AHMEDABAD

Before the Insurance Ombudsman for Gujarat

Case No.11-004-0003-11
Mr. Nilesh K Soni V/s. United India Insurance Co.Ltd.
Award dated 28-05-2010.

Repudiation of Mediclaim:

The insured was hospitalized for the treatment of Spinal Canal Stenosis. The Respondent had repudiated the mediclaim on the ground that the disease was chronic in nature and hence pre-existing disease.

The Respondent produced medical opinion which revealed that Spinal Canal Stenosis was a chronic degenerative affection of Spinal column that developed and progressed slowly over a period of several years.

This forum also obtained independent medical opinion which also revealed as under:

"Chronic extensive, multiple level purely degenerative changes without any pathological findings may most probably have developed over a period of many years, specialized Spine Surgeon usually comes last in the picture, hence I feel the likely of pre-existence in this case".

This forum observed that the treatment underwent by the insured in the second policy year for spinal canal stenosis was a pre-existing health condition at the time of inception of cover for the first time, hence the decision of the Respondent to repudiate the claim is justified.

Case No.11-002-0009-11
Mr. Puneet Anand V/s. The New India Assurance Co. Ltd.
Award dated : 05-05-2010

Repudiation of Mediclaim invoking clause 4.3 (waiting period of 2 years)

The Insured was hospitalized for the treatment of Acute Ulcerative tonsillitis with pharyngitis.

The Complainant submitted that the insured was hospitalized for the treatment of fever and blood infection and not tonsillitis. He further stated that the problem was acute and not chronic. The Complainant also produced copy of first consultation paper showing complaint of fever with vomitting sensation.

The Respondent produced hospital records clearly mentioning that the insured was hospitalized for Acute Ulceractive Tonsillitis.

This forum observed that hospitalization was in the second policy year and as per terms and conditions of the policy, Ear, nose and throat disorder has a waiting period of two years hence Respondent's decision to repudiate the claim was justified.

In the result, the complaint fails to succeed.

Case No.11-004-0022-11
Mr.Premjibhai G. Detroja V/s. United India Insurance Co. Ltd.
Award dated 10-05-2010

Delay in settlement of Mediclaim :

The insured underwent treatment for Lumber Canal Stenosis. Claim lodged was not settled by the Respondent even after a lapse of more than 7 months hence the complainant preferred a complaint with this forum.

The Respondent submitted and agreed to settle the claim after disallowing some expenses from total claim amount.

This forum decided that the Respondent's submission to settle the claim as per the terms and conditions of the policy is justified.

In the result partially succeeded.

Case No.11-004-0032-11
Mr. S.H.Gohel V/s. United India Insurance Co. Ltd.
Award dated - 27-04-2010

Repudiation of Mediclaim on the ground of late intimation of hospitalization.

The Complainant was hospitalized for the operation of bilateral fracture of Tibia fibula of left leg. The Respondent had repudiated the claim invoking clause 11(a) of the MOU of the Group Mediclaim Policy which reads as under:

"Members are required to intimate to TPA within 72 hours from the date of hospitalization or else the claim can be repudiated".

The Complainant produced copy of intimation letter as also copy of proof of delivery sheet from courier as evidence that intimation was received by the TPA within 72 hours as envisaged under policy condition.

This forum observed that the Respondent's decision to repudiate the claim was not justified as the contention of the Respondent that intimation for hospitalization was not given as per rules was not correct.

In the result, complaint succeeds.

Case No.11-004-0039-11
Mr. Jagdish N Chaudhry V/s. United India Insurance Co. Ltd.
Award dated – 26-04-2010

Repudiation of Mediclaim on the ground of late intimation of hospitalization.

The Complainant was hospitalized for the treatment of P Falcifarum Maleria with Thrombocytopenia with Vitamin B12 deficiency. The Respondent had repudiated the claim invoking clause 11(a) of the MOU of the Group Mediclaim Policy which reads as under:

"Members are required to intimate to TPA within 72 hours from the date of hospitalization of else the claim can be repudiated".

The Complainant produced copy of intimation letter and copy of fax receipt to substantiate that intimation was sent to TPA well within the time limit.

This forum observed that the Respondent's decision to repudiate the claim was not justified, as the conditions of the Respondent that intimation for hospitalization was not given as per rules was not correct.

In the result complaint succeeds.

11-004-0051-11
Mr. Asgarali M Pathan V/s. United India Insurance Co. Ltd.
Award dated - 26-04-2010

Delay in settlement of Mediclaim :

The Insured was hospitalized for the treatment of Acute Urinary Tract infection with Gastritis and Acute Ureteric Colic. The Respondent had not settled the claim even after a lapse of more than 5 months period from the date of submission of claim papers.

The Respondent in their written submission stated that claim was not admissible as per clause 4.10 of the policy issued i.e. conversion of OPD in to hospitalization.

The Complainant produced copies of hospital records showing diagnosis, details of conditions, clinical findings, laboratory investigations, X-ray KUB, treatment during hospitalization and prescriptions.

The Respondent had not communicated their decision of repudiation of the subject claim to the complainant which was a deficiency in their service. The Respondent also did not obtain an opinion of a medical man and took on their own decision that claim was conversion of OPD into hospitalization.

This forum observed that since the insured underwent treatment in a hospital on the advice by the specialist physician, Respondent's decision to repudiate the claim was not justified.

In the result complaint succeeds.

Case No.11-004-0054-11
Mr. Bharatbhai S Patel V/s.United India Insurance Co. Ltd.
Award dated 10-05-2010

Delay in settlement of Mediclaim :

The Insured underwent treatment for Endoscopic Septoplasty and B/L Endoscopic sinus surgery. The dispute related to non settlement of the claim by the Respondent even after a lapse of more than 7 months period from the date of submission of claim papers.

The Respondent submitted that as per the terms and conditions of the family floater Group Mediclaim policy, full claim is not payable.

This forum was convinced by the decision of the Respondent to settle the subject claim partially as per the terms and conditions of the policy.

In the result the complaint partially succeeded.

Case No.11-004-0055-11
Mr. Narendrabhai J Rathod V/s. United India Insurance Co. Ltd.
Award dated 10-05-2010

Delay in settlement of Mediclaim :

The Complainant approached this forum for non-settlement of his claim by the Respondent even after a loss of more than 7 months period from the date of submission of claim papers. The insured underwent bilateral tibial knee replacement surgery for which according to the Respondent's submission, as per terms and condition of the family floater Group Mediclaim policy, 75% of admissible amount of claim is payable.

This forum decided that the decision of the Respondent to settle the subject claim for 75% of admissible amount is justified as per the terms and conditions of the subject policy.

In the result the complaint partially succeeded.

Case No.11-004-0056-11
Mr.Pravinbhai P Patel V/s. United India Insurance Co. Ltd.
Award dated 10-05-2010

Delay in settlement of Mediclaim:

The insured underwent surgery for total knee replacement. Claim lodged with the Respondent was not settled even after lapse of more than 7 months period from the date of submission of claim papers.

The Respondent submitted that as per the terms and conditions of the subject Group Mediclaim policy 75% of admissible amount is payable.

This forum decided that the decision of the Respondent to settle the subject claim is justified.

In the result, complaint partially succeeded.

Case No.11-004-0060-11
Mr. Amit N Christian V/s. United India Insurance Co. Ltd.
Award dated 30-04-2010

Repudiation of mediclaim was on the ground of late intimation of hospitalization.

The insured was hospitalized for the treatment of high grade fever, cough and cold. The Respondent submitted that the complainant did not send intimation for hospitalization within 24 hours but sent late by 17 days.

The Complainant by producing copy of acknowledgement receipt of the TPA submitted that intimation was delayed by one day.

This forum observed that there was no other infirmity in the claim except to the delay in intimation by one day and the Respondent had discretionary power to condone delay upto 30 days but they had not exercised in the subject claim. Therefore it was decided that Respondent's decision to reject the claim was not just and fair hence set aside.

In the result complaint succeeds.

Case No.11-004-0092-11
Mr. Maheshbhai N Patel V/s. United India Insurance Co. Ltd.
Award dated : 30-04-2010

Delay in settlement of Mediclaim:

The Complainant was hospitalized for left eye cataract operation. The dispute was related to the non settlement of the claim by the Respondent, even after a lapse of more than 4 months period from the date of submission of claim papers.

The Respondent submitted that as per terms and conditions of the subject family floater group mediclaim policy only an amount of Rs.15000/- was payable for cataract operation.

This forum upheld the decision of the Respondent to settle the subject claim as per the terms and conditions of the policy.

In the result, the complaint partially succeeds.

Case No.11-004-0093-11
Mr. Manilal R Patel V/s. United India Insurance Co. Ltd.
Award dated 30-04-2010

Delay in settlement of Mediclaim:

The insured was hospitalized for total knee replacement surgery. Claim lodged with the Respondent was not settled even after lapse of more than 7 months period from the date of submission of claim papers.

The Respondent submitted that as per the terms and conditions of the family floater Group Mediclaim policy 75% of admissible amount was payable for total knee replacement surgery.

This forum found that the decision of the Respondent to settle the subject claim partially was justified as per terms and conditions of the policy.

In the result, complaint partially succeeded.

Case No.11-004-0443-10
Mr. Jethalal J Soni V/s. United India Insurance Co. Ltd.
Award dated – 30-04-2010

Delay in settlement of Mediclaim:

The Complainant was hospitalized twice for the treatment of breathlessness, weakness, Diabetes Mellitus, Respiratory distress etc.

The complainant submitted that the claim was lodged within the stipulated period and same was settled by the TPA but payment was not released for want of fund from the Respondent.

The Respondent admitted the claim after disallowing some items giving reasons thereof.

This forum found that the Respondent's decision was justified in partial settlement.

In the result the complaint partially succeeds.

Case No.11-004-0094-11
Mr. Kalpeshbhai S Patel V/s. United India Insurance Co. Ltd.
Award dated – 30-04-2010

Delay in settlement of Mediclaim:

The insured was hospitalized for Rt.eye cataract operation. The complainant submitted that the Respondent had not settle the claim even after a lapse of more than 5 months period from the date of submission of claim papers.

The Respondent submitted that as per terms and conditions of the family floater Group Mediclaim Policy, an amount of Rs.15000/- only is payable for cateract operation.

This forum found the decision of the Respondent to settle the claim partially justified.

In the result, complaint partially succeeds

Case No.11-002-0553-10
Mr. Asit H. Oza V/s. New India Assurance Co. Ltd.
Award dated – 27-04-2010

Partial settlement of Mediclaim:

The insured was hospitalized for the surgery of Appendicitis. Claim was lodged for Rs.38613/- whereas the Respondent had settled the claim disallowing Rs.15000/- towards surgeon's fee paid to the surgeon in cash other than hospital payment in terms of their internal circular which states that if the fees are paid in cash then the payment is limited to a sum of Rs.10,000/- and Rs.1567/- towards Anasthesia and O.T charges in proportion to more than 1% S.I of Room rent.

The Complainant submitted that he was entitled for the reimbursement upto S.I Rs.1 Lac.

This forum observed that most of the transactions entered into by the doctors and hospitals with patients are in cash only and ceiling on reimbursement of Surgeon's fee was based on their internal circular which was neither part of policy condition nor the complainant was informed. Moreover the Respondent was not justified in disallowing Rs.1,567/- by treating old S.I as Rs.50,000/- whereas S.I in instant case was Rs.1,00,000/- because the insured was covered first time under Mediclaim Policy 2007 in which claim took place.

This forum decided that complainant was entitled for reimbursement upto S.I. of Rs.1,00,000/ so the Respondent was not justified in deducting sum of Rs.16,567/-.

In the result complaint succeeds.

Case No.11-002-0557-10
Mr. Sanjay U Mehta V/s. The New India Assurance Co. Ltd.
Award dated 23-04-2010

Partial settlement of Mediclaim:

The Respondent settled the mediclaim after disallowing Rs.5099/-.

The Complainant submitted that he had incurred genuine expenses which were related to hospitalization/post hospitalization treatment of the insured.

The Respondent submitted that if at all the claim is payable, their liability comes to Rs.4699/-.

This forum was convinced with the Respondent's decision to pay Rs.4699/- towards full and final settlement of the claim.

In the result, the complaint partially succeeds.

Case No.11-002-0570-10
Mr. Jigar M Shah V/s. The New India Assurance Co. Ltd.
Award dated 23-04-2010

Partial settlement of Mediclaim :

The amount claimed was Rs.2,10,065/-. The subject policy was for a Sum Insured Rs.1,50,000/-+ Cumulative Bonus Rs.11,750/-. The Respondent partially settled the claim for Rs.59,250/-(old S.I Rs.50,000/-+C.B Rs.9,250/- _invoking clause 4.3 which stipulates that Hypertension has a waiting period of 2 years and the complainant had increased S.I Rs.1,00,000/- which falls within the waiting period hence not payable. The Complainant submitted that he had Acute Myocardial Infarction hence underwent treatment of PTCA (PAMI) with stenting of RCA which Respondent presumed was a result of

Hypertension. The Complainant also produced copy of discharge summary from the treating hospital which didn't show that he had history of hypertension.

The Respondent did not produce any evidence to show that complainant was suffering from hypertension or treatment given to him was for hypertension.

As per clause 4.3 of the terms and conditions of the subject policy there is no waiting period for myocardial infarction.

This forum observed that it is not established that the complainant had undergone treatment for hypertension or his ailment was related to hypertion, so the decision of the Respondent to treat hospitalization expenses due to hypertension is not justified.

In the result the complaint succeeds.

Case No.11-004-0076-11
Mr. R.P.Khatri V/s. United India Insurance Co. Ltd.
Award dated 30-04-2010

Delay in settlement of Mediclaim:

The Complainant was hospitalized for the surgery of extra peritoneal colostomy. The Respondent had not settled the claim even after a lapse of more than 5 months period from the date of submission of claim papers.

The Respondent submitted that as per the terms and conditions of the family floater group mediclaim policy an amount of Rs.18000/- was payable for the operation underwent by the complainant.

This forum found that the decision of the Respondent to settle the claim as per terms and conditions of the policy was in order.

In the result, the complaint partially settled.

Case No.11-004-0087-11
Mr. Kishore I Rana V/s. United India Insurance Co. Ltd.
Award dated 30-04-2010

Delay in settlement of Mediclaim:

The insured was hospitalized for the treatment of Pyrexia (U.I). The Respondent had not settled the claim even after a lapse of more than 4 months period from the date of submission of claim papers.

The Respondent agreed to settle the claim after deducting admission fee.

The forum was convinced by the Respondent's decision to settle the claim partially.

In the result, complaint partially succeeds.

Case No.11-004-0089-11

Mr. Nilesh D Naik V/s. United India Insurance Co. Ltd.
Award dated – 30-04-2010

Delay in settlement of Mediclaim:

The insured was hospitalized for the treatment of left knee joint replacement surgury. The dispute related to the non settlement of the claim by the Respondent ever after a lapse of more than 5 months period from the date of submission of claim papers.

The Respondent agreeing to settle the claim submitted that as per the terms and conditions of the subject family floater Group Mediclaim Policy, 75% of admissible amount is payable.

This forum was convinced by the decision of the Respondent to settle the claim partially.

In the result, the complaint partially succeeded.

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Case no 11-04-0079-11
Smt Vinodini J Shah
Vs
United India Insurance Co.Ltd
Award Dated: 10.06.10

Repudiation of Mediclaim: The Insured was hospitalized for treatment of Knee Replacement and the claim was repudiated by the Respondent by invoking clause no 5.7 of policy condition stating that overwriting in name . age and date was made by hospital and the claim was made in fraudulent manner .The Complainant has stated that the cuttings have been initialed by the hospital authorities .In the claim ,the corrections needs to be examined and the forum has neither powers and infrastructure to undertake the exercise .Hence without getting into merits of the case and passing any award for the same the complaint is deemed as beyond jurisdiction.

AHMEDABAD OMBUDSMAN CENTRE
Case no 11-04-0185-11
Subhashchandra C Kapadia
Vs
United India Insurance Co.Ltd
Award Dated : 10.06.10

Repudiation of Mediclaim : The Insured was hospitalized for treatment of Knee Replacement and the claim was repudiated by the Respondent by invoking clause no 5.7 of policy condition stating that pain in knee joint was not shown in proposal since the disease was preexisting. Respondent `s contention that the subject claim is not payable due to non declaration of pre existing diseases at the time of inception of cover is not tenable as the subject policy was group

policy and there was no specific enquiries about any pre existing disease to be covered. The policy covers persons from 3 months to 80 yrs without any medical check up and all preexisting diseases are covered after 30 days. So the respondent `decision to repudiate the claim is not justified.

The complaint succeeds on its merits.

AHMEDABAD OMBUDSMAN CENTRE
Case no 11-05-0128-11

Sunil S Shethaijwala
Vs
Oriental Insurance Co.Ltd
Award Dated : 31.05.2010

Repudiation of Mediclaim : The Insured was hospitalized for treatment of Le central retinal venous occlusion and was discharged on the same day after treatment. The Complainant submitted the claim and the claim was repudiated by the Respondent by invoking policy condition no 2.3which inter alia states that the hospitalization for minimum period of 24 hours requires . The Complainant pleaded that the treatment was a surgical process for eye undertaken in operation theatre .The certificate of doctor states that the procedure was not an OPD procedure and due to advancement of medical technology the procedure has been changed and hospitalization was not required for 24 hours for treatment. So the respondent `decision to repudiate the claim is not justified.

The complaint succeeds on its merits.

Ahmedabad Ombudsman Centre
Case no 11-02-0125-11
Mr. shaileshbhai M Patel
Vs
The New India Assurance Company Ltd
Award Date: 31.05.2010

Partial Settlement of Claim under Mediclaim Policy: The claimant has submitted the claim for reimbursement of expenses incurred in hospitalization from 16.10.2009 to 18.10.09 for treatment of removal of left tibia implant 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 2001 for sum insured 50000/ and increased to 1 lakh from 25.02.2008.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.

Ahmedabad Ombudsman Centre
Case no 11-02-0196-11
Mr. Anish M Bhatt
Vs
The New India Assurance Company Ltd

Award Date : 31.05.10

Partial Settlement of Claim under Mediclaim Policy: The claimant has submitted the claim for reimbursement of expenses incurred in hospitalization from 01.02.10 to 03.02.10 for treatment of Benign hyperplasia of prostate. The respondent has settled the claim after deduction of Rs 13719/ 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 Complainant has pleaded that there is no mention in policy condition that any amount paid in cash in excess of Rs 10,000/ will not be reimbursed. The Respondent has submitted that the deduction of RS 12000/ as per internal instructions of their higher office and Rs 1719/ as per policy condition 2..It was established from the documents that the decision of the respondent to restrict the payment of surgeons fees to Rs 10000/is not justified and they have been directed to make the payment to the complainant .The complaint stands to succeed.

Ahmedabad Ombudsman Centre
Case no 11-004-0171-11
Mr .Bharat P Patel
Vs
United India Insurance Company Ltd

Award Date: 31-05.2010

Non settlement of Claim under Mediclaim policy: The complainant has submitted the claim and the Respondent have not settled the claim even after a lapse of 9 months. The Insured was covered under two policies. Other insurer New India insurance has settled the claim full as per policy condition .Since the insurance operates on the principle of indemnity so equity and Respondent and the New India Insurance co should consider the hospitalization expenses in proportion to their insured amount. Hence the Respondent is directed to make the payment in proportion to the insured amount to the complainant .The complaint stands succeeds.

Ahmedabad Ombudsman Centre
Case no 11-004-0034-11
Mr .Mohammed S Dhalech
Vs
United India Insurance Company Ltd
Award Date : 31.05.2010

Repudiation of Claim under Mediclaim policy: The complainant has submitted the claim for reimbursement of expenses incurred in hospitalization from 08.07.09 to 15.07.09 .The respondent has repudiated the claim by invoking exclusion clause 4.10 of policy i.e conversion of OPD into hospitalization .The Respondent has submitted that no intimation was given .The Complainant submitted that the intimation was sent to TPA timely .Letter of agent was submitted in conformation of sending the intimation. The Complainant could not submit the name of courier nor the copy of POD Hence it could not established that the intimation was sent in time ,therefore the decision of respondent to repudiate the claim is justified .The complaint fails to succeed

Ahmedabad Ombudsman Centre
Case no 11-002-0555-10
Mr .Dilipbhai Karshanbhai Mandalia
Vs
New India Assurance Company Ltd
Award Date: 31.05.2010

Repudiation of Claim under Mediclaim policy: The complainant has submitted the claim for reimbursement of expenses incurred in hospitalization from 01.10.09 to 05.10.09 .The respondent has repudiated the claim by invoking exclusion clause 4.4.1 of policy stating that hospitalization was not justified in first claim and no intimation was given for second claim .The Complainant pleaded that the insured was hospitalized on 1.10.09 to 2.10.09 first time and from 03.10.09 to 5.10.09 second time .The intimation was given on 1.10.09 and it was continuous treatment and the Respondent has not taken any medical opinion for requirement of hospitalization . Hence it is established that the decision of respondent to repudiate the claim is not justified and directed to settle the claim. Thus the complaint succeeds.

Ahmedabad Ombudsman Centre
Case no 11-005-0577-10
Mr .Mukesh C Shah
Vs
Oriental Insurance Company Ltd
Award Date: 31.05.2010

Repudiation of Claim under Mediclaim policy: The complainant has submitted the claim for reimbursement of expenses incurred in hospitalization for treatment of decreased bone strength from 21.07.09 to 27.07.09 .The respondent has repudiated the claim by invoking exclusion clause 4.8 of policy stating that the disease was a genetic disorder. The discharge summary records the disease suffered as Acute and fracture on RT leg tibia due to fall from bicycle and it was corrective procedure for previous operation. The claim for previous operation was settled by the Respondent .Hence it was established that the insured was hospitalized for corrective Osteotomy of Rt. Tibia not for treatment of any genetic disorder. The complaint succeeds and the Respondent was directed to settle the claim.

Ahmedabad Ombudsman Centre
Case no 11-004-163-11
Mr Manhar G Dargi
Vs
United India Insurance Company Ltd
Award Date: 31.05.2010

Non settlement of Claim under Mediclaim policy: The complainant has submitted the claim for reimbursement of expenses incurred in hospitalization from 07.07.09 to 09.07.09 for treatment of right side per arthritis shoulder .The respondent has submitted to settle the claim of Rs 21125/. The grievances thus resolved.

Ahmedabad Ombudsman Centre
Case no 11-002-546-10
Smt Sangeetaben Desai
Vs
New India Assurance Company Ltd
Award Date: 31.05.2010

Repudiation of Claim under Mediclaim policy: The complainant has submitted the claim for reimbursement of expenses incurred in hospitalization from 05.09.09 to 06.09.09 for treatment of pre existing disease. The respondent has repudiated the claims by invoking exclusion clause 4.1 of the policy . However both the parties mutually agreed for payment of the claim for Rs 4380 .The grievances thus resolved.

Ahmedabad Ombudsman Centre
Case no 11-004-207-11
Mr. Urvesh P Shah
Vs

United India Insurance Company Ltd

Award Date: 31.05.2010

Repudiation of Claim under Mediclaim policy: The complainant has submitted the claim for reimbursement of expenses incurred in hospitalization from08.08.09 to13.08.09 . The respondent has repudiated the claims by invoking exclusion clause 5.3 of the policy on the ground that the claim intimation was submitted late. However both the parties mutually agreed for payment of the claim for Rs 22600/ .The grievances thus resolved.

Ahmedabad Ombudsman Centre
Case no 11-009-230-11
Mr. Pravinbhai O Prajapati
Vs
Reliance Genaral Insurance Company Ltd

Award Date: 28.06.2010

Repudiation of Claim under Mediclaim policy: The complainant has submitted the claim for reimbursement of expenses incurred in hospitalization from15.07.09 to21.07.09. The respondent has repudiated the claims by invoking exclusion clause 15 of the policy on the ground that the claim was fraudulent. However both the parties mutually agreed for payment of the claim for Rs 6000/ .The grievances thus resolved.

Ahmedabad Ombudsman Centre
Case no 11-02-0145-11
Mr.Chaturbhai K Patel
Vs
The New India Assurance Company Ltd

Award Date: 28.6.10

Partial Settlement of Claim under Mediclaim Policy: The claimant has submitted the claim for reimbursement of expenses incurred in hospitalization from 22.11.09 to 25.11.09 for treatment of Hypertension. The respondent has settled the claim after deduction by invoking clause 4.3 of policy which stipulates waiting period of two years for the disease. The respondent had settled the claim for initial sum insured with CB .and the increased sum insured is not applicable because of waiting period .The Respondent has rightly settled the claim .The complaint fails to succeed.

Ahmedabad Ombudsman Centre
Case no 11-04-0015-11
Mr.Bhavesh K Patel
Vs
United India Insurance Company Ltd

Award Date: 21.06.10

Repudiation of Claim under Mediclaim Policy: The Complainant has submitted the claim for reimbursement of expenses incurred in hospitalization from 11.09.08 to 15.09.08 for treatment of accidental injuries .The claim was repudiated by the Respondent as per clause 5.4 of policy condition which excludes the claim in case of late submission of files .The complainant submitted that his hands were injured and earlier four claim were settled on representation ,the subject claim should be settled in the same light.In the result complaint succeeds on its own merits.

AHMEDABAD OMBUDSMAN CENTRE
Case no 11-02-0112-11
Mohanbhai K Dholkia
Vs
New India Assurance Co.Ltd
Award Dated: 21.06.10

Repudiation of Mediclaim : The Insured was hospitalized for treatment of chest pain and Ischemic heart disease and the claim was repudiated by the Respondent by invoking clause no 4.1 of policy condition stating that the disease was pre existing when the cover is incepted .The discharge summary has confirmed the history of DOE and chest pain since 3-4 years. The claim was preferred earlier for cashless facility for coronary angioplasty, doe chest pain complaints since 3-4 years which was declined. So the respondent `s decision to repudiate the claim is justified.

The complaint fails to succeed.

Ahmedabad Ombudsman Centre
Case no 11-04-0199-11
Mr.Alpesh C Shah
Vs
United India Insurance Company Ltd
Award Date: 21.06.10

Repudiation of Claim under Mediclaim Policy: The Complainant has submitted the claim for reimbursement of expenses incurred in hospitalization on 26.05.09 for treatment of Em.D & C and polypectomy .The claim was repudiated by the Respondent as per clause 5.3 and 5.4 of policy condition which excludes the claim in case of late intimation and late submission of files .The complainant submitted that his son and daughter were busy in examination and he met with accident ,therefore there was delay in intimation and submission of claim papers. The Respondent should have considered the claim due to reasons, valid for condonation of delay in submissions and intimation. In the result complaint succeeds on its own merits.

Ahmedabad Ombudsman Centre

Case no 11-004-226-11
Mr. Pravinbhai O Prajapati
Vs
United India Insurance Company Ltd
Award Date: 14.06.2010

Repudiation of Claim under Mediclaim policy: The complainant has submitted the claim for reimbursement of expenses incurred in hospitalization from01.01.10to05.01.10. The respondent has repudiated the claims stating that no indoor papers, IPD number,or treatment papers were available during the course of Investigation . However both the parties mutually agreed for payment of the claim for Rs 4500/ .The grievances thus resolved.

Ahmedabad Ombudsman Centre
Case no 11-010-0075-11
Mr. Nirav K Sutariya
Vs
IFFCO TOKIO Genaral Insurance Company Ltd
Award Date: 23.07.2010

Repudiation of Claim under Mediclaim policy: The complainant has submitted the claim for reimbursement of expenses incurred in hospitalization from18.08.09to26.08.09. for treatment of high grade dengu fever The respondent has repudiated the claims stating that the hospital and claimant had fraudulently prepared claim papers to take undue advantage . The Complainant had submitted discharge summary along with first consulatation letter advising to hospitalized in confirmation of taking treatment during the hospitalization .Hence the submitted documents has proved that the claim was not fraudulent .In the result the complaint stands succeed on its own merits.

Case no 11-02-0254-11
Mr Jigar J Shah
Vs
New India Assurance Co.Ltd
Award Dated: 23.07.10

Repudiation of Mediclaim : The Insured was hospitalized for treatment of abscess on 27.06.08 and discharged on 28.06.08 .The claim for reimbursement was submitted and the same was repudiated by the Respondent by invoking clause no 2.3 of policy condition stating that the minimum period of hospitalization should be 24 hours .The Complainant has submitted the copy of operative note and discharge summary which has confirmed that admission in hospital was necessary because of surgery under spinal anesthesia and the insured was admitted at 9.00 AM and was discharge

at 10.am on the next day i.e. more than 24 hours. Hence the respondent `s decision to repudiate the claim is not justified.

The complaint fails to succeed.

Ahmedabad Ombudsman Centre
Case no 11-02-0219-11
Mr. Bhupendra B patel
Vs
The New India Assurance Company Ltd
Award Date: 31.05.10

Partial Settlement of Claim under Mediclaim Policy: The claimant has submitted the claim for reimbursement of expenses incurred in hospitalization on08.02.10 for treatment of Lt. Eye Cataract. The respondent has settled the claim after deduction 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 Complainant has pleaded that he was having policy since 2000 for sum insured of Rs 35000/ and it was increased to 100000/ under mediclaim policy 2007. It is established from the submitted documents that the revised terms and condition will be applicable to the increased sum insured with waiting period of two years for cataract .Since the old medical policy has no condition for restricting the limit of expenses . The Respondent has applied two standards while settling the claim for the terms and conditions under the same policy. Therefore the Respondent has been directed to make the partial payment .The complaint stands to succeed.

Ahmedabad Ombudsman Centre
Case no 11-002-309-11
Mrs. Lilaben K Jadav
Vs
New India Assurance Company Ltd
Award Date: 15.07.2010

Non Settlement of Claim under Mediclaim policy: The complainant has submitted the claim for reimbursement of expenses incurred in hospitalization from06.06.09to18.06.09. The respondent has not settled the claim even after lapse of 9 months. During the course of hearing the Respondent has submitted that they were making the payment of the claim for Rs 89501/ as per terms and conditions of the policy .The complaint partially succeed.

AHMEDABAD OMBUDSMAN CENTRE
Case no 11-02-0112-11
Mohanbhai K Dholkia
Vs
New India Assurance Co.Ltd
Award Dated: 21.06.10

Repudiation of Mediclaim : The Insured was hospitalized for treatment of chest pain and Ischemic heart disease and the claim was repudiated by the Respondent by invoking clause no 4.1 of policy condition stating that the disease was pre existing when the cover is incepted .The discharge summary has confirmed the history of DOE and chest pain since 3-4 years. The claim was preferred earlier for cashless facility for coronary angioplasty, doe chest pain complaints since 3-4 years which was declined. So the respondent `s decision to repudiate the claim is justified.

The complaint fails to succeed.

AHMEDABAD OMBUDSMAN CENTRE
Case no 11-04-0118-11
Govindbhai G Patel
Vs
United India Insurance Co.Ltd
Award Dated: 30.06.10

Repudiation of Mediclaim: The Insured was hospitalized from 18.04.09 to 05.05.09 for treatment of decompartment ccf + uti and the claim was repudiated by the Respondent stating that the disease was pre existing when the cover is incepted .The discharge summary has confirmed the history of DM + IHD since 2 years, haemorrhoidectomy before 2 years and TURP before 2 years was recorded. . The certificates issued by the hospitals had supported the history of illness and the disease of the subject claim was also a complication of pre existing disease. So the respondent `s decision to repudiate the claim is justified.

The complaint fails to succeed.

Ahmedabad Ombudsman Centre
Case no 11-04-0105-11
Mr. Subodhbhai B Shah
Vs
United India Insurance Company Ltd

Award Date: 21.06.10

Repudiation of Claim under Mediclaim Policy: The Complainant has submitted the claim for reimbursement of expenses incurred in hospitalization from 04.05.09 to 05.05.09 for operation for Cystoscopy + DJ removal surgery .The claim was repudiated by the Respondent as per clause 5.3 and 5.4 of policy condition which excludes the claim in case of late intimation and late submission of files .The complainant has not submitted any convincing and valid reasons to justify in submission of papers after 5o days, therefore looking to the long duration of delay it is not a fit and deserving case for consideration of condonation of delay . In the result complaint fails to succeed.

AHMEDABAD OMBUDSMAN CENTRE
Case no 11-02-0261-11
Smt Pragnaben R Pandya
Vs
New India Assurance Co.Ltd
Award Dated: 10.08.10

Partial Repudiation of Mediclaim : The Insured was hospitalized for treatment of abdominal hysterectomy and incisional hernia repair from 05.01.10 to 13.01.10 and the claim was partially settled by the Respondent by stating that expenses pertaining to operation of incisional hernia was excluded as per policy condition. It is observed that first Caesarian was done 28 years back and second 24 years back which is the proximate cause for incisional hernia which is not admissible as per terms and conditions of policy .The hospital has shown the expenses pertaining to operation charges for hernia separately .Hence the respondent has correctly disallowed the expenses of hernia operation. The complaint fails to succeed.

AHMEDABAD OMBUDSMAN CENTRE
Case no 11-05-239-11
Mr HirenV Doshi
Vs
Oriental Insurance Co.Ltd
Award Dated: 09.08.10

Repudiation of Mediclaim: The complainant lodged the claim for reimbursement of expenses incurred in treatment during hospitalization from 23.11.08 to 06.12.08 and the claim was repudiated by the Respondent invoking clause 1 of the policy .The discharge summary has shown that the insured was a known case of PDA closure[4 years of age} and ASD closure (6months) and this fact was not disclosed in the proposal form .The treating doctor has certified that surgery for PDA closure done at the age of 4 yrs has no relation with the present illness. As per opinion of independent doctor ,ASD closure has relation with the Rheumatic Heart Disease .The discharge summary also mentions left eye Panopthalmolitis which is inflammation of entire eye covered by pyogenic organism .It is established that the present illness Infective Endocarditis relates to the previous ASD closure done prior to the inception of the policy and the decision of the Respondent to treat it as a complication of pre existing heart disease which have a waiting period of 4 year is justified . The complaint fails to succeed.

Ahmedabad Ombudsman Centre
Case no 11-004-0364-11
Mr. Dinesh M Jain

Vs
United India insurance Company Ltd
Award Date: 05.08.2010

Repudiation of Claim under Mediclaim policy: The complainant has submitted the claim for reimbursement of expenses incurred in hospitalization. The respondent has repudiated the claim on the ground stating that hospitalization was not required. As a result of mediation by this forum, both the parties mutually agreed for payment of the claim for Rs 10000/ .The grievances thus resolved.

Ahmedabad Ombudsman Centre
Case no 11-004-0418-11
Mr. Vipul R Shukla
Vs
United India insurance Company Ltd
Award Date: 05.08.2010

Repudiation of Claim under Mediclaim policy: The complainant has submitted the claim for reimbursement of expenses incurred in hospitalization. The respondent has repudiated the claim on the ground of abnormal delay in submission of claim papers. As a result of mediation by this forum, both the parties mutually agreed for payment of the claim for Rs 20563/ .The grievances thus resolved.

Ahmedabad Ombudsman Centre
Case no 11-04-0245-11
Mr. Kamlesh S Shah
Vs
United India Insurance Company Ltd
Award Date: 23.07.10

Repudiation of Claim under Mediclaim Policy: The Complainant has submitted the claim for reimbursement of expenses incurred in hospitalization from 21.04.09 to 23.04.09 for treatment of enteric fever .The claim was repudiated by the Respondent as per clause 5.4 of policy condition which excludes the claim in case of late submission of files .The complainant submitted that the claim file was submitted delayed for 3 days only. Looking to the short duration of delay in submission of claim file, it is fit and deserving case for consideration of condonation of delay. In the result complaint succeeds on its own merits.

Ahmedabad Ombudsman Centre
Case no 11-09-0379-11
Mr. Rajesh V Jain
Vs

Reliance General Insurance Company Ltd
Award Date: 30.08.10

Repudiation of Claim under Mediclaim Policy: The Complainant has submitted the claim for reimbursement of expenses incurred in hospitalization from 01.10.09 to 26.10.09 for treatment of brain tumor .The claim was repudiated by the Respondent as per clause 3 of policy condition which excludes the claim in case of incurred within first year from the date of cover. The complainant submitted that the claim was in second year of policy and the exclusion was not operative. The Respondent has pleaded that the insured was suffering from continuous vomiting which is a symptom of brain tumor since 6 months. From the documents submitted ,it gets established that the clause no 3 states that expenses incurred on the subject diseases within the first year from the cover of the policy will not be payable and the clause does not stipulate that expenses incurred for treatment will not be paid if the symptoms of disease are noticed in first year. Hence the decision of the Respondent to repudiate the claim is not justified. The complaint succeeds on its own merit.

Ahmedabad Ombudsman Centre
Case no 11-04-0340-11
Mr.Bhikhabhai A Patel
Vs
United India Insurance Company Ltd
Award Date: 30.08.10

Partial Settlement of Claim under Mediclaim Policy: The claimant has submitted the claim for reimbursement of expenses incurred in hospitalization on 10.09.09 for treatment of Cataract. The respondent has settled the claim after deduction by invoking clause 4.2 of policy which stipulates waiting period of two years for the disease. The respondent had settled the claim for initial sum insured and the increased sum insured is not applicable because of waiting period .The Respondent has rightly settled the claim .The complaint fails to succeed.

Ahmedabad Ombudsman Centre
Case no 11-03-0425-11
Mr. Ramanlal S Parmar
Vs
National Insurance Company Ltd
Award Date: 30.08.10

Repudiation claim under Mediclaim Policy: The claimant has submitted the claim for reimbursement of expenses incurred in hospitalization from 26.06.09 to 28.06.09 for treatment of renal calculus. The respondent has repudiated the

claim by invoking exclusion clause 4.3 of the policy which stipulates waiting period of two years for treatment of the disease from the date of operation. The policy was renewed after break of 22 days treating the policy as a fresh policy .It gets established that the explanation for break of 22 days in renewal of policy was not convinced .The Respondent has rightly repudiated the claim .The complaint fails to succeed.

AHMEDABAD OMBUDSMAN CENTRE
Case no 11-04-352-11
Mr Harkant G Vachharajani
Vs
United India Insurance Co.Ltd
Award Dated: 30.08.10

Repudiation of Mediclaim: The complainant lodged the claim for reimbursement of expenses incurred in treatment during hospitalization from 10.10.09 to 20.10.09 and the claim was repudiated by the Respondent invoking clause 5.7 of the policy treating the illness as pre existing disease but not declared at the time of inception of policy. The discharge summary has shown the history of disease since 6 months i.e. after the date of cover. The subject policy covers persons from age group of 3 months to 80 years without any medical check up and with coverage of all pre existing diseases after 30 days from the date of cover .Moreover the proposal form has no specific question enquiring about preexisting disease to be covered. It gets established that fraud has not been proved by the respondent showing that the DLA was aware of his illness. Hence the decision of the respondent to repudiate the claim is not justified. The complaint stands to succeed.

AHMEDABAD OMBUDSMAN CENTRE
Case no 11-05-0133-11
Mr Shailesh R Shah
Vs
Oriental Insurance Co.Ltd
Award Dated: 30.08.10

Repudiation of Mediclaim: The complainant lodged the claim for reimbursement of expenses incurred in treatment during hospitalization from 27.06.08 to 03.07.08 and the claim was repudiated by the Respondent invoking exclusion clause 4.10 of the policy stating that the benefits to the policyholder in connection with or in respect of expenses incurred at hospital primarily for diagnostic purpose is not payable .It gets established that hospitalization was not necessary as the insured had only 3 consultations during the entire period he was supposedly hospitalized and treatment was given was administration of eye drops and tablets which could have been done

on OPD basis .Respondent therefore has justified in rejecting the claim The complaint fails to succeed.

AHMEDABAD OMBUDSMAN CENTRE
Case no 11-02-0313-11
Mr Dhaval Bhanushanker Bhatt
Vs
New India Assurance Co.Ltd
Award Dated: 30.08.10

Repudiation of Mediclaim: The complainant lodged the claim for reimbursement of expenses incurred in treatment during hospitalization on 30.11.2009 for Cataract and the claim was repudiated by the Respondent invoking exclusion clause 4.3 of the policy which excludes the claim payment for cataract for first two years .It gets established that hospitalization was for cataract operation and the policy has the exclusion clause for the disease. Respondent therefore has justified in rejecting the claim. The complaint fails to succeed.

Ahmedabad Ombudsman Centre
Case no 11-009-0405-11
Mr. Girishkumar S Mavani
Vs
Reliance General Insurance Company Ltd
Award Date: 30.08.10

Repudiation of Claim under Mediclaim policy: The complainant has submitted the claim for reimbursement of expenses incurred in hospitalization from 08.10.09 to 12.10.09. The respondent has repudiated the claim by invoking clause 15, violation of terms and conditions of reliance Health Policy. As a result of mediation by this forum, both the parties mutually agreed for payment of the claim for Rs 16144/ .The grievances thus resolved.

Ahmedabad Ombudsman Centre
Case no 11-02-0330-11
Mr. Alok A Jhaveri
Vs
The New India Assurance Company Ltd
Award Date: 30.08.10

Partial Settlement of Claim under Mediclaim Policy: The claimant has submitted the claim for reimbursement of expenses incurred in hospitalization from 27.10.09 to 02.11.09 for treatment of Acute Gastro Enteritis. The respondent has settled the claim after deduction by invoking clause 2.3, and

Note 2 of policy and disallowing under doctor `s charges and procedure charges. The Responded has submitted that he has paid Rs 9000/ in cash to the doctor against receipt issued without no. and date on the letter head of a hospital other than the insured was admitted. The complainant has pleaded that only infrastructure was provided by the hospital and fees was paid to the doctor and policy has also no condition that any payment made in cash will not reimbursed. It gets established that the payment was made on the receipt on the letter head and procedure charges has been deducted as per policy condition. Therefore the Respondent has justified in settling the claim as per conditions of the policy .The complaint fails to succeed.

Ahmedabad Ombudsman Centre
Case no 11-02-0350-11
Mr. Sunil J Pithwa
Vs
The New India Assurance Company Ltd
Award Date: 30.08.10

Repudiation of Claim under Mediclaim Policy: The claimant has submitted the claim for reimbursement of expenses incurred in hospitalization from 06.03.10 to10.03.10 for treatment of iron deficiency anemia with viral fever with bleeding gums. The respondent has repudiated the claim by invoking clause 4.4.6 of policy which excludes expenses incurred in connection with convalescence ,general debility, run down condition or rest cure obesity treatment .A copy of discharge summary has recorded the history of sustaining injury due to fall from stairs and leading to fracture and abscess of tooth .The respondent has not submitted any written statement .It gets established that the present claim was for the disease due to excessive bleeding because of extraction of tooth due to accident and the said exclusion clause is not operative. Therefore the Respondent has not justified in repudiating the claim as per conditions of the policy .The complaint stands to succeed.

Case no 11-02-0278-11
Mr. Kaushal /Gopal M Bhavsar
Vs
The New India Assurance Company Ltd
Award Date: 30.08.10

Partial Settlement of Claim under Mediclaim Policy: The claimant has submitted the claim for reimbursement of expenses incurred in hospitalization from17.09.09 to 23.09.09 for treatment of Acute Infective Hepatitis. The respondent has settled the claim after deduction by invoking clause 2.3 and Note 2 of policy and disallowing under doctor `s charges. The Responded has submitted that he has paid Rs 7200/ in cash to the doctor which is not part of the hospital bill and any cash payment which is not part of hospital bill is not

payable. It gets established that the internal circular submitted by the respondent cannot be sustainable since there is no condition where it has been mentioned that all payments in respect of hospitalization must be paid by cheque and internal circular which is not part of the policy condition. Therefore the Respondent has not justified in settling the claim as per conditions of the policy .The complaint stands to succeed.

Ahmedabad Ombudsman Centre
Case no 11-05-0365-11
Mr. Sureshkumar T Shah
Vs
Oriental Insurance Company Ltd
Award Date: 30.08.10

Repudiation of Claim under Mediclaim Policy: The claimant has submitted the claim for reimbursement of expenses incurred in hospitalization from 22.01.10 to25.01.10 for treatment of poly cystic kidney disease CRF. The respondent has repudiated the claim by invoking clause 4.15 of policy which excludes expenses incurred towards treatment of Genetical disorders and cell implantation. The complainant pleaded that the insured was diagnosed as chronic renal failure with history of 8 months. .It gets established from the literature, submissions and material on record that the Poly Cystic Kidney disease is a genetic disorder and expenses on treatment of these diseases are excluded. Therefore the Respondent has justified in repudiating the claim as per conditions of the policy .The complaint fails to succeed.

Ahmedabad Ombudsman Centre
Case no 11-004-0341-11
Mr. Rameshbhai S Telaiya
Vs
United India Insurance Company Ltd
Award Date: 30.08.10

Repudiation of Claim under Mediclaim policy: The complainant has submitted the claim for reimbursement of expenses incurred in hospitalization. The Respondent has repudiated the claim on the ground of abnormal delay in submission of claim papers. As a result of mediation by this forum, both the parties mutually agreed for payment of the claim for Rs 5000/ .The grievances thus resolved.

Ahmedabad Ombudsman Centre
Case no 11-04-0319-11
Mr. Hansmukh bhai J Bhatt
Vs
United India Insurance Company Ltd

Award Date: 30.08.10

Repudiation of Claim under Mediclaim Policy: The claimant has submitted the claim for reimbursement of expenses incurred in hospitalization from 05.01.10 to07.01.10 for treatment of AC Viral fever, URTI and Gastritis. The respondent has repudiated the claim on the grounds that the insured was not present at the hospital at the time of checking and no indoor records .OPD papers and consultation papers were provided to the investigators. .It gets established from the submissions and material on record that the Respondent `s decision to repudiate the claim is not justified as the investigator visited the hospital after the insured has discharged and the complainant has produced first consultation letter and treatment papers with medical bills and test reports .The complaint stands to succeed.

Ahmedabad Ombudsman Centre
Case no 11-04-0237-11
Mrs. Ramilaben B Thakkar
Vs
United India Insurance Company Ltd

Award Date: 30.08.10

Repudiation of Claim under Mediclaim Policy: The Complainant has submitted the claim for reimbursement of expenses incurred in hospitalization from August 09 to November09 .The claim was repudiated by the Respondent as per clause 5.3 and 5.4 of policy condition which excludes the claim in case of late submission of files and late intimation. The complainant submitted that she was staying away from the relatives, her children being minor and school going student and since head of the family was hospitalized, the intimation was not given. Looking to the reasons given by the complainant ,the Respondent have discretionary powers to condone such delays .Since the Respondent has not shown another discrepancies in the subject claim or raised any objections against claimed amount ,they could have exercise their discretionary power to condone delay in settlement the claim on non standard basis which they have not done. In the result complaint succeeds partially.

Ahmedabad Ombudsman Centre
Case no 11-02-0386-11
Mr Manoj kumar M Sharma
Vs
New India Assurance Company Ltd

Award Date: 30.08.10

Repudiation of Claim under Mediclaim Policy: The Complainant has submitted the claim for reimbursement of expenses incurred in hospitalization from 06.02.10 to 08.02.10for treatment of diarrhea and vomiting .The claim was repudiated by the Respondent as per clause 2.1of policy condition which states

that besides having 15 inpatients beds, the hospital should have fully equipped theatre of its own ,nursing staff and doctors under its employment round the clock .It gets established that the Respondent `s insistence on submission of hospital registration certificate is the policy condition and the complainant could not submit any evidence of the hospital . Hence no relief to the complainant has been given .In the result complaint fails to succeed.

Ahmedabad Ombudsman Centre
Case no 11-04-0243-11
Mr. Arpit C Butala
Vs
United India Insurance Company Ltd
Award Date: 30.08.10

Partial Settlement of Claim under Mediclaim Policy: The claimant has submitted the claim for reimbursement of expenses incurred in hospitalization on 06.03.09 for operation with IOL implant. The respondent has settled the claim after deduction stating that they are on higher side. The Responded has submitted that the package rates are fixed and MOU is signed by the doctors .It gets established that the Respondent had not gone by clause 14 of the policy which clearly specifies the overall limit of admissible amount of claim for cataract operation .MOU for package rates with doctors is neither forms the policy contract nor was communicate to the complainant .Therefore the Respondent has not justified in settling the claim as per conditions of the policy .The complaint stands to succeed.

Ahmedabad Ombudsman Centre
Case no 11-05-0203-11
Mr Hansmukh R Sharma
Vs
Oriental Insurance Company Ltd
Award Date: 30.08.10

Repudiation of Claim under Mediclaim Policy: The Complainant has submitted the claim for reimbursement of expenses incurred in hospitalization from 01.06.09 to 02.06.09for treatment of Fissure and fistula of anal and rectal region .The claim was repudiated by the Respondent as per clause 2.1& 4.3of policy condition which states that Ayurvedic treatment ,hospitalization are expenses are admissible when the treatment is taken as inpatient in govt hospitals and the disease has waiting period for two years. The complainant pleaded that he was covered for 6 years from the respondent and treatment was not an Ayurvedic basis because it was chronic fissure .It gets established that the complainant has not submitted the evidence for having insurance for six years .Hence the decision of respondent to repudiate the claim is justified

as the disease has waiting period of 2 years and the treatment was taken from Ayurvedic clinic .In the result complaint fails to succeed.

Ahmedabad Ombudsman Centre
Case no 11-004-0360-11
Mr. Sureshbhai A Panchal
Vs
United India Insurance Company Ltd
Award Date: 16.08.10

Repudiation of Claim under Mediclaim policy: The complainant has submitted the claim for reimbursement of expenses incurred in hospitalization. The Respondent has repudiated the claim on the ground of abnormal delay in submission of claim papers. As a result of mediation by this forum, both the parties mutually agreed for payment of the claim for Rs 4618/ .The grievances thus resolved.

Ahmedabad Ombudsman Centre
Case no 11-02-0442-11
Mr. Natwarlal C Patel
Vs
The New India Assurance Company Ltd
Award Date: 30.08.10

Partial Settlement of Claim under Mediclaim Policy: The claimant has submitted the claim for reimbursement of expenses incurred in hospitalization from18.02.10 to 21.02.10. The respondent has settled the claim after deduction by invoking clause2.1, 2.3 and 2.4and Note 2 of policy and disallowing under room charges, doctor `s charges. The Responded has submitted that the insured has opted for higher room rent than the entitled category hence proportionate reduction as per policy condition was made. It gets established that the policy was issued mediclaim policy 2007 on submission of fresh proposal and the revised terms and conditions are operative. Therefore the Respondent has correctly settled the claim as per conditions of the policy .The complaint fails to succeed.

Ahmedabad Ombudsman Centre
Case no 11-05-0002-11
Mr. Pravin R Shah
Vs
Oriental Insurance Company Ltd
Award Date: 04.05.2010

Partial Settlement of Claim under Mediclaim Policy: The claimant has submitted the claim for reimbursement of expenses incurred in hospitalization from 04.04.09to 03.04.09 for treatment of Hernia The respondent has partially settled the claim within the overall limit of the initial sum insured at inception with bonus on the ground that increase sum insured is not payable because hernia is excluded for two years as per terms and conditions of the policy .It gets established that the Respondent has correctly settled the claim as per policy conditions because the sum insured was increased in on 04.08.07 and the subject claim falls under two years exclusion .The complaint fails to succeed.

Ahmedabad Ombudsman Centre
Case no 11-02-0001-11
Mr. Kamlesh J Shah
Vs
The New India Assurance Company Ltd
Award Date: 14.05.10

Partial Settlement of Claim under Mediclaim Policy: The claimant has submitted the claim for reimbursement of expenses incurred in hospitalization from21.11.09 to 23.11.09. The respondent has settled the claim after deduction by invoking clause2.1, 2.3 and 2.4and Note 2 of policy and disallowing under room charges, doctor `s charges. The Responded has submitted that the operation of cataract is excluded for first two years, hence the increased sum insured would not qualify for payment . It gets established that the policy was issued mediclaim policy 2007 and the disease has waiting period for two years for the increased sum insured .The respondent has applied two standards while settling the claim ,by limiting the hospital expenses as per revised conditions and treating the claim under exclusion clause under the same policy . The Respondent has not justified in settling the claim .The complaint stands to succeed.

Ahmedabad Ombudsman Centre
Case no 11-011-0019-11
Mr Ganeshbhai S Mali
Vs
Bajaj Allianz General Insurance Company Ltd
Award Date: 04.05.10

Repudiation of Claim under Mediclaim Policy: The Complainant has submitted the claim for reimbursement of expenses incurred in hospitalization from 10.04.09 to 11.04.09for treatment of Acute Otomycosis with complaint of pain in Rt ear .The claim was repudiated by the Respondent as per exclusion clause C- 2of policy condition which excludes the reimbursement of expenses incurred

on surgery on ears, /tonsils within two years. The complainant pleaded that disease was acute and was not prevailing at the time of insurance .It gets established that the Respondent has not rejected the claim on the ground of pre existing disease but the claim is not payable as per clause c-2. Hence the Respondent is justified in repudiating the claim .In the result complaint fails to succeed.

Ahmedabad Ombudsman Centre
Case no 11-04-0044-11
Mr Kailash S Sharma
Vs
United India Insurance Company Ltd
Award Date: 29.04.10

Repudiation of Claim under Mediclaim Policy: The Complainant has submitted the claim for reimbursement of expenses incurred in hospitalization from13.07.09 to20.07.09 .The claim was repudiated by the Respondent as per clause 11(a) of the MOU with the group which states that the intimation should be given within 72 hours. The complainant submitted that the intimation was given on 18.07.09. Looking to the reasons given by the complainant ,the Respondent have discretionary powers to condone such delays .Since the Respondent has not shown another discrepancies in the subject claim or raised any objections against claimed amount ,they could have exercise their discretionary power to condone delay in settlement the claim on non standard basis which they have not done. The complainant has also deprived the Respondent from their right to inspect the factum of hospitalization by sending late intimation. Therefore it is justifiable to pay the claim on non standard basis. In the result complaint succeeds partially.

Ahmedabad Ombudsman Centre
Case no 11-04-0059-11
Mr Mafatbhai R Patel
Vs
United India Insurance Company Ltd
Award Date: 31.05.10

Repudiation of Claim under Mediclaim Policy: The Complainant has submitted the claim for reimbursement of expenses incurred in hospitalization from08.05.09 to09.05.09 .The claim was repudiated by the Respondent on the ground that hospitalization was for investigation purpose only. The Respondent has submitted that the investigation reports in the file were within normal limit and with no active line of treatment and the treatment for the diseases taken was outside the scope of the policy. It gets established that complainant was hospitalized for investigation .Hence the Respondent has justified in repudiating the claim. . In the result complaint succeeds partially.

Ahmedabad Ombudsman Centre
Case no 11-02-0062-11
Mr. Sunil G Shah
Vs
The New India Assurance Company Ltd
Award Date : 14.05.10

Partial Settlement of Claim under Mediclaim Policy: The claimant has submitted the claim for reimbursement of expenses incurred in hospitalization from 01.02.10 to 03.02.10 for treatment of Benign hyperplasia of prostate. The respondent has settled the claim after deduction of Rs 13719/ 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 Complainant has pleaded that there is no mention in policy condition that any amount paid in cash in excess of Rs 10,000/ will not be reimbursed. The Respondent has submitted that the deduction of RS 07000/ as per internal instructions of their higher office and Rs 369/ as per policy condition 2..It was established from the documents that the decision of the respondent to restrict the payment of surgeons fees to Rs 10000/is not justified and they have been directed to make the payment to the complainant .The complaint stands to succeed.

Ahmedabad Ombudsman Centre
Case no 11-09-0068-11
Mr. Manish R Shah

Vs
Reliance General Insurance Company Ltd
Award Date: 26.05.10

Repudiation of Claim under Mediclaim Policy: The Complainant has submitted the claim for reimbursement of expenses incurred in hospitalization from 06.05.09 to 09.05.09 for treatment of stone in upper ureter with hydronephrosis .The claim was repudiated by the Respondent invoking exclusion clause 15 of the policy which excludes reimbursement of expenses if the claim is found fraudulent .The respondent has submitted that the insured had not paid the hospital bill even though the receipt has been issued by the hospital .The hospital authority has certified that they were unable to provide the information, copy of record and medical bill as paper work was incomplete. The decision under the case depends upon the verification of truth as to the hospitalization .The examination of various records evidences requires the adjudication by a competent court which is beyond the jurisdiction of this forum .The complaint stands disposed.

Ahmedabad Ombudsman Centre
Case no 11-009-0074-11
Mr. Partesh Pankh
Vs

Reliance General Insurance Company Ltd
Award Date: 25.05.10

Repudiation of Claim under Mediclaim policy: The complainant has submitted the claim for reimbursement of expenses incurred in hospitalization. The Respondent has repudiated the claim on the ground of concealment of actual facts as regards the cause and nature of accident which tantamount to breach of policy condition. As a result of mediation by this forum, both the parties mutually agreed for payment of the claim for Rs 65000/ .The grievances thus resolved.

Ahmedabad Ombudsman Centre
Case no 11-04-0191-11
Mr. Pragnesh A Darji
Vs
United India Insurance Company Ltd
Award Date: 31.05.10

Repudiation of Claim under Mediclaim Policy: The Complainant has submitted the claim for reimbursement of expenses incurred in hospitalization on 13.07.09 .The claim was repudiated by the Respondent as per clause 5.3 of policy condition which excludes the claim in case of late intimation. The complainant submitted that he has given the intimation to the TPA on the same day .He has submitted a copy of fax date 17.07.09 about intimation of hospitalization .It gets established that the intimation was given after 4 days, hence the claim is liable to be rejected .The Respondent is justified in repudiating the claim . In the result complaint fails to succeeds .

Case no 11-005-0200-11
Mr. Rasikbhai J Prajapati
Vs
Oriental Insurance Company Ltd
Award Date: 27.05.10

Repudiation of Claim under Mediclaim policy: The complainant has submitted the claim for reimbursement of expenses incurred in hospitalization. The Respondent has settled the claim shortly by Rs 40000/. As a result of mediation by this forum, both the parties mutually agreed for payment of the claim for Rs 21000/ .The grievances thus resolved.

Case no 11-02-00573-10
Mrs . Niruben R Shah
Vs
The New India Assurance Company Ltd
Award Date : 04.05.10

Partial Settlement of Claim under Mediclaim Policy: The claimant has submitted the claim for reimbursement of expenses incurred in hospitalization from 31.08.09 to 01.09.09 for treatment of Sinusitis .The respondent has settled the claim after deduction of Rs 13719/ 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 Complainant has pleaded that there is no mention in policy condition that any amount paid in cash in excess of Rs 10,000/ will not be reimbursed. The Respondent has submitted that the deduction of RS25000/ as per internal instructions of their higher office .It was established from the documents that the decision of the respondent is not justified .when the claim is not payable as per the revised terms and condition and is being considered for initial sum insured at inception application of new terms to old sum insured is not justified .Similarly applying provision which are not part of the terms of the policy and not communicated to the insured are against the principle of insurance. Hence the Respondent have been directed to make the payment to the complainant .The complaint stands to succeed.

Case no 11-09-0321-11
Mr. Vipul R Shah
Vs
Reliance General Insurance Company Ltd
Award Date: 30.08.10

Repudiation of Claim under Mediclaim Policy: The Complainant has submitted the claim for reimbursement of expenses incurred in hospitalization from 25.01.10 to 29.01.10 for treatment of Ischemic ,hypercoagulable status hypertension with history since 2 years .The claim was repudiated by the Respondent on the ground of preexisting disease.The respondent has submitted that the indoor case paper and discharge summary has confirmed the history of hypertension since 2 years .The complainant pleaded that the history was for 2-3 days and the hospital has wrongly recorded as 2 years. The insured has submitted the affidavit declaring that he is suffering from hypertension since 2 days . The decision under the case depends upon the verification the history of hypertension ,calling for statement from the treating doctors .The examination of various records evidences requires the adjudication by a competent court which is beyond the jurisdiction of this forum .The complaint stands disposed.

Case no 11-04-0247-11
Mr. Rashmi C Trivedi
Vs
United India Insurance Company Ltd
Award Date: 30.08.10

Repudiation of Claim under Mediclaim Policy: The Complainant has submitted the claim for reimbursement of expenses incurred in hospitalization from

17.07.07 to 30.09.07 .The claim was not settled by the Respondent .The respondent has stated that the complainant has given the intimation of hospitalization but no claim papers had been submitted .If the complainant submit the proof of submitting the papers, they would consider the claim. Since the Respondent had not received the papers and they are prepared to consider the claim on merits on receipt of papers, the issue is resolved. In the result complaint stands to succeeds.

Case no 11-03-0542-10
Mr. Mahmadbhai B Avadiya
Vs
National Insurance Company Ltd
Award Date: 14.05.10

Repudiation of Claim under Mediclaim Policy: The Complainant has submitted the claim for reimbursement of expenses incurred in hospitalization from 09.10.09 to10.10.09 for treatment of bilateral D.J .Stent removal .The claim was repudiated by invoking clause 4.3 of the policy which states that the reimbursement of expenses for treatment of the disease are not payable for first two years of operation of the policy .The respondent has pleaded that ureteric stone which falls under the first policy year with them. It gets established that the insured was having policy since 2002 and transferred to Respondent without break in insurance and with claim free years .Hence the policy has run with previous insurer claim free for the last four years and the subject claim is admissible as per guidelines issued by the Respondent `s controlling office .Hence it is not justified to treat the policy as a fresh policy and to repudiate the claim applying clause 4.3 of policy which is against their own instructions .In the result complaint stands to succeeds on its own merits..

Ahmedabad Ombudsman Centre
Case no 11-004-339-11
Mr. Jagdish P Patel
Vs
United India Insurance Company Ltd
Award Date: 23.07.2010

Non Settlement of Claim under Mediclaim policy: The complainant has submitted the claim for reimbursement of expenses incurred in hospitalization from22.12.09to26.12.09. The respondent has not settled the claim. As a result of mediation by this forum, both the parties mutually agreed for payment of the claim for Rs 13000/ .The grievances thus resolved.

Ahmedabad Ombudsman Centre
Case no 11-03-0288-11
Mr. Sunil S Shah
Vs
National Insurance Company Ltd
Award Date: 19.07.10

Partial Settlement of Claim under Mediclaim Policy: The claimant has submitted the claim for reimbursement of expenses incurred in hospitalization from 27.10.09 to 29.10.09 for operation of fistula. The respondent has settled the claim after deduction by invoking clause 3.12 of policy and disallowed under various heads like surgery charges, o. t. charges etc. The Respondent has not submitted any supported documents for reasonable and customary expenses. The surgery was also performed under spinal anesthesia which was not an Ayurvedic method. Since the treatment was under allopathic method and it is also difficult to define reasonable expenses in the absence of standard package. Therefore the Respondent has been directed to make the partial payment .The complaint stands to succeed.

Ahmedabad Ombudsman Centre
Case no 11-02-0281-11
Mr. Bhargav G Saraiya
Vs
The New India Assurance Company Ltd
Award Date: 31.05.10

Partial Settlement of Claim under Mediclaim Policy: The claimant has submitted the claim for reimbursement of expenses incurred in hospitalization from 18.01.10 to 19.01.10 for treatment of Rt. Ureteric Stone. The respondent has settled the claim after deduction by invoking clause2.3 and Note 2 of policy and disallowing under various heads like surgery charges, consultation charges etc. The Complainant has pleaded that he has not been informed about the condition of reimbursement of fees paid by cash upto Rs 10000/nor the policy document has any mention that amount paid in cash in excess of Rs 10000/willnot be reimbursable. It is established from the documents submitted that the complainant has paid the amount in cash and receipts with sr no and date was issued and limiting the amount of fees is internal circular not the part of policy condition. Therefore the Respondent has been directed to make the partial payment .The complaint stands to succeed.

Ahmedabad Ombudsman Centre
Case no 11-04-0316-11
Mr. Chirag K Shah
Vs
United India Insurance Company Ltd

Award Date: 21.07.10

Partial Settlement of Claim under Mediclaim Policy: The claimant has submitted the claim for reimbursement of expenses incurred in hospitalization from 01.09.09 to 9.09.09 for treatment of viral hepatitis e. The respondent has settled the claim after deduction as per policy condition and disallowed under various heads. The Respondent has submitted that 20% of claim amount shall be borne by the member of gold plus policy and the cost of gluco meter, medical expenses for post hospitalization beyond 60 days are also not payable. Hence the deductions made from the claim amount by the respondent are justified. The complaint fails to succeed

AHMEDABAD OMBUDSMAN CENTRE
Case no 11-09-0322-11
Mr Prem L Rohra
Vs
Reliance General Insurance Co.Ltd
Award Dated: 21.07.10

Repudiation of Mediclaim : The Insured was hospitalized for treatment of bleeding per rectum and the claim was repudiated by the Respondent by invoking clause no 4.1 of policy condition stating that the disease was pre existing when the cover is incepted .The discharge summary has confirmed the history of Doppler guided Haemmrroidectomy since 3 years back. The claimant has not disclosed the disease for which he under went surgery while submitting the proposal at the time of inception of policy. So the respondent `s decision to repudiate the claim is justified.

The complaint fails to succeed.

Ahmedabad Ombudsman Centre
Case no 11-002-331-11
Mr. Gulabchand R Bagdi
Vs
New India Assurance Company Ltd
Award Date: 15.07.2010

Non Settlement of Claim under Mediclaim policy: The complainant has submitted the claim for reimbursement of expenses incurred in hospitalization from28.06.09to30.06.09. The respondent has not settled the claim. During the course of hearing the Respondent has submitted that they were making the payment of the claim for Rs 11261/ .The complaint partially succeed.

Ahmedabad Ombudsman Centre
Case no 11-002-297-11
Mr. Shalin Mehta
Vs
New India Assurance Company Ltd

Award Date: 14.07.2010

Non Settlement of Claim under Mediclaim policy: The complainant has submitted the claim for reimbursement of expenses incurred in hospitalization from05.10.09to11.10.09 for treatment of Knee replacement. The respondent has not settled the claim as the group policy has been cancelled under policy condition clause 5.7 by giving 30 days notice. .The Respondent has submitted that the subject claim is from prior the date of withdrawal of policy, they will be liable for the claim .Respondent has been directed to settle the claim and make the payment of the claim .The complaint stands succeed.

AHMEDABAD OMBUDSMAN CENTRE
Case no 11-04-0303-11
Mr Nayankumar N Thakkar
Vs
United India Insurance Co.Ltd
Award Dated: 13.07.10

Repudiation of Mediclaim : The Insured was hospitalized for treatment for fracture middle phalynx index finger from 11.02.10 to 12.02.10 and the claim was repudiated by the Respondent stating that the disease was pre existing when the cover is incepted .The discharge summary has confirmed the history of injury before 25 years back and the treatment was taken by the insured in the first year of the policy . So the respondent `s decision to repudiate the claim under exclusion clause no 4.1 of policy condition is justified.

The complaint fails to succeed.

AHMEDABAD OMBUDSMAN CENTRE
Case no 11-09-0260-11
Mr Narottam K Patel
Vs
Reliance General Insurance Co.Ltd
Award Dated: 06.7.10

Repudiation of Medi claim: The claimant has submitted the claim for hospitalization from 24.01.09 to 27.01.09 for treatment of injuries due to fall from scooter and the claim was repudiated by the Respondent by invoking clause no 15 of policy condition stating that the claimant had not paid hospital bill amount or other charges and fraudulent means used and false statement provided. The Complainant has stated that the hospital bill s have been paid whereas a hand written letter shows that the bill had not been paid .It is difficult to verify as to whether the hospitalization had really taken place ,and the amounts for which receipts have issued has been actually paid .the subject claim is questionable ,the hospital authority needs to be examined and the forum has neither powers and infrastructure to undertake the exercise .Hence

without getting into merits of the case and passing any award for the same the complaint is deemed as beyond jurisdiction.

Case no 11-02-0264-11
Mr. Yogeshchandra A Dave
Vs
New India Assurance Company Ltd
Award Date: 30.06.10

Partial Settlement of Claim under Mediclaim Policy: The claimant has submitted the claim for reimbursement of expenses incurred in hospitalization from 21.01.10 to 24.01.10 for treatment of abdominal hysterectomy. The respondent has settled the claim after deduction by invoking clause2.3 and Note 2 of policy and disallowing under various heads like surgery charges, OT charges etc. The Complainant has pleaded that he has neither been informed about the condition of reimbursement of fees paid by cash upto Rs 10000/nor the policy document has any mention that amount paid in cash in excess of Rs 10000/willnot be reimbursable. It is established from the documents submitted that the complainant has paid the amount in cash and receipts with sr no and date was issued and limiting the amount of fees is internal circular not the part of policy condition. Therefore the Respondent has been directed to make the partial payment .The complaint stands to succeed.

Case no 11-02-0255-11
Mr. Ramesh H Patel
Vs
New India Assurance Company Ltd
Award Date: 30.06.10

Partial Settlement of Claim under Mediclaim Policy: The claimant has submitted the claim for reimbursement of expenses incurred in hospitalization on 20.08.09 for treatment of Rt. Eye Cataract. The respondent has settled the claim after deduction by invoking clause2.1 and 4.3 of policy and disallowing under various heads like surgery charges, OT charges etc. The Complainant has pleaded that he has not informed revised terms and conditions of the policy and ceiling on expenses under various heads .He has the policy for one lakh sum insured ,he is entitle for full claim. It is established from the submitted documents that the revised terms and condition will be applicable to the increased sum insured with waiting period of two years for cataract and the old medical policy has no condition for restricting the limit of expenses. The Respondent has applied two standards while settling the claim for the terms and conditions under the same policy. Therefore the Respondent has been directed to make the partial payment .The complaint stands to succeed.

AHMEDABAD OMBUDSMAN CENTRE
Case no 11-09-0412-11

Mr Mukesh M Chachan
Vs
Reliance General Insurance Co.Ltd
Award Dated: 17.08.10

Repudiation of Medi claim: The claimant has submitted the claim for hospitalization from 16.11.09 to 21.11.09 for treatment and surgery for repositioning of the pacemaker and the claim was repudiated by the Respondent stating that the repositioning of pacemaker was not due to medical complication but due to physical comfort and blackening of skin mentioned in discharge card, it is not related to disease/illness/injury. It is observed that the insured was hospitalized at the advice of doctor and the first consulting doctor has confirmed that the insured was presented with a history of breathlessness for about 6 months prior to the admission of hospital and advised for the surgery .Hence the decision of the Respondent to repudiate the claim on the subject ground is nor tenable in view of materials on record and policy provisions. The complaint stands succeeds on its own merits.

Ahmedabad Ombudsman Centre
Case no 11-04-0270-11
Mr. Santukumar Budhrani
Vs
United India Insurance Company Ltd
Award Date: 17.08.10

Partial Settlement of Claim under Mediclaim Policy: The claimant has submitted the claim for reimbursement of expenses incurred in hospitalization from 08.01.10 to 9.01.10 for Angioplasty. The respondent has settled the claim after deduction as per policy condition and disallowed under various heads. The Respondent has submitted that Angioplasty is a major cardiac surgery and as per policy condition 70% of sum insured or Rs 2lakh whichever is less is reimbursable .The complainant submitted that as per medical definition angioplasty is not a major surgery but it is a procedure or technique used to widen vessels narrowed by stenosis . Hence it is established from the documents that the angioplasty is a major surgery and the deductions made from the claim amount by the respondent is justified. The complaint fails to succeed

AHMEDABAD OMBUDSMAN CENTRE
Case no 14-05-0406-11
Mr Kanhaiyalal D Rawal
Vs
Oriental Insurance Co.Ltd
Award Dated: 16.7.10

Repudiation of Medi claim: The claimant has submitted the claim for hospitalization from 13.10.09 to 21.10.09 for treatment of acute myocardial infarction + ACT LVF + k/c/o DM type II +IHD and the respondent has repudiated the claim stating that the disease was preexisting prior to taking the policy. The discharge summary has recorded the history of IHD since 6 years. The complainant has stated that the history of illness was wrongly written as 6 years instead of 6 months. The treating doctor has certified the illness as 6 months .One affidavit has also been submitted for correcting the history of disease .It is difficult to undertake the exercise of deciding issues on the strength of affidavits and the forum has neither powers and infrastructure to undertake the exercise .Hence without getting into merits of the case and passing any award for the same the complaint is deemed as beyond jurisdiction.

AHMEDABAD OMBUDSMAN CENTRE
Case no 11-09-0382-11
Mr Rakesh R Patel
Vs
Reliance General Insurance Co.Ltd
Award Dated: 17.08.10

Repudiation of Medi claim: The claimant has submitted the claim for hospitalization from 12.10.09 to 13.10.09 for treatment of Congenital Heart disease and Atrial Septal Defect left to right and the claim was repudiated by the Respondent by invoking clause no 3 and 10 of policy stating that the insured has symptoms before taking the policy but to take advantage of first year exclusion she had consulted doctor last day of policy. It is established from the documents submitted that the first year exclusion clause was not operative and the hospitalization was for treatment of Congenital Heart Disease Atrial Septal Defect and the disease was Internal Congenital disease which have permanent exclusion clause. Hence the decision of the Respondent to repudiate the claim is justified.The complaint fails to succeed.

Ahmedabad Ombudsman Centre
Case no 11-04-0284-11
Mr. Navinchandra S Somani
Vs
United India Insurance Company Ltd
Award Date: 12.08.10

Partial Settlement of Claim under Mediclaim Policy: The claimant has submitted the claim for reimbursement of expenses incurred in hospitalization from 24.02.10 to 01.03.10 for treatment of right Knee Replacement. The respondent has partially settled the claim by invoking clause 1.2 of policy

limiting the amount of reimbursement upto 70% of sum insured or Rs 200000/ whichever is less. The Complainant has pleaded that he was having policy from 1997 for sum insured of Rs 100000/, from 2002 for 150000and from 2008 for 200000/ under mediclaim policy 2007. It is established from the submitted documents that the revised terms and condition will be applicable to the increased sum insured with waiting period of two years for the subject disease. Since the old medical policy has 150000/ sum insured with C.Bonus for Rs 60000/ before renewal from 2008 with no condition for restricting the limit of expenses. The Respondent has applied two standards while settling the claim for the terms and conditions under the same policy. Therefore the Respondent has been directed to make the balance payment .The complaint stands to succeed.

Ahmedabad Ombudsman Centre
Case no 11-03-0359-11
Mrs. Lalita P Vakotar
Vs
National Insurance Company Ltd
Award Date: 12.08.10

Non Settlement of Claim under Mediclaim Policy: The claimant has submitted the claim for reimbursement of expenses incurred in hospitalization from 13.06.07 to 02.07.07 for treatment of CABG bypass Surgery. The respondent has neither settled the claim nor submitted any written statement .On examination of documents it is observed that the insured was also covered under Baroda Health Policy and she firstly claimed the reimbursement from the Gujrat Govt. and received the amount then approached to the Respondent on 08.08.07 with many reminders .It is established from the documents that the Respondent is guilty of deficiency in service and not settling the claim even after receipt pf requirement Therefore the Respondent has been directed to make the full payment with interest from the date of receipt of requirement .The complaint stands to succeed.

Ahmedabad Ombudsman Centre
Case no 11-04-0361-11
Mr.Bharat M Parekh
Vs
United India Insurance Company Ltd
Award Date: 12.08.10

Repudiation of Claim under Mediclaim Policy: The Complainant has submitted the claim for reimbursement of expenses incurred in hospitalization on 0908.08 for treatment of cataract. The claim was repudiated by the Respondent as per clause 5.3 and 5.4 of policy condition which excludes the claim in case of late intimation and late submission of files .The complainant submitted that

the intimation of hospitalization was given to TPA in time with wrong policy no. and there was delay in submission of claim papers for 22 days only. It is pertinent to note that the hospitalization was for one day, it would not be possible for the respondent to verify the hospitalization. Hence the Respondent should have considered the claim due to reasons, valid for condonation of delay in submissions and intimation. In the result complaint succeeds on its own merits.

AHMEDABAD OMBUDSMAN CENTRE
Case no 11-03-0289-11
Mrs Lilaben N Dave
Vs
National Insurance Co.Ltd
Award Dated: 09.08.10

Repudiation of Mediclaim: The Insured was hospitalized for treatment of Lumber steno sis, canal steno sis – bladder urgency from 01.09.09 to 04.09.09 and the claim was repudiated by the Respondent stating that the disease was pre existing when the cover is incepted .The discharge summary has confirmed the history of low back pain since 20 weeks, radiation lower limbs both upto ankle on and off 7-8 years. So the respondent `s decision to repudiate the claim under exclusion clause no 4.1 of policy condition is justified because pre existing diseases are excluded from the coverage under the policy

The complaint fails to succeed.

Case no 11-02-0351-11
Mr Priyavadan Shah
Vs
New India Assurance Co.Ltd
Award Dated: 09.08.10

Repudiation of Mediclaim: The Insured was hospitalized for treatment of Gilbert Syndrome with Acute Gastroenteritis with Hemolytic Jaundice from 15.06.09 to 20.06.09 and the claim was repudiated by the Respondent stating that the disease was genetic deficiency in nature. It is established that the insured was treated for a genetic disease and the Gilbert syndrome is a genetic disease .All genetic disease are excluded from the purview of mediclaim policy. So the respondent `s decision to repudiate the claim under exclusion clause no 4.15of policy condition is justified.

The complaint fails to succeed.

Ahmedabad Ombudsman Centre
Case no 11-002-383-11
Mr. Rajkumar K Tahiliani
Vs

New India Assurance Company Ltd
Award Date: 09.08.2010

Partial Settlement of Claim under Mediclaim policy: The complainant has submitted the claim for reimbursement of expenses incurred in hospitalization. The respondent has partially settled the claim. As a result of mediation by this forum, both the parties mutually agreed for payment of the claim for Rs 9157/ .The grievances thus resolved.

Ahmedabad Ombudsman Centre
Case no 11-002-0423-11
Mrs. Ramaben N Mehta
Vs
New India Assurance Company Ltd
Award Date: 09.08.2010

Partial Settlement of Claim under Mediclaim policy: The complainant has submitted the claim for reimbursement of expenses incurred in hospitalization. The respondent has partially settled the claim. As a result of mediation by this forum, both the parties mutually agreed for payment of the claim for Rs 18790/ .The grievances thus resolved.

AHMEDABAD OMBUDSMAN CENTRE
Case no 11-02-0280-11
Mr Gopiram Padia
Vs
New India Assurance Co.Ltd
Award Dated: 09.08.10

Repudiation of Mediclaim: The Insured was hospitalized for treatment of Ischemic Heart disease from 25.10.09 to 28.10.09 and the claim was repudiated by the Respondent stating that the disease was pre existing when the cover is incepted .The Respondent has submitted that the insured was 58 years old at the time of taking the policy and he was diagnosed to have a 95% lesion in the LAD on the 41 st days of policy .treatment for the subject disease has a waiting period of two years .As per proposal form patient had hyperlipidemia and current illness is a complication of hyperlipidemia .The complainant has pleaded that the necessary medical examination reports were submitted with the proposal form and he had never symptoms of disease. It gets established from the material submitted that the LAD 95% lesion can not develop within 41 days from the date of cover and complainant was suffering from some ailment of heart as is proved from the medical report. The complaint fails to succeed.

Ahmedabad Ombudsman Centre
Case no 11-08-0249-11

Mrs. Savitaben Rathore
Vs
Royal Sundaram Alliance Insurance Company Ltd
Award Date: 09.08.10

Repudiation of Claim under Mediclaim Policy: The claimant has submitted the claim for reimbursement of expenses incurred in hospitalization from 16.11.09 to 22.11.09 for treatment of vomiting with gastritis with dehydration and the claim was repudiated by the Respondent on the ground that the bill submitted was exaggerated and many discrepancies' in hospital record were observed .The respondent has neither submitted written statement nor was present during the course of hearing .Therefore the respondent's contention the subject claim is not payable due to exaggerated bill is not supported by any evidences, and repudiating the claim is not justified. The complaint stands to succeed.

Ahmedabad Ombudsman Centre
Case no 11-009-0238-11
Mr. Shamjibhai N Kevadia
Vs
Reliance General insurance Company Ltd
Award Date: 21.07.2010

Repudiation of Claim under Mediclaim policy: The complainant has submitted the claim for reimbursement of expenses incurred in hospitalization. The respondent has repudiated the claim by invoking clause no 2 of the policy. As a result of mediation by this forum, both the parties mutually agreed for payment of the claim for Rs 7000/ .The grievances thus resolved.

Ahmedabad Ombudsman Centre
Case no 11-002-0426-11
Mr. Anirudh R Parikh
Vs
New India Assurance Company Ltd
Award Date: 30.08.2010

Repudiation of Claim under Mediclaim policy: The complainant has submitted the claim seven times for reimbursement of expenses incurred in hospitalization from Feb 2009 to Feb 2010 for treatment of chemotherapy and surgery. The respondent has settled all the claims except last claim and that claim was rejected by invoking clause no 7 of the policy which states that if a claim spreads over two policy periods the total benefit will not exceed the sum insured of the policy during which period the insured was hospitalized. The complainant pleaded that the claim should be considered as per clause no 3.5 of the policy which states that any one illness will be deemed to mean continuous period of illness for which treatment is undergone and includes relapse within 45 days. it gets established that the complainant has submitted

the subject claim bills afterthought when the limit of reimbursement exhausted .Hence the decision of the respondent is justified in settling the claim. The complaint fails to succeed.

Ahmedabad Ombudsman Centre
Case no 11-003-0431-11
Mr. Girish R Adhyaru
Vs
National Insurance Company Ltd
Award Date: 30.08.2010

Partial Settlement of Claim under Mediclaim policy: The complainant has submitted the claim for reimbursement of expenses incurred in hospitalization on 16.02.10 for surgery of left eye cataract. The respondent has settled the claims after some deductions stating that as per reasonable and customary charges are payable. The Respondent submitted that the insured has chosen the Crystalense against aspheric IOL .The policy is meant for treatment for restoring the condition not for the purpose of removal of glasses for better vision. It gets established that the respondent has settled the claim as per terms and conditions of policy and cases settled by other insurers by full amount can not be used as precedence for the subject claim .Hence the decision of the respondent is justified in settling the claim. The complaint fails to succeed.

Ahmedabad Ombudsman Centre
Case no 11-002-0426-11
Mr. Anirudh R Parikh
Vs
New India Assurance Company Ltd
Award Date: 30.08.2010

Repudiation of Claim under Mediclaim policy: The complainant has submitted the claim seven times for reimbursement of expenses incurred in hospitalization from Feb 2009 to Feb 2010 for treatment of chemotherapy and surgery. The respondent has settled all the claims except last claim and that claim was rejected by invoking clause no 7 of the policy which states that if a claim spreads over two policy periods the total benefit will not exceed the sum insured of the policy during which period the insured was hospitalized. The complainant pleaded that the claim should be considered as per clause no 3.5 of the policy which states that any one illness will be deemed to mean continuous period of illness for which treatment is undergone and includes relapse within 45 days. it gets established that the complainant has submitted the subject claim bills afterthought when the limit of reimbursement exhausted .Hence the decision of the respondent is justified in settling the claim. The complaint fails to succeed.

Ahmedabad Ombudsman Centre
Case no 11-004-0429-11
Mr. D R Chaudhary
Vs
United India Insurance Company Ltd
Award Date: 19.08.2010

Repudiation of Claim under Mediclaim policy: The complainant has submitted the claim for reimbursement of expenses incurred in hospitalization for treatment of Morbid Obesity. The respondent has repudiated the claim stating that the expenses of Cosmetic Surgery are excluded as per clause no 4.5 of the policy. It gets established that Laparoscopic Gastric Bypass surgery is a variant of bar iatric surgery .such surgery is dine on morbidly obese patient to treat morbid obesity and its complications .Obesity is a disease .The Insured developed joint pain due to morbid obesity and was on high risk for further complications .Bar iatric surgery is a life saving surgery and not a cosmetic surgery. The respondent could not submit the any evidence to prove the surgery as cosmetic surgery. Hence the decision of the Respondent to repudiate the claim is not justified. The complaint stands to succeed.

AHMEDABAD OMBUDSMAN CENTRE
Case no 11-04-0372-11
Mr. Vishal S Shah
Vs
United India Insurance Co.Ltd
Award Dated: 17.08.10

Repudiation of Mediclaim: The Insured was hospitalized for treatment of Bronchitis and acid peptic disease with GERD from 03.05.09 to 0505.09 and the claim was repudiated by the Respondent stating that the disease was pre existing when the cover is incepted .The Respondent has submitted that the insured was moderately heavy smoker ,suffering from recurrent bronchitis .It gets established from the opinion of independent doctor on the basis of various papers and medical history recorded by various consultant that the insured was suffering from the disease repeatedly in past which was preexisting from the taking of the policy .Hence the decision of the respondent to repudiate the claim is justified . The complaint fails to succeed

Case No.11-009-0193-11
Mr. Ashok kumar Jindal V/s. Reliance General Insurance Co. Ltd.
Award dated 09-06-2010

Mediclaim:

Repudiation of Mediclaim on the ground of fraudulent claim and false statement and declaration were made by the complainant.

The insured was hospitalized for the treatment of viral fever, viral myositis and acute gastritis.

The Respondent had repudiated the claim invoking clause 2 and clause 15 of the terms and conditions of the subject policy. Clause 2 prevented the Respondent from paying claim of untrue or incorrect statements, misrepresentation, misdescription or nondisclosure of material information are found. Clause 15 deals with the fraudulent claim.

The Respondent produced copies of hospital records revealing as under:

i) In the Hospital Nursing chart, temperature noted was between 97 to 99 degree.
ii) Insured was not given medicine for fever or myositis.
iii) During hospitalization the insured was treated with Anti Anxiety and Anti Depressent.
iv) Past history was of Anxiety, Nervousness and Insomania.

Moreover this forum also obtained independent medical opinion which showed that hospitalization was for psychiatric treatment. Therefore the Respondent's decision to repudiate the claim was upheld.

Case No.11-002-0140-11
Mr. Sanjay C. Shah
V/s.
The New India Assurance Co. Ltd.
Award dated 03-06-2010

Partial settlement of Mediclaim:

The Respondent had settled the claim partially disallowing Rs.25,000/- on the ground that the operating surgeon had received Rs.60000/-seperately outside hospital bill hence as per their claim guideline they had deducted the amount in excess of 25% of Sum Insured Rs.1,00,000/- under the policy.

This forum opined that expenses which are part of hospitalization bill are fully reimbursable, no where the policy conditions qualify that only those amounts are payable which are part of hospital bill as stated in Respondent's circular.

This forum also opined that several expenses like medicines, prosthetics, pacemakers etc. for which separate receipts are issued and which do not form part of hospital bill but are considered part of hospitalization bill and reimbursable.

In view of the above, Respondent's decision to pay the Surgery charges limited to 25% of Sum Insured was not justified hence was set aside.

In the result complaint succeeds.

Case No.11-004-0131-11
Mr. Jagdipsingh Thadani
V/s.
United India Insurance Co.Ltd.
Award dated 03-06-2010

Patrial settlement of Mediclaim:

The Respondent had settled the mediclaim disallowing Rs.32,150/- on the ground that the Complainant was entitled for reimbursement of medical expenses to the extent of 10% of Sum Insured of Rs.1,75,000/- for cataract surgery.

The Complainant submitted that the Respondent made modification from 01-03-2009 in the policy by revising percentage from 10% to 25% for cataract operation whereas he had renewed his policy from 15-05-2009 with clear instruction to the agent to opt for modified condition.

The Respondent submitted that the Complainant had not exercised option for modified conditions in a prescribed proforma.

This forum observed that the Complainant had not substantiated with any evidence that he had instructed his agent to opt for modified conditions.

In the result, the complaint fails to succeed.

Case No.11-004-0205-11
Mr. Maheshkumar J Shah
V/s.
United India Insurance Co. Ltd.
Award dated 03-06-2010

Partial settlement of Mediclaim:

The Respondent had settled the claim disallowing Rs.40150/-on the ground that the Complainant was entitled for reimbursement of medical expenses to the extent of 10% Sum Insured for cataract surgery.

The Complainant submitted that when surgery took place on 04-12-2009 the condition was modified as 25% of S.I from 01-03-2009.

This forum observed that for existing policies modified condition would be applicable only when consent is given by the policy holders. If consent is not given then it would be applicable from 08-07-2010. The Complainant had given consent on 22-03-2010 i.e. after the date of hospitalization hence modified conditions was not applicable to the subject policy.

In the result, the complaint fails to succeed.

Case No.11-002-0153-11
Mr. Mahendra S Kothari
V/s.
The New India Assurance Co. Ltd.
Award dated 31-05-2010

Partial settlement of Mediclaim:

The Respondent had settled the claim disallowing Rs.4893/- invoking policy clause 2.1,2.3 and 2.4 which limit the reimbursement of expenses in proportion to entitled room category and room charges limited to 1% of basic sum insured.

The Respondent calculated 1% of room charges on old sum insured and invoked policy conditions of revised mediclaim policy 2007.

This forum commented that the Respondent was not justified in applying two standards for the terms and conditions under same policy. Total expenses were well within the old sum insured and Cumulative Bonus hence complainant was entitled for payment of full amount and deduction was not justified.

In the result, the complaint succeeds.

Case No.11-004-0174-11
Mr. Ravjibhai B Patel
V/s.
United India Insurance Co. Ltd.
Award dated 31-05-2010

Repudiation of Mediclaim:

The Respondent had repudiated the mediclaim invoking clause 4.1 of family floater Group Mediclaim Policy which interalia stated that the company is not liable to make any payment under the policy in respect of any claim if disease/injury which are pre-existing when the cover incepts for the first time.

The Respondent submitted that cataract surgery was undergone after 4 months from the date of inception of the policy hence it was treated as pre-existing disease and claim was repudiated.

This forum observed that the subject Group Mediclaim policy covers persons from age group of 3 months to 80 years without any medical checking and with coverage of all pre-existing diseases after 30 days from the inception of the policy. Therefore the underwriting decision of the Insurer was not affected by the non disclosure of pre-existing disease. So the Respondent's decision to repudiate the claim invoking exclusion clause 4.1 of the policy was not justified.

In the result, the complaint succeeds.

Case No.11-004-0187-11
Mr. Yogesh S. Patel
V/s.
United India Insurance Co. Ltd.
Award dated 31-05-2010

Repudiation of Mediclaim:

The Respondent had repudiated the mediclaim invoking clause 5.7 of the family floater Group Mediclaim Policy which interalia stated that the company is not liable to make any payment under the policy in respect of any claim if disease/injury which are pre-existing when the cover incepts for the first time.

The Respondent submitted that knee joint replacement surgery was undergone after 30 days from the date of inception of the policy hence it was treated as pre-existing disease and claim was repudiated.

This forum observed that the subject group mediclaim policy covers persons from age group of 3 months to 80 years without any medical checkup and with coverage of all pre-existing diseases after 30 days from the inception of the policy. Therefore the underwriting decision of the Insurer was not affected by the non disclosure of pre-existing disease. So the Respondent's decision to repudiate the claim invoking exclusion clause 5.7 of the policy was not justified.

In the result, the complaint succeeds.

Case No.11-004-0159-11
Mr.Ravindra R. Saptarshi
V/s.
United India Insurance Co. Ltd.
Award dated 31-05-2010

Repudiation of Mediclaim:

The Respondent had repudiated the mediclaim invoking clause 4.1 of the family floater Group Mediclaim Policy which interalia stated that the company is not liable to make any payment under the policy in respect of any claim if disease/injury which are pre-existing when the cover incepts for the first time.

The Respondent submitted that Cataract surgery was undergone after 3 months from the date of inception of the policy hence it was treated as pre-existing disease and claim was repudiated.

This forum observed that the subject group mediclaim policy covers persons from age group of 3 months to 80 years without any medical checkup and with coverage of all pre-existing diseases after 30 days from the inception of the policy. Therefore the underwriting decision of the Insurer was not affected by the non disclosure of pre-existing disease. So the Respondent's decision to repudiate the claim invoking exclusion clause 4.1 of the policy was not justified.

In the result, the complaint succeeds.

Case No.11-005-0127-11
Mr. Jinivar R. Mehta
V/s.
The Oriental Insurance Co. Ltd.

Award dated 31-05-2010

Repudiation of Mediclaim:

The Respondent had repudiated the claim invoking clause 4.8 of the terms and conditions of the subject policy which excludes 'Run down condition' from the scope of the policy.

The Complainant had observed religious fast for prolonged period of 45 days hence his health deteriorated which resulted into run down condition due to Keto Acidosis and Hypokalamia.

The Respondent obtained opinion from the medical man who opined that patient had keto acidosis with hypokalamia because of 45 days fast.

This forum observed that Health Insurance Policy is for the purpose of indemnifying the expenses incurred for the treatment of natural disease/illness/injury etc. but in the subject case deteriorated health condition was invited by the Complainant voluntarily which is out of purview of this policy.

In the result the complaint fails to succeed.

Case No.11-005-0156-11
Mr. Ashok H. Bhatt
V/s.
The Oriental Insurance Co. Ltd.
Award dated 31-05-2010

Repudiation of Mediclaim:

The Respondent had repudiated the claim on the ground that i) the hospital was not fulfilling the criteria of 15 beds required. ii) the complainant underwent treatment for renal calculus in the first policy year which has a waiting period of two years.

The Complainant submitted that he had underwent treatment not only exclusively for renal calculus but also for Gastritis and enteritis hence his claim is reimbursable.

The Complainant also produced copy of mediclaim medical report signed by the treating surgeon who had mentioned 18 beds in the hospital.

This forum observed that the Respondent could not produce any evidence to prove that the hospital has less than 15 beds.

Moreover copy of discharge card revealed that Complainant underwent treatment of severe Gastritis, enteritis and renal calculi.

In view of the above, the Respondent was directed to settle the claim on pro-rata basis.

In the result, complaint partially succeeds.

Case No.11-005-0107-11
Mr. Sharadbhai S. Shah

V/s.
The Oriental Insurance Co. Ltd.
Award dated 31-05-2010

Partial settlement of Mediclaim:

The Respondent had settled the mediclaim partially after deducting Rs.38,576/-. The insured had undergone cataract operation in both the eyes and lodged claim for Rs.68,576/-. The Respondent after obtaining various packages from the hospital, settled the claim on the basis of the package of semi special package charges whereas the complainant claimed for higher than the super deluxe package charges.

The Complainant submitted that there is no fix limit of indemnity for cataract surgery hence full claim should be paid.

The Respondent submitted that claim lodged appeared to be higher than usual and customary package charges hence claim was settled for semi special package charges.

This forum in the absence of any other more cogent stand of mediation took the path of Golden mean. In other words the average between two i.e. Deluxe package (between semi special and super deluxe).

In the result, the complaint partially succeeds.

Case No.11-004-0538-10
Mr. Dipak Gupta
V/s.
United India Insurance Co. Ltd.
Award dated 31-005-2010

Repudiation of Mediclaim:

The Respondent had repudiated the mediclaim on the ground that the intimation of hospitalization was not given within 24 hours of hospitalization.

The Complainant produced copy of E-mail received by TPA of the Respondent showing the lodgment of intimation for hospitalization late by one day.

This forum had on record copies of letters addressed by the complainant to the Respondent stating the reason for late intimation by one day. The Respondent wrote to the TPA for review and suitable reply to the complainant even though the TPA had not paid the claim.

This forum opined that the Respondent should have settled the claim on their own exercising their discretionary power to condone the delay of one day and directed to make full payment of the claim.

In the result complaint succeeds on its own merit.

Case No.11-004-0165-11
Mr. Chaturbhuj H Kakkad

V/s.
United India Insurance Co. Ltd.
Award dated 28-05-2010

Delay in settlement of Mediclaim:

The Respondent had not settled the claim even after a lapse of more than 6 months period from the date of submission of claim papers.

After registration of the complainant and hearing of both the parties was fixed up, the Respondent admitted the claim for settlement hence dispute was resolved.

Case No.11-004-0084-11
Mr. Bhulabhai C. Patel
V/s.
United India Insurance Co. Ltd.
Award dated 25-05-2010

Delay in settlement of Mediclaim:

The Respondent had not settled the claim even after a lapse of more than 7 months period from the date of submission of claim papers.

The Respondent in their written submission stated that as per the terms and conditions of the Group Mediclaim Policy Rs.12000/- is payable for Fistulectomy.

Since the Respondent admitted the claim for settlement, the dispute was resolved.

Case No.11-002-0066-11
Mr. Deepak R. Shah
V/s.
The New India Assurance Co. Ltd.
Award dated 18-05-2010

Partial settlement of Mediclaim :

The Respondent had settled the Mediclaim for Rs.17,700/- disallowing Rs.14,750/- invoking policy clauses 2.1,2.3,2.4 which limit the reimbursement of expenses in proportion to entitled room category and room charges limited to 1% of basis sum insured and exclusion clause 4.3 which interalia states that treatment for Tonsillitis has a waiting period of two years from the date of policy.

Deduction in respect of various charges was explained by the Respondent due to the reason that insured had opted for a room with a rent higher than 1% of the Sum Insured of Rs.50,000/- in terms of clause 2.3, 2.4 and note 1 reducing the amount payable accordingly. Moreover applying the

provisions of their internal circular Rs.23,500/- made cash payment in excess of Rs.10,000/- to Anesthetist and Surgeon was disallowed.

This forum observed that since prior to renewal of mediclaim policy 2007, Sum Insured was Rs.50,000/- with Cumulative Bonus of Rs.25,000/- and total expenses were well within this limit. Complainant was entitled for the payment of full amount of Rs.32,450/- the Respondent was not justified in applying two standards for terms and conditions under the same policy as also arbitrary imposing provisions of their internal circular which were neither communicated to the party nor form the part of terms and conditions of the policy.

In the result, the complaint succeeded on its own merit.

Case No.11-002-0120-11
Mr. Rameshbhai R. Shah
V/s.
The New India Assurance Co. Ltd.
Award dated 18-05-2010

Partial settlement of Mediclaim:

The Respondent had settled the claim for Rs.40,587/- disallowing Rs.11,033/- invoking policy clauses 2.1, 2.3 and 2.4 which limit the reimbursement of expenses in proportion to entitled room category and room charges limited to 1% of the basis of sum insured.

The Respondent calculated 1% of Room charges on old sum insured and invoked policy clauses of revised mediclaim policy-2007.

This forum commented that the Respondent was not justified in applying two standards for the terms and conditions under same policy. Since prior to renewal of policy with revised terms and conditions, Sum Insured was Rs.50,000/- without cumulative bonus and total expenses were Rs.51,922/- hence Complainant was entitled for the payment of an amount of Rs.50,000/- being Sum Insured.

In the result, the complaint partially succeeds.

Case No.11-002-0102-11
Mr. Pravinchandra M Sheth
V/s.
The New India Assurance Co. Ltd.
Award dated 17-05-2010

Partial settlement of Mediclaim:

The Respondent had settled the claim for Rs.20,000/- being old Sum Insured prior to renewal of the subject policy with revised terms and conditions of Mediclaim policy 2007 with Sum Insured Rs.1,00,000/-.

The Complainant submitted that the sum Insured under the subject policy was increased from 20,000/- to Rs.1,00,000/- hence he is entitled for full reimbursement of the claim.

This forum observed that the claim under the subject policy arose in second year of revised mediclaim policy 2007 and the illness prostate surgery has two years waiting period hence the Respondent had considered initial Sum Insured of Rs.20,000/-. Therefore respondent's decision to settle the claim for Rs.20,000/- was justified.

In the result, the complainant fails to succeed.

Case No.11-002-0071-11
Mrs. Bhamini J Gandhi
V/s.
The New India Assurance Co. Ltd.
Award dated 17-05-2010

Repudiation of Mediclaim:

The Respondent had repudiated the mediclaim invoking exclusion clause 4.3 which stipulated that treatment for ear, nose and throat disorder (Septoplasty) are excluded from the scope of the policy for two year and the subject claim had occurred in the second year of policy.

The forum opined that materials on record confirmed that the insured was hospitalized for Septoplasty + Turbinate Reduction under L.A in the second policy year, so the Respondent was justified in rejecting the claim invoking clause 4.3 of the policy.

In the result, the complaint fails to succeed.

Case No.11-004-0311-11
Mr. Ravindra R Saptarshi
V/s.
United India Insurance Co. Ltd.
Award dated 28-06-2010

Repudiation of Mediclaim :

Respondent had repudiated the mediclaim invoking clause 4.1 of family floater group mediclaim policy which interalia states that the company is not liable to make any payment under the policy in respect of any claim if disease/injury which are pre-existing when the cover incepts for the first time.

The Respondent submitted that cataract surgery was undergone after two and a half months from the date of inception of policy hence it was treated as pre-existing disease and claim was repudiated.

This forum observe that the subject group mediclaim policy covers persons from age group of 3 months to 80 years without any medical check-up and with coverage of all pre-existing diseases after 30 days from the inception

of the policy. Therefore the underwriting decision of insurer was not affected as the non discharge of pre-existing disease. So the Respondent's decision to repudiate the claim invoking exclusion clause 4.1 of the policy was not justified.

In the result, the complaint succeeds.

Case No.11-002-0114-11
Mr. Bharatbhai B. Narola
V/s.
The New India Assurance Co. Ltd.
Award dated 09-06-2010

Repudiation of Mediclaim:

The Respondent had repudiated the Mediclaim by invoking policy clause 4.3.16 which stipulates that the policy will cover Prolapse Intra-Vertebral Disc (PID) unless arising from accident after two years from the date of inception of the policy.

The Complainant submitted that his previous claim for the treatment of spondylosis was settled and present treatment is also for the same ailment hence his claim should be settled.

This forum obtained an independent written opinion from a medical man who opined that spondylosis is not a disease while PID is an abnormal condition/illness which occurs in few individuals.

On the basis of the independent opinion, this forum upheld the decision of the Respondent to repudiate the claim.

In the result, the complaint fails to succeed.

Case No.11-002-0215-11
Mr. Saurabh V. Parikh
V/s.
The New India Assurance Co. Ltd.
Award dated 10-06-2010

Repudiation of Mediclaim:

The Respondent had repudiated the Mediclaim invoking clause 4.3 on the ground that the operation of Osteoarthritis of knee is specified disease/ailment which has a waiting period of four years from the inception of the first policy and the claim occurred in the first policy year.

The Complainant produced a copy of an unauthenticated leaflet giving terms and conditions of the family floater Group Mediclaim policy consisting clause B-12 which reads:

"All pre-existing disease are covered under the policy".

The Respondent submitted that the claim was not repudiated on the ground that the disease was pre-existing but it was repudiated because of osteoarthritis of knee has a waiting period of four years and claim occurred in first year only. The Respondent produced copy of special conditions of the subject policy which mentions that all other terms and conditions shall be as per standard group Mediclaim policy 2007, and according to it the subject disease has waiting period of four years.

This forum decided that Respondent's decision was justified hence claim upheld.

In the result complaint fails to succeed.

Case No.11-004-0567-10
Mr. Harshad M Sanghvi
V/s.
United India Insurance Co. Ltd.
Award dated 10-06-2010

Repudiation of Mediclaim

The Respondent had repudiated the Mediclaim on the ground that the claim papers were submitted late. The insured was discharged on 20-07-2009 but claim file was submitted on 19-09-2009 i.e. after two months from the date of discharge and as per clause 5.4, claim papers should have be submitted within 7 days from the date of discharge from hospital.

The Complainant submitted that he had submitted claim file on 06-08-2009 which was acknowledged by the Respondent. Subsequently they raised query for Form-C which was complied with on 19-09-2009 and hence the Respondent took date of submission of claim file as 19-09-2009.

This forum observed that the complainant did not substantiate his plea by producing documentary evidence to prove that claim file was submitted on 06-08-2009. It was also observed that the complainant in the past approached this forum for his claim was rejected on the ground of late submission of claim file.

However this forum directed the Respondent to pay 60% of claim amount on non-standard basis.

In the result complaint partially succeeds.

Case No.11-005-0121-11
Mr. Urmilaben M Jain
V/s.
The Oriental Insurance Co. Ltd.
Award dated 10-06-2010

Repudiation of Mediclaim :

Claim repudiated by the Respondent invoking clause 4.3 of the terms and conditions of the subject policy which interalia states that during the period of insurance cover, the expenses on treatment of total knee replacement surgery are not payable if it occurred within 4 years from the commencement of the risk.

Complainant submitted that merely knee joint pain before 6 months cannot be construed as Osteoarthritis as diagnosed by the attending surgeon.

The Respondent submitted that attending doctor commented that disease was developed before 6 months when the insured first consulted him which went back in fourth policy year.

This forum observed that the symptoms were manifested during the currency of the fourth policy year prior to expiry of waiting period of 4 years. Hence the Respondent's decision to repudiate the claim was justified.

In the result, complaint fails to succeed.

Case No.11-005-0497-10
Mr.Amrutlal T. Kotadia
V/s.
The Oriental Insurance Co. Ltd.
Award dated 10-06-2010

Repudiation of Mediclaim:

Claim repudiated by the Respondent invoking clause 4.13 of the subject policy which excludes Naturopathy treatment unproven procedure or treatment experimental or alternative medicine and related treatment including acupressure, acupuncture, Magnetic and such other therapies etc".

The insured was treated under Magnetic Therapy.

The Complainant Produced copy of an Award, given by Hon. Insurance Ombudsman, Kolkata, for similar treatment given in favour of the Complainant.

This forum observed that the Award of the Hon. Insurance Ombudsman, Kolkata referred by the Complainant where the ground for repudiation were different and no relevance to the subject claim as terms and condition of the two policies are different.

In the result, the complaint fails to succeed.

Case No.11-002-0241-11
Mr. Kantilal V. Thakkar
V/s.
The New India Assurance Co. Ltd.
Award dated 21-06-2010

Partial repudiation of Mediclaim:

The Respondent had partially repudiated the claim invoking policy condition 2.2, 2.3 and 2.4 which limit the reimbursement of expenses in proportion to entitled room category and room charges limited to 1% of basic Sum Insured.

The Complainant had lodged claim for Rs.12,442/- whereas the Respondent had settled the Mediclaim for Rs.8,992/- deducting Rs.3,450/- (Rs.1,500/- being room charges in excess of 2% of Sum Insured and Rs.1,950/- being consultation, surgeon and O.T charges in proportion of 1% of Room charges).

This forum observed that prior to renewal of policy, Sum Insured was Rs.75,000/- with Cumulative Bonus of Rs.30,000/- and total expense were well within this limit, hence complainant was entitled for the payment of full claim.

The Respondent was not justified in applying two standards for the terms and conditions under the same policy.

In the result, the complaint succeeds.

Case No.11-002-0228-11
Mr. Umesh P Khatri
V/s.
The New India Assurance Co. Ltd.
Award dated 23-06-2010

Partial repudiation of Mediclaim:

Respondent had partially settled the Mediclaim by disallowing Rs.15000/- on the ground that bill other than hospital charges for Rs.25000/- towards Surgeon's fee was paid in cash, so as per guideline issued maximum Rs.10,000/- towards Surgeon's fee is payable.

The Complainant disputed about deduction on the ground that no such provision is there in the subject policy and instructions issued by the Respondent which were not made known to him.

This forum referred clause 1 of the terms and conditions of the subject policy which interalia states that reimbursement of hospitalization expenses are reimbursable. Moreover in terms and conditions of the policy it is not stated that reimbursement of amount which are not part of hospital bill is excluded from the purview of the policy. Under the subject claim the Surgeon's fee was very much part of the hospitalization bill. The Respondent reimburses several expenses like medicines, prosthetics/pacemakers for which separate receipt are issued and which do not form part of hospital bill but are considered part of hospitalization bill and being reimbursed.

In the result, the complaint succeeds.

Case No.11-002-0233-11
Mr. Sanjay B Shah

V/s.
The New India Assurance Co. Ltd.
Award dated 28-06-2010

Partial repudiation of Mediclaim:

The Respondent had partially settled the claim disallowing Rs.13,419/- by invoking clause 2.1, 2.3 and 2.4 Note 1 of the terms and conditions of the Mediclaim policy 2007. The Respondent had given justification in applying new terms and conditions of Mediclaim policy 2007 restricting room charges as 1% of the Sum Insured per day or actual expenses whichever is less and accordingly scaling down various expenses proportionately.

This forum worked out the correct deductions of Rs.10,648/- whereas the Respondent had disallowed Rs.13,197/- hence excess deduction of Rs.2,549/- was wrongly made by the Respondent.

In the result, the complaint partially succeeds and Respondent was directed to make payment of Rs.2,549/- to the Complainant.

Case No. 11-002-0251-11
Mr. Prashant C. Joshi
V/s.
The New India Assurance Co. Ltd.
Award dated 30-06-2010

Partial repudiation of Mediclaim:

The Respondent partially settled the claim disallowing Rs.17,500/- as per details below:

i)	Rs. 12,500/-	Surgeon's charges paid in cash in excess of Rs.10000/-.
ii)	Rs. 2000/-	Anesthesia charge paid in cash
iii)	Rs. 3000/-	O.T charges as per clause 3.13 in excess of customary and reasonable charges.

This forum observed that most of transactions entered in to by doctors and hospital with patients are in cash only. Moreover ceiling on reimbursement of doctor/surgeon's charges paid in cash, based on internal instruction issued by the Respondent which are neither part of policy condition nor they were informed to the Complainant. Respondent is not justified in disallowing O.T charges in absence of convincing any documentary proof.

In the result, the complaint succeeds.

Case No.11-004-0221-11
Mr. Bhailal D Modi
V/s.

United India Insurance Co. Ltd.
Award dated 30-06-2010

Repudiation of Mediclaim:

Claim repudiated by the Respondent invoking clause 5.4 on the ground of late submission of claim papers.

The Complainant was hospitalized and operated for cataract on 19-11-2009 and discharged on same day but he submitted claim papers on 11-12-2009 instead of within 7 days from discharge as required under the terms and conditions of the subject policy.

This forum observed that as per the circular issued by the Head Office of the Respondent, if the claim papers are submitted within 30 days from the date of discharge from hospital then this delay can be considered and in the present case the delay was for 14 days only. Hence this forum found that the Respondent could have exercised their discretion by giving relaxation for delay in submission of claim papers upto 30 days.

Therefore respondent's decision to repudiate the claim is set aside and directed to make payment of admissible amount.

In the result complaint succeeds.

Case No.11-002-0124-11
Mrs. Vatsalaben M Shah
V/s.
The New India Assurance Co. Ltd.
Award dated 30-06-2010

Partial repudiation of Mediclaim:

The Complainant was operated for ventral Hernia and submitted claim for reimbursement for Rs.1,02,828/-.

The Respondent had settled the claim for Rs.70,188/- deducting an amount of Rs.32,640/- showing break-up as under:

i) Surgeon charges	Rs.9000/-	as per clause 2.3 & 2.4 of terms and condition of the policy, Room charges in excess of 1% of Sum Insured is not allowed.
ii) Consultation charge	Rs.2000/-	- do -
iii) Dressing charges	Rs.2500/-	Date wise breakup not given
iv) Medicine	Rs. 28/-	Patient's name not mentioned
- do -	Rs. 175/-	- do -
v) Miscellaneous	Rs.17547/-	Paid for Zone-III & claim is for Zone-I
vi) Extra abdominal belt	Rs.990/-	Not payable

The Complainant has sought relief for an amount of Rs.7078/- as detailed below:

1)	Rs.2500/-	Dressing charges paid during two months
2)	Rs.28/-	Patient's name was not mentioned in cash memo

3) Rs.175/- Medicine charges
4) Rs.2400/- Room Nursing charges
5) Rs.990/- Extra long abdominal belt
Total Rs.7078/-

The Respondent submitted that reconsideration request was put up to their claim review committee but the committee had upheld the decision of deductions.

This forum found that the Complainant had consented for major chunk of deductions hence an amount of Rs.3,500/- as exgradia was recommended to be paid to the complainant.

In the result complaint partially succeeds.

Case No.11-002-0265-11
Mr. Bhanwarlal Kankaria
V/s.
The New India Assurance Co. Ltd.
Award dated 30-06-2010

Partial repudiation of Mediclaim:

The Respondent had settled the claim after deducting following expenses:

Surgery charges	Rs.20000/- (Surgeon) Rs.1500/- (Anesthetist)	Paid to the Surgeon and Anesthetist in cash, but other than hospital payment done in cash. Maximum amount admissible Rs.10000/-
Room, Nursing & other expenses	Rs. 1183/-	As per policy terms and condition 2.1,2.3 & 2.4 proportionately reduced due to higher rent charges in excess of 1% of S.I was paid.

The Complainant made cash payment of Rs.30,000/- for surgery and Rs.1500/- to Anesthetist however the Respondent reimbursed a sum of Rs.10,000/- only in terms of their internal guidelines.

The Complainant pleaded that the insured underwent operation of Hysterectomy and the claim for reimbursement submitted by him for Rs.44784/-. The claim was settled for Rs.22,101/- deducting an amount of Rs.22683/-.

This forum opined that most of the transactions entered into by the doctors and hospitals with patients are in cash only. Moreover the ceiling of Rs.10000/-, issued by the respondent as based on internal instructions which were neither part of policy condition nor they were informed to the complainant. Insurance contracts are based on principle of utmost good faith which is reciprocal, but in the present case the Respondent had violated this cardinal principle.

Respondent is justified in disallowing a Sum of Rs.1183/- by treating Sum Insured of Rs.1,00,000/- and room charges, nursing charges and other charges paid in excess of 1% of S.I Rs.1,00,000/- are correctly disallowed.

Policy Clause 1 interalia refers to reimbursement of hospitalization expenses whereas Respondent's internal circular qualifies expenses which are not part of hospital bill. Under the subject claim, the Surgeon's and Anesthetist fees are very much part of the hospitalization bill hence it becomes reimbursable.

As per Note 1, the amount payable under clause 2.3 i.e. Surgeon's and Anesthetist fees shall be at the rate applicable to the entitled room category. In the subject claim per day room rent paid @ Rs.1500/- whereas entitlement was Rs.1000/-.(1% of S.I.100000/-) So reimbursable will be Rs.21,000/- only(1000 x 31500 ÷ 1500).

In the result, the complaint partially succeeds.

Case No.11-004-0151-11
Mr. Narendra R. Trivedi
V/s.
United India Insurance Co. Ltd.
Award dated 30-06-2010

Repudiation of Mediclaim:

The claim had been repudiated by the Respondent invoking policy exclusion clause 5.3 and 5.4 which excludes the reimbursement of expenses in case the intimation for hospitalization is not given within 24 hours of hospitalization and the claim file is not submitted within 7 days from the date of discharge respectively. The Respondent alleged that intimation for hospitalization was given after a delay of more than 90 days and the claim papers were submitted after about four months.

This forum observed from the material on record that intimation as well as submission of claim papers were late by one day each. That was not such an exorbitant delay which should lead to repudiation of claim when no other infirmity in claim was observed.

In the result the complaint succeeds.

Case No.11-004-0218-11
Mr. Mohanlal B. Shah
V/s.
United India Insurance Co. Ltd.
Award dated 07-07-2010

Partial repudiation of Mediclaim:

The Respondent had settled the claim for Rs.5000/- after disallowing Rs.13,500/- invoking clause 1.2 of the subject policy which stipulates that reimbursement towards cataract surgery is restricted to 10% of the Sum Insured subject to maximum of Rs.25000/-.

The Complainant submitted that he should be paid as per revised terms and conditions of the subject policy which stipulates that actual expenses or 25% of sum insured whichever is less should be paid.

This forum observed that by not intimating revised terms and conditions of the subject policy, the Respondent had violated cardinal principle of any insurance contract i.e. "Uberine fides" which is reciprocate and not given opportunity to the complainant to opt for the revision and thus there was a breach of good faith.

An award directing the Respondent to pay 25% of Sum Insured Rs.50,000/- i.e. Rs.12,500/- towards full and final settlement of the subject claim after deducting Rs.5000/- which was already paid was pronounced.

In the result, the complaint partially succeeds.

Case No.11-003-0116-11
Mr. Nikhil A Thakkar
V/s.
National Insurance Co.Ltd.
Award dated 08-07-2010

Repudiation of Mediclaim:

The Respondent had repudiated the claim on the ground that all types of malignancies within two years of the policy are excluded from the scope of the subject policy.

The Complainant submitted that his mother suffered from breast Cancer and claim lodged for the expenses incurred was reimbursed.

The Respondent submitted that mother of the Complainant was not covered under the policy though claim was paid through an error. They also produced copy of insurance certificate wherein name of the mother was not included.

There are numbers of hospital papers on record which recorded that the insured suffered from cancer of Oesophagus within one year from commencement of risk. In view of the above, this forum decided that decision of the Respondent to repudiate the claim was justified.

In the result, the complaint fails to succeed.

Case No.11-002-0275-11
Mr. Bachubhai O Shah
V/s.
The New India Assurance Co. Ltd.
Award dated 09-07-2010

Repudiation of Mediclaim:

The claim was repudiated by invoking clause 4.3 of Mediclaim policy which stipulates that expenses incurred on treatment of Hypertension and diabetes mellitus has waiting period of two years from the time of inception of

the policy and the insured was hospitalized for the treatment of Intra Cranial Haemorrhage + HTN+D.M.

The Respondent submitted that under the subject policy, old sum insured was Rs.40,000/- and increased subsequently to Rs.1,00,000/- under revised Mediclaim policy 2007. The revised terms and conditions stipulates waiting period of 2 years for HTN+D.M. So first two claim was settled for initial sum insured Rs.40,000/-.

The Complainant submitted that sum insured under the policy was increased from Rs.40,000/- to Rs.1,00,000/- without insisting for any medical report hence full claim within the limit of S.I of Rs.1,00,000/- should be reimbursed.

This forum opined that the disease DM+HTN were prior to the date of enhancement of S.I, hence decision of the Respondent to repudiate the claim was justified.

In the result, the complaint fails to succeed.

Case No. 11-004-0291-11
Mr. Rameshbhai L. Patel
Vs
United India Insurance Co. Ltd.
Award dated 09-07-2010

Partial repudiation of Mediclaim:

The Respondent had partially settled the claim for Rs.15000/-invoking clause 1.2 of the previous policy which stipulates that reimbursement towards cataract surgery is restricted to 10% of the sum insured subject to a maximum of Rs.25000/.

The Complainant submitted that he should be paid according to terms and conditions of the subject policy which stipulates that reimbursement towards cataract surgery is restricted to actual expenses incurred or 25% of S.I whichever is less.

The Respondent submitted that Cataract has waiting period of two years hence revised terms and conditions would be applicable after two years from the date of revision.

This forum opined that Respondent's argument was not tenable because waiting period for cataract was to be taken from the date of inception of the policy.

In the result, the complaint succeeds.

Case No.11-011-0211-11
Mr. Mr. Babubhai V. Sudhani
V/s.
The Bajaj Allianz Life Ins. Co. Ltd.
Award dated 13-07-2010

Delay in settlement of Mediclaim:

The Complainant met with an accident which caused him head injury and dental injury. Claim lodged for hospitalization and treatment of head injury was settled but the claim lodged for the treatment of broken upper central incisors for which Root canal therapy was given followed by dowel pin restoration and jacket crown preparation was not settled even after a lapse of more than 10 months period without giving any reason.

The intimation was sent to the Respondent about the complaint and the date of hearing, they neither submitted their Self Contained Note in their defense nor attended the hearing scheduled by this forum to represent their views. After, several written and telephonic reminders, Respondent submitted a Note which gave details of earlier claim paid which was not under dispute.

This forum opined that the Respondent had no grounds for denying the claim for dental surgery caused by an accidental injury as per terms and conditions of the policy. The Respondent was directed to pay full claim along with interest.

In the result the complaint succeeds.

Case No.11-002-0279-11
Mr. Yogendra S. Shrimali
V/s.
The New India Assurance Company Ltd.
Award dated 20-07-2010

Repudiation of Mediclaim:

The Claim had been repudiated by the Respondent invoking clause 4.8 of Mediclaim policy which excludes payment of hospitalization expenses in respect of all psychiatric and psychosomatic disease/disorder.

The Respondent produced copy of discharge card from hospital and certificate from attending doctor showing that hospitalization was for Acute psychotic Episode. The Respondent also obtained opinion from a medical man who opined that the insured had taken treatment for psychiatric episode.

The Complainant produced copy of certificate from treating doctor who stated that psychiatric episode is not a psychosomatic disorder.

There was on record in indoor case papers showing active line of treatment was for psychiatric disorder only. This forum also referred medical dictionary where definition of psychiatric episode is stated as “a symptom or feature of mental illness” hence decided that Respondent’s decision to repudiate the claim was justified.

In the result the complaint fails to succeed.

Case No. 14-017-0295-11
Mr.Pankajkumar Gupta
V/s.
Star Health & Allied Insurance Co. Ltd.
Award dated 09-08-2010

Repudiation of Mediclaim

The Claim was rejected by the Respondent on the grounds that there was discrepancy in records relating to age of the insured and circumstance of injury in query reply and in FVR Report.

The Respondent produced copy of first consultation papers stating that the insured fell down while crossing the road divider which caused fracture and age was recorded as 63 years whereas the treating Surgeon had certified that the insured fell down in house and discharge card shows age 63 years which was tampered to read as 55 by the complainant.

The complainant submitted that the doctor had committed mistakes by recording fell down on road and stating age 63 instead of 55. He also produced copy of voter's card issued by election commission showing age 55 years.

This forum opined that no FIR was lodged with police authority and discrepancies in age and circumstance of injury were found hence Respondent's decision to repudiate the claim was upheld.

Case No. 11-005-0332-11
Mr. Surendrakumar Raval
V/s.
The Oriental Insurance Co. Ltd.
Award dated 09-08-2010

Repudiation of Mediclaim:

The claim was repudiated by The Respondent on the ground that the treatment was OPD hence the claim is not payable.

The Respondent during the course of hearing argued without producing copy of the circular that repudiation was done in accordance with the provision of their internal circular.

The Insured was diagnosed to have WET ARMD (Sub retinal Neo Vascular Membrane) and was advised to undergo Intra Vitreal Injection Avastine. Accordingly, Insured underwent the treatment of Intra Vitreal Injection Avastine in a hospital.

The Complainant pleaded that the insured was hospitalized on the advice of the Surgeon and treatment given was a surgical process for eye undertaken in an operation theatre for which, Hospitalization for 24 hours is not required.

This forum had on record a copy of certificate of treating doctor stating that the procedure was not an OPD procedure and needed to be carried out under local anesthesia in operation theatre with strict operative protocol like surgical operation of cataract.

This forum observed that the Respondent had not informed the complainant about the instructions of their internal circular thereby violated the principal of utmost good faith. Hence the decision of the Respondent to repudiate the claim on the ground that the treatment was OPD one, was not convincing hence not justified.

In the result the complaint succeeds.

Case No. 11-003-0342-11
Mr. Devendrasinh B. Solanki
V/s.
National Insurance Co. Ltd.
Award dated 10-08-2010

Repudiation of Mediclaim:

The claim was repudiated by the Respondent on the ground that the diseases were pre-existing at the time of inception of the subject policy.

The Respondent submitted that the subject policy was incepted from 23-11-2007 and renewed with break of 3 days from 25-11-2008 was a separate and fresh policy and under the subject policy pre-existing diseases are covered only after three consecutive claim free policy years.

The insured was hospitalized for the treatment of Pitutary Microadenoma +DM+HTN+Asthma. The complainant submitted that continuity benefit was available to him as an employee and member of Bank of India, National Swasthya Bima Policy since he was holding policy with New India Assurance Co. Ltd. since last 15 years. He also stated that his first claim was settled for the same disease.

The Respondent stated that their TPA had inadvertently paid first claim which was not reimbursable.

This forum opined that the subject policy excludes pre-existing disease for three consecutive claim free policy years, the Respondent had rightly treated the policy as fresh and separate from New India Assurance Co. Ltd. and claim occurred in second policy year hence Respondent's decision to repudiate the claim was upheld.

Case No. 11-002-0403-11
Mr. Nayankumar A. Nayee
V/s.
The New India Assurance Co. Ltd.
Award dated 12-08-2010

Repudiation of Mediclaim:

The claim was repudiated invoking clause 4.3-16 and 4.3-17 on the grounds that the subject disease which is specified disease/ailment has a waiting period of two years from the inception of the policy.

The complainant submitted that under the subject policy all pre-existing diseases are covered hence his claim should be settled.

The Respondent submitted that the deceased was hospitalized for the treatment of HTN/DM +CRF + Pneumonia + Septicemia and HTN +D.M has a

waiting period of two years hence the claim was repudiated and not on the grounds that disease was pre-existing.

The Respondent produced copy of the schedule of the subject Group Mediclaim policy wherein it is stated that all other terms and conditions shall be as per standard group Mediclaim policy 2007.

This forum observed that treatment taken by the insured was within waiting period of two years for the subject disease, hence Respondent was justified in repudiating the claim.

In the result, the complaint fails to succeed.

Case No. 11-004-0377-11
Mr. Jayantibhai P. Makwana
V/s.
United India Insurance Co. Ltd.
Award dated 12-08-2010

Partial repudiation of Mediclaim:

The Respondent had partially settled the claim invoking clause 1.2 of the subject policy which stipulates reimbursement towards major surgery is restricted to 70% of Sum Insured or actual expenses incurred whichever is less.

The Respondent while settling claim has taken the S.I for the policy year 2006-07 because increase in S.I affected in policy year 2007-08, 2008-09 and 2009-10 was not considered.

The Complainant submitted that in the year 2006-07 there was no capping for major surgery and the Respondent had applied new terms and conditions on old sum insured which was not justified.

This forum opined that the Respondent should have settled the claim applying old terms and conditions taking 100% S.I + C.B of the policy year 2006-07 when there was no capping for major surgery.

In the result the complaint succeeds.

Case No. 11-009-0256-11
Mr. Paresh Ramniklal Pandya
V/s.
Reliance General Insurance Co. Ltd.
Award dated 16-08-2010

Repudiation of Mediclaim:

The claim was repudiated by the Respondent invoking clause 5 of the subject policy which excludes any dental treatment unless it is an injury as a result of accident.

The Complainant stated that the claim is not in respect of routine wear and tear but is due to infection which resulted into surgery lasting for 6 hours and also required hospitalization so the claim should be paid.

Respondent submitted that the treatment taken for Chronic Generalized Periodontitis with poor hygiene and cigarette smoking since 30 years in a dental clinic which remains closed on Sundays and opens between 9.30 am to 1.00 pm and4.30 pm to 8.00 pm and the treatment was not as a result of accidental injury.

This forum opined that it is established that dental treatment taken by the complainant was as a result of chronic infection. As the treatment was not due to dental injury sustained in an accident. Exclusion clause 5 of the subject policy attracts the subject disease and benefit of the policy get excluded. Respondent was justified in rejecting the claim.

In the result, the complaint fails to succeed.

Case No. 11-003-0419-11
Mr. Ajitsinh B. Chavda
V/s.
National Insurance Co. Ltd.
Award dated 17-08-2010

Repudiation of Mediclaim:

The Claim was repudiated by the Respondent invoking clause 4.14 of the subject policy which excludes reimbursement of expenses for OPD treatment.

The Complainant submitted that due to dog bite Anti Rabies Vaccination was administered in hospital hence it was a day care treatment and not a domiciliary hospitalization treatment, therefore claim should be settled.

The Respondent submitted that the treatment given for dog bites was domiciliary in nature. The Respondent produced copy of the certificate of treating doctor who had treated the case as OPD basis.

This forum opined that it is established that the complainant took treatment as outdoor patient without hospitalization hence the decision of the Respondent to repudiate the claim was justified.

In the result, the complaint fails to succeed.

11-005-0391-11
Mr. Balmukund N. Nagori
V/s.
The Oriental Insurance Co. Ltd.
Award dated 17-08-2010

Partial repudiation of Mediclaim:

The Respondent had partially settled the claim on the ground that claim occurred in 3rd year of the policy and according to terms and conditions of the family floater policy claim equal to 80% of S.I of the 1,00,000/-is payable.

The Complainant submitted that he had switched over his policy with the Respondent from the New India Assurance Co. Ltd. hence benefit of renewal of policy without any break should be given to him. The Complainant also quoted the earlier award of this forum where the forum had treated the policy as renewed in chain.

This forum accepted that continuity of policy as renewed in continuation without any break was established in earlier award. But the complainant had increased S.I from Rs.25000/- to Rs.100000/- three years prior to the claim occurred hence directed the Respondent to pay as under:

1) Full S.I Rs.25000/- prior to increase in S.I plus
2) 90% of balance S.I of Rs.75000/- as per clause 5.1 of the subject policy treating the policy ran for 3 years.

Thus, complaint partially succeeds.

Case No.11-010-0376-11
Mr. Mahipalbhai M. Shah
V/s.
Iffco Tokiyo General Insurance Co. Ltd.
Award dated 17-08-2010

Repudiation of Mediclaim:

The claim was repudiated by the Respondent invoking clause 11 of the policy which defines "Hospital/Nursing Home" to qualify as service provider.

The Respondent submitted that the hospital was registered with local authority under Bombay Shop and establishment act 1948 instead of under Bombay Nursing Home act. Besides the hospital does not comply with the criteria of 15 beds.

The Complainant stated that the hospital should be registered with the local authority and should be under supervision of a qualified medical practitioner hence it fulfills the criteria for the definition of the hospital.

This forum opined that in the terms and condition of the policy it is not mentioned that hospital should be registered under Bombay Nursing Home Act. In the present case hospital is registered with local authority as hospital hence fulfills the criteria as a hospital.

In the result, the complaint succeeds.

Case No.11-004-0317-11
Mr. S.T.Patel
V/s.

United India Insurance Co. Ltd.
Award dated 18-08-2010

Partial Repudiation of Mediclaim:

The Respondent had partially settled the Mediclaim for Rs.22500/- on the ground that clause 1.2 of the terms and conditions of the policy imposes capping for the reimbursement of surgery for Hernia as 15% of Sum Insured or maximum Rs.30,000/-.

The Complainant submitted that he held policy since last 10 years and the Respondent had imposed cap subsequently without his consent modifying the terms and conditions which should have not been made applicable and his entire claim should be paid.

The insured was operated for cholecystectomy (removal of gall bladder) and umbilical hernia for which as per the requirement of the TPA the treating surgeon had given bifurcation for surgery charges as Rs.15000/- and Rs.40,000/- for cholecystectomy and hernia respectively.

This forum observed that the Respondent had revised their terms and conditions for the subject policy and accordingly for the surgery of Hernia, reimbursement should be "actual expenses or 25% of the S.I whichever is less".

In the subject claim S.I was Rs.1,00,000/- hence Rs.25,000/- was payable for hernia and for cholocystectomy there was no capping hence Rs.15000/- was fully payable. Since surgeon's fees for two operation was Rs.55000/- hence balance amount of Rs.41,751/- (total claim for Rs.96751/-) pertain to other expenses. In the absence of exact bifurcation, 50% of Rs.41,751/- become payable for cholocystectomy.

Therefore Respondent was directed to pay Rs.60,875/-(Rs.25000/- +Rs.15000/-+20875/-) towards reimbursement of the subject claim after deducting Rs.22500/- already reimbursed earlier.

In the result, the complaint partially succeeds.

Case No. 11-009-0414-11
Mr. Bharatbhai L. Thummar
V/s.
Reliance General Insurance Co. Ltd.
Award dated 18-08-2010

Repudiation of Mediclaim:

The Respondent was repudiated the claim invoking clause 10 of the terms and conditions of the policy which excludes reimbursement of expenses for treatment of congenital external diseases.

The insured had diagnosed to have Left Eye posterior sub capsular cataract and was operated for the same.

The Respondent had called for the opinion of the operating Surgeon to know the cause of the disease but the Surgeon stated that the cause of cataract can not be commented.

Thereafter the Respondent obtained opinion of their panel Doctor with MBBS degree who opined that "insured had no injury to eye or wears any spectacles hence is a congenital Entity in 5 years old child". The claim was repudiated invoking clause 10 of the terms and conditions of the policy.

The complainant submitted that the disease can be called congenital disease only if cataract develops in both eyes.

This forum also obtained independent opinion of a Medical man who opined that the condition need not necessarily be congenital as it start as a small opaque area usually near the back of the lens right in the path of light, the disease would have presented much earlier so it is less likely to be congenital hence since birth in a 5 years old child has no scientific support.

This forum opined that the disease was not a congenital disease hence Respondent's decision to repudiate the claim without corroborative evidences is not justified.

In the result, the complaint succeeds on its own merit.

Case No.11-002-0380-11
Mr. Palvesh K. Patel
V/s.
The New India Assurance Co. Ltd.
Award dated 30-08-2010

Repudiation of Mediclaim:

The claim was repudiated invoking clause 5.5 of the terms and conditions of the policy stating that as per investigation report there was manipulation in the claim documents.

An analysis of material on record shows that the insured was hospitalized for treatment of Urinary track infection (UTI) + fever.

This forum observed that Respondent had not produced any document or evidence to establish that there was misrepresentation of any material fact/particulars or that claim was in any manner fraudulent.

In the result, complaint succeeds on its own merit.

Case No.11-002-0438-11
Mr. Pratik M. Khimasia
V/s.
The New India Assurance Co. Ltd.
Award dated 30-08-2010

Repudiation of Mediclaim:

The Claim was repudiated by the Respondent on the ground that Oral Chemotherapy is not covered but Parenteral chemotherapy is covered.

The Complainant submitted that he was advised for oral chemotherapy which is an advance form of medical treatment that is less painful and does not require hospitalization.

The Respondent submitted that the insured was neither hospitalized nor underwent Parenteral chemotherapy but underwent oral chemotherapy at home which is not within the scope of the subject policy.

This forum opined stating preface for the policy schedule that the claim to be payable should have hospitalization upon the advice of a duly qualified medical practitioner but in the present case there was no hospitalization hence Respondent's decision to repudiate the claim was justified.

In the result, the complaint fails to succeed.

Case No.11-009-0398-11
Mr. Tushar Y Bhatt
V/s.
Reliance General Insurance Co. Ltd.
Award dated 30-08-2010

Repudiation of Mediclaim:

Respondent had repudiated the claim invoking clause 10 of the terms and conditions of the policy which excludes reimbursement of expenses for hospitalization for congenital internal disease.

The Complainant submitted that the disease, Hiatus Hernia has nothing to do with internal congenital disease and the Respondent had wrongly repudiated his claim on baseless ground.

This forum obtained an independent opinion from a medical man who opined as under:

"By reviewing all the reports, Barium swallow and meal and operative notes and the age of presentation, the condition need not necessarily be congenital as the symptoms occurred two months before surgery. A congenital anomaly would have presented in early life".

Moreover, this forum observed from material on record that the Respondent had defined Hiatus Hernia to a 14 years aged insured as internal congenital disease on their own without substantial scientific proof or by obtaining opinion of medical man.

In the result, the complaint succeeds.

Case No. 11-008-0263-11
Mr. Rahul P. Dayani
V/s.
Royal Sundaram Alliance Ins. Co. Ltd.
Award dated 30-08-2010

Repudiation of Mediclaim :

Claim repudiated by the Respondent invoking condition 6 of the Health Shield Insurance policy which stipulates that in the event of misrepresentation, misdescription or non disclosure of any material fact the policy shall be void.

The Respondent relied upon the certificate of the treating doctor who had recorded as "known case of Hypertension since 5 years" and the policy was only 2½ years old therefore disease was pre-existing and the complainant had not disclosed it violating the principle of utmost good faith.

The complainant submitted that the insured was treated for bilateral pneumonia + ARDS + Septicemia +D.M which has no nexus with Hypertension. He further submitted that mere mentioning of past history reported by a relative has no value to treat the disease as pre-existing.

This forum observed that Respondent's decision for repudiation of the claim on the basis of non-disclosure of material fact was justified.

In the result, the complaint fails to succeed.

Synopses APR 10

Case No.11-002-0539-10
Mr. Yogesh D. Nayi
V/s.
The New India Assurance Co. Ltd.
Award dated 23-04-2010

Mediclaim

Complainant hospitalized for treatment of Fissure in Ano at Shri Jalaram Surgical Hospital and claim form submitted for the same.

Respondent settled the claim deducting a sum of Rs.7663/- as per terms and conditions of the policy clauses 2.3 and 2.4. The claim has to be considered on the basis of Sum Insured prior to revision of policy 2007 and as per clause 4.3 fissure has waiting period of 2 years. The policy was incepted with Sum Insured of Rs.25000/- more than 9 years back. The reimbursement of expenses sought by the Complainant is well within Sum Insured prior to increase and deduction is as per policy 2007 are not justified and directed to pay the full amount.

In the result complaint succeeds.

Case No.11-002-0571-10
Mr. Dineshkumar R. Shah
V/s.
The New India Assurance Co. Ltd.
Award dated 27-04-2010

Mediclaim

Claim lodged for reimbursement of expenses for Cataract operation in both the eyes of Complainant's wife was partially settled by the Respondent invoking Policy clause 2.3, 2.4 and note 1 of the mediclaim policy 2007. The subject policy initially had S.I of Rs.60,000/- since 26-04-2005 and increased to Rs.1,00,000/- in 2008 with revised policy condition (2007). Under Mediclaim policy 2007 as per clause 4.3, treatment for cataract has a waiting period of two years from the date of the policy.

The claim was settled considering the old sum insured of Rs.60,000/- condition for new policy can not be made binding on the old sum insured. Deduction made by the respondent as per new mediclaim policy 2007, are not justified.

In the result complaint succeeds and directed to pay a difference of Rs.6050/- to the Complainant.

Case No.11-004-0569-10
Mr. Murlidhar J Balchandani
V/s.
United India Insurance Co. Ltd.
Award dated 27-04-2010

Mediclaim

Complainant hospitalized for Lt. Eye cataract surgery on 24-12-2009 and claimed for Rs.31,314/-.

Respondent settled the claim for Rs.5000/- by deducting an amount of Rs.26,314/-(10% of S.I of Rs.50,000/-as per policy condition). The forum observed that reimbursement of expenses for cataract revised actual expenses or 25% of Sum Insured whichever is less. Further the Respondent have to get confirmation from existing policy holder as per their Cir.No.ARO/Misc/8706/2008 dated 26-03-2009. The Respondent has not submitted documentary evidence as Proposal form for revised policy or confirmation for acceptance of condition of revised policy.

Therefore, Respondent is failed to justify deny claim as per policy clause 1.2.

In the result complaint succeeds and Respondent is directed to pay full amount of Rs.31,314/- less: payment received.

Case No.11-005-0576-10
Mr. Kaushik G. Shah
V/s.
The Oriental Insurance Co. Ltd.
Award dated 28-04-2010

Mediclaim

The insured Mrs. Savitaben was admitted at HCG Medi Surge hospital, Ahmedabad for Acute exacerbation of Lower respiratory tract infection and known case of Koch's with renal cell carcinoma plus multiple metastasis. She was again admitted for carcinoma kidney, liver, lungs, brain, metastasis and D.M.

The claim had been repudiated by the Respondent alleging withholdment of material information with regard to two separate policies instead of increasing Sum Insured at the time of renewing policy No.2007/9864.

During the course of hearing, Complainant submitted that he had never signed any proposal or submitted policy copies duly signed by him and proposer on request of agent he had given cheques to renew policy No.2007/4864 and to increase sum insured. There is fraud on the part of agent and Respondent.

The forum neither has necessary power nor infrastructure to undertake the exercise to prove the truth hence forum passed award directing complainant to resolve grievance to approach any other forum as may be considered appropriate.

Case No. 11-009-0540-10
Mr. Suresh K Trivedi
V/s.
Reliance General Insurance Co. Ltd.
Award dated 29-04-2010

Mediclaim

Complainant admitted at Shlok Hospital on 18-06-2009 for treatment of infective Hepatitis.

Claim lodged for treatment expenses was repudiated by the Respondent on the ground that fraudulent claim by referring treatment papers which are not in line of treatment of Hepatitis. Further receipts issued by hospital are also not in order and creates doubts as to its correctness or validity. The claim has been repudiated on the basis of fraud and proving a fraud requires an elaborate legal procedure calling for examination of documents, calling for vitness under oath etc. which is beyond jurisdiction of this forum.

In order to decide the issue, it would be necessary to have application of legal process (like Admission/Denial of documents etc.) a task which is beyond the scope of this Forum. It falls outside the ambit of this Forum. Hence without going into the merits of the case and passing any quantitative award for the same, the Complainant is deemed beyond the jurisdiction of this Forum leaving it for the Complainant to pursue other means to resolve the grievance either with in the framework of Government
Rules under reference or taking recourse to any other forum as may be considered appropriate.

Case No.11-002-0099-11
Mr. Jagdish M Patel
V/s
. The New India Assurance Co. Ltd.
Award dated 18-05-2010

Repudiation of Floater Group Mediclaim Policy:

Claim for reimbursement of expenses for cataract surgery of complainant's father was repudiated by the Respondent invoking policy clause 4.3 which stipulates that expenses incurred on treatment for cataract has a waiting period of two years from the date of inception of policy. It is observed that the waiting period for cataract surgery can be overruled if the policy has been renewed in continuation without any break for 3 years in succession, but the claim has arisen in the first policy year.

The insured had a Mediclaim policy with Oriental Insurance Co. Ltd. since 2005-06 and thereafter he switched to the New India Assurance Co. Ltd. from 12-04-2007 to 11-04-2008 and renewed up to 11-04-2009. Thereafter the said policy was not renewed by the Complainant, but he took a fresh policy covering himself and his family members from the Oriental Insurance Co. Ltd. for the period from 21-04-2009 20-04-2010 and a fresh policy from the New India Assurance Company for the period from 29-04-2009 to 28-04-2010.

The subject complaint relates for the claim under the policy with the New India Assurance Co. Ltd. which is a fresh policy and as per the terms and conditions of the policy, surgery for cataract has waiting period of two years. The Respondent is justified in rejecting the claim in terms of Clause 4.3.

In the result complaint fails to succeed.

Case No.11-005-0072-11
Mr. Bhupendra R. Shah
V/s.
Oriental Insurance Co. Ltd.
Award dated 24-05-2010

Partial settlement of Mediclaim:

Claim lodged for treatment of Road Traffic Accident by the complainant was settled by the Respondent disallowing an amount of Rs.20,030/- as per the opinion of Respondent's panel doctor.

Complainant submitted that the Respondent has not given any reason for deductions made and also did not quote the terms and conditions of policy under which the deductions were made.

This forum observed that the treating doctor's opinion for the treatment given and expenses incurred by the Complainant carry more weitage than the opinion given by a Doctor based on papers.

In the present case the deduction made at the instance of Panel Doctor's opinion are arbitrary and no justification was given except for an amount of

Rs.800/- towards bed charges where actual entitlement is Rs.4000/- while the hospital has charged Rs.4800/- and directed to pay an amount of Rs.19,230/- to the Complainant.

In the result complaint partially succeeds.

Case No.11-002-0065-11
Mr. Haresh R. Chopda
V/s.
The New India Assurance Co. Ltd.
Award dated 26-05-2010

Repudiation of Mediclaim:

Claim lodged for reimbursement of expenses on hospitalization and treatment of the complainant's daughter was repudiated by the Respondent on the ground that as per policy terms and conditions the hospital must have minimum 15 inpatient beds whereas only 14 beds were shown.

As a result of mediation by this forum, both the parties mutually agreed for settlement of claim, so grievance was resolved.

Case No.11-004-0132-11
Mr. Falgun B Shah
V/s.
United India Insurance Co. Ltd.
Award dated 27-05-2010

Repudiation of Mediclaim:

Claim lodged for reimbursement of expenses on hospitalization and treatment of the complainant was repudiated by the Respondent on the ground negligence on the part of insured in intimating the claim.

As a result of mediation by this forum, both the parties mutually agreed for settlement of claim, so grievance was resolved.

Case No.11-005-0200-11
Mr. Rasikbhai J Prajapati
V/s.
The Oriental Insurance Co. Ltd.
Award dated 27-05-2010

Partial settlement of Mediclaim:

Claim lodged by the complainant for short payment of Rs.40,000/- from claim amount.

Respondent submitted that as per terms and conditions of policy, complainant is eligible to get old S.I Rs.60,000/- + C.B Rs.21000/- and were prepared to pay the amount.

As a mediation of this forum both the parties mutually agreed and signed a mutually acceptable agreement for balance payment of Rs.21,000/- hence grievance was resolved.

Case No.11-004-0117-11
Mr. Sunil S. Choudhary
V/s.
United India Insurance Co. Ltd.
Award dated 28-05-2010

Partial settlement of Mediclaim:

Claim lodged for reimbursement of expenses for hospitalization and treatment of complainant's wife was partially settled by the Respondent. Respondent paid Rs. 50,000/- as cashless facility from total claim amount of Rs.94,662/- by disallowing Rs.44,662/- invoking Clause 1.2 of the mediclaim policy which limits the claim amount for Hysterectomy to the maximum of 50,000/- or 20% of Sum Insured whichever is less. The S.I was Rs.4.50 Lacs.

Since the claim was preferred during the policy period when the revised terms and conditions were in force the Insured is entitled for 25% of Sum Insured i.e. Rs.1,12,500/- or actual admissible expense amounting to Rs.80,522/- which ever is less. Since a sum of Rs.50,000/- was paid as cashless the Complainant is entitled to payment of balance amount of Rs.30,522/-.

In the result complaint partially succeeds.

Case No.11-003-0067-11
Mr. Virendra M Shah
V/s.
The National Insurance Co. Ltd.
Award dated 31-05-2010

Partial settlement of Mediclaim:

Claim lodged for partial settlement of mediclaim by disallowing Rs.7,115/- towards pre- and post hospitalization treatment of diabetes, HBP on the ground that complainant was operated for prostate gland and pre and post hospitalization expenses are not related to the disease for which he was hospitalized.

Respondent submitted that treatment for D.M, HBP and IHD have considered and paid treatment expenses during hospitalization period and

disallowing expenses of pre- and post hospitalization incurred for D.M, HBP and IHD as they were not related with current disease.

Respondent's decision to settle the claim partially by disallowing Rs.7115/- is justified.

In the result complaint fails to succeed.

Case No.11-004-0168-11
Mr. Balbhadra M Thakkar
V/s.
United India Insurance Co. Ltd.
Award dated 31-05-2010

Non settlement of Mediclaim:

The insured was hospitalized for the treatment of knee joint replacement surgury. The dispute related to the non settlement of the claim by the Respondent even after a lapse of more than 7 months period from the date of submission of claim papers.

The Respondent agreeing to settle the claim submitted that as per the terms and conditions of the subject Mediclaim Policy, 75% of S.I is payable.

This forum was convinced by the decision of the Respondent to settle the claim partially and directed to pay a Sum of Rs.75,000/- to the Complainant.

In the result, complaint partially succeeds.

Case No.11-004-0033-11
Mr. Jagdish M Jain
V/s.
United India Insurance Co. Ltd.
Award dated 03-06-2010

Repudiation of Mediclaim:

The Respondent had repudiated the mediclaim invoking clause 5.7 of the family floater Group Mediclaim Policy which interalia stated that the company is not liable to make any payment under the policy in respect of any claim if disease/injury which are pre-existing when the cover incepts for the first time.

The Respondent submitted that knee joint replacement surgery was undergone after 3 months from the date of inception of the policy hence it was treated as pre-existing disease and claim was repudiated.

This forum observed that the subject group mediclaim policy covers persons from age group of 3 months to 80 years without any medical checkup and with coverage of all pre-existing diseases after 30 days from the inception of the policy. Therefore the underwriting decision of the Insurer was not affected by the non disclosure of pre-existing disease. So the Respondent's decision to repudiate the claim invoking exclusion clause 5.7 of the policy was not justified.

In the result, the complaint succeeds.

Case No.11-004-0043-11
Mr. Navinkant M Desai
V/s.
United India Insurance Co. Ltd.
Award dated 03-06-2010

Repudiation of Mediclaim:

Claim lodged for treatment expenses of complainant's wife for Knee Replacement.

The Respondent had repudiated the claim invoking clause 5.7 of the family floater Group Mediclaim Policy which interalia states that the company is not liable to make any payment under the policy in respect of any claim if disease/injury which are pre-existing when the cover incepts for the first time.

The Respondent submitted that knee joint replacement surgery was undergone within 3 months from the date of inception of the policy hence it was treated as pre-existing disease and claim was repudiated.

This forum observed that the subject group mediclaim policy covers persons from age group of 3 months to 80 years without any medical checkup and with coverage of all pre-existing diseases after 30 days from the inception of the policy. Therefore the underwriting decision of the Insurer was not affected by the non disclosure of pre-existing disease. So the Respondent's decision to repudiate the claim invoking exclusion clause 5.7 of the policy was not justified.

In the result, the complaint succeeds.

Case No.11-004-0057-11
Mr. Viral Vinodbhai Shah
V/s.
United India Insurance Co. Ltd.
Award dated – 03-06-2010

Repudiation of Mediclaim: on the ground of late intimation of hospitalization.

The Complainant was hospitalized for the treatment of Hip Replacement. Claim Repudiated by the Respondent on the ground of late intimation of hospitalization.

The Respondent had repudiated the claim invoking clause 11(a) of the MOU of the Group Mediclaim Policy which reads as under:

"Members are required to intimate to TPA within 72 hours from the date of hospitalization or else the claim can be repudiated".

The Complainant produced copy of intimation letter to substantiate that intimation was sent to TPA well within the time limit.

This forum observed that the Respondent's decision to repudiate the claim was not justified, as the conditions of the Respondent that intimation for hospitalization was not given as per rules was not correct.

In the result complaint succeeds.

Case No.11-004-0179-11
Mr. Gopalbhai R. Rana
V/s.
United India Insurance Co. Ltd.
Award dated 03-06-2010

Repudiation of Mediclaim:

Claim lodged for reimbursement of expenses for hospitalization and treatment of Complainant's mother was repudiated by the Respondent invoking policy clause 1 which excludes reimbursement of expenses in case the intimatin of hospitalization is not given within 72 hours of the hospitalization.

Complainant had not submitted any evidence that intimation for hospitalization was sent to TPA/Insurer. Therefore as per terms and conditions of the policy, claim repudiated by the Respondent is justified.

In the result complaint fails to succeed.

Case No.11-002-0197-11
Mr. Rajendra M Shah
V/s
. The New India Assurance Co. Ltd.
Award dated 03-06-2010

Partial settlement of Mediclaim:

Claim lodged for reimbursement of expenses of Intra Ventricular SOL operation of complainant's daughter at Bombay Hospital.

The Respondent had settled the claim for Rs.20,000/- being old Sum Insured prior to renewal of the subject policy with revised terms and conditions of Mediclaim policy 2007 with Sum Insured Rs.1,00,000/-.

The Complainant submitted that the sum Insured under the subject policy was increased from 25,000/- to Rs.1,00,000/- hence he is entitled for full reimbursement of the claim.

The Respondent had considered initial Sum Insured of Rs.25,000/- + C.B Rs.11,250/- for the reimbursement of the claim. The increased Sum Insured was not considered because the subject disease has a waiting period of two years as per the revised terms and conditions of the policy. The Respondent deducted a sum of Rs.7,250/- for treatment in Zone-I, Mumbai.

The forum observed that this is not justifiable as claim was paid considering initial Sum Insured for which premium was paid without any Zonal

consideration and there was no such condition for charging premium Zone wise and settling claim accordingly.

In the result complaint partially succeeds and directed to pay a sum of Rs.7,250/- to the complainant.

Case No.11-004-0166-11
Mr. Biren C. Pathak
V/s.
United India Insurance Co. Ltd.
Award dated 09-06-2010

Delay in settlement of Mediclaim:

Claim lodged for reimbursement of treatment expenses of Complainant's mother was repudiated by the Respondent invoking Exclusion Clause 4.8 of the policy treating the disease as congenital.

Complainant submitted that he should be given definition of Congenital External Disease, since the treatment was in respect of Congenital Internal disease/defect claim is payable.

Respondent's contention that the subject claim is not payable in view of Clause 5.2 and 5.7 of the policy is not tenable. The claim has been repudiated on the grounds that the treatment given to the insured was in respect of congenital external disease/defect.

Respondent's repudiation does not hold good because the insured was treated for a congenital internal disease/defect which does not form part of the exclusion under the policy.

In the result complaint succeeds and directed to make payment of Rs.99,816/- to the complainant.

Case No.11-002-0138-11
Mr. Galabhai P Mori
V/s.
The New India Assurance Co. Ltd.
Award dated 09-06-2010

Non settlement of Mediclaim:

The Claim lodged for reimbursement of treatment expenses of Complainant's wife for Rs.29,654/- was not settled by the Respondent.

As a result of mediation by this forum, both the parties agreed to settle the claim and accordingly the dispute was amicably resolved without any formal award.

Case No.11-004-0085-11
Mr. Daxesh M Laiwala
V/s.

United India Insurance Co. Ltd.
Award dated 10-06-2010

Repudiation of Mediclaim:

Claim lodged for reimbursement of treatment expenses of complainant's mother for Rt. hip surgery after 3 months from the date of inception of policy was repudiated by Respondent invoking policy clause 5.2 and 5.7.

The subject claim has been repudiated invoking Exclusion clause 5.7 of the policy which interalia states that the company is not liable to make any payment under this policy in respect of any claim if such claim be in any manner fraudulent or supported by any fraudulent means or device whether by the insured person or by any other person acting on his behalf.

The policy was incepted on 11-05-2009 and complainant underwent Rt. Hip surgery on 14.8.2009 i.e. after 3 months form the date of inception of policy. History of disease also goes prior to inception of policy as the treating doctor noted the history as on 24-04-2009 for DHS fixation for fracture in Lt. Lip.

Complainant has not submitted copy of Policy or Certificate or receipt of premium paid duly signed an authorized official of the company. There is on record a Xerox copy of Certificate No.JWS/U/M/0000000822 which is without official seal of the Respondent Insurer.

The decision under the case depends upon the verification of authenticity of the certificate of insurance. The examination of various evidences requires the adjudication by a competent court which is beyond the jurisdiction of this forum.

This forum operates within the limited and specific process laid down by RPG Rules 1998 to ensure speedy disposal on examination of materials on records only. In this case, contents of money receipts and its authenticity, needs to be examined strictly as per law of evidence by a competent court of law. This forum neither has necessary powers nor infrastructure to undertake this exercise.

However without passing award it has been advised to complainant to approach any other forum that he may be considered appropriate.

Case No.11-004-0103-11
Mr. Hasmukhbhai K Pandya
V/s.
United India Insurance Co. Ltd.
Award dated 11-06-2010

Repudiation of Mediclaim:

The Claim has been rejected by the Respondent on the ground of non receipt of intimation regarding hospitalization.

Complainant proved the intimation date wise to the TPA of the Insurer and submitted treating doctor's certificate showing chemotherapy on various dates due to cancer affected to the complainant's wife.

The Respondent has not scrutinized the papers properly and also has not raised any dispute about the treatment, bills and treating doctors paper etc., or the genuineness of claims, it is fair to settle the claims dated 23-06-2009, 26-08-2009 and 06-10-2009 where intimation for hospitalization was given within the stipulated period of 72 hours.

In the result complaint succeeds partially and directed to make payment of Rs.31,975/- as against 62,939/- to the complainant.

Case No.11-004-0225-11
Mr. Nareshkumar C. Vashita
V/s.
United India Insurance Co. Ltd.
Award dated 14-06-2010

Repudiation of Mediclaim:

Claim lodged for reimbursement of treatment expenses of Complainant's daughter was repudiated by the Respondent invoking policy clause 5.3.

The complainant is educationally backward and not aware with rules hence intimation was sent late by four days. The delay was considered by policy issuing office on merit on a case to case basis but was not done for the subject claim.

In the result complaint succeeds and directed to make payment of Rs.12,368/- to the complainant.

Case No.11-009-0073-11
Mr. Pathik Sanghvi
V/s.
Reliance General Insurance Co. Ltd.
Award dated 22-06-2010

Partial settlement of Mediclaim:

Claim lodged for reimbursement of treatment expenses of Complainant's was settled by the Respondent by deducting a sum of Rs.37,450/- from the total claim amount of Rs.82,450/- invoking clause 6.

The Respondent submitted that since the symptoms were observed in the first year of the policy and proximate cause of bleeding was insertion of Birth Control Device the claim could have been repudiated invoking clause 6, however they made part settlement of claim

Hospital charges were on the higher side as compared to other hospitals at Baroda and so they admitted reasonable (50%) of claim amount.

While Respondent has alleged that charges of hospital were on the higher side as compared to other hospitals, Respondent has not submitted any list of comparative charges from other hospitals. The terms and conditions of the policy provides payment of claim with in the limits of the Sum Insured and there are no other parameters to unilaterally decide what is reasonable.

From the discussions as at above it gets indisputably established that the deductions made by the Respondent are arbitrary and are not justified particularly in respect of operation charges of Rs.29,696/-.

The complaint thus partially succeeds.

Case No.11-004-0162-11
Mrs. Sadhvi Sukhmaniben
V/s.
United India Insurance Co. Ltd.
Award dated 23-06-2010

Repudiation of Mediclaim:

Claim lodged for reimbursement of expenses for treatment of complainant was repudiated by the Respondent invoking clause 4.10 on the ground that hospitalization is not necessary.

It is pertinent to make a mention of the operative clause of Mediclaim Insurance Policy which in effect serves as prefer to all provisions. Because just a day before the date of hospitalization, Insured consulted Dr. Sailesh Trivedi of Anand Hospital who prescribed some medicines for 15 days and advice to follow up after 15 days. Complainant is admitted at the hospital the very next day. She is admitted under the same doctor however hospitalization is not preceded by any specialist's opinion. It is also pertinent to refer that various diagnostic tests carried out during hospitalization are within normal range.

In the absence of any medical advice for hospitalization and just a day before hospitalization, consultation for treatment on OPD basis substantiates submission of Respondent that it is a case of Conversion of OPD to hospitalization. Respondent is therefore justified repudiating the claim.

In the result complaint fails to succeed.

Case No.11-002-0195-11
Mr. Rajnikant R Desai
V/s.
The New India Assurance Co. Ltd.
Award dated 23-06-2010

Partial settlement of Mediclaim:

Claim lodged for cataract surgery expenses was settled by the Respondent by disallowing Rs.12,500/- under various heads like room charges and miscellaneous charges per terms and condition of the policy.

The policy was renewed since 2001 with old sum insured Rs.20,000/-+ Rs.10,000/-C.B. The waiting period of two years for cataract surgery is not applicable to the old S.I. Respondent had applied new terms and condition of Mediclaim policy 2007 on old sum insured restricting room charges to 1% of S.I or actual amount whichever is less.

This forum commented that the Respondent was not justified in applying two standards for the terms and conditions under same policy. Total expenses were well within the old sum insured and Cumulative Bonus hence complainant was entitled for payment of full amount and deduction was not justified.

In the result, the complaint succeeds.

Case No.11-004-0229-11
Mr. Hitesh M. Patel
V/s.
United India Insurance Co. Ltd.
Award dated 23-06-2010

Declaration of 'No Claim' under Mediclaim:

Claim lodged for treatment expenses of Complainant's wife was made as 'No Claim' by the Respondent on the ground of late intimation of hospitalization.

As a result of mediation of this forum both the parties mutually agreed to settle the claim for Rs.27000/-and accordingly complaint was resolved without any formal award.

Case No.11-002-0115-11
Mr. Natvarlal D Patel
V/s
. The New India Assurance Co. Ltd.
Award dated 24-06-2010

Repudiation of Mediclaim:

Claim lodged for reimbursement of treatment expenses of Complainant's son was repudiated by the Respondent invoking Clause 4.4.16 of the Mediclaim Policy which inter alia states that Genetic Disorders and Stem Cell Implantation/Surgery are excluded from the purview of the policy.

Consulting Surgeon has certified that the disease is not congenital external defect or anomaly but Respondent produced an opinion from Dr.

Dhaivat S. Desai, M.D (Medicine) who has opined that the insured is suffering from Hemolytic Anemia due to Hereditary Spherocytosis. In Hereditary Spherocytosis, there is Red Blood Cell membrane abnormality and it is a congenital disorder, may be manifest late. So according to Mediclaim Policy Clause 4.4.16, claim is not payable.

This forum obtained opinion from Dr. Kiran Vadalia, M.S., F.C.P.S., F.I.A.M.S., L.L.B., D.B.M. on the nature of disease. He opined that the hereditary spherocytosis is a genetic condition. The policy excludes all genetic conditions under clause 4.4.16, whether the patient was aware or not and whether the condition is internal or external, the anemia splenomegally and gall stones, all are arising from the condition of hereditary spherocytosis. The claim therefore is not admissible and the decision of the insurer is found in order.

In the result complaint fails to succeed.

Case No.11-004-0188-11
Mr. Kiritkumar M Gandhi
V/s.
United India Insurance Co. Ltd.
Award dated 24-06-2010

Repudiation of Mediclaim:

Claim lodged for reimbursement of expenses for treatment of complainant was not settled by the Respondent.

The Respondent had repudiated the Mediclaim invoking clause 4.1 of family floater Group Mediclaim Policy which interalia stated that the company is not liable to make any payment under the policy in respect of any claim if disease/injury which are pre-existing when the cover incepts for the first time.

The Respondent submitted that the subject claim has been repudiated invoking exclusion clause 5.2 & 5.7 it means fraudulent claim. This forum observed that the subject Group Mediclaim policy covers persons from age group of 3 months to 80 years without any medical checking and with coverage of all pre-existing diseases after 30 days from the inception of the policy. Therefore the underwriting decision of the Insurer was not affected by the non disclosure of pre-existing disease. So the Respondent's decision to repudiate the claim invoking exclusion clause 4.1 of the policy was not justified.

In the result, the complaint succeeds.

Case No.11-002-0134-11
Mr. Pragnesh B Desai
V/s.
The New India Assurance Co. Ltd.
Award dated 25-06-0134-11

Partial settlement of Mediclaim:

Claim lodged for reimbursement of treatment expenses of complainant's wife was partially settled by the Respondent deducting an amount of Rs.39,463/- from total claim amount of Rs.1,02,137/- invoking clause 2.1, 2.3, 2.4 and note 1 and 2 of the policy.

Complainant has not submitted details of loss as P-II Form, Consent letter as P-III form to act as per RPG rules 1998.

In view of the above, the Complaint is considered as beyond jurisdiction of this forum and the Complainant is directed to take up the matter with any other forum.

Case No.11-002-0235-11
Mr. Vishnubhai K Patel
V/s.
The New India Assurance Co. Ltd.
Award dated 28-06-2010

Partial settlement of Mediclaim:

Claim lodged for reimbursement of treatment expenses of complainant's wife was partially settled by the Respondent deducting an amount of Rs.7825/- from total claim amount of Rs.19,433/- invoking clause 2.1, 2.3, 2.4 and note 1 and 4.3 of the policy.

Deduction in respect of various charges was explained by the Respondent due to the reason that insured had opted for a room with a rent higher than 1% of the Sum Insured of Rs.25,000/- in terms of clause 2.3, 2.4 and note 1 reducing the amount payable accordingly.

This forum observed that since prior to renewal of mediclaim policy 2007, Sum Insured was Rs.25,000/- with Cumulative Bonus of 25% and total expenses were well within this limit. Complainant was entitled for the payment of full amount of Rs.19433/- the Respondent was not justified in applying two standards for terms and conditions under the same policy.

In the result, the complaint succeeds and directed to make payment of Rs.7825/-.

Case No.11-004-0206-11
Mr. Jayesh C Sharedalal
V/s.
United India Insurance Co. Ltd.
Award dated 30-06-2010

Repudiation of Mediclaim:

Claim lodged for reimbursement of expenses for treatment of Complainant's wife was repudiated by the Respondent on the ground that hospitalization is less than 24 hours which is violation of policy clause 2.3.

The Respondent submitted that 8 claims were lodged in the policy year 2009-10 for a total amount of Rs.4,07,656/- up to 06-07-2009 and since the policy has a Sum Insured of Rs.4,00,000/-, the limit was exhausted after payment of total claims of Rs.4,00,000/-. The claim submitted on 15-01-2010 for USG guided tapping of plural fluid and blood transfusion was rejected by Respondent on the basis of "No Hospitalization".

The treating physician has categorically certified that the insured had Metastatic Breast Cancer and IV PCV was administered to the insured, hospitalization was essential for drainage of pleural effusion. Thus, it is by dint of the advancement in treatment technique that admission for long period to the hospital reduced to the extent of few hours for Life saving treatment by blood transfusion and removal of malignant fluid from lungs.

Since the insured was admitted under emergency conditions this prior approval which is mandatory could not be obtained. The seriousness of the emergency could be gagged from the fact that the insured expired on 26-01-2010 within 11 days from the date of discharge from hospital.

However Repudiation of claim for hospitalization on 15-01-2010 by Respondent is not justified.

In the result complaint partially succeeds and directed to make payment of Rs.16,744/- to the complainant.

Case No.11-013-0198-11

Mr. Rupesh R. Kothari
V/s.
HDFC ERGO Gen. Insurance Co. Ltd.
Award dated 30-06-2010

Non settlement of Mediclaim:

Claim lodged for reimbursement of expenses for treatment of Complainant was not settled by the Respondent on the ground that the treatment could have been taken on OPD basis.

The complainant has produced a copy of certificate of treating doctor showing that the complainant was treated for Bilateral Planter Facitis with Radial shock Wave therapy. Ortho Lithotripsy under general anesthesia which require admission in hospital and observation post procedure and anesthesia for at least 24 hours as in any operation.

The Respondent has produced copy of operation theatre register in respect of complainant which shows that nature of Anesthesia given was local. This is at variance with certificate issued by the treating Dr. S.S. Shah who has certified that the Complainant was treated under general anesthesia.

In order to decide the case, this forum sought opinion from Dr. Kiran Vadalia, M.S, FCPS FIAMS LLB DBM. Dr. Vadalia has opined that treatment papers reveals that the Complainant had been treated under local anesthesia which is the usual mode of anesthesia and according to the literature and the promotional material supplied by the treating doctor. Further close scrutiny of the bill and the discharge card shows that the date has been converted from 02-02-2010 to 03-02-2010. This is deliberate attempt to convert hospitalization for more than 24 hours. Dr. Vadalia opined that insurer has justified refusal of claim on the ground of being an OPD treatment not warranting any hospitalization.

In the result complaint fails to succeed.

Case No. 11-009-0242-11
Mr. Kiritbhai G. Dave
V/s.
Reliance General Insurance Co. Ltd.
Award dated 24-06-2010

Mediclaim rejected as 'No Claim':

Claim lodged for reimbursement of treatment expenses of Complainant's wife was made as 'No Claim' by the Respondent.

As a result of mediation by this forum both the parties mutually agreed and signed to settle the claim for Rs.27,000/- on non standard basis and grievance was thus resolved without any formal award.

Case No. 11-004-0244-11
Mr. Barkatali Umedali Merani
V/s
. United India Insurance Co. Ltd.
Award dated 30-06-2010

Repudiation of Mediclaim:

Claim lodged for reimbursement of treatment expenses of Complainant's wife was repudiated by the Respondent invoking clause 5.4 of Mediclaim policy which interalia states that all papers should be submitted to the TPA within 7 days from the date of discharge from hospital.

The insured was discharged on 25-03-2009 while claim papers submitted by the Complainant on 12-05-2009. However Respondent's decision to repudiate the claim is justified.

In the result complaint fails to succeed.

Case No.11-004-0267-11
Mr. Jaswin V. Inamdar

V/s.
United India Insurance Co. Ltd.
Award dated 9th July 2010

Repudiation of Mediclaim:

The claim was repudiated by the respondent stating that the hospitalization was not required and as per terms and conditions of the policy the claim is not payable.

The Respondent submitted that the common treatment of Enteric fever is oral and can be done on OPD basis.

From the analysis of materials on record, the hospitalization was not justified however Respondent's decision to repudiate the claim is upheld without any relief to the complainant.

Case No.11-005-0294-11
Mr. Pankaj B Soni
V/s.
The Oriental Insurance Co. Ltd.
Award dated 22-07-2010

Repudiation of Mediclaim:

The Claim lodged for reimbursement of treatment expenses of Complainant's son was repudiated by Respondent invoking clause 4.2 on the grounds that the insured contracted the disease within 30 days from the date of commencement of risk.

The Complainant submitted that his son was under treatment of Dr. Mukund Jani from 05-09-2009 to 30-09-2009 for Pneumonia before he was again admitted at Ankur Institute of Child Health from 03-10-2009 to 05-10-2009 under the treatment of Dr. Raju C. Shah. He was diagnosed Viral Diarrhea with Wheezing. The treating doctor Raju C. Shah certified on 08-06-2010 that the diagnosis arrived at the hospital has no relation with previous disease of the insured.

The policy was incepted on 29-05-2009 but the insured was covered under the policy w.e.f. 14-08-2009. Complainant has himself admitted that insured first consulted Dr. Mukund B. Jani of Shriji Hospital on 03-09-2009 for cough and fever for which hospitalization took place on 03-10-2009. Thus it is proved that the insured was suffering from fever (pneumonia) as on 03-09-2009, within 30 days from the date of commencement of risk.

Hence the Respondent's decision to repudiate the claim invoking clause 4.2 is justified.

In the result complaint fails to succeed.

Case No.11-003-03-11
Mr. Rameshchandra A. Parikh

V/s.
National Insurance Co. Ltd.
Award dated 06-08-2010

Partial settlement of claim:

Claim lodged for reimbursement of treatment expenses of Complainant's wife was settled by Respondent disallowing an amount of Rs.800/-from total claim amount of Rs.14552/-.

Respondent submitted several reasons for deducting the amount like late submission of claim file and there is a breach of policy clause 9.2, the reason for delay shown by the complainant was not satisfactory and non availability of RBS report.

Complainant agreed to submit RBS report from hospital hence this forum directed the Respondent to make payment of Rs.800/- to the complainant.

In the result complaint succeeds.

Case No.11-003-0262-11
Mr. Vallabhbhai G. Godhani
V/s.
National Insurance Co. Ltd.
Award dated 09-08-2010

Partial repudiation of Mediclaim:

Two claims lodged by the Complainant for reimbursement of cataract surgery expenses of Complainant's wife was settled by the Respondent deducting an amount of Rs.20,000/- from each claim.

The Respondent submitted that the insured used the "Multi-focal IOL", against "Aspheric IOL" (generally allowed/considered in case of cataract treatment). Clause No.3.12 of the individual Mediclaim policy issued to the insured says that "Reasonable and Customary Expenses means reasonable and customary surgical/medical treatment expenses with in the scope of cover of this policy to treat the condition for which the insured person was hospitalized". The exclusion clause No.4.6 of the policy says "Surgery for correction of eye sight, cost of spectacles, contract lenses, hearing aids etc". As per this exclusion, payment for correction of eye sight and cost of spectacles and contact lenses are denied.

The insured has accepted both the cheques and confirmed that the same has been deposited with the bank and realization, indicates that insured's is agreeing and/or accept both claims in to-to (Full and final payment).

Respondent further submitted that insured has spent Rs.28,000/- for multi-focal IOL but the best Aspheric IOL lenses available in Indian Market are up to Rs.8,000/-.

Policy clause 3.12 relates to reasonable and customary surgical/medical treatment expenses within the scope of cover of this policy to treat the condition for which the insured person was hospitalized.

Exclusion clause 4.6 of the policy states surgery for correction of eye sight cost of spectacles, cataract lenses, hearing aids etc.

Under the subject claim reasonable cost of lens can be taken as Rs.15,000/-.

However this forum directed the Respondent to make payment of Rs.14000/- to the complainant.

In the result complaint partially succeeds.

Case No.11-004-0292-11

Mr. Rameshbhai L Patel
V/s.
United India Insurance Co. Ltd.
Award dated 09-08-2010

Repudiation of Mediclaim:

Claim repudiated by the Respondent on the ground that as per terms and condition of policy, hormonal therapy is not payable.

Complainant submitted that his wife had Rt. Breast cancer for which hospitalization expenses and chemotherapy expenses were paid by the Respondent but hormonal treatment expenses were rejected, it is required to avoid side effect of chemotherapy.

Treating doctor has certified that hormonal therapy was advised because patient had developed Metastatis of bones.

Respondent submitted that the treatment for hormone therapy is not covered under the policy but not quoted any policy condition. However Respondent's decision to repudiate the claim is not justified.

In the result complaint succeeds.

Case No.11-002-0306-11
Mr. Ghanshyam S. Patel
V/s.
The New India Assurance Co. Ltd.
Award dated 09-08-2010

Partial settlement of Mediclaim:

The Respondent settled the claim by deducting an amount of Rs.7,319/- invoking clause 2.1, 2.3 and 2.4 Note 1 of the Mediclaim Policy (2007). The subject policy initially had a Sum Insured of Rs.35,000/- with 15% Cumulative Bonus since 26-12-2005. The Sum Insured was increased from Rs.35,000/- to Rs.1,00,000/-w.e.f. 26-12-2007 with revised terms and conditions in 2007 and

it was renewed for the period from 26-12-2008 to 25-12-2009 with 5% Cumulative Bonus.

The policy for the period from 26-12-2008 to 25-12-2009 was Mediclaim policy (2007) where under as per clause 2.1 Room, boarding and nursing expenses provided by the hospital not exceeding 1% of Sum Insured is payable. The claim was settled by the Respondent on the basis of initial Sum Insured of Rs.35,000/-.

The Respondent has wrongly considered S.I. of Rs.35,000/- and no justification or explanation has been given by the Respondent in applying new terms and conditions of Mediclaim Policy (2007) on the initial Sum Insured of Rs.35,000/- restricting room charges as 1% of the Sum Insured per day or actual amount whichever is less and accordingly scaling down various expenses proportionately. Reimbursement for Hospitalization under the policy is limited to Sum Insured of Rs.35,000/- + 15% C.B and it is unfair to link Hospitalization expenses with ceiling of room rent as one percent of the S.I so far as the subject claim is concerned.

The clause 4.3 waiting period of 2 years for Benign Ear, Nose and Throat disorder is applicable to revised Sum Insured and not to the old Sum Insured. The Respondent is not justified in applying two standards for the terms and conditions under the same policy.

However the Respondent is justified in deducting a sum of Rs.494/- for pre-hospitalization medical charges exceeding 30 days.

In the result complaint partially succeeds and directed to pay an amount of Rs.6825/- instead of Rs.7319/-.

Case No.11-002-0335-11
Mr. Bakulbhai R. Patolia
V/s.
The New India Assurance Co. Ltd.
Award dated 09-08-2010

Repudiation of Mediclaim:

Claim repudiated by the Respondent invoking exclusion clause 4.6 of the Mediclaim policy.

The clinical history from treating doctor and issued certificate states that the Iron deficiency, anemia does not mean that Blood transfusion is needed. The patient was treated with iron deficiency and clause 4.6 nowhere mentioned that anemia is excluded from the provisions of the policy. Further this is not a congenital disease. It is a nutrition related problem.

The Respondent pleaded that patient was admitted for the C/o fever with rigor with nausea and vomiting with giddiness and breathlessness and diagnosed as iron deficiency anemia with known case of hypothyroidism, hence blood transfusion was not given, anemia is not payable as per terms and exclusion clause 4.4.6.

Going through the treatment papers, it gets established that the insured had undergone treatment for Iron deficiency Anemia and Hypothyroidism, diseases which do not form part of exclusion under subject clause. So decision of the Respondent to repudiate the claim is not justified.

In the result the complaint succeeds.

Case No.11-004-0338-11
Mr. Prahladbhai S. Nai
V/s.
United India Insurance Co. Ltd.
Award dated 09-08-2010

Partial settlement of Mediclaim:

Claim lodged for reimbursement of treatment expenses was settled by the Respondent deducting an amount of Rs.8,659/- from total claim amount of Rs.13,659/-invoking policy clause 4.2. issued in 2007, Cataract is a specified illness hence expenses in respect of it are restricted to 10% of S.I or maximum Rs.25000/-whichever is less. Since the S.A under the policy is Rs.50,000/- the Respondent has rightly settled the claim for Rs.5,000/-.

The complainant submitted that he had been holding Mediclaim policy since last 6 years and as per policy condition, he is entitled for 25% of Sum Insured for cataract operation.

Since the subject claim has occurred during the policy renewed on 24-01-2010, old terms and conditions are applicable on the initial Sum Insured as the revised sum insured has a waiting period of two years from the date of increase in Sum Insured.

From the discussion as at above it is evident that the Respondent is justified in settling the claim on the basis of terms and condition of the policy at inception which stipulates claim for cataract surgery as 10% of Sum Insured. The increase in Sum Insured and the new terms and conditions are applicable for the policy renewed for the period 2010-2011 and so benefit of 25% of Sum Insured can not be given to old Sum Insured.

In the result, the complaint fails to succeed.

Case No.11-004-0318-11
Mr. Vishal N. Parmar
V/s.
United India Insurance Co. Ltd.
Award dated 10-08-2010

Repudiation of Mediclaim:

The claim was repudiated by the Respondent stating that as per investigation report the insured was not present at the hospital when their

investigator visited the hospital for investigation and no indoor record, treatment papers, first consultation paper were provided to the investigator.

The Complainant pleaded that the investigator visited hospital at night after his discharge from hospital.

The Complainant was asked to submit hospital treatment papers but till date he has failed to submit the same. In P-II Form, the Complainant has not stated extent of monetary loss and quantum of relief sought.

The Respondent is ex-parte and they also failed to submit treatment papers of the complainant and investigation report.

This forum neither has necessary powers nor infrastructure to undertake the exercise of verifying the true fact when investigator visited hospital or calling for hospital doctor and investigator as witness. In order to decide the issue it would be necessary to have application of legal process (like admission/denial of documents, affidavits etc.) a task which is beyond the scope of this Forum.

Hence without getting into merits of the case and passing any quantitative award for the same, the complainant is deemed as beyond jurisdiction for this Forum, leaving it for the complaint to 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.

Case No.11-002-0326-11
Mr. Ashish K Shah
V/s.
The New India Assurance Co. Ltd.
Award dated 10-08-2010

Repudiation of Mediclaim:

Claim lodged for reimbursement of Osteoarthritis treatment of complainant's mother was repudiated by the Respondent invoking exclusion clause 4.3.

The complainant submitted that the Respondent's plea to repudiate the claim under Clause 4.3 of the subject family floater Master Policy is not correct as the subject policy covers all pre-existing diseases.

The Respondent stated that the complainant's family is covered under the said family floater master policy through M/s. Jeevan Suraksha Medicare Services Pvt. Ltd., but they had not issued any certificate to the Complainant in this regard. The Respondent further stated that the insured was operated for osteoarthritis of left knee which has a waiting period of four years as per clause 4.3 of the policy hence the claim is rightly rejected. The claim has not been rejected on the grounds that disease was pre-existing as alleged by the Complainant.

The forum observed that the subject policy was incepted w.e.f. 29-04-2009 with Sum Insured of Rs.3,00,000/- and claim occurred in September

2009 i.e. in the first policy year. The Tailor made Floater Group Mediclaim Policy shows extra loading for relaxation given for Pre-existing diseases, 30 days waiver and coverage of maternity but there is a list of the Specified diseases/ailments/surgeries where waiting period of two to four years has been specified.

In view of observation as at above, it is apparent that since the treatment taken by the insured is within the waiting period of four years for the subject disease, it is not payable and Respondent is justified in rejecting the claim.

Case No.14-004-0416-11
Mr. Girishkumar S. Gandhi
V/s.
United India Insurance Co. Ltd.
Award dated 10-08-2010

Non settlement of Mediclaim:

Claim lodged by the Complainant for cataract operation was not settlement by the Respondent showing the reason that late submission of claim intimation.

As a result of mediation by this forum the Respondent and the Claimant mutually agreed for payment of a sum of Rs.29,445/-towards full and final settlement of the subject claim and as a token of this agreement both the parties signed a joint statement to this effect.

The grievance was thus resolved without any formal award.

Case No.11-009-0373-11
Smt. Minaxiben R. Shah
V/s.
Reliance General Insurance Co. Ltd.
Award dated 11-08-2010

Non Settlement of Mediclaim:

Claim lodged for reimbursement of treatment of Acute Pyelonephritis, Fever, pain, Nausea etc. and Respondent has not settled the claim.

As a result of mediation by this forum the Respondent and the claimant mutually agreed for payment of Rs.20,000/- towards full and final settlement of the Subject Claim and signed a mutually acceptable agreement to this effect.

Since the dispute was thus amicably resolved between the Respondent and the Complainant, no formal award is required to be issued.

Case No.11-002-0389-11
Mr. Yasin S. Rangwala
V/s.

The New India Assurance Co. Ltd.
Award dated 12-08-2010

Partial settlement of Mediclaim:

The claim was partially settled by the Respondent invoking clause 2.3 other than main hospital bill and Surgeon, Anesthetist, Consultant charges to be limited to entitled category to Room charges.

As a result of mediation by this forum the Respondent and the claimant mutually agreed for payment of balance Rs.24,000/- towards full and final settlement of the Subject Claim and signed a mutually acceptable agreement to this effect.

Since the dispute was thus amicably resolved between the Respondent and the Complainant, no formal award is required to be issued.

Case No.11-002-0407-11
Mr. Pushpak R. Makwana
V/s.
The New India Assurance Co. Ltd.
Award dated 12-08-2010

Non settlement of Mediclaim:

The claim was rejected by the Respondent on the ground that there were variations in room charges and inflating bills.

As a result of mediation by this forum the Respondent and the claimant mutually agreed for payment of Rs.7,500/- towards full and final settlement of the Subject Claim and signed a mutually acceptable agreement to this effect.

Since the dispute was thus amicably resolved between the Respondent and the Complainant, no formal award is required to be issued.

Case No.11-002-0301-11
Mr. Mansukhlal M Shah
V/s.
The New India Assurance Co. Ltd.
Award dated 16-08-2010

Partial settlement of Mediclaim:

Claim partially settled by the Respondent on the basis of Sum Insured plus 30% C.B (2.50 + 0.75 CB = 3.25 Lacs). Complainant required to get Rs. 3.50 lacs.

The Complainant submitted that he had purchased the policy for himself and his wife in the year 1997 and it has been renewed in continuation without any break till date. So he is entitled for a No Claim Bonus of Rs.1,00,000/-

and balance payment of Rs.25,000/-. He further stated that Respondent has by mistake mentioned NCB as Rs.75,000/- in the subject policy.

Respondent submitted that under their Mediclaim Policy (2007) maximum NCB has been capped at 30% and the claim in respect of insured has been settled as per terms and conditions of the policy.

The revised Mediclaim Policy (2007) has provision for Maximum no claim bonus of 30%. The Respondent is therefore justified in settling the claim taking no claim bonus as Rs.75000/-.

In the result complaint fails to succeed.

Case No.11-009-0399-11
Mr. Rameshbhai Mungra
V/s.
Reliance General Insurance Co. Ltd.
Award dated 16-08-2010

Repudiation of Mediclaim:

Claim lodged for treatment expenses of the Complainant was repudiated by the Respondent invoking exclusion clause 15 on the ground of fraudulent claim.

Respondent has rejected the claim on the grounds that it is a fraudulent claim and false statement and declarations were made by the Complainant and material information was not disclosed regarding correct nature of illness suffered by the insured.

Insured was admitted for treatment of Abdominal pain, Vomiting, Diabetes and Fever but in Hospital no detailed input output chart was maintained in case of severe dehydration.

Complainant has stated that he was treated for abdominal pain, fever, vomiting and Diarrhea.

The treating doctor has misled the Insurer by issuing fake receipt.

On examination of material on record shows that the insured was hospitalized for treatment of Acute Gastroenteritis and discrepancies between disease and treatment pattern and payment of hospital bills are violation of terms and conditions of policy clause 15. Therefore, the Respondent's decision to repudiate the claim is justified.

In the result complaint fails to succeed.

Case No.11-008-0236-11
Mr. Yogesh A Kosti
V/s.
Royal Sundaram Alliance Insurance Co. Ltd.
Award dated 17-08-2010

Repudiation of Mediclaim:

Claim repudiated by the Respondent on the ground of treating hospital does not fulfill minimum 15 beds and Clause 10 of the policy.

The Respondent submitted that as per indoor case papers insured remained afebrile hence her stay was unwarranted and as per their investigation report no doctor was available at the hospital.

The Complainant stated that the hospital is registered with AMC under Bombay nursing home registration act 1949.

In the discharge summary, only symptoms are mentioned no diagnosis is given. As per fitness certificate, disease mentioned as Typhoid however pathology test report Serum Widal done was negative.

In view of the above the Respondent is justified in repudiating the claim as per clause 10 of the policy.

In the result complaint fails to succeed.

Case No.11-004-0347-11
Mr. Tanmay A Divetia
V/s.
United India Insurance Co. Ltd.
Award dated 17-08-2010

Repudiaiton of Mediclaim:

The claim was repudiated by the Respondent stating that the hospitalization was not necessary and claim is inadmissible on the grounds that Aspiration knee and Above knee plaster does not require hospitalization.

Complainant had an accidental fall from Scooter and first consulted Dr. S.S. Desai with concussion of Brain, contusion of muscles of Rt. Thigh, no clinical evidence of fracture in lower limb and advised X-ray of right femer and Rt. Knee, C.T Scan of Brain and opinion of Neuro and Orthopaedic Surgeon.

Orthopaedic Surgeon was advised Aspiration of knee, Above knee, below knee brace and above knee plaster.

Consulting Doctors had not advised hospitalization so claim was repudiated by the Respondent.

From the examination of materials of record, it is proved that the treatment taken by the Complainant was not required hospitalization.

In the result complaint fails to succeed.

Case No. 11-017-0257-11
Mr.Mansukhbhai M. Bhalodi
V/s
Star Health & Allied Insurance Co. Ltd
Award dated 17-08-2010

Rejection of Mediclaim:

The Claim was rejected by the Respondent under exclusion for pre-existing disease on the ground that as per prescription the patient is diagnosed

to have degenerative Meniscal injury which is not, suggestive/indicative of trauma, so should be long standing.

There is on record MRI of Right Knee joint without date from Harilal Jechand Doshi Sarvajanik Hospital which records referred by Dr. R.Mehta and date as 28-01-2008. Discharge Summary of Wockhardt Hospital where the complainant was hospitalized gives final diagnosis as (2 months old) Rt. ACL Tear with Medial Meniscuses Bucket an Handle Tear with (N) DNV with history of difficulty in walking since two months. The Medical Certificate filled in by treating Doctor Rupesh N. Mehta on 04-03-2010 records diagnosis as ACL with Medial Meniscuses injury with history of two months and date of first consultation as 28-01-2010. There is also on record a certificate from treating doctor Rupesh Mehta certifying that Complainant had post traumatic (two months old) history of fall from stair case at home and had Rt.ACL tear with Medial meniscuses injury.

The Complainant in his written submission to this forum and representation to the Respondent had confirmed that the hospitalization was due to injury sustained while he fell from stair case at home.

Respondent has not produced any evidence to prove that the disease was not due to injury while the discharge summary of the hospital and medical report of treating Orthopedist give history as two months.

In the result, the complaint succeeds on its own merits.

Case No.11-004-0363-11
Mr. Chandrakant C. Patel
V/s.
United India Insurance Co. Ltd.
Award dated 17-08-2010

Repudiation of Mediclaim:

Claim repudiated by the Respondent on the ground that hospitalization was not required and the treatment given was an OPD procedure.

The investigation report signed by Insured, and hospital authority has stated that patient was a known case of B.P and Hypertension.

Prior to hospitalization, Insured had complaint of High B.P and bleeding from nose.

On scrutiny of materials on record shows that the hospitalization was not necessary.

In the result complaint fails to succeed.

Case No. 11-004-0409-11
Mr. Bhupendra D. Prajapati
V/s.
United India Insurance Co. Ltd.
Award dated 17-08-2010

Repudiation of Mediclaim:

The claim was repudiated by the Respondent on the ground that the subject disease has a waiting period of two years as per clause 4.3 of the terms and conditions of the policy.

The Complainant submitted that the policy was incepted in 2000 with the New India Assurance Co. and renewed in continuation till 2007. In 2007, he renewed the policy with Bajaj Allianz for the period 28-12-2007 to 27-12-2008 for Sum Insured of Rs.50,000/- with 24% Cumulative Bonus and thereafter the policy was renewed with the Respondent.

The Respondent stated that as per the terms and conditions of the policy treatment for Prostatitis has two years exclusion and therefore as per policy clause 4.3 the claim was repudiated.

There is on record a copy of the subject policy which confirms the date of commencement of the risk with the Respondent as 28-12-2008.

There are copies of Mediclaim form, Medical Certificate, bills and discharge summary on record which reveal that the insured suffered from Prostatitis since 24-09-2009 (5 days) and within one year from commencement of risk from 28-12-2008 under the policy with the Respondent.

Since the insured suffered from Prostatitis within one year from the date of commencement of the coverage and terms and conditions of the subject policy exclude coverage for Prostatitis during the first two years of the operation of the policy.

The Respondent has not treated renewal of Bajaj Insurance policy as renewal in continuation.

Hence decision of the Respondent to repudiate the claim is as per the terms and conditions of the policy and is justified.

In the result, complaint fails to succeed.

Case No.11-004-0449-11
Mr. Mukundrai K Vasant
V/s.
United India Insurance Co. Ltd.
Award dated 17-08-2010

Repudiation of Mediclaim:

Claim repudiated by the Respondent invoking clause 5.3 and 5.4 because of late intimation by 2 days and late submission of papers by 11 days.

As a result of mediation by this forum the Respondent and the claimant mutually agreed for payment of Rs.14000/- towards full and final settlement of the Subject Claim and signed a mutually acceptable agreement to this effect.

Since the dispute was thus amicably resolved between the Respondent and the Complainant, no formal award is required to be issued.

Case No.11-002-0005-11
Mrs. Manguben I Amin
V/s.
The New India Assurance Co. Ltd.
Award dated 18-08-2010

Partial settlement of Mediclaim:

75% of the total claim amount was settled by the Respondent invoking clause 5.3 of the policy which stipulates that for joint knee replacement surgery expenses, 75% of the sum insured or claim amount whichever is less shall be paid.

On examination of policy documents it is observed that it has a special attachment to and forming part of the policy which listing special limit under policy for some major diseases under heading joint replacement (knee/hip or any other joints) as 75% of Sum Insured which under the subject policy works out to Rs.2,25,000/-. When the claim is examined in the context of this clause it is observed that Actual claim amount is Rs.1,75,429/- which is well within 75% of the Sum Insured.

In the result, the complaint succeeds.

Case No.11-004-0147-11
Mr. Rameshbhai M Patel
V/s.
United India Insurance Co. Ltd.
Award dated 18-08-2010

Partial settlement of Mediclaim:

Claim settled by the Respondent by deducting an amount of Rs.65000/- from claim amount.

Complainant had submitted hospital bills, medicine bills, doctor fees etc. with list of total expenses amounting to Rs.1,08,292/-.

The Respondent has not given any reason as to why claim was not paid for full sum insured of Rs.1.00 lac.

Since the Respondent has not justified or given any reason for deduction made out of the claim amount and they have not submitted any explanation during the course of hearing this forum directed to pay an amount of Rs.65000/- to the Complainant.

In the result complaint succeeds.

Case No.11-002-0216-11

Mr. Bhairav N. Jariwala
V/s.
The New India Assurance Co. Ltd.

Award dated 18-08-2010

Partial settlement of Mediclaim:

Claim lodged for reimbursement of hospitalization and treatment expenses of complainant's son was settle by the respondent by deducting an amount of Rs.55000/- from claim amount invoking policy clause 4.1, 4.2 and 4.3.

Complainant submitted that Sum Assured under the policy was 1,50,000/- + 5000/- C.B, so Complainant is entitled for Rs.1,55,000/- but the Respondent has paid only Rs.1,00,000/-.

Respondent submitted that the increased S.I of Rs.50000/- is within the lock in period of 30 days the insured became illness and 5000/- is not payable because in the previous policy year the Complainant had preferred a claim in Feb.2009 (the policy was issued by other D.O) and this information was not disclosed by him in the proposal for renewal with enhanced S.I to Surat D.O-III. However cannot consider this 55000/-.

Complainant produced a certificate from treating physician that consultation for fever one month back has no relation with disease and disease cannot be treated as it set in during the lock in period of 30 days.

Respondent has not proved any documentary evidence that the present disease had relation with claim paid in Feb.2009 hence decision of the respondent is not justified.

In the result complaint succeeds and directed the Respondent to make payment of Rs.50,000/- to the complainant.

Case No.11-002-0217-11
Mr. Vimal N. Daftari
V/s.
The New India Assurance Co. Ltd.
Award dated 18-08-2010

Repudiation of Mediclaim:

Claim lodged for reimbursement of treatment expenses of Complainant's son was repudiated by the Respondent invoking policy exclusion clause 4.4.2.

Respondent explained the case with reference to the exclusion clause 4.4.2 of the Mediclaim policy but it is observed that hospitalization benefit under the policy is available in case when circumcision is necessary for treatment of illness or disease.

The surgery was not for any cosmetic or aestheti treatment and was also not plastic surgery. It was performed to cure balooning of prepucial skin while passing urine, however Respondent's decision to repudiate the claim invoking exclusion clause 4.4.2 is not justified.

In the result complaing succeeds.

Case No.11-004-0269-11

Mr. Tejpal C. Kataria
V/s.
United India Insurance Co. Ltd.
Award dated 18-08-2010

Repudiation of Mediclaim:

Claim repudiated by the Respondent on the grounds that when the investigator visited the hospital, Complainant was not present in the hospital and patient was admitted in General ward while charges are being claimed for special room.

The Complainant could not provide any satisfactory explanation for this.

Respondent submitted that the patient was not admitted at the hospital and hospital has inflated the bill not only in respect of room rent but also visiting charges. Hospital bills show admission in special room for 7 days and doctor's visit for 14 times. There is reasons to believe that hospital has supported the Complainant in converting OPD treatment into hospitalization.

It is established that Complainant has made mis statements about details of hospitalization, thus Respondent is justified in rejecting the claim on the ground of misrepresentation of material information.

In the result complaint fails to succeed.

Case No.11-002-0271-11
Mr. Hitendrabhai S. Gavdekar
V/s.
The New India Assurance Co. Ltd.
Award dated 18-08-2010

Repudiation of Mediclaim:

Claim repudiated by the Respondent on the ground that no prior intimation was given for hospitalization in the context of clause 11 of Mediclaim policy. The claim papers were submitted by the Complainant, after a gap of more than 3 months. The provision of clause 11, it is apparent that the complainant should have submitted the claim intimation within 7 days from the date of hospitalization and it is established that there was exorbitant delay in giving the intimation of hospitalization.

Therefore, Respondent's decision to repudiate the claim invoking clause 11 is justified.

In the result complaint fails to succeed.

Case No.11-002-0276-11
Mr. Rajendra J. Mashru
V/s.
The New India Assurance Co. Ltd.
Award dated 18-08-2010

Partial settlement of Mediclaim:

Respondent has settled the claim by deducting an amount of Rs.12,026/- on the ground that subject disease was a congenital internal disease which has waiting period of two years.

The Complainant had submitted a certificate issued by treating doctor showing that diabetes ketoacidosis is not a congenital disease.

Respondent has not attended the hearing to this forum and not produced any evidence to prove that juvenital diabetes is congenital internal disease/defect.

On examination of policy documents it is observed that the initial sum assured is commenced in 2003 and not applicable waiting period of two years. Thus respondent's decision to deny the balance amount of Rs.12,026/- is not justified.

In the result complaint succeeds.

Case No.11-004-0307-11
Mr. Mahendra D. Vasani
V/s.
United India Insurance Co. Ltd.
Award dated 19-08-2010

Non settlement of Mediclaim:

Claim lodged by the Complainant for reimbursement of expenses was not settled by the Respondent. Total claim amount was Rs.3,10,159/-.

As a mediation by this forum the Respondent and the Complainant mutually agreed for payment of a sum of Rs.1,05,000/-towards full and final settlement of the subject claim and as a token of this agreemetn both the parties signed a joint statement to this effect.

Since the dispute was thus amicably resolved between the Respondent and the Complainant, no formal award is required to be issued.

Case No.11-002-0252-11
Mr. Radheshyam C. Shah
V/s.
The New India Assurance Co. Ltd.
Award dated 19-04-2010

Partial settlement of Mediclaim:

Claim lodged for reimbursement of treatment expenses of complainant's wife was partially settled by the respondent by deducting an amount of Rs.3,200/- invoking policy clause 2.3 and note 2.

The Respondent had submitted that the consulting doctor had received a sum of Rs.3,200/- separately in cash it does not form part of the hospital bill hence this amount is not payable.

Policy provision do not restrict reimbursement of expenses which are part of hospital bill but cover all payments that are part of hospitalization bill and as per Respondent's circular, allows fees paid in cash to be entertained up to a limit of Rs.10,000/-.

In view of this respondent's decision to deduct the amount of Rs.3,200/- is not justified.

In the result complaint succeeds.

Case No.11-002-0415-11
Mr. Vinod S. Parikh
V/s.
The New India Assurance Co. Ltd.
Award dated 30-08-2010

Partial settlement of Mediclaim:

Claim settled by the Respondent by Rs.22,011/- after deducting an amount of Rs.4,400/- from total claim amount of Rs.26,411/-. The deductions made were for O.T Ultra strips which are non medical and hence deducted out of claim amount.

Complainant had not taken treatment of diabetes but before surgery of perianal abscess, blood sugar test was required which is part of the expenses for treatment and same is payable under the Mediclaim policy.

There is on record bills No. R637 and R 6 for Rs.1,381/- each totaling to Rs. 2762/- hence complainant is eligible to get reimbursement of Rs.2,762/- only.

In the result complaint partially succeeds.

Case No.11-002-0434-A-11
Mr. Mansuri Ismailbhai Kalubhai
V/s.
The New India Assurance Co. Ltd.
Award dated 30-08-2010

Delay in settlement of Mediclaim:

Claim lodged for reimbursement of treatment expenses of Complainant's wife was not settled by the respondent.

The Respondent submitted that the amount payable under the subject claim is Rs.13,066/- and the float under preparation.

Since the period of more than 6 months has elapsed, the claim lodged the respondent has to expedite preparation of the float.

In the result complaint succeeds.

Case No. 11-005-0274-11
Mr. Ramubhai G. Bharwad
V/s.
The Oriental Insurance Co. Ltd.
Award dated 30-08-2010

Repudiation of Mediclaim:

Claim lodged for reimbursement of treatment expenses was repudiated by the Respondent invoking clause 4.15 of the 110ediclaim policy.

The insured was hospitalized for Liver Transplantation due to decompensate chronic liver disease and Wilsons's disease and was operated for the same.

Dr. Anand Khakhar M.S, DNB of Apollo Hospital, Chennai has certified that the patient was suffering from decompensate chronic liver disease due to Wilson's disease. He was presented to them with history of cirrhosis and liver disease of short duration only. This is not unusual in these patients. Almost all the patients in his category are completely asymptomatic and healthy until their liver disease starts to decompensate.

The Respondent produced extracts from Medical Journal on Wilson disease to show that Wilson disease is a genetic disorder that prevent the body from getting rid of extra copper. The Wilson's disease is the most common of a group of hereditary disease that cause copper overload in the liver.

Since the insured was hospitalized for and operated upon for a disease which was genetic disorder the Respondent is justified in repudiating the claim as per terms and conditions of the policy.

In the result the complaint fails to succeed.

Case No.11-005-0203-11
Mr. Hasmukh Raghuram Sharma
V/s.
The Oriental Insurance Co. Ltd.
Award dated 30-08-2010

Repudiation of Mediclaim:

Claim repudiated by the Respondent invoking Clause 2.1 and 4.3 of the Mediclaim policy. The Complainant pleaded that the plea of the Respondent that as per new Terms and conditions of the policy claim has been repudiated because ayurvedic treatment has not been taken in a Govt. Hospital/Medical College Hospital is not tenable because the policy was renewed in continuation for the last 6 years whereas the Respondent says the policy is in 2nd year and

the treatment taken was not an ayurvedic hence, hospitalization in Government hospital is not necessary.

The Respondent pleaded that for ayurvedic treatment hospitalization expenses are admissible only when the treatment is taken as in-patient in a Government Hospital/Medical College Hospital and treatment taken for Fissure and Fistula in anus was in second year policy which has a waiting period of 2 years.

On referring the documents

Case No.11-005-0203-11
Mr. Hasmukh Raghuram Sharma
V/s.
The Oriental Insurance Co. Ltd.
Award dated 30-08-2010

Repudiation of Mediclaim:

Claim lodged for reimbursement of treatment expenses of the complainant was repudiated by the Respondent invoking clause 2.1 and 4.3 of the Mediclaim policy.

The complainant underwent surgery at an ayurvedic clinic, as per clause 2.1 of the terms and conditions of the policy the claim is not admissible. Treatment of Fissure and Fistula taken in second year of the policy is excluded under clause 4.3.

Complainant pleaded that his policy was not a fresh one it was renewed in continuation since last 6 years.

Since the complainant did not produce previous policies to show that policy was incepted 6 years back so the decision of the Respondent to repudiate the claim is justified.

In the result complaint fails to succeed.

CASE NO. 11-017-0202-11
MR. HARSHAD R. SUKHADIA
VS
STAR HEALTH AND ALLIED INSURANCE CO. LTD.

Award Date: 23.07.10

Mediclaim rejected invoking clause 14 of the Mediclaim policy stating that the treatment could have been taken by the insured OP (out patient) basis, since insured had taken Ayuvedic treatment. From the materials on records, it is established that as per terms and conditions of the policy Ayuvedic treatment is not excluded from the purview of the policy. Hence the decision of Respondent to repudiate the claim is set aside and directed to pay full claim amount.

CASE NO. 11-09-0282-11
MR.
VS
RELIANCE GENERAL INSURANCE CO. LTD.

Award Date: 21.07.2010

Mediclaim repudiated invoking clause 1 of Health wise policy. Insurance commenced since 05.50.2008, insured hospitalized on 28.12.09 to 03.01.09 for the treatment of Tuberculosis. The history on records prove that insured was suffering from the Pulmonary Kochi's since 3 years and PHO – RA since 5 years, which is prior to inception of the policy, the clause -1, attracts the subject disease and benefits of the policy gets excluded. From the submission of both the parties, material on records it establishes that insured was suffering from disease prior to taking insurance. Hence, the decision of Respondent to repudiate the claim is upheld without any relief to the Complainant.

Award dated 13.5.2010

Case No.11-002-0070-11

Mr.Jayesah S Patel

Vs.

New India Assurance Co.Ltd.

Mediclaim Policy

The claim had been partially settled by Respondent by disallowing Rs.18400/- The complainant was entitled for reimbursement of medical expenses up to the limit of Sum Insured (SI) of Rs. 50000. The policy for the period from 04.09.2008 to 03.09.2009 was Mediclaim Policy (2007) where under as per clause 2.6 note 2 no payment shall be made under clause 2.3 other than part of the hospitalisation bill. Clause 2 of policy interalia states that reasonable customary and necessary expenses are reimbursable towards Surgeon, Anesthetic, Medical practitioner, Consultations and Specialist fees.
Major deduction was in respect of Surgeon's fee for which Respondent has issued internal guideline to pay reasonable customary and necessary Surgeon fee and Anesthetist fee limited to maximum of 25% of Sum Insured provided the Insured pays such fees through cheque and Surgeon/Anesthetists provides a numbered bill. If the fees are paid in cash then the payment is limited to a Sum of Rs.10, 000/- only, provided the Surgeon/Anesthetists provide a numbered bill
Deductions in respect of Consulting and room charges was explained by the Respondent due to the reason that insured had opted for a room with the a rent higher than 1% of the SI of Rs. 50000/- in terms of clause 2.3, 2.4 and 2.6 note 1 reducing the amount payable accordingly

The Complainant was covered under the policy since 2006 with a Sum Insurance (SI) of Rs 50000/. The policy is renewed for the period from 04.9.2008 to 03.9.2009 with revised terms and condition. The revised terms and condition of the policy link the benefits payable under the policy with the room rent which has a ceiling of maximum 1% of the Sum Insured.
However this claim has been considered by the Respondent for the intial sum insured of Rs, 50000/- and as such new terms and condition can not be made applicable to old sum insured.
Respondent's decision to disallow a sum of claim Rs.17800/- from the claim amount not justified.

The Respondent was directed to entertain the claim for full amount.

Award dated 31.5.2010

Case No.11-002-0019-11

Mr. Tapan Parmar

Vs.

New India Assurance Co.Ltd.

Janta Mediclaim Policy

The claim had been partially settled by Respondent by disallowing Rs.20800/- treating surgery performed on insured as inter mediate surgery as defined under Janta Mediclaim Policy.

Payment under Janta Mediclaim policy are made on the basis of a schedule of expenses for various type of surgeries which are categorized and benefits are fixed for room charges , operation theatre charges, anesthesia charges and surgeon fee. The subject was claim settled as per benefits available under the category intermediate surgery. The respondent submitted definitions of various types of surgery according to it inter mediate surgery is defined as a surgery involving the incision of deep fascia or deeper structures but not endangering the life of patient in normal circumstances. It may or may not be done under General Anesthesia.
Since the claim was preferred for intermediate surgery and respondent had made the payment accordingly the complaint was dismissed.

Award dated 31.5.2010

Case No.11-002-0019-11

Mr. Tapan Parmar

Vs.

New India Assurance Co.Ltd.

Janta Mediclaim Policy

The claim had been partially settled by Respondent by disallowing Rs.20800/- treating surgery performed on insured as inter mediate surgery as defined under Janta Mediclaim Policy.

Payment under Janta Mediclaim policy are made on the basis of a schedule of expenses for various type of surgeries which are categorized and benefits are fixed for room charges , operation theatre charges, anesthesia charges and surgeon fee. The subject was claim settled as per benefits available under the category intermediate surgery. The respondent submitted definitions of various types of surgery according to it inter mediate surgery is defined as a surgery involving the incision of deep fascia or deeper structures but not endangering the life of patient in normal circumstances. It may or may not be done under General Anesthesia.

Since the claim was preferred for intermediate surgery and respondent had made the payment accordingly the complaint was dismissed.

Award dated 31.5.2010

Case No. 11-002-0126-11

Mr. Mishrimal H Chopra

Vs.

New India Assurance Co.Ltd.

Mediclaim Policy

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

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

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

Thus complaint succeeded and Respondent was directed to settle claim for deducted amount of Rs. 15800/.

Award dated 31.5.2010

Case No. 11-002-0126-11

Mr. Dilipbhai Karshanbhai Mandaliya

Vs.

New India Assurance Co.Ltd.

Mediclaim Policy

The complainant was hospitalised twice at two different hospitals. Reimbursement for treatment of first hospitalisation had been repudiated on the ground that Hospitalisation was not justified and claim is inadmissible as per clause 4.4.1 and reimbursement for second hospitalisation expenses had been repudiated for the reason that no intimation for hospitalisation was given hence claim was repudiated invoking clause 11 of the policy

The complainant had already given intimation for his first hospitalisation on 1.10.2009. Since treatment was continuous during the hospitalisation for the period from 1.10.2009 to 5.10.2009 without any break the complainant submitted that he did not give any intimation for second hospitalisation as intimation was given on 1.10.2009. However all the claim papers were submitted on 3.11.2009 within 30 days from the date of discharge. This cannot be taken as valid reason for repudiation of claim particularly so when no other infirmity is observed in claim papers, bills and receipts.

The Complainant was hospitalised on the basis of advice from a doctor and the hospital he has given treatment as suggested by the treating physician over which he had no control. Respondent had submitted no medical opinion that hospitalisation was not required at Urmil Hospital from 1.10.2209 to 2.10.2009 to justify repudiation

The respondent was directed to pay an amount of Rs. 26904/ to the Complainant.

Award dated 13.5.2010

Case No. 11-002-0560-10

Mr. Vaghjibhai J Sanghvi

Vs.

New India Assurance Co.Ltd.

Mediclaim Policy

The claim was partially settled by invoking policy exclusion Clause 7 disallowing increase in Sum Insured with effect from 29.4.2008. As per clause 7 the subject disease of insured excluded for the first year of policy.

An analysis of material on record shows that the sum insured under the above policy was Rs.15, 000/- when the policy was incepted in 2002. The Sum Insured was increased from Rs.15, 000/- to Rs.1.00 Lac at the time of renewal for the period from 29-04-2008 to 28-04-2009 with 30% cumulative bonus (CB) on original Sum Insured of Rs.15,000/-.

The Insured was admitted at Gujarat Cancer Research Institute, Ahmedabad from 03.05.2008 to 20.06.2008 for treatment of Acute Myeloblastic Leukemia (Blood Cancer)

The claim lodged for hospitalisation for an amount of Rs. 131080/- was settled by the Respondent for a sum of Rs. 19500/- (original Sum Insured of Rs.15, 000/- with 45% Bonus thereon – Rs.4500).

The Respondent submitted that at the time of renewal of policy in 2008 under revised conditions, the Sum Insured was increased by Rs.85,000/- and the complainant had agreed to revised terms and condition effective from 2008. Revised policy conditions would apply to increase Sum Insured. As per the revised terms and conditions, cancer treatment is excluded for the first policy year. So the increase in sum insured is not effective for reimbursement of expenses incurred on treatment of Myeloblastic Leukemia (Blood Cancer

The complaint was dismissed since increase in sum insured was not effective due to clause 7.

Award dated 31.5.2010

Case No. 11-003-0067-11

Mr. Virendra M Shah

Vs.

National Insurance Co. Ltd.

The claim had been partially settled by Respondent by disallowing Rs.7115/- towards pre & post hospitalisation treatment of diabetes (DM) High

Blood Pressure (HBP) and Ischemic Heart Disease (IHD) on the grounds that complainant was operated for prostate gland and pre and post Hospitalisation expenses are not related to the disease for which he was hospitalised.

The Complainant underwent surgery for LUTS (Lower Urinary Track Syndrome) at Kidneyline Hospital, Ahmedabad on 16.11.2009. Claim for hospitalisation for an amount of Rs. 40000/ was settled by the Respondent under cashless facility as requested by the complainant. Subsequently complainant lodged claim for pre and post hospitalisation for an amount of Rs. 21020/- Respondent settled claim for Rs.13905/ and disallowed an amount of Rs. 6895/ being treatment for Diabetes and HBP and an amount of Rs. 220/ as no proper receipts were submitted. Total amount disallowed was Rs. 7115/.

Complainant submitted that he was positively suffering from diabetes, HBP and IHD before during and after the surgery and for any surgical operation conservative treatment is necessary. Treatment of DM, HBP and IHD was necessary because without control of such diseases surgery cannot be performed. Complainant further submitted that respondent gives false excuses that diabetes, HBP and IHD are not related to current disease.

Respondent submitted that the subject hospitalisation was for treatment of prostate gland and not for DM, HBP and IHD they have considered and paid expenses incurred for treatment of DM, HBP and IHD during the period of hospitalisation. They had only disallowed expenses incurred for DM, HBP and IHD for pre and post hospitalisation period as they were not related with current disease.

It revels that Complainant claimed for his routine medicine expenses for DM, HBP and IHD. The claim was in respect of LUTS. The respondent settled claim for treatment of DM, HBP and IHD during the period of hospitalisation.

Complaint was dismissed since Respondent justified in not paying for pre and post hospitalisation expenses in respect of DM, HBP and IHD

Award dated 31.5.2010

Case No. 11-008-0561-10

Mr. Kantilal P Panchal

Vs.

Royal Sundaram Alliance Insurance Co. Ltd

Mediclaim Policy

The Complainant was covered under the policy for Sum Insured (SI) of Rs. 150000/ with 30 % Cumulative Bonus (CB) thereon. The Complainant underwent left eye cataract surgery on 9.11.2009 and lodged claim for Rs. 25109/-.

The Respondent settled the claim for Rs. 7500/ being maximum limit for subject treatment as per terms and condition of the policy.

The complainant submitted that he renewed the policy continuously without any break since last three years however he is not aware about terms and condition of the policy.

The Complainant was covered under the policy since 2007 with a Sum Insurance (SI) of Rs 150000/. As per schedule of benefit of the policy C -6 Treatments relating to cataract are subject to a limit of Rs. 7500/ per policy.
Complainant's contention was not found tenable that he was not aware of the terms and condition of the policy. The policy issued to him gives all the terms and conditions of the policy and it was been renewed in continuation for the last 3 year.
The decision of the Respondent to settle the claim for an amount of Rs. 7500/- was justified as per terms and conditions of the Policy.

Award dated 31.5.2010

Case No. 14-003-019-11

Mr. Pukhraj Garg

Vs.

National Insurance Co. Ltd

Mediclaim Policy

The insured was hospitalised at Shalby Hospital, Ahmedabad from 27.10.2009 to 28.10.2009 for treatment of left knee osteoarthritis. Claim was lodged for Rs. 166809/ along with claim form and all requisite documents to TPA M D India on 27.11.2009 for which TPA M D India issued claim acknowledgement sheet.

The claim was neither settled nor rejected since November 2009. No evidence on record established communication from respondent after lodgment of claim.

The Complainant complied with all the requirements stipulated by the Respondent. By not settling the claim in time, it gets established that respondent has shown gross negligence and callousness in following Protection of Policyholders' Interests) Regulations, 2002 of IRDA.

Absence of any reasonable explanation for the inordinate delay and considering the facts of the case, relevant papers on record it proved that respondent was acted negligently and it was an apparent case of deficiency in service. The delay in settlement of the claim by the respondent was not justified.

Award dated 15.6.2010

Case No. 11-002-0101-11

MrS. Vidyotma a/s Vidya Halwai

Vs.

New India Assurance Co. Ltd

The claim had been partially settled by Respondent by disallowing a total amount of Rs.24029/- under various heads like room charges, Consultant's fee, Surgeon's charges, Anesthetist charges, O.T. charges etc. The complainant was entitled for reimbursement of medical expenses up to the limit of Sum Insured (SI) of Rs. 100000/- plus cumulative bonus of Rs.20000/-. The policy was renewed for the period from 19.04.2009 to 18.04.2010 is Mediclaim Policy (2007) where clause 2 of policy interalia states that reasonable customary and necessary expenses are reimbursable towards Surgeon, Anesthetic, Medical practitioner, Consultations and Specialist fees.

Respondent has stated that the amounts disallowed are due to the reason that patient has opted for a room with higher room rent than the entitled category as per policy clauses 2.3, 2.4 and 2.6 note 1. They have taken the Sum Insured in respect of the insured as RS. 100000/ and accordingly worked out the amount payable.

The Complainant had produced copy of circular dated 31.3.2009 Ref. HO/Health/ Circular-08/2009IBD/ADMN:24 issued by head of office the respondent issuing guideline for renewal of Mediclaim policy for senior citizen.

The circular interalia state that at the time of granting approval of Mediclaim Policy 2007, IRDA has stipulated that existing Senior Citizen, being the policy holders, shall not be compelled to migrate to revised product on renewal if it is to their disadvantage hence in such cases where senior citizen

have expressed their unwillingness for such migration their policies would be continued as per the old terms and conditions.

The revised policy (2007) was made applicable by the Respondent since August 2007. The above referred circular should have been issued simultaneously by the respondent so that the existing senior citizen policy holder could have option to renew their Mediclaim policies as per their willingness.

In subject case the complainant was deprived from availing the option and terms and condition of revised Mediclaim policy (2007) were not favorable to her.

There was on record an application dated 22.2.2010 made by the complainant to the respondent requesting to continue the policy as per old terms and condition of the policy they being the senior citizens

As per the directive of the IRDA complainant can not be forced to migrate to the revised Mediclaim Policy (2007) hence old terms and condition are applied to the subject policy. The subject claim is to be governed as per old terms and condition of the policy

The Respondent's decision to disallow a sum of claim Rs.17433/- from the claim amount was not justified.

Award dated 15.6.2010

Case No. 11-002-0113-11

Mr. Jayesh A Shah (Nagda)

Vs.

New India Assurance Co. Ltd

The claim was partially settled by invoking policy Clause 4.1 disallowing increase in Sum Insured with effect from 6.05.2005. As per clause 4.1 expenses incurred on treatment for Diabetes Mellitus and Hypertension are covered on payment of additional premium.

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It examined that the initial Sum Insured (SI) under the subject policy was Rs. one lac /- when the policy was incepted in 2001. The Sum Insured was increased by Rs. one lac in the year 2005 and it was again increased by

Rs. one lac at the time of renewal for the period from 06.05.2009 to 05.05.2010. The renewal was subject to the terms and condition of Mediclaim Policy (2007). Total SI under the policy was Rs. 3 lacs during the period when claim occurred.

The complainant underwent Coronary Artery Bypass Graft (CABG) on 13.8.2009. Discharge diagnosis was Coronary Artery Disease (CAD). Claim lodged by the complainant for reimbursement of Sum of Rs. 270933/ was partially settled by the Respondent for Rs. 100000/- on the grounds that complainant was suffering from diabetes since last six years i.e. prior to increase in sum insured in the year 2005 and the complainant had not declared about his pre existing diabetic condition while increase in Sum Insured in the year 2005 and 2009. Increase in SI in 2005 and 2009 was like a new insurance policy and hence benefit of coverage of pre existing diseases was not available due to nature of disease.

Since Insured did not disclose the history of diabetes at the time of increasing the SI in 2005 and 2009 nor did he pay any extra premium for diabetes at the time of renewal in 2009, the increase in SI is not applicable to the subject disease which was preexisting prior to increase and was not disclosed by the complainant.

The complaint was dismissed.

Award dated 24.6.2010

Case No. 11-002-0155-11

Mr. Govind R Bhatt Jimmy)

Vs.

New India Assurance Co. Ltd

INDIVIDUAL MEDICLAIM POLICY

The Complainant had acute inflammation and severe pain in his right breast, he consulted a doctor who advised him for surgery to remove his right breast to cure the disease. He produced certificate dated 4.2.2010 from treating

which states that the complainant was suffering from right breast Gynecomastia and had complaint of severe pain.

The claim was repudiated invoking clause 4.5 of the Mediclaim policy on the ground surgery performed was for cosmetic purpose hence the claim is inadmissible.

The forum took an independent opinion from a specialist who opined that complainant was operated for a lump in the right breast of 4.3 cms size. This is a medical condition and its removal cannot be termed as a cosmetic condition.

The respondent was directed to pay the claim.

Award dated 15.6.2010

Case No. 11-002-0214-11

Mr. Nitin C Sharedalal

Vs.

New India Assurance Co. Ltd

INDIVIDUAL MEDI CLAIM POLICY

The claim was repudiated by invoking Clause 3.4 on the grounds that Oral Chemotherapy is not covered under the policy. The policy covers expenses incurred for Parenteral chemotherapy for which time limit of 24 hours hospitalisation is not applicable.

It was observed that Complainant was not hospitalised and claims are for reimbursement of Oral Chemotherapy and various diagnostic test, the respondent decision to repudiate the subject claim was justified.

Award dated 21-07-2010

Case No.11-003-0304-11

Mr. Rajendra A Shah

Vs.

Natioanal Insurance Co.Ltd.

Mediclaim Policy

A Claim for Morbid Obesity System was repudiated as the treatment excluded under exclusion clause 4.19

It was confirmed that Repudiation ground of Morbid Obesity is correct the Respondent was justified in repudiation.

The case was thus dismissed.

Award dated 21-07-2010

Case No.11-005-0310-11

Mr. Lalbhai N Prajapati

Vs.

The Reliance General Insurance Co.Ltd.

Mediclaim Policy

The repudiation was affected invoking clause 5.9 alleging misrepresentation with regard to claim particulars. The Respondent has based his opinion on the strength of the investigation done by Third party administrator (TPA). Which says that insured was present in the school on 20.8.2009, however as per hospital record he was hospitalized on 20.8.2009 at the hospital.
Since the allegation leveled by the respondent was supported by the evidences the Respondent was justified in repudiation.

Award dated 30-08-2010

Case No. 11-002-0435-11

Mr. Bhupendra Morakhia

Vs.

The New India Ass. Co.Ltd.

Mediclaim Policy

The dispute was about non consideration of Cumulative bonus of Rs. 66,250/-

The respondent explained that as per the Mediclaim policy 2007 incase of a claim under the policy on renewal of policy for next year cumulative bonus earned under the policy shall be withdrawn. Since there was claim in the preceding policy year 2007-08, on renewal of the policy for the year 08-09 there was no cumulative bonus as per the terms and condition of the policy. By mistake cumulative bonus under the policy was not deleted from the policy bond while the policy was renewed for the year 08-09.

Since a claim under the policy in the policy year 2007-08 and there was no cumulative bonus for the policy on renewal for the year 2008-09 and decided that the complainant can not have benefit from the mistake of the respondent.
The complaint was dismissed.

Award dated 30-08-2010

Case No. 11-004-0378-11

Mr. Nitinbhai Bhatt

Vs.

United India Insurance Co.Ltd.

Mediclaim Policy

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

The subject policy covers all preexisting diseases after 30 days of from the inception of the policy without any loading or exclusions for preexisting diseases. So there was no apparent cause for willful nondisclosure of preexisting disease by the complainant. The underwriting decision of insurer is not affected by the non discloser of preexisting disease.

The clause 9 (a) of agreement between the Respondent and the Master Policy Holder in very clear terms states that New Entrants (insured for the first time) : All preexisting diseases will be covered after 30 days with certain exceptions, the subject disease is not part of these exceptions. This clause does not qualify that a preexisting disease has to be declared by the proposer

Respondent's contention that the claim is not payable due to non declaration of the preexisting disease at the time of inception of cover was not found tenable as neither in the agreement nor in the policy conditions it has been specified that all preexisting disease are to be declared to avail the cover. There was also no specific question in the proposal form asking for declaring preexisting diseases eligible to be covered under the policy. Instead the question asked is "Have you ever suffered from any diseases" which is not relevant looking to the special provision of the policy.

So the respondent's decision to repudiate the claim invoking exclusion clause 4.1 of the policy was not justified.

The respondent was directed to pay the claim.

Award dated 30-08-2010

Case No. 11-009-0308-11

Mrs. Darshnaben Gajjar

Vs.

Reliance Gen. Insurance Co.Ltd.

Mediclaim Policy

Claim for hospitalization was repudiated by invoking clauses 21. The Respondent explained that the Complainant was admitted for diagnostic purpose and rest. The complainant had not submitted X-Ray and CT Scan reports. Respondent further explained that treatment papers confirm that complainant was given only oral medicines and not provided with any such active line of treatment for which hospitalization was required.
It observed that the complainant was treated for accidental injury over left Knee. According to indoor case papers complainant underwent X-ray and CT Scan however complainant had not submitted X-ray and CT Scan reports which can give exact nature of injury. Treatment papers bring out that the Complainant was treated at Krupa Hospital, Surat on OPD basi

Award dated 30-08-2010

Case No. 11-009-0439-11

Mrs. Ushaben J Kataria

Vs.

Reliance Gen. Insurance Co. Ltd.

Mediclaim Policy

A claim for hospitalization for total knee replacement surgery was repudiated on the grounds of pre-existing disease.
Respondent alleged that as per discharge summary of Wockhardt hospital and last page of RGIL claim form complainant suffered arthritis since 4-6 years but the duration was changed by erasing and same was authenticated by signature

The decision under the case depends upon the verification of the truth as to the history recorded by the hospital it has to be obtained on the strength of an affidavit and proper legal procedure will be required which is beyond the jurisdiction of this forum.

The complainant was advised to take recourse to any other forum as may be considered appropriate.

BHOPAL

CATEGORY: MEDICLAIM

SUB CATEGORY: TOTAL REPUDIATION OF CLAIM

Shri Nawab Khan……..……..…..……..….Complainant

V/s

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

Order No.: BPL/GI/1011/001 **Case No.: GI/RSI /0911/68**

Order Dated 5.04.2010

Brief Background

Mr. Nawab Khan (hereinafter called Complainant) was covered under Hospital Cash Insurance Policy No. HCSBIL0012 for the period from 31.12.08 to 30.12.09 for Daily benefit for Rs. 3000/- and Hospital Benefit Plus Insurance Policy No. SN00000925000100 for the period from 18.10.08 to 17.10.09 for Hospital confinement Daily benefit for Rs. 1000/- with convalescence benefit Rs. 15000/- and Health Shield Insurance Policy No. HLSBIL0013 for the period from 18.5.2008 to 15.5.2009 for S.I. Rs. 100000/- issued by M/s Royal Sundaram Alliance Insurance Co. Ltd., Chennai. (Hereinafter called Respondent)

As per the complainant the three Insurance policies are issued by Respondent through Credit card and there were claims for the treatment for the hospitalization period from 14.4.2009 to 9.5.2009 at Ayush Hospital, Bhopal were submitted to Respondent but all three claims are rejected and the Policies are also cancelled. The complainant further approached the higher office of Respondent vide letter dated 2.9.2009 but instead of settlement of claims, the Policies cancelled by Respondent. Aggrieved with the attitude and decision of the Respondent, he approached this office for necessary settlement of his claim for Rs. 170553/- for Claim and Rs. 15000/- for the Cancellation of Policy.

As per self contained note dated 18.01.2010 along with Hospital record and Investigation report etc. the Respondent submitted that a claim on 8.6.2009 was made for the undergone treatment for enteric fever and on investigation found that there are lots of gross discrepancies and inconsistencies in the subject claim those discrepancies were not corroborating WITH ACUTAL FACTS HENCE IT WAS CONDLUDED THAT THE CLAIM BEING MADE BY THE COMPLAINANT IS FRAUDULENT IN Nature. The Respondent by highlighting the facts of Investigation report further mentioned that as per the statement of complainant he was suffering from fever since last 2 days prior to hospitalization while as per the Discharge summary of Hospital the complainant was admitted in the hospital with history of nausea, weakness and

fever with chill for the last 10 days prior to admission. Similarly, on scrutinizing the indoor case sheets it is found that they are made in one go and even the fabricated papers are not fabricated to perfection as it apparent from the record that the date mentioned in the vital charts record is 5.4.09, 6.4.09, 7.4.09, 8.4.09 and 9.4.09 which are the dates when the complainant was not even admitted to the Hospital, in case of enteric fever the pulse is thready which is not shown in this case and the treating doctor has not written his day to day comments in the indoor comments in the indoor sheets although the patient was alleged to be admitted in the hospital from 14.04.09 to 09.05.2009 moreover, the fees charged by the doctor are for only 5days. The Respondent further mentioned that from the above facts it is apparent that the complainant has fabricated the alleged hospitalization records and stage managed to hoodwink to gain unlawfully from the Respondent therefore, the claims are repudiated apart from the canceling the Policy as the Fraud vitiates the contract of Insurance as per the Policy condition **"No liability under the Policy will be admitted, if claim is fraudulent or supported by fraudulent means".** It is prayed in Self contained note by Respondent to dismiss this instant complaint.

Observations:

There is no dispute that the complainant was covered under the above mentioned Policies for daily benefits and for medical expenses. During the course of hearing the Complainant reiterated all the points as mentioned in his complaint letters and specifically stated that the claims are repudiated on the false ground and and requested this forum for the settlement of claim for Rs. 170543.00 and also for the refund of Premium for the cancelled Policies. On the other side the Respondent stated that as per the indoor Nursing chart the patient was admitted in the hospital for 4.4.2009 to 9.4.2009 while the claim was lodged for the hospitalization period 14.4.2009 to 9.5.2009 similalry, the attending doctor visited and charged for only **5 days** which indicates that the claim is made by fraudulent means. On asking the respondent shown the Photocopy of indoor Nursing chart in support of his version. On going through the above produced Nursing chart it is observed that it is not the full impression of original paper as the date starting portion is not clear in the produced Photocopy, then the forum asked the respondent to produced original copies as obtained by their investigator from the Hospital to check the factual information about the actual dates of Admission etc. for which the respondent shown his inability as the same are not presently available in the file. The forum also asked the Respondent to submit specific and concrete evidence establishing that the documents produced

for claim by complainant are fabricated or by fraudulent means, the Respondent asked for **some time** to produce the same. Similarly, the Complainant also stated that the photocopy of indoor nursing chart as shown by Respondent are incomplete and surprisingly expressed that he was admitted for the period from 14.4.2009 to 9.5.2009 then how hospital can give Nursing chart for the period from 4.4.2009 to 9.4.2009 and also questioned the Respondent that the above chart may pertain to other patient record as there is no name is mentioned in the Nursing chart. The complainant also stated that he will also try to obtain the above information from Hospital and asked some time for the submission of same. At the request of both parties, the forum allowed next date of **01.04.2010** to both the parties to submit the relevant evidence/hospital documents in support of their statement. **On 01.10.2010** both the parties appeared in the forum. The forum first asked the Respondent for the submission of document for which the extension of time was sought. **There are no document submitted** by Respondent but stated that as per the indoor papers it found that the chart is prepared by one person only and the temperature recorded is also found constant. The forum again asked the respondent to submit any proof/document to establish that the patient was not admitted for the period from 14.4.2009 to 9.5.2009 and also to prove that the submitted claim documents are forged &/or made by fraudulent means, the respondent did not submit any document. The forum again asked the Respondent to justify that why this claim is not payable? In response, the Respondent did not reply in positive but reiterated that the claim is not admissible as per the Investigation report of investigation Agency deputed by them only. On the other side the Complainant submitted a certificate issued by Dr. S. Chakrawarti, Director of Ayush hospital & Research Centre along with Case sheet and Nursing Chart duly signed by Hospital. I have personally gone through the above documents produced by complainant and found that the complainant was admitted in the hospital for the period from 14.04.2009 to 09.05.2009 for complicated falciferum Malaria with viral hepatitis (jaundice). The forum asked the Respondent about the payable claim amount under the above policies if otherwise the claim is payable, the respondent stated that he has no calculation. Similarly, the Respondent was also asked that the claim is submitted by complainant for Rs. 170543/- for **daily cash benefits** and **medical expenses** and for **Convalescence Benefit** whether there are any restriction in the No. of days for daily cash benefit or any exclusion is being operated under the above produced claim? The Respondent could not deny firmly about the above coverage and even Policy condition is not submitted.

Under the circumstances explained above, it is established that the decision of Respondent to Repudiate the bove claim and cancellation of Policy as well **is not Just and Fair** as there are sufficient documents **viz. Case sheet, Nursing chart, Pathological reports, Bills from**

Chemist, Discharge card and Dr. Certificate etc. to establish that the complainant was admitted in the hospital for the period from 14.4.2009 to 9.5.2009 for the treatment of Malaria and Jaundice while on the other side the Respondent found failed to substantiate their decision i.e. there is no establishment that the claim is fraudulent or supported by fraudulent means. Therefore, the respondent is **directed to pay the claim for Rs. 169837/-** as found payable as per the claim documents submitted by complainant under the coverages available in the Policies and also **to restore the Cancelled Policies** for the remaining Policy Period **within 15 days from the date of receipt of consent letter from the complainant,** failing which it will attract a simple interest of **9% p.a.** from the date of this order to the date of actual payment.

==========end==========

Category: Mediclaim
Sub Category: Total Repudiation of claim

Dr. Shriniwas Toshniwal.....Complainant
V/s
National Insurance Co.Ltd., D.O.IV, Indore.....Respondent

Order No.: BPL/GI/10-11/002 **Case No.: GI/NIC/1002/115**
Order Dated 6.04. 2010

Brief Background

Shri Shriniwas Toshniwal (hereinafter called Complainant) had obtained a Mediclaim Policy No. 321700/48/07/850003467 for S.I of Rs. 50000/- for the period from 10.03.2008 to 09.03.2009 including his wife Smt. Prabha Toshniwal from National Insurance Co. Ltd., D.O.4, Indore. (Hereinafter called Respondent)

As per the Complainant a claim for his wife Smt. Prabha Towhiniwal for the hospitalization in Yashlok Hospital, Indore for the period from 19.06.2008 to 6.10.2008 for the diagnosis of Fracture rt. Tibia fibula, Paralysis, Hypertension for Rs.69831/-was submitted to TPA of Respondent which is rejected by them. The complainant further approached the Regional Office of Respondent vide his registered letter dated 25.4.2009 but there also no response.

Aggrieved with the Repudiation of claim for Rs. 69831/-, the complainant approached this forum for the settlement of claim.

As per Self Contained note dated 18.02.2010 along with other claim related documents submitted by respondent that after receiving the claim intimation and claim papers their TPA E-Meditek Solutions Ltd. has scrutinized and observed that for fracture of Rt. Tibia the Plaster of Paris was given and for Paralysis, Depression and Hypertension the Monitoring and Physiotherapy was done. The Respondent further mentioned that they sought the Medical Opinion from Panel Dr. K.G.Agarwal who has also opined that the patient was hospitalized due to fracture in Leg and only Plaster of paris was given which is only an OPD procedure and Hospitalization is not required for the same. The Respondent further mentioned in the self contained note that as per the IPD record the doctor has not given any Active Treatment nor the patient has obtained nor complained for any sickness or Illness and also that the IPD record is not updated and or manipulated and the documents suggests that the Hospitalization was done only for **Nursing Care** and not for the Active Treatment. It is further mentioned that as per Discharge Summary the patient was under Physiotherapy treatment for which hospitalization is not necessary. It is further concluded by Respondent that the claim is not payable under the condition No. 4.10, 4.27, and 4.22 of the Policy.

Observations:

There is no dispute that the complainant's wife was covered under the above-mentioned policy and was hospitalized for the period from 19.6.2008 to 06.10.2008 at Yashlok Hospital Indore for the diagnosis of fracture upper 1/3 of Tibia and Fibula bone with Hypertension, Depression, Paralysis etc. During the course of hearing the Respondent stated that as per the documents provided by complainant and Hospital record the patient was admitted in Yashlok Hospital on 19.6.2008 under Dr. J.B. Lahothy, M.S. (Ortha.) for the treatment of Rt. Tibia fracture for which Plaster of Paris was given and for Paralysis, Depression & Hypertension the Physiotherapy and Monitoring was done but no active treatment was given which falls under the category of exclusion clause No. 4.22 "the Stay in hospital for domestic reason where No active regular treatment is given by specialist. The Respondent further stated that even in case of Fracture there is no need of Hospitalization as only Plaster of Paris is caste. On asking the Respondent produced the day to day indoor record of Yashlok Hospital and stated that as per the remarks/noting of the sheet it is clear that there was no active regular treatment for any disease

and no surgery done but simply Nursing care is done for more than **3 months** which indicates that the patient was hospitalized for the **Nursing care** only and not for any active treatment which can be given at home also as commonly done in the other similar cases of Fracture, Depression, Hypertension and Paralysis cases etc. On asking the Respondent stated that though the TPA is a team of expert of Medical line even than they sought the Medical opinion from Dr. K.G.Agarwal, M.B.B.S to know the factual position in above case and as per the his Medical Opinion report the Plastering of Fracture is only OPD procedure and Hospitalization is not required. The Opinion report of K.G.Agarwal is also submitted by respondent where it is opined that "hospital record is showing that Hospitalization was done only for Nursing Care and not for the Active Treatment". The forum asked the question from Respondent that it is a Renewal of previous Policies continued from more than 6 years and the Disease of Paralysis, Depressions etc. are not in nature of pre-existing and even if the Hospitalization was done for the above mentioned diseases than why the hospitalization expenses for above diseases are not payable? It is clarified by Respondent that there is no issue of Pre-existing disease but for the necessity of Hospitalization and applicability of Policy exclusion clause No. 4.10, 4.22 & 4.27 as in the above case there was no requirement of Hospitalization being **no active regular treatment given** and or the hospitalization for the duration of more than 3 month is found to be for the **Nursing care only** which is not covered under the preview of issued Mediclaim Policy. I have gone through the Policy condition as produced by Respondent and found that Condition No. No. 4.22 states "Stay in hospital for domestic reason where no active regular treatment is given by specialist" while exclusion condition No. 4.10 states "Expenses incurred primarily for evaluation/diagnostic purposes not followed by active treatment during hospitalization while the condition No. 4.27 states that "Treatment which the insured was on before hospitalization and required to be on after discharge for the ailment/disease/injury **different from the one for which hospitalization was necessary"** On asking the Respondent stated that however the actual expenses incurred for the treatment of Fracture in Tibia and Fibula Rt. Leg may be considered under the scope of Policy being the main reason for hospitalization. On asking the Respondent explained that as per the produced Bill from Hospital and Cash memo for medicines etc. the expenses for treatment of fracture may be in between 5000/- to 7000/- approximately. I have also gone through the Hospital bill No. 31 dated 6.10.2008 and observed that out of total bill for Rs. 56900/- (before Service Tax) **Rs. 55000/- are charged for Room Rent and Dr. Visit charges** and only Rs. 1900/- are charged for Plaster and Catheterization.

In view of the circumstances stated above and on going through the various documents made available by both the parties, it is found that the decision for repudiation of above claim taken by Respondent is **just & fair** under the Policy condition No. 4.10, 4.22, & 4.27. However, the Expenses incurred for the treatment of Fracture Rt. Leg found payable under the scope of Policy. Therefore, the Respondent is directed to pay Rs. 7500/- only (Rupees Seven Thousand Five Hundred) to the complainant as lump sum **for the expenses of treatment for fracture only** within **15 days** from the **date of receipt of consent letter from the complainant,** failing which it will attract a simple interest of **9% p.a.** from the date of this order to the date of actual payment.

==========end==========

CATEGORY: MEDICLAIM

SUB CATEGORY: TOTAL REPUDIATION OF CLAIM.

Mr. Ashok Kumar Jain……. ……..…….Complainant

V/s

National Insurance Co. Ltd., Indore D.O.……Respondent

Order No.: BPL/GI/10-11/03 Case No.: GI/NIC/1002/114
Order Dated 6.04.2010.

Brief Background

Mr. Ashok Kumar Jain (hereinafter called Complainant) informed that he had obtained Sampoorna Suraksha Bima Policy No. 321700480835000002130 covering his wife Smt. Shobha Jain for the period from 25.10.2008 to 24.10.2009 for Sum Insured of Rs. 1,00,000/- from National Insurance Co. Ltd., Indore (hereinafter called Respondent).

As per the complainant his wife was hospitalized in Shreepad Hospital, Indore for the period 20.10.2009 to 21.10.2009 with the complaint of pain in abdomen, loose motion and vomiting since 5-6 days. The treating Doctor diagnosed her as “Acute Gaestroenteritis with dehydration”. After discharge from the hospital, he preferred a claim for Rs. 6054/- to the Respondent’s TPA E-Meditek, Indore who repudiated the claim vide letter dated 10.11.2009 on the ground that the patient was not found in the hospital during physical investigation after intimation of hospitalization. He made an appeal with the Respondent vide his letter dated 25.11.09 but in

vain. Aggrieved with the decision of the Respondent's TPA, he approached this office for necessary settlement of his claim.

The Respondent in its reply-dated 18.02.2010 stated that the Complainant had lodged a claim of his wife Smt. Shobha Jain against pain in abdomen, loose motion and vomiting since 5-6 days and hospitalized in Shripad Hospital, Indore for the period 20.10.09 to 21.10.09. After receipt of claim intimation and claim papers, it's TPA M/s E-Meditek Solutions Limited has scrutinized all the claim papers but during the physical verification of the patient neither the patient was available in the hospital nor the hospital authorities were able to provide IPD papers to the TPA. The Respondent sought report of another panel doctor Mr. K.G. Agrawal where he revealed that the patient was treated by I.V. Fluids, Antibiotics and other supportive medicines and the fact that the Acute Gastro Intestinal controls in about 48 hours after administration but she was discharged from the hospital before 48 hours. It reiterated that the patient was hospitalized in the same hospital for six times in a year for the same diagnosis. Finally it is concluded by Respondent that looking to the TPA record, past claim experience and report of its panel doctor, the facts leads to that the patient was not available in the hospital, six claims were already taken by the complainant for the same illness. Hence being the fraudulent claim, the company shall not be liable to make any payment under general condition No. 7 of Sampoorna Suraksha Policy.

Observations:

There is no dispute that the Complainant was covered under the above-mentioned policy. During the course of hearing the Respondent presented the claim intimation letter dated 21.10.2009. In the intimation there was an endorsement made by Mr. Ganesh Mishra of E-Meditek Solutions Ltd., Indore dated 21.10.2009 at 5.10pm **that he supported with one Mr. Anubhav of M/s E-Meditek visited M/s Shripad Nursing Home, Indore for physical verification but the patient was not found in the hospital and there was no record for hospitalization of the patient Mrs. Shobha Jain**. Further the Respondent submitted that the complainant was paid claim amount of Rs. 23478/- during 2007-2008 and Rs. 17897/- during 2008-09 for the same hospital and same treatment. Being fraudulent claim, the Respondent repudiated the claim under general condition No. 7 of the Sampoorna Suraksha Bima. I have

gone through the evidences submitted by the Respondent which shows that the patient was not found in the hospital and nothing was recorded in the hospital for the admission of the patient. Further I have gone through the expert opinion of Dr. K.G. Agrawal submitted by the Respondent who opined that the Acute Gastro Intestinal control takes about 48 hours after administration of antibiotics but the patient was discharged before 48 hours which creates doubts about the admission of patient in the Hospital.

In view of the circumstances stated above and on going through the documents as made available by both the parties, it is found that the decision of the Respondent to repudiate the above claim is **fair and justified.** I found no reason to intervene with the decision taken by the Respondent. Hence the complaint is dismissed without any relief.

==========END==========

Category: MEDICLAIM SUB CATEGORY: TOTAL REPUDIATION

Shri Kamlesh Mundra…..…….……Complainant

V/s

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

Order No.: BPL/GI/10-11/004 Case No.: GI/OIC/0912/084
Order Dated 7.04. 2010

Brief Background

Mr. Kamlesh Mundra (hereinafter called Complainant) had obtained Mediclaim policy No. 152890/48/2009/50259 for S.I of Rs. 75000/- for the period from 22.09.2008 to 21.09.2009 covering his wife Smt. Ranjna Mundra from The Oriental Insurance Co. Ltd., Itarsi Branch (Hereinafter called Respondent)

As per the Complainant the claim papers were submitted to TPA but the claim is closed as no claim by them without intimation to him and no communication done by TPA. The complainant further mentioned that the documents being desired by TPA are not available with him though the claim in previous was settled by old TPA. The complainant further approached to the higher

offices of Respondent but there also no action taken. Aggrieved with the above and non settlement of claim for Rs. 63558/-, complainant approached this forum for settlement of claim.

As per self contained note along with the various claim related documents, the Respondent submitted that the patient was suffering from cancer disease from 2005 while the Policy is issued w.e.f. 22.09.2005 causing pre-existing disease at the time of first Insurance which was not disclosed by Complainant in the Proposal form thus non-disclosure of material facts has violated the principle of Utmost Good faith also. The Respondent further mentioned that their TPA vide their letters dated 23.4.09, 30.04.09 & 7.5.2009 requested complainant to submit the Histopathology report but the previous medical documents and Policies etc. but not submitted by complainant even till today which is also contravene the Policy condition No. 5.6 hence the claim is not settled for non-compliance, non-cooperation in the submission of Histopathology report.

Observations:

There is no dispute that the complainant's wife Mrs. Ranjana Mundra was covered under the above-mentioned policy for S.I. Rs. 75000/- and was admitted in Bombay Hospital and Medical Research Centre, Mumbai for the period from 24.3.2009 to 3.4.2009 for the 2 Cycle of Chemotherapy for the diagnosis of Cancer Ovary Rt. Side for which the claim for Rs. 63558/- was submitted to TPA M/s Dedicated Health services Pvt. Ltd. During the course of hearing the complainant reiterated almost all the points as mentioned in the complaint letters and specifically stated that his wife is suffering from above disease since 2005 and all the relevant documents for above claim were submitted to TPA but **there is no communication** from TPA and the claim is closed by them. The Complainant also stated that there were two claims for same disease are settled by Respondent but this claim is not being settled. On asking the complainant disclosed that the disease was first detected in **August 2005 or October 2005**. On asking the Complainant also disclosed that the first Insurance Policy was obtained in year 2004. The forum asked the Complainant to produce the Histopathology report and or other Medical report/document through which the above disease i.e. Cancer was detected, the complainant stated that it is not available with him. Then the forum again asked the complainant that why such important report is not available with him when the above report is very important for the long treatment of such kind of disease? The Complainant could not reply

in positive. Similarly, the forum also asked the complainant to submit the first Policy as said to be obtained in the year 2004, the complainant stated that it is also not available with him. On the other side the Respondent stated that the above Policy was first issued in the year 2005 **w.e.f.22/9/2005** and as per discharge summary of Bombay Hospital, Mumbai in respect of Admission in the Hospital for the period from **7.5.2008 to 10.5.2008** it is mentioned in the column of **History** that the **patient is a known case of Cancer Rt. Ovary and received 6 cycles of Chemotherapy in 2005**. Since the first Policy was issued on 22.9.2005 and patient received 6 cycles of Chemo in 2005 therefore, the Histopathology report was asked by their TPA to confirm whether it is a case of Pre-existing or not but the Complainant is not providing the above report in spite of reminder letter dated 23.4.2009, 30.04.2009, 7.5.2009 and even requested vide letter dated 7.11.2009 by their TPA. The Respondent further added that due to non submission of above Histopathology report by the complainant which is a vital document to decide the fate of claim, the claim deserves to be No claim. The Respondent also stated that the statement of Complainant about **No communication from their TPA** to complainant is **not true** as the complainant himself mentioned in his letter dated 15.5.2009 written to TPA by him that **this letter has reference your letter dated 23.4.2009** which were written by TPA to complainant for the compliance of previous Policies and previous hospitalization and medical records. The forum also asked the question to complainant whether there was any claim **pertaining to the diagnosis and treatment done in year 2005** was lodged with Respondent for the Reimbursement? The Complainant replied that the claim was **not lodged**, then, the forum questioned why the claim was not lodged for such huge expenditure when as per him the Policy was in force since 2004**?** The complainant could not reply in positive but stated that earlier two claims are paid by other TPA of Respondent for the same disease. On the other side the Respondent explained that every claim has its own merits and as per Policy record available in the File the first Insurance Policy is in operation since 22/9/2005 only and if the disease is detected in **August or October, 2005** then the disease is falls either Pre-existing clause or under first year exclusion clause.

In view of the circumstances stated above, it is found that Non settlement of above claim by Respondent **is Just and fair** as the claim related vital information i.e. Histopathology report and previous Insurance Policies are not being provided by the complainant neither to the Respondent nor to this forum. I am also of the opinion that it is the duty of complainant to provide/submit all the claim related important document to Respondent in support of his claim for the Reimbursement of any benefit covered under the Mediclaim Policy, for which the

complainant found fail in the above case. Therefore, the complaint is dismissed without any relief.

==========end==========

CATEGORY: MEDICLAIM
SUB CATEGORY: TOTAL REPUDIATION OF CLAIM
Mr. Liyakat Hussain Saify…….....Complainant

V/s

M/s Iffco Tokio General Ins. Co. Ltd., Bhopal……. ……Respondent

Order No.: BPL/GI/10-11/05 Case No.: GI/ITG/1109/78
Order Dated 9.04.2010

Brief Background

Mr. Liyakat Hussain Saify, (hereinafter called Complainant) had Mediclaim Policy No. 52048665 for the period 01.07.2007 to 30.06.2008 for Sum Insured Rs. 5,00,000/- from M/s Iffco Tokio General Insurance Co. Ltd. Bhopal (Hereinafter called Respondent).

As per the complainant he was in the book of the Respondent right from 1.07.2005 to 30.06.2009. He was hospitalized in Bombay Hospital, Indore on 02.06.08 for presenting complaint of burning inictuntion with increased frequency of urination and intermittent low grade fever since 4-5 days and discharged on 04.06.2008. He was diagnosed having cystitis with ? Prostitis with Febrile UTI with Systemic Hypertension Allergic Bronchitis with rhinorrhea with Chronic Gastritis. After discharge from the hospital, he preferred a claim with the Respondent's TPA Paramount Health Services Pvt. Ltd. Delhi. The TPA asked separate certificate from treating doctor of Bombay Hospital, Indore inspite of discharge certificate regarding the duration of hypertension, duration of recurrent UTI and the cystoscopy done in part. A certificate dated 19.09.2008 of Dr. Vivek Jha of Bombay Hospital, Indore was submitted stating that the UTI problem was cured of the symptoms and that cystoscopy was done approx. 4 to 5 years back and the present symptoms appeared during 6-7 months ago. He pleaded that there is no condition or exclusion printed or attached with the policy which would state the terms of pre existing disease. But there was no response from the Respondent. Aggrieved with the delay in settlement of claim, he approached this forum for settlement of his claim.

The Respondent vide its letter dated 01.04.2010 submitted that complainant hospitalized from 2nd June,2008 to 4th June,2008 as a case of recurrent urinary tract infection, Prostitis and gastritis. In discharge summary the patient is a case of chronic Gastritis for the past 5-6 years and has underwent cystoscopy 4-5 years back confirming that ailments existed prior to the inception of the policy with ITGI. As the client has not completed 3 years prior to the claim hit and there was only 2 policies prior to the current policy with them, the claim was processed and denied under the exclusion no. 1 of what is not covered under the Head Pre-existing condition. It also repeated that pre-existing condition is covered only if the insured person has maintained an individual Medishield Insurance Policy with them for a consecutive 3 year period prior to the present Policy coverage and no claim, care, treatment or advice has been recommended by or received from a medical practitioner in relation to such pre-existing condition during that 3 year period.

Observations:

It is an admitted fact that the complainant was covered under Medishield Policy No. 52048665 taken from the Respondent for the period 01.07.2007 to 30.06.2008. The complainant was admitted in the hospital for complaint of burning inictuntion with increased frequency of urination and intermittent low grade fever since 4-5 days. The patient was under treatment of Dr. Vivek Jha, Urosurgeon of Bombay Hospital, Indore. During hearing the complainant submitted that the claim was for U.T.I. which was 6-7 months old as per Dr. Vivek Jha certificate dated 19.09.2008. The certificate was taken on record. The Respondent referred to the history of Discharge Summary of Bombay Hospital, Indore where the patient was of recrrent UTI on treatment. Prostitis for which Cystoscopy was done in past. Chronic Gastritis since 5-6 years, endoscopy at multiple occasions showed antral gastritis. Recurrent episodes of URTI taken antibiotics off & on. On the other hand the history shows that the patient was no H/o DM/Br.Asthma/PTB/IHD, No H/o bowel dysfunction/LOC/Seizures/Limb weakness, No H/o known drug allergy/Dysarthris/Diplopia, No H/o any surgery in past.

I have also gone through the certificate dated 19.09.2008 of treating Dr. Vivek Jha who confirmed and replied the queries of TPA letters dated 24.07.08,15.09.08, 30.09.08 and 03.11.08 that the duration of patient Hypertension is 5-6 months and suffering from recurrent UTI since 6-7 months, past H/o cystoscopy approx. 4-5 years back and patient was cured of his symptoms in between. Further the patient was giving H/o allergic bronchitis from 6-7 months

which is more relevant than the Discharge summary. During hearing when the Respondent was asked about the complainant's prior treatment claims from the inception on their books i.e. 01.07.2005, it could not submit any claim details. It seems that in the present case the papers submitted by the complainant were not taken care and the Respondent's view was focused only on cystoscopy which was done 4-5 years back and which doesn't relate to present complaint.

In view of the circumstances stated above, it is found that the decision of the Respondent to repudiate the claim is unfair and unjust. In the instant case, the Claim repudiated due to wrong interpretation of policy conditions. The reason mentioned by the Respondent does not prove the documentary support in this complaint. Hence, the Respondent is directed to settle the claim for Rs. 33243/- under the policy within 15 days from 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==========

CATEGORY: MEDICLAIM: SUB CATEGORY: TOTAL REPUDIATION

Mr. Kunal Das Gupta……..Complainant
V/s
National Insurance Co.Ltd. D.O.IV, Indore…….....Respondent

Order No.: BPL/GI/10-11/007 **Case No.: GI/NIC/0912/089**
Order Dated 12.04. 2010

Brief Background

Mr. Kunal Das Gupta (hereinafter called Complainant) had obtained a Mediclaim Policy No. 285200/48/08/8500000112 for S.I of Rs. 100000/- for the period from 24.07.2008 to 23.07.2009 including his wife Smt. Anuradha Das Gupta from National Insurance Co. Ltd., D.O. Bhilai, (Hereinafter called Respondent)

As per the Complainant he is a Policy holder from 23.3.1999 and a claim for his wife for **Hysterectomy Operation** done on 26.2.2009 for Rs. 33000/- was lodged with Respondent but instead of settlement it is informed by Respondent that there is a break in the Policy. The complainant further mentioned that it was never informed to him that there is a break in insurance as there was no reminder for Renewal of Policy was given and it was also not informed that it is a fresh Insurance. The complainant also mentioned that prior to coming to

this forum he approached to National Consumer Forum, Delhi where it was advised to first go to the Insurance Ombudsman then he registered his complaint in this forum and also clarified in writing that there is no other complaint registered for this case in any other court/forum except this forum. The Complainant further approached to the higher office of Respondent vide his letter dated 9.10.2009 but there also no response. Aggrieved with the Repudiation of claim for Rs. 33000/-, the complainant approached this forum for the settlement of claim.

As per Self Contained note dated 23.12.2009 submitted that the claim for the hospitalization at Suraj Hospital for the period from 25.2.2009 to 2.3.2009 for total Abdominal Hysterectomy with Bilsalphino ophorectomy. It is added that the claim was under Policy issued for the period from 24.7.2008 to 23.7.2009 which was not get renewed in continuation to its expiry hence the above police is treated as a Fresh Policy/first year of Insurance and the Policy contains the clause No. 4.3 where during the first two year of Operation of Policy, the expenses relating to Hysterectomy and Genito-urinary surgeries are not payable and accordingly the claim was repudiated. It also confirmed in the self contained note by Respondent that **there is no notice is received in the above case from any Consumer forum till today** and only notice is received from Insurance Ombudsman, Bhopal.

Observations:

There is no dispute that the complainant's wife was covered under the above-mentioned policy and was hospitalized for the period from 25.2.2009 to 2.3.2009 where Abdominal Hysterectomy was done on 26.2.2009. During the course of hearing the complainant reiterated almost all the points as mentioned in main complaint letters and stated that at the time of insurance of above Policy in 2008 it was never informed by Respondent that it is a fresh Insurance and also there was no Reminder letter was sent by the Respondent for the renewal of above Policy before expiry therefore the policy should be treated as Renewal and not fresh one. On asking the Complainant stated that during last 10 year of Insurance there was no renewal notice was sent by Respondent to him and the earlier insurances were also obtained by him by giving the Premium to authorized representative of Respondent. On asking the complainant also stated that the above insurance is obtained by him by giving Premium Cheque to Respondent and not by cash. On the other side the Respondent also confirmed that stated that the earlier Policy was valid upto 5.5.2008 and the above Policy in question is issued for the period from 24.7.2008 to 23.07.2009 only after receiving the Premium cheque No. 243935 dated 22.7.2008 drawn on

Central Bank of India for Rs. 4293/- from the complainant. It is also stated by Respondent that there is Break in Insurance for 2 months and 20 days therefore the Policy is not a Renewal of Old policy but a contract of fresh Insurance. The Respondent further stated by showing the Policy copy that since it was treated as Fresh Policy hence the Cumulative Bonus was not given to the Policy holder which is a main indication of status of Policy as regards Renewal or fresh. The Respondent also stated that there is no legal obligation to the Insurance Company to send the Renewal Notice to the Policy holder as it is a Annual contract of Insurance and it is left to the Insured's choice to continue the contract or not at the time of expiry of contract. It is further clarified by Respondent that there is no practice in their office to send the Renewal Notice to other Policy holder also. It is further added by Respondent that unless premium is received in advance the Policy can not be issued to any person and in the above case the premium in the form of Cheque was received from the complainant on 23.7.2008 accordingly; the Policy was issued w.e.f. 24.7.2008 to 23.7.2009 as fresh Insurance. The Respondent further stated by producing the Policy clause that as per Policy clause No. 4.3 during first two year of the operation of the Policy the expenses on treatment of **Hysterectomy** and Surgery of Genito Urinary system are not payable therefore, the claim was not payable and repudiated.

In view of the circumstances stated above and on going through the various documents made available by both the parties, it is found that the decision for repudiation of above claim taken by Respondent under the Policy exclusion clause No. 4.3 **is just & fair** as it is well established that the Policy in question is a **Fresh Insurance** and not a Renewal of Previous Policy. **Therefore, the complaint is dismissed without any relief.**

==========END==========

CATEGORY: **MEDICLAIM**
SUB CATEGORY: **PARTIAL REPUDIATION OF CLAIM**

Mr. Shiv Sahay Sharma…….. ……..…Complainant
V/s
The New India Assurance Co. Ltd., …….. ……Respondent

Order No.: BPL/GI/10-11/10 **Case No.: GI/NIA/1001/109**

Order Dated 15.04. 2010

Brief Background

Shri Shiv Sahay Sharma (hereinafter called Complainant) was covered under Mediclaim Policy No. 451400/34/09/11/0000009 for S.I of Rs. 95000/- for the period 06.04.2009 to 05.04.2010 together his wife Mrs. Shashi Sharma obtained by his Son Mr. Viren Sharma issued by The New India Assurance Co. Ltd., D.O.II, Bhopal. (Hereinafter called Respondent)

As per the Complainant there is an abnormal delay in payment of claim for Rs. 6513/- for the claim made on 24.6.2009 for removal of Cataract from the left eye of his wife smt. Shashi Sharma. It is further added that the policy is continued since last 11 years and a Discharge voucher was received from TPA for sanctioning the claim for Rs. 3100/- only out of submitted claim for Rs. 6513/- and the deduction are on illogical, ridiculously therefore, the deduction are not acceptable to him hence the matter was reported to the higher authority of Respondent but there also no response. Aggrieved with the non settlement of claim for full amount, complainant approached this forum for necessary settlement of total claim for Rs. 6513/-

The Respondent vide its letter dated 8.2.2010 stated the complaint is pending with their TPA M/s Vipul Med Corp TPA private Ltd. and they have asked the TPA for claim File and shall be in a position to submit the facts on receipt of the same from TPA. On 5.4.2010 the Respondent informed that the file is received to them and the same will be submitted at the time of hearing.

Observations:

There is no dispute that the complainant's wife Smt. Shashi Sharma was covered under the above-mentioned policy and Cataract Surgery of left Eye was done on 24.6.2009 at Faiz Eye Hospital. During the course of hearing the Complainant reiterated almost all the points as mentioned in his main complaint letters and specifically stated that there are deductions for Rs. 3413/- is on illogical ground. On asking the Complainant confirmed that the entire expenses are for the treatment of Cataract and suspected Glaucoma and as per the advices of treating doctor only. On the other side the Respondent by producing the Policy condition and Medical bills stated that there are expenses for Rs. 2200/- are incurred prior to 30 days from the date of hospitalization and Rs. 600/- are charged by Hospital under the head of OTHER while Rs. 400/- and Rs. 213/- for medicines are deducted being not supported with doctor's prescription

therefore, the above total amount of Rs. 3413/- was deducted from the claim amount. On asking the Respondent stated that the complainant was not asked to produce the details for above deduction by their TPA. On asking the Respondent also opined that in cataract case where no long hospitalization is required there is possibility
that the charges as mentioned in the Hospital Bill under the head of Other for Rs. 600/- may pertains to nursing charges etc.

In view of the circumstances stated above and on going through the medical documents as made available by both parties, it is found that the deduction of Rs. 2200/- is genuine being found not covered under the scope of Policy while other deduction for Rs. 1213/- found **not just & Fair** as the expenses are incurred for treatment of Cataract only and within the 60 days from the discharge of Hospital. Therefore, the **Respondent is directed to pay the above claim for Rs. 1213/- 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==========

BHUBANESWAR

Health wise policy

BHUBANESWAR OMBUDSMAN CENTER

Complaint No.14-009-0662

Smt Sarada Das

Vrs

Reliance General Insurance Co Ltd.
Bhubaneswar

Award dated 12th April 2010

Complainant had taken a Health wise policy from Reliance General insurance Co Ltd, which was valid till 03.01.2009. She was admitted within the policy period for acute pancreatitis from 18 to 28 th October 2008. A claim was lodged with the Insurance Company, which has not been settled yet.

Hon'ble Ombudsman heard the case on 25.02.2010 where complainant was present but insurer failed to attend. After going through the documents direction was given to the insurer to settle the claim within 30 days and the forum was instructed to forward copies of all treatment papers including bills and cash memo etc to the insurer along with the order.

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Hospital Benefit Plus

BHUBANESWAR OMBUDSMAN CENTER

Complaint No.11-008-0696

Sri Debasish Pattnaik

Vrs

Royal Sundaram General Insurance Co Ltd. Bhubaneswar

Award dated 23rd September 2010

The complainant and his family are covered under Hospital Benefit Plus insurance Policy of Royal Sundaram General Insurance Co Ltd from 2.4.2009 to 1.4.2010. His mother was admitted for treatment of Maleria fever. The claim preferred was refused by the insurer citing the reason that the Nursing Home did not meet the criteria laid down in the policy. Although subsequently the claim was settled, complainant demanded interest for the delay.

Hon'ble Ombudsman heard the case on 23.09.2010 where both parties were present. On perusal of records, and hearing both sides, observed that the initial hesitation by insurer to pay was due to their doubts on the status of the nursing home. But on being satisfied they have settled the claim. An Insurer aught to check the genuineness of submitted documents before paying a claim. There fore the question of awarding interest was not in the interest of justice and hence dismissed the complaint.

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Medicare Bima Policy

BHUBANESWAR OMBUDSMAN CENTER

Complaint No.15-003-0698

Sri Badri Narayan Panda

Vrs

National Insurance Co. Ltd., Bhubaneswar DO-II

Award dated 20 Sept 2010

Complainant and his relatives took UCO Medicare Bima Policy with National Insurance Company Ltd in April 2009 through it's corporate agent, the UCO Bank. Insurer issued the policy but supplied the Medi claim Card 11 months late. The renewal of the policy was also denied as UCO Bank ceased to be their agent. Complainant claimed proportional refund of premium on 3 policies issued as above.

Hon'ble Ombudsman heard the case on 20.09.2010., where both sides were present. Complainant pleaded that he had to under go lots of problem in renewing policies for delay in issue of cards. Insurance Company however explained that the delay in issuance of card has no way brought any financial loss to complainant.

Hearing both sides and perusing the documents submitted, Ombudsman held that the insurer remained passive to the entreaties of the complainant but RPG Rule does not afford him to provide relief under such account and hence dismissed the complaint.

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CHANDIGARH

CHANDIGARH OMBUDSMAN CENTRE

CASE NO. GIC/706/UII/14/10

Ajay Aggarwal Vs United India Insurance Co. Ltd.

ORDER DATED: 26TH July, 2010 **Mediclaim**

FACTS: Sh. Ajay Aggarwal had purchased a mediclaim policy No. 221100/48/06/20/ 00000940. On 19.06.2007, he suffered from severe abdominal pain and was admitted in SGPS Apollo Hospital, Ludhiana for treatment. All relevant documents were submitted to the company. But till date he has not received his claim amount in spite of repeated follow ups. Parties were called for hearing on 26.07.2010 at Chandigarh

FINDINGS: The insurer clarified the position by stating that the complainant was admitted at SGPS Apollo Hospital, Ludhiana from 19.06.2010 to 20.06.207 with vomiting. During hospitalization, he was extensively investigated but was not provided any active treatment. As per terms and conditions of the policy, any hospitalization, primarily for investigation is not admissible. Hence the claim was repudiated.

DECISION: Held that once a person is hospitalized on the advice of a doctor in a reputed hospital like Apollo Hospital, he has no control over what investigations are advised by the doctor or what line of treatment is taken by the doctors. It is the doctor, treating the patient who can decide about the hospitalization. The repudiation of the claim is not justified by the insurer. The insurer is directed to pay a sum of Rs. 6944/- towards full and final settlement of the claim within 15 days from the date of receipt of consent from the party. The complaint is closed.

CHANDIGARH OMBUDSMAN CENTRE

CASE NO. GIC/624/NIA/14/10

Amarjit Singh Minhas Vs. New India Assurance Co. Ltd.

ORDER DATED: 26TH July, 2010 **Mediclaim**

FACTS: Shri Amarjit Singh Minhas had taken Overseas Mediclaim Policy bearing no. 361000/34/08/45/00000267 from 28.03.09 to 26.05.09 for going to Newzealand. While at Hamilton(NZ) on 12.05.09, in the evening he had a severe Heart attack on the road side. He was taken to hospital and immediately operation was done and a stunt was placed. All the claim

documents were submitted to insurance company but till date his claim was not paid. Parties were called for hearing on 26.07.2010 at Chandigarh

FINDINGS: The insurer clarified the position by stating that the Overseas Mediclaim Policy was issued on the basis of Proposal Form submitted by the complainant. Since he had not declared any adverse medical history in the proposal form, so policy was issued without any extra impositions/exclusions. All the medical bills received were forwarded to M/s Heritage Health TPA Pvt. Ltd. They have repudiated the claim on the ground of pre-existing disease. During the course of hearing, it was brought to the notice of this forum that the claim was repudiated on the ground of suppression of material information in the proposal form submitted by the complainant. The insurer submitted that the complainant tried to manipulate proposal papers after he learnt about the repudiation of the claim. The complainant, being a retired employee of the insurer, had managed to get access to the original proposal papers and tried to destroy the original proposal papers in order to get the payment of claim.

DECISION: It is a matter which requires application of legal process to establish tampering of records by the complainant. This forum works on the basis of papers on records and does not have the resources to undertake legal process so without announcing a formal award the complaint is considered beyond jurisdiction of this forum and complainant can take up the matter with any other forum for redressal of his grievance.

CHANDIGARH OMBUDSMAN CENTRE

CASE NO. GIC/688/ICICI/14/10

K.K.Khanna Vs. ICICI Lombard

ORDER DATED: 26th July, 2010 **MEDICLAIM**

FACTS: Dr. K.K. Khanna's wife, Smt. Pratibha Khanna was insured under Mediclaim Policy bearing no. 4016/0000893 issued by ICICI Lombard General Insurance Co. for the period 06.10.2005 to 05.10.2006. During the policy period, she was admitted in Medicare Nursing Home, Gandhinagar, Jammu for treatment. They incurred an expenditure of Rs. 13663.97 on her

treatment. All the claim documents were submitted for reimbursement of claim but till date they did not receive the payment. Parties were called for hearing on 26.07.2010 at Chandigarh.

FINDINGS: The insurer clarified the position by stating that as per Rule 13(b) of Redressal of Public Grievance Rules, 1998, no complaint shall lie later than one year after the insurer had rejected the representation or sent his final reply on the representation of the complainant. The complainant was covered under Group health insurance policy No. 4016/0000893 issued to J&K State Employee for the period from 06.10.2005 to 05.10.2006. The complainant's wife was hospitalized for Chronic Renal Failure on 19.02.2006 and was discharged on 20.02.2006. A claim was filed with Family Health Plan (TPA). It is submitted that said claim was closed on 28.03.2007. The said claim of complainant was closed for certain requirements. The insurer submitted that till date said documents have not been submitted to them. As per rule 13(b) of Redressal of Public Grievance Rule, 1998, no complaint shall lie unless the complaint is made not later than one year after the insurer has rejected the representation or sent his final reply.

DECISION: In the light of the above, the case is considered beyond jurisdiction of this forum.

CHANDIGARH OMBUDSMAN CENTRE

CASE NO. GIC/692/UII/14/10

Saravjit Singh Vs United India Insurance Co. Ltd.

ORDER DATED: 26th July, 2010 **MEDICLAIM**

FACTS: Sh. Saravjit Singh had purchased a Family Medicare Floater policy bearing No. 20060148080600000114 for the period 07.07.08 to 06.07.09. His two sons named Amanjeet Singh and Prabjeet Singh got injured in a road accident on 05.03.2009 and were admitted at CMC Hospital. The claim was preferred to the insurer with all relevant claim papers. But till date he has not received claim payment. Parties were called for hearing on 26.07.2010 at Chandigarh

FINDINGS: The insurer clarified the position by stating that the complainant's minor son met with an accident while driving the motor cycle and the other son was pillion rider. Since both the sons were minor, the claim was rejected as the injuries suffered were due to an accident while indulging in an unlawful activity and self intentional injury. Hence the claim was rejected.

DECISION: Held that the insured for whom the claim was lodged are minors and they met with an accident while driving the motorcycle on their return from school. The FIR clearly mentioned that the motorcycle was being driven by insured's elder son with the younger son as a pillion rider and was hit by a truck while they were returning from their school. The claim has been repudiated on the ground that the injuries suffered by the insured were as a result of an accident due to unlawful activity. It is established that being minor with age of 14 years and 11 years respectively are not supposed to drive a motorcycle and since the injuries are the result of an unlawful act, the insurer is justified in repudiating the claim. No further action is called for. The complaint is dismissed.

CHENNAI

Complaint No.IO (CHN) 11.02.1468/ 2009-10
AWARD No. IO (CHN)/G/01/2010-11 dated-19th May 2010
(mediclaim)
Mr.Daksh Prakash Suri vs The New India Assurance Co Ltd.

The complainant was covered under a Mediclaim policy of the above insurance co from 1999 onwards. During the policy period 2008-09 he was hospitalized from 17.11.2008 to 22.11.2008.and underwent Laproscopic Sleeve Gastrectomy and lodged his claim for Rs 2,86,506/-The claim was rejected by the insurer under clause 4.4.6 of the policy which excludes obesity treatment. The insured contended that the treatment was necessary to better his health condition and not for any cosmetic reason. The insured had stated that he was weighing 145 kgs and due to this he was having lot of health problems. He was very much at risk of death and he was asked to reduce weight before undergoing cardiac surgery.

The insured had stated that he was having breathing problems, was diagnosed to have Aneurysm, history of day time sleepiness, and obstructive sleep apnoea .He said that he was not able to take anesthesia when he underwent hip surgery in 2004.His ejection fraction of heart was only 30%and for which he was advised surgery. The insured had contended that the surgery was a life saving surgery and not a cosmetic one and hence the claim should be settled. The insurer had stated that all complications are due to obesity and as per policy condition any treatment for obesity and its complications are not payable.

I t has been observed that the insured had undergone hip replacement surgery in 2004-05 and in Jan 2010 he underwent surgery for Aortic Arch+ Proximal descending Aorta Replacement and the insurer has settled both the claims for Rs 2,31,080/- and rs

4,05,000/-respectively.The discharge summary relating to Gastrectomy in Nov 2008 does not indicate anything on aneurysm of the arch of the aorta.The principal diagnosis at the time of admission and discharge was only Morbid obesity.The other diagnosis is Gout and sleep Apnoea.The only reference to aortic aneurysm is in the history where it has been stated that the complainant is a known case of COPD since 10 years. Further the surgery for Aortic Arch was performed in Jan 2010 more than a year after the Gastrectomy and there is no reference to Gastrectomy in the discharge summary of Apollo Hospital. Therefore it is observed that the Laproscopic Sleeve Gastrectomy was done only for obesity and had nothing to do with treatment for Aneurysm of Aorta. The insurer has repudiated the claim due to a specific clause in the policy which says that obesity treatment and its complications are not payable. Based on all the factors the decision of the insurer in rejecting the claim is in order

The complaint is dismissed.

Complaint No.IO (CHN) 11.04.1561/ 2009-10
AWARD No. IO (CHN)/G/03/2010-11 dated-24 th May 2010
(mediclaim)
Mr.S.Kumar vs United India Insurance Co Ltd.

The complainant had taken individual Mediclaim policy with the above insurance co for a sum insured of rs 50,000/-from 20.06.2009 to 19.06.2010.According to the complainant he had an accidental fall from the staircase and injured his front teeth.He was admitted in the hospital for replacement with multi unit ceramic bridge and was in the hospital from 18.08.2009 to 19.08.2009.The insurer had mentioned that the extraction was necessitated due to chronic abscess and not due to any accident as stated by the insured.Hence they have repudiated the claim.

The complainant had mentioned that he had an accidental fall on 17.08.2009 in which his upper jaw was broken and he was having pain and swelling due to which he was not able to open his mouth.The insurer had mentioned that there was no mention of any accident in the discharge summary and argued that hospitalisation was not required for dental treatment.The procedure could have been carried out as out patient.On a perusal of discharge summary The Doctors while examining found discoloured upper incisors and signs of dento alveolar abscess.Hence surgical extraction was done under local anaesthesia along with enucleation of an infected cyst and granulamatous tissue. Further the hospitalisation was also less than 24 hours.The discharge summary also does not mention any accidental fall resulting in the breaking of the teeth or jaw.All these reveal that the dental treatment taken is independent of accident and insured's contention of accidental fall and subsequent injuring of teeth resulting in hospitalisation was not proved with clinching evidence.Hence insurer is justified in repudiating the claim.The complaint is dismissed.

Complaint No.IO(CHN) 11.08.1652/ 2009-10

AWARD No. IO (CHN)/G/04/2010-11 dated 24th May 2010
(Mediclaim)
Mr.G.Suresh Kumar vs Royal Sundaram Alliance Ins Co Ltd.

The complainant had taken Health Shield Insurance policy from the above insurer since 2003 and he was hospitalized from 28.05.2009 to 30.05.2009.due to Acid Peptic Disease.The insured stated that he suddenly felt giddiness and pain and was admitted in the hospital He has also mentioned that he was not taking alcohol regularly.The insurer had mentioned that from the discharge summary they found that the ailment was mainly due to alcoholic consumption and this being an exclusion under the policy the claim was rejected.

The complainant had mentioned that he was suffering from fever and stomach pain and was also experiencing giddiness He was admitted in the hospital for treatment and when he opted for cashless facility he was not given and was asked to seek reimbursement.The insurer contended that the insured was admitted for Acid Peptic Disease which is the second stage of Gastritis from 28.05.2009 to 30.05.2009.They stated that the discharge summary has mentioned that he is a chronic case of consumption of alcohol.According to them the current ailment is a complication of alcoholism and hence the claim was repudiated.

The chief complaints at the time of admission have been recorded as history of abdominal pain intermittently since last one week and it has also been recorded that the complainant gave history of chronic alcohol consumption.At the time of discharge he was advised strict stoppage of alcohol.In the light of these facts the stand of the insurer that alcohol consumption had caused the ailment can not be entirely ignored.However it is also to be noted that except for a noting in the discharge summary no records were submitted to prove that the acid peptic disease was caused only due to alcoholic consumption.The policy has run for more than 5 years and there was no hospitalisation during the period.The medicines and injections were given only for pain,fever and diabetes and no treatment relating to chronic consumption of alcohol was given.Further the treating doctor has also certified that the ailment has not been caused due to alcohol.Under these circumstances in order to render justice to both the parties an exgratia amount of Rs 25,000/- is awarded

The complaint is partly allowed on exgratia basis.No other relief is allowed..

Complaint No.IO(CHN) 11.04.1672/ 2009-10
AWARD No. IO (CHN)/G/05/2010-11
(mediclaim)
Mr.R.Ranganathan vs United India Insurance Co Ltd.

The complainant had stated that he had taken a mediclaim policy for self and family from 22.02.2006 through IOB .The insured had noticed a cyst in the neck of his daughter in Aug 2009 and consulted ENT Dr who prescribed some medicines and subsequently advised MRI scan to be taken base on which he suggested surgery of excision of the cyst.The claim was rejected by the TPA and reiterated by the insurer on the ground that the cyst was congenital external disease which is excluded under the scope of the policy. The insurer has further mentioned that Thyroglossal cyst had been existing since birth of the child which could not have escaped the attention of the complainant.The TPA had requested the insured to get an opinion from the Doctor in support of his claim that the cyst was not congenital which has been submitted.

Award dated –24th May 2010.

Acyst was noticed in the neck of the insured's daughter in Aug2009 and as per the advise of an ENT doctor she was hospitalized from 28.09.2009 to 2.10.2009.which was not in the network hospital.Hence TPA has recommended reimbursement of medical bills.The insured had argued that what was not visible can not be treated unless it creates some problem.He further said that the cyst was not visible and there was no swelling when his daughter was operated for tonsillitis earlier in a Govt hospital.The insurer had stated that as per discharge summary the cyst was congenital and existing since birth of child which could not have escaped notice of the insured.

As per clause 4.8 the policy excludes "Convalescence,general debility,run down condition or rest cure,congenital external disease or defects or anomalies sterility venereal disease-----"It is clear that the policy excludes congenital diseases or defects which are external to the body.The insurer /TPA have concluded that the Thyroglossal cyst was external since there was swelling on the throat.In the present case it can be seen from the discharge summary ,that under general anesthesia treatment was given and the cyst was inside the body and as such the thyroglossal cyst is an internal defect that is inside the body and not external.The swelling was noticed only six months before the surgery and the complainant was having continuous coverage for two years.Taking all factors into account the decision of the insurer in repudiating the claim is not in order and hence they are directed to process and settle the claim as per other terms and conditions of the policy.

The complaint is allowed.No other relief is allowed.

Complaint No.IO(CHN) 11.08.1627 / 2009-10
AWARD No. IO (CHN)/G/07/2010-11 dated24thMay 2010
(Mediclaim)
Mr.Ramanathan Vellayan vs Royal Sundaram Alliance Ins Co Ltd

The complainant had taken Health shield Insurance Cover with the above insurance co for his father and he has been taking the policy from 05/01/2006.The insured was admitted into the hospital twice with various complaints and in the discharge summary it was mentioned that he was suffering from HT for the past 4 years.The complainant had mentioned that the duration of HT was wrongly stated by his father at the time of admission as 4 years instead of 2 years.Moreover all the ailments for which he was treated were not towards treatment of HT and its complications.The insurer has rejected the claim stating that the Ht was there for 4 years as mentioned in the discharge summary and hence rejected the claim as pre existing.

The complainant had mentioned that the policy was taken through SBI credit card which offered discount on first year premium.His father was hospitalized in Hospital from 17.05.2009 to 21.05.2009 with complaints of vomiting ,giddiness,loss of appetite,acute loss of memory,incontinence of urine.He was again hospitalized from 25.05.2009 to 14.06.2009with worsened health condition.During primary investigation his father had informed that he had BP for 4 years and all other complaints for the past 6 months.The complainant had stated that his father was suffering from Hyper tension from 2007 only and this fact was also conveyed by his mother to the treating Doctor.

The insurer had mentioned that as per discharge summary the patient was a known case of hypertension for past 4 years and chronic multiple infarcts which was a complication of pre existing hypertension.The insurer's contention was that though the patient was diagnosed with Prostatomegaly and Parkinson's disease,the predominant treatment is towards systemic hypertension and cerebral infarction which are directly related conditions of his preexisting condition.The claim was rejected under pre existing clause of the policy.

The history of hypertension was recorded at the time of first hospitalisation as known case of hypertension on tablet Losar25,1 od 4years and at the second hospitalisation merely as known case known case of hypertension(no duration was mentined.)During the first hospitalisation on examination the patient was conscious and oriented where as at the time of second hospitalisation it is recorded Conscious and disoriented.From the discharge summary relating to cataract surgery done on 23.04.2009 it was observed that 'history of systemic hypertension –on treatment was mentioned.Although all the records indicate that the patient was treated for hypertension ,nowhere it had been mentioned since how long the person was suffering from hypertension In the absence of any records to indicate the exact period of pre existing condition the stand of the complainant that it was only two years old can not be brushed aside Besides the patient was also treated for other ailments in addition to hypertension and its complications.

In the light of the above to render justice to both the parties an exgratia amount of rs25,000/-is awarded.

The complaint is partly allowed as Ex gratia.

Complaint No.IO (CHN) 11.08.1628 / 2009-10

AWARD No. IO (CHN) /G/08/2010-11 dated-24th May 2010.
(Mediclaim)
Mrs.K.Shanthi vs Royal Sundaram Alliance Ins Co Ltd

The complainant and her husband are covered under Health Shield Insurance policy with the above insurer for the last 5 years. She was admitted in the hospital from 04.12.2009 to 07.12.2009.for Acute Febrile Illness and the claim was settled by the insurer only for Rs19,405 deducting an amount of Rs10,800/-.When she represented to the insurer they have mentioned that the amount payable towards the expenses incurred on Hospital and nursing charges are restricted to 1.5%of the sum insured as per terms and conditions of the policy. Accordingly they have settled the claim amount.

It was observed that the complaianant's wife was hospitalized from 4.12.2009 to 7.12.2009.for fever and submitted claim for rs 30,205/- and the claim was settled for rs 19,405/-The insurer has allowed only rs 4,500/- towards hospital charges and nursing charges as only 1.5%of the sum insured is payable towards the said expenses as per policy terms and conditions.In this case room rent works out to rs 1,500/- per day and hence rs 4,500/-for 3 days were allowed.On a perusal of the policy terms and conditions it was revealed that Room ,Boarding expenses are covered subject to a limit of 1.5%of the sum insured per day. It was also observed that the insurer while enclosing the cheque had given detailed working of the amounts allowed and those disallowed.Under these circumstances the decision of the insurer in repudiating the claim is justified .

The complaint is dismissed.

Complaint No.IO(CHN) 11.17.1559 / 2009-10
AWARD No. IO (CHN)/G/ 09/2010-11
Mediclaim Policy
Mr Mathew Alexander vs Star Health And Allied Insurance Co Ltd
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The complainant had taken Star Senior Citizen's Red Carpet Insurance from the above insurer for the period from 14.05.2009 to 13.05.2010 for a sum insured of Rs.2 lakhs. Before taking the policy he was admitted to CMC hospital Vellore on 17.03.2009for pleural Effusion and was discharged on 04.04.2009.Both Malignancy and TB were ruled out. Two months later he had swelling in the leg and various tests were taken and he again got admitted at the same hospital and specific diagnosis was made and chemotherapy was started on 24.06.2009.The insurer had stated that Pre authorization request received from the hospital confirms T-cell Lymphoma-cancer of 3

months on 24.06.2009.They have therefore repudiated the claim stating that he had intentionally concealed information about pre existing ailments at the time of proposal.

Award dated-21.05.2010.

The insured had mentioned that two months after his first hospitalisation from 17.03.2009 to 4.04.2009 he developed swelling in the lower left leg .Hence he underwent various tests at Sundaram Medical Foundation ,Apollo Hospital and since there was no clear diagnosis he went back to CMC Hospital Vellore where various tests were conducted.He stated that in the first admission there was no malignant but the second admission was for malignancy and he had undergone chemotherapy on 24.06.2009.

The representative of the insurer had stated that in the discharge summary of the complainant it was revealed that the insured was suspicious of lymphoma the facts of which was not disclosed in the proposal form by the insured. He said that the policy was dated 14.05.2009 and biopsy was done on 20.05.2009.ie within a week's time.Treating doctor's report has confirmed that the insured had taken treatment for 3 months prior to hospitalisation.It was observed from the records that there was no malignancy or TB as per the discharge summary of March 2009,but June 2009 discharge summary does state that on followup ,his pleural effusion had decreased but he noticed an inguinal region lymbh node in the left inguinal region which was biopsied and diagnosed as Lymphoma.Hence it is seen that prior to the hospitalisation he had undergone a biopsy on 20.05.2009 and diagnosed as having lymphoma for which the Ist cycle of chemo was done on 24.06.2009.The policy had incepted on 14.05.2009 Further pre authorization form also mentions the medical history of cancer as 3 months –Tcell lymphoma All the records clearly establish that the patient was under observation from march 2009 and on 14.05.2009 he has submitted the proposal and biopsy was done on 20.05.2009

On a perusal of the proposal form it is observed that the insured has answered NO to the question "whether suffering from any disease,/illness irrespective of whether hospitalized or not in the last 12 months"Taking all the factors into account the decision of the insurer in repudiating the claim is justified.

The complaint is dismissed.

Complaint No.IO (CHN) 11.02.1013 / 2010-11

AWARD No. IO (CHN) /G/010/2010-11

(Mediclaim)

Dr.Sreedevi Padmanabhan vs The New India Assurance Co Ltd.

The complainant and her husband had taken Mediclaim policy with the above insurance co from 07/08/2009 to 06/08/2010.for a sum insured of rs 1lac.They have been renewing the policy regularly from 2002 except for a gap of 10 days in 2008-09 renewal .The renewal for this year was done on 07/08/2008 as against

28/07/2008.During the policy period 2008-09 the complainant was hospitalized between 01/07/2009 to 06/07/2009 for abdominal hysterectomy and submitted a claim for rs 63,350/-The claim was rejected on the ground of policy exclusion 4.3where expenses are not payable for a waiting period of two years treating 08/09 policy as a fresh policy because of a break of 10 days during renewal.

Award dated-14thJune2010.

The insured had mentioned that she was not aware that a break in insurance would debar her from the benefits of continuous insurance cover as she had the mediclaim policy for the past so many years. Moreover her policy for 2008-09 states that the date of issuance of first policy was 2000 and nowhere it is mentioned that it was the fresh policy. When this was brought to the notice of the insurer they said that the software program prints this by default. The insurer had mentioned that the insured had their first policy from 22.01.2000to 21.01.2001,then there was a break of 1 year and 6 months before she was insured again from 23.07.2002 to 22.07.2003which was treated as fresh policy and since they were continuously covered until 2007-08 with a break of 3 days in 2004-05 and 2 days in 2005-06 which were condoned. In the present renewal since there was no request from the insured it was treated as a fresh policy calling fresh proposal form which attracts two year exclusion clause and hence they have rejected the claim.

It was observed from the records that the policy for the period from 07/08/2008 to 06/08/2009 bears the previous mediclaim policy number and specifically mentioned as RENEWED. This obviously gives an impression that the said policy is the renewal of previous policy despite there being break in the policy period.The insurer had not produced any records if any issued to the insured to indicate the fact of the policy having been treated as a fresh one from 07/08/2008.The break period is also not for a long duration which could have been condoned by the competent authority. Hence taking all the factors into account the decision of the insurer in rejecting the claim on the ground of treating the policy as a fresh one is not justified.The insurer is therefore directed to process and settle the claim as per other terms and conditions of the policy.

The complaint is allowed.

Complaint No.IO(CHN) 11.08.1674 / 2009-10
AWARD No. IO (CHN)/G/13/2010-11 dated 14th June 2010
(Mediclaim)
Mr.S.Chandrasekaran vs Royal Sundaram Alliance Ins Co Ltd

The insured had taken Health Shield Premiere Insurance Policy for a sum insured of rs 1,50,000/- from 03 10 2009 to 02 10 2010.for self and his wife.She was admitted in the hospital for Sinusitis with Polyposis and the insurer had settled the claim for

Rs10,238/-out of a total claim of Rs 19,756/-.The insurer had deducted rs 8,048/- towards pre hospitalisation expenses incurred beyond 30 days as the policy does not allow the same.The insured had represented that the expenses were incurred for various tests and the doctor advised the patient with medication to control her BP before undergoing the FFSS surgery,because of which hospitalisation has to be postponed.

The insured had stated that he was periodically visiting the hospital from 3.11.2009 to 14.12.2009 for BP check up and the delay in performing the surgery was only under the advice of the Doctor.The insurer had quoted the relevant policy condition relating to Pre hospitalisation which reads as under "Reasonable and customary expenses incurred towards tratment of disease /illness/injury for a period of 30 days prior to hospitalisation"The contention of the insured that the surgery had to be postponed by the treating doctor because of the patient's uncontrolled BP level as the compelling reason,has not been substantiated by any medical evidence on records.The discharge summary also does not provide any information relating to the patient's BP levels.Moreover the policy does not provide for any relaxation in case of any medical condition of the patient to consider the expenses in disputeWhen a specific number of days has been mentioned in the policy under the Pre or Post Hospitalisation benefits the decision of the insurer in not allowing those expenses incurred beyond 30 days prior to hospitalisation is justified.

The complaint is dismissed..

Complaint No.IO (CHN) 11.14.1678 / 2009-10

AWARD No. IO (CHN) /G/15/2010-11 dated-21stJune2010

(Mediclaim)

Mr.P.Raja vs CholamandalamMS GIC Ltd

The complainant had taken a mediclaim policy from the above insurance co .He was hospitalized from 10/11/2009 to 19/11/2009 for C5-C6 Anterior Cervical Disectomy and he submitted the bills for settlement.The insurer had mentioned that the complainant was diagnosed and treated for C5-C6 bulge with Posterior Disc Osteophyte complex and he was having the problem for the last 2 years as per the case sheet.As per the insurer the said history of complaints which is specifically mentioned in the case sheet issued by the treating hospital clearly showed that it was an outcome of pre existing disease.Hence the insurer had rejected the claim stating that the ailment was prior to the commencement of the policy.

The insured had stated that the ailment was there only for the last 6 months and he further mentioned that his doctor has also confirmed that the ailment was there since six months only.He had also informed that with this pain he could not

have continued for two years without getting the same treated. The insurer had rejected the claim based on the noting in the case sheet viz history of neck pain 2 years.History of left arm pain 6 months.History of fasciculatin 3 months.From the case sheet and discharge summary ,it is found that the complainant was not taking any medication for the same.Further previous consultation /prescription in this regard were also not submitted.The discharge summary mentions history of left arm pain of 6 months duration ,fasciculation of left deltoid of 3 months duration. The discharge summary and case sheet had identical points with respect to history of left arm pain 6 months and fasciculation of left deltoid of 3 months. But the history of neck pain of 2 year duration found only in the case sheet and not in the discharge summary.The insurer could not produce any clinching evidence to confirm that the neck pain is the root cause for the C5-C6 bulge and connected treatment.Under these circumstances the rejection of the claim by the insurer under preexisting condition is not in order.The insurer is directed to process and settle the claim as per other terms and conditions of the policy.

The copmlaint is allowed.

Complaint No.IO(CHN) 11.04.1024 / 2010-11
AWARD No. IO (CHN)/G/022/2010-11 dated 12thJuly 2010.
(Mediclaim)
Mr.P.Hariharan vsUnited India Insurance Co Ltd.

The complainant was covered under group Mediclaim policy of the insurer from01/11/2008 to 31/10/2009 and the complainant was hospitalized between 07/08/2009 to 08/08/2009.for Ankylosing spondilitis for an amount of rs 1,11,232/-.The treatment involved administering of injections and it has to be done under the supervision of a Doctor due to likelihood of severe side effects.The insured had mentioned that similar claim for rs 71,086/-for the hospitalisation between 24.09.2009 to 25.09.2009 was paid and the earlier claim was not settled.Since both the claims are for the same ailment the insured requested for settlement of this claim also.

The insurer had argued that the treatment involved is only administering of injection which falls under day care procedure and hence the claim was rejected.The insurer has further mentioned that second claim was paid inadvertently by the TPA and they have taken up the matter with the TPA for recovery of the amount.

The complainant had mentioned that with the onset of the ailment ,he suffered from severe back strain ,ankle and knee pain in joints ,unable to walk had severe headache and unable to lead a normal life.He consulted his doctor and had also taken second opinion regarding the treatment. He was informed that the treatment would bring with it severe side effects such as heartpain ,headache,vision problem,continous vomiting and was also advised to interact with a named patient who contracted TB as side effect In spite of all this he agreed for the treatment as the ailment was causing him much pain and problems.Considering the severity doctor has advised him to take 3 dosages of medicine Remicade injection which has to be administered through IV.Three bottles of 100ml each as a dosage were given in 14 hours and said that for 4 hours he was unable to see and thereafter his vision was blurred and he also had vomiting.

The insurer had argued that there was no need for hospitalisation and the treatment was possible under OPD.The discharge summary also has not mentioned any side effects of the medicine.As regards the second claim which was settled by the TPA for the same treatment the insurer had mentioned that it was a wrong settlement and they have advised the TPA to recover the amount.The entire procedure though looked simple as administering of injections only as a day care procedure ,viewing from the side effects involved and the continuous monitoring for any possible emergency like situation,the doctor rightly advised the patient to opt for admission as an inpatient so that the risk of treating as an outpatient can be avoided.In this case also the patient had problems of blurred vision and continuous vomiting .Taking into account the condition of the patient and the risk of serious side effects which require constant monitoring admission as an inpatient has been neceesitated.Hence the contention of the TPA/Insurer that the treatment could have been taken as an outpatient is not tenable and the insurer is not justified in rejecting the claim.They are therefore advised to process and settle the claim as per other terms and conditions of the policy.

The complaint is allowed.

Complaint No.IO(CHN) 11.02.1098 / 2010-11
Award noIO (CHN)/G/023/2010-11 dated 12thJuly 2010
(Mediclaim)
Mr.S.Sundararajan vs The New India Assurance Co Ltd

The complainant had taken Good Health Mediclaim polcy as a card holder of Citi Bank from 2001for a sum insured of rs 1,50,000/-Since the insured had to undergo Heart surgery for Aortic Valve Disease he applied for Pre Authorisation approval to the TPA who authorized only rs31,500/-.He preferred a claim with the insurer for rs2,33,000/-over and above the preauthorization amount.The insurer had rejected the request informing that the ailment for which he was admitted in the hospital was a congenital Internal Disease /Defect and therefore the claim was restricted to 20%of the sum insured as per the terms and conditions of the policy.

The complainant had mentioned that he was neither a diabetic nor a hypertensive but had gastric and other problems which were finally diagnosed as aortic heart disease caused due to calcium deposit.He had to undergo surgery and hence applied for cashless facility and was sanctioned only rs31,500/-The TPA had taken an opinion from their panel doctor who has opined that bicuspid Aortic Valve with Aortic stenosis is a congenital internal disease.It is observed from the policy condition that Limits have been mentioned for specified illness .In the table for limits for specified ailments under serial no 7 Congenital Internal Disease/Defect the condition is not covered for two years and thereafter the limit per claim payable is 20% of the sum insured.In the instant case the condition for which the complainant had been hospitalized was established by insurer/TPA as congenital Internal Disease /Defect and hence the decision of the insurer in restricting the claim to 20% of the sum insured is in order

The complaint is dismissed.

Complaint No.IO(CHN) 11.02.1040 / 2010-11
Award No IO(CHN)/G/024/2010-11 dated 19thJuly2010.
(Mediclaim)
Mr.T.K.Manilal vs The New India Assurance Co Ltd.

The complainant had stated that he has been insuring his family members for the past several years and has taken Janata mediclaim policy for a sum insured of rs50,000/.His son who was 18 years old had severe pain and swelling in both breasts for the last 6 months and as per the advice of the Doctor had undergone surgery.The claim was rejected by the insurer on the ground that gynaecomastia was not payable as per clause 4.4.2 of the policy .The insurer has asked for a biopsy certificate but the certificate produced by the complainant states that biopsy was not done.The insurer also has concurred with the decision of the TPA in repudiating the claim.

The complainant had mentioned that he was mediclaim policy holder for number of years and his son was hospitalized from 20.10.2008 to 23.10.2008 for a surgery with a complaint of pain and swelling in both the breasts.He underwent surgery for Gynaecomastia,excision biopsy and liposuctionon 21.10.2008 and cashless facility for rs15,000/- was initially approved by the TPA but later it was withdrawn and the claim for reimbursement was also declined under clause 4.4.2of the policy.The representative of the TPA stated that Gynaecomastia is enlargement breast in male and generally in the age group of 16-18 years it occurs for some with pain and the surgery done is for cosmetic purpose.A liposuction is a cosmetic surgery which focuses on getting rid of stubborn fatty deposits .He further stated that had the biopsy been done and the result positive they would have considered the claim.The treating doctor has mentioned in the certificate that the tissue coming out through suction was not suitable for biopsy and hence biopsy was not done.Taking all factors into account it is clear that the procedure for bilateral gynaecomastia in this case falls under exclusion clause 4.4.2of the policy relating to cosmetic or aesthetic treatment and hence the decision of the insurer in repudiating the claim is in order.
The complaint is dismissed.

Complaint No.IO(CHN) 11.05.1046 / 2010-11

Award No. IO (CHN)/G/025/2010-11 dated 19thJuly 2010
(Mediclaim)
Mr .S.Krishnan vs The Oriental Insurance Co Ltd

The complainant and his wife were covered under the Mediclaim policy of the above insurance co since 01.03.2005.The complainant was hospitalized from 05/07/2009 to 23/07/2009for treatment of his injury on his left elbow due to a slip and fall which developed into swelling.He has lodged a claim for rs 3,55,000/- and the insurer had settled the claim only for rs 2,05,000/-

.The insurer had mentioned that the insured was a policy holder since 2004 with a sum insured of rs 1,00,000/-which was increased to rs 2,00,000/-in the year 2005and further enhanced to rs 3,00,000/- in 2006.The insurer had argued that the insured was suffering from DM/Ht for the past 4 years as mentioned in the medical process sheet of TPA and the present illness had been aggravated by the Diabetic condition of the insured.The present hospitalisation had taken place in July 2009 and they have taken into account the SI for the year 2005-06 ie rs 2,00,000/-plus CB of rs 5,000/- and paid the amount as per policy terms and conditions since DM was contracted during the policy period ie 4 years prior to 2009-10 policy period.

The complainant had stated that he had a slip and fall and injured his left elbow and went to the hospital for a check up and was hospitalized for treatment from 5/7/2009 to 23/07/2009.He had applied for cashless facility but was approved only for rs 2.05 lakhs by the TPA.After discharge he had submitted his bill for rs3.55 lakhs but the claim was denied on the grounds that he was diagnosed with Diabetes Mellitus /Hypertension for 4 years. The insurer had argued that the insured has increased the sum insured in the year 2006 to rs3lakhs and since the insured has been suffering from diabetes for 4 years they have taken the sum insured for the policy year 2005-06 ie rs2lakhs and CB of rs5,000/ and approved for cashless facility only for rs2,05,000/-.

On a perusal of the records and on hearing both the parties it is found from the discharge summary that the insured was a diabetic for 2 ½ years and HT for 1 ½ years Though the insurer and the TPA had argued that the diabetic condition had aggravated the present ailment of the complainant their contention has not been substantiated by any clinching evidence by way of any medical records.The insurer seems to have relied on the notings made by the TPA in one of their processing sheets wherein it has been mentioned that "as per hospital reply history of diabetes mellitus /HT ;4 years"whereas this statement is not supported by any written confirmation from the treating doctor or any other hospital records.The complainant had produced his earlier admission in the hospital from 10/11/2006 to 13/11/2006 and the discharge summary revealed that he was diagnosed Diabetes Mellitus for the first time and bears no past history of DM.Therefore the past history of duration of DM mentioned in the discharge summary for the period 05/07/2009 to 23/07/2009 as 2 ½ years appears to be correct in the absence of any written records to the contrary.Hence in the instant case it is not a case of pre existing disease as defined in the policy.Taking all the factors into account the decision of the insurer in restricting the claim to the sum insured to the one applicable for the year 2005-06 namely rs2,00,000/- plus cumulative bonus of rs5,000/-is not justified.The insurer is therefore directed to process and settle the balance claim as per the sum insured and cumulative bonus as applicable to the policy period 01/03/2009 to 28/02/2010.

The complaint is allowed.

Complaint No.IO(CHN) 11.03.1106 / 2010-11

Award no IO(CHN)/G/026/2010-11 dated 26thjuly2010.

(Mediclaim)

Mr.M.Moosa vs National Insurance Co Ltd

The complainant had taken hospitalisation benefit policy from the above insurance co for a sum insured of rs1lakh and cumulative bonus of rs20,000/-He was admitted to the hospital with a complaint of giddiness from 14.11.2008 to 20.11.2008.His request for cashless was also not considered.The insurer has mentioned that the claim was repudiated by them on the ground that the hospitalisation was not followed by any active line of treatment and the expenses incurred were primarily for evaluation and diagnostic purpose during hospitalisation as per the exclusion clause 4.10 of the policy.The insured had mentioned in his letter that he had a fall from the bed also one day.While he was traveling from chennai to Kanceevaram he felt uncomfortable and went to the hospital for consultation and checkup and argued that the claim is payable.

The complainant had mentioned that he was feeling giddiness while traveling to Kancheepuram and immediately went to nearby hospital and consulted the chief Doctor on OP who said that he would need to be under observation.Asper the doctor's advice he was admitted to the hospital from 14.11.2008 to 20.11.2008.,subjected to various tests and checkup and oral treatment was given to him.The insured stated that all tests were found to be normal and his illness could not be diagnosed.He said that he was covered under the policy from the year 2000.The TPA /insurer had mentioned that as per their doctor's opinion there was no active line of treatment and the hospitalisation was mainly for evaluation /diagnostic purpose only.They argued that hospitalisation was not warranted and hence they have repudiated the claim.

It has been observed that the insured had giddiness which was subjective in rotation not associated with sweating or palpitation or dyspnea with no significant past medical history.During the stay in the hospital he was subjected to various investigations and referred to various specialists for evaluation. The patient was advised Tablet for 2 weeks in view of benign positional vertigo.The request letter for cashless approval raised by the hospital mentions the diagnosis as Giddiness for evaluation and the proposed line of treatment as Cardiac evaluation and ortho evaluation for rt shoulder pain.The discharge summary does not clearly spell out the specific reason for inpatient admission and mention that he was admitted for evaluation for giddiness.After admission for evaluation of giddiness some other incidental diagnosis relating to skin and sinus related problems were also carried out In as much as policy clearly states that the policy does not pay expenses for evaluation not followed by active line of treatment.the decision of the insurer in rejecting the claim under clause 4.10 is in order.

The complaint is dismissed.

Award dated no IO(CHN)/G/28/2010-11 dated 30thJuly2010.
(Medicalim)
Mr.G.Hariharan vs Royal Sundaram Insurance Co Ltd.

The complainant had taken hospital cash insurance policy from the above insurance co from 28.11.2008 to 27.11.2009 and as per this policy daily cash reimbursement of rs1,500/- is payable during hospitalisation.The complainant had stated that he met with a fire accident on 5.12.2008 and was admitted in the hospital.He had spent rs1,97,015/- for the hospitalisation for 86 days and he said that he continued his treatment on OP basis.The claim was settled by the insurer for rs19,800/-quoting that he was eligible to stay in the hospital for 12 days.The insurer had mentioned that their decision was based on medical opinion and on the remarks in the indoor case sheets.According to them such a long stay in the hospital was not required when there was improvement in the condition after 10 days after which he could have continued OP treatment .

The complainant had mentioned that he was treated by renowned plastic surgeon for healing his wound and physiotherapy was given to him as he was unable to sit stand and walk.He also mentioned that no skin grafting was done instead the wound was cleaned and dressed every alternate days.The insurer had represented that IP register of the hospital shows the date of admission as 5.12.2008 but there is no mention of date of discharge .Further the indoor case sheet clearly mentioned that since 17.12.2008 onwards the patient was feeling better and doing well,wounds were healing.The medical opinion obtained by the insurer had also mentioned that no major complication occurred during the stay and 10 to 12 days of stay in the hospital is required since the %of burn was between 8%to9% and not 15%In view of all these factors insurer had stated that they have settled the claim only for 12 days.and paid rs19,800/-@rs1,650/- per day.

It has been observed from the copies of case sheets that the patient was gradually improving and the recovery was uneventfull.The personal difficulties experienced by the insured during hospitalisation could have been taken care at home.Considering all the factors the insurer is justified in restricting the stay in the hospital to 12 days and the settlement of the claim for rs19,800/- is in order.

The complaint is dismissed.

Complaint no-11.04.1127 (Mediclaim)
Award no-IO(CHN)/G/ 29/2010-11 dated 30th July2010.
Mr.S.Venkataraman vs United India Insurance Co Ltd
(mediclaim)

The complainant had taken an individual mediclaim policy for himself and his wife from 2nd july 2001 for a sum insured of rs1lakh.His wife was hospitalized from 28.09.2009 to 05/10/2009 and lodged a claim for Rs63,155/-The insurer had settled the claim only for rs20,000/-.The insurer had argued that the mediclaim policy was changed from 09/07/2007with amendments in the terms and conditions ,introducing

cap limits for certain specified ailments and treatments.The complainant was also issued new policy from 15/07/2007 and the present claim has arisen in the third year of the policy and the caps/restrictions as applicable under this policy was applied in this claim.As the claim relates to Hysterectomy 20%of the SI was paid as per the policy terms and conditions.

On a perusal of the documents it was observed that the complainant's wife was hospitalized for abnormal uterine and vaginal bleeding and diagnosed as Adenomyosis with DUB and operated for LAVH surgery.The insurer had informed that the policy wordings had undergone changes from 09/07/2007 and the same was communicated to the policyholder.The insured had also confirmed receipt of policy terms and conditions in the years 07-08,08-09,and 09-10 and the insured's argument that to consider the claim as per the terms prevailing prior to the year 2007 is not acceptable since the hospitalisation had occurred during the policy period 2009-10.Hence the decision of the TPA/insurer in restricting the claim to 20%of the sum insured as per the policy terms of 2009-10in respect of Hysterectomy is justified.

The complaint is dismissed.

Complaint no-11.14.1136 (Mediclaim)
Award no-IO(CHN)/G/31/2010-11dated 20th Aug2010
Dr.K.Santhana Krishnan vs Cholamandalam MS Gen Ins Co Ltd
(mediclaim)

The complainant had taken a mediclaim policy for himself and his parents from 2ndAug2008.for a sum insured of rs4,00,000/-On 9thSep medical checkup was done on a reference from the insurer,the reports did not show any abnormalities.On 27.09.2008 she went to Vijaya hospital for a checkup for tiredness,weight loss,Anorexia and Nausea and she was diagnosed to have carcinoma –Pylorus.She was admitted in Stanely hospital with complaints of DISPEPSIA-2 months vomiting and abdomen pain –1 month.Later from 08/10/2008 she was on chemotherapy treatment periodically under a medical oncologist with Apollo hospital.Hence the insured had argued that the disease was not known till it was detected at the time of check up at vijaya hospital and in view of this it can not be treated as pre existing disease.

The insurer had argued that Stanely hospital records revealed that the patient was having DISPEPSIA for 2 months prior to admission where as the Apollo hospital DS indicated it as 1 month.As the disease was diagnosed in advanced stage medically it was estimated that it was pre existing.The claim was therefore rejected under pre existing clause.

The complainant had mentioned that as a matter of routine yearly checkup his mother underwent investigations at Vijaya Hospital for tiredness ,weight loss,anorexia and nausea on 27.09.2008 as they suspected cancer ,endoscopy and biopsy were done and confirmed ca,Pylorus The insured had stated that since he found the treatment to be expensive he shifted his mother to Govt Hospital on 30 .09.2008 and was diagnosed as carcinoma stomach.His mother was discharged from the govt hospital and admitted at Apollo Hospital on 8.10.2008

where surgery and chemotherapy was done.As per insured until the disease was diagnosed by Vijaya Hospital there were no indications of the disease and hence preexisting condition will not apply The insurer had mentioned that initially the discharge summary from Apollo only was submitted and the discharge summary from Vijaya and Stanely were not submitted .The insurer had argued that the symptoms for which she was admitted at Vijaya hospital indicated that she was suffering from advanced stage of the disease.

The perusal of various records indicate that even though the actual diagnosis of Adeno-carcinoma stomach appears to have been made after commencement of the policy the fact that the manifestation of the disease was in the advanced stage at the time of hospitalisation,which was within 2 months ,a very early period from the commencement of the policy ,suggests that the patient would have known the symptoms of ailment prior to the policy.By the complainant's own admission and the noting in the discharge summary of Stanley hospital it may not be inaccurate to conclude that the insured had been suffering from Dyspepsia/Vomitting/abdominal pain for 2 months ie around end of July 2008 which is prior to commencement of the policy.The fact that the insured had chosen to consult a leading hospital in a city far away from her place of residence without undergoing any initial treatment in a local clinic or hospital strengthens the insurer's contention that the insured had noticeable serious and known ailments /symptoms if not carcinoma as such.Taking all the factors into account the decision of the insurer in rejecting the claim is justified under pre existing condition clause or under the first 30 days exclusion clause .

The complaint is dismissed.

Complaint no11.05.1220. (Mediclaim)
Award no IO(CHN)/G/38/2010-11dated 31.08.2010
Mr.S.Balasubramanian vs Oriental Insurance Co Ltd

The complainant and his wife are covered under the Mediclaim policy of the insurer continuously from 2003.The complainant's wife after a month long fever and intense medication had a fall with seizure on 21.10.2009.Based on the brain scan she was admitted in the hospital for treatment from 22.10.2009 to 27.10.2009.The claim was rejected by the TPA on the ground of policy exclusion 4.8 dealing with treatment of psychiatric and psychomatic disorder.The insurer had stated that the patient was admitted with complaints of irrelevant talks ,confusion and fall followed by seizure.She was diagnosed of diabetes mellitus with bipolar mood disorder.The treating Doctor has confirmed that the patient was under treatment for mood disorder since 1997 and was under his treatment since 2005 for physicatric disease.Hence the claim was rejected under policy exclusion clause 4.8.

The complainant's wife had fever and seizure disorderon 21.10.2009,fell down injuring her head. She was on intense medication ,lost energy and became unconscious and consulted a doctor who happened to be a psychiatrist. According to the insured this was the first instance at which she was treated for this condition and she was not under

anybody's treatment prior to this. The insurer stated that the treatment was for bipolar disorder which falls under psychiatric treatment which was excluded under condition 4.8 of the policy. The consultation slips indicate that she was treated for fever prior to the hospitalisation at Taj Hospital. The MRI scan showed frontal lacunar infarct. From the discharge summary it is found that the patient was treated for bipolar mood disorder and diabetes mellitus.

The complainant had argued that his wife was not treated for psychiatric treatment whereas the treating DR had confirmed past history of the ailment and mentioned that the patient had been on treatment for Mood disorder from 1997from different psychiatrists. She was treated by him from 02.11.2005.Since the insurer was able to establish with treating doctor's letter that the ailment suffered by the complainant's wife was psychiatric and psychosomatic disorders falling under policy exclusions the rejection of the claim by the insurer is fully justified.

The complaint is dismissed.

Complaint no-11.07.1224 (Mediclaim)
Award no-IO(CHN)/G/39/2010-11 dated 31.08.2010
Mr.G.Srinivasan vs Star Health Allied Insurance Co Ltd

The complainant had taken Family Health Optima Insurance from the above insurance co for a sum insured of rs 2,00,000/-from 21.10.2008 to 20.10.2009 covering self and his wife.The complainant's wife had a fall and fractured her right ankle and was admitted in the hospital from 13.01.2010 to 23.01.2010.The insured had submitted the bills for rs 1,06,832.20 and the insurer had settled the claim directly to the hospital for rs72,648 and the balance was paid by the insured. The insurer had stated that some of the charges billed by the hospital was on the high side and hence as per the opinion of their medical team they have reduced the amount on various heads and settled the amount as reasonable and customary expenses as per policy terms and conditions.

The complainant's wife was hospitalized for fracture of right ankle.She underwent surgery and the insurer offered rs72,000/-as cashless facility initially ansd later paid further amount of rs6,157/-The insurer had disallowed an amount of rs28,023/-which in their opinion was in excess of reasonable expenses for this type of hospitalisation. The complainant had argued that since the hospital was among the networked hospital the insurer has to reimburse full claim amount as demanded by the hospital.Even though the intention of the insurer in pruning the hospitalisation expenses to a reasonable extent is well intentioned the insured can not be blamed for this.Having decided to settle the claim unless the quantum or %is specified for each expense under various heads it is difficult to fix the yardstick in respect of hospitalisation expenses incurred.For eg,the policy condition in respect of Room,Boarding expenses provide for

a %cap on sum insured subject to a maximum of certain quantumdepending upon the classification of cities.There is no such specific provision with regard to the heads under which the insurer has scaled down the amounts from the actual hospitalisation expenses incurred.The insurer is advised to rework and settle the balance claim on the basis of actual expenses incurred subject to other terms and conditions of the policy.

The complaint is allowed.

Complaint no-11.03.1228.(Mediclaim)
Award no-IO(CHN)/G/40/2010-11dated.31.08.2010
Mr.S.Chandran vs National Insurance Co Ltd.

The complainant was covered under the mediclaim policy of the insurer continuously from 2005 and the policy excluded hypertension and diabetes.During the policy period 2007-08 the complainant was treated for Adenomysis on OPD basis and lodged a claim for rs17,579/-The TPA had rejected the claim under exclusion clause 2.3 of the policy since the required minimum period of hospitalisation of 24 hours in this case was not complied with.

It is observed from the records that the insured was initially hospitalized between 04.12.2006 to 06.12.2006 for Right UL consolidation/Bronchiectasis.He had history of HT and this claim was settled.In continuation of the above treatment he had further consultation for treatment of Adenomyosis on OPD at Apollo Hospital,Chennai between 11.04.2007 and 22.10.2007.The insurer had argued that though the complainant was under continous treatment after the hospitalisation of Dec 2006,the treatment was by way of out patient consultations ,diagnostic tests and prescriptions of medicinesThe policy conditions did not provide for payment of claim for treatment as outpatient.Also the present out patient follow up treatment falls beyond the 60 day period of the earlier claim for hospitalisation.Taking all the factors the insurer is justified in repudiating the claim .

The complaint is dismissed.

Complaint no11.03.1231 (Mediclaim)
Award no-IO(CHO)/G/41/2010-11dated 31.08.2010
Mr.A.Shanmugam vs National Insurance Co Ltd

The complainant and his wife were covered under the mediclaim policy continuously from 2006 and the complainant was hospitalized for CABG surgery during 26.03.2009 to 06.04.2009.The claim was not considered by the TPA /insurer on the grounds of pre existing disease exclusion.According to the insurer as per the discharge summary the

patient is a known case of hypertension since 5 years.and the claim fall under preexisting disease exclusion4.1 of the mediclaim policy.

The insured suffered chest pain and got admitted into the hospital where he was advised to undergo early Angiogram.He then got admitted into Apollo First Medical for Coronary Angiogram which revealed recent IWMI and triple vessel disease and advised early CABG surgery.The history of Hyper tension is given as 3 years on treatment.Then he was admitted at Apollo Hospital Chennai for undergoing CABG surgery from 26.03.2009 to 06.04.2009 In that discharge summary the H/O of HT is given as 5 years.The claim was rejected by the TPA/ insurer on the ground that HT was pre existing quoting clause 4.1of the policy.It is observed from various discharge summaries in respect of 4 hospitalisations within a short duration of 4 months HT is mentioned as 3 years on treatmentin some and 5 years in few discharge summaries.The insurer could not produce any evidence to prove that the complainant was suffering from HT for the last 5 years or whether HT was preexisting prior to the policy commencement.If we take into account the duration of HT as 3 years the actual diagnosis of HT should have been April 2006 ie Just before commencement of the policy.The hospital gives history of past ailments only on an approximation as stated by the patient and not based on any past medical records.So considering the inconsistencies in the various Discharge summaries the submission of the complainant that the approximate duration of the past history of HT as 3 years appears reasonable.In the absence of any evidence to confirm the actual date of diagnosis of HT the contention of the complainant that HT was not preexisting can not be faulted.Therefore the insurer is directed to process and settle the claim in accordance with the other terms and conditions of the policy.

The complaint is allowed.

DELHI

Case No.GI/225/OIC/09
In the matter of Shri Pratap Singh Bhandari Vs
The Oriental Insurance Company Limited

Mediclaim - AWARD dated 05.04.2010

1. This is a complaint filed by Shri Pratap Singh Bhandari (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 his claim under OMP Policy taken by him. The brief facts of the case are as follows:

2. The complainant had taken the Overseas Mediclaim Policy with respondent company in September 2007 for his visit to Belgium. On arrival in Belgium, the complainant had allegedly sustained an injury on his foot due to fall of heavy luggage. He had consulted the local doctor immediately on 19.09.2007. Based on the medical opinion and nature of his wound, the complainant was operated on 05.10.2007. He had presented the bill for the above operation undertaken in a hospital in a foreign country. However, the respondent company had rejected the claim on the ground that on the date of his arrival i.e. 19.09.2007 the consulting Orthopedic Surgeon had certified that "the wound existed already quite a time, although the specific date of appearance is unknown". Therefore, and also relying on one or two statements made by other local doctors, the respondent company had come to the conclusion that the above infection has existed even prior to his arrival in Belgium and as such it is pre-existing ailment and in terms of the policy conditions, treatment for such pre-existing condition are not covered.

3. The complainant has pleaded before this forum on the date of personal hearing that he has been taking individual mediclaim policy at Udaipur with the same respondent company since 2001 without any claim. He periodically visits Belgium where his daughter lives. He had no intention of going only to get his leg operated during his visit to Belgium. Thirdly and most importantly that he had referred the matter to the local TPAs Coris Assistance who having gone through the estimates and expenses and have specifically confirmed, that the operation could be undertaken and the payment would be made subject to policy limitations.

4. Specially one doctor had categorically stated as follows:

> "The wound existed already quite a time, although the specific date of appearance is unknown".

5. Based on this opinion the respondent company have come to the conclusion that the condition is pre-existing. While for a moment even assuming that this particular condition as opined by the local doctor could have existed before his entering into Belgium, the fact remains that as rightly contended by the complainant, the local TPAs were the representative of the respondent company and have categorically vide their mail addressed to his daughter have cleared the operation and undertook to reimburse the amount subject to policy limitation etc.

6. From the above I am inclined to agree with the contention of the complainant that he had only gone for the operation after getting written approval for the operation. The mail also is dated on 05.10.2007 i.e. date of the operation. The opinion given by the respective doctors prior to the operation could have been perused by the local TPAs. It therefore postulates that local TPAs have cleared for his operation and it therefore goes without saying that they are fully aware of the medical records and the circumstances under which this operation was advised and conducted. It is a well established principle of law that if a person seeking permission to do certain thing, and if such a permission is granted, his action in following the permission cannot be challenged subsequently. This is called "principle of Estoppel" in Law. I have also gone through the records of the complainant regarding his previous medical history during last 7-8 years and there has been no claim whatsoever under those policies.

7. I also do not find any reason why the complainant should go to Belgium only with the intention to get his leg operated. The above suspicion does not stand to reason since the medical facilities and treatment are any day better and more convenient in India than in any other Country.

8. In the result I am afraid, having given the consent for the operation through the TPA and applying the principle of Estoppel, the respondent company cannot now deny the payment for the claim. As such I direct the respondent company to process and settle the claim for the operation conducted on 05.10.2007.

9. With this direction the complaint is disposed of.

10. Copies of the Award to both the parties.

Case No.GI/107/OIC/09
In the matter of Shri Davinder Pal Tuli Vs
The Oriental Insurance Company Limited

Mediclaim - AWARD dated 05.04.2010

1. This is a complaint filed by Shri Davinder Pal Tuli (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 his mediclaim. The brief facts of the case are as follows:

2. That the complainant had taken a Group Mediclaim Policy through M/s. Sputnik Medical & Research Foundation. The policy is from 05.05.2008 to 04.05.2009. The complainant was admitted between 09.12.2008 to 12.12.2008 and he had submitted a total bill for his treatment in the hospital. However, the respondent company has rejected the claim on the ground that the policy does not cover pre-existing disease during the first year. Since he was treated for CAD and HT which were pre-existing and as such in terms of the policy condition 4.3, the claim has been rejected.

3. Now taking up the available medical records, I find that the respondent had relied merely on the OPD discharge slip given by Kalra Hospital wherein it was shown that his BP was 210/130 also they have relied on the discharge summary also, wherein certain diagnosis were mentioned therein. I have also gone through the certificate issued on behalf of Kalra Hospital dated 07.03.2009. The doctor who had certified the same had clarified that his BP reading of 210/130 has come back to 140/19 subsequently. Even during his hospitalization the BP was within the normal limits. It is also confirmed that he was not prescribed any anti hypertensive drugs thereafter. Initial high BP could be due to reactionary rise in response to anxiety generated due to sudden neurological deficit of speech.

4. I am inclined to rely on the certificate issued by the doctor which does not appear to be influenced by anybody. The opinion mention therein is based on facts and medical situation. Therefore reliance on the OPD observation of existence of CAD and HT etc. do not deserves much reliance. Therefore, the respondent company had committed an error in denying the claim for his hospitalization treating the same as pre-existing. I also find that though it is not relevant to the actual claim, that these policies are given to some members in a medical and research foundation and that too for a person who was 59 years old. It would be better for the respondent company to go for pre- medical tests especially when the age of the policy holder is almost 60 years. Without taking such underwriting precautions, denying the claim at a later stage may not be proper.

5. In the result I direct the respondent company to process his claim for the treatment for the periods mention above and consider the same.

6. Copies of the Award to both the parties.

Case No. GI/118/UII/09
In the matter of Dr.V.K.Purang
Vs
United India Insurance Company Limited

AWARD dated 02.07.2010 – Mediclaim

1. This is a complaint filed by Dr.V.K.Purang (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 respect of non-settlement of mediclaim.

2. The complainant submitted that the Insurance Company was not justified in rejecting his mediclaim. He was under insurance along with his family for about 10 years with the United India Insurance Company Limited and no claim was made by the complainant in all these years. The complainant was admitted for acute low backache in Surgicentre Nusing Home in Vivek Vihar, Delhi for three days. He was investigated and treated by Orthopediac surgeon. All relevant documents along with discharge slip were given to the

company for reimbursement of the expenses. He could not submit the bills for medicines used as he himself was Orthopediac surgeon and utilized sample medicines as the same was not purchased from the market. Denial of his claim was not justified only on this ground that bills for medicines were not produced. It was submitted by him that his claim be admitted and the insurance company be directed for making payment of the claimed amount.

3. The Insurance Company repudiated the claim of the complainant on the ground that the hospitalization was primarily for investigation purposes. However, it was admitted by the Insurance Company that the complainant was hospitalized from 23.08.2007 to 27.08.2007 at Surgicentre Nursing Home and Maternity Centre. The hospitalization for the treatment of Limbago due to PVD as per the discharge summary of the hospital. The Insurance Company stated that the complainant was admitted only for investigation purposes and no active treatment was given during his stay in the hospital. It has been further stated that the claim of the complainant is not admissible under the policy.

4. The representative of the Insurance Company was present during the course of hearing. He almost repeated the reasons as given earlier and it was stated that claim of the complainant is not admissible because hospitalization was only for the purpose of investigation and not for treatment. The complainant had also not submitted the bills for purchase of medicines.

5. I have duly considered the submissions made by both the parties. After due consideration of the matter, I hold that the Insurance Company is not justified in repudiating the claim of the complainant because admittedly the complainant was admitted in the hospital for treatment and there may be truth in the statement of the complainant that he used the sample medicines for his treatment as he himself is a orthopedic surgeon. Investigations which were made in the hospital were part and parcel of the treatment. Therefore, assertion of the insurance company that there was no active treatment during the course of hospitalization was not justified. Accordingly, I direct the Insurance Company to make the payment of Rs.22040/-.

6. 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/161/RGI/09
In the matter of Shri Bhaskar Mohan Kedia
Vs
Reliance General Insurance Company Limited

AWARD dated 02.07.2010 – Mediclaim

1. This is a complaint filed by Shri Bhaskar Mohan Kedia (herein after referred to as the complainant) against the decision of the Reliance General Insurance Company Limited (herein after referred to as respondent insurance company) in respect of short payment of mediclaim.

2. The complainant submitted that the insurance company was not justified in not giving him the accrued cumulative bonus to which he was entitled while settling his claim. The complainant submitted that though he had submitted a claim for Rs.2,43,713/-but the same was settled for Rs.1,50,000/- which was paid to him. He further mentioned that he has been insured for the last 3 years and had not lodged any claim. He was entitled to cumulative bonus also which was not given by the Insurance Company. He requested to this forum to direct the insurance company for making the payment of accrued cumulative bonus under the policy for the last 3 years amounting to Rs.27500/-. He also claimed that since the insurance company failed to give accrued no claim bonus while settling the claim, he needs to be compensated for the same.

3. During the course of hearing, the representative of the Insurance Company agreed to pay no claim bonus accrued under the policy amounting to Rs.22500/- instead of claimed amount of Rs.27500/-.

4. I have duly considered the submissions made by the complainant that the insurance company was not justified in not making the payment of accrued no claim bonus while settling the claim. During the course of hearing, the representative of the Insurance Company agreed for making payment of Rs.22500/- for settling claim. It means the insurance company admits its fault of nonpayment of accrued no claim bonus to which the policy holder was entitled at the time of settling the claim. Accordingly, I direct the Insurance Company to make the payment of Rs.22500 /- along with penal interest at the rate of 8% from 11.02.2009 to the date of payment.

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/130/OIC/09
In the matter of Shri Anil Kumar Aggarwal
Vs
Oriental Insurance Company Limited

AWARD dated 02.07.2010 – Mediclaim

1. This is a complaint filed by Shri Anil Kumar Aggarwal (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 respect of repudiation of mediclaim.

2. The complainant submitted that his mediclaim given to the insurance company in January, 2008 to Raksha TPA, Faridabad was not settled and the same subsequently repudiated. It has been submitted by him that he was not given any reply with regard to his claim and requested this forum to interfere for settling his claim. However, he has been informed by the TPA vide letter dated 29.05.2008 that his claim is non-payable

stating that treatment could be taken as OPD basis. It has been informed by him that he has taken his daughter Ms.Ruchika to the hospital under emergency and the doctor advised to admit her in the hospital. It is argued by him that he had got his daughter admitted in the hospital under advice of the doctor.

3. The Insurance Company not only not responded to the queries of the complainant but also not complied with various letters written by my office. However, on the date of hearing, a reply was submitted dated 02.07.2010 stating therein that the claim of the complainant is not admissible as per policy terms and conditions. It has been mentioned in the reply by the Insurance Company that Ms.Ruchika, 17 years old daughter of the policy holder was admitted at Apollo Hospital on 16.01.2008 with history of headache for 5 days, one episode of loss of consciousness 5 days back associated with nausea and stiffness of limbs.

   It has been mentioned by the insurance company that the claim was rejected on the ground that the hospitalization was done only for investigation purposes and there was no need for hospitalization. No abnormality was revealed as a result of her physical examination. No final diagnosis was made at the time of discharge. It has been mentioned that the claim of the policy holder was not admissible as per policy terms and conditions. During the course of hearing, the representative of the insurance company stated that there was no need of hospitalization and she could have been treated as an outdoor patient. Therefore, the claim is not admissible.

4. I have duly considered the submissions of the complainant that claim was admissible and the same was repudiated citing wrong reasons. I have also perused the written submissions as furnished during the course of hearing by the representative of the insurance company. After due consideration, I hold that the insurance company was not justified in repudiating the claim of the policy holder because the Ms.Ruchika was admitted in the hospital on account of emergency and as per the advice of the doctor, she was admitted in the hospital. The complainant had to act upon the advice of the doctor while showing his daughter to the doctor. It appears to be a genuine case of hospitalization of the insured person. Therefore, in my view the claim was wrongly

rejected by the insurance company. The same ought to have been accepted. Accordingly, I pass the Award that a sum of Rs.21173/- be paid to the complainant.

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/134/UII/09
In the matter of Shri Sanjeev Goswami
Vs
United India Insurance Company Limited

AWARD dated 02.07.2010 – Mediclaim

1. This is a complaint filed by Shri Sanjeev Goswami (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 respect of non-settlement of mediclaim.

2. The complainant submitted that he was covered by Individual Health policy No.40401/48/08/97/00002963 for the last 3 years. He was operated for Acute Necrotizing Pancreatitis with Colonic Leak at Sir Ganga Ram Hospital, Rajinder Nagar, New Delhi. The claim was submitted to the Insurance Company in February, 2009 after discharge from the hospital. His claim has been refused by the company stating that the disease is covered in Exclusion Clause 4.6 of the policy. It has been submitted by the complainant that the discharge summary given by the hospital did not mention this fact as the reason was cited by the company for rejecting his claim. It is further stated by the complainant that the company had taken decision unilaterally and had not provided any opportunity to him before rejecting his claim. It was stated by him that he was in sound health and had never made any claim for the last three years. It has been argued by him that the decision of the insurance company rejecting his claim under exclusion clause 4.6 of the policy is not only denial of his legitimate right under the law but also put him in embarrassing condition along with his family. He spent a huge amount of Rs.11,65,000/-

for getting treatment from Sir Ganga Ram Hospital and Lotus Hospital though he was insured only for Rs.3,00,000/-. He argued that his illness was not due to use of alcohol. He requested the forum to direct the company for making the payment of his claim.

3. The claim of the complainant was repudiated by the insurance company citing detailed reasons. It has been submitted by the company that Shri Sanjeev Goswami is insured with them with effect from 10.03.2006 to till date without any break. The insured was admitted in Sir Ganga Ram Hospital on 05.12.2008 with diagnosis of Acute Necrotizing Pancreatitis with colonic leak and treated for the same and lodged a claim. The complainant had lodged a claim with the company and the company had appointed Dr.Vipin Gupta to visit hospital and verify from records of the complainant at hospital. Dr.Gupta had submitted his report with diagnosis of Acute Chronic Pancreatitis with Renal Dysfunction with colonic leak –cause of which had been labeled as Alcoholism. It has been submitted by the company that doctor's report alcoholism and its related disorders are excluded from the scope of Individual (gold) Health Insurance policy. It has been mentioned that the claim of the complainant was not admissible as per terms and conditions of the policy. The company also sought details from the hospital where the complainant was treated using RTI Act, 2005 but the same was not disclosed to the company. It has been further submitted by the company that Sir Ganga Ram Hospital allowed Dr.Vipin Gupta to peruse the medical records relating to the complainant. Thus, it appears that the claim of the complainant was repudiated mainly on the basis of report of Dr.Vipin Gupta who opined that the claim is not admissible as per exclusion mentioned in Para 4.6 of the policy which reads as under:

"Convalescence, general debility: run down condition or rest cure, congenital external disease of defects or anomalies, sterility, venereal disease, intentional self injury and use of intoxication drugs/alcohol."

Even for the sake of repetition, it appears worthwhile to quote the opinion of Dr.Vipin Gupta on the basis of which the claim of the complainant was turned down:

"OPINION : In view of the above observations I am of opinion that the present claim is not within the purview of mediclaim policy as alcoholism related disorders have been excluded from mediclaim policy and hence the present claim is not admissible as per policy terms and conditions."

4. During the course of hearing also the representative of the insurance company based his arguments on the opinion of Dr.Vipin Gupta. He argued that the claim of the complainant was not admissible. Therefore, the same was rightly repudiated.

5. I have very carefully gone through the detailed reasons submitted by the insurance company for repudiating the claim including the opinion of Dr.Vipin Gupta,MBBS on the basis of which the complainant's claim was turned down. I have also duly considered the submissions made by the complainant. Before the case was finally taken up, opinion of medical expert was also taken by this office. The opinion of Dr.Vipin Gupta was submitted to the medical expert along with entire file for his perusal. The medical expert Dr.M.S.Sagar, MBBS, MD, registration No.MCI-4959 had given his opinion which reads as under:

"OPINION : This is a case of hospitalization for the management of pain in left hypochondrium and epigastrium since one month followed by severe pain and nausea since one week with history of Prolapsed Intravertebral Disk since 2 years investigated and diagnosed as Acute Necrotizing Pancreatitis with Colonic Leak and managed with Necrosectomy with closed drainage with loop ileostomy and other supportive treatment. The investigation done and treatment given was relevant and consistent with the diagnosis/illness.

With there being no H/o chronic alcoholism/Intoxication mentioned in the discharge summaries of both the hospitalization, undersigned is of the opinion, the claim is admissible, as it is not falling under any of the exclusion clauses of the mediclaim policy. It may be settled as per policy terms and conditions.

It is further clarified that the two major causes of acute pancreatitis are (i) biliary calculi which occurs in 50-70% of the patients and alcohol and other rare causes being drug induced hyper-parathyroidism/hypercalcemia, trauma following Endoscopic Retrograde Cholangio Pancreatography, Hereditary, Idiopathic, auto-immune etc.

The report is submitted without any prejudice."

As is evident, as per the opinion of Dr.M.S.Sagar, the claim of the complainant is admissible as it is not falling under any of the exclusion clauses of the mediclaim policy. In view of the detailed reasoning given by Dr.M.S.Sagar, in conclusion of his opinion that the claim of the complainant is admissible and the disease from which he suffered and for which he was treated in the hospital does not fall in the exclusion clause 4.6 of the mediclaim policy. Hence the claim of the complainant was wrongly repudiated and the same ought to have been accepted by the company. The complainant spent huge amount on his treatment. He has been under insurance cover for the last three years. He had not claimed any benefit under the policy during the last three years. He has been insured for a sum insured of Rs.3,00,000/-. Having considered all facts on record and circumstances of the case, I am of the opinion that the claim of the complainant is admissible as per policy terms and conditions. Dr.Vipin Gupta, is MBBS on the opinion of which the company had repudiated the claim of the complainant whereas Dr.M.S.Sagar is MD,MBBS and ex-Registrar (AIIMS), the opinion expressed by him can be termed as opinion expressed by more qualified doctor. Therefore, the claim of the complainant can be held acceptable on the basis of opinion expressed by Dr.M.S.Sagar. Since complainant had not claimed any amount during the last three years, accordingly **I direct the Insurance Company to make payment of Rs.3,00,000/- along with cumulative bonus as admissible under the policy.**

6. 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/125/UII/09
In the matter of Shri P.C.Chawdhury
Vs
United India Insurance Company Limited

AWARD dated 02.07.2010 – Mediclaim

1. This is a complaint filed by Shri P.C.Chowdhury (herein after referred to as the complainant) against the United India Insurance Company Limited (herein after referred to as respondent insurance company) in respect of non-renewal of mediclaim policy.

2. The complainant submitted that he has written a number of letters to the insurance company but no reply has been given to his letters. He even met the Divisional Manager personally on 13.04.2010 requested to redress the complaint. He was given assurance by the Manager to respond to his letters within a week but no response was received. Even his e-mail letters remained uncomplied. He has submitted that his mother Smt. Hemlata Chowdhury, 83 years old was insured with the company since 1992. Suddenly, the premium was increased and no reasons were given. Since no reasons were given for enhancing the premium so excessively (240%), he had not paid the premium with the result the policy got lapsed. He expressed his anguish that his old mother who paid all premiums since 1992 faithfully without claiming a single paisa is at risk of dying without mediclaim cover with all mala fide intention of the company as the company is not responding to his genuine requests. Even his letters written to Grievance Redressal Cell of the company remained unreplied. He also requested to convey him actual amount of premium to be paid by him for continuance of policy and to condone the delay in payment to confirm continuity with no loss of benefit. He has requested the company to use its discretionary power to go beyond rules in favour of the complainant's mother and the policy on his mother be restored with the same premium from back date.

3. The representative of the insurance company during the course of hearing submitted that the premium has been charged as per tariff, as per table for the sum insured. It has been submitted by him that the company had not been unfair to the complainant. However, he expressed his inability to continue the policy from the back date because premium was not paid and consequently the policy lapsed.

4. I have very carefully considered the submissions of the complainant and also gone through the reply as submitted by the insurance company and also the verbal submissions made by the representative of the company during the course of hearing. After due

consideration of the matter, I find that replies were not given by the insurance company to the complainant in response to his letters. Complainant had also met the Divisional Manager and also approached the Grievance Cell for redressal of his grievance but of no avail. Had the Insurance Company conveyed to the complainant the reasons of enhancing the premium so excessively, complainant would have made the payment of premium and consequently policy would have continued, but the same was not done? The Insurance Company needs to be more responsible and is required to respond to various query letters written by the complainant. The request of the complainant to continue the policy despite the non-payment of premium appears to be unreasonable and against the established terms and conditions of the policy, but in my considered view, it is a deserving case to bestow benefits to the policy holder who has been paying premiums since 1992 without claiming any reimbursement. Therefore, it would be doing justice to her if a fresh policy is issued to complainant's mother waiving the pre-existing conditions/first year exclusion clause on payment of requisite amount of premium. The competent authority of the company may use its discretion power for the same. The complaint of the complainant stands 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/181/NIC/09
In the matter of Shri Pradeep Aggarwal
Vs
National Insurance Company Limited

AWARD dated 12.07.2010 – Mediclaim

1. This is a complaint filed by Shri Pradeep Aggarwal (herein after referred to as the complainant) against the decision of National Insurance Co. Ltd (herein after referred to as respondent Insurance Company) regarding non- payment of Mediclaim.

2. Complainant submitted that his claim though approved has not been paid so far. It has been reported by the complainant that his claim was approved by the TPA on 20.08.2008 but so far he has not been paid the claimed amount by the TPA or by the Insurance Company. The complainant did not attend the hearing fixed for today.

3. The representative of the Insurance Company attended the hearing. It has been reported by him that payment for the claim of Rs.40205/- was not made so far. He had placed on records a letter dated 10.07.2008 to the effect that claim of Rs.40205/- is payable and Mumbai Office has confirmed that the payment was not released by that office. However, as a matter of precaution it has been advised to ensure as to other such payment was released by TPA E-Meditek Solutions Pvt. Ltd.

4. I have considered the submissions as placed on records by the complainant. I have also heard the representative of the Insurance Company and also letters received from the Insurance Company placed on records. After due consideration of the matter I hold that insurer was not justified for not releasing a sum of Rs.40205/- so far. The claim was found acceptable by the TPA and there has been confirmation by the TPA that it had not made any payment so far. Thus there appears to be a gross negligence on the part of the insurer in not making the payment promptly after approved by the TPA. TPA has approved the claim vide their letter dated 20.08.2008.

5. Accordingly, I direct the Insurance Company to make the payment of Rs.40205/- without further loss of time. It is also further directed that Insurance Company will make payment of Penal Interest w.e.f. 01.09.2008 to the date of payment @ 8% on the claim amount.

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.

Copies of the Award to both the parties.

Case No.GI/213/OIC/09
In the matter of Shri Rajinder Kumar
Vs
The Oriental Insurance Company Limited

AWARD dated 26.07.2010 – Mediclaim

1. This is a complaint filed by Shri Rajinder Kumar (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 repuiation of Mediclaim.

2. Complainant submitted that his claim was not settled irrespective of frequent complaints to the insurer. He had contacted CMD, Grievance cell and DO-09 of Oriental Insurance Co. Ltd. through many mails and couriers. It has been stated in the complaint that claim was not settled as there was delay in lodging claim. TPA changed the address without intimation and that was the reason for late submission of the claim. He had suffered financial loss due to irresponsible behavior of the Insurance Company's officer.

3. The insurer intimated the complainant vide letter dated 17.12.2008 that the claim of the complainant has become non-payable by TPA M/s. Genins India Ltd. due to violation of Policy terms and conditions. While going through the documents submitted by the complainant, it was observed by the Insurance Company that the complainant was admitted in the hospital on 31.08.2008 and discharged on 02.09.2008 whereas complainant had intimated to TPA on 09.09.2008 hence there was a delay of nine days and therefore claim was not tenable. The representative reiterated the stand of the Insurance Company that the claim was made No Claim case as it was filed late by few days. Vide letter dated 28.12.2009, the Insurance Company intimated this office that complaint submitted the claim beyond the stipulated period as prescribed under clause 5.5 of the policy and intimation was also not received as per clause 5.4 of the policy, however, it has also been mentioned in the letter that the claim is medically admissible.

4. I have considered the submission of the complainant. I have also considered the reason given by the Insurance Company for repudiation of the claim. After due consideration of the matter, I hold that Insurance Company was not justified in treating the claim of the complainant as no claim. There was delay of few days in submission of the claim and such delay is properly explained by the complainant that he sent the claim to the TPA in time but due to change of address of TPA, delay occurred. In my considered view, delay has been caused due to reasonable cause and the claim otherwise admissible cannot be rejected on such ground. The Sr. divisional Manager of the Insurance Company had categorically stated in the letter dated 28.12.2009 that the claim is medically admissible, but for the delay. I, therefore, direct the Insurance Company to make payment of the claim of Rs.15875/- along with 8% penal interest from the date of repudiation to the date of payment.

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 the Award to both the parties.

Case No.GI/204/NIC/09
In the matter of Shri Subhash Chander
Vs
National Insurance Company Limited

AWARD dated 26.07.2010 – Mediclaim

1. This is a complaint filed by Shri Subhash Chander (herein after referred to as the complainant) against the decision of National Insurance Co. Ltd (herein after referred to as respondent Insurance Company) for repudiation of Mediclaim.

2. The complainant submitted that he had taken a Mediclaim policy from National Insurance Co. ltd. for the period 21.12.2007 to 20.12.2008. The policy has been renewed by the same Insurance Company. On 18.03.2009, due to severe pain, his wife who was covered by the above referred policy, consulted Dr. Rakesh Gupta and who suggested

that she needed immediate operation. Accordingly she was admitted to Nazar Kunwar Surana Hospital, Delhi. There he had shown his Mediclaim card and asked him that he was insured along with his wife by the Insurance Company with TPA Alankit Healthcare Limited, whether the hospital had cashless facility with the TPA. He confirmed cashless facility with regard to availability of cashless facility from M/s. Alankit Healthcare Ltd. He was informed that due to some RO-II problem, they are unable to process his claim as cashless and requested him to file the claim for reimbursement. He made payment of the treatment expenses in the hospital. He was informed by the Insurance Company vide letter dated 09.06.2009 that since treatment was taken in Nazar Kunwar Surana Hospital, New Delhi which is outside the approval list of hospital provided to him at the time of insurance his claim was rejected. He approached the grievance cell but of no avail. It has been submitted by him that the hospital where treatment was taken is qualified and the rejection was not in order. Whenever, one falls ill, one has to rush to the nearest hospital, this is what he did. It is submitted by him that while taking his wife to the hospital, approved list of hospital was not consulted. It has been submitted by him that his claim is genuine and he be paid the claim immediately.

3. The Insurance Company rejected the claim and conveyed the complainant on 09.06.2009 the reasons cited for rejection was that the hospital in which treatment was taken is outside the list of approved hospital and such list was provided to the complainant at the time of insurance. Representative of the Insurance Company stated that though the hospital where active treatment was taken was earlier in the approved list but later on the same was excluded from the approved list of hospitals. He submitted that complainant could have got treatment of his spouse only at the approved hospital for getting the reimbursement of the treatment expenses.

4. I have considered the submissions of the complainant very carefully. I have also seen the written submission of the Insurance Company for not entertaining the claim of the policy holder. After due consideration of the matter, I hold that Insurance Company was not justified in rejecting the claim because complainant had taken Mediclaim policy only to get reimbursement of the treatment expenses. The policy was renewed year after year

and while policy was taken for the first time this hospital was included in the approved list. Moreover, hospital where treatment was taken is registered one and therefore there is no reason not to allow the claim of the policy holder on account of treatment taken in the registered hospital. In my considered view, policy holder cannot be bound to get the treatment in the particular hospital for getting the reimbursement because treatment can be taken by the policy holder at his convenience and not at the convenience of the insurer. **I, therefore, direct the Insurance Company to make the payment of Mediclaim amounting to Rs.47,525/- and also to pay penal interest @8% from the date of rejection to the date of actual payment.**

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 the Award to both the parties.

Case No. GI/219/UII/09
In the matter of Shri Deepak Sharma
Vs
United India Insurance Company Limited

AWARD dated 26.07.2010 – Mediclaim

1. This is a complaint filed by Shri Deepak Sharma (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 respect of repudiation of mediclaim.

2. The complainant had submitted that he was admitted in the hospital in the month of December,2007. He was insured vide policy No. 010500/2006/4806003310/1 under TPA Medsave Health Care Pvt. Ltd. Later on TPA was changed to M/S.TTK Health Care and the Insurance Company United India Insurance Company Limited forwarded the papers to M/S.TTK Health Care Private Limited. He had submitted all papers for settling his claim and the same are available with M/S.TTK Health Care Private Limited but the company continued to drag the matter and had not settled the claim till date. He had

requested also on 27.05.2009 to the company to settle the claim but it had failed to do so inspite of number of visits. It is submitted by him that he had given reply by e-mails to each and every letter received by him from the insurer.

3. The insurance company had not responded to the request of the complainant to settle his mediclaim promptly but on persistent requests made by the complainant, the company had paid some attention to the claim of the complainant. In order to settle the claim of the complainant, certain information is desired to be furnished by the complainant. The filing of such information, it appears, was necessary for the settlement of the mediclaim.

   However, desired informations have not been submitted by the company, therefore, the company had closed the claim for non-compliance of the information. No one appeared on behalf of the company during the course of hearing. However, it is mentioned that some official contacted this office very late in the evening when the hearing was over and that too on calling by the officer attached with this office. However, no information regarding settlement of the claim was given.

4. I have considered the written submissions of the complainant and also the verbal submissions made by him during the course of hearing. I have also gone through the various replies given by the company which are placed on record. After due consideration of the matter, I hold that the insurance company was not justified in not settling the mediclaim of the complainant though the policy holder filed a claim of Rs.2,09,319/-. However, he was insured only for a sum of Rs.1,00,000/-. I find that the company had not given any specific reason for not allowing the mediclaim of the complainant. As a matter of fact, it had sought certain information from the complainant itself to enable it to decide the issue. The company ought to have independently enquired before settling the mediclaim. The insurance company cannot make complainant as witness against itself for taking decision. **I, therefore, direct the company to make payment of Rs.1,00,000/- to the policy holder which is the sum insured in this case. Moreover, there has been inordinate delay in taking the decision in this case. The policy holder has submitted its claim on 29.12.2007 immediately after treatment was**

over. Therefore, it is a fit case where the insurance company is also required to make the payment of penal interest also @ 8% from 01.02.2008 till the time the payment is made.

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/217/UII/09
In the matter of Shri Kamal Mehta
Vs
United India Insurance Company Limited

AWARD dated 26.07.2010 - non settlement of post hospitalization expenses

1. This is a complaint filed by Shri Kamal Mehta (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 respect of non-settlement of post hospitalization expenses.

2. The complainant submitted that his parents aged 63 years were covered by mediclaim policy No.02180048074100000319 issued by United India Insurance Company Limited. This policy was administered by 3rd party TTK Health Care Private Limited. Sometime in the month of January/February, 2009, his mother and father were hospitalized. Hospital expenses were paid directly by the insurer under cashless facility. Subsequently on 13.04.2009, the claims of Rs.5456/- and Rs.18795/- for post hospitalization treatment expenses were submitted along with necessary bills but the insurer had not made the payment so far.

3. No one came to attend the hearing on behalf of the company which shows that whatever replies placed on records of this office by the company, the same only have to be considered before making a decision.

4. I have considered the submissions of the complainant placed on record and have also heard the complainant's verbal submissions. I have also perused the papers submitted by the company. After due consideration of the matter, I hold that the company was not justified in not settling the claim in respect of reimbursement of post hospitalization treatment expenses. The company had already made payment of treatment of hospitalization through its TPA. **There is no justification for the company not to make payment for post-hospitalization treatment. I therefore, direct the company to make the payment of Rs.24251/- to the complainant.**

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/176/RSA/09

In the matter of Shri Ravi Mahajan
Vs
Royal Sundaram Alliance Insurance Company Limited

AWARD dated 26.07.2010 – Mediclaim

1. This is a complaint filed by Shri Ravi Mahajan (herein after referred to as the complainant) against the decision of Royal Sundaram Alliance Insurance Co. Ltd (herein after referred to as respondent Insurance Company) for repudiation of Mediclaim.

2. The complainant submitted that he had taken a policy no. CS00027399000100 in May 2006 from Royal Sundaram Alliance Insurance Co. Ltd. under Hospital care Insurance Plan and the same was renewed for the year 2007-08. There was no medical checkup insisted upon/undertaken by the insurer at the time of granting/issuing the said policy. He felt chest pain and was taken to Escorts hospital, New Delhi for urgent medical care, where he was admitted and diagnosed and had undergone Angioplasty. He was discharged from the hospital on 22.07.2007. He lodged a claim for hospitalization care for the duration of the hospitalization i.e. from 18.07.2007 to 22.07.2007. The Insurance Company had rejected the claim on the ground that he suffered from pre-existing disease.

It was stated by the Insurance Company that atherosclerosis in the coronary artery takes few years to develop and that the attending doctor has mentioned Hypertension, in the column "previous medical history" of the claim form. He requested the Insurance Company to reconsider the claim but the same was rejected again on the same ground. In March 2008, he was again admitted in the same hospital and had to undergo By-pass surgery for which he had to remain in the hospital from 17.03.2008to 26.03.2008. He felt uncomfortable after the hospital and again admitted in the hospital; from 29.03.2008 to 02.04.2008. Accordingly second claim was lodged in the month of May 2008. The insurer vide letter dated 13.05.2008 intimated him that his claim was not admissible as the policy did not cover pre-existing disease. While doing so, the Insurance e Company had not discussed the facts in details and had not gone into the point of the treating doctor that the patient was not the known case of Hypertension in the past but was detected to the hypertensive at the time of admission. Moreover an individual can become a frank case of CAD in short period when non critical plaque, ruptures and causes critical CAD resulting in unstable angina. He had again requested the insurer to reconsider the claim. He also referred to the decision of Hon'ble Supreme Court wherein it was held that the Insurance Company was to pay medical claim even in case of pre-existing disease. It has been stated by him that a decision of the Hon'ble Supreme Court is referred by him had not been discussed by the Insurer while rejecting his claim. He had requested that the insurer be directed to pay for the hospitalization duration in accordance with the health policy, as the treating doctor can only opine/clarify or give the specific view over the issue.

3. On behalf of the Insurance Company, written submissions were placed on record. Representative of the insurer also attended the hearing. Firstly it has been stated that complaint of the complainant is not entertainable as the same was filed beyond the period of one year as stipulated under rule 13 (b) of Redressal of Public Grievance, Rule 1998. Secondly, it was stated that the claim is not admissible in view of the fact that policy holder was suffering from pre-existing disease. The Insurance Company had consulted the panel doctor and has referred to the opinion expressed by such doctor, which had been taken to account while repudiating the claim of the policy holder. It was stated that

the policy holder was admitted for symptoms of unstable angina and it was diagnosed as coronary artery disease having a block of 90% in arteries, which takes longer time to develop and it could be few year for development of such block of 90% and hence is a pre-existing disease, from which policy holder was suffering and got treatment. It was mentioned by the complainant's letter that hospitalization of the policy holder was for pre-existing ailments which is outside the scope and purview of the policy coverage.

4. I have very carefully considered the written submissions of the insurer and also the verbal arguments of the representative during the course of hearing. I have also considered the verbal submissions of the complainant and also gone through his written submissions placed on records. After due consideration of the matter, I hold that Insurance Company was not justified in rejecting the claim of the complainant, as there was conflicting opinion of the experts on the issue as to whether blockage is as a result of short period or long period. It is an admitted fact that policy holder was not examined while giving the policy by the Insurance Company and if it so, the Insurance Company had to admit that he was not suffering from the disease for which he was admitted and got the treatment. There is no record to state that the policy holder was treated for a similar disease earlier and admitted for treatment of such disease in past. **Accordingly I direct the Insurance Company to make the payment of Rs.30,000/- (it is worked out (Rs.1500/- per day for the total duration of hospitalization for 20 days) along with penal interest @8% from the date of rejection to the date of actual payment.** The contention of the Insurance Company that complaint was filed beyond the limit prescribed as per Rule 13 (3)(b), the same is not acceptable because the limit has to be seen with reference to the last letter received by the complainant from the insurer and if this taken into account, the complainant filed within the prescribed limit. Therefore, I reject the contention of the Insurance Company that complaint was filed beyond the period prescribed under Rule 13 (3)(b).

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 the Award to both the parties.

Case No. GI/179/NIC/09
In the matter of Shri Sunil Sethi
Vs
National Insurance Company Limited

AWARD dated 27.07.2010 – Mediclaim

1. This is a complaint filed by Shri Sunil Sethi (herein after referred to as the complainant) against the National Insurance Company Limited (herein after referred to as respondent insurance company) in respect of Non-settlement of mediclaim.

2. The complainant submitted that he was insured since 30.04.2004 under ICICI Lombard General Insurance Company Limited. The health insurance policy was renewed year after year without any break with ICICI Lombard General Insurance Company Limited till 29.04.2008. During this period no claim was made and the same has been endorsed in the renewal notice of the insurance company. On 29.04.2008, the same health insurance policy has been renewed with the National Insurance Company Limited. It has been submitted by him that in the month of September,2009, he had gone for health check up offered by SRL Diagnostic. On finding some discrepancy in the report, he consulted Dr.Atul Gupta and had been taking the medicines as prescribed by him since then. It is submitted by him that to the best of his knowledge he had never consulted any doctor for any disease earlier. Neither he was hospitalized. However, on 27.04.2009, he was hospitalized in Escorts Institute and Research Centre for investigation as he had pain in his chest for the last two to three days. After coronary angiography, he was advised for stint by the doctor. Next day request for pre-authorization of cashless facility was sent to the company. The complainant was required to furnish certain details which were submitted but the cashless facility was denied. He had to pay entire amount of hospital bill. He had submitted original treatment papers for reimbursement of the claim of Rs.2,75,730/- but his claim was not processed.

However, vide letter dated 14.07.2010, the complainant was conveyed by the company that this is the first year of the policy with the company and no benefit can be given. This fact can be verified from the copy of the policy and the claim of the complainant was repudiated. The insurance company also informed the complainant that complainant was a known case of diabetes and hypertension which he had not informed in the proposal form submitted by him before taking the policy, that is to say, that since the complainant had not disclosed the material facts regarding his health while taking the policy, he misrepresented the company and therefore, the claim is not payable under the policy clause 4.1.

However during the course of hearing, the representative of the insurance company stated that the claim is admissible and claim will be settled within a week from the date of hearing on 16.07.2010 but uptil now there is no communication to this effect from insurance company.

3. I have considered the submissions of the complainant as discussed above. I have also perused the letter of the insurance company dated 14.07.2010 whereby the claim of the complainant was repudiated. After due consideration of the matter, I hold that the company was not justified in repudiating the claim because complainant was covered by the Health policy and he had taken the policy on 30.04.2004 from ICICI Lombard General Insurance Company Limited upto 20.04.2008. Thereafter from 20.04.2008 his policy has been renewed by National Insurance Company Limited. Since complainant had been insured from 30.04.2004, even after changing the insurance company, he cannot be denied the benefits accrued from the earlier policy. He had not claimed any reimbursement on his previous policies. Even Clause 4.1 of the policy is not against the complainant because pre-existing diseases are also covered after four continues claim free policy years and such clause is also applicable to the insurer**. I, therefore, direct the company to make the payment of Rs.2,75,730/- along with penal interest @ 8% from 01.07.2009 till the time the payment is made.**

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/194/RGI/09
In the matter of Shri Sanjay Dudeja
Vs
Reliance General Insurance Company Limited

AWARD dated 04.08.2010 – Mediclaim

1. This is a complaint filed by Shri Sanjay Dudeja (herein after referred to as the complainant) against the decision of Reliance General Insurance Co. Ltd (herein after referred to as respondent Insurance Company) for repudiation of Mediclaim.

2. The complainant submitted that he is a holder of Mediclaim insurance policy bearing no. 282550096303 from Reliance General Insurance Co. Ltd. During the course of the policy, he was hospitalized at St. Stephen hospital, Tees Hazari, New Delhi on 21.05.2008 and discharged on 24.05.2008. During the hospitalization he was diagnosed and treated for "Inferior Wall Mi with Cad with Unstable Angina with Htn with Dm". He submitted that his claim for the treatment to the Insurance Company on 23.07.2008 but the Insurance Company had denied the claim on account of late submission. It has been submitted by him that doctors had advised him complete bed rest for 2 months. He is a only adult male member in the family, his wife and 2 children were not in a position to submit a claim. Moreover, the Insurance Company also did not inform him that claim must be submitted within stipulated time. He has been filing the claim. He had given reminders in December 2008 and July 2009 but he had not been given the claim so far.

3. Written submissions were placed on record on behalf of the Insurance Company. The claim was repudiated earlier by TPA vide letter dated 06.08.2008 on account of late submission of the claim. However, during the course of hearing, Insurance Company's

representative stated that claim will be settled within 2 weeks, such assurance was given on 16.07.2010. A letter dated 31.07.2010 was received from the Insurance company wherein it has been informed that Insurance Company had paid a sum of Rs.1,72,724/- against the claim amount of Rs.1,73,700/-.

4. After due consideration of the matter I hold that the Insurance Company had repudiated the claim on unsubstantiated grounds. Insurance Company ought to have required the complainant to submit the reasons for not submitting the claim on time. The complainant was prevented by sufficient cause from filing the claim within stipulated time. The claim was repudiated on 06.08.2008. As regards the claim of Rs.173700/- put up by the complainant, the Insurance Company had already paid a sum of Rs.172724/- but had not paid the interest. **Accordingly I direct the Insurance Company to make the payment of Interest @ 8% from the date of repudiation i.e. 06.08.2008 to the date of payment of Rs.172724/-.**

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 the Award to both the parties.

Case No. GI/186/UII/09
In the matter of Shri Sachin Vasudeva
Vs
United India Insurance Company Limited

AWARD dated 05.08.2010 – Mediclaim

1. This is a complaint filed by Shri Sachin Vasudeva (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 respect of repudiation of mediclaim.

2. The complainant submitted that his wife Smt. Babita was hospitalized on 06.10.2008 in Friends Medical Centre (Cosmos Hospital) at Kalindi Colony for treatment of bi-polar disorder. She was discharged on 03.11.2008 from the hospital. Hospital raised the bill for an amount of Rs.2,65,430/-. The complainant further spent a sum of Rs.2257/- on medicines and accordingly the total claim filed by him was for an amount of Rs.2,67,687/-. Within a week of admission of his wife to the hospital, he informed M/S.Medsave, the TPA of United India Insurance Company about the hospitalization and was given a file number. Thereafter within a week of discharge, he filed all the documents for reimbursement of his claim with M/S.Medsave. Such documents were filed on 07.11.2008. He further filed post hospitalization claim for an amount of Rs.21327/- on 17.01.2009 after expiry of 60 days from the date of discharge. He received a sum of Rs.175679/- in the month of March, 2009. He came to know that an amount of Rs.92008/- was deducted out of the claimed filed by him. It was stated by him that his wife developed an acute pain in her knee on account of physiotherapy which was given to her for her treatment. Reasons for deduction of a sum of Rs.57750/- out of the claimed amount were not clear. He filed the original bill of the hospital with the company and has paid the full amount of the claim. Having due consideration to the condition of the patient, precaution was taken by the hospital and the hospital has charged accordingly. It is his submissions that since he has made the payment to the hospital he needed to be fully compensated by the company.

3. Detailed submissions were placed on record by the insurance company. It has been submitted on behalf of the company that the hospital raised the bill arbitrarily and it has excessively charged, that is to say, it has charged more than the hospital would have charged in normal case. However, during the course of hearing, the complainant gave detailed reasons for charging of the hospital as the patient was suffering from a disease for which hospital had to take adequate care. In a letter dated 10.07.2010 it has been mentioned by the company that Mrs. Babita wife of the complainant was admitted in the hospital for the period 06.10.2008 to 03.11.2008 for treatment of bi-polar disorder (affective) Type-I, currently Mania and hospital bill was submitted to their TPA M/s.Medsave Healthcare Pvt. Ltd. for an amount of Rs.267687/- and for post

hospitalization for Rs.21327/-. TPA got the case investigated from M/S.Nucleus Insurance Risk Manager Pvt. Ltd. And on the basis of their report paid Rs.175679/- and Rs.17169/-. Reasons were submitted by the company for not making payment in respect of balance amount under different heads. It has been further mentioned that their investigator found that hospital has excessively charged from the patient as compared to the tariff of the hospital itself. It has been submitted in the letter that as against payable as per tariff, doctor's consultation should have been Rs.350/- per day but Rs.2000/- was charged. Similarly for nursing care, the same should be Rs.250/- per day as against Rs.500/- per day charged by the hospital. It was mentioned that charges for private nursing are not payable as per policy conditions. Charges for physio-therapy are not available in the hospital record. The matter was again got examined by the company and a supplementary reply was submitted on 05.08.2010 which is placed on record wherein it has been stated that as per medical opinion expressed by a panel doctor, consultation charges @ Rs.1000/- per day can be allowed for the team of doctors. Thus insurance company is further ready to make payment of Rs.22750/- as per clarification obtained from the hospital.

4. I have very carefully considered the submissions of the complainant and also the verbal arguments made during the course of hearing. I have also very carefully perused the letters including the letter dated 05.08.2010 placed on record and also its representative. After due consideration of the matter, I hold that as regards reimbursement on account of post hospitalization treatment, the insurance company is justified in making the payment of Rs.17169/- out of total claimed amount of Rs.21327/- as it had given proper justification in not allowing the balance amount. As regards the claim of the policy holder in respect of an amount of Rs.92008/- which the insurance company had denied. The matter got examined by the company itself by its panel doctor who had examined the claim of the policy holder in details and found that the policy holder is still to be compensated by some amounts. I have also perused very carefully the report as given along with letter dated 05.08.2010. I find that there is no justification to restrict the payment of doctors' charges to Rs.1000/- per day as against charges @ Rs.2000/-per day in respect of Dr.Sunil Mittal and Team and 09 days visit of Dr.Sandeep Choudhary. The

complainant had made payment to the hospital as per bills raised and fees charged by the doctors. The policy conditions nowhere provide that doctors have to be paid up to a certain limit. Therefore, I am of considered view that the policy holder has to be paid the full amount charged from him by the hospital by way of doctors' fees. Similarly, there is no reason not to allow the payment of nursing charges charged by the hospital and paid by the policy holder. I find that terms and conditions of the policy do not exclude the payment of nursing charges. Terms and conditions of the policy given to the policy holder nowhere provide that policy holder will not be paid nursing charges. Therefore the policy holder is also eligible for nursing charges as charged by the hospital. The claim of the policy holder for an amount of Rs.4000/- is not supported by documentary evidences therefore, the same is not payable. **Thus, a sum of Rs.88000/- is to be paid to the policy holder by the insurer towards doctors' fees and nursing charges as charged by the hospital. It is awarded 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/244/OIC/09
In the matter of Shri A.K. Nirwani
Vs
Oriental Insurance Company Limited

AWARD dated 09.08.2010 - Mediclaim premium

1. This is a complaint filed by Shri A.K.Nirwani (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 respect of excess/wrong charging of mediclaim premium.

2. The complainant submitted that he had taken a mediclaim policy No.211200/48/2011/15 from Oriental Insurance Company Limited for the last many years. For the first time, he

observed that wrong/excess premium in the financial year 2007-2008 was charged. He sent an e-mail on 08.07.2007 for the same. After correspondence of about two years, he got some refund against excess/wrong charges of premium. He had enclosed a statement of computation of premium for the year 2006-07 to 2009-2010. He desired that the insurance company should give him the working of the premium charged, that is, rate of premium less discount allowed, if any etc. for all years. There is an increase in premium in his case. He further desired details of discount of adjustment, family discount and other entitlement according to the policy.

During the course of hearing, he stated that he was not communicated the reasons for ever increasing the premium and was not given the details of various discounts he is entitled to. He desired to have a detailed computation of premium after allowing all discounts for which he is entitled. He further stated that the insurance company did not require him to state as to whether he needed the services of TPA or not. He was made to charge of the TPA without his knowledge/permission.

3. During the course of hearing, representative of the insurance company stated that the policy holder will be provided detailed working of the premium charged as requested by him. As a matter of fact, he made available circular dated 23.08.2006. A copy of which was also supplied to the policy holder. It has been stated by the representative that premiums have been charged every year as per circular of the insurer.

4. I have considered the submissions of the complainant. I have also considered the verbal submissions of the representative of the insurance company**.** After due consideration of the matter, **I consider it fair and reasonable to direct the insurance company to provide the policy holder the detailed working of the premium charged from the financial year 2006-07 onwards which will perhaps satisfy him the reasons for the increase of premium and various entitlement as per policy conditions. The complaint is disposed of accordingly.**

5. Copies of the Award to both the parties.

Case No. GI/240/NIC/09
In the matter of Shri N.K. Goel
Vs
National Insurance Company Limited

AWARD dated 09.08.2010 – Mediclaim

1. This is a complaint filed by Shri N.K.Goel (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 repudiation of mediclaim.

2. The complainant submitted that he took a Floater Mediclaim policy of Rs.5 lakh from Wazirpur Branch of National Insurance Company vide policy No. 360803/48/08/8500001999 valid from 23.10.2008 to 22.10.2009. On 09.06.2009, his son Shri Mayank Goel, one of the beneficiaries in the policy, was admitted to Khanna Nursing Home for two days for treatment of his knee injury. He checked the list of authorized hospitals from the brochure of National Insurance Company which was provided to him at the time of issue of the said policy and found the name of Khanna Nursing Home in the list. He further stated that Khanna Nursing home is the registered hospital with the authorities. He lodged the claim with Park Mediclaim TPA Pvt. Ltd and after rigorous follow up with them, he found that his claim has been repudiated stating that Khanna Nursing Home is not in the list of authorized hospitals and hence the claim is not paid.

3. The insurance company had repudiated the claim only because the treatment was not taken by the policy holder in the approved hospital.

4. I have considered the submissions of the complainant as made out in writing as well as made by him verbally during the course of hearing. I have also perused the reply of the insurance company and reasons cited for repudiating the claim. After due consideration of the matter, I find that the insurer was not justified in repudiating the claim. Treatment of the beneficiary of the policy was done during the currency of the policy. The hospital at which treatment was taken was in the list of approved hospitals when policy was taken.

Therefore, there is no justifiable reason with the insurer to repudiate the claim. **Accordingly, Award is passed with the direction to the insurance company to make the payment of claim of Rs.34922/- to the claimant as lodged by him. The company is further directed to pay penal interest @ 8% from the date of repudiation till the time the payment is made.**

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/174/ICICI Lombard/09
In the matter of Shri Amit Gupta
Vs
ICICI Lombard General Insurance Company Limited

AWARD dated 09.08.2010 - Mediclaim

1. This is a complaint filed by Shri Amit Gupta (herein after referred to as the complainant) against the decision of the ICICI Lombard General Insurance Company Limited (herein after referred to as respondent insurance company) repudiating his mediclaim.

2. The complainant submitted that he was holding a health policy No. 4034/FPS/03620089/00/000 from ICICI Lombard General Insurance Company Limited which was valid up to May, 2010. He submitted a claim to the TPA, TTK Health Services Pvt. Ltd. On 31.03.2009 vide receipt No.1334. He started following up with them after a month. He was time and again told that his claim was in process. He had approached the higher authorities also and ultimately he got a call from the company that his claim has been rejected due to the reason the intestinal obstruction was due to a band which was congenital in nature. The policy has a clause of permanent exclusion which says that any type of Internal/external congenital illness is not covered under the policy.

During the course of hearing, the complainant attended the proceedings. He had submitted that the insurance company was not justified in repudiating his claim. The

complainant paced on record a certificate given by the treating doctor wherein it has been stated by the doctor as under:

"Further to the certificate issued on 25.05.2009, patient Shri Amit Gupta, aged 31 years Male, came to Fortis Hospital Noida with symptoms S/O SAIO of two months duration which had been aggravated since last 5 days. On exploration, a thick band was found obstructing the distal ileum about 1 ft. proximal to Ileocacal junction. The cause of the band cannot be pinpointed. It may have been congenial as mentioned earlier or could have developed in the recent past. There is no diagnostic method to determine the exact cause/duration of the band. It is worthwhile noting that the patient was alright for 31 years of his life and started manifesting signs and symptoms of SAIO since last two months only."

The complainant was treated in Fortis hospital from 04.03.2009 to 17.03.2009 and a claim of Rs.2,17,000/- on account of hospital treatment and Rs.32000/- on account of post hospitalization treatment was filed with the insurer which was rejected by the company.

3. Written submissions were placed on record by the insurance company wherein it has been mentioned that the complainant had taken Health insurance policy No. 4034/FPS/03620089/00/000. The complainant was hospitalized on 04.03.2009 for treatment of Acute Intestinal Obstruction and got discharge on 17.03.2009. Thereafter a claim was filed. On analyzing of the claim documents it was found that above mentioned ailment was due to the band in distal ilem (small intestine) which is congenital. It has been stated by the company that congenital illness is not covered under the policy and this fact was informed to the policy holder vide letter dated 17.06.2009. The company stated that the policy holder suffered from internal congenital illness which falls in permanent exclusion clause 3.4 of the policy. Therefore, claim for reimbursement was not admissible.
4. I have very carefully considered the submissions of the complainant. I have also very carefully perused the written submissions of the insurance company particularly the reasons cited for repudiation of the claim. After due consideration of the matter, I hold that the insurance company was not justified in repudiating the claim because complainant got the treatment in the hospital during the currency of the policy. The treating doctor clearly stated that the disease from which the complainant suffered was not a confirmed congenital disease. The complainant was hale and hearty up to the age

of 31 years and hospitalized at the age of 31. Had the complainant suffered with congenital ailment, the complainant would have got the treatment for the same from birth. The supporting documents placed on record by the company did not confirm positively that the ailment from which the complainant was suffering was a congenital illness. It only expressed the opinion that it may be due to congenital reasons. In my considered view, the case of the complainant does not fall in the exclusion clause 3.4 (permanent exclusion). The claim is admissible and the same is admissible from the very beginning. **Accordingly Award is passed with the direction to the insurance company to make the payment as claimed by the complainant amounting to Rs.2,49,000/- along with interest @ 8% from the date of repudiation till the time the payment is made.**

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/230/NIA/09
In the matter of Shri Sudhir Saxena
Vs
The New India Assurance Company Limited

AWARD dated 17.08.2010 – Mediclaim

1. This is a complaint filed by Shri Sudhir 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) for repudiation of Mediclaim.

2. The complainant submitted that he had a Mediclaim policy from New India Assurance Co. Ltd. He was medically examined before the policy was issued to him. He renewed the policy for the 2nd year for the period 09.01.2009 to 08.01.2009. he fell unconscious suddenly and was taken to Central Hospital, Ganesh Nagar, Tilak Nagar, New Delhi. Thereafter he was shifter to another hospital immediately to Jaipur Golden Hospital, Rohini. He was treated in Jaipur Golden Hospital for CVA in the first phase and for

neurogenic bladder in the second phase. He had applied to M/s. Raksha TPA Pvt. Ltd for approval of cashless hospitalization facility but the latter declined it stating that he had 3 year old history of seizure disorder with hemipressions. They had based their decision on the observation of the attending doctor at Central Hospital on registration cum discharge sheet that the patient has HTN, not taking medicines regularly and patient has past history of convulsions. He pleaded to the TPA that he never had HTN in the past but such plea did not convince TPA. However, the TPA stated that he will consider the reimbursement of medical expenses if he lodges the claim. He lodged 2 separate claims for Rs.35,772/- for the first phase and Rs.19,851/- for the second phase that is the total claim amounting to Rs.55,623/-. He further stated that his claim was rejected by the TPA stating reasons as HTN comes under 2 years exclusion. He further represented to the Insurance Company and the Insurance Company also agreed to the decision taken by the TPA for rejecting the claim. It has been stated by him that their decision of the Insurance Company is based on the observation of the treating doctor and the treating doctor had made the observation on the basis of the statement of the person who accompanied him in the hospital. It has been stated by him that the treating doctor had clarified the position on 21.05.2009 and such clarification was not taken into account by the Insurance Company. The attending doctor clarified the position that his observation were based on the statement given by the attendant accompanying the patient. The patient was unconscious and could not have corroborated or countered it. The complainant also filed the decision of the State Commission Delhi in support of his argument that Insurance Company was not justified in rejecting his claim.

3. The Insurance Company has not allowed the claim of the complainant. Insurance Company confirmed to have received the claim lodged by the complainant for an amount of Rs.55623/-. The TPA rejected the claim for the cited reasons as under:-

"As per the terms and conditions, disease (hypertension) comes under two years exclusion. Hence claim cannot be entertained CVA (HTN) with UTI with neurogenic bladder".

The medical board also agreed with the decision of the TPA. The Insurance Company's decision appears to have been based on the observation of the treating doctor.

4. I have considered the submissions of the complainant. I have also seen the reasons given by the Insurance Company for repudiating the claim of the complainant. After due consideration of the matter I find that Insurance Company is not justified in repudiating the claim because before the policy was issued to the complainant he was medically examined. He was not found to have been suffering from Hypertension and the disease based on the basis of which decision has been taken. I have perused the policy issued to the complainant wherein nothing has been mentioned about HTN. Moreover, the treating doctor clarified that his observation were based on the statement of the attendant who accompanied the policy holder at the time of admission. **Accordingly award is passed, I direct the Insurance Company to make the payment of claim as per norms.**
5. Copies of the Award to both the parties.

Case No.GI/268/NIA/09
In the matter of Shri Harmohinder Singh
Vs
The New India Assurance Company Limited

AWARD dated 30.08.2010 – Mediclaim

1. This is a complaint filed by Shri Harmohinder Singh (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) for repudiation of Mediclaim.

2. The complainant submitted that his claim is pending since September 2008. All documents required were submitted time to time by the complainant, but the claim has not been settled so far. He has also approached Grievance Cell but of no use. He stated that claim could not be settled as original payment receipts were not placed on record.

3. During the course of hearing complainant as well as representative of the company was present and matter was discussed. It was found that the original receipts were also placed on record. The Insurance Company's representative stated that the claim is admissible but could not be settled only because of want of original payment receipts. The matter has been considered. Since original payment receipts were already made available to the

Insurance Company, the Insurer is directed to settle the claim immediately. It is further directed that interest @ 8% on the admissible amount of claim from the date of repudiation to the date of payment is also to be paid. It is awarded accordingly.

4. Copies of the Award to both the parties

Case No.GI/254/RSA09
In the matter of Shri Suresh Chand Sharma
Vs
Royal Sundaram Alliance Insurance Company Limited

AWARD dated 30.08.2010 - Mediclaim

1. This is a complaint filed by Shri Suresh Chand Sharma (herein after referred to as the complainant) against the decision of Royal Sundaram Alliance Insurance Co. Ltd. (herein after referred to as respondent Insurance Company) for repudiation of Mediclaim.
2. Complainant submitted that he had taken Double Protection Insurance policy under Health Insurance policy for his wife Smt. Maya Sharma and paid a sum of Rs.10,530/- for the policy through Standard Chartered Bank and a membership card was issued bearing no. HE-00107946000100-EO-56 w.e.f. 22.03.2007 for a period of two years and the insured person Smt. Maya Sharma was allotted personalized health card no. HE-121421183A. The insured person could avail the medical facilities in Hospitals approved by the company. On 05.01.2009 the insured Smt. Maya Sharma had some problem in the breast and consulted Dr. R.K. Singh, Mammologist, Kailash Hospital, Sector-27, Noida who started her treatment as a case of lesion in left breast and advised certain investigations and prescribed certain medicines. Thereafter doctor advised her to undergone operation. Accordingly she was admitted in Deepak Memorial Hospital, Vikas Marg, Delhi on 30.01.2009. The attending Dr. R.K. Singh treated the patient throughout as a case of lesion in left breast and infection. He prescribed medicines for checking and controlling infection throughout treatment. She was operated upon and no medical conclusion was drawn that she was suffering from Breast Lumps and was given a treatment for the same. On 07.02.2009 he submitted original bills, prescriptions etc. to the Medicare TPA Services (I) Pvt. Ltd., but they did not accept the same and advised to submit the bills to Company's office. Accordingly all original documents, doctor's

prescription, test reports, discharge summary etc. were submitted on 23.02.2009. He was informed telephonically that the claim has been repudiated. He has submitted that the claim was repudiated on flimsy grounds without examining the prescription and bio-reports and treatment given to the insured person. During the course of hearing complainant states that his wife Smt. Maya Sharma was not treated for breast lumps. She was treated only for lesion and infection in left breast; therefore, claim ought to have been admitted by the Insurance Company. It has been repudiated on false reasons.

3. Written submission was placed on record on behalf of the Insurance Company. It has been stated that the insured was admitted for breast lumps and it is not covered in the first 2 years of the duration of the policy. It is also been written in the reply whereby one could understand that the claim is not admissible because the treatment for breast lump was taken within 2 years of taking of the policy. During the course of hearing also the representative of the Insurance Company reiterated the reasons for rejection of the claim as communicated to the policy holder.

4. I have considered the submissions of the complainant very carefully. I have perused the documents placed on record. After due consideration of the matter I find that claim of the complainant was rejected on vague grounds. The insured was not treated for breast lump as a matter of fact she was treated for breast Abscess and infection though the breast lump existed but the same was not treated. Therefore in my view the claim is admissible and Insurance Company was not justified in repudiating the same. Accordingly, Award is passed with the direction to the Insurance Company to make the payment of the claim f Rs.38,155/- along with penal interest @ 8% from the date of repudiation to the date of payment.

5. Copies of the Award to both the parties.

Case No.GI/271/NIC/09
In the matter of Shri Anil Sood
Vs
National Insurance Company Limited

AWARD dated 18.08.2010 - Mediclaim

1. This is a complaint filed by Shri Anil Sood (herein after referred to as the complainant) against the decision of National Insurance Co. Ltd. (herein after referred to as respondent Insurance Company) for Repudiation of Mediclaim.

2. Complainant submitted that his father was hospitalized on 10.02.2009 in an emergency at Jain Hospital, Jagarati Enclave, Delhi. He was discharged on 14.02.2009 after staying in ICU for 2 days. The claim of Rs.54381/- was lodged with the TPA Park Mediclaim Consultant Pvt. Ltd. It has been informed b y the Insurance Company vide their letter dated 08.05.2009 that the treatment at Jain Hospital, Delhi is not covered as per list of the approved hospital. Representation was made further to the Sr. Divisional Manager vide his letter dated 23.05.2009 informed that his claim was not acceptable. He submitted that no valid reasons were assigned while rejecting the claim. It has been submitted by him that the Mediclaim policy of his parents is in force for the last 15 years. The complainant further stated that hospital at which treatment was taken included in the list of hospital provided to him by the TPA at the time of taking the insurance policy.
3. It has been stated by the Insurance Company that the treatment is taken in a hospital which is not found in the approved list of hospitals of the Insurance Company.
4. I have considered the submission of the complainant. I have also perused the reply of the Insurance Company. I find that Insurance Company was not justified in repudiating the claim because the same was rejected on technical grounds and it was not decided on merits. The hospital at which treatment was taken by the policy holder is the one which was listed in the list of hospitals approved by the TPA. Therefore, there is no justification to say by the Insurance Company that since treatment was not taken in the one of the listed hospitals which were approved, the claim is not admissible.

   Accordingly, award is passed with the direction to the Insurance Company to make the payment of Rs.54381/- to the policy holder along with 8% interest from the date of rejection to the date of payment.
5. Copies of the Award to both the parties.

Case No.GI/211/Bajaj/09
In the matter of Shri Sanjay Aggarwal Vs
Bajaj Allianz General Insurance Company Limited

AWARD dated 18.08.2010 – Mediclaim

1. This is a complaint filed by Shri Sanjay Aggarwal (herein after referred to as the complainant) against the decision of Bajaj Allianz General Insurance Co. Ltd. (herein after referred to as respondent Insurance Company) for Repudiation of Mediclaim.

2. The complainant submitted that his wife Smt. Meena Aggarwal was covered under Health Guard Policy. She had been operated for the Bladder outlet Obstruction on 11.11.2008 at M/s. Northex Stone Clinic. Cashless facility was denied because there was no previous claim papers/ history. Entire treatment documents were submitted for reimbursement on 24.11.2008 but the same was denied on the ground that fact was not disclosed that she was also operated in the past for the same disease on 25.09.2007. It has been submitted by him that she was covered under the policy since 12.09.2005 with National Insurance Company Ltd. and the same was renewed with Bajaj Allianz General Insurance Co. ltd. in time on 11.09.2007. As the policy document was not received, he was advised for the reimbursement and the same was done. It has been submitted by him that his claim has not been settled as yet by the Insurance Company.
3. The insurance Company had submitted a letter dated 22.03.2010 which has been placed on record. It has been submitted that the complainant as well as his wife Smt. Meena Aggarwal are covered under the policy. It further mentioned that it was found from the discharge card that the patient was suffering from Bladder Outlet Obstruction since 15 days prior to the inception of this policy (i.e. 12.09.2007) and the same was not declared in the proposal form and the same thus amounted to non-disclosure of material information and wrong declaration in the proposal form that is why the claim has been repudiated.
4. I have considered very carefully the submissions of the complainant. I also perused the reply of the Insurance Company. After due consideration of the matter, I find that the Insurance Company was not justified in repudiating the claim for non-disclosure of the material fact because the complainant along with his wife had taken the policy in 2005 with another insurance Company and the policy continued with Bajaj Allianz General Insurance Co. ltd. Smt. Meena Aggarwal suffering from the similar disease and operated on 25.09.2007. The present claim relates to her treatment on 11.11.2008. In my

considered view, the Insurance Company was not justified in repudiating the claim. The claim is admissible. **Accordingly, Award is passed with the direction to the insurance Company to make the payment of Rs.19730/-.**

5. Copies of the Award to both the parties.

Case No. GI/293/OIC/09
In the matter of Shri Sanjay Gupta
Vs
Oriental Insurance Company Limited

AWARD dated 01.09.2010 - Mediclaim

1. This is a complaint filed by Shri Sanjay 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 respect of repudiation of mediclaim.
2. The complainant submitted that he had taken mediclaim policy from Oriental Insurance Company Limited and had got himself and his members insured against the ailments. On 21.04.2009, his wife Smt. Seema Gupta got admitted in hospital and was operated on 22.04.2009 and was discharged from the hospital on 26.04.2009. Claim filed with all supporting vouchers, investigations in original were enclosed and submitted to the authorized TPA M/S.Vipul Medicorp on 11.05.2009. On enquiry from Vipul Medicorp, a letter dated 13.05.2009 was handed over to him on 25.05.2009 wherein it was asked to provide previous year mediclaim policies. Two years mediclaim policies were submitted to the TPA on 11.05.2009 itself. However, for fulfilling their requirement vide his letter dated 28.05.2009. Mediclaim policies with effect from 25.07.2001 were submitted to them. Vipul Medicorp again vide their letter dated 02.06.2009 addressed to the Branch Manager of the Oriental Insurance Company Limited, Jaipur sought query, whether the policy may be considered in continuance of the earlier policy of the New India Assurance Company Limited. Vide letter dated 01.08.2009, I was informed by the TPA on 06.08.2009 rejecting the claim on the ground that policies running in the first year and that as per Clause 4.3 “During first 2 years operation of the policy, expenses related to surgery of hysterectomy for prolapsed uterus are not payable.”

He made representation to the Grievance Redressal Officer of the insurance company at RO, Jaipur but was not given reply. Through the said letter, he raised question that the policy is running since 25.07.2001 and was not lapsed even for a single day. The first policy being taken from United India Assurance Company and it continued with them till 21.07.2006. From 22.07.2006, it was shifted to the New India Assurance Company Limited and continued till 21.07.2008. The New India Assurance Company Limited had also given him NCB and considered the same in continuance of the earlier policy from United India Assurance Company Limited. The same was shifted to United India because as sum insured was increased by New India Assurance Company Limited to Rs.1.00 lac for every person. It is submitted by him that he was never informed at the time of under writing that the Oriental Insurance Company Limited will consider the policy as fresh and that he will not be entitled to continuance benefits of the policy. Had this been told to him, he would have continued the policy with earlier insurer.

3. No reply was placed on record on behalf of the company. However, during the course of hearing, its representative attended stated that the policy taken with the insurer is treated as fresh and therefore, continuance benefits are not allowed in the policy. However, representative stated that the claim is admissible on merits. She says that Clause 4.13 is applicable in this case.

4. I have considered the submissions of the complainant very carefully. I have also perused the reasons given by the insurer. After due consideration of the matter, I hold that the insurance company was not justified in repudiating the claim on the ground that the policy has been taken fresh by the policy holder. The fact remains that the mediclaim policy is continued from 25.07.2001. However, the policy holder changed the insurers but the policy was continued and that too with the Government Insurance Company. First he had taken insurance from United India Insurance Company Limited. Thereafter from the New India Assurance Company Limited and during the relevant time the policy was issued by the Oriental Insurance Company Limited. In my view, there was no justification to treat the policy as fresh because the same continued since 25.07.2001. The policy was also given benefit of NCB @ 30% by the New India Assurance Company Limited. The claim is admissible on merits as also agreed to by the representative of the company during the course of hearing. **Accordingly, Award is passed with the**

direction to the insurance company to make the payment of Rs.32567/- along with penal interest @ 8% from 01.08.2009 till the time the payment is made.

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/277/UII/09
In the matter of Ms.Shashi Kala
Vs
United India Insurance Company Limited

AWARD dated 01.09.2010 - Mediclaim

1. This is a complaint filed by Ms.Shashi Kala (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 respect of repudiation of mediclaim.
2. The complainant stated that he had taken policy from the United India Insurance Company Limited. He was admitted in the hospital at Jaipur and submitted all relevant papers and documents for reimbursement. His claim was rejected by the company with the remarks that his policy was running in the second year of insurance and the claim for diseases payable only after completion of two years. It has been submitted by him that his medicalim insurance policy is running in the third year and not second year as stated by the insurer. He got the first insurance from New India Assurance Company Limited. In the second year, he switched over to United India Insurance Company Limited and his policy was treated as in continuation. Otherwise, he would not have shifted from the New India Assurance Company Limited to United India Insurance Company Limited. At his age for getting mediclaim policy from United India Insurance Company Limited, he was required to undergo fresh medical tests but the insurance company had waived such requirements because it was treated in continuation with the previous policy and no proposal was called from him at the time of switching over. But now the present insurer

says that it would not treat the policy in continuation but treat the policy as a fresh, that is to say, it will not give the benefit of insurance taken by the complainant with the earlier insurer. It was also pleaded during the course of hearing that no proposal was taken by present insurer that would also suggest that the company intended to provide continuity benefit of the insurance taken from earlier insurer.

3. Written submissions were placed on record on behalf of the company. The insurance company was also represented. During the course of hearing, it was stated that the claim was not payable because the policy was running in second year of insurance. The diagnosed disease Fibroid Uterus and total abdominal hysterectomy with B/L salpingoophrectomy done under GA which as per terms and conditions of the policy, during the first two years of running of policy, charges related to hysterectomy are not payable and the claim was not payable. The claim was again reviewed as mentioned vide letter dated 23.10.2009 and it was found that since policy was running in the second year of insurance with the present insurer, the claim is not payable as per policy clause 4.3. The insurance company did not accept the request of the complainant to give the benefit of earlier insurance taken from the New India Assurance Company Limited

4. I have considered the submissions of the complainant very carefully and have also perused the documents as placed on record on behalf of the insurance company particularly letter dated 23.10.2009. After due consideration of the matter, I hold that the insurance company was not justified in repudiating the claim because the insurer in practice had allowed the continuity of the benefit of earlier insurance. It had not behaved in a manner while issuing policy to the policy holder which one does while issuing fresh policy. Moreover, the present insurer had also not taken proposal from the insured and also had waived the condition of medical examination of the insured who was above the age when medical examination was required. The Insurance Company had not issued the policy from the date of payment which was 20.12.2007. It had made the insurance effective from the date when earlier policy period was expiring with the previous insurer. Therefore, the complainant was under bonefide belief that the present insurer will allow the continuity benefit of the policy. Therefore, as a matter of fact, the treatment was taken in the third year of the policy and thus the claim is payable. **Accordingly Award is**

passed with the direction to the company to make the payment of the claim amounting to Rs.38407/- to the complainant.

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/279/UII/09
In the matter of Shri S.K. Sharma
Vs
United India Insurance Company Limited

AWARD dated 08.09.2010 - Mediclaim

1. This is a complaint filed by Shri S.K. Sharma (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 repudiation of Mediclaim.

2. The complainant submitted that he had taken a Mediclaim policy from United India Insurance Co. Ltd. which was valid for the period 07.06.2008 to 06.06.2009. He stated that his son met with an accident on 13.11.2008 and he was treated in the hospital. He applied for the reimbursement to the Insurance Company but the Insurance Company had repudiated the claim stating that treatment was taken in OPD, which is a violation of the terms and conditions of the policy and the claim is not tenable. It has been stated by him that due to accident his son lost his teeth. Due to teeth injury, treatment was taken as an out- door patient. It is submitted by him that the claim is admissible and the claim has been repudiated wrongly.
3. The Insurance Company had repudiated the claim on the ground that it was not a case of hospitalization; and treatment was taken as an outdoor patient. However, during the course of hearing the representative of the Insurance Company agreed to make the payment of the claim as he was convinced of the fact that the treatment was done as outdoor patient on account of the teeth injury due to accident.
4. I have considered the submission of the complainant. I have also perused the reply placed on record on behalf of the Insurance Company. After due consideration of the matter I hold that Insurance Company was not justified in repudiating the claim because

in case of dental treatment due to accident, the claim is admissible and no hospitalization is required and treatment can be done as an OPD. **Accordingly, Award is passed with the direction to the Insurance Company to make the payment of Rs.8340/-.**

5. Copies of the Award to both the parties.

Case No.GI/284/UII/09
In the matter of Shri Sita Ram Gupta
Vs
United India Insurance Company Limited
AWARD dated 08.09.2010 - Mediclaim

1. This is a complaint filed by Shri Sita Ram Gupta (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 non-settlement of Mediclaim.
2. The complainant submitted that he had taken a Mediclaim policy bearing no. 040300/48/05/20/00001001 from M/s. United India Insurance Co. Ltd. The claim was filled but the claim was not settled by the Insurance Company. He had approached even the grievance cell of the Insurance Company but had not received any response and the claim was not settled. During the course of hearing the complainant stated that the claim was still unsettled. He had made requisite documents available to the Insurance Company for settling the claim. In fact two claims are pending with the Insurance Company to be settled relating to the treatment of complainant and his wife.
3. The representative of the Insurance Company attended the hearing and it was found that no reply was filed accept the letter dated 29.09.2009 which was placed on record, wherein it has been stated that the Insurance Company acknowledged the receipt of the various claims for the treatment of the complainant as well as his wife. Further details are required from the complainant. The Insurance Company had not taken any decision on the claims filed by the complainant so far.
4. I have very carefully considered the submissions of the complainant. I also perused the reply as placed in record on behalf of the Insurance Company. After due consideration of the matter I hold that Insurance Company was not justified in not settling the Mediclaim of the complainant so far because the complainant had made available all requisite

documents needed for settling the claim as stated by him and there is no reason to disbelieve him. The representative of the Insurance Company did not argue anything against the complainant. **Accordingly, I consider fair and reasonable to pass the Award with the direction to the Insurance Company to make payment of the claims amount, amounting to Rs.52836/- (33900/- + 18936/-). Since the claims have not been settled so far, it is further Awarded that Insurance Company will make the payment of penal interest also @8% from the date of last correspondence 02.11.2009 till the date of actual payment.**

5. Copies of the Award to both the parties.

Case No. GI/280/NIC/09
In the matter of Shri Mahesh Wadhwa
Vs
National Insurance Company Limited

AWARD dated 18.09.2010 - Mediclaim

1. This is a complaint filed by Shri Mahesh Wadhwa (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 repudiation of mediclaim.
2. The complainant submitted that he had been taking mediclaim policy from the National Insurance Company Limited for the last four years. He had an eye operation done at All India Institute of Medical Sciences with the consent of the insurer. He was assured that he would get reimbursement of the expenses incurred on his treatment. However, his claim was denied stating that it was a pre-existing disease. He again contacted the insurer but the company could not settle his claim.

3. The claim of the complainant was repudiated by the TPA vide its letter dated 07.03.2009 as per the medical reports of All India Institute of Medical Sciences that the patient is giving the history of diminution of vision since 2-3 years. As per terms and conditions of the policy, under clause 4.1, the claim is not payable.

4. I have considered the submissions of the complainant very carefully. I have also perused the reasons submitted by the company for repudiating the claim. After due consideration of the matter, I hold that the insurer was not justified in repudiating the claim because the complainant had taken the policy for the last four years and was also enjoying cumulative bonus of 10% which has been confirmed also by the present insurer. Since policy was taken much before the complainant had undergone treatment, the observation of the company that the claim is not payable on account of pre-existing disease is not correct. Therefore, Award is passed with the direction to the company to make payment of Rs.12951/- along with penal interest @ 8% from the date of repudiation of the claim to the date of actual payment.
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/307/NIC/09
In the matter of Shri Nitin Kumar Goyal
Vs
National Insurance Company Limited

AWARD dated 18.09.2010 – Mediclaim

1. This is a complaint filed by Shri Nitin Kumar Goyal (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 repudiation of mediclaim.
2. The complainant submitted that the insurance company is not paying the claim for treatment of fracture which occurred in the policy term taken in the name of Shri Vinay Kumar Goyal. He had also approached the Grievance Cell of the company but he had not received the claim reimbursement amount so far. The complainant requested that the insurance company be directed to make the payment of claim amount. It is submitted by him that his brother Shri Vinay Kumar Goyal was admitted in Shanti Mukund Hospital because of a fracture. The claim was authorized as cashless but later on such facility was denied. Claim papers were submitted with the company but the file was closed on the

ground of pre-existing on 23.04.2009. He did not receive any reply. The policy is running in the 4th year when the claim was made.

3. It has been submitted on behalf of the company that the claim was repudiated under Clause 4.1 (pre-existing disease) as per terms and conditions of the policy. It was further stated that while scrutinizing the claim documents, it was found from the certificate issued by Hindu Rao Hospital dated 11.02.1993 stating that the patient is suffering from post polio residual paralysis right lower limb whereas policy under 3rd year with effect from 22.02.2006 which makes the disease pre-existing. The patient was admitted on 30.09.2008 with history of fall at home with pain and not able to walk, severe pain at right hip. H/O poliomyelitis at the age of 2 years. After examination and investigations he was managed with multiple cannulated leg screw fixation done on 01.10.2008 and discharged on 03.10.2008. The sum and substance of the argument of the company is that on account of pre-existing disease, the claim was repudiated.
4. I have considered the submissions of the complainant very carefully and have also perused the reply of the company. After due consideration of the matter, I hold that the company was not justified in repudiating the claim because it was not a pre-existing disease. The case of a person who was treated in the hospital was not covered under pre-existing disease. The complainant had clearly stated that Shri Vinay Kumar Goyal was a known case of polio. This fact was known to the company very well at the time of giving insurance cover. As a matter of fact, he had polio when he was of two years of age. The treatment for which the claim was made with the company did not relate to the polio with which Shri Goyal was suffering. He fell at home and got injured for which he was hospitalized and treated. Therefore, in my considered view, since he was not treated for polio for which he put up the claim but he was hospitalized because of his fall at home. Such a claim is admissible. Anybody can fall and got injured not necessarily due to polio. Therefore, it appears wrong to relate the treatment for which the reimbursement has been claimed to the polio with which Shri Vinay Kumar Goyal was suffering. Accordingly, Award is passed with the direction to the company to make the payment of claim amounting to Rs.32858/- along with penal interest @ 8% from the date of repudiation of claim to the date of actual payment.

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/316/NIC/09
In the matter of Shri Roopak Singh Chauhan
Vs
National Insurance Company Limited

AWARD dated 20.09.2010 - Mediclaim

1. This is a complaint filed by Shri Roopak Singh Chauhan (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 repudiation of mediclaim.
2. The complainant submitted that he had put up two claims – one on behalf of himself and the other related to his daughter's name Baby Kanishka Chauhan. He had stated that he and his daughter were hospitalized in Shakuntla Nursing Home in the month of June,2009. In order to get medical reimbursement, he submitted the relevant papers to the insurance company on 07.07.2009. Within 15 days, he got rejection letter from the company stating that he had not taken the treatment in their listed hospital that is why they rejected both of his claims. He approached Regional Manager of the company stating that there was no clause as per IRDA requiring treatment only in the networked hospitals as it was a matter of person's life. The insured can take treatment wherever he/she feels convenient. The only mandatory condition for reimbursement is hospitalization and the hospital should be registered with the state government. But the company continued to have that stand, that is to say, that the claims were rejected on the ground that treatment was not taken in their networked hospital.
3. It has been stated in the reply by the insurance company which is placed on record that expenses incurred during the hospitalization in Shakuntla Nursing Home, New Delhi which is outside the approved lists of Delhi Hospitals provided by the company to the insured along with the policy are not payable.

4. I have considered the submissions of the complainant and have also perused the reasons placed on record on behalf of the company for not admitting the claim of the complainant with regard to reimbursement of expenses incurred on the treatment. After due consideration of the matter, I hold that the insurer was not justified in repudiating the claim merely because the treatment was not taken by the complainant and his daughter in a hospital which was not approved by it. The claim is admissible on merits. Repudiation of claims merely because the treatment was taken in a hospital not approved by the insurer cannot be a ground for rejection. **I, therefore, pass the Award with the direction to the company to make the payment of claim to the insured amounting to Rs.32085/- along with penal interest @ 8% from the date of repudiation of the claim to the date of actual payment.**

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/333/NIA/10
In the matter of Shri Amit Jain Vs
The New India Assurance Company Limited.

AWARD dated 22.09.2010 - Mediclaim

1. Shri Amit Jain made a complaint to this Forum on 30.07.2010 against New India Assurance Co. Ltd in respect of non settlement of Medicalim, under policy no. 311200/34/09/11/00001260.
2. On intervention of this office, we have been informed by the Insurance Company vide its letter dated 15.09.2010 that it has settled the claim of Shri Amit Jain for Rs.8650/- vide cheque no. 175917 dated 01.09.2010.
3. There is no further relief to be granted to the complainant.
4. The complaint is disposed of finally.
5. Copies of the Award to both the parties.

Case No.GI/299/NIC/10
In the matter of Shri Ram Mohan Vs
National Insurance Company Limited

AWARD dated 22.09.2010 - Mediclaim

1. Shri Ram Mohan made a complaint to this Forum on 22.07.2010 against National Insurance Co. Ltd in respect of non settlement of, under policy no. 360304/48/07/8500001912.

2. On intervention of this office, we have been informed by the Insurance Company vide its letter dated 16.09.2010 that Company has settled the claim and paid the balance amount to Shri Ram Mohan for Rs.53854/- vide cheque no. 348654 dated 15.09.2010.
3. There is no further relief to be granted to the complainant.
4. The complaint is disposed of finally.
5. Copies of the Award to both the parties.

Case No.GI/110/NIC/10
In the matter of Shri Parveen Singla Vs
National Insurance Company Limited

AWARD dated 22.09.2010 - Mediclaim

1. Shri Parveen Singla made a complaint to this Forum on 19.03.2010 against National Insurance Co. Ltd in respect of repudiation of Mediclaim, under policy no. 360100/48/08/8500000461.
2. On intervention of this office, we have been informed by the Insurance Company vide its letter dated 15.09.2010 that Company had settled the claim of Shri Parveen Singla for Rs.9199/- vide cheque no. 111461 dated 26.07.2010.
3. There is no further relief to be granted to the complainant.
4. The complaint is disposed of finally.
5. Copies of the Award to both the parties.

Case No.GI/169/OIC/09

In the matter of Smt. Shashi Gupta
Vs
The Oriental Insurance Company Limited

AWARD dated 13.09.2010 - Mediclaim

1. This is a complaint filed by Smt. Shashi 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 non settlement of Mediclaim.

2. Complainant submitted that her son was admitted in the hospital on advice of the treating doctor who is a MBBS, MD. The Hospitalization was done on account of Impending paralysis due to possible Disc Prolapsed as stated by the treating doctor in the discharge summary dated 16.07.2009. She had put up the Mediclaim for the first time for the treatment of his son amounting to Rs.13842/-. She approached the grievance cell of the Insurance Company also. The Mediclaim policy has been taken without any break for11 years. It has been submitted by the complainant that Insurance Company be directed to reimburse the Mediclaim of Rs.13842/- which was admissible as per Mediclaim policy.
3. It has been stated on behalf of the Insurance Company that as per discharge summary of the patient Shri Akshay Gupta he was admitted with complaints of Severe back ache after holding a bucket of water, unable to walk, giddiness. He was not able to go to toilet/ bathroom. Raksha TPA rejected the claim due to the reason that patient was admitted only for investigation purposes and therefore the claim is not payable. The matter was also considered by Regional Office and whereby the decision of the TPA was upheld.
4. I have considered the submission of the complainant. I also perused the reply placed on record on behalf of the Insurance Company. After due consideration of the matter I hold that the Insurance Company was not justified in repudiating the claim on the ground that the patient was admitted in the hospital only for the investigation purposes. Complainant son was admitted in the hospital on the advice of the treating doctor and to my mind, the doctor is the best judge to advise the patient with regard to admission in the hospital and the patient is bound to follow doctor's advice. Accordingly, Insurance Company was not justified in repudiating the claim, the claim is otherwise admissible. **Accordingly,**

Award is passed with the direction t o the Insurance Company to make the payment of Rs.13842/-, along with penal interest @ 8% from the date of repudiation to the date of payment.

5. Copies of the Award to both the parties.

Case No.GI/298/NIA/09
In the matter of Shri C.P. Singhal
Vs
The New India Assurance Company Limited

AWARD dated 13.09.2010 - Mediclaim

1. This is a complaint filed by Shri C.P. Singhal (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) for inadequate settlement of Mediclaim.
2. Complainant submitted that he had taken a Mediclaim policy with New India Assurance Co. Ltd. for himself and his family. His wife got multiple injuries on 16.09.2007 and she also received head injury. The complainant submitted that his wife met with an accident and got serious injuries and sustained multiple injuries and she lost consciousness after motorcyclist hit her and run over her. She was admitted in the hospital and claim was lodged with the TPA. However, further treatment for tooth and facial injury were given later on as his wife was not in a position to take such treatment. It is stated by the complainant that since she was having head injury also, doctor advised not to take treatment relating to injury relating to tooth that is why the treatment was taken after 60 days of the hospitalization. It has been submitted by him that the claim is payable because the tooth injury was as a result of accident and for which hospitalization was not needed.
3. The Insurance Company rejected the claim because hospitalization expenses are payable only upto 60 days from the discharge from the hospital and the complainant had submitted claim bills for treatment after the claim was repudiated by the TPA. During the course of hearing also the Insurance Company continued to state the same reasons.

4. I have considered the submissions of the complainant. I also perused the reply placed on record on behalf of the Insurance Company. After due consideration of the matter I hold that Insurance Company was not justified in repudiating the claim relating to treatment of tooth injury which was caused due to accident. Complainant's wife met with an accident with motorcycle and got multiple injuries including serious head injury and tooth. As per the advice of doctor, the injuries were treated first on account of damage done to the head and she was advised not to take treatment relating to tooth and the treatment of tooth injury caused by accident was done after discharge from the hospital. Moreover for treatment of tooth injury caused by accident was not required hospitalization and can be taken as OPD. The Insurance Company had not showed any other reasons for rejecting the claim that means the claim is admissible and only rejected on technical grounds. The limit of post hospitalization of 60 days may be in respect of treatment of the disease which was treated in the hospital but in this case, the tooth injury was not treated in the hospital, and it was treated thereafter therefore, the same cannot be taken with the other treatment in the hospital. **Accordingly, in my view the claim is admissible and therefore, Award is passed with the direction to the Insurance Company to make the payment of Rs.23652/- along with the penal interest @8% from the date of repudiation to the date of payment.**

5. Copies of the Award to both the parties.

Case No.GI/285/NIA/09
In the matter of Shri Rajeev Sood
Vs
The New India Assurance Company Limited

AWARD dated 13.09.2010 - Mediclaim

1. This is a complaint filed by Shri Rajeev Sood (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) for non- settlement of Mediclaim.
2. Complainant submitted that he had taken Mediclaim policy from New India Assurance Co. Ltd. He filed a claim and put up all relevant documents with TPA vide letter dated 29.05.2006 for settlement of the claim. However, the TPA has repudiated the claim on

the ground that the hospitalization was done only for investigation purposes and not for the treatment. He had approached the Grievance Cell also but he had not received any response from that office also. He has further submitted that TPA was basically wrong in repudiating the claim. He visited Delhi Heart & Lung Institute for treatment who admitted him. Treating doctor is the best judge in the matter and the patient had to follow the advice of the treating doctor. He was admitted in the hospital w.e.f. 25.05.2009 to 28.05.2009 and TPA was informed but did not visit the hospital in order to examine his condition. His bills were submitted to the TPA clearly stating that he was admitted in the hospital and not for investigation purpose.

3. The Insurance Company stated in its reply that complainant was hospitalized and submitted the documents for reimbursement of medical expenses. Such claim has been forwarded to TPA and the TPA stated that the claim has been made non tenable.
4. I have considered the submissions of the complainant. I also perused the reply of the Instance Company which was placed on record. After due consideration of the matter I hold that Insurance Company was not justified in repudiating the claim because the complainant was admitted in the hospital whereat he had been given treatment. Complainant was admitted in the hospital only on the advice of the doctor and which he was supposed to follow. The Insurance Company was not justified in stating that complainant was admitted in the hospital only for investigation purposes. The complainant had complied with terms and conditions of the policy which enable him reimbursement of the expenses. **Accordingly, award is passed with the direction to the Insurance Company to make the payment of Rs.51048/-. It is further directed that the Insurance Company will pay interest @ 8% from the date of repudiation to the date of actual payment.**
5. Copies of the Award to both the parties.

Case No. GI/283/NIA/09
In the matter of Shri Satish Chauhan
Vs
New India Assurance Company Limited
AWARD dated 14.09.2010 - Mediclaim

1. This is a complaint filed by Shri Satish Chauhan (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 repudiation of mediclaim.
2. The complainant submitted that he had submitted his claim for an amount of Rs.41194/- to M/s.Raksha TPA on 08.05.2009. TPA sent the same to the insurance company. He tried to contact TPA on phone but was not successful. Thereafter TPA informed him that the insurance company had not taken any action. It has been submitted by him that his claim related to accident wherein he was injured badly and due to injury and fracture, many stitches were made. He was so badly injured in the accident that he was not able to speak and recognize for sometime. His legs and hands were also injured and that is why he could not put up his claim in time. He requested that the company was not justified in repudiating the claim only because the claim was filed late when there were sufficient reasons for him to file the claim late. He requested the forum to instruct the insurance company to settle his claim.
3. The Insurance Company informed the complainant that as per clause 11 of the policy, his claim cannot be entertained. The company further informed vide letter dated 28.12.2009 to this forum that the claim was filed by the complainant in respect of himself for Rs.41194/-. The claim was closed due to late submission of relevant documents as per policy condition 11. During the course of hearing also, the representative of the company stated that the claim was repudiated on the ground that the claim was late submitted.

4. I have considered the submissions of the complainant very carefully and have also perused the reply which is placed on record on behalf of the company. After due consideration of the matter, I hold that the company was not justified in repudiating the claim merely because the claim was filed late. There were sufficient reasons with which the complainant was prevented for filing the claim in time. He was severely injured and so much so, he was not able to speak and recognize even due to injury sustained by him in the accident. **In my considered view, the complainant was prevented by sufficient reasons for filing the claim in time. Accordingly, Award is passed with the direction to the company to make the payment of the claim amounting to Rs.41194/- along**

with penal interest @ 8% from the date of repudiation to the date of actual payment.

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/308/RGI/09
In the matter of Shri Mukesh Kumar Agarwal
Vs
Reliance General Insurance Company Limited

AWARD dated 28.09.2010 - Mediclaim

1. This is a complaint filed by Shri Mukesh Kumar Agarwal (herein after referred to as the complainant) against the decision of the Reliance General Insurance Company Limited (herein after referred to as respondent insurance company) in respect of non- settlement of mediclaim.
2. The complainant submitted that he had sent all original receipts, bills diagnostic reports, discharge summary and prescription of doctor as per norms of the policy to the insurer but unfortunately he had been reimbursed less by an amount of Rs.4760/-. However, he had sent additional payment certificate of Dr.Ashish Guatam, Yashoda Hospital, Ghaziabad towards consultation fees for record and break up. Clarification was also given. He had requested to get his claim settled. He further submitted that as per instructions, he had submitted all requisite documents to TPA E-meditek Solution, Gurgaon on 05.10.2009 through courier and the same were received by TPA office on 06.10.2009 for reimbursement of Rs.4760/-. However no action was taken by TPA. Neither he had received any reply.
3. The insurance company had submitted reply dated 24.09.2010 which is placed on record. It has been submitted therein that the complainant Shri Mukesh Kumar Agarwal obtained Reliance Healthwise policy valid from 30.11.2007 to 29.11.2009 covering himself along with his spouse and one son. On 19.06.2009, Smt. Sadhna Agarwal got admitted in Yashoda Hospital and Research Centre Limited, as a case of Large Multi Nodular Goitre. She remained there for 11 days from 19.06.2009 to 29.06.2009 for the treatment and

preferred a claim of Rs.4760/- under the policy. The main claim of hospitalization was settled as per policy terms and conditions. It was further submitted in the reply that the documents for pre & post hospitalization expenses were received on 04.12.2009 by the TPA, though this was beyond 90days after the discharge from hospital. It is further stated that the claim was repudiated by the TPA which was just and fair and in accordance with the contract of insurance which are envisaged in the policy.

4. I have considered the submissions of the complainant very carefully and have also perused the reply of the company which is placed on record. After due consideration of the matter, I hold that the company was not justified in repudiating the claim because complainant had submitted requisite documents to the TPA within the stipulated period of 90 days from the date of discharge. He had sent the documents through courier on 05.10.2009 and the same were received in the office of TPA on 06.10.2009. **Accordingly, Award is passed with the direction to the company to make the payment of Rs.4760/- along with penal interest @ 8% from the date of repudiation to the date of actual payment.**

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/310/RGI/09
In the matter of Shri Sanjeev Gosain
Vs
Reliance General Insurance Company Limited

AWARD dated 28.09.2010 - Mediclaim

1. This is a complaint filed by Shri Sanjeev Gosain (herein after referred to as the complainant) against the decision of the Reliance General Insurance Company Limited (herein after referred to as respondent insurance company) in respect of repudiaton of mediclaim.

2. The complainant submitted that he had taken mediclaim policy No. 282550101071 issued by Reliance General Insurance Company Limited. The policy covers himself, his wife and his two children. He submitted that the insurer had denied its liability vide its letter dated 13.09.2008 on the trivial ground which is not based on truth and ground reality. He submitted that he had been continuously insured for the last so many years. He further stated that from 07.05.2004 to 25.04.2007, he had taken insurance cover from the United India Insurance Company Limited and since 26.04.2007 he is insured with the present insurer, that is, Reliance General Insurance Company Limited. He says that it is established that since he had been continuously insured under mediclaim insurance policy, therefore, Clause 4.1 (pre-existing disease) does not apply in his case as per terms and conditions of the policy. The company was not justified in closing his case as No Claim on the ground that it was a pre-existing disease. He submitted that he is entitled for compensation in respect of claim against expenses incurred by him on account of treatment of his wife at City Hospital. All relevant papers were handed over to the company for settling the claim. He requested that his claim be got settled.

3. Reply had been received on behalf of the company which is placed on record. It has been submitted therein that the complainant Shri Sanjeev Gosain had obtained Reliance Healthwise policy valid from 26.04.2008 to 25.04.2009 covering himself along with his wife. On 16.07.2008, he got admitted in City Hospital as a case of Right Sacroilitis, Discogenic pain. He remained there for 3 days from 16.07.2008 to 19.07.2008 for the treatment and preferred a claim of Rs.32468/-under the policy. As per the consultation paper dated 16.07.2008 patient was having pain in lower back since 2 years. The policy inception date is 26.04.2008. Thus the symptoms of presenting ailment were prior to the inception of the policy and the disease is pre-existing. The Claim had been repudiated by the TPA of the company which was just and fair and in accordance with the terms and conditions of the policy. The sum and substance of the argument of the company is that the claim is not admissible as the disease was pre-existing.

4. I have considered the submissions of the complainant very carefully and have also perused the reply of the company which is placed on record. After due consideration of the matter, I hold that the company was not justified in repudiating the claim on account of pre-existing disease because the complainant is continuously under health cover. He had taken mediclaim policy with effect from 07.05.2004 to 25.04.2007 from the United India Insurance Company Limited and thereafter with effect from 26.04.2007 with the present insurer. Thus, the claim of the complainant is admissible and the same cannot be rejected on the ground of pre-existing disease. The complainant filed a claim in the 5th year. **Accordingly, Award is passed with the direction to the company to make the payment of Rs.31627/- along with penal interest @ 8% from the date of repudiation to the date of actual payment.**

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/300/RGI/09
In the matter of Smt.Geetanjali Sahni
Vs
Reliance General Insurance Company Limited

AWARD dated 28.09.2010 - Mediclaim

1. This is a complaint filed by Smt. Geetanjali Sahni (herein after referred to as the complainant) against the decision of the Reliance General Insurance Company Limited (herein after referred to as respondent insurance company) in respect of repudiation of mediclaim.

2. The complainant submitted that she had developed a severe pain at her back in the month of January, 2009. She consulted an Ortheopadecean, Dr.Rajiv Maheswari. Later on, the disease was diagnosed as Pilonidal Abscess and was hospitalized at Jaipur golden Hospital between 23-26/01/2009. As per the mediclaim policy, the above hospital was providing cashless facility but it was found that such hospital was deleted from the list

but this fact was not communicated to her and thus it was a proof of deficiency in service. She incurred an expenditure of Rs.40000/- from her pocket for hospitalization charges and after six months of submission of bills, she got repudiation letter dated 10.08.2009 from the company stating inadmissibility of claim due to exclusion clause. The clause states Fistula in Anus whereas she got operated for Pilonidal Abscess at Naval Cleft. She stated that Pilonidal Abscess is not found mentioned in the exclusion clause, therefore, the insurance company was not justified in repudiating the claim.

3. E-Meditek TPA of the insurance company vide its letter dated 10.8.2009 informed the complainant that the claim cannot be settled as per exclusion clause No.3. It also quoted policy exclusion clause No.3 but had not mentioned specifically as to what particular disease the complainant was suffering from and the same is excluded. The company also informed vide letter dated 12.11.2009 to the complainant wherein it has been stated that the treatment of the complainant related to disease mentioned as Pilonidal Abscess which in medical term is also known as Pilonidal cyst which comes under the category of Benign Cyst as per policy terms and conditions. Thus, the claim is not payable. During the course of hearing also, the representative of the insurance company vehemently argued that the claim of the complainant was rightly repudiated as the same is not payable because the disease for which the treatment was taken in the hospital related to the disease which is excluded as per policy clause No.3.

4. I have very carefully considered the submissions of the complainant and have also perused the written submissions of the company which are placed on record and also verbal arguments on the part of the company. After due consideration of the matter, I hold that the company was not justified in repudiating the claim because the disease with which the complainant was suffering and treated in the hospital did not find place specifically in the exclusion clause No.3. As a matter of fact, the company was also not very specific in its replies as mentioned in the preceding paragraph that the disease is specifically excluded in the clause. The company had tried to relate the disease of the complainant to one of the diseases which are excluded as per clause No.3. The treating doctor has very clearly stated that the complainant was admitted with severe pain in

Naval cleft, swelling, tenderness and redness present towards the naval cleft and the disease was diagnosed as Pilonidal Abscess. This disease, in my considered view, is not found mentioned in the exclusion clause No.3. Therefore, there is no justification on the part of the company to repudiate the claim of the complainant. In my considered view, the claim is admissible. **Accordingly Award is passed with the direction to the company to make the payment of claim of Rs.35352/- along with penal interest @ 8% from the date of repudiation of the claim to the date of actual payment.**

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/209/Universal Sompo/10
In the matter of Shri V.S. Balasubhramanian Vs
Universal Sompo General Insurance Company Limited

AWARD dated 30.09.2010 - Mediclaim

1. Shri V.S. Balasubhramanian made a complaint to this Forum on 19.05.2010 against Universal Sompo General Insurance Co. Ltd in respect of non settlement of Medicalim, under policy no. 2817/50379819/00/000.

2. On intervention of this office, we have been informed by the Insurance Company that it had reviewed the matter and had corrected the policy of the insured as desired by him, and the copy of corrected endorsement has been delivered to the complainant.
3. There is no further relief to be granted to the complainant.

4. The complaint is disposed of finally.

5. Copies of the Award to both the parties.

GUWAHATI

GUWAHATI OMBUDSMAN CENTRE
Complaint No. 11-003-0066/10-11

Dr. Tulsi Prasad Saikia

- Vs -

The National Insurance Co. Ltd.

Date of Order : 06.09.2010

Mrs. Seema Saikia, wife of the Complainant, was one of the insured persons under the above policy covering the period from 11.08.2008 to 10.08.2009. The Insured Mrs. Seema Saikia felt difficulties in breathing on 17.07.2009 with symptoms of acidity and she was admitted in the Hospital on 18.07.2009 and treated there after undertaking several laboratory examinations and discharged therefrom on 19.07.2009. A claim was lodged thereafter by the Complainant before the Insurer seeking reimbursement of Rs.9,846.00 being the expenses incurred in connection with her treatment and it is alleged that the Insurer has repudiated the claim without any justified ground.

During hearing, the Complainant has stated that his wife Mrs. Seema Saikia was admitted in the Hospital on 18.07.2009 when she felt uneasiness in breathing. He has produced the Discharge Certificate, Hospital Bill and Laboratory Report. According to him, he had submitted all those documents before the Insurer but the claim was repudiated. In the repudiation letters received from the TPA – E-Meditek (TPA) Services Ltd. and the Insurer, the above authorities informed the Complainant about repudiating his claim applying policy exclusion Clause No. 4.8. It was contended in both the above letters that Mrs. Seema Saikia (Insured) was admitted in the Hospital for treatment of "Anxiety Neurosis" and in view of Policy Exclusion Clause No. 4.8 "Anxiety Disorder" related claims are not payable. The Discharge Record of G.N.R.C. Hospital which shows that the disease for which Mrs.Seema Saikia was admitted and treated in the Hospital was finally diagnosed to be - (1) Anxiety Neurosis & (2) PUS and for all the above diseases, she was treated.

The representative of the Insurer has however submitted that "Anxiety Neurosis" has not been specifically excluded under Clause No. 4.8 of the policy conditions. According to the representative, although the claim was repudiated by the TPA, they had requested the TPA to reconsider the matter as ground of repudiation was not acceptable to them also. He has also admitted that for the diseases like "Anxiety Neurosis" and "PUS", the Insured was treated and none of the above diseases were excluded by the policy conditions. On a perusal of the Exclusion Clause No. 4.8 of the policy terms and conditions, we find no mention about exclusion of those two diseases from the purview of the policy. However, it is observed that although the decision of the TPA was found to be not acceptable to the Insurer, but the Insurer has agreed on the decision of TPA and communicated their decision to the Complainant vide letter dated 18.08.2010.

Considering all the above facts and circumstances, repudiation of the claim appears to have been made in deviation of the policy terms and conditions, and hence the same requires reconsideration. The decision of the Insurer is set-aside. Insurer was directed to settle the claim within 15 days.

GUWAHATI OMBUDSMAN CENTRE
Complaint No. 11 -009-0001/10-11

Mr. Debasish Dutta

- Vs -

Reliance General Insurance Co. Ltd.

Award dated : 11.06.2010

Mrs. Sutapa Dutta was an insured under the above "Reliance Healthwise Policy" covering the period from 27.08.2009 to 26.08.2009. On 22.01.2010, the Insured became ill after taking some drugs being prescribed by Dentist and on the same day, she was hospitalized at Life Line Hospital, Tinsukia. After necessary treatments, she was discharged on 25.01.2010 and her ailment was diagnosed to be "Anxiety neurosis with panic attack with nasobronchial allergy". Thereafter the Complainant had submitted the claim before the Insurer seeking reimbursement of the expenses incurred in the Hospital. It is alleged that the Insurer has repudiated the claim without any justified ground.

The Insurer has contended in their repudiation letter that the Insured was hospitalized for psychiatric problems and applying Policy Exclusion Clause Nos. 22 and 28, the claim was repudiated. The Exclusion Clause Nos. 22 & 28 of the policy are reproduced below :-

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

Clause = 22 :- Treatment of mental disease / illness, stress, psychiatric or psychological disorders.

Clause = 28 :- Charges incurred primarily for diagnostic, X-ray or laboratory examinations or other diagnostic studies not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any disease, illness or injury, for which confinement is required at a Hospital / Nursing Home or at home under Domiciliary Hospitalization as defined."

During hearing, the Complainant has stated that his wife was admitted and treated in the Hospital for complications / problems due to taking medicines prescribed by Dentist. The medicines prescribed on 11.01.2010 was followed by check up on 19.01.2010 when also the Dentist had prescribed certain medicines. It was stated by the Complainant in his letter dated 27.03.2010 that he had purchased the medicines prescribed by the Dentist only on 21.01.2010 and after taking those medicines, complications developed on the following day. He thereby intended to submit that due to medicinal reactions, the Insured

suffered from the diseases for which she was required to be hospitalized. However, the Discharge Certificate issued by the Hospital failed to disclose any such observations as to the past history or history of the disease requiring hospitalization and treatment. It was only diagnosed to be "Anxiety neurosis with panic attack with nasobronchial allergy". The certificate issued by the attending Doctor, shows that Insured was hospitalized on 22.01.2010 after taking medicines prescribed by Dentist Surgeon and she was treated for Hypertnsitivity of the drugs. This was, of course, stated on 25.03.2010 i.e. when the claim was repudiated holding the fact that the treatment was provided for psychiatric problems. Had it been a fact that she was required to be hospitalized for medicinal reactions, it would have been mentioned in the Discharge Certificate issued by the Hospital on 25.01.2010. This fact has not been recorded in the Hospital records and hence the certificate issued by the Doctor after two months from the date of discharge, cannot be accepted. The Policy Exclusion Clause No. 22 provides that the expenses incurred in connection with the treatment of mental ailments / psychiatric problems are not payable. The TPA of the Insurer M/s Medi Assist Pvt. Ltd. after taking medical opinion from their expert Doctors held that the Insured was provided with the treatment for psychiatric problems and repudiated the claim in view of the Policy Exclusion Clause No. 22 & 28 which cannot be said to be improper and irregular in view of the policy conditions. This being the position, I find no scope to interfere with the decision of the Insurer and the complaint is accordingly treated as closed.

GUWAHATI OMBUDSMAN CENTRE
Complaint No. 11 -018-0036/10-11

Mr. Deepak Kr. Das

- Vs -

Future Generali India Insurance Co. Ltd.

Award date = 13.09.2010

Mr. Deepak Kr. Das was the insured person under the "Individual Health Suraksha Insurance Policy" bearing Pol. No. FHI-H007092-2009 procured from the above Insurer for a Sum Insured of Rs. 1.00 Lac covering the period from 04.05.2009 to 03.05.2010. It is stated that on the intervening night of 25th & 26th September, 2009, he became senseless since 11-00 P.M. and then he was taken and admitted in the Hospital for treatment wherefrom he was discharged on 29.09.2009. On completion of usual treatments, a claim was lodged before the Insurer which was repudiated.

The Note of the Insurer shows that the Insurer has repudiated the claim considering the ground of delay in submission of the claim in violation of the policy conditions and considering the fact that the Complainant was admitted and treated in the Hospital for a disease which existed prior to inception of the above policy and hence claim was repudiated applying policy exclusion clause 3.1.

The Case Summary and Discharge Record produced before this Authority shows that the Complainant was admitted and treated in the Hospital from 26.09.2009 and discharged on 29.09.2009 and the disease, for which he was suffering and treated, was diagnosed as

"Status Epilepticus". The chief complaints for which he was admitted was recorded as "Repeated attacks on G.T.C.S. since 8.30 P.M. of 25.09.2009. The history of his illness, as recorded by the Hospital in Case Summary and Discharge Record also discloses that he was having similar attack in the month of January, 2009 and that was the second time, he was the victim of such attack again for which he was admitted and treated in the Hospital from 26.09.2009. The claim was lodged for such hospitalization and treatment and the claim appears to have been repudiated.

During hearing, the representative of the Insurer has stated that the policy in question commenced with effect from 04.05.2009 on the basis of the proposal form submitted by the Complainant wherein nothing was disclosed while answering to question Nos. 15 and 16 of the proposal form. It is observed that the Complainant has not disputed about the findings of the Hospital Authority about his sufferings from the said Epileptic attack in the month of January, 2009. Although he was aware about the said Epileptic attack prior to his submission of the proposal on 04.05.2009 but failure to mention about such health conditions in answer to question No. 15 of the proposal form appears to be a suppression on material facts.

Since the claim was relating to treatments for Epileptic attacks for which the Complainant was suffering and treated for "Epileptic disease" and aware of it since January, 2009 i.e. prior to inception of the policy on 04.05.2009 which he had suppressed in the proposal form, the claim appears to be not payable in view of the policy exclusion clause No. 3.1. Denial of the claim by the Insurer, in such circumstances cannot be said to be improper and irregular and we find no deviation from the policy terms and conditions by the Insurer in dealing with the claim. Thus, finding no ground to interfere with the decision of the Insurer, the complaint is treated as closed.

GUWAHATI OMBUDSMAN CENTRE
Complaint No. 11 -010-0185/09-10

Mr. Meghnath Dulal

- Vs -

IFFCO-TOKIO General Insurance Co. Ltd.

Award dated : 19.04.2010

The Complaint was a member / beneciary under the above "Group Medisheild Policy" procured from the above Insurer through TPA M/s Golden Multi Services Club Ltd. covering the period from 31.03.2006 to 30.03.2007. The Insured / Complainant was hospitalized on 12.08.2006 and was discharged on 22.08.2006 after receiving necessary treatments. On completion of usual treatment, he had submitted a claim before the Insurer through TPA under the above policy and it alleged that the TPA / Insurer has repudiated the claim without any justified ground.
The copy of the letter dated 15.06.2007 shows that the claim of the Complainant was closed by the TPA M/s Paramount Health Services Pvt. Ltd. on the ground that the

documents produced were considered to be not sufficient to meet the query of the Insurer / TPA. The letter dated 17.11.2006 issued to the Insured by the TPA during settlement process of the claim shows that the Complainant was asked to submit the following documents :-

(1) All previous consultation and treatment papers required before admission.
(2) Justification for prolonged hospitalization required.

The medical documents shows that the Complainant was treated first at Khatarbari State Dispensary since 08.08.2006 and on being referred by that Dispensary on 11.08.2006, he attended the S.M.K. Civil Hospital, Nalbari on 12.08.2006 when he was admitted in the Hospital. The letter dated 21.03.2007 written to the TPA by the Complainant also shows that he had produced all previous treatment particulars before the Insurer. Regarding justification for prolonged hospitalization, the Complainant has produced the medical certificate issued by the treating Doctor / Hospital wherein it was stated that he was treated in the Hospital for 10 days and such hospitalization / treatment was required as he was a patient suffering from "PUS with Malaria". Of course, there is a mistake as to the date of discharge wherein it was stated to be on 22.08.2008 which appears to be a slip of pen. The total period of hospitalization is stated to be only for 10 days i.e. from 12.08.2006 which indicates the date to be 22.08.2006. The Discharge Certificate and the medical certificate issued by the said Hospital on 14.09.2006 also goes to show that he was hospitalized only from 12.08.2006 and discharged on 22.08.2006 and after discharge, he was treated as an outdoor patient till 12.09.2006. The duration of hospitalization depends upon the seriousness of the disease suffered by a patient and this has been clarified by the attending Doctor of that hospital that 10 days hospitalization was required to control the disease like "PUS with Malaria". The explanation offered by the treating Doctor regarding duration of hospitalization should not be ignored. In the absence of any note or submissions from the Insurer, as regards the ground of repudiation, we have also not been able to ascertain as to what was the exact cause for such repudiation. It was only presumed that the TPA was not satisfied with the explanation offered by the Doctor regarding the duration of the hospitalization, as this was wanted by them.

In view of the above facts and circumstances, there was an irregularity in the settlement process of the claim and the Insurer should take a decision afresh. The process of settlement of the claim shall be completed within 15 days.

GUWAHATI OMBUDSMAN CENTRE
Complaint No. 11 -003-0026/10-11

Mr. Ramswarup Tibrewala

- Vs -

The National Insurance Co. Ltd.

Award dated : 29.06.2010

Mr. Ramswarup Tibrewala was an insured under Pol. No. 200201/48/08/8500000338 (Mediclaim Policy) procured from the above Insurer covering the period from 05.09.2008 to 04.09.2009. During the period covered under the policy, he became ill and was

admitted in the Hospital on 18.07.2009 and discharged on 23.07.2009 and again admitted on 25.07.2009 and discharged on 05.08.2009 after providing necessary treatments for "Cardiac" ailments. On completion of usual treatments, a claim was lodged before the Insurer being supported by documents and it is alleged that the Insurer has offered to settle the claim only at Rs.3,00,000/- even though he spent Rs.8,05,404/- in the treatment and the Sum Assured under the policy also stands at Rs.5,00,000/-.

The "Self Contained Note" of the Insurer shows that the Complainant / Insured had submitted all the relevant papers before the Insurer for re-imbursement of the expenses incurred in connection with his hospitalization but the claim was repudiated initially by their TPA M/s E-Meditek (TPA) Services Ltd. by wrongly incorporating policy clause No. 4.1 of "Individual Mediclaim" which was however reviewed, on receipt of the letter dated 17.12.2009 from the Complainant and thereafter the claim was settled at Rs. 3,00,000/-. It is further stated in the note that while recommending settlement of the claim at Rs.3,00,000/-, the TPA did not mention any reason how they have arrived at the said amount.

During hearing, the representative of the Insurer has stated that the Sum Assured under "V-Arogya Policy" was raised upto Rs.5,00,000/- with effect from 05.09.2007 and the TPA can go upto Rs.5,00,000/- while settling the claim subject to availability of supporting documents. The representative has also stated that the TPA, due to some misunderstanding, settled the claim at Rs.3,00,000/- but the TPA has failed to explain the circumstances till date considering which the claim was settled at such an amount and they have also been keeping all the claim related documents with them. According to the Complainant, he has produced all the related documents in support of his claim and submission of such required documents have also been admitted by the Insurer in their note. Since the Sum Assured under the policy stands at Rs. 5,00,000/- and supporting documents have also been filed alongwith the claim, the TPA can proceed to settle the claim upto the limit of the policy, which is also the contention of the Insurer. Anyway, the Insurer has failed to justify as to why the claim has been settled only at Rs.3,00,000/- repudiating a substantial amount from the total claim. Keeping in view the above circumstances, I feel deduction of substantial amount from the claim is not justified and there is scope for reconsideration of the matter and proceed to settle the claim afresh on perusal of required documents. Hence, the Insurer was directed to settle the claim within 15 days.

GUWAHATI OMBUDSMAN CENTRE
Complaint No. 11-002-0042/10-11

Mr. Sawarmal Khakholia

- Vs -

New India Assurance Co. Ltd.

Award dated : 05.08.2010

Mr. Sawarmal Khakolia was the insured under "Mediclaim Insurance Policy" bearing Pol. No. 530900/34/08/11/00000355 covering the period from 11.03.2009 to 10.03.2010. During

the period covered under the policy, he was admitted in the Hospital and treated twice during the period from 01.09.2009 to 03.09.2009 and again on 12.09.2009 to 17.09.2009 and in both the occasions, he was treated for the disease which was diagnosed to be "Alcoholic Hepatitis". On completion of usual treatment, a claim was submitted before the Insurer seeking reimbursement of the expenses incurred in connection with the treatments and it is alleged that the Insurer has repudiated the claim without any justified ground.

Mr. Khakholia has produced the Discharge Certificates for the above hospitalization and treatments in the Central Clinic and Nursing Home. Both the above Discharge Certificates clearly proves that the disease suffered by the Insured was diagnosed to be "Alcoholic Hepatitis" and he was provided with conservative treatments during the above hospitalization periods. However, the claim lodged by the Complainant was repudiated by the Insurer and communicated their decision to the Insured / Complainant vide letter dated 08.03.2010. In the repudiation letter, the Insurer has clearly informed the Insured that he was suffering from "Alcoholic Hepatitis" and treated for that during Hospitalization period and as per Exclusion Clause No. 4.4.6 of Mediclaim Policy (2007) all alcoholic related diseases are excluded from the purview of the policy. Since the Insured suffered from "Alcoholic Hepatitis" and treated, the claim for reimbursement was repudiated applying policy condition No. 4.4.6.

The Policy Exclusion Clause No. 4.4.6 states that the Company shall not be liable to make any payment under the policy in respect of treatments for diseases arising out of use of Drugs / Alcohol etc. It is alleged by the Complainant that he was not furnished with any copy of the above policy terms and conditions (2007) alongwith the copy of the policy. Anyway, he has received the policy document in time and it appears from the copy of the policy document that the "Mediclaim Policy (2007) clause" was attached alongwith the policy document and this was supposed to be received by the Insured. Although the Insured has denied about receipt of such policy clause but admittedly he did not raise any objection on receipt of the policy document without it. Hence, the plea raised by the Complainant appears to be not tenable. The policy exclusion Clause No. 4.4.6 excludes reimbursement of expenses for the diseases arising out and use of alcohol and hence repudiation of the claim by the Insurer, applying the above clause, cannot be said to be improper and irregular. Accordingly, the complaint is treated as closed finding no ground to interfere with the decision of the Insurer.

GUWAHATI OMBUDSMAN CENTRE
Complaint No. 11 -005-0163/09-10

Mr. Subrata Saha Bhowmick

- Vs -

The Oriental Insurance Co. Ltd.

Award dated : 06.05.2010

Mrs. Sangeeta Saha Bhowmick was one of the insured persons under the above "Group Mediclaim Policy" for a Sum Assured of Rs. 50,000/- covering the period from 22.05.2010 to 21.05.2010. It is alleged that the Insured Mrs. Sangeeta Saha Bhowmick was admitted in the Nemcare Hospital, Guwahati on 25.07.2009 and discharged there from on 02.08.2009 after receiving necessary treatments. On completion of usual treatments, a claim for Rs.85,803/- was lodged before the Insurer which includes the Hospital bill worth Rs. 23,958/-. The Insurer has settled the claim partially and paid the Hospital bill worth Rs.23,958/- as "Cashless" and it is alleged that the balance amounts of the claim have not been paid till the date of lodging this complaint.

The Insurer has contended that they have been informed by TPA M/s Heritage Health TPA Pvt. Ltd., Kolkata that the delay in settlement of the claim is taking place for want of submission of the required documents by the Complainant. but the Complainant did not submit the required documents till date.

During hearing, the representative of the Insurer, has said about non-submission of documents which causes the delay in taking decision. It is stated by the Complainant that he has not yet received any communication from the Insurer regarding his claim. However, letters dated 30.12.2009, 25.01.2010 & 26.02.2010 goes to show that the TPA was writing to M/s Sourav Diesel Sales & Service Pvt. Ltd. (Employer of the Complainant) for production of the following documents:-

(1) Original USG (Ultrasonography) Report.
(2) Original Hospital Final Bill, and
(3) Original Money Receipt of Balance Amount.

Anyway, due to communication gap and non receipt of the required documents, the claim is still pending before the Insurer and final decision could not be taken. Submission of those documents by the Complainant has also not been proved. In order to complete the process of settlement of the claim, it is felt necessary that the Complainant shall co-operate with the Insurer and arrange to produce the required documents at the earliest.

Insurer was directed to complete the process of settlement of the claim within 15 days from the date of receipt of the required documents from the Complainant.

HYDERABAD

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.003.375.2009-10

Sri D Amratlal V/**s** National Ins. Co. Ltd.

Award No:G-001/06.04.2010

The complainant's wife Smt. Leela Bai underwent Angioplasty on 05.12.2008 and claims for Rs.150000/- was submitted to the insurer. She has been insured with the same insurer since 2006. However, the claim was rejected by the insurer on the ground that she has been suffering from HTN since 15 years and a diabetic since 5 years. The policy covers pre-existing diseases only after five claim free years.

Sri Amratlal submitted that he has been renewing the mediclaim policy since 30.03.2005 and his wife was admitted with pain in chest in the Bangalore Hospital on 05.12.2008. She had undergone surgery for heart block. She had submitted the claim for reimbursement, it was rejected by insurer on the plea that the treatment she underwent was for a pre-existing disease. However, the complainant contended that the treating doctor has certified that there is no relation to the patient's ailment to her past history of HTN and DM.

The insurer contended that they issued Sampoorna Arogya Bima policy for the first time in March, 2007 and the present claim was submitted in the 3rd year of the policy. Prior to this policy the complainant's wife was covered under a different mediclaim policy. It is further pleaded that the discharge summary clearly stated the patient was suffering from HTN since 15 years and a diabetic since 5 years prior to hospitalization. It is also submitted that the policy does not cover heart and circulatory diseases for a period of 5 years from inception of the first policy.

ORDER

I heard the contentions of both the parties and perused the reports/documents submitted. It is observed that the complainant's wife was hospitalized with complaints of chest pain, sweating and breathlessness and subsequently found to be having occlusion of coronary vessels. She was subject to angioplasty and treated with supportive medication. The claim in respect of the said hospitalization was repudiated by the insurer referring to the health history of the patient. Though the complainant's son argued that his mother did not have heart problem prior to the day she was admitted in hospital, the two disorders such as diabetes and Hypertension are the main contributing factors for heart ailments. Despite the fact that the treating doctor's certificate opining that the patient suffered from atherosclerotic disease and is unrelated to DM & HTN, it was held that the patient's past history has a direct bearing on the

coronary occlusion. Hence, while upholding the decision of the insurer in repudiating the claim, the complaint is disallowed.

In the result the complaint is dismissed.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.017.260. 2009-10

Sri Lakshminarayana V/**s** Star Health & Allied Ins. Co. Ltd.

Award No:G-003/05.04.2010

Sri Lakshminarayana's wife took treatment at Sagar hospital for piles in the second year of the policy and a claim was preferred for Rs.55,465. The insurer rejected the claim on pre-existing disease grounds citing exclusion no. 1 and 4 (1st year exclusion).

The complainant contended that he gave the medical history of his wife at the time of taking the policy. His wife was suffering from piles problem for one and a half years only by which time he had already taken the policy. He further submitted that he was insured with New India Assurance Co. before associating with Star Health. So he contended that the 4 year exclusion clause should not apply in his case. Moreover, the hospital also had sent a re-consideration request stating that sigmadoscopy was done about six months before and the claim for the hospitalization was settled by the insurer.

The insurer stated that Sri Lakshminarayana took Family Health Optima Insurance policy for the first time in December, 2007 and renewed it in December, 2008. He preferred a claim in respect of his wife for her hospitalization from 28.8.2009 to 29.8.2009 for treatment of hemorrhoids. It is contended that the patient had past history of the said ailment since 4 years as per the discharge summary which meant that the disease was a pre-existing at the inception of the policy. Therefore, the claim was not entertainable as per the terms of the policy.

O R D E R

Both the parties were heard. The evidence relied upon by the insurer to assert that the complainant's wife had piles problem before she was covered for the first time is her alleged statement in the discharge summary. The complainant stated that his wife developed the

problem much after the policy was first taken. Surgery for piles was carried out which resulted in the present claim after about 20 months from the date of taking the policy. There is no medical evidence to corroborate the statement of the insurer's representative that piles problem must have existed for long before surgery was required. On the contrary, it was inclined to accept the complainant's explanation with regard to the history of the ailment and his submission that a person with piles problem could not have borne the problem for more than a year. The insurer's reliance on the discharge summary to ascertain the history of the disease cannot be found fault with but such evidence by itself cannot be treated as sacrosanct.

In the circumstance, rejection of the claim on the ground of pre-existing disease cannot be upheld. The insurer is directed to settle the claim in terms of the policy on receipt of the consent from the complainant.

In the result, the complaint is allowed.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11. 012. 0273. 2009-10

Sri K V Joy V/s ICICI Lombard Gen. Ins. Co. Ltd.

Award No:G-008/16.04.2010

Sri Joy stated that he paid Rs.15,000 towards premium to cover an employee of his under a health policy through his debit card. The next day, the representative of the insurer explained that the policy could not be made through debit card payment and requested for a cheque and took a cheque for the same amount. While taking the cheque, he promised that the amount paid through card would be refunded. The person who contacted them for the policy again asked for another cheque from the employee himself stating that the employee could not get insurance cover on the cheque issued by the employer. Since then, the complainant has been trying to contact him but in vain. The complainant sought refund of the amount paid by him. The insurer replied that none of its representatives collected any premium from the complainant and, therefore, the question of refunding any sum of money to the complainant did not arise. The complainant is aggrieved and hence this complaint.

Sri Joy contended one Mr Naveen Kumar from ICICI Lombard approached him for selling a health policy to his employee and completed transaction through his debit card on payment of Rs.15,000 towards premium. The next day, he came back again and took a cheque

for the same amount saying the debit card payment was not valid to issue the policy. After some days, he again came and said that the payment by the employer could not be accepted and asked for payment by cash. The complainant stated that the said person had switched of this mobile phone and the insurer's office also was not responding. He did not get the policy document. The debit entry on his debit card was not reversed.

The insurer contended that in spite of a thorough verification of their records, they were unable to trace the premium receipt details. The complainant provided the debit slip and account statement but it could not be ascertained if the payment had been credited to the insurer's account. The insurer requested that if the complainant could provide the payment details from his banker, they would be in a position to verify further in the matter.

O R D E R

It is evident that the complainant was hoodwinked by an imposter. The insurer has no knowledge of the transaction. The complainant's representative showed debit advice of a transaction for Rs.15,000, but the account into which the money was credited remains a mystery. In any case, the insurer cannot be fastened with any liability for this transaction.

In the result, the complaint is dismissed.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11. 003. 0365. 2009-10

Sri D V S Prabhakararao V/s National Insurance Co. Ltd.

Award No:G-009/19.04.2010

Sri Prabhakararao insured since 2004 got his wife admitted in Indo-American Cancer Institute for Carcinoma Nasopharynx. As the cashless facility was rejected by the TPA, he settled the bill and filed a claim for reimbursement for Rs.1,92,031 towards hospitalization and Rs.44,840 towards pre and post hospitalization expenses. The TPA settled an amount of Rs.1,27,000 only after applying group capping as per the policy. Sri Prabhakararao is aggrieved and hence this complaint.

The complainant has contended that the insurer had not informed him of the terms and conditions of the policy at any point of time since 2004. All these years, he received only the

policy schedule without conditions. He stated that the capping should not be applied for medicines because the prices of medicines could not be negotiated whereas the doctors/hospital could be chosen.

While approving the claim for Rs.1,27,000, the TPA gave break-up of the settlement as follows:

1. Room charges under Group A	for Rs.15000/- fully settled.
2. Professional Fees under Group B	for Rs.5500/- fully settled.
3. Investigation fees/medicines/ Lab expenses etc. under Group C	for Rs.1,85,031/- settled only for Rs.1,20,000/- @50% of the SI.

The pre and post hospitalization expenses were not settled due to the cap applicable.

O R D E R

As per the terms and conditions of the policy, the expenses incurred are covered under three different groups. There is a ceiling provided under each group. The insurer has applied the ceiling after aggregation of IMRT package expenses under Group 'C'. The complainant's claim is that the insurer did not supply him with the terms and conditions and, therefore, the ceilings should not be applied in his case cannot be accepted because the policy categorically mentions that the policy was subject to the terms and conditions attached to the policy. If the terms were not attached, he could have asked for the same and obtained from the insurer. That the insurer did not supply the terms and conditions cannot negate the existence of the terms and conditions since obviously there cannot be a policy without terms and conditions.

Since the terms of the policy provide for sub-limits under different groups, the insurer cannot be found fault with for applying the ceiling provided under each of the three groups. Nevertheless, IMRT package cannot be entirely taken as falling in only Group 'C' of medicines/investigation charges. IMRT package comprises rent for the machine, medical attention, nursing, consultation and medicines. Since the whole procedure was done as a package, the hospital would have refused to give any break-up. This, however, does not mean that the entire expenses had to be taken as that of medicines. In the absence of any break up available, it was reckoned fair and equitable that 50% of IMRT expenditure has to be treated as falling within Group 'C' while the remaining 50% relating to Group 'A' and Group 'B'.

In view of the above, the insurer is directed to re-process the claim after clubbing 50% of IMRT expenditure with the expenditure under Group 'C'. In other words, the insurer has to rework out eligible claim under the three groups, 'A', 'B' and 'C' after splitting IMRT package expenses as above.

In the result, the complaint is treated as allowed partly.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11. 005. 0373. 2009-10

Sri. Rakesh Kumar Surana **V/s** Oriental Insurance Co. Ltd.

Award No:G-013/22.04.2010

Smt. Sanju Surana, wife of Sri. Rakesh Kumar Surana, was covered under mediclaim policy initially taken 7 years ago. She was hospitalized for hysterectomy from 24.9.2008 to 28.9.2008. The claim submitted for Rs.87,495 was rejected by the insurer on the ground that there was a break in insurance cover by 15 days after the expiry of the previous policy. The policy for 2007-08 was reckoned as fresh policy and policy condition 4.3 was applied in denying the claim. Aggrieved, Sri Rakesh Kumar Surana filed this complaint.

The complainant contended that the delay in renewing the policy lay with the staff of the insurance company. The policy was first issued in 2004 and renewed till 2007 without break. In 2007, the complainant had issued cheque towards the premium on 30.3.2007 just a day after the due date for renewal. The said cheque was cleared on 13.4.2007 but the policy was renewed only from 16.4.2007. The policy was again renewed from 15.4.2008 to 14.4.2009 during which period the claim was lodged. The officials of the insurer clarified that there was breakdown of the systems due to which the renewal could not be effected in time. Now, the insurer shifted the blame on to the complainant and he had been deprived of his just claim.

The insurer stated that the policy for 2007-08 was renewed from 16.4.2007 to 15.4.2008 after a gap of 15 days after expiry of the previous policy. The policy for 2008 was renewed from 15.4.2008. The claim was repudiated as there was a break in insurance policy cover. Under condition number 4.3, hysterectomy treatment shall become payable only on completion of two claim-free years of continuous insurance. Since there was break in insurance, the claim fell within the purview of policy exclusion.

O R D E R

I have heard both the parties and perused the documents furnished. The cheque towards premium for renewal of the insurance policy for 2007-08 was apparently handed over by the complainant to the development officer of the insurance company. As per the papers placed on record, the renewal cheque dated 30.3.2007 was submitted in the insurer's office on 10th April by way of a note submitted to the Divisional Manager, who permitted it. The cheque was realized on 13-4-07. However, the policy was issued from a later date i.e., 16.4.2007.

The complainant stated that he issued the cheque on 30.3.2007. The development officer requested the officer in-charge on 10.4.2007 to allow him to accept and underwrite the policy. Then, after the approval for its acceptance, the policy was issued with effect from 16.4.2007 though the cheque was receipted on 10th April itself and the said amount was debited to the complainant's account on 13.4.2007. The complainant stated that there was delay of just one day in issuing the cheque and that could not mean break in policy cover.

The request of the development officer dated 10-4-2007 seeking approval for underwriting the policy shows that the complainant had issued the cheque as claimed by him. The policy was made effective from 15-4-2007 although the cheque was encashed on 13-4-2007 itself. The insurer's representative also failed to produce the relevant file, which could have thrown light on the rival contentions. In the reply dated 22-4-2010, the insurer's representative has not even made a mention of my direction to him about production of the file. This letter merely reiterated the reason earlier stated for rejection of the claim.

The insurer's inability to produce the file lends credence to the complainant's claim that the insurer's office obtained his cheque on 30-3 -07 but the same was not accounted for by the insurer that day. The complainant could not have invented the reason of systems breakdown. The insurer's representative has not rebutted the complainant's claim of misuse of his cheque or systems breakdown. If the complainant had delayed in issuing the cheque towards the premium due, the development officer would not have asked for condonation of the delay. Further, if the delay was more than 10 days, the officer in-charge had no authority to condone the delay at his level. Yet, he condoned the delay suggesting that the insurer's office had kept the cheque unauthorisedly with them and, therefore, the policy had to be renewed even though belatedly.

In view of the above, it was held that the insurer had no sound reason for rejection of the claim. The complainant, in my view, belatedly paid the premium but the delay appears to have

been within the grace period. Since, in any case, the complainant's wife underwent hysterectomy, which was not a medical condition which had developed during the period of the alleged delay in renewing the policy, and since she has been covered since 2004, it was deemed it fit to hold that the complainant is entitled to relief.

It was recognize that there was a break in the policy even though the complainant cannot be held responsible for the break. Yet, it was deemed it that the relief cannot be in terms of the policy. Instead, the insurer is directed to pay the amount to the complainant as *ex gratia*.

The complainant has asked for interest, compensation, etc. in addition to the claim amount as relief. This is impermissible. the insurer is directed to examine the claim, subject it to the restrictions as laid down in the policy, and pay that amount as *ex gratia*.

In the result, the complaint is partly allowed as *ex gratia*.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11. 017.355. 2009-10

Sri T G Raghavendra **V/s** Star Health & Allied Insurance Co. Ltd.

Award No:G-020/12.05.2010

Sri Raghavendra took Senior Citizens Red Carpet Insurance Policy for his father Sri Ganesh Kumar for Rs.100000/-. The insurer did not obtain any proposal but the contract was finalized on telephone. On 19.01.2009, his father was admitted in Narayana Hrudayalaya, a network hospital for Metabolic Encephalopathy. The insurer denied cash-less facility and subsequently the claim was also repudiated under pre-existing disease clause. Aggrieved, Sri Raghavendra filed this complaint.

The complainant submitted that he obtained the policy through telemarketing when the caller from the insurer explained all the benefits. He contended that the insurer did not even obtain a proposal even on a later date. When his father was admitted in Narayan Hrudayalaya Hospital, a cashless request was forwarded to the TPA. The TPA deputed its doctor to the hospital who on his visit to the hospital rejected the cash-less facility on the ground of pre-existing disease. The complainant stated that the insurer while selling the policy on phone was not informed of any exclusions. He, therefore, stated that repudiation was not in order.

The insurer vide its letter dated 18.6.2009 rejected the claim under PED clause. It stated that the complainant did not declare his father's health condition that he was Metabolic Encephalopathy/Sepsis/Normal Pressure Hydrocephalus which amounted to misrepresentation and violation of condition number 7 of the policy. The insurer also submitted that the patient also suffered from Generic Tonic Clonic Seizures and took treatment in the past. The claim was repudiated as the present treatment was for a pre-existing disease which the patient suffered before inception of the policy.

O R D E R

The submissions of both the parties were heard and perused the documents furnished by them. The record in the form of the CD produced as evidence by the insurer conclusively established that the complainant obtained the policy without disclosing his father's ailments. It is evident that the complainant was duly informed about the scheme and more particularly about non-coverage of pre-existing diseases. The audio tape contradicts the complainant's plea that he was misled and not educated about the scheme. The claim undoubtedly was in relation to a pre-existing disease not covered by the policy.

In view of the above, it was convinced that the insurer's decision to repudiate the claim was wholly justified.

In the result, the complaint is dismissed without any relief.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11. 002. 007. 2010-11

Sri Rajnikath H.Fofariya V/s New India Assurance Co. Ltd.

Award No:G-022/12.05.2010

Sri Fofariya and his wife are covered under mediclaim policy for Rs.1,00,000, having increased the sum assured from Rs.50,000 in 2008. Sri Fofariaya got admitted in Ratkal Specialty Clinic on 5.2.2009 with complaints of difficulty in passing urine and underwent treatment for Stricture Anterior Urethra and Urethroplasty. He submitted a claim for Rs.77,450 which the TPA rejected under clause 5.5 stating that the claimant submitted

enhanced hospital bill, which was otherwise only Rs.40,000 and this amounted to a fraud. Aggrieved, Sri Fofariaya filed this complaint.

The complainant submitted that there are two methods of treating his problem- one by complete excision of urethra and another which is complicated and requires more attention and skills. He opted for the second method. He stated that he paid the bill completely and that there was no fraud in his claim. He also stated that the charges he claimed, as billed by the hospital, were much lower than any other private nursing home.

The insurer vide their note contended that the hospital where the complainant underwent surgery had been blacklisted. The insurer stated that the complainant submitted inflated claim and this was proved after investigation by them. Hence, the claim was denied. The doctor stated that the revised bill for the treatment was only Rs.40,000 and the earlier bill was given at the request of the patient.

O R D E R

All the documents examined submitted were examined. The hospital originally issued a bill for Rs.77,470 on 16-2-2009. When the insurer's representative confronted the doctor (Dr Ratkal), he gave a letter dt.19-3-09 stating that the revised bill was only for Rs.40,000 and that the earlier bill for Rs.77,470 was issued as per the request of the patient. The said doctor, however, issued another letter dated 7-5-2009 stating that the bill was Rs.77,470 and that the bill was genuine. He followed this up with yet another letter addressed to the insurer stating that there was gross confusion in the case and that the hospital charged the complainant Rs.77,470 and that this included his charge of Rs.40,000 and that in his letter dated 19-3-09, he had mentioned only his charges and had not included other charges and fee of others. The doctor is the reason for the confusion. His statements are contradictory in nature. The bill for Rs.77,470 included Rs.18,000 as the surgeon's (Dr Ratkal)'s charge and Dr Ratkal's visits charge of Rs.2750. There is, therefore, no truth in his subsequent statement that his charges amounted to Rs.40,000. The truth appears to be that the complainant incurred aggregate expenditure of Rs.40,000.

The insurer rejected the claim under clause 5.4 of the policy. The said clause refers to cancellation of policy if the contract is entered into fraudulently by the insured by giving false declaration at the time of proposal. This clause does not entitle the insurer to reject a claim if the claim is inflated. Nevertheless, the insurer is obliged to pay only reasonable expenses as per

clause 2 of the policy. Thus, the insurer can deny payment of the inflated claim to the extent it is inflated. The insurer is of the view that the treatment would have costed Rs.40,000. It was held this amount to be reasonable for the treatment that the complainant had undergone. Accordingly, the insurer is directed to settle the claim at Rs.40,000.

In the result, the complaint is allowed in part.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11. 005. 008. 2010-11
Sri Shantilal N Jain V/s Oriental Insurance Co. Ltd.
Award No:G-024/13.05.2010

Sri Shantilal N Jain and his family consisting of his wife and two children are covered under Mediclaim policy since 2006-07. His wife was admitted in Jaysree Nursing Home on 6.10.09 to 7.10.09 for treatment of D & C. Sri Jain preferred a claim on the insurer but the TPA rejected it on the ground that there was no active line of treatment. Aggrieved, Sri Shantilal N Jain filed this complaint.

The complainant submitted that the treatment his wife underwent did not require 24 hours hospitalization and the policy condition also exempted D&C from 24 hours hospital confinement. He also refuted the charge that there was no active treatment stating that his wife was treated under general anesthesia.

The TPA of the insurer, M/s Raksha, rejected the claim quoting exclusion clause 4.1 which stated that expenses towards evaluation and diagnostic purposes without active line of treatment were excluded from the policy purview.

O R D E R

The complainant preferred two claims for DD&C procedure that his wife underwent. The insurer's TPA has paid one claim for hospitalization while rejecting the first claim. The insurer's TPA stated that the second claim was settled erroneously. It appears clear that DD & C is a procedure which is carried out for diagnostic purposes. The complainant's wife under went D & C. There was also no active line of treatment following admission in the hospital. The policy does not provide for reimbursement of claims on expenses incurred towards evaluation and diagnostic purposes without active line of treatment.

In view of the above, it was held that the action of the insurer in rejecting the claim is justified.

In the result, the complaint is dismissed without relief.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11. 008. 413. 2010-11

Sri. N V Venkata Krishnaiah V/s Oriental Insurance Co. Ltd.

Award No:G-026/13.05.2010

Sri. N V Venkata Krishnaiah has Health Shield Policy of the insurer covering himself, his wife and his daughter for Rs.2,00,000 each since 2003. Sri N V Venkata Krishnaiah underwent cataract operation to both the eyes on 7.11.09 & 16.11.09 at Karthik Netralaya Hospital and submitted a claim for Rs.60,000. However, the insurer settled Rs.7500 only stating that the policy has a monetary cap of Rs.7500 per policy period for cataract operations. Aggrieved, Sri N V Venkata Krishnaiah filed this complaint.

The complainant submitted that he had cataract operation done to his eyes in two episodes and preferred claim for Rs.60,000/-. However, the insurer settled only Rs.7500/-. He requested that his claim was reasonable and should be allowed.

The insurer vide their note dated 27.4.10 submitted that the complainant's claim made on 7.11.09 had been settled for Rs.7,500. The other claim dated 16.11.09 was rejected as the maximum limit for treatment of Cataract under the policy was Rs.7500 which had been exhausted by the insured.

O R D E R

The complainant underwent cataract operation to both the eyes with an interval of 10 days incurring an expenditure of Rs.60,000. He made two claims. The insurer settled the first claim for Rs.7500 after applying the ceiling of Rs. 7500 as per the policy. The complainant made another claim for Rs. 52,500 after the cataract operation of the second eye on the premise that he had incurred an aggregate expenditure of Rs.60,000 for both eyes. The insurer rejected the claim on the ground that the ceiling for cataract operation as per the policy was Rs.7500 which had already been paid.

The complainant vehemently argued that the ceiling of Rs.7500 for cataract operation was unreasonable. He contended that other insurers paid the claims in relation to cataract in full. He, therefore, stated that the insurer erred in applying a ceiling of Rs.7500. In the course of the hearing conducted, the complainant was requested to look at the relevant condition of the policy. In response to this, he stated that he knew the existence of the condition. Yet, he argued that the condition specifying a ceiling for cataract at Rs.7500 was irrational as no hospital would carry out the said surgery for Rs.7500 and that the insurer was the only one who had such an unreasonable ceiling. He requested that his claim was close to the prevalent rate for cataract and that had to be paid to him by the insurer.

After hearing the complainant patiently, Ombudsman stated that his arguments are specious. The complainant entered into a contract of insurance with the insurer. The terms of the policy are unambiguous in that the agreement provides for payment of only Rs.7500 for cataract surgery. The ceiling has no exceptions. In the circumstances, the insurer was bound to pay only Rs.7500 for cataract operations regardless of actual expenditure incurred by the complainant. The insurer settled the claim as per the policy. It is, therefore, beyond doubt that the complaint is devoid of any merit. The complainant is literate and he is aware of the ceiling for cataract and yet he preferred this complaint. The insurer have no hesitation in stating that the complaint is vexatious.

In the result, the complaint is dismissed.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11. 005. 0390. 2009-10

Sri. D M Chikka Thimmaiah V/s Oriental Insurance Co. Ltd.

Award No:G-027/20.05.2010

Sri. Thimmaiah took treatment at Manipal Hospital for Renal problem (constructive AVF) on 31.05.2007 during the 4th year of the Mediclaim Policy. The claim was rejected by the TPA, Medi Assist on PED ground under clause 4.1. It is stated that the first policy commenced in 2005 and the complainant has history of HTN, ESRD since 8 eight years as per the consultation papers of Kanva Hospital. The complainant is aggrieved and hence this complaint.

The complainant contends that he was hale and healthy and did not have HTN or ESRD. He consulted Kanva Hospital as he felt ill health and there he was referred to Manipal Hospital. There, he was detected to be suffering from HTN and Renal problem. He submits that he is continuously using medicines for renal problem and recently, he was advised dialysis. He submits that he was in deep financial distress.

The TPA rejected the claim on pre-existing condition attributing the hospitalization for renal problem to HTN and ESRD the complainant was suffering for 8 years (a complication of Hypertension). The consultation papers of Kanva Hospital were referred to come to the conclusion.

ORDER

I have heard the submissions of both the parties and perused the documents submitted. It is observed from the documents submitted that the complainant consulted Dr. G K Prakash and was diagnosed to be suffering from mild hypertension and renal problem. Subsequently he was treated for kidney problem with hemodialysis. The initial consultations at Kanva Diagnostic Services, he was referred to be suffering from hypertension for 7 to 8 years, which was denied by the complainant. However, the Manipal North side Hospital talks about the patient being hypertensive since 2 years only. Though the insurance company official produced two opinions and one of them – a nephrologists - opined that it would take longer period to reach a stage of Critical Renal Failure, it cannot be said about every patient. The duration could vary depending on the patient overall health condition. It is also possible as the complainant himself stated that he was not aware, the symptoms of HTN might be very mild and increased rapidly at a later stage. The complainant's submission that he would have taken the policy for higher sum if he were aware that he was suffering from hypertension needs consideration with due credence. Hence, it is possible that he might be hypertensive of low intensity but completely ignorant of when he took the policy for the first time in 2004. The symptoms might have come to surface only 2 years before he took the treatment at Kanva Diagnostic Services in March, 2007 and at Manipal North side Hospital. Considering the submissions of the complainant and the insurer's representative, the complainant might have suffered from mild hypertension by the time he took the policy but completely

unaware. This cannot be construed to be a pre-existing disease to connote exclusion under the policy. It is observed that the insurer refrained from processing the policy as it was concluded that the complainant had history of HTN. Hence, the insurer is directed to process and settle the claim in the light of policy terms and conditions.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11. 004. 0392. 2009-10

Sri D Ratnakara Rao V/s United India Insurance Co. Ltd.

Award No:G-028/20.05.2010

Sri D Ratnakar Rao submitted a claim for Rs.96,818/- incurred for treatment of Sri D Pullaiah, his father aged 70 years, in M/s. Axon Hospital, Hyderabad during 19.9.08 to 22.9.08 and 14.10.08 to 24.10.08. The insurer rejected the claim stating that Arogyadaan Mediclaim Insurance Policy is specially designed to cover only the account holder, his spouse and two dependent children, who are below the age of 65 years. The insurer stated that the policy did not permit cover of Sri D Ratnakar Rao's father. Earlier, Sri Pullaiah was covered under a mediclaim policy with National Insurance Co. and two claims were paid in the Year 2006 for Meningitis. The diagnosis done by Axon hospital now was hypothyroidism with Electrolisation Imbalance (Metabolic Encephalopathy) and this related to the previous treatment for meningitis, thus excluding the claim as per the policy as per exclusion 7 (i) of the policy Aggrieved, Sri D. Ratnakara Rao filed this complaint.

The complainant contended that his father, Sri Pullaiah, was admitted in M/s Axon Hospital, Hyderabad in a very serious condition. The information was given to the TPA. Sri Pullaiah was treated in the hospital from 19.9.08 to 22.9.08 and again from 14.10.08 to 24.10.08 and he expired on 24.10.08. The complainant Sri Ratnakar Rao settled a total bill of Rs.96,818/- and submitted his claim for reimbursement but the insurance company rejected it on false grounds. Hence, he approached this office for settlement and also for award of damages of Rs.50,000/- for mental agony.

The insurer did not submit any note to this office. However, the insurer vide their repudiation letter contended that Arogyadaan is a specially designed policy to cover only

Andhra Bank account holder, his/her spouse and two dependent children below the age of 65 years. However, the patient Sri Pullaiah was aged 70years and, therefore, the policy could not cover Sri Pullaiah. Further, the complainant had taken two claims in respect of Sri Pullaiah from National Insurance Co. for the same ailment. Hence, the treatment for which the claims preferred now fell under pre-existing disease. As per clause 7.1 and condition No. 5.4 of Arogyadaan Policy, the claims were not payable.

O R D E R

The submissions of both the parties were heard and perused the documents submitted. Since the insurer has agreed to settle the claim as per the terms and conditions of the policy, the insurer is directed to ensure that the claim is settled expeditiously.

In the result, the complainant is treated as allowed.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11. 005. 012. 2010-11

Sri Bulli Subbarayudu V/s Oriental Insurance Co. Ltd.

Award No:G-029/26.05.2010

Sri Subbarayudu covered under mediclaim policy issued by Oriental Insurance Co. was admitted at Star Hospital from 29.6.08 to 17.7.08 for undergoing CABG. When he preferred a claim for Rs.125000/- the claim was rejected by the insurer on the grounds that the complainant was suffering from Hypertension since 7 years and the present illness was a complication of Hypertension. Since Hypertension is a pre-existing disease the claim was rejected. Aggrieved, Sri Subbarayudu filed this complaint.

The complainant contended that he submitted claim papers along with bills and prescriptions for settlement of his claim but the insurer rejected the claim vide letter dated 27.12.08 under policy condition number 4.1(pre-existing disease) on the pretext that CABG was a complication of hypertension. Coronary Artery disease is not an exclusive complication of hypertension and can be caused due to other factors such as increase in levels of triglycerides and high LDL levels which alter lipid profile and lead to CAD. The complainant stated that rejection of the claim by the insurer was not proper.

The insurer in their note contended that the policy was in force continuously for three years from 28.3.2006 and the complainant underwent operation for Coronary Artery By-pass Grafting. The complainant was suffering from hypertension for last 7 years which led to CAD and hence the claim was repudiated under exclusion number 4.1. The insurer also clarified that hypertension is excluded for 2 years from the date of commencement of the policy under exclusion number 4.3.

O R D E R

It is observed from the documents submitted that there is a contradiction about the past history of hypertension of the complainant. He was admitted at Mullapudi Kamaladevi Hospital, Tanuku. As per the prescription of this hospital, the complainant was found to have accelerated hypertension without mentioning its duration whereas the documents of Star Hospital record the history of hypertension for 7 years. However, the complainant denied to have given such information as he himself was sure that he had no hypertension. It is possible, as the complainant submitted, that the doctor at Star Hospital could have recorded the history of his patient's history of hypertension on presumption. The insurer has based its decision to repudiate the claim on the general remark in the discharge summary by the doctor. The insurer has no other evidence to further substantiate their stand.

The complainant's denial that he had no history of hypertension is supported by the record of previous hospitalization in Mullapudi Kamaladevi Hospital. He also has obtained a certificate from the doctor of this hospital which states that the complainant had no history of hypertension. Moreover, this doctor also opined that hypertension itself could not be the only cause for the patient's Acute Coronary Syndrome. The complainant stated that he used to go for health check up regularly and submitted a certificate from his family doctor certifying that the complainant did not have hypertension during the last 10 years.

The complainant's submissions are plausible. The insurer's representative relied upon only one noting in the discharge summary. There is no evidence to substantiate that. The prescription in the first hospital did not mention existence of hypertension. The treating doctor also stated that hypertension could not be the sole Cause of CAD. Another doctor whom the complainant consulted vouched that the complainant did not suffer from hypertension. The evidence, therefore, is overwhelmingly in favour of the complainant.

In view of the above, credence was given to the complainant's submissions and hold that the insurer was not justified in repudiation of the claim. Accordingly, the insurer is directed to settle the claim as per the terms and conditions of the policy.

In the result, the complainant is allowed.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11. 004. 0382. 2009-10

Sri A Nagaraj V/s United India Insurance Co. Ltd.

Award No:G-030/26.05.2010

Sri A Nagaraj was admitted in M/s Seven Hills Hospital, Visakhapatnam from 6.7.08 to 9.7.08 on complaint of loss of consciousness and a claim for Rs.21,361 was submitted for reimbursement. The insurer rejected the claim stating that the treatment taken was for a pre-existing disease. Aggrieved, Sri A Nagaraj filed this complaint.

The complainant contended that his illness was a sudden development and not a pre-existing disease. He also stated that he gave intimation of his hospitalization immediately to the insurance company. He stated that the allegation of the insurer that his ailment was pre-existing was baseless. He stated that his genuine claim was rejected to avoid payment.

The insurer submitted that the policy was issued to the complainant for the first time from 4.8.04 to 8.6.05 and renewed for a further period of one year. However, the next renewal was delayed by 94 days from 11.9.07 to 10.9.08 and hence the latest policy was considered a fresh one. The insurer contended that the complainant was a known case of DM and Hypertension and he was on regular medication. The insurer referred to the observations of the treating doctor of M/s Seven Hills Hospital that the complainant had history of DM and HTN and presented with two episodes of fall with loss of unconsciousness over a period of 2 years.

The insurer stated that the policy renewed after a gap of 94 days was treated as fresh one and the treatment the complainant underwent was treated as pre-existing disease. Hence, the claim was repudiated under exclusion number 4.2 of the policy.

O R D E R

As per the hospital records, the complainant had the problem of fall with loss of consciousness two years before. It is also a fact that the complainant failed to renew his Arogyadaan policy on its

second renewal in time from 8.6.07. He renewed the policy after a delay of 94 days. The insurer's contention that the delay is inordinate is valid.

The complainant fell unconscious and thereafter went to the hospital for diagnosis of his problem and its treatment. The hospital conducted certain tests such as MRI on the complainant so as to exclude the possibility of neurological disorders. Even after MRI, the doctors could not identify the cause of his problem. The insurer could possibly hold that the treatment was not active and that it only involved diagnostic tests against which payment was not permissible. The complainant, however, had to go to the hospital since he had fallen unconscious and MRI was taken at the instance of the doctor. Whether falling unconscious was a disease or not is debatable. Even after tests, the doctors have not come out with the cause of the problem. In the circumstances, it is difficult to say with certainty that the complainant's problem was part of a pre-existing disease.

Notwithstanding the foregoing, it is clear that the treatment did not involve active medication. Costs of diagnosis are outside the purview of the policy unless the diagnosis is followed by active treatment of a disease. Since, however, the complainant had to approach the hospital after falling unconscious and MRI was conducted to rule out any neurological problem, MRI charges are liable to be paid to the complainant.

While endorsing the insurer's decision to reject the claim on account of transient ischemic attack (loss of temporary consciousness), the insurer is directed to pay MRI scan charges to the complainant on submission of the relevant bill as ex gratia. In the result, the complainant is partly allowed as ex gratia.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11. 05. 013. 2010-11

Sri Gande Narsaiah V/s New India Assurance Co. Ltd.

Award No:G-039/8.06.2010

Sri Gande Narsaiah preferred two hospitalization claims on health insurance policy covering himself and his wife. He took the policy for the first time form 10.3.06 to 9.3.09 for Rs.15,000 and it was renewed with break of 52 days from 30.4.07 to 29.4.08 and again from 30.4.08 to 29.4.09. The sum insured was enhanced from Rs.15000 to Rs.1,00,000 for the latest

policy. He preferred two claims in the latest policy period which were rejected by the insurer on the grounds that the treatment taken was for a pre-existing disease which was existing even before taking the policy for the first time. Aggrieved, Sri Gande Narsaiah filed this complaint.

The complainant submitted that his claim was repudiated by the insurer relying on the history of his health inadvertently mentioned in the discharge summary. He argued that he had DM/HTN only for ten months but the treating doctor had mistakenly mentioned it as 10 years. He represented to the TPA that he was not suffering from DM/HTN. His illness as per the hospital records was just 10 hours before his admission. His claim was rejected even after submitting a letter from the treating doctor clarifying the position with regard to his health history.

The insurer stated that at the time of taking the first policy, a proposal was submitted along with a doctor's certificate specifying that the insured persons were suffering from diabetes and hypertension. The insurer further stated that the hospital noting corroborated with this and hence the claims were repudiated on the ground that the treatment taken for the present illness was a complication of DM & HTN.

O R D E R

The complainant initially took a policy covering himself and his wife for Rs.15,000 each. He did not renew the policy in time and renewed only after a gap of 52 days for the same sum insured of Rs.15000. However, the sum insured was enhanced to Rs.1,00,000 for the policy period 30.4.08 to 29.4.09. He preferred a claim for acute coronary syndrome for Rs.21,988 which the insurer rejected stating that his illness was a complication of a pre-existing disease. The complainant preferred two more claims for Rs. 12,651 and Rs.1,56,588.

The complainant claimed that he did not have DM/HTN. He stated that the discharge summary was wrong. He obtained a clarification from the treating doctor to this effect. The complainant pleaded that he did not know about the details filled in by the physician in the proposal form about diabetes and hypertension. He said that he merely signed the proposal and the rest was filled in by the branch manager.

The discharge summary cannot be taken lightly notwithstanding a subsequent clarification issued by the treating doctor. The proposal form contained physician's noting that the complainant suffered from DM/HTN. The insurer's representative could not have maliciously included a wrong certificate from the physician. As per practice, the proposal

together with the physician's certificate has to be furnished by the proposer himself. It is, therefore, possible that the complainant indeed had some health problems when the policy was obtained for the first time. However, the insurer's version would have been wholly credible if there was an endorsement of pre-existing diseases in the policy issued. The policy document did not have such an endorsement. Because of this reason, it was considered it appropriate to award ex gratia to the complainant. The sum insured under the initial policy was only 15,000 and the same was increased in the latest policy.

In view of the above, the insurer is directed to pay ex gratia of Rs.15,000 to the complainant.

In the result, the complaint is allowed in part as ex gratia.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11. 003. 0334. 2009-10

Smt. G Lalitha V/s National Insurance Co. Ltd.

Award No:G-040/11.06.2010

Sri G G S N Rama Rao and his wife were covered under a mediclaim policy for Rs.5,00,000 since November, 2006. Sri Rama Rao was admitted in Apollo Hospital for foot ulcer from 31.1.08 to 21.2.08. His foot was amputated. The hospital had sent a request to the TPA for cash-less facility which was rejected for non-availability of full details . He was again hospitalized for kidney problem during April 2008. The bill came to Rs.46,440. He was also hospitalized from 8.6.08 to 14.6.08 with complaints of high fever and low urine output. He was detected to be suffering from heart block and PTCA was done. Cost of this treatment amounted to Rs.2,18,875. Smt. G Lalitha submitted the claim for a total amount of SI of Rs.5,00,000 but the claims remained unsettled. Aggrieved, Smt. G Lalitha filed this complaint.

The complainant stated that her husband was first admitted for treatment of a wound on his left leg but the doctors amputated his leg. Thereafter, he was hospitalized twice and was on regular medication. Despite medical care, he did not survive and passed away on 7.9.2008. As the claims were not settled by the TPA, she approached insurance company's grievance cell on 4.12.09 and failed to get any response.

The insurer did not submit any reply. There was no letter from the TPA/Insurer to the complainant. The TPA rejected the Apollo Hospital's request for cash-less facility for treatment

on grounds of insufficient information. TPA had asked for the first prescriptions for treatment of diabetes of the patient.

O R D E R

The complainant's husband took a hospitalization policy in November, 2006 and renewed it in time. He had a diabetic foot when he got admitted in Apollo Hospital consequent to an injury he sustained. His leg was amputated in January, 2008. Subsequently, he was hospitalized for kidney problem in April the same year and in June he developed heart problem and was subjected to angioplasty.

It is evident from the hospital records submitted by the insurer's representatives that the records have been tampered with inasmuch as the dates at a few places have been altered. The entries showing the past health history appear to have been corrected. However, the entry on the third page of the record filed with this office remained unaltered which showed that late Sri Rama Rao was a patient of DM for 2 years prior to the said hospitalization. Further, the insurer also submitted a consultation slip dated 15.10.2006 of the deceased in which he was found to be a diabetic patient and diabetic related medicines were prescribed. These documents show that the complainant's husband must have had diabetic history before taking the policy in November 2006. Hence, the insurer's claim that hospitalization expenses fell within the purview of exclusion clause 4.1 relating to pre-existing disease has merit.

Notwithstanding the foregoing, the complainant's submission that her husband's heart problem was not directly related to diabetes has to be considered. Diabetes can lead to heart problem but not always necessarily so. The complainant is genuinely under the impression that her husband had no history of any serious ailment. She also has had no knowledge of tampering of the hospital records. It is a borderline case where hospitalization for the heart ailment in which PTCA was conducted might or might not be due to diabetes.

Considering the totality of the case and the unenviable circumstances in which the complainant is placed, it was held this to be a fit case for award of ex gratia. Accordingly, the insurer is directed to pay a sum of Rs.50,000 (fifty thousand rupees only) as ex gratia to the complainant.

In the result, the complaint is allowed in part as ex gratia of Rs.50,000.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G.11.017.398.2010-11

Mr Bhimani Mansoor V/s Star Health & Allied Insurance Co. Ltd.

Award No:G-047/24.06.2010

Mr Bhimani Mansoor covered his family members under a hospitalization policy from 1.1.2005 continuously with a public sector insurance company and switched over to Star Health Insurance's Family Health Optima cover from 1.1.2009. There was no break in the cover. Mr Bhimani Mansoor's wife underwent Hysterectomy due to complications of ovarian cyst (Chocolate Cyst). When Mr Bhimani Mansoor claimed the expenses towards hospitalization, the insurer rejected the claim on the ground of pre-existing disease. Aggrieved, f Mr Bhimani Mansoor filed this complaint.

The complainant submitted that basing on the promises given on extending all the benefits of existing policy, he shifted to the present insurer. Moreover, as per exclusion No.5 of the policy, exclusions under 2, 3 & 4 are not applicable if there is continuous insurance under any insurance scheme with any Indian insurer. The proposal was accepted with specifically stating this to be 5th renewal. The treating doctor in his medical report also had not declared it as pre-existing disease.

The insurer contested that as per their in-house medical experts, the ovarian cyst was a long standing pathological disease that must have been present prior to inception of the present policy and so it was a pre-existing disease. The insurer further contended that the insured did not declare it in the proposal and this amounted to misrepresentation of fact. The claim was rejected rightly as per exclusion number 1 of the policy.

O R D E R

The complainant's wife underwent Hysterectomy operation for removal of ovarian cyst. The claim of expenses towards hospitalisation fell within the first year of the policy in respect of the present insurer. However, the complainant has been under coverage of another hospitalization policy issued by National Insurance Co. Ltd. Moreover, the complainant had no reason to shift the company if he had to forgo the benefits he was enjoying on an existing policy. The insurer's contention that the disease would have taken several years to develop is

unacceptable. Even if this contention is correct, condition no. 3 of the policy excludes hysterectomy only for two years. Condition No.5 nullifies this. Thus, by virtue of having insurance cover continuously since 2005, the complainant is eligible to claim for pre-existing diseases also as per the policy issued to the complainant.

In view of the above, it was held that the insurer erred in repudiating the claim. Accordingly, the insurer is directed to pay the claim in full at Rs.81,770.

In the result, the complaint is allowed.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.004.109.2010-11

Sri B.S. Manohar V/s United India Insurance Co. Ltd.

Award No:G-052/5.07.2010

Sri B.S. Manohar was covered under insurer's Individual Health Insurance Policy along with his spouse for Sum Insured of Rs.1,25,000/- each from 13.12.2004 and the policy had been continuously renewed without break. He preferred a claim on the policy for Acute Inferior Wall MIPTCA and Stenting to LCX on 20.12.08 for which he had incurred hospitalization expenditure of Rs.1,66,573/-. The insurer settled the claim for 70% of SI for Rs.87,500/-, being the ceiling imposed under the policy for major surgery. As he was diagnosed with having blocks in his heart, he underwent Open Heart Surgery on 9.10.09 during the same policy period and submitted hospitalization bills for Rs.1,66,000/- for payment of the balance amount of SI, i.e. Rs.37,500/- under the policy. The claim was rejected by insurer's TPA stating that *"as per policy terms & conditions for major surgical procedure, only 70% of SI is payable which they have already paid in previous claim"*. Sri B.S. Manohar represented to the insurer to reconsider their decision stating that his second hospitalization had to be treated as fresh illness, referring to the policy provisions *3.0 "Any One Illness"* and the ceiling had to be applied for each hospitalization separately. There was no reconsideration by insurer. Aggrieved, Sri B.S. Manohar filed this complaint for redressal.

The complainant submitted that he took VRS from the SBI and after VRS he took Mediclaim policy with the insurer during the year 2004 and it had been continuously renewed without any break. The complainant submitted that his claim merited admission under the policy as his second hospitalization took place after a lapse of 289 days of his first one for cardiac

surgery. The complainant reiterated strongly relied upon policy proviso 3.0 dealing with Any One Illness which states that occurrence of same illness after a relapse of 105 days had to be treated as fresh illness for the purpose of the policy. His claim for reimbursement of second hospitalization bill should be clearly treated as *"fresh illness*" for the purpose of the policy and reimbursed with the balance amount of SI. He contended that repudiation of his claim was totally unjustified and unlawful.

The insurer contended that their repudiation was justified as they had admitted the complainant's first claim to the maximum permitted amount under the policy. Proviso 1.2 of the policy restricted coverage under the policy in respect of major surgeries to 70% of SI or Maximum Rs.2 lakhs. For the first cardiac major surgery, the complainant was paid 70% of SI of Rs.125000/- i.e. Rs.87,500/- in full and the second hospitalisation for the same disease occurred in the same policy period. Hence, they could not admit the claim having already paid the full amount payable under the policy.

O R D E R

There is no dispute on admission of the first claim by the insurer and its restriction to 70% of SI as per proviso 1.2 of the policy to the complainant. On perusal of the terms and conditions of the policy issued to the complainant, clause 1.2 b clearly specifies the benefit as 70% of Sum Insured for major surgeries for reimbursement of expenses during the policy period. This had already been settled by the insurer in the first claim submitted by the insured. Though after a lapse of 289 days the insurer underwent surgery which could be reckoned as fresh illness. Yet, the aggregate benefit for major surgeries has to be limited to 70% of SI for the policy period. This limit had already been reached for the first surgery itself. Thus, the question of making payment for the second surgery during the same policy period is ruled out.

In view of the foregoing, it was held that the insurer rightly rejected the second claim of surgery benefit.

In the result, the complaint is dismissed.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11. 08. 101. 2010-11

Smt. Usha Ramgopal V/s Royal Sundaram Alliance Ins. Co. Ltd.

Award No:G-056/12.07.2010

Smt. Usha Ramgopal is covered under insurer's Health Shield policy for Rs.1,00,000 from 28.11.2006 and the policy has been continuously renewed without break. She underwent Quantum Magnetic Resonance Treatment for 21 days at SBF Health Care Private Ltd. from 14.10.09 to 3.11.09 for complaints of pain in both knees (Osteo arthritis) and made a claim the insurer. The hospital recorded in their noting that the complainant was suffering from knee pains for the past three years. The claim was rejected by the insurer on the ground of pre-existing disease. Aggrieved, she filed this complaint.

The complainant stated that before taking the treatment, she wrote to the insurer about the treatment she was proposing to undergo and asked the insurer to inform her if the cost was covered or not under the policy. The letter was acknowledged by the insurer but she did not receive any reply. Referring to the hospital noting, she said that the period of 3 years mentioned was approximate and disagreed that she had pain before taking the first policy.

The insurer repudiated the claim on the ground of pre-existing disease basing on the records of the hospital where the complainant took the treatment.

O R D E R

The only reason for rejection of the claim by the insurer is that the complainant took treatment for a pre-existing disease. The insurer's arrived at this finding that the complainant suffered from osteo arthritis even while the policy was obtained based on the hospital record which mentioned that the complainant had the problem for three years.

The complainant obtained the policy on 28-11-2006 and underwent medical treatment from 14-10-2009. This means that the complainant underwent treatment before completion of three years of obtaining the policy. The insurer inferred that since the hospital stated that the complainant suffered from the problem for 3 years, she had the problem even before she took the policy. The insurer also stated that the onset of osteo arthritis is gradual and pain increases over the years.

The insurer has no evidence other than the hospital record to show that the complainant had suffered from the problem before she took the policy. The record of the hospital does not establish that the complainant had the problem before 28-11-2006, the date on which she took the policy. Three years mentioned in the hospital record obviously did not mean 365 days. It was expressed in

complete years. It could have been 2 year 7 months or 3 years 4 months or variations thereof. To assume that the hospital expressed the period exactly would be unreasonable.

In view of the above, it was held that the insurer's incorrectly assumed that the complainant underwent treatment for a pre-existing disease.

Notwithstanding the erroneous reason mentioned by the insurer for rejection of the claim, it is noticed that the clinic where the complainant underwent treatment did not qualify to be hospital or a nursing home. Further, the complainant did not have to be hospitalized for 24 hours at a stretch. Instead, she required to stay in the clinic for 2 hours or thereabout everyday for 21 days. Therefore, the claim was rightly liable to be rejected on these grounds.

The question is whether the claim is payable by the insurer although the terms of the policy did not allow the claim. The complainant addressed a letter to the insurer seeking clarification if the policy covered the proposed treatment. There was no reply to this. In a sense, silence of the insurer conveyed acquiescence. Secondly, the insurer rejected the claim on the ground of pre-existing disease relying on a casual statement of the hospital. It was held that the insurer was not justified in its inference. Nevertheless, it would be unjust to grant full relief to the complainant because the insurer should have pressed other justifiable grounds for rejection of the claim.

In the circumstances, it was held that the insurer rejected the claim on an erroneous ground. Equally, it was held that the complainant is not entitled to full claim since there were other justifiable reasons for rejection of the claim, which the insurer failed to invoke. On balance, therefore, it was held that this is a case calling for grant of ex gratia. Accordingly, the insurer is directed to pay ex gratia of Rs.20,000 to the complainant.

In the result, the complaint is partly allowed as ex gratia.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.04.031.2010-11

Sri Dasari Ramesh V/s United India Insurance Co. Ltd.

Award No:G-064/23.07.2010

Sri Dasari Ramesh took Individual Health Insurance Policy with the insurer for SI of Rs.2,00,000/- for the period 29.12.2008 to 28.12.2009. He sustained fracture in right hand and was hospitalized at Priya Nursing Home, Nirmal from 19.02.2009 to 23.02.2009. He preferred a claim on the insurer for hospitalization expenses after 4 months. The Insurer rejected the claim

for delay and non-submission of relevant claim documents. Aggrieved, Sri Dasari Ramesh filed this complaint for redressal.

The complainant stated that he had submitted all the documents for reimbursement of hospitalization expenses and BM of BO Nirmal recommended for admission of the claim, as he happened to be a valued client, placing all their Bajaj Show Room business with them. He also stated that the queries raised by E-Meditek, their TPA, were replied by him. Yet the claim remained unsettled. The complainant stated that he did not receive a reply from the insurer.

The insurer stated that the complainant was covered under their Individual Health Insurance Policy and submitted re-imbursement claim bills after 4 months from the date of discharge from the hospital. The complainant also did not submit the Discharge Summary from the hospital. The complainant intimated the TPA vide his letter dt. 17.3.2009 that he had a fall in the bath room and sustained fracture in the right hand. But subsequently vide his letter dt. 29.6.2009, he confirmed that he had a fall from the motor cycle and fractured his right hand resulting. These statements contradicted each other. The complainant submitted medical expenses bill on the letter pad of the hospital which would in general circumstances be on Bill/Memo format duly substantiated by cash receipt. The Insurer also contended that the complainant failed to comply with Policy Conditions 5.3 & 5.4.

O R D E R

The complainant delayedly submitted the claim documents. He also did not submit the Discharge Summary. The complainant further stated that he had a Personal Accident Policy with the insurer and he preferred claim on the policy for weekly benefits. Then he was advised by the BM to submit the medical expenses bill to the TPA and he complied with this. The PA claim was settled by the insurer.

There was inordinate delay in making the claim. Further, the claim is not supported by proper documents.

In view of the above, it was held that the complainant did not comply with the policy conditions. Therefore, the insurer rightly rejected the claim.

In the result, the complaint is dismissed without any relief.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.02.157.2010-11

Sri A.A. Khader V/s The New India Assurance Co. Ltd.

Award No:G-069/2.08.2010

Sri A.A. Khader took the insurer's Janata Mediclaim Policy for his family for quite a long time and his daughter Ms. Husaima covered for a S.I. of Rs.50,000/-. He submitted a reimbursement claim of his daughter for hospitalization and treatment undergone for Obsessive Compulsive Disorder [OCD] at NIMHANS, Bangalore. The TPA rejected the claim stating that there was no active line of treatment quoting exclusion clause 4.10. On representation, they revised the repudiation clause and quoted 4.4.6 & 4.4.11 stating that psychiatric and psychosomatic disorders were not payable. Aggrieved, Sri A.A. Khader filed this complaint for redressal.

The complainant stated that his daughter admitted at NIMHANS, Bangalore for OCD mixed with poor insight and it was the first claim of his daughter. It was rejected by TPA quoting clause 4.10. On appeal, the TPA / Insurer revised the repudiation clauses 4.4.6 & 4.4.11. Representation was sent to NIA Baroda for re-consideration and also appeal made by NDDB employees Credit Co-op. Society Ltd., which manages the entire mediclaim, for admission of claim but it was rejected.

The insurer stated that on perusal of claim document submitted by the complainant, it was noted that his daughter was hospitalized for OCD, which fell under policy exclusion. On further scrutiny the tests done in the hospital were inconsistent with positive existence of any ailment, sickness or injury for which admission was required.

O R D E R

The complainant admitted that his daughter underwent treatment for OCD. His contention that OCD did not fall under Policy exclusion clause 4.4.6 has no basis. The policy excludes treatment of psychiatric and psychosomatic disorders. OCD is a disorder of this kind. Therefore, the insurer correctly applied the exclusion clause while denying the claim.

In view of the above, merit was found in the complaint.

In the result, the complaint is dismissed without any relief.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.02.135.2010-11

Sri A. Deepak V/s The New India Assurance Co. Ltd.

Award No:G-070/2.08.2010

Sri A. Deepak covered his family under insurer's Mediclaim policy and preferred a claim for hospitalization of his wife for abdominal pain and submitted bills for reimbursement. The claim was rejected by TPA stating that there was no active line of treatment and admission was only for evaluation. He represented to policy issuing office and also to the Grievance dept. and there was no revision in the decision of TPA. Aggrieved, Sri A. Deepak filed this complaint for redressal.

The complainant stated that his wife suffered with severe abdominal pain and on the advice of doctor she was admitted in a hospital in an ordinary ward. She was treated by the doctor by conducting various tests and she was on drips during her stay in the hospital. She was diagnosed to have been suffering from Liver Fatty changes and discharged from hospital on improvement.

The insurer stated that the insured person consulted her physician for abdominal pain and advised scanning. As per scan report, it was a case of 'Mild *Fatty Liver'.* For further evaluation of the problem, she was referred to St. Philomena's Hospital where she underwent various tests purely for evaluation. During the stay at hospital, she was given only oral medication as symptomatic treatment. The same could be done on OPD basis and hence the insurer repudiated the claim under policy exclusion clause 4.4.11.

O R D E R

The discharge summary clearly states that the hospitalization of the complainant was only for evaluation. During hospitalization, there was no specific course of treatment in the hospital. The noting in the discharge summary does not suggest any active line of treatment. The claim that the complainant took injections bought from outside is not supported by any evidence. The claim, therefore, fell under policy exclusions. Insurance is a contract, the terms and conditions of which bind both parties. Hence, it was held that the insurer correctly repudiated the claim. Consequently, merit was found in the complaint.

In the result, the complaint is dismissed without any relief.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.17.142.2010-11

Sri Gopinath R Agnihotri V/s Star Health & Allied Ins. Co. Ltd.

Award No:G-074/2.08.2010

Sri Gopinath R Agnihotri covered his family under the insurer's the Family Health Optima Insurance Renewal Policy for a Sum Insured of Rs.3,00,000/- for the period 13.12.2008 to 12.12.2009. He preferred a claim on the insurer, on the above policy, for his hospitalization at Bharathi Nursing Home for the period 28.12.2008 to 21.01.2009. He underwent surgery for Gastric Outlet Obstruction. On field visit report, pre-authorization was given by the insurer but later it was declined and the insured was asked to submit reimbursement bill. On submission of bills, the claim was repudiated attributing it to PED after seeking his previous hospitalization details. Representation to review the decision was also not considered. Aggrieved, the insured person filed this complaint for redressal.

The complainant stated that he was hospitalized for GI Dismotality and, underwent surgery. Pre-authorization given was cancelled and on submission of reimbursement claim, it was repudiated attributing his hospitalization and surgery to PED. The present operation was entirely for a different problem which was not a PED. The doctors, who performed surgery, stated that the syndrome for which he was operated was not a PED. The complainant stated that the repudiation was not just.

The insurer stated that prior to inception of their first policy during 2007, the insured underwent surgery for chronic pancreatitis and this was mentioned by him in the policy proposal. The complainant had undergone laparotomy, release of adhesions and anterior gastro jejunostomy, which is a consequence of previous surgery namely cholecysectomy and choledocho duodenostomy for chronic pancreatitis. The notable feature intra operatively was extensive bowel adhesions which were due to the previous surgeries. Refashioning of GJ was done under Epidural Anesthesia. Extensive interloop bowel adhesions were due to the previous surgery done during 2007. The claim of the complainant fell under Exclusion No.1 of the policy and it was rejected as PED.

O R D E R

It is noticed that the complainant is a k/c Chronic Pancreatitis and it is to be established by the insurer that present disease suffered by complainant leading to third surgery is a direct consequence of chronic pancreatitis. Relying on the clinical and surgical history of complainant, the insurer presumed it as "Sequlae of Chronic Pancreatitis?". The opinion of the team of doctors was that the problem could not be diagnosed in any of the clinical tests and that surgery was the

only remedy. This coupled with the affidavits of the doctors lends some weight to the complainant's claim. One of the insurer's representatives, a hospital administrator, is equally confident that the present medical problem had its roots in the previous surgeries.

The affidavits do not directly address the issue whether the present surgery was a complication of the erstwhile surgeries. They only state that the earlier surgeries have had no direct nexus with the present complication. Do the affidavits rule out an indirect nexus? Or do they imply that there was a possibility of indirect nexus? These questions cast some doubts on the claim of the complainant. Yet, the complainant's claim is not liable to be dismissed summarily because of what the doctors did not state.

The question is whether the claim is payable by the insurer. The insurer is within its rights in denying the claim owing to lack of clarity on the issue whether the present problem of the complainant was an off shoot of the earlier surgeries.

In the circumstances, since much can be said either way, it was held that this is a case calling for grant of ex gratia. Accordingly, the insurer is directed to pay ex gratia of Rs.1,20,000 to the complainant.

In the result, the complaint is allowed as ex gratia.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.08.166.2010-11

Sri M. Chandrakanta Rao V/s Royal Sundaram Alliance Ins. Co. Ltd.

Award No:G-075/2.08.2010

Sri M. Chandrakantha Rao proposed his wife Smt. Rekha Rao for the insurer's Health Shield Insurance Policy and the insurer issued their policy for SI of Rs.1,50,000/-. The insured person also enjoyed cumulative bonus of Rs.90,000/- under the policy. She was suffering from Osteo Arthritis of both the knees and she underwent QMR therapy treatment at M/s SBF Health Care Pvt. Ltd., Bangalore for a period of 21 days from 11.1.2010 to 31.1.2010. While the treatment was nearing the end, she suffered severe back pain. She was advised further 21 days of QMR therapy for spine and she underwent the therapy from 03.02.10 to 23.02.10. She preferred a claim on the insurer for both the treatments. The insurer rejected the claim stating that QMR therapy was taken as day care treatment and the policy does not cover it. The requirement of 24 hours

hospitalization was not excluded for QMR therapy under their policy. Appeal made to review the decision quoting the Ombudsman, Kolkata Award was not considered. Aggrieved, the proposer and the insured person filed this complaint for redressal.

The complainant stated that she underwent QMR therapy treatment for getting relief for both her knee joints and also for lower back pain in two rounds of 21 days of treatment. She stated that she was feeling better after the treatment. The complainant further stated that her lawful claim was rejected by the insurer in a casual manner without looking into the merits. They rejected it stating that it was a day care procedure, not covered under the policy, in spite of furnishing the ruling of Insurance Ombudsman, Kolkata.

The insurer stated that the complainant did not undergo QMR therapy as an in-patient and her period of stay in the centre was only 3 hours every day. The policy stipulated mandatory 24 hours hospitalization for claim admissibility. QMR therapy taken on OPD basis was not covered under the policy. They further stated that only five categories of OPD treatment were recognized under the policy to admit the claim for less than 24 hrs. hospitalization and QMR therapy was not one of them. They further stated that QMR therapy was not recognized by the Medical Council of India. The insurer thus justified denial of the claim.

O R D E R

The complainant did not have to be hospitalized for 24 hours at a stretch. Instead, she was required to stay in the clinic for two or three hours everyday for 21 days. A key condition of the policy is hospitalization as in-patient for a minimum period of 24 hours. Such time limit is inapplicable to treatment of cataract, tonsillectomy, eye surgery lithoscopy and D&C. (Clause C – Benefits of the policy). Insurance policy is a contract, the terms of which have to be construed strictly. The policy does not exclude QMR treatment from the requirement of hospitalization of 24 hours. The complainant's claim, therefore, is not covered under the policy. The other contentions of the complainant including reliance on the order of the Insurance Ombudsman, Kolkata are not relevant to this complaint.

In view of above, it was held that insurer rightly rejected the claim.

In the result, the complaint is dismissed without any relief.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.12.154.2010-11

Smt. R. Vijaya V/s ICICI Lombard Gen. Ins. Co. Ltd.

Award No:G-076/4.08.2010

Smt. Vijaya R took three mediclaim policies with three different insurers for various SI limits. She was covered under mediclaim policies for more than 3 years with M/s National Insurance Co. Ltd. and M/s Royal Sundaram Alliance Ins. Co. She was having a mediclaim policy with M/s ICICI Lombard Gen. Ins. Co. Ltd. for the past two years, i.e. the policy on which complainant preferred a claim was a first renewal. The complainant hospitalized for severe back pain and she underwent major surgery for L4-5 Canal Stenosis with Retrolisthesis. The hospital charged Rs.,2,65,821/-. Within 3 days of post operative period, she sustained severe back pain and on taking MRI it was diagnosed that there was migration of PLIF cage and again she was operated to remove implant and to reposition it. Second surgery costed her Rs.71,179/-. Total hospital expenses incurred by her amounted to Rs. 3,37,000/-. The National Insurance Co. provided Cash Less facility to the hospital and paid Rs.80,000/- as per their policy. The reimbursement claim was preferred on the second insurer, i.e. M/s Royal Sundaram and they took 2 ½ months for settlement of claim and paid an amount of Rs.1,20,000/- as per their policy. She submitted her claim for balance amount of Rs.1,37,000/- on the third insurer, after ascertaining the amount to be claimed on the third insurer. She stated the reasons for delayed submission of claim. The insurer sent SMS message stating that her claim was rejected without stating the reason for it. She made voluminous correspondence with the insurer asking for the reason(s) for non settlement or for settlement of the claim. The third insurer neither acknowledged nor sent any reply. Peeved and aggrieved by the deficiency in service, Smt. Vijaya R filed this complaint for redressal.

The complainant stated that she was a senior citizen and her genuine claim was rejected by the insurer. The first two insurance companies settled her claim, without any correspondence, on submission of claim papers. The third insurer did not bother to reply to her various registered letters seeking reasons for denial of her legitimate claim under the policy. They were silent after sending 'SMS' intimating rejection of claim without any reason.

The insurer stated that the complainant was hospitalized for Spondylopathies [Spinal disorders]. The claim was not tenable under the policy. Any claim for spinal disorders was not payable for the first two years of the policy as per exclusion No. 2.2, applicable to the Benefit 'A' of the policy. Accordingly, the claim of the complainant was repudiated and a letter was sent to her.

O R D E R

The policy provides for exclusion, for first two years of risk with the company, of a few specified diseases. The claim preferred by the complainant fell under exclusion of the policy. The complainant's representative claimed that the complainant underwent treatment for disc problems while exclusion was for spinal problems. Disc related problems are spinal problems. Thus, the insurer correctly applied exclusion to the claim. Insurance is a contract, the terms of which bind both parties equally.

In view of the above, it was held that the insurer correctly repudiated the claim and I find no merit in the complaint.

In the result, the complaint is dismissed without any relief.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.04.176.2010-11

Sri Jerome Noronha V/s United India Insurance Co. Ltd.

Award No:G-079/5.08.2010

Sri Jerome Noronha, Sr. Branch Manager of Canara Bank, covered his family under "CANMEDICLAIM" policy issued by the insurer for covering Canara Bank account holders under Group Mediclaim Policy. Sri Jerome Noronha's daughter was hospitalized from 22.4.2009 to 23.4.2009 and again from 15.6.2009 to 17.6.2009 for pain in the abdomen and she was diagnosed to be suffering from the complications of Ovarian Cyst. The TPA rejected the claim stating policy exclusion Nos. 4.1 & 4.10 of policy. On rejection of claims by TPA, Sri Jerome Noronha took up the matter with the insurer. The RO examined the case and informed Sri Jerome Noronha that they concurred with the decision of the TPA. Sri Jerome Noronha sent a legal notice to which the insurer replied adding other grounds of non-disclosure of material facts in the proposal form. Aggrieved, Sri Jerome Noronha filed this complaint.

The complainant stated that his daughter was admitted twice for abdominal pain and hospitalization bills were rejected by the TPA and the insurer. Because of the delay in communicating the decision by TPA, he stated that he lost the opportunity to claim the expenses from his Bank. He stated that his claim did not fall under policy exclusions 4.1 and 4.10. He further stated that his daughter underwent laparotomy 8 years back for

mucinous cyst adenoma and laparoscopic ovarian cystectomy 5 years back for the same disease only. The present ailment had no nexus with the previous surgeries. His daughter's earlier disease was treated and cured completely. He stated that he had submitted a certificate from the doctor who treated his daughter clarifying the objections raised by TPA doctor that it was not a pre-existing disease or a complication of previous problems. He further stated that doctor also clarified the necessity of in-patient treatment as also the line of treatment during the hospital stay. In spite of this, neither the TPA nor the insurer admitted the claim.

The insurer stated that there was no deficiency in service in resolving the complaint of the complainant either by their TPA or by them. Relying on the noting of discharge summary, the TPA rejected the claims as they were fell under exclusion clause No.s 4.1 & 4.10. The complainant covered his family under CANMEDICLAIM Group Policy and it was renewed from 4.3.2009 to 3.3.2010. While obtaining the first year policy, in the proposal form against Q. 15 [f] - asking for details of any suffering in the past for diseases of uterus, ovaries or breast or any specific gynecological disorders - the complainant replied "NO" for all the female members covered under the policy. The complainant mis-represented the facts inasmuch as the complainant's daughter suffered from problems of ovaries and she underwent surgeries twice in the past. The complainant first took the policy from 28.02.2008 and so if there was any hospitalization prior to 4 years from the date of the first year of the policy, i.e. in the present case from 28.02.2004 to 27.02.2008, for same illness or complications of it, it shall be treated as pre-existing. Discharge summary on 17.6.2009 specified that the complainant's daughter underwent laparoscopic cystectomy for ovarian cysts 5 years back. The present claim, therefore, related to a pre-existing disease. The insurer further contended that there was no active line of treatment during the stay at the hospital in both the hospitalizations and it again fell under policy exclusion 4.1. Hence, they stated that rejection of the claim was just. The insurer also stated that the claim form was submitted to the TPA by the complainant on 20.5.09, i.e. after a gap of 26 days from D.O.D. Thus, allegation of the complainant that he lost his opportunity to claim it from bank was baseless.

O R D E R

The complainant claimed two hospitalization claims on the second year policy with the insurer: the first, hospitalization for one day with claim bill of Rs.12,387/- and, the second, hospitalization for 2 days with claim bill of Rs. 13,256/-. On perusal of the bills and discharge summaries, it is noticed that investigations were carried out for evaluating the problem and the treatment was only symptomatic / conservative without any active line. The certificate dated 29.6.09 issued by Apollo Hospital doctor does not strengthen the case of the complainant on the line of treatment in the hospital. It states requirement of IPD to conduct investigations and laboratory tests.

The complainant's daughter underwent surgeries in relation to ovarian cysts in the past. The present hospitalization claims also related to ovarian cysts. There is adequate evidence to show that the present episodes of hospitalization were for evaluation. Further, they had nexus with the pre-existing problem even though the complainant furnished medical opinion to the contrary. Regardless of this, it has to be noted that the complainant did not reveal earlier surgeries while taking the policy. He, therefore, suppressed material information knowingly. This is fatal to the claims since insurance is a contract of good faith and the complainant transgressed this principle.

In the result, the complaint is dismissed without any relief.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11. 004. 060. 2010-11

Sri T. Namassivaya V/s United India Insurance Co. Ltd.

Award No:G-080/9.08.2010

Sri T. Namassivaya, an Andhra Bank account holder, took AB Arogyadan Health Insurance Policy during 2006 and subsequently renewed it till date. He preferred a claim for CAGB surgery on the policy. It was denied by the TPA stating it as PED. He represented to the insurer for reconsideration of the decision but the insurer upheld the decision of TPA. Aggrieved, Sri T. Namassivaya filed this complaint.

The complainant contended that he was covered under AB Arogyadan Policy from 9.8.2006 and it was renewed up to 10.9.2010. The contention of insurer that he obtained the policy during 2008 was incorrect. If it was not a renewal, he would not have been covered under the policy by the bank since the maximum age at entry was 65 years and he crossed 65 years

during 2008. He further stated that if he was suffering from chronic problem of heart disease, the cardiologist who checked up his ECG reports would not have allowed him for his overseas trip from 4.3.2009 to 15.03.2009. He further stated that if he really knew the risk factors, he would not have travelled four countries and he would have got operated soon after inception of the problem. He further added that if he had taken insurance knowing the risk factors, he would have gone for more value than Rs.50,000/- as it was known to everyone that cardiac surgeries cost more than Rs.50,000/-.

The insurer contended that the complainant took the first insurance policy of AB Arogyadan from 11.9.2008 to 10.9.2009 and preferred reimbursement claim for CABG for hospitalization from 6.5.2009 to 16.5.2009 on first year policy itself. The root cause for CABG was DM and HTN and these two cannot develop within months. The complainant was suffering from DM and HTN before taking the first policy, i.e. condition pre-existing and these two diseases led to CABG. The claim fell under policy exclusion of PED and hence rejected.

O R D E R

The documents submitted show that there was no continuity of insurance cover to the complainant. He was first covered from 9.8.2006 to 8.8.2007 and, therefore, he has been insured for less than three years as on the date of the present hospitalization. The complainant, therefore, cannot be covered for PED. The question is whether the problem for which he underwent surgery was PED. He underwent TMT which is proscribed for a known case of ICD. Obviously, he was not a known case of ICD when he took TMT. On this evidence, ICD has to be ruled out as PED in the case of the complainant.

Notwithstanding the above, the complainant was under medication for cholesterol. The complainant admitted that his cholesterol was under control. The complainant's problem with cholesterol was prior to obtaining the policy. CABG has had something to do with cholesterol problem.

In view of the above, it was held that the complainant's was a borderline case of PED. Yet, the evidence in support of the insurer's contention of PED is inconclusive. In the circumstances, it was held that this is a case to be considered for payment of a sum of Rs.10,000 (Rs. ten thousand only) as ex gratia.

In the result, the complainant is partly allowed, as exgratia.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11. 09. 197. 2010-11

Sri R. Saravanan V/s Tata AIG General Insurance Co. Ltd.

Award No:G-087/13.08.2010

Sri R. Saravanan took the insurer's Health Care+ Policy covering his mother, which provided daily cash benefit in case of hospitalization of the insured person either due to accident or due to sickness other than pre-existing diseases. The insured person, i.e. complainant's mother, met with road accident on 3.8.2009 and she was hospitalized from 3.8.2009 to 23.8.2009. Sri R. Saravanan preferred a claim for payment of hospitalization benefit @ Rs.10,000/- under the policy for 20 days. The insurer investigated the claim and basing on their investigator's report, repudiated the claim referring to policy proviso No.7 dealing with "Concealment or Fraud". The insurer stated that actual hospitalization was from 3.8.2009 to 20.8.2009 and the insured person for her own reasons postponed her discharge from the hospital, even after preparing the Discharge Summary dated 20.8.2009 of which investigator took a photo print. By postponing hospital stay for another 3 days from 20.8.2009 to 23.8.2009 and making a claim for entire period, the claim of complainant fell under their policy proviso 7 and hence they repudiated the claim. Aggrieved, Sri R. Saravanan filed the complaint for redressal.

O R D E R

Pursuant to the notice given by this office, both the parties attended hearing on 12.8.2010.

The complainant reiterated what had been stated by him in the complaint. The insurer stated that after further reviewing the claim, they offered to settle the claim for 17 days @ Rs.10,000/- as per policy. The complainant stated that as the case was pending before this forum, he had not given any consent for their offer. When asked if the offer was acceptable to him, he replied in the affirmative. Since both the parties to the dispute have resolved the complaint through consent, the insurer is directed to pay a sum of Rs.1,70,000/- to the complainant for 17 days stay in the hospital as per policy by the insurer.

In the result, the complaint is treated as allowed.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11. 02. 204. 2010-11

Sri A Venkateshwara Rao V/s The New India Assurance Co. Ltd.

Award No:G-089/13.08.2010

Sri A.Venkateswara Rao has mediclaim policy for himself and his family since 27-7-2004. The sum assured for himself and his wife was Rs.50,000 which was enhanced to Rs.1,00,000 while renewing the policy for the policy period 28-7-2006 to 27-7-2007. Sri A.Venkateswara Rao's wife underwent surgery for brain tumour in March 2010. The insurer settled the claim for expenses towards hospitalization at Rs.52500 (including CB of Rs.5000) ignoring the enhanced sum assured on the ground that it was a case of PED. Aggrieved, Sri A.Venkateswara Rao filed this complaint.

The complainant submitted that his claim was wrongly restricted inasmuch as brain tumour was detected after enhancement of sum assured to Rs. 1,00,000. He stated that the insurer assumed that brain tumour was PED whereas no such problem had manifested until April 2007 while the sum assured was enhanced on 28-7-2006 itself.

The insurer stated that the sum assured was enhanced with effect from 28-7-2007 while renewing the policy for the period from 28-7-07 to 27-7-08. Therefore, brain tumour detected in April 2006 constituted PED.

O R D E R

The complainant initially took a policy covering himself and his wife for Rs.50,000 each. He renewed the policy on 28-7-2006 for the policy period 28-7-2006 to 27-7-2007. The confusion has arisen because of the mistaken belief of the insurer that the complainant took the policy enhancing sum assured to Rs.1,00,000 on 28-7-2007. Brain tumour was detected for the first time only in April 2007, much after the sum assured was enhanced. Therefore, there is no merit at all in the contention that brain tumour constituted PED for the enhanced sum assured.

In view of the above, the insurer is directed to settle the claim on the sum assured of Rs. 1,00,000 together with CB, if any.

In the result, the complaint is allowed.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.17.165.2010-11

Sri G. Mohan V/s Star Health & Allied Insurance Co. Ltd.

Award No:G-097/14.09.2010

Sri G. Mohan took insurer's Family Health Optima Insurance Plan covering his family for SI limit of Rs.5.00 lakhs. He preferred a claim for hospitalization of his wife due to severe nose blocks for which she underwent surgery at Vikram ENT Hospital, Coimbatore. The hospital, being a non-net work hospital, cashless benefit was denied by the insurer and Sri G. Mohan preferred reimbursement claim for Rs.1,00,732/-. The insurer settled the claim for Rs.66,898/- imposing restrictions on Surgeon & Asst. Surgeon Fees, OT charges, Laser and DI Fibre charges. Sri G. Mohan made a representation for reviewing the claim and the insurer did not respond to it. Aggrieved by the silence of the insurer, Sri G. Mohan filed this complaint for redressal.

The complainant stated that he and his family were covered under Mediclaim policies for the past 15 years with different insurers under Group Mediclaim Policies of his employer and on leaving his employment during December 2008 he took medical insurance policy with M/s Star Health & Allied Insurance Co. for SI limit of Rs.5.00 lakhs, hoping they would provide prompt service. He stated that his wife suffered severe nose blocks which were preventing her from breathing normally. She visited Dr. P.G. Viswanathan, a well known ENT surgeon at Coimbatore, and on conducting investigations he diagnosed her problem as "DNS+ Hypertrophic Allergic Rhinitis+ AC Polyp" and recommended her to undergo surgery. She underwent surgery at Vikram Hospital, Coimbatore and on admission they sent pre-authorization request stating the estimated cost as Rs.1,07,000/-. It was denied by the Insurer as the hospital is not their net work hospital and informed him to prefer a reimbursement claim. On submission of claim, they called for the details of the previous insurance policies. He stated as he was covered under Group Mediclaim Policies of his employer, he did not have the policy copies and so he furnished the policy numbers to the insurer. The claim was settled by insurer after lot of persuasion for Rs.66898/- after deducting the claim on different heads. The limits imposed on the claim were not specified on the face of the policy and hence they were arbitrary in nature and resulted in unfair deduction. The complainant stated that he was entitled for total hospitalization claim submitted by him.

The insurer stated that the complainant preferred the claim for Nasal Obstruction – KTP Laser Septplasty + Turbinoplasty + ESS + AC Polypectomy L/Side under LA. They stated that three procedures had been done simultaneously. They further stated that the cost of usage of anesthetic, surgery theatre and surgeon fees were limited since all the three procedures were conducted simultaneously. The charges of the hospital were found to be disproportionate to the charges of premier establishments. The policy stipulated admission of hospitalization expenses which were reasonably and necessarily incurred and so their restriction was in accordance with the policy terms and conditions only.

O R D E R

The claim of complainant is supported with pre-authorization request sent to the insurer showing breakup of the details of estimated hospitalization expenses. The hospital billed the same amount in their final bill for the fees/charges stated by them. The complainant had paid the bill and submitted for reimbursement. The complainant probably had no say in the billing. The insurer was aware that there would be a claim. Thus, even though it was not a net work hospital, the insurer could have negotiated with the hospital. This was not done. Therefore, restriction of the claim is arbitrary. Nevertheless, the claim appears to be slightly excessive especially when three procedures were done simultaneously. On balance, it was considered this to be fit case for grant of ex gratia. Taking all facts into consideration, the insurer is directed to pay Rs.25,000/- (twenty-five thousand only) as an ex gratia to the complainant.

In the result, the complaint is allowed in part as ex gratia.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11.004.192.2010-11

Sri Rajendra Bhojraj Mangharam V/s United India Insurance Co. Ltd.

Award No:G-100/14.09.2010

Sri Rajendra BM was covered under insurer's medical insurance polices since 2005. He preferred a claim for bilateral inguinal hernia mesh repair [TEP] which he underwent on 23.10.2009 at Wockhardt Hospital, Bangalore for Rs.63,394/-. The insurer settled the claim for Rs.30,000/- invoking policy condition No.1.2 which restricted payment of hospitalization expenses at 15% of SI or subject to a maximum of Rs.30,000/. There was no reconsideration by

insurer on appeal made by Sri Rajendra. Aggrieved, Sri Rajendra B M filed this complaint for redressal.

The complainant submitted that he was not aware of modifications made in the policy coverage by the insurer. The restriction in all fairness should not apply to him as the change was not brought to his notice while renewing the policy. The insurer failed to intimate the changes in the policy coverage before accepting the renewal. He further stated that he paid the renewal premium in good faith on the understanding that the insurer would continue his medical policy on the same old terms and conditions only. The complainant further stated that the same clause was revised by the insurer to allow 25% of SI on the next renewal.

The insurer contended that their repudiation was justified as they had admitted the complainant's claim to the maximum permitted amount under the policy. Proviso 1.2 of the policy restricted coverage in respect of Hernia to 15% of SI or Maximum Rs.30,000/-. The TPA paid the amount to hospital under cashless facility. Hence, they could not admit the claim for the balance amount having already paid the full amount payable under the policy. The insurer further stated that the policy on which the complainant preferred the claim was not a first year policy with the revised terms and conditions and it was the second year policy. The contention of complainant that he was not informed of modifications was incorrect.

O R D E R

The insurer admitted the claim by applying restriction of 15% of SI as per proviso 1.2 of the policy to the complainant. Clause 1.2 [b] of the policy issued to the complainant clearly specifies the benefit as 15% of Sum Insured for Hernia subject to a maximum of Rs.30,000/-. This policy with such a restriction happened to the second policy issued to the complainant. The amount payable under the policy had already been settled by the insurer with the hospital. Thus, the question of making any payment for the balance hospitalization expenses of surgery during the same policy period did not arise.

In view of the foregoing, it was held that the insurer rightly rejected the claim of complainant.

In the result, the complaint is dismissed without any relief.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11. 08. 259. 2010-11

Sri Ajay Agarwal V/s Royal Sundaram Alliance Ins. Co. Ltd.

Award No:G-105/14.09.2010

Sri Ajay Agarwal took insurer's Health Shield Gold Insurance Policy covering his family comprising of his mother and his brother from 14.8.2007 and the policy was renewed without any break. His mother underwent surgery for Total Knee Replacement for the problem of "Bilateral Osteoarthritis of Both Knees". He preferred a claim for Rs.1,62,454/-. The claim was rejected by the insurer on the ground of pre-existing disease. Aggrieved, Sri Ajay Agarwal filed this complaint.

The complainant stated that his mother was keeping good health and she experienced problem in her legs only during April 2009 and she underwent surgery during September 2009. At the time of taking the policy, she was leading normal life. The problem surfaced for the first time during April 2009 only. The denial of claim by insurer on the ground of PED was unjustified.

The insurer repudiated the claim on the ground of pre-existing disease basing on the records of the hospital where the complainant's mother took the treatment. They further stated that "Osteoarthritis" was a degenerative wear and tear process occurring in joints that were impaired by age, vascular insufficiency or previous injury or disease. The insured person was operated to replace both the knees which clearly indicated that the position of the patient was last stage of degeneration of the ailment and therefore it was pre-existing in nature. The osteoarthritis leading ultimately to bilateral knee replacement takes a long time to develop and in this case the patient was suffering from ailment since the past 5 years as the same was apparent from the medical records. The insurer further quoted the decision of Mumbai Ombudsman in support of their rejection.

O R D E R

The only ground for rejection of the claim by the insurer is that the complainant took treatment for a pre-existing disease. The insurer arrived at this finding that the complainant suffered from osteoarthritis even before the policy was obtained based on the hospital record which mentioned that the complainant's mother had the problem for five years. The complainant obtained the policy on 14.8.2007 and underwent surgery on 21.9.2009. This means that the complainant underwent treatment before completion of three years of obtaining the policy. The

insurer inferred that since the hospital stated that the complainant suffered from the problem for 5 years, she had the problem even before she took the policy. The insurer also stated that the onset of osteo arthritis is gradual and pain increases over the years. The insurer, however, has no evidence other than the hospital record to show that the complainant had suffered from the problem before she took the policy. To assume that the hospital expressed the period exactly would be unreasonable.

The insurer rejected the claim on the ground of pre-existing disease relying on a medical record of the hospital. However, the treating doctor noted existence of her ailment for the past 9 months only. The insurer could not defend its contention with substantial evidence to show that the ailment was in existence prior to the commencement of policy.

In the circumstances, it was held that the insurer rejected the claim on an erroneous ground. Equally, it was held that the complainant is not entitled to full claim as the disease suffered by the insured person is degenerative in nature and its onset cannot be adjudged easily. It is probable that the complainant's mother had some symptoms of osteo arthritis which she had not recognized. The evidence in support or against the complaint is inconclusive. On balance, therefore, it was held that this is a case calling for grant of ex- gratia. Accordingly, the insurer is directed to pay ex gratia of Rs.1,00,000 to the complainant.

In the result, the complaint is partly allowed as ex gratia.

HYDERABAD OMBUDSMAN CENTRE

COMPLAINT No. I.O.(HYD) G -11. 02. 252. 2010-11

Sri Laxmi Prasad Mathur **V/s** New India Assurance Co. Ltd.

Award No:G-106/14.09.2010

Sri Laxmi Prasad Mathur took the insurer's Mediclaim policy covering his family for SI limit of Rs.1,50,000/- for the period 22.9.2009 to 21.9.2010 and opted for Zone III cover. He preferred two claims on the policy for gall bladder treatment he underwent as an in-patient at Asian Institute of Gastroenterology, Hyderabad. The TPA proportionately reduced the hospital expenses stating that he occupied a room which was other than his entitled category, referring to policy provisions under clauses 2.3, & 2.4. Sri Laxmi Prasad Mathur filed an appeal to the insurer but in vain. Aggrieved, Sri Mathur filed this complaint for redressal.

The complainant stated that he was continuously covered under the policy of the insurer for the past so many years. The deduction made by the insurer in proportion to entitled room rent for all expenses was unjustified. He further stated that there was no difference in the other charges whatever the room the patient opted to stay in the hospital. He stated that he was forced to opt for a higher category room as his entitled category rooms in the hospital were full. The complainant stated that the deduction made by the TPA in the hospital bill was not permissible under the policy.

The insurer contended that the TPA deducted the proportionate amount in the hospital bill claimed by the complainant invoking policy conditions 2.1, 2.3 & 2.4 for two claims at Rs.6074/- & Rs.8296/-. The complainant opted for a higher category room than his entitled category and so the deduction made by them was in tune with the policy terms and conditions issued to the complainant. The insurer, therefore, justified the restriction of the claim.

O R D E R

The insurer/ TPA reduced the complainant's claim proportionately claiming the same to be in accordance with the Note under clause 2 of the policy. The clause stipulates that if the insured person opts for a higher category room than his entitlement then the claim is subject to proportionate reduction. There is no dispute that the complainant occupied the room which he was not entitled to. Thus, the insurer was justified in restricting the room rent eligibility as the same is provided for in the policy. The question is whether the doctor's fee, costs of investigations and other expenses are liable to be reduced in proportion to the entitlement of room rent. The Note can be pressed into service if the charges are dependent upon the room rent. If, however, the charges are not dependent upon the category of the room occupied by the patient, the question of proportionate deduction does not arise. The insurer has not produced any evidence which showed that the charges varied with the room occupied. Following this, the premise on which the insurer/ TPA effected proportionate reduction in respect of charges is incorrect.

In view of the above, it was held that the deduction effected other than under room rent is arbitrary and unjustified. The insurer is directed to pay the deducted claim amount of both claims for Rs.12,220/- (Rs.14,370/- minus difference in Room Rent of Rs.750/- + Rs.1400/- which is to be deducted as per policy clause 2.1).

In the result, the complaint is allowed in part at Rs.12,220/-.

KOCHI

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-002-023/2010-11

Deepak N.Ruparel
Vs
The New India Assurance Co.Ltd.

AWARD DATED 04.06.2010

The complainant had taken mediclam policy in 2007 and since then renewing the same covering himself and his family members. During the currency of the policy renewed in March 2009, his mother was hospitalized for treatment of osteoarthritis of both knees. During hospitalization, she underwent cytotron therapy. The claim raised as to that was repudiated by the insurer on the ground that the said treatment was not recognized by the Indian Medical Council and cited exclusion clause 4.4.19 – experimental and unproven treatment. The complainant objected to this and argued that Indian Medical Council is not a body to recognize whether a treatment or a stream of treatment is eligible for admitting or denying a claim filed by any insured.

The insurer, in their self contained note, stated that cytotron therapy is an alternate treatment to knee replacement surgery and as per their panel doctor certificate, this treatment is yet to be recognized by the Indian Medical Council. So the claim is not covered by the policy.

During the course of personal hearing, the insurer was requested to produce material showing the Council's approved stream of medicines, but they didn't do so. The insurer has no case that the said treatment did not require hospitalization. So it is only to be presumed that hospitalisation was required for undergoing the said treatment. The certificate from the panel doctor of the insurer states that the Indian Medical Council is not the body to approve or disapprove methods of treatment and that, it does not deal with alternate systems of medicine including homeopathy, ayurveda, magneto therapy, etc. Cytotron therapy uses the principle of RFQMR to subject the affected area by magnetic waves causing healing. However, the certificate does not state that it is an unproven or experimental treatment. The exclusion clause as to unproven treatment is not clear. Therefore, it is only to be taken that the treatment does not fall under the exclusion clause quoted by the insurer. An award is, therefore, passed for Rs.70,000/- [the basic sum insured + cumulative bonus] as against the claimed amount of Rs.1,50,000/- together with interest @ 8% p.a. since the date of claim till payment.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-004-029/2010-11

Krishna Kumar M.Bhatia
Vs
United India Insurance Co.Ltd.

AWARD DATED 07.06.2010

The complainant, along with his family members, was covered by the Individual Health Insurance policy. During the currency of the policy, he was admitted in hospital, where he was diagnosed as having 'chronic lymphocytic leukemia'. The claim for Rs.62,747/- was repudiated by the insurer stating that pre-existing diseases are not covered by the policy.

During the personal hearing, the insurance company submitted that hospitalization was done for diagnosis and not for treatment. Since the disease was in '0' stage, no treatment was recommended. As per policy exclusion clauses, the charges incurred at hospital or nursing home primarily for diagnosis, X-ray or lab examinations or other diagnostic studies are not covered under the policy. If hospitalization was only for diagnostic purposes and no treatment was imparted during hospitalization, there will not be any coverage.

On verifying the treatment particulars, it was clear that hospitalization was only for evaluation and the expenses incurred were for hospitalization and not for any treatment. Though the repudiation was made as if it was a pre-existing disease, the insurance company in their self contained note, specifically contended that there was no treatment and it will not come under the purview of the policy. Since the claim will not be covered by the policy, the complainant is not entitled to the claim or any relief. Hence the complaint is **DISMISSED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-003-005/2010-11

D.K.George
Vs
National Insurance Co.Ltd.

AWARD DATED 09.06.2010

The complainant, a mediclaim policyholder, was admitted to the hospital for treatment. A claim for Rs.97,627.19 was repudiated by the insurer stating that present treatment was taken within 105 days of the earlier treatment for the same illness and the claim under the policy has already been exhausted.

The Point : Initial sum assured was Rs.50,000/-. Subsequently, the sum assured was enhanced to Rs.1,00,000/-. While the treatment was taken for the earlier illness, the sum assured was Rs.50,000/-. There was also a cumulative bonus of Rs.12,500/-. Hence during that period, there was a coverage of Rs.62,500/- The claim allowed for the earlier treatment was Rs.40,025/- and there was a balance coverage of Rs.22,475/-. Since the disease was contracted during the previous

period, the enhanced sum assured will not be available for the treatment of the same illness within 105 days. So the claim will sustain only under the previous policy. Hence the complainant is entitled to get the amount within the balance of Rs.22,475/-, subject to limitation/ceiling under each head of expense. An award is, therefore, passed directing the insurer to pay a sum of Rs.11,231/- together with interest @ 8% p.a. since the date of claim till payment and cost of Rs.1,000/-.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-005-094/2010-11

Hirji Pasvir Dand
Vs
Oriental Insurance Co.Ltd.

AWARD DATED 22.06.2010

The complainant, holder of individual medical policy, had taken treatment for duodenal ulcer. A claim for Rs.13,046/- was repudiated by the TPA on the ground that the alleged disease is excluded from domiciliary hospitalization.

The complainant was never admitted to the hospital. The claim raised is only a domiciliary hospitalization claim. As per policy condition, in order to amount to domiciliary hospitalization, the condition of the patient must be such that he cannot be removed to the hospital or nursing home or the patient could not be removed due to lack of accommodation in any hospital in that city, town or village. But the condition of the patient was not such as could not be removed to the hospital. He has no case that he was not admitted for want of facility in the hospital. Hence the claim will not come within the ambit of domiciliary hospitalization. Hence the repudiation made is correct. The complaint is, therefore, **DISMISSED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-005-079/2010-11

Alice Joy
Vs
The Oriental Insurance Co.Ltd.

AWARD DATED 22.06.2010

The complainant, holder of mediclaim policy, was admitted in hospital on complaint of osteoporosis with compression fracture. The claim for hospital expenses was repudiated stating that there was no active treatment during hospitalization.

On going through the bills, only Rs.29.91 alone was charge for medicines. Investigations like lab tests, X-ray & CT scan were conducted. On getting the report, she was discharged. The bills given during hospitalization were the medicines advised for use on discharge. Hence it is clear that there was no active treatment during hospitalization. The hospitalization was virtually for investigation. On completing the investigation, she was discharged. As per policy conditions, the expenses incurred at hospital or nursing home primarily for evaluation/diagnostic purpose which is not followed by active treatment for the ailment during hospitalized period are excluded. Hence this case will come in the sweep of exclusion clause under the policy. So the repudiation made is correct. The complaint is, therefore, **DISMISSED**.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No.IO/KCH/GI/11-005-052/2010-11

Smt.Kamarunissa Shaik
Vs
The Oriental Insurance Co.Ltd.

AWARD DATED 22.06.2010

The complainant, holder of Health Insurance policy, was hospitalized for treatment of left ovarian cyst with bulky uterus. During the hospitalization, ovarian cystectomy with hysterectomy was done. The claim for hospital expenses was repudiated on the ground that the expenses incurred during the first 30 days are excluded.

As per policy exclusion clause, the treatment of diseases contracted during the first 30 days of commencement of policy is excluded. The policy was incepted on 11.09.2009. The bill dated 11.09.2009 shows that various tests were conducted on that day itself. Hence it is clear that investigation had started on 11.09.2009. The discharge summary shows that she was admitted on 30.09.2009 and discharged on 06.10.2009. Hence the treatment was within one month and the exclusion clause is applicable. The repudiation made is correct. In the result, the complaint is **DISMISSED**.

MUMBAI

THE OFFICE OF THE INSURANCE OMBUDSMAN

(MAHARASHTRA & GOA)

MUMBAI

Complaint No. GI- 304 of 2009-2010

Award No. IO/MUM/A/ 05 /2010-2011

Complainant : Shri Alston Fernandes

V/s

Respondent: Iffco Tokio General Insurance Co. Ltd.

Shri Alston Fernandes approached this Forum with a complaint against Iffco Tokio General Insurance Company for improper claim processing and non-disbursal of claim amount for claims lodged under the Group Medishield Insurance Policy bearing no.52042588 of 2007-08 and 52078905 of 2008-09 amounting to Rs. 1.02 lakhs and Rs. 12,097/- respectively pertaining to his father's chemotherapy treatment and other medications suggested by the doctor from time to time.

The analysis of the case reveals that the dispute is essentially relating to coverage of expenses for cost of medications which was prescribed on a long-term basis. It appears that the Company raised a point that while the above medications were administered, bills for some of them were not supported by a prescription, while for some others, they were not in the name of the patient and major portion of the expenses exceeded the pre and post hospitalization limit.

It is established that the treatment of cancer and similar other critical ailments require continued medical treatment but Mediclaim Insurance Policy covers reimbursement of cost of hospitalization expenses reasonably and necessarily incurred with a certain limitation on the period of hospitalization viz. one month pre-hospitalisation period, the actual hospitalization period and a post hospitalization period of two months. Thus the entire treatment would be handled in three segments (a) pre-hospitalisation expenses (b) actual hospitalization period expenses and (c) post hospitalization period expenses.

In the above case it is observed from the details supplied by the Insurance Company that out of the 11 claims submitted by the Insured, they have settled 8 claims. In respect of the two disputed claims, it is noted that they have been rejected as major part of the expenses exceeded the pre and post hospitalization limit. It is observed from the statements provided that while the hospitalization was dated 20/2/2008, most of the bills submitted pertained to the year 2007. The bills which were of Jan and March and September, 2008 could not be paid as it was not in the patient's name. Since the nature of treatment would be continuous and long standing, the Insured cannot assume that the entire expenses even beyond the period as prescribed would be covered by the Policy.

The other issue of non settlement is fairly simple. If the medicine bills are not supported by proper prescriptions or are not duly substantiated, it would be difficult for the Insurance Company to consider and reimburse the same.

Based on information provided, the decision of the Insurance Company cannot be questioned.

Dated at Mumbai, this _16th day of April, 2010.

THE OFFICE OF THE INSURANCE OMBUDSMAN
(MAHARASHTRA & GOA)

MUMBAI

Complaint No. GI- 1027 of 2009-2010

Award No. IO/MUM/A/027 /2010-2011

Complainant : Shri Kishor Doshi
V/s
Respondent: The New India Assurance Co. Ltd.

Complainant, Shri Kishor Doshi approached this Forum with a complaint against The New India Assurance Company Limited in respect of partial settlement of his claim lodged under Mediclaim Policy No. 111900/34/09/11/2186 valid from 24/6/2009 to 23/6/2010. Records were perused and parties to the dispute were called for a personal hearing on 21st April, 2010.

Accordingly, the Company's TPA have informed this Forum vide fax message dated 26thApril, 2010, that they have approved the balance claim for Rs. 1,53,767/- and would be forwarding the payment details shortly to this Forum.

In view of the above, the complaint stands closed at this Forum.

Dated at Mumbai, this 26th day of April, 2010.

(S. Viswanathan)
Insurance Ombudsman

THE OFFICE OF THE INSURANCE OMBUDSMAN
(MAHARASHTRA & GOA)

MUMBAI

Complaint No. GI- 1111 of 2009-2010

Award No. IO/MUM/A/ 073 /2010-2011

Complainant : Shri Devdatt N. Redkar
V/s
Respondent: The Oriental Insurance Co. Limited

Complainant, Shri Devdatt N. Redkar along with his family members were covered under Mediclaim Policy bearing No. 111400/48/2009/310 valid from 5/6/2008 to 4/6/2009 issued by the Oriental Insurance Co. Ltd. Shri Redkar was covered for a sum insured of Rs. 1.25 lakhs. Shri Redkar underwent Enhanced External Counter Pulsation (EECP) procedure at IPC Heart Care Centre for his complaints of IHD. When Shri Redkar submitted the bills for reimbursement of medical expenses to the Insurance Company amounting to Rs. 1,10,515/-, the Company's TPA, rejected the claim on the ground that the treatment taken by the Insured was an unproven procedure. They invoked policy exclusion clause 4.13 to repudiate the claim.

Scrutiny of the papers reveal that the Complainant underwent a non-surgical nature of treatment as recommended by his doctor. The issue for consideration would be whether such a type of treatment would be admissible under the Policy.

From the Discharge Summary of IPC Heart Care Centre, it is noted that Shri Redkar was a k/c/o of IHD post PTCA done in Jan. 2006 with HTN and IDDM. Following complaints of heaviness in the chest on brisk walking, he underwent Coronary Angiography at Cumballa Hill Hospital on 18/3/2009 which revealed moderate stenosis for which he was recommended Enhanced External Counter Pulsation (EECP), a non-surgical mode of treatment by Dr. Pratiksha Debdas, M.D, at IPC Heart Care Centre. The treatment commenced from 20/4/2009 and concluded on 22/6/2009. Shri Redkar underwent 45 sittings of EECP treatment for an hour per day costing Rs. 1.35 lakhs but IPC offered the above treatment at a package rate of Rs. 1 lakh, and accordingly he applied for reimbursement of the same along with other expenses incurred by him for investigations and medications.

The claim was rejected by the TPA invoking clause 4.13 of the Policy. The Insurance Company have also simply reiterated the stand taken by their TPA and denied the entire claim without examining the case in its entirety. It is felt that the matter should have been examined at the Company level before the rejection letter was sent by the TPA to the Insured or atleast on

receipt of the representation from their Insured, because it is evident from discharge summary of the hospital that the said treatment was received by Shri Redkar in different sittings for an hour every day, which would mean it was an outpatient procedure. This is also corroborated from the information down loaded from the Center's Website wherein it is mentioned patients receive EECP treatment on an outpatient basis and the treatment does not involve hospitalization or recuperation. Thus, the claim would also attract policy condition 2.3 which states " Expenses on Hospitalisation are admissible only if hospitalization is for a minimum period of 24 hours." This treatment also does not fall under the waiver of 24 hours hospitalization clause as hospitalization itself is not warranted.

The supporting papers submitted by the Complainant have been examined by this Forum and it is observed that the said treatment is US-FDA approved in 1995 for treatment of Coronary Artery Disease and angina and in 2002, EECP was approved as a treatment for congensive heart failure also. However, from the papers submitted by the complainant there is no information about approval of the same by its Indian counterpart which would be significant for our consideration.

As an unproven treatment as also under policy condition 2.3 the claim is non-admissible. However, it is noted from the claim form (as per the schedule of expenses incurred by the claimant), apart from EECP treatment charges, the complainant had also incurred expenses for Angiography, 2D Echo etc.. The Insurance Company should therefore examine and reimburse such expenses that are admissible other than the EECP charges.

Dated at Mumbai, this 9th day of June, 2010.

9th day of August, 2010.

THE OFFICE OF THE INSURANCE OMBUDSMAN

(MAHARASHTRA & GOA)

MUMBAI

Complaint No. GI- 648 of 2009-2010

Award No. IO/MUM/A/168/2010-2011

Complainant : Shri Mohammed S. Siddiqui

V/s

Respondent: United India Insurance Co. Ltd.

Shri Mohammed S. Siddiqui along with his wife were covered under an Individual Mediclaim Policy bearing No. 020500/48/05/4320 valid from 17/10/2005 to 16/10/2006 for a sum insured of Rs. 2 lakhs each. Smt. Shajahanbanu was admitted to Guru Nanak

Hospital on 16/4/2006 for complaints of giddiness and chest pain under the care of Dr. Shimpi. She was treated and discharged on 17/4/2006.

A claim lodged by Shri Siddiqui for reimbursement of hospitalization expenses incurred by him amounting to Rs. 5,565 plus post hospitalization expenses was repudiated by the TPA/ Insurance Company on the ground that hospitalization was for less than 24 hours. Shri Siddiqui represented to the Insurance Company for reconsideration but not receiving any favourable reply approached this Forum for redressal of his grievance.

As regards the Insurance Company's contention that hospitalization was not necessary, the relevant records produced before this Forum would be vital for consideration. On examination of the first consultation paper, it is observed that Smt. Shahjahan Banu had complaints of chest pain, pain in left upper limb, uneasiness and restlessness. Dr. Shimpi notings were "Symptoms strongly suggestive of Angina" She was therefore, advised hospitalization at Gurunanak Hospital under the care of Dr. Shimpi in ICU. She was diagnosed as a " k/c/o HTN, Anginal Pain under observation." Under history it was recorded as chest discomfort/chestpain. Signs and symptoms were noted as giddiness and pain in left upper limb. . The treatment details reveal she was administered Injection NTG (Nitroglycerine) and Nitropatch (S0S). Injection Nitroglycerine is a drug that dilates blood vessels and is used to prevent and treat Angina. Angina occurs when the heart muscle is not getting adequate blood. The drug (Nitropatch) works by relaxing and widening blood vessels so that blood can flow more easily to the heart. (Information downloaded from the Internet)

The need for hospitalization is justified by the fact that she had symptoms of heart problem for which she was administered Inj. NTG and therefore, to brush aside the whole episode as frivolous is not correct. Further, the preamble of the Mediclaim Policy states that upon the advice of a duly qualified physician/medical specialist/medical practitioner, if expenses are incurred due to hospitalisation for medical/surgical treatment at any nursing home/hospital in India as an inpatient it would be payable. In the instant case there was an advice for hosptialisation by the consulting doctor. Therefore, the Insurance Company's stand that hospitalization was not necessary is not sustainable.

Coming to the issue of hospitalization less than 24 hours, it should be noted that the Insured was admitted on 16/4/2006 at 13:42 hours and hospital papers reveal that she responded to the conservative line of management and recovered from her illness as evident from the notings – "stable and asymptomatic with no chest pain" and hence discharged the following day at 10:41 hours. Had the intention of the Insured not been clear, she would have stayed back to comply with the basic criteria of 24 hours hospitalisation and then the Insurance Company would not have grudged the extra payment anyway.

It appears that proper application of mind was not done by the TPA as well as the Insurance Company to examine the claim. Considering all the aspects of the claim and without violating the spirit of the policy condition 2.3 (24 hours hospitalization) it would be reasonable to allow 85% of the admissible expenses incurred towards hospitalization. They are also directed to pay the post hospitalisation claim amounting to Rs. 2516.77 after proper scrutiny of the bills. In this regard they should call for the prescriptions/reports etc. from the Insured wherever applicable, and the complainant is also advised to co-operate with the Insurance Company in complying with the requirements as called for.

Dated at Mumbai, this 9th day of August, 2010.

THE OFFICE OF THE INSURANCE OMBUDSMAN

(MAHARASHTRA & GOA)

MUMBAI

Complaint No. GI- 196of 2010-2011

Award No. IO/MUM/A/ /2010-2011

Complainant : Shri Arvind M. Thar

V/s

Respondent: The New India Assurance Co. Limited

Shri Arvind M. Thar approached this Forum with a complaint against New India for partial settlement of his claim in respect of cataract surgery (Rt. Eye) undergone by him at Bombay City Eye Institute and Research Centre. In his letter dated 13/5/2010 he mentioned that while his claim for left eye cataract surgery done on 20/11/2009 was settled for the full admissible expenses, the second claim for cataract surgery done to the right eye at the same hospital was restricted by the Insurance Company to Rs. 24,000/-. Records were perused and parties to the dispute were called for a personal hearing on 19th July, 2010.

Recommendation: As the hospital was not in the list of hospitals which had agreed to the rates of the TPA, the Ombudsman directed the Company to settle both the claims in full within 3 days and inform the payment particulars to this Form.

Pursuant to the hearing, Complainant, Shri Thar vide email dated 30/7/2010 informed this Forum that he has received the settled and recommended amount from Mediassist in full.

The Insurance Company have also confirmed settlement of both the claims in full vide cheque nos. 748825 and 748826 dated 24th July, 2010 for Rs. 18716/- and Rs. 4773/- drawn on Axis Bank.

In view of the same, the complaint stands closed at this Forum.

Dated at Mumbai, this _____ day of August, 2010.

(S. Viswanathan)
Insurance Ombudsman

THE OFFICE OF THE INSURANCE OMBUDSMAN

(MAHARASHTRA & GOA)

MUMBAI

Complaint No. GI- 845 of 2009-2010

Award No. IO/MUM/A/ 204/2010-2011

Complainant : Shri Chaitanya Gujarathi

V/s

Respondent: The New India Assurance Co. Limited

Shri Chaitanya P. Gujarathi along with his wife and son were joint- policyholders of Mediclaim Insurance with The New India Assurance Co. Limited, since 6th January, 1992 for a sum insured of Rs. 1 lakh each. The Policy was renewed continuously without any interruption and at the time of renewal on 6/1/2009, the sum insured under the policy for his wife and son was enhanced by Rs. 4 lakhs. Reportedly there was no pre-insurance medical check up done and it also appears from the records submitted by the Company that they did not insist for submission of a fresh proposal form either. Immediately, after a couple of months i.e. on 24/3/2009, Smt. Beena C. Gujarathi, wife of the complainant was admitted to Sanjeevani Surgical & General Hospital for left breast lump. She underwent excision biopsy under G.A and discharged the following day. Thereafter, she was again hospitalized from 7/4/2009 to 13/4/2009 for Mastectomy.

Shri Gujarathi lodged a cashless claim for the expenses incurred by him for the both the hospitalizations. After thorough processing, the TPA/Company settled the claim for Rs. 1,50,000/- (original SI of Rs. 1 lakh plus 50% CB accrued thereon) as against his total claim of Rs. 2,40,469/- on the ground that the breast lump was a pre-existing ailment at the time when she opted to increase the SI from 1 lakh to Rs. 4 lakhs. The reimbursement claims lodged thereafter for chemotherapy treatment and radiation taken till Sept. 2009 also remained unsettled.

Aggrieved with the decision of the Company, Shri Gujarathi represented to the Company which was not considered and ultimately the complaint was referred to this Forum for intervention of the Insurance Ombudsman.

The analysis of the complaint reveals that Smt. Beena Gujarathi along with her son were covered under a Mediclaim Policy bearing No. 140100/34/08/11/00012816 issued by New India valid from 6/1/2009 to 5/1/2010 for a total sum insured of Rs. 5 lakhs each bifurcated as Rs. 1 lakh +50% CB & Rs. 4 lakhs with no CB). A cashless claim lodged for biopsy of left breast lump followed by surgery at Sanjeevani Surgical and General Hospsital was settled by the Company only for Rs.1.50 lakhs as against a claim of Rs.2.40 lakhs . This has become a subject of dispute and it is necessary to adjudicate, even though the Company has settled the claim.

The complainant's stand point was that the total SI under the policy was Rs. 5.50 at the time of his wife's hospitalisation and hence he was entitled to receive the full

amount of claim. Let us examine the medical papers of Smt. Gujarathi to see how far the Insurance Company was justified in their decision.

As per documents submitted to this Forum, Smt. Gujarathi first consulted her family physician, Dr. Anjana S. Shah on 19/3/2009 who advised for a Bilateral Mammography test to be done. The same was carried out on 20/3/2009 and the report revealed " ill defined irregular mass lesion noted in the upper outer quadrant of the left breast and a biopsy is recommended. She underwent biopsy on 23/3/2009 as recommended at Sanjeevani Hospital and as per the discharge card the diagnosis was mentioned as Left Breast Lump. In the column of brief history and examination it was mentioned Lump in left breast gradually increasing in size (since 3 months). No pain/discharge. The surgical pathological report for the biopsy done revealed signs of Infiltrating duct carcinoma Grade III. Hence she was posted for MRM (Modified Radical Mastectomy) on 7/4/2009. The Histopathology report of Tata Memorial Hospital dated 20/4/2009 confirmed Infiltrating duct Carcinoma, Grade III.

The Company restricted their liability upto Rs.1 lakh sum insured plus appropriate CB on the same, on the ground that Rs. 4 lakh increase to the existing sum insured by Shri Gujarathi would not be available for the present claim as the breast lump for which the Insured was admitted was pre-existing based on the hospital notings. This argument was based on the fact that the hospital papers recorded 'lump in left breast gradually increasing in size since 3 months.'

In fact from the underwriting point of view, all increases are fresh contracts to the extent of the increased amount and would be subject to the existing terms,conditions and exclusions of the policy and also would be liable to be examined thoroughly in the light of existing diseases.

The Insured took the increased SI coverage from 6/1/2009 and got admitted to the hospital on 23/3/2009 after consultation on 19/3/2009 which was even less than 3 months and coinciding with the history of lump noted in the hospital papers. Therefore, the chances of it being pre-existing prior to enhancement cannot be ruled out.

There is also another aspect of circumstantial evidence to this. The policy framers of Mediclaim policy, to keep pace with the increased cost of medical facility, had upgraded the maximum sum insured limit to Rs. 3 lakhs in 1996 and later on to Rs. 5

lakhs so that the policy holders could avail higher sum insured. The existing Insureds did take advantage of the new policy benefitsat that time which Smt. Gujarathi did not avail. She continued with the sum insured of Rs. 1 lakh and probably felt the need for an enhanced sum just before the hospitalization/ surgery was considered inevitable. It could also be a coincidence that Smt. Gujarathi did avail the same later but it would always appear to be a reasoned move as the surgery was done close on the heels of increase of sum insured.

The hospital notings are clear to suggest Grade III carcinoma and since it was a lump, which was external, some unusualness/discomfort and developments would have been certainly noticed by the Complainant.

In the light of above analysis, the claim of Shri Chaitanya Gujarathi for balance payment as per increased sum insured is not tenable. However, considering his long association with the Insurance Company and looking to the nature of ailment suffered by his wife, I take a compassionate view on the matter and award a lumpsum amount of Rs. 50,000/- as a special case on an ex-gratia basis.

Dated at Mumbai, this _30th day of August, 2010

THE OFFICE OF THE INSURANCE OMBUDSMAN
(MAHARASHTRA & GOA)

MUMBAI

Complaint No. GI- 1189 of 2009-2010

Award No. IO/MUM/A/209/2010-2011

Complainant : Shri Damien Marwein
V/s
Respondent: National Insurance Co. Ltd.

Shri Damien Marwein was covered under a Group Mediclaim Policy bearing No. 250800/46/08/8500000230 valid from 21/5/2008 to 20/5/2009 issued by National Insurance Company Limited covering various Consultants of 21st Century Healthcare Solutions. He had an insurance cover of Rs. 75,000/-

Shri Marwein was hospitalized for treatment of Right UV junction Calculus on 6th Oct. 2008 at Aastha Health Care where he underwent laproscopic surgery for the same and discharged the same day. He was again admitted on 9/10/2008 to 13/10/2008 for Urinary Tract Infection. He incurred a total expense of Rs. 46,065/- for which he lodged a claim with the Insurance

Company under cashless as well as reimbursement. The TPA of the Insurance Company on processing the claim found it inadmissible as per clause 4.3 of the Policy (waiting period of 2 years for the ailment). Shri Marwein represented to the Insurance Company's higher office through his employer emphasizing that the exclusion clause 4.3 referred to by the Insruance Company for rejecting his claim does not mention the ailment UTI and Calculus in policy terms and conditions issued to them. Hence the rejection of the claim was unfair and erroneous.

Scrutiny of the papers reveal that the claim has been repudiated by the Insurer as per the policy provision 4.3. Under the captioned Group Mediclaim Policy, Excl. 4.3 indicates, calculus disease along with some other disease as listed therein are not payable for first two years of the operation of the policy. In the instant case, Shri Merwein was covered for the first time under the policy valid from 21/5/2008 to 20/5/2009 and the hospitalization was on 6/10/2008 to 13/10/2008 i.e. during the currency of the first policy period. Therefore strictly as per the policy terms and conditions the claim was not payable.

It has to be noted that all general insurance medical policies are annual contracts renewable on mutual consent and the claims are governed by the terms and conditions of the policy of the year in which it is lodged. The renewed policy is a fresh contract and the Company can offer fresh terms and conditions but, it is utmost necessary for the Insurance Company to ensure that such terms and conditions are made known to their Insureds. In the instant case, the Insurance Company, vide their letter dated 1st December, 2009, addressed to their Insured, have admitted their mistake of having attached the old policy terms and conditions instead of the revised one.

Since the Insurance Company by their act of omission have placed the Insured in a situation wherein the Insured was led to nourish the hope of being eligible for the claims lodged by him, it is felt that an ex-gratia payment of 50% of the admissible expenses should be allowed to the complainant to meet the ends of justice.

Dated at Mumbai, this 31st day of August, 2010.

17th day of September, 2010

BEFORE THE INSURANCE OMBUDSMAN
(MAHARASHTRA & GOA)

MUMBAI

Complaint No. GI-218of 2010-2011

Award No. IO/MUM/A/ 248/2010-2011

Complainant : Shri Thomas J. Joseph

Respondent: The New India Assurance Company Ltd.

ShriThomas J. Joseph along with his wife were covered under Mediclaim Policy 142000/34/09/11/6080 issued by New India Assurance Co. Limited valid from 29/9/2009 to 28/9/2010.

Smt. Jessy Thomas, wife of the complainant was hospitalized for Laparoscopic Myomectomy at National Institute of Laser & Endoscopic Surgery (NILES) on 22/2/2010. When a claim was preferred by Shri Joseph, the TPA/Insurance Company rejected the claim invoking clause 4.3 of the mediclaim policy which is applicable to diseases contracted in the first-two years of the policy. Not satisfied with the decision of the Company, Shri Joesph represented to the Company and when the matter was not resolved, he approached the Office of the Ombudsman seeking intervention of the Ombudsman in the matter of settlement of his claim.

It is observed from the medical records submitted that Smt. Joseph had complaints of severe dysmenorrhea and Pelvic Sonography revealed anterior wall fibroid which necessitated Myomectomy to be done.

It is quite clear from the scope of the exclusion clause 4.3 that Myomectomy comes prominently as an exclusion for the first two years of the policy operation. As this was the second year of the policy operation, it directly fell under the clause 4.3 and therefore has been rightly rejected. The complainant's plea that she was not aware of the terms and conditions of the policy as it was not given to him would not hold good simply because, the Insured could have asked for the same when he noticed that it was not attached to the policy, moreover this claim being lodged in the second year, and the Insured renewing the contract with all terms intact, the charge would not be sustainable.

Dated at Mumbai, this 17th day of September, 2010.

Complaint No. GI-103 of 2010-2011
Award No. IO/MUM/A/250 /2010-2011-20.9.2010
Complainant: Shri. Phiroz M. Amaria
Respondent: The New India Assurance Co. Ltd.

Shri Phiroz Amaria was covered under Mediclaim Policy (2007) issued by The New India Assurance Co. Ltd. Shri. Amaria was diagnosed to have Right Eye Choroidal Neovascularisation and underwent the treatment of Intravitreal injection Lucentis at Shroff Eye Clinic on 7.1.2009, 11.2.2009 & 16.3.2009. When he lodged claim of Rs.1,22,004/- , M/s Medi Assist India Pvt. Ltd.., TPA of the Insurer rejected the claim stating that as : "…..It is an OPD treatment, that does not require hospitalization, hence this claim is not admissible as per Policy terms & condition under clause 1.0." Not convinced with this decision, when complainant represented to the Grievance Cell of the Insurance Company for re-consideration of his claim, he did not receive any reply. Being aggrieved Shri. Amaria approached this Forum. The parties to the dispute were called for personal hearing. Complainant conveyed his inability to attend the hearing and requested to take his written submission on record. He represented that this injection was administered in the operation theatre and the greatest degree of surgical care had to be ensured whilst administering the injection and post administration, the patient was kept under observation for a reasonable length of time. He further stated that advancement in medical science has rendered 24 hours hospitalization redundant for this treatment. He also mentioned

that the treatment of Age Related Macular Degeneration falls into the category of eye surgery and as per policy clause 3.4, eye surgery is listed for waiver of 24 hours' hospitalization. He stated that in the past Company had settled the claims of similar nature and felt that this time the claim was rejected based on their internal circular of February 2009 which is not applicable in his case, as his policy was incepted much prior to this date.

Observations :

Age related macular degeneration was treated earlier by a method called hot laser therapy or photocoagulation where a laser was used to seal the leaky vessels. However, this treatment carried the risk of damaging the surrounding healthy tissues too and hence was not recommended. Presently, there has been a breakthrough in the mode of treatment for the said disease. Photodynamic therapy and Anti VEGF (vascular endothelial growth factor) injections like Lucentis, Avestin and Macugen, which arrest the growth of leaky new blood vessels are being preferred by doctors. These drugs were approved by FDA in the year 2006. Treatment by anti VEGF injections involves new drugs like Lucentis, Macugen and Avestin injections to be injected into the eye. After the injection, the patient will remain in the doctor's office for a while and the eye will be monitored. This drug treatment can help slow down vision loss from AMD and in some cases improve sight.

This Forum received a number of complaints in non-settlement of claims for ARMD by way of such Anti VEGF injections. This Forum also observed that a majority of these cases were from New India Assurance Co. Although the Company/TPAs were settling the claims earlier, the Company issued a Circular dated 9th February, 2009, the basis of which is not clarified to the Forum, which interalia stated that treatments using Anti VEGF injections were OPD treatments, which did not require hospitalization and were hence beyond the scope of this policy.

During hearing of such cases, the complainants have submitted to the Forum certificates from leading Ophthalmologists mentioning the fact that this procedure is not a surgical intervention but it to be carried out in Operation theatre to maintain a sterile environment. It is pertinent to quote the Certificate issued by Dr.Lalit Verma, Hon.Gen.Secy, All India Ophthalmological Society, Senior consultant Indraprastha Apollo Hospital, New Delhi, Director of Vitreo-Retina & Laser, Centre for sight, New Delhi states as: *" I am to say that Intravitreal Injection of drugs like Avastin, Lucentis. Macugen or Steriods and other related drugs are done in the operation theatre. For administration of these injections, procedure needs to be carried out under aseptic conditions, which included the use of surgical hand dis-infection, sterile gloves, a sterile drape and a sterile eyelid speculum (or equivalent) and the availability of sterile paracentesis (if required). All this, you will understand/appreciate involves surgical procedure. It is not an OPD treatment as appears to have been interpreted for settling a Mediclaim. It is requested that you may kindly take suitable action at your end for settling the claims by treating such cases as that of surgical procedure and not OPD procedure."*

The Company also produced certificates from qualified Ophthalmologists and one such certificate issued by Dr. Nayana Potdar, Associate professor in the department of Ophthalmology – Lokmanya Tilak Municipal General Hospital – Sion states as:- *" This is to inform that injection Avestin is given intravitreal for Age related macular degeneration in operation theatre under aseptic precaution and this can be done as an OPD procedure without indoor admission."*

One of the Complainants brought to the notice of the forum that the Govt. of India has approved the import of RANIBIZUMAB (Lucentis injection) vide import permission letter

6932/06 dated 28.09.2006 by the Company called Novartis. It is observed that patients are being treated with injection Avestin or Lucentis or Macugen depending as the case may be and these injections are being purchased through the representatives of Novartis and the Company delivers the injection directly to the hospital on receipt of payment from the patients. The Complainants also informed the Forum that the company has a procedure to give one injection free for purchase of two injections. It is also found that the treatment involves administering 3 injections over a period of 3 to 6 months depending on the prognosis of the patient. It is also observed that injection Avestin is significantly lower in cost as compared to Lucentis and Magugen.

On an examination of all the facts/documents produced before the Forum by the Complainant and the Company, the Forum was of the view that:-

- The treatment undergone by the Complainant seems to be one of advancement of medical technology in as much as the injections which are administered have been permitted to be imported only from 2006.
- The information collected through websites indicates that this procedure is simple and is done in "Doctor's Office". The Doctor's Office in the opinion of the Forum cannot be the consulting room under the environment, which is existing in our country and it is therefore understood that the injections are administered in the operation theatre which has a sterile environment.
- The complainants have brought to the notice of the Forum that before the injection is administered the patient undergoes a pre-operative evaluation like blood test, FFA (Fundus Fluroscein Angiogram) etc to assess the fitness of the patient for administering the injection.
- The various certificates issued by the medical practitioners indicate that it is a day care procedure though in one of the complaints, the treating hospital viz. Aditya Jyot Eye Hospital Pvt.Ltd., has mentioned " intravitreal injections are always to be given in the operating theatre. According to the hospital protocol they are admitting the patient in the hospital for one day". This indicated that in some cases, patients are discharged on the same day and in some other case they stay in hospital for a day.
- This Forum was of the opinion that lot of new technologies are being introduced in treating diseases and the third party administrators who are expected to have expertise in the field of medicine are supposed to help the Insurer to keep abreast of changes, so that Insurers can bring about new products/modify existing products. It is a sad fact that the mediclaim policies are not updated to keep in pace with such changes.

The facts that have been brought to the notice of the Forum clearly indicated that this procedure is an advancement of medical technology where minimum of 24 hours of hospitalization is not required. Based on the available information, the Forum noteed that the treatment is a prolonged one wherein depending upon the prognosis the patient have to be administered more number of injections. Looking at the treatment undertaken by the complainant, the Forum found that the doctors have been administering Lucentis injections, which is costlier than Avestin and the criteria for choosing Lucentis over Avestin is not clear. Besides, the various certificates issued by the eye specialists indicated divided opinion amongst the doctors regarding the procedure being an inpatient or outpatient one.

It was held that it would be reasonable that the complainant bears a part of the expenses. Accordingly, taking a practical view of the facts of the case, which had been brought to the

notice of the Forum, the Forum arrived at the conclusion that the cost of the treatment is to be shared equally between the complainant and the Company.

5th day of October, 2010

THE OFFICE OF THE INSURANCE OMBUDSMAN

(MAHARASHTRA & GOA)

MUMBAI

Complaint No. GI 12 of 2010-2011

Award No. IO/MUM/A/ 275 /2010-2011

Complainant : Ms. Sonu Belani

V/s

Respondent: The New India Assurance Co. Limited

Ms. Sonu Belani had taken a Mediclaim Insurance cover of Rs. 2 lakhs from New India for the first time on 10/5/2007. The said policy was renewed for a further period of one year effective from 10/5/2008 to 9/5/2009 and a Policy bearing No. 110800/34/08/11/00002484 was issued to her. However, the said policy was cancelled immediately by the Insurance Company due to dishonour of the cheque by the drawee's bank for want of funds. Thereafter, Ms. Belani proposed for a fresh cover on 12/6/2008 by paying the premium in cash. The said policy was renewed for a further period of one year vide Policy bearing No. 110800/34/09/11/00003967 valid from 12/6/2009 to 11/6/2010.

Ms. Belani lodged a claim for Rs. 26,186/- under the renewed policy in respect of her hospitalisation from 2/9/2009 to 11/9/2009 at Dr. Desai's Sushrut Clinic for complaints of severe back ache. As per the hospital's discharge summary, she was diagnosed as Acute PID L5-S1. The TPA on processing the claim, found that the claim was inadmissible as per exclusion clause 4.3 of the Policy and conveyed their decision accordingly to the Insured vide their letter dated 15/3/2010.

The facts under this claim are fairly straight forward. As per details/documents submitted by the Insurance Company, the Insured/Complainant issued premium cheque bearing no. 990927 dated 7/5/2008 drawn on United Bank of India for renewal of her Mediclaim policy which was received by the Insurance Company on 7/5/2008. The same was accounted by the Company on 10/5/2008 and premium cheque was presented to the Company's banker i.e. Corporation Bank on the same day. Cheque was returned by the drawee's bank i.e. from United Bank of India on 16/5/2008 for want of funds and the dishonoured cheque with Banker's remarks was received by the Company on 20/5/2008. The policy was immediately cancelled ab-initio on 20/5/2008 vide endorsement no. 110800/34/08/11/84000030. The Insured was intimated about the cheque dishonour and cancellation of the policy through registered AD letter dated 20/5/2008. The insured proposed for fresh insurance only on 12/6/2008 resulting into a break in continuity of the policy by about 1 month.

It is observed from the medical papers that Smt. Belani was treated for Acute PID at Sushrut Clinic on 2/9/2009. The Insured's policy was in operation for two years and the claim has been preferred in the second year of the policy. Since PID was specifically excluded during the first two years of the policy operation, the claim was repudiated invoking the relevant clause which appears to be in order.

Dated at Mumbai, this 5th day of October, 2010.

8.10.2010 Mediclaim

Complaint No.GI-415 of 2009-2010
Award No.IO/MUM/A/287/2010-2011-8.10.2010
Complainant : Shri Sharadchandra N. Risbud
Respondent : National Insurance Co. Ltd.

Shri Sharadchandra Risbud was covered under Mediclaim Policy issued by National Insurance Co. Ltd. with exclusion "ACCIDENT IN SEPT 2003 INJURY TO RIGHT LEG STEEEL ROD IS FIXED IN LALWANI HOSP." Shri Risbud was hospitalized for Subtrochanteric Fracture Right Femur and underwent Interlocking IM nailing with bone grafting. When complainant lodged a claim under the Policy, Insurance Co. rejected the same under exclusion clause appearing on the policy. Not satisfied with the decision of the TPA, complainant represented to them by stating that – he underwent surgery in September 2003 which was honestly declared in the proposal form. In September 2005, implants fixed in the year 2003 were removed. In June, 2006, he had a fall in Madras and admitted in Sundaram Medical Foundation and the same was immediately informed to the Office of TPA, Madras. Complainant stated that the episode of fall in Madras was an accident and no way related to the history of past surgery of the year 2003. Insurance Company however maintained their stand. Being aggrieved complainant approached this Forum.

It was noted that the complainant had the history of accident in the years Septembers 2003 and underwent DHS fixation. It was noted that the discharge card had a mention of h/o fall. In the present case, since the complainant underwent entirely new episode of fall, it was held that the fracture resultant from the same cannot be solely termed as pre-existing or complication of earlier fracture.

It was also observed that the implants fixed in the earlier surgery were removed in the year 26.9.2005 i.e. four months prior to the current surgery. As per the information available on Internet, the removal of the dynamic hip screw is usually not adhered to due to the increased risk of re-fracture after implant removal. In the present case, the complainant underwent the fracture immediately four months after removal of DHS. On discharge, the complainant was advised medication of Tab. Osteophos 70 mg once a week for 6 weeks. Osteofos 70 (Generic Fosamax 70mg) once in a week is used to treat osteoporosis.

Thus considering the information downloaded from the internet site, removal of DHS and Osteoporosis are the risk factors to cause the fracture. However, in the hospital papers, the episode of accidental fall was clearly mentioned and there was no document on record to conclusively proof that complainant was suffering from Osteoporosis. Under the circumstances, benefit of doubt was awarded in favour of the complainant to the extent of 50% of the admissible expenses.

THE OFFICE OF THE INSURANCE OMBUDSMAN
(MAHARASHTRA & GOA)

MUMBAI

Complaint No. GI 888 of 2009-2010

Award No. IO/MUM/A/300/2010-2011

Complainant : Shri K.Nagraj Shetty
V/s
Respondent: The Oriental Insurance Co. Limited

Shri K. Nagraj Shetty along with his wife were insured under an Individual Mediclaim Policy with the Oriental Insurance Company valid from 5/12/2007 to 4/12/2008 for a sum insured of Rs. 4 lakhs each.

In the following year, Shri Shetty was hosptialised at Wockhardt Hospital from 14/8/2009 to 21/8/2009 for Acute MI (Anterior Wall) in a k/c/o HTN. The Insured's claim for reimbursement was repudiated by the TPA of the Insurer, M/s. Raksha TPA, as per exclusion clause 4.3.on the ground that medical papers of Wockhardt Hospital clearly reveal that the Insured was a known case of HTN and for reimbursement of expenses for treatment of HTN a waiting period of 2 years is applicable. Further, HTN being a known risk factor of heart related ailments, the present illness is a complication of pre-existing HTN and hence the claim was inadmissible. Not happy with the decision, Shri Shetty represented to the Company for review and not getting any favourable reply, he approached the Office of the Insurance Ombudsman for redressal of his grievance.

Analysis of the case reveals that Shri Nagraj Shetty was first covered under Mediclaim Policy from 10/12/2007 at the age of 59 yrs. As per the underwriting practice of the Company he was evaluated through medical/pathological tests for which M/s. Expert Medicolegal Consultancy was authorized by Oriental Insurance to send a suitable medical report. It is closely observed from Expert Medicolegal Consultancy's report that the conclusion drawn was Prostate Enlargement from USG Report and Old Fracture of Upper and of Right Tibia as per the X-ray of Both Knees which were suggested to be specifically excluded together with its consequences. However, it is observed that the Policy was issued without any exclusions to Shri Shetty reflecting the casual manner of policy underwriting.

The dispute is regarding pre-existence of HTN for which Shri Shetty was under medications as per the hospital records. It is necessary to examine how far the contention of the TPA and the Company would be valid to sustain their rejection.

Shri Shetty was admitted to Wockardt Hospital on 14th August, 2009 for chief complaints of sudden onset of chest pain, severe in intensity, radiating to left arm, scapula bilateral along with sweating and palpitations. The discharge summary of Wokhardt Hospital in respect of hospitalization for which the present claim was preferred mentioned the diagnosis as Acute MI (Ant. Wall) in a k/c/o HTN. Past History mentioned k/c/o HTN on medications. His BP was recorded as 140/104 mmHg. It was also mentioned that he had a history of Aspirin Intake + Losartan+Hydrochlormiazide and Atorvastatin. Coronary Angiography done revealed severe Left Anterior Descending Artery revealed Proximal LAD 80% Stenosis, Distal LAD 90% stenosis, Left circumflex artery OM2 showed 80% Ostial and 90% mid stenosis. The conclusion as per the CAG Report was Severe LAD and OM disease. In the column of Plan of action it was mentioned "relatives not willing for intervention". He was medically managed and discharged from the hospital on 21/8/2009.

The medical analysis of the case out of the hospital recordings would reveal that first of all the ECG indicates signs of Hyperacute, Anterior Wall Myocardial Infarction. The 2D Echo suggested he had a poor Left Ventricle Ejection Fraction which was mentioned as only 20% together with severe Hypokinesia. Discharge summary as well as Indoor case papers of the hospital clearly record that Insured was already on some medications for HTN. Further, CAG revealed Proximal LAD and Distal LAD Stenosis of 80% and 90% respectively which bore evidences to having stenosis of severe nature which would be of evolving and developing nature over a period. Long standing hypertension would evidently be a favourable factor to cause the same. It therefore, follows that there was sufficient documentary evidence to establish the pre-existence of the disease.

The complainant countered the rejection of the claim stating that he did not suffer from hypertension as substantiated by the pre-insurance health check up report. Further, the history in the hospital papers were wrongly entered. His treating doctor, Dr. D.K. Kumbla, vide certificates dated 17/12/2009 and 22/12/2009 certified that "Shri Shetty did not have any previous history of HTN/DM and that he was treated for Acute Myocardial Infarction and in his case, HTN was not the cause. Further, his previous medical history was Nil.

It is a known fact that the patient or his relative inform the past medical history of the patient to the attending doctor at the time of admission to the hospital for proper diagnosis and treatment of the illness. Such history given to the doctor is recorded in the hospital case papers. In the instant case, the case papers recorded Shri Shetty had a h/o HTN for which he was on medications. Apart from that it was also mentioned that he had h/o of aspirin intake and three other medicines were noted which are proven drugs for HTN and High Cholesterol. In the face of the above recordings in the discharge summary/ Indoor case papers of the hospital, it is difficult to accept the

certificate of the treating doctor which appears to have been issued based on the request made by the Insured consequent upon the rejection of the claim.

As regards, the complainant plea that his pre-insurance medical reports were all normal, it should be noted that if the Insured was under medications for some ailment, the test results would obviously show normal results for the same. Therefore, the defence taken by the complainant, that the reports were normal and therefore, he was eligible for the claim is not tenable.

Based on the documentary evidence, as examined above, the stand of the Insurer to reject the claim under exclusion clause 4.3 cannot be faulted.

Dated at Mumbai, this 14th day of October, 2010.

BEFORE THE INSURANCE OMBUDSMAN
(MAHARASHTRA & GOA)
MUMBAI

Complaint No. GI 442 of 2010-2011
Award No. IO/MUM/A/ 370 /2010-2011

Complainant: Shri khushroo Rusi Ghaswalla
V/s
Respondent: United India Insurance Company Limited.

Shri Khushroo Rusi Ghaswalla along with his family members were covered under an Individual Mediclaim Policy bearing No. 020901/48/09/97/000001742 valid from 10/11/2009 to 9/11/2010.

On 18/12/2009, the Complainant's daughter, Ms. Parinaz Ghaswalla was hospitalized at Mehta International Eye Institute, Mumbai for complaints of blurred vision, distortion while driving and problem with working on the computer since 3 months. She was diagnosed with Very High Myopia in both eyes for which she was advised Lasik Laser Vision Correction. A claim preferred for Rs. 45,000/- was repudiated by the Insurer on the ground that cosmetic/aesthetic of any description such as correction of eye sight was not admissible under the policy as per exclusion clause 4.3. The attending doctor, Dr. Cyres K. Mehta under whose care Ms. Parinaz Ghaswala was admitted certified that Ms. Ghaswala was suffering from High Myopia and the lasik surgery was done to save further loss to her eye sight and it was not at all a cosmetic or aesthetic surgery. He mentioned that the eye surgery was also not performed for the correction of eye sight but to get rid of her blurring and distortion of vision which was affecting her job performance.

It is recorded in the discharge card of the Hospital that Ms. Ghaswalla had blurred vision, distortion of vision at night while driving and also while working on the computer and she was a

case of very high Myopia, which is a severe visual disability. Her spectacle prescription for Distance Spherical was mentioned as minus 8 in the right eye and minus 10 in the left eye.

People who have minus number glasses more than 6 diopter in power are said to have high or pathologic myopia. The eyeball in such cases is enlarged leading to thinned out coats of the eyeball so the central area may be very weak (chorioretinal degeneration) leading to poor vision. The retina in these eyes is weak in the periphery also and usually has some degeneration, atrophic holes, or even retinal tears. These retinal holes or tears may sometimes lead to a serious condition of retinal detachment, leading to sudden loss of vision, and may require major surgery urgently to settle the retina.

It is clear from the medical records that in the instant case the surgery was necessitated to deal with optical ailment which was disabling the person. Hence for no reason it can be termed as treatment for cosmetic or aesthetic reason. The decision of the Insurance Company is intervened by the following order.

Dated at Mumbai, this _25th day of November, 2010.