AHMEDABAD

Ahmedabad Ombudsman Centre

Case No.11-004-0175-10

Mr. Hari Unnithan V/s. United India Insurance Co. Ltd.

Award dated 08-10-2009

Partial settlement of Group Mediclaim Policy. Complainant lodged a claim for short payment of cashless facility and non receipt of pre and post hospitalization expenses during his treatment.

Respondent rejected the claim as complainant had not replied on various queries raised by TPA. Neither the Complainant nor Respondent have submitted policy copy. Complainant have not submitted details of treatment records. In the absence of sufficient documents, this forum also directed the Respondent to take decision for settlement of claim as per terms and conditions of policy after receiving reply/documents from the complainant.

Ahmedabad Ombudsman Centre

Case No.11-003-0213-10

Ms. Purnima B. Jasani V/s. National Insurance Co. Ltd.

Award dated 13-10-2009

Non settlement of Mediclaim. Complainant had admitted hospital for treatment of Breast Cancer and claim lodged for Rs.69,746/- towards treatment expenses was not settled by the Respondent. Complainant had submitted all claim documents to TPA and taken follow-up action with TPA. Respondent had neither appeared on the date of hearing nor submitted any written submission to defend the claim.

From the papers on record, no infirmity is observed with regard to the admissibility of claim. The subject policy has been renewed in continuation w.e.f. 2002. The Respondent is not justified in denying the claim without any reason. In the result the complaint succeeds on its own merit.

Ahmedabad Ombudsman Centre

Case No.14-004-0215-10

Mr. Arvindbhai K. Vaghela V/s. United India Insurance Co. Ltd.

Award dated 13-10-2009

Mediclaim rejected. Complainant underwent Eye surgery and claim lodged for reimbursement of hospitalization expenses was repudiated by the Respondent invoking clause 2.3 of the policy stating that it necessitated minimum 24 hours hospitalization. The decision of the Respondent to repudiate the claim is not justified because for the eye surgery hospitalization for 24 hours is not a condition for settlement of claim. In the result the complaint succeeds on its own merits.

Ahmedabad Ombudsman Centre

Case No.11-004-0201-10

Mr. Vasantlal D. Thakor V/s. United India Insurance Co. Ltd.

Award dated 15-10-2009

Mediclaim rejected. Complainant's hospitalization and treatment expenses was repudiated by the Respondent invoking clause 5.3 and 5.4 of the policy. Respondent in their written submission stated that the insured had not given any intimation for admission of patient to the hospital as required under clause 5.3 (immediately within 24 hours). The insured also not submitted claim documents within the stipulated time.

The Complainant had shown the reason for delay in submitting the claim papers that treating doctor had not responded to give them claim papers.

The Respondent's decision to reject the claim simply on the ground of late submission is justified as per the terms and conditions of the policy but, it is very harsh to reject a claim for a merely 16 days delay in submission of claim papers. As per policy conditions, there is a provision for condoning the delay which was not exercised for the subject claim. Therefore, the forum directed the Respondent to pay Rs.8,500/- to the Complainant on ex-gratia basis.

Ahmedabad Ombudsman Centre

Case No.11-003-0219-10

Mrs. Sheelaben H. Shah Vs. National Insurance Co. Ltd.

Award dated 20-10-2009

Repudiation of Mediclaim. Complainant had taken treatment of Fibrocystic Breast Disease and claim rejected by the Respondent on the ground that cancer treatment is not covered. Complainant had not taken treatment for cancer and did not submit any claim for cancer treatment. Claim papers

submitted for right breast lumpectomy due to Fibro cystic disease. As per the certificate issued by the hospital, advised her surgery (MRM) as early as possible.

The Respondent had neither appeared on the date of hearing nor submitted any written submission to give their point of view. Therefore, Respondent is directed to settle the claim amount with interest @ 8%.

Ahmedabad Ombudsman Centre

Case No.11-002-0233-10

Mr. Dipakbhai R. Shah V/s. The New India Assurance Co. Ltd.

Award dated 28-10-2009

Mediclaim lodged for reimbursement of hospitalization and treatment expenses of complainant's son was repudiated by the Respondent by invoking exclusion clause 4.2 of the Mediclaim Policy. Respondent stated that on the very next day after inception of the policy, the insured was hospitalized and according to clause 4.2 of the terms and conditions of the policy, the claim falls within first 30 days of the inception of the policy is excluded. The Respondent's decision to repudiate the claim is upheld without any relief to the Complainant.

Case No.14-004-0237-10

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

Award dated 29-10-2009

Complainant's wife was hospitalized for laser surgery of her eye and claim lodged for reimbursement of expenses was repudiated by the Respondent invoking 5.4 of the policy states delay in submission of claim papers. Complainant submitted claim papers 17 days delay after discharge from hospital.

During the course of hearing, the Respondent pleaded that they are prepared to consider the claim for sum of Rs.5000/- (10% of S.I) as per terms and conditions of the policy. The TPA advised the complainant to submit claim papers within 30 days from discharge from hospital. Therefore repudiation of claim is not justified. Further the insured had not underwent cataract surgery, as limit of expenses on cataract surgery cannot be applied to other eye surgeries.

In the result complaint succeeds and directed to pay full amount of Rs.41,073/- within 15 days from the date of receipt of consent from the complainant.

Case No.11-004-0235-10

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

Award dated 30-10-2009

Mediclaim rejected. Treatment expenses of Complainant's father made as 'No Claim' by the Respondent on the ground of late submission of claim intimation and claim papers.

During the course of Hearing, the Complainant explained to this forum that he has given the claim papers to the Agent and was unaware of the provisions of stipulated time limit to submit claim papers, he could not submit the claim in time.

As a result of mediation by this forum, the Respondent and the Complainant mutually agreed for a sum of Rs.9128/- as full and final settlement of the subject claim and signed a mutually acceptable agreement to this effect.

Ahmedabad Ombudsman Centre

Case No.11-009-0199-10

Mr. Dilipbhai C. Bhrambhatt V/s. Reliance General Insurance Co. Ltd.

Award dated 03-11-2009

Health Insurance Policy. Complainant lodged two claims for reimbursement of treatment expenses of himself and his wife were repudiated by the Respondent. The first claim is in respect of Complainant's wife was repudiated invoking clause 15 of the policy for manipulation and misrepresentation of facts. Respondent had proved that the claim is fraudulent or fraudulent means or devices are used by the insured person to obtain benefit under the policy. On scrutiny of claim documents, they have noticed certain irregularities and discrepancies in information provided by hospital and complainant.

The second claim i.e. Complainant's treatment expenses repudiated by Respondent invoking clause 15, 1 and 2. An analysis of materials on record, the complainant had fallen from Motor Cycle on 22-01-2009 and was having

swelling Tenderness and Hematoma on right leg for which doctor advised hospitalization but as per claim form he had infected right leg nail and operation for removal of nails and debridement. As per claim form nailing for fracture Tibia and Fibula 1 year back was pre-existing. Medical Practitioner's Report records that complainant was operated for removing the infected nail which was used during the operation for fractured Tebio-Fibula about a year back. This injury had occurred prior to taking the policy as is borned out by the date of commencement of policy viz. 04-06-2008.

Therefore both the claims repudiated by the Respondent is justified.

Ahmedabad Ombudsman Centre

Case No.11-002-0242-10

Mr. Brijendra Nath Vidholia Vs. The New India Assurance Co. Ltd.

Award dated 13-11-2009

Mediclaim Policy

The Complainant was admitted at Escort Heart Institute & Research Centre for the period from 03-06-2009 to 04-06-2009 and again on 05-06-2009 and was diagnosed Bradycardia, Hypertension, Coronary Artery Disease and Symptomatic 2:1 AV Block with RBBB. He underwent Dual Chamber Pace Maker implant on 06-06-2009.

The Respondent repudiated the claim stating that the claim attracts clause 5.5 which stipulates that the Policy shall be NULL & VOID and no benefit shall be payable in the event of misrepresentation or nondisclosure of any material fact. Claim also attracts Exclusion Clause 4.1 which excludes pre-existing diseases and the present treatment of Pace Maker Installation is related to circulating system of heart and H.T. and CABG have a direct relationship to blood circulation.

Policy first incepted in the year of 2002. The Complainant had submitted that New proposal form dated 20-09-2007 for the Mediclaim policy 2007, Under question No.10 Medical history items 2 to 5 answered as 'No' and under item 7 and 8 relating to knowledge of any positive existence or presence of any ailment and suffering from Hypertension and diabetes answered as 'No'.

This cannot be taken as suppression and nondisclosure of material fact of previous Heart disease because he has attached copy of previous policy

wherein exclusion of cataract and pre-existing disease are mentioned. The Respondent while issuing the policy has over look for this fact and not recorded it in the new policy for the year 2007-2008 though they have allowed 20% discount on premium for both the insured under the policy.

Respondent is not justified in repudiating the claim invoking Clause 4.1 as the claim has occurred in 5th policy year. Respondent's contention that the claim attracts clause 5.5 related to misrepresentation and concealment of material fact is also not justified.

From the discussions of both the parties and materials on record, the Forum directed to the Respondent to pay Sum of Rs.1,15,000/- on ex-gratia basis to the complainant and complaint partially succeeds.

Ahmedabad Ombudsman Centre

Case No.11-004-0267-10

Mr. Vipul H. Modi V/s. United India Insurance Co. Ltd.

Award dated 24-11-2009

Mediclaim lodged for reimbursement of expenses incurred for the Cataract operation of Complainant's wife was partially settled by the Respondent on the ground of late submission of claim papers. After allowing grace period of 15 days, there was further delay of 17 days in submission of claim papers.

As a result of mediation by this forum, the Respondent and the Complainant mutually agreed for a sum of Rs.26,725/- as full and final settlement of the subject claim and signed a mutually acceptable agreement to this effect.

Ahmedabad Ombudsman Centre

Case No.11-002-0257-10

Mr. Divang M. Shah V/s. The New India Assurance Co. Ltd.

Award dated 27-11-2009

Mediclaim rejected by Insurer. Smt. Rajvi D.Shah, wife of the Complainant was hospitalized for treatment of Hysterectomy and claimed for the expenses was partially settled by the Respondent which was not agreeable by the Complainant. Respondent deducted a sum of Rs.17,500/- from the claimed amount showing as per terms and conditions of Policy clauses 2.1, 2.3 and

2.4. According to Mediclaim Policy 2007, as per terms and conditions, expenses payable 1% of S.I for room category. S.I increased from Rs.50,000/- to Rs. 1,00,000/- in the year of 2007. Policy incepted in the year of 2001. No justification or explanation given by Respondent in applying new terms and condition of medclaim policy. Even an old sum insured restricting room charges to 1% of sum insured per day or actual whichever is less and accordingly reducing other expenses and sum insured is Rs.50,000/- and total expenses well within this limit, i.e., Rs.36,413/-. However deduction of Rs.17,500/- is not justified and Respondent is directed to pay full claim amount.

Ahmedabad Ombudsman Centre

Case No.11-002-0245-10

Mr. Umeshkumar S. Shah V/s. The New India Assurance Co. Ltd.

Award dated 30-11-2009

Mediclaim lodged for treatment expenses of unstable angina, myocardial Ischemia, Hypertension, Diabetes etc. had repudiated by the Respondent invoking exclusion clause 4.1 i.e. pre-existing disease when the cover was incepted.

On perusal of material on record shown the policy incepted in the year of 1996 and renewed in continuation up to 2008 without any break. Initial Sum Insured was Rs.37,500/- which was subsequently increased to Rs.60,000/- and Rs.75,000/- in the year 1998 and 1999 respectively. While increasing S.I for policy period from 2000-2001, Proposal form submitted and policy received without cumulative bonus. Thereafter policy was renewed up to 2008 and C.B of 35% allowed. Complainant's existing health problem have no connection with pre-existing disease and even pre-existing diseases are covered after completion of 4 years from the date of the first incepted. However Respondent's decision to reject the claim on the ground of pre-existing disease is not justified and directed to pay original S.I of Rs.37,500/- to the complainant. Therefore complaint partially succeeds.

Ahmedabad Ombudsman Centre

Case No.11-002-0256-10

Mr. Pravinbhai C. Chevil V/s. The New India Assurance Co. Ltd.

Award dated 18-12-2009

Mediclaim rejected. The Complainant had claimed an amount of Rs.20,366/- for Gall Bladder Stone in 2008 and he was hospitalized for the present treatment on 07-03-2009 was repudiated in the context of policy clause 4.1, pre-existing disease and policy benefit will not be available until 48 months of continuous coverage have elapsed since inception of the first policy.

The complainant did not disclose the fact that he is suffering from Hypertension since 2002 and other heart related diseases are excluded. No any additional premium paid for coverage of Hypertension and Heart related disease. The policy was renewed as per revised mediclaim policy 2007 on 12-03-2008 during which the subject claim have been lodged. The policy incepted in 2002 and renewed in continuation without any break. Introduction of new mediclaim policy 2007 existing policy discontinued and Complainant had not disclosed hypertension since 2002 and heart related disease in the proposal form.

Therefore, the Respondent's decision to repudiate the claim is justified.

Ahmedabad Ombudsman Centre

Case No.11-009-0282-10

Mr. Udaybhansing Nataprasad V/s. Reliance Gen. Insurance Co. Ltd.

Award dated 28-12-2009

Mediclaim repudiated. Complainant's son was suffering from Typhoid and hospitalized on 31-12-2008 and discharged on 06-01-2009. The claim had been repudiated invoking clause 15 on the ground that it is fraudulent claim and false statement made by the Complainant. Out of the total claim amount of Rs.18000/-, about Rs.11500/-towards room rent and doctor's visit charges.

The claim had been repudiated on the basis of fraud and provide a fraud require and elaborate legal procedure calling for examination of documents, calling for witness under oath which is beyond the jurisdiction of this forum. Hence without getting into merit of the case and passing any quantitative award for the same the complaint is deemed as beyond jurisdiction of this forum leaving it for complainant to resolve the grievance any other forum as may be considered appropriate.

Case No.11-009-0321-10

Mr. Viral B. Patel V/s. Reliance Gen. Insurance Co. Ltd.

Award dated 31-12-2009

MediClaim lodged for reimbursement of expenses incurred for the treatment of **Breast Cancer** of Complainant's wife was made as 'No Claim' by the Respondent. The dispute is about the hospitalization of 0-03-2009 was for cosmetic Surgery which is excluded in the terms and conditions of the policy and claim is not payable.

As a result of mediation by this forum, the Respondent and Complainant mutually agreed for payment of a sum of Rs.83,124/- as full and final settlement of the subject claim. The grievance was thus resolved.

Ahmedabad Ombudsman Centre

Case No.11-004-0327-10

Mr. Kishorbhai J. Patadia V/s. United India Insurance Co. Ltd.

Award dated 31-12-2009

Repudiation of MediClaim lodged for treatment reimbursement of expenses of Gynec problem of Complainant's wife was made as 'No Claim' by the Respondent on the ground of late submission of claim intimation and claim papers.

As a result of mediation by this forum, the Respondent and Complainant mutually agreed for payment of a sum of Rs.9,841/- as full and final settlement of the subject claim. The grievance was thus resolved.

Ahmedabad Ombudsman Centre

Case No.11-002-0233-10

Mr. Dipakbhai R. Shah Vs. New India Assurance Co. Ltd.

Award dated 28-10-2009

Repudiation of Mediclaim

The insured was a son of the Complainant. He was hospitalized for the treatment of Enteric fever and gastritis. Claim lodged for reimbursement of expenses towards hospitalization and treatment was repudiated on the ground that claim occurred within first 30 days from the inception of the policy is excluded from the purview of the policy.

The Respondent submitted that on a very next day after inception of the policy, the insured was hospitalized hence claim was repudiated.

It was established that Respondent's decision to repudiated the claim was justified and Complaint fails to succeed.

Ahmedabad Ombudsman Centre

Case No.11-009-0216-10

Shri Jigar M. Pandya Vs. Reliance General Insurance Co. Ltd.

Award dated 05-11-2009

Repudiation of Mediclaim. The insured underwent a surgical procedure known as Lithropsy for removal of Kidney stone on 10-02-2009. Date of commencement of risk under the policy was 14-08-2008. The claim repudiated by the Respondent on the ground of Pre-existing as the insured had a history of 'Lithuria' (one type of stone) prior to inception of policy. Respondent relied upon the discharge card of the treating surgeon who had recorded history of Lithuria since last 7-8 years.

The Complainant produced a certificate of the treating surgeon stating that Lithuria has no relation with Renal calculus.

This forum observed that Respondent failed to produce any sustainable documentary evidence to prove that the disease Lithuria has nexus with the Renal Calculus and Renal calculus was existing prior to the inception of the subject policy. Hence Repudiation of the claim by the Respondent was set aside and directed to settle the claim.

Case No.14-004-0240-10

Shri Chandreshbhai L Patel Vs. United India Insurance Co. Ltd.

Award dated 12-11-2009

Delay in settlement of Mediclaim. The insured was first hospitalized on 22-02-2009 for surgery of fractured left leg due to vehicular accident. Claim lodged for the treatment was settled by the Respondent in full. Subsequently, he was again hospitalized on 05-03-2009 because of acute pain in left leg. He had intimated to the Respondent about his second time hospitalization and asked to treat it post hospitalization treatment in continuation of his first claim. He again lodged his claim on 15-04-2009 after obtaining fitness certificate on 09-04-2009.

In-spite of lapsation of 6 months period from the date of lodgment of the claim and representation made to Divisional Office and Regional Office of the Respondent, nothing was heard by the insured. Being aggrieved with this, he approached this forum. This forum had held hearing wherein in-spite of receipt of the notice for the same, the Respondent neither remained present nor submitted any written note in their defense.

Therefore, this forum took ex-parte decision and directed to the Respondent to pay the claimed amount to the Complainant.

Ahmedabad Ombudsman Centre

Case No.11-009-0244-10

Mr. Kiran P. Christian Vs. Reliance General Insurance Co. Ltd.

Award dated 12-11-2009

Repudiation of Mediclaim. The Complainant was hospitalized for the treatment of enteric fever and claim lodged for the reimbursement of treatment expenses was repudiated on the ground that the claim was a fraudulent one.

The Respondent submitted as follows:

i) Malaria Report was positive but no anti-malarial treatment was given.
ii) The Complainant had stated to the investigator that he had not paid hospital bill and will pay after claim will be passed.
iii) Claim form submitted was signed by someone other than the complainant.
iv) Treating doctor is interested in claim amount.
v) Third party interest in the claim is visible.

The Complainant produced a letter from the treating doctor also stamped receipt, confirming that he had received amount of his bill.

This forum observed that it was difficult to verify as to whether the hospitalization had really taken place, and the amount of bill was paid. The claim form was also under dispute. Hence the complaint was treated as beyond the jurisdiction of the forum and the complainant was asked to pursue other means to resolve the grievance either within the framework of Government Rules under reference or taking recourse to any other forum as may be considered appropriate.

The Complaint, thus stood resolved.

Ahmedabad Ombudsman Centre

Case No.11-004-0266-10

Ms. Meghnaben N. Ramanandi Vs. United India Insurance Co. Ltd.

Award dated 20-11-2009

Repudiation of Mediclaim. Complainant claimed for reimbursement of expenses of operation of Goiter was repudiated by the Respondent on the ground of late submission of claim papers than the stipulated time limit according to terms and conditions of the mediclaim policy.

Aggrieved by the said repudiation, the complainant filed a petition with this forum.

However, as a result of mediation by this forum the Respondent and the complainant mutually agreed for an amount towards full and final settlement of the subject claim and signed a mutually acceptable agreement.

The grievance was, thus resolved.

Ahmedabad Ombudsman Centre

Case No. 11-004-0279-10

Mr.Vallabhbhai H. Patel Vs. United India Insurance Co. Ltd.

Award dated 20-11-2009

Repudiation of Mediclaim. Complainant claimed for reimbursement of expenses of Cataract operation, was repudiated by the Respondent on the ground of late submission of claim papers than the stipulated time limit according to terms and conditions of the subject policy.

As a result of mediation by this forum, both the parties mutually agreed for a payment of particular amount towards full and final settlement of the subject claim and signed an agreement to that effect.

The grievance was, thus resolved.

Ahmedabad Ombudsman Centre

Case No. 11-002-0271-10

Mr.Chandrakant K Kotecha Vs. The New India Assurance Co. Ltd.

Award dated 26-11-2009

Partial settlement of Mediclaim. Complainant claimed for reimbursement of expenses of Cataract operation, was partially settled by the Respondent on the ground that the complainant had not produced bill for the cost of Intra Ocular lens implanted. Aggrieved by this decision, the Complainant approached this forum and filed a petition.

However, as a result of mediation by this forum the Respondent and the complainant mutually agreed for balance amount deducted from the claim and signed a mutually acceptable agreement.

The grievance was, thus resolved.

Ahmedabad Ombudsman Centre

Case No. 11-005-0272-10

Mr.Piyush M Thakkar Vs. Oriental Insurance Co. Ltd.

Award dated 27-11-2009

Repudiation of Mediclaim. Complainant's wife was hospitalized for surgical operation of breast abscess and claimed for reimbursement of expenses, was repudiated by the Respondent on the ground that there is a history of recent delivery and breast abscess is well known complication after child birth and pregnancy & child birth related diseases are not covered in the scope of policy. Aggrieved by this decision, the Complainant approached this forum and filed a petition.

The Respondent submitted a certificate of their Medical adviser who opined that the insured was suffering from breast abscess which had developed due to deficient feeding.

The Complainant produced a certificate of the treating doctor who has certified that "Breast Abscess can occur irrespective of pregnancy and delivery". In the subject case, there was a gap of 40 days between the delivery and operation.

This forum observed that the insured developed Breast abscess after delivery due to heavy growth of gram positive staphylococcus aurous as is borne out from the report of culture and not due to pregnancy as alleged by the Respondent. Moreover deficient feeding is not related to pregnancy or childbirth.

In the result, the complaint succeeded.

Ahmedabad Ombudsman Centre

Case No. 11-002-0265-10

Mr.Nareshchandra P. Shah Vs.n The New India Assurance Co. Ltd.

Award dated 27-11-2009

Repudiation of Mediclaim. Complainant was suffering from left Eye Vitreous Hage (an age related Macular Degeneration) and was hospitalized for administering inter vitreal injectin viz. Lucentis to improve the vision. Claim lodged for reimbursement of expenses towards hospitalization and treatment was repudiation by the Respondent on the basis their internal circular which reads as under:

"For treating ARMD the drugs like avastin or lucentis or Macular is given as intra vitreal injection is an OPD treatment which is excluded from the scope of cover".

The complainant produced certificates of the President Vitreo Retrinal Society of India and the Hon. Gen. Secretary, All India Opthalomological Society who certified that intravitreal injection is a surgical procedure required to be carried out in operation theatre taking lot of care to prevent infection and other things and it is not an OPD procedure.

This forum observed that the Respondent failed to submit any written statement or produce any opinion from an expert in their defense. Moreover, an internal administrative instruction can not form part of the policy condition and hence cannot be made operative unilaterally without informing the insured.

In the result, the complaint succeeds.

Ahmedabad Ombudsman Centre

Case No.11-009-0291-10

Mr. Alpesh K Panchal V/s. Reliance General Insurance Co. Ltd.

Award dated 10-12-2009

The insured was hospitalized for treatment and Surgical operation of Ureterorenoscopy for lower Ureteric Stone + Extracorporeal shock wave lithotripsy (ESWL) for Kidney Stone. Claim repudiated by the Respondent on the ground of pre-existing disease.

The Complainant submitted that he had a past history of Lithotripsy procedure for removal of right upper ureteric stone in the year 2000 and 2005. He further stated that thereafter he had no complaint except sudden onset of pain at right side of abdomen on 29-04-2009, hence it was not pre-existing at the time of taking the subject policy on 25-08-2007. But complainant had not disclosed the previous history in the proposal form.

The Respondent to establish the disease was Pre-existing produced the Discharge Summary from the Hospital and a certificate of the treating Surgeon wherein he had confirmed that the complainant had a history of Kidney stone which was removed by the procedure of Lithotripsy in the year 2000 and 2005. Medical opinion confirms that "People who have already had more than one Kidney stone are prone to develop more stones". Moreover the subject claim has been preferred in the 2nd year of the policy and as per terms and conditions of the policy any pre-existing disease has a waiting period of two years.

This forum opined that the Respondent succeeded to prove pre-existence of the disease prior to the inception of the subject policy by producing sustainable documentary evidence hence Respondent's decision to repudiate the claim is upheld and complaint failed to succeed.

Ahmedabad Ombudsman Centre

Case No.11-004-0306-10

Mrs. Falguniben M. Vaidya V/s. United India Insurance Co. Ltd.

Award dated 30-12-2009

The insured was hospitalized for the treatment of HTN+ IHD+ Acute Pancreatitis + Gall bladder stone and claim lodged for 69,443/- was repudiated invoking clause 4.3 which stipulates that during the first two years from inception of policy, the expenses on treatment of Gall Bladder stone removal is not payable.

The Respondent alleged that Gall bladder stone could be likely cause of pancreatitis hence claim is not payable.

Material on record reveals that Surgery for Gall Bladder stone removal was not performed, but treatment given was I.V. Fluid+ Antibiotic + Insulin + other supplement.

This forum observed that interpretation of the Respondent is not correct and repudiation of claim on the ground of gall bladder stone removal is not justified.

In the result the complaint succeeds.

Ahmedabad Ombudsman Centre

Case No.11-002-0312-10

Shri Ashok T. Chauhan Vs. The New India Assurance Co. Ltd.

Award dated 31-12-2009

Partial settlement of Mediclaim

An amount of Rs.34,600/- was deducted out of the claimed amount of Rs.52,479/- invoking clause 2.3, 2.4 and 2.6 of Note 1 of the Revised Mediclaim Policy 2007. The insured was hospitalized for surgery of Cholocystectomy with perianal fistula. The Respondent settled the claim partially for all expenses in proportion of 1% of Sum Insured for Room charges and secondly as per their internal circular cash payment made in excess of Rs.10,000/- was also disallowed.

The Complainant was having previous policy for S.I. of Rs.50,000/- + Cumulative bonus of Rs.5,000/-.

The Respondent applied double standard in settlement of mediclaim as under:-

1) 1% of Rent taken on old Sum Insured
2) Invoked clauses of revised mediclaim policy 2007.

Moreover, on the basis of their internal circular, out of cash payment of Rs.35000/- they disallowed Rs.25,000/-which was exceeding Rs.10,000/-.

This forum observed that prior to renewal of policy, Sum Insured was Rs.55,000/-(Rs.50,000/-+ 5,000/-C.B) and total expenses were well within this limit hence deduction of Rs.34,600/- was not justified.

In the result the complaint succeeds and Respondent is directed to pay the deducted amount.

Case No.11-002-0289-10

Mr. Nuralla N. Rajani Vs. The New India Assurance Co. Ltd.

Award dated 31-12-2009

Complainant was covered under a Mediclaim policy and claim lodged for reimbursement of treatment expenses of Cancer in right buccal mucosa was repudiated by the Respondent on the basis of the patient was ex-gutkha chewer and hence concluded that the habit to use of tobacco leaded to cancer.

The treating hospital had certified, probable cause for cancer was malalignment of teeth and etiology of disease is multifactoral, some of the possible causes being dental trauma and genetic factors also.

The Respondent then took a plea that claim is not payable due to Genetic disorder as per the clause 4.4.16 of the terms and conditions of the policy. The exclusion clause "Tobacco chewing leading to cancer was first included in the year 2007 and this condition was not operative prior to the year 2007 when the policy first incepted from 26-05-2000.

The judgment of Hon. High Court of Gujarat under LPA No.1029 to 2003, 10034 1004 of 2003 and SCA No.9425 of 2002 dated 12-12-2001 indicates that "the cover for the disease which was not excluded in the first year of the cover would continue even in subsequent renewals, if the renewal premium was paid in time.

This forum observed that the Respondent did not produce any documentary evidence to prove that the complainant was a Gutkha chewer and use of tobacco chewing led to the cancer hence Respondent is not justified in repudiating the claim.

In the result, the complaint succeeds.

Ahmedabad Ombudsman Centre

CASE NO. 11-005-0224-10

Mr. J D SHAH V/S ORIENTAL INSURANCE CO.LTD.

Award Dated : 24.11.09

Complaint lodged for Partial settlement of Mediclaim. Respondent applied clause 2.1(3) restricting the sum insured stating that disease arthritis having waiting period of two years. Renewal of policy in the year 2007-08,

with increased sum insured wherein disease is having restriction for four years. The insurance is in continues period without any break since April 2005. Insured admitted in the month of March 2009 and lodged claim with Respondent. Upon scrutiny of the papers it is decided to allow benefit in the year 2006-07 policy wherein Sum insured is upto 150,000/- with CB. The respondent was directed to pay the claim.

Ahmedabad Ombudsman Centre

CASE NO. 11-002-0249-10

MR.ASHOK CHAUHAN V/S THE NEW INDIA ASSURANCE CO.LTD.

Award Dated : 10-11-2009

Mediclaim repudiated invoking clause 5.5 of the Mediclaim Policy on the grounds of fraud, misrepresentation, concealment of facts. Insured admitted hospital for the treatment of entric fever and a claim preferred for Rs. 17210/-. Respondent submitted note alongwith evidence wherein attending doctor admitted that he has favoured in preparing excessive billing to the tune of Rs. 8000/-. It is established that as per policy conditions Respondent's decision to repudiate the claim is upheld without any relief to the complainant.

Ahmedabad Ombudsman Centre

CASE NO. 11-012-0264-10

MR.ASHSIH V. BHAVSAR V/S

ICICI LOMBARD GENERAL INSURANCE CO.LTD.

Award Dated : 27.11.2009

Mediclaim repudiated invoking clause 2.14 of the Critical Care policy on the grounds of pre-existing disease. Insured hospitalized for the treatment of Renal failure. Respondent submitted set of papers and reports, from the available records it is noticed that insured suffering from Hypertension since 2007, and past history of kidney related disease since one year. It is established that Respondent's decision to repudiate the claim is upheld without any relief to the complainant.

Ahmedabad Ombudsman Centre

CASE NO. 11-004-0247-10

MR. KISHORKUMAR R. THAKKAR V/S

UNITED INDIA INSURANCE CO. LTD.

Award Dated : 23.11.2009

Mediclaim repudiated invoking clause 5.3 on the grounds late submission of intimation. Insurerd admitted on 30.08.09 to 06.09.08, and submitted all relevant claim form and papers on 06.10.10 for Rs.11342/-, which means intimation lodged after 35 days late. As per policy conditions intimation must be given within 24 hours to Insurer. As a result of mediation by this Forum, the Respondent and complainant mutually agreed for sum of Rs.8500/- as full and final settlement of the claim.

Ahmedabad Ombudsman Centre

CASE NO. 11-009-0284-10

Mr. Dipak H. Shukla V/S RELIANCE GENERAL INSURANCE CO.LTD.

Award Dated: 11.11.2009

Repudiation of Mediclaim - Complainant himself met with an accident and admitted to the hospital on 17.01.09 and discharge on 19.01.09 for the treatment of "Segmental Double Fracture libia. Respondent rejected the liability invoking clause 21 of the policy stating that treatment could have been taken on OPD basis. From the papers submitted by complainant and also Respondent, it gets established that insured though insured was hospitalized from 17.1.09 to 19.01.09, as the knee POP is OPD process for which hospitalization is not necessary. The Respondent's decision to repudiate the claim is upheld without any relief to the complainant.

Ahmedabad Ombudsman Centre

CASE NO. 11-002-0295-10

Mr. Ranjanben B.Patel V/S THE NEW INDIA ASSURANCE CO. LTD.

Award Dated : 28.12.2009

Repudiation of Mediclaim invoking clause 3.2 of Mediclaim policy (2007) stating that Hospital/Nursing Home is not eligible to provide the services under the policy terms. As such main dispute is number of beds in hospital

10, as per policy conditions either hospital must be having minimum 15 beds or must be register as "Hospital/Nursing Home" as per policy conditions. Respondent submitted investigation report wherein number of beds in hospital shown as 10, while their TPA has rejected the claim on the basis of their investigation alleged that number of beds are 7 in hospital. This shows inconsistency in the reports of Respondent in respect of number of beds.

Ahmedabad Ombudsman Centre

CASE NO.11-002-0290-10

Mr. DILIP R. PATEL V/S THE NEW INDIA ASSURANCE CO.LTD.

Award Date: 04.12.2010

Mediclaim rejected invoking clause 4.12, insured underwent treatment for pregnancy, hence respondent rejected the claim Respondent submitted entire set of papers and policy conditions, it was found that insured was suffering abdominal pain for which hospitalization was undertaken. The said facts was shown to the representative of Respondent and agree to compromise for an amount of Rs.6225/-.

Ahmedabad Ombudsman Centre

CASE NO.11-004-305-10

MR. RAJENDER R. PATEL V/S UNITED INDIA INSURANCE CO.LTD.

Award Date: 18.12.2009

Mediclaim repudiated invoking clause 5.3 & 5.4 of the mediclaim policy stating that intimation of claim must be given to the insurer within 24 hours and all supported claim papers/reports must be submitted within 7 days after discharge from the hospital. Insured admitted on 07.10.09 to 25.10.09, and all relevant papers claim form etc. submitted on 30.01.2009. Complainant submitted claim papers late by 89 days. Respondent submitted all relevant papers, which established exorbitant delay on the part of complainant in submission of papers. The decision of Respondent to reject the claim is upheld without any relief to the complainant.

Case no 11-012-0191-10

Mrs.Alkaben N,Parmar Vs ICICI Lombard Insurance Company Ltd

Award Date : 05-11-2009

Repudiation of Claim under Mediclaim policy: The complainant has submitted the claim for Accidental Death of her husband while he was traveling by train and fell from the compartment resulting into injury on back of the head causing hemorrhage. The respondent has repudiated the claim by invoking item no 6 of General exclusions -3 of the policy which excludes any loss or damage arising out of or as a result of any act of self inflicted injury, attempted suicide or suicide. As per the copy of Police Panchnama, statement of the Guard and copy of final verdict of SDM it was the case of suicide and these are the legal and official evidence which has to be relied upon .Hence the decision of the respondent to repudiate the claim is upheld without any relief to the complainant .The complaint fails to succeed .

Ahmedabad Ombudsman Centre

Case no 14-003-0178-10

Mr .Ramesh M.Shah Vs National Insurance Company Ltd

Award Date : 15-10-2009

Delay in Settlement of Claim under Mediclaim policy: The complainant has submitted the claim for reimbursement of expenses incurred in hospitalization for treatment of sub retinal bleeding in both the eyes and macular Edema from 29-07-2008 to 30-07-2008 ,04-08-2008 to 05-08-2008 and on 29-01-2009 at Banker's Retina Clinic .The respondent was silent for the bills submitted for bills of 29-07-2008 to 30-07-2008 and 04-08-2008 to 05-08-2008 but they have repudiated the claim of bills of 29-01-2009by invoking clause 2.6 which provides that hospitalization should be for a minimum period of 24 hours .It gets established that the respondent has neither settled the claim nor any reason was given for delay in settlement which shows deficiency in service however respondent 'submission that claim for hospitalization in jan.2009 attracts clause 2.6 is justified but cannot be applied for claims of July and August 2008.Hence the Respondent has been directed to pay the admissible amount for claims of July and August 2008with interest .The complaint succeeds partially.

Ahmedabad Ombudsman Centre

Case no 11-004-220-10

Mr .Jayantibhai R.Patel Vs United India Insurance Company Ltd

Award Date : 23-10-2009

Repudiation of Claim under Mediclaim policy: The complainant has submitted the claim on 27-07-2008 for reimbursement of expenses incurred in hospitalization from 14-06-2008 to 17-06-2008 .The respondent has repudiated the claim by invoking clause 5.4 of policy which states that all supporting documents relating to claims must be filled with TPA within 7 days from the date of discharge .The complainant has pleaded that the bill was prepared by the hospital on 30-06-2008 and after that he has submitted the claim. It gets established that the respondent has not considered the reasons for delay in submission of claim papers. Considering the facts and circumstances of the case ,delay should have condoned by the respondent .Therefore the decision of the respondent to repudiate the claim is set aside and directed to pay RS 7059/ to the complainant .The complaint stands disposed

Ahmedabad Ombudsman Centre

Case no 11-002-0094-10

Ms .Ami Mittal Shah Vs The New India Assurance Company Ltd

Award Date: 06-10-2009

Partial settlement of Claim under Mediclaim policy: The complainant has submitted the claim for reimbursement of expenses incurred in hospitalization from 20-11-2008 to 23-11-2008 for treatment of Contusion Chest ® with Contusion ® thigh with PCL injury .The respondent has settled the claim partially by invoking clause 4.4.4 of policy which states that cost of braces ,equipment or external prosthetic devices, non durable implants ,eyeglasses ,cost of spectacles and contact lenses, hearing aids , including cochlear implants and durable medical equipments .The respondent has repudiated the claim under policy clause 4.4.11 stating that the treatment given in the hospital did not warrant hospitalization and on representation by the complainant they have settled the claim .The respondent has disallowed the cost of braces ,ice bag ,rib belt ,walker ,salary loss. Therefore the decision to repudiate the claim for RS 10855/ is justified .The complaint fails to succeeds.

Ahmedabad Ombudsman Centre

Case no 11-002-0188-10

Mrs .Dahiben G .Patel Vs The New India Assurance Company Ltd

Award Date: 07-10-2009

Repudiation of Claim under Mediclaim policy: The complainant has submitted the claim for reimbursement of expenses incurred in hospitalization from 06-08-2007 to 11-08-2007,13-10-2007 to 24-10-2007 and 10-02-2008 for treatment of cancer Oesophagus. The respondent has repudiated the all claims on the grounds of non submission of particulars regarding the claim which was settled by the respondent in 1997. The respondent submitted that the services of TPA has been terminated hence the claims stands unsettled .The complainant has stated that she has submitted all the papers regarding the claims and papers of claim of 1997 was not with her. These papers should be with the respondent. Therefore it is proved that the respondent has not settled the claim and the respondent has been directed to settle all three claims and pay the amount to the complainant with interest till the date of payment calculated as per IRDA Protection of Policy holders (Interest) Regulations 2002.The complaint stands succeeds.

Case no 11-002-161-10

Mr Jitendra I Soni Vs The New India Assurance Company Ltd

Award Date: 30-09-2009

Repudiation of Claim under Mediclaim policy: The complainant has submitted the claim for reimbursement of expenses incurred in hospitalization from 09-01-2009 to 10-01-2009and from 12-01-2009 to 13-01-2009 for treatment of vein occlusion and occluar Ischemic Sign Syndrome in both eyes. The respondent has repudiated the claims on the ground stating that for treating the ARMD the drugs like avastin or Lucentis or Macugen and other related drug is given as intravetral injection and it is OPD treatment through injection is given in the operation theatre .Hence such treatment is excluded from the scope of cover. On the basis of submissions it is established that the hospitalization is decided by the treating doctor depending upon the gravity of the disease and it was advised by the treating doctor to admit in the hospital. The circular of the Respondent deciding such treatment as OPD has been issued on 09-02-2009 and it was not part of policy condition .Therefore the decision of the respondent to repudiate the claim set aside and directed to make the payment to the complainant. The complaint stands succeeds .

Ahmedabad Ombudsman Centre

Case no 11-004-165-10

Mr Pravinchandra K Sanghavi Vs United India Insurance Co. Ltd

Award Date: 30-09-2009

Repudiation of Claim under Mediclaim policy: The complainant has submitted the claim on 30-03-2009 for reimbursement of expenses incurred in hospitalization from 28-02-2009 to 05-03-2009 for treatment of left knee joint replacement .The respondent has repudiated the claims on the ground of late submission by 10days. The complainant has submitted that the claim papers have been submitted on 17-03-2009 in the office of the company hence there was no delay in his part. However both the parties mutually agreed for payment of the claim .The grievances thus resolved.

Ahmedabad Ombudsman Centre

Case no 11-009-196-10

Mr Pratap Sevaram Mistry Vs Reliance General Insurance Co. Ltd

Award Date: 29-09-2009

Partial Settlement of Claim under Mediclaim policy: The complainant has submitted the claim of RS 13589/ for reimbursement of expenses incurred in hospitalization from 03-03-2008 to 07-03-2008 for treatment of Jaundice .The respondent has settled the claims partially by invoking clause 15 of the RGIL Policy . However on mediation by this forum both the parties mutually agreed for payment of RS 6500/as full and final settlement of the claim .The grievances thus resolved.

Ahmedabad Ombudsman Centre

Case no 11-004-185-10

Ms Rajvi D Shah Vs United India Insurance Company Ltd

Award Date: 30-09-2009

Repudiation of Claim under Mediclaim policy: The complainant has submitted the claim for reimbursement of expenses incurred in hospitalization from 24-02-2009 to 25-02-2009 for treatment of Morbid Obesity along with Co_Morbiditis by way of an operation Laparoscopic

Gastric Bye pass .The respondent has repudiated the claim by invoking clause no 4.3 of the policy stating that the Cosmetic Surgery is not allowed. ON examination of submissions of the respondent ,opinion of treating surgeon and medical references it is proved that Bariatic Surgery administered on the insured was not cosmetic surgery .Hence the decision of the respondent is not justified .The respondent has been directed to make the payment of claim to the complainant .The complaint stands succeeds .

Ahmedabad Ombudsman Centre

Case no 14-004-138-10

Mr Sharadchandra S Panchal Vs United India Insurance Company Ltd

Award Date: 19-09-2009

Repudiation of Claim under Mediclaim policy: The hearing was arranged on the basis of irrevocable consent to this forum by the complaint to act as per RPG Rules .However after the hearing was concluded ,the complainant has submitted that he is not satisfied with the hearing proceedings .Since the complainant has shown his dissatisfaction even before pronouncement of formal award by this forum ,no order is desired The complaint is disposed

Ahmedabad Ombudsman Centre

Case no 11-017-329-10

Mr Mansukhbhai H Patel VsStar Health & Allied Insurance Company Ltd

Award Date: 31-12-2009

Partial Settlement of Claim under Mediclaim policy: The complainant has submitted the claim for reimbursement of expenses incurred in hospitalization from 31-05-2009 to 05-06-2009 for treatment of Diabetes Mellitus + Infective Hepatitis .The respondent has settled the claims partially deducting amount towards expenses incurred on treatment of DM which was in existence for 2-3 years. However on mediation by this forum both the parties mutually agreed for payment of RS15607/as full and final settlement of the claim .The grievances thus resolved.

Ahmedabad Ombudsman Centre

Case no 11-005-309-10

Mr .Saurabh V Parikh Vs

Oriental Insurance Company Ltd

Award Date : 31-12-2009

Repudiation of Claim under Mediclaim policy: The complainant has submitted the claim on 06-07-2009 for reimbursement of expenses incurred in hospitalization from 27-04-2009 to 03-05-2009 .The respondent has repudiated the claim on the ground of late submission of claim file by two months and eight days while as per terms and conditions of policy all supporting documents relating to claims must be filled with TPA within 7 days from the date of discharge .The complainant has pleaded that the claim was first lodged with United India Co. and they have settled the claim and given the certified copies of all claim papers on 01-07-2009 and then he has submitted the same to the respondent Considering the facts and circumstances of the case ,delay should have been condoned by the respondent .Therefore the decision of the respondent to repudiate the claim is set aside and directed to pay RS 64192/ to the complainant .The complaint stands succeeds.

Ahmedabad Ombudsman Centre

Case no 11-002-302-10

Mr.Premnath K Ahuja Vs

The New India Assurance Company Ltd

Award Date : 31-12-2009

Repudiation of Claim under Mediclaim policy: The complainant has submitted the claim for reimbursement of expenses incurred in hospitalization for treatment of acute Carcinoma of Left Retro molar Trig one with history of Tobacco Chewer . The Respondent has repudiated the claim by invoking exclusion clause 4.4.6 of terms and conditions of the Policy .The respondent has produced a certificate of DR S Gami confirming that the complainant was tobacco chewer whereas the complainant has denied and the respondent has repudiated the claim on the basis of mere noting of MD doctor and it was also not confirmed the tobacco chewing by

complainant was the cause of cancer . The Investigating doctor has not submitted any supporting evidence showing that the complainant 'cancer was as a result of tobacco chewing. Hence the decision of the respondent to repudiate the claim is not justified and directed to settle the claim as per rules. The complaint stands succeeds.

Ahmedabad Ombudsman Centre

Case no 11-004-287-10

Mr. Jignesh V Patel Vs

The United India Insurance Company Ltd

Award Date : 15-12-2009

Repudiation of Claim under Mediclaim policy: The complainant has submitted the claim for reimbursement of expenses incurred in hospitalization from 26-03-2008 to 16-04-2008 for treatment of post LSCS superior mesenteric Artery Thrombosis with DIC . The Respondent has repudiated the claim by invoking exclusion clause 4.12 of terms and conditions of the Policy which reads as treatment arising from or traceable to pregnancy and child birth .Since the repudiation was on the grounds that the hospitalization at sterling hospital was due to treatment arising from or traceable pregnancy and papers on record without any ambiguity confirm that hospitalization was for post LSCS superior mesenteric Artery Thrombosis and was treated by a Gastro Enteric Surgeon and not a Gynecologist . Hence the decision of the respondent to repudiate the claim is not justified and directed to make the payment with interest to the complainant. The complaint stands succeeds.

Ahmedabad Ombudsman Centre

Case no 11-004-297-10

Ms Kalyani V Trivedi Vs

United India Insurance Company Ltd

Award Date : 11-12-2009

Repudiation of Claim under Mediclaim policy: The complainant has submitted the claim on 12-06-2009 for reimbursement of expenses incurred in hospitalization for treatment of disease of Spinal Cord from 23-04-2009 to 27-04-2009 .The respondent has repudiated the claim on the ground of

late submission of claim file by 45 days while as per terms and conditions of policy all supporting documents relating to claims must be filled with TPA within 7 days from the date of discharge .The complainant has pleaded that post hospitalization treatment was continued up to02-06-2009 and the claim has been submitted the respondent and there is no delay in submission of papers. The clause for submission of papers also stipulates that in case of post hospitalization treatment (limited to 60 days) the papers should be submitted within the stipulated time period. Considering the facts and circumstances of the case , the respondent should have gone through papers and delay have been condoned . .Therefore the decision of the respondent to repudiate the claim is set aside and directed to pay RS 82220/ to the complainant .The complaint stands succeeds on its merits..

'

Ahmedabad Ombudsman Centre

Case no 11-003-253-10

Mr Babulal C Khamar Vs

National Insurance Company Ltd.

Award Date : 07-12-2009

Repudiation of Claim under Mediclaim policy: The complainant has submitted the claim for reimbursement of expenses incurred in hospitalization for treatment of Autosomal Dominant Polycystic Kidney from 05-09-2008 to 06-09-2008 and from 06-09-2008 to 09-09-2008 .The respondent has repudiated the claim by invoking exclusion clause 4.15 which excludes the reimbursement for expenses incurred for treatment of Genetical disorders/Stem cell implantation /surgery and late submission oft the claim file .On examination of literature it is proved that the ADPKD is a Genetic disorder however the respondent has not opted for the opinion of an expert about the disease .Hence the decision of the respondent to repudiate the claim is upheld without any relief to the complainant . The Complaint fails to succeed.

Ahmedabad Ombudsman Centre

Case no 11-002-252-10

Mr.Kamlesh R Sadhu Vs

The New India Assurance Company Ltd

Award Date: 04-12-2009

Partial Settlement Claim under Mediclaim policy: The complainant has submitted the claim for reimbursement of expenses incurred in hospitalization for treatment of Obstructive Sleep Apnea . The Respondent has settled the claim in partial by invoking exclusion clause 1(D){c}of the group medi claim policy which excludes the reimbursement of non –medical expenses including CPAP,CAPD Oxygen concentrator for Bronchial Asthmatic condition infusion pump. On examination of terms of the policy it is found that the decision of the respondent to repudiate the claim is justified .The complaint fails to succeed.

Case no 11-011-467-10

Mr. Kanubhai B Patel Vs

The Bajaj Allianz General Insurance Company Ltd

Award Date : 26-02-2010

Repudiation of Claim under Mediclaim Policy: The claimant has submitted the claim for reimbursement of expenses incurred in hospitalization for operation of Rt .Eye Cataract. The respondent has repudiated the claim by invoking exclusion clause C(3) of policy which states that treatment expenses for Cataract is excluded for first two years .The complainant has stated that he has requested the respondent for the policy in continuation of old policy with national insurance co. along with accrued bonus ,the policy was issued treating it a fresh policy. It is established by the papers submitted that the policy issued by the respondent without mentioning accrued bonus was accepted by the complainant .No request for cancellation of policy was made by him even he renewed the same .Hence the subject policy has exclusion clause in operative and the decision of the respondent to repudiate the claim is justified .The complaint fails to succeed.

Case no 11-004-0448-10

Mr. Prakash Shah vs

The United India Insurance Company Ltd

Award Date: 26-02-2010

Partial Settlement Claim under Mediclaim policy: The complainant has submitted the claim for Rs 219388/ for reimbursement of expenses incurred in hospitalization for treatment of Rt.Knee Joint Replacement The Respondent has settled the claim for RS 205287 in partial by invoking clause 1.2 of the policy which restrict the reimbursement of expenses incurred for major surgery up to70% of sum insured or maximum of RS 2 Lacs and pre and post hospitalization expenses up to 10% of sum insured. During the course of hearing it is confirmed by the respondent that they have considered the one part of the clause , the other part of the clause relating to payment up to 10% of S.I. towards pre and post hospitalization expenses overlooked Hence the respondent has been directed to pay RS 14101/ to the complainant towards full and final settlement of claim .The complaint is succeeded

Case no 11-03-376-10

Mr. Rati lal C Prajapati Vs

The National Insurance Company Ltd

Award Date : 26-02-2010

Repudiation of Claim under Mediclaim Policy: The claimant has submitted the claim for reimbursement of expenses incurred in hospitalization from 11-07-2009 to 15-07-2009 for treatment of Ischemic Heart Disease ,Hypertension Diabetes Mellitus with history of 6 months.. The respondent has repudiated the claim by invoking exclusion clause 4.3 of policy which states that treatment of diseases such as Cataract ,diabetes ,hypertension is excluded for first two years .The policy has been issued by respondent for 2lakhs sum insured since 17-06-2008.It is established by the papers submitted that the complainant has taken treatment for diabetes mellitus and hypertension within 2 years of policy incepted and expenses are excluded Hence the subject policy has exclusion clause in operative and the decision of the respondent to repudiate the claim is justified .The complaint fails to succeed.

Case no 11-02-0403-10

Mr. Niranjan V Maniar Vs

The New India Assurance Company Ltd

Award Date : 26-02-2010

Partial Settlement of Claim under Mediclaim Policy: The claimant has submitted the claim for reimbursement of expenses incurred in hospitalization on 07-09-2009 for treatment of Cataract The respondent has partially settled the claim by invoking clause 2.1,2.3,and 2.4 and Note 1 as also condition no 4.3 of policy and disallowing under various heads like room charges surgeon' charges etc. The policy has taken by the Complainant since 03-04-2000 for sum insured 35000/ and increased to 1 lakh from 2007.The respondent has applied two standards in terms & conditions under the same policy .It is established by the papers submitted that the increased sum insured attracts waiting period of two years and enhanced sum insured cannot be considered for settlement of claim .The revised terms & conditions effected from 2007 cannot be applied for old sum insured and waiting period has already expired .Hence the decision of the respondent to repudiate the claim is set aside and they have been directed to make the payment to the complainant .The complaint stands to succeed.

Case no 11-04-0389-10

Mr. Ganeshbhai Patel Vs

The United India Insurance Company Ltd

Award Date : 26-02-2010

Repudiation of Claim under Mediclaim Policy: The claimant has submitted the claim for reimbursement of expenses incurred in hospitalization on 20-11-2008 for treatment of cardiac disease and primary treatment for jaw injury and settled by the respondent . The Complainant subsequently took dental treatment on OPD basis and submitted the claim . The respondent has repudiated the claim by invoking clause 4.7 of policy stating that hospitalization is not justified .Hence the decision of the respondent to repudiate the claim is justified as per exclusion clause and no relief is given to the Complainant. The complaint fails to succeed

Case no21-01-0380-10

Ms Champaben R Patel Vs

Life Insurance Corporation of India

Award Date : 26-02-2010

Repudiation of Accidental Claim under Life Insurance Policy: The claimant has submitted the claim for accident benefit on death of the DLA on 27-04-2009 due to tetanus .The respondent has repudiated the claim stating that

available evidences failed to prove the accidental death. It is established that the DLA was admitted in the hospital for treatment of crush injury over left leg but no police complaint ,post mortem report has been done which can prove the accident ..Hence the decision of the respondent to repudiate the claim is justified as per exclusion clause and no relief is given to the Complainant. The complaint fails to succeed

Case no 11-04-0407-10

Mr Hansmukhbhai V Thakkar Vs

United India Insurance Company Ltd

Award Date: 24-02-2010

Repudiation of Claim under Mediclaim policy: The complainant has submitted the claim on 03-06-2009 for reimbursement of expenses incurred in hospitalization from 06-04-2009 to 14-04-2009 .The respondent has repudiated the claim due to late submission of claim . However on mediation by this forum both the parties mutually agreed for payment of RS 86590/as full and final settlement of the claim .The grievances thus resolved.

Case no 11-009-314-10

Ms Rekhaben M Kukreja vs

Reliance General Insurance Company Ltd

Award Date: 29-01-2010

Repudiation of Claim under Mediclaim policy: The complainant has submitted the claim for reimbursement of expenses incurred in hospitalization from 30-07-2008 to 05-08-2008.The respondent has repudiated the claim by invoking terms& conditions no 12 of policy . However on mediation by this forum both the parties mutually agreed for payment of RS 8900/as full and final settlement of the claim .The grievances thus resolved.

Case no 11-03-371-10

Ms Rasilaben D Herbha Vs

The National Insurance Company Ltd

Award Date: 29-01-2010

Repudiation of Claim under Mediclaim Policy: The claimant has submitted the claim for reimbursement of expenses incurred in hospitalization from 27-04-2009 to 11-05-2009 for treatment of CAD, IHD triple vessel disease, with history of diabetes mellitus type 2 since 5years. The respondent has repudiated the claim by invoking exclusion clause 4.1 of policy which states that treatment of all diseases/injuries which are pre existing when the cover is incepted for the first time are excluded from policy for first 4 years. The respondent has pleaded that the complainant was having diabetes mellitus since 5 years and it is major risk factor in case of coronary artery disease. The respondent has not produced any concrete evidence to prove that the present illness was as a complication of diabetes whereas the treating doctor has stated that present disease is not connected to diabetes .Therefore the decision of the respondent to repudiate the claim under exclusion clause 4.1 is not justified and they have been directed to make the payment to the complainant .The complaint stands to succeed.

Case no 11-04-0333-10

Mr. Vinaychandra D Parmar Vs

The United India Insurance Company Ltd

Award Date : 29-01-2010

Repudiation of Claim under Mediclaim Policy: The claimant has submitted the claim for reimbursement of expenses incurred in hospitalization on 23-04-2009 for treatment of Angiography and the same was settled by the respondent .The complainant was again hospitalized on 14-05-2009 and submitted the claim on 19-06-2009. The respondent has repudiated the claim stating that the intimation of hospitalization is not given within 24 hours and the claim file is not submitted within 15 days from the date of discharge .The hospitalization was for 24hours it would be hardly possible to verify by the respondent and post hospitalization treatment was continued up to 09-06-2009 .Thus the delay was only 3 days and the respondent has considered the delay and should have condoned the same .Therefore the decision of the respondent to repudiate the claim is set aside and directed to make the payment to the complaint .The complaint stands succeeds.

Case no 11-04-0318-10

Mr. Kamlesh H Shah Vs

The United India Insurance Company Ltd

Award Date : 06-01-2010

Repudiation of Claim under Mediclaim Policy: The claimant has submitted the claim for reimbursement of expenses incurred in hospitalization from 19-05-2009to 25-05-2009 for treatment of Acute Viral Hepatitis. The respondent has repudiated the claim stating that the intimation of hospitalization is not given within 24 hours as required under the terms &conditions of the policy .The complainant has pleaded that he was not conversant with the procedure and he was under tension of hospitalization .The policy clause denying the claim has provision for condonation of delay in submission of claim papers. Therefore looking to the circumstances and the facts there is no other infirmity in the bills and receipts produced by the complainant claim requires some consideration .Hence the respondent has been directed to make the payment on ex gratis basis to the complaint .The complaint stands succeeds.

Case no 11-002-0425-10

The New India Assurance Company Ltd. Vs

Mrs. Pushpa V Shah

The ursement of expenses incurred in hospitalization from 18-08-2009 to 20-08-2009 for treatment of Malaria .The respondent has settled the claim partially by invoking clause 2.10 of policy which states that the certain expenses are not admissible as per condition of policy .The respondent has submitted that RS 600/debited towards room rent charges treating it as nursing charges .As regards the visit charges ,no bifurcation charges is shown by hospital as visit charges or consultation charges .The respondent has not provided any satisfactory explanation for deduction of RS 900/ Hence The respondent has been directed to make the payment of RS 900/ to the Complainant The complaint has partially succeeds .

Ahmedabad Ombudsman Centre

Case no 11-002-0437-10

Ms. Janakben M Golater Vs

The New India Assurance Company Ltd

Award Date: 31-03-2010

Repudiation of Claim under Mediclaim policy: The complainant has submitted the claim for reimbursement of expenses incurred in hospitalization from 25-04-2009 to 26-04-2009 for treatment of Acute

Coronary Syndrom and history of Hypertension .The respondent has repudiated the claim by invoking clause 4.1 of policy which states that all diseases /injuries which are pre existing when the cover is incepted are excluded for first four years. The complainant has pleaded that at the time of inception of policy very medical tests were asked for and policy was issued without any specific exclusion of disease or loading on premium in spite of abnormal ECG .History of HT recorded by treating doctor without duration , does not establish that the complainant was suffering from HT prior to inception of policy .The treating doctor has also confirmed on annexure A that there is no history of HT .Hence the decision of the respondent to treat the disease as pre existing is not based on any corrobative evidence therefore they have been directed to make the payment to the complainant . The complaint has succeeds .

Ahmedabad Ombudsman Centre

Case no 11-005-0413-10

Mr Vijay P Mudia Vs

The Oriental India Insurance Company Ltd

Award Date: 11-03-2010

Settlement of Claim under Mediclaim policy: The complainant has submitted the claim for reimbursement of expenses incurred in hospitalization from 20-02-2009 to 21-02-2009 for treatment of Cough and breathlessness and during the treatment the insured was died .The respondent has settled the claim and kept the money in abeyance to decide the legal heir or title .The complainant submitted the copy of will executed by insured and the copy of bank passbook opened in the name of the insured .Hence the decision of the respondent to keep the amount is not justified and was directed to deposit the claim amount into the bank account opened in the name of trust by obtaining indemnity bond. The grievances resolved.

Case no 11-012-398-10

MR Ashok H Shah Vs

Star Health and Allied Insurance Company Ltd

Award Date: 31-03-2010

Repudiation of Claim under Mediclaim policy: The complainant has submitted the claim for reimbursement of expenses incurred in hospitalization from 19.06.2009to 23.06.2009.The respondent has repudiated the claim by invoking terms& conditions no 3.11 of policy . However on mediation by this forum both the parties mutually agreed for payment of RS 5000/as full and final settlement of the claim .The grievances thus resolved.

Case no 11-005-517-10

MR Jignesh S Patel Vs

The Oriental Insurance Company Ltd

Award Date: 31-03-2010

Repudiation of Claim under Mediclaim policy: The complainant has submitted the claim for reimbursement of expenses incurred in hospitalization from 22.05.2009to 25.05.2009.The respondent has repudiated the claim by invoking terms& conditions no 4.12 of policy. However on mediation by this forum both the parties mutually agreed for payment of RS 32400/as full and final settlement of the claim .The grievances thus resolved.

Case no 11-04-0506-10

Mr. Kishore C Mehta Vs

The United India Insurance Company Ltd

Award Date : 31-03-2010

Repudiation of Claim under Mediclaim Policy: The claimant has submitted the claim for reimbursement of expenses incurred in hospitalization for treatment of left eye cataract by phaco-emulsification with IOL implantation on 26-09-2009 . The respondent has repudiated the claim stating that the intimation of hospitalization is not given within 24 hours .The hospitalization was for 24hours it would be hardly possible to verify by the respondent and the complainant has submitted that the hospitalization day was Saturday and he was discharge on the same day .TPA has changed the office hence the messenger could not find the office .The respondent has considered the delay and should have condoned the same .Therefore the decision of the respondent to repudiate the claim is set aside and directed to make the payment to the complaint .The complaint stands succeeds.

Ahmedabad Ombudsman Centre

Case no 11-02-0494-10

Mr. Gunjan R Thakur Vs

The New India Assurance Company Ltd.

Award Date : 30-03-2010

Repudiation of Claim under Mediclaim Policy: The claimant has submitted the claim for reimbursement of expenses incurred in hospitalization from 26-06-2009to 28-06-2009 for treatment of Acute Lower Back Pain ,PID ? L5 –S1 –L4 . The respondent has repudiated the claim stating that the treatment expenses for pro-lapse Inter Vertebral Disc for first two policy years are excluded unless it arises from an accident .The complainant has submitted that insured while unloading the oil barrel at home suffered acute back pain and it was accidental back pain .The first consultation paper and discharge summary shows the lower back pain after bending forward while working at home .The claim has occurred in waiting period ,therefore the decision of the respondent to repudiate the claim is justified .The complaint fails to succeed.

Case no 11-04-0522-10

Mrs Manjulaben C Mehta Vs

United India Insurance Company Ltd

Award Date : 31-03-2010

Non Settlement of Claim under Mediclaim Policy: The claimant has submitted the claim for reimbursement of expenses incurred in hospitalization from 11-08-2009to 13-08-2009 for treatment of Cystoscopy + BM,RGP . The respondent has neither settled the claim nor replied to the complainant .Moreover they have neither submitted the reply to this forum nor were present in the hearing .Therefore the respondent has been directed to settle the claim and make the payment with interest till the date of payment as per policyholder 'protection act. The complaint stands to succeed.

Case no 11-02-0470-10

Mrs Manjulaben C Mehta Vs

United India Insurance Company Ltd

Award Date : 31-03-2010

Non Settlement of Claim under Mediclaim Policy: The claimant has submitted the claim for reimbursement of expenses incurred in hospitalization from 11-08-2009to 13-08-2009 for treatment of Cystoscopy + BM,RGP . The respondent has neither settled the claim nor replied to the complainant .Moreover they have neither submitted the reply to this forum nor were present in the hearing .Therefore the respondent has been directed to settle the claim and make the payment with interest till the date of payment as per policyholder 'protection act .The complaint stands to succeed.

Award dated 15-10-2009

Case No. 11-002-0217-10

Mr. Rameshchandra Keshavlal Zala Vs. New India Ass..Co. Ltd.

The claim was partially settled by Respondent under Individual Medishield policy by disallowing Rs.7500/- out of the total amount of Rs.42286/-claimed by the Complainant. As per the Respondent's written submission the amount disallowed was towards surgery charges paid to the Hospital in cash.

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. 7500/.

Award dated 15-10-2009

Case No.11-005-0197-10

Ms. Rajni R Gangarade Vs. Oriental Insurance Co.Ltd.

The MediClaim was repudiated by the Respondent invoking Exclusion Clause 4.8 of Mediclaim Policy which specifically excludes the claim for expenses incurred on treatment arising out of use, misuse or abuse of drugs/ alcohol or use of intoxicating substances or such abuse or condition etc.

The insured was under treatment of Dr. Jitendra Jadvani at Yogini Hospital from 23.8.2008 to 27.8.2008 for Viral Hepatitis, Hypoprotemia and prehepatic failure. As per certificate (undated) of Dr. Jitendra Jadvani DI was suffering from Hepatitis, Hypoprotemia and Ascites. Further he had stated in his reference letter to Dr. Sanjay Rajput that insured was suffering from Alcoholic Hepatitis how ever he was not sure about Alcoholic Hepatitis and insured was referred to Sanjay Rajput for further expert medical management.

As per discharge summary of Sardar Patel Hospital, Ahmedabad Insured was hospitalized at the hospital from 27.8.2008 to 1.9.2008 diagnosis was Hepatic Encephalopathy and he was treated for Viral Hepatitis, Ascites and Hypoprotemia. Insure died on 13.10.2008. the hospitalization was for treatment or a consequence of DI's alcohol abuse.

Since the Respondent has produced concrete evidence to show that the Insured was a case of Chronic Alcoholism and treated for Alcoholic Liver Disease and also produced evidence in support of his contention that the insured was in the habit of consuming alcohol the claim was dismissed.

Award dated 15-10-2009

Case No.11-009-0254-10

Mrs. Manishaben Ashwin Modi Vs. Reliance Gen. Insurance Co.Ltd.

The dispute relates to repudiation of Mediclaim by invoking clause 15.0 of the Policy.

On mediation by Forum, the Respondent agreed to settle the claim for a sum of Rs.25000/- as full and final settlement of the claim to which the Complainant also agreed. An agreement to this effect was signed jointly by both the Complainant and the Respondent.

As the complaint was resolved mutually between the two parties, no formal award is issued.

Ahmedabad Ombudsman Centre

Award dated 15-10-2009

Case No.11-004-0277-10

Mr. Rajeshkumar K Panchal Vs. The United India Ins.Ltd.

The complainant submitted that he has lodged the claim under Mediclaim policy for reimbursement of a sum of Rs.15831/- incurred by him for medical treatment of his wife. Respondent repudiated the claim invoking exclusion Clause 5.3 & 5.4 of Mediclaim Policy.

On mediation by this forum, the Respondent offered to pay an amount of Rs.12665/- which was accepted by the complainant and token of his agreement he signed a joint statement to this effect with the Respondent.

The case was disposed on compromise

Award dated 15-10-2009

Case No.11-002-0069-10

Mr.Parag Ishwarlal Joshi Vs. New India Assurance Co.Ltd.

The Mediclaim Claim lodged for treatment of Right Herniotomy operation was repudiated by the Respondent on the ground that the subject disease was "Congenital External Condition".

The Respondent had not obtained opinion of the medical expert to arrive at the decision.

This forum earlier in similar type of case had obtained opinion from an independent specialist Dr. Jitendra Desai, MS, DLO, FICS(USA), FFIMAS, according to it :

The inguinal hernia may develop at any age.

And if the hernia is present at any time of birth or in the early infancy or say before the first birthday, then it can be called congenital external Hernia. If it appears for the first time after this period, even though it is through the patent processus Vaginalis, due to the opening of collapsed processus vaginalis due to secondary factors it is considered as Acquired and not congenital external hernia".

The age of the insured was 5 years (age nearer birthday) at the time of treatment with H/o disease six months.

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

Award dated 30-11-2009

Case No. 11-002-0248-10

Mr. Mukesh Gupta Vs. New India Assurance Co.Ltd.

The dispute is about the short payment of the claim under Mediclaim policy by an amount of Rs.15717/-

There is on record a written submission from the Respondent that the Complainant opted for higher room rent than entitled category invoking clause 2.3 and 2.4 note 1 of the policy. They have taken the Sum Insured in respect of the insured as Rs. 35000/ and accordingly worked out the amount payable. There is on record a copy of the policy document for the period 28.10.2008 to 27.10.2009 where the sum insured had been given as Rs. 100000/ with cumulative bonus of Rs. 7750/.

As per Mediclaim policy (2007) claims related to subject ailment has a waiting period of two years from the date of inception of policy.

The Complainant's pleaded that his Mediclaim policy has been in force since last 9 years without break with the Respondent. Respondent has to consider new sum insured Rs. 1 lac for application of new policy conditions else the claim should be settled considering the old Sum Insured without applying the new condition of restricting room rent to 1% of the Sum Insured.

The Respondent submitted that they had obtained fresh proposal form at the time of renewal of policy in the year 2007 when the new policy conditions came into force. The Complainant had also accepted them and paid the premium accordingly.

The claim was preferred in the policy year for the period from 28.10.2008 to 27.10.2009. Since under the policy there is a waiting period of two years for the subject disease the Respondent has considered the claim for the policy year 2006-2007 where the Insured was covered for SI of Rs. 35000/ with CB of 10%. The respondent has rightly considered SI of Rs. 35000/ being SI prior to the renewal of policy with increase in SI by Rs. 65000/ for the policy year 07-08.

Considering the claim with SI prior to policy year 07-08 before revision of terms and condition of the policy and settling the claim by applying revised terms and condition of the policy renewed from year 07-08 by the respondent is not justified and is arbitrary. The insured is entitled for SI of Rs. 35000/ with CB of Rs. 2000/ as terms and condition of the policy prior to policy year 07-08 which did not link hospitalization expenses with the ceiling of room rent as one percent of the Sum Insured.

The insured is entitled for SI Rs.35000/ with CB Rs. 2000/- (10% of SI 20000/-). Total amount claimed is Rs. 27402/- and respondent is not

justified in applying new terms and conditions when the claim is being considered for Sum Insured prior to Mediclaim Policy 2007.

The Respondent was directed to pay balance amount of the claim.

Ahmedabad Ombudsman Centre

Award dated 30-11-2009

Case No. 11-004-0269-10

Mr. Pankaj M Bagri Vs. The United India Insurance Co.Ltd.

Mediclaim had been repudiated caused by invoking General Exclusion of the Mediclaim policy on the ground that hospitalisation was for less than 24 hours.

The claim form dated 30.3.2009 submitted by the complainant gives details of dates only; there is no mention of time of admission and time of discharge. The details about time of admission and discharge were given when called for by the Respondent. Discharge at mid night 12.00 O'clock is difficult to believe as normally a Hospital does not discharge a patient at midnight. Even if we take it as correct then it is but natural that after midnight the date changes and date of discharge should have been mentioned as 24.3.09.

From the papers on record it is not established that the insured was discharged at midnight on 23.03.2009 which confirms that hospitalisation was for less than 24 hours.

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

Ahmedabad Ombudsman Centre

Award dated 29-12-2009

Case No.11-002-0299-10

Mr. Mr. Harishankar Govindram Sharma Vs.

United India Ins. Co.Ltd.

The MediClaim 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. 29955/.

Ahmedabad Ombudsman Centre

Award dated 30-12-2009

Case No.11-002-0303-10

Mr. Mr. Thakorlal Thakor Vs. New India Ass.. Co.Ltd.

The Mediclaim had been repudiated invoking clause 4.4.11 of the policy by M/s MD India Healthcare (Services) TPA Pvt. Ltd. vide there letter dated 30.6.2009 stating that giving drugs like avastin or Lucentis or Macugen and other related drug as intravetral injection, is an OPD treatment though the injection is given in the operation theatre. In view the nature of treatment, it falls outside the scope of Health Policy. Hence, the treatment of ARMD with administration of above referred drugs or any other

drug is excluded from the scope of cover. Therefore hospitalisation is not required. Hence we repudiate the claim under following clause 4.4.11 as per terms and conditions of the policy. "Diagnostic, X ray, or laboratory examination not consisted with or incidental to the diagnosis of positive existence and treatment of any ailment, sickness or injury, for which confinement is required at a Hospital/Nursing Home."

The Complainant submitted that treatment of ARMD falls squarely in the category of Eye Surgery and as per clause 3.4 of the terms and conditions of the subject policy it does not require 24 hours hospitalization

The Complainant also produced copies of certificate issued by Dr. Clyrus Shroff, President Vitreo Retinal Society of India and Dr. Lalit Verma, Hon. Gen. Secretary, All India Opthaimological Society. Both the doctors have certified that intravitreal injection is an intra vitreal surgical procedure required to be carried out in operation theatre taking lot of care to prevent infection and other things, and it is not an OPD procedure

The forum viewed that the circular issued by the corporate office of the Respondent dated 09-02-2009 which excludes the payment of such treatment treating it as an OPD process is an internal administrative instruction and does not form part of the policy conditions. It cannot be made operative unilaterally without informing the insured. It also does not form list of exclusions which are part of terms and conditions of the policy.

Thus complaint succeeded and Respondent was directed to settle claim

---

Award dated 3-12-2009

Case No.11-004-0283-10

Mr. Rameshbhai D Patel Vs. United India ins. Co. Ltd.

The dispute is about the quantum of claim amount under Mediclaim policy. The complainant had incurred an expense of Rs. 46113/ for hospitalization and treatment while the Respondent had settled the claim for Rs. 15244/ So, there was short payment of Rs. 30869/- for which complainant wants reimbursement.

The claim was settled by invoking policy clause 1.2 which stipulates that the reimbursement of expenses incurred for Hernia will be 15% of the Sum Insured or maximum Rs. 30000/- and pre and post hospitalization expenses shall be maximum 10% of Sum Insured

The claim was settled for a sum of Rs. 15244/- by the Respondent out of which Rs. 15000/ was towards hospitalization expenses (15 % of Sum Insured) while Rs. 244/- was for pre and post hospitalization expenses (10% of Sum Insured subject to actual expenses).

The complainant submitted that he underwent two surgeries for Obstucted umbical Hernia and left direst inguinal Hernia hence he is entitled for Rs 30000/ of claim amount.

Respondent submitted that as per policy condition they have rightly settled the claim for Rs. 15244/ (15% of Sum Insure of Rs. 100000/ for hospitalization expenses plus Rs.244/ towards pre and post hospitalisation expenses (10% of SI subject to actual) as per terms and conditions of Policy.

As per terms and conditions of the policy in case of hospitalization for treatment for Hernia reimbursement of expenses is restricted to 15 % 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.

Award dated 31-12-2009

Case No.11-004-0293-10

Mr. Yusuf Ismailji Baxamusa Vs.

United India ins. Co. Ltd.

The dispute is about the short payment under Mediclaim policy which according to the Respondent is Rs.11250/- and the Complainant is demanding Rs. 45000/ on the grounds that Sum Insured under the policy for the year 2008-09 is Rs. 100000/ with cumulative bonus of Rs. 35000/-

The complainant was covered under the policy with a sum insured of Rs.75000/- since1999. The Sum Insured was increased from Rs.75000/ to Rs. 1.25 lac for policy year 2007-08 with revised terms and conditions. The Complainant renewed the policy for the period from 17.11.2008 to 16.11.2009 for Sum Insured of Rs. 1 lac with total cumulative bonus of Rs. 35000/. The subject claim is preferred in policy year 2008-09.

The Respondent submitted that the Complainant is entitled for SI of Rs. 75000/ along with cumulative bonus of Rs. 26250/ (35% of SI) Total Rs. 101250/-and they have to make balance payment of Rs. 11250/ since TPA has already reimbursed an amount for Rs. 90000/-.

The Respondent renewed the subject Policy with revised terms and conditions where in as per exclusion clause 4.3 joint replacement due to degenerative condition and age related Osteoarthritis will be covered under the Policy after 2 years from the date of inception of the cover. Since the enhanced sum insured under the renewed Policy is effective with effect from 17.11.2007 claim will be governed by two year waiting period as per clause 4.3 of the policy.

The decision of the Respondent to settle the claim for an amount equal to the original Sum Insured of Rs. 75000/- + Cumulative Bonus there on @ 35% Rs. 26250/ total Rs. 101250/ is justified as per terms and conditions of the Policy.

The complaint succeed partially

==========

Award dated 9-12-2009

Case No.11-012-0288-10

Mr.Ashish Amrathlal Gorakh Vs. ICICI Lombard Gen. ins. Co. Ltd.

Complainant had lodged claim under Mediclaim policy for expenses of Hospitalization & treatment for Knee Joint Replacement.

Claim repudiated by the Respondent by invoking exclusion clause 1 of Mediclaim policy which excludes payment for all diseases/injuries which are pre-existing when the cover incepts for first time.

The policy is incepted on 12.9.2006 and the subject claim was preferred in the second policy year for the period from 12.9.2007 to 11.9.2008. The insured underwent surgery for left total knee replacement and right total knee replacement in the month of February 2007 and July 2008 respectively. At the time of left total knee joint replacement insured had history of Osteoarthritis for two-three years as also there were symptoms for right knee. The History of the disease obviously goes prior to the inception of the policy.

As per medical experts opinion Osteoarthritis of knee is a chronic slowly progressive illness which after many years of existence becomes symptomatic. Initially there is waxing and waning of symptoms with or without treatment. After this the interval of symptoms free period goes on diminishing and patient require oral medicines but they will do with it for few more years. When symptoms become continuous and little more severe

patient require definitive ortho treatment and do well again for few to many years with it. Only after several years of existence this degenerative arthritis progress to such a stage with secondary changes that some operative intervention is necessary.

Exclusion clause No.1 of policy issued by the Respondent is operative hence case dismissed.

Award dated 13-01-2010

Case No.11-010-0322-10

Mr. D S Patel Vs. IFFCO-TOKIO Gen. Insurance Co. Ld.

The Complainant underwent Angioplasty on 18.4.2009 The Mediclaim was repudiated by invoking clause 2 of the Policy on the grounds that the claim occurred within 90 days from the date of commencement of insurance cover Viz. 22.1.2009. Date of issue of policy is 7.1.2009 and risk commences after completion of 15 days form the date of issue of the policy.

The complainant submitted that he was not informed about any of the policy condition.

The policy was issued on 7.1.2009 with a provision that insurance cover would commence after completion of 15 days from the date of issue thus date of commencement of risk under the policy is 22.1.2009. Date of hospitalisation was 18.4.2009 thus claim occurred after 86 days from the date of commencement of insurance cover.

The claim had been repudiated by invoking clause 2 of the policy which interalia states that "Any expenses on Hospitalisation for any critical illness other than Major injuries which incept during first 90 days of commencement of this insurance cover. This exclusion shall not apply in case of the insured Person having been covered under a Group or individual Medical Insurance Policy with any of Indian Insurance Companies for a continuous period of preceding 12 months without any break".

Since the claim submitted by the complainant does not fulfill the policy conditions for critical illness claim benefit the repudiation of the claim by the respondent is justified. The Complaint dismissed.

Ahmedabad Ombudsman Centre

Case No.11-002-0339-10

Mr. Madhusudan V Bhatt Vs.

The New India Assu. Co. Ltd.

Award dated 27-01-2010

Partial repudiation of Mediclaim. The dispute is about the amount of payment which according to the Respondent is Rs.42000/- and the Complainant is demanding Rs. 54944/ on the grounds that Sum Insured under the policy for the year 2008-09 is Rs. 100000/ with cumulative bonus of Rs. 10250/-

The complainant was covered under the policy with a sum insured of Rs.35000/-since 2001. The Sum Insured was increased from Rs.35000/ to Rs. 1 lac for policy year 2007-08 with revised terms and conditions. The Complainant renewed the policy for the period from 24.10.2008 to 23.10.2009 for Sum Insured of Rs. 1 lac with total cumulative bonus of Rs. 10250/. The subject claim is preferred in policy year 2008-09.

The Respondent submitted that the Complainant is entitled for SI of Rs. 35000/ along with cumulative bonus of Rs. 7000/ (20% of SI) Total Rs. 42000/-and they have made the payment of Rs. 42000/ initially Rs. 40250/ and subsequently Rs. 1750/

Since the enhanced sum insured under the renewed Policy is effective with effect from 24.10.2007 claim will be governed by two year waiting period as per clause 4.3 of the policy.

The decision of the Respondent to settle the claim for an amount equal to the original Sum Insured of Rs. 35000/- + Cumulative Bonus there on @ 20% Rs. 7000/ total Rs. 42000/ is justified as per terms and conditions of the Policy.

Therefore claim was dismissed.

Ahmedabad Ombudsman Centre

Award dated 29-01-2010

Case No.11-002-0357-10

Kaniyalal H Dodiya Vs. New India Assu.Co. India

The dispute relates to repudiation of Mediclaim due to non-submission of requirements for claim processing.

The complainant submitted that despite of timely submission of claim forms along with relevant papers the claim was not settled by the Respondent.

From the perusal of record it was found that the complainant had submitted discharge letter, discharge summary with detailed medical history and past policy details in compliance of the requirements. It was also observed that the respondent had written on the query letter itself that policy was incepted from 10.9.2004 and they have no claim details under the policy for the period from year 2004 to 2008 and TPA E_Meditek acknowledged requirements on 9.5.2008 with the re-mark "Query received"

Since the complainant submitted all the requirements and same were received by the Respondent the decision to repudiate the subject claim by the Respondent was found unjust and unfair, there were no other infirmity found in the papers submitted. The Respondent was directed to settle the claim.

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

It has been find that No evidence submitted by Sr. Branch Manager of LIC that DLA was in the habit of drinking alcohol or chewing tobacco. The investigation report confirms that DLA had an income of Rs.5,000/- per month so meager to finance insurance for Rs.5.00 lacs but the respondent did not question about income and occupation of DLA at the time of granting insurance. The Respondent has failed to prove deliberate

misstatement in proposal in respect of income, occupation and habit of consuming alcohol and tobacco. There is no documentary evidence to support ground of repudiation of claims. So Respondent's decision to repudiate the claim is set aside and directed to settle the claim.

Ahmedabad Ombudsman Centre

CASE NO. 11-005-0224-10

Mr. J D SHAH V/S

ORIENTAL INSURANCE CO.LTD.

Award Dated : 24.11.09

Complaint lodged for Partial settlement of Mediclaim. Respondent applied clause 2.1(3) restricting the sum insured stating that disease arthritis having waiting period of two years. Renewal of policy in the year 2007-08, with increased sum insured wherein disease is having restriction for four years. The insurance is in continues period without any break since April 2005. Insured admitted in the month of March 2009 and lodged claim with Respondent. Upon scrutiny of the papers it is decided to allow benefit in the year 2006-07 policy wherein Sum insured is upto 150,000/- with CB. The respondent was directed to pay the claim.

Ahmedabad Ombudsman Centre

CASE NO. 11-002-0249-10

MR.ASHOK CHAUHAN V/S

THE NEW INDIA ASSURANCE CO. LTD.

Award Dated : 10-11-2009

Mediclaim repudiated invoking clause 5.5 of the Mediclaim Policy on the grounds of fraud, misrepresentation, concealment of facts. Insured admitted hospital for the treatment of entric fever and a claim preferred for Rs.

17210/-. Respondent submitted note alongwith evidence wherein attending doctor admitted that he has favoured in preparing excessive billing to the tune of Rs. 8000/-. It is established that as per policy conditions Respondent's decision to repudiate the claim is upheld without any relief to the complainant.

Ahmedabad Ombudsman Centre

CASE NO. 11-012-0264-10

MR.ASHSIH V. BHAVSAR V/S

ICICI LOMBARD GENERAL INSURANCE CO.LTD.

Award Dated : 27.11.2009

Mediclaim repudiated invoking clause 2.14 of the Critical Care policy on the grounds of pre-existing disease. Insured hospitalized for the treatment of Renal failure. Respondent submitted set of papers and reports, from the available records it is noticed that insured suffering from Hypertension since 2007, and past history of kidney related disease since one year. It is established that Respondent's decision to repudiate the claim is upheld without any relief to the complainant.

Ahmedabad Ombudsman Centre

CASE NO. 11-004-0247-10

MR. KISHORKUMAR R. THAKKAR V/S

UNITED INDIA INSURANCE CO. LTD.

Award Dated : 23.11.2009

Mediclaim repudiated invoking clause 5.3 on the grounds late submission of intimation. Insurerd admitted on 30.08.09 to 06.09.08, and submitted all relevant claim form and papers on 06.10.10 for Rs.11342/-, which means intimation lodged after 35 days late. As per policy conditions intimation must be given within 24 hours to Insurer. As a result of mediation by this Forum, the Respondent and complainant mutually agreed for sum of Rs.8500/- as full and final settlement of the claim.

without any relief to the complainant.

CASE NO. 11-009-0284-10

Mr. Dipak H. Shukla V/S

RELIANCE GENERAL INSURANCE CO.LTD.

Award Dated: 11.11.2009

Repudiation of Mediclaim - Complainant himself met with an accident and admitted to the hospital on 17.01.09 and discharge on 19.01.09 for the treatment of "Segmental Double Fracture libia. Respondent rejected the liability invoking clause 21 of the policy stating that treatment could have been taken on OPD basis. From the papers submitted by complainant and also Respondent, it gets established that insured though insured was hospitalized from 17.1.09 to 19.01.09, as the knee POP is OPD process for which hospitalization is not necessary. The Respondent's decision to repudiate the claim is upheld without any relief to the complainant.

Ahmedabad Ombudsman Centre

CASE NO. 11-002-0295-10

Mr. Ranjanben B.Patel V/S

THE NEW INDIA ASSURANCE CO. LTD.

Award Dated : 28.12.2009

Repudiation of Mediclaim invoking clause 3.2 of Mediclaim policy (2007) stating that Hospital/Nursing Home is not eligible to provide the services under the policy terms. As such main dispute is number of beds in hospital 10, as per policy conditions either hospital must be having minimum 15 beds or must be register as "Hospital/Nursing Home" as per policy conditions. Respondent submitted investigation report wherein number of beds in hospital shown as 10, while their TPA has rejected the claim on the basis of their investigation alleged that number of beds are 7 in hospital. This shows inconsistency in the reports of Respondent in respect of number of beds.

Ahmedabad Ombudsman Centre

CASE NO.11-002-0290-10

Mr. DILIP R. PATEL V/S

THE NEW INDIS ASSURANCE CO.LTD.

Award Date: 04.12.2010

Mediclaim rejected invoking clause 4.12, insured underwent treatment for pregnancy, hence respondent rejected the claim Respondent submitted entire set of papers and policy conditions, it was found that insured was suffering abdominal pain for which hospitalization was undertaken. The said facts was shown to the representative of Respondent and agree to compromise for an amount of Rs.6225/-.

Ahmedabad Ombudsman Centre

CASE NO.11-004-305-10

MR. RAJENDER R. PATEL V/S

UNITED INDIA INSURANCE CO.LTD.

Award Date: 18.12.2009

Mediclaim repudiated invoking clause 5.3 & 5.4 of the mediclaim policy stating that intimation of claim must be given to the insurer within 24 hours and all supported claim papers/reports must be submitted within 7 days after discharge from the hospital. Insured admitted on 07.10.09 to 25.10.09, and all relevant papers claim form etc. submitted on 30.01.2009. Complainant submitted claim papers late by 89 days. Respondent submitted all relevant papers, which established exorbitant delay on the part of complainant in submission of papers. The decision of Respondent to reject the claim is upheld without any relief to the complainant.

Ahmedabad Ombudsman Centre

CASE NO.11-004-336-10

MR. ATUL T. SHETH V/S

UNITED INDIA INSURANCE CO.LTD.

Award Date: 08.01.2010

Mediclaim repudiated invoking clause 5.3 of Health Insurance policy on the grounds of late intimation of claim after the stipulated time as per terms and conditions of the policy. Insured admitted to the hospital on 06.05.2009 to 12.05.2009 & submitted papers late by 35 days. As a result of mediation by this forum the Respondent and Complainant mutually agreed for a sum of Rs. 11923/- as full and final settlement of the subject claim. Respondent was directed to pay the amount as per mutually acceptable agreement signed by both the parties as on 05.01.2010.

Ahmedabad Ombudsman Centre

CASE NO.11-005-0347-10

MR. MOHAN K. PUJARI V/S

THE ORIENTAL INSURANCE CO.LTD.

Award Date: 15.02.2010

Mediclaim partially settled by the Respondent. The disputed amount is Rs. 49,548/-. Insured hospitalized for the treatment of CAD+HTN+DM on 01.05.06, for which insured incurred an amount of Rs.1`,74,548/-. Respondent paid Rs.125000/- stating reason that Sum insured is restricted to Rs.125000/- hence, they had paid that amount. Respondent remain absent during the hearing but submitted notes alongwith necessary policy conditions in support of the complaint. While scrutinizing all the papers it is found that insured is adequately covered since 2001,then after he increased / decrease the sum insured every alternate year. In the year 2006 insured was covered for Rs. 3,00,000/ and No exclusion or restricting **claim amount is shown in the policy copy. Repudiation set aside. Allowed balance claim amount for payment.**

Ahmedabad Ombudsman Centre

CASE NO.11-004-0435-10

Mr. GIRISH A. SHAH V/S

UNITED INDIA INSURANCE CO.LTD.

Award Date: 22.02.2010

Mediclaim repudiated on the grounds of late intimation invoking clause 5.4 of the policy. Insured was hospitalized on 20.03.09 and discharged on 21.3.09 and submitted papers on 20.05.09, which means delay of submission of papers by 53 days. Respondent submitted set of papers, no other dispute is mentioned by the Respondent. Complainant stated that because of continue treatment he has sent papers late. This fact was shown to the representative of Respondent and agree to settle the claim on compromise basis. Repudiation of claim set aside. Full amount of claim is allowed for payment.

Ahmedabad Ombudsman Centre

CASE NO.11-009-0382-10

MR. VIPUL S. ACHARYA V/S

RELIANCE GENERAL INSURANCE CO.LTD.

Award Date: 09.02.2010

Mediclaim was rejected invoking clause 15 of the Health wise policy, on the grounds attempt of fraud or mis-representation regarding health of the insured. Insured was hospitalized for the treatment of infective hepatitis on 01.06.09 and discharged on 06.06.09 and submitted relevant reports bills etc. timely. All the relevant papers have been scrutinized and found no irregularties on the part of insured. The facts were shown to the representative of respondent and agree to compromise the claim for Rs. 10700/-.

Ahmedabad Ombudsman Centre

CASE NO.11-002-0377-10

MR. KAMLESH B. PATEL V/S

THE NEW INDIA ASSURANCE CO.LTD.

Award Date: 08.02.2010

Medilciam was rejected on the grounds of non-submission of requirement of Respondent. The insured undcrwent Ayurved treatment hence there is no question of M R I and X-ray report. There is provision to cover Ayurved treatment. The claim is restricted to 25% of Sum Insured. The Sum insured is Rs.1,00,000/- hence, 25 % comes to Rs. 25000/- which is below the claim amount. Repudiation of claim set aside. Allowed full claim amount for payment.

Ahmedabad Ombudsman Centre

CASE NO. 11-009-0378-10

MR. DINESH K. SITAPARA V/S

RELIANCE GENERAL INSURANCE CO.LTD.

Award Date: 08.02.2010

Mediclaim was repudiated invoking clause 11 (B) of policy terms and conditions stating that insured is not co-operating during the visit of Respondent's representative's visit the place of insured. From the available papers and records it is established that hospitalization is justified but repudiation clause is not justified. Hence, Respondent and insured mutually agreed and signed on 08.02.2010 for an amount of Rs. 6000/-. Respondent directed to pay the mutually agreed amount.

Ahmedabad Ombudsman Centre

CASE NO.11-002-0358-10

MR. R M SHAH V/S

UNITED INDIA INSURANCE CO.LTD.

Award Dated: 15.01.2010

Partial repudiation of Mediclaim – insured admitted to hospital on 28.05.09 to 29.05.09 for the treatment of Ischemic Seizure. Insured incurred expenses in total Rs. 49915/- and submitted all relevant bills/report to the Respondent. Respondent partially repudiated claim for Rs.8450/- stating

the reason that amount spent on medicines report were beyond 60 days period. On scrutiny of the all papers and found papers were in order for Rs. 6600/-. Directed Respondent to pay an amount of Rs. 6600/- within 15 days.

Ahmedabad Ombudsman Centre

CASE NO.11-009-354-10

MR. BHARAT S.PATEL V/S

RELIANCE GENERAL INSURANCE CO.LTD.

Award Dated:29.01.2010

The Mediclaim was repudiated invoking clause 21 stating that hospitalization less than 24 hours. Insured admitted hospital on 15.01.2009 and discharged on 16.01.2009. insured met with accident and had fracture at supracondyular region of humerus and there was swelling of soft tissue around elbow joint. Respondent's referee Doctor opined that the treatment given at hospital is as per normal standard, which does not require hospitalization. On scrutiny of the papers it has been observed that on certificate time and date has been overwritten, hence this can be ascertained only by calling hospital authority person and application of legal process like admission / denial of documents, which is beyond jurisdiction for this forum leaving it for the complainant to pursue other means to resolve the grievance either within the frame work of Government Rules under reference or taking recourse to any other forum as may be considered appropriate .

Ahmedabad Ombudsman Centre

CASE NO.11-002-0340-10

MR. GAJENDRA G. PARMAR V/S

THE NEW INDIA ASSURANCE CO.LTD.

Award Dated: 11.01.2010

Partial repudiation of Mediclaim – invoking clause 4.3 of the Mediclaim policy. Insured underwent surgery – piles having waiting period of two years. Respondent submitted that they have considered initial sum insured of Rs.

25000/- prior to renewal of policy in the year 2007. The total expenses incurred Rs. 11,194/- settled Rs. 4219/- and deducted Rs. 6975. As such clause 4.3 is not applicable, insured is eligible for full claim amount which is less than the sum insured. Respondent is directed to pay the balance claim amount.

Ahmedabad Ombudsman Centre

CASE NO.11-003-349-10

MR. M P PANCHAL V/S

NATIONAL INSURANCE CO.LTD.

Award Date: 15.01.2010

Partial repudiation of Mediclaim on the grounds cash payment to Surgon/doctor during the hospitalization is restricted. The disputed amount is Rs. 20350/-, insured paid fees of Rs. 26000/- in cash to surgeon (receipt attached) other than hospital Doctor. Respondent approved only Rs. 5650/- in this bill and deducted Rs. 20350/- stating internal circular restriction is shown on cash payment to surgeon/doctors during the hospitalization. As per the circular it is mentioned that surgeon /Anesthetist fee should be reimbursed maximum 25% of sum insured. Sum insured under the policy is 175000/-, hence 25% comes Rs.43750/-, charges claimed by the insured is well within this limit. Partial settlement set aside. Directed Respondent to pay an amount of Rs. 20350/- within 15 days.

Ahmedabad Ombudsman Centre

CASE NO.11-002-262-10

MR. PRANLAL C. SUTARIYA V/S

THE NEW INDIA ASSURANCE CO.LTD.

Award Date: 15.01.2010

Repudiation of Mediclaim on the grounds of OPD treatment. Insured underwent eye surgery – intravitereal injection is an vitreal surgical procedure requires care to prevent infection. Respondent & complainant submitted papers, from the available opinion of doctors it is established that

insured underwent for surgery which is not OPD procedure as per the internal circular issued by the Respondent's higher office, which is also not known to the insured. Repudiation set aside. Directed to settle the claim for full amount with 15 days.

Ahmedabad Ombudsman Centre

CASE NO.11-09-400-10

MR. S R KOSHTI V/S

RELIANCE GENERAL INSURANCE CO.LTD.

Award Date: 22-02-2010

Mediclaim repudiated invoking clause 6 of Reliance Health wise policy stating that Hospital does not fulfill minimum 15 bed criteria. Respondent submitted entire set of papers, it is established that hospital is having only 7 beds and not registered with appropriate authority as per policy conditions. The decision of Respondent is upheld without any relief to the Complainant.

Ahmedabad Ombudsman Centre

CASE NO.11-002-459-10

MR. HEMANT N. MAKWANA V/S

THE NEW INDIA ASSURANCE CO.LTD.

Award Date: 31.03.2009

Partial repudiation of Mediclaim invoking clause 4.3 of the Mediclaim policy. The insured renewed policy in the month of October 2007 with enhanced sum insured of Rs.1,00,000/-. Insured lodged claim in the month of August 2008, for the treatment of right side uretirc stone & incurred expenses of 50,680/0 .As per new policy terms and conditions this disease fall under the head of waiting period of 2 years. But the policy was continue from earlier year hence earlier Sum Insured Rs. 25000/- approved by the Respondent. The decision of Respondent is upheld without any relief to the Complainant.

Ahmedabad Ombudsman Centre

CASE NO.11-002-414-10

SMT. FALGUNI P.PATEL V/S

THE NEW INDIA ASSURANCE CO.LTD.

Award Date: 26.03.10

Mediclaim repudiated invoking clause 3.2 of the Mediclaim policy on the grounds that the hospital where insured received treatment does not qualify the "Hospital" as per the terms and conditions of the policy. Respondent submitted set of papers it is established insured met with accident and sustained injury hence on urgent basis insured received the treatment. The subject hospital does not have registration and requisite number of beds, as per the policy conditions, the claim could have considered on non-standard basis, as insured met with accident and minor surgery was performed. Repudiation set aside and directed Respondent to pay the 50% of admissible amount of the claim.

Ahmedabad Ombudsman Centre

CASE NO.11-10-439-10

MR. PARAG M. PAREKH V/S

IFFCO TOKIO GENERAL INSURANCE CO. LTD.

Award Date: 22.03.2010

Repudiation of Mediclaim invoking clause 5(1) &6 on the grounds that insured was suffering from diseases which were pre-existing, when the cover was incepted for the first time. The insured was covered with the New India Assurance co. .Ltd. prior to taking insurance with ITGI in the year July 2008. Respondent submitted set of papers and other evidences, it is noticed that the insured lodged two claims for different disease which fall under two policy periods. One claim for the treatment or Renal calculus and other for urethral structure. Repudiation partially set aside and directed Respondent to pay the admissible amount of claim for the treatment of Renal calculus and repudiating the claim for the treatment of urethral structure is upheld.

Ahmedabad Ombudsman Centre

CASE NO.11-004-524-10

MR.MILAN P. ZAVERI V/S

UNITED INDIA INSURANCE CO. LTD.

Award Date: 26.03.2010

Repudiation of Mediclaim invoking clause 5.3 of Mediclaim policy on the grounds of late submission of papers. The insured was admitted to hospital on 11.07.09 to 20.07.2009 for treatment of cirrhosis of liver. Intimation for the hospitalization was given on 24.07.2009, which is treated as late submission of papers. Complainant stated that he has submitted entire set of papers on 24.07.09, this fact was shown to the representative of Respondent. Respondent agree to waive this condition and mutually agree for the settlement. Hence Repudiation set aside. Respondent and complainant mutually agree for an amount of Rs.97000/- and signed on 26.03.2010 by both the parties.

Ahmedabad Ombudsman Centre

CASE NO.11-004-410-10

MR.CHETAN S. SHAH V/S

UNITED INDIA INSURANCE CO. LTD.

Award Date: 10.03.2010

Partial repudiation of Mediclaim invoking clause 1.2-C of the Mediclaim policy. Insured admitted for the treatment of Hysterectomy. This disease is restricted to actual amount spent or 25% of S.I. which ever is less, as per prospectus of the Mediclaim policy. The Respondent approved 20% of claim amount. From the available papers documentary evidence it is established that insured is eligible to get 25% of Sum Insured instead of 20%. Respondent is directed to pay the balance 5% of sum insured within 15 days.

Ahmedabad Ombudsman Centre

CASE NO.11-002-476-10

MR. D R MAKWANA V/S

THE NEW INDIA ASSURANCE CO.LTD.

Award Date: 31.03.2010

Mediclaim repudiated invoking clause 4.3 on the grounds disease suffered by insured is having waiting period of 2 years as per policy conditions. Insured hospitalized for the treatment of high grade fever. Respondent produced that insured was treated fro severe tonsillitis with high grade fever. Policy is incepted since first year, hence Respondent applied exclusion 4.3 stating that disease covered is having restriction of two years. Respondent's decision to repudiate the claim is upheld without any relief to the complainant.

Ahmedabad Ombudsman Centre

CASE NO.11-009-402-10

MR.RAJENDER G. MODI V/S

RELIANCE GENERAL INSURANCE CO.LTD.

Award Date: 26.03.2010

Mediclaim was repudiated invoking clause 15 of the Reliance Health wise policy. Insured was hospitalized for the treatment of uretric stone and total claim for Rs.74826/-. Respondent rejected the liability under clause 15 on the grounds stating that irr- regularties during the hospitalization period. Respondent in support produced Cash paid receipt no.635 dated 31.8.2009 paid to Doctor for Rs.60400/-. During the hearing also insured confirmed for this cash payment. Respondent creating doubt on this cash payment to Doctor. It is established that there wrongly exclusion applied by the Respondent. As a result of mediation by this Forum, the Respondent and the complainant mutually agreed for a sum of Rs. 40,000/- in full and final settlement of the subject claim. The Respondent is directed to pay as per mutually accepted agreement signed on 25.03.2010 by both the parties.

BHOPAL

CATEGORY: MediclaiM Sub Category: TOTAL Repudiation of claim

CASE NO. 1.

Mr. Dilip Yadav……..……..……..……..... Complainant

V/s

Reliance Gen. Insurance Co. Ltd……...Respondent

Order No.: BPL/GI/09-10/32 Case No.: GI/RGI/0709/32

Dated 09.10. 2009

Brief Background

Shri Dilip Yadav (hereinafter called Complainant) was insured under a Mediclaim policy No. 282510224187 for the period 25.08.2008 to 24.08.2009 for S.I. Rs. 100000/- obtained from Reliance General Insurance Co. Ltd., (Hereinafter called Respondent)

As per the complainant all the Mediclaim documents for the hospitalization of his son Mr. Ashwin Yadav were submitted to Respondent on 20.03.2009 for Rs. 3364/- and followed-up vide his letters dated 25.5.2009 and 30.06.2009 but neither the claim is settled nor any response given by Respondent. Aggrieved with the non-settlement of claim the complainant approached this forum for necessary settlement of his claim alongwith interest.

The Respondent vide its self contained note letter dated 01.10..2009 together with other claim related documents submitted that on scrutiny of documents it was found that the patient had taken treatment on OPD basis for fracture of lateral mallieolus and as per Policy condition, OPD treatment is not covered therefore the claim was repudiated.

Observations:

It is an admitted fact that the Complainant's Son was covered under the within mentioned policy. During the course of Hearing the Complainant stated that his son was treated in Dashore Ortho + Polyo clinic for the treatment of Fracture where total expenditure for Rs. 3364/- was incurred. On asking from the complainant please produce the Hospitalization detail i.e. Discharge summary etc. to substantiate his plea about hospitalization but he could

not furnish any document confirming Hospitalization details but explained that in case of Fracture where only Plaster was given and requires no hospitalization therefore, the expenses should be paid. The Respondent stated that the above Policy covers the expenses for the Hospitalization of a minimum 24 Hrs. in a defined Hospital/Nursing home but in above case the treatment are taken at Clinic and even no Hospitalization was there consequently the claim is not payable. The complainant further explained that the decision is not conveyed by Respondent. The respondent explained that the decision was well conveyed to complainant on the address given and produced the Re-print copy of Repudiation letter.

In view of the circumstances stated above and on going through the documents it is observed that the above expenses are not covered under the Scope of Policy hence the decision of Repudiation taken by Respondent is jus and fair. Therefore, found no reason to interfere in the decision taken by Respondent. The complaint is dismissed without any relief.

==========END OF MEDICLAIM CASE 1==========

Case No. 2

Category: Mediclaim Sub Category: Repudiation of claim

Mr. V.S.V.Kumar……..……..……..…….…….. Complainant

V/s

Star Health and Allied Insurance Co. Ltd.0……...Respondent

Order No.: BPL/GI/09-10/37 Case No.: GI/SHI/0809/41

Bhopal Dated 29.10.2009

Brief Background

Shri V.S.V.Kumar (hereinafter called Complainant) was insured under a Mediclaim policy No. P-201100/01/2009/00873 for the period 31.07.2008 to 30.07.2009 for floater S.I. of Rs. 200000/- obtained from Star Health and Allied Insurance Co. Ltd., (Hereinafter called Respondent)

As per the complainant before obtainment of above Mediclaim Policy from Star Health & Allied Insurance Co. he had insured with New India Assurance Co. Ltd., I.C.I.C.I.Lombard and Royal Sundaram Alliance Insurance Co. Ltd. and His wife was operated for Cataract for which a claim for Rs. 43500/- was submitted to Respondent but after a 4 months the claim is

Refused by Respondent. The complainant approached the higher authority of Respondent but there is also no favorable response. Aggrieved with the non-settlement of claim the complainant approached this forum for necessary settlement of his claim alongwith interest.

The Respondent vide its Self contained Note letter dated 09.09.2009 together with Policy condition and other claim related documents submitted that a claim for the hospitalization period from 16.2.2009 to 17.2.2009 and 27.2.2009 to 28.2.2009 for Cataract operation for Rs. 41298/- was submitted but as per the submitted documents, the claim falls under the 2 year exclusion clause No. 3 whereby "Cataract will not be covered in the first two years Policy Period. The respondent mentioning the previous Policy details also added that there is a gap of more than 10 months between I.C.I.C.I Lombard and Royal Sundaram Policy hence it can not be treated as renewal of ICICI Policy, therefore, the claim was out of the scope of the Policy. The Respondent further mentioned that in addition to that the Hospital is not registered with Local Authorities and the No. of Beds is only 5 as against the minimum requirement of 15 beds of the Policy condition. It is further mentioned in the Self contained note that the claim is rejected as per the exclusion of policy and the Rejection letter was sent to complainant on 5.5.2009.

Observations:

It is an admitted fact that the Complainant's wife was covered under the within mentioned policy and claim for Cataract operation for the Hospitalization period from 16.2.2009 to 17.2.2009 for RE: IOL surgery and for 27.2.2009 to 28.2.2009 for LE IOL surgery at Hi-Tech Eye Care and Laser Centre, Bhopal. During the course of Hearing the Complainant reiterated almost all the points as mentioned in the complaint letters and specifically stated that at the time of obtainment of Policy and even at the time of Surgery for Cataract it was assured by Representatives of Respondent that the Cataract claim is payable and it is also stated by complainant that the claim was registered by Respondent, various documents were asked which were submitted and during follow-ups it was never disclosed that the above claim for cataract will not be payable but the same rejected vide Respondent's letter dated 18.06.2009 instead of payment of claim. The complainant questioned to Respondent that **why** the claim was registered and documents were asked if the claim was not payable at all?, **why** the same was not denied at the time of his first intimation of claim?. On the other side, the Respondent stated that their Policy was issued for the period from 31.7.2008 to 30.7.2009 and prior to this Policy the complainant was having Policy from Royal Sundaram for the period from 3.10.2007 to 2.10.2009 **for Daily Cash benefit only** and not for Medical expenses benefit which can not be considered as Health Policy and prior to Royal Sundaram there were gap of 10 Months from the expiry of The New India Assurance

Co.'s Policy which was expired on 31.01.2007. The Respondent further stated that under their above Policy the expenses incurred on Treatment of Cataract are limited to Rs., 12000/- in the entire Policy period with the **specific condition that** "the Company shall not be liable to make any payment for the expenses on Treatment of Cataract during the first two years of continuous operation of Insurance cover, while the above expenses are incurred within 7 months of inception of Insurance cover and even if the previous insurer's Policy i.e. for Daily Cash Benefit Policy obtained from Royal Sundaram is considered as a continuous cover then also two years are not completed as on the date of Surgery as the previous policy Period starts from **3.10.2007** and prior to this there was a gap of approximately 10 months moreover, the Hospital is not registered and even does not come under the category of Hospital as per the Policy condition, hence the claim found not payable as per the terms and condition of Policy. The Respondent further added that the claim was repudiated and was communicated to complainant vide their letter dated 05.05.2009 and 21.7.2009. The Respondent also clarified that every claim is first registered and processed and then only it is settled either as a Payment of claim or as a Repudiation of Claims because for Fair customer services the claim can not be repudiated without registration and processing of Claim.

In view of the circumstances stated above and on going through the documents it is observed that the above Medical expenses incurred on 16.2.09 & on 26.2.09 for the Cataract surgery are found excluded from the scope of Policy as the same are incurred within the Two years of inception of cover as the previous Health Policy from different Insurer (The New India Assurance Co. Ltd.) was valid upto 31.1.2007 and during this period a fresh policy from different Insurer (Royal Sundaram Alliance Insu. Co.Ltd.) for Daily Cash Benefit only and not for a comprehensive Health Insurance Policy for the period from 3.10.2007 to 2.10.2009 was obtained and **even if** the Daily Cash Benefit Policy of Royal Sundaram is considered as a Medical Policy then also the treatment period falls within the **Two year's Exclusion clause**. Therefore, found no reason to interfere in the decision taken by Respondent as the same found just & fair. The complaint is dismissed without any relief.

==========end of case No. 2 ==========

Case No. 3

Category: Mediclaim Sub Category: TOTAL Repudiation of claim.

Mr. Shyam Kumar Goyal..... ……..……..…….Complainant

V/s

The New India Assurance Co. Ltd., D.O.III, Indore…..……...…Respondent

Order No**.: BPL/GI/09-10/38** Case No.: GI/NIA/0809/40

Order Dated 3.11.2009

Brief Background

Mr. Shyam Kumar Goyal (hereinafter called Complainant) had obtained Mediclaim policy No. 451300/34/06/20/00000705 for the period 02.03.2007 to 01.03.2008 from The New India Assurance Co. Ltd., D.O.III, Indore (Hereinafter called Respondent) for the coverage of his family including his Son Mr. Nirpit Goyal.

As per the Complainant he is continuously obtaining Mediclaim Policy from the Respondent since year 2000 and a claim for the eye treatment of his son for Rs. 69950/- was preferred which is repudiated by TPA vide letter dated 2.12.2008 on the ground that **Myopia less than 7 is not covered.** The complainant further mentioned that as per the treating doctor the Myopia is 7.5. I.e. more than 7 which indicates that the claim is rejected by TPA on intentionally and without support of Policy condition? Aggrieved with the Repudiation of claim on falls ground by TPA, the Complainant approached this forum for necessary settlement of Claim.

The Respondent in its self contained note dated 25.08.2009 submitted that after going through all the medical papers and taking opinion from the doctor the claim was rejected on the ground that myopia is less than 7 is not covered under the Mediclaim Policy. The Respondent further mentioned that as per Opinion given by Dr. O.P.Agarwal, Rohit Eye Hospital & Child care Centre, Indore the Eye No. is (R) -3.75 to -7.5 (L) -2.5 to -4.5.

There is no dispute that the complainant was covered under the above-mentioned policy and undergone Laser Keratomilleusis Eye Surgery at Shroff Eye Hospital on 2.2.2008 and incurred Rs. 69950/-. During the course of hearing the complainant reiterated almost all the points as mentioned in his main complaint letters and stated that the above claim is Rejected by TPA on the basis of Myopia less than 7 is not covered while there is nothing mentioned in the Policy condition moreover the Panel Doctor of TPA in his opinion has mentioned " Mr. Nirpit Goyal underwent Lasik for Myopia with a correction of -7.5 which clearly suggests that the TPA has rejected intentionally though it was well payable. On the other side the Respondent stated that the patient was a known case of Myopia since last few years and the surgery is opted for cosmetic purpose to avoid the use of Spects and contact lenses etc. which are not covered under the scope of Policy accordingly the

claim is Repudiated by TPA. On asking whether there is any evidence confirming that the surgery is done for Cosmetic purposes, it is replied that presently there is no such documents but the merit of case suggests that there is no injury &/or disease to the patient to undergo the above kind of Lasik surgery treatment. The respondent further explained that the Policy covers the expenses incurred for the treatment due to disease/injuries sustained during the currency of Policy and not for any cosmetic purposes. In response thereof, the complainant argued that the above Policy is continued since year 2000 and there is no claim is lodged and the above treatment is not for any cosmetic purposes but as per the advices of treating doctor being essential treatment.

In view of the circumstances stated above and on going through the documents made available by both the parties, it is established that the decision of TPA to Repudiate the claim **is not just and fair** because as per the Discharge certificate dated 6th Feb., 2008 issued by Dr. Anand Shroff, Corneal and Refractive Surgeon, Shroff Eye Hospital, Mumbai **"both Eyes had significant Cylinder and patient was not suitable for contact lenses. Also there was a high difference in numbers between both eyes. Hence, LASIK was suggested as a Therapeutic Treatment and not Cosmetic."** On the other side the Respondent found fails to substantiate their decision of Repudiation under the terms and conditions of Policy. Therefore, the Respondent is directed to pay the above claim for Rs. 69900/- or Sum Insured available under the within mentioned Policy which ever is less 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 OF CASE NO. 3==========

CASE NO. 4

CATEGORY: MEDICLAIM SUB CAT. TOTAL REPUDIATION OF CLAIM

Shri Sanjeev Verma……..……..……..……..Complainant

V/s

The Oriental Insurance Co. Ltd., Branch Indore....……..…Respondent

Order No.: BPL/GI/09-10/039 Case No.: GI/OIC/0809/043

Order Dated 6.11.2009

Brief Background

Mr. Sanjeev Verma (hereinafter called Complainant) had obtained Mediclaim policy No. 151208/48/06/04535 for S.I of Rs. 200,000/- for the period from 19.03.2008 to 18.03.2009 from The Oriental Insurance Co. Ltd., CBO VII, Indore. (Hereinafter called Respondent)

As per the Complainant he was admitted in CHL Apollo Hospital, Indore on 2.11.2008 and all the documents were submitted to TPA but the claim is repudiated under the Policy condition No. 4.1 i.e. on the ground of pre-existing disease. The complainant further mentioned that there is a wrong interpretation of above condition by Respondent as he is continuously obtaining Health Insurance Policies since 1998 without break from different insurers. Complainant further mentioned that in the year 1996 he was injured in the Road accident and was fully cured due to proper treatment and doing his own business. First time he obtained Mediclaim Policy in the year 1998 from National Insurance Co. Ltd. which remain continued their upto two years and in the year 2000 to 2005 he obtained Mediclaim Policy from The New India Insurance Co. Ltd., and finally in the year 2005 i.e. on 19.3.2005 to till today he is continuously Insured with Oriental Insurance Co. Ltd. without any break. It is further mentioned that a claim for Slipped disc L4L5 was lodged with Oriental Insurance co. which was paid by the Respondent but this time for the same disease the claim is denied under the condition No. 4.1 of revised mediclaim Policy. The complainant further approached to the higher authorities of Respondent but there is also no favorable response. Aggrieved with the Non settlement of claim, the complainant approached this forum for the necessary settlement of claim for Rs. 92193/-

The Respondent vide their letter dated 7.9.2009 informed that the claim was dealt by their TPA E-Meditek Solutions Ltd., therefore, they are requesting them to forward a Self contained Note with background of the case and copies of documents in support of their contention to us but nothing is received neither from Respondent nor from TPA even after our reminder letter dated 17.9.2009 and 15.10.2009.

Observations:

There is no dispute that the complainants was covered under the above-mentioned policy and a claim for Rs. 92193/- for the hospitalization period from 2.11.2008 to 8.11.2008 for diagnosis of L4-L5 & K5S1 Disc Prolapsed with EHL weak on left side where surgery was done by Dr. A.K.Jinsiwale on 3.1.2008. During hearing the Complainant reiterated almost all the points as mentioned in his main complaint letters and stated that he is continuously covered under Mediclaim Policies since 1998 and the present illness is from 2006 for which a claim already paid by Respondent in 2006 then the Policy condition No. 4.1 i.e. pre-existing disease does not apply for the treatment of 2008. The complainant also produced

the Policy details starting from 19.3.1998 to 18.3.2009 without break. On the other side the Respondent requested that the above case pertains to their Indore Office and presently he has no documents to submit anything because the same are received to his Indore Office from TPA just one day ago hence the same are not available or even he can not explain anything in support of their defense. The Respondent further requested on behalf of the competent authority of Policy Issuing D.O. at Indore to give an opportunity of 10 days to Review the case and if the claim found payable the same will be directly paid to Complainant other wise the forum may pass the Judgment even without helding any further hearing. The forum conditionally allowed the 10 days time to Review the case with specific condition that the proceeding of Review will be updated to this Forum latest by 4.11.2009 as the same will not be entertained after 4.11.2009 and the case will be decided as per the merit of the case. But none document is received from Respondent even till today i.e. up to 9.11.2009.

In view of the circumstances stated above and on going through the available documents, it is established that the decision of Repudiation of above claim on the ground of Pre-existing disease is not Justified as it is beyond any doubt that the complainant is insured with different Public sector Insurance companies under Mediclaim Policies since 1998 without any break and in the year 2006 one claim for the same disease stands paid by Respondent while on the other side Respondent found fail to substantiate their decision as neither the self contained note along with the relevant documents nor the proceedings of Review submitted within the above mentioned 10 days period. Therefore, the Respondent is directed to settle and pay the above Claim for Rs. 92193/- 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 OF CASE NO. 4 =================

CASE NO. 5

CATEGORY: MEDICLAIM SUB CATGRY: TOTAL REPUDIATION

Shri Anurag Saxena…..……..…………………………….……....Complainant

V/s

United India Insurance Co. Ltd., Br. Ratlam....…………………Respondent

Order No.: BPL/GI/09-10/041 Case No.: GI/UII/0909/050

Order Dated 10.11. 2009

Brief Background

Mr. Anurag Saxena (hereinafter called Complainant) had obtained a family Mediclaim policy No. 190402/48/08/97/00913 for the period from 12.09.2008 to 11.09.2009 for S.I. Rs. 75000/- including his daughter Ku. Anipra Saxena for S.I. Rs. 50000/- from United India Insurance Co. Ltd., Br. Ratlam hereinafter called Respondent)

As per the Complainant a claim for his daughter was submitted to TPA on 21.4.2009 and the requirement as demanded by TPA including Registration certificate of Dr. Gulani was submitted hence the exclusion clause No. 2.1 does not apply in his case but the claim is repudiated by Respondent. The complainant further approached the higher office of Respondent where the same was reviewed and found to be repudiated under Policy clause No. 2.1 being the Hospital is not registered with Local Authority and the bed No. is 10 as against the requirement of 15 beds under the Policy. Aggrieved with the Repudiation of claim, the complainant approached this forum for settlement of his claim.

The respondent vides its self contain Note dtd.12.10.09 together with claim correspondence submitted that the claim related compliance as demanded by TPA vide their letter dated 25.4.2009 and 15.5.2009 as regards delay in submission of claim, Hospital Registration No. and time of Admission and discharge from Hospital etc. are not complied by the Respondent. The Respondent further mentioned that their Regional Office has also reviewed the case and the claim is finally repudiated and the same was conveyed to complainant vide letter dated 21.8.2009.

Observations:

There is no dispute that the complainant's daughter was covered under the above-mentioned policy and a claim for Rs. 5008/- for one day hospitalization on 8.3.2009 to 9.3.2009 at Gulani Hospital & Diagnostic Centre, Bairagarh, Bhopal for the treatment of **Viral Pneumonitis** was submitted to Respondent on 21.4.2009 i.e. delay in the submission of approximately 40 days from the discharge of Hospital. During the course of hearing the Respondent explained that there was a delay in the submission of Claim nearly for 40 days and the Hospital is not registered with Local Authority and the Minimum requirement of 15 Bed is also not fulfilled as the Hospital is having only 10 Beds. The Respondent further stated that the Time of Admission and Discharge of Admission was asked by their T.P.A. but the same is also not complied with by the Complainant therefore, the claim is Repudiated and was conveyed to complainant vide their letter dated 21.8.2009. On asking it is explained by Respondent that as per Policy condition the Hospital must be Registered with Local Authority or the Minimum 15 Nos. of Beds must be their but in the above case it is certified to their TPA by the attending Dr. Rakesh Gulani that the Hospital/nursing home is 10 bedded and having no Registration Number which comes under the Exclusion clause No. 2.1 of the Mediclaim Policy hence the above claim is not admissible. A certificate No. 548/BPL/1338 as provided by Complainant was shown to the Respondent and was asked that the above Nursing Home is Registered with M.P.Nursing Home Association then how they can say that it is not registered then it is explained by Respondent that it is a Registration No. of M.P.Nursing Home Association only and not by the Local Govt. Authority.

In view of the circumstances stated above, It is observed that there is delay in the submission of claim by the complainant which is violation of Policy condition as regards timely intimation and submission of claim documents similarly, the Hospital is registered with Nursing Home Association and not with the Govt. Authority and is a 10 bedded hospital which does not fulfill the requirement of Hospital/Nursing home as required in the Policy consequently the claim is rightly denied by the Respondent as regards the Policy condition is concerned. But there is also no doubt that the complainant's daughter was suffering from Viral Pneumonitis and was under active treatment of Dr. Gulani since 25.2.2009 and was hospitalized on 8.3.2009 to 9.3.2009 and the claim is otherwise genuine hence the Repudiation of entire claim on the above mentioned grounds found not justified as the same are not under the control of Patient. Therefore, I am of the considered opinion that looking to the genuiness of claim and violation of Policy condition as well the claim may be settled on compromised basis upto the 75% of claimed Amount as a special case. **Therefore, the Respondent is directed to pay Rs. 3756/-** on Non- Standard basis 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 OF CASE NO.5==========

CASE NO. 6 CATEGORY: MEDICLAIM

SUB Category: TOTAL REPUDIATION OF CLAIM

Shri L.N.Induria……..……..…..……..…….Complainant

V/s

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

Order No.: BPL/GI/0910/043 Case No.: GI/RSI /0909/49

ORDER Dated 18.11. 2009

Brief Background

Mr. L.N.Induria (hereinafter called Complainant) had obtained Heath Insurance Policy No. HC00478453000101C037 for S.I. Rs. 100000/- under Health Shield Insurance Policy for the Period from 06.12.2008 to 05.12.2009 including for his wife Prabha Induria and his son & daughter from M/s The Royal Sundaram Alliance Insurance Co. Ltd., Chennai. (Hereinafter called Respondent)

As per the Complainant, his wife Smt. Prabha Devi Induria was hospitalized on 01.04.2009 in Jupiter Hospital Thane (Mumbai) for the treatment of Right Dural Av Fistula. It was detected by Dr. Pankaj Agarwal of Bhopal on 16.03.2009 as she had some problem in her

right ear since Jan., 2009 for the first time. Dr. R.S.Pagare M.S. (ENT) examined her on 17.2.2009 and started the treatment. It is further mentioned by the complainant that when she did not respond to the treatment of Dr. Pagare they consulted Dr. Pankaj Agarwal on 16.03.2009 where it was suspected to be **Dural Av Fistula** then they further consulted Dr. Sunil Malik at Bhopal and both the Doctors advised to go to Mumbai to consult with Dr. B.S.Singhal and Dr. Anil P Karapurkar, Endovascular Neurosurgeon where she was hospitalized on 01.4.2009 and treatment was given and total expenditure for Rs. 673968/- was incurred but the claim for Rs. 100,000/- (being Insurance for Rs. 1.00 Lakhs only) is being denied by Royal Sundaram on the basis of treating that it is a pre-existing disease without any reasonable medical findings. The Complainant further mentioned that the Insurance Co. is taking plea of pre-existing disease for Diabetes and hypertension which has nothing to do with the above disease. Aggrieved with the Repudiation of above claim on wrong ground, the complainant approached this forum for necessary settlement of his claim for Rs. 100.000/-

As per self contained note of Respondent it is submitted that the above Policy is in force since 04.12.2007 and claim for Mrs. Prabha Induria who complained of pain the right side of ear and was diagnosed for "Right Dural AV Fistula" for the period commencing from 01.04.2009 to 07.04.2009 for a total estimated amount of Rs. 673968/- while the Sum Insured is Rs. 100000/- only. The Respondent further mentioned that they have deputed Investigator and found that as per the copy of report from the department of Catheterization dated 01.04.2009 the complainant had a bruit in the Right Ear Synchronous with Pulse 1½ years ago which was treated by an ENT surgeon and had regressed. Since the patient was suffering from the symptoms of the ailment prior to inception of the policy hence the claim is inadmissible under the terms of the policy. The Respondent further mentioned in the self contained note that after denial of the claim the complainant produced a revised report stating that the complainant was suffering from the said ailment since 1 ½ months and not 1 ½ years as mentioned in the earlier report made by the treating doctor which indicates that the complainant after denial of the claim as an after thougt has got the report rectified as it was always there that before lodging the claim with us the complainant could have got this report rectified if at all the averments made by the complainant was true. It is further mentioned that the claim was repudiated as the present complaint is a prima facie case of pre-existing disease.

Observations:

There is no dispute that the complainant's wife was covered under the within mentioned Policy and was hospitalized in Jupiter Hospital, Thane, Mumbai for the period from 01.04.2009 to 07.04.2009 where Embolisation of Dural AV Fistula was done on 3.4.2009

and incurred Rs. 673968/- as expenses for the above treatment. The only dispute is whether the above is a pre-existing disease or not. During the course of hearing the complainant reiterated almost all the points as mentioned in him complaint letters and stated that the claim is repudiated by Respondent on the ground of pre-existing disease of Diabetes and Hypertension while the above treatment was for Right side Dural AV Fistula which was started in the month of Jan., 2009 and not prior to this. The complainant also stated that there was a typographical mistake in mentioning the period of clinical history by Department of Catheterization Laboratory of Jupiter Hospital which was corrected by concerning Doctor. The complainant by producing the Discharge Summary, prescription of Dr. Anil P. Karapurkar dated 30.3.2009 and report of Deptt. Of Neurovascular Laboratory of Jupiter Hospital dated 3.4.2009 as evidence and firmly stated that the period of bruit in the right ear synchronous with the Pulse is mentioned as 1 ½ Months not year. On the other side the Respondent stated that as per the report of Deptt. of Catheterization Laboratory the complainant was suffering of disease from last 2 to 3 years which found pre-existing to the inception of Policy and also stated that the correction in the period is arranged after their denial of claim hence the claim is not admissible. The forum asked the Respondent to show the documents where the period of disease is mentioned as 2-3 years the respondent produced the hand written report of Deptt. Of Catheterization Laboratory. On reading the above report it is found that the above period (2-3 years) is mentioned as past history of Diabetes and Hypertension and not for the Dural AV Fistula for which the claim was lodged by the complainant accordingly the attention of Respondent was drawn towards the same and was asked whether there is any evidence confirming that the Hypertension & Diabetes is the sole reason for Dural AV fistula, the reply was in negative and stated that there is no such document in the file.

Under the circumstances explained above and on going through the documents made available by both the parties, I am of the considered opinion that the decision of Repudiation of above claim by Respondent **is not just and fair** as the claim was submitted for Embolization of Drual AV fistula while the claim is repudiated on the basis of pre-existing of Diabetes and Hypertension. There is no concrete evidence proving that the complainant was suffering from claimed disease since last 1 ½ year while the complainant submitted at least 3 documents i.e. discharge summary, first prescription dated 30.3.2009 of Dr. Anil P. Karapurkar etc. confirming that the above disease was since last 1 &/or 1 ½ months. Similarly, the Respondent also found fails to substantiate that the above fistula is a pre-existing &/or consequence of Hypertension and Diabetes as no evidence is produced. Therefore, the respondent is **directed to pay the claim for Rs. 100000/- (Rupees One lakh)** to the complainant **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 OF 6==========.

Case no. 7 category: Mediclaim

Sub Category: TOTAL Repudiation of Claim

Shri Sudhir Arora…….. ……..…… Complainant

V/s

Iffco Tokio General Insurance Co.Ltd.,……..…..Respondent

Order No.: BPL/GI/09-10/48 **Case No.:** GI/ITG/0910/066

Order Dated 21.12.2009

Brief Background

Shri Sudhir Arora (hereinafter called Complainant) had taken a Mediclaim Policy No. 52098518 for the period 11.09.2008to 10.09.2009 from Iffco Tokio Gen. Insu. Co. Ltd., (Hereinafter called Respondent) together with his son Master Aman Arora for Basic Sum Insured of Rs. 50000/-

As per the complainant his son Aman Arora was aged 14 year was injured by Dog Bite on 06.08.2009 and immediately reported to Family Doctor where Anti Rabbis injection was injected and after 2 hours sent back to home by Doctor as there was no need of Hospitalization and it was advised for 5 more injection as per time schedule which were completed on 3/9/2009 and the total expenses for Rs. 1924/- along with the necessary documents were submitted to Respondent for payment of claim but the same is rejected by Respondent. Aggrieved with the Rejection of claim, complainant approached this forum for necessary settlement of claim for Rs. 1924/-

The Respondent vide its letter dated 01.12.2009 along with Policy condition submitted that the patient Mr. Aman has been treated on 8/8/2009 on OPD basis for Dog bite which are not covered under exclusion No. 13 which requires minimum 24 Hrs. Hospitalization as in patient.

Observations:

I have gone through all the materials on record and submissions made during hearing and my observations are summarized below.

It is an admitted fact that the Complainant's son was covered under the above mentioned Policy and was treated for Dog Biting injury. During the course of hearing the Respondent explained that as per Policy condition No. 13 under the list of WHAT IS NOT COVERED "Any expense on treatment of Insured person as Outpatient in a hospital" are not covered while the above expenses are incurred at clinic and there was no hospitalization. The Respondent further stated that they have reviewed the case and found that even the above case does not fall under the category of Domiciliary Hospitalization as per the conditions available under the Policy. The forum draw the attention of Respondent towards nature of injury that it is a Accidental injury due to Dog Bite and the treatment did not require Hospitalization and also towards Exclusions where the above kind of treatment are not specifically excluded under the Policy, it is replied by Respondent that the Policy is Mediclaim Hospitalization benefit Policy and there is no specially relaxation for Dog Bite treatment under the condition of Hospitalization and Domically Hospitalization.

In view of the circumstances stated above and on going through the Policy conditions and documents made available by both parties, it is established that there is no specific relaxation for the exemption of Hospitalization/Domiciliary Hospitalization Expenses under the Dog Biting treatment **similarly** it is also an established fact that it is an Accidental injury and required the special kind of treatment moreover not specifically excluded under the scope of Policy. It is also found that the Dog Biting is an Accidental injury and due to technological advances the treatment does not requires the Hospitalization. Therefore, the Medical Expenses of Rs. 1924/- incurred by the complainant in the above case are recommended on **Ex-gratia basis** as a special case. The Respondent is directed to pay Rs. 1924/- 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 of 7==========

CASE NO. 8 CATEGORY: MEDICLAIM

SUB CATEGORY: TOTAL REPUDIATION OF CLAIM

Mrs. Shweta Jotwani…… ……..……Complainant

V/s

The New India Assurance Co. Ltd., D.O. (I), Bhopal ……Respondent

Order No.: BPL/GI/09-10/58 **Case No.: GI/NIA/0910/65**

Order Dated 29.01.2010

Brief Background

Smt. Shweta Jotwani (hereinafter called Complainant) is covered under Mediclaim policy No. 450100/34/07/20/000000019 for S.I of Rs. 100000/- for the period 26.04.2007 to 25.04.2008 issued by The New India Assurance Co. Ltd., D.O.I, Bhopal (Hereinafter called Respondent)

As per the Complainant she was having stomach pain and was hospitalized to Bhopal Memorial Hospital & Research Centre for the period from 2.4.2008 to 5.4.2008 where she was treated and diagnosed for her Restrosternal Pain for evaluation and at the time of discharge she was directed to consult the doctor after seven days. It is further mentioned that after discharge from the Hospital, the documents were submitted to Respondent for claim which is rejected by TPA on the wrong reasons and grounds that she was hospitalized only for investigations. The complainant further mentioned that this rejection of claim is against the discharge summary and Doctor Opinion and the claim is fit for payment under the Policy. The complainant further represented to the higher authority of Respondent but there also no response. Aggrieved with the Repudiation of claim, complainant approached this forum for necessary settlement of claim for Rs. 14096/-.

Observations:

There is no dispute that the complainant was covered under the above-mentioned policy and was hospitalized at Bhopal Memorial hospital for the period from 2.4.2008 to 5.4.2008 for the diagnosis of Retrosternal pain for evaluation. During the course of hearing the complainant reiterated almost all the points as mentioned in main complaint letters and by producing the medical records stated that she was suffering the above problems from March 2008 and was consulted with Global Lever &

Gastroenterology Centre, Bhopal on 4.3.2008 where she was treated for the problems of acute pancreatitis and pathological tests for Haemogram, Biochemistry and USG whole abdomen were conducted but there is no relief hence she consulted to Dr. Subodh Varshney, Bhopal Memorial Hospital & Research Centre, where she was advised to Admit

for the process of MRCP for SOD/Gall Bladder dysfunction and Ba Swallow, MRCP and Esophageal Motility tests were conducted and discharged on 5.4.2009 with the advice to Review in Gastro-Surgery after 7 days. The complainant further stated that the procedure of above tests is invasive and conducted by Hospital after obtaining consent in writing by Hospital as some complication of Bleeding and perforation may arise due to above procedure which needs medical supervision of expert doctor available in the hospital. The complainant further stated that the above hospitalization was not at their wish but only as per the need and advices of Dr. Subodh Varshney who is the Head and is renowned senior specialist of Surgical Gastroenterology. On asking, the complainant showed the hospital indoor documents i.e. prescription of Dr. Varshney, consent letter obtained by Hospital before above procedure of MRCP and further stated that claim for above hospitalization and for pre and post Hospitalization is wrongly rejected by TPA without going through the gravity of Hospitalization. The Respondent also produced the USG Abdomen report conducted on 15.3.2008 at Global liver & GE centre and dated 19.2.2008 done at People's General Hospital wherein revealed "Poor function of Gall Bladder" and "Distended Gall Bladder? Poor functioning" respectively. On the other side the Respondent stated that the claim is rejected by their TPA on the ground that the present hospitalization was for the investigation and evaluation of the ailment only which could have been done on outpatient basis without the necessity of Admission for the same. The forum asked to Respondent whether their TPA obtained any Medical Opinion from the competent doctor that the complicated process like MRCP and Esophageal Motility can be done without necessity of Hospitalization? It is replied by respondent that there is no such opinion available in the file. Then the Respondent's attention is drawn towards the discharge summary of Hospital where it is mentioned under the column of **course during Stay** "IV Fluid Antibiotics and supportive treatment" in response thereof the respondent explained that the claim is settled by TPA and as per their Medical team opinion the above investigation could have been done on outpatient basis without the necessity of admission.

In view of the circumstances stated above and on going through the medical documents made available by both parties, it is established that the decision of the Respondent to repudiate the above claim **is not just & Fair** as the hospitalization is as per the advices of treating doctor for the complicated processes of course for the evaluation of disease for the diagnosis of Retrosternal pain and poor function of Gall Bladder being suffered by complainant since last 1 ½ months. The consent letter obtained by Hospital prior to Proceeding of E.R.C.P confirms the necessity of hospitalization while on the other side the Respondent found fails to substantiate their assumption that there was no need for the hospitalization. Therefore, the decision of TPA to repudiate the claim is kept aside and the **Respondent is directed to pay the above claim for Rs. 13996/- only** (i.e. Rs. 14096/-

less Rs. 100/- for Registration charges) as found payable from the claimed documents 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 OF CASE NO. 8==========

CASE NO. 9 CATEGORY: MEDICLAIM

SUB CATEGORY: TOTAL REPUDIATION

Shri K.K.Dhruve……..Complainant

V/s

United India Insurance Co. Ltd., Br. Ratlam.....……Respondent

Order No.: BPL/GI/09-10/059 **Case No.: GI/UII/0910/063**

Dated 29.01.2010

Brief Background

Mr. K.K.Dhruve (hereinafter called Complainant) had obtained a family Mediclaim Policy No. 191303/48/07/97/00001844 including her wife smt. Mradula Dhruve for S.I. Rs. 75000/- from United India Insurance Co. Ltd., Br. IV, Indore. (Hereinafter called Respondent)

As per the Complainant his wife Mrs. Mrudula Dhruve age 73 years now deceased was admitted to Greater Kailash Nursing Home, Indore on 2.6.2008 and advised by Dr. Ashok Bajpai for Fibrosis of Lungs and for the treatment, the Respondent settled claim for Rs. 57500/- through cash less settlement. The complainant further put up a claim for Rs. 17500/- being balance of Sum Insured under the Policy and the claim amount paid but the claim is rejected by TPA vide their letter dated 14.7.2009 without giving opportunity in spite of waiver clause in Policy terms for some delay. The complainant further approached Respondent but there was no response. Aggrieved with the Rejection of claim for balance amount of Rs. 17500/-the complainant approached this forum for settlement of his claim along with interest.

The respondent vide its self contained letter dtd.27.01.2010 together with TPA process sheet and letter etc. submitted that the claims for Mrs. Mradula Dhruve was admitted three times for Greater Kailash Hospital, Indore during 2.6.2008 to 5.10.2008 for complications for which Cashless facility was provided by TPA and amount paid to Hospital and the above disputed claim was for Post hospitalization for period which is allowed under the Policy maximum for 60 days but the claim was submitted after three month from the stipulated period of 67 days which is the breach of Policy condition No. 5.4 therefore claim was rejected. The Respondent further mentioned that as per process sheet of TPA the medicines purchased during Post Hospitalization period were mostly for the treatment of breast cancer which was disallowed already in the authorization letter to Hospital by TPA on 19.9.2008.

Observations:

There is no dispute that the complainant's wife was covered under the above-mentioned policy and a claim for Rs. 15500/- was submitted to Respondent's TPA after the delay of 3 months. During the course of hearing the complainant reiterated almost all the points as mentioned in the complaint letters with specific statement that there was Sum Insured of Rs. 75000/- under the Policy and claim for Rs. 15500/- for the Amount Deposited to Hospital for Rs. 17500/- and for post hospitalization expenses were submitted. It is also stated by complainant by producing the Bills etc. that the treatment was continued even till her death on 28.4.2009 for the disease of **Fibrosis of Lungs** which is a commonly a terminal disease but the Respondent did not pay the attention towards the above circumstances and rejected the claim on the basis of delay in submission of above claim. On the other side the Respondent explained that the claim is rejected by TPA under the Policy condition no.5.4 as there was inordinate delay in the submission of post Hospitalization claim. On asking from both Respondent and complainant about otherwise admissible Post Hospitalization claim amount for the period upto 60 days from the discharge of the Hospital i.e. 5.10.2008 it is calculated and agreed in writing for Rs. 5291/- by both parties which observed the main dispute of the above case also.

In view of the circumstances stated above and on going through the documents made available by both the parties, it is established that the entire rejection of above claim by Respondent under Policy condition No. 5.4 (Delay in submission of Post Hospitalization claim by 3 months) **is not just and fair** as the reason for above delay is **continuous treatment** and **death of patient** where the above delay could have been condoned under the Waiver Clause available in the Policy. As regards the 2nd plea of Respondent for the medicines purchase mainly for treatment pertaining of Breast Cancer, the same also found contradictory to the process sheet of TPA where it is mentioned that the claim for the period

27.9.2008 to 13.10.2008 for Rs. 35380/- is settled and paid for **C50 Malignant Neoplasm of Breast** hence the Post hospitalization expenses for the above disease found likewise payable. Therefore the decision of Respondent for Rejection of above claim is set aside and directed to pay the above claim for **Rs. 5921/-** (as found payable from the Bills produced and also agreed in writing by complainant) 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 OF CASE NO. 9==========

CASE NO. 10 CATEGORY: MEDICLAIM

SUB CATEGORY: TOTAL REPUDIAITON

Mr. Shankar Das Narwani…… ……..……..Complainant

V/s

The New India Assurance Co. Ltd., D.O. (I), Bhopal ……Respondent

Order No.: BPL/GI/09-10/60 **Case No.: GI/NIA/0912/90**

Dated 25.02.2010

Brief Background

Shri Shankar Das Narwani (hereinafter called Complainant) was covered under Mediclaim policy No. 450100/34/08/01/000000054 for S.I of Rs. 200000/- for the period 31.07.2008 to 30.07.2009 together with his wife Mrs. Kavita Narwani issued by The New India Assurance Co. Ltd., D.O.I, Bhopal. (Hereinafter called Respondent)

As per the Complainant the Cataract Operation of his wife smt. Kavita Narwani was undergone on 26.01.2009 and claim was lodged with Respondent but the same is not settled. It is further mentioned that there was mention of Diabetes in the Discharge ticket by an oversight by the Staff of treating doctor which was later corrected by Dr. Gurdeep Singh vide his clarification letter dated 9.6.2009 but the same is not considered by the TPA of Respondent and refused to pay the claim. It is further mentioned by complainant that he is continuously obtaining the insurance Policy since 31.07.2001 without break and his wife is

not a patient of Diabetes. The complainant further approached the higher authority of Respondent but there also no favorable response. Aggrieved with the Repudiation of claim, complainant approached this forum for necessary settlement of claim for Rs. 14500/-.

As per self contained note dated 29.12.2009 the Respondent submitted that the claim was repudiated by their TPA on the ground of case history wherein it has been mentioned that Mrs. Kavita narwani was hjaving diabetes at the time of taking Insurance cover. It is further mentioned that on receipt of representation from Complainant the same was sent to TPA for re-examination but the TPA found the claim not payable which was conveyed to complainant vide their letter dated 30.11.2009.

Observations:

There is no dispute that the complainant's wife Smt. Kavita Narwani was covered under the above-mentioned policy and Cataract Surgery of RE: IOL done on 26.01.2009 by Dr. Grudeep Singh at H-tech Eye Care and Laser Centre, Bhopal and incurred Rs. 14500/- for the same. During the course of hearing the Complainant reiterated almost all the points as mentioned in his main complaint letters and specifically stated that his wife was never a patient of Diabetes and the mention of above disease in the Discharge ticket was a clerical mistake by the Staff which was later on corrected in writing by the treating Doctor vide his certificate dated 9.6.2009. On the other side the Respondent explained that the claim is rejected by their TPA on the basis of Discharge ticket where it is mention that the patient was having of Diabetes for 10 years. The forum drawn the attention of Respondent that the it is a claim for Cataract and not for the treatment of Diabetes & or any Diabetes related complication then what is the impact of Diabetes in Surgery of Cataract?, similarly whether any opinion of other doctor and any pathological reports confirming that the patients was having of Diabetes since last 10 years is obtained and also is there any medical opinion from competent doctor that the above Cataract is a consequence of diabetes obtained, the Respondent could not reply in positive and stated that the same is not available as complete file not provided by the TPA.

In view of the circumstances stated above and on going through the medical documents made available by both parties, it is established that the decision of the Respondent to repudiate the above claim **is not just & Fair** as the treatment was for Cataract and the treating Doctor has confirmed in writing that there was clerical mistake regarding status of Diabetes and Hypertension which has been written in the discharge ticket and also confirmed that the patient is Non diabetic and the B.P. is also normal. Therefore, the decision of TPA to repudiate the above claim is kept aside and the **Respondent is directed to pay the above claim for Rs. 14500/- 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 OF CASE NO. 10==========

Case no. 11 **category:** **MEDICLAIM**

SUB-CATEGORY: TOTAL REPUDIATION

Shri Deepak Arora……..……..Complainant

V/s

National Insurance Co.Ltd., D.O.I, Jabalpur.....….....Respondent

Order No.: BPL/GI/09-10/61 **Case No.: GI/NIC/0912/88**

Dated 26.02.2010

Brief Background

Shri Deepak Arora (hereinafter called Complainant) had obtained Mediclaim Policy No. 320700/48/05/8500001296 for S.I of Rs. 200000/- for the period from 08.03.2007 to 07.03.2008 including his father Mr. K.L.Billa issued by National Insurance Co. Ltd., D.O.I, Jabalpur. (Hereinafter called Respondent)

As per the Complainant his father Mr. K.L.Billa was hospitalized from 26.12.2007 to 20.01.2008 due to heart problem and lodged the claim with Respondent but the same is not settled by them. It is further mentioned that his father was implanted the Pacemaker 15 years back i.e. in the year 1993 and the Police was obtained on 8.3.2005 till today and at the time of taking the Mediclaim Policy the fact of implantation of Pacemaker was explained to Respondent where it was assured that it shall be covered and if that it would have replied by Respondent that the above claimed heart diseases shall not be covered then why he would have taken the Mediclaim Policy for his father?. The complainant further approached the higher office of Respondent vide his letter dated 9.9.2009 but there also no favorable response. Aggrieved with the non settlement of claim for Rs. 74011/-, the complainant approached this forum for the settlement of claim.

As per Self Contained note dated 21.01.2010 along with other claim related documents submitted by respondent that the complainant was admitted in hospital for treatment of IHD and according to received documents it was found that the patient had undergone Pacemaker Implantation 15 years back which found Pre-existing in nature and excluded under clause No. 4.1 which states as **"The company shall not be liable to make any payment under this Policy in respect of any expenses whatsoever incurred by any Insured person in connection with or in respect of all diseases/injuries which are pre-existing when the cover incepts for the first time".** It is further mentioned by Respondent that on the basis of above finding their TPA informed the complainant vide their letter dated 5.6.2008 specifically quoting the above mentioned Policy exclusion.

Observations:

There is no dispute that the complainant's father was covered under the above-mentioned policy and was hospitalized for the period from 26.12.07 to 28.12.2007 at Jabalpur Hospital & Research Centre and at Wockhardt Heart Hospital, Nagpur for the period from 29.12.2007 to 30.12.2007 and further 15.01.08 to 20.01.2008 at Jabalpur for the diagnosis and treatment of CAD on PMM/Nephropathy and Ischemic Heart Disease respectively with the history of a known case of Ischemic Heart disease with ischemic cardiomyopathy with permanent pacemaker implantation with PTCA with stenting to RCA and LAD done in the past. During the course of hearing the Complainant's representative stated almost all the points as mentioned in the main complaint letters and specifically stated that the Insurance was obtained in the month of March 2005 and at the time of Insurance it was informed to Respondent that Mr. K.L.Billa is a heart patient and the Pacemaker was implanted in the year 1993 and there was no problem during last two and half year but the claim for the treatment for hospitalization for the period from 26.12.2007 to 30.12.2007 for Rs. 74000/- is not being paid. On the other side the Respondent explained that the above Policy is subject to Exclusion clause No. 1 for pre-existing diseases which states that the company shall not be liable to make any payment under the Policy in respect of any expenses whatsoever incurred by any insured person in connection with or in respect of all diseases/injuries which are pre-existing when the cover incepts for the first time while as per Discharge card and Summary of both the hospital it was found that Mr. K.L.Billa is a known Cardiac Patient with Pace maker implanted 15 years back and reimplanted one and half year ago which found pre-exiting to the first inception of Policy as the same was first obtained in March, 2005 the Policy condition and copies of Discharge Card and Summary for both hospitals are produced by Respondent. The Respondent further stated by producing the Proposal form duly signed by proposer that the above Heart disease and Implantation of Pacemaker is not disclosed at

the time of Proposal for first Insurance as the Answer to the Question of High blood pressure, Heart Disease, other circulatory disorders etc. are is given as “NO” which found the non disclosure of Material Fact also in the case. It is further added by Respondent that in consequence of Pre-existing disease clause the claim is not payable.

In view of the circumstances stated above and on going through the various documents viz. Discharge Card, Summary, Proposal form and Policy clause etc. as made available by both the parties, it is established that the decision for repudiation of above claim taken by Respondent is **just & fair** as it is well established that the complainant’s disease was pre-existing at the time of first inception of Policy which is excluded under the terms & condition No. 4.1 of Policy. **The complaint is dismissed without any relief.**

==========end of case no. 11==========

CASE NO. (1)

Category: Mediclaim **Sub Category: Partial Repudiation of claim**

Shri Hari Narayan Tiwari……..……..……..Complainant

V/s

The Oriental Insurance Co. Ltd., Branch Bhopal..……..…Respondent

Order No.: BPL/GI/09-10/034 Case No.: GI/OIC/0809/042

Order Dated 28.10.2009

Brief Background

Mr. Hari Narayan Tiwari (hereinafter called Complainant) had obtained Mediclaim policy No. 151110/48/08/000611 for S.I of Rs. 50,000/- for the period from 13.08.2008 to 12.08.2009 from The Oriental Insurance Co. Ltd., D.A.B., Bhopal. (Hereinafter called Respondent)

As per the Complainant a Mediclaim for himself for Rs. 30341/- was submitted to on 9.3.2009 to Respondent but the claim is settled and paid on 23.5.2009 for Rs. 20000/- only after deduction of Rs. 10341/-unneccesarirly. The complainant further added that on asking from the Respondent, the same is provided by respondent on 23.6.2009 by mentioning half detail of payment and stating that the claim is discharged in full satisfaction. The complainant further added that he is not having the knowledge of English and the Discharge was signed by him assuming that it is a receipt of Cheque. The complainant also approached to the higher office of Respondent but there is also no favorable response. Aggrieved with the Deduction of Rs. 10341/- from claim amount, he approached this office for settlement of his balance claim amount.

As per self contained note letter dated 27.8.2009, the Respondent explained that the settlement of claim accepted by complainant after taking a note of the contention of their letter dated 11.5.2009. The Respondent further explained that the offer letter was not

objected by complainant and the retention of Cheque for settlement for Rs. 20000/- had amounted to acceptance of full and final settlement which has resulted in his estoppels from raising any further relief.

Observations:

There is no dispute that the complainants was covered under the above-mentioned policy and claim for Rs. 20000/- stands settled & paid after obtainment of satisfaction voucher from complainant. The only dispute is for deduction of Rs. 10341/- from the claim amount. During the course of hearing the complainant reiterated almost all the points as mentioned in his main complaint letters and stated that the amount of Rs. 10341/- is deducted wrongly by respondent. The complainant was asked by this forum why the satisfaction voucher is given for Rs. 20000/- as against the full claim amount, it is replied that he was in immediate need of Money and thought that it is a part payment. On the other side the Respondent explained that the claim is settled for Rs. 20000/- after obtainment of clean Discharge voucher from complainant as full & final settlement of claim. On asking why the deduction detail is not informed to complainant in writing, it was replied that the same was conveyed to complainant during his visit to their office and was also informed at the time of obtainment of Discharge voucher. The respondent was further asked by the forum why the deduction of Rs. 10341/- are made from the Claim amount**?** It is replied that the above amount observed as inflated &/or unnecessary. Then, the respondent was further asked to substantiate their observation of inflated &/or unnecessary amount i.e. whether any investigation was carried out by any one and also whether there is any proof/confirmation in support of their observation of higher/unnecessary amount. It is replied that as such there is no documentary evidence but observed inflated/unnecessary expenses as per their claim experiences etc. The forum further asked to Respondent to submit the head wise details of deduction from the claim amount, which was submitted by respondent. On the other side the complainant stated that there is nothing inflated/unnecessary expenses in the claim as the expenses are incurred in accordance with the advices of Hospital and treating doctor and the above amount is actually paid by him to Hospital, pathologist & chemists.

In view of the circumstances stated above, it is established that the deduction of Rs. 10341/- from claim amount **is not just & Fair** because the same are made merely on the basis of assumption without getting investigation etc. which should have been carried out before the deduction of amount or there must be some concrete evidence of exaggerated

amount and the same should have been duly conveyed to complainant in writing. Hence, the Respondent is directed to **pay the balance claim amount of Rs. 10241/-** (as per the following calculation: Rs. 10341/- less Rs. 100/- for Registration charges as the same are not covered under the Policy) 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 of case No. 1==========

Case No. 2

Category: Mediclaim Sub Category: Partial REPUDIATION of claim

Shri Abhishek Neema……..……..……..……..Complainant

V/s

The Oriental Insurance Co. Ltd……....Respondent

Order No.: BPL/GI/09-10/036 Case No.: GI/OIC/0909/044

Order Dated:29.10.2009

Brief Background

Mr. Abhishek Neema (hereinafter called Complainant) had obtained Mediclaim policy No. 152600/48/20/00798 for S.I of Rs. 100000/- for the period from 10.09.2008 to 09.09.2009 from The Oriental Insurance Co. Ltd., Ujjain. (Hereinafter called Respondent)

As per the Complainant he is continuously obtaining two Mediclaim Policies since 2005 for Rs. 50,000/- which were clubbed in one policy for S.I. Rs. 100000/- w.e.f. 10.9.2008 and a claim for Rs. 17581/- for himself was submitted to Respondent and the claim stands paid after deducting of Rs. 3897/- from claim amount under the head of Room Rent & nursing charges considering S.I. Rs. 40750/- being the diabetes is 5 years old and at that time the Policy was having a Balance S.I. of Rs. 40750/-. The complainant further mentioned that earlier also there was deduction Rs. 1500/- from the claim amount for the same reason (

Room Rent & Nursing charges) which were paid by T.P.A. after his representation but this time they are not considering the total S.I. Rs. 1.00 Lakh. The complainant further approached the higher office of Respondent but there is also no response. Aggrieved with the above Deduction of Rs. 3897/- from claim amount, complainant approached this office for settlement of his balance claim amount.

As per self contained note letter dated 05.10.2009, the Respondent explained that the claim is settled by their TPA and deductions are done as per Policy condition for the S.I. of Rs. 50000/- as the benefit can not be given on Revised Sum Insured being old disease.

Observations:

There is no dispute that the complainants was covered under the above-mentioned policy for S.I. Rs. 1.00 Lakh and prior to this he was having two Mediclaim Policies for S.I. 50000/- each and the claim is settled by T.P.A. for Room Rent & Nursing expenses for Rs. 1750/- as against the claimed amount of Rs. 5647/- i.e. after deduction of Rs. 3897/- from the claim amount. During the hearing the Respondent stated that the complainant is a known case of Diabetes since last 5 years and earlier he was having Policy with S.I. Rs. 50000/- hence he is entitled for Room Rent for the earlier S.I. and not on Revised Sum Insured. The Respondent was asked by this forum if S.I. was Rs. 50000/- where according to 1% condition for Room rent & Nursing expenses but the claim is settled for Rs. 350/- per days which means the S.I. is treated Rs. 35000/- then it is replied that the same is settled by T.P.A. which seems a mistake on their part. The Respondent was further asked that prior to current Policy complainant was having two Policies for Sum Insured of Rs. 50,000/- on each Policy then why the total S.I. should not be treated as Rs.1.00 lakh? It is replied that it is a renewal of one Policy which was having S.I. of Rs. 50,000/- because technically only one Policy is Renewed and not more than one Policy to club etc.

In view of the circumstances stated above, it is established that the deduction of Rs. 3250/- from the claim amount **is not just & Fair** because prior to the current Policy where the S.I. is considered as Revised, the complainant was having two Policies for S.I. of Rs. 50,000/- each which indicates the total S.I. of Rs. 1,00,000/-. As per the Policy condition the maximum limit is 1% of S.I. for Room, Boarding and Nursing Expenses which comes to Rs.

5000/- for 5 days Admission but the T.P.A. has paid Rs. 1750/- for the same. However the other deductions i.e. Registration Charges, Telephone etc. are found not covered under the scope of Policy. Therefore, the Respondent is directed to Pay the Difference claim amount of Rs. 3250/- 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 of case No. 2 ==========

CASE NO. 3

CATEGORY: MEDICLAIM SUB CATEGORY: PARTIAL REPUDIATION

Shri Vinod Agarwal……..……..……..Complainant

V/s

United India Insurance Co. Ltd., Br. Ratlam...……Respondent

Order No.: BPL/GI/09-10/040 Case No.: GI/UII/0909/047

Order Dated 10.11. 2009.

Brief Background

Mr. Vinod Agarwal (hereinafter called Complainant) had obtained a family Mediclaim policy No. 190402/48/06/12/00535 from United India Insurance Co. Ltd., Br. Ratlam hereinafter called Respondent)

As per the Complainant a deduction of Rs. 300/- from his claim amount is made by Respondent moreover the reason of deduction is also not being informed even after his

repeated written requests for the last 2 years. The Complainant further approached the higher office of the Respondent but there is also no favorable response. Aggrieved with the deduction of Rs. 300/- from claim amount and without clarifying the reason of above deduction by respondent, the complainant approached this forum for settlement of his claim for full amount along with interest.

The complaint was registered on 16.09.2009. A letter was sent to the Respondent alongwith copy of complaint to submit self contained note while the prescribed forms were issued to the complainant.

The respondent vides its self contain letters dtd.12.10.09 together with claim correspondence submitted that the claim for Ku. Yashi (daughter) for the hospitalization period from 26.6.2007 to 28.6.2007 was submitted to TPA on 18.12.2007 i.e. after laps of five months as against the condition of filing the claim within 7 days from the date of discharge from the Hospital which was asked from the claimanant vide their letter dated 4.1.2008 then the insured approached their office and submitted an application to consider his claim sympathetically on 14.1.2008 but he could not explain the appropriate reason for delay submission of claim papers however, looking to the commercial relation with the claimanant and on his request they decide to settled the claim for Rs. 1800/- after imposing the penalty for delay in submission of claim papers which was agreed by him also. Accordingly, the claim disbursement vouchers was given to claimanant for discharge the Voucher and return the same but the same was not submitted till 7.3.2008 consequently reminder letter was sent on 7.3.2008 but the same was not returned by complainant therefore, the claim was closed as No Claim.

Observations:

There is no dispute that the complainant's daughter was covered under the above-mentioned policy and a claim for Rs. 2263/- was submitted to **Respondent after the delay of 5 months**. During the course of hearing the complainant reiterated almost all the points as mentioned in the complaint letters with specific statement that the Reason of deduction is not clarified by Respondent even after his repeated written request. It is also stated by Complainant that the amount is deducted by Respondent intentionally and without proper support of condition. On the other side the Respondent explained that prima-facie the claim was deserved to be repudiated on the ground of Policy condition No. 5.4 which expects the submission of claim within 7 days after discharge from the Hospital but on the request of

Complainant the commercial decision is taken after imposing Penalty of Rs. 463/- being delay in submission of claim documents. The forum asked from the Respondent why the above reason is not conveyed &/or intimated to Complainant even after his repeated written request then it is replied that the claim was regularly followed up by the complainant and the same was conveyed and even an amount of settlement of claim for Rs. 1800/- was conveyed which was agreed by complainant but the Discharge voucher for Rs.1800/- duly signed not submitted even their reminders. Then the forum again asked the question from the Respondent why the consent for settlement of claim for Rs. 1800/- is not obtained at that time, the Respondent replied that during verbal discussion he was agreed so consent was not obtained. The Complainant explained that it was never committed by him that's why the Discharge voucher is not submitted by him.

In view of the circumstances stated above, it is established that the due exercise to handle with the above kind of claim (where the violation of Policy condition No. 5.4 due to inordinate delay in the submission of claim documents is clearly established) is not done by the Respondent as neither the claim is settled on Sub Standard/ compromised settlement nor the deduction of Rs. 300/- found justified. As per the merit of the case the claim deserves to be repudiated &/or on compromised basis where the claim could have been settled maximum 75% of claim amount with the consent of complainant but the above claim is settled after deducting of Rs. 300/- assuming that the charges are on higher side &/or not relevant even without consent of the Complainant. Moreover, the reason of deduction of Rs. 300/- and the details of deduction as well are not conveyed to complainant in spite of his repeated requests in writing. The Policy holder has the right to know about the deduction of any amount from his claim amount which found not done in the above claim. Similarly, it is also observed that the Respondent has settled the claim considering the commercial relation with the complainant and also that the deduction of Rs. 163/- for the medicine purchased on 6.7.2009 and Rs. 200/- for the nursing charges are found well payable under the scope of Policy. Therefore, the Respondent is directed to pay the claim for Rs. 2163/- as per the following calculation: - Rs. 1800/- + Rs. 163/- + Rs. 200/- to the complainant within 15 days to 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 of case no. 3==========

CASE NO. 4 CATEGORY: MEDICLAIM

SUB CATEGORY: PARTIAL REPUDIATION OF CLAIM

Mr. Vishwanath Verma……..……..…….…….... Complainant

V/s

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

Order No.: BPL/GI/09-10/46 **Case No.: GI/SHI/0909/55**

Order Dated 17.12.2009

Under the Redressal of Public Grievances Rules, 1998.

Brief Background

Shri Vishwanath Verma (hereinafter called Complainant) together with his wife Mrs. Kemali Devi insured under a Mediclaim policy no. P-201100/01/2009/002007 for the period 19.02.2009 to 18.02.2010 for floater S.I. of Rs. 100000/- obtained from Star Health and Allied Insurance Co. Ltd. (Hereinafter called Respondent)

As per the complainant on 20.6.2009 his wife suffered Chest Pain and other problems and was hospitalized in Birla Hospital, Satna as per the advices of Heart Specialist Dr. S.K.Shrivastava and remained hospitalized till 23.06.2009 and the claim for Rs. 12821/- along with all the documents were submitted to Respondent but the Respondent settled the claim for Rs. 6413/- as against Rs. 12821/- by wrongly deducting amount from the claimed bills. It is further mentioned by complainant that the claim cheque for Rs. 6413/- is not accepted by him and was returned to respondent and the matter was represented to their higher authority but there also no favorable response. Aggrieved with the non settlement of full claimed amount the complainant approached this forum for necessary settlement of his claim alongwith interest.

The Respondent vide its Self contained Note letter dated 3.11.2009 along with Policy condition and other claim related documents submitted that a claim was evaluated by their in-house medical officers and the medicines which are not relevant to the management of the disease were disallowed as per the terms of the Policy and the D.D. for payable amount

for Rs. 6413/- was sent to the Complainant on 20.7.2009 along with the Working sheet showing the deductions details. The Respondent further mentioned that the claim is settled as per the terms of the Policy.

Observations:

It is an admitted fact that the Complainant's wife was covered under the within mentioned policy and claim for the diagnosis of C.A.D. for the Hospitalization period from 20.6.2009 to 23.6.2009 for medical treatment for Rs. 12821/-was submitted to Respondent. During the course of hearing the Complainant stated that his wife was suffering from the Chest pain and giddiness and was hospitalized in Birla Hospital where the treatment was given by Doctor and all the expenses bills for Rs. 12821/- were submitted but the claim for Rs. 6413/- is settled by Respondent which was returned as not acceptable. The Respondent described that the claim for Rs. 6413/- was settled for the management of disease after deduction of Medicines which are not relevant to the management of disease as all the Tests are found Negative which indicates that the hospitalization was for the diagnosis and not for the treatment of any disease. On asking about which medicine is found not relevant to treatment, it was described that the 'Pipsor' costs Rs. 5520/- found not relevant to the diagnosis. The forum again asked the Respondent that the above medicine is duly prescribed by the attending Doctor S.K.Shrivastava, M.D.(Medicines) who is suppose to be a competent person for treatment then how other can say that it is not relevant? The respondent could not reply in positive but explained that as per the diagnosis there was no need of above Medicine.

In view of the circumstances stated above and on going through the documents it is observed that the Medical expenses are **incurred as per the advices & prescription of Treating doctor** and the claim otherwise also considered payable by Respondent hence the deduction for Rs. 5520/- against one Medicine i.e. Pipsor found not just and fair as the deduction is made without any opinion &/or investigation while other deduction i.e. for Stationery charges etc. are found not covered under the scope of Policy. Therefore, the Respondent is directed to settle and pay the claim for the amount **of Rs. 11933**/- as per the following calculations: Rs. 6413/- already sanctioned **+** Rs. 5520/- for Medicine (Pipsor) 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 of case no. 4==========

CASE NO. 5 CATEGORY: MEDICLAIM

Sub CATEGORY: PARTIAL REPUDIATION OF CLAIM

Shri Ashok Agarwal…….. …….. Complainant

V/s

Iffco Tokio General Insurance Co.Ltd.,……..…..Respondent

Order No.: BPL/GI/09-10/53 **Case No.: GI/ITG/0910/060**

Order Dated 21.01.2010

Brief Background

Shri Ashok Agarwal (hereinafter called Complainant) had taken a Mediclaim Policy No. 52031059 for the period 18.10.2006 to 17.10.2007 from Iffco Tokio Gen. Insu. Co. Ltd., (Hereinafter called Respondent) for Sum Insured of Rs. 200000/-

As per the complainant he has undergone surgery in CHL Hospital at Inodre for the hospitalization period 8.10.2007 to 11.10.2007 and provided cashless services by TPA and Rs. 7000/- was deposited by him as demanded by Hospital and the post hospitalization expenses incurred within 60 days were also incurred by him. Due to unavoidable circumstances the complainant shift to Indore from Ujjain and was late to submit the Post hospitalization claim to the Respondent as submitted on 7.7.2009 but the Post hospitalization claim is not considered by Respondent due to delay in submission of claim. The complainant further approached higher office of Respondent but there also no response. Aggrieved with the non settlement of Post hospitalization claim for Rs. 9424/- by the Respondent, the complainant approached this forum for necessary settlement of claim.

The Respondent vide its letter dated 26.11.2009 along with Policy condition submitted that the complainant submitted post hospitalization expenses claim for Reimbursement on 11.09.2009 against the hospitalization period of 08.10.2007 to 11.10.2007 which is against the Policy condition No. 6 which speaks about the submission of claim within 30 days from the completion of treatment hence found not payable. The respondent further mentioned that the above denial is communicated to complainant vide their letter dated 18.09.2009

Observations:

It is an admitted fact that the Complainant was covered under the above mentioned Policy and was admitted in the CHL Hospital, Indore for the period from 8.10.2007 to 11.10.2007 for the diagnosis of Rt. Lower Ureteric Stones and was operated where the total expenses for Rs. 37824/- were incurred and out of which Rs. 7000/- was deposited to Hospital by Complainant while other expenses are paid by Respondent/TPA being cash less settlement of claim. After discharge from the Hospital the complainant also incurred medical expenses of Rs. 1204/- for the period from 20.10.2007 to 26.10.2007 while pre-hospitalization expenses for Rs. 1220/- incurred on 3.10.2007 and submitted the claim for pre and post hospitalization claim to TPA of Respondent for Reimbursement vide his letter dated 7.7.2009 i.e. after **20 months** after the completion of treatment due to his reported shifting from Ujjain to Indore including an amount of Rs. 7000/- which were deposited to hospital by him vide Receipt No. 19079 dated 11.10.2007. (Total claim amount Rs. 9424/-) During the course of hearing the Respondent by producing the cheque No. 137976 dated 11.01.2010 stated that the cheque for Rs. 7000/- is prepared and ready to pay to complainant but the claim for pre & post hospitalization for Rs. 2424/- is not payable as the same was submitted for claim after 22 months (appox.) as against the expected period of 30 days which found violation of Policy condition.

In view of the circumstances stated above and on going through the Policy conditions and documents made available by both the parties, it is found that the complainant is entitled to receive Rs. 7000/- from the Respondent because the same are incurred by Respondent and found well payable as a part of above claim for the hospitalization period of 8.10.2007 to 11.10.2007, similarly, it is also established that the Complainant submitted claim documents for pre and post hospitalization expenses for Rs. 2424/- after 22 months from the completion of treatment which found clear violation of Policy General condition No. 6 which speaks that the claim documents must be submitted within 30 days from the completion of treatment.

Moreover, the reason behind such inordinate delay also found not satisfactory to condone the above delay hence the claim for Rs. 2424/- found not payable. Therefore, the Respondent is directed **to pay Rs. 7000/- only** 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 OF CASE NO. 5==========

CASE NO. 6 CATEGORY: MEDICLAim

Sub Category: Partial REPUDIATION OF CLAIM

Mr. Manoj Gattani……..……..……..…….... Complainant

V/s

Reliance Gen. Insurance Co. Ltd……...Respondent

Order No.: BPL/GI/09-10/54 Case No.: GI/RGI/0910/57

Order Dated 22.01.2010

Brief Background

Shri Manoj Gattani (hereinafter called Complainant) had taken a Mediclaim policy No. 28251007766101 for the period 11.09.2008 to 10.09.2009 from Reliance General Insurance Co. Ltd., (Hereinafter called Respondent)) for S.I. Rs. 1.00 Lakhs.

As per the complainant a claim was submitted for Rs. 9269/- for his hospitalization at SNG Hospital, Indore for the diagnosis of acute Gastroenteritis which is settled by Respondent after deducting Rs. 628/- unnecessary and the 2nd claim being post hospitalization expenses for Rs. 33147/- was submitted on 17.8.2009 which is settled only for Rs. 935/- after disallowing Rs. 32212/- and the 3rd claim for the Hospitalization in City Nursing Home, Indore for the period from 5.9.2009 to 9.9.2009 for Rs. 13848/- for the diagnosis of Acute

Pancreatitis was submitted on 7.10.2009 which is not settled by Respondent even after his regular follow-up and submission of all the required information. Aggrieved with the delay in settlement, unnecessary deductions and non settlement of claims for Rs. 628/-+32212/-+13848/-(total Rs. 46688/-.) the complainant approached this forum for necessary settlement of his claims.

The Respondent vide their self contained note dated 24.12.2009 along with Policy condition, claim related documents submitted that the 1st claim was for the ailment Acute Gastroenteritis hospitalization for the period from 12.5.2009 to 15.5.2009 for Rs. 9269/- was paid for Rs. 8341/- after deduction of Rs. 600/- for irrelevant investigation and Rs. 28/- being medicine prescription was not available. The 2nd claim was reported as Post Hospitalization and on scrutiny of claim documents it was found that the above reported treatment on OPD basis was for different ailment i.e. Chronic Pancreatitis however an amount of Rs. 935/-was found relevant towards Post hospitalization hence the same was paid and rest amount of Rs. 32212/- found out of scope of Policy coverage as per Policy terms and condition hence deducted. As regards 3rd claim for the hospitalization period 5.9.2009 to 9.9.2009 for the ailment Acute Pancreatitis is under process and deficiency letter send to complainant towards requirement of document which are still awaited and the same will be processed soon after the complainant submits the deficiencies compliances.

Observations:

I have gone through all the materials on record and findings of hearing and my observations are as follows.

It is an admitted fact that the Complainant was covered under the within mentioned policy and was hospitalized at SNG Hospital, Indore for the period from 12.5.2009 to 15.5.2009 for the Diagnosis of Acute Gastroenteritis and the 2nd claim for the investigation and treatment as Out Patient at Asean Institute of Gastroenterology, Hyderabad for the diagnosis of **Chronic Pancreatitis** while the 3rd claim is lodged for the hospitalization at City Nursing Home, Indore for the diagnosis of Ac. Pancreatitis which is under process. During the course of hearing the complainant reiterated almost all the points as mentioned in his complaint letters and stated that the respondent deducted wrongly Rs. 628/- in first

hospitalization claim and Rs. 32212/- in 2nd claim as Post Post hospitalization claim while he will comply the required information as desired by Respondent after getting it from the Doctor. On the other side the Respondent stated that in first hospitalization claim the USG whole Abdomen Investigation report was found irrelevant to the diagnosis for which Rs. 600/- was deducted while Rs. 28/- for the medicines "Electrol Powder" was not supported with prescription. The Respondent further stated by producing the Medical records that on scrutiny of reported Post hospitalization claim for Rs. 33147/- it was found that the above treatment is for different ailment i.e. for chronic Pancreatitis taken under the advices of doctor of Asean Institute of Gastroenterology as Out Patient or on OPD basis where no hospitalization was there while the previous Hospitalization was for Acute Gastroenteritis therefore the treatment except for Rs. 935/- found for other disease and not for continuous treatment of the disease, illness for which the complainant was hospitalized giving rise to an admissible claim under the Policy moreover, there was no hospitalization hence the same could not be considered neither under the category of Post Hospitalization claim nor as Hospitalization claim. The respondent further explained that the another claim i.e. 3rd for the hospitalization period of 5.9.2009 to 9.9.2009 is under process and pending due to requirement of medical documents and clarification of treating doctor as regards nature of disease from the complainant which is not provided by complainant even after their letter dated 2.11.2009, 7.12.09 and on phone also. The respondent produced copy of deficiency letter dated 2.11.2009 and 7.12.2009 addressed to Complainant which was handed over to the Agent Mr. Gangwal and also requested during hearing to the Complainant to provide the above information so that the claim settlement could be finalized. The complainant accepted that it was informed over phone for the above deficiency and he will provide the same after getting it from doctor. On asking the Respondent stated that USG whole abdomen was done as per the advices of Doctor.

In view of the circumstances stated above and on going through the documents, it is established that the amount of Rs. 628/- is deducted wrongly in the first claim as the same was as per the advices of treating doctor while the 2nd claim reported for Post hospitalization is rightly denied by Respondent as the same found for different ailment and out of scope of Policy. The 3rd claim for the Hospitalization period 5.9.2009 to 9.9.2009 is under process and pending for the compliances of required information to Respondent by complainant hence the same can not be considered as part of this judgment. Therefore, the Respondent is **directed to pay Rs. 628/-** as wrongly deducted under first hospitalization claim to complainant within **15 days** days from the receipt of consent letter from 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 of 6==========

Case no. 7 category: MEDICLAIM

SUB CATEGORY: PARTIAL REPUDIATION OF CLAIM

Shaily Jagdish Maheshwari..……..…….. Complainant

V/s

Reliance Gen. Insurance Co. Ltd……... Respondent

Order No.: BPL/GI/09-10/56 **Case No.: GI/RGI/0911/73**

Order Dated 28.01.2010

Brief Background

Ku. Shaily Maheshwari (hereinafter called Complainant) was covered under a Mediclaim Policy No. 1001082278 for the period 4.6..2008 to 3.6.2009 issued by Reliance General Insurance Co. Ltd., (Hereinafter called Respondent)) for S.I. Rs. 50000/-

As per the complainant a Mediclaim claim was submitted to Respondent which is settled after disallowing Rs. 6619/- in respect of hospitalization in Arihant Hospital assuming that the above hospitalization is not justified. It is further mentioned that a certificated issued by Doctor was also submitted on 13.7.2009 to Respondent but the claim for Rs. 6619/- is not settled by TPA. The complainant further approached to Respondent vide letter dated 24.9.2009 but there also no response. Aggrieved with the unnecessary deduction for Rs. 6619/- the complainant approached this forum for settlement of claims.

The Respondent vide their self contained note dated 30.12.2009 submitted that the claim was submitted for Rs. 29598/- for the Hospitalization period from 14.3.2009 to 22.3.2009 and

as per scrutiny of available documents the claim for Rs. 22784/- was paid on 20.3.2009 while Rs. 6619/- were not payable as per Policy terms and condition.

Observations:

It is an admitted fact that the Complainant was covered under the within mentioned policy and was hospitalized at Arihant Hospital & Research Centre, Indore for the period from 14.3.2009 to 17.3.2009 as per the advices of Hospital doctor for the main complaints of Fever on & off, Throat pain blood with Exp. and chakkar etc. where various Pathological tests were advised and arranged at Hospital and total expenditure for Rs. 6619/- were incurred. Later on the complainant was admitted in Anand Hospital and Research Centre, Indore for the diagnosis of DNS with Rhinosinusitis where she was operated for Septoplasty and Bulla partial excision done on 20.3.2009 and remained hospitalized for the period from 20.3.2009 to 22.3.2009. During the course of hearing the Respondent stated that the first hospitalization was for Routine checkup and for Pathological tests only and the stay in a Hospital was without undertaking any treatment or there is no active regular treatment by the Hospital which is excluded from the scope of Policy hence the same was not paid while the other hospitalization claim for the hospitalization period from 20.3.2009 to 22.3.2009 stands paid. The forum drawn the attention of Respondent towards first prescription of Arihant Hospital & Research centre where it is clearly mentioned that "Admit Private Ward" and also a certificate dated 8.7.2009 issued by Arihant Hospital under the signature of Dr. Paras Maru where it is mentioned that the case is further referred to ENT Surgeon Dr. Subir Jain. Then how their TPA can say that the above hospitalization was not relevant? The Respondent could not reply in positive but reiterated that as per Discharge Card of Arihant Hospital there was no mention about Diagnosis. On asking the Respondent explained that the amounts of Rs. 770/- for Service Charges and Rs. 50/- for Registration fee out of Bill for Rs. 6619/- charged by Arihant Hospital are absolutely out of scope of Policy.

In view of the circumstances stated above and on going through the documents, it is established that the entire rejection of claim for the Hospitalization at Arihant Hospital & Research centre, Indore for the period from 14.3.2009 to 17.3.2009 **is not just and fair** as the same is done as per the advices of Doctor and due to health problems being suffered by complainant who later on diagnosed as DNS with Rhinosinusitis as a case of Nasal obstruction. Moreover the hospitalization is also stands justified by Hospital vide their certificate dated 8.7.2009, however, an amount 820/- under the head of Service charges and Registration charges by above hospital found not covered under the scope of Policy. **Therefore, the Respondent is directed to pay Rs. 5799/- to complainant** within **15 days**

days from the receipt of consent letter from 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 OF CASE NO. 7==========

CASE NO. 1 FOR CATEGORY: MEDICLAIM

SUB CATEGORY: DELAY IN SETTLEMENT

Mr. Ganpat Kumhar…..……..……..…….. Complainant

V/s

Reliance Gen. Insurance Co. Ltd……... Respondent

Order No.: BPL/GI/09-10/45 Case No.: GI/RGI/0709/34

Order Dated 23.11.2009

Brief Background

Shri Ganpat Kumhar (hereinafter called Complainant) had taken a Mediclaim policy No. 282510265674 for the period 18.07.2008 to 17.07.2009 from Reliance General Insurance Co. Ltd., (Hereinafter called Respondent) including for Master Nikhal Kumhar (son) for S.I. Rs. 2.00 Lakhs.

As per the complainant his son Master Nikhal was admitted in Jahangir Hospital, Pune for the period from 24.10.2008 to 15.11.2008 and the cashless facility was agreed by respondent but it was agreed for very short amount the hospital management did not agree for cashless facility and finally all expenses paid by complainant to Hospital and submitted the claim for Reimbursement basis for Rs. 134070/- on **6.2.2009** but since then neither claim is settled nor any response received from the Respondent. Aggrieved with the non-settlement of claim the complainant approached this forum for necessary settlement of his claim.

During hearing it is informed by Respondent that the Policy No. as provided to them by this forum for self contained note etc. is not matching with their record hence they are unable to submit the self contained note and also explained that as per the documents shown just now by complainant to him it reveals that the important documents like pre-hospitalization/first consultant record are not provided so far by the complainant even after their reminder causing pendency in processing of claim as the same are essential for the processing of claim. On asking from the Complainant about wrong policy No. and non submission of claim related all the documents, he expressed that it is a mistake by an oversight on his part and assured to submit the required medical documents within short period to Respondent. In the above hearing both the parties asked for extension of hearing for another 15 days which is agreed by this forum with the advices to both to submit written representation to this forum for the above extension of Hearing. The next date of hearing was fixed for 19.11.2009 at Bhopal. In the meantime the Respondent submitted self contained note mentioning that the claim documents submitted with delay of **58 days** and the deficiency of documents were raised by TPA vide their letters dated 19.01.09, 10.2.09, 18.2.09, 14.3.09, 20.3.09 but the required documents were not submitted by the complainant therefore, the claim was closed as No claim vide their letter dated 8.4.2009. The Respondent further mentioned that due to direction given by this form to complainant the complainant provided authority letter to direct obtain the documents from the hospitals which were obtained and the claim was re-processed and on processing the documents it is found that the child had poor stream of urine since birth while the inception date of policy is 18.7.2008 and this particular ailment is found to be prior to the inception of Policy and the claim is also falling under the category of first year exclusion hence the claim was finally repudiated. On 19.11.2009 the Respondent was appeared but the Complainant informed over phone that he reached to previous hearing place i.e. LIC D.O. Indore assuming that this hearing is also arranged at same place and requested to fix the hearing for 20.11.2009 so that he could appear in the forum which was allowed by forum and conveyed to both the parties. On 20.11.2009 both appeared in the forum.

Observations:

It is an admitted fact that the Complainant's Son Master Nikhel was covered under the within mentioned policy and was hospitalized at Jehangir Hospital, Pune for the period from 24.10.2008 to 15.11.2008 with ailment "severe UTI, PU valves with VUR grade V and VUJ obstruction and urinary bladder diverticulum". During the course of hearing the Complainant reiterated almost all the points as already mentioned in his complaint letters and specially stated that there is delay in communicating the denial by Respondent and also that the disease was for the last few days and not since birth. On the other side the Respondent

stated that the above claim is of 8-9 month old child (Date of birth is 1.2.2008) at the time of surgery for which the first time Insurance was obtained after 5 months of his birth in the month of 17.8.2008 (for the period from 18.7.2009 to 17.7.2009) and the reported claim is not admissible on various grounds viz. 1) Inordinate delay in the submission of claim which is submitted **with delay of 58 days** 2) as per the documents received from the Hospital and indoor case paper it is evident that child had Poor Stream of Urine since Birth which found **pre-existing** at the time of inception of first Policy and 3) also falling under the category of **first year exclusion** and not payable during the first year coverage of above mentioned Policy. In this regard the Respondent submitted the Discharge summary of Jehangir Hospital and Order sheet dated 24.10.2008 of Hospital. I have gone through both the documents and observed that in Order sheet under the head of History noted "Poor stream since birth" while in the discharge summary it is mentioned "Child had H/O Straining while passing urine, Child had poor stream of urine Since Birth." The Complainant also submitted a certificated dated 2.2.2009 issued by above hospital stated that the patient was detected to have VUR during his admission had H/O UTI 10 days prior to admission. On the above produced document the Respondent explained that it is a clarification on duration of UTI which is a complication of Grade V (L) VVR with left VUJ obstruction + PU valves + Urinary Bladder diverticulum's ® lateral wall and the above are congenital in nature as were existing since birth as also confirmed in the reports.

In view of the circumstances stated above and on going through the documents, it is established that the patient was suffering the above disease since birth and prior to commencement of Insurance hence, the decision of Repudiation taken by Respondent on the grounds mentioned above (i.e. pre-existing, Delay in submission of claim, First year Exclusion etc.) **is just and Fair**. The complaint is dismissed without any relief.

==========END OF CASE NO. 1==========

BHUBANESWAR
MEDICAL-MEDICLAIM (1)

BHUBANESWAR OMBUDSMAN CENTER

Complaint No.11-017-0616

Sri Gopal Mishra

Vrs

Star Health and Allied Insurance Co. Ltd., Bhubaneswar

Award dated 03rd November 2009

Complainant had taken a Family Health Insurance Policy with Star Health and Allied Insurance Company Ltd for his family. His daughter who is covered under the policy was hospitalised for a planned surgery arising out of an accident and on discharge a claim was lodged. Insurer repudiated the claim on the grounds of 2 years exclusion clause of the policy.

Hon'ble Ombudsman heard the case on 28.10.2009 where both the parties were present. Representative of Insurer informed that the decision has been taken by his company to settle the claim on receipt of documents. The Insurance Company was directed to settle the claim within 30 days of receipt of the consent letter and copies of documents submitted to the forum are to be provided to insurer along with the order for early settlement.

****

(2)

BHUBANESWAR OMBUDSMAN CENTER

Complaint No.11-002-0624

Sri S sundararajan

Vrs

New India Assurance Co Ltd.

Bhubaneswar DO-III

Award dated 19th November 2009

Complainant had taken a Mediclaim Policy with New India Assurance Co Ltd for himself and his wife. Both were treated at Kottakal Arya vaidyasala. Complainant submitted all treatment papers for his hospitalization but Insurer has not settled the claim on the grounds that Kottakal Arya Vaidysala is not a Government Hospital.

Hon'ble Ombudsman heard the case on 28.10.2009 where both sides were present. Insurance company expressed that they are unable to settle the claim as the treatment is not taken at a Govt Hospital as provided in the policy. However complainant has submitted documents to this forum which proves that the Vaidyasala is ecognized by the state authorities and a

registration no is allotted. Therefore Hon'ble ombudsman on perusal of all documents and terms and conditions of the policy, held that the treatment centre is a registered one and the policy condition allows for treatment at such centres and hence directed the insurer to settle the claim on receipt of consent letter and the bills/ cash memos for the treatment.

****

(3)

BHUBANESWAR OMBUDSMAN CENTER

Complaint No.14-005-0630

Sri Firoz Ahmed

Vrs

Oriental Insurance Co Ltd.

CBO-I,Bhubaneswar

Award dated 23rd December 2009

Complainant had taken a Mediclaim Policy with Oriental Insurance Co Ltd for himself and his wife. Complainant during policy period was treated for right side haemorrhages at SCB Medical college hospital. After discharge he preferred a claim. Insurer has not settled the claim even after submission of documents.

Hon'ble Ombudsman heard the case on 24.11.2009 where both sides were present. Insurance company expressed that they are unable to settle the claim as the prescription relating to four bills has not been submitted. Complainant argued that all documents have been submitted. Hon'ble ombudsman on perusal of all documents directed the insurer to settle the claim on receipt of order without waiting for consent letter.

****

(4)

BHUBANESWAR OMBUDSMAN CENTER

Complaint No.12-012-0635

Sri Subash Chandra Mishra

Vrs

ICICI Lombard General Insurance Co. Ltd., Bhubaneswar

Award dated 01st January 2010

Complainant had taken a Family Plus Health Insurance Policy with ICICI Lombard General Insurance Company Ltd for his family. On receipt of the policy the complainant informed insurer to cancel the policy, citing the reasons. Even after reminders neither the policy was cancelled nor, pro-rata premium refund was made.

Hon'ble Ombudsman heard the case on 24.11.2009 where insurer was absent. But by the time order was being prepared, insurer confirmed in writing that the policy has been cancelled and the refund of premium has been done through the credit card account if complainant as the premium was paid through that account only. Hence Hon'ble Ombudsman felt no necessity of a formal order and ordered closure of the complaint.

****

(5)

BHUBANESWAR OMBUDSMAN CENTRE

Complaint No.11-004-0643

Sri Ajay Kumar Das

Vrs

United India Insurance Co. Ltd., Hyderabad D.O-IV

Award dated 13th January 2010

Complainant had taken a Mediclaim policy from United India Insurance Co. Ltd. and had preferred a claim which was turned down by the insurance company on the plea that the ailment treated for was pre-existing.

Hon'ble Ombudsman heard the case on 22.12.2009 where both parties were present. After hearing the both parties and perusing the documents Hon'ble Ombudsman held that the treatment was not for any pre-existing disease as the policy is renewed by insurer and for the same ailment earlier claim has been settled. The earlier contract of insurance has been renewed without any conditions and therefore directed the insurance company to pay the claim to the complainant within one month of receipt of consent letter.

****

CHANDIGARH

CHANDIGARH OMBUDSMAN CENTRE

CASE NO. GIC/386/NIC/11/10
Jasbeer Singh Vs National Insurance Co. Ltd.

ORDER DATED: 07th October, 2009 **MEDICLAIM**

FACTS: Sh. Jasbeer Singh was covered under mediclaim policy No. 361102/48/08/8500003840 for the period 18.10.08 to 17.10.09 covering himself and his family. His son Moksh was admitted in Parkash Children Hospital from 30.04.2009 to 04.05.2009 and incurred a sum of Rs. 12485/-. He submitted all the claim papers to TPA. However, TPA vide its letter dt. 17.07.2009 rejected the claim on the ground that Parkash Hospital was not in the list of authorized hospitals of the insurer. Parties were called for hearing on 07.10.2009 at New Delhi.

FINDINGS: The insurer clarified the position by stating that the hospital is not in the list of 64 hospitals approved by the insurer.

DECISION: Held that making of the claim as no claim on the basis of hospital not being on approved list of 64 hospitals of the insurer is not in order. On going through the discharge summary, the bonafides of the treatment are justified. The claim is payable. It is hereby ordered that the admissible amount of claim should be paid by the insurer to the complainant.

CHANDIGARH OMBUDSMAN CENTRE

CASE NO. GIC/353/NIC/11/10

Kasturi Lal Vs National Insurance Co. Ltd.

ORDER DATED: 01st October, 2009 **MEDICLAIM**

FACTS: Sh. Kasturi Lal had taken a mediclaim policy vide cover note No. 325364 dt. 18.07.2008 for the period 21.07.08 to 20.07.09 covering himself and his family. It is stated by the insured that he is regularly purchasing this policy for the last 7 years. The insured underwent Cataract Surgery (RE) Multifocal at Grewal Eye Institute, Chandigarh and incurred expenses of Rs. 56000/-. He was, however, paid a sum of Rs. 41200/- against the amount of Rs. 56000/-. It is further stated that inspite of several contacts with the insurer, he has not been informed the reason for less payment. Parties were called for hearing on 01.10.2009 at Chandigarh.

FINDINGS: The insurer clarified the position by stating that as per their investigation, it has been learned that the IOL which has been used in the surgery should cost a maximum of Rs. 20000/- whereas in the bill given by Grewal Eye Institute, the amount has been mentioned as Rs. 35000/-. Hence Rs. 15000/- was deducted from the bill.

DECISION: Held that on going through the records and after speaking to Dr. Amit of Grewal Eye Institute, he stated that the cost of IOL is depending on the package received. For a multifocal package the cost of IOL is Rs. 35000/-. There is no reason to doubt the veracity of the statement of Dr. Amit. Since the complainant has paid Rs. 35000/- for the lens, he is entitled to the reimbursement accordingly. It is hereby ordered that the balance amount due should be paid by the insurer to the complainant alongwith interest @8% per annum w.e.f. 31.03.2009.

CHANDIGARH OMBUDSMAN CENTRE

CASE NO. GIC/360/NIC/11/10

Tarun Winlass Vs National Insurance Co. Ltd.

ORDER DATED: 21st October, 2009 **MEDICLAIM**

FACTS: Sh. Tarun Winlass had taken a mediclaim insurance policy No. 420400/48/07/8500000284 covering his wife Mrs. Sarita Windlass. She was admitted in Prime Heart and Vascular Institute, Mohali from 09.05.08 to 16.05.08. Her periphery angiography followed by angioplasty was

performed on 10.05.2008 to 12.05.08. He submitted all the claim papers to TPA. However, his claim was treated as not admissible by TPA vide its letter dt. 17.09.2008 with the remark "sent to BO/DO for rejection". It is stated by the insured that after this he has sent number of reminder to TPA but got no response. Parties were called for hearing on 09.10.2009 at Chandigarh.

FINDINGS: The insurer clarified the position by stating that the treatment was for Fibro Muscular Dysphasia and peripheral vascular disease. Fibro Muscular Dysphasia is a part of exclusion clause 4.3 of terms and conditions of the policy regarding first year exclusions. Moreover, this is a rare disease which is congenital in nature. Both congenital disease and Fibro muscular Dysphasia are not payable in the first year of the policy. A congenital disease will not manifest itself after a person has crossed 35 years of age and had been leading normal healthy life before that. This fibrous development appears to be a recent growth in the body for which treatment was taken. The insurer was asked to give details of congenital disease. He stated that this was not a congenital disease However it was a genetic disorder and genetic disorder is not payable as per exclusion clause 4.15.

DECISION: Held that on going through the clarification about Fibro Muscular Dysplasia from the internet, this appears to be a common disease in middle age women and there is nowhere mentioned that this is a genetic disorder. Thus giving the benefit of doubt to the complainant, the claim in my view is payable. However to give weightage to the contention of the insurer that genetic disorders are not payable, the settlement of the claim on non standards basis to the extent of 70% of the admissible amount would meet the ends of justice.

CHANDIGARH OMBUDSMAN CENTRE

CASE NO. GIC/409/NIC/12/10

Paramjit Singh Vs National Insurance Co. Ltd.

ORDER DATED: 30th October, 2009 **MEDICLAIM**

FACTS: Sh. Paramjit Singh had taken a mediclaim policy No. 404001/48/08/8500000119 for the period 30.07.08 to 29.07.09 covering himself and his family. His wife was admitted in hospital and mediclaim claim for Rs. 105844/- was sent to insurer on 02.02.2009 but the claim has not been settled in spite of reminders. Further it is also stated that he has requested by fax on 23.07.09 for renewal of his mediclaim policy but same has also not been renewed. Parties were called for hearing on 30.10.2009 at Chandigarh.

FINDINGS: The insurer clarified the position by stating that this was the first year of the policy with them. The patient was suffering from Kidney related disease for the last 4-5 years. Hence it was

treated as a case of pre-existing disease and the claim was repudiated under clause 4.1 of terms and conditions of the policy. On a query, whether treatment in the hospital was for kidney related disease, the insurer stated that the patient was admitted for kidney related disease but during investigation it was found that she was suffering from Hepatitis C and accordingly treatment was taken for Hepatitis C.

DECISION: Held that the contention of the complainant that the patient was treated for Hepatitis appears justified. There is no record to show that treatment was taken for kidney related disease. Giving the benefit of doubt to the complainant and taking a fair and just view, the claim for hospitalization between 06.12.2008 to 08.12.2008 is payable. The repudiation of the claim is, therefore, not in order. It is hereby ordered that the admissible amount of claim should be paid by the insurer to the complainant.

CHANDIGARH OMBUDSMAN CENTRE

CASE NO. GIC/504/NIC/11/10

Neel Kamal Gulati Vs National Insurance Co. Ltd.

ORDER DATED: 03rd November, 2009 **MEDICLAIM**

FACTS: Sh. Neel Kamal Gulati had taken a mediclaim policy No. 361100/48/08/8500004374 for the period 31.03.2009 to 30.03.2010 covering his family. His son Tanish Gulati was admitted in Batra Hospital from 03.04.2009 to 04.04.2009. All the papers were submitted to TPA, M/s Vipul MedCorp TPA Pvt. Ltd. However, the claim was rejected by the TPA vide its letter dt. 06.07.09 on the ground that patient admitted for diagnosis purpose which is not covered as per Exclusion clause 4.10 of terms and conditions of the policy. Parties were called for hearing on 03.11.2009 at New Delhi.

FINDINGS: The insurer clarified the position by stating that the hospitalization was for evaluation. All testes were normal. There was no effective procedure done in the hospital. Hence the claim was repudiated.

DECISION: Held that the contention of the insurer that hospitalization was for evaluation / diagnosis purposes is showed by discharge summary. The repudiation of the claim on the ground of exclusion clause 4.10 of terms and conditions of the policy is, therefore, in order. No further action is called for. The complaint is dismissed.

CHANDIGARH OMBUDSMAN CENTRE

CASE NO. GIC/439/OIC/11/10

Roop Kishore Soni Vs Oriental Insurance Co. Ltd.

ORDER DATED: 06th November, 2009 **MEDICLAIM**

FACTS: Sh. Roop Kishore Soni's wife Smt. Manju Soni was insured under mediclaim policy bearing No. 231100/48/2009/1160 for the period 05.01.2009 to 04.01.2010. As she was not well she was hospitalized on 19.05.2009. He applied for cashless facility but the same was denied. His wife expired on 24.05.2009. He applied for the claim on 10.06.2009 and submitted all the documents. The TPA, M/s Vipul Medcorp rejected the claim on 02.09.09 stating that any disease after pregnancy and a child birth is not covered. He stated that his wife had an abortion on 07.05.09 and thereafter she was normal. She was admitted to the hospital on 19.05.2009 as she was suffering from Pneumonia. He alleged that he was not told about the diseases which were covered under the policy. Also at the time of cashless facility he was not informed whether the disease mentioned in the pre-authorization letter was covered or not. Parties were called for hearing on 06.11.2009 at Chandigarh.

FINDINGS: The insurer clarified the position by stating that this was a case of complication after abortion. Since no maternity cover is available in the mediclaim policy, the claim is not payable as per the finding of TPA, M/s Vipul MedCorp (TPA) Pvt. Ltd. On a query, whether death summary was available, the insurer replied in the affirmative.

DECISION: Held that the abortion was on 07.05.09 and the DLA was admitted in the hospital on 19.05.09 after suffering from pneumonia. She expired on 24.05.09 during this hospitalization and the cause of death given in death summary is cardiac arrest. Taking the above into consideration, the death had not taken place in continuation of abortion related problem but during a separate hospitalization. Moreover, since the cause of death is cardiac arrest which does not appear to have correlation with abortion, the claim is payable. The repudiation of the claim is, therefore, not in order. It is hereby ordered that the admissible amount of claim should be paid by the insurer to the complainant.

CHANDIGARH OMBUDSMAN CENTRE

CASE NO. GIC/495/NIA/11/10

Kamal Pahwa Vs. New India Assurance Co. Ltd.

ORDER DATED: 09th November, 2009 MEDICLAIM

FACTS: Shri Kamal Pahwa was having a Mediclaim Insurance Policy from The New India Assurance Co Ltd. since 2006. In 2008-09, the policy was renewed after a gap of 13 days. This gap was due to illness of the agent who was renewing his policy from 2006. On renewal it was never informed to him that his policy was not considered as continuous policy and claim will not be paid. On 07-06-09, he was operated in Bassi Hospital, Ludhiana for stone in kidney. The claim was lodged with the insurance company but they repudiated the claim on the ground that there was gap of 13 days between the renewal of insurance so claim is not payable. Parties were called for hearing on 09.11.09 at Chandigarh.

FINDINGS: The insurer clarified the position by stating that there was a gap of 13 days between the renewal of insurance in 2007-08 and 2008-09 policies. Since there was a gap, the policy of 2008-09 was treated as a fresh policy. Stone in the kidney is covered under exclusion clause 4.3 of terms and conditions of the policy relating to first two year exclusions. Hence the claim was repudiated. On a query, whether a fresh proposal form was filled up by the complainant at the time of renewal of the policy after a gap of 13 days, neither the insurer nor the complainant could give a satisfactory reply.

DECISION: Held that while the contention of the insurer that the claim is not payable within the first 2 years of the policy is justified, this would need clarification regarding the renewal having been done after following usual procedures for issuing a fresh policy. If a fresh proposal form and fresh medical examination report were available with the insurer, the claim is not payable. However, in the absence of these documentary formalities, the policy should be treated as continuous and accordingly treated as the 3rd year of the policy and hence the claim is payable. The insurer is advised to check-up their records accordingly and settle the claim as per either of the two options given above.

CHANDIGARH OMBUDSMAN CENTRE

CASE NO. GIC/550/NIC/11/10

Subhash Singh Vs National Insurance Co. Ltd.

ORDER DATED: 19th February, 2010 **MEDICLAIM**

FACTS: Sh. Subhash Singh was covered under Bhai Ghanhya Sehat Sewa Scheme vide policy No. 400104/46/08/85/00000096 for the period 01.10.08 to 30.09.09. The insured met with an accident on 04.07.09 and was hospitalized at Arora Hospital. When he showed his mediclaim card for cashless treatment, he was informed that his card has been blocked. The parties were called for hearing on 19.02.2010 at Chandigarh

FINDINGS: The insurer clarified the position by stating that in the above mentioned case Mrs. Krishna Devi, mother of the complainant declared her age as 69 years, but age recorded as per election commission voter list (ID No. 07/063/108015), is 77 years. Hence the card of the entire family was blocked on account of misrepresentation and violation of utmost good faith which is material for all insurance contracts. Further the policy does not cover any person with more than 75 years of age.

DECISION: On the basis of papers on record and submission made by the insurer, it is established that there was misrepresentation about age in respect of mother of the complainant making the policy as null and void *ab-initio*. The insurer is justified in rejecting the claim. The complaint is dismissed without any relief to the complainant.

CHANDIGARH OMBUDSMAN CENTRE

CASE NO. GIC/553/NIC/11/10

Ram Avtar Gupta Vs National Insurance Co. Ltd.

ORDER DATED: 19th February, 2010 **MEDICLAIM**

FACTS: Sh. Ram Avtar Gupta had taken a mediclaim insurance policy No. 421600/48/05/8500000540 for the period 29.03.06 to 28.03.07 covering himself and his wife. He was admitted in Escort Hospital, New Delhi under emergent condition. He spent a sum of Rs. 2,01,860/- on hospitalization. He furnished all relevant papers and formalities to insurer who forwarded the same to TPA, M/s Vipul MedCorp TPA Pvt. Ltd. However, his claim was rejected by TPA after a gap of 2 years on the pretext that his disease was pre-existing. The parties were called for hearing on 19.02.2010 at New Delhi.

FINDINGS: The insurer clarified the position by stating that as per proposal form submitted by the complainant, he has declared on the back side of the proposal in column No. 18 that his angioplasty was completed in April 2005 at Escort Heart Institute. M/s Vipul MedCorp TPA Pvt. Ltd. has repudiated the claim on the ground that the patient underwent Coronary Angioplasty. He was diagnosed as a case of Hypertension, Coronary Artery Disease, Post PTCA. The insured has a pre-existing disease as mentioned in the proposal form. Therefore, the claim is not payable as per terms and conditions of the policy.

DECISION: The claim for hospitalization has been repudiated on the ground that patient underwent coronary angioplasty. There is on record a proposal form dated 23.03.06 submitted at the time of taking the policy wherein in reply to question No. 3, the complainant has answered as NIL meaning thereby that he has never suffered from blood pressure, heart disease including ischemic heart and other circulatory disorder etc. (rheumatic fever). However, on the reverse side of the proposal form, in reply to column No. 18, it is stated that his angioplasty was completed in April 2005 at Escort Heart Institute. The information given thus is contradictory. Angioplasty is normally performed when a patient is suffering from heart disease and so as per proposal form some disease of heart was pre-existing. Since policy does not cover pre-existing diseases, the insurer is justified in repudiating the claim.

CHANDIGARH OMBUDSMAN CENTRE

CASE NO. GIC/681/UII/14/10

Subhash Jain Vs United India Insurance Co. Ltd.

ORDER DATED: 15th March, 2010 **MEDICLAIM**

FACTS: Sh Subhash Jain had taken a mediclaim policy bearing No. 201000/48/09/97/ 00000848. He had submitted the claim of his son Sh. Kamal Jain to the TPA on 14.10.2009 for Rs.

14927/-. But now even after a lapse of two months he has neither received any reply nor any claim payment. The hearing was held on 15.03.2010 at Chandigarh.

FINDINGS: The insurer submitted that the complainant was informed by the TPA vide their letter dated 11.11.2009 that the claim was repudiated on the ground that no active management was done during the hospitalization. The bill is only for the investigation done and there was no active treatment. This was followed by letter Ref: DO:IV:09 dated 06.01.2010. They informed him that there was no active management done during hospitalization, so the claim is not payable.

DECISION: An analysis of material on record reveals that the hospitalization was for one day only and by way of treatment, a tablet of medicine for anxiety was given. Main charges for the hospitalization on aspect of investigations only amounted to about Rs. 9000/-. From the facts and circumstances of the case and materials on record, it is established that the hospitalization was basically for investigation purpose and it was not consistent with or incident to the diagnosis. There was no positive existence for presence of any ailment sickness or injury for which hospitalization was required. The respondent has therefore justified the repudiation of the claim. The complaint is dismissed.

CHANDIGARH OMBUDSMAN CENTRE

CASE NO. GIC/620/OIC/11/10

Manmohan Mehra Vs Oriental Insurance Co. Ltd.

ORDER DATED: 15th March, 2010 **MEDICLAIM**

FACTS: Sh. Manmohan Mehra had taken a mediclaim policy from insurer bearing No. 233300/48/2009/1558 covering self and his wife Smt. Poonam Mehra for sum insured of Rs. 3,00,000/- each for the period 31.03.2009 to 30.03.2010. He submitted that he had initially taken the policy from United India Insurance Co. Ltd. in April 2000, then from National Insurance Co. Ltd. from April 2001 continuously without break for 5 years upto April, 2006. Thereafter he shifted to Oriental Insurance Co. Ltd. from 31.03.2006 without any break. His wife was admitted on 07.05.2009 at Fortis Escort's Hospital, Amritsar and was operated for osteoarthritis of both knees and discharged on 15.05.2009. The total bill charged by the hospital was Rs. 283000/-. The matter was taken up with TPA, M/s E-Meditek Solutions Ltd. who provided a cashless facility for Rs. 2.00 lakh only. Thereafter, he submitted the claim papers for balance payment of Rs. 83000/- to the insurance company. He wrote several letters to the insurance company, finally he received a letter dt.

21.07.2009 on 13.10.2009 from TPA stating that at the time of onset of the disease in 2007, the sum insured was restricted to Rs. 2.00 lakh only. Hence as per clause of Indemnity 3.16, the claim is not payable. Parties were called for hearing on 15.03.2010 at Chandigarh.

FINDINGS: The main dispute is about non payment of cumulative bonus under the policy accrued up to 2008. The complainant submitted that he was not informed about the new terms and conditions and also about the condition that surgery for knee due to artheritis has a waiting period of four years.

DECISION: The insurance contracts are based on the principle of good faith which is reciprocal. If the insured is required to inform the insurer the material information about his health, insurer in turn has also the obligation to inform the insured about any changes made in terms and conditions of the policy. From the papers on record in the subject claim, it is established that since the terms and conditions of the policy were not informed/attached with the policy. There is breach of good faith on the part of the insurer, the insurer is therefore directed to pay a sum of Rs. 40,000 on *ex-gratia* basis to the complainant as full and final settlement of claim within 15 days from the date of receipt of consent from the party.

CHANDIGARH OMBUDSMAN CENTRE

CASE NO. GIC/644/NIC/14/10

Mukand Singh Vs National Insurance Co. Ltd.

ORDER DATED: 17th March, 2010 **MEDICLAIM**

FACTS: Sh. Mukand Singh was covered under Bhai Ghanhya Sehat Sewa Scheme vide policy No. 400104/46/08/85/00000096 for the period 01.10.08 to 30.09.09. The complainant was in need of treatment and was admitted in Noor Multi-specialty Hospital, Barnala. However, TPA refused their authorization and informed that card issued by them has been blocked by insurer due to age difference. It is stated by the insured that the age as per TPA card is 68 years and also as per the voter card issued by electoral commission age is 68 years. The premium which was due has been paid by him before taking the policy from the insurer. He spent a sum of Rs. 27246/- on his hospitalization. Parties were called for hearing on 17.03.2010 at Chandigarh.

FINDINGS: The insurer clarified the position by stating that the complainant, declared his age as 68 years but as per the election commission card the age revealed as 75 years as on 01.01.2009, so there is difference in premium received. Mr. Mukand Singh Falls in 3rd premium slab but he paid

premium according to 2nd slab. Hence the card of the entire family was blocked on account of misrepresentation and violation of utmost good faith which is material in all insurance contract. The complainant submitted electoral card No. PB/10/084/339250 which gives the age of Sh. Mukand Singh as 55 years as on 01.01.1995. Accordingly, he was 68 years of age on the date of inception of the policy.

DECISION: Held that the insurer contention that his age is 75 years as on 01.01.2009 is not tenable. The insurer is, therefore, directed to pay the admissible amount of claim within 15 days from the date of submission of requirement by the complainant.

DELHI

Case No. GI/100/NIC/09

In the matter of Shri Mukesh Kumar Vs

National Insurance Company Limited

AWARD dated 03.11.2009

1. This is a complaint filed by Shri Mukesh Kumar (herein after referred to as the complainant) against the decision of the National Insurance Company Limited (herein after referred to as respondent insurance company) in rejecting his claim in respect of his spinal operation under mediclaim policy No.360501/48/07/8500004313 taken with the respondent company for a sum of Rs.39000/-.

2. The brief facts of the case are as follow:

3. The complainant has taken mediclaim policy with the respondent company vide policy No. 360501/48/07/8500004313 for the period 23.03.2009 to 22.03.2010 covering self, wife and two children. Subsequently, the complainant had undergone spinal surgery in the All India Institute of Medical Sciences (AIIMS) during the period 19.06.2008 to 30.08.2008. He has submitted the claim for the spinal surgery to the respondent company who have however repudiated the claim on the ground that the above operation is due to "Spinal Congenital" and as such the same is excluded under policy clause 4.8. The basis of rejection of the policy is as per the discharge summary of the AIIMS (EX: R1). On going through the above discharge summary, it is no doubt written against the diagnosis "Spinal Congenital".The complainant claims that the above remark was a mistake and he has produced a remark by the same surgeon who had undertaken the surgery, that is, Dr.D.K.Gupta who made the clarification in response to the complainant's letter dated 06.01.2009 (EX: C1). In the above letter, Dr.D.K.Gupta had given a clarification that the case was not congenital. It was signed by Dr.D.K.Gupta himself. However, the TPA on behalf of the respondent company was not accepting the above clarification. It is also found that

before the surgery at AIIMS, the complainant was admitted into Kalra Hospital between 11.07.2008 to 13.07.2008, the discharge summary at the Kalra hospital (EX:C2) has not mentioned anywhere about the complaint being congenital. In fact the neurosurgeon in that hospital had advised spinal surgery. Apart from these above two documents, it is common knowledge that if a patient is suffering from congenital spinal problem, such a treatment would have been necessitated in the early years of the childhood of the patient (complainant) and problems could not wait around 30 years for them to surface. It is also recorded that the complainant was having problems only since 1 year. In view of the above documents and circumstances available, there is considerable doubt that the above complaint could be due to congenital problems. Therefore, I give the benefit of doubt to the complainant supported by both the documents quoted above, that is, (EX: C1 & C2). As such, I hold that holding the above treatment as congenital under policy clause 4.8 of the policy is not fair. As such, I direct the respondent company to scrutinize the claim as per the bills submitted and settle the same.

4. The complaint is disposed of accordingly.

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

6. Copies of the Award to both the parties.

Case No. GI/119/OIC/09

In the matter of Shri Pale Ram Gupta Vs.

The Oriental Insurance Company Limited

AWARD dated 04.11.2009

1. This is a complaint filed by Shri Pale Ram Gupta (herein after referred to as the complainant) against the decision of The Oriental Insurance Co. Ltd. (herein after referred to as respondent Insurance Company) for not settling the claim under a mediclaim policy.

2. In the course of personal hearing, it was clarified by the respondent company that the complainant had submitted bills only in respect of the treatment in Ganga Ram Hospital for the period of his treatment from 13.11.2007 to 16.11.2007. No bills were submitted in respect of further treatment taken by him elsewhere.

3. This Forum is therefore directing the respondent company to settle the claim to the extent the bills were already submitted and for the balance amount, they may consider the same after the complainant submits documents proof of further treatment.

4. The complaint is disposed of accordingly.

5. 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.

6. Copies of award to both the parties.

Case No. GI/77/NIA/09

In the matter of Shri R. Saxena Vs.

The New India Assurance Company Limited

AWARD dated 04.11.2009

1. This is a complaint filed by Shri R. Saxena (herein after referred to as the complainant) against the decision of The New India Assurance Co. Ltd. (herein after referred to as respondent Insurance Company) in repudiating his mediclaim.

2. The brief facts of the case are as follows:
3. The complainant had taken a mediclaim policy with the respondent company for the period 24.01.2008 to 23.01.2009. Thereafter, the complainant was admitted into a hospital for the treatment of stroke between 14.02.2008 to 20.02.2008. The claim for Rs.92083/- was preferred on the respondent company. However, the respondent company had repudiated the claim on the ground that the medical bills and other relevant documents were submitted after a lapse of 30 days and as per the policy conditions, the claim was repudiated. In the course of the personal hearing, the complainant had explained that he is an old man, living alone without his wife and both his children having settled abroad. He also looks very much disoriented after recovery of the stroke. He had further explained that due to such disorientation he was unable to coordinate actively and as such the delay had occurred. The respondent company had conveyed that apart from the technical reason of delay in submission of the documents, they have no doubt as to veracity of the treatment and the claim made there under.
4. Under the circumstances, I direct the respondent company to waive the delay of submission of documents in the light of the circumstances explained by the complainant which are poignant.

5. The complaint is disposed of accordingly.
6. 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.

7. Copies of award to both the parties.

Case No. GI/320/ICICI Lomb/08

In the matter of Ms. Anju Trehan Vs

ICICI Lombard General Insurance Company Limited

AWARD dated 06.11.2009

1. This is a complaint filed by Ms. Anju Trehan (herein after referred to as the complainant) against the decision of ICICI Lombard General Insurance Co. Ltd. (herein after referred to as respondent Insurance Company) for rejecting her claim under medical insurance policy.
2. The brief facts of the case are as follows:
3. The complainant had taken a health insurance policy with the respondent company. During the course of the above policy she underwent an operation at Ganga Ram Hospital between 19.11.2006 to 23.11.2006. Her claim for Rs.134966/- was rejected by the respondent company on the ground that during the first two years of the policy hysterectomy or fibromyoma is excluded. On going through the papers it is observed that the above operation was conducted within 2 years from the date of first taking the policy. However, point to be considered is whether the particular treatment strictly falls within the meaning of the exception mention in the policy. On going through the discharge summary (EX.R1) it is established that in view of the various history mentioned therein eventually the surgery resulted in removal of ovaries. As per Wikipedia it is clarified as follows: (EX.R2)

> "The removal of an ovary together with a Fallopian tube is called salpingo-oophorectomy or bilateral salpingo-oophorectomy if both ovaries and tubes are removed. Oophorectomy and salpingo-oophorectomy are not common forms of birth control in humans; more usual is tubal ligation, in which the Fallopian tubes are blocked but the ovaries remain intact. In many cases, surgical removal of the ovaries is performed concurrently with a hysterectomy. The surgery is then called "ovariohysterectomy" casually or "total abdominal hysterectomy with bilateral salpingo-
>
> oophorectomy" (sometimes abbreviated TAH-BSO), the more correct medical term. However, the term "hysterectomy" <u>is often used colloquially yet incorrectly to refer to removal of any</u> parts of the female reproductive system, <u>including just the ovaries</u>."

4. On also going through the policy condition once again I find that even the above operation can be broadly considered as hysterectomy, the condition is explicit in limiting "hysterectomy for malignancy". Therefore the condition is qualified condition apart from this; there is a considerable doubt as to the actual nature of operation actually conducted on the complainant. And therefore the benefit of doubt is given to the complainant.

5. In the result I direct the respondent company to process the claim as per the bills etc. and settle the claim.

6. 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.

7. Copies of award to both the parties.

Case No. GI/120/NIC/09

In the matter of Shri Deepak Aggarwal Vs

National Insurance Company Limited

AWARD dated 17.11.2009

1. This is a complaint filed by Shri Deepak Aggarwal(herein after referred to as the complainant) against the decision of the National Insurance Company Limited (herein after referred to as respondent insurance company) in rejecting his mediclaim for treatment of Pulmonary Thromboembolism.

2. The brief facts of the case are that the above complainant has taken a mediclaim policy with the respondent company for the first time from 05.05.2006 and continued thereafter. He was admitted in the hospital from 30.11.2007 to 04.12.2007 in respect of treatment of Pulmonary Thromboembolism. The total claim amount for Rs.2,52,882/- was preferred on the respondent company who have rejected the claim on the ground that the disease was pre-existing. They have based their rejection on the data submitted by their TPA Alankit Health Care Limited vide their letter dated 28.02.2008 (EX: R1). TPA has based their opinion referring to the discharge summary of Action Medical Institute dated 31.10.2006(EX:R2). The TPAs have observed as under:

   "While scrutinizing the claim documents, it has been observed from the Discharge Summary that patient had history of seizure/migraine 1 year back & on medication since then, hence query has been raised for the treatment taken for one year back for seizure and in reply to the query an old Discharge summary received for the hospitalization of 30.10.2006 to 31.10.2006 clearly mentioning the history of complex partial seizure with secondary generalization in 2001 where as policy only one and half year old w.e.f. 05.05.2006 which makes the disease pre-existing."

3. On perusing the discharge summary (EX: R2), it is merely mentioned in Column No.3 – Past History that he had history of complex partial seizure with secondary generalization in 2001. From the above, it is clear that his past history of the complainant goes back to year 2001 prior to his hospitalization on 30.10.2006. In other words, till about 5 years, there have been no symptoms nor any record of treatment taken by this person. When there is such a long gap of over 5 years. It is not very fair to treat this disease as pre-existing. Lapse of over 4 years in having any

symptoms makes it to the advantage of the patient. Secondly, the IRDA has also laid guidelines on pre-existing disease taking back the history of symptoms and treatment only up to 4 years backward. Added to this the National Consumer Redressal Commission has also held accordingly.

4. In view of the above discussions, I feel that his state of health and symptoms observed during 2001 whereas the policy is from 2005 onwards are not fair. In the result, I hold that the repudiation of the claim by the respondent company is not based on sound principles. Accordingly I direct the respondent company to process and settle the claim after due scrutiny of the bills.

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

6. Copies of the Award to both the parties.

Case No. GI/155/UII/09

In the matter of Shri Dalip Kumar Vs

United India Insurance Company Limited

AWARD dated 18.11.2009

1. This is a complaint filed by Shri Dalip Kumar (herein after referred to as the complainant) against the decision of the United India Insurance Company Limited (herein after referred to as respondent insurance company) for not settling his claim in respect of his admission into hospital for one day.

2. The brief facts of the case are that the complainant was covered under the mediclaim policy and during the currency of the policy, he was admitted into the hospital for one day from 24.11.2008 to 25.11.2008. He had undergone angio and submitted a bill for Rs.14500/- for the above treatment. The respondent company has however denied the claim on the ground that "the problem is not acute in nature." They have relied on the opinion given by Dr.J.S.Duggal in a very casual manner not supported by any medical reasons. He has merely said "The disease seems to be pre-existing in nature." Therefore, the respondent company could not establish medically that the complainant has been in fact suffering from such a disease prior to taking the policy.

3. I, therefore, give the benefit of doubt to the complainant and as such direct the respondent company to process the claim and settle the same as per rules.

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

5. Copies of the Award to both the parties.

Case No. GI/165/NIA/09

In the matter of Shri S.R.Thapar Vs

New India Assurance Company Limited

AWARD dated 19.11.2009

1. This is a complaint filed by Shri S.R.Thapar (herein after referred to as the complainant) against the decision of the New India Assurance Company Limited (herein after referred to as respondent insurance company) in limiting his claim arising out of his treatment of sleep apnoea.

2. The brief facts of the case are that the complainant is covered under a group mediclaim policy issued by the respondent company in respect of the LIC of India. The complainant is covered under the above policy. The complainant was admitted into Kailash Health Care Limited for the period 30.03.2007 to 31.03.2007. As per the medical records available, he was treated in connection in sleep apnoea. The Insurance Company has however released the payment in respect of his hospitalization treatment but denied the cost of CPAP machine quoting Condition No.1 of the policy as non-medical expenses. The respondent company had in fact cited the case of the National Commission where the commission has accepted the cost of CPAP machine to be paid by the Insurance Company which happened to be the same which is the respondent company here.

3. I have sought to go through the policy itself under which the above complainant was covered and on going through the policy condition 1.0. No example of non-medical expenses was provided. Therefore, the contention of the respondent company that CPAP is excluded under the policy is not tenable. Now the Insurance Company probably due to the judgement of the Apex Forum have now specifically excluded CPAP machine under Clause 10(D),sub-clause C of the policy.

4. Since under the policy in question under which the complainant is covered, no such specific exclusion is stipulated in respect of CPAP machine, therefore, this case would still be covered under the previous judgement of the Apex Court and as such I am constrained to direct the respondent company to settle his claim towards the cost of purchase of CPAP machine.

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

6. Copies of the Award to both the parties.

Case No. GI/159/NIA/09

In the matter of Shri Anil Kumar Malhotra Vs

New India Assurance Company Limited

AWARD dated 19.11.2009

1. This is a complaint filed by Shri Anil Kumar Malhotra (herein after referred to as the complainant) against the New India Assurance Company Limited (herein after referred to as respondent insurance company) in respect of mediclaim policy taken by him in respect of for him and his family.

2. The dispute is pertaining to a claim in respect of treatment of his wife Smt. Neetu Malhotra for CSF Rhino rhea. The main contention of the respondent company is that the claim has been limited to Rs.50000/-only being the sum insured in the policy before the same was enhanced to Rs.1,00,000/- during the period 03.01.2007 to 02.01.2008. She had in fact been treated in Batra Hospital from 28.08.2007 and a claim for the same has already been settled for Rs.61167/-only. She was again admitted in Fortis Hospital on 18.09.2007 and the claim for the same was preferred on the respondent company. As per the papers made available to me, it is not very clear whether the respondent company had treated the fresh policy given from 03.01.2007 which was effected only due to the fact that a cheque issued by the complainant was disowned and as such there was a break in the policy. The reason for restricted her claim to Rs.50000/- only seems to be that the policy taken for Rs.1,00,000/- after the break will not cover the enhanced amount in respect of her pre-existing ailments. The respondent company also in their reply has relied on a good health certificate obtained from the doctor of the complainant. Unfortunately, such a certificate is not made available to this forum. The proposal form also is not made available before the forum to study if there has been any suppression or admission about her pre policy health conditions.

3. In the result the fact seems to be confusing and the forum has no other option but to treat the sum insured as available under the policy to be the maximum amount upto which a claim can be settled.

4. I, therefore, direct the respondent company to process her bills in respect of her second treatment and settle the claim subject to scrutiny of the bills as per the sum insured available under the policy issued for the period 03.01.2007 to 02.01.2008.

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

Case No. GI/133/UII/09

In the matter of Smt.Sangeeta Rani Vs

United India Insurance Company Limited

AWARD dated 19.11.2009

1. This is a complaint filed by Smt. Sangeeta Rani (herein after referred to as the complainant) against the decision of the United India Insurance Company Limited (herein after referred to as respondent insurance company) rejecting her claim for the treatment taken under mediclaim policy.

2. The brief facts are that the complainant had taken a mediclaim policy with the respondent company for the period 10.04.2007 to 09.04.2008. She was admitted in Goyal Hospital & Urology Centre for treatment between 27.11.2007 to 06.12.2007. The treatment was given as per the diagnosis mentioned as "Uncontrolled DM with LT.deep palmer Abscess (operated) with Cellulitis with Septicimia follow injury with knife. The main reasons on which the claim has been rejected by the respondent company is that the complainant was a known case of DM and due to pre-existing condition under the policy, the claim is rejected.

3. But on going through the discharge summary, it is obvious that her condition of "Uncontrolled DM" is due to Septicimia as a result of knife injury. Therefore, the proximate cause for the uncontrolled DM is the knife injury and not the diabetes before the policy.

4. I, therefore, give the benefit of doubt to the complainant in absence of any expert medical opinion made available by the respondent company. In the result, I direct

the respondent company to process the claim and the bills thereunder and settle the same as per rules.

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

6. Copies of the Award to both the parties.

Case No. GI/112/OIC/09

In the matter of Smt.Anjali Gupta Vs

Oriental Insurance Company Limited

AWARD dated 19.11.2009

1. This is a complaint filed by Smt.Anjali Gupta (herein after referred to as the complainant) against the decision of the Oriental Insurance Company Limited (herein after referred to as respondent insurance company) in not settling the claim in respect of treatment of her daughter baby Astha who was admitted in Chikitsa Multi Specialty Hospital between 07.09.2008 to 08.09.2008.

2. The brief facts of the case are that the complainant had taken a health policy with the respondent company for the period 23.12.2007 to 22.12.2008 covering her daughter also under the policy. The daughter of the complainant baby Astha was admitted into the above hospital due to a reaction on her skin and she was treated for one day in the above hospital between 07.09.2008 to 08.09.2008. The

respondent company have taken a stand in the first instance that the disease for which the patient was admitted is Vitiligo, a chr.Skin disease which is not payable as per company policy.

3. I have gone through the entire policy conditions and the above disease does not fall within any of those exceptions and I wonder as to how the respondent company has taken such step. Therefore the above disease is admissible under the policy subject to other conditions.

4. The respondent company had in the first instance rejected the entire claim on the ground that the treatment in the hospital was not warranted and a out-patient treatment could serve the purpose. However, subsequently, they have admitted to pay the bill of Rs.4230/- entailed by the complainant for the treatment in the hospital. Having admitted the hospital treatment of the patient, they cannot escape both pre and post hospitalization expenses which are covered under policy conditions subject to scrutiny of the bills. The various bills are provided by the complainant marked (EX:C1) covering the entire expenses including pre and post hospitalization and actual hospitalization. The total amount claimed therefore works out to Rs.61858.74.

5. On scrutinizing the above bills and as pointed out by the respondent company certain expenditure/treatment/tests were not warranted as they were not prescribed. Therefore, I would like to scrutinize the above bills before coming to a conclusion. As per the bills and expenses made available therein Sl.No.2,3,4,5,6,7,8,10,11,12,14 & 15 are towards purchase of medicines etc. which are supported by prescriptions and chemist bills as per the amount shown therein. As such those amounts connected with both pre & post hospitalization is payable. As regards bills of item No. 1,9,13 & 16 are concerned, I find that there are some tests conducted for UVB. I find that there have been no specific prescriptions for these tests by the doctor concerned nor are they supported by the reports. Therefore, these items cannot be paid for the reasons mentioned above.

6. In the result, the respondent company is directed to release payment of Rs.11858.34 only to the complainant. The rest of the claim amount as claimed by the complainant is not tenable and as such there is no order as to the payment to those amounts.

7. The Award shall be implemented within 30 days of receipt of the same. 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/141/NIA/09
In the matter of Shri Deepak Kumar Jain Vs

New India Assurance Company Limited

AWARD dated 20.11.2009

1. This is a complaint filed by Shri Deepak Kumar Jain (herein after referred to as the complainant) against the decision of the New India Assurance Company Limited (herein after referred to as respondent insurance company) for rejecting his claim under mediclaim policy for the treatment taken for Neuro Cardio Depressor.

2. The brief facts of the case are that the complainant had taken a mediclaim policy with the respondent company for the period 04.10.2008 to 03.10.2009. He was admitted in Delhi Heart Hospital for treatment of the above disease. The discharge summary of the hospital (EX:R1) is available on the file. The main contention of the respondent company in rejecting the claim is based on the opinion of the TPAs who had held that the above symptoms are arising out of Alcoholism and as such they are exceptions under the policy.

3. On going through the discharge summary while elaborating the case summary, it is also mentioned that the patient is a moderate alcoholic. The respondent company had not submitted any expert medical opinion to support the view that the present treatment is definitely due to alcoholism. I also have gone through the wikipedia on the above subject. Unfortunately the medical journals have not conclusively attributed the above disease as a direct or indirect cause of alcoholism.

4. I am, therefore, constrained to pass the benefit of doubt to the complainant and as such direct the Insurance Company to scrutinize the bills and settle the claim subject to other conditions of the policy.

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

6. Copies of the Award to both the parties.

Case No. GI/153/NIC/09

In the matter of Ms. Sunita Vs

National Insurance Company Limited

AWARD dated 30.11.2009

1. This is a complaint filed by Ms. Sunita (herein after referred to as the complainant) against the National Insurance Company Limited (herein after referred to as respondent insurance company) in respect of her treatment for Cholelithiasis with DUB taken between 31.08.2007 to 05.09.2007 in the City Hospital.

2. The brief facts of the case are that the complainant was covered under mediclaim policy for the first time from 13.02.2007 to 12.02.2008 for a sum insured of Rs.60000/-only. She was admitted in the City Hospital on 31.08.2007 and was discharged on 05.09.2007 in connection of the treatment for Cholelithiasis with DUB. She has submitted her claim with the respondent company amount of which is nowhere ascertainable as no claim papers or hospital bills are made available before me. The respondent company has not given any reply on her claim and has only submitted a claim file to this Forum. However, after much persuasion, they have given a reply.

3. In the first place, I must place on record the indifference of the respondent company in properly presenting their case etc. They cannot expect the Ombudsman to study the claim file and give Award/Order.

4. Anyway after going through the reply, it appears that they have rejected the claim on the ground that as per records available with the hospital where she was treated that she had pain in abdomen off and on, Nausea & Vomiting since one and a half years. They have also relied on the opinion of their panel doctor who insisted that Acid Peptic disease which she had, prior to this hospitalization in important indicator for treatment of pre-existing nature of the disease. They sought clarification from the complainant about her alleged treatment connected with Acid Peptic disease. She has however denied any such treatment hitherto. Subsequently, their doctor had seen the record in the city hospital which among other data had made the following observations:

Pain Abdomen off & on)

Nausea & Vomiting Off & on	)	1- ½ years
Polymenorrhagia	)	

5. Based on that information, the respondent company had rejected the claim as pre-existing disease which has not been declared by the complainant in the proposal form. It is very essential that the proposal form has to be seen to ascertain whether the complainant had suppressed about her hospitalization for pain in abdomen etc. Unfortunately, the respondent company has not provided the copy of the proposal form to this Forum.

6. Based on the material before me, evidence is not very conclusive, but there could be a probable fact that the complainant had in fact symptoms relating to the treatment which she had undergone during the treatment in question.

7. In view of the confusing material made available before me and in the absence of proposal form which is a vital document to determine whether or not she has suppressed the fact, I am unable to confirm the decision of the respondent company in denying the claim which is based on more of suspicion than confirmed data.

8. In the result, I give the benefit of doubt to the complainant and direct the respondent company to process the claim and settle the same as per rules.

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

10. Copies of the Award to both the parties.

MEDICLAIM

Case No.GI/97/NIC/09

In the matter of Smt. Mamta Shrivastava Vs

National Insurance Company Limited

AWARD dated 26.02.2010

1. This is a complaint filed by Mrs. Mamta Srivastava (herein after referred to as the complainant) against the decision of National Insurance Co. Ltd (herein after referred to as respondent Insurance Company) for rejecting her mediclaim for Rs.15535/- in respect of treatment received by her in Shri Krishna Hospital on 12.08.2008.

2. The main grounds for rejection of the claim as mentioned by the respondent company as per their letter dated 08.02.2010 is as follows:
   "The case was referred to TPA M/s. Genins India, who on scrutiny observed that the expenses pertain to hospitalization in Shri Krishna Hospital of Ghaziabad, which is not included in the Panel list of hospitals for National Insurance Co. Ltd. DRO-II office. Hence, this claim was repudiated."

3. I have gone through the policy issued by the respondent company. That only defines what is a hospital or nursing home. Any treatment taken in any medical institute, if it fulfills the requirement under the definition of the policy, the claim is to be paid subject to scrutiny of the bills. The respondent company merely by declaring a panel of hospitals only for treatment is beyond the scope of the policy. However, I can understand where the respondent Insurance Company, based on the bad experience of a particular hospital can black list such hospital for valid reasons. In such cases, the Insurance Company can exclude treatment to be taken in those hospitals which have been specifically black listed. However, not entertaining the claims for treatment taken in any other hospital which fulfills the criteria of the hospital or nursing home within the definition of the policy, the claim cannot be rejected on that ground.

4. Therefore, I direct the respondent company to process the claim and settle the same subject to other policy limitations etc.

Case No. GI/135/NIC/09

In the matter of Smt. Jayashree Bhan Vs

National Insurance Company Limited

AWARD dated 17.11.2009

1. This is a complaint filed by Smt.Jayashree Bhan (herein after referred to as the complainant) against the decision of the National Insurance Company Limited (herein after referred to as respondent insurance company) in rejecting her mediclaim in respect of her treatment for severe stenosis.

2. The brief facts of the case are that the complainant has been covered under the mediclaim policy for the first time from 26.02.2008 to 25.02.2009. In fact, she has been admitted into health insurance from this date. On enquiry by the forum as to why she has taken a policy for the first time at that late age, she explained that her husband Shri S.K.Bhan who was previously working with a company and since he retired in 2003, his mediclaim cover was no longer available for them thereafter. The main question for rejecting of the claim by the respondent company vide their letter dated 13.03.2009, the TPA, Alankit Health Care Limited have rejected the claim (EX: R1) on the ground that "while scrutinizing the claim documents, it has been observed that policy only one year and 11 days old w.e.f. 26.02.2007 and patient diagnosed as Severe AS which can not occur in one year that too without producing any symptoms which makes the disease pre existing.

3. At this stage, I would like to examine the discharge summary given by the hospital (EX: R2). The discharge summary is silent about the year of diagnoses. It only says SEVERE AS, SEVERE AR, DYSPNOEA. There is no mention anywhere in the discharge summary as to the probable time from which these symptoms would have developed.Whereas in the rejection letter, the TPAs have come to the conclusion that SEVERE AS cannot occur in one year. The opinion of the TPAs has not been supported by any expert medical opinion. Therefore, in the absence of such medical opinion who has given an opinion after examining the discharge summary, I am afraid merely coming to a conclusion that such a stage cannot happen within one year is not tenable proposition.

4. I am, therefore, of the opinion that the rejection of the claim is not fully justified and is based on personal opinion and not supported by cogent medical records. I, therefore, give the benefit of doubt to the complainant and direct the respondent company to process the claim of the complainant and settle the same after due scrutiny of the bills.

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

6. Copies of the Award to both the parties.

Case No. GI/35/NIC/09

In the matter of Shri Raju Khotwani Vs

National Insurance Company Limited

AWARD dated 01.12.2009

1. This is a complaint filed by Shri Raju Khotwani (herein after referred to as the complainant) against the National Insurance Company Limited (herein after referred to as respondent insurance company) for rejecting a claim under mediclaim policy for the treatment undergone by the insured between 06.10.2008 to 08.10.2008 for treatment of Hemorrhoids and Sinusitis. The respondent company had rejected the claim for Rs.4741/- on the ground that the treatment of the above disease is not payable during the first two years of the policy in terms of Clause 4.3 of the mediclaim policy.

2. On going through the records made available, there is no doubt that the treatment received comes within the exception of 4.3 of the policy clause. But the question is,

in the instant case, that the complainant had produced copies of the policies having been taken by him continuously for the period 22.07.2005 to 21.07.2006, 22.07.2006 to 21.07.2007, 22.07.2007 to 21.08.2008 and 22.07.2008 and 21.07.2009, that is, during the period when the treatment was taken. No doubt, as per the contention of the respondent company, this has occurred during the very first year of the policy taken with the respondent company. However, as per IRDA which are now being crystallized by way of instructions that continuity of the policies even having been taken by any of the four public sectors insurance companies have been construed as continuous policies. From the facts available to me, it is established that he was taking the policies with the Oriental Insurance Company Limited from 22.07.2005 till the date of shifting to the respondent company on 22.07.2008. I have perused the copies of the policies and convinced that the policies were in continuous operation without any break whatsoever. Therefore, the present policy has to be construed as the fourth year of the policy in continuation as if the same was with the respondent company only.

3. In the result, the exception quoted therein would not be operating. Therefore, applying the above principle and continuity of the policy and portability of the policy in public sector undertakings where there is no break, the claim would be admissible as if the policy was with the respondent company from the original date taken with the previous insurance company.

4. In the result, I direct the respondent company to process the claim and settle the same subject to scrutiny of bills etc.

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

6. Copies of the Award to both the parties.

Case No. GI/160/UII/09

In the matter of Smt.Madhu Mathur Vs

United India Insurance Company Limited

AWARD dated 01.12.2009

1. This is a complaint filed by Smt.Mathu Mathur (herein after referred to as the complainant) against the decision of the United India Insurance Company Limited (herein after referred to as respondent insurance company) in restricting her claim in respect of treatment of Bilateral Total Knee Replacement under two health policies taken by her.

2. The brief facts of the case are that the complainant had first obtained mediclaim policy with a Micro office branch for a total sum insured of Rs.2,25,000/- on 21.01.2003. It is also established that the complainant had again taken a fresh policy for a sum insured of Rs.1,75,000/- covering herself in the policy along with her husband on 23.01.2008. Thereafter she had undergone Total Knee Replacement surgery on 25.03.2008 and submitted a bill for Rs.3,93,675/-. The respondent company had settled the claim for a total sum of Rs.1,75,000/- only. Keeping in view the conditions of the policy wherein for major surgeries, the claim amount would be restricted to 70% of the sum insured subject to a limit of Rs.2,00,000/-.

3. I have gone through the policy documents and also the conditions regarding limitations to the percentage of claim on various categories. Therefore, the decision of the respondent company in limiting the claim to Rs.1,75,000/- is in order.

4. Now the point regarding second policy having been taken by her in the year 2008 covering herself along with her husband, the respondent company has contended that while taking the second policy, she had not disclosed about the existence of the previous policy taken in a Micro Office Branch. Secondly, they contend that as per guidelines, one person cannot be covered under two different policies. In addition to this point, they have also considered the above disease as a pre-existing since as per hospital records recorded during her surgery on 25.03.2008, it was mentioned in the column- past history as under:

Past History

No history of Diabetes Mellitus, Hypertension, Asthma

Avulsion fracture of lateral malleolus – 4 years back.

5. The respondent company has not submitted this forum the important documents to ascertain whether their contention are true or false. The most important document for me is the proposal form submitted by the complainant for obtaining second policy. In the absence of proposal form, this forum cannot ascertain whether or not there is concealment about the existence of the previous policy. Secondly, whether there is a column in the proposal form eliciting such information is also not available to this forum.

6. As regards taking the second policy is concerned, the copy of instructions regarding prohibition of having two policies separately has also not been provided to this Forum. In the absence of those material facts, I am unable to give a clear order in favour of the respondent company.

7. I would like to examine the admissibility of the second policy as if it is a valid policy ignoring for a while about the existence of a previous policy.

8. On going through the hospital records pertaining to the past history, it is mentioned that she had Avulsion fracture of lateral malleolus – 4 years back. In the IRDA guidelines and also as per the existing policy guidelines, any disease or symptoms which existed beyond 4 years from the inception of the policy are not to be considered as pre-existing disease. Even the recommended definition of pre-existing conditions by IRDA also limit the period of pre-existing condition to go back only to 4 years. From the medical records available, it is written – 4 years back. Though the exact date or month when such a complaint developed is not mentioned, I would like to give the benefit of doubt to the complainant. Since the history of her fracture goes beyond 4 years from the inception of the policy, the said condition of health cannot be construed as pre-existing.

9. I, therefore, hold that holding the above disease as pre-existing disease under the second policy is not in order. In the result, I direct the respondent company to process the claim afresh under the second policy and settle the claim subject to policy limitation percentage.

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

11. Copies of the Award to both the parties.

MEDICLAIM

Case No. GI/155/UII/09

In the matter of Shri Dalip Kumar Vs

United India Insurance Company Limited

AWARD dated 01.12.2009

1. In the above Award dated 18.11.2009, inadvertently the amount of claim has been mentioned as Rs.14500/- In fact, we find from records made available to us, the claim bill is for Rs.180814/-.

2. Therefore, the respondent company is directed to process the bills and release the payment subject to other policy terms and conditions and limitation as contained in policy condition 1.2 (E) if any.

INDIVIDUAL MEDICLAIM

Case No.GI/163/UII/09

In the matter of Shri Devendra Kr. Mundra Vs

United India Insurance Company Limited

AWARD dated 13.01.2010

1. This is a complaint filed by Shri D.K. Mundra (herein after referred to as the complainant) against the decision of United India Insurance Co. Ltd (herein after referred to as respondent Insurance Company) for rejecting his claim under individual mediclaim policy taken by him. The brief facts of the case are as follows:

2. That the complainant has been taking individual mediclaim policy with the respondent company since 06.06.2005 and being continued thereafter till the relevant year i.e. 2007-08. As in 2008 the sum insured is Rs.4,00,000/- and with no claim bonus the total sum assured stands at Rs.4,40,000/-. The complainant had suddenly taken ill in February 2008 and has been admitted first at Sitaram Bhartia Institute of Science & Research Institute, Delhi but was later on shifted to Escorts Hospital, New Delhi where he had undergone heart surgery for installation of pace maker. After his discharge he had filed a claim with the insurance company through their TPA E-Meditek Solutions Ltd. Though the actual amount claimed by him for the treatment worked to Rs.987472/-. The claim is limited to Rs.4,40,000/- only, in view of the sum insured available under the policy. The respondent company through their TPA have however, repudiated his claim vide their letter dated 27.08.2008. They have rejected the claim under terms of exclusion clause 4.1 as it is found after the scrutiny of the treatment records that the disease is pre-existing, so claim is not payable. There is no elaboration in the rejection letter as to the reasons how they have arrived at the conclusion that the disease is pre-existing. They have merely and mechanically quoted the provisions of the policy in rejecting the claim.

3. I found that the respondent company had not filed any parawise comments clearly taking any stand for repudiating the claim.

4. I have however, gone through the previous medical papers relating to the complainant, I have gone through the discharge summary dated 08.03.2008 given by the Escorts Hospital. Under the diagnosis column it is written "POST CABG- (1983) & REDO CABG (1997). It has been further clarified in the history that CABG has been done in 1983 and 1997. The complainant had also contended during the course of personal hearing that at the time of taking the policy for the first time in the year 2005, the respondent company had got himself medical examination and based on the

medical reports his policy was accepted. Unfortunately, the respondent company is unable to provide me with the copy of the medical reports done before accepting the proposal. They have vide their letter dated 16.01.2009 addressed to the complainant have admitted that the medical examination reports are not available in their record. The proposal form submitted by the complainant at the time of his proposal for insurance for the first time during the year 2005 is also not made available to me to see if he had suppressed any of his medical state of health prior to a proposal.

5. In the instant case the respondent company in the first place could not produce neither the proposal form nor the medical reports. In other words they could not produce any proof to establish that the complainant had suppressed any information regarding his state of health prior to taking the insurance nor did they present the copy of the pre medical examination. Therefore it postulates that the respondent company had accepted the proposal with full knowledge about his state of health, specially the discretion to accept the proposal would have been based on the medical reports taken at that point of time. In the absence of those records, the benefit of doubt will definitely go to the complainant. Even otherwise I find that in the history of the patient is mentioned in the discharge summary CABG has been done in 1997 which is more than 5 years before the date of proposal. I feel sufficient time is lapsed between his CABG in 1997 and his proposal in 2005. It is also seen that no claim has been lodged by the complainant during first two years of the policy suggesting thereby there were no malofied intentions of taking the policy for the first time with an apprehension of immediate medical treatment. For the reasons discussed above I am afraid the respondent company could not prove nor place any valid evidence against the complainant justifying their repudiation. I must add that the respondent company was grossly negligent and indifferent to the proceedings.

6. In the result giving full benefit of doubt to the complainant, especially in the light of gross negligence on the part of the respondent company in losing an important documents like proposal form and pre acceptance medical reports, I direct the respondent company to settle the claim as per the sum insured available including bonus i.e. Rs.4,40,000/- after scrutinizing the various bills and as subject to under policy limitations etc.

Case No. GI/11/UII/09

In the matter of Shri Mool Chand Hundiya Vs

United India Insurance Company Limited

AWARD dated 27.01.2010

1. This is a complaint filed by Shri Mool Chand Hundiya (herein after referred to as the complainant) against the decision of the United India Insurance Company Limited (herein after referred to as respondent insurance company) in restricting his claim under Health Insurance policy taken by him with the respondent company.

2. The brief facts of the case are that the complainant had taken a Health Insurance Policy(Gold) with the respondent company for the period 26.12.2007 to 25.12.2008. Subsequently, the complainant had under gone bypass heart surgery in Apollo Hospital, Gandhi Nagar between 26.12.2007 to 25.12.2008. He had incurred an expenditure of Rs.1,85,380/-. He had preferred a claim for the above expenses. However, the respondent company having processed the claim has settled the claim for an amount of Rs.122500/- towards the hospitalization and a sum of Rs.14145/- towards post hospitalization expenses. The respondent company has submitted that

the reason for restricting the amount for bypass surgery is as per the policy condition No.1.2. As per the above condition for major surgeries & angioplasty, the sum insured under the policy is restricted to 70% of the sum insured or maximum Rs.2,00,000/-. In the instant case, though the amount claimed for the hospitalization is Rs.1,85,380/-, however, keeping in view the sum insured under the policy, the total claim could be worked out at Rs.1,75,000/- only. Therefore, 70% of the sum insured as per policy number 141102/48/07/97/0000534, as already discussed above, the claim amount worked out to only Rs.1,22,500/- being 70% of the sum insured. In addition, a sum of Rs.14145/- towards post hospitalization is also in order.

3. The only question for consideration is whether the complainant who has been taking the policy for the last so many years had been specifically provided with the policy conditions amended recently restricting the claim amount to percentages as contained in policy condition 1.2 of the policy?

4. I have gone through the policy copy provided by the respondent company and I find that apart from the details of persons covered under the policy, period of the policy, sum insured and the policy charge, various conditions have not been attached with the policy which fact has been further confirmed by the complainant in the course of personal hearing. The respondent company had only provided the form with a copy of the health insurance policy guidelines but they have not provided the various conditions of the policy specially those restricting the sum insured to 70%. As per IRDA's policy holders' interest Regulation 2002, Section 7 of the said section provides that a general insurance policy should clearly state and attach the conditions of restrictions, exceptions etc. along with the policy. In the instant case, the respondent company failed to comply with the above mandatory requirements prescribed by IRDA. Therefore, though they are right as per policy condition No.1.2 in restricting the claim amount to 70% but in the absence of, bringing the same to the notice of the insured by attaching the same to the policy, they cannot take advantage of this condition. It is well established principle of law that insurance

contract being “adhesive” in nature, any change in policy conditions have to be invariably communicated to the policy holder in writing especially when they are changed to the detriment of the policy holder.

5. Therefore, I am constrained to direct the respondent company to settle the claim subject to total sum insured available under the policy for their default in not communicating these restrictions. I trust the respondent company shall invariably in future attach all conditions and exceptions along with the policy document to the policy holder to avoid unnecessary payment beyond policy limitations.

6. The complaint is disposed of accordingly.

7. Copies of the Award to both the parties.

MEDICLAIM

Case No. GI/311/NIA/09

In the matter of Shri Sandeep Gupta Vs

New India Assurance Company Limited

AWARD dated 27.01.2010

1. This is a complaint filed on behalf of Smt. Prem Lata Gupta (herein after referred to as the complainant) against the decision of the New India Assurance Company Limited (herein after referred to as respondent insurance company) in limiting her

claim under mediclaim policy of Rs.50000/- only as against the sum insured of Rs.1,00,000/-.

2. The brief facts of the case are that that the complainant has been taking the above mediclaim policy with the respondent company for a sum insured of Rs.50000/- y since more than 8 years continuously. However, the respondent company had on their own, as per IRDA guidelines suo-motto, increased the sum insured from Rs.50000/- to Rs.1,00,000/- since it has been decided by IRDA that the minimum sum insured under the policy should be Rs.1,00,000/-.

3. The complainant has been claiming amounts under the above policy as per bills submitted by him in respect of treatment of his mother who is the policy holder. The respondent company has however disallowed the claim amount over and above Rs.50000/- on the ground that the enhanced sum insured of Rs.50000/- will not be applicable to the pre-existing diseases. Since the complainant was getting treatment since 2004, the sum insured was limited to Rs.50000/- only, that is, prior to the enhancing of the sum insured.

4. I have gone through the policy conditions and also the various facts mentioned therein. It is not doubt true, in normal circumstances, that enhancement in the sum insured will be treated as fresh policy as far as they are connected to the pre-existing diseases. However, the distinction has to be made in the instant case where the sum insured has been increased by the respondent company themselves in order to comply with the IRDA guidelines and not at the instance of the insured. Had the sum insured been enhanced at the instance of the insured, then the stand of the respondent company in limiting the sum insured to Rs.50000/- is in order. However, since the same has been enhanced on their own to comply the statutory requirement as laid down by IRDA, the sum insured shall stand at Rs.1,00,000/- and

the respondent company should honour claims upto Rs.1,00,000/- sum insured even though the same has been enhanced.

5. In the result, I direct the respondent company to settle all pending bills which have gone beyond the original sum insured of Rs.50000/- including any subsequent bills made thereafter till date subject to however within the limitation of the sum insured as it stands today, that is, Rs.1,00,000/- only.

6. With this direction, the complainant is disposed of accordingly.

7. Copies of the Award to both the parties.

Case No.GI/303/NIA/09

In the matter of Shri Sant Lal Khurana Vs

The New India Assurance Company Limited

ORDER dated 28.01.2010

1. Shri Sant Lal Khurana has made a complaint to this Forum on 09.12.09 against The New India Assurance Co. Ltd. in respect of non settlement of Mediclaim, under claim No. 08/9394 & 08/9414.

2. On intervention of this office, we have been informed by the New India Assurance Co. Ltd. vide their letter dated 20.01.2010 that they have settled the claim of Shri Sant Lal Khurana for Rs.2452/- vide cheque no. 265853 dated 20.01.2010.

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

4. The complaint is disposed of finally.

5. Copies of the Order to both the parties.

MEDICLAIM

Case No.GI/253/NIC/09

In the matter of Shri Mayur Jain Vs

National Insurance Company Limited

ORDER dated 28.01.2010

1. Shri Mayur Jain has made a complaint to this Forum on 24.09.2009 against National Insurance Co. Ltd. in respect of non settlement of Mediclaim, under policy No. 8500001127/08

2. On intervention of this office, we have been informed by the National Insurance Co. Ltd. that they have settled the claim of Shri Mayur Jain for Rs.12797/- vide cheque no. 61891 dated 19.11.2009.

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

4. The complaint is disposed of finally.

5. Copies of the Order to both the parties.

MEDICLAIM

Case No.GI/231/NIC/09

In the matter of Shri Deepak Garg Vs

National Insurance Company Limited

ORDER dated 28.01.2010

1. Shri Deepak Garg has made a complaint to this Forum on 02.09.2009 against National Insurance Co. Ltd. in respect of non settlement of Mediclaim, under policy No. 361501/48/08/8500000875.

2. On intervention of this office, we have been informed by the National Insurance Co. Ltd. that they have settled the claim of Shri Deepak Garg for Rs.3545/- vide cheque no. 61846 dated 19.11.2009.

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

4. The complaint is disposed of finally.

5. Copies of the Order to both the parties.

MEDICLAIM

Case No.GI/226/UII/09

In the matter of Shri Manohar Motiyani Vs

United India Insurance Co. Ltd.

ORDER dated 24.02.2010

1. Shri Manohar Motiyani has made a complaint to this Forum on 02.09.2009, against United India Insurance Co. Ltd. regarding inadequate settlement of Mediclaim under policy no. 14030148079700004188.

2. On intervention of this office, we have now been informed by United India Insurance Co. Ltd. vide their e-mail dated 10.02.2010 that they have made the payment of Rs.18,318/- vide cheque no. 582862 dated 10.12.2009 and Rs. 9,692/- vide cheque no. 658731 dated 18.12.2009 drawn on Citi Bank in favour of Shri Manohar Motiyani.

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

4. Hence the complaint is disposed of.

5. Copies of the Order to both the parties.

MEDICLAIM

Case No.GI/67/NIC/09

In the matter of Ms. Neeta Gupta Vs

National Insurance Company Limited

ORDER dated 24.02.2010

1. Ms. Neeta Gupta has made a complaint to this Forum on 03.03.2009, against National Insurance Co. Ltd. regarding non-settlement of Mediclaim under policy no. 360700/48/08/8500002030.

2. On intervention of this office, we have now been informed by National Insurance Co. Ltd. that they have settled the claim of Ms. Neeta Gupta for Rs.13,271/- vide cheque no. 558242 dated 18.11.2009.

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

4. Hence the complaint is disposed of.

5. Copies of the Order to both the parties.

MEDICLAIM

Case No. GI/74/NIC/09

In the matter of Smt.Sangeeta Vs

National Insurance Company Limited

AWARD dated 24.02.2010

1. This is a complaint filed by Smt.Sangeeta (herein after referred to as the complainant) against the decision of the National Insurance Company Limited (herein after referred to as respondent insurance company) in respect of her claim for hospitalization under the policy taken for the period 08.11.2007 to

07.11.2008.

2. The brief facts of the case are that the complainant was hospitalized for severe right sided Headache in Sanjeevan Medical Research Centre Private Limited between 30.08.2008 to 05.09.2008. As per the discharge summary given by the hospital under the supervision of Dr.Prem Aggarwal, it is merely mentioned as chronic sinusitis. When the claim was submitted with the respondent company for a sum of Rs.19202/-, the company has rejected the claim without giving any reasons for rejecting the claim except quoting the opinion of the TPAs. The said TPA vide their letter dated Nil has opined that since the sinusitis is a chronic disease and the same is not payable during the first two years of the policy as per exclusion clause 4.3. While there is no confusion with the chronic sinusitis is specifically excluded under clause 4.3 of the policy, the fact remains that no medical evidence has been produced to establish that the patient complainant has been really suffering from chronic sinusitis before her admission and treatment in the hospital on the aforesaid dates. Even during the personal hearing, the complainant had categorically explained that she had never any problem even before her admission into the hospital. She had suddenly developed headache which could not be chronic.

3. I would like to once again go through the discharge summary which merely says chronic sinusitis. The respondent company could not establish any details of either consultation treatment by the complainant about being treated for sinusitis ever before her date of admission into the hospital. I also wonder as to what basis the doctor on the discharge summary had mentioned as chronic sinusitis. No doubt the treatment given for those days during the admission into the hospital is for sinusitis but they could not establish that she was already suffering from sinusitis and that it is chronic. This appears to be an opinion based without any substance. I have also gone through the opinion of the doctor who feels that “We can reasonably conclude the present case is of secondary sinusitis.” Somehow the case has not been properly

presented with any background of medical papers by the respondent company. The company had not even properly defended the case and not enumerated any reasons before this forum as to why the case has been rejected apart from merely reproducing the opinion of the TPA that it attracts exception clause 4.3 of the policy. Therefore, I have no option but to give the benefit of doubt in the absence of any medical records to confirm that the patient has actually been suffering from chronic sinusitis. As such I direct the respondent company to settle her claim as per hospital bills submitted by her subject to scrutiny etc.

4. At the cost of repetition I am constrained to note that the respondent National Insurance Company has not taken proper care to defend the case nor presented any material to the contrary which has resulted in the present award being passed for want of material and benefit of doubt.

5. With these directions, the complaint is disposed of accordingly.

6. Copies of the Award to both the parties.