife Preeti Jain, Daughter Priyanka Jain, Kanishk Jain, Ritika Jain under various followings Mediclaim policies/ certificate Nos. HLSBIL0013/HS00072786000101 for S.I of Rs. 100000/- for the period from 18.06.2007 to 17.06.2008 **and** under Policy No. HN00000333000100N001 covering his son Kanish Jain separately for Rs. 100000/- for the period from 18.2.2008 to 17.2.2009 **and also** under Hospital Cash Insurance Policy No. HCSBIL0003/CS00004465000102 for the period from 31.8.2007 to 30.8.2008 for daily Benefit for Rs. 1000/- for Prasanna Kumar Jain, Preeti Jain, Priyanka Jain (Priyanka included through Endorsement No. 003 ) & Kanishk Jain **and also** Hospital Benefit Plus Insurance Policy No. SN00000176000100 for Hospital confinement Daily benefit for Rs. 1000.00 for Mr. Prasanna Kumar Jain and Ritika Jain for the period from 19.2.2008 to 18.2.2009 and also Hospital Cash Insurance Policy No. HCSBIL0012/CS00080429000100 for Daily benefits Rs. 2500/- for Mr. Prasanna Kumar Jain, Preeti Jain, Kanishk Jain and Priyanka Jain for the period from 23.8.2007 to 22.8.2008 issued by Royal Sundaram Alliance Insurance Co. Ltd., (hereinafter called Respondent).

**As per the Complainant**, he is continuously insured since 2005 through Daily cash Policies and since 2006 under Health Shield Insurance with the respondent and his son Kanishk was admitted in Peoples General Hospital, Bhopal for the period from 28.4.08 to 2.5.2008 and he himself hospitalized in City Hospital, Bhopal for the period from 5.5.2008 to 10.5.2008 for the treatment of Septicemia and submitted the claims documents to Respondent on 12.5.2008 and 19.5.2008 but the claims were not settled even after his follow-ups. Later on his daughter Priyanka Jain suffered from Loose motion and fever and was hospitalized on 4.6.08 in Shivam hospital and remained admitted up to 7.6.2008 and Ritika jain was hospitalized due to viral hepatitis and UTI in City Hospital for the period 8.6.2008 to 14.6.08 and during these critical period his wife Preeti jain felt sick due to acute Gastroenteritis & Dehydration etc. and was hospitalized in Shivam Hospital for the period from 14.6.2008 to 17.6.2008.(who later died on 23.6.2008) As per complainant the claim documents for all above claims were submitted to Respondent in due course of time but the claims are not settled intentionally and kept pending unnecessarily and on enquiry always false assurances given that your claims are being settled. In the meantime, in the month of July Mr. Chakradhar from Chennai said to be Investigation Doctor also approached him and after interrogation of few things it was assured by Mr. Chakradhar that you will get the claim amount in 2nd week of August 2008 but even than the claims were not settled then he reminded by Fax messages dtd. 22.8.08, 29.8.2008 but no response then he again reminded to respondent through fax on 13.9.2008 and also lodged first complaint through Fax to this forum i.e. Insurance Ombudsman, Bhopal on 13.9.2008 for early action in the matter. But inspite of repeated follow-ups the claims were repudiated instead of settlement by respondent vide their letter dated 18.9.2008 stating that "On perusing the various claim documents submitted by you, all claims are exaggerated and stage managed and made by fraudulent means and closed all the claims by mentioning policy condition "No liability under the Policy will be admitted, if the claim is fraudulent or supported by fraudulent means. Aggrieved with the delaying attitude, allegation of fraud and decision of

nonpayment of claims he approached this forum first time on 13.9.2008 and finally on 31.12.2008 for necessary settlement of above mentioned claims separately for Rs. 33881/-, 63001/-, 18534/-, 6000/-, and 28500/- respectively for the above mentioned five claims.

**Observations:**

There is no dispute that the complainant and his family members were covered under various Mediclaim policies for Medical expenses and daily cash benefits issued by Respondent. The matter of dispute observed to be claims made by fraudulent means. During hearing the complainant repeated all the points as mentioned in his application forms (submitted to this forum) and described that due to unfortunate period/ bad luck he and his family members suffered diseases co-incidentally within short span of time and approached to the best doctors/hospital in the city for their best treatment and all the Admission, Pathological tests, Medicines are carried out in accordance with the advices of Doctors &/or Hospitals only and also stated that there is no unfair, fraudulent exercise committed by him to make claim but because of necessity of patient and advices of Treating doctor/hospital only. It is also stated by complainant that her wife Preeti who was sick and hospitalized on 14.6.2008 at Shivam hospital died on 23.6.2008. It is also stated by complainant that he is a Asst. Engineer in M.P.State Water Resources Deptt. Bhopal and has no time to do this kind of alleged fraudulent exercises and also explained that how it is possible to manage the Doctors, Pathologist, Chemist and Hospital Staff of different reputed Hospitals of city to make exaggerated and fraudulent claims as opined by Respondent. During hearing it is described by respondent that first of all as per Policy condition the complainant is not entitled to lodge the complaint after 90 days of repudiation of claim to this forum because all the claims were repudiated by them on 18.9.2008 and also explained that the above claims are repudiated due to repeated fraudulent claims made by the complainant. In response thereof the forum expressed that the complainant approached within 3 months of Repudiation of claim similarly as per the jurisdiction of this forum the complainant can approach within 1 year of the rejection by the insurer of the representation of the complainant or the insurer's final reply to the complainant's representation. On asking from the respondent to explain/substantiate their decision of repudiation (on the ground of fraudulent means) of all 5 claims case wise to explain how the each claim found to be made by fraudulent means, it is explained by respondent that the details has been submitted directly by their corporate Office Chennai. Immediately the forum explained to respondent that the self contained note was submitted by Chennai office for another case pertain

to claim for Mr. Prasanna Kumar Jain for the Hospitalization period 6.10.2008 to 11.10.2008 under the other policies and not for the above mentioned 5 claims. Then, the respondent stated that presently he has no case wise details of above preferred 5 claims and requested for 7 days time to submit the case wise details. As regards not having the case wise details by representative of Respondent for the above 5 claims the letter dtd. 9.4.2009 was shown to respondent where it was clearly mentioned to bring the details of all 5 case separately moreover, the same was also intimated/reminded telephonically to their Corporate Office at Chennai on 22.4.2009 then why the case wise details are not brought by him. The respondent agreed to above points but again requested to provide 7 days time to submit the case wise details to substantiate their decision. The forum allowed the period and advised to produce the same by 5.5.2009 positively which was agreed by both parties. On 5.5.2009 the complainant presented in this forum on time, but the respondent did not appear in this forum even after telephonic reminder on 4.5.2009 and on 5.5.2009 also which observed to be non-

cooperation by respondent to this forum in above claims. However, on going through the documents i.e. Discharge summary, Pathological Reports, Hospital bill and bills for medicines purchased from chemist etc. as submitted by complainant for the above 5 cases separately and found that in **Case No. 1 i.e. claim for Kanishk jain** it is revealed that he was admitted in Peoples General Hospital on 28.4.2008 to 2.5.2008 for the diagnosis of Lower respiratory Tract infection where various examinations i.e. X-ray, Blood, Urine etc. were conducted and the total expenditure for Hospital/pathological expenses including medicines from chemist etc. for Rs. 19881/- is claimed by complainant. On going through the Respondents letter dated 18.9.2008 sent to Complainant as provided by complainant wherein the discrepancies as regards claim of Kaniska Jain are pointed out on the basis of medical records only and not substantiated by any Medical opinion and denial of concerning doctor/hospital, moreover, the discrepancies required to be clarified by Doctor/hospital which found not obtained and even not produced as evidence by Respondent, therefore, the claim found payable to the complainant for the above claim under the Medical expenses policy and under Daily Cash Benefit Policies for **Rs. 33881/-** as per the followings: Rs. 19881.00 for medical expenses and Rs. 14000/- for Daily Cash benefits for 4 days.

**Case No. 2. pertains to Mr. Prasanna Kumar Jain**

On going through the documents i.e. Discharge Summary, various pathological reports of Blood, Urine, X—ray report, USG Abdomen, ECG., Bill for Hospital and for medicines purchased from chemist it found that he was hospitalized in City Hospital, Bhopal for the period from 05.5.2008 to 10.5.2008 for the Diagnosis "Septicemia (MOD) and an amount of Rs. 13770/- paid to Hospital and Medicines for Rs. 26801/- was incurred for the treatment. The non-genuiness of above claim is not proved by respondent neither through self contained note nor during hearing or even not explained to the complainant, therefore, the complainant found entitled to receive the above claim amount for Rs. 40601/- for Medical expenses + Rs. 22500/- for Daily cash benefits. (Total amount comes to **Rs. 63101/-**) under the various policies (mentioned above) issued by respondent.

**Case No. 3 Priyanka Jain**

On going through the Claim documents produced by complainant (i.e. Discharge Summary, Pathological tests, Hospital bill and cash memo for medicines purchased from chemist etc.) it is revealed that Priyanka Jain was suffering from Loose motion, Vomiting, Fever, Cough etc. and diagnosed for Acute Gastroenteritis with A.R.I. and was hospitalized in Shivam Hospital, Bhopal for the period from 4.6.2008 to 7.6.2008 and claimed Rs. 6800/- for hospital bill and medicines purchased from chemist + Rs. 10500 as Daily cash benefits under two policies. (mentioned above) The non-genuiness/fraud/not payable of above claim is not proved by respondent neither through self contained note nor during hearing or even not explained to the complainant, therefore, the complainant found entitled to receive the above claim amount for **Rs. 17300/-** from the respondent.

**Case No. 4 Ritika Jain:-** As per the claim documents produced by complainant it is found that Ritika Jain was hospitalized in City Hospital, Bhopal for the period from 8.6.08 to 14.6.08 for the diagnosis Viral Hepatitis with UTI and was covered for Daily cash benefit in a single policy @ 1000/- per day. The above claim is also not defended/proved fraudulent or

even found not explained to complainant therefore, the complainant is entitled to get claim for **Rs. 6000/-** (for the hospitalization period of 6 days) from the respondent.

**Case No. 5 Preeti jain:-** As per the claim documents viz. Hospital bills, pathological reports, Discharge Summary etc. produced by complainant it revealed that Preeti Jain was hospitalized in Shivam hospital, Bhopal for the period from 14.6.2008 to 17.6.2008 for the diagnosis of Acute gastroenteritis with dehydration (who later on reported died on 23.6.2008 as confirmed from the death certificate produced by complainant) where an amount of Rs. 16312/- paid to Hospital and chemists and claim for Daily cash benefits under 2 policies (mentioned above) for Rs. 10500/- for 3 days preferred to respondent but the respondent found failed to proved this claim as not payable being not defended/substantiated neither in self contained note nor in hearing or even not explained to complainant. Therefore, the complainant is found entitled to receive the above mentioned claimed amount for **Rs. 26812/-** from the respondent.

**Under the circumstances explained above**, the Decision taken by Respondent for the repudiation of all above 5 claims on the ground of fraudulent or supported by fraudulent means are not substantiated by documentary evidences, no case wise proper opportunity was given to complainants as to how the claims are made by fraudulent means or even not explained to this forum neither in the self contained note nor during the hearing, moreover, not presented on 5.5.2009 even after the request for the extension of period for the submission of case wise evidences in support of their decision. **Therefore, the respondent is directed to pay the above mentioned 5 claim amount for Rs.33881/-+Rs.63101/-+Rs.17300/-+Rs.6000/-+Rs.26812/- respectively for the above mentioned case No. 1 to 5 separately to the claimant (The total amount for all above 5 claims is for Rs. 147094/- as found covered under the Policies mentioned in the first Para of this judgment) within 15 days from the date of receipt of consent letter from the complainant failing which it will attract a simple interest of 9% p.a. from the date of this order to the date of actual payment.**

----------_____END_____----------

**CATEGORY:** **Mediclaim Policy**

**SUB CATEGROY:** **Total Repudiation of Claim**

**Order No.: BPL/GI/09-10/003** **Case No.: GI/NIA/0309/113**

**Dated 7th May, 2009.**

Shri Sachin Sarda V/s The New India Assurance Co. Ltd., .DO.-2, Indore

## Brief Background

Mr. Sachin Sarda (hereinafter called Complainant) had obtained Mediclaim policy No. 450800/34/08/11/00000355 for S.I of Rs. 50000/- covering his wife Smt. Pratibha Sarda and daughter Rishita aged 2 year for the period 25.05.2008 to

24.05.2009 from The New India Assurance Co. Ltd., Indore (hereinafter called Respondent)

**As per the Complainant** his daughter was hospitalized (15.11.2008 to 22.11.2008) and diagnosed "Juviline Diabetes Type I. The TPA has repudiated above claim under clause No. 4.1, 4.3 and 4.6 as per Mediclaim Policy 2007. However his above policy is a renewal of earlier Policy No. 45080034072000000460 where the above disease was covered after 30 days waiting period and also that his claim should have been processed on 1st year Policy but not on 2ndyear Policy as he has taken 1st year policy on utmost good faith and accordingly any changes/modification of new policy are applicable for the proposers who entered 1st time but not for renewal one. On receipt of TPA letter dtd. 19.1.2009 complainant approached the higher office of respondent vide letter dtd. 21.1.2009 but there was also no response from their side. Aggrieved with the decision of the Respondent's TPA, he approached this office for necessary settlement of his claim.

**The Respondent** in its reply-dated 02.04.2009 (along with TPA letter dtd. 19.1.2009 and other claim documents including policy clause) submitted that on receipt of the claim documents the claim was scrutinized by their TPA and the team of their doctors is of the opinion that the said claim is not admissible under clause No. 4.1, 4.3 & 4.4.6 of Policy condition.

**Observations:**

There is no dispute that the complainant's daughter Rishita was covered under the above-mentioned policy for the period from 25.5.2008 to 24.5.2009 and was hospitalized at Greater Kailash hospital, Indore for the period from 15.11.2008 to 22.11.2008 where she was diagnosed as **Juvenile Diabetes Type I**. The matter of dispute observed for the application of Policy clause for the disease (Diabetes) i.e. whether the claim for present ailment (Diabetes) falls under the clause of current policy No. 45080034081100000355 or should be processed as per the terms condition/clause of previous police No. 45080034072000000460 (25.5.07 -08) being renewed without break. It is a case of 2 year old girl who was first time insured on 25.5.2007 to 24.5.2008 and further for the period from 25.5.2008 to 24.5.2009 and is diagnosed for **Juvenile Diabetes Type I** in the month of Nov. 2008 while during this period in the year 2007 i.e. after the issuance of first policy but before the renewal/issuance of current policy, the existing Mediclaim policy stands revised by respondent. During hearing the complainant pleaded almost all the points as mentioned in his main complaint letter and reiterated that this policy is a renewal of 1st/previous Policy No. 450800/34/07/20/00000460 valid for the period from 25.5.2007 to 24.5.2008 which was renewed by Pol.No. 450800/34/08/11/00000355 without break for the period from 25.5.2008 to 24.5.2009 and during this period the company has changed the terms & condition of Mediclaim policy in 2007 where so many changes as regards pre-existing disease, waiting period etc. are taken place as compare to conditions of previous policy. Complainant further stated that as per previous policy the waiting period for Diabetes was only 30 days while as per new/revised mediclaim Policy the waiting period is for 2 years and also that these changes/revised Mediclaim Policy should be applicable on the insureds who enters first time for the Insurance and not on the existing policy holders. On asking from the complainant whether the changes in the Policy &/or about the revised Mediclaim policy was told to him at the time of renewal of this Policy and also whether the Proposal form for renewal of this policy was given by him, it was accepted by complainant that the same was informed by Agent and the proposal form was also submitted by him at the time of

2nd Insurance i.e. Renewal of previous Policy. During the course of hearing the respondent explained that in 2007 the existing Mediclaim Policy was revised by their company for all India level where so many provisions as regards terms & condition for claim were changed and also that the above Insurance for the current period was done under the provisions of new Mediclaim Policy where no relaxation is available for the existing policy holder except for Cumulative Bonus. Similarly, the respondent by producing a Medical Opinion report of Dr. K.G.Agarwal, also stated that the above claim is not payable even under the Previous year Policy because as the previous Policy condition also excludes the diseases which existed prior to inception of the Insurance clarifying that as per Medical Opinion from Dr. K.G.Agarwal, the above disease a congenital disorder transmitted to child by genes by parents or forefather/mother hence child suffers from Diabetes since birth". The above point is immediately denied by complainant that the above disease is a pre-existing. The complainant was asked by the forum by drawing his attention towards the letter dtd. 19.01.2009 sent by TPA to him where the disease is explained as Pre-existing (condition No. 4.1) whether their opinion of pre-existing was challenged &/or represented by him to TPA or has any Opinion from the medical experts proving that it is not a pre-existing disease? It was explained by complainant that he does not have any opinion from doctor in support of his plea for no pre-existing and also that the above points with T.P.A. are not challenged/represented by him in response to their letter dtd. 19.01.2009 but requested to forum to submit the same by next day through fax i.e. on 7.5.2009. The forum allowed him to submit the same up to 7.5.2009 with the condition that it will be for keeping pending the decision only and for not any further hearing process. The respondent further stated that the Company has revised the Mediclaim policy in 2007 and introduced new Mediclaim Policy in place of previous Policy as per their corporate objectives i.e. Claim ratio etc. and reiterated that the claim falls under the current year policy as there are no relaxation to existing policy holders for the new Mediclaim Policy 2007. On 7.5.2008 the complainant sent through Fax the opinion of Dr. Satish Kumar Londhe certifying that the disease was not existed prior to 14 Nov. 2008 and also opinion of Dr. Sunil M.Jain, certifying that it is not a congenital disease. I have also gone through the policy clauses applicable to both the policies i.e. for first policy and the current policy and found that the pre-existing diseases are excluded from both the policy while the current year policy is having special condition No. 3 i.e. waiting period for specified diseases/ailments/condition of "Diabetes mellitus" for Two years from the time of inception of the cover.

**In view of the circumstances stated above**, the decision of the Respondent to repudiate the claim is **just & Fair** as it is beyond any doubt that the claim falls under the period of current policy (25.5.2008 to 24.5.2009) obtained after the introduction of new Mediclaim Policy as a fresh contract of Insurance for which proposal form was obtained by complainant &/or submitted by Respondent. The present policy specifically contains condition No. 4.1 for pre-existing disease and 4.3 having provision that the **"Diabetes melitus**" is not covered for the first 2 year from the inception of policy while the disease found diagnosed within 6 month from the inception of Policy. The complainant's plea about the interest of existing policy holder for changing/revised the Policy conditions found not valid in this case as 1) Being the commercial organization, the respondent has right to review their Policies on time to time as regards Premium and claim experiences etc. to make necessary changes in the present policies, if required, under the provisions of Regulatory agencies i.e. I.R.D.A. etc. and 2) it is a annual contract between Insured and Insurer and previous contract does not have any condition that in future the Policy, Conditions and provisions will not be changed moreover, the changes have taken place prior to issue of policy and not during the currency of present

policy, Therefore, found no reason to interfere with the decision taken by respondent. The complaint is dismissed without any relief.

_____----------END----------_____

**CATEGORY:** **Mediclaim Policy**

**SUB CATEGROY:** **Total Repudiation of Claim**

**Order No.: BPL/GI/09-10/005** **Case No.: GI/NIA/0409/003**

**Dated 15th May, 2009.**

**Shri Sanjay Dhakde** V/s The New India Assurance Co. Ltd., . Bhopal

## Brief Background

Mr. Sanjay Dhakde (hereinafter called Complainant) had obtained Mediclaim policy No. 451400/34/07/11/00000651 for S.I of Rs. 30000/- covering his wife Smt. Mala Dhakde for the period 05.03.2008 to 04.03.2009 from The New India Assurance Co. Ltd., Bhopal. (hereinafter called Respondent)

**As per the Complainant** he himself was hospitalized in RML Patel Hospital, Bhopal on 22.11.2008 to 30.11.2008 for the disease of Malaria and the all the documents submitted to Universal Medi-Aid Service, (TPA)for the settlement of claim for Rs. 22696/- which has been repudiated by TPA, then, he approached to Respondent office where matter was taken up by them with TPA and appointed Investigator and after receiving the report they submitted the file to TPA where the claim is repudiated on the basis of Investigation report of Mr. R.S.Dubey and other medical discrepancies found in medical bills and discharge summary and also in the light of clause No. 3.3(e) and 4.4.11. Then, complainant again approached to Respondent where the respondent taken the similar stand of Repudiation. Aggrieved with the decision of the Respondent & TPA, he approached this office for necessary settlement of his claim.

**The Respondent** in its reply-dated 27.04.2009 (along with TPA letter dtd. 14.3.2009 and Investigation Report of Mr. R.S.Dubey) submitted that on investigation of the case there were various discrepancies found viz. Hospital has not mentioned daily record, Hospital is managed by Homeopathic Doctor, Hospital has been shifted to another place and there was no need for the patient to get admitted in ICCU as his conditions was not critical etc. and also that the claim is repudiated on the basis of Investigation report.

**Observations:**

There is no dispute that the complainant was covered under the above-mentioned policy for the period from 05.03.2008 to 04.03.2009 and was hospitalized at RML

Patel Hospital for the treatment of Malaria. During hearing the complainant reiterated that he was sick and hospitalized in hospital and Rs. 23000/- appx. was paid by him and expressed his inability to the discrepancies/queries raised by TPA and in Investigation report. During the hearing the Respondent stated that the claim found not payable as per Medical discrepancies observed by TPA and findings of investigator. I have also gone through the Investigation report of Mr. R.S.Dubey and also the discrepancies find out by TPA and observed that the Signatures initials right from the prescription to Hospital bills, Medicines bills of different firm, Pathological reports etc. are done by Dr. Arvind Katiyar who is a BHMS (Homeopathic doctor), as per the statement of complainant to Investigator he was remained on the same bed in the same room throughout his stay in hospital while as per bill hospital charged Rs. 3600/- @ Rs. 1200/- for only 3 days for ICCU only and no charges for another 5 days are mentioned in the Bill. Similarly, Rs. 4800/- for visiting Doctors consultation for two times for 8 days are charged but no Receipt of recipient doctors are submitted, the Medical bills said to be issued by Rajput Medical Store could not be verified being the carbon copies not produced to investigator. All the points mentioned above clearly indicates that the reported claim is not supported by proper medical documents &/or is not corroborated with the treatment, but it is also beyond any doubt that the complainant suffered disease and treatment was given by hospital/Doctors no matter their professional qualification/competence because the patient is not so highly educated to confirm the above things before the treatment.

**In view of the circumstances stated above**, the decision of the Respondent to **repudiate** the entire claim is not just & Fair because it is not a absolute bogus claim but found inflated one &/or the disease is not corroborated with the reported treatment/documents which were given by Doctors/hospital, therefore, it would be justify to settle the claim up to **70% of claimed amount**. Hence, the respondent is directed to pay **Rs. 15789/-** to the Complainant as per the following calculations:- Rs. 22706/- (claimed amt.) Less Rs. 150/- (Registration charges not covered) = Rs. 22556/- Less Rs. 6767/- (30% being found inflated/not supported by documents etc.) = Rs. 15789/- within 15 days from the receipt of consent letter from the Complainant failing which it will attract a simple interest of 9% p.a. from the date of this order to the date of actual payment.

----------_____END_____----------

**CATEGORY:** **Mediclaim Policy**

**SUB CATEGROY:** **Total Repudiation of Claim**

**Order No.: BPL/GI/09-10/006** **Case No.: GI/NIA/0409/004**

**Dated 20th May, 2009.**

**Shri Anoop Kumar Gupta V/s The New India Assurance Co. Ltd.**

## Brief Background

Mr. Anoop Kumar Gupta (hereinafter called Complainant) had obtained Mediclaim policy No. 451400/34/06/20/00000259 for S.I of Rs. 150000/-+ cumulative

Bonus covering his wife Smt. Manjula Gupta for the period from 20.2.2007 to 19.2.2008 from The New India Assurance Co. Ltd., Bhopal. (Hereinafter called Respondent)

**As per the Complainant** his wife due to serious problem of endometritis and had a fever was forced to admit in the hospital for the period 14.9.07 to 15.9.07 and was continuously on medication. After discharge a claim for Rs. 8683/- was lodged with TPA submitting all original bills but claim is repudiated on the ground that the "Patient did not require hospitalization and could have treated as an outdoor patient". Then he represented the matter with TPA and to the respondent office vides letter dtd. 17.3.2008 & 22.1.2008 respectively but there was also no favorable response. Aggrieved with the decision, he approached this office for necessary settlement of his claim.

**The Respondent** in its reply-dated 27.04.2009 submitted that the TPA has repudiated said claim on the ground that "The Patient did not require hospitalization and could have treated as an outdoor patient".

**Observations:**

There is no dispute that the complainant's wife was covered under the above-mentioned policy and was hospitalized in Agarwal hospital, Bhopal for the PID with cellulitis. The only dispute is for **requirement of hospitalization**. During hearing the complainant reiterated that his wife was suffering from stomach pain and infection since 5-7 days prior to admission and was consulted with Dr. Neelima Agarwal and as per the advices of doctor various tests were conducted and hospitalized on 14.9.2007 but the claim repudiated by TPA. The complainant also stated that after receiving information from TPA, he approached to the attending doctor about the same where the doctor confirmed that the hospitalization was essential. The complainant also submitted certificate as evidence issued by Dr. Neelima Agarwal, confirming that the "**Admission was essential"**. During the hearing the Respondent stated that as per the documents submitted by complainant the TPA found that there was no need of hospitalization and the patient could have treated as an outdoor patient, hence, the claim is rejected by their TPA. On asking about how the TPA arrived at the conclusion that the hospitalization was not required, it was explained that it is the opinion of their Medical Team only. The respondent was further asked to submit the opinion of TPA proving that hospitalization was not required, but no document in support of their decision was submitted by the Respondent by describing that it is not available in the file. I have also gone through the claimed documents submitted by complainants and observed that as per Blood investigation report there were WBC count was 11900 cumm. and Neutrophils was 75% and ESR was 40 mmFHR, similarly, as per Sonography examination report the Cervix is reported bulky with multiple nebothian cysts.

**In view of the circumstances stated above**, the decision of the Respondent to repudiate the claim **is not just & Fair** because the hospitalization was done with the advices of competent doctor for the proper treatment while the respondent found failed to substantiate their decision, therefore, the Respondent is directed to pay the lodged claim for Rs. 8683/- to the claimant within 15 days from the receipt of consent letter from the Complainant failing which it will attract a simple interest of 9% p.a. from the date of this order to the date of actual payment.

----------_____END_____----------

**CATEGORY:** **Mediclaim Policy**

**SUB CATEGROY:** **Total Repudiation of Claim**

**Order No.: BPL/GI/09-10/007** **Case No.: GI/OIC/0109/097**

**Dated 22nd May, 2009**.

**Shri Satish Chauhan**...**V/S The Oriental Insurance Co. Ltd., Indore**

## Brief Background

Mr. Satish Chauhan (hereinafter called Complainant) had obtained Mediclaim policy No. 151200/48/08/1892 for S.I of Rs. 50000/-alongwith his wife Smt. Deepika for the period from 15.10.2007 to 14.10.2008 from The Oriental Insurance Co. Ltd., Indore. (Hereinafter called Respondent)

**As per the Complainant** he himself was hospitalized in Gurjar Hospital, Indore on 7.10.2008 to 13.10.2008 and intimated to Respondent over phone by hospital but it was advised to submit in writing, lateron he called his brother from the village and due to holidays the office was closed and finally, the intimation was given on 13.10.2008 and requested to visit the hospital but no body from the respondent side visited hospital and the claim is repudiated by respondent instead of settlement. Later on complainant represented to the higher office of respondent vide letter dated 17.12.2008 but there was also no favorable response. Aggrieved with the decision, he approached this office for settlement of his claim.

**The self contained note submitted** by Respondent on 19.5.2009 by fax but the same is not legible while necessary documents are received from complainant.

**Observations:**

There is no dispute that the complainant was covered under the above-mentioned policy and was hospitalized in Gurjar hospital, Indore on 7.10.2008 and remained hospitalized up to 13.10.2008 for the treatment of Enteric fever with vomiting. The only dispute is for Delay in intimation and submission of documents to the respondent. During hearing the complainant reiterated that on 7.10.2008 the TPA was informed over telephone by Hospital staff and he is alone at Indore together with his wife who is not so educated hence he called his brother from the village and accordingly he arranged to submit intimation to TPA through his brother only. It is also explained by Complainant that during these days holidays were also there causing intimation in writing on 13.10.2008 and waited in hospital up to 2.00 p.m on the day of discharge with the hope that someone will visit the hospital but no body from TPA visited hospital, finally he submitted all the claim related documents for Rs. 13203/- on 27.10.2008. During the course of hearing the Respondent stated that as per policy condition No. 5.4 the notice of hospitalization should be given within 48 hours of admission or before discharge from hospital but in this case there was delay in intimation and also in submission of claim related documents causing repudiation of claim by TPA. It is also explained by respondent that it is a 3rd claim from the complainant and prior to this 2 claims for the treatment of complainants wife were also preferred by complainant which stands

paid to complainant which means that the complainant is well aware about the importance of timely intimation of claim. On asking from complainant why the claim was not intimated in time, he explained that he is alone at Indore and he himself was hospitalized and his wife is not educated to do the same work. On asking from the Respondent whether the claimed documents submitted by complainant got checked/verified from the hospital as regards genuineness of hospitalization and treatment etc., it was explained that the same is not done. Further on asking it was explained by respondent that otherwise the claim is admissible in all respect except for the delay in proper intimation of hospitalization and submission of documents as well.

**In view of the circumstances stated above**, I am of the considered opinion that the decision for repudiation of entire claimed amount **is not just & Fair** because the complainant was well covered and hospitalized as per the terms & condition except for delay in written intimation to TPA which is because of he himself was suffering from the disease and was hospitalized **but** found late **simultaneously in the submission** of claim documents within 7 days of discharge from the hospital as required under Policy condition No. 5.5, Hence, the Respondent is directed to **settle and pay the claim up to 70% of Admissible Claim Amount** to complainant within 15 days from the receipt of consent letter from the Complainant failing which it will attract a simple interest of 9% p.a. from the date of this order to the date of actual payment.

----------_____END_____----------

**CATEGORY:** **Mediclaim Policy**

**SUB CATEGROY:** **Total Repudiation of Claim**

**Order No.: BPL/GI/09-10/09** **Case No.: GI/ICI/0109/90**

**Dated 4th June, 2009**

**Mr. Rajesh Bordia V/s I.C.I.C.I.Lombard General Insurance Co.Ltd**

## Brief Background

Mr. Rajesh Bordia (hereinafter called Complainant) had obtained Health Insurance Policy No. 4034/FFH/W-125857/00/000 for Rs. 200000/- for his father Mr. Sardarmal Bordia and mother Pratibha Bordia for the period from 05.03.2008 to 04.03.2009 from I.C.I.C.I. Lombard General Insurance Co. Ltd. (hereinafter called Respondent)

**As per the Complainant** he obtained Policy using online facility of respondent on 5.3.2008 and paid the premium to respondent and all medical tests as suggested and required by respondent were done before the issuance of policy. After some

time his father has gone under routine health checkup on 24.3.2008 and stress Test was conducted at Mahavir hospital, Dahod where they suggested Angiography which was done on 6.5.2008 at Baroda heart Institute, Baroda where Bye-pass Surgery (CABG) was suggested which was done at Asian Heart Institute, Mumbai on 4.6.2008 and remained hospitalized up to 10.6.2008 and applied for cash less facility with TPA who denied the same on the basis of "Pre-existing Diseases". After surgery claim was lodged with TPA for reimbursement basis and all the documents were furnished as required by TPA vide their SMS dtd. 3.7.2008, E-mail dtd. 12.7.2008. After submitting all documents complainant followed up the matter and all the times it is told by TPA that they did not receive the required documents which have already been submitted by complainant. Aggrieved with non settlement of claim neither on cash less nor on Reimbursement basis and even non acknowledgement of received documents, and finally closed as No claim for the wants of documents, complainant approached this forum for the necessary settlement of claim.

As per self contained note letter dtd. 05.05.2009 it is submitted by Respondent that the complainant's father was hospitalized for treatment of Ischemic Heart Disease (TVD) and filed a claim with TTK healthcare which was closed by TPA for requirement of documents accordingly shortfall letters were sent to the complainant by T.P.A by mentioning list of required documents viz. prior consultation paper advising stress test, stress test report, ECG reports with subsequent paper for chest pain and Angina, previous CAG report with hospitalization papers with 2-D report and consultation papers of Dr. Mahendra Mehta etc. The respondent also requested this forum to ask the complainant to submit the above documents for their processing of claim as per the policy terms.

**Observations:**

There is no doubt that the Complainant was covered under the above-mentioned policy for the S.I. Rs. 200000/- for the period from 5.3.2008 to 4.3.2009. On 24.3.2008 the Stress test was done where found positive and advised for CAG which was carried out on 6.5.2008 at Baroda Heart Institute & Research Centre, Baroda and advised for CABG which was also done on 4.6.2008 at Asian Heart Institute, Mumbai. The matter of dispute observed for pre-existing disease at the time of inception of Policy. During the course of hearing the complainant reiterated almost all the things as mentioned in his complaint letters by emphasizing that the disease observed only after the Stress test conducted on 24.3.2008 as a routine checkup and before that there was no problem to his father. The complainant also stated that if there was any pre-existing disease then it should have been discovered in the pre-insurance medical tests conducted at the Pathological lab suggested by the Respondent. The complainant also submitted various Medical document i.e. Indoor case records, Stress Test Report etc. pertains to Baroda Heart Institute and Asian Heart Institute **first time to this forum**. On asking from complainant why the same documents were not submitted to this forum together with your complaint, it is explained that it is a mistake on his part and the same should have been submitted by him together with the complaint letter. On the other side, the Respondent explained that in the above case the insurance was obtained on 5.3.2008 and within 19 days the TMT test was found positive which clearly indicates that the problem was not a fresh one but was persisting since long therefore cash less facility was denied by their TPA considering the ailment is pre-existing and the complainant was asked & insisted to submit the relevant documents for their processing of claim to find out the duration of disease. An Investigator was also deputed to find out the facts of the case. Respondent further stated that on Investigation of documents of Baroda Heart Institute where the Angiography was done it is mentioned in the case sheet of hospital that **Chest pain**

**was on & off since 1 year** and TMT +ve 1 month ago at Dahod. The copy containing seal and signature of hospital produced by Respondent together with the Questionnaire replied by the attending Dr. Mahesh Basarge to the answer of Question **No. 1 When did the patient consulted you for the first time? For what complaints?** It is answered by doctor **"C/o Chest pain for 1 year duration/D.O.A 6/05/08, TMT positive 1 month back.** It is also stated by Respondent that the copy of above-mentioned Case sheet of Baroda Heart Institute as submitted by complainant to TPA in support of his claim is **found different as regards duration of chest pain**. I have personally gone through both the case sheets as submitted by complainant to this forum and compared with the copy submitted by Respondent which was obtained by their Investigator from the Hospital and observed that in the copy submitted by complainant the duration of chest pain is mentioned as "On **& off TMT +ve 1 mth ago** at Dahod **while** in the copy submitted by respondent the duration of chest pain is mentioned as **"On & off since 1 yrs TMT +ve 1 mth ago at Dahod.** Similarly, the rubber stamps put into the sheets are entirely different which compelled to believe that both sheets are different altogether as regards the duration of disease only. The case sheet of Baroda Hospital as produced by respondent was shown to complainant and asked about the difference, it is stated by him that probably different case sheets are provided by Hospital. The respondent further stated that the disease diagnosed within the 19 days of the currency of policy compelled them to believe that the disease is not fresh one being the ailment is chronic in nature takes substantially longer time to establish in to present state which is also confirmed in the hospital record (case sheet)and confirmed by the attending doctor that the duration of chest pain is since 1 year which suggests that patient was a known case of heart related disease before policy inception which found pre-existing disease hence as per policy clause the claim is not payable. On asking it is also clarified by Respondent that now there is no need of submission of any documents by complainant as the same are collected through their Investigator and only reason for not settling the claim is pre-existing disease.

In view of the circumstances stated above, the **decision of the Respondent for not paying the claim on the grounds of;** diagnosis of chronic nature of ailment within first 15-20 days of commencement of Policy, written confirmation by attending doctor to Investigator and also noting in the case sheet of Baroda Heart Institute **is just and fair.** Besides this, delay in providing the Hospital case summary etc. to the Respondent as well as to this forum, difference in the Case sheet of Baroda Heart Institute as regards duration of disease which was a vital information to decide the fate of claim, moreover, the reason for going to Stress test on 24.3.2008 as explained **routine test** though various tests i.e. Blood count, ESR, ECG, SGPT etc. were already conducted on or after 5.3.2008 then the need to undergo the said **routine test** within 10-15 days suggests that the symptoms of heart related ailment were persisted at the time of commencement of policy. Therefore, found no reason to interfere with the decision of respondent. The complaint is dismissed without any relief.

----------END----------

**CATEGORY:** **Mediclaim Policy**

**SUB CATEGROY:** **Total Repudiation of Claim**

**Order No.: BPL/GI/09-10/12 Case No.: GI/RSI/0309/116 Dated 12th June, 2009**

**Mr. Rajesh Patel V/s Royal Sundaram Alliance Insurance Co.Ltd**

## Brief Background

Mr. Rajesh Patel (hereinafter called Complainant) had obtained Hospital Cash Insurance Policy No. HCSBIL0003 and certificate No.CS00012693000103 for Rs. 1000/- Daily benefit which increased for Rs. 3000/- per day together with his wife Anjali Patel respectively and his mother Yashoda for Rs. 1000/- per day for the period from 6.12.2008 to 5.12.2009 from Royal Sundaram Alliance Insurance Co. Ltd. (hereinafter called Respondent)

**As per the Complainant** he is having Policy since Nov. 2005 and continuously renewing without break. In the month of June 2007, his mother was suffering from chest pain and on investigation it was diagnosed as Breast cancer for which the treatment was continued and in Oct. 2007 she was admitted in Tata Hospital, Mumbai and all the documents were furnished to the respondent but no response from their side and on one day, over phone, it was informed that the mother related claim will be accepted after next renewal. The complainant further mentioned that after this conversation, his mother was hospitalized so many times for which the claim were not preferred to respondent but recently his mother was hospitalized for the period from 15.12.2008 to 18.12.2008, 27.12.2008 to 28.12.2008 and 3.2.2009 to 13.2.2009 but the respondent is saying that we did not pay the claim for old disease though it is not a old disease because the policy was taken in Nov. 2005 then on what basis respondent is considering old disease. Aggrieved with non settlement of claim @ Rs. 1000/- per day for the hospitalization by respondent, the Complainant approached this forum for the necessary settlement of claims.

**As per self contained note** letter dtd. 18.05.2009 together with Policy, Clause, Claim form and other documents it is submitted by Respondent that under the claims for hospitalization up to Oct. 2007 the representation against Repudiation of claim was made by complainant on 23.11.2007 which was replied by them on 25.11.2007 and thereafter one year has lapsed since the complainant has approached this forum on 4.3.2009 whereas the time got barred in the month of Nov. 2008 as per the Rule 13(3)(b) of the Redressal of Public Grievances Rules, 1998. It is also submitted by respondent that the complainant had made claims for the ailment of the breast cancer suffered by Mrs. Yashoda under the Hospital cash policy No. CS00012693000101 (valid from 6.12.2006 to 5.12.2007) and the claim for Breast Cancer on various dates 28.6.2007, 7.7.2007 & 29.10.2007 was denied by them since she was treated for acute case of breast cancer within 1 ½ year of Policy inception the same could not have developed with such a short possible time and this was confirmed by the panel of Doctors also. It is further submitted by respondent that in view of medical records, Panel Doctor's Opinion as well as the policy terms and conditions the claim was repudiated vides their letter dated 27.8.2007 and 19.11.2007 on the ground that the patient was admitted for breast cancer and the medical documents revealed malignant changes, which takes longer time to develop and could not have developed within a period of 1 year and 6 months of inception of policy and hence is Pre-existing which was outside the scope and purview of the Policy coverage. The respondent further submitted that the instant matter deserves to be dismissed.

**Observations:**

There is no dispute that the Complainant's wife was covered for Daily Benefits for Rs. 1000/- per day only under the above-mentioned policy. There is also no dispute about the previous claims for the period 21.6.2007 to 27.06.2007, 30.06.2007 to 07.07.2007 & 8.10.2007 to 21.10.2007 lodged by complainant to the respondent which was repudiated by respondent on the ground of Pre-existing ailment of Breast Cancer and final reply of complainants representation was also given on 25.11.2007 to complainant which causes prevention of complainant to approach this forum for the above claims as the complainant made complaint on 4.3.2009 as against the time limit up to the end of Nov. 2008 as per the stipulated time limit of 'Redressal of Public Grievances Rules, 1998'. The dispute is for the non settlement of claims for the hospitalization period from 15.12.2008 to 18.12.2008, 27.12.2008 to 28.12.2008 and 03.2.2009 to 13.2.2009. During the course of hearing the complainant reiterated almost all the points mentioned in the main complaint letter and stated that the cancer was detected in June 2007 and how the hospitalization for the above mentioned period (Dec. 2008 onward can be treated as pre-existing disease to the commencement of Policy and also asked how long the above disease can be treated as Pre-existing. The Respondent stated that the above claims are for the hospitalization of the treatment of 'Breast Cancer' and the previous claims were also for the same disease i.e. "Breast Cancer" which were repudiated on the grounds of Pre-existing disease hence, the above claims are also not payable under the Policy terms. The respondent was asked on what ground the above treatment is considered as pre-existing and submit the opinion of doctor and also the present status of above claims, it is explained by Respondent that as per the medical records and Panel Doctor's opinion, the earlier claims were repudiated and the above cases are also found in continuation to previous claims hence the same also deserves repudiation on the ground of Pre-existing, accordingly, the above claims are repudiated. I have personally gone through the Policy, clause, claim forms and medical records submitted by the complainant for the above mentioned hospitalization claims (for the period from 15.12.2008 and onward) and observed that in all claim forms the diagnosis is mentioned as 'Ca Breast' by complainant which is also confirmed from the hospital record under Regd. No. 1338/08 wherein the diagnosis is mentioned as **"Ca (L) Breast"**. Similarly, there is no mention in the policy and clause about the deletion of exclusion clause of pre-existing disease.

In view of the circumstances stated above, the decision of the Respondent for not paying/repudiation of the above mentioned claims for the period from 15.12.2008 onward are **just and fair** because the earlier claims for the hospitalization of the treatment of same disease i.e. Breast Cancer were also found not payable/stands repudiated under the scope of policy which were duly conveyed to the complainant by Respondent in due course of time, therefore, found no reason to interfere with the decision of respondent in the abovementioned current claims. The complaint is dismissed without any relief.

----------_____END_____----------

**CATEGORY:** **Mediclaim Policy**

**SUB CATEGROY:** **Total Repudiation of Claim**

**Order No.: BPL/GI/09-10/013** **Case No.: GI/UII/0209/106**

**Dated 24th June, 2009**

**Shri Brijesh Narayan Mishra V/s United India Insurance Co. Ltd.,**

## Brief Background

Mr. Brijesh Narayan Mishra (hereinafter called Complainant) had obtained Mediclaim policy No. 191303/48/20/00000352 for S.I of Rs. 30000/-along with his wife Smt. Gayatri Mishra for the period from 29.05.2007 to 28.05.2008 from United India Insurance Co. Ltd., Indore (Hereinafter called Respondent)

**As per the Complainant** he was admitted in the hospital on 14.04.2008 to 23.04.2008 and after discharge all the claim related documents were submitted to respondent but after a period of 10 months the claim is not sanctioned by respondent and even not informed. Then, the complainant approached to the higher authorities of respondent but no favorable response from their side. Aggrieved with the non settlement of claim by respondent, the complainant approached this forum for necessary settlement of his claim.

The complaint was registered on 24.02.2009. A letter was sent to the Respondent along with copy of complaint to submit self contained note while the prescribed forms were issued to the complainant and the same are submitted by both the parties.

**The respondent** vides its self contain letters dtd.20.04.09 & 20.05.2009 together with Medical opinion of TPA submitted that as per the documents submitted by the complainant the claim was processed by their TPA and observed that there is violation of policy condition No. 5.3 & 5.4 as the claim was intimated/submitted after 33 days as against immediate notification of admission, the name of complainant is entered later on in the Admission Register of Hospital, the USG of Abdomen report dated 14.04.08 which bears name of complainant as patient but the report pertains to **Female** as it shows **Uterus** is normal in size, shape and echotexture etc and both **Ovaries** are normal in size, shape and echotexture, and No adnexal cyst seen. Moreover, the above USG report is fraudulently signed by Dr. Ashok Jain for the name of Doctor Aman Gupa, Sonologist, similarly other pathology reports are also found signed by single person in the name of other different doctor/pathologist. The respondent further mentioned in the self contained note that during the admission period the patient was given the same medicines from starting of treatment to the end of treatment as against the usual Medical practice. Similarly, the Tests are not properly advised by Doctor, Specially, the Bilirubin Test dated 14.4.08 was 8.4 whereas on 17.4.2008 it was 10.2 (increase in jaundice) but before discharge there is no further test (to check whether it is upto normal level or not) found in record. The respondent also expressed his surprise about why the Cash less facility is not opted by the complainant when it was available even in the same hospital. All the cashmemoes from chemist are unsigned. The respondent also deputed Investigator but the complainant never made available to the investigator being said that he is out of station. It is concluded by Respondent that in view of the above findings it seems

that all the documents are fabricated and the claim was made fraudulently hence the claim is not payable as per policy condition No. 5.3 & 5.4 and 5.7 and requested this forum to dismiss the complaint.

**Observations:**

There is no dispute that the complainant was covered under the above-mentioned policy and a claim for Rs. 21085/- was preferred to respondent for the hospitalization of complainant for the period from 14.04.2008 to 23.04.2008 due to Enteric Fever and hepatitis. As per the claim form & other documents submitted by complainant it is found that the claim is submitted to respondent after 33 days i.e. on 26.5.2008 on reimbursement basis as against the cash less basis which was well available in the same hospital. During the course of hearing the complainant stated that he was hospitalized and claim was submitted but the same is not paid by respondent. The Respondent stated almost all the points mentioned in their self contained note by producing the evidences mainly USG report, other pathological reports, Admission register of Hospital & other claim documents and explained that the USG report pertains to female patient while the complainant is male, other pathological reports are signed by person other than the authorized person in other words only name of pathologists are used by signing the reports by other person to make a claim. On going personally through the above evidences it found that the USG report of Dr. Aman Gupa, M.D. (Sonologist) is signed by Dr. Ashok Jain as compare from the signature of Dr. Ashok Jain available on the other documents, moreover the above USG report of Mr. Brijesh Narain Mishra (Complainant himself) contained the information pertaining to **female** patient as having reports of **Uterus & Ovaries** etc. similarly, other pathological reports i.e. Blood examination, Bio Chemical value report are also found signed by person other than authorized Doctor as clearly observed that name of Dr. Usha Sethi, (DCP Pathologist) & Dr. Jitendra Baraniya (M.D.Pathology) are used by signing by other person to prepare the above reports. On asking from the complainant on the above anomalies and also about the delay in intimation of claim, the Complainant explained that he does not know about the above anomalies and also that the information of hospitalization was given on telephone by his son. But none document is submitted by complainant in support of his statement. Similarly on asking about why the cash less facility was not availed, it is explained by complainant that he is not aware about the same facility. The Respondent further stated that the entry in the Admission register is also suggests that the same is entered later on to accommodate entries of person who in all probability would not have been hospitalized, in support of this the copy of register is also produced by Respondent where it is found that the complainant's Sl. No. is 35 though Sl. No. 33 & 34 are blank. The respondent further stated that the above claim is not payable and deserves to be repudiated.

**In view of the circumstances stated above**, the decision for not paying/repudiation of above claim taken by respondent is **just & Fair** because there is sufficient ground to believe that the claim related documents are fabricated &/or made by fraudulently means for taking claim from the respondent besides inordinate delay in the submission of claim for no specific reason even when the Cash less facility was available in the same hospital, Therefore, found no reason to interfere with the decision of respondent. The complaint is dismissed without any relief.

_____----------END----------_____

**CATEGORY:** **Mediclaim Policy**

**SUB CATEGROY:** **Total Repudiation of Claim**

**Order No.: BPL/GI/09-10/014** **Case No.: GI/OIC/0409/002**

**Dated 25th June, 2009**

Shri Laxman Prasad Sharma V/s The Oriental Insurance Co. Ltd.,

## Brief Background

Mr. Laxman Prasad Sharma (hereinafter called Complainant) had obtained Mediclaim policy No. 152110/2008/1372 for S.I of Rs. 50000/-along with his wife Smt. Leela Sharma for the period from 06.01.2008 to 05.01.2009 from The Oriental Insurance Co. Ltd., Bhopal (Hereinafter called Respondent)

**As per the Complainant** he is having insurance coverage from 6.1.2006 and Medical investigation papers were submitted to respondent at the time of taking first Policy where his wife Smt. Leela Sharma was not suffering from hypertension, Diabetes etc. The complainant also mentioned that on 22.12.2008 his wife was admitted in **Akshay Heart hospital,** Bhopal with the complaint of vomiting, severe headache, Ghabrahat and was referred to Bhopal Memorial Hospital & Research centre, Bhopal for further treatment on 27.12.2008 where **pace-maker** was implanted and was discharged on 2.1.2009. The total expenditure incurred for Rs. 145415/- and during hospitalization period claim for cash less facility was preferred but no reply was from the respondent, then, complainant submitted the claim for Reimbursement the expenses, but claim is repudiated by Respondent without proper consideration under exclusion clause No. 4.1 (on the ground of pre-existing disease) vide letter dated 6.2.2009. The complainant represented against denial of claim on pre-existing ground with the plea that at the time of taking policy his wife was not suffering from any disease. It is also mentioned by complainant that he does not know how the reference for pre-existing was made in Discharge ticket of Akshay Hospital, probably on the basis of oral description by someone which is not correct and has no documentary support. Then complainant approached to the higher authority of respondent but they also refused to sanction the claim. Aggrieved with the decision of repudiation by respondent, the complainant approached this forum for necessary settlement of his claim.

**The respondent** vides itself contain letters submitted that the claim is repudiated by their TPA on the grounds that the treatment was taken for the pre-existing ailments and they upheld the decision of TPA for repudiation of claim on the ground of Pre-existing ailments.

**Observations:**

There is no dispute that the complainant's wife was covered under the above-mentioned policy and was hospitalized in Akshay Hospital, Bhopal on 22.12.2008 to 27.12.2008 for **Chest Pain**, Ghabrahat, Severe Headache where diagnosed for DM II/HTN/CAD/NSTE Ant. MI with II HB-CHB and Angiography was done on 24.12.2008 wherein **LAD found 90% stenosis with plaque extending to the ostium and PLV Prox. 100 Occlusion with Thrombus and recommended for CABG** being double Vessel Disease for further management at Bhopal Memorial Hospital & Research Centre for the period from 27.12.2008 to 02.01.2009 and the claim for total expenditure of Rs.145415/- incurred for the treatment of heart related ailment at both the hospital was submitted to respondent on reimbursement basis being the Cash less facility was denied. The only dispute is for the pre-existing of above disease at the time of commencement of first Policy. During the course of both hearing the complainant explained almost all the points as mentioned in his main complaint letter and expressed his dissatisfaction to the poor claim services of respondent and also informed that a fresh claim for the treatment of above heart disease is also lodged on the renewed policy to the respondent which is also pending. The complainant also stressed that his wife was not suffering any disease at the time of taking 1st policy as the pre-insurance medical tests were conducted and submitted to respondent. On asking from complainant how the Diabetic and Hypertension for 10 years are mentioned in the Hospital Discharge Summary, it is stated by complainant that probably the same is mentioned by hospital on the basis of oral version of his neighbors and relatives who brought her to the hospital. The complainant was further asked whether he contacted hospitals/concerning doctors for their reporting of above diseases since 10 years or he has obtain any correction/confirmation from the doctors/hospital that she is not diabetic & Hypertensive since last 10 years, the complainant explained that he did not contact to hospital for the same and also has no certificate/confirmation for the same. During the course of both the hearings the Respondent stated that the claim is processed by their TPA M/s E-Meditek Solutions Ltd. and as per the documents submitted by claimanant they observed the treatment is for pre-existing ailment which is not covered under the scope of policy and accordingly was informed to complainant vide their letter dated 18.2.2009. It is also explained by respondent that the complainant also approached their grievance cell, Head Office who attended the above complainant and called the entire file from the TPA and found that the decision taken by E-Meditek Solutions Ltd. was in order which was also informed to the complainant by their Head Office vide their letter dated 23.3.2009. The Respondent also produced the Policy clause and stated that the pre-existing diseases are excluded in clause No. 4.1 The respondent was asked to submit the documents in support of pre-existing disease, it was explained that the claim is processed by TPA and the entire exercise is done by them only and the same has been informed to complainant by TPA also and also stated that they do not have any such kind of documents as the file is with their higher office but reiterated that the same has been conveyed to complainant and the documents are well available with the complainant. On going personally through the medical documents of both hospitals and other documents submitted by both the parties and observed that the treatment was for DM II/HTN/CAD etc. and as per the Discharge summary dated 2.01.2009 of Department of Cardiology, Bhopal Memorial Hospital & research Centre, Bhopal the history of Diabetic and Hypertensive for 10 years which found main reason for repudiation of claim by respondent. Moreover, the file is also reviewed by the Respondent's Head Office who also found the treatment was for pre-existing ailment which is excluded in the policy.

**In view of the circumstances stated above and at the strength of documents**, the decision for repudiation of above claim **is just & Fair** because the Discharge summary of Hospitals clearly speaks that the **history of Hypertension & Diabetes is since 10 years** whereas the policy is commenced from 06.01.2006 only, which stands conveyed to the Complainant by the Respondents in due course of time, while the complainant did not produce any documents from the concerning hospitals/doctors proving that it is not a case of Hypertensive & Diabetes since 10 year &/or the above period is mentioned on the basis of oral information of neighbors &/or relatives. Therefore, found no reason to interfere in the decision taken by Respondent. The Complaint is dismissed without any relief.

----------_____END_____----------

**CATEGORY:** **Mediclaim Policy**

**SUB CATEGROY:** **Total Repudiation of Claim**

**Order No.: BPL/GI/09-10/017** **Case No.: GI/NIC/0509/012**

**Dated 22nd July, 2009.**

**Smt. Shubhangi Agarwal V/s National Insurance Co.Ltd., Br. Bhopal**

## Brief Background

Smt. Shubhangi Agarwal (hereinafter called Complainant) was covered under Mediclaim policy No. 321301/48/07/8500000504 for S.I of Rs. 60000/- for the period from 29.03.2008 to 27.03.2009 issued by National Insurance Co. Ltd., Br. Office, Bhadbhada Road, Bhopal. (Hereinafter called Respondent)

**As per the Complainant** she was continuously insured with respondent from last 8 years and was admitted in Life Line Hospital, Bhopal on 3.1.2009 for operation of **Missed Abortion** and all the documents were submitted to TPA of respondent for the settlement of claim but the claim is denied by TPA and respondent as well vide their letter dated 11.5.2009 after 3 months of submission of claim. The complainant further mentioned that her legitimate claim of missed abortion is tenable in the light of an article published in **IRDA Journal, June 2005** page 19 in that, **the writer passed an award and allowed the claim of missed abortion on the ground that clause No. 4.12 disallow the maternity benefit as pregnancy relates to living fotes"** and requested this forum to direct the respondent to pay the claim of Missed Abortion with cost of delay.

**As per Self Contained note** dated 30.6.2009 along with other claim related documents & Policy clause submitted by respondent that the complainant was admitted to Life Line Hospital on 3.1.2009 up to 4.1.2009 for treatment of **Missed Abortion and the pregnancy related charges are excluded from the scope of cover as per exclusion No. 4.12 of the policy which was conveyed to complainant vide our letters dated 26.3.2009 and 5.5.2009.**

**Observations:**

There is no dispute that the complainant was covered under the above-mentioned policy and was hospitalized for the treatment of Missed Abortion. The only dispute is for whether the expenses incurred for Missed abortion are payable under the policy or not. During the course of hearing the complainant described almost all the matters as mentioned in the main complainant letter and requested this forum to interpret the above issue by treating that condition in which a dead immature embryo or fetus is not expelled from the uterus because a Missed abortion is a nature's way of terminating something that was not likely to result in a normal delivery while the Policy clause disallow only maternity benefit as pregnancy relates to living foetus as also mentioned in the article published in IRDA journal, June 2005. The Respondent **by reading Policy condition No. 4.12** stated that their policy specifically excludes "any expenses whatsoever incurred in connection with or in respect of Treatment arising from or traceable to pregnancy/childbirth including caesarean section, miscarriage, abortion or complications thereof including changes in chronic conditions arising out of pregnancy" hence the above claim found not payable. Forum personally gone through the Policy clause produced by Respondent and copy of article published in IRDA Journal, June 2005 produced by complainant and observed that the Policy specifically excludes any expenses in respect of treatment arising from or traceable to Pregnancy, Miscarriage, Abortion or complications thereof arising out of Pregnancy. As regards the importance of above quoted article is concerned, the same found pertains to prior to year 2005 while the present policy condition/clause is clear speaking and does not warrant any interpretations particularly in the above instance case.

**In view of the circumstances stated above**, the decision for repudiation of above claim taken by Respondent is **just & fair** as the same found excluded under the terms & condition No. 4.12 of Policy, therefore the complaint is dismissed without any relief.

----------_____END_____----------

**CATEGORY:** **Mediclaim Policy**

**SUB CATEGROY:** **Total Repudiation of Claim**

**Order No.: BPL/GI/09-10/018** **Case No.: GI/NIC/0609/025**

**Dated 23rd July, 2009**

**Mr. Brijbhushan Parikh V/s National Insurance Co.Ltd**

## Brief Background

Mr. Brijbhushan Parikh (hereinafter called Complainant) had obtained Mediclaim policy No. 321102/48/08/8500000005 for S.I of Rs. 75000/- for the period from 01.04.2008 to 31.03.2009 along with Insurance coverage for his wife Smt. Krishna

Parikh, issued by National Insurance Co. Ltd., Br. Office IV, Indore (Hereinafter called Respondent)

As per the Complainant his wife Smt. Krishna Parikh was suffering of severe attack of **"Paroxysmal Vertigo"** for which she was hospitalized at City Nursing Home, Indore, as per the advices of Dr. R.S.Mehta and the expenses for domiciliary treatment and post hospitalization for Rs. 5455/- was preferred to respondent but the claim is denied by them under the condition No. 4.10 i.e. the expenses incurred at Hospital primarily for evaluation/diagnostic purpose which is not followed by active treatment for the Ailment during the hospitalization. The complainant further mentioned that the reason of Denial of claim because the disease is Recurrent Vertigo and nystagmus occurring when the head is placed in a certain position usually not associated with lesions of the central nervous system which is known as neurological disorder and CT Scan, ECG, CBC, PPBS, TSH and LIPID PROFILE ARE related to the same Ailment she suffered of any for which she had have under gone the treatment pre and post hospitalization. Since his wife had a severe problem of sudden recurrence and an intensification of symptoms which warranted the immediate nursing care and therefore she was advised hospitalization and the pathological test followed by the active treatment was exclusive for the Paroxysmal Vertigo and not for diagnostic purposes at all. Aggrieved with the decision taken by respondent the complainant approached this forum for necessary settlement of claim.

As per self contained note dated 03.07.2009 along with other claim related documents submitted by respondent that on the basis of available information and documents it was found to TPA that the patient was admitted in hospital for Investigation, evaluation/diagnostic purposes which was not followed by active treatment during hospitalization which is excluded under the condition No. 4.10 of the policy hence the claim is rejected by TPA. The respondent further mentioned that they further referred the file to their panel doctor Dr. K.G.Agarwal for his opinion and as per his opinion also the claim is not admissible under the scope of policy, accordingly, the claim is repudiated by them vide their letter dated 28.5.2009

**Observations:**

There is no dispute that the complainant was covered under the above-mentioned policy and was hospitalized in City Nursing Home, Indore for the period from 25.12.08 to 27.12.2008 for the complaints of Paroxysmal Vertigo. During the course of hearing the Respondent stated that as per the documents available to the TPA and the opinion of Doctor K.G.Agarwal the patient was admitted in the hospital for the evaluation and diagnostic purpose only and there was no advice of attending Doctor Dr.R.S.Mehta. The respondent also stated that there is no active treatment followed by Hospitalization and only oral Conservative line of Treatment was given in the hospital hence there was no need of hospitalization. The respondent further stated that the policy does not cover the Expenses incurred primarily for evaluation/diagnostic purposes not followed by active treatment during hospitalization therefore the claim is not admissible and repudiated accordingly by them. I have personally gone through the policy condition No. 4.10 and various medical documents provided by complainant and observed that the complainant's wife Smt. Krishna Parikh was suffering from "chronic vertigo" for last 1 year and consulted with Dr. Sunil Banthia on 19.12.2008 for the complaint of chest pain with perspiration, Extertional dyspnoea and weakness then she consulted with Dr. D.L.Binnani on 20.12.2008 for the complaints of Vertigo 2 days with vomiting and

advised for various investigations i.e. ECG, PPBS, TSH, Lipid Profile etc. and finally consulted with Dr. R.S.Mehta, M.D., FRCP (consulting physician and Neurologist where the treatment was prescribed along with the advices for CT Scan head and admitted in City Nursing home for the period from 25.12.2008 to 27.12.2008 for the complaint of Paroxysmal vertigo 4-5 days and 2-3 times a year from last 1 year. On going through the Discharge summary of Nursing home it is also found that the complainant was advised treatment for further period i.e. after the discharge from Nursing home. Similarly, the certificate dated 4.4.2009 issued by Dr. Kailash Lakhotia, Director of City Nursing home as produced by complainant also confirms that the patient was **admitted as advised by and under treatment of Dr. R.S. Mehta.** The complainant also produced prescription of Dr. Kishore Mittal dated 5.5.2009 wherein the above cited disease/problems and treatment are found continued. It is also observed that the claim is repudiated by Respondent on the basis of that the Disease is not diagnosed in the pathological reports and also observed that the condition No. 4.10 is applied without understanding the meaning of condition by the Respondent. As per the condition No. 4.10 the **"Expenses incurred primarily for evaluation/diagnostic purposes not followed by active treatment during hospitalization"** while in the above claim there are not only expenses incurred for hospitalization but continuous treatment (for the problem of Paroxysmal Vertigo) prior & after the hospitalization are also incurred. In other words the claimed amount is inclusive of cost of medicines, Pathological examinations, consultants fees, and hospitalization charges for Rs. 960/- only. As it is already mentioned above that the patient was suffering from Paroxysmal Vertigo and the treatment was also given for the same problems by the expert Neurologist etc. and the above mentioned/undergone pathological investigations are related to the same ailment moreover, she was under the treatment of Dr. R.S.Mehta which also confirms that the hospitalization was advised by the concerning competent doctor. Available documents also suggest that the hospitalization was not done merely for the evaluation/diagnostic purposes but the same found a process of treatment of Paroxysmal Vertigo.

**In view of the circumstances stated above**, the decision for repudiation of claim **is not just & fair. Therefore, the respondent is directed to pay the claim amount for Rs. 4796/- as per the following calculation:- Rs. 5456/- less Rs. 260/- being expenses not covered under the policy and Rs. 400/- being no supportive document provided to complainant within 15 days from the receipt of consent letter from the Complainant** failing which it will attract a simple interest of 9% p.a. from the date of this order to the date of actual payment.

_____----------END----------_____

**CATEGORY:** **Mediclaim Policy**

**SUB CATEGROY:** **Total Repudiation of Claim**

**Order No.: BPL/GI/09-10/21** **Case No.: GI/NIA/0509/11**

**Dated 29th July, 2009.**

**Shri Basant Kumar Jain V/s The New India Assurance Co. Ltd.,** .

## Brief Background

Dr. Basant Kumar Jain (hereinafter called Complainant) had obtained Mediclaim policy No. 450800/34/07/11/00001574 for S.I of Rs. 100000/- along with his wife for the period 27.09.2007 to 26.09.2008 from The New India Assurance Co. Ltd., Indore (hereinafter called Respondent)

**As per the Complainant** he was admitted in Hospital for the period from 18.10.2007 to 20.10.07 at Indore and on 22.10.2007 where Coronary Angiography was done at Bombay Hospital, Indore and all the relevant documents were submitted to the TPA of respondent for Reimbursement of Expenses for Rs. 10979/- but the claim is repudiated vide their letter dated 31.1.2009. Then, the complainant approached the higher authority of respondent with the plea that the respondent has settled his previous claim for Bye-pass Surgery for Rs. 25000/- on 18.12.2001 and Rs. 101711/- for Angioplasty in 2004 then why this claim is not being paid? but there is also no favorable response. Aggrieved with the non settlement of claim, he approached this forum for necessary settlement of claim for Rs. 10979/-

The Respondent in its self contained note dated 09.07.2009 (along with Policy, Proposal form, & other claim related documents) submitted that the complainant is insured with them since 27.9.2001 continuously without break and the above Policy was renewed under REVISED Mediclaim 2007 Policy which involves certain amendments through various clauses and same were explained in detail to the insured and a copy of the clause has also been provided to the insured. The present claim is scrutinized by TPA and previous claim papers were called and on going through the previous claim papers it was observed that the present claim relates to a disease which existed before the commencement of Policy and hence the claim was repudiated under clause No. 4.1 i.e. pre-existing.

**Observations:**

There is no dispute that the complainant was covered under the above-mentioned policy for the period from 27.9.2007 to 26.9.2008 and was hospitalized at Shree Indore Cloth Market Hospital, Indore and at Bombay Hospital, Indore, for the period from 18.10.2007 to 20.10.2007 and 22.10.2007 for Coronary Angiography. The only dispute is for pre-existing condition No. 4.1 of the Policy. During the course of hearing the complainant stated that the claim for above angiography is not paid by respondent under the policy condition of pre-existing disease though the Respondent has paid two claim for the above nature of disease in 2001 and in 2004 for Rs. 25000/- and Rs. 101711/- for Bye-pass and Angioplasty respectively. The complainant also stated that he is continuously insured since 1998 without break. The Respondent stated that the present claim falls under the Revised Mediclaim Policy 2007 containing clause No.4.1 whereby the Pre-existing diseases are excluded with the provision of deletion of above exclusion (pre-existing disease condition) "**after Four Consecutive Claim Free Policy Year**". Since the above disease was pre-existing to the inception of Policy and there was a claim for Angioplasty (Heart related disease) for the hospitalization period July 2004 (which stands paid for Rs. 101711/-) and the present claim is within 4th year of Policy and not after the Four claim free year Policy period hence the claim found not payable and accordingly was informed to complainant by their TPA vide their dated 18 March, 2008. The Respondent also stated that in 2007 the entire Mediclaim Policy is changed and revised all together hence the claim is settled under the purview of

conditions and clause of revised Mediclaim policy where no special relaxation to the existing Policy holders. On asking, the Respondent also explained that the present Insurance Policy was issued after obtaining of fresh Proposal form from the complainant and all the major changes were well in the knowledge of complainant. The Proposal form duly signed by Complainant produced by the Respondent.

**In view of the circumstances stated above**, the decision of the Respondent to repudiate the claim is **just & Fair** as it is beyond any doubt that the claim falls under the period of current policy (27.09.2007 to 26.09.2008) obtained after the introduction of new Mediclaim Policy 2007 as a fresh contract of Insurance for which proposal form was obtained from complainant. The present policy specifically contains condition No. 4.1 for pre-existing disease which contains that the exclusion of pre-existing disease will be deleted **AFTER Four consecutive Claim Free Policy Year** while there was a claim for the above disease (for the Heart disease -Angioplasty) for the hospitalization period of 1.7.04 to 7.7.2004 under the Policy period 27/9/03 to 26/9/2004 which means the present claim falls under the 4th year Renewal. Therefore, found no reason to interfere with the decision taken by respondent. The complaint is dismissed without any relief.

----------_____END_____----------

**CATEGORY:** **Mediclaim Policy**

**SUB CATEGROY:** **Total Repudiation of Claim**

## Order No.: BPL/GI/09-10/24 Case No.: GI/NIA/0609/28

**Dated 20th Aug., 2009**

**Shri R.K.Jain V/s The New India Assurance Co. Ltd., Br. Itarsi**

## Brief Background

Mr. R.K.Jain (hereinafter called Complainant) had obtained Mediclaim policy No. 451402/34/08/1100000041 for S.I of Rs. 300000/- for the period 13.09.2008 to 12.09.2009 from The New India Assurance Co. Ltd., Branch Itarsi. (Hereinafter called Respondent)

As per the Complainant he was admitted in Bombay Hospital, Indore for Surgery on 23.10.2008 due to abdomen pain and all the bills and documents were submitted to Respondent but the claim is rejected by TPA vide their letter dated 18 March, 2009 then complainant approached the higher authority of Respondent but there is also no favorable response. Aggrieved with the non settlement of claim, he approached this forum for necessary settlement of claim for Rs. 95090/-

The Respondent in its self contained note dated 08.07.2009 (along with T.P.A letter sent to Complainant) submitted that after going through all the documents

submitted by claimanant it is found that the complainant had undergone for Sub acute Intestinal Obstruction surgery in 2004 and as per reply of the treating doctor and as per discharge summary of 2004 Operation for Ca-Colon hence the claim is repudiated under clause No. 4.1 (i.e. pre-existing disease)

**Observations:**

There is no dispute that the complainant was covered under the above-mentioned policy for the period from 13.9.2008 to 12.9.2009 and was hospitalized at Bombay Hospital, Indore for the period from 11.10.2008 to 31.10.2008 for the Diagnosis of Intestinal Obstruction with complaints of Distension of Abdomen and pain in Abdomen where the **'Exploratory Laprotomy with Adhesiolysis'** (Surgery) was done on 23.10.2008. The only dispute is for pre-existing condition No. 4.1 of the Policy is applicable or not. During the course of hearing the complainant stated almost all the points as mentioned in his main complaint letters and also that the previous disease of Cancer was disclosed at the time of First Insurance i.e. in 2005 and his Insurance is continued without break. It is also stated by Complainant that at the time of First insurance it was told to him by Agent of Respondent that the claim occurred for 1st year will not be entertained. The complainant further stated that the above disease is not a part of previous disease but a fresh disease but the claim is not paid by the Respondent. On the other side, the Respondent explained that as per Medical record the complainant was suffering from Cancer disease which was operated in 2004 followed by Chemotherapy of 6 cycles and the present disease is diagnosed as Intestinal Obstruction and found to have Small Bowel obstruction for which the above Surgery (Adhesiolysis) is done by Dr. Rajesh Gujarati on 23.10.2008 The Respondent further stated that as per the Certificate given by treating doctor (Dr. Rajesh Gujarati) the cause of above disease (Adhesions) is due to Previous Surgery or Chemotherapy which was done in 2004-2005 i.e. prior to inception of first Policy. The Respondent further stated that the above policy contains Exclusion condition No. 4.1 where by the Pre-existing Diseases/condition is excluded from the scope of Policy, hence, the above claim found not payable. The Policy condition and Certificate of Dr. Gujarati produced by the Respondent. The Respondent was asked by this forum that if the Previous Disease was disclosed by Complainant at the time of first Insurance then, how it could be treated as Pre-existing disease which occurred after 3 years, it is explained by Respondent that the above claim is Repudiated under the Policy Clause No. 4.1 which speaks that "Any complication arising from pre-existing disease/ailment/injury will be considered as a part of Pre-existing condition" no matter whether it was disclosed or not disclosed at the time of Insurance. It is further added by Respondent that the above condition also has provision that "the above Exclusion will be deleted after four consecutive claim free Policy years" but the above claim occurred on the 3rd year Policy only, hence, the claim could not be paid.

**In view of the circumstances stated** above and the Medical records, the decision of the Respondent to repudiate the above claim is **just & Fair** as it is well established from the Hospital documents that the complainant was diagnosed to have cancer of colon in Oct. 2004 and underwent right Radical extended hemicolectomy with ileo-transverse anastomosis on 28.10.2004 and six cycle of **Chemotherapy** up to 7.4.2005. The present treatment pertains to complaints of Distension of Abdomen and pain in Abdomen which **was suspected to have Sub acute intestinal Obstruction where multiple interloop Adhesions found present in small bowel** for which **Exploratory Laparotomy with Adhesiolysis** is done by Dr. Rajesh Gujarati on 23.10.2008. Dr. Rajesh Gujarati in his certificate dated 10.01.2009 has clarified that **"the cause of Adhesions can certainly be due to previous Surgery or**

**Chemotherapy"** and also clarified that **"at no point it was Denied that the cause of adhesion could be post operative**. Since the above treatment found to be for complication arising from pre-existing disease/ailment/injury of Oct 2004 and the first Insurance Policy commenced w.e.f. 13.9.2005 i.e. prior to inception of Policy hence observed to be a Part of pre-existing Condition which is excluded from the scope of current Policy under the condition No. 4.1. Therefore, found no reason to interfere with the decision taken by Respondent. The complaint is dismissed without any relief.

----------_____END_____----------

**CATEGORY:** **Mediclaim Policy**

**SUB CATEGROY:** **Total Repudiation of Claim**

**Order No.: BPL/GI/0910/25** **Case No.: GI/RSI /0609/16**

**Dated 31st August, 2009.**

**Shri Manish Kumar Verma V/s The Royal Sundaram Alliance Insurance Co. Ltd.,**

## Brief Background

Mr. Manish Kumar Verma (hereinafter called Complainant) was covered under Mediclaim Health Shield Insurance policy/certificate No. HN00000620000100-N001 for S.I of Rs. 100000/- for the period from 20.03.2008 to 19.03.2009 by M/s The Royal Sundaram Alliance Insurance Co. Ltd., Chennai (hereinafter called Respondent).

**As per the Complainant**, he was admitted in Pushkar General Hospital; Bhopal on 15.12.2008 due to pain in abdomen, vomiting, loose motion, burning in urine and ghabhrahat and after various investigations, the doctor diagnosed as Acute Gastroenteritis with Septicemia. On 16.12.08, his wife informed to the Respondent in their Customer Care at Chennai centre asked for Claim Form. The Complainant was hospitalized up to 24.12.2008. On discharge from the Hospital, Medical claim for Rs.55100/- was preferred with the Respondent on 6th January, 2009 along with all medical documents but the same was delayed on the part of Respondent even after the regular follow-ups/reminders. The Respondent assured to settle the claim very soon after completion of an investigation. In the meantime, the policy was renewed with the loading and another policy Hospital Benefit Plus Insurance was also given with the premium of Rs. 2999/- Moreover a letter dated 08.05.2009 was sent to the complainant repudiating his claim for Rs. 55230/- On this way instead of settlement of claim the Policies viz Health Shield Insurance for the period 27.03.09 to 26.03.10 was also cancelled w.e.f. 06.05.09 stating that the " Policy shall be void and all premium paid hereon shall be forfeited to the company. Aggrieved with the attitude and decision of the Respondent, he approached this office for necessary settlement of his claim.

**As per self contained** note of Respondent the complainant had inflated the medical store bills for boosting the claim amount to be made. Due to exaggerated and fraudulent claims made by the complainant, the claim was repudiated apart

from canceling the policy as the fraud viates the contract of Insurance as per the relevant policy conditions reproduced below:-

Fraud

"If any claim is in any respect fraudulent, or if any fraudulent means or devices are used by the Insured Person or anyone acting on his behalf to obtain any benefit under this policy, all benefits under this policy will be forfeited and the Company may choose to void the Policy and reclaim all benefits paid in respect of such insured person"

Accordingly the claims are repudiated and policies are cancelled.

**Observations:**

There is no dispute that the complainant was admitted in the Pushkar General Hospital, Bhopal from 15.12.2008 to 24.12.2008 for the treatment of Acute Gastroenteritis & Septicemia where an expenses of Rs. 55100/- was incurred for treatment. This fact was also enumerated by the TPA M/s Health India Medical Services Pvt. Ltd that the complainant was admitted in ICU for 2 days and then shifted to private ward and diagnosed as a case of Acute Gastroenteritis with Septicemia. As per the Respondent the dispute is that the medical bills were exaggerated and inflated for boosting the claim amount. During hearing on asking from the respondent to submit the evidence of Fraud and inflated bills, he only reiterated that our Investigator has mentioned that the medical Store bills were boosted. On asking the question up to what extent it was boosted and what are the concrete evidence to prove the same. He only submitted a plain paper with the seal of medical store that the bills were exaggerated on the request of the complainant. But The Respondent was failed to submit the quantum of exaggerated bills where the medicines were purchased without prescription. On the other side I found a copy of questionnaire for Medical Store (Shri Medical Store) wherein the answer of question No. 5, it was mentioned that no extra bills without purchasing the drugs was issued and only prescribed medicines were provided by them. The Respondent had cancelled the policies and the premium amounting to Rs. 4318/- forfeited without the concrete evidence on their part. The Respondent was failed to prove the fraud and quantum of inflated medical bills. I have also gone through the copies of medical bills which were duly acknowledged by the attending doctor. The prescriptions were also attached with the medical bills

**Under the circumstances explained above**, the complainant is well entitled for the Medical expenses under the policy/certificate No. HN00000620000100-N001 for S.I of Rs. 100000/- for the period from 20.03.2008 to 19.03.2009. Therefore, the respondent is **directed pay the claim for Rs. 55100/-** as found payable as per the claim documents submitted by complainant and also refund the premium of 4318/-(**Total Rs. 59418**/-) which was arbitrarily forfeited to the company by the Respondent **within 15 days from the date of receipt of consent letter from the complainant, failing which it will attract a simple interest of 9% p.a. from the date of this order to the date of actual payment.**

**----------_____END_____----------**

**CATEGORY:** **Mediclaim Policy**

**SUB CATEGROY:** **Total Repudiation of Claim**

**Order No.: BPL/GI/09-10/27** **Case No.: GI/NIA/0609/27**

**Dated 8th Sept., 2009.**

**Dr. P.S.Bindra V/s The New India Assurance Co. Ltd., D.O.Bhopal**

## Brief Background

Dr. P.S.Bindra (hereinafter called Complainant) had obtained Mediclaim policy No. 451400/34/08/20/00000267 for S.I of Rs. 300000/- for the period 24.07.2007 to 23.07.2008 from The New India Assurance Co. Ltd., D.O.II, Bhopal (Hereinafter called Respondent)

**As per the Complainant** he was having no health problem and felt chest pain and discomfort on 27.7.2007 and consulted Dr. P.K. Pandey, who advised to further check up at higher centre accordingly Angiography was done at Escort Hospital Delhi where it is found that Main Arteries was blocked but collateral Arteries were developed. The Bye Pass Surgery is done on 3.9.2007 and a claim for Rs. 293165/- was submitted to respondent but the claim is rejected by TPA of respondent under the clause No. 4.1 i.e. pre-existing disease at the time of commencement of Policy. Then the complainant represented the matter with the Respondent but no favorable response. Aggrieved with the Repudiation of claim, complainant approached this forum for necessary settlement of claim for Rs. 293165/- and interest etc.

The Respondent in its self contained note dated 14.08.2009 submitted that there is a break in insurance for 87 days of date of expiry of 27.4.2007 of the earlier Policy and also mentioned that the complainant has enhanced the Sum Insured from Rs.. 1.50 Lakh to Rs. 3.00 Lakhs which reveals that the complainant was well aware about the above ailment at the time of obtainment of above Policy. The Respondent further mentioned that as per Medical records their TPA observed there were 100%, 90%, and 95% blockage in 3 Vessel which suggests that it is a pre-existing nature of ailment prior to commencement of Insurance accordingly, the claim is Repudiated under the condition No. 4.1 of the Policy i.e. Pre-existing disease.

**Observations:**

There is no dispute that the complainant was covered under the above-mentioned policy for the period from 24.7.2007 to 23.7.2008 and was hospitalized at Escorts Hospital, Delhi for the period from 31.08.2007 to 12.09.2007 where Angiography and CABG for 3 Vessels done on 3.9.2007. It is also an admitted fact that there was break in Insurance period for 86-87 days prior to above Policy and the complainant was uninsured for the period from 26.4.2007 to 23.7.2008. During the course of hearing the complainant told that the break of insurance was due to negligence of Development Officer concerned and it was assured by him that I will not get any problem in receiving the claims due to this break in Insurance. Complainant also reiterated that in the policy document No. 451400/34/07/20/00000267, the insurance company considered the date of proposal and declaration as 27.04.05 i.e. beginning of the policy. On asking from the Respondent about the fresh medical report and proposal form due to break in the policy period, it replied that the complainant is a good client in our book and he

is paying huge premium for his other insurances and being reputed client, they did not find need of fresh proposal and medical check up and the above Policy was issued without any fresh proposal and Medical/Health checkup report. The Respondent also described that the Sum Insured was enhanced by complainant in the above policy which also shows that the complainant was well aware about his illness. The Complainant reiterated that he never faced such type of symptoms in previous year. He is a routine morning walker for 2 to 3 km. per day and all of sudden he faced some heaviness in his heart. For precautionary measures he consulted National Hospital on 27.08.07 and underwent CAG at Escorts Hospital, New Delhi on 31.08.09.

**In view of the circumstances stated above**, the decision of the Respondent to repudiate the claim **is not just & Fair** because the above claim is Repudiated merely on the basis of assumption that the above disease is occurred prior to commencement of above policy (which is a Renewal of Previous Policy after the break of 34 days) without obtaining any medical opinion and documentary evidence. Moreover, the above said Break of Insurance is also observed due to Respondent's negligence. The respondent's plea about the enhancement of Sum Insured in the above Policy also not found a sole & valid reason to establish that the complainant was well aware about the above disease at the time of fresh Insurance. On the other side, as per the Certificate dated 10.01.2008 issued by Dr. P.K.Pandey, M.D. (who is the first attending Doctor on 27.8.2007 to complainant) it is certified that "Patient had **no H/O suggestive of DM, HT, IHD, TB, Asthma, Drug allergy in past.** Similarly, as per the Discharge Summary of Escorts Heart Institute & Research Centre (where the Coronary angiography and further management are done) wherein the Status of above disease i.e. Coronary artery Disease is diagnosed as **"Current"** and also under the column of History of presenting illness it is mentioned that the complainant presented with complaint of Chest discomfort on exertion **for last 2-3 days**. Since, there is no documentary evidence that the complainant was suffering from above disease prior to commencement of above Policy i.e. during the break period and also keeping other facts in the mind it is observed that the due care at the time of acceptance of above Insurance and at the time of settlement of claim is not taken by Respondent and his TPA respectively, therefore, the Respondent is directed to settle & pay the Admissible claim amount for Rs**. 288476/-** to the Complainant **within 15 days** from the receipt of consent letter from the complainant, failing which it will attract a simple interest of 9% p.a. from the date of this order to the date of actual payment.

----------_____**END**_____----------

**CATEGORY: ---------** **Mediclaim Policy**

**SUB CATEGROY: ------** **Partial Repudiation of Claim**

**Order No.: BPL/GI/09-10/11** **Case No.: GI/RSI/0309/115**

**Dated 12th June, 2009**

**Mr. Rajesh Patel V/s Royal Sundaram Alliance Insurance Co.Ltd**

## Brief Background

Mr. Rajesh Patel (hereinafter called Complainant) had obtained Hospital Cash Insurance Policy No. HCSBIL0003 and certificate No.CS00012693000102 for Rs. 1000/- Daily benefit which increased for Rs. 3000/- per day together with his wife Anjali Patel respectively and his mother Yashoda for Rs. 1000/- per day for the period from 6.12.2007 to 5.12.2008 from Royal Sundaram Alliance Insurance Co. Ltd. (hereinafter called Respondent)

**As per the Complainant** he is obtaining Policy since Nov. 2005 and continuously renewing without break and at the time of renewal of 2nd renewal the policy was upgraded by Daily benefit for Rs. 3000/- per day as against Rs. 1000/- per day on payment of extra premium and it was also told over phone that the benefit will be doubled in case of hospitalization in ICU. On 21.6.2008 his wife met with an accident and was admitted in the Hospital where she was kept in ICU for 2 days and claimed for the same. After some time the respondent paid Rs. 6000/- in two installment on the basis of 3000/- per day and on representation respondent asked to submit the documents for admission in ICU which was provided by complainant but the respondent denied to pay the benefit for the admission in ICU i.e. double to the Daily benefit which comes to Rs. 12000/- @ Rs. 6000/- per day. Aggrieved with non settlement of claim for ICU benefit for Rs. 6000/-, complainant approached this forum for the necessary settlement of claim.

**As per self contained** note letter dtd. 18.05.2009 together with Policy, Clause, Claim form and other documents it is submitted by Respondent that on receipt of above claim the claim was settled and paid for Rs. 6000/- vide their cheques dated 17.07.2008 & 5.8.2008 as full & final settlement of claim since the Sum of daily benefits for per day was only Rs. 3000/- for 2 days. It is also submitted by respondent in his self contained note that the claim for ICU benefits **which was never provided** to the complainant is baseless and untenable as complainant cannot claim anything beyond the benefits available under the certificate of Insurance by quoting the judgment of the **Hon'ble Supreme Court** in Oriental Insurance Co. Ltd. V/s Sony Cherian (II 1999 CPJ 13 SC) where it has held that **" The insurance policy between the insurer and the insured represents a contract between the parties. The Insurance cannot claim anything more than what is covered by the Insurance Policy. That being so the insured has also to act strictly in accordance with the statutory limitations or terms of the policy expressly set out therein".** The respondent further submitted that the above complaint may please be dismissed on the above ground.

**Observations:**

There is no dispute that the Complainant's wife was covered under the above-mentioned policy for daily benefit Rs. 3000/- per day and she was admitted in Hospital for the period from 21.6.2008 to 23.6.2008 in Bhopal Fracture Hospital for the treatment of injuries sustained due to Accident. The only dispute is for the ICU benefit for Rs. 6000/- not paid by the respondent being not covered under the policy. The complainant stated that as per the tele discussion on 23.11.2007 and 26.11.2007 with the customer care support of respondent before the renewal of above policy it was advised to him that the policy can be upgraded by Rs. 3000/- per day for Mr. Pawan Patel (Husband) and for herself (Anjali Patel) but for her mother it cannot be upgraded and also that by upgradation of Policy they will get Rs. 3000/- per day and if admit in ICU they well get just double amount per day on payment of more premium i.e. Rs. 5739/- which was agreed by complainant vide their e-mail letter dtd.27.11.2007. The complainant also stated that the details of

hospitalization under ICU was demanded by the respondent which was provided to them but now they are saying that the ICE benefits are not covered under the policy. The complainant was asked to submit the Policy, clause &/or any documents proving that the ICU benefits are covered by respondent, it was replied that they have not issued the correct policy as per their above mentioned offer in writing for the coverage of ICU benefits. The complainant questioned the respondent that if the same was not covered then why the detail of ICU hospitalization was asked for? The respondent replied that it was an offer from complainant about the ICU benefits at the time of renewal of policy but the same was not accepted by them. On asking from the respondent by this forum, the Respondent further explained that the premium for same benefit (ICU benefit) is also not charged from the claimanant and reiterated that the cover was given for Daily Benefit for Rs. 3000/- per day only and since the ICU benefits was not provided under the policy hence, the claim for same benefit are not payable. On going through the above Policy & clause, it is observed that the Policy does not cover the Double ICU benefit and also found that the complainant is entitled for Rs. 3000/- per day only in the event of hospitalization for a consecutive period of more than 24 Hrs. Similarly, on going through the claim form for above claim duly filled and signed by complainant it reveals that the claim was submitted for Rs. 9000/- to the respondent which indicates that it was a claim for 3 days hospitalization @ Rs. 3000/- per day for Daily cash benefits only. As regards complainant's plea for offer for the coverage of above ICU benefit in tele/e-mail correspondence it revealed that there was no acceptance of above offer by respondent and the remuneration of above proposal i.e. Premium is also not charged, therefore, the contact of Insurance for the above benefit does not establish in the above case.

In view of the circumstances stated above, I am of the considered opinion that the **decision of the Respondent for not paying the claim for ICU benefit for Rs. 6000/- is just and fair because the same are beyond the scope of policy,** Therefore, I found no reason to interfere with the decision of respondent. The complaint is dismissed without any relief.

----------END----------

**CATEGORY:** **Mediclaim Policy**

**SUB CATEGROY:** **Partial Repudiation of Claim**

**Order No.: BPL/GI/09-10/26** **Case No.: GI/NIA/0609/29**

**Dated 8th September, 2009**

**Dr. S.R. Pathak...V/s The New India Assurance Co. Ltd.,. Bhopal**

## Brief Background

Dr. S.R. Pathak (hereinafter called Complainant) had obtained Mediclaim policy No. 451400/34/08/11/0000372 for the period from 26.11.08 to 25.11.08 covering his wife for Rs. 1,00,000/- and Rs. 50,000/- for his daughter Ku. Megha Pathak from The New India Assurance Co. Ltd., Bhopal (hereinafter called Respondent).

**As per the Complainant** his wife Dr. Maya Pathak was admitted in Muljibhai Patel Urological Hospital, Nadiad for the period 23.02.2009 to 26.02.09 for the treatment of left renal stone, DM, HTN On Discharge from the hospital, he preferred a claim for Rs. 63940/- with TPA of Respondent M/s Universal Medi Aid Services Pvt. Ltd which partially settled by Respondent be deduction of Rs. 20840/- from the claim amount on the ground that the policy conditions are governed by mediclaim policy 2007. The Complainant made an appeal to higher offices of the Respondent vide his letter dated 28.04.09 but the claim was not settled from their side. Aggrieved with the decision of the Respondent's TPA, he approached this forum for necessary settlement of his claim.

**Observations:**

There is no dispute that the Complainant was covered under the above-mentioned policy.

On going through the claim documents which were preferred to the Respondent, It is found that the policy issued was Mediclaim Policy (2007) which was very well mentioned on the policy docket. It is true that the complainant was paying Zone-1 premium under policy which means he can avail treatment in any zone and the liability of the company will be 100% of the sum insured. But the Complainant is governed under the policy clause 2.0 sub clause 2.1 to 2.6 and note 1 & 2 which provides reimbursement of expenses with certain limitations. I have also gone through the recent hospital rate list of M/s Muljibhai Patel Urological Hospital, Nadiad where the charges for entitled category (Gen. Ward) is 50% of the charges for the availed category, hence the charges reimbursed taking into consideration the clause No. 2.1 are found genuine.

**In view of the circumstances stated above**, the decision of the Respondent to deduct Rs. 20840/- from the Claimed Amount is **fair & justified** because as per policy clause No. 2.1 the patient is entitled for 1% of Sum Insured for Room Rent charges and as per Clause 2.0 Note 1 the other charges are also payable according to Room entitled category. In this case the patient was entitled for the Room category as "General Ward" consequently the other charges under 2.3 and 2.4 etc. are also limited to the charges applicable to the entitled category i.e. for General ward. The TPA has rightly settled the claim in the light of Mediclaim Policy 2007 No. 451400/34/07/11/00000496 which were in force as on the date of Hospitalization considering charges Schedule of concerning Hospital applicable for Admission in General Ward. Therefore, found no reason to interfere with the decision taken by the Respondent. The complaint is dismissed without any relief.

_____----------**END**_____----------

**CHANDIGARH**

## Chandigarh Ombudsman Centre

## CASE NO. GIC/288/OIC/14/09

## Mahender Gupta Vs Oriental Insurance Co. Ltd.

Order dated 23.09.08 **MEDICLAIM**

FACTS: Sh. Mahender Gupta insured had taken a mediclaim policy no. 261700/48/2007/00863. He was hospitalized in Max Devki Devi Heart and Vascular Institute, New Delhi for the period 10.08.2007 to 11.08.2007. He spent a sum of Rs. 41002/- on his treatment. He submitted all the papers relating to his claim to TPA on 14.08.07. The complainant was assured by the TPA that the claim will be settled with a period of 7 days. However, his claim has not been settled in spite of several reminders. Parties were called for hearing on 23.09.08 at Chandigarh.

FINDINGS: During the course of hearing the insurer clarified that the TPA had repudiated the claim in Nov. 2007 on the basis of Exclusion Clause 4.1 of terms and conditions of the policy being pre-existing disease. On a query, as to what was the pre-existing disease the insurer furnished an opinion of Dr. Tandon from Sita Ram Bhartiya Institute, New Delhi, in which it was stated that the patient was suffering from DM – II from the last 25 years. On a query, whether the complainant was treated in Sita Ram Bhartiya Institute, the insurer replied in the negative and stated that the claim was for choronary angiography done in Max Heart and Vascular Institute. On a query, whether discharge summary from Max Heart Institute was available, the insurer replied in the affirmative.

DECISION: Held that the certificate given by Dr. Tandon is dated June 2007 whereas the discharge summary is dated 11.08.07. The discharge summary of Max Heart Institute, where the treatment was taken states that the complainant is diabetic from the last 15 years. There are thus two statements, one stating that the patient is diabetic for 25 years and the second which is in the discharge summary stating that the patient is diabetic for 15 years. Hence, more weightage should be given to the discharge summary of Max Heart Institute where the patient had taken treatment. Giving benefit of doubt to the complainant, the disease falls within the insurance cover of over 20 years. Hence 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.

## CHENNAI

### MEDICLAIM-29.5.09

## Chennai Ombudsman Centre

## Case No.IO(CHN) 11.05.1627/2008 – 09

## Mrs. Veena G. Dansingani

**vs**

## The Oriental Insurance Co. Ltd

## Award 02 dated 29.05.09

**The Complainant had been covered under the mediclaim policy of the insurer for the past 15 years. Her claim for Ayurvedic treatment taken during the year 2008 was rejected**

**by the insurer on the grounds that Ayurvedic treatment taken in hospitals other than Government/ Medical college hospitals were exclusions as per the revised policy conditions since 15/09/2006.**

**It was observed that the revised policy conditions came into effect from 15/09/2006. The claim under the policy was reported in the year 2008. Besides, insured has confirmed that they had approached the government hospital and found that the treatment required by her was not available at the government ayurvedic hospital due to lack of infrastructure facilities. Further if intimation had been given to the insurer or the TPA about the proposed hospitalization and the nature of treatment, the insured would have been informed about the change in the conditions of the policy issued to her. Also the conditions in the mediclaim policy of the insurer have been approved by the IRDA which is the statutory body empowered to validate such changes in policy conditions. Hence, the rejection of the claim by the insurer excluding ayurvedic treatment taken in other than Government Hospital / Medical College hospitals are as per policy terms and the complaint is dismissed.**

**MEDICLAIM-29.5.09**

**Chennai Ombudsman Centre**

**Case No.IO(CHN) 11.03.1002/2009 –10**

**Mr. Naw Ratan Lall Baid**

**vs**

**National Insurance Co. Ltd**

**Award 004 dated 29.05.09**

**The Complainant, was covered under Mediclaim Policy of the insurer. During the policy period , the insured was hospitalized and underwent CABG. He submitted a claim bill for Rs.2,14,457/- to the insurer. The insurer settled the claim for Rs.1,72,500/- only, on the grounds that the insured is not eligible for availing the increased sum insured for an already existing ailment.**

**As per policy conditions, any increase in sum insured will not qualify for expenses towards already pre existing ailments but considered for any ailments which manifests afresh after the increase of sum insured. The insurer has been able to prove that the ailments were pre existing at the time of increase of sum insured and hence not eligible for the benefits of the increased sum insured. Hence, the rejection of the claim by the insurer is in order and the complaint is dismissed.**

**MEDICLAIM-29.5.09**

**Chennai Ombudsman Centre**

**Case No.IO(CHN) 11.09.1006/2009 –10**

**Mr. K. Palanisamy**

**vs**

**Reliance General Insurance Co. Ltd**

**Award 006 dated 29.05.09**

**The Complainant and his family were covered under the Surgical and Accident Hospitalisation Policy of the insurer through membership of the Road Safety Club Pvt. Ltd. The complainant's son who was covered under the policy suffered from Aberropia disease relating to the eye. The same was cured by surgical procedure and rejected by the insurer on the grounds that it was a cosmetic surgery which is excluded under the policy.**

**The surgery itself was decided since the patient was not comfortable with wearing of the glasses. It is noted that with glasses only the vision defects can corrected and the condition did not require surgical intervention. The vision correction was carried out to dispense with glasses and falls under exclusions of the policy. The policy certificate contains a clause "Important Exclusions" – wherein 'Cosmetic or Asthetic treatment' of any description was excluded unless necessitated due to an accident or as a part of any illness. It is held that no facts have emerged wherein the insured could convincingly prove that the eye surgery was necessitated due to medical reasons and not to avoid wearing of spectacles or contact lens. Hence rejection of the claim by the insurer as per policy terms is in order and the complaint is dismissed.**

**MEDICLAIM-29.5.09**

**Chennai Ombudsman Centre**

**Case No.IO(CHN) 11.03.1008/2009 –10**

**Prof. Preetam Arthur**

**vs**

**National Insurance Co. Ltd.**

**Award 007 dated 29.05.09**

**The Complainant,had taken a Mediclaim policy for his father and mother. He had declared all their illness and the medicines they were taking and had also been subject to medical examination at the time of inception of the policy. During the policy period the complainant's father was hospitalized for CABG surgery. The insurer rejected the claim on the grounds of pre existing disease exclusion of the Mediclaim policy.**

**The complainant has contended that CAD was not pre-existing and was noticed during 2008 and the same is not solely due to pre existing diabetes and hypertension. It is a known fact that the presence of both diabetes and hypertension for several years does predispose a person to heart disease. Besides, it is observed that there were three blocks, which needed grafts, which definitely establishes that the heart ailment had started some time back, and not a very recent development.**

**It is seen that the insurer was very well aware of the risks attached to insuring a person over 70 years of age, since they have called for medical reports and conducted medical examination. If the insurer wanted, they could have insisted on a treadmill test as well, which they have decided not to insist. But no evidence is available to establish that not only hypertension and diabetes but also coronary heart disease was pre existing at the time of inception of policy. TPA have not found any previous ECG or ECHO reports in support of existence of coronary artery disease at the time of taking the policy. The insurer and TPA have not produced any clinching evidence to establish preexisting heart disease. Therefore in the absence of any report, which establishes the exact date of commencement of the heart ailment and also not able to rule out completely, the part played by pre existing ailments of diabetes and hypertension in the onset of the disease, an amount of Rs.50,000/- is awarded as Ex-Gratia .**

**MEDICLAIM-29.5.09**

**Chennai Ombudsman Centre**

**Case No.IO(CHN) 11.04.1032/2009 –10**

**Mr. K.Sabarimuthu**

**vs**

**United India Insurance Co. Ltd.**

**Award 008 dated 29.05.09**

**The complainant was covered under Mediclaim policy issued by the insurer. During the policy period, he was hospitalized for back pain. His claim was rejected on the ground that the treatment could have been taken as OPD basis.**

**The insured underwent MRI scan and on the basis of the same, he was hospitalized for further treatment. The insurer also has not disputed the ailment suffered by the complainant but has merely contended that the same did not require hospitalization and could have been treated as an out patient. The patient had no say regarding whether hospitalization has to be resorted to or not which decision rested with the treating doctor only. The treating doctor is the best judge to decide whether the condition of a patient warrants hospitalization or not. The insured not being such a well informed person depended on the doctor's advice and got admitted to the hospital for the treatment. The insurer/TPA has not been able to produce any documents to establish that the hospitalisation was not warranted. In view of the same, an amount of Rs.10,000/- is awarded as Ex Gratia.**

MEDICLAIM-29.5.09

**Chennai Ombudsman Centre**

**Case No.IO(CHN) 11.02.1639/2008-09**

**Mrs. G. Latha**

**vs**

**The New India Assurance Co. Ltd.**

**Award 010 dated 29.05.09**

**The Complainant and her mother were covered under the Mediclaim Policy of the insurer. The complainant's mother had a fall when getting off a staircase and injured her left knee and was hospitalized on an emergency basis. The insured's claim was rejected by TPA, on the ground that the patient's condition did not warrant hospitalization.**

**As per the advices of Ortho specialist only, the patient was hospitalized, since the doctor felt that necessary tests and observation in the hospital only would reveal the exact nature of injury and for deciding about the further course of treatment. The treating doctor is the only person who can decide about the requirement or otherwise of the necessity of hospitalization. MRI scan was taken to rule out major complications and requisite medicines were prescribed to treat the condition. Some of the tests fall in the category of routine in nature and few of the others fall under the essential category, which are absolutely required for further advanced level treatment in case the need arises.**

**The treatment being medical management, the insurer has not established that the patient was admitted other than on an emergency condition. Hence, an amount of Rs.9,000/- is awarded as Ex Gratia.**

MEDICLAIM-12.6.09

**Chennai Ombudsman Centre**

**Case No.IO(CHN) 11.03.1632/2008-09**

**Mr. A. Jinnah**

**vs**

**National Insurance Co. Ltd.**

**Award 014 dated 12.06.09**

The complainant and his family have been covered under Mediclaim Policy of the insurer. During the policy period his son was hospitalized for removal of kidney stone and the claim was only partly settled. Out of the total claim of Rs.37,133/- the TPA allowed cashless facility of Rs 30,000/- only and the balance was not paid although he submitted the original bills. The complainant contended that the provisions contained in the policy and the payment made by the TPA did not match with each other and requested for settlement of the claim in full.

After the proceedings, the insurer had informed that the TPA have released the balance claim amount. It is seen that the bill has been revised at the intervention of the TPA to Rs.37,133/- and the insured has paid the amount and got himself discharged without waiting for the TPA to make the payment. Since the hospital bill had been revised downward at the intervention of the TPA, the TPA was justified in calling for the claim form, receipt etc to confirm the actual cost of the treatment which has been paid by the insured to the hospital authorities. And as directed, immediately after the required documents were submitted, the claim has been settled. Hence, there was no deficiency in service on the part of the insurer/TPA. No amount is granted for cost/interest/compensation for mental agony or expenses of any other kind. The claim having been settled in full by the insurer as above, no further relief allowed and the complaint was dismissed.

**MEDICLAIM-12.6.09 Chennai Ombudsman Centre**

**Case No.IO(CHN) 11.05.1615/2008-09**

**Mr. S. Arjunan**

**vs**

**The Oriental Insurance Co. Ltd**

**Award 015 dated 12.06.09**

**The Complainant was covered under Nagrik Suraksha Individual policy of the insurer. During the policy period, the complainant had an injury due to an accident and took treatment under Naturopathy. Since its was not cured, the insured got hospitalized and claimed Rs.50,000/- from the insurer. The insurer rejected the claim on the grounds that the claim was preferred after a lapse of five months and no FIR had been filed in proof of accident.**

**The rejection of the claim on the grounds of inordinate delay in submitting the claim related records as per the policy terms cannot be faulted. Although the happening of the road accident per se need not be established, it is vital that the circumstances in which the injury was suffered should be established. The insured could not prove beyond doubt**

**the happening of the event and also the accident and subsequent treatment soon after the "accident". It is noted that the treatment the insured undertook was much after the so called accident and hence the complaint is dismissed.**

**MEDICLAIM-12.06.09**

**Chennai Ombudsman Centre**

**Case No.IO(CHN) 11.05.1615/2008-09**

**Mr. V.S. Srinivasan**

**vs**

**National Insurance Co. Ltd**

**Award 016 dated 12.06.09**

**The Complainant had been covered under Mediclaim policy of the Insurer. During the policy period , his claim for angiogram charges was rejected by the insurer on the grounds of exclusion 4.1, that insured was suffering from diabetes which is a preexisting disease. The insured was again hospitalized for CABG surgery and the same was rejected by the insurer on the grounds of exclusion 4.1 of the medicalim policy relating to pre existing ailments.**

**The complainant has himself stated that he had marginal diabetes and was on control. Also at the time of the CABG surgery, the complainant is said to be suffering from 'severe triple disease' and it is accepted that the disease does not reach this stage suddenly. Besides the recording in the hospital notes of established institutions and on the basis of which the complainant was given treatment cannot also be wished away. If the records were indeed incorrect the complainant could have got the same rectified. The insurer only contend that diabetes and hypertension have contributed to the severity of the disease. . The insurer could not prove with clinching evidence that coronary artery disease was present before obtaining the policy for the first time.**

**During the policy period , insured was detected to have blocks after which only the increase in sum insured was made. As per the policy terms, the increased sum insured is not eligible for treatment of any pre existing condition prior to enhancement of sum insured. Regarding applicability of revised policy terms also in case of a claim, one has to have a holistic view and not a segmented view and therefore need not depend purely on complainant's version of the case and an amount of Rs.1,10,000/- is awarded as ex-gratia.**

**MEDICLAIM-12.6.09**

**Chennai Ombudsman Centre**

**Case No.IO(CHN) 11.02.1655/2008-09**

**Mr. K. Ravi**

**vs**

**The New India Assurance Co. Ltd**

**Award 017 dated 12.06.09**

**The Complainant and his spouse have been covered under the Mediclaim Policy of the insurer. During the policy period, the complainant's spouse was admitted for removal of Left ovarian cyst. The insured submitted a claim for Rs.78,965/- with the insurer. The insurer/TPA settled the claim for Rs.41,610/- only disallowing Rs.37,355/-. The insurer attributed the reasons for restriction of the claim was due to policy terms.**

It was pointed out that in Chennai, it is not the regular practice for a doctor to charge the fees depending on the room occupied by the patient as may be prevalent in some other cities.

While looking into the amounts allowed under various heads as per the detailed break up provided by the TPA, it is seen that the expenses under surgeon charges, OT charges, Misc. charges, lab charges and consultation charges which are essential in nature for the type of treatment undertaken had to be necessarily incurred and no reason can be seen for any reduction in the amount. The treatment has been taken in a well established hospital and in n the absence of any practice for charging the various expenses depending on the room occupied by the patient, the actual expenses are to be considered subject to disallowing room rent over and above the eligibility, documentation charges, expenses towards non medical expenses and instances where proper bills are not submitted. Taking into account, the expenses which are absolutely necessary for the appropriate treatment an amount of Rs.25000/- is awarded as Ex Gratia.

**MEDICLAIM-12.6.09**

**Chennai Ombudsman Centre**

**Case No.IO(CHN) 11.03.1657/2008-09**

**Mr. V. V. Seshan**

**vs**

**National Insurance Co. Ltd**

**Award 018 dated 12.06.09**

**The Complainant and his wife had been covered under the Mediclaim policy of the insurer from 2002. During the policy period, the wife of the complainant underwent surgery for disarticulation of left great toe. While processing the claim, the TPA sought details of coverage under earlier group policy from 1982 to 2002 with proof, to establish continuity of coverage. The insured submitted details from 1999 to 2002 and the insured's erstwhile employer had confirmed that the insurer's Mumbai Office had covered the insured for the period 1981-1999. The insurer's Mumbai office has not provided the coverage details even though insured's previous employer gave a confirmation to this effect. The insurer treated the insurance cover with them as a fresh one and rejected the claim under pre existing disease exclusion, without taking into account the previous coverage details submitted by the insured since it was not substantiated with proof.**

The insurer could not prove with evidence that the insured was not covered in group mediclaim policy of the insured's ex-employer. Besides it is seen that the complainant was covered under the individual policy when he was almost 70 years of age. Although the complainant had not disclosed his earlier insurance particulars in the proposal form at the time of inception of cover, but for the fact that the complainant was already in the group scheme, the insurer would not have accepted the proposal. In view of the same, the insurer is advised to process and settle the claim of the complainant as per the other terms and conditions of the policy held by him at the relevant period of the hospitalization claim and the complaint is allowed.

MEDICLAIM-12.6.09

**Chennai Ombudsman Centre**

**Case No.IO(CHN) 11.04.1033/2009-10**

**Mr. R. Moorthy**

**vs**

**United India Insurance Co. Ltd**

**Award 020 dated 12.06.09**

**The Complainant had been covered under the Mediclaim policy of the insurer . During the policy period, the insured was hospitalized on three occasions for DM-Nephropathy, Retinopathy, Diabetic Foot syndrome and for cataract. The insured submitted the bills for settlement of the said claims. The insurer rejected the claim on the grounds of pre existing disease exclusion**.

**During the policy year the complainant was hospitalized for Nephropathy, Retinopathy and Diabetic Foot. The discharge summary mentions that the insured was having history of diabetes since 20 years. The proposal form by the insured also contain details of pre**

**existing diabetes and heart ailments. The insurer's contention with regard to rejection of the two claims pertaining to diabetic related treatment is in order.**

**The insured underwent cataract surgery during the policy period and the insurer rejected the cataract surgery also under pre existing condition. The current policy being the second year without a break and as per the terms and condition of current year policy, other insurance companies policies without break are also deemed to be taken as continuous coverage, the hospitalization expenses for cataract surgery has to be considered in the normal course and the insurer is hereby directed to process and settle the claim pertaining to** cataract surgery only **as per other terms and conditions of the policy. No other relief is allowed.**

**The complainant is advised to submit the proof of sending the claim papers to the insurer/TPA. In spite of the same, if the original claim papers are not traceable, the complainant is directed to submit duplicate copies of the relevant documents to the insurer/TPA pertaining to the cataract surgery, for enabling them to process and settle the claim as per other terms and conditions of the policy.**

MEDICLAIM-12.6.09 Chennai Ombudsman Centre

**Case No.IO(CHN) 11.08.1026/2009-10**

**Dr. S. Krishna Shankar**

**vs**

**Royal Sundaram Alliance Insurance Co. Co. Ltd**

**Award 021 dated 12.06.09**

**The Complainant had taken the Medisafe policy for himself and his parents. During the policy period, his mother had complaints of right ear discharge and was found to be a very aggressive type of cholesteatoma. The Insurer rejected the claim on the ground that the disease for which the treatment was taken was pre-existing.**

**In this case both the development of the disease as well as infection were contributing factors. The Insurer could not pinpoint accurately when the disease could have manifested for the first time. In order to establish the actual onset of the disease, the matter was referred to a specialist whose opinion has also been that it is not really possible to fix an exact time frame for the onset of the disease. Considering the nature of the ailment and its associated pain, it can be taken that the problem was attended as soon as the symptoms were manifest. On the other hand, the insurer has not produced any clinching evidence to establish that the ailment was existing when the policy was first incepted. In the absence of clinching evidence like prescriptions for treatment taken or other investigative reports, it is not possible to ascertain the exact date. Since no facts have emerged to establish that the policy was taken when the insured was already suffering from the ailment, the insurer is directed to process and settle the claim as per the other Terms and conditions of the policy.**

MEDICLAIM-12.6.09

**Chennai Ombudsman Centre**

**Case No.IO(CHN) 11.02.1010/2009-10**

**Mrs SM Visalakshi**

**vs**

**The New India Assurance Co. Ltd**

**Award 022 dated 12.06.09**

**The Complainant and husband had been covered under the Mediclaim policy of the insurer. During the policy period the insured was hospitalized for phobic Anxiety with CHR, Depression +. Her claim was rejected by the TPA/insurer on the grounds that the treatment falls under exclusion 4.4.6 relating to psychiatric and psychosomatic disorders.**

**The insured was hospitalized for Phobic anxiety with CHR depression. She had submitted all the relevant papers to the insurer. The insured's representative contended that during 2004, he was informed that the said treatment was allowed. Insurance policies, though it is renewed continuously without break, each years policy is a fresh contract and both parties to the contract are governed by any revision in the terms. The revised policy with the modifications has been introduced after the approval from the competent authority. Besides, it is seen from the policy schedule that in 2007, the complainant has submitted a fresh proposal form. The renewal of the policy in effect pre supposes that insured had agreed for the revised terms. The terms as per condition 4.4.6 mention that "TREATMENT RELATING TO ALL PSYSHIATRIC AND PSHYCHOSOMATIC DISORDERS" are specifically excluded from the scope of the policy. The medical records submitted by the insured also points out that treatment was taken for the condition excluded by the policy. Since insurer had rejected the claim as per the terms and conditions of the policy, the complaint is dismissed.**

**MEDICLAIM-19.6.09**

**Chennai Ombudsman Centre**

**Case No.IO(CHN) 11.12.1057/2009-10**

**Mrs. Sarojini Balakrishnan**

**vs**

**The ICICI Lombard General**

**Insurance Co. Ltd**

**Award 023 dated 19.06.09**

**The Complainant was covered under the Health Care Policy of the insurer. She was hospitalized for cough, cold and breathing problems. Relevant bills were submitted to the TPA for reimbursement of the claim amount but they remained unpaid. The insured reminded the TPA for which there was no response.**

**It is seen that in letter of the complainant to the TPA on 28/05/2008, the TPA was asked to note the change in address. Despite this, the cheque was sent by the TPA to the address on the policy document and not to the changed address informed by the insured..**

**It is a matter of concern that the senior citizen has not been able to avail cashless facility or even get the reimbursement in reasonable time. Although the said TPA has an office in Chennai, it is seen that all claim documents in the present claim are being handled from Mumbai for reasons best known to the insurer. This is one area the insurer may look into if it wants to improve its image in the market. However, it seen that the complainant has changed her residential address thrice and the change in address has been informed to the TPA, the cheque has been sent as per the policy document address. No records are available with the insured as to whether the change in address had indeed been informed to the insurer for effecting in the policy records.**

**However, the insurer having effected the claim payment as per the terms and conditions of the policy and the cheque has since been received by the insured, the complaint is dismissed. No relief of any other sort is allowed.**

**MEDICLAIM-19.6.09**

**Chennai Ombudsman Centre**

**Case No.IO (CHN) 11.05.1058/2009-10**

**Mr. K.V. Sriram**

**vs**

**The Oriental Insurance Co. Ltd.**

**Award 024 dated 19.06.09**

**The Complainant was covered under Individual Mediclaim policy taken by his wife for her family. During the policy period, the complainant was hospitalized for appendicitis as an emergency procedure. He submitted his claim papers with the insurer for settlement. His claim was rejected by the insurer on the grounds of pre existing condition.**

**The complainant developed sudden and severe stomach pain coupled with vomiting and back pain and was hospitalized. It is a fact that the policy is only two months old. There is no specific exclusion for the surgery of appendicitis. From the discharge summary, it is found that the patient was admitted at the hospital with severe abdominal pain. No previous history of any abnormal health condition was noticed. Since the condition occurred all of a sudden, the patient had to be hospitalized. The scan report also did not confirm existence of appendicitis.**

**It merely states that "possibility of appendicitis can not be excluded. The treating doctor also opined that since final HPE showed gangrenous appendicitis, surgery had to be done on an emergency basis. It is a known fact that treatment for appendicitis because of its very nature cannot be deferred. The treating doctor considers the situation as a sudden one and rules out any symptoms suggestive of the same earlier. Neither the insurer nor the TPA were able to prove with clinching evidence, that the condition suffered by the insured was of a pre existing nature and hence the insurer is advised to process and settle the claim as per the other terms and conditions of the policy.**

**MEDICLAIM-19.6.09**

**Chennai Ombudsman Centre**

**Case No.IO (CHN) 11.04.1059/2009-10**

**Mr.A. Radhakrishnan**

**vs**

**United India Insurance Co. Ltd.**

**Award 025 dated 19.06.09**

**The Complainant and his family had been covered under Mediclaim policy of the insurer. During the policy period, his spouse was hospitalized for Right ureteroscopy and stenting. The claim was filed with Heritage Health Services, the TPA. The insured's file was returned and he was advised to file the papers with Family Health Services. When the claim papers were filed with Family Health Services, the TPA had informed the complainant to submit the papers through the insurer. But the insurer also had not entertained the same citing delay in submission of the papers.**

**From the above, it is noticed that the issue is not due to policy coverage, requirement of hospitalization, reasonableness of expenses etc. but due to procedural aspects which have to be dealt with in a less harsh manner and not resorting to extreme step of denying the claim. It is a fact that insured should have approached the TPA for cash less facility as soon as his wife was required to undergo surgery. If this had been done, at that stage itself the TPA issue could have been sorted out and the claim settlement in the present scenario might not have arisen. The insurer is also bound by directions in the form of circulars from their higher office with regard to admission of claim.**

**At this juncture, it is difficult to find out the reasons why the insured could not furnish the claim papers well in time. It is also noted that the insured fully depended on his Agent, who possibly bungled the issue and insurer is refusing the claim.**

**Considering the facts of the case, the insurer is directed to condone the delay and process and settle the claim for 50% of the admissible loss subject to compliance of claim requirements and other terms and conditions of the policy. The complainant is directed to submit immediately, all relevant claim papers, in original along with claim form to the TPA. It may be noted that this is a one time relaxation and can not be taken as precedence in future. The award is passed on Ex Gratia basis.**

**MEDICLAIM-19.6.09**

**Chennai Ombudsman Centre**

**Case No.IO (CHN) 11.02.1060/2009-10**

**Mr.G. Balamurali**

**vs**

**The New India Asssurance Co. Ltd.**

**Award 026 dated 19.06.09**

The complainant had covered his family including his mother under the Good Health Policy of the insurer. During the policy period, his mother was hospitalized for post menopausal bleeding. The total expenses was Rs 87,722/-. Although the sum insured for his mother was Rs 2.00 lacs and Cashless facility of Rs 44,000/- was given, the insurer refused to pay the balance amount stating that as per the New Good Health Policy there was Cap on various heads and the maximum amount payable for this ailment was only Rs 44,000/-.

**The dispute is regarding the TPA having applied the revised terms of the 2008 policy relating to the specified ailment, even though the complainant and his family had been covered under the mediclaim policy of the same insurer from as early as 2000. The complainant has also stated that the revised terms were not known to him. The point to be considered is whether the insurer was right in applying the new policy conditions.**

**It is to be noted that the all insurance policies are approved by the Insurance Regulatory Authority, and as such the insurer was well within their rights to introduce the policy in 2008. It is seen that the insurer has sent a Renewal Notice on which the revised terms and conditions are printed. The insurance certificate issued also has the highlights of the terms in which this ailment has been specifically listed. Besides it is seen that the good health policy has the 20% cap in sum insured for very same diseases even in 2004.**

**Although some new features were introduced in 2008, the limit of 20% for hysterectomy was applicable even in 2004. But it is also seen from the earlier policy copies submitted**

**by the complainant that claims have been made by the complainant's mother as well as other family members in the past, which is reflected in the cumulative bonus of the various members. As such the contention of the complainant that he was not aware of the policy terms and conditions is not acceptable. Further, the insurer has submitted the copy of the relevant renewal notice as well as the policy certificate to establish that the revised terms had been brought to the notice of all the policy holders and hence, the complaint is dismissed.**

**MEDICLAIM-22.6.09**

**Chennai Ombudsman Centre**

**Case No.IO (CHN) 11.03.1056/2009-10**

**Dr. R. Shanmuganathan**

**vs**

**National Insurance Co. Ltd**

**Award 028 dated 22.06.09**

The complainant, and his family were covered under mediclaim policy of the insurer. The complainant's spouse was hospitalized for ovarian cancer. The claim was rejected by the insurer stating that they have treated the current policy as a fresh policy. The complainant's contention that he and his family were insured since six years by another insurer without a break and the current policy is a renewal and his claim was genuine which was not considered by the insurer. The point to be established is whether the insurer is justified in rejecting the claim as a preexisting one and not giving the benefit of continuous cover.

The fact that the complainant has filled up the proposal and as stated by him at the hearing, the decision to change the insurer was made by the complainant himself. But it has been stated by the complainant that since he filled in the previous company details, he was under the impression that he was having continuous cover. He has stated that he was not aware since he did not receive the terms and conditions along with the policy schedule.

The importance of continuity of cover is regarding the possibility of an ailment being preexisting. In the case of the spouse of the complainant , based on the records submitted ,it can be reasonably concluded that the ailment was first diagnosed during the policy period. If the ailments had existed prior to obtaining the present policy, the patient could have very well claimed under the earlier policy. The fact that no claim has been made with the earlier insurer clearly established that there was no disease at the time of taking this policy from the insurer. The insurer has not submitted any clinching evidence to establish that the insured was suffering from cancer prior inception of the present policy. The complainant also cannot demand continuity of cover since he is himself a educated person and has taken the decision to change his insurer for his personal convenience. Also when he was changing the insurer it was his duty to understand the terms and conditions of the policy. Merely because he has mentioned the name of the earlier insurer he cannot assume that he will have

the benefit of continuity of insurance. So he cannot technically blame the insurer. However, .the company also could not establish that the disease was pre-existing.

Hence to meet the ends of justice to both the parties, Rs 30,000/- (Rupees thirty thousand only) is awarded as Ex-gratia .

**MEDICLAIM-22.6.09**

**Chennai Ombudsman Centre**

**Case No.IO (CHN) 11.02.1061/2009-10**

**Mr. E.S. Unnikrishnan**

**vs**

**The New India Assurance Co. Ltd**

**Award 029 dated 22.06.09**

**The Complainant and his wife had been covered under Mediclaim policy of the insurer. During the policy period the complainant's spouse was hospitalized for abdominal pain and constipation. The claim was filed with the TPA. The insurer/TPA rejected the claim on the grounds that the condition of the patient did not warrant hospitalization but could have been treated as an out patient and no active line of treatment was given. The Point to be considered is whether the stand of the insurer rejecting the claim on the grounds that no active line of treatment which is an exclusion under the policy is in order.**

**The insured got hospitalized after exhausting all avenues like homeopathy and treatment with local doctors. Problem of constipation which was not cured even after 20 days, it is but natural that the patient seeks treatment in a major hospital. When she consulted the doctor in the hospital, it is the treating doctor who decides on the hospitalization or otherwise of the patient and the patient does not have much say in this since most of the specialists are visiting doctors. Besides, it is seen from the prescriptions submitted by the complainant, the insured had made genuine and bonfire attempts and tried to be treated on OPD basis before resorting to take treatment at a hospital.**

**In view of the above facts, it is found that hospitalization was necessary to treat this condition and ruling out any major illness and hence the decision of the insurer to reject the claim on the grounds of non requirement of hospitalization is not in keeping with the spirit of the policy. The insurer is directed to process and settle the claim as per the other terms and conditions of the policy.**

MEDICLAIM-29.9.09

**Chennai Ombudsman Centre**

**Case No.IO(CHN) 11.02.1118/2009-10**

**AWARD No.34 dated 29.09.09**

**Mr. N. Krishnamurthy**

**vs**

**The New India Assurance Co. Ltd.**

The insured had taken individual mediclaim policy for the period 11.02.2008 to 10.02.2009.in which he has covered his wife also for a sum insured of Rs 2 lakhs.He has taken treatment for his wife for osteoarthritis involving both the knees at Bangalore from 30.04.2008.to 20.05.2008.The treatment is known as "Rotational Field Quantum Magnetic Resonance",a day care procedure involving 60 minutes per day.The insurer had rejected the claim on the ground that the treatment did not fall under the policy coverage. The insured had represented that similar treatment were allowed in a complaint lodged with the ombudsman office of Chandigarh,Kolkatta and approved by TPA T.T.K.Healthcare services at Vishakapatnam for New India Assurance Co Ltd.

The complainant's wife underwent RFQMR(Rotational Field quantum magnetic resonance) treatment at Bangalore for 21 days as she was suffering from severe pain in both the knees. The SBF centre where the treatment was taken cannot be taken as hospital as defined in the policy.

As per the policy condition minimum criteria as to number of beds ,operation theatre, qualified nursing staff ,Medical practitioner should be available in the place where the treatment is taken . The insured's argument that in other ombudsman's centre cases of similar nature were decided in favour of the insured can not be accepted because they might have taken a decision to allow or disallow a particular claim depending on the merits of each case and the policy condition of the respective insurer.

In the present case even though the procedure is latest one the policy issued has not included the same in their coverage. The place where the treatment was taken does not conform to the definition of hospital as per the policy. Further the treatment also does not fall under the list of treatment where concession is given for dispensing with 24 hours hospitalisation due to advancement of technologies.

Hence the decision of the insurer in repudiating the claim is justified and the complaint is dismissed.

MEDICLAIM-29.9.09

**Chennai Ombudsman Centre**

**Case No.IO(CHN) 11.05.1124/2009-10**

**AWARD No.36 dated 29.09.09**

**Mrs. Natasha Fernandes**

**vs**

**The Oriental Insurance Co. Ltd.**

The above complainant was covered under individual mediclaim policy from 02.11.2007to 01.11.2008.She had undergone surgery for Osteoma left proximal, Postemo medical aspect of Tibia and lodged a claim with the insurer.The claim was repudiated stating that the illness was contracted by the insured during the first thirty days of taking the policy as per the policy terms and conditions.

The insured's father had represented that his daughter was having severe pain in her left leg and consulted a Dr on 03.12.2007.and MRI Scan was taken which indicated no problem.CT scan report indicated of Bone Marrow oedema and hence went to Cancer Institute on 11.12.2007.The insured had mentioned that they were not happy with the treatment and consulted a Doctor at Sri Ramachandra Hospital where she was admitted on 01.08.2008. and discharged on 08.08.2008.The insurer had argued that the problem was first noticed within 30 days of taking the policy based on the report of cancer institute where they have mentioned that she had pain for three weeks which was within 30 days of taking the policy.

The repudiation by the insurer has been done only on the basis of cancer institute report and this cannot be completely relied since the pain in the leg has been wrongly mentioned as right leg instead of left leg and it is possible that the duration also has been wrongly mentioned. It is also to be noted that the first consultation was on 3.12.2007 which is 32 days from the inception of the policy Further the records of the hospital where the surgery was performed has also indicated that the pain in the left knee was there since six months.Since no clinching evidence was produced to establish that the ailment was pre existing or was contracted within the first 30 days the decision of the insurer in repudiating the claim is unjustified.

The complaint is allowed.

MEDICLAIM-29.9.09

**AWARD No. IO (CHN)/G/037/2009-10**

**Complaint no-11.04.1129.**

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**Mr.M.S.Sekar vs United India insurance co ltd.**

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The complainant had taken Andhra bank Arogyadan floater mediclaim policy from 27.07.2006 and was continuously renewing the policy and the current policy period is from 27.07.08 to 26.07.09.He was admitted in the hospital from 31.08.2008 to 10.09.2008 for stroke.The insured had mentioned that while taking the policy he had declared that he was a diabetic for the past 10 years and Hypertension for the past 7 years. The insurer had rejected the claim on the ground of preexisting disease based on the opinion taken from an expert Doctor.

The insured had represented that there could be several causes for a person to get stroke and it need not be only due to diabetes and hypertension.

**Award dated-29 th Sep 2009.**

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It is an accepted medical fact that both diabetes and hyper tension pre disposes the affected person to several major ailments including stroke The claim has also arisen before completion of 3 claim free years. Hence the decision of the insurer in repudiating the claim cannot be faulted. However it is also an established fact that DM and HTN are not the only causes for a person to be affected by the stroke. It is found from the discharge summary that the patient was admitted in the hospital with history of right sided weakness and giddiness with history of hyper tension since 7 years and diabetes for ten years. The discharge summary has also not mentioned any reason relating to pre existing disease for the hospitalisation. Hence presence of the disease alone cannot be a ground for rejection because the patient was also under medication to control the disease.

Taking all the above factors and in order to do justice to both an ex gratia amount of rs 25,000/- is awarded.

# DELHI

Case No.GI/284/NIC/08

**In the matter of Shri Surinder Singh Chadha Vs**

**National Insurance Company Limited.**

**AWARD dated 06.04.2009**

Shri S.S. Chadha was admitted in the Escorts Heart Institute and Research Centre on 08.10.2007 and was discharged on 09.10.2007. His medical claim amounting to Rs.73091/- has been rejected by National Insurance Co. Ltd. On the grounds that pre-existing disease condition in the terms and conditions of the policy applies in this case.

Shri S.S. Chadha had taken the first policy on 19.03.2000 which covers the period 19.03.2000 to 18.03.2003. Subsequently the policy also was renewed regularly. However, while renewing the policy in 2003, there is one day gap i.e. the policy was renewed on 20.03.2003 whereas it should have been renewed a day before i.e. on 19.03.2003. The Insurance has treated it as a gap and therefore the policy renewed has been taken as a fresh policy. The Insurance Company in its letter dated 27.11.2008 addressed to Ombudsman writes as under:

"Our policy terms and conditions clause no. 4.3 says that if continuity of cover is not maintained with National Insurance Company Limited subsequent cover will be treated as fresh for application of clause 4.1, 4.2, 4.3 above."

Before me the representative of the Insurance Company Shri D.P. Rana fairly concedes that in case this one day gap could have been condoned it would not have been considered as a fresh policy but continuation of the first policy. In that situation pre-existing disease condition would not have been applied.

Before me Shri Chadha submitted that he has been a regular insurance policy holder and all the premiums were paid on time without fail over the years. He submitted that one day gap should have been condemned. He submitted before me a copy of letter dated 18.06.1999 from Ms. V. Sushila Manager of General Insurance Corporation of India addressed to National Insurance Co. Ltd. stating that "All benefits of continuous renewal will be available if the policy is renewed within 7 days grace period…….".

I have considered the submissions made on behalf of the policy holder as well as the Insurance Company, Renewal on 20.03.2003 was at 15 hrs. If it would have been just before midnight between 19.03.2003 and 20.03.2003, the policy would have been in time. There is only 15 hrs gap. In my opinion this insignificant gap could have been condoned.

In view of the above I am of the opinion that in instant case the one day gap should be condemned and accordingly the claim of Shri S.S. Chadha should be allowed subject to verification of item wise permissibility of the claim in accordance with the terms and conditions of the policy.

The Award shall be implemented within 30 days of receipt of the same. The compliance of the same shall be intimated to my office for information and record.

Case No.GI/306/NIA/08

**In the matter of Shri S.L. Jain Vs**

**New India Assurance Company Limited.**

**AWARD dated 13.04.2009**

1. The Policy holder mediclaim of Rs.9335/- has been rejected on the ground that treatment was taken at OPD whereas the policy conditions require hospitalization for allowing the claim. Insurance Company's repudiation letter dated 08.01.2008 is on my record.

2. No one appeared on behalf of Insurance Company for the hearing.

3. Before me it is submitted by Shri Sharad Jain, policy holder's son that indeed there was a surgical operation for the removal of cyst on the face of the patient. This was performed on 23.08.2007 in Operation Theatre of Sama Nursing Home. Though it was mentioned an OPD case, it is **effectively** one day hospitalization where the patient was taken straight to the operation theater and the surgical procedure is undertaken.

4. In this context, a copy of this Company's general Circular No. HO: ISC: 60:15:56:89 dated 26.10.1989 is submitted before me on this very issue which reads as follows:

> "Please refer to our earlier Circular no. on the above subject. In view of the above difficulties faced by the subsidiaries in processing the claims in respect of which the patient was operated in the out-patient, department and discharged on the same day, it has been decided by GIC that if the operation had been carried out by a qualified surgeon in any operation theatre of the Hospital/Nursing Home but the patient was registered as out-patient and discharged on the same day, such claims may be admitted under Hospitalization Section of the Mediclaim Insurance Policy".

5. I feel in a situation like this where the patient had undergone surgery in a hospital; one should not take a narrow view. It was indeed de-facto (though not de jure), hospitalization for one day. It was mentioned to be OPD because the patient is

released straight from the Operation Theatre. Further, the Insurance Company's clarification issued on 26.10.1989 clearly permits the claim.

6. Accordingly it is directed that Policy Holder's claim of Rs.9335/- should be allowed subject to verification of item wise permissibility.

7. The Order should be complied with by 15.05.2009.

## Case No.GI/305/NIA/08

**In the matter of Shri A. Thomas Vs**

**New India Assurance Company Limited.**

**AWARD dated 13.04.2009**

1. Shri A. Thomas was admitted to R.G. Stone Urological Research Institute for Kidney Stone treatment. His mediclaim has been refused by New India Assurance Co. Ltd. on the ground that Kidney Stone was a pre-existing disease.

2. Before me Shri Thomas, who himself appeared referred to the medical certificate dated 19.07.2008 from Dr. Prakash Joshi Medical Superintendent of R.G. Stone Urological Research Institute which inter-alia reads as under:

> "Patient gives history suggestive of spontaneous passage of calculi for last 20 years but there is no concrete proof for the same as he never required any hospitalization or medication. His present problem was only for one day. Therefore it is difficult to say that it was pre-existing."

3. On the other hand, the Insurance Company representative referred to the discharge card from R G Stone Urological Research Institute which in its clinical notes mentions as under:

> "Stone passer over 20 yrs from both sides".

With reference to the same, it was argued that it was a case of pre-existing disease.

4. Shri Thomas submitted that he had taken the policy since 1990 and had never made any mediclaim under this policy. Bonus to the tune of 50% has also accumulated because no claim has been made anytime earlier. Though he had some pain but he had never noticed the fact that there is some problem like Kidney Stone till he was hospitalized on 15.06.2007 in R G Stone Urological Research Institute. Secondly it was pointed out that calculi is not same as stone and the age of the stone which was

removed from his kidney can not be determined so as to necessarily suggest that it was existing at the time of taking the policy way back in 1990.

5. I have considered the contentions raised by both sides. In my opinion patient's knowledge of the pre-existing disease should be inseparably fastened with the concept of pre-existing disease. If a patient did not know about the disease and he came to know about it much later, this should not be held against him. There may be common symptoms of different diseases and in a medical situation subsequent to taking the policy one may discovers that such symptoms related to a specific disease in him.

6. Coming to the instant case apparently Shri Thomas was experiencing for many years some pain but he did not know that it was kidney stone. As passer of calculi did not necessarily mean that in the year 1990 indeed Shri Thomas had a Kidney stone of the size which required removal. People live a life with a passer of calculi without the need of medical intervention.

7. In view of the above circumstances, I feel at the time of taking policy in 1990, there was no pre-existing disease. Doctor's Certificate referred to above also mentions that there is no proof of pre-existing disease. If it was, it was indeed not in the knowledge of Shri Thomas. As I have already indicated while dealing with the Insurance claims, the concept of pre-existing disease should necessarily be fastened with pre-existing knowledge of the disease. In this case on both accounts, Insurance Company in my opinion is not justified in rejecting the claim. Total claim in this case is Rs.56310/-. The Insurance Company is directed to verify this claim and allow the same subject to permissibility with reference to the specific items of expenditure claimed.

8. The payment should be made to Shri Thomas by 30.05.2009

## Case No.GI/324/UII/08

**In the matter of Shri Manindra Nath Das Vs**

**United India Insurance Company Limited.**

**AWARD dated 13.04.2009**

1. Young Malabi Das thought peaks - sculpted by God - are pinnacles of glory. She participated in a Mountaineering Expedition sponsored by IMF in the Himalayas and climbed the peak Papsura (6451m) on 04.10.2005 in Himachal Pradesh. But while scaling down she fell into a crevasse and died. The postmortem report which was undertaken on 09.10.2005 gives the cause of death as Asphyxia due to Pulmonary Edema. The Insurance Company has repudiated the claim on the ground that "death

is not caused due to solely and directly from accident caused by external violent and visible injury."

2. Before me, the representative of the Insurance Company referred to the following conditions in the Para 1 of the policy documents which reads as follows:

> "If at any time during the currency of this policy, the insured shall sustain any bodily injury resulting solely and directly from accident caused by external violent and visible means, then the Company shall pay to the insured or his legal personal representative(s) as the case may be."

He submitted that in the postmortem report there is no mention that she sustained any bodily injury resulting solely and directly from the accident caused by external violent and visible means.

3. Before me Malabi's father appeared. He submits that the postmortem report was not exhaustive. He stated that her ribs were broken because of the fall and there were internal injuries which were not specifically taken note of by the Doctor. He further submitted that there is no doubt that her death was because of the accident. As such he submits that claim should be allowed.

4. I have considered the submissions made before me. In this case there is no doubt or debate about the fact that this young lady lost her life because of an accident, i.e., by falling into the crevasse. Hon'ble Supreme Court in the case of Jyoti Ademma Vs. Plant Engineer, Nellore vide Appeal No. (Civil) 6201 of 2004 decided on 11th July, 2006 have explained the term "accident" as under:

> "The expression "accident" means an untoward mishap which is not expected or designed. "Injury means physiological injury. In Fenton v. Thorley & Co. Ltd., (1903) A.C. 448, it was observed that the expression "accident" is used in the popular and ordinary sense of the word as denoting and unlooked for mishap or an untoward event which is not expected or designed."

In the instant case obviously this is an untoward mishap. This was not expected or designed. It is obviously an accident that led to the death of Malabi.

5. As regards the "bodily injury", I feel "bodily injury" should be given a wider connotation to cover cases where body organs' functioning is seriously impacted because of the accident. The term "injury" should not be restricted to denote situations only when blood is spilt, a bone is broken or skull is smashed. All that is required is it should be "physiological" as explained by the Supreme Court in the case referred to above. Injury could be internal, invisible but discernible. It could be injury to body muscles, tissues or cells seriously impacting functions of body organs, yet invisible and may not find mention in the standard format of a postmortem report. Injury could be inferred, from the circumstances and the cause of death.

6. As regards the cause of death in my opinion it should also be **proximate cause** not necessarily only the immediate cause.

7. Terms "violent" and "Visible" occurring in the policy should also have relaxed contextual interpretation. Death in this case was not a normal death, unseen and unknown. It was a "violent" death by way of a fall into the crevasse. It was "visible" with full fledged rescue mission with participation of Army Helicopters.

8. At this juncture I may like to point out the Insurance authorities in the repudiation letter dated 07.01.2008 have misdirected themselves by connecting "violent" and "visible" to the term "injury" which is not correct. Para 1 of the policy connects these terms to accident (i.e. accident caused by external violent and visible means). Injury itself need not be violent and visible.

9. Coming to the instant case, as per the postmortem report, she died because of "Asphyxia due to Pulmonary Edema". Edema is described as "the presence of abnormally large amount of fluid in the intercellular tissue spaces of the body" (Door law's Medical Dictionary). Delving into the medical literature, I find the Pulmonary Edema is caused because of left sided heart failure involving left ventricle. To extract - from Wikipedia, the free encyclopedia "it is due to failure of the heart to remove fluid from lung circulation (cardiogenic pulmonary edema) or a **direct injury** to lung parenchyma (non cardiogenic pulmonary edema)". In instant case, it is clear from the record that Malabi was a hale and hearty girl (who had no medical problems), a pre condition for Mountaineering. Obviously there was a sudden left sided heart failure or direct injury to lung parenchyma leading to Pulmonary Edema. Heart failure cannot happen suddenly to a healthy human being in ordinary circumstances. This has occurred because of the fall from the height which impacts the body organs with tremendous severity and attendant climatic conditions. There is obviously injury to the heart cells in the sense heart functioning has been severely impacted, or there has been a direct injury to lung parenchyma. As such I am inclined to infer that there has been an internal injury to the heart or lung because of sudden impact causing Pulmonary Edema. Therefore I feel that the bodily injury conditionality is fulfilled in this case. The claim therefore should be allowed.

10. Before parting, may I say these are situations of compelling compassion not uncommon to Insurance Sector, deserving a considerate holistic view, of course, within the terms and conditions of the policy. Terms and conditions should be interpreted giving them reasonable elasticity in stead of being bogged down in semantics. This reminds me of the following lines of Poet John Donne:

> **"No man is an island, entire of itself, every man is a piece of the continents a part of the main;** if a clod be washed away by the sea, Europe is the less, as well as if a promontory were, as well as if a manor of thy friends or of thine own were; **any man's death diminishes me, because I am involved in mankind; and therefore never send to know for whom the bell tolls; it tolls for thee."**

Probably these are situations where the Insurance Companies should be involved in mankind. This has sound business sense as it would increase goodwill and consequently in expand business.

11. Considering the totality of the circumstances, I conclude that the claim should be allowed in full, that is Rs.3 lakhs/-, to meet the ends of equity and justice.

12. The Insurance Company is directed to make the payment by 15.05.2009.

**Post Script: May her soul rest in peace.**

**Case No. GI/304/OIC/08**

**In the matter of Shri Arvind Bahl Vs**

**Oriental Insurance Company Limited**

**AWARD dated 15.04.2009**

1. Shri Arvind Bahl underwent treatment at Pushpawati Singhania Research Institute, New Delhi. He was admitted on 30.07.2007 and was discharged on 09.08.2007. The symptoms mentioned in the discharge summary were as under:

| Presenting Symptoms: | Duration |
|---|---|
| * Recurrent loose motion | for 2 years |
| - Watery | |
| - 5-6 times/day | |
| * Weight loss – 13 kg | |
| * Anorexia* H/O bleeding P/R for 2-3 days in last month | |

Final Diagnosis : Anal growth cause – Ulcerated inflamed adenomatous Polyp (Biopsy report awaited)

The mediclaim amounting to Rs.86273/- has been repudiated on the ground that this was a pre-existing disease and, therefore, the claim was not allowable. The policy in this case was taken for the first time on 19.07.2006 and was renewed on 19.07.2007.

2. Before me Shri Bahl submitted that there was a wrong description in the discharge summary in the sense that they had mentioned wrongly that the symptoms were for the last two years which was not correct. It should have been for the last two months. However, his efforts to get the discharge summary corrected by the hospital have failed since by their letter dated 01.09.2007, the hospital has informed that unless there is a query in this regard from the Insurance Company, it will not be possible for them to give a clarification in this regard.

3. Before me Shri Bahl vehemently stated that even in the discharge summary the reference was to symptom and not to disease. He was never aware that he was suffering from any disease. He further submitted that the kind of symptoms that are mentioned like recurrent loose motion, watery, 5-6 times daily, cannot persist for two years without leading to serious medical conditions.

4. On the other hand, the representative of the Insurance Company Shri Upkar Singh supported the action of the Insurance Company.

5. I have considered the submissions of the policy holder and the Insurance Company. There appears to be some confusion with regard to facts. It is improbable that the loose motion 5-6 times a day persisted for two years. In that case, it would have threatened the very survival of the policy holder. Secondly, symptoms and disease are not synonyms. There may be common symptoms for different kinds of disease. Sometimes symptoms may not relate to any disease. Take for example, chest pain. It may relate to heart problem. It may relate to indigestion which by itself is not a disease. Unless there is evidence that symptoms are co-relatable to a specific disease at a given point of time, it cannot be linked with the concept of pre-existing disease. In the instant case, there are no reports/documents or episodes duly documented or evidenced by way of pathological and other reports that the disease diagnosed during hospitalization between 30.07.2007 to 09.08.2007 indeed existed on the date of taking the policy, that is, 19.07.2006. In my view, the discharge summary has to be evaluated considering all these relevant facts which have a bearing to the issue instead of adopting a literal interpretation.

6. Considering all the facts together, I conclude that there is no specific proof for a pre-existing disease for refusing the mediclaim. The same should be allowed subject to itemwise verification of permissibility. The payment should be effected by 31.05.2009. The compliance of the Award shall be intimated to my office for information and record.

7. Copies of the Award to both the parties.

**Case No. GI/297/NIC/08**

**In the matter of Shri Ajay Kumar Vs**

**National Insurance Company Limited**

**ORDER dated 15.04.2009**

1. Shri Ajay Kumar was hospitalized on 17.11.2006 and was discharged from the hospital on 21.11.2006. His mediclaim has been approved to the extent of Rs.17613/-by the TPA, E-Meditek Solutions Limited, Gurgaon and has been forwarded to the Head office at Mumbai since 07.01.2008 but so far he has not been paid the amount.
2. Before me Shri P.K.Gupta, Administrative Officer of the National Insurance Company Limited promised that payments will be made soon on receipt of reply from the Mumbai office to their reference.
3. It is directed that since the amount has been approved; the payments will be effected by 15.05.2009 under intimation to this office.
4. Complaint is disposed of finally.
5. Copies of the Order to both the parties.

**Case No. GI/309/ICICI Lombard/08**

**In the matter of Smt.Sunita Bhasin Vs**

**ICICI Lombard General Insurance Company Limited**

**AWARD dated 21.04.2009**

1. The mediclaim amounting to Rs.17448/- has been refused on the ground that the hospitalization was only for the purpose of investigation and not for treatment of any disease. Shri Kartik Bhasin was admitted in Sir Ganga Ram Hospital on 01.07.2008 and was discharged on 03.07.2008. Discharge summary diagnosed the problem as "moderate depression with obsessive features with specific phobia (Aerophobia)." During hospitalization certain tests were undertaken.

2. The Insurance Company has repudiated the claim on the ground that it was only for investigation and not for any treatment for a specific disease. In this

connection, Sh.Sat Prakash who appears for the Insurance Company relied upon the exclusion clause of the policy which reads as under:

"3. Exclusions

The Company shall not be liable to make any payment under this policy in connection with or in respect of any expenses whatsoever incurred by any insured person in connection with or in respect of:

x) Charges incurred at Hospital or Nursing Home primarily for diagnostic, X-ray or laboratory examinations or other diagnostic studies not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any diseases, illness or injury whether or not requiring hospitalization/Domiciliary Hospitalization."

3. Shri Surender Kumar Bhasin, husband of the policy holder appeared before me. He submitted that his son was suffering from depression for which he was admitted in the hospital and certain tests were undertaken as were directed by the doctor in the hospital itself.

4. I have carefully considered the submissions made by both the parties. A careful analysis of the exclusion clause shows that if hospitalization is for diagnostic investigation, "not consistent with or incidental to diagnosis and treatment of an existing disease, illness or injury" then alone it could be disqualified under the policy for the purpose of reimbursement. It is not that. A stigma will be attached for diagnostic investigations which are incidental to the treatment of an existing disease. In common parlance, if one is getting admitted in the hospital looking for a disease, expenditure will not be admitted. But in case, in course of treatment of a disease (whether or not requiring hospitalization) the diagnostic investigations are undertaken, the expenditure incurred should not be disqualified.

5. In instant case, the discharge summary clearly shows that the patient was suffering from depression and therefore, it is in course of treatment of depression that certain tests were undertaken as decided by the doctor of hospital. The policy holder had no say in the matter.

6. In view of the above, I am of the opinion that the case does not fall under exclusion clause. It is directed that the Insurance Company should allow the claim. The payment should be made by 31.05.2009.

. 7. Copies of the Award to both the parties.

**Case No. GI/302/ICICI Lombard/08**

**In the matter of Shri Ravinder Sahai Vs**

# ICICI Lombard General Insurance Company Limited

## AWARD dated 21.04.2009

1. This mediclaim relates to the Health Insurance policy No. 4034/RIS/002162/00/000(Renewal No.4034/RIS/02069025/00/000) covering Shri Ravinder Sahai and his wife Smt.Rama Sahai. Mrs. Sahai was operated upon in Indian Spinal Injuries Centre, Delhi for treatment of Avascular Necrosis of left hip. She was hospitalized for the purpose on 14.01.2008 and got discharged on 19.01.2008. Her mediclaim amounting to Rs.2,31,680/- has been refused by the Insurance Company on the ground that she was taking steroid as a treatment for Systemic Lupus Erythematosus(SLE) for about one year in last three years and the present problem of Avascular Necrosis was because of taking steroid. As such, the Insurance Company was of the opinion that it was a pre-existing disease which was not disclosed.

2. Shri Sat Prakash on behalf of the Insurance Company took me through exclusion clause of the policy document which reads as under:

   "4.Exclusions

   The company shall not be liable or make any payment for any claim directly or indirectly caused by, based on, arising out of or howsoever attributed to any of the following:

   4.1 Any pre-existing illness - The claim arising on account of or in connection with any pre-existing illness shall be excluded from the scope of cover under the policy. This exclusion shall cease to apply if the insured has taken the Healthcare Policy from the company, without a break, for a period of 4 consecutive years immediately preceding the period of insurance."

   He referred to the certificate dated 30.03.2008 of Dr.Asha Kubba of the same hospital who certifies that Avascular Necrosis occurs because of steroid therapy of SLE. Shri Sat Prakash emphasized the words **"arising on account of or in connection with any pre-existing illness"** occurring in the exclusion clause as extracted above. He submits that indeed there is a cause and effect relationship between steroid therapy taken for SLE and the problem of Avascular Necrosis. That is why, he argues that the claim is arising on account of or in connection with pre-existing illness.

3. Shri Ravinder Sahai submitted that Systemic Lupus Erythematosus(SLE) and Avascular Necrosis(AN) are two different diseases. SLE is treated by a dermatologist, being a skin disease. Avascular Necrosis is treated by an orthopedic surgeon, having to do with bones. As such it cannot be held that claim in relation to Avascular Necrosis was a claim in relation to a pre-existing disease.

4. I have considered the submissions made by both the sides. On a careful reading between the lines of the exclusion clause it transpires that **the claim should be connected with a pre-existing illness to attract disqualification.** Connection between pre-existing illness and present illness is irrelevant as long as the claim is for the present illness and not for pre-existing illness. If the claim is for the existing illness, it cannot be disallowed on the ground that there is a connection between pre-existing illness and present illness.

5. In the instant case, the past illness was Systemic Lupus Erythematosus(SLE). Claim under our consideration is not for that illness. Claim is for subsequent problem of Avascular Necrosis. That the latter disease could be caused because of steroid therapy taken for the earlier disease is irrelevant to the issue before us.

6. The modern medicine is a necessary evil. Often treatment for one disease leads to another disease because of the side effect of the medicines. But what the poor patient can do? He has Hobson's choice. He has to go by the advice of the doctors and finally depend upon God. There is a popular epithet (not my view) that **God gives the cure, doctor takes the fees**.

7. Keeping in view the above facts, the claim is allowed. The Insurance Company should comply with the direction by 31.05.2009.

8. Copies of the Award to both the parties.

## Case No.GI/321/OIC/08

**In the matter of Ms. Sunita Kathuria Vs**

**Oriental Insurance Company Limited.**

**AWARD dated 24.04.2009**

1. The Insurance Company has repudiated this policyholder's claim of medical expenses amounting to Rs.14,290/- on the ground that hospitalization in Maharaja Agrasen Hospital was only for the purpose of investigation and not for any active treatment. Prior to the hospitalization in Maharaja Agrasen Hospital, he had also taken treatment from others doctors, Dr. Avnish Baweja, Psychiatrist as well as doctors at Nirmal Hospital Dr. Ravikant Guglani. The patient was having severe Headache, nausea with repeated vomiting for 4-5 days. The panel doctor of the Insurance Company, Dr. Sharad Mathur investigated the matter. He found that all the tests reports for the patient were normal and finally he concluded that patient was admitted in the hospital for investigation purpose only and therefore he suggested repudiation of the claim.

2. Before me it was submitted on behalf of the policy holder that severe headache with vomiting and nausea persisted and therefore he was admitted in the Hospital. After admission into the hospital it was the doctor's discretion what test to do or not to do. If after investigation the test reports were normal, it did not mean that there was no active treatment. Accordingly it is submitted that he was entitled to get reimbursement.

3. The official from the Insurance Company however, reiterated her contention that no claim was allowable since there is no active treatment. She invited my attention to Para 4.10 of the policy conditions.

4. I have carefully considered the submissions made before me by both sides. Severe headache accompanied by vomiting which persisted for a period of time

by itself could be considered to be disease or symptoms of the disease requiring treatment. Headache could also be related to Tumor in the brain or other severe problems. Even in the discharge summary, the disease is identified as Migraine without aura. Medicines also have been prescribed i.e Tab. Nise and Tab. Lonazep.

5. That the test reports were within normal parameters would not mean that there is no active treatment. Similarly that only two medicines were prescribed would not also mean that there is no treatment. Smallness of the dose of the medication is not a determining factor for existence or non existence of a disease.

6. Considering the above facts, I am of the opinion that the policyholder's claim should be allowed. The Insurance Company is directed accordingly.

**Case No. GI/298/NIC/08**

**In the matter of Shri Rameshwar Das Singhal Vs**

**National Insurance Company Limited**

**AWARD dated 04.05.2009**

1. In this case, the grievance is that the amount of Rs.13492/- towards medicalim approved by E-Meditek Solutions Limited, TPA on 15.11.2007 has not yet been paid to the policy holder by the National Insurance Company Limited.

2. Before me the representative of the Insurance Company Shri P.K.Gupta could not present any valid reason for such non payment except stating that TPA should have made the payment.

3. TPA acts on behalf of the Insurance Company but the liability is that of Insurance Company itself. If there is failure by the TPA that is regarded as failure of the Insurance Company.

4. Since there is no valid reason for non payment of the medicalim of the policy holder, it is directed that payment should be effected by the Insurance Company by 20.05.2009 under intimation to this office.

5. Copies of the Award to both the parties.

**Case No. GI/296/NIC/08**

**In the matter of Shri B.M.K.Joshi Vs**

**National Insurance Company Limited**

**AWARD dated 04.05.2009**

1. Shri B.M.K.Joshi policy holder himself appeared. His mediclaim of Rs.27763/- for hospitalization during the period 05.01.2007 to 09.01.2007 in Shri Balaji Action Medical Institute has been repudiated by the National Insurance Company Limited on the following ground: "As per discharge summary dated 05.01.2007 to 09.01.2007 mention ALD(Alcoholic liver disease) which is standard exclusion; hence rejected."

2. Shri Joshi at the time of hearing invited my attention to para 4.1 as well as 4.8 of the policy conditions. With reference to para 4.1, he submitted that he had taken the policy for the first time on 28.04.1999 and more than 4 years had elapsed since then. As such any handicap with reference to any pre-existing disease does not apply in his case. With regard to para 4.8, reading between lines, he pointed out that exclusion is only with regard to "accidents due to misuse or abuse of drugs/alcohol or use of intoxicating substances." In his case, there is no accident as such. He was hospitalized for treatment for breathlessness. He also claimed that not only the claim should be allowed, he should also be compensated for the delayed payment.

3. No one appeared on behalf of the Insurance Company.

4. As rightly pointed out by Shri Joshi, the concept of pre-existing illness will not be applicable here since policy is more than 4 years old. With regard to the exclusion provisions, considering the terminology of para 4.8, I find same is also not applicable to facts of the case.

5. In view of the above, I am of the opinion that the policy holder claim should be allowed. He should be paid interest @ 8% from the due date of payment to the date of actual payment. The compliance should reach this office by 30.05.2009

6. Copies of the Award to both the parties.

**Case No. GI/315/NIC/08**

**In the matter of Shri Jai Pal Kapoor Vs**

**National Insurance Company Limited**

**ORDER dated 04.05.2009**

1. Shri Jai Pal Kapoor had taken a health insurance policy on 11.10.2007. He was hospitalized in Saroj Hospital and Heart Institute on 30.01.2008 and was discharged on 05.02.2008. The admission slip of the hospital mentions that he was an old patient of CAD/CAV. In terms of Clause 4.1 of the policy, this has been treated as pre-existing disease not disclosed by the policy holder at the time of taking policy. Accordingly, the claim has been repudiated.

2. Before me it was submitted that Shri Kapoor had never any complaints earlier and did not know that he was having any heart problem as such. He was admitted for a different problem that is, slurring of speech which is a neurological disorder. It is only during his hospitalization he came to know about the problem of Coronary Artery Disease (CAD).

3. The representative of the Insurance Company Shri H.K.Soni reiterated that it was suppression of information regarding pre existing disease and therefore, the claim is not admissible.

4. I have considered the submissions made be fore me. To determine the issue in this case, one is to find whether the treatment was for any pre-existing disease or not. The policy holder's claim has been refused on the ground that the policy holder had pre-existing disease of Coronary Artery Disease. But the perusal of the discharge summary of Saroj Hospital and Heart Institute does not show any treatment for Coronary Artery Disease.

   The treatment was for slurring of speech resulting from infract in brain which is a neurological disorder. It is not the case of the Insurance Company that neurological disorder was a pre-existing disease. Infract has occurred because of very high BP. Though incidentally, there might have been some other tests, like ECG, undertaken, these are only peripheral but the main focus of treatment is for the neurological

disorder of infract. As such I am of the view that since the treatment was not for any pre-existing disease, the claim could not have been refused.

5. Before parting, I may also mention that when the patient had first approached Maharaja Agrasen Hospital with a problem of slurred speech on 31.08.2008, there was no mention in the casualty ward card regarding any Coronary Artery Disease. Next day, after taking MRI of the brain, it was concluded that it was infract in the brain. Subsequently, he was admitted to Saroj Hospital and Heart Institute. In the discharge summary of Saroj Hospital where the policy holder underwent treatment from 31.01.2008 to 05.02.2008, there is no mention of any Coronary Artery Disease. In the column for past history all that is mentioned is : No history of DM/HT. In reply dated 01.02.2008 to the TPA Alankit Heath Care Limited, Saroj Hospital also writes: "As per patient's history given no past history of HT/DM/CVA". But on the same day, however, on other hospital's slip CR No.100181 bed No.13, a mention is made of: old CAD and CVA. These facts would show indeed there was no known past history of CAD/CVA. Even if it was pre-existing, it was a silent existence of a disease unknown to the patient.

5. As I have pointed out, the treatment has been for the neurological problem which was not pre-existing. In this connection, I have also consulted a panelist doctor who has gone through the prescription, investigation reports etc for coming to this conclusion.

6. Finally, since treatment was not for pre-existing disease, exclusion Clause 4.1 of the policy will not apply to the instant case. Apparently the Insurance Company has been swayed away by the fact that the policy was only about three months old having been taken on 11.10.2007.

7. In view of the above discussions, I come to the conclusion that the policy holder is entitled to the claim. The Insurance Company is accordingly directed to make the payment subject to verification of allowability of the specific items and expenditure in terms of policy conditions.

**Case No. GI/327/Reliance/08**

**In the matter of Shri Vinay Singh Negi Vs**

**Reliance General Insurance Company Limited**

**AWARD dated 04.05.2009**

1. In this case, policy holder's mediclaim has been refused on the ground that he had not informed the Insurance Company or the TPA about his hospitalization within 7 days from the date of hospitalization as stipulated in the policy under Head Claim

Notification (Para 1). Secondly, he had also not submitted his claim within 30 days from the date of discharge from the hospital as stipulated in Para 3 of the policy under the head Claim Processing.

2. Policy holder Shri Negi was hospitalized on 09.08.2008 in Neelkanth Hospital, New Delhi for Dengu Fever and was discharged on 12.08.2008. The mediclaim was filed on 18.09.2008 that is, after 36 days from the date of discharge.

3. Before me it is submitted on behalf of the Insurance Company that these terms and conditions were to be strictly implemented as the conditions precedent for allowing the claim. He also pointed out that in this policy namely Reliance Healthwise policy there are no relaxation provisions. As such, the claim has been repudiated.

4. Shri Negi who was present at the time of hearing submitted that there was nobody in the family in Delhi to take care of him during hospitalization. As such he could not inform the concerned insurance authorities about his illness since at the material point of time he was fighting with high fever. He submits that he however, tried to contact the TPA on phone but was not successful. However, he had informed his employer Van Boxsel Engineering Private Limited who had taken the policy from the Insurance Company for its employees including him.

He pointed out that after discharge from the hospital since he was feeling extremely weak since his family is in the native place in Uttranchal, he went away there and that contributed to delay in submission of the claim. He further submitted that the delay was only marginal, that is, 6 days and therefore, should have been condoned by the Insurance Company. In fact, he had made a representation in this regard by his letter dated 15.09.2008 while submitting his medical bills to the Insurance Company.

5. I have considered the submissions made by both the sides. These conditionalities, that is, intimation within 7 days from the date of hospitalization or submission of claim within 30 days from the date of discharge are only part of the claims procedure laid down in the policy. In fact, the relevant sub-head in the policy is mentioned as “claims procedure” It is a settled position of law that procedure provisions are generally directory and not mandatory. Therefore, in interpretation of these conditions there should be an inevitable element of elasticity to consider all relevant circumstances for any delay especially where there is only marginal delay. In other words, these conditions should not be treated as core conditionalities, non observance of which should kill the policy itself.

6. Coming to the instant case, since there was no other family member with him and he himself was lying on bed with high fever of Dengu, he could not inform the Insurance Company within the stipulated time of 7 days. In fact, out of 7 days, four days he

was on the hospital bed itself and after discharge, he left for his native place because he was feeling extremely weak and unwell.

7. Considering all the circumstances, I am of the view that this failure of non intimation should be condoned. Similarly, with regard to the filing of the claim, there has been a delay only for 6 days. I feel that this should not be considered fatal to the claim in the circumstances.

8. Finally it is directed that policy holder claim should be allowed and the compliance should be sent to this office by 31.05.2009.

9. Copies of the Award to both the parties.

## Case No.GI/17/UII/09

**In the matter of Mr. Raj Kishore Vs**

**United India Insurance Company Limited.**

**AWARD dated 08.05.2009**

1. Policy holder Shri Raj Kishore is 34 year old serving as a driver. His mediclaim amounting to Rs.38,850/- has been refused by the Insurance Company on the ground that there was no positive finding of the disease during hospitalization and as such as per the clause 4.10 of the mediclaim policy claim was considered non allowable.

2. Before me it is submitted that the policy holder was suffering from fever and breathlessness for last two months. He was admitted to Escorts Heart Institute and Research Centre on 01.09.2007 and was discharged on 04.09.2007. The Insurance Company was informed about hospitalization within due time. Driver was illiterate and as advised by the doctors he was admitted to the hospital. It is submitted that when doctor advises patient to be admitted, patient practically has no option but to get admitted into hospital. On behalf of the Insurance Company it was argued that it was only for investigation and evaluation and there is no active treatment. As such the claim is not allowable.

3. I have considered the submissions made by both sides; It is not a case where without any symptoms Mr. Raj Kishore was admitted in hospital, that, too to a Super Specialty hospitals like Escorts. Admission was on doctor's advice. Fever for two months accompanied by breathlessness is a serious symptom which a person can not ignore. That during the course of treatment nothing very abnormal have been found with regard to his health is not justification for refusing the claim. In fact on the discharge comments, I find that symptoms are mentioned and it is mentioned that he was admitted for evaluation and management. Management obviously means

medical management which in other words means treatment. It is also mentioned in the discharge summary that he was treated conservatively for the same. Considering all these circumstances I am of the opinion that there was active treatment. It is not that only when a serious disease is discovered during treatment then only the Insurance Company should pay. Accordingly it is directed that the claim should be allowed.

## Case No.GI/03/NIA/08

**In the matter of Mr. C.R. Das Vs**

**New India Assurance Company Limited.**

**AWARD dated 14.05.2009**

1. Mr. C.R. Das, retired Chairman of MMTC (who is in his eighties) had taken a joint Medisave policy from New India Assurance Co. Ltd in 1995 along with his wife Smt. Renu Das. This was a combined policy covering mediclaim and personal accident. This policy is continuing (Since Mrs. Renu Das passed away on 09.02.2008, Mr. Das remains the only policy holder.)

2. Smt. Renu Das was admitted in Apollo Hospital on 08.01.2008 or treatment of Cancer and she was discharged on 02.02.2008 but she passed away soon after i.e. on 09.02.2008. In respect of her treatment at Apollo Hospital, Mr. Das submitted his mediclaim for Rs.5,56,017/-. The Insurance Company has however settled the claim for a sum of Rs.55000/- only which has not been accepted by Mr. Das. The claim has been restricted with reference to Para 6.3 of the present policy which is existing for the period 01.10.2007 to 30.09.2008. This conditionality runs as under:

> "If the policy is to be renewed for enhanced sum insured, as a continuation of the earlier policy either with this company or with any other insurance company in India, then the restriction as applicable to a fresh policy will apply to the additional sum insured, as if a separate policy has been issued for the same."

Apparently it is the view of the TPA and the Insurance Company that as per the original policy taken in the 1995, this was a maximum amount allowable under policy option No. '5' which was relevant to this policy. In terms of option '5' specific items are mentioned with regard to Room Rent, Board and Nursing expenses, Hospitalization Benefits, Fees of Surgeon and Anesthesia and other specific items

totaling to Rs.55650/-. Probably the TPA (TTK Health Care Services) has put a round sum figure at Rs.55000/- limiting the claim to this figure.

3. Before me Mr. Das himself appeared. He pointed out that clause 6.3 of the present policy is not applicable to his case for the reason the he had never enhanced the sum assured at any time. The sum assured automatically got increased because of no claim bonus year after year. He pointed out that he had never made mediclaim in the intervening period and this was for the first time he was making this claim. He further submitted that TPA had asked for the copies of the policy documents for the year 1996-97 and 1997-98 which were not available with him, As such he could not produce the same. He argued that present policy certificate No. GH-OCT-07-01-616 covering the period of hospitalization clearly showed sum assured at Rs.2.50 Lacs and including the bonus of Rs.50,000/- accumulated, he was entitled to claim of Rs.3 Lacs out of the total expenditure incurred amounting to Rs.5,56,017/-.

4. Secondly, Mr. Das pointed out that in the original policy itself which was taken in the year 1995 (he has submitted a copy) there was no pre condition as comparable to Para 6.3 of the present policy certificate which was issued to him. Para 3 of the original policy issued in the year 1995, exclusion was for the expenses with regard to any disease suffered during the first thirty days of the policy. In instant case it was after many years from taking the first policy that this claim was made. As such neither with reference to original policy certificate nor with reference to the present policy certificate covering the period of hospitalization, claim can be restricted to Rs.55000/- as done by the TPA.

5. He further submitted that Exclusion clause 3(c) of the original policy which spoke of pre-existing disease also does not apply in his case as cancer was detected with Mrs. Das in 1996 whereas policy's inception year is 1995.

6. He finally expressed his frustration that at the ripe old age of 84 he is made to run from pillar to post for his rightful claim. He requested that he should be duly compensated for the travails.

7. On the other hand the officer on behalf of the Insurance Company reiterated this claim that with reference to para 6.3 of the present policy, claim should be restricted to Rs.55000/-.

8. I have carefully considered the statements made by the policy holder as well as the Insurance Company. As regards Exclusions in para 3 (c ) of the policy taken in 1995 the exclusion clause with reference to preexisting disease does not hit the claim as cancer was discovered in Mrs. Das subsequently in 1996 Though this office requested for the original policy documents taken in the year 1995, which should be available with the Insurance Company, the same has not provided to this office. The

Insurance Company has just given the details of MediSave-96 (in general, not specific to Mr. Das) which gave the maximum coverage at Rs.54000/- and the premium rate was shown to be Rs.420/-By analogy, it is submitted that in the year 1995, the sum assured would be Rs.55000/- considering that the premium was fixed at Rs.443/-. In other words, an original policy document for the Medisave policy taken in 1995 is not made available which ideally should be the basic document to determine the ssue. The Insurance Company has also not produced any documents to show that Mr. Das had specifically enhanced the sum assured while renewing the policy, on his own initiative.

9. Secondly, confusion still prevails on the factual aspects in the sense the original policy taken in 1995 was called Medisave policy covering mediclaim as well as personal accident. The policy document which is issued for the period 01.10.2007 to 30.09.2008 is named as Good Health Policy. One is not clear as to whether it is the same policy that was taken in 1995 which is in continuing with a different name with altered conditions. There is a reference to option no. '5' in the original policy taken in 1995, but in the policy for the period under consideration, no mention is there to option '5' but the sum assured is mentioned at Rs.2.5 Lacs. Further I find in between, in the year 2001, policy has been issued with the name "Good Health Policy", but here again there is reference to different option i.e. option No. '9' (vide certificate dated 07.11.2000 and certificate no. 712500/07308/GH Oct 2000). In this policy there is no mention of the sum assured. I wonder whether it is the same MediSave policy of 1995 i.e. existing in subsequent years in new avatar.

10. Whatever it may be, in absence of any documents produced by the Insurance Company to show that Policy holders had specifically increased the sum assured with reference to original policy taken in 1995, I would presume that increase in sum assured (which stands at 2.5 lacs in the policy document relevant to period 01.10.2007 to 30.09.2008) was on account of bonus accumulation year after as claimed by Mr. Das. As such clause 6.3 is not applicable to restrict the claim.

11. May I add that it is settled position of law that burden of proof is on the party who makes an assertion. Here the Insurance Company has failed to prove their assertion.

12. Even otherwise I feel the term "Fresh Policy" used under clause 6.3 may not necessarily refer to original policy. It may merely mean a new policy. It is possible to interpret that the term "Fresh policy" merely makes a distinction between an old policy holder who enhanced the sum insured while continuing the original policy taken earlier, and another man, who takes a new policy with present terms and conditions. Clause 6.3 may imply that the restriction applicable to the new policy holder taking the policy now for the first time would also apply to an old policy holder who enhanced his sum insured with regard to enhanced sum. In other words

restriction fastened to new policy will apply to old policy (as regards increase in sum assured) not the vice versa. If the term fresh policy would be intended to refer to original old policy, it would have been very clearly so stated. As such instead of the term "fresh policy" they would have used the word Original policy or the first policy in clause 6.3.

13. To put it in nutshell, two different interpretations are possible with regard to clause 6.3 of the present policy relevant to the period 01.10.2007 to 30.09.2008 with which we are concerned. When two interpretations are possible it is the settled positions of law that interpretation favourable to the policy holder should be adopted.

13A I may summarise my findings hereunder:

i) In absence of any evidence to the contrary produced by the Insurance Company, the policy holders claim that he had not enhanced the sum assured (but increase in sum assured was because bonus accumulation) has to be accepted. As such clause 6.3 the present policy relevant to policy period 01.10.2007 to 30.09.2008 does not apply so as to reduce the sum assured to Rs.55000/-

ii) Even otherwise the term "fresh policy" occurring in clause 6.3 of the present policy is capable of two interpretations. According to settled position of law, the policy holder is entitled to the interpretation favourable to him.

iii) The exclusion clause 3 (c) of the original policy which precludes pre-existing diseases does not hit this claim, since cancer was detected in Mrs. Das in 1996 subsequent to taking the policy in 1995.

14. In view of the above discussion I conclude that the policy holder's claim should be allowed to the extent of Rs. 3 Lacs (i.e. sum assured Rs.2.5 Lacs + bonus Rs.50000/-). He should also be paid interest at the rate of 8% from the due date to the date of payment. The Insurance Company is directed to make the payment and comply by 15.06.2009.

**P.S: Old (customer) is gold. Do not melt it away.**

**Case No. GI/338/Reliance/08**

**In the matter of Shri Sugriv Aggrawal Vs**

**Reliance General Insurance Company Limited**

**AWARD dated 25.05.2009**

1. Shri Sugriv Aggrawal has taken health insurance policy and claimed an amount of Rs.23588/-for hospitalization in Saroj hospital, Delhi. The only ground of which the claim has been repudiated by the Insurance Company is that the claim was not made within the stipulated period of 60 days from the date of discharge from the hospital. The policy holder was discharged from Saroj Hospital on 26.04.2008 whereas the claim was received by the Insurance Company on 16.07.2008.

2. Before me it is submitted that in terms of the policy, the treatment after hospitalization up to a period of 90 days was permitted. Since after the surgery, he was still under going treatment, he was under impression that he can make the claim after 90 days period including both the hospital expenditure and post hospitalization expenditure. In any case, the delay was not for a long duration.

3. It is further submitted that he had also undergone another surgery on 09.07.2008 for related treatment and the claim with regard to the same was already settled by this Company. To summarise, it is sought to be argued that the illness was continuing and the policy holder thought that including 90 days period of post hospitalization, claim can be made.

4. I find the period of delay in submission of the claim is rather negligible. Considering the circumstances of the case where the treatment was still continuing and there was provision for post hospitalization treatment upto 90 days for reimbursement, I am of the view that delay should be condoned and the claim should be allowed to the extent permissible within the policy conditions. The compliance of the Award shall be intimated to my office for information and record by 30.06.2009.

5. Copies of the Award to both the parties.

**Case No. GI/30/UII/09**

**In the matter of Shri Kamal Rustagi Vs**

**United India Insurance Company Limited**

**AWARD dated 18.06.2009**

1. The policy holder Shri Ankit Rustagi died in an accident on 10.02.2007. His father Shri Kamal Rustagi submitted the relevant papers on 28.12.2007 lodging his claim for the sum assured of Rs.3,00,000/-. This letter was received by the Insurance Company on 08.04.2008. So far, the sum assured has not been paid for the reason that in the insurance policy Shri Ankit had not mentioned the name of any nominee. The Insurance Company vide its e-mail dated 18.11.2008 has asked him to submit the legal heir certificate so as to pay the claim. Shri Kamal Rustagi has yet to receive the legal heir certificate from the concerned authorities of the state government.

2. At the time of hearing it is submitted on behalf of Shri Kamal Rustagi that he was not aware that Shri Ankit had not mentioned the name of any nominee in the policy. He being the legal heir was entitled to the claim, it was submitted. It was also further submitted that the Insurance Company has not informed the claimant that no nominee was mentioned by Shri Ankit. It was only through e-mail dated 18.11.2008 that Shri Kamal Rustagi came to know about it. As such, it is claimed that while making payment for the sum assured for the period of delay the interest should also be allowed.

3. I have considered the submissions made by both the sides. In my view for the delay attributable to the Insurance Company only the legal heir would be entitled to interest. Considering the facts of the case, I find that the claim was in fact submitted long after the death. While death took place on 10.02.2007, the claim was filed on 28.12.2007 and the Insurance Company received this letter on 08.04.2008 and their e-mail intimating non-mention of nominee in the policy document is dated 18.11.2008. I am of the view that for this period from 08.04.2008 to 18.11.2008, the delay is attributable to the Insurance Company. As such interest should be paid on the sum assured @ 8% for this period whenever the claim would be finalized.

4. However, I hasten to add that the claim would be payable only to the legal heir as per the relevant certificate issued by the concerned authorities.

5. Compliance of the Award shall reach to my office for information and records.

6. Copies of the Award to both the parties.

**Ghanshyam Shukla Vs**

**National Insurance Company Limited.**

**Award dated 29.06.2009**

1. Non-settlement of mediclaim amounting to Rs. 5934/- by the National Insurance Company Limited is the subject matter of the grievance. No one appeared on behalf of the Insurance Company for hearing nor there is any written communication from them. The policy holder who appeared before me informed that he had submitted all the relevant papers to TPA Genins India Limited on 06.12.2008. So far the claim has not settled nor he has heard any thing from the Insurance Company or from the TPA.
2. On consideration of the facts of the case, it is directed that the claim should be settled by 31.07.2009. Compliance of the Award shall reach to my office for information and record.
3. Copies of the Award to both the parties.

Case No.GI/47/NIC/09

**In the matter of Shri Bimal Khanna Vs**

**National Insurance Company Limited.**

**AWARD dated 30.06.2009**

1. The policy holder was hospitalized in Molchand Hospital for Skin infection during the period 03.04.2008 to 05.04.2008. The hospital bill amounted to Rs.20409/- and accordingly the policy holder had submitted his claim to the Insurance Company. The Insurance Company has allowed the claim to the tune of Rs.15,293/-.

2. Before me the grievance is two folds. Firstly it is argued before me that full amount should be paid as no reason has been mentioned why a part if it was disallowed. Secondly there has been long delay in the matter of partial settling of the claim and the policy holder deserves compensation for the same. The claim was made on 21.04.2008 and the amount by way of partial settlement of the claim was paid by cheque dated 05.03.2009 which reached the policy holder in April 2009.

3. No one appeared on behalf of the Insurance Company. In response to the notice from the Insurance Ombudsman, the Insurance Company has sent a written reply dated 06.03.2009 but there is no detail in this communication why a part of the claim was refused.

4. In the circumstances it is directed that the Insurance Company should revisit the case with regard to quantum of disallowance. If any amount has been disallowed but such disallowance is not permitted as per policy stipulation, same should now be allowed. A confirmation should be sent to this office by 31.07.2009 regarding action taken. Interest should also be paid to the policy holder @ 8% from the due date when the claim should have been settled as per the policy conditions till the date of actual payment.

**Case No. GI/45/NIC/09**

**In the matter of Shri Shailesh Kumar Vs**

**National Insurance Company Limited**

**AWARD dated 30.06.2009**

1. The repudiation of mediclaim for hospitalization during 22.10.2007 to 26.10.2007 is the subject matter of grievance. (The policy holder is not able to state the exact quantum but says it is around Rs.50000/-) The policy holder was admitted to Kartik Nursing Home and Urology Centre, Delhi for lumber pain and vomiting. The Insurance Company has refused the claim on the ground that this is within one month from the inception of the risk period. The risk period as per the policy was 17.10.2007 to 16.10.2008. Apparently, the Insurance Company had no knowledge that this was only a case of renewal since the policy holder had taken the original policy with this insurance company in the immediately preceding year covering the period 12.09.2006 to 11.09.2007.

2. It is submitted before me that for renewal of the original policy on his request, Bank of Baroda, Bhikaji Came Palace, Delhi who was the authorized agent of the Insurance Company had debited his saving bank account for the quantum of renewal premium on 11.09.2007 but there was apparently delay on the part of the bank in sending the

premium amount to the Insurance Company. Premium amount was received by the Insurance Company after delay of more than a month and the policy was issued effective from 17.10.2007. It is vehemently argued before me by the policy holder that it was not his fault that the premium amount did not reach the Insurance Company in time. The policy holder invited my attention to policy prospectus general instructions 4 which reads as, "The premium may be deducted from the bank account of the account holder by the bank and paid as per procedure to National Insurance Company Limited."

3. With reference to the same, it is argued that since the premium was deducted from his account on time, he should not lose the benefit under the policy.

4. On the other hand, the representative of the Insurance Company submitted that in terms of Section 64VB of the Insurance Act, no insurance contract can be entered into unless the premium is received in advance. Since in this case, with reference to date of receipt of premium, policy has been issued and therefore, the risk period determined in the policy is in consonance with the provisions of the Insurance Act. The representative of the Insurance Company also invited my attention to Para 8 of the prospectus of the policy which reads as under:

"The policy shall commence from either (a) the date of debit of premium from the bank account of the account holder if the instrument with the proposal/renewal advice is dispatched to the Company on the same date or (b) the actual date of dispatch of the instrument with proposal/renewal advice of (c) the date of deposit of premium with the Company to comply to provisions of section 64 VB of Insurance Act.

5. I have carefully considered the submissions made by both the sides. Para 8 of the prospectus which has been relied upon the Insurance Company is not part of the Contract document, that is, the policy. It is only a general brochure circulated for attracting the customers. On verification of a prototype of a policy document, I find under the heading "Additional Conditions", it is mentioned as under:

"Policy will commence from the date of debit of premium from the insured's bank"

6. In this case, the bank account has been debited on 11.09.2007 and there is no debate on this fact. Therefore, the risk date should commence from 11.09.2008. In

other words, there will be no break period but continuation of the original policy taken in the preceding year. Even in term of Section 64 VB, the risk date starts from the date "Premium payable is received by him (Insurance Company)." In this case, Bank of Baroda is the agent of the Insurance Company for collection of premium. Therefore, receipt of money by Bank of Baroda will tantamount to receipt of money by Insurance Company itself since receipt by the agent is for all legal purposes a receipt by the Principal.

7. In the instant case, money obviously has been received by Bank of Baroda and therefore, I take it as a receipt by the Insurance Company itself. In this view of the matter, I am of the opinion that the policy risk date should start from 11.09.2007 which in effect would mean continuation of the original policy taken in preceding year.

8. Condition of allowability of mediclaim if the disease occurs within one month from the date of taking the policy is only referable to the risk date of the original policy, not renewed policy. In this case, therefore, considering the facts as narrated above this conditionality will not apply since the period covered is under the renewed policy.

9. Accordingly, it is directed that medicalim should be allowed subject to necessary verification and other conditionalities stipulated in the policy. The compliance of the Award shall intimate to my office for information and record by 31.07.2009

10. Copies of the Award to both the parties.

## Case No.GI/43/OIC/09

**In the matter of Shri Sudhir Chand Goyal Vs**

**Oriental Insurance Company Limited.**

**AWARD dated 10.07.2009**

1. The policy holder underwent an eve operation in Shroff Eye Centre, Delhi on 15.09.2006 and made a claim of Rs.20700/-, but so far the claim has not been finalized.

2. At the time of hearing the representative of the Insurance Company submitted that the necessary papers and documents were not yet filed by the policy holder and as such the

claim could not be settled. He refers to the letter dated 18.03.2008 from Raksha TPA to the policy holder asking for specific documents like prescriptions and treating doctors certificate.

3. On behalf of the policy holder it was submitted that all the necessary papers were already filed with the Insurance Company.

4. At the time of hearing on verification of the records carried by the representative of the Insurance Company it was found that the requisitions from the TPA were substantially complied with, except for some avoidable queries.

5. Under the circumstances considering that there is already sufficient delay; the claim should be finalized without making further queries by 15.08.2009.

## Case No.GI/111/UII/09

**In the matter of Ms. Meera Sharma Vs**

**United India Insurance Company Limited.**

**AWARD dated 09.07.2009**

1. Ms. Meera Sharma was hospitalized in National Heart Institute, New Delhi for a period of two days from 17.07.2008 to 18.07.2008. The mediclaim which was around Rs.10,000/- has been repudiated by the Insurance Company on the ground that there is no active treatment and hospitalization was only for investigation purposes.

2. At the time of hearing it was submitted by the policy holder that she approached the hospital because of heaviness in head and severe shooting pain in the arms with accelerated hypertension. In this severe condition she considered hospitalization an absolute necessity to save her life because the symptoms simulated a heart attack.

3. On the other hand, the Insurance Company representative submitted that it was only for the purpose of investigation and there was no active treatment.

4. I don't understand why the Insurance Company took the view that there was no active treatment. Prescription dated 18.07.2008 issued by the hospital clearly shows that there was accelerated hypertension and specific drugs are prescribed. As per discharge

summary there have been certain investigation like Cardiac Doppler test etc. which was part of treatment.

5. Considering the circumstances I feel indeed it was a case of active treatment. Therefore I, direct that the claim should be allowed.

## Case No.GI/73/NIC/09

**In the matter of Shri Saurabh Gupta Vs**

**National Insurance Company Limited.**

**AWARD dated 09.07.2009**

1. Shri Saurabh Gupta was hospitalized to St. Stephen Hospital, Delhi on 25.08.2008 and was discharged on 27.08.2008. The mediclaim amounting to Rs.10,257/- has been disallowed on the ground that the treatment was only for investigation and there was no active treatment.

2. At the time of hearing it was submitted by Shri Saurabh Gupta, the policy holder that he had got hurt on his right knee and doctors had advised him to be admitted and certain tests were undertaken, apart from advising further course of action in terms of certain exercises and surgery.

3. The representative of the Insurance Company however, reiterated that it was only for investigation and not for any treatment. He argued that whatever investigations were done, could have been done through OPD treatment instead of hospitalization.

4. I have considered the submissions made by both the sides. The circumstances leading to hospitalization as described by the policy holder in written submission as under:

> "I went to the St. Stephen hospital in the emergency ward as I got hurt on my right knee, where after the initial examination & treatment doctors decided to admit me in the hospital. They treated me with few pills and on second day my MRI was performed and my ACL was found teared, but as there was high swelling on my knee doctors suggested me to undergo few exercises which will reduce the swelling and strengthen the muscle and they told me to undergo surgery only after exercises are done. Since that was doctor's decision therefore I obeyed that and they discharged

me from the hospital after three days from admission. As per the doctors suggestion I went for those exercises regularly and undergone a surgery for ACL repair and after one month at Sant Parmanand hospital whose claim has partially settled by the Insurance Company."

He has also enclosed a certificate dated 28.08.2008 from St. Stephen hospital certifying that he was admitted as an emergency case.

5. I have considered the submission made by both the sides. Active treatment should not only mean gulping of capsules or medicines prescribed by the doctors. Treatment necessarily includes in its ambit investigations without which further treatment cannot be undertaken. Certain treatments like physical exercise or physiotherapy may not involve taking of any medicine at all. In the instant case the circumstances indicate that he was admitted as an emergency case as he had got injured on the right knee. The investigation which followed was part of the treatment.

6. That the treatment could have been done as an OPD patient is beside the point. Issue is not whether there should have been hospitalization or not. Issue is whether there was hospitalization or not. In this case he has been hospitalized and that is a fact.

7. In view of the above, I am of the opinion that a mediclaim should be allowed.

**Case No. GI/52/NIA/09**

**In the matter of Shri Ratan Kumar Panda Vs**

**New India Assurance Company Limited**

**AWARD dated 13.07.2009**

1. Smt. Sonalika Panda was admitted in Action Medical Institute, Paschim Vihar, New Delhi on 31.05.2008 and was discharged on 04.06.2008 for treatment of "Generalized Anxiety Disorder with panic attack". The Insurance Company has refused the claim on the ground that this was a treatment for a psychiatric ailment which comes under the exclusion provisions of the policy.

2. At the time of hearing, it was presented before me on behalf of the policy holder that it was only a neurological disorder and Dr.Rajul Aggarwal under whose treatment she was there was a neurologist and not a psychiatrist.

3. On going through the papers submitted and the discharge summary, I find the diagnosis is given as "Generalized Anxiety Disorder with panic attack". There is no indication of a psychiatric problem as such. These symptoms may be common to psychiatric disorder as well as ordinary tension syndrome.

4. In absence of any specific diagnosis that it was a psychiatric treatment, I feel that the claim of Rs.20415/-should not have been disallowed.

5. It is directed that the claim of Rs.20415/- should allow subject to permissible deductions in term of policy conditions. The compliance of the Award should reach to my office for information and record by 14.08.2009.

6. Copies of the Award to both the parties.

Case No.GI/105/OIC/09

**In the matter of Shri V.K. Puri Vs**

**Oriental Insurance Company Limited.**

**AWARD dated 14.07.2009**

1. Policy holder Shri Nitin Puri was hospitalizaed in Naional Heart Institute, Delhi during the period 15.02.2008 to 16.02.2008 for suspected Mediastinal Right Hilar Mass- ? Lymph Node. The mediclaim of Rs.27,246/- has been rejected on the ground that there is no active treatment and only investigations have been done and the treatment was only for routine check-up.

2. At the time of hearing, the Insurance Company's representative Shri Suneja pointed out that two days before the hospitalization into National Heart Institute, the policy holder had approached AIIMS on 13.02.2008 but they did not find it necessary to admit him. He argues that these investigations treatment could have been done through OPD treatment instead of getting hospitalized.

3. On behalf of the Policy holder it was submitted that suspected Mediastinal Right Hilar Mass- ? Lymph Node was pointer to a serious disease for which the policy holder was advised to get admitted in the hospital and necessary investigations were done including bronchoscopy. It should not be taken as if he was getting hospitalized without any reason and only in search of a disease.

4. I have considered the submissions made by both the sides. Getting admitted to a hospital is not a pleasure trip for a person. If on suspicion of some serious ailment or disease, one gets admitted to a hospital and certain investigations are done for him during hospitalization, this can not be described as if there is no active treatment. In fact, diagnostic procedures are only essential part of active treatment. Only gulping capsules or tablets should not be treated as active treatment leaving aside all other procedure of investigation outside its ambit. That would be an illogical approach.

5. In view of the above I direct in this case, the claim should be allowed. The Insurance Company is directed accordingly.

**Case No. GI/40/NIA/09**

**In the matter of Shri M.K.Rajora Vs**

**New India Assurance Company Limited**

**AWARD dated 14.07.2009**

1. The claim of Rs.4289/- towards eye treatment has been refused on the ground that this could have been done by OPD treatment in stead of hospitalization. Further, it is also stated that no active treatment was given during hospitalization.

2. Before me it is submitted by the policy holder that hospitalization was required for examination of FUNDUS, a part of retina and the investigation was part of treatment itself.

3. I have considered the submissions made by both the sides. Policy document does not provide necessity of hospitalization as a pre-condition. In this case, there is no doubt

about hospitalisation. As regards treatment, it is said that during the course of hospitalization, dilation was done to retina and therefore, it is definitely a treatment.

4. In view of the above, I am of the view that claim should allowed.

5. Before parting to the Award, I may mention that at the time of hearing the complainant had stated that claim was for Rs.4289/- which is fully disallowed. But in the letter dated 05.03.2009 from the Insurance Company to Ombudsman, it is mentioned that claim was for Rs.5710/- out of which Rs.5000/- was allowed. This needs verification. The Insurance Company is directed to ascertain the correct amount of claim and allow it as directed above.

6. The compliance of the Award should reach to my office for information and record by 31.08.2009.

7. Copies of the Award to both the parties.

**Case No. GI/51/NIA/09**

**In the matter of Shri M.K.Gupta Vs**

**New India Assurance Company Limited**

**AWARD dated 14.07.2009**

1. The mediclaim of Rs.8073/- has been repudiated by the Insurance Company on the ground that the original documents has not been submitted in connection with the claim.

2. It is submitted, at the time of hearing, by the policy holder that in fact the original documents including the claim form were submitted on 28.11.2007 and he produced receipt for such submission before me. Apparently, these papers were misplaced by the TPA's office and on instructions of the TPA, duplicate copies were submitted on 28.04.2007. In this connection, they referred to TPA, Raksha's letter dated 19.07.2008, a copy of which has been submitted for my records.

3. At the time of hearing, it was submitted by the representative of the Insurance Company with reference to receipt given for submission of documents on 28.11.2007, that the claim form was signed on 30.11.2007. Similarly, the certificate

from the doctor was also signed on 30.11.2007. These could not have been submitted on 28.11.2007 as claimed by the policy holder.

4. I have considered the submissions made by both the sides. The TPA, Raksha had itself advised vide its letter dated 19.07.2008 that photocopies should be filed to settle the claim. This means that they have conceded that the original documents are misplaced or not traceable and therefore had agreed to settle the claim on the basis of Xerox papers.

5. At the time of hearing, the representative of the Insurance Company however states that unless original documents are produced, the claim should not be allowed because the policy holder might make a double claim with another insurance company. I feel that should not be a consideration where original policy documents are lost and only available documents are Xerox copies. To avoid misuse, probably an undertaking can be taken from the policy holder and in case of a double claim, action also can be initiated. But if someone lost its original documents or these were misplaced by the Insurance Company office, there should be a way out and policy holder should not lose the benefit of the policy.

6. In this case, it appears considering the TPA's letter that the original documents were filed on 28.11.2007 (though there can be some confusion regarding one or two documents) and these were not traceable. Under the circumstances, it is directed that on the basis of duplicate documents, the claim should be allowed by way of taking an undertaking/indemnity bond from the policy holder. The compliance of the Award should reach to my office for information and record by 14.07.2009.

7. Copies of the Award to both the parties.

**Case No. GI/66/NIA/09**

**In the matter of Shri Y.S.Rana Vs**

**New India Assurance Company Limited**

**AWARD dated 14.07.2009**

1. The policy holder's wife Smt.Sadhana Rana was admitted to Moolchand Hospital during the period 07.06.2008 to 08.06.2008 for suspected soft tissue tumor in the left breast which was there since last 6 months. The total claim of Rs.17568/- has been refused on the ground that it was a pre-existing disease. In this case there are two days gap in renewal of the policy. Last year's policy had expired on 08.03.2008 and the policy should have been renewed from the same day but it was done two days after.

2. In view of this break, the renewed policy was treated as a fresh policy and as such the treatment was treated as a treatment for pre-existing disease.

3. At the time of hearing, the policy holder submitted that he had handed over the cash to the agent two days prior to 08.03.2008 for making the necessary payment but there was a failure on his part which should not be attributed to him. In any case, he submitted that this marginal delay of two days should have been condoned by the Insurance Company. The policy holder also submitted that he assumed that the agent had paid the amount in time and therefore did not anticipate any break in policy.

4. The representative of the Insurance Company submitted that continuation is permitted only when a policy holder has applied for it and not otherwise. Though the continuation could have been done considered in this case but the policy holder had not applied for it. To a query, he argued that it was not the Insurance Company's responsibility to advise the policy holder to file any continuation application. Apparently, he means that consumer education or getting the customers to understand their rights is not the responsibility of the Insurance Company.

5. I have considered the submissions made by both the sides. It is conceded by the Insurance Company's representative that the continuation can be considered as per the existing guidelines at an appropriate level in the Insurance Company but in this case, since the policy holder was not aware, he had not applied for the same nor the Insurance Company had informed him about it.

6. Considering the circumstances and especially considering the fact that the delay was absolutely marginal, it is directed that it should be condoned and continuity of the policy should be restored and the claim of Rs.17568/- should be allowed subject to verification of permissibility under the policy conditions. The compliance of the Award should reach to my office for information and record by 14.08.2009

7. Copies of the Award to both the parties.

## Case No.GI/72/UII/09

**In the matter of Shri S.K. Sharma Vs**

**United India Insurance Company Limited**

**AWARD dated 16.07.2009**

1. The insured person, Mrs. Shakuntla Sharma was covered under mediclaim policy since 1997. During 2001 she was found to be suffering from diabetes but this fact was not disclosed to the Insurance Company. For hospitalization during the period 22.06.2007 to 05.07.2007 in Moolchand Hospital for treatment of diabetes and other related problems, she submitted a claim for Rs.1,17,431/-. The Insurance Company has settled the claim for Rs.1,00,000/- which was the sum assured for the year 2001-02 when diabetes was detected but not disclosed.

2. The sum assured of Rs.1,00,000/- was enhanced to Rs.1,25,000/- for the policy year 2006-07 (policy period 21.05.2006 to 20.05.2007). In the immediately next year i.e. 2007-08 it has been further enhanced to Rs.1,50,000/-. For this year policy period runs from 21.05.2007 to 20.05.2008. The hospitalization under consideration comes within this period. It is the policy holder's claim that for this year the total sum assured being Rs.1,50,000/-, the whole amount of the mediclaim of Rs.1,17,431/- should have been allowed. It is further pointed out that for this year policy there was accumulated bonus of Rs.52500/-. Together therefore the limit should be Rs.1,50,000/- + 52,500/-= 2,02,500/-, it was claimed.

3. On the other hand, the representative of the Insurance Company submitted that since it was a pre-existing disease which was there since 2001 and this was an undisputed

fact the limit should be fixed with regard to sum assured prevalent for that year. Since for that year sum assured was Rs.1,00,000/-, the claim though made in the year 2007-08 should be restricted to that amount.

4. I have considered the submissions made by both the sides. There is no dispute about the fact that diabetes was discovered in the policy year 2001-02 where sum assured was Rs.1,00,000/- and there was no bonus accumulation for that year. But in the mean time bonus has accrued to the tune of Rs.52,500/- on an enhanced sum assured of Rs.1,50,000/-. I feel since the claim is made in the year 2007-08, the policy holder should also get the benefit of bonus accumulation in the proportionate manner, comparing the enhanced sum assured for the year 2007-08 with the sum assured in 2001-02. Further relief will be quantified accordingly.

**Case No. GI/94/NIA/09**

**In the matter of Smt. Sunita Mangla Vs**

**New India Assurance Company Limited**

**AWARD dated 28.07.2009**

1. For hospitalization during the period 18.01.2008 to 20.01.2008, the policy holder submitted a mediclaim for Rs.11180/-. The Insurance Company has allowed the claim to the extent of Rs.5079/- disallowing the balance amount which was represented admission charges.

2. Before me it is submitted that the admission was for a soft tissue injury which could have been managed as an OPD patient.

3. I feel that when admission has indeed taken place and the Insurance Company has allowed the claim, the charges in relation to admission could not have been disallowed. That the treatment could have been done as an OPD patient is irrelevant to the issue. Only conditionality for allowing a claim is hospitalization. Once hospitalization takes place, admission charges cannot be disallowed unless specifically so permitted in the policy conditions.

4. Before me the representative of the Insurance Company is not able to show me any provision in the policy which permits disallowance of admission charges. Hence, it is directed that the admission charges should now be allowed. The compliance of the Award should reach to my office for information and record by 31.08.2009

5. Copies of the Award to both the parties.

**Case No. GI/90/NIA/09**

**In the matter of Shri B.N.Ojha Vs**

**New India Assurance Company Limited**

**AWARD dated 28.07.2009**

1. The policy holder was hospitalized for two days, that is, from 31.01.2008 to 01.02.2008 in Neera Hospital, Lucknow. His mediclaim for Rs.93,505/- has been rejected on the ground that the hospitalization was for investigation and not for any active treatment.

2. It is pointed out at the time of hearing that the mediclaim policy included medicines purchased to the tune of Rs.87470/- on different dates within 60 days of post hospitalization period which were unrelated to the treatment during hospitalization. This fact is certified by Dr.A.K.Aggarwal, Senior Consultant, Nephrology, Indraprastha Apollo Hospitals. It is also pointed out that the policy holder had undergone a kidney transplant in 2006 and the medicine purchased related to treatment of kidney or protection of kidney and had nothing to do with the hospitalization under consideration.

3. On the other hand the policy holder submitted that he was admitted to hospital not only for investigation purpose. He had diabetes. As he suffered from hypoglycemia he was admitted to hospital in an unconscious condition and they had done some tests including blood sugar test. Though no medicines were given in the hospital itself, they prescribed medicines which were purchased by him for post hospitalization treatment. Since insurance policy stipulations permit the post hospitalization medicines for 60 days, he was justified in making the claim. He

pointed out that this was his first hospitalization after the kidney transplant and the claim is genuine.

4. The representative of the Insurance Company submits a copy of the hospital bill No.1053 dated 01.02.2008 which only gives following three items expenditure:

| | | |
|---|---|---|
| (i) | Registration | Rs. 25/- |
| (ii) | A.C.Room Charges | Rs.900/- |
| (iii) | Blood Sugar Test | Rs.120 |
| | Total | Rs.1045/- |

He pointed out that this itself would show that there is no active treatment since no medicines are prescribed. He submits that the whole idea of the policy holder for hospitalization is to cover the medicines in relation to kidney transplant (which has taken place in 2006) for a period of 60 days of post hospitalization. He submits a copy of the certificate dated 28.05.2008 from Dr.Anil Kumar Singh, Nephrologist, Nishtha Clinic, Aliganj, Lucknow.

5. I have carefully considered the submissions made by both the sides. For allowing the mediclaim, conditionality is not **inevitability of hospitalization** duly certified by some authority but **only hospitalization** for treatment. Active treatment does not necessarily mean gulping of capsules or tablets. The investigations are part of active treatment and therefore refusal of the claim on that ground is not justified. Therefore, I am of the view that expenses during hospitalization should be allowed subject to policy terms.

6. Coming to the post hospitalization expenses by way of purchase of medicines, I am of the view that there should be connectivity between the treatment in hospital and the post hospitalization medicines. Post hospitalization treatment is only a spill over of treatment during hospitalization. The term “hospitalization” permeates the post hospitalization period. It is not a period lifted from the calendar without a contextual connotation. Therefore medicines for which reimbursement is sought should be in connection with treatment during hospitalization which extends beyond the hospital premises after discharge. Hospitalization cannot be permitted to be

used as a **colourable device** only to cover medicines during post hospitalization period unconnected with ailments for which hospitalization took place.

7. In the instant case, I find from the receipts of the medicines that only some of the medicines are relatable to the diabetes, that is, disease for which he was admitted in the hospital. These medicines should be allowed in the post hospitalization period. Other medicines should not be permitted because they are not connected with the treatment in the hospital. The Insurance Company will verify the individual bills and accordingly calculate the permissible amount and pay the same to the policy holder.

8. Copies of the Award to both the parties.

**Case No. GI/78/NIA/09**

**In the matter of Ms.Rama Naidu Vs**

**New India Assurance Company Limited**

**AWARD dated 28.07.2009**

1. Ms. Rama Naidu's mediclaim for her hospitalization for the period 12.03.2008 to 19.03.2008 in Apollo Hospital has not been settled yet. She had submitted her claim on 22.05.2008 for Rs.2,46,198/-.

2. At the time of hearing, it was submitted by the Insurance Company that policy holder had not filed the following documents in original:

   (i) Payment receipt for Rs.25000/- of Apollo Hospital
   (ii) Original main hospital bill
   (iii) Investigation report and Echo report

   For this reason, the Insurance Company had issued letters to the policy holder on 02.08.2008, 22.08.2008 and on 09.09.2008.

3. Policy holder Ms.Naidu who was present submitted that the original documents were submitted along with the claim. She had retained only the photocopies which were submitted in response to query letters. But the Insurance Company has not settled the claim yet.

4. The representative of the Insurance Company submits that as per their regulation, original documents should necessarily be submitted.

5. I have considered the submissions made by both the sides. It is ordinarily expected that along with the claim, the original bills and report are also submitted. Ms. Naidu submitted in fact she had submitted the original documents which obviously were misplaced by the Insurance Company. In my opinion, in a situation where the originals are lost or untraceable for some reason, there should be an alternative method for settling the claim. It is not acceptable that if the original documents are lost, the claim is lost for ever. There may be situations where neither party like Insurance Company or policy holder may be responsible for loss of papers like crash of an aircraft carrying the papers or a fire accident at the premises where the originals were kept. In the instant case, the Insurance Company could have obtained the confirmation from the Apollo Hospital regarding the payments made. As an additional pre-cautionary measure, they could also ask for an indemnity bond to prevent any double claim. I am not able to appreciate the Insurance Company's getting locked up in their thought process by the term **"original documents."**

6. It is directed that the claim should be settled by 15.09.2009. The Insurance Company should obtain the necessary confirmation regarding payments from the Apollo Hospital and obtain Indemnity bond from the policy holder, if necessary and settle the claim accordingly.

6. Copies of the Award to both the parties.

**GUWAHATI**

**GUWAHATI OMBUDSMAN CENTRE**

**Complaint No. 11-003-0189/08-09**

Mr. Manash Chakraborty ..... Complainant - Vs -

The National Insurance Co. Ltd. ..... Opposite Party/Insurer

**Award Dated : 01.06.2009**

Mrs. Maya Chakraborty, mother of the Complainant, was an insured under a "Mediclaim Policy" of the National Insurance Co. Ltd. from 31.03.2007 to 30.03.2008. The Insured was hospitalized for treatment at "The Calcutta Medical Research Institute" wherein she died on 10.06.2007 while undergoing treatment. A claim was lodged, which was rejected on the ground of non submission of certain documents.

The death certificate produced by the Complainant discloses that Maya Chakraborty, 78 Years of age, died on 10.06.2007 at 6-25 AM due to "Cardio Respiratory Failure" being the immediate cause and the antecedent cause of death is stated to be "Cerebral Hemorrhagic Infarct with Diabetic Gastro poresis". The letter dated 21.08.2008 issued by the Insurer addressing the Complainant goes to show that the above claim was treated as "No Claim" by the TPA due to non submission of the documents like :- (1) Details of VP Shunt procedure and reason for procedure required from the attending Doctors and (2)Legal Heir Certificate.

During hearing, the Complainant stated that his mother was covered under the mediclaim policy of the Insurer since last 20 years and there was no claim earlier and the claim lodged for her last treatment has also been repudiated. He has, of course, admitted that in 1996 his mother Maya Chakraborty had undergone "VP Shunt Procedure" but thereafter she was comfortably living. He has further stated that his mother died due to "Cerebral Hemorrhagic Infarct with Diabetic Gastro poresis" which had no connection with such VP Shunt procedure. The representative of the Insurer has also admitted that their TPA had insisted production of VP Shunt procedure / report and the Legal Heir Certificate but due to non submission of such documents, the claim was repudiated. He has however failed to state as to why the above VP Shunt procedure / report is required by the TPA. He knows nothing about having any relevancy of VP Shunt procedure with that of the ailments for which the Insured was treated and died. It is submitted by the Complainant that in 1996, his mother was treated by that procedure but thereafter she was leading a normal life and was covered along under the above Mediclaim Policy till the date of her death. The representative of the Insurer has failed to justify as to why documents mentioned in the repudiation letter were required. Considering the entire facts and circumstances, the claim appears to have been repudiated / treated as "No Claim" on a ground without justification and the same is set-aside. The Complainant has claimed to have produced the Legal Heir Certificate before the Insurer and in case the TPA / Insurer has not received the same, the Complainant shall be required to submit a copy of the said report before the Insurer for further action. The Insurer was directed to settle the claim within fifteen days.

**GUWAHATI OMBUDSMAN CENTRE**

**Complaint No. 14-011-0193/08-09**

Mrs. Anjali Handique …….. Complainant

- Vs -

Bajaj Allianz Gen. Insurance Co. Ltd. ….. Opposite Party/Insurer

**Award Dated : 28.05.2009**

Mr. Nabin Handique, husband of the Complainant obtained a mediclaim policy No. OG–05–2401–9960-00000041 from Bajaj Allianz Gen. Insurance Co. Ltd.. During currency of policy, the insured died on 08.07.2008 due to accident. The claim lodged before the Insurer was repudiated on the ground of non submission of required documents. Being aggrieved, the Complainant has approached this Authority for redressal of her grievances.

The Insurer has contended in their "Self Contained Note" that the complainant has not substantiated her plea that the Insured died due to an accident with cogent documentary proof. It is further submitted that after scrutinizing the medical card submitted by the complainant it was found that the signature of the deceased did not tally with that of the signature put in the proposal form which proves that the proposal form was not signed by the deceased. Hence, the claim is not payable.

Although the claim was repudiated due to non submission of documents, but it appears that the Complainant had submitted all the required documents to the Insurance Company through TPA who had forwarded the same to the Insurance Company vide letters dated 08.12.2008 and 20.03.2009. On a perusal of those letters, it appears that almost all the documents, material to the claim, have been submitted by the Complainant before TPA which were forwarded to the Insurer. Police Report, Postmortem Report and Death Report are considered to be the basic requirements for establishing the said fact material to the claim. During hearing, the representative of the Insurer has admitted that they have received the Police Report, Postmortem Report and also the copy of the Ejahar from the Complainant. He has however stated that the Police Report is silent as to how the Insured sustained injuries which causes his death and according to him, specific proof is required. It is however seen that the Police report is clear enough to establish that the deceased sustained injuries due to fall and the report is also clear that the body of the injured was found lying on the ground by Police who arranged to send it to the Hospital wherein he was declared dead. Postmortem report also shows that ante-mortem injuries on the Head, Chest and Knee were found and all those injuries were the main cause of death of the deceased.

The Insurer also alleged that signature of the Insured in the medical card appears to be not tallied with the signature given by him in the proposal form and this was confirmed by the Handwriting Expert. Normally a policy is issued considering the proposal submitted by the Proposer. The Insurer has clearly admitted that they have issued the policy in question to the Insured Nabin Handique wherein the Complainant was made nominee. Hence raising a ground that his signature in the proposal form did not tally with other documents appears to be immaterial. Considering all the above facts and circumstances, repudiation of the claim appears to be not based on sound principle which is set aside. The Insurer shall reconsider their decision and arrange to proceed to settle the claim within fifteen days from the date of this Order.

**KOCHI**

**OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

# Complaint No.IO/KCH/GI/11-004-534/2008-09

**A.B.Ismail**

**Vs**

**United India Insurance Co.Ltd.**

## AWARD DATED 09.06.2009

The complainant, who is the holder of a mediclaim policy, was admitted in the hospital for treatment of cervical dorsal disc disease from 23.04.2008 to 28.04.2008. The claim was repudiated on the ground that the patient was given only oral treatment and apart from investigation, no active indoor treatment was given. As per policy condition, such hospitalization is not covered.

The discharge summary received from the hospital is produced. In the discharge summary, diagnosis if made as cervical dorsal disc disease. MRI cervical spine shows protrusion of C2-C3, C3-C4 and C5-C6 discs. At the time of discharge, 5 types of tablets are prescribed with advice to report immediately in case of any side effects, rashes or itches at the time of taking medicines and also to report immediately after completion of the prescribed medicines. From the above, it looks that the medicines prescribed are to be taken only under strict medical supervision. Hence it cannot be said that the treatment can be taken on an OPD basis. The repudiation is set aside and an award is, therefore, passed directing the insurer to pay the eligible amount of Rs.7,080/- together with interest @ 8% interest p.a. and cost of Rs.500/-.

**OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

# Complaint No.IO/KCH/GI/11-004-232/2009-10

**A.Ramachandran**

**Vs**

**United India Insurance Co.Ltd.**

## AWARD DATED 09.09.2009

The complainant was having a health insurance policy for Rs.75,000/- covering himself and his family members w.e.f. 1996. During the period in which the policy was in force, his wife underwent hysterectomy operation incurring an expense of about Rs.34,772/-. The claim was passed only for Rs.15,000/- being 20% of sum assured. It was submitted by the insurer that drastic changes have been made in mediclaim policy condition during the year2007. As per revised policy condition, coverage for hysterectomy is limited to 20%. It was argued by the complainant that the policy was in existence since 1996. It is not just on the part of the insurer to change the terms and conditions every year. If at all they want to make any changes for any reason whatsoever, it will be applicable to new policies and the existing policyholders must continue to get the existing benefit. Hence the partial repudiation is unjust and against natural justice.

The treatment was taken during the currency of policy for the period 22.09.2008 to 21.09.2009 and hence coverage will be only as per policy condition relating to policy issued for the period 22.09.2008 to 21.09.2009. It is to be noted that mediclaim policies are issued only for one year. To continue benefit later, the policy has to be renewed. Of course, the policy gives some special benefits for continuing the policy by reviving every year. But this benefit will not be there if there is a break. Hence it looks that even if the policies are renewed, each policy constitutes a distinct contract. Hence the insurer is entitled to alter the terms and conditions at the time of renewal. In the present case, in the renewed policy, there is a limitation of 20% of sum insured for hysterectomy. As the insurer has already paid this amount, the complainant is not eligible to get anything more. The complaint is, therefore, **DISMISSED**.

**OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

# Complaint No.IO/KCH/GI/11-017-045/2009-10

**Abraham P.Simon**

**Vs**

**Star Health and Allied Insurance Co.Ltd.**

**AWARD DATED 14.07.2009**

The complaint under Rule 12 [1][b] read with rule 13 of RPG Rules 1998 is against partial repudiation of claim under mediclaim policy. The complainant was holding a mediclaim insurance policy since 14.10.2007. While the policy was in force, he had undergone ayurvedic treatment expending Rs.13,098/-. He was paid only Rs.4,746/-. Aggrieved by this partial repudiation of the claim, he approached this forum for justice.

Part of the claim for lab examinations and post hospitalization treatment was disallowed by the insurer. Various tests such as FBS, lipid profile, liver function test, etc. were conducted. The expenses for these tests were disallowed on the ground that there is no mention about these tests in the treatment records. These tests were done only as a routine checkup. Also samples for test were taken at 6:00 am i.e., before admission. Hence these tests have nothing to do with the treatment given. But it is to be noted that the insured has undergone ayurvedic treatment in which krithams and other sugar containing medicines were given. Before giving such medicines, sugar level, cholesterol level, etc. are to be ascertained. Hence it cannot be said that these tests do not form part of treatment, even if there is no mention of the same in hospital records produced. As per policy condition, post hospitalization expenses are limited to 7% of IP treatment bill. Hence disallowing the post hospitalization expenses in excess of this amount is found to be in order. The insured is thereby eligible for reimbursement for the expenses incurred towards lab tests also. An award is, therefore, passed directing the insurer to pay the eligible amount of Rs.707/- with interest @ 8% p.a. and a cost of Rs.1,000/-.

**OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

# Complaint No.IO/KCH/GI/11-003-407/2008-09

**Smt.Annie Shibu**

**Vs**

**National Insurance Co.Ltd.**

**AWARD DATED 08.04.2009**

The complainant's husband, Shri Shibu Raphael, was covered by a mediclaim policy. During the currency of the policy, he had undergone a surgery for removal of thyroglossal cyst. The claim raised for Rs.11,851/- was repudiated on the ground that thyroglossal cyst is a congenital disease. As congenital disease is excluded from the scope of the policy, the claim is not payable. They have referred the file to their panel doctor and the panel doctor also has certified that the surgery was to rectify a congenital defect.

Thyroglossal duct is the one formed during gestation. That is the duct through which thyroid is developed from the tongue portion of embryo. When thyroid is located at the proper place, the duct will be closed. By way of anomaly, sometimes the duct will not get closed, then it will remain as a cavity. If it gets inflammated, it has to be removed. Hence thyroglossal duct is a congenital defect. But it is to be noted that all congenital defects are not excluded from the policy. Congenital defects, which are external only, are excluded from the policy. If the defect is an internal one, it will come within the coverage of the policy. At the age of 44, the internal cyst was inflated. That necessitated the treatment. Hence the treatment is only as to an internal congenital anomaly. Hence exclusion will not apply. An award is, therefore, passed for payment of Rs.11,851/- with 8% interest p.a. and a cost of Rs.500/-.

**OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

## Complaint No.IO/KCH/GI/11-004-422/2008-09

**Smt.Bincy Udayakumar**

**Vs**

**United India Insurance Co.Ltd.**

**AWARD DATED 20.04.2009**

The complainant's husband had taken a policy for the period 25.04.2007 to 24.04.2008 covering himself and his family members for a sum of Rs.50,000/-. On expiry of the term of the policy, it was renewed for Rs.75,000/-. During the currency of the first policy, the complainant's husband was

hospitalized twice and the claims raised were settled. Subsequently, he was admitted on 18.03.2008 and remained in the hospital till his death on 22.05.2008. The claim was allowed to the extent of initial sum assured of Rs.50,000/- only, as the illness was pre-existing as far as the enhanced sum assured was concerned. The question to be considered is whether on the ground that the illness was pre-existing for the present policy, the enhanced portion of sum assured can be declined. On going through the policy condition, there is absolutely no clause restricting the claim in respect of enhanced portion of sum assured to the ailments which were pre-existing. Also for the purpose of renewal, no medical report was insisted. Hence there is no misrepresentation or suppression of material fact. It was renewed as per terms and conditions of earlier policy. In the renewal, no restrictive clause was provided. Hence there is absolutely no justification in repudiating the claim amount on the ground that he was having ailment at the time of renewal. An award is, therefore, passed directing the insurer to pay the difference in sum assured of Rs.25,000/- with 8% interest p.a. and a cost of Rs.500/-
.

**OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

## Complaint No.IO/KCH/GI/11-005-021/2009-10

**C.Harikumar**

**Vs**

**The Oriental Insurance Co.Ltd.**

**AWARD DATED 10.07.2009**

The complainant was covered under a mediclaim policy for an assured sum of Rs.50,000/- and a domiciliary benefit of Rs.10,000/-. While the policy was in force, on 23.08.2008, at about 13:35 hrs., while playing cricket, he sustained an injury on the knee. He was immediately taken to GG Hospital. Ligament tear was suspected by the doctor and MRI was carried out. The doctor suggested surgery. The insured chose to obtain a second opinion. Hence he got discharged on request and consulted SP Fort Hospital wherefrom he was advised POP casting for 45 days and surgery thereafter, if necessary. The treatment continued from SP Fort Hospital for 45 days as OP. The claim was repudiated on the ground that there was no hospitalization for a minimum period of 24 hours.

The patient was admitted at GG Hospital on 19:43 hrs on 23.08.2008 and was discharged on 24.08.2008 at 17:30 hrs. The complainant himself had admitted that there was no hospitalization for 24 hours. There MRI scan was taken and discharged without giving any medicine. In order to qualify for reimbursement, there must be active treatment from hospital. Hospitalization merely for investigation is not covered under the policy. Also there is no hospitalization for minimum period of 24 hours which is a must for claiming insurance coverage. In the SP Fort Hospital, there was no IP treatment. Though policy covers domiciliary hospitalization, the treatment does not qualify the condition for domiciliary hospitalization. This being a fit case for repudiation, the complaint stands **DISMISSED**.

**OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

# Complaint No.IO/KCH/GI/11-005-029/2009-10

**Capt.Dr.P.M.T.Panicker**

**Vs**

**The Oriental Insurance Co.Ltd.**

**AWARD DATED 23.06.2009**

The complainant's wife was covered under a Individual Mediclaim Policy covering the period 24.12.2007 to 23.12.2008. Due to severe head ache, she was admitted to the nearest hospital viz., Azeezia Medical College Hospital, in the department of neurology on 06.10.2008 and was treated by Dr.Vinod Thampi. The treatment was for NIDDM. During admission, CT scan was taken. As there was no abnormality in the scan report, she was sent to Trivandrum for angiography of brain and MRI scan. As there were no abnormalities in these reports also, she was discharged on 09.10.2008 after prescribing some tablets and injection. Her claim for Rs.16,166/- was repudiated on the ground that during hospitalization, there was no active line of treatment and hospitalization was only for investigation, CT scan and MRI scan. However, it was submitted by the complainant that his wife was admitted only with the advice of a doctor who is well qualified and having so many masters degree. Hence he is eligible to get the claimed amount.

On going through the records produced, it can be seen that the patient was hospitalized on 06.10.2008 and CT scan was taken later. She was directed to go to Trivandrum for MRI scan and MRI angiography. Those reports also show normal study. On the day of admission itself, she left the hospital to proceed for Trivandrum for MRI and angiography. She reported back only on 09.10.2008 with scan reports and as all the reports show normal study, she was discharged on 09.10.2008 itself. No active line of treatment was given in the hospital. During the hospitalization, her stay in the hospital was only for few hours. Though she was given some injection, which was on 06.10.2008 and 09.10.2008, the dates of admission and discharge respectively. Hence with no hesitation, it can be said that during hospitalization, there was no active line of treatment and hospitalization was only for investigation. The test result also shows normal study. Out of a total amount of Rs.16,166/-, only a meager amount is spent for medicine. As hospitalization was merely for investigation, not followed by active line of treatment, the expenses are not covered under the policy, the repudiation is to be upheld and complaint is **DISMISSED**.

**OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

# Complaint No.IO/KCH/GI/11-005-510/2008-09

**Denny Antony**

**Vs**

**The Oriental Insurance Co.Ltd.**

**AWARD DATED 29.04.2009**

The complainant and his family members were covered by a mediclaim policy. During the currency of the policy, his wife had undergone treatment for periodontitis from 07.02.2008 to 15.03.2008. The claim was repudiated on the ground that [1] there was no hospitalization for more than 24 hours [2] the treatment was taken from a dental clinic and not from a hospital or nursing home as specified under the policy conditions and [3] the treatment is not for any illness but for wear & tear due to ageing.

The policy condition is very specific that in order to become eligible for reimbursement, at least 24 hours treatment must be there and also the treatment must be taken from a hospital or nursing home as defined under the policy conditions. It is clear that the insured underwent treatment from a dental clinic where there is no facility for indoor treatment. Also there is no hospitalization for a continuous period of 24 hours. As the policy conditions are very specific with regard to exclusion clause, the repudiation is to be upheld and the complaint is **DISMISSED**.

**OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

## Complaint No.IO/KCH/GI/11-002-211/2009-10

**Dr.Antony Oliapuram**

**Vs**

**The New India Assurance Co.Ltd.**

**AWARD DATED 08.09.2009**

The complainant has been insured with The New India Assurance Co.Ltd. Continuously from 03.01.1995 to 02.01.2006. For renewal w.e.f. 02.01.2006, cheque was given to the insurance company on 28.12.2005. But the cheque was dishonoured for want of sufficient balance in the bank account. Later the policy was renewed on 23.02.2006 by making fresh remittance and new proposal. During the 2nd year of the renewed policy, the insured was admitted in the hospital or treatment of CAD, from 13.03.2007 to 17.03.2007. The claim was repudiated on the ground that the patient was hypertensive for the last 4 years. AS the policy was renewed on 23.02.2006 with a break, the renewed policy is to be taken as a new policy and hence, the hospitalization is in the 2nd policy year. As per policy condition, all pre-existing illness and illness arising out of pre-existing conditions are excluded. Hypertension is a contributory factor for CAD and hence, the claim is repudiated as if the treatment is for a pre-existing illness. It was submitted by the complainant that the cheque was

remitted in the office on 28.12.2005. But it was dishonoured by the bankers only on 02.02.2006. The cheque was dishonoured as there was inordinate delay on the part of the insurer in presenting the cheque for collection. As the cheque was dishonoured due to the fault of the insurer, the policy is to be treated as a continuous policy and hence the claim must be paid.

There is no dispute to the fact that the cheque was remitted on 28.12.2005 but it was dishonoured for want of sufficient funds. The insurer has submitted that the cheque was presented for clearing on 30.12.2005, 3 days before expiry of the policy. The cheque was dishonoured not because of the fault of the insurer but because of the fact that sufficient balance was not available in the bank account. As the cheque was issued towards premium, the complainant has the duty to see that sufficient balance is kept in the account for clearing the cheque. Whatever delay must have been caused, had there been sufficient balance in the account, the cheque would not have been dishonoured. Hence the renewed policy can be taken as a new policy only.

The claim was repudiated on the ground that hypertension is a contributor factor for CAD. The insurer has revised the terms and conditions of the policy w.e.f. 16.08.2007. But the renewed policy was issued on 23.02.2007. Hence revised policy condition is not applicable to this policy. As per pre-revised policy condition, only injury/disease when incepted for the first time is excluded. The related conditions are not excluded as per pre-revised policy condition. As hypertension is not a heart disease, treatment for CAD cannot be treated as treatment for pre-existing illness. Hence the repudiation has to be set aside. An award is, therefore, passed directing the insurer to pay the claim amount of Rs.14,723/- with 8% interest and a cost of Rs.500/-.

**OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

## Complaint No.IO/KCH/GI/11-002-344/2009-10

**E.C.Elizabeth**

**Vs**

**The New India Assurance Co.Ltd.**

**AWARD DATED 14.10.2009**

The complainant is having a mediclaim policy. During the currency of the policy, she was admitted in V.G.Saraf Memorial Hospital on 17.03.2009 and was discharged on 23.03.2009. The treatment was approved under cashless scheme. The pre-authorisation was given for Rs.8,000/-. During the period of hospitalization, CT scan was taken expending an amount of Rs.4,500/-. This amount was not

reimbursed by the hospital authorities. Instead she was advised to claim the same from the insurance company. On lodging the claim, she was informed that as the original bill was not produced, they are not in a position to honour the claim. The case of the complainant is that he has submitted the bills to the hospital authorities.

Initially, pre-authorisation was given for Rs.8,000/-. After discharge from the hospital on 23.03.2009, on 26.03.2009, the hospital requested to enhance the authorization limit to Rs.10,535/-. The insurer produced this claim form. In the claim form, the hospital authorities have not included claim for CT scan. Hence the insurer has not allowed this amount. As the claim for CT scan was not preferred, it cannot be said that the amount was repudiated by the insurance company. In the request for enhancement, they have only shown the bill for Rs.6,035/-. The difference is the scan bill for Rs.4,500/-. It looks that though the scan bill was submitted to the hospital authorities, they have not claimed the same from the insurance company. Without claiming the same with proper bills and receipts, it is not possible for the insurer to make the payment. If the hospital authorities have not claimed, the remedy is against the hospital authorities and not against the insurer. The complaint, therefore, stands **DISMISSED**.

## OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

# Complaint No.IO/KCH/GI/11-004-538 to 540/2008-09

**Shri George Mathew**

**Vs**

**United India Insurance Co.Ltd.**

**AWARD DATED 17.06.2009**

The complainant was covered under a mediclaim policy since 1998. He had undergone IP treatment from Medical Trust Hospital from 03.04.2008 to 04.04.2008 and from St.Gregorios Cardio Vascular Centre from 22.04.2008 to 16.05.2008. The first claim was repudiated on the ground that the illness was pre-existing and the second claim was repudiated on the ground that the claimant had undergone EECP treatment which is not a recognized and approved line of treatment by medical fraternity. Only allopathic and ayurvedic treatments will be covered under the policy.

The policy commenced in 1998. Pre-existing diseases are excluded as per Cl.4.1 of policy conditions. But as per Cl.5.13, if there are 3 claim free years, from the 4$^{th}$ year onwards, pre-existing diseases will also be covered. In the present case, since the policy commenced in 1998 and 3 claim free years are already over, the claim is to be admitted even if the disease is a pre-existing one. Hence the repudiation is to be revoked.

The other claim was repudiated on the ground that the insured had undergone Enhanced External Clounter Pulsation treatment, not approved by medical fraternity, which is neither allopathic nor ayurvedic. The internet clippings show that FDA has approved EECP as a treatment for coronary disease, in 1995. Also in 2002, FDA approved it as a treatment for congestive heart failure. Hence the insurer cannot repudiate the claim on the ground that this treatment is not approved and recognized by medical fraternity. Even if it is assumed that the treatment is not allopathic or ayurvedic, it is a procedure approved by FDA. There is no condition in the policy whereby such treatment is not covered. Hence the repudiation is to be revoked.

An award is, therefore, passed directing the insurer to pay an amount of Rs.68,647/- under both the claims, with interest @ 8% p.a. and a cost of Rs.2,000/-.

**OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

## Complaint No.IO/KCH/GI/11-005-132/2009-10

**Jesmon Pappu**

**Vs**

**The Oriental Insurance Co.Ltd.**

**AWARD DATED 05.08.2009**

The complainant was holding a mediclaim policy since 2001. On 17.10.2008, he was admitted at MAGJ Hospital and undergone treatment for bronchitis. On 18.10.2008, various tests were conducted and discharged on 20.10.2008. The claim was repudiated on the ground that there was no active line of treatment from the hospital and hospitalization was merely for conducting tests and investigation which is not covered as per policy condition.

There is no dispute to the fact that the insured was admitted in the hospital from 17.10.2008 to 20.10.2008 for lower respiratory track infection. The repudiation is made only on the ground that there was no active line of treatment. Here in this case, the bills produced show that on 18.10.2008 itself, all tests were conducted. Only during these tests LRT infection was confirmed. There is no case that there was no treatment after the tests. It looks that the patient was purchasing medicines everyday from the pharmacy. Hence it is clear that the medicines were prescribed only after diagnosis. Hence it cannot be said that the medicines were not prescribed for 3 days at a stretch indicates that the diagnosis was not made on 18$^{th}$. It was made only after 18$^{th}$, after getting the test results. Hence it cannot be said that hospitalization was merely for conducting tests. There is no active line of treatment and repudiation on this ground is not correct. An award is, therefore, passed directing the insurer to pay the eligible amount of Rs.4,987/- with interest @ 8% p.a. and a cost of Rs.500/-.

**OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

# Complaint No.IO/KCH/GI/11-004-385/2008-09

**K.P.Mayan**

**Vs**

**United India Insurance Co.Ltd.**

**AWARD DATED 07.04.2009**

The complainant was having mediclaim policy with Iffco Tokyo Insurance Co.Ltd. since 2003 and with United India Insurance Co.Ltd. since 2004. He was hospitalized twice from 10.10.2006 to 17.10.2006 and also from 16.12.2006 to 21.12.2006 at CMC Vellore. The claim was repudiated first on the ground that the illness was pre-existing and later, on the ground that the hospitalization was merely for the purpose of investigation, which is not covered under the policy. The case history of both the hospitalization is more or less the same. During hospitalization, only some oral medicines were given apart from undergoing some special tests. It looks that the hospitalization was only for taking rest. He was discharged on both occasions with advice for life style modification such as diet control, stoppage of smoking and taking liquor. The complainant himself had admitted that he had to go to hospital on account of some illness and fatigue. The existence of some illness or fatigue is not sufficient enough to attract coverage under the policy. Also admission merely for tests and investigation will not come under the policy. Hence the claim is not covered by the policy and the complaint is, therefore, DISMISSED.

**OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

# Complaint No.IO/KCH/GI/11-002-137/2009-10

**K.P.Peter**

**Vs**

**The New India Assurance Co.Ltd.**

**AWARD DATED 09.07.2009**

The complainant was having a mediclaim policy for Rs.30,000/-. He renewed the policy for an enhanced sum assured of Rs.1,00,000/- w.e.f. 10.10.2007 and 10% bonus for Rs.30,000/- earlier sum assured was also given, thereby giving a total coverage of Rs.1,03,000/-. During the currency of this policy, he was hospitalized on 24.09.2008 to 02.10.2008 and underwent heart surgery at Lisie Hospital. He claimed hospital expenses of Rs.1,34,769/-. However, the insurer allowed only Rs.33,000/- being the pre-revised sum assured and bonus.

It was submitted that as per policy condition, if the sum assured is enhanced, then as far as the enhanced sum assured is concerned, it is to be treated as a fresh policy from the date of enhancement of sum assured. Enhanced sum assured will not be available for any illness contracted before enhancement of sum assured. As per the hospital reports produced, the insured is a known case of hypertension and coronary artery disease. Effort Angina is a gradually progressing disease. Usually surgery is done when pain on exertion is not controlled by medicines, and it will take years to reach such a stage requiring surgery. The surgery was done within 11 months of enhancing the sum assured and as far as the enhanced sum assured is concerned, it is to be taken as a pre-existing illness and hence, the claim is to be restricted to pre-revised sum assured.

The contention of the insurer is that the insured is a known case of hypertension and CAD will reach such a stage requiring surgery only after continuous medication for years. However, as per the hospital records, hypertension was there only for 2 months, i.e., after enhancing the sum assured. Also the doctors of the TPA only opined that it may take years to reach such a stage. They are not very specific that how much time it will take to reach such a stage. There is nothing in the hospital records to show that the insured had CAD or hypertension at the time of revival. Hence it is not possible to take it as pre-existing one. It is also to be noted that the sum assured was enhanced for Rs.1,00,000/- as the insurer increased the minimum sum assured to Rs.1,00,000/-. The insured had no option to revive the policy to its original sum assured of Rs.30,000/-. Hence it has only the effect of substituting the sum assured of Rs.30,000/- with Rs.1,00,000/-. Hence an award is to be passed for payment of the full sum assured. An award is, therefore, passed directing the insurer to pay the balance amount of Rs.70,000/- with interest @ 8% p.a. and cost of Rs.1,000/-.

**OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

## Complaint No.IO/KCH/GI/11-003-254/2009-10

**K.Prabhakaran Namboothiri**

**Vs**

**National Insurance Co.Ltd.**

**AWARD DATED 17.08.2009**

The complainant has been holding a mediclaim policy since 2000. His wife was also included in the scheme w.e.f. 06.03.2008. His wife was hospitalized at Gautam Hospital, Kochi, and Cytotron treatment was taken for osteoarthritis by spending an amount of Rs.1,14,180/-. The claim was repudiated on the ground that cytotron therapy was magnetic therapy which is excluded as per Cl.4.13 of policy conditions. The complainant then submitted a certificate from the treating doctor giving the details of treatment. The treating doctor has certified that cytotron treatment is not a magnetic treatment and it is Rotational Field Quantum Magnetic Resonance [RFQMR]. Even then, the claim was repudiated as naturopathy, unproven procedure, experimental or alternative treatment, etc. are not covered under the policy.

The exclusion Cl.4.13 reads that 'Naturopathy, unproven procedure/treatment, experimental or alternative medicine/treatment including acupuncture, acupressure, magneto-therapy etc.' are not covered under the policy. From the mere reading of the exclusion clause 4.13, it is clear that magneto therapy or any therapy similar to that is not covered under the policy. The net report and also the certificate obtained from the treating doctor clearly state that magnetic therapy and magneto therapy are one and the same. Both are treatment involving the use of static electro magnetic field. Hence the treatment imparted is a magnetic treatment which comes under exclusion clause. The complaint is, therefore, liable to be **DISMISSED**.

**OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

## Complaint No.IO/KCH/GI/11-003-585/2008-09

**K.U.Jacob**

**Vs**

**National Insurance Co.Ltd.**

**AWARD DATED 11.06.2009**

The complainant and his family members were covered under a mediclaim policy. In the complaint, it is stated that he was admitted in Medical Trust Hospital due to chest pain on 15.09.2008. After undergoing some tests, as advised by the doctor, he was discharged on 17.09.2008. But the claim was repudiated on the ground that hospitalization was only for tests and there was no active line of treatment following the tests. It was submitted that he was admitted in the hospital not merely for tests, but for chest pain.

The covenant under the mediclaim policy is that "the company will pay to the insured person, the amount of expenses as reasonably and necessarily incurred for the disease contracted or illness suffered, the treatment for which hospitalization is required". The policy specifies some exclusion

also. As per exclusion clause 4.10, hospitalization merely for investigation and diagnostic purpose is not covered. On going through the hospital records, it looks that there was no active treatment for chest pain. He was only given some oral medicines for acidity. Also all the test results show normal study. Out of a total amount of Rs.17,993.95, Rs.109.30 alone was expended for medicines. That also was for acidity and not for chest pain. All the other amounts are spent for tests only. Hence it can very well be taken that hospitalization was only for investigation. Hence the complaint is liable to b e **DISMISSED**.

## OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

# Complaint No.IO/KCH/GI/11-004-600/2008-09

**Shri K.U.Sunilkumar**

**Vs**

**United India Insurance Co.Ltd.**

**AWARD DATED 25.06.2009**

The complainant was covered under an individual mediclaim policy for the period 12.08.2008 to 11.08.2009. During the currency of the policy, he had undergone treatment at Central Research Institute of Panchakarma, Cheruthuruthy, from 13.08.2008 to 10.09.2008. The claim raised was repudiated on the ground that claim form was not submitted within the stipulated 15 days of discharge and also there is no genuine need for hospitalization, as the treatment could very well be taken on OPD basis. Aggrieved by this, the complainant approached this forum for justice.

The hospitalization was done in a Govt.Hospital for 29 days. At the time of admission, his condition was noted as 'weakness and muscle wasting with difficulty in raising left hand'. Treatment given was Abhayangam, Annalapenam, Upanaha, etc. Apart from that, other medicines were also given. Hence it cannot be said that there was no active line of treatment from the hospital. The contention of the insurer is that the treatment could be done on an OPD basis. But it is to be noted that some of the treatments such as annalepanam is a kind of massage which require certain expertise. A layman could not apply this kind of treatment. Hence it cannot be said that there is no genuine need for hospitalization.

Another reason for repudiation is that the claim form was not submitted within 15 days. It was conceded that he had undergone 29 days continuous treatment. Though, it is mandatory that claim must be submitted within 15 days of discharge, no prejudice has been caused to the insurer on account of this delay. The stipulation of 15 days time is only a formality and no difference would be there if the bill is submitted within 15 days or after 15 days. The insurer has no case that on account of such delay, they lost any opportunity in scrutinizing the bill. Hence repudiation is to be set aside and an award is, therefore, passed directing the insurer to pay the eligible amount of Rs.11,000/- with interest @ 8% p.a. and a cost of Rs.750/-.

**OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

# Complaint No.IO/KCH/GI/14-004-487/2008-09

**K.V.Varghese**

**Vs**

**United India Insurance Co.Ltd.**

**AWARD DATED 03.06.2009**

The complainant is covered by a mediclaim insurance policy covering the period 22.09.2007 to 21.09.2008. He was admitted in Little Flower Hospital and was discharged on 09.09.2008. His claim for reimbursement was repudiated by the insurer. During the course of hearing, the representative of the TPA submitted that they are not in a position to ascertain whether the illness is pre-existing or not, in the absence of treating doctor's certificate. That is why the claim was repudiated. Finally, the insurer agreed to settle the claim for the eligible amount of Rs.9,782/- as against the claimed amount of Rs.11,986/-. The complainant also agreed for this settlement. An award is, therefore, passed directing the insurer to pay the eligible amount of Rs.9,782/- with interest @ 8% p.a. and a cost of Rs.300/-.

**OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

# Complaint No.IO/KCH/GI/11-004-442/2008-09

**Kunjamma Thomas**

**Vs**

**United India Insurance Co.Ltd.**

**AWARD DATED 18.05.2009**

The complainant, Smt.Kunjamma Thomas, was covered by a mediclaim insurance policy for the period 12.07.2007 to 11.07.2008. She was treated as IP at Ayurvaid hospital from 17.09.2007 to 30.09.2007. The TPA repudiated the claim vide their letter dated 21.12.2007. It was submitted by the insured that as she is allergic to allopathic medicine, she was compelled to take ayurvedic treatment.

Suspecting rheumatic disease, the doctor admitted her in Ayurvaid Hospital on 17.09.2007. After discharge, she was admitted in Lourdes Hospital for which, cashless treatment was given. Only the ayurvedic treatment was disallowed. During the course of hearing, the insurer agreed to honour the claim. The claim was for Rs.15,465/- and the insurer agreed to pay the eligible amount of Rs.13,550/-. The complainant accepted the settlement. An award is, therefore, passed directing the insurer to pay the claim amount of Rs.13,550/- at 8% interest p.a. and a cost of Rs.500/-.

**OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

# Complaint No.IO/KCH/GI/11-005-098/2009-10

**Manju Sabin**

**Vs**

**The Oriental Insurance Co.Ltd.**

**AWARD DATED 23.06.2009**

The complainant was covered under a mediclaim policy for the period 08.02.2008 to 07.02.2009. On 23.08.2008, she was admitted in Global Hospital, Bangalore, and treated for right ureteric calculi. She was discharged on 24.08.2008. Thereafter, complications ensued and she was brought to Ernakulam and admitted at PVS Hospital. There the ailment was diagnosed as post right URS with DJS with renal failure with septicemia. She was treated on antiseptics and on improving, was discharged on 08.09.2008. The claim raised for treatment at PVS Hospital, was repudiated on the ground that the treatment is a continuation of treatment at Bangalore and that was for renal calculus which is a first year exclusion as per policy condition. For IP treatment at Bangalore for renal calculus, no claim was preferred. It was submitted by the complainant that the second treatment is not a continuation of the first one at Bangalore. The treatment is only for septicemia and renal failure which is covered under the policy.

The question to be decided is whether the treatment at PVS Memorial Hospital is the continuation of treatment at Bangalore for renal calculus. Hospital records produced show that the hospitalization was in connection with the ailment of post right URS and DJS, renal failure septicemia. On 29.08.2008, MRI of abdomen was done. The result showed bilaterally enlarged kidney and acute nephritis. In the 'history', it is given as difficulty in passing urine for 3 days, enlarged kidney and fatty liver. It is specifically stated that the patient came with renal failure and septicemia following right URS and DJS one week back. Hence it can only be taken as a continuation of treatment taken at Bangalore for renal failure, which is an exclusion as per policy condition, for 1st year. Hence the complaint is liable to be **DISMISSED**.

**OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

# Complaint No.IO/KCH/GI/11-002-087/2008-09

**Smt.Mary Grace T.J.**

**Vs**

**The New India Assurance Co.Ltd.**

## AWARD DATED 18.06.2009

The complainant's daughter was covered by a mediclaim insurance policy. She was admitted in Sunrise Hospital from 06.09.2008 to 07.09.2008 for treatment of endometriosis. The claim was repudiated on the ground that the treatment was for infertility which is excluded as per policy condition. Also at the time of taking treatment, the insured was married; only dependent children are eligible to be covered by policy taken by their parents. As she is married, she is no longer dependent on her parents and as far as the complainant's daughter is concerned, the policy is null and void. In the discharge summary originally submitted, it was reported as 'Nalligravida anxious to conceive'. The discharge summary submitted after repudiating the claim by the TPA deleting the word 'Nalligravida anxious to conceive' is only to accommodate the claim. Hence they are not in a position to honour the claim.

It was submitted by the complainant that the treatment was not for infertility but for removal of cyst. As her daughter is now doing some research work, she is not at all anxious to conceive. The hospital records produced show that treatment was done on diagnosing endometriosis. The certificate from the treating doctor also states that the treatment was not for infertility but for dysmenorrhoea [pain during menstrual course]. Endometriosis is an abnormal gynec condition. When endometriosis occurs in a critical location, it may result in grave dysfunction of organs which may even lead to death. Also in mild endometriosis cases, a woman may become pregnant. Hence it cannot be said that the treatment was for infertility. Another reason for repudiation is that at the time of revival of policy, the insured was married and as such, she is not dependent on her parents. As the policy was revived without disclosing this fact, the policy is to be treated as null and void as far as the daughter is concerned. But it is to be noted that nowhere in the policy condition, the term dependent is defined. At the time of revival of policy, no new proposal was submitted. It was an automatic renewal on payment of renewal premium. Hence it cannot be said that at the time of revival, material facts have been suppressed. Hence the repudiation has to be set aside. An award is, therefore, passed directing the insurer to pay the eligible amount of Rs.40,039/- with interest @ 8% p.a. and cost of Rs.500/-.

**OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

# Complaint No.IO/KCH/GI/14-003-027/2009-10

**Mary Shibi Jaison**

**Vs**

**National Insurance Co.Ltd.**

**AWARD DATED 19.06.2009**

During the currency of the policy issued for the period 20.02.2009 to 19.02.2009, the complainant had undergone IP treatment from Sunrise Hospital for cervical encirclage. The claim raised was repudiated on the ground that the treatment was relating to pregnancy, which is excluded as per policy condition. As per Cl.4.12 of policy condition, any treatment arising from or traceable to pregnancy/child birth or complications thereof is not covered under the policy. The hospital records produced show that as the cervix was short by 2-25 cm. Cervical encirclage was done on 04.10.2008. From the above, it is clear that surgical procedure done was something relating to pregnancy only. As policy condition is very specific that any treatment relating to pregnancy or any complication arising therefrom is excluded from the scope of the policy, the repudiation is to be upheld and complaint is to be **DISMISSED**.

**OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

# Complaint No.IO/KCH/GI/11-005-473/2008-09

**Smt.Mini Jacob**

**Vs**

**The Oriental Insurance Co.Ltd.**

**AWARD DATED 21.04.2009**

A mediclaim policy was issued to Shri P.X.Jacob covering himself and his family members for the period 28.01.2008 to 27.01.2009. His wife, Smt.Mini Jacob, was admitted in Govt.Ayurveda Hospital on 23.07.2008 and was discharged on 09.08.2008 after treatment for 18 days. The claim was repudiated on the ground that there was no active line of treatment from the hospital and as per policy condition, no claim will be paid in respect of hospitalization merely for investigation and diagnosis which is not followed by active line of treatment.

The complainant was hospitalized for 18 days in a Govt.Ayurveda Hospital for treatment of pain and swelling in all joints and back. As per discharge summary, during hospitalization, the patient underwent Abhyangam & Patrapotalee swed and oral medicines were also given. It is to be noted that the complainant was hospitalized in a Govt.Hospital. If hospitalization is not a must for imparting treatment, she will not be permitted to take inpatient treatment. Also oral medicines were given and underwent Abhyangam and Patrapotalee swed. Hence it cannot be said that there was no active line of treatment. The repudiation has, therefore, to be set aside and an award is, therefore, passed for the eligible amount of Rs.5,130/- with 8% interest p.a. and a cost of Rs.500/-.

**OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

## Complaint No.IO/KCH/GI/14-003-592/2008-09

**P.B.Ramesh**

**Vs**

**National Insurance Co.Ltd.**

**AWARD DATED 11.06.2009**

The complainant and his family members were covered under a mediclaim policy since 14.05.2003. On 09.09.2008, his minor son, Nikesh, was admitted in Little Flower Hospital, Angamaly, and discharged on 10.09.2008, after hydrocele excision and circumcision. The claim was repudiated under exclusion clause 4.3 and 4.5. It was submitted by the insurer that though the complainant was having policy w.e.f. 14.05.2003, his child Nikesh was included only w.e.f. 13.05.2007. That was after revision of mediclaim scheme w.e.f. 01.04.2007. As per revised condition w.e.f. 01.04.2007, treatment for hydrocele and all treatments for genitourinary system were excluded.

The case summary and discharge card from Little Flower Hospital, Angamaly, is produced. The presenting complaint is swelling in the right scrotum for 3 months duration and also phimosis. The treatment given was hydrocele excision and circumcision. Hence it is clear that both the treatment comes under exclusion clause as hydrocele and illness of genitourinary systems were excluded as per policy conditions 4.3 and 4.5. The complaint is, therefore, liable to be **DISMISSED**.

**OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

## Complaint No.IO/KCH/GI/14-004-555/2008-09

**P.K.Joy**

**Vs**

**United India Insurance Co.Ltd.**

**AWARD DATED 19.06.2009**

The complainant and his family members are covered under a mediclaim policy issued on 31.07.2007. While the policy was in force, his wife had undergone IP treatment at 'Thrissur Institute of Head and Neck surgery' for 2 days from 14.07.2008. He raised the claim only on 24.07.2008. The claim was repudiated on the ground that intimation was not given to the TPA within the stipulated time. However, it was submitted by the insured that the intimation was given to the TPA on the date of hospitalization itself over phone from a telephone booth.

The repudiation is only on a technical ground. The insurer conceded that there is no ground other than the reason that, proper intimation was not given within the stipulated time. The complainant has produced all the bills and discharge summary and other records. The claim appears to be a genuine one. If intimation had been given, the insurer could have ascertained the genuineness of the claim. Nothing else is expected to be done by giving intimation. Documents produced itself are sufficient to verify the genuineness of the claim. The amount claimed also is not an exorbitant one. The insured had stated that he had informed the TPA over phone. In the result, there is no justification in repudiating the claim on a technical ground. An award is, therefore, passed directing the insurer to pay the eligible amount of Rs.3,295/- with 8% interest p.a. and a cost of Rs.500/-.

**OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

## Complaint No.IO/KCH/GI/11-004-467/2008-09

**Shri P.O.George**

**Vs**

**United India Insurance Co.Ltd.**

**AWARD DATED 27.04.2009**

The complainant was holding a mediclaim policy covering himself and his family members. In March 2007, his wife was admitted in the hospital for 3 days. Subsequently, on recurring knee pain, she was admitted in St.James Hosiptal, Chalakudy and continued treatment for 10 days as IP. During the

period of hospitalization, she has undergone physiotherapy and oral medicines were also given. The claim was repudiated on the ground that hospitalization was not required for the treatment as it could be done on an OPD basis.

The patient was admitted in the hospital for treatment for synovitis. Synovitis is an inflammatory condition of synovial membrane of a joint as a result of arthritis. The joint usually swells due to fluid collection. The movement of limbs will be restricted depending upon the gravity of situation. There will be severe pain too. In such a condition, going to the hospital daily for physiotherapy for 10 days is not possible. Hence it cannot be said that hospitalisation is not required. The repudiation has, therefore, to be set aside and an award is passed for payment of claim amount of Rs.3,364/- with interest @ 8% p.a. and a cost of Rs.250/-.

## OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

# Complaint No.IO/KCH/GI/11-005-043/2009-10

**Rabu Rasheed**

**Vs**

**The Oriental Insurance Co.Ltd.**

**AWARD DATED 09.06.2009**

The complainant, Mrs.Rabu Rasheed, was covered by a mediclaim policy since 03.12.2001. She had undergone surgery for breast cancer. On 15.12.2008, she was admitted in Lakeshore Hospital and discharged on 17.12.2008. The claim was repudiated on the ground that there was no active line of treatment. The treatment imparted could be done on OPD basis. The hospitalization was merely for investigation. In the complaint, it was stated that as she was feeling fatigue, she met a doctor at Lakeshore Hospital, where she had been treated for cancer. There she was admitted for 2 days and tests were conducted. Cholesterol was checked as her weight was increasing. Then she consulted a physician who prescribed some medicines. As there was pain the legs and ankles, she had consulted an orthopedic doctor too.

As per Cl.4.10 of policy conditions, expenses incurred at the hospital primarily for evaluation/diagnostic purpose which is not followed by active treatment for the ailment during hospitalization is not covered under the policy. From the hospital records produced and from the statement of the complainant, it is very clear that there was no active line of treatment from the hospital. Only some tests were done and after that, she was discharged prescribing some medicines. Out of the IP bill of Rs.6,450/-, only Rs.30/- is spent for medicines. All the other amounts were for tests and consultation & doctor's fee. At the time of discharge, some medicines were prescribed. But those medicines were not taken from the hospital. Hence it is clear that there was no active line of treatment and hospitalization was only for investigation. The complaint, therefore, stands **DISMISSED**.

**OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

# Complaint No.IO/KCH/GI/11-004-231/2009-10

**Sheela Sudhakaran**

**Vs**

**United India Insurance Co.Ltd.**

## AWARD DATED 16.09.2009

The complainant and her husband have been covered under a mediclaim policy. During the currency of the policy, her husband was hospitalized on 20.09.2008 for abdominal pain and treatment taken up to 22.09.2008. The illness was diagnosed as parenchymal liver disease, infective diarrhoea and hypertension. The claim was repudiated as pre-existing illness and also caused due to abuse of alcohol. It was submitted by the complainant that her husband was not an alcohol addict. On losing Gulf job, he was occasionally taking drinks for one year and then he discontinued it. His ailment was not due to alcohol.

The claim was repudiated on the ground that the illness was alcohol induced liver disease and also the illness was a pre-existing one. No other reason was shown for repudiation. The hospital records show that at the time of admission, the patient was apparently healthy. He was not pale. No jaundice was noticed. His condition was good, except the fact that his liver was palpably enlarged. From the discharge summary, it looks that diagnosis is only early stage of liver disease. Other details show that he was healthy and on account of this illness, his body condition was not affected. Hence it is clear that the illness is in the early stage. Hence it cannot be said that the illness is pre-existing. From the discharge summary, it can be seen that he was not having even jaundice. Nowhere, it is stated that the illness is alcohol related or alcohol induced. His overall health condition was good except for the illness. Just for the fact that he had the habit of taking drinks for some time, it cannot be said that the illness is alcohol related or alcohol induced. Hence the repudiation is to be set aside. An award is, therefore, passed directing the insurer to pay the amount of Rs.6,936/- with interest @ 8% pa and a cost of Rs.750/-.

**OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

# Complaint No.IO/KCH/GI/14-002-235/2009-10

**Sunil Jacob**

**Vs**

**The New India Assurance Co.Ltd.**

**AWARD DATED 08.09.2009**

The complainant was holding a health policy covering himself and his family members since 19.08.2005. On 06.07.2008, his father was admitted to Cardiology Department of Bishop Benzigar Hospital, Kollam. On 30.07.2008, he was taken to Lisie Hospital wherefrom CABG was done. A claim for Rs.1,37,164/- was repudiated by the insurer on the ground that the illness was due to a pre-existing condition and hence is not covered under the policy. As per the records produced from Lisie Hospital, he was diabetic for 8 years and hypertensive for 20 years. As both these diseases are contributory factors for CAD, the treatment undergone must be taken as treatment for pre-existing disease and hence is not covered as per Cl.4.10 of policy condition. It was submitted by the complainant that his father was never hypertensive or diabetic. He was hale and healthy before admission in the hospital. The certificate from the hospital may be due to an ambiguous remarks made by someone during the queries to the patient while interaction. The report from Benzigar Hospital shows that his pressure reading and sugar level are within normal limits. Hence repudiation of claim on the guise of pre-existing illness is not at all justifiable.

From the hospital records produced, it can be seen that he was admitted at Lisie Hospital for angiogram on the advice of Benzigar Hospital and CABG was done. He was taken to Lisie Hospital for an expert check up on suspecting CAD. Here he had disclosed before the doctor that he was hypertensive for 20 years and diabetic for 8 years. Usually clinical history will be written based on the statement of the patient. The patient was brought to the hospital in a conscious state. Hence it is likely that the clinical history was recorded by the statement of patient himself. This history is necessary for the doctor to ascertain the stage of the disease, the progressive nature and to arrive at proper diagnosis. The person who approaches a doctor for expert check up after diagnosis of CAD will definitely furnish full and correct details. Hence this statement and clinical history has high probative value. The complainant had argued that the BP reading and sugar level recorded Benzigar Hospital shows normal reading. But it is to be noted that the patient was under treatment in that hospital and hypertension & diabetes might have been controlled by proper medication. Hence the normal reading has no value in determining whether the patient was diabetic or hypertensive. As per policy condition, all pre-existing conditions are excluded and any illness caused due to pre-existing condition is excluded. Diabetes and Hypertension are contributory factors for CA and hence the treatment taken was for a pre-existing disease. The complaint is, therefore, liable to be **DISMISSED**.

**OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

# Complaint No.IO/KCH/GI/11-014-588/2008-09

**Sunil Kumar**

**Vs**

**Cholamandalam MS General Insurance Co.Ltd.**

## AWARD DATED 05.05.2009

The complainant was issued with a Pravasi Bharati Bhima Yojana Policy covering the period 18.07.2006to 17.07.2008. On 12.12.2006, he sustained serious injuries while working abroad. He was admitted in a hospital at Ras-Al-Khaimah. He had lost sensation of his limbs. On discharge from there, he was brought to India and continued treatment at Baby Memorial Hospital, Indo-American Brain & Spine Centre, Vaikom and subsequently, he took ayurvedic treatment from Kozhikode. He spent more than Rs.1,00,000/- for treatment. His claim was repudiated on the ground that there was inordinate delay in preferring the claim. As per policy condition, claim should be preferred within one month of insured event, however, the claim was lodged only after 1 year and 11 months.

It is true that there is violation of policy condition on the part of the insured, as he had not lodged the claim application within the stipulated time of accident. But it is to be noted that due to accident, the insured sustained spinal injury. He lost sensation and he could not even write or put his signature. He was under continuous treatment since then. He had undergone both, allopathic and ayurvedic treatment. From the documents produced, it is clear that during the treatment at Baby Memorial Hospital, Kozhikode and Indo-American Brain & Spine Centre, Vaikom, his movements were restricted and was virtually bedridden. The claim was repudiated merely on a technical ground that there was inordinate delay in submitting the claim. The claim also appears to be genuine. Hence a lenient view has to be taken in this case. The insured spent more than Rs.1,00,000/- for his treatment. As per policy condition, total amount payable, if claim stands admitted, is only Rs.50,000/-. Hence it is found proper to award an ex-gratia of Rs.25,000/-.

**OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

# Complaint No.IO/KCH/GI/11-004-538 to 540/2008-09

**Smt.Thankamma**

**Vs**

**United India Insurance Co.Ltd.**

**AWARD DATED 17.06.2009**

The complainant's husband. Shri George Mathew, was covered under a policy for a sum assured of Rs.75,000/- for the period 24.03.2007 to 23.03.2008. Her husband was treated at Lourdes Hospital from 16.10.2007 to 19.10.2007 for 'cough little sputum'. The claim was repudiated on the ground that the treatment could be taken on an OPD basis and there was no need for such hospitalization. However, it was submitted by the complainant that he was forced to undergo IP treatment after undergoing an OP treatment for more than 5 days. As his blood sugar was very high, his blood sugar position had to be monitored and controlled and that is why, he was admitted in the hospital.

The hospital records show that FSB reading as above 130. This indicates that blood sugar level was very high. In order to control cough, the blood sugar level had to be monitored and insulin was also given. The patient was admitted only after one week's OP treatment. Hence it cannot be said that treatment could be taken on OPD basis. The repudiation has, therefore, to be set aside and an award is passed directing the insurer to pay the eligible amount of Rs.3,951/- with 8% interest p.a. and a cost of Rs.500/-.

**OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

## Complaint No.IO/KCH/GI/11-004-571/2008-09

**V.T.Thomas**

**Vs**

**United India Insurance Co.Ltd.**

**AWARD DATED 19.06.2009**

The complainant and his family members were covered under a mediclaim policy. While the policy was in force, his wife was admitted in Nangelil Hospital, Kothamangalam on 14.06.2007 and was discharged on 22.06.2007 after ayurvedic treatment such as podikizhi, massage, steam bath, etc. She was also put under traction for 7 days. The claim raised was repudiated on the ground that traction is not an approved ayurvedic treatment and also no investigation was done before giving such treatment.

There is no dispute as to the fact that ayurvedic treatment was given and the same is covered under the insurance policy. The only question involved is whether there was a genuine need for hospitalization. During hospitalization, massage, podikizhi, steam bath and other medicines were given; she was also put on traction. These treatments cannot be given without hospitalization. The TPA while repudiating the claim only said that no investigation was done and also traction is not an approved line of treatment under ayurveda. It is to be noted that mode of diagnosis differ from system to system. No particular procedure is exclusive to any system of medicine. Hence the repudiation is to be set aside. An award is, therefore, passed directing the insurer to pay the eligible amount of Rs.4,450/- with interest @ 8% p.a. ad a cost of Rs.500/-.

**OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

## Complaint No.IO/KCH/GI/14-004-278/2009-10

**Smt.Bincy Udayakumar**

**Vs**

**United India Insurance Co.Ltd.**

**AWARD DATED 29.09.2009**

The complainant's husband had taken an individual health insurance policy covering himself and his family members. After his death, his daughter, who was also covered under the policy, was admitted in hospital from 31.12.2008 to 02.01.2009 incurring an expenditure of Rs.2,025/-. The claim was raised requesting to make payment in favour of the complainant. But the TPA allowed the claim for Rs.1,740/- and the cheque was issued in the name of the deceased policyholder. Her request to issue a fresh cheque and allow the amount of Rs.285/- , wrongly deducted, was turned down by the insurer.

Rs.285/- was deducted from the claim amount. The claim pay out statement shows that Rs.90/- is towards utility charges, Rs.15/- towards registration fee, Rs.50/- as RMO charges and Rs.130/- towards medicines. The claim for medicines is supported by bills. Hence this cannot be disallowed citing reason as 'details not available'. Also RMO charges is nothing but doctor's fee, which is also payable. It is not stated that this utility charges of Rs.130/- is. If it is for treatment as IP, it is also payable. Hence the complainant is eligible for Rs.270/- more than what is allowed earlier. Hence an award is passed directing the insurer to pay Rs.2,010/- inclusive of Rs.1,740/- admitted earlier, together with interest @ 8% p.a. and a cost of Rs.250/-.

**OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

# Complaint No.IO/KCH/GI/14-004-245/2009-10

**Job Joseph**

**Vs**

**United India Insurance Co.Ltd.**

**AWARD DATED 09.09.2009**

The complainant's wife is covered by a mediclaim policy issued to the complainant for a sum of Rs.75,000/-. His wife, being a cancer patient, had undergone 3 courses of chemotherapy as OP. The claim was repudiated on the ground that the treatment was taken as OP and the policy covers only hospitalization expenses. It was submitted by the insurer that usually 24 hours hospitalization is a must for mediclaim coverage. For chemotherapy, the minimum period of 24 hours hospitalization is not insisted. However, the treatment must be taken in a hospital on IP basis. Here the insured had taken oral chemotherapy from her residence. There was no hospitalization at all. Hence the claim is not payable. The policy condition is very specific that in order to be eligible for coverage under the policy, the medicine should be taken while in hospital. The only difference is that, for chemotherapy, 24 hours hospitalization is not necessary. Here in this case, chemotherapy is taken from her residence. Hence the repudiation is to be upheld and the complaint is liable to be **DISMISSED**.

**OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

# Complaint No.IO/KCH/GI/11-009-575/2008-09

**Joseph John**

**Vs**

**Reliance General Insurance Co.Ltd.**

**AWARD DATED 11.05.2009**

The complainant had obtained a mediclaim policy for the period 15.10.2007 to 14.10.2008 covering himself and his family members. On 17.05.2008, he was admitted in Lakeshore Hospital and was discharged on 23.05.2008. His son aged 2 years was admitted in Lakshmi Hospital and took treatment from 28.05.2008 to 30.05.2008. His wife also was hospitalized and took treatment from 04.06.2008 to 05.06.2008 for cervical erosion. All the claims were submitted on 15.07.2008. But all the claims were repudiated on the ground that claim forms were not submitted in time.

As per policy condition, upon happening of the disease or illness, immediate notice must be given to the TPA. For this purpose, toll free number is given in the policy document itself. Also claim must be lodged within 30 days from the date of discharge. This is a condition precedent to the company's liability. It was submitted by the insured that he had informed the same over phone on the number given by the agent. However, it was clarified by the representative of the insurer that toll free number was given in the policy document and upon calling this number, the system will automatically generate a complaint number and this number must be quoted in all further correspondence. Here no such complaint number is available with the complainant and it is to be presumed that no such intimation was given over phone. Another condition that claim must be lodged within 30 days of discharge from the hospital was also not complied with by the insured. He tries to offer some explanation that test reports were not received in time. However, it is to be noted that, all the amount claimed in the claim for relates to payment before date of discharge. As the policyholder has failed to comply with the condition stipulated as per policy condition, there is no reason to interfere in the decision of the insurer and the complaint is, therefore, **DISMISSED**.

**OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

## Complaint No.IO/KCH/GI/11-003-536/2008-09

**M.B.Abdulla**

**Vs**

**National Insurance Co.Ltd.**

**AWARD DATED 27.05.2009**

The complainant had his family members were covered under a mediclaim policy covering the period 07.01.2008 to 06.01.2009. On 22.05.2008, his son was admitted in Specialists' Hospital and the claim was repudiated on the ground that the treatment was for kidney stone which is a first year exclusion under the policy. It was submitted that his son had a fall from bicycle due to which he was having recurrent stomach pain. On approaching a pediatrician, he was advised to undergo ultra sound, which showed light swelling only. Then he was referred to a urologist who advised CT scan. On taking scan, as no abnormality was found, he was discharged prescribing some pain killer.

On going through the hospital report, it can be seen that he was first advised to undergo ultra sound scan. At the time, he was not admitted in hospital. As there are no abnormalities found except a slight swelling, he was referred to an urologist who advised CT scan for which he was admitted in the hospital for one day. The CT scan showed no serious abnormalities. The swelling had disappeared by itself. He was discharged by giving some analgesics and paracetamol. It looks that no active line of treatment was given in the hospital. Analgesics were given before admission in the hospital and he was discharged prescribing the same medicines. Therefore, the hospitalization was only for diagnostic purpose. Policy condition is very specific that such hospitalization is not covered under the policy. The complaint is, therefore, liable to be **DISMISSED**.

**OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

# Complaint No.IO/KCH/GI/11-004-318/2009-10

**Martin Dominic**

**Vs**

**United India Insurance Co.Ltd.**

**AWARD DATED 29.09.2009**

The complainant and his family members were covered under a mediclaim policy during the period 29.07.2008 to 28.07.2009. His wife was admitted in Lakeshore Hospital on 17.12.2008 and was diagnosed of umbilical hernia. After surgery, she was discharged on 23.12.2008. As the claim was repudiated, she approached this forum for justice.

The claim was repudiated as per exclusion clause 4.11, as if it is a pregnancy related complication. It was submitted by the insurer that 6 months back, she had undergone a cesarean section and hernia was approached via the previous LSCS. Hence hernia was caused due to LSCS done and hence it is to be treated as a complication arising out of pregnancy and is to be repudiated.

It was submitted by the complainant that hernia was diagnosed at the stage of 6$^{th}$ month of pregnancy. As there was not much complication, they waited till delivery. Hence the surgery for hernia has nothing to do with the LSCS done 6 months back. The discharge summary of Lakeshore Hospital shows that the swelling was there even before pregnancy. Herniated organ was large intestine. The only thing is that the hernia was approached through the LSCS scar. Just because of the fact that hernia was approached via LSCS scar, it cannot be said that hernia was due to LSCS done. Also it is to be noted that what is excluded as per Cl.4.11 is only complication arising out of pregnancy. Here the hernia was not caused due to pregnancy. The treating doctor also has certified that the hernia has nothing to do with the LSCS done. Hence the repudiation is faulty and an award is passed for payment of the eligible amount of Rs.56,755/- with interest @ 8% pa and cost of Rs.2,000/-.

**OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI**

# Complaint No.IO/KCH/GI/14-004-079/2009-10

**P.T.George**

**Vs**

**United India Insurance Co.Ltd.**

## AWARD DATED 13.07.2009

The complainant and his family members were covered under a health insurance policy. The complainant's father was admitted in CA Hospital from 12.07.2008 to 13.07.2008 for viral disease and claimed an amount of Rs.2,497/-. The TPA called for some requirements vide their letter dated 03.01.2009. Thereafter, the complainant submitted some details obtained from the hospital. As full particulars required by them were not received by the insurer, they closed the file. It was submitted by the insurer that they have not repudiated the claim and they are prepared to consider the claim on getting required details. It was submitted by the complainant that all possible records which were obtained from the hospital including discharge card were submitted and the insurer was unnecessarily delaying his claim.

The TPA by letter dated 03.01.2009 had asked the complainant to produce certificate from the treating doctor with regard to duration of complaint as to past ailments of DM, HTN, COPD and EA. The complainant produced some of the records that he was able to collect from the hospital. It looks that the details called for by the TPA is only to ascertain whether the ailment was pre-existing. No other reason was given by the insurer for repudiation. But it is to be noted that the policy was taken in 2002 and has run for more than 9 years without any break. Hence even if the treatment is for a pre-existing ailment, the insurer has to honour the claim. As per policy condition, if there are 3 claim free years, pre-existing illnesses will also be covered. Hence there is no justification in delaying the claim on this ground. The TPA could also have collected the details from the hospital, if necessary. An award is, therefore, passed directing the insurer to pay the amount of Rs.2,497/- with 8% interest p.a. and a cost of Rs.250/-.