DELHI

MEDICLAIM

Case No.GI/UII/427/10

In the matter of Shri Rajeev Saini

Vs

United India Ins. Co. Ltd.

AWARD DATED 11.7.2011 :NON SETTLEMENT OF MEDICLAIM

1. This is a complaint filed by Shri Rajeev Saini (herein after referred to as the complainant) against the decision of United India Ins. Co. Ltd. (herein after referred to as respondent Insurance Company) relating to non settlement of mediclaim.

2. Complainant stated that he has a Mediclaim policy no. 222700/48/09/41/0000218 with United India Ins. Co. Ltd. with effect from 11.04.2009 to 10.04.2010 with sum insured of Rs. 100000/-, his claim has been rejected by the Ins. Co. stating that he was suffering from P.E.D where as facts remains that he suffers from particular disease only from 29.06.2009. He further stated that his reports such as U.S.G, Lipid profile etc where normal at Ganga Ram Hospital. He was not suffering from any serious disease. He visited Ins. Office a number of times but his Grievance has not been settled so far. He also approached the GRO of the company but he did not receive any response. He has approached this forum for early settlement of claim. Wife of the complainant stated that her husband was hale and hearty before taking the policy. His illness of Cancer was deducted after taking the policy.

3. Representative of the company stated that claim is not payable and the company had repudiated the claim because complainant was suffering from Cancer and Cancer is a disease that takes considerable time to develop and it has been pleaded by him that complainant was suffering from P.E.D. The company had repudiated the claim rightly.

4. I have considered the submissions of the complainant as well as the representative of the company. I have also perused the letters dated 16.12.2009 and 06.02.2010. After due consideration of the matter, I hold that company was not justified in repudiating the claim due to P.E.D because Cancer was detected after taking the Ins. Policy. Company had not brought on record any evidence to effect that Cancer to the insured was detected prior to taking the policy and he was treated for the same. Therefore in my view the claim is payable. Accordingly an Award is passed with a direction to the insurance company to make the payment of admissible amount.

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/429/NIC/10

In the matter of Shri Vinay Kumar Bhargava

Vs

National Ins. Co. Ltd.

AWARD DATED 11.7.2011 : NON SETTLEMENT OF MEDICLAIM

1. This is a complaint filed by Shri Vinay Kumar Bhargava (herein after referred to as the complainant) against the decision of National Ins. Co. Ltd. (herein after referred to as respondent Insurance Company) relating to non settlement of mediclaim.

2. Complainant stated that he commuted daily from Kosi to Delhi by train to attend his office situated at Kalkaji, New Delhi, on 05.12.2008 at about 6:55 pm during his routine commutation he fell from the moving train at Okhla Railway station and got badly injured. He was taken to AIMS Trauma centre by the police with severe head injury and was got admitted at 7:57pm, he was discharged in the next morning because there was no bed available. Then he was taken to Jai Hospital and Research Centre, Agra for further treatment and remained admitted there for a period of 3 days, from 08.12.2008 to 10.12.2008. He further submitted that his employer mistakenly submitted all the relevant documents to National Ins. Co. Delhi office instead of submitting the same to Vipul Medcrop TPA Pvt. Limited. There after required documents were submitted to the TPA. The TPA raised several queries with respect to settlement of the claim. He was informed by the TPA that his claim filed had been forwarded to Ins. Co. for seeking decision on the admissibility of the claim. Personal Accidental claim was settled by the company. However Mediclaim was rejected on the ground that documents were submitted after stipulated date. He submitted that he was suffering due to injury and he submitted the claim to the TPA. He requested this forum but no report was given.
3. During the course of hearing representative of the company stated that claim is payable and he promised to settle the claim within a weak and also promised to submit the report to this forum but there was no action was taken.

4. I have considered the submissions of the complainant as well as of the representative of the company. The claim was not settled as promised by the representative of the company during the course of hearing. In my view claim is genuine because the documents were first submitted by the employer to the Ins. Co. which was required to be given to the TPA. The claim of the complainant is genuine and payable as a matter of fact Personal Accidental claim was already settled by the Ins. Company. **Accordingly an Award is passed with the direction to the Ins. Co. to make the payment of Rs. 67,282.**

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.

7. Copies of the Award to both the parties.

Case No.GI/441/ NIC/10

In the matter of Shri Roy Thomas

Vs

National Ins. Co. Ltd.

AWARD DATED 11.7.2011 : NON SETTLEMENT OF MEDICLAIM

1. This is a complaint filed by Shri Roy Thomas (herein after referred to as the complainant) against the decision of National Ins. Co. Ltd. (herein after referred to as respondent Insurance Company) for non settlement of Mediclaim.

2. Complainant stated that he is an employee of M/s. Outlook Publishing (India) Pvt. Ltd. and M/s. Outlook Publishing (India) Pvt. Ltd. have taken Group Mediclaim Insurance for its staff and their dependants from National Ins. Co. Ltd. during the insurance period from 23.03.2010 to 22.03.2011. The policy no. is 250500/46/09/8500000410. As an employee of M/s. Outlook Publishing (India) Pvt. Ltd. he has been hospitalized for 7 days from 11.07.2010 to 17.07.2010 for Ayurvedic treatment. Before taking the admission in hospital, he spoke to Medi Assist and which advised him to claim the bill. He submitted the bill along with discharge summery with all requisite documents but his claim has been denied, stating that claim is admissible. He had requested this forum to get his claim paid amount of Rs. 12,545. During the course of hearing also the complainant stated that claim is payable as a matter of fact he has taken Ayurvedic treatment and the same is not excluded in the policy. He pleaded that similar claim were allowed.

3. Representative of the company stated that claim is not payable as per 4.12 clause of the policy. He also referred to repudiation letter dated 07.08.2010 where in it has been mentioned that Ayurvedic treatment is not covered under policy.

4. I have considered the submissions of the complainant as well as the representative of the company. I have also perused the repudiation letter dated 07.08.2010. After due consideration of the matter, I hold that company was not justified in repudiating the claim because insured had not taken Ayurvedic treatment but in fact under same therapy. He had taken a course of treatment in hospital known as Arya Vaidya Sala Kottakkal Delhi and in my considered view claim is payable. Accordingly an Award is passed to direct the Ins. Co. to make the payment of Rs. 12,545.

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.**

Copies of the Award to both the parties.

Case No.GI/415/NIA/10

In the matter of Shri Sanjeev Sondhi

Vs

New India Assurance Co. Ltd.

AWARD DATED 11.7.2011 :NON SETTLEMENT OF MEDICLAIM

1. This is a complaint filed by Shri Sanjeev Sondhi (herein after referred to as the complainant) against the decision of New India Assurance Co. Ltd. (herein after referred to as respondent Insurance Company) relating to non settlement of mediclaim.

2. Complainant stated that his daughter met with an accident and got her knee injured. She was hospitalized on 01.04.2010 under intimation to TPA and operated on same day. TPA had issued preliminary approval for Rs, 15000/- only on next day when patient was to be discharged. TPA passed the claim for just Rs. 17334/- against total claim of Rs. 52149. He tried to convince the TPA that his policy is for Rs. 1 lacs plus 22000 as additional bonus for not claiming any medical expense in previous years, hence he should be paid full amount but ignored. He is a corporate company customer for the 10 years. Therefore the restriction of room rent is wrong. He submitted this forum that he be paid Rs. 34,815 that is a balance amount along with compensation of harassment. During the course of hearing also, he requested that company was not justified to make the deduction while settling the claim. During the course of hearing he also had furnished the details of expenses which are reimbursable to him with reference to admissible room rent, according to which a sum of Rs. 38,658 is payable to him by the Ins. Co.

3. I have considered the submissions of the complainant as well as of the representative of the company. I have also perused the reply dated. 11.07.2011 submitted by the company. After due consideration of the matter, I hold that insured is entitled to total claim of Rs. 38,658 as against his claim of Rs. 52,149. The complainant had already been paid a sum of Rs. 17,334. Thus he is further entitled to a sum of (Rs. 38658-17334=21324) amount is payable. **Accordingly an Award is passed with a direction to the Ins. Co. to make the payment of Rs. 21,324.**

4. 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.

5. Copies of the Award to both the parties.

Case No.GI/319/UII/10

In the matter of Smt. Gulab Baid

Vs

United India Ins. Co. Ltd.

AWARD DATED 28.7.2011 :INADEQUATE SETTLEMENT OF MEDICLAIM

1. This is a complaint filed by Smt. Gulab Baid (herein after referred to as the complainant) against the decision of United India Ins. Co. Ltd. (herein after referred to as respondent Insurance Company) relating to inadequate settlement of Mediclaim.

2. Complainant stated that as against the total claim of Rs. 46951, the company had paid only sum of Rs. 32501. The company had not paid the balance amount of Rs. 14,450.It has been stated by the company that only room rent was in excess so the complainant agreed for the deduction of Rs. 2000 on account of room rent and requested this forum to get the balance amount (12450) paid.

3. I have considered the submissions of the complainant as well as the representative of the company. After due consideration of the matter, I hold that the claim has not been settled as per the terms and conditions of the policy. Complainant is not entitled to room rent of Rs. 2000. She is also not entitled to registration charges of Rs. 100. As per policy term and condition she is entitled to only 80% of the payable amount. She has claimed in her case the payable amount is worked at Rs. 35, 881 (46951-2000 room rent-100 registration charges = 44851, 80% = 35881). She had already been paid a sum of Rs. 32501, thus she is further entitled to a sum of (Rs. 35881-32501=3380 balance amount). Accordingly an Award is passed with the direction to the Ins. Co. to make the payment of Rs. 3380.

4. **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.**

5. Copies of the Award to both the parties.

Case No.GI/405/RGI/10

In the matter of Smt. Janki Devi Bisht

Vs

Reliance Gen. Ins. Co. Ltd.

AWARD DATED 27.7.2011 : PARTIAL SETTLEMENT OF MEDICLAIM

6. This is a complaint filed by Smt. Janki Devi Bisht (herein after referred to as the complainant) against the decision of Reliance Gen. Ins. Co. Ltd. (herein after referred to as respondent Insurance Company) relating to partial settlement of mediclaim.

7. Complainant stated that as per advice of this forum she approached the GRO of the company but she did not receive any reply. She has submitted all requisite documents to the company for settlement of the claim but the company did not settle the claim so far. She has approached this forum for early settlement of the claim. During the course of hearing she stated that company was not justified to retain the balance amount. She requested that Ins. Co. be direct to pay the balance amount to Rs. 10,305/-.

8. Representative of the company stated that she has not submitted the requisite documents in support of claim of Rs. 10, 305. The company also filed the written reply dated 03.06.2011 where in it has been stated that complainant purchased a Reliance Gen. Ins. Policy bearing no. 1302/282510179077 for the period of 27.04.2009 to 26.04.2010, claim of Rs. 25,239/- was filed and a sum of Rs. 14,934 was paid vide cheque no. 126718 dated 21.12.2009 and a sum of Rs. 10, 305 was not paid as complainant had not given test report and other details for settling the balance claim.

9. I have considered the submissions of the complainant as well as of the representative of the company. I have also perused the letter dated 22.12.2009 of team Medi Assist and also company's written reply dated 03.06.2011. After due consideration of the matter, I hold that company was not justified in not properly settling the claim. It had paid only sum of Rs. 14,934 out of total claim amount of Rs. 25,239, the complainant had submitted all requisite documents to be enable the company to settle the claim. I have also perused the claim and I found that complainant is further entitled to a sum of Rs. 9960/- and the remaining amount is not payable. Accordingly an Award is passed with the direction to the Ins. Co. to make the payment of Rs. 9960/- to the complainant along with the penal interest @ 8% from 21.12.2009 to the date of actual payment.

10. **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.**

11. Copies of the Award to both the parties.

Case No.GI/414/ NIC/10

In the matter of Shri Abhay Kumar

Vs

National Ins. Co. Ltd.

AWARD DATED 28.7.2011 :NON SETTLEMENT OF MEDICLAIM

1. This is a complaint filed by Shri Abhay Kumar (herein after referred to as the complainant) against the decision of National Ins. Co. Ltd. (herein after referred to as respondent Insurance Company) for non settlement of Mediclaim.

2. Complainant stated that his father traveled to Canada in month of July and August 2009, he is a policy holder of Policy no. 2009/170400/48/03/000009 for the policy period 01.07.2009 to 13.09.2009. He was admitted in the hospital and was diagnosed for hyponatraemia. The claim was lodged but the claim was not settled by the Ins. Company, matter was taken up to the higher authorities. The claim was denied subsequently vide letter dated 10.09.2009. He submitted that the claim is payable and reasons given for repudiation of the claim are not justified because patient was not having any symptoms relating to disease for which was treated prior to policy. The symptoms of the disease

(hyponatraemia) appeared nearly after 1 month and 3 weeks from the inception of the policy and were acute in nature, so the disease cannot be considered as a pre-existing condition.

3. Representative of the company stated that claim is not payable because the patient suffered from pre-existing disease.

4. I have considered all the submissions of the complainant as well as the representative of the company. After due consideration of the mater, I hold that company was not justified in not settling the claim because patient did not suffer from pre-existing disease. The disease for which the patient was treated while in Canada appeared after taking the policy. I have also perused the repudiation letter dated 01.10.2010. Thus the claim cannot denied on the ground that he was suffering from pre-existing disease. The claim is payable. Accordingly an Award is passed with the direction to the Ins. Co. to make payment of equalent of (4655-100) 4555 Canadian dollars.

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/404/RGI/10

In the matter of Shri Ashok Gupta

Vs

Reliance Gen. Ins. Co. Ltd.

AWARD DATED 28.7.2011 : NON SETTLEMENT OF MEDICLAIM

12. This is a complaint filed by Shri Ashok Gupta (herein after referred to as the complainant) against the decision of Reliance Gen. Ins. Co. Ltd. (herein after referred to as respondent Insurance Company) relating to non settlement of mediclaim.

13. Complainant stated that as desired by this forum he had approached the Grievance Redressal Cell of the company for Redressal of Grievance but he did not receive any response. He had submitted all requisite documents to settle the claim but so far the Mediclaim has not been settled. He has approached this forum for early settlement of the claim. During the course of hearing also the complainant stated that all requisite documents were submitted to medi assist such documents were sent through courier but the claim has not been decided so far.

14. Representative of the company stated that certain documents were not submitted till now. The claim will be processed after all requisite documents are filed. Written reply dated 03.06.2011 of the company was also filed, where in it has been stated that complainant had taken Reliance Health Wise Gold Policy from 10.03.2010 to 11.03.2010, covering

insured himself and his daughters. On 13.11.2009 he was admitted in "Metro Hospital & Cancer Institute" and discharged on 17.11.2009 and submitted claim for Rs. 23,287 Company submitted that insured had not given requisite documents to settle the claim.

15. I have considered all the submissions of the complainant as well as the representative of the company. I have also perused the written reply of the company. After due consideration of the matter, I hold that company was not justified in not settling the claim of the insured despite the fact that he had submitted all requisite documents to the insurer for doing the needful. Claim is payable. Accordingly an Award is passed with a direction to the Ins. Co. to make the payment of Rs. 23, 287.

16. **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.**

17. Copies of the Award to both the parties.

Case No.GI/412/ NIC/10

In the matter of Shri Rakesh Kumar Singhal

Vs

National Ins. Co. Ltd.

AWARD DATED 28.7.2011 : NON SETTLEMENT OF MEDICLAIM

5. This is a complaint filed by Shri Rakesh Kumar Singhal (herein after referred to as the complainant) against the decision of National Ins. Co. Ltd. (herein after referred to as respondent Insurance Company) for non settlement of Mediclaim.

6. Complainant stated that he had taken a Mediclaim policy bearing no. 360900/48/09/8500000236 for the period 25.05.2009 to 24.05.2010 for himself his wife and his son. This is 5th year of the policy with effect from 25.05.22005 with 20% cumulative bonus. He filed the claim for Rs. 43,156/- on account of re-imbursement for the treatment of his wife. He followed up the claim with Alankit Health Care Ltd. his claim has been repudiated vide letter dated 25.01.2010 stating that treatment was taken at the Navjeevan Hospital which is outside the approved list of Delhi Hospitals. He approached this forum for settlement of his Mediclaim.

7. Ins. Company was not represented at the time of hearing. However, I considered the submissions of the complainant. I have also perused the repudiation letter dated 25.01.2010. After due consideration of the matter, I hold that the company was not justified in repudiation the claim only because the treatment was taken in the hospital

which is outside the approved list of hospitals in Delhi. Admissible claim cannot be declined mainly on technical ground. The company ought to have decided the claim on merits. Claim is payable. Accordingly an Award is passed with the direction to the Ins. Co. to make the payment of Rs. 43, 156.

8. **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.**

9. Copies of the Award to both the parties.

Case No.GI/414/ NIC/10

In the matter of Shri Abhay Kumar

Vs

National Ins. Co. Ltd.

AWARD DATED 28.7.2011 :NON SETTLEMENT OF MEDICLAIM

1. This is a complaint filed by Shri Abhay Kumar (herein after referred to as the complainant) against the decision of National Ins. Co. Ltd. (herein after referred to as respondent Insurance Company) for non settlement of Mediclaim.

2. Complainant stated that his father traveled to Canada in month of July and August 2009, he is a policy holder of Policy no. 2009/170400/48/03/000009 for the policy period 01.07.2009 to 13.09.2009. He was admitted in the hospital and was diagnosed for hyponatraemia. The claim was lodged but the claim was not settled by the Ins. Company, matter was taken up to the higher authorities. The claim was denied subsequently vide letter dated 10.09.2009. He submitted that the claim is payable and reasons given for repudiation of the claim are not justified because patient was not having any symptoms relating to disease for which was treated prior to policy. The symptoms of the disease (hyponatraemia) appeared nearly after 1 month and 3 weeks from the inception of the policy and were acute in nature, so the disease cannot be considered as a pre-existing condition.

3. Representative of the company stated that claim is not payable because the patient suffered from pre-existing disease.

4. I have considered all the submissions of the complainant as well as the representative of the company. After due consideration of the mater, I hold that company was not justified in not settling the claim because patient did not suffer from pre-existing disease. The disease for which the patient was treated while in Canada appeared after taking the

policy. I have also perused the repudiation letter dated 01.10.2010. Thus the claim cannot denied on the ground that he was suffering from pre-existing disease. The claim is payable. Accordingly an Award is passed with the direction to the Ins. Co. to make payment of equalent of (4655-100) 4555 Canadian dollars.

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/339/RGI/10

In the matter of Shri Sudhir Kumar

Vs

Reliance Gen. Ins. Co. Ltd.

AWARD DATED 29.7.2011 : NON SETTLEMENT OF MEDICLAIM

1. This is a complaint filed by Shri Sudhir Kumar (herein after referred to as the complainant) against the decision of Reliance Gen. Ins. Co. Ltd. (herein after referred to as respondent Insurance Company) relating to non settlement of mediclaim.

2. Complainant stated that he had taken Health Ins. Policy from Reliance Gen. Ins. Co. Ltd. bearing no. 282520123424 with effect from the 09.07.2007 to 08.07.2009 he had a severe Heart Attack on 14.11.2008 and took the treatment for this at M/s Fortis Escorts Hospital, Amritsar from 14.11.2008 to 17.11.2008 there after he came to Delhi and had to undergo Angioplasty (Primary PTCA) from Escorts Hospital, New Delhi. He was admitted to the hospital from 19.11.2008 to 23.112008. He submitted that he filed all requisite documents with Ins. Co. for settlement of the claim on 12.12.2008 & 29.12.2008. He had made a number of visits to the Ins. Co. but his claim was not passed. He requested this forum to get the claim paid at an early date.

3. Representative of the company assured to settle the claim and submit report within 10 days but so far the claim has not been settled written reply dated 09.05.2011 was also filed where in it has been stated that as per the nature of ailment which cannot arise in the matter of days, the complainant had also not disclosed the material facts in the proposal forms and did not provide documents in support of past history. The claim is not payable as per policy exclusion no. 1 and terms and condition number 2.

4. I have considered the submissions of the complainant as well as of the representative of the company. I have also perused the written reply of the company dated 09.05.2011.
After due consideration of the matter, I hold that company was not justified in holding that claim is not payable. In my considered view claim is payable in terms and conditions

of the policy. Accordingly an Award is passed with a direction to the Ins. Co. to make the payment of Rs. 48195.

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.**

8. Copies of the Award to both the parties.

Case No.GI/402/UII/10

In the matter of Shri Bheekha Ram Prajapati

Vs

United India Ins. Co. Ltd.

AWARD DATED 1.8.2011 NON SETTLEMENT OF MEDICLAIM

1. This is a complaint filed by Shri Bheekha Ram Prajapati (herein after referred to as the complainant) against the decision of United India Ins. Co. Ltd. (herein after referred to as respondent Insurance Company) relating to non settlement of medi claim.
2. Complainant stated that he had taken Mediclaim policy for himself and his family from United India Ins. Co. Ltd. The policy no. is 141104/48/09/06/00000079. He further submitted that his wife was admitted in hospital from 29.07.2009 to 31.07.2009 for treatment. After treatment, papers were submitted. There after she was again admitted in the hospital on 13.10.2009 to 16.10.2009 in Palanpur hospital. He had submitted the documents relating to both the treatments to the Ins. Company. He had not received any information from the company so far though he had contacted personally as well as on phone. Thus the claims were repudiated. No specific reasons were stated by the company. He had also approached the Grievance Cell of the company but he had not received any response. Ultimately he had come to this forum for resolution of his complaint. He did not attend the hearing at Jaipur though he was duly informed.
3. Representative of the company stated that claim is not payable. He also referred to the repudiation letter of Meditake solutions Ltd. wherein it has been stated that claim is not payable in view of clause 4.8 of the policy.

4. I have considered the submissions of the complainant as well as of the representative of the company. After due consideration of the matter, I hold that company was not justified in repudiating the claim because claims are payable. Exclusion clause 4.8 of the policy is not applicable in the facts of insured case. **Accordingly an Award is passed with the direction to the Ins. Co. to make the payment of Rs. 11759.**

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/503/OIC/10

In the matter of Shri S.L. Bairwa
Vs Oriental Ins. Co. Ltd.

AWARD DATED 3.8.2011 : NON SETTLEMENT OF MEDICLAIM

1. This is a complaint filed by Shri S.L. Bairwa (herein after referred to as the complainant) against the decision of Oriental Ins. Co. Ltd. (herein after referred to as respondent Insurance Company) relating to non settlement of mediclaim.

2. Complainant stated that he had submitted claim on 21.05.2010 for Dental injury sustained by his daughter Ms. Anita on 10.05.2010. After completion of treatment at Gupta Child & Dental Clinic he submitted the claim papers to Personnel Department at R.O. through SVC for reimbursement of expense of Rs. 4,638.40. He had pursued the claim but the claim was not settled. Later on company informed him that the claim is not admissible on the ground that treatment did not require hospitalization. He had even approached the higher authority for review of his claim but the Competent Authority also held the claim is not payable because the medical establishment at which treatment was taken does not fall under the definition of Hospital or Nursing home. During the course of hearing also, complainant stated that company was not justified in rejecting the claim.

3. Representative of the company stated that claim is not payable because treatment was taken at an establishment which is neither Hospital nor Nursing home. Company also filed reply dated 03.02.2011 wherein it has been stated that complainant is a permanent employ of the company and he and his family are insured under Group Mediclaim Policy taken from OIC Ltd.

4. I have considered the submissions of the complainant as well as the representative of the company. I have also perused the written reply of the company dated 03.02.2011. After due consideration of the matter, I hold that company was not justified in denying the claim to the insured because injury of the teeth caused due to Troma as mentioned by the doctor on 21.05.2010 in the prescription. As injury was caused due to Troma, patient is not required to get treatment in hospital. There is no requirement of hospitalization in case injury is caused due to Troma. Therefore in my view the company was not justified in repudiating the claim. The claim is payable. **Accordingly an Award is passed with the direction to the Ins. Co. to make the payment of Rs. 4,638.40.**

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/598/NIA/10

In the matter of Shri Noor Mohammad
Vs
New India Assurance Co. Ltd.

AWARD DATED 3.8.2011 : NON SETTLEMENT OF MEDICLAIM

1. This is a complaint filed by Shri Noor Mohammad (herein after referred to as the complainant) against the decision New India Assurance Co. Ltd. (herein after referred to as respondent Insurance Company) relating to non settlement of medi claim.

2. Complainant stated that his daughter Mediclaim was wrongly rejected by the Ins. Co. on the ground that she was treated conservatively and treatment was taken as on OPD basis and his daughter's admission in the JLN Hospital, Ajmer was not justified. He had been pursuing matter against the rejection of the claim. It was submitted by him that it was not his choice to get his daughter in hospital and since his daughter was not recovering and his family was disturbed, on that account, he had no option but to get her admission in the hospital. He had also approached the Grievance Cell of the company and ultimately to this forum to get the payment of Rs. 2245 by the Ins. Company. During the course of hearing also complainant stated that claim is payable and company was not justified in rejecting the claim.

3. Representative of the company stated that claim is not payable because the admission in the hospital was not required and patient could have been treated as an outdoor patient.
4. I have considered the submissions of the complainant as well as of the representative of the company. I have also perused the letter dated 10.02.2011 of the Chief Regional Manager of Ins. Company. After due consideration of the matter, I hold that claim is payable and company was not justified in repudiating the same because the patient was admitted in the hospital for the treatment. **Accordingly an Award is passed with the direction to the Ins. Co. to make the payment of Rs. 2245.**

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/187/UII/10
In the matter of Smt. Phoolwanti Devi
Vs
United India Ins. Co. Ltd.

AWARD DATED 4.8.2011 INDADEQUATE SETTLEMENT OF MEDICLAIM

6. This is a complaint filed by Smt. Phoolwanti Devi (herein after referred to as the complainant) against the decision of United India Ins. Co. Ltd. (herein after referred to as respondent Insurance Company) relating to inadequate settlement of mediclaim.
7. Complainant stated that she got injured in leg due to fall. She was first admitted in Balotra Jahnavi Hospital there after seeing the report and X-ray, she decided to get herself treated in Ahmadabad hospital. She was admitted in hospital in Ahmadabad at about 11:00 Pm and was operated on 19.04.2009. E-Mediteke Solutions Ltd. was also informed and approached for cashless facility for an amount of Rs. 54100. The total bill of the hospital was Rs. 62637, deposited a sum of Rs. 8537 in cash. There after she incurred certain expenses on medicines and physiotherapy etc. She submitted that the claim of Rs. 30813 was not settled by the company. She also approached the Grievance cell of the company but she had got no response. During the course of hearing complainant's husband stated that the company has not settled the claim for Rs. 30813 so far.
8. Representative of the company stated that claim could not be settled due to the fact that there were cutting on the bills and that needs time to settle the claim. Representative of the company was given 2 weeks time to get the claim settled and to submit report but report has not been submitted so far.
9. I have considered the submissions of the complainant as well as of the representative of the company. I have also perused the letter dated 23.09.2009 and 03.11.2010 of the company. After due consideration of the matter, I hold that company was not justified in not settling the claim because the patient had been treated in the hospital and therefore the claim is payable. However it is found that the sum of Rs.4, 500 was paid by the company to the hospital in the cashless facility and same was also included in the pending claim of Rs. 30,813. Therefore a sum of Rs 4500 and Rs. 250 for registration charges are not to be given to the insured. Thus complainant is further entitled to sum of Rs. 26063 (30813-4500-250). **Accordingly an Award is passed with the direction to the Ins. Co. to make the payment of Rs. 26063.**

    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/423/RGI/10

In the matter of Shri Avnesh Singhal

Vs

Reliance Gen. Ins. Co. Ltd.

AWARD DATED 4.8.2011 NON SETTLEMENT OF MEDICLAIM

1. This is a complaint filed by Shri Avnesh Singhal (herein after referred to as the complainant) against the decision Reliance Gen. Ins. Co. Ltd. (herein after referred to as respondent Insurance Company) relating to non settlement of medi claim.

2. Complainant stated that patient got problem and had taken treatment and further stated that he had complied with all requirements of the company to enable it to settle the claim but the company had not paid the claims. As matter of fact, it had repudiated the claim. During the course of hearing it was stated that he was admitted in the hospital under the advice of treating doctor as he was feeling pain continuously and he was taking treatment.
3. Representative of the company stated that claim is not payable because hospitalization was not required and treatment could have been taken as an OPD patient. The claim has been rightly repudiated. He also filed written reply of the company wherein it has stated that complainant had obtained Reliance Health wise Gold Policy valid from 14.03.2009 to 13.03.2010 covering himself, his son and spouse. He was admitted at Jain hospital Jaipur on 29.08.2009 as suspected case of DVT and Spinal canal stenosis and discharged on 01.09.2009. It was further stated that the admission was primarily for evaluation and to confirm the cause of present illness and no active line of treatment was given during the stay in hospital.
4. I have considered the submissions of the complainant as well as of the representative of the company. I have also perused the repudiation letter dated 19.12.20069 and company's reply dated 29.06.2011. After due consideration of the matter, I hold that company was not justified in repudiating the claim because insured was admitted in the hospital as he feeling pain and as per advice of the doctor tests are required to ascertain the exact cause of the illness. Therefore claim is payable. **Accordingly an Award is passed with the direction to the Ins. Co. to make the payment of Rs. 42,212.**

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/467NIA/10

In the matter of Shri Avinash Kumar Sinha

Vs New India Assurance Co. Ltd.

AWARD DATED 24.8.2011 : NON SETTLEMENT OF MEDICLAIM

1. This is a complaint filed by Shri. Avinash Kumar Sinha (herein after referred to as the complainant) against the decision of New India Assurance Co. Ltd. (herein after referred to as respondent Insurance Company) relating to non settlement of Mediclaim.

2. Complainant stated that while going to office he met with an accident and his right elbow got fractured and he admitted to Bhagwati Hospital, Delhi in emergency. After investigation and report of x- ray, Doctor's concluded that he had multiple fractures for which operation is necessary. Accordingly, he had under gone operation and discharged from hospital on 24.05.2010. He submits that hospital is in the panel of TPA Raksha, therefore he requested hospital to seek approval from TPA Raksha for the said operation. He requested for the arrangement of the payment of Rs. 34,783. During the course of

hearing also he submitted that the company had not settled the claim fully out of claim of Rs. 34,783 relating to post hospitalization only a sum of Rs. 13,673 was paid. He has requested this forum that company be directed to make the payment of the balance amount.

3. Representative of the company promised to look into the matter.

4. I have considered the submissions of the complainant as well as of the representative of the company. I have also perused the reply of the company and the repudiation letter. After due consideration of the matter, I hold that company was not justified in not making entire payment of post hospitalization treatment. There appears no justification in making payment only of Rs. 13,673 out of Rs. 34,783 relating to post hospitalization treatment. The balance amount excluding Rs. 3000 being doctor's home visits is payable to the insured. **Accordingly an Award is passed with the direction to the Ins. Co. to make the payment of Rs. 18110 (34783-13673-3000 doctor's home visits).**

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/340/Star/10
In the matter of Shri. C.S. Mann
Vs
Star Health Allied Ins. Co. Ltd.

AWARDDATED 20.9.2011 NON SETTLEMENT OF MEDICLAIM

1. This is a complaint filed by Shri. C.S. Mann (herein after referred to as the complainant) against the decision of Star Health Allied Ins. Co. Ltd. (herein after referred to as respondent Insurance Company) relating to non settlement of Mediclaim.

2. Complainant stated that he is the holder of Star Health Senior Citizen Policy bearing no. P/161100/01/2010/00341 for the period 11.08.2009 to 10.08.2010. He further submitted that he developed excess bleeding through Stool and approached Pushpavati Singhania Institute, N.D., which was on the net work of the Ins. Company. He had intimated the Star Health Allied Ins. Company about his treatment and submitted the claim along with all requisite documents but the Ins. Company rejected the claim. During the course of hearing also complainant stated that claim is payable because hospitalization was not required as per the policy.

3. Representative of the company stated that claim is not payable because hospitalization was not for 24 hours so the claim was refused rightly.

4. I have considered the submissions of the complainant as well as of the representative of the company. After due consideration of the matter, I hold that company was not justified in rejecting the claim, this claim is payable despite the fact that hospitalization is less than for 24 hours. There was no requirement in this particular case for hospitalization for more than 24 hours and a sum of Rs. 2,000 is payable. Accordingly an Award is passed with the direction to the Ins. Company to make payment of Rs. 2,000 to the insured.

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/306/OIC/10
In the matter of Smt. Ritu Pandey
Vs
Oriental Ins. Co. Ltd.

AWARD DATED 20.9.2011 REPUDIATION OF OVERSEAS MEDICLAIM

1. This is a complaint filed by Smt. Ritu Pandey (herein after referred to as the complainant) against the decision of Oriental Ins. Co. Ltd. (herein after referred to as respondent Insurance Company) repudiation of Overseas Mediclaim Policy.

2. Complainant stated that she had purchased an overseas Mediclaim policy from Oriental Ins. Co. Ltd. her claim was repudiated by TPA (Heritage Health) on account of delay in intimation to Insurance Company or its designated agency. Her overseas Mediclaim policy no. is 24/plan2/3/121800/10244/1215977. She had also approached GRO of the Company but she had not received any reply. She had purchased the policy through an agent as a prerequisite for her to travel to USA on 30.05.2009. Her date of departure was 01.08.2009. She suffered from severe diarrhea and was admitted to the emergency department of Emerson Hospital Concord Massachusetts USA on 05.08.2009. At the time of admission, she shared her insurance details with the hospital staff and her treatment was done on cashless basis in Emersion hospital. However, on return to India, she received a statement dated 10.12.2009 form Emerson hospital that USD 1524.07 is amount due for her treatment. She had written to TPA, but she has not received any reply. She had approached the customer service department of Oriental Insurance Company and she received a reply from them on 31.03.2010 with an assurance that complaint will be resolved soon. However, a mail from TPA has put the onus on her stating that claim was intimated late. Meanwhile, hospital delegated the collection of dues to their collection agency and she is being mentally harassed by the collecting agency. She states that she was not provided the schedule of the policy. As a

matter of fact at the time of giving policy only single pager policy documents was given wich did not mention any such conditions. She availed the cashless facility of hospital. She approached this forum to get the claim settled.

3. Representative of the company stated that claim is not payable because claim was intimated late on 20.08.2010 after 4 months from arrival. The
insured did not follow the procedure to settle the claim. Claim was not intimated to foreign TPA. It was also intimated that the policy documents were given to the insured.

4. I have considered the submissions of the complainant as well as of the representative of the company. I have also perused the correspondence between the insured and the company. After due consideration of the matter, I hold that claim is payable and the company was not justified in repudiating the claim only because the claim was intimated late. As stated by the complainant in the complaint that she shared the policy details with the hospital staff while in the hospital for the treatment in USA. She had a genuine belief that since cashless facility was allowed to her by the hospital and she shared policy details with the staff of the hospital, it was enough on her part. She is being constantly harassed. In my view claim is payable. Accordingly an Award is passed with the direction to the Ins. Company to make the payment in Indian Rs equalent to 1424 US dollars.

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/500/NIA/10
In the matter of Shri. Mohan Jha
Vs
New India Assurance Co. Ltd.

AWARD DATED 22.9.2011 NON SETTLEMENT OF MEDICLAIM

1. This is a complaint filed by Shri. Mohan Jha (herein after referred to as the complainant) against the decision of New India Assurance Co. Ltd. (herein after referred to as respondent Insurance Company) regarding non-settlement of Mediclaim.

2. Complainant stated that his claim has been denied by MediAssist India Pvt. Ltd., the TPA of New India Insurance Co. Ltd., for the reasons mentioned that he was not admitted for more than 24 hours in the hospital. He submitted that the claim arose due to fall of unbalancing motorcycle facing ditch on the narrow road full of rain water. The hospital was available approx. 50 km far away from his village and he was unable to go there.

Moreover, the day care centre (clinic) was also available approx. 20 km far away from his village where he had taken treatment by the qualified doctor. X-ray was taken, fracture was diagnosed, after completing the plaster to his left leg, the doctor suggested him to take rest and physiotherapy exercise for 2 months. He has approached this forum to get this claim paid. During the course of hearing also complainant submitted that he got injured due to imbalance on motorcycle while driving in rain.

3. Representative of the company stated that claim is not payable as he was treated as OPD patient.

4. I have considered the submissions of the complainant as well as of the representative of the company. I have also perused the repudiation letter. After due consideration of the matter, I hold that the company was not justified in denying the claim because complainant got injured due to
accident and for which hospitalization is not necessary. Accordingly an Award is passed with the direction to the Ins. Company to make the payment of Rs. 7548/- along with penal interest at the rate of 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 same shall be intimated to my office for information and record.**

6. Copies of the Award to both the parties.

KOLKATA

SYNOPSIS OF FIRSTQUARTER STARTING FROM APRIL 2011 – JUNE 2011
PERTAINING TO AWARD/RECOMMENDATION/ORDER AGAINST NON-LIFE CASES
PASSED BY HON'BLE OMBUDSMAN, KOLKATA

MEDICLAIM

Kolkata Ombudsman Centre
Case No. 481/11/011/NL/12/2009-10

Sri Pradeep Kumar Bose

Vs.

National Insurance Company Ltd.

Order Dated : 13.04.2011

Facts & Submissions :

This complaint was filed against repudiation of claim under Swasthya Bima Policy issued by National Insurance Company Ltd.

The complainant Shri Pradeep Kumar Bose in his complaint stated that his wife Smt. Dipa Bose was suffering from abdominal pain and was admitted at AMRI Hospital, Salt Lake Kolkata on 10.07.2009 where total abdominal hysterectomy was done on the same day and she was discharged on 14.07.2010. As per discharge summary the diagnosis of the disease was '*Multiple fibroid uterus with bilateral chocolate cyst of ovary'.* He further stated that at the time of hospitalization all the required procedural steps were taken and the papers were sent to M/s Genins India Ltd., TPA of the insurance company for cashless facilities but they denied the same. After that he lodged a claim to the TPA for reimbursement of hospital expenses. The insurance company repudiated the claim stating that '*he was covered under individual mediclaim policy with other company and subsequent break in insurance can not be considered by giving continuation of cover'.*

The insurance company stated that Sri Bose was covered under Swasthya Bima Policy, w.e.f. 16.02.2009 through Bank of India, Sealdah Branch for a total floater sum insured of Rs.1 lakh. The proposal form itself revealed that Shri Bose and his family were covered under individual mediclaim policy with New India Assurance Company Ltd. for the period 10.02.2008 to 09.02.2009. Under the circumstances, firstly, there was a gap of 7 days of the policy coverage and secondly his cover changed from Individual Mediclaim Policy to Swasthys Bima Policy. The matter was reviewed by the Appropriate Authority and as per their advise a reference was made to Bank of India circular no. 13 (Ref. RBD:SJ) where it was clearly mentioned that delay could be condoned for a grace period of 15 days only in case of renewal of existing '*Swasthya Bima Policy'.* Since the insured was covered under Individual Mediclaim policy with other company, subsequent break in insurance could not be considered by giving continuation of cover. Since the insured was covered under individual mediclaim policy with other company, this break could not be condoned as per the policy of the company.

DECISION:

The only dispute in this case whether the break of 7 days could be condoned by the present insurer. The insurer had reviewed this case but did not condone the break of 7 days in view of the guidelines which mentioned that delay could be condoned for a grace period of 15 days only in case of renewal of existing Swasthya Bima Policy. Therefore, strictly speaking, insurer's decision was technically correct but it was not fair and justified. It was noted that the insured had paid the cheque in time and delay occurred only due to some procedural lapses on the part of the bank which was later admitted by the bank. If the cheque had been deposited by the bank who was in this case the tie up partner of the insurer in time, there would not have been any break in the policy period as if the insurer has held it in their custody during this period. Since there was no fault on the part of the insured in complying with the policy requirements he could not be penalized for the delay committed by the bank in sending the cheque to the insurer in time. Here, Hon'ble Ombudsman condoned the delay of 7 days and directed the insurance company to pay

the claim considering that in any case the complainant could not be held responsible for the delay.

Kolkata Ombudsman Centre
Case No. 080/11/003/NL/05/2010-11

Shri Trinayan Ghosh

Vs.

National Insurance Company Ltd.

Order Dated : 13.04.2011

Facts & Submissions :

This complaint is filed against partial repudiation of claim under Individual Mediclaim Insurance Policy issued by National Insurance Company Ltd.

The complainant Shri Trinayan Ghosh stated that his wife Smt. Sumita Ghosh was suffering from pain & swelling at left elbow following a Road Traffic Accident (RTA) on 01.08.2009 and was admitted at Peerless Hospital & B.K.Roy Research Centre on 03.08.2009 where she underwent an operation on 07.08.2009 and was released on 11.08.2009. As per discharge summary the diagnosis of the disease was '*displaced, communuted intercondylar fracture left humerus with diabetes, hypertension & hypothyroid on treatment'.* He lodged a claim for Rs.1, 01,884.50 on 14.09.2009 to the TPA of the insurance company M/s Heritage Health TPA Pvt. Ltd. for reimbursement of hospital expenses. TPA vide their letter dated 20.03.2010 paid Rs.52,158./- towards full and final settlement of his claim. He represented to the insurance company against partial settlement. Being aggrieved, he approached this forum for redressal of his grievance seeking monetary relief of Rs.49, 726/-.

The insurance company stated that Smt. Sumita Ghosh wife of the complainant was admitted in the Peerless Hosptial & B.K.Roy Research Centre on 03.08.2009 for pain and swelling at left elbow following a road traffic accident on 01.08.2009 and was discharged on 11.08.2009. She filed a claim for Rs.1,01,884/-. TPA processed the claim and arrived at payable amount of Rs.52,158/-, for the balance amount TPA asked the complainant to submit the following documents (i) Self-statement regarding injury (ii) FIR/Police Verification Report (iii) History sheet at the time of admission (iv) History sheet of past medical illness with duration (v) Indoor treatment sheet & O.T. Notes. Due to non-receipt of the above documents, TPA has repudiated the claim vide their letter dated 24.12.2009**.**

DECISION:

Since the complainant did not attend the hearing, it was an ex-parte decision. The complainant made a claim for Rs.1,01,884/- which was settled at Rs.52, 158/-. It was observed that the insured had sent documents along with his letter dated 29.12.2009 such as self statement regarding injury, F.I.R lodged by hospital, case summary by the hospital etc. In our opinion the case summary of the hospital should be sufficient to decide the claim of the insured. We have further noticed from the status of payment that an amount of **Rs.23,519.90** (aggregating Rs.2050/-, Rs.1,710/-, Rs.4,100/- Rs.14,000/-, Rs.364.70, Rs.80.50. Rs.339/-, Rs.835.70 & Rs.40/-) relating to DM & HTN had been disallowed by the TPA. However, we find that the claim pertains to the treatment of accidental injury which is established by the F.I.R lodged by the hospital. Hon'ble Ombudsman did not understand how the expenses relating to DM and HTN could be segregated and disallowed by the TPA. He opined that there was no justification in disallowing these expenses because they pertained to the hospitalization period and since all the necessary papers had been submitted by the insured there could not be any excuse for not settling the balance amount of claim. The insurer was therefore directed to settle the balance amount of the claim on the basis of papers already submitted by the insured and also allowing the DM & HTN related treatment expenses for which there was no valid reason for disallowance.

Kolkata Ombudsman Centre

Case No. 099/11/003/NL/05/2010-11

Shri Prahlad Rai Kedia

Vs.

National Insurance Company Ltd.

Order Dated : 29.04.2011

Facts & Submissions :

This complaint is filed against repudiation of claim under Individual Mediclaim Insurance Policy issued by National Insurance Company Ltd. as per exclusion clause no. 4.8 of the policy.

The complainant Shri Prahlad Rai Kedia in his complaint has stated that he was admitted at Shree Vishudhanand Hospital & Research Centre, Kolkata on 14.04.2009 where he was treated conservatively and was discharged on 10.05.2009. As per discharge summary the diagnosis of the disease was *'Depressive Psychosis'.*

He lodged a claim for Rs.29,274.81 to the TPA of the insurance company M/s Genins India Ltd. for reimbursement of hospital expenses. TPA vide their letter dated 30.04.2009 repudiated the claim stating that *'all psychiatric & Psychosomatic disorders/ diseases falls under exclusion clause no. 4.8 of the mediclaim policy'.* He represented to the insurance company on 10.08.2009 against such repudiation and requested the insurance company to reprocess the wrong repudiation and settle his claim at the earliest. His appeal was not considered by them. Being

aggrieved, he approached this forum for redressal of his grievance seeking monetary relief of Rs.32,788/-.

The insurance company in their written submission dated 27.07.2010 stated that Shri Prahlad Rai Kedia took admission in Shree Vishudhananda Hospital & Research Institute on 14.04.2009 and discharged on 10.05.2009 and finally diagnosed that the patient suffered from 'depressive psychosis'. The claim documents/ papers was processed by their TPA and they have the opinion that the treatment was done for depressive psychosis, which is excluded by policy clause no. 4.8 and accordingly the claim was repudiated.

DECISION:

In this case two discharge certificates of the same hospital viz. Shree Vishudhanand Hospital & Research Institute have been filed. The first discharge certificate pertains to the period from 31.03.2009 to 08.04.2009 and the diagnosis was Amoebic Hepatitis. The second certificate pertains to the period 14.04.2009 to 10.05.2009 and the diagnosis was depressive psychosis. According to the complainant, his claim pertains to the period 14.04.2009 to 10.05.2010 during which he was treated for stomach disorder. However, hospital papers have caused a confusion regarding the actual nature of the disease and treatment received by the patient. It is seen from the indoor treatment papers that reason for hospitalization was vomiting, watery – stool and pain in abdomen. The initial diagnosis was Amoebic Hepatitis. However, going by the discharge certificate for this period, we find that he was diagnosed as a patient of Depressive Psychosis, treatment of which is excluded under clause 4.8 of the policy. The treating doctor has also noted 'anxiety and depressed look' during the hospitalization period and prescribed medicine both for anxiety and stomach problems.. The doctor has also given a clarification on the nature of the disease certifying the condition as acute Amoebic Hepatitis with gastroenteritis. We cannot give much weight to this certificate of Dr. D. D. Kothari dated 08.08.2009, which is conflicting with his own observation in the indoor treatment papers and discharge certificate.

After evaluation of all the facts and circumstances of the case, this forum is of considered opinion that due to difference in the doctor's observations on different dates, it cannot be said with certainty that he was hospitalized only for the treatment of depressive psychosis as claimed by the insurer or only for Amoebic Hepatitis as claimed by the insured. Therefore, repudiation of total claim is not justified in this case.

Under the circumstances while upholding the decision of the insurer, we allow an ex-gratia payment of Rs.10,000/- (Rupees Ten Thousand) only to the complainant to take care of treatment for the Amoebic Hepatitis and this will meet the ends of justice.

Vs.

National Insurance Company Ltd.

Order Dated : 30.06.2011

Facts & Submissions :

This complaint is filed against repudiation of claim under Individual Mediclaim Insurance Policy issued by National Insurance Company Ltd. as per exclusion clause no. 4.10 of the policy.

The complainant Shri Tushar Kanti Bor in his complaint has stated that his wife Smt. Aruna Bor was suffering from ligament injury and as per advice of Dr. T.K. Maitra on 15.07.2008 she was admitted at Divine Nursing Home Pvt. Ltd., Kolkata on the same day where she was treated conservatively and discharged on 19.07.2008. As per discharge summary the diagnosis of he disease was *'Ligamenteous injury of lower lumber spine (L5 - S1)'.*

He lodged a claim for Rs.12, 003/- on 26.11.2008 to the TPA of the insurance company M/s MD India Healthcare Services (TPA) Pvt. Ltd.., for reimbursement of hospital expenses. TPA vide their letter dated 20.03.2009 repudiated the claim stating that *'expenses incurred primarily for evaluation/ diagnostic purposes not followed by active treatment during hospitalization are not payable under clause no. 4.10 of the policy'.* He represented to the insurance company on 27.03.2010 against such repudiation and requested the insurance company to consider and settle his claim as early as possible. His appeal did not yield any result. Being aggrieved, he approached this forum for redressal of his grievance seeking monetary relief of Rs.12, 003/-.

The insurance company in their written submission dated 21.03.2011 stated that the subject claim was lodged for treatment of ligament injury of lower lumber L5 – S1. The claim documents were examined by their TPA and it was found by them that the patient was hospitalized for investigation only and she received tablets, IM injections which could be taken at out patient department and hospitalization was not at all necessary. Therefore, the claim was repudiated as per exclusion clause no. 4.10 of the Revised Mediclaim Policy.

DECISION:

It is seen that the insured was first examined by an Orthopaedic Surgeon who prescribed some medicines and advised x-ray but without waiting for the result of the medicines, he recommended immediate admission in the nursing home on the same day. The final diagnosis of

the treating doctor in the nursing home was ligament injury of lower lumber spine. Although the discharge summary does not mention the details of treatment but from the break-up of the hospital expenses we find that the total cost of medicines during hospitalization was just Rs.614/-. Compared to this amount, pathological tests of Rs.2,440/- and room rent of Rs.5,085/- are definitely excessive and point to the fact that the main purpose of hospitalization was evaluation and investigation of the problem. Although, her treatment could have been done on OPD basis also, but considering the fact that the admission in the hospital was on doctor's specific advice and once she was admitted she had no say in the matter of treatment, we are of the opinion that total repudiation of the claim is not justified in this case. At least no insured would personally desire to remain confined in hospital unnecessarily and without any cause and not to make any personal monetary gain.

After evaluation of all the facts and circumstances of the case, we allow on ex-gratia basis an amount equal to 50% of the claimed/admissible amount as per terms and conditions of the policy to cover the cost of the essential part of the treatment.

The insurer is therefore directed to pay the above amount within 15 days from the date of receipt of this order along with consent letter from the complainant.

Kolkata Ombudsman Centre

Case No. 083/11/005/NL/05/2010-11

Shri Prabir Banerjee

Vs.

The Oriental Insurance Company Ltd.

Order Dated : 30.06.2011

Facts & Submissions :

This complaint was filed against repudiation of claim under Individual Mediclaim Insurance Policy issued by The Oriental Insurance Company Ltd. as per exclusion clause no. 4.12 of the policy.

The complainant Shri Prabir Banerjee in his complaint has stated that his wife Smt. Barnali Banerjee was suffering from ventral hernia and was admitted at Tulip Nursing Home Private Limited on 22.12.2009 where she underwent prolene mesh repair of ventral hernia and abdominoplasty done on 23.12.2009 and was discharged on 29.12.2009. As per discharge summary the diagnosis of the disease was *'large ventral hernia'*.

At the time of hospitalization, TPA of the insurance company M/s Medicare TPA Services (I) Pvt. Ltd. refused the cashless facility. He lodged a claim on 25.01.2010 to the TPA of the

insurance company for reimbursement of hospital expenses. TPA vide their letter dated 07.02.2010 repudiated the claim stating that as per doctor's prescription, the ventral hernia is just above the LUCS scar and results from LSCS in 2004. As, per policy norms the maternity and its related complications are not covered, cashless request could not be accorded (clause 4.12). He represented to the insurance company on 12.02.2010 requesting them to consider his case sympathetically. He did not get any favourable reply from them. Being aggrieved, he approached this forum for redressal of his grievance seeking monetary relief of Rs.50, 000/-.

The insurance company in their written submission dated 18.04.2011 stated that the claim was repudiated by their TPA with the following remarks *'as per doctors prescription the ventral hernia is just above the LUCS Scar and is hence, due to LSCS in 2004*". As per policy norms the maternity and its related complications are not covered under the policy. On receipt of the representation dated 12.02.2010 from the complainant, they sought the opinion of their panel doctor who remarked as under:-

'As per Dr. Amitabha Lahiri, I do agree that pregnancy itself is not responsible for ventral hernia, but twice caesarian section is responsible for ventral hernia. Consequences of caesarian section (ventral hernia) is also not payable, as caesarian section is an excluded risk".

DECISION:

Since the representative of the insurance company did not attend the hearing, we propose to deal with the matter on ex-parte basis for them.

This office examined the documents which had been filed by the parties before this forum. It is seen that Dr. Sandip Kumar Nath, panel doctor of the TPA supported repudiation of the claim on the ground that the ventral hernia was just above the LUCS scar and resulted from LSCS in 2004. Thereafter, their panel specialist Dr. Soven Ghosh opined that the ventral hernia is consequence of two caesarian operations done in the past and near the location of the caesarian section. It is also seen that the caesarian section is an excluded risk as per clause no. 4.12 of the policy. On the other hand we find that Dr. Amitabha Lahiri, MD & Consultant Gynaecologist, who had examined the patient, clearly opined that the ventral hernia was not related to pregnancy. Thus there is a difference of opinion between the doctors which lead us to the conclusion that the exact cause of the ventral hernia in this case is not free from doubt. The patient had a caesarian operation during child birth 5 years back in 2004 and therefore it cannot be conclusively said that her present condition has resulted as a consequence of caesarian section. Giving the benefit of doubt to the insured, we accept the opinion of the attending consultant Dr. Amitabha Lahiri who has ruled out the possibility of hernia resulting from pregnancy.

After careful evaluation of all the facts and circumstances of the case, we conclude that the claim is admissible and the insurer's decision is set aside and directed to admit the claim and pay the same as per terms and conditions of the policy.

Kolkata Ombudsman Centre
Case No. 089/11/002/NL/05/2010-11

Smt. Vandana Balasaria

Vs.

The New India Assurance Company Ltd.

Order Dated : 27.06.2011

Facts & Submissions :

This complaint is filed against repudiation of a claim under Overseas Mediclaim Insurance Policy issued by The New India Assurance Company Limited.

The complainant Smt. Vandana Balasaria in her complaint has stated that she was suffering from sudden and severe case of mouth ulcers for which she got herself admitted in Baptist Health Centre, South Jacksonville, USA on 06.11.2008 (11.06.2008 as per the USA date format). She was advised medication by Dr. Judy B Harrison and was discharged on the same day.

After her travel from USA, she lodged a claim to the insurance company for Rs.22,462/- on 28.11.2008 with all supporting documents for reimbursement of hospital expenses. TPA of the insurance company M/s Heritage Health TPA Pvt. Ltd. vide their letter dated 31.12.2009 repudiated the claim stating as:

'You have taken medical treatment on 11th June 2008 during your journey to abroad. It has been 01 year & 06 months since the date of incidence. This is contrary to the condition that any claim under the policy to be submitted along with all documents at least not late than 31 days after the end of the trip. However in your present case the claim documents submitted to us on 07.th December 2009 which beyond 31 days. The incident reported does not falls within the purview of the policy coverage due to the reason stated above (point – 2 general exclusions applicable to all section)'.

She represented to the insurance company on 08.04.2010 stating that she submitted all the documents to the insurance company on 28.11.2009 and repeatedly followed up with the insurance company in Kolkata and also the head office at Mumbai. She did not receive any

positive feed back from them. Being aggrieved, she approached this forum for redressal of her grievance seeking monetary relief of Rs.24, 298/-.

The representatives of the insurance company, who attended the hearing, stated that they were not aware about the nature or quantum of the claim as their TPA has not informed them in details. Since it is an Overseas Mediclaim Policy it is to be serviced by their overseas administrator as mentioned in the policy. They further requested that 7 (seven) days time to take necessary steps for settlement of the claim.

DECISION:

After hearing the submissions of both the parties, we are of the opinion that the insurer has not cared to take any step for settling this claim. The TPA without applying their mind has erroneously read the date of the bill and rejected the claim on an absurd ground that it was time barred without understanding the US format of writing all documents in month, date, year format. The representatives of the insurance company were totally in the dark and not aware about the facts of the case. Since they have requested for seven days time, we direct them to obtain all the papers from their TPA and settle the claim within 15 days from the date of receipt of this order along with consent letter from the complainant. They will also allow penal interest as per company's policy for delayed settlement from the date the claim was submitted till the date of actual payment.

Kolkata Ombudsman Centre
Case No. 097/11/003/NL/05/2010-11

Smt. Pritikana De Biswas

Vs.

National Insurance Company Ltd.

Order Dated : 20.06.2011

Facts & Submissions :

This complaint is filed against partial repudiation of claim under Individual Mediclaim Insurance policy issued by National Insurance Company Ltd.

The complainant Smt. Pritikana De Biswas in her complaint has stated that her son Rajarshi De Biswas was suffering from painful gynaecomastia and was admitted under Dr. Gautam Guha at Binayak Health World, Kolkata on 23.05.2009 where he underwent subcutaneous Mastectomy after liposuction done on 24.05.2009 and he was discharged on 29.05.2009. As per discharge summary the diagnosis of the disease was '*Bilateral painful gynaecomastia'*.

At the time of hospitalization TPA of the insurance company M/s Genins India TPA Ltd. provided cashless facility of Rs.27,400/- based on the sum insured of Rs.50,000/-. She lodged a supplementary claim on 28.08.2009 for Rs.27, 693/- to the TPA of the insurance company for reimbursement of hospital expenses. TPA vide their letter dated 01.09.2009 settled Rs.16, 308/- towards full and final settlement of the claim. She represented to the insurance company on 01.03.2010 against such partial repudiation and requested them to review her claim on the basis of sum insured of Rs.1 lakh. Her representation did not yield any result. Being aggrieved, she approached this forum for redressal of her grievance seeking monetary relief of Rs.11,386/-. The complainant has given her unconditional and irrevocable consent for the Insurance Ombudsman to act as a mediator between herself and the insurance company and to give recommendation as per Form – P-III dated 16.07.2010.

The insurance company in their written submission dated 25.03.2011 stated that the insured was provided cash less facility by the TPA for Rs.27,400/- based on sum insured of Rs.50,000/-. The insured was further paid Rs.16,308/- against the supplementary claim of Rs.27,693/-. The claim was also reviewed as per the request of the complainant but no further amount was payable.They further stated that the patient was suffering for last 5 years as declared by his father in the pre-hospitalization form. The insured enhanced the sum insured of her son from Rs.50,000/- to Rs.75,000/- on 18.01.2008 and again from Rs.75,000/- to Rs.1 lakh though the sum insured of the proposer remain unchanged till date since inception. The proposer did not declare the material fact that her son was suffering from "painful gynaecomastia" which is externally visible disease while enhancing the sum insured for her son. The policy condition no. 5.12 specifies that "continuing or recurrent nature of disease/ complaints which insured has ever suffered will be excluded from the scope of cover so far as enhancement of sum insured is considered".

Under the above circumstances the admissibility of the liability is limited to sum insured of Rs.50,000/- and the capping under the policy. After review, the claim was settled at Rs.Rs.43,708/- (Cashless Rs.27,400/- and reimbursement of Rs.16,308/-) . They are of the opinion that the insured is not entitled to any further payment regarding the said claim.

DECISION:

Since the complainant did not attend the hearing, we propose to deal with the matter on ex-parte basis for her.

This office examined the documents submitted by both the parties to this forum. It is seen that the insured was suffering from the disease for the last 5 years but this fact was not disclosed while enhancing the sum insured by the proposer. Hence the application of policy condition no. 5.12 is correct. According to this condition, the claim will be restricted to the original sum insured of Rs.50, 000/- and the benefit of enhancement will not be available. However, we have noted that the benefit of cumulative bonus of Rs.22, 500/- was not considered while settling the claim. This fact has been admitted by the representative of the insurance company. Therefore, while. upholding the decision of the insurer to restrict the claim to the original sum insured, we direct them to recalculate the claim after taking into consideration the cumulative bonus of Rs.22,500/- . The additional payment on account of cumulative bonus as per terms and

conditions of the policy should be paid to the complainant by the insurance company within 15 days from the date of receipt of the order along with the consent letter from the complainant.

Kolkata Ombudsman Centre
Case No. 098/11/002/NL/05/2010-11

Shri Vinod Kumar Singh

Vs.

The New India Assurance Company Ltd.

Order Dated : 20.06.2011

Facts & Submissions :

This complaint is filed against repudiation of a claim under Mediclaim Policy (2007) issued by the New India Assurance Company Ltd., due to treatment taken at the hospital for evaluation purpose only which falls under exclusion clause no. 4.4.11 of the policy.

The complainant Shri Vinod Kumar Singh in his complaint has stated that his son Master Harsh Rathod was suffering from severe pain in the abdomen (periumbilical region) associated with vomiting and as per advice of Dr. P.S. Bhattacharya he was admitted at Apollo Gleneagles Hospitals, Kolkata on 12.12.2009 where he was treated conservatively and he was discharged on 18.12.2009. As per discharge summary the diagnosis of the disease was '*Cholelithiasis, Hypovolumic shock'.*

During hospitalization, a request was made for cashless benefit, which was denied by the TPA of the insurance company M/s Medicare TPA Services (I) Pvt. Ltd. Subsequently, complainant lodged a claim on 17.02.2010 for Rs.49,751.39 to the TPA for reimbursement of hospital expenses. Insurance company vide their letter dated 20.04.2010 repudiated the claim stating that "*the child has been admitted in the hospital only for investigation purpose and initially diagnosed as Cholelithiasis and subsequently as per USG report dated 30.03.2010 it shows no evidence of gall bladder and CBD stone nor any billiary sludge. Mediclaim policy 2007 clause no 4.4.11 clearly excludes 'diagnosis, x-ray or laboratory examination not consistent with or incidental to the diagnosis of positive existence and treatment or any ailment, sickness or injury for which confinement is required at a hospital / nursing home'. Under the circumstances, the above claim is not coming under the purview of the policy".* Being aggrieved, he approached this forum for redressal of his grievance seeking monetary relief of Rs.49, 751.39.

We wrote to the insurance company to send their written submissions along with their consent for the Insurance Ombudsman to act as a mediator between the parties on 08.06.2010 followed by a reminder dated 14.03.2011, but we did not receive any written submission from the insurance company.

DECISION:

Since the representative of the insurance company did not attend the hearing, we propose to deal with the matter on ex-parte basis for them.

We have heard the submissions of the complainant and also examined the documents filed by him before this forum. We have not received any written submissions of the insurance company but it is seen from the repudiation letter of the insurance company dated 20.04.2010 that the claim was repudiated on the ground that the child was admitted in the hospital only for investigation purposes and initial diagnosis was Cholelithiasis. Subsequently as per USG report dated 30.03.2010, there was no evidence of gall bladder/CBD stone, nor any billary sludge. They have further stated that as per the exclusion clause no. 4.4.11 the claim was not entertainable.

After perusing the exclusion clause no. 4.4.11 and examining the details of investigation and treatment as mentioned in the discharge summary, it is clear that the child was not given any treatment for *Cholelithiasis* which was the primary final diagnosis of the doctor. Doctor carried out investigations for diagnosis of gall stone, but doctor's observation was not supported by the USG report taken subsequently 3 months after discharge of the patient. However, he was treated with antibiotics & IV fluid and other supporting management for the secondary diagnosis of hypovolumic shock condition. We are, therefore, of the opinion that the decision of the insurer to apply the exclusion clause no. 4.4.11 is correct so far as the treatment of *Cholelithiasis is concerned*. However, considering the fact that the child had other complications like vomiting severe pain in abdomen etc. which warranted his immediate admission in the hospital and for which treatment with antibiotics was done, we allow only an amount of Rs.10,000/- to cover the cost of such treatment out of the total claim. This in our opinion will meet the ends of justice. We therefore, direct the insurance company to pay Rs.10,000/- (Ten thousand only) to the complainant within 15 days from the date of receipt of the order along with the consent letter from the complainant.

Kolkata Ombudsman Centre

Case No. 103/14/003/NL/05/2010-11

Shri Satya Brata Gupta

Vs.

National Insurance Company Ltd.

Order Dated : 23.06.2011

Facts & Submissions :

This complaint is filed against delay in settlement of a claim under Individual Mediclaim Insurance Policy issued by National Insurance Company Ltd.

The complainant Shri Satya Brata Gupta in his complaint has stated that he was suffering from NSTEMI and was admitted at Calcutta Heart Clinic & Hospital, Kolkata on 03.07.2009 and subsequently transferred to AMRI Hospitals, Salt Lake, Kolkata on 04.07.2009 for urgent Coronary Angiography & Revascularisation where PTCA & stenting was done and he was discharged on 07.07.2009. As per discharge summary the diagnosis of the disease was '*PTCA & stenting done to LAD recent NSTEMI'.*

He lodged a claim for Rs.1, 69,019 on 19.08.2009 to the TPA of the insurance company M/s E-Meditek TPA Services Ltd. for reimbursement of hospital expenses. But after a lapse of considerable period of time he did not get any reply either from the TPA or from the insurance company. He represented to the insurance company on 12.02.2010 requesting them to settle his claim, but did not get any favourable reply from them Being aggrieved, he approached this forum for redressal of his grievance seeking monetary relief of Rs.1,37,841/- The complainant has given his unconditional and irrevocable consent for the Insurance Ombudsman to act as a mediator between himself and the insurance company and to give recommendation as per Form – P-III dated 16.07.2010. Subsequently, the complainant vide his letter dated 08.10.2010 has informed this forum that he had received a letter dated 27.07.2010 from the TPA of the insurance company along with a cheque dated 26.07.2010 for Rs.77,230/- with the advise to send them pre-receipted voucher for Rs.77,230/- towards full and final settlement of hospitalization claim. But he did not accept this settlement at Rs.77, 230/- because this is much less than the admissible amount.

DECISION:

After hearing both the parties, we find that the matter has not been correctly settled by the insurer and there are still certain points of difference which need to be looked into by them. The complainant is therefore advised to submit his calculation sheet to the insurance company and the insurer is directed to look into the complainant's calculation and correct the discrepancies including the cumulative bonus. They are further directed to complete this exercise and make the payment of any amount due as per revised calculation, within 15 days after receiving the calculation sheet and consent letter from the complainant.

Kolkata Ombudsman Centre
Case No. Shri Satya Brata Gupta

Shri Netai Chakraborty

Vs.

The New India Assurance Company Ltd.

Order Dated : 23.06.2011

Facts & Submissions :

This complaint is filed against repudiation of a claim under Mediclaim Policy (2007) issued by The New India Assurance Company Limited.

The complainant Shri Netai Chakraborty in his complaint has stated that he was suffering from BRVO with macular edema of left eye and was admitted at Implant's Better Sight Centre Pvt. Ltd., Kolkata on 10.09.2009 under Dr. Somen Ghosh where he underwent an operation of "Intravitreal of Avastin" on the same day and was discharged on 11.09.2009.

He lodged a claim on 09.11.2009 for Rs.13,052/- to the TPA of the insurance company M/s Heritage Health TPA Pvt. Ltd., for reimbursement of hospital expenses. TPA vide their letter dated 09.12.2009 repudiated the claim stating that *"as per discharge certificate the patient was operated for "Intravitreal of Avastin" but this treatment is not covered under Health Policy and the claim is non-admissible".* He represented to the insurance company on 06.04.2010 against repudiation decision and requested them to consider his claim sympathetically. His appeal was not considered by them. Being aggrieved, the complainant approached this forum for redressal of his grievance seeking monetary relief of Rs.13,052/-.

The insurance company in their written submission dated 24.03.2011 stated that the insured lodged a claim to their TPA for the treatment of 'Intravitreal Avastin' and this claim was turned down by the TPA due to their internal circular no. HO/Health/Circular/04/09/IBD Admin/14 dated 09.02.2009. They further stated that for treatment of ARMD, the drugs such as avastin are given as injection, which is an OPD treatment and therefore it was excluded vide their above circular. They are issuing policy documents after duly endorsing this exclusion by affixing rubber stamp in all cases to inform the insured that in the event of such treatment the claim was not entertainable. In this case also they think that they have rightly enclosed the policy conditions and therefore the company has no liability in this case. They have further stated that if there is

any slip in affixing such stamp that should be treated as a mistake and should not be construed as admission of such types of claims.

DECISION:

We have heard the submissions of both the parties and perused the policy documents and other evidences filed before this forum. It is seen that the policy document issued to the complainant did not bear a stamp regarding exclusion of Avastin drugs from the coverage of the policy**.** However, we agree with the insurer's comments that any slip in affixing such stamp should be treated as a mistake and should not be construed as admission of such types of claim. Since the policy for the period 09.07.2009 to 08.07.2010 is subsequent to the issue of the Insurer's circular excluding the drugs from the policy coverage, we are of the opinion that the action taken by the insurer is in accordance with the prescribed terms and conditions of the policy. However, total repudiation is not fair to the complainant. After careful evaluation of all the facts and circumstances of the case we allow an ex-gratia payment of Rs.3,000/- to the insured for the service lapse on the part of the insurer. We direct the insurance company to pay Rs.3,000/- (three thousand) only as ex-gratia payment to the complainant within 15 days from the date of receipt of the consent letter from the complainant by the insurance company.

Kolkata Ombudsman Centre
Case No. 110/14/004/NL/05/2010-11

Shri Sukumar Majumdar

Vs.

United India Insurance Company Ltd **Ltd.**

Order Dated : 20.06.2011

Facts & Submissions :

This complaint is filed against delay in settlement of claim under Individual Health Insurance Policy issued by United India Insurance Company Ltd.

The complainant Shri Sukumar Majumdar in his complaint has stated that his wife Smt. Swapna Majumdar was suffering from fibroid uterus and as per advice of Dr. Dibyendu Banerjee she was admitted at North Point Nursing Home Pvt. Ltd., Kolkata on 08.04.2009 where she underwent 'Total Abdominal Hysterectomy with B.S.O' on 09.4.2009 and was discharged on 12.04.2009. As per discharge summary the diagnosis of the disease was '*Fibroid Uterus'*.

He lodged a claim on 20.04.2009 to the insurance company for reimbursement of hospital expenses. But after a lapse of several months, he wrote to the insurer on 12.10.2009, requesting them for early payment of the said claim. However, till date he did not get any reply from them. Being aggrieved, he approached this forum for redressal of his grievance seeking monetary relief of Rs.22.580/-.

The insurance company in their written submission dated 23.03.2011 stated that the insured was supposed to be admitted to Charnock Hospital and Research Centre Pvt. Ltd. and their TPA had approved an amount of Rs.10, 000/- for the treatment. However, they were intimated that the insured was not admitted in Charnock Hospital and Research Centre Pvt. Ltd. but in North Point Nursing Home Pvt. Ltd. on 08.04.2009. The claim forms were submitted to their office. They contacted the TPA and came to know that no claim documents were submitted to them after the cashless was approved and they have not received any further communication from the insured. They further stated that due to repair work in their office and change in officials they were unable to locate the file and requested the insured to submit a copy of the documents once again and he has agreed to submit the same.

DECISION:

Since the representative of the insurance company did not attend the hearing, we propose to deal with the matter on ex-parte basis for them.

We have heard the submissions of the complainant and also examined the documents filed by him before this forum. We could not verify the position of the insurer in this regard. It is clear from their written submission that all the papers submitted by the complainant are lost and they have requested the insured to submit the documents once again and assured him that the matter would be looked into accordingly. The complainant is also ready to cooperate in this regard. He was accordingly advised by us, to submit the copies of all the documents to the insurer. Since the original documents are lost by the insurance company, the insurer will settle the claim on the basis of the photo copies of the documents to be submitted by the complainants. The insurer is directed to settle and pay the claim as per terms and conditions of the policy within 15 days from the date of receipt of the documents and consent letter from the complainant.

Kolkata Ombudsman Centre

Case No. 119/14/009/NL/06/2010-11

Shri Mohan Kumar Dey

Vs.

Reliance General Insurance Company Ltd.

Order Dated : 27.06.2011

Facts & Submissions :

This complaint is filed against delay in settlement of claim under Reliance Healthwise Policy issued by Reliance General Insurance Company Ltd.

The complainant Shri Mohan Kumar Dey in his complaint has stated that his daughter Miss Sibani Dey was suffering from swelling pain in lower jaw for last 1 ½ years. She was admitted at Life Line Diagnostic Centre cum Nursing Home, Kolkata on 09.01.2009 where she underwent an operation and was discharged on 11.01.2009. As per discharge summary the diagnosis of the disease was *'Swelling Lower Jaw (Left Mandible)'*.

He lodged a claim on 23.03.2009 to the TPA of the insurance company M/s Medi Assist for reimbursement of the hospital expenses. After that the TPA vide their letter dated 29.04.2009 which was received by him on 03.06.2009 requested him to submit some documents which was complied with on 11.06.2009. After a lapse of considerable period of time his claim was not settled by the insurance company. He represented to the insurance company on 16.11.2009 stating that on enquiry with the TPA he came to know that they have closed the file on 15.05.2009 due to non-receipt of his reply to their letter dated 29.04.2009 in time. He has already clarified them vide his letter dated 29.07.2009 that the said letter dated 29.04.2009 was received by him through ordinary post on 03.06.2009 and subsequently he deposited all the required documents on 11.06.2009 with a request to re-open his file and settle his claim. Delay by the postal department was not his fault. Being aggrieved, he approached this forum for redressal of his grievance, seeking monetary relief of Rs.16, 994/-.

We wrote to the insurance company to send the self-contained note along with their consent for the Insurance Ombudsman to act as a mediator between the parties on 18.06.2010 & 28.03.2011 followed by a reminder dated 28.04.2011, but we did not receive any written submission from the insurance company so far.

DECISION:

Since both the parties did not attend the hearing, we propose to deal with the matter on ex-parte basis.

We find that the TPA has not settled the claim for non-submission of certain documents by the insured. Since the insured has already submitted the required documents on 11.06.2009, we direct the insurance company to re-open the file and settle the claim as per terms and conditions of the policy within 15 days from the date of receipt of this order along with consent letter from the complainant.

Kolkata Ombudsman Centre
Case No. 129/11/003/NL/06/2010-11

Smt. Amita Das

Vs.

National Insurance Company Ltd.

Order Dated : 27.06.2011

Facts & Submissions :

This complaint is filed against repudiation of claim under Individual Mediclaim Insurance Policy issued by National Insurance Company Ltd., on the ground of pre-existing disease as per exclusion clause no. 4.1 of the policy.

The complainant Smt. Amita Das in her complaint has stated that her son Shri Debasish was suffering from Aneamia and was admitted at Apex Institute of Medical Sciences, Kolkata on 10.06.2009 where he was treated conservatively and he discharged on 15.06.2009. As per discharge summary the diagnosis of the disease was 'Sigmoid Colon'.

She lodged a claim to the TPA of the insurance company M/s Heritage Health TPA Pvt. Ltd. for reimbursement of hospital expenses. *TPA vide their letter 30.11.2009 repudiated the claim stating that 'as per prescription of Dr. Sandip Kumar Bhattacharyya the patient has been suffering from sigmoid colon since six months which are pre-existing. Considering the inception of the policy (i.e., 01.12.2008) & severity of the disease, our medical doctor's opined the claim as non-admissible & it stands repudiated as per clause no. 4.1 of standard mediclaim policy'.* She represented to the insurance company on 29.04.2010 against repudiation and requested the insurance company to settle her claim. But her appeal was not considered by them. Being aggrieved, she approached this forum for redressal of her grievance seeking monetary relief of 35,000

The insurance company in their written submission dated 17.05.2011 has stated that the complainant's son Shri Debashis Das was hospitalized on 10.06.2009 and discharged on 15.06.2009 for the treatment of Sigmoid Colon at Apex Institute of Medical Sciences. Shri Das has submitted the claim to their TPA M/s Heritage Health TPA Pvt. Ltd on 08.07.2009 for Rs.31, 077/. The claim was repudiated on 30.11.2009 on the ground that as per prescription of Dr. Sandip Kumar Bhattacharyya, the patient has been suffering from Sigmoid Colon since six months which is pre-existing considering the inception of the policy i.e., 01.12.2008 and severity of the disease under clause no. 4.1 of standard mediclaim policy during the first year of the policy.

They further stated that the treating doctor, vide his certificate dated 05.08.2009 stated that the onset of the disease, should be within six months. Their TPA vide their letter dated 24.08.2009 requested Shri Das to submit the details of treatment undertaken as the patient had been suffering from the last six months. TPA vide their letter dated 31.08.2009, wrote to the claimant that due to non-submission of proper reply after several reminders, the claim stands close. Subsequently, the complainant vide letter dated 09.10.2009 has submitted a certificate of Dr. S.K. Bhattacharyya stating that the patient was first seen by him on 08.06.2009. He further stated that he never had nay documentation of anemia before. Thus, there was difference in the opinion of the same doctor in respect of the duration of disease.

DECISION:

We have heard the submissions of both the parties and examined the documents filed before this forum. The only basis for repudiation of the claim by the insurer is the observation of the treating doctor that the patient had been suffering from Sigmoid Colon since six months. However, no other document like prescriptions of the doctor for earlier treatment, medical examination reports etc. could be produced by the insurer to irrefutably prove the onset of the disease prior to the date of the policy. The doctor later on gave a certificate dated 05.08.2011 clarifying that it is difficult to predict the onset of the disease. However, it should be within 6 months period.

After careful evaluation of all the facts and circumstances of the case, we are of the opinion that the insurer has failed to establish the exact period of the onset of the disease. The treating doctor is also not sure about the exact onset of the disease. Therefore, giving benefit of doubt to the insured we come to the conclusion that it is a border line case and since no evidence was produced by the insurer to establish the pre-existence of the disease, we allow the claim of the insured. While setting aside the decision of the insurer, we direct them to admit the claim and make the payment as per terms and conditions of the policy within 15 days from the date of receipt of this order along with consent letter from the complainant.

Kolkata Ombudsman Centre
Case No. 155/11/002/NL/06/2010-11

Smt. Dipanjana Dutta

Vs.

The New India Assurance Company Ltd.

Order Dated : 27.06.2011

Facts & Submissions :

This complaint is filed against partial repudiation of a claim under Mediclaim Policy (2007) issued by The New India Assurance Company Limited.

The complainant Smt. Dipanjana Dutta in her complaint has stated that she was suffering from ovarian cyst and was admitted at Bhagirathi Neotia Woman & Child Care Centre, Kolkata on 17.03.2009 where Laparotomy plus Right Ovarian Cystectomy, Partial right salpingectomy plus left ovarian cystectomy plus adhesiolysis and appendectomy operation was done and she was discharged on 24.03.2009. As per discharge summary the diagnosis of the disease was *'Bilateral Ovarian Cyst'.*

She lodged a claim on 29.04.2009 for Rs.1, 10,068/- to the TPA of the insurance company M/s Medicare TPA Services (I) Pvt. Ltd. for reimbursement of hospital expenses. TPA vide their letter dated 22.06.2009 settled Rs.42, 174/- towards full and final settlement of the claim. She represented to the insurance company on 03.08.2009 against partial payment and requested the insurance company to review her claim for balance amount of Rs.45, 000/- on account of doctor's fees. The TPA of the insurance company vide their letter dated 11.09.2009 repudiated the claim for non submission of numbered money receipt from doctors. Being aggrieved, she approached this forum for redressal of her grievance seeking monetary relief of Rs.45, 000/-.

The insurance company in their written submission dated 05.10.2010 stated that the insured lodged a claim of Rs.1, 10,068/-. Out of which Rs.42, 174/- was paid to the insured. Rs.45, 000/- was deducted under clause 2.3 (note-2) of the mediclaim policy (2007), because doctors/surgeon/anesthetist bills were not in order.

They further stated that as per clause 2.3 (note-3) of the policy, bills raised by surgeon/anesthetist directly and not included in the hospitalization bill may be reimbursed upto a specified limit, provided the surgeon/anesthetist provides a numbered bill/receipt. In this case, the insured had submitted one money receipt for Rs.6,000/- dated NIL on the letterhead of Dr. D. Gupta, an un-numbered money receipt of Rs.3,000/- dated Nil of Dr. P. Bhattacharya and un-

numbered money receipts of Rs.20,000/- and Rs.16,000/- dated 15.05.2009 of Dr. Shankar Mitra and Dr. (Mrs.) Sakuntala Mitra respectively. Insured vide her letter dated 03.08.2009 has mentioned that Rs.45, 000/- in respect of surgeon/anesthetist fee were paid by cheque but nothing is mentioned to this effect in the money receipts. Therefore, considering the above stated clause 2.3 of the policy, the amount of Rs.45, 000/- was disallowed.

DECISION:

We have heard the submissions of both the parties and examined the documents submitted by them before this forum. We find that the insured has given full details of the payment made by cheques and has also filed supporting evidence like money receipt bearing registration number of the doctors and bank statement showing encashment of the cheques. Therefore, we are of the opinion that adequate proof of payment of the doctors' fees has been produced by the insured. The claim is absolutely genuine and the insurer is directed to admit the claim of Rs.45, 000/- (Forty five thousand) and pay the same as per terms and conditions of the policy within 15 days from the date of receipt of this order along with consent letter from the complainant.

Kolkata Ombudsman Centre
Case No. 169/11/005/NL/06/2010-11

Smt. Chandrika Bhattacharjee

Vs.

The Oriental Insurance Company Ltd..

Order Dated : 29.06.2011

Facts & Submissions :

This complaint is filed against repudiation of claim under Individual Mediclaim Insurance Policy issued by The Oriental Insurance Company Ltd. on the ground of pre-existing disease as per exclusion clause no. 4.1 of the policy.

The complainant Shri Basab Bhattacharjee in his complaint has stated that he was suffering from epigastric & umbilical hernia and was admitted at Belle Vue Clinic on 16.03.2010 where he underwent an operation on 17.03.2010 and he was discharged from the nursing home on 20.03.2010.

He lodged a claim on 12.04.2010 for Rs.1, 22,715/- to the TPA of the insurance company M/s Medicare TPA Services (I) Pvt. Ltd. for reimbursement of hospital expenses. TPA vide their

letter dated 03.06.2010 repudiated the claim stating that '*policy is less than 4 years. The member underwent CABG in 2002. Currently admitted for repair of epigastric hernia related to the CABG Scar. The claim is repudiated under clause 4.1'.* He represented to the insurance company on 09.06.2010 stating that he had discussed with eminent doctors and they have clearly opined that the disease/ injury were not at all pre-existing and requested them to review his case. He did not get any favourable reply from the insurance company. Being aggrieved, he approached this forum for redressal of his grievance seeking monetary relief of Rs.1, 22,715/- plus interest.

The insurance company in their written submission dated 20.08.2010 stated that premium due for Shri Basab Bhattacharjee was Rs.20, 436/- for renewal on or before 24.03.2007. Premium cheque for Rs.20, 347/- was received on 23.03.2007 and while scrutinizing it was found that premium was short by Rs.89/- and their department could not underwrite the business through computer system. The matter was communicated to the complainant. Later cheque for Rs.89/- was received by their department on 27.03.2007 and then the department could underwrite the business. Section 64 VB of insurance act states that the full premium payable under any policy shall be paid in advance to get any insurance cover. In the instant case without having the full premium their department was not in a position to comply with this act. There was a break of 3 days due to which the policy was treated as a fresh one effective from 27.03.2007. Accordingly, all the conditions applicable to a fresh policy was attracted and the claim was repudiated under exclusion clause no. 4.1 of the policy. They have further pointed out that earlier also he had lost similar continuity in the policy in the year 200-2001 by 5 days and 2003-2004 by 2 days.

DECISION:

We have heard the submissions of both the parties and examined the documents filed before this forum. It is seen that renewal premium of an amount of Rs.20,436/- for the year 2007-2008 was paid on time on 23.03.2007 and only a fragment amount of Rs.89/- towards service tax remained due. This amount was also paid by the insured on 27.03.2007 as 24.03.2007 and 25.03.2007 were Saturday and Sunday, due to which he could not ascertain the exact amount of service tax to be paid to the insurance company. Moreover, the amount remaining to be paid was the service tax which is a Central Government levy and not a part of the premium. Since the premium amount was paid in full on due date, there is no justification in treating it as a new policy due to a break of 3 days and thereby denying the benefit of the continuity of the policy. There is nothing to suggest that the insured had intentionally delayed the payment of the service tax. It is also seen that Sr. Divisional Manager of the Insurance Company has the power to condone the delay in payment of premiums by 7 to 15 days. Under the circumstance, the decision of the insurer for not condoning the delay of 3 days for late payment of the service tax appears to be very harsh and cannot be justified in the facts and circumstances of the case. The decision of the insurer is set aside and delay of 3 days is hereby condoned. The insurer is directed to admit the claim and

make the payment as per terms and conditions of the policy within 15 days from the date of receipt of this order along with consent letter from the legal heir of the complainant.

Kolkata Ombudsman Centre
Case No. 174/11/003/NL/07/2010-11

Shri Chand Kumar Khara

Vs.

National Insurance Company Ltd.

Order Dated : 23.06.2011

Facts & Submissions :

This complaint is filed against repudiation of a claim under Individual Mediclaim Insurance Policy issued by National Insurance Company Ltd. as per exclusion clause no. 4.10 of the policy.

The complainant Shri Chand Kuamr Khara in his complaint has stated that he was suffering from snoring & weakness at daytime, extensive sleeping causing seizure like symptoms and was admitted at Peerless Hospital & B.K. Roy Research Centre on 02.01.20010 where he was suggested CPAP machine with 12 cm of H20 for overnight use and he was discharged on 03.01.2010. As per discharge summary the diagnosis of the disease was '*obstructive sleep apnoea causing seizure like symptoms'.*

He lodged a claim for Rs.43,241/- on 22.03.2010 to the insurance company for reimbursement of hospital expenses. The TPA of the insurance company M/s Heritage Health TPA Pvt. Ltd. vide their letter dated 25.02.2010 repudiated the claim stating that 'as per document of Peerless Hospital & B.K. Roy Research Centre dated 03.01.2010 the patient got admitted only for investigation not followed by active treatment in hospital, which is non-admissible as per clause no. 4.10 of standard mediclaim policy. He represented to the insurance company on 22.03.2010 requesting them to settle his claim but did not get any favourable reply from them. Being aggrieved, he approached this forum for redressal of his grievance seeking monetary relief of Rs.43,241/-.

The insurance company in their written submissions dated 26.05.2011 stated that the insured claimed the amount of Rs.43,241/-., but he was admitted in the hospital mainly for the purpose of medical investigation not followed by any active treatment. Therefore, expenses for such purpose is non-admissible as per their policy condition no. 4.10.

DECISION:

We have heard the submissions of both the parties and examined the documents filed by them. The grounds of repudiation has been clearly explained by the representative of the insurance company. It is seen that use of CPAP machine for diagnosis or treatment purpose is clearly excluded under exclusion clause no. 4.16 of the mediclaim policy. However, considering, the advance age of the insured we are of the opinion that admission into the hospital for doctor's direct supervision for use of this machine for the first time was necessary and considering his financial problems we allow an ex-gratia payment of Rs.5,000/- which will meet the ends of justice. We therefore direct the insurance company to pay the above ex-gratia payment of Rs.5,000/- (Rupees five thousand) only to the complainant within 15 days from the date of receipt of the consent letter from the complainant.

Kolkata Ombudsman Centre
Case No. 091/11/004/NL/05/2010-11

Shri Arun Kumar Kesh

Vs.

United India Insurance Company Ltd.

Order Dated : 13.07.2011

Facts & Submissions :

This complaint is filed against partial repudiation of claim under Individual Health Insurance Policy issued by United India Insurance Company Ltd.

The complainant Shri Arun Kumar Kesh in his complaint has stated that his wife Smt. Mausumi Kesh was suffering from pain in lower abdomen for last 6 months and was admitted at Apollo Gleneagles Hospitals, Kolkata on 27.07.2009 where she underwent total abdominal hysterectomy with bilateral salpingo-oopherectomy with adhesiolysis and enterolysis done on 29.07.2009 and she was discharged on 02.08.2009. As per discharge summary the surgery was for '*Total abdominal hysterectomy with bilateral salpingo-oopherectomy with adhesiolysis done in a case of endometriosis'.*

At the time of hospitalization, TPA of the insurance company M/s Heritage Health Services Pvt. Ltd. sanctioned Rs.40, 000/- on cashless basis. He lodged a claim for balance amount of Rs.66,416.74 (Rs.1, 06,416.74 – Rs.40,000/-) to the TPA of the insurance company for reimbursement. TPA vide their letter dated 06.11.2009 settled Rs.7, 678/-. He represented to the insurance company on 18.02.2010 stating that he is not satisfied with the above settlement and requested them for review of his claim. He did not get any favourable reply from the insurance company. Being aggrieved, he approached this forum for redressal of his grievance seeking monetary relief of Rs.66,416.74. The complainant has given his unconditional and irrevocable consent for the Insurance Ombudsman to act as a mediator between himself and the insurance company and to give recommendation as per Form – P-III dated 28.06.2010.

The insurance company in their written submission dated 20.07.2010 stated that the insured lodged a claim for total abdominal hysterectomy with bilateral salpingo oopherectomy with adhesiolysis in a case of endometriosis. The claim was processed by their TPA and initially Rs.40,000/- was paid directly to the hospital as cashless facility. On submission of further bills of Rs.66,416/-, the TPA paid Rs.7,678/-, totaling the settled amount at Rs.47,678/-. Explaining the reason for partial payment, Insurer has mentioned that as per policy condition no. 1.2, expenses for specified illness, point 'c' the limit for the said disease (hysterectomy) is 20% of the sum insured subject to a maximum of Rs.50,000/-. They further stated that their TPA has correctly settled the claim.

DECISION:

Since the complainant did not attend the hearing and did not ask for adjournment, we propose to deal with the matter on ex-parte basis for him.

We have heard the submissions of both the parties and perused the written submissions of the complainant. In this case, we find that there is a difference of opinion between the treating doctor and the panel doctor of the TPA. As per the discharge summary, the surgical procedure performed was 'TAH with BSO with adhesiolysis in a case of endometriosis'. According to the opinion of TPA's panel doctor (Dr. Soven Ghosh), adhesiolysis is needed to be done to complete hysterectomy and it is a part and parcel of hysterectomy. In some cases of hysterectomy, BSO is done, in some cases it is not done, both the case is hysterectomy. However, according to the opinion of the treating Dr. Arnab Basak, the subject operation was not only mere hysterectomy but it is inclusive of some other operation side by side which was considered necessary at the material time to save the patient. The term hysterectomy as per Butterworth's medical dictionary meant removal of the whole or body of the uterus. In the instant case, as per discharge summary of the hospital; surgery was done for 'total abdominal hysterectomy with Bilateral Salpingo-Oophorectomy with Adesiolysis done in a case of endometriosis. The actual cause of the disease is endometriosis for which surgical procedure was done for removal of multiple organs, not only of uterus but also of Ovaries, fallopian tubes and other small organs not related or attached with uterus. Here the application is different from simply removal of uterus. As such it can be seen that it is not only removal of uterus which means hysterectomy but other organs also which cannot be brought under the ambit of hysterectomy as the main cause is endometriosis and not usually fibroid uterus. Therefore it is found that clarification of Dr. Soven Ghosh specialist doctor of the insurer is biased as he has overlooked the main cause 'endometriosis'. Rather the certificate given by the treating doctor is more justified.

The problem that now lies is how to bifurcate total medical expenses of removal of uterus i.e., hysterectomy, oopherectomy and other surgical procedures. Accordingly it will be befitting if an ex-gratia amount of Rs.15,000/- over and above the amount already settled is allowed to meet the ends of justice. We therefore direct the insurance company to pay Rs.15,000/- (Fifteen thousand) only.

Kolkata Ombudsman Centre

Case No. 120/11/003/NL/06/2010-11

Shri Ajit Kumar Ghosh

Vs.

National Insurance Company Ltd.

Order Dated : 13.07.2011

Facts & Submissions :

This complaint is filed against partial settlement of a claim under Individual Mediclaim Insurance Policy issued by National Insurance Company Ltd.

The complainant Shri Ajit Kumar Ghosh in his complaint has stated that his daughter Miss Swati Ghosh was suffering from right ear discharge and giddiness and was admitted at KKR ENT Hospital and Research Institute, Chennai on 20.08.2007 where she underwent right modified radical mastiodectomy operation on 21.08.2007 and she was discharged on 25.08.2007. As per discharge summary the diagnosis of the disease was '*Right chronic suppurative otitis media with cholesteatoma with giddiness'.*

He lodged a claim for Rs.26,146.50 on 27.11.2007 to the TPA of the insurance company M/s Medsave Healthcare (TPA) Ltd. for reimbursement of hospital expenses. TPA vide their letter dated 17.09.2008 settled Rs.14,155/- towards full and final settlement of the claim. He represented to the insurance company on 24.09.2009 against such partial settlement and requested them for payment of his balance claim of Rs.11,991/- at the earliest. He did not get any favourable reply from them. Being aggrieved, he approached this forum for redressal of his grievance seeking monetary relief of Rs.11, 991/-.

We wrote to the insurance company to send the self-contained note along with their consent for the Insurance Ombudsman to act as a mediator between the parties on 18.06.2010 followed by a reminder dated 28.04.2011 but no explanation or self-contained note has been received from the insurance company so far.

DECISION:

Hon'ble Ombudsman did not find any infirmity in the fresh calculation submitted at the time of hearing. The amount disallowed in respect of room rent, doctor's advice and nursing charges have been in accordance with the limits laid down in the policy condition. The complainant was advised to refer to the respective policy conditions and reconcile the difference. Hence, he directed the Insurer to pay the balance amount as per their revised calculations within 15 days.

Kolkata Ombudsman Centre
Case No. 173/11/002/NL/06/2010-1111

Smt. Nivedita Kundu

Vs.

The New India Assurance Company Ltd.

Order Dated : 19.07.2011

Facts & Submissions :

This complaint is filed against partial repudiation of claim under Mediclaim Policy (2007) issued by the New India Assurance Company Ltd.

The complainant Smt. Nivedita Kundu in her complaint has stated that her daughter Miss Atreyee Kundu was involved a road traffic accident on 27.01.2010 and then she consulted Dr. Amal Bhattacharya, Orthopedic Surgeon on whose advise she was admitted at Mediview Nursing Home (P) Ltd. Kolkata on 28.01.2010 where she underwent right elbow fracture operation on 29.01.2010 and she was discharged on 01.02.2010.

She lodged a claim for Rs.40, 103/- to the TPA of the insurance company M/s Medicare TPA Services India (P) Ltd. for reimbursement of hospital expenses. TPA vide their letter dated 08.03.2010 settled Rs.28, 288/- towards full and final settlement of the claim. She represented to the insurance company on 31.03.2010 against partial payment and requested to pay balance amount of Rs.11, 815/-. But her representation did not yield any result. Being aggrieved, she approached this forum for redressal of her grievance seeking monetary relief of 11,815/-.

The insurer submitted their written submission vide their letter dated 08.07.2011 stated that the insured has not pressed for an amount of Rs.3, 816/- and the point at issue is the non payment of Rs.8,000/- towards doctor's fees. They have further clarified that insured made payment to two doctors amounting to Rs.18, 000/- which has been restricted to Rs.10,000/- as per clause no.2.0 Note 3 (b) of the policy condition.

DECISION:

We have heard the submissions of both the parties and examined the relevant policy rules. The ceiling prescribed in clause no. 2.0 Note 3 (b) is applicable in this case but in our opinion this to be applied separately for each doctor's bill. The complainant has submitted cash payment receipts from Dr. M. Pal Choudhury for Rs.3,000/- which is to be fully allowed being less than Rs.10,000/-. The second cash receipt is from Dr. A. Bhattacharya for Rs.15,000/- and Rs.800.00 (Rs.350.00 + Rs.450.00) which is to be restricted to Rs.10,000/- only. In result, the complainant gets a relief of Rs.3,000/- only. The insurer is directed to pay Rs,.3,000/- (three thousand) only

within 15 days from the date of receipt of this order along with consent letter from the complainant.

Kolkata Ombudsman Centre
Case No. 175/11/004/NL/07/2010-11

Shri Abhijit Basu

Vs.

United India Insurance Company Ltd.

Order Dated : 13.07.2011

Facts & Submissions :

This complaint is filed against repudiation of claim under Individual Health Insurance Policy issued by United India Insurance Company Ltd. under exclusion clause no. 4.7 of the policy.

The complainant Shri Abhijit Basu in his complaint has stated that his wife Smt. Nina Basu was suffering from impacted wisdom teeth and was admitted at Microlap Nursing Home, Kolkata on 29.01.2009 where she underwent surgical removal of impacted wisdom teeth and was discharged on 30.01.2009. He lodged a claim of Rs.35,093.65 to the insurance company on 19.02.2009 for reimbursement of hospital expenses. The insurance company vide their letter dated 28.05.2009 repudiated the claim stating that '*dental treatment only arising from trauma or accident is payable'. Therefore as per terms and conditions of the policy the claim is not admissible'.* He represented to the insurance company on 22.06.2009 stating that the exclusion clause 4.7 clearly states dental treatment or surgery of any kind is payable unless requiring hospitalization. There is no mention of accident and trauma in the exclusion clause. Therefore, all dental surgery requiring hospitalization cannot come within the ambit of the exclusion clause 4.7. He did not get any favourable reply from them.

DECISION:

The clause 4.7 clearly excluded only those dental treatments which do not require hospitalization. There is no condition in this clause that the treatment should be the outcome of some trauma or accidental injury. It is seen that in the instant case, hospitalization was required for 2 days. Therefore, the case was clearly outside the purview of the clause 4.7. As regards exclusion under condition no. 4.1, we do not find any justification in treating the condition as pre-existing simply based on a medical journal. It is not supported by any medical expert's opinion.

After careful evaluation of all the facts and circumstances of the case, Hon'ble Ombudsman opined that the decision of the insurer to apply exclusion clause no. 4.7 of the policy to repudiate

the claim is erroneous and the same is set aside. The claim is clearly admissible and the insurer is directed to settle the same as per other terms and conditions of the policy.

Kolkata Ombudsman Centre
Case No. 191/11/003/NL/07/2010-1

Shri Pawan Kumar Khandelia

Vs.

National Insurance Company Ltd.

Order Dated : 22.07.2011

Facts & Submissions :

This complaint is filed against repudiation of a claim under Individual Mediclaim Insurance Policy issued by National Insurance Company Ltd. as per exclusion clause no. 2.6 of the policy.

The complainant Shri Pawan Kumar Khandelia in his complaint has stated that his wife Smt. Shashi Khandelia was suffering from subretinal nevovascular membrane right eye and consulted Dr.Premlata Kapoor on 07.01.2009 & 10.05.2009 who advised administering of lucentis injection to help her prevent from early blindness. She was admitted in N.G. Medicare & Calcutta Infertility Clinic, Kolkata on 08.01.2009 where 1st dose of intravitreal injection of lucentis was given to the right eye and she was released on the same day. Again she was admitted in the same clinic on 11.05.2009 for the 2nd dose of lucentis and was released on the same day. As per discharge summary, the diagnosis of the disease was '*subretinal nevovascular membrane of right eye'*

He lodged a claim for Rs.1, 16,703/- on 11.07.2009 to the TPA of the insurance company M/s E-Meditek (TPA) Services Limited for reimbursement of hospital expenses. TPA vide their letter dated 23.10.2009 repudiated the claim under 2.6 of the policy. He represented to the insurance company on 04.06.2010 requesting them to settle his claim. He did not get any favourable reply from them. Being aggrieved, he approached this forum for redressal of his grievance seeking monetary relief of Rs.1,16,703/-.

The insurance company only forwarded the letter of their TPA dated 09.05.2011 which stated that the claim was excluded under exclusion clause no. 2.6 of the policy.

DECISION:

It had been observed that in the instant case, hospitalization was for less than 24 hours and treatment was done under local anesthesia. Thus, the claim was clearly excluded in view of clause no. 2.6 of the policy conditions and the standing administrative instructions pertaining to that period. Although, the administrative instructions relating to treatment of age related macular degeneration with injectible drugs have been relaxed subsequently vide their Circular No.

HO/HIM/Circular/2010-11/003 dated 20.10.2010, but the claim of the insured is prior to issue of this circular. Hence, the decision of the insurer was technically correct, but considering the fact that use of this injection was necessary to save the patient from blindness, Hon'ble Ombudsman allowed an ex-gratia amount of Rs.15,000/- which would meet the ends of justice.

Kolkata Ombudsman Centre
Case No. 195/11/003/NL/07/2010-11

Shri Dilip Kumar Das

Vs.

National Insurance Company Ltd.

Order Dated : 18.07.2011

Facts & Submissions :

This complaint was filed against repudiation of a claim under Individual Mediclaim Insurance Policy issued by National Insurance Company Ltd. on the ground of pre-existing disease as per exclusion clause no. 4.1 of the policy.

The complainant Shri Dilip Kumar Das stated that his wife Smt. Gopa Das was suffering from respiratory distress and was admitted at The Calcutta Medical Research Institute, Kolkata on 04.09.2009 where she was treated conservatively and was discharged on 10.09.2009. As per discharge summary the diagnosis of the disease was *'severe hypertension with acute left ventricular failure, cervical spondylosis, dyslipidemia, ischemic heart disease'.*

He lodged a claim for Rs.46,462/- on 26.10.2009 to the TPA of the insurance company M/s Heritage Health TPA Pvt. Ltd. for reimbursement of hospital expenses. TPA vide their letter dated 30.11.2009 repudiated the claim stating that '*as per prescription of Dr. Koushik Chakraborty dated 06.10.2009 the patient has been suffering from HTN since 5 years which are pre-existing. Considering the inception of the policy i.e., 08.03.2006 and severity of the disease their medical doctor's opined the claim as non-admissible and stands repudiated as per clause no. 4.1 of the standard mediclaim policy'*. He represented to the insurance company on 22.04.2010 against repudiation and requested them to settle his claim. His appeal was not considered by them. Being aggrieved, he approached this forum for redressal of his grievance seeking monetary relief of Rs.42,462/- with interest.

The insurance company stated that Smt. Gopa Das wife of Shri Dilip Kumar Das was hospitalized on 25.10.2009 for severe hypertension with acute left ventricular failure and lodged claim with their TPA for cashless hospitalization under the above policy. But the TPA did not authorize cashless hospitalization on the ground that it was pre-existing (hypertensive LVF for four years) under clause 4.1 of individual mediclaim policy. To support of their contentions TPA has referred to the following documents/ papers.

i) Pre-authorization form signed by the treating doctor stated that duration of HTN is for 4 years.
ii) The prescription of Dr. Kaushik Chakraborty dated 06.10.2009 shows that the duration of HTN was 5 years.
iii) Detailed case history taken by the attending doctor on admission revealed that HTN existed for 4 years.

However Dr. Kaushik Chakraborty had later denied the duration of HTN of 5 years by his letter dated 05.12.2009.

They further stated that on examination of the Echo Cardiography report, their panel doctor had opined that 'Echocardiography shows concentrate hypertrophy and pulmonary HTN. Both the complications do not appear in a patient of 4 months hypertensive. It takes 4-5 years to develop the above. So the duration of 4 years is correct as per Echo Report. On account of pre-existence of HTN claim for Hypertensive LVF is not admissible.

DECISION:

It was understood that the TPA had repudiated the claim stating that the insured had HTN for 5 years which they later on changed to 4 years based on the case history forum of CMRI, Kolkata. A copy of this case history form has been submitted to this forum by the insurer. It is also seen that the copy of the history sheet submitted by the insurer is totally illegible and we cannot read anything except "4 years". We requested the insurer to produce the original case history form / legible copy of the case history form, which could not filed by them.

Under the circumstances we are unable to accept the contention that the duration of the disease is 4 years. We have further noted that the discharge summary of the hospital does not certify anything about the duration of HTN. The chief complaint noted in the discharge summary is sudden onset of respiratory distress.

After careful evaluation of all the facts and circumstances of the case, Hon'ble Ombudsman opined that the insurer has not established their case with irrefutable evidence to show that the insured had a 4 years old history of HTN. Although the words '4 years' appear illegibly in the case history of CMRI, it is not a conclusive proof. The doctor's prescription dated 06.10.2009 was also silent about the duration of the ailment. Therefore, total repudiation of claim in this case

is not justified. Giving benefit of doubt to the insured, Hon'ble Ombudsman allowed an amount of 50% of the admissible claim to the complainant. Insurer is directed to pay the amount.

Kolkata Ombudsman Centre
Case No. 196/11/011/NL/07/2010-11

Shri Madan Singh

Vs.

Bajaj Allianz General Insurance Company Ltd.

Order Dated : 18.07.2011

Facts & Submissions :

This complaint was filed against repudiation of a claim under Hospital Cash Identification and Schedule issued by Bajaj Allianz General Insurance Company Ltd., on the ground that the disease was exclusion under the policy terms and conditions.

The complainant Shri Madan Singh in his complaint has stated that his son Master Atul Singh was suffering from viral fever from 01.01.2010 and he consulted Dr. Subhashish Roy in the OPD who advised bed rest and prescribed medicines. As the fever did not subside, doctor advised hospitalization and on 12.01.2010 he was admitted at South Eastern Railway Hospital, Kolkata where he was treated conservatively and discharged on 18.01.2010. As per discharge certificate the diagnosis of the disease was *'acute tonsilitis'*.

He lodged a claim to the insurance company for reimbursement of hospital expenses. Insurance company vide their letter dated 18.02.2010 repudiated the claim stating that the treatment for tonsils or sinuses are excluded during the first year of the policy. He represented to the insurance company on 27.02.2010 against repudiation stating that the primary reason for suffering and hospitalization was viral fever and not acute tonsillitis and viral fever is not an exclusion under the said policy. Acute tonsillitis is secondary reason of suffering which was diagnosed after hospitalization i.e., 12 days after initial suffering from viral fever and requested them to re-examine and settle his claim. His appeal was not considered by them. Being aggrieved, he approached this forum for redressal of his grievance seeking monetary relief of Rs.7,000/- along with interest.

The insurance company in their written submission dated 24.06.2011 stated that the claim was repudiated on the ground of exclusion clause no. C 7 as the disease was finally diagnosed as "Acute Tonsilitis". They have quoted the Exclusion clause C7 of the Hospital cash as under.

"Without prejudice to exclusion 1 above, the treatment of cataracts, benign prostatic hypertrophy, hysterectomy, menorrhagia, fibromyoma, D&C, endometriosis, hernia of all types, hydrocele, fistula, haemorrhoids, fissure in ano, stones in the urinary and billary systems, surgery on ears, tonsils of sinuses, skin and all internal tumors/cysts/nodules/polyps of any kind including breast lumps, gastric or duodenal ulcer, backache, prolapsed intervertebral disc during the first year of a series of daily hospital allowance'.

In view of the above, the claim was repudiated vide their letter dated 18.02.2010.

DECISION:

It was understood that at the time of hospitalization, the diagnosis of the doctor was viral fever but the final diagnosis at the time of discharge was acute tonsillitis. Thus the exact cause of the disease could not be established by either party.

After careful evaluation of all the facts and circumstances of the case, we are of the opinion that it is a mixed case of viral fever and acute tonsillitis and therefore total repudiation is not justified. Hon'ble Ombudsman , therefore, directed the insurance company to pay 50 % of the claimed admissible amount.

Kolkata Ombudsman Centre
Case No. 225/11/003/NL/07/2010-11

Shri Debabrata Chatterjee

Vs.

National Insurance Company Ltd.

Order Dated : 13.07.2011

Facts & Submissions :

This complaint was filed against repudiation of a claim under Individual Mediclaim Insurance Policy issued by National Insurance Company Ltd., as per exclusion clause no. 4.12 of the policy.

The complainant Shri Debabrata Chatterjee stated that his wife Smt. Mala Chatterjee was suffering from incisional hernia and was admitted at West Bank Hospital, Howrah on 26.04.2010 where she underwent an operation on 27.04.2010 and she was discharged on 05.05.2010. As per discharge summary the diagnosis of the disease was '*Strangulated Incisional Hernia'.*

He lodged a claim to the TPA of the insurance company M/s Genins India Ltd.for reimbursement of hospital expenses. The insurance company vide their letter dated 16.07.2010 repudiated the claim stating that '*this is a case of strangulated incisional hernia in a post caesarian scar, done for pregnancy, which is not covered in Mediclaim Policy. Hence the claim is not payable as per clause no. 4.12 of standard mediclaim policy'.*

The insurance company stated that the insured visited Dr. A. Dasgupta on 16.03.2010 where he stated in his prescription as 'Repair of Incisional Hernia – 1983 (Post C.S. Scar)' which meant that repair of hernia was done in 1983 for post C.S. Scar. Cashless facility of the insured was not sanctioned at that moment by the hospital authority as the disease was stated as 'recurrent incisional hernia'. A query was raised to the hospital in respect to the underlying incisional scar through which the recurrent hernia occurred. In answer to which Dr. A. Dasgupta gave explained in writing on 29.04.2010 that patient had incisional hernia in post Caesarean section scar. This was operated in 1983.They further stated that the prescription of Dr. A. Dasgupta dated 16.03.201o mentions all the operative interference in words and diagrammatically noting that a previous repair of incisional hernia (post C.S.Scar) was done and the clinical history mentions as recurrent incisional hernia – meaning that the hernia has been repaired once and has recurred again – if so be the case, then there is no documentary evidence regarding previous repair of hernia through the hysterectomy scar. The clinical documents in the file speaks of recurrent incisional hernia – post C.S. Scar but the discharge certificate and the changed certification dated 20.07.2010 of the same arising through a different scar does not have documented evidence in the file. Thus the contradictory opinion of the treating doctor, Dr. A.Dasgupta left them with no option but to close the file as per exclusion clause no. 4.12 of the Standard Mediclaim Policy.

DECISION:

It is seen that the insurer has repudiated the claim on the ground that the incisional hernia is the outcome of pregnancy and related matters which falls under the exclusion clause no. 4.12 of the policy condition. Their finding is based on the treating doctor's opinion given at different point of time. It is seen that the doctor had performed laparatomy, TAH and BSO on 26/07/2008 and observed 'Region of Incisional Hernia- 1983 (post C.S.Scar)'. Thereafter, the same doctor, at the time of performing hernia operation had diagnosed the problem as 'Recurrent incisional hernia abdomen + local inflammation' in the record sheet of the patient dated 26.04.2010. The doctor further clarified in his certificate dated 29/07/2010 that 'the patient had incisional hernia in post C.Section Scar which was operated in 1983. This hernia has now recurred and it is operated on 27/04/2011'. The complainant, on the other hand has relied on the the discharge summary dated 5/05/2010 wherein, doctor has noted that the patient had past history of laparatomy and hysterectomy on 26/07/2008 and incisional hernia has developed through the scar after this operation. Thus we find that the treating doctor has given contradictory statements on different occasions and the Insurer has not made any attempt to get his final opinion in this matter. After careful evaluation of all the facts and circumstances of the case, we are of the opinion that the history and diagnosis as recorded in the discharge summary of the West bank Hospital should be regarded as final. In the discharge summary, doctor has clearly mentioned that Incisional Hernia has developed through the previous operation scar of laparotomy and

hysterectomy done in 26.07.2008. This means that it is not the outcome of post caesarean section hernia operation done way back in 1983.

In view of the above, we conclude that the insurer has failed to prove conclusively that that the present position has arisen out of pregnancy and caesarean section in 1983. They have based their findings on the observations of the doctor given before the surgery and have totally ignored the final remarks of the doctor in the discharge summary. Thus their decision is erroneous being based on improper appreciation of facts. Hence, Hon'ble Ombudsman directed them to admit the claim and settle the same as per terms and conditions of the policy.

Kolkata Ombudsman Centre
Case No. 226/11/005/NL/07/2010-11

Shri Bijoy Kumar Mukherjee

Vs.

The Oriental Insurance Company Ltd.

Order Dated : 22.07.2011

Facts & Submissions :

This complaint was filed against repudiation of claim under Individual Mediclaim Insurance Policy issued by The Oriental Insurance Company Ltd. on the ground of pre-existing disease as per exclusion clause no. 4.1 of the policy.

The complainant Shri Bijoy Kumar Mukherjee in his complaint has stated that he was suffering from chest discomfort and was admitted at Belle Vue Clinic, Kolkata on 19.08.2009 where he was treated conservatively and was discharged on 21.08.2009. As per discharge summary the diagnosis of the disease was '*hypertension, diabetes mellitus, benign hypertrophy of prostate'.* Again he was admitted at B.M. Birla Heart Research Centre, Kolkata on 04.10.2009 where he underwent coronary angiography on 05.10.2009 and he was discharged on 06.10.2009. As per discharge summary the diagnosis of the disease was '*haemodynamically insignificant coronary artery disease, diabetes mellitus, hypertension'.*He lodged a claim to the TPA of the insurance company M/s Heritage Health TPA Pvt. Ltd. on 16.10.2009 for reimbursement of hospital expenses. TPA vide their letter dated 31.12.2009 repudiated the claim stating that *'as per discharge summary of B.M. Birla Heart Research Centre dated 06.10.2009 the patient has been suffering from i) coronary artery disease ii) diabetes mellitus iii) hypertension. As per past medical history of patient has been suffering from DM since 10 years and hypertension since 10 years which is pre-existing. Considering the inception of the policy i.e., 16.12.2008 and severity of the disease, their medical doctor's opined the claim as non-admissible and stands repudiated as per clause no. 4.1 of standard mediclaim policy'.*

The insurance company stated that Shri Bijoy Kumar Mukherjee had individual mediclaim policy from 21.10.1998 which was renewed every year continuously till 2007-2008. In the year 2008, the premium was paid by cheque on 27.10.2008 and policy was issued for the period from 27.10.2008 to 26.10.2009. Clearly there was a gap of six days. However, the premium cheque was dishonoured due to the reason that payee's name was not mentioned and finally the insured paid the premium by cash on 16.12.2009 and the policy no. 311300/48/2009/4899 was issued for the period 16.12.2008 to 15.12.2009. Thus, there was a gap of 56 days between expiry of continuous policy No. 311300/48/2008/3109 (expiry date 20.10.2008) and policy no. 311300/48/2009/4899 (inception date 16.12.2009). The insured was admitted at B.M.Birla Heart Research Centre on 04.10.2009 and discharged on 06.10.2009 for diabetes, hypertension and coronary artery disease. Their TPA took the date of inception to be 16.12.2008 and considering the severity of the disease rejected the claim under exclusion clause no. 4.1 of standard mediclaim policy.

DECISION:

The claim was repudiated as there was a gap of 62 days in the continuation of the policy. It is seen that the insured had an individual mediclaim policy from 21.10.1998 onwards which was renewed every year continuously till 2007-2008. In the year 2008 his renewal cheque was dishonoured due to some technical difficulty and ultimately after a gap of 56 days the policy it was renewed for the year 20080-2009. Under the circumstances the gap of 62 days has not been condoned by the insurer and therefore the insurer's decision to treat it as a new policy is technically correct. However, we find that there are lapses on the part of both the insured and the insurer in this regard. The insured has treated the matter very casually and issued a blank cheque without the name of the payee to his agent and did not care to find out from his bank whether the cheque was debited from his account or not. The insurer is also at fault in accepting the cheque without the payee's name and keeping it for 2 months before informing the insured. The first delay of 6 days would have been normally condoned by the competent authority. However, delay of further 56 days could have been avoided if the insurer did not accept the defective cheque and informed the insured in time. Since both the parties are at fault, total repudiation of the claim does not appear to be fair in this case.

After evaluation of all the facts and circumstances of the case, we allow an ex-gratia amount of Rs.15000/- to the complainant which will meet the ends of justice. We therefore direct the insurance company to pay the above ex-gratia amount of Rs.15000/-.

Kolkata Ombudsman Centre
Case No. 233/11/002/NL/07/2010-11

Smt. Neera Ajmani

Vs.

The New India Assurance Company Ltd.

Order Dated : 19.07.2011

Facts & Submissions :

This complaint was filed against partial repudiation of claim under Mediclaim Policy (2007) issued by the New India Assurance Company Ltd.

The complainant Smt. Neera Ajmani stated that her daughter Miss Neha Ajmani was detected having LUPS during 2003 and was hospitalized. Her claim was fully settled by the insurer and thereafter she was running normal life. As per terms and condition of mediclaim policy (2007) minimum sum insured should be Rs. 1 lakh and accordingly they had enhanced sum insured to Rs. 1 lakh from Rs.50,000/- and renewed the policy without any deletion/exclusion clause and accordingly she had been paying higher premium. Her daughter felt sick and she had to be admitted in CMRI on 06.08.2009. Unfortunately she could not recover and passed away on 23.08.2009 due to septicemia.

She lodged a claim for Rs.4 lakhs to the TPA of the insurance company M/s Medi Assist for reimbursement of hospital expenses. TPA vide their letter dated 13.11.2009 settled Rs.65,000/- towards full and final settlement of the claim. She represented to the insurance company on 20.11.2009 against partial payment and requested them to pay balance payment of Rs.52,500/- on the basis of sum insured Rs.1 lakh and cumulative bonus Rs.17,500/- . The TPA of the insurance company vide their letter dated 19.03.2010 informed the complainant that their previous decision for payment of Rs.65,000/- was in order. Being aggrieved, she approached this forum for redressal of her grievance seeking monetary relief of 52,500/-.

The insurance company stated that the claim under the policy was settled for Rs.50,000/- against the sum insured of Rs. 50,000/- plus Rs.15,000/- against the CB. The enhanced sum insured for Rs.50,000/- could not be taken into account for the purpose of settlement of the instant claim because the patient was suffering from 2003 (as per prescription of Dr. A Chatterjee) and sum insured was enhanced in 2008. As per their policy condition 6.0 "*if the policy is to be renewed for enhanced sum insured then the restriction as applicable to a fresh policy will apply to additional sum insured as if a separate policy has been issued for the difference. In other words, the enhanced sum insured will not be available for an illness, disease, injury already contracted under the preceding policy periods".*

DECISION:

It is seen that there is no dispute about the fact that the insured was a known case of LUPUS since 2003. There is, also, no dispute that the policy clause no. 6.0 will be applicable to the enhanced sum insured, if the prescribed waiting period of 4 years is not complete. The claim of the complainant pertains to the period 2009-2010 and the sum insured was enhanced by Rs. 50,000/- in 2008 to fulfill the new Mediclaim condition of minimum S.I. of Rs. 100,000/-. We

have seen from the Mediclaim Policy (2007) conditions that there are waiting periods prescribed for certain specified diseases in clause 4.3 but the ailment of the insured does not fall under any of the listed diseases. Therefore exclusion clause no. 4.3 cannot be applied in this case. As regards the general exclusion for pre-existing disease in clause 4.1 , we find that pre-existing ailment i.e. LUPUS was detected in 2003 and since then 5 years have elapsed before the sum insured was enhanced in 2008. Therefore the condition of 4 years waiting period is also satisfied in this case.

Thus in view of the above, we find that the claim of the complainant cannot be excluded either under 4.1 or 4.3. In other words, enhanced sum insured will be available for considering the present claim. The decision of the insurer in this respect is not valid and the same is set aside. The claim of the complainant was clearly admissible under the policy conditions and the insurer is directed to admit the claim and make the payment as per terms and conditions of the policy by the Hon'ble Ombudsman..

Kolkata Ombudsman Centre
Case No. 250/11/002/NL/08/2010-11

Shri Sujan Mukherjee

Vs.

The New India Assurance Company Ltd.

Order Dated : 19.07.2011

Facts & Submissions :

This complaint was filed against repudiation of a claim under Mediclaim Policy (2007) issued by the New India Assurance Company Ltd., as per exclusion no. 4.3 of the policy.

The complainant Shri Sujan Mukherjee stated that he was suffering from pain in left hip with stiffness and shortening of left lower limb past one year and was admitted at Apollo Gleneagles Hospitals, Kolkata on 16.07.2009 where left side total hip replacement done on 17.07.2009 and he was discharged on 21.07.2009. As per discharge summary the diagnosis of the disease was '*AVN left hip with gross destruction of head and acetabular changes'.*

At the time of hospitalization the TPA of the insurance company M/s Medi Assist sanctioned Rs.60, 000/- on cashless basis. Further he lodged a claim for the balance amount of Rs.40,000/- to the TPA of the insurance company M/s Medi Assist for reimbursement of above hospital expenses. TPA vide their letter dated 15.09.2009 repudiated the claim stating that '*as per the initial pre-authorization request, treating doctor has certified as the cause for present avascular necrosis of left hip is idiopathic. There was no history of fall or fracture in the past. Hence it is a degenerative condition where the insured has undergone total left hip replacement is having 4 years waiting period under the policy. Duration of the ailment mentioned in the pre-authorization request has been changed by the hospital in discharge summary. Change of*

duration of ailment also not acceptable. In view of the above, claim stands repudiated for the enhanced sum insured and cumulative bonus on it under policy exclusion no. 4.3. Hence, we regret our inability to admit this liability under the present policy conditions'. He represented to the insurance company against such repudiation and requested them to review and settle his claim for Rs.40,000/- considering the total sum insured of Rs.1 lakh. The TPA of the insurance company reviewed the claim and informed the complainant vide their letter dated 22.01.2010 that the claim remains inadmissible and their previous decision was in order.

The insurance company stated that the insured was covered under the policy with 20% CB on sum insured of Rs.50,000/- and CB of 5% on sum insured of Rs.50,000/-. The cashless claim was settled for Rs.60,000/- but the balance amount of Rs.40,000/- as claimed by the insured could not be settled as the disease was pre-existing. They have further stated that the treating doctor has certified that the cause of present avascular Necrosis of Left Hip is idiopathic. There was no history fall or facture in the past. Hence, it is degenerative condition and for which the insured has undergone total left hip replacement. The joint replacement due to degenerative condition is having 4 years waiting period under the policy. So, the balance amount of the claim could not be settled on sum insured of Rs.50,000/- with 5% CB. However, duration of the ailment mentioned in the pre-authorization request for cashless has been changed by the hospital in the discharge summary which was not at all acceptable by them.

DECISION:

It is seen that the insured was covered under the policy with CB 20% on sum insured of Rs.50,000/-. The sum insured of Rs.50,000/- was enhanced in the policy period 2008-09 and therefore as per clause no. 6.0 of the policy conditions, all the restrictions as applicable to a fresh policy will apply to the additional sum insured of Rs.50,000/- as if a separate policy has been issued for the difference. It is also seen that there is a waiting period of 4 years for joint replacement due to degenerative condition in case of fresh policy. In this case the final diagnosis as per discharge summary is 'AVN left hip with gross destruction of head and acetabular changes' and as per doctor's certificate dated 16.07.2009 the cause of acetabular neurosis - is idiopathic. According to Butterworth's medical dictionary the term 'idiopathy' means 'a morbid condition occurring without apparent external cause, a primary disease/ condition which is not secondary to any other disease". The TPA panel doctor has reached a conclusion that it is a degenerative condition since there was no history of fall or fracture in the past. They have clearly overlooked the fact that the cause of the disease is certified by the treating doctor as idiopathic meaning any pathological condition of unknown aetiology. The opinion of TPA's doctor is not acceptable to this forum for two reasons; first the doctor is not a specialist in this field and secondly he has not examined the patient. On the other hand, the treating surgeon has clearly certified that this is not a degenerative condition. As regards changes made in the duration of the disease, according to us, it is not very relevant to decide the merit of the case. Since the cause of the disease could not be conclusively established by the TPA's panel doctor and the treating

doctor has certified that it is not a degenerative condition, it clearly does not fall under exclusion clause no. 4.3 for which 4 years waiting period is necessary.

After careful evaluation of all the facts and circumstances of the case, we are of the opinion that the decision of the insurer is not correct and the same is set aside. The insurer was directed to admit the claim giving the benefit of enhanced sum insured of Rs.50, 000/-.

Kolkata Ombudsman Centre
Case No. 295/11/004/NL/08/2010-11

Shri Probir Kumar Banerjee

Vs.

United India Insurance Company Ltd.

Order Dated : 29.07.2011

Facts & Submissions :

This complaint was filed against partial repudiation of claim under Individual Health Insurance Policy issued by United India Insurance Company Ltd.

The complainant Shri Probir Kumar Banerjee in his complaint has stated that his wife Smt. Sumita Banerjee was admitted at Woodlands Medical Centre Ltd., Kolkata on 10.04.2009 where she underwent Total Abdominal Hysterectomy with Bilateral Salpingo Oophorectomy on 10.04.2009 and was discharged on 14.04.2009. As per discharge summary the final diagnosis of the disease was *'DUH – Menometrorrhagia – Multiple Cervical Mulcous Poly (Nabothian Follicies) Badly Eroded Cervix'.*

He lodged a claim on 05.05.2009 for Rs.73, 857.18 to the TPA of the insurance company M/s Heritage Health Services Pvt. Ltd. for reimbursement of the hospital expenses. TPA vide their letter dated 17.06.2009 settled Rs.23, 732/- towards full and final settlement of the claim. He represented to the insurance company on 10.07.2009 for review of his claim. Insurance company vide their letter dated 21.12.2009 informed the complainant that their previous decision was in order as per policy terms and conditions. Being aggrieved, he approached this forum for redressal of his grievance, seeking monetary relief of Rs.70,000.

The insurance company stated that their TPA M/s Heritage Health Services had rightly settled the claim for Rs.23732/- being 20% of individual sum insured for hospitalization claim plus 10% for pre and post hospitalization as per condition of gold policy. Capping has been imposed on specified disease i.e., cataract, hernia, hysterectomy etc. w.e.f. 09.07.2007 in gold policy and the restriction is clearly mentioned in the gold policy. As the same claim was preferred in 2nd year of the policy after the capping was imposed, the insured had accepted the policy after knowing the full facts of capping.

They further stated that the insured made an appeal for short payment of claim and after going through the detailed conditions of gold policy and the nature of disease they were also of the same opinion of their TPA and found no justification for reconsidering the case.

DECISION:

She underwent a hysterectomy surgery for which a maximum amount payable is restricted to 20% of the sum insured as per clause 1.2 of the policy. The sum insured in this case was Rs. 1 lakh on the basis of which the claim was settled at 20% + 10% towards pre and post hospitalization of Rs.3,732/- . However while settling the claim, the insurer overlooked the fact that the surgery undergone was not purely hysterectomy but there was added surgery for removal of fallopian tubes and ovaries which fall under non-hysterectomy surgery. The doctor has also certified that it was an emergency life saving procedure and not a simple hysterectomy.

The problem was how to bifurcate total medical expenses of removal of uterus i.e., hysterectomy, oopherectomy and other surgical procedures. Accordingly, it will be befitting if an ex-gratia amount of Rs.10,000/- over and above the amount already settled was allowed to meet the ends of justice. Hon'ble Ombudsman, therefore, directed the insurance company to pay Rs.10,000/- (Ten thousand) only.

Kolkata Ombudsman Centre
Case No. 330/11/008/NL/09/2010-11

Smt. Pampai Chatterjee

Vs.

Royal Sundaram General Insurance Company Ltd.,

Order Dated : 16.08.2011

Facts & Submissions :

This complaint was filed against repudiation of a claim under Hospital Cash Insurance Schedule issued by Royal Sundaram Alliance Insurance Company Ltd., on the ground of pre-existing disease as per exclusion clause no. 1 of the policy.

The complainant Shri Samir Kumar Chatterjee in his complaint has stated that his wife Smt. Pampai Chatterjee was suffering from post operative infection after hysterectomy and was admitted at SSKM Hospital, Kolkata on 24.11.2009 where she was treated conservatively and she was discharged on 14.12.2009.

He lodged a claim to the insurance company for reimbursement of hospital expenses. The insurance company vide their letter dated 14.06.2010 repudiated the claim stating that the insured admitted for post operative infection and the medical records reveal that the patient is a known case of myoma since 2006 and fibroid uterus since 2007, both are pre-existing diseases. The patient underwent hysterectomy for pre-existing ailment and present hospitalization is a complication of surgery done for pre-existing disease, which is outside the scope of the policy He represented to the insurance company on 26.05.2010 stating that due to diabetic disorder the wounds of the operation did not heal up properly and circumstances forced him to get her hospitalized again at SSKM Hospital and requested them to reconsider his claim and allow him to avail the full benefit of the Hospital Cash Insurance. He did not get any reply from them. Being aggrieved, he approached this forum for redressal of his grievance seeking monetary relief according to policy terms and conditions.

The insurance company in their written submission dated 09.012.2010 stated that the insured had taken a hospital cash insurance policy, which allows a cash benefit of Rs.2,000/- for every 24 hours of hospitalization. A claim was made under the policy by the complainant for expenses incurred for his wife Smt. Pampai Chatterjee for treatment of 'post operative infection after hysterectomy' for which the complainant's wife was admitted at SSKM Hospital, Kolkata from 24.11.2009 to 14.12.2009. On receipt of the claim they had investigated the claim, which revealed that the insured was suffering from Myoma since 2006 and fibroid since 2007. The present hospitalization was for post operative infection after hysterectomy and she had undergone hysterectomy on 21.10.2009 for fibroid and myoma. The claim was denied as all claim related to pre-existing conditions are inadmissible under the terms and conditions of the policy. Further USG done on 23.04.2009 revealed bulky uterus having internal myomas, which confirmed the fact that the complainant was suffering from pre-existing ailment of myoma and fibroid. This has also been categorically mentioned in the treating doctor's prescription. The insured underwent total abdominal hysterectomy at Belle Vue Clinic from 20.10.2009 to 27.10.2009 for which a sum of Rs.14, 000/- was paid to the complainant erroneously.

DECISION:

The complainant had taken a hospital cash insurance policy which allows a cash benefit of Rs.2,000/- for every 24 hours of hospitalization. It is seen from discharge summary that the operation was performed for secondary stitching for wound gapping following a hysterectomy operation. The investigation conducted by the insurer has revealed that the patient was suffering from myoma since 2006 and fibroid since 2007 for which she had undergone a hysterectomy operation on 21.10.2009. The present hospitalization was necessary for correcting the wound resulting from the surgical failure at the time of hysterectomy operation. The discharge summary does not speak of any complication resulting from hysterectomy. It says that due to improper stitching, the wound occurred at a gap and due to diabetic condition the same turned into a serious condition requiring further hospitalization for secondary stitching. Thus the primary cause for hospitalization was not any complication resulting from hysterectomy operation but a complication caused by improper stitching at the time of hysterectomy. We do

not find any close nexus between the hysterectomy and the present cause of hospitalization, therefore total denial of hospital benefit is not fair in this case.

After careful evaluation of all the facts and circumstances of the case we allow an ex-gratia payment of Rs.12,000/- which will meet the ends of justice. Hon'ble Ombudsman, therefore, directed the insurance company to pay the above ex-gratia payment of Rs.12,000/- (Rupees Twelve Thousand) only.

Kolkata Ombudsman Centre
Case No. 349/11/009/NL/09/2010-11

Shri Aloke Kumar Choudhary

Vs.

Reliance General Insurance Company Ltd

Order Dated : 18.08.2011

Facts & Submissions :

This complaint was against repudiation of a claim under Reliance Healthwise policy issued by Reliance General Insurance Company Ltd. on the ground of late submission of required documents.

The complainant Shri Aloke Kumar Choudhury stated that he was suffering from pain in abdomen, fever associated with nausea and vomiting and was admitted at Recovery Nursing Home (P) Ltd., Kolkata on 31.08.2009 and as per advice of the doctor he was shifted to Belle Vue Clinic on 02.09.2009 where he was treated conservatively and discharged on 07.09.2009. As per discharge summary the diagnosis of the disease was *'Severe Abdominal Pain like ? Intestinal Colic ? Intestinal Urticaria, Urinary Cristaluria'.*

At the time of hospitalization, the TPA of the insurance company M/s Medi Assist had refused to pay cashless facility. He lodged a claim on 20.11.2009 to the TPA for reimbursement of hospital expenses. TPA vide their letter dated 05.01.2010 requested him to furnish some more details for processing of the claim. On 18.01.2010 he submitted all the information and documents to them. TPA vide their letter dated 19.04.2010 repudiated the claim stating that they have not received the required documents in spite of several reminders and they presume that he is no more interested in pursuing the claim and they closed the claim as 'No Claim'. He represented to the TPA of the insurance company through e-mail on 05.05.2010 against such repudiation and requested them to review and settle his claim. But he did not get any favourable reply from them. Being aggrieved, he approached this forum for redressal of his grievance seeking monetary relief

of Rs.49, 356/-. The insurance company stated that due to non-submission of required document they had closed the claim as 'No Claim'.

DECISION:

It is seen that the claim is pending due to communication gap between the insurer and the insured. We find that there was a delay on the part of the complainant to submit the claim papers. But we also find considerable delay on the part of the insurance company in communicating their decision to the complainant about the repudiation of the claim. The representative of the insurance company also admitted that their communications were sent by ordinary posts.

After careful evaluation of all the facts and circumstances of the case we are of the opinion that the claim of the complainant is genuine. The delay in the submission has been explained by the insured but no decision has been taken by the insurer to condone the delay. We find that the insurer has taken a decision to reject the claim without considering the explanation given by the insured and they also did not coordinate with the insured properly. Under the circumstances, their action to close the case is not fair and valid. We have also noted that there is considerable delay on the part of the insurer in communicating their decision to the insured and they have sent letters through ordinary posts for which the complainant cannot be made to suffer. After considering all these aspects, we condone the delay for submission of the claim document and direct the insurance company to admit the claim and pay the same as per terms and conditions of the policy within 15 days from the date of receipt of this order along with consent letter from the complainant.

Kolkata Ombudsman Centre

Case No. 191/11/003/NL/07/2010-1

Shri Debasis Roy

Vs.

National Insurance Company Ltd.

Order Dated : 24.08.2011

Facts & Submissions :

This complaint is filed against repudiation of a claim under Mediclaim Policy (2007) issued by the New India Assurance Company Ltd. on the ground that the hospitalization for excision of mucous cyst was not justified.

The complainant Shri Debasis Roy stated that his wife Smt. Sudipa Roy was suffering from small cyst on the upper lip and subsequently as per the advice of the doctor she was admitted at Charring Cross Nursing Home (P) Ltd. on 28.05.2009 where she underwent an operation on the same day and was discharged on 29.05.2009. As per discharge summary the diagnosis of the disease was '*Mucous cyst. Excision done under LA'*.

He lodged a claim to the TPA of the insurance company M/s Medi Assist India TPA Pvt. Ltd., for Rs.6,498.90 in connection with hospital expenses for reimbursement. TPA vide their letter dated 22.07.2009 repudiated the claim stating that '*the claim is denied as the said procedure can be done on an OPD basis and hospitalization is not justified. Hence, we regret our inability to admit this liability under the present policy conditions'.* He represented to the insurance company against such repudiation on 30.09.2009 stating that the doctor is the best judge to decide about the operation, whether the operation would be in OPD or Day Care Centre. But he did not get any favourable reply from them.

The insurance company stated that the patient Smt. Sudipa Roy was admitted for surgical management of mucous cyst on upper lip under local anaesthesia. The said procedure can be done on OPD basis, hospitalization was not justified here, so the claim is denied.

DECISION:

The TPA of the insurer has repudiated the claim on the ground that the said treatment could have been done on OPD basis and hospitalization was not justified. However, we find that the admission in the nursing home for operation was specifically advised by the treating doctor vide his prescription dated 27.05.2009. We are, therefore, inclined to accept the complainant's submission that the treating doctor is the best judge of the situation and it is not possible for patient to refuse the advice of the doctor. In this case the patient was advised by her surgeon and she had no choice but to follow such advice.

After careful evaluation of all the facts and circumstances of the case, we are of the opinion that the decision of the insurer to repudiate the claim is erroneous and the same is set aside. Hon'ble Ombudsman directed to admit the claim and settle the same as per terms and conditions of the policy.

Kolkata Ombudsman Centre

Case No. 446/14/004/NL/10/2010-11

Shri Nirmal Kumar Ganguly

Vs.

United India Insurance Company Ltd.

Order Dated : 29.08.2011

Facts & Submissions :

This complaint is filed against delay in settlement of claim under Individual Health Insurance Policy issued by United India Insurance Company Ltd.

The complainant Shri Nirmal Kumar Ganguly stated that he was suffering from pain in neck region radiating to (L) shoulder and left arm with weakness of left upper limb for last one month and was admitted at AMRI Hospitals, Kolkata on 27.12.2008 where he underwent C7 corpectomy and fusion was done on 14.01.2009 and he was discharged on 03.02.2009. Thereafter he was again hospitalized on 04.12.2009 for removal of the implant. He was discharged on 16.12.2009 and as per the discharge summary the final diagnosis was 'follow up case of Renal Cell CA with C7 Corpectomy and fusion'.

He lodged a claim on 15.02.2010 to the TPA of the insurance company M/s MD India Healthcare Services (TPA) Pvt. Ltd., for reimbursement of hospital expenses. After lapse of more than four months his claim was not settled by them. He represented to the insurance company on 12.07.2010 requesting them to settle his claim sympathetically. His representation did not yield any result. Being aggrieved, he approached this forum for redressal of his grievance, seeking monetary relief of Rs.56,327/-.

The insurance company stated that Shri Nirmal Kumar Ganguly lodged a claim to their TPA, M/s MD India Healthcare Services (TPA) Pvt. Ltd for his hospitalization. They have taken opinion from their panel doctor according to whom the claim is not admissible as this is a case for removal of dislodged screw of implant of C-7 in a known pre-existing case of renal cell carcinoma. They further stated that the policy was incepted since 2002 whereas ailment is a complication of follow up case of renal cell CA with C7 corpectomy and fusion done in 2001. So, ailment was not only pre-existing but was also in the knowledge of the insured before inception of the policy. Hence the claim is not admissible under policy condition no. 4.1 of the policy.

DECISION:

It had seen that the insured was admitted at AMRI Hospitals, Kolkata on 04.12.2009 with history of pain in the neck region for one month. On investigation it was found that the pain resulted from displacement of an implant due to loosening of a screw. It is further seen that the implant was fixed on 14.01.2009 and not in 2001 as stated by the insurance company in their self-contained note. Even otherwise, it is clear from the policy condition no. 4.1 that the claim in respect of any pre-existing disease is admissible after expiry of 48 months of continuous coverage since inception of the policy with the company. In the present case the insured had taken the first policy in 2002 and therefore 48 months of continuous coverage is already over.

Under the circumstances we are of the opinion that the policy exclusion clause no. 4.1 is not applicable in this case. The claim of the insured is genuine and admissible under the policy conditions. The decision of the insurance company for repudiating the claim is set aside and they are directed by the Hon'ble Ombudsman to settle the claim as per terms and conditions of the policy within 15 days from the date of receipt of this order along with the consent letter from the complainant.

Kolkata Ombudsman Centre
Case No. 447/14/003/NL/10/2010-11

Shri Motilal Prasad

Vs.

National Insurance Company Ltd.

Order Dated : 14.09.2011

Facts & Submissions :

This complaint is filed against delay in settlement of a claim under Individual Mediclaim Insurance Policy issued by National Insurance Company Ltd.

The complainant Shri Motilal Prasad stated that his wife Smt. Lalmani Devi was admitted at Adarsh Netralaya and Centre of Cataract Surgery, Siwan, Bihar on 06.11.2009 where she underwent left eye cataract surgery by Dr. Sharad Choudhury on the same day and was discharged on 07.011.2009

He lodged a claim for Rs.5, 000/- to the TPA of the insurance company M/s Heritage Health TPA Pvt. Ltd. for reimbursement of hospital expenses. TPA vide their letter dated 21.11.2009 requested him to submit the original documents and the same was complied on 15.12.2009. Again TPA vide their letter dated 13.03.2010 informed the complainant to submit the documents viz. (i) biometry report, (ii) discharge summary in proper format (iii) original tax invoice of the lens used and sticker and (iv) hospital registration number on own letter head for settlement of the claim. He represented to the insurance company on 21.05.2010 stating that Siwan is a small town in Bihar and it is not possible to get the required documents. Moreover treatment expenses claimed are very low as compared to that of renowned hospitals of metro cities. He further stated that he is an ordinary house cook in Kolkata and this sum is lot for him and requested them for settlement of his claim on the basis of available documents. His appeal was not considered by them. Being aggrieved, the complainant approached this forum for redressal of his grievance seeking monetary relief of Rs.5,000/-.

The insurance company stated that the complainant's wife Smt. Lalmani Devi had undergone cataract surgery on 06.11.2009 at Adarsh Netralaya and Centre of Cataract Surgery at Siwan, Bihar and claimed reimbursement of Rs.5,000/- from their TPA,M/s Heritage Health TPA Pvt. Ltd. TPA vide their letter dated 13.03.2010 asked the following clarification and documents for disposal of the claim.

i) Original tax invoice of the lens used and sticker
ii) Original discharge summary
iii) Biometry report
iv) Hospital registration number on letter head.

DECISION:

It had seen that the policy has been continued without any break since 16.08.2004 and no claim was made prior to 2009. Initially the sum insured was Rs.15,000/- upto 15.07.2007 and it was enhanced to Rs.50,000/- from 16.08.2007. The TPA of the insurance company had rejected the claim on the plea that certain documents as required by their TPA have not been submitted by the insured. However, from the documents submitted to this forum we find that the insured has submitted all documents necessary for the settlement of the claim. The claim is for a paltry sum of Rs.5,000/- which is quite justified considering the place of the surgery. Repudiating the claim on grounds of non submission of papers is absolutely unjustified. The cost would have been much more if the insured had been admitted in a nursing home of repute. Since the discharge summary and the breakup of the doctor's charges and cost of the lens have been submitted to the TPA, the claim should be settled based on these documents. The claim was genuine and the insurer is directed to admit the claim and pay the same of Rs.5,000/- (five thousand) by the Hon'ble Ombdusman.

Kolkata Ombudsman Centre
Case No.454/11/009/NL/10/2010-11

Smt. Nivedita Da

Vs.

Reliance General Insurance Company Ltd.

Order Dated : 20.092011

Facts & Submissions :

This complaint is filed against repudiation of a claim under Group Reliance Healthwise policy issued to Emami Ltd. by Reliance General Insurance Company Ltd., on the ground of late submission of required documents as per exclusion clause no. 5.5 of the policy.

The complainant Smt. Nivedita Datta in her complaint has stated that her father Shri Arun Bikash Datta was admitted at AMRI Hospitals, Kolkata on 09.06.2009 due to sudden onset and loss of conscious where he was treated conservatively and he was discharged on 26.06.2009. As per discharge summary the diagnosis of the disease was '*Left Thalamic bleed. Hemiparesis'.*

She lodged a claim on 01.10.2009 to the TPA of the insurance company M/s Family Health Plan (TPA) Ltd. for reimbursement of hospital expenses. TPA vide their letter dated 12.04.2010 repudiated the claim stating that '*the claim submitted after completion of maximum time stipulated by the insurance company for mediclaim policy, the claim is repudiated due to delayed submission under clause 5.5'.* She represented to the insurance company on 12.04.2010 stating that her father was discharged on 26.06.2009 and he suddenly expired on 03.07.2009 and his death made her unwell for more than two months and therefore she was unable to submit her claim in time. But her representation did not yield any result.

DECISION:

Since the representative of the insurance company neither submitted their SCN nor attended the hearing, it was decided to deal with the matter on ex-parte basis. Considering the submissions of the complainant, Hon;ble Ombudsman opined that the action of the insurer in rejecting her claim for delay in submission of claim documents is very harsh and cannot be considered as justified. It is seen that she has made several representations of the insurance company but they did not care to reply. The complainant has explained the reasons for delay in submission of the papers, being the sudden death of her father which caused her considerable mental pain and she became unwell. In our opinion, the insurance company has rejected the claim based only on the policy terms and conditions without going through the merit of the case. The reasons given by the complainant for delay in submission were found to be satisfactory and reasonable. After considering all these aspects, she condoned the delay for submission of the claim documents and direct the insurance company to admit the claim and pay the same as per terms and conditions of the policy.

Kolkata Ombudsman Centre

Case No. 473/11/004/NL/11/2010-11

Smt. Sudeshna Gooptu

Vs.

United India Insurance Company Ltd.

Order Dated : 20.09.2011

Facts & Submissions :

This complaint was filed against repudiation of claim under Individual Health Insurance Policy issued by United India Insurance Company Ltd. on the ground that treatment of age related Macular degeneration with macugen injection fell outside the scope of the policy.

The complainant Smt. Sudeshna Gooptu stated that her husband Shri Amaresh Gooptu was admitted at Calcutta Medical Research Institute (CMRI) on 29.04.2010 where he underwent treatment for macular degeneration and was administered intravitreal injection 'Macugen' in both eyes and was released on 30.04.2010. The total expenditure during those two days hospitalization was Rs.1,07,250/-. At the time of hospitalization the TPA of the insurance company M/s Heritage Health Services Pvt. Ltd. denied cash less facility stating that as per circular of the insurance company dated 09.09.2009 the treatment for ARMD is an OPD procedure only and the same was not covered under mediclaim policy.

She represented to the insurance company on 27.04.2010 stating that since her policy was renewed on 03.05.2009 and the circular issued on 09.09.2009, the insurance company should settle all claims upto September 2009. She received a reply from the insurance company that expenses arising out of ARMD treatment with injection Macugen etc. are not covered within the scope of the policy.

The insurance company stated that Smt. Sudeshna Gooptu sought a cash less facility from their TPA M/s Heritage Health Services Pvt. Ltd. for treatment of her husband Shri Amaresh Gooptu who was admitted to Calcutta Medical Research Institute, Kolkata on 29.04.2010 to 30.04.2010. During the course of hospitalization Shri Gooptu was administered with 'Macugen' injection. The cashless was rejected by their TPA as per their Head Office Circular dated 09.09.2009. They further stated that Smt. Gooptu in her representation stated that insurance company had been entertaining and settling such claims upto September 2009 and her claim for reimbursement was denied as because the subject hospitalization took place after the issuance of the said circular. On the contrary to eliminate diverse interpretations and to put an end to the spate of references of such cases for clearance at Head Office level, their competent authority issued the said circular which is based on expert medical advice.

DECISION:

It was seen that the policy of the insured was renewed for the period from 03.05.2009 to 02.05.2010 and the circular no. HO: TPA:054 :09 dated 09.09.2009 issued by the insurer Head Office denying the benefit of mediclaim in cases of injection avastin/lucentis/macugen in operation theatre in the case of ARMD was not in existence at the time of the renewal of the said contract. However, the event took place on 29.04.2010 by which date the circular had come into existence. Therefore, although we find some merit in the contention of the complainant that his claim is to be settled on the basis of terms and conditions prevailing on the date of inception of the contract by both the parties (insurer and insured) but considering that the event took place

after the issue of the circular we also find equal merit in the contention of the insurer that the claim is technically not admissible as per their administrative circular. We have noted that the said circular was never communicated to the insured and therefore he was in total dark regarding admissibility of his claim. It is further seen that some other public sector insurance company like National Insurance Company Limited has already relaxed their conditions allowing this injection for mediclaim purpose. It is not understood how the present insurer being a public limited company, has not followed the example of National Insurance Company by relaxing its restrictive policy. The insured had stated that he was admitted into the hospital on specific recommendation of the treating doctor but he could not produce any doctor's recommendation in this respect. Therefore, the insurer's contentions that the treatment could have been taken on OPD basis also contained some merit. The insured had claimed an amount of Rs.1,07,250/- which was much higher than the normal claims in such cases. Therefore reasonableness of the claim had also to be considered.

After careful evaluation of all the facts and circumstances of the case, we are of the opinion that total repudiation of the claim in this case was not justified considering that the contract was renewed prior to the issue of the circular and the insurer's failure to intimate it to the insured. Therefore, Hon'ble Ombudsman allowed an ex-gratia payment of Rs.20,000/- which would meet the ends of justice and directed the insurance company to pay the above ex-gratia payment of Rs.20,000/- (Rupees twenty thousand) only.

Kolkata Ombudsman Centre

Case No. 525/14/002/NL/12/2010-11

Shri Manoj Kumar Paul

Vs.

The New India Assurance Company Ltd.

Order Dated : 30.09.2011

Facts & Submissions :

This complaint was filed against repudiation of claim under mediclaim policy (2007) issued by The New India Assurance Company Ltd.

The complainant Shri Manoj Kumar Paul stated that due to certain vision problem in the left eye he was under the treatment of Dr. Debasis Bairagi of CMRI, Kolkata who advised him 3 doses of intravitreal injection Avastin at one month interval. The first two doses were given on 16.10.2009 and 16.11.2009. He was admitted at Calcutta Medical Research Institute Kolkata on 30.03.2010. As per discharge certificate the diagnosis of the disease was 'CNVN'.

At the time of hospitalization cashless facility was denied by the TPA M/s Medicare TPA Services (I) Pvt. Ltd. He lodged a claim for 9,334/- on 14.04.2010 to the TPA of the insurance company for reimbursement of above expenses. TPA vide their letter dated 19.05.2010 repudiated the claim stating that *'treatment cost for injection avastin is not payable as per directive from the insurance company'. Hence the claim is repudiated.'* He represented to the insurance company on 26.07.2010 requesting them to settle his claim.

The insurance company stated that Shri Manoj Kumar Paul was admitted to CMRI on 30.03.2010 for Intravitreal Injection of Avastin. As per discharge summary the patient was given Avastin injection in the left eye. The complainant submitted a claim for Rs.9,334/- for intravitreal injection of avastin.

The claim was rejected as per their H.O. Circular No. HO/HEALTH/CIRCULAR/04/2009-IBD-ADMN:14 dated 09.02.2009 in regard to the coverage for treatment of age related macula Degeneration (ARMD) under mediclaim policy (2007) Janata Mediclaim Policy, Senior Citizen Mediclaim Policy, Group Mediclaim policy and all health covers which states as under:

"*For treating the ARMD, the drugs like avastin onr lucentis or macugen and other related drug is given as intravitreal injection. It is an OPD treatment through this injection is given in the operation theatre. In view of the nature of treatment, it falls outside the scope of out health policies. Hence the treatment of ARMD with administration of above referred drugs or any other drug is excluded from the scope of cover".*

DECISION:

The *contents of the Circular No. HO/HEALTH/CIRCULAR/04/2009-IBD-ADMN:14 dated 09.02.2009 issued by the insurer Head Office. It is seen that the policy was renewed for the period from 01.03.2009 to 28.02.2010 after the issue of the circular denying the benefit of mediclaim in case of treatment through Avastin in the operation theatre on the ground that it is an OPD treatment. Since the circular was already in existence at the time of the renewal of the contract, the decision of the insurer to repudiate the claim is technically correct. However, considering the fact that such treatment is now allowed by other public sector insurance company like National Insurance Company Limited and it is the only treatment available for treatment of ARMD (which if not arrested, leads to loss of vision) , the total repudiation of the claim does not appear to be fair and justified.*

After careful evaluation of all the facts and circumstances of the case, we allow an ex-gratia payment of Rs. 5,000/- to the insured, which will meet the ends of justice. Hon'ble Ombudsman directed the insurance company to pay the above ex-gratia payment of Rs.5,000/- (Rupees Five thousand only) to the complainant.

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Kolkata Ombudsman Centre
Case No. 527/11/003/NL/12/2010-111

Shri Pratap Chandra Guha

Vs.

National Insurance Company Ltd.

Order Dated : 30.09.2011

Facts & Submissions :

This complaintwas filed against repudiation of a claim under Individual Mediclaim Insurance Policy issued by National Insurance Company Ltd., as per exclusion clause no. 4.16 of the policy.

The complainant Shri Pratap Chandra Guha in his complaint has stated that he was suffering from respiratory disorder and was admitted at North City Hospital & Neuro Institute Pvt. Ltd., Kolkata on 04.01.2010 where he was treated conservatively and was discharged on 06.01.2010. As per discharge summary the diagnosis of the disease was '*Obstructive Sleep Apnoea'.*

He lodged a claim for Rs.14,327/- to the TPA of the insurance company M/s E-Meditek (TPA) Services Ltd. for reimbursement of hospital expenses. TPA vide their letter dated 05.03.2010 repudiated the claim stating that *'Diagnosis - obstructive sleep apnoea. Pot conservative management. Policy continues since 2002. Claim is not payable under clause no. 4.16 of the policy'.* He represented to the insurance company on 09.03.2010 against repudiation requesting them to settle his claim without any further delay. He did not get any favourable reply from them. Being aggrieved, he approached this forum for redressal of his grievance seeking monetary relief of Rs.14,327/- along with applicable bank interest.

The insurance company in their written submission dated 13.09.2011 stated that Shri Pratap Chandra Guha was admitted in North City Hospital & Neuro Institute Pvt. Ltd., Kolkata on 04.01.2010 with a complaint of respiratory disorder and was discharged on 06.01.2010 and the diagnosis of the disease was obstructive sleep aponoea as revealed from the discharge summary of the hospital. He lodged a claim to their TPA M/s E-Meditek (TPA) Services Ltd and the same was repudiated by them stating that the disease mentioned in the discharge summary obstructive sleep aponoea, IHDI is not payable as per policy condition no. 4.10 of the policy.

They further stated that in view of the above they have repudiated the claim on the basis of following grounds :

i) In the claim form, the insured did not reply to item no. 3 of the claim form by which the nature of disease contracted, could be justified.
ii) There was no advice of Dr. Chayan Roy for admission to hospital as per policy condition no. 5.3 as stated in the claim intimation letter dated 04.01.2011.
iii) There was no proof of any active treatment during hospitalization except some investigation.

DECISION:

It had been observed that the insurer had first repudiated the claim under clause no. 4.16, which pertains to use of external equipments. When the insured pointed out that no such equipment was used by him and the clause is not applicable in his case, the insurer reviewed the claim and finally repudiated it under policy condition no. 4.10, stating that hospitalization expenses were incurred primarily for evaluation and diagnostic purpose and no active treatment was done during hospitalization. However, we find from the discharge summary that the insured was admitted with respiratory disorder specially during sleep and was diagnosed as suffering from obstructive sleep apnea. He was given certain medicines which were necessary for relieving him from respiratory disorder. Therefore, it cannot be said that no active treatment was done during hospitalization. It is true that medicine charges are quite low as compared to the diagnostic charges, but considering that he had respiratory disorder for which immediate treatment was necessary, we are of the opinion that total repudiation of the claim is not justified.

After careful evaluation of all the facts and circumstances of the case, we allow an ex-gratia payment of Rs.5,000/- to the insured, which will meet the ends of justice. Hon'ble Ombudsman directed the insurance company to pay the above ex-gratia payment of Rs.5,000/- (Rupees five thousand only) to the complainant.

Kolkata Ombudsman Centre
Case No. 529/11/002/NL/12/2010-11

Shri Sitaram Goenka

Vs.

The New India Assurance Company Ltd

Order Dated : 28.09.2011

Facts & Submissions :

This complaint was filed against repudiation of a claim under Janata Mediclaim Policy issued by the New India Assurance Company Ltd. on the ground of pre-existing disease as per exclusion clause no. 4.1 of the policy.

The complainant Shri Sitaram Goenka in his complaint has stated that his wife Smt. Sarala Devi Goenka was suffering from Hyperacidity and Flatulence off and on for the last 4 years and was admitted at ILS Hospital, Kolkata on 27.09.2009 where she underwent Laparoscopic Cholecystectomy operation on 28.09.2009 and was discharged on 30.09.2009. As per discharge summary the final diagnosis of the disease was '*symptomatic gallstone DS + DM + HTN'.*

He lodged a claim to the TPA of the insurance company M/s Heritage Health TPA Pvt. Ltd. for reimbursement. TPA vide their letter dated 18.12.2009 repudiated the claim stating that '*as per discharge summary certificate the patient was operated for 'symptomatic gall stone DS +DM + HTN". Looking at the policy inception date of 24.11.2008, as per medical officers opinion, this disease is pre-existing therefore as per terms and conditions of the policy the claim is non-admissible'.*

The insurance company stated that Shri Sitaram Goenka lodged a claim on 23.11.2009 for the treatment of his wife Smt. Sarala Devi Goenka who was suffering from gallstone disease with Diabetes Mellitus, Hypertension and allied complications and operated on 28.09.2009 at ILS Hospital, Kolkata. From the discharge certificate of the said hospital they observed that the patient was admitted with complaint of hyperacidity and flatulence off and on – 4 years. The insured availed this particular treatment under 3rd year policy period. Therefore the claim has been found non-admissible as per condition no. 4.1 of Janata Mediclaim Policy, which excludes pre-existing disease for first four year of continuous coverage.

DECISION:

We find that the claim arose in the 3rd year of the policy and therefore the same is admissible as the waiting period for gall stone surgery is 2 (two) years under clause no. 4.1 and it was erroneously taken as 4 years by the insurer. Since the insurer had admitted the mistake and Hon'ble Ombudsman directed to settle the claim and pay the same as per terms and conditions of the policy.

Kolkata Ombudsman Centre

Case No. 549/11/003/NL/12/2010-11

Shri Rama Prasad Choudhury

Vs.

National Insurance Company Ltd.

Order Dated : 30.09.2011

Facts & Submissions :

This complaint was filed against repudiation of a claim under Individual Mediclaim Insurance Policy issued by National Insurance Company Ltd., as per exclusion clause no. 4.10 of the policy.

The complainant Shri Rama Prasad Choudhury stated that due to syncope attack 3 times over 3 days, he was admitted at Desun Hospital & Heart Institute, Kolkata on 26.01.2010, where he was referred to consultant psychiatrist and was treated conservatively and he was discharged on 03.02.2020. As per discharge summary the diagnosis of the disease was *'Hyponatremia – drug induced siady, WPW syndrome with syncope, acute depressive disorder, anaemia'.*

He lodged a claim for Rs.53,449.30 on 24.03.2010 to the insurance company for reimbursement of hospital expenses. The insurance company vide their letter dated 13.07.2010 repudiated the claim stating that *''the said hospitalization was for 'diagnosis' which is excluded under clause no. 4.10 of the policy. In view of the above we have no other way but to treat the claim as repudiated.'* He represented to the insurance company on 24.07.2010 against repudiation and requested them to review and settle his claim. Even on review, the insurance company vide their letter dated 25.08.2010 intimated the complainant that their previous decision of repudiation as per exclusion clause no. 4.10 of the policy was in order. Being aggrieved, he approached this forum for redressal of his grievance seeking monetary relief of Rs.53,449.80.

The insurance company in their written submission dated 13.09.2011 stated that on 12.02.2010 they got a claim intimation from Shri Rama Prasad Choudhury who was admitted at Desun Hospital, Kolkata on 26.01.2010 and discharged on 03.02.2010. At the time of giving the intimation, no doctor's advice was available. They received the entire claim file from Shri Choudhury on 24.06.2010 and they wrote to the insured for giving the doctor's certificate specifying the disease contracted, for which, hospitalization was required. The attending Dr. Bibek Brata Das, who attended the patient first, before hospitalization did not specify the disease contracted and therefore they referred the matter to their TPA for their opinion. On receipt of TPA's opinion, they confirmed that their views was correct as the hospitalization was primarily for evaluation/ diagnosis purpose which was not followed by active treatment during hospitalization as per clause no. 4.10 of the policy.

DECISION:

It had been observed that the insurer repudiated the claim on the ground that there is no specific recommendation of the treating doctor for the hospitalization of the insured. However, from the discharge summary we find that the insured was admitted with a history of syncope attack three times over three days and on admission his sodium, potassium and hemoglobin level were also

low. He was also referred to consultant psychiatrist and was treated for depression. The discharge summary, however, does not mention emergency or serious condition of the insured. Moreover, there is no advice of the treating doctor recommending hospitalization. It is also clear from the discharge summary that no active treatment was done by the doctors and the total bill for pharmacy was merely Rs.1,317/- as against Rs.18,565/- for investigation charges.

After careful evaluation of all the facts and circumstances of the case, we are of the opinion that the insured was admitted in the hospital primarily for investigation purpose, but he was also treated for associated problems, like low sodium, potassium and hemoglobin level. Considering the mixed types of problems, we allow an ex-gratia payment of Rs.5,000/- to the insured which will meet the ends of justice. Hon'ble Ombudsman directed the insurance company to pay the above ex-gratia payment of Rs.5,000/- (Rupees five thousand only) to the complainant within 15 days from the date of receipt of this order along with consent letter.

SYNOPSIS OF THIRD QUARTER STARTING FROM OCTOBER 2011 – DECEMBER 2011 PERTAINING TO AWARD/RECOMMENDATION/ORDER AGAINST NON-LIFE CASES PASSED BY HON'BLE OMBUDSMAN, KOLKATA

MEDICLAIM

Kolkata Ombudsman Centre
Case No. 481/11/011/NL/12/2009-10

Shri Tapas Banik

Vs.

Bajaj Allianz General Insurance Company Ltd.

Order Dated : 14.01.2011

Facts & Submissions :

This complaint was in respect of repudiation of claim under Individual Health Guard Policy issued by Bajaj Allianz General Insurance Company Ltd. on the ground of pre-existing disease as per exclusion clause no. 13A of the policy.

The complainant Shri Tapas Banik stated that complaint of swelling in left groin for 1 year and was admitted at ILS Multispeciality Clinic Kolkata on 05.11.2008 where he underwent Laparoscopic Left hernioplasty (TEP) on 06.11. 2008 and was released on 08.11.2008. As per discharge summary the diagnosis of the disease was 'Left Inguinal Hernia'.

He lodged a claim to the insurance company along with all relevant documents towards the expenditure incurred in connection with the above treatment for reimbursement. The insurance company vide their letter dated 04.12.2008 repudiated the claim stating that *'verification of the claim documents reveal that Mr. Tapas Banik was hospitalized for the treatment of left inguinal hernia. The claim stands repudiated under policy exclusion clause 13A as the illness existed prior to the inception of policy with Bajaj Allianz General Insurance Company Ltd. and the same is not disclosed on the proposal form'.* He represented to the insurance company on 08.07.2009 requested the insurance company to reconsider their decision as the disease was not existing at the time of commencement of the policy because he was insured with other insurance company since 2000.

The insurance company stated that the complainant was covered under Individual Health Guard policy for the period 15.06.2008 to 14.06.2009. The complainant has not disclosed the facts which are material to the policy issued to the insured. In the present case; the fact was that the complainant was suffering from the said disease and had also undergone some treatment which was never intimated to the insurers and thus the repudiation of the claim of the complainant was well within the right and the complaint needs to be dismissed in the light of the abovementioned facts. On 05.11.2008 the complainant was admitted in ILS Multispeciality clinic and was treated for Left Inguinal Hernia. The pre-authorization letter issued by the hospital at the time of admission clearly states that the duration of the ailment is for the past 1 year, i.e., prior to the risk inception period. The insurance company submits that the discharge summary further states a surgical history of Rt. Sided hernioplasty 6 years back however this medical condition was not declared in the proposal form. Insurer has further submitted that in the proposal form, the complainant gave deliberate wrong answers and did not disclose that he has been suffering from Left Inguinal Hernia prior to the risk inception period and the same was not disclosed in the proposal form and in view of the same the insurance company repudiated the claim, under clause D 13 A of the policy terms and conditions.

DECISION:

It revealed that the complainant was earlier covered by Group Mediclaim Policy with Iffco Tokio General Insurance Company Ltd. and changed over to Bajaj Allianz General Insurance Company Ltd. from the year 2008 onwards. The sum insured under the Bajaj Policy for the relevant period was Rs.50,000/-. It is seen that the complainant had a surgical history of right sided hernioplasty 6 years back as mentioned in the discharge summary. However this fact was not disclosed in the proposal form at the time of switching over to the new insurer. The complainant answered in the negative to the specific question, whether he has suffered from any diseases or undergone any surgery in the past. It is well settled that the contract of insurance is based on the principle of utmost good faith wherein the parties to the insurance contract must deal in good faith making full and true disclosure of all material fact in the proposal form. The facts that the insured had undergone surgery in the past and he did not disclose the same in the proposal form are not disputed. Hence, Hon'ble Ombudsman agreed with the insurer's decision of repudiation on the ground of suppression of material facts and it was upheld.

Kolkata Ombudsman Centre
Case No. 534/11/005/NL/12/2010-11

Smt. Dipali Bhattacharya

Vs.

The Oriental Insurance Company Ltd.,

Order Dated : 20.10.2011

Facts & Submissions :

This complaint was filed against partial repudiation of claim under Group Mediclaim Policy issued by the Oriental Insurance company Ltd. to Calcutta University covering the family members of employees and pensioners on floater basis.

The complainant Smt. Dipali Bhattacharya stated that her husband Shri Santirup Bhattacharya was suffering from chronic appendicitis and he was an OPD patient of N.R.S. Medical College and Hospital. As per advice of the outdoor doctor of the said hospital he was admitted at N.R.S. Medical College and Hospital on 19.05.2009 where he underwent appendectomy operation on 25.05.2009 and was discharged on 09.06.2009. As per discharge summary the diagnosis of the disease was '*chronic appendicitis with myelodysplastic syndrome'.* Subsequently her husband expired.

She lodged a claim for Rs.68,918/- on 06.07.2009 to the TPA of the insurance company M/s Paramount Health Services (TPA) Pvt. Ltd. for reimbursement of hospital expenses. TPA had settled Rs.18,667/- towards full and final settlement of the claim. She represented to the insurance company on 28.01.2010 against partial settlement and requested them to settle her balance claim. But her appeal was not considered by them.

The insurance company stated that a Group Mediclaim policy was issued to University of Calcutta covering therein family members of employees and pensioners on floater basis with sum insured of Rs.50,000/- to Rs.5,00,000/- per family unit for the period 01.01.2009 to 31.12.2009 as per the MOU. Shri Santirup Bhattacharya, the insured was hospitalized at NRS Medical College and hospital for the period 19.05.2009 to 09.06.2009 and his claim was settled for Rs.18,027/- by their TPA. Smt. Dipali Bhattacharya the complainant in her complaint has stated that her claim is for Rs.68,918/- and that expenses for disposable kit and blood cross match was not allowed by their TPA. However, the insured had been hospitalized earlier for the period 27.02.2009 to 07.03.2009 for appendicitis for which a claim was settled by them for Rs.9,803/-. The policy has a capping of Rs.10,000/- for appendicitis for the entire policy period.

Subsequently, Shri Bhattacharya was again hospitalized at NRS Medical College and Hospital for the period 19.05.2009 to 09.06.2009 for appendicitis and myelodyplastic syndrome for which a claim for Rs.52,460/- was lodged. The complainant's claim for appendicitis is Rs.16,330/- for which Rs.16,133/- was deducted and further Rs.197/- was paid as appendicitis has a capping of Rs.10,000/-. The total claim for myelodyplastic syndrome is Rs.36,130/- out of which Rs.17,830/- was allowed.

DECISION:

It transpired that the claim for appendicitis operation had been correctly settled by the insurer at Rs.10,000/- (Rs.9, 803/- allowed against the first claim and Rs.197/- against the second claim for appendicitis). This capping of Rs.10, 000/- is prescribed under the MOU to the policy. Out of the total claim for treatment of myelodyplastic syndrome Rs.36,130/- the insurer had already allowed Rs.17,830/- after deducting following amounts :-

i) SDP disposable kit : SDP donor servicing and blood cross match for Rs.17,300/-;
ii) Investigation charges of Rs.640/-;
iii) Miscellaneous charges of Rs.220/-.

The deduction of Rs.17, 300/- was made in view of Note to clause no. 1 of the policy which states that hospitalization expenses incurred for donating an organ by the donor (excluding cost of organ if any) to the insured person during course of organ transplant will also be payable but in the instant case blood/platelet collected from donor and transfusing the same to the patient was not considered equivalent to organ donation.

After careful evaluation of all the facts and circumstances of the case, we are of the opinion that the insurer has disallowed the cost of SDP disposable kits and cost of blood/platelet on the ground that it is not equivalent to organ donation. However, this narrow interpretation of the policy clause is neither practical nor justified in the instant case. It is seen that the insured was earlier hospitalized for appendicitis problem but his surgery could not take place as SDP disposable kit was not available. The SDP kit was an indispensable aid for the surgery. This special requirement was overlooked by the TPA. Considering that the insured did not survive post surgery and the widow is facing financial hardship we allow an ex-gratia payment of Rs.15,000/- to her, which will meet the ends of justice. We direct the insurance company to pay the above ex-gratia payment of Rs.15,000/- (Rupees fifteen thousand only) to the complainant.

Kolkata Ombudsman Centre
Case No. 537/11/002/NL/12/2010-11

Shri Suresh Jhunjhunwala

Vs.

The New India Assurance Company Ltd.,

Order Dated : 20.10.2011

Facts & Submissions :

This complaint was filed against repudiation of claim under Mediclaim Policy (2007) issued by the New India Assurance Company Ltd. on the ground that the Ozone therapy is not authorized by Indian Medical Association as per exclusion clause no. 4.4.19 of the policy.

The complainant Shri Suresh Jhunjhunwala stated that he was suffering from severe low back pain since last 2 years and he consulted orthopaedic surgeon, neurosurgeon and was treated with physiotherapy. Subsequently he consulted Dr. Keki E. Turel, a senior Neurosurgeon of Bombay Hospital and Research Centre and as per his advice he was admitted at the same hospital on 09.03.2009, where he was given various medicines and some examinations were carried out for in depth diagnosis of the disease. Along with other treatments, 10cc of Ozone plus injection Depumedrol 2cc plus injection Hylurinidase plus injection Liqnocaine was injected in L3-L4-L5 neural foramen and disc space and was discharged from the hospital on 15.03.2009.

He lodged a claim of Rs.2,90,873/- for reimbursement of pre and post hospitalization expenses. The TPA of the insurance company M/s E. Meditek Solutions Ltd. vide their letter dated 01.08.2009 asked him to provide all MRI & X-ray films and the same was complied with by him. After that the TPA vide their letter dated 15.10.2009 repudiated the claim stating that *'as the Therapeutic procedure (Ozone Therapy) is not authorized by Indian Medical Association, so the claim is hereby rejected as per clause no. 4.4.19 of the Mediclaim policy (2007) of N.I.AC.'.* He represented to the insurance company on 13.11.2009 against repudiation and requested them to settle his claim cancelling the repudiation decision made by their TPA.

The insurance company stated that the insured was admitted at Bombay Hospital & Medical Research Centre, following low back ache with radiation of pain down left leg from 09.03.2009 to 15.03.2009 and subsequently he lodged a claim for Rs.2,90,873/- with their TPA M/s E-Meditek Solutions Ltd. Their TPA vide their letter dated 15.10.2009 clearly stated to the insured that Ozone Therapy is not recognized by Indian Medial Council and the repudiation was in accordance with mediclaim policy (2007) clause no. 4.4.19.

DECISION:

The only point of dispute is whether the Ozone therapy received by the complainant is still under experimental and debatable stage and not yet endorsed by the Medical Council of India. The complainant has produced an opinion from his treating doctor wherein the surgeon has stated that after all necessary investigations, they decided for Ozone therapy with steroid injections which was relatively an innocuous procedure as compared to traditional surgery, although the therapy

gave him immediate relief from pain but the next day he had a recurrence of the problem and then he was advised a details session of physiotherapy. The contention of the insurance company is that Ozone therapy is not recognized as a conventional treatment for neuro-surgical problems by Indian Medical Council and therefore it is excluded under clause no. 4.4.19 of the Mediclaim Policy (2007) which excludes experimental treatment/ unproven treatment. The insurer had not submitted any written opinion of Indian Medical Council in this respect. However, it is seen from the medical journals and internet sources that Ozone therapy is now practiced in several leading hospitals including AIIMS, Delhi as an alternative treatment for pain management. It is, no doubt an unconventional treatment performed without surgery by specialist radiologist. The effectiveness of the surgery is still debatable and in the instant case, we find that the patient had a recurrence of the problem the very next day which indicates that the relief was temporary. The complainant has made a claim for Rs.2,90,873/- which, in our opinion, is very high, considering that the Ozone therapy is a substitute for physiotherapy and it does not involve any surgical procedure which could justify such a huge medical bill. From the details of the bills, we find that a major portion was spent for investigations and evaluation purpose, which were not consistent with the treatment undertaken.

After careful evaluation of all the facts and circumstances of the case and considering the fact that no specific opinion of the Medical Council of India is available with the insurer, Hon'ble Ombudsman opined that total repudiation of the claim in this case was not justified. The Ozone therapy is a undoubtedly a recognized non-surgical procedure preferred by many leading practitioners in reputed hospitals but considering that it's effectiveness is not yet established and it is essentially a pain relieving management and not a permanent cure, he allowed only an ex-gratia payment of Rs.30,000/- to the insured, which would meet the ends of justice. Insurer was hereby directed to obtain IMC's observation regarding approval of Ozone Therapy and forward a copy of the same to this office within 45 days.

Kolkata Ombudsman Centre
Case No. 543/11/014/NL/12/2010-11

Shri Soubir Narayan Mukherjee

Vs.

Cholamandalam MS General Insurance Co. Ltd.

Order Dated : 20.10.2011

Facts & Submissions :

This complaint was filed against repudiation of a claim under Overseas Travel Insurance Policy (Student Platinum) issued by Cholamandalam MS General Insurance Company Ltd. on the ground of delay in submission of claim documents.

The complainant Shri Soubir Narayan Mukherjee stated that he was covered under Overseas Travel Insurance Policy (Student Platinum) for the period from 05.05.2008 to 04.05.2009. Under

the policy he was entitled for compassionate visit upto the amount stated in the policy schedule (which is US$ 7500). In November 2008 his mother was diagnosed with cancer and had to undergo operation followed by chemotherapy, radiation and other treatment. He returned back to India on 17.11.2008 and immediately informed the insurance company and received a claim reference number and a claim form. He lodged a claim along with relevant documents to the insurance company's Delhi office for reimbursement. There was no response from the insurance company from their Delhi office. Then he contacted their Kolkata office who advised him to submit the necessary documents for the claim and the same was complied with by him. Subsequently he received a letter from their Third Party Administrator, M/s International SOS Services (India) Pvt. Ltd. dated 22.12.2009 stating that '*on perusal of the claim documents it is observed that you have submitted the complete set of documents after 30 days of return to India and we regret to inform that your claim is inadmissible.* Dissatisfied with the decision of the insurance company he represented to them on 25.01.2010 for review of his claim. On review the insurance company vide their letter dated 18.03.2010 informed him earlier decision stands as the documents have been received after 7 months of the policy expiry date.

The insurance company stated that the claim of Shri Soubir Narayan Mukherjee was made under Travel Insurance Policy (Student Platinum) for the period from 05.05.2008 to 04.05.2009. The insured was covered for a number of benefits under the policy including 'compassionate visit'. The relevant clause on compassionate visit is as under:-

'In the event parent (s) spouse/ child of the insured is hospitalized for more than seven consecutive days, the insurer or overseas administrator or Indian administrator, after obtaining confirmation of need for a companion from our panel doctor/ overseas administrator or Indian administrator will provide a round trip economy class air ticket, or first class railway ticket (the cost of whichever of he two is lesser), to allow the insured to be at the beside of his parent(s), spouse/ child for the duration of his/her stay in the hospital'.

They further stated that the insured did not submit the claim documents within the stipulated period as per terms and conditions of the policy. The date of loss was 17.11.2008 and the claim documents were sent to them in November 2009 which is after 7 months of the expiry of the policy and the claim is not admissible under the policy condition and the same was communicated to him vide their letter dated 22.12.2009 and 18.03.2010. stating that '*all claims must be submitted to Indian Administrator or Overseas Administrator not later than one (1) month after the return date or (Risk End date) or the completion of the treatment or transportation home, or in the event of death, after transportation of the mortal remains/ burial'.*

DECISION:

It showed that the policy was effective for the period from 05.05.2008 to 04.05.2009. Thereafter, the policy was not renewed by the complainant. As per essential condition of the policy, all the claims must be submitted to the Indian/ Overseas administrator not later than one month after the

return date or risk date or completion of the treatment. The complainant has mentioned that the disease like cancer does not have a fixed treatment period but he himself has stated in the claim form that her treatment was over by 12.06.2009. Thereafter, as per policy condition he should have submitted all the documents latest by 12.07.2009. But he neither renewed the policy nor submitted the documents during a reasonable period after the expiry of the policy. His claim was received after 7 months from the expiry of the policy and therefore, violation of the contract terms was a sufficient ground for the insurer to reject the claim. However, on humanitarian ground, we find some merit in the contention of the complainant that cancer is a totally unpredictable disease and he waited till the major portion of the treatment was over for submission of the document. He has spent a hefty amount of Rs.95,000/- to be present by the side of his ailing mother. He is facing lot of financial constraints and considering the facts that he was all along communicating with the insurance authorities and he had no intention to delay the submission of the claim, he allowed an ex-gratia payment of Rs.20,000/- to him, which would meet the ends of justice.

Kolkata Ombudsman Centre
Case No. 550/11/004/NL/12/2010-11

Shri Ram Chandra Agarwal

Vs.

United India Insurance Company Ltd.,

Order Dated : 24.10.2011

Facts & Submissions :

This complaint was filed against repudiation of claim under Individual Health Insurance Policy issued by United India Insurance Company Ltd. as per exclusion clause no. 4.8 of the policy.

The complainant Shri Ram Chandra Agarwal that his wife Smt. Veena Agarwal was suffering from alveolar abscess in multiple teeth and was admitted at Ballygunge Maternity & Nursing Home on 04.04.2009 where she underwent pulpectomy under LA in multiple teeth followed by conservative procedures and was discharged on the same day.

He lodged a claim for Rs.92,480/- on 15.05.2009 to the TPA of the insurance company M/s Heritage Health TPA Pvt. Ltd. for reimbursement of hospital expenses. TPA vide their letter dated 01.07.2009 repudiated the claim stating that '*as per discharge certificate the patient was treated for pulpectomy of multiple teeth, but dental treatment only arising from accident is payable. Therefore, as per terms & conditions of the policy, the claim is not admissible'.* He represented to the insurance company on 27.03.2010 against repudiation and requested them to settle his claim. He did not get any favourable reply from them.

The insurance company stated that the insured Smt. Veena Agarwal was admitted in Ballygunge Maternity & Nursing Home on 04.04.2009 for the treatment of Alveolar abscess of multiple teeth and she was discharged on the same day after necessary treatment. A claim was lodged by the insured for the medical expenses incurred for the treatment.

They further stated that as per policy condition, claim of dental treatment or surgery is not payable unless necessitated by accident and requiring hospitalization as per exclusion clause no. 4.8 of the policy. Accordingly, their TPA repudiated the claim vide their letter dated 01.07.2009 and they also agree that the claim is not admissible and the repudiation was in order.

DECISION:

This forum had been furnished with two sets of mediclaim policy (Gold) terms and conditions. One set by the insured (term period 31.12.2008 to 30.12.2009) which under its exclusion clause no. 4.7, state that mediclaim expenses are not payable for 'dental treatment or surgery of any kind unless requiring hospitalization'. Further its clause no. 2.3 state 'expenses on hospitalization for minimum period of 24 hours are admissible. However, the time limit is not applied to specific treatments, i.e, Dialysis, Chemotherapy, Radiotherapy, Eye Surgery, Dental Surgery'.

On the contrary the same policy (Gold) terms and conditions furnished by Insurer under cover of their letter ref. 307/Ombudsman/408/2011 dated 11.08.2011 state under exclusion clause no.4.8 that 'Dental treatment or surgery of any kind unless necessitated by accident and requiring hospitalization. This clause does not exist in the policy documents of the insurer. Therefore, we are satisfied that exclusion clause no. 4.8 is not applicable in this case. The case of the complainant is to be decided in accordance with clause no. 2.3 and 4.7 under which the claim is admissible.

In view of the above, Hon'ble Ombudsman did not find that the order of the insurer was correct and he directed to admit the claim and pay the same as per terms and conditions of the policy.

Kolkata Ombudsman Centre
Case No. 591/11/003/NL/01/2010-11

Shri Parimal Kumar Paul

Vs.

National Insurance Company Ltd.,

Order Dated : 24.10.2011

Facts & Submissions :

This complaint was filed against repudiation of claim under Individual Mediclaim Insurance Policy issued by National Insurance Company Ltd., on the ground that the expenditure incurred during hospitalization for evaluation / diagnostic purpose is not admissible as per exclusion clause no. 4.10 of the policy.

The complainant Shri Parimal Kumar Paul stated that on 19.03.2009 his wife Smt. Anjana Paul fell at home and sustained excessive pain at neck. As per advice of Dr. P. Chakraborty, she was admitted at Ruby General Hospital Ltd., Kolkata on 19.03.2009 where she was treated conservatively and was discharged on 21.03.2009. As per discharge summary the diagnosis of the disease was *'C4-C5 Disc Prolapse'*.

He lodged a claim on 11.05.2009 for Rs.16, 492/- to the TPA of the insurance company M/s MD India Healthcare Services (P) Ltd. for reimbursement of hospital expenses. Insurance company vide their letter dated 29.06.2009 repudiated the claim as per exclusion clause no. 4.10 of the policy stating that expenses were incurred primarily for evaluation/diagnostic purposes and it was not followed by active treatment during hospitalization. He represented to the insurance company on 24.12.2010 against repudiation.

DECISION:

It showed that the insurer had not sent their written submission in spite of reminders for which their views could not be ascertained. The TPA has repudiated the claim under clause no. 4.10 stating that hospitalization expenses were primarily for diagnostic and investigation purpose and the patient received only oral medicine. But it is seen from the discharge summary that the insured was admitted into the hospital with complaints of cervical swelling and pain following blunt trauma after sustaining fall at home toilet. The patient was admitted on the specific advice of the doctor for investigation and pain management. However, we find that along with the treatment of the fall trauma the patient also had some routine investigations for Lipid profile, E.C.G, Cholesterol test which are not consistent with the treatment of accidental injuries. The cost of treatment for fall trauma is admissible under the policy as the insured had acted as per her doctor's advice.

After careful evaluation of all the facts and circumstances of the case, Hon'ble Ombudsman allowed and ex-gratia payment of Rs.10,000/- as relating to the treatment of the accidental injury which would meet the ends of justice and she directed the insurance company to pay the above ex-gratia payment of Rs.10,000/- (Rupees ten thousand only) to the complainant.

Kolkata Ombudsman Centre
Case No. 607/11/002/NL/01/2010-11

Shri Farindra Chettri

Vs.

The New India Assurance Company Ltd.,

Order Dated : 27.10.2011

Facts & Submissions :

This complaint was filed against repudiation of a claim under Group Mediclaim (Tailormade) Insurance Policy issued by the New India Assurance Company Ltd. as per exclusion clause no. 2.3 of the policy.

The complainant Shri Farindra Chettri in his complaint has stated that his son Master Sougat Chettri was scratched by a cat on left leg and as per Dr. Jaydeep Chakraborty's advice he was given four doses of anti rabies Injection (Indirab) on 31.08.2009, 04.09.2009, 11.09.2009 and 25.09.2009 without any admission in the hospital.

He lodged a claim for Rs.2,650/- to the insurance company for reimbursement of above expenses. The insurance company repudiated the claim on the ground of non-hospitalization of the patient. He represented to the insurance company on 09.12.2010 against repudiation stating that anti rabbis treatment needs no compulsory hospitalization and by not being hospitalized, the insurance company has saved a lot of money and requested them to settle his claim.

The insurance company stated that the claim of the insured was repudiated on the grounds of non-hospitalization. The aforesaid policy is primarily a hospitalization benefit policy, for which hospitalization for a minimum period of 24 hours is must, though relaxation in the duration of stay in certain cases is provided in clause 2.3 of the policy are as under.

'Expenses requiring hospitalization for minimum period of 24 hours are admissible, however, this time limit will not apply to specific treatments i.e., dialysis, chemotherapy, radiotherapy, eye surgery, lithotripsy (kidney stone removal), tonsillectomy, D & C taken in hospital/ nursing home, anti rabies vaccine (rabies) and even if the insured is discharged on the same day, the treatment will be considered to be taken under hospitalization benefit. Since these

were planned procedures, hospitalization need not be more than 24 hours unless there is complication after the procedure'.

Since the term discharge is involved in the procedure laid down in this clause, admission in hospital automatically gets associated with the procedure as there cannot be 'discharge from the hospital' without admission in the hospital. Relaxation in the clause is for the duration of staying the hospital not for the admission i.e., exemption from the admission in the hospital is not provided in the policy, hence the claim was repudiated under clause no. 2.3 of Group Mediclaim (Tailormade) insurance policy.

DECISION:

It showed that the insured got 4 vaccines in OPD on different dates and was not hospitalized for the treatment. The insurer repudiated the claim strictly in accordance with their policy condition that the policy is primarily a hospitalization benefit policy and since there was no hospitalization, the claim is not payable. The decision of the insurer is technically in order. However, considering the fact that the course of 4 injections was administered to a small child who could not have been admitted on different dates in the hospital and the claim is also for a meager amount of Rs.2,650/-, Hon'ble Ombudsman allowed the claim on ex-gratia basis. We direct the insurance company to pay the above ex-gratia payment of Rs.2,650/- (Rupees two thousand six hundred and fifty only) to the complainant within 15 days from the date of receipt of this order along with consent letter.

Kolkata Ombudsman Centre
Case No. 627/14/002/NL/01/2010-11

Shri Dipankar Dutta

Vs.

The New India Assurance Company Ltd.,

Order Dated : 28.10.2011

Facts & Submissions :

This complaint was filed against delay in settlement of mediclaim under Good Health Policy issued to CITI bank Credit Card Holders by the New India Assurance Company Ltd.

The complainant Shri Dipankar Dutta in his complaint has stated that his wife Smt. Debasree Dutta was suffering from COPD, LRTI, DM, HTN with IHD and was admitted at Paramount Nursing Home, Kolkata on 07.05.2010, where she was treated conservatively and was discharged on 14.05.2010. Again, she was admitted at the same nursing home on 21.05.2010,

where she expired on 30.05.2010. As per death certificate of the said nursing home, the cause of death was cardio respiratory failure in a case of COPD with LRTI with DM II with HTN with IHD.

He lodged two claims on 08.07.2010 for Rs51,037/- and Rs.47,782/- in connection with above two hospital expenses to the TPA of the insurance company M/s TTK Healthcare Services Pvt. Ltd. for reimbursement. TPA vide their letter dated 15.07.2010 requested him to submit certain documents for settlement of his claim and the same was complied with on 27.09.2010. After submission of the documents, his claim was not settled by them. He represented to the insurance company on 12.10.2010, requesting them for early settlement of his claim. His appeal was not considered. Being aggrieved, he approached this forum for redressal of his grievance seeking monetary relief of Rs.98,819/-.

The insurance company stated that the wife of the complainant Smt. Debasree Dutta was hospitalized twice from 07.05.2010 to 14.05.2010 for cough and respiratory distress and from 21.05.2010 to 30.05.2010 for LRTI acute respiratory distress. The complainant lodged claims with their TPA M/s TTK Healthcare Services Pvt. Ltd. for reimbursement.

As per the case history sheet of the nursing home and the treating doctor's certificate, it is stated that the patient is a known case of DM/COPD/HTN. As per Good Health Policy condition no. 4.1, pre-existing diseases and subsequent complications are excluded from the scope of the policy. As per clause 4.1 (a), this exclusion will not be applicable after four consecutive policy years provided there was no hospitalization for the pre-existing disease, during the said four years of insurance under their Good Health mediclaim policy. Their TPA had sent three reminders on various dates calling for the treating doctor's certificate and asking him to clarify whether the patient was hospitalized for DM/HTN/COPD in the past four years. Subsequently a final reminder was sent on 21.09.2010 but the complainant did not produce the necessary certificates and they closed the claim files. They have further stated that the admissibility of claim can be decided only on submission of the above documents as per policy conditions.

DECISION:

Since the representative of the insurance company did not attend the hearing, it was decided to deal with the matter on ex-parte basis for them. It is seen that the claim has been closed by the TPA without considering the documents submitted by the insured on the ground that the treatment particulars of the last 4 years have not been submitted by the insured. The TPA has asked to file the investigation reports and a clarification from the treating consultant regarding the duration of HTN/DM/COPD and past history of these diseases. The complainant has categorically stated that the insured did not have any history of these diseases prior to her hospitalization. Moreover, since the case is very old and his wife has already expired more than a year back, the treating doctors are not ready to give any clarification. It is seen that the insurance

company has only endorsed the decision of the TPA without considering the explanation given by the complainant. The insurer has also not found any proof of treatment undertaken by the insured for these ailments. A mere remark by the treating doctor that the patient is a known case of HTN/DM/COPD can not be taken as a conclusive evidence of any preexisting condition in the absence of any supporting documents like treatment particulars. Since the case was closed without making any independent enquiries by the TPA, it is highly unfair for the insurance company to accept the TPA's decision and insist on production of certain documents which are not in the possession of the complainant. The insurer has repudiated the claim and the onus lies on them to justify the repudiation with convincing documentary evidences. The complainant has categorically stated that the insured did not have any problem during last 4 years and the insurance company has also not found any adverse material in this respect. Therefore, the decision of the insurance company to close the claim file was not in order and therefore, directed by the Hon'ble Ombudsman to admit the claim and settle the same as per terms and conditions of the policy on the basis of the documents submitted by the complainant.

Kolkata Ombudsman Centre
Case No. 628/11/002/NL/01/2010-11

Shri Gobindlal Saraogi

Vs.

The New India Assurance Company Ltd.,

Order Dated : 28.10.2011

Facts & Submissions :

This complaint is filed against repudiation of claim under mediclaim policy (2007) issued by The New India Assurance Company Ltd on the ground that treatment of eye with Lucentis injection is an OPD treatment and not admissible under the policy.

The complainant Shri Gobindlal Saraogi in his complaint has stated that due to retina problem in his left eye he was under the treatment of Dr. Sourav Sinha who advised him 3 doses of Intravitreal Injection of Lucentis in the left eye. He was admitted at Nemesis Eye Centre, Kolkata on 27.10.2009 where first dose of Lucentis was given and discharged on the same day. Subsequently he was admitted at B.B.Eye Foundation, Kolkata on 30.11.2009 & 04.01.2010 where 2nd and 3rd dose of Lucentis were given and discharged on the same days. As per discharge certificates, the diagnosis of the disease was *'choroidal neovascular membrance 'CNVM' left eye'*.

He lodged a claim on 27.01.2010 for Rs.1,41,640/- to the TPA of the insurance company M/s Medi Assist for reimbursement of the above expenses. TPA vide their letter dated 18.03.2010

repudiated both the claim stating that '*insured admitted in B.B.Eye Foundation for Choroidal Neovascular Membrane in Lt. eye for multiple administration of Lucentis injection on 27.10.2009, 10.11.2009 and 04.01.2010. Administration of injection like lucentis/avastin/ macugen etc. though needs to be done in sterile condition it does not warrant getting admitted as an in-patient in a hospital. It can be administered even in a clinic and therefore, the claim merits denial under operative clause 1.0 of the policy. Hence we regret our inability to admit this liability under the present policy condition'.* 'He represented to the insurance company on 05.04.2010 requested them to settle his genuine and boafide claim. The insured Shri Gobindlal Saraogi was treated by Lucentis intravitreal injection for choroidal neovascular membrance (CNVM) in his left eye but the treatment like age related macular degeneration (ARMD) and choroidal neovascular membrance (CNVM) done by administration of Lucentis/Avastin/Macugen and other related drugs as intravitreal injection, are not payable under this policy. In view of the above the claim was repudiated.

DECISION:

After perusal of the contents of the Circular No. HO/HEALTH/CIRCULAR/04/2009-IBD-ADMN:14 dated 09.02.2009 issued by the insurer Head Office,it was understood that the policy was renewed for the period from 07.05.2009 to 06.05.2010 after the issue of the circular denying the benefit of mediclaim in case of treatment through Lucentis in the operation theatre on the ground that it is an OPD treatment. Since the circular was already in existence at the time of the renewal of the contract, the decision of the insurer to repudiate the claim is technically correct. However, considering the facts that such treatment is the only treatment available for treatment of ARMD (which if not arrested, leads to loss of vision), and the procedure is an advancement of medical treatment where 24 hours of hospitalization is not required, the total repudiation of the claim is not fair and justified. The claim preferred by the complainant is on higher side as administering Lucentis injection is costlier than Avastin and doctor has not give any specific cause for their choice of administering Lucentis over other similar drugs. The complainant has informed that the expenses on administering injection Avastin/ Lucentis/ Macugen for treatment of ARMD/CNVM is now allowed by some other insurer and consumer forums. We would, therefore like to advise the insurer to find out the stand taken by other public sector insurance companies in this respect and review their circular if necessary to bring uniformity in their approach. They should also take opinion of specialists in this line to determine whether the procedure is an advancement of medical technology which does not require hospitalization for 24 hours and can be covered under clause 3.4.

After careful evaluation of all the facts and circumstances of the case, Hon'ble Ombudsman allowed an ex-gratia payment of Rs.30,000/- to the insured, which will meet the ends of justice. she direct the insurance company to pay the above ex-gratia payment of Rs.30,000/- (Rupees thirty thousand only) to the complainant.

Kolkata Ombudsman Centre
Case No. 604/11/005/NL/01/2010-11

Shri Dilip Kumar Debansi

Vs.

The Oriental Insurance Company Ltd.,

Order Dated : 28.11.2011

Facts & Submissions :

This complaint was filed against repudiation of claim under Individual Mediclaim Insurance Policy issued by The Oriental Insurance Company Ltd., on the ground that the disease occurred in the 1st year of the policy and the same is excluded under the scope of the policy.

The complainant Shri Dilip Kumar Debansi in his complaint has stated that his son Shri Bappaditya Debansi developed certain problems in his eyes in June 2009 and was unable to see properly. He consulted Dr. Nibaran Gangopadhyay who suggested immediate eye surgery to rectify the problem. As per doctor's advice he was admitted at Better Sight Centre Pvt. Ltd. on 27.06.2009, where he underwent Lasik surgery and was discharged on 28.06.2009. As per discharge summary the diagnosis of the disease was '*Myopia with Myopic Astigmatism'*.

He lodged a claim for Rs.28,920/- on 15.07.2009 to the insurance company for reimbursement of hospital expenses. The insurance company's regional office vide their letter dated 16.11.2009 repudiated the claim, on the ground that the claim is not payable in the first year policy. He represented to the insurance company on 23.02.2010 against such repudiation stating that his son was covered under Group Mediclaim policy of the Oriental Insurance Company till 31st March 2004 and subsequently individual mediclaim policy from 01.04.2004 which is evident from the CB allowed by the insurance company and requested them to settle the claim at the earliest.

The insurance company in their written submission dated 27.10.2011 has stated that the complainant Shri Dilip Kumar Debansi lodged a claim for the treatment of his son Bappaditya Debansi who was admitted at Better Sight Centre Pvt. Ltd., Kolkata on 27.06.2009 for the treatment of eye trouble/symptom of RD myopic and was discharged on 28.06.2009. They also stated that the injury was not a sudden occurrence but must be pre-existence for more than two years. They further stated that there was a break in the policy from 31.03.2008 to 02.06.2008 and this break has not been condoned by the competent authorities of their divisional office. Under the circumstances the policy is not continued policy, so the claim stands declined.

DECISION:

The complainant had approached this forum with two specific complaints. His complaint against non-condonation of break in the policy period by the competent authorities is without any merit and does not fall under the scope of the Redressal of Public Grievances Rules, 1998. As regards his second complaint that the eye problem was not a pre-existing condition, we find that the insurer has treated the ailment as pre-existing on the basis of their panel doctor's opinion. It is not based on the observations or opinion of the treating surgeon. We find from the discharge summary that the final diagnosis was Myopia with Myopic Astigmatism. As per Butterworth's medical dictionary 'Astigmatism' may also result from local injury or disease. The opinion of the panel doctor is not conclusively proved.

Therefore, after careful evaluation of all the facts and circumstances of the case, we are of the opinion that the surgery was not performed solely for correction of a pre-existing condition but also for treatment of eye ailment which could have resulted from infection. We, therefore allow relief to the insured by way of ex-gratia payment and direct the insurance company to pay Rs.5,000/- (Rupees five thousand only) as ex gratia to the complainant.

Kolkata Ombudsman Centre
Case No. 606/11/009/NL/01/2010-11

Smt. Dipsikha Basu Sarkar

Vs.

Reliance General Insurance Company Ltd.

Order Dated : 22.11.2011

Facts & Submissions :

This complaint is filed against repudiation of a claim under Reliance Healthwise policy issued by Reliance General Insurance Company Ltd., on the ground that the hospitalization was less than 24 hours, as per exclusion clause no. 3 of the policy.

The complainant Smt. Dipsikha Basu Sarkar stated that her son Master Diptangshu Sarkar got a deep injury over the right side of his forehead and was admitted at AMRI Hospitals, Kolkata on 01.08.2010 where repair of injury was done by Dr. S.K. Mitra (Paediatric Surgeon) and he was discharged on 02.08.2010. As per discharge summary the diagnosis of the disease was *'cut injury over the rt. side of the forehead'.*

She lodged a claim on 18.08.2010 for Rs.22,166/- to the TPA of the insurance company M/s Medi Assist (TPA) Pvt. Ltd for reimbursement of hospital expenses. TPA vide their letter dated 26.08.2010 repudiated the claim stating that *'diagnosis cut injury over rt. side of forehead. Repair of injury done. DOA 01.08.2010 at 07.12. PM and DOD 02.08.2010 at 11.59 A.M. So less than 24 hours hospitalization. Hence the claim denied as per basic cover clause 3 of Reliance Healthwise policy conditions. Hence, we regret our inability to admit this liability under the present policy conditions'.* She represented to the insurance company on 29.10.2010

stating that her claim is admissible under clause -2 sub clause L of the said policy schedule under 'Day Care Treatment' and she is entitled the claim amount of 22,166/- and requested them to consider the same in the light of the above clause.

The insurance company stated that the insured suffered a diagonal cut injury over right side of forehead and treatment for the same was taken. On scrutiny of the treatment particulars they found that the duration of hospitalization from the time of admission till time of discharge was less than 24 hours. Thereafter, their TPA repudiated the claim under exclusion clause No. 3 of the policy.

DECISION:

The insured was a 5 year old child, who was admitted into the hospital for surgery of a deep cut injury. The period of stay was less than stipulated 24 hours and therefore, the claim was rejected under clause 7 of the policy. The complainant has contended that her claim is payable under clause 3 of the policy as it was a day care treatment. However, her contention is not tenable as the treatment for cut injury does not fall under the treatments specified under clause 3. The decision of the insurer is, therefore, sustainable under the policy conditions. However, considering the tender age of the child, Hon'ble Ombudsman opined that hospitalization beyond the period recommended by the doctor was neither desirable nor convenient for him.

After careful evaluation of all the facts and circumstances of the case, she granted relief to the complainant by an ex gratia payment of Rs.10,000/-, which would meet the ends of justice. We direct the insurance company to pay the above ex-gratia payment of Rs.10,000/- (Rupees Ten thousand only) to the complainant.

Kolkata Ombudsman Centre
Case No. 625/11/009/NL/01/2010-11

Shri Soumya Kanti Dass

Vs.

Reliance General Insurance Company Ltd.,

Order Dated : 22.11.2011

Facts & Submissions :

This complaint is filed against repudiation of a claim under Reliance Healthwise policy issued by Reliance General Insurance Company Ltd., on the ground that the hospitalization was less than 24 hours, as per exclusion clause no. 7 of the policy.

The complainant Shri Soumya Kanti Dass in his complaint has stated that his daughter Riddhika Das was suffering from trigger thumb (locking of fingers) and was admitted at Orthopaedic Centre, Kolkata on 26.06.2009 where she underwent an operation for release of trigger thumb by Dr. Amitava Dutta and was discharged on the same day .

He lodged a claim for Rs.9,326.79 to the TPA of the insurance company M/s Medi Assist (TPA) Pvt. Ltd. for reimbursement of hospital expenses. Insurance company vide their e-mail letter dated 30.03.2010 repudiated the claim under clause 7 of the policy. He represented to the insurance company on 26.10.2010 stating that his claim is admissible under clause -3 related to 'Day Care Treatment' and requested them to review his claim.

The insurance company stated that the insured had suffered trigger thumb (locking of fingers) and treatment tot same was taken. Subsequently the complainant Shri Soumya Kanti Das lodged a claim for reimbursement of expenses incurred towards the treatment. On scrutiny of the treatment particulars they found that the duration of hospitalization from the time of admission till time of discharge was less than 24 hours. Provision under clause 7 of the policy stated that '*hospitalization expenses mean expenses on hospitalization for minimum period of 24 hours, which are admissible under this policy. However, this time limit will not apply for specific treatments defined under Day Care Treatment taken in a hospital/ nursing home'.* In view of the above they repudiated the claim on 30.03.2010 as per clause 7 of the policy.

DECISION:

The insured was a 4 years child who was admitted into the hospital for surgery of trigger thumb. The period of stay was less than stipulated 24 hours and therefore the claim was rejected under clause 7 of the policy. The complainant has contended that his claim is payable under clause 3 of the policy as it was a day care treatment. However his contention is not tenable as the treatment for trigger thumb (locking of fingers) does not fall under the treatments specified in clause 3 as day care treatment. The decision of the insurer is, therefore, sustainable under the policy conditions. However, considering the tender age of the child, Hon'ble Ombudsman opined that hospitalization beyond the period recommended by the doctor was neither desirable nor convenient for the child.After careful evaluation of all the facts and circumstances of the case, Hon'ble Ombudsman granted relief to the complainant by an ex gratia payment of Rs.5,000/-, which would meet the ends of justice.

Kolkata Ombudsman Centre

Case No. 631/11/003/NL/01/2010-11

Shri Dipak Sen

Vs.

National Insurance Company Ltd.

Order Dated : 15.11.2011

Facts & Submissions :

This complaint was filed against repudiation of claim under Individual Mediclaim Insurance Policy issued by National Insurance Company Ltd., as per exclusion clause no. 3.11 of the policy.

The complainant Shri Dipak Sen stated that he was suffering from Epistaxis i.e., severe bleeding from the nose with high blood pressure he consulted Dr. Tushar Kanti Ghosh on 21.08.2009 who advised him to admit at Divine Nusring Home, Kolkata for endoscopy and surgery to stop the bleeding. As per doctor's advice he was admitted at Divine Nursing Home Pvt. Ltd., Kolkata on 21.08.2009 where endoscopic examination and electro cantery of bleeding point was done and he was discharged on 22.08.2009. As per discharge summary the diagnosis of the disease was *'Epistaxis'*.

He lodged a claim on 15.10.2009 for Rs.10,061.46 to the TPA of the insurance company M/s Genins India TPA Ltd. for reimbursement of hospital expenses. Insurance company vide their letter dated 18.01.2010 repudiated the claim as per exclusion clause no.3.11 of the policy stating that the present claim pertains to a case of Epistaxis and hospitalization was for less than 24 hours, hence the claim is not payable. He represented to the insurance company on 04.02.2010 against repudiation stating that the treating doctor had advised discharge after 20 hours of observation and that it is not necessary to stay for 24 hours for claim as it is a case of ENT treatment. He further stated that he is holding the policy for last 10 years and no claim has been made till date and requested them to reconsider and settle his claim. The insurance company reviewed the claim and informed the complainant vide their letter dated 17.08.2010 that their previous decision of repudiation was in order.

The insurance company in their written submission dated 02.03.2011 stated that the insured Shri Dipak Sen lodged a claim for Rs.10, 061.46. As per discharge certificate of Divine Nursing Home Pvt. Ltd. he was admitted in the hospital on 21.08.2009 for his Epistaxis and was discharged on 22.08.2009. They have repudiated the claim vide their letter dated 18.01.2010 on the ground that the present claim pertains to a case of Epistaxis and hospitalization was less than 24 hours. The claim is not payable as per clause no. 3.11 of the policy. They further stated that on receipt of the representation dated 24.06.2010 from the complainant for reconsideration of his claim they have reviewed the claim and informed the complainant vide their letter dated 17.08.2010 for their inability to reconsider the claim.

DECISION:

The insurer had repudiated the claim under policy clause no. 3.11 as hospitalization was for less than 24 hours. However, the exact time of admission and discharge is not mentioned in the discharge certificate or the claim form. Only the treating doctor's certificate mentions the admission time as 13.20 hours and discharge time as 10.00 A.M next day. The insured had suffered profuse bleeding from nose and was admitted in the hospital on emergency basis on the

specific advice of the doctor. Under the circumstances, his claim is otherwise admissible but for the fact that the period of stay in hospital was less than stipulated 24 hrs. Although, the insurer is technically correct in rejecting his claim as per policy clause 3.11, but they have not considered the fact that if he had stayed longer in the hospital, it would have caused additional financial burden to the insurance company and inconvenience to the patient and his relatives. It is also seen that the insured is an old customer of the insurance company and has never made any claim in the last several years. The TPA has applied the time limit of 24 hours mechanically but on humanitarian ground we are of the opinion that total repudiation of the claim is not justified in this case. After careful evaluation of all the facts and circumstances of the case, Hon'ble Ombudsman allowed an ex-gratia payment of Rs.6,000/- to the insured, which would meet the ends of justice.

Kolkata Ombudsman Centre
Case No. 645/11/002/NL/02/2010-11

Shri Aparesh Chandra Saha

Vs.

The New India Assurance Company Ltd.,

Order Dated : 28.11.2011

Facts & Submissions :

This complaint is filed against repudiation of claim under mediclaim policy (2007) issued by The New India Assurance Company Ltd., on the ground that any treatment with intravitreal injection is not payable as per their circular.

The complainant Shri Aparesh Chandra Saha stated that due to bleeding hemorrhage in his eyes, he was admitted at Sankara Nethralaya, Kolkata on 15.06.2010 under treatment of Dr. Swakshyar Saumya Pal, where first dose of Intravitreal Injection of Lucentis was given in the left eye and he was discharged on the same day. Further he was admitted at the same hospital on 20.07.2010 and 24.08.2010 where 2nd and 3rd dose of Lucentis were given and was discharged on the same day. As per discharge certificates the diagnosis of the disease was '*age related macular degeneration with choroidal neovascular membrane'.*

He lodged two claims on 01.07.2010 & 13.09.2010 for Rs.54,947/- and Rs.75,767/- respectively to the TPA of the insurance company M/s Medicare TPA Services (I) Pvt. Ltd. for reimbursement of the above expenses. TPA vide their letters dated 23.07.2010 & 17.09.2010 repudiated both the claims stating that '*as per circular of NIA, treatment expenses for intravitreal injection is not payable. Hence the claim is rejected'.* He represented to the insurance company against repudiation on 26.11.2010 stating that the circular on the basis of which his claim was rejected was not supplied to him at the time taking the policy.

The insurance company stated that Shri Aparesh Chandra Saha, the insured was admitted to Sankara Nethralaya for three times for his age related Macular Degeneration with Choroidal Neovascular Membrane and was given injection of Intravitreal Lucentis in left eye on 15.06.2010, 20.07.2010, 24.08.2010 and was discharged on the same day He lodged claims for Rs.54,947/- and Rs.76,767/- respectively for the said hospitalizations, but the same is not payable as per their Head Office circular No. HO/HEALTH/CIRCULAR/04/2009 dated 09.02.2009, which excludes ARMD treatment by administering the drugs like Avastin, Lucentis and Macugen, on the ground that it is an OPD treatment.

DECISION:

After perusal of the contents of the Circular No. HO/HEALTH/CIRCULAR/04/2009-IBD-ADMN:14 dated 09.02.2009 issued by the insurer Head Office that the policy was renewed for the period from 12.05.2010 to 11.05.2011 i.e subsequent to the issue of the circular clarifying that the treatment through Lucentis in the operation theatre is an OPD treatment and outside the scope of the policy. The complainant has contended that there was no specific endorsement in this regard in his policy contract. This argument is not tenable as the procedure being OPD treatment, there is no need of specific mention of the exclusion in the contract as all OPD procedures are excluded under the policy. Moreover, the circular of the company was already in existence at the time of the renewal of the contract and therefore, its applicability in the insured's case cannot be questioned. Under the circumstances, we find that the decision of the insurer to repudiate the claim is technically correct and within the framework of the policy conditions. However, considering the facts that such treatment is the only treatment available for ARMD (which if not treated, leads to loss of vision), and the treatment can be covered under clause 4.3 of the policy (relating to 'cataract and age related eye ailments' with two years of waiting period), the total repudiation of the claim is not found to be fair and justified. Moreover expenses on administering injection Avastin/ Lucentis/ Macugen for treatment of ARMD/CNVM is now allowed by National Insurance Co. after a waiting period of two years. In the present case, the insured has waited for 15 long years, without any claim. But, we find that the claim preferred by the complainant is on higher side because of Lucentis injection, which is costlier than Avastin and doctor has not give any specific reason for their choice of administering Lucentis over other similar drugs. After careful evaluation of all the facts and circumstances of the case, Hon'ble Ombudsman allowed an ex-gratia payment of Rs.40,000/- to the insured, which would meet the ends of justice. She directed the insurance company to pay the above ex-gratia payment of Rs.40,000/- (Rupees forty thousand only) to the complainant.

Kolkata Ombudsman Centre

Case No. 646/11/013/NL/02/2010-11

Shri Jayanta Kumar Datta

Vs.

HDFC ERGO General Insurance Co. Ltd.

Order Dated : 28.11.2011

Facts & Submissions :

This complaint was filed against repudiation of claim under Group Mediclaim Policy issued by HDFC ERGO General Insurance Company Ltd., in favour of Pancard Clubs Limited and covering individual members under the group and the complainant in the present case was one such group member.

The complainant Shri Jayanta Kumar Datta stated that he was admitted at Christian Medical College, Vellore -4 on 06.01.2010, due to kidney problem, where he was treated conservatively and was discharged on 07.01.2010. As per discharge summary the diagnosis of the disease was '*chronic kidney disease, Stage IV, type – 2 DM, Hypertension, Bronchial asthma'.*

He lodged a claim on 25.02.2009 for Rs.16,276.76 to the TPA of the insurance company M/s Medi Assist for reimbursement of hospital expenses. Insurance company vide their letter dated 11.05.2010 repudiated the claim stating that *'the claimant hospitalized from 06.01.2010 to 07.01.2010 with complaints of CKD stage 1, type 2 DM, HTN, bronchial asthma and underwent medical management. Patient was admitted in Christian Medical College, Vellore. The claim stands repudiated for not fulfilling the purview of the policy terms and conditions'.* He represented to the insurance company on 27.12.2008 against repudiation and requested them to settle his claim.

The insurance company in their written submission dated 24.11.2011 has stated that the claim of Shri Jayanta Kumar Datta has been settled and a cheque of Rs.9,401/- bearing no. 965588 dated 05.04.2011 has already been released in favour of Shri Datta.

DECISION:

The complainant had approached this forum for non-payment of Rs.5,180/- due to non submission of reports and Rs.1,450/- for admissible expenses. After going through various deductions made by the TPA, this forum found that deduction of Rs.1,450/- on account of Glucostrips was in order and the same was accepted by the complainant at the time of hearing. As regards the deduction of Rs.5,180/-, it had been observed that TPA had deducted this amount for non-submission of investigation reports. However, Hon'ble Ombudsman found from the discharge summary that all these reports are available in the discharge summary itself and certified by the doctors. Copy of the discharge summary is already available with the TPA, but they did not care to go through the same. Further this office found that the insured had written several letters to the insurance company enclosing the copies of these reports vide his letters dated 28.04.2011 and 24.08.2011. Under the circumstances, Hon'ble Ombudsman did not find any justification for deduction of Rs.5,180/-. The claim was genuine and the insurance company

was directed to settle and pay the balance amount of Rs.5,180/- (Rupees Five thousand one hundred eighty) to the complainant.

Kolkata Ombudsman Centre
Case No. 654/1/004/NL/02/2010-11

Smt. Anjulika Dutta

Vs.

United India Insurance Company Ltd.,

Order Dated : 30.11.2011

Facts & Submissions :

This complaint was filed against repudiation of claim under Group Mediclaim policy issued by United India Insurance Company Ltd.

The complainant Smt. Anjulika stated that she was suffering from acute abdominal pain with continuous vomiting with weakness and was taken to gastroenterologist Dr. Asif Ali at Mission Hospital, Durgapur on 03.05.2010 who advised certain tests and medicines. She got admitted at Vivekananda Hospital, Durgapur on 05.05.2010 where she was treated conservatively and was discharged on 07.05.2011. At that time cashless facility was refused by the TPA of the insurance company.

She lodged a claim for Rs.27,901.76 to the TPA of the insurance company for reimbursement of above hospital expenses along with pre and post hospitalization expenses. TPA vide their letter dated 05.08.2010 repudiated the claim stating that as per the documents received; patient was admitted primarily for investigations only during her stay at hospital and no active line of treatment was done and as per policy terms and conditions, the claim is not payable under clause no. 7.7 of the policy.

The insurance company in their written submission dated 08.11.2011 stated that on scrutiny of claim documents it was observed that the insured was hospitalized for acute pancreatitis and chronic dyspepsia but during hospitalization patient underwent all investigations like endoscopy, CT abdomen which does not require hospitalization. The insured did not submit original investigation reports and reports were written on doctor's letter head which does not support the need for hospitalization. The patient is known case of APD for which she is under continuous treatment and during this hospitalization only evaluation was done which can be availed as an outpatient. The claimant stayed in the hospital only for two days and was discharged on request, which suggest that patient's condition was normal and unnecessary hospitalization shown. Hence the claim was repudiated under clause 7.7 of the policy.

DECISION:

The insured had approached this forum for repudiation of her mediclaim for her treatment of acute pancreatitis, chronic dyspepsia, anaemia and evaluation etc. From the documents submitted to this forum we find that she had first approached Dr. Ashif Ali Ahmed of the Mission Hospital, Durgapur who had recommended several investigations like C.T.Scan of whole abdomen, colonoscopy, X-ray etc. He also prescribed her medicines vide his prescription dated 03.05.2010. Thereafter the insured got admitted in the Vivekananda Hospital, Durgapur on 05.07.2010 and stayed there for 2 days and got discharged on her own request. The discharge certificate does not say she was admitted under emergency condition and since her admission followed her consultation in the Mission Hospital, Durgapur, it is clear that she had primarily got admission for investigations suggested by Dr. Ashil Ali Ahmed. She had undergone tests like C.T. Scan of whole abdomen, colonoscopy and other tests as suggested by her previous doctor. Her treatment was also not very signification in the hospital. Major part of the bill pertains to investigation and post hospitalization period. The pharmacy bill was also for Rs.423/- only.

After careful evaluation of all the facts and circumstances of the case we agree with the insurer's view that the patient did not require immediate hospitalization and her admission in the hospital was mainly for evaluation and investigation. Under the circumstances, the decision of the insurer to repudiate the claim under clause 7.7 is found to be in order and the same is upheld. However, considering the fact that she was a senior citizen and was admitted in the hospital not only for investigation but also for pain management for pancreatitis, we give her some relief in the form of ex-gratia payment of Rs.5,000/- which would meet the ends of justice. Hon'ble Ombudsman directed the insurance company to pay the above ex-gratia payment of Rs.5,000/- (Rupees Five thousand only) to the complainant.

Kolkata Ombudsman Centre

Case No. 690/11/003/NL/02/2010-11

Shri Arun Coomer Bose

Vs.

National Insurance Company Ltd.

Order Dated : 15.11.2011

Facts & Submissions :

This complaint is filed against partial repudiation of claim under Varistha Mediclaim Insurance Policy issued by National Insurance Company Ltd.

The complainant Shri Arun Coomer Bose stated that he was suffering from expansile swelling of right inguinal region and was admitted at Sri Aurobindo Seva Kendra, Kolkata on 11.09.2009 where he underwent an operation of right inguinal hernia with prolene mesh and was discharged

on 20.09.2009. As per discharge summary the diagnosis of the disease was *'indirect right inguinal hernia, ischaemic heart disease & hypertension'.*

He lodged a claim on 12.10.2009 for Rs.59,281.94 to the TPA of the insurance company M/s E-Meditek Solutions Ltd., for reimbursement of hospital expenses. Insurance company vide their letter dated 10.02.2010 settled Rs.37,904/- towards full and final settlement of the claim. He represented to the insurance company on 24.02.2010 and requested for refund of 20% co-payment charges of Rs.8,673/- as he has not opted for co-payment.

The insurance company stated that an amount of Rs.8,673/- was deducted from the claimed amount on account of co-payment @ 20% which is not justified as the insured did not opt for the same. The deduction on account of co-payment should be 10% for which they have referred to TPA for payment of the difference amount.

DECISION:

The insurer admitted the mistake in the deduction on account of co-payment and had issued necessary direction to the TPA for payment of the difference arising out of co-payment after reviewing the file. The insurer was directed by the Hon'ble Ombudsman to make the payment of the difference amount within 15 days from the date of receipt of this order along with consent letter. The insurer was further directed to pay interest @ 2% above the prevailing bank rate from 11.11.2009 [i.e., one month after the date of receiving the claim form from the insured by the insurer/TPA on 12.10.2009] till the date of payment of the claim

Kolkata Ombudsman Centre
Case No. 685/11/002/NL/02/2010-11

Shri Debjit Ghosh

Vs.

The New India Assurance Company Ltd.,

Order Dated : 15.12.2011

Facts & Submissions :

This complaint was filed against repudiation of claim under mediclaim policy (2007) issued by The New India Assurance Company Ltd., on the ground that the treatment with intravitreal injection falls outside the scope of the policy.

The complainant Shri Debjit Ghosh stated that his mother Smt. Anima Ghosh was admitted at Disha Eye Hospital & Research Centre, Barrackpore, Kolkata on 16.04.2010 where first dose of Intravitreal Injection of Macugen was administered in her left eye and she was discharged on 17.04.2010. Further she was admitted at the same hospital on 08.07.2010 where 2nd dose of Intravitreal Injection Macugen was administered in her left eye and she was discharged on 09.07.2010.

He lodged two claims on 28.04.2010 & 12.07.2010 for Rs.46,114/- and Rs.43,000/- respectively to the TPA of the insurance company M/s Medicare TPA Services (I) Pvt. Ltd., for reimbursement of the above expenses. But the TPA repudiated the claim stating that '*as per NIA circular no. HO/Health/Circular/04/2009:IBD ADMIN:14 dated 09.02.2009 intravitreal injection falls outside the scope of the policy. The claim therefore remains excluded and not payable".* He represented to the insurance company on 06.09.2010 through his advocate requesting them to review his claim.

The insurance company stated that Smt. Anima Ghosh was admitted at Disha Eye Hospital & Research Centre on 16.04.2010 and 08.07.2010, where she was administered 1st and 2nd dose of intravitreal macugen on two occasions. As per circular no. HO/Health/Circular/04/2009:IBD ADMIN:14 dated 09.02.2009 administration of drugs like Avastin or Lucentis or Macugen and other related drug for treatment of Age Related Macular Degeneration (ARMD) is excluded from the scope of cover under mediclaim policy (2007).

DECISION:

After a thorough perusal of the contents of the Circular No.HO/HEALTH/CIRCULAR/04/2009-IBD-ADMN:14 dt. 09.02.2009 issued by the insurer's Head Office regarding coverage for the treatment of ARMD under the policy. It clarifies the stand of the Company that treating ARMD with drugs like Avastin/Macugen/Lucentis is an OPD treatment, though injection is administered in OT. As OPD treatment is outside the scope of the policy, the treatment of ARMD with injections is not covered under the policy. This circular is effective from 09.02.2009 and therefore, it is applicable to all such similar claims arising after this date. Under the circumstances, the decision of the insurer to repudiate the claim is within the framework of the policy condition and technically correct. However, considering the facts that such treatment is the only treatment available for ARMD (which leads to loss of vision), and the procedure is an advancement of medical treatment where 24 hours of hospitalization is not required, the total repudiation of the claim is not fair and justified. We find that such treatment is allowed by other public sector insurers after a specified waiting period. In this case the insured is a senior citizen, with a four years old policy without any claim history. Therefore, after careful evaluation of all the facts and circumstances of the case, Hon'ble Ombudsman allowed an ex-gratia payment of Rs.30,000/- to the insured, which would meet the ends of justice.

Kolkata Ombudsman Centre
Case No. 691/11/003/NL/02/2010-11

Shri Naman Dalmia

Vs.

National Insurance Company Ltd.,

Order Dated : 15.12.2011

Facts & Submissions :

This complaint was filed against repudiation of claim under Individual Mediclaim Insurance Policy issued by National Insurance Company Ltd., as per exclusion clause no. 4.10 of the policy

The complainant Shri Naman Dalmia in his complaint has stated that his mother Smt. Bimla Devi Dalmia was suffering from nausea & uneasiness and as per advice of Dr. S.B. Das dated 10.01.2010 she was admitted at R.S.V Hospital, Kolkata on 11.01.2010 where she was treated conservatively and was discharged on 12.01.2010. As per discharge summary, the diagnosis of the disease was '*hypertension, lumber spondylosis, cervical spondylosis'.*

He lodged a claim for Rs.13,528/- to the TPA of the insurance company M/s Heritage Health TPA Pvt. Ltd. for reimbursement of hospital expenses. TPA vide their letter dated 28.04.2010 repudiated the claim stating that *'as per document of RSV hospital the patient got admitted only for investigation but not followed by active treatment in hospital, which is non-admissible. Hence our medical doctor opined this as non-admissible and stands repudiated as per clause no. 4.10 of standard mediclaim policy.'* He represented to the insurance company on 30.06.2010 stating that (i) his policy is a 20 years old policy and this is the first claim (ii) the condition in which the patient was admitted was very critical and required immediate hospitalization (iii) after due investigation it was revealed that the patient was suffering from lumber and cervical spondylosis (iv) staying further in the hospital was not required as per the doctor's advice discharge was done and (iv) treatment for spondylosis could be taken at home for which staying in hospital was not required and requested them to settle his claim.

The insurance company in their written submission dated 26.05.2011 has stated that Smt. Bimla Devi Dalmia mother of the complainant was admitted in RSV Hospital on 11.01.2010 with complaint of nausea & uneasiness and also known to be hypertensive. The disease detected in hospital was lumbar spondylosis and cervical spondylosis, HTN. She was discharged on 12.01.2010 and claimed the amount for Rs.13,528/-. The claim has been repudiated as per exclusion clause no. 4.10 of the policy since the expenses was incurred for investigation purpose only.

DECISION:

The complainant had approached this forum against the decision of the insurer to repudiate the claim on the ground that no active treatment was done during hospitalization and purpose of admission was just to investigate the disease which could have been done on OPD basis also. It is seen from the discharge summary that the insured was hospitalized with complaints of nausea, uneasiness as per doctor's prescription dated 10.01.2011. Doctor had advised urgent admission for investigation and necessary treatment. From the bills filed before us we find that almost the entire expenditure pertains to investigation, room rent etc and only a paltry sum of Rs.65/- was incurred on medicines. As per the policy clause no.4.10, expenses incurred primarily for evaluation/ diagnostic purpose not followed by active treatment during hospitalization is excluded from the scope of the policy. In the present case, we find that although hospitalization was at the advice of the doctor but the doctor has not mentioned that hospitalization was necessary in view of the critical condition of the patient. Rather doctor advised urgent admission for investigation and necessary treatment (prescription dated 10.01.2010). It is also a fact that no active treatment followed the investigation in the hospital. Therefore, the case is covered by the exclusion clause no. 4.10 of the policy and the decision of the insurer is in order. However, considering the fact that the insured is a senior citizen and her policy is 20 years old without any claim so far, total repudiation of the claim is not justified on humanitarian grounds.

After careful evaluation of all the facts and circumstances of the case, we give her some relief in the form of ex-gratia payment of Rs.5,000/- which will meet the ends of justice. Hon'ble Ombudsman directed the insurance company to pay the above ex-gratia payment of Rs.5,000/- (Rupees five thousand only) to the complainant.

Kolkata Ombudsman Centre

Case No. 692/11/003/NL/02/2010-11

Shri Bimal Kumar Drolia

Vs.

National Insurance Company Ltd.,

Order Dated : 22.12.2011

Facts & Submissions :

This complaint is filed against partial repudiation of claim under Individual Mediclaim Insurance Policy issued by National Insurance Company Ltd.

The complainant Shri Bimal Kumar Drolia was suffering from sudden onset of facial and left sided weakness and as per advice of Dr. B. Madeka he was admitted at Calcutta Medical Research Institute, Kolkata on 21.09.2008, where he was treated conservatively and discharged on 28..09.2008. As per discharge summary, the diagnosis of the disease was '*large cerebral*

infarction in right MCA territory in a case of complete occlusion of right I C A at its origin dyslipidaemia, urinary tract infection'.

However, he lodged a claim for Rs.1,87,050/- in addition to the amount already advanced to the hospital for reimbursement. Out of Rs.1,87,050/- TPA settled Rs.86,558/- after deducting Rs.1,00,492/- towards full and final settlement of the claim. He represented to the insurance company on 23.10.2009 against partial settlement requesting them to settle the doctor's fees of Rs.60,000/- paid to Dr. B.B. Singhal and Rs.4,500/- to Dr. Madeka.

The insurance company stated that Shri Bimal Kumar Drolia took admission at CMRI on 21.09.2008 and discharged on 28.09.2008 for large cerebral infarction in right MCA territory in a case of complete occlusion of right I C A at its origin dyslipidaemia, urinary tract infection. The total sum insured under the policy is Rs.2.50 lakh + Rs.65,000/- C.B = Rs.3,15,000/-. He lodged a claim of Rs.1,87,050/- out of which their TPA M/s Medsave Health Care (TPA) Ltd. settled Rs.86,558/- and Rs.1,00,492/- was not settled which is not covered under the mediclaim policy such as incorrect bill, bill without date and excess billing.

DECISION:

From the analysis of case records we find that Dr. Bhartendu Madeka, under whom the insured was admitted in CMRI hospital, had referred the case to Dr. B.S. Singhal, a specialist from Mumbai just for a second opinion and not for any active treatment. While referring the case, Dr. Bhartendu Madeka mentioned that the patient had developed a seizure disorder and requested Dr. Singhal to examine him and to give his opinion for the same. The treating doctor's preference for a specialist from Mumbai, instead of other neurosurgeons from the city who were present in the hospital clearly indicates that it was his personal choice and not warranted by medical exigency. This office did not find any prescription of Dr. Singhal, advising any special line of treatment Under the circumstances, Hon'ble Ombudsman agreed with the contention of the insurance company that the fee of Rs.60,000/- paid to Dr. Singhal just for a second opinion, was exorbitant and unnecessary. The disallowance of this was in order and the same is upheld. However, the amount of Rs.4,200/- paid to Dr. Madeka was for his home/hospital visits during hospitalization and post hospitalization period. This was clearly payable and the insurance company was therefore, directed to settle the claim of Rs.4,200/- (Rupees four thousand two hundred only) paid to Dr. Bhartendu Madeka.

Kolkata Ombudsman Centre
Case No. 698/11/002/NL/02/2010-11

Shri Arup Chakraborty

Vs.

The New India Assurance Company Ltd.

Order Dated : 22.12.2011

Facts & Submissions :

This complaint was filed against repudiation of claim under Group Mediclaim Policy issued by The New India Assurance Co. Ltd. in favour of Aditya Birla Nuvo Limited and covering individual members under the group.

The complainant Shri Arup Chakraborty in his complaint has stated that his mother Smt. Sandhya Chakraborty was suffering from scalp ulcer and as per advice of Dr. M. Mukhopadhyay she was admitted at Nightingale Diagnostic & Medicare Centre, Kolkata on 24.07.2010 where she underwent an excision biopsy of scalp ulcer (Rt) and she was discharged on 26.07.2010. As per discharge summary, the diagnosis of the disease was 'excision of scalp ulcer (Rt)'. Before admitting his mother in the hospital he was given prior approval of Rs.10,000/- on 21.07.2010 for cashless treatment from TPA of the insurance company M/s Medi Assist. But after operation when hospital processed the final bill of Rs.16,049/- they have cancelled the full claim on the ground that the operation was done in L/A instead of G/A.

Subsequently, he lodged a claim on 09.08.2010 for Rs.16,049/- to the TPA of the insurance company M/s Medi Assist for reimbursement of hospital expenses. TPA vide their letter dated 07.09.2010 repudiated the claim stating that *' the patient was admitted for scalp ulcer (Rt) side and was treated surgically by excision biopsy under LA and only oral medication were given. No active line of treatment has been given. The same could be done on OPD basis. As per the policy terms and conditions hospitalization for procedures usually done in OPD are not payable. Hospitalization is not justified and warranted. Hence the claim is not admissible under the policy clause of OPD'.* He represented to the insurance company on 20.12.2010 stating that the doctor advised that this scalp ulcer operation should be done under 'in-patient' and at-least one day hospitalization was essential for further care and treatment, requesting them to settle his claim.

The insurance company only enclosed the copy of the repudiation letter which was written to them by their TPA mentioning the ground of repudiation of the claim that 'the patient was admitted for scalp ulcer (Rt) side and was treated surgically by excision biopsy under LA and only oral medication were given. No active line of treatment has been given. The same could be done on OPD basis. As per the policy terms and conditions hospitalization for procedures usually done in OPD are not payable. Since hospitalization was not justified and warranted. Hence the claim was disallowed.

DECISION:

The complainant had approached this forum for repudiation of the mediclaim in respect of his mother who underwent an excision biopsy of scalp ulcer. It is seen from the treating Dr. M. Mukhopadhyay's prescription dated 17.07.2010 that the patient was advised admission at Nightingale Hospital for operation for excision biopsy of scalp ulcer (Rt) under GA. As per the advice of the doctor, the patient got admitted and underwent the surgery under LA. The insurer has repudiated the claim on the ground that the operation was done under LA and only oral medication was given and no active line of treatment followed the biopsy. As such, the treatment could have been done on OPD basis. However, after analysis of the medical records, we are inclined to agree with the complainant that hospitalization was specifically advised by the treating doctor and the patient had no choice but to follow his advice. Once admitted, the patient

has no control over the procedure adopted by the doctor. Moreover, it is for the treating doctor to decide whether it should be an OPD procedure or it warranted hospitalization. The TPA's panel doctor had not examined the patient and therefore, their opinion cannot be accepted in preference to the treating doctor's opinion.

Under the circumstances, Hon'ble Ombudsman opined that the decision of the insurer in rejecting the claim on the basis of the TPA doctor's opinion that it was an OPD procedure is not in order and the same is set aside. The insurance company was directed to admit the claim and settle the same as per terms and conditions of the policy.

Kolkata Ombudsman Centre

Case No. 699/11/009/NL/02/2010-11

Smt. Surabhi Gupta

Vs.

Reliance General Insurance Company Ltd.

Order Dated : 08.12.2011

Facts & Submissions :

This complaint is filed against partial repudiation of a claim under Reliance Healthwise policy issued by Reliance General Insurance Company Ltd.

The complainant Smt. Surabhi Gupta stated that she was suffering from perineal abscess and as per advice of Dr. J. Bhaumik she was admitted at Bhagirathi Neotia Woman & Child Care Centre, Kolkata on 02.03.2010 where she underwent an operation (proctoscopy) and she was discharged on 05.03.2010. As per discharge summary the diagnosis of the disease was *'perineal abscess'*.

She lodged a claim for Rs.51,584.74 to the TPA of the insurance company M/s Medi Assist India Pvt. Ltd for reimbursement of hospital expenses. TPA vide their letter dated 16.04.2010 informed her to submit immediately the treating doctor's certificate and IPD papers certified by the hospital and the same was complied with on 22.05.2010. Subsequently the TPA vide their letter dated 18.06.2010 settled Rs.21,000/- towards full and final settlement of the claim. But she did not accept the claim cheque. She represented to the insurance company on 24.07.2010 requesting them to allow the surgeon's fees for Rs.25,300/- for surgical operation and send her a fresh cheque for Rs.46,300/-.

The insurance company stated that the insured Smt. Surabhi Gupta was suffering from Perineal Abscess and got admitted at Bhagirathi Neotia Hospital on 02.03.2010 under Dr. D.J. Bhaumik and was discharged on 05.03.2011 after abscess drainage under regional anaesthesia had been done. On going through the claim papers, the hospital bill of Rs.51,583/- was found exorbitant. Following a survey conducted by an efficient team of doctors and hospital networking executives, it was found that considering the type of accommodation, maximum expenses incurred for perineal abscess surgery is Rs.21,000/- and accordingly, they have settled the claim at this Rs. 21,000/-

DECISION:

The insured has approached this forum for disallowances of surgery fees of Rs.25,300/- and medicines of Rs.583/- on the ground that her claim was exorbitant. No other reason has been given to support the disallowances. The insurer has restricted the claim to Rs.21,000/- on the basis of a survey claimed to have been conducted by an efficient team of doctors and hospital networking executives. A copy of the survey report (in the form of a statement showing package charges for different surgeries) was submitted to this forum, but we find that the statement does not contain the signatures of the doctors or networking executives, who had conducted the survey. Moreover, it does not give the names of the hospitals surveyed by the team and whether Bhagirathi Neotia Hospital was also covered. Even the statement does not reflect the source of different package charges and whether these are actually offered and if so, effective from which dates?. In the absence of signatures of the team members and the date and method of survey being not clear, authenticity of the report is highly doubtful. We find that disallowances were made on the sole ground that bills are exorbitant. The insured has submitted the original bills and proof of payment for surgeon's fee and cost of medicines. The genuineness of the bills and payments made was never doubted by the insurer. More over the insurer has failed to give any justification for applying the package charges, when the patient was not actually charged on that basis. As per their calculation, the insurer has allowed only Rs.503/- for medicines and nothing for OT charges. This is an absurd situation and cannot be accepted under any condition. The action of the TPA in denying the surgeon's charges in full was found to be extremely arbitrary and unfair. Therefore, decision of the insurer to disallow Rs.30,583/- on this account was set aside. Hon'ble Ombudsman directed to settle the claim by allowing the surgeon's fee as per other terms and conditions of the policy.

Kolkata Ombudsman Centre
Case No. 713/11/009/NL/02/2010-11

Shri Surendra Kumar Bachhawat

Vs.

Reliance General Insurance Company Ltd.,

Order Dated : 08.12.2011

Facts & Submissions :

This complaint is filed against repudiation of a claim under Reliance Healthwise policy issued by Reliance General Insurance Company Ltd., on the ground of pre-existing disease as per exclusion clause no. 1 of the policy.

The complainant Shri Surendra Kumar Bachhawat stated that his wife Smt. Nisha Bachhawat was suffering from fibroid uterus with menorrhagia and was admitted at Bhagirathi Neotia Woman & Child Care Centre, Kolkata on 16.03.2010 where she underwent total abdominal hysterectomy with Bilateral Salphingo Oopherectomy operation on 17.03.2011 and was discharged on 21.03.2011. As per discharge summary the diagnosis of the disease was *'fibroid uterus with menorrhagia for 3-4 years'.*

He lodged a claim for Rs.2,47,807 on 03.04.2010 to the TPA of the insurance company M/s Medi Assist for reimbursement of hospital expenses. TPA vide their letter dated 15.09.2010 repudiated the claim stating that '*the insured admitted in Bhagirathi Neotia Woman & Child Care Centre on 16.03.2010 for fibroid uterus with menorrhagia and underwent total abdominal hysterectomy with bilateral salphingo oopherecctomy, insured covered under mediclaim policy since 08.04.2008. As per discharge summary, insured was suffering with fibroid uterus with menorrhagia for the last 3-4 years. In view of the above, the ailment condition is pre-existing for the 1st policy inception and the claim stands repudiated under policy exclusion no.1'.* He represented to the insurance company against such repudiation on 11.10.2010 requesting them to settle his claim.

The insurance company stated that the insured Smt. Nisha Bachhawat was admitted in Bhagirathi Neotia Woman & Child Care Centre on 16.03.2010 for fibroid uterus with menorrhagia and underwent total abdominal hysterectomy with bilateral salphingo oopherectomy. Subsequently the complainant lodged a claim to the insurance company for reimbursement of expenses incurred towards the treatment. They further stated that the insured was covered under mediclaim policy since 08.04.2008. As per discharge summary the insured was suffering with fibroid uterus with menorrhagia for the last 3-4 years. In view of the above, the ailment condition is pre-existing for the 1st policy inception and the claim stands repudiated under policy exclusion no. 1.

DECISION:

The complainant has submitted documentary evidence to show that the first policy from the present insurer incepted in 2007 (from 08.04.2007 to 07.04.2008). Thereafter the policy was renewed without any break and the claim arose in the 3rd year i.e., 08.04.2009 to 07.04.2010. The insurer's contention that the insured was covered under the policy since 08.04.2008 is not correct as the proof of continuous coverage from 08.04.2007 has been submitted by the insured. Moreover, the insurer has mentioned in their written submission that under exclusion no. 1 of the policy all pre-existing diseases are covered from the 3rd year of the policy after 2 continuous renewals or from the 5th year of this policy after 4 continuous renewals subject to the Plan opted.

The insurer has not checked the Plan opted by the insured while applying this condition. The insured has submitted documents which show that she was covered under Gold Plan effective from 08.04.2007 under which the pre-existing disease is covered after 24 months of continuous cover since the inception of the first policy with them. Thus it is very clear that clause no. 1 is not applicable as the waiting period of 24 months have elapsed in this case. We are not going into the dispute regarding the nature of pre-existing disease. It is clear that his claim was made in the 3rd year of the policy and therefore, it is clearly admissible. The decision of the insurer is set aside. The insurer was directed to admit the claim and settle the same as per terms and conditions of the policy.

Kolkata Ombudsman Centre
Case No. 723/11/003/NL/03/2010-11

Shri Ayan Kar

Vs.

National Insurance Company Ltd.,

Order Dated : 08.12.2011

Facts & Submissions :

This complaint is filed against repudiation of claim under Individual Mediclaim Insurance Policy issued by National Insurance Company Ltd., on the ground of pre-existing disease as per exclusion clause no. 4.1 of the policy.

The complainant Shri Ayan Kar stated that he was suffering from hoarse voice and was admitted at Prince Nursing Home, Kolkata on 04.05.201 where he underwent an operation and was discharged on 05.05.2010.

He lodged a claim on 21.06.2010 for Rs.34,209.32 to the TPA of the insurance company M/s Heritage Health TPA Pvt. Ltd. for reimbursement of hospital expenses. TPA vide their letter dated 08.10.2010 repudiated the claim stating that *'as per discharge certificate of Prince Nursing Home dated 05.05.2010 the patient has been suffering from hoarse voice. As per prescription of Prof. (Dr.) Santanu Banerjee dated 17.02.2010, the patient had already been suffering from hoarseness since 7-8 years which are pre-existing. Looking at the policy inception date (i.e. 31.01.2008) & nature of the disease, our medical doctor's opined the claim as non-admissible & stands repudiated as per clause no. 4.1 of standard mediclaim policy'.*

The insurance company stated that the insured was admitted in the Prince Nursing Home on 04.05.2010 for the treatment of his 'hoarse voice' and was discharged on 05.05.2010. He claimed reimbursement of Rs.34,209/- for hospitalization expenses but it was found that the

insured had been suffering from 'hoarseness' for last 7-8 years as per the prescription of Prof. Dr. Santanu Banerjee dated 17.02.2010. Since the policy was first incepted on 30.01.2008, the disease was treated as pre-existing and they repudiated the claim under clause no. 4.1 of the standard mediclaim policy.

DECISION:

It showed that the claim had arisen in the 3rd year of the policy. The insurance company has repudiated the claim of Rs.34,209/- based on the prescription of Dr. Santanu Banerjee dated 17.02.2010, wherein doctor has noted that the patient was suffering from hoarseness of voice for the last 7 to 8 years which was prior to inception of policy on 30.01.2008. The copy of Dr. Santanu Banerjee's prescription has been filed and we find that the insured had consulted the specialist on 17.02.2010 and the doctor had diagnosed "angiomatous nodule". The doctor has also mentioned history of hoarseness of voice for 7 to 8 years. Although the treating doctor has subsequently clarified that the insured was suffering from hoarseness of voice for the last 8 months but this certificate was obtained after 10 months of the surgery and therefore, it cannot be treated as relevant and valid. No doctor could possibly remember the history of the patient after 10 months of the surgery. However, Dr. Santanu Banerjee's prescription mentions only history of hoarseness of the voice which cannot be strictly considered as a disease or ailment. Dr. Bannerjee has not opined that the condition of 'angiomatous nodule' which necessitated the surgery was 7-8 years old. Mere hoarseness may also result from local infection or excessive use of the vocal cord. The complainant has submitted that he was a marketing personnel and his professional duties involve continuous and loud speaking for long hours. He could not have carried on his profession, if the condition had been persisting for 7-8 years. The insurance company has not provided any irrefutable evidence such as doctor's prescription or investigation report for the period prior to the inception of the policy. Under the circumstances, TPA's panel doctor's opinion that the condition of the patient was pre-existing, was not conclusively proved.

After careful consideration of all the facts and circumstances of the case Hon'ble Ombudsman opined that the insurer's decision based solely on the notings of Dr.Bannerjee was not valid and the same was set aside. Hon'ble Ombudsman directed the insurance company to settle the claim as per policy terms and conditions.

Kolkata Ombudsman Centre

Case No. 793/14/003/NL/03/2010-11

Shri Subhas Samanta

Vs.

National Insurance Company Ltd.,

Order Dated : 22.12.2011

Facts & Submissions :

This complaint is filed against delay in settlement of claim under Individual Mediclaim Insurance Policy issued by National Insurance Company Ltd.

The complainant Shri Subhas Samanta stated that he was admitted at Disha Eye Hospital & Research Centre, Barrackpore, Kolkata on 16.03.2010 where first dose of Intravitreal Injection of Macugen was administered in his left eye and he was discharged on 17.03.2010.

He lodged a claim on 24.03.2010 for Rs.45,355/- to the TPA of the insurance company M/s Medsave Healthcare (TPA) Ltd., Kolkata for reimbursement of the above expenses. But after a lapse of almost four months his claim was not settled. He represented to the insurance company on 20.07.2010 stating that he has submitted the claim documents on 24.03.2010 but he did not get any response from them and requested them to settle his claim. He did not get any favouable reply from them. Being aggrieved, the complainant approached this forum for redressal of his grievance seeking monetary relief of Rs.45,355/- in 'P-II' form details. The complainant has given his unconditional and irrevocable consent for the Insurance Ombudsman to act as a mediator between himself and the insurance company and to give recommendation as per Form – P-III dated 16.05.2011.

The insurance company stated that Shri Subhas Samanta took admission at Disha Eye Hospital & Research Centre Pvt. Ltd. Barrackpore on 16.03.2010 and was discharged on 17.03.2010 without any advice from hospital for the treatment of 'LE (BRVO MACULAR EDEMA) and the patient was administered intravitreal injection macugen for this problem. Their TPA was not clear about admissibility of the claim and sought the opinion of the head office. The matter is still pending as they are awaiting the clarification by the Head Office.

It showed that the claim was initially repudiated by the TPA on the ground that administering Macugen injection is not covered under policy and is excluded under clause 4.8 of the policy. However, the insurer was not satisfied with the TPA's action and they have referred the matter to their Head Office for their clarification and advice. We are in possession of the Circular No. 026/2010-11 dated 20.10.2010, issued by the Head Office of the Company, wherein certain conditions have been prescribed for allowing this treatment. One of the conditions is that the claim should arise after 2 continuous years of operation of the policy. Moreover, the treatment should be taken in a hospital or nursing home and it will be admissible for the use of drugs like Lucentis, Macugen etc. From the details filed before us, we find that all the conditions are satisfied in this case and since the claim has arisen in the 3rd year since the inception of the policy, it is clearly covered by policy. The insurer was directed to further verify whether all the conditions were satisfied and after that pay the claim.