AHMEDABAD OMBUDSMAN CENTRE

Case No.11-009-0160-12

Shri Arjun C. Murjani V/s. Reliance General Insurance Co. Ltd.

Award dated 4th April 2012

Repudiation of Mediclaim

Complainant's wife hospitalized for the treatment of Umbilical Hernia and claim lodged for expenses was repudiation by the Respondent invoking clause 10 of the Health wise policy i.e. Congenital External disease.

Patient was earlier operated for lower section caesarean in the year 1995 and 2001. Umbilical Hernia develop in an around the area of the Umbilicus. So Respondent's decision to repudiate the claim is justified.

In the result complaint fails to succeed.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0628-12

Shri Rajeshkumar Choudhary V/s. United India Insurance Co. Ltd.

Award dated 4th April 2012

Repudiation of Mediclaim

Complainant's ENT treatment expenses for Rs.35,112/- was rejected by the Respondent invoking Policy Clause 4.3 i.e. some treatments are excluded for two years. First consultation on 2-10-2010 shows duration of disease 4-6 weeks and policy commencement on 31-8-2010. This attracts Exclusion clause 4.1 – Pre-existing disease. 4.2 excludes diseases contracted during the first 30 days. Hospital's explanation that admission was not recorded in their register.

In view of all the above things, Complainant's claim is suspicious and Respondent's decision is upheld without any relief to the complainant.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0168-12

Shri Gautam B. Kankaria V/s. The New India Assurance Co. Ltd.

Award dated 05-04-2012

Partial settlement of Mediclaim

Complainant's wife hospitalized for operation of Laparoscopic Myomectomy and claim lodged for Rs.78,272/- which was settled by the Respondent for Rs.47,977/- deducting Rs.30,275/- invoking policy condition 2.1, 2.3, 2.4 and Note 1 and also 4.3.

Respondent proved the deduction criteria and this forum justified the Respondent's decision. Therefore complaint fails to succeed without any relief to the complainant.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-009-0206-12

Shri Naraindas Adwani V/s. Reliance General Insurance Co. Ltd.

Award dated 5th April 2012

Repudiation of Mediclaim

Complainant's hospitalization expenses, was repudiated by the Respondent on the ground of violation of terms and conditions No.15 of the Health wise policy.

As per investigation Report the insured was treated for stone removal, but treatment papers submitted for malaria and various false documents collected from different Medical stores, Laboratories etc. by the complainant for reimbursement of the claim amount. These discrepancies proved by the Respondent, so this Forum justified the decision of the Respondent.

In the result, complaint fails to succeed.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-017-0505-12

Smt. Ritu S. Patkar V/s. Star Health & Allied Insurance Co. Ltd.

Award dated 5th April 2012

Repudiation of Mediclaim

Hospitalization expenses for Rs.84,093/- of the insured was repudiated by the Respondent invoking exclusion clause 2 of the Family Health Optima policy.

From investigation report traced out the insured was suffering various diseases since 1 year but this fact was not mentioned in the Proposal Form. However the Respondent cancelled their policy and her first claim for Rs.84,093/- was repudiated and for second claim for Rs.1,21,589/- was not issued claim form because of cancellation of policy.

The decision of Respondent to cancel the policy due to non disclosure of material fact is justified.

In the result complaint fails to succeed.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0216-12

Shri Hasmukhbhai T. Patel V/s. United India Insurance Co. Ltd.

Award dated 5th April 2012

Partial Repudiation of Mediclaim

Complainant registered a case for partial repudiation of his wife's hospitalization expenses. The Respondent was not attended the Hearing arranged by this Forum and not submitted any documents required by this Forum giving reason that the claim file is not traceable and requested to adjourn the case for one month.

Therefore the Forum decided the complaint is considered beyond the jurisdiction and closed the file without any quantitative award.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0188-12

Shri Sunilkumar V. Dave V/s. Oriental Insurance Co. Ltd.

Award dated 6th April 2012

Repudiation of Mediclaim

Complainant's claim for treatment expenses for Coronary Artery Disease, Type-2 D.M & HTN was repudiated by the Respondent under exclusion clause 4.1 and 4.3 of the Mediclaim policy.

Complainant was a known case of D.M & HTN, but not disclosed in the Proposal Form. According to Respondent, present surgery also related to past history of D.M & HTN, so disease considered as pre-existing.

In the result complaint fails to succeed.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0619-12

Mrs. Bhartiben Y. Nirmal V/s. Oriental Insurance Co. Ltd.

Award dated 6th April 2012

Repudiation of Mediclaim

Complainant's hospitalization expense was repudiated by the Respondent invoking Policy Clause 5.4 & 5.5, late intimation and late submission of claim papers. During the Hearing, the complainant agreed the late submission and there was no advice by a qualified doctor for admission and no active line of treatment was available.

In view of this Respondent's decision is just and proper and complaint fails to succeed.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0531-12

Shri Bharat B. Vyas V/s. The New India Assurance Co. Ltd.

Award dated 9th April 2012

Repudiation of Mediclaim

Complainant's insured daughter was hospitalized for fever and claim lodged for expenses was repudiated by the Respondent giving reason that the treatment was taken from a declined hospital.

Respondent was informed all policy holders about the declined hospital, so Respondent's decision to repudiate the claim is proper and valid.

In the result complaint fails to succeed.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0218-12

Shri Sultansingh Singhvi V/s. United India Insurance Co. Ltd.

Award dated 9th April 2012

Repudiation of Mediclaim

Complainant's hospitalization expenses for Rs.75,530/- for the treatment of Heart Disease, chest pain, Coronary Angio and by pass surgery was repudiated by the Respondent invoking policy condition 4.1.

From the hospital record, it is evidence that insured had pre-existing disease which is relevant to present claim.

Therefore, Respondent's decision to reject the claim is justified and complaint is fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-002-0212-12

Shri Arvindkumar N. Patel V/s. The New India Assurance Co. Ltd.

Award dated 9th April 2012

Partial settlement of Mediclaim

Complainant's daughter's treatment expenses settled by the Respondent partially giving reason that old Sum Insured + C.B is eligible to get reimbursement because for increased sum insured is waiting period of two years for such treatment. The increased sum insured from 25-5-2008 and hospitalization took place on 27-4-2010. However Respondent's decision to reject the claim on the basis of increased sum insured is proper and valid.

In the result complaint fails to succeed.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-009-0208-12

Shri Ketul A. Pancholi V/s. Reliance General Insurance Co. Ltd.

Award dated 10th April 2012

Repudiation of Mediclaim

Complainant's hospitalization expenses, was repudiated by the Respondent on the ground of violation of terms and conditions No.15 of the Health wise policy.

As per investigation Report the insured was treated for loose motion, but treatment papers submitted for UTI with Gastritis and various false documents collected from hospital by the complainant for reimbursement of the claim amount. During hospitalization, hospital has allowed the patient to go outside. These discrepancies proved by the Respondent, so this Forum justified the decision of the Respondent.

In the result, complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-002-0549-12

Shri Kairav U. Shah V/s. The New India Assurance Co. Ltd.

Award dated 10th April 2012

Repudiation of Mediclaim

Complainant's chronic renal failure treatment expenses with other five dialysis was claimed for Rs.3,64,178/- was repudiated by the Respondent giving reason that as per exclusion clause 4.16, Genetic disorder and stem cell implantation/surgery was not payable.

On scrutiny of all treatment papers, it is proved that the treatment was for kidney diseases are permanently excluded and Respondent's decision is fully justified.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0574-12

Shri Avinash N. Patel V/s. The New India Assurance Co. Ltd.

Award dated 10th April 2012

Repudiation of Mediclaim

Complainant's son was treated for Balanoposthitis and expenses claimed was repudiated by the Respondent giving reason that the said disease is under the category of congenital external disease under exclusion clause 4.4.6 which is not payable.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0577-12

Shri Deval P. Parikh V/s. The New India Assurance Co. Ltd.

Award dated 10th April 2012

Repudiation of Mediclaim

Complainant's insured wife treated for ARMD and expenses claimed was repudiated by the Respondent on the basis of out of coverage of such treatment.

Respondent clarified that ARMD treatment drugs like Avastin or Lucentis or Macugen and other related drugs given an OPD basis in operation theatre falls outside the scope of the Health policies.

In the result complaint fails to succeed.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0590-12

Shri Muradbhai S. Panjnani V/s. The New India Assurance Co. Ltd.

Award dated 11th April 2012

Partial settlement of Mediclaim

Hospitalization expense of complainant's wife was partially settled by the Respondent as per policy condition No.2.1, 2.3, 2.6 Note-1.

On perusal of all claim documents, it is proved that Respondent's decision is just and proper.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0228-12

Shri Dharmendrakumar D. Patel V/s. The New India Assurance Co. Ltd.

Award dated 11th April 2012

Repudiation of Mediclaim

Complainant's insured mother treated to the Sanjeevani Heart and Medical Hospital, Ahmedabad and expenses claimed was repudiated by the Respondent giving reason that the hospital is one of the declined list of the Respondent which was communicated to the insured and Xerox copy of the News paper cutting submitted to this forum.

In view of this the forum agreed the Respondent has taken a right decision to repudiate the claim. .

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0584-12

Shri Shailesh B. Rupera V/s. United India Insurance Co. Ltd.

Award dated 11th April 2012

Partial settlement of Mediclaim

Complainant's daughter's hospitalization expenses was settled for Rs.63,895/- by the Respondent and deducted an amount of Rs.3,243/- without giving any reason.

Moreover the Respondent had not attended the Hearing arranged by this Forum and also not submitted any documentary evidence. It falls outside the ambit of this forum. Hence complaint stand closed without passing any quantitative award.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0538-12

Shri Pramodbhai R. Patel V/s. United India Insurance Co. Ltd.

Award dated 11th April 2012

Repudiation of Mediclaim

Complainant's hospitalization expenses claimed was repudiated by the Respondent giving reason that the Discharge Summary and Room rent bill was different name of hospital. Hence there was a discrepancy, so claim is not payable.

The policy is also an unconventional group insurance so this forum closed the file without passing any quantitative award.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0591-12

Shri Vasanthkumar M. Bhatt V/s. The New India Assurance Co. Ltd.

Award dated 12th April 2012

Partial settlement of Mediclaim

Hospitalization expense of complainant's wife was partially settled by the Respondent as per policy condition No.2.1, 2.3, 2.6 Note-1.

On perusal of all claim documents, it is proved that Respondent's decision is just and proper.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0639-12

Shri Ranjitbhai K. Patel V/s. United India Insurance Co. Ltd.

Award dated 12th April 2012

Repudiation of Mediclaim

A claim lodged for Rs.4,27,549/- for the surgery of Laparoscopic Sleeve Gasterectomy to cure Morbid Obesity of the Complainant was repudiated by the Respondent invoking exclusion clause 4.4 and 4.4.6 of the policy condition.

Complainant was suffering from Morbid Obesity since last 15 years which was not disclosed in the Proposal form. Therefore Respondent's decision to repudiate the claim is just and proper without any relief to the complainant.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0230-12

Shri Laxmanbhai S. Patel V/s. United India Insurance Co. Ltd.

Award dated 13th April 2012

Repudiation of Mediclaim

Complainant hospitalized for Knee replacement and expenses claimed was repudiated by the Respondent giving reason that subject disease is a pre-existing so claim is not payable.

The policy is an unconventional group insurance so this forum closed the file without passing any quantitative award.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0579-12

Shri Umeshkumar P. Patel V/s. United India Insurance Co. Ltd.

Award dated 13th April 2012

Repudiation of Mediclaim

Complainant's father treated for cataract and expenses claimed was repudiated by the Respondent giving reason that the notice was not given in time, so claim is not payable as per policy condition 5.3.

The Respondent was not attended the Hearing fixed by this forum and also not submitted the related documents.

The policy is an unconventional group insurance so this forum closed the file without passing any quantitative award.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0587-12

Shri Baldevbhai A. Patel V/s. United India Insurance Co. Ltd.

Award dated 13th April 2012

Repudiation of Mediclaim

Complainant treated for cataract and expenses claimed was repudiated by the Respondent giving reason that the notice was not given in time and documents also submitted late, so claim is not payable as per policy condition 5.3 & 5.4.

The Respondent was not attended the Hearing fixed by this forum and also not submitted the related documents.

The policy is an unconventional group insurance so this forum closed the file without passing any quantitative award.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0240-12

Shri Natvarsing Majpatiya V/s. The New India Assurance Co. Ltd.

Award dated 16th April 2012

Partial settlement of Mediclaim

Complainant's two different hospitalization expenses claimed for total amount of Rs.27,998/-, out of which Respondent settled for Rs.5,048/- by deducting an amount of Rs.22,950/- giving reason that as per the Discharge Summary of second hospitalization shows the treatment for Acute Anxiety that is under exclusion clause No.4.4.6 of the Mediclaim policy.

The Respondent submitted all hospital records for proving their decision and this Forum justified their decision.

In the result, the Complaint fails to succeed.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0546-12

Shri Nitin J. Shah V/s. Oriental Insurance Co. Ltd.

Award dated 16th April 2012

Repudiation of Mediclaim

A claim of Rs.2,04,156/- was lodged by the complainant for the treatment of Recurrent Carcinoma right maxilla was repudiated by the Respondent invoking clause 7.16 of the policy terms.

Complainant had policy since last 4 years and three claims were settled by National Insurance Company for the same disease. This year IRSS International had shifted his policy to the Respondent insurer.

The policy is an unconventional group insurance so this forum closed the file without passing any quantitative award.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0585-12

Shri Pratik A. Dhabaliya V/s. Oriental Insurance Co. Ltd.

Award dated 16th April 2012

Non settlement of Mediclaim

A claim of Rs.1,78,262/- was lodged by the complainant for the treatment of the insured for Acute Anterior Wall Myocardiac Infarction was not settled by the Respondent. The insured died on the same day due to Cardiac Arrest.

Complainant had got claim from the New India Assurance Company but the Respondent Insurer sent e-mail to this forum saying that they had settled the claim for Rs.1,24,988/-and given cheque number. This amount has not received by the complainant.

Respondent's local representative reported for Hearing without any document.

The policy is an unconventional group insurance so this forum closed the file without passing any quantitative award.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-019-0620-12

Ms. Yesha V. Shah V/s. Apollo Munch Health Insurance Co. Ltd.

Award dated 16th April 2012

Repudiation of Mediclaim

A claim of Rs.2,57,980/- for the treatment of Morbid Obesity of the Complainant was repudiated by the Respondent invoking Section 6, Exclusion –e (v) of the policy. Secondly the details of obesity was not disclosed in the proposal form, hence claim repudiated due to non disclosure of material facts.

Complainant stated that her proposal was accepted by the Respondent with excess premium for the excess weight of 85 Kg. In the Discharge Summary and Clinical examination shows weight 117 Kg.

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

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AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-009-0567-12

Shri Kiran S. Shah V/s. Reliance General Insurance Co. Ltd.

Award dated 16th April 2012

Repudiation of Mediclaim

Two claims lodged by the Complainant for his treatment expenses were repudiated by the Respondent invoking exclusion clause No.1 and 2 of the Policy Terms and Conditions.

On scrutiny of available records, it is proved by this Forum that the decision of the Respondent to repudiate the Claim is valid and proper.

Thus complaint closed without any relief to the complainant.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0242-12

Shri Ketan D. Bhavishi V/s. The New India Assurance Co. Ltd.

Award dated 17th April 2012

Partial settlement of Mediclaim

Treatment expenses of the complainant's son, was settled by the Respondent partially giving reason that as per Clause No.2.3 Note, other than part of hospitalization bills not payable.

A close examination of the calculation by the Hon. Insurance Ombudsman shows that they are in accordance with the terms and condition of the policy and Respondent's decision justified.

The Complaint thus stands disposed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0606-12

Shri Shaileshkumar N. Prajapati V/s. Oriental Insurance Co. Ltd.

Award dated 17th April 2012

Repudiation of Mediclaim

A claim for treatment expenses of Left Lower Limb Radiculopathy with Acute Limber Disc Prolapse was lodged by the complainant which was repudiated by the Respondent by invoking clause 2.3- note stating that the claim is not payable because the treatment was done in out patient department.

There is no concrete evidence to prove the treatment was done in inpatient basis.

Thus the Respondent's decision is justified and complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-017-0640-12

Mrs. Dinbala N. Shodhan V/s. Star Health and Allied Insurance Co. Ltd.

Award dated 17th April 2012

Partial settlement of Mediclaim

Complainant lodged a claim for treatment expenses during the visit of out of country was settled by the Respondent partially deducting 30% of the claimed amount because after discharge from hospital, the complainant stayed at Health Resort Hotel. That expense was not admissible.

Complainant first claimed for loss of pass port which was settled by the Respondent. Second claim for hospitalization was settled and discharge voucher signed by the complainant. Thereafter, claimed for Hotel stayed expense which was not admissible as per special exclusion clause No.10 of the Health Insurance Policy.

In the result the complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0588-12

Shri Nitin J. Shah V/s. Oriental Insurance Co. Ltd.

Award dated 17th April 2012

Repudiation of Mediclaim

Complainant's daughter had taken Root Canal dental treatment and expenses claimed was repudiated by the Respondent invoking policy condition 4.7 and 2.2 item VIII.

There no evidence of accident and no proof of 24 hours hospitalization, so Respondent's decision to repudiate the claim is just and proper.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0541-12

Shri Ashok G. Purohit V/s. Oriental Insurance Co. Ltd.

Award dated 18th April 2012

Repudiation of Mediclaim

Hospitalization expense of the complainant's father was repudiated by the Respondent invoking pre-existing disease. Complainant opined that his previous claim was settled by the National Insurance Co. for the same treatment. Thereafter policy was transferred to the Respondent Insurer with continuity benefit through Agent.

On scrutiny of records, there is no proof for continuation of previous policy. Previous policy was Individual Mediclaim policy and S.I Rs.1.00 Lac whereas present policy S.I 5.00 Lac and Family Floater policy.

In view of the above, Respondent's decision is justified.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0243-12

Mrs. Nalini P. Shah V/s. United India Insurance Co. Ltd.

Award dated 18th April 2012

Repudiation of Mediclaim

Claim for hospitalization expenses of the complainant was repudiated by the Respondent invoking policy terms and condition No.2.3.

As per treatment records and medical certificate proved the treatment was an OPD basis and there was no requirement of Indoor admission. However the Forum justified the decision of the Respondent is valid and proper. Thus complaint stands disposed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0248-12

Shri Vikas D. Patel V/s. The New India Assurance Co. Ltd.

Award dated 18th April 2012

Partial settlement of Mediclaim

Complainant's hospitalization expense partially settled by the Respondent as per policy condition 2.1 and 4.3.

Respondent calculated as per Old S.I and as per Increased S.I, there is a waiting period of two years for the subject disease.

In the result complainant fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-009-0600-12

Shri Pareshbhai M. Patel V/s. Reliance General Insurance Co. Ltd.

Award dated 18th April 2012

Repudiation of Mediclaim

Complainant's claim for treatment expenses of Doppler of right upper limb, confirms thoracic outlet obstruction and X-ray report showed old healed fracture of 8th rib, an internal congenital defect was repudiated by Respondent invoking policy clause 3 – pre-existing disease.

Policy incepted in the year of 2009 April and hospitalization in the year of February 2009. There is a waiting period of two years for the same treatment, so claim is not payable.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0626-12

Shri Raju G. Desai V/s. Oriental Insurance Co. Ltd.

Award dated 18th April 2012

Repudiation of Mediclaim

An amount of Rs.20,711/- claimed by the complainant for the treatment expense of Lt. Inguinal Hernia was repudiated by the Respondent invoking exclusion clause 4.3.

Complainant, a driver employed with a private builder covered policy since 2002 with the New India Assurance Co. and switched over to the Respondent Insurer from November 2009 with continuity benefit. The Complainant had not taken up the issue of continuity immediately when he got the fresh policy from the Respondent Insurer.

So Respondent's decision to repudiate the claim is upheld without any relief to the Complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0571-12

Shri Natvarbhai G. Khristi V/s. Oriental Insurance Co. Ltd.

Award dated 24th April 2012

Repudiation of Mediclaim

Complainant hospitalized for treatment of prolapsed inter vertebral disc disorder due to accidental injury while lifting the heavy weight and claimed for Rs.61,834/- was repudiated by the Respondent invoking exclusion clause 4.3.

Claim occurred in the first year of the policy and there is a waiting period of two years for the subject disease.

In the result, complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-0252-12

Shri Natvarlal R. Patel V/s. National Insurance Co. Ltd.

Award dated 24th April 2012

Repudiation of Mediclaim

A claim of Rs.1,67,087/- for the treatment expense of the complainant for heart surgery was repudiated by the Respondent under exclusion clause 4.0 and 4.1.

Complainant is a 52 years old male and policy taken first time in the year of 3rd June 2009 and surgery done on 6th April 2010. As per the opinion of the Panel doctor of the Respondent, the disease was pre-existing and submitted copy of doctor's letter to this forum for proof.

In the result, complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0264-12

Ms. Alpa Vinodchandra Dave V/s. United India Insurance Co. Ltd.

Award dated 24th April 2012

Repudiation of Mediclaim

Complainant's insured father hospitalized for the treatment of Multiple Cerebral Infarcts & Left Hemiparalisis and lodged claim for Rs.43,914/- which was repudiated by the Respondent giving reason that the disease was pre-existing, claim occurred within 3 months from the date of inception of the policy.

This was a Group Mediclaim policy and Policy issued to the Share holders of Unisafe Health Club.

The policy is an unconventional group insurance so this forum closed the file without passing any quantitative award.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0578-12

Shri Pratik D. Ahir V/s. Oriental Insurance Co. Ltd.

Award dated 24th April 2012

Partial settlement of Mediclaim

Complainant's insured father hospitalized and total treatment expense claimed for Rs.369208/- which was settled by the Respondent only for Rs.90,000/- giving reason that the old policy was individual and S.I Rs.1.00 Lac then policy was converted to Happy Family Floater and S.I Rs.3.00 Lac. As per enhanced policy, there is a waiting period of two years for the treatment of Coronary Artery Disease. Therefore Respondent settled on the basis of Old S.I of Rs.1.00 Lac.

In the result, compliant fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-017-0558-12

Shri Labhubhai T. Goyani V/s. Star Health & Allied Insurance Co. Ltd.

Award dated 24th April 2012

Partial settlement of Mediclaim

Complainant's treatment expenses claimed for Rs.17,315/- which was settled by the Respondent for Rs.13,590/- giving reason that reasonable expenses paid and excess charges not paid.

Complainant has not produced any package charge details and not informed with full particulars within 24 hours from the date of hospitalization.

Thus, Respondent's decision to settle the claim partially is upheld without any relief to the Complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0254-12

Shri Devang B. Trivedi V/s. The New India Assurance Co. Ltd.

Award dated 24th April 2012

Partial settlement of Mediclaim

Complainant's claim for treatment expenses of his daughter was settled by the Respondent for Rs.65,000/- by deducting an amount of Rs.17,063/- invoking Clause 4.1 and 6 (c) of the policy.

The initial S.I was Rs.35,000/- since 2001 and S.I increased to Rs.50,000/- since 2002 and further increased S.I to Rs.1.00 Lac since 2007.

As per MMR, the insured had the disease since her age of 5 years, So it is considered as pre-existing disease at the time of enhanced S.I. As per policy record, S.I at the time of hospitalization, 50,000/-+ 20% C.B is eligible and complainant accepted the claim payment as full and final settlement of the subject claim.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0624-12

Shri Rajendra H. Bhatt V/s. Oriental Insurance Co. Ltd.

Award dated 25th April 2012

Non settlement of Mediclaim

A claim of Rs.1,56,182/- was lodged by the Complainant for his bypass Surgery expenses was not settled by the Respondent because the complainant has not submitted the required documents in-spite of repeated reminders.

The policy is an unconventional group insurance so this forum closed the file without passing any quantitative award.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0656-12

Shri Chinubhai H. Shah V/s. the New India Assurance Co. Ltd.

Award dated 25th April 2012

Repudiation of Mediclaim

A cataract surgery expenses of complainant's wife was repudiated by the Respondent invoking condition No.4.13 of the group mediclaim policy.

The policy is an unconventional group insurance so this forum closed the file without passing any quantitative award.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0270-12

Shri Parag M. Parikh V/s. the New India Assurance Co. Ltd.

Award dated 26th April 2012

Partial settlement of Mediclaim

Complainant's claim for treatment expenses of his mother was settled by the Respondent for Rs.75,000/- by deducting balance amount invoking Clause 4.1 and 6 of the policy.

The initial S.I was Rs.50,000/- since 1999 with C.B of Rs.25,000/- and S.I increased to Rs.1,00,000/- since 2009 with C.B of Rs.2,500/-.

As per MMR, the insured had treated and died within 7 months from the receipt of fresh policy. So it is considered as pre-existing disease at the time of enhanced S.I. As per policy record, S.I at the time of hospitalization, 50,000/-+ 25,000/- C.B is eligible and Respondent settled the claim accordingly.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0644-12

Shri Champakbhai M. Shah V/s. the New India Assurance Co. Ltd.

Award dated 27th April 2012

Repudiation of Mediclaim

Complainant's total Knee replacement expense claimed was repudiated by the Respondent invoking policy condition 4.16.

The policy is an unconventional group insurance so this forum closed the file without passing any quantitative award.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0673-12

Shri Samratha Raj Singh V/s. the New India Assurance Co. Ltd.

Award dated 27th April 2012.

Partial Repudiation of Mediclaim

Complainant's wife operated for Total Laparoscopic Hysterectomy + Supra umbilical Hernia and claimed an amount of Rs.43,967/- out of which Respondent settled Rs.31,187/- by deducting Rs.12,780/- invoking exclusion clause 4.4.6 which states obesity treatment and its complications. The insured had a previous surgery in the year of 1996 which was not disclosed in the proposal form.

However Respondent's decision is just and proper. In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-009-0267-12

Shri Dipakbhai T. Panchal V/s. Reliance General Insurance Co. Ltd.

Award dated 30th April 2012

Repudiation of Mediclaim

A claim lodged an amount of Rs.47,900/- for Hysterectomy treatment expenses of Complainant's wife was repudiated by the Respondent due to non disclosure of material facts under terms and conditions No.2.

As per hospital papers shows, Hysterectomy operation done 4 years back, policy incepted in the year of 2007 and treatment occurred in 2010 which is proved pre-existing disease.

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

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0694-12

Shri Dilipbhai O Parikh V/s. The New India Assurance Co. Ltd.

Award dated 1st May 2012

Partial repudiation of Mediclaim

Two claims lodged by the complainant for cataract surgery of his both the eyes for Rs.29,837/- and 29,312/- respectively were settled by the Respondent for Rs.24,000/-each surgery and remaining amount repudiated as per clause 3.13 of the mediclaim policy (2007).

As per New India Assurance Co's circular dated 18-01-2011, the capping of Rs.24,000/- for cataract operation is applicable. According to this Respondent settled the claim for Rs.24,000/- for each operation is just and proper.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0272-12

Shri Darshan P. Thakker V/s. The New India Assurance Co. Ltd.

Award dated 1st May 2012

Repudiation of Mediclaim

A claim amount of Rs.8,301/- for the treatment expense of complainant's daughter for Bronchiolitis was repudiated by the Respondent invoking clause 3.2 of the terms and conditions of the policy giving reason that the hospital was not having 15 beds.

Complainant proved another one insured was treated in the same hospital which was settled by the Respondent. In this case Respondent was absent for hearing but in the Self Contained Note they confirmed their original decision to reject the claim.

Thus complaint stands disposed without any relief to the complainant.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0675-12

Shri Rajkumar R. Shah V/s. The New India Assurance Co. Ltd.

Award dated 1st May 2012

Repudiation of Mediclaim

Complainant's wife treated for hysterolaparoscopy and expense lodged for Rs.6,416/- was repudiated by the Respondent under exclusion clause 4.4.6 of the policy, the said treatment falls under permanent exclusion.

First consultation shows complaint since 1 and a half years which was not disclosed while renewing the policy. Therefore this forum do not find any new ground to interfere their decision.

In the result complaint fails to succeed without any relief to the complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-011-0698-12

Shri Hareshbhai P. Mali V/s. Bajaj Allianz General Insurance Co. Ltd.

Award dated 1st May 2012

Partial settlement of Mediclaim

A claim of Rs.35,145/- was lodged by the complainant for eye treatment expenses of his son which was partially settled by the Respondent for Rs.12,000/- by deducting an amount of Rs.23,145/- as per policy condition D, sub condition 6 (g).

Complainant argued that this is not an age related cataract, his son's eye was injured by sudden fire of crackers and admitted to hospital for treatment. As per the hospital records, his son was admitted on 25-4-2011, treated for left eye cataract and discharged on the same day.

According to this Respondent's decision to settle the claim partially as per terms and condition of the policy is just and fair without any relief to the complainant.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0695-12

Shri Jignesh S. Vataliya V/s. The New India Assurance Co. Ltd.

Award dated 1st May 2012

Repudiation of Mediclaim

A claim lodged an amount of Rs.40,754/- for treatment expenses of right knee recurrent synovitis disease of the Complainant was repudiated by the Respondent as per terms and conditions of the policy Clause No.4.10.

As per hospital papers shows, patient was therapeutic surgery wherein the diseased synovium has been removed to treat him which is common name as biopsy. So, the hospitalization was not for biopsy report, which is erroneous to consider as no active line of treatment.

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

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0693-12

Ms. Deepa J. Puthoor V/s. The New India Assurance Co. Ltd.

Award dated 1st May 2012

Repudiation of Mediclaim

A claim lodged an amount of Rs.15,220/- for treatment expenses of Dengu Fever disease of the Complainant was repudiated by the Respondent as per terms and conditions of the policy Clause No.2.3. As per hospital papers shows, patient was admitted less than 24 hours, but treating doctor certified that the patient was suffering dengu fever from 4-10-2010 to 19-10-2010 and was fit on 20-10-2010.

The Respondent rejected the claim on the basis of correction made in MMR and less than 24 hours admission which is not a satisfactory report.

Therefore Respondent's decision to repudiate the claim is set aside and the Forum directed to give payment within 15 days from the receipt of consent from the complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0652-12

Shri Ankur K Jariwala V/s. The New India Assurance Co. Ltd.

Award dated 2nd May 2012

Repudiation of Mediclaim

A claim lodged an amount of Rs.23,000/- for treatment expenses of Ectropion disease of the Complainant's son was repudiated by the Respondent as per terms and conditions of the policy Clause No.4.4.2.

Both the parties were absent when the Hearing scheduled by this Forum. As per available papers it is proved that the patient was a 3 year old child had gone for squint surgery which was not a cosmetic surgery.

Therefore Respondent's decision to repudiate the claim is set aside and the Forum directed to give payment within 15 days from the receipt of consent from the complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0650-12

Mrs. Ramilaben I Vyas V/s. the New India Assurance Co. Ltd.

Award dated 2nd May 2012

Repudiation of Mediclaim

Two claims lodged for cataract surgery expenses of complainant's both eyes were repudiated by the Respondent invoking condition No.4.13 of the group mediclaim policy.

The policy is an unconventional group insurance so this forum closed the file without passing any quantitative award.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0284-12

Shri Omprakash C. Gupta V/s. the New India Assurance Co. Ltd.

Award dated 3rd May 2012

Repudiation of Mediclaim

A claim lodged for Rs.13,428/- for treatment expenses of complainant was repudiated by the Respondent giving reason that no active treatment was taken, hospitalization was only investigation purpose.

Evidence on record support the grounds for repudiation and it gets established that the complainant was hospitalized for Vertigo investigation purpose with no supportive active medical line of treatment which is out of the scope of the mediclaim policy.

Hence the Respondent is justified in repudiating the claim.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0288-12

Shri Rajeshkumar V. Soni V/s. The New India Assurance Co. Ltd.

Award dated 3rd May 2012

Repudiation of Mediclaim

A claim amount of Rs.56,995/- for the treatment expense of complainant for Lt. Buccal Mucosa Cancer was repudiated by the Respondent invoking clause 4.4.6 of the terms and conditions of the policy.

As per hospital papers, complainant had a habit of tobacco chewing and taken treatment in the year of 2003. That time claimed amount was paid because in the old policy there was no exclusion clause but in the new policy terms and condition of 2007 it is excluded.

Therefore Respondent rightly repudiated the claim without any relief to the complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0690-12

Mrs. Prafulaben M. Shah V/s. The New India Assurance Co. Ltd.

Award dated 3rd May 2012

Repudiation of Mediclaim

A claim amount of Rs.3,08,108/- for the treatment expense of complainant for obstructive sleep apnea with LRTI with obesity was repudiated by the Respondent invoking clause 4.4.6 of the terms and conditions of the policy.

On referring all the treatment records, it is proved that the complainant was treated for obesity. Obesity is excluded as per policy clause 4.4.6, so Respondent rightly repudiated the claim without any relief to the complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-004-0290-12

Shri Pradeep N.Nahata V/s. United India Insurance Co. Ltd.

Award dated 4th May 2012

Partial settlement of Claim

Complainant lodged a claim for Rs.94,676/- for the treatment of his wife's surgery for abdominal hysterectomy with large Hernia was settled by the Respondent for 50,000/- by deducting Rs.44,676/- .

From the hospital records, Multiple Uterine Fibroid and incisional hernia cannot develop within a short period. Both diseases were pre-existing disease, then also Respondent paid Rs.50,000/-for Uterine Fibroid surgery expenses so Respondent's decision cannot interfere by this forum.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0674-12

Smt. Geetiben Trivedi V/s. The New India Assurance Co. Ltd.

Award dated 4th May 2012

Repudiation of Mediclaim

A claim amount of Rs.37,495/- for the treatment expense of complainant for Congenital external disease was repudiated by the Respondent invoking clause 4.4.6 of the terms and conditions of the policy.

On referring all the treatment records, it is proved that the complainant was treated for Hallus valgus, which is not payable as per policy clause 4.4.6, so Respondent rightly repudiated the claim without any relief to the complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0686-12

Shri Piyush R. Shah V/s. The New India Assurance Co. Ltd.

Award dated 4th May 2012

Partial repudiation of Mediclaim

A claim lodged by the complainant for cataract surgery of his wife for Rs.33,276/- was settled by the Respondent for Rs.30,076/- and remaining amount repudiated as per clause 3.13 of the mediclaim policy (2007).

As per New India Assurance Co's circular dated 18-01-2011, the capping of Rs.24,000/- for cataract operation is applicable. The cost of cataract surgery in India falls anywhere between Rs.10,000/- to Rs.24,000/-normally. However prices may get higher depending on the city and the hospital one chooses to get the surgery done. According to this Respondent decided on the issue of reasonable and customary charges is standard procedure which is acceptable to all their offices.

In the result complainant fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0687-12

Shri Ramesh G. Kriplani V/s. The New India Assurance Co. Ltd.

Award dated 4th May 2012

Repudiation of Mediclaim

A claim amount of Rs.45,658/- for Uterine Fibroid surgery expense of complainant's wife was repudiated by the Respondent as per policy terms and condition No. 4.3 as pre-existing disease.

As per policy conditions, the said disease falls under two years exclusion and the treatment occurred in the 2nd year policy so Respondent rightly repudiated without any relief to the complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-010-0682-12

Shri Ramjibhai L. Pavasiya V/s. Iffco Tokiyo General Insurance Co. Ltd.

Award dated 7th May 2012

Partial settlement of Mediclaim

Complainant claimed for Rs.60,432/- for treatment expenses of his wife was partially settled by the Respondent for Rs.54,872/- after deducting an amount of Rs.5,599/- on the ground that the remaining amount is not pertaining to current illness expense.

The Respondent's written submission clearly proved the break up of deduction, so Respondent's decision is justified by this forum.

In the result, the complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0685-12

Shri Rajendra M. Modi V/s. The New India Assurance Co. Ltd.

Award dated 7th May 2012

Partial repudiation of Mediclaim

Complainant's wife's hospitalization expense claimed for Rs.62,222/-, was partially settled by the Respondent for Rs.40,000/- giving reason that as per policy clause 3.13 and also some amount deducted is not eligible to get reimbursement as per policy terms and conditions.

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

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0688-12

Shri Pankaj R. Shah V/s. The New India Assurance Co. Ltd.

Award dated 8th May 2012

Partial settlement of Mediclaim

A claim lodged by the complainant for cataract surgery for Rs.33,246/- was settled by the Respondent for Rs.30,046/- and remaining amount repudiated as per clause 3.13 of the mediclaim policy (2007).

As per New India Assurance Co's circular dated 18-01-2011, the capping of Rs.24,000/- for cataract operation is applicable. The cost of cataract surgery in India falls anywhere between Rs.10,000/- to Rs.24,000/-normally. However prices may get higher depending on the city and the hospital one chooses to get the surgery done. According to this Respondent decided on the issue of reasonable and customary charges is standard procedure which is acceptable to all their offices.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0350-12

Shri Mahendrakumar B. Jhaveri V/s. The New India Assurance Co. Ltd.

Award dated 8th May 2012

Partial settlement of Mediclaim

A claim lodged by the complainant for surgery of his wife for Rs.76,810/- was settled by the Respondent for Rs.68,540/- and remaining amount repudiated as per clause 3.13 of the mediclaim policy (2007).

Prices may get higher depending on the city and the hospital one chooses to get the surgery done. According to this Respondent decided on the issue of reasonable and customary charges is standard procedure which is acceptable to all their offices.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0681-12

Shri Dineshbhai K. Gajjar V/s. The New India Assurance Co. Ltd.

Award dated 8th May 2012

Partial settlement of Mediclaim

Complainant hospitalized for surgery of Lt. Buccal Muccosa (Cancer) and claimed Rs.1,96,053/- which was settled for Rs.1,64,287/- by deducting Rs.31,766/- as per terms and condition No.2.3 and subsequent circular of the Respondent Insurer.

Buccal Muccosa treatment is likely cause of regular chewing of tobacco. If, it proved, this claim warrants total rejection. Even complainant not attended the Hearing scheduled by this Forum.

However, Respondent's decision to settle the claim partially is just and fair without any relief to the Complainant.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0311-12

Smt. Ashaben S. Gandhi V/s. United India Insurance Co. Ltd.

Award dated 8th May 2012

Repudiation of Mediclaim

Complainant treated for Hysterectomy and expenses claimed for Rs.58,369/- was repudiated by the Respondent giving reason that the notice was not given in time and documents also submitted late, so claim is not payable as per policy condition 5.3 & 5.4.

The Respondent was not attended the Hearing fixed by this forum and also not submitted the original claim file. The insured also not produced original premium receipt.

The policy is an unconventional group insurance, the master policy holder has no insurable interest. So the complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0651-12

Smt. Dinaben R. Patel V/s. The New India Assurance Co. Ltd.

Award dated 8th May 2012

Partial settlement of Mediclaim

Complainant hospitalized for surgery of Tongue (Cancer) and claimed Rs.39,152/- which was settled for Rs.31,152/- by deducting Rs.8,000/- as per terms and condition No.2.3 Note 2 of the policy by the Respondent Insurer.

The complainant, some amount paid by cash which was not included in the bill. Respondent clearly mentioned in the settlement sheet that payment made by cash other than hospital bill will not be payable. However, Respondent's decision to settle the claim partially is just and fair without any relief to the Complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0317-12

Mr. Sejalbhai S. Dalal V/s. United India Insurance Co. Ltd.

Award dated 10th May 2012

Repudiation of Mediclaim

Complainant's insured wife hospitalized for the treatment of Arthritis with panic disorder and lodged claim for Rs.11,281/- which was repudiated by the Respondent giving reason that the disease was pre-existing and non disclosure of Psychiatric disorder.

This was a Group Mediclaim policy and Policy issued to IRSS International who has no insurable interest. The premium paid also to IRSS International Ltd., not to the Respondent Insurer.

In view of all the above, it is not possible to interfere the Respondent's decision to reject the claim.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0356-12

Mr. Melvin Castelino V/s. The New India Assurance Co. Ltd.

Award dated 9th May 2012

Partial Settlement of Mediclaim

Complainant hospitalized for Renal failure disease and claimed for Rs.23,764/- which was partially settled by the Respondent for Rs.15,674/-, deducting an amount of Rs.8,090/- by invoking Clause 2.1, 2.3 Note-2 and 2.4 of the Mediclaim Policy.

On scrutiny of both the party's documents, the Forum confirmed the Respondent rightly decided to settle the claim partially.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0297-12

Mr. N.D. Genani V/s. United India Insurance Co. Ltd.

Award dated 9th May 2012

Repudiation of Medi claim

A claim lodged by the Complainant for Rs.50,000/- + Interest for dental treatment expenses of his wife was repudiated by the Respondent on the ground of dental treatment except accidental is out of scope of Mediclaim policy.

Complainant argued that as per policy clause, dental surgery requiring hospitalization is payable.

The Respondent's panel doctor opined that the disease is prevalent in age related one and it can effect at any part of the body.

Therefore the forum agreed the decision of the Respondent without any relief to the complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0663-12

Mr. Saryu J. Shah V/s. the New India Assurance Co. Ltd.

Award dated 9th May 2012

Repudiation of Mediclaim

Complainant hospitalized and treatment expenses of Rs.27,892/- was lodged which was repudiated by the Respondent invoking Policy Condition No.4.4.11.

On referring the records the insured complainant was treated on OPD basis and hospitalized only for diagnostic purpose.

Therefore Respondent's decision to repudiate the claim invoking policy condition No. 4.4.11 is justified without any relief to the complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0660-12

Smt. Kinnari A. Shah V/s. The New India Assurance Co. Ltd.

Award dated 8th May 2012

Partial Settlement of Mediclaim

Complainant hospitalized for Uterus Fibroid disease and claimed for Rs.54,639/- which was partially settled by the Respondent for Rs.30,639/-, deducting an amount of Rs.24,000/- by invoking Clause 2.3 and 2.4 of the Mediclaim Policy. Complainant has paid Rs.30,000/-to doctor by cash in which complainant is eligible to get only Rs.10,000/- and also paid Rs.2000/- by cash to Asstt. Surgeon which is not payable as per above clause.

On scrutiny of both the party's documents, the Forum confirmed the Respondent rightly decided to settle the claim partially.

In the result, complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0320-12

Shri Premchand Aherwal V/s. The New India Assurance Co. Ltd.

Award dated 10th May 2012

Partial Settlement of Mediclaim

Complainant's wife hospitalized for Fistulectomy disease and claimed for Rs.38,917/- which was partially settled by the Respondent for Rs.23,317/-, deducting an amount of Rs.15,600/- by invoking policy condition 3.2 of the Mediclaim Policy.

On scrutiny of both the party's documents, the Forum confirmed the Respondent rightly decided to settle the claim partially.

In the result, complaint fails to succeed.

AHMEDABAD OMBUDSMAN CENTRE

Shri Dollarbhai P. Vora V/s. the New India Assurance Co. Ltd.

Award dated 10th May 2012

Repudiation of Mediclaim

Complainant hospitalized for treatment of Lower Respiratory Tract Infection and claimed Rs.16,564/- was repudiated by the Respondent giving reason that treatment for LRTI with known case of depression since 7 days is a permanent exclusion clause No.4.4.6 of the policy.

On referring the treatment papers shows the treatment was for LRTI, high fever and vomiting. There is no proof of Psychiatric treatment.

Therefore Respondent's decision to repudiate the claim is not justified and the Forum directed to settle the claim.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0280-12

Shri Pankaj J. Pitroda V/s. United India Insurance Co. Ltd.

Award dated 9th May 2012

Repudiation of Mediclaim

Complainant hospitalized for treatment of Mild Urinary Track Infection and claimed for Rs.11,661/- was repudiated by the Respondent on the basis of hospital records and Investigation Report.

On scrutiny of all records, the Forum also justified that the treatment could have an OPD basis, so claim rightly repudiated by the Respondent.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0146-12

Shri Mahendra H. Bhatt V/s. United India Insurance Co. Ltd.

Award dated 9th May 2012

Partial settlement of Mediclaim

Complainant have two policies, one Individual Policy for Rs.5.00 Lac and another one Super Top Up Medicare Policy for Rs.15,00,000/-, threshold limit of 5.00 Lac.

Complainant hospitalized for surgery of Brain Tumor and claim lodged was settled by the Respondent as per policy condition 1.1. Respondent's decision as explained in their note is valid and proper.

In the result complaint fails to succeed.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-0303-12

Shri Kiritbhai C. Parikh V/s. National Insurance Co. Ltd.

Award dated 14th May 2012

Repudiation of Mediclaim

Complainant hospitalized for Left Leg Cellulitis and Diabetes and expense claimed for Rs.24,598/- had been repudiated by the Respondent giving reason that claim papers show history of D.M since 10 years and High B.P since 6 years considering pre-existing condition, the policy clause 4.1.

On referring all documents, the Forum approved the Respondent's decision is just and proper.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0334-12

Mrs. Ripal S. Shah V/s. Oriental Insurance Co. Ltd.

Award dated 14th May 2012

Partial repudiation of Mediclaim

Complainant's husband treated for acute hepatitis ad claimed for Rs.39,142/-was settled by the Respondent for Rs.29,542/- giving reason that deductions are towards usual customary and necessary charges.

Complainant can not submit any concrete evidence to get full payment of the bill.

In the result complaint fails to succeed.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0362-12

Shri B.D. Sutharia V/s. the New India Assurance Co. Ltd.

Award dated 14th May 2012

Partial settlement of Mediclaim

Cataract surgery of both the eyes of the complainant and claimed total expense Rs.68,567/- was settled by the Respondent for Rs.48,000/- on the ground of, as per Circular from Insurance Co., irrespective of the policy incept surgery performed after 1st July 2010, cataract surgery expense restricting limit of Rs.24,000/- for each surgery.

Complainant argued that policy renewed on 14-03-2010 and at that time no restriction for payment of cataract surgery. Complainant submitted evidence of another cataract surgery expense of same hospital paid full claim by National Insurance Co. to one of the Insured.

The Forum replied that the settlement of another Insurer can not be required with this claim and the Respondent's decision is valid and proper.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-0365-12

Shri Kanaiyalal A. Modi V/s. National Insurance Co. Ltd.

Award dated 14th May 2012

Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Chronic Liver disease with URTI with Anemia and claimed for Rs.16,148.27 was repudiated by the Respondent on the basis of pre-existing disease.

The Respondent not submitted required documents to this Forum and also not attended the Hearing scheduled by this office.

In view of these the Forum is constrained to close the complaint without going into the merits and without passing any quantitative Award.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0381-12

Shri Khagan R. Patel V/s. the New India Assurance Co. Ltd.

Award dated 14th May 2012

Partial Settlement of Mediclaim

Complainant's wife hospitalized for abdominal wall reconstruction with repair of umbilical hernia and claimed for Rs.1,15,129/- which was partially settled by the

Respondent for Rs.32,500/-, deducting an amount of Rs.77,779/- by invoking Clause 2.1, 2.3 Note 1 and 2.4 of the Mediclaim Policy.

On scrutiny of both the party's documents, the Forum confirmed the Respondent rightly decided to settle the claim partially.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0390-12

Mrs. Usha P. Vyas V/s. The New India Assurance Co. Ltd.

Award dated 14th May 2012

Repudiation of Mediclaim

Complainant hospitalized and expenses claimed for Rs.1,22,046/- was repudiated by the Respondent on the ground of exclusion clause 4.4.10 of the mediclaim policy.

The Respondent submitted the patient had HIV positive, treating doctor also certified the same.

The complainant had not attended for Hearing scheduled by this forum and also not submitted the P-II & P-III Forms.

From the documents submitted by both the parties, it is proved that the treatment was due to complication of HIV positive and the Respondent is rightly repudiated the claim.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0391-12

Mrs. Alkaben B. Patel V/s. Oriental Insurance Co. Ltd.

Award dated 14th May 2012

Repudiation of Mediclaim

Complainant hospitalized for treatment of Malaria and other related disease and expenses claimed for Rs.22,700/- was repudiated by the Respondent invoking Policy clause 5.4 and 5.5.

Complainant argued that the intimation was given to the Agent cannot be acceptable.Documents submitted after 51 days from the date of discharge from hospital. Discharge summary of the hospital shows middle aged lady, there is no name and age.

In view of these complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0395-12

Shri Kiran G. Shah V/s. the New India Assurance Co. Ltd.

Award dated 14th May 2012

Partial Settlement of Mediclaim

Complainant's wife hospitalized for adenomyotic uterus with dysfunctional uterine bleeding disease and claimed for Rs.80,841/- which was partially settled by the Respondent for Rs.39,288/-, deducting an amount of Rs.41,553/- by invoking Clause 2.3 and 2.4 of the Mediclaim Policy.

Complainant paid Rs.50,000/- by cash to the doctor for operation charges out of this Respondent paid only Rs.10,000/-.

Neither the Respondent nor the Complainant has provided the copies of claim file.

On scrutiny of both the party's documents, the Forum confirmed the Respondent rightly decided to settle the claim partially.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0323-12

Mrs. Sandhyaben Thakkar V/s. Oriental Insurance Co. Ltd.

Award dated 15th May 2012

Repudiation of Mediclaim

Complainant hospitalized for treatment of Urinary Track Infection and expenses claimed for Rs.13,173/- was repudiated by the Respondent invoking exclusion clause 4.1 of the Mediclaim Policy. The history sheet of the patient and Discharge Summary shows that known case of Diabetic Mellitus and Hypertension since 1 ½ years. Respondent passed claim for Rs.11,543/- in the month of March 2010 for the same illness. Previous history from various consultants shows the patient was a known case of Diabetic Mellitus, Hypertension and Urinary Track Infection since 4 years.

In view of these the Respondent's decision is right and proper.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0570-12

Shri Jivanlal C. Prajapati V/s. the New India Assurance Co. Ltd.

Award dated 15th May 2012

Partial Settlement of Mediclaim

Complainant's wife hospitalized for Thyroid disease at Tata Memorial Hospitl, Mumbai and claimed for Rs.62,583/- which was partially settled by the Respondent for Rs.37,950/-by invoking Clause 2.1, 2.3 Note 1 and 2.4 & 2.10 of the Mediclaim Policy.

The Respondent confirmed that the insured had paid premium of Zone-III and treatment taken in Zone-I.

On scrutiny of both the party's documents, the Forum confirmed the Respondent rightly decided to settle the claim partially.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0539-12

Shri Hardik J Shah V/s. The New India Assurance Co. Ltd.

Award dated 15th May 2012

Repudiation of Mediclaim

A claim amount of Rs.1,08,711/-lodged by the Complainant for renal failure treatment expense for one of the insured Mrs. Snehletha R. Sutharia was repudiated by the Respondent as per policy terms and condition No. 4.1 as pre-existing disease. The deceased insured was a known case of HTN & IHD since 15 years.

Moreover, on scrutiny of treatment papers and policy documents, there is no insurable interest of the Complainant.

In the result, the complaint fails to succeed.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0340-12

Shri Kishorbhai V. Kukadia V/s. The New India Assurance Co. Ltd.

Award dated 16th May 2012

Repudiation of Mediclaim

A claim amount of Rs.50,000/- for treatment expense of complainant was repudiated by the Respondent as per policy terms and condition No. 3.2.

Respondent submitted two different judgment delivered by CDRC, Gujarat State, Ahmedabad on the same issue that Hospital having less than 15 inpatient beds cannot be considered as one single unit. So it is violation of terms of the policy, so Respondent rightly repudiated without any relief to the complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-005-0156-12

Smt. Ashaben S. Rangwala V/s. Oriental Insurance Co. Ltd.

Award dated 16th May 2012

Repudiation of Mediclaim

Late Shri Sudhirbhai T. Rangwala's hospitalization and treatment expenses of Rs.4,13,304/- was repudiated by the Respondent on the ground of exclusion clause 4.1 (pre-existing disease). The insured had spinal tumor since 1971 and hypertension since 5 years which were not disclosed in the Proposal Form. Insured was suffering from Septicemia, Acute Renal failure, Infected Bed sores, Acute M.I, Acute LVF, Bilateral Lz consolidation.

According to non-disclosure of material information in the Proposal Form, the Respondent cancelled the policy under condition No.5.9 and rejected the entire claim.

In the result complaint fails to succeed.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0368-12

Shri Ramanbhai A. Panchal V/s. United India Insurance Co. Ltd.

Award dated 15th May 2012

Repudiation of Mediclaim

Complainant's son hospitalized for abdominal pain and mild fever etc and claimed for Rs.5,500/- was repudiated by the Respondent on the reasons that as per investigation report, there is no Indoor record, no laboratory report, treating doctor is not a qualified doctor and hospital refused to stamp and sign in the claim papers.

In view of these, this Forum approved the decision of the Respondent to reject the claim.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0484-12

Shri Bhabubhai J. Shah V/s. the New India Assurance Co. Ltd.

Award dated 18th May 2012

Partial settlement of Mediclaim

Cataract surgery of both the eyes of the complainant and claimed total expense Rs.70,046/- was settled by the Respondent for Rs.48,000/- on the ground of, as per Circular from Insurance Co., irrespective of the policy incept surgery performed after 1st July 2010, cataract surgery expense restricting limit of Rs.24,000/- for each surgery.

Complainant argued that policy renewed on 26-02-2010 and at that time no restriction for payment of cataract surgery. Complainant submitted evidence of another cataract surgery expense of same hospital paid full claim by National Insurance Co. to one of the Insured.

The Forum replied that the settlement of another Insurer can not be required with this claim and the Respondent's decision is valid and proper.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0344-12

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

Award dated 17th May 2012

Repudiation of Mediclaim

Complainant's mother treated for fracture & Screw fixation and expenses claimed for Rs.38,225/- was repudiated by the Respondent giving reason that the documents submitted late, so claim is not payable as per policy condition 5.4.

The Respondent was not attended the Hearing fixed by this forum and also submitted that the policy was issued in the name of Privilege Hospitality Pvt. Ltd., who is a corporate type of firm. The insured also not produced original premium receipt.

The policy is an unconventional group insurance, the master policy holder has no insurable interest. So the complaint cannot be considered by this Forum.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0347-12

Mr. Chean V. Mehta V/s. United India Insurance Co. Ltd.

Award dated 17th May 2012

Repudiation of Mediclaim

Complainant treated for Cataract Surgery and expenses claimed for Rs.12,568/- was repudiated by the Respondent invoking exclusion clause 4.1 of the Mediclaim policy.

The Respondent was not attended the Hearing fixed by this forum and also stated that the policy issued to a corporate type of firm. The insured also not produced original premium receipt.

The policy is an unconventional group insurance, the master policy holder has no insurable interest. So the complaint can not be considered by this Forum.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0413-12

Mr. Mustak Ali K. Pathan V/s. The New India Assurance Co. Ltd.

Award dated 21st May 2012

Repudiation of Mediclaim

A claim amount of Rs.24,894/- for hospitalization and treatment expenses of the Complainant's wife due to abdominal pain was repudiated by the Respondent under exclusion clause 4.6 of the Mediclaim Policy.

On scrutiny of all documents, it is proved that the hospitalization was only for diagnostic purpose, no line of treatment has taken. Therefore complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0353-12

Mr. Bharatsinh C. Rathod V/s. United India Insurance Co. Ltd.

Award dated 21st May 2012

Repudiation of Mediclaim

A claim lodged for Rs.29,630/- for treatment expenses of the Complainant for Stricture Urethra was considered as 'NO CLAIM' giving reason that no satisfactory answer was given either the insured or the doctor.

On referring the treatment papers, the Forum justified the decision of the Respondent as 'No Claim' is right and proper.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-009-0403-12

Mr. Rameshbhai J. Gobani V/s. Reliance General Insurance Co. Ltd.

Award dated 22nd May 2012

Repudiation of Mediclaim

Complainant's 8 years old daughter hospitalized for treatment of Left eye primary constant manifest convergent squint disease and expense claimed for Rs.47,158/- was repudiated by the Respondent on the ground of exclusion clause No.10, i.e. patient is suffering from primary squint which is congenital external disease.

Complainant produced a treating doctor's certificate that the disease is not congenital one, there is no other concrete evidence to prove the disease is not congenital external disease. Therefore the Respondent's decision cannot be questioned by this Forum.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0378-12

Shri Naraindas I. Manghnani V/s. the Oriental Insurance Co. Ltd.

Award dated 23rd May 2012

Partial settlement of Mediclaim

Complainant claimed for 98,430/- for the treatment of eye surgery which was settled by the Respondent for Rs.63,000/- as per Clause 13.2 of the Mediclaim policy.

On referring all documents like policy terms and conditions, treating doctor's certificate etc., the Forum justified the Respondent's decision to settle the claim partially is just and proper.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-012-0697-12

Shri Mukesh J. Makwana V/s. ICICI Lombard General Insurance Co. Ltd.

Award dated 23rd May 2012

Repudiation of Mediclaim

A claim lodged by the Complainant for Major Medical Illness or procedure fixed benefits of Rs.3.00 Lacs on hospitalization due to Heart Attack was repudiated by the Respondent on the basis of Discharge Summaries of the Hospitals and treatment records shows that the treatment was not for Myocardial Infarction.

Myocardial Infarction benefit should be a patient having diagnosis proof of chest pain, ST-T elevation, Cardiac Troponin to at least 3 times etc. In absence of these the Respondent repudiated the benefit of the Insured as per policy terms and conditions.

The Forum approved the decision of the Respondent and thus the complaint stands disposed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-009-0488-12

Mr. Ramdhar R. Yadav V/s. Reliance General Insurance Co. Ltd.

Award dated 25th May 2012

Partial settlement of Mediclaim

A claim amount of Rs.27,446/- was lodged by the Complainant for hospitalization and treatment expense of his wife was settled by the Respondent for Rs.20,585/- stating that 25% of the claimed amount was deducted because the patient was taken for investigation outside the hospital during hospitalization for X-ray Chest and USG Abdomen and Laboratory Report in Auto Rickshaw. It proves that an OPD treatment converted into IPD treatment for which claim was made.

Hence the Respondent cannot be questioned to deduct 25% of the claim amount.

In the result the complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0457-12

Mr. Pareshbhai R. Shukla V/s. United India Insurance Co. Ltd.

Award dated 25th May 2012

Repudiation of Mediclaim

A claim lodged for Rs.41,310/- by the Complainant for his treatment expense for right lower 3rd Ureteric calculi disease was repudiated by the Respondent due to late submission of claim papers.

Complainant submitted claim papers after 14 days from discharge from hospital. As per terms and conditions of Group Mediclaim Policy, claim papers should be submitted within 7 days from the date of discharge from hospital.

The policy is an unconventional group insurance, the master policy holder has no insurable interest. The premium amount was also not mentioned in the policy certificate. So the Forum suggested the decision of the Respondent.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0375-12

Mrs. Shobnaben V. Patel V/s. United India Insurance Co. Ltd.

Award dated 24th May 2012

Partial Repudiation of Mediclaim

Complainant's hospitalization for treatment of Uterus Fibroid and Hysterectomy operation and total expenses for 43,848/- was lodged, out of which Respondent paid for Rs.20,000/- giving reason that as per policy terms and conditions No.1.2, claim payable for above disease up to 20% of Sum Insured or 50,000/- maximum whichever is less.

On analysis of materials of record shows that the Respondent is rightly settled the claim partially without any relief to the complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0503-12

Mr. Chintan V. Kathariya V/s. United India Insurance Co. Ltd.

Award dated 24th May 2012

Repudiation of Mediclaim

Complainant hospitalized for treatment of fever and headache and expensed claimed for Rs.17,921/- had been repudiated by the Respondent stating that at the time of investigation the patient was not in the hospital saying that the patient was gone out for sonography report, but he came back without any report. In his room another patient was found.

Complainant could not produce any concrete evidence to prove that he was under hospitalization on the particular days.

Therefore Complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0462-12

Mr.Ghanshyambhai S. Thakkar V/s. the New India Assurance Co. Ltd.

Award dated 22nd May 2012

Repudiation of Mediclaim

Complainant's wife treated for Cataract Surgery and expenses claimed for Rs.15,000/- was repudiated by the Respondent invoking exclusion clause 4.13 of the Mediclaim policy.

The Respondent was not attended the Hearing fixed by this forum and also stated that the policy issued to a corporate type of firm. The insured also not produced original premium receipt.

The policy is an unconventional group insurance, the master policy holder has no insurable interest. So the complaint can not be considered by this Forum.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0417-12

Shri Naitik Pravinbhai Parikh V/s. the New India Assurance Co. Ltd.

Award dated 28th May 2012

Repudiation of Mediclaim

A claim amount of Rs.8,807/- for treatment of Pelvic abscess of the complainant was repudiated by the Respondent as per policy terms and condition No. 4.3 as pre-existing disease.

As per policy conditions, the said disease falls under two years exclusion and the treatment occurred in the 2nd year policy so Respondent rightly repudiated without any relief to the complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0407-12

Shri Kalpitkumar D. Rami V/s. United India Insurance Co. Ltd.

Award dated 28th May 2012

Repudiation of Mediclaim

A Claim amount of Rs.1,11,292/- for treatment expense of Morbid Obesity and bariatric surgery to the Complainant's wife was repudiated by the Respondent invoking policy condition No.5.3.

The Complainant requested that the reason for delay was due to unavoidable circumstances that his parent's were hospitalized in another hospital which was not considerable.

However Respondent's decision to repudiate the claim is justified without any relief to the complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0442-12

Shri Jatin J. Shah V/s. the New India Assurance Co. Ltd.

Award dated 28th May 2012

Partial settlement of Mediclaim

Complainant's mother hospitalized and treatment expense claimed for Rs.69,660/- was settled by the Respondent for Rs.66,530/-, deducting an amount of Rs.3,130/- invoking policy condition 2.1 and 4.4.21.

The Respondent has shown all deductions in detailed in the claim settlement sheet so it is not possible to interfere with the decision of the Respondent.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0448-12

Shri Tejas K. Patel V/s. the New India Assurance Co. Ltd.

Award dated 29th May 2012

Repudiation of Mediclaim

A claim amount of Rs.60,930/- for treatment of Vaginal Hysterectomy expense of complainant's wife was repudiated by the Respondent as per policy terms and condition No. 4.3 as pre-existing disease.

As per policy conditions, the said disease falls under two years exclusion and the treatment occurred in the 2nd year policy so Respondent rightly repudiated without any relief to the complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0638-12

Shri Paresh Pravinchandra V/s. the New India Assurance Co. Ltd.

Award dated 29th May 2012

Repudiation of Mediclaim

Complainant hospitalized for treatment of uncontrolled Diabetes Mellitus and claimed for Rs.39,739/- was rejected by the Respondent as per policy clause No.4.1 – exclusion of pre-existing disease and non payment of additional loading premium.

Complainant requested that his previous claim was settled by the Respondent for same disease so present claim also payable.

As per available documents, complainant was suffering diabetes mellitus since 12 years and additional loading premium was not paid. So Respondent rejected the claim is just and proper.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0421-12

Shri Rajnikant N. Shukla V/s. Oriental Insurance Co. Ltd.

Award dated 30th April 2012

Repudiation of Mediclaim

A claim of Rs.43,602/- was lodged by the Complainant for his Eye Surgery expenses including interest was not settled by the Respondent saying that as per Group mediclaim policy Condition No.8, Cataract limit is payable for Rs.15,000/- which was settled but the complainant had not received the same.

The policy is an unconventional group insurance and premium receipt was not shown by the Complainant, so this forum closed the file without passing any quantitative award.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0633-12

Shri Hitendra A. Shah V/s. the New India Assurance Co. Ltd.

Award dated 30th May 2012

Partial settlement of Mediclaim

Complainant's daughter hospitalized for treatment of Appendicitis and claimed for Rs.33,815/- which was settled by the Respondent for Rs.25,875/- by deducting an amount of Rs.7,940/- as per policy condition No.2.3.

The reasons for deductions are clearly explained by the Respondent in the settlement sheet.

Therefore Respondent's decision cannot be interfered by this Forum.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0438-12

Shri Virendra S. Amin V/s. United India Insurance Co. Ltd.

Award dated 30th May 2012

Repudiation of Mediclaim

Complainant's son was hospitalized for treatment of alternating Exotrapia with left eye Master eye operation and expense claimed for Rs.19,515/- was repudiated by the Respondent under exclusion clause 4.1 of the Mediclaim policy.

On referring the treatment papers, it is proved that the operation was for squint, Bilateral for both eyes which is found since birth i.e., Congenital disease is not admissible. Hence claim was repudiated by the Respondent without any relief to the Complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0632-12

Shri Jagdish R. Patel V/s. The New India Assurance Co. Ltd.

Award dated 29th May 2012

Partial settlement of Mediclaim

Complainant's wife hospitalized for treatment of Diabetes Mellitus + Pulmonary Tuberculosis and expense claimed for Rs.72,000/- out of which Respondent paid an amount of Rs.54,000/- by deducting an amount of Rs.18,000/- as per Policy Terms and Conditions 2.1, 2.3 & 2.4.

Complainant produced doctor's bill separately which was not payable and his request to pay the deducted amount cannot be accepted as there is no justification in his demand.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-009-0403-12

Mr. Rameshbhai J. Gobani V/s. Reliance General Insurance Co. Ltd.

Award dated 22nd May 2012

Repudiation of Mediclaim

Complainant's 8 years old daughter hospitalized for treatment of Left eye primary constant manifest convergent squint disease and expense claimed for Rs.47,158/- was repudiated by the Respondent on the ground of exclusion clause No.10, i.e. patient is suffering from primary squint which is congenital external disease.

Complainant produced a treating doctor's certificate that the disease is not congenital one, there is no other concrete evidence to prove the disease is not congenital external disease. Therefore the Respondent's decision cannot be questioned by this Forum.

In the result complaint fails to succeed.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0378-12

Shri Naraindas I. Manghnani V/s. the Oriental Insurance Co. Ltd.

Award dated 23rd May 2012

Partial settlement of Mediclaim

Complainant claimed for 98,430/- for the treatment of eye surgery which was settled by the Respondent for Rs.63,000/- as per Clause 13.2 of the Mediclaim policy.

On referring all documents like policy terms and conditions, treating doctor's certificate etc., the Forum justified the Respondent's decision to settle the claim partially is just and proper.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-012-0697-12

Shri Mukesh J. Makwana V/s. ICICI Lombard General Insurance Co. Ltd.

Award dated 23rd May 2012

Repudiation of Mediclaim

A claim lodged by the Complainant for Major Medical Illness or procedure fixed benefits of Rs.3.00 Lacs on hospitalization due to Heart Attack was repudiated by the Respondent on the basis of Discharge Summaries of the Hospitals and treatment records shows that the treatment was not for Myocardial Infarction.

Myocardial Infarction benefit should be a patient having diagnosis proof of chest pain, ST-T elevation, Cardiac Troponin to at least 3 times etc. In absence of these the Respondent repudiated the benefit of the Insured as per policy terms and conditions.

The Forum approved the decision of the Respondent and thus the complaint stands disposed.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-009-0488-12

Mr. Ramdhar R. Yadav V/s. Reliance General Insurance Co. Ltd.

Award dated 25th May 2012

Partial settlement of Mediclaim

A claim amount of Rs.27,446/- was lodged by the Complainant for hospitalization and treatment expense of his wife was settled by the Respondent for Rs.20,585/- stating that 25% of the claimed amount was deducted because the patient was taken for investigation outside the hospital during hospitalization for X-ray Chest and USG Abdomen and Laboratory Report in Auto Rickshaw. It proves that an OPD treatment converted into IPD treatment for which claim was made.

Hence the Respondent cannot be questioned to deduct 25% of the claim amount.

In the result the complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0457-12

Mr. Pareshbhai R. Shukla V/s. United India Insurance Co. Ltd.

Award dated 25th May 2012

Repudiation of Mediclaim

A claim lodged for Rs.41,310/- by the Complainant for his treatment expense for right lower 3rd Ureteric calculi disease was repudiated by the Respondent due to late submission of claim papers.

Complainant submitted claim papers after 14 days from discharge from hospital. As per terms and conditions of Group Mediclaim Policy, claim papers should be submitted within 7 days from the date of discharge from hospital.

The policy is an unconventional group insurance, the master policy holder has no insurable interest. The premium amount was also not mentioned in the policy certificate. So the Forum suggested the decision of the Respondent.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0375-12

Mrs. Shobnaben V. Patel V/s. United India Insurance Co. Ltd.

Award dated 24th May 2012

Partial Repudiation of Mediclaim

Complainant's hospitalization for treatment of Uterus Fibroid and Hysterectomy operation and total expenses for 43,848/- was lodged, out of which Respondent paid for Rs.20,000/- giving reason that as per policy terms and conditions No.1.2, claim payable for above disease up to 20% of Sum Insured or 50,000/- maximum whichever is less.

On analysis of materials of record shows that the Respondent is rightly settled the claim partially without any relief to the complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0503-12

Mr. Chintan V. Kathariya V/s. United India Insurance Co. Ltd.

Award dated 24th May 2012

Repudiation of Mediclaim

Complainant hospitalized for treatment of fever and headache and expensed claimed for Rs.17,921/- had been repudiated by the Respondent stating that at the time of investigation the patient was not in the hospital saying that the patient was gone out for sonography report, but he came back without any report. In his room another patient was found.

Complainant could not produce any concrete evidence to prove that he was under hospitalization on the particular days.

Therefore Complainant fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0462-12

Mr.Ghanshyambhai S. Thakkar V/s. the New India Assurance Co. Ltd.

Award dated 22nd May 2012

Repudiation of Mediclaim

Complainant's wife treated for Cataract Surgery and expenses claimed for Rs.15,000/- was repudiated by the Respondent invoking exclusion clause 4.13 of the Mediclaim policy.

The Respondent was not attended the Hearing fixed by this forum and also stated that the policy issued to a corporate type of firm. The insured also not produced original premium receipt.

The policy is an unconventional group insurance, the master policy holder has no insurable interest. So the complaint can not be considered by this Forum.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0417-12

Shri Naitik Pravinbhai Parikh V/s. the New India Assurance Co. Ltd.

Award dated 28th May 2012

Repudiation of Mediclaim

A claim amount of Rs.8,807/- for treatment of Pelvic abscess of the complainant was repudiated by the Respondent as per policy terms and condition No. 4.3 as pre-existing disease.

As per policy conditions, the said disease falls under two years exclusion and the treatment occurred in the 2nd year policy so Respondent rightly repudiated without any relief to the complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0407-12

Shri Kalpitkumar D. Rami V/s. United India Insurance Co. Ltd.

Award dated 28th May 2012

Repudiation of Mediclaim

A Claim amount of Rs.1,11,292/- for treatment expense of Morbid Obesity and bariatric surgery to the Complainant's wife was repudiated by the Respondent invoking policy condition No.5.3.

The Complainant requested that the reason for delay was due to unavoidable circumstances that his parent's were hospitalized in another hospital which was not considerable.

However Respondent's decision to repudiate the claim is justified without any relief to the complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0442-12

Shri Jatin J. Shah V/s. the New India Assurance Co. Ltd.

Award dated 28th May 2012

Partial settlement of Mediclaim

Complainant's mother hospitalized and treatment expense claimed for Rs.69,660/- was settled by the Respondent for Rs.66,530/-, deducting an amount of Rs.3,130/- invoking policy condition 2.1 and 4.4.21.

The Respondent has shown all deductions in detailed in the claim settlement sheet so it is not possible to interfere with the decision of the Respondent.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0448-12

Shri Tejas K. Patel V/s. the New India Assurance Co. Ltd.

Award dated 29th May 2012

Repudiation of Mediclaim

A claim amount of Rs.60,930/- for treatment of Vaginal Hysterectomy expense of complainant's wife was repudiated by the Respondent as per policy terms and condition No. 4.3 as pre-existing disease.

As per policy conditions, the said disease falls under two years exclusion and the treatment occurred in the 2nd year policy so Respondent rightly repudiated without any relief to the complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0638-12

Shri Paresh Pravinchandra V/s. the New India Assurance Co. Ltd.

Award dated 29th May 2012

Repudiation of Mediclaim

Complainant hospitalized for treatment of uncontrolled Diabetes Mellitus and claimed for Rs.39,739/- was rejected by the Respondent as per policy clause No.4.1 – exclusion of pre-existing disease and non payment of additional loading premium.

Complainant requested that his previous claim was settled by the Respondent for same disease so present claim also payable.

As per available documents, complainant was suffering diabetes mellitus since 12 years and additional loading premium was not paid. So Respondent rejected the claim is just and proper.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0421-12

Shri Rajnikant N. Shukla V/s. Oriental Insurance Co. Ltd.

Award dated 30th April 2012

Repudiation of Mediclaim

A claim of Rs.43,602/- was lodged by the Complainant for his Eye Surgery expenses including interest was not settled by the Respondent saying that as per Group mediclaim policy Condition No.8, Cataract limit is payable for Rs.15,000/- which was settled but the complainant had not received the same.

The policy is an unconventional group insurance and premium receipt was not shown by the Complainant, so this forum closed the file without passing any quantitative award.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0633-12

Shri Hitendra A. Shah V/s. the New India Assurance Co. Ltd.

Award dated 30th May 2012

Partial settlement of Mediclaim

Complainant's daughter hospitalized for treatment of Appendicitis and claimed for Rs.33,815/- which was settled by the Respondent for Rs.25,875/- by deducting an amount of Rs.7,940/- as per policy condition No.2.3.

The reasons for deductions are clearly explained by the Respondent in the settlement sheet.

Therefore Respondent's decision cannot be interfered by this Forum.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0438-12

Shri Virendra S. Amin V/s. United India Insurance Co. Ltd.

Award dated 30th May 2012

Repudiation of Mediclaim

Complainant's son was hospitalized for treatment of alternating Exotrapia with left eye Master eye operation and expense claimed for Rs.19,515/- was repudiated by the Respondent under exclusion clause 4.1 of the Mediclaim policy.

On referring the treatment papers, it is proved that the operation was for squint, Bilateral for both eyes which is found since birth i.e., Congenital disease is not admissible. Hence claim was repudiated by the Respondent without any relief to the Complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0632-12

Shri Jagdish R. Patel V/s. The New India Assurance Co. Ltd.

Award dated 29th May 2012

Partial settlement of Mediclaim

Complainant's wife hospitalized for treatment of Diabetes Mellitus + Pulmonary Tuberculosis and expense claimed for Rs.72,000/- out of which Respondent paid an amount of Rs.54,000/- by deducting an amount of Rs.18,000/- as per Policy Terms and Conditions 2.1, 2.3 & 2.4.

Complainant produced doctor's bill separately which was not payable and his request to pay the deducted amount cannot be accepted as there is no justification in his demand.

In the result complaint fails to succeed.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0469-12

Shri Snehal S. Macwan V/s. United India Insurance Co. Ltd.

Award dated 23rd May 2012

Partial settlement of Mediclaim

Complainant's mother hospitalized for treatment of Urethral Stenosis and Stone disease and expense claimed for Rs.37,467/- out of which Respondent paid an amount of Rs.14,441/- by deducting an amount of Rs.23,026/- under Policy Condition No.1.2.

Respondent produced all hospitalization benefits and limits restricted percentage etc., which proved the Respondent is rightly settled the claim.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-009-0459-12

Mr. Vinodkumar M. Shah V/s. Reliance General Insurance Co. Ltd.

Award dated 29th May 2012

Repudiation of Mediclaim

Complainant hospitalized for treatment of Bilateral cerebellar + left pontine infarct + Atherosclerotic and expense claimed for Rs.2,43,827/- was repudiated by the Respondent under exclusion clause No.2 – non disclosure of material information.

The Respondent proved the complainant had history of epilepsy and history of CV Stroke which was not disclosed in the Proposal Form.

In view of this the Forum justified the Respondent's decision to repudiate the claim is just and proper hence complaint fails to succeed.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0476-12

Mrs. Bharti C. Chauhan V/s. The New India Assurance Co. Ltd.

Award dated 4th June 2012

Repudiation of Mediclaim

Complainant hospitalized for treatment of Diaria and Vomiting and claimed for Rs.17,783/- was repudiated by the Respondent stating that the treatment taken hospital is in declined list.

The Complainant is illiterate and she had requested, her economical condition is very poor and she had policy since 4 years and this is the first claim so claim may release. But Respondent repudiated the claim as per terms and conditions of the policy, hence complaint dismissed without any relief to the Complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-002-0331-12

Shri Shivkaransingh S. Bhadoriya V/s. The New India Assurance Co. Ltd.

Award dated 4th June 2012

Repudiation of Mediclaim

Complainant hospitalized for treatment of Blood Vomiting, Abdominal discomfort, Blackish stool etc. and claimed for Rs.2,92,254/- was repudiated by the Respondent as per Clause 4.4.6 of mediclaim policy.

Hospital Discharge Summary shows the history was use of alcohol related. Moreover pre-existing disease was not disclosed in the Proposal Form. So Policy Condition No.5.5 – Fraud, Misrepresentation, Concealment is also attracted.

In view of these, Respondent's decision to repudiate the claim is justified without any relief to the Complainant.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0478-12

Shri Hemantbhai T. Dhruv V/s. United India Insurance Co. Ltd.

Award dated 4th June 2012

Repudiation of Mediclaim

A claim of Rs.1,85,350/- lodged by the Complainant for treatment expenses of his wife was repudiated by the Respondent as 'No Claim' by invoking Policy Condition 5.3 and 5.4 i.e. abnormal delay (claim papers submitted after 6 months from hospitalization), Pre-existing disease and also wrong date of birth mentioned in the Proposal Form.

In view of the above, the subject complaint is devoid of substance. Hence the decision of the Respondent to reject the claim cannot be interfered and complaint stands disposed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-009-0497-12

Shri Sanjay V. Patel V/s. Reliance General Insurance Co. Ltd.

Award dated 4th June 2012

Repudiation of Mediclaim

A claim of Rs.1,90,735/- lodged by the Complainant for treatment of Peritonitis with adhesions was repudiated by the Respondent under non disclosure of material facts in proposal form- under T & C No.2 Duty of disclosure.

Complainant had not submitted policy documents, P-II & P-III forms and supporting documents like copies of Claim Form, Claim intimation, hospital bills etc.

In view of all the above reasons, complaint dismissed without any relief to the complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-003-0481-12

Shri Tanmay M. Shah V/s. National Insurance Co. Ltd.

Award dated 5th June 2012

Repudiation of Mediclaim

Complainant claimed for Rs.42,836/- for treatment expenses of his Late father was repudiated by the Respondent invoking exclusion clause 4.1 of the Baroda Heath Policy.

Claim lodged was in the first year of the policy, and as per treatment records, patient suffered from Cirrhosis of Liver and Diabetes Mellitus since 7 years.

In view of the above the decision of the Respondent to repudiate the claim is valid and proper and complaint stands disposed without any relief to the Complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-003-0465-12

Shri Satish A. Shah V/s. National Insurance Co. Ltd.

Award dated 4th June 2012

Repudiation of Mediclaim

A claim lodged for Rs.37,800/- by the complainant for his dental treatment due to accidental injury was repudiated by the Respondent under policy condition No.4.7 and 2.6.

Complainant has not proved any accidental injury like FIR with police authority. No hospitalization, treatment taken an OPD basis. As per policy condition, OPD dental treatment is not payable.

Therefore Respondent's decision to repudiate the claim is just and proper without any relief to the complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0636-12

Shri Amit B. Prajapati V/s. Oriental Insurance Co. Ltd.

Award dated 22nd June 2012

Repudiation of Mediclaim

A claim of Rs.60,761/- for Eye-Vetritis surgery was lodged by the complainant which was repudiated by the Respondent under clause 2.3 of the policy informing that procedure was same as avastine injection which is not payable.

Complainant cannot produce any concrete proof like 24 hours hospitalization, doctors certificate etc. Therefore the Forum justified the Respondent's repudiation is just and proper.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0617-12

Mr. Paras K. Gosaliya V/s. United India Insurance Co. Ltd.

Award dated 21st June 2012

Repudiation of Mediclaim

A claim lodged for Rs.65,746/- by the Complainant for his mother's treatment expense for Lt. Ureteric calculi disease was repudiated by the Respondent due to late submission of claim papers.

Complainant submitted claim papers after 2 months from discharge from hospital. As per terms and conditions of Group Mediclaim Policy, claim papers should be submitted within 7 days from the date of discharge from hospital.

The policy is an unconventional group insurance, the master policy holder has no insurable interest. The premium amount was also not mentioned in the policy certificate.

So the Forum suggested the decision of the Respondent to repudiate the claim is just and proper. In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-0598-12

Mr. Kawaljeetsingh Bhatia V/s. National Insurance Co. Ltd.

Award dated 21st June 2012

Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Laparoscopic removal of ruptured chocolate cyst right ovary with lavage and drainage and total claimed for Rs.2,68,937/- which was repudiated by the Respondent as per policy terms and conditions No.4.3.

Policy incepted in the year of 2008 July and hospitalization in the year of April 2010, here there is a waiting period of two years for the above disease that means two months are remaining for completing two years.

However Respondent's decision cannot be interfered. In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0609-12

Smt. Kiranben K. Ajmera V/s. United India Insurance Co. Ltd.

Award dated 20th June 2012

Partial settlement of Mediclaim

Complainant claimed an amount of Rs.35,739/- for expense of her Rt. Eye Cataract surgery was settled by the Respondent Rs.30,739/- by deducting Rs.5,000/-, giving reason that "the higher charges of operation and operation theatre charges". The preamble of policy 1.1, it is specifically written that company will pay expenses reasonably and necessary incurred. In item 2 also stated the above information.

Complainant was absent in the Hearing scheduled by this Forum. In view of these there is not ground to interfere the Respondent's decision.

Thus Complaint stands disposed without any relief to the complainant.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0611-12

Shri Pankil N. Mashroowala V/s. United India Insurance Co. Ltd.

Award dated 20th June 2012

Partial settlement of Mediclaim

Complainant's wife hospitalized for treatment of multiple Fibroid, Post Meno & Pausal Bleeding and expense claimed for Rs.61,701/- was settled by the Respondent for Rs.53,701/- by deducting an amount of Rs.8,000/-, giving reason that operation and operative charges are very high.

Complainant's argument is deduction shown excess billing is not correct and as per policy terms and conditions, there is no capping in operation/O.T charges.

Respondent clarified the deduction made as per the decision of the TPA's Panel doctor.

The company will pay expenses reasonably and necessarily incurred. So there is no room for interfere in the decision of the Respondent.

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AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-003-0540-12

Mr. Rameshchandra H. Trivedi V/s. National Insurance Co. Ltd.

Award dated 20th June 2012

Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Coronary Angiography, Hypertension and D.M and expense claimed for Rs.10,534/- was repudiated by the Respondent due to Exclusion clause 4.1 – pre-existing disease. Policy incepted in the year of 2008 and claim occurred in the year of 2010 i.e. third year of policy. Claim free policy years – 4 years.

In view of the above the complaint stands disposed without any relief to the complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-003-0559-12

Mr. Bhavanbhai K. Patel V/s. National Insurance Co. Ltd.

Award dated 18th June 2012

Partial repudiation of Mediclaim

Complainant hospitalized at GEM Hospital, Coimbatore for the treatment of Large Type IV Hiatus Hernia and claim lodged for Rs.2,90.801/- was settled for Rs.1,89,336/- under clause 4.16 and 3.12 of the Individual Mediclaim Policy.

During the operation, hospital has used two instruments cost of Rs.50,000/- & Rs.75,000/-, purchased for the complainant was not paid by the Respondent because there was no prescription and no purchase bill including Govt. Tax.

In view of this Respondent's decision to settle the claim partially is appropriate and complaint closed without any relief to the complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0608-12

Shri Gangadharan V/s. United India Insurance Co. Ltd.

Award dated 18th June 2012

Denial of Reinstatement of Mediclaim Policy

Complainant's renewal premium cheque was dishonoured due to insufficient fund in his account so policy has cancelled, 2nd cheque for premium was rejected by the Respondent for continuity of policy.

Complainant was paying premium for his mediclaim along with his family members since last 15 years without any break period and no claim was lodged.

Respondent sent notice for filling Fresh Proposal Form along with premium as per terms and conditions, but Complainant submitted the same except Medical Report which was not accepted by the Respondent.

In view of these, the Forum suggested the decision of the Respondent and complaint closed without any relief to the Complainant.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0607-12

Shri Gautam J. Sheth V/s. United India Insurance Co. Ltd.

Award dated 18th June 2012

Repudiation of Mediclaim

Complainant hospitalized for treatment of Psychiatric illness and claimed for Rs.47,717/- which was repudiated by the Respondent on the ground of exclusion clause of the Mediclaim policy.

Another claim lodged by the complainant for Rs.70,000/- for treatment of Right hand and head injury.

On referring the hospital records, treating doctors certificate and panel doctor's opinion, it is proved that the patient was treated for Psychiatric illness. However Respondent's decision to repudiate the claim is appropriate.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0494-12

Shri Ram Sanghani V/s. The New India Assurance Co. Ltd.

Award dated 6th June 2012

Partial repudiation of Mediclaim

Complainant lodged a claim of Rs.1,23,273/- for his treatment of injury on Lateral tibia & cordial fracture was settled by the Respondent only for Rs.49,530/- as per terms and conditions of the Policy clause No.2.1, 2.3 and 2.4.

Complainant got injury while driving scooter in the muddy road. S.I. of Rs.1.00 Lac with C.B Rs.44,000/- i.e. his total claim eligibility is Rs.1,44,000/- but there is no FIR to prove the accidental injury.

On referring the records of both the parties, the Forum justified the decision of the Respondent to settle the claim partially is right and proper.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0601-12

Shri Gulabrai K. Dhankani V/s. The New India Assurance Co. Ltd.

Award dated 7th June 2012

Partial repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Hysterectomy and Incisional Hernia and expense claimed was partially repudiated by the Respondent giving reason that Hysterectomy treatment expense was paid and Incisional Hernia expense was repudiated because the disease related to Tubal Ligation denied under Clause 4.4.13 of the Mediclaim policy.

The treating doctor certified that H/o. Tubal Legation operation, maternity related was done in 1985. Policy incepted in the year of 1994.

This proves Respondent's decision to deny the claim of Incisional Hernia under Clause 4.4.13 is just and proper.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0425-12

Shri Khumansinh Vaghela V/s. The New India Assurance Co. Ltd.

Award dated 7th June 2012

Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Acute Gastro Enteritis and expense claimed for Rs.17,464/- was repudiated by the Respondent giving reason that the treated hospital was one of the declined list.

Complainant informed that as a policy holder, he was not informed of declined hospital list by the Insurer and there is no mention any were in the policy also, so he was unaware of the declined hospital.

Respondent produced the judgment of the Gujarat High Court regarding the list of declined hospital. In view of this Respondent's decision agreed by the Forum.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0627-12

Mrs. Kundanben P. Parikh V/s. The New India Assurance Co. Ltd.

Award dated 7th June 2012

Partial Settlement of Mediclaim

Complainant's deceased husband hospitalized at Apollo Hospital for the complaint of Altered level of Consciousness and expenses claimed for Rs.1,33,920/- was partially settled by the Respondent for Rs.1,05,228/- by deducting an amount of Rs.28,692/- as reasonable and customary charges as per clause 3.13 of the Mediclaim Policy.

Complainant's argument is the Respondent has not provided any list of reasonable charges. Deceased patient's condition was very serious, so home visit of doctor was necessitated and their charges should be paid.

Policy covers medicine charges and hospitalization expenses, so Respondent's decision to settle the claim partially is justified.

Complaint thus stands disposed without any relief to the complainant.

AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-004-0545-12

Shri Natvarlal C. Patel V/s. United India Insurance Co. Ltd.

Award dated 8th June 2012

Repudiation of Mediclaim

Complainant's wife hospitalized for the treatment of Ureter Calculus and expenses claimed for Rs.26,726/- was repudiated by the Respondent for the reason that the complainant has not submitted claim papers. The Respondent has not attended the Hearing scheduled by this Forum. The policy was tailor-made group insurance issued to Privilege Hospitality Pvt. Ltd.As per terms and conditions of Group Mediclaim Policy, claim papers should be submitted within 7 days from the date of discharge from hospital.

The policy is an unconventional group insurance, the master policy holder has no insurable interest. The premium amount was also not mentioned in the policy certificate. So the Forum suggested the decision of the Respondent to repudiate the claim is just and proper. In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0547-12

Shri Vipin R. Barot V/s. United India Insurance Co. Ltd.

Award dated 11th June 2012

Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Prolapsed inter vertebral Disc with Lumber Spondylosis and expense claimed for Rs.38,706/- was repudiated by the Respondent giving reason that as per investigation report, treatment can be on OPD basis, no Neurological deficit and no fracture.

Complainant has not produced any concrete evidence to prove the treatment should be hospitalization. No consultation paper and Medical Certificate without date.

Hence the decision of Respondent to repudiate the claim is valid and proper.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0562-12

Dr. Parul T. Shah V/s. United India Insurance Co. Ltd.

Award dated 13th June 2012

Repudiation of Mediclaim

Complainant lodged a claim of Rs.42,416/- for the treatment of his husband was repudiated by the Respondent on the ground that claim not payable as per exclusion, Ayurvedic treatment not covered.

Patient was diagnosed Scleroderma (Kushtharog) and there is no specific allopathic treatment for the disease so Ayurvedic treatment taken.

As per policy terms and Conditions of the policy, treatment taken from, a Govt. Ayurvedic Medical College only reimbursable others are not covered.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0563-12

Shri Satish R. Jayswal V/s. United India Insurance Co. Ltd.

Award dated 14th June 2012

Repudiation of Mediclaim

Complainant hospitalized for treatment of Chronic Renal failure and expense claimed for Rs.1,03,310/- was repudiated by the Respondent by invoking Policy Condition 5.3 and 5.4 i.e. abnormal delay (claim papers submitted after 3 months from hospitalization), Pre-existing disease and also mentioned he is a business man in the Proposal Form, actually he is a Rickshaw driver.

In view of the above, the subject complaint is devoid of substance. Hence the decision of the Respondent to reject the claim cannot be interfered and complaint stands disposed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0597-12

Mr. Krunal D. Patel V/s. United India Insurance Co. Ltd.

Award dated 15th June 2012

Repudiation of Mediclaim

Complainant's mother treated for fracture Lt. Tibia and expenses claimed for Rs.1,04,298/- was repudiated by the Respondent giving reason that discrepancies of operative note, so claim is not payable.

The Respondent was not attended the Hearing fixed by this forum and also submitted that the policy was issued to the Share holders of Unisafe Health Club Pvt. Ltd., who is a corporate type of firm. The insured also not produced original premium receipt.

The policy is an unconventional group insurance, the master policy holder has no insurable interest. So the complaint cannot be considered by this Forum.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0637-12

Shri Arvindkumar A. Mehta V/s. Oriental Insurance Co. Ltd.

Award dated 14th June 2012

Repudiation of Mediclaim

Complainant treated for Piles and expense claimed for Rs.11,892/- was repudiated by the Respondent giving reason that the said disease falls under 2 years exclusion clause under policy condition No.4.3.

On referring the hospital records, it is observed that all details showing regarding payment break-up but there is no room number and no room charges shown.

The Complainant's argument that he was not provided with the copies of Policy Terms and Conditions is not valid ground for interference in the decision of the Respondent. Thus complaint stands disposed without any relief to the Complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-003-0575-12

Shri Prabhudayal B. Bhadoda V/s. National Insurance Co. Ltd.

Award dated 22nd June 2012

Repudiation of Mediclaim- Complainant hospitalized for treatment of Left Renal Calculi with complete obstruction to Urinary flow and expense claimed for Rs.55,,880/- was repudiated by the Respondent giving reason that the complainant had taken treatment was in one of their declined list of hospitals.

Complainant argued that he was not aware of the fact at the time of hospitalization and was not communicated any letter by the Respondent.

Respondent produced Xerox copy of news paper of declined list in which the name of the hospital was shown.

In view of the above, the decision of the Respondent Insurer to reject the claim can not be questioned and complaint stands disposed without any relief to the Complainant.

AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-003-0603-12

Shri Maheshbhai K. Gandhi V/s. National Insurance Co. Ltd.

Award dated 22nd June 2012

Repudiation of Mediclaim

Complainant hospitalized for treatment of Falcipharum Malaria, Dengu fever, ARF Thrombocytopenia & Hyper Bilrubinaemia and expense claimed for Rs.1,20,000/- was repudiated by the Respondent as per policy exclusion No.4.1 – pre-existing disease.

Thereafter on review of the claim papers the Respondent settled the claim for Rs.1.00 Lac and complainant also confirmed the same to accept. So the Forum without going into the merits of the case and without passing any award decided to close the complaint.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0635-12

Mrs. Dipikaben D. Darji V/s. The New India Assurance Co. Ltd.

Award dated 25th June 2012

Repudiation of Mediclaim

Complainant hospitalized for Chest pain and Backache and claimed for Rs.10,761/- was repudiated by the Respondent as per Policy clause 4.1 – exclusion of pre-existing disease and non payment of additional loading premium.

Complainant had HTN and Diabetes Mellitus since list 8 years and additional premium not paid for pre-existing disease. Moreover, first consultation paper is not available. Hence it appears to be a case of OPD treatment converted into Inpatient treatment for Mediclaim.

In view of these there is no new ground to interfere the Respondent's decision and complaint stands disposed without any relief to the Complainant.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0616-12

Shri Govind G. Jagnani V/s. United India Insurance Co. Ltd.

Award dated 25th June 2012

Partial repudiation of Mediclaim

Complainant's insured mother hospitalized for the treatment of Falcipharum Malaria with CAD & Early ARDS and lodged claim for Rs.13,164/- which was settled by the Respondent for Rs.7,868/-but not presented in the bank and lying with the Complainant. The policy is Golden India fresh with pre-existing disease covered after 6 months, she is treated all pre-existing ailment so claim valid only 60%.

This was a Group Mediclaim policy and Policy issued to the Share holders of IRSS International.

The policy is an unconventional group insurance so this forum closed the file without passing any quantitative award.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-009-0653-12

Shri Ashokkumar I Dave V/s. Reliance General Insurance Co. Ltd.

Award dated 29th June 2012

Repudiation of Mediclaim

Complainant hospitalized for treatment of CAD and expense claimed for Rs.1,72,740/- was repudiated by the Respondent invoking clause 1 – pre-existing disease of the Medicaim policy.

Complainant admitted with complaint of chest pain and underwent Angiography. Complainant had previous history of Coronary artery bypass surgery. The subject claim was second year of inception of policy. This falls under policy exclusion clause No.1. Complainant was suffering from Diabetes since last 5-6 years.

In view of these the Respondent's decision to repudiate the claim is valid and proper.

AHMEDABAD OMBUDSMAN CENTRE

Case No.1-002-0679-12

Shri Sanjay C. Parikh V/s. The New India Assurance Co. Ltd.

Award dated 29th June 2012

Repudiation of Mediclaim

Complainant's 15 years old daughter hospitalized for Rt. Eye total detachment surgery and expense claimed for Rs.44,256/- was repudiated by the Respondent under Clause 5.5.

Treating doctor certified that the cause of retinal break probably myopia and in this case it is detected 19-11-2010.

Respondent failed to produce any evidences for fraud, misrepresentation and concealment during Hearing regarding above clause.

In view of the above facts Respondent and Complainant mutually agreed to settle the claim for Rs.24,000/-, so the complaint redressed without any formal award.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0562-12

Dr. Parul T. Shah V/s. United India Insurance Co. Ltd.

Award dated 13th June 2012

Repudiation of Mediclaim- Complainant lodged a claim of Rs.42,416/- for the treatment of his husband was repudiated by the Respondent on the ground that claim not payable as per exclusion, Ayurvedic treatment not covered.

Patient was diagnosed Scleroderma (Kushtharog) and there is no specific allopathic treatment for the disease so Ayurvedic treatment taken.

As per policy terms and Conditions of the policy, treatment taken from, a Govt. Ayurvedic Medical College only reimbursable others are not covered.

In the result complaint fails to succeed.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0563-12

Shri Satish R. Jayswal V/s. United India Insurance Co. Ltd.

Award dated 14th June 2012

Repudiation of Mediclaim

Complainant hospitalized for treatment of Chronic Renal failure and expense claimed for Rs.1,03,310/- was repudiated by the Respondent by invoking Policy Condition 5.3 and 5.4 i.e. abnormal delay (claim papers submitted after 3 months from hospitalization), Pre-existing disease and also mentioned he is a business man in the Proposal Form, actually he is a Rickshaw driver.

In view of the above, the subject complaint is devoid of substance. Hence the decision of the Respondent to reject the claim cannot be interfered and complaint stands disposed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0597-12

Mr. Krunal D. Patel V/s. United India Insurance Co. Ltd.

Award dated 15th June 2012

Repudiation of Mediclaim

Complainant's mother treated for fracture Lt. Tibia and expenses claimed for Rs.1,04,298/- was repudiated by the Respondent giving reason that discrepancies of operative note, so claim is not payable.

The Respondent was not attended the Hearing fixed by this forum and also submitted that the policy was issued to the Share holders of Unisafe Health Club Pvt. Ltd., who is a corporate type of firm. The insured also not produced original premium receipt.

The policy is an unconventional group insurance, the master policy holder has no insurable interest. So the complaint cannot be considered by this Forum.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0637-12

Shri Arvindkumar A. Mehta V/s. Oriental Insurance Co. Ltd.

Award dated 14th June 2012

Repudiation of Mediclaim

Complainant treated for Piles and expense claimed for Rs.11,892/- was repudiated by the Respondent giving reason that the said disease falls under 2 years exclusion clause under policy condition No.4.3.

On referring the hospital records, it is observed that all details showing regarding payment break-up but there is no room number and no room charges shown.

The Complainant's argument that he was not provided with the copies of Policy Terms and Conditions is not valid ground for interference in the decision of the Respondent. Thus complaint stands disposed without any relief to the Complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-003-0575-12

Shri Prabhudayal B. Bhadoda V/s. National Insurance Co. Ltd.

Award dated 22nd June 2012

Repudiation of Mediclaim

Complainant hospitalized for treatment of Left Renal Calculi with complete obstruction to Urinary flow and expense claimed for Rs.55,,880/- was repudiated by the Respondent giving reason that the complainant had taken treatment was in one of their declined list of hospitals. Complainant argued that he was not aware of the fact at the time of hospitalization and was not communicated any letter by the Respondent.

Respondent produced Xerox copy of news paper of declined list in which the name of the hospital was shown.

In view of the above, the decision of the Respondent Insurer to reject the claim can not be questioned and complaint stands disposed without any relief to the Complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-003-0603-12

Shri Maheshbhai K. Gandhi V/s. National Insurance Co. Ltd.

Award dated 22nd June 2012

Repudiation of Mediclaim

Complainant hospitalized for treatment of Falcipharum Malaria, Dengu fever, ARF Thrombocytopenia & Hyper Bilrubinaemia and expense claimed for Rs.1,20,000/- was repudiated by the Respondent as per policy exclusion No.4.1 – pre-existing disease.

Thereafter on review of the claim papers the Respondent settled the claim for Rs.1.00 Lac and complainant also confirmed the same to accept. So the Forum without going into the merits of the case and without passing any award decided to close the complaint.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0635-12

Mrs. Dipikaben D. Darji V/s. The New India Assurance Co. Ltd.

Award dated 25th June 2012

Repudiation of Mediclaim

Complainant hospitalized for Chest pain and Backache and claimed for Rs.10,761/- was repudiated by the Respondent as per Policy clause 4.1 – exclusion of pre-existing disease and non payment of additional loading premium.

Complainant had HTN and Diabetes Mellitus since list 8 years and additional premium not paid for pre-existing disease. Moreover, first consultation paper is not available. Hence it appears to be a case of OPD treatment converted into Inpatient treatment for Mediclaim.

In view of these there is no new ground to interfere the Respondent's decision and complaint stands disposed without any relief to the Complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0616-12

Shri Govind G. Jagnani V/s. United India Insurance Co. Ltd.

Award dated 25th June 2012

Partial repudiation of Mediclaim

Complainant's insured mother hospitalized for the treatment of Falcipharum Malaria with CAD & Early ARDS and lodged claim for Rs.13,164/- which was settled by the Respondent for Rs.7,868/-but not presented in the bank and lying with the Complainant. The policy is Golden India fresh with pre-existing disease covered after 6 months, she is treated all pre-existing ailment so claim valid only 60%.

This was a Group Mediclaim policy and Policy issued to the Share holders of IRSS International.

The policy is an unconventional group insurance so this forum closed the file without passing any quantitative award.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-009-0653-12

Shri Ashokkumar I Dave V/s. Reliance General Insurance Co. Ltd.

Award dated 29th June 2012

Repudiation of Mediclaim

Complainant hospitalized for treatment of CAD and expense claimed for Rs.1,72,740/- was repudiated by the Respondent invoking clause 1 – pre-existing disease of the Medicaim policy.

Complainant admitted with complaint of chest pain and underwent Angiography. Complainant had previous history of Coronary artery bypass surgery. The subject claim was second year of inception of policy. This falls under policy exclusion clause No.1. Complainant was suffering from Diabetes since last 5-6 years.

In view of these the Respondent's decision to repudiate the claim is valid and proper.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0679-12

Shri Sanjay C. Parikh V/s. The New India Assurance Co. Ltd.

Award dated 29th June 2012

Repudiation of Mediclaim

Complainant's 15 years old daughter hospitalized for Rt. Eye total detachment surgery and expense claimed for Rs.44,256/- was repudiated by the Respondent under Clause 5.5.

Treating doctor certified that the cause of retinal break probably myopia and in this case it is detected 19-11-2010.

Respondent failed to produce any evidences for fraud, misrepresentation and concealment during Hearing regarding above clause.

In view of the above facts Respondent and Complainant mutually agreed to settle the claim for Rs.24,000/-, so the complaint redressed without any formal award.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0709-12

Shri Hareshbhai K. Patel V/s. The New India Assurance Co. Ltd.

Award dated 29th June 2012

Repudiation of Mediclaim- A claim amount of Rs.17,400/- lodged by the Complainant for his son's Dental treatment was repudiated by the Respondent invoking clause 1, OPD treatment claim is not payable.

Insured was an accidental fall while traveling in a motorcycle driven by another person. Treatment was taken from various dates. As per policy clause No.3.4, there is no need for 24 hours hospitalization for dental treatment but in this case, no hospitalization and no surgery only primary care was given. Hence claim is not payable

Thus complaint disposed without any relief to the complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0344-12

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

Award dated 17th May 2012

Repudiation of Mediclaim

Complainant's mother treated for fracture & Screw fixation and expenses claimed for Rs.38,225/- was repudiated by the Respondent giving reason that the documents submitted late, so claim is not payable as per policy condition 5.4.

The Respondent was not attended the Hearing fixed by this forum and also submitted that the policy was issued in the name of Privilege Hospitality Pvt. Ltd., who is a corporate type of firm. The insured also not produced original premium receipt.

The policy is an unconventional group insurance, the master policy holder has no insurable interest. So the complaint cannot be considered by this Forum.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0347-12

Mr. Chean V. Mehta V/s. United India Insurance Co. Ltd.

Award dated 17th May 2012

Repudiation of Mediclaim

Complainant treated for Cataract Surgery and expenses claimed for Rs.12,568/- was repudiated by the Respondent invoking exclusion clause 4.1 of the Mediclaim policy.

The Respondent was not attended the Hearing fixed by this forum and also stated that the policy issued to a corporate type of firm. The insured also not produced original premium receipt.

The policy is an unconventional group insurance, the master policy holder has no insurable interest. So the complaint can not be considered by this Forum.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0413-12

Mr. Mustak Ali K. Pathan V/s. The New India Assurance Co. Ltd.

Award dated 21st May 2012

Repudiation of Mediclaim

A claim amount of Rs.24,894/- for hospitalization and treatment expenses of the Complainant's wife due to abdominal pain was repudiated by the Respondent under exclusion clause 4.6 of the Mediclaim Policy.

On scrutiny of all documents, it is proved that the hospitalization was only for diagnostic purpose, no line of treatment has taken. Therefore complaint fails to succeed.
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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0353-12

Mr. Bharatsinh C. Rathod V/s. United India Insurance Co. Ltd.

Award dated 21st May 2012

Repudiation of Mediclaim

A claim lodged for Rs.29,630/- for treatment expenses of the Complainant for Stricture Urethra was considered as 'NO CLAIM' giving reason that no satisfactory answer was given either the insured or the doctor.

On referring the treatment papers, the Forum justified the decision of the Respondent as 'No Claim' is right and proper.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0344-12

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

Award dated 17th May 2012

Repudiation of Mediclaim

Complainant's mother treated for fracture & Screw fixation and expenses claimed for Rs.38,225/- was repudiated by the Respondent giving reason that the documents submitted late, so claim is not payable as per policy condition 5.4.

The Respondent was not attended the Hearing fixed by this forum and also submitted that the policy was issued in the name of Privilege Hospitality Pvt. Ltd., who is a corporate type of firm. The insured also not produced original premium receipt.

The policy is an unconventional group insurance, the master policy holder has no insurable interest. So the complaint cannot be considered by this Forum.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0347-12

Mr. Chean V. Mehta V/s. United India Insurance Co. Ltd.

Award dated 17th May 2012

Repudiation of Mediclaim

Complainant treated for Cataract Surgery and expenses claimed for Rs.12,568/- was repudiated by the Respondent invoking exclusion clause 4.1 of the Mediclaim policy.

The Respondent was not attended the Hearing fixed by this forum and also stated that the policy issued to a corporate type of firm. The insured also not produced original premium receipt.

The policy is an unconventional group insurance, the master policy holder has no insurable interest. So the complaint can not be considered by this Forum.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0413-12

Mr. Mustak Ali K. Pathan V/s. The New India Assurance Co. Ltd.

Award dated 21st May 2012

Repudiation of Mediclaim

A claim amount of Rs.24,894/- for hospitalization and treatment expenses of the Complainant's wife due to abdominal pain was repudiated by the Respondent under exclusion clause 4.6 of the Mediclaim Policy.

On scrutiny of all documents, it is proved that the hospitalization was only for diagnostic purpose, no line of treatment has taken. Therefore complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0353-12

Mr. Bharatsinh C. Rathod V/s. United India Insurance Co. Ltd.

Award dated 21st May 2012

Repudiation of Mediclaim

A claim lodged for Rs.29,630/- for treatment expenses of the Complainant for Stricture Urethra was considered as 'NO CLAIM' giving reason that no satisfactory answer was given either the insured or the doctor.

On referring the treatment papers, the Forum justified the decision of the Respondent as 'No Claim' is right and proper.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0469-12

Shri Snehal S. Macwan V/s. United India Insurance Co. Ltd.

Award dated 23rd May 2012

Partial settlement of Mediclaim

Complainant's mother hospitalized for treatment of Urethral Stenosis and Stone disease and expense claimed for Rs.37,467/- out of which Respondent paid an amount of Rs.14,441/- by deducting an amount of Rs.23,026/- under Policy Condition No.1.2.

Respondent produced all hospitalization benefits and limits restricted percentage etc., which proved the Respondent is rightly settled the claim.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-009-0459-12

Mr. Vinodkumar M. Shah V/s. Reliance General Insurance Co. Ltd.

Award dated 29th May 2012

Repudiation of Mediclaim

Complainant hospitalized for treatment of Bilateral cerebellar + left pontine infarct + Atherosclerotic and expense claimed for Rs.2,43,827/- was repudiated by the Respondent under exclusion clause No.2 – non disclosure of material information.

The Respondent proved the complainant had history of epilepsy and history of CV Stroke which was not disclosed in the Proposal Form.

In view of this the Forum justified the Respondent's decision to repudiate the claim is just and proper hence complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0476-12

Mrs. Bharti C. Chauhan V/s. The New India Assurance Co. Ltd.

Award dated 4th June 2012

Repudiation of Mediclaim

Complainant hospitalized for treatment of Diaria and Vomiting and claimed for Rs.17,783/- was repudiated by the Respondent stating that the treatment taken hospital is in declined list.

The Complainant is illiterate and she had requested, her economical condition is very poor and she had policy since 4 years and this is the first claim so claim may release. But Respondent repudiated the claim as per terms and conditions of the policy, hence complaint dismissed without any relief to the Complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-002-0331-12

Shri Shivkaransingh S. Bhadoriya V/s. The New India Assurance Co. Ltd.

Award dated 4th June 2012

Repudiation of Mediclaim

Complainant hospitalized for treatment of Blood Vomiting, Abdominal discomfort, Blackish stool etc. and claimed for Rs.2,92,254/- was repudiated by the Respondent as per Clause 4.4.6 of mediclaim policy.

Hospital Discharge Summary shows the history was use of alcohol related. Moreover pre-existing disease was not disclosed in the Proposal Form. So Policy Condition No.5.5 – Fraud, Misrepresentation, Concealment is also attracted.

In view of these, Respondent's decision to repudiate the claim is justified without any relief to the Complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0478-12

Shri Hemantbhai T. Dhruv V/s. United India Insurance Co. Ltd.

Award dated 4th June 2012

Repudiation of Mediclaim

A claim of Rs.1,85,350/- lodged by the Complainant for treatment expenses of his wife was repudiated by the Respondent as 'No Claim' by invoking Policy Condition 5.3 and 5.4 i.e. abnormal delay (claim papers submitted after 6 months from hospitalization), Pre-existing disease and also wrong date of birth mentioned in the Proposal Form.

In view of the above, the subject complaint is devoid of substance. Hence the decision of the Respondent to reject the claim cannot be interfered and complaint stands disposed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-009-0497-12

Shri Sanjay V. Patel V/s. Reliance General Insurance Co. Ltd.

Award dated 4th June 2012

Repudiation of Mediclaim

A claim of Rs.1,90,735/- lodged by the Complainant for treatment of Peritonitis with adhesions was repudiated by the Respondent under non disclosure of material facts in proposal form- under T & C No.2 Duty of disclosure.

Complainant had not submitted policy documents, P-II & P-III forms and supporting documents like copies of Claim Form, Claim intimation, hospital bills etc.

In view of all the above reasons, complaint dismissed without any relief to the complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-003-0481-12

Shri Tanmay M. Shah V/s. National Insurance Co. Ltd.

Award dated 5th June 2012

Repudiation of Mediclaim

Complainant claimed for Rs.42,836/- for treatment expenses of his Late father was repudiated by the Respondent invoking exclusion clause 4.1 of the Baroda Heath Policy.

Claim lodged was in the first year of the policy, and as per treatment records, patient suffered from Cirrhosis of Liver and Diabetes Mellitus since 7 years.

In view of the above the decision of the Respondent to repudiate the claim is valid and proper and complaint stands disposed without any relief to the Complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-003-0465-12

Shri Satish A. Shah V/s. National Insurance Co. Ltd.

Award dated 4th June 2012

Repudiation of Mediclaim

A claim lodged for Rs.37,800/- by the complainant for his dental treatment due to accidental injury was repudiated by the Respondent under policy condition No.4.7 and 2.6.

Complainant has not proved any accidental injury like FIR with police authority. No hospitalization, treatment taken an OPD basis. As per policy condition, OPD dental treatment is not payable.

Therefore Respondent's decision to repudiate the claim is just and proper without any relief to the complainant.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0636-12

Shri Amit B. Prajapati V/s. Oriental Insurance Co. Ltd.

Award dated 22nd June 2012

Repudiation of Mediclaim

A claim of Rs.60,761/- for Eye-Vetritis surgery was lodged by the complainant which was repudiated by the Respondent under clause 2.3 of the policy informing that procedure was same as avastine injection which is not payable.

Complainant cannot produce any concrete proof like 24 hours hospitalization, doctors certificate etc. Therefore the Forum justified the Respondent's repudiation is just and proper.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-0554-12

Mr. Vinodbhai M. Lakum V/s. National Insurance Co. Ltd.

Award dated 21st June 2012

Partial settlement of P.A. Claim

Complainant claimed for 4 weeks TTD for accidental injury on his Lt. Knee which was settled by the Respondent only for 2 weeks as per Panel doctor's certificate, X-ray report and MR Report.

Treating doctor advised rest for 4 weeks but there is no other concrete evidence to prove the accident occurred.

In view of this the Respondent's decision to settle the claim partially is right and proper without any relief to the complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0617-12

Mr. Paras K. Gosaliya V/s. United India Insurance Co. Ltd.

Award dated 21st June 2012

Repudiation of Mediclaim

A claim lodged for Rs.65,746/- by the Complainant for his mother's treatment expense for Lt. Ureteric calculi disease was repudiated by the Respondent due to late submission of claim papers.

Complainant submitted claim papers after 2 months from discharge from hospital. As per terms and conditions of Group Mediclaim Policy, claim papers should be submitted within 7 days from the date of discharge from hospital.

The policy is an unconventional group insurance, the master policy holder has no insurable interest. The premium amount was also not mentioned in the policy certificate. So the Forum suggested the decision of the Respondent to repudiate the claim is just and proper.In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-0598-12

Mr. Kawaljeetsingh Bhatia V/s. National Insurance Co. Ltd.

Award dated 21st June 2012

Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Laparoscopic removal of ruptured chocolate cyst right ovary with lavage and drainage and total claimed for Rs.2,68,937/- which was repudiated by the Respondent as per policy terms and conditions No.4.3. Policy incepted in the year of 2008 July and hospitalization in the year of April 2010, here there is a waiting period of two years for the above disease that means two months are remaining for completing two years.

However Respondent's decision cannot be interfered. In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0609-12

Smt. Kiranben K. Ajmera V/s. United India Insurance Co. Ltd.

Award dated 20th June 2012

Partial settlement of Mediclaim

Complainant claimed an amount of Rs.35,739/- for expense of her Rt. Eye Cataract surgery was settled by the Respondent Rs.30,739/- by deducting Rs.5,000/-, giving reason that "the higher charges of operation and operation theatre charges".

The preamble of policy 1.1, it is specifically written that company will pay expenses reasonably and necessary incurred. In item 2 also stated the above information.

Complainant was absent in the Hearing scheduled by this Forum. In view of these there is not ground to interfere the Respondent's decision.

Thus Complaint stands disposed without any relief to the complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0611-12

Shri Pankil N. Mashroowala V/s. United India Insurance Co. Ltd.

Award dated 20th June 2012

Partial settlement of Mediclaim

Complainant's wife hospitalized for treatment of multiple Fibroid, Post Meno & Pausal Bleeding and expense claimed for Rs.61,701/- was settled by the Respondent for Rs.53,701/- by deducting an amount of Rs.8,000/-, giving reason that operation and operative charges are very high.

Complainant's argument is deduction shown excess billing is not correct and as per policy terms and conditions, there is no capping in operation/O.T charges.

Respondent clarified the deduction made as per the decision of the TPA's Panel doctor.

The company will pay expenses reasonably and necessarily incurred. So there is no room for interfere in the decision of the Respondent.

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AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-003-0540-12

Mr. Rameshchandra H. Trivedi V/s. National Insurance Co. Ltd.

Award dated 20th June 2012

Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Coronary Angiography, Hypertension and D.M and expense claimed for Rs.10,534/- was repudiated by the Respondent due to Exclusion clause 4.1 – pre-existing disease. Policy incepted in the year

of 2008 and claim occurred in the year of 2010 i.e. third year of policy. Claim free policy years – 4 years.

In view of the above the complaint stands disposed without any relief to the complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-003-0559-12

Mr. Bhavanbhai K. Patel V/s. National Insurance Co. Ltd.

Award dated 18th June 2012

Partial repudiation of Mediclaim

Complainant hospitalized at GEM Hospital, Coimbatore for the treatment of Large Type IV Hiatus Hernia and claim lodged for Rs.2,90.801/- was settled for Rs.1,89,336/- under clause 4.16 and 3.12 of the Individual Mediclaim Policy.

During the operation, hospital has used two instruments cost of Rs.50,000/- & Rs.75,000/-, purchased for the complainant was not paid by the Respondent because there was no prescription and no purchase bill including Govt. Tax.

In view of this Respondent's decision to settle the claim partially is appropriate and complaint closed without any relief to the complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0607-12

Shri Gautam J. Sheth V/s. United India Insurance Co. Ltd.

Award dated 18th June 2012

Repudiation of Mediclaim

Complainant hospitalized for treatment of Psychiatric illness and claimed for Rs.47,717/- which was repudiated by the Respondent on the ground of exclusion clause of the Mediclaim policy.

Another claim lodged by the complainant for Rs.70,000/- for treatment of Right hand and head injury.

On referring the hospital records, treating doctors certificate and panel doctor's opinion, it is proved that the patient was treated for Psychiatric illness. However Respondent's decision to repudiate the claim is appropriate.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0494-12

Shri Ram Sanghani V/s. The New India Assurance Co. Ltd.

Award dated 6th June 2012

Partial repudiation of Mediclaim

Complainant lodged a claim of Rs.1,23,273/- for his treatment of injury on Lateral tibia & cordial fracture was settled by the Respondent only for Rs.49,530/- as per terms and conditions of the Policy clause No.2.1, 2.3 and 2.4.

Complainant got injury while driving scooter in the muddy road. S.I. of Rs.1.00 Lac with C.B Rs.44,000/- i.e. his total claim eligibility is Rs.1,44,000/- but there is no FIR to prove the accidental injury.

On referring the records of both the parties, the Forum justified the decision of the Respondent to settle the claim partially is right and proper.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0601-12

Shri Gulabrai K. Dhankani V/s. The New India Assurance Co. Ltd.

Award dated 7th June 2012

Partial repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Hysterectomy and Incisional Hernia and expense claimed was partially repudiated by the Respondent giving reason that Hysterectomy treatment expense was paid and Incisional Hernia expense was repudiated because the disease related to Tubal Ligation denied under Clause 4.4.13 of the Mediclaim policy.

The treating doctor certified that H/o. Tubal Legation operation, maternity related was done in 1985. Policy incepted in the year of 1994.

This proves Respondent's decision to deny the claim of Incisional Hernia under Clause 4.4.13 is just and proper.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0425-12

Shri Khumansinh Vaghela V/s. The New India Assurance Co. Ltd.

Award dated 7th June 2012

Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Acute Gastro Enteritis and expense claimed for Rs.17,464/- was repudiated by the Respondent giving reason that the treated hospital was one of the declined list.

Complainant informed that as a policy holder, he was not informed of declined hospital list by the Insurer and there is no mention any were in the policy also, so he was unaware of the declined hospital. Respondent produced the judgment of the Gujarat High Court regarding the list of declined hospital.

In view of this Respondent's decision agreed by the Forum.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0627-12

Mrs. Kundanben P. Parikh V/s. The New India Assurance Co. Ltd.

Award dated 7th June 2012

Partial Settlement of Mediclaim

Complainant's deceased husband hospitalized at Apollo Hospital for the complaint of Altered level of Consciousness and expenses claimed for Rs.1,33,920/- was partially settled by the Respondent for Rs.1,05,228/- by deducting an amount of Rs.28,692/- as reasonable and customary charges as per clause 3.13 of the Mediclaim Policy.

Complainant's argument is the Respondent has not provided any list of reasonable charges. Deceased patient's condition was very serious, so home visit of doctor was necessitated and their charges should be paid.

Policy covers medicine charges and hospitalization expenses, so Respondent's decision to settle the claim partially is justified.

Complaint thus stands disposed without any relief to the complainant.
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AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-004-0545-12

Shri Natvarlal C. Patel V/s. United India Insurance Co. Ltd.

Award dated 8th June 2012

Repudiation of Mediclaim- Complainant's wife hospitalized for the treatment of Ureter Calculus and expenses claimed for Rs.26,726/- was repudiated by the Respondent for the reason that the complainant has not submitted claim papers. The Respondent has not attended the Hearing scheduled by this Forum. The policy was tailor-made group insurance issued to Privilege Hospitality Pvt. Ltd.As per terms and conditions of Group Mediclaim Policy, claim papers should be submitted within 7 days from the date of discharge from hospital.The policy is an unconventional group insurance, the master policy holder has no insurable interest. The premium amount was also not mentioned in

the policy certificate. So the Forum suggested the decision of the Respondent to repudiate the claim is just and proper.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0547-12

Shri Vipin R. Barot V/s. United India Insurance Co. Ltd.

Award dated 11th June 2012

Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Prolapsed inter vertebral Disc with Lumber Spondylosis and expense claimed for Rs.38,706/- was repudiated by the Respondent giving reason that as per investigation report, treatment can be on OPD basis, no Neurological deficit and no fracture.

Complainant has not produced any concrete evidence to prove the treatment should be hospitalization. No consultation paper and Medical Certificate without date.

Hence the decision of Respondent to repudiate the claim is valid and proper.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0560-12

Shri Biharilal H. Shah V/s. United India Insurance Co. Ltd.

Award dated 12th June 2012

Partial repudiation of Mediclaim

Complainant lodged a claim of Rs.3,907/- for post hospitalization expense was rejected by the Respondent. Complainant previously treated for unstable Angina with DM connected with previous IHD & CABG. He is 80 years aged and due to non-availability of

room in the hospital, he was attended post hospitalization at his residence which expense is not payable.

Respondent was not attended the Hearing scheduled by this forum as also not submitted any documents like SCN, P-IV Form etc.

In absence of these the Forum constrained to close the complaint without going into its merits and without passing any quantitative award.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0555-12

Dr. Hirak S. Shah V/s. United India Insurance Co. Ltd.

Award dated 12th June 2012

Non settlement of Mediclaim

Complainant claimed for treatment of his accidental injured leg had rejected by the Respondent as per investigation report. The panel doctor opined the treatment was for removal of old implant.

Complainant could not produce any satisfactory proof that the injury was due to fresh accidental fall from bike.

Respondent called for supporting documents but not submitted. Complainant availed Mediclaim for this treatment from another Insurer.

In view of these there is no new ground to interfere to the decision of the Respondent and complaint stands disposed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0631-12

Shri Ishwarbhai B. Gaglani V/s. The New India Assurance Co. Ltd.

Award dated 12th June 2012

Partial settlement of Mediclaim

Cataract surgery of the complainant and claimed total expense Rs.52,438/- was settled by the Respondent for Rs.24,000/- on the ground of, as per Circular from Insurance Co., irrespective of the policy incept surgery performed after 1st July 2010, cataract surgery expense restricting limit of Rs.24,000/- for each surgery.

Respondent this fact was specifically mentioned on the first page of the policy document.

So there is no need to interfere with the decision of the Respondent, thus complaint stands disposed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0562-12

Dr. Parul T. Shah V/s. United India Insurance Co. Ltd.

Award dated 13th June 2012

Repudiation of Mediclaim

Complainant lodged a claim of Rs.42,416/- for the treatment of his husband was repudiated by the Respondent on the ground that claim not payable as per exclusion, Ayurvedic treatment not covered.

Patient was diagnosed Scleroderma (Kushtharog) and there is no specific allopathic treatment for the disease so Ayurvedic treatment taken.

As per policy terms and Conditions of the policy, treatment taken from, a Govt. Ayurvedic Medical College only reimbursable others are not covered.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0563-12

Shri Satish R. Jayswal V/s. United India Insurance Co. Ltd.

Award dated 14th June 2012

Repudiation of Mediclaim

Complainant hospitalized for treatment of Chronic Renal failure and expense claimed for Rs.1,03,310/- was repudiated by the Respondent by invoking Policy Condition 5.3 and 5.4 i.e. abnormal delay (claim papers submitted after 3 months from hospitalization), Pre-existing disease and also mentioned he is a business man in the Proposal Form, actually he is a Rickshaw driver.

In view of the above, the subject complaint is devoid of substance. Hence the decision of the Respondent to reject the claim cannot be interfered and complaint stands disposed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0597-12

Mr. Krunal D. Patel V/s. United India Insurance Co. Ltd.

Award dated 15th June 2012

Repudiation of Mediclaim

Complainant's mother treated for fracture Lt. Tibia and expenses claimed for Rs.1,04,298/- was repudiated by the Respondent giving reason that discrepancies of operative note, so claim is not payable.

The Respondent was not attended the Hearing fixed by this forum and also submitted that the policy was issued to the Share holders of Unisafe Health Club Pvt. Ltd., who is a corporate type of firm. The insured also not produced original premium receipt.

The policy is an unconventional group insurance, the master policy holder has no insurable interest. So the complaint cannot be considered by this Forum.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0637-12

Shri Arvindkumar A. Mehta V/s. Oriental Insurance Co. Ltd.

Award dated 14th June 2012

Repudiation of Mediclaim

Complainant treated for Piles and expense claimed for Rs.11,892/- was repudiated by the Respondent giving reason that the said disease falls under 2 years exclusion clause under policy condition No.4.3.

On referring the hospital records, it is observed that all details showing regarding payment break-up but there is no room number and no room charges shown.

The Complainant's argument that he was not provided with the copies of Policy Terms and Conditions is not valid ground for interference in the decision of the Respondent. Thus complaint stands disposed without any relief to the Complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-003-0575-12

Shri Prabhudayal B. Bhadoda V/s. National Insurance Co. Ltd.

Award dated 22nd June 2012

Repudiation of Mediclaim

Complainant hospitalized for treatment of Left Renal Calculi with complete obstruction to Urinary flow and expense claimed for Rs.55,,880/- was repudiated by the Respondent giving reason that the complainant had taken treatment was in one of their declined list of hospitals.

Complainant argued that he was not aware of the fact at the time of hospitalization and was not communicated any letter by the Respondent.

Respondent produced Xerox copy of news paper of declined list in which the name of the hospital was shown.

In view of the above, the decision of the Respondent Insurer to reject the claim can not be questioned and complaint stands disposed without any relief to the Complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-003-0603-12

Shri Maheshbhai K. Gandhi V/s. National Insurance Co. Ltd.

Award dated 22nd June 2012

Repudiation of Mediclaim

Complainant hospitalized for treatment of Falcipharum Malaria, Dengu fever, ARF Thrombocytopenia & Hyper Bilrubinaemia and expense claimed for Rs.1,20,000/- was repudiated by the Respondent as per policy exclusion No.4.1 – pre-existing disease.

Thereafter on review of the claim papers the Respondent settled the claim for Rs.1.00 Lac and complainant also confirmed the same to accept. So the Forum without going into the merits of the case and without passing any award decided to close the complaint.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0635-12

Mrs. Dipikaben D. Darji V/s. The New India Assurance Co. Ltd.

Award dated 25th June 2012

Repudiation of Mediclaim

Complainant hospitalized for Chest pain and Backache and claimed for Rs.10,761/- was repudiated by the Respondent as per Policy clause 4.1 – exclusion of pre-existing disease and non payment of additional loading premium.

Complainant had HTN and Diabetes Mellitus since list 8 years and additional premium not paid for pre-existing disease. Moreover, first consultation paper is not available. Hence it appears to be a case of OPD treatment converted into Inpatient treatment for Mediclaim. In view of these there is no new ground to interfere the Respondent's decision and complaint stands disposed without any relief to the Complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-009-0653-12

Shri Ashokkumar I Dave V/s. Reliance General Insurance Co. Ltd.

Award dated 29th June 2012

Repudiation of Mediclaim

Complainant hospitalized for treatment of CAD and expense claimed for Rs.1,72,740/- was repudiated by the Respondent invoking clause 1 – pre-existing disease of the Medicaim policy.

Complainant admitted with complaint of chest pain and underwent Angiography. Complainant had previous history of Coronary artery bypass surgery. The subject claim was second year of inception of policy. This falls under policy exclusion clause No.1. Complainant was suffering from Diabetes since last 5-6 years.

In view of these the Respondent's decision to repudiate the claim is valid and proper.

AHMEDABAD OMBUDSMAN CENTRE

Case No.1-002-0679-12

Shri Sanjay C. Parikh V/s. The New India Assurance Co. Ltd.

Award dated 29th June 2012

Repudiation of Mediclaim

Complainant's 15 years old daughter hospitalized for Rt. Eye total detachment surgery and expense claimed for Rs.44,256/- was repudiated by the Respondent under Clause 5.5.

Treating doctor certified that the cause of retinal break probably myopia and in this case it is detected 19-11-2010.

Respondent failed to produce any evidences for fraud, misrepresentation and concealment during Hearing regarding above clause.

In view of the above facts Respondent and Complainant mutually agreed to settle the claim for Rs.24,000/-, so the complaint redressed without any formal award.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.1-002-0709-12

Shri Hareshbhai K. Patel V/s. The New India Assurance Co. Ltd.

Award dated 29th June 2012

Repudiation of Mediclaim

A claim amount of Rs.17,400/- lodged by the Complainant for his son's Dental treatment was repudiated by the Respondent invoking clause 1, OPD treatment claim is not payable.

Insured was an accidental fall while traveling in a motorcycle driven by another person. Treatment was taken from various dates. As per policy clause No.3.4, there is no need for 24 hours hospitalization for dental treatment but in this case, no hospitalization and no surgery only primary care was given. Hence claim is not payable

Thus complaint disposed without any relief to the complainant.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-0703-12

Mr. Gunvantlal T. Patel V/s. National Insurance Co. Ltd.

Award dated 20th July 2012

Partial Repudiation of Mediclaim

Complainant's wife aged 60 years was hospitalized for treatment of Knee replacement and expense claimed for Rs.1,40,432/- was settled by the Respondent for Rs.97,750/- which was not accepted by the Complainant.

As per terms and conditions of the policy, there is some restriction for maximum limit per illness, so 25% of the claim amount deducted by the Respondent. There is no Indoor case papers and first consultation paper only prescription is available.

Therefore, the Forum decided to upheld the decision of the Respondent without any relief to the Complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.14-003-0680-12

Shri Manishbhai K. Sheth V/s. National Insurance Co. Ltd.

Award dated 23rd July 2012

Repudiation of Mediclaim

Complainant's hospitalization and treatment for CABG was repudiated by the Respondent under the purview of policy condition No.4.1 – pre-existing disease. This disease is for four continuous claim free years. This is the 2nd year policy so claim is not admissible.

Further claim documents submitted very late which is beyond 30 days from discharge so claim is inadmissible under clause No.10.

In view of these complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-017-0701-12

Shri Prashant Rajgarhia V/s. Star Health & Allied Insurance Co. Ltd.

Award dated 20th July 2012

Repudiation of Mediclaim

Complainant's mother hospitalized for treatment of DM. HT & hypothyroid and expense claimed for Rs.1,71,590/- was repudiated by the Respondent invoking clause 1 of the terms and conditions of the subject policy.

Complainant was having Diabetic safe policy wherein D.M. and HP are covered but Respondent had not received claim intimation for this policy.

In view of this Respondent's decision to repudiate the claim under pre-existing disease is proper and valid.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0707-12

Mr. Khoja Zulfikar A.M V/s. United India Insurance Co. Ltd.

Award dated 23rd July 2012

Repudiation of Mediclaim

Complainant's father hospitalized for treatment of Rt. Hand Thumb amputation and claimed for Rs.16,440/- was repudiated by the Respondent by invoking exclusion clause No.2.1. As per policy section II, claim is eligible only for Government hospital

treatment. The insured was treated at a Private hospital, therefore claim repudiated by the Respondent.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0707-12

Mr. Khoja Zulfikar A.M V/s. United India Insurance Co. Ltd.

Award dated 23rd July 2012

Repudiation of Mediclaim

Complainant's father hospitalized for treatment of Rt. Hand Thumb amputation and claimed for Rs.16,440/- was repudiated by the Respondent by invoking exclusion clause No.2.1. As per policy section II, claim is eligible only for Government hospital treatment. The insured was treated at a Private hospital, therefore claim repudiated by the Respondent.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0691-12

Shri Amrutlal K. Nai V/s. The New India Assurance Co. Ltd.

Award dated 23rd July 2012

Partial settlement of Mediclaim

Complainant treated for Heart disease and claimed for Rs.1,24,168/- was partially settled by the Respondent for Rs.94,500/- and deducted 29,668/- giving reason that the claim for Heart disease waiting period is 4 years. Old sun Insured was Rs.90,000/-,

thereafter S.I increased to 1.00 Lac but as per Clause No.4.3, Respondent is settled claim on the basis of Old S.I of Rs.90,000/- + 4,500/- C.B.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0678-12

Shri Ashokbhai K. Patel V/s. Ooriental Insurance Co. Ltd.

Award dated 17th July 2012

Repudiation of Mediclaim

Complainant's wife hospitalized for Cataract surgery and claimed for Rs.30,442/- was repudiation by the Respondent by invoking exclusion clause 4.3 of the mediclaim policy. The claim occurred in the first year of the policy and the cataract expense is restricted for two years.

The insured was having policy since last 8 years, unfortunately there was a gap for 3 days for renewal of policy so Respondent issued fresh policy, in the same year insured underwent treatment.

However as per policy exclusion clause No.4.3, claim is not eligible.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0648-12

Dr. Nimish H. Shah V/s. United India Insurance Co. Ltd.

Award dated 10th July 2012

Partial settlement of Mediclaim

Complainant's wife hospitalized two times and claim lodged two separate amounts which was paid by the Respondent after deducting some amount as excess billing and high charge of O.T etc. as per policy condition No.1.2.

On scrutiny of both the parties, the Forum agreed that the Respondent's decision to settle the claim partially is just and proper and complaint fails to succeed without any relief to the complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0648-12

Dr. Nimish H. Shah V/s. United India Insurance Co. Ltd.

Award dated 10th July 2012

Partial settlement of Mediclaim

Complainant's wife hospitalized two times and claim lodged two separate amounts which was paid by the Respondent after deducting some amount as excess billing and high charge of O.T etc. as per policy condition No.1.2.

On scrutiny of both the parties, the Forum agreed that the Respondent's decision to settle the claim partially is just and proper and complaint fails to succeed without any relief to the complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0658-12

Shri Yogendra B. Patel V/s. Oriental Insurance Co. Ltd.

Award dated 9th July 2012

Repudiation of Mediclaim

Complainant hospitalized for treatment of Piles and claimed for Rs.30,000/- was repudiated by the Respondent under Exclusion Clause 4.3. The Complainant was policy holder with Reliance General Insurance Co. since 2007 subsequently he renewed with the Respondent from February 2010 hence complainant is entitle for piles treatment.

Considering the above, the Forum advised the Respondent to settle the claim 75% of the admissible amount as a special case.

In the result complaint partially succeeds.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0642-12

Mr. Dixit K. Trivedi V/s. United India Insurance Co. Ltd.

Award dated 10th July 2012

Repudiation of Mediclaim

Complainant hospitalized for viral fever and claimed for Rs.18,412/- was repudiated by the Respondent on the ground of Black listed hospital.

Complainant is employee of Police department of Gujarat Govt. and his police was incepted since 2008, since long he has not received any intimation about the declined hospital.

Respondent failed to produce appropriate evidences in support of repudiation of claim so the Forum instructed the Respondent to grant Rs.17,112/- on Ex-gratia basis as a special case.

In the result complaint partially succeeds.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-009-0661-12

Mrs. Pravinaben A Patel V/s. Reliance General Insurance Co. Ltd.

Award dated 10th July 2012

Repudiation of Mediclaim

Complainant hospitalized for treatment of Rhematic Heart Disease and claimed for 22,774/- was repudiated by the Respondent on the ground of Pre-existing disease.

The policy was incepted since 2007, as per policy terms and conditions, pre-existing covered after 2nd year renewal, hospitalization was in the year of January 2011, this was the first claim.

As per report of Colour Doppler Echocardiography, the disease long standing Chronic ailment of RHD. However, Respondent's decision to repudiate the claim is upheld without any relief to the Complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-017-0641-12

Mr. Krishna Patil V/s. Star Health and Allied Insurance Co. Ltd.

Award dated 24th July 2012

Partial repudiation of Mediclaim

Complainant's son hospitalized for Enteric Fever and claimed Rs.16,116/- which was settled by the Respondent for Rs.10,316 as per policy conditions, reasonably and necessarily expenses.

Complainant not attended the Hearing and also not submitted any documentary evidences.

However the Forum decided to proceed exparte and closed the file without any relief to the complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-0655-12

Mrs. Purvi T. Chauhan V/s. National Insurance Co. Ltd.

Award dated 26th July 2012

Repudiation of Mediclaim

Complainant's son hospitalized and claimed for Rs.15,546/- was repudiated by the Respondent on the ground of late intimation and late submission of claim papers.

Respondent was absent for Hearing and not submitted required documents to prove his decision.

Complainant has given intimation by telephonically to the Respondent, about her son's hospitalization which was shown documentary evidence to this Forum.

Therefore the Forum directed to settle her full claim amount within 15 days from the date of consent from the complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-0668-12

Mr. Bharatbhai I Panchal V/s. National Insurance Co. Ltd.

Award dated 30th July 2012

Partial settlement of Mediclaim

Complainant's daughter hospitalized and claim lodged for Rs.22,380/- which was settled by the Respondent for Rs.15,905/- by deducting Rs.6,475/- on the ground of reasonable and customary charges.

On referring all treatment records, the Forum also agreed that the decision of the Respondent to settle the claim partially is just and proper.

In the result the complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0706-12

Smt. Madhuben R. Rathod V/s. The New India Assurance Co. Ltd.

Award dated 30th July 2012

Repudiation of Mediclaim

Complainant hospitalized one hour each for four days for Avastin Injection and four claims totaling to Rs.28,542/- lodged was repudiated by the Respondent as per policy terms and conditions claim is not payable under clause No.3.4.

On referring all treatment records, the Forum also agreed that the decision of the Respondent to repudiate the claim is just and proper.

In the result the complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-009-0725-12

Shri Manish M. Gupta V/s. Reliance General Insurance Co. Ltd.

Award dated 14th July 2012

Repudiation of Mediclaim

Complainant hospitalized for treatment of spondilytis and claimed for Rs.13,598/- was repudiated by the Respondent as per clause No.15.

First consultation was not submitted, hospitalization was not a doctor's advise and required documents were not submitted by the complainant. Therefore the Respondent's decision to repudiate the claim under clause 15 is valid and proper.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0657-12

Shri Krishnakumar M. Agarwal V/s. United India Insurance Co. Ltd.

Award dated 28th August 2012

Partial Repudiation of Mediclaim

Complainant's wife hospitalized for Osteoarthritis of both the Knees and claim lodged for Rs.2,10,000/- out of which Respondent settled cash facility for Rs.70% of Sum Insured i.e. 1,40,000/- and post hospitalization expense for Rs.9,656/- was paid as per rules of Gold Policy.

On analysis of materials on record, the Forum also denied the complainant's demand for remaining amount.

In the result complaint fails to succeed without any relief to the complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0717-12

Shri Chirag P. Modi V/s. Oriental Insurance Co. Ltd.

Award dated 28th August 2012

Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Rt. Eye Optical Coherence Tomography and Fundus Fluvoscein and claimed for Rs.1,39,103/- was repudiated by the Respondent under clause 2.3.

Respondent submitted concrete evidence to prove the subject treatment was on OPD basis which was not payable as per policy condition.

In view of this the Forum decided to upheld the Respondent's decision without any relief to the Complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-0723-12

Mr. Kamlesh J. Rami V/s. National Insurance Co. Ltd.

Award dated 28th August 2012

Repudiation of Mediclaim

Complainant's wife hospitalized for Head injury and claim lodged for Rs.9,390/- was repudiated by the Respondent under exclusion clause 4.1. From the treatment papers and Discharge Summary proved the insured was having past history of HTN which was not disclosed in the Proposal Form.

In view of this the Forum denied the claim and upheld the Respondent's decision without any relief to the complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-0724-12

Mr. Rahul N. Patel V/s. National Insurance Co. Ltd.

Award dated 28th August 2012

Partial Repudiation of Mediclaim

Complainant hospitalized for the treatment of Acaculus Cholecytitis and Diffuse Fatty Liver and claim lodged for Rs.17,743/- which was settled partially by the Respondent for Rs.11,443/- as per terms and conditions of the policy.

Complainant was having three separate policies in different dates and different S.I. However Respondent rightly settled the claim as per admissible amount.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-0667-12

Mr. Rajeshbhai Patel V/s. National Insurance Co. Ltd.

Award dated 1st August 2012

Repudiation of Mediclaim

Complainant's son hospitalized for treatment of Gastroenteritis and claimed for Rs.3,362/- was repudiated by the Respondent giving reason that patient is treated as an OPD basis.

On referring the treatment papers, it proved that there was no active treatment was given and does not show advise for admission.

In view of this Respondent's decision to repudiate the claim is upheld without any relief to the complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0712-12

Mr. Himatlal K. Jain V/s. United India Insurance Co. Ltd.

Award dated 6th August 2012

Partial Repudiation of Mediclaim

A claim amount of Rs.10,792/- lodged by the Complainant for his daughter's treatment expenses was partially settled by the Respondent for Rs.5,000/-under clause 29.1.

Complainant has not submitted P-II & P-III Forms and also not attended the Hearing scheduled by this forum.

In view this complaint stands closed without passing any quantitative award.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-009-0705-12

Mrs, Nipaben P. Vyas V/s. Reliance General Insurance Co. Ltd.

Award dated 7th August 2012

Repudiation of Mediclaim

A Claim amount of Rs.31,889/- was lodged by the complainant for her treatment of Urinary Track Infection was repudiated by the Respondent by invoking Clause 2 and 15 of the Mediclaim policy.

Various discrepancies in hospitalization date and fitness certificate date and non availability of other required documents claim repudiated by the Respondent is just and fair.

In the result complaint fails to succeed.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0713-12

Mr. Nimeshbhai Desai V/s. United India Insurance Co. Ltd.

Award dated 8th August 2012

Partial Repudiation of Mediclaim

Complainant's Cataract expense claimed for Rs.30,340/- which was settled by the Respondent for Rs.26,111/- on the ground of total error in claim form and doctor's bill. Thereafter complainant submitted a corrected bill from his doctor which was not accepted by the Respondent.

On scrutiny of all documents, it is proved the Respondent's decision to settle the claim partially is just and proper.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-009-0733-12

Mr. Paresh Sanghvi V/s. Reliance General Insurance Co. Ltd.

Award dated 14th August 2012

Repudiation of Mediclaim

Complainant's hospitalization expense claimed for Rs.12,989/- was repudiated by the Respondent on the ground of pre-existing disease.

The policy was incepted since March 2008 and hospitalized for the treatment of Ghout Arthritis on June 2010 which proves the treatment is after coverage of pre-existing.

During the Hearing both the parties amicably redressed and Respondent has offered to pay an amount of Rs.9,800/- which was agreed by the Complainant, so there no formal award is required to be issued.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-0720-12

Shri Mahendra C. Shah V/s. National Insurance Co. Ltd.

Award dated 14th August 2012

Partial settlement of Mediclaim

Complainant's wife hospitalized for Cataract surgery and claimed Rs.55,800/- which was settled by the Respondent for Rs.43,800/- on the grounds of policy conditions No.3.12. Complainant's argument that the insured was previously operated for another Eye cataract and claimed for Rs 60,000/- which was paid for Rs51,800/- so this claim should be paid same amount.

Respondent justified their deduction and the Forum accepted the same. In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-0718-12

Mr. Uday S. Trivedi V/s. National Insurance Co. Ltd.

Award dated 16th August 2012

Partial settlement of Mediclaim

A claim amount of Rs.70,335/- was lodged by the Complainant for Hysterectomy treatment expense of his wife was partially settled by the Respondent for Rs.37,335/- on the grounds of maximum limit.

The Sum Insured has raised by the Complainant in the year 2010-11 from Rs.1.00 Lac to Rs.1.75 Lac so claim again sanctioned for 13,997/- total comes to Rs.51,332/-.

Complainant has not submitted the P-II & P-III Forms and also not attended the Hearing scheduled by this Forum.

In view of this the Forum considered the decision of the Respondent to settle the claim partially without any relief to the complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-005-0722-12

Mr. Malay Gunvantlal Shah V/s. Oriental Insurance Co. Ltd.

Award dated 3rd August 2012

Repudiation of Mediclaim

Complainant's wife hospitalized for Coronary Artery Bypass surgery and the expense claimed by the complainant was repudiated by the Respondent by invoking exclusion clause No.5.4.

The policy was issued to one tailor made Group M/s. JMSL Web Solution Pvt. Ltd. which fall outside the ambit of this Forum. Hence the complaint closed without any quantitative award.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-0720-12

Shri Mahendra C. Shah V/s. National Insurance Co. Ltd.

Award dated 14th August 2012

Partial settlement of Mediclaim

Complainant's wife hospitalized for Cataract surgery and claimed Rs.55,800/- which was settled by the Respondent for Rs.43,800/- on the grounds of policy conditions No.3.12. Complainant's argument that the insured was previously operated for another Eye cataract and claimed for Rs 60,000/- which was paid for Rs51,800/- so this claim should be paid same amount.

Respondent justified their deduction and the Forum accepted the same. In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-0718-12

Mr. Uday S. Trivedi V/s. National Insurance Co. Ltd.

Award dated 16th August 2012

Partial settlement of Mediclaim

A claim amount of Rs.70,335/- was lodged by the Complainant for Hysterectomy treatment expense of his wife was partially settled by the Respondent for Rs.37,335/- on the grounds of maximum limit.

The Sum Insured has raised by the Complainant in the year 2010-11 from Rs.1.00 Lac to Rs.1.75 Lac so claim again sanctioned for 13,997/- total comes to Rs.51,332/-.

Complainant has not submitted the P-II & P-III Forms and also not attended the Hearing scheduled by this Forum.

In view of this the Forum considered the decision of the Respondent to settle the claim partially without any relief to the complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-005-0722-12

Mr. Malay Gunvantlal Shah V/s. Oriental Insurance Co. Ltd.

Award dated 3rd August 2012

Repudiation of Mediclaim

Complainant's wife hospitalized for Coronary Artery Bypass surgery and the expense claimed by the complainant was repudiated by the Respondent by invoking exclusion clause No.5.4.

The policy was issued to one tailor made Group M/s. JMSL Web Solution Pvt. Ltd. which fall outside the ambit of this Forum. Hence the complaint closed without any quantitative award.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0662-12

Shri Rajendrakumar N. Shah V/s. The Oriental Insurance Co. Ltd.

Award dated 3rd September 2012

Repudiation of Mediclaim

Complainant lodged a claim of Rs.30,121/- for the treatment of his wife for Bulky Uterus with Fibroid was repudiated by the Respondent as per Policy Clause No.4.3 (xiv).

Respondent justified with this Forum that the decision to repudiate the claim is just and proper.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0645-12

Shri Bharat V. Shah V/s. The Oriental Insurance Co. Ltd.

Award dated 4th September 2012

Partial Repudiation of Mediclaim

A Claim amount of Rs.3,09,443/- was lodged for Knee replacement expenses of the insured was partially paid by the Respondent for Rs.1,83,496/- stating that the policy was tailor made issued in the name of JMSL Web Solutions Pvt. Ltd.

The Hon. Insurance Ombudsman also opined the policy was issued to one tailor made Group M/s. JMSL Web Solution Pvt. Ltd. which fall outside the ambit of this Forum. Hence the complaint closed without any quantitative award.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0665-12

Shri Jethnand D. Chandnani V/s. The Oriental Insurance Co. Ltd.

Award dated 5th Sept. 2012

Repudiation of Mediclaim

Complainant's wife hospitalized for the treatment Knee replacement and the expense claimed by the complainant was repudiated by the Respondent by invoking exclusion clause No.5.4.

The policy was issued to one tailor made Group M/s. JMSL Web Solution Pvt. Ltd. which fall outside the ambit of this Forum. Hence the complaint closed without any quantitative award.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0719-12

Mr. Jatin N. Shah V/s. The New India Assurance Co. Ltd.

Award dated 3rd September 2012

Repudiation of Mediclaim

Three claims lodged by the Complainant for treatment expenses of his mother in different dates which were repudiated by the Respondent giving reason that "exclusion of BP & its related diseases". The treatment related to Blood Pressure, as per policy terms and conditions the same is clearly excluded.

In view of this the Respondent rightly repudiated the claims without any relief to the complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0734-12

Shri Nikhilkumar J. Patel V/s. The United India Insurance Co. Ltd.

Award dated 7th September 2012

Repudiation of Mediclaim

A claim amount of Rs.9,139/- was lodged by the Complainant for the treatment of his wife was repudiated by the Respondent on the ground of, as per investigation report the treatment could have been on OPD basis, the report signed by MBBS doctor which was not acceptable by the Respondent.

The claim repudiated by the Respondent before 2 years and 8 months, hence this Forum does not find any point to interfere with the Respondent's decision.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0731-12

Shri Vinodbhai M. Mehta V/s. United India Insurance Co. Ltd.

Award dated 7th September 2012

Partial Repudiation of Mediclaim

Complainant claimed an amount of Rs.37,600/- for his cataract surgery was partially settled for Rs.11,062/- invoking policy clause No.1.2 (a). The clause restricts the expenses for cataract for 10% of Sum Insured. The complainant's S.I is Rs.1,50,000/- so the eligible amount is Rs.15,000/-. Hence the Respondent again offered to make payment

of difference Rs.3,938/- which was not accepted by the Complainant because his demand was 25% of Sum Insured.

As per terms and conditions of the policy, it is not possible to interfere the decision of the Respondent and complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0729-12

Mrs. Himani Patel V/s. The New India Assurance Co. Ltd.

Award dated 6th September 2012

Partial Settlement of Mediclaim

A claim amount of Rs.27,175/- was lodged by the complainant for her treatment expense which was settled by the Respondent for Rs.22,175/- deducting an amount of Rs.5,000/- invoking policy condition 2.3.

On referring the documents of both the parties, the Forum approved the Respondent's decision to settle the claim partially is rightly.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0727-12

Mr. Arvind K. Budhdev V/s. United India Insurance Co. Ltd.

Award dated 7th September 2012

Repudiation of Mediclaim

Complainant hospitalized for the treatment of liver and the expense claimed by the complainant was repudiated by the Respondent by invoking exclusion clause No.5.4.

The policy was issued to one tailor made Group Club Veritus IRSS International which fall outside the ambit of this Forum. Hence the complaint closed without any quantitative award.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0730-12

Shri Govindbhai K. Banker V/s. United India Insurance Co. Ltd.

Award dated 10th September 2012

Repudiation of Mediclaim

Complainant has a Group Mediclaim and P.A Policy holder under the above Insurer issued to the Account holders of Canara Bank. Complainant lodged a claim amount of Rs.2,54,000/- for his treatment expense which was repudiated by the Respondent on the ground of pre-existing disease.

On scrutiny of all documents, the Forum suggested to upheld the Respondent's decision without any relief to the complainant.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0716-12

Shri Somabhai M. Patel V/s. The Oriental Insurance Co. Ltd.

Award dated 7th September 2012

Repudiation of Medicaim

A Claim amount of Rs.1,70,000/- was lodged by the Complainant for the treatment of Ulcerative colitis of his son was repudiated by the Respondent on the basis of late intimation and non submission of required documents to the TPA.

Respondent reported that the Claim amount is Rs.51,994/-, but both the parties failed to submit the claim form as an evidence of claim amount lodged.

The policy is a tailor made Family Floater Mediclaim issued to JMSL Web Solution which fall outside the ambit of this Forum. Hence the complaint closed without any quantitative award.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0728-12

Shri R. K. Parmar V/s. The New India Assurance Co. Ltd.

Award dated 10th September 2012

Repudiation of Mediclaim

Complainant had two Jan Arogya Bima Policies under the above Insurer for Sum Insured of Rs.5,000/- each.

A Claim lodged by the Complainant for treatment expenses of his wife for the treatment of loss over control-passing stool – 1 year was repudiated by the Respondent under policy condition 4.12.

As per investigation report of the panel doctor of the Respondent, the patient had Recto vaginal fistula due to delivery. But her delivery was normal and 25 years back.

The complainant's argument is not acceptable, hence Respondent's decision upheld without any relief to the complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0699-12

Shri Rakesh R. Shah V/s. The Oriental Insurance Co. Ltd.

Award dated 10th September 2012

Repudiation of Mediclaim

Complainant treated for Eye –sub-retinal bleeding and claim lodged for Rs.40,000/- was repudiated by the Respondent by invoking policy clause No.2.3.

Complainant was not attended the Hearing scheduled by this Forum and also not submitted the P-II & P-III Forms filled in duly signed which was issued by this Forum for getting evidences.

Respondent proved that the claim is not payable as per policy provisions clause No.2.3 hence the complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0736-13

Shri Prakash R. Shah V/s. The Oriental Insurance Co. Ltd.

Award dated 10th September 2012

Repudiation of Mediclaim

A claim amount of Rs.3,800/- lodged by the complainant for his 3 years old daughter's hospitalization and treatment expense was repudiated by the Respondent on the ground of Policy Clause No.5.5.

Complainant was not attended the Hearing scheduled by this Forum and also not submitted any documentary evidence to prove the hospitalization.

Considering all the above complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-0738-12

Dr. Chetan S. Kapadia V/s. National Insurance Co. Ltd.

Award dated 13th September 2012

Repudiation of Mediclaim

A Claim amount of Rs.62,835/- was lodged by the Complainant for his daughter's treatment expense was repudiated by the Respondent invoking policy exclusion clause No.4.12.

Patient was treated for Intra Abdominal region Mass swelling on Para umbilical region which is due to previous LSCS operation. LSCS operation was done on 21st August 2010 and the present operation also on the same site which proved the complication is due to LSCS.

In view of this the Respondent's decision to repudiate the claim is upheld without any relief to the complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0732-12

Shri Subash L. Shah V/s. The Oriental Insurance Co. Ltd.

Award dated 10th September 2012

Repudiation of Mediclaim

Complainant's wife treated her both eyes sub-retinal bleeding through "Avastin Surgery" and claimed Rs.26,336/- was repudiated by the Respondent giving reason that an OPD treatment is excluded from the scope of cover.

Moreover the Respondent paid claim for same patient in the year of 2010 for Laser surgery, so this is the second time claim.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0742-12

Shri Rajesh C. Patel V/s. The Oriental Insurance Co.Ltd.

Award dated 14th September 2012

Partial Repudiation of Mediclaim

Complainant hospitalized for treatment of Acute Lumber Disc Lesion with Radiculitis and expense claimed for Rs.12,282/- was settled by the Respondent for Rs.5,000/-stating that as per terms and conditions of the policy, non surgical ailment maximum payable amount paid.

The policy is Group Mediclaim issued to JMSL Web Solutions Pvt. Ltd., Mumbai and Original claim file was not produced by the Respondent.

Hence the Forum closed the case without passing any quantitative Award.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0739-12

Shri Lalitbhai M. Patel V/s. The New India Assurance Co.Ltd.

Award dated 14th September 2012

Non Settlement of Mediclaim

Complainant hospitalized for treatment of Thrombosed Extro Piles and expense claimed for Rs.19,197/- was not settled by the Respondent stating that the disease was pre existing disease hence claim was not payable as per clause No.4.13 of the Conditions of the policy.

The policy is a tailor made Family Floater Mediclaim issued to JMSL Web Solution which falls outside the ambit of this Forum. Hence the complaint closed without any quantitative award.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0740-12

Shri Lalit Kumar Verma V/s. The New India Assurance Co. Ltd.

Award dated 21st September 2012

Repudiation of Mediclaim

Complainant hospitalized for treatment of Myo Cardial Infarction and expense incurred Rs.2,35,000/- was repudiated by the Respondent by invoking policy clause No.4.1. Policy was incepted on 19-11-2001 and renewed in chain but the complainant had not declared HTN in revised Proposal form.

On scrutiny of all treatment records proves the patient was taking regular treatment for HTN since 10 years, so repudiation is right and proper.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0762-12

Shri Samir R. Shah V/s. The New India Assurance Co. Ltd.

Award dated 21st September 2012

Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of blood transfusion and claimed Rs.7,108/- was repudiated by the Respondent under clause 4.4.6 of the policy. Complainant was absent during the hearing scheduled by this Forum.

On referring the treating doctor's certificate and all other documents, the Forum also confirmed the Respondent's decision is right and proper.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0744-12

Mr. Gopaldas G. Kabra V/s. The New India Assurance Co. Ltd.

Award dated 21st September 2012

Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Poitural Hypotention Vsovagal Singopal Attack and expense claimed for Rs.6,269/- was repudiated by the Respondent giving reason that the treatment could have been treated an OPD basis.

The patient had treated an Inpatient basis and admitted on the advice of a doctor.

Hence the complaint succeeds and directed the Respondent to settle the admissible amount.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0751-12

Shri Himanshu R. Parekh V/s. United India Insurance Co. Ltd.

Award dated 28th September 2012

Partial Repudiation of Mediclaim

Complainant's wife treated for Hysterectomy and claimed for Rs.70,516/- which was settled by the Respondent for Rs.12,500/- under exclusion clause of the policy condition No.4.3 and 4.1.

Complainant's old Sum Insured was R.50,000/-, thereafter S.I. increased to Rs.1,50,000/- in the year of 2010 and Rs.2,50,000/- in the year of 2011.

On referring the treatment papers and as per policy terms and conditions, complainant is eligible to get 25% of Old S. I.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-004-0750-12

Mr. Deepak R. Tarachandani V/s. United India Insurance Co. Ltd.

Award dated 24th September 2012

Repudiation of Mediclaim

Complainant hospitalized for treatment of Falciparum Malaria and claimed for Rs.10,740/- was repudiated by the Respondent giving reason that at the time of investigation by the TPA of the Respondent, the time of discharge was reported wrongly by the Complainant.

The treating doctor certified the actual time and date of admission and discharge which was submitted by the complainant. However during the Hearing the complainant and Respondent mutually agreed to settle the claim for Rs.9,239/-. However the complaint was amicably redressed between both the parties and no formal award was required to be issued.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0746-12

Shri Rajesh B. Parikh V/s. United India Insurance Co. Ltd.

Award dated 24th September 2012

Repudiation of Mediclaim

Complainant's wife hospitalized and treatment expenses claimed for Rs.24,643/- was repudiated by the Respondent giving reason that the policy was not an individual capacity. It is a Tailor Made Family Floater Group Mediclaim issued to the members of Veritus Insurance Services. These members have to take treatment at Network hospital. The insured had not taken treatment to listed Network hospital.

In view of these the Respondent's decision can not be interfered and complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0745-12

Shri Shankarlal D. Koshti V/s. United India Insurance Co. Ltd.

Award dated 26th September 2012

Partial Repudiation of Mediclaim

Complainant's son hospitalized for Acute Hepatitis B and claimed an amount of Rs.23,254/- which was settled by the Respondent for Rs.16,054/- by deducting an amount of Rs.7,200/- giving reason that the extra billing and high visit charges deducted.

The policy provides for reimbursement of expenses reasonably and necessarily incurred, hence Respondent is rightly deducted the claim.

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CHENNAI OMBUDSMAN CENTER

Case No.IO (CHN) 11.04.1664/2011-12

Mr. R. Padmanabhan

vs

United India Insurance Co. Ltd.

Award No.002 dated 18.04.12

The complainant 's claim for the treatment cost was not allowed by the TPA on the grounds that (1) the Hospitalisation was mainly for investigation and evaluation (2) Psychiatric treatments not covered under the policy and (3) the ailment was pre-existing.

The rejection of the claim by the insurer did not fall under any of the three policy conditions namely exclusion of expenses of investigation & evaluation only without any treatment, exclusion of psychiatric treatments and pre-existing disease

exclusion. Hence, the rejection of the claim by the insurer on grounds of these three conditions were not tenable and the complaint is allowed.

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<u>Office of Insurance Ombudsman, Chennai</u>

<u>Case No.11.08.1705/2011-12</u>

<u>Mr.M.Lakshmanan</u>

<u>Vs</u>

<u>Royal Sundaram Alliance Insurance Co.Ltd</u>

<u>Award No. IO(CHN)/G/004/2012-13 dt.20/4/2012</u>

The complainant Shri M.Lakshmanan preferred a complaint with the forum for restriction of his claim for Radio therapy for the treatment undergone by his wife for Cancer during the policy period 2011-12. The Insurer submitted that though the eligible sum insured including CB is Rs.1,45,000/-, the maximum amount payable in respect of Radio therapy is specified as 10% of the sum insured. Hence for 2 months, a sum of Rs.29,000/- was paid.

On perusal of the terms and conditions of the policy, it is noted that the expenses incurred towards "<u>Hospitalisation</u>" of the insured person are payable subject to the terms, conditions, limitations and exclusions mentioned in the policy. Under the clause C of the policy various treatments including "Radiotherapy" are covered under the "hospitalization" benefit, if the same necessitate hospitalization for less than 24 hours due to medical/technological advancement/ infrastructure facilities. In the instant case, there appears to be no in-patient admission even for less than 24 hours for each radiotherapy treatment, and the same has been given as an out-patient. The payment of Doctor fees subject to a limit of 40% of the sum insured and treatment charges up to 50% of the sum insured (in case of all cancer treatments) arise only in case of in-patient treatments and therefore, the decision of the insurer in not allowing the said expenses under these heads as claimed by the complainant is justified. In view of the foregoing points, the demand of the complainant for considering the other expenses under the Heads "doctor fees" and "treatment expenses" in excess of the 10% of the sum insured already considered by the

insurer, is not tenable since the contract of insurance is strictly based on the policy conditions.

The complaint was dismissed.

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Office of Insurance Ombudsman, Chennai

Case No.11.05.1681/2011-12

Shri M.Rahumathullah

Vs

OrientalInsurance Co Ltd

Award No. IO(CHN)/G/005/2012-13 dt.20/4/2012

The complainant preferred a complaint against the insurer for non-settlement of a claim in respect of his wife's Hospitalisation for 'cellulitis foot' during the period from 3/9/2011 to 6/9/2011,stating that the ailment was the complication of pre-existing Diabetes and excluded as per policy clause No.4.1 of the policy conditions. It is noted that the insured was covered under the mediclaim policy with the insurer continuously from 5/3/2003. But the policy could not be renewed in time by the insured in the year 2009 and there was a break of 6 days and the policy started again from 11/03/2009. The insurer contends that the policy after the break was treated as a fresh one, since the break was not condoned, which was also endorsed on the policy itself signifying the same and as per policy conditions the ailments contracted during the previous policy periods also were treated as pre-existing.

It is noted by the Forum, from the Discharge summary of the Hospital that the insured was a known case of Diabetes Mellitus (DM) Type II and Hyper Tension (HT) for 4 years, which were therefore contracted by the insured person during the policy period in the year 2007, hence treated as pre-existing ailments. The present treatment for "Cellulites foot" during the hospitalization was mainly managed with regular antibiotics, as stated in the Discharge summary. In addition to Cellulites foot, the insured was evaluated for Abdominal pain in the epigastric region, for which obviously some diagnostic studies like

'USG abdomen' were done and some blood investigations were also done to rule out Micro filarial infections, since the insured was said to be having pain and swelling in the right lower limb for 1 week duration. More over, blood glucose monitoring had been done as evidenced by the bills for various lab tests done during hospitalisation. The necessity for in-patient treatment in the hospital for these ailments/evaluations is not clearly mentioned in the Discharge Summary and moreover the insurer/TPA also has not raised any queries on that aspect. The only ground for rejection of the claim by the insurer is the pre-existing ailment clause 4.1 of the policy.

While, it is justified in treating the policy from 11/3/2009 as a fresh policy, as per policy conditions, the insurer could have properly guided the insured to seek condonation by submitting his explanations for non-renewal of the policy in time and explored the possibility of its continuity, if non-renewal was due to any genuine reasons and beyond his control, as a part of customer service, taking into account the fact that he was a policy holder from the year 2003. Secondly, the insurer has not substantiated by any medical records or treating Doctor's certificate to confirm that the ailments for which the insured was admitted in the hospital were actually the complications of any pre-existing ailments namely DM and/or HT, in this case.

Hence the forum considered an ex-gratia of Rs.5000/- payable by the insurer.

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Office of Insurance Ombudsman, Chennai

Case No.11.03.1712/2011-12

Shri Prakash J Mehta

Vs

National Insurance Co Ltd

Award No. IO(CHN)/G/008/2012-13 dt.30/4/2012

The Complainant complained against the short settlement of his Hospitalisation claims occurred twice within the same policy period. The insured/complainant was admitted in the hospital in April 2011 for treatment following complaints of breathlessness, fever, cold and cough for one week and was diagnosed to have posterior Ventricular Septal Rupture (VSR) after undergoing various diagnostic studies. He underwent VSR repair and on discharge he was stable. Again in June 2011, he felt uneasiness with the same symptoms and the Doctor told him that his heart muscle had been ruptured and again he was admitted in the same hospital and underwent Pseudo Aneurysm Repair. His two claims (1) for Rs.2,73,116/-and (2) Rs.2,18,556/- were settled by the TPA for Rs.1,32,205/- and 79,305/- respectively. Though the current sum insured was Rs.4,00,000/-plus CB, since the present ailment is said to have been the complication of the Hyper tension suffered by the insured since 4 years, enhanced sum insured of Rs.4,00,000/- is not applicable as per clause No.5.12 of the policy. Accordingly the TPA settled a sum of Rs.1,32,205/- applying the sub-limits for various heads of expenses in respect of the first claim and the second claim was settled for the balance amount available under the respective heads, since it was considered as the follow up treatment as a consequence of the first surgery undergone by the insured 2 months ago, quoting the policy condition No.3.0 in respect of "Any One Illness", which states that "Any illness which relapses within 105 days from the date of discharge will be treated as 'Single' illness".

The insurer has not clarified or produced any clinching evidence in respect of the following points. (1) The basis on which 'the ailments for which the insured was treated' were considered as the complication of Hypertension which was contracted by the insured four years ago. No medical records or copy of the Indoor case papers are produced for substantiating their stand on this aspect. (2) No clinching evidence/ medical records are produced by the TPA to substantiate that the treatment undergone by the insured during the second hospitalization was in fact the consequence of or a case of "relapse" of the previous ailment for which he underwent surgery two months ago.(3) The insurer has not confirmed having received any fresh proposal form at the time of enhancement of sum

insured in the year 2007-08, when the sum insured was increased to Rs.4,00,000/-and whether any medical test report was collected at that time, as envisaged under the clause 5.12 of the policy.

Therefore, the insurer was directed by the forum to process and settle the claim taking into account the sum insured and CB as applicable for the year 2010-11 and taking the hospitalization during two different periods as treatments for two different ailments, without applying the "single illness" clause, subject to the Limits under different Heads of expenses for each claim separately and as per other terms and conditions of the policy.

The complaint was allowed.

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Chennai Ombudsman Centre

Case No.IO (CHN) 11.12.1715/2011- 12

Mr. Narasimhan Sreenivasan

vs

ICICI Lombard GeneralInsurance Co. Ltd

Award No.009 dated 14.05.12

The Complainant's request for the information regarding the list of Net work Hospitals abroad for availing cashless Hospitalisation was not provided by the insurer and when the policy was cancelled, only partial refund of premium was made and the complainant is seeking full refund of premium.

The provisions mentioned in the policy for cancellation, vide clause No.20 of Part III of schedule, if the request for cancellation is made by the insured, the premium would be refunded by the insurer for the period the policy has been in force at the Company's short period scales whereas in this case the insurer has offered on pro rata basis. Consequent to the cancellation intimation, the action of the insurer to offer refund of premium on pro rata basis for the unexpired period of insurance

cover as per the terms and conditions of the policy is in order and the complaint was disallowed.

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Chennai Ombudsman Centre

Case No.11.04.1714/2011-12

Shri V.Krishnamurthy

Vs

United India Insurance Co Ltd

Award No. IO(CHN)/G/015/2012-13 dt.18/5/2012

The complainant preferred a complaint against the insurer for short settlement of his claim for his daughter's hospitalization.The TPA sent the Discharge voucher for reimbursement of the claim originally disallowing certain amounts and when additional documents were submitted to allow the disallowed items, a new Discharge voucher was sent to him with a bigger disallowance deducting part of the Professional charges citing condition No.1.2. He alleged that the amendment relating to such policy condition was not brought to his notice. He raised his objection to the insurer's applying the policy condition No.1.2 relating to restriction of Room Rent to 1% of the sum insured and thereby limiting various other charges like Dr.fees, OT Charges, Pharmacy bills etc mentioned in the Hospital bills vide sub clauses in 1.2 of the policy, citing the reason that such a condition was neither in vogue during the previous years' policies held with the same insurer nor was he intimated of the introduction of such an important change in the policy condition at the time of renewal of the policy in the year 2011-12.

The insurer contended that the revised D.V was necessitated based on the clarification received regarding the nature of expense relating to service charge – as Nursing charges

The forum viewed that of course, as a measure of good customer service, the insurer could have communicated the salient features of the impending changes in the policy conditions, along with the Renewal Notice. But, at the same time after acceptance of the policy by the insured after its renewal, without raising any objections to the revised terms and conditions therein, questioning of such revision after occurrence of a claim under the policy and demanding the pre-revised limits in respect of various heads of Hospital expenses, is not tenable. Obviously, the Mediclaim policies are normally on 'annual contract basis' and the policies are subject to revisions depending upon various factors affecting the insurers' claims outgo ratio and sustainability of the portfolio in the market.

The complainant contends that as per the fundamental principle of 'utmost good faith', which is of a continuing nature, the insurer is not expected to effect material alteration in the policy without express consent of both the parties to the contract. But it is to be noted that the insurer changes policy conditions affecting the benefits of the policy holders, only after obtaining the specific approval of the Authorities concerned namely Insurance Regulatory Development Authority. When once the policy conditions are revised, uniformly for all policy holders under a particular scheme of the Mediclaim policy, it is justified on the part of the insurers, to apply the said revised conditions while settling the claim, since the Terms and Conditions of the policy are the governing factors under the contract of insurance. Hence the revised calculation while sending a revised Discharge Voucher was found to be as per the Terms and conditions of the policy.

The complaint was dismissed.

Office of Insurance Ombudsman, Chennai

Case No.11.17.1747/2011-12

Mrs.D.R.Santhakumari

VS

Star Health & Allied InsuranceCo.Ltd

Award No. IO(CHN)/G/016/2012-13 dt.22/05/2012

The Complaint, preferred by the insured's wife, was relating to short settlement of a claim submitted to the insurer for the Hospitalisation expenses incurred for the treatment of Intra Cerebral Hematoma suffered by her husband, following an acute onset of drowsiness. The patient underwent craniotomy and evacuation of ICH. The claim was settled by the insurer to the extent of Rs.50,000/- as against the total claim of Rs.2,51,844/-, quoting the reason that (1) The insured had been admitted for Acute Intra Cerebral Hemorrhage , which was treated as a complication of High Blood Pressure, and the patient was said to be in Hypertensive Emergency as per the Death summary issued by the Hospital. (2) The claim payable had been arrived at in accordance with the Endorsement clause said to have been enclosed with the policy.

It was observed by the Forum from the Death summary issued by the Hospital which states that "the patient got admitted with features of HT- emergency- Acute CVA without any previous systemic illness", and does not indicate any past history of Hyper tension.

Though the insurer stated that the patient had history of old Antero Septal Myo-cardial Infarction and BP, as revealed by the Pre-Authorisation Requisition, such records produced by the insurer do not substantiate their stand to the effect that the ailment for which the patient was admitted in the Hospital, namely Intra Cerebral Hematoma was the complication of any pre-existing Hypertension said to have been suffered by the insured person prior to inception of the first policy. The treating doctor vide his certificate in clarification of the queries raised by the insurer on the Pre-auth requisition, stated that the patient did not have any previous cardiac symptoms. The treating doctor vide his certificate dt. 3/12/2011 states that the patient was not a known Hypertensive or No other systemic illness or Co-morbid conditions. Therefore, the decision of the insurer to treat the ailment for which the insured was admitted in the hospital as a complication of Hyper Tension is not supported by any clinching evidence. The insurer also had not produced the copy of the relevant "Endorsement" said to have been enclosed with the policy terms and conditions issued to the policy holder. Therefore the insurer was directed to process the claim subject to other terms and conditions of the policy without invoking the restriction as per the Endorsement quoted by them.

The complaint was allowed.

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Chennai Ombudsman Centre

Case No.IO (CHN) 11.05.1774/2011-12

Mr. G. Ashwin

vs

The New India Assurance Co. Ltd.

Award No.017 dated 22.05.12

The complainant's car met with an accident and police issued G.D. report, wherein the name of the driver is mentioned. The insurer rejected claim on the grounds that the car was not driven by the driver at the time of accident, but by the insured himself, quoting some discrepancy in the GD report.

From the perusal of the records it was found that though the complainant's driving license expired on 26/06/11, efforts were made to renew the same only on 02/08/11 after the accident on 30/07/11 (ii) insertion noticed in the copies of the GDR without any

authentication by the issuing authorities and (iii) the complaint to the traffic police mentioning that the complainant himself was driving the vehicle as alleged by the insurer, there are possibilities that the complainant only could have driven the vehicle and substituted the name of the driver the police records. In view of the above, the decision of the insurer to reject the claim on the grounds that the complainant had misrepresented material facts with reference to the driver of the vehicle at the time of accident, to the insurer and also as per Driver's clause of the policy, the complaint is dismissed.

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Chennai Ombudsman Centre

Case No.IO (CHN) 11.02.1804/2011-12

Mr. R. Mayakannan

vs

The New India Assurance Co. Ltd.

Award No.019 dated 22.05.12

The complainant stated that his claim for the hospitalization expenses for undergoing treatment for accidental consumption of acid by his 17 year old daughter was rejected by the insurer on the grounds that it was a case of willful act and not payable under the policy. The complainant contended that it was an accident only and not willful and the same has been mentioned by the Police Certificate also.

The insurer rejected the claim on the ground that the consumption of acid was not accidental but with the intention of causing serious self hurt and as per the Terms & Conditions of the policy which excludes claims arising out of "Intentional Self Injury". The concentrated acid when it was accidentally taken may at best be discontinued the moment a few drops were tasted but the hospital records mention that a quantity of 10-20ml consumed give rise to a view that this could not have been an accidental happening. In the absence of any

substantiating proof by way of police records, hospital records highlighting the nature of mishap as accidental, the number of days in the hospital, the nature of treatment given with surgical intervention if any and the efforts taken in saving the life of the patient, the stand of the insurer denying the claim based on the investigation report that the treatment was consequent to "Intentional Self Injury" cannot be faulted and the complaint is dismissed.

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Chennai Ombudsman Centre

Case No.IO (CHN) 11.04.1778/2011-12

Mr. R. Shankarnarayanan

vs

United India Insurance Co. Ltd.

Award No.023 dated 23.05.12

The complainant 's daughter was diagnosed to be suffering from Seizure Disorder and Post Cervical Lymph Nodes. The insurer rejected the claim on the grounds of pre existing disease exclusion clause stating that as per the discharge summary the patient had this illness prior to taking the policy and had suppressed the material information regarding the pre existing illness.

It is noted that the complainant's daughter was hospitalized for Seizure Disorder and Post Cervical Lymph Nodes. When the insured submitted the bills for reimbursement, his claim was rejected by the TPA on the grounds of pre existing disease exclusion and upon representation, the insurer rejected the claim on the grounds of suppression of material facts as per condition 5.11 of the policy. The TPA also corrected their rejection reason from 4.1 to 5.11 clause of the platinum policy during the hearing. The complainant took the policy for the first time during 2008. From the discharge summary, it is found that the patient was suffering from the illness since 2000. The complainant had not denied regarding the illness his daughter had prior to taking the policy. His contention was that his daughter's illness was completely cured through medicine at the time of

obtaining the policy and hence the relevant column regarding "any previous illness suffered" in the proposal form was filled with the answer as "No" . Medicines taken since 2000 by the patient was also not denied. The complainant's statement as above indicate that he had not declared the illness suffered by his daughter at the time of obtaining the policy for the first time from the insurer. As stated by the insured, the Platinum policy coverage for his daughter did extend coverage for pre existing ailments. The insurer on the other hand, stated that at the time of granting insurance cover, they were guided by the declarations contained in the proposal. The proposal did not have any adverse features regarding the health condition of Ms. Vidya Saraswathi and on the basis of the same, they issued the policy. At the time of submission of the claim papers only, they came to know of the history of seizure disorder dating back to the year 2000 whereas their policy was effective from the year 2008 only. As stated by the insurer, they were not presented with the full facts regarding the health condition of the complainant's daughter while obtaining the policy but came to know the details only from the discharge summary. Hence their contention was that had they known the health status of the person to be insured at the time of taking the policy, they would have dealt with the proposal differently as per the underwriting guidelines by imposition of suitable warranties, charged extra premium or even could have declined the policy. Therefore, the decision of the insurer to reject the claim on the grounds that they have not been provided with the opportunity of deciding about the proposal due to non disclosure of health status of the person to be insured at the time of taking the policy, cannot be faulted and the Insurance Ombudsman is not inclined to interfere with the decision of the insurer.

The complaint is dismissed.

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Chennai Ombudsman Centre

Case No.IO (CHN) 11.04.1771/2011-12

Mr. P. Gomathi Sundarvel

vs

United India Insurance Co. Ltd.

Award No.024 dated 23.05.12

The complainant's claim for emergency Tubal pregnancy-Left tube surgery was restricted to maternity expenses allowed as per condition 1.7 of the policy whereas the insured contends that the surgery underwent by his wife can in no way be treated as a treatment traceable to pregnancy only but should be viewed as an emergency life saving one and needed settlement of the full claim.

Normally, pregnancy occurs in uterus, whereas in this case had happened in the Left tube suggestive of Ectopic pregnancy. The hospitalization in this case needs to be viewed not like a pregnancy related condition as was normally understood but a life saving instance which was different and the decision of the insurer applying condition 1.7 of the policy limiting the claim payable to maternity related expenses only is not correct and the insurer was directed to settle the claim in full and the complaint was allowed.

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Chennai Ombudsman Centre

Case No.11.12.1782/2011-12

Mrs.Paramdeep Kaur Ahuja

Vs

ICICI Lombard General Insurance Co Ltd

Synopsis to Award No. IO(CHN)/G/025/2012-13

The complainant's claim for the hospitalization expenses in respect of her father was partly settled by cashless approval by the insurer and the balance claim was settled talking into account the eligible room rent category thus disallowing major part of the claim. She contended that though the ceiling on the room rent is acceptable, reducing the other charges in proportion to the eligible room rent is not correct.

The Insurer submitted that the insured took treatment in the Hospital with a room rent of Rs.8900/- per day exceeding his entitled limit of Rs.1500/- per day. Therefore all Hospital charges are paid in proportion to his eligibility for room rent as per policy conditions.

When the insured sought to explain the basis of settlement, the insurer stated that as per Special Condition No.XXV the expenses under different heads were restricted in proportion to the eligible room rent of Rs.1500/- per day (as applicable to Grade B – Punjab) vis-à-vis the actual room rent of Rs.8900/- per day which works out to 16.8% and applied deduction of 10% co-pay as per policy condition No.iii. The complainant during the hearing seemed to have been convinced of the settlement of the claim explained as above by the insurer's representative, which may be in accordance with the policy conditions, but sought to know as to why the discount allowed by the Hospital to the extent of Rs.5340/-towards Room Rent was not deducted from the actual room rent as per the bill and the other expenses were accordingly re-worked. There is some merit in the argument of the insured. The insurer has not clarified on this aspect. But on perusal of the Bill, it is not specifically mentioned that the discount is towards Room Rent as stated by the insured and it appears to be on the overall bill. However, obviously the said discount would involve a component of "Room Rent", though the actual quantum cannot be

ascertained. Therefore, the "other Expenses" reduced on proportionate basis as stated above would also get reduced to that extent. In order to extend the said benefit, since actual amount could not be worked out in the absence of the exact quantum of discount towards Room Rent, the Insurance Ombudsman was inclined to grant an ex-gratia of Rs.2,000/- (Rupees two thousand only) to the insured.

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Office of Insurance Ombudsman, Chennai

Case No.11.04.1759/2011-12

MrA.P.James

Vs

United India Insurance Co Ltd

Award No. IO(CHN)/G/026/2012-13

The Complainant stated that his claim for Cataract surgery was paid by the insurer taking into account the sum insured of Rs.50,000/- applicable for the previous policy period instead of considering the current sum insured of Rs.75,000/-. The Insurer submitted that the sum insured in respect of the previous year was taken into account for settling the claim for Cataract surgery on the basis of the Underwriting Guidelines and Administrative Instructions issued by their Head Office which states that "Notwithstanding enhancement, for claims arising in respect of ailment contracted during a preceding policy period, liability of the company shall be only to the extent of the sum insured under the policy in force at that time when it was contracted or suffered". Hence the limit of 25% was applied on the sum insured of Rs.50,000/- which was the sum insured for the preceding year and settled the claim accordingly.

It was observed by the forum that the said condition stated by the insurer for processing the claim in dispute, has not been included in the Terms and conditions of the policy issued to the complainant for the year 2011-12. The insurer's representative stated during

the hearing that the said condition was being made effective for Renewal policies effective from May 2011. But, the complainant's policy was renewed in April, 2011 itself and therefore, the condition cited above cannot be deemed as part of the policy condition, though there is an internal circular to this effect. Moreover, the insurer has not produced any medical records in respect of the insured to substantiate that the ailment was contracted or suffered by him during the previous policy period. In the absence of specific condition in the policy restricting the sum insured in respect of an ailment contracted during the preceding policy period, the decision of the insurer to apply the sum insured for the year 2010-11 for processing the claim is not justified. Therefore, the insurer was directed to process the claim taking into account the current sum insured applicable for the year 2011-12 namely Rs.75,000/- and apply the limit of "Actual expenses incurred OR 25% of the sum insured whichever is less," as per policy condition No.1.2. Accordingly the balance amount of Rs.6,250/- becomes payable to the insured, being the difference in amount calculated based on the sum insured of Rs.75,000/-for the year 2011-12, over the amount already settled by way of cashless pre-authorisation.

The complaint was allowed.

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Office of Insurance Ombudsman, Chennai

Case No.11.17.1780/2011-12

Mr.T.D.Jose

Vs

Star Health & Allied Insurance Co Ltd

Award No. IO(CHN)/G/027/2012-13

The Complainant stated that his claim for his hospitalization expenses was rejected by the insurer stating that the ailment for which he was hospitalized was pre-existing and the same was not disclosed in the proposal form at the inception of the policy. He contends that since he was alright after the treatment and no significant diagnosis was made prior to the policy date, he had no 'undisclosed pre-existing disease', as construed by the insurer.

The Insurer submitted that the claim of the complainant was rejected since the Discharge summary reveals the past history of the ailment as existing prior to the inception of the policy, which was not disclosed by the insured in the proposal form, which amounts to Non-disclosure of material facts, attracting the policy condition No.7.

It is noted that the claim was preferred by the insured with the insurer for his Hospitalisation expenses incurred for his treatment of "Viral Meningitis", following an altered sensorium. The insured underwent Lumbar Puncture on 06.09.2011. On perusal of the Discharge summary for the period from 6/5/2010 to 11/05/2010 of Kovai Medical Centre, it is observed that the insured was admitted for evaluation of altered mental status. Idiopathic Thrombocytopenic Purpura (ITP) was suspected and various clinical examinations were done and Bone Marrow Aspirate was suggestive of peripheral platelet destruction and he was started on steroids which he responded, but the cause of altered mental status was not clear. CNS Vasculitis needed to be considered. Again from 30/8/2011 to 07/09/2011 he was admitted in the same hospital with altered sensorium suspecting Meningitis or CNS Vasculitis and investigations revealed low platelet counts

and later the Lumbar Puncture and other observations revealed "Viral Meningitis". On perusal of the copy of the proposal form, it is observed that the insured had not furnished the "Health History" though it is evident from the medical records that prior to his availing the policy, he had taken a specialized nature of treatment for an ailment which required 'hospitalization' and further monitoring to avoid recurrence. Therefore, the insurer's decision to repudiate the claim on the grounds of (1)pre-existence of the disease and (2) Non-disclosure of material facts cannot be faulted.

The complainant raised an issue, as to whether his future claims if any would not be affected OR once again the same ground of rejection namely the 'Non-disclosure' aspect would be maintained by the insurer. The insurer was advised to inform the insured in clear terms about the continuance or otherwise of the current policy till its expiry date and also about future Renewals vis-à-vis the conditions relating to admissibility of claims which may arise there-under in future. The subject matter relating to "Renewal of the policy and its terms" are beyond the scope of this forum and hence the insurer was advised to look into the matter and take appropriate action as per the policy conditions, under advice to the insured suitably, in advance.

The complaint stands dismissed.

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Chennai Ombudsman Centre

Case No.IO (CHN) 11.171800/2011-12

Mr. Ajit Babu

vs

Star Health & Allied Insurance Co. Ltd.

Award No.028 dated 08/06/12

The Complainant's claim for Total Knee Replacement surgery undergone by his wife was rejected by the insurer on the ground that the problem was relating to a pre-existing disease. According to the policy terms, Pre existing disease means any ailment or injury or related conditions(s) for which the insured person had signs or symptoms and/or was diagnosed and/or received medical advice/treatment within 48 months prior to insured person's first policy with the Company. Since the policy had not completed the stipulated number of years before commencement of hospitalization, as per policy terms, the stand of the insurer rejecting the claim on the grounds of pre-existing disease condition cannot be faulted and the complaint was dismissed.

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Chennai Ombudsman Centre

Case No.IO (CHN) 11.11.1803/2011-12

Mr. J. Reegan

vs

Bajaj Allianz General Insurance Co. Ltd

Award No.029 dated 8.06.12

The Complainant's claim for the accidental damages to his car was not considered by the insurer stating that the insured had given false declaration of NCB while availing the

policy. The insured contended that he had not given or furnished any wrong declaration in the proposal form.

The insurer had written for confirmation of NCB and had not received any reply regarding the NCB eligibility and its quantum from the previous insurer, as per the Motor Tariff provisions within the stipulated number of days, it is deemed that the insured was eligible for NCB. In the light of the above, the rejection of the claim by the insurer is not tenable and the complaint of the insured allowed.

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Chennai Ombudsman Centre

Case No.IO (CHN) 11.04.1816/2011-12

Mr. Md. Iqbal

vs

United India Insurance Co. Ltd.

Award No.031 dated 12/06/12

The insured person was hospitalized for treatment of SVB Aortic VSD. The policy coverage in respect of the person was since 3 months of age. The claim was repudiated by the insurer on the ground that the ailment was a congenital one which is not covered under the policy. As per the Platinum Policy coverage granted, under exclusion 4.1 of the policy, no expenses are payable for "All congenital disease (internal and external). Though there may be policies extending coverage for "Congenital diseases" available in the market, the policy issued by the insurer specifically excludes coverage for "Congenital diseases". Since the claim of the complainant was not payable as per the exclusions under the policy, the stand of the insurer rejecting the claim on that count cannot be faulted and the complaint was dismissed.

Office of Insurance Ombudsman, Chennai

Case.No. 11.02.1069/2012-13

Mr.P.Raghavan

vs

New India Assurance

Award No. IO(CHN)/G/032/2012-13

The complainant complained about the insurer's repudiation of his claim for the Hospitalisation expenses incurred for the treatment of his wife in an Ayurvedic Hospital for an Ortho problem.The claim was repudiated by the insurer on the ground that the treatment involved Panchakarma which is a specific exclusion under the Group Policy issued to the Retired employees of LIC Officers.

On perusing the treatment records submitted by the insured, it is noted that after exhausting the various allopathic treatments under the care of Ortho specialists for the last four years, she had finally resorted to the Ayurvedic treatment in the Specialised Ayurvedic treatment centre, and the insured had undergone the in-patient treatment, as advised by the treating Doctor, which according to the insured has yielded good results and the patient improved with mobility. Though the name of the "Type of treatment" is given as Panchakarma in the certificate issued by the treating Doctor, various other treatments as mentioned in the Discharge Summary were also administered to the patient for the multiple complaints which she was suffering from, in addition to the oral medication. As mentioned in the discharge summary the patient improved in all aspects of the complaints for which she was admitted. It is inferred that the patient was admitted in the well equipped Ayurvedic Hospital only for getting relief of severe pain in the hip and legs and mainly for difficulty in walking (which was diagnosed 'Vatha vyadhi') and the above said treatment proved very useful, which could not be achieved in the previous allopathic treatments. Therefore, the specific exclusions mentioned in the policy cannot be strictly made applicable in this case, since the treatments given to the patient are not of the nature of ordinary "massages" or for the purpose of rejuvenation therapy or rest cure involving panchakarma treatments also. Such exclusions are intended to avoid liability of the insurers towards claims arising out of treatments involving in-patient admission for a long duration, normally resorted to undergo health management or to keep the body with good physique without involving treatment of any specific illness or

disease. The treatment records of the insured in this case, evidence the necessity of such treatments for the purpose of medical relief and not for any other purpose. Hence the rejection of the entire claim by the insurer invoking the exclusion clause of the policy is not justified. Therefore, the Insurance Ombudsman was inclined to grant an Ex-gratia of Rs.40,000/- (Rupees forty thousand only) to the insured.

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Office of Insurance Ombudsman, Chennai

Case.No. 11.04.1832/2011-12

Mr.V.Srinivasan

Vs

United India Insurance

Award No. IO(CHN)/G/033/2012-13

The Complainant stated that he had preferred a claim with the insurer for the expenses incurred by him for I & D following foreign body entering into the sole of his left foot which developed into an abscess. The claim was rejected by the TPA stating that there was no hospitalization for the surgery. He contends that as per the policy condition there is no need for hospitalization for 24 hours for undergoing I and D of abscess.

The Insurer submitted their that the records submitted by the insured did not contain the Discharge Summary, Hospital Bill and other related expenses incidental to Hospitalisation. Since the treatment had been undertaken entirely on OP basis without any Hospitalisation, the claim was repudiated by the TPA under various clauses of the policy such as 1.1 and 2.3.

On perusal of the treatment details as furnished in the various records submitted by the complainant, it is noted that the insured had undergone "Incision and Drainage of the Abscess" on 9th December, 2010 and he had been taking OP treatment from last week of November, 2010 following an injury in his left foot which might have caused the abscess, requiring the said treatment. Though during the hearing, the complainant stated that he would check up with the treating Doctor for producing the Admission-Discharge

Summary of the Hospital in their Letter Head, it appears that the same was not issued by the Hospital, since no Admission-Discharge procedure was done in this case. The complainant has produced a copy of the Medical certificate issued by the Doctor furnishing the treatment details, which does not fulfill the requirements of the insurer as per the policy in order to consider it as an in-patient treatment. The said certificate also mentions that the patient was not put to the normal "Admission-Discharge procedure" while undergoing the treatment in the Hospital. This indicates that the treatment was done purely as an out-patient procedure, without the necessity of in-patient admission into the Hospital. The policy envisages admission of claims in respect of treatments taken in a Hospital as defined in the policy, as an in-patient requiring the care and treatment by the Doctor and Nurses with all the infra-structure necessary for such treatments, for a minimum duration of 24 hours or less than 24 hours under specified circumstances as the case may be, as specified in the policy. Since the treatment undergone by the insured does not come within the ambit of the policy terms, the decision of the insurer in repudiating the claim on the ground of non-Hospitalisation of the insured is justified.

The complaint was dismissed.

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Chennai Ombudsman Centre

Case No.IO (CHN) 11.04.1815/2011-12

Mr. . Kishore Andukuri

vs

United India Insurance Co. Ltd.

Award No.034 dated 21.06.12

The complainant's claim for surgical removal of multiple impacted super numery teeth in mandible under general anesthesia was rejected by the insurer. As per Condition No.4.8 of the policy, the insurer shall not be liable to make any payment in respect of "Dental

treatment or surgery of any kind unless necessitated by accident and requiring hospitalization". The hospital records indicate that the treatment was a planned one and not as a result of any accident. Further, only diagnostic tests have been carried out and the complainant had not undergone the planned treatment and got discharged. The policy did not pay for any dental treatment unless the same was as a result of accident and requiring hospitalization. The instant case did not satisfy the policy terms with regard to dental treatment and denial of the cashless facility and also the claim, cannot be faulted and the complaint dismissed.

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Chennai Ombudsman Centre

Case No.IO (CHN) 11.19.1830/2011-12

Mr. R. Chandiran

vs

Apollo Munich Health Insurance Co. Ltd

Award No.035 dated 26.06.12

The complainant's claim for Personal Accident in respect of the accidental injuries suffered by him was rejected by the insurer on the ground that the claim was not intimated to them and also due to Non-disclosure of actual occupation in the proposal form.

As per the records, the claim intimation and submission of claim form falls on the same date, it is implied that the claim intimation should have been within 15 days after the date of accident followed by submission of claim form. The complainant worked in a small organization without any appointment order or any designation handling various types of work. In the proposal form, in addition to the column for signature of the proposer, another column is provided for signature of the advisor of the insurer, wherein the advisor had countersigned. There was ample opportunity for the insurer to obtain a

statement from the advisor regarding the correctness of the designation of the complainant. Since the insurer had not replied for the queries regarding premium rating, it is observed that the designation of the proposer has no bearing with regard to premium rating. In view of the same, the claim of the complainant is allowed.

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Office of Insurance Ombudsman, Chennai

Case.No. 11.05.1833/2011-12

Mr.S.Sathish Kumar

Vs

Oriental Insurance

Award No. IO(CHN)/G/036/2012-13

The Complainant stated that his motor cycle which was insured with the insurer was lost on 11/12/2011 .His claim lodged with the insurer was rejected stating that the intimation of the claim was not made within 48 hours of occurrence of the theft.

The Insurer submitted that the intimation of theft was given to them after a delay of 8 days. As per policy condition claim intimation should be given in writing within 48 hours of its occurrence. Hence the claim was not payable.

It is observed that the vehicle which was parked in front of the insured's house in the car shed on 11/12/2011 at night was found missing the next day morning and immediately the insured had notified the theft to the police. The complainant stated that though he had informed the police in writing immediately on noticing the theft, no acknowledgement was given by the police for the intimation and he could get the FIR only on 19/12/2011. The complainant had informed the insurer of the theft of the vehicle only on 19/12/2011 in writing. Thereafter the insurer had arranged for an investigation and the Investigator vide his Report dt.31.12.2011 confirmed the genuineness of the theft. The insurer repudiated the claim vide their letter dt.4/01/2012, quoting the delayed intimation as the reason for rejection. The complainant had stated that he was not aware

of the policy condition relating to intimation of claim to the insurer within the stipulated time limit of 48 hours; otherwise he would have complied with the same. It is observed that there appears to be no compelling reason beyond the control of the insured for having intimated the insurer about the theft of the insured vehicle beyond the stipulated time limit of 48 hours, except his ignorance about the said condition. It appears that he waited for the FIR from the police, before informing the insurer.

The page 3 of the policy schedule contains the condition that "Claim for theft of vehicle not payable if theft not reported to company within 48 hours of its occurrence." The policy does not insist on production of FIR at the time of claim intimation. Insurance is a contract between the two parties- the insured and the insurer- and the same is governed by the terms and conditions which are to be observed by both the parties scrupulously. Therefore the decision of the insurer in rejecting the claim on the ground that the claim intimation was delayed beyond 48 hours from the time of occurrence of theft of the vehicle, which action is termed as a violation of the policy condition, is justified. Hence the complaint stands dismissed.

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Office of Insurance Ombudsman, Chennai

Case No. 11.17.1011/2012-13

Mr.S.Ramasubramaniam,

Vs

Star Health & Allied Insurance Co. Ltd

Award No. IO(CHN)/G/038/2012-13

The Complainant stated that he took Senior Citizen Red Carpet Policy with the insurer for a sum insured of Rs.1 lac. He was hospitalized for CABG surgery and claimed Rs.75,000/- towards the expenses allowed under the policy. The insurer settled Rs.61,600/- and informed that the amount payable was worked out as per various sub limits and co-pay

clause. He contends that maximum amount payable for the Coronary Artery Disease was Rs.75,000/- and the same needs to be considered.

The Insurer submitted their Self contained note (SCN) wherein they stated that the sub limits under the various heads as stated in the operative clause of the policy and co-pay clause were applied and in accordance with the policy proviso, the claim had been worked out and settled. The limit of Rs.75,000/- in respect of Heart Disease against the sum insured of Rs.1,00,000/- is specified as the LIMIT of company's liability for the ENTIRE policy period of one year as per the policy terms. Hence the claim settlement has been done as per policy conditions.

The insurer has stated that the sum insured of Rs.2,00,000/-for the current year could not be considered due to the fact that the insured was suffering from the symptoms of the heart ailment prior to the date of renewal of the policy for the current period. The insurer has relied on the insured's OP records namely the consultation sheet dt.5/01/2011 of Dr.M.Jayarajah of Sooriya Hospital wherein it is stated that the patient was having "Chest Discomfort for 3 days", which falls on the expiring policy period during which time the sum insured was only Rs.1,00,000/-. Moreover the Dr's Consultation sheet dt.11/01/2011 of Dr. K.R.Balakrishnan also mentions that the Diagnosis was Unstable Angina with Right Bundle Branch Block (RBBB) and the Doctor had recommended CABG surgery. As per the pre-authorisation requisition, the duration of the symptoms of severe Chest pain-recurrent- is mentioned as 10 days, which is also mentioned in the First consultation report dt.15/01/2011 of Dr.R. Ravikumar of Fortis Malar Hospital. The treating Doctor's Medical Certificate forming part of the claim form also confirms that the patient was suffering from the severe chest pain angina since 5/1/2011. Since the policy was renewed with effect from 13/01/2011 with an enhancement in the sum insured from Rs.1,00,000/- to Rs.2,00,000/-, and the heart ailment's symptoms were made known to the insured by the consulting Doctors after various tests and investigations well before the due date of renewal of the policy, (irrespective of the date of remittance of renewal premium) the insurer's decision to apply the pre-enhanced sum insured of Rs.1,00,000/- for the current period of insurance, for settlement of this claim, cannot be faulted. . When the sum insured is considered as Rs.1,00,000/-, the applicable limit for CAD as per the Table

mentioned in the policy is Rs.75,000/-which is construed as the maximum payable during the entire policy period, in case of the recurrence of the same ailment namely CAD during the same policy period. The claim settlement is however subject to various other sub-limits also under various Heads of expenses like Hospital Stay, Surgeon Fees, other treatment Charges including OT charges in accordance with the Policy conditions "A to E", based on which the claim was settled for an amount of Rs.61,600/- after applying 30% co-pay on the net admissible claim. Therefore, it is noted that the claim settlement made by the insurer is in order, in accordance with the policy conditions.

The complaint stands dismissed.

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Chennai Ombudsman Centre

Case No.IO (CHN) 11.13.1818/2011-12

Mr. S. Manivannan

vs

HDFC Ergo General Insurance Co. Ltd.

Award No.040 dated 29.06.12

The complainant's claim for the treatment undergone by him for Heart Disease was repudiated by the Insurer stating that the ailment was pre-existing and pre-existing ailments are not covered under the policy. The complainant obtained the policy through telemarketing. On listening to the recorded conversation of the telemarketing, it is revealed that for questions relating to any previous ailments/diseases suffered by the proposer and hospitalization if any, the complainant replied in the negative. Though the insured has argued that he was treated for heart related condition and not hypertension and hypertension is not the root cause for all heart related issues, failure to disclose his pre existing illness at the time of obtaining the policy falls under breach of utmost good faith. The homoeopathic/allopathic doctors have confirmed the pre existing illness which

established the non disclosure of the pre existing condition by the complainant. In view of the same, the denial of the claim by the insurer on the basis of condition relating to non disclosure of pre existing condition cannot be faulted and the complaint was dismissed.

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Chennai Ombudsman Centre

Case No.IO (CHN) 11.04.1015/2012-13

Mr. Y. Radhakrishna

vs

United India Insurance Co. Ltd.

Award No.041 dated 29.06.12

The complainant's claim for his treatment by means of administration of Lucentis Injection for the eye problem was rejected by the TPA stating that the procedure was considered as an OP treatment, and the insurer also had not reconsidered their decision, on his representation to insurer's Grievance cell.

The complainant underwent treatment of "left eye peripapillary choroidal Neovascular Membrane" and an operative procedure was given with "Injection Lucentis. The complainant would like the insurers to cover "age related diseases", but the insurers taking into account their overall experience of the mediclaim portfolio have offered certain terms and conditions to the insuring public wherein the illness suffered by the complainant was not covered. Insurance policy being a contract, its terms and conditions are to be strictly adhered to by the insurer and the insured. The rejection of the claim complying with condition 4.19 of the policy hence cannot be faulted and the complaint was dismissed.

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Chennai Ombudsman Centre

Case No.IO (CHN) 11.05.1034/2012-13

Mr. LNC. Balasubramanyam

vs

The Oriental Insurance Co. Ltd.

Award No.042 dated 29.06.12

The complainant's DEGENERATIVE ARTHRITIS BOTH KNEES" were treated through RFQMR therapy. The insurer rejected the claim on the grounds that the hospital in which treatment was taken was not falling under the definition of "Hospital".

The insurer had not questioned the efficacy/usefulness of the treatment. The insurer only pointed out that RFQMR treatment as per the records, is an OPD treatment and the hospital in which the treatment was taken did not comply with the definition of "hospital" as defined under the policy. In view of the treatment not complying with the terms of the policy, the insurer had not considered the claim and the complaint was dismissed.

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Chennai Ombudsman Centre

Case No.IO (CHN) 11.05.1650/2011-12

Mr. Bharat Kumar P. Jain

vs

The Oriental Insurance Co. Ltd

Award No.043 dated 29.06.12

The complainant had submitted his hospitalization claim bills to the TPA. Queries raised were answered but the claim was not settled.

The complainant had misplaced the original bills and was unable to submit the same, instead submitted attested copy of the receipt. The TPA called for an affidavit duly notarized to confirm that the original receipt was misplaced and no other claim would be preferred by him from any other source. But the insured did not comply with the requirement but sent a legal notice to the insurer demanding settlement of the claim. The complainant after attending the hearing had agreed to comply with the requirements of the insurer. After submission of the same, the TPA had settled the claim in full and in view of the same, the complaint stands resolved satisfactorily.

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Chennai Ombudsman Centre

Case No.IO (CHN) 11.03.1016/2012-13

Mr. M.K. Devarajan

vs

National Insurance Co. Ltd

Award No.044 dated 11.07.12

The complainant's claim was settled by the TPA taking into account the sum insured for the previous policy period, quoting the reason that the enhanced portion of the sum insured is not eligible for two years period from the date of enhancement as per policy terms.

The insurer had applied condition No.4.3 & 5.12 of the policy for restriction in the claim amount payable. While hydrocele, hernia & bladder neck surgery were performed at the same time, the clubbing of the procedures by the insurer as one surgery cannot be faulted. At the same time, the restriction of sum insured invoking condition 5.12 of the policy is not correct as the illness for which treatment was taken did not fall under continuing or recurring illness and hence the enhanced sum insured had to be considered and not the previous year's sum insured. In addition to the same, eligible ICU charges as per policy terms needs to be considered. The complainant's claim with respect to calculation of claim as per enhanced sum insured and eligible ICU charges were allowed.

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Chennai Ombudsman Centre

Case No.IO (CHN) 11.04.1857/2011-12

Mr. .V. Gururajan

vs

United India Insurance Co. Ltd.

Award No.045 dated 25.07.12

The complainant's claim for the hospitalization expenses was settled by the TPA taking into account the pre-enhanced sum insured instead of the current sum insured. The complainant contended that as per the policy, the claim is admissible to the extent of 70% of the sum insured in respect of CAD and balance claim had to be considered by the insurer.

As per the discharge summary, the complainant was suffering from coronary artery disease and history of diabetic since 15 years. Based on the discharge summary, the ailment suffered and treatment taken was for a pre existing condition. As per policy terms for claims arising in respect of ailment, disease or injury contracted or suffered during a preceding policy period, liability of the Company shall be only to the extent of the sum insured under the policy in force at the time when it was contracted or suffered". The disease was existing at the time of increase in the sum insured and the insurer while settling the claim had taken the pre enhanced sum insured as per policy terms settled 70% of the sum insured in respect of major surgery. Hence the action of the insurer in settling the claim complying with the policy terms cannot be faulted and the complaint was dismissed.

Office of Insurance Ombudsman, Chennai

Case No.11.03.1035/2012-13

Mr.Y.Venkata Ranga Rao

Vs

National Insurance Co Ltd

Award No. IO(CHN)/G/046/2012-13 dt.25/7/2012

The Complainant stated that that his claim for his hospitalisation expenses was repudiated by the TPA stating that the hospitalization mainly involved diagnostic studies and evaluation without necessitating in-patient admission. He contends that he was admitted as advised by the treating Doctor for treatment and hence the claim is admissible.The Insurer submitted that the claim was rejected by the TPA since the hospitalization was mainly for evaluation and diagnostic studies without any active line of treatment, which could have been done on OPD basis.

It is noted from the treating Doctor's Certificate that the insured was admitted in the Emergency Department of Apollo Hospital –Tondiarpet with breathing difficulty and back pain, where some initial treatment was given to reduce his elevated BP and for further evaluation & treatment he was shifted to the Main Hospital, where CT was done which ruled out Aortic Dissection, after which medications improved his condition. It is noted that neither the Indoor case papers of the Main Apollo Hospital nor their Discharge Summary reveal the fact that the insured was shifted from Apollo Hospital-Tondiarpet in an emergency condition. The Discharge Summary also does not furnish the details of treatment given justifying the necessity of in-patient admission. Therefore, the TPA could not consider the claim based on the documents produced by the insured. However, on the basis of the direction of this Forum, the complainant furnished a certificate obtained from the treating Doctor of Apollo Hospital- Tondiarpet along with the case sheet, which confirmed that he was shifted from that Hospital to Main Hospital for ascertaining the actual cause of the Low Back Pain by other diagnostic studies, since no conclusive

diagnosis could be made at Apollo Tondiarpet. The in-patient admission into the Hospital was justified by the treating Doctor who states that "Dissecting Aneurysm is a life threatening condition and since no dissection was noticed he was kept under observation for any fluctuations in BP and recurrence of symptoms". Considering the emergency condition of the patient and to rule out possible aortic dissection when the BP was in an elevated condition, the Doctor's advice for in-patient admission for further evaluation and treatment could not have been ignored by the patient, which otherwise would have proved detrimental to the patient's health. Therefore, under the above circumstances, the stand taken by the TPA that the treatment could have been taken as an out-patient is not justified. Hence the insurer is directed to process and settle the claim as per other terms and conditions of the policy.

The complaint is allowed .

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Office of Insurance Ombudsman, Chennai

Case No.11.11.1033/2012-13

Mr.Naren Kandala

Vs

Bajaj Allianz General Insurance Co Ltd

Award No. IO(CHN)/G/047/2012-13 dt.25/7/2012.

The Complainant stated that his claim for the treatment following the injuries suffered in a RTA was repudiated by the insurer stating that the treatment was relating to a pre-existing condition of the bone. He contends that there was no history of any such ailments as stated by the insurer.

The Insurer submitted that the treatment undergone by the insured was directed towards the underlying disease condition namely Unicameral Bone Cyst, which is confirmed by Histopathology report. Even trivial trauma would result into pathological fractures. The PA policy does not cover any expenses towards treatment of any disease conditions.

It is noted that the complainant who had been covered under the Generic Contingency Policy had to be hospitalized following an injury suffered by him consequent to a fall from his two wheeler. He was initially admitted in Rakshit Hospital where he was diagnosed to have suffered Fracture in Proximal 3rd Right Humerus. He was discharged against medical advice and he got admitted into Miot Hospitals for further management. Various Diagnostic tests including CT and X-ray were taken and the Diagnosis of "Pathological Fracture Proximal Humerus Right – Unicameral Bone cyst" was made by the treating Doctor at Miot Hospitals and treatment was accordingly given. He was treated by Resection of bone with Lesion and Rib grafting–right, after evaluation by Orthopaedic surgeon, Medical Oncologist and Anaesthetist. The CT and X-ray reports reveal the Osteolytic lesion in proximal humerus with pathological fracture of neck of humerus- fibrous dysplasia. The post operative X-ray shows 'Tumor resection done'. The claim preferred by the insured with the insurer was rejected on the ground that the insured was admitted and treated for an illness, ie.,

pathological fracture due to a bone cyst and not arising out of an accidental bodily injury, as per the policy terms and conditions. The insurer has stated that " Unicameral Bone Cysts are Osteolytic, solid lesions. Pathologically, it is a cavity in the bone lined by a thin membrane and contains serous or sero-sanguinous yellow-coloured fluid. The ends of the long bones are the common sites, the commonest being the upper end of the humerus. The cyst itself may not produce any symptoms and attention is brought to it by a pathological fracture through it. The insurer repudiated the claim stating that the treatment undergone by the insured was directed towards the underlying disease condition namely "Unicameral Bone Cyst" which is confirmed by Histopathology Report; Even trivial trauma would result into pathological fracture in such a condition. The policy issued to the insured does not cover expenses towards treatment of any disease conditions. It covers only treatment arising out of an accidental bodily Injury- which is defined as "a sudden, unintended and fortuitous external and visible event"; and a Bodily injury as "Physical bodily harm or injury but not any mental sickness disease or illness". On perusal of the policy terms and conditions, it is observed that the intention of the policy is to cover only treatments for bodily injury sustained in an unforeseen accident. In the instant case, though there seems to be a fall by the insured from the two wheeler, the treatment given to the insured was primarily arising out of the "Bone Cyst" the diagnosis of which appears to have been made consequent to the Pathological Fracture suffered following the alleged accidental fall. Therefore, considering the various aspects of the nature of ailment, the treatment undergone by the insured and the relevant policy conditions, the decision of the insurer in repudiation of the claim is found justified and hence the Insurance Ombudsman is not inclined to interfere with the said decision. The complaint is dismissed.

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<u>Office of Insurance Ombudsman, Chennai</u>

<u>Case No.11.19.1037/2012-13</u>

<u>Mr.K.Sivaraj</u>

<u>Vs</u>

Apollo Munich Health Insurance Co Ltd

Award No. IO(CHN)/G/048/2012-13 dt.25/7/2012

The Complainant stated that his claim for the Hospitalisation expenses in respect of his wife was rejected by the insurer, affixing the Rubber Stamp as CLAIM REJECTED BY FHPL, which made the complainant unable to claim thro' other policy provider

The Insurer submitted their Self contained note (SCN) wherein they stated that the claim was relating to a complication of pregnancy, which is out of purview of the policy as specified under clause 3 (a).

It is noted that the complainant's wife who was covered under the insurer's Easy Health policy was admitted in the Hospital for treatment of Peripartum Cardio myopathy with Acute LV Failure and severe LV Dysfunction and the complainant preferred a claim for the same. The claim was repudiated by the insurer invoking the exclusion clause 6 e viii, which states that "We will not make any payment for any claim in respect of any insured person directly or indirectly for, caused by , arising from or in any way attributable to any of the following unless expressly stated to the contrary in this policy. Save as and to the extent provided for under 3 a-pregnancy, miscarriage, maternity or birth". The insurer contends that the claimed hospitalization was related to the treatment of a pregnancy related complication. The complainant contended that the insured was not suffering from any Heart ailment prior to this admission or during the course of her pregnancy. It is observed that the insured was admitted for Peripartum Cardiomyopathy (PPCM) which is a form of dilated cardiomyopathy that is defined as deterioration in cardiac function presenting typically between the last month of pregnancy and upto five months postpartum. In essence, the heart muscle cannot contract forcefully enough to pump adequate amounts of blood for the needs of the body's vital organs. After 13 days of delivery of twin-babies, the insured suffered this problem and was treated for the same in the Hospital. The policy envisages exclusion of "treatments arising out of pregnancy and its related disorders", which in the normal course would give an impression that the treatments taken during the course of pregnancy and /or at the time of delivery of the child are excluded from the

scope of the policy. In the instant case, the hospitalization had taken place after the child birth, though it might have been the complication of pregnancy. So, invoking the above said exclusion clause to repudiate the claim is not justified. Hence, the insurer is directed to process the claim and settle it subject to other terms and conditions of the policy.

The complaint is allowed.

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Office of Insurance Ombudsman, Chennai

Case No. 11.17.1036/2012-13

Mr.Akshay Patwary,

vs

Star Health & Allied Insurance Co.Ltd.,

Award No. IO(CHN)/G/049/2012-13 dt.25/07/2012

The Complainant stated that his claim for Acute Appendicitis for an amount of Rs.82,556/- in addition to the cashless settlement of Rs.45,000/- was settled by the insurer for a sum of Rs.43,750/-, deducting various items of expenses. His represented to reconsider these deductions since all those expenses were reasonably and necessarily incurred and hence those deductions were unfair.

The Insurer submitted that the claim was settled taking into account the various limits and sub-limits as per policy conditions.

It is noted that the claim was preferred by the insured with the insurer for his Hospitalisation expenses incurred for his treatment of "Acute Appendicitis with Gangrenous Omentum", over and above the Cashless settlement of Rs.45,000/- made to the Hospital. The claim for reimbursement of the balance amount preferred by the insured was settled by the insurer, for an amount of Rs.43,750/- applying the limits under the Room Rent and Nursing Expenses restricted to 2% of the sum insured subject to a maximum of Rs.4,000/- per day as per the policy and as applicable for his sum insured of

Rs.2,00,000/-,and restricting the other expenses of hospitalization in proportion to the Room Rent thus total amount settled being Rs.88,750/-towards the entire claim including Cashless settlement. When the insured demanded further payment of the balance claim amount the insurer stated that the claim settlement was done as per the various other sub-limits under various Heads of expenses like Hospital Stay, Surgeon Fees, other treatment Charges including OT charges in accordance with the Policy conditions- A to G, and also as per the "Reasonable and Necessary" clause as mentioned in the preamble of the Terms and conditions of the policy based on which the claim was settled for an amount of Rs.88,750/-. The complainant contends that the condition namely "All Expenses relating to Hospitalisation will be considered in proportion to the Room Rent stated in the policy" was not prominently quoted in the Terms and conditions and on the Schedule and this change effected by the insurer was not communicated to the insured before the renewal of the policy in the year 2011. However, the claim settlement has to be necessarily done by the insurer in accordance with the said policy conditions stated both in the schedule as well as the terms and conditions. Therefore, it is noted that the claim settlement made by the insurer is in order.

Hence the complaint was dismissed.

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Chennai Ombudsman Centre

Case No.IO (CHN) 11.04.1017/2012-13

Mr.R.Vijayakumar

vs

United India Insurance Co. Ltd

Award No.050 dated 26.07.12

The complainant's wife had uterus & Ovaries removal for adenomyosis with endometriosis surgeries and spent Rs.1,05,440/- towards the procedure. The insurer as per the policy settled 25 % of sum insured treating the surgery as hysterectomy only. The

insured contended that the surgery involved not only hysterectomy but included open abdominal surgery for removal of adenomyosis with endometriosis and to be treated as major surgery. As per policy clause 1.2, medical expenses for treatment of hysterectomy is restricted to 25% of the sum insured. Since the sum insured being Rs.75,000/-, the insurer had settled the claim for Rs.18,750/-. The decision of the TPA/insurer to treat the surgery as "hysterectomy" and settling the claim as per the policy terms cannot be faulted. Though the removal of both ovaries and uterus together were easier compared to leaving the ovaries, based on the number of days of hospitalization involved and the elaborate procedure in the surgical management, the same cannot strictly be treated at par with stand alone hysterectomy but viewed more than a mere hysterectomy requiring a little more consideration. Hence the contention of the insured in this connection cannot entirely be ignored. In order to render justice to both the parties to the dispute, an ex-gratia payment of Rs.40,000/-was awarded.

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Chennai Ombudsman Centre

Case No.IO (CHN) 11.03.1057/2012-13

Mr. S. Krishnamoorthy

vs

National Insurance Co. Ltd.

Award No.051 dated 26.07.12

The complainant's claim for hospitalization expenses was repudiated by the TPA stating that the claim was not admissible as per clause 4.3 of the policy relating to exclusions of certain ailments within two years of inception of the fresh policy.

The policies taken should be continuous without any break and in the instant case as far as the present insurer is concerned, the policy is in the second year. The insurer in the Note forming part of exclusion condition 4.3 of the policy states that "If continuity of cover is not maintained with National Insurance Company, subsequent cover will be treated as fresh for application of clauses 4.1,4.2 & 4.3 above". The policy of the insured

with the present insurer itself is in the second year attracting the provisions of condition 4.3 of the policy. The contention of the insurer declining the claim on the grounds of condition 4.3 of the policy cannot be faulted and the complaint is dismissed.

Chennai Ombudsman Centre

Case No.IO (CHN) 11.02.1031/2012-13

Mr. B.S. Jayaraman

vs

The New India Assurance Co. Ltd.

Award No.052 dated 26.07.12

The complainant's claim for treatment as an out-patient for Cellulities of the foot was rejected by the insurer since out patient's treatment were not covered under the scope of the policy. The complainant's claim was rejected on the grounds that he was not hospitalized for taking this treatment. The complainant himself had stated during the hearing that he was not hospitalized as the treatment did not warrant admission as in-patient and Insurance Companies should take into consideration the advances in the field of medicine and should not insist on admission being a criteria for payment of mediclaim. When the policy terms did not provide for an out patient treatment, the insurer cannot breach the terms and offer settlement. The policy terms are the basis for dealing with the claims under the policies. In view of the insurer rejecting the claim as per the policy terms, the complaint is dismissed.

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Office of Insurance Ombudsman, Chennai

Case.No. 11.17.1056/2012-13.

Mr.D.Palanisamy(for A.Geetha)

Vs

Star Health & Allied Insurance Co.Ltd.,

Award No. IO(CHN)/G/054/2012-13 dt.26/07/2012

The Complainant stated that the claim for the hospitalisation expenses incurred by the insured was repudiated by the insurer stating that the claim was not admissible as per the policy, since the medical records revealed that the treatment did not require hospitalization. Aggrieved by this, the complainant has approached this forum.

The Insurer submitted that the claim was rejected by them since the hospital records, investigation reports and the discharge summary reveal that the treatment given to the insured during hospitalisation could have been given as an out-patient and in-patient admission was not required for the same. The policy covers only treatments which necessitate in-patient admission in to a Hospital and the subject claim was found not admissible by their medical team and hence rejected.

It is noted that the claim was preferred by the complainant's sister, with the insurer for the Hospitalisation expenses incurred for her treatment of "Cyclical Mastalgia", following complaint of left side chest pain, with breast engorgement and Breathlessness and treated with IV Fluids, IV antibiotics and analgesics. . It is noted that the insured was admitted in the Hospital at the wee hours with the complaints of Chest pain and Breathlessness. Immediately ECG was taken and the patient was said to be treated with IV Fluids and Antibiotics. It appears that the hospitalisation was resorted to for evaluation of the actual cause for the chest pain and to rule out any Heart ailment. It was later diagnosed as cyclical Mastalgia and accordingly the medicines were prescribed for the same before discharging the patient. Therefore, the circumstances leading to the emergency admission of the patient into the hospital for the diagnosis and treatment cannot be construed as "unnecessary". The admission seemed to have been felt necessary considering the health condition of the patient and the line of treatment was decided by the treating Doctor

when once the actual diagnosis was made out, ruling out the Heart ailment as the cause for chest pain and breathlessness. The insured has contended that issuance of the ID card immediately after the renewal of the policy would have enabled them to avail of the treatment in a net work hospital, which would have been easier on all aspects. Delayed issuance of the Idcard has resulted in undue hardship for the insured. Therefore, the insurer is directed to process the claim and settle the same subject to other terms and conditions and limits applicable under the policy.

The complaint is allowed.

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Chennai Ombudsman Centre

Case No.IO (CHN) 11.03.1799/2011-12

Mr. G. Ramamoorthy

vs

National Insurance Co. Ltd

Award No.055 dated 26.07.12

The complainant's claim for accidental damages to his car was settled by the insurer partially and damages relating to rear axle was not considered stating that the damages to the same was not as a result of the accident.

It is found from the records that the vehicle was having regular maintenance and hence wear and tear cannot be the reason for the damages. The insurer depended on the theory that the impact of the accident was not severe so as to cause damages to the rear axle and also because of non bursting of air bags and no damages to shock absorbers of the vehicle. Merely harping on the probability and in the absence of insurer proving with clinching evidence that the damages to the rear axle had happened not due to accident, the damages to the disallowed part should have happened as a result of accident only and hence the complaint is allowed.

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Chennai Ombudsman Centre

Case No.IO (CHN) 11.03.1029/2012-13

Mrs. R. Poornima

vs

National Insurance Co. Ltd

Award No.056 dated 26.07.12

The complainant's husband was hospitalized for severe calcific Aortic stenos . The insurer had settled the claim restricting to pre enhanced sum insured and citing policy terms regarding pre existing ailments and claims falling under sum insured enhancement.

The complainant was having continuous coverage since several years and records like previous consultation, treatment, medicines taken etc. were not submitted by the insurer establishing that the insured was suffering from any pre existing condition at the time of enhancement of sum insured. Hence, the contention of the insurer invoking condition 3.5 of the policy becomes untenable. As per condition No.5.12 of the policy sum insured increase can be effected subject to satisfactory medical check up and exclusion of recurring nature of diseases/complaints which the insured has ever suffered. No records were submitted to prove that the ailment suffered was of continuing or recurring nature. In view of the complaint not falling under policy exclusions as per condition No3.5 & 5.12 of the policy, the complaint is allowed.

Chennai Ombudsman Centre

Case No.IO (CHN) 11.02.1090/2012-13

Mr. Navin Bhansalai

vs

The New India Assurance Co. Ltd

Award No.057 dated 26.07.12

The complainants claim for the hospitalization expenses for his surgical treatment was rejected by the TPA quoting clause No.4.4.11 on the ground that the same was "Diagnostic study not consistent with diagnosis of positive existence of any ailment". The TPA informed the insured as to how the various amounts payable were arrived at as per policy terms with category wise break up and also the reason why a particular amount was disallowed. The insurer stated that restriction on room rent, ICU/ICCU charges, Surgeon's charges and other related charges as per the condition NOs2.1,2.2,2.3 & 2.4 were applied while arriving at the amount settled. In view of the same, the decision of the insurer settling the claim as per policy terms cannot be faulted and the complaint is dismissed.

Office of Insurance Ombudsman, Chennai

Case.No. 11.02.1850/2011-12

Mr.G.Balasubramanian

vs

New India Assurance

Award No. IO(CHN)/G/058/2012-13 dt.30/07/2012

The Complainant stated that he was covered under the Mediclaim Policy issued by the insurer for a sum insured of Rs.3 lacs. The insured had cataract eye surgeries for both of his eyes and claimed Rs.50,886/- & Rs.50,618/- towards the same. The insurer settled Rs.48,000/- at the rate of Rs.24,000/- towards each eye as per policy terms. The insured contended that he was a customer of the insurer for several years and considering his sum insured and high cost of the lens his claim needs consideration. The Insurer submitted that the insured had incurred expenses of Rs.1,01,504/- but, as per policy terms, the insured is eligible for a maximum of Rs.24,000/- in respect of each eye and an amount of Rs.48,000/- was allowed.

The policy condition No.3 of the Mediclaim Policy -2007 states "The amount payable for any cataract surgery will be limited to Actual or Maximum of Rs.24,000/- whichever is less either for cashless or for Reimbursement". Accordingly as per this limit the TPA had settled the claim for Rs.48,000/- for cataract surgeries on both eyes for the insured. But the insured states that the relevant condition was not made known to him by the insurer in the terms and conditions along with his policy. The insurer had not substantiated that

this condition was incorporated in the policy issued to the insured for the year 2011-12. However, it is to be noted that, obviously the Mediclaim policies are normally on 'annual contract basis' and the policies are subject to revisions depending upon various factors affecting the insurers' claims outgo ratio and sustainability of the portfolio in the market. Therefore such changes are inevitable and the same would be applicable for all policy holders uniformly. These changes are effected in the policies at the time of renewal after obtaining the approval of Insurance Regulatory Development Authority. Therefore, the limit specified in the policy for Cataract Surgery to the extent of Rs.24,000/- per eye, irrespective of the Sum insured, which has been applied by the TPA while settling the claim of the complainant is strictly in accordance with the policy conditions. However, the insurer is expected to ensure that such important changes are brought to the notice of the insured by way of Renewal Notices and also by incorporating the same in the policy terms and conditions which should be attached with the policy schedule. Since the insurer has not substantiated as to whether the above said change in the policy condition was in fact communicated to the insured, in order to render justice to both the parties to the dispute, the Insurance Ombudsman is inclined to grant an ex-gratia of Rs.20,000/- (Rupees twenty thousand only)

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Office of Insurance Ombudsman, Chennai

Case No.11.04.1095

Shri C.L.Subramaniam

Vs

United India Insurance Co Ltd

Award No. IO(CHN)/G/059/2012-13

The Complainant stated that his claim for the reimbursement of the expenses incurred for the Ayurvedic treatment was repudiated by the TPA stating that the treatment taken in a Govt. Medical College Ayurvedic Hospital only is considered and not Private Ayurvedic Hospitals even if it fulfills the Hospital definition as per the policy conditions, which is made effective from 1/5/2011. He contends that only after getting the oral guidance of the TPA official, with regard to the admissibility of the claim he went ahead with the treatment. The policy condition introduced in the current policy amounts to restrictive practice which is against Ayurvedic system of treatment.

The Insurer submitted their Self contained note (SCN) wherein they stated that the claim was repudiated as per policy condition which excludes Ayurvedic treatments taken in a Hospital other than in a Government Hospital or Medical College.

As per policy condition No.2.1 N.B. 2, it is stipulated that "Ayurvedic treatments taken as an in-patient only in a Government Hospital/ Medical College Hospital are admissible".The said clause gives an inference that such treatments taken in a government Hospital OR a Medical College Hospital – whether Government or Private -are admissible. The clause does not specifically indicate as to the treatment taken in "Private Medical college Hospitals" are not admissible. The Hospital where the insured took treatment has been attached with a Medical college, which fact can be verified from the website of the Hospital and the same fulfills the basis criteria of admissibility of Ayurvedic treatment claims under the policy. Since the Hospital has an affiliated Medical college the admissibility of the claim for the treatment in the said Hospital cannot be denied under the policy.Hence the decision of the insurer in repudiating the claim is not justified and

the insurer is directed to process the claim and settle it subject to other terms and conditions of the policy.

The complaint was allowed.

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Office of Insurance Ombudsman, Chennai

Case No.11.17.1094/2012-13

Mr.S.Kamaraj

Vs

Star Health & Allied Insurance Co Ltd

Award No. IO(CHN)/G/060/2012-13

The Complainant stated that his claim for the Hospitalisation expenses incurred for the treatment of his wife for Multi Nodular Goiter surgery was rejected by the insurer stating that the ailment must have been pre-existing considering the large size of the Nodules and also clearly seen in the photo of the insured affixed in the proposal form. He represented to insurer's Grievance cell stating that the swelling was not found at the inception date of the policy and it was a sudden occurrence after which only the Doctor was consulted. More over, he was holding policy with another insurer continuously and hence benefits under the Portability scheme should be considered. But the insurer reiterated their stand of repudiation of the claim under clause No.7 – Non-disclosure of material facts.

The Insurer submitted that the claim was repudiated since as revealed by the USG report, the large size of the Nodules would take longer time and would have been present prior to inception of the policy just 3 ½ months prior to the surgery. Since there was misrepresentation/Non-disclosure of the ailment in the proposal form the claim was not considered as per clause No.7 of the policy.

On scrutiny of both the contentions of the insured and the insurer, it is observed that

though the size of the Nodules appear to be large as evidenced by the USG as opined by the medical team of the insurer, it is not established by the insurer by way of any medical records or indoor case papers to substantiate that the symptoms were in fact present prior to the inception of the policy with them. Mere surmises and the photograph of the insured produced at the time of proposal cannot be assumed as evidence of presence of the swelling in the neck before commencement of the policy. Therefore the contention of the insurer alleging suppression of material facts or non-disclosure of health conditions at the time of proposing the insurance by the proposer is not tenable. The fact that the insured was covered under the policy with another insurer prior to this policy also corroborates that there was no reason for the insured to suppress any such information and he might have continued his policy with the same insurer if the ailment was detected during the earlier policy period itself. Even though the continuity benefits as expected by the insured under the current policy cannot be extended as if it is under the portability scheme, in the absence of clear evidence for the ailment being considered as a pre-existing one, the decision of the insurer in repudiating the claim invoking Non-disclosure clause of the policy is not justified. Hence the insurer is directed to process the claim and settle it subject to other terms and conditions of the policy. The insurer may also instruct the Agents suitably to guide the proposed insured persons in respect of the terms and conditions of the policy correctly, especially relating to the "continuance of the policy" in the event of the policy is being switched over from other insurer.

The complaint was allowed.

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Office of Insurance Ombudsman, Chennai

Case No.11.04.1125/2012-13.

Shri K Suryanarayanan

Vs

United India Insurance Co Ltd

Award No. IO(CHN)/G/061/2012-13

The Complainant stated that he had preferred a claim with the TPA for the expenses incurred by him for Dental Caries Full mouth Rehabilitation under General Anesthesia. The claim was rejected by the TPA stating that Dental treatment or surgery of any kind unless requiring Hospitalisation, is not covered under the policy. He contends that hospitalization for undergoing the procedure was necessary since the insured is a minor.

The Insurer submitted that the claim was rejected under clause 4.5, which excludes "Dental treatment or surgery of any kind unless necessitated by accident and requiring Hospitalisation".

The complainant contends that the full mouth Rehabilitation was done under General Anaesthesia. He states that the insured had to undergo this process duly admitted in the hospital in view of his being a small child who otherwise would not tolerate the pain during the treatment. He also contends that full day admission was needed in order to enable the Doctor to have an observation on him after the procedure which took around 3 hours, and it was also decided by the Doctor. Therefore the complainant pleads for considering the claim in view of the fact that the policy condition relating to hospitalization has been fulfilled, which had to be resorted to out of necessity. However, it is to be noted that the insurance being a contract between two parties namely the insurer and the insured, the terms and conditions of the same have to be scrupulously followed by both the parties. The policy Exclusion condition No.4.5 of Platinum policy under which the son of the complainant is covered states: "Dental treatment or surgery of any kind unless necessitated by accident and requiring hospitalization". Since the policy exclusion clause is very specific about the dental treatment other than accidental injuries, the claim

preferred by the complainant with the insurer is not admissible. Therefore the decision of the insurer in repudiation of the claim is justified.

The complaint stands dismissed.

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Office of Insurance Ombudsman, Chennai

Case No.11.03.1121/2012-13

Thomas Fernando

Vs

National Insurance Co Ltd

Award No. IO(CHN)/G/062/2012-13

The Complainant stated that that his claim for his wife's TWO Hospitalisation expenses was settled by the TPA, deducting huge amount.

The Insurer submitted that the first claim For Rs.14,106/- is pending for want of essential documents for processing the claim. Despite reminders, the documents have not been furnished by the insured but informed them that the Reports called for were misplaced. The second claim was settled as per the limits prescribed under the policy towards Room Rent and other Non-medical expenses.

it is noted that the complainant had preferred two claims in respect of the hospitalization of his wife. The first claim was kept pending for want of some diagnostic test reports and the second claim was settled for Rs.43,831/- and the complainant seeks settlement of the balance claim also. The first claim was not processed by the TPA since they had called for X-ray and ECG report in addition to thyroid profile of the insured during the admission. While the insured replied that X-ray and ECG reports are misplaced and confirmed that No Thyroid test was taken, the TPA could not proceed further as these were essential documents for processing the claim. On perusal of the Discharge summary of Sacred Heart

Hospital, Tuticorin, it is observed that the insured was admitted with the complaints of difficulty in breathing with high blood pressure. The patient was subjected to some blood and other investigations as evidenced by the Bills produced to that effect, which included X-ray, ECG and Thyroid Profile .But the Discharge summary does not furnish the reports of these 3 tests. Normally the TPA would settle the claim after deducting the expenses for the respective Tests if the related reports are not submitted by the insured unless it would throw some light on the pre-existing aspect of the ailment. The insured had been covered for several years and the insurer has also not quoted/excluded any specific Pre-existing ailments for the insured. Therefore, the decision of the insurer/TPA to hold back the claim indefinitely for want of some reports, is not justified. The insurer is directed to process the claim and settle the same excluding the expenses in respect of X-ray, ECG and Thyroid profile and subject to other terms and conditions of the policy.

The second claim was said to have been settled as per the Room Rent limit specified in the policy. It was observed that while calculating the eligible limit for Room Rent, the TPA had not taken into account the accrued cumulative bonus. Therefore, the insurer was directed to re-process the claim taking into account the revised Room Rent based on the accrued cumulative bonus added to the basic sum insured and subject to other policy terms and conditions and pay the difference in the amount payable over and above the amount already paid under the second claim.

The complaint was allowed .

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Office of Insurance Ombudsman, Chennai

Case No.11.19.1091/2012-13

Mr.Muthukumaran

Vs

Apollo Munich Health Insurance Co Ltd

Synopsis to Award No. IO(CHN)/G/064/2012-13

The Complainant stated that his claim for the Hospitalisation expenses in respect of his son for the Circumcision Surgery was rejected by the insurer, stating that the same is a Standard Exclusion under the policy. He contends that the policy provides for payment of a claim in respect of Operations on the penis including operations on the foreskin under Day Care procedures.

The Insurer submitted that the policy specifically excludes circumcision from the scope of the policy as per clause No.2(e) vii.

It is noted that the clause No.2 states that "We will not make any payment for any claim in respect of any insured person directly or indirectly for, caused by , arising from or in any way attributable to any of the following unless expressly stated to the contrary in this policy.(e)vii: ....Circumcisions".

The complainant contends that "the exclusion in No.2 (e) will apply unless expressly stated to the contrary in the policy. Since Circumcision is expressly provided under "Day care procedure"in the policy, the general exclusion does not apply". It is to be noted that the policy covers various ailments and procedures both under full time Hospitalisation and Day care procedures. Various Day care procedures are listed out in the policy which includes 'operations on the foreskin'. This does not give an indication that this procedure is covered under the policy, overlooking the exclusion clause No.2 (e) vii. The policy covers and admits liability subject to various terms and conditions and exclusions mentioned therein. Therefore, the decision of the insurer in repudiating the claim on the ground that the circumcision surgery is specifically excluded from the scope of the policy, is justified.

The complaint is dismissed.

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Office of Insurance Ombudsman, Chennai

Case No.11.05.1028

Mr.P.Sundararaj

Vs

Oriental Insurance Co Ltd

Award No. IO(CHN)/G/065/2012-13.

The Complainant stated that he was covered under the Group Mediclaim Policy issued to employees of LMW for the period from 07/12/09 to 06/12/10. During the policy period, the insured took treatment for ischemic Heart disease from 29/07/10 to 10/08/10. When the claim was submitted, it was rejected by the TPA stating that the treatment was with regular oral medicines and did not involve active treatment. It was unapproved and the patient was provided with alternate medical management. The insured contended that he was given active medical treatment during the hospitalization. He was treated in a hospital for 12 days with medicines. He contended that his treatment was under hospitalization condition and should be considered.

The Insurer submitted that the insured was treated with oral medicines and diagnostic tests were conducted and the same could have been taken as an outpatient. The patient was given only oral medications and the discharge summary of the hospital does not explain whether it includes any other line management. The stay of 12 days was not justified for giving oral medicines without any active treatment. Hence their rejection of the claim as per policy terms 4.10 & 4.13 was in order.

The clause No.4.10 and clause No. 4.13 respectively read as under: "Expenses incurred at Hospital or Nursing Home primarily for evaluation/diagnostic purpose which is not

followed by active treatment for the ailment during the Hospitalisation period." and "Naturopathy treatment, unproven procedure or treatment, experimental or alternative medicine and related treatment including acupressure, acupuncture, magnetic and such other therapies etc.". On a perusal of the Discharge Summary of the Hospital, it is stated that the patient underwent Active Medical Treatment (A.M.T). From the details furnished therein, it is not clear as to what treatment was given to the patient and why in-patient was required for such treatment. The treatment involved oral medication/ Bed rest as mentioned by the treating Doctor in his Certificate dt.12/11/2010. The policy allows claims arising out of in-patient admission wherever it is felt absolutely necessary and not for treatment involving Hospitalization which could have been possibly taken as an Out-patient. Even if 'hospital definitions' and related conditions as stipulated in the policy are fulfilled as stated by the insured, the medical records submitted by the insured to the Forum do not substantiate the necessity of Hospitalisation for such treatment undergone by the insured. Therefore, the decision of the insurer to repudiate the claim in question is justified.

The complaint was dismissed.

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Chennai Ombudsman Centre

Case No.IO (CHN) 11.04.1055/2012-13

Dr.B. Sasi Sekaran

vs

United India Insurance Co. Ltd

Award No.066 dated 31.07.12

The complainant stated that himself and his brother have taken mediclaim policy in their individual capacity with the same insurer and included their mother under the respective policies . Claim for the hospitalization of his mother under his policy was rejected linking the settlement made under his brother's policy. While part of the expenses were paid under his brother's policy and when the spill over was claimed by him, the same was rejected for some untenable reasons.

The insurer applied the limits as per the complainant's brother's policy, settled the claim and rejected the remaining part of the claim under his policy. It is found that the insurer has not handled the claim properly even after pointing out by the complainant. The claim amount exceeding the sum insured under the complainant's brother's policy had to be dealt with under the complainant's policy which was not done by the insurer. Hence, insurer was directed to settle the claim under the complainant's policy and the complaint allowed.

Chennai Ombudsman Centre

Case No.IO (CHN) 11.04.1093/2012-13

Mr. V. Narayanaswami

vs

United India Insurance Co. Ltd

Award No.067 dated 31.07.12

The complainant's wife's claim for ayurvedic treatment was rejected on the ground that ayurvedic treatment unless taken in a Govt. Hospital/Medical College is not covered under the policy. Since, the policy issued to the insured was not subject to that condition, the claim was considered by the insurer subject fulfilling formalities connected to ECS mode of settlement. While settling the claim, the insurer disallowed certain expenses which was questioned by the complainant.

On scrutiny of the policy terms and conditions, it is observed that expenses like admission, diet and treatment accessories disallowed were not specifically excluded. In view of the above, the insurer was directed to pay the disallowed amount. The complaint is allowed.

Chennai Ombudsman Centre

Case No.IO (CHN) 11.04.1092/2012-13

Mrs.E.Sugumari

vs

Reliance General Insurance Co. Ltd

Award No.068 dated 31.07.12

The complainant's claim for reimbursement of her hospitalization expenses was rejected by the insurer stating that the insured had history of hernia surgery 14 years back-which contributed to the occurrence of incisional hernia. The insurer had stated that since there was a break period of 5 days and change of plan, the insured was not eligible for the claim as per policy terms.

There was a break period of 5 days while renewing the policy and as per the insurer, the insured opted for change of plan which was not substantiated by either any request letter or fresh proposal form. The insurer chose to reject the claim as though the policy was incepted for the first time without taking note of the policy provisions. The insurer had not applied the policy provision relating to 15 days grace period to treat the policy as a continuous one by which the claim could have been considered. The insurer's decision to reject the claim on the ground that the policy is a fresh one without continuity is not correct and the complaint is allowed.

Chennai Ombudsman Centre

Case No.IO (CHN) 11.05.1140/2012-13

Mr.V. Chandra

vs

The Oriental Insurance Co. Ltd

Award No.069 dated 31.07.12

The complainant had "eye attack" treated with 'Lucentis' injection. The TPA had declined the claim stating that the condition suffered by the patient falls under "Age Related Macular Degeneration" and not payable under the policy. There was no specific clause in the policy terms excluding such treatment with "Lucentis" injection. From the papers submitted, it is found that the administration of the said injection was carried out in the operation theatre under sterile condition looking like in-patient treatment. Since the procedure did not require 24 hours hospitalization, the insurer contends that the same should be treated as a day care procedure not warranting 24 hours stay in the hospital. The procedure presented a combination of both in-patient as well as out-patient treatments. The policy terms did not specify it as an exclusion and the reference to the Head Office of the insurer was as a specific case and there was no common circular to this effect. In view of the above stated, the complainant's claim cannot strictly be brushed aside either as a day care procedure or an out-patient treatment without any specific exclusion under the policy and an exgratia of Rs.1,50,000/- was allowed.

Chennai Ombudsman Centre

Case No.IO (CHN) 11.03.1049/2012-13

Mr. K.J.Janakar

vs

National Insurance Co. Ltd

Award No.071 dated 31.07.12.

The Complainant stated that that his claim for cataract surgery was settled by the TPA to the extent of Rs.31,500/- by cashless as against the total expense of Rs.1,60,000/- The insurer stated that the cataract claim was settled as per the PPN Package – and the balance expenses were relating to "correction of eye sight" and accommodative Lens charges which are inadmissible under the policy conditions. The point to be considered is whether the decision of the insurer to restrict the claim for Cataract surgery, as per policy conditions, is in order. As per the Certificate dt.6/8/11 issued by the Hospital, it is stated that the patient wanted to be independent of glasses for all practical purposes (distance, intermediate and near), hence advised Accommodative IOL implantation to give good quality vision. The clause No.4.6 mentions that "Surgery for correction of eye-sight, cost of spectacles, contact lenses, etc…" are excluded from the scope of the policy. It is noted that the scope of the policy extends only to the extent of payment of claims in respect of "Cataract Surgery solely for the purpose of treatment of Defective Vision with a reasonable cost of IOL" normally charged by a Hospital. The advanced type of Intra Ocular Lens which is highly expensive, is opted for by the insured according to his own needs and necessity and the insurer or the TPA are not authorised to question the implantation of the same, but at the same time, the insurer can allow reimbursement of expenses only to the permissible limit as per the policy terms, in accordance with the 'Reasonable and customary expenses' clause. Even though the insured contends that his sum insured was adequate enough to cover the entire cost of IOL, the insurer has to strictly go by the policy terms and limits, as agreed by the Net work Hospitals with the TPA. It is to be noted that the TPAs are vested with the role of negotiating with the net work hospitals

for charging reasonable cost for various treatments, which is very vital in the present scenario especially with a view to ensure the sustainability of the Medi-claim portfolio for the welfare of large number of insuring public. Therefore, since putting caps for Cataract surgeries by the insurers is as per acceptable norms, the decision of the insurer in restricting the claim of the complainant to the limit, as per the PPN agreement with the Net work Hospital and the TPA, is justified and hence the Insurance Ombudsman is not inclined to interfere with the said decision.

The complaint is dismissed.

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Chennai Ombudsman Centre

Case No.IO (CHN) 11.02.1141/2012-13

Ms. S. Pratheeksha

vs

The New India Assurance Co. Ltd

Award No.073 dated 31.07.12

The complainant' claim for surgical expenses towards MYOPIA in both eyes were rejected by the insurer on the ground that the same fell under policy exclusion 4.4.2 relating to cosmetic treatment. The insurer stated that the said claim becomes payable if the index is more than -7.5.

Since the index of -7.5 fixed by the insurer is not forming part of policy terms and also "the cosmetic" nature is also not substantiated the decision of the insurer rejecting the claim under clause 4.4.2 of the policy relating to cosmetic surgery is not tenable and the complaint was allowed.

Chennai Ombudsman Centre

Case No.IO (CHN) 11.17.1186

Mr.V. Sampathkumar

vs

Star Health & Allied Insurance Co. Ltd

Award No.075 dated 07.08.12

The complainant stated that his claim for the Hospitalization expenses incurred for the treatment of his wife for Hypoglycemia was rejected by the insurer stating that there was no active line of medical management during Hospitalization warranting in-patient admission. The complainant's wife's hospitalization claim for a period of 10 days was settled by the insurer. After some time, hospitalization for a period of 3 days in an emergency state for low blood sugar was denied by the insurer on the ground that the same was for diagnostic purpose without any active line of treatment. Though the dispensing of medicines could be by way of out patient treatment, one has to look into the circumstances under which the patient was admitted to the hospital. The patient had 10 days of hospitalization for swelling of left leg ankle and backache five days prior to this hospitalization. The sudden reduction in the blood sugar level after a 10 days hospitalization made the patient to go in for hospitalization as an emergency necessity. Though the nature of treatment without this background could be by way of out-patient treatment, anybody else in a similar situation would seek specialist attention and monitoring to rule out any major illness. The patient's admission has to be viewed in the context which is very different from persons going for a routine health check up by way of host of diagnostic tests and Rs.25,000/- is awarded as Ex-gratia.

Chennai Ombudsman Centre

Case No.IO (CHN) 11.05.1159/2012-13

Mr. H. Manish Thakkar

vs

The Oriental Insurance Co. Ltd

Award No.076 dated 07.08.12

The complainant had that his wife was suffering from Multiple fibroids so, the complainant took her to Jaslok hospital, Mumbai. He contends that the treatment called MRI guided Focussed Ultrasound was taken to remove the multiple fibroids which is the latest technique done only at that Hospital which is a reputed one in India. The claim was settled by the TPA for a sum of Rs.1,00,000/- with the remarks "Reasonable Expenses only payable as per policy". The complainant claimed the balance amount of Rs.3,02,066/- The insurer contends that the procedure carried out for removal of fibroids was not approved by IMA and excluded from the scope of the policy as per clause No.4.13 .They also contend that it is a Non-invasive procedure which does not require any Hospitalisation and is being done as an Out-patient procedure, as verified from the web-site of the Hospital. However, considering the expenses that would have been incurred for treatment of a similar ailment , as per clause 3.12, the have considered a sum of Rs.1,00,000/- being the reasonable expenses and settled the claim, irrespective of the availability of sum insured to the extent of Rs.5 lacs. The point to be considered is whether the decision of the insurer to restrict the claim as per "reasonable and necessary" clause of the policy conditions, is in order.

From the in-door case papers submitted by the insured it is noted that even though the procedure is purely a day-care treatment, the patient had to be prepared and had to be on fast since morning, anesthesia was administered for each sitting and needed to be under constant monitoring periodically through out, till late night for noting the vital parameters and also insertion of catheter was done continuously, which are not practically possible on OPD basis of treatment. When the Hospitalisation is required as suggested by the treating Doctor, the claim under Hospitalisation has to be considered as provided under the Policy. When the claim had been accepted by the insurer considering the same as a technological advancement even though it was construed that the treatment could have been done as a day care procedure, limiting the claim to Rs.1,00,000/- lacks proper justification. When the supposed OP procedure is accepted within the scope of the policy by the insurer, then there is no justification for restricting the claim to Rs.1 lac, in the

absence of any clear guidelines in the policy conditions. The reasoning put forth by the insurer for limiting the cost for the said procedure, under the claim, equating with the cost for conventional Hysterectomy surgery in the same or similar Hospital is not tenable. As far as the remarks made by the insurer regarding the 'Head of Expense' in respect of the 'procedure done' shown as "Investigations" is concerned, it is noted that the Total amount of Rs.3,75,000/-against MRGFUS in the consolidated Bill has the break-up details for the said procedure consisting of 3 sittings and Doctors' and Anasthetist's fees. It appears that the Hospital had charged the same under the Head "Investigations" instead of "Treatment Charges". In view of the foregoing points, the decision of the insurer in restricting the claim under the clause 3.12 is not justified. Therefore, the insurer is directed to process the claim and arrange to settle the balance amount eligible under the Individual Medi-claim policy, subject to other terms, conditions and Limits under the said policy. The complaint is allowed.

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Chennai Ombudsman Centre

Case No.IO (CHN) 11.02.1153/2012-13

Mr.C.Baskar

vs

The New India Insurance Co. Ltd

Award No.077 dated 07.08.12.

The complainant had taken the insurer's Mediclaim. The insured had to be hospitalized for treatment of Multinodular goiter for which Total Thyroidectomy was performed on admission in the hospital from 30/07/2011 to 02/08/2011. The claim was settled by the TPA for an amount of Rs.43,216/-, deducting a major amount of Rs.60,000/- towards Surgeon Fees. The TPA/insurer deducted the amount towards the Surgeon Fees as it was not forming part of the Main Bill of the Hospital and according to the policy conditions it cannot be considered. The point to be considered is whether the decision of the insurer to restrict the Surgeon fees to Rs.10,000/- only, as per policy condition is in order.

It is observed that the Surgeon fees has been paid in cash to the "Mc Arthy Thyroid clinic" for Rs.70,000/- as "Operation Fee" vide Receipt No.35435 dt.30/07/2011 at 16.24 hours , quoting the name of the Consultant as Prof.M.Chandrasekaran duly signed by the Cashier. Only after payment of the Surgeon fees the patient had been admitted in the Prashanth Multi speciality Hospitals at 17.40 hours on 30/07/2011 and underwent surgery on 31/07/2011 and discharged on 2/8/2011.. The Surgeon fees was already collected prior to the actual Hospitalisation and the same was not included by the Hospital in the final bill of the Hospital.

The Forum observes that the insurance is a contract between two parties namely the insured and the insurer. The Terms and conditions are the prime factors governing the insurance contract between the parties. The Insurer had stated that the conditions are generally attached to the policies, but in this case no definite proof had been submitted for having attached the same. But it is noted that the insured had been availing the medi claim policy with the insurer previously and this is not the first policy but the current policy was availed as a Renewal. So, he must have been aware that the policy Schedule should be attached with the relevant Terms and conditions. On the policy schedule it is mentioned that the "Policy is subject to the terms and conditions attached". It is necessary on the part of the insured to seek the relevant conditions of the policy, if the said attachment was found missing. The insured is also equally expected to know the relevant conditions of the policy governed under the contract of insurance. The insured persons should be aware of atleast the salient features of the terms and conditions of the contract of insurance. Therefore, the complainant's plea that the Terms and conditions were not attached with the policy which led to the insured's lack of knowledge of the relevant policy condition under which the surgeon fees was restricted is not tenable. The decision of the insurer to settle the claim strictly in accordance with the policy condition cannot be faulted. Therefore the Insurance Ombudsman is not inclined to interfere with the said decision.

The complaint is dismissed.

Chennai Ombudsman Centre

Case No.IO (CHN) 11.20.1154/2012-13

Mr. Noor Mohamed

vs

Universal Sompo Insurance Co. Ltd

Award No.078 dated 07.08.12.

The Complainant stated that he had taken a Mediclaim policy with the insurer under IOB Healthcare, covering self and family members. His mother was hospitalized for Gall stone, hypertension & DM. The Insurer stated that prior to the present claim, the insured had policy with multiple gaps with the result continuation benefits cannot be given. The first policy with them was renewed with a gap of 8 days and the present policy is in the third year and attracting PED clause of the policy. Their policy grant coverage for pre existing diseases provided policy had continuity and in force for a period of 36 months without any claim. Since, the complainant did not have continuity and had not completed 36 months of uninterrupted coverage, his claim cannot be considered as per clause No.1 of the policy. The point to be considered is whether the decision of the insurer to reject the claim as a case of pre-existing disease as per policy conditions, is in order.

Based on submitted medical documents claimant was suffering with Gall Bladder problem since the year 2004, whereas the policy has been in force since last 2 years". It is noted that the policy from 29/12/2009 to 28/12/2010 was treated as a fresh policy since the earlier policies availed in the years 2006-07, 2007-08 and 2008-09 were not taken into account in view of the break in the Renewals for 2007-08, 2008-09 and 2009-10 policies. On perusal of the two Discharge summaries of two spells of Hospitalisations, it is mentioned that the insured had undergone treatment for Gall bladder problem in the year 2004 for which Cholecystectomy was performed. The present hospitalizations were also considered as relating to the same ailment, which has been treated as Pre-existing. It is to be noted that the proposal form is an important document based on which the policy is accepted and therefore, the proposer is expected to furnish all relevant information relating to the health condition of the proposed insured persons, in order to enable the

insurer to decide acceptance of cover or otherwise. The ailment for which the claim had been preferred was relating to a pre-existing health condition and the same would be covered under the scope of the policy only after 36 months of continuous cover in accordance with the policy conditions. Since the continuous cover of 36 months is not completed in respect of the insured with the insurer, in view of the break in almost each renewal, the said ailment was not covered under the scope of the policy by the insurer. Therefore, under the circumstances mentioned above, the decision of the insurer to repudiate the two claims of the insured is justified and the same does not require the interference at the hands of the Insurance Ombudsman.

The complaint is dismissed.

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Chennai Ombudsman Centre

Case No.IO (CHN) 11.08.1161/2012-13

Mr.R.Sankara narayanan. Ramanathan

vs

The Royal Sundaram Insurance Co. Ltd

Award No.079 dated 07.08.12

The Complainant stated that he had taken a Mediclaim policy with the insurer. During the policy period, he was hospitalized for CABG surgery. After the completion of the procedure, he submitted his claim for Rs.1,81,000/- The insurer rejected the claim under exclusion relating to tobacco abuse. Insurer stated that the patient is a chronic smoker since the last 30 years and smoking is one of the strongest risk factor for heart disease. They further added that heart disease due to tobacco abuse is specifically not covered under their policy. The point to be considered is whether the decision of the insurer to reject the claim on the ground of exclusion of "claims arising out of tobacco abuse" as per policy condition, is in order.

On perusal of the Discharge Summary it is mentioned that the insured was a chronic Smoker for 30 years. The discharge Summary only describes the habit of the insured by mentioning the same. It does not give any specific health condition of the patient to conclude that the habit of smoking or the use or "abuse" of tobacco had only caused the heart ailment or contributed to his coronary artery disease. There is no material evidence on record to come to any conclusion that the use of tobacco by the insured had only resulted into the Coronary Artery Disease suffered by the insured necessitating the Bye-pass surgery. Therefore, denial of the entire claim invoking the said condition of the policy by the insurer is not fully justified. However, it is observed that the complainant's other health parameters do not suggest being the most probable cause for the onset of the heart disease suffered by the insured. Therefore, it becomes a logical conclusion leading the insurer to reject the claim as a case of "tobacco abuse", which cannot be brushed aside, and which factor has also not been denied by the insured in any of his representations to the insurer. He only pleaded to have no knowledge of the relevant condition invoked by the insurer, at the time of renewal of the policy and also questioned the applicability of the same. But, it is to be noted that the terms and conditions incorporated in the policy have to be necessarily followed by both the parties to the contract of insurance. Therefore, in order to render justice to both the parties to the dispute, the insurance ombudsman is inclined to grant an Ex-gratia and the complaint is allowed.

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Chennai Ombudsman Centre

Case No.IO (CHN) 11.05.1124/2012-13

Mr.S. Ramanathan

vs

The Oriental Insurance Co. Ltd

Award No.080 dated 08.08.12

The Complainant's claim for medical expenses of his spouse for the increased sum insured was not considered by the insurer citing policy conditions relating to restriction of sum insured in such cases.

The complainant and his family were insured under Individual Mediclaim Policy subject to Mediclaim Insurance Policy (Individuals) clause. Under the head IMPORTANT condition 8 (c) of the policy states that "If the policy is to be renewed for enhanced sum insured then the restrictions as applicable to a fresh policy (condition 4.1, 4.2 & 4.3 will apply to additional sum insured) as if a separate policy has been issued for the difference". Condition No.4.1 (Exclusion) of the Mediclaim policy reads as under:- "The Company shall not be liable to make any payment under this policy in respect of any expenses what so ever incurred by any person in connection with or in respect of 'pre existing health condition or disease or ailment' - - - - - - - - - - - are excluded up to 4 years of this policy being in force continuously. In the present case, the insured has been taking treatment for cancer as evident from the records and combining the clauses of 8c & 4.1, 4.2 & 4.3, the insurer has repudiated the claim for the enhanced sum insured and allowed the claim up to the original sum insured and hence the contention of the complainant for considering the enhanced sum insured was dismissed.

Chennai Ombudsman Centre

Case No.IO (CHN) 11.17.1180/2012-13

Mr. N.R. Jeyaprakash

vs

Star Health & Allied Insurance Co. Ltd

Award No.081 dated 08.08.12

The complainants claim for the hospitalization expenses incurred for his treatment of lipoma of cord was rejected by the insurer stating that the same was a cosmetic surgery which is excluded under the policy.

During the hearing, the insurer based on the additional documents submitted by the complainant had agreed to re-open and consider the claim, as per other terms and conditions of the policy. Hence, the complaint is allowed.

Chennai Ombudsman Centre

Case No.IO (CHN) 11.17.1198/2012-13

Mr. S. Subramani

vs

Star Health & Allied Insurance Co. Ltd.

Award No.082 dated 08.08.12

The complainant stated that his claim for Hospitalization expenses were restricted to a lesser amount as compared to the sum insured under the policy.

The insurer as per the discharge summary stated that the patient was suffering from pre existing hypertension prior to obtaining the policy with them. As per their Head Office circular, for persons below 60 years of age suffering from pre existing hypertension, hospitalization treatment for the same are allowed subject to a limit of 25% of the sum insured or Rs.50,000/- whichever is less. By this endorsement, the insurer had only extended a concession, not in the scope of the terms of the original policy. The discharge summary as well as the treating doctor's version confirm that the disease existed prior to obtaining the policy for the first time with the insurer and the decision of the insurer restricting the claim payable under the policy to Rs.50,000/- as per the policy endorsements and terms cannot be faulted and the complaint is dismissed.

Chennai Ombudsman Centre

Case No.IO(CHN) /11.07.1137/2011-12

Sangeetha venkatesan

Vs

Tata Aig Insurance Co. Ltd.

Award No.084 dated 08.08.12

The Complainant stated that she had preferred a claim under the policy with the Insurer for the expenses incurred by her for the treatment undergone by her during her stay abroad. The claim was rejected by the Insurer stating that the expenses for the treatment claimed by her is not covered under the policy. She contends that the terms and conditions of the policy was not given to her, hence the claim should be admitted.

The Insurer submitted that the claim was relating to various tests on OPD, for pregnancy related condition, which is specifically excluded from the scope of the policy. Hence the claim was repudiated. complainant was covered under the insurer's Travel Guard Platinum policy from 17/05/2011 to 20/06/11 during her overseas travel including US and Canada.

The insurer issued a Schedule of Travel Insurance and sent it through the Agent by e-mail to the insured without any attachments of the terms and conditions, before departure to US. The complainant has stated that even the hard copy of the Terms and conditions of the policy was not sent to her and the insurer also had not confirmed having sent it to the insured along with the policy, prior to her departure. While in US, the insured had to undergo some Blood investigations following some discomforts on the advice of a Doctor. Diagnostic tests done were relating to Thyroid functions and Pregnancy. She preferred her claim for reimbursement of the expenses for the treatment on her return to India. The claim was rejected by the Insurer stating that the ailment is not covered under the scope of the policy as the same was relating to Pregnancy which is a specific exclusion under the policy issued to her. The Section –Accident & Sickness Medical Expense – Exclusions: (o) reads "Pregnancy and all related conditions, including services and supplies related to the diagnosis or treatment of infertility or other problems related to inability to conceive a child; birth control, including surgical procedures and devices". insured had first consultation with the Doctor on 27/5/2011 and incurred an expense of $79 towards Thyroid Lab Test on 28/05/11. Again on 3rd June 2011 she incurred US$ 500 towards

Doctor consultation, on which date she was diagnosed to have Pregnancy-10 weeks.On 3rd June she underwent Lab Tests pertaining to pregnancy and proceeded with the treatment as per the expenses claimed on 15/6, 18/6 and 20/6/2011. Therefore it is clear that the insured had initial consultations with the Doctor not with the sole purpose of taking treatment for Pregnancy related issues, but it was a generalized one and it included Thyroid Function tests. Only after the consultation on 3rd June, probably the Doctor would have ruled out other causes for the discomforts suffered by the insured and confirmed the "pregnancy", after which the related treatments were prescribed. Therefore, in the absence of clear evidence of the Diagnosis as 'pregnancy' at the first consultation stage itself, it is not justified on the part of the insurer to reject the entire claim as arising out of "pregnancy related". The total expense of $579 namely for Thyroid function test ($79) and Doctor consultation ($500) merits consideration towards settlement of the claim by the insurer.

The contention of the complainant that the entire claim should be considered in view of the fact that the terms and conditions were not attached with the policy schedule before her departure to US is not tenable. When the 'kit' containing terms and conditions were not enclosed with the schedule she should have immediately mailed to the insurer or the Agent who had sent the soft copy of the schedule to her. Since the policy has a specific exclusion relating to 'pregnancy related treatments' from the scope of the policy, those expenses which are directly relating to 'pregnancy' are not payable and the decision of the insurer to that extent is upheld by the Insurance Ombudsman.

The complaint is allowed as an Ex-gratia.

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DELHI OMBUDSMAN CENTRE

Case No. GI/472/NIC/10
In the matter of Smt. Shikha Kulshrestha
Vs National Insurance Company Ltd.

AWARD DATED 9.4.2012 NON SETTLEMENT OF DEATH CLAIM

1. **This is a complaint filed by Shika Kulshrestha (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 non settlement of death claim.**

2. **Complainant stated that her Late husband Dr. Rakesh Kulshrestha had taken a personal accidental policy from Bhilwada (Rajasthan) bearing no. 310603/42/08/8100000537. The insured died on 26.03.2009 in a road accident. She had already sent her representation to the company wherein she has stated that her husband had taken personal accident policy as he was having faith in the Insurance Company but the claim has not been settled so far by the Insurance Company. Insurance Company desired her for submission of photocopy of the bank account which she had submitted. During the course of hearing also the brother of the complainant submitted that company was not justified in not settling the claim. He further argued that premium was paid on 22.09.2008 through cheque and personal accidental policy was issued.**

3. **Representative of the company stated that claim is not payable because premium could not be released because the cheque given by the insured was lost in transit. Company also filed written reply dated 27.02.2012 wherein it has been mentioned that insured had given a cheque bearing no. 998169 for Rs. 8979/- drawn in favor of SBBJ, Mandalgarh and BO- Bhilwara issued the said policy for the period 22.09.2008 to 21.09.2009 covering the risk of Dr. Rakesh Kulshreshtha. The said cheque was deposited by Bhilwara branch at Punjab National Bank. But inspite of all reminder to the Punjab National Bank, Bhilwara on 19.11.2008 and 17.03.2009, the bank did not give credit of this cheque in collection account. Meanwhile insured Dr. Rakesh Kulshreshtha met with an accident on 26.03.2009 and died. Insured's wife lodged the claim under P. A. policy for payment of claim on 28.04.2009. As in this claim 64VB was not complied with, the claim was repudiated.**

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 dated 27.02.2012 placed on record. After due consideration of the matter, I hold that**

personal accidental claim is payable because the personal accident policy which was taken by the diseased was in force at time of death of insured. Premium was paid wide cheque no. 998169 dated 22.09.2008 for an amount of Rs. 8979 and policy was issued for the period 22.09.2008 to 21.09.2009 covering the risk of Dr. Rakesh Kulshreshtha. It appears the failure of the insurer's bank and not to collect the premium because premium was duly deposited by the insured and the insured was not informed by the insurr for not collecting the premium till the death of the insured on 26.03.2009. Therefore, claim is payable. Accordingly an Award is passed with the direction to the Insurance Company to make the payment of Rs. 3,30,000.

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.**

DELHI OMBUDSMAN CENTRE

Case No. GI/153/UII/11
In the matter of Smt. Prafulla Dutta
Vs United India Insurance Company Ltd.

AWARD DATED 12.4.2012 NON SETTLEMETN OF MEDICLAIM

1. **This is a complaint filed by Smt. Prafulla Dutta (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 Mediclaim.**

2. **Complainant stated that company was not justified in making such deductions while settling the claim. She further stated that she was not satisfied with the reply given by the company to her. She has come to this forum to get the balance amount paid to her. During the course of hearing also it was pleated that the claim was payable but company did not settle the claim properly. Infact full claim is admissible. It was further submitted that cashless was denied on the day of operation and advised to go ahead for reimbursement as per policy terms and conditions. The company had not followed the terms and condition while settling the claim. As against the total claim of Rs. 52,483 the company had allowed only a sum of Rs. 22,483 and thus made deductions of Rs. 30,000 in respect of each eye. It was further pleaded that the original monofocal lence which was allowed by the**

insurance company infact is available free of cost in Govt. hospitals and camps organized by NGOs.

3. **Representative of the company stated that there is no caping in allowance of claim.**

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 deductions of Rs. 60,000 while settling the claim. There appears to be no justification what so ever to allow the cost of lens only at the rate of Rs. 8,400 as against claimed by the insured of Rs. 38,400 in respect of each eye. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 60,000 along with the penal interest at the rate of 8% from the date of settlement of the claim to the date of actual payment on an amount of Rs. 60,000.**

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.**

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DELHI OMBUDSMAN CENTRE

Case No. GI/128/UII/11
In the matter of Sh. Harpal Singh Narang
Vs United India Insurance Company Ltd.

AWARD DATED 12.4.2012 REPUDIATION OF MEDICLAIM

1. **This is a complaint filed by Sh. Harpal Singh (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 repudiation of Mediclaim.**

2. **Complainant stated that he had submitted the claim to the insurance company on 20.12.2010 along with all requisite documents. He was informed on 07.01.2011 that his claim was repudiated stating the reason that information about the accident was not given immediately to the insurance company. He further**

submitted that accident took place on 30.09.2010 and on 01.10.2010, he had informed the insurance company on phone. Since he could not present himself personally due to accident and he was advised to submit the claim after treatment. He became completely fit only on 20.12.2010 and then he submitted the claim to the insurance company. He further stated that he intimated to the insurance company about the accident on phone on 01.10.2010 and whereas accident took place on 30.09.2010 though he does not have proof for informing the company in this manner. He has come to this forum with a request to get the claim paid. During the course of hearing also complainant stated that he met with an accident and got injury in knee and rest was prescribed by the doctor for six weeks though company was informed late about the accident.

3. **Representative of the company stated that claim is not payable due to late intimation to the insurance company about the occurrence of incident. It was further argued by the representative of the company that complainant ought to have given information about the accident in written application and therefore, due to late intimation (about three months) the claim is not payable.**

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 denying the claim only on technical ground. Company could not deny the fact that complainant met with an accident and got injured and if this is so, this claim could not denied on the technical ground. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 30.000.**

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.**

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DELHI OMBUDSMAN CENTRE

<u>Case No. GI/164/NIC/11</u>
<u>In the matter of Sh. Gulshan Kumar</u>
<u>Vs National Insurance Company Ltd.</u>

<u>AWARD DATED 10.5.2012 REPUDIATION OF CLAIM</u>

1. **This is a complaint filed by Sh. Gulshan Kumar (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 he had taken a policy in January 2009. He further stated that he was facing some problem relating to heart in the month of January 2011. He admitted in Ganga Ram Hospital and there he was informed that his arteries were blocked and he was advised to be operated immediately. Accordingly he was operated and insert the stunt inside the heart. He had gone to the insurance company and TPA for settlement of the claim. He was denied cashless facility with the assurance that claim would be settled within 45 days but till this date claim was not settled. He is facing a financial problem and borrowed some money from his friends and relatives to pay the cost of treatment. He has come to this forum with request to pay the claim. During the course of hearing, complainant pleaded 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. Company also filed a written reply dated 24.08.2011. company also clarified subsequently that in case claim is found payable, the same is payable only to the extent of Rs. 1 Lakh due to balance sum insured. It is mentioned in the reply that claim was reported to the TPA M/s. Focus Health Care Pvt. Ltd. and claim was denied on the basis of various investigations/scrutiny of papers under exclusions clause 4.3 of the policy. It was stated that the disease for which claim was put up has 2 years of waiting period.**

4. **I have considered the submission of the complainant as well as of the representative of the company. I have also perused the written reply of the company dated 24.08.2011. After due consideration of the matter, I hold that company was not justified in repudiating the claim because the disease for which treatment was taken by patient does not have any waiting period. Clause 4.3 of the policy is not applicable. Therefore, claim is payable. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 1 lakh.**

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.**

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DELHI OMBUDSMAN CENTRE

Case No. GI/163/NIC/11
In the matter of Sh. Dharambir Gupta
Vs National Insurance Company Ltd.

AWARD DATED 10.5.2012 REPUDIATION OF CLAIM

1. **This is a complaint filed by Sh. Dharambir 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 he had taken a policy in January 2009. He had gone to the Hospital centre for sight to take the treatment of the eyes of his wife in the month of December 2010. His wife had taken the treatment of some injury in eyes which is not related to cataract. He lodged the claim of cataract operation in second year. He requested the doctor to postpone the operation of cataract because right now he was not having sufficient fund for such treatment thus treatment taken by his wife was partly or fully not connected with the cataract operation. He has come to this forum to resolve the issue and instruct the insurance company to make him the payment of the claim. During the course of hearing also complainant stated that claim is payable but company had denied it wrongly.**

3. **Representative of the company stated that claim is not payable as per terms and conditions of the policy. Company also filed written reply dated 18.04.2011 wherein it has been mentioned that claim was denied as per clause 4.3 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 repudiation letter and also the written reply of the company which is placed on record. After due consideration of the matter, I hold that company is not justified in repudiating the claim because treatment was taken by the patient did not relate to the cataract. Complainant was treated with regard to the disease of eye not related to cataract. Therefore, in my view clause 4.3 is not applicable and the claim is payable. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 15,000.**

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.**

DELHI OMBUDSMAN CENTRE

Case No. GI/167/OIC/11
In the matter of Sh. Mahak Singh
Vs Oriental Insurance Company Ltd.

AWARD DATED 10.5.2012 REPUDIATION OF MEDICLAIM

1. **This is a complaint filed by Sh. Mahak Singh (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 medi-claim.**

2. **Complainant stated that on 28.09.2010 at 9:30 a.m., he had acute severe chest pain. He was taken to Bhagat Hospital, after ECG and some emergency medication, he was shifted to Delhi Heart and Lung Institute at Panchkuian Road, New Delhi. After reaching the hospital he had a cardiac arrest and was put on ventilator support after that, he has taken to Cath Lab for primary PCI, there he also got heart attack. After the necessary treatment, he was dischared on 04.10.2010. He submitted all his original bills, discharge summary, relevant test reports etc. to the TPA M/s. Safe way TPA services pvt. Ltd. His claim no. is 41319 and claim amount is Rs. 3,53,904. TPA required to submit the Consultation note and the same were also provided. However, the TPA rejected his claim vide letter dated 03.12.2010 stating that it was for the management for disease which is complication of pre-existing disease. He further stated that he is a non diabetic person with normal Blood Pressure and leaving normal life. The same could be verified from the discharge summary. He did not have any pre-existing disease of any sort which is also clear from the insurance policy. Chest pain and cardiac arrest that followed was very sudden, there is no such family history. He has come to this forum to get the claim settled. During the course of hearing, complainant argued that he is covered under family floater policy the sum insured is Rs. 7 lacs. He was hale and hearty before the illness was detected on 28.09.2010. He underwent Ango plasty and spent a sum of Rs. 3,59,000.**

3. **Representative of the company stated that complainant did not provide evidence for the pre-existing disease. It was further argued that by the representative of the company that medical tests and their readings show that patient was suffering**

from pre-existing disease at the time of inception of the policy. Company also filed written reply dated 07.02.2011 wherein it has been stated that as per the opinion of medical team, the illness of the insured is not of acute nature and is also related to pre-existing disease which is not covered into policy given to the complainant.

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 discharge summary of the hospital, besides the repudiation letter. 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 there is no evidence placed on record by the insurance company that the complainant was suffering from particular disease for which he was treated prior inception of the policy. The discharge summary does not speak about any illness prior to the detection of the present disease. Therefore, in my view company is not justified in concluding that hospitalization for which the treatment was taken is a complication of pre-existing disease. In my considered opinion claim is payable. Complainant was treated for the disease detected during the currency of the policy. Therefore, claim is payable. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 3,59,760.**

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.**

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DELHI OMBUDSMAN CENTRE

Case No. GI/451/UII/11
In the matter of Sh. Ashok Kumar Gaur
Vs United India Insurance Company Ltd.

AWARD DATED 16.5.2012 REPUDIATION OF MEDICLAIM

1. **This is a complaint filed by Sh. Ashok Kumar Gaur (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 repudiation of mediclaim.**

2. **Complainant stated that he had submitted all requisite documents required for settlement of the claim to the United India Insurance Company but till date he had not received any reply. He has come to this forum with request to get the claim settled at an early date. During the course of hearing, complainant argued that company was not justified in declining the claim. He further submitted that all requisite documents were already submitted for settlement of the claim.**

3. **Representative of the company stated that request for condoning the delay is pending with RO- Chennai as per record. There was delay in intimating to the company and also in submitting the papers.**

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 declining the claim on account of delay because officials of the insurance company have power to condon the delay in intimating the claim and late submission of documents. If the claim is payable on merits, the same could not be declined on the technical grounds. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 1,24,123.**

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.**

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DELHI OMBUDSMAN CENTRE

Case No. GI/204/UII/11
In the matter of Sh. Kamaljeet Dhingra
Vs United India Insurance Company Ltd.

AWARD DATED 16.5.2012 NON SETTLEMENT OF CLAIM

1. **This is a complaint filed by Sh. Kamaljeet Dhingra (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 taken mediclaim policy from Instant Health Care Pvt.Ltd. for the period 16.04.2009 to 15.04.2010. He renewed the policy for the period 16.04.2010 to 15.04.2011 by giving cheque of Rs. 10,473 on 22.03.2010. His wife Pooja Dhingra was admitted in Jeewan Hospital and nursing home on 19.12.2010 and gave birth to child. She was discharged from hospital on 22.12.2010. The total bill was Rs. 25,300. Cash less facility was refused by the company therefore, he deposited all necessary documents to the company for the reimbursement of bills on 28.12.2010. He had approached the Insurance Company for a number of times for settlement of the claim but he had not received any response. He also approached the GRO of the company and from that office too he did not get any reply. He has come to this forum to take some steps to get the claim paid. During the course of hearing complainant argued that claim is payable but the company had not paid it though there is no break in the policy.**

3. **Representative of the company stated that complaint relates to R.O.- II. Company also filed a written reply dated 03.05.2012 wherein it has been stated that policy no. was not mentioned in the notice therefore, it was difficult to trace the record.**

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. After due consideration of the matter, I hold that company was not justified in not settling the claim for such a long time. Admittedly, insured was admitted in the hospital and got treatment and discharged. Claim was made in the second year of the policy period. There is no break in the policy. Therefore, there is no reason not to pay such claim. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 25,300 along with the penal interest at the rate of 8% w.e.f. 01.02.2011 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.**

DELHI OMBUDSMAN CENTRE

Case No. GI/192/NIA/11
In the matter of Sh. Kulbhushan Sethi
Vs New India Assurance Company Ltd.

Award DATED 21.5.2012 NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Kulbhushan Sethi (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 settlement of mediclaim.**

2. **Complainant stated that he has submitted original bill, payment receipt and other papers to Raksha TPA but the TPA demanded original discharge summary. He submitted this through speed post but the same was not received by the Raksha TPA. He doesn't know as to where the original discharge summary had gone. Whether the same was misplaced by the Raksha TPA or misplaced by the P & T department but the fact remained that he had sent the same. He also submitted attested discharge summary not only once but 4 to 5 times. He had requested the insurance company to settle the claim. During the course of hearing it was submitted by the complainant that he submitted all requisite documents in time but the claim was made as no claim. The company was not justified to make it a no claim case.**

3. **Representative of the company stated that documents were received by the Raksha TPA. It was assured by the TPA that claim will be considered by the TPA and whatever admissible would be given. Company also filed written reply dated 16.09.2012 wherein it has been mentioned that claim has been settled for an amount of Rs. 31,118 and payment would be released soon.**

4. **I have considered the submissions of the complainant as well as of the representative of the company. I have also perused written reply of the company**

dated 16.05.2012 which is placed on record. After due consideration of the matter, I hold that now company has approved the claim and infact settled the claim for an amount of Rs. 31,118 and payment would be released within 2-3 day. Accordingly complaint may be treated as disposed off.

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

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DELHI OMBUDSMAN CENTRE

Case No. GI/200/Star/11
In the matter of Smt. Pushpa Mishra
Vs Star Health & Allied Insurance Company Ltd.

AWARD DATED 16.5.2012 NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Smt. Pushpa Mishra (herein after referred to as the complainant) against the decision of Star Health & Allied Insurance Co. Ltd. (herein after referred to as respondent Insurance Company) relating to non-settlement of mediclaim.**

2. **Complainant stated that she had purchased a health policy from Star Health & Allied Insurance Company Ltd. The policy was issued by Howrah Branch office of the company on 17.07.2010 for the age proof, She had given the copy of passport such proof was given to the agent who booked the policy. Suddenly she became sick and was hospitalized. After discharge from the hospital, she submitted the bill for reimbursement of the expenses. However, company refused to reimburse the expenses incurred in the treatment due to mismatch of date of birth. She had sent e-mail and she also wrote to the GRO of the company but she had not received any reply. She has come to this forum for intervention and with direction to the insurance company to settle her claim. Authorized representative of the complainant stated that the company was not justified in cancelling the policy and consequently not justified in repudiating the claim.**

3. **Representative of the company stated that claim was correctly repudiated. Company also filed written reply dated 16.08.2011 wherein it has been stated that branch office Howrah issued the policy bearing no. P/191113/01/2011/000628 for the period 17.07.2010 to 16.07.2011 covering Mrs. Pushpa Mishra for the sum insured of Rs. 2,00,000 under senior citizens and carpet insurance policy. Company had received the claim of insured for the treatment of Urosepsis, Bronchial Asthma,**

Hypertension and Hypothyroid at AMRI Hospital – Saltlake, Kolkata. The claim was considered and the same was rejected on the ground mentioned in the reply. Company also submitted further that policy issued to the complainant was cancelled due to mismatch of date of birth. Hence company is not liable under 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 and also subsequent letter dated nil. After due consideration of the matter, I hold that though claim is not payable due to the fact that mediclaim policy given to the complainant was cancelled but the reason for cancellation of the policy was not on account of the fault of the complainant. Complainant had given proof of the date of birth and submitted the passport for that purpose but the date of birth mentioned in the passport was manipulated so as to make her illegible for issuance of the policy because she was of 60 years on the date of issuance of policy as per date of birth mentioned in the passport. Therefore, mismatch in the date of birth was not on account of the complainant but was on account of some other person. Since complainant was not of 60 years of age at the time policy was issued, the policy could not have been issued at all but the fault was not on account of the complainant. In my view complainant is entitled to refund of the premium paid by her. Company is here by directed to refund the premium received by it. Accordingly an Award is passed with the direction to the Insurance Company to refund the premium to the complainant.**

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.**

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DELHI OMBUDSMAN CENTRE

Case No. GI/118/UII/11
In the matter of Sh. Vinod K. Lamba
Vs United India Insurance Company Ltd.

AWARD DATED 21.6.2012 INADEQUATE SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Vinod K. Lamba (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 his daughter Ms. Shaila Lamba insured under the policy was admitted to Fortis, New Delhi on 21.11.2007. She was discharged on 22.11.2007. M/s. E-meditek agreed to pay only a sum of Rs. 50,000 and the balance of Rs. 21,245 had to be paid by the complainant. Though admission was cashless, E-meditek stated that it was a new policy however, complainant stated and informed the E-meditek that it was a continuing policy since 2001 and therefore they should have settle the entire claim. After treatment at Fortis, the patient was admitted at Pushpawati Singhania Research Institute, Shekh Sarai and forwarded the bills amounting to Rs. 30,384 with original MRI report and bills. Complainant had approached the insurance company many a times but the claim was not settled.**

3. **During the course of hearing representative of the company was required to submit reply within 10 days but no reply was submitted so far though considerable time had elapsed.**

4. **I have considered the submissions of the complainant as mentioned above. Company did not file any reply despite specific direction to submit the same. After due consideration of the matter, I hold that company was justified in not considering the enhanced sum insured for settling the claim. However insured is entitled to previous sum insured as well as cumulative bonus for Rs. 20,000. The company had already paid a sum of Rs. 50,000 as cashless facility and thus available previous sum insured. The balance claim may be considered out of the cumulative bonus limited to Rs. 20,000. Thus insured is found entitled to further relief of Rs. 20,000. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 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.**

DELHI OMBUDSMAN CENTRE

Case No. GI/233/NIC/11
In the matter of Sh. Satya Prakash
Vs National Insurance Company Ltd.

AWARD DATED 21.6.2012 NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Satya Prakash (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 non settlement of mediclaim.

2. **Complainant stated that the claim relating to reimbursement of medical expenses incurred on the hospitalization of his wife Smt. Indra Mani Goyal was given on 22.12.2010. This claim was made under Family floater plan parivar Mediclaim with sum insured of Rs. 5 lakhs. The amount incurred on hospitalization and treatment of the patient amounted to Rs. 2,19,368.85 cashless facility was allowed by the hospital for and amount of Rs. 82725 and thus net amount claimed was Rs. 136643. It was mentioned by the complainant that TPA was not justified in restricting the cashless facility to the amount of Rs. 82725. M/s. Alankit Health care TPA Ltd. informed on 17.01.2011 about disallowing a sum of Rs. 134769 out of the net claim of Rs. 136644. A sequel claim in respect of ongoing treatment of his wife was also filed for an amount of Rs. 13483 thus total amount of Rs. 148252 (134769 + 13483) is still pending. The company had not explained the reasons for not admitting this amount. He had written a number of letters to the company but that too of no avail. Patient was detected brain tumor in 2009 and was treated accordingly. It was submitted in the complaint that company was not justified in making disallowance of Rs. 134769 and also the claim of Rs. 13483. The reasons given for disallowance were unjustified and untenable. During the course of hearing brother of the complainant argued vehemently that company was not justified in disallowing a sum of Rs. 123316 on account of Limit exhaust as per old S.I. and also disallowance various small amounts stating pre 30 days. During the course of hearing, it was argued that company was not justified in making payment of Rs. 84600/- out of total claim of Rs. 232831. As per policy terms and conditions 50 % of sum insured is admissible. Patient suffered with cancer and thus out of sum insured balance is payable out of 50% of sum insured per disease. Thus claim of the complainant is fully admissible. It was further mentioned that in view of the disease pre hospitalization expenses for 30 days becomes irrelevant because there is no need of hospitalization for particular period in her case in view of the nature of disease for which she was treated.**

3. **Representative of the company stated that claim was settled as per terms and conditions of the policy. There has been variation in the sum insured though it was admitted that in the policy period 2006 to 2009 the sum insured was Rs. 5 lacs and the same was continued. Company also filed written reply dated 20.09.2011 wherein it has been mentioned that Sh. Satya Prakash Goyal i.e. the complainant took policy in 2006 – 2007 for the sum insured of Rs. 1 lakh for his wife under individual mediclaim in the year 2008 – 2009. The policy was converted by him into parivar mediclaim for the sum insured of Rs. 5 lacs. As per TPA Smt. Indra Mani Goyal has history of carcinoma since 2006. Therefore, company as per company's guidelines, the enhanced sum insured is not applicable in case of pre existing disease. Therefore, claim was settled as per limit under respective categories.**

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 reply of the company and also the reasons submitted for disallowance of Rs. 1,34,769 vide letter dated 17.01.2011 of Alankit Health care TPA Ltd. and also perused the detailed representation submitted on behalf of the complainant. After due consideration of the matter, I hold that the claim was partially settled. Deductions have been wrongly made while settling the claim. Company was not justified in settling the claim with reference to the previous sum insured because the disease for which claim was submitted was detected much after the enhancement of the sum insured. Therefore, claim has to be settled with reference to enhanced sum insured. The sum insured in the policy for which relevant period is Rs. 5 lacs and as per policy terms and conditions the claim is restricted to 50% of the sum insured and since in this particular case the total claim is below the 50% of the sum insured , entire claim is payable. Accordingly company is not found justified in settling the claim by making total payment of Rs. 84600 including cashless payment. Thus insured is further found entitled to sum of Rs. 1,44,776 including pre and post hospitalization expenses. Accordingly an Award is passed with the direction to the insurance company to make the further payment of Rs. 1,44,776 along with penal interest at the rate of 8% w.e.f. 01.02.2011 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.**

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DELHI OMBUDSMAN CENTRE

Case No. GI/249/NIC/11
In the matter of Sh. Pradeep Kumar Bansal
Vs National Ins. Company Ltd.

AWARD DATED 17.7.2012 REPUDIATION OF MEDICLAIM

1. **This is a complaint filed by Sh. Pradeep Kumar Bansal (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 repudiation of mediclaim.**

2. **Complainant stated that he had already approached the GRO of the company with regard to settlement of his claim but the claim had not been settled so far. He has come to this forum with request to get the claim settled. During the course of**

hearing also complainant stated that company was not justified in repudiating the claim merely because treatment was taken by the patient in hospital which was not included in the approved list of the hospitals by the company.

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

4. **I have considered the submissions of the complainant. I have also perused the repudiation letter dated 30.11.2009. After due consideration of the matter, I hold that company was not justified in repudiating the claim merely because the hospital where treatment was taken by the patient is outside the approved list of the hospitals provided by the company. In my considered view claim could not be denied only on the ground that treatment was not taken in the hospital which was not approved by the company. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 22,108.**

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.**

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DELHI OMBUDSMAN CENTRE

Case No. GI/242/OIC/11
In the matter of Sh. Chitresh Kumar Nagar
Vs Oriental Insurance Company Ltd.

AWARD DATED 17.7.2012 REPUDIATION OF MEDICLAIM

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

2. **Complainant stated that his wife Smt. Mamta Nagar had felt pain all of a sudden which was unbearable and therefore, she consulted the doctor at Lal Bahadur Shastri hospital. There after she was referred for angiography to G.B. Pant hospital. At G.B. Pant hospital, seeing the condition of the patient angiography was done and it was found that there was blockage of 60 to 70% and she was treated in the hospital. He further stated that all requisite documents relating to settlement of**

the claim were submitted to TPA Medi Assist India Pvt. Ltd., Sant Nagar but the claim was repudiated stating that in policy bearing no. 27301/48/2011/6295 dated 07.10.2011 said that claim will be payable after two years. He further stated that in case, she was not treated in time she could not here survived and therefore the treatment was taken by the patient. He has come to this forum with request to get the claim settled. During the course of hearing also complainant argued that claim is payable but company had denied it wrongly.

3. **Representative of the company stated that claim is not payable as per clause 4.1 of the policy. It was further argued by the representative of the company that hypertension is responsible for the disease for which the patient was treated therefore, the claim is not payable. Company also filed written reply dated 12.10.2011 wherein it has been mentioned that on scrutiny of the claim it was found that patient was suffering from hypertension, DM 2 and CAD the said ailment falls under two years exclusion as per clause 4.1 of the policy and hence the liability was denied.**

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 12.10.2011 and also repudiation letter dated 22.06.2011. After due consideration of the matter, I hold that company was not justified in repudiating the claim in view of clause 4.1 of the policy because the disease for which treatment was taken by the insured and submitted the claim did not find place in any of the items as mentioned in the clause 4.1 of the policy. The clause 4.1 does not mention that any complication arising out of the disease mentioned in clause 4.1 is also not payable. The insured had suffered pain all of a sudden and ultimately her angiography was done and stent was inserted as a treatment of removal of blockage in the heart. Cardiac Artillery disease is not mentioned in clause 4.1 of the policy. Therefore, in my considered view, claim is payable and company was not justified in repudiating the claim. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 74461.**

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/212/NIC/11
In the matter of Sh. S.N. Gupta
Vs National Insurance Company Ltd.

AWARD DATED 17.7.2012 REPUDIATION OF MEDICLAIM

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

2. **Complainant stated that he has been having medical insurance since 2002 till today without any break. He had taken mediclaim insurance from Oriental Insurance Company from 12.02.2002 to 12.02.2008 and w.e.f. 12.02.2008 to 11.02.2012, he has taken mediclaim insurance policy from National Insurance Company Ltd. His wife Smt. Manorma Gupta was hospitalized on 06.09.2012 to 11.09.2010 for having breathlessness. He submitted all the relevant documents to the company on 06.10.2010. He further informed that his claim was repudiated on 20.05.2011. He submits further that clause 4.1 of the policy is not applicable in his case because he is insured medically since long. He has come to this forum with request to direct the insurance company to reimburse a sum of Rs. 41848 at the earliest. During the course of hearing it was argued by the complainant that company was not justified in repudiating the claim.**

3. **Representative of the company stated that claim is payable only after 4 years of claim free period. Company also filed written reply dated 09.09.2011.**

4. **I have considered the submissions of the complainant as well as of the representative of the company. I have also perused letter dated 20.05.2011 of the company and also written reply dated 09.09.2011. After due consideration of the matter, I hold that company was not justified in repudiating the claim because complainant has been taking the mediclaim policy since 12.02.2002 and thus claim was made in the 8th year of the policy period. It is to be mentioned here that complainant had taken the mediclaim policy from 12.02.2002 to 11.02.2008 from Oriental Insurance Company Ltd. and from 12.02.2008 onwards had taken the mediclaim policy from National Insurance Company. In my considered view since complainant has been taking the mediclaim policy without any break and that to from the public sector this appears to be fitness of things, to allow continuity**

benefit. Thus in my view claim is payable. The disease was not existing on 12.02.2002. Therefore, claim could not be denied on account of pre-existing disease. The claim is payable. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 30790.

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/275/UII/11
In the matter of Sh. Om Dutt
Vs United India Insurance Company Ltd.

AWARD DATED 24.7.2012 REPUDIATION OF MEDICLAIM

1. **This is a complaint filed by Sh. Om Dutt (herein after referred to as the complainant) against the decision of United India Insurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to repudiation of mediclaim.**

2. **Complainant stated that he had submitted his mediclaim bearing no. 221900/48/11/97/90000009 in reference of his policy no. 221900/48/09/97/00003874 to the insurance company but his mediclaim was rejected by the insurance company. He further stated that he had already submitted all the requisite documents to enable the company to take suitable action in the matter. He has come to this forum with request to get the claim settled at an early date. During the course of hearing, it was further stated by the complainant that his claim is payable and company denied it due to wrong reasons. He further submitted that all the requisite documents had already been submitted by him.**

3. **Representative of the company stated that claim is not payable due to clause 5.3 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 repudiation letter dated 18.05.2011. After due consideration of the matter, I hold that company was not justified in repudiating the claim because claim which is otherwise admissible**

cannot be rejected on technical grounds, such as of delay in intimation. Therefore, in my considered view claim is payable. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 36,802 along with the penal interest at the rate of 8% from the date of repudiation 18.05.2011 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.**

DELHI OMBUDSMAN CENTRE

Case No. GI/278/NIA/11
In the matter of Sh. Jeet Singh
Vs New India Assurance Company Ltd.

AWARD DATED 24.7.2012 REPUDIATIO OF MEDICLAIM

1. **This is a complaint filed by Sh. Jeet Singh (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 on 22.02.2011 his wife Smt. Sukhjeet Kaur felt acute pain in chest as well as in left shoulder. He took her to M.G.S. Heart institute, Punjabi Bagh and got admitted there. She was advised to go for stunting after doing Angiography. She was discharged on 26.02.2011. Raksha TPA was informed on the same day but to his utter surprise cashless facility was denied. He submitted all requisite documents relating to the claim. He found that his case was closed. With lot of persuasion, he got the case reopened. He further stated that agent advised him to change the policy. During the course of hearing, complainant pleaded that claim is payable but company had denied it wrongly.**

3. **Representative of the company stated that claim is not payable due to clause 4.3 of the policy. The claim is made in the first year of the policy period. Company also filed written reply dated 21.10.2011 wherein it has been stated that the disease falls under clause 4.3 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 which is placed on record. After due consideration of the matter, I hold that company was not justified in repudiating the claim stating that clause 4.3 is applicable. I have perused the policy schedule particularly the clause 4.3 of the policy and I find the disease for which the treatment was taken by the patient is not the one which finds place in the diseases mentioned in clause 4.3. Therefore, in my considered 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.**

DELHI OMBUDSMAN CENTRE

Case No. GI/250/NIC/11
In the matter of Sh. Sunil Bansal
Vs National Insurance Company Ltd.

AWARD DATED 26.7.2012 REPUDIATION OF MEDICLAIM

1. **This is a complaint filed by Sh. Sunil Bansal (herein after referred to as the complainant) against the decision of National Insurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to repudiation of hospitalization claim.**

2. **Complainant stated that he had already sent his representation to the GRO of the company but he had not received any reply. Grievance Redressal Officer forwarded his complaint to the concerned insurance company's office to take necessary action but even after a long wait, he had not received even a single letter from the insurance company. he has come to this forum with a request to get his claim settled at an early date. During the course of hearing, complainant stated that company was not justified in repudiating the claim as the hospital where the treatment was taken did not find place in the approved list of hospitals by the company. He further submitted that policy is continued for considerable time.**

3. **Representative of the company stated that claim is not payable for the reasons mentioned in the repudiation letter.**

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 13.07.2009. After due consideration of the matter, I hold that company was not**

justified in repudiating the claim merely because the hospital where the treatment was taken by the patient is outside the approved list of the Delhi Hospitals. The claim is payable. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 30713.

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.**

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DELHI OMBUDSMAN CENTRE

Case No. GI/255/UII/11
In the matter of Sh. Keshav Madhav
Vs United India Insurance Company Ltd.

AWARD DATED 26.7.2012 REPUDIATION OF MEDICLAIM

1. **This is a complaint filed by Sh. Keshav Madhav (herein after referred to as the complainant) against the decision of United India Insurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to repudiation of mediclaim.**

2. **Complainant stated that though he had gone to the hospital for check up but the doctor advised him to undergo surgery in the eye. Surgery was performed on 23.09.2010. Documents relating to claim were submitted on 04.10.2010. He has submitted that his claim has not been settled so far. He has come to this forum for getting his claim settled at an early date. During the course of hearing, it was stated by him that though the claim was fully allowable but the company had paid only a sum of Rs. 22,650 out of the total claim of Rs. 55,550.**

3. **During the course of hearing, company's representative was required to submit the reasons as to why a sum of Rs. 22,650 was paid out of the claim of Rs. 55,550 within a week. Company had not filed any 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 adequately settling the claim. Company had paid only a sum of Rs. 22,650 out of total claimed amount of Rs. 55,550. Company's**

representative could not produce the reasons for making deductions while settling the claim even after specific direction. In my considered view, in such circumstances it has to be held that balance claim is also payable. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 32,485 (55135 – 22650).

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.**

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DELHI OMBUDSMAN CENTRE

Case No. GI/266/NIA/11
In the matter of Sh. Praveen Kumar
Vs New India Assurance Company Ltd.

AWARD DATED 26.7.2012 REJECTION OF MEDICLAIM

1. **This is a complaint filed by Sh. Praveen Kumar (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 rejection of mediclaim.**

2. **Complainant stated that he has been taking mediclaim policy from New India Assurance Company Ltd. for the last 13 years without any break. This year, he fell sick and hospitalized in National Heart Institute. Subsequently, he lodged the claim and submitted all the original papers in respect of his hospitalization to TPA. As and when any query was raised by them, he complied with the same. He was surprised to receive a letter dated 18.02.2011 informing him that claim has been rejected by the insurance company. He submitted that the reasons given for rejection of the claim are baseless. He had approached the GRO of the company but he had not been favored with any reply. He has come to this forum and an intervention to settle the claim.**

3. **Representative of the company informed this forum on the date of hearing that the claim is approved a sum of Rs. 64215 is being paid to Smt. Veena Kumari. However, as promised payment, has not been paid so far. Company also filed written reply dated 19.10.2011 wherein, it has been stated that Sh. Praveen Kumar**

was admitted to National Heart Institute with complaint of bilateral lower limbs for 3 months with breathlessness and fever. In the hospital patient was diagnosed as suffering from chronic liver disease. Since patient did not submit the required papers, the file was closed as no claim and it was communicated to the insured on 04.06.2011.

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 with is placed on record. After due consideration of the matter, I hold that company was not justified in repudiating the claim, because claim is payable that appears precisely the reason that it has approved the claim of Rs. 64,215. However, no information was given for making payment of the approved amount so far. However, no intimation for release of the approved amount was furnished to this office. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 64,215.**

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.**

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DELHI OMBUDSMAN CENTRE

Case No. GI/203/UII/11
In the matter of Smt. Sushma Bala
Vs United India Insurance Company Ltd.

AWARD 31.7.2012 REPUDIATION OF MEDICLAIM

1. **This is a complaint filed by Smt. Sushma Bala (herein after referred to as the complainant) against the decision of United India Assurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to repudiation of mediclaim.**

2. **Complainant stated that she had taken mediclaim policy from United India Insurance Company Ltd. She underwent a Cardiac angiography at Ganesh Diagnostic centre on 01.08.2010. Before going for the said test, company was informed in advance. There is a latest technology wherein, the patient does not need any hospitalization and surgery. E-mail dated 28.07.2010 was sent with the purpose of prior intimation. In response to the e-mail, a ticket no. ID – 4377 was**

allotted to her by Sh. Praneet of TPA. Company had not communicated to her about the denial of the test at said diagnostic center. He submitted a claim for the said test to TPA on 05.08.2010 for an amount of Rs. 20,450. On 05.09.2010 when she enquired about the status of the claim she was informed that claim was denied because of OPD reasons. She had again taken up the matter with the company. IRDA office was also informed. She also approached the GRO of the company but she had got no response. She has requested this forum for intervene and to instruct the company to pay the claim without any further delay. During the course of hearing, complainant arued that claim is payable but the company had denied it citing clause 4.5 of the policy.

3. **Representative of the company stated that claim is not payable due to policy condition. Company also filed written reply dated 13.07.2012 wherein, it has been stated that claimant underwent angiography under OPD. This procedure is not covered under OPD day care procedure and therefore, claim was rightly repudiated.**

4. **I have considered the submissions of the complainant as well as of the representative of the company. I have also perused repudiation letter. After due consideration of the matter, I hold that claim is payable as per clause 2.3 of the policy as a day care procedure. Coronary angiography is payable even if perform as an OPD procedure. In my considered view claim is payable. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 20,450.**

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/263/Star/11
In the matter of Sh. Govind Mandal Vs
Star Health & Allied Insurance Company Ltd.

AWARD DATED 31.7.2012 REPUDIATION OF MEDICLAIM.

1. **This is a complaint filed by Sh. Govind Mandal (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 has taken mediclaim policy from Star Health & Allied Insurance Company Ltd. for the period 20.06.2008 to 19.06.2009. During the policy period 20.06.2010 to 19.06.2011 Roshan who was covered in the policy was admitted for treatment but the insurance company rejected the claim. He further submitted that he had submitted 2 claims bearing no. 0105067 and 0109380 but the company had not replied. He has requested this forum to get the claims settled. During the course of hearing, he submitted that he had given two claim to the insurance company for settlement but one claim was partially settled and company had given only a sum of Rs. 43,277 out of total claim of Rs. 47,907 but the company had not paid the another claim. He pleads that the claims are fully admissible.**

3. **Representative of the company stated that claims were settled as per terms and conditions of the policy and nothing is payable to the policy holder.**

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 partially settling the claim. Company had paid only a sum of Rs. 43,277 out of total claim of Rs. 43,907. Company had made deductions which were not called for while settling the claim by making payment of Rs. 42,965. Complainant is still entitled to Rs. 45,00 on account of wrong deductions made by the company while settling the claim as per assessment sheet furnished to my office. As regards another claim, Company was not justified in not making the payment so far. I find from the assessment sheet that the claim was duly approved by the competent authority for an amount of Rs. 15,181. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 19681 (4500 +15181).**

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/315/UII/11
In the matter of Sh. Satya Priya kamran
Vs United India Insurance Company Ltd.

AWARD DATED 1.8.2012 REPUDIATION OF MEDICLAIM

1. **This is a complaint filed by Sh. Satya Priya Kamran (herein after referred to as the complainant) against the decision of United India Insurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to repudiation of mediclaim.**

2. **Complainant stated that due to sudden severe pain in his right kidney on 10.12.2010, he was admitted in Chandra Laxmi Hospital, Sector 4, Plot no. 337, Vaishali, Ghaziabad-201010. He made a telephone call immediately after being admitted to E-meditek (TPA) services Ltd. for seeking cashless services for his treatment at the hospital but was informed that Chandra Laxmi hospital was not on their network and was advised that the claim can be reimbursed subsequently. He was discharged after treatment on 14.12.2010. He had submitted the claim along with relevant documents by speed post on 23.12.2010 to E-meditek (TPA) for reimbursement. On 27.01.2011, as he did not receive any response from E-meditek, he wrote to them to expedite his claim. However, no reply was received, therefore, he again issued a reminder on 02.02.2011 to expedite the settlement. In response E-meditek informed that his claim has been repudiated in view of late intimation. Thereafter, he wrote to the company about the arbitrary denial of the claim. Finally vide E-mail dated 11.02.2011, he was informed that claim was rejected. He has come to this forum with request 1. To get him bonafide claim of Rs. 23,664 paid. 2. Initiate the appropriate action for the callous, arbitrary and irresponsible attitude of the TPA as well as the officials of United India Insurance Company Ltd. in not responding and prolonging the settlement of the claim despite several reminders and causing mental harassment, pain etc. During the course of hearing, he again repeated that claim documents were submitted and he intimated the insurance company also but his claim was denied and that was done on flimsy ground.**

3. **Representative of the company stated that claim was denied due to late intimation. company also filed written reply dated 10.01.2012 wherein it has been stated that claim was repudiated due to non intimation of the claim.**

4. **I have considered the submissions of the complainant as well as of the representative of the company. I have also perused the detailed written submissions of the complainant as given in writing. I have also perused the repudiation letter and written reply of company which are placed on record. After due consideration of the matter, I hold that company was not justified in repudiating the claim because the claim is payable on merits, the same could not be denied on technical grounds. The claim is payable. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 23,150. As regards other reliefs claimed by the complainant, it is to be held that such other reliefs are not found acceptable under the facts and circumstances of the case. Needless to say, it is beyond the purview of the forum to initiate any action against the TPA and officials of the company.**

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.**

DELHI OMBUDSMAN CENTRE

Case No. GI/297/OIC/11
In the matter of Sh. Ravi Sharma
Vs Oriental Insurance Company Ltd.

AWARD DATED 1.8.2012 REPUDIATION OF MEDICLAIM

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

2. **Complainant stated that he was shocked after he received a letter on 06.04.2011 from the insurance company after 130 days of depositing the claim papers on 26.11.2010. Company had rejected his claim on the ground that it was his first year of policy. While rejecting the claim, company also referred to clause 4.3 of the policy. Company had not attached any terms and conditions while issuing the policy. It is his first claim in his life and he is paying approximately Rs. 25000 every year for the last 7 years without any break in his policy. Company was not justified to disallow the cashless facility. The company had not responded to any of his letters. Company had taken 130 days in communicating its decision. There needs to be some time frame for settlement of the claim. He had taken the policy for**

emergency and for his retirement and when he would not get his claim then what is a use of giving such huge premiums to the insurance company. He has come to this forum with a request to get his claim settled. During the course of hearing, complainant stated that he has been taking a mediclaim policy since 2003 and is continued till date and he had got no claim so far. Company was not justified in rejecting the claim on the ground that claim was made in the first year of the policy. He is required to be given the benefit of continuity.

3. **Representative of the company stated that claim was made in the first policy period whereas disease has 4 years of waiting period and thus claim was rightly rejected as per clause 4.3 of the policy. company also filed written reply dated 20.10.2011 wherein it has been stated that the policy was taken by the insured for the first time with the Oriental Insurance Company Ltd. which is effective from 01.02.2010 and claim disease Osteo Arthritis B/L for knee replacement is excluded during first four policy year as per exclusion clause 4.3 of the policy and accordingly the claim was denied by the company and the same was conveyed to the insured.**
4. **I have considered the submissions of the complainant as well as of the representative of the company. I have also perused repudiation letter and written reply of the company which are placed on record. I have also gone though the photo copies of the policy documents for different years. After due consideration of the matter, I hold that hold that company was not justified in repudiating the claim because while issuing the policy w.e.f 01.02.2010 by the present insurer, the complainant is covered continuously without any break since 2003. Complainant was under the bonafide belief while getting the mediclaim policy issued from the present insurer, that he would be getting continuity benefit in current policy. It is also worth considering, the earlier mediclaim policies were also issued from the public sector company. In my considered view complainant deserves to be given continuity benefit of the earlier policies and having due regards of the same, complainant becomes entitled to the payment of the claim. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 92,360.**

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.**

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DELHI OMBUDSMAN CENTRE

Case No. GI/341/NIA/11
In the matter of Sh. B.C. Gupta
Vs New India Assurance Company Ltd.

AWARD DAATED 12.9.2012 INADEQUATE SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. B.C.Gupta (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 he had submitted a mediclaim bill to the New India Assurance Company Ltd. for an amount of Rs. 56,304 on 02.03.2011 but he was paid only a sum of Rs. 41885 on 09.08.2011. He has requested the company to convey him reasons for less payment of claim but company had not responded any reply from there also. He has come to this forum with the request to help him in getting balance amount of the claim. During the course of hearing, complainant stated that though he put up a claim of Rs. 56304 but he was paid only a sum of Rs. 41885. He pleaded that he was not provided the reasons for short payment. He had provided all requisite documents to the insurance company to enable it to settle the claim.**

3. **Representative of the company stated that claim was settled as per policy terms and conditions. Company also filed written reply dated 07.05.2012 wherein it has been stated that 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 07.05.2012 as well as process sheet giving the details of the deductions while settling the claim. After due consideration of the matter, I hold that claim was not properly settled because deductions have been made despite the fact that insured had provided the details of the various items claim and supportive evidence. Careful perusal of the detailed submissions compel me to hold 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. 14119.**

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/338/Bajaj/11
In the matter of Sh. Chandrakant Jha
Vs Bajaj Allianz General Insurance Company Ltd.

AWARD DATED 12.9.2012 REPUDIATION OF OMP CLAIM

1. **This is a complaint filed by Sh. Chandra Kant Jha (herein after referred to as the complainant) against the decision of Bajaj Allianz Gen. Ins. Co. Ltd. (herein after referred to as respondent Insurance Company) relating to repudiation of mediclaim under OMP.**

2. **Complainant stated that he had submitted his claim to M/s Bajaj Allianz General Insurance Company Ltd. and submitted all requisite documents along with the claim. he also submitted replies to various letters to the insurance company. He submitted travellage Identification and schedule policy number OG-11-1101-000000298 covering the period from 12.08.2010 to 07.02.2011. The coverage subsequently was extended up to 18.02.2011. He further submitted that no proposal form before of Travellage had been supplied to him. Therefore, the question of submission of travel proposal from does not arise. He further informed that he was treated at Credit Valley Hospital, Mississauga Canada and spent 747.91 Canadian dollars. He further informed that he had fallen ill with acute severe chest pain, headache, heart palpitation, fever etc. He was compelled to report at Credit Valley hospital for treatment on 30.12.2010. He has come to this forum with a request to get the claim settled. During the course of hearing, complainant stated that he had taken overseas mediclaim policy before going to Canada. While in Canada, he fell ill and got treated after getting admission in the hospital and there after submitted the claim. Though claim was payable but the company repudiated it.**

3. **Company was not represented during the course of hearing.**

4. **I have considered the submissions of the complainant I did not have the benefit of verbal submissions, 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 there is no doubt about the fact that while going abroad the complainant had taken overseas mediclaim policy and while in Canada, the insured fell ill, got admitted in the hospital and was treated and also paid the charges for treatment. In my considered view claim is payable. Accordingly an Award is passed with the direction to the insurance company to make the payment of admissible amount equallent to 647.91 Canadian dollars.**

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

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

DELHI OMBUDSMAN CENTRE

Case No. GI/354/UII/11
In the matter of Sh. P.L. Gandhi
Vs United India Insurance Company Ltd.

AWARD DATED 14.9.2012 NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. P.L. Gandhi (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 mediclaim.**

2. **Complainant stated that he had submitted the claim to United India Insurance Company Ltd. he has also approached the company but the claim was not settled though considerable time had already elapsed. She has come to this forum with request to get the claim settled at an early date. During the course of hearing, son of the complainant submitted that claim was filed late and explanation for late submission of the claim was filed. He further informed that the patient had already expired. He pleaded that claim is a payable and all requisite documents relating to claim were already submitted.**

3. **Representative of the company stated that claim would be settled. Company did not file any reply despite a specific direction to that effect.**

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. Complainant had submitted all requisite documents relating to the claim. Even then the claim was not settled. I have perused the details relating to the claim which are placed on recorded, I find that the 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.**

DELHI OMBUDSMAN CENTRE

Case No. GI/352/UII/11
In the matter of Sh. Muzaffar Azim
Vs United India Insurance Company Ltd.

AWARD DATED 14.9.2012 PARTIAL SETTLEMENT OF MEDICLAIM.

1. **This is a complaint filed by Sh. Muzaffar Azim (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 partial settlement of mediclaim.**

2. **Complainant stated that his mother Mrs. N.Azim was hospitalized at the Indraprastha Apollo Hospital, Sarita Vihar, New Delhi from 27.04.2011 to 30.04.2011 for undergoing operation for the removal of Gall blader stone, which was detected on 24.04.2011 by ultrasound as per advice of Dr. Biswas at Bansal Hospital, New Friends Colony, New Delhi. He requested for the cashless facility by submitting pre authorization form but such facility was denied to him. He submitted the claim for an amount of Rs. 56025 as per the discharge voucher dated 14.05.2011. The company had settled the claim by making payment of Rs. 42236 as against the total claim of Rs. 56025. During the course of hearing it was pleaded**

that claim was not settled properly. He also pleaded that company did not settle the claim in respect of an amount of Rs. 800. It has been desired in the complaint that a complaint to be registered against the insurance company for denial of cashless facility and for wrong deductions in the reimbursement.

3. **Representative of the company stated that claim was settled properly. Company also filed reply.**

4. **I have considered the submissions of the complainant as well as of the representative of the company. I have perused the documents on record. After due consideration of the matter, I hold that company had not settled the claim properly as it had made certain deductions which were not actually called for. In my considered view company was not justified in making deductions of Rs. 5843, Rs. 301, and Rs. 5563 on account of package, investigation, and OT Consumables respectively. Accordingly complainant is further found entitled to a sum of Rs. 11707. It is not possible to accede to the request of the complainant for registering complaint against the insurance company as desired by him as same is outside the purview of the undersigned.**

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/291/NIC/11

In the matter of Sh. V.M. Gupta
Vs National Insurance Company Ltd.

AWARD dated 14.9.2012 INADEQUATE SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. V.M. 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 inadequate settlement of mediclaim.**

2. **Complainant stated that he had already approached the GRO of the company but he had not been favored with any solution to his problem. It is found that complainant had been taking mediclaim policy for the last 4 to 5 years without any break with National Insurance Company Ltd. He was hospitalized in Forties Escort Heart Institute on 02.03.2010 with the complaint of heaviness in chest since last two months. He submitted the bill for pre and post hospitalization expenses for an amount of Rs. 1,98,262 on 30.04.2010 to M/s Vipul Medicorp Ltd. As epr his mediclaim policy of Rs. 2,40,000 (S.I + C.B), his claim has been settled for Rs. 1,17,000. He further submitted that the claim was not properly settled. He has come to this forum with a request to get the balance claimt paid. During the course of hearing, it was pleaded by the complainant that claim was not settled adequately.**

3. **Representative of the company stated that claim is settled with reference to sum insured of Rs. 1,50,000. Complainant had taken mediclaim policy in 2005 to 2006 with sum insured of Rs. 1,50,000, the sum insured was increased to Rs. 2 lacs in 2006 to 2007. He further stated that complainant had not submitted the discharge voucher for receipt of Rs. 29001. Company did not file any reply.**

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 did not settle, the claim properly. Company was not justified in settling the claim with reference to pre enhanced sum insured of Rs. 1,50,000 because there is no waiting period for the disease for which the patient was treated. In case of the complainant for settlement of the claim, The enhanced sum insured has to be taken into account. Thus it is held that the claim has to be settled with reference to enhanced sum insured of Rs. 2,00,000 plus communitive bonus. This is also held**

further that there is no caping in respect of communative bonus. The same has to be given to 100% because it is not a part of sum insured but additional benefits to the insured. The complainant is entitled to a sum of Rs. 2,32,500. Accordingly an Award is passed with the direction to the insurance company to make the payment of difference of Rs. 2,32,000 and amount already released by way of cashless and other wise.

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/253/UII/11

In the matter of Sh. Gopal Prakash Gupta
Vs United India Insurance Company Ltd.

AWARD DATED 14.9.2012 NON SETTLEMENT OF MEDICLAIM

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

2. **Complainant stated that he was admitted in Emergency situation on 22.03.2011 at Max hospital, Saket New Delhi where at it was diagnosed that he had suffered heart attack. On 23.03.2011 Angiography was performed on him. on 25.03.2011, he was shifted from Max Hospital to Indraprastha Apollo Hospital, New Delhi for immediate bypass surgery. He was discharged from Apollo hospital on 03.04.2011. Claim papers including bills of the hospital were submitted on 16.04.2011. The bill included Apollo hospital standard package deal of Rs. 292,000 for bypass surgery. The matter was perused with Vipul Medicorp TPA sent discharge voucher for Rs. 1,80,255 against the total claim of Rs. 3,15,564 but it was not accepted by him. He further stated that another discharge voucher for revised amount of Rs. 198103 was received by him vide TPA letter dated 11.07.2011 mentioning that same is based on his room rent entitlement of Rs. 5000 per hay, TPA have reduced the various items of package deal of Rs. 292,000 (having room rent of Rs. 9500 per day) proportionately to Rs. 184,710. He further informed that Apollo hospital**

package amount was based on his room entitlement of Rs. 5000 per day. The Apollo hospital package based on room rent of Rs. 5000 per day is Rs. 2,25,000 so instead of paying only Rs. 184710 against the total deal package of Rs. 292,000 TPA should pay him based on the standard package amount of Rs. 2,25,000 plus other approved expenses. However, the TPA refused to settle his claim. He has come to this forum with request to direct the insurance company to immediately settle the claim considering the packaged of Rs. 2,25,000. During the course of hearing complainant submitted that as per package deal he is entitled a sum of Rs. 2,25,000, if he had taken the room rent entitled category. Sum insured is Rs. 5 lacs and thus patient was entitled to a room rent of Rs. 5000 per day.

3. **Representative of the company stated that 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 documents placed on record. After due consideration of the matter, I hold that company was not justified in not settling the claim as per terms and conditions of the policy. The claim is required to be settled with reference to entitled room rent category and as per this criteria and as stated by Apollo Hospital, the Complainant is entitled to total claim of Rs. 2,25,000. Company had already partially settled the claim. Therefore, in my considered view complainant is further needs to be paid difference of Rs. 2,25,000 and amount already paid. Accordingly and Award is passed with the direction to the insurance company to make the payment of Rs. 2,25,000 less the amount already paid to the insured.**

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

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

DELHI OMBUDSMAN CENTRE

<u>Case No. GI/370/UII/11</u>
<u>In the matter of Sh. Satish Arora</u>
<u>Vs United India Insurance Company Ltd.</u>

<u>AWARD DATED 20.9.2012 NON SETTLEMENT OF MEDICLAIM</u>

1. This is a complaint filed by Sh. Satish Arora (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 mediclaim.

2. Complainant stated that company had not settled the claim. As advised he had already sent his representation to the GRO of the company but he did not get any response from there too. He has come to this forum with request to get the claim settled. He did not attend the hearing.

3. Representative of the company was requested to submit the report in this case within reasonable time.

4. I have considered the submissions of the complainant as made in the complaint. Representative of the company had not submitted any report so far. On behalf of letter dated 19.02.2010 written by claims department to Divisional Manager, I find that clarification was sought by claims department, from Divisional manager whether claim could be processed on the basis of photocopies of the documents filed by the complainant. I consider it fair and reasonable to hold that claim is payable. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 1061.

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/296/NIA/11
In the matter of Sh. Kuldeep Aggarwal
Vs
New India Assurance Company Ltd.

AWARD DATED 20.9.2012 INADEQUATE SETTLEMENT OF MEDICLAIM

1. This is a complaint filed by Sh. Kuldeep Aggarwal (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 Smt. Bhawna Aggarwal who was covered under mediclaim policy was admitted in Maharaja Agrasen hospital due to high fever. She was hospitalized because she was advised to get admitted in the hospital. Claim was submitted after the discharge from the hospital for an amount of Rs. 56373 but he had been paid only a sum of Rs. 20,000. He has come to this forum with a request to get him paid the balance amount. During the course of hearing, it was argued on behalf of the complainant that company was not justified to make deductions of Rs. 36,373 while settling the claim. The company had paid only a sum of Rs. 20,000 as cashless facility as against the total claim of Rs. 56,373.**

3. **Representative of the company stated that claim will be reconsidered on Receipt of the original documents. Insured had not submitted the requisite documents.**

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 properly. Company had allowed the cashless facility only to the extent of Rs. 20,000. Insured had made the payment to the hospital in respect of balance amount of Rs. 36,373. In my considered view complainant needs to be further paid a sum of Rs. 35829/-. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 35829.**

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/369/UII/11
In the matter of Sh. Anup Srivastava
Vs
United India Insurance Company Ltd.

AWARD DATED 20.9.2012 PARTIAL SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Anup Srivastava (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 partial settlement of medi claim.**

2. **Complainant stated that he had health insurance policy issued by United India Insurance company. His wife Smt. Swati Srivastav had under gone a surgery at Dr. Kamlesh Tondon Nursing home and Maternity home, 4/48, Lajpat Kunj, Agra and was hospitalized from 27.01.2011 to 30.01.2011. complainant further stated that he submitted all the requisite documents in support of his claim on 12.02.2011. other queries raised by the TPA were also complied with by him. Original receipt was also given but the claim was not settled even after 8 months and he was losing his faith in the insurance company for delaying the payment of the claim. He has come to this forum with a request to get the claim paid. During the course of hearing, complainant submitted that claim was partially settled by the insurance company because company had paid only a sum of Rs. 29,158 as against the total claim of Rs. 47047. He requested to ensure payment of balance amount.**

3. **Representative of the company insisted upon the production of original receipt of Rs. 15,000.**

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 17.11.2011 and also the email dated 10.09.2012. After due consideration of the matter, I hold that complainant is found further entitled to a sum of Rs. 12,800 on account of procedures and on account of pharmacy. Company was not justified in making deduction on account of Procedure and pharmacy. Accordingly an Award is passed with the direction to the insurance company to make the further payment of Rs. 12,800.**

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/377/OIC/11
In the matter of Sh. Hari Krishan Maurya
Vs
Oriental Insurance Company Ltd.

AWARD DATED 20.9.2012 REPUDIATION OF MEDICLAIM

1. **This is a complaint filed by Sh. Hari Krishan Maurya (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 admitted in Indraprastha Apollo Hospital with severe chest pain. At the hospital CAG was done and diagnosed as IHD Acute Inferior wall MI, Sever Single Vessel Disease. He was treated in the hospital and was discharged. At the time of admission hospital has requested for cashless treatment but TPA had rejected the cashless facility on ground of 4.1 clause of the policy. He did not have any history of disease. He had submitted all requisite documents for reimbursement of the claim. He approached the insurance company's office a number of times and he was informed all the times that his claim is under process. However, he shocked to know that his claim was rejected. He has come to this forum with a request to settle the claim as soon as possible. During the course of hearing also complainant stated that claim is payable but company had denied it.**

3. **Representative of the company stated that claim is not payable due to clause 4.3 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 repudiation letter and other documents placed on record. After due consideration of the matter, I hold that**

company was not justified in repudiating the claim because claim is payable. the disease for which treatment was taken by the patient and claim was preferred did not have any waiting period. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 2,34,431.

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/273/UII/11
In the matter of Sh. Pradeep Gambhir
Vs
United India Insurance Company Ltd.

AWARD DATED 20.9.2012 NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Pradeep Gambhir (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 not settlement of mediclaim.**

2. **Complainant stated that as advised, he had sent his representation to the GRO of the company but he did not get any reply. He had approached this forum with a request to instruct the insurance company to settle his claim under the policy. He further informed that he had taken mediclaim policy known as Super Top up policy. Before taking the policy from the present insurer, he had taken insurance policies from New India Assurance Company Ltd. He put up a claim relating to treatment of his wife Smt. Ritu Gambhir and submitted requisite documents relating to claim to TPA mediassist Pvt. Ltd. for reimbursement of the claim. Company denied the claim citing 4.3 clause of the policy. He has submitted that the clause 4.3 of the policy is not applicable in his case as he had been taking mediclaim policy for the last 7 to 8 years. During the course of hearing, the complainant pleaded that he had been taking mediclaim policy without any break for many years.**

3. **Representative of the company stated that he needed time to submit reply. He was allowed 15 days time to submit reply but no reply was submitted so far.**

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 on the ground of clause 4.3 of the policy because complainant has been taking mediclaim policy for the last 7 to 8 years in continuation without any break. In my considered view complainant deserves to be given continuity benefit. Therefore, claim is held as admissible. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 65,240.**

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.**

GUWAHATI OMBUDSMAN CENTRE

Complaint No. 11-002-094/11-12

Dr. Utpal Sarma

- Vs -

New India Assurance Co. Ltd.

Date of Order : 17.08.2012

Complainant: The Complainant stated that he procured Janata Mediclaim Policy No. 530900/34/09/14/00000072 for his entire family members from the New India Assurance Co. Ltd. covering the period from 20.05.2009 to 19.05.2010. While the policy was in force, his mother Mrs. Nani Sarma Devi was admitted in Nightingale Hospital, Guwahati on 22.03.2010 and was discharged on 24.03.2010. Thereafter, the Complainant lodged a claim before the Insurer along with all supporting documents. It is alleged that the claim was treated as "No Claim" by the Insurer without any justified ground and communicated their decision to the Complainant

vide letter dated 21.09.2010. Being aggrieved, the Complainant has filed this complaint.

<u>Insurer</u> : The Insurer has stated in their "Self Contained Note" that the Insured was repeatedly requested by their E-Meditek TPA Services Ltd. to submit very essential document settle the claim. But the Insured failed to submit the complete documents in due time. So, their TPA treated the claim as "No Claim".

<u>Decision</u> : The copy of Claim Form submitted by the Complainant to the Insurer goes to show that the Complainant lodged a claim for Rs.1,32,100.00 in connection with hospitalization and treatment of his mother Mrs. Nani Sarma Devi in Nightingale Hospital, Guwahati from 22.03.2010 to 24.03.2010. The copies of Discharge Certificates from Nightingale Hospital, Guwahati discloses about Hospitalization and treatment of Mrs. Nani Sarma Devi for the above mentioned period. According to the Complainant, his mother was suffering from Cancer and she obtained Chemotherapy treatment in the above Hospital. He has also alleged that although he submitted all the claim related documents, the Insurer has not yet settled the claim. The representative of the Insurer stated that their TPA has rejected the claim stating that they have not received some documents / information from the Complainant. In supporting his contention he produced the copy of letter from E-Meditek TPA Services Ltd. which is marked as Annexure – C. It discloses from the Annexure – C that the TPA requested the Insured to submit the following document:-

(1) They received bills of Apollo Hospital without any Discharge Certificate. They requested to provide exact plot of treatment and original Discharge Certificate.

Due to non-receipt of the above document, the Insurer has rejected the claim of the Complainant vide repudiation letter dated 21.09.2010. The Complainant also failed to produce any Discharge Certificate from Apollo Hospital before this Authority. The Complainant stated in his statement that he did not claim any Apollo Hospital's bills. He claimed only Nightingale Hospital's bill. Since the Complainant did not claim any Apollo Hospital's bills, there is no question of submission of Discharge Certificate from Apollo Hospital. Hence, the Insurer is advised to settle the claim on the basis of bills of Nightingale Hospital only.

Under the above facts and circumstances, the Insurer was accordingly directed to settle the claim within 15 days allowing penal interest @ 8% P.A. on the settled amount.

<u>GUWAHATI OMBUDSMAN CENTRE</u>

<u>Complaint No. 11-009-032/11-12</u>

Mr. Ajay Kr. Gupta

- Vs -

Reliance Gen. Insurance Co. Ltd.

<u>Date of Order : 24.04.2012</u>

<u>Complainant</u>: The Complainant stated that he procured Reliance Healthwise Policy No. 1511792825000266 from the above Insurer for entire family member covering the period from 23.08.2009 to 22.08.2010. While the policy was in force, his wife Mrs. Suman Gupta was hospitalized in Max Health Care, New Delhi on 21.02.2010 for operation of multiple Cyst Right Lobe of Thyroid wherefrom she was discharged on 25.02.2010. After completion of usual treatment, the Complainant had submitted a claim before the Insurer seeking re-imbursement of the expenses incurred in connection with her hospitalization and treatment in the above Hospital. It is alleged that the Insurer has repudiated the claim holding that the claim is not payable in view of Exclusion Clause No. 1 of the policy. Being aggrieved, the Complainant has filed this complaint.

<u>Insurer</u> : The Insurer has stated in their "Self Contained Note" that as per the submitted documents in PA vide Prescription of Dr. P. Chowbey fax dated 19.02.2010 the patient suffered from K/C/O B/L Thyroid Nodule with Rt. Lobe Thyroid Cyst, FNAC done & found Colloid Nodular Goitre with Cystic changes (Multiple). The Patient was hospitalized from 21.02.2010 to 25.02.2010 for Endoscopic Rt. Lobectomy which was done on 22.02.2010. Since Beneficiary is covered from 23.08.2008 so the disease is PED to the inception of the policy hence merits repudiation as per Policy Exclusion Clause 1 of RGICL HW Policy. The

Insured was informed about the inability to process the claim through a letter dated 20.04.2010.

<u>Decision :</u> The fact of having the Health Insurance coverage is not in dispute and the Insurer has also admitted about receiving the claim from the Complainant. The copy of Discharge Summary issued by Max Hospital, New Delhi shows that Mrs. Suman Gupta was admitted in that Hospital on 21.02.2010 and was discharge on 25.02.2010 and during hospitalization period an operation was done on 22.02.2010 for Endoscopic Right Lobectomy. The patient was diagnosed with Multiple Cyst Right Lobe of Thyroid. The copy of Claim Form makes it clear that the Complainant lodged his claim before the Insurer on 15.03.2010 being supported by all papers. The Complainant, in his statement, has stated that the Insurer has repudiated the claim on the ground of pre-existing disease. The "Self Contained Note" as well as copy of repudiation letter dated 20.04.2010 from TPA – Medi Assist disclose that the claim is not payable as the patient suffered from K/C/O B/L Thyroid Nodule with Rt. Lobe Thyroid cyst, FNAC done on 2003 and found colloid nodular goiter with cystic changes (multiple) before procuring the policy. Presently admitted (DOA 21.02.2010 and DOD 25.02.2010) for Endoscopic Rt. Lobectomy (Done on 22.02.2010). Since benefit covered from 23.08.2008 so the disease is pre-existing disease before inception of the policy hence merits repudiation as per Policy Exclusion Clause 1 of the policy. The Complainant has stated that the first policy was taken on 23.08.2007 and not on 23.08.2008. But the TPA wrongly mentioned the first commencement date of the policy as 23.08.2008 instead of 23.08.2007 in their repudiation letter. In support of his contention, he produced the copies of policy documents since 23.08.2007. On perusal of the copies of policy documents, it reveals that the policy period 23.08.2009 to 22.08.2010 was his third years policy. It is clearly mentioned in the terms and conditions of the Reliance Health Policy that in case of pre-existing disease, this policy covers relevant medical expenses incurred from the 3rd year of the policy after 2 continuous renewals of this policy with the Company. It appears that that the Complainant lodged his claim on 15.03.2010 which is 3rd year of the policy coverage.

Under the above facts and circumstances, it is ample clear that the Complainant lodged the claim on 3rd year of the policy after 2 continuous renewal of the policy and the Insurer is liable to settle the claim of the Complainant as per policy condition. The Insured is entitled to receive the claim amount. The Insurer is

accordingly directed to settle the claim within 15 days from the receipt of this order. With this observation, the complaint is disposed of.

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GUWAHATI OMBUDSMAN CENTRE

Complaint No. 11-011-117/11-12

Mr. Prafulla Borah

- Vs -

Bajaj Allianz General Insurance Co. Ltd.

Date of Order : 10.09.2012

Complainant: The Complainant stated that he procured Suraksha Policy No. OG-09-2405-6014-00004459 from the above Insurer covering the period from 07.11.2008 to 06.11.2013. While the policy was in force, he was admitted in Popular Nursing Home, Patna on 19.11.2011 and was discharged on 30.11.2011. He thereafter lodged a claim before the Insurer alongwith all supporting documents. But the Insurer has repudiated the claim without any justified ground. Being aggrieved, the Complainant has filed this complaint.

Insurer : The Insurer has stated in their "Self Contained Note" that on receipt of the documents it is understood that the Complainant got admitted at Popular Nursing Home, Patna on 19.11.2011 for the treatment of disease "Old # (Rt) proximal humerus (treated elsewhere) – Diabetic" as stated in Discharge slip of Popular Nursing Home. Thus it is clear that the patient was admitted for implant removal from old fracture proximal humerus whereas the scope of the policy is only for accidental hospitalization during the policy period. From the contents of the Case Summary of Good Health Hospital, Guwahati it is gathered that the Complainant "Mr. Prafulla Baruah had a H/c of fall on level ground on 20.10.2010 severe pain developed and he had to be admitted to Good Health Hospital on 22.10.2010. On examination it was found that he suffered 3 part fracture RT proximal humerus. Emergency management had to be done with IV fluid

analgerics, antibiotics etc. Clinically he was diagnosed to be a case of fracture neck humerus". In view thereof it is clear that the Complainant underwent a treatment for which no claim intimation was made nor any claim registered during the period 22.10.2010. In view of the foregoing it is clear that the claim does not come under the scope of the policy and hence not admissible and merits repudiation.

<u>Decision :</u> The copy of the policy document discloses that the Complainant Mr. Prafulla Borah obtained the Suraksha Policy No. OG-09-2405-6014-00004459 from the Bajaj Allianz General Insurance Co. Ltd. covering the period from 07.11.2008 to 06.11.2013. According to the Complainant, during the period covered under the policy, his right hand was fractured due to accidental fall. First he was treated at Baptist Christian Hospital, Tezpur and they referred him to Guwahati for better treatment. It appears from the copy of the Discharge Certificate from Good Health Hospital, Guwahati that Complainant Mr. Prafulla Borah was hospitalized in that Hospital on 22.10.2010 and was discharged on 27.10.2010. The disease was diagnosed with 3 part Fracture Proximal Humerus Rt. Comminutted Diabetes and treatment was provided for Proximal Humerus locking plate fixation. After few months the Complainant felt trouble in the same place. Again he consulted with his treating Doctor at Pratiksha Hospital, Guwahati on 02.08.2011 who certified that the implant became loose. The treating Doctor referred the Complainant to Dr. John Mukhopadhaya of Popular Nursing Home, Patna on 05.11.2011. The copy of Discharge Certificate from Popular Nursing Home, Patna discloses that Mr. Prafulla Borah was admitted in that Hospital on 19.11.2011 and was discharged on 30.12.2011 after necessary treatments. During that hospitalization period, the old implant was removed and new implant was fixed. Thereafter, the Complainant lodged a claim being the expenses incurred in connection with his treatment in Popular Nursing Home, Patna before the Insurer being supported by documents. It is apparent from the copy of repudiation letter dated 19.12.2011 that the claim of the Complainant was repudiated on the plea that the patient was admitted for implant removal from old fracture proximal humerus. The scope of the policy is only for accidental hospitalization, hence the claim is not payable. The representative of the Insurer stated that on verification of the claim documents, they found that the treatment was done for removal of implant from right shoulder and re-fixing it using bone graft for an old injury sustained one year back and as per Discharge Certificate, date of injury was one year old. They repudiated the claim on the ground that implant was removed from old fracture. There was no history mentioned in the Discharge Certificate that it occurred due

to accident. They did not receive any claim intimation for past hospitalization in Good Health Hospital, Guwahati for the period from 22.10.2010 to 27.10.2010 nor any claim was registered for the same. It is crystal clear from the above mentioned documents that the Complainant suffered right hand fracture due to accidental fall on 20.10.2010 for which he was hospitalized in Good Health Hospital, Guwahati for the period from 22.10.2010 to 27.10.2010. It is apparent that the accident occurred during the coverage of the above policy. The Complainant stated that he did not claim for expenses incurred in connection with his hospitalizations at Tezpur and Guwahati. He also stated that treatment for the above fracture was still going on so that he did not claim the first hospitalization. The copies of the medical documents also prove that the treatment of the Complainant was going on for a long period. Finally problem occurred in the same place for which he was treated and hospitalized earlier at Tezpur and Guwahati. Again he had to hospitalize for the same problem. Since it was a continuous treatment of earlier accidental fall, the second hospitalization and treatment of the Complainant at Patna is definitely for the same accidental fall. Hence, the repudiation of the claim by the Insurer cannot be said to be proper and justified. The Insurer is liable to settle the claim of the Complainant in respect of the admissible bills for treatment at Popular Nursing Home, Patna.

Considering all the aspects of the matter, I have no hesitation to hold that the decision of repudiation of the claim by the Insurer is not justified. In the result, this complaint is allowed. Insurer was accordingly directed to settle the claim within 15 days allowing penal interest @ 8% P.A. on the settled amount.

GUWAHATI OMBUDSMAN CENTRE

Complaint No. 11-003-151/11-12

Mrs. Anu Bordoloi

- Vs -

United India Insurance Co. Ltd.

Date of Order : 12.04.2012

Complainant: The Complainant stated that her husband Dr. T.N. Bordoloi procured Mediclaim Policy No. 130300/48/09/97/00000252 from the United India Insurance Co. Ltd. covering the period from 19.03.2010 to 18.03.2011. While the policy was in force, her husband was hospitalized at Brahmaputra Diagnostics & Hospital Limited, Dibrugarh on 28.05.10 due to both kidney failure and during hospitalization, he expired on 27.07.2010. Thereafter, the Complainant, being the nominee under the policy, lodged a claim before the Insurer alongwith all supporting documents. But, the Insurer has repudiated the claim without any justified ground. Being aggrieved, the Complainant has lodged this complaint before this Authority.

Insurer : The Insurer has stated in their "Self Contained Note" that the Insured suffered from Hypertensive (HTN) for last 20 years and the patient was under medication for last 10 years for which their panel doctor opined it to be pre-existing disease and in terms of clause 4.1 of the policy, claim results due to pre-existing disease, is outside the scope of coverage of the policy and accordingly they have repudiated the claim.

Decision : It is an admitted fact that the Insured died on 27.07.2010 while the aforesaid policy was in force. Lodging the claim under the policy with all supporting documents has also not been disputed. The copy of repudiation letter dated 11.03.2011 shows that the Insurer repudiated the claim on the ground that the Insured Dr. T.N. Bordoloi was suffering from Hypertensive (HTN) for last 20 years and he was under medication for last 10 years, which falls under condition of Exclusion 4.1 of the policy. Hence, under the above conditions, they are not in a position to settle the claim and treated the claim as "NO CLAIM". The Complainant in her statement has stated that her husband was hospitalized at Brahmaputra Diagnostics & Hospital Ltd., Dibrugarh on 28.05.2010 due to both kidney failure and during hospitalization, he expired on 27.07.2010. However, she cited that her husband died due to both kidney failure only. She has further stated that her claim is genuine and the Insurer has repudiated her claim without any justified ground. The representative of the Insurer has stated that they have repudiated the claim on the ground of pre-existing disease and in terms of clause 4.1 of the policy as the Insured suffered from Hypertensive (HTN) for last 20 years and the patient was under medication for last 10 years. He has further stated that if the claim occurred after 48 months, that too without any disease which is existed, the claim would have been payable, but since the claim reported within 39

months from the first policy, the claim is not payable as per clause 4.1 of the policy. In the copy of History Sheet dated 28.05.2010 issued by the Brahmaputra Diagnostics & Hospital Limited, Dibrugarh it is mentioned that the patient is Hypertensive (HTN) for last 20 years on regular medication and for 10 years on medication. But, to substantiate this claim of pre-existing disease, the Insurer has failed to produce any medical certificate or treatment particulars prior to commencement of the policy. For taking such a drastic decision like repudiation of a claim, the burden on the Insurer is very heavy to prove that the patient had pre-existing disease prior to taking of the policy. They must prove by submitting medical certificate, laboratory test report, treatment details etc. prior to commencement of the policy to show that before taking up the mediclaim policy, the patient had any pre-existing disease. But, in the instant case, the Insurer has failed to prove that prior to taking up the policy, the patient Dr. T.N. Bordoloi was suffering from Hypertension.

Considering all the aspects of the matter as discussed above, I have no hesitation to hold that the decision of repudiation of the claim by the Insurer on the ground of pre-existing disease is not justified. In the result, this complaint is allowed holding that the Complainant is entitled to received the claim amount. Insurer was accordingly directed to settle the claim within 15 days allowing penal interest @ 8% P.A. on the settled amount.

GUWAHATI OMBUDSMAN CENTRE

Complaint No. 11-002-063/11-12

Mrs. Mitali Saikia

- Vs -

New India Assurance Co. Ltd.

Date of Order : 27.07.2012

Complainant: The Complainant stated that she was an insured under the above "Janata Mediclaim Policy" procured from the above Insurer covering the period from 23.05.2009 to 22.05.2010. It is stated that on 07.11.2009, the Insured was admitted for treatment in the All India Institute of Medical Sciences, New Delhi wherefrom she was discharged on 13.11.2009. On completion of usual treatment,

the Insured had submitted a claim before the Insurer and it is alleged that the Insurer has repudiated the claim without any justified ground. Being aggrieved, the Complainant has filed this complaint.

Insurer : The Insurer has stated in their "Self Contained Note" that the TPA has repudiated the claim applying policy clause No. 4.4.13 in which the pregnancy or pregnancy related complications are not covered in the policy. On scrutiny of medical documents by the Doctor of TPA, it is confirmed by them that the patient was hospitalized and treated for pregnancy related complications.

Decision : The fact of having insurance coverage under the above policy is not in dispute and the Insurer has also not disputed about hospitalization and treatment of the Insured within the period covered under the policy. According to the Complainant, she was hospitalized in the All India Institute of Medical Sciences, New Delhi (AIIMS) on 07.11.2009 and she was discharged from that Hospital on 13.11.2009 incurring expenditure of Rs.42,147.00. Accordingly, she lodged a claim for the said amount before the TPA of the Insurer being supported by documents. The claim of the Complainant has been repudiated by the Insurer on the ground that the pregnancy or pregnancy related complications are not covered under the above mediclaim policy. The copy of repudiation letter dated 27.03.2010 from the E-Meditek – (TPA) Services Ltd. shows that patient was admitted with C/O incontinence of urine after LSCS on 26.08.2009. H/O obstructed labour with uterine rupture. DIAG- LT. Uretero vaginal fistula (Post LSCS). Pregnancy related complication not payable under clause No. 4.4.13. The Complainant has produced the copy of Discharge Summary of All India Institute of Medical Sciences, New Delhi (AIIMS) which is marked as Annexure – III. It appears from Annexure – III that the Complainant was admitted in the above Hospital for Developed Urine incontinence with complaint of normal voiding in between. H/O LSCS 26th August, 2009 (Previous LSCS – 2003). The hospitalization and treatment given at All India Institute of Medical Sciences, New Delhi (AIIMS) during the period from 07.11.2009 to 13.11.2009 was a part of her continuous treatment of the LSCS on 28.08.2009. Representing the Insurer, Mr. Bipul Gogoi has stated that their TPA, E-Meditek has repudiated the claim as per policy condition No. 4.4.13. In support of his contention, he has produced the terms and conditions of Mediclaim Policy (2007) before this Authority which is marked as Annexure – B. He has highlighted the relevant exclusion clause 4.4.13 wherein the exclusion clause No. 4.4.13 under the above policy reads as under :-

4.4.13 - Treatment arising from or traceable to pregnancy, childbirth, miscarriage, abortion or complications of any of these including caesarean section, except abdominal operation for extra uterine pregnancy (Ectopic Pregnancy), which is proved by submission of Ultra Sonographic Report and Certificate by Gynecologist that it is life threatening one if left untreated.

The above policy exclusion clause clearly discloses that pregnancy, childbirth, miscarriage, abortion or complications of any of these including caesarean section are not covered and expenses incurred for such treatment are not payable under the above policy. The Insurer has repudiated the claim applying the above policy exclusion clause.

Keeping in view the above circumstances, the Complainant had taken treatment for pregnancy related complication in the above cited Hospital during the period from 07.11.2009 to 13.11.2009. As per policy conditions, the claim of the Complainant is not payable in view of the policy exclusion clause No. 4.4.13 and hence repudiation of the claim by the Insurer is found to be without any irregularity. This being the position, the complaint is treated as closed finding no scope to interfere with the decision of the Insurer.

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GUWAHATI OMBUDSMAN CENTRE

Complaint No. 11-002-012/11-12

Mrs. Mohila Saikia

- Vs -

Oriental Insurance Co. Ltd..

Date of Order : 24.05.2012

Complainant: The Complainant stated that she procured Individual Mediclaim Policy No. 322406/48/2011/119 from the above Insurer covering the period from 30.04.2010 to 29.04.2011. While the policy was in force, he was admitted in Sri Sankaradeva Nethralaya. After completion of usual treatments, she lodged a claim for Rs.17,755/- before the Insurer being supported by documents. But, the Insurer has repudiated the claim without any justified ground. Being aggrieved, he has lodged this complaint.

Insurer : The Insurer has stated in their "Self Contained Note" that the Complainant has taken medical treatment from Sankardeva Nethralaya, Guwahati w.e.f. 16.07.2010 - 17.07.2010 and she was diagnosed as Macular Hole – 04 Hypertension undergone a Retina correction surgery on 16.07.2010. The claim was repudiated on the ground that the correction of Retina is excluded under policy condition No. 4.3, 4.6 in the first year of the policy and this was intimated to the Insured on 02.12.2010.

Decision : There is no dispute in between the parties that the Complainant Mohila Saikia procured mediclaim policy No. 322406/48/2011/119 covering the period from 30.04.2010 to 29.04.2011 for a Sum Insured of Rs.50,000/-. It is stated by the Complainant that she was hospitalized in Sri Sankaradeva Nethralaya, Guwahati on 16.07.2010 and was discharged on 17.07.2010. During hospitalization, a hole was detected in her Right Eye and operation was done on 16.07.2010. Thereafter, he lodged a claim for Rs. 17,755/-/- before the Insurer along with all supporting documents being the expenses incurred in connection with her treatment. From the copy of repudiation letter dated 02.12.2010, it is seen that the Insurer has

repudiated the claim on the ground that as per the policy condition Nos. 4.3, 4.6 of Exclusion in 1st year the correction of Ratina are not covered under the policy. Discharge Summary issued from Sri Sankaradeva Nethralaya, Guwhati shows that Mohila Saikia obtained treatment in that Hospital. It is mentioned in the Diagnosis that Macular Hole – OU Hypertension. It is also mentioned in the operation procedure that 23 G VIT+B.BLUE ASSISTED ILM PEELING+FGE+SF6 (RIGHT EYE) Under LA done by Dr. Satyen Deka. Discharge Certificate makes it clear that the patient Mohila Saikia was not treated for correction of Eye sight rather she underwent Macular Hole Surgery. This surgery is evidently not covered within the Exclusion Clause 4.6 of the policy conditions.

Under the above facts and circumstances of the case, I hold that the decision of the Insurer in repudiating the claim of the Complainant is not based on justified ground and hereby decision of repudiation is set aside. The Complainant is entitled to get the entire claim amount. The Insurer is accordingly directed to settle the claim within 15 days from the receipt of this order. With this observation, the complaint is disposed of.

GUWAHATI OMBUDSMAN CENTRE

Complaint No. 11-011-115/11-12

Mrs. Shanti Baruah

- Vs -

Bajaj Allianz General Insurance Co. Ltd.

Date of Order : 06.06.2012

Complainant: The Complainant stated that he procured Mediclaim Policy No. OG-12-2405-8401-00000255 from the above Insurer for her son and herself covering the period from 23.06.2011 to 22.06.2012. While the policy was in force, she felt severe pain in knee part in the month of October & November, 2011. She went to Chennai for treatment in Apollo Hospital and she was admitted in that Hospital on 30.11.2011 and was discharged on 24.12.2011. During hospitalization period, spine surgery was done on 01.12.2011. After completion of usual treatments, she lodged

a claim before the Insurer along with all supporting documents. But the Insurer has repudiated the claim without any justified ground. Being aggrieved, the Complainant has filed this complaint.

<u>Insurer</u> : The Insurer has stated in their "Self Contained Note" that they received the claim papers from the Complainant. On studying the same, they found that the Complainant was admitted into the Hospital for treatment of Thorocic Spine Decompression + Fusions necessitating surgery. Provisions laid down under C3 of the policy states "Any Medical expenses incurred during the first four consecutive annual periods in connection with joint replacement surgery, surgery for prolapsed inter vertebral disc (unless necessitated due to accident), Surgery to correct deviated nasal septum and hypertrophied turbinate, congenital internal diseases or anomalies for laser treatment for correction of eyesight due to refractive error". The surgery underwent by the Complainant is a surgery for prolapsed into vertebral disc which does not come under the scope of the policy within first four consecutive annual periods during which the Complainant has the benefit of Health Guard Policy with them which is waiting period for such treatment to be entertained under the policy. The policy of the Complainant commenced on 23.06.2011 and she had no such insurance coverage with them for any previous consecutive period.

<u>Decision</u> : It is apparent from the copy of policy document that Mrs. Shanti Baruah obtained Individual Health Gaurd Policy No. OG-12-2405-8401-00000255 for her son and herself from the above Insurer covering the period from 23.06.2011 to 22.06.2012. According to the Complainant, she lodged a claim under the above policy before the Insurer seeking reimbursement of the expenses incurred in connection with her treatment during the period from 30.011.2011 to 24.12.2011. But the Insurer has repudiated the claim without any justified ground. The representative of the Insurer stated that the Insured Mrs. Shanti Baruah was hospitalized for treatment of Thorocic Spine Decompression + Fusions necessitating surgery. The surgery underwent by the Complainant is a surgery for prolapsed into vertebral disc which does not come under the scope of the policy within first four consecutive annual periods during which the Complainant has the benefit of Health Guard Policy with them which is waiting period for such treatment to be entertained under the policy. The policy was taken for the first time and the treatment of the above disease was during the first year of the operation of the policy. Under this condition, the claim is not admissible. The Insurer has produced the terms and conditions of Health Guard Policy Document before this Authority which is marked as Annexure – B. It is clearly mentioned in C (B) of the policy

terms and conditions that Any Medical expenses incurred during the first four consecutive annual periods in connection with joint replacement surgery, surgery for prolapsed inter vertebral disc (unless necessitated due to accident), Surgery to correct deviated nasal septum and hypertrophied turbinate, congenital internal diseases or anomalies for laser treatment for correction of eyesight due to refractive error. The copy of policy document (Annexure – II) discloses that the Insured Mrs. Shanti Baruah obtained the said policy covering the period from 23.06.2011 to 22.06.2012 from the Bajaj Allianz General Insurance Co. Ltd. for the first time.

In the case in hand, the Complainant sought reimbursement of the expenses incurred in connection with her treatment in Apollo Hospital, Chennai during the first year of operation of the policy. It is ample clear that the Complainant has failed to fulfill the criteria in accordance with the terms and conditions of the policy.

Under the above facts and circumstances, I have no hesitation to hold that the Insurer has rightly repudiated the claim of the Complainant. Finding no ground to interfere with the decision of the Insurer, the complaint is dismissed and is treated as closed.

KOCHI

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/ KCH/GI/11-005-216/2011-12

Shri K K Thomas

Vs.

Oriental Insurance Co.Ltd.

Award dated 10.4.2012

The complainant and his family members were covered under a mediclaim policy taken with the above Insurer. When his daughter was hospitalized for a surgical removal of an extra growth on her forehead, a claim was preferred towards expenses incurred. The same was repudiated by the insurer for the reason that hospitalization was not necessary in this instance. As the complainant felt that he is eligible for the reimbursement of expenses incurred by him on this count, this complaint.

Records were perused and hearing held. A perusal of the hospital records shoed that the daughter of the complainant underwent excision of dermoid under local anaesthesia. The respondent-insurer cannot claim that there was no active line of treatment during hospitalization when the above excision was done during hospitalization which was followed by the doctor's advice for one week's rest. There is nothing in the medical records to suggest that hospitalization was not required. The rejection has no legal basis at all. Hence the repudiation is not sustainable.

The complainant had spent an amount of Rs. 3188/- . In the result, an award is passed directing the respondent-insurer to pay Rs. 3188/- with cost of Rs. 500/- to the complainant within the time prescribed failing which the amount shall carry interest at 9% pa from the date of complaint (15.6.11) till payment is effected.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/ KCH/GI 11-005-245/11-12

M P Nishath

Vs.

Oriental Insurance Co Ltd

Award dated 22.5.2012

The complainant's mother, who was covered under a mediclaim policy with the above insurer, was hospitalized. When a claim was preferred, it was rejected. Her appeals to the higher offices did not yield any result. Hence this plea.

Records were perused and hearing held. The hearing was attended only by the complainant. The insurer did not even submit the self-contained note. It is found from the available documents that the TPA had rejected the claim for the reason that there was a break of 30 days in the renewal of the policy in 2009 and the ailment for which treatment was taken was a pre-existing one. However, umpteen circumstances were available which would support the contention taken by the complainant that the policy was issued in continuity of insurance cover. One is that no fresh proposal was called for from the complainant at the time of issuing policy in the disputed year. Another circumstance was that the previous policy number was also mentioned in the fresh policy issued and cumulative bonus accrued had been carried over. So, when the policy is in continuity, the question of pre-existence of disease does not arise, thus tiding over clause 4.1.

In the result, an award is passed directing the insurer to pay Rs. 20628/- with cost of Rs. 1000/- to the complainant within the period prescribed failing which Rs. 20628/- shall carry interest @ 9% pa from the date of filing of complaint (27.6.11) till payment is effected.

<u>OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI</u>

Complaint No. IO/ KCH/GI 11-005-270/11-12

Thomas Varghese

Vs.

Oriental Insurance Co Ltd

<u>Award dated 30.5.2012</u>

The complainant and his wife were covered under a health insurance policy with the above insurer. When a claim was preferred towards expenses incurred on his wife's hospitalization, the same was repudiated. Hence this complaint.

Records were perused and hearing held. The respondent-insurer's representative submitted that the complainant's wife had undergone treatment in connection with a disease she was suffering from for the last two months. Hence, the claim was repudiated on the ground that it was pre-existing and also on the ground that the patient contracted the ailment during the first 30 days from the commencement date of the policy. As per the medical certificate issued by the attending doctor, the complainant should have contracted the ailment before two months from the date of surgery. As per the exclusion clause cited by the respondent-insurer, the 'company shall not be liable to make any payment in respect of expenses incurred by an insured person in connection with or in respect of any disease other than those stated in clause 4.2 contracted by the insured during the first 30 days from the commencement date of the policy. Pre-existing disease contemplates a situation wherein the insured had already been afflicted with the ailment prior to the inception of the policy. Hence, in the policy conditions which govern the policy issued to the complainant, there is no exclusion clause with regard to pre-existing disease. So, even if the ailment is a pre-existing one, the same is not excluded under the policy. By repudiating the claim, much inconvenience had been caused to the complainant.

In the result, an award is passed directing the respondent-insurer to pay Rs. 28870/- (being the expense incurred) with cost of Rs. 2000/- to the complainant within the period prescribed failing which Rs. 28870/- shall carry interest at 9% pa from the date of filing of complaint (4.7.11) till payment is effected.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/ KCH/GI/11-005-293/11-12

A Prakash

Vs.

Oriental Insurance Co Ltd. Award dated 6.6.2012

The complainant had a mediclaim policy which covered his father also. His father underwent angioplasty for which he preferred a claim with the insurer. The same was repudiated on the ground that the patient suffered from hypertension and diabetes even prior to the inception of the policy. However, the complainant submitted that it was a mistake which crept into the discharge summary. However, his case was not reconsidered. Hence, the complaint.

Records were perused and hearing held. The officer representing the respondent-insurer submitted that in the two discharge summaries and two certificates issued by the attending doctors, there is consistent mention that the father of the complainant was suffering from the diseases mentioned herewith; they had conducted an enquiry into the new certificate submitted from the same hospital and it was found that the hospital records do not justify the contents of the new certificate. On a scrutiny of the medical certificates, it is found that there is mention that the patient had history of DM and HTN but the term history cannot be stretched or explained to mean that those ailments were pre-existing, without any specific and conclusive evidence as to when onwards the patient was suffering from those ailments. So, also, the complainant had produced the results of various investigations and examinations done and none of the reports would reveal that the father of the complainant was suffering from Diabetes/HTN. Hence, the ailments were not pre-existing.

In the result, an award is passed directing the respondent-insurer to pay to the complainant, an amount of Rs. 100000/-(max eligible limit) within the period prescribed failing which, the amount shall carry interest @ 9% pa from the date of complaint (13.7.11) till payment. No cost.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/ KCH/GI/11-003-292/11-12

Joseph Saigal

Vs.

National Insurance Co Ltd.

Award dated 6.6.2012

The complainant was covered under a mediclaim policy with the above insurer. He underwent angioplasty for which he preferred a claim. It was repudiated under clause 4.1 of the policy conditions. As there was no response from the Grievance Cell for the representation made to the Insurer, this complaint.

Records were perused and hearing held. As per the respondent-insurer's representative, the policy was issued subject to the exclusion of hypertension and as per policy conditions, expenses for treatment of pre-existing diseases are admissible only after four continuous claim free years. A perusal of the records revealed that this is a case where the complainant had voluntarily disclosed in the proposal form submitted by him for taking the policy that he was suffering from Hypertension. Such disclosure was made based on the medical report issued by the doctor who examined him. In the said report, the doctor had stated that he was suffering from Hypertension for the last five years, on treatment. So, there is the admission on the part of the complainant that he was hypertensive at the time of taking the policy which is supported by the contents of the medical report. Hence, the complainant is estoped from raising a contention that he was never hospitalized for treatment in connection with hypertension and as such, it is not pre-existing.In the result, the complaint is dismissed. There is no order as to cost.

Kolkata Ombudsman Centre

Case No. 203/11/002/NL/07/2011-12

Shri Biswanath Majumder

Vs.

The New India Assurance Company Ltd.,

Order Dated : 20.04.2012

Facts & Submissions :

Both the parties were called for a personal hearing on 16.04.2012. The complainant attended and submitted the grounds of his complaint. He informed that he has received a cheque of Rs.1.25 lakh against the claimed amount of Rs.1.40 lakh. He stated that the IDV once fixed cannot be varied and requested for settlement of the balance amount of Rs.15,000/-. The representative of the insurance company on the other hand reiterated their stand as mentioned in their written submission dated 29.02.2012 and discussed above. They have filed valuation certificates of 3 surveyors stating the correct IDV of the vehicle should be between Rs.1.25 lakh to Rs.1.30 lakh.

DECISION:

The complainant has approached this forum for settlement of his balance amount of theft claim of Rs.15,000/-, which was deducted by the company on the ground that the IDV of the vehicle was on the higher side as the vehicle was very old. From the perusal of the documents we find that the total loss has been established by the final police report as well as the investigator and there is no dispute in this respect. In order to justify the settlement at a lower IDV, the insurance company have submitted valuation certificates from 3 surveyors, who have estimated the correct IDV of the vehicle between Rs.1.25 lakh to Rs.1.30 lakh. However, we find that the IDV of the insured vehicle was fixed at Rs.1.40 lakh and the same was accepted by the insurance company and the premium was charged accordingly. Under the tariff rules, the IDV is decided by negotiation and mutual agreement and generally, there is no scope for its variation. Hence, at the time of settlement the insurance company cannot allege that the IDV is on a higher side. Moreover, there is also variation in the valuation certificates and therefore, it cannot be conclusively said that the correct IDV of the vehicle should be Rs.1.25 as decided by the insurance company.

After careful evaluation of all the facts and circumstances of the case we are of the opinion that the valuation determined by the insurance company is not justified after accepting the IDV of Rs.1.40 lakh. The decision of the insurance company is set aside. They

are directed to settle the claim at Rs.1,39,000/- (Rs, 1,40,000/- less policy excess of Rs. 1000/-) and pay the balance amount.

Kolkata Ombudsman Centre
Case No. 282/11/003/NL/08/2011-12

Shri Arup Kumar Basu

Vs.

National Insurance Company Ltd.,

Order Dated : 17th April, 2012

Facts & Submissions :

Both the parties were called for a personal hearing on 12.04.2012. The complainant attended and submitted the grounds of his complaint. He stated that he was admitted in the hospital on the specific advice of the doctor who is the best judge of the situation. All the tests were performed as per doctor's advice over which he had no control. His claim is absolutely genuine and covered under the policy. The representative of the insurance company on the other hand reiterated their stand as mentioned in their written submission dated 12.03.2012.

DECISION:

The complainant has approached this forum against repudiation of his claim for hospitalization on the ground that this could have been done in OPD basis. From the documents submitted to this forum, we find that the complainant was suffering from very high fever upto 104 degree with vomiting and was admitted in the hospital as per the advice of the attending physician. During hospitalization various blood tests were conducted and he was diagnosed positive for Malaria (B.T. Malaria). The insurer has repudiated the claim under exclusion clause no. 4.10 of the policy with the plea that he was admitted for evaluation of the ailment and was given oral medicines which could have been done in OPD. From the prescription of Dr. Shivaji Chatterjee, it is clear that he took his first treatment on 20.09.2010 and again on 27.09.2010 but in the absence of improvement the same doctor advised admission in the hospital. Hence, it is evident that the primary intention of the insured was not to be hospitalized for evaluation of all the body parameters. Since he continued suffering from high fever with vomiting and there was not perceptible improvement in his condition, he was admitted as per doctor's advice. After undergoing necessary tests, he was diagnosed for malaria and treated for the same. However, we find number of tests were conducted which were not linked to his diagnosis.

After careful evaluation of all the facts and circumstances of the case, we are of the opinion that total repudiation of the claim is not justified in this case. The complainant's condition definitely warranted hospitalization following very high fever and as per doctor's advice he was admitted and treated for fever and malaria. However, considering that several tests, unrelated with the final diagnosis were also conducted, which could

have been done on OPD basis, we allow 50% of the admissible claim towards the treatment of malaria. The insurance company is directed to pay 50% of the admissible claim towards the treatment of malaria to the complainant within 15 days from the date of receipt of this award along with consent letter.

Kolkata Ombudsman Centre
Case No. 288/11/003/NL/08/2011-12

Shri Arindam Bhattacharya

Vs.

National Insurance Company Ltd.,

Order Dated : 27th April, 2012

Facts & Submissions :

Both the parties were called for a personal hearing on 23.04.2012. The complainant attended and explained the grounds of his complaint. He stated that his claim was arbitrarily repudiated by the insurance company on the ground of pre-existing disease for which there is no valid ground. The treating doctor has certified that the present surgery might not be related to the previous surgery done 4 years back. He also pointed out that all LUCS cases do not necessarily convert into incisional hernia. But this fact has not been appreciated by the insurance company. Since there is no conclusive evidence to link the present surgery to past history of LUCS, there is no valid ground to repudiate the claim. The representative of the insurance company on the other hand reiterated their stand as mentioned in their written submission dated 07.03.2012 and discussed above.

DECISION:

The complainant has approached this forum against repudiation of his mediclaim by the insurance company under policy clause no. 4.1 which excludes all pre-existing diseases for 4 continuous claim free years. From the discharge summary it is seen that the insured was admitted in the hospital for repair of incisional hernia. She had a past history of LUCS done 4 years back. The TPA repudiated the claim stating that the claim is non-admissible as it is related to previous surgery done in November 2007. The complainant has produced a certificate from the treating surgeon clarifying that the present surgery for repair of incisional hernia performed under his care and supervision cannot be conclusively related to the earlier surgery done 4 years back. As per Butterworth's Medical Dictionary Incisional Hernia means a protrusion of an internal organ through a defect in the wall of the Anatomical Cavity in which it lies or into subsidiary compartment of that Cavity. Although the Incisional Hernia may occur through a scar which is pre-existing in this case but there is no conclusive evidence that this has resulted directly from the pre-existing LUCS. The treating doctor is also of the opinion that the present surgery may not be related to the earlier surgery.

After careful evaluation of all the facts and circumstances of the case, we are of the opinion that benefit of doubt should be given to the insured in view of the certificate of the treating surgeon. The decision of the insurance company to repudiate the claim is set

aside. The insurance company is directed to admit the claim and settle the same as per terms and conditions of the policy.

Kolkata Ombudsman Centre
Case No. 342/11/003/NL/09/2011-12

Dr. Tapan Mukherjee

Vs.

National Insurance Company Ltd.,

Order Dated : 17th April, 2012

Facts & Submissions :

Both the parties were called for a personal hearing on 12.04.2012. The complainant attended and explained the grounds of his complaint. He stated that he did not receive any communication from the TPA after submitting his claim papers as the change in address was not updated in the records of the insurance company and the TPA's communications were sent to the old address. The representative of the insurance company on the other hand informed that they are ready to settle the claim and have called for the file from the TPA.

DECISION:

It is seen that the claim was not processed by the TPA as the TPA had sent 3 letters to the complainant at his old address which were not received by him. It is seen that the complainant had duly informed the insurer about the change in address and had also given the new address and telephone number in the claim form and the hospitalization papers. Under the circumstances, unilateral decision of the TPA to treat the claim as 'No claim' is highly unjustified and erroneous and the same is set aside. The insurer has now agreed to settle the claim. The complainant has claimed that he has submitted all the necessary papers. He is directed to cooperate with the Insurer and comply with their further requirement if any. The insurer is directed to settle the same as per terms and conditions of the policy within 15 days from the date of receipt of the claim file along with all necessary papers along with consent letter from the complainant.

Kolkata Ombudsman Centre
Case No. 362/14/002/NL/09/2011-12

Dr. Dhirendra Nath Nandi

Vs.

The New India Assurance Company Ltd.

Order Dated : 20th April, 2012

Facts & Submissions :

Both the parties were called for a personal hearing on 16.04.2012. The complainant was represented by his son Shri Parthasarathi Nandi, who submitted the grounds of complaint. He stated that there was no specific exclusion of this treatment in his policy conditions and there was no endorsement of internal circular dated 09.02.20009 in this regard on the policy schedule. He further stated that the claim is genuine and the same should be paid.

The representative of the insurance company on the other hand reiterated their stand as mentioned in their written submission dated 23.11.2011 and discussed above.

DECISION:

The complainant has approached this forum against the repudiation of his hospitalization claim for ARMD treatment by administering Lucentis injections on two occasions. The Insurer has repudiated the claim in view of the clarification issued by their Head Office vide internal Circular No. HO/HEALTH/CIRCULAR/04/2009-IBD-ADMN:14 dated 09.02.2009 issued by the insurer's Head Office, regarding coverage for the treatment of ARMD under the policy. According to their panel doctor's opinion; the said treatment is an OPD procedure and falls outside the scope of the health insurance cover. The Insurer has taken a stand that the treatment does not require hospitalization, nor it can be allowed under 'Day Care' treatment or under 'Advancement of treatment' clause. The complainant has, on the other hand, contended that there is no specific exclusion of the treatment in the policy condition. This argument is not tenable as the policy is primarily a hospitalization benefit policy and once the treatment is considered as OPD procedure, it gets automatically excluded from the scope of the policy. Therefore, it is not necessary to have a specific exclusion clause for this purpose. The complainant has filed a specialist's opinion from Dr. Rajvardhan Azad stating that the treatment is a surgical procedure and

not an OPD procedure. We are unable to accept this position, since it is not universally accepted by the medical fraternity and it varies from case to case.

As per the discharge summary, we find that the claim falls in the policy period from 03.05.2009 to 02.05.2010. The policy for this period was renewed subsequent to the issue of the Company's circular dated 09.02.2009 clarifying Company's stand on this issue. Therefore, the case of the insured is to be governed by the aforesaid circular, which does not allow the insurance coverage to the said treatment. Under the circumstances, the Insurer's decision to repudiate claim is as per the Departmental circular and cannot be termed as violation of policy conditions.

However, we find that the contents of the circular were not communicated to the insured at the time of renewal of the policy for 2009-10. Moreover, some other public sector insurers do allow this claim after a waiting period of two years. In his case, the policy is several years old. A sudden withdrawal of the benefit without any intimation has caused great agony and distress to the insured.

Considering all the above facts, we allow some relief to mitigate hardship of a senior citizen by way of ex-gratia payment of Rs.30,000/- which will meet the ends of justice. We 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. 468/11/017/NL/11/2011-12

Shri Ratan Kumar Choudhury

Vs.

Star Health and Allied Insurance Company Ltd.

Order Dated : 30th April, 2012

Facts & Submissions :

Both the parties were called for a personal hearing on 26.04.2012. The complainant attended and explained the grounds of his complaint. He stated that he has been insured since 09.02.2009 from the Oriental Insurance Company Ltd. and switched over to the present insurer w.e.f. 09.02.2008 and still continuing without any break. While renewing the policy the new insurer allowed the continuity of the policy without any break to the extend of Rs.1,75,000/- each for insured person. Since the claim has arisen in the 7th year of the policy, the exclusion clause 1 cannot be applied. He further alleged that the insurer did not clarify at the time of rollover that pre-existing diseases are not covered. On one hand they have committed continuity and on the other hand they have denied his claim, which is highly unfair.

The representative of the insurance company on the other hand reiterated their stand as mentioned in their written submission dated 23.12.2011 and discussed above.

DECISION:

The complainant has approached this forum against repudiation of his claim by the insurance company under exclusion clause no. 2.1 of the policy. It is seen that the complainant has been insured along with his family member with the Oriental Insurance Company Ltd. w.e.f. 09.02.2004 and after completion of 4 policy periods with the O.I.C he renewed his policy with the present insurer since 09.02.2008. The claim has arisen in the 3rd year of the policy period with the present insurer. It is further seen that while accepting the first insurance with Star Health and allied Insurance Company Ltd., the insurer covered him with the following endorsement:-

" In view of previous Mediclaim insurance particulars (1588/2007 of THE ORIENTAL INSURANCE Co. LTD.) submitted to the Company , this insurance will be deemed to be continuous without any break to the extent of Rs.1,75,000/- each for

insured persons Mr. Ratan Kumar Choudhury, Mrs. Uma Choudhury and of Rs.1,25,000/- insured person Mr. Subham Choudhury respectively.

In consequence of the above, the 30 days, 1st year, 2nd year exclusions will not be applicable up to Rs.1,75000/- each for insured persons Mr. Ratan Kumar Choudhury, Mrs. Uma Choudhury and of Rs.1,25,000/- insured person Mr. Subham Choudhury mentioned in the schedule of the policy. All other terms and condition of the policy remain unaltered."

The complainant was hospitalized during 12/12/2010 to 15/12/2010 and underwent laparoscopic operation for hernia. From the OPD case sheet it was revealed that the complainant has been suffering from the GERD symptoms for last three years and as per definition of pre-existing disease and policy exclusion, it can be covered only after 48 months of continuous coverage.

A careful reading of the above endorsement in the policy makes it clear that the Insurer has committed that the insurance will be deemed to be continuous without any break. Thus, the primary intention of the insurer as reflected from the wordings of the first para of the endorsement was to give benefit of continuity without any break, which should automatically result in waiver of all standard waiting periods for specific diseases including pre-existing diseases. The specific wordings in the endorsement "continuous without any break" do not have any meaning unless effect of continuity is given in respect of pre-existing diseases (waiver of exclusion clause 1) as the Insurer's policy already contains clause no. 5, which allows waiver of specific waiting periods of 30 days/1st year/2nd year under exclusion clause no.2/3/4 in case of the insured person/s having been covered under any insurance scheme with any of the Indian Insurance companies for a continuous period of preceding 12 months / 24 months respectively without any break. There was no need to make a specific endorsement in respect of these clauses. Hence, the only purpose of making a special endorsement in the policy allowing the benefit of continuity could be to waive the exclusion clause no. 1 and not exclusion clause nos. 2, 3 and 4 for which a provision (clause no 5) already exists in the policy. If otherwise, the insured stands to lose heavily and any benefit committed by the insurer becomes meaningless. Moreover, it was a natural expectation that after taking continuous policy since 2004 and paying heavy premiums, one will not lose the benefit of coverage for preexisting diseases. The new Insurer did not clarify specifically at the time of accepting the proposal that benefit of continuity cannot be extended to pre-existing diseases. This is

unfair and unjustified. Had it been clarified, the insured could have renewed the policy with the previous insurer. Since, the policy has been accepted as a continuous policy by the present insurer, the continuity starts from 2004 and any disease appeared in 2007 can not be considered as pre-existing.

After careful evaluation of all the facts and circumstances of the case we are of the opinion that the 2nd para in the endorsement made in the policy is quite vague and meaningless. It is also unfair to the insured and insurer's decision based on this endorsement is erroneous and the same is set aside. The insurance company is directed to admit the claim and settle the same as per terms and conditions of the policy within 15 days from the date of receipt of this award along with consent letter.

Kolkata Ombudsman Centre
Case No. 342/11/003/NL/09/2011-12

Dr. Nipanjan Ghosh

Vs.

Reliance General Insurance Company Ltd.,

Order Dated : 28th May, 2012

Facts & Submissions :

Both the parties were called for a personal hearing on 11.05.2012. The complainant attended and submitted the grounds of his complaint. He stated that the lump on his forehead was first noticed 4 months back and when it started growing rapidly, the doctor advised him for surgery as it had malignant potential.

The representative of the insurance company did not attend the hearing, we therefore propose to deal with matter ex-parte on the basis of their written submission and other material submitted to this forum.

DECISION:

The complainant has approached this forum against repudiation of his claim for surgery of a rapidly growing tumor on his forehead which was surgically removed under general anesthesia. It is seen from the prescription of Dr. Srijon Mukherji dated 30.11.2010 that the complainant was suffering from an enlarging fore head lump for last 4 months. There was no history of trauma and it was painless. He was advised admission for excision of the lump under G.A. and also histopathology test .Accordingly, he was admitted and operated upon. The insurer rejected the claim with the plea that there was no history of trauma and the operation was done only for cosmetic purpose. However, the insurer is silent on the fact of rapidly growing lump. No one can allow a lump to grow continuously though it may be benign. This is an abnormal condition of the body and needs correction by surgical intervention. The insurer has failed to support their theory that the removal of the lump was for cosmetic purpose.

After careful evaluation of all the facts and circumstances of the case, we are of the opinion that the insurer's decision to repudiate the claim under basic cover clause no. 1 and policy exclusion clause no. 22 is not based on strong grounds and the same is set

aside. The insurer is directed to admit the claim and settle the same as per terms and conditions of the policy within 15 days from the date of receipt of this award along with consent letter.

Kolkata Ombudsman Centre
Case No. 168/14/002/NL/06/2011-12

Smt. Anjali Ghosh

Vs.

The New India Assurance Company Ltd.,

Order Dated : 28th May, 2012

Facts & Submissions :

HEARING :

Both the parties were called for a personal hearing on 11.05.2012. The complainant attended and submitted the grounds of her complaint. She stated that her son sustained an accidental injury at home and was admitted in the hospital for operation on the specific advice of the surgeon. She also stated that she has submitted all the papers available with her and she is not responsible for misplacement of the x-ray plate and report of the hospital. She requested for early settlement of her claim on the basis of the documents submitted to this forum.

The representative of the insurance company on the other hand attended and submitted that their investigation is still incomplete and requested for further time.

DECISION:

The complainant has approached this forum for delay in settlement of her claim for non-submission of papers required by the insurance company. From the case record, we find that the complainant's son sustained an injury to maxillary bone due to an accidental fall at home. As per the advice of the Dental Surgeon he was hospitalized for corrective surgery. A claim was lodged with the TPA and they further requested for the following documents:-

- **i) Self statement of injury,**
- **ii) Original x-Ray plate and report,**
- **iii) Copy of treatment sheet and O.T. Note.**

The complainant could submit only first one, i.e., self statement of injury. For x-ray the surgeon has given certificate that the said report has been misplaced by the institution. As regards the treatment papers and OT note, the insurance company has also admitted that it is not possible for the insured to collect the papers from the hospital. They are therefore of the view that TPA should have deployed the investigator into the case and collect the

requisite document. By not doing so they have ignored the claim procedural management resulting into hardship to the insured. It is further seen from the discharge certificate that the insured had undergone surgery under GA for reduction of maxillary bone. The TPA/insurer has not raised any question about the nature of the surgery. Mere non submission of x-ray plate/ report should not make the claim inadmissible as the complainant has submitted all other supporting documents like doctor's prescription and advice for surgery, discharge certificate of the hospital, final bill of the hospital, payment receipts etc. Moreover the insurer has also not approved the way it has been rejected by the TPA and we are also unable to give more time to the TPA to complete their investigation as the claim is already two years old.

After careful evaluation of all the facts and circumstances of the case, we are of the opinion that the insurance company has no valid reasons for closing the matter unilaterally. They are directed to admit the claim without insisting any further document and settle the same as per terms and conditions of the policy within 15 days from the date of receipt of this award along with consent letter.

Kolkata Ombudsman Centre

Case No. 506/11/005/NL/11/2011-12

Shri Rabindra Nath Sen

Vs.

The Oriental Insurance Company Ltd,

Order Dated : 28th May,2012

Facts & Submissions :

Both the parties were called for a personal hearing on 11.05.2012. The complainant attended and submitted the grounds of his complaint explaining the reasons for delay in submission of the claim form. He stated that both he and his wife were admitted in the hospital at the same time and after their discharge there was nobody at home to help them in preparing the claim form. Both of them are old and were very weak after discharge and were advised to take rest for 2 months. Considering these facts, the delay should have been condoned by the insurance company.

The representatives of the insurance company on the other hand reiterated their stand as mentioned in their written submission dated 19.04.2011 and discussed above.

DECISION:

The complainant has approached this forum for repudiation of his claim as he could not submit his claim papers within the prescribed time limits. It is seen that the TPA has repudiated the claim mechanically citing condition no. 5.5 which stipulates that claim should be submitted within 7 days after discharge from the hospital. They have not commented on the merit of the claim and they have also not examined the reasons and circumstances for the delay in submission of the claim papers. It is seen from the case records that the , couple who are elderly citizens aged 67 years and 57 years, were hospitalized together for malarial disease. After their discharge, they were very weak and were advised to take rest for 2 months. There was no other person at home to assist them in the matter of claim submission. Their explanation is found satisfactory and convincing. The reasons, in our opinion are sufficient to condone the delay but the insurance company has not given any serious thought to this aspect. In this respect we refer to IRDA Circular No. IRDA/HLTH/MISC/CIR/216/09/2011 dated 20.09.2011 which lays down certain guidelines dealing with the delayed claims which states as under :-

The insurers' decision to reject a claim shall be based on sound logic and valid grounds. It may be noted that such limitation clause does not work in isolation and is not absolute. One needs to see the merits and good spirit of the clause, without compromising on bad claims. Rejection of claims on purely technical grounds in a mechanical fashion will result in policyholders losing confidence in the insurance industry, giving rise to excessive litigation.

Therefore, it is advised that all insurers needs to develop a sound mechanism of their own to handle such claims with utmost care and caution. It is also advised that the insurers must not repudiate such claims unless and until the reasons of delay are specifically ascertained, recorded and the insurers should satisfy themselves that the delayed claims would have otherwise been rejected even if reported in time.'

From the submissions of the insurance company, we find that they have not dealt with the matter with due care and caution and have also not disputed the genuineness and merit of the claim.

After careful evaluation of all the facts and circumstances of the case, we are of the opinion that the decision of the insurance company to repudiate the claim under exclusion clause no. 5.5 is not based on sound logic and valid grounds and the same is set aside. The insurer is directed to condone the delay, admit the claim and settle the same as per other terms and conditions of the policy within 15 days from the date of receipt of this award along with consent letter.

Kolkata Ombudsman Centre
Case No. 507/11/005/NL/11/2011-12

Dr. Tapan Mukherjee

Vs.

The Oriental Insurance Company Ltd.,

Order Dated : 28th May, 2012

Facts & Submissions :

Both the parties were called for a personal hearing on 11.05.2012. The complainant attended and submitted the grounds of his complaint explaining the reasons for delay in submission of the claim form. She stated that both she and her husband were admitted in the hospital at the same time and after their discharge there was nobody at home to help them in preparing the claim form. Both of them are old and were very weak after discharge and were advised to take rest for 2 months. Considering these facts, the delay should have been condoned by the insurance company.

The representatives of the insurance company on the other hand reiterated their stand as mentioned in their written submission dated 19.04.2011 and discussed above.

DECISION:

The complainant has approached this forum for repudiation of her claim as he could not submit her claim papers within the prescribed time limits. It is seen that the TPA has repudiated the claim mechanically citing condition no. 5.5 which stipulates that claim should be submitted within 7 days after discharge from the hospital. They have not commented on the merit of the claim and they have also not examined the reasons and circumstances for the delay in submission of the claim papers. It is seen from the case records that the couple who are elderly citizens aged 67 years and 57 years, were hospitalized together for malarial disease. After their discharge, they were very weak and were advised to take rest for 2 months. There was no other person at home to assist them in the matter of claim submission. Her explanation is found satisfactory and convincing. The reasons, in our opinion are sufficient to condone the delay but the insurance company has not given any serious thought to this aspect. In this respect we refer to IRDA Circular No. IRDA/HLTH/MISC/CIR/216/09/2011 dated 20.09.2011 which lays down certain guidelines dealing with the delayed claims which states as under :-

The insurers' decision to reject a claim shall be based on sound logic and valid grounds. It may be noted that such limitation clause does not work in isolation and is not absolute. One needs to see the merits and good spirit of the clause, without compromising on bad claims. Rejection of claims on purely technical grounds in a mechanical fashion will result in policyholders losing confidence in the insurance industry, giving rise to excessive litigation.

Therefore, it is advised that all insurers needs to develop a sound mechanism of their own to handle such claims with utmost care and caution. It is also advised that the insurers must not repudiate such claims unless and until the reasons of delay are specifically ascertained, recorded and the insurers should satisfy themselves that the delayed claims would have otherwise been rejected even if reported in time.'

From the submissions of the insurance company, we find that they have not dealt with the matter with due care and caution and have also not disputed the genuineness and merit of the claim.

After careful evaluation of all the facts and circumstances of the case, we are of the opinion that the decision of the insurance company to repudiate the claim under exclusion clause no. 5.5 is not based on sound logic and valid grounds and the same is set aside. The insurer is directed to condone the delay, admit the claim and settle the same as per other terms and conditions of the policy within 15 days from the date of receipt of this award along with consent letter.

Kolkata Ombudsman Centre
Case No. 199/14/004/NL/07/2011-12

Shri Anup Kumar Sahu

Vs.

United India Insurance Company Ltd.,

Order Dated : 25th June, 2012

Facts & Submissions :

Complaint No. :

HEARING:

Both the parties were called for a personal hearing on 18.06.2012. The complainant attended and explained the grounds of his complaint. He stated that the insurance company has erroneously overlooked his previous policy with the National Insurance Company Limited which was duly disclosed to the Divisional Manager at the time of taking the new policy and the Divisional Manager had confirmed its continuity.

The representative of the insurance company also confirmed that the policy has been continued without any break and the claim has arisen in the 3rd year of the earlier policy taken from National Insurance Company Ltd.

DECISION:

The complainant has approached this forum against repudiation of claim by the insurance company under exclusion clause no. 4.3 of the policy. It is seen that the complainant, an employee of Sahara India Parivar was covered under the company's Group Mediclaim Policy with National Insurance Company Ltd. from 01.04.2008 to 31.03.2009 and again from 01.04.2009 to 31.03.2010. In 2010 he switched over to the present insurer and renewed his policy without any break effective from 01.04.2010 to 31.03.2011. We also find that he had disclosed about the existence of his previous policies with National Insurance Company Ltd. as the earlier policy numbers are endorsed in the present policy under the head 'previous policy number'. The insurance company has remained silent

against the representation of the complainant that he had duly disclosed full details of his earlier policies to the Divisional Manager who had confirmed continuity of the policy and the same was endorsed by mentioning the previous policy number in the new policy. Thus, it is very clear that the claim has arisen in the 3rd year the policy without any break and the claim for Cholecystitis is payable as per the terms and conditions. This fact is not also disputed by the representative of the insurance company. We, therefore, set aside the erroneous decision of the insurance company and direct them to admit the claim and settle the same as per terms and conditions of the policy within 15 days from the date of receipt of this award along with consent letter.

Kolkata Ombudsman Centre

Case No. 262/11/009/NL/07/2011-12

Shri Krishna Kumar Agrawal

Vs.

Reliance General Insurance Company Ltd.,

Order Dated : 25th June, 2012

Facts & Submissions :

Both the parties were called for a personal hearing on 18.06.2012. The complainant attended and explained the grounds of his complaint. He stated that his claim was arbitrarily repudiated by the insurance company stating that the disease was pre-existing. He submitted that the previous hernia was operated in 1997 and there is no link between the old hernia and the present disease which occurred after 13 years during which period he did not suffer any problem.

The representative of the insurance company on the other hand reiterated their stand as mentioned in their written submission dated 25.04.2012 and discussed above.

DECISION:

The complainant has approached this forum against repudiation of his claim for hernia operation which took place during 3rd year of the policy. The claim was repudiated under policy exclusion clause no. 1 & 2 on the ground that the complainant did not disclose about the previous hernia operation he had undergone in 1997. On perusal of the policy schedule it is found that policy allows coverage of pre-existing diseases after 2 or 4 continuous renewal subject to the plan opted and hernia operation is covered after one year of taking the policy. From the discharge summary of the hospital and other medical records, we do not find any valid and strong ground to repudiate the claim as a successful hernia operation done in 1997 cannot be considered as pre-existing disease in 2010 i.e., after 13 years. As per the definition of pre-existing disease in the policy condition it means ***"a chronic disease/illness/injury and consequences of such disease/illness/injury existing or known to exist at the commencement of the policy period, even if the same has not been treated, including disease/illness/injury treated or for which medical advice has been sought in the last six months before commencement of the policy period and including their consequences".***

In this case the previous hernia had occurred 13 years ago in 1997 and the patient did not have any complication or problems during this long period. The insurance company has not established that the earlier disease was a chronic condition existing at the

commencement of the policy period and the insured had sought the advice of the doctor in the last six months. Therefore, the present condition can not be treated as pre-existing as per the above definition.

After careful evaluation of all the facts and circumstances of the case, we are of the opinion that the decision of the insurance company to repudiate the claim under exclusion clause no. 1 & 2 of the policy is erroneous and same is set aside. The insurer is directed to admit the claim and settle the same as per terms and conditions of the policy within 15 days from the date of receipt of this award along with consent letter.

Kolkata Ombudsman Centre
Case No. 690/11/009/NL/02/2011-12

Shri Rajesh Kumar Singh

Vs.

Reliance General Insurance Company Ltd.

Order Dated : 29th June, 2012

Facts & Submissions :

Both the parties were called for a personal hearing on 18.06.2012. The complainant attended and explained the grounds of his complaint. He stated that his claim was arbitrarily rejected by the insurance company on the ground that he had a history of pre-existing HTN on the basis of the prescription of the doctors of Balaji Heart Centre. He contented that this inference is not correct as he was on these drugs for treatment of 'Antiproteinurea' 5-6 years ago. He submitted the doctor's certificate as well as treatment papers in this regard. He further stated that the HTN was actually detected sometimes in September 2009 as confirmed by Dr. Virendra Prasad Sinha of Balaji Heart Centre, Patna. He also referred to the discharge summary of All India Institute of Medical Sciences, New Delhi, where there is no mention of any history of HTN.

The representative of the insurance company on the other hand reiterated their stand as mentioned in their written submission dated 25.04.2012 and discussed above.

DECISION:

The complainant has approached this forum against repudiation of his claim for heart surgery on the ground of pre-existing HTN. It is seen that the insurer has repudiated the claim based on a prescription dated 04.10.2009 of Dr. Virendra Prasad Sinha of Balaji Heart Centre, Patna wherein he had mentioned 'HTN-5-6 years on Amlodepine 2.5' and Losar-25' The complainant has strongly disputed this inference and contended that this particular comment of the doctor cannot be taken as a proof of pre-existing HTN. He has further clarified that he was under treatment for Antiproteinurea and was prescribed these two drugs as Antiproteinurea agent. In support of his contention, he has submitted copies of the prescriptions of the treating doctor Dr. Pankaj Hans of Dr. Ruban Memorial Hospital between 02.02.2003 to 30.03.2003, which clearly show that the treatment continued for over 2 months after which Dr. Pankaj Hans had advised to stop all medicines. The complainant has also produced a certificate from Dr. Pankaj Hans dated 13.10.2010 confirming that the patient was suffering from post infectious glomerulonephritis and was prescribed these medicines for control of this condition and not for the treatment of HTN. In fact, we find that HTN was detected sometimes in September 2009 as confirmed by the certificate of Dr. Virendra Prasad Sinha. If we look at

the discharge summary of AIIMS hospital, we find that he was diagnosed as a patient of HTN but doctor has not recorded past history of HTN indicating that HTN was a recent detection. The insurance company has failed to produce any evidence to counter the various certificates produced by the complainant.

After careful evaluation of all the facts and circumstances of the case, we are of the opinion that the main ground of repudiation has not been established by the insurance company with any strong documentary evidence. On the other hand, the complainant has produced several documentary evidence including prescriptions from reputed doctors confirming that HTN was recent detection. Under the circumstances the insurance company's decision to repudiate the claim is found to be erroneous and the same is set aside. The insurance company is directed to admit the claim and settle the same as per terms and conditions of the policy within 15 days from the date of receipt of this award along with consent letter.

Kolkata Ombudsman Centre
Case No. 341/11/003/NL/09/2011-12

Shri Shib Sankar Bhowmick

Vs.

National Insurance Company Ltd.,

Order Dated : 29th June, 2012

Facts & Submissions :

Both the parties were called for a personal hearing on 12.04.2012. The complainant attended and submitted the grounds of his complaint. He stated that he is insured with the present insurer since 1999 and according to the provision of the clause no. 4.1 any pre-existing ailments (DM & HTN) are covered after 4 claim free years.

The representative of the insurance company on the other hand reiterated their stand as mentioned in their written submission dated 29.03.2012 and discussed above.

DECISION:

The complainant has approached this forum for delay in settlement of the claim. However, he claimed that he has submitted all the required documents on 10.06.2010 followed by number of reminders to the insurer but without any result. On examination of the policy schedule submitted to this forum, it is found that the complainant was enjoying 30% N.C.B for the relevant policy period 23.07.2008 to 22.07.2009 indicating that he has been insured continuous for at-least last 6 years. Hence automatically all the pre-existing diseases are covered as per clause no. 4.1 and there was no need for the TPA to ask for a certificate from the treating doctor regarding the history of HTN and DM. It is seen that the TPA has closed the claim without looking into the past insurance record of the claimant. We, therefore, direct the insurance company to verify the records and if 4 claim free years have been covered then the claim becomes admissible. In that case, they are directed to admit the claim and settle the same as per terms and conditions of the policy within 15 days from the date of receipt of this award along with consent letter.

Kolkata Ombudsman Centre
Case No. 461/11/003/NL/11/2011-12

Smt. Kamlesh Gupta

Vs.

National Insurance Company Ltd.,

Order Dated : 28th May, 2012

Facts & Submissions :

Both the parties were called for a personal hearing on 11.05.2012. The complainant was represented by her husband Shri Satish Kumar Gupta who explained the grounds of complaint. He stated that the insurance company has made huge deductions from her wife's total claim and did not give the benefit for the full sum insured of Rs.2.50 lakh and CB. He further contented that his wife's claim is fully payable considering the policy cover upto Rs.2.50 lakh.
The representative of the insurance company on the other hand reiterated their stand as mentioned in their written submission dated 23.12.2011 and discussed above.
DECISION:
The complainant has approached this forum against partial repudiation of her claim for knee replacement surgery on the ground that the benefit of enhanced sum insured is not available. As per the Insurer's record (not disputed by the party) the complainant was covered under mediclaim policy as per details given below-

Policy period	Sum Insured	C.B	Insurer
04/02/2005 to 03/02/2006	100000	Nil	With UII
04/02/2006 to 03/02/2007	100000	Nil	NIC
04/02/2007 to 03/02/2008	100000	15000	NIC
04/02/2008 to 03/02/2009	100000 Additional=75000	20000	NIC
04/02/2009 to 03/02/2010	100000 75000 Additional=75000	25000 3750	NIC
04/02/2010 to 03/02/2011	100000	15000	NIC

	75000 75000	nil	

The claim for total knee replacement occurred during 6th policy year. Hence the claim for knee replacement due to osteoarthritis was admissible as per policy condition no 4.3 para 3, but it was restricted to the SI prior to enhancement as per condition no. 5.3. The said condition stipulates as under- :

"5.12. Sum Insured under this policy can be enhanced only at the time of renewal up to next higher slab if sum insured under expiring policy is up to Rs.100000/- and next two higher slabs if sum insured under expiring policy is above Rs.100000/- subject to satisfactory medical check up with regard to health of the insured person and acceptance of additional premium for enhanced Sum Insured. However, continuing or recurrent nature of diseases/complaints which the insured has ever suffered will be excluded from the scope of cover so far as enhancement of Sum Insured is considered."

The prescription of Dr. P. K. Banerjee dated 17/12/2008 filed along with her first complaint registered under complaint no. 458/11/003/NL/11/2011-12 shows that she was having complaints of pain in both knees. More over it is of common knowledge that osteoarthritis is a chronic ailment for which knee replacement is the final stage of treatment. Hence, condition no 5.12 of the policy will be applicable for this disease and accordingly, the Sum Insured has been correctly considered by the insurer at Rs.1,00,000/- + C.B. of Rs.15,000/- (reduced one step due to claim in the previous year), ignoring the enhanced SI and CB. However, we find that the calculation of admissible amount is slightly erroneous and the following additional amount is payable to the complainant by the insurer.

Heads	Amount allowable under the policy in relation to sum insured and CB (Rs.1,15,000/-)	Amount eligible	Amount allowed	Difference to be paid by insurer.
Room Rent	1% for 5 days	Rs. 5,750/-	Rs. 5,000/-	Rs. 750/-
Doctor's Fees	25%	Rs.28,750/-	Rs.25,000/-	Rs.3,750/-
Others	50%	Rs.57,500/-	Rs.50,000/-	Rs.7,500/-
Total:-		Rs.92,000/-	Rs.80,000/-	Rs.12,000/

After careful evaluation of all the facts and circumstances of the case, we are of the opinion that an additional amount of Rs.12,000/- under different heads is payable to the insured. The insurance company is directed to pay Rs.12,000/- (Rupees twelve thousand) only to the complainant within 15 days from the date of receipt of this award along with consent letter.

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

Shri Sundeep Daga

Vs.

The Oriental Insurance Company Ltd.

Order Dated : 23rd July, 2012

Facts & Submissions :

Both the parties were called for a personal hearing on 16.07.2012. The complainant attended and explained the facts and grounds of his complaint. He stated that he had no history of sinusitis, he was only suffering from nasal obstruction which was cured by the surgery. The Insurance company has not established history of chronic sinusitis with any supporting documents or expert opinion.

The representative of the insurance company on the other hand reiterated their stand as mentioned in their written submission dated 26.06.2012 and discussed above.

DECISION:

The complainant has approached this forum against repudiation of his claim for surgery of Inferior Turbinates Hypertrophy on the ground that the disease was an after effect of long standing sinusitis which is excluded for first two years from the policy inception. The claim has arisen in the second year of the policy and based on the TPA's doctors opinion that the disease was an after effect of sinusitis and related disorders, the insurer have repudiated the claim under exclusion clause no. 4.3 of the policy. On perusal of the

documents submitted to this forum we find that the first prescription of Dr. Kundu dated 03.03.2010 does not mention any history of sinusitis, while the history of nasal airway obstruction for last 6 months is mentioned in the prescription. The said doctor has again confirmed in his letter dated 22.02.2011 that there is no definite relationship between hypertrophied inferior turbinate and sinusitis. The TPA and the insurer's panel doctors have not given any definite opinion to counter the treating doctor's certificate. From the medical literature it is seen that the probable causes of the enlarged turbinates are sometimes allergies or environmental irritants besides chronic sinusitis. The insurer has not conclusively established that the problem has originated from only from chronic sinusitis and not from other factors.

After careful evaluation of all the facts and circumstances of the case we are of the opinion that the repudiation is not based on strong evidence. We, therefore, set aside the decision of repudiation under exclusion clause no. 4.3 is set aside. Insurer is directed to admit the claim and settle the same as per terms and conditions of the policy within 15 days from the date of receipt of this award along with consent letter.

Kolkata Ombudsman Centre
Case No. 471/11/002/NL/11/2011-12

Shri Soumen Biswas

Vs.

The New India Assurance Company Ltd.,.

Order Dated : 16th July, 2012

Facts & Submissions :

Both the parties were called for a personal hearing on 09.07.2012. The complainant attended along with his brother-in-law and submitted the grounds of his complaint. He stated that the arthritis was first detected in 2008 following an accident, but before that he was totally fit. He further stated that it was not a planned surgery as he had taken the policy in 2006 and continued with the same insurer without any break or claim. Since the policy conditions of 2006 did not contain any exclusion for arthritis related surgery, his case should be governed by the terms and conditions existing in 2006 and not under the revised condition of 2007. He also contended that before changing the policy conditions to his disadvantage in 2007, the insurer did not intimate him in advance and therefore, he had no choice but to continue with the same policy. He further pleaded for sympathetic consideration of his case as he is not earning much and had to spend a huge amount on the operation, which has caused great financial hardship to him.

The representatives of the insurance company on the other hand reiterated their stand as mentioned in their written submission dated 13.01.2012 and discussed above.

DECISION:

The complainant has approached this forum against repudiation of his claim for total hip replacement surgery by the insurance company on the ground that such surgery is excluded for four years under exclusion clause no. 4.3 of the mediclaim policy 2007. On perusal of the policy clause no. 4.3 it is seen that it relates to age related osteoarthritis and osteoporosis. Applying this clause, the insurance company has repudiated the claim since it has arisen within four years from the commencement of the policy in 2006. From the medical records it is seen that the insured was hospitalized at Apollo Hospitals, Chennai on 13.07.2010 with complaints of stiffness in the right hip for the last two years and he was diagnosed for osteoarthritis and finally surgery was performed for total hip replacement on 14.07.2010 which is in the fourth years of the policy. The age of the insured was 34 years at the time of the surgery and going by the history of present illness we find that the ailment is two years old and therefore, strictly it cannot be called age related osteoarthritis or osteoporosis. It is further seen that the claim has fallen short of just four months of completion of four years of the policy and during this period the insured had not made a single claim. It is definitely not a planned surgery as his condition had suddenly deteriorated due to an accidental fall. Moreover, his plea that there was no such condition under his first policy in 2006 has also some merit. Therefore taking a humanitarian view of the facts and circumstances of the case, we are of the opinion that total repudiation of the claim is not justified. Considering that the policy was first time incepted on 20.11.2006 when the Sum Insured was Rs. 5000/- we allow relief by way of ex-gratia payment of Rs.50,000/- to the complainant. The complainant has accepted the amount towards full and final settlement of the claim. The insurer is directed to pay the above ex-gratia payment of Rs.50,000/- (fifty thousand only) within 15 days from the date of receipt of this award along with consent letter.

Kolkata Ombudsman Centre
Case No. 481/11/004/NL/11/2011-12

Smt. Sandhya Ghosal

Vs.

United India Insurance Company Ltd.,,.

Order Dated : 27th July, 2012

Facts & Submissions :

Both the parties were called for a personal hearing on 23.07.2012. The complainant attended and explained the facts and grounds of her complaint. She stated that her claim was wrongly repudiated by the insurance company on the ground of pre-existing disease. She stated that her brother was earlier insured with HDFC ERGO General Insurance Company Ltd., but he changed to United India Insurance Company Ltd. due to low premium. She confirmed that there was no claim for one year from April 2008 to March 2009. She has submitted the treatment particulars of her brother at Paramount Health Care from 24.10.2010 to 28.10.2010.

The representative of the insurance company on the other hand reiterated their stand as mentioned in their written submission dated 02.07.2012 and discussed above.

DECISION:

The complainant has approached this forum against repudiation of the mediclaim of his brother by the insurance company on the ground of pre-existing disease. From the analysis of the facts it is seen that the first policy was taken from HDFC ERGO for the period 30.04.2008 - 29.04.2009 and there was no claim against the said policy. The renewal was done with United India as premium was less and there was no claim during 2009-10. These facts have not been disputed by the insurer. The insured was first admitted in Paramount Health Care Hospital from 24.10.2010 to 28.10.2010 and was diagnosed for "Colitis". Subsequently he was admitted in SSNH Hospital from 17.11.2010 to 20.11.2010. He finally died on next date i.e., 21.11.2010 due to heart failure. As per the medical records, he was hospitalized with following problems:-

a) **Sudden onset of disorientation and inability to recognize any person;**
b) **Hiccough (+) and unable to move his right side of body;**
c) **High grade temperature associated with vomiting and intermittent pain- chest**

The insurer repudiated the claim considering the ailments as pre-existing on the strength of the opinion of two doctors, one of who is the treating doctor of Paramount Health Care Hospital. Both of them have certified that the ailments were chronic and pre-existing. But nobody has commented as to the probable date of origin of disease. Insurance company also could not provide any documentary evidence to prove that disease started before inception of the policy. Hence, nothing proves that ailments were pre-existing before inception of policy.

Another point the insurer has made that the complainant was not nominated by the insured and there is no proof that she has spent for the treatment of her brother. As payment under Mediclaim Policy is the nature of reimbursement, it should be paid to the person who submits the original bills and claims for reimbursement in the case of death of the insured. There is no nomination facility under the captioned mediclaim policy. At best the insurer may take suitable declaration from the claimant to absolve themselves from future liability of any nature.

After examination of all the facts and circumstances of the case, we are of the opinion that the insurer has failed to establish the ground of repudiation of the claim. Giving benefit of doubt to the complainant, we direct the insurance company to admit the claim and settle the same.

Kolkata Ombudsman Centre
Case No. 483/11/009/NL/11/2011-12

Shri Sarvesh Jalan

Vs.

Reliance General Insurance Company Ltd..

Order Dated : 27th July, 2012

Facts & Submissions :

Both the parties were called for a personal hearing on 20.07.2012. The complainant attended and explained the facts and grounds of his complaint. He stated that the policy for the claim year was issued under Standard Plan but earlier he had a policy under Gold Plan. He disputed the pre-existence of the disease and referred to his doctor's certificate that the problem had surfaced just a month prior to the surgery. He also disputed the admission history of the Fortis Hospital and stated that the hospital has later certified that the history of swelling of 10 years was a typographical error.

The representatives of the insurance company on the other hand clarified that under Standard Policy all the pre-existing diseases have a waiting period of 48 months. Since the claim has arisen in the 3rd year of the policy with them and the disease is pre-existing, they have repudiated the claim They however, could not clarify whether the duration of pain is 10 years or 10 months as mentioned in the admission history and physical assessment form. They also could not clarify the concluding comments of the TPA in their report dated 21.03.2011 that the duration and the ailment although shown as 10 years in the IPD papers is not confirmed as it is not written clearly.

DECISION:

The complainant has approached this forum against repudiation of his claim by the insurance company for surgery under exclusion clause no. 1 and 2 of the policy conditions. From the documents submitted to this forum, it is observed that the insured had taken a policy for the period from 30.08.2010 to 29.08.2011 under the Standard Plan which was a continuation of his earlier policy under Gold Plan taken from 2007 onwards. He had first consulted the doctor on 08.10.2010 and the doctor advised him for admission for the surgery of inguinal hernia. In his first prescription the doctor has not given any history of pain or swelling in the inguinal region. The Discharge Summary for the period from 24.11.2010 to 04.12.2010 shows the final diagnosis as right inguinal hernia and Kochs abdomen. The past medical history shows only appendectomy done 7 years back. However, the insurance company has referred to the admission history and physical assessment form of Fortis Hospital, in which doctor has mentioned in the column Present complaint and duration that the patient had pain in the right inguinal region with

swelling for last 10 *us* (word not clear). Although TPA has inferred the duration as 10 years but they have also commented in concluding remark of their investigation report dated 21.03.2011 that the duration is not confirmed as it is not written clearly. They had contacted the hospital authorities for clarification but they denied giving satisfactory answer to their officers. Thus, it is clear that just on the basis of guess work, they have concluded that the duration of swelling and pain is 10 years. The complainant, on the other hand, has countered this observation of the TPA by producing a certificate from his treating doctor confirming that he has been suffering from pain for last one month. The hospital has also certified vide their certificate dated 20.08.2011 that the history of 10 years is a clerical error and the history of the disease was only for 1 month. The insurance company / TPA have not offered any comments to counter these certificates. Moreover, we find that the complainant was earlier covered by the Gold Plan since 2007 under which the pre-existing disease has a waiting period of 24 months. Therefore, it is highly unlikely that a young man with swelling and pain for 10 years would wait for 4 years for the surgery when he was entitled after 2 years under Gold Plan.

After careful evaluation of all the facts and circumstances of the case we are of the opinion that the repudiation is not based on sound and valid documentary evidence. The investigation done by the TPA clearly establishes that they had a confusion regarding the period of inception of the disease. Under the circumstances their decision to treat the disease as per-existing is erroneous and the same is set aside. The insurance company is directed to admit the claim and settle the same as per terms and conditions of the policy.

Kolkata Ombudsman Centre
Case No. 509/11/003/NL/11/2011-12

Shri Arun Kumar Dhurka

Vs.

National Insurance Company Ltd.,

Order Dated : 20th July, 2012

<u>Facts & Submissions </u>:

Both the parties were called for a personal hearing on 13.07.2012. The complainant attended and explained the facts and grounds of complaint. He stated that his claim was repudiated by the insurance company without any justified reason. He referred to the N.I.C Circular dated 20.10.2010 which relaxed the condition for such treatment and allowed the same after a waiting period of 2 years. He further stated that he was admitted in the hospital in the morning of 11.10.2010 and was discharged in the evening due to shortage of beds. He has taken the policy since 2004 and as per relaxation norms his claim is admissible.

The representatives of the insurance company on the other hand reiterated their stand as mentioned in their written submission dated 11.01.2012 and discussed above. They pointed out that the hospital bill included only the cost of the injection and no other expenses have been showed in the bill. The circular relating to treatment of ARMD case was effective from the date of issue i.e., 20.10.2010 but since both the renewal of the policy and the treatment were prior to the date of the circular, no relief can be given under the circular. The claim of the insured would be determined under clause 2.6 of the policy which required minimum 24 hours hospitalization.

DECISION:

The complainant has approached this forum against repudiation of his claim for treatment of ARMD on the ground that it was an OPD procedure and not allowable under clause 2.6 Note. The complainant has referred to the N.I.C Circular No. CRO-I/Tech/A/CIR/09/10 dated 20.10.2010 under which the treatment is allowed subject to certain conditions, which according to him are fulfilled in his case. He has stated that he has been insured with the same insurance company without any break since 2004 without any claim for which he was enjoying C. B. of Rs.60,000/- on SI of Rs. 2 lakh. Considering his long association with the insurance company, the claim should have been paid to him according to circular.

The insurance company on the other hand has contented that the circular was issued after the date of the operation and therefore, it is not applicable in his case. Since his stay in the hospital was for less than 24 hours, his claim is not admissible under clause 2.6 also.

We have perused the circular issued by the Head Office of the National Insurance Company dated 20.10.2010. It is seen that the circular has clarified how to deal with AMRD related claims in terms of existing policy conditions. The said circular has allowed this treatment under the policy subject to the following conditions.:-

i) **The treatment is taken in a Hospital, Nursing Home or Day Care Centre, which fulfills the criteria as laid down in the Medical Policy;**
ii) **The claim has arisen after two continuous years of operation of the policy;**
iii) **The treatment would be admissible for the use of Lucentis etc or any other approved drugs.**
iv) **The expenses incurred towards this treatment should be necessary, customary and reasonable.**

The complainant is insured for more than 2 years and other conditions also appear to be satisfied in his case. The insurance company has argued that the date of issue of the circular is after the date of the treatment of the insured but we find from the circular that the approval for relaxation of the policy condition was taken by the Head Office vide their note dated 04.10.2010. Hence the matter was decided in principle on 04.10.2010, although

notified by way of a circular dated 20.10.2010. Therefore, for all practical purposes, it can be said that this relaxation was approved w.e.f. 04.10.2010 and the benefit of the same should be available to the complainant as his treatment is subsequent to the date of approval.

After careful evaluation of all the facts and circumstances of the case, we are of the opinion that the claim of the complainant is admissible in view of the provisions of the above circular. The insurance company is therefore, directed to admit the claim and settle the same.

Kolkata Ombudsman Centre
Case No. 471/11/002/NL/11/2011-12

Shri Soumen Biswas

Vs.

The Oriental Insurance Company Ltd.,

Order Dated : 23rd July, 2012

Facts & Submissions :

Both the parties were called for a personal hearing on 16.07.2012. The complainant attended and explained the facts and grounds of his complaint. He disputed the history of HTN or Diabetes and stated that he did not have any cardiac problem prior to surgery. Since he suffered a severe chest pain for the first time, he consulted the doctor, who advised immediate hospitalization for PTCA. He further contended that Diabetes was detected for the first time in November 2010 after the surgery was performed and during hospitalization he was not given any medicine for control of diabetes which shows that he was a non-diabetic patient.

The representative of the insurance company on the other hand reiterated their stand as mentioned in their written submission dated 30.05.2012 and discussed above.

DECISION:

The complainant has approached this forum against repudiation of his claim by the insurance company on the ground that the claim falls under exclusion clause no. 4.3 of the policy. Facts of the case are that the complainant was covered under Happy Family Floater Policy since 18.11.2009. He was admitted in hospital following severe chest pain as per the advice of Dr. Manotosh Panja from 20.10.2010 to 25.10.2010 in the first year of the policy period. As per discharge summary his final diagnosis was Coronary Artery Disease. However, the claim was repudiated by the TPA of the insurance company based on Dr. Panja's prescription dated 01.11.2010 which showed that the complainant was on "PIOGLITAZONE" which is anti-diabetic drug. So they have concluded that the patient was diabetic and the ailment for which he was hospitalized is the complication of diabetes. However, from the documents submitted to this forum it is seen that the treating doctor has nowhere mentioned that the ailment was complication of diabetes. In fact, the prescription as referred to by Insurer was dated 01.11.2010 which is of post hospitalization period from 20.10.2010 to 28.10.2010. No documentary evidence has been produced by the insurer to conclusively establish that the insured was diabetic prior to the inception of the policy. On the other hand complainant has produced a certificate from Dr. Panja dated 14.08.2011 to the effect that he was not a diabetic patient. This certificate has not been countered by the TPA.

After careful evaluation of all the facts and circumstances of the case we are of the opinion that the repudiation of the claim by the insurer, under exclusion clause no 4.3 is not correct and the same is set aside. The Insurer is directed to admit the claim and settle the same as per terms and conditions of the policy.

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Kolkata Ombudsman Centre
Case No. 471/11/002/NL/11/2011-12

Shri Lalu Sinha

Vs.

The New India Assurance Company Ltd.,.

Order Dated : 20th July, 2012

Facts & Submissions :

Both the parties were called for a personal hearing on 13.07.2012. The complainant attended and explained the facts and grounds of his complaint. He stated that he has produced certificates from the treating doctors who are of the opinion that his present ailment has no links with CAGB done in 2003. He further submitted that he had undergone a similar treatment under Dr. Joshi in June 2010 which was duly paid by the insurance company.

The representative of the insurance company on the other hand reiterated their stand as mentioned in their written submission dated 06.06.2012 and discussed above.

DECISION:

The complainant has approached this forum against repudiation of his claim by the insurance company on the ground that the 'Pathogenesis of SFA obstruction' is the same as Coronary Artery disease for which CABG was done in 2003. From the medical reports and other documents it is seen that the insured had undergone Coronary Artery Bypass Grafting (CABG) in 2003. The policy continued from 2003 to 2008 but due to a break of 12 days in 2009 a fresh policy was issued. The treating doctors have certified that his present operation is not related to earlier operation of CABG (Dr. A. Chakrabori's certificate dated 20.10.2010). Dr. Joshi who had treated the patient after CABG done earlier has also confirmed vide his certificate dated 31.07.2010 that the insured did not have any symptom of PAD in 2003 when CABG was done. The insurance company's contention that 'Pathogenesis of SFA obstruction for F.P Bypass Grafting' done in 2010 is directly related to CABG done in 2003 is not substantiated with any medical record/expert opinion. CABG may be one of the predisposing factors but after lapse of 7 years of operation and living a normal life, one should not be denied the claim on the ground of pre-existing disease.

After careful evaluation of all the facts and circumstances of the case, we are of the opinion that the decision of the insurance company to repudiate the claim under exclusion clause no. 4.1 is not based on valid grounds. We, therefore, set aside the erroneous decision and direct them to admit the claim and settle the same as per terms and conditions of the policy.

Kolkata Ombudsman Centre
Case No. 537/14/012/NL/12/2011-12

Shri Dayal Vishnani

Vs.

ICICI Lombard General Insurance Company Ltd

Order Dated : 10th August 2012

Facts & Submissions :

Both the parties were called for a personal hearing on 06.08.2012. The complainant attended and explained the grounds of his complaint. He stated that at the time of taking the policy he had disclosed true physical condition to his agent who had told him that all pre-existing diseases would be covered after a waiting period of 2 years. He further stated that his present claim pertains to surgery of tumor in the kidney which has no relation with CABG or HTN detected in 2002. Therefore, the denial of the claim is unfair.

The representative of the insurance company on the other hand reiterated their stand as mentioned in their written submission dated 03.05.2012 and discussed above. She informed that the claim was repudiated under clause 2.2 of the policy due to pre-existing HTN in 2002. Since the disease was pre-existing it could be covered only after 48 months of waiting period.

DECISION:

The complainant has approached this forum against repudiation of his claim on the ground of concealment of material facts at the time of first inception of the policy in 2008. From the documents submitted to this forum we find that in the proposal form dated 24.03.2008 the insured had mentioned that he did not have any past illness or pre-existing disease/ surgery/ symptoms. Based on such statement on the part of the insured, the policy was issued without excluding any pre-existing diseases. However, during the

policy period 2011-12 (i.e., 4th year of the policy) he has preferred a claim for surgery of renal tumor which was denied by the insurance company on the plea that he had CAD post CAGB and HTN way back in 2002 which he did not disclose at the time of filling the proposal form when the policy was first incepted with them in 2008. Although, withholding this information amounts to breach of policy exclusion clause 2.2 (i) and definition clause of pre-existing illness, but the Insurer has not explained how the CAGB done in 2002 could lead to tumor in kidney which was found to be Carcinoma 2nd stage as per biopsy report. The claim has arisen in the 4th year of the policy and it could be denied only if it is established by medical or expert opinion or any other evidence that CABG in 2002 has direct link with the present ailment i.e., nephrectomy/ kidney tumor. Since the claim is not related to any heart ailment the exclusion clause 2.2 cannot be attracted in this case. The claim also cannot be denied for breach of standard policy condition in schedule III relating to misrepresentation/fraud as the concealed information has no direct bearing on the present claim. Moreover, there is nothing to suggest any malafide/fraudulent intention on the part of the insured, who has never defaulted in payment of premium.

After careful evaluation of all the facts and circumstances of the case, we are of the opinion that the decision of the insurance company to repudiate the claim is not fair and justified and the same is set aside. The Company is directed to admit the claim and settle the same.

Kolkata Ombudsman Centre
Case No. 540/11/004/NL/12/2011-12

Shri Man Mohan Kumar Swaika

Vs.

United India Insurance Company Ltd.,

Order Dated : 10th August, 2012

<u>Facts & Submissions</u> :

Both the parties were called for a personal hearing on 06.08.2012. The complainant attended and explained the grounds of his complaint. His main objection was that the charges for extra one day stay in the hospital and visiting surgeon's fee was not allowed. The patient had stayed for extra one day on doctor's advice and a specialist was called from Hyderabad for the operation and therefore, his fee should be fully allowed.

The representative of the insurance company on the other hand reiterated their stand as mentioned in their written submission dated 24.01.2012 and discussed above.

<u>DECISION</u>:

The complainant has approached this forum against disallowance of full room rent and doctor's fee on the ground that the insured had availed a higher category of room instead of entitled category. He has contended that the said room was chosen due to non-availability of entitled category of room on the date of surgery fixed by the visiting surgeon. From the computation provided by the insurer we find that the room rent was charged @ Rs.4,000/- per day against his entitlement of Rs.2,750/- being 1% of he sum insured. This is as per policy condition and is correctly computed. The charge for extra one day has also been reimbursed and no further amount is payable on this account. As regards the doctor's fee we find that the surgery was performed by a visiting doctor from Hyderabad who was chosen and invited by the insured's family. It is not known whether the fee charged by visiting doctor is as per the standard rates charged by the local doctors for the said surgery. The insurance company has proportionately reduced the doctor's charges under clause 1.2 but the formula adopted by them is not prescribed under the policy. As per clause 1.2, charges payable for the doctor's fee shall be limited to the charges applicable to the entitled category. We find that the applicable rate to the entitled category has not been ascertained by the TPA. Under the circumstances the method adopted by the insurance company to reduce the admissible amount proportionately is not justified. Such deduction is not laid down under the policy. The insurance company is accordingly directed to reconsider the claim in the light of the rates applicable to the entitled category which should be available with the hospital authority. In case there are no variable rates then the visiting doctor's fee equivalent to the charges of the local surgeon is to be allowed subject to overall limits prescribed in the policy. This exercise should be completed and additional amount, if any, should be paid within 15 days from the date of receipt of this award along with consent letter.

Kolkata Ombudsman Centre
Case No. 611/11/002/NL/01/2011-12

Shri Radheshyam Murarka

Vs.

The New India Assurance Company Ltd.,.

Order Dated : 17th August 2012

<u>Facts & Submissions</u> :

Both the parties were called for a personal hearing on 13.08.2012. The complainant attended and explained the grounds of complaint. He stated that the original money receipt of Rs.30,000/- has already been submitted to the TPA vide his letter dated

18.08.2008. Moreover it is also included in the hospital bill. He is facing lot of financial hardship and requested for early settlement of the claim which was denied without any valid reason.

The representative of the insurance company on the other hand reiterated their stand as mentioned in their written submission dated 01.03.2012 and discussed above. However, they could not comment on the complainant's letter dated 18.08.2008 submitted to the TPA with the original bill.

<u>DECISION</u>:

The complainant has approached this forum against total repudiation of his claim under exclusion clause no. 4.1 of the policy. From the analysis of the facts, we find that the insured and his wife have been continuously covered under the policy since 2005. The claim pertains to the policy period 2007-08 for CABG/PTCA with stenting to the LAD and RCA. Initially the TPA of the insurance company had approved Rs.20,000/- towards cashless facility but the complainant took the discharge before availing the benefit. Subsequently TPA rejected the claim with the plea that the disease was pre-existing based on a remark on the discharge summary prescription dated 18.05.2008 that a similar episode had occurred 10 years back. Against the repudiation the complainant obtained a certificate dated 14.05.2008 from Dr. U.K. Roy clarifying that the patient suffered from chest pain due to hyperacidity and gastritis 10 years back. Based on the clarification of the doctor, the insurance company directed the TPA to reopen the claim file. The TPA reopened the claim file and requested the complainant to submit the original money receipt of Rs.30,000/- vide their letter dated 23.02.2009 and 09.03.2009. In their letter TPA had written that in case the original receipt is submitted the claim can be considered. We find that the claimant had been consistently responding to the TPA through various letters and had submitted the original money receipt to the TPA along with his letter dated 18.08.2008. The copy of the letter duly received by the TPA has been submitted to this forum. Moreover, we find that the hospital bill dated 18.05.2008 includes the amount of Rs.30,000/- shown as an advance payment. This document submitted in original, should have been sufficient to process the claim of the TPA without insisting on further documents. The insurance company/ TPA have not commented on the complainant's letter dated 18.08.2008 enclosing the original money receipt. The representatives of the insurance company contended that the letter of 18.08.2008 was received by the TPA without any verification of the enclosures. But in their subsequent communications TPA has not made any reference to the letter dated 18.08.2008. The insurance company has raised an objection that his complaint is time barred before this forum as the same was filed after a lapse of one year. The complainant has pointed out that as his claim was pending for a long time, he lodged a complaint with IRDA in response to which the insurance company had intimated him vide their letter dated 21.03.2011 that his claim was repudiated on the ground of pre-existing disease. Thus, the final repudiation letter was received by him on 21.03.2011 against which the complainant approached this forum on 14.11.2011 i.e., within one year. Hence the contention of the insurance company that the claim is not admissible in this forum is not correct.

After careful evaluation of all the facts and circumstances and rival submissions in this case, we are of the opinion that the decision of the insurance company to repudiate the claim on the ground of pre-existing disease and non submission of original money receipt is erroneous and the same is set aside. The insurance company is directed to accept the Xerox copy of the money receipt and settle the claim.

Kolkata Ombudsman Centre
Case No. 614/11/003/NL/01/2011-12

Shri Chandrachur Chattopadhyay

Vs.

National Insurance Company Ltd.

Order Dated : 14th August 2012

Facts & Submissions :

Both the parties were called for a personal hearing on 09.08.2012. The complainant attended and submitted that his only complaint is that the CB was not considered for settlement of the claim.

The representatives of the insurance company on the other hand informed this forum that they have directed the TPA to consider the CB of Rs.82,500/- on the basis of which a further amount of Rs.46,200/- is payable to the insured.

DECISION:

The only dispute is that CB of Rs. 82,500 was not considered by TPA. The insurance company has confirmed during hearing that they have directed the TPA to settle a further amount of Rs.46,200/- which is payable on account of CB. The insurance company is directed to pay the above amount of Rs.46,200/- (Rupees forty six thousand two hundred) to the complainant within 15 days from the date of receipt of this award along with consent letter.

Kolkata Ombudsman Centre
Case No. 632/11/017/NL/01/2011-12

Shri Devendra Singh Tomar

Vs.

Star Health and Allied Insurance Co. Ltd.

Order Dated : 17th August 2012

Facts & Submissions :

Both the parties were called for a personal hearing on 13.08.2012. The complainant attended and explained the grounds of complaint. He stated that the treating doctor has confirmed that the cause of the ailment was insect bite and the same was confirmed by the visiting doctor of the insurer. Therefore, repudiation of the claim is not justified and pleaded for early settlement of the claim.

The representative of the insurance company on the other hand reiterated their stand as mentioned in their written submission dated 26.03.2012 and discussed above.

DECISION:

The complainant has approached this forum against repudiation of the claim by the insurance company under clause no. 2 of the policy on the ground that infection had incepted during first 30 days of the policy period. From the analysis of the facts it is revealed that the insured was admitted at Desun Hospital & Heart Institute, Kolkata from 09.05.2011 to 14.05.2011 for the treatment of necrotizing fascitis. Before admission into the hospital the patient had first consulted Dr. Manish Jain at Indore on 19.04.2011 with complaints of localized cellulities and necrosis of left thigh. In the prescription, Dr. Jain had mentioned the probable causes as "Insect Bite" and "Herpetic" with "?" mark. She was advised for admission in the Hospital. Accordingly, she was admitted on 19.04.2011 in Bombay Hospital, Indore and was finally diagnosed for "Acute localised necrotising cellulites of the left thigh ? cause.....". She was discharged with stable condition with the suggestion of follow up treatments. Subsequently she came to Kolkata and on 09/05/2011 she consulted in the emergency department Desun Hospital, and as per doctor's advice she was again admitted for the period of 09/05/2011 to 14/05/2011. During hospitalization she was operated for excision of nacrotizing fascitis

The Insurer rejected the claim with the plea that disease occurred during first thirty days and it falls under exclusion clause no 2 which excludes any disease contracted by the insured person during first 30 days from the commencement date of the policy. It shows that the Insurance Company has considered the cause of ailment as viral infection, one of the two probable causes doubted by Dr. Manish Jain in his first prescription dated 19/04/2011. The possibility of other cause i.e. 'insect bite' was not considered by the

Insurance Company even though the doctor had clarified subsequently vide his letter dated 12/05/2011 as under-

"As per history given by the patient H/O insect bite with localised cellulites and necrosis of thigh Clinically features also suggestive of insect bite with localised severe cellulites c necrosis of skin with severe pain and tenderness of her left thigh region. Patient was admitted for the treatment of the above on 19 April."

The insurer have stated that their Medical Officer Dr. Somnath Patra, had also visited the patient at Desun Hospital and submitted his report on 11-05-2011, in which he mentioned that the cause may be insect bite. Why his opinion was not followed is not clear. Further we find that Desun Hospital in their discharge certificate under "Clinical Summary" have mentioned that the patient was admitted with complaints of swelling on left thigh due to insect bite on 19-04-2011. Thus opinion of all the doctors is in favour of 'insect bite' being the probable cause. But Insurance Company rejected this possibility without clarifying medically or otherwise as to why the other cause was not accepted.

After careful evaluation of all the facts and circumstances of the case, we are of the opinion that the decision of the insurance company to repudiate the claim under exclusion clause no. 2 is erroneous and the same is set aside. The insurance company is directed to admit the claim and settle the same as per terms and conditions of the policy within 15 days from the date of receipt of this award along with consent letter.

Kolkata Ombudsman Centre
Case No. 644/11/004/NL/01/2011-12

Shri Dipendra Chandra Roy

Vs.

United India Insurance Company Ltd.

Order Dated : 28th August, 2012

Facts & Submissions :

Both the parties were called for a personal hearing on 23.08.2012. The complainant attended and explained the grounds of complaint. He stated that he was suffering from excruciating low back pain and on the doctor's advice he was immediately hospitalized.

Several investigations were undertaken as per doctor's recommendation and there was positive diagnosis of Lumber disc prolapse and lumber spondylosis. He further submitted that he is a Senior Citizen aged about 66 years and suffering from several diseases but the disease for which he was hospitalized is not pre-existing.

The representatives of the insurance company on the other hand reiterated their stand as mentioned in their written submission dated 28.03.2012 and discussed above.

DECISION:

The complainant has approached this forum against repudiation of his claim by the insurance company under exclusion clause no. 4.10 of the policy stating that the hospitalization was primarily for investigation purpose and no active line of treatment was done. From the analysis of the facts it is seen that the complainant is a known case of DM and heart ailment. He had undergone CABG in 1995. He was admitted into the hospital as advised by the doctor, who conducted various tests for evaluation purpose and management of the pain. The final diagnosis as per discharge summary of the hospital was 'Lumber disc prolapse, Lumber spondylosis, Type 2 diabetes mellitus, S/p CABG'. On discharge, he was advised to wear lumber corset and take complete bed rest for 14 days. The MRI report reveals positive existence of disease 'lumbar disc prolapse' which was managed along with treatment of other existing diseases. Considering his advance age of 66 years and gravity of the problem of previous ailments, the advice of the doctor for hospitalization cannot be called improper. Though the line of treatment during hospitalization was mainly for cardiac/ DM which is pre-existing but the cost of treatment for the present ailment which was diagnosed and treated cannot be denied.

After careful evaluation of all the facts and circumstances of the case, we are of the opinion that the treatment cost relating to the lumber disc prolapse is payable under the policy. After examining the hospital bills, we allow the MRI Lumber Spine charges of Rs.22,400/- and 50% of the bed charges, i.e. Rs.5,000/-, 50% of the doctors consultation fees, i.e., Rs.1,100/- and Rs.55/- medicine (actual) totalling Rs.28,555/-. The insurance company is directed to pay Rs.28,555/- (Rupees twenty eight thousand five hundred fifty five only) to the complainant.

Kolkata Ombudsman Centre
Case No. 471/11/002/NL/11/2011-12

564/11/005/NL/12/2011-12

Vs.

The Oriental Insurance Company Ltd..

Order Dated : 10th September, 2012

Facts & Submissions :

Both the parties were called for a personal hearing on 09.08.2012. The complainant attended and explained the facts and grounds of his complaint. He stated that he was advised rest by the doctor for 107 days during which he was undergoing regular treatment and physiotherapy which was necessary for rehabilitation and strengthening of muscle. During this period he was confined to home and joined office only after getting a fitness certificate from the treating doctor. In support of his contention he has further submitted that it is not mentioned in the policy that weekly compensation will be allowed only on loss of the earning capacity since he was unable to join his duty as per doctor's certificate, it is a sufficient ground for admissibility of the claim.

The representatives of the insurance company on the other hand reiterated their stand as mentioned in their written submission dated 27.02.2010 and discussed above. They stated that it is a benefit policy under which the disablement must be total and absolute for a temporary period. The doctor's advice for extended rest period has no link with the claim for temporary total disablement. From the prescription of the doctor it is clear that the condition of the patient was gradually improving and therefore, it cannot be said that the disablement was total and absolute for 107 days as claimed by the insured.

DECISION:

The complainant has approached this forum against partial settlement of his claim under policy condition no. 12 (f) on the ground that disability was not total and absolute during the period of claim. From the facts presented to this forum we find that the insured was hospitalized on 29.07.2010 after being injured in a road accident and was discharged on 05.08.2010. During hospitalization he had undergone surgery for fracture of shoulder, knee nd fingers. The complainant lodged a claim for weekly compensation for 107 days from 29.07.2010 to 13.11.2010 as per policy condition no. 12 (f) which states as under :-

"If such injury shall be the sole and direct cause of temporary total disablement, then so long as the Insured shall be totally disabled from engaging in any employment or occupation of any description whatsoever, a sum at the rate of one percent (1%) of the Capital Sum Insured stated in the Schedule hereto per week, but in any case not exceeding Rs.5000/- per week in all, under all Policies."

"Provided that the compensation payable under the foregoing Sub-Clause shall not be payable for more than 104 weeks in respect of any one injury calculated from the date of commencement of the disablement and in no case shall exceed the Capital Sum Insured."

The insurance company settled the claim for Rs.26,429/- for 37 days on the ground that his condition was gradually improving and he was undergoing physiotherapy which generally starts after the patient is in a position to move around. Moreover, he had started walking with a stick, hence the condition under the policy that disablement should be total and absolute was not fulfilled. From the prescriptions of the treating doctor we find that the complainant was advised rest for two weeks as per discharge certificate dated 05.08.2010 which was further extended by two months by his subsequent prescription dated 13.08.2010 and 03.09.2010. Finally the doctor certified vide his prescription dated 19.11.2010 that the complainant was fit to join duty in normal capacity from 19.11.2010. During the period of rest the doctor had advised the patient to walk with a stick, use knee guard and undergo physiotherapy.

Perusal of the policy condition shows that the term 'temporary total disablement' is not defined under the policy. As per wordings of the policy condition total disablement should be considered in terms of ability of the person to engage himself or herself in any employment or occupation. The complainant is an insurance agent by profession. He has produced a statement of commission earned during his period of disability i.e. for months of August, September and October 2010. From the statement we find that he earned the following agency commission during this period.

August 2010	**-**	**Rs.25,988.90**
September 2010	***-***	***Rs.28,825.04***
October 2010	***-***	***Rs.12,210.44***

In General Insurance, renewal business are generally booked under same agent's code whether it is physically procured by the agent or insured deposited it directly. This is to avoid snatching of one's renewal premium by other agent. Hence commission statement does not give a true picture as to whether the complainant was capable of engaging himself in his occupation as agent during hospitalization or treatment period. For this reason insurance company has also not denied the compensation during hospitalization

though, he earned commission as an agent during hospitalization. However, agent's absence in the field will not ensure procurement of renewal automatically. This has been reflected in the commission statement of October 2010 which has been reduced to the tune of more than 50%. It is also a fact that an agent is required to travel extensively to collect the renewal premium as well as generate new business. From this point of view, we find some merit in the complainant's submission that he was not in a position to engage himself during the whole period of treatment till he was certified to join duty. Moreover agents are not the direct employee of the insurance company and there is no system of attendance in the office for agents, they have no fixed duty hours. Hence insurance company is not in a position to certify his attendance.

The insurance company was intimated about the accident on 12.08.2010 and they issued the claim form on 16.08.2010 and reminded him for submission of documents on 26.10.2010. They had ample scope of investigating the case during this period to know about the actual condition of the insured. No such action was taken. In view of the above, it will be difficult to justify insurer's decision to curtail the period of compensation from 108 days to 37 days.

After careful evaluation of all the facts and circumstances of the case, we are of the opinion that the decision of the insurance company is based on insufficient facts and narrow interpretation of the policy clause. Giving a benefit of doubt to the complainant, we set aside the decision of the insurance company and direct them to settle the claim for 108 days as per other terms and conditions of the policy.

Kolkata Ombudsman Centre
Case No. 649/11/008/NL/02/2011-12

Shri Rupendra Nath Biswas

Vs.

Royal Sundaram Alliance Insurance Co. Ltd.,.

Order Dated : 10th September, 2012

Facts & Submissions :

Both the parties were called for a personal hearing on 04.09.2012. The complainant attended and explained the facts and grounds of complaint. He stated that he is completely fit after CABG and leading a normal life. However, he has completely stopped smoking on the advice of the doctor. Earlier he used to smoke about 30 cigarettes per day

and continued smoking for 30 years. He denied that he is an alcoholic and stated that he used to drink occasionally.

The representative of the insurance company on the other hand reiterated their stand as mentioned in their written submission dated 05.04.2012 and discussed above. He further stated that medically it is proved that smoking leads to hardening of the blood vessels. Since the insured is a known smoker for 30 years, they have repudiated the claim under exclusion clause no. 20 of the policy.

DECISION:

The complainant has approached this forum against repudiation of his claim under exclusion clause no. 20 of the policy on the ground that he is a known smoker for 30 years which constitutes one of the strongest risk factors for heart ailments. The decision of the Insurance Company is based on the observations of the treating doctor in the discharge summary of B.M Birla Heart Research Centre, where in doctors identified 4 risk factors, HTN-4 years, DM-4 years, LOC on 15.03.2011 and smoker – 30 years. The complainant during hearing has admitted that he used to smoke 30 cigarettes per day and continued doing so for last 30 years till CABG was done. It is medically established that continuous and excessive use of tobacco is one of the critical risk factors for cardio vascular ailments. Cigarette smoking not only leads to HTN but also causes stiffness of arteries and increases the risk of cardio vascular complications. In this case the abuse of tobacco by the insured is established. This has also led to other complications like HTN etc. Loss of consciousness is again a result of insufficient blood circulation caused by the artery blockage. Since LOC was for temporary period this cannot be treated as a major risk factor. Although it is difficult to say which factor has contributed to what extent but it is undoubtedly the long term abuse of tobacco which has contributed the most. It is further seen from the proposal form there was a specific questions relating to the smoking habit to which the insured had replied in the negative. He admitted during hearing that he had overlooked this point. The complainant's plea that the process of excess calcification led to the thickness of arteries and the process had initiated at his teenage long before he had started smoking, is not supported by any medical record or other evidence. The insurance company has repudiated the claim under exclusion clause no. 20 which reads as under :-

"Use of intoxicating drugs alcohol and the treatment of alcoholism, solvent abuse, drug abuse, or any addiction and medical conditions resulting from or related to such abuse or addiction. Diseases due to tobacco abuse such as Atherosclerosis, Ischemic Heart Disease, Coronary Artery disease, Hemorrhagic stroke, ischemic stroke, Chronic Obstructive Pulmonary Disease , Chronic Obstructive Airway disease, Emphysema, Chronic Bronchitis, Burger's Disease, (Thromboangitis Obliterans). All types of pre malignant conditions/ cancer in situ, oral cancer, Leukoplakia, Larynx cancer, Cancer of Oesophagus, Stomach, Kidney, Pancreas and Cervical Cancers only due to tobacco abuse only".

After careful evaluation of all the facts and circumstances of the case, we are of the opinion that smoking is established as the strongest risk factor in this case. However, considering that he was also a patient of DM and HTN which are covered under the

policy, we allow partial relief of 20% of the total admissible claim amount which will meet the ends of justice. The insurance company is directed to pay the above amount as per terms and conditions of the policy within 15 days from the date of receipt of this award along with consent letter.

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Kolkata Ombudsman Centre
Case No676/14/004/NL/02/2011-12

Shri Satyendra Prasad Sinha

Vs.

United India Insurance Company Ltd.,

Order Dated : 24th September, 2012

Facts & Submissions :

Both the parties were called for a personal hearing on 18.09.2012. The complainant attended and submitted the facts and grounds of complaint. He stated that out of the four documents required by the insurer two have already been submitted and he is ready to submit the remaining documents.

The representatives of the insurance company on the other hand reiterated their stand as mentioned in their written submission dated 30.03.2012 and discussed above. He further stated that the claim will be settled by the TPA on receiving the required documents.

DECISION:

The complainant has approached this forum for delay in settlement of his claim. The claim is pending as certain documents required by the TPA have not been submitted by the insured. After examining the papers submitted by both the parties, we find that only two documents remain to be submitted by the complainant.

i) **Original money receipt for Rs.20,000.- against hospital bill no. 29238 dated 20.04.2011.**
ii) **Original and photocopies of all the investigations reports.**

The complainant is directed to produce the above documents for verification by the Insurance company. The Insurer is directed to settle the claim as per terms and conditions of the policy.

Lucknow Ombudsman Centre

Complaint No.: L-1133/26/001/2011-12

Award No.-IOB/Lko/146/001/12-13

Manju Vs. TATA AIA,

Award dated:16.08.2012

HEALTH

Facts : Smt Manju had taken a policy on 30.05.2009 under "*Health Protector plan* " for risk cover Rs 8lac,ADB for Rs 5lac term life benefit Rs 7lac and critical illness benefit for Rs 8 lac. Unfortunately the L.A was diagnosed for Rheumatic Heart disease, severe Mitral stenosis along with Dilated LA/RA/RV. Life assured was operated for PTMC in AIIMS New Delhi. Life assured preferred critical illness claim which was repudiated by the insurance company on the ground that condition occurred (Mitral Stenosis) is not a qualifying conditions under critical illness. Respondent insurance company argued that as per the policy condition Mitral valve Stenosis for which PTMC was done is not covered under critical illness benefit.

Findings:- In order to substantiate the claim it was found that the life assured under went for an operation after ECG suggested Heart ailment. As per respondent, PTMC is a semi invasive procedure where a balloon is used to dilate the already narrowed mitral valve. This does not fall under the category of Heart Attack. Policy conditions no 9 of the policy " Heart Valve Surgery" also suggest that Balloon or catheter techniques are excluded from the given benefits.

Decision: It was observed by the forum that the life assured had under gone an operation for PTMC. As per the policy condition the said operation does not fall in the category of Heart attack which is specifically mentioned in the policy condition. The respondent insurance company repudiated the claim on the basis of specific policy condition hence intervention of this forum was not warrented. The apex Court in General assurance society

V/S Chadramani Jain and others (1966)3SCR500 has also given their verdict on the same lines.

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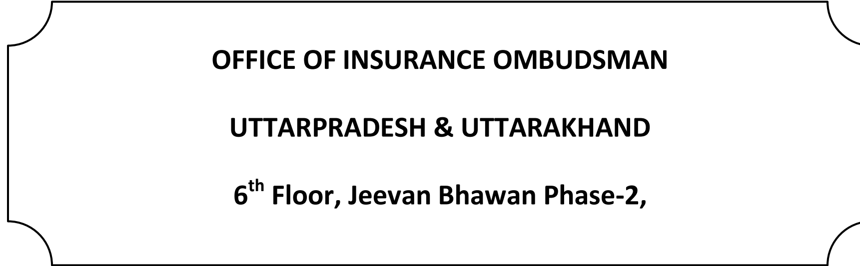

<u>Complaint No. G-64/11/08/12-13</u>

<u>Award No.IOB/LKO/04/382/08/12-13</u>

<u>Dr. D.K. Jain Complaint No. G-64/11/08/12-13</u>
<u>vs</u>
<u>Future Generali India Insurance Company Ltd.</u>

Fact: Dr. D.K. Jain ,The complainant's wife was insured with Future Generali India Insurance Company Ltd. under Individual Health Suraksha Policy for period 14.01.2011 to 1301.2012 having sum insured Rs. 1,00,000/-. She got admitted at Adinath Hospital on 02.09.2011 for treatment of dengu fever. The complainant preferred a claim with the insurer for Rs. 33752/- . During investigation it was revealed that the complainant and his wife do not reside at the address mentioned in proposal form and policy and the complainant is himself owner - director of Adinath Hospital, Ghaziabad. His wife is also a doctor in the same hospital. The respondent company repudiated the claim on the ground of mis -representation and suppression of material fact.

FINDING: The complainant has submitted that though he is on board of directors of the hospital, this does not disqualify him from taking a genuine mediclaim. He had been

taking insurance cover since 2009 but this was his first claim. Also this does not make any difference whether he resides at his registered address given in the proposal form or at the upper floor of the hospital. The respondent further added that the hemogram blood test is bearing a date of July 2011 whereas the patient was admitted in the month of September 2011. This also makes the claim suspicious. The respondent company however could not produce any cogent evidence in support of their submission.

DECISION. It appears that neither the repudiation of claim is on justifiable ground nor the complainant extended his full co-operation to the respondent insurer. Merely because the complainant was related to the patient does not make the claim suspicious unless, it is proved , by substantial evidence by the respondent insurance company. However, the respondent insurance company's arguments are not based on sound footing, Hence denial of mediclaim is not justified. In these circumstance the ends of justice will meet by giving some relief to the customer. Forum awarded Rs. 20000/- to the complainant on ex-gratia basis.

OFFICE OF INSURANCE OMBUDSMAN

UTTARPRADESH & UTTARAKHAND

6th Floor, Jeevan Bhawan Phase-2,

Complaint No. G-08/11/19/12-13
Award No.IOB/LKO/04/47/19/12-13

Dr. Preet Pal Singh vsNational Insurance Company Ltd.

Fact:The Complainant's mother Mrs.Jagawati Devi was insured with National Insurance Company Ltd. under mediclaim policy for period 18.06.2010 to 17.06.2011 having sum insured Rs 2,00,000.00.

On complaint of progressively increasing pain in right knee she got admitted at Fortis Hospital Mohali on 07.01.2011 where she underwent right side total knee replacement on 08.01.2011. Out of total expenses of Rs. 1,81,210.00 the insurers have settled the claim for Rs. 63,285.00 only.

Insurer submitted that "It is admitted that after 4 years, pre-existing diseases will be included. The claimant is eligible for reimbursement up to the sum insured under the policy, before 4 years i.e. from 18.06.2006 to 17.06.2007, the sum insured of which is Rs.50,000.00. Osteo Arthritis falls under waiting period of 4 years i.e. 5th year running policy. Accordingly the calculation have been made and the insured is entitled for an amount of sum insured + CB(i.e.57375/-) as per policy where the sum insured is Rs. 50000.00 for Smt Jagwati Devi.

Hence the claimant has been correctly paid as per terms and conditions of the policy".

Findings: Forum fond that the respondent has not made it clear why the ailment is being linked with sum insured of the policy for the year 2006-07. The insurers seem to be a bit confused as to quantum of their liability. It is clearly mentioned in Discharge Summery-"*Patient admitted with complaints of progressively increasing pain right knee*

since I year". **The policy period of the subject policy is 18.06.2010 to 17.06.2011 where sum insured is Rs. 2,00,000.00. In previous policy also. Sum Insured is same . The stand taken by the respondent insurance company that the disease Osteo Arthritis falls under waiting period of 4th and 5th year of the policy is untenable. No where in the policy conditions it is stipulated that the Sum Insured will be restricted to the sum insured initially opted(in this case Rs.50000/-). If this logic is applied the very purpose of enhancing sum insured gets defeated.**

Decision: Forum observed that the respondent company has not processed the claim on fair and equitable basis. The claim is very much payable in full. The respondent company was directed to pay balance amount Rs. 1,17,925.00 to the insured complainant.

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MUMBAI OMBUDSMAN CENTRE

Complaint No. GI-1092 of 2011-2012

Award No. IO/MUM/A/GI /2012-2013

Complainant's father was hospitalised at P.D. Hinduja National from 15/3/2011 to 6/4/2011 for Radiotherapy for CA Prostate. The claim papers were submitted to the TPA through Broker on 28/4/2011. The claim was rejected by the TPA on the ground of delay in submission of claim papers. Complainant represented to the Insurance Company requesting condonation of delay and reconsideration of the claim. The Company however upheld the stand taken by the TPA. The complainant contended that she could not submit the claim papers in time due to situations which were beyond her control.

Observations of the Forum : In the present case, there was no dispute that there had been some delay in submission of claim papers by the Insured with reference to the time limit laid down in the policy. However, when one looks at the stipulation that the claim papers should be submitted within 7/15/30 days etc. from the date of discharge, the question arises as to whether this is a mandatory condition and non-observance will deprive a claim under the policy. A common sense approach to this issue will point out that in a Mediclaim insurance policy, it is the insured who is interested in getting reimbursement of the claim at the earliest opportunity and it in his/her own interest that he/she submits the claim papers expeditiously. The general experience is that claims are preferred well in time and cases of delayed submission are very few. Again one has to ask the question whether there is any adverse selection against the insurer, if a claim is submitted with delay. Obviously the answer is in the negative, except in cases where a fraudulent claim is preferred which has to be established by the insurer with the support of documentary evidence. Hence in the absence of concrete evidence which leads the Insurer to conclude that the delayed submission of the claim is an attempt to cover the fraudulent intention on the part of the insured, the Insurers cannot deny the claim only on the pretext of delayed submission. The stipulation of submission of claim papers within 7/15 or 30 days is an enabling provision for the insured to facilitate prompt settlement of the claim and this cannot be used in detriment to the interest of the insured.

It was also observed that the delay in submission of claim was not so inordinate so as to have changed the characteristics of the claim or in any way aggravated the claim. Therefore, delay in submission of the claim was not in any way material to the claim and did not assume such significance as to have a bearing on the liability of the insurers so as to impel them to repudiate the liability under the claim. Further, the Company did not find out whether the said claim was not payable even if it had been reported in time. In other words, they had not examined the merits of the case and have just denied the claim on grounds of delay.

For all the reasons as mentioned above, coupled with the fact that the Insured was a senior citizen undergoing treatment for cancer, a relief was granted to the complainant and Insurance Company was directed to settle the claim for the admissible expenses.

MUMBAI OMBUDSMAN CENTRE

Complaint No. GI- 2442 of 2011-2012
Award No. IO/MUM/A/GI /2012-2013

Complainant approached this Forum with a complaint against the Insurance Company in the matter of non-settlement of his claims in respect of treatment taken by him for Age related Macular degeneration (ARMD/CNVM right eye) by way of Lucentis Injection. The claim lodged by him was denied by the Company stating it was an unapproved OPD procedure excluded from the scope of the Policy. The complainant represented but the Company however upheld its stand of rejection.

Observations of the Forum : This Forum had heard number of complaints in this regard in the past and on an examination of all the facts/documents produced before the Forum by the Complainant and the Company, the Forum was of the view that:-

- **The treatment undergone by the Complainant seems to be one of advancement of medical technology in as much as the injections which are administered have been permitted to be imported only from 2006.**
- **The information collected through websites indicates that this procedure is simple and is done in "Doctor's Office". The Doctor's Office in the opinion of the Forum cannot be the consulting room under the environment, which is existing in our country and it is therefore understood that the injections are administered in the operation theatre which has a sterile environment.**
- **The complainants have brought to the notice of the Forum that before the injection is administered the patient undergoes a pre-operative evaluation like blood test, FFA (Fundus Fluroscein Angiogram) etc to assess the fitness of the patient for administering the injection.**
- **The various certificates issued by the medical practitioners indicate that it is a day care procedure though in one of the complaints, the treating hospital viz. Aditya Jyot Eye Hospital Pvt.Ltd., has mentioned "intravitreal injections are always to be given in the operating theatre. According to the hospital protocol they are admitting the patient in the hospital for one day". This indicates that in some cases, patients are discharged on the same day and in some other case they stay in hospital for a day.**
- **This Forum is of the opinion that lot of new technologies are being introduced in treating diseases and the third party administrators who are expected to have expertise in the field of medicine are supposed to help the Insurer to keep abreast**

of changes, so that Insurers can bring about new products/modify existing products. It is a sad fact that the Mediclaim policies are not updated to keep in pace with such changes.

The facts that have been brought to the notice of the Forum clearly indicated that this procedure is an advancement of medical technology where minimum of 24 hours of hospitalization is not required. Based on the deposition, the forum noted that the treatment is a prolonged one wherein depending upon the prognosis the patient have to be administered more number of injections. Looking at the treatment undertaken by the complainant, the Forum found that the doctors have been administering Lucentis injections, which is costlier than Avestin and the criteria for choosing Lucentis over Avestin is not clear. Besides, the various certificates issued by the eye specialists indicate divided opinion amongst the doctors regarding the procedure being an inpatient or outpatient one.

Though the Forum was able to appreciate the case of the complainant in expecting the Insurer to settle the claims in as much as the treatment being a prolonged one and repetitive in nature but for all the reasons stated above, it was held that it would be reasonable that the complainant bears a part of the expenses. Accordingly, a practical view of the facts of the case was taken and it was decided that the cost of the treatment is to be shared equally between the complainant and the Company.

MUMBAI OMBUDSMAN CENTRE

Complaint No. GI-524/2011-2012

Award No. IO/MUM/A/GI- /2012-13

Complainant who was covered under Individual Mediclaim Policy admitted to Cumballa Hill Hospital with diagnosis of Obstructive Sleep Apnoea with Morbid Obesity and underwent Lap Sleeve Gastrectomy. The claim was repudiated by the TPA stating that the treatment taken was for obesity excluded under the policy. The complainant represented against the said repudiation to the Grievance Cell of the Insurance Company pleading that the treatment was not for obesity but for resolution of Sleep Apnoea with Hypertension which could not be resolved with conservative medical management; however failed to receive any response from the Company. Aggrieved, she approached this Forum for intervention in the matter of settlement of the claim.

The complainant then produced a certificate from Metabolic Surgeon, stating that as per details provided to him patient had failed to have resolution of Sleep Apnoea with hypertension and obesity with conservative medical management and these conditions, if remained uncontrolled may result in complications like cardiac/renal failure, brain stroke and early sudden death. Hence she underwent Lap Sleeve Gastractomy under his advice, and this surgery resolves sleep apnoea in over 90% patients, hypertension in over 60% patients, besides over 70% weight loss. He further stated that this surgery has metabolic impact and is not a cosmetic surgery and the patient has undergone the same as a life saving measure. However the TPA denied reconsideration of the claim.

<u>Observations of the Forum</u> : As per the certificate issued by the doctor, this surgery is typically advised to patients with one or more uncontrolled co-morbidities with BMI greater than 33 and results in improvement or resolution of co–morbidities, besides weight loss. Complainant met all the requisite criterion she was advised this surgery as a life-saving measure. Though improvement and resolution of other co-morbidities in obese patients has been observed as a result of weight loss after sleeve gastrectomy, nevertheless the fact remains that this surgery is an option for people who cannot lose weight by other means or who suffer from serious health problems related to obesity. In the present case complainant was obese and suffered from Obstructive Sleep Apnoea with recently diagnosed hypertension, hypothyroidism, cardiomegaly, B/L knee osteoarthritis which could not be resolved conservatively. Thus, it can be inferred that it

was primarily her condition of Obesity which necessitated the surgery. Since the treatment of Obesity is excluded from the scope of the Policy, Insurance Company repudiated the claim. Company's repudiation was therefore upheld.

MUMBAI OMBUDSMAN CENTRE

Complaint No. GI-583/2011-2012

Award No. IO/MUM/A/GI- /2012-13

Complainant's son was admitted to Jaslok Hospital for the treatment of Enteric fever. Against the claim lodged for reimbursement of hospitalization expenses of Rs.19,572/-, TPA paid an amount of Rs.16,339/-, deducting Rs.125/- as thermometer charges and Rs.3,108/- towards 20% Surcharge on the hospital bill. He was again admitted to the same Hospital from 18.12.2010 to 23.12.2010 for Relapse of Typhoid fever and the claim for Rs.28,170/- lodged for the said hospitalization was settled by the TPA for Rs.23,626/- deducting Rs.4,544/- on account of Surcharge. Complainant represented to the Insurance Company against short-settlement of both the claims; however failed to receive any response from the Company. Being aggrieved, he approached this Forum for intervention in the matter for settlement of the balance claim amounts.

Observations of the Forum : On perusal of the papers it was observed that the dispute centered around the issue of deduction of amounts of Rs.3,108/- & Rs.4,544/- as surcharge from the hospital bills amounting to Rs.16,549/- and Rs.25,034/- respectively. The complainant argued that there is no mention in the proposal form/policy about any such condition for deduction on account of surcharge in case of claim in respect of Jaslok Hospital and, if at all the Insurance Company has issued an internal circular to that effect, the same cannot be held binding on the insured persons unless it is specifically made known to them. The Insurance Company submitted that TPA has deducted 20% from the claim amount towards surcharge as per the Company's Circular as these charges do not constitute medical expenses.

TPA deducted surcharge on instructions from the Insurance Company based on communication from Jaslok Hospital stating that due to the implementation of new software and restructuring of billing systems, they have decided to merge the 20% Surcharge into the individual components of the bill. Although it was noted that Exclusion clause of the policy empowered the Insurance Company to disallow Service charges or any

other charges levied by the Hospital, however as far as the insured was concerned, he was not aware of such charges levied by the hospital in the absence of any such specific mention in the bill. Moreover, in a similar complaint heard earlier, it had been brought to the notice of the Forum that Jaslok Hospital had clarified that the Hospital has revised the tariff w.e.f. 15th April, 2009 and 20% surcharge, service charge and ward charges which were charged earlier have been abolished. Further, Jaslok Hospital & Research Centre reiterated as follows : "We once again categorically clarify that Jaslok Hospital does not have any component by the name of Surcharge charged in the bills. We have abolished this component in totality. Any deduction on the authorization of the policy holders based on this category will be illegal & unjustifiable." Considering the clarification given by Jaslok Hospital, disallowance of an amount by the Insurance Company as 20% surcharge based on an internal circular issued by them to the TPA, was held as unjustified.

Complaint No. GI-76/2011-2012

Award No. IO/MUM/A/GI- /2012-13

Complainant who was covered under Individual Mediclaim Policy was admitted to Jaslok Hospital for the treatment of type II Odontoid fracture due to an alleged fall. The claim lodged under the policy was repudiated by the TPA stating that hospitalization was for investigation purpose only not followed by any active line of treatment during stay. Complainant represented to the TPA/Company stating that she was advised hospitalization for immediate surgery, but the Spine & Ortho Consultant after examining her, decided to go in for conservative treatment for three months after which the decision whether to go in for surgery or not was to be taken. Finally, after three months she had to undergo a surgery at Hinduja Hospital, the claim for which was paid by the Company. As both the hospitalizations pertained to the same treatment, she requested for reconsideration of the claim. The TPA however after review, reiterated their stand of repudiation.

<u>Observations of the Forum</u> : On analyzing the facts and circumstances of the case, it was seen that prior to her admission in Jaslok Hospital, complainant had consulted Breach Candy Hospital with history of fall and complaints of neck pain. Since the X-ray taken at the time did not reveal a fracture, she was prescribed only oral tablets. However, as her neck pain persisted, she again approached Breach Candy Hospital when the X-ray & CT scan revealed Type II Odontoid fracture and she was advised immediate surgery for which she was admitted to Jaslok Hospital. After further investigations and on examining her condition Jaslok Hospital decided to follow conservative treatment to see if the fracture could heal naturally and hence she was advised to continue use of hard cervical collar till the decision about final treatment could be made and was discharged from the

hospital. Thereafter, she even consulted Neurosurgeon at Hinduja Hospital for second opinion. Therefore the Company's stand that the hospitalization was only for diagnostic/investigation purposes not consistent with or incidental to the diagnosis and there was no treatment of positive existence of an ailment/injury requiring hospitalization, was not found to be in order as it was noted that complainant already had a diagnosed fracture at the time of her admission to Jaslok Hospital and was hospitalized for further treatment of the same on the advices of a Spinal & Neurological Surgeon but the treating Orthopaedic surgeon at the hospital decided to treat her conservatively. It was thus held that the hospitalization cannot be said to be for investigation purpose only as there was positive existence of an ailment for which she was advised treatment, though conservatively. Company was directed to entertain the claim.

MUMBAI OMBUDSMAN CENTRE

Complaint No. GI-1091/2011-2012

Award No. IO/MUM/A/GI- /2012-13

Complainant's mother was admitted to Sanjay Gandhi Post Graduate Institute of Medical Sciences, Lucknow from 09.12.2010 to 10.12.2010 for the treatment of Hepatitis C for which he lodged a claim under the policy. The claim was rejected by the TPA under Exclusion clause 4.1 of the policy stating that the ailment was pre-existing to the inception of the policy. Complainant represented to the Company against repudiation of the claim; however the Company upheld the stand taken by the TPA. Aggrieved, he approached this Forum for redressal of his grievance.

Observations of the Forum : It was observed that complainant availed of the policy for the first time w.e.f. 23.08.2010. On 29.08.2010 his mother consulted the doctor with complaints of low grade fever since 1 month with SGOT & SGPT readings as 103 & 101 respectively. In view of her raised liver enzymes she was investigated for Chronic Liver Disease and was diagnosed as suffering from Hepatitis C. On 08.10.10 she was referred to M.D. for further treatment and was started on Inj. Viraferon peg (80) weekly for total 24 weeks from 10.11.2010. On 09.12.2010 she was admitted to Sanjay Gandhi Post Graduate Institute of Medical Sciences, Lucknow for IFN therapy as given weekly with 5th dose of IFN given on 08.12.10. She was found stable after injection and discharged on 10.12.10 with advice to continue the therapy for 24 weeks with monitoring for side-effects. The claim was rejected by the TPA under policy exclusion clause 4.1 stating that Chronic hepatitis C is defined as an infection with Hepatitis C virus persisting for more than six months and date of policy inception being 23.08.2010, admission to the hospital on 09.12.2010 was for an ailment pre-existing to policy inception. The reason cited by the TPA was not acceptable to the complainant who argued that the patient was detected of Hepatitis C-geno 3 in October 2010 which justifies that there was no such past history found in the patient. Also that the diagnosis column mentioned the name of the disease

& the RNA value as found on 04.11.10 (after the related testing) and on the basis of which the patient was advised to start immediately Inj. Viraferon peg (80) weekly X 24 weeks (min) + ribavirin 1000 mg.

The *symptoms* of hepatitis C are difficult to recognize, for they are progressive in nature and often very mild, at least in the early stages of infection. For more than six months following initial infection, the disease is virtually undetectable. The most common symptom, commencing sometimes years after initial infection, is fatigue. Other symptoms include mild fever, muscle and joint aches, nausea, vomiting, loss of appetite, vague abdominal pain, and sometimes diarrhea. Many cases go undiagnosed because the symptoms are suggestive of a flu-like illness which just comes and goes, or these symptoms are so mild that the patient is unaware of anything unusual. Individuals infected with HCV are often identified because they are found to have elevated liver enzymes on a routine blood test or because a hepatitis C antibody is found to be positive at the time of blood donation. In general, elevated liver enzymes and a positive antibody test for HCV (anti-HCV) means that an individual has chronic hepatitis C. Low level infection, in which the infected individual is virtually asymptomatic but still highly contagious, may continue for years, even decades, before progressing significantly.

From the above it can be seen that though infection may persist, the disease may remain undetected for months together since initial infection as the symptoms are very mild and progressive in nature in the initial stage. Even in the instant case, although the patient was diagnosed of Chronic Hepatitis C only after investigations carried out thereafter, the fact cannot be denied that she had symptoms of the disease – in this case mild fever, which date back prior to the inception of the policy, though it is possible that she might not be aware of the existence of the same and hence went undiagnosed till she was investigated for the same. The policy was in its first year of operation. Hence the decision of the Insurance Company to repudiate the claim as arising out of a pre-existing condition/ailment was found to be in order.

MUMBAI OMBUDSMAN CENTRE

BEFORE THE INSURANCE OMBUDSMAN

(MAHARASHTRA & GOA)

MUMBAI

Complaint No. GI- 392 of 2011-2012

Award No. IO/MUM/A/ /2012-2013

Complainant : Shri N.K. Avashia

V/s.

Respondent : United India Insurance Co. Ltd.

Shri N.K. Avashia approached this Forum with a complaint against United India Insurance Company in the matter of non-settlement of his wife's claim amounting to Rs. 12,214.29 lodged in March 2006 as also for expunging of the exclusion of 'Cataract' which is continuing till date since the date of inception of the Policy in 2004.

United India Insurance Company submitted that Insured and his wife were covered under the old Individual Mediclaim Policy under which as per exclusion clause 4.1, pre-existing disease are permanently excluded from the scope of the Policy. In the present case, ailment of cataract was specifically excluded from the scope of the policy for both Shri & Smt. Avashia and therefore, the same will be a permanent exclusion as they have opted for old Individual Mediclaim Policy. The coverage of pre-existing diseases after 3 years is only available to those who have opted for the new scheme i.e. Individual Health Policy.

As regards, the claim of Smt. Avashia, the Company mentioned that Smt. Avashia was hospitalized from 13/12/2005 to 14/12/2005 for treatment of Interstitial Lung Disease at Bhailal Amin General Hospital for which the history as per the hospital papers were written as since 1 ½ yrs and since the claim has been lodged in the first year of the policy, the ailment becomes pre-existing and hence not payable under the policy.

On perusal of the hospital case summary it was noted that the patient had history of Lung disease since 1 ½ years. Since the claim has been reported in the first year of the policy itself and the ailment has been diagnosed to be of a chronic nature with history of 1 ½ yrs, it would fall prior to incept of the policy and hence the Company's stand was held to be tenable.

As regards the complainant's request for deletion of the specific exclusion of Cataract imposed by the Company on the face of the Policy, it was noted that in the year

2007, United India's erstwhile Mediclaim Policy was replaced by new Health Insurance products. which extended the benefit of coverage of pre-existing ailments after 48 months of continuous coverage, which hitherto was permanently excluded from the scope of the Policy. However, the Senior citizens who were their existing Policy holders were not compelled to migrate to the new scheme if it was to their disadvantage and were allowed to renew the policy on existing terms & conditions. The Insurance Company mentioned that in case of Shri Avashia, the Individual Mediclaim Policy which incepted from 21/12/2004 was continued as per his choice and it was being continuously renewed by him. It was observed that the Policy was issued with exclusion of Cataract for Shri Avashia and his spouse based on the pre-insurance medical examination done.

It was noted that General Insurance Council directed all Non-life Insurance Companies to adopt the uniform definition of Pre-existing diseases and related exclusion wordings for all Medical expenses Policies issued or renewed after June 1 2008. It was felt that the idea of introduction of the coverage of Pre-existing ailment/condition after four consecutive policy periods was with a purpose of extending the benefit of coverage of pre-existing ailments which hitherto were totally excluded from the scope of the Policy.

United India Company however clarified that as per exclusion clause 4.1 of the Individual Mediclaim Policy, the pre-existing ailment and its complications are permanently excluded from the scope of Individual Mediclaim Policy. The pre-existing clause waiver (i.e. coverage of pre-existing diseases after 4 years) was applicable to the revised Health Policies only. In this connection, whether the directives issued by General Insurance Council would also apply to those Policy holders for whom the erstwhile Mediclaim Policies are continued, is not clear and the Company also has not given their comments on the same.

Under the circumstances, there was no option but to go by the terms and conditions forming part of the Individual Mediclaim Policy issued to Shri Avashia. The only alternative available to the complainant, if he wished that his pre-existing disease should be covered under the policy, was to shift to the revised Individual Health Policy. Hence a direction was given to the Company to get in touch with the complainant and explain the merits and demerits of revised Individual Health Policy in comparison with the existing Individual Mediclaim Policy coverage-wise as also premium-wise and give an opportunity to the complainant to exercise his option for choosing the policy suitable to him at the time of renewal in 2012-2013.

The complainant was advised to approach the Insurance Company and take appropriate decision in the matter.

MUMBAI OMBUDSMAN CENTRE

THE OFFICE OF THE INSURANCE OMBUDSMAN
(MAHARASHTRA & GOA)

Complaint No. GI- 939/2011-2012

Award No. IO/MUM/A/ GI- /2012-2013
Complainant : Shri Mrugank Desai

Respondent: United India Insurance Co. Ltd.

Shri Mrugank Desai was covered under Individual Health Insurance Policy No.021200/48/10/97/00007544 for the period 30.03.2011 to 29.03.2012 for Sum Insured of Rs.1,50,000/-, issued by United India Insurance Co. Ltd. On 27.04.2011 Shri Desai was admitted to K.D. Ambani Hospital for Coronary Angiography and was diagnosed as suffering from Coronary Artery Disease. He was advised 1) PTCA to RCA (Multiple stents) and later OM; 2) CABG (LAD not critically diseased). Meanwhile, he consulted Dr. Ramakant Panda who advised him to undergo External Counter Pulsation (ECP) treatment and Cardiac Rehabilitation for the same. Accordingly, he underwent External Counter Pulsation therapy starting from 09.05.2011 daily for 35 days at Asian Heart Institute, Bandra, Mumbai. On lodging a claim for Rs.1,05,459/-under the policy, the TPA/Insurance Company paid only Rs.23,359/-for CAG whereas the expenses incurred on ECP treatment were denied on the ground that it was an unproven treatment.

This Forum had received similar complaints in the past wherein the Insurance Company, in support of their decision had forwarded opinion of Dr. Gupta of Adroit Consultancy Medico Legal Services stating that while EECP treatment is recognized by US FDA, there is no approval for this treatment by DGHS or Indian FDA and it is still an experimental treatment in India. Against this, one of the complainants submitted a certificate from Dr. Ramakant Panda stating that Enhanced External Counter Pulsation (EECP) is a standard test approved by the American Heart Association (AHA) as one the medical treatment for patient with Coronary Artery Disease. Dr. Panda has also clarified

that since there are no guidelines given by any other Cardiology Association in India, AHA's guidelines are being followed in general.

Dr. Ramakant Panda of Asian Heart Institute is a world-renowned cardiac surgeon and it can be definitely said that he will practice only those treatments which are tested and conducive to human healthcare and hence it was difficult to believe a medical treatment practiced by Dr. Panda being termed as experimental or unproven. But unfortunately this was the Company's stand. As per certificate dt. 09.05.2011 issued by Dr. Aashish Contractor of Asian Heart Institute, Phase II Cardiac Rehabilitation is the 'standard of care' treatment for patients on Medical Management, Angioplasty as well as CABG patients, which is followed all over the world. I feel that at the most the companies can take a stand that EECP treatment does not require hospitalization and hence does not come under the purview of a Hospitalization Benefit Policy.

Again, the treatment indicates that is a non-invasive treatment and is economical compared to other treatments for Heart diseases. I find the persons who have undergone EECP treatment are able to lead a fairly better quality of life after the treatment and many a complainant who has come and deposed in person bears ample testimony for the effectiveness of the treatment. It is also said that EECP treatment is approved by FDA in U.S.A. in 1995 for treatment of Coronary Artery Diseases and angina and in 2002 it was approved for treating congestive heart failure. It is also seen that many leading Heart Hospitals and cardiologists are practicing the same in India.

It is unfortunate that Insurance Companies are not keeping themselves ahead in times by including coverage of all new types of treatments. The question whether there is an appropriate body in India which approves such new method of treatments remains unanswered by the companies. Providing Healthcare is the basic objective of Health Insurance Policy and there should be a comprehensive and coordinated effort by all Insurance Companies to seek relevant information from Hospitals, leading Doctors and arrive at an exhaustive list of treatments which are to be included in the Mediclaim Policy. Insurance Industry is a customer-centric Industry and they have to provide a basket of services to the insuring public, who can afford to have adequate health Insurance cover. The Third Party Administrators who are supposed to have expertise in the field of medicine should play an enabling role and help the Insurance Companies to keep abreast of the changes, bring in new products and modify existing products. I would like to exhort all insurance companies to work under the banner of General Insurance Council and revisit the terms and conditions, benefits and privileges under a Health Insurance policy so that the insured public will get the best for their money's worth.

At the same time, I would like to bring to the notice of the complainant that the proceedings in this Forum are summary in nature and different from that adopted by

Consumer Forums/Civil courts. The Forum has inherent limitations in going beyond the provisions of the policy contract. The relief to the consumer will lie only when I find that there is a breach of policy conditions while denying a claim. I cannot grossly overlook the terms and conditions stipulated in a product which has been approved by the Regulator.

In the present case where the Insurance Company has denied the expenses of EECP treatment, which is mainly an out-patient procedure, I find that the procedure does not strictly qualify for reimbursement since Mediclaim Policy issued by the Company is primarily to cover expenses of hospitalization. Thus I do not find that the denial is in contravention of any of the policy conditions. At the same time I would like to record that I am not able to fully appreciate the stand of the Company that EECP treatment is an unproven and experimental treatment. However, it is essentially an OPD procedure not requiring confinement to hospital. I therefore do not find any justifiable reason to intervene with the decision of the Insurance Company.

O R D E R

The balance claim of Shri Mrugank Desai in respect of expenses incurred on ECP treatment undergone by him at Asian Heart Institute from 09.05.2011 daily for 35 days is not tenable. The case is disposed of accordingly.

Dated at Mumbai, this ______ day of October, 2012

INSURANCE OMBUDSMAN

MUMBAI OMBUDSMAN CENTRE

BEFORE THE INSURANCE OMBUDSMAN

(MAHARASHTRA & GOA)

MUMBAI

Complaint No. GI-1027of 2011-2012

Award No. IO/MUM/A/GI- /2012-2013

Complainant: Smt. Kalyani Venkatraman

V/s

Respondent: The New India Assurance Company Limited

Smt. Kalyani Venkatraman approached this Forum with a complaint against New India Assurance Company Limited in the matter of non-collection of loading premium for compulsory coverage of DM for the year 2009-2010.

Insurance Company submitted that Smt. Kalyani Venkatraman was earlier covered with their Warden Office DO No.112500 during the period 2007-08, 2008-09, 2009-10. In the year 2010, she approached their Office for renewal of the Policy. Based on the Policy document for the year 2009-10 of Warden Office DO, their Office renewed her policy for the year 2010-11, however without allowing CB benefit. When insured submitted CB confirmation from DO 112500, it came to their knowledge that Smt. Kalyani was diabetic and her policy issued for the year 2007 had exclusion of diabetes. Accordingly, their Office passed endorsement incorporating CB under the Policy and also collected loading premium for diabetes stating in the said endorsement that "This is the First Year where Diabetes loading is collected." As per the Company's contention, although the Warden Office DO had collected loading premium for Diabetes in the years 2007-08 & 2008-09, this qualification was specifically incorporated in the endorsement in view of the fact that the said DO had not collected the loading premium for the year 2009-10. The Company stated that it was not possible to collect loading premium for the year 2009-10 at their Office, since the policy for the year 2009-10 had been issued by their different Office and also the said policy had already expired.

The complainant argued that the extra premium was paid by her for the years 2007-2008 and 2008-2009, but for reasons not known to her, the DM loading was not reflected in policy for the year 2009-2010. As she had paid renewal through blank cheque, the reasons for this non-inclusion of loading for DM by the Insurer was beyond her control and comprehension. She mentioned that she had sent representations in this regard to the regional office of both the above referred divisional offices, however, there was no proper response from them. She stated that even though the non-charging of loading for the year 2009-2010 was not her fault, she was still willing to pay the loading for that year, but the Insurance Company wass reluctant to accept the same.

From the previous policy copies submitted to the Forum, it was observed that the previous Divl. Office 112500 did collect the loading premium for compulsory coverage of DM for the years 2007-2008 and 2008-2009 apparently based on the declaration made by the Complainant. Why then they did not collect it for the year 2009-2010 is best known to them. The decision of DO141700 to treat the loading for DM paid in the year 2010-2011 as the first year of loading would not be correct as the complainant had paid loading premium right from the time it was applicable under the policy ie. 2007-2008 and its renewal. The non-collection of the loading in the year 2009-2010 was entirely due the lapse on the part of the Insurance Company. Any shortfall or errors in the policy or in collection of premium is the responsibility of the Insurance Company and not the Insured; no doubt the Insured should have checked the policy issued to her and raised the issue at the appropriate time.

The Insurance Company was directed to collect the appropriate premium towards loading for coverage of DM for the year 2009-2010 and grant the continuity benefit to the complainant to that effect by passing suitable endorsement at their end to resolve the dispute in the present case.

O R D E R

The decision of the Insurance Company to treat the loading for coverage of DM collected by them under Policy No. 141700/34/10/11/00003697 vide Endorsement No.141700/34/10/11/82000177 as the first year of loading is not tenable and they are therefore directed to grant the benefit of continuity by collecting the loading premium for the year 2009-2010 .

Insurance Ombudsman

<u>MUMBAI OMBUDSMAN CENTRE</u>

BEFORE THE INSURANCE OMBUDSMAN

(MAHARASHTRA & GOA)

<u>MUMBAI</u>

Complaint No. GI-1922/2010-11

Award No. IO/MUM/A/GI- /2012-13

Complainant: Shri Sudhir G. Upadhye

<u>Respondent: Oriental Insurance Company Limited.</u>

Shri Sudhir G. Upadhye was covered under Individual Mediclaim Policy No.123200/ 48/2010/2762 for the period 27.01.2010 to 26.01.2011 for Sum Insured of Rs.1,00,000/-, issued by The Oriental Insurance Company Ltd. Shri Upadhye approached this Forum with a complaint against non-settlement of his claim under the policy, by the Insurance Company.

All the papers produced before the Forum were scrtutinized. It was observed that Shri Sudhir Upadhye aged 45 years, availed of Individual Mediclaim Policy from The Oriental Insurance Co. Ltd. for the first time w.e.f. 27.01.2010. At the time of taking the policy he was not required to undergo any pre-insurance health check-up and in the proposal form had mentioned "nil" against the column "pre-existing disease". On 22.11.2010 he was admitted to Jyotirmoy Hospital & Heart Care Centre with complaints of severe chest pain radiating to left arm (back) with sweating. As per noting in the hospital discharge card he had no h/o DM/HT/IHD/Smoking/Alcohol. ECG done revealed Acute Inferior Infarction with reciprocal changes in anterior heads. He was transferred to Icon Hospital for Coronary angiography wherein he was diagnosed of severe DVD with LV dysfunction with DM and was advised CABG. He underwent CABG at P.D. Hinduja Hospital on 15.12.2010.

The claim lodged for the said hospitalization was denied by the TPA on the ground that the policy was in its first year of operation and CAG documented advanced coronary artery disease with major occlusion of two vessels which indicated that the ailment was long-standing and pre-existing to the inception of the policy. Shri Upadhye contested the repudiation stating that he never experienced any symptoms of heart disease prior to his admission in November 2010 and hence the disease cannot be termed as pre-existing. He also produced a certificate from Dr. Pravin Kahale, Interventional Cardiologist, Icon

Hospital stating that he had no past history of ischemic heart disease as per history given by patient. The Insurance Company referred the file to Dr. Bomi B. Ichaporia, M.D. (Med.), D.M. (Card), Consultant Cardiologist & Physician who after perusal of the papers, opined that it is quite possible that the insured was unaware of his underlying condition i.e. CAD and indeed the discharge summary of Hinduja Hospital mentions that the patient had no complaints such as chest pain, dyspnoea (breathlessness), palpitations, orthopnoea or oedema (swelling) of the feet. However, he has further stated that the discharge summary also indicated that he had four stenoses (i.e. blockages) in his coronary arteries, three of them severe (90%,80% & 80% lesions) and underlying blockages such as these typically develop over several months and years although it is not possible to say exactly when they first occurred. He was therefore of the opinion that they must almost certainly have been present at the time of inception of the policy about 10 months earlier, though they could possibly have been somewhat less severe.

Analysis of the case reveals that the complainant aged 45 years, was diagnosed of Double Vessel CAD with DM and had to undergo CABG for the same in December 2012 i.e. within 11 months from inception of the policy. His CAG report showed proximal 90% stenosis, mid segment 80% stenosis. RCA 80% lesion in the mid segment. 70% lesion in the distal artery which normally develop over a period of time. On examining the classical theories in regard to the factors leading to CAD it is seen that development of CAD is a long-drawn slow process. Though the complainant has argued that he did not suffer from any heart disease prior to this hospitalization, the fact that just as in the case of a silent angina, the persons having no chest pain also run the same risk of having heart attack as those with angina would substantiate a whole host of cases where despite showing no symptoms, people have developed CAD. The decision of the Company therefore appears to be technically in order. However, considering the relatively young age of the complainant and the nature of ailment suffered by him, I am inclined to take a sympathetic view of the situation and give him some benefit by allowing the claim partially on ex-gratia basis.

Under the circumstances, I pass the following Order:

ORDER

The Oriental Insurance Co. Ltd. is directed to pay Rs.25,000/- on ex-gratia basis to the complainant Shri Sudhir G. Upadhye against his claim for reimbursement of expenses incurred on his hospitalization at Jyotirmoy Hospital & Heart Care Centre, Dombivli from 26.11.2010 to 27.11.2010 and at P.D. Hinduja Hospital from 12.12.2010 to 22.12.2010 for the treatment of IHD. There is no order for any other relief. The case is disposed of accordingly.

INSURANCE OMBUDSMAN

MUMBAI OMBUDSMAN CENTRE

BEFORE THE INSURANCE OMBUDSMAN

(MAHARASHTRA & GOA)

MUMBAI

Complaint No. GI-395 of 2011-2012

Award No. IO/MUM/A/GI- /2012-2013

Complainant: Shri Suresh Bhadrecha

V/s

Respondent: Oriental Insurance Company Limited

Complainant, Shri Suresh Bhadrecha approached this Forum with a complaint against Oriental Insurance Company in the matter of partial-settlement of his hopitalisation claims lodged in respect of his wife, Smt. Dipti Bhadrecha, pertaining to her various hospitalisations for treatment of Ca Ovary stage IV.

On scrutiny of all the documents submitted to the Forum, it is observed that the earliest policy available on record for Shri Bhadrecha and his family members was for the year 2006-2007 of Reliance General with an accrued CB of 10% on sum insured of Rs. 4 lakhs for Shri Bhadrecha and his spouse and Rs. 50,000/- each for his two daughters. The said policy was a renewal of New India, DO 130200 with whom he was holding the policy since 2004-2005 as evident from the accrued CB of 10% granted by Reliance General Insruance Company. He was holding the policy with Reliance General Insurance Company from 2/11/2006- 1/11/2010. Shri Bhadrecha then opted for a Family Floater Policy for a floater sum insured of Rs. 8 lakhs from 2/11/2010-2011.

Immediately within a month and a half, i.e. on 22/12/2010, Smt. Bhadrecha was admitted to Kokilaben DA Hospital & Medical Research Centre for complaints of diffused abdominal pain associated with nausea and loose motions since 2-3 months with severity of pain increased during the past 1 month and h/o fever since 1 month. She was investigated and during evaluation she was found to have pelvic mass right hydroureteronephrosis, thickened interior wall and right plueural effusion. The diagnosis was Carcinoma Ovary with metastasis in Peritoneum, Omentum, Liver and Spleen. She was treated conservatively and discharged on 27/12/2010. Thereafter she underwent 3 cycles of chemotherapy at Sushruth Hospital on 30/12/2010, 20/1/2011 and 10/2/2011.

She was readmitted to Kokilaben Hospital on 7/3/2011 for Cytorective Surgery. The diagnosis as per the discharge summary was "Ca Ovary Stage IV post- 3 neoadjuvant chemotherapy". CT Scan of the Abdomen and Pelvis done revealed illdefined pelvic mass 7x6 cms involving sigmoid mesocolon, Peritoneal Nodules+ Splenic Metastasis+. She underwent exploratory Laparotomy plus Hystrectomy + Bilateral Salphingo ophrectomy + Omentectomy+ Bilateral Pelvic Node dissection + Anterior Resection and Splenectomy on 8/3/2011. Subsequently, she underwent chemotherapy from 7/4/2011 to 29/10/2011.

Shri Bhadrecha lodged claims amounting to Rs. 8 lakhs in respect of his wife's hospitalization and chemotherapy treatments. The TPA settled the claims lodged upto the surgery lodged for Rs. 5,79,944/- to the extent of the original sum insured of Rs. 4 lakhs and the subsequent claims have all been rejected by the Company stating that the sum insured had exhausted for the said illness. The complainant contended that the ailment was not pre-existing as it was detected after taking the policy from Oriental Insurance Company and since he was covered for a floater sum of Rs. 8 lakh, the same should be paid.

It is observed from the hospitalisation papers that the ailment was diagnosed as "Carcinoma Ovary with Metastasis". Metastasis means spreading of the disease from the primary origin to other regions of the body. In the instant case it is recorded in the first hospitalization papers itself that the disease had already spread to the Periotoneum, Omentum, Liver and Spleen. The discharge summary of the second hospitalisation for surgery mentions the diagnosis as "Ca Ovary Stage IV. Further, the CT Scan of the Abdomen and Pelvis done revealed illdefined pelvic mass 7x6 cms. She had prior symptoms in the form of diffused abdominal pain associated with nausea and loose motions since 2-3 months (which falls prior to the subject policy) with a history of passing stools after eating 10 times a day, for which she must have certainly consulted some doctors and taken treatment. Therefore, in view of the above notings in the hospital papers, it is logical that the ailment was present and the process of carcinoma had started even before the policy with floater sum insured of Rs. 8 lakhs was taken and hence pre-existence of the disease cannot be ruled out. It should be noted that all increases are fresh contracts to the extent of the amount increased and therefore the increased portion would attract the waiting period of 4 years as per clause 7(c) of the policy.

Based on the medical notings, the contention of the Insurance Company that the disease was pre-existing to the incept of floater policy and therefore the claim was settled to the extent of original sum insured is tenable. However, looking to the nature of the disease suffered by the Insured coupled with the fact that the ailment though existing was detected only during hospitalisation by way of investigations, I take a compassionate view

on the matter and grant a lumpsum amount of Rs. 50,000/- to mitigate the grievance of the complainant.

ORDER

In the facts and circumstances, the Insurance Company decision to settle the claim to the extent of original sum insured is tenable. However, they directed to pay to the complainant a lumpsum amount of Rs. 50,000/- on ex-gratia in respect of his wife's claim for chemotherapy treatment taken at Daycare Agnels and Sushrut Hospital on the dates mentioned above. The case is disposed of accordingly. There is no order for any other relief.

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Insurance Ombudsman

MUMBAI OMBUDSMAN CENTRE

BEFORE THE INSURANCE OMBUDSMAN

(MAHARASHTRA & GOA)

MUMBAI

Complaint No. GI-476/2011-2012

Award No. IO/MUM/A/GI- /2012-13

Complainant: Shri Suresh M. Karanjolkar

V/s

Respondent: Oriental Insurance Company Limited.

Shri Suresh M. Karanjolkar was covered under Individual Mediclaim Policy No.122200/48/2010/8976 for the period from 1/3/2010 to 28/2/2011 for Sum Insured of Rs.1 lakh issued by The Oriental Insurance Company Ltd.

Shri Karanjolkar was admitted to KEM Hospital for Ischaemic Heart Disease Acute AWMI on 8/4/2010. He underwent Coronary Angiography which revealed Coronary Artery Disease – Triple Vessel Disease and was advised CABG. He did not undergo the surgery but was conservatively treated and discharged from the hospital on 16/4/2010. A claim lodged by him for reimbursement of hospitalization expenses of Rs.13,984/- was repudiated by M/s. M.D. India Healthcare Services exclusion clause 4.1 stating that current illness is a complication of Hypertensin which is since 7-8 years as per the hospital papers. Shri Karanjolkar represented against rejection of the claim to the Insurance Company stating that the history of HTN 7-8 years has been wrongly recorded by the doctor and the doctor has issued a revised medical report to be read as HT since last 7-8 months instead of 7-8 years. However, the TPA/Insurance Company did not settle his claim.

Analysis of the case revealed that the complainant had disputed the history of HTN of 7-8 years, on the basis of which his claim was repudiated by the TPA/Insurance Company. History of HTN had been initially recorded by the doctor at KEM as 7-8 years and later on it was scored off to read as 7-8 months. However, in the claim form, the complainant's family physician has mentioned that HTN was detected on 5/4/2010 i.e. 2-3 days prior to his hospitalization which is contradictory to the history of HTN initially recorded in the KEM Hospital papers of 7-8 years as well as the subsequent corrected history of 7-8 months. Since there was discrepancy in the history of HTN recording, it would have been appropriate for the Company to verify with the attending doctor about the factual position. However, this was not done. Since the existence of HTN at the time of proposing for insurance has not been established by the Company by way of any past treatment records, the denial of the claim only on the history recorded is not tenable. At the same time, the fact cannot be overlooked that the Angiography report revealed occlusions and the doctor qualified it as TVD i.e. triple vessel disease with stenosis of 90% 70% and 50-60% which suggests that the ailment was not of a recent origin and must have been there for quite some time, as blockages typically develop over several months and years. Further, apart from HTN, he had other risk factors such as Hypercholesterolaemia and obesity,as per the medical documents, all of which would have contributed to his health condition.

Since pre-existence of HTN is not conclusively proved in this case, it would be equitable to grant the benefit of doubt to the complainant and therefore, the decision of the Insurance Company is intervened by the following Order.

ORDER

In the facts and circumstances, Oriental Insurance Co. Ltd. is directed to settle the claim of the complainant and pay 50% of the admissible expenses against his claim for reimbursement of expenses incurred on his hospitalization at KEM Hospital from 8/4/2010 to 16/4/2010. There is no order for any other relief. The case is disposed of accordingly.

INSURANCE OMBUDSMAN

MUMBAI OMBUDSMAN CENTRE

Complaint No. GI- 640 of 2011-2012
Award No. IO/MUM/A/GI- /2012-2013
Complainant: Shri Suresh S. Bharadwaj
Respondent: National Insurance Co.Ltd.

Shri Suresh S. Bharadwaj was covered under Tailormade Group Mediclaim Floater Policy No. 250500/46/10/8500000017 for the period 01.04.2010 to 31.03.2011 for floater Sum Insured of Rs.2,00,000/- per family, issued by National Insurance Co. Ltd., D.O. 250500 to cover employees of M/s. Reliance Mediaworks Ltd. and their family members. In February 2011, Shri Bharadwaj was diagnosed as suffering from Hepatocellular carcinoma for which he was admitted to Jaslok Hospital from 03.03.2011 to 04.03.2011 and underwent CT guided RF ablation of Hepatoma. The claim lodged under the policy for reimbursement of hospitalization expenses of Rs.2,35,188/- was repudiated by M/s. Medi Assist India TPA Pvt. Ltd. under exclusion clause nos. 4.8 & 4.15 of the policy which exclude genetic disorders and diseases caused due to alcohol abuse. He argued that he had undergone multiple body check up tests in renowned hospital including Alpha 1 anti Trypsin Level test in the year 2010 all of which showed normal results, hence his present ailment cannot be termed as a genetic disorder. Further, the opinion of his treating doctor Dr. Samir Shah clearly eliminated any relevance of alcohol consumption as far as

HCC in this case is concerned and also that he was occasionally taking alcohol in past which too he stopped from August, 2010. He further argued that though there was family history, it could not necessarily be the same with every member of the family.

The Insurance Company on the other hand, maintained that Shri Bharadwaj had a strong family history of Liver cirrhosis and he also had a history of alcohol consumption. As alcohol consumption was a very strong cause and risk factor for developing cirrhosis/fatty liver disease the present ailment HCC was a complication of alcohol. The company based its decision on the opinion given by Dr. A.B. Patil MBBS, DFM, MD and Dr. Molinna Khana Gaestroenterologist stating that in the instant case there is a correlation between the predisposing factors like strong familial history of liver disease, alcohol consumption and HCC. Though the Insurance Company had initially taken the stand that the ailment suffered by Shri Bharadwaj was due to "genetic disorder", they finally repudiated the claim under exclusion clause 4.8 of the policy, relating it to his history of alcohol consumption.

Hepatocellular carcinoma accounts for most liver cancers. This type of cancer occurs more often in men than women. It is usually seen in people aged 50 or older. In most cases, the cause of liver cancer is usually scarring of the liver (cirrhosis). Cirrhosis may be caused by Alcohol abuse, Autoimmune diseases of the liver, Hepatitis B or C virus infection, Inflammation of the liver that is long-term (chronic), Iron overload in the body (hemochromatosis).

In the instant case, Shri Bharadwaj had developed cirrhosis of the liver. There was also a strong history of liver disease in the family. However, none of the tests undergone by him showed any genetic disorders. Also, his Alpha 1 antitrypsin level test showed normal results from which it can be reasonably concluded that his was not an acquired genetic disorder. The next question then arose as to what could have led to liver cirrhosis in his case. Shri Bhardwaj certainly had a history of alcohol consumption which is one of the strong causes for developing liver cirrhosis. Though it wass stated that he had stopped taking alcohol since August 2010, cirrhosis may manifest even at a later stage. Under the given circumstances, in his case cirrhosis of the liver being caused due to his habit of alcohol consumption appears to be a strong possibility. Nevertheless, to prove that his liver cirrhosis was of alcoholic etiology, the clinching evidence would have been a liver biopsy. However, there wass no histopathology report on record to establish that his liver cirrhosis was of alcoholic nature. Therefore it was held that though the Company's decision to repudiate the claim relying on exclusion clause 4.8 of the policy cannot be faulted with absolutely, the same was not substantiated by conclusive evidence. Under the circumstances, it was felt that the complainant be given some benefit of doubt by partially allowing the claim to resolve the dispute under the present complaint. The decision of the Company is therefore intervened by the following Order:

O R D E R

National Insurance Co. Ltd. is directed to settle the claim lodged by Shri Suresh Bharadwaj for his admission to Jaslok Hospital from 03.03.2011 to 04.03.2011 for the treatment of Hepatocellular carcinoma, upto the limit of 50% of the Sum Insured available under the policy. There is no order for any other relief. The case is disposed of accordingly.

Dated at Mumbai, this day of October, 2012.

INSURANCE OMBUDSMAN

MUMBAI OMBUDSMAN CENTRE

BEFORE THE INSURANCE OMBUDSMAN

(MAHARASHTRA & GOA)

MUMBAI

Complaint No. GI-272/2011-2012

Award No. IO/MUM/A/GI- /2012-13

Complainant: Smt. Prity N. Doshi

Respondent: The New India Assurance Company Ltd.

Smt. Prity N. Doshi was covered under Individual Mediclaim Policy No.140300/34/ 09/11/00021765 for the period 19.02.2010 to 18.02.2011 for Sum Insured Rs.5,00,000/- plus nil C.B. Smt. Prity was admitted to Bhartiya Arogya Nidhi General Hospital, Vile Parle, Mumbai from 18.11.2010 to 19.11.2010 and diagnosed of right eye 3rd cranial nerve partial paresis. The claim lodged under the policy for reimbursement of hospitalization expenses of Rs.28,597/- was repudiated by TPA M/s Medi Assist India Pvt. Ltd. under exclusion clause 4.4.11 of the policy stating that no treatment requiring indoor hospitalization was given and hospitalization was for diagnostic and evaluatory purpose.

On scrutiny of the papers it is observed that as per discharge card of the hospital, Smt. Doshi was admitted on 18.11.2010 with presenting symptoms "Right Eye Ptosis, vision hazy and double vision, rt. Pupil not reactive to light reflex, right side headache and vomiting twice with vertigo, since yesterday and cough." All the routine test findings showed normal results, MRI revealed no significant intracranial or intraorbital abnormality, CT revealed no significant arterial abnormality in brain and neck, so also no

abnormality was noticed in X-ray. She was treated with eye drops and oral tablets and was discharged from the hospital on 19.11.2010.

The stand taken by the company was not acceptable to the insured who produced a certificate dt. 20.01.2011 from her treating doctor Dr. Shilpa Kulkarni which stated "Patient presented with severe giddiness. There are many systemic and intracranial causes responsible for it, so she was admitted and her MRI and other investigations were also done."

As per information available on the internet about the condition suffered by the complainant when accompanied by headache and altered consciousness could be suggestive of incidence of a serious disease. Smt. Doshi presented with symptoms such as drooping of eyelids, headache and giddiness, thus suggesting a possibility of complications of serious nature and hence the treating doctor might have thought it fit to admit her for investigation and observations to decide on the future course of treatment. Fortunately for her the test results did not reveal any serious irregularities and with certain oral medications, she was discharged from the hospital on the next day. From the course followed in the hospital, it is seen that the patient was mainly subjected to investigations and major expenses consisted of these evaluative tests which were possible on OPD basis; therefore I cannot also find fault with the stand taken by the Company that these tests were possible on OPD basis and did not warrant hospitalization, which appears to be technically in order. At the same time, considering Smt. Doshi's presenting symptoms the need for hospitalization cannot be said to be altogether unwarranted. Mediclaim policy enjoins liability upon the Insurance Company to pay expenses for hospitalization done on the advice of a duly qualified medical practitioner. Under the circumstances, taking a balanced view I would like to give some benefit in favour of the complainant by allowing the claim to the extent of 50%, to resolve the dispute in the present case.

INSURANCE OMBUDSMAN
MUMBAI

MUMBAI OMBUDSMAN CENTRE

BEFORE THE INSURANCE OMBUDSMAN

(MAHARASHTRA & GOA)

MUMBAI

Complaint No. GI-1028/2011-2012

Award No. IO/MUM/A/ GI- /2012-13

Complainant: Shri R. Shrinivas

Respondent: United India Insurance Co. Ltd.

Shri R. Shrinivas approached this Forum with a complaint against United India in the matter of partial-settlement of his wife Smt. Shyamala Shrinivas's claim who underwent angiography followed by angioplasty at N.M. Wadia Institute of Cardiology, Pune on 27.07.2011. The hospital bill amounted to Rs.4,46,782/- against which TPA M/s. MDIndia Health Services Pvt. Ltd. paid Rs.3,23,806/- on cashless basis. Shri Shrinivas represented to the Insurance Company against short-settlement of the claim; however the Company upheld the decision of the TPA.

The Company was advised to forward a copy of the entire underwriting set with clarification on the circumstances under which the proposal was underwritten and also a detailed break-up of claim settlement done by the TPA Thereafter, vide e-mail dt. 11.06.2012 the Company was reminded to forward the details viz. :

1. **Whether SAIL floated a tender calling for quotes from different insurance companies**
2. **Details of tender documents submitted by the Company**
3. **Since when has the policy incepted with your office**
4. **Details of earlier policies held by SAIL alongwith respective terms and conditions**
5. **Details of Intermediary, if any who organized the policy**
6. **A copy of the proposal received from SAIL**

7. **The underwriting/acceptance procedure followed by the Company**
8. **The manner in which the policy terms & conditions were made know to the individual beneficiaries**
9. **Year-wise details of total amount of premium charged, no. & amount of claims lodged and settled.**

However there was no response from the Company despite several reminders sent thereafter and even after a reference was made to the D.G.M. of the Company's Delhi Regional Office-I vide letter dt. 26.08.2012..

On scrutiny of the documents, it is observed that United India Insurance Co. Ltd. issued a Group Tailormade Mediclaim Policy to cover retired employees of Steel Authority of India Ltd. and their spouses for the period 01.01.2011 to 31.12.2011. Vide Endorsement No. 041100/48/11/41//82000012 dt. 01.01.2011 to the policy, it was declared and agreed that the condition or clauses covered under the above-mentioned policy shall be read as per Tender document-2011 in place of MOU. As per Technical Specification of SAIL Mediclaim Scheme incorporated in the Tender document the Sum Insured under the policy for hospitalization was Rs.2 lacs per member with a facility of clubbing the Sum Insured between the member and his/her spouse. The Scheme also provided for, among other things, capping in the area of room rent charges, the Implants/Stents used under various procedures like cataract surgery, coronary angioplasty, joint related disorder requiring knee/hip joint replacement excluding the associated procedure charges. The Ceiling rates payable for different types of Coronary Stents were to be as per the actual rates or the rates as mentioned under the Scheme, whichever was lower.

The dispute is about restricting the cost of stents under the claim. The Insurance Company in support of their stand, has quoted condition no. 21 of the SAIL Mediclaim Scheme which provides for such ceiling rates for different types of Coronary Stents and have stated that these cappings have been mentioned in the Technical Specifications given by the SAIL in their Tender Document itself and not imposed by the Insurance Company. Though the Company has forwarded a copy of the Tender Document purported to have been given by SAIL, the said copy does not bear the signature or seal of any authorized person of SAIL or that of the Insurance Company to evidence that the copy of the Tender document referred to by the Insurance Company as finally incorporated as a part of the policy document issued to SAIL is the same which was proposed by SAIL.

Also, in the instant case the basis on which these limits on the rates of Implants/Stents has been fixed is not known when the market rates of the same could be on the higher side, thereby putting the insured to disadvantage.

Taking into account all these aspects, the Insurance Company was directed to submit the details as mentioned hereinabove which would have thrown light on the circumstances under which such restricted cover was sought by SAIL, whether such policy was issued for the first time or whether it was a renewal of an earlier policy, the terms and conditions offered under the previous policy, if any, the manner in which the beneficiaries under the policy were informed about the policy terms and conditions, etc. This

information was important to enable the Forum to examine the case in its entirety and arrive at a logical conclusion. However, despite repeated reminders, the Company did not provide the required information and has thus failed to conclusively establish their stand in restricting the claim. I am therefore, constrained to allow an ex-gratia payment to the complainant to resolve the dispute.

INSURANCE OMBUDSMAN
MUMBAI

MUMBAI OMBUDSMAN CENTRE

BEFORE THE INSURANCE OMBUDSMAN

(MAHARASHTRA & GOA)

MUMBAI

Complaint No. GI- 1074 of 2011-2012

Award No. IO/MUM/A/GI- /2012-2013

Complainant : Shri Rajesh C. Bhansali

Respondent : The New India Assurance Co. Ltd.

Shri Rajesh Bhansali alongwith his family members was covered under Mediclaim Policy (2007) bearing No.111200/34/09/11/00007639 issued by The New India Assurance Co. Ltd. for the period 11.09.2009 to 10.09.2010. His wife Smt. Anjana Bhansali who was covered for total Sum Insured of Rs.1,75,000/- with nil C.B. for the said year, was admitted to S.L. Raheja Hospital, Mumbai from 25.08.2010 to 26.08.2010 for the treatment of Ca Breast. Shri Bhansali lodged a claim under the policy for reimbursement of hospitalization expenses of Rs.1,66,836/- which was settled by M/s. Raksha TPA Pvt. Ltd. for an amount of Rs.1,13,262/- deducting Rs.53,574/- under various heads. Out of these, the deduction of Rs.37,754/- made towards 25% Co-Payment was not acceptable to

The complainant argued that there was no such condition mentioned on the policy issued to him for the relevant year. He has further mentioned that policy issued for the succeeding year viz. 2010-11 incorporated the relevant clause and hence deduction towards co-payment from the amount claimed under the said policy was acceptable to him.

The Insurance Company contended that the clauses incorporating the condition about co-payment and loading of premium were attached as an additional sheet to the main policy terms and conditions. Considering the fact that the average claim amount

settled during two previous policies was exceeding 90% of the average Sum Insured, as per clause 6(d) of the policy, the Company is authorized to deduct an amount equivalent to 25% of the admissible claim as co-payment as per relevant Clause 6(d) of the policy.

On perusal of the policy document for the period 2009-10 it is observed that the premium charged in respect of Smt. Anjana Bhansali is Rs.3,255/- which is the same amount as charged for the policy period 2008-09 which implies that despite her adverse claim ratio during the previous two policy periods, no loading of premium had been charged in the year 2009-10 by the Company. Similarly, there is no mention about any co-payment on the face of the policy whereas the policy issued for the subsequent year 2010-11 mentions "Claim Exp Loading" as 100% & "Co-payment" – 15%. From this it can be inferred that the Company has chosen not to impose loading & co-payment while renewing the policy for the year 2009-10. Also from the wording of clause 6(d), it appears that the Company has discretionary powers in this regard whether to impose Co-pay and loading of premium or not. Having failed to mention about the same even on the policy schedule at the time of renewal, it can be said that the Company has waived the application of this condition for that particular policy year and hence the decision of the Company to invoke the said condition directly at the time of settlement of the claim and deduct the amount towards co-payment is not justified.

INSURANCE OMBUDSMAN
MUMBAI

MUMBAI OMBUDSMAN CENTRE

BEFORE THE INSURANCE OMBUDSMAN

(MAHARASHTRA & GOA)

MUMBAI

Complaint No. GI-40/2012-13

Award No. IO/MUM/A/GI-   /2012-13

Complainant: Shri Ranjit Gupta

Respondent: The New India Assurance Co. Ltd.

Shri Ranjit Gupta as a certificate-holder of UTI bearing No. SC9510410000790 was covered alongwith his wife Smt. Indrani Gupta under UTI's Senior Citizen's Unit Plan (a health insurance cover jointly managed by UTI and The New India Assurance Co. Ltd.) for Sum Insured of Rs.2,50,000/- w.e.f. 19.03.2001. Smt. Indrani Gupta herself being a holder of another Certificate no. SC99104410000179, was also covered alongwith her husband under the same Plan for Sum Insured of Rs.2,50,000/- w.e.f. 17.09.2004. In addition to this, Smt. Gupta was covered with United India Insurance Co. Ltd. vide Policy No. 500600/48/10/41/00000191 for the period 05.12.2010 to 04.12.2011 for Sum Insured of Rs.3,00,000/-. On 22.08.2011 Smt. Gupta underwent EUS guided FNAC of Pancreatic head mass at Deenanath Mangeshkar Hospital, Pune. She was then admitted to Ruby Hall Clinic from 24.08.2011 to 16.09.2011 for the treatment of Ca Pancreas where she underwent Whipples Pancreaticoduodenectomy. The total hospitalization expenses amounted to Rs.6,71,877/- out of which United India Insurance Co. Ltd. settled Rs.2,55,000/- (deducting Rs.45,000/- from the total SI towards 15% Co-pay) under their policy and The New India Assurance Co. Ltd. reimbursed Rs.1,50,000/- (being the maximum limit per person per illness) under the membership certificate of Shri Ranjit Gupta while rejecting the claim lodged for Rs.1,50,000/- under the membership certificate of Smt. Indrani Gupta on the ground that as per clause no. 17 of he MOU there is a limit of Rs.1.5 lacs per any one illness per spouse and also as per Clause 10 of the policy Terms & Conditions which laid down that a member shall not be allowed to take multiple cover. The reason stated by the Company for denial of claim under Smt. Gupta's membership was not acceptable to Shri Gupta who represented to the Insurance Company arguing that the limit of Rs.1.5 lacs per illness per spouse should apply separately to each of the certificates, one held by Smt. Gupta as a primary member and another as a spouse in the policy held by Shri Gupta as a primary member.

On hearing the deposition of both the parties, Ombudsman observed the following:

- **The investors in UTI who are the end beneficiaries of the Insurance Scheme cannot be bound by the MOU between UTI and NIA unless the important terms and conditions which have a bearing on the Indemnity are explicitly mentioned in the Certificates issued to them.**
- **While Mr. Gupta has invested in 1995 and taken the Policy, Mrs. Gupta has taken the Policy in 1999. When the MOU specifically prevents multiple policies for a single Unit holder UTI and NIA should have taken care in not issuing the policy to Mrs. Gupta. Unfortunately this has not been done.**
- **Both Mr. and Mrs. Gupta are independent investors and accordingly they have taken the insurance cover. Hence restricting the cover to Rs.1.50 Lacs per illness per spouse can be applied to only one policy.**

- The case of Mrs. Gupta is more or less like a person holding two policies with two different companies and nothing prevents the person from making a claim under the two policies to the extent of loss and both the companies have to indemnify the loss.
- The restrictive condition of a member or his spouse should not be covered under more than one policy is not clearly made known to the investor. Such being the case not allowing the benefit under the second policy is not fair.

Having gone through all the documents submitted to the Forum and the personal depositions presented by both the parties to the dispute and having analyzed the provisions of the MOU and the Terms and conditions of the policy, the following points emerge:

Though Clause 5 of the MOU lays down that "The member shall not be allowed to take multiple insurance cover", the MOU does not contain any specific clause prohibiting the member's spouse from investing in the Plan as an individual member whereby he/she would become eligible for a separate/additional insurance cover. Besides, the MOU has been entered into between Unit Trust of India and The New India Assurance Co. Ltd. (referred to as "the Trust" and "the NIAC" therein). The provisions of the MOU are not within the knowledge of the individual unit-holders of the Trust who are not a party to the same and hence cannot be held binding on them. This applies equally to the clause providing for reference to the Trust in case of any dispute/difference as to the quantum of claim to be paid under the policy and the clause restricting jurisdiction to Bombay courts. Also this clause speaks about dispute about any claim to be made by hospital/nursing home on the Insurance Company and not by an individual member. It may also be pointed out that the dispute here is not only about quantum, since in the instant case, liability itself has been disputed by the Company under the membership certificate of Smt. Gupta.

As regards the Terms and conditions of the Group Policy, again it is not known nor has the Company clarified whether the same were made available to the individual members covered under the policy. The Company has also referred to Clause no. 4 of Instructions To Members under the UTI Senior Citizens Unit Plan which specifies a maximum limit of Rs.1.5 lacs per illness per spouse. However, in the instant case, Shri Ranjit & Smt. Indrani Gupta are independent investors in the Scheme and a plain interpretation of this condition would imply that the said limit would apply to each certificate-holder separately. The stipulation that a member shall not take multiple cover (though not even mentioned in these "Instructions"), in my opinion speaks about restriction on any single member going in for multiple certificates whereby he may seek to make claims for himself or his spouse under each of these or more than one certificate. But if his spouse is a holder of a separate certificate as an independent investor as is the case here, the said restriction of Rs.1.5 lacs would apply to herself and her spouse again as a primary-member separately. Going by this logic and the principles of natural justice and equity, I

am of the opinion that Smt. Gupta is entitled to the claim up to the limit of Rs.1.5 lacs under the separate certificate issued in her individual name under the Plan.

INSURANCE OMBUDSMAN
MUMBAI

MUMBAI OMBUDSMAN CENTRE

BEFORE THE INSURANCE OMBUDSMAN
(MAHARASHTRA & GOA)
MUMBAI
Complaint No. GI- 1279 of 2011-2012
Award No. IO/MUM/A/GI /2012-2013

Complainant: Shri Ratnakar Luley
V/s
Respondent: Royal Sundaram Alliance Insurance Co. Limited

Shri Ratnakar Luley along with his spouse was covered under a Family Health Protector Insurance Policy No. HLAMFF0001 issued by Royal Sundaram Alliance Insurance Company Limited from 13/7/2010 to 12/7/2011 for a floater sum insured of Rs. 3 lakhs. Shri Luley was admitted to Central India Institute of Medical Science from 13/4/2011 to 21/4/2011 for treatment of C3-C4 and C5-C6 PIVD with Myelo-radiculopathy.

He filed a claim for Rs.1.17 lakhs which was repudiated by the Insurer on the ground that the ailment for which the Insured had taken treatment(i.e. Inter-vertebral Disc Prolapse) had a two year waiting period as per the policy condition. Further, the medical papers reveal that the Insured had a past history of depression and Night walking Disorder for the past 10 years for which he was under regular psychiatric treatment and this material fact was not disclosed at the time of proposal. Hence the claim was declined by them on the ground of non-disclosure of material fact which was pre-existing. They have also invoked clause 6 of the Policy which is Misdescription which states " The Policy shall be void and all premium paid hereon shall be forfeited by the Company in the event of mis-representation, misdescription or non-disclosure of any material fact.

Analysis of the case reveals that Shri Luley was admitted to Central India Institute of Medical Sciences on 13/4/2011 with complaints of pain in both upper limb with tingling numbness since 3 months. The provisional diagnosis was mentioned as Cervical Cord Stenosis and the final diagnosis as per the MRI report was C3-C4 and C5-C6 PIVD with Myelo Radiculopathy. Past history noted in the medical papers was k/c/o depression under treatment of anti-psychiatric drug, H/o of RTA with HI 3 months back. MRI of Cervical Spine gave the impression of ' Spondylotic changes in Cervical Spine. Moderate Posterocentral right paracentral extrusion of C3-C4 disc indenting the ventricle

surface of cord with changes of compressive myelopathy, Protrusion of C4-C5 disc indenting the ventral surface of cord, C5-C6 protrusion causing left neural narrowing and indentation of existing left C7 nerve root'. He underwent Dissectomy and bone grafting at C3-C4 and C5-C6 levels on 14/4/2011 and was discharged from the hospital on 21/4/2011.

Shri Luley contended that his hospitalization was related to the accidental injury. The Maxcare Hospital Papers, where he was immediately treated by Dr. Abhijeet Deshmukh , MBBS, MS (Abdominal Surgeon & Laparoscopist) following the accident, has made the following notings - H/o Vehicular Accident at about 7.15 p.m on 24/12/2010. No history of unconsciousness, ENT bleed , vomiting. H/o pain in upper lip. Local examination – Left upper lip 2x1 cm and 0.5x0.1 mm buccal . Left leg middle finger 0.5 x0.1 cm. Abrasions chin 1x1 cm, Abrasions right toe 1x1 cm. Treatment – Injection TT given suturing done in layers." He was prescribed some oral medications and advised to follow up on 27/12/2010. He was also advised to take Orthopaedic Surgeon's opinion.

From the above it is seen that the Insured had sustained only injuries/abrasions to his lips, left leg middle finger and right toe in the accident. There was no other serious injury/ies mentioned nor was there any advice for an X-ray or MRI. There is also no mention about any injury to the collar bone as alleged by the Complainant. it is not known whether there was any orthopaedic consultation done as advised. The contention of the complainant therefore, that he had to undergo surgery of the Collar Bone which was injured during the accident does not get established from the accident treatment papers. On the contrary, it is noted from the MRI report that he had spondylotic changes in Cervical Spine at C3-C4 and C5-C6 levels(which refers to the impaired function of the Spinal Cord caused by degenerative changes in the disc and facet joints). Further, the diagnosis was mentioned as Prolapsed Intervertebral Disc with Myelo Radiculopathy (which is slipped disc with disease of the spinal cord and spinal nerve roots).

It is observed that the Insurance Company has also referred the case file to their panel doctor, Dr. S. Prem Kumar, M.S. Ortho who opined "The claimant had undergone dissectomy and bone grafting C3-C4 and C5 C6. He had sustained a road traffic accident on 24/12/2010. MRI reveals spondylosis with C3-C4 and C5-C6 disc prolapsed with compressive myelopathy at C3-C4 level. It is possible that following a RTA disc prolapsed can occur in an already degenerated spine and produce compressive myelopathy. In my opinion spine degeneration is pre-existing but there is no evidence to state that disc prolapse was pre-existing. It could have occurred due to RTA."

There is no documentary evidence to show the nexus between the accident and the ailment suffered by the complainant, but at the same time the possibility of the ailment due to accident also cannot be totally ruled out. Even the Company's panel doctor has opined that PIVD could have occurred in an already degenerated spine due to RTA. Considering such a possibility and also the fact that it could be ascribed to the impaired function of the Spinal cord, as evidenced by the MRI Report, only 50% of the claim amount be settled by the Insurance Company to resolve the dispute in the present case. As regards, the other defence of non-disclosure about past history of depression/night walking disorder, taken by the Insurance Company for non-settlement of the claim, the

same although ought to have been disclosed by the complainant, has no direct bearing to the present claim.

INSURANCE OMBUDSMAN
MUMBAI