BHUBANESWAR

Medi-Claim

BHUBANESWAR OMBUDSMAN CENTER

COMPLAINT NO-11-014-0797

Sri Aswin Kumar Sahoo

Vrs

Cholamandam MS General Ins. Company Ltd., Bhubaneswar B.O.

Award Dated 10th Day of Oct., 2011

This Complaint is filed by the Insured-Complainant against the Opposite Party-Insurer for Repudiating his Medi-Claim.

It is stated by the Complainant that he had taken the individual Health Policy of Insurance from the Opposite Party-Insurer. For his suffering from fever and lobar pneumonia, he received treatment initially at the In-Patient Department of the Government (State) Hospital and incurred an expenditure of Rs.32,280.67. Subsequent to his treatment, when he went to submit his Health-claim Application with the O.P. at its State Branch Office, Bhubaneswar, the same was not accepted from him for want of the Health-Card which had not been issued to him by the O.P. till July 2010. After several contacts and upon deposit of Rs.50/- by him, the Health-Card was issued to him by the O.P. in August 2010 where after his Claim-Application was received by the State Branch Office of the O.P. The O.P. itself made delay in processing the matter for issue of the Health Card to him and it did not accept his claim beforehand without the Health Card and still the O.P. repudiated his Claim raising the ground of late submission of Claim-Application by him. For the negligence of State Branch Office of the O.P. in issue of the Health Card, he could not submit his claim with the Health Card earlier. Being aggrieved thereby, he has filed this Complaint.

In the counter filed by the O.P., it is stated that the rights and obligations of the parties to the insurance contract are strictly governed by the terms and conditions of the policy which stipulates that the claim shall be submitted to the Insurer within 30 days from the date of completion of treatment. But, for the hospitalization treatment undergone by the Complainant for the period from 06.06.2010 to 16.06.2010, the intimation was given to it on 06.08.2010. As the claim was lodged after 30 days of completion of the treatment, there is breach in the policy condition made by the Complainant for which the claim has been denied. Further, it is stated that along with the Claim Application, the Complainant submitted two Cash Memos to support the fact of purchase of medicines in his name for Rs.16,023/- and Rs.15,145/- and upon verification made by the investigator from the concerned shop-owner it was confirmed that no such bills were issued by his store. The O.P. has further stated that the Complainant has been working as Self Record Room In-charge in the Hospital and by misusing his official position in the hospital; he cooked up the record to gain unlawful benefit through the policy with the help of some others. With the above contentions, it prays for dismissal of the case.

In the hearing the Complainant in person and the representative of the O.P. put in their appearances and reiterated their respective stands as already stated in the complaint letter and SCN respectively. As regards the genuineness of the medical bills, the complainant pleads his ignorance and submits that he would discuss the matter with the proprietor of the shop and would explain the position if a fortnight time would be allowed to him.

After analyzing the documents on record it is held that there is a clear delay in intimating to the insurer and this clearly violates the policy condition. There is no documentary proof to support the assertion of the complainant that his claim was not accepted by the insurer in the absence of Health Card. Once policy condition is breached by one party, the other party is free to avoid the policy. So the action of the O.P. in repudiating claim cannot be faulted with.

As regards the two nos. of fake bills submitted by the complainant, even though he asked for a fortnight time to clarify from the shop owner, even after lapse of some months in the meantime, he has not bothered to explain the position. Prima facie, available document i.e., Shop owner's writing, the genuineness of which is not questioned by the Complainant, clearly brings out that the above two cash memos are fake. Though the scope of this forum is limited to ascertain on the genuineness or otherwise of a document, yet on the basis of the materials as are made available, a conclusion is possible that the above two medical bills are not genuine. The Complainant's claim is based on the above two bills which are found to be not genuine. On this ground also, rejection of the claim of the Complainant by the O.P. cannot be said to be uncalled for. In the circumstances, the Complainant is not entitled to the medi-claim from the O.P. Hence, it is ordered that the Complaint is dismissed.

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Medi-Claim

BHUBANESWAR OMBUDSMAN CENTER

COMPLAINT NO-11-017-0798

Smt.Niraja Mohanty
Vrs
Star Health and Allied Ins. Co. Ltd., Chennai
Award Dated 11th Day of Oct., 2011

This Complaint is filed by the Insured-Complainant against the Opposite Party-Insurer for partial Repudiation her Medi-Claim.

The grievance of the Complainant is that she had taken the Health Insurance Policy from the Opposite Party- Insurer for her husband late Durga Prasad Mohanty (the insured hereinafter). Unfortunately, the insured met with a road accident and sustained injuries including fracture of bones in his right leg. For treatment, the insured was admitted into Usthi Hospital, Bhubaneswar where he received treatment as an In-patient from 16.05.2010 to 04.06.2010. In his treatment an expenditure of Rs.2, 00,768/- was incurred. Post-operation complications having arisen in him, further treatments were taken in Ayush Hospital, Bhubaneswar, Neelachal Hospital, Bhubaneswar and Appolo Hospital, Bhubaneswar. Despite treatment, the insured died on 29.06.2010 due to cardiac arrest. Subsequent to his death, she (the Complainant) filed insurance claim in July, 2010 enclosing the bills of all above hospitals in support of her medi-claim. But, the O.P. paid her only Rs.55,000/- as against the payment of Rs.2,00,768/- and also as against the sum insured of Rs.1,00,000/-. As per the policy, she is to get the full insured sum of Rs.1,00,000/- towards her medi-claim. Since the balance amount of Rs.45,000/- has not been paid to her in spite of her requests, she has to file the Complaint seeking for a direction to the O.P. to pay her the balance amount of Rs.45,000/-.

In the Self-Contained Note, it is stated by the O.P. that the medi-claim made in respect of the insured on treatment for fracture injuries was accepted by it and in terms of the policy, Cash-less treatment authorization for the sum of Rs.55,000/- was given to the treating Hospital. However, the

subsequent Claim Application relating to treatment of the insured for cirrhosis of liver were pre-existing and continuing prior to the inception of the policy. As per the 'Exclusions' condition of the policy, the Company i.e.; the O.P shall not be liable to make payment under the policy towards any expense incurred in respect of all diseases existing and suffered by the insured person during the immediately preceding twelve months from the date of proposal. On the above grounds, it rejected the claim and had communicated the fact of rejection to the Claimant on 18.11.2010.

At the oral hearing, both the parties make their appearances and submit more or less the same facts as are stated in their respective pleadings. The OP further submitted that as per the policy conditions the insured is to bear the 30% of the expenses. He submits that as per the policy stipulations, Company's liability is Rs.75, 000/- when the sum insured is of Rs.1, 00,000/- for the disease concerning breakage of bones. He states that as the Company is liable to pay only 70% of Rs.75,000/- which comes to Rs.52,500/-. But, the Company has allowed Rs.55, 000/- towards medi-claim for the above treatment and therefore no further payment for fracture of right leg of the insured is payable by the insurer.

On perusal of the conditions of the policy it is held that the policy condition clearly misunderstood by the O.P. 'Exclusions' condition of the policy provides that the Company shall not be liable to make any payment in respect of any expenses whatsoever incurred by the insured in connection with or in respect of the items listed under Clause 1 to 22. Further, Clause 5 under the Exclusions condition provides that 50% of each and every claim arising out of all pre-existing diseases as defined and 30% of all other claims are to be borne by the insured. There is no dispute that the present Claim is relating to breakage of bones which comes within the "all other claims" category as mentioned in Clause 5. What is plainly specified in this clause is the extent of the claim to be borne by the insured out of the claim made by him or her relating to the treatment. It does not say that 50% or 30% as the case may be, out of the Company's liability would be borne by the insured. If such a meaning is to be given to the clause it will render the extent of Company's liability shown in terms of money specified in the table given in the policy document meaningless. If such meaning is to be understood, under no circumstance this stipulation regarding company's monetary liability to the extent mentioned would never be reached. All that it means is that the insured is to bear 50% or 30%, as the case may be, out of his claim and the rest is to be paid by the Company but subject however to the limit of Company's liability as specified in the table furnished in the policy. The table shows that in respect of the disease relating to breakage of bones when sum insured is Rs.1,00,000/-, the extent of Company's liability is Rs.75,000/-. Rs.2,00,768/- being the amount for which claim was lodged by the Complainant and 30% of claim amount is to be borne by the insured as per the policy condition, the balance 70% is to be borne by the company subject of course to the limit as prescribed therein. So, the insurer's liability comes to Rs.1,40,538/- subject to a maximum amount of Rs.75000/-. Hence, the insurer is liable to pay Rs.75,000/- to the Complainant towards medi-claim for the treatment undertaken for the fractured wound suffered in his right leg due to the accident. But Rs.55,000/- being paid, the Complainant is entitled to balance amount of Rs.20,000/- towards her medi-claim for the treatment relating to the fracture wound of the life insured.

Apropos of the other treatments for which other claim was made, it appears that the treatment of the insured was taken for cirrhosis of liver and chronic renal failure and the above two diseases were existing and was being suffered by the insured more than 12 months prior to the inception of the policy. Exclusion Clause No-1 of the policy condition provides that no payment by the Company i.e., the Insurer shall be made for the disease as defined in the policy existing or suffered by the insured for which treatment or advice was recommended or received immediately preceding 12 months from the date of proposal. So, the above diseases squarely fall within the Exclusion Clause of Pre-existing disease in respect of which the Insurer does not incur any liability for payment. It may be mentioned that the medical certificate also reflects that the disease diagnosed was also fracture of tibia. In respect of the fracture injury full extent of Company's liability has been already allowed. So, no further payment on this account is payable in terms of the policy to the Claimant. To conclude, therefore, as has been already

found, the Complainant is entitled to Rs.20,000/- more towards the treatment received for fracture of the bones of the insured. Hence, it is ordered, that the Complaint is allowed in part. The "AWARD" is passed for Rs.20,000/- in favour of the Complainant. The O.P. is directed to pay the amount under the AWARD, that is, Rs. 20,000/- to the Complainant in time.

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BHUBANESWAR OMBUDSMAN CENTER

COMPLAINT NO-11-004-0810

Sri Jankilal Aditya (Since Dead) & after him Prava Aditya
Vrs
United India Ins. Company Ltd., Rourkela B.O.
Award Dated 28th Day of Oct., 2011

This Complaint is filed by the Insured-Complainant against the Opposite Party-Insurer for Repudiating his Medi-Claim.

It is stated by the original Complainant that being a retired employee of Steel Authority of India Ltd., Rourkela Plant, he along with his wife namely Smt. Prava Aditya was covered under O.P.'s Group Medi-Claim policy of insurance meant for retired SAIL employees and their spouses. The policy extended the benefit of hospitalization treatment by way of Cash-Less or Reimbursement mode to the limit of Rs.2, 00,000/- per member. It is stated that getting diffused pain in her abdomen, his wife- Smt. Prava Aditya was admitted for treatment into one of the empanelled Hospitals under the policy namely Aditya Care Hospital, Bhubaneswar on 25.02.2010. Upon intimation and the request made by him, the O.P. provisionally sanctioned Rs.20, 000/- for the treatment of his wife in the above Hospital on Cash-Less basis. In the course of the treatment of his wife at the Hospital which continued over a period of time, upon call being given to the Neuro-surgeon of the Hospital on 05.03.2010, it was diagnosed by him (the Neuro-surgeon) that all symptoms manifesting in the patient namely Smt. Aditya were on account of her having tumor at D-3 and D- 4 level of the left lateral receptor. When this diagnosis was made, the Insurer cancelled the above sanction without any just cause. By then, the medical expenses in the Hospital on her treatment had gone around Rs.40, 000/-. By cancellation of the sanction when the Cash Less treatment benefit was denied by the O.P., for monetary constraint he had no option but to shift his wife to Ispat General Hospital, Rourkela for free treatment as an ex-employee. But he could get discharge of his wife from the Aditya Care Hospital only after payment of Rs.37, 817/- towards the medical charges in the Hospital which amount he arranged by borrowing Rs. 38,000/-on interest @5%. After some days of treatment in IGH, Rourkela his wife got recovery from her illness. Thereupon, he submitted his claim for Rs.37,817/- with the O.P. who repudiated his claim on the ground that after scrutiny made by the panel of their Doctors, discrepancy was found between the 'Discharge Card' and the 'Request for Authorization Letter' (RAL) with regard to the suffering of the insured. Against rejection of his claim , he represented to the Company but, when no reply was received by him he has to file the Complaint seeking the relief to get the claim amount of Rs.37,817/- with interest of Rs.14,000/- approximately. In P-II he has quantified the total relief sought for by him at Rs.50,000/-.

The Opposite Party neither filed the counter nor any one on behalf of the O.P. bothered to appear during the hearing to put forth their version as against the contentions raised by the Complainant in the Complaint petition. A mention may be made here that during the pendency of the proceedings the Complainant Mr. Jankilal Aditya died. Smt. Prava Aditya, wife of late Jankilal Aditya intimating about the death of her husband has made a request to allow her to appear and pursue the Complaint. After

seeking the permission from the Forum her son appeared at the hearing and supported all material facts as are stated in the Complaint. Since the O.P. has chosen neither to file the counter nor to participate in the hearing, the matter is being decided on the basis of the materials as are available on record.

The copy of the denial of authorization letter filed with the Complaint would show that the Claim Department had noticed the discrepancy between the information given in the "Discharge Card" of the patient and the RAL as per which the patient was admitted and cancelled the sanction which was given for cashless treatment. Perusal of Denial of Authorization Letter would show that while cancelling the sanction, it was simultaneously indicated that denial of authorization for Cash-Less Access is not to be construed as denial of treatment which the policyholder may take as per his or her treating doctor's advice. It is further mentioned that denial of authorization letter shall not be construed to mean that policyholder cannot raise any claim under terms, exclusions and conditions of the policy and in such cases he has to file the claim for reimbursement.

The policy terms and condition provide hospitalisation benefit and reimbursement of treatment expenses and/or Cash Less Benefit. Thus, the policy conditions as reflected in the booklet read alongside the letter of cancellation of sanction given on the basis of Request for Authorization Letter make the position abundantly clear that expenses on the medical treatment of the insured by way of reimbursement is payable by the Insurer to the insured as per the terms &conditions of the policy.

Clause 7 of the policy conditions deals with Exclusions. It provides that the Company shall not be liable to make payment in respect of expenses whatsoever incurred by the insured person in connection with the diseases, injuries as listed under Sub-clause nos. 1 to 13. The letter of repudiation would show that Smt. Prava Aditya who was admitted into the Aditya Care Hospital for treatment of amoebic colitis with FPD and fever was diagnosed to have neurofibroma at D3 and D4 levels. Neither of the two diseases or conditions comes within the Exclusion items of disease/injury/ condition as specified under Exclusion clause of the Policy conditions vide condition no 7. So, as per the terms of the policy, the insured is entitled to the benefit of reimbursement of medical expenses incurred on her (Smt Prava Aditya's) treatment upto the limit of Rs.2, 00,000/-. In the circumstances, therefore, repudiation of the claim as was communicated by the TPA is not justified. The insurer should have settled the reimbursement claim in favour of the Claimant. Hence, it is ordered, that the Complaint is allowed. The O.P. is directed to settle the medi-claim of Smt. Prava Aditya relating to her treatment in Aditya Care Hospital, Bhubaneswar by way of reimbursement of the admissible amount of medical expenses, in time.

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BHUBANESWAR OMBUDSMAN CENTER

COMPLAINT NO-11-002-0819

Sri Sitikanta Mohapatra

Vrs

New India Assurance Company Ltd.

Award Dated 5th Day of Dec., 2011

This is a Complaint filed against repudiation of insurance medi-claim of the Complainant by the Opposite Party-Insurer.

It is stated by the Complainant that being one of the employees of Glaxo Smithkline Pharmaceuticals Co. Ltd. (for short 'Company 'hereafter), he, his wife- Mrs. Anuradha Mohapatra and his son were all covered under the O.P.'s Tailor-made Floater Group Medi-claim policy of insurance. On account of her suffering from the disease of Endocervicitis, his wife Mrs. Anuradha Mohapatra underwent surgery in Trachelorrhaphy and DHL on 13.04.2010 at the private Nursing Home at Cuttack namely, Kshetramohan Seva Sadan, Ranihat, Cuttack where she remained on 13.04.2010 and 14.04.2010 as an in-patient for surgery and treatment. After the treatment, in terms of the policy, he (Complainant) submitted the Medi-claim for Rs.26,164/- through his 'Company' to the O.P. which rejected his claim on the ground that the disease for which treatment was taken, came within the 'Exclusion Clause' no. - 4.8 of the policy under the condition 'sterility'. When such information was given to him, he consulted the treating doctor of his wife namely- Dr. (Prof.) S. Kanungo, Honorary Consultant, Kshetramohan Seva Sadan, Cuttack who clearly opined that diseases /conditions which are excluded under Clause No. 4.8 of the policy do not take within its fold the disease of Endocervicitis for which treatment was taken by his (Complainant's) wife Mrs. Anuradha Mohapatra. On the strength of above opinion of the treating doctor, he made a representation to the O.P. which, however, did not bear any result. Being aggrieved thereby, he has filed this Complaint.

In the Self-Contained Note it is stated by the O.P. that on the medi-claim filed in respect of his wife by the Complainant, opinion of its panel doctor namely Dr. Ismail Bandookwala was taken and after consideration of the Claim papers of the Complainant, the said panel doctor opined that the treatment taken in respect of the wife of the employee namely Sitikanta Mohapatra (Complainant) "can be considered as treatment for infertility/sterility and the Claim falls under Exclusion Clause of the policy". Basing on the opinion of the panel doctor, the claim of the Complainant was rejected. Along with the Self-Contained Note, one copy each of the policy condition containing the Exclusion clause 4.8, the opinion of the panel doctor, Claim Form and other treatment papers are submitted by the O.P.

At hearing, both the parties repeated the facts as already stated by them.

According to the O.P., the disease of Endocervicitis is a treatment for infertility/sterility. The Complainant claims that Endocervicitis is not related to infertility/sterility. Both sides draw support for their respective stand from the opinion of their doctors. It would appear from the opinion report of Dr. Ismail Bandookwala, the panel doctor of the O.P. that on perusal of the Discharge Summary and First consultation report and the type of surgery and treatment taken, he (Panel Doctor) found that the patient- Mrs Anuradha Mohapatra had blocked fallopian tubes and she was given three doses cerverix which is a vaccination against cervical viral infection which is entirely an 'unrelated treatment' not covered under the policy. He has lastly recorded his opinion that above can be considered as treatment for infertility / sterility. The nature of the opinion as expressed in the paper does not positively indicate that the treatment taken was for sterility/infertility. As against such indefinite opinion of the Panel Doctor of the O.P., the medical opinion given by Prof. Dr. S. Kanungo, the Honorary Consultant of Kshetrmohan Seva Sadan, Ranihat, Cuttack which is filed by the Complainant, is that the disease from which the patient Mrs. Anuradha Mohapatra who underwent Trachelorrhaphy and DHL on 13.04.2010, suffered was 'Endocervicitis' which disease is no way related to any of the conditions excluded under clause 4.8 of the policy including infertility and sterility. The copy of the Claim Form filed by the O.P. would show that the doctor, namely Dr. (Prof.) Shyama Kanungo was the

treating doctor of the patient Mrs. Anuradha Mohapatra. His opinion is directly contrary to the indefinite opinion of the panel Doctor of the O.P

As already noted, the panel doctor of the O.P. gave an indefinite opinion saying that the nature of treatment taken by the patient 'can be considered as treatment for infertility/sterility'. Use of the word 'can' by the panel doctor is obviously suggestive of the fact that the treatment may or may not be a treatment for infertility/sterility. As against the above opinion of the panel doctor, the opinion of Dr. (Prof.) Shyama Kanungo is forth-right and clear inasmuch as his opinion is that the diseases Endocervicitis from which the patient suffered is no way also related to infertility and sterility. The issue leaves no further scope for doubt when Stedman's Medical Dictionary is referred. The medical term "Endocervicitis" has been defined in the Dictionary to mean - inflammation of mucus membrane of cervix uteri. It is not explained that Endocervicitis means or is related to sterility. When the opinion of the panel doctor of the O.P. is not definite and when O.P. has not taken any steps to get the opinion of any third doctor after receipt of contrary and positive opinion of Dr. (Prof.) Shyama Kanungo in this regard, the conclusion is inevitable that the treatment taken for Mrs. Anuradha Mohapatra is not a treatment for either infertility or sterility. Clearly, therefore, the disease for which the insured Mrs. Anuradha took treatment does not come within Exclusions clause no-4.8 of the policy. Since no other ground is raised against the claim and since the disease is found not coming within the condition of infertility/sterility, the Complainant is entitled to have his claim settled by the O.P. Hence, it is ordered that the Complaint is allowed. The O.P. is directed to settle the medi-claim in time in favour of the Complainant for the amount to the extent admissible under the policy subject to the acceptance of this "AWARD" by the Complainant.

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BHUBANESWAR OMBUDSMAN CENTER

COMPLAINT NO-14-002-0856

Sri Sailesh Kumar Pattnaik & Smt. Krushan Priya Pattnaik

Vrs

New India Assurance Company Ltd., H.O., Mumbai

Award Dated 22nd Day of Dec., 2011

Non-payment of the cumulative medi-claim amount due in respect of the deceased Nrusingha Charan Pattnaik is the grievance raised by the Complainant.

It is stated by the Complainants that the deceased Nrusingha Charan Pattnaik joined on 09.08.1996 as a member of Senior Citizen's Unit Plan scheme sponsored by Unit Trust of India in association with the Opposite Party. The scheme provided benefit of medical cover on treatment in any of the selected hospitals all over India. It is stated in the Complaint that in the year 2009 Late Narasingh Charan Pattanaik was diagnosed to be suffering from cancer, treated for the same incurring heavy expenses and in spite of the same he died on 23.11.2010. Being the

son and the widow respectively of the deceased, they lodged the medi-claim with the U.T.I. as well as with the O.P., but did not get reimbursement of the medical expenses incurred in the treatment of Late Narasingh Charan Pattanaik, the Scheme-member. Being aggrieved thereby, they have filed the Complainant against the O.P.

In response to the notice issued to the O.P., it is stated by the O.P. that it (O.P.) has never issued any policy to the Complainant nor is it in any way connected with him on the policy taken from U.T.I. Along with it's above statement, it has filed a copy of an unsigned memorandum of Tripartite Agreement between U.T.I. Affiliated Medical/ Nursing Home and the O.P. meant to provide hospitalization benefits to the eligible members under the Senior Citizens Unit scheme of the UTI for the perusal of the forum.

At hearing, the Complainant No-1 submitted about the suffering as well as the treatment of his father for cancer in different hospitals, expenses incurred in the process, lodgment of claim with the U.T.I. and also with the Insurance Company of the O.P. But, the claim was not settled by the OP on the ground that there was no contract between U.T.I. and New India Assurance Co. Ltd. for implementation of the scheme in relation to which the present claim is raised by the Complainants. He further stated that the scheme of the Memorandum of Agreement and the Identity Card would otherwise also show that the benefits of treatment facility were allowed at selected hospitals and the medical expenses arising from the treatment of the individual member concerned was reimbursable by NIAC only to the hospital/ nursing home where treatment was taken and not to the concerned member direct. It is submitted by him that the Complaint filed for payment by the Complainant against it cannot thus lie. The Complainants have not filed any copy of the insurance policy issued by the O.P. in favour of the complainant. After perusing the documents on record it is concluded that it does not put any liability on the O.P. to pay the hospitalization expenses of the member to the individual member under the scheme. In these premises, the Complaint in the present form as laid in this forum is not maintainable against the O.P. Hence, it is ordered that the Complaint is dismissed.

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BHUBANESWAR OMBUDSMAN CENTER

COMPLAINT NO-11-009-0826

Sri K. Madhusudan Rao
Vrs
Reliance Gen. Ins. Co Ltd.

Award Dated 12th Day of Jan., 2012

This is a Complaint filed against the partial repudiation of insurance medi-claim of the Complainant by the Opposite Party- Insurer.

It is stated by the Complainant that he had taken the Reliance Health Policy of Insurance for himself, his wife and his two dependent children –one daughter and one son. During the cover period of the policy the Complainant met with an accident on the road necessitating his hospitalization and medical treatment in Surya Hospital, Visakhapatnam and Yashoda Super Speciality Hospital. In the treatment that

was taken by him, an expenditure of Rs.40,295/- was incurred. He submitted his medical claim for the same amount of Rs.40,295/- enclosing the medical papers, bills and receipts. But the O.P. allowed Rs.36,095/- towards the claim unreasonably disallowing his claim for Rs.3,660/-. When his representation for such unjust deduction of Rs.3,660/- from out of his above claim yielded no result, he has to file the Complaint seeking relief for the amount of Rs.3,660/- as quantified by him in Form P-II.

In its Self-Contained Note, it is stated by the O.P. that the medi-claim lodged by the Insured-Complainant for Rs.40,295/- was sent to its authorized Third Party Administrator namely M/s. Heritage Health Service Pvt. Ltd. (T.P.A. hereafter) for examination of the Claim. After verification, the T.P.A. disallowed seven items in the claim valuing at Rs.4,200/- as, some of those were claimed without supporting bills and the rest were found not allowable as per the terms and conditions of the policy. On the recommendation of the T.P.A., it settled the claim for Rs.36,095/- as against the demand of Rs.40,295/- made by the insured. It is stated that the insured accepted the settled amount of Rs.36.095/- paid to him vide cheque dated 10.11.2010 without demur. Filing of the present Complaint is, therefore, without any justification and is aimed only at dragging the insurer to unnecessary litigation. With these contentions, dismissal of the Complaint is sought by it**.**

At hearing, the Complainant appearing in person and Mr. S.P. Das, Legal Officer representing the O.P. reiterated the facts as are stated by parties in their respective pleadings.

Along with the Self-Contained Note, the detailed statement of the claim reflecting the reasons for disallowing of the individual item of the claim has been filed by the O.P. There is a difference of Rs.4200/- in the claimed amount and settled amount against which, the Complainant has limited his grievance for Rs.3660/- without elaborating as to for which item/items, he has given up his claim for Rs.540/- (Rs.4200/- - Rs.3600/-). The Professional charges towards which Rs.1,000/- was claimed has been disallowed on the reason that 'R.M.O. charge is not payable'. The claim statement itself would show that this amount of Rs.1,000/- is charged towards Professional charges i.e.; Duty-doctor's fees which has also been paid as reflected in the money receipt. Similarly, Rs.475/- was disallowed in the room rent head for the third days very much payable as per the conditions of the policy and therefore there was no justification for the O.P. to reject the claim insofar as those relate to doctor's fee and the room rent for the part of the 3rd day treatment towards which Rs.475/- was charged. The Complainant is therefore entitled to Rs.1.000/- towards Professional charges and Rs.475/- towards room rent for 29.05.2010 which have been thus inappropriately disallowed by the O.P**.**

The miscellaneous expenses for which Rs.400/- was charged are neither elaborated in the bill nor clarified by the Complainant in his Complaint nor explained by him in the course of hearing. So, rejection of the claim for Rs.400/- as has been made by the O.P. is not unjustified. The amount of professional charges amounting to Rs.300/- has been disallowed by the O.P. on the ground that there is no supporting prescription relating to this treatment. The date of the receipt of this item does not come within the two periods of treatment in two hospitals. The medical prescription of neither of the two above Hospitals shows that the patient was advised by the doctor of these two Hospitals where the treatments were taken to take specialist consultation at Sharada Hospital in connection with his treatment. In such circumstances, rejection of this item of claim cannot therefore, be found fault with. The next item disallowed is Rs.140/- towards x-ray examination as per the advice of the hospital but due to non-submission of the X-ray report. In such circumstances, this amount towards the medi-claim ought not to have been disallowed.

The statement would indicate that towards Ambulance charges Rs.2500/- was claimed out of which Rs.750/- has been allowed which is as per the policy terms and conditions. As such, disallowing of Rs.1750/- from the Ambulance charges by the O.P. cannot be found fault with. Subsequent two items disallowed are for Rs.31/- and Rs.104/- towards cost of medicines for want of supporting doctor's prescription. But, it is found that during the period of treatment in Surya Hospital these medicines were sold from the Surya Hospital Sale Counter. It is a common knowledge that medicines are not to be sold

without the doctor's prescription or instructions and more so, at the private hospital's sale counter of the hospital where the patient receives treatment. In such circumstances, the receipts being issued by and sale being made from the sale-counter of Surya Hospital, such amount should not have been disallowed.

Thus, in view of the discussion made above and by taking into consideration the materials on record, the Complainant is found entitled to further amount of Rs.1750/- (Rs.1,000/- + Rs.475/- + Rs.140/ + Rs.31/- + Rs.104/-) towards his mediclaim. Hence, it is ordered that the Complaint is allowed in part. The O.P. is directed to pay further amount of Rs.1750/- towards the medi-claim dues of the Complainant in time. The "AWARD" is accordingly recorded.

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BHUBANESWAR OMBUDSMAN CENTER

COMPLAINT NO-11-012-0868
Sri Bipin Mohapatra

Vrs

ICICI Lombard Gen. Ins. Co. Ltd.Mumbai

Award Dated 31st Day of Jan., 2012

This is a Complaint filed by the Complainant for delay made by the Opposite Party-Insurer in settling his (Complainant) Medi-claim based on the O.P.'s Group Health (Floater) Policy of Insurance taken for the members of Handloom Weavers Society and their family members of whom he (the Complainant) is one.

The say of the Complainant is that being a member of Sankat Tarini Weavers Co-operative Society Ltd., he with his family members was covered under O.P.'s Handloom Weavers' Health Insurance Scheme. His wife- Kabita Mohapatra was hospitalized in the SCB Medical College, Cuttack on 03.07.2009 for child birth and in the treatment taken by her in the SCB Medical college, an expenditure of Rs.6057/- towards hospital charges and medicinal expenses was incurred and the amount was paid by him. For his own illness, he consulted the doctor at the OPD of SCB Medical College on 01.09.2009 who diagnosed his suffering as fever and piles. He was advised to undertake several pathological tests and to take medicines. On pathological tests and medicines he incurred the expenditure of Rs.1401/-. After the treatment, he submitted the medi-claim for Rs.6057/- towards the treatment of his wife and for Rs. 1401/- for self enclosing the prescriptions, Bills & cash memos and Test Reports to the competent authority of the society which forwarded his claim to the insurance company. But, in spite of his several approaches made by him, his medi-claim is not settled by the O.P.. Thus being aggrieved, he has filed this Complaint praying for a direction to the O.P. to settle his claim and to pay the claim amount with interest for the delay in making the settlement.

Though noticed, the O.P. has filed no counter to the Complaint. Nor did it appear to participate in the hearing. For hearing, the complainant alone appeared and made his submissions. Since the O.P. fought shy at every stage of the proceedings, the matter is being disposed off on the basis of submissions of the complainant and materials as are made available by the participating party.

During hearing, the Complainant stated his contentions as stated earlier and his contentions as well as submissions made during hearing remain unchallenged.

The copies of the discharge certificate, treatment papers, Outdoor prescription, Medicine Bill and diagnostic test report clearly support the Complainant's claim of hospitalization treatment of his wife and OPD treatment for himself. Facts asserted in the Complaint remain uncontroverted. There being no challenge, these facts are therefore to be accepted.

The complainant has submitted the copies of the money receipts of the SCB Medical College and various Medicine Stores showing expenditure of Rs.6044/- in the treatment of his wife Kabita Mohaptra and Rs. 1401/- on the treatment of himself at SCB Medical College Hospital, Cuttack.. The total amount in respect of both the treatment comes to Rs.7445/-. The benefit features of the policy as reflected in the policy Benefit sheet filed by the Complainant would show that benefits of maternity hospitalization treatment and OPD treatment are allowed under the policy. The expenditures incurred as shown are well within the monetary limits fixed. In the circumstances, the O.P. ought to have settled the claim of the Complainant soon after receipt of the Claim and the relevant documents from the Complainant. In these premises, the Complainant is entitled to the medi-Claim from the O.P. He is also entitled to interest for the period of delay made in the settlement of his medi-claim by the O.P. Hence, it is ordered that the Complaint is allowed. The O.P. is directed to settle the medi-Claim of the Complainant taking the bills for Rs.7445/- into consideration in favour of the Complainant in time and to pay the settled amount to the Complainant with interest @ 8% per annum from the date of submission of the claim papers with relevant documents till the date of payment of the settled amount.

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BHUBANESWAR OMBUDSMAN CENTER

COMPLAINT NO-11-004-0888

Mrs. Jabin Sultana

Vrs

United India Insurance Company Ltd., Hyderabad D.O. IV

Award Dated 21st Day of Mar., 2012

This Complaint is filed by the Insured-Complainant against the Opposite Party-Insurer for delay in settlement of her Medi-Claim.

It is stated by the Complainant that as enrolled members of M/S Good Health Plan Ltd., Hyderabad ('GHPL' hereinafter) she had taken the AB-Arogyadaan Medi-claim policy of insurance from the O.P.-Insurer through GHPL for herself, her husband and her two sons. During the currency of the policy due to sudden loss of his consciousness, her husband was admitted on 05.07.2011 to the Aditya Care Hospital, Bhubaneswar where he was diagnosed with having Complete Heart Blockage. The treating Physician advised for implantation of pace-maker in him. She requested the authorized TPA of the Insurer to allow cash-less treatment facility for her husband in the Hospital. But the same was denied by the O.P. on the reason that the disease in relation to which request for cash-less treatment was sought was a pre-existing disease in him. The treatment was taken. In the treatment of her husband that was taken in the above Hospital from 05.07.2011 to 10.07.2011 as an in-patient, an expenditure of Rs. 2, 32,006/- was incurred. She lodged the medi-claim with the O.P. and further sent the treating doctor's certificate clarifying that the disease in her husband was not a pre-existing one and requested the O.P. to reconsider her claim. When she got no response from the O.P. she has to file the Complaint praying for settlement of her medi-claim.

In the Self-Contained Note, it is stated by the O.P. that it took up matter with the TPA to settle the claim and to work out immediate settlement it contacted the insured for submission of the original bills which are yet to be received. It is stated that when the bills would be received, it would get the medi-claim settled. Advancing above contentions, it asks for dropping of the case. Subsequently, it is informed by the O.P. that, it has in the meantime got the claim settled and has sent the cheque for the settled amount to the insured who over telephone has confirmed the receipt of the cheque by her towards full satisfaction of her claim.

At hearing, the Complainant's husband who appeared on behalf of the Complainant reiterated the same facts as are stated in the Complaint and at the same time, he admitted that towards the claim, his wife has already received the cheque for Rs.80,000/- only. But, the amount is paid by deducting Rs.20,000/- from the total sum insured of Rs.1, 00,000/- without any reason being shown for making such deduction. On the other hand, the O.P. submits that the claim in question pertained to its Hyderabad office and that he has been informed by the Hyderabad office that as per the policy conditions the deduction has been made and accordingly, the claim has been settled for Rs.80,000/-.

As per conditions of the policy and to be specific clause no.- 4.18 under Standard Exclusions clause of the medi-claim policy states that hospitalization expenses on pace-maker implantation surgery is limited to 80% of the Sum insured subject to Rs.4,00,000/- and when the same is explained to the Complainant's representative he has not raised any quarrel over the same. Thus, policy condition makes it clear that the extent of amount payable towards hospitalization expenses by the insurer in relation to pace-maker implantation surgery in the insured is limited to 80% of the sum insured subject to the maximum of Rs.4,00,000/-. In the matter at hand, the sum insured under the policy taken by the complainant is undisputedly Rs.1,00.000/. The medi-claim in question made by the complainant relates to pace-maker implantation surgery in her husband. For this, the maximum hospitalization expenses which the insured is entitled to get from the insurer is 80% of the sum insured, Rs.1,00,000/- being the sum insured, maximum amount payable by the insurer to the insured in the case is Rs.80,000/-. The same amount having been paid, the complainant is not entitled to any further amount towards her medi-claim. The medi- claim has thus, been rightly settled for Rs.80,000/- in terms of the policy condition. In these circumstances, as the matter stands now, the Complainant being not entitled to any further amount towards the claim, the complaint is liable to be dismissed. Hence, it is ordered that the Complaint is dismissed.

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BHUBANESWAR OMBUDSMAN CENTER

COMPLAINT NO-11-003-0891

Sri Dhitabrata Nayak

Vrs

National Insurance Company Ltd. Mumbai D.O. VII

Award Dated 22nd Day of Mar., 2012

This Complaint is filed by the Insured-Complainant against the Opposite Party-Insurer for delay in settlement of his Medi-Claim.

It is stated by the Complainant that he had taken a Health-first Floater policy of insurance through M/S Karvat Healthcare Services Pvt. Ltd. from the O.P.-Insurer for himself, his father and mother. During the currency of the policy, his mother experienced breathing problem for which she got admitted into the Kalinga Hospital and when approached the TPA of the O.P. for

Cashless treatment facility in the Hospital was denied by it stating the disease in her to be a pre-existing one. All the same, his mother received her treatment in the Kalinga Hospital as an in-patient and after discharge from the hospital he lodged the medi-claim with the O.P. enclosing all requisite documents in original. In spite of his several approaches, when his claim is not settled by the O.P., he has to file the Complaint praying for settlement of his claim. In Form P-II, he has quantified the relief sought at Rs.22,870/- which includes the treatment expenses for Rs.17398/- and Rs.5742/-claimed towards interest for the period of delay in settlement of his claim, postal & telephone expenses incurred by him to secure payment from the O.P. and the mental harassment he suffered. The O.P. did not file any counter/ Self-Contained Note.

At hearing, the Complainant appearing in person further added that in the treatment of his mother in the Kalinga Hopital, where Angiogram was done on her, an expenditure of Rs.17,398/- was incurred. He submitted that in spite of supplying all required documents, the claim amount has not yet been paid to him. On the other hand the O.P.'s representative made his appearance to participate in the hearing and submitted that the claim was processed in its Mumbai D.O. VII and the Medi-claim has been settled for Rs.16,997/-. He submitted that on receipt of Discharge Voucher, the settled amount would be sent to the claimant. In support of his above submissions, he filed photocopies of the E-mail received from O.P.'s Mumbai D.O. VII which confirm the fact submitted by him. The letter shows that out of the total claim made for Rs. 17,398/-, deduction of Rs. 401/- was made. The details of such deduction are reflected in the letter. When confronted, the Complainant did not make any submission on the correctness or otherwise of the amount for which the claim has been settled by the O.P. Resultantly, the amount for which the claim is settled, is appropriate. In the above circumstances, it is ordered that the Complaint is allowed. The O.P. is directed to pay the settled amount of Rs.16,997/- (Rupees Sixteen thousand nine hundred and ninety seven only) to the Complainant on his furnishing the Discharge Voucher to the O.P.

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BHUBANESWAR OMBUDSMAN CENTER
COMPLAINT NO-14-012-0884

Sri Gandharba Seth
Vrs
ICICI Lombard Gen. Ins. Co. Ltd., Mumbai
Award Dated 26th Day of Mar., 2012

This Complaint is filed by the Insured-Complainant against the Opposite Party-Insurer for delay in settlement of his Medi-Claim based on the O.P.'s Group Health (Floater) Policy of Insurance taken for the members of Handloom Weavers Society and their families of whom he (the Complainant) is one.

The grievance of the Complainant is that being a member of Pallishree Weavers Co-operative Society Ltd. he along with his family members was covered under O.P.'s Handloom Weavers' Health Insurance Scheme. On account of his own and his wife's illness during the cover period of the policy, they consulted the doctor of SCB Medical College Hospital, Cuttack on 11.06.2009 and 09.07.2009 respectively .Their ailments were diagnosed upon different pathological tests as UTI (Urinary Tract Infections) for which they took treatments from the Doctor of the above Hospital who prescribed

medicines for them both. In their treatments i.e., on pathological tests and medicines, a total expenditure of Rs.8156/- was incurred. After the treatment, he submitted the medi-claim for Rs.3616/- towards the treatment of his wife and for Rs. 4540/- on his own treatment enclosing the Medical Prescriptions, Bills & cash memos and Test Reports to the 'Society' which forwarded his claim to the Insurer which did not settle the claim. When, in spite of his several approaches medi-claim is not settled by the O.P., he has to file this Complaint praying for a direction to the O.P. to settle his claim and to pay him the claim amount with interest for the delay in making the settlement.

In their Self-Contained Note the O.P. stated that the claim of the Complainant has been settled for Rs4, 330/- and the cheque No.836208 for the amount has been received by the Complainant.

The Complainant alone through his representative appeared at the hearing and the O.P. has chosen to remain absent. During hearing, it is submitted by the Complainant's representative that the complainant has received a cheque for Rs. 4330/- though he had incurred expenditure of Rs. 9000/- approximately in the treatment of self and his wife at the OPD of SCB Medical College Hospital, Cuttack. He submitted that the above payment has been made in respect of Complainant's own treatment and that the claim in respect of Complainant's wife has not been settled which remained uncontroverted as the OP was absent in the hearing.

After perusing various documents it is held by Ombudsman that the complainant has not raised any objection regarding settlement of his own claim and the amount. Thus the claim relating to his wife, Smt. Chhaya Seth, for Rs.3516/- which is not settled by the insurer is considered by this Forum. In the SCN also the O.P. has not mentioned anything relating to this claim. The benefit features of the policy would show that benefits of OPD treatment allowed under the policy is limited to Rs. 7500/- and Rs4,330/- having already been paid in relation to self claim of the Complainant, the balance amount available for payment on OPD treatment is Rs.3170/-. Hence, the maximum amount for which the claim in respect of Smt. Chhaya can be settled is Rs.3170/- though her bills are for Rs.3516/-. Since O.P. has raised no dispute on the claim made for Smt. Chhaya Seth, she is found entitled to receive Rs.3170/- from the O.P. towards her medi-claim and the O.P. is liable to pay interest for the period of delay made in the settlement of Complainant's medi-claim insofar as it relates to his wife's claim, as the OP has not explained the delay in settlement of the said claim. Hence, it is ordered that the Complaint is allowed. The O.P. is directed to settle the medi-Claim of the Complainant for Rs.3170/- with penal interest i.e., @ 8% per annum to be paid from the date of claim till payment of the amount as has been found by this Award.

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DELHI

MEDICLAIM

DELHI OMBUDSMAN CENTRE

Case No. GI/511/UII/10
In the matter of Shri. P.K. Das Gupta
Vs
United India Ins. Company Ltd.
AWARD DATED 3.10.2011 REPUDIATION OF MEDICLAIM

1. This is a complaint filed by Shr. P.K. Das Gupta (herein after referred to as the complainant) against the decision of United India Ins. Company Ltd. (herein after referred to as respondent Insurance Company) relating to repudiation of Mediclaim.

2. Complainant stated that company was not justified in not settling the claim so far. He had submitted the claim for reimbursement of hospitalization expenditure. The claim is remains unsettled even after 2 years. He worked with M/s. Vipul Facility Management Pvt. Ltd., Gurgaon form Oct 2005 to April 2009. During this period he was entitled for Mediclaim as per his work agreement with the company through M/s. Vipul Medi Corp TPA Pvt. Ltd., New Delhi. His wife Smt. Madhumita Das Gupta was admitted in Yashoda Hospital, Secunderabad on 06.08.2008 for operation of Total abdominal hysterectomy+ Bilateral Saplingo oophorectomy. He did not avail cashless facility during the hospitalization period. Hence he submitted the original documents pertaining to hospitalization expenditure of Rs. 63698/- to M/s Vipul Med Corp's New Delhi office on 31.08.2008 for reimbursement. However, it had not accepted his claim by stating that the claim falls under para 4.1 of Mediclaim Ins. Policy which is a case of pre-existing disease. He made lots of efforts to prove that his wife case is not of Pre-existing disease but the company did not hear. The company was not justified in stating that his wife was suffering from Pre-existing disease. It was only about 3 months prior to the operation on 06.08.2008 that she had felt some other gynecological problems, hence doctor advised her to go abdominal hysterectomy operation. He has requested this forum for getting claim paid. Complainant did not attend the hearing.

3. Representative of the company stated that claim is not payable as per clause 4.1 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 in case of insured clause no. 4.1 of the policy is not applicable, Hence claim is payable. **Accordingly an Award is passed with the direction to the Ins. Company to make the payment of Rs. 63698/- along with penal interest at the rate of 8% from 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**.

MEDICLAIM

DELHI OMBUDSMAN CENTRE

Case No. GI/512/UII/10

In the matter of Shri. Anil Kumar

Vs

United India Ins. Company Ltd.

AWARD DATED 4.10.2011 NON SETTLEMENT OF MEDICLAIM

1. This is a complaint filed by Shri. Anil Kumar (herein after referred to as the complainant) against the decision of United India Ins. Company Ltd. (herein after referred to as respondent Insurance Company) regarding non-settlement of Mediclaim.

2. Complainant stated that his wife Smt. Rita Singhal remained admitted for treatment in Max Hospital from 12.01.2010 to 13.01.2010. Thereafter from 24.01.2010 to 28.01.2010. He has not been reimbursed the treatment expenses despite the fact that he has a Mediclaim policy. He has approached the Ins. Company a number of times but his claim was not paid. He has requested this forum to get him paid his Mediclaim. His Mediclaim policy no. is 41700/48/09/97/00002049. During the course of hearing also complainant stated that he submited all requisite documents, he is insured since 19.01.2002. He called the agent for collecting the cheque of premium which was to be paid on 18.01.2009 and due to his mistake there was gap in the policy.

3. Representative of the company stated that claim could not be settled due to non compliance on the part of the insured. He also promised to submit reply but he had not submitted reply so far.

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 not so far settling the claim. The insured had taken the policy since 19.01.2002 and he had been paying premium for renewal on time. He also paid premium by handing over the cheque to the agent in respect of the policy which was to be renewed on 18.01.2008 but
   due to the error of the agent the policy could be renewed from 30.01.2010. Insured genuinely believed that his policy was continued and he is entitled to the benefit of the continuity of the policy. Accordingly in my view claim is payable and the company was not justified in not deciding the claim despite the submissions of all the requisite documents of the insured. **Accordingly an Award is passed with the direction to the Ins. Company to settle the claim and pay him the entitled amount.**

7. 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**.

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4.10.11-MEDICLAIM

DELHI OMBUDSMAN CENTRE

Case No. GI/513/RGI/10
In the matter of Shri. Tek chand Arora
Vs Reliance Gen. Ins. Company Ltd.

AWARD DATED 4.10.2011 REPPUDIATION OF MEDICLAIM

1. This is a complaint filed by Shri. Tek Chand Arora (herein after referred to as the complainant) against the decision of Reliance Gen. Ins. Company Ltd. (herein after referred to as respondent Insurance Company) regarding repudiation of Mediclaim.

2. Complainant stated that company was not justified in rejecting the claim by giving wrong reasons after 4-5 months of submissions of all requisite documents. He had requested to TPA to reopen the case and investigate the matter but his request was denied. He reiterated that all original documents have been submitted to the TPA. He also submitted documents to IRDA and Grievance cell of the company but he did not get any relief so far. He has come to this forum with a request to get the claim settled. During the course of hearing complainant stated that claim is payable because admission in the hospital was as per advice of the treating doctor. He had consulted the doctor prior to the admission of the patient. He submitted his claim which was rejected on flimsy ground.

3. Representative of the company stated that patient over stayed in the hospital. The patient could have been discharged from the hospital after 3 days whereas patient stayed for 8 days. He also referred to written reply of the company dated 09.06.2011 wherein it has been stated that complainant had taken individual policy valid from 17.09.2009 to 16.09.2010 covering himself along with spous, son and daughter. On 27.09.2009 shri. Tek Chand Arora himself got admitted in the Ch. Chhaju Ram Hospital as case of complaint of mild abdominal pain right hypochondrium. He was discharged on 04.10.2009 and preferred a claim of Rs. 28260/- under the policy. It has
been stated further that the claim was repudiated by the TPA of the company with just and in accordance with the exclusion of contract of insurance which was envisaged in the policy document.

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 and also repudiation letter dated 15.03.2010. After due consideration of the matter I hold that Ins. Company was not justified in repudiating the claim because the claim is payable. Complainant was admitted in the hospital due to medical reasons and as per advice of the Dr. **Accordingly an Award is passed with the direction to the Ins. Company to make the payment of Rs. 28,260.**

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**.

MEDICLAIM

DELHI OMBUDSMAN CENTRE

Case No. GI/536/RGI/10
In the matter of Shri. R.M. Makyadath
Vs Reliance Gen. Ins. Company Ltd.

AWARD DATED 4.10.2011 REPUDIATION OF MEDICLAIM

1. This is a complaint filed by Shri. R.M. Makyadath (herein after referred to as the complainant) against the decision of Reliance Gen. Ins. Company Ltd. (herein after referred to as respondent Insurance Company) regarding repudiation of Mediclaim.

2. Complainant stated that he had taken a Reliance Healthwise policy for his son from Reliance Gen. Ins. Company Ltd. bearing no. 282510380378 for the period 01.04.2009 to 31.03.2010. His son was admitted in emergency in Rashmi Medical Centre on 02.05.2009 and was subsequently discharged on 04.05.2009 after due treatment. He lodged the claim for Rs. 12,789.30 with the TPA Medi Assist India Pvt. Ltd. on 19.05.2009. Whatever document required from him, the same were duly submitted but the claim was not settled. He continued to follow up the claim. He was required to submit earlier policy copy, he made that also available but inspector came to his residence for investigation. Enquiry was also made from the clinic. He submitted that his claim is absolutely genuine and Ins. Company is not justified in doubting. He has requested this forum to get the claim settled. During the course of hearing also insured stated that despite the submission of all requisite documents the company had not settled the claim.

3. Representative of the company stated that claim is not payable. He also referred to written submission of the company, wherein it has been stated that on the scrutiny of the documents, it has been found that the claimant was hospitalized for the complaint of high fever and taken treatment. It was found by the company that there was discrepancy, due to that the claim was
repudiated under condition no. 2 of the policy so the repudiation of the claim is justified.
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. After due consideration of the matter, I hold that company was not justified in repudiating the claim because the claim is payable. The patient remained admitted in the hospital, he got the treatment and paid the

bills of the hospital. The claim is genuine thus there is no justification for denying the claim. **Accordingly an Award is passed with the direction to the Ins. Company to make the payment of Rs. 12,789.**

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**.

-MEDICLAIM

DELHI OMBUDSMAN CENTRE

Case No. GI/545/RGI/10
In the matter of Shri. Rakesh Anand
Vs Reliance Gen. Ins. Company Ltd.
AWARD DATED 4.10.2011 REPUDIATION OF MEDICLAIM

1. This is a complaint filed by Shri. Rakesh Anand (herein after referred to as the complainant) against the decision of Reliance Gen. Ins. Company Ltd. (herein after referred to as respondent Insurance Company) regarding repudiation of Mediclaim.

2. Complainant stated that his Mediclaim is pending for settlement. Company had given the reason that hospitalization was less than 24 hours whereas he was admitted for more than 24 hours in the hospital. He submitted the representation to the TPA but the same was not entertained and no satisfactory reply was given. He has come to this forum with a request to direct the Ins. Company to settle the claim. During the course of hearing also complainant stated that claim is payable.

3. Representative of the company stated that claim is not payable due to pre-existing disease. No benefits could be given to the earlier policies taken by him. He also referred to the written reply of the company dated 25.08.2011 wherein it has been stated that complainant Shri. Rakesh Anand obtained individual policy valid from 20.01.2008 to 19.01.2009 covering himself along with spous ,son and daughter. On 02.12.2008 Smt. Sunita Anand got admitted in Indraprastha Apollo Hospital as a case of complaints of Microhaemaeturia , post lithotripsy. She was discharged on 03.12.2008 and preferred a claim of Rs. 38940. The patient was admitted for less than 24 hours in the hospital and the claim was repudiated by the TPA which is just and in accordance with exclusion of contract of insurance.

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. After due consideration of the matter, I hold that claim is payable. The insured is entitled to the benefits of the policy. He had taken insurance since 2003. For admissibility of the claim in respect of such treatment, there is no requirement of the hospitalization for more than

24 hours as patient had taken treatment through advanced technology as advised by the doctor. Thus claim is payable. **Accordingly an Award is passed with the direction to the Ins. Company to make the payment of Rs. 38,940.**

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**.

MEDICLAIM

DELHI OMBUDSMAN CENTRE

Case No. GI/528/NIA/10
In the matter of Shri. G.K. Sethi
Vs New India Assurance Company Ltd.

AWARD DATED 4.10.2011 INADEQUATE SETTLEMENT OF MEDICLAIM

1. This is a complaint filed by Shri. G.K. Sethi (herein after referred to as the complainant) against the decision of New India Assurance Company Ltd. (herein after referred to as respondent Insurance Company) regarding inadequate settlement of Mediclaim.

2. Complainant stated that as advised he had gone to the GRO of the company. He submitted that the Ins. Company and TPA had not reimbursed his claim fully. He has approached this forum to get his claim paid at an early date. During the course of hearing complainant stated that claim was not settled adequately because as against the claim of Rs. 3,12,551, the company had paid only a sum of Rs. 1,56,000. He requested for the payment of the balance amount.

3. Representative of the company stated that claim is payable only at the rate of 80% of the sum insured. The company had already paid the sum of Rs. 2, 30,000 whereas as per policy the payable amount is worked out to Rs. 80% of 3,12,000 to Rs. 2,49,600.

4. I have considered the submission of the complainant. I have also considered the verbal arguments of the representative of the company. I have perused the letter dated 12.04.2011. After due consideration of the matter, I hold that insured is entitled to only 80% of sum insured for hospitalization treatment. Company had already paid sum of Rs. 2,30,000 as per policy. 80% of sum insured is payable which is worked out to Rs. 2,49,600 since insured has been paid only 2,30,000 as against admissible amount Rs. 2,49,600, he is further entitled to Rs. (2,49,600 – 2,30,000) = 19,600+ post hospitalization expenses claimed by the insured. **Accordingly an Award is passed with the direction to the Ins. 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**.

MEDICLAIM

DELHI OMBUDSMAN CENTRE

Case No. GI/553/HDFC/10
In the matter of Shri. Jagram
Vs HDFC ERGO Gen. Ins. Company Ltd.

AWARD DATED 5.10.2011 REPUDIATION OF MEDICLAIM

1. This is a complaint filed by Shri. Jagram (herein after referred to as the complainant) against the decision of HDFC ERGO Gen. Ins. Company Ltd. (herein after referred to as respondent Insurance Company) regarding repudiation of Mediclaim.

2. Complainant stated that he had taken a policy from HDFC ERGO Gen. Ins. Company Ltd. He fell ill and was treated in a Lake View Nursing Home. Thereafter he submitted all relevant papers to settle the claim. Some more documents were demanded from him, the same were also submitted. He also fulfilled the requirements relating to the Nursing Home where he got treated. It has been submitted by him, the hospital where he got treated is registered from Delhi Government for treatment and have all facilities of a hospital. He had submitted all claim papers in the original. During the course of hearing the complainant argued that the company was not justified in repudiating the claim.

3. Representative of the company stated that claim is not payable. Matter was investigated and the claim was found to be inflated. There are many discrepancies in the bills. He also referred to a letter dated 25.10.2010 of the company whereby company had informed the insured that treatment was taken in hospital which did not meet the hospital criteria as per policy terms and conditions and due to mis-representation of the facts, the claim is not payable.

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 23.10.2010. After due consideration of the matter, I hold that company was not justified in repudiating the claim because the hospital at which the treatment was taken by the patient is registered by the State Government. Therefore it meets the requirements of the terms and conditions of the policy. **Accordingly an Award is passed with the direction to the Ins. Company to make the payment of Rs. 26,410.**

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**.

MEDICLAIM

DELHI OMBUDSMAN CENTRE

Case No. GI/566/UII/10
In the matter of Shri. Ravinder Kochhar
Vs
United India Ins. Company Ltd.

AWARD DATED 5.10.2011 PARTIAL SETTLEMENT OF MEDICLAIM

1. This is a complaint filed by Shri. Ravinder Kochher (herein after referred to as the complainant) against the decision of United India Ins. Company Ltd. (herein after referred to as respondent Insurance Company) regarding partial settlement of Mediclaim.

2. Complainant stated that his daughter who was covered in Mediclaim policy bearing no. 221600/48/09/41/00002913 was hospitalized for treatment from 02.02.2010 to 08.02.2010 and thereafter from 09.02.2010 to 17.02.2010. Original bills relating to hospitalization for the period 02.02.2010 to 08.02.2010 were misplaced in the hospital. As advised by the TPA the hospital submitted the certificate certifying that said bills were misplaced by them. For the hospitalization, from 09.02.2010 to 17.02.2010 original bills were submitted. Such bills were submitted well in time to the TPA but the TPA rejected the claim on 14.04.2010 for the reason that original papers pertaining to first period of hospitalization were not submitted. He submitted that treatment papers relating to first period of hospitalization were misplaced and this fact was submitted to the TPA. If TPA had any doubt it could have got the matter investigated but it was not justified to reject the claim. He has come to this forum to get his claim settled. It is further stated that the claim is genuine. During the course of hearing also complainant stated that company had not settled the claim so far and there was no justification for rejecting the claim as a matter of fact he submitted duplicate bills also.

3. Representative of the company stated that insured had given only copy of the bills. Company had furnished details from which it became clear that it had settled the claim of the complainant relating to hospitalization from 09.02.2010 to 17.02.2010 but it had not settled the claim for the hospitalization period from 02.02.2010 to 08.02.2010 on account of non submission of original papers to the TPA.

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 not settling the claim relating to expenses incurred on the treatment for hospitalization for the period 02.02.2010 to 08.02.2010 because it was not impossible for the company to make inquiry from the hospital relating to treatment of the insured. In fact hospital certified about the misplacement of the paper relating to that period. In my view claim is payable because the complainant had submitted duplicate papers for that period. Accordingly claim is payable for this hospitalization also. **An Award is passed with the direction to the Ins. Company to make the payment of Rs. 39,332**

along with penal interest at the rate to 8% on total amount of claim of Rs. 83,313 from the date of payment II hospitalization to the date of actual payment of Rs. 39,332.

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**.

MEDICLAIM

DELHI OMBUDSMAN CENTRE

Case No. GI/565/Star/10
In the matter of Shri. Surender Agarwal
Vs Star Health Allied Ins. Co. Ltd.

AWARD DATED 5.10.2011 REPUDIATION OF MEDICLAIM

1. This is a complaint filed by Shri. Surender Agarwal (herein after referred to as the complainant) against the decision of Star Health Allied Insurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to repudiation of Mediclaim.

2. Complainant stated that he had taken a Mediclaim Insurance Policy no. P/161100/01/000/31 on 10.04.2010. At the time of taking policy, he was having sound health and has never had any heart ailment. He was at that time 45 years of age. On 31.12.2009, he suddenly felt some pain in the chest and shifted to Delhi, where heart surgery was conducted in Sri Balaji Action Medical Institute, Pashim Vihar, New Delhi. He had spent a sum of Rs. 2, 42,648 towards the cost of his ailment. Ins. Company did not provide cashless facility to him. Therefore, he had to make payment after taking loan from his relatives. He is under pressure to repay back the loan amount. He has come to this forum with a request to settle the claim to an early date. During the course of hearing representative of the insured stated that claim is payable.

3. Representative of the company stated that claim is not payable. He referred the letter dated 03.05.2010 of the company wherein it has been stated that Ins. Company had issued the policy for the period 09.04.2009 to 08.04.2010 covering only himself for a sum of Rs. 3,00,000 under Medi Classic individual Policy.

4. I have considered the submissions of the complainant as well as of the representative of the company. I have perused very carefully the discharge summary and also letters dated 02.05.2011 and 18.03.2010 of the company. After due consideration of the matter, I hold that insurance company was not justified in repudiating the claim because the Ins. Company had not submitted any evidence to the effect that the insured was suffering from the same disease for which he was treated before inception of the policy.
Discharge summery also does not speak about the existence of Pre-existing disease or for that matter, the period for which the insured was suffering from hyper tension and DM-2.

Suspicion how so ever strong cannot take the place of evidence. Therefore the reasoning given by the Ins. Company for not admitting the liability, remained unsubstantiated by any corroborative evidence, is not acceptable. In my view claim is payable because the disease for which treatment was taken by the insured was detected after issuance of the policy and the same cannot be described as Pre-existing. **Accordingly an Award is passed with the direction to the Ins. Company to make the payment of Rs. 2, 42,648 along with the penal interest at the rate of 8% from the date of repudiation (e.g. 18.03.2010) 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**.

MEDICLAIM

DELHI OMBUDSMAN CENTRE

Case No. GI/517/NIA/10
In the matter of Shri. Praveen Kumar Sharma
Vs New India Assurance Company Ltd.

AWARD DATED 18.10.2011 REPUDIATION OF MEDICLAIM

1. This is a complaint filed by Shri. Praveen Kumar Sharma (herein after referred to as the complainant) against the decision of New India Assurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to repudiation of Mediclaim.

2. Complainant stated that he is covered in Mediclaim policy from 18.03.2009 to 17.03.2010 from United India Ins. co. Ltd. and from 18.03.2010 to 17.03.2011 from New India Assurance Company Ltd. both the policies were taken from RAPID Healthcare Pvt. Ltd. during the first year he had taken claim for his wife from East West Assist Pvt. Ltd. And this year in May,2010 from Safeway TPA Services Pvt. Ltd. for the same disease and now in July,2010 his wife was again hospitalized on 21.07.2010 to 22.07.2010. He submitted a claim no. 38889 dated 09.08.2010 and claim no. 40771 dated 18.09.2010. This time Safe Way TPA Pvt. Ltd. had rejected the claim with remarks that this disease is covered after two years. He has come to this forum for settlement of the claim. During the course of hearing complainant stated that the claim related to same disease which was settled by the company earlier but this time the claim was refused. He submitted further that claim was repudiated wrongly. Claim is payable.

3. Representative of the company stated that claim is not payable as disease has two years waiting period. The Company stated that the claim was rightly repudiated by the TPA.

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 claim is payable as claim pertains to third of policy period**. Accordingly an Award is passed with the direction to the Ins. 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**.

MEDICLAIM

DELHI OMBUDSMAN CENTRE

Case No. GI/508/RGI/10
In the matter of Shri. Adish Jain
Vs Reliance Gen. Ins. Company Ltd.

AWARD DATED 30.10.2011 REPUDIATION OF MEDICLAIM

1. This is a complaint filed by Shri. Adish Jain (herein after referred to as the complainant) against the decision of Reliance Gen. Ins. Company Ltd. (herein after referred to as respondent Insurance Company) relating to repudiation of Mediclaim.

2. Complainant stated that he submitted claim relating to the treatment of his wife Smt. Kavita to the Reliance Gen. Ins. Company Ltd. but the company had repudiated the claim stating that she was not required hospitalization but the treating doctor advised her to get admitted in the hospital. Insurance company was also intimated regarding this fact but he had not received any reply from the company. Therefore he has come to this forum with request to get the claim settled. During the course of hearing also he stated that claim is payable. The patient was admitted in the hospital at the advice of doctor.

3. Representative of the company stated that claim is not payable because admission in the hospital was only for evaluation purposes. Company also filed written reply wherein it has been stated that complainant Shri. Adish Jain obtained individual policy from 17.09.2009 to 16.09.2010 covering himself along with his wife, son and daughter. On 31.03.2010 Smt. Kavita Jain got admitted in RS Grover Memorial hospital as complaint of Hepatitis. She was discharged on 01.04.2010 and preferred a claim for Rs. 21836. It was further mentioned that the patient was admitted with a complaint of Hepatitis and related disease and was again admitted to observe adverse effects of injection pegasys 180 mcg administration subcutaneously and
patient was discharged on 03.06.2010. it was further mentioned that such a injection is given on the OPD basis and it is not required hospitalization.

4. I have considered the submissions of the complainant as well as of the representative of the company. I have perused the repudiation letter dated 04.10.2010 and also reply of the

company dated 09.06.2011. After due consideration of the matter, I hold that company was not justified in repudiating the claim because claim is payable. Looking in to the circumstances of the case and taking into account. The treatment taken by the insured, it appears justified to me to hold that first claim is payable. Second claim is held not payable because there is merit in the contention of the Ins. Company that there was no justification for subsequent hospitalization particularly when the effect of the injection was already known as result of first hospitalization. Subsequently hospitalization appears to be just to meet the condition of hospitalization otherwise the same was not needed. **Accordingly the claim relating to first hospitalization is only held admissible thus an Award is passed with the direction to the Ins. Company to make the payment of Rs. 95,105.**

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**.

MEDICLAIM

DELHI OMBUDSMAN CENTRE

Case No. GI/571/ICICI/10
In the matter of Shri. R.K. Chadha
Vs ICICI Lombard Gen. Ins. Company Ltd.

AWARD DATED 18.10.2011 REPUDIATION OF MEDICLAIM

1. This is a complaint filed by Shri. R.K. Chadha (herein after referred to as the complainant) against the decision of ICICI Lombard Gen. Ins. Company Ltd. (herein after referred to as respondent Insurance Company) relating to repudiation of Mediclaim.

2. Complainant stated that his wife Smt. Anjana Chadha is a policy holder of policy bearing no. 40341/FFH/W-1127441/00/000. She filed the claim with ICICI Lombard Gen. Ins. Company Ltd. but the claim was repudiated by the Ins. Company on baseless and untrue grounds. All requisite documents have been submitted for settling the claim. GRO of the company was also approached but no response was received. He has come to this forum for settling the claim. During the course of hearing, it was argued by him that company rejected the claim wrongly. His wife was detected cancer she did not have the disease before taking the policy. During the course of hearing insured was requested to get the clarification from treating doctor whether she was bleeding for 5 to 6 years or from 2 to 3 months as mentioned in the discharge summery such clarification was received and is placed on record wherein, it has been stated that bleeding occurred in last 2 to 3 months.

3. Representative of the company stated that claim is not payable because patient suffered from pre-existing disease. Company also filed written reply dated 14.09.2011 wherein it has been stated that complainant had taken a health insurance policy for the period

30.08.2009 to 29.08.2010. This policy was issued on the basis of information provided by the insured with no declaration of pre-existing disease. The policy was also renewed for the
period 30.08.2010 to 29.08.2011. In the written reply company had justified it stand that claim is not payable due to pre-existing disease.

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 27.11.2010 and also written reply dated 14.09.2011 besides discharge summery and doctor's clarification. After due consideration of the matter, I hold that company was not justified in repudiating the claim due to pre-existing disease because patient did not suffer from the pre-existing disease. The treating doctor clarified that the bleeding was since 2 to 3 months and not from 5 to 6 years therefore, claim is payable. Cancer was detected much after taking the policy. Company did not bring evidence of record that cancer was diagnosed and treatment was taken relating to cancer prior to taking policy. Therefore, repudiation of claim on account of pre-existing disease was totally unjustified. Therefore in my view claim is payable. **Accordingly an Award is passed with the direction to the Ins. Company to make the payment of Rs. 1, 52,433.**

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.

MEDICLAIM

DELHI OMBUDSMAN CENTRE

Case No. GI/554/UII/10
In the matter of Shri. Anup Joshi
Vs
United India Ins. Company Ltd.

AWARD DATED 18.10.2011REPUDIATION OF MEDICLAIM

1. This is a complaint filed by Shri. Anup Joshi (herein after referred to as the complainant) against the decision of United India Ins. Company Ltd. (herein after referred to as respondent Insurance Company) relating to repudiation of Mediclaim.

2. Complainant stated that he had taken health insurance policy with United India Insurance Company Ltd. for the last 3 years without any break. He filed a claim on 06.01.2011. All requisite documents were submitted for reimbursement of the claim in time. All the queries raised by the TPA were answered but the Ins. Company denied the claim on 08.09.2010 stating reason that the hospital in which treatment had taken was not in the

approved list of the hospital. The complainant has requested to get the claim paid. During the course of hearing representative of the complainant stated that company denied the claim without proper justification and reasons.

3. Representative of the company stated that the file relating to claim is not available in the office at the moment.

4. I have considered the submissions of the complainant as well as of the representative of the company. Representative of the company stated that the relevant file is not available. Enough opportunities were allowed to the company to be decide the issue claim on the merit. Complainant had submitted all requisite documents to enable the company to settle the claim. Company was not justified in repudiating the claim only on technical ground that the hospital in which the treatment was taken was not in approved list. The company had not denied the claim on merit. The claim otherwise
admissible cannot be denied on technical ground. The hospital in which the treatment was taken is a reputed hospital and it is situated well within Delhi. Company is not justified in repudiating the claim. **Accordingly an Award is passed with the direction to the Ins. Company to make the payment of Rs 5 lakh along with penal interest at the rate of 8% with effect from 02.9.2010 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.

MEDICLAIM

DELHI OMBUDSMAN CENTRE

Case No. GI/576/Star/10
In the matter of Shri. Pawan Kumar Mathur
Vs Star Health Allied Ins. Company Ltd.

AWARD DATED 18.10.2011 REPUDIATION OF MEDICLAIM

1. This is a complaint filed by Shri. Pawan Kumar Mathur (herein after referred to as the complainant) against the decision of Star Health Allied Ins. Company Ltd. (herein after referred to as respondent Insurance Company) relating to repudiation of Mediclaim.

2. Complainant stated that he filed the claim bearing no. 73723 on 06.12.2010. He was admitted in Indraprastha Apollo hospital, New Delhi at 10.00 pm. He submitted all requisite documents for settling the claim. He had received a letter from the company wherein he was conveyed that his claim has been repudiated. He submits further that the claim has been repudiated without considering the claim property. He requested this forum to get the claim paid. He is a policy holder of the company. The documents

submitted by him on 16.12.2010 have been misplaced at end of the branch office of the company. The same had been submitted by him on 16.12.2010. He submitted all documents in original along with X-ray film, Ultrasound films, CD of Digital X-ray duly verified by the treating doctor of Indraprastha Apollo Hospital. He had submitted the copies of the such documents by speed post on 25.01.2011 which was delivered on 27.01.2011. During the course of hearing, the complainant admitted that it did not disclose HTN, in fact his manager filled the form and it did not mention that he was suffering from HTN though he signed the proposal.

3. Representative of the company stated that claim is not payable because insured did not disclose the hyper tension and insured was treating for the hyper tension relating disease.

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 and other correspondence between the insured and the insurer. After due consideration of the matter, I hold that company was not justified in repudiating the claim because complainant was not treated for the disease which was pre-existing. Therefore claim is payable. **Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 29,680.**

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.

MEDICLAIM

DELHI OMBUDSMAN CENTRE

Case No. GI/562/RGI/10
In the matter of Shri. Priyank Kumar Singhal
Vs Reliance Gen. Ins. Company Ltd.

AWARD DATED 18.10.2011 REPUDIATION OF MEDICLAIM

1. This is a complaint filed by Shri. Priyank Kumar Singhal (herein after referred to as the complainant) against the decision of Reliance Gen. Ins. Company Ltd. (herein after referred to as respondent Insurance Company) relating to repudiation of Mediclaim.

2. Complainant stated that a Mediclaim policy no. 2825-1023-7223 was taken on 15.01.2008 from Reliance Gen. Ins. Company Ltd. In April 2008 he felt some problem in his eye, for which he went to hospital in emergency in RP eye centre AIIMS. He was required to come on 05.04.20058 in OPD. He was examined in detailed and he was admitted in general ward. The treatment went on till 09.04.2008 on that date he was discharged from the hospital but he was required to visit the hospital on weekly basis for medical examination. On 25.04.2008 he sent the original bill and prescribed claim form

to the insurance company. When he did not receive any reply from the company and TPA, he visited the insurance company. He was informed by the insurance company that his claim was under process however he received a denial on phone and letter dated 04.03.2009 stating that the disease could be treated on the OPD basis only and there was no requirement for hospitalization. During the course of hearing complainant argued that claim is payable. Company's representative stated that claim is not payable.

3. I have considered the submissions of the complainant as well as of the company. After due consideration of the matter, I hold that company was not justified in repudiating the claim because the insured took the admission in the hospital as advised by the doctor because doctors needed him to observe in the hospital under medication since he was admitted in the hospital and
taken treatment as per advice of the treating doctor of AIIMS, Company could not deny the claim on the ground that he could have taken the treatment as a OPD patient. In my view claim is payable. **Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 10904 along with the penal interest at the rate of 8% from the date of repudiation04.03.2009 to the date of actual payment.**

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**.

DELHI OMBUDSMAN CENTRE

Case No. GI/522/UII/10
In the matter of Shri. Praveen Agarwal
Vs United India Ins. Company Ltd.

AWARD DATED 18.10.2011 REPUDIATION OF MEDICLAIM

1. This is a complaint filed by Shri. Praveen Agarwal (herein after referred to as the complainant) against the decision of United India Ins. Company Ltd. (herein after referred to as respondent Insurance Company) relating to repudiation of Mediclaim.

2. Complainant stated that he was insured through Instant Healthcare Pvt. Ltd. for the period 08.12.2008 to 07.12.2009. He has been insured since 07.12.2004 by the Instant Health Care Pvt. Ltd. he was hospitalized for the treatment active Colitis and submitted documents for reimbursement on dated 12.12.2009 to E-Meditek Solutions Ltd. The TPA had raised the queries that he had complied with. He was confirmed on phone that his claim was under process but vide letter on dated 13.09.2010 it was informed to him that his claim is repudiated due to delay of submission of papers. He has come to this forum

for getting the claim paid. During the course of hearing also complainant stated that company had not settled the claim so far.

3. Company vide its letter dated 24.11.2010 stated that insured did not provide information documents in time and finally sent it on 02.03.2010. Thus there is delay of 65 days. It was not found worth to condone the delay. Therefore, company had expressed its inability to pay the claim.

4. I have considered the submissions of the complainant as well as of the company. I have perused the reasons given in company's letter and also the repudiation letter. After due consideration of the matter, I hold that company was not justified in not settling the claim so far. The claim is payable and
insured had made reasonable compliance of the requirements of the company for settlement of the claim. **Accordingly an Award is passed with the direction to the Ins. 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.

MEDICLAIM

DELHI OMBUDSMAN CENTRE

Case No. GI/523/NIC/10
In the matter of Shri. Surender Kumar
Vs National Ins. Company Ltd.

AWARD DATED 18.10.2011 REPUDIATION OF MEDICLAIM

1. This is a complaint filed by Shri. Surender Kumar (herein after referred to as the complainant) against the decision of National Ins. Company Ltd. (herein after referred to as respondent Insurance Company) relating to repudiation of Mediclaim.

2. Complainant stated claim was filed on 15.10.2009 for reimbursement if expenses with Alankit Healthcare Pvt. Ltd. The company had submitted the reasons for repudiation that claim comes under clause 4.1 of the policy. He had submitted all the policies since July 2000 then there is no question of application of clause 4.1. He has submitted the policy to the Ins. Company but he had received no response. He had come to this forum for redressal of his grievance. During the course of hearing also complainant stated that he had taken the Mediclaim policy since 2000, there is a gap of only 5 days in the policy. He says claim is payable. Company is not justified in repudiating the claim.

3. Representative of the company stated that claim is not payable due to pre-existing disease. Company also filed written reply dated 10.05.2011.

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 as well as repudiation letter dated 29.01.2010. After due consideration of the matter, I hold that company was not justified in repudiating the claim on the ground of pre-existing disease because complainant is insured since 2000 whereas repudiation letter mentioned that the policy is in 4th year with effect from 16.07.2005. Clause 4.1 of the policy is not applicable. Accordingly claim is payable**. Thus Award is passed with the direction to the Ins. Company to make the payment of Rs. 29,938 along with the 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**.

MEDICLAIM

DELHI OMBUDSMAN CENTRE

Case No.GI/574/NIA/10

In the matter of Shri. Surender Kumar Gupta

Vs

New India Assurance Gen. Ins. Company Ltd.

AWARD DATED 22.11.2011 PARTIAL SETTLEMENT OF MEDICLAIM

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

2. Complainant stated that he got operated in Fortis Hospital, Vasant Kunj, New Delhi on 08.04.2010. He filed his mediclaim with New India Assurance Gen. Ins. Company Ltd., with all relevant documents for Rs. 1,23,587. On 03.05.2010, he received a letter from Raksha TPA for breakup of Rs. 1,06,000 in the main hospital bill. As desired breakup was also given in respect of other expenses. He was paid only a sum of Rs. 53,520 on 27.11.2010. He has come to this forum for ensuring the payment of balance claim. During the course of hearing also he requested for payment of balance amount.

3. Representative of the company requested time of 10 days to reconsider the claim and for submission of the report but no report was submitted so far.

4. I have considered the submissions of the complainant. I have also perused the documents placed on record. After due consideration of the matter, I find that company had partially settled the claim. As against an admissible amount of Rs. 85,654, a sum of Rs. Only

53,520 was paid by the Ins. Company. Thus a sum of Rs. 32,134 is further payable to the complainant. **Accordingly an Award is passed with the direction to the Ins. Company to make the payment of Rs. 32,134.**

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**.

MEDICLAIM

DELHI OMBUDSMAN CENTRE

Case No.GI/502/HDFC/10
In the matter of Shri. Vipin Rawat
Vs HDFC Ergo Gen. Ins. Company Ltd.

AWARD DATED 22.11.2011 NON SETTLEMENT OF MEDICLAIM

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

2. Complainant stated that on 24.03.2010 his motorcycle skided on the road and he sustained injury in his left hand which caused swelling and difficulty in movement of hand. He contacted immediately Dr. Narendra Tyagi (Medical consultant appointed by his employer) who after examination prescribed him some medicines. He also advised him to undergo X-ray. Thereafter he consulted orthopedic surgeon Dr. Gaurav Govil whose diagnosis and prescription gave no relief. Thereafter, he went to his parent residing near Aligarh in U.P and got himself examined by Dr. Virender Chowdhry, Sr. Orthopedic surgeon who diagnosed fractured bone piece which is displayed from its initial position and advised surgery. He had communicated the advice of the doctor on phone to Family Health Plan (TPA) Ltd. After discharge from the hospital, he submitted his claim for Rs. 24,599 and submitted all requisite documents. He also furnished the additional information desired by the TPA. Thereafter he contacted TPA on 27.04.2010 on phone and he was informed that the claim filed was closed due to non submission of certificate / information along with other documents. Ultimately, the claim was repudiated. He also approached the GRO of the company. He also explained the circumstances due to which delay occurred in submission of the documents. He has come to this forum for getting the claim settled and paid. Complainant did not attend the office despite an opportunity provided to him.

3. Company was also not represented by any officer on the date of hearing.

4. I have very carefully considered the submissions of the complainant. After due consideration of the matter, I hold that company was not justified in repudiating the claim

because the claim is payable. The insured got injury due to accident and therefore company is liable for reimbursement of the expenses incurred by the complainant for the treatment of the injury. All requisite documents and additional information as desired by the company have been submitted by the insured and in my view nothing is further wanted from him. Company was not justified at all to repudiate the claim. The claim is payable. **Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 24,599/- along with the penal interest at the rate of 8% from the date of closing the file 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**.

MEDICLAIM

DELHI OMBUDSMAN CENTRE

Case No.GI/518/Chola/10

In the matter of Shri. I.S. Soni Vs

Cholamandalam Gen. Ins. Company Ltd.

AWARD DATED 22.11.2011 NON SETTLEMENT OF MEDICLAIM

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

2. Complainant stated that he was an employee of M/s Yamaha Motor India Ltd. and took retirement in 2004 but still he was insured with M/s Cholamandalam Gen. Ins. Company Ltd. He submitted that he submitted a claim relating to treatment of his wife to company's TPA Paramount Health services. He submitted that his wife fell from her flat and got injured. Firstly she was treated at Aims Truma Centre from 11.03.2008 to 26.04.2008 and he incurred an sum of Rs. 41219/- against which he was given only a claim of Rs. 24103/- and a sum of Rs. 17116 was deducted by stating that he did not enclose receipt whereas he had enclosed all receipts relating to this claim. As his wife was not well despite the treatment in Trauma Centre Aims, he got her treated at Holifamily Hospital on 19.05.2009 but that was also not successful. He had submitted the bills for an amount of Rs. 88930 on 26.06.2009. He submitted 3rd bill of an amount of Rs. 18193/- of Holifamily hospital. He again got her treated at Aims From 02.12.2009 to 28.01.2010 and submitted the claim for an amount of Rs. 1,43,395 and still the treatment is continuing. His claim was returned by stating that his wife jumped from 3rd floor. Thereafter, she got infection and she was treated at Aims for which he had to submit bill for an amount of Rs. 30,521. He
submitted that company had not settled the claim for almost 3 years. He has come to this forum with a request to settle the claim at an early date.

3. Representative of the company on the date of hearing requested time to prepare the case however, reply dated 01.11.2011 was submitted wherein it has been stated that claim was made under policy no. HWT 000 1104-000- 00R which was issued and health insurance for the period 19.09.2009 to 18.10.2010. Patient was admitted in the Holifamily hospital from 13.05.2009 to 19.09.2009 with history of fall from height. As per discharge summery the patient is a non case of cytological disorder. It is further stated by the company that all the admissions of the patient was as a result of depression and intentional self injury by jumping from height. In the reply of the it has been stated that the claim deserves to be dismissed.

4. I have considered the submissions of the complainant. I have also perused the written reply of the company. After due consideration of the matter, I hold that the company was not justified in not settling the claim so far. As admitted by the insured, first claim was settled partly as against the claim of Rs. 41,219, a sum of Rs. 24103 was paid by leaving a balance amount of Rs. 17116. Hence, I fail to understand when the company can settle the first claim, why it can't settle the subsequent claims. Admittedly, patient fell from height and got injured and was treated in different hospitals and claims have been filed by the complainant. In my view company was not justified in not settling the claim so far. The claim is payable under the policy. **Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 2,85,220 along with penal interest at the rate of 8% on amount of claims one month after the submission of claims.**

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**.

MEDICLAIM

DELHI OMBUDSMAN CENTRE

Case N o.GI/471/RGI/10
In the matter of Shri. Amit Bahl
Vs
Reliance Gen. Ins. Company Ltd.

AWARDDATED 22.11.2011 NON SETTLEMENT OF MEDICLAIM

1. This is a complaint filed by Shri. Amit Bahl (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 done his best to get the claim settled so far but he could not get it done. All requisite documents relating to settlement of the claim have been submitted and complainant could have been happy to provide any further information to the Ins. Company. He has come to this for getting the claim of Rs. 65,384/- settled at an early date. During the course of hearing also complainant stated that claim is payable and the company was not justified in not paying the claim.

3. Representative of the company did not attend the hearing on last day. However, he attended the hearing held on 25.07.2011 and he also filed written reply dated 22.07.2011 wherein it has been stated that complainant Shri. Amit Bahl obtained Reliance Health Wise Gold Policy valid from 05.02.2010 to 04.02.2011 covering himself along with spouse and son. He is covered under the policy since 05.02.2008 with sum insured of Rs. 4,00,000. On 22.02.2010 he himself got admitted in Kalra Hospital with the complaint of sudden onset of headache with giddiness and profuse sweating. He was discharged from the hospital on 25.02.2010. The claimant preferred a claim of Rs. 38,956 under the policy. It has further been mentioned in the reply that on verification it was found that there was gross
discrepancy and manipulation noted in final bill of hospital and it is observed that hospital prepared two sets of final bills one in the name of Medi Assist India TPA Pvt. Ltd for Rs. 29,681/- and second in the name of patient for Rs. 25,850. The claim was repudiated by TPA of the company and the same was justified.

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, repudiation letter and other relevant papers placed on record. After due consideration of matter, I consider it fair and reasonable if the complainant be made payment of Rs. 34,950. **Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 34.590.**

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.

MEDICLAIM

DELHI OMBUDSMAN CENTRE

Case No.GI/460/Bharti/10
In the matter of Shri. Rakesh Kumar
Vs Bharti Axa Gen. Ins. Company Ltd.

AWARD DATED 22.11.2011 NON SETTLEMETN OF MEDICLAIM

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

2. Complainant stated that he has been getting his medi-claim insurance since 2007 from M/s Instant Health Care Pvt. Ltd. As usual before 30.10.2009, he had issued a cheque no. 33615 for an amount of Rs. 12,802 on 20.10.2009 and had obtained provisional receipt of serial no. 7257 and thus he had deposited the premium before due date . The policy was expiring on 30.10.2009. On 01.11.2009, due to dengue fever to his son Shivam, he consulted at Max Balaji hospital, Parparganj but as no bed was available on that day, he had to get his son admitted at Pushpanjali hospital, Vaishali. He did not receive the policy for the year 2009 to 2010. There he could not get the cashless facility. He had submitted the requisite documents for reimbursement of the expenses relating to treatment of his son to Instant health care Pvt. Ltd. He was issued a card by TPA E-meditek of M/s Oriental Ins. Company. There after he was issued the policy bearing no. 00005928 in the year 2010 in month of February from Bharti Axa Gen. Ins. Company Ltd. In March 2010 E-meditek TPA, on the basis of last policy bearing no. 221600/48/08/41/00002908, his claim was repudiated stating that treatment was not taken in the listed hospitals in NCR. Complainant submitted further that for the last 2 years he was being insured by United
India Ins. Company Ltd. and the Instant health care Pvt. Ltd. of his own changed the company and got him issued the policy after 4 months from Bharti Axa Gen. Ins. Company. He was not provided policy during the treatment. Therefore, he could not know as to how he should proceed about settlement of claim. He had approached various departments such as IRDA but he could not get any satisfactory reply. He had come to this forum for settlement of his claim.

3. Representative of the company stated that Bharti Axa Gen. Ins. Company is not liable to make the payment because the policy coverage for the period when treatment was taken was not to issued by this company. He also referred to the written reply of the company dated 08.08.2011 wherein it was stated that patient was covered under Group health policy no. 00005928 of Instant health care Pvt. Ltd. wherein the policy is effective from 01.01.10. The patient admission date as per the complaint is on 01.11.2009 which does not fall under the policy period.

4. I have considered the submissions of the complainant as made in the complaint and as made by his representative during the course of hearing. I have also considered the submissions of the representative of the company. I have also carefully perused the written reply dated 08.08.2011, certificate of the Insurance dated 07.02.2010 issued by instant health care Pvt. Ltd. on behalf of Bharti Axa Gen. Ins. Company Ltd. with code no. IHPL/20056/0830 for the period 31.10.2009 to 31.10.2010, Policy issued wide endorsement no. 1 dated 28.01.2010 by the Bharti Axa Gen. Ins. Company Ltd., to instant health care Pvt. Ltd. for the period 01.01.2010 to 31.12.2010. After due consideration of the matter, I hold that the Ins. Company was under obligation to entertain the claim of the insured on the basis of the certificate of insurance issued to the insured covering himself and his family which covered the period of treatment. Certificate of insurance clearly indicates that Shri. Rakesh Kumar Jain and his family are duly insured with effect from 31.10.2009 to 31.10.2010. I hold the company is liable for payment of the claim keeping view of certificate of insurance issued by the Ins. Company covering the complainant along with his family with effect from 31.10.2009 to 31.10.2010. The complainant had duly paid the premium wide cheque no. 633615 dated 20.10.2009 amounting to Rs. 12,802 to renew previous policy no. 221600/48/08/41/00002908 which was going to expire on 31.10.2009. **Accordingly an Award is passed with the direction to the Ins. Company to make the payment to the insured 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**.

MEDICLAIM

DELHI OMBUDSMAN CENTRE

Case No. GI/621/HDFC/10
In the matter of Sh. Harpreet Singh
Vs
HDFC ERGO Gen. Ins. Company Ltd.

AWARD DATED 1.12.2011 : NON SETTLEMENT OF MEDICLAIM

1. This is a complaint filed by Sh. Harpreet Singh (herein after referred to as the complainant) against the decision of HDFC ERGO Gen. Ins. Co. Ltd. (herein after referred to as respondent Insurance Company) relating to repudiation of claim.

2. Complainant stated that he is a policy holder of HDFC ERGO with the UHID No. HDFC 0000026161. He got his wrist bone fractured and got admitted for surgery in a network hospital of the insurance company. He gave intimation to the company for authorization of cashless treatment to which he was entitled in time. But on the second day, he received

message of the company denying authorization on frivolous grounds. After two weeks of surgery, he submitted the reimbursement bill but did not receive any reply from the company for a long time. He sent a reminder and e-mail dated 01.10.2010 to which the TPA sent an E-mail stating that the claim is repudiated for delay in submission of documents. Complainant submitted that it was a case of cheating by the insurance company because in documents it promises the cashless treatment, but it denied the same in his case. The reason for repudiation is not valid as the claim was submitted just after the completion of post hospitalization period and the company was informed prior to admission in the hospital. He further submitted that he had to pay the bill of the hospital after borrowing money from other people. He has requested this forum to take action against the company. During the course of hearing also complainant argued that the claim is payable. He submitted that he fell and got injury in hand. He filed the claim within the 7 days of post hospitalization of the admission therefore there is no justification for denying the claim.

3. Company was not represented by any officer at the time of hearing.

4. I have considered the submissions of the complainant as made by him in the complaint and as submitted verbally during the course of hearing. As mentioned above, company was not represented by any officer at the time of hearing. I have perused the repudiation letter. After due consideration of the matter, I hold that company was not justified in repudiating the claim because admissible claim can not be declined merely on the ground that the claim was filed late, though the complainant stated that claim and requisite documents were submitted well in time. Complainant was insured, he fell and got injury and thereafter was treated in hospital. In my view claim is payable. **Accordingly an Award is passed with the 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.**

MEDICLAIM

DELHI OMBUDSMAN CENTRE

Case No. GI/02/NIA/11
In the matter of Sh. Suresh Kumar Dwivedi
Vs
New India Assurance Company Ltd.

AWARD DATED 19.12.2011 NON SETTLEMENT OF MEDICLAIM

1. This is a complaint filed by Sh. Suresh Kr. Dwivedi (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 repudiation of claim.

2. Complainant stated that his motor cycle bearing registration no. DL-4S,AN3653 was stolen on 25.12.2008. He had informed the police on 26.12.2008 on 100 number and also lodged the FIR. He also informed the Ins. Company and had submitted al requisite documents to the surveyor of the company but he had not been given any reply. He came to know later on, that his claim file has been lost and when he contacted the Ins. Company and wanted to know the reasons for closing the claim, he was informed that he had left one key in the motor cycle and another key was with him due to which his claim filed was closed. He requested to reopen the claim file. He has come to this forum for redressal of his grievance. During the course of hearing also complainant argued that his motor bike was stolen and ignition key was not left in the vehicle. The vehicle was parked inside the locked premises when the same was stolen. He submitted all requisite documents for settlement of the claim but the company had denied the claim wrongly.

3. Company was not represented by any of its officer at the time of hearing.

4. I have considered the submissions of the complainant as made in the complaint and also made verbally during the course of hearing. I have also perused letter dated 27.08.2009 of the company. After due consideration of the matter, I hold that company was not justified in denying the claim because claim is payable. Complainant had suffered the total loss as his motor cycle was stolen and that remained untraced. He submitted all requisite documents and also complied with other formalities for settlement of the claim. In my considered view claim is payable**. Accordingly an Award is passed with the direction to the Ins. Company to make the payment of Rs. 11,950 (12000-50) to the complainant along with the penal interest from the date of closing the file 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.**

MEDICLAIM

DELHI OMBUDSMAN CENTRE

Case No. GI/547/NIC/10
In the matter of Sh. Pradeep Tokas
Vs National Insurance Company Ltd.

AWARD DATED 19.12.2011 DELAY IN SETTLMENT OF MEDICLAIM

1. This is a complaint filed by Sh. Pradeep Tokas (herein after referred to as the complainant) against the decision of National Ins. Company Ltd. (herein after referred to as respondent Insurance Company) relating to settlement of the pending claim.

2. Complainant stated that he is an associate of Competent Software Pvt. Ltd. and he along with his family are covered in Group Mediclaim Floter policy bearing no. 361000/46/08/850200000256 by National Ins. Company Ltd., for the period of 28.01.2009 to 27.01.2010. This was a corporate policy between his organization "Competent Software Pvt. Ltd." and National Ins. Company Ltd. He further submitted that he had submitted a reimbursement bill to the Ins. Company and Vipul Medicorp TPA against the expenses incurred by him for the treatment of his wife Smt. Kavita Tokas. He received a query related to hospital that hospital is not approved. He had responded along with the registration certificate of the hospital total amount of the claim is Rs. 11,260. He had given a number of reminders to the TPA and also to the Ins. Company but the claim is not settled as yet. He had come to this forum for redressal of his grievance.

3. During the last date of hearing representative of the company assured to settle the claim within 15 days and also promised to send a report but so far claim was not settled and no report was submitted as promised by the representative of the Ins. Company.

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 not settling the claim so far. The claim is payable. **Accordingly an Award is passed with the direction to the Ins. Company to make the payment of Rs. 11,260.**

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.**

MEDICLAIM

DELHI OMBUDSMAN CENTRE

Case No. GI/505/OIC/10
In the matter of Sh. Ashok Bhatia
Vs
Oriental Ins. Company Ltd.

AWARD DATED 19.12.2011 : REPUDIATION OF MEDICLAIM

1. This is a complaint filed by Sh. Ashok Bhatia (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 repudiation of mediclaim.

2. Complainant stated that his wife Mrs. Santosh Bhatia suffered accidental injury on 18.12.2009 and treated by Dr. Bajpai's Bone and Joint clinic, Piampura, Delhi. Claim under mediclaim policy bearing no. 215600/48/2009/2811 was made with TPA M/s Genins India Ltd but claim was rejected arbitrarily. He approached the GRO of the company but he has received no response. He has come to this forum for settlement of his grievance. During the course of hearing also complainant stated that claim is payable.

3. Representative of the company stated that claim is not payable because patient was not hospitalized. Company also filled a repudiation letter dated `21.02.2011.

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 claim is payable. The patient got injury due to fall and was treated. For admissibility of the claim. There was no requirement of hospitalization for more than 24 hours, therefore, claim is payable. Complainant was also allowed claim under policy no. 215600/48/2010/3319. The company is liable to pay the balance amount payable under mediclaim policy. **It is "Awarded" accordingly.**

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

6. **Copies of the Award to both the parties.**

MEDICLAIM

DELHI OMBUDSMAN CENTRE

Case No. GI/640/OIC/10
In the matter of Sh. Naresh Gupta
Vs Oriental Insurance Company Ltd.

AWARD DATED 20.12.2011 : REPUDIATION OF MEDICLAIM

1. This is a complaint filed by Sh. Naresh Gupta (herein after referred to as the complainant) against the decision of Oriental Insurance Co. Ltd. (herein after referred to as respondent Insurance Company) relating to repudiation of mediclaim.

2. Complainant stated that company had denied the claim relating to hospitalization of his wife Mrs. Manju Gupta arbitrarily. The company had given the reason for not allowing the claim that it falls under the exclusion clause 4.3. He therefore, submitted that mediclaim policies are in continuation since 29.11.2002. He also represented the matter to the Oriental Ins. Company Ltd., but he had received no response. He therefore, approached this forum for an intervention and resolution of his claim. He further submitted that insurance is affected through intermediary taking floater policy issued by

the Oriental Ins. Company Ltd., it was confirmed that the benefits under previous mediclaim policies which are in continuation will be available which are also corborated by the circular no. HO/DGM(T)/91/2006/CR-6073 confirming that the insured will be given the benefit of continuity on renewal of mediclaim insurance policy of other nationalized/ private companies. Therefore, company was not justified in denying the claim under policy no. 215600/48/2010/3148 for the period from 28.11.2009 to 27.11.2010 treating as 1st year policy. During the course of hearing also complainant argued that he is eligible for continuity benefit.

3. Representative of the company stated that claim is not payable because claim was preferred in the first year of the policy. The disease has 2 years
waiting period. Complainant is not entitled to continuity benefit because he had taken policy from the present insurer for the first time.

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 company was not justified in repudiating the claim because in my considered view complainant is entitled to the benefit of the continuity of the policies. As per record, complainant is insured since 28.11.2008 to 27.11.2009 with IFFCO and thereafter renewed by Oriental Ins. Company Ltd., with effect from 20.10.2009 to 27.11.2010. Complainant was under belief that he is insured since 2002, he is entitled to benefit of the continuity. Policy is taken through broker and for change of insurer in my considered view insured cannot be denied the continuity benefit of the policies. **Accordingly an Award is passed with the direction to the Ins. Company to make the payment of Rs. 62,962.**

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.**

MEDICLAIM

DELHI OMBUDSMAN CENTRE

Case No. GI/476/NIC/10
In the matter of Sh. Praful Chand
Vs National Ins. Company Ltd.

Award DATED 20.12.2011 :NON SETTLEMENT OF MEDICLAIM

1. This is a complaint filed by Shri. Praful Chand (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 and his wife were insured since 4 to 5 years under individual mediclaim policy without any break with the National Ins. Company Ltd. He was hospitalized in Indraprastha Apollo Hospital on 19.11.2009 for the treatment of Corpus Callosum Tumour. The Pre and post hospitalization expenses claims documents had been submitted with the TPA M/s Alankit Healthcare Ltd. However a cheque for Rs. 3,850 only was sent as pre and post hospitalization expenses settlement. It is further stated that as per mediclaim policy bearing no. 350201/48/08/8500004305 Rs. 397500 (SI +CB) is payable. Out of which Rs. 249833 (Indraprastha Hospital Rs. 177833 + Max Devki Devi Foundation Rs. 72,000) only have been paid as hospitalization/cashless expenses. Since he was not satisfied with the claim settlement his son Abhishek sent an e-mail with a request to re-check/ re-calculate the bills and also provide all the expenses break up as per his individual mediclaim policy sub limits. However the same has not been responded so far. He has come to this forum for getting the claim settled. During the course of hearing it was argued by the wife of the complainant that respect of claim relating to policy period 2008 -2009, Company had only a sum of Rs. 3850 out of pre and post hospitalization expenses out of Rs. 1,11,560. This claim relates to policy no. 350201/48/08/8500004305 and the same is pending in Jhandewalan branch. She further stated that a claim of Rs. 2,54,745 is also pending for the policy period 2009-2010 with Daryaganj branch in respect of policy no. 361001/48/09/8500001985. Both the pending claims are payable because company had not submitted any reply in respect of such claims.
3. Representative of the company did not attend the hearing on the both the occasions.

4. I have considered the submissions of the complainant. I hold that Company was not justified in setting the claim relating to post and pre hospitalization expenses by making payment of Rs. 3850 as against the claim 1,11,560. I fail to understand as to why the company had not clarified the basis of settlement. Therefore, company was also not justified in not paying the claim for an amount of 2,54,745 in respect of policy no. 361001/48/09/8500001985. Both the pending claims are payable because company had not submitted any reply in respect of such claims. I am therefore, compelled to issue award. **Accordingly an Award is passed with the direction to the Ins. Company to make the payment of Rs. 107710 (1,11,560 – 3850) relating to mediclaim policy no. 35021/48/08/8500004305 and also make the payment of Rs. 2,54,745 relating to policy no. 36100/48/09/8500001985.**

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.**

MEDICLAIM

DELHI OMBUDSMAN CENTRE

Case No. GI/40/NIC/11
In the matter of Sh. Rakesh Trehan
Vs

National Ins. Company Ltd.

Award dated 22.12.2011 : DENIAL TO SETTLE THE MEDICLAIM

1. This is a complaint filed by Sh. Rakesh Tehran (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 settlement of mediclaim.

2. Complainant stated that as advised, he had submitted his representation to the GRO of the company and had not received any response. He has come to this forum for redressal of his grievance. During the course of hearing, he submitted that company had denied the claim wrongly. He put up a claim of Rs. 88,900. He argued that the claim was wrongly denied by the company.

3. Representative of the company stated that claim is not payable as per policy clause 4.16.

4. I have considered the submissions of the complainant as well as of the representative of the company. I have also perused latter dated 19.12.2010 of Sr. Divisional Manager on the addressed to the complainant. After due consideration of the matter, I hold that company was not justified in denying the entire claim of the complainant because except to the cost of CPAP, the remaining claim is admissible. Out of total claim of Rs. 88,900 only cost of CPAP machine is not payable. It is further clarified that cost of CPAP machine is not admissible in view of clause 4.16 if the policy but the remaining claim is admissible. Accordingly an Award is passed with the direction to the Ins. Company to make the payment of Rs. 18,130.

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.**

MEDICLAIM

DELHI OMBUDSMAN CENTRE

Case No. GI/38/UII/11
In the matter of Sh. Radhey Shyam
Vs
United India Ins. Company Ltd.

Award dated 22.12.2011 : NON SETTLEMENT OF MEDICLAIM

1. This is a complaint filed by Sh. Radhey Shyam (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 settlement of mediclaim.

2. Complainant stated that he had taken a mediclaim policy from United India Ins. Company Ltd. His policy no. is 221600/48/10/97/00000721. In the month of September 2009, he was admitted in Joy Nursing Home (14.09.2010 to 17.09.2010) and again admitted in the hospital from 17.09.2010 to 19.09.2010 due to pain in the brain. He submitted all the requisite documents to the TPA E-meditek but his claim was not settled so far. He has come to this forum with a request to get the claim settled. During the course of hearing also complainant argued that claim is payable and he had submitted all requisite documents to enable the company to settle the claim.

3. Company was not represented by any of its officers at the time of hearing.

4. I have considered the submissions of the complainant as made in the complaint and also verbally made during the course of hearing. I have also perused the repudiation letter dated 05.04.2011. After due consideration of the matter, I hold that company was not justified in repudiating the claim only because of late submission. The claim was repudiated on flimsy ground. **Accordingly an Award is passed with the direction to the Ins. Company to make the payment of Rs. 26,658/- along with the penal interest from the date of repudiation that is 05.04.2011 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.**

MEDICLAIM

DELHI OMBUDSMAN CENTRE

Case No. GI/58/RGI/11

In the matter of Sh. Manoj Jindal

Vs Reliance Gen. Insurance Company Ltd.

AWARD DATED 27.12.2011 REPUDIATION OF MEDICLAIM

1. This is a complaint filed by Sh. Manoj Jindal (herein after referred to as the complainant) against the decision of Reliance Gen. Insurance Co. Ltd. (herein after referred to as respondent Insurance Company) relating to repudiation of mediclaim.

2. Complainant stated that he fell ill and admitted on 13.06.2010 in N.R.I. hospital, Housing Board Colony, PH-III,Baddi,The-Nalagarh, Distt.- Salon, Himachal Pradesh. He was discharged on 14.06.2010. Again he fell ill on 15.04.2010, admitted again and discharged on 16.06.2010. He was given cashless treatment. He came to Delhi and again fell ill and

admitted in the hospital on 17.06.2010 in Maharaja Agrasen hospital, Punjabi Bagh, New Delhi he requested for cashless treatment on 18.06.2010 from Reliance Gen. Ins. Company Ltd., but cashless facility was denied. He was discharged on 19.06.2010 from Maharaja Arasen Hospital. He sent all bills amounting to Rs. 19092 but company refused to pay the claim under exclusion no. 21 and 28. He submitted again reminder to the company but he had not received reply. He has come to this forum for settlement of his claim. Father of the complainant stated that claim is payable but company had denied the claim wrongly.

3. Representative of the company stated that claim is not payable as hospitalization was not required. Company also filed written reply dated 14.12.2011 wherein it has been stated that complainant obtained Reliance Health wise silver policy valid from 08.07.2009 to 07.07.2010 covering himself, his wife and two children under a sum insured of Rs. 3 lacs. On 17.06.2010, Sh. Manoj Jindal was admitted in Maharaja Agrasen Hospital,
Delhi with complaints of uneasiness, palpitation and mild shortness of breathe since 4 days and diagnosed as case of Coronary Artery Disease with Unstable Angina. Company further stated that as per his request for cashless facility it was found that complainant had a history of alcoholism and same has been confirmed by the patient to the surveyor but later on hospital denied the categorically the alcoholism. The claim was denied due to alcoholic abuse.

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 26.07.2010 and also written reply dated 14.12.2011. After due consideration of the matter, I hold that company was not justified in denying the claim by stating exclusion 21and 28 as the same are not applicable under full force. Patient was admitted in the hospital and treated also. Tests were done to know the exact cause of the disease and to decide the line of the treatment. Therefore, in my view claim is payable. **Accordingly an Award is passed with the direction to the Ins. Company to make the payment of Rs. 19092.**

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.**

MEDICLAIM

DELHI OMBUDSMAN CENTRE

Case No. GI/09/99/OIC/11
In the matter of Sh. D.P. Chawla
Vs Oriental Insurance Company Ltd.

AWARD DATED 27.12.2011 REPUDIATION OF MEDICLAIM

1. This is a complaint filed by Sh. D.P. Chawla (herein after referred to as the complainant) against the decision of Oriental Insurance Co. Ltd. (herein after referred to as respondent Insurance Company) relating to repudiation of mediclaim.

2. Complainant stated that he was not paid his mediclaim despite the fact that he had sent reminders to Oriental Ins. Company Ltd. He further submitted that he was admitted in Saroj Hospital and Angiography was done successfully on 18.08.2004. But Genins India had denied the claim. He had to arrange the payment of the bill amounting to Rs. 1,20,000. He stated that he had never made any claim regarding the ailment. His policy is continuing since 2000 without any break till date. He was informed that claim is not payable as per exclusion clause 4.1. He submitted further that he does not have diabetes mellitus which is false. He never had septicemia again it is false. He developed sudden onset of shortness of breath for which angiography and angioplasty was done. Claim has been preferred in respect of the treatment taken by him. He has come to this forum for settlement of the claim. The son of the complainant argued during the course of hearing that patient was not suffering from Pre-existing disease and company was not justified in denying the claim.

3. Representative of the company stated that he still needs time to trace the record from the TPA. He was required to submit reply but so far no reply had been submitted.

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 under clause no. 4.1of the policy because there is no evidence on record that patient was suffering from the disease for which the treatment was taken and claim submitted. Claim is payable. **Accordingly an Award is passed with the direction to the Ins. Company to make the payment of Rs. 1,20,000.**

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.**

MEDICLAIM

DELHI OMBUDSMAN CENTRE

Case No. GI/52/RGI/11

In the matter of Smt. Baljeet Kaur

Vs Reliance Gen. Insurance Company Ltd.

AWARD DATED 29.12.2011 :REPUDIATION OF MEDICLAIM

1. This is a complaint filed by Smt. Baljeet Kaur (herein after referred to as the complainant) against the decision of Reliance Gen. Insurance Co. Ltd. (herein after referred to as respondent Insurance Company) relating to repudiation of mediclaim.

2. Complainant stated that she had submitted all the requisite documents relating to the claim under mediclaim policy bearing no. 1301/282510370186. She had also approached the GRO of the company. The company repudiated the claim. She had not received any response from the GRO of the company. During the course of hearing it was stated that claim is payable. She got injured and got admitted in the hospital. Company was not justified in denying the claim.

3. Representative of the company stated that claim is not payable because hospitalization was not required. Company also filed a written reply dated 09.12.2011 wherein it has been stated that Mr. Baljeet singh obtained Reliance health wise gold policy valid from 13.01.2009 to 12.01.2010 covering himself with his wife Mrs. Baljeet Kaur under a sum of Rs. 2 lacs. On 28.12.2009 Mrs. Baljeet Kaur got admitted in central hospital, New Delhi with complaints of slipping from bike with right foot injury. A claim of Rs. 11,522 was preferred. Company further stated that she was hospitalized only for evaluation proposes and hospitalization was not needed. The claim was properly repudiated.

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 as well as written reply of the company. After due consideration of the matter, I hold that company was not justified in repudiating the claim because complainant got injured and admitted in the hospital for treatment. She was not admitted in the hospital for evaluation purposes, she was admitted for the purpose of treatment. In my view claim is payable**. Accordingly an Award is passed with the direction to the Ins. Company to make the payment of Rs. 11,522 along with the penal interest 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.**

MEDICLAIM

DELHI OMBUDSMAN CENTRE

Case No. GI/37/RGI/11

In the matter of Sh. Gulshan Kumar

Vs

Reliance Gen. Insurance Company Ltd.

AWARD DATED 27.12.2011 REPUDIATION OF MEDICLAIM

1. This is a complaint filed by Sh. Gulshan Kumar (herein after referred to as the complainant) against the decision of Reliance Gen. Insurance Co. Ltd. (herein after referred to as respondent Insurance Company) relating to repudiation of mediclaim.

2. Complainant stated that he has been taking mediclaim policy for his wife Smt. Kanta from Punjab National Bank from 2007 which had arrangement with Reliance Gen. Ins. Company Ltd. This scheme was discontinued between Punjab National Bank and Reliance Gen. Ins. Company from 2009. After the scheme was discontinued, he renewed the policy timely from Reliance Gen. Ins. Company with continuity benefit from September 2009 till date. Unfortunately his wife was hospitalized on 07.10.2010 and was discharged on 14.10.2010 after treatment. He submitted the claim for Rs. 1,88,577 which has been denied by the company's TPA stating that disease was pre existing. He submitted further that as per policy terms and conditions all diseases are covered after second year of renewals. His policy is continued for 4 years and there is no justification in denying the claim. He is a senior citizen and is feeling difficulty in making day to day expenses. He has come to this forum for getting the claim paid. During the course of hearing complainant argued that claim is payable and company was not justified in denying the same. He requested that he be allowed the continuity benefit of earlier policies.

3. Representative of the company stated that claim is not payable due to pre-existing disease. The claim is made in 2nd year of the policy. Company also filed written reply wherein it has been stated that Mrs. Kanta got admitted in Fortis Rajan Dhall hospital as a case of lower respiratory tract infection pleural effusion with diabetes mellitus.

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 company was not justified in repudiating the claim because insured deserves to be given the benefit of the continuity. Patient is insured since 2007 but claim was made in the 4th year of the policy. It is admitted fact that earlier policy was taken through Punjab National Bank from insurer and since 2009 the policy was taken directly from the same insurer. The fact remains that same Ins. Company provided the medical cover. Therefore, keeping in view the length of the medical cover the claim is found payable. **Accordingly an Award is passed with the direction to the Ins. Company to make the payment of Rs. 1,88,577.**

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.**

MEDICLAIM

DELHI OMBUDSMAN CENTRE

Case No. GI/43/NIC/11
In the matter of Sh. Anil Kumar
Vs
National Insurance Company Ltd.

AWARD DATED 27.12.2011 :INADEQUATE SETTLEMENT OF MEDICLAIM

1. This is a complaint filed by Sh. Anil Kumar (herein after referred to as the complainant) against the decision of Natinal Insurance Co. Ltd. (herein after referred to as respondent Insurance Company) relating to inadequate settlement of mediclaim.

2. Complainant sated that he is a holder of mediclaim policy no. 360200/48/10/8500000824 valid from 31.05.2010 to 30.05.2011 for a cover of Rs. 5 lacs plus cumulative bonus of Rs. 2,50,000 to each insured namely Mr. Anil Kumar and Mrs. Jayshree Kumar. Besides the above, he was also availing his company's Group Mediclaim Policy from East West Assist Pvt. Ltd., wherein the complainant was covered for an amount of Rs. 5,00,000. Unfortunately on 21.06.2010 the complainant suffered Dilated Cardiomyopathy with severe LV dis-function, LAH etc. and got admitted to Indraprastha Apollo Hospital, New Delhi wherein he was treated for his illness w.e.f. 21.06.2010 to 29.06.2010. The total cost of treatment was worked out to Rs. 9,94,897. Out of total cost of treatment, a sum of Rs. 5,00,000 was paid by East West Assist Pvt. Ltd. wherein he was covered for an amount of Rs. 5,00,000. Therefore, the complainant made the claim only to the extent of Rs. 4,94,879 against the mediclaim policy issued by Ins. Company. It is further stated by him that charges for the hospitalization bill item no. 96 for medical records was not claimed by him while settling the claim. He received the letter bearing reference number NICDR2/23615 dated 24.09.2010 though with cheque no. 886667 dated 24.09.2010 for Rs. 4.34,183 against his claim of Rs. 4,94,897. He submitted further in terms of the policy no. 360200/48/10/8500000824, he was entitled to the full amount of the claim of Rs. 4,94,897.59 and company was not justified in restricting the payable amount to Rs. 4,34,183. Complainant first opted the settlement of claim against his Group Mediclaim Policy and thereafter in respect of remaining claim with company, he further submitted that actual cost incurred by him respect of room was Rs. 61,600 as per policy, he is entitled to 1% of sum insured or Rs. 10,000 per day for 8 days the same worked out to Rs. 80,000 thus total room rent paid is admissible. Similarly, he is entitled to actual cost incurred by way of the surgeon, Anesthetist, Medical Practitioner, Consultants specialists fee etc. There is a cap of 25% of sum insured which is worked out of Rs. 1,75,000 as against the actual amount incurred of Rs. 61,520. In respect of other charges there was a cap of 50% sum insured in respect of Anesthesia, blood, Oxygen, OT Charges, Surgical Appliances, Medicines, Drugs, Diagnostic Material etc. which worked out to Rs. 3,75,000 to which he is entitled. Thus as per caps in the policy A, B and C, he is entitled to a sum of Rs. 4,98,120 (61,600 + 61,520 + 3,75,000). He has submitted that he be further paid a sum of Rs. 60,715 in full settlement of his claim under mediclaim policy bearing no. 360200/48/10/8500000824.

3. Representative of the company stated that claim was settled by the Ins. Company as per terms and conditions of the policy. Company had already paid a sum of Rs. 4,34,183. Company also filed written reply dated 24.06.2011 where in it has been stated that complainant was entitled to total claim of Rs. 9,94,897. A sum of Rs. 5 lacs was paid to the complainant by East West Assistance Pvt. Ltd. which worked out to 50.2437% of the total claim and remaining 49.7563% of the total claim was considered by Park mediclaim TPA Pvt. Ltd. and paid a sum of Rs. 4,34,183. According to company, the company had settled the claim reasonably and complainant is not entitled to any further relief.

4. I have considered the submissions of the complainant as made in the complaint and as verbally made during the course of hearing. I have also considered the verbal arguments of the representative of the company and I have perused the written reply dated 24.06.2011. After due consideration of the matter, I hold that company had not settled the claim appropriately because whereas capping has been considered in case of complainant under head (C) but the same had not been considered under A & B. Complainant is entitled to the full amounts under the head A and B whereas the same had been allowed only to the accent of 50%. There does not seem any justification for restricting the expenses admissible under head A and B to 50% of the claims whereas restriction is with reference to the sum insured. Thus complainant is further entitled to relief of Rs. 60,715. **Accordingly an Award is passed with direction to the Ins. Company to make the payment of Rs. 60,715.**

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.**

MEDICLAIM

DELHI OMBUDSMAN CENTRE

Case No. GI/86/NIA/11

In the matter of Sh. Mahesh Chandra

Vs

New India Assurance Company Ltd.

AWARD DATED 29.12.2011 : PARTIAL SETTLEMENT OF MEDICLAIM

1. This is a complaint filed by Sh. Mahesh Chandra (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 partial settlement of mediclaim.

2. Complainant stated that he is a mediclaim policy holder of New India Assurance Company Ltd., from 17.03.2000, with policy numer 320203/34/08/11/00001024 and he had never taken the claim for any treatment till August 2009. His policy is continuous and he had always paid premium of his policy on time. On 10.08.2009, he was admitted in the paneled hospital of New India Assurance Company Ltd., i.e. Kukreja hospital, C-1, Vishal Enclave, Rajori Garden, New Delhi. He was treated there and discharged on 14.08.2009. He put up a claim for hospitalization for an amount of Rs. 40,831 out of which a sum of Rs. 19,494 was paid to the hospital by the TPA and rest of the payment was paid by him. He had submitted the bill for remaining amount for reimbursement but he was paid only a sum of Rs. 940 and was not paid the remaining amount of Rs. 18,231. He had made efforts to get the reimbursement by company but such efforts were in vain. He has come to this forum for ensuring the payment of balance amount. During the course of hearing also it was argued that company was not justified in making deductions while settling the claim. Company had not responded to his various letters.

3. Representative of the company stated that details were not filed in respect of certain expenses. However, it was admitted fairly by the representative of the company that a sum of Rs. 800 was payable to the complainant out of
rent payable. During the course of hearing the representative of the company also agreed to release the further payment of Rs. 15,731 (14,931 +800) to the insured.

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 claim was not adequately settled by the company and as mentioned above even the company's representative agreed that insured is further entitled to some relief. **Accordingly an Award is passed with the direction to the Ins. Company to make the further payment of Rs. 15,531 along with the panel interest at the rate of 8% from the date of payment of Rs. 940 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.**

MEDICLAIM

DELHI OMBUDSMAN CENTRE

Case No. GI/85/OIC/11
In the matter of Sh. Amit Arora
Vs Oriental Insurance Company Ltd.

AWARD DATED 29.12.2011 REPUDIATION OF MEDICLAIM

1. This is a complaint filed by Sh. Amit Arora (herein after referred to as the complainant) against the decision of Oriental Insurance Co. Ltd. (herein after referred to as respondent Insurance Company) relating to repudiation of mediclaim.

2. Complainant stated that he had received no reply from the GRO of the company. He had submitted all requisite documents. The insurance company was not justified to deny the claim as policy continued since many years. He was insured with National Ins. Company Ltd., from 25.09.2006 to 24.09.2009. He had already provided the copy of all insurance policies from 25.06.2006 to till date. Now he has taken insurance policy from Oriental Ins. Company Ltd. The present insurer accepted his case as continued policy. He has requested to reopen the case and take a appropriate action in this matter. During the course of hearing it was argued that company was not justified to deny the claim because insurance was taken since 2006. All requisite documents were submitted to the company for settlement of the claim.

3. Representative of the company stated that claim is not payable because claim was made within the first year of the policy and insured is not entitled to benefit of continuity of policy taken from other insurer.

4. I have considered the submissions of the complainant as well as of the representative of the company. I have also perused repudiation letter dated 28.03.2011. After due consideration of the matter, I hold that complainant is entitled to benefit of the continuity because complainant is insured from 25.09.2006 to 24.09.2009 with National Ins. Company Ltd., and thereafterfrom the present insurer w.e.f. 25.06.2009 till date. Complainant was under the bonafide belief that he would be allowed to benefit of the continuity by the present insurer. Therefore, complainant is entitled to such benefit in the policy. Claim was denied only because the claim was made in the first year of the policy whereas the fact remained that claim was made in the 4th year of the policy. **Accordingly an Award is passed with the direction to the Ins. Company to make the payment of Rs. 2 lacs. Though the claim was made for Rs. 3,50,610 but the same has been restricted to the sum insured of Rs. 2 lacs.**

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.**

MEDICLAIM

DELHI OMBUDSMAN CENTRE

Case No. GI/50/UII/11

In the matter of Sh. Gopal Jain

Vs

United India Insurance Company Ltd.

AWARD DATED 29.12.2011 INADEQUATE SETTLEMENT OF MEDICLAIM

1. This is a complaint filed by Sh. Gopal Jain (herein after referred to as the complainant) against the decision of United India Insurance Co. Ltd. (herein after referred to as respondent Insurance Company) relating to inadequate settlement of mediclaim

2. Complainant stated that he was insured by platinum health policy of M/s United India Insurance Company Ltd. He had to be hospitalized in Saroj hospital and heart institute on 26.11.2010. He claimed reimbursement for an amount of Rs. 83600. He received a sum of Rs. 55,172 towards the settlement of his claim and M/s E-meditek had deducted Rs. 28428 out of the claim of Rs. 83600. He further states that he is protesting for deduction of Rs. 24965 for bill no. 7717. He had attached the cash memo in this bill dated 02.12.2010. He further argued that bill no. 7717 for an amount of Rs. 24965 relating to medicines as prescribed by doctor on discharge from the hospital. Therefore, this amount is payable to him. During the course of hearing also he argued that he is entitled to reimbursement of the expenses in respect of the medicines purchased by him as prescribed by the doctor on discharge from the hospital.

3. Representative of the company stated that company while considering the claim related to post hospitalization expenses, as per policy terms and conditions the claim had already settled.

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 not settling the claim relating to post
hospitalization expense. Insured had incurred an expenditure of Rs. 24,965 on account of purchase of medicines for treatment of post hospitalization period. Such medicines were purchased as per advice of the doctor on discharge from the hospital. Therefore, company ought to have considered this claim also. The claim is payable. It has been informed by the Senior Divisional Manager of the company that besides already making payment of Rs. 55172, company also made payment of Rs. 17278 to the complainant against the claim of Rs. 24965 for post hospitalization treatment. Out of the post hospitalization claim of Rs. 24965 only a sum of Rs. 24028 is payable out of which a sum of Rs. 17278 has already paid. Therefore, complainant is only entitled to a further relief of Rs. 6750. **Accordingly an Award is passed with the direction to the Ins. Company to make the payment of Rs.6750.**

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.**

MEDICLAIM

DELHI OMBUDSMAN CENTRE

Case No. GI/84/NIA/11
In the matter of Sh. Anuj Bhatia
Vs
New India Assurance Company Ltd.

AWARD DATED 29.12.2011 PARTIAL SETTLEMENT OF MEDICLAIM

1. This is a complaint filed by Sh. Anuj Bhatia (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 partial settlement of mediclaim.

2. Complainant stated that he had lodged a claim to Raksha TPA bearing no. 90221011104297 relating to treatment of his wife who was admitted in the hospital from 23.09.2010 to 27.09.2010. He put up a claim for Rs. 86485. Company had paid him only a sum of Rs. 42343 (35323+7020). The company stated, the deductions were made while settling the claim with reference to the entitlement in the policy. Complainant stated that he had got the estimate cost from the hospital which showed minimum charges applicable for economy segment at Rs. 67188. He has come to this forum for ensuring payment of balance amount. During the course of hearing also complainant submitted that company was not justified in making deductions as done by it while settling the claim.

3. Representative of the company stated that claim was settled as per policy terms and conditions.

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 making payment of only Rs. 42343 out of claim of Rs. 86485. In my considered view, he is entitled to some further relief. **Accordingly an Award is passed with the direction to the Ins. Company to make the payment of Rs. 11,391.**

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.**

MEDICLAIM

DELHI OMBUDSMAN CENTRE

Case No. GI/80/NIA/11
In the matter of Smt. Anita Mohan
Vs

New India Assurance Company Ltd.

Award dated 27.12.2011 FOR INADEQUATE SETTLEMENT OF MEDICLAIM

1. This is a complaint filed by Smt. Anita Mohan (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 inadequate settlement of mediclaim.

2. Complainant stated that she submitted a claim for an amount of Rs. 57,246 to the TPA. The bill was approved for only Rs. 25,790. She had made representation to the GRO of the Company. She was surprised to know that while settling the claim, company had made unnecessary deductions. She had come to this forum for ensuring balance payment to her amounting to Rs. 31,456. During the course of hearing also she stated that claim was partially settled by the Ins. Company.

3. Representative of the company stated that company paid pre and post hospitalization expenses as per terms and conditions of the policy. As regards, hospitalization claim the same was also paid by the company as per policy terms. Sum insured in case of the complainant is 1 lac and thus she is entitled to room rent only at the rate of 1% of the sum insured and the hospitalization claim was settled with reference to the admissibility of the room rent payable. Company also submitted written reply dated 05.09.2011 wherein it has been stated that TPA has settled the claim for Rs. 25,790 and sent the cheque for Rs. 8642 also when was found payable. The same was also being paid. Thus the claim has been settled for an amount of Rs. 34,432.

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 dated 05.09.2011. After due consideration of the matter, I hold that company had settled the claim as per terms and conditions of the policy. As against the total claim for Rs. 57,247 the company had settled the claim for an amount of Rs. 34,432. Complainant is further found entitled to the sum of Rs. 9586. **Accordingly an Award is passed with the direction to the Insurance Company to pay her a sum of Rs. 9586.**

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.**

MEDICLAIM

DELHI OMBUDSMAN CENTRE

Case No. GI/603/NIC/10
In the matter of Sh. Siddharth Srivastav
Vs
National Ins. Company Ltd.

AWARD DATED 5.1.2012 NON SETTLEMENT OF MEDICLAIM

1. This is a complaint filed by Sh. Siddharth Srivastav (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 had taken individual mediclaim policy from National Ins. Company Ltd., on April 2010. The policy no. is 351800/46/10/8500000168 and card no. is NIC-IHI-04081. He further stated that he had been suffering from ACL ligament from last five years. It was diagnosed in January 2010 and one surgery was required to reconstruct that ligament. So orthosurgeon sent cashless request to TPA East West Pvt. Ltd. The TPA rejected by saying Pre- existing disease are not covered. He further stated that in the policy it has been clearly mentioned that Pre-existing are covered from day one. He argued and submitted papers but company did not respond. After two months cashless request was rejected. He had under gone surgery and sent claim for reimbursement of the expenses. But the company denied the claim due to pre-existing disease. He felt frustrated by such attitude of the company so he has come to this forum for settlement of his grievance. The complainant did not attend the hearing despite allowance of three opportunities.

3. Representative of the company stated that claim is not payable because insured did not disclose the disease while taking the policy as he was required to do in the proposal form itself.

4. I have considered the submissions of the complainant as made in the complaint. I have also considered the verbal arguments of the representative of the company. I have perused letter dated 06.05.2011 written by TPA to divisional manager of Ins. Company. After due consideration of the matter, I hold that company was not justified in denying the claim due to pre-existing disease because pre-existing disease are covered in the policy therefore claim is not payable. Complainant had taken a mediclaim policy for himself and his family members for the period 09.04.2010 to 08.04.2011. The policies issued were Group Tailor made floater policy with pre-existing disease cover. **Accordingly an Award is passed with the direction to the Ins. Company to make the payment of Rs. 1,14,406.**

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.

MEDICLAIM

DELHI OMBUDSMAN CENTRE

Case No. GI/88/OIC/11
In the matter of Sh. Sanjeev Kumar Dhawan
Vs Oriental Ins. Company Ltd.

AWARD DATED 12.1.2012 INADEQUATE SETTLMENT OF MEDICLAIM

1. This is a complaint filed by Sh. Sanjeev Kumar Dhawan (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 inadequate settlement of mediclaim.

2. Complainant stated that he had taken a health Ins. Policy bearing no. 252106/48/09/02077 where in his parents Sh. Vinod Kumar Dhawan and Smt. Saroj Dhawan were ensured for Rs. 2,50,000. His father Sh. Vinod Kumar Dhawan suffered from heart problems and was treated at Yashoda super speciality hospital and heart institute, Ghaziabad and Fortis Escort heart institute and Research Centre, Delhi. Ultimately, his father expired in Fortis Heart institute. He filed the claim. Company had settled cashless claim to the hospital to the tune of Rs. 88032. Such cashless facility related to treatment at Escorts Heart institute and Research centre. The claim for expenses incurred at Yashoda hospital, Ghaziabad was submitted to Raksha TPA on 09.03.2011 for sum of Rs. 2,34,200. Since sum of Rs. 88,032 was already paid, a sum of Rs. 1,61,968 was payable against the claim. In July 2010, he received a cheque for an amount of Rs. 1,11,079 in the name of his Late father as a cheque was short of the policy value and issued in the name of dead person, he returned the cheque for making corrections but he had not received the corrected cheque. No, any other response was received from the company. He had made efforts to get the claim settled but company had not settled the claim so far. He has requested this forum for making the payment of Rs. 1,61,968 along with penal interest of 24% and also compensation for harassment. During the course of hearing complainant stated that company had paid him a sum of Rs. 1,11,079. It also allowed the cashless facility.

3. Representative of the company stated that claim was settled as per policy terms and conditions and complainant is not entitled to any further relief. while settling the claim enhanced sum insured was not taken undercounts because the sum insured was increased in 2007 and the claim related to policy 2009-2010. During the pre-existing disease, the claim was payable only with reference to the previous sum insured of Rs. 2,00,000.

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 justified in settling the claim with reference to the previous sum insured of Rs. 2,34,200 due to treatment of pre-existing disease. Sum insured was increased in 2007 and the claim related to 2009-2010. However, Policy continued since 2004 therefore enhanced sum insured will not be available in the policy period 2009-2010. I find that a sum of Rs. 1,11,079 was received late by the complainant due to technical reasons that earlier the cheque was issued in the name of complainant's father who was already dead. Therefore,

complainant needs to be compensated on account of late payment by the company a sum of Rs. 1,11,079. Accordingly company becomes liable for penal interest on this amount from the date of issuance of first cheque to the date of actual payment of Rs. 1,11,079. **Accordingly an Award is passed with the direction to the Ins. Company to pay penal interest to the complainant at the rate of 8% on sum of Rs. 1,11,079 from July 2010 to the date of actual payment of this 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.**

MEDICLAIM

DELHI OMBUDSMAN CENTRE

Case No. GI/70/NIA/11
In the matter of Sh. Gopal
Vs
New India Assurance Company Ltd.

AWARD 24.2.2012 NON SETTLEMENT OF MEDICLAIM

1. This is a complaint filed by Sh. Gopal (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 claim.

2. Complainant stated that whatever documents were required by the Ins. Company, the same were submitted to it but the Ins. Company had not made the payment of the claim. The complainant has come to this forum with a request for getting the sum of Rs. 4,140 paid. During the course of hearing also complainant argued that claim is payable. He further submitted that he underwent some tests as he is a cancer patient and submitted the claim papers to the Ins. Company for making the payment.

3. Representative of the company promised to look in to the matter, but no reply was submitted.

4 I have considered the submissions of the complainant as well as of the representative of the. After due consideration of the matter, I hold that company was not justified in not making the payment on account of expenditure incurred by the complainant for tests. Complainant is a cancer patient and got certain tests conducted at All India Institute of Medical Sciences. It comes under advance technology treatment. In my view claim is payable. **Accordingly an Award is passed with the direction to the Insurance Company to make the payment of Rs. 4,140.**

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.

MEDICLAIM

DELHI OMBUDSMAN CENTRE

Case No. GI/49/NIA/11
In the matter of Sh. Kamal Raja Vinaik
Vs
New India Assurance Company Ltd.

AWARD DATED 24.2.2012 NON SETTLEMENT OF CLAIM

1. This is a complaint filed by Sh. Kamal Raja Vinaik (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 claim.

2. Complainant stated that his wife was admitted in Max hospital saket on 13.08.2010 and was diagnosed for circumferential Avulsion right little finger with amputation of Distal Phalon caused due to accident. Doctor operated on the same day i.e. on 13.08.2010 and the procedure was carried out in the operation theatre. Total bills of the operation along with rental charges of wound assistance console amounted Rs. 10,395. She was admitted again on 23.08.2010 for the same procedure was done the entire bill for procedures performed on 13.08.2010 to 14.08.2010 and 23.08.2010 to 24.08.2010 was submitted to Insurance Company. The total amount of these bills worked out to Rs. 1,33,201 but the insurance company sent him a cheque for Rs. 60054 only. On 15.02.2011, he informed the Raksha TPA at Mathura Road that the claim settled by the company was not acceptable. He has come to this forum with a request to get the claim settled. During the course of hearing complainant stated that claim was not settled properly. Deductions were made by the Insurance Company while settling the claim was unacceptable. His wife finger was damaged and the surgery was made later on.

3. Representative of the company stated that claim was settled as per terms and conditions of the policy as against the total claim of Rs. 1,33,201. Company approved and paid the claim of Rs. 60054. Company also filed a reply dated 06.07.2011 wherein it has been stated that Mrs. Ritu Vinaik was admitted in Max Healthcare Institute on 13.08.2010 and was discharged on 14.08.2010. The claim was intimated on 01.09.2010. As per policy condition the claim must be intimated within 7 days. Hence the claim stands not payable. However, the claim was settled by the TPA for Rs. 60054 as per policy terms and conditions. During the course of hearing complainant was required to submit entitlement as per room rent category.

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 along with the working sheet for settlement of the claim and also perused the entitlement as per room rent category furnished by the complainant. After due consideration of the matter, I hold that claim was not settled adequately. In my considered view company was not justified in making deductions as per entitlement of room because there are certain expenses which are required to be incurred irrespective of the entitlement of the room rent for the patient. However, in view of the entitlement submitted by the complainant, it appears certain that claim was not settled adequately and complainant needs to be allowed further relief. Complainant had not considered pre and post hospitalization expenses of Rs. 5558 and 10,395 respectively and some modification is also required in disallowances made by the company while settling the claim of Rs. 60054. It was found that claim could have been settled by the insurance company. Thus the complainant is found entitled to a sum of Rs. 96,899 whereas the company had settled the claim of Rs. 60054. **Accordingly an Award is passed with the direction to the insurance company to pay him further a sum of Rs. 36,845.**

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.

1. **Copies of the Award to both the parties.**

MEDICLAIM

DELHI OMBUDSMAN CENTRE

Case No. GI/90/IFFCO/11
In the matter of Ms. Neelam
Vs
IFFCO Tokio General Insurance Company Ltd.

AWARD DATED 24.2.2012 PARTIAL SETTLMENT OF MEDICLAIM

1. This is a complaint filed by Ms. Neelam (herein after referred to as the complainant) against the decision of IFFCO Tokio Insurance Co. Ltd. (herein after referred to as respondent Insurance Company) relating to partial settlement of claim.

2. Complainant stated that she is a member of Group Linked Insurance with Iffco Tokio sponsored by his employer having card no. PHS-ID-IT FAS 11938318-SVIP. She further stated that on 24.07.2010, she met with an accident due to fall from a distance of approx 12 feet and she got injured in left elbow, left arm and shoulder and a hair line fracture in her left leg. She got advice from doctor who recommended her to get admited immediately at Bhagwan Mahavir Hospital, after giving first aid i.e. relocated and plastered her elbow and there after her elbow was operated. She had submitted medi-claim bills for Rs. 74,292 against the entitlement for Rs. 75,000 but she received the claim payment voucher from paramount health services (TPA) Pvt. Ltd. for only Rs.

28,460. She submitted that since it was an emergency case, she had to be admitted in the hospital as per doctor's advice and taken room which was available at that time and suitable to her because she needed attached bathroom. She stated that company was not justified in making deductions of Rs. 42,350 instead of Rs. 12,250. She has come to this forum for settlement of her grievance. Complainant also furnished a certificate from the hospital where she was treated about entitlement for the treatment. During the course of hearing, complainant stated that company was not justified in making deductions. The claim was inadequately settled.

3. Representative of the company stated that at the most complainant is entitled to sum of Rs. 2330 otherwise claim was settled as per terms and conditions of the policy.

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 14.10.2011. After due consideration of the matter, I hold that claim was inadequately settled because the expenses incurred in the treatment of the insured cannot be disallowed arbitrarily. The facts have been obtained about the entitlement of the insured relating to entitlement category of the expenses. Insured was entitled to a room rent of Rs. 750 per day whereas the minimum room rent in the hospital was Rs. 1000 that is not say that the insured could not have been provided room less than Rs. 1000 per day. In my considered view the insured is entitled to the reimbursement of the expenses relating to the minimum room rent payable to the insured at the rate of Rs. 1000 per day and thus it is found that complainant is further entitled to some relief. **Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 21,249.**

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.**

DELHI OMBUDSMAN CENTRE

Case No. GI/115/UII/11
In the matter of Sh. Ram Avtar Aggarwal
Vs
United India Insurance Company Ltd.

AWARD DATED 2.3.2012 NON SETTLEMENT OF MEDICLAIM

2. This is a complaint filed by Sh. Ram Avtar Aggarwal (herein after referred to as the complainant) against the decision of United India Insurance Co. Ltd. (herein after referred to as respondent Insurance Company) relating to non settlement of claim.

3. Complainant stated that he had taken treatment in Sunder Lal Hospital, Ashok Vihar, Delhi by getting admitted from 02.01.2010 to 08.01.2010. Due to his illness, he could not submit the papers on time for which he has tendered his apologies. He has requested for reimbursement of a sum of Rs. 3230. He did not attend the date of hearing. Neither the company was represented on the date of hearing.

4. Company had repudiated the claim because documents were submitted beyond the prescribed time.

5. I have considered the submissions of the complainant a made in the complaint. I have also perused the repudiation letter and noted the content. After due consideration of the matter, I hold that claim otherwise admisible could not be declined on technical ground. In my considered view enen, if the documents were submitted late claim is payable. **Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 3230.**

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

6. Copies of the Award to both the parties.

MEDICLAIM

DELHI OMBUDSMAN CENTRE

Case No. GI/117/UII/11
In the matter of Sh. Ajit Kumar

Vs
United India Insurance Company Ltd.

AWARD DATED 2.3.2012 NON SETTLEMENT OF MEDICLAIM

1. This is a complaint filed by Sh. Ajit kumar (herein after referred to as the complainant) against the decision of United India Insurance Co. Ltd. (herein after referred to as respondent Insurance Company) relating to non settlement of claim.

2. Complainant stated that he had submitted claim on 29.06.2009 for a sum of Rs. 23,250 to United India Insurance Company Ltd. Subsequently, he received letter from one Mr. Raju, Administrative officer at Faridabad office desiring him to submit the certificate from the concerned consultant of Escorts to process the claim. The same was also submitted but he had not received the payment so far even after submitting the desired certificate. He has come to this forum with a request to getting the claim settled. During the course of hearing, it was argued by the complainant that claim is payable.

3. Representative of the company stated that claim is not payable as hospitalization was only for evaluation purposes. Company had repudiated the claim on the ground that the patient was admitted for evaluation purposes and no active treatment was given during the hospitalization and therefore claim is not payable.

4. I have considered the submissions of the complainant as well as of the representative of the company. I have also perused the reasoning given by the company while repudiating the claim in the repudiation letter dated 31.07.2009. After due consideration of the matter, I hold that company was not justified in repudiating the claim because patient was given treatment during the period of hospitalization besides several investigation.

   Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 21,250.

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.

MEDICLAIM

DELHI OMBUDSMAN CENTRE

Case No. GI/109/NIC/11
In the matter of Smt. Sarbati Devi Gupta
Vs National Insurance Company Ltd.

AWARD DATED 2.3.2012 REPUDIATION OF MEDICLAIM

1. This is a complaint filed by Smt. Sarbati Devi Gupta (herein after referred to as the complainant) against the decision of National Insurance Co. Ltd. (herein after referred to as respondent Insurance Company) relating to repudiation of claim.

2. Complainant stated that her husband Sh. Mohan Lal Gupta died on 30.04.2011. He had filed a complaint on 01.02.2011 as advised. He had already sent representation to the GRO of the company but the company had rejected the claim. It was mentioned that during the night of 1st and 2nd June,2010, when he went to the bathroom, he fell down and became unconscious resulting a hit on his head and a deep cut on the right hand elbow. Mr. M.L. Gupta was admitted in a Maharaja Agrasen hospital on 2nd June. Where after a preliminary examination in the casualty, he was advised admission by the doctor for necessary investigation and treatment and he was discharged on 04.06.2010. Cash less facility was denied. Authorized representative of the complainant stated that claim is payable and the same was denied by the Ins. Company.

3. Representative of the company stated that claim is not payable as admission was only for evaluation purposes.

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 company had not taken under account the circumstances under which patient was admitted in the hospital. In my view claim is payable. **Accordingly an Award is passed with the direction to the Insurance Company to make the payment of Rs. 30,002.**

7 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.

MEDICLAIM

Case No. GI/137/RGI/11
In the matter of Sh. Rajinder Kathuria
Vs
Reliance Gen. Insurance Company Ltd.

AWARD DATED 13.3.2012 NON SETTLEMENT OF MEDICLAIM

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

2. Complainant stated that he had purchased mediclaim policy Gold Plan (Cashless) from Reliance General insurance Co. Ltd. for his medical needs in emergency on 17.04.2008 for the first time and renewed the same for second year on 18.04.2009. He was hospitalized under sudden chest pain on 26.01.2010 in Sir Ganga Ram hospital, Rajinder Nager, New Delhi and there he had under gone a heart treatment. He informed the insurance company immediately as it was a cashless policy but the company did not allow such facility and his family members had to run pillar to pillar to gather the cash required for my treatment from near and dears. After discharge from the hospital he approached the insurance company and submitted all requisite documents as per their requirement. Whenever he approached the insurance company, he was informed that the case was under process. However, later on the TPA informed that the claim is not payable. He has come to this forum with a request to get the claim settled. During the course of hearing, authorized representative of the complainant stated that claim is payable but company refused to do it with wrong reasons.

3. Representative of the company stated that claim is not payable. Company also filed a written reply dated 13.02.2012 wherein it has been stated that complainant was given Health wise gold policy valid from 17.04.2008 to 16.04.2009 covering himself his wife

and 2 children with sum insured of Rs. 3 lacs. The complainant was hospitalized in Sir Ganga Ram hospital with complaint of chest pain since 18 hours and diagnosed Acute Transmural Myocardial Anterior infraction. During the hospitalization request was received for cashless benefit but from the request it was noted that patient had a history of Alcohol abuse and ailment was related to alcoholism therefore, claim is not found admissible.

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 25.03.2011 and also E-mail dated 17.02.2010 of Neena Singh, health claims from where it is noted that the claimed amount is approved. After due consideration of the matter, I hold that company was not justified in repudiating the claim for the reasons as mentioned in the repudiation letter because there was no evidence to the effect that insured was ill prior to taking the policy. There claim is payable. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 2,17,070 along with the 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.**

MEDICLAIM

DELHI OMBUDSMAN CENTRE

Case No. GI/136/RGI/11
In the matter of Sh. Tarun Gupta
Vs Reliance Gen. Insurance Company Ltd.

AWARD DATED 13.3.2012 INADEQUATE SETTLEMENT OF MEDICLAIM

1. This is a complaint filed by Sh. Tarun Gupta (herein after referred to as the complainant) against the decision of Reliance Gen. Insurance Co. Ltd. (herein after referred to as respondent Insurance Company) relating to inadequate settlement of mediclaim.

2. Complainant stated that on 16.04.2010 at about 19 hours while entering the street, he got his foot entangled with protruding pipe soiled with mud and water and fell on left side due to which his left arm and elbow got multiple fractures. He was rushed to Sant Parmanand Hospital, Civil Lines, Delhi at 19:30 hours, where X-Rays and plaster were done and advised for further treatment to be taken at specialty hospital. On 17.04.2010, he was examined by Dr. Harsh Bhargav, Sr. consultant at Indraprastha Apollo Hospital, Delhi and advised for CT scan, medication, tests before undertaking surgery or other treatment. He also informed TPA on 17.04.2010. He was admitted in the hospital on 20.04.2010 and requested for cashless facility. He was discharged from the hospital on 24.04.2010 with the total hospital bill amounting to Rs. 1,66,375. Complainant had

submitted in the complaint that claim was not settled adequately and requested to pay the balance amount of Rs. 96411 and also other claims as made in para b and e of para 18. Complainant did not attend on the date of hearing. Facts on record suggest that total expenses are incurred amounted to Rs. 2,05,154 whereas cashless facility was allowed only to the extent of Rs. 88,500 and further the amount of Rs. 15,089 was allowed to the complainant and thus out of total expenditure of Rs. 2,05,154 the company had allowed including cashless facility a sum of Rs. 1,03,589 thus leaving balance claim of Rs. 96411 payable.

3. Representative of the company was requested during the course of hearing to provide the details of the deductions made while settling the claim. Nina Singh, health claims sent an e-mail on 17.02.2012 which is place on record wherein it has been mentioned that out of total claim at the time of cashless of Rs. 1,86,275, cashless was settled for Rs. 88500 leaving a balance for Rs. 97775 out of which only a sum of Rs. 79782 is payable and remaining amount of Rs. 17993 is not payable. Break was also given in the amounts which are held not payable.

4. I have considered the submissions of the complainant as made in the complaint. I have also perused the e-mail dated 17.02.2012 of Nina Singh, health claims. After due consideration of the matter, I hold that company was not justified in not settling the claim adequately as per sheet given by Nina Singh vide e-mail dated 17.02.2012. The amount which was not found admissible was worked out to Rs. 17993 and amount payable was worked out to Rs. 79782. Company was not justified in not allowing the Doctor Visit charges as claimed. Company was also not justified in not allowing investigation charges amounting to Rs. 2760. Thus, I consider fair and reasonable if the dis-allowable amount is restricted to Rs. 9233 (17993-6000-2760). Thus complainant is held further entitled to a sum of Rs. 88542 (79782 + 8760). **Accordingly an Award is passed with the direction to the Ins. Company to make the payment of Rs. 88542 along with penal interest at the rate of 8% from the date of release of payment 15089 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.**

MEDICLAIM

DELHI OMBUDSMAN CENTRE

Case No. GI/147/NIC/11
In the matter of Sh. Rajeev Gupta
Vs National Insurance Company Ltd.

AWARD DAATED 15.3.2012 REPUDIATION OF MEDICLAIM

1. This is a complaint filed by Sh. Rajeev Gupta (herein after referred to as the complainant) against the decision of National Insurance Co. Ltd. (herein after referred to as respondent Insurance Company) relating to repudiation of mediclaim.

2. Complainant stated that he had taken a policy from National Insurance Company Ltd. on 09.08.2004 and has been paying regularly a premium in the month of August. His son Aditya Gupta was admitted in the hospital due to dengue fever at Shanti Nursing Home. He filed the claim for Rs. 7179/- and the Insurance Company had rejected the claim. During the course of hearing it was argued by him that claim is payable but the company had denied it wrongly.

3. Representative of the company stated that claim is not payable because there was no active treatment in hospital of the patient and only investigation was carried out. Company also filed written reply dated 08.08.2011 wherein, it has been mentioned that insured person was admitted with disease of fever/dengue and the TPA had come to the conclusion that patient was admitted with a complaint of fever and various tests were done but throughout the admission period the temperature remains around about 98 F and no treatment was given. Therefore, TPA repudiated the claim under clause 4.1 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 it is quite evident from the discharge summary that patient was admitted in the hospital and treated also besides necessary tests and investigation done on him. In my considered view claim is payable. **Accordingly an Award is passed with the direction to the Ins. Company to make the payment of Rs. 7179.**

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.**

MEDICLAIM

DELHI OMBUDSMAN CENTRE

Case No. GI/144/NIC/11
In the matter of Sh. Dharam Pal Sharma
Vs National Insurance Company Ltd.

AWARD DATED 15.3.2012 REPUDIATION OF MEDICLAIM

1. This is a complaint filed by Sh. Dharam Pal Sharma (herein after referred to as the complainant) against the decision of National Insurance Co. Ltd. (herein after referred to as respondent Insurance Company) relating to repudiation of mediclaim.

2. Complainant stated that he is a policy holder for the year 2009 – 2010 his wife Smt. Brijesh Sharma was admitted in Jeevan Mala Hospital, New Delhi and had taken treatment for her illness. He further stated that his wife first visited the hospital on 26.03.2010 and her summery examination papers were prepared regarding her illness, the junior doctor of the hospital who was preparing the summary examination papers, by mistake wrote four years instead of six months regarding the period of illness and such mistake was later on rectified. After treatment was completed, he filled up the claim for the medical expenses incurred. His claim was rejected on account of 2 grounds, (1) the summary examination papers dated 26.03.2010 the period of illness has been changed from four year to six months and there is no stamp or signatures of the doctors so there is a manipulation, (2) there is a gap of five days in policy between 2006-2007 and 2007-2008 which has not been condoned by the competent authority. He had visited the hospital again and correction was got made by the same doctors and told about the objections made by the insurance company for restriction of the claim. He further stated that his wife was treated in to 2010 but his claim was rejected and he was orally conveyed the decision. During the course of hearing complainant argued that claim is payable but company had denied it wrongly.

3. Representative of the company stated that claim is not payable due to pre-existing disease which has 4 years waiting period.

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 claim was put up in 3rd year of the policy whereas the disease for which she was treated has only 2 years waiting period and not for 4 years. Moreover, the disease was not detected prior to the inception of the policy. There was a gap in the policy period but the policy is continued since 19.06.2007. The claim was made in 3rd policy period, the gap in the policy would have no hindrance in the allow ability of the claim. The claim is payable. **Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 67,428.**

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.**

MEDICLAIM

DELHI OMBUDSMAN CENTRE

Case No. GI/158/Star/11
In the matter of Smt. Priyanka Bhattacharya

Vs Star Health General Insurance Company Ltd.

AWARD DATED 21.3.2012 REPUDIATION OF MEDICLAIM

1. This is a complaint filed by Smt. Priyanka Bhattacharya (herein after referred to as the complainant) against the decision of Star Health General Insurance Co. Ltd. (herein after referred to as respondent Insurance Company) relating to repudiation of mediclaim.

2. Complainant stated that star health insurance company ltd. had rejected the claim on flimsy and imaginative grounds though claim was genuine. It is further mentioned in the complaint that from later part of January 2010 her daughter Tanisha was suffering from fever. After many blood tests and treatment her fever was not showing down ward trend. Doctor gave her a lot of medicines including the TB medicine. Even the Tuberculosis skin test was done but the same was found negative and her health deteriorated and then on advice of doctor she was admitted in Max Hospital, Patpar Ganj, Delhi on 14.02.2010. There besides biopsy many other tests were conducted and it was found that she was suffering from Hodgkins Lymphoma. Though she was suffering from cancer even then doctor advised for TB treatment. There after she was taken to Pushpanjali hospital for 2nd opinion there the doctor advice to gave dis-continue the TB treatment and she was asked to get the MRI of brain done. The MRI report dated 25.02.2010 confirmed that she had Hodgkins disease for which she was treated. Insurance company rejected the claim on ground of pre-existing-disease. During the course of hearing complainant stated that company was not justified in rejecting the claim. She repeated almost what is already contened in the complaint. She further argued that the policy was taken in the first time on 21.09.2009. She filed all requisite documents for settlement of the claim. It was further informed that her daughter was treated at AIMs and her bone Marrow transplant was done and now she is absolutely fine. So this claim does not relate to the treatment taken in AIMS.

3. Representative of the company stated that claim is not payable due to pre-existing disease. Company was required to submit any reliable evidence to the effect that insured was suffering from pre-existing disease at the inception of the policy. Company's representative assured to submit such evidence within a week time.

4. I have very carefully 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 company was not justified in rejecting the claim on the ground as mentioned in the repudiation letter dated 27.09.2010 because there is no evidence on record that the patient was suffering with disease at the time of taking policy for which she was treated. **Accordingly an Award is passed with the 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.**

EDICLAIM

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.

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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 cannot 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.

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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.

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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.

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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.

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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.

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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.

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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.

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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.

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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.

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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.

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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.

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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.

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