AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0755-12

Shri Chandrakant L. Master V/s. The New India Assurance Co. Ltd.

Award dated 5th October 2012

Partial Repudiation of Mediclaim

Complainant hospitalized for treatment of Fracture in left Medial Tibia Condoyle + Pulmonary Thromboembolism and claim lodged for Rs.1,03,201/- was partially settled by the Respondent for Rs75,992/- by deducting an amount of Rs.27,209/- invoking policy exclusion clause 11.

Complainant submitted claim papers after 43 days instead of 30 days from the date of discharge from hospital, so Respondent rightly deducted 20% of claim amount.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-0764-12

Shri Jayant K Patel V/s. National Insurance Co. Ltd.

Award dated 8th October 2012

Partial repudiation of Mediclaim

Complainant hospitalized for CABG (By pass) surgery and total claim lodged for Rs.1,87,223/- was settled by the Respondent for Rs.1,11,910/- giving reason that as per terms and conditions of policy, maximum limit was paid.

On referring the related documents of both the parties, the Forum also decided the Respondent's decision is right and proper.

In the result complaint fails to succeed.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0758-12

Shri Indravijaysinh H. Vaghela V/s. The Oriental Insurance Co. Ltd.

Award dated 5th October 2012

Partial repudiation of Mediclaim

A claim amount of Rs.26,957/- was lodged by the complainant for treatment of his son for Abdominal pain was settled by the Respondent for Rs.18,300/- giving reason that as per discharge summary the patient was discharged after fully cured. Thereafter insured underwent certain lab test and got medicines which expense considered an OPD treatment.

Hence the Respondent's decision to partial repudiation is upheld without any relief to the complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0763-12

Mr. Manish P. Parikh V/s. The New India Assurance Co. Ltd,

Award dated 9th October 2012

Repudiation of Mediclaim

A Claim amount of Rs.18,419/- for the treatment expense of complainant's wife for Renal failure and Gastroenteritis was repudiated by the Respondent on the ground of Policy exclusion clause No.4.4.16.

During the Hearing both the parties agreed on mutual ground the treatment has taken for acute gastroenteritis and claim is genuine and Respondent offered to pay an amount of Rs.13,814/- and complainant accepted the same as full and final settlement of his claim.

As a result complaint closed without any formal award to be issued.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0779-12

Mr. Amratbhai A. Patel V/s. The New India Assurance Co. Ltd.

Award dated 12th October 2012

Non settlement of Mediclaim

Complainant hospitalized for treatment of Osteoarthritis of left knee and expense claimed for Rs.94,943/- was repudiated by the Respondent as per clause No.4.3 of the tailor made policy condition having cap of 4 years.

The policy is not issued an individual capacity and premium also not received directly from the Insured. Hence as per policy clause 4.3, claim is not payable.

Therefore, complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-017-0773-12

Mr. Rameshchandra Panchal V/s. Star Health and Allied Ins. Co. Ltd.

Award dated 15th October 2012

Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Viral fever and claimed expense for Rs.15,178/- was repudiated by the Respondent by invoking exclusion clause No.7 of the terms and condition of policy.

On referring all documents of both the parties, it gets established that the decision of the Respondent to repudiate the claim is valid and proper without any relief to the complainant.

AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-005-0777-12

Mr. Dilipkumar Tibarewal V/s. The Oriental Insurance Co. Ltd.

Award dated 15th October 2012

Repudiation of Medi- claim

Complainant's wife hospitalized for operation of Right Laparoscopic Salpingectomy with left Tubal ligation and expense claimed for Rs.78,419/- was repudiated by the Respondent invoking clause No.4.13 of the Happy Floater Policy.

Complainant argued that the S.I of the policy is Rs.5,00,000/-, at the time of issuing the policy, the reasonable and necessary expenses, subject to limits are payable but when required not paid.

According to the treatment records, the Respondent shall not be liable to make any payment under this policy as the Exclusion Clause No.4.13 specifically states that such treatment shall not be payable.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0756-12

Mr. Jayanti M. Shah V/s. United India Insurance Co. Ltd.

Award dated 15th October 2012

Repudiation of Mediclaim

Complainant claimed Rs.15,000/- for operation expenses of his Rt. Eye Sub-Retinal Bleeding which was repudiated by the Respondent giving reason that treatment taken in a Daycare hospital on OPD basis hence claim is not payable under preview of policy condition.

On scrutiny of all the records of both the parties, the Forum also denied the claim.

In the result complaint fails to succeed.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-017-0774-12

Mr. Kiran R. Panchal V/s. Star Health and Allied Ins. Co. Ltd.

Award dated 16th October 2012

Repudiation of Mediclaim

Complainant's son hospitalized for treatment of AGE with Dysentery and claimed expense for Rs.5,324/- was repudiated by the Respondent by invoking exclusion clause No.7 of the terms and condition of policy.

On referring all documents of both the parties, it gets established that the decision of the Respondent to repudiate the claim is valid and proper without any relief to the complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0784-12

Mr. Gunvantlal M. Shah V/s. United India Insurance Co. Ltd.

Award dated 15th October 2012

Partial Repudiation of Mediclaim

Complainant hospitalized for treatment of H.T and Chest pain and claimed for Rs.15,528/- which was settled by the Respondent for Rs.11,518/- giving reason that the insured was treated two separate hospitals and two amounts claimed. Out of this first claim considered and second claim rejected on the ground of Exclusion clause No.5.3 of the policy condition.

While going through the hospital records and policy conditions, the forum directed the Respondent to grand Rs.2,640/- to the Complainant over and above sanctioned amount.

In the result complaint partially succeeds.

AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-002-0762-12

Mr. Ketanbhai A. Vora V/s. The New India Assurance Co. Ltd.

Award dated 18th October 2012

Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Infected Sebaceous Cyst Rt. Axel and claim lodged for Rs.15,076/- was repudiated by the Respondent under exclusion clause No.4.3.

Complainant was having policy since 2007 from Reliance General Insurance up to 2010. Thereafter policy taken from the Insurer after a lapse of five days so policy considered fresh and exclusion clause 4.3 is covered.

In view of this, complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-009-0786-12

Mr. Chaitanyaprasad G. Joshi V/s. Reliance General Insurance Co. Ltd.

Award dated 19th October 2012

Repudiation of Mediclaim

A claim amount of Rs.25,211/- lodged by the complainant for treatment expenses of his Rt. Elbow and head area was repudiated by the Respondent under clause No.18 (Alcohol related) and violation of hospitalization less than 24 hours.

On referring the treatment papers and doctor's certificate, it is proved the insured was treated an OPD basis and having habit of Alcohol occasionally so he had fall from slop near to his residential flat.

In view of this, complaint fails to succeed.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0768-12

Mr. Anandbhai B. Shah V/s. The New India Assurance Co. Ltd.

Award dated 19th October 2012

Partial Repudiation of Mediclaim

Complainant's father hospitalized for treatment of LVF+ Pneumonia+ CV Stroke, Septic Shock, Multi Organ failure, DM, HT etc. and claim lodged for Rs.3,59,115/- was settled by the Respondent for Rs.90,407/-giving reason that the insured was having two policies one for Super Top-up Medicare policy S.I Rs.5,00,000/- and one Individual Mediclaim Policy for S.I.2,00,000/-. But the Super Top-up policy excludes medical treatment of pre-existing disease within 48 months, so not eligible to get claim. However, Respondent settled 70% of S.I. of Individual Mediclaim Policy.

As per terms and conditions of the policy and treatment records the Forum also denied the claim.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-0772-12

Mr. Bharat L. Ghadhvi V/s The National Insurance Co. Ltd.

Award dated 22nd October 2012

Repudiation of Mediclaim

A claim amount of Rs.44,792/- was lodged by the complainant for treatment of his wife for Anemia + Lower Respiratory Tract Infection was repudiated by the Respondent under Policy exclusion Clause 4.1.

The insured patient was a known case of HTN and h/o. Hypothyroidism since 3 years. Treatment occurred within 6 months of taking policy.

In view of this the complaint fails to succeed.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0771-12

Mr.Jitendra Chauhan V/s. The New India Assurance Co. Ltd.

Award dated 30th October 2012

Repudiation of Mediclaim

Complainant hospitalized for treatment of Chest pain, Gabhraman and CAG done and total expense claimed for Rs.34,323/- was repudiated by the Respondent under exclusion 4.3 for 2 years. Claim lodged was in the first year of the policy.

Complainant was having policy with the Reliance General Insurance Co. up to 22-10-2009. Thereafter on 25-01-2010, insured with the above Insurer. So there was a break of 3 months cannot be considered for continuity. However, Respondent's decision cannot be interfered by this Forum.

In the result, the complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-003-0769-12

Mr. Yogesh R. Trivedi V/s. National Insurance Co. Ltd.

Award dated 25th October 2012

Repudiation of Mediclaim

Complainant's son hospitalized for treatment of Viral Hepatitis and expenses claimed for Rs.7,216/- was repudiated by the Respondent by invoking Policy clause No.4.2.

Complainant was having policy with another company but he had filled fresh proposal form for Mediclaim Policy with the Respondent from 15-04-2010 to 14-04-2011 and within 30 days the treatment was occurred. However as per terms and condition of policy, the claim is not eligible.

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.11-017-0778-12

Shri Gopal G. Gangwal V/s. Star Health and Allied Ins. Co. Ltd.

Award dated 1st November 2012

Partial Repudiation of Mediclaim

Complainant's wife hospitalized for accidental injury and claim lodged for Rs.86,680/- was settled partially for Rs.57,399/-by the Respondent as per terms and conditions of the policy.

Respondent shown all the deduction details and break up of paid amount reasonably and customary.

On scrutiny of all the documents the Forum also denied the requirement of the complainant for balance amount.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-004-0791-12

Mr. Vinodkumar J. Parmar V/s. United India Insurance Co. Ltd.

Award dated 2nd November 2012

Repudiation of Mediclaim

Complainant hospitalized for treatment of Renal Colic and expense claimed for Rs.6,137/- was repudiated by the Respondent as per Policy Condition No.5.3 and 5.4 that means the Complainant had not intimated the hospitalization immediately and claim papers submitted late by 16 days.

Further the policy is not an individual capacity, it is a tailor made group madiclaim policy issued to Privilege Hospitality Pvt. Ltd., the premium amount also not paid direct to the Insurer.

Considering all the above, there is no new ground to interfere the Respondent's decision. However complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-005-0793-12

Mr. Balkund N. Nagori V/s. The Oriental Insurance Co. Ltd.

Award dated 2nd November 2012

Partial Repudiation of Mediclaim

Complainant's wife hospitalized for Cataract operation and claimed for Rs.31,049/- was partially paid by the Respondent for Rs.15,000/- as per Policy Clause No.5.3, Cataract surgery expense is restricted up to Rs.15,000/-.

Further the policy is not an individual capacity, it is a tailor made group madiclaim policy issued to Trissure Healthcare Trust, Mumbai., the premium amount also not paid direct to the Insurer.

Considering all the above, there is no new ground to interfere the Respondent's decision to settle the claim partially. However complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-0792-12

Shri Rajesh T. Gandhi V/s. National Insurance Co. Ltd.

Award dated 5th November 2012

Repudiation of Mediclaim

Complainant's daughter hospitalized for treatment of Acute Appendicitis and expense claimed for Rs.9,959/- was repudiated by the Respondent giving reason that the treatment taken from a declined hospital.

Complainant was not aware of the declined name of the hospital at the time of hospitalization. Respondent proved that they have informed to the B.M of the Insurer stating that as per High Court Order and Company's Circular regarding delisted hospital.

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.11-005-0794-12

Shri Balkund N. Nagori V/s. The Oriental Insurance Co. Ltd.

Award dated 5th November 2012

Partial settlement of Mediclaim

Complainant's wife hospitalized for Eye Cataract surgery and expense claimed was for Rs.30,769/- which was settled for Rs.15,000/- by the Respondent as per Policy clause No.5.3 of Family Floater Group Mediclaim

Complainant has no right to claim under the policy as he could not produce any concrete evidence to show that he and his wife were insured with the Respondent under the subject policy.

In the result, complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0795-12

Shri Balkund N. Nagori V/s. The Oriental Insurance Co. Ltd.

Award dated 2nd November 2012

Partial settlement of Mediclaim

Complainant's wife hospitalized for the treatment of Carbunal on back and expense claimed was for Rs.30,208/- which was settled for Rs.26,418/- by the Respondent as per Policy clause No.5.1 (c) (It is restricted 90% of claimed amount) of Family Floater Group Mediclaim

Complainant has no right to claim under the policy as he could not produce any concrete evidence to show that he and his wife were insured with the Respondent under the subject policy. Hence Respondent's decision to settle the claim partially is upheld without any relief to the Complainant.

In the result, complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-002-0797-12

Mr. Surendra G. Sheth V/s. The New India Assurance Co. Ltd.

Award dated 6th November 2012

Partial settlement of Mediclaim

Complainant's wife hospitalized for treatment of Osteoarthritis and expenses claimed was for Rs.1,55,175/- which was settled by the Respondent for Rs.1,22,355/- as cashless facility as per policy condition No.2.1, 2.3 and 2.6 note 1.

Again complainant lodged for pre and post hospitalization expense plus difference of first claim total comes to Rs.49,717/- which is higher than S.I hence Respondent paid Rs.10,500/- as per terms and conditions of the policy.

Respondent produced all break up to this Forum so the Forum also denied the complainant's argument.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-017-0778-12

Shri Gopal G. Gangwal V/s. Star Health and Allied Ins. Co. Ltd.

Award dated 1st November 2012

Partial Repudiation of Mediclaim

Complainant's wife hospitalized for accidental injury and claim lodged for Rs.86,680/- was settled partially for Rs.57,399/-by the Respondent as per terms and conditions of the policy.

Respondent shown all the deduction details and break up of paid amount reasonably and customary.

On scrutiny of all the documents the Forum also denied the requirement of the complainant for balance amount. In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-004-0791-12

Mr. Vinodkumar J. Parmar V/s. United India Insurance Co. Ltd.

Award dated 2nd November 2012

Repudiation of Mediclaim

Complainant hospitalized for treatment of Renal Colic and expense claimed for Rs.6,137/- was repudiated by the Respondent as per Policy Condition No.5.3 and 5.4 that means the Complainant had not intimated the hospitalization immediately and claim papers submitted late by 16 days.

Further the policy is not an individual capacity, it is a tailor made group madiclaim policy issued to Privilege Hospitality Pvt. Ltd., the premium amount also not paid direct to the Insurer.

Considering all the above, there is no new ground to interfere the Respondent's decision. However complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-005-0793-12

Mr. Balkund N. Nagori V/s. The Oriental Insurance Co. Ltd.

Award dated 2nd November 2012

Partial Repudiation of Mediclaim

Complainant's wife hospitalized for Cataract operation and claimed for Rs.31,049/- was partially paid by the Respondent for Rs.15,000/- as per Policy Clause No.5.3, Cataract surgery expense is restricted up to Rs.15,000/-.

Further the policy is not an individual capacity, it is a tailor made group madiclaim policy issued to Trissure Healthcare Trust, Mumbai., the premium amount also not paid direct to the Insurer.

Considering all the above, there is no new ground to interfere the Respondent's decision to settle the claim partially. However complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-0792-12

Shri Rajesh T. Gandhi V/s. National Insurance Co. Ltd.

Award dated 5th November 2012

Repudiation of Mediclaim

Complainant's daughter hospitalized for treatment of Acute Appendicitis and expense claimed for Rs.9,959/- was repudiated by the Respondent giving reason that the treatment taken from a declined hospital.

Complainant was not aware of the declined name of the hospital at the time of hospitalization.

Respondent proved that they have informed to the B.M of the Insurer stating that as per High Court Order and Company's Circular regarding delisted hospital.

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.11-005-0794-12

Shri Balkund N. Nagori V/s. The Oriental Insurance Co. Ltd.

Award dated 5th November 2012

Partial settlement of Mediclaim

Complainant's wife hospitalized for Eye Cataract surgery and expense claimed was for Rs.30,769/- which was settled for Rs.15,000/- by the Respondent as per Policy clause No.5.3 of Family Floater Group Mediclaim

Complainant has no right to claim under the policy as he could not produce any concrete evidence to show that he and his wife were insured with the Respondent under the subject policy.

In the result, complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0795-12

Shri Balkund N. Nagori V/s. The Oriental Insurance Co. Ltd.

Award dated 2nd November 2012

Partial settlement of Mediclaim

Complainant's wife hospitalized for the treatment of Carbunal on back and expense claimed was for Rs.30,208/- which was settled for Rs.26,418/- by the Respondent as per Policy clause No.5.1 (c) (It is restricted 90% of claimed amount) of Family Floater Group Mediclaim

Complainant has no right to claim under the policy as he could not produce any concrete evidence to show that he and his wife were insured with the Respondent under the subject policy. Hence Respondent's decision to settle the claim partially is upheld without any relief to the Complainant.

In the result, complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-002-0797-12

Mr. Surendra G. Sheth V/s. The New India Assurance Co. Ltd.

Award dated 6th November 2012

Partial settlement of Mediclaim

Complainant's wife hospitalized for treatment of Osteoarthritis and expenses claimed was for Rs.1,55,175/- which was settled by the Respondent for Rs.1,22,355/- as cashless facility as per policy condition No.2.1, 2.3 and 2.6 note 1.

Again complainant lodged for pre and post hospitalization expense plus difference of first claim total comes to Rs.49,717/- which is higher than S.I hence Respondent paid Rs.10,500/- as per terms and conditions of the policy.

Respondent produced all break up to this Forum so the Forum also denied the complainant's argument.In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-017-0805-12

Shri Ranjan K. Mirani V/s. Star Health & Allied Insurance Co. Ltd.

Award dated 7th November 2012

Partial Repudiation of Mediclaim

Complainant hospitalized for treatment of Fibroid and expense claimed for Rs.59,904/- was settled for Rs.48,373/- by the Respondent as per policy conditions, "reasonably and necessarily incurred.

Complainant has not attended the hearing scheduled by this Forum. However the Forum agreed the decision of the Respondent to deduct an amount of Rs.11,531/-.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-009-0803-12

Shri Govind D. Sailor V/s. Reliance General Insurance Co. Ltd.

Award dated 7th November 2012

Repudiation of Mediclaim

Complainant hospitalized for treatment of Coronary Artery Disease and expense claimed for Rs.1,23,507/- was repudiated by the Respondent invoking Exclusion clause No.1 and 2 of the Healthwise policy.

From available papers proved that the complainant was suffering from HTN & D.M since 20 years.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-0806-12

Shri Kiritbhai C. Shah V/s. The National Insurance Co. Ltd.

Award dated 7th November 2012

Repudiation of Mediclaim

Complainant hospitalized four different hospitals for treatment of Knee replacement and related treatment, total expense claimed for Rs.3,16,358/- was repudiated by the Respondent on the ground of pre-existing disease.

Complainant had individual mediclaim policy with Oriental Insurance Co. Thereafter National Swasthya Policy with the Respondent with a break of 20 days, hence it is considered as a fresh policy.

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.11-002-0796-12

Mr. Chirag D. Patel V/s. The New India Assurance Co. Ltd.

Award dated 6th November 2012

Repudiation of Mediclaim

A Claim amount of Rs.16,057/- was lodged by the complainant for treatment expense of complainant himself was repudiated by the Respondent under exclusion clause No.4.4.6.

On primary scrutiny of all available records it is proved that the treatment was taken an OPD basis. So Respondent's decision to repudiate the claim is just and proper.

AHMEDABAD OMBUDSMAN CENTRE

Case No.14-003-0780-12

Mr. Bipin J. Shah V/s. The National Insurance Co. Ltd.

Award dated 6th November 2012

Partial settlement of Mediclaim

Complainant's wife hospitalized for Knee Replacement and expense claimed by the Complainant for Rs.1,57,393/- was partially settled for Rs.1,30,000/- by deducting an amount of Rs.27,393/- giving reason that policy issued to V.M. Assurance Service Pvt. Ltd., was cancelled by the Respondent before hospitalization of the patient.

Moreover, the matter is admitted to Gujarat High Court and City Civil Court, Ahmedabad hence the matter can not be entertained by this Forum.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0816-12

Mr. Shantibhai T. Patel V/s. The New India Assurance Co. Ltd.

Award dated 22nd November 2012

Repudiation of Mediclaim

Complainant's wife hospitalized for operation of Vaginal Hysterectomy and expense claimed was for Rs.28,090/-which was repudiated by the Respondent as the disease falls under 2 years exclusion clause and complainant lodged his claim in the first year of the policy.

Complainant argued that he was having policy with the Respondent since last 10 years so it should not be considered under Exclusion Clause No. 4.3.

Respondent informed that the policy was not continuously renewed, every time with a break of 45 days and making fresh proposal and previous policy's space mentioning as Nil.

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

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0782-12

Mr. Khalid Husain S. Luhar V/s. United India Insurance Co. Ltd.

Award dated 22nd November 2012

Repudiation of Mediclaim

Complainant's son treated for Haematuria of Uncertain Etiology + Doubtful PU Valve and expense claimed for Rs.22,856/- was repudiated by the Respondent under clause No.4.1. His earlier claim had paid by the Respondent for the same treatment.

On scrutiny of medical papers, the treatment found to be genetic, hence the repudiation of the present claim can not be interfered.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-005-0811-12

Mr. Freny Engineer V/s. the Oriental Insurance Co. Ltd.

Award dated 27th November 2012

Partial settlement of Mediclaim

Complainant hospitalized for treatment of Stenosis disc prolapse and Laminectomy and expense incurred for Rs.1,06,836/-was lodged for which Respondent settled for Rs.62,000/- by deducting an amount of Rs.44,836/- as per policy condition No.13 – reasonable and customary.

Complainant was preferred to remain absent in the Hearing scheduled by this Forum.

Respondent produced all details of deduction hence the Forum also denied the complaint against Respondent's decision.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0820-12

Mr. Hasmukhbhai N. Chavda V/s. United India Insurance Co. Ltd.

Award dated 28th November 2012

Repudiation of Mediclaim

Complainant's wife treated for Piles and expenses claimed for Rs.17,000/- was repudiated by the Respondent on the ground of discrepancy of hospital's name mentioned in the Claim Form and Investigator's report.

Treating doctor clarified the doubts and hospital also certified the patient's treatment.

As a result of mediation of this Forum, both the parties mutually agreed to settle the claim for Rs.12,566/-without any formal award.

The complaint thus stands disposed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0815-12

Ms. Rupal N. Gandhi V/s. the Oriental Insurance Co. Ltd.

Award dated 28th November 2012

Repudiation of Mediclaim

Complainant's father was hospitalized for Knee replacement and total claim lodged for Rs.1,71,000/- was repudiated by the Respondent giving reason that the disease falls under one year exclusion clause.

Complainant was having Individual Mediclaim Policy since 5 years but every year they have renewed to different insurer without break. The complainant lodged claim under a Group Mediclaim Policy which was first time issued by the Insurer. As per policy terms and conditions, the subject disease excluded for one year.

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

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AHMEDABAD OMBUDSMAN CENTRE

Cases Nos.11-002-0842-12 & 1099-12

Shri Jyotindra R. Barot V/s. The New India Assurance Co. Ltd.

Award dated 3rd December 2012

Partial repudiation of Mediclaim

Complainant lodged two claims for cataract surgeries of his wife's both the eyes and total expenses incurred was for Rs.75,216/- out of which Respondent settled for Rs.56,216/- by deducting an amount of Rs.19,000/- under policy clause 3.13.

The Forum has asked to provide a PPN rate which was not available at the time of Hearing. Therefore it was considered to be appropriate to intervene in the partially repudiation decision.

As a result of mediation of this Forum, both the parties mutually agreed to settle the claim for Rs.7,000/-without any formal award.

The complaint thus stands disposed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0807-12

Shri Mohamad Yunus Dhobi V/s. United India Insurance Co. Ltd.

Award dated 3rd December 2012

Partial Repudiation of Mediclaim

Complainant's wife hospitalized and expense claimed for Rs.28,395/- was settled by the Respondent for Rs.10,000/- stating that as per Group policy, Maternity benefit will be payable @ 10% of S.I of Rs.1.00 Lac.

It is an unconventional Group Mediclaim Policy without insurable interest, so Respondent's decision to settle the claim partially is upheld without any relief to the Complainant. Thus the complaint stands disposed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0844-12

Smt. Harshidaben Khatri V/s, The New India Assurance Co. Ltd.

Award dated 5th December 2012

Partial settlement of Mediclaim

Complainant hospitalized for Hysterectomy surgery and claimed for Rs.74,559/- was partially settled by the Respondent for Rs.56,003/- by deducting an amount of Rs.18,555/- invoking policy condition No. 3.13 which limit the expenses on the basis of customary and reasonable charges.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0844-12

Smt. Harshidaben Khatri V/s, The New India Assurance Co. Ltd.

Award dated 5th December 2012

Partial settlement of Mediclaim

Complainant hospitalized for Hysterectomy surgery and claimed for Rs.74,559/- was partially settled by the Respondent for Rs.56,003/- by deducting an amount of Rs.18,555/- invoking policy condition No. 3.13 which limit the expenses on the basis of customary and reasonable charges.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-009-0855-12

Mr. Dharmendra M Kothari V/s. Reliance General Insurance Co. Ltd.

Award dated 5th December 2012

Repudiation of Mediclaim

Complainant treated for Acute Traumatic Rt. Knee ACL injury with Effusion and expenses claimed for Rs.15,704/- was repudiated by the Respondent on the ground of under Local Anesthesia as well as other medicines given, there is no need of hospitalization for the same.

On referring the treatment records, it is proved that the treatment was genuine.

As a result of mediation of this Forum, both the parties mutually agreed to settle the claim for Rs.11,500/-without any formal award.

The complaint thus stands disposed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0849-12

Ms. Kalpanaben Nagri V/s. The New India Assurance Co. Ltd.

Award dated 6th December 2012

Partial settlement of Mediclaim

Complainant's treatment expenses for Cataract surgery to both the eyes and incurred Rs.68,400/- for each eye was settled by the Respondent total Rs.48,000/- i.e. Rs.24,000/- to each eye as per terms and conditions of the Mediclaim policy No.3.13.

Complainant aged 65 years could have made preliminary enquiries in this regard before opting for such high cost cataract surgery while options are available.

Hence 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.11-002-0843-12

Mr. Vishnubhai Patel V/s. The New India Assurance Co. Ltd.

Award dated 6th December 2012

Partial settlement of Mediclaim

Complainant's wife hospitalized for treatment of Uterus Fibroid and spend Rs.33,422/- which was settled by the Respondent for Rs.22,651/- by deducting an amount of Rs.10,771/- invoking policy condition No.2.1,2.2, 2.3 & 2.4 note 1.

Respondent had explained entire things and reasons for deductions in details as per terms of the policy conditions. However there is no valid ground to interfere in the decision of the Respondent.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0830-12

Shri Natvarbhai R. Soni V/s. The Oriental Insurance Co. Ltd.

Award dated 5th December 2012

Repudiation of Mediclaim

Complainant's wife hospitalized and claimed for Rs.8,600/- during hospitalization and Rs.15,431/- for after hospitalization treatment was repudiated by the Respondent as per policy condition No.4.10.

This was a group insurance policy issued to unconventional group of members without any insurable interest. The details of premium paid are also not readily available.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0822-12

Shri Mehul D. Barot V/s. United India Insurance Co. Ltd.

Award dated 5th December 2012

Rejection of Mediclaim

Complainant hospitalized for Gabharaman, Perspiration, Anorexia and AGE pain and claimed for Rs.5,484/- was rejected by the Respondent as 'No Claim' as per the opinion of Panel Doctor of the Respondent.

Complainant's treating doctor informed that he was treated for abdomen pain and gastritis which is not a valid ground for admissible of claim.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-009-0855-12

Mr. Dharmendra M Kothari V/s. Reliance General Insurance Co. Ltd.

Award dated 5th December 2012

Repudiation of Mediclaim

Complainant treated for Acute Traumatic Rt. Knee ACL injury with Effusion and expenses claimed for Rs.15,704/- was repudiated by the Respondent on the ground of under Local Anesthesia as well as other medicines given, there is no need of hospitalization for the same.

On referring the treatment records, it is proved that the treatment was genuine.

As a result of mediation of this Forum, both the parties mutually agreed to settle the claim for Rs.11,500/-without any formal award.

The complaint thus stands disposed.

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AHMEDABAD OMBUDSMAN CENTRE

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Award dated 6th December 2012

Partial settlement of Mediclaim

Complainant's treatment expenses for Cataract surgery to both the eyes and incurred Rs.68,400/- for each eye was settled by the Respondent total Rs.48,000/- i.e. Rs.24,000/- to each eye as per terms and conditions of the Mediclaim policy No.3.13.

Complainant aged 65 years could have made preliminary enquiries in this regard before opting for such high cost cataract surgery while options are available.

Hence Respondent's decision to settle the claim partially is upheld without any relief to the complainant.

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Respondent had explained entire things and reasons for deductions in details as per terms of the policy conditions. However there is no valid ground to interfere in the decision of the Respondent.

In the result complaint fails to succeed.

****

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0830-12

Shri Natvarbhai R. Soni V/s. The Oriental Insurance Co. Ltd.

Award dated 5th December 2012

Repudiation of Mediclaim

Complainant's wife hospitalized and claimed for Rs.8,600/- during hospitalization and Rs.15,431/- for after hospitalization treatment was repudiated by the Respondent as per policy condition No.4.10.

This was a group insurance policy issued to unconventional group of members without any insurable interest. The details of premium paid are also not readily available.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

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Complainant's treating doctor informed that he was treated for abdomen pain and gastritis which is not a valid ground for admissible of claim.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0854-12

Smt. Jayshreeben V. Shah V/s. The Oriental Insurance Co. Ltd.

Award dated 10th December 2012

Repudiation of Mediclaim

Complainant's husband hospitalized for treatment of Cardiac Asthma and expense claimed for Rs.5,818/- was repudiated by the Respondent under exclusion clause No.4.1. Complainant lodged again a claim of Rs.48,413/- for the treatment of the same insured person also repudiated by the Respondent giving reason that the treatment was related to Cardiac disease which is having waiting period of 4 year. The treating was in the first year of inception of the policy.

In view of this, complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0857-12

Mr. Rajubhai Jivani V/s. United India Insurance Co. Ltd.

Award dated 7th December 2012

Repudiation of Mediclaim

Complainant hospitalized for treatment of irritable bowl syndrome and expense incurred 3,526/- was repudiated by the Respondent as per section II, under UNI Micro Policy, treatment should be taken from a Government Hospital whereas the insured treated in a private hospital. Further the intimation submitted after 29 days as per claim form, so as per policy condition No.5.4 claim is not admissible.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0852-12

Mr. Manojkumar Suthariya V/s. United India Insurance Co. Ltd.

Award dated 7th December 2012

Partial Repudiation of Mediclaim

Complainant's wife's cataract surgery expenses claimed for Rs.41,541/- was settled by the Respondent for Rs.29,871/- and deducted an amount of Rs.11,670/- on the ground of old sum insured was considered for reimbursement.

On mediation of this Forum, both the parties mutually agreed to compromise and Respondent agreed to pay an additional amount of Rs.4,680/- which was accepted by the Complainant.

Thus complaint amicably resolved without any formal award.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0859-12

Shri Jagdishsinh Chudasma V/s. Oriental Insurance Co. Ltd.

Award dated 14th December 2012

Repudiation of Mediclaim

Complainant hospitalized for treatment of Coronary Artery Disease and expense claimed for Rs.2,14,807/- was repudiated by the Respondent on the ground of pre-existing disease under exclusion clause No.4.3 of the Mediclaim policy.

Complainant argued that he had not received any policy terms and conditions but his proposal form has not shown and defects in personal history column.

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.11-012-0868-12

Smt. Jignaben I Modi V/s. ICICI Lombard Gen. Insurance Co. Ltd.

Award dated 13th December 2012

Repudiation of Damage Claim under Private Car Package Policy

Complainant's insured vehicle was accidentally damaged and sustained claim for Rs.4,68,940/- was repudiated by the Respondent giving reason and at the time of accident the insured vehicle was using for commercial purpose which is exclusion under limitation as to use.

Original R.C. Book was now produced during the Hearing giving reason that the vehicle was under hypothecation so original documents are with bankers.

In view of this, complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0887-12

Shri Vinodray H. Bagdai V/s. The New India Assurance Co. Ltd.

Award dated 14th December 2012

Partial settlement of Mediclaim

Complainant's wife hospitalized for Hysterectomy surgery and lodged claim of Rs.70,981/- was settled for Rs.65,595/- by the Respondent and deducted an amount of Rs.5,000/- invoking policy condition No.3.13 on the basis of Customary and Reasonable charges.

Complainant's argument that his S.I of Rs.1,25,000/-, so he should get full claim amount.

Respondent has produced list of package charges for other hospitals and shown the reason for deduction. However Respondent's decision to deduct Rs.5,000/- is justified and complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

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Original R.C. Book was now produced during the Hearing giving reason that the vehicle was under hypothecation so original documents are with bankers.

In view of this, complaint fails to succeed.

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Complainant's argument that his S.I of Rs.1,25,000/-, so he should get full claim amount.

Respondent has produced list of package charges for other hospitals and shown the reason for deduction. However Respondent's decision to deduct Rs.5,000/- is justified and complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-0867-12

Mr. Mayursen H. Chauhan V/s. National Insurance Co. Ltd.

Award dated 12th December 2012

Repudiation of Mediclaim

Complainant's wife hospitalized for abdominal pain and operated for removal of tumor which expense claimed for Rs.14,375/- was repudiated by the Respondent under exclusion clause No.4.8 of the mediclaim policy.

The respondent could not produce any concrete evidence for treatment of sterility which is excluded as per policy clause 4.8.

As a result of mediation of this Forum, the Respondent has agreed and offered to pay an amount of Rs.10,781/- as full and final settlement which was accepted by the Complainant.

Thus the complaint amicably redressed during the Hearing without any formal Award.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0821-12

Mr. Satishbhai V. Mangukia V/s. United India Insurance Co. Ltd.

Award dated 11th December 2013

Repudiation of Mediclaim-Complainant's wife hospitalized for treatment of Severe Hamatemesis and during treatment she had blood vomiting so as per the advise of the doctor she has shifted to another hospital at Bombay by ambulance and expense claimed for Rs.2,15,332/- was rejected by the Respondent giving reason that non compliance of required documents and late submission of claim intimation.

This is tailor made Group master policy issued to Veritus Insurance Services Pvt. Ltd. The complainant failed to produce original policy copy and premium paid receipt for evidence.

Considering all the above, Respondent's decision to reject the claim is right and proper without any relief to the complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0879-12

Mr. Manishkumar S. Antala V/s. Oriental Insurance Co. Ltd.

Award dated 12th December 2012

Partial Repudiation of Mediclaim

Complainant's mother hospitalized for Coronary Artery Disease and expense claimed for Rs.1,35,010/- was partially settled by the Respondent for Rs.60,712/-and repudiated an amount of Rs.74,298/- under exclusion clause No.4.1.

Complainant was having Individual Mediclaim policy since 2001 and Sum Insured was Rs.75,000/-, thereafter enhanced Sum Insured to 3.00 Lacs in the year 2010-11 and changed the product to Happy family floater policy. The insured was suffering from IHD since 2 years hence the applicable sum insured would be Rs.75,000/-.

Therefore the Respondents decision to repudiate the claim partially is upheld without any relief to the Complainant.

AHMEDABAD OMBUDSMAN CENTRE

case No.11-004-0821-12

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Therefore the Respondents decision to repudiate the claim partially is upheld without any relief to the Complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0882-12

Mr. Raghuram M. Sharma V/s. Oriental Insurance Co. Ltd.

Award dated 12th December 2012

Partial Settlement of Mediclaim

Complainant hospitalized for treatment of Benign Enlargement of Prostate and claim lodged for Rs.45,558/- was partially settled by the Respondent for Rs.39,578/- by deducting an amount of Rs.5,980/-.

During the Hearing Respondent informed that the complainant had lodged complaint with Consumer Forum vide Case No.660/12 at Surat so complaint stands closed under Rule No.13(3) © of the Redressal of Public Grievance 1998.

Thus, the complaint stands disposed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0808-12

Mr. Bhadresh A. Shah V/s. Oriental Insurance Co. Ltd.

Award dated 12th December 2012

Partial Settlement of Mediclaim

Complainant hospitalized for treatment of Asthma-cough and claim lodged for Rs.50,825/- was partially settled by the Respondent for Rs.15,440/- by deducting an amount of Rs.35,385/- stating that as per hospital papers, patient is known case of COPD.

Insured was suffering Asthma since 7 years so claim settled under clause 4.1, 4.2 and 4.3 of the Mediclaim policy.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0819-12

Shri Rameshbhai K. Mehta V/s. United India Insurance Co. Ltd.

Award dated 7th December 2012

Partial Repudiation of Mediclaim

Complainant hospitalized for treatment of his Ear Otitis Media with a perforation in the Drum with mixed hearing loss and incurred expense for Rs.54,960/- was settled by the Respondent for Rs.24,165/- and deducted an amount of Rs.30,795/- as per package rate MOU signed by hospital.

Respondent paid Rs.24,165/- which is more than the PPN rate of Rs.18,000/-, so deduction of Rs.30,795/- is in order.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-009-0889-12

Mr. Mukesh V. Batavia V/s. Reliance General Insurance Co. Ltd.

Award dated 19th December 2012

Repudiation of Mediclaim

Complainant's son treated for accidental head injury and expenses claimed for Rs.30,801/- was repudiated by the Respondent giving reason that the treatment is an OPD basis and no active line of treatment hence claim is not admissible.

During the Hearing insured produced the proof of treatment, as a result of mediation of this Forum, both the parties mutually agreed to settle the claim for Rs.15,000/-without any formal award.

The complaint thus stands disposed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0888-12

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

Award dated 19th December 2012

Partial repudiation of Mediclaim

Complainant's wife hospitalized for surgery of Gall bladder stone and incurred expense of Rs.1,21,549/- was settled by Respondent for Rs.92,636/- and deducted an amount of Rs.28,913/- invoking policy condition No.3.13.

Respondent further stated that the claim lodged is in the first year policy and Gall Bladder Stone disease has waiting period of 2 years as per policy. However the Respondent's decision to settle the claim partially is just and proper.

In the result, complaint fails to succeed.

****

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0882-12

Mr. Raghuram M. Sharma V/s. Oriental Insurance Co. Ltd.

Award dated 12th December 2012

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During the Hearing Respondent informed that the complainant had lodged complaint with Consumer Forum vide Case No.660/12 at Surat so complaint stands closed under Rule No.13(3) © of the Redressal of Public Grievance 1998.

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Complainant hospitalized for treatment of Asthma-cough and claim lodged for Rs.50,825/- was partially settled by the Respondent for Rs.15,440/- by deducting an amount of Rs.35,385/- stating that as per hospital papers, patient is known case of COPD.

Insured was suffering Asthma since 7 years so claim settled under clause 4.1, 4.2 and 4.3 of the Mediclaim policy.

In the result complaint fails to succeed.

****

AHMEDABAD OMBUDSMAN CENTRE

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Award dated 7th December 2012

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Respondent paid Rs.24,165/- which is more than the PPN rate of Rs.18,000/-, so deduction of Rs.30,795/- is in order.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

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Mr. Mukesh V. Batavia V/s. Reliance General Insurance Co. Ltd.

Award dated 19th December 2012

Repudiation of Mediclaim

Complainant's son treated for accidental head injury and expenses claimed for Rs.30,801/- was repudiated by the Respondent giving reason that the treatment is an OPD basis and no active line of treatment hence claim is not admissible.

During the Hearing insured produced the proof of treatment, as a result of mediation of this Forum, both the parties mutually agreed to settle the claim for Rs.15,000/-without any formal award.

The complaint thus stands disposed.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0888-12

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

Award dated 19th December 2012

Partial repudiation of Mediclaim

Complainant's wife hospitalized for surgery of Gall bladder stone and incurred expense of Rs.1,21,549/- was settled by Respondent for Rs.92,636/- and deducted an amount of Rs.28,913/- invoking policy condition No.3.13.

Respondent further stated that the claim lodged is in the first year policy and Gall Bladder Stone disease has waiting period of 2 years as per policy. However the Respondent's decision to settle the claim partially is just and proper.

In the result, complaint fails to succeed.

****

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0891-12

Mr. Trilok B. Sanghani V/s. The New India Assurance Co. Ltd.

Award dated 18th December 2012

Partial Repudiation of Mediclaim

Complainant's son hospitalized for surgery of Appendicitis and incurred expense of Rs.66,499/- was settled by the Respondent for Rs.45,400/- and deducted an amount of Rs.21,099/-invoking policy c+ndition 2.1, 2.2, 2.3, 2.4 & 3.13.

The Respondent produced list of package charges of other hospitals where similar operations are being performed on package basis. Hence Respondent's decision to settle the claim partially is right and proper.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-007-0899-12

Mr. Vinod D. Nagrecha V/s. Tata AIG General Insurance Co. Ltd.

Award dated 27th December 2012

Repudiation of Daily Benefit Claim

+Complainant's wife hospitalized for surgery of Tubo Ovarian Mass P0/ +ith Hysterectomy and daily benefit claim for 18 days @2000/day was repud7ated by the Respondent invoking policy condition E(2) which excludes the treatment underwent by the insured.

Complainant stated that they have no idea to operate for Hysterectomy but to get relief from abdominal pain.

Respondent explained the entire things that the Hysterectomy surgery is excluded from the scope of coverage as per condition No.E-2 of policy.

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.11-003-0875-12

Mr. Suhasbhai M. Mehta V/s. National Insurance Co. Ltd.

Award dated 26th December 2012

Partial Repudiation of Mediclaim

Complainant claimed an amount of Rs.1,32,709/- for his left eye cataract expense which was settled by the Respondent for Rs.72,709/- under clause No.3.12 of the Mediclaim policy.

Complainant's argument was that his earlier claim for his right eye cataract was fully paid so this claim also should get full amount.

Respondent opined that IOL is available for various ranges, the complainant's lens charge was Rs.90,000/-which is on higher side so sanctioned Rs.30,000/- for IOL and deducted Rs.60,000/-.

The Forum also agreed the Respondent's decision hence complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-011-0864-12

Smt. Bhartiben M. Naik V/s. Bajaj Allianz Gen. Ins. Co. Ltd.

Award dated 20th December 2012

Repudiation of Mediclaim

Complainant's husband hospitalized for Coronary angiography and PTCA stenting for which expenses incurred for Rs.3,39,287/- was repudiated by the Respondent invoking Policy Exclusion Clause C1.

Complainant stated that she has not been given terms and condition of the policy. The policy started from 01-02-2008 and Angio was done on 06-03-2011.

As per Discharged Summary of the hospital and other documents proved the insured was suffering k/c/o, HT Hyper lipidemia which is excluded as per policy conditions Clause-1.

In view of this, complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-009-0824-12

Mr. Ashok Jindal V/s. Reliance General Insurance Co. Ltd.

Award dated 24th December 2012

Repudiation of Mediclaim

Complainant's son hospitalized for treatment of Arthroscopic removal of Lt. Knee (Loose Body) and claim lodged was repudiated by the Insurer invoking exclusion clause No.10.

The enquiry report of Panel doctor shows that operation of Right knee joint two years back. Previous claim file was not made available. Hence there is no new ground for interventions in the decision of the Respondent.

In the result complaint fails to succeed.

****

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0831-12

Shri Vithalbhai Chauhan V/s. The New India Assurance Co. Ltd.

Award dated 24th December 2012

Repudiation of Mediclaim

A claim lodged by the Complainant for treatment expense of complainant's wife was repudiated by the Respondent as per policy terms and condition No. 3.2.

Respondent submitted 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.11-004-0909-12

Mr. Sharad N. Shah V/s. United India Insurance Co. Ltd.

Award dated 26th December 2012

Partial Repudiation of Mediclaim

Complainant's wife hospitalized for surgery of Abdominal Hysterectomy and claimed for Rs.1,01,203/- which was settled by the Respondent for Rs.59,450/-by deducting an amount of R.41,753/- giving reason that as per policy condition 2.1, there is restriction of 25% of S.I for the subject treatment.

On referring all the records, it is proved that the Respondent is rightly deducted the claimed amount, hence complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0826-12

Mr. Dinesh K. Sharma V/s. The Oriental Insurance Co. Ltd.

Award dated 26th December 2012

Repudiation of Mediclaim

Complainant's wife hospitalized for umbilical Hernia and expense of Rs.28,260/- lodged was repudiated by the Respondent giving reason that non-compliance of required documents.

Complainant was not present in the Hearing scheduled by this Forum and also not produced sufficient documents.

In the result complaint fails to succeed.

****

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0876-12

Shri Arvind I. Panchal V/s. United India Insurance Co. Ltd.

Award dated 31st December 2012

Partial settlement of Mediclaim

Complainant hospitalized for treatment of Mild Mitral Stenosis, severe Mitral Regurgitation, Mild Arotic Regurgitation etc., and expense claimed for Rs.2,88,758/- out of which Respondent paid an amount of Rs.52,500/- by deducting an amount of Rs.2,36,258/- 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.11-002-0881-12

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

Award dated 31st December 2012

Repudiation of Mediclaim

Complainant's hospitalized for treatment of squint operation i.e. corrective of eye sight and expense incurred Rs.20,851/- was repudiated by the Respondent by invoking policy clause No.4.4.2. Policy was incepted on 20-06-2011 and treatment taken on 5th July 2011 i.e., within one month of taking policy, it is treated as pre-existing disease.

On scrutiny of all treatment records proves policy clause No.5.5.is also attracted misrepresentation, concealment, so repudiation is right and proper.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0799-12

Mrs. Shilpabn Kotak V/s. United India Insurance Co. Ltd.

Award dated 28th December 2012

Repudiation of Mediclaim

Complainant claimed Rs.30,000/- for operation expenses of her Lt. Ovarian Cyst which was repudiated by the Respondent giving reason that treatment taken in a Declined hospital hence claim is not payable under preview of policy condition.

Complainant also confirmed this fact that an emergency basis treatment taken in the nearest hospital which was a declined list in one.

On scrutiny of all the records of both the parties, the Forum also denied the claim.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-0908-12

Shri Chetankumar N. Thakkar V/s. National Insurance Co. Ltd.

Award dated 28th December 2012

Repudiation of Mediclaim

Complainant hospitalized for Dental treatment due to accidental damage and expense claimed for Rs.16,700/- was repudiated by the Respondent giving reason that the claim papers submitted by the complainant late by 60 days, hence claim repudiated under clause 10 of the policy terms and conditions.

On scrutiny of treatment papers, payment receipt, and date of treatment proved, the Respondent's decision to repudiate the claim is upheld without any relief to the complainant.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0900-12

Shri Anil N. Shah V/s. United India Insurance Co. Ltd.

Award dated 28th December 2012

Repudiation of Mediclaim

Complainant hospitalized for treatment of Lt. Eye Laser surgery and expense claimed for Rs.8,384/- was repudiated by the Respondent by invoking Policy Condition 5.3 delayed intimation.

On perusal of claim papers reveals, there is no active treatment, only OPD treatment on 3 occasions.

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.11-002-0895-12

Mr. Archit A. Soni V/s. The New India Assurance Co. Ltd.

Award dated 28th December 2012

Repudiation of Mediclaim

Complainant's son treated for Tight Phimosis & Multiple renal calculi and expenses claimed for Rs.15,270/- was repudiated by the Respondent invoking Clause 4.4.6 but Respondent could not produce any documentary evidence to prove the disease is congenital external one.

As a result of mediation of this Forum, both the parties mutually agreed to settle the claim for Rs.12,678/-without any formal award.

The complaint thus stands disposed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.14-003-0780-12

Mr. Bipin J. Shah V/s. National Insurance Co. Ltd.

Award dated 6th November 2012

Partial repudiation of Mediclaim

Complainant and his wife was covered a Group Mediclaim Policy through V.M. Assurance Services Pvt. Ltd. issued by National Insurance Co. Ltd. A Claim amount of Rs.1,57,393/- lodged by the Complainant for treatment expenses of his wife's Knee transplantation which was settled for Rs.1,30,000/- under cashless basis and remaining amount of Rs.27,393/- repudiated by the Respondent giving reason that the policy was cancelled by the Respondent before admitting the patient to the hospital.

According to the Respondent, various complaints received from public against the policy holder, the Respondent cancelled the policy contract and informed to the Hon. High Court and City Civil Court also.

In view of these complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0915-12

Shri Malay M. Choksi V/s. United India Insurance Co. Ltd.

Award dated 2nd January 2013

Repudiation of Mediclaim

Complainant's wife hospitalized for pregnancy related treatment and expenses claimed for Rs.1,02,610/- was repudiated by the Respondent under exclusion clause No.4.11 of the Individual Mediclaim policy.

On referring all the records, the forum also denied the claim hence complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0874-12

Shri Manan H. Sonchhatra V/s. United India Insurance Co. Ltd.

Award dated 2nd January 2013

Repudiation of Mediclaim

Complainant's wife hospitalized for Tubal pregnancy and expenses claimed for Rs.32,916/- was repudiated by the Respondent under exclusion clause No.4.11 of the Individual Mediclaim policy.

On referring all the records, it is proved that the insured patient's left tube was damaged so removed by laparoscopy surgery for which the forum also denied the claim hence complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0912-12

Mr. Chandrakant P. Soni V/s. The New India Assurance Co. Ltd.

Award dated 2nd January 2013

Repudiation of Mediclaim

Complainant's 69 years old wife treated for pacemaker & CAG and incurred total expenses of Rs.68,666/- was repudiated by the Respondent under exclusion clause No.4.1 as pre-existing disease.

Treating hospital's progress note shows H/o DM – 25 years, Br. Asthma 30-40 years and Hystrectomy many years back. This facts was not disclosed in the proposal form hence policy attracts null & void – Condition No.5.5.

In view of this, complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0915-12

Shri Malay M. Choksi V/s. United India Insurance Co. Ltd.

Award dated 2nd January 2013

Repudiation of Mediclaim

Complainant's wife hospitalized for pregnancy related treatment and expenses claimed for Rs.1,02,610/- was repudiated by the Respondent under exclusion clause No.4.11 of the Individual Mediclaim policy.

On referring all the records, the forum also denied the claim hence complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0920-12

Mr. Lalitbhai M. Vaghela V/s. The Oriental Insurance Co. Ltd.

Award dated 3rd January 2013

Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of ovarian cyst and expense of Rs.19,307/- lodged was repudiated by the Respondent invoking clause No.4.3 which prevents them from honouring the claim in the first year of the policy. This particular disease is restricted for two years for claiming hence claim repudiated is rightly and no relief to the complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0834-12

Shri Rajendrakumar K. Bajpai V/s. United India Insurance Co. Ltd.

Award dated 4th January 2013

Repudiation of Mediclaim

Complainant's son hospitalized two times first at Gandhidham and second at Sterling Hospital, Ahmedabad for vehicular injury and expense claimed for Rs.71,893/- was repudiated by the Respondent on the basis of referring both the hospital records and opinion of panel doctor of the Respondent proved that the insured was known case of 19 years Hemophilia which is pre-existing prior to inception of policy considered under exclusion clause 4.1.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0906-12

Mr. Sanjiv J. Kad V/s. The New India Assurance Co. Ltd.

Award dated 4th January 2013

Repudiation of Mediclaim

Complainant treated for Synovial Chondromatosis & Osteonecrosis of Head of Left Femur and expenses claimed for Rs.64,167/- was repudiated by the Respondent invoking Clause No.1 and Clause No.4.4.6.

Complainant was having alcoholic habit which was certified by the treating doctor. Complainant argued that the disease is no relation with alcoholism, hence claim should be paid which is not accepted by the Respondent.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0914-12

Shri Manish H. Shahi V/s. United India Insurance Co. Ltd.

Award dated 4th January 2013

Partial Repudiation of Mediclaim

Complainant hospitalized for treatment of Rt. Ingunial Hernia and expenses claimed for Rs.47,562/- was partially repudiated by the Respondent under exclusion clause No.4.3 of the Individual Mediclaim policy.

Complainant was having policy since 2008 for S.I of Rs.1.00 Lac and 2010-11 S.I increased to Rs.2.00 Lacs which is considered a fresh policy. However Respondent settled his claim on the basis of old S.I and deducted remaining amount under exclusion clause No.4.3 which is right and proper.

In the result, complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-0933-12

Mr. Atul S. Thakkar V/s. National Insurance Co. Ltd.

Award dated 7th January 2013

Partial Repudiation of Mediclaim

Complainant lodged Mediclaim for Rs.2,27,443/- with Oriental Insurance Co. who had sanctioned Rs.80,000/- and balance Rs.1,47,443/- claimed with the Respondent. The total S.I with the Respondent for Rs.52,500/-. Out of this the Complainant earlier claimed for Rs.14,180/- hence balance sum insured available would be Rs.38,400/- which was sanctioned by the Respondent during the Hearing and complainant accepted the same.

Therefore there is formal award and decided to close the complaint.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0851-12

Mr. Ladjibhai M. Maredia V/s. United India Insurance Co. Ltd.

Award dated 8th January 2013

Repudiation of Mediclaim

A 67 years old Complainant hospitalized for treatment of Renal Stone and claim lodged for Rs.46,934/- was rejected by the Respondent invoking clause 4.3 of the policy. Sum Insured Rs.50,000/- and the subject treatment restricted for two years. Treatment taken in 2nd year policy but if the treatment taken in a Govt. Hospital, S.I is payable instead he had taken treatment in a private hospital.

In view of this, complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0930-12

Mr. Dhariya Raval V/s. The Oriental Insurance Co. Ltd.

Award dated 8th January 2013

Repudiation of Mediclaim

Complainant's mother treated for lower End Radious Rt. Without DNVD and expense claimed for Rs.9,503/- was repudiated by the Respondent stating that required documents was not submitted in-spite of several reminders. Cashless amount settled but hospital balance bill was not reimbursed because policy was not an individual it is Group Master Policy there is no insurable interest.

In view of this Respondent's decision is upheld without any relief to the complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0926-12

Mr. Kaushikbhai K. Shah V/s. The Oriental Insurance Co. Ltd.

Award dated 8th January 2013

Partial Repudiation of Medi Claim

A claim of Rs.51,191/- for treatment of CVA stroke was settled by the Respondent for Rs.25,000/- invoking policy condition No.4.1, current is complication of D.M since 15 years. Old Sum Insured was Rs.25,000/- 4 years back. Thereafter S.I increased to Rs.50,000/-,but as per the treatment records, insured has pre-existing disease so claim settled on the basis of Old Sum Insured.

In the result, complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0847-12

Mr. Dineshpuri K. Goswami V/s. The New India Assurance Co. Ltd.

Award dated 8th January 2013

Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Fibroid Uterus and expenses claimed for Rs.98,311/- was repudiated by the Respondent giving reason that the treatment taken in a declined list of hospitals.

Complainant argued that he was not aware of the declined name of the hospital at the time of taking policy and till date not received any information about valid list of hospitals.

Respondent informed that the information was given to all agents and enclosed with policy issued to Policy Holders. In view of this, complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-007-0927-12

Smt. Sarojni R. Pandey V/s. Tata AIG General Insurance Co. Ltd.

Award dated 9th January 2013

Repudiation of Mediclaim

The Complainant insured Group Accident and Sickness Hospital Cash policy with the Respondent. Claim lodged for daily benefit for 97 days due to treatment of Labyurnthitis, Vertigo and heaviness in Head at a Govt. Ayurvedic Hospital was denied by Respondent giving reason that as per the opinion of Dr.(Mrs. Neha N. Mulye) that the treatment could have been done on OPD basis which falls outside the purview of policy terms and conditions.

Earlier hospitalization claim paid for Rs.25,000/- as daily benefit claim which was with the purview of Policy Terms and Conditions.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0968-12

Mr. Jitendrakumar B. Patel V/s. The Oriental Insurance Co. Ltd.

Award dated 10th January 2013

Partial settlement of Mediclaim

Complainant's wife treated for severe Anemia and Polyarthritis +URTI and expenses claimed for Rs.43,233/- which was partially settled for Rs.36,792/- by deducting an amount of Rs.6,441/-, giving bifurcation as 10% co-payment as per policy condition and remaining amount's bills, medicines were found beyond 60 days treatment.

On scrutiny of all documents, it is proved that the Respondent has rightly deducted the above amount.

Hence complaint dismissed without any relief to the complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.14-002-0959-12

Mr. Abbasali Y Khunt V/s. The New India Assurance Co. Ltd.

Award dated 11th January 2013

Repudiation of Mediclaim

Complainant's 72 years old father hospitalized several times for treatment of COPD + IHD and total expenses claimed for Approx. Rs.1,46,461/- which was fully repudiated by the Respondent under pre-existing. The insured was known case of COPD since 10 years as evidenced from treating doctors.

Complainant's argument the same illness, Respondent had paid twice in 2004 and twice in 2008 so these claims should be received by him.

Respondent replied previous claims paid by mistakes and recovery procedure had been initiated.

In view of this, the complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0939-12

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

Award dated 15th January 2013

Repudiation of Mediclaim

A 65 years old female complainant hospitalized for slight chest pain and breathing problem for which total claim lodged was for Rs.14,239/-.

Respondent repudiated the claim under policy clause 4.4.6 and 4.4.11. Hospital papers do not show the time of admission and discharge. Hospital bill showing only Rs.5,300/-.

In view of these 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.11-002-0974-12

Mr. Vinod R. Gangwani V/s. The New India Assurance Co. Ltd.

Award dated 15th January 2013

Repudiation of Mediclaim

Complainant hospitalized for treatment of Para Umbilical Hernia and expenses incurred Rs.61,917/- was repudiated by the Respondent as per policy clause 4.4.6.

Complainant was having heavy weight and height but treating doctor certified the disease is not developed from heavy weight. Thereafter Respondent agreed to settle the claim partially for Rs.23,920/-.

In the result complaint succeeds partially.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0979-12

Dr. Ajay N. Rajput V/s. The New India Assurance Co. Ltd.

Award dated 15th January 2013

Partial Settlement of Mediclaim

Complainant accidentally fall in bathroom resulting into fracture Neck Femur left side and expense claimed for Rs.68,596/- was settled by the Respondent for Rs.58,296/- and deducted Rs.10,300/- invoking policy condition No.2.3 and 3.13.

Complainant objected to deductions, he must get full payment as he has paid full payment to hospital in cash.

On scrutiny of documents of both the parties, the forum also denied the claim, thus complaint disposed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0919-12

Ms. Ketu J. Shah V/s. The Oriental Insurance Co. Ltd.

Award dated 16th January 2013

Repudiation of Medi Claim

Complainant's insured father aged 72 years hospitalized for Post Coronary Artery Bypass Grafting and expenses claimed for Rs.98,697/- was repudiated by the Respondent invoking policy clause 4.1,4.3 and 5.2 of the policy.

Complainant is a member of Group Insurance, no insurable interest so Respondent proved that the present claim is not payable as per their tailor made policy clause No.5.2.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0925-12

Mr. Mohanlal G. Bagdi V/s. The Oriental Insurance Co. Ltd.

Award dated 16th January 2013

Repudiation of Medi Claim

Complainant's insured father hospitalized for COPD+DM+UTI and expenses claimed for Rs.52,485/- was repudiated by the Respondent stating delay in submission of claim papers.

Complainant is a member of Group Insurance, no insurable interest. Complainant informed that due to family problem and not knowing the rules, the delay occurred. Respondent proved that the present claim is not payable because delay in intimation of 38 days.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0962-12

Mr. Rameshkumar J. Upadhyay V/s. The New India Assurance Co. Ltd.

Award dated 16th January 2013

Repudiation of Mediclaim

Complainant's wife hospitalized for D & C and Hysterectomy for which claim lodged for Rs.8,386/-was repudiated by the Respondent as per policy clause 3.2 & 4.13. Insured admitted at a hospital was having less than 15 beds and not having registration number.

Considering all the above, Respondent's decision to repudiate the claim is upheld.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0837-12

Mr. Amratlal M. Mehta V/s. The New India Assurance Co. Ltd.

Award dated 16th January 2013

Repudiation of Mediclaim

Complainant's wife aged 71 years has hospitalized for 3 hours and claimed for Rs.4,260/- was repudiated by the Respondent under policy condition No.2.3.

Complainant's argument that if 24 hours keep the patient to hospital, they will add the Room Rent also and expense would have increased.

Considering the background of the claimant and patient, the forum suggested to the Respondent to pay the claimed amount as a special case.

In the result, complaint succeeds.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0832-12

Mr. Mahadev G. Rathvi V/s. The New India Assurance Co. Ltd.

Award dated 16th January 2013

Repudiation of Mediclaim

Complainant's insured son aged 20 years has hospitalized for treatment of Ankylosing Spondylitis and expense claimed for Rs.43,462/- was repudiated by the Respondent under exclusion clause 4.3.

On referring the hospital case papers proved the patient was detected to have Ankylosing Spondylitis – an arthritic disorder of the spine in young adults, mostly men, can not be equated with Non-infective arthritis.

Hence Respondent's decision is set aside and advised to pay the claim amount within 15 days.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0833-12

Ms. Meena D.Shah V/s. United India Insurance Co. Ltd.

Award dated 16th January 2013

Repudiation of Mediclaim

Complainant was a member of a Group Mediclaim Floater Policy who is 64 years old house wife met with an accident and expense incurred Rs.8,339/- was repudiated by the Respondent giving reason that the patient was not hospitalized and treatment taken on OPD basis. Complainant lodged another claim for Rs.10,301/- for medical treatment and plaster for same accidental injury was paid by the Respondent hence the first claim also should be paid.

Complainant has not produced any premium receipt and she is a member of Group Master policy holder, had no insurable interest.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0838-12

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

Award dated 16th January 2013

Partial Settlement of Mediclaim

Complainant's wife's hospitalization expenses settled for Rs.65.643/- and deducted Rs.1032/- as per Policy clause 4.4.2 which is not agreeable by the Complainant.

Respondent clarified the deducted amount is for the charges of non-medical items which is not payable by the Insurance Company.

On scrutiny of all documents the Forum also denied the claim.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0931-12

Mr. Rajan H. Patel V/s. Oriental Insurance Co. Ltd.

Award dated 17th January 2013

Partial repudiation of Mediclaim

Complainant has a member of a Group Master Policy issued to Trident Hospitality by the Respondent Insurer.

Complainant's wife hospitalized for treatment of Chest pain and HTN and expense claimed was partially settled by the Respondent as per Group Mediclaim Policy conditions.

On referring the policy documents, it appears that this is Group Master policy holder has no insurable interest.

Therefore, Respondent's decision to settle the claim partially is right and proper hence complaint fails to succeed.

****

AHMEDABAD OMBUDSMAN CENTRE

Case No.21-023-009-13

Smt. Nina B. Parikh V/s. India First Life Insurance

Award dated 17th January 2013

Repudiation of Mediclaim

Complainant was having a Health Insurance Plan with the above Insurer covering her spouse and children. Total premium was for Rs.59,700/-per month and commencement of the policy was on 23-11-2012. Thereafter claim intimation for hospitalization was received for her insured husband for heart problem on 7.3.212 in

which history of HTN mentioned since last 10 years and operated for Ca Bladder in 1996 and lithotripsy 6 times.

Therefore Claim for Rs.2,17,725/- repudiated by the Respondent and policy also cancelled on the basis of suppression of material information.

On scrutiny of documental evidence, the Forum also denied the claim, thus complaint disposed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0937-12

Mr. Rajnikant H. Shah V/s. United India Insurance Co. Ltd.

Award dated 21st Day of January 2013

Partial Repudiation of Mediclaim

Complainant hospitalized for Knee replacement and claimed for Rs.3,59,438/- which was assessed by the Respondent for Rs.3,52,048/-and already paid Rs.2,23,484/- and balance amount also paid Rs.40,552/- to the policy holder of JMSL Web Solution. Complainant is a member of Group Master Policy holder and he is no insurable interest.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-017-0969-12

Mr. Hiren M. Shukla V/s. Star Health & Allied Insurance Co. Ltd.

Award dated 21st January 2013

Repudiation of Mediclaim

Complainant hospitalized for treatment of Sinusitis and expenses claimed for Rs.11,507/- was repudiated by the Respondent under exclusion clause No.4 during first year.

As per hospital records, insured was hospitalized for treatment of Giddiness perspiration and weakness, so the Forum recommended to allow payment of 75% of the claimed amount.

In the result complaint succeeds partially.

****

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-009-0840-12

Mr. Suresh M. Kathiria V/s. The Reliance General Insurance Co. Ltd.

Award dated 21st January 2013

Repudiation of Mediclaim

Complainant's 15 years old insured son hospitalized for treatment of 2 years old healed fracture of right femur shaft and expense claimed for Rs.19,809/- was repudiated by the Respondent as per policy condition No.2.

As per hospital record, he had osteomyelitis of Rt. Femur at the age of 2 years which was not disclosed while proposing insurance on 29-11-2007. Hence claim was repudiated due to non-disclosure of material fact, so complaint fails to succeed.

****

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-009-0965-12

Mr. Dindayal Kejriwal V/s. The Reliance General Insurance Co. Ltd.

Award dated 21st January 2013

Repudiation of Mediclaim

Complainant himself hospitalized for treatment of CRF + DM+HTN and expense claimed for Rs.46,126/- was repudiated by the Respondent as per policy condition No.1 & 2.

As per Investigation report, he had Diabetes since last 3 years which was not disclosed while proposing insurance on 13-03-2008. Hence claim was repudiated due to non-disclosure of material fact, so complaint fails to succeed.

****

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-009-0938-12

Mr. Rajnikant V. Patel V/s. The Reliance General Insurance Co. Ltd.

Award dated 21st January 2013

Repudiation of Mediclaim

Complainant was hospitalized for treatment of Acute PID L4 L5 with L3, 4 & L5 and expense claimed for Rs.27,244/- was repudiated by the Respondent as per policy clause 1 and condition No.2.

As per hospital record, the insured had history of Back pain or low backache since 6 years which is rectified as 6 months but there is no valuable signature and Rubber Stamp. Hence claim was repudiated due to non-disclosure of material fact, so complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0839-12

Mr. Alok Rai V/s. United India Insurance Co. Ltd.

Award dated 23rd January 2013

Repudiation of Mediclaim

Complainant hospitalized for treatment of sudden decrease of vision in right eye and expense claimed for Rs.38,409/- was repudiated by the Respondent as per policy condition No.8.2 & 8.3 i.e., late intimation and late submission of claim papers.

The complainant was a member of the Master Policy Holder of the Group Insurance who is no insurable interest.

In the result, complaint fails to succeed.

****

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0823-12

Mr. Pravinbhai A. Patel V/s. The Oriental Insurance Co. Ltd.

Award dated 23rd January 2013

Repudiation of Mediclaim

Complainant's son hospitalized for treatment of Jaundice and expense claimed was repudiated by the Respondent under clause 4.15 of the policy.

Complainant argued that his earlier claim for the same treatment in the year of October 2008 was paid by the Respondent.

On referring the documents of both the parties, the Forum recommended as a special case the Respondent to admit the claim for eligible amount.

In the result, complaint succeeds.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-009-0943-12

Smt. Sardaben Panchal V/s. Reliance General Insurance Co. Ltd.

Award dated 22nd January 2013

Repudiation of Mediclaim

Complainant hospitalized for treatment of abdominal pain and expense claimed for Rs.13,811/- was repudiated by the Respondent invoking clause No.1, pre-existing and T & C No.2 & 15.

Respondent proved with documentary evidence that the insured was suffering abdominal pain since last 3 years i.e., prior to inception of policy.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-009-0964-12

Mr. Tarunbhai S. Modi V/s. Reliance General Insurance Co. Ltd.

Award dated 23rd January 2013

Repudiation of Mediclaim

Complainant hospitalized for treatment of Acute Viral Hepatitis and expense claimed for Rs.32,237/- was repudiated by the Respondent under clause No.2 and 15.

Complainant argued that he was admitted to hospital as per the advise of doctor due to fever, vomiting and abdominal pain but as per the discharge summary, it is proved that the treatment for Acute Viral Fever.

Hence the complaint dismissed.

****

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-1046-12

Mr. Pareshbhai Ishwarlal Soni V/s. National Insurance Co. Ltd.

Award dated 23rd January 2013

Partial repudiation of Mediclaim

Complainant's insured son aged 21 years hospitalized for treatment of Acute Viral Hepatitis, Acute Gastritis, Dehydration and expense claimed was for Rs.28,215/- which was settled for Rs.15,066/- by deducting Rs.13,149/- stating not payable as per PPN rate fixed to the Hospital.

Hospital justified the Hepatitis is not included in package list and treatment is different so PPN rate is not applicable in this disease.

Hence the Forum directed to the Respondent to pay admissible full amount within 15 days from the date of receipt of consent from complainant.

In the result complaint succeeds.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-009-0945-12

Mr. Batukbhai G. Rathod V/s. Reliance General Insurance Co. Ltd.

Award dated 23rd January 2013

Repudiation of Mediclaim

Complainant hospitalized for treatment of Gouty Arthritis and expense claimed for Rs.24,067/- was repudiated by the Respondent under clause No.2 and 15.

Complainant was a policy holder since last 5 years and his job is hair cutting. He is not aware of the details of policy conditions.

Considering the background of the Insured claimant, the Forum directed the Respondent to pay 75% of the admissible claim as a special case to the complainant within 15 days from the date of receipt of consent from the Complainant.

In the result complaint succeeds partially.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-1004-12

Mr. H. N. Mehta V/s. United India Insurance Co. Ltd.

Award dated 19th February 2013

Repudiation of Mediclaim

Complainant hospitalized for treatment of infected Calosty Rt. Lateral Mallelus and expense incurred for Rs.8,279/- was repudiated by the Respondent under Clause 2.3.

According to the Respondent, the treatment underwent by the insured does not require hospitalization it could have been taken on OPD basis.

In the result, complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-1011-12

Mr. Uttam P. Majmudar V/s. The Oriental Insurance Co. Ltd.

Award dated 19th February 2013

Partial settlement of Mediclaim

Complainant hospitalized for treatment of unstable Angina and incurred total expense of Rs.1,60,494/- which was settled by the Respondent for Rs.47,254/- invoking policy condition No.4.1, 4.2 and 4.3.

Respondent submitted that the insured's old S.I was Rs.50,000/- since 2005-06. In the year 2009-2010 S.I increased to Rs.1,50,000/-. Claim lodged in the second renewal after enhancement of S.I, as per policy conditions waiting period is 4 years for the subject claim. Patient was a k/c/o HTN, DM since long hence exclusion clause for enhanced S.I and co-payment of 10% is applicable.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0991-12

Mr. Chetan R. Mehta V/s. The New India Assurance Co. Ltd.

Award dated 19th February 2013

Partial settlement of Mediclaim

Complainant's wife hospitalized for treatment of Osteoarthritis Rt. Knee and incurred total expense of Rs.1,63,235/- which was settled by the Respondent for Rs.42,000/- invoking policy condition No.6 which is not acceptable by the Complainant.

Respondent submitted that the insured's old S.I was Rs.35,000/-+ 7000 C.B since 2006-07. In the year 2009-2010 S.I increased to Rs.1,00,000/-. Claim lodged in the second renewal after enhancement of S.I, as per policy conditions waiting period is 4 years for the subject claim. Patient underwent of Osteoarthritis Rt. Knee which attracts exclusion clause 4.3 hence exclusion clause for enhanced S.I and old S.I of Rs.35,000/- + C.B Rs.7000/- is applicable.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0872-12

Dr. Chirag V. Pandya V/s. The New India Assurance Co. Ltd.

Award dated 20th February 2013

Partial settlement of Mediclaim

Complainant hospitalized for treatment of Dengu fever and expense incurred for Rs.65,442/- which was settled by the complainant for Rs.58,328/- as per terms and conditions of the policy clause 2.1, 2.3 and 2.4.

On scrutiny of available documents, the Forum also agreed the decision of the Respondent for settling the claim partially is right and proper.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-1013-12

Mr. Nilesh K. Shah V/s. United India Insurance Co. Ltd.

Award dated 20th February 2013

Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Piles and expense incurred was for Rs.11,001/- which was repudiated by the Respondent stating that treatment was taken in a private Ayurvedic hospital. As per policy conditions, the claim is payable if treatment is taken in a Government Ayurvedic Hospital as per clause No.2, N.B. 2.1 (2).

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-017-1059-12

Mrs. Chandrikaben Thakkar V/s. Star Health & Allied Insurance Co. Ltd.

Award dated 20th February 2013

Repudiation of Medeiclaim

Complainant hospitalized for treatment of Acute Abdomen pain and incurred expense for Rs.1,20,594/-had been rejected as per policy condition No.1. Thereafter the claim was paid partially after registering the case to this Forum for Rs.83,259/- by the Respondent and deducted Rs.37,335/- stating reasonable and customary charges.

Respondent produced details of deductions and complainant preferred to remain absent during the hearing.

In the result, the complaint is deemed to have been closed in view of the Respondent's decision.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-012-1047-12

Mr. Ashvinkumar N. Patel V/s. ICICI Lombard General Insurance Co. Ltd.

Award dated 20th February 2013

Repudiation of Mediclaim

Complainant's wife aged 52 years hospitalized for treatment of joint replacement surgery, Hypertension and Hypothyroidism and expense incurred was for Rs.2,29,000/- which was rejected by the Respondent due to non-disclosure of material facts and policy was cancelled and entire premium was refunded.

Respondent produced the entire treatment papers from 2001 to 2009 which were not disclosed in the Proposal.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-1010-12

Mr. Dharmesh Rami V/s. The Oriental Insurance Co. Ltd.

Award dated 20th February 2013

Repudiation of Mediclaim

Complainant's son aged 6 years hospitalized for treatment of Rt. Eye Cataract and expense incurred for Rs.26,390/- was rejected as per exclusion clause No.4.3. Complainant argued that his claim is payable as he got left eye cataract claim in the year of 2006 for Rs.26,000/-.

Proposal signed on 3-3-2010 without disclosing material facts of diminishing vision of Rt. Eye and treatment taken on 28-12-2010 which is having 2 years waiting period.

Insured was covered Individual policy since 2002 but in the year of 2010 plan changed to Happy Family Floater policy for which there is a waiting period of two year.

In view of these complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-1001-12

Mr. Janak P. Bhatt V/s. the New India Assurance Co. Ltd.

Award dated 18th February 2013

Partial settlement of Mediclaim

Complainant's son hospitalized for treatment of Acute Appendicitis and expense claimed for Rs.26,564/- which was settled by the Respondent for Rs.16,000/- by deducting an amount of Rs.10,564/- on the grounds of PPN charges.

Respondent stated that the hospital where the insured patient had taken treatment is a member of PPN having MOU with TPA to provide cashless and reimbursement of treatment facility for specified disease/surgery at specified rates. According to that rate claim settled, nothing is more payable.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-009-0987-12

Chelaji G.K. Patel V/s. Reliance General Insurance Co. Ltd.

Award dated 18th February 2013

Repudiation of Mediclaim

Complainant hospitalized for treatment of Viral Fever and expense claimed was for Rs.66,159/- which was repudiated by the Respondent as per Policy exclusion clause No.1, Condition No.2 and clause 15.

On referring to all available documents of both the parties, the Forum also denied the claim.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0996-12

Mr. Divyang K. Khatri V/s. the New India Assurance Co. Ltd.

Award dated 19th February 2013

Partial repudiation of Mediclaim

Complainant hospitalized for treatment of Kidney Stone and expense incurred for Rs.63,710/- was settled by the Respondent invoking policy condition No.2.3 and note 2 of the mediclaim policy.

Respondent submitted List of PPN for operation of kidney stone for similar type of hospital charging Rs.35,000/- wherein Respondent paid only Rs.25,880/-.

However the Forum directed to pay the difference of Rs.9,120/- to the complainant as a special case because as per PPN rate the complainant is eligible to get Rs.35,000/- for the subject treatment.

In the result complaint succeeds partially.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-0901-12

Mr. Vedprakash D. Chiripal V/s. National Insurance Co. Ltd.

Award dated 18th February 2013

Partial settlement of Mediclaim

Complainant's wife hospitalized for accidental fall in Bath Room resulting into fracture and expense incurred was for Rs.71,729/- which was partially settled by the Respondent for Rs.27,783/- and deducted Rs.43,345/- as per clause 3.13.

Moreover hospitalization was less than 24 hours, it appears to be a case of outpatient treatment converted into inpatient treatment.

Therefore 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.11-002-0878-12

Mr. Dipak J. Pujara V/s. The New India Assurance Co. Ltd.

Award dated 18th February 2013

Partial settlement of Mediclaim

Complainant's wife hospitalized for treatment of Acute Intestinal Obstruction and PUJ Obstruction and expense claimed was for Rs.69,318/- which was partially settled for Rs.15,750/-and repudiated the remaining amount as per policy clause No.4.1 and 6. The old Sum Insured was Rs.15,000/- and increased S.I to Rs.50,000/- on 14-10-2007 which is considered as fresh Insurance and claim falls under 3rd year of the increased S.I.

There is on record the insured was treated for same disease in the year of 2006-07, it is considered as pre-existing disease.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-0863-12

Mr. Hitesh J. Daxini Vs. National Insurance Co. Ltd.

Award dated 18th February 2013

Repudiation of Mediclaim

Complainant's wife hospitalized for treatment for Iron Deficiency, Anemia + Urinary Tract Infection and incurred Rs.22,098/- was repudiated by the Respondent as per clause No.4.8.

Insured patient's urine report was not showing ITI infection because 3 days treatment has taken before taking report.

Respondent submitted that non submission of required documents, as also admission card shows patient had delivered a baby boy before 22 days.

In view of this, complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-009-0976-12

Mr. Kamlesh M. Patel V/s. Reliance General Insurance Co. Ltd.

Award dated 18th February 2013

Partial repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Fibroid Uterus and incurred Rs.92,617/- was settled by the Respondent for Rs.50,000/-, deducting Rs.42,617/- giving reason that deduction is reasonable and customary charges.

Respondent clearly mentioned in the claim settlement advice showing all deductions and if not satisfied, have to object within 7 days but Complainant accepted the payment as full and final settlement.

However, Respondent's decision to repudiate the deducted amount is upheld without any relief to the complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0893-12

Mr. Nanubhai M. Shah V/s. United India Insurance Co. Ltd.

Award dated 18th February 2013

Repudiation of Mediclaim

Complainant hospitalized for treatment of Recurrent Right Thigh Lipoma and incurred Rs.1,22,880/- was repudiated by the Respondent under policy condition No.5.3 and 5.4.

Complainant himself agreed delay in submission of claim papers and intimation of hospitalization. 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.11-004-0947-12

Mr. Navin S. Shah V/s. United India Insurance Co. Ltd.

Award dated 18th February 2013

Repudiation of Mediclaim

Complainant's son hospitalized for treatment of Acute Viral Hepatitis from 24-04-2011 to 27-04-2011 and incurred expense for Rs.9,686/- was repudiated by the Respondent due to late intimation and late submission of claim papers.

Complainant proved that the claim intimation was given on 25-04-2013 by fax and no official visited the hospital for verification.

In view of this decision of the Respondent is set aside and Respondent is hereby directed to settle the admissible claim

In the result complaint succeeds.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0856-12

Mr. Rajendra G. Patel V/s. The Oriental Insurance Co. Ltd.

Award dated 18th February 2013

Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of both knees replacement and incurred expense for Rs.2,80,478/- which was repudiated by the Respondent as per policy condition No.4.3.

As per records policy renewal period of 2006-07 & 2007-08, there was a break of 6 days which is considered as fresh policy so subject claim arose in 3rd year of the policy and also patient was suffering knee joint pain since 7 years.

Considering all the above, the complaint lacks merit and Respondent's decision is upheld.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0892-12

Shri Arunbhai C. Shah V/s. The New India Assurance Co. Ltd.

Award dated 18th February 2013

Repudiation of Mediclaim

Complainant's insured wife aged 61 years was hospitalized for treatment of Lap. Incisional Hernia and incurred expense was repudiated by the Respondent invoking exclusion clause No.4.4.13.

Respondent opined that the insured patient has history of 3 Caesarean section and site of Hernia at Caesarean mentioned by the treating doctor.

Insured operated for Caesarean 32 years back and as a result Hernia developed is not agreeable by the Complainant.

Scrutiny of all available documents proved that the decision of the Respondent to repudiate the claim is valid and proper.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0885-12

Mr. Rameshbhai K. Patel V/s. United India Insurance Co. Ltd.

Award dated 18th February 2013

Repudiation of Mediclaim

Complainant's son hospitalized for treatment of Acute Viral Hepatitis, Jaundice and incurred expense for Rs.17,841/- was repudiated by the Respondent giving reason that the patient treated in a declined list of hospital.

Complainant was not aware of the declined name of the hospital even the representative of the Respondent visited the hospital also not informed the hospital is one of the declined list.

Respondent submitted the copy of Annexure mediclaim paper of declined hospital list revised with effect from 16.8.2010 in which list the name of the hospital was shown.

In view of this, complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-009-0985-12

Mr. Naresh P. Patel V/s Reliance General Insurance Co. Ltd.

Award dated 18th February 2013

Repudiation of Mediclaim

Complainant hospitalized for Kidney Transplantation and expense incurred for Rs.6,29,421/- was repudiated by the Respondent invoking Policy Clause No.1 & 2.

Complainant is a policy holder since last 4 years and hospital record wrongly written history of 5-7 years.

In the Claim form treating doctor clearly written the ailment was pre-existing. Also proposal form shows non disclosure of material facts.

In view of this, complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-009-0986-12

Mrs. Ashaben S. Desale V/s Reliance General Insurance Co. Ltd.

Award dated 19th February 2013

Repudiation of Mediclaim

Complainant's daughter Ms. Hemlata hospitalized for the treatment of Viral fever and incurred expense for Rs.10,127/- was repudiated by the Respondent giving reason that the hospital does not fulfill the eligibility criteria not having 15 beds.

During the Hearing complainant was absent so it was decided to proceed ex-parte.

On scrutiny of all available papers it is proved that 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.11-004-1049-12

Mr. Suvrut N. Chokshi V/s. United India Insurance Co. Ltd.

Award dated 19th February 2013

Partial settlement of Mediclaim

Complainant aged 64 years was hospitalized for Cataract and expense incurred for Rs.36,129/- was settled by the Respondent for Rs.31,129/- and deducted Rs.5,000/- as per policy clause 3.11.

Respondent produced paper where similar operations are being performed on package basis, the rates are inclusive of all charges.

In view of this the Forum also denied the complaint.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-1042-12

Mr. Tejas D. Shah V/s. United India Insurance Co. Ltd.

Award dated 19th February 2013

Partial settlement of Mediclaim

Complainant hospitalized for treatment of abdominal infection and again admitted to another hospital for treatment of Typhilitus + AGE and total expenses incurred was for Rs.68,921/- which was settled by the Respondent for Rs.34,947/- stating that as per policy conditions under the reasonable and customary charges as well as in proportion to applicable Room Charges etc.

Respondent issued a letter addressed to the insured stating details of rejection with reasons as per policy conditions. Policy condition No.1.2 clearly explains as to how much is payable under category A to E.

In the result, complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-018-1072-12

Smt. Madhukanta M. Mehta V/s. Future Generali India Insurance Co. Ltd.

Award dated 19th February 2013

Repudiation of damage claim under Commercial Vehicle Policy

Accidental damages sustained to the insured Car and claim lodged by the complainant was repudiated by the Respondent on the ground of violation of policy conditions related to the "coverage of insurance".

It was noticed that Insurer issued the policy on the basis of commercial vehicle basis which was confirmed by both the parties.

The complainant was informed during the Hearing that Commercial lines of insurance are not considered by this Forum, she can pursue the complaint with other appropriate authority as per policy conditions.

Thus complaint stands disposed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-018-1086-12

Mr. Narendra J. Shah V/s. Future Generali India Insurance Co. Ltd.

Award dated 19th February 2013

Non payment of damage claim under Vehicle Insurance Policy

Complainant lodged a damage claim of Rs.8,000/- for accidental damage of his insured vehicle which was not paid by the Respondent giving reason that the insurer granted insurance coverage with 25% NCB on the declaration of insured that he does not have any claim with earlier Insurance Company. But the earlier insurer ICICI Lombard had settled one old claim which was not mentioned in the Proposal Form by the insured.

However claim had been rejected on the basis of concealment of material facts at the time of taking Insurance.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-1004-12

Mr. H. N. Mehta V/s. United India Insurance Co. Ltd.

Award dated 19th February 2013

Repudiation of Mediclaim

Complainant hospitalized for treatment of infected Calosty Rt. Lateral Mallelus and expense incurred for Rs.8,279/- was repudiated by the Respondent under Clause 2.3.

According to the Respondent, the treatment underwent by the insured does not require hospitalization it could have been taken on OPD basis.

In the result, complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-1011-12

Mr. Uttam P. Majmudar V/s. The Oriental Insurance Co. Ltd.

Award dated 19th February 2013

Partial settlement of Mediclaim

Complainant hospitalized for treatment of unstable Angina and incurred total expense of Rs.1,60,494/- which was settled by the Respondent for Rs.47,254/- invoking policy condition No.4.1, 4.2 and 4.3.

Respondent submitted that the insured's old S.I was Rs.50,000/- since 2005-06. In the year 2009-2010 S.I increased to Rs.1,50,000/-. Claim lodged in the second renewal after enhancement of S.I, as per policy conditions waiting period is 4 years for the subject claim. Patient was a k/c/o HTN, DM since long hence exclusion clause for enhanced S.I and co-payment of 10% is applicable.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0991-12

Mr. Chetan R. Mehta V/s. The New India Assurance Co. Ltd.

Award dated 19th February 2013

Partial settlement of Mediclaim

Complainant's wife hospitalized for treatment of Osteoarthritis Rt. Knee and incurred total expense of Rs.1,63,235/- which was settled by the Respondent for Rs.42,000/- invoking policy condition No.6 which is not acceptable by the Complainant.

Respondent submitted that the insured's old S.I was Rs.35,000/-+ 7000 C.B since 2006-07. In the year 2009-2010 S.I increased to Rs.1,00,000/-. Claim lodged in the second renewal after enhancement of S.I, as per policy conditions waiting period is 4 years for the subject claim. Patient underwent of Osteoarthritis Rt. Knee which attracts exclusion clause

4.3 hence exclusion clause for enhanced S.I and old S.I of Rs.35,000/- + C.B Rs.7000/- is applicable. In the result complainant fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-1030-12

Mr. Nayan V. Dalal V/s. United India Insurance Co. Ltd.

Award dated 19th February 2013

Repudiation of Mediclaim

Complainant was a member of Tailor Made Group Family Mediclaim Policy issued to Veritas Insurance Services by United India Insurance Co. Complainant's mother hospitalized for treatment of AF + HTN+IHD+CVA and incurred expense for Rs.28,882/- which was repudiated by the Respondent stating that the treatment was pre-existing disease. Complainant was not a policy holder who is a member of Master Policy holder which is an unconventional Group Insurance who has no insurable interest.

In the result complainant fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0872-12

Dr. Chirag V. Pandya V/s. The New India Assurance Co. Ltd.

Award dated 20th February 2013

Partial settlement of Mediclaim

Complainant hospitalized for treatment of Dengu fever and expense incurred for Rs.65,442/- which was settled by the complainant for Rs.58,328/- as per terms and conditions of the policy clause 2.1, 2.3 and 2.4.

On scrutiny of available documents, the Forum also agreed the decision of the Respondent for settling the claim partially is right and proper.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-1013-12

Mr. Nilesh K. Shah V/s. United India Insurance Co. Ltd.

Award dated 20th February 2013

Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Piles and expense incurred was for Rs.11,001/- which was repudiated by the Respondent stating that treatment was taken in a private Ayurvedic hospital. As per policy conditions, the claim is payable if treatment is taken in a Government Ayurvedic Hospital as per clause No.2, N.B. 2.1 (2).

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-017-1059-12

Mrs. Chandrikaben Thakkar V/s. Star Health & Allied Insurance Co. Ltd.

Award dated 20th February 2013

Repudiation of Medeiclaim

Complainant hospitalized for treatment of Acute Abdomen pain and incurred expense for Rs.1,20,594/-had been rejected as per policy condition No.1. Thereafter the claim was paid partially after registering the case to this Forum for Rs.83,259/- by the Respondent and deducted Rs.37,335/- stating reasonable and customary charges.

Respondent produced details of deductions and complainant preferred to remain absent during the hearing.

In the result, the complaint is deemed to have been closed in view of the Respondent's decision.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-012-1047-12

Mr. Ashvinkumar N. Patel V/s. ICICI Lombard General Insurance Co. Ltd.

Award dated 20th February 2013

Repudiation of Mediclaim

Complainant's wife aged 52 years hospitalized for treatment of joint replacement surgery, Hypertension and Hypothyroidism and expense incurred was for Rs.2,29,000/- which was rejected by the Respondent due to non-disclosure of material facts and policy was cancelled and entire premium was refunded.

Respondent produced the entire treatment papers from 2001 to 2009 which were not disclosed in the Proposal.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-1009-12

Dr. Dhiren A. Darji V/s. The New India Assurance Co. Ltd.

Award dated 20th Feb.2013

Repudiation of Mediclaim

Complainant's mother hospitalized for treatment of Morbid Obesity and HP and incurred expenses for Rs.2,45,130/- was repudiated by the Respondent as per Exclusion clause No.4.4.6.

Complainant argued that it was a life threatening obesity, so she was given treatment and hence claim should be paid.

As per case papers and Discharge Summary, the insured was a known case of HTN since 2 to 3 years and treatment underwent by the insured is excluded from the coverage, hence claim repudiated by the Respondent under exclusion clause No.4.4.6 is in order.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-1018-12

Mr. Mayurkumar R. Bhatt V/s. United India Insurance Co. Ltd.

Award dated 20th Feb. 2013

Partial Repudiation of Mediclaim

Complainant hospitalized for treatment of Occipital EPH and expense incurred for Rs.60,000/- was settled by the Respondent for Rs.35,000/- as per policy condition No.1.2. But the complainant argued that the restriction is not applicable to him because it is an accident case.

Respondent stated that the claim amount is Rs.60,000/- and S.I Rs.50,000/- hence 70% of S.I i.e, 35,000/- is approved as per terms and conditions of the policy.

Considering all the available documents, the Forum also denied the complainant's argument and complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0910-12

Shri Nishith S. Mehta V/s. United India Insurance Co. Ltd.

Award dated 20th Feb. 2013

Repudiation of Mediclaim

Complainant's mother hospitalized two times for treatment of HTN, DH, IHD & Acute Gastritis and total expenses claimed for Rs.1,15,631/- was repudiated by the Respondent under policy clause 5.3 & 5.4. Complainant submitted claim papers late by 14 days and 30 days because he was engaged with her mother's care take and his mother was expired during the treatment.

Considering the magnitude of the claim amount, delay in submission of authentic claim documents without valid reasons, it is not possible to interfere in the decision of the Respondent.

In the result, complaint rejected.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-009-0911-12

Mr. Bhavesh Bhogilal Shah V/s. Reliance General Insurance Co. Ltd.

Award dated 20th Feb. 2013

Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Calculus Cholecystectomy and incurred expenses for Rs.73,856/- was repudiated by the Respondent by invoking exclusion clause No.1 – Pre-Existing Disease.

Complainant argued that he had Mediclaim policy since last 11 years with the New India Assurance Co. Ltd. up to 2008. The policy incepted with the Respondent since 14th March 2008 and renewed without break up to 2011. As per investigation report of the Respondent, the insured had all symptoms, complaints and treatment taken for present illness started prior to taking Health wise policy on 2008 and patient has not declared previous history in Proposal Form.

In view of these complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-1000-12

Mr. Alpesh B. Patel V/s. Oriental Insurance Co. Ltd.

Award dated 20th Feb. 2013

Repudiation of Mediclaim

Complainant's insured wife hospitalized for treatment of DM + Episiotomy Wound Infection and expense claimed for Rs.25,741/- was repudiated by the Respondent under the clause 4.12 – pregnancy and childbirth related disease are not covered in the scope of policy.

On scrutiny of documents, the forum also denied the claim hence the complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-1017-12

Mr. Indravadan Patel V/s. National Insurance Company Ltd.

Award dated 20th Feb. 2013

Repudiation of Mediclaim

Complainant's wife treated in two hospitals for CAD + HTN+Angina and total expenses incurred was for Rs.1,46,554/- which was repudiated by the Respondent because the policy incepted since 2002 with exclusion clause of above diseases. The treatment taken by the insured was not covered by the subject policy hence claim repudiated by the Respondent.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-017-1048-12

Mr. Jayesh M. Shah V/s. Star Health & Allied Insurance Co. Ltd.

Award dated 20th Feb. 2013

Partial settlement of Mediclaim

Complainant's insured son hospitalized for treatment of Dengue Fever + Gastritis and expense incurred for Rs.19,640/- which was settled by the Respondent for Rs.16,072/- and deducted Rs.3,568/- on the ground of reasonable and customary charges.

From the submission of both the parties, it is established that the total amount paid by the Respondent is fair and proper.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-018-0870-12

Mr. Nirav G. Jagani V/s. Future Generali India Insurance Co. Ltd.

Award dated 20th Feb. 2013

Repudiation of Motor Claim

Complainant's insured Car was damaged due to accident and expenses incurred was repudiated by the Respondent on the ground of violation of condition No.8 of the policy.

Complainant had not given correct information about his previous policy taken from Royal Sundaram and taken advantage as 20% NCB from the Respondent at the time of taking the policy.

As per investigation report, Respondent repudiated the claim on the ground of non disclosure of claim received from previous Insurer.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0871-12

Mr. Mafatlal G. Shah V/s. The New India Assurance Co. Ltd.

Award dated 20th Feb. 2013

Partial settlement of Mediclaim

Complainant treated for Lt. Inguinal Hernioplasty with Mesh Repair and total expense incurred Rs.31,069/- was settled by the Respondent for Rs.17,500/- as per the agreement of PPN rate with hospital.

In view of this, complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0880-12

Mr. Devdatt S. Majmudar V/s. United India Insurance Co. Ltd.

Award dated 20th Feb. 2013

Repudiation of Mediclaim

A claim amount of Rs.35,237/- for Eye cataract surgery of the complainant was repudiated by the Respondent giving reason that late intimation and late submission of claim papers as per condition No.5.3 & 5.4.

The complainant himself agreed that there was delay in intimation and submission of claim papers.

In the result complainant fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0865-12

Mr. Kanaiyalal P. Patel V/s. The New India Assurance Co. Ltd.

Award dated 20th Feb. 2013

Repudiation of Mediclaim

Complainant hospitalized for treatment of Cancer Rt. Buccal Mucosa at Bombay Hospital and taken Radiotherapy at Aaruni Hospital at Rajkot and expenses claimed for Rs.4,52,000/- and Rs. 1,27,000/- which were repudiated by the Respondent invoking clause 4.4.6 of the terms and condition of the policy.

As per hospital records, Complainant have habits of smoking and chewing tobacco for more than 6 years, hence claim repudiated by the Respondent is right and proper.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0884-12

Mr. Sudhakar S. Agrawal V/s. United India Insurance Co. Ltd.

Award dated 20th Feb.2013

Repudiation of Mediclaim

The complainant treated for Introvitreal Avastin Surgery and claimed for Rs.15,500/- was repudiated by the Respondent giving reason that as per Circular NO.ARO/HEALTH/2009/3151 dated 25th Sept.2009 of their R.O stating that opinion of their Panel doctor, the subject treatment is an OPD procedure only which is not covered under Mediclaim.

In view of this, complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.14-003-0902-12

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

Award dated 20th Feb. 2013

Repudiation of Mediclaim

Complainant's insured daughter treated for Rt. Eye Keratoconus Cornea Surgery and claimed for Rs.25,927/- was repudiated by the Respondent giving reason that the subject disease is genetic disorder which falls under exclusion clause 4.15 so claim is not admissible.

The Complainant informed that the same treatment taken in Lt. Eye after two years of Rt. Eye treatment was paid by the Respondent for Rs.24,033/- and 1st claim repudiated.

Respondent could not prove the disease was genetic disorder, hence complaint succeeds and directed to settled the admissible amount.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-1058-12

Mr. Pradip P. Shah V/s. Oriental Insurance Co. Ltd.

Award dated 21st Feb.2013

Repudiation of Mediclaim

Complainant hospitalized for treatment of Anemia, weakness etc. and claimed expenses for Rs.36,170/- was repudiated by the Respondent giving reason that the subject treatment attracts exclusion clause No.4.8 of Policy Condition.

Complainant is a policy holder since 1998 and previous claims were paid so present claim should be paid.

As per Investigation report, insured was diagnosed as a case of Anemia i.e., deficiency of B12 which is exclusion clause of the policy.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-009-1079-12

Mr. Girishbhai Patel V/s. Reliance General Insurance Co. Ltd.

Award dated 21st Feb. 2013

Repudiation of Mediclaim

Complainant's daughter has hospitalized for Mental Retardation due to Cerebral Palsy and treated for Laparoscopic Hysterectomy and claim for Rs.39,432/- was repudiated by the Respondent for non fulfillment to preamble condition No.1.1 and invoking condition No.2 of the Health wise policy.

Complainant has not submitted any new ground for intervention in the decision of the Respondent.

In the result, the complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-1027-12

Mr. Manaharbhai J. Shah V/s. The New India Assurance Co. Ltd.

Award dated 21st Feb.2013

Repudiation of Mediclaim

The Complainant treated for Vertigo Basilar insufficiency and incurred expense for Rs.46,495/- was repudiated by the Respondent as per policy exclusion clause No.4.1 pre-existing disease.

According to complainant, policy since 2001 so pre-existing disease was payable after 4 years. As per hospital records, k/c/o – HTN since 25 years. The subject treatment was related to HTN which excluded from the coverage of the policy.

In view of this, complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-1031-12

Mr. Rajendra C. Yagnic V/s. United India Insurance Co. Ltd.

Award dated 21st Feb. 2013

Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Diabetic foot and claimed for Rs.40,227/- was repudiated by the Respondent on the ground that S.I is Rs.2.00 Lacs and claim previous paid for Rs.2.30 Lacs towards 4 different claims was exhausted.

As per 1st consultation paper, the subject disease was since 15 years which was not shown in the Proposal Form.

In the result complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-0928-12

Mr. Bhanubhai B. Contractor V/s. National Insurance Co. Ltd.

Award dated 21st Feb. 2013

Repudiation of Mediclaim

Complainant hospitalized for Knee replacement and claimed Rs.2,01,330/- was repudiated by the Respondent due to pre-existing disease and fraudulent documents submitted by the Complainant.

Policy issued in 2009 and treatment taken in 2010, the subject disease will not develop within a short period.

Policy is a Group Insurance and individual so there is no insurable interest.

In view of this, complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-002-0841-12

Shri Harishankar Sharma Vs. The New India Assurance Co. Ltd.

Award dated 21st Feb.2013

Partial Settlement of Mediclaim

Complainant hospitalized for treatment of Inguinal Hernia & Gall Bladder and incurred for Rs.48,590/- was settled by the Respondent for Rs.27,282/- as per terms and conditions of policy clause 2.1, 2.3 and 2.4.

Complainant had paid operation charges for Rs.25,000/- by cheque to the doctor and Rs.3,500/- as Anesthesia charges separately which is failure on the part of the complainant to produce single hospital bill.

Considering the above, the 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.11-005-1073-12

Mr. Ashokkumar Sharma V/s. Oriental Insurance Co. Ltd.

Award dated 21st Feb. 2013

Repudiation of Mediclaim

Complainant's wife treated for Rt. Eye Sub retinal Neo-vascular Membrane and spent total amount of Rs.51,300/- towards expenses which was repudiated by the Respondent under policy clause 2.3 Note : procedure or treatment usually done in outpatient department are not payable.

The insured was treated an OPD basis which is not payable so complaint is dismissed without any relief to the Complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-1085-12

Mr. Ashish R. Shah Vs. Oriental Insurance Company Ltd.

Award dated 21st Feb. 2013

Repudiation of Mediclaim

Complainant was a member of tailor made Family Floater Group Mediclaim policy and claim lodged for treatment of his father for Carcinoma Bladder + DVT+ Septicemia + Acute Renal failure for Rs.70,000/-, subsequently insured died.

Respondent repudiated the claim under clause No.7.16 of Group Policy and patient was having Dialysis Malignant cancer excluded and the insurance covered in first year policy. Hospital's record also proves, treatment for post operated hospitalization.

In view of this, complainant fails to succeed.

****

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-0913-12

Mr. Mohanlal D. Parmar Vs. National Insurance Co. Ltd.

Award dated 21st Feb. 2013

Partial repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Lt. Breast Cancer and incurred claim for Rs.85,099/- was settled by the Respondent for Rs.49,189/- as per policy condition Section 'C'.

Respondent stated that limit of benefits U/S.'C' under the policy available for the insured beneficiary was exhausted and so a sum was partially disallowed.

In view of this, complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-1029-12

Mr. Pravinchandra P. Shah Vs. United India Insurance Co. Ltd.

Award dated 22nd Feb.2013

Partial repudiation of Mediclaim

Complainant hospitalized for Knee replacement and claimed for Rs.1,08,038/- was settled by the Respondent for Rs.70,000/- invoking policy condition 1.2.1 – only 70% of S. I of Rs.1.00 Lac.

Complainant argued that he is a Senior Citizen so claim should be paid full. Respondent stated that instance case claim settled as per condition applicable to senior citizens i.e. actual claim or 70% of S.I whichever is less.

Considering the above, Respondent's decision upheld without any relief to the complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-0860-12

Mr. Bharat G. Patel Vs. National Insurance Co. Ltd.

Award dated 22nd Feb. 2013

Repudiation of Mediclaim

Treatment for P. Falciparam of the Complainant and claim lodged for Rs.15,073/- was repudiated by the Respondent giving reason that the complainant was treated in a declined list of hospital.

In the result complainant fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0848-12

Mr. Suresh V. Desai V/s. The New India Assurance Co. Ltd.

Award dated 25th Feb. 2013

Repudiation of Mediclaim

Complainant hospitalized for treatment of Intra Vitreal Lucentis surgery and expense claimed for Rs.15,726/- was repudiated by the Respondent under exclusion No.4.13 of the policy.

Treatment for ARMD & drugs like Avastin, Lucentis, Mecugen or other related drugs are not payable so claim repudiated.

In the result complainant fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-0886-12

Mr. Bhavik V. Patel V/s. National Insurance Co. Ltd.

Award dated 25th Feb. 2013

Repudiation of Mediclaim

Complainant's wife treated for accidental injury and claimed for Rs.33,256/- was rejected due to non-disclosure of existing disease and also deficiency of accidental proof.

Respondent stated that after accidental injury she was taken treatment and claimed Rs.4,317/- which was already paid. Thereafter insured was admitted due to difficulty in breathing and history of chest pain since 2 years which was not disclosed in proposal.

Considering the above facts, Respondent's decision to reject the claim is upheld without any relief to the Complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-1077-12

Mr. Suresh D. Patel Vs. United India Insurance Co. Ltd.

Award dated 26th Feb. 2013

Partial repudiation of Mediclaim

Complainant treated for Lt. Ureteric Stone and incurred expense of Rs.31,654/- was settled by the Respondent for Rs.12,570/- as per MOU signed by the Respondent.

Complainant argued that he was not known about the MOU and not given any list of hospital but this was advertised in local News paper on 16-05-2011 hence the Forum also denied the claim.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-014-1089-12

Mr. Manubhai R. Patel V/s. Cholamandalum MS General Insurance Co.Ltd.

Award dated 27th Feb. 2013

Repudiation of Mediclaim

Complainant hospitalized for treatment of Particle embolization under Doppler guidance and expense claimed for Rs.35,500/- was repudiated as per General exclusion clause No.C-1 i.e. pre-existing.

As per available records, policy incepted on May 3, 2011 and MRI date 02-02-2011 which is prior to inception of the policy.

In view of this denial of the claim by the Respondent is as per terms and conditions of the policy hence complaint disposed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0894-12

Mr. Shantilal M. Jain V/s. Oriental Insurance Co. Ltd.

Award dated 1st March 2013

Repudiation of Mediclaim

Complainant treated for Transient Ischemic Attack (TIA) and expense incurred for Rs.1,77,535/- was repudiated by the Respondent under clause 4.1 of the policy.

As per available records, the policy is in first year and insured was suffering HTN since 3 years hence claim is rightly repudiated by the Respondent.

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AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-003-0948-12

Mr. Nilesh Patel V/s. National Insurance Co. Ltd.

Award dated 1st March 2013

Repudiation of Mediclaim

Complainant's wife hospitalized MTP with Laparoscopic and expense claimed for Rs.99,328/- was repudiated by the Respondent giving reason that maternity was not covered in the policy.

On scrutiny of available documents, it is proved the hospitalization was for maternity so the forum also denied the claim hence complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-010-0031-13

Mr. Ramanbhai N. Dave V/s. Iffco-Tokio General Insurance Co. Ltd.

Award dated 1st March 2013

Repudiation of Mediclaim

Left Eye treatment taken by complainant's son and expense claimed for Rs.15,318/- was repudiated by the Respondent under policy Definition No.14.

On referring the available documents, it is proved that the mediclaim lodged is beyond the scope of the subject policy hence the claim repudiated by the Respondent is upheld.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-0951-12

Mr. Harishchandra Mahendra V/s. National Insurance Co. Ltd.

Award dated 1st March 2013

Partial repudiation of Mediclaim

Complainant hospitalized for treatment of fecal impaction+ Urine retention+ HTN+ Bil. Inguinal Hernia etc. and expense claimed for Rs.98,834/- which was settled by the Respondent for Rs.82,515/- by deducting an amount of Rs.16,319/- as per terms and condition of the policy. Complainant not agreed with the deduction and demanding deducted amount with interest and compensation for causing mental torture.

As per available documents, Respondent's decision can not be ignored hence complaint disposed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-0975-12

Mr. Mukesh R. Mehta Vs. National Insurance Co. Ltd.

Award dated 1st March 2013

Partial settlement of Mediclaim

Complainant's mother hospitalized for treatment of Knee replacement and expense claimed total Rs.1,52,434/- which was settled by the Respondent for Rs.79,063/- by deducting an amount of Rs.73,371/- giving reason that as per policy condition Section A,B & C and old S.I.Rs.75,000/-+Bonus Rs.23,750/-. As per new S.I Rs.1,25,000/-, 4.3 of policy clause is operative after 4 years. Hence claim is settled by the Respondent rightly and nothing is payable more to the complainant so the forum dismissed the case.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-011-0032-13

Mr. Liladhar H. Sankalpura Vs. Bajaj Allianz General Insurance Co. Ltd.

Award dated 1st March 2013

Repudiation of Motor Claim

Complainant's insured vehicle was accidentally damaged and claim lodged for Rs.2,34,823/- was repudiated by the Respondent giving reason that the Complainant/Driver was not holding valid Driving License at the time of accident so claim is not payable.

Respondent produced a copy of Judgment passed by National Consumer Dispute Redressal Commission in favour of the Insurer for the same reason that the accident occurred between the period of expiry of License and renewal of license.

In view of this, complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-012-0108-13

Mr. Sugatan Kuttappan Vs. ICICI Lombard General Insurance Co. Ltd.

Award dated 1st March 2013

Repudiation of Motor Claim

Complainant has a Private Car Package Policy under his Indigo Car for IDV of Rs.3,80,717/-. Complainant lodged a total loss claim of Rs.4,24,809/- due to burn by way of his journey which was repudiated by the Respondent of misrepresentation of the complainant.

On referring the documents submitted by both parties, the forum also agreed the complaint made false and fraudulent statement to derive insurance benefit under the policy hence complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-0123-13

Mr. Kanubhai V. Patel Vs. National Insurance Co. Ltd.

Award dated 5th March 2013

Repudiation of Mediclaim

Complainant claimed Rs.24,561/- for his cataract surgery expense which was repudiated by the Respondent under clause 5.3 of the policy. Cataract surgery is a planned surgery which should be informed in advance to the Respondent.

Complainant intimated in advance to the agent but Respondent have not received and claim file received after 12 days from the surgery.

Complainant could not prove that he has given intimation to the agent so Respondent's decision to repudiate the claim is upheld.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0983-12

Mr.Rameshbhai H. Patel Vs. The New India Assurance Co. Ltd.

Award dated 5th March 2013

Partial repudiation of Mediclaim

A 63 years old complainant hospitalized for treatment of Benign Prostate Enlargement and total expense claimed for Rs.58,726/- was partially settled for Rs.41,225/- by deducting Rs.17,500/- invoking Clause 3.13 of Mediclaim policy.

According to the Respondent, normal hospital package charges would be around Rs.32,000/- whereas they have paid Rs.41,225/- in all and deducted Rs.17,500/-. Complainant showed estimated expense in the claim intimation Rs.30,000/- plus (approx.).

Looking to all the above facts, Respondent's decision is right and proper so complaint fails to succeed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-004-0935-12

Mr. Hasmukhbhai J. Doshi Vs. United India Insurance Co. Ltd.

Award dated 5th March 2013

Partial repudiation of Mediclaim

Complainant hospitalized for Rt. Eye surgery and expense claimed for Rs.58,190/- which was settled by the Respondent for Rs.44,090/- by deducting and amount of Rs.14,000/- reasonable and customary charges allowed.

Treating hospital has estimated Rs.50,000/- for the same treatment but complainant had not informed to the Respondent.

In view of this Respondent's decision is valid and proper so complaint dismissed.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-014-1130-12

Mr. Baldevbhai Makwana Vs. Cholamandalam MS Gen. Ins. Co. Ltd.

Award dated 5th March 2013

Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Rt. Lower Ureteric Stone and expense claimed for Rs.65,120/- was rejected by the Respondent due to misrepresentation of facts and discrepancies in claim documents.

As per the Investigation report, Respondent rejected the claim but Complainant could not prove the real facts.

In view of this complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0941-12

Mr. Paresh R. Patel Vs. United India Insurance Co. Ltd.

Award dated 6th March 2013

Partial settlement of Mediclaim

Complainant hospitalized for treatment of Fistula + Bleeding piles etc. and expense claimed for Rs.36,679/- was settled by the Respondent Rs.34,284/- by deducting an

amount of Rs.2395/- as per policy condition 3.11 which is not acceptable by the Complainant.

Complainant submitted handwritten Discharge summary, bills etc which shows Rs.27,800/-only and its details reveal excess charges. Hence deductions are valid and proper so complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-002-0039-13

Shri Vijay Gururam Agrawal Vs. The New India Assurance Co. Ltd.

Award dated 6th March 2013

Partial settlement of Mediclaim

Complainant hospitalized for treatment of Rt. Side upper Ureteric Stone and expense claimed for Rs.21,944/- which was settled by the Respondent for Rs.16,583/- by deducting an amount of Rs.5,361/- invoking policy condition 2.3.

Respondent is fully justified in their written submission as per policy clause 2.3 of Mediclaim policy 2007.

In view of this complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-0030-13

Smt. Anandiben J.Patel Vs. National Insurance Co. Ltd.

Award dated 6th March 2013

Repudiation of P.A Claim (Accidental death)

Complainant's deceased husband was covered under Group Janata Personal Accident Policy and death claim due to road accident was lodged by the complainant was repudiated by the Respondent stating reason that the policy was cancelled in 2005 as per Notice published in leading daily news paper "Gujarat Samachar" and death occurred on 2011.

In view of this complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-1084-12

Mr. Chirayu J. Pandya Vs. Oriental Insurance Co. Ltd.

Award dated 6th March 2013

Repudiation of Mediclaim

Complainant's mother hospitalized for treatment of Adeno Carcinoma of Anorectal and expense incurred for Rs.5,62,936/- was repudiated by the Respondent stating that as per policy condition No.7.16 claim is not payable.

Complainant covered tailor made Family Floater Group Mediclaim Policy, not individual and taken since one month only and treatment underwent since 6 months which is considered as pre-existing disease.

In view of this complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0038-13

Mr. Chetan V. Thakkar Vs. The New India Assurance Co. Ltd.

Award dated 7th March 2013

Repudiation of Mediclaim

Complainant's father hospitalized for treatment of Cardio Respiratory Arrest, during the treatment insured died and expense claimed for Rs.3,12,000/- was repudiated by the Respondent stating that the insured was suffering HTN since last 17 years and policy covered since 16 years but no loading premium was paid hence considered pre-existing disease.

On scrutiny of all documents of both the parties the forum also denied the claim hence complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0018-13

Mr. Shantilal P Rathod Vs. The New India Assurance Co. Ltd.

Award dated 7th March 2013

Partial repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Breast cancer and expense claimed for Rs.10,347/- was partially offered to pay for Rs.3,200/-by the Respondent which was refused to accept by the Complainant.

Complainant opined that biopsy was done to the insured wife under general anesthesia so hospitalization was required hence claim should be paid fully.

As per report of biopsy indicated only category -4 for it FNAC suggested which is only OPD procedure so Respondent considered claim for Rs.3,200/- under non hospitalization as per policy condition No.5.17.

In view of this, complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0071-13

Mr. Sanjay Patel Vs. The New India Assurance Co. Ltd.

Award dated 7th March 2013

Partial repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Adenonyosis Cystic Payperplasia and expense claimed for Rs.52,155/- was settled by the Respondent for Rs.27,173/- and balance rejected invoking policy condition 2.1, 2.3 & 2.4.

Hospital failed to provide estimated expense at the time to admission and bill submitted by the hospital is Rs.45,000/-.

In view of this, Respondent's decision to settle the claim partially is valid and proper so complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0067-13

Mrs. Javnika Santoshkumar Vs. The New India Assurance Co. Ltd.

Award dated 7th March 2013

Repudiation of Mediclaim

Complainant hospitalized for treatment of Adhesiolysis, GAC intasation along with Fulgration of small endometriotic spots, Posts to uterus and claimed Rs.29,446/- was repudiated by the Respondent under permanent exclusion clause No.4.4.6, i.e. infertility treatment which is permanent exclusion.

Complainant proved with medical certificate that she has taken treatment for severe pain in abdomen and not for infertility treatment.

In view of this the Forum allowed the complaint and recommended to the Respondent to settle 75% of the claimed amount within 7 days from the date of receipt of consent from the complainant hence complaint succeeds.

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AHMEDABAD OMBUDSMAN CENTRE

case No.11-003-0030-13

Smt. Anandiben J.Patel Vs. National Insurance Co. Ltd.

Award dated 6th March 2013

Repudiation of P.A Claim (Accidental death)

Complainant's deceased husband was covered under Group Janata Personal Accident Policy and death claim due to road accident was lodged by the complainant was repudiated by the Respondent stating reason that the policy was cancelled in 2005 as per

Notice published in leading daily news paper "Gujarat Samachar" and death occurred on 2011.

In view of this complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-1084-12

Mr. Chirayu J. Pandya Vs. Oriental Insurance Co. Ltd.

Award dated 6th March 2013

Repudiation of Mediclaim

Complainant's mother hospitalized for treatment of Adeno Carcinoma of Anorectal and expense incurred for Rs.5,62,936/- was repudiated by the Respondent stating that as per policy condition No.7.16 claim is not payable.

Complainant covered tailor made Family Floater Group Mediclaim Policy, not individual and taken since one month only and treatment underwent since 6 months which is considered as pre-existing disease.

In view of this complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0038-13

Mr. Chetan V. Thakkar Vs. The New India Assurance Co. Ltd.

Award dated 7th March 2013

Repudiation of Mediclaim

Complainant's father hospitalized for treatment of Cardio Respiratory Arrest, during the treatment insured died and expense claimed for Rs.3,12,000/- was repudiated by the Respondent stating that the insured was suffering HTN since last 17 years and

policy covered since 16 years but no loading premium was paid hence considered pre-existing disease.

On scrutiny of all documents of both the parties the forum also denied the claim hence complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0018-13

Mr. Shantilal P Rathod Vs. The New India Assurance Co. Ltd.

Award dated 7th March 2013

Partial repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Breast cancer and expense claimed for Rs.10,347/- was partially offered to pay for Rs.3,200/-by the Respondent which was refused to accept by the Complainant.

Complainant opined that biopsy was done to the insured wife under general anesthesia so hospitalization was required hence claim should be paid fully.

As per report of biopsy indicated only category -4 for it FNAC suggested which is only OPD procedure so Respondent considered claim for Rs.3,200/- under non hospitalization as per policy condition No.5.17.

In view of this, complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0071-13

Mr. Sanjay Patel Vs. The New India Assurance Co. Ltd.

Award dated 7th March 2013

Partial repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Adenonyosis Cystic Payperplasia and expense claimed for Rs.52,155/- was settled by the Respondent for Rs.27,173/- and balance rejected invoking policy condition 2.1, 2.3 & 2.4.

Hospital failed to provide estimated expense at the time to admission and bill submitted by the hospital is Rs.45,000/-.

In view of this, Respondent's decision to settle the claim partially is valid and proper so complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0067-13

Mrs. Javnika Santoshkumar Vs. The New India Assurance Co. Ltd.

Award dated 7th March 2013

Repudiation of Mediclaim

Complainant hospitalized for treatment of Adhesiolysis, GAC intasation along with Fulgration of small endometriotic spots, Posts to uterus and claimed Rs.29,446/- was repudiated by the Respondent under permanent exclusion clause No.4.4.6, i.e. infertility treatment which is permanent exclusion.

Complainant proved with medical certificate that she has taken treatment for severe pain in abdomen and not for infertility treatment.

In view of this the Forum allowed the complaint and recommended to the Respondent to settle 75% of the claimed amount within 7 days from the date of receipt of consent from the complainant hence complaint succeeds.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0064-13

Mr. Aakash B. Shah Vs. The New India Assurance Co. Ltd.

Award dated 7th March 2013

Partial settlement of Mediclaim

Complainant hospitalized for Dengu fever treatment and expense claimed for Rs.39,166/- was partially settled by the Respondent for Rs.15,610/- as per PPN MOU charges.

The Bodyline hospital where the insured was admitted, under PPN MOU network and the rate of Dengu fever is Rs.15,000/- so Respondent paid Pre & Post hospitalization Rs.15,610/- and advised the hospital to refund excess amount of Rs.23,556/- collected from the insured which was not refunded by the hospital.

In view of this, the complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0021-13

Mr. Gopal N. Shah Vs. United India Insurance Co. Ltd.

Award dated 7th March 2013

Partial settlement of Mediclaim

Complainant's wife hospitalized for treatment of Knee replacement and expenses claimed for Rs.2,15,342/- was settled by the Respondent for Rs.1,41,275/- as per capping for Major surgeries is 70% of Sum Insured.

Respondent not attended the Hearing scheduled by this forum and also not submitted any documents so the Forum is not in a position to resolve the Grievance. Hence complaint is considered as beyond jurisdiction without passing any quantitative award.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-0122-13

Mr. A. H. Ansari Vs. National Insurance Co. Ltd.

Award dated 7th March 2013

Partial settlement of Mediclaim

Complainant's 6 years old son hospitalized for treatment of Humerous Rt. Lower and with displaced fragment and expense claimed for Rs.37,012/- was settled by the Respondent for Rs.25,026/- by deducting an amount of Rs.11,986/-invoking clause 3.12 of the policy.

Complainant was absent in the Hearing scheduled by this form also not submitted required documents to this Forum hence complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0017-13

Mr. Chandrakant G. Shah Vs. The New India Assurance Co. Ltd.

Award dated 7th March 2013

Partial repudiation of Mediclaim

Complainant hospitalized for treatment of Knee replacement and expense claimed for Rs.1,45,361/- was partially settled by the Respondent for Rs.97,500/- and deducted Rs.48,361 invoking 4.3.

Complainant submitted that his S. I Rs.1,25,000/- + Bonus approx. 35,000/- since last 10 years, Respondent compulsorily increase S.I but claim will not pay fully which is not acceptable.

Looking to the background of the Claimant and available documents, Forum recommended to pay 50% of the deducted amount as a special case within 7 days from the date of receipt of consent from the complainant.

In the result complaint partially succeeds.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-1083-12

Mr. Sanjay J Vaghela Vs. United India Insurance Co. Ltd.

Award dated 7th March 2013

Partial settlement of Mediclaim

Complainant hospitalized for treatment of Acute Appendicitis and expense claimed for Rs.31,053/- was settled by the Respondent for Rs.16,000/- by deducting an amount of Rs.15,053/- stating the reason that as per the rate of PPN MOU.

Complainant had not produced any advance estimate cost of the treatment to the Respondent.

On referring the documents of both the parties, the Forum also denied the claim hence complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0934-12

Mr. Anup H. Sanghvi Vs. Oriental Insurance Co. Ltd.

Award dated 7th March 2013

Repudiation of Mediclaim

Mr. Anup H. Sanghvi was a member of Tailor made Family Floater Group Mediclaim policy issued to R.B. Hospitality & Health Services and Osteo Arthritis with Hypertension treatment taken by Mr. Anup's mother and expense incurred for Rs.2,63,007/- was repudiated by the Respondent under clause 6.2 and 8.2 of the policy.

No advance intimation to the Respondent for Knee replacement and also this the first year policy.

Group mediclaim policy is not an individual capacity which is an unconventional Group Insurance.

In the result, complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0957-12

Mr. Jayantilal S. Shah Vs. United India Insurance Co. Ltd.

Award dated 8th March 2013

Repudiation of Mediclaim

Complainant treated for Bilateral Inguinal Hernia and expense incurred for Rs.26,271/- was repudiated by the Respondent under clause 5.4 (late submission of claim papers by 4 months and 5 days).

Complainant covered insurance since last 10 years and this is the first claim but as per records policy renewed after 21 days so it was considered as fresh and this is the 2nd year policy. In view of this Respondent's decision is upheld and complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0905-12

Mr. Pratik M. Patel Vs. Oriental Insurance Co. Ltd.

Award dated 11th March 2013

Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Bulky Adenomyotic Uterus and expense claimed for Rs.66,156/- had rejected by the Respondent under clause 4.3 of the Mediclaim policy.

Complainant was covered insurance with Reliance Gen. Ins. Co. since 2008 and policy renewed with the Respondent on 02-02-2010 but as per records this is a fresh policy and previous number has not mentioned in the current policy hence Respondent's decision is upheld.

Therefore complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0961-12

Mr. Jasmin Gandhi Vs. United India Insurance Co. Ltd.

Award dated 11th March 2013

Repudiation of Mediclaim

Complainant treated for Rt. Hip Osteoarthritis and expense incurred for Rs.3,48,357/- was repudiated by the Respondent under clause 5.4 (late submission of claim papers by 5 months and 9 days).

From submission of documents of the parties it is observed that there was inordinate delay in submission of claim papers which is prohibited to investigate into the relevant details of this high cost claim.

In view of this Respondent's decision is upheld and complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-009-1092-12

Mr. Sandip B. Patel Vs. Reliance General Insurance Co. Ltd.

Award dated 11th March 2013

Repudiation of Mediclaim

Complainant's one year old daughter hospitalized for treatment of Diabetes Mellitus type -1 with diabetic Ketoacidosis and expense claimed for Rs.56,966/- was rejected by the Respondent invoking policy clause No.1 and 10. He is argued that he is the policy holder for last 4 years so claim should be paid.

Complainant is residing at Unja, Mehsana and admitted at Ahmedabad hospital, there was no first consultation paper. Treating doctor mentioned having history of D.M type -1.

Considering all the above, the Respondent's decision is upheld and complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0095-13

Mr. Bajranglal Kedia Vs. The New India Assurance Co. Ltd.

Award dated 11th March 2013

Partial settlement of Mediclaim

Complainant hospitalized for treatment of unstable Angina and expense claimed for Rs.3,99,326/- was partially settled by the Respondent for Rs.3,82,063/- by deducting Rs.17,263/- as per policy terms and conditions No.2.3. Respondent submitted all details of deductions which proves deductions are as per terms and conditions of the policy only.

On scrutiny of documents of both the parties, it is established that the Respondent's decision is right and proper hence complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0089-13

Mrs. Saneeta V. Shah Vs. The New India Assurance Co. Ltd.

Award dated 11th March 2013

Partial settlement of Mediclaim

Complainant hospitalized for treatment of Multiple Fibroid disease and expense claimed for Rs.74,740/- was partially settled by the Respondent for Rs.20,859/- by deducting Rs.53,911/- as per policy terms and conditions No.2.3.

Complainant paid Surgeon's fee separately which bill produced was not acceptable because it considered as other than hospital bill.

Respondent submitted all details of deductions which proves deductions are as per terms and conditions of the policy only.

On scrutiny of documents of both the parties, it is established that the Respondent's decision is right and proper hence complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0079-13

Smt. Urmilaben G. Gandhi Vs. The New India Assurance Co. Ltd.

Award dated 11th March 2013

Repudiation of Mediclaim

Complainant hospitalized for Spinal surgery and expense claimed for Rs.1,47,205/- was repudiated by the Respondent giving reason that late submission of claim papers (late by 7 months).

Discharge summary of the hospital signed only medical officer. No signature of consultant doctor or preparing person. Total bill shows Rs.1,38,822/- which is also unsigned. Reason for late submission of claim papers is also not acceptable. Hence complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-1141-13

Mr. Mahesh Patel Vs. National Insurance Co. Ltd.

Award dated 11th March 2013

Partial settlement of Mediclaim

Complainant's wife hospitalized for treatment of Bilateral Ethmoidal Pollyp and expense claimed for Rs.84,329/- was settled by the Respondent for Rs.50,809/- by deducting an amount of Rs.33,520/-invoking clause 3.12 of the policy.

Complainant was absent in the Hearing scheduled by this forum also shown some discrepancies in the bill, Discharge summary etc., hence Respondent's decision to settle the claim partially is upheld and complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-1154-12

Mr. Narshibhai K. Ponakia Vs. National Insurance Co. Ltd.

Award dated 11th March 2013

Repudiation of Mediclaim

Complainant hospitalized for treatment of Piles and expense claimed for Rs.18,366/- was repudiated by the Respondent giving reason that the insured treated in a declined list of hospital.

Complainant's argument was that he was not aware, about the declined list of hospitals. He has not received any list of declined hospital but Respondent circulated the matter to all agents and all branches also all Divisional offices and advertisement given in the News paper also.

In view of this, the complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-010-1197-12

Mr. Tribhuvan J. Parmar Vs. Iffco Tokio General Insurance Co. Ltd.

Award dated 11th March 2013

Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Pyrexia with abdominal pain and expense incurred was for Rs.10,155/- which was repudiated by the Respondent invoking policy condition No.11, i.e. minimum requirement of inpatient beds are 15 whereas insured treated hospital was having only 8 beds.

In the Discharge Card, no I.P number mentioned. Investigation Report shows non-co-operation by hospital doctors which proves to be a case of OPD converted into IPD.

Considering all the above the Forum also denied the claim and complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-017-1131-12

Mr. Laljibhai B. Sojitra Vs. Star Health & Allied Insurance Co. Ltd.

Award dated 12th March 2013

Partial Repudiation of Mediclaim

Complainant hospitalized for treatment of Viral Fever – Falciparum Malaria and expense claimed for Rs.18,149/- was partially settled for Rs.11,500/-by the Respondent and deducted an amount of Rs.6,649/- on the ground of reasonable and necessary and non medical expense as per policy condition.

Bill assessment sheet shows details of deductions hence Respondent settled the claim partially is right and proper, so complaint dismissed.

****

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-008-1173-12

Mr. Damodharbhai Bhavsar Vs. Royal Sundharam Allianz Ins. Co. Ltd.

Award dated 12th March 2013

Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of history of fall and laceration would along with pre-existing ailments of Hypertension and Diabetes since 20 years, which is excluded from the scope of coverage, so claim of Rs.10,000/- repudiated by the Respondent.

This is 1st year policy and duration of vertigo is 8 months, Diabetes and Hypertension is since 20 years. Investigation Report also shows treatment could have been done on OPD basis.

In view of this complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-1153-12

Mr. B..M. Shah Vs. National Insurance Co. Ltd.

Award dated 12th March 2013

Partial settlement of Mediclaim

Complainant's wife hospitalized for treatment of Lower end Humorous with lunar styled Rt. and expense claimed for Rs.14,457/- was settled by the Respondent for Rs.8,000/- by deducting an amount of Rs.6,457/- stating the reason that as per the rate of PPN MOU.

Insured hospitalized for the treatment of accidental injury on Rt. Wrist join. There is no proof of more than 24 hours hospitalization and also no advise to hospitalize of any first consultant.

On referring the documents of both the parties, the Forum also denied the claim hence complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-1094-12

Mr. Jayantilal L. Hirpara Vs. The New India Assurance Co. Ltd.

Award dated 12th March 2013

Repudiation of Mediclaim

Complainant himself hospitalized for treatment of Piles and expense claimed for Rs.25,920/- was repudiated by the Respondent invoking clause No.3.2 of policy condition ie., the hospital was not having minimum 15 inpatient beds where the insured treated.

The Discharge card has no signature only rubber stamp of Dr. Hiren Vaidya is affixed. Hospital bill issued by Dr.Nandlal B. Thesia for Rs.21,700/- in a plain paper using rubber stamp of Shreyans Ano-Rectal and Day-care Hospital, Surat which create doubts.

Considering all the above the forum also denied the claim and case dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-1078-12

Mr. Haresh R. Shah Vs. Oriental Insurance Co. Ltd.

Award dated 12th March 2013

Partial settlement of Mediclaim

Complainant hospitalized for treatment of Lower Ureteric Stone with Colic and expense claimed for Rs.38,336/- was settled by the Respondent for Rs.27,335/- by deducting an amount of Rs.10,999/- stating the reason that as per the rate of PPN MOU.

Complainant's argument that he is not aware of the PPN rate and had not received any copy of list of PPN hospital.

On referring the documents of both the parties, the Forum also denied the claim hence complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0963-12

Mr. Trikambhai J Chauhan Vs. United India Insurance Co. Ltd.

Award dated 11th March 2013

Non settlement of Mediclaim

Complainant hospitalized for breathlessness, cough, fever etc. and expense claimed for Rs.58,777/- was not settled by the Respondent due to pre-existing disease.

As per Discharge summary, patient was a history of bronchitis + DM + HTN + Renal failure since 2011 but policy incepted since 2009.

Insurance was not taken on Personal Line it is a tailor made Group Insurance so the Forum is not in a position to take any decision.

Therefore complaint dismissed without passing any quantitative award.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.14-002-0980-12

Mrs. Rupaben Majmudar Vs. The New India Assurance Co. Ltd.

Award dated 12th March 2013

Repudiation of Mediclaim

Complainant hospitalized for treatment of head injury due to accidental fall and incurred expense of Rs.38,781/- was repudiated by the Respondent stating that the treatment was covered P.A claim and already paid by the Respondent for Rs.17,066/- to the hospital as cashless payment and Rs.18,781/- inclusive of post hospitalization expense.

As per record the same claim occurred in the year of 2010 and again claimed recently which is not payable hence complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0040-13

Mr. Nareshchandra A. Patel Vs. Oriental Insurance Co. Ltd.

Award dated 12th March 2013

Partial settlement of Mediclaim

Complainant hospitalized for treatment of Abdominal pain and expense incurred for Rs.66,389/- was partially settled by the Respondent for Rs.30,000/- as per PPN rate and deducted Rs.36,389/- which is not acceptable by the Complainant because he was treated at CIMS hospital and this hospital is not under PPN or GIPSA network.

The policy is not individual which is a Tailor made Group Insurance, premium paid details are not available and also complainant not attended the Hearing scheduled by this Forum.

In view of this complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0022-13

Mr. Alpesh M. Dhorajia Vs. Oriental Insurance Co. Ltd.

Award dated 12th March 2013

Repudiation of Mediclaim

Complainant accidentally fall from scooter on 17-3-2011 and hospitalized three times and expense incurred for two times were Rs.29,278/- which was repudiated by the Respondent giving reason that hospitalization was not required and claim is not admissible as per 2.2 of the mediclaim policy.

Third claim, Respondent informed that the same will be settled within a week's time in which the complainant agreed to follow up.

In the result complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0077-13

Mr. Parmanand R. Parikh Vs. The New India Assurance Co. Ltd.

Award dated 12th March 2013

Partial deduction of Mediclaim

Complainant's 75 years old wife hospitalized 2 times for treatment of Acute Bronchitis + HTN + DM and total expense incurred for Rs.23,411/- was settled partially for Rs.16,383/- by the Respondent and deducted Rs.7,028/- on the ground of on going treatment of HTN & DM since years.

Again she was admitted with complaint of gabhraman, breathlessness etc. and died during hospitalization and expense incurred for Rs.45,630/- was settled by Respondent for Rs.43,485/- by deducting an amount of Rs.2,045/- without any reason.

On going through the available documents, the Forum directed the Respondent to admit the deducted amounts on ex-gratia basis hence complaint succeeds.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0023-13

Mr. Sanjay B. Sharma Vs. Oriental Insurance Co. Ltd.

Award dated 12th March 2013

Partial repudiation of Mediclaim

Complainant hospitalized for surgery of neck of femur due to accidental fall at home and expense incurred Rs.1,05,383/- was settled by the Respondent for Rs.40,075/- as per the rate of PPN MOU.

There is no first consultation paper. Hospital Indoor case papers are not available so the Respondent's decision is upheld without any relief to the complainant.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0046-13

Mr. Rajesh R. Patni Vs. Oriental Insurance Co. Ltd.

Award dated 13th March 2013

Repudiation of Mediclaim

Complainant's mother hospitalized two different hospitals for treatment of cough, breathlessness, fever and diagnosed COPD with COR-P with CO2 narcosis + Hypertension + Diabetes and total expenses claimed for Rs.1,22,868/- was repudiated by the Respondent due to pre-existing disease and policy is in first year.

As per Discharge Summary of both the hospitals, the insured was having history of HTN & DM and policy incepted in the 1st year only so claim repudiated under clause 4.1 and 4.3 of the Mediclaim policy.

Therefore complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0936-12

Shri Dhaval D. Pujara Vs. United India Insurance Co. Ltd.

Award dated 12th March 2013

Repudiation of Mediclaim

Complainant's father hospitalized for treatment of Cataract and expense claimed for Rs.24,992/- was rejected by the Respondent on the ground of delay in submission of claim papers which is violation of Policy condition No.5.4. Another reason showing that the policy is in the first year which is not acceptable by the complainant, this is the second year policy. Respondent giving one more reason the policy is not individual, it is a tailor made group Insurance.

In view of all the above the forum dismissed the case without giving any quantitative award.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-0109-13

Mrs. Roopal K. Shah Vs. The New India Assurance Co. Ltd.

Award dated 13th March 2013

Partial settlement of Mediclaim

Complainant's husband hospitalized for treatment of Neck # dislocation of Humenus hand and expense incurred Rs.32,481/- was partially settled by the Respondent for Rs.24,700/- and deducted for Rs.7,780/- invoking policy condition No.3.13.

Insured sustained vehicular injury, but FIR was not lodged. Insured hospitalized two times, first Discharge summary not submitted and second discharge summary not signed by hospital authority.

Considering all the above, the Respondent's decision is upheld and complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0963-12

Miss. Teena V. Jobaliya Vs. United India Insurance Co. Ltd.

Award dated 13th March 2013

Non settlement of Mediclaim

Complainant's father hospitalized for treatment of Coronary Artery Disease and expense incurred for Rs.1,85,116/- was not settled by the Respondent giving reason that non compliance of required documents.

The policy is not an individual capacity it is a tailor made group insurance which falls outside the ambit of this Forum. Hence complaint dismissed without passing any quantitative award.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0059-13

Mr. Sethu Madhavan P Vs. Oriental Insurance Co. Ltd.

Award dated 13th March 2013

Repudiation to renewal of Family Floater Policy

Complainant had Group Family Floater policy with the Respondent through Oriental Royal Dena Bank for three years. Forth year policy has issued by the Respondent on Individual capacity by accepting higher premium from the Complainant because insured was above 55 years. Insured was an ex-employee of Dena Bank.

Insured's complaint is premium of Individual policy is higher than Family Floater policy.

Family Floater policy is eligible under the age group of 21 to 55 years whereas the insured's age was above 60 years.

In view of this complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0978-12

Mr. Amratlal G. Patel Vs. United India Insurance Co. Ltd.

Award dated 14th March 2013

Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Lump in Lt. Breast and expense incurred for Rs.14,610/- was repudiated by the Respondent giving reason that the insured treated in a declined list of hospital.

Complainant argued that the policy incepted in 26-06-2010 and declined list of hospitals affected from 16-08-2010. No information received by the complainant about the declined list of hospital.

On scrutiny of available documents, the Forum denied the complaint.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0944-12

Mr. Mahendrabhai K. Patel Vs. United India Insurance Co. Ltd.

Award dated 14th March 2013

Partial repudiation of Mediclaim

Complainant hospitalized for treatment of Kidney Stone and expense incurred for Rs.1,65,096/- was settled by the Respondent for Rs.1,29,475/- and deducted an amount of Rs.35,621/- as per the rate of PPN MOU.

Complainant's earlier claim has paid without any deduction in June 2012 so this claim also should be paid fully.

Respondent settled the claim as per terms and conditions of the policy, hence complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0060-13

Mr. Govindlal J. Chunvalia Vs. Oriental Insurance Co. Ltd.

Award dated 14th March 2013

Partial settlement of Mediclaim

Complainant's wife hospitalized for cataract surgery and expense incurred for Rs.59,549/- has settled by the Respondent for Rs.52,000/- by deducting an amount of Rs.7,549/- under policy condition No.13.1 & 13.2.

Complainant's argument that the insured's another eye cataract surgery done in 2009 in same hospital was paid by the same insurance company for Rs.59,000/- without any clause so this claim also should be paid fully.

On scrutiny of available documents proved the Respondent's decision is just and fair hence complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0088-13

Shri Iqbal A. Somani Vs. Oriental Insurance Co. Ltd.

Award dated 14th March 2013

Repudiation of Mediclaim

Complainant's mother hospitalized for treatment of breathlessness & HTN and expense incurred for Rs.75,481/- was repudiated by the Respondent under exclusion clause 6.5 of the Mediclaim Policy.

This is a Tailor made Group Insurance Policy without any insurable interest and premium paid details are also not available hence the subject policy does not cover the risk of the patient.

Therefore complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0062-13

Mr. Satish B. Patel Vs. Oriental Insurance Co. Ltd.

Award dated 14th March 2013

Repudiation of Mediclaim

Complainant hospitalized for treatment of Tuber Culoma, D.M, Headache, Giddiness, weakness, High Cough and fever and expense incurred for Rs.24,422/- was repudiated by the Respondent invoking exclusion clause 5.5 of the Mediclaim policy.

Complainant submitted claim papers after 94 days which is not acceptable by the Respondent so complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0084-13

Mr. Mahendra R. Shah Vs. Oriental Insurance Co. Ltd.

Award dated 15th March 2013

Repudiation of Motor Claim

Complainant lodged a full IDV of Rs.30,000/- under his Maruti Omini Car theft was repudiated by the Respondent because R.C. book was not renewed after 2008, so the insured vehicle had no valid registration at the time of loss of the vehicle.

On scrutiny of available documents, it is proved that the Respondent's decision is just and proper so complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0953-12

Mr. Bhavesh S. Patel Vs. United India Insurance Co. Ltd.

Award dated 14th March 2013

Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Labour pain & expense claimed for Rs.11,291/- was repudiated by the Respondent giving reason that late submission of claim papers.

Respondent submitted that the claim papers received late by 14 days and the policy was a tailor made Group Insurance not individual policy. The group master policy holder has no insurable interest.

In view of this, the complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0087-13

Shri Iqbal A. Somani Vs. Oriental Insurance Co. Ltd.

Award dated 14th March 2013

Repudiation of Mediclaim

Complainant's mother hospitalized for treatment of respiratory failure and expense incurred for Rs.62,356/- was repudiated by the Respondent giving reason that non compliance of required documents.

This is a Tailor made Group Insurance Policy without any insurable interest and premium paid details are also not available hence the subject policy does not cover the risk of the patient.

Therefore complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-1133-12

Mr. Ashok Sharma Vs. The New India Assurance Co. Ltd.

Award dated 15th March 2013

Repudiation of Mediclaim

Complainant's 4 years old son hospitalized for treatment of Craniosynostosis of both the eyes and expense incurred for Rs.99,556/- was repudiated by the Respondent under exclusion clause 4.4.6 of the policy.

There is a non disclosure of material facts at the time of taking the policy hence complaint dismissed.

****

AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-002-1132-12

Mr. Mukesh S. Valecha Vs. The New India Assurance Co. Ltd.

Award dated 15th March 2013

Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Bicorate Uterus Excision of Rudimentary and expense incurred for Rs.1,37,596/- was repudiated by the Respondent invoking clause No.4.4.13.

Insured was having 17 weeks pregnancy so claim is not admissible and complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0954-12

Mr. Suresh G. Andani Vs. United India Insurance Co. Ltd.

Award dated 15th March 2013

Repudiation of Mediclaim

Complainant's mother hospitalized for treatment of Knee replacement and expense incurred for Rs.2,45,712/- was repudiated by the Respondent under exclusion clause No.4.1. There is a cap of 3 years for subject treatment.

Policy is Tailor made Group Family Floater which is an unconventional group insurance. It is not considered an Individual capacity, so complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-106-13

Mr. Jignesh V. Prajapati Vs. Oriental Insurance Co. Ltd.

Award dated 15th March 2013

Repudiation of Mediclaim

Complainant's mother treated for HTN + DM + Acute Renal failure etc. and expense claimed for Rs.2,20,742/- was repudiated by the Respondent under exclusion clause No.4.1. Pre-existing disease is covered after continuous 4 years renewal. This is fourth year policy.

As per Discharge Summary of the hospital, DM – years & HTN – 1 year.

Considering all the above, Respondent's decision is upheld and complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-009-0144-13

Mr. Manojkumar N. Shah Vs. Reliance General Insurance Co. Ltd.

Award dated 15th March 2013

Repudiation of Mediclaim

Complainant treated for Coronary Heart disease and expense claimed for Rs.2,16,466/- was repudiated by the Respondent invoking exclusion clause No.1 & 2.

Insured was a history of Renal transplantation in 1991 with HTN since 20 years. Insured had not disclosed HTN while policy inception.

Looking to all, Respondent's decision is upheld and complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-1126-12

Smt. Prabhaben G. Shah Vs. The New India Assurance Co. Ltd.

Award dated 15th March 2013

Repudiation of Mediclaim

Complainant's husband hospitalized for treatment of CAD and expense of Rs.1,42,935/- claimed was repudiated by the Respondent under exclusion clause No.4.1 of the Mediclaim policy.

Complainant's argument is policy incepted since 2002 but as per hospital records, insured was suffering HTN since 15 years and present disease also related to HTN.

Considering all the available documents, the forum also denied the claim and complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-1128-12

Mr. Kinnar N. Shah Vs. The New India Assurance Co. Ltd.

Award dated 18th March 2013

Partial repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Adenocyote Uterus and expense of Rs.39,937/- claimed was partially settled for Rs.27,993 by the Respondent and deducted an amount of Rs.11,947/-invoking policy condition No.3.13.

Doctor charged operation charges for Rs.20,000/- which is very high so Respondent sanctioned Rs.10,000/- and remaining amount deducted is customary and reasonable charges.

Looking to all the forum also agreed the Respondent's decision and complaint dismissed.

****

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-1169-12

Mr. Nisargkumar Sheth Vs. The New India Assurance Co. Ltd.

Award dated 18th March 2013

Partial repudiation of Mediclaim

Complainant hospitalized for treatment fracture Tibia for which total claim lodged was for Rs.2,13,151/- out of this Respondent settled for Rs.68,082/- by deducting Rs.1,45,069/- as per policy clause No.2.1, 2.3, 2.4 and 4.4.

Complainant claimed two claims, the second claim for post hospitalization Rs.58,100/- was approved only for Rs.7,100/-.

Respondent clarified all deductions and justified deductions were made by the Respondent is as per terms and conditions of the policy hence complaint dismissed.

****

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-1152-12

Mr. Mukesh Kapadia Vs. National Insurance Co. Ltd.

Award dated 18th March 2013

Repudiation of Mediclaim

Complainant has hospitalized for cataract surgery and expense incurred for Rs.21,513/- was repudiated by the Respondent due to non submission of query reply.

Complainant's son was an employee of Essar Group and covered group Insurance earlier. Current policy is an Individual Mediclaim and not mentioned earlier policy number.

Current policy considered fresh policy so cataract disease is not payable as per clause 4.3.

In view of this complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-002-1148-12

Mr. Dilip Shah Vs. The New India Assurance Co. Ltd.

Award dated 18th March 2013

Partial repudiation of Mediclaim

Complainant hospitalized for treatment of Para Umbilical Hernia and expense incurred for Rs.2,41,426/- was settled for Rs.56,925/- and deducted an amount of Rs.1,84,501/- invoking policy condition No.2.0 & 3.13 and as per the rate of PPN MOU.

Complainant submitted that his policy incepted since 1997 and no claim was lodged during this period. The deducted amount of Rs.1,84,501/- was paid by him, should be reimbursed by the Insurer.

Respondent has explained the reasons for deductions in details hence the Forum dismissed the complaint.

****

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0998-12

Mr. Pradeep H. Sanghvi Vs. United India Insurance Co. Ltd.

Award dated 18th March 2013

Repudiation of Mediclaim

Complainant hospitalized for treatment of Left Shoulder Supraspinatus Tendiopathy, Radial Shock wave therapy etc. and expense incurred for Rs.12,500/- and again admitted to another hospital which expense was Rs.1,400/-. Both the claims were repudiated by the Respondent under clause 2.3 of the mediclaim policy.

The treatment could have been done an OPD basis, it is not necessary for 24 hours admission so claim rejected by the Respondent.

On scrutiny of documents, it is proved that the Respondent's decision is just and proper hence complaint dismissed.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-0116-13

Mr. Krishnachandra Nathwani Vs. National Insurance Co. Ltd.

Award dated 19th March 2013

Partial Repudiation of Mediclaim

Complainant hospitalized for treatment of Prostactomy (Ca. Prostate) and expense incurred for Rs.2,67,913/- which was settled by the Respondent for Rs.1,54,300/- by deducting an amount of Rs.1,13,613/- as per clause 3.12 of Swasthya Bima Policy.

Complainant's argument that policy condition was not known to him so his claim should be paid fully is not acceptable by this Forum hence Respondent's decision to settle the claim partially is upheld and complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-1125-12

Mr. Pankaj S. Pandya Vs. The New India Assurance Co. Ltd.

Award dated 15th March 2013

Repudiation of Mediclaim

Complainant hospitalized for treatment of Polysystic Kidney disease and expense incurred for Rs.13,790/- was repudiated by the Respondent as per policy condition No.4.4.16.

Respondent proved through various documentary evidences that the complainant was treated for genetic disorder which is not admissible hence complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0125-13

Mr. Umang M. Mathur Vs. Oriental Insurance Co. Ltd.

Award dated 18th March 2013

Repudiation of Medi Claim

Complainant's father hospitalized for treatment of Coronary Artery Disease and expense claimed for Rs.1,87,228/- was repudiated by the Respondent due to pre-existing disease under exclusion clause 4.1.

Respondent proved with concrete evidence that the treatment was due to HTN & DM so Respondent was rightly rejected the claim.

Therefore complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-1002-12

Mr. Rakesh H. Patel Vs. National Insurance Co. Ltd.

Award dated 20th March 2013

Partial repudiation of Mediclaim

Complainant two times hospitalized for treatment of Knee Haemarthrisis and first claim lodged for Rs.58,433/- was settled by the Respondent for Rs.54,334/- under purview of Policy condition A,B & C @ 25% of S.I under 'B' limit. 2nd claim lodged within 105 days for Rs.51,825/- was settled by the Respondent for Rs.20,586/-giving reason that 2nd claim was within 105 days from the date of discharge of 1st hospitalization for same illness is considered under policy condition No.3.

Complainant had not attended the Hearing scheduled by this forum and Respondent proved by submitting policy terms and conditions hence Respondent's decision is upheld and complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0989-12

Mr. Ilesh H. Sureja Vs. United India Insurance Co. Ltd.

Award dated 19th March 2013

Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Rt. Ovarian Cyst and expense incurred for Rs.50,000/- was repudiated by the Respondent giving reason that the insured admitted in a declined list of hospital.

Complainant argued that he was not aware of the declined list of hospital at the time of taking the policy and was also not informed by the Insurer.

Policy was not an individual, it was a tailor made Group Floater Mediclaim which is beyond the scope of this Forum.

Therefore complaint dismissed without any competitive award.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0988-12

Mr. Prabhudas V. Halvadia Vs. United India Insurance Co. Ltd.

Award dated 20th March 2013

Repudiation of Mediclaim

Complainant's hospitalization expense was rejected by the Respondent as per policy condition No.4.1 (pre-existing disease).

Policy was not an individual, it was a tailor made Group Floater Mediclaim which is beyond the scope of this Forum.

Therefore complaint dismissed without any competitive award.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0126-13

Shri Girishkumar H. Shah Vs. Oriental Insurance Co. Ltd.

Award dated 20th March 2013

Repudiation of Mediclaim

Complainant hospitalized for treatment of Ischemic Heart Disease +D.M-II and incurred expense for Rs.17,146/- was repudiated by the Respondent on the ground of pre-existing disease under exclusion clause 4.1.

Complainant was history of D.M-II since 14 years and this is the first year policy. Pre-existing is excluded up to 4 years.

Therefore complaint dismissed.

****

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0127-13

Mr. Pranav K. Shah Vs. Oriental Insurance Co. Ltd.

Award dated 20th March 2013

Repudiation of Mediclaim

Complainant's mother hospitalized for treatment of Varicose Vein of right lower extremity and expense incurred for Rs.50,000/- was repudiated by the Respondent under clause 2.3 stating that the treatment can be on OPD basis, there is no need of hospitalization.

The policy is a tailor made Group Mediclaim issued to a Charitable Trust which is beyond the scope of this Forum.

In view of this complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-009-0099-13

Smt. Rasilaben B. Mayani Vs. Reliance General Insurance Co. Ltd.

Award dated 20th March 2013

Repudiation of Mediclaim

Complainant treated for acute fissure in ano; Sphinecterectomy and expense incurred for Rs.23,823/- was repudiated by the Respondent on the ground of Policy clause 31, giving reason that allopathic surgical treatment given by an ayurvedic doctor hence claim stands denied.

As per hospital bill issued by Dr. Nandlal Thesia (BAMS) shows the surgical treatment given by him is an ayurvedic doctor not an allopathic doctor so Respondent's decision is upheld and complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-009-0100-13

Smt. Nayanaben S. Shah Vs. Reliance General Insurance Co. Ltd.

Award dated 20th March 2013

Repudiation of Mediclaim

Complainant hospitalized for treatment of UTI, Hypothyroidism and DM and expense incurred for Rs.11,350/-was repudiated by the Respondent invoking exclusion clause No.1 of the policy – pre-existing disease.

Complainant had history of DM since 4 years and HTN since 7 years but not disclosed in the proposal form.

In view of this complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-005-0105-13

Mr. Dilip D. Suthar Vs. Oriental Insurance Co. Ltd.

Award dated 20th March 2013

Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Umbilical Hernia and expense incurred for Rs.38,260/- was repudiated by the Respondent giving reason that Obesity related treatments are not payable as per policy condition No.4.19.

As per treating doctor's certificate, it is clearly mentioned that reason for Umbilical Hernia is due to obesity. Treatment of obesity or Morbid obesity are not payable.

In view of this complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-1003-12

Mr. Bipinbhai A. Gosalia Vs. National Insurance Co. Ltd.

Award dated 21st March 2013

Partial repudiation of Mediclaim

Complainant was covered a Family Floater Mediclaim policy for S.I Rs.5.00 Lacs and any pre-existing disease is limited to 1.00 Lac if hospitalization is required.

In the second year of the policy, complainant hospitalized for treatment of CAD, unstable angina etc and expense incurred for Rs.2,72,207/- was settled by the Respondent Rs.1.00 Lac only which was not agreeable by the complainant. As per MMR, Complainant had history of HTN since 3-4 years which is considered pre-existing disease. Pre-existing disease will be payable after 36 moths of coverage of policy but in this case complainant covered Individual policy previously with another company so his claim paid partially to that extent.

In view of this complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-1184-12

Mr. Kishore Khandhar Vs. National Insurance Co. Ltd.

Award dated 21st March 2013

Partial settlement of Mediclaim

Complainant's wife hospitalized for treatment of Rt. Knee joint replacement and expense claimed for Rs.1,68,686/- was settled by the Respondent for Rs.1,17,934/- by deducting an amount of Rs.50,572/- stating the reason that as per the rate of PPN MOU.

Respondent explained the reason for deduction is mainly as per PPN MOU, but the actual claim settlement was more than the eligible amount.

On referring the documents of both the parties, the Forum also denied the claim hence complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-1183-12

Mr. Narendra C. Shah Vs. The New India Assurance Co. Ltd.

Award dated 21st March 2013

Partial settlement of Mediclaim

Cataract Surgery expense of the complainant for Rs.66,000/- was settled by the Respondent for Rs.44,000/- by deducting an amount of Rs.22,000/- invoking policy condition No.3.13.

Respondent has explained the reasons for deductions in details during the hearing and complainant's argument have been noted but the same can not be valid ground hence Respondent's decision upheld and complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-1182-12

Mr. Jetin Sheth Vs. The New India Assurance Co. Ltd.

Award dated 21st March 2013

Partial settlement of Mediclaim

Complainant's son hospitalized for treatment of Hepatitis and expense incurred for Rs.42,901/- was settled by the Respondent for Rs.23,673/- by deducting an amount of Rs.19,228/- as per PPN rate fixed to the hospital.

Complainant was advised to get back from the hospital as excess charges collected by them.

Complainant claimed one another claim of Rs.9,234/- for post hospitalization which was also paid by the Respondent for Rs.5,680/-.

In view of this, the complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-009-0140-13

Mr. Jitesh V. Dave Vs. Reliance General Insurance Co. Ltd.

Award dated 21st March 2013

Repudiation of Mediclaim

Complainant hospitalized for treatment of Planter Fascinates + Dislipidemia and expense incurred for Rs.8,281/- was repudiated by the Respondent on the ground of violation of policy clause 19.

From available papers proved that the insured treated through oral medicines only, no injectable medicines provided, it could be treated on OPD basis.

However complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-017-0132-13

Mr. Narendra C. Bhatt Vs. Star Health & Allied Insurance Co. Ltd.

Award dated 22nd March 2013

Repudiation of Mediclaim

Complainant hospitalized for treatment of Cirrhosis of Liver, Hypoalbuminemia Oesophagal Varices etc and expense incurred for Rs.29,702/- was repudiated by the Respondent on the ground of condition No.7 (Misrepresentation/Non-disclosure of material facts).

This is the first year policy and hospital paper reveals the insured patient was having the disease prior to inception of medical insurance policy.

Copy of the proposal form filled in by the insured replies in Negative about past history of the illness.

Considering all the above, the forum also denied the claim and complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-017-0141-13

Mr. N.D. Gajipara Vs. Star Health & Allied Insurance Co. Ltd.

Award dated 22nd March 2013

Partial settlement of Mediclaim

Complainant hospitalized for treatment of P. Vivax Malaria complicated by thrombocytopenia and expense incurred for Rs.16,350/- was settled by the Respondent for Rs.12,050/- on the ground of reasonable and customary charges.

Respondent confirmed an additional cheque of Rs.2,700/- also sanctioned which was not received by the Complainant hence agreed to send duplicate cheque immediately. The balance remaining amount of Rs.1600/- deducted being non medical items.

In view of this complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0137-13

Mr. Dashrathbhai R. Patel Vs. United India Insurance Co. Ltd.

Award dated 22nd March 2013

Partial Settlement of Mediclaim

Complainant hospitalized for treatment of Acute Posterior Circulation stroke and expense incurred for Rs.25,745/- was settled by the Respondent for Rs.21,495/- by deducting an amount of Rs.4,250/- under policy clause 1.2 (c) which states that no payment shall be made other than hospital bill.

Respondent explained in details for deductions made by them and clarified the Complainant's confusion also. Therefore Respondent's decision is upheld and complaint dismissed.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0990-12

Mr. Sachin G. Trivedi Vs. United India Insurance Co. Ltd.

Award dated 20th March 2013

Repudiation of Mediclaim

Complainant's new born baby girl aged 4 days only was hospitalized four time in different hospitals and claims lodged total around Rs.92,000/- was repudiated by the Respondent giving reason that Congenital ailment is not covered under the scope of the policy.

Complainant's argument the insured daughter first admitted for jaundice for which patient was required to be hospitalized for the treatment of phototherapy for more than 24 hours. Second time admitted for treatment of fever not for congenital external disease.

The subject policy is Floater Group Mediclaim issued to the Employer of the Complainant to cover risk of employees and their dependent.

There is a permanent exclusion under item 14 and policy clause No.4.17 also shown exclusion of genetic disorder.

In view of this complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-1014-12

Dr. Chandulal M. Bhavsar Vs The New India Assurance Co. Ltd.

Award dated 25th March 2013

Partial settlement of Mediclaim

A claim of Rs.1,35,855/- was lodged by the Complainant for treatment of Acute Cholecystis was settled by the Respondent for Rs.1,20,053/- by deducting an amount of Rs.15,802/- under various heads shown in the claim settlement sheet as per Policy condition 2.0, 2.3 and note 2.

On scrutiny of documents of both the parties, it is proved that the Respondent's decision to deduct an amount of Rs.15,802/- is right and proper hence complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-1056-12

Smt. Ramilaben R. Shah Vs. National Insurance Co. Ltd.

Award dated 25th March 2013

Repudiation of Mediclaim

A 63 years old insured female hospitalized for treatment of Acute Anterior Wall MI and expense incurred for Rs.1,87,303/- was rejected by the Respondent as per exclusion clause No.4.1 of the Swasthya Bima Policy.

As per hospital records history of HTN since 1½ years but her husband informed HTN since 1 ½ months only. There is a cap of 36 months from the date of inception of the policy for treatment of pre-existing disease whereas the claim lodged within 13 months and 2 days.

Further insured was residing at Mumbai and policy also taken from Mumbai but in the complaint letter address mentioned at Gujarat State. Policy copy does not show Assignee's name or Nominee's name. In view of this, complaint dismissed.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0136-13

Mr. Ashokkumar M. Jain Vs. United India Insurance Co. Ltd.

Award dated 22nd March 2013

Partial repudiation of Mediclaim

Complainant's Mitral Valve replacement expense claimed for Rs.2,32,877/- had been partially settled by the Respondent for Rs.1,05,000/- giving reason that pre-existing disease considering 70% of S.I. Complainant's current policy's S.I Rs.2,50,000/- but 4 years before S.I Rs.1,50,000/- hence claim approved on the basis of old S.I.

Complainant is an Insured patient and himself working as an Insurance Agent then also suffering this type of problems.

On scrutiny of available documents, the Forum also denied the claim and complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0057-13

Mr. Kanaiyalal K. Sharma Vs. United India Insurance Co. Ltd.

Award dated 25th March 2013

Partial settlement of Mediclaim

Complainant hospitalized for treatment of Piles and expense incurred for Rs.36,676/- was settled partially by the Respondent for Rs.33,176/- and deducted Rs.3,500/- as per clause 1.2 (c) of Mediclaim policy.

No Discharge Summary of the hospital in the record, Original case file not submitted by the Respondent, all treatment papers stamped in the name of Hospital, no doctors signature and qualification of the doctor.

In view of this, Respondents decision is upheld and complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0033-13

Mr. Irfan Modi Vs. United India Insurance Co. Ltd.

Award dated 25th March 2013

Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of pregnancy related and expense incurred for Rs.56,590/- was repudiated by the Respondent on the ground of late intimation and late submission of claim papers under clause No.8.2 and 8.3.

The policy was a tailor made Group family floater issued to Veritas Insurance Services Pvt. Ltd and premium paid amount was not known. It is an unconventional group master policy without any insurable interest.

Therefore decision of the Respondent is upheld and complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-1181-12

Mr. Nitinkumar D. Patel Vs. The New India Assurance Co. Ltd.

Award dated 25th March 2013

Repudiation of Mediclaim

Complainant hospitalized for treatment of Anal Rectal Poly and expense incurred for Rs.25,881/- was repudiated by the Respondent invoking policy clause 4.3, 2 years waiting period for the said disease.

The subject disease can not be developed immediately, the policy incepted from 9-10-2010 to 8-10-2011 and treatment taken from 23-7-2011 to 29-7-2011 i.e. 1st year of the policy.

Considering all the above, Respondent's decision to repudiate the claim is upheld and complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No. 11-004-0053-13

Mr. Kinchit Sunil Mehta Vs. United India Insurance Co. Ltd.

Award dated 25th March 2013

Partial repudiation of Mediclaim

Treatment expense of Mr. Sunil Mehta father of the complainant for Coronary Artery Disease and incurred Rs.1,71,296/- was partially settled by the Respondent for Rs.24,500/- giving reason that payment considered 70% of the old S.I of Rs.35,000/-. Policy incepted in 2004 with S.I Rs.35,000/- and increased S.I Rs.1.00 Lac from 2008, from 2009 Rs.1.25 Lac and from 2011 S.I increased to Rs.1.50 Lacs.

Complainant requested to pay as per old S.I + 50% NCB comes to Rs.52,500/- which was not acceptable by the Respondent.

Complainant fails to produce the copy of Proposal Form of 2008-09 to get concession in premium against CB.

Looking to all complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-003-1005-12

Mr. Babaldas V. Patel Vs. National Insurance Co. Ltd.

Award dated 25th March 2013

Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of unbearable back pain and leg pain for which expense incurred Rs.39,157/- was repudiated by the Respondent giving reason that stay period in hospital is less than 24 hours. Complainant's argument that the insured patient has to morning puja-seva hence could not stay at night in the hospital so she has again admitted on the next day morning. If she slept in the hospital then the insurer have no objection to approve the claim. There is discrepancy in the age of insured, policy copy shows 57 years, Discharge summary shows 63 years and MRI report shows 60 years.

Considering all the above, the complaint dismissed.

AHMEDABAD OMBUDSMAN CENTRE

Case No.11-004-0098-13

Mr. Narayandas K. Kundaliya Vs. United India Insurance Co. Ltd.

Award dated 26th March 2013

Repudiation of Mediclaim

Complainant hospitalized for diagnosis of conservative treatment and expense incurred for Rs.22,503/- was repudiated by the Respondent on the ground of late intimation and late submission of claim papers.

Complainant hospitalized two times in 2009 and intimation given to the Respondent after 53 days from the date of discharge from hospital. Date of loss on 24-11-2009 and date of complaint to this forum on 23-04-2012.

The papers made available reveals forged signatures of the complainant in Claim Form, Complaint letters, Form P-II etc which emerged as a case of misrepresentation of material facts at the time of Hearing.

Respondent agreed to waive the late intimation but the forum objected that it is not a simple reason, it is a fabricated claim to cheat the Respondent.

Hence complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case No.11-002-1150-12

Mr. Anilbhai T. Soni Vs. The New India Assurance Co. Ltd.

Award dated 26th March 2013

Repudiation of Mediclaim- Hospitalization expense of Complainant for Rs.17,479/- for the treatment of Enteric fever was repudiated by the Respondent invoking clause 3.2 of the mediclaim policy.

Original claim papers are not traceable since date of loss was 14-09-2009 and complaint lodged to this forum only on 27.01.12 after 2 years and 3 months. Considering the inordinate delay in submission of the complaint and since the Respondent could not trace out the original claim files, the complaint is hereby dismissed.

Hence the complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case no.11-004-0098-13

Mr.N.K.Kundaliya Vs. The United India Insurance Co. Ltd. Award dated 26.03.2013

Repudiation of Mediclaim

The Mediclaim was rejected on the grounds of late intimation and late sub mission of the claim papers to insurance company. The insured was admitted two times First hospitalization period w.e.f. 24.11.09 to 27.11.09 and second hospitalization w.e.f. 11.12.09 to 15.12.09, the intimation for first claim received on 30.11.09 and not intimation for second hospitalization, as per policy conditions within 24 hours insured must inform to insurance company or TPA of the insurance Company. The claim papers were submitted 53 days late.

Hence the complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case no.11-017-1012-12

Mr. Vinodkumar Ranka Vs Star Health & Allied Insurance Co. Ltd.

Award Dated 26.03.13

Repudiation of Mediclaim.

The Mediclaim was repudiated on the grounds of OPD treatment. The insured had back pain. The symptoms and duration of illness are not consistent with the diagnosis. The treatment papers does not suggest need for hospitalization. The treatment is taken on OPD basis.

Hence, the complaint dismissed.

AHMEDABAD OMBUDSMAN CENTRE

Case no.11-009-1007-12

Mr. G.S.Ghelani Vs Reliance Gen. Ins. Co. Ltd.

Award Dated : 26.03.2013

Repudiation of Mediclaim

The claim was repudiated invoking clause no.15 (2) of the policy conditions on the grounds of false statement by insurer at the time to taking insurance. The Respondent stated that the insured was admitted for viral fever, the insured was having policy since last 3 years. As per First consultation letter dated 11.08.10, there is no any noting of disease but tablets were prescribed. The claim form and bills appears to be fabricated or false.

Hence, the complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case no.11-005-1145-12

Mr. Pradip R. Shah Vs Oriental Insurance Co.Ltd.

Date of Award: 28.03.13

Partial repudiation of Mediclaim

The insured hospitalized for Left side hemiparesis incurring total expenses of Rs. 1,21,789/- which was partially settled for Rs.78,584/-. The Respondent stated that deduction were made in connection with pre& post hospitalization expenses invoking condition no. 4.26 stating that doctors visit at home for pre & Post hospitalization period is not admissible, hence deduction is justified.

Hence, the complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Claim no. 11-002-0014-13

Mr. Chandrakant V. Baloni Vs The New India Assurance Co. Ltd.

Date of Award: 28.03.2013

Partial repudiation of Mediclaim

The insured hospitalized for chronic liver disease for which he claimed for Rs. 77,806/- which had been partially settled for Rs.53000/-by Respondent deducting Rs. 26400/- stating under the Head of "Customary and reasonable grounds" as per policy clause 3.13. It is established that insured has produced other than hospital bill, which is not payable.

Hence the complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Claim no. 11-005-1158-12

Mr. Rakesh A. Shah Vs Oriental Ins. Co.Ltd.

Date of Award : 28.03.13

Partial Repudiation of Mediclaim

The insured hospitalized for viral treatment and incurred expenses for Rs. 17,360/- which was partially settled for Rs. 9,910/- deducted Rs. 7,452/-. Respondent stated that deduction were made as per PPN rates applicable for fever management. There is MOU between hospital authority and Insurer's TPA for fixed rate of expenses for certain treatment. Hence, as per MOU the TPA of insurer has written letter for refund of the excess amount paid, but hospital has denied for the refund.

Hence, complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Claim no. 11-004-0082-13

Mr. Dipal Patgel Vs United India Insurance Co. Ltd.

Date of Award: 28.03.13

Repudiation of Mediclaim

The insured lodged claim for surgery or Harnia which was repudiated invoking condition no.4.8 of the policy. The treating doctor mentioned in his report that the cause of Hernia as "Patency of Processus Vaginalis. Secondly, the hernia was noted by the parents, hence it is not congenital in nature.

Hence, complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Claim no.11-004-0083-13

Mr.V D Nagrecha Vs United India Insurance Co. Ltd.

Date of Award : March 28,2013

Repudiation of Mediclaim

The insured underwent treatment of "TO Mass + PUS" for which Hysterectomy was done. The insured lodged claim for Rs.1,08,379/- was partially settled for Rs.51,625/- and deducted Rs. 56,751/- stating that treatment "Hysterectomy" was done for which maximum 25% of sum insured allowed as per the provisions of the policy. The original claim file was not produced for verification by the Respondent's representative during the hearing.

Hence, the complaint dismissed.

AHMEDABAD OMBUDSMAN CENTRE

Claim n o. 11-009-1008-13

Mr.Pradeepkumar Sachan Vs Reliance General Insurance Co.Ltd.

Date of Award : 26.03.2013

Repudiation of Mediclaim

Insured hospitalized for the treatment of P Vivex Malariz + Anemia and lodged claim for Rs.18001/-. Respondent stated that the claim was rejected on the grounds of discrepancies in claim papers submitted by the insured viz. first consultation letter was not properly mentioned patient's details, patient admitted with high grad fever, but indoor papers shows only fever count on first day and next day Temprature was normal. Respondent stated that treating doctor has apologise for fake claim, his hospital Aditya Multi Specialty Hospital was black listed by all four Public Sector General Insurance Companies.

Hence, the complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Claim no. 11-009-1020-12

Mr. S D Doshi Vs Reliance Gen.Ins.Co.Ltd.

Date of Award : 29.03.2013

Repudiation of Mediclaim

The insured was admitted for Atypical fedbrile seizure - Epilepsy. The Respondent rejected the claim on the grounds of pre-existing disease invoking exclusion clause no. 1, as such as per self contained note the insured was having 3 episodes of seizures in last 3 years. As per the records first policy is taken on 24.03.08 while duration of the disease arises on 09.02.2008, prior to taking policy.

Hence, the complaint dismissed.

****

AHMEDABAD OMBUDSMAN CENTRE

Case no. 11-011-0146-13

Mr. Amitbahi B.Pancheruta Vs Bajaj Allianz General Insurance Co.Ltd.

Date of Award: 29.03.2013

Repudiation of Mediclaim

The insured was admitted for convulsions with Dandy-Walker Variant. Respondent rejected the liability invoking Section 2 of Health Guard Exclusion specifically excluded from the scope of coverage. Respondent submitted that insured underwent treatment of convulsion and was diagnosed to be suffering from Dandy Walker Variant which is a congenital brain malformation. Hence, claim was rejected.

Hence, the complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case no. 11-002-0119-13

Mr.Devan R.Mistry Vs The New India Assurance Co.Ltd.

Date of Award: 29.03.2013

Repudiation of Mediclaim

The insured underwent treatment of Umbilical Hernia. The claim was repudiated invoking clause no.4.4(13) of the Mediclaim policy which states that treatment arising from or traceable to pregnancy. Respondent stated that insured underwent caesarian section, at the time of birth of two children around 15 years back and ventral Hernia develops at the site of previous surgery. Hernia is due to previous LSCS operation hence it is treated as permanent exclusion 4.4.13 of the policy conditions.

Hence, the complaint dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case no. 11-005-1159-12

Mr. Saumil S. Mistry Vs Oriental Ins.Co.Ltd.

Date of Award : 29.03.13

Repudiation of Mediclaim -

The insured hospitalized for the treatment of CAD as per discharge summary. The claim was repudiated stating the that insured is k/c/o DM, for which wait period of 2 years. It is established that insured is covered in the first year policy, hence wait period for 2 years is applicable.

Hence, the compliant dismissed.

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AHMEDABAD OMBUDSMAN CENTRE

Case no. 11-002-0015-13

Smt.Minakshi G.Thakore Vs The New India Assurance Co.Ltd.

Date of Award: 26.03.13

Repudiation of Mediclaim

The insured was hospitalized for the diagnosis for compound dislocation Left Hand little finger pip joint with CLW as per Discharge summary, which was rejected on the grounds that insured taken treatment in declined hospital. Insured stated in PII form that because of accidental injury in emergency Ambulance 108 and got the treatment. It is established that the repudiation of the subject claim is valid and proper.

Hence, complaint dismissed.

****

AHMEDABAD OMBUDSMAN CENTRE

Case no. 11-017-0026-13

Mr.Mukesh M.Shukla

Date of Award: 20.03.2013

Repudiation of Mediclaim

The insured was hospitalized for the diagnosis forf Bronchial Asthma as per Discharge summary and the claim was repudiated on the grounds of pre-existing disease, as per condition no.1, of the policy. After examining the papers, it is established that the decision of Respondent is intervened. The claim is hereby admitted for 75% of the admissible claim amount.

Hence, complaint succeed.

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CHANDIGARH OMBUDSMAN CENTER

CASE NO. GIC/704/ROYAL/11/10

SURENDER KUMAR GUPTA Vs. ROYAL SUNDRAM ALLIANCE INSURANCE CO.

FACTS : Complainant had taken medi-claim policy for the period 03.09.2008 to 02.09.2009 and he was hospitalized during a period from 27.01.2009 to 02.02.2009. However, a claim lodged for the reimbursement of treatment expenses was rejected on the ground of 'pre-existing disease'.

FINDINGS: Insurance Company had contended that disease of the insured was diagnosed as 'Bronchial Asthma', which was inadmissible under policy 'pre-existing' exclusion clause. The 'Discharge Summary' of the hospital confirmed that patient was treated for 'Acute Bronchial Allergy'. Therefore, it was held that since 'Bronchial Asthma' remains a sort of chronic disease and of permanent nature, 'Bronchial Allergy' can develop at any time, affecting health for a small period, complainant's ailment could not be termed a 'pre-existing' one.

DECISION : Accordingly, Company was asked to settle the claim as per its admissibility under the terms and conditions of the policy.

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CHANDIGARH OMBUDSMAN CENTER

CASE NO. GIC/974/Royal-Sundram/11/10

Sushil Kumar Pandey Vs. Royal Sundram

FACTS : A medi-claim insurance was done for the period 20.10.2009 to 19.10.2010. Thereafter, son of the insured, insured under the policy, was hospitalized in Fortis Escorts Hospital during a period from 04.11.2009 to 14.11.2009. However, its claim

was denied under the policy clause, which excludes treatment taken for 'pre-existing diseases'.

FINDINGS : It was noted that previous medi-claim insurance taken by the Insured had expired on 14.10.2009 and thus there existed a gap of 5 days in between the previous year's policy and the renewed policy, which was effective from 20.10.2009. The insurer had argued that owing to 5 days gap in between the old policy and the new policy, renewed policy was treated a fresh one. Hence, any treatment, except taken for accidental injuries, was, as per the policy clause, not covered during the first 30 days of the policy. Additionally, it was contented that 'Discharge Summary' clearly mentioned that at the time of admission in the hospital, i. e., on 04.11.2009, symptoms of patient's ailment were 15 day's old.

DECISION : However, Company's decision to deny the claim was held unjustified because complainant submitted evidence of his having remitted premium vide his cheque, which was dated 06.10.2009 and contended that gap in renewal insurance of 5 days was caused by the Company's Agent, whom premium cheque was delivered in time.

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CHANDIGARH OMBUDSMAN CENTER

CASE NO. GIC/89/ICICI/12/11

Paramjeet Kaur Vs. ICICI Lombard

FACTS : Insured had taken a Travel Health (Over-seas Medi-claim) policy for a period from 06.04.2008 to 04.07.2008. Thereafter, there was a delay in the finalization/ clearance of her documents by the host country and ultimately the foreign trip was matured after one year in April, 2009. However, she had to pay premium for the second time to get insurance cover for the foreign trip for the period 20.04.2009 to 18.07.2009.

FINDINGS : The insurer had explained that policy was issued to cover a foreign trip slated for a period from 06.04.2008 to 04.07.2008 and appropriate premium was charged. Subsequently, during the policy period a request was received for shifting the policy period, which was allowed without charging any additional premium and necessary endorsement was made to alter the period as 06.06.2008 to 03.09.2008. It was pointed out that after the expiry of the altered period, still another request was received to change the period of insurance, which was disallowed and a fresh policy was issued to cover the foreign trip, conducted during the period 20.04.2009 to 18.07.2009 by charging premium afresh.

DECISION : The action of the insurance company was considered justified because in the particular situation, whatever relief was available under the provisions of the policy, had been duly given to the insured. The policy provided for conducting foreign trip within stipulated time from the commencement of the policy period.

CHANDIGARH OMBUDSMAN CENTER

CASE NO. GIC/125/NIC/11/11

Gurnam Singh Vs. National Insurance Company Ltd.

ORDER DATED: 07.02.2013 **Medi-claim**

FACTS : A hospitalization claim was denied under a Group Medi-claim policy, terms and conditions of which were finalized by the Company with a Trust. It was specifically provided in the Memorandum of Understanding that a Member of the Trust, exceeding 75 years age, would be ineligible and insurance of other members of his family would be based upon his eligibility under the policy. As per voter's list, age of one member was more than 75 years at the time of commencement of policy; hence hospitalization claim of his daughter-in-law was declined.

FINDINGS : During hearing, the complainant had pleaded that at the time of insurance and payment of premium, age of the member was not verified. However, after the lodging of claim, age as recorded in the Voter's List, was considered for blocking the insurance coverage of the whole of family. It was further contested that details given in the Voter's List were flawed and could not be considered conclusive evidence for determining age of an individual. Incidentally, the concerned member was a Matriculate and it was held that in this context his Matriculation Certificate would be considered an acceptable proof of his age.

DECISION : Age of the Member as given in the Matriculation Certificate confirmed that he was less than 75 years on the date of insurance, hence claim preferred in respect of the treatment of his daughter-in-law was held maintainable under the policy.

CHANDIGARH OMBUDSMAN CENTER

CASE NO. GIC/154/UII/11/11

S. K. Thapar Vs. United India Insurance Company Ltd.

ORDER DATED: 19.03.2013 **Mediclaim**

FACTS : A complainant was insured under a medi-claim policy for the period 17.02.2009 to 16.02.2010 and during the currency of the policy, he was hospitalized in a reputed Medical College & Hospital, but its hospitalization claim was rejected by the Company.

FINDINGS : The complainant had said that he had developed some problem, which necessitated his admission in the hospital. He had further informed that during hospitalization certain tests were conducted and after two days he was discharged from the hospital. On his part, representative of the Company had argued that during hospitalization only investigations were conducted and there was no active line of treatment.

DECISION : The claim was held payable because 'Discharge Summary' given by the hospital clearly mentioned about post-hospitalization treatment, prescribing medicines to be taken for the cure of ailment and patient was asked to revisit for follow-up treatment/ check-up at regular intervals.

DELHI OMBUDSMAN CENTRE

Case No. GI/393/OIC/11
In the matter of Sh. Bharat Gupta
Vs
Oriental Insurance Company Ltd.

AWARD DATED 30.10.2012 REPUDIATION OF MEDICLAIM

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

2. **Complainant stated that he had taken mediclaim policy from Oriental Insurance Company w.e.f. 31.01.2010 to 30.01.2011 and this policy is being renewed continuously. He further mentioned that TPA M/s Vipul Medicorp Pvt. Ltd. has repudiated the claim for stone treatment in R. G. Urology & Laparoscopy Hospital, New Delhi when he was admitted in hospital on 05.04.2011 stating that patient is a case of renal stone. He further stated that he had taken the mediclaim policy to take care of his medical expenses in future. Insurance company did not provide any terms and conditions and gave only a schedule giving details only of family members which are covered in the policy. He has come to this forum with request to get the genuine claim settled.**

3. **Representative of the company pleaded that claim was made In the first year of the policy period. The disease have two years waiting period.**

4. **I have considered the submissions of the complainant as well as of the representative of the company. I have also perused the repudiation letter dated 25.04.2011. After due consideration of the matter, I hold that company was not justified in stating that claim is not admissible as per clause 4.3 of the policy and that policy incepts from 31.01.2010 because insured has been taking policy since 31.01.2008 and the same is continued at least up to 30.01.2012 as per complaint. Policies are renewed continuously without any gap in the policy period. Therefore, complainant deserves the benefit of the continuity in the policy. I hold that claim is payable and company was not justified in denying it. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 51640.**

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/392/OIC/11

In the matter of Sh. Bharat Jain

Vs

Oriental Insurance Company Ltd.

AWARD DATED 30.10.2012 REPUDIATION OF MEDICLAIM

1. **This is a complaint filed by Sh. Bharat Jain (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 his mother Smt. Sudha Jain was hospitalized and admitted in Sukhda Hospital during 20.04.2011 to 21.04.2011. He submitted all requisite documents along with the claim to the TPA Genins India Ltd. for reimbursement of expenses of Rs. 29147/- incurred on treatment on 12.05.2011. The TPA denied the claim on flimsy ground. He further mentioned that he had complied with all the requirements of the company for settlement of the claim. He also sent his representation to the GRO of the company but of no use. He has approached this forum to intervene in the matter and instruct the company to settle the claim. During the course of hearing also, authorized representative of the complainant pleaded that claim is payable but company denied it. Earlier policies were taken from National Insurance Company Ltd.**

3. **Representative of the company stated that claim is not payable because policy was taken for the first time from the present insurer and complainant is not entitled to the benefit of of insurance taken from previous insurer.**

4 **I have considered the submissions of the complainant as well as of the representative of the company. Company had not submitted any reply. After due consideration of the matter, I hold that company was not justified in denying the claim on the ground that policy was taken by the insured for the first time from the insurance company. I find that earlier policies were taken from National Insurance Company and thereafter, policy was taken from the present insurer well before the**

expiry date of the previous policy issued by the previous insurer i.e. to say the present insurer had issued the policy from the date earlier policy expired. The intention of the present insurer was quite clear to allow continuity of the policy. Therefore, claim could not be denied on the ground that policy was taken for the first time by the insured. Complainant deserves to be given continuity benefit of the insurance policy taken from the previous insurer. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs.29,147/- along with the penal interest at the rate of 9% w.e.f. 03.09.2011 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/320/Star/11
In the matter of Sh. R.l. Raina
Vs
Star Health & Allied General Ins. Company Ltd.

AWARD DATED 25.10.2012

1. **This is a complaint filed by Sh. R.L. Raina (herein after referred to as the complainant) against the decision of Star Health & Allied General Ins. Co. Ltd. (herein after referred to as respondent Insurance Company) relating to partial settlement of mediclaim.**

2. **Complainant stated that as advised, he had already approached the GRO of the company who informed him that the stand which company had already taken was justified. He further stated that he is insured for Sum of Rs. 2,00,000 and according to the company its maximum liability is Rs. 1,50,000 for CVD. Treatment was taken in the hospital which was approved by the insurance company. The total claim was for Rs. 3,71,892 out of which the insurance company has reimbursed Rs. 92,735. The company had introduced a strange clause of Co-pay which is not a part of the policy document and such clause was introduced to harass the policy holder. The company was deficient in its services. The company did not provide cashless facility and thus a senior citizen was put to harassment who had to arrange the huge**

amount to settle the hospital bill on 07.01.2011. He is a heart patient. He has come to this forum with a request to ensure him minimum permissible amount and not to resort Co-pay condition which is not a part of the policy. During the course of hearing, complainant argued that company was not justified to settle the claim only for a sum of Rs. 92,735 as against the total claim of Rs. 3,71,892. Claim was not settled as per terms and conditions of the policy.

3. **Representative of the company pleaded that claim was settled as per terms and conditions of the policy and complainant is not entitled to any further relief.**

4. **I have considered the submissions of the complainant very carefully as well as of the representative of the company. I have also perused claim process sheet. After due consideration of the matter, I hold that claim was settled as per terms and conditions of the policy as regards hospitalization bill but company had not considered the post hospitalization expense of Rs. 5143 which is found payable. Thus complainant is found entitled to sum of Rs. 5143. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 5143.**

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/398/UII/11
In the matter of Sh. Jasmer Singh
Vs
United India Insurance Company Ltd.

AWARD DATED 30.10.2012 REPUDIATION OF MEDICLAIM

1. **This is a complaint filed by Sh. Jasmer Singh (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 claim on 05.09.2010. He submitted all requisite documents relating to the claim to enable the company to decide his**

claim. He has come to this forum with a request to get the claim settled as soon as possible. During the course of hearing, it was pleaded by the complainant that claim was payable but company had denied it without any justification.

3. **Representative of the company pleaded that claim is not payable as patient was admitted within 3 to 4 days of taking 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 reasons as given by the TPA for rejection of the claim wherein it is mentioned that on scrutiny of the claim documents it was found that patient was admitted in Sarvoday Hospital on 05.09.2010 and discharged on 06.09.2010. Patient had not intimated for taking admission in the hospital. After due consideration of the matter, I hold that company was not justified in rejecting the claim only on technical ground. Claim is found payable. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 17,400.**

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/384/NIA/11
In the matter of Sh. Deepak Gupta
Vs
New India Assurance Company Ltd.

AWARD DATED 30.10.2012 PARTIAL SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Deepak Gupta (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 partial settlement of mediclaim.**

2. **Complainant stated that his mother Smt. Kanta Devi Gupta was admitted in Garg hospital on 26.07.2010 and unfortunately expired on 25.08.2010 in the same hospital. She was covered in mediclaim insurance policy bearing no.**

310600/34/09/11/00001640 issued by New India Assurance Company Ltd. Claim was submitted to the company along with requisite documents on 18.09.2010. However, the Raksha TPA rejected the claim stating the reasons that 2 or 3 reports were short in the claim though, the same were deposited by him. He further stated that hospital refused to co-operate with him stating the reason that hospital could not trace the old papers. It is quite possible that some reports were misplaced in the insurance company's office. He further submitted that claim should have not been rejected merely because some reports were wanting though the claim was put up for an amount of Rs. 4,00,000 but sum insured was Rs. 1,00,000. Moreover, some claim was made earlier also therefore, the claim was not much which is pending. He has come to this forum with request to get his claim settled by the insurance company. During the course of hearing complainant stated that his mother was insured for the amount of Rs. 1, 00,000 but company had allowed an amount of Rs. 84,015 though he submitted the claim for an amount of Rs. 4,00,000. He pleaded further that he is to be paid balance amount of the claim.

3. **Representative of the company stated that company closed the filed as no claim is pending.**

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 allowing the full claim, whereas Smt. Kanta Devi was insured for a mount of Rs, 1,00,000 but she was given only sum of Rs. 84015 against the claim amount of Rs. 4,00,000 merely because some papers were not filed by the claimant. Company was not justified in not allowing the full claim up to Rs. 1,00,000 being sum insured. Company had not provided in any details of deductions made by it while settling the claim. In my considered view complainant deserves to be paid balance amount of Rs. 15,985 (Rs. 1,00,000 – Rs. 84015). Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 15,985.**

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/251/NIC/11

In the matter of Sh. Shreyak Jhaveri.
Vs
National Ins. Co. Ltd.

AWARD DATED 25.10.2012 – NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Shreyak Jhaveri (hereinafter referred to as the complainant) against National Ins. Co. Ltd. (hereinafter referred to as respondent insurance company) relating to repudiation of mediclaim.**

2. **Complainant stated that he along with his family were covered under the group mediclaim policy of Medicare Service Club, Kolkata issued by National Ins. Co. Ltd. from 01.07.2001 to 30.06.2009 without any break for a sum of Rs.3,00,000. He got his policy renewed on 07.07.2009 and enhanced the sum insured to Rs.5 lacs. His wife Smt. Neeta Jhaveri got admitted in hospital on 17th May 2010 and underwent a surgery known as Sterrotic J Wire Insertion of left Breast+wide Excision Lupectomy. Micro calcification was detected on her routine examination only. He lodged the claim for Rs.94,948. National Insurance Company rejected his claim stating that this was the first year of the policy and the disease for which claim was made has waiting policy of 2 years. He further mentioned that he is covered since 2001 with public sector insurance companies only. Hence renewal with National Insurance Company cannot be termed as 1st year of the policy. He further submitted that he has been paying insurance premium since 2001 continuously and hence he requested this forum to consider his case sympathetically and direct the insurance company to pay him his claim of Rs.94,948. During the course of hearing also he requested for the benefit of continuity while submitting the proposal. he also requested to condone the delay but company did not communicate its decision and thus company is presumed to have condoned the gap in the policy period.**

3. **Representative of the company submitted the Biopsy report. Company was also required to submit the proposal for the policy period from 07.07.2009 to 06.07.2010 and representative was required to submit report within a week time but he did not submit any report.**

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 considered the reasons of the repudiation of the claim. After due consideration of the matter, I hold that company was not justified in repudiating the claim for the reasons as discussed in repudiation letter because the complainant was insured right from 01.07.2001 to 30th June 2009 either with National Insurance Company or with United Insurance Company and thereafter, with effect from 07.07.2009 with National Insurance Company. The disease for which claim was preferred has two years waiting period. The insured got the policy renewed by National Insurance Company with effect from 07.07.2009 under the bonafied belief that it being the public sector company it would allow him the continuity benefit he also requested to condone the gap and the company had not communicated its decision for waiving the gap .Thus, he was under the bonafied belief that gap in the policy might have been waived by the insurance company. It is also worth mentioning here that the complainant has been taking policy from the public sector insurance company. In my considered view complainant deserve to be given continuity benefit and thus it is held that company was not justified in repudiating the claim only on technical ground, the claim is payable. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs.83,123 .**
5. **The award shall be implemented within 30 days of receipt of the same. The compliance of the award shall be intimated to my office for information & record.**
6. **Copies of the Award to both the parties.**

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DELHI OMBUDSMAN CENTRE

Case No.GI/385/OIC/11

In the matter of Sh. Rajnish Bhatia.
Vs
Oriental Ins. Co. Ltd.

AWARD DATED 29.10.2012 : NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Rajnish Bhatia (hereinafter referred to as the complainant) against Oriental Ins. Co. Ltd. (hereinafter referred to as respondent insurance company) relating to repudiation of mediclaim.**

2. **Complainant stated that he had taken a mediclaim insurance policy bearing no. 271901/48/2011/2020 from Oriental Ins. Co. Ltd. He further submitted that his mediclaim policy is continued without any break for the last five years and he is renewing the mediclaim policy in time. On 17.04.2011 he got pain in his chest and got admitted in Maharaja Agrasen hospital. On investigation, he was found to have CAD- Acute Lateral Wall MI Double Vessel Disease. He contacted the TPA on 20.04.2011 and desired cashless approval for Rs. 1 lac but such facilities were denied to him. Accordingly he submitted his claim to the TPA on 26.04.2011. He was also required to submit other requisite documents which also he submitted on 30.10.2011. He also placed on record a certificate of Doctor that he was not suffering from any disease earlier. As a matter of fact his claim was approved for Rs.1,90,702 but he was communicated by the TPA through letter that his claim was repudiated. He also sent representation to the grievance redressal officer of the company but he was not favored with any reply. He has come to this forum with a request to get his claim settled. During the course of hearing also he pleaded that claim is payable but company denied it without any justification. He also pleaded that he deserves to be given a benefit of continuity in the policy.**

3. **Representative of the company stated that claim is not payable and the insured is not entitled to continuity benefit of the policy. Company also filed written reply dated 08.02.2012 wherein it was mentioned that claim is not payable due to clause 4.3 of the policy. It has been mentioned that claim in reference is to be settled only with reference to sum insured of Rs.1 lac.**

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 matter, I hold that complainant is entitled to the continuity benefit of the policy because he has been taking mediclaim insurance policy since five years. It is further held that there is no waiting period for the disease for which insured got admitted in the hospital and was treated. His claim is payable and is to be considered with reference of the sum insured as mentioned in the relevant policy period. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs.1,90,702 as per the assessment sheet of TPA.**

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

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

DELHI OMBUDSMAN CENTRE

Case No.GI/383/UII/11

In the matter of Sh. Shyam Sunder Sharda.
Vs
United India Ins. Co. Ltd.

AWARD DATED 29.10.2012 – INADEQUATE SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Shyam Sunder Sharda (hereinafter referred to as the complainant) against United India Ins. Co. Ltd. (hereinafter referred to as respondent insurance company) relating to non-settlement of mediclaim.**
2. **Complainant stated that he has been taking mediclaim policy from United India Ins. Co. Ltd. since 1999. He submitted that he was admitted in Vinayak hospital on 14.05.2011 and from there he was referred to Sir Ganga Ram hospital on 22.may.2011. He was admitted in Sir Ganga Ram hospital on 22.05.2011 and discharged on 25.05.2011 after treatment to coronary angiography. He put up the claim in Med assist (TPA) Pvt. Ltd., for an amount of Rs.4,12,080. He had received a sum of Rs. 1,35,000 vide D.D no. 388990 on 22.07.2011. This was on the basis of his illness in 2007 wherein his policy was for Rs. 1 lac + C.B 35,000 he submits further that there is no such clause in the policy that he would be paid on the basis of his illness in 2007. Moreover there is a difference in illness in 2007 and 2011. There are many diseases relating to heart and it is wrong to say it was the same disease. He further asserted that as per existing policy, he is entitled to Rs.2,18,750 (1,75,000+ C.B 43,750) though he pursued the matter with the insurance company and grievance cell but he did not receive any solution. He further stated that he is an old man of 79 yrs. And company is harassing him for no reason. He has come to this forum with a request to get him paid the due amount from the insurance company.**

3. **Representative of the company stated that claim was settled as per policy terms and conditions as applicable. He further submitted that in case of the complainant, claim was correctly settled with reference to the pre-enhanced sum insured.**

4. **I have considered the submissions of the complainant as well as of the representative of the company. After due consideration of matter and after perusing the claim process sheet, I hold that claim was not properly settled**

because in case of complainant the claim needs to be settled with reference to enhanced sum insured and cumulated-bonus because the disease for which claim was filed by the complainant was not the disease for which any specific waiting period was mentioned in the policy. In my considered view the claim has to be settled with reference to the sum insured relevant to the policy period when claim was made as the disease does not have any waiting period. Thus complainant is further found entitled to the relief of Rs.83,750. As per terms and conditions of the policy, complainant is entitled to a sum of Rs.2,18,750 whereas, complainant has been paid only a sum of Rs.1,35,000. Thus, he is further found entitled to a sum of Rs.83,750 (2,18,750-1,35,00). Accordingly an Award is passed with the direction to the insurance company to make further payment of Rs.83,750.

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

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DELHI OMBUDSMAN CENTRE

Case No.GI/416/NIA/11
In the matter of Sh. Sanjeev Bansal
Vs New India Assurance Company Ltd.

AWARD DATED 02.11.2012 REPUDIATION OF MEDICLAIM

1. **This is a complaint filed by Sh. Sanjeev Bansal (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 claim.**

2. **Complainant stated that has mediclaim policy issued from New India Assurance Company Ltd. bearing no. 31060034100100201253. It is further found that he has registered his claim with Raksha TPA for reimbursement of the expenses for the treatment of his daughter Ms. Radhika Bansal. TPA raised various quarries and complainant sent replies but the TPA had closed the file. He also approached the GRO of the company but he did not get any reply. He has come to this forum with request to look into the matter. During the course of hearing, complainant stated that claim was not settled so far by the insurance company though claim is payable.**

3. **Representative of the company stated that claim would be settled soon. Representative of the company was required to submit reply within a fortnight 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 because the claim is payable. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 17,987.**

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/418/OIC/11
In the matter of Sh. Ravi Kumar Sharma
Vs
Oriental Insurance Company Ltd.

AWARD DATED 2.11.2012 REPUDIATION OF MEDICLAIM

1. **This is a complaint filed by Sh. Ravi Kumar 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 his claim was not settled so far by the insurance company. He further informed that he had taken a Floater mediclaim insurance policy from M/s. Oriental Insurance Company Ltd. bearing no. 271601/48/2011/4772 for the period 31.12.2010 to 30.12.2011. He was informed by the TPA M/s. Vipul Medicorp Ltd. Gurgaon that claim was not payable as policy was one year old policy. He further submitted that policy had started from year 2003 from other insurance companies and has been continued since then. He renewed the policy from M/s Oriental Insurance Company Ltd. as he was informed by the manager of the**

Oriental Insurance Company Ltd. that policy would be considered as a continued policy and since all his other insurance policies are with the Oriental Insurance Company Ltd. transferred the policy but the TPA stated that the policy is of only one year. He further stated that his mother Mrs. Kaushalya Sharma was admitted in hospital. The claim was rejected by the Vipul TPa medicorp Ltd. During the course of hearing, complainant argued that he has been taking mediclaim policy since 2003. The claim is payable but the insurance company had denied it due to pre-existing disease.

3. **Representative of the company pleaded that claim is not payable due to pre-existing disease.**

4. **I have considered the submissions of the complainant as well as of the representative of the company. I have also perused repudiation letter dated 25.09.2012. After due consideration of the matter, I hold that claim is payable because complainant has been taking mediclaim policy right from 31.12.2003 and the same is continued till date. Company had not placed on record any evidence that the disease for which claim was submitted existed prior to inception 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. 4,24,230.**

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/391/NIC/11
In the matter of Smt. Neelam Chaudhary
Vs
National Insurance Company Ltd.

AWARD DATED 2.11.2012 NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Smt. Neelam Chaudhary (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 non-settlement of mediclaim.**

2. **Complainant stated that she put up claim with reference to mediclaim policy bearing no. 451500/46/09/8500000004. She submitted that cashless facility was denied. she was admitted in the hospital due to septicemia. She has approached the insurance company and she did all her efforts to get her claim but of no use. She has come to this forum with a request to get the claim paid. During the course of hearing complainant pleaded vehemently that claim is payable. She had submitted all requisite documents relating to the claim but company did not settle the claim so far.**

3. **Representative of the company pleaded that claim would be settled by the company. TPA filed letter dated 20.09.2012.**

4. **I have considered the submissions of the complainant as well as of the representative of the company. I have also perused the letter dated 20.09.2012 of TPA which is placed on record from which it appears that claim is payable and TPA had found it on reviewing that claim is payable. After due consideration of the matter, I hold that company was not justified in not settling the claim so far. The claim did not relate to maternity. As a matter of fact patient was admitted and treated for other disease unrelated to maternity. Therefore, claim is payable. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 61,600.**

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/445/Apollo/11
In the matter of Sh. Manish Aggarwal
Vs
Apollo Munich Health Insurance Company Ltd.

AWARD DATED 7.11.2012 REPUDIATION OF MEDICLAIM

1. **This is a complaint filed by Sh. Manish Aggarwal (herein after referred to as the complainant) against the decision of Apollo Munich Health Insurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to repudiation of mediclaim.**

2. **Complainant submitted his claim with reference to his policy bearing no. 110101/11051/1000083609. Complainant further submitted that he had filed his mediclaim with the insurance company on 14.03.2011 which was repudiated by the insurance company on 24.03.2011 stating the reason that the disease has two years waiting period. He further informed that he was admitted in an emergency condition on 05.01.2011 in Tirath Ram Sahay Hospital. Insurance company allowed the cashless facility to the extent of Rs. 12,000. He was discharged from the hospital on 06.01.2011. It was further mentioned by him that he has taken the mediclaim insurance policy from the present insurer in continuation with earlier insurer under the bonafide belief that he would be given the benefit of continuity of earlier policies by the present insurer. He has come to this forum with a request to get his claim paid. During the course of hearing, it was submitted by the complainant that he felt unconscious and advised by the doctor to get admitted in the hospital. Though company not only denied cashless facility but it denied the claim. He was not satisfied with the reasons given by the company for repudiating the claim. He has requested to ensure the payment of balance amount.**

3. **Representative of the company pleaded that insured was treated for ENT and so the disease has two years waiting period and the claim is not payable. Company also filed written reply dated 02.04.2012 wherein it has been mentioned that policy bearing no.110101/11051/1000083609 on 20.04.2011 for the non medical category for the period 12.05.2010 to 11.05.2011 was issued. This policy was renewed w.e.f 12.05.2011. It was further mentioned that claim was correctly repudiated in accordance with the 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 repudiation letter and also 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 because he was admitted in hospital as per advice of doctor. Insurance company has allowed cashless facility only for a sum of Rs. 12,000. In my considered view complainant is further entitled to a sum of Rs. 30,006. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 30,006.**

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/379/UII/11
In the matter of Sh. Gokul Chand
Vs
United India Insurance Company Ltd.

AWARD DATED 7.11.2012 REPUDIATION OF MEDICLAIM

1. **This is a complaint filed by Sh. Gokul Chand (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 submitted the claim papers late by 28 days that was because of the reason that when he got discharge from hospital, he had to reach to his village to see his ailing father. He get the news from his village that his father was seriously ill. Therefore, he reached his village rather than to submit papers to the insurance company in time. That was the reason to submit papers late to the insurance company. He had pursued the claim with the insurance company but the claim was not settled. He has come to this forum with request to get his claim settled. He did not attend the hearing, despite the allowance of two opportunities first on 17.09.2012 and lastly on 19.10.2012. He also pleaded that his claim relating to treatment of his wife was partially settled as he was paid a sum of Rs. 4941/- against claim of Rs. 98801.**

3. **Representative of the company pleaded that claim was filed late by 28 days and therefore claim was rejected by the TPA. Company also filed the written reply dated 30.07.2012 wherein, it was submitted that Sh. Gokul Chand Sharma was admitted in hospital on 15.11.2010 to 18.11.2010 due to illness known as Pyrexia. Intimation was not given to the TPA about the admission and the claim documents were submitted to TPA on 16.12.2010 for reimbursement. Thus intimation was given by the insured after 31 days and documents were submitted after 28 days of the discharge. Company hold that there was no genuine reason for late submission of the documents and the decision of the TPA to repudiate the claim was up held by the company. His earlier claim was settled properly.**

4. **I have considered the submissions of the complainant as well as of the representative of the company. I have also perused repudiation letter as well as the written reply of the company which are placed on record. After due consideration of the matter, I hold that company was not justified in rejecting the claim only on**

the technical ground. Company ought to have considered the claim on merits. The claim otherwise admissible could not be declined on technical ground. In my view claim is payable. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 9744 + 2269 = 12013.

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/321/OIC/11
In the matter of Sh. P.S. Bajaj
Vs Oriental Insurance Company Ltd.

AWARD DATED 9.11.2012 REPUDIATIN OF MEDICLAIM

1. **This is a complaint filed by Sh. P.S. Bajaj (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 and his wife were insured vide policy bearing no. 215200/48/2011/1688 on 04.02.2011. His wife was admitted to Max Super Specialty Hospital. She had thrown blood from her mouth, She was discharged after treatment and she incurred an expenditure of Rs. 33908 as medical expenses. The claim was made on 09.02.2011. He was required to submit further details vide TPA letter dated 21.02.2011. Such requirements were immediately complied with. He further submitted that even after 4 months, the claim was not processed. He further submitted that she has been taking this policy for the last 20 years. Complainant did not attend on the date of hearing for the first time on 25.07.2012 but attended the hearing on 31.10.2012 and pleaded that claim was payable.**

3. **Representative of the company pleaded that claim is not payable because no active treatment was taken by the patient in the hospital and patient was admitted only for investigation purposes. There claim was repudiated.**

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 because claim was payable. Patient**

was admitted in the hospital and was also treated. She was admitted in the hospital under emergency condition. For proper diagnosed, tests were required to conduct on the patient. 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.**

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DELHI OMBUDSMAN CENTRE

Case No.GI/306/RGI/11
In the matter of Sh. Ravi Bhalla
Vs Reliance General Insurance Company Ltd.

AWARD DATED 9.11.2012 NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Ravi Bhalla (herein after referred to as the complainant) against the decision of Reliance General Insurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to non settlement of mediclaim.**

2. **Complaint relates to a non issuance of this year's policy in continuation to the previous policy and hence denial of reimbursement for the latest insurance claim for cataract surgeries. Complainant had been pursuing the matter through e-mail and also by personal visits to the office from where policy was issued. Complainant had complaint against the employees of the insurance company and for not renewing the policy in time even after persuasion of the complaint. He visited the company before expiry of the previous policy but the insurance company refused to either back date the current policy or giving the policy holder an endorsement allowing him to claim the reimbursement for his cataract surgeries carried out in April 2011. During the course of hearing, it was pleaded that gap in the policy was on account of the non co-operation of staff of the company. He handed over the cheque for renewal on 27.10.2010 but the company misplaced the cheque. He again issued the cheque dated 01.11.2010 but company presented the cheque for encashment on 08.12.2010 and policy was accordingly issued w.e.f. 03.12.2010.**

3. **Representative of the company promised to look into the matter and admissibility of the claim but that remained only an assurance.**

4. **I have considered the submissions of the complainant as well as of the representative of the company. After due consideration of the matter, I hold that claim is payable and gap in the policy due to the fault of the company. Insured had timely made the payment for renewal. It has been the fault of the company to misplace the same. Complainant had again given the cheque on 1.11.2010 and that was also put up for encashment much later on 08.12.2010. Therefore, company is required to waive the gap in the policy period. Complainant is not to suffer on account of fault of the company. Accordingly it is held that claim is payable. Thus an Award is passed with the direction to the insurance company to make the payment of Rs. 44,200.**

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/307/RGI/11
In the matter of Sh. Manish Kumar
Vs Reliance General Insurance Company Ltd.

AWARD DATED 9.11.2012 PARTIAL SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Manish Kumar (herein after referred to as the complainant) against the decision of Reliance General Insurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to partial settlement of motorclaim.**

2. **Complainant stated that his mother Smt. Madhu Rani owned a vehicle with registration no. DL3CQ7438 which was insured by Reliance General Insurance Company Ltd. for the period 14.11.2010 to 13.11.2010 but unfortunately the vehicle got stolen from the main road in front of hanuman Mandir, Kashmiri Gate, Delhi on 13.11.2010. As a matter of fact, he was inside Hanuman Mandir and when he came out of the temple, he came to know that vehicle was not there. He reported the theft at PCR helpline no. 100 vide DD no.36A on 13.11.2010 and also lodged the FIR bearing no. 232/2010 at Police Station, Kashmiri Gate. He also reported the matter to the insurance company. He further submitted that he also reported the fact of theft of the insured vehicle in due time to the Reliance General**

Insurance Company and its surveyor and submitted all requisite documents to the insurance company. During the course of hearing, It was pleaded by the complainant that company had paid a sum of Rs. 2,47,000 as against the IDV of Rs. 2,75,000. Thus company settled the claim less by an amount of Rs. 28,000. He requested that company directed to pay a sum of Rs. 28,000.

3. **Representative of the company stated that claim was settled as per consent of the policy holder. However, company will consider refunding of the premium receipt for renewal of the vehicle. Policy for subsequent period w.e.f. 14.11.2010 to 13.11.2011.**

4. **I have considered the submissions of the complainant as well as of the representative of the company. After due consideration of the matter, I hold that since claim was settled by the insurance company as per consent of the insured. In my considered view complainant is not entitled to any further relief. As regards the premium given by the insured to the company for the period 14.11.2010 to 13.11.2011, as the vehicle was stolen on 30.11.2010 i.e. the last day of the previous policy, Complainant well deserves the refund of the premium for the policy period 14.11.2010 to 13.11.2011. Accordingly an Award is passed with the direction to the insurance company to refund the premium amount of Rs. 9019.**

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/356/IFFCO Tokio/11
In the matter of Sh. Tupen Armaud
Vs IFFCO TOKIO General Insurance Company Ltd.

AWARD DATED 9.11.2012 REPUDIATION OF MOTOR CLAIM

1. **This is a complaint filed by Sh. Tupen Armaud (herein after referred to as the complainant) against the decision of IFFCO TOKIO General Insurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to repudiation of motor claim.**

2. **This complaint related to theft of vehicle bearing registration no. 25CDP37. Complainant submitted that the vehicle was stolen on 18.01.2011. He had reported the theft of this care bearing registration no. 25CDP37 on 18.01.2011 to the police station Subdarjan enclave on the basis of which FIR no. 16/11 was registered under section 379 of IPC. He further submitted that despite the fact the police was able to arrest the accused who had taken the car but police had not recovered the car. He had informed to M/s IFFCO Tokio about the theft of the vehicle. Claim was registered by the insurance company. However, the insurance company rejected the claim vide its letter dated 26.05.2011. The company presumed that ignition key of the vehicle was left inside when it was left unattended and which was termed as by the company as gross negligence and failure to take reasonable care to prevent and protect the vehicle from loss and damage. He further submitted that argument of the company there was violation of condition no-5 of the policy was absolutely un called for. He has come to this forum with a request to get the claim paid. Complainant did not attend the hearing being a foreign citizen.**

3. **Representative of the company pleaded that claim is not payable due to gross negligence on the part of the driver of the owner of vehicle. The driver left the ignition key in the vehicle and the same was taken away. There was violation of condition no. 5 of the policy. company also filed written reply dated 21.10.2011 wherein, it was mentioned that a Tyota Inova car bearing registration no. 25CDP37 was insured vide policy no. 73967696 for the period 19.09.2010 to 18.09.2011. This car was stolen on 18.01.2011 while it was unattended and keys were left in the ignition of the vehicle.**

4. **I have considered the submissions of the complainant as well as of the representative of the company. After due consideration of the matter, I hold that company was not justified in repudiating the claim because insured had suffered a total loss because his insured vehicle was stolen during the currency of the policy. Though some persons were arrested in this regard but the vehicle remained un traced. Therefore, it is held that insured suffered the total loss and he needs to be compensated for the loss/damage sustained by him. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 8,39,000.**

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/453/NIA/11
In the matter of Smt. Rama Naidu
Vs New India Assurance Company Ltd.

AWARD DATED 16.11.2012 NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Smt. Rama Naidu (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 non settlement of mediclaim.**

2. **Complainant stated that her claims were not settled properly by the insurance company. she has requested the New India Assurance Company Ltd. a number of times and then approached the Chairman of the company but company had not settled her claims satisfactorily. She further stated that TPA has been harassing her by making repeated request for submission of original bills though she had already submitted replies to such queries. She states that she is an unemployed woman trying to live with dignity despite the disease she is suffering from. Since insurance company does not have the cashless agreement with Apollo hospital, she has to pay the cost of treatment by borrowing money and since company had not settled the claims, she is not in a position to repay the loan. She has come to this forum with a request to get her claims settled at an early date. During the course of hearing also, she pleaded that her claims are pending since long. She was not justified with the settlement of the claims as the claims were not settled properly and fully. She further submitted that the claims related to the policy period wherein, co-pay condition was not stipulated.**

3. **Representative of the company pleaded that claims had been settled as per terms and conditions of the policy. company also filed reply dated 31.10.2012 wherein it has been stated that company can charged premium even up to 200% of charged premium by loading up to 200% of basic premium. This loading/excess should be applied only after completion of minimum of 2 policy period. it was further mentioned that in the year 2010-11 already 100% loading and 15% co-payment is included in the policy but due to change in software in year 2011-12 i.e. from Gensiys to CWISS and due to oversight the co-payment was not mentioned on the face of the policy no. 31150334110100000146 and it was further pleaded that claims were settled by the Raksha TPA as per terms and conditions of the policy. It was further mentioned that co-payment has to be made by the insured.**

4. **I have considered the submissions of the complainant as well as of the representative of the company. I have also perused the written reply of the company. After due consideration of the matter, I hold that company was not justified in applying the co-payment provision when the same was not stipulated on the face of the policy for the period from 06.05.2011 to 05.05.2012. Since co-payment percentage of SI is not stipulated in the policy to which all the 4 claims relate, company is under obligation to settle these claims without applying co-payment percentage of SI. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 3,68,574/- subject to deduction of any payment made if any to the ensured.**

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/439/NIC/11
In the matter of Smt. Prem Lata Sagar
Vs National Insurance Company Ltd.

AWARD DATED 20.11.2012 REPUDIATION OF MEDICLAIM

1. **This is a complaint filed by Smt. Prem Lata Sagar (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 claim for Rs. 23,580 was submitted to M/s Raksha TPA Pvt. Ltd. but the TPA had rejected the claim with the observation that patient was hospitalized as a diagnosed case of L4-L5 and was treated conservatively with 18 mg injection and discharged with follow up advice. As per policy conditions of National Insurance Company OPD procedure is not covered hence the claim stands not payable. Insured wrote to the TPA that the claim is payable under clause 2.6 of the policy which states that if an operation is done under anesthesia, the claim is payable even if the patient does not remain in the hospital for 24 hours.**

Complainant further submitted that patient was in the hospital from 7:00 am to 7:00 pm and it was on his resistance that he was discharged from the hospital because he had no intention to stay in the hospital until next morning. During the course of hearing also, complainant stated that claim was payable but company had denied it due to wrong reasons and as per clause 2.6 of the policy, the claim is payable.

3. **Company was not represented on the date of hearing.**

4. **I have considered the submissions of the complainant. I have also seen the letter of the company addressed to the insured. After due consideration of the matter, I hold that company was not justified in rejecting the claim because insured's case is very well covered under clause 2.5 of the policy. As per definition of surgery from clause 2.5 of the policy one can conclude that relief from suffering is also surgery and in case of insured injection was given to give relief to the insured from suffering. It is also covered in the surgery. Therefore, 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.**

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DELHI OMBUDSMAN CENTRE

Case No.GI/406/UII/11

In the matter of Sh. Prabhu Dayal.

Vs

United India Ins. Co. Ltd.

AWARD DATED 5.11.2012 : DELAY IN SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Prabhu Dayal (hereinafter referred to as the complainant) against United India Ins. Co. Ltd. (hereinafter referred to as respondent insurance company) relating to repudiation of mediclaim.**

2. **Complainant stated that he had taken mediclaim policy bearing no.221503/48/10/97/00000682. He further submitted that Naresh Kumar got admitted**
   in the hospital on 25.9.2010. He submitted bills along with requisite documents to the insurance company for payment, but he did not get any response from the insurance company. He also approached grievance redressal office of the company but he did not get response from there too. He has come to this forum with a request to get him paid his mediclaim at an early date. He did not attend the hearing.

3. **Representative of the company agreed to settle the claim as per terms and conditions of the policy. He was required to submit report in this regard but he did not submit any report.**

4. **I have considered the submissions of the complainant as submitted in the complaint. I have also considered the submissions of the representative of the company, promise made by the representative of the company to settle the claim early, remained only an assurance. I have also perused repudiation letter dated 25.11.2010 wherein, it has been mentioned that claim was repudiated only because of the fact that patient did not intimate the insurance company about the admission in the hospital. After due consideration of matter, I hold that company was not justified in repudiating the claim only because intimation was not given about hospitalization. Company did not consider the case on merit. In my considered view claim is payable. Accordingly an Award is passed with the direction to the insurance company to make payment of Rs.21,256 along with the panel interest at the rate of 9% from the date of repudiation (25.11.2010) to the date of actual payment.**

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

   Copies of the Award to both the parties.

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DELHI OMBUDSMAN CENTRE

Case No.GI/395/NIA/11

In the matter of Smt. Harminder Kwatra.

Vs

New India Assurance Co. Ltd.

AWARD DATED 5.11.2012 : INADEQUATE SETTLEMNT OF MEDICLAIM

1. **This is a complaint filed by Smt. Harminder Kwatra (hereinafter referred to as the complainant) against New India Assurance Co. Ltd. (hereinafter referred to as respondent insurance company) relating to partial settlememt of mediclaim.**

2. **Complainant stated that she has been taking mediclaim policy since 2000 from New India Assurance Co. Ltd., New Delhi and did not claim any amount from the company till May,2011. On 01.05.2011 she felt pain in Gall Bladder and got admitted at Sir Ganga Ram hospital, Rajinder Nagar and was operated on 03.05.2011 and was discharged on 04.05.2011. on admission to the hospital, she approached Raksha TPA for cashless facility, despite repeated telephone calls to TPA from the hospital, such facility was not approved and consequently she had to pay enter amount of the bill for her treatment to the hospital. She submitted the bill for reimbursement on 10.05.2011 to Divisional Manager of New India Assurance Co. Ltd. for an amount of Rs.49,673. Raksha TPA passed the bill only for an amount of Rs.36,281 on 30.06.2011 she took up the matter again for the balance amount and subsequently bill for Rs.8,069 was passed. During the course of hearing it was pleaded that company was not justified in making deductions while settling the claim company had paid only a sum of Rs.44,350 and she pleaded that she will be paid the balance amount of Rs.5,323.**

3. **Representative of the company pleaded that claim was settled as per term and conditions of the policy and company had paid 44,350 out of total claim of Rs.49,673.**

4. **I have considered the submissions of the complainant as well as of the representative of the company. I have also perused the process sheets. After due consideration of matter, I hold that company had settled the claim partially. Deductions made while settling the claim was not made with sufficient reasons. Accordingly complainant needs to be further compensated. Thus an Award is passed with the direction to the insurance company to make further payment of Rs.3,226.**

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

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

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DELHI OMBUDSMAN CENTRE

Case No.GI/412/OIC/11

In the matter of Sh. Abhishek Gupta.

Vs

Oriental Ins. Co. Ltd.

1. **This is a complaint filed by Sh. Abhishek Gupta (hereinafter referred to as the complainant) against Oriental Ins. Co. Ltd. (hereinafter referred to as respondent insurance company) relating to repudiation of mediclaim.**

2 Complainant stated that he had filed the claim for Rs.30,438 for treatment of his wife Mrs. Supriya Gupta on 04.02.2011 to the insurance company. The insurance company rejected the claim stating that his wife was treated for viral fever, Vit-A deficiency etc. The TPA concluded that treatment was given primarily for psychiatric purposes. Complainant further stated that he was not satisfied with the decision of the TPA, he also sent his representation to grievance redressal office of the company. He has requested this forum to get him reimbursed the hospitalization expenses. During the course of hearing complainant stated that claim was payable but company had denied it.

3 Representative of the company argued that claim was not payable as per terms and conditions of the policy in view of exclusion 4.8 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 repudiation letter. After due consideration of matter, I hold that company was not justified in repudiating the claim because insured was admitted and got treatment at the hospital. 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.30,438.

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

6 Copies of the Award to both the parties.

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DELHI OMBUDSMAN CENTRE

Case No.GI/396/NIA/11

In the matter of Sh. Amar Bahadur.

Vs

New India Ins. Co. Ltd.

AWARD DATED 5.11.2012 : NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Amar Bahadur (hereinafter referred to as the complainant) against New India Ins. Co. Ltd. (hereinafter referred to as respondent insurance company) relating to non-settlememt of mediclaim.**
2. **Complainanat stated that his son who is 40 years of age has been feeling pain in his back from the last six years. Recently he was diagnosed to have Spinal Tumour which he was advised surgery on urgent basis. He had gone to Max hospital Saket for the treatment of his son. Company refused to give cashless facility despite the fact that he has been taking mediclaim insurance policy since 2004. He was having no option but to get his son operated. Fortunately surgery was performed successfully and patient was discharged after some days. He had to pay the bill of the hospital for about 2 lacs. He further submitted that he is working as a driver in private company and is drawing salary. He is getting only a sum of Rs.17,000 per month and he has to take care of his family. He had to take loan on heavy interest to get his son operated. He had taken a policy and the same is continued without break. He changed his insurance from New India Assurance to Reliance Ins. Company. He is an illiterate man, company had rejected his claim. He has come to this forum with a request to get his claim paid. During the course of hearing it was stated by him that he is taking mediclaim policy from 2002 without any break. He pleaded that company denied the claim without any justification.**
3. **Representative of the company pleaded that claim is not payable as the disease for which claim was submitted has two years of waiting period and the claim was made in the second year of the policy period. Company also filed 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 letter dated 14.11.2011 which states that TPA was justified to repudiate the claim as ailment suffered was falling under first two years of and according to policy conditions 4.3 claim is not payable. After due consideration of matter, I hold that company was not justified in repudiating the claim on the ground that claim was put up in the 2nd year of the policy period because complainant was taking mediclaim insurance policy with effect from 27.04.2004 continuously. It is to be mentioned here that complainant took policy from New India Assurance with effect from 27.04.2004 to 26.04.2006, thereafter with Reliance General Ins. Co. with effect from27.04.2006 to 26.04.2009 and thereafter from New India Assurance with effect from 27.04.2009 which is continued till date. It is to be noted that policy is continued without any break and claim was put up in the 7th policy period. In my considered view since policy is running without any gap, complainant is required to be given the benefit for the continuity in the policy. The claim was not made in the second policy period. In my considered opinion claim is payable. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 1,83,469.**

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

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DELHI OMBUDSMAN CENTRE

Case No.GI/419/STAR/11

In the matter of Smt. Seema Aggarwal.

Vs

Star Health & Allied Ins. Co. Ltd.

AWARD DATED 8.11.2012 : INADEQUATE SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Smt. Seema Aggarwal (hereinafter referred to as the complainant) against Star Health & Allied Ins. Co. Ltd. (hereinafter referred to as respondent insurance company) relating to mediclaim.**

2. **Complainant stated that she took a mediclaim policy bearing no.161211/01/2012/000042 from Star Health and Allied Ins. Co. Ltd. she further stated that she became ill all of a sudden on 26.06.2011 and she had to be admitted in a hospital in Uttam Nagar at Gandhi Nursing Home. As a matter of fact, she was admitted in the hospital on the advice of the doctor. Company was informed about her admission but company denied cashless facility. Therefore, she had to arrange for making payment of the hospital bill when she was discharged. She further stated that company was deliberately withholding the claim. She has come to this forum with a request to get her mediclaim settled. She did not attend the hearing.**

3. **Representative of the company pleaded that claim was settled as per terms and conditions of the policy. Company was requested to file the details of settlement and also the reasons for making deductions while settling the claim but company had not provided the claim process sheets and also the reasons for making deductions.**

4. **I have considered the submissions of the complainant as well as of the representative of the company. I have also very carefully perused the letter dated 03.01.2012 written by the company to the insured stating that her claim is payable only to extent of Rs.42,479 and have sent demand draft to her with amount. I have also perused bill assessment sheet. After due consideration of matter I hold that company was not justified in partially settling the claim. As per assessment sheet provided a sum of Rs.42,471 is payable against the claim of an amount of Rs.92,516. On careful perusal of the reasons for not allowing claimed amount under various heads, I find that reasons have been given vaguely. There appears to be arbitraries on the part of the company to restrict the stay in the hospital only to 7 days. In my considered view complainant needs to be given the claim with reference to the total stay in the hospital. There does not seem to be any worthwhile reasons to restrict the stay in the hospital for seven days. Complainant needs to be further paid. Accordingly an Award is passed with the direction to the insurance company to make payment of Rs. 91,677 subject to deduction of amount already paid if any.**

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

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DELHI OMBUDSMAN CENTRE

Case No.GI/432/STAR/11

In the matter of Sh. Vivek Sharma. Vs Star Health & Allied Ins. Co. Ltd AWARD DATED 8.11.2012 : DENIAL OF MEDICLAIM

1. **This is a complaint filed by Sh. Vivek Sharma (hereinafter referred to as the complainant) against Star Health & Allied Ins. Co. Ltd. (hereinafter referred to as respondent insurance company) relating to mediclaim settlement.**

2. **Complainant submitted that he had sent his representation to the grievance redressal office of the company. He was admitted in Jaipur hospital in emergency situation. He was informed that cashless facility may not be possible however expenses can be reimbursed. Therefore, after treatment, he submitted the requisite documents on 03.05.2011 but no response despite repeated calls and visits to the office. He further submitted that Star Health has fraudulently denied his claim and questioning his integrity that he had hidden the disease. He further stated that his claim is payable. He has come to this forum with a request to get his claim settled. He did not attend on the date of hearing.**

3. **Representative of the company pleaded that claim was settled as per terms and conditions of the policy. Company informed the insured vide this letter dated 21.02.2012 that company had considered the claim and accepted the settlements in terms of policy and had paid a sum of Rs.42,283 vide demand draft bearing no.716403 payable on Standard Chartered Bank dated 20.02.2012 in full and final payment of the bill for hospitalization. Company also later on furnished bill assessment sheets.**

4. **I have considered the submissions of the complainant as well as of the representative of the company. I have also perused latter dated 21.02.2012 and also bill assessment sheets. After due consideration of matter I hold that company had made certain deductions which were not required while settling the claim company had paid only a sum of Rs.42,283 out of total claim of Rs.47,398. Thus making deductions of Rs.5,115. Complainant needs to be paid further. Accordingly an Award is passed with the direction to the insurance company to make further payment of Rs. 2,215.**

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

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

DELHI OMBUDSMAN CENTRE

Case No.GI/452/UII/11

In the matter of Sh. Sunil Kr. Khetarpal.

Vs

United India Ins. Co. Ltd.

AWARD DATED 8.11.2012 : DENIAL OF MEDICLAIM

1. **This is a complaint filed by Sh. Sunil Kr. Khetarpal (hereinafter referred to as the complainant) against United India Ins. Co. Ltd. (hereinafter referred to as respondent insurance company) relating to mediclaim settlement.**

2. **Complainant submitted that he is having policy bearing no.222700/48/09/97/00001559 issued by the United India Ins. Co. Ltd. He was hospitalized and filed claim papers but the claim was rejected by the insurance company. He had sent his representation to the grievance redressal office of the company. He has come to this forum with a request to get his claim settled.**

3. **Representative of the company pleaded that claim is not payable due to policy clause 4.8. company also filed written reply dated 18.01.2012 wherein it has been mentioned that Sh. Sunil Kr. GKhetarpal age 48yrs was admitted at Pushpanjali Crosslay Hospital Ghaziabad on 02.02.2010 and was discharged on 09.02.2010. he was diagnosed as case of Carcinoma Right Upper Alveolus . It was further mentioned in the reply that as per case prescription of Dr. Puneet Gupta dated 01.02.2010 patient was a known case of Tobacco Chewing and the disease was a direct complication of the Tobacco chewing therefore, claim was found not payable as per clause 4.8 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 reply of the company dated 30.10.2012 which is placed on record and also repudiation letter dated 09.07.2010. After due consideration of matter, I hold that company was not justified in repudiating the claim because to facts of the complainant, clause 4.8 of the policy is not applicable. Accordingly an Award is passed with the direction to the insurance company to make payment of Rs. 2,10,000.**

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

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DELHI OMBUDSMAN CENTRE

Case No.GI/428/NIA11

In the matter of Smt. Joita Soni.

Vs

New India Assurance Co. Ltd.

AWARD DATED 8.11.2012: NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Smt. Joita Saini (hereinafter referred to as the complainant) against New India Assurance Co. Ltd. (hereinafter referred to as respondent insurance company) relating to settlement of mediclaim.**

2. **Complainant submitted that she had filed a claim with reference to her policy bearing no.312800/34/09/11/000001685. Claim was partially settled by the insurance company. She has followed the claim with insurance company since 28.09.2011 and also sent representation to the grievance redressal office of the company. She further stated that she and her husband have been taking the mediclaim policy for the last ten years. She was diagnosed a case of Carcinoma Breast Stage-2 for which she was treated for about a year . Facts relating to the case were submitted to the insurance company. Her claim was rejected by the insurance company without any valid reason. She further stated that she is of sixty years of age with Multiple Health complications. She has come to this forum with a request to get her claims settled. During the course of hearing also it was pleaded by the complainant that her claims were not settled as per terms and conditions of the policy, she has been taking insurance policy for the last 11yrs.**

3. **Representative of the company submitted that complainant had filed four claims which were settled. She is further entitled to a sum of Rs.23,140. Company also filed written reply, wherein it has been mentioned that all the claims were 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. After due consideration of matter, I hold that there appears to be considerable force in the arguments of the complainant that her**

claims have not been properly settled. Company had settled the claims partially. Complainant also pleaded during the course of hearing that she had not received a sum of Rs.73,794 as asserted by the insurance company. During the course of hearing representative of the company admitted that complainant is found further entitled to a sum of Rs.23,140 which also strengthens the belief that claims have not been settled properly. The complainant is thus found entitled to further relief. Accordingly an Award is passed with the direction to the insurance company to make further payment of Rs. 96934 (73794+23140).

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

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DELHI OMBUDSMAN CENTRE

Case No.GI/390/NIC/11
In the matter of Sh. Harinder Dutt Sharma.

Vs

National Ins. Co. Ltd.

AWARD DATED 16.11.12 : REPUDIATION OF MEDICLIAM

1. **This is a complaint filed by Sh. Harinder Dutt Sharma (hereinafter referred to as the complainant) against National Ins. Co. Ltd. (hereinafter referred to as respondent insurance company) relating to repudiation of mediclaim.**

2. **Complainant submitted that he had submitted all requisite documents to the insurance company relating to the claim for enabling it to make the payment. He also approached the grievance redressal office of the company but he has not been favoured with any reply. He has come to this forum with a request to get his claim settled. During the course of hearing also complainant stated that claim was payable but company had denied it.**

3. **Representative of the company stated that claim was not payable due to pre existing disease. Company also submitted written reply dated 30.12.2011 wherein it was mentioned that the claim was reviewed by TPA M/s Akankit health care TPA Ltd. and it was observed that patient was a known case of CAD, PTCA 1.5 yrs back with HTN on regular treatment. Policy is in 2nd yr which makes the disease pre existing and for these reasons claim is inadmissible as per clause 4.1 of this policy.**

4. **I have considered the submissions of the complainant as well as of the representative of the company. after due consideration of matter I hold that company was not justified in denying the claim due to pre existing disease because the illness for which the insured got admitted in the hospital and got the treatment did not exist prior to taking the policy. Therefore in my considered view, claim is payable. Accordingly an Award is passed with the direction to the insurance company to make payment of Rs.53,893.**

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

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DELHI OMBUDSMAN CENTRE

Case No.GI/333/STAR/11

In the matter of Sh. Sandeep Kumar.

Vs

Star Health & Allied Ins. Co. Ltd.

1. **This is a complaint filed by Sh. Sandeep Kumar (hereinafter referred to as the complainant) against Star Health & Allied Ins. Co. Ltd. (hereinafter referred to as respondent insurance company) relating to partial settlememt of mediclaim.**

2. **Complainant stated that his mother Smt. Saroj Bala was admitted at Sunder Lal Jain hospital on Doctor's advice. She was suffering from Severe Headache, she was treated for the same in the hospital, she submitted bill for hospitalization treatment for Rs.26,150. Company had approved only for Rs.4,000. Company could not give any reasonable and correct reason for this. He also approached the grievance redressal office of the company but he was not satisfied with the reply. He has come to this forum with a request to get the claim settled. During the course of hearing it was pleaded by the complainant that claim was payable but the company had not paid the full amount.**

3. **Representative of the company argued that claim was not payable as no active treatment was taken by the insured.**

4. **I have considered the submissions of the complainant as well as of the representative of the company. I have also perused the letter dated 10.02.2011**

written by the insurance company wherein it has been mentioned that company has received final bills for Rs.25,769 from the hospital and settled the claim with the hospital on 25.01.2011 for sum of Rs.3,627 as per pre authorization granted to the hospital. According to company that was the maximum permissible amount for the treatment of the insured in the hospital. After due consideration of matter, I hold that company was not justified in stating that the sum of Rs.3,627 was the maximum permissible amount t to the insured for the treatment of the hospital because insured had incurred the expenditure of Rs.25,769. Accordingly an Award is passed with the direction to the insurance company to make further payment of Rs. 2,6150 less amount paid earlier.

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

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DELHI OMBUDSMAN CENTRE

Case No.GI/468/NIA/11
In the matter of Sh. Ravi Krishan Aggarwal
Vs
New India General Insurance Company Ltd.

AWARD DATED 20.12.2012 INADEQUATE SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Ravi Krishan Aggarwal (herein after referred to as the complainant) against the decision of New India General Insurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to inadequate settlement of mediclaim.**

2. **Complainant stated that he has been taking mediclaim insurance policy since 07.03.2002. The current policy bearing no. 31160034100100200612 is for the period 10.03.2011 to 09.03.2012. He further submitted that on 31.03.2011, he had serious medical problem and on advise of his family doctor Dr. R.L. Passi, he was rushed to National Heart Institute, East of Kailash for immediate medical treatment. Since, he was covered under captioned medical insurance policy, the hospital referred the case to Raksha TPA who advised them to proceed for treatment and later on take reimbursement as per letter dated 02.06.2011. On 23.06.2011, he had submitted the claim for Rs. 54,925 along with all relevant original documents. But the insurance company had not settled the claim. As a**

matter fact, insurance company repudiated the claim vide its letter dated 07.12.2011. As per doctors hospital certificate, his position on 31.05.2011 was precarious and anything could have happened to him and thus his admission in the hospital was necessary for requisite investigation. He has come to this forum with a request to get his claim settled at an early date. During the course of hearing, it was pleaded by him that claim was payable. He further informed this forum that out of claim of Rs. 54,925, company had paid a sum of Rs. 28,059 to him and company is to pay balance amount. The sum insured was Rs. 3 lacs. Company was not justified in not making deductions to the tune of Rs. 26,868.

3. **Representative of the company argued that claim was settled as per terms and conditions of the policy and nothing further is admissible to him. Company filed reply dated 23.011.2012 wherein, it was mentioned that amount payable under 2.3 and 2.4 shall be at the rate applicable to entitled room category. In case insured opts for a room with rent higher than the entitled category as under 2.1, the charges payable under 2.3 and 2.4 shall be limited to the charges applicable to entitled category. As the insured has taken a policy of 3 lacs and his entitled room category is of 1% SI per day i.e. 3000 but he has taken treatment with higher room rent. So proportionate charges are payable as per 2.4 and 2.1, deduction of Rs. 13948 is justified on this ground.**

4. **I have considered the submissions of the complainant as well as of the representative of the company. I have also perused the reply dated 23.11.2012 which is placed on record. After due consideration of the matter, I hold that there appears to be no justification to make deductions in respect of diagnostic charges, as such charge does not depend on the room that patient occupies. In my considered view such deduction was not called for and the complainant is entitled to relief to this extent. Accordingly an Award is passed with the direction to the company to make the payment of Rs. 13,948.**

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/463/NIA/11
In the matter of Sh. Gian Prakash
Vs
New India Assurance Company Ltd.

AWARD DATED 20.12.2012 NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Gian Prassad (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 non settlement of mediclaim.**

2. **Complainant stated that he had filed a mediclaim bill for an amount of Rs. 13,793 for his hospitalization in Kalyani Hospital. The insurance company declined the same after an inordinate delay of 7 months. He also had made the representation to the GRO of the company but no satisfactory reply was given to him. He further informed that he got paralysis 9 years ago and since then he had been incurring expenditure on his domiciliary treatment. He is a retired person and pensioner. He has come to this forum with request to instruct the insurance company to reimburse him a sum of Rs. 13,793 along with a interest. During the course of hearing, authorized representative of the complainant sated that claim was payable but company had denied it. Company did not respond to the various letters written by the insured to reconsider its decision.**

3. **Representative of the company argued that claim was not payable due to the fact that insured was admitted only for investigation purposes and no active treatment was taken.**

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 because insured was treated in the hospital after taking admission. The complainant filed all the documents relating to admissibility of the claim relating to hospitalization. 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. 12613.**

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/456/RGI/11
In the matter of Sh. Bhupesh Garg
Vs
Reliance General Insurance Company Ltd.

AWARD DATED 21.12.2012 REPUDIATION OF MEDICLAIM

1. **This is a complaint filed by Sh. Bhupesh Garg (herein after referred to as the complainant) against the decision of Reliance General Insurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to repudiation of mediclaim.**

2. **Complainant stated that company was not justified in repudiating the mediclaim for an amount of Rs. 26,656 relating to the hospitalization expenses of his wife Mrs. Preeti Garg. The mediclaim policy UCO Bima Medicare scheme was in force since 01.12.2006. It is further mentioned by the complainant that company had arbitrarily repudiated the claim without looking into the fact and it was ignored that policy was in force from the last 4 years. He had already sent his representation to the GRO of the company but he was not satisfied with the reply given by the GRO of the company. He has come to this forum with a request to get the claim settled. During the course of hearing, it was pleaded by the complainant that the patient was covered in the Group mediclaim policy.**

3. **Representative of the company pleaded that claim is not payable due to pre existing disease. Company also filed written reply dated 19.11.2012 wherein it was mentioned that complainant obtained Reliance UCO bank family floater policy valid from 01.12.2009 to 30.11.2010 covering himself with his two daughters and his wife. On 26.07.2010 Mrs. Preeti Garg was admitted at Sir Ganga Ram Hospital as a case of Post Menopausal bleeding with Endometrial polyp for which she underwent HPV/Pap smear with colposcopy, hysteroscopic polypectomty and D & C and discharged on 27.07.2010.**

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 and also a repudiation letter. After due consideration of the matter, I hold that company was not justified in denying the claim because claim was filed by the insured in the 4th policy period. Complainant was covered in the Group mediclaim policy continuously. 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.26656 along with penal interest with effect from 01.10.2010 till the date of payment at the rate of 8%.**

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/457/RGI/11
In the matter of Sh. Munna
Vs
Reliance General Insurance Company Ltd.

AWARD DATED 21.12.2012 NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Munna (herein after referred to as the complainant) against the decision of Reliance General Insurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to non settlement of mediclaim.**
2. **Complainant stated that company was not justified in repudiating the mediclaim for an amount of Rs. 1,63,500 relating to the hospitalization expenses of his wife Mrs. Laxmi. The mediclaim policy UCO Bima Medicare scheme was in force since 01.12.2006. It is further mentioned by the complainant that company had arbitrarily repudiated the claim without looking into the fact that policy was in force for the last 4 years. He had already sent his representation to the GRO of the company but he was not satisfied with the reply given by the GRO of the company. He has come to this forum with a request to get the claim settled. During the course of hearing, it was pleaded by the complainant that the patient is covered in**

the Group mediclaim policy in which he was insured was taken from the National Insurance Company.

3. **Representative of the company pleaded that claim is not payable due to pre existing disease. Company also filed written reply dated 20.11.2012 wherein it was mentioned that complainant obtained Reliance UCO bank family floater policy valid from 01.12.2009 to 30.11.2010 covering himself, with his son and his wife Mrs. Laxmi. On 18.10.2012 Mrs. Laxmi got admitted at Saroj Hospital as a case of CAD-Acute Inferior wall MI, NIDDM as mentioned in discharge summary.**

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 and also a repudiation letter. After due consideration of the matter, I hold that company was not justified in denying the claim because claim was filed by the insured in the 4th policy period. Complainant was covered in the Group mediclaim policy continuously. 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.163500.**

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/466/Star/11
In the matter of Sh. V.N. Sharma
Vs
Star Health & Allied General Insurance Company Ltd.

AWARD DATED 26.12.2012 NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. V.N. Sharma (herein after referred to as the complainant) against the decision of Star Health & Allied General Insurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to settlement of mediclaim.**

2. **Complainant stated that he had purchased a policy bearing no. P/161100/01/2012/605139 under Senior Citizen Red Carpet Insurance from Star**

Health & Allied Insurance Company Ltd. Complainant stated that company guaranteed cashless of Rs. 47,439 whereas he submitted a claim for Rs. 59,527 duly verified by the hospital but the claim was passed only for Rs. 4947. The dispute relates to deduction of Rs. 16,505 giving the reasons "Reasonable and Necessary". He submitted that this sort of reason is not tenable and could not stand scrutiny of insurance laws. The insurance covered complete hospitalization of ailing person. He further submitted that a sum of Rs. 12,930 was deducted on account of reasons that the same is not payable which is absolutely wrong, unjustified and arbitrary in bill Assessment sheet no. 1. Insurance company ought to have given justified reasons for making deductions. The items were purchased during Jeevan Nursing Home stay from 04.10.2011 to 14.10.2011 and verified by the treating doctor. He submits that company must pay for complete hospitalization charges as stated in insurance policy. He further submitted that company also ought to have paid physio therapy charges of Rs. 12,000. He has come to this forum with a request to direct the insurance company to pay him a sum of Rs. 41,435. During the course of hearing, it was pleaded by him that claim was partially settled by the insurance company and as per terms and conditions of the policy, he requested to pay further amount.

3. **Representative of the company stated that claim was settled as per terms and conditions of the policy. Company also filed written reply dated 02.02.2012 wherein, it was stated that company had issued the policy bearing no. P/161100/01/2012/005139 for the period 21.08.2010 to 20.08.2011 and P/161100/01/2012/005139 for the period 21.08.2011 to 20.08.2012 covering Mrs. Lata Sharma for sum insured of Rs. 2 lacs under Senior Citizen Red Carpet insurance policy. Company had received the claim relating to treatment of Mrs. Lata Sharma for compression fracture D-9 – D-12 at Jeewan Nursing Home at New Delhi. A bill for Rs. 1,15,516 was submitted. Company informed the cashless for an amount of Rs. 42,492 to the hospital. Company also received request for reimbursement by the insured. Thus company settled the claim for an amount of Rs. 56,131 (42,492 + 4947 + 8692).**

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 2.02.2012 which is placed on record. After due consideration of the matter, I hold that, complainant is further entitled to a sum of Rs. 7811. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 7811 along with the penal interest at the rate of 8% till the last payment release.**
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/454/RGI/11
In the matter of Sh. Jagjit Singh
Vs
Reliance General Insurance Company Ltd.

AWARD DATED 26.12.2012 NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Jagjit Singh (herein after referred to as the complainant) against the decision of Reliance General Insurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to non settlement of mediclaim.**

2. **Complainant stated that as directed, he had sent his representation to the GRO of the company but he did not receive any response. So, he has come to this forum with a request to ensure settlement of his claim. He is a holder of health insurance policy of Reliance General Insurance Company Ltd. bearing no. 1305/702825000932 category gold from last 3 to 4 years. He had a problem on 04.12.2010 at around 4:30 am and had to rush to Sir Ganga Ram Hospital by his family members. He was diagnosed and treatment was given to him in the hospital. He was taken to lab for the procedure of angioplasty (Stent), and got discharged on 07.12.2010. He submitted the claim and all requisite documents and he was shocked to know that his claim was denied. he was also insured by Max Life Insurance Company and company allowed the claim just within 7 days. He has come to this forum with a request to get him paid his claim. During the course of hearing, it was pleaded that claim was payable but company had denied it. He further submitted that he was not suffering from any disease prior to taking the policy.**

3. **Representative of the company argued that claim was not payable. He also relied upon the written reply of the company dated 19.11.2012 wherein, it was stated that complainant obtained Reliance health wise silver policy valid from 02.07.2007 covering himself along with his spouse and daughter under a sum insured of Rs. 2,00,000. On 04.12.2010 , he was admitted in Sir Ganga Ram Hospital, Delhi and**

was dignosed as a case of Hypertension, CAD, Acute MI and SVD, where he was managed surgically and was discharged on 07.12.2010. He put up a claim of Rs. 1,94,865. On examination of documents, it was found that he suffered from Hypertension since past previous years. It was further found that he was earlier admitted in the hospital on 02.07.2007 with history of Hypertension since 2 to 3 years. The ailment was found to be pre existed and 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 of the company which is placed on record. After due consideration of the matter, I hold that company was not justified in denying the claim on the ground of pre-existing-disease because the disease for which claim was submitted and denied by the insurance company was not the disease that existed prior to taking the policy. It is to be mentioned that though, the claim was filed by the complainant for an amount of Rs. 1,94,865 but since he had already received the claim of Rs. 1,00,000 from other the insurance company, the claim in this policy is restricted only to the balance amount of Rs. 94,865. In my considered view claim is payable and the same was wrongly repudiated. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 94,865.**

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/525/UII/11
In the matter of Sh. Atul Kumar Jain
Vs
United India Insurance Company Ltd.
AWARD DATED 26.12.2012 NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Atul Kumar Jain (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 non settlement of mediclaim.**

2. **Complainant stated that he had already sent his representation to the GRO of the company but he did not get any reply. His claim is pending for almost a year without any valid reason. He further submitted that he had taken mediclaim policy bearing no. 221500/48/10/20/00000335 from United India Insurance Company Ltd. He was admitted in Adhinath hospital Indirapuram Ghaziabad on 07.09.2010 till 11.09.2010 due to Pneumonia and chest pain. He immediately informed TPA about his hospitalization. He submitted the claim along with all requisite documents immediately after his discharge from the hospital but company declined the claim on the ground that there was no need of hospitalization. He has come to this forum with a request to get his claim paid. During the course of hearing also complainant argued that claim was payable but company had denied it.**

3. **Representative of the company pleaded that claim was not payable as the admission was not required for the insured.**

4. **I have considered the submission 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 declining the claim because facts remained that insured was admitted in the hospital and get treatment. It is only a matter of perception that hospitalization was not required on the part of the company. 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. 23,510.**

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/515/RGI/11
In the matter of Sh. Sachidanand Jha
Vs
Reliance General Insurance Company Ltd.

AWARD DATED 27.12.2012 NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Sachidanand Jha (herein after referred to as the complainant) against the decision of Reliance General Insurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to settlement of mediclaim.**

2. **Complainant stated that as advised he had sent his representation to the GRO of the company. He is a holder of mediclaim policy bearing no. 1315702825001064 category gold. He got his kidney transplant in Apollo Hospital and which cost him Rs. 5,58,197. He submitted that his illness fell in the category of critical illness due to which his cover becomes doubled but company had paid him only a sum of Rs. 75,804 whereas, he claimed an amount of Rs. 3,00,000. The Kidney was donated to him by his wife and she was also covered in the policy. He had accepted the payment given by the company and requested the company to pay him the balance amount. He has come to this forum with a request to settle the balance claim. During the course of hearing, it was also pleaded by the complainant that one claim was settled by the company by making payment of Rs. 80,000 but he did not accept the payment because company was required to give a benefit for critical illness. The sum insured was Rs. 1,00,000 and in case of critical illness the sum insured becomes doubled. Claim was filed late by 95 days.**

3. **Representative of the company pleaded that company paid Rs. 80,000 due to delay in submission of the claim. Second claim was settled as per terms and conditions of the policy. company also filed written reply dated 13.12.2012 wherein, it was mentioned that complainant had obtained Reliance Health wise policy covering himself his wife and son with sum insured of Rs. 1,00,000 for the period 03.11.2009 to 02.11.2011. He was covered under Reliance Health wise policy since 03.11.2007. Complainant was admitted at Shri Moolchand Kharaiti Ram Hospital Ayurvedic Research Institute, Delhi as a case of dengue fever with follow up case of renal failure. He submitted a claim for Rs. 2,53,496. It was found by the company that claim documents were submitted 95 days after discharge from the hospital. Whereas, the same should have been submitted within 30 days from the date of discharge. Claim was settled for an amount of Rs. 80,000 on non standard basis. Subsequently, patient admitted at Indraprastha Apollo Hospital on 07.8.2011 and underwent nephrectomy on 08.08.2011 and submitted a claim of Rs. 5,58,197. Company also settled 2 claim relating to complainant's wife and his claim for Rs. 5,58,197 was settled for an amount of Rs. 75,804. It was further mentioned that claims have been 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 13.12.2012 which is placed on record. After due consideration of the matter, I hold that company was not justified in not giving benefit of critical illness suffered by the complainant. Merely, because clam documents were filed late, claim could not be settled on sub standard basis because claim was admissible. In case of critical illness the sum insured becomes double of the normal amount. There is no doubt about the fact that complainant had suffered a critical illness. Therefore, complainant is entitled to double of the amount sum insured which ought to have been given by the insurance company. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 2,00,000.

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.**

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DELHI OMBUDSMAN CENTRE

Case No.GI/479/NIC/11

In the matter of Sh. Ashish Jain

Vs

National Ins. Co. Ltd.

AWARD DATED 20.12.2012 : DENIAL OF MEDICLAIM

1. **This is a complaint filed by Sh. Ashish Jain (hereinafter referred to as the complainant) against National Ins. Co. Ltd. (hereinafter referred to as respondent insurance company) relating to Mediclaim**

2. **Complainant submitted that he along with his wife and daughter are covered in the mediclaim policy bearing no.360300/48/10/8500002341 by National Ins. Co. Ltd. he further submitted that his wife felt difficulty in seeing for about 8 to10 days. Perhaps she felt such difficulty after she had eye-flew. He had gone to consult the doctor at centre for sight and consulted Dr. Mohan Kumar where at doctor advised her to get done emergency surgery. The hospital was not on the panel therefore claim was made for reimbursement. The insurance company informed him that expenditure was incurred by him in relation to cosmetic surgery and therefore claim is not payable as per clause 4.7 of the policy. He had again consulted Dr. Mohan Kumar who issued a certificate to the effect that emergency surgery was undertaken to save the sight in the eye. He deposited such certificate issued by the**

Dr. with the insurance company. The claim was again rejected under clause 4.1 of the policy because refractive surgery was done 6yrs ago. He also made representation to the grievance redressal office of the company wherein it was stated that no surgery was done 6yrs ago but infact the procedure was performed for removal of specs and the present surgery had to be done as she stopped seeing after eye-flew. He further submitted that insurance company was not justified in rejecting the claim on one pretext or the other. He has come to this forum with a request to get his claim paid. During the course of hearing he submitted that claim was payable but company had denied it under clause 4.1 of the policy.

3. **Representative of the company pleaded that claim was not payable due to exclusion clause 4.1 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 02.09.2011. After due consideration of matter, I hold that company was not justified in repudiating the claim because patient was operated only for saving the sight in the eye after she suffered eye-flue. She could have become blind but for the surgery. The surgery was done in the emergency condition. The treatment taken by the patient did not relate to the earlier procedure undergone by the patient 6yrs. earlier. There is no reasonable evidence on the record that this claim related to pre-existing disease. In my considered view claim is payable and it was repudiated on the wrong ground. Accordingly an Award is passed with the direction to the insurance company to make payment of Rs. 49,845.**

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

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

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DELHI OMBUDSMAN CENTRE

Case No.GI/472/NIC/11

In the matter of Sh. Shishupal Singh.

Vs

National Ins. Co. Ltd.

AWARD DATED 20.12.2012 : INADEQUATE PAYMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Shishupal Singh (hereinafter referred to as the complainant) against National Ins. Co. Ltd. (hereinafter referred to as respondent insurance company) relating to Mediclaim.**
2. **Complainant stated that he had lodged reimbursement claim in the mediclaim policy bearing no.361001/48/10/8500003300 for an amount of Rs.1, 03,243 but M/s Vipul Med. Corp. Tpa Pvt. Ltd. approved only a sum of Rs.40,000. He made representation to the branch manager against the deduction made by the TPA. He further submitted that company was not justified in making such a huge deduction, sum insured in his case is Rs.2 lacs. The policy issued by the insurance company does not mention any clause relating to deduction. He has come to this forum with a request to instruct the insurance company to release the balance amount to the insured. During the course of hearing complainant submitted that company had agreed to make payment of Rs.80, 000 on account of operation of both the eyes whereas he had spent a sum of Rs.1,03,243. He got his both the eyes operated.**
3. **Representative of the company stated that reasonable amount payable to the complainant amounted to only Rs.80,000 but the complainant had not returned the discharge voucher duly signed. However he fairly agreed that there is no capping in the policy.**

4. **I have considered the submissions of the complainant as well of the representative of the company. After due consideration of matter, I hold that company was not justified in restricting the claim of the complainant to the extent of Rs.80,000 on the ground of reasonability. There is no capping in the policy with regard to allowable amount of claim. Complainant is entitled to reimbursement of the expenses incurred by him in getting the both eyes operated. Accordingly an Award is passed with direction to the insurance company to make payment of Rs. 1,03,146.**

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

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DELHI OMBUDSMAN CENTRE

Case No.GI/RGI/474/11

In the matter of Sh. Manoj Kumar.

Vs

Reliance Gen. Ins. Co. Ltd.

AWARD DATED 20.12.2012 - NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Manoj Kumar (hereinafter referred to as the complainant) against Reliance Gen. Ins. Co. Ltd. (hereinafter referred to as respondent insurance company) relating to Mediclaim.**

2. **Complainant stated that he is a holder of Reliance Medical policy since 27.09.2011. He got the treatment of his daughter in the hospital and had spent a sum of Rs.47,727. He had submitted the bill to Medi Assist TPA of the company for reimbursement but he did not get any reply. He also sent his representation to the Grievance redressal office of the company and again he did not get any reply. Now he has come to this forum with a request to get his claim settled. During the course of hearing it was pleaded by him that claim was payable but company had denied it.**
3. **Representative of the company relied upon the written reply submitted on behalf of the company dated 26.11.2012. Wherein it was mentioned that complainant obtained reliance health wise silver policy on 06.06.2009 covering himself his wife and daughter with sum insured of Rs.2 lacs. Kashish was admitted in Sancheti Hospital, New Delhi on 27.09.2011 with complaint of high grade fever, burning micturition, abdominal pain & vomiting since 3 days diagnosed as a case of recurrent UTI. It was further mentioned that on verification of the records of the hospital, it was noted that urinary tract infection was not found to be consistent with investigation reports. The claim was denied on the ground of issue of disclosure and fraudulent claims.**

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 26.11.2012 which is placed on record. After due consideration of matter, I hold that company was not justified in repudiating the claim on flimsy grounds. There is no doubt that insured was admitted in hospital and got treatment for the disease for which claim is payable. In my considered view claim is**

payable. Accordingly an Award is passed with the direction to the insurance company to make payment of Rs. 45,727.

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

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DELHI OMBUDSMAN CENTRE

Case No.GI/STAR/483/11

In the matter of Sh. Prashant Jain.

Vs

Star Health & Allied Ins. Co. Ltd.

AWARD DATED 20.12.2012 : PARTIAL SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Prashant Jain (hereinafter referred to as the complainant) against Star Health & Allied Ins. Co. Ltd. (hereinafter referred to as respondent insurance company) relating to Mediclaim.**

2. **Complainant stated that he holds a mediclaim policy bearing no. P/161121/01/2012/001041 from Star Health & Allied Ins. Co. Ltd. complainant further mentioned that the service of the company are very poor and does not appear to be responsible towards their customers. It was further submitted that he fell from a height of 15ft. on 25.09.2011 and sustained injury in left upper and lower limbs, he was admitted on 25.09.2011 in Medanta hospital ,Gurgaon operation was done on the same day and discharged on 27.09.11.He had incurred an expenditure of Rs 1,66,664 and Paid in cash. He submitted all requisite documents to the insurance company for settlement of the claim on 10.10.2011. He had second operation done on 09.11.2011 in Sita Ram Bhartia, New Delhi and incurred an expenditure of Rs 79,775.Company partly approved the claim .complainant did not attend on the date of Hearing.**

3. **Representative of the company pleaded that the claim was properly settled .A sum of Rs 1,13,742 was paid against the claim was Rs 1,66,064 and further a sum of Rs 62,413 was paid as against claim of Rs 79,775 company also filed reply on 18.02.12 where in it was mentioned that claims were settled properly. Company had paid**

1,13,742 against the total bill of Rs 1,66,064 relating to claim No-71710 and further a sum of Rs 62,413 against the total of Rs 79,775.

4. **I have considered the submissions the complainant as well as of the representative of the company .I have also perused letter dated 18.02.2012 and also bill assessment sheet relating to claim of Rs 1, 66,064 .After due consideration of matter,I hold that the company was not justified in making deduction on the ground of reasonability etc. thus I hold that complainant is entitled to further relief . Accordingly an Award is Passed with the direction the insurance company to make further Payment of Rs. 65,975 (51,545+14,430).**

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

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DELHI OMBUDSMAN CENTRE

Case No.GI/Reliance/473/11

In the matter of Sh. Davinder Luthra.

Vs

Reliance Gen. Ins. Co. Ltd.

AWARD DATED 20.12.2012 : DENIAL OF MEDICLAIM

1. **This is a complaint filed by Sh. Davinder Luthra (hereinafter referred to as the complainant) against Reliance Gen. Ins. Co. Ltd. (hereinafter referred to as respondent insurance company) relating to Mediclaim.**

2. **Complainant submitted that he had taken a mediclaim policy from the insurance company on 07.12.2007 for himself and his family members for the period 30.12.2007 to 29.10.2008. While taking the policy he disclosed all details and pre-existing ailment to the sales person. He and his family were covered with New India Insurance company Ltd. vide policies issued for the last 10 yrs. He was assured that he would be given all benefits in the policy. The policy was renewed in time. He submitted claim relating Renal stone but the insurance company rejected the same. He further submitted that he disclosed all the facts prior to taking the policy and as per terms and conditions in the gold policy pre-existing diseases will be covered from 3rd yr of the policy period after two continuous renewals and both**

the claim arose in the 3rd yr. He has come to this forum with a request to get his claims settled. During the course of hearing, it was pleaded by him that claim was payable but company denied it. Earlier policy was taken from Reliance.

3. **Representative of the company pleaded that claim is not payable due to pre-existing disease. Policy holder did not disclose the pre-existing disease while taking the policy. Company also filed written reply dated 26.11.2012 wherein it was mentioned that complainant had obtained Reliance Health Wise Gold policy on 30.12.2009 covering himself with his spouse with sum insured of Rs.4 lacs. Smt. Sangeeta Luthra was admitted at RG Urology & Laparoscopy Hospital on 09.12.2010 with complaints of pain in right flank and diagnosed as a case of right upper ureteric calculus and known case of Hypertension on regular treatment. It was further mentioned that patient is having a history of right renal stone as mentioned in the certificate issued by the treating doctor. Claim was repudiated on the ground of non-disclosure and pre-existing disease.**

4. **I have considered the submissions of the complainant as well as of the representative of the company. I have also perused the written reply of the company which is placed on record. After due consideration of matter, I hold that company was not justified in repudiating the claim because complainant has been taking mediclaim policy for the last 9yrs. Infact complainant has taken mediclaim policy in continuation since 30.12.2007 complainant had taken policy in continuation as well in advance, therefore claim is payable. Accordingly an Award is passed with the direction to the insurance c company to make payment of Rs. 83625 (52811+30814).**
5. **The award shall be implemented within 30 days of receipt of the same. The compliance of the award shall be intimated to my office for information & record.**
6. **Copies of the Award to both the parties.**

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DELHI OMBUDSMAN CENTRE

Case No.GI/NIA/486/11

In the matter of Sh. Ballu Gupta.

Vs

New India Assurance Co. Ltd.

AWARD DATED 26.12.2012 : INDADEQUATE SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Ballu Gupta (hereinafter referred to as the complainant) against New India Assurance Co. Ltd. (hereinafter referred to as respondent insurance company) relating to Mediclaim settlement.**

2. **Complainant submitted that company was not justified in making deductions of Rs.48, 891 while settling the claim. Company had not given sufficient reasons for making such deductions. He has come to this forum with a request to instruct the insurance company for making payment of the balance amount. During the course of hearing it was submitted that company did not settle the claim properly and deductions were made arbitrarily as against the claim of Rs. 1, 23,957, company had paid only a sum of Rs.75, 066.**
3. **Representative of the company pleaded that claim was settled properly. Company had filed written reply dated 06.06.2012 wherein details of deductions were mentioned which further mentioned that insured claimed an amount of Rs. 1,23,957 and was paid only a sum of Rs. 77,886.**

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 as well as assessment sheet. After due consideration of matter, I hold that complainant needs further relief because deductions have been made arbitrarily on the basis of room rent charged. It has came to my notice that that lowest room available in the hospital was for Rs.4,000 per day therefore deductions with reference to the room rent in respect of certain charges do not appear to be justified. Accordingly an Award is passed with the direction to the insurance company to make further payment of Rs. 35,755.**
5. **The award shall be implemented within 30 days of receipt of the same. The compliance of the award shall be intimated to my office for information & record.**
6. **Copies of the Award to both the parties.**

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DELHI OMBUDSMAN CENTRE

Case No.GI/STAR/485/11

In the matter of Sh. Hitesh Jain.

Vs

Star Health & Allied Ins. Co. Ltd.

AWARD DATED 26.12.2012 : NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Hitesh Jain (hereinafter referred to as the complainant) against Star Health & Allied Ins. Co. Ltd. (hereinafter referred to as respondent insurance company) relating to Mediclaim settlement.**

2. **Complainant submitted that as required, he had sent his represenatation to the redressal office of the company but the same was rejected. He submitted the claim of Rs.23,827 against hospitalization of his son Mr.Rishabh Jain on 14.06.2011 but the same was rejected on the basis of unjustified reasons. He has mediclaim policy since two years with the same insurance company and earlier it was with Reliance in continuation for 2yrs. In total policy period of 4yrs he did not file any other claim. On 24.05.2011 his son suddenly felt stomach pain, he consulted family doctor Mr. Rajeev Bhatnagar, his son got temporary relief but again he started feeling pain. Dr. was consulted ultimately he was admitted in the hospital in the emergency condition to Sh. Balaji Hospital. He further submitted that insurance company rejected the claim due to prior treatment for Anti Tuberculosis though the T.B test was negative. He has come to this forum with a request to get his claim paid. During the course of hearing also complainant pleaded that claim was payable but the same was denied.**

3. **Representative of the company pleaded that claim was not payable due to pre-existing disease. Company also filed written reply dated 14.02.2012 wherein it was mentioned that policy was issued for the period 28.04.2010 to 27.04.2011 and the same was renewed for further period covering complainant, his wife and sons under family health optima insurance 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 matter, I hold that company was not justified in repudiating the claim on the ground of pre-existing disease because that ground was untenable and unacceptable. In my considered view under the facts and circumstances of the case the claim was payable and company ought to have accepted the claim. Accordingly an Award is passed with direction to the insurance company to make payment of Rs.23627 + interest with effect from 13.09.2011 at the rate of 8% till payment.**
5. **The award shall be implemented within 30 days of receipt of the same. The compliance of the award shall be intimated to my office for information & record.**
6. **Copies of the Award to both the parties.**

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DELHI OMBUDSMAN CENTRE

Case No.GI/NIA/490/11

In the matter of Sh. Satish Kumar Gera.

Vs

New India Assurance Co. Ltd.

AWARD DATED 26.12.2012 : NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Satish Kumar Gera (hereinafter referred to as the complainant) against New India Assurance Co. Ltd. (hereinafter referred to as respondent insurance company) relating to Mediclaim settlement**

2. **Complainant submitted that he submitted mediclaim with all original requisite documents to Raksha TPA. He also complied with remaining queries of the Rakha TPA vide letter dated 08.07.2011 and 14.07.2011. He also submitted previous insurance policies. He was insured from 1999 to 2000 onwards with New India Assurance Co. Ltd. and from 2006-2007 to 2009-2010 with IFFCO Tokio Gen. Ins. Co. Ltd. and from 2010-2011 onwards with New India Assurance Co. Ltd. He further submitted that his claim was repudiated by Raksha TPA. He made representation to the grievance cell of the company against such repudiation but the repudiation was confirmed. He has come to this forum with a request to direct the insurance company to make the payment of the claim. During the course of hearing which was attended by the authorized representative of the complainant submitted that claim was payable but company had denied it.**

3. **Representative of the company pleaded that claim is not payable in view of clause 4.3 of the policy. Company also filed written reply dated 29.02.2012 wherein it was mentioned that though insured had taken continuous policies for the last 10yrs from other insurance company but the present insurance company is not bound to accept it as a continuous policy. Company had not given the commitment about the continuity benefits. The matter was also referred to medical board which also justified the repudiation of the claim.**

4. **I have considered the submissions of the complainant as well as of the representative of the company. After due consideration of matte, I hold that**

company was not justified in repudiating the claim on the ground of that claim is not payable in view of clause 4.3 of the policy because In my considered opinion clause 4.3 of the policy is not applicable. The disease for which claim was preferred by the insured does not have any waiting period. The insured was treated for coronary artery disease, single vessel disease and unstable enzyme. Accordingly an Award is passed with the direction to the insurance company to make payment of Rs.2,00,000 to the insured.

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

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DELHI OMBUDSMAN CENTRE

Case No.GI/ICICI LOMB/500/11

In the matter of Sh. Gautam Maggu.

Vs

ICICI Lombard Gen. Ins.Co. Ltd.

AWARD DATED 26.12.2012 : DENIAL TO SETTLE MEDICLAIM

1. **This is a complaint filed by Sh. Gautam Maggu Gera (hereinafter referred to as the complainant) against ICICI Lombard Gen. Co. Ltd. (hereinafter referred to as respondent insurance company) relating to motorclaim settlement.**

2. **Complainant submitted that his bike with registration no. DL8SAR0511, which was insured under policy no. 3005/54041936/01/000 was stolen from his premises on 17.12.2010. An FIR was lodged for the same on 21.12.2010 vide no.413 and insurance company was also informed of theft. All requisite documents were submitted by him to Mr. Bhupender Rawat on 18.01.2011. He was informed that his claim was rejected but company had not assigned any proper reason for its decision. He has come to this forum with a request to get the claim settled. During the course of hearing complainant submitted that the vehicle remained untraced and he submitted this report to the insurance company but company had denied the claim but the same was payable.**

3. **Representative of the company stated that claim was not payable due to gross negligence on the part of the insured. Company also filed written reply dated 23.03.2012 wherein it was mentioned that complainant had taken a two wheeler policy bearing no.3005/5404/1936/01/000 for the period May/11/2010 to May/10/2011. On Dec/22/2010 complainant informed the insurance company that he parked his vehicle outside his residence on Dec/17/2010 and next morning Dec/18/2010 he found that his vehicle was missing. An investigation was conducted and it was found that complainant had left the insured vehicle unlocked with the key. There was unreasonable delay in sending intimation to the insurance company.**

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 matter, I hold that claim is payable as insured had suffered a total loss because his insured vehicle was stolen during the currency of the policy. The delay in intimating the insurance company was on account of the illness of the father of the insurer who suffered a paralytic strok. In my considered view claim was payable and company was not justified in repudiating the matter. Accordingly an Award is passed with the direction to the insurance company to make payment of Rs.39,570 (39,620-50) along with the panel interest from the date of repudiation (with effect from) 28.02.2011 to the date of actual payment at the rate of 8%.**
5. **The award shall be implemented within 30 days of receipt of the same. The compliance of the award shall be intimated to my office for information & record.**
6. **Copies of the Award to both the parties.**

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DELHI OMBUDSMAN CENTRE

Case No.GI/APOLLO/532/11

In the matter of Sh. Dinesh Sikka.

Vs

Apollo Munich Gen. Ins.Co. Ltd.

AWARD DATED 26.12.2012 FOR REJECTION OF MEDICLAIM

1. **This is a complaint filed by Sh. Dinesh Sikka Gera (hereinafter referred to as the complainant) against Apollo Munich Gen. Co. Ltd. (hereinafter referred to as respondent insurance company) relating to settlement of Mediclaim.**

2. **Complainant submitted that on 25.09.2011 his wife Shweta Sikka was admitted to Joy Nursing Home. She was hospitalized on the advice of the treating Doctor. She was diagnosed for UTI. She was discharged on 28.09.2011 from the hospital. The claim for Rs. 28,898 was submitted to the insurance company for payment but the same was rejected by the insurance company stating that treatment could have been taken as an OPD patient instead of hospitalization. He further submitted patient was in severe abdominal pain and vomiting and therefore she was admitted on the advice of the treating doctor. He has come to this forum with a request to get the claim paid. During the course of hearing complainant submitted claim was payable.**

3. **Representative of the company pleaded that claim was not payable as the admission in the hospital was only for investigation purposes and no pre-active treatment was taken in the hospital. Company filed detailed reply wherein it was submitted that the insured was admitted in the hospital only for investigation and evaluation purpose which could have been done on outpatient basis and claim was rejected correctly.**

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 and also the repudiation letter dated 07.12.2011. After due consideration of matter, I hold that company was not justified in repudiating the claim because insured was admitted in the hospital only on the advice of the treating doctor and she was not only admitted in the hospital but was also treated. In my considered view claim is payable. The same was rejected on flimsy ground. Accordingly an award is passed with the direction to the insurance company to make payment of Rs. 28,898.**
5. **The award shall be implemented within 30 days of receipt of the same. The compliance of the award shall be intimated to my office for information & record.**
6. **Copies of the Award to both the parties.**

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DELHI OMBUDSMAN CENTRE

Case No.GI/529/OIC/11

In the matter of Sh. Sanjeev Aggarwal.

Vs

Oriental Ins. Co. Ltd.

AWARD DATED 26.12.2012 : REJECTION OF MEDICLAIM

1. **This is a complaint filed by Sh. Sanjeev Aggarwal (hereinafter referred to as the complainant) against Oriental Ins. Co. Ltd. (hereinafter referred to as respondent insurance company) relating to settlement of Mediclaim.**

2. **Complainant submitted that he had taken mediclaim insurance policy from Oriental Insurance Co. bearing no.271901/48/2011/2441. Policy was being taken by him without any break. 1st he took policy in 15.11.2007 from Reliance Gen. Ins. Co. Ltd. and thereafter the policy was taken with effect from 14.11.2010 from Oriental Insurance Co. Ltd. while switching the company he was assured by the agent that he would be allowed the continuity benefit by the Oriental Insurance Co. Ltd. When he received policy bearing no.271901/48/2010/1997 that contained carefully the policy no. 282510356354 and thus he became assured that he would be given continuity benefit by the present insurer therefore company was not justified in repudiating the claim on that ground. He has come to this forum with a request to allow him the claim and also the continuity benefit. During the course of hearing it was argued by the complainant that claim was payable but the same was denied by the company without proper justification.**

3. **Representative of the company argued that claim was filed within the 2nd policy period and therefore the same was not payable. Company also filed written reply dated 15.05.2012 wherein it was mentioned that company had issued the policy for the period 15.11.2009 to 14.11.2010. Insured was hospitalized at Narender Mohan Hospital and Heart centre on 02.04.2011 and was discharged on 03.04.2011. He submitted the claim on 09.04.2011 for an amount of Rs. 35,210 toward hospitalization expenses. It was further mentioned in the reply that treatment for renal stone and hydronephrosis is not covered in the 1st two yrs of the policy 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 which is placed on record. After due consideration of matter I hold that company was not justified in repudiating the claim on the ground that claim was made in the 2nd yr of the policy period because complainant had taken policy from the insurance company under the bonafied belief that he would be given the continuity benefit of the policy taken from previous insurer. Complainant has been taking policy since 2007. In my considered view complainant**

deserves to be given the benefit of continuity of the previous policy. Thus it is found that claim was payable and company was not justified in denying it. Accordingly an Award is passed with the direction to the insurance company to make payment of Rs.34,660.

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

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DELHI OMBUDSMAN CENTRE

Case No.GI/NIA/531/11

In the matter of Sh. Manjeet Singh.

Vs

New India Assurance Co. Ltd.

AWARD DATED 26.12.2012 : INDADEQUATE SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Manjeet Singh (hereinafter referred to as the complainant) against New India Assurance Co. Ltd. (hereinafter referred to as respondent insurance company) relating to Mediclaim settlement.**

2. **Complainant submitted that he had submitted his mediclaim for an amount of Rs.55,303 on 01.12.2010 for shoulder surgery performed at fortis Escorts Hospital on 14.11.2010. he had submitted all requisite documents alomg with the claim. He was paid only a sum of Rs. 12,673 against the total claim of Rs.55,303. He took up the matter with the insurance company for inadequate settlement. He was further paid a sum of Rs. 26,430 and thus a sum of Rs. 15,000 is still to be paid by the ins. Co. he pursued the matter with the insurance company but no further response was given. He has come to this forum with a request to get him paid the balance amount. During the course of hearing authorized representative of the complainant argued that claim was not settled properly and company be directed to pay the balance amount of Rs. 15,000.**

3. **Representative of the company argued that claim was settled as per terms and conditions of the policy. Company also filed written reply dated 19.03.2012 wherein it has been mentioned that while settling the claim by the TPA, TPA had made deductions as were required in terms of the policy. Room rent payable was Rs. 5,000 per day as sum insured was Rs. 5lacs hence total room rent payable was Rs.10,000 for 2 days as against Rs.25,000 similarly deductions have been made from consultation charges, pharmacy etc. based on room rent limit.**

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. I have also gone through the claim formed and claim process sheets. After due consideration of matter, I hold that complainant needs to be paid further because complainant was paid firstly a sum of Rs. 12,673 and subsequently Rs. 26,430 as against the total claim of Rs. 55,303. Since complainant had paid room rent less than 1% of the sum insured because of allowance of subsidy on the room rent by the hospital entire claim amount is payable. Thus complainant is further entitled to a sum of Rs.16,200 (55,303- 12,673-26,430).**
5. **The award shall be implemented within 30 days of receipt of the same. The compliance of the award shall be intimated to my office for information & record.**
6. **Copies of the Award to both the parties.**

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DELHI OMBUDSMAN CENTRE

Case No.GI/545/UII/11
In the matter of Ms. Sunita Jain
Vs
United India Insurance Company Ltd.

AWARD DATED 10.1.2013 REPUDIATION OF MEDICLAIM

1. **This is a complaint filed by Smt. Sunita Jain (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 she was covered under the GMC policy of capital IQ information system, vide policy no. 040200/48/10/41/00000896. She was admitted in the hospital on 30.03.2011 and was discharged on 06.04.2011. Claim was intimated on 18.04.2011 though claim, was submitted within 15 days of the**

discharge from the hospital but she was not knowing that she was to intimate the company within 24 hours of the hospitalization. During the course of hearing, it was submitted on behalf of the complainant that patient was covered in the policy. Claim was submitted in time and claim was payable. Delay in intimation was also duly explained.

3. **Representative of the company pleaded that claim was not payable due to delay in giving intimation to the company.**

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 10.01.20112. After due consideration of the matter, I hold that company was not justified in denying he claim merely, because intimation of hospitalization was not given within the 24 hours of the hospitalization. The claim otherwise admissible can not be declined only on the ground that intimation was not given within 24 hours of the hospitalization. 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. 40386/- along with penal interest at the rate of 8% from the date of repudiation of the claim to the date of actual payment.**

5. **The Award shall be implemented within 30 days of receipt of the same. The compliance of the 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/528/Star/11
In the matter of Sh. Sunil Goel
Vs
Star Health & Allied General Insurance Company Ltd.

AWARD DATED 10.1.2013NON SETTLMENT OF MEDICLAIMS

1. **This is a complaint filed by Sh. Sunil Goel (herein after referred to as the complainant) against the decision of Star Health & Allied General Insurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to non settlement of two claims and inadequate settlement of one claim.**

2. **Complainant stated that he had taken family mediclaim policy known as family health optima insurance plan bearing no. P/161100/01/2011/004085 from M/s Star Health and Allied General Insurance Company Ltd. He submitted that in his complaint he desired the remedy against the unprofessional and unethical attitude and behavior of the company and lodged his request relating to passing of claim for an amount of Rs. 91,919 which included unreasonable deductions beyond policy terms, interest and compensation towards cost of follow up and mental harassment. He had already made his representation to the GRO of the company but the GRO of the company had rejected his claim and thus his complaint was not resolved and understood and he was not satisfied with the reply received from the GRO. He has come to this forum with a request to do the need full in the matter. During the course of hearing complainant stated that claim was not settled properly and in one time. The same was settled in pieces. As against the claim of Rs. 91,919, company had paid him a sum of Rs. 84,738.**

3. **Representative of the company submitted that claim was settled properly. Representative of the company was required to submit written reply but the same was not 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 company's letter dated 02.03.2012 addressed to the complainant along with its enclosures i.e. bill assessment sheets. After due consideration of the matter, I hold that complainant needs to be given further relief because company had not completely and reasonable settled the claim. Company had given a sum of Rs. 84,778 out of Rs. 91,919. Accordingly an Award is passed with the direction to the insurance company to make further payment of Rs. 6714. .**

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/548/Star/11
In the matter of Sh. Surrender Kumar Nagi
Vs

Star Health & Allied General Insurance Company Ltd.

AWARD DATED 10.1.2013 NON SETTLMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Surrender Kumar Negi (herein after referred to as the complainant) against the decision of Star Health & Allied General Insurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to non settlement of mediclaim.**

2. **Complainant stated that he fell ill all of a sudden and was admitted in the hospital at Jeevan Jyoti in emergency condition on 17.06.2011 at night. He was referred to other hospital by the doctor therefore, he got admission in another hospital Metro hospital, Preetvihar. Whereat, he was treated from 17.06.2011 to 20.06.2011 in ICU ward and discharged. He submitted the claim which was rejected on false grounds. He has come to this forum with a request to get the claim settled. During the course of hearing, it was pleaded by the complainant that claim was payable but the company had denied the same. Complainant further stated that he had submitted all requisite documents for settling the claim.**

3. **Representative of the company pleaded that claim was not payable because correct information was not given by the insured and due to suppression of information claim was not payable. Company also filed written reply dated 23.04.2012 wherein it was mentioned that claim was filed for treatment of CAD/HT/ACS at J.J. Clinic and hospital. The claim was rejected.**

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 denying the claim because the disease for which treatment was taken by the insured was not pre-existing at the time of taking the policy. Insured suffered pain all of a sudden and got admitted in the hospital and treated for heart disease. Therefore, claim is payable. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 105000. .**

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/563/UII/11
In the matter of Smt. Usha Gupta
Vs
United India Insurance Company Ltd.
AWARD DATED 10.1.2013 REPUDIATION OF MEDICLAIM

1. **This is a complaint filed by Smt. Usha Gupta (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 his son Late Sh. Rajesh Gupta had taken a mediclaim policy bearing no. 040401/48/11/97/00001268 with sum insured of Rs. 3 lacs from United India Insurance Company Ltd. His mediclaim policy continued for 6 years and he had not taken a single claim. he was admitted for the first time in Maharaja Agrasen hospital, Punjabi Bagh on 05.08.2011. Company was approached for cashless facility. The TPA of the company Mediassist India Pvt. Ltd. firstly approved the initial claim amount but the next day Sh. Rajesh Gupta died. Claim was filed for reimbursement of the expenses. However, the company rejected the claim under exclusion clause 4.9 that he was alcoholic. It was submitted further that death summary did not speak that diseased was alcoholic. She has approached the company many a times to reconsider the decision but she had not been favored with any reply. She has come to this forum with request to ensure settlement of the claim as per terms and conditions of the policy.**

3. **Representative of the company pleaded that claim was not payable. He also referred repudiation letter dated 30.09.2011, wherein it was mentioned that claim was not payable under exclusion clause 4.9.**

4. **I have considered the submissions of the complainant as well as of the representative of the company. I have also perused the repudiation letter. After due consideration of the matter, I hold that company was not justified in repudiating the claim because nowhere in discharge summary it was revealed that the disease was caused due to use of alcohol. Therefore, exclusion quoted by the company is not found relevant. Until and unless it was established by the company by any reasonable evidence that claim related to any treatment of a disease which was caused due to use of alcohol, the claim is held to be payable. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 58240. .**

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/547/OIC/11
In the matter of Smt. Sita Gupta
Vs
Oriental Insurance Company Ltd.

AWARD DATED 11.1.2013 REPUPDIATION OF MEDICLAIM

1. **This is a complaint filed by Smt. Sita Gupta (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 medi claim.**

2. **Complainant stated that she was covered by the policy issued by Oriental Insurance Company Ltd. she was admitted in Medanta Hospital, Gurgaon. The claim was filed and the same was declined by the mediassist India TPA Ltd. on the ground that patient Smt. Sita Gupta was a known case of HTN (hyper tension) since one year and DM (diabetes) since one year before suffering from heart attack. She also approached the GRO of the company but she did not get any response. She also personally visited on 17.02.2012. However, she was again informed that claim was correctly denied. It was further submitted by her that she was admitted to the Medanta hospital, Gurgaon for the first time just after suffering from heart attack at home all of a sudden. Dr. Neeraj Gupta who was consulted by the patient had submitted that there was no past history. During the course of hearing, which was attended by the husband of the complainant it was argued that claim was payable but company had denied it. The policy was taken with sum insured of Rs. 5 lacs. Policy was taken for the first time on 03.011.2010. the claim was filed which was rejected.**

3. **Representative of the company pleaded that claim was not payable because disease had 2 years waiting period.**

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

17.11.2011. After due consideration of the matter, I hold that company was not justified in repudiating the claim because the disease for which the treatment was taken by the patient and for which claim was submitted is not having any waiting period. In case of patient coronary angiography was done and there after coronary stunting was done on 05.09.2011. In my considered view CAD was not the disease wherein waiting period was given. In my view claim was payable and company was unjustified in denying the claim. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 350600.

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/553/Star/11

In the matter of Smt. Shashi Jain.

Vs

Star Health & Allied Ins. Co. Ltd.

AWARD DATED 10.01.2013 INADEQUATE SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Smt. Shashi Jain (hereinafter referred to as the complainant) against Star Health & Allied Ins. Co. Ltd. (Hereinafter referred to as respondent insurance company) relating to mediclaim.**

2. **Complainant submitted that he has taken a policy bearing no. P/161111/01/2011/000251 from Star Health & Allied Ins. Co. Ltd. she further stated that policy is in continuation since 2007. She was admitted at National Heart Institute for a surgery. Claim was submitted along with all Requisite documents. A matter of fact cashless facility was requested and company's officer visited the hospital at the time of admission. However cashless was denied. Then she filed claim for reimbursement and submitted all requisite documents through speed post dated 19.07.2011. Though she submitted claim for an amount of Rs. 89,895 but company had paid her only a sum of Rs. 65,900. She had not received the**

reasons for deduction while settling the claim. Complainant did not attend on the date of hearing.

3. **Representative of the company pleaded that claim was settled as per terms and conditions of the policy. He filed claim process sheets.**

4. **I have considered the submissions of the complainant made in the complaint. I have also considered verbal submissions of the representative of the company and perused the bill assessment sheets. After due consideration of matter, I hold that claim was not fully settled. So much so accurate reasons were not submitted for making deductions in respect of items mentioned at S.No. 8 to 10 and thus in my considered view complainant needs further to be paid. Accordingly an Award is passed with the direction to the insurance company to make further payment of Rs. 10,745.**

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

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

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DELHI OMBUDSMAN CENTRE

Case No.GI/582/APOLLO/11

In the matter of Sh. Rakesh Jain.

Vs

Apollo Munich Gen. Health Ins. Co. Ltd.

AWARD DATED 12.02.2013 : DENIAL OF MEDICLAIM

1 **This is a complaint filed by Sh. Rakesh Jain (hereinafter referred to as the complainant) against Apollo Munich Gen. Health Ins. Co. Ltd. (Hereinafter referred to as respondent insurance company) relating to mediclaim.**

2 Complainant submitted that he was issued mediclaim insurance policy by Apollo Munich health Gen. Ins. Co. Ltd. He filed the claim in month of Oct, 2011 and submitted all requisite documents to the TPA but it declined the claim on the ground that the hospital in which patient got the treatment was black listed. He further submitted that he had the list of blacklisted hospitals wherein the name of the hospital namely Navjeevan Hospital where patient got the treatment was not there in that list. He submitted such list to the insurance company but company denied the claim. During the course of hearing complainant submitted that company was not justified in denying the claim. He was not provided the list of all black listed hospitals while issuing the policy. He further submitted that the hospital where patient was treated was not blacklisted then.

3 Representative of the company pleaded that claim was not payable because treatment was taken in the blacklisted hospital and the insured was communicated the list of hospitals which were blacklisted. Company also filed written reply dated 23.06.2012.

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 which is placed on record. After due consideration of matter, I hold that company was not justified in denying the claim because insured was under the bonafied belief that patient got the treatment in the hospital which was not blacklisted. There is no reason not to believe the insured that the hospital under reference was not blacklisted when insured got the treatment. In my considered view claim was payable and company ought to have allowed such claim. Accordingly an award is passed with the direction to the insurance company to make the payment of Rs. 40,100.

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

Copies of the Award to both the parties.

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DELHI OMBUDSMAN CENTRE

Case No.GI/554/star/11
In the matter of Sh. Dali Singh
Vs
Star Health & Allied General Insurance Company Ltd.

AWARD DATED 7.2.2013 REPUDIATION OF MEDICLAIM

1. **This is a complaint filed by Sh. Daljit Singh (herein after referred to as the complainant) against the decision of star Health & Allied General Insurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to repudiation of mediclaim.**

2. **Complainant stated that his complaint relates to rejection of mediclaim for treatment of his son Master Sukhkirat Singh by Star Health & Allied General Insurance Company Ltd. against the policy claim no. CLI/2011/161116/005504. The insurance company had rejected his claim on the ground that treatment relating to congenital external defect is not payable. He submitted that he provided all evidence to the insurance company in support that the defect for which his son was treated was not congenital in nature. He also provided certificate from the treating doctor and medical history of his son by treating doctor to support his claim. Even after a number of reminders and submitting his representation to the GRO of the company, his complaint was not resolved. He has come to this forum with request to instruct the insurance company to reimburse the sum of Rs. 57993. During the course of hearing also complainant pleaded that claim was payable but company had denied it. He further pleaded that his son was not suffering from the congenital defect as certified by the doctor.**

3. **Representative of the company pleaded that claim was not payable as per reasons given in the repudiation letter. As per repudiation letter in view of exclusion clause 11 claim is not payable.**

4. **I have considered the submissions of the complainant as well as of the representative of the company. I have also perused the repudiation letter dated 02.02.2011. After due consideration of the matter, I hold that company was not justified in denying the claim because the child did not suffer from congenital external defect. As per treating doctor cerebral palsy is not a congenital defect in all cases, it is due to lesion brain. In my considered view claim apears to be payable and company was not justified in denying it. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 57,818.**

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/552/NIC/11
In the matter of Sh. Kuldeep Singh
Vs
National Insurance Company Ltd.

AWARD DATED 7.2.2013 INADEQUATE SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Kuldeep Singh (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 inadequate settlement of mediclaim.**

2. **Complainant stated that he is an employee of Press Trust of India and member of PTI group medical Insurance Scheme vide policy no. 350601/46/108500000143 of National Insurance Company Ltd. He further submitted that his wife Smt. Alka had under gone treatment at Tirath Ram Shah Charitable Hospital, Raipur Road, Delhi. She felt severe paid in neck and nausea. Treating doctor advised her for MRI. She was discharged form the hospital on 27.07.2011 by the treating doctor. He further submitted that his wife had a serious head injury and spinal tuberculosis earlier. Based on all these symptoms, she was advised to get admitted in the hospital. He submitted the claim for an amount of Rs. 20,433 to the insurance company for reimbursement but the company rejected the claim on flimsy ground without any worthwhile reason. He approached the chairman of the company for a review. However, the officials of the company did not consider his case favorably and once again rejected it. Therefore, he had approached this forum. He had earlier sent his representation to the GRO of the company. During the course of hearing, complainant submitted that he submitted the hospitalization claim for an amount of Rs. 20,433 and post hospitalization claim of Rs. 8799 but company settled the claim for Rs. 17,348 out of hospitalization claim of Rs. 20,433 and further paid a sum of Rs. 7674 out of the post hospitalization claim of Rs. 8799.**

3. **Representative of the company submitted that both the claims were settled were reasonably.**

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 the insurance company had settled the claims partially. I have perused the details of the claims and the settlement done by the company and I find that complainant needs to be compensated by making further payment of Rs. 4210. Accordingly an Award is passed with the direction to the Insurance Company to make further payment of Rs. 4210.**

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/559/UII/11
In the matter of Sh. Harish Nagpal
Vs
United India Insurance Company Ltd.

AWARD DATED 7.2.2013 NON SETTLMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Harish Nagpal (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 non settlement of mediclaim.**

2. **Complainant stated that he along with his wife Smt. Savita Nagpal were insured under individual health insurance policy for more than a decade. The policy was renewed in continuation. He had not preferred any claim on his health during all this period except once when he was hospitalized following road accident. In the year 2010, he purchased an additional super Top – up medicare policy with the objective of providing himself additional health insurance cover since he and his wife are advancing in age and all around cost of treatment of disease is increasing. On 26.05.2011, he suffered heart attack when he was returning from Gurgaon in his car. He drove the car straight to the emergency department of RML hospital, where he received some first aid. Later he was shifted by his relatives to the Fortis**

Ascort heart institute, Okhla. He was hospitalized for 3 weeks up to 15.06.2011. In Escort hospital, he underwent the treatment of angioplasty and coronary artery bypass graft surgery. As a part of hospitalization expenses was received from TPA under his individual health insurance policy, he lodged further claim with the TPA for payment of the balance amount, agent . He submitted all requisite documents to the TPA. He received a letter from TPA stating that his claim filed was closed as no claim due to non submission of unspecified documents. He enquired into the matter and he was informed that the file was closed due to non submission of proposal form. He brought to the notice to the TPA that proposal form is supposed to be with the under writer and do not with the insured, and the claim should not be closed due to this reason. He did not receive any reply from the company. He personally visited the office and whereat he was assured by the Division manager Mr. P.C. Yadav and Ms. Suman that document have been mailed to TPA and the claim filed will be reopened but later on he came to know that his claim filed stands closed for the reason that he has hyper tension since 2 years and policy is in first year. He further submitted that the intention of the company was bad from the very beginning firstly the company delayed the renewal of the super top up medicare policy for which he had to approach the GRO and later he received a no claim letter. He further mentioned that super top up medicare policy was issued when he was already insured in continuation for more than a decade. The sum insured in super top up medicare policy was over and above the sum insured in the individual health insurance policy. He had been true to disclose before the doctor at the hospital that he was taking medicine for hypertension and diabetes for 1 to 2 years. He had not consulted any other doctor for this purpose. He had not suffered even a minor complaint of Angina before 26.05.2011. Total amount of the bill issued by Fortis Escort heart institute was of Rs. 5,54,999 and out of this only a sum of Rs. 1,40,000 was paid by the TPA by way of cashless. The balance of Rs. 4,15,000 is payable by the TPA. He has come to this forum with request to instruct the insurance company to pay the balance amount along with penal interest. During the course of hearing also complainant pleaded that claim was payable but company had denied it. He had taken the super top up medicare policy besides individual health policy. He exhausted his sum instead in individual policy and therefore, balance amount is payable out of super top up medicare policy.

3. **Representative of the company pleaded that claim was not payable due to pre existing disease.**

4. **I have very carefully considered the detailed written submissions of the complainant and also the submissions verbally made by him during the course of hearing. I have also considered verbal arguments of the representative of the**

company and also perused the repudiation letter dated 19.01.2012. After due consideration of the matter, I hold that company was not justified in repudiating the claim on the ground that the disease has 2 years waiting period because no evidence was brought on record on behalf of the insurance company that complainant or for that matter patient suffered from any heart disease for which he was treated prior to taking up the super top up mediclaim policy. It is also made clear that company had not submitted any written reply in support of its ground for repudiating the claim. As admitted by the complainant himself he was allowed cashless facility for an amount of Rs. 1,40,000 against the individual mediclaim health policy and desires consideration of balance claim against super top up medicare policy under reference, I do not find any hindrance in not consideration of balance claim of the complainant against super top up policy wherein sum insured is Rs. 5 lacs. Under the facts and circumstances of the case, in my view claim is payable. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 4,14,999.

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/569/UII/11
In the matter of Sh. Arvind Sharma
Vs
United India Insurance Company Ltd.

AWARD DATED 12.2.2013 NON SETTLMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Arvind Sharma (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 non settlement of mediclaim.**

2. **Complainant stated that he is a mechanic by profession. While he was at his hometown in Kanpur last year he fell ill. He gave the information about the illness to E-meditech TPA through his agent. He submitted the claim but company did not**

settle the claim. He was required to submit some information which he submitted as desired. He also approached the GRO of the company relating to settlement of his claim. He has come to this forum with request to get the claim settled. During the course of hearing, complainant submitted that company did not settle the claim though he submitted all requisite documents to the TPA.

3. **Representative of the company pleaded that claim could not be settled due to non submission of certain 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 declining the claim on the ground of delay in intimation and submission of claim documents. The claim otherwise admissible can not be declined on flimsy grounds. In my considered view claim was payable as insured fell ill and got treatment. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 9587.**

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/567/UII/11
In the matter of Sh. Hans Kumar Jain
Vs
United India Insurance Company Ltd.

AWARD DATED 12.2.2013 NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Hans Kumar Jain (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 settlement of mediclaim.**

2. **Complainant stated that he was insured by United India Insurance Company Ltd. for the last 15 years. He had to get admitted in Ganga Ram Hospital on 16.11.2011 due to Hernia. He had to pay a sum of Rs. 1,29,771 to the hospital. Company had provided cashless facility only to the extent of Rs. 1,00396 and he had to pay**

balance amount of Rs. 29,375. He has perused the matter a lot but company had not reimbursed him a sum of Rs. 29375. He got a reply from the TPA and was given the reason for the deduction. He has come to this forum with request to instruct the insurance company to release balance amount. During the course of hearing, complainant argued that claim was partially settled as claim should have been settled with reference to sum insured of Rs. 4,50,000. He was required to submit hospital tariff with reference to entitled room category.

3. **Representative of the company pleaded that claim was settled properly with reference to sum insured of Rs. 3,50,000 which infact was the sum insured when pain relating to hernia was detected.**

4. **I have considered the submissions of the complainant as well as of the representative of the company. After due consideration of the matter I hold that, company was justified in settling the claim with reference to the sum insured of Rs. 3,50,000 because when the pain was detected relating to hernia, the sum insured was Rs. 3,50,000. Therefore, as regard the sum insured of Rs. 3,50,000 considered by the company while settling the claim, it appeared justified but as deduction was made by the company while settling the claim it appeared that deductions were not correctly made because as per terms and conditions of the policy insured was entitled to reimbursement of the expenses accordingly to entitled room category and not proportionately. Therefore, complainant needs to be further compensated. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 21474.**

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/524/UII/11
In the matter of Sh. Amrit Lal Taparia
Vs
United India Insurance Company Ltd.

AWARD DATED 12.2.2013 NON SETTLEMNT OF MEDICLAIM

1. **This is a complaint filed by Sh. Amit Lal Taparia (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 non settlement of mediclaim.

2. **Complainant stated that he was insured vide Tailor made floater group policy bearing no. 021600/48/09/41/00000387 for the period from 17.04.2009 to 16.04.2010 for sum insured of Rs. 1,00,000. This policy was taken from United India Insurance Company Ltd. It was further submitted that his wife Smt. Vimla Taparia was admitted in the hospital for operation on 29.03.2010. The condition of the patient was critical, therefore, relatives of the patient were busy with the patient. The intimation through fax was given on 02.04.2010 at that time patient was admitted in the hospital. The claim was rejected on the ground that late intimation was given to the TPA. It was further submitted by him that intimation was timely given as the same was given within 7 days from the date of hospitalization. During the course of hearing, it was pleaded by the complainant that claim was payable but company had denied it. He submitted all requisite document to the insurance company for settlement of the claim. He also informed the company on 02.04.2010 about the hospitalization.**

3. **Representative of the company pleaded that claim was not payable due to late intimation about the hospitalization.**

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 the ground of late intimation. The intimation was given about the hospitalization. Moreover, claim which is admissible cannot be declined on technical ground. The claim is payable 75% of the sum insured or claimed amount whichever is less. In case of complainant 75% of the claimed amount is more than 75% of sum insured. Hence, company's liability with regard to claim is limited to Rs. 75,000 only. In my view claim was payable and company ought to have settled the claim.**

   Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 75,000 along with penal interest from the date of repudiation 23.04.2010 at the rate of 8% 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/549/UII/11
In the matter of Sh. Pradeep
Vs United India Insurance Company Ltd.
AWARD DATED 19.2.2013 NON SETTLMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Pradeep (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 settlement of mediclaim.**

2. **Complainant stated that he had mediclaim insurance policy through bank of Rajasthan, Kota. This policy was family medical policy. He has been making payment of the premium through bank of Rajasthan. Vide this policy bearing no. 140400/48/10/41/00001956. Six members of the family were covered including Smt. Radha Aggarwal. In case of Smt. Radha Devi Aggarwal cancer was detected in month of September – October and she was admitted in hospital at Kota from 09.10.2010 to 12.10.2010 in respect of which information was passed on to insurance company, Jaipur. This policy was issued by the insurance company from its office at Kota. Information was also given to TPA Vipul medicorp Pvt. Ltd. through courier. Meanwhile, patient Smt. Radha Devi Aggarwal was admitted at Tata memorial Bombay dated 25.10.2010 and remained there till 08.11.2011. The patient was seriously ill, the patient was discharged on 08.11.2011. There after she was treated as OPD patient and she was given chemo therapy every 7th day. In such circumstances the priority was the treatment of the critically ill patient rather than filling the claim. He collected the documents relating to treatment and thereafter, some time was taken by the hospital and ultimately, claim was submitted to TPA Vipul Medicorp Pvt. Ltd., Jaipur. Company had raised some querry which was also satisfied. Explanation was also given to the TPA for late submission of the claim. The complainant further submitted that company be directed to renew the policy on the basis of the premium as was taken for his policy through bank of Rajasthan, Kota. During the course of hearing, it was pleaded by him that claim was payable but company had denied it.**

3. **Representative of the company pleaded that documents were not submitted in time and thus claim was not payable due to late submission of 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 denying the claim only on the ground that claim and related documents were filed late. In my considered view, the circumstances due to which claim and relating documents were filed late have also to be considered. In my view claimant was prevented by the sufficient cause from filing the claim related documents within the stipulated time frame. There is no reason not to believe the version of the complainant that company and TPA was informed timely with regard to admission of the patient. The claim otherwise admissible can not be declined on technical ground as the reasonable reasons have been given for the late submission of the documents. Accordingly it is held that claim is payable. Thus an Award is passed with the direction to the insurance company to make the payment of Rs.1,00,000 along with penal interest at the rate of 8% w.e.f. 15.05.2011 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.**

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DELHI OMBUDSMAN CENTRE

Case No.GI/310/OIC/12
In the matter of Sh. S.K. Aggarwal
Vs
Oriental Insurance Company Ltd.
AWARD DATED 19.2.2013 NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. S. K. Aggarwal (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 settlement of mediclaim.**

2. **Complainant stated that as advised, he had sent his representation to the GRO of the company. He submitted that his wife Smt. Lalita Aggarwal was admitted in Bhandari hospital and Reasearch centre on 26.08.2011. Unfortunately, she could not be saved and she passed away on 30.08.2011. He has lodged a claim on 09.09.2011 for Rs. 1,27,004. He had pursued the claim but of no use. He informed that he was once incharge of the main branch of Punjab National Bank, as an**

assistant general manager and subsequently as deputy general manger. It was very unfortunate for him to run pillar to post for the settlement of genuine claim. He had submitted all requisite documents to enable the company to settle the claim. The death was not on account of pre-existing disease but was on account of different reasons which have been specifically confirmed by the hospital authorities on 03.09.2011. He has come to this forum with request to get the claim settled. During the course of hearing, it was pleaded by him that company was not justified in declining the claim on the ground, she suffered earlier in 1995. She fell ill in 1995 but got cured in 1997. She became conscious in the morning of 26.08.2011 and was admitted in hospital whereat, she was expired on 30.08.2011.

3. **Representative of the company pleaded that claim was not payable due to pre-existing-disease as per clause no. 4.1 of the policy.**

4. **I have considered the submissions of the complainant as well as of the representative of the company. After due consideration of the matter, I hold that company was not justified in repudiating the claim on the ground of pre-existing-disease as patient was not found to have suffered from disease due to which she was admitted and unfortunately expired prior to exception of the policy. Therefore, in my view claim was payable and company ought to have settled the claim. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 1,25,996.**

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/153/RGI/12
In the matter of Smt. Rabiya Banu
Vs Reliance General Insurance Company Ltd.
AWARD DATED 19.2.2013 NON SETTLEMENT OF DEATH CLAIM

1. **This is a complaint filed by Smt. Rabiya Banu (herein after referred to as the complainant) against the decision of Reliance General Insurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to repudiation of death claim.**

2. **Complainant stated that her son Mohd. Javed was insured vide policy no. 1804502815008536 by Reliance General Insurance Company Ltd. who expired in Dubai during policy period. The DLA held the passport no. H 9655638 and was working and living in Dubai. She further stated that company had sent surveyor at her residence and all documents relating to claim were handed over to the insurance company. Company had declined the claim only due to the fact that nominee in the policy was made of Sh. Zafar Paute who was already dead before taking this policy. She further stated that company was not justified in repudiating the claim and closing the file only on that account. The DLA died during the currency of the policy due to accident in a foreign country and DLA has family comprising of wife, 3 children and mother. During the course of hearing, complainant submitted that her son died in Dubai who was insured for a sum of Rs. 10,00,000 by Reliance General Insurance Company Ltd. She pleaded that the claim is payable and the same could be paid to the widow of the DLA Smt. Nazma Bano. She further submitted that the father of the DLA died much prior to taking the policy by DLA. Therefore, name of nominee was incorrectly mentioned in the policy due to the negligence of the person who filled the proposal form. Life assured was issued the policy before going to Dubai and such policy was issued through agent who was not knowing the death of the father of DLA and therefore, wrongly filled his name as nominee but the fact remained that the father of the DLA pre-deceased him. She further pleaded that after the death of DLA, claim is payable to the widow of the DLA and company was not justified in denying the claim only on the ground that nominee was deceased when policy was issued to the DLA.**
3. **Representative of the company was not prepared for the arguments as it appears that he was not aware about the facts of the case.**

4. **I have very carefully considered the submissions of the complainant and perused the documents placed on record. I have also perused letter dated 07.058.2012 wherein, it was mentioned that in absence of proper nominee details, the claim could not be entertained. After due consideration of the matter, I hold that company was not justified in observing that claim could not be entertained in absence of proper nominee details because company cannot deny that DLA died due to accident during the currency of the policy bearing no. 1804502815008536. Merely, because in the policy issued to the DLA dead person was mentioned as nominee, the company cannot escape its liability. No other deficiency was pointed out of the insurance company. In my considered view claim was payable and company ought to have discharged its liability in time. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 10 lacs to the widow of the DLA Smt. Nazma Bano.**

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/450/UII/11
In the matter of Sh. Shaleen Vyas
Vs
United India Insurance Company Ltd.

AWARD DATED 27.2.2013 NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Shaleen Vyas (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 settlement of mediclaim.**

2. **Complainant stated that as required, he had made his representation to GRO of the company but he did not get any response. He further submitted that company had not settled the claim though, considerable time had elapsed. As against total claim of Rs. 3,28,903 company had paid only a sum of Rs. 1,11,983 vide cheque no. 894338 dated 29.08.2011. It was further stated that company was not justified in making a deduction of Rs. 2,16,920 while settling the claim. He has come to this forum with a request to get the balance claim settled. During the course of hearing, it was pleaded by him that claim was partially settled by the company. He requested for the payment of the balance claim.**

3. **Representative of the company submitted that after review of the claim company decided to pay 35% of total claim. During the course of hearing, representative of the company was required to submit the peruse reasons for payment of only 35% of the claim but the company had not filed its 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 settling the claim partially. Company had paid only a sum of Rs. 1,11,983 as against total claim of Rs. 3,28,903. Company had not provided any reasons in not paying the full amount. Despite specific querry raised during the course of hearing, company had not clarified as to why it had paid only 35% of claimed amount. In my considered view company was not justified in**

making deductions while settling the claim. There appears to be no rationale in restricting the claimed amount to 35%. Accordingly an Award is passed with the direction to the insurance company to make the further payment of Rs. 2,16,250.

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

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DELHI OMBUDSMAN CENTRE

Case No.GI/586/Star/11
In the matter of Sh. Sanjeev Gupta
Vs
Star Health & Allied Insurance Company Ltd.

AWARD DATED 26.2.2013 NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Sanjeev Gupta (herein after referred to as the complainant) against the decision of Star Health & Allied General Insurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to settlement of mediclaim.**

2. **Complainant stated that his brother Sh. Anup Gupta had taken policy and renewed it also with Star health & Allied Genenral Insurance Company Ltd. for a sum insured of Rs. 10,00,000 effective from 28.12.2010 to 27.12.2011. He further submitted that his brother Sh. Anup Gupta was suffered from left basal ganglia bleed on 27.07.2011. He was immediately taken to Saroj hospital, Rohini and there after he was referred to Sir Ganga Ram Hospital for further treatment. He was shifted to Sir Ganga Ram Hospital in a life saver ambulance equipped with ventilator, oxygen etc. along with doctor to avoid risk during transit. At Sir Ganga Ram Hospital, Sh. Anup Gupta underwent major surgery twice, first on 28.07.2011 and second on 29.09.2011. Claims were filed with the insurance company but the company settled the claims after making deductions. As against total claim of Rs. 5, 26,671, the company had paid only Rs. 3,55,867 making deduction of Rs. 1,70,804 He further submitted that deductions were un reasonable and un called for. He has come to this forum with a request to pay the dis allowed amounts of the claims amounting to Rs. 1,70,804 along with penal interest. During the course of hearing, it was pleaded that claims were not settled properly and while settling the claims deductions were made which were not required.**

3. **Representative of the company pleaded that claims were settled properly and complainant does not deserve any further relief.**

4. **I have considered the submissions of the complainant as well as of the representative of the company. I have also perused claim settlement sheets. After due consideration of the matter, I hold that claims were not settled properly and certain deductions have been made which infact were not required to be made while settling the claims. Complainant further needs to be compensated by the company. Accordingly an Award is passed with the direction to the insurance company to make further payment of Rs. 17687.**

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/589/Apollo/11
In the matter of Sh. B.K. Sharma
Vs
Apollo Munich Health Insurance Company Ltd.

AWARD DATED 26.2.2013 NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. B.K. Sharma (herein after referred to as the complainant) against the decision of Apollo Munich Health Insurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to settlement of mediclaim.**

2. **Complainant stated that claim relating to treatment of Sh. Hari Prakash Sharma was filed with insurance company. he was covered in the policy bearing no. 1000159966. He had undergone an operation of changing the valve of heart in sarvada hospital, Sector – 8, Faridabad. An expenditure of Rs. 1,90,000 was incurred. Operation was done on 18.11.2011. All requisite documents were submitted to the company but the company did not settled the claim. Company was reminded about the claim. He has come to this forum with a request to get the claim settled. During the course of hearing, it was pleaded that mediclaim policy is**

continuing since 2007. Patient was admitted on 15.11.2011 and discharged on 21.11.2011. Claim filed was payable but company denied it.

3. **Representative of the company pleaded that claim was not payable due to non submission of requisite documents. Company also filed written reply dated 05.09.2012 wherein in para- 8 it was submitted that claim was submitted for reimbursement of Rs. 1,90,000 incurred on treatment of disease during hospitalization period from 15.11.2011 to 21.11.2011 at Sarvada hospital. Bills were further required by the company to be submitted by the insured but such details were not provided to the insurance company. Company had denied the assertion of Sh. B.K. Sharma that all documents were submitted to the company. Due to non submission of the requisite documents, the claim was closed.**

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 which is placed on record. After due consideration of the matter, I hold that company was not justified in not settling the claim so far despite the submission of all the requisite documents to the insurance company. I have no reason not to believe the version of the father of the patient that all requisite documents have been provided to the company. I have perused the discharge summary and other related documents. In my view claim was payable and company ought to have allowed it. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 1, 20,000.**

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

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

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DELHI OMBUDSMAN CENTRE

Case No.GI/585/Star/11
In the matter of Sh. Sanjay Goel
Vs
Star Health & Allied Health Insurance Company Ltd.

AWARD DATED 26.2.2013 NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Sanjay Goel (herein after referred to as the complainant) against the decision of Star Health & Allied General Insurance**

Company Ltd. (herein after referred to as respondent Insurance Company) relating to settlement of mediclaim.

2. **Complainant stated that he was insured vide policy no. P/161118/01/2011/005731 issued by Star Health & Allied General Insurance Company Ltd. This policy was issued on 26.02.2010. He further submitted that he was admitted in Jaipur Golden hospital on 16.02.2012 and was discharged on 18.02.2012. He had chest and stomach problems. He submitted the claim for an amount of Rs. 16,461 but company had declined to pay the claim. He also approached the GRO of the company but the claim was not settled. He has come to this forum with a request to get his claim settled. During the course of hearing, it was pleaded that claim was payable but company had denied it. He was advised by the doctor to get admitted in the hospital.**

3. **Representative of the company pleaded that there was no necessity of getting admission in the hospital and thus claim was not payable. Company also filed written reply dated 24.04.2012 wherein, it was submitted that company had issued the policy bearing no. P/161118/01/2010/002791 for the period 26.02.2010 to 25.02.2011 and P/161118/01/2011/005763 for the period 26.02.2011 to 26.02.2012 covering Sh. Sanjay Goyal, Smt. Alka Goel, master Tanish Goel and master Vansh Goel for the sum insured of Rs. 4,00,000. Company had received the claim for treatment of Sh. Sanjay Goel for the treatment of coronary syndrome and Gastritis at Jaipur Golden hospital. On perusal of the hospital records, company found that hospitalization was not required and even patient was admitted for investigation and evaluation only and there was no active treatment.**

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 declining the claim because insured was not only admitted in the hospital on the advice of the doctor but was also treated. In my considered view claim was payable and company ought to have allowed it. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 16123.**

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/591/UII/11
In the matter of Sh. Jatinder Kaur Bagga
Vs
United India Insurance Company Ltd.

AWARD DATED 26.2.2013 NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Jatinder Kaur Bagga (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 settlement of mediclaim.**

2. **Complainant stated that she had already approached the GRO of the company but she did not get any response. She further stated that she was covered vide policy no. 221605/48/10/06/0001794 issued by United India Insurance Company Ltd. She was having pain in her back for some time and consulted the doctor J.S. Ranyal on 03.03.2011 who advised X-ray, blood tests after which she was prescribed medicine and physiotherapy but she did not get desired relief even after 1 ½ months and she took another opinion from Dr. P.M. Singh on 14.05.2011 who advised MRI and bone density tests and after seeing the reports he advised her to consult at Rajiv Gandhi Cancer Institute. On 16.05.2011 she visited Rajiv Gandhi cancer Institute and registered herself vide CR no. 131523. Certain tests were advised, which were duly done and on the basis of the reports she was advised Chemotherapy. Since it was a serious ailment, she had gone to Sir Ganga Ram hospital on 23.05.2011 for second opinion before starting the treatment. She was advised to undergo certain tests. She was not convinced with the treatment given to her and she consulted at AIMS, Dr. P.K. Julka department of Radiology and oncology on 25.5.2011. He perused the various reports of her and advised for admission of administer some medicine once for a week under supervision and observation. She got admitted in the hospital on 02.06.2011 and got discharged on 03.06.2011. During the course of hearing, it was pleaded by the complainant that claim was payable but company had denied it by submitting that she was having lumps in the body.**
3. **Representative of the company pleaded that claim was not payable due to pre-existing disease. Clause 4.1 of the policy was referred to by the representative of the company for denying the claim. Company also filed written reply dated 12.07.2012 wherein it was mentioned that Smt. Bagga was suffering from a disease**

i.e. carcinoma left breast with bone metastatsis. Complainant was first manifested 3 years ago. As per consultation Slip dated 31.05.2011 for AIIMS. Company had issued the mediclaim policy bearing no. 221505/48/10/06/00001794 for the period 10.03.2010 to 09.03.2011 for the first time. In the written reply, the decision of TPA of repudiating the claim was held correct due to pre-existing disease.

4. **I have considered the submissions of the complainant as well as of the representative of the company. I have also perused the reply of the company, repudiation letter and other documents placed on record. After due consideration of the matter, I hold that company was not justified in rejecting the claim on ground of pre-existing disease because there was no evidence on record brought by the insurance company that patient was suffered from Carcinoma prior to taking the policy. As per reply of the company dated 12.07.2012, the policy was taken w.e.f. 10.03.2010 with it for the first time though, she was taking policy from early period. Company had not brought on record any evidence that she was having carcinoma on or before on inception of the policy. Therefore, in my view claim was payable and company ought to have allowed it. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 1,73,027.**

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/593-A/OIC/11
In the matter of Smt. Sneh Gupta
Vs
Oriental Insurance Company Ltd.

AWARD DATED 6.3.2013 NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Smt. Sneh Gupta (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 non settlement of mediclaims.**

2. **Complainant stated that she was covered vide policy no. 271901/48/2011/1988 for period from 22.09.2010to 21.09.2011. She filed the claim relating to two hospitalization first for the period 25.08.2011 to 30.08.2011 and again for 01.09.2011 to 07.09.2011. As regards first claim which was filed by her on 06.09.2011, TPA E-meditek has done it as no claim as this claim relates to hysterectomy where as hospital performed the surgery for ovarian cyst which is mentioned in the discharge summary. The second claim was rejected by the E-meditek on the ground of post operative complication relating to hysterectomy and according to TPA, hysterectomy is covered after 2 years. She further stated that she was not satisfied with the reasons given by the TPA for rejection of the second claim. Actual reason for hospitalization of Mrs. Sneh Gupta was intestinal obstruction and the treatment was given for the same problem. The discharge summary clearly states that the diagnosis is Intestinal obstruction. She further stated that the mediclaim policy is continued since 22.09.2000to 21.09.2007 with Oriental Insurance Company Ltd. and there after the policy was taken from Reliance General Insurance Company Ltd. for 2 years and then again from Oriental Insurance Company Ltd. She further states that the policy was continued. The company was not justified in rejecting the claim. She also approached the GRO of the company but she was not provided any solution. She had filed the first claim for an amount of Rs. 1,27,321 and second claim for an amount of Rs. 47,059. She is a salaried person and had borrowed the money to pay for the treatment. She has come to this forum with a request to get her claims paid. During the course of hearing also it was pleaded by the complainant that claims are payable.**

3. **Company was not represented during the course of hearing despite specific information given by this office on date of hearing.**
4. **I have considered the submissions of the complainant very carefully. I did not have the benefit of arguments or written reply of the company because neither the company was represented on the date of hearing nor it file any reply on the complaint of the complainant. I have also perused the discharge summary issued by the hospital relating to both the claims. After due consideration of the matter, I hold that both the claims are payable. The policies continued without any gap since 22.09.2000 till date. Both the claims relating to the policy no. 271901/48/2011/1988 for the period 22.09.2010 to 21.09.2011. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 171042 (125521 + 45521).**

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/403/NIC/11
In the matter of Smt. Shirin Akhtar
Vs National Insurance Company Ltd.

AWARD DATED 6.3.2013 NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Smt. Shirin Akhtar (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 partial settlement of motor claim.**

2. **Complainant stated that she got her private car wagon R with registration number DL-8-CQ-8763 insured with National Insurance Company Ltd. vide policy no. 121191125 valid from 15.05.2011 to 14.05.2012. On 09.09.2011 when she was returning from her work place namely Zakir Hussain college, the vehicle got suddenly stopped and the engine got automatically off. It was raining and in some areas the pits were filled with water. Her vehicle got stopped suddenly engine automatically off. Thereafter, her driver pushed the vehicle out of the water logged area and called Maruti on road services (MOS) immediately. The MOS came to the spot and inspected the vehicle and suggested her to take it to some authorized Maruti service station without igniting the engine. As per the instructions she got the vehicle towed and taken it to the nearby Apra Auto, Okhla. Apra Auto inspected the vehicle and asked her to fill up the insurance claim form which she did and waited for the processing of insurance claim. After 2 or 3 days she came to know that work shop did not start the work due to non issuance of the work order from the insurance company. She got the contact number of surveyor Sh. Vipin and enquired about the status of the claim but there was no satisfactory reply. Thereafter, her husband followed up with the insurance company. she further stated that a mail was received from Mr. P.K. Sapra, relationship manager of the company who admitted the liability of only Rs. 2500. She further stated that she had spent a sum of Rs. 37947 on repair of the vehicle against which the company has paid only a sum of Rs. 35,00. She has come to this forum with request to direct the insurance company to pay the entire amount of money spent by her on repairing of the vehicle. She also sought further compensation for mental harassment. During the course of hearing, it was pleaded that claim was partially**

settled by the company and company had accepted its liability only to the extent of Rs. 3507 as against the total claim of Rs. 37,947. It was further mentioned that the car was being driven by the driver and the car stoped all of a sudden due to water logging and once the vehicle stopped, no attempt was made to restart it.

3. **Representative of the company stated that claim was paid as per policy terms and conditions. Company also submitted written reply dated 18.01.2012 which stated the liability of the company to Rs. 3507/- and as regards remaining claim of the complainant which was stated to be a consequential loss which is not allowable. It was further mentioned that engine head and allied parts have been disallowed, since the damages to these components were not due to insured tariff, but due to non taking sufficient step to safe guard the vehicle from the further loss or damage after the primary accident leading to the aggravation of the loss, this is an exclusion under the policy terms and conditions.**

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 partially settling the claim because I have no option but to accept the version of the complainant that once insured vehicle stopped all of a sudden due to water logging, no effort was made to restart the vehicle. Company was not justified at all to pay only a sum of Rs. 3500 to work shop. Accordingly company is directed to consider the overhauling of the engine and pay the admissible amount to the complainant. 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.**

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DELHI OMBUDSMAN CENTRE

Case No.GI/491/UII/11
In the matter of Sh. Prahlad Gupta
Vs
United India Insurance Company Ltd.

AWARD DATED 6.3.2013 REPUDIATION OF MEDICLAIM

1. **This is a complaint filed by Sh. Prahlad Gupta (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 was taking mediclaim insurance policy for the last 5 years. He further submitted that he remained in hospital from 10.05.2011 to 12.05.2011 in Holi Family Hospital and he submitted original bill along with original documents to Medsave TPA Pvt. Ltd. He has perused the matter with TPA but he did not get any convincing reply. Company also rejected his earlier claim which was got settled through Ombudsman. His claim was rejected by the insurance company ultimately. He submitted that his claim was genuine and therefore, he has come to this forum with a request to get him paid the claimed amount of Rs. 21,440. During the course of hearing also, it was pleaded by him that though claim was payable yet the company denied it. Similar, claim was allowed earlier.**

3. **No reply was submitted on behalf of the company. Representative of the company pleaded that claim was not payable.**

4. **I have considered the submissions of the complainant as well as of the representative of the company. I have perused the repudiation letter dated 03.02.2012. Company did not file any reply despite the direction to the representative of the company on the date of hearing on 11.12.2012. After due consideration of the matter, I hold that claim was payable and insurance company was not justified in repudiating it. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 21326.**

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/570/APOLLO/11

In the matter of Sh. Ashish Gupta.

Vs

Apollo Munich Gen. Health Ins. Co. Ltd.

AWARD DATED 12.02.2013 : PARTIAL SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Ashish Gupta (hereinafter referred to as the complainant) against Apollo Munich Gen. Health Ins. Co. Ltd. (Hereinafter referred to as respondent insurance company) relating to mediclaim.**

2. **Complainant stated that as advised by this office, he had sent his representation to the grievance redressal officer of the company but his claim was again rejected. He has come to this forum with a request to get his claim settled. During the course of hearing it was pleaded by the complainant that company had settled the claim partially. Two claims were filed, in the second claim deduction was made which was unjustified. Deductions for the room rent were unjustified. It was further pleaded by him that patient remained in the hospital throughout and the patient did not move out of the hospital.**

3. **Representative of the company pleaded that claim was settled properly.**

4. **I have considered the submissions of the complainant as well as of the representative of the company. After due consideration of matter, I hold that company had not settled the claim properly because patient remained in the hospital throughout and the claim should have been settled as if the patient stayed at stretch in the hospital, though for sometime room was not available for the patient in the hospital but the fact remained that the patient remained throughout in the hospital and therefore claim should have been treated s only one claim and settled accordingly. There appears to be no justification on for making deduction of Rs.8,188 while settling the claim submitted for Rs.15,956. Company had settled the claim for Rs.23, 026 out of claim of Rs. 23,326 making deduction of Rs.300. this settlement of the claim may be treated as properly settled but as regards other claim was settled for Rs.7,768 after making deduction of Rs.8,188, that was not properly settled by the company. In my considered view as there is no capping for room rent in the policy issued by the company to the insured, Company was not**

justified in making deduction for room rent. This is admissible. Accordingly an Award is passed with the direction to the insurance company to make payment of Rs. 8,000.

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

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

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DELHI OMBUDSMAN CENTRE

Case No.GI/572/NIC/11

In the matter of Sh. Ved Prakash Ahuja.

Vs

National Ins. Co. Ltd.

AWARD DATED 12.02.2013 FOR NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Ved Prakash Ahuja (hereinafter referred to as the complainant) against National Ins. Co. Ltd. (Hereinafter referred to as respondent insurance company) relating to mediclaim.**

2. **Complainant submitted that company was not justified in denying the claim as per clause 4.3 of the policy because the disease for which he suffered was not pre-existing therefore clause 4.3 had no application. Company was unnecessarily harassing him by declining the claim. During the course of hearing which was attended by the son of the complainant, argued that claim was payable but company denied it. Complainant fell ill, he felt pain in the chest and was admitted in the hospital.**

3. **Representative of the company pleaded that claim was not payable due to the facts that such claim was not admissible in the 2nd year of the policy period. Company also filed written reply dated 09.04.2012 wherein it was mentioned that after scrutiny of the case and discussion with settling agency company, it came to know that sh. Ved Prakash Ahuja was admitted in the hospital on 11.09.2011 and discharged on 16.09.2011 from Orchid Hospital & Heart Centre for Chronic**

Ischaemic Heart Disease and as per mediclaim policy terms and conditions heart diseases is not payable in the 2nd year of the policy period.

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 written reply of the company as well as repudiation letter. After due consideration of matter, I hold that company was not justified in denying the claim on the ground that policy was running in the 2nd year and the claim relating to heart disease is not payable in the 2nd yr of the policy period because heart disease does not have any waiting period. Accordingly an Award is passed with the direction to the insurance company to make payment of Rs. 34,409.**
5. **The award shall be implemented within 30 days of receipt of the same. The compliance of the award shall be intimated to my office for information & record.**
6. **Copies of the Award to both the parties.**

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DELHI OMBUDSMAN CENTRE

Case No.GI/579/OIC/11

In the matter of Sh. Nikhil Kareer.

Vs

Oriental Ins. Co. Ltd.

AWARD DATED 12.02.2013 : NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Nikhil Kareer (hereinafter referred to as the complainant) against Oriental Ins. Co. Ltd. (Hereinafter referred to as respondent insurance company) relating to mediclaim.**

2. **Complainant stated that he had got happy family floater policy from Oriental Ins. Co. Ltd. He further stated that his wife was admitted and got treatment at Sir Ganga Ram Hospital and he paid bill of the hospital for an amount of Rs.35,000 for her treatment but he had not been reimbursed by the insurance company. He had also sent his representation to the grievance redressal officer of the company. He has come to this forum with a request to instruct the insurance company to settle the claim. Complainant did not attend on the date of hearing.**

3. **Representative of the company pleaded that claim was settled as per terms and conditions of the policy. It was further argued that claim was settled with reference to the pre-enhanced sum insured which was Rs. 1 lac. Company had submitted written reply wherein it was stated that claim was settled for Rs.15,035, after making deductions of Rs.7,655. As per happy family floater policy, sum insured of Rs.1lac was applicable. The TPA had already released the payment of Rs.15,035 vide cheque dated 01.03.2012.**

4. **I have considered the submissions of the complainant as well as of the representative of the company. After due consideration of matter, I hold that company had not settled the claim properly because claim was settled with reference to pre-enhanced sum insured of Rs.1lac whereas the claim should have been settled with reference to the sum insured when claim was filed i.e. to say company ought to have settled the claim with reference the sum enhanced sum insured. Thus complainant is found further entitled to the sum of Rs.2,146. Accordingly an Award is passed with the direction to the insurance company to make further payment of Rs. 2,146.**

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

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

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DELHI OMBUDSMAN CENTRE

Case No.GI/573/NIC/11

In the matter of Sh. Prashant Vaidya.

Vs

National Ins. Co. Ltd.

AWARD DATED 12.02.2013 : DELAY IN SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Prashant Vaidya (hereinafter referred to as the complainant) against National Ins. Co. Ltd. (Hereinafter referred to as respondent insurance company) relating to mediclaim.**

2. **Complainant stated that he had taken a mediclaim policy from National Ins. Co. Ltd. in June, 2010. He suffered severe pain in his legs and after investigation it was**

diagnosed Left Vericose Veins and he was advised by the Dr. to undergo a surgery at Metro Hospital and Cancer Institute, Preet Vihar,New Delhi. TPA Alankit health care was informed and it was conveyed that the claim is admissible. After discharge from the hospital on 03.07.2010, post-hospitalization treatment was completed on 03.09.2010. The claim form along with all requisite medical bills was submitted to the TPA on 06.09.2010. On 15.11.2010 he received a reply from the insurance company that claims was rejected as the claim papers were not submitted within 30 days of the discharge. He further submitted that since post hospitalization was completed on 03.09.2010, the claim documents were submitted on 06.09.2010 and thus within 30 days of the treatment. He further submitted that his treatment continued till 03.09.2010 then how can he have submitted the claim before that date. He has come to this forum with a request to get the claim settled at an early date. During the course of hearing also complainant argued that claim was payable but company had denied it.

3. **Representative of the company argued that company intended to settle the claim and requested the submissions of the bank details but due to non-submission of required documents on the part of insured, claim could not be settled.**

4. **I have considered the submissions of the complainant as well as of the representative of the company. After due consideration of matter, I hold that company was not justified in not settling the claim so far because claim was payable. Complainant was under the bonafied belief that he was required to submit the claim within 30 days of the completion of the treatment though he was required to submit the claim within 30 days of the date of discharge. In my considered view claim is payable and was also agreed by the representative of the company during the course of hearing. Claim otherwise admissible can not be declined on technical ground i.e. only on the ground of delay of submission of the claim. Accordingly an Award is passed with the direction to the insurance company to make the payment of admissible amount along with panel interest at the rate of 8% with effect from 10.11.2010 to the date of actual payment.**

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

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

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DELHI OMBUDSMAN CENTRE

Case No.GI/606/UII/11

In the matter of Sh. Gautam Chand Jain.

Vs

United India Ins. Co. Ltd.

AWARD DATED 19.02.2013 : DENIAL OF MEDICLAIM

1. **This is a complaint filed by Sh. Gautam Chand Jain (hereinafter referred to as the complainant) against United India Ins. Co. Ltd. (Hereinafter referred to as respondent insurance company) relating to mediclaim.**

2. **Complainant submitted that he had submitted claim and related documents through registered post to TPA on 06.07.2011. He further submitted that subsequently whatever information was desired by the TPA, was also provided to him. He had contacted the insurance company but he was not informed anything about the claim. He also approached regional office of the company at Jaipur and requested for early settlement of the claim. Though he had submitted the claim and related documents in time, yet his claim was rejected on the ground for late submissions of the claim. He has come to this forum with a request to instruct the insurance company to settle the claim along with panel interest at the rate of 12%. During the course of hearing, it was pleaded by the complainant that claim was payable but company had denied it due to late submissions of the claim.**

3. **Representative of the company pleaded that claim was not payable due to late submissions of the claim. Company also filed written reply dated 15.05.2012 wherein it was mentioned that insured Sh. Gautam Chand Jain was admitted in Joshi Hospital on 26.05.2011 and discharged on 1.06.2011. He submitted his claim papers to the TPA M/s E-Meditek Ltd Jaipur on 11.07.2011 i.e. with delay of 40 days. TPA requested the insured to file reasons for late submissions of the document but insured had not provided required documents in time which was the violation of condition no. 5.4 of our policy, therefore 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 reply of the company which is placed on record. After due consideration of matter, I hold that company was not justified in denying the claim on the ground that claim was filed late. In my considered view an admissible claim can not be declined only on the ground of**

delay. The claim was payable. Accordingly an Award is passed with the direction to the insurance company to make payment of Rs. 38,743.

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

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

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DELHI OMBUDSMAN CENTRE

Case No.GI/31/UII/12

In the matter of Sh. Babulal Chejara.

Vs

United India Ins. Co. Ltd.

AWARD DATED 19.02.2013 : NON SETTLEMENT OF MEDICLAIM.

1. **This is a complaint filed by Sh. Babulal Chejara (hereinafter referred to as the complainant) against United India Ins. Co. Ltd. (Hereinafter referred to as respondent insurance company) relating to mediclaim.**

2. **Complainant submitted that he had a hospitalization cover vide policy bearing no. 140400/48/09/97/00000262 which got renewed on scheduled time. Complainant further submitted that the claim under reference related to the treatment to his son Anil Kumar which was repudiated by the insurance company TPA M/s E-Meditek Services Ltd. the claim was repudiated on the ground of delayed submissions. He further submitted that claim was intimated at the correct time as per guidelines. His son suffered from head injury and had to be operated. The treatment of his son is still continuously. Even after discharge from the hospital on march/29/2010. He had to continue to consult the doctors again and again. He had filed the claim for the first time though he has been taking medical policy for the last 10yrs. And he never believed in putting the fake claim just to recover insurance premium. He has come to this forum with a request to get the claim settled. During the course of hearing which was attended by the authorized representative, it was pleaded that claim was payable but company had denied it on flimsy ground.**

3. **Representative of the company pleaded that claim was not payable due to delay in submitting the claim.**

4. **I have considered the submissions of the complainant as well as of the representative of the company. I have also perused repudiation letter dated 11.09.2010. After due consideration of matter, I hold that company was not justified in denying the claim only on the ground of delay occurred in submission of the claim. In my considered view the admissible claim cannot be declined only on the ground of delay. Claim was payable and company ought to have allowed it. Accordingly an Award is passed with the direction to the insurance company to make payment of Rs. 20,596 along with panel interest at the rate of 8% with effect from 24.09.2010.**

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

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

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DELHI OMBUDSMAN CENTRE

Case No.GI/48/UII/12

In the matter of Sh. K.C Jain.

Vs

United India Ins. Co. Ltd.

AWARD DATED 19.02.2013 INADEQUATE SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. K.C Jain (hereinafter referred to as the complainant) against United India Ins. Co. Ltd. (Hereinafter referred to as respondent insurance company) relating to mediclaim.**

2. **Complainant submitted that he was insured vide policy no. 140604/48/11/97/00000412 by United India Ins. Co. Ltd. He has been taking mediclaim Ins. Policy for the last 9 yrs. He further submitted that he had submitted all requisite documents at various stages of hospitalization. The TPA**

E-Meditek randomly passed the claim for Rs.1,10,000. Thereafter a sum of Rs.30,000 was given thus total sum of Rs.1,40,000 was given as against the claim of Rs. 2,70,800. He has sum insured of Rs.3lacs and as per policy term was eligible to get 70% of sum insured which comes to Rs. 2,10,000. Though he did not attended the hearing but requested to settle the claim on the basis of the papers already filed on records.

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

4. **I have considered the submissions of the complainant as submitted by him in the complaint as well as the verbal arguments of the representative of the company. After due consideration of matter, I hold that claim was partially settled by the insurance company and had paid a sum of Rs.1,40,000 as against the claimed amount of Rs.2,70,800. Insured was having the sum of Rs.3 lacs at the time of filing the claim, insured was entitled to 70% of the sum insured which is worked out of Rs. 2,10,000 and which is less than the claimed amount. Since complainant was entitled to 70% of the sum insured but he had been given only a sum of Rs. 1,40,000. The complainant needs to be further compensated by making payment of Rs. 70,000. Accordingly an Award is passed with the direction to the insurance company to make further payment of Rs.70,000.**

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

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

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DELHI OMBUDSMAN CENTRE

Case No.GI/271/UII/12

In the matter of Sh. Anil Gupta.

Vs

United India Ins. Co. Ltd.

AWARD DATED 19.02.2013 :INADEQUATE SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Anil Gupta (hereinafter referred to as the complainant) against United India Ins. Co. Ltd. (Hereinafter referred to as respondent insurance company) relating to mediclaim.**

2. **Complainant submitted that on Aug, 2, 2011, he had undergone an Angiography and Angioplasty in Fortis Escorts Hospital, Jawaharlal Nehru Marg, Malviya Nagar, Jaipur. He paid for his medical treatment an amount of Rs. 3.24 lacs. He submitted the claim along with medical reports to the TPA, however TPA had only paid a sum of Rs. 1.57 lacs as maximum payable amount of 70% of Rs. 2.25 lacs whereas he was entitled to Rs. 2.8 lacs being 70% of (2.75 lacs + 1.25 lacs) as he had taken two insurance policies one for Rs. 2.25 lacs and another for Rs. 1.25 lacs. He had requested many a times the office of the company and TPA to settle the claim. However all his requests were of no. avail. He also resorted to issue the legal notice for appropriate settlement of the claim. However his claim was not settled properly so far. He has come to this forum with a request to issue necessary directions to the insurance company to release the remaining amount of Rs. 1.23 lacs at the earliest. During the course of hearing it was pleaded that the claim should have been settled by the insurance company with reference to the sum insured in both the policies as both the policies period relates to 2011-2012.**

3. **Representative of the company pleaded that claim was settled properly. Company also filed written reply dated 28.01.2013 wherein details of the policies were given. It was further mentioned that patient was admitted in the hospital on 02.07.2011 and treated for PTCA+STENTING TO AD AND LEFT PDA which comes under major surgeries. Since patient was a non-case of hypertension for ½ years at the time of surgery, the sum insured was taken for the policy period of 2009-2010 for settling the claim. Insured was entitled to a**

sum of Rs. 2,27,500 and thus company admitted that a sum of Rs. 70,500 was still admissible.

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 28.01.2013 which is placed on record. After due consideration of matter. I hold that company was not justified in taking the sum insured for the period 2009-2010 in respect of both the policies while settling the claim because patient was admitted on 2.08.2011 and thus sum insured has to be taken 2, 75,000 and 1, 25,000 relevant to the policy period 2011-2012. The disease has no waiting period. The disease was detected for the first time in policy period 2011-12 and it's for the purpose of settlement of the claim sum insured of Rs.4 lacs (2.75 lacs+1.25lacs) should have been taken by the insurance company while settling the claim. As per terms and conditions of the policy complainant was entitled to 70% of sum insured or expenditure incurred by him on the treatment whichever is less. As mentioned in the complaint, he spent a sum of Rs.3,24,000 for his treatment whereas 70% of total sum insured of both the policies is worked out to Rs.2,80,000 whereas as per letter dated 28.01.2013 complainant was paid only a sum of Rs.2,27,000 thus complainant is further found entitled to a sum of Rs. 53,000. Accordingly an Award is passed with the direction to the insurance company to make further payment of Rs. 53,000.**

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

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

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DELHI OMBUDSMAN CENTRE

Case No.GI/230/NIC/12.

In the matter of Sh. Anant Kedia.

Vs

National Ins. Co. Ltd.

AWARD DATED 21.2.2013: DELAY IN SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Anant Kedia (hereinafter referred to as the complainant) against National Ins. Co. Ltd. (Hereinafter referred to as respondent insurance company) relating to mediclaim.**

2. **Complainant submitted that he has been taking mediclaim insurance policy from National Insurance Co. Ltd. for the last many years. In last year, he was diagnosed a case of cancer for which claim was submitted to Vipul TPA, Jaipur. He was filing the claims for Re-imbursement but the company was not responding to him. After every few months company demanded documents from him though, he had already submitted. It appears that company was deliberately delaying the payment. Considerable time has elapsed since claims were been made. He had submitted all the prescriptions and discharged slips relating to the claims. He has come to this forum with a request to get the claims paid / settled at an early date. During the course of hearing, it was pleaded by him that company did not settle the claims so far, though he submitted all requisite documents to the insurance company for settlement of the claims. As sum insured is Rs.5 lacs for the policy period 25.02.2011 to 24.02.2012, it was pleaded by him that claims needed to be settled with reference to sum insured of Rs.5 lacs.**

3. **Representative of the company argued that company decided to settle the claims and sent discharge vouchers but duly signed discharged vouchers were not received perhaps the discharged vouchers were sent at wrong address.**

4. **I have considered the submissions of the complainant as well as of the representative of the company. After due consideration of matter, I hold that company was not justified in not settling the claims so far. It is also quite surprising that discharged vouchers were sent at wrong address. Company is to send discharged vouchers at the correct address now. It is to be mentioned that**

since sum insured was Rs.5 lacs with effect from 25.02.2011, while settling the claims, the insured sum insured of Rs. 5 lacs has to be considered. Cumulative bonus if any has also to be considered while settling the claim. The claims are payable. Accordingly an award is passed with the direction to the insurance company to make payment of Rs.4, 03,225.

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

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

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DELHI OMBUDSMAN CENTRE

Case No.GI/96/NIC/12.

In the matter of Smt. Mamta Rawat.

Vs

National Ins. Co. Ltd.

AWARD DATED 21.2.2013 : DENIAL OF MEDICLAIM

1. **This is a complaint filed by Smt. Mamta Rawat (hereinafter referred to as the complainant) against National Ins. Co. Ltd. (Hereinafter referred to as respondent insurance company) relating to mediclaim.**

2. **Complainant submitted that her husband and her family are covered under the mediclaim policy bearing no. 3201102/48/10/8500000262 for sum insured of Rs. 1 lac each for the period 03.05.2010 to 02.05.2011. She further submitted that the claim to M/s Vipul Medicorp Ltd,Indore on 24.12.2010. All required documents were submitted along with the claim. Treatment was taken at Nanavati Hospital Mumbai for sudden chest pain. Whatever queries were raised on behalf of the TPA, the same were satisfied. The claim is pending for so long without any justification. She submitted that her husband died on 22.02.2011. She has come to this forum with a request to get the claim settled. During the**

course of hearing it was pleaded by the complainant that claim was denied for no valid reasons though the claim was payable.

3. **Representative of the company pleaded that claim was not payable due to pre-existing disease. Company also filed written reply dated 29.01.2013 wherein it was mentioned that the claim pertains to Indore office and the claim was processed. It further mentioned that patient was admitted as case of chest pain and discomfort. The claim was repudiated by the TPA.**

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 matter, I hold that company was not justified in repudiating the claim on the ground of pre-existing disease because no evidence was brought on record that insured was having the disease at the inception of the policy for which claim was preferred. In my considered view claim was payable and company was unjustified in denying the claim. Accordingly an Award is passed with the direction to the insurance company to make payment of Rs. 80,000.**

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

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

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DELHI OMBUDSMAN CENTRE

Case No.GI/571/NIC/11

In the matter of Sh. Vijay Singh Bhora.

Vs

National Ins. Co. Ltd.

AWARD DATED 26.2.2013 :INADEQUATE SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Vijay Singh Bhora (hereinafter referred to as the complainant) against National Ins. Co. Ltd. (Hereinafter referred to as respondent insurance company) relating to mediclaim.**

2. **Complainant submitted that he got cataract removed from his right eye by operation on 15.12.2010. The package amount was Rs.14,000 out of which the sum of Rs. 10,800 was cashless and he had to pay balance amount of Rs. 4,446. He paid up the claim for reimbursement for this amount but company had paid only a sum of Rs. 906 and balance amount was deducted. He has come to this forum with a request to get him paid the balance amount amounting to Rs. 3,540. He did not attend the hearing.**

3. **Representative of the company pleaded that claim was settled reasonably and complainant does not deserve any further relief. Company submitted written reply dated 21.09.2013 wherein it was mentioned that complainant was issued mediclaim policy bearing no. 370603/48/10/8500000627 for the period 30.10.2010 to 29.10.2011. Complainant was hospitalized from 13.12.2010 to 16.12.2010 for treatment of cataract. Complainant filed the claim for Rs. 4,446, company had paid a sum of Rs.906 by making deduction of balance amount. Company had given reasons for not allowing the balance amount.**

4. **I have considered the submissions of the complainant as well as of the representative of the company. I have also perused company's letters dated 21.01.2013 and dated 24.04.2012. After due consideration of matter, I hold that company was not justified in not making the payment of Rs.3200 on account of stay in the hospital and professional charges paid up by the complainant. Accordingly an award is passed with the direction to the insurance company to make further payment of Rs.3,200.**

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

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

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DELHI OMBUDSMAN CENTRE

Case No.GI/583/OIC/11.

In the matter of Sh. Prateek Gupta.

Vs

Oriental Ins. Co. Ltd.

AWARD DATED 26.2.2013 : DENIAL OF MEDICLAIM

1. **This is a complaint filed by Sh. Prateek Gupta (hereinafter referred to as the complainant) against Oriental Ins. Co. Ltd. (Hereinafter referred to as respondent insurance company) relating to mediclaim.**

2. **Complainant submitted that he submitted claim for the treatment of his father who was admitted to Moolchand Hospital in the year 2010. He submitted all requisite documents to TPA long back but had not received any reply even after six months. However thereafter he received one letter wherein the claim was rejected on the wrong ground. The purpose of taking the policy is to get the claim in case necessity arises. During the course of hearing it was pleaded by the complainant that claim was payable but company had denied it on wrong grounds.**

3. **Representative of the company argued that claim was not payable because patient was being given treatment of hypertension which has two years waiting period. From the letter dated 22.09.2011 it appears that the claim was repudiated upon the recommendation TPA. After going through the documents submitted by the insured, company found that patient was taking Anti-Hypertension drugs but in the discharged summary it was mentioned that**

patient was non-hypertensive which proves misrepresentation of facts by the insured. It was further mentioned that hypertension and its related complications fall under two year exclusion. Hence claim was not payable as per clause 4.3 and 5.9 of the policy terms and conditions.

4. **I have considered the submissions of the complainant as well as of the representative of the company. I have also perused repudiation letter dated 22.09.2011 and also discharged summary issued by the hospital. After due consideration of matter, I hold that company was not justified in repudiating the claim because the disease for which insured was treated and filed claim does not have any waiting period. The company ought to have admitted the claim as it was payable. Insured took the treatment relating to blockage in heart. Accordingly an Award is passed with the direction to the insurance company to make payment of Rs.1, 87,700.**

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

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

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DELHI OMBUDSMAN CENTRE

Case No.GI/588/OIC/11.

In the matter of Smt. Sumitra Devi.

Vs

Oriental Ins. Co. Ltd.

AWARD DATED 26.02.2013 NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Smt. Sumitra Devi (hereinafter referred to as the complainant) against Oriental Ins. Co. Ltd. (Hereinafter referred to as respondent insurance company) relating to mediclaim.**

2. **Complainant submitted that her husband died during the treatment. He was taking mediclaim insurance policy for the last 20 yrs. He was admitted in the**

hospital on 4.05.2010 and discharged on 18.05.2010, she submitted the claim for an amount of Rs.1, 86,000. She has come to this forum with a request to get the claim settled.

3 Representative of the company did not attend on the date of hearing.

4 I have very carefully considered the submissions of the complainant. I have also perused letter dated 28.09.201. After due consideration of matter, I hold that company was not justified in not deciding the claim so far. In my considered view claim was payable and company ought to have decided it and paid it. Accordingly an award is passed with the direction to the insurance company to make payment of Rs. 1,50,000.

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

6 Copies of the Award to both the parties.

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DELHI OMBUDSMAN CENTRE

Case No.GI/593/NIC/11
In the matter of Smt. Sneh Gupta
Vs National Insurance Company Ltd.

AWARD DATED 6.3.2013 NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Smt. Sneh 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 mediclaim.**

2. **Complainant submitted that her husband met with an accident and was hospitalized from 13.01.2011 to 16.01.2011. The TPA M/s Alankit Health Care Ltd. was intimated by an e-mail within a week of accident. Claim was submitted but such claim was rejected by the National Insurance Company Ltd. due to reason that intimation was not given on time. And the claim was filed after 30 days of discharge. Complainant submitted that it was not correct statement on the part of the company because claim was submitted within the 30 days of discharge. As per**

policy terms and conditions, she was entitled to reimbursement of expenses incurred after hospitalization within a period of 60 days. She has come to this forum with a request to get her claim settled. During the course of hearing, it was pleaded by the complainant that claim was payable but company had denied it due to late intimation of the claim. She was required to file discharge summary and papers relating to claim within 15 days.

3. **Representative of the company pleaded that claim was not payable because claim was filed late.**

4. **I have considered the submissions of the complainant as well as of the representative of the company. After due consideration of the matter, I hold that company was not justified in repudiating the claim only on the ground that intimation was given late and claim was filed late. In my view claim otherwise admissible cannot not be denied only on technical ground. The claim was payable. Accordingly an Award is passed with the direction to the insurance company to make the payment of admissible amount on the basis of claim papers submitted by the insure**

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/561/OIC/11
In the matter of Sh. Suprem Kumar
Vs Oriental Insurance Company Ltd.

AWARD DATED 6.3.2013 NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Suprem Kumar (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 mediclaim.**

2. **As advised, he had sent his representation to the GRO of the company but he did not receive any reply. He further submitted that he had been issued policy known as happy family floater policy bearing no. 214303/48/2011/4210. He further submitted that in the second year of policy period, his father Sh. Ram bhajan fell ill. He was informed that in case of admission at Indian Heart Institute, he would not**

be given cashless facility but on admission he came to know that Indian Heart Institute was not on the penal of the company. Therefore, he had to make payment. His father became ill again and he got him admitted in Batra hospital. He came to know there that he was not be given cashless facility there. He was short of money. He had to pay for treatment. Thereafter, he submitted the mediclaim but he did not get his claim so far. He has come to this forum with request to get his claim settled. During the course of hearing also, he submitted that he filed two claims with insurance company but the company did not settle the claims so far.

3. **Representative of the company pleaded that claims are not payable due to non submission of 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 so far because claims are payable and company ought to have decided such claims by now. Complainant had already submitted all requisite documents relating to treatment. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 67,144.**

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/508/NIA/11
In the matter of Sh. Gurbachan Singh Narula
Vs
New India Assurance Company Ltd.

AWARD DATED 6.3.2013 NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Gurbachan Singh Narula (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 mediclaim.**

2. **Complainant stated that he has been taking mediclaim insurance policy for the last 15 years and that same is continued without any break. On 11.06.2008, he gave a cheque for renewal of the said policy which due to inadvertence was returned by his bank. The moment he came to know about it, he met the branch manager who conveyed him that the cheque had not been received and he should wait till the cheque received. He again met the branch manager on 17.06.2008 who conveyed that policy can be renewed only after three tests pertaining to ECG, Urine and Blood Sugar. Since it was a joint policy along with his wife, he got the tests conducted between20.06.2008 to 26.06.2008 and took the same to the branch. He was advised to go to the Divisional branch of the company. He got the message from the branch that the report submitted was approved and he should pay the amount by cheque on the same day. He submitted the cheque. The policy was commenced w.e.f. 27.08.2008. he was never informed that it was a new policy and not the old policy which had he renewed. On 07.12.2009 his wife Smt. Kuljeet Kaur suffered paralytic stroke and she was admitted at Surya hospital on 12.12.2009. He lodged a claim for an amount of Rs. 30,277 regarding her hospitalization but said claim was denied by the TPA on the ground that attack took place within 2 years of the policy period and the same could not be entertained. He further submitted that his policy was continued for the last 15 years. He had given the representation but there was no response. He has come to this forum with a request to get the claim paid. He also had under gone an eye operation on 22.10.2010 for cataract for which the bill of Rs. 18,000 was submitted. This claim was passed for cataract for Rs. 16,200 as against claim of Rs. 18,000.**

3. **Representative of the company pleaded that claim was not payable as Hypertension has two years waiting period. Company also filed written reply dated 20.02.2013 wherein it was mentioned that a claim was lodged and which was paid for Rs. 18,766. Insured did not renew the cover in time and policy bearing no. 320303/48/06/20/70000177 issued w.e.f. 28.08.2008. Claim was reported in next policy bearing no. 320303/34/09/15/00000332 for the period28.08.2009 to 27.08.2010 which was rejected. The claim related to Mrs. Kuljeet Kaur, the claim was rejected. Hypertension and relating complication have 2 years waiting period. Further claim relating to operation of Sh. Gurbachan Singh for cataract this claim was approved by the TPA for Rs. 16,200 but cheque could not be credited in the insured account. Now the fresh cheque is issued of Rs. 16,200.**

4. **I have considered the submissions of the complainant as well as of the representative of the company. I have also perused reply of the company which is placed on record. After due consideration of the matter, I hold that company was not justified in denying the claim relating to paralytic stroke as this disease does**

not have any waiting period. The claim is held payable. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 26897. As regards claim relating to cataract the same was already settled by the insurance company and complainant was paid a sum of Rs. 16,200 as against the claim of Rs. 18000. This claim was settled properly.

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/562/RGI/11
In the matter of Sh. Jatinder Singh
Vs Reliance General Insurance Company Ltd.

AWARD DATED 6.3.2013 REPUDIATION OF MEDICLAIM

1. **This is a complaint filed by Sh. Jatinder Singh (herein after referred to as the complainant) against the decision of Reliance General Insurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to mediclaim.**

2. **Complainant stated that he had taken a family floater mediclaim policy silver plan of Reliance General Insurance Company Ltd. He submitted claim to the TPA on 05.04.2011 with all requisite documents. The TPA had raised a number of queries and the same were satisfied by him. Firstly, the claim was rejected on the ground that original documents have been tempered with and altered to make a claim with ulterior motive. Complainant had denied such allegations because he submitted all documents relating to treatment at Rajiv Gandhi Institute and Research Centre. All the documents were computer generated and there is no possibility to make alteration. He visited the TPA, he was assured that, that was a mistake and company would settle the claim but the same would be done by Mumbai office. He had pursued the matter, and again the claim was rejected. He has made representation to the GRO of the company also. It was also mentioned by the TPA that material facts were not disclosed in the proposal form. He also submitted that he had got a plan from Reliance General Insurance Company Ltd. wherein, pre-**

existing disease are covered from 3rd year onwards. Claim was made after two policy period i.e. for 3rd year. He has come to this forum with request to get the claim settled. During the course of hearing also complainant pleaded that claim was payable but company had denied it.

3. **Representative of the company pleaded that claim was not payable due to pre-existing disease. It was further argued that patient had symptom of disease prior to taking the policy. The patient was advised mammography prior to inception of the policy and thus claim was not payable. Company also filed written reply dated 20.02.2013 wherein, it was mentioned that Sh. Jatinder Singh obtained health wise policy from 10.12.2010 covering himself along with spouse and 2 children with sum insured of Rs. 3 lacs. On 14.03.2011. Smt. Jatinder Kaur got admitted in Rajive Ganndhi Cancer Institute and Research Centre and diagnosed a case of left duct ectasia, and she was discharged on 17.03.2011. Claim was submitted for the said hospitalization for Rs. 65,740. On scrutiny of the documents it was noticed that insured was suffering from the same ailment condition since last 2 years as mentioned in the discharge summary of the treating hospital. Policy was taken for the first time on 26.05.2008 and patient was suffering from ailment condition prior to inception of the policy. This fact was revealed from the OPD paper dated 24.05.2008 when Dr. Mrs. Bhupinder Kaur advised her to undergo mammography. Due to pre-existing disease, 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 of the company and also repudiation letter which are placed on record. After due consideration of the matter, I hold that company was not justified in denying the claim on account of pre-existing disease because cancer was detected much after taking the policy. There is no evidence on record brought by the company that patient was detected cancer patient prior to inception of the policy. Patient was not treated for cancer prior to inception of the policy there was no such evidence on record. Though she was advised mammography but that was negative. Thus in my view, company was not justified in denying the claim due to pre-existing disease. The claim was payable. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 56,090**

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.**

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DELHI OMBUDSMAN CENTRE

Case No.GI/06/NIA/12
In the matter of Ms. Anjula Shukla
Vs
New India Assurance Company Ltd.

AWARD DATED 11.4.2013 REPUDIATION OF MEDICLAIM

1. **This is a complaint filed by Ms. Anjula Shukla (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 relates to denial of claim. Complainant submitted that company was not justified in denying the claim amounting to Rs. 3200. During the course of hearing, it was pleaded that claim was not settled properly. Sum insured of Rs. 1,00,000 was taken for settlement of the claim. It was pleaded that claim should have been settled with reference to enhanced sum insured of Rs. 4 lacs. It was further pleaded that insured did not suffer from with pre-existing disease. Sum insured was enhanced from Rs. 1 lakh to 4 lakh in October 2009. Insured consulted doctor Sh. Shyam Aggarwal and no abnormality was found. She again consulted the doctor at Max Balaji hospital as she felt a lump. And on further investigation Carcinoma left breast was confirmed on 29.06.2010. The TPA sanctioned the room rent for Rs. 1000 per day whereas, room rent should have been allowed at the rate of Rs. 4,000 per day.**

3. **Representative of the company argued that claim was settled properly with reference to the sum insured of Rs. 1,00,000. Company also submitted written reply dated 21.05.2012, wherein, it was mentioned that insured was diagnosed a case of Carcinoma in 2001 when sum insured was Rs. 1 lakh under the policy. Sum insured was increased to Rs. 4 lacs in 2009.**

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 making deduction of Rs. 3200 because cancer was detected when sum insured was Rs. 4 lacs. Therefore, there was no justification to make any deduction on account of pre-existing**

disease. Accordingly an Award is passed with the direction to the insurance company to make further payment of Rs. 3200.

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.**

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DELHI OMBUDSMAN CENTRE

Case No.GI/04/RGI/12
In the matter of Sh. Arun Kumar Gupta
Vs
Reliance General Insurance Company Ltd.

AWARD DATED 11.4.2013 NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Arun Kumar Gupta (herein after referred to as the complainant) against the decision of Reliance General Insurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to mediclaim.**

2. **Complainant stated that he had taken mediclaim policy bearing no. 1305712825000173 from Reliance General Insurance Company Ltd. He submitted hospitalization bills along with necessary documents to the TPA mediassist India Pvt. Ltd. claiming amount of Rs. 10,091 but the company had settled the claim for Rs. 3,166 stating that consultation papers are not attached. He further submitted that he had submitted all requisite documents to the insurance company for settlement of the claim. He has come to this forum with a request to get him paid the balance amount. During the course of hearing, it was pleaded by the complainant that he was paid less than the amount due to him and requested for payment of the balance amount.**

3. **Representative of the company pleaded that requisite details were not submitted by the insured, therefore, certain deductions were made.**

4. **I have considered the submissions of the complainant as well as of the representative of the company. After due consideration of the facts on record including claim settlement sheets, I hold that complainant is further entitled to some relief. Company was not justified in settling the claim for Rs. 3166 as against the total claim of Rs. 10,091. Certain deductions were made which was absolutely un called for. Insured had submitted all requisite documents to the insurance**

company for proper settlement of the claim. Accordingly an Award is passed with the direction to the insurance company to make the further payment of Rs. 6565.

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/482/NIC/11

In the matter of Sh. Vipul Roy.

Vs

National Ins. Co. Ltd.

AWARD DATED 5.03.2013 NON SETTLEMENT OF MEDICLAIM

1This is a complaint filed by Sh. Vipul Roy (hereinafter referred to as the complainant) against National Ins. Co. Ltd. (Hereinafter referred to as respondent insurance company) relating to mediclaim.

2Complainant submitted that his Mother-in-law, Mrs. Sumedha was admitted in Apollo Hospital for pneumonia and her request for cashless was denied. He submitted the requisite documents for settlement of the claim. He pursued the matter but the claim was not settled so far. He also further submitted that he had not received some previous reimbursements also from the company relating to his Father's (late Prof. U.N Roy) treatment. When he had injury in 2005. He also further submitted that claim was not settled relating to treatment of his mother Smt. Nirmala Roy. She was being treated for cancer. He himself along with his wife Dr. Madhu Roy is Professionals. He has come to this forum with a request to get the pending claims settled. During the course of hearing also complainant submitted that that claims are payable yet company had not paid and settled the claims.

3Company was not represented on the last date of hearing i.e. on 15.02.2013 though company was represented on earlier occasion and the case was adjourned only on account of the fact that company's representative needed time to prepare the case.

4 I have considered the submissions of the complainant. I did not have the benefit of the arguments of the representative of the company. In my considered view claims

were payable and company was not justified in not settling the claims so far. Accordingly an Award is passed with the direction to the insurance company to make the payment relating to the treatment of Mrs. Sumedha amounting to Rs.37,308 and make payment of Rs. 8,998 for treatment of Sh. U.N. Roy.

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

6 Copies of the Award to both the parties.

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DELHI OMBUDSMAN CENTRE

Case No.GI/438/NIC/11

In the matter of Sh. Vijay Kumar Seth.

Vs

National Insurance Company Ltd.

AWARD DATED, 5.3.2013 INADEQUATE SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Vijay Kr. Seth (hereinafter referred to as the complainant) against National Ins. Co. Ltd. (Hereinafter referred to as respondent insurance company) relating to mediclaim.**

2. **Complainant submitted that he was taking mediclaim ins. Policy for the last many years without any break and continued to renew the same in time. He did not claim any amount in 5 yrs with the result there was cumulative bonus of Rs.50,000. He submitted further that the cumulative bonus of Rs. 50,000 was not considered while settling the claim against his policy bearing no. 360300/48/09/850004875 while settling the claim, only sum insured of Rs.2 lacs was considered instead of 2,50,000 including 50,000 bonus. He further submitted that company was not justified in making deductions of Rs.97,750 while settling the claim. He had already represented before the Grievance redressal officer of the company. He has come to this forum with a request to direct the insurance company to release further a sum of Rs.97,750. During the course of hearing complainant pleaded that he was paid less by an amount of**

Rs.67,500 though room rent was admissible for 4 ½ days but he was paid only for 4 days.

3. **Representative of the company pleaded that claim was settled as per terms and conditions of the policy. Company also filed written reply dated 5.11.2012 wherein it was mentioned that cumulative bonus was also considered while settling the claim. Company had paid a sum of Rs.1,82,500 including cashless of Rs.1,45,000.**

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 matter, I hold that company settled the claims as per terms and conditions of the policy and had duly taken into account cumulative bonus of Rs.50,000 i.e. the claim was settled with reference to sum insured of Rs.2 lacs and Rs.50,000 as cumulative bonus. However it is found that though complainant had paid rent for 4 ½ days to the hospital but company had paid only for 4 days. Thus in my considered view complainant further is required to be paid rent for half day which is worth Rs.1,250. Accordingly an Award is passed with the direction to the insurance company to make further payment of Rs.1,250.**

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

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DELHI OMBUDSMAN CENTRE

Case No.GI/513/NIC/11

In the matter of Sh. Jagdish Singh.

Vs

National Insurance Company Ltd.

AWARD DATED 5.3.2013 NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Jagdish Singh (hereinafter referred to as the complainant) against National Ins. Co. Ltd. (Hereinafter referred to as respondent insurance company) relating to mediclaim.**

2. **Complainant submitted that his Father had been working with Escort group. He got retired in 2010. He was using this policy for the past 8 yrs. He further submitted that his Father as beneficiary of a group mediclaim policy, issued to the employees of the Escort group and after retirement, he started renewing the policy with National Ins. Co. Ltd. His father got admitted at Ballabhgarh Nursing Home from 2/july/2011 to 5/july/2011, thereafter he remained admitted in Metro Hospital from 05.07.2011 to 08.07.2011. He had sent representation to the Grievance Redressal Officer of the company but his grievance was not taken seriously in that office. Alankit TPA did not settle the claim, therefore he has come to this forum for redressal of his grievance. During the course of hearing it was pleaded by him that though claims are payable yet his claims are not settled. His fathers along with the other family members of family were covered in the policy.**

3. **Representative of the company pleaded that the claim is not payable. He referred to the repudiation letter dated 24.10.2011. it has been mentioned in the repudiation letter that patient was a known case of CVA with HTN with DM and therefore claim was inadmissible for the hospitalization from 02.07.2011 to 05.07.2011 under the clause of 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 dated 24.10.2011. After due consideration of matter, I hold that company was not justified in repudiating the claim because claim is payable. The patient was covered in the policy for quite some time, earlier he was covered in group policy and thereafter the policy was issued individually to him by the insurance company. In my view, clause 4.3 of the does not have any application. The claim is payable and company ought to have allowed it. Accordingly an Award is passed with the direction to the insurance company to make payment of Rs. 39,462.**

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

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

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DELHI OMBUDSMAN CENTRE

Case No.GI/512/NIC/11

In the matter of Sh. Pradeep Kr. Jain.

Vs

National Insurance Company Ltd.

AWARD DATED 5.3.2013 NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Pradeep Kr. Jain (hereinafter referred to as the complainant) against National Ins. Co. Ltd. (Hereinafter referred to as respondent insurance company) relating to mediclaim.**

2. **Complainant submitted that he has been taking insurance policy from the last 15 yrs without any break so there does not arise any question of pre-existing disease. He had already mailed last 5 yrs policy to the Alankit Health Care TPA Ltd. He had taken the treatment from the Doctor which can be only given in operation theatre. He had filed Doctor's certificate in this regard. He has given answers to all the queries of the TPA though he pursued a lot but fact remains that his claim remained unsettled. He had also approached grievance redressal officer of the company but nothing happened. During the course of hearing it was pleaded by the complainant that he has been taking mediclaim ins. Policy since 1997 continuously with the same ins. Company and company was not justified in denying the claim on the ground of pre-existing disease.**

3. **Representative of the company pleaded that claim is not payable due to pre-existing disease. Company also filed written reply dated 16.01.2013 wherein it has been mentioned that the patient was suffering from back pain since 10 yrs and had taken treatment as an OPD patient. It has been mentioned in the written reply that claim was not payable due to clause 4.1 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 repudiation letter and the reply of the company which are placed on record. After due consideration of matter, I hold that company was not justified in repudiating the claim on the ground of 4.1 of the policy because the complainant is insured since 1997 and there is no evidence on record that he was suffering from back pain at the time of taking the policy in 1997. In my considered view claim was payable and company was not justified in repudiating the claim on flimsy ground. Accordingly an Award is passed with the direction to the insurance company to make payment of Rs. 40,394.**

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

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DELHI OMBUDSMAN CENTRE

Case No.GI/467/BAJAJ/11

In the matter of Sh. Manjeet Malik.

Vs

Bajaj Allianz Gen. Insurance Company Ltd.

AWARD DATED 5.3.2013 NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Manjeet Malik (hereinafter referred to as the complainant) against Bajaj Allianz Gen. Ins. Co. Ltd. (Hereinafter referred to as respondent insurance company) relating to motorclaim.**

2. **Complainant submitted that his vehicle bearing registration no. HR55F7664 was insured by Bajaj Allianz Gen. Ins. Co. Ltd. vide policy bearing no.OG-10-1115-1803-00000308. This vehicle met with an accident on 03.09.2010. The no. of photos were taken of this vehicle after accident and he submitted all required documents to the insurance company for settlement of the claim but company had not settled the claim till date. He also approached the grievance redressal officer of the company but he did not get any reply from there too. He has come to this forum with a request to get his claim settled. During the course of**

hearing, it was pleaded by the complainant that claim was payable but company had denied it due to overloading.

3. **Representative of the company pleaded that claim was not payable due to over loading when the vehicle met with an accident, it was found that it was overloaded.**

4. **I have considered the submissions of the complainant as well as of the representative of the company. I have also perused surveyor's report dated 07.01.2011. I have also perused the written reply of the company dated 21.11.2012. After due consideration of matter, I hold that merely because the vehicle was overloaded at the time of accident claim cannot be denied because it cannot be concluded with certainty that overloading was the only cause for the accident. The fact remained that vehicle met with an accident and got damaged. In my considered view company ought to have settled the claim, repudiation was not called for. In my considered view claim is payable because insured vehicle met with an accident and got damaged. The surveyor had already accessed the loss suffered by the insured vehicle due to accident. Payment of the loss accessed by the surveyor appointed by the company was required to be made. Accordingly an Award is passed with the direction to the insurance company to make payment of accessed loss of Rs.1,21,685.**

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

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DELHI OMBUDSMAN CENTRE

Case No.GI/598/OIC/11

In the matter of Sh. Ankur Gupta.

Vs

Oriental Insurance Company Ltd.

AWARD DATED 7.3.2013 DENIAL OF MEDICLAIM

1. **This is a complaint filed by Sh. Ankur Gupta (hereinafter referred to as the complainant) against Oriental Ins. Co. Ltd. (Hereinafter referred to as respondent insurance company) relating to mediclaim.**

2. **Complainant submitted that he is a policy holder of Oriental Ins. Co. Ltd. His policy bearing no.271600/48/20111857 is since 15.02.2010. He further submitted that his father Mr. Yogesh Kumar Gupta was admitted in the hospital due to pain in the chest on 18.08.2011 and remained there upto 27.08.2011. After discharge from the hospital Original documents were submitted by M/s Vipul Medcorp Pvt. Ltd. for reimbursement. However the claim was rejected due to hypertension and related ailments as the same were not covered in the first two yrs of the policy period. Thereafter he pursued the matter with the insurance company but he was not responded. He also approached the grievance redressal officer of the company but his claim was again rejected. He further submitted that before this policy his father was having insurance policy by United India Ins. Co. Ltd. for 4-5 yrs. He has come to this forum with a request to get the claim paid. During the course of hearing. It was pleaded that the claim was payable but company denied it.**

3. **Representative of the company pleaded that claim was not payable as the disease has two yrs waiting period. Company also filed written reply dated 22.02.2013 wherein it was mentioned that Sh. Yogesh Kr. Gupta was admitted in the hospital from 18.08.2011 to 20.08.2011 and diagnosed with CAD-Acute IWMI, Hypertension. The insured has taken Happy Family Floater policy first with the company on 15.02.2010 vide policy bearing no. 271600/48/2010/11569 and after it was renewed on 15.02.2011 to 14.02.2012 vide policy bearing no. 271600/48/2011/1857. It was further mentioned that the claim was not payable in view of clause 4.3 of the policy as the disease was not covered in the first two yrs of the policy period.**

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 matter, I hold that company was not justified in denying the claim because the disease for which insured got admitted in the hospital and had been treated, does not have any waiting period. In my considered view claim is payable and company ought**

to have settled the claim. Accordingly an Award is passed with the direction to the insurance company to make payment of Rs. 3 Lacs.

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

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DELHI OMBUDSMAN CENTRE

Case No.GI/610/NIC/11

In the matter of Sh. Rajan Jain.

Vs

National Insurance Company Ltd.

AWARD DATED 7.3.2013 DENIAL OF MEDICLAIM

1. **This is a complaint filed by Sh. Rajan Jain (hereinafter referred to as the complainant) against National Ins. Co. Ltd. (Hereinafter referred to as respondent insurance company) relating to mediclaim.**

2. **Complainant submitted that he is a holder of mediclaim insurance policy issued by National Ins. Co. Ltd. from 1.08.2004 and the same continued upto 31.07.2012. He further submitted that on 31.10.2011 at 2a.m, he felt high heart beat and Ghabrahat, his family immediately shifted him to casualty of Escorts Heart Institute & Research Centre Ltd. He was immediately admitted to the hospital and was shifted to ICU at about 4 a.m. After admission, some tests were conducted, next day he got discharged from the hospital. He paid the hospital bill and submitted all requisite documents along with the claim to Alankit Health Care Ltd. TPA of the insurance company for reimbursement. However his clam was denied due to 4.1 of the policy. He also approached the grievance redressal officer of the company. He has come to this forum with a request to get his claim settled. During the course of hearing, it was pleaded by him that claim was payable but company denied it.**

3. **Representative of the company pleaded that claim was not payable as admission was not required.**

4. **I have considered the submissions of the complainant as well as of the representative of the company. After due consideration of matter, I hold that company was not justified in repudiating the claim because insured was admitted in the hospital due to emergency and also got treatment, therefore claim was payable. Accordingly an Award is passed with the direction to the insurance company to make payment of Rs.22,999.**

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

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DELHI OMBUDSMAN CENTRE

Case No.GI/605/NIA/11

In the matter of Smt. Sunita Aggarwal.

Vs

New India Assurance Company Ltd.

AWARD DATED 7.3.2013 PARTIAL SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Sunita Aggarwal (hereinafter referred to as the complainant) against New India Assurance Co. Ltd. (Hereinafter referred to as respondent insurance company) relating to mediclaim.**

2. **Complainant submitted that she was insured vide policy bearing no. 32350334110100000310. She further stated that she is insured for about 12-13 yrs. In month of Aug, she consulted her Dr. who advised her to get the knee replaced. She contacted the agent and she was assured that she would be released the sum insured along with the bonus. Infact she contacted TPA also. She got operated on 06.09.2011 and discharged on 11.09.2011. Her claim was given only for Rs.1 lac. She was not completely briefed before taking the knee**

replaced about the amount she will get. She has come to this forum with a request to get her claim paid. During the course of hearing, it was pleaded by her that she was paid only a sum of Rs.1 lac and thus her claim was partially settled by the insurance company. She requested for release of the balance amount. She also had cumulative bonus.

3. **Representative of the company pleaded that claim was settled with the reference to pre-enhanced sum insured of Rs.1 lac and claim was settled correctly as per policy terms and conditions. Company also filed written reply, wherein it was mentioned that insured Sh. Sunita Agarwal reported the claim under the policy bearing no. 32350334100100000370 for hospitalization from 04.09.2011 to 11.09.2011. However, company admits in the reply that insured could be allowed cumulative bonus and while settling the claim pre-enhanced sum insured was taken into account which was Rs.1 lac.**

4. **I have considered the submissions of the complainant as well as of the representative of the company. I have also considered written reply of the company which is placed on record. After due consideration of matter, I hold that complainant deserves further relief as company had not considered the cumulative bonus while settling the claim. Company had paid only a sum of Rs.1 lac being the sum insured which was correctly applied but company did not consider the cumulative bonus also while settling the claim. Company had already agreed to consider the payment of cumulative bonus to the insured in the written reply. Accordingly an Award is passed with the direction to the insurance company to make further payment of Rs. 30,000 being the cumulative bonus applicable relevant to the policy period which was applied by the insurance company while settling the claim when sum insured was Rs. 1 lac.**

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

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DELHI OMBUDSMAN CENTRE

Case No.GI/608/NIC/11

In the matter of Smt. Sheetal Nayyar.

Vs

National Insurance Co. Ltd.

AWARD DATED 7.3.2013 INADEQUATE SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Sheetal Nayyar (hereinafter referred to as the complainant) against National Ins. Co. Ltd. (Hereinafter referred to as respondent insurance company) relating to motorclaim.**

2. **Complainant submitted that he had submitted bill along with all requisite documents to National Ins. Co. Ltd. at its R.K Puram Branch. Company sent him a cheque bearing no. 495305 dated 22.07.2011 for an amount of Rs.16,273. He was surprised to note that payment was short by an amount of Rs.15,530 whereas he submitted all required documents relating to the claim. He has come to this forum with a request to get him released the balance payment at an early date. During the course of hearing, it was pleaded by the complainant that claim was settled inadequately. Company had paid only a sum of Rs. 16,273 and he needed to be paid further an amount of Rs. 15,503. He requested company for release of the balance amount but company had not responded to his request. As a matter of fact a cheque sent to him by company became state due late receipt.**

3. **Representative of the company did not attend.**

4. **I have considered the submissions of the complainant. I did not have the benefit of the arguments of the representative of the company nor the written submissions of the company or its representative. I have perused the letter dated 11.01.2012 when loss was assessed at Rs.16, 273. The claim relates to loss of CNG Kit, Glass & Stepney. After due consideration of matter, I hold that loss due to theft of the items i.e. CNG Kit, Glass & Stepney was not correctly assessed and the same needs to be modified. Accordingly an Award is passed with the direction to the insurance company to make payment of Rs. 24,884.**
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GUWAHATI OMBUDSMAN CENTRE

Complaint No. 11-G11-014/12-13

Md. Mukhtar Ahmed

- Vs -

ICICI Lombard General Insurance Co. Ltd.

Date of Order : 16.11.2012

Complainant: The Complainant stated that he procured Critical Care (Secure Mind) Policy No. 4065/CCSM/02038826/00/000 from the ICICI Lombard General Insurance Co. Ltd. covering the period from 15.06.2011 to 14.06.2012 for a Sum Insured of Rs.6,00,000/-. While the policy was in force, he was admitted in International Hospital, Guwahati on 21.10.2011 and was discharged on 28.10.2011. Thereafter, the Complainant lodged a claim before the Insurer along with all supporting documents. 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 Complainant has presented a claim for Myocardial Infarction under the subject policy. They observed that the Insured was diagnosed as a case of Type 2 Diabetes Mellitus and Hypothyrodism. The ECG showed labile T wave changes in inferolateral leads. Further, the Echo showed fair LV systolic function with diastolic dysfunction. The same is evident from the discharge summary of International Hospital, Guwahati. They further stated that the Complainant's treating doctor submitted a statement dated 28.01.2012 that disclosed to the fact that the Complainant was not diagnosed as case of Myocardial Infraction. The statement has been signed by his treating doctor. Accordingly, the claim was repudiated as "out of scope of policy coverage" in view of no evidence of Myocardial Infarction as defined under the policy.

Decision : There is absolutely no dispute as to the fact that the Complainant Mukhtar Ahmed procured Secure Mind Policy No. 4065/CCSM/02038826/00/000 form the ICICI Lombard General Insurance Co. Ltd. covering the period from 15.06.2011

to 14.06.2012 for a Sum Insured of Rs. 6.00 Lacs. From the statement of the Complainant as well as from the Discharge Certificate, it is clear that Mukhtar Ahmed was admitted in International Hospital, Guwahati on 21.10.2011 and was discharged on 28.10.2011 as he was suffering from some Cardiological problems. The Discharge Certificate shows that he was diagnosed as :-

CAD - Unstable Angina, Type 2 Diabetes Mellitus, Hypothyroidism

He was admitted in the Hospital with chest pain, palpitation and dyspnoea on exertion. It is also stated in the Discharge Certificate that he was diagnosed as Type 2 Diabetes Mellitus and Hypothyroidism. ECG showed labile T wave changes in inferolateral leads. Echo showed fair LV systolic function with diastolic dysfunction (Grade – I). It reveals from the repudiation letter that the Insurer repudiated the claim on the ground that there was no evidence to show that the Complainant was suffering from Myocardial Infarction. In the repudiation letter, they stated that on processing the claim documents it is understood that the Complainant was diagnosed as a case of Coronary Artery Disease – Unstable Angina, Type 2 Diabetes Mellitus & Hypothyroidism which is evident from the Discharge Summary of International Hospital dated 27th October, 2011. The Insurer also stated that as per policy terms and conditions, in respect of treatment of Unstable Angina claim is not payable. I have carefully scrutinized the entire terms and conditions of the policy documents. The copy of policy document shows that under Major Medical Illness and Procedures, the following are covered :-

- **Diagnosis of the following illness namely : Cancer, End Stage Renal Failure and Multiple Sclerosis.**
- **Undergoing of the following surgical procedures : Major Organ Transplant, Heart Valve Replacement or Coronary Artery Bypass Graft.**
- **Occurrence of the following medical events : Stroke, Paralysis and Myocardial Infarction.**

Now, the crux of the matter is to find out whether the Complainant suffered from Myocardial Infarction during the period of hospitalization in International Hospital from 21.10.2011 to 28.10.2011 or not. As per policy terms and conditions, he will be entitled to get the claim if he was suffering from Myocardial Infarction during the period of hospitalization. From the Discharge Certificate, there is nothing to

show that the Insured was not diagnosed as a case of Myocardial Infarction. He was diagnosed as suffering from Coronary Artery Disease with Unstable Angina. In the policy terms and conditions itself, the Myocardial Infarction has been defined as follows:-

Myocardial Infarction (Heart Attack) :

The first occurrence of an acute Myocardial Infarction leading to the death of a portion of heart muscle (Myocardium) as a result of inadequate blood supply to the relevant area.

The diagnosis for the same must be evidenced by all of the following :

- **An episode of typical chest pain.**
- **The occurrence of a typical new acute infarction changes (ST-T elevation) on the electrocardiograph and progressing to development of pathological Q waves.**
- **Elevation of Cardiac Troponin (T or I) to at least 3 times the upper limit of normal reference range or an elevation of CPK-MB to at least 200% of the upper limit of the normal reference range.**

But excluding non-STEMI with elevation of troponin I or T. Other acute coronary syndromes including but not limited to angina or chest pain are excluded from this definition.

It is manifestly clear from the policy terms and conditions that other acute Coronary Syndromes including Angina or Chest Pain are excluded from the definition of Myocardial Infarction.

From the certificate of Dr. Neil Bordoloi, Consultant Cardiologist of International Hospital, Guwahati dated 27.10.2011, it is apparent that Mr. Mukhtar Ahmed was suffering from acute Coronary Syndromes - Unstable Angina. It is also pertinent to mention here that in the certificate of Dr. Neil Bordoloi, Consultant Cardiologist, International Hospital dated 28.01.2012, in Question No. 8 whether there was any

H/O Myocardial Infarction / IHD noted at the time of consultation / Hospitalization during 21st October, 2011 to 28th October, 2011, he answered in the negative.

Considering all the above aspects, I have no hesitation to hold that the Complainant is not entitled to get the claim as per policy terms and conditions in much as he was not suffering from Myocardial Infarction but he was suffering from Coronary Artery Disease with Unstable Angina during the hospitalization period. Finding no scope to interfere with the decision of the Insurer, the complaint is treated as closed.

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GUWAHATI OMBUDSMAN CENTRE

Complaint No. 11-G4-024/12-13

Mr. Badal Chakraborty

- Vs -

The Oriental Insurance Co. Ltd

Date of Order : 14.02.2013

Complainant: The Complainant stated that he procured Policy No. 321204/48/2011/875 from the above Insurer covering the period from 24.10.2010 to 23.10.2011. During the period covered under the policy, he was hospitalized in Hayat Hospital, Guwahati on 22.04.2011 and was discharged on 29.04.2011. After completion of usual treatments, he lodged a claim seeking reimbursement of the expenses incurred in connection with his hospitalization and treatment before the Insurer along with all supporting documents. But the Insurer has repudiated the claim without any justified ground. Feeling aggrieved, the Complainant has lodged this complaint.

Insurer : The Insurer has stated in their "Self Contained Note" that an Individual Mediclaim Policy was issued to Mr. Badal Chakraborty under Policy No.

321204/48/2008/309 with risk effected from 24.10.2007 – 23.10.2008 & subsequently renewed on time under Policy No. 321204/48/2009/267 w.e.f. 24.10.2008 – 23.10.2009, Policy No. 321204/48/2010/903 w.e.f. 24.10.2009 – 23.10.2010 & Policy No. 321204/48/2011/875 w.e.f. 24.10.2010 to 23.10.2011. The Complainant lodged a claim to Raksha TPA for his treatment in Hayat Hospital w.e.f. 22.04.2011 to 29.04.2011. The TPA repudiated the claim under clause No. 4.1, pre-existing disease of the Individual Mediclaim Policy. It is stated by the Insurer that the discharge summary reveals that the Complainant was treated for CAD, Triple Vessel Disease & Hypothyroidism which has a waiting period of four years. They also stated that the clinical not attached to the Angiography report of GNRC dated 15.02.2011 shows that the patient was suffering from CAD & HTN since past four years. Since the disease was pre-existing, hence, the claim was repudiated.

<u>Decision</u> : It is stated by the Complainant in his complaint petition that in the fourth year of his above mentioned Mediclaim Policy, due to sudden pain in chest he was admitted in Hayat Hospital, Guwahati on 22.04.2011 and was discharged on 29.04.2011. During the hospitalization period, CABG done on 23.04.2011. Thereafter, he lodged a claim for Rs.1,80,000/- before the Insurer along with all supporting document. But, the Insurer has repudiated the claim without any justified ground.

The representative of the Insurer stated that the TPA has repudiated the claim of the Complainant on the ground of pre-existing disease under clause No. 4.1 of the Individual Mediclaim Policy. The medical report discloses that the Complainant was suffering from CAD & HTN since past four years and as per policy terms and conditions, waiting period for CAD & HTN is four years. But, the Insured was hospitalized when the policy was running for fourth year. Therefore, the Complainant was not entitled to get the claim amount.

It appears from the "Self Contained Note" as well as from the statement of representative of the Insurer that the Insured Mr. Badal Chakraborty took first policy bearing Policy No. 321204/48/2008/309 with effect from 24.10.2007 – 23.10.2008. In proof of their contention, they have produced a copy of the first policy taken by the Insured before this Authority for perusal. The Insurer has also produced a copy of relevant policy bearing Pol. No. 321204/48/2011/875 covering the period from 24.10.2010 to 23.10.2011. The copy of Discharge Summary from

Hayat Hospital, Guwahati shows that the Insured Mr. Badal Chakraborty was admitted in the Hospital on 22.04.2011 with the history of chest pain and was discharged on 29.04.2011. The disease of the Complainant was diagnosed as (1) CAD : Triple Vessel Disease (2) Hypothyroidism. The copy of Coronary Angiography Report dated 07.03.2011 from GNRC Hospital, it appears that the Complainant had gone for Coronary Angiography on 07.03.2011 and impression was as CAD : TVD. It is also clearly mentioned in the Medical Certificate dated 15.02.2011 that the Complainant was suffering from CAD for last 4 (four) years and HTN for last 4 (four) years. Hence, it appears that the Complainant was suffering from CAD & HTN since last four years prior the date of hospitalization. As per the Insurer, the claim attracts the Policy Condition No. 4.1. On a close perusal of copy of terms and conditions of the policy that the Policy Condition No. 4.1 reads as under :

4.1 "Pre-existing health condition or disease or ailment / injury : Hypertension & Coronary Artery Disease which are pre-existing (treated/untreated, declared/not declared in the proposal form), when the cover incepts for the first time are excluded upto 4 years of this policy being in force continuously."

From the above policy conditions, it is ample clear that the Insured who is suffering from HTN & CAD whether it is treated / untreated, declared / not declared in the proposal form, is not entitled to get the claim amount for the said diseases within four years from the date of inception of the policy. In the instant case, the Complainant was treated for HTN & CAD within the four years from the date of commencement of the policy. Therefore, the Complainant is not eligible to get the claim amount as per terms and conditions of the policy.

Considering the above conditions, I am of the view that the decision of the Insurer in repudiating the claim of the Complainant appears to be proper and justified. Finding no material to interfere with the decision of the Insurer, the complaint is treated as closed

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GUWAHATI OMBUDSMAN CENTRE

Complaint No. 11-002-111/11-12

Mr. Chiron Kr. Das

- Vs -

New India Assurance Co. Ltd.

Date of Order : 30.11.2012

Complainant: The Complainant stated that he procured Mediclaim Policy No. 530209/34/09/11/00000291 from the New India Assurance Co. Ltd. covering the period from 17.03.2010 to 16.03.2011. While the policy was in force, he was admitted in Medica Superspeciality Hospital, Kolkata on 10.10.2010 and was discharged on 21.10.2010. During hospitalization period, C3-4 anterior discectomy and spacer, C6 Corpectomy with C5-7 cage fusion, stabilization with plates and screws done under GA on 12.10.2010. Thereafter, the Complainant lodged a claim for Rs.2,88,000/- before the Insurer along with all supporting documents. 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 their TPA, E-Meditek repudiated the claim as per clause No. 4.3 as the Insured was hospitalized for the treatment of C3-4 and C6-7 OPLL which is not covered for the duration of two years from the inception of the policy.

Decision : It appears that they have repudiated the mediclaim mainly on the ground that as per clause No. 4.3 Prolapse Inter Vertebral Disc is not covered for first two years of the policy. In other word, the waiting period for treatment of Prolapse Inter Vertebral Disc is two years. According to the E-Meditek (TPA), they have repudiated the claim as the patient was admitted for treatment of C3-4 & C6-7 OPLL (Ossification of Posterior Longitudinal Ligament) and Cervical Discectomy done which is not covered for the duration of two years from the time of inception of the policy as per clause No. 4.3. Controverting the argument of the Insurer, the Complainant has strongly contended that his disease for which he was admitted in the Hospital is not Prolapse Inter Vertebral Disc, but it is a Cervical

Spondylotic Myelopathy and it is a completely separate and distinguishable ailment having no similarity with the Prolapse Inter Vertebral Disc. The Discharge Certificate makes it ample clear that the Complainant Mr. Chiron Kr. Das was admitted in Medica Superspeciality Hospital, Kolkata on 10.10.2010 and was discharged from the Hospital on 21.10.2010. The disease was diagnosed with "C3-4, C6-7 OPLL with spinal cord compression & myelomalacia". Operation was done for C3-4 anterior discectomy and spacer, C6 Corpectomy with C5-7 cage fusion, stabilization with plates and screws done under GA on 12.10.2010. From the said medical document, it is apparent that the Complainant was treated for "Cervical Myelopathy". As per medical term, "Cervical Myelopathy" is a form of "Cervical Spondylosis" and "Prolapse Inter Vertebral Disc" is "Slip Disc Condition". Hence, there is a vast difference between "Cervical Myelopathy" and "Prolapse Inter Vertebral Disc". As per Discharge Certificate, the Complainant was treated for "Cervical Myelopathy" not for "Prolpase Inter Vertebral Disc". It is crystal that the TPA as well as the Insurer have taken a decision without going through the details of the case which causes much inconvenience to the Complainant. I am of the considered view that the claim of the Complainant is tenable. The Complainant is entitled to get claim amount as per admissible bills submitted by him.

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-G12-016/12-13

Sri Nilamoni Hazarika

- Vs -

HDFC ERGO General Insurance Co. Ltd.

Date of Order : 21.12.2012

Complainant: The Complainant stated that he procured Health Suraksha Policy No. 51080009 for his entire family members from the above Insurer covering the period from 14.02.2012 to 13.02.2013. While the policy was in force, his wife Mrs. Manashi Hazarika was admitted in the Swagat Hospital, Guwahati on 25.04.2012 for Gallbladder Stone operation and was discharged on 27.04.2012. After completion of usual treatments, he lodged a claim for Rs.45,860/- before the Insurer along with all supporting document. But, the Insurer has repudiated the claim without any justified ground. Being aggrieved, he has lodged this complaint.

Insurer : The Insurer has not submitted their "Self Contained Note".

Decision : It is stated by the Complainant that during the period covered under the policy, his wife Mrs. Manashi Hazarika was hospitalized on 25.04.2012 and was discharged on 27.04.2012. The copy of Discharge Certificate from Swagat Endolaparoscopic Surgical Research Institute also discloses about hospitalization of Mrs. Manashi Hazarika during the above mentioned period. It also appears from the copy of Discharge Certificate that the disease of the patient was diagnosed with cholecystitis & Thalassemia heterogeneous. The copies of bill / cash memos, money receipts discloses about the expenses incurred by him due to treatment for his wife Mrs. Manashi Hazarika in the above cited Hospital. The Complainant further stated that the claim lodged by him was repudiated by the Insurer without any justified ground.

On perusal of the copy of repudiation letter addressed to the Complainant, it appears that the Insurer has repudiated due to the ailment falls under 2 years exclusion clause of the policy. The Insurer clarified the Complainant through the repudiation letter that as per documents patient is going to admit in the Hospital for the surgical treatment of Calculus Cholecystitis (Gall Stone). As per confirmation from HDFC ERGO policy was 1st incepted on 29.10.2010, this is 2nd year running policy and not completed 2 years. As per policy wordings clause 6 under specific waiting period this disease is covered after waiting period of 2 years as policy did not completed 2 years hence cashless is denied under 2 years waiting period exclusion.

The Complainant has stated in his statement that the above policy was continued since 14.02.2012. It indicate that the above policy was taken by the Complainant from the HDFC ERGO Insurance Co. Ltd. only on 14.02.2012. It is clearly mentioned in the policy terms and condition that this policy doesn't cover any pre-existing diseases which principal Insured or any of the family member is or has been suffering from until a waiting period of 48 months. This policy has a waiting period for 2 years for medical conditions like Hernia, Cataract, Piles, Gall Bladder Stones & Kidney stones. It is crystal clear from the copy of policy terms and conditions that the medical benefit for Gall Bladder Stone disease is payable only after completion of two years of the policy. In the instant case, the policy of the Complainant did not cross the two year from the date of inception of the first policy. Therefore, the Complainant is not entitled to get the reimbursement of the claim amount as per terms and conditions of the policy.

Under the above factual back ground and the legal position, I have no hesitation to hold that the decision of the Insurer in repudiating the claim of the Complainant was just and reasonable. In the result, this complaint is dismissed and is treated as closed

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GUWAHATI OMBUDSMAN CENTRE

Complaint No. 11-G1-027/12-13

Sri Pradip Kr. Dey

- Vs -

The New India Assurance Co. Ltd.

Date of Order : 10.01.2013

Complainant: The Complainant stated that he procured Mediclaim Policy No. 530702/34/10/11/00000408 from the New India Assurance Co. Ltd. covering the period from 23.09.2010 to 22.09.2011. While the policy was in force, he was hospitalized in International Hospital, Guwahati on 04.09.2011 and was discharged

on 06.09.2011 for treatment of Acute Vertigo – Peripheral Type – BPPV. After completion of usual treatments, he lodged a claim for Rs. 28,667/- before the Insurer on 26.09.2011 along with all supporting documents. But the TPA on behalf of the Insurer has repudiated the claim. Being aggrieve, he has filed this complaint.

Insurer : The Insurer has stated in their "Self Contained Note" that this was first year running policy. As per Exclusion Clause 4.3, waiting period for specified diseases / ailments / conditions from the time of inception of the cover, the policy will not cover the diseases / ailments / conditions for the duration ; Hypertension - Two years.

Decision : It reveals from the copy of Discharge Certificate from International Hospital, Guwahati that the Insured Mr. Pradip Kr. Dey was admitted in that Hospital during the period from 04.09.2011 to 06.09.2011. The copy of claim form makes it clear that the Complainant lodged a claim for Rs.28,667.00 before the Insurer on 26.09.2011. The copies of Hospital Bills, Cash Memos produced by the Complainant before this Authority also discloses about the expenditures incurred by him in connection with his hospitalization & treatment in the International Hospital, Guwahati. It is stated by the Complainant that his claim was repudiated by the Insurer without any justified ground.

The copy of Repudiation letter dated 19.12.2011 issued by E-Meditek (TPA) Services Ltd. shows that they have repudiated the claim on the ground that the Insured was admitted in International Hospital, pt H/o – systemic Hypertension & UP GI bleeding. Policy Note – This was first year running policy. As per Exclusion Clause 4.3, the claim is not payable. On a close perusal of the Discharge Certificate, it is mentioned in the Clinical Summary that the patient Pradip Kr. Dey was admitted on 04.09.2011 with history of sudden onset vertigo, positional with vomiting 1 day. Known illness : Hypertension on Prolomet XL 25. The patient was diagnosed with Background (1) Systemic Hypertension, (2) Past history of upper GI Bleed and Current Problem (1) Acute vertigo - peripheral type – BPPV (2) Transient AF – Spontaneous reverted to sinus rhythm. It indicates from the diagnosis of the Hospital that the patient / Insured suffered from Acute vertigo only because of his background diseases of "Systemic Hypertension" and "Upper GI Bleed". The Doctor

of the International Hospital diagnosed the said diseases as "Background". The Insurer has submitted the copy of policy terms and conditions before this Authority. On perusal of the terms and conditions of the policy, it reveals that from the time of inception of the cover, the policy will not cover the "Hypertension" for the duration two years. It is ample clear that the Complainant is not entitled to get the claim amount as per terms and conditions of the policy.

Under the above factual back ground and the legal position, I have no hesitation to hold that the decision of the Insurer in repudiating the claim of the Complainant was just and reasonable. In the result, this complaint is dismissed and is treated as closed.

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GUWAHATI OMBUDSMAN CENTRE

Complaint No. 11-017-118/11-12

Mr. Pranjal Pathak

- Vs -

The Star Health and Allied Insurance Co.Ltd.

Date of Order : 08.02.2013

Complainant: The Complainant stated that he procured Family Health Optima Insurance Policy No. P/191311/01/2011/000868 for his entire family members from the Star Health and Allied Insurance Co. Ltd. covering the period from 18.03.2011 to 17.02.2012. While the policy was in force, he was admitted in Nemcare Hospital, Guwahati on 28.09.2011 and was discharged on 30.09.2011. Thereafter, he lodged a claim before the Insurer along with all supporting documents. But, the Insurer has repudiated the claim without any justified ground. Being aggrieve, he has filed this complaint.

Insurer : The Insurer has not submitted their "Self Contained Note".

<u>Decision :</u> The copy of Discharge Certificate from Nemcare Hospital, Guwahati discloses that the Insured Mr. Pankaj Pathak was hospitalized in that Hospital on 28.09.2011 and was discharged on 30.09.2011. According to the Complainant, he was hospitalized in the above Hospital for treatment of Tuberculosis (infection in left Epididymitis). He also alleged that the claim lodged for reimbursement of the expenses incurred in connection with his treatment was repudiated by the Insurer without any justified ground.

It is very unfortunate that the Insurer has neither submitted their "Self Contained Note" nor they responded to the correspondences made from this Office. They have also not sent anybody to appear for hearing held on 27.09.2012 & 22.11.2012. It is very much clear that the Insurer is not at all bothered about the complaint which was lodged by the Complainant before this Authority.

The copy of E-Mail dated 22.011.2011 sent by the Insurer to the Complainant produced by the Complainant before this Authority discloses that their medical team has observed from the investigation reports, hospital records including the discharge summary that there was no specific treatment for the Insured and the admission was mainly for investigation and evaluation purpose. As per Exclusion No. 13 of the above policy, the Company is not liable to make any payment for expenses incurred at Hospital primarily for Diagnostic, X-ray, Laboratory Examinations not consistent with or incidental to the diagnosis and treatment of the positive existence of any ailment. They therefore regret their inability to admit the claim of the Complainant under the above policy and they thereby repudiated the claim. It is clear from the above E-Mail that the Insurer has repudiated the claim of the Complainant on the ground that the hospitalization of the Complainant was mainly for investigation and evaluation purpose. On a close perusal of the copy of Discharge Certificate from Nemcare Hospital, Guwahati, it appears that the patient was admitted with h/o (L) testicular swelling & pain for 15 – 20 days and the patient was diagnosed with "Left sided Granulomatous Epididymitis". It is also mentioned in the column of Treatment as "Conservative" that means conservative treatment was provided to the Complainant. From the Discharge Certificate, it is ample clear that the Complainant was given conservative treatment in that Hospital. It is an admitted fact that nobody wants to get admitted in a Hospital at his own choice as Hospital is not an amusement centre. Patient is admitted in a Hospital with an advice of Doctor. It is also apparent that without going through the proper investigation Doctor is not supposed to prescribe

any medicine to the Patient. In the instant case also, the Complainant was admitted in the Hospital as per advice of Doctor. After going through the various tests, the disease of the Complainant was diagnosed with "Left sided Granulomatous Epididymitis".

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.

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GUWAHATI OMBUDSMAN CENTRE

Complaint No. 11-G2-019/12-13

Mr. Ramesh Agarwalla

- Vs -

National Insurance Co. Ltd.

Date of Order : 29.01.2013

Complainant: The Complainant stated that he procured Policy No. 200600/48/10/8500000283 for his entire family members from the above Insurer covering the period from 25.08.2010 to 24.08.2011. During the period covered under the policy, his wife Ms. Jyoti Agarwalla was hospitalized in Fortis Hospital, Bangaluru from 16.08.2011 to 01.09.2011, from 10.09.2011 to 13.09.2011 and from 20.09.2011 to 26.09.2011 for Rheumatic Arthritis. Hip Joint (Both) were replaced. Thereafter he lodged a claim for Rs.3,55,538.00 before the Insurer along with all supporting documents. They informed him by E-mail that they would pay Rs.61,390.00. Again they informed him over phone that they would pay Rs.95,474.00. But they did not send any cheque till now. Feeling aggrieved, the Complainant has lodged this complaint.

Insurer : The Insurer has stated in their "Self Contained Note" that the Insured Ramesh Agarwala has taken mediclaim policy from their Company are as under :

Policy No.	Policy period	Sum Assured	Cum Bonus
20060048078500000278	25.08.2007 to 24.08.2008	1,00,000/-	Nil
20060048088500000264	25.08.2008 to 24.08.2009	1,00,000/-	5,000/-
20060048098500000290	25.08.2009 to 24.08.2010	3,00,000/-	10,000/-
20060048108500000283	25.08.2010 to 24.08.2011	3,00,000/-	25,000/-
20060048118500000255	25.08.2011 to 24.08.2012	3,50,000/-	40,000/-

They also stated that the Insured Jyoti Agarwalla was admitted in the Hospital from 16.08.2011 to 01.09.2011, 10.09.2011 to 13.09.2011 & 20.09.2011 to 26.09.2011 for Rheumatic Arthritis, both hips (M06). They further stated that on scrutiny of the case, they found that all the hospitalizations were within 105 days from the date of discharge from the Hospital. So, as per policy condition No. 3.0, the entire claim shall be treated as one illness. Further policy condition No. 4.3, Rheumatic Arthritis there is a waiting period of first two years of the operation of the policy. Since enhanced sum insured of Rs. 3.00 Lacs has not completed full two years from the date of enhancement, the claim shall be based on the original sum insured of Rs. 1.00 lac plus cumulative bonus of Rs.5,000/- = Rs.1,05,000/-. Therefore, they settled the claim treating sum insured for the entire period of hospitalization of Rs. 1,05,0000/- and the claim is settled for Rs.61,390.00.

<u>Decision</u> : According to the Complainant, his wife Mrs. Jyoti Agarwalla was hospitalized in Fortis Hospital, Bangaluru from 16.08.2011 to 01.09.2011, from 10.09.2011 to 13.09.2011 and from 20.09.2011 to 26.09.2011 for Rheumatic Arthritis. Hip Joint (Both) were replaced. The copies of Discharge Summaries also discloses about hospitalization of Mrs. Jyoti Agarwalla in Fortis Hospital, Bangalore on the above mentioned dates for treatment of Rheumatic Arthritis. The Complainant also stated that he lodged claim with the Insurer along with entire documents. The Insurer informed him by E-mail that they would pay Rs.61,390.00. Again the Insurer informed him verbally over phone that they would pay Rs.95,474.00. Surprisingly, they did not send any cheque till now.

The representative of the Insurer stated that on receipt of the claim they have verified the papers and found that all the hospitalizations were within 105 days from the date of discharge from the Hospital. So, as per policy condition No. 3.0,

the entire claim shall be treated as one illness. Further policy condition No. 4.3, Rheumatic Arthritis there is a waiting period of first two years of the operation of the policy. Since enhanced sum insured of Rs. 3.00 Lacs has not completed full two years from the date of enhancement, the claim shall be based on the original sum insured of Rs. 1.00 lac plus cumulative bonus of Rs.5,000/- = Rs.1,05,000/-. Therefore, they settled the claim treating sum insured for the entire period of hospitalization of Rs. 1,05,0000/- and the claim is settled for Rs.61,390.00.

It appears from the "Self Contained Note" of the Insurer that the Insured Mr. Ramesh Agarwalla took first policy on 25.08.2007 with Sum Insured of Rs. 1,00,000/- and he enhanced the Sum Insured from Rs.1,00,000/- to Rs.3,00,000/- with effect from 25.08.2009. The copy of Discharge Summary (Annexure – I) (first hospitalization Discharge Summary) shows that the Insured Mrs. Jyoti Agarwalla was admitted in the Hospital on 16.08.2011 for treatment of Rheumatic Arthritis i.e. within second year of enhancement of the Sum Insured. The copy of Discharge Summary (last hospitalization Discharge Summary) also discloses that the Insured was admitted on 20.09.2011 in the Hospital for the same disease. Hence, it appears that entire claim can be treated as one illness as it was within a period of 105 days. As per Insurer, the claim attracts the Policy Condition Nos. 3.0 & 4.3. In support of their contention, they produced terms and conditions of the policy before this Authority which is marked as Annexure – B. On a close perusal of Annexure – B that the Policy Condition Nos. 3.0 & 4.3 reads as under :

<u>3.0</u> "Any One Illness : will be deemed to mean continuous period of illness and it includes relapse within 105 days from the date of discharge from the Hospital / Nursing Home where treatment may have been taken. Occurrence of same illness after a lapse of 105 days as stated above will be considered as fresh for purpose of this policy."

<u>4.3</u> "Surgery of Rheumatism are not payable for first two years of operation of the policy."

Considering the above conditions, the Insurer has settled the claim of the Complainant on the basis of the original Sum Insured of Rs.1,00,000/- plus Cumulative bonus of Rs.5,000/- = Rs.1,05,000/- not on the enhanced Sum Insured of Rs.3,00,000/- as it has not completed full two years. Accordingly, they have settled the claim of the Complainant at Rs.61,390.00. I don't find any irregularity in settlement of the claim and the Insurer has rightly settled the claim at Rs.

63,390.00 on the basis of original Sum Insured of Rs. 1,05,000.00 (including Cumulative Bonus).The Insurer was accordingly directed to arrange to make payment of Rs.63,390.00 including 8% penal interest on the settled amount from the date of submission of claim papers to the Complainant within 15 days from the date of receipt of this Award.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-005-500/2011-12

M P Thomas

Vs

Oriental Ins. Co. Ltd

AWARD No. IO/KCH/GI/073/2012-13 dated 12.10.2012

The complainant had been taking Individual Mediclaim Policy from the Respondent-Insurer from 1995 onwards.He was involved in an accident on 09.02.2011. He was admitted at St. James Hospital , Chalakudy on 11.04.2011 and was discharged on 19.04.2011. The claim was rejected by the insurer. Therefore, the complaint.

The complainant submitted that the rejection of the claim is illegal.

The insurer submitted that the complainant was treated after 62 days of the accident. There was no active line of treatment during hospitalization and there was no need for hospitalization. So the claim was repudiated under clause 4.10 of the policy conditions.

Decision:- Discharge summary shows the diagnosis as Periarthritis (Rt) Shoulder. The treatment and course in hospital is noted as NSAIDS and Physio. Medicines prescribed during hospitalization and medication advised after discharge are also mentioned. In the mediclaim medical report, it is specifically stated that the disease suffered by the complainant required hospitalization. The medical bills would reveal that the expenses incurred are mainly for medicines and physiotherapy and not for investigations and diagnosis purposes. There is no case for the Insurer that the treatment provided to the complainant during hospitalization was unnecessary or not for the ailment suffered by him. There is sufficient evidence to show that the complainant had undergone 'active line of treatment' during hospitalization. So, the claim is not hit by clause 4.10 of the policy conditions. In the result, an award is passed directing the insurer to pay Rs. 4032/- to the

complainant within the prescribed period failing which, the amount shall carry interest @ 9% per annum from the date of complaint till payment is effected. No. cost.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-007-494/2011-12

Sunil Kumar

Vs

TATA AIG Gen. Ins. Co. Ltd

AWARD No. IO/KCH/GI/074/2012-13 dated 16.10.2012

The complainant had taken Health Care Plus Policy from the Respondent-Insurer w.e.f. 30.04.2010. The wife of the complainant had low back pain and was admitted and undergone a full course of Ayurveda treatment for 24 days in Agasthya Medical Centre, Tripunithura. The claim for the same was rejected on the ground that there was no necessity for hospitalization. Therefore, the complaint.

The complainant submitted that as per the policy conditions , he is entitled to receive Rs. 5000/- per day for each day of hospitalization. The medical opinion taken by the insurer is of no value at all.

The insurer submitted that from the nature of the ailment suffered by the wife of the complainant, no hospitalization was necessary. The treatment provided to her could have been given on OPD basis. Expert opinion taken by them also supports such a view. So, the claim was repudiated on valid grounds.

Decision:-As per discharge summary the diagnosis is Lumbar Disc Prolapse. She was given medicated oil bath for 9 days, Navarakizhi for 12 days and Vasthi for 7 days. Medicines were also given. The contents of the discharge summary are not challenged by the insurer. Treating doctor's certificate states that after careful examination the patient was advised 21 days full course ayurveda treatment as in patient. The insurer is relying on an expert opinion obtained from an allopathic doctor for rejection of claim. The two systems of treatment are entirely different and an Allopathic doctor can not give an expert opinion

as to the course of treatment given in an Ayurveda hospital So, there is no ground or basis to discard the opinion given by the treating doctor regarding necessity for treatment as in patient. So, the claim submitted by the complainant definitely comes under Part E of the policy conditions. In the result, an award is passed directing the insurer to pay Rs. 115000/- to the complainant within the prescribed period failing which, the amount shall carry interest @ 9% per annum from the date of filing of the complaint till payment is effected with cost of Rs.2500/-.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-002-429/2011-12

R Sreekumar

Vs

New India Assurance Co. Ltd

AWARD No. IO/KCH/GI/075/2012-13 dated 16.10.2012

The complainant had been taking Mediclaim Policy from the Respondent-Insurer from 2001 onwards. The wife of the complainant was admitted at KIMS Hospital, TVM and was diagnosed as Chronic HCV infection. PEG-interferon injection was advised and she was admitted at PRS, Hospital for starting the course of injection. The complainant submitted 4 claims and the same were not paid. Therefore, the complaint.

The complainant submitted that hospitalization was on the advice given by the doctor. The repudiation of the claims are not based on policy conditions.

The insurer submitted that for administration of the injection, no hospitalization was required. Expert opinion also confirms the same. The claims were denied on that ground.

Decision:- Clause 3.4 of the policy conditions defines the term "Hospitalisation". The ailment suffered by the wife of the complainant and the advice rendered by the treating doctor for taking a course of Interferron injection is not disputed by the insurer. Severity of the ailment, age of the patient, physical condition etc. are normally taken into consideration for advising hospitalization. Hospitalisation is normally recommended for taking Interferron injection. From the medical records it is evident that the hospitalization of the wife of the complainant comes within the definition given under clause 3.4. The advice given by the doctor is not challenged by the insurer. So the hospitalization of the wife of the complainant can not be disputed by the insurer. In the result, an award is passed directing the insurer to pay Rs. 77380/- to the complainant within the prescribed period failing which, the amount shall carry interest @ 9% per annum from the date of filing of the complaint till payment is effected and cost of Rs.2000/-.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-002-509/2011-12

P Vijayakumari

Vs

New India Assurance Co. Ltd

AWARD No. IO/KCH/GI/076/2012-13 dated 17.10.2012

The complainant had taken a Mediclaim policy covering herself and her children. The claim submitted in connection with the hospitalization of her daughter was repudiated by the insurer on the ground that the treatment was for psychiatric and psychosomatic disorder.The complainant submitted that her daughter was involved in a road accident and suffered head injury. The present ailment is on account of this injury and shock suffered in the said accident.. Therefore, the complaint.

The insurer submitted that the treatment was for Head ache and Psychosis with conversion symptoms. The accident which took place one year prior to hospitalization has

no connection with the ailment for which she underwent treatment. Treatment of Psychiatric and Psychosis disorders are excluded under clause 4.4.6 of the policy conditions. The repudiation of the claim is as per policy conditions.

Decision:- The treatment certificate reveals that the patient was treated only by Neuro Surgeon in the Neurosurgery Department. Merely because psychiatric consultation was done, it cannot be concluded that the treatment was for psychiatric disorder. No medication was prescribed by the psychiatrist. Temporal bone fracture with pneumocephalus can cause injury or irritation to the brain. Also no evidence is available to show that she was ever treated earlier for psychiatric disorder. No symptoms of mental disorder is noted in the treatment certificate. So it can be concluded that the treatment taken, was for the manifestations related to head injury suffered in the earlier road traffic accident. In the result, an award is passed directing the insurer to pay Rs. 20394/- to the complainant within the prescribed period failing which, the amount shall carry interest @ 9% per annum from the date of filing of the complaint till payment is effected. No. cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-004-539/2011-12

M Vijayalal

Vs

United India Insurance Co. Ltd

AWARD No. IO/KCH/GI/079/2012-13 dated 18.10.2012

The complainant had been taking Individual Health Insurance Policy from the Respondent-Insurer from 2006 onwards without any break. The wife of the complainant was admitted in Sun Rise Hospital for Osteoporosis. When the claim was submitted the same was rejected by the insurer on the ground that hospitalization is not justified. Therefore, the complaint.

The complainant submitted that his wife was admitted in the hospital on the advice of the doctor. Hospitalisation was not for evaluation purpose, but for treatment of the ailment.

The insurer submitted that the treatment which the wife of the complainant had undergone , could have been done on OPD basis. Hospitalisation was mainly for evaluation and diagnostic purpose and there was no active line of treatment during hospitalization. The claim is hit by Clause 4.10 of the policy conditions.

Decision:-Discharge summary shows the diagnosis as Osteoporosis and reveals that Intravenous infusion of medicine was done under the observation of the doctor. Positive existence of Osteoporosis was diagnosed on account of investigations(Densitometry) done during hospitalization. Investigations done are consistent with the diagnosis made and treatment provided is for the ailment diagnosed. There is nothing to show that hospitalization of the complainant's wife was unnecessary and not based on the advice of the treating doctor. It can be concluded that there was active treatment during hospitalization and the hospitalization was unavoidable. So the claim is not hit by clause 4.10 of the policy conditions and the repudiation is not sustainable. In the result, an award is passed directing the insurer to pay Rs. 14200/- to the complainant within the prescribed period failing which, the amount shall carry interest @ 9% per annum from the date of filing of the complaint till payment is effected. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/14-005-540/2011-12

Mathews K Joseph

Vs

TATA AIG General Insurance Co. Ltd

AWARD No. IO/KCH/GI/083/2012-13 dated 31.10.2012.

The complainant had taken Health Care Plus Policy from the Respondent-Insurer.He submitted a claim seeking Daily Hospitalisation Cash Benefit provided under the policy. The claim for the same was rejected initially. Later insurer offered to settle the claim for Rs. 6000/-. The complainant was hospitalized for 17 days and he is entitled to Rs. 3000/- per day for 17 days of hospitalization. Therefore, the complaint.

The complainant submitted that it was found that he was suffering from unstable angina. The doctor suggested angioplasty. In order to avoid surgery, he consulted a doctor practicing Naturopathy and on his advice, he was admitted in the hospital for 17 days and underwent treatment there. As per the policy conditions , he is entitled to receive Rs. 3000/- per day for each day of hospitalization.

The insurer submitted that in this case hospitalization was not medically necessary. There is no treatment for unstable angina or heart disease in Naturopathy.Expert opinion taken by them also supports such a view. As a goodwill gesture, they offered to Rs. 6000/- to the complainant.

Decision:- There is no mention of "goodwill gesture" in the offer letters and the logic for offering Rs. 6000/- is unknown.As per the doctor's report and connected investigation reports from Co-Operative Hospital, Thrissur, the complainant was suffering from unstable angina.. The insurer is relying on an expert opinion obtained from an allopathic doctor for rejection of claim. The two systems of treatment are entirely different and an Allopathic doctor is thoroughly incompetent to certify regarding the treatment available in Naturopathy. Naturopathy is an accepted system of medicine and it has got accepted standards of treatment. Further Naturopathy treatment is not excluded under the policy. Discharge summary and other reports reveals that admission at Naturopathy Hospital was ordered by the attending physician and the treatment was provided under his care and supervision. It also shows considerable improvement in various critical readings after treatment and the complainant himself emphasized that he was much relieved of the symptoms of the ailment. So, the claim submitted by the complainant definitely comes under Part E of the policy conditions. In the result, an award is passed directing the insurer to pay Rs. 48000/- to the complainant with 9% interest from the date of the filing of complaint till the date of award within the prescribed period, failing which, the amount shall carry further interest @ 9% per annum from the date of award till payment is effected. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-004-549/2011-12

K Rameshan

Vs

United India Insurance Co. Ltd

AWARD No. IO/KCH/GI/090/2012-13 dated 08.11.2012.

The complainant had been taking Health Insurance Policy from the Respondent-Insurer from 1993 onwards without any break. He underwent treatment for low back pain in a reputed Ayurveda Medical College Hospital. The claim for the same was rejected by the insurer on the ground that the treatment was not taken in a Govt. Medical College. Therefore, the complaint.

The complainant submitted that he took the treatment in a recognized Ayurveda Medical College Hospital and there is no provision in the policy conditions which excludes the same. So, he is entitled for the entire claim.

The insurer submitted that as per policy conditions clause 2.1, for ayurvedic treatment, hospitalization expenses are admissible only when the treatment is taken as inpatient in a Govt. Hospital/ Medical College Hospital. So the repudiation is legal and proper.

Decision:- As per medical records, the complainant had taken treatment in a Private Ayurveda Medical College Hospital as inpatient for 17 days. Clause 2.1 (2) of the policy conditions, states that " For reimbursement, Ayurveda treatment has to be taken in a Government Hospital / Medical College Hospital" . There is a dispute regarding interpretation of this provision. The word "Govt." is pre-fixed to the word "Hospital", but it is not pre-fixed to the word "Medical College Hospital". So it can be seen that, the intention was to include Govt. Hospitals as well as Medical College Hospitals. Private as well as Govt. Medical College Hospitals are to satisfy the prescribed minimum standards in the same footing. Also the term "Hospital" would take in Medical College Hospitals as well. So, if it was the intention of the framers of the policy conditions to exclude Private Medical College Hospitals, it was sufficient to state as " Govt. hospitals" as that term would take in Govt. Medical College Hospitals as well. So, the conclusion that can be

arrived at is that claim for treatment in a Govt. Hospital or Medical College Hospital (whether Govt. or Private) is admissible. In the result, an award is passed directing the insurer to pay an amount of Rs. 17000/- to the complainant within the prescribed period failing which, the amount shall carry interest @ 9% per annum from the date of filing of the complaint till payment is effected with cost of Rs. 1000/-.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-002-557/2011-12

M T Chakkunny

Vs

New India Assurance Co. Ltd

AWARD No. IO/KCH/GI/091/2012-13 dated 08.11.2012.

The complainant had been taking Mediclaim Policy from the Respondent-Insurer from 1996 onwards. The sum insured was enhanced to Rs. 1 lac in 2007. The complainant suffered stroke in 2008 and 2009 and the expenses for the same was reimbursed by the insurer. He suffered stroke again in 2010 and the claim was partially settled. Hence, the complaint.

The complainant submitted that there is no basis for partial repudiation of the claim.

The insurer submitted that as the complainant had contracted the ailment during the period of the preceding policy, the claim was limited to the sum insured prior to enhancement. The stroke suffered is a complication of pre-existing hypertension for which a waiting period of 2 years is applicable from the date of enhancement of sum assured. Clause 6(d) of the policy conditions is attracted.

Decision:- Discharge summary shows the diagnosis as Cerebro Vascular Disease, Recurrent Brainstem Stroke, Systemic Hypertension, Dyslipidemia and Cellulitis. In the history portion it is stated that he has history of left hemiplegia since 2 years and hypertension

since 2 ½ years. This shows that the contract of hypertension was prior to 26.05.2008. So, evenafter the enhancement of sum insured to Rs. 1 lac, the waiting period of 2 years for treatment of hypertension had exhausted. So, clause 4.3 of the policy conditions cannot be applied for rejection of claim. It is evident that the complainant contracted hemiplegia in the policy period 2008-09. ie, after the enhancement of the sum insured to Rs. 1 lac. Also there is no evidence from the side of the insurer to show that the complainant had contracted Brainstem stroke or Cerebro Vascular Disease during the policy period preceding the enhancement of the sum insured. So, it can be seen that clause 6 (d) of the policy conditions is not attracted. The complainant is entitled to the benefit of the enhanced sum insured. So, partial repudiation of the claim is unsustainable. In the result, an award is passed directing the insurer to pay an amount of Rs. 34375/- to the complainant within the prescribed period failing which, the amount shall carry interest @ 9% per annum from the date of filing of the complaint till payment is effected. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-004-369/2011-12

Shibu K

Vs

United India Insurance Co. Ltd

AWARD No. IO/KCH/GI/093/2012-13 dated 14.11.2012.

The complainant had taken Family Mediclaim Policy from the Respondent-Insurer. Son of the complainant suffered Pneumonia and was admitted at KIMS Hospital, Tvm. He had spent more than Rs. 68000/- and the insurer provided Rs. 27000/- towards cash less facility rejecting the balance on the ground that the child was suffering from Cerebral Palsy. Therefore, the complaint.

The complainant submitted that though Rs. 30000/- was authorized towards cash less facility, actually Rs. 27000/- was paid to the hospital. The hospitalization was mainly for treatment of Pneumonia. Even if the expenses for pre-existing disease are excluded , he is entitled to further Rs.3000/- from the insurer.

The insurer submitted that they had settled the claim for Rs. 59527/-. The son of the complainant was suffering from Seizure disorder and Cerebral Palsy which were pre-existing diseases.The expenses incurred for the treatment of these were disallowed as per clause 4.1 of the policy conditions. No more amount is payable.

Decision:- In the approval letter from TPA the amount authorized towards cashless facility is shown as Rs. 30000/-. In the mediclaim computation sheet dt. 29.05.2012, it is shown that Rs. 29527/- was approved for payment apart from Rs. 30000/- already paid as cashless facility. The complainant's contention is that TPA had issued a cheque for Rs. 27000/- only to the hospital. The letter issued by KIMS, Hospital clearly mentions that TPA had extended cashless facility of Rs. 27000/- which included service tax and the cheque details are also provided. The insurer had not adduced any contra evidence to show that they had paid Rs. 30000/- towards cashless facility. The available evidence would lead to the conclusion that the insurer had provided cashless facility to the tune of Rs. 27000/- only. The complainant is therefore, entitled to the difference of Rs. 3000/- . In the result, an award is passed directing the insurer to pay an amount of Rs. 3000/- to the complainant with 9% interest from the date of filing of the complaint till the date of the award within the prescribed period failing which, the amount shall carry further interest @ 9% per annum from the date of award till payment is effected. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-017-566/2011-12

V P Satheesh Menon

Vs

Star Health & Allied Insurance Co. Ltd

AWARD No. IO/KCH/GI/095/2012-13 dated 16.11.2012.

The complainant had taken a Medi-Classic Health Insurance Policy from the Respondent-Insurer. After a medical check-up on 3.2.2011, the policy was issued w.e.f. 8.2.2011, though he had paid full premium on 3.2.2011 itself. He was admitted in Hospital on 11.3.2011 in connection with Thyroid removal. The claim was rejected by the insurer on the ground that it was within the waiting period of 30 days. Therefore, the complaint.

The complainant submitted that he had never been treated for ailment connected with Thyroid earlier to the present hospitalization. The rejection of the claim happened as a result of delayed inception of the policy for no fault of his. The repudiation is illegal.

The insurer submitted that the policy was issued on 8.2.2011, when the full premium was received. As the complainant had contracted the ailment within the first 30 days of inception of the policy, the claim was validly repudiated as per policy conditions.

Decision:- As regards the dispute in respect of the inception date of the policy, there is no convincing material to accept either of the contentions raised by the parties. So the complaint will be considered as if the policy was issued w.e.f. 8.2.2011. As per discharge summary , he was admitted on 15.3.2011 and discharged on 19.3.2011. In the history portion it is shown that he had swelling front of neck -10 days. He was diagnosed for Papillary Carcinoma Thyroid and underwent thyroidectomy on 16.3.2011. In the medical certificate issued by the hospital, the date of 1st consultation is shown as 11.3.2011. So the ailment was diagnosed at the earliest on 11.3.2011 only. What is material is knowledge of contract of the ailment. Mere throat pain cannot be attributed as knowledge of contract of the present ailment. It can be due to several reasons. Therefore, it can be concluded that the diagnosis and knowledge of the ailment is after 11.3.2011 and beyond 30 days from the inception of the policy. So, clause 3.2 of the policy conditions is not attracted and the repudiation of the claim is not sustainable. In the result, an award is passed directing the insurer to pay an amount of Rs. 60189/- to the complainant within the prescribed period failing which, the amount shall carry interest @ 9% per annum from the date of filing of the complaint till payment is effected. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-017-553/2011-12

Valliyil Yousuf

Vs

Star Health & Allied Insurance Co. Ltd

AWARD No. IO/KCH/GI/096/2012-13 dated 20.11.2012

The complainant had taken 'Red Carpet Insurance Policy' from the Respondent-Insurer from 21.7.20009 onwards. He was admitted to "Arvind Eye Hospital", Coimbatore in connection with pain in the eye on 4 occassions. The claims were repudiated by the insurer . Therefore, the complaint.

The insurer submitted that for one claim the intimation alone was received, which was closed for non-receipt of requirements and the other 3 claims were rejected since all these hospitalizations were for treatment related to the complications of the cataract surgery performed in March, 2010. As per exclusion clause 3 of the policy conditions, there is a waiting period of 2 years for cataract treatment reimbursement. The rejection of the claims are legal and proper.

Decision:- The complainant has not adduced any evidence to prove that the required documents were submitted to the insurer in the case of the 4th claim. Hence this forum can not interfere with the decision of the insurer to close the claim.

On a careful reading of the policy exclusion clause 3, it is evident that if the treatment taken for the eye is not in connection with Cataract, then this clause won't be applicable. In the discharge summary in respect of 1st claim , the diagnosis is shown as post operative inflammation in the right eye and there is sufficient evidence to show that IOL surgery was done in March 2010. So in this case the exclusion clause is attracted and the repudiation of the claim is in order.

For the 2nd claim, the insurer has not produced the discharge summary and claim form though they have received the same. The complainant has produced the Retina discharge summary for this admission wherein it is mentioned that the treatment undertaken was for Rt. Corneal rupture with swelling and inflammation. No contra evidence has been

adduced by the insurer to prove that this claim is related to treatment for cataract. So, the rejection of the claim is not sustainable.

The discharge summary in respect of 3rd claim, shows the diagnosis as Perforated corneal ulcer and post operative endophthalmitis in Rt. Eye. The surgery immediately preceding this admission was the one for corneal rupture. So here also the rejection of the claim is not sustainable. There is provision for 30% co- payment in the policy. In the result, an award is passed directing the insurer to pay an amount of Rs. 33860/- to the complainant within the prescribed period failing which, the amount shall carry interest @ 9% per annum from the date of filing of the complaint till payment is effected. No cost

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-002-577/2011-12

P K Deepa

Vs

New India Assurance Co. Ltd

AWARD No. IO/KCH/GI/099/2012-13 dated 21.11.2012

The complainant had taken Mediclaim policy from the Respondent-Insurer . She fell ill and was admitted in Axon Hospital, Bangalore and underwent an emergency surgery. TPA of the insurer allowed cashless facility of Rs. 30240/- When the claim for reimbursement of balance amount of Rs. 28843/- was submitted, there was no response from the side of the insurer. Hence, the complaint.

The complainant submitted that the surgery was for removal of Gall Bladder stone.The insurer denied the claim stating that there was package scheme for each surgery and she was unaware of the same.

The insurer submitted that they disallowed the claim as per PPN Tariff. For Cholecystectomy, there is a package scheme and the entire payable amount was already

provided. Complainant had opted for Zone 3 and availed treatment in Zone 2 . So 10% deduction is provided in the claim amount.

Decision:- Discharge summary reveal that the complainant was diagnosed for Cholelithiasis with Recurrent Cholecystitis and she underwent laproscopic Cholecystectomy. The policy conditions donot provide package tariff for Cholecystectomy. The package tariff agreement between the insurer and the Hospital is beyond the scope of the policy. Insured is not a party to the agreement and is not aware of it. The insurer is bound to honour the claim subject to policy conditions. In the result, an award is passed directing the insurer to pay an amount of Rs.25959/- to the complainant within the prescribed period failing which, the amount shall carry interest @ 9% per annum from the date of filing of the complaint till payment is effected. No cost

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-004-579/2011-12

Raju Mathew Vs United India Insurance Co. Ltd

AWARD No. IO/KCH/GI/100/2012-13 dated 23.11.2012

The complainant had been taking Medi-claim policy from the Respondent-Insurer for the last 15 years. During 2009-10 policy period the sum assured was Rs. 525000/- and Bonus accrued was Rs. 157000/-. He underwent aortic valve replacement surgery in 2010 and submitted claim for Rs. 538955/- . The insurer allowed only Rs. 250000/- on the ground that the disease was pre-existing. Therefore, the complaint.

The complainant submitted that he suffered Rheumatic Heart disease for the first time in Aug 2010. There is no medical evidence to show that the ailment was a pre-existing one as alleged by the insurer. He is entitled for full re-imbursement.

The insurer submitted that the original sum assured of the policy was Rs. 250000/- and later it was enhanced. The disease suffered would come within the ambit of pre-existing disease . They are ready to pay Rs. 50000/- more.

Decision:- Discharge summary shows the diagnosis as Rheumatic Heart Disease with Severe Calcific AS. In the history portion it is shown that the complainant was having systemic hypertension for 2 years and class II dyspnoea, worsened to class III last 2-3 years.There is no history of angina or syncope. There is no mention that Rheumatic Heart disease is a complication of dyspnoea The insurer's contention is that the present ailment is a complication of the pre-existing ailment – dyspnoea. In the medical certificate issued by the treating doctor also it is mentioned under column 8 that the present ailment is not a complication of the pre-existing disease. When the insurer is ignoring the contents of the discharge summary and medical certificate issued from the hospital, they should provide ample medical evidence to prove their contention which they have failed miserably. There is complete lack of evidence to show that the Rheumatic Heart Disease suffered by the complainant is a pre-existing disease. In the result an award is passed directing the Respondent-Insurer to pay to the complainant an amount of Rs. 270404/- with interest @9% per annum from the date of filing of the complaint till the date of this award and cost of Rs. 2500/- within the prescribed period failing which the amount shall carry further interest @9% per annum from the date of award till payment is effected.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-004-463/2011-12

S Pandyaraj

Vs

United India Insurance Co. Ltd

AWARD No. IO/KCH/GI/101/2012-13 dated 26.11.2012

The complainant had taken Medi-claim policy from the Respondent-Insurer. He underwent bypass surgery and the claim for the same was rejected on the ground that the disease was pre-existing. Therefore, the complaint.

The complainant submitted that before his current admission , he never underwent treatment earlier for any ailment connected with heart.

The insurer submitted that verification of hospital records revealed that the complainant had suffered 'retrosternal pain and exertional angina' in 2008 and had taken treatment at that time. So, he was suffering from a pre-existing disease connected with heart at the time of taking the present policy which is specifically excluded under the policy.

Decision:- Discharge summary shows the diagnosis as 'Severe Triple Vessel Coronary Artery Disease and Systemic Hypertension". He underwent bypass surgery. No proof has been produced by the insurer to substantiate their claim that the complainant was suffering from disease connected with heart since 2008.In the discharge summary as well as the attending doctor's report, there is no mention of any earlier treatment or disease . If he was treated in the same hospital as claimed by the insurer, it should have found a place in these reports without fail. In the absence of any evidence pointing to pre-existence of the ailment, the repudiation of the claim on that ground is unsustainable. In the result an award is passed directing the Respondent-Insurer to pay to the complainant an amount of Rs.182834/- with interest @9% per annum from the date of filing of the complaint till the date of this award within the prescribed period failing which the amount shall carry further interest @9% per annum from the date of award till payment is effected. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-003-581/2011-12

K Vijayan

Vs

National Insurance Co. Ltd

AWARD No. IO/KCH/GI/102/2012-13 dated 27.11.2012 /27.03.2013

The complainant had taken Varistha Medi-claim policy from the Respondent-Insurer. He underwent prostate surgery and the claim for the same was rejected on the ground that the disease was pre-existing. Therefore, the complaint.

The complainant submitted that he was not suffering from any ailment connected with urinary system earlier. Nothing was suppressed by him at the time of submission of proposal form. The denial of the claim is baseless and against policy conditions.

The insurer submitted that discharge summary from the hospital revealed that the complainant was on treatment for prostatism since 5-6 years. So, at the time of submission of the proposal form , he very well knew that he had prostate problem. So, the claim is hit by clause 4.1 of policy conditions, as the ailment was a pre-existing one.

Decision:- In the discharge summary issued from the hospital there is only the isolated statement that he was having history of prostatism on treatment since 5-6 years. The insurer did not succeed in collecting any document which will show that the complainant was under treatment earlier. In the medical report obtained by the insurer before issuing the policy , it is stated that there is no defect in the genitor-urinary system on examination. There is no evidence that the complainant had taken treatment for ailment connected with prostate or he knew about such ailment. Clause 4.1 of the policy states that pre-existing diseases will be covered after one claim free year under the policy. There is no case for the insurer that there were claims during the first policy year. Even if it is admitted that the present ailment was a pre-existing one , as per this provision , the claim is payable. So, the repudiation of the claim is unsustainable. In the result an award is passed directing the Respondent-Insurer to pay to the complainant an amount of Rs.40280/- with interest @9% per annum from the date of filing of the complaint till the date of this award within the prescribed period failing which the amount shall carry further interest @9% per annum from the date of award till payment is effected. No cost

The award was reviewed on 27.03.2013 and found that the liability of the insurer is limited to Rs. 20000/- as per Clause 1.0(1). So the award amount was corrected as Rs.20000/-

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-004-627/2011-12

R Gopalakrishnan

Vs

United India Insurance Co. Ltd

AWARD No. IO/KCH/GI/105/2012-13 dated 06.12.2012

The complainant had been taking Mediclaim Policy from the Respondent-Insurer since 1998. During the policy period 2010-11, he was hospitalized due to Parkinsonism. He submitted claims for hospitalization and post-hospitalisation expenses to the insurer. The insurer settled the claims partially only. Therefore, the complaint.

The complainant submitted that there is no valid reason for making deductions in the claims submitted by him. As per policy conditions he is entitled for full re-imbursement.

The insurer submitted that the deductions were made strictly in accordance with the policy conditions.

Decision:- Discharge summary shows the diagnosis as Type 2 Diabetes Mellitus, Hypertension, Parkinsonism and Rt. Vocal cord atrophy. The details of treatment given and the medicines prescribed after discharge are given. There is no valid contention from the side of the insurer in relation to the 3 claims submitted by the complainant. Policy conditions provide for pre as well as post hospitalization benefits in addition to hospitalization benefit. Also no ailment is excluded as per the policy schedule. The partial rejection of the claims is not as per policy conditions. Also there was delay and harassment to the claimant. In the result an award is passed directing the Respondent-Insurer to pay to the complainant an amount of Rs.6446/- with interest @9% per annum from the date of filing of the complaint till the date of this award within the prescribed period failing which the amount shall carry further interest @9% per annum from the date of award till payment is effected and Cost of Rs. 1000/-

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-003-626/2011-12

M A Varghese

Vs

National Insurance Co. Ltd

AWARD No. IO/KCH/GI/109/2012-13 dated 13.12.2012

The complainant had taken Mediclaim policy from the Respondent-Insurer for the period 8.12.2010 to 7.12.2011. The daughter of the complainant was admitted in Lakeshore Hospital due to abdominal pain and underwent surgery for Appendicitis. The claim was repudiated by the insurer under Clause 4.2 of the policy conditions. Therefore, the complaint.

The complainant submitted that the hospitalization was not within 30 days of the commencement of the policy. The repudiation of the claim under clause 4.2 of the policy conditions is baseless and illegal.

The insurer submitted that the policy provides for gestation period of 30 days from the date of commencement of the policy. The ailment was contracted within 30 days of the inception of the policy. So, the claim is hit by clause 4.2 of the policy conditions.

Decision:- Discharge summary shows the diagnosis as Recurrent Appendicitis. Clause 4.2 of the policy conditions states that the Co. shall not be liable to make any payment under the policy in connection with or in respect of any hospitalization expenses incurred in the first 30 days of the inception of the policy. Even though the word "hospitalization" is not specifically defined in the policy, the general meaning and even as per other policy conditions, it means inpatient treatment. So, it does not mean mere treatment or diagnosis. So, the exclusion contained in clause 4.2 of the policy conditions does not attract even if the ailment was contracted within 30 days but , hospitalization is after the first 30 days of inception of the policy. In the present case the hospitalization is more than 180 days after the inception of the policy. Therefore, clause 4.2 is not at all attracted. The repudiation of the claim can not be sustained. In the result, an award is passed directing the insurer to pay an amount of Rs.32904/- to the complainant within the prescribed

period failing which, the amount shall carry interest @ 9% per annum from the date of filing of the complaint till payment is effected. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-009-656/2011-12

C Sudha

Vs

Reliance General Insurance Co. Ltd

AWARD No. IO/KCH/GI/111/2012-13 dated 19.12.2012

The complainant had taken a Health Policy from the Respondent-Insurer. She was hospitalized for Cervical Spondylosis at Arya Vaidya Ashramam Ayurveda Hospital, Kodungallur for 5 days. The claim was rejected by the insurer on the grounds that the treatment could have been done on OP basis and there was delay in submission of the claim. Therefore, the complaint.

The complainant submitted that the treatment could not have been done on OP basis. As the claim includes post-hospitalisation expenses also , there is no delay in submiision of the claim . The repudiation is illegal and irregular.

The insurer submitted that the treatment provided could have been taken on OP basis. The admission and discharge records reveal that all the medicines provided during hospitalization were advised to be taken after discharge as well.This itself shows that only OP treatment was necessary. Also there was delay in submitting the claim. So, the claim was repudiated under exclusion No. 21 and procedural clause No. 3 of the policy conditions.

Decision:- Discharge summary shows the diagnosis as Cervical Spondylosis and Rasnadhithalam and Rookshaswedam were advised for 7 days and 4 Kizhis were administered. The Discharge summary and other treatment records reveals that apart from medicines at least two procedures were advised to be done during hospitalization. These procedures can be done only under strict supervision of the attending doctor. Attending doctors report also describes the nature of ailment and procedures done The decision of the doctor to treat the patient as IP can not be questioned by the insurer or TPA. Adequate and proper treatment for the ailment is active line of treatment for that particular ailment. Here it can be seen that the patient was provided active line of

treatment during hospitalization. Also, as no prejudice was occasioned to the insurer or the TPA due to the delay in submission of the claim, repudiation of the claim on that ground is not feasible. Since the exclusion No. 21 is not at all attracted in this case, the repudiation on that ground can not be justified. In the result an award is passed directing the Respondent-Insurer to pay to the complainant an amount of Rs.12817/- with interest @9% per annum from the date of filing of the complaint till the date of this award within the prescribed period failing which the amount shall carry further interest @9% per annum from the date of award till payment is effected. No cost

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-004-661/2011-12

Suresh Kumar

Vs

United India Insurance Co. Ltd

AWARD No. IO/KCH/GI/114/2012-13 dated 02.01.2013

The complainant had been taking Mediclaim policy from the Respondent-Insurer for the last 5 years. His daughter developed Protrusion of Left Eye and was admitted at Vasan Eye Care Hospital, Kozhikode. The claim for the same was repudiated by the insurer stating that the admission was only for investigations and hence not payable. Therefore, the complaint.

The complainant submitted that the admission and investigations were done as per the advice of the treating doctor. There was active line of treatment during hospitalization. He is entitled to get the medical expenses in full.

The insurer submitted that only investigations were done during hospitalization.There was no active line of treatment and only some eye drops were applied. The claim comes under exclusion clause 4.8 of the policy conditions.

Decision:- The Discharge summary shows the diagnosis as Axial Proptosis Left eye. It is noted that the case was investigated with C.T. Scan, Blood Routine and Thyroid Function tests. There is nothing in evidence that the investigations and treatment adopted could have been done on out-patient basis. So, note to clause 2.3 is not at all attracted in this case. Axial Proptosis of eye can be mainly due to two reasons, Goiter and Inflammation of the orbit. It is seen that all the investigations are consistent with and incidental to the diagnosis. Investigations are also done to confirm the diagnosis and also to rule out the existence of certain ailments doubted by the treating doctor. Therefore, exclusion clause 4.8 is not at all attracted in this case and the repudiation of the claim is not sustainable. In the result, an award is passed directing the insurer to pay an amount of Rs.5140/- to the complainant within the prescribed period failing which, the amount shall carry interest @ 9% per annum from the date of filing of the complaint till payment is effected. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-017-699/2011-12

Arun Sunny

Vs

Star Health & Allied Insurance Co. Ltd

AWARD No. IO/KCH/GI/115/2012-13 dated 03.01.2013

The complainant had taken Family Health Optima Insurance Policy from the Respondent-Insurer. On account of abdominal pain he was admitted in Krishna Hospital. The claim for Rs. 16367/- was partially repudiated by the insurer. Therefore, the complaint.

The complainant submitted that his claim included hospitalization as well as post hospitalization expenses. The insurer offered only Rs. 5279/- which was not accepted. He is entitled for the full amount.

The insurer submitted that there was a minor mistake in the calculation. The complainant is entitled to reimbursement of Rs. 5845/- towards hospital expenses and Rs. 353/- towards post hospitalization expense. As per clause 1.0 of the policy conditions, the complainant is entitled to only 7% of the hospitalization expenses towards post hospitalization expenses.

Decision:- On verification of bills, it is found that out of Rs. 6367/- spent by the complainant towards hospitalization expenses, he is entitled to receive Rs. 5845/-. A limit is provided under clause 1.0(G) for payment of post hospitalization expenses. It is 7% of hospitalization expenses incurred excluding room rent subject to a maximum of Rs. 5000/-. So in this case, though the complainant had claimed post hospitalization expenses of Rs. 10000/- , he is entitled to Rs. 553/-. Though no intentional mistake was committed by the insurer, on account of the delay caused and harassment meted out to the complainant, he is entitled to cost of Rs. 500/-. In the result, an award is passed directing the insurer to pay an amount of Rs.6198/- with cost of Rs. 500/- to the complainant within the prescribed period failing which, the amount shall carry interest @ 9% per annum from the date of filing of the complaint till payment is effected.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-005-618/2012-13

C C Kartha

Vs

Oriental Insurance Co. Ltd

AWARD No. IO/KCH/GI/117/2012-13 dated 08.01.2013

The complainant had taken Medi-claim policy from the Respondent-Insurer from 1997 onwards. When the policy was renewed for the year 2007-08, the insurer did not provide the cumulative bonus.He sent a letter to the insurer to restore the cumulative bonus. The insurer vide letter dt. 14.08.2009 informed that he had been issued with a revised policy and if he so desires he can go back to the pre-revised plan . There was no communication between the complainant and the insurer thereafter. He had preferred the present complaint before this Forum on 18.11.2012.

Decision:- As per Rule 13 (3) (b) of RPG Rules, as the present complaint had been filed beyond one year from 14.08.2009, the complaint is barred by limitation. In the result, the complaint is dismissed as barred by limitation. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-004-691/2011-12

Dinu Kurian

Vs

United India Insurance Co. Ltd

AWARD No. IO/KCH/GI/119/2012-13 dated 09.01.2013

The complainant had taken an Individual Health Policy from the Respondent-Insurer. On account of pain in the genital organ, he underwent surgery at Muthoot Medical Centre, Pathanamthitta. The claim was rejected by the insurer stating that there was no active line of treatment during hospitalization. Therefore, thye complaint.

The insurer submitted that the repudiation of the claim under Clause 4.10 of the policy was not correct and they are ready to settle the claim for an amount of Rs. 7235/-

Decision:- As per the discharge summary, it is quite evident that the complainant underwent surgical excision of sebaceous cyst in the scrotum. So, there was active line of treatment during hospitalization. This aspect was overlooked by the insurer while

repudiating the claim. So, the complainant was entitled to receive Rs. 7235/- atleast on 28.09.2011. On account of delayed payment, he is entitled to reasonable interest also. In the result, an award is passed directing the insurer to pay an amount of Rs.7235/- with 9% interest from date of filing of the complaint till the date of award, to the complainant within the prescribed period failing which, the amount shall carry further interest @ 9% per annum from the date of award till payment is effected. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-004-682/2011-12

K A Cyril

Vs

United India Insurance Co. Ltd

AWARD No. IO/KCH/GI/120/2012-13 dated 09.01.2013

The complainant had taken Health Insurance Policy from the Respondent-Insurer. He slipped and fell down and suffered severe back pain. He was admitted in Fatima Hospital, Kochi and underwent treatment for 2 days The claim was repudiated by the insurer on the ground that there was no active line of treatment. Therefore, the complaint.

The insurer submitted that during hospitalization there was no active line of treatment. Only investigations were done. So, the claim is hit by Exclusion Clause 4.10 of the policy conditions. The repudiation of the claim is sustainable.

Decision:- The Discharge summary shows the diagnosis as deconditioned spine and contusion. MRI, Ultra Sound scanning and physiotherapy were done during hospitalization. MRI revealed mild posterior disc bulge. So, the investigations done are consistent with the diagnosis and therefore, can not be said that they were unwarranted The wisdom of the doctor to admit the patient in the hospital and provide treatment cannot be questioned by the insurer. So, in this case clause 2.3 and 4.10 of the policy conditions are not attracted. The repudiation of the claim is unsustainable. In the result, an award is passed directing the insurer to pay an amount of Rs.8432/- to the complainant within the prescribed period failing which, the amount shall carry interest @ 9% per annum from the date of filing of the complaint till payment is effected. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-004-702/2011-12

Baiju P P

Vs

United India Insurance Co. Ltd

AWARD No. IO/KCH/GI/123/2012-13 dated 16.01.2013

The complainant had taken Individual Health Insurance policy from the Respondent-Insurer. His minor daughter suffered abdominal pain and was treated as in-patient at Little Fl;ower Hospital, Angamaly. The claim for the same was repudiated by the insurer stating that no hospitalization was necessary. Therefore, the complaint.

The complainant submitted that the admission and investigations were done as per the advice of the treating doctor. She was provided treatment during hospitalization. He is entitled to get the medical expenses in full.

The insurer submitted that only investigations were done during hospitalization.There was no active line of treatment . The claim comes under exclusion clause 4.8 of the policy conditions.

Decision:- The Discharge summary shows the final diagnosis as Mesenteric Adentis. Medicines were given during hospitalization and also advised to continue after discharge. The investigations done are consistent with and incidental to the final diagnosis. For proper diagnosis, investigations were done and they have confirmed the primary diagnosis done by the doctor. It is seen that , this is not a case where the treatment could have been done on OP basis. So, the claim is not hit by exclusion Clause 4.8 of the policy conditions. Also Note to Clause 2.3 is not attracted. The repudiation of the claim is not sustainable. In the result, an award is passed directing the insurer to pay an amount of Rs.2578/- with 9% interest from date of filing of the complaint till the date of award to the complainant within the prescribed period failing which, the amount shall carry further interest @ 9% per annum from the date of award till payment is effected. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-004-709/2011-12

A V Saraswathy

Vs

United India Insurance Co. Ltd

AWARD No. IO/KCH/GI/125/2012-13 dated 17.01.2013

The complainant had been taking Mediclaim policy from the Respondent-Insurer since 12.07.2005. The sum assured was enhanced to Rs. 50000/- w.e.f. 12.07.2008. In 2011, she was hospitalized and the claim for the same was settled for Rs. 25000/- restricting the S.A. on the ground of pre-existing ailment. Therefore the complaint.

The complainant submitted that if at all, he had undergone treatment for a pre-existing disease, the period of 48 months from the date of inception of the 1st policy has elapsed and hence Clause 4.1 of the policy conditions is not attracted.

The insurer submitted that Clause 4.1 of the policy conditions is attracted and the complainant is entitled to the benefit of increased Sum Insured only on completion of 48 months from 12.07.2008.

Decision:- A reading of Clause 4.1 along with the definition of the term "Pre-existing condition" would reveal that Clause 4.1 is silent about the effect of enhancement of sum assured. In Clause 4.1, it can be seen that an emphasis is given to the portion-" since inception of his/her first policy with the company". Here the period of 48 months shall run from 12.07.2005 which is the inception of the first policy. So, it is to be inferred that Sum Insured/ Enhanced Sum Insured is not directly or indirectly linked with pre-existence of the ailment. A provision which is not there in the conditions can not be read into the policy conditions, so as to deny the benefit provided under the policy. Also, a lawful claim of the insured can not be curtailed or limited to a lesser amount by getting settlement vouchers executed by them. So, the partial repudiation of the claim is unsustainable. In

the result, an award is passed directing the insurer to pay an amount of Rs.25000/- to the complainant within the prescribed period failing which, the amount shall carry interest @ 9% per annum from the date of filing of the complaint till payment is effected. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-003-680/2011-12

B M Sidhique

Vs

National Insurance Co. Ltd

AWARD No. IO/KCH/GI/127/2012-13 dated 22.01.2013

The complainant had been taking Mediclaim policy from the Respondent-Insurer since 2003. The sum assured was enhanced to 3 lacs on 17.02.2011. He suffered CAD and undergone Angioplasty at AIMS on 7.6.2011. The claim for the same was settled partially only. Therefore, the complaint.

The insurer submitted that the complainant had suffered pre-existing Hypertension and the same is excluded under the policy in relation to the enhanced portion of the sum assured. So, the basic sum assured available is Rs. 250000/- and all the benefits were paid as per the policy conditions. Nothing more is payable.

Decision:- From the medical records , it can be seen that hypertension was first detected on 22.09.2010. So, it is a pre-existing disease for the enhanced Sum Insured of Rs. 50000/- as per 4.1 of the policy conditions. As per the relevant policy schedule, the cumulative bonus accrued is Rs. 56250/-. So, the total sum insured available is Rs. 306250/- . The reimbursement must be based on that amount whereas in this case it was done on the basis of Rs. 281250/-. The complainant is entitled to further amount of Rs. 12625/- under Head (C). In the result, an award is passed directing the insurer to pay an amount of Rs.12625/- with 9% interest from date of filing of the complaint till the date of award to the complainant within the prescribed period failing which, the amount shall carry further interest @ 9% per annum from the date of award till payment is effected. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-017-743/2011-12

Shamin Rodrigues

Vs

Star Health &Allied Inurance Co. Ltd

AWARD No. IO/KCH/GI/130/2012-13 dated 30.01.2013

The complainant was taking mediclaim policy from 2003 onwards from United India Insurance Co. She had taken a policy from the Respondent-Insurer in 2011 believing that she would get continuity of the earlier policy. Her husband was admitted in Cochin Hospital for severe shoulder pain and the claim for the same was rejected by the insurer stating that he was suffering from pre-existing Diabetes.Therefore, the complaint.

The complainant submitted that the treatment was for Adhesive Capsulitis and there was no treatment for DM. There was no willful suppression of material facts in the proposal form. She is entitled to the re-imbursement.

The insurer submitted that as per expert opinion obtained, the husband of the complainant was suffering from Adhesive Capsulitis even prior to the inception of the policy. There is no evidence to the effect that there was previous insurance without any break. The husband of the complainant was suffering from DM atleast 2 years prior to the inception of the policy. There was suppression of material facts relating to health condition in the proposal form. The repudiation is legal.

Decision:- On considering the discharge summary and treating doctor's certificate, there is complete lack of evidence that the husband of the complainant had taken treatment for Adhesive Capsulitis prior to 29.01.2011. In these circumstances, the repudiation of the claim on the ground that the ailment was a pre-existing one cannot be sustained.

In the discharge summary and treating doctor's certificate which form part of the claim form, there is mention that the husband of the complainant is a diabetic for 2 years. This is not disclosed in the proposal form . This is against the contents of the declaration which forms part of the proposal form and signed by the complainant. The complainant and her husband was very much aware of the fact that he was a diabetic on medication. So, there is clear suppression of material facts regarding the actual health status of the husband of the complainant in the proposal form. In the circumstances, the repudiation of the claim on the ground of suppression of material fact is quite justified. In the result, the complaint is dismissed. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-003-769/2011-12

K K Rajakumaran

Vs

National Insurance Co. Ltd

AWARD No. IO/KCH/GI/135/2012-13 dated 07.02.2013

The complainant and his family were covered under Individual Health Insurance Policy taken from the Respondent-Insurer. His son had an accidental fall and was admitted in a hospital. His wife was also admitted in hospital for headache. The claim for the same was rejected by the insurer. Therefore, the complaint.

The complainant submitted that both the hospitalizations were as per the advice of the treating doctor. This was not for tests and investigations alone. He is entitled to get full re-imbursement in both the claims

The insurer submitted that hospitalization was only for investigations and evaluation and there was no active line of treatment during the one day hospitalization. Exclusion clause 4.10 of the policy conditions is attracted.

Decision:- The discharge card and medical report of the son did not reveal any fracture. Only sling was provided as he was having pain. X-ray was not followed by any active treatment during hospitalization. In the absence of any active treatment, exclusion Clause 4.10 is attracted and therefore, repudiation of the 1st claim is sustainable.

The discharge card and medical report shows that the wife of the complainant was admitted with severe head ache and CT scan was taken. Urinary infection was found out and medications were given during hospitalization. When the attending doctor was satisfied that CT scan was necessary, as the patient was having severe head ache, the wisdom of the doctor can not be doubted. For proper diagnosis of the cause of ailment, investigations are necessary.. She was also having urinary infection. The attending doctor is the most competent person to decide whether the patient is to be admitted or not. The discharge card would reveal that there was active line of treatment during hospitalization. So, Clause 4.10 is not attracted. So, the repudiation of the 2nd claim is not sustainable. In the result, an award is passed directing the insurer to pay Rs 3281/- to the complainant within the prescribed period failing which, the amount shall carry interest @ 9% per annum from the date of filing of the complaint till payment is effected. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-005-741/2011-12

Vasantha Sajeendrababu

Vs

Oriental Insurance Co. Ltd

AWARD No. IO/KCH/GI/137/2012-13 dated 15.02.2013

The complainant had taken Mediclaim policy from the Respondent-Insurer since 2009. She underwent ear surgery in connection with ear infection and loss of hearing. The claim for the same was repudiated by the insurer stating that the disease was a pre-existing one. Therefore, the complaint.

The complainant submitted that she had not suffered the ailment or any symptoms of the ailment prior to 11.01.2011. So, it is improper to repudiate the claim on the ground of pre-existing disease. She is entitled to the full claim amount.

The insurer submitted that the complainant was suffering from the ailment since 2 years as per the contents of the discharge summary issued from Thangam Hospital. So, as per Clause 4.1 of the policy conditions, the claim was repudiated.

Decision:- The discharge summary shows the diagnosis as bilateral CSOM- Safetype. Here it is mentioned that the complainant was complaining of bilateral ear discharge and decreased hearing since 2 years. In the OP ticket from the ENT Hospital and the one by Dr. Vinayakumar, there is no mention regarding the age of the illness. There is no medical evidence to support the statement in the discharge summary regarding the age of the ailment. It is well settled law that unsupported statements in a medical document cannot be taken as the basis for repudiation of the claim. So, the repudiation is not valid. Even in a case where it is admitted that the complainant was suffering from the ailment since two years from 26.9.2011, she ought to have contracted the same by 26.09.2009, which is after the date of the first policy. So, Clause 4.1 of the policy conditions is not attracted. In the result, an award is passed directing the insurer to pay an amount of Rs.58667/- with 9% interest from date of filing of the complaint till the date of award to the complainant within the prescribed period failing which, the amount shall carry further interest @ 9% per annum from the date of award till payment is effected. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-004-812/2011-12

K P Kishorebabu

Vs

United India Insurance Co. Ltd

AWARD No. IO/KCH/GI/139/2012-13 dated 27.02.2013

The complainant had taken a health Insurance policy covering his family from the Respondent-Insurer. His wife was admitted in a hospital for surgery and the claim for the same was settled partially by the insurer. Therefore, the complaint.

The complainant submitted that fibroid growth in the uterus of his wife was surgically removed. The restriction mentioned in Clause 1.2(a) of the policy conditions is not applicable in the case and he is entitled to receive re-imbursement of the entire medical expenses.

The insurer submitted that as per Clause 1.2(a), the claim is restricted to 25% of the sum insured. As the sum assured is Rs. 50000/- , the claim was settled for Rs. 12500/- and nothing more is payable.

Decision:- The Discharge card and summary shows the diagnosis as Huge Fibroid Uterus. The wife of the complainant underwent Myomectomy.The medical record would reveal that the wife of the complainant underwent Myomectomy and not Hysterectomy. Both are entirely different procedures. Here fibroid tumor of the uterus was removed and not the uterus. Hysterectomy is the removal of the uterus.As per Clause 1.2(a) , liability of the insurer is restricted to 25% of the sum assured in case of Hysterectomy. Myomectomy is not included in this Clause. Therefore, the restriction contained therein is not applicable. So, the partial repudiation of the claim is not sustainable. In the result, an award is passed directing the insurer to pay a further amount of Rs.19759/- to the complainant within the prescribed period failing which, the amount shall carry interest @ 9% per annum from the date of complaint till payment is effected. No cost

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-002-824/2011-12

V M Rajan

Vs

New India Assurance Co. Ltd

AWARD No. IO/KCH/GI/147/2012-13 dated 08.03.2013

The complainant and his wife are covered under a medi-claim policy issued by the Respondent-Insurer. His wife was admitted in hospital on 2 occassions . Both the claims were rejected by the insurer. Therefore, the complaint.

The complainant submitted that his wife was hospitalized due to urinary tract infection on 2 occassions. Both were as per the advice of the treating doctor. Both the claims are to be allowed.

The insurer submitted that the patient is a known case of Diabetes and the hospitalization was only for investigations.There was also bulk purchase of medicines. The repudiation was under Clause 4.4.11 of the policy conditions.

Decision:- As per the discharge summary from the 1st hospital, the diagnosis is urinary tract infection, type 2 Diabetes Mellitus and CAD. Urinary tract infection was treated with antibiotics. Merely because she was a known case of Diabetes and CAD, the insurer can not contend that she need not be admitted in the hospital for treatment of urinary tract infection. In the discharge summary from the 2nd hospital, the diagnosis is Type 2 Diabetes, PVD and CAD. The detailed scrutiny of the medical records of both claims would reveal that investigations done during hospitalization were consistent with the diagnosis made. The doctor who is attending the patient is the most competent person to decide whether she is to be admitted in the hospital or not. This is a clear case where Clause 4.4.11 is not attracted. It is seen that in both claims some bulk purchase of medicines were done without proper authorization from the doctor. These will have to be disallowed from the claim amount. In the result, an award is passed directing the insurer to pay an amount of Rs 14984/- to the complainant within the prescribed period failing which, the amount shall carry interest @ 9% per annum from the date of filing of the complaint till payment is effected. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-004-719/2011-12

Raju Paul

Vs

United India Insurance Co. Ltd

AWARD No. IO/KCH/GI/154/2012-13 dated 19.03.2013

The complainant had taken a Health policy from the Respondent-Insurer. He suffered severe eye disease on both eyes and admitted in Giridhar Eye Institute for administration of Lucentis injection. The claim was rejected by the insurer on the ground that the treatment could have been done on OPD basis. Therefore, the complaint.

The complainant submitted that the hospitalization was as per the advice of the treating doctor and clause 2.3 is not at all attracted in his case. He is entitled to re-imbursement.

The insurer submitted that hospitalization was not required and the treatment could have been done on OPD basis. Clause 2.3 of the policy conditions is attracted. The repudiation is legal and proper.

Decision:-The final diagnosis is Parafoveal Telangiectasia Choroidal Neovascular Membrane in the right eye and Parafoveal Telangiectasia in the left eye. The procedure done is Intravitreal Lucentis right eye under local anesthesia. As per the medical literature available, the association of Ophthalmologists has advised hospitalization for administration of Lucentis injection and it is further stated that the same is to be considered as a surgical procedure. Constant observation of the patient is necessary while administering the same as there is chance of various side effects. Also the doctor who attended the patient is the most competent person to decide whether hospitalization is required or not. In the circumstances note to Clause 2.3 of the policy conditions is not at all attracted in this case. So, the repudiation of the claim is not sustainable. In the result, an award is passed directing the insurer to pay an amount of Rs 50000/- to the complainant within the prescribed period failing which, the amount shall carry interest @ 9% per annum from the date of filing of the complaint till payment is effected. No cost

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-004-764/2011-12

R Rajamma

Vs

United India Insurance Co. Ltd

AWARD No. IO/KCH/GI/155/2012-13 dated 20.03.2013

The complainant had taken an Individual Mediclaim policy from the Respondent-Insurer. She suffered infection in the upper respiratory tract and was hospitalized. The claim for the same was first rejected and later partially settled. Therefore, the complaint.

The complainant submitted that she was admitted in the hospital as per the advice of the treating doctor. The deductions are against the policy conditions. She is entitled to the balance amount.

The insurer submitted that though the claim was initially rejected, it was settled subsequently. The deductions done are on valid grounds and as per policy conditions.

Decision:- On a perusal of the deductions done by the TPA it is seen that out of the total deduction of Rs. 3619/- , expense to the tune of Rs. 3184/- is reimburseable to the complainant. Also , the complainant is entitled to interest on account of the delay occasioned in settling the claim. In the result, an award is passed directing the insurer to pay a further sum of Rs. 3184/- with 9% interest from 13.07.2011 till date of award with cost of Rs. 600/- within the prescribed period failing which Rs. 3184/- shall carry further interest at 9% per annum from the date of award till payment is effected.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-005-815/2011-12

T I Mohamedali

Vs

Oriental Insurance Co. Ltd

AWARD No. IO/KCH/GI/157/2012-13 dated 21.03.2013

The complainant had taken a Mediclaim policy from the Respondent-Insurer. Since when he suffered chest pain in 2001 , he was under the continuous treatment of Dr, George Eraly and on 27.10.2011 as per the advice of the doctor, he was admitted in the hospital . The claim was rejected by the insurer. Therefore, the complaint.

The complainant submitted that as per the advice of the doctor only he was admitted and active treatment was received during hospitalization. The repudiation of the claim under Clause 4.10 of the policy conditions is illegal.

The insurer submitted that the hospitalization was mainly for evaluation/diagnostic purpose which is excluded under Clause 4.10 of the policy conditions. The repudiation is legal and proper.

Decision:- Discharge Summary shows the diagnosis as Ischemic Heart Disease and Rest Angina. It is also stated therein that during hospitalization , active treatment was provided by medication and he had been advised to continue active medical treatment for two months. When the treating doctor asserts that there was active line of medical treatment during the hospitalization period, there is no contra evidence to doubt the veracity of the assertion made in the medical documents. So, the repudiation of the claim invoking exclusion Clause 4.10 is not sustainable. In the result, an award is passed directing the insurer to pay an amount of Rs 9483/- to the complainant within the

prescribed period failing which, the amount shall carry interest @ 9% per annum from the date of filing of the complaint till payment is effected. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-005-807/2011-12

B Krishnakumar

Vs

Oriental Insurance Co. Ltd

AWARD No. IO/KCH/GI/159/2012-13 dated 27.03.2013

The complainant had taken Individual Mediclaim policy from the Respondent-Insurer. He underwent surgery for removal of gall bladder. The claim was not settled by the insurer. Therefore, the complaint.

The complainant submitted that he never received any letter from the insurer rejecting the claim. He is entitled to receive the entire hospital expenses.

The insurer submitted that the additional documents (investigation reports) demanded from the complainant was not produced. Hence the claim was closed due to non-availability of documents.

Decision:- The diagnosis as per Discharge Summary is acute emphysematous cholecystitis. Open retrograde cholecystectomy was done. So, as per the medical evidence available, the complainant underwent cholecystectomy during hospitalization and for his treatment, he had incurred an expense of Rs. 29698/-. When the insurer is admitting hospitalization and the surgical procedure underwent by him and also the expenses incurred, investigation reports do not assume much importance. So, the rejection of the claim on the ground of non-production of investigation reports is not sustainable. In the result, an award is passed directing the insurer to pay an amount of Rs. 29663/- with 9% interest from 10.01.2012 till the date of award, within the prescribed period failing which the amount shall carry further interest at 9% per annum from the date of award till the payment is effected. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-003-784/2011-12

Jancy Varghese

Vs

National Insurance Co. Ltd

AWARD No. IO/KCH/GI/160/2012-13 dated 28.03.2013

The complainant had been taking mediclaim policy from the Respondent-Insurer through Bank of India. The daughter of the complainant was involved in an accident and underwent surgery on 7.4.2010. The claim for the same was not settled by the insurer. Therefore, the complaint.

The insurer submitted that the relevant policy was taken after a break of 72 days. So, the injury for which treatment was taken was a pre-existing one. The liability of the insurer is excluded under Clause 4.1 of the policy conditions. The rejection of the claim is proper.

Decision:- As per treatment certificate , the daughter of the complainant was admitted as a case of Contracture (L) 1st web space with hypertrophy scar with few hypopigmented patches in the left arm and forearm. Here the age of the injury is not noted. In the certificate issued by the plastic surgeon , the age of the injury is mentioned as 1 year old. Clause 4.1 excludes the liability in respect of injuries which are pre-existing when the cover incepts for the 1st time. As far as the complainant is concerned the cover incepted for the 1st time on 15.01.2008. The term "fresh cover" and " cover for the first time" are distinct and independent entities. So, it can be concluded though the relevant cover is a fresh cover, the injury suffered was not a pre-existing one as contemplated under Clause 4.1 of the policy conditions. So, the repudiation of the claim can not be sustained. In the result, an award is passed directing the insurer to pay an amount of Rs. 24099/- within the prescribed period failing which the amount shall carry interest at 9% per annum from the date of filing of the complaint till the payment is effected. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-003-796/2011-12

M Thankom

Vs

National Insurance Co. Ltd

AWARD No. IO/KCH/GI/161/2012-13 dated 28.03.2013

The complainant had taken Individual Mediclaim policy from the Respondent- Insurer. She underwent cataract surgery in Vasan Eye care Hospital and the insurer released only Rs. 18000/- towards cashless facility. Her claim for re-imbursement of the balance amount was denied by the insurer. Therefore, the complaint.

The insurer submitted that the Tariff rate agreed between the TPA and the Hospital is Rs. 18000/- for Cataract surgery with foldable IOL and the same was released by the TPA. Had it been a case where aberration free lens was used, the liability would have been Rs. 21000/-. Also the pre-hospitalisation expenses of Rs. 2075/- are payable.

Decision:- In none of the medical documents, it is stated that aberration free foldable lens was used in relation to the surgery. As non- aberration free foldable lens was used, the tariff rate is only Rs. 18000/- That amount has already been released by the TPA. The insurer has found that Rs. 2075/- spent by the complainant towards pre-hospitalisation expenses is payable. In the result, an award is passed directing the insurer to pay an amount of Rs. 2075/- within the prescribed period failing which the amount shall carry interest at 9% per annum from the date of filing of the complaint till the payment is effected. No cost.

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Kolkata Ombudsman Centre
Case No. 662/11/009/NL/02/2011-12

Shri Sunil Kumar Tainwala

-Vs-

Reliance General Insurance Company Ltd.,

Order Dated : 18-10- 2012

Facts & Submissions :

This complaint was filed against repudiation of claim under Reliance Healthwise Policy issued by Reliance General Insurance Company Ltd.

The complainant, Shri Sunil Kuamr Tainwala had stated that his son Master Yamir Tainwala was suffering from fever with severe headache for last 3 days and was admitted at Belle Vue Clinic, Kolkata on 24.01.2011 where he was treated conservatively with antibiotic, proton pump inhibitor and other supportive medicines and he was discharged on 29.01.2011. He lodged a claim on 08.02.2011 for Rs.82,136/- to the TPA of the insurance company. TPA vide their letter dated 04.07.2011 repudiated the claim stating that *"it is found that the insured has complaint of sinusitis and headache. The beneficiary is covered from 04.03.2010. There is a waiting period of 1 year for sinusitis. Current year policy does not show the previous year policy number. Continuity of earlier policy not given as per mail from underwriting office, hence claim merits repudiation as per exclusion clause 3. More over patient had a history of episodic hemicranic throbbing and headache 2 years back which have been recurred for last 1 month. Hence this present complaint is preexisting to the policy inception and falls under policy exclusion clause 1."* He represented to the insurance company on 05.08.2011 against repudiation stating that viral fever is not pre-existing. His appeal was not considered by them.

The insurance company had stated that the insured was covered under the policy from 04.03.2010 and was suffering from sinusitis and headache. There was a waiting period of 1 year for sinusitis. Hence the present disease was pre-exiting to the policy inception and fell under policy exclusion clause no. 1 i.e., all pre-existing diseases were not covered until 24/48 months of continuous covers have elapsed, since inception of the first policy with them.

DECISION:

The complainant had approached this forum against repudiation of his claim as per exclusion clause no. 1 & 3 of the policy. From the facts presented to this forum, we find that the first policy had incepted on 01.03.2008 but there was a break in the policy in 2009-10 which was not regularized by the insurer. The complainant claimed that the premium for 2009-10 was deposited by cheque but due to negligence on the part of the insurer the cheque was not encashed. However, this is not the issue before this forum and the complainant has also not made any representation to the insurer in this regard. The current policy was renewed for 2010-11 as a fresh policy under which a waiting period of one year for sinusitis is prescribed under clause no.3. As per discharge summary the final diagnosis was fever with meningism and sinusitis. While sinusitis is not admissible in the first year of the policy, the expenses for fever and meningism are admissible as there was no specific exclusion for the same.

Hon'ble Ombudsman was of the opinion that it will be fair to allow 50% of the admissible claim amount towards the treatment of fever and meningism. Hence the Insurance Company was directed to pay the above amount.

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Kolkata Ombudsman Centre

Case No. 697/14/002/NL/02/2011-12

Shri Subho Mukherjee

-Vs-

The New India Assurance Company Ltd.,

Order Dated : 18-10- 2012

Facts & Submissions :

This complaint was filed against delay in settlement of claim under Mediclaim Policy issued by the New India Assurance Company Ltd.

The complainant, Shri Subho Mukherjee had stated that he was suffering from convulsion and seizure disorder and was admitted at Aditya Hospital, Kolkata on 23.05.2011, where he was treated conservatively and was discharged on 26.05.2011. He lodged a claim on 30.06.2011 for Rs.12,123.17 to the insurance company and the same was sent to their TPA on 07.07.2011. TPA vide their letter dated 19.10.2011 asked to submit certain documents and the same was complied on 25.10.2011. However, after a lapse of considerable period his claim was not settled. He represented to the insurance company on 20.02.2012 but he did not get any reply.

The insurance company in their written submission dated 19.04.2012 had stated that the insured was requested to comply with queries of the TPA. He has not yet submitted the money receipt for Rs.10,000/- due to which the settlement is pending.

DECISION:

The complainant has approached this forum for delay in settlement of his claim by the insurance company. From the facts presented to this forum, it had been observed that the claim was pending for non-submission of certain documents including original money receipt of Rs.10,000/-. The complainant had produced evidence to show that he had already submitted the documents to the TPA. The same had confirmed by the insurance company that the amount was reflected in the discharge bill of the hospital. This was a sufficient compliance on the part of the insured. Hence the insurance company was directed to settle the claim and pay the same on the basis of the discharge bill of the hospital.

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Kolkata Ombudsman Centre

Case No. 701/11//009/NL/02/2011-12

Shri Rajesh Kumar Shaw

-Vs-

Reliance General Insurance Company Ltd.

Order Dated : 18-10- 2012

Facts & Submissions :

This complaint was filed against repudiation of claim under Reliance Healthwise Policy issued by Reliance General Insurance Company Ltd. as per exclusion clause no. 20 of the policy.

The complainant, Shri Rajesh Kumar Shaw had stated that his wife Smt. Renu Shaw was suffering from sebaceous cyst and as per advice of Dr. Ashoke Kumar Chatterjee on 13.05.2011 she was admitted at United Nursing Home (P) Ltd., Kolkata on 06.06.2012 where she underwent excision of the cyst and was discharged on 07.06.2011. He lodged a claim on 30.06.2011 for Rs.11,024/- to the TPA of the insurance company. TPA vide their letter dated 30.09.2011 repudiated the claim stating that "patient has not received any active line of treatment and stay was for dressing purpose, which could be done in O.P.D." He represented to the insurance company on 18.10.2011, but the same was turned down.

The insurance company in their written submission dated 25.04.2012 have stated that the patient was suffering from infected sebaceous cyst managed surgically under local anesthesia. During hospitalization patient did not receive any active line of treatment. Dressing could be done in OPD. Hence as per exclusion clause no. 20 the claim is not payable.

Since the insurance company had decided to admit the claim and settle the same, no further intervention was necessary. The insurance company was directed to settle the claim and pay the same as per terms and conditions of the policy.

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Kolkata Ombudsman Centre

Case No. 708/11/004/NL/02/2011-12

Mr. Gulam Rasool

-Vs-

United India Insurance Company Ltd.

Order Dated : 12-10- 2012

<u>Facts & Submissions :</u>

This complaint is filed against repudiation of claim under Group Health Insurance Policy issued to Aviva Life Insurance Company Limited for their employees, as per exclusion clause no. 4.8 of the policy.

The complainant, Mr. Gulam Rasool had stated that his father Mohammed Yusuf was suffering from severe vertigo and was admitted at The Calcutta Medical Research Institute, Kolkata on 03.07.2011 where he had undergone certain investigations and treated conservatively. He was discharged on 11.07.2011. He lodged a claim for Rs.40,237/- to the TPA of the insurance company. TPA vide their letter dated 04.10.2011 repudiated the claim stating that *the patient was admitted for undergoing routine investigations and was treated only with oral medications. As the policy clearly states that the course in the hospital should warrant hospitalization, the claim is not admissible under clause 4.8 of the policy'.* He represented to the insurance company against repudiation on 07.11.2011 stating that his father was at CMRI for 8 days under the close observation and treatment of 5 specialist doctors but the same was turned down. Being aggrieved by the decision of the insurance company the complainant approached this forum for redressal of his grievance seeking monetary relief of Rs.40,237/- along with interest.

The insurance company had stated that the insured was a member of the Group Mediclaim Policy issued to Aviva Life Insurance Company Ltd., for the period from 13.04.2011 to 12.04.2012. He filed a claim in respect of his father Mr. Mohammed Yusuf who was admitted in Calcutta Medical Research Institute, Kolkata on 03.07.2011 for severe vertigo and was discharged on 11.07.2011. The insured / claimant has submitted an estimate of Rs.37,192/ from the above hospital for cashless approval with their TPA. He lodged a claim amounting to Rs.32,057/- towards several tests and investigations undergone in the hospital. As per policy exclusion clause no. 4.8, charges incurred at hospital or nursing home primarily for diagnostic purpose and investigations not consistent with or incidental to the diagnosis and treatment of the positive existence or presence of any ailment, sickness or injury, for which confinement is required at a hospital/ nursing home. Further condition no. 2.3.

DECISION:

From the facts presented to this forum we find that Mohammed Yusuf father of the complainant is covered under Insurer's Group Mediclaim Policy for the period from 13-4-2011 to 12-4-2012. He is a known patient of vertigo, type-2 DM, HTN etc. for a long time. On 02-07-2011, he visited OPD in CMRI with complaints of vertigo, general weakness, dyspepsia, flatulence, sleep disorder etc. His condition otherwise was not critical and the doctor did not advice hospitalization. He was prescribed medicines for diabetes vertigo

vitamins etc. The patient was admitted on the next day i.e., on 03.07.2011, but we do not find specific recommendation for hospitalization either in the discharge summary or in the consultation papers. Only the record of in-patient was stamped with "EMO's advice for admission'. This endorsement was not signed by the EMO. On admission provisional diagnosis of Type-2 DM, HTN with dizziness (vertigo). He was conscious, alert, oriented, afebrile with normal pulse rate. There was no critical problem warranting immediate hospitalization.

During hospitalization, several investigations were done for pathology, cardiology, chest x-ray, Audiometry, CT Scan Brain, MRI Brain, EEG, Baer (Brainstem Auditory Evoked Response) Study, Cervical Spine x-ray etc. He was treated conservatively with anti-hypertensives, OHA and antibiotics. Advice of an ENT specialist and Neurologist were taken and followed. The MRI report reveals mild cerebral atrophy.

The insured had submitted a certificate issued by treating Dr. Biswajit Ghosh Dastiderr on 10-7-2011 which revealed hospitalization was certainly beneficial for him both in terms of diagnosis and management.

The insurance company repudiated the claim as per policy Exclusion No.4.8. They had further referred to condition no.2.3, which excluded procedures/treatment usually done in out patient department even if converted as an in patient in the hospital for more than 24 hours.

Hon'ble Ombudsman was of the opinion that total repudiation of the claim is not justified. Some tests revealed existence of positive illness like "mild cerebral atrophy". But some tests produced normal results and there was no specific advice of doctor for admission. Considering the above facts, we allow 50% of the admissible amount of the claim to the complainant. The insurance company is directed to pay the above 50% of the admissible claim 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 No. 718/11/004/NL/03/2011-12

Shri Santanu Das

-Vs-

United India Insurance Company Ltd.

Order Dated : 12-11- 2012

Facts & Submissions :

The complaint is filed against repudiation of claim under Family Medicare Policy issued by United India Insurance Co. Ltd.

The Complainant Shri Santanu Das had stated that he was admitted in Sagar Hospital, Bangalore on 2nd December, 2010 due to sudden attack of Dengue but could not intimate the insurer in time as he had gone to Bangalore on official assignment where he stayed alone. He gave a delayed intimation on 16th December, 2010 and requested the Insurer to condone the delay explaining the reasons for the same. He submitted the claim form with necessary documents to TPA, M/S Heritage Health on 12.01.2012. The TPA sought further clarification for delayed submission of claim vides their letter dated 24.2.2011 to which, the complainant replied on 25.3.2011.

The Insurance Company had stated that Sri Santanu Das took a Family Medicare Policy for the first time for the period from 15.2.2010 to 14.02.2011 for himself and his wife under their Family Medicare Policy, for a sum insured of Rs.1,50,000/-. The claim documents were submitted to TPA on 12.01.2011 i.e. after lapse of one month and three days from the date of his discharge from the hospital. The Insurance Company also stated that the complainant intimated them about his hospitalization on 16.12.2010 i.e. on the 14th day of his hospitalization. The Insurance Company has referred to policy condition no.5.3 of the policy issued to Mr. Santanu Das as under:-

"Upon happening of any event which may give rise to a claim under this policy notice with full particulars shall be sent to the TPA named in the schedule immediately and in case of emergency hospitalization within 24 hours from the time of hospitalization."

They have also referred to policy condition No.5.4 which required that all claim documents should be submitted within 7 days after completion of such treatment. Waiver of this condition may be considered in extreme cases of hardship where it is proved to the satisfaction of the Company that under the circumstances in which the insured was placed it was not possible for him or any other person to give such notice or file claim within the prescribed time limit.

The insured's representation dated 27.06.2011 was turned down by the competent authority as the explanation was not found satisfactory.

DECISION:

The complainant has approached this forum for repudiation of his claim on the ground of violation of policy conditions no. 5.3 and 5.4. From the facts presented to this forum, we find that the insured had fallen ill while he was in Bangalore on official visit and was hospitalized for treatment of viral fever and Dengue. As he was alone in Bangalore with no family members by his side, he could not send a timely intimation about hospitalization to the TPA. He submitted the claim papers on return from Bangalore after discharge. The insured submitted a waiver petition explaining that the situation was beyond his control but his explanation was not found satisfactory by the competent authority. From the reply of the Insurer, we find that they have not given any sound reason for rejecting his petition, which is in contravention of the spirit of IRDA Circular No. IRDA/HLTH/MISC/CIR/216/09/2011 dated 20.09.2011 The said circular lays down certain guidelines for dealing with delayed claims and states that :-

'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.'

According to Hon'ble Ombudsman the explanation cited by the complainant was genuine and reasonable. No case of malafide intention had been pointed out by the insurer. Hence the insurer was directed to admit the claim and settle the same.

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Kolkata Ombudsman Centre

Case No. 729/14/009/NL/03/2011-12

Shri Subrata Karmakar

-Vs-

Reliance General Insurance Company Ltd.

Date of Order: 26th November, 2012

Order Dated : 26-11- 2012

Facts & Submissions :

The complaint is filed against delay in settlement of claim under Individual Mediclaim Policy issued by Reliance General Insurance Co. Ltd.

The complainant Shri Subrata Karmakar had stated that as per prior appointment with Christian Medical College, Vellore, he intimated the TPA of Insurance Co. Medi-Assist about his proposed treatment of Left Type Tymphanoplasty and in reply, the said TPA primarily issued pre-authorization to the said hospital for cashless facilities. But after hospitalization, the authorization was withdrawn without any valid reasons. He submitted his claim to TPA on 11.01.2011 after returning to Kolkata. He also replied to their letters dated 05.04.2011 explaining the reasons for delay in submission of documents. The TPA repudiated the claim vide their letter dated 02.06.2011 for non-submission of required documents. Being aggrieved, he approached this forum for redressal of his grievance seeking monetary relief of Rs.11,441/- .

The Insurance Company in their written submission dated 23.8.2012 have stated that the claim could not be settled on account of non-submission of certain documents which the insured was repeatedly requested for.

DECISION:

The complainant has approached this forum against delay in settlement of his case on the ground of non-submission of certain documents. From the facts submitted to this forum we find that the complainant has duly complied with all the requirements of the TPA. The original discharge summary containing details of the investigation results and history of the disease has been submitted to the TPA of the insurance company. As informed by the insurer's representatives, the only pending requirement is consultation paper dated 16.12.2010. The complainant has already explained that this paper was submitted to the hospital at the time of admission and the gist of the prescription is mentioned in the discharge summary.

Hon'ble Ombudsman was of the opinion that the complainant had adequately complied with the requirements of the TPA. The insurance company was directed to settle the claim and pay the same as per terms and conditions of the policy.

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Kolkata Ombudsman Centre

Case No. 730/11/003/NL/03/2011-12

Shri Samir Kumar Das

-Vs-

National Insurance Company Ltd.

Order Dated : 12-11- 2012

Facts & Submissions :

This complaint is filed against repudiation of claim under Baroda Health Policy issued by National Insurance Company Ltd.

The complainant, Shri Samir Kumar Das has stated in his complaint dated 09-03-2012 that his wife Mrs. Tapasi Das was admitted in Sanjeevani Multispeciality Hospital for the period from 30-04-2011 to 05-05-2011 for treatment of hypertension with Ischemic Heart Disease.

On 02-06-2011, the complainant submitted the claim form along with all relevant documents to the Insurance Company for reimbursement of Rs.16,958/-. The Insurance Company repudiated the claim vide their letter dated 18th November, 2011 as per policy exclusion no.4.3. Later the Insurance Company informed vide their letter dated 02.12.2011 that the claim is repudiated as per exclusion clause no 4.1 instead of 4.3. The complainant represented to the insurance company on 09.12.2011 stating that a certificate was issued by Bank of Baroda certifying payment of premium paid through insured's Savings Account for the period from 14.09.2009 to 13.09.2010 for Rs.914/-, but his appeal was not considered by them.

The insurance company stated in their Self-contained Note dated 28.03.2012 that Smt. Tapasi Das was admitted at Sanjeevani Multispeciality Hospital for the period from 30-04-2011 to 05-05-2011 for treatment of hypertension with ischemic heart disease. They repudiated the claim as per policy exclusion clause no. 4.1 that excludes all pre-existing diseases in the first year of the policy. The policy for 2011-12 was treated as a fresh policy due to delay in the payment of premium. The insured accepted the policy and did not pray for continuity of benefits under the old policies. As such, the Insurance Company repudiated the claim since the disease was pre-existing.

DECISION:

From the facts presented to this forum, it had been found that the insured is an old customer of the bank and her policy was running for several years without any break. While renewing the policy for the year 2009-10 there was a delay of 10 days in receiving the payment by the insurance company from Bank of Baroda who are their authorized agent to collect the premium. The premium was duly debited from the bank account of the complainant on 14.09.2009 and the payment was also confirmed by the Bank of Baroda through an official receipt dated 14.09.2009 given on a printed stationery of the insurance company. In this receipt the bank has acknowledged receipt of premium of Rs.914/- towards mediclaim insurance policy for the period from 14.09.2009 to 13.09.2010. Under the circumstances, the customer was satisfied that his premium was paid in time. The insurance company however claimed that they received the instrument with proposal/ renewal advice on 23.09.2009 and renewed the policy on 24.09.2009. They have held the bank responsible for late dispatch of the papers, but surprisingly, they have not made any enquiries/correspondence with the bank in this regard. The insured is a

layman and we cannot expect him to go beyond the official confirmation given by the bank, who was the authorized agent to collect the premium. It was the duty of the bank to send the papers in time and keep a proper record of dispatch. The insurance company was also expected to verify the reason for delay/lapse before renewing the policy with break, the consequences of which were well known to them. As per terms of the agreement, the policy shall commence either from the date of debit of premium from the insured's bank account if the instrument with the proposal/ renewal advice is dispatched on the same date or the actual date of dispatch. In this case there is no evidence produced by the company to show that the actual date of dispatch by the bank was 23.09.2009 instead of 14.09.2009 i.e the date of debit of the premium amount. The complainant on the other hand has produced a valid certificate from the bank authorities who are authorized agents to collect the premium on behalf of the insurance company showing that renewal premium for the period from 14.09.2009 to 13.09.2010 have been duly received. Under the circumstances, there is no valid ground for the insurance company to renew the policy after a gap of 10 days. There decision in this regard was erroneous and they were directed by Hon'ble Ombudsman to condone this break treating the policy as a continuous policy since 14.09.2009 on which date the premium was collected by the corporate agent and settle the claim.

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Kolkata Ombudsman Centre

Case No. 738/11/005/NL/03/2011-12

Shri Hemant Jajodia

-Vs-

The Oriental Insurance Company Ltd.

Order Dated : 16-11- 2012

<u>Facts & Submissions</u> :

This complaint is filed against partial repudiation of claim under Happy Family Floater Policy issued by The Oriental Insurance Company Ltd.

The complainant, Shri Hemant Jajodia had stated that his father was suffering from Left Renal Carcinoma and was admitted at Breach Candy Hospital Trust, Mumbai on 27.06.2011 where he underwent Radical Nephrectomy operation on 28.06.2011 and was discharged on 06.07.2011. As per discharge summary the diagnosis of the disease was 'Renal Mass'.

He lodged a claim on 11.07.2011 for Rs.5,11,356/- but the TPA paid Rs.4,96,839/- towards full and final settlement of the claim. He represented to the insurance company on 13.10.2011 against partial settlement but the same was turned down. Being aggrieved, he approached this forum for redressal of his grievance seeking monetary relief of Rs.12,954/- as per 'P-II' form details.

The insurance company have stated in their written submission dated 26.05.2012 their TPA have settled Rs.4,96,839/- vide cheque no. 480064 dated 11.08.2011 and an amount of Rs.14,407/- was deducted as per terms and conditions of the policy vide (clause no. 1.2.a, 4.16,,4.17,4.25).

DECISION:

The complainant has approached this forum against partial repudiation of his claim on account of inadmissible items under condition nos. 1.2 a, 4.16, 4.17, 4.25 of the policy. From the details of the deductions submitted by the insurer, we find that TPA has deducted Rs.1,700/- for bed charges, which is not correct. From the discharge certificate it is found that patient was admitted in SCU for two days for which Rs.6,000/- (1% of S.I) was allowed. But SCU stands for Surgical Intensive Care Unit. Accordingly the room rent eligibility was Rs.12,000/- i.e., 2% of Rs.6.00 lakh per day towards admission in SCU. The insurance company has allowed only Rs.6,000/- per day. The actual bill was @ Rs.6,850/- per day for these two days. Hence under this head a further amount of Rs.1,700/- (Rs. 850 x 2) is payable.

Regarding other deductions Hon'ble Ombudsman found that these are as per policy terms and conditions. Hence, she directed to pay the above Rs.1,700/- (Rupees one thousand seven hundred only) to the complainant.

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Kolkata Ombudsman Centre

Case No. 743/11/005/NL/03/2011-12

Shri Kamal Kumar Chatterjee

-Vs-

The Oriental Insurance Company Ltd.

Order Dated : 16-11- 2012

Facts & Submissions :

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

The complainant, Shri Kamal Kumar Chatterjee stated that he was suffering from chest discomfort and headache with vertigo and was admitted at Apollo Gleneagles Hospitals, Kolkata on 22.10.2011 where he was evaluated clinically and treated conservatively. He was discharged on 24.10.2011 and as per discharge summary the diagnosis of the disease was '*accelarated systemic hypertension ischemic heart disease'.*

At the time of hospitalization the cashless facility was denied by the TPA of the Insurance Company M/s E-Meditek (TPA) Services Limited. Subsequently he lodged a claim to the TPA but the insurance company vide their letter dated 17.01.2012 repudiated the claim stating that *'the disease from which he is suffering may be treated in OPD instead of in patient management. Moreover no active line of management is observed during hospitalization except oral medication. The insured was admitted only for evaluation and diagnostic purpose hence the claim is treated as 'No claim' as per exclusion clause no. 4.10 of the policy.*

The insurance company in their written submission dated 30.05.2012 have stated that insured was suffering from accelerated systemic hypertension and was hospitalized on 22.10.2011. The patient was admitted in the hospital for rise in blood pressure. He was evaluated clinically and treated with some oral medication that could have been managed in OPD instead of in-patient management. Moreover, no active line of treatment is seen. Since the patient was admitted only for evaluation and diagnostic purpose, the claim is denied as per policy terms and condition clause no. 4.10.

DECISION:

The complainant has approached this forum against repudiation of his claim on the ground that hospitalization was only for evaluation and diagnostic purpose and no active line of treatment was done in the hospital. From the discharge summary of hospital we find that the insured was admitted in the emergency of the Apollo Hospital with complaints of chest discomfort and headache since morning on 22.10.2011. After

examination, his blood pressure was found to be 200/100 and he was advised admission in CCU. From the discharge summary, we find that the final diagnosis of the patient was accelarated systemic hypertension with ischemic heart disease. The course in the hospital included clinical evaluation and investigation followed by conservative management with infusion GTN. The insurer has pointed out that his condition could have been controlled in OPD instead of in patient management.

Hon'ble Ombudsman was of the opinion that total repudiation of claim was not justified considering the patient was 73 years old and suffering from very high blood pressure (200/100). Moreover, the doctor had specifically advised for admission in CCU. She then directed the insurance company to pay the amount.

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Kolkata Ombudsman Centre

Case No. 756/11/005/NL/03/2011-12

Sri Siba Prasad Mishra,

-Vs-

The Oriental Insurance Company Ltd.

Date of Order: 26th November, 2012

Order Dated : 26-11- 2012

Facts & Submissions :

The complaint is filed against total repudiation of claim under Family Medicare Policy issued by Oriental Insurance Co. Ltd. due to delay in submission of claim documents.

The complainant Shri Siba Prasad Mishra had stated that his mother was admitted in Charring Cross Nursing Home on 19.4.2011 and was discharged on 26.4.2011. He could not send intimation to the TPA within the prescribed time as he was busy with the treatment of his mother and there was no one to look after her. The Insurance Company

vide their letter dated 29.08.2011 repudiated his claim under clause no.5.5 of the policy on grounds of delay in intimation. He represented to the insurance company on 17.09.2011 with a waiver petition but the same was turned down. Being aggrieved he approached this forum for redressal of his grievance seeking monetary relief of Rs.30,367.60.

The insurance company had not submitted any written statement. They have repudiated the claim vide their letter dated 13.10.2011 referring to policy clause no. 5.5. However, on receiving the waiver petition they have forwarded the same to TPA with an instruction to square off the claim.

DECISION:

The complainant had approached this forum against repudiation of his claim due to delay in intimation and submission of claim documents as per policy condition no. 5.5. The complainant has submitted a waiver petition explaining the reasons of delay, which appears to be reasonable. The insurance company has also written to their TPA to review the claim and settle the same. Hence she directed the insurance company 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. 758/11/009/NL/03/2011-12

Shri Sarvottam Das Mundhra,

-Vs-

Reliance General Insurance Company Ltd.

Date of Order: 26th November, 2012

Order Dated : 26-11- 2012

Facts & Submissions :

The complaint was filed against partial repudiation of claim under Individual Mediclaim Policy issued by Reliance General Insurance Co. Ltd.

The Complainant Shri Sarvottam Das Mundhra had stated that he was admitted in B.M. Birla Hearth and Research Centre on 12.4.2011 and was discharged on 23.4.2011 after surgery of Aortic Valve. The Insurer did not consider Rs.40,500/- towards *"Closed OT Package charges"* at the time of sanctioning cashless disbursement. After discharge, he submitted his claim of Rs.1,02,403/- including Rs.40,500/- for closed O.T. Package charges. The Insurance Company has settled an amount of Rs.60,854/- deducting Rs.41,549/- which included Closed OT Package charges of Rs.40,500/-. The complainant represented to the Insurance Company vide his letter dated 01.10.2011 against the deductions made by them. Since he did not receive any response from them, he approached this forum for redressal of his grievance seeking monetary relief of Rs.40,861/-.

The Insurance Company had stated that the insured had undergone a treatment by availing cashless facility. They did not consider the charges for "CLOSED PACKAGE OT' of Rs.40,500/- as the same was not coming under the head - "expenses incurred'. However, they have requested their TPA to pay an amount of Rs.177/- towards pharmacy bill.

DECISION:

From the facts submitted to this forum we find that the complainant had opted for a closed surgery package under which he was eligible for unlimited stay in the hospital at no extra cost whereas under open packages the stay is limited to maximum 3 days in ICCU and 8 days in room. The complainant stayed for 12 days from 12.04.2011 to 23.04.2011 out of which he was under the surgery package for eleven days (6 days in ICCU and 5 days in room). Thus, as per the restriction under open package, he has exceeded his stay in ICCU by 3 days. The insurance company has paid him the full amount of Rs.1.74 lakh under the open package and disallowed Rs.40,500/- claimed under Closed Package. Since the package was selected by the insured on his own without Insurer's approval, the insurer is correct in settling the claim under the lower cost package. However, they have not allowed the charges for additional 3 days' stay in ICCU (under open package), which is payable under the policy. It is seen from the hospital bill that ICCU charges for one day is Rs.4,950/-. Hon'ble Ombudsman directed the insurance company to pay three days ICCU charges @ Rs.4950-/- for 3 days i.e. Rs.14,850/- (Rupees fourteen thousand eight hundred fifty only) to the complainant.

Kolkata Ombudsman Centre

Case No. 759/11/003/NL/03/2011-12

Shri Arun Kumar Singh

-Vs-

National Insurance Company Ltd.

Order Dated : 16-11- 2012

Facts & Submissions :

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

The complainant, Shri Arun Kumar Singh has stated in his complaint dated 09.01.2012 and 22.03.2012 that he was suffering from severe chest pain with vomiting and sweating and as per advice of Dr. R.L. Joshi on 23.05.2011 he was admitted at Alpha Medical Services (P) Ltd., Howrah where he was treated conservatively and was discharged on 26.05.2011. He lodged a claim on 06.07.2011 for Rs.19,456.50 to the TPA of the insurance company. TPA vide their letter dated 16.09.2011 settled Rs.8,364/- deducting Rs.11,092.50 towards full and final settlement of the claim. He represented to the insurance company on 17.11.2011 against partial repudiation but his representation was turned down. Being aggrieved by the decision of the insurance company, he approached this forum for redressal of his grievance seeking monetary relief of Rs.11,092.50.

The insurance company have stated in their written submission dated 11.05.2012 that on doctor's advice the insured was admitted in hospital for gastritis on 23.05.2011 and was discharged on 26.05.2011. TPA M/s Heritage Health TPA Pvt. Ltd. settled the claim at Rs.8,364/- deducting Rs.11,092/- under following heads.

Category	Total claim amount	Eligibility	Total paid	Deduction
Room rent 25% of S.I.	Rs.6,000/-	Rs.13,125/-	Rs.2,100/-	Rs.3,900/- beyond 1% per day room rent
Doctor's fee 25% of S.I.	Rs.4,800/-	Rs.13,125/-	Rs.2,100/-	Rs.2,700/- as per average doctor's fees in this grade of hospital
Other Head 50% of S.I	Rs.8,656/-	Rs.26,250/-	Rs.4,164/-	Rs.4,492/- (Service charge Rs.630/-, Rs.3,070/- not related to gastritis and Rs.793/- for glucometer not allowed..
TOTAL	Rs.19,456/-	Rs.52,500/-	Rs.8,364/-	Rs.11,092/-

DECISION:

The complainant had approached this forum against partial repudiation of his claim on account of certain inadmissible items as per terms and conditions of the policy. From the details of the deductions submitted to this forum we find that the deductions made under the head bed charges is correct as the claim under this head is restricted to 1% of the sum insured for 4 days. Similarly, deductions of Rs.4,492/- made under the head miscellaneous charges is found to be correct. This amount includes registration charges of Rs.630/- (not payable), cost of glucometer of Rs.793/- (not payable) and pathological tests amounting to Rs.3,075/- not related to gastritis. However the deductions made by the insurance company under the head professional charges was not correct and an amount of Rs.2,700/- is further payable to the complainant under this head.

Hence Hon'ble Ombudsman directed to pay the above Rs.2,700/- (Rupees two thousand seven hundred only) to the complainant.

Kolkata Ombudsman Centre

Case No. 235/14/G3/NL/07/2012-13

Shri Paul Thomas K,

-Vs-

United India Insurance Company Ltd.

Order Dated : 30-11- 2012

Facts & Submissions :

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

The complainant, Shri Paul Thomas K. has stated in his complaint dated 26.06.2012 that he was suffering from fever for last one month and was admitted at Devamatha Hospital, Kerala on 09.05.2011 where he was treated conservatively and was discharged on 14.05.2011. As per discharge summary the diagnosis of the disease was 'severe negative malaria/ LRT 2'.

He sent an intimation to the insurance company vide his letter dated 11.05.2011 and subsequently lodged a claim to the TPA. He also complied with all the requirements of TPA. After a lapse of considerable period his claim was not settled. He represented to the insurance company on 30.01.2012 but his representation was not considered by them. Being aggrieved, he approached this forum for redressal of his grievance seeking monetary relief of Rs.6,090/- and Rs.2,050/- for other expenses.

The insurance company in their written submission dated 03.08.2012 have stated that the insured was admitted in the hospital for treatment of his illness on 09.05.2011 and he was discharged on 14.05.2011. On scrutiny of the claim file they observed that the insured submitted claim form after 29 days of discharge from the hospital. Mediclaim Gold policy

terms and conditions no.5.4 all claim documents be filed with TPA within 15 days from the date of discharge.

DECISION:

The complainant has approached this forum against repudiation of his claim on the ground of delayed submission of claim documents by 29 days. From the facts presented to this forum, we find that the complainant was hospitalized in Kerala from 09.05.2011 to 14.05.2011 for treatment of severe negative malaria/LRT 2. After his discharge, he was on rest as advised by his doctor and submitted the claim papers after returning to Patna on 13.06.2011. His claim was repudiated by the TPA due to delay in submission of claim.

Facts and circumstances of the case, Hon'ble Ombudsman that the insurance company never doubted the genuineness of the claim. The only ground of repudiation is delayed submission of the documents. However, the Insurer never asked for any clarification from the complainant for delay in submission of the claim documents. Moreover, no repudiation letter has been sent to the complainant. Under the circumstances repudiation of his claim without considering his explanation was not justified. Hence, she directed them to admit and settle the claim.

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kolkata Ombudsman Centre

Case No. 425/11/G3/NL/09/2012-13

Shri Sachchidanand Gupta

-Vs-

United India Insurance Company Ltd.

Order Dated : 30-11- 2012

Facts & Submissions :

This complaint is filed against repudiation of claim under Individual Health Insurance Policy issued by United India Insurance Company Ltd. on the ground of pre-existing disease.

The complainant, Shri Sacchidanand Gupta had stated that he was suffering from swelling of legs and shortness of breath and was admitted at Holy Family Hospital New Delhi from

08.01.2011 15.01.2011 for investigation and treatment. As per discharge summary the diagnosis of the disease was '*DM-II, CAD old MI with L.V. Dysfunction & Ventricular Arrhythmia, B/L Pulmonary Fibrosis (Old Koch's), severe hypothyroidism, Lumber canal stenosis'.*

He lodged a claim on 27.03.2011 for Rs.51,402/- to the insurance company but his claim was repudiated by the Insurance Company vide their letter dated 14.11.2011 on various grounds viz. (i) treated for pre-existing disease (ii) late intimation of claim, (iii) concealment of material facts and (iv) no advice of the doctor for admission. He represented to the insurance company against repudiation on 11.12.2011, but the same was not considered favourably by them.

The insurance company in their written submission dated 14.11.2012 have stated that as per the medical report of Max Healthcare submitted along with the proposal form, the insured was suffering from diabetes from 1994, hypertension, mild breathlessness with ischemic changes, mild anemia, CAD, severe obstructive airway disease. The insured lodged a claim for reimbursement of Rs.57,402/- for his hospitalization from 08.01.2011 to 15.01.2011. The intimation of admission in the hospital was given on 04.02.2011 and the documents were submitted on 27.03.2011. As per discharge summary the insured was diagnosed for DM-II, CAD old, MI with LV dysfunction Ventricular Arrhythmia, Pulmonary Fibrosis (Old Koch's) Lumber Canal Stenosis.

They further stated that after examination of all papers, the following points were observed:

- **i) The claimant was suffering from several diseases and no certificate given regarding cure of the diseases at the time of insurance by the insured;**
- **ii) The intimation was given after 26 days from the date of admission. This is in violation of condition no. 5.3 of the policy.**
- **iii) The claimant submitted all papers after two months from date of discharge. This is violation of condition no. 5.4 of the policy.**
- **iv) As per discharge summary the claimant was diagnosed for pre-existing diseases which are excluded for 4 years under the policy.**

The insurance company has also given their consent for the Insurance Ombudsman to act as a mediator between the complainant and themselves and give his recommendation for the resolution of the complaint.

DECISION:

The complainant has approached this forum against repudiation of his claim on a number of grounds viz. pre-existing diseases, concealment of material facts, delayed intimation and submission of claim form etc. From the facts presented to this forum, we find that the policy was first time incepted with the present insurer from 31.01.2008. The complainant was earlier insured with National Insurance Company Ltd. but due to switch over to the present company, the benefit of continuity was lost. From the discharge summary of the hospital we find that the insured was hospitalized from 08.01.2011 to 15.01.2011 and was diagnosed with several problems DM (18 years) HTN (5 years) CAD old MI with LV dysfunction,

Ventricular Arrhythmia, Pulmonary Fibrosis (old Koch's), severe hypothyroidism, Lumbar Canal Stenosis etc. Since the policy was issued as fresh policy and the claim had arisen in the 3rd year, it was repudiated because of pre-existing diseases like DM, HTN, CAD and Koch's (as confirmed by the history recorded by the doctor) for which there is a waiting period of 48 months under exclusion clause no. 4.1. This part of the decision is found to be in order. However, the complainant was also diagnosed for severe hypothyroidism and Lumber Canal Stenosis, which were detected for the first time and claim relating to the investigation and treatment of these diseases is admissible under the policy. The other grounds of non-disclosure and late intimation were not pressed by the insurer.

Hon'ble Ombudsman was of the opinion that total denial of the claim is not justified in this case. Considering that the insured is 80 years old and he developed some new complications which were not pre-existing, we allow 50% of the total admissible claim to the complainant towards treatment of these diseases.

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Kolkata Ombudsman Centre

Case No. 626/11/009/NL/01/2011-12

Shri Prabhat Kumar Kanodia

-Vs-

Reliance General Insurance Company Ltd.

Order Dated : 27-12- 2012

Facts & Submissions :

This complaint is filed against repudiation of claim under Reliance Healthwise Policy issued by Reliance General Insurance Company Ltd. on the ground of pre-existing disease.

The complainant, Shri Prabhat Kuamr Kanodia had stated and 31.12.2012 that his wife Smt. Manju Kanodia was suffering from diabetes and hypertension and was admitted at Escorts Heart Institute & Research Centre, New Delhi on 18.08.2010 where she underwent coronary angiography on 19.08.2010 and was discharged.

At the time of hospitalization, cashless facility was denied by the TPA of the insurance company. He lodged a claim to the TPA of the insurance company which was repudiated on the ground of pre-existing diseases HTN & DM. He represented to the insurance company on 07.03.2011 against repudiation, but the same was turned down. Being aggrieved by the decision of the insurance company the complainant approached this forum for redressal of his grievance seeking monetary relief of Rs.26,875/- along with compensation.

The insurance company had stated that Shri Prabhat Kumar Kanodia lodged a claim to their TPA for the treatment of his wife Smt. Manju Kanodia. On scrutiny of the prescription dated 18.08.2010 of 'Fortis Hospital' they found that Smt. Kanodia had been suffering from HTN for 15 years and DM for 5 years which are major active contributory

factors for the coronary artery disease suffered by Smt. Kanodia. In the clinical summary, of Fortis Hospital it is noted that *'she is a known case of coronary artery disease and underwent coronary angiography in 2007'.* Prescription for diabetic medicine was noted. In view of the above facts their TPA repudiated the claim as per terms and conditions of the policy and informed the insured vide their letter dated 30.09.2010.

DECISION:

The complainant had approached this forum against repudiation of his claim for non-disclosure of pre-existing conditions of HTN and DM as per policy condition no. 1. However, the complainant has taken the mediclaim policy under SILVER PLAN which covers the pre-existing disease from the third year of policy after two continuous renewals with the insurer. The complainant has taken policy since 01.03.2007 to 28.02.2011 continuously. The present claim was lodged for hospitalization on 19.08.2010 which falls under fourth year of policy when the pre-existing diseases are covered under SILVER PLAN. The insurer has also confirmed under point no. 2 of their letter submitted to this forum on 19.12.2012 that in case of pre-existing diseases, the same is covered after 2 years under Silver Plan. Hence under the captioned policy the claim is admissible even they were pre-existing.

In view of the above Hon'ble Ombudsman directed to pay and settle the claim.

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Kolkata Ombudsman Centre

Case No. 073/11/G1/NL/04/2012-13

Shri Phatik Chandra Das

-Vs-

The New India Assurance Company Ltd.

Order Dated : 12-12- 2012

Facts & Submissions :

This complaint was filed against repudiation of claim under Group Mediclaim Policy of LICI Employees and their dependents issued by The New India Assurance Company Ltd.

The Complainant Shri Pathik Chandra Das had stated that he was admitted in Saviour Clinic on 06.03.2011 and discharged on 12.03.2011 for a surgery. He lodged a claim to the insurance company on 21.3.2011 for total amount of Rs.58,071/- along with necessary documents. The Insurance Company asked him vide their letter dated 21.4.2011 to submit the printed numbered money receipt for Rs.40,000/- of Dr. M. Mukhopadhyaya towards his operation charges. In reply, the complainant clarified vide his letter dated 19.5.2011 that the Doctor had confirmed that he gives only hand written money receipt. He requested them to verify the payment from the doctor. However, the Insurance Company is ready to settle the bill without considering the doctor's fee. Being aggrieved, the complainant approached this forum for redressal of his grievance seeking monetary relief of Rs.58.070.95.

The insurance company had stated that the treating doctor Dr. M. Mukhopadhyay charged Rs.40,000/- against his professional fees by submission of a kachha numbered money receipt. They wrote to the complainant on 25.4.2011 for submission of formal numbered money receipt from the said doctor. They again communicated the complainant that without the above, they are unable to reimburse the complainant the doctor's fees.

<u>DECISION</u>:

The complainant had approached this forum against delay in settlement of the claim on the ground that there is no printed receipt for the doctor's professional fee. From the facts presented to this forum, we find that the only dispute is regarding the format of money receipt of Rs. 40000/- issued by the surgeon for his professional charges. The complainant has submitted a printed receipt which is filled up by the doctor in hand. The receipt is duly signed and stamped by the doctor, who has also clarified that this is the practice followed by him. The insurance company, however, is insisting on a printed receipt, which is not prescribed under the policy issued to the member. Under the circumstances, denial of the claim is not justified. If the insurer had any doubt about the genuineness of the claim they should have verified from the doctor, which they have not done. Settling the bill without surgeon's fee is quite absurd. The explanation of the complainant is found to be satisfactory and accordingly, Hon'ble directed the insurance company to settle the claim on the basis of the money receipt submitted by the insured.

Kolkata Ombudsman Centre

Case No. 104/11/G1/NL/05/2012-13

Shri Sankar Das

-Vs-

The New India Assurance Company Ltd.

Date of Order: 12th December, 2012

Order Dated : 12-12- 2012

Facts & Submissions :

This complaint is filed against repudiation of claim under Group Mediclaim Policy of LICI Employees and their dependents issued by The New India Assurance Company Ltd. as per exclusion clause no. 5.4 of the policy.

The complainant, Shri Sankar Das has stated in his complaint dated 19.03.2012 that his wife Smt. Rina Das was suffering from low back pain and as per advice of Dr. Ronen Roy of Fortis Hospitals, Kolkata on 18.03.2011, she underwent MRI tests as an out patient of the same hospital on 21.03.2011. He lodged a claim for Rs.9,000/- through his employer in April 2011. The insurance company vide their letter dated 26.05.2011 repudiated the claim due to late submission of claim documents. The employer requested the insurer vide their letter dated 24.11.2011 to condone the delay explaining that due to the year ending pressure of work the employee was very much busy in March and April 2011. Their request was however, turned down.

The insurance company had stated that the complainant Shri Sankar Das lodged a claim in respect of the treatment of his wife Smt. Rina Das. The claim was repudiated by them on the ground of delay of 15 days in submission of claim documents. As per policy condition no. 5.4, claim bill must be filed within 20 days of discharge from the hospital. The policy document is the only document of contract and it is agreed between insured and insurer from the inception of the policy, both the parties should maintain it scrupulously. They

advised the employer (LICI Howrah Divisional Office) to pursue the matter with the higher authority for condonation of delay.

DECISION:

The complainant had approached this forum against repudiation of his claim on the ground of delayed submission of claim documents. From the facts presented to this forum we find that the insured had undergone MRI Scan on the advice of the doctor but the claim was not lodged within the prescribed period of 20 days. The insurance company has repudiated the claim for violation of policy condition no. 5.4 which lays down a time limit of 20 days for submission of the claim papers from the discharge of the hospital. From the documents submitted to this forum we find that L.I.C.I, Howrah Divisional Office, the employer had requested the insurance company to condone the delay explaining the reasons for the same. The insurance company turned down the request and advised the employer to pursue the matter with their higher authority. However, we find that the insurance company did not intimate the details of the higher authority to the LICI or the insured. Meanwhile, 1 ½ years has already passed and no fruitful result is expected from a fresh representative to the higher authority at this stage.

Under the circumstances, Hon'ble Ombudsman condoned the marginal delay of 15 days considering the circumstances under which the insured was placed. The insurance company was directed to admit the claim, settle and pay the same to the complainant as per terms and conditions of the policy.

Kolkata Ombudsman Centre
Case No. 616/11/009/NL/01/2011-12
Md. Parwez Alam

-vs-
Reliance General Insurance Company Ltd.,

Date of Order : 15th January, 2013
FACTS/SUBMISSIONS

This complaint was filed against repudiation of claim under Reliance Healthwise Policy issued by Reliance General Insurance Company Ltd. due to non submission of required documents.

The complainant, Md. Parwez Alam had stated that his mother Smt. Nafisa Khatoon was suffering from chest pain with shortness of breath and dyspepsia since one week and was admitted at Desun Hospital & Heart Institute, Kolkata on 09.07.2010 where she underwent PTCA on 20.07.2010. She was discharged on 26.07.2010. He lodged a claim on 04.08.2010 for Rs.3,77,000/- to the TPA of the insurance company M/s Medi Assist India TPA Pvt. Ltd. TPA vide their letter dated 16.08.2012 requested him to submit the following documents viz. (i) the first consultation papers with detail past history of the patient treating taken earlier (ii) provide a letter from treating doctor since when the patient is having hypertension and diabetes and (iii) to provide ICP papers. The same was complied on 20.09.2010 and 07.01.2011. Subsequently, TPA vide their letter dated 16.01.2012 repudiated the claim for non submission of the required information/ documents in spite of several reminder. He represented to the insurance company against repudiation on 24.02.2011 stating that he had submitted the required documents on 20.09.2010 and 07.01.2011 to their TPA and requested them to settle his claim, but the same was turned down.

The insurance company had stated that the complainant was asked to submit the following documents:-

(a) First consultation paper with past history of the details of the treatment taken;

(b) Medical certificate from the treating doctor regarding when the patient is having

hypertension and diabetes and

(c) ICP papers of the hospital.

The complainant had provided the ICP but F.C.P and medical certificate from the treating doctor regarding duration of HTN & DM is still pending. Hence they have not been able to process the claim of the complainant.

DECISION:

The complainant had approached this forum against repudiation of his claim due to non-submission of certain documents. He has claimed that all the requisite documents have been submitted to the TPA and has produced copies of the documents with acknowledgement. From the documents we find that the complainant had first consulted Dr. S. S. Das who had certified that the patient was suffering from HTN for one year and DM for less than one year. Dr. Das has also certified hat there is no history of any major illness and the patient was not on any drug. The hospitalization took place after 19 months from the date of inception of the policy. Hence considering the doctor's certificate, the question of pre-existing diseases does not arise in this case.

Hon'ble Ombudsman were of the opinion that the insured had complied with the requirements of the TPA and submitted the necessary documents which clearly establish that HTN and DM were not pre-existing in this case. Hence she directed to admit the claim and settle the same as per terms and conditions of the policy.

Kolkata Ombudsman Centre

Case No. 065/11/G2/NL/04/2012-13
Smt. Kaberi Ghosh

-vs-
National Insurance Company Ltd.,

Date of Order : 09 th January, 2013
FACTS/SUBMISSIONS

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

The Complainant Smt. Kaberi Ghosh had stated that her husband Shri Birendra Nath Ghosh was admitted in West Bank Hospital on 20.09.2011 for 1st cycle of chemotherapy. Mr. Ghosh was admitted 3 times in the said hospital and TPA MedSave Health Care Ltd. had sanctioned cashless benefits on these occasions but at the time of Radio Therapy, they denied the claim due to pre-existing disease as per policy condition no.4.1. The complainant had submitted a certificate from the treating doctor stating that the lung cancer was not pre-existing. She represented to the insurance company against repudiation on 17.02.2012, but the same was turned down.

The insurance company in their written submission dated 01.08.2012 have stated that on receipt of the complaint from the insured, they had called for all the 3 claim files from their TPA. On scrutiny, they found that though the TPA had primarily given their consent for cashless benefits on the basis of hospital authority's preliminary observation, but subsequently, they had rejected all the 3 cashless benefits as the disease was pre-existing as per Policy Clause No.4.1. They had further stated that the insured while taking his first policy in the year 2011, had mentioned in the proposal form under heading "details of pre-existing diseases/illness" as "NO" and therefore, they repudiated the claim towards suppression of material fact as per clause no.4.1 of the policy issued to the insured.

DECISION:

The complainant had approached this forum against repudiation of her claim for cancer treatment of her husband who was admitted at West Bank Hospital from 20.09.2011 and 21.09.2011. From the medical records it was seen that the insured had pre-existing HTN and COPD. The insurance company had repudiated the claim under clause no. 4.1 of the policy stating that his lung cancer was pre-existing for last six years. This finding had not been supported by any documentary evidence. The treating doctor of West Bank Hospital has certified that cancer was detected in August 2011 whereas he was suffering from COPD from 2009 and HTN for one year. The policy had incepted since 27.10.2010 and we find that TPA has already allowed cashless benefit for three cycles of chemotherapy in October and November 2011. These are well documented by the hospital bills. This contradicts the statement of the insurance company that they had rejected cashless benefit for chemotherapy. Since pre-existence of cancer has not been established by the insurance company the repudiation of the claim under exclusion clause no. 4.1 is not justified. The insurance company has further contended that the claim was also repudiated for non-disclosure of pre-existing COPD and HTN in the proposal form. Hon'ble Ombudsman found that this ground was not relevant for repudiation of the claim for treatment of lung cancer which was not pre-existing. Hence, the insurer was directed to admit the claim and settle the same as per terms and conditions of the policy.

Kolkata Ombudsman Centre

Case No. 086/11/G1/NL/04/2012-13
Smt. Indrani Dana

-vs-
The New India Assurance Company Ltd.,

Date of Order : 09 th January, 2013
FACTS/SUBMISSIONS

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

The Complainant Smt. Indrani Dana has stated in her complaint dated 14.10.2011 and 25.04.2012 that she was admitted in Spectrum Clinic & Endoscopy Research Institute, Kolkata on 13.02.2011 and was discharged on 18.2.2011 wherein she had undergone hysterectomy operation. She submitted her claim to the TPA for a total amount of Rs.86,492/- but TPA settled for Rs.57,917/-. She represented to the insurance company against partial settlement, but her appeal was not considered.

The insurance company stated that the insured submitted the total claim for Rs.86,492/- included hospital expenses of Rs.81,584/-, Rs.4595/- for pre-hospitalization and Rs.312.75 for post hospitalization treatment against which TPA paid Rs.57,917/-. Since the doctor's fee was not incorporated in the hospital bill and was paid in cash, they could pay Rs.10,000/- for the same and Rs.7000/- towards assistant charges. Thus, they had paid the insured under the head "Physician, Surgeon, Anest./Asst. Fees, a total amount of Rs.17,000/- against the total amount of Rs.36,500/-. They had also deducted Rs.5480/- as inadmissible non-medical sundries. Deduction on pre-hospitalization was Rs.3595/- Hence total deduction comes to Rs.24,980/- + 3595/- = Rs.28,575/- and balance amount of Rs.57,917/- was paid to the insured.

.DECISION:

The complainant had approached this forum against partial repudiation of her claim. From the facts presented to this forum, we find that the insurance company has made a

total deduction of Rs.28,575/- that included surgeon/ anesthetist fees of Rs.19,500/- , RMO's fees of Rs.2,500/- and miscellaneous non-medical items. From the details presented to this forum, we find that the insured had made a claim of Rs.36,500/- for surgeon's fee which was paid in cash and not included in the hospital bill. Therefore the insurer restricted this reimbursement to Rs.10,000/- as per Note 3 (b) of the policy. However, the policy condition does not restrict the total payment under this head to Rs. 10,000/-. Therefore, ceiling of Rs. 10000/- is to be applied separately to each bill of surgeon/ anesthetist and clubbing these for the capping purpose is erroneous. The insured has submitted a separate bill for Rs.4,500/- raised by the anesthetist which has to be considered separately from the surgeon's bill. Similarly, R.M.O fees of Rs.2,500/- is also payable as representative of Insurer could not point out any policy condition under which RMO fee is excluded. Deductions for record charges, sheet and other non medical items are correct. The physician fees and investigation charges prior to 30 days of the surgery is not admissible.

In view of the above, the insurance company was directed by Hon'ble Ombudsman to pay Rs.7,000/- (Rs.4,500/- towards anesthetist charges and Rs.2,500/- towards R.M.O charges) to the complainant.

Kolkata Ombudsman Centre

Case No. 098/11/G21/NL/05/2012-13

Smt. Seema Tibrewal

-vs-

Bharti AXA General Insurance Co. Ltd.,

Date of Order : 29 th January, 2013

FACTS/SUBMISSIONS

This complaint is filed against repudiation of claim under Smart Health Insurance Policy issued by Bharti AXA General Insurance Company Ltd.

The complainant Smt. Seema Tibrewal, had stated that her husband Sri Chandra Prakash Tibrewal was suffering from fever and some discomfort from mid June, 2011 and was subsequently diagnosed as a case of Metastatic High Grade Carcinoma with Neuroendocrine Differenciation (Liver Cancer). He was treated at Global Hospital & Health City, Chennai; Jaslok Hospital and Research Centre; Mumbai, Belle Vue Clinic, Kolkata and Apollo Gleneagles Hospital, Kolkata from time to time. First claim for Rs.5,50,040/- was submitted on 9th August, 2011, 2nd claim for Rs.4,24,860/- was submitted on 9th Sept, 2011 and 3rd claim for Rs.1,68,251/- on 16th Sept, 2011. Ultimately her husband expired on 22.10.2011.

The TPA repudiated the claim on the ground misstatement and non-disclosure of material facts relating hospitalization for hernia 8 years back. The insurance company in their written submission dated 10.08.2012 have stated that the insured submitted the claim documents on 09.08.2011 and the claim was recommended for investigation. On perusal of the claim documents and the investigation report, it was noted that the insured had the history of following ailments before taking the policy. As per the discharge summary of Global Hospital it is mentioned as

i) **Known case of hypertension on treatment**
ii) **History of surgery for hernia 8 years back.**

They further stated that the insured has not disclosed the above conditions at the time of taking the policy. At the time of investigation Mr. Kailash Tibrewal brother of the insured

had confirmed in writing that there is "No hospitalization before such admission" and "No past history of Hypertension". In view of the above facts, the claim was repudiated on the grounds of misrepresentation of material facts at the time of taking the policy under Exclusion clause 6.1 of the policy.

DECISION:

The complainant had approached this forum against total repudiation of claim for treatment of cancer as per policy general condition no. 6.1 for non-disclosure of previous history of HTN and surgery of hernia. From the facts presented to this forum we find that the claim has arisen in the second year of the policy for treatment of 'Metastatic Liver Cancer' in different hospitals. There is no dispute about the fact that the disease was detected after the commencement of the policy. The insured expired on 22.10.2011 and after his death three claims were submitted for different periods of hospitalization. The insurance company has repudiated the claim for violation of general condition no. 6.1 for non-disclosure of previous surgery of hernia and pre-existence of HTN. The insurance company has submitted documentary evidence which shows that the insured had undergone a surgery for hernia 8 years back. During last 8 years, neither the insured had any hernia related problem nor is it medically proved that there is any link between the past surgery and the present disease of liver cancer. Therefore, in our opinion, the past surgery of hernia cannot be regarded as material fact for the settlement of the present claim. Although he is a known case of HTN as per discharge summary of Global Hospital dated 15.07.2011, where he was admitted for treatment of liver disease, but the treating doctor has not mentioned the duration of the HTN and therefore, pre-existence of HTN was not conclusively established in this case. The family has spent Rs.11,43,153/- for treatment of cancer which was undisputedly detected after the commencement of the policy. Considering the fact that the said disease was in no way linked to the surgery of hernia or HTN, denial of the claim on the ground of non-disclosure of material fact is not at all justified. Hence, Hon'ble Ombudsman directed them to admit three claims and settle the same as per terms and conditions of the policy .

Kolkata Ombudsman Centre

Case No. 099/11/G1/NL/05/2012-13
Sri Tripti Sekhar Dutt Roy

-vs-
The New India Assurance Co. Ltd.,
Date of Order : 15th January, 2013
FACTS/SUBMISSIONS

This complaint is filed against partial repudiation of claim under Janata Mediclaim Policy issued by New India Assurance Co Ltd.

The complainant Shri Tripti Sekhar Dutt Roy had stated that his wife Smt. Ila Dutt Roy was admitted to Ekbalpur Nursing Home in unconscious state from 15.02.2010 to 20.02.2010. As per discharge summary the diagnosis of the disease was *'acute LRTI, UTI with sepsis'.* TPA deducted certain amounts while settling his claim on account of doctors' charges, ambulance charges and emergency administration charges. He represented to the insurance company on 26.04.2012 against partial settlement, but his appeal was turned down.

The insurance company in their written submission dated 31.07.2012 have stated that their TPA has rightly deducted the non admissible amounts under following heads:-

i) **The Insured submitted bill of consultant fees for Rs. 4200 vide hospital bill No. 005038, wherein Rs. 1200/- of Dr. B. Dasgupta's fees was included. TPA settled maximum permissible amount of Rs.2100/- (Rs.350/- x 6) under head Doctors fees. So, any further amount on that head is not admissible.**
ii) **Rs. 500/- for Emergency Management charges is not payable as per our policy condition 4.4.22 which are not related to admission charge.**
iii) **Rs. 700/- for Ambulance charge is not payable as per our policy condition no. 2.7 as the Patient was not admitted in emergency ward or ICU.**

DECISION:
The complainant has approached this forum against partial repudiation of his claim. From the details submitted to this forum by the insurance company we find that deductions

made on account of doctor's consultation fees is in order. The patient was hospitalized for six days for which the insurance company has reimbursed doctors fees @ Rs.350/- per day as per schedule of charges under "visit charges" which is in order. As per schedule the doctor visit charges per day is Rs.350/- irrespective of number of visits, so under this head the claim has been settled correctly. However, Hon'ble Ombudsman found that ambulance charges of Rs.700/- is admissible under the condition. Similarly the emergency management charges of Rs.500/- is payable as its fall under the hospitalization charges as per clause 2.3 (other medical expenses).

In view of the above, the insurance company she directed to pay Rs.1,200/- (Rs.700/- towards ambulance charges and Rs.500/- towards emergency management charges) to the complainant.

Kolkata Ombudsman Centre

Case No. 136/14/G1/NL/05/2012-13
Sri Sisir Kumar Nag

-vs-
The New India Assurance Co. Ltd.,

Date of Order : 29th January, 2013
FACTS/SUBMISSIONS

This complaint is filed against delay in settlement of claim under Mediclaim Policy issued by The New India Assurance Company Ltd.

The complainant Shri Sisir Kuamr Nag has stated in his complaint dated 11.05.2012 that he was admitted at Wockhardt Hospitals, Kolkata on 04.02.2010 for cataract operation (right eye) and was discharged on the same day. He lodged a claim for Rs.18,337.05 to the TPA of the insurance company. But after a lapse of considerable period his claim was not settled. He represented to the insurance company on 26.02.2011 and 23.08.2011, but he did not get any reply. Being aggrieved by the decision of the insurance company, the complainant approached this forum for redressal of his grievance seeking monetary relief of Rs.18,337.05. The complainant has given his unconditional and irrevocable consent for the Insurance Ombudsman to act as a mediator between himself and the insurance company and to give recommendation as per Form – P-III.

The insurance company in their written submission dated 18.09.2012 have stated that Shri Sisir Kuamr Nag was admitted at Wockhardt Hospitals, Kolkata on 04.02.2010 for cataract operation of his right eye and discharged on the same day. The insured opted for cashless and the TPA approved cashless of Rs.10,000/- on 03.02.2010. TPA has settled the claim for Rs.10,000/- (maximum payable as per terms and conditions of Senior Citizens Mediclaim Policy) by cashless direct payment to the hospital. In view of the above, the maximum amount payable under the policy has been paid and the claim has been rightly settled.

The insurance company has also given their consent for the Insurance Ombudsman to act as a mediator between the complainant and themselves and give his recommendation for the resolution of the complaint.

DECISION:

The complainant had approached this forum against partial repudiation of his claim for cataract surgery. The insurance company has settled the claim through cashless payment of Rs.10,000/- by the TPA, being the maximum amount payable for cataract surgery under the policy condition. The settlement is as per policy condition no. 2.2 and 2.3 of the policy and is found to be in order. However, we find that the complainant is further entitled to Rs.1,243/- towards pre-hospitalization expenses upto 30 days prior to the surgery subject to ceiling of 5% of the hospital bill (5% of Rs.24,860/-) and post hospitalization expenses of Rs.417/- upto 60 days subject to maximum ceiling of 10% of the hospital bill. Hon'ble Ombudsman directed to pay the above (Rs.1,243 + Rs.417) = Rs.1,660/- to the complainant within 15 days from the date of receipt of this award along with consent letter.

Kolkata Ombudsman Centre
Case No. 188/11/G2/NL/06/2012-13

Shri Anand Krishna Maitin

-vs-
National Insurance Company Ltd.,

Date of Order : 21st January, 2013
FACTS/SUBMISSIONS

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

The complainant, Shri Anand Krishna Maitin hadstated that he was suffering from recurrent chest infection for last 1 ½ year accompanied with cough and respiratory distress and was admitted at Narayana Hrudayalaya Hospitals, Kolkata on 04.04.2011 where he was treated conservatively and was discharged on 05.04.2011. He lodged a claim on 10.04.2012 for Rs.16,425/- to the TPA of the insurance company. TPA vide their letter dated 19.08.2011 repudiated the claim as per clause no. 2.6 (B) as the patient was admitted for less than 24 hours. He represented to the insurance company against repudiation on 17.11.2011 but it was turned down.

The insurance company in their written submission dated 13.08.2012 have stated that the insured was admitted at Narayana Hrudayalaya Hospitals, Kolkata on 04.04.2011 at 18:25:38 hours and discharged on 05.04.2011 at 16:03:46 hours which is less than 24 hours as per discharge summary. Moreover, during hospitalization only some medical tests were carried out which was not followed by any active line of treatment. Hence the claim could not be paid as per clauses 26 and 4.10 of Standard Mediclaim Policy.

DECISION:

The complainant had approached this forum against repudiation of his claim on the ground that the hospitalization was less than 24 hours and no active line of treatment was done in the hospital. From the facts presented to this forum we find that the patient is a senior citizen of 75 years and was admitted for acute respiratory disorders due to COPD. During hospitalization he was on constant oxygen and intravenous injections. The recorded time as per discharge summary of the hospital falls short of the required 24 hours by 2 hours 21 minutes which is marginal considering the delay in admission procedure in the hospitals. Moreover, considering his advance age and severity of the disease hospitalization was definitely necessary. The treatment included constant oxygen, intravenous injections, nebulization etc. which is an active line of treatment.

Considering all the facts and circumstances of the complaint, we are of the opinion that denial of the claim on a flimsy ground like hospitalization for less than 24 hours is not fair and the decision is set aside. Hon'ble Ombudsman directed to admit the claim and settle the same as per terms and conditions of the policy.

Kolkata Ombudsman Centre
Case No. 190/11/G4/NL/06/2012-13

Shri Sanjiv Chopra

-vs-
The Oriental Insurance Company Ltd.,

Date of Order : 21st January, 2013

FACTS/SUBMISSIONS

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

The complainant, Shri Sanjiv Chopra had stated in his complaints dated 23.08.2011 and 08.06.2012 that he was suffering from right eye problem and was admitted at B. B. Eye Foundation, Kolkata on 11.12.2010 where intravitreal injection Avastin was administered in his right eye and he was discharged on the same days.

He lodged a claim on 17.02.2011 to the TPA of the insurance company. The TPA vide their letter dated 25.05.2011 repudiated the claim stating that the 'treatment is not covered as per insurance company's guidelines. He represented to the insurance company on 19.01.2012, but the same was turned down.

The insurance company in their written submission dated 20.07.2012 have stated that the claim lodged under the captioned policy was repudiated since the patient was treated with injection Avastin which is administered due to age related macular degeneration 'ARMD' and the procedure involved is within OPD protocol.

DECISION:

The complainant has approached this forum against repudiation of his claim of ARMD treatment with Avastin Injection on the ground that it is an OPD treatment. From the facts

presented to this forum we find that under the same policy following ARMD claims were paid -

Date of admission		Amount
11.09.2010	-	Rs.10,000/--
18.09.2010	-	Rs. 8,000/-
23.09.2010	-	Rs. 8,000/-

At the time of fourth claim for admission on 11.12.2010, the TPA raised a new issue that the treatment can be done on OPD basis. However, we find that there was no specific exclusion under the policy for this type of treatment. Even their internal guidelines, which were issued in July 2012 denying the claim, came much later after taking the injection. Therefore, the decision of the insurance company to repudiate the claim is erroneous and the same is set aside. The insurance company was directed to admit the claim and settle the same as per terms and conditions of the policy.

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Kolkata Ombudsman Centre
Case No. 062/14/G4/NL/04/2012-13

Smt. Tapati Bhattacherjee

-vs-
The Oriental Insurance Company Ltd.,

Date of Order : 22nd February, 2013
FACTS/SUBMISSIONS

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

The complainant, Smt. Tapati Bhattacherjee had stated that her husband Shri Samarendra Bhattacherjee was admitted at AMRI Hospitals, Kolkata on 26.02.2011 for right side hemicolectomy and was discharged on 21.03.2011.

She lodged a claim on 18.05.2011 to the TPA of the insurance company but the claim was not settled due to delay of 59 days in submission of her claim papers. On her representation, the Divisional Manager has condoned the delay but T.P.A has asked her to get approval from the Regional Manager. She represented to Regional Manager of the

insurance company on 14.09.2011 but after a lapse of considerable period her claim was not settled. Being aggrieved the complainant approached this forum for redressal of her grievance seeking monetary relief of Rs.2,19,997/- as per 'P-II' form details. The complainant has given her unconditional and irrevocable consent for the Insurance Ombudsman to act as a mediator between herself and the insurance company and to give recommendation as per Form – P-III dated 28.05.2012.

The insurance company stated that the patient was suffering from malignant neoplasm of prostate and he submitted all the claim related papers to the TPA after a delay of 59 days, which violates the condition 5.4 and 5.5 of the policy. The claimant made a representation to their R.M on 14.09.2011 for condonation of delay in submission of papers and it was forwarded to the regional office for final decision.

DECISION:

The complainant has approached this forum against delay in settlement of claim as her petition was pending before the competent authority. The representative of the insurance company has informed that their competent authority has condoned the delay and accordingly they will advice the TPA to settle the claim. They have sought one month's time for settlement of the claim. The insurer is directed to settle the claim as per terms and conditions of the policy. The complainant was directed by Hon'ble Ombudsman to comply with the requirements of the Company.

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Kolkata Ombudsman Centre
Case No. 142/11/G3/NL/05/2012-13

Smt. Kalpana Chanda

-vs-
The Oriental Insurance Company Ltd.,

Date of Order : 22nd February, 2013
FACTS/SUBMISSIONS

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

The complainant, Smt. Kalpana Chanda had stated that due to an accidental fall at home on 23.11.2011, she suffered injury to left knee and was admitted at AMRI Hospitals, Kolkata on the same day where she underwent an operation on 25.11.2011. She lodged a claim of Rs.72,563/- to the insurance company towards hospitalization and post hospitalization expenses. However, the TPA vide their letter dated 18.01.2012 settled Rs.40,221/- towards hospitalization claim and further Rs.3,246/- towards pre and post hospitalization expenses. She represented to the insurance company on 26.03.2012 against partial settlement, but her representation was not considered.

The insurance company in their written submission had stated that the insured Smt. Kalpana Chanda was admitted to AMRI Hospitals, Kolkata on 23.11.2011 due to severe fracture in her left knee and she was discharged on 01.12.2011 with a stable condition. Their TPA has extended a cashless facility to the tune of Rs.50,000/- to the hospital authority. Subsequently they made reimbursement of Rs.40,221/- and Rs.3,246/- towards balance hospitalization and pre and post hospitalization expenses respectively. They further stated that the insured was eligible to room rent @ Rs.2,250/- per day. But she had opted for higher category @ Rs.2,800/- and has accepted the deduction of Rs.4,400/- on account of the same. Further an amount of Rs.18,300/- was claimed towards physiotherapist but there was no specific advice of the doctor in this respect. Under the circumstances the decision of the TPA not to reimburse the same as post hospitalization expenses (which in any case is limited to 10% of the sum insured) is justified. Other

deductions were made by the TPA in conformity with policy specific condition such as 1.2 and 4.14.

DECISION:

The complainant has approached this forum against partial repudiation of her claim due to deduction of certain inadmissible items by the insurance company. From the facts presented to this forum it is seen that a total amount of Rs.48,468/- was deducted by the insurance company under various heads. From the breakup of the amount it is seen that an amount of Rs.10,752/- was deducted on account of non-medical items like aya charges, consumable items like knee cap, MRD charges, ambulance charges and expenses incurred after 60 days of the discharge. These deductions have been correctly made by the TPA as per the policy terms and conditions. However, an amount of Rs.18,300/- spent toward physiotherapy charges during post hospitalization period was deducted without any justification. As per policy condition no. 3.2 post hospitalization expenses include all relevant medical expenses during the period upto 60 days and the admissible amount is limited to 10% of the sum insured. The complainant has submitted doctor's prescription dated 27.12.2011 with the specific advice for physiotherapy for one month which falls during the post hospitalization period of 60 days. Since this advice is supported by doctor's prescription and it is a relevant medical expense incurred during the post hospitalization period, the same is payable subject to maximum 10% of the sum insured. As regards the O.T. charges of Rs.500/- and Assistant Surgeon fees of Rs.6,050/-, the same is also payable as it is related to the surgery. As regards the deduction of Rs.9,763/- under the policy conditions 1.2C and 1.2D we find that the hospital has a variable rate system (according to room rent) for surgeon, anesthetist and OT charges but it has no room rent for Rs.2,250/- for which the complainant is entitled. Under the circumstances, the above fees has been lowered proportionately from the available room rent i.e., Rs.2,800/- and this adjustment in the absence of entitled room category is the only method to give reasonable and fair effect for the claim. Further an amount of Rs.3,102/- disallowed on account of professional charges and investigation charges the same has been restricted to the hospital tariff and disallowancewas correct.

In view of the above, we conclude that an amount of Rs.6,550/- (Rs.500/- + Rs.6,050/-) is further payable to the insured complainant. The physiotherapy charges are also payable subject to the overall limit of 10% of pre & post hospitalization expenses. The insurer was directed to pay the above amount.

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Kolkata Ombudsman Centre
Case No. 170/11/G16/NL/05/12-13

Smt.Maitrayee Banerjee

-vs-
Star Health & Allied Insurance Co. Ltd.,

Date of Order : 19th February, 2013
FACTS/SUBMISSIONS

This complaint was filed against total repudiation of claim under Senior Citizens Red Carpet Insurance Policy issued by Star Health and Allied Insurance Co. Ltd.

The complainant Smt. Maitrayee Banerjee had stated that her husband Shri Gautam Banerjee was covered under Senior Citizen Red Carpet Policy for the period from 06.06.2011 to 05.06.2012. He was suffering from back and abdominal pain during September 2011 and on investigation Hydronephrosis of the right kidney was detected. He was admitted in Woodlands Multispeciality Hospital for the first time on 23.10.2011 and was discharged on 25.10.2011 after undergoing Cysto and URS on 24.10.2011. He was again admitted in the same hospital for Right Nephroueterectomy. She submitted a claim for Rs.1,55,651/- to the insurance company but the claim was repudiated on the ground of non-disclosure of the material fact that the insured was treated for the same disease before inception of the policy. She represented to the insurance company on 06.02.2012 for settlement of her claim, but the same was turned down.

The Insurance Company had stated that the said policy had incepted on 06.06.2011 and the date of admission was on 06.11.2011 i.e. within 5 months of the inception of the policy. The Insured is a case of urothelial carcinoma of pelvicalyceal cyst spread to renal parenchyma. There was a seeding growth from tumor and as per their medical experts it implies non functioning kidney which reveals the pre-existing nature of disease. Since the insured has not disclosed the material fact about his medical history/health condition in the proposal form at the time of proposing for insurance with them, they repudiated the claim as per Policy Condition No.7 which reads as follows:-

"The Company shall not be liable to make any payment under the policy in respect of any claim is in any manner or supported by any means or device, misrepresentation whether by the insured person/or by any other person acting on his behalf."

The insurance company has also given their consent for the Insurance Ombudsman to act as a mediator between the complainant and themselves and give his recommendation for the resolution of the complaint.

DECISION

The complainant has approached this forum against repudiation of her mediclaim on grounds of non-disclosure of pre-existing disease. The insurance company has now agreed to admit the claim and settle the same subject to submission of all the original documents. The complainant was directed to comply with the requirements of the insurance company and insurance company was 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. 174/11/G1/NL/05/2012-13

Smt. Rupa Mondal,

-vs-
The New India Assurance Co. Ltd.,

Date of Order : 19th February, 2013
FACTS/SUBMISSIONS

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

The complainant Smt. Rupa Mondal has stated in her complaint dated 30.05.2012 that the insurance company unilaterally deducted an amount of Rs.17,885/- out of her total claim for Rs.28,385/-. She represented to the insurance company vide her letter dated 18.4.2012 but did not receive any reply.

The insurance company in their written submission dated 03.07.2012 have stated that Smt. Rupa Mondal was admitted in Divine Nursing Home on 29.10.2011 and was discharged on the next day where she was diagnosed for B/C Carpel Tunnel Syndrome. She submitted a total amount of claim for Rs.28,385/-, out of which, Rs.10,500/- was settled by their TPA on 02.07.2012 and the balance of Rs.17,885/- was deducted for inadmissible items in terms of policy conditions & exclusions.

The insurance company has also given their consent for the Insurance Ombudsman to act as a mediator between the complainant and themselves and give his recommendation for the resolution of the complaint.

DECISION:

The complainant has approached this forum against partial settlement of her claim by the insurance company. From the facts presented to this forum we find that out of total claim of Rs.28,385/- an amount of Rs.17,885/- were deducted by the TPA towards inadmissible items under various heads. From the break-up of the deductions, it is seen that the fees of the surgeon and anesthetist have been clubbed and limited to maximum of Rs.10,000/- since the amount was paid in cash. However, we find that both the doctor and anesthetist have given separate bills and these cannot be clubbed together for applying the ceiling of Rs.10,000/-. Moreover the doctor's fee and O.T. charges had been reduced proportionately, since the patient stayed in a higher category of room. This calculation of the TPA is also not correct as the note under clause 2 says that the amounts payable under 2.3 (surgeon fee etc) and 2.4 (medicines, O.T. charges etc.) shall be at the rates applicable to the entitled room category and in case insured opts for a room with higher rent then the charges shall be limited to the charges applicable to the entitled category. In this case the TPA has not ascertained from the nursing home whether there are variable rates for separate category of room. In case such variable rates exist then the payment shall be limited to the charges applicable to the entitled category. If there are no such variable rates then the full amount is to be paid. The formula for proportionate deductions as adopted by the TPA is not in accordance with the policy terms and conditions. The complainant has claimed some bills which are not payable due to the reason that these bills pertain to the period prior to pre-hospitalization period of 30 days. Similarly service charges paid to the hospital are not admissible as per policy terms and conditions.

Under the circumstances, the insurer is directed to verify from hospital about the existence of variable rates for expenses listed under policy condition no. 2.3 & 2.4 linked with bed charges. If it does exist these charges should be paid as should have been paid had the insured availed room as per her entitlement. If it does not exist insurer should

allow the expenses under 2.3 & 2.4 of the policy condition without proportionate deduction but subject to other terms and conditions of the policy. This exercise had to be completed by the insurer.

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Kolkata Ombudsman Centre
Case No. 208/11/G3/NL/06/2012-13

Smt. Usha Shah

-vs-
United India Insurance Co. Ltd.,

Date of Order : 19th February, 2013
FACTS/SUBMISSIONS

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

The Complainant Smt. Usha Shah had stated in her complaint dated 30.05.2012 that she had taken a Health Insurance Policy for herself and her husband for an individual sum insured of Rs.2,25,000/- each under Gold Policy. She suffered from Trichodermal Cyst etc., in December 2011 and was hospitalized in Woodland Nursing Home for the period from 09.12.2011 to 11.12.2011. She submitted her claim to M/s. Medicare TPA Services for reimbursement. They settled her claim for Rs.11,660/- towards hospitalization and deducted Rs.56,498/- out of her total claim for Rs.68,158/-. She represented to the insurance company on 03.02.2012 against partial settlement, but the same was turned down.

The insurance company in their written submission dated 30.08.2012 have stated that the claim was lodged for Rs.68,158/- against her total sum insured of Rs.2,25,000/-. Since the health policy issued to her is subject to standard exclusions and conditions, they deducted certain amounts in compliance of the said policy conditions. They have referred the note under clause no.1.2c & D which reads as follows:-

"The amount payable under 1.2 C & D above shall be at the rate applicable to the entitled room category. In case insured opts for a room with rent higher than the entitled category as in 1.2 A above, the charges payable under 1.2 C & D shall be limited to the charges applicable to the entitled category",

Further, Note 2 under the same clause states inter-alia *"No payment shall be made under 1.2C other than as part of the Hospitalization bill."*

Accordingly, they have deducted Rs.28,000/- towards fees paid to the Doctor/ Surgeon/Assistant Doctors etc., as the same was not incorporated in the hospital bill as stated under Note 2 of Clause 1.2. TPA has further deducted Rs.2,300/- towards Investigation & like charges. This deduction was as per the entitled room category since the insured opted for room higher than the entitled category. Likewise, OT charges of Rs.8,775/- was proportionately reduced and they have disallowed Rs.4,704/-.

The insurance company have also given their consent for the Insurance Ombudsman to act as a mediator between the complainant and themselves and give his recommendation for the resolution of the complaint.

DECISION:

The complainant had approached this forum against disallowance Rs.56,498/- for inadmissible items under various heads. From the break-up of the deductions, it is seen that surgeon's/doctor's fee of Rs.28,000/- was totally disallowed as per note under clause 1.2 C of the policy. The claimant has submitted four separate bills; Rs.18,000/- paid to Dr. G.S.Pipara, the Surgeon, Rs.2,000/- paid to Dr. B.K.Jha, the Assistant Surgeon, Rs.3,000/- paid to Dr. B.M. Bhalotia, the Anesthetist charges and Rs.5,000/- paid to Dr. K.B.Singh for consultation fee during the period from 24.09.2011 till 11.12.2011. The entire amount was disallowed by the TPA as these bills were not included in the hospital bill. However, the note under clause 1.2 C says that no payment shall be made under 1.2C other than as part of the hospitalization bill. The word used is 'hospitalization bill' and not 'hospital bill'. Hospitalization was an event which includes all relevant expenses on surgery and treatment of the patient. The doctor/ surgeon fee is an integral part of the hospitalization expenses and it cannot be denied on the ground that it was not included in the hospital bill. The TPA's interpretation of the note under clause 1.2C has led to an absurd conclusion that the surgery was performed without the services of a surgeon. Therefore, the complainant is entitled to reimbursement of the doctor's fee except Rs.5,000/- paid to

Dr. K.B.Singh for consultation from the period prior to 30 days of the hospitalization and without giving date-wise break-up. This calculation was lso not correct as the note under policy condition no. 1.2 says that the amount payable under 1.2C & D shall be limited to the charges applicable to the entitled category. Since the TPA has not produced any certificate from the hospital that they are charging variable rates as per the room category, the full amount is to be allowed under this head. As regards deductions of Rs.6,417/- under the head medicines, the complainant had produced the batch number and expiry date of the medicine and therefore, this amount is also payable. The pre hospital doctor's fee of Rs.400/- and non admissible items of Rs.1,157/- have been correctly disallowed.

From the above, it is clear that the complainant is entitled to get a further amount of Rs.6,417/- (medicines) + Rs.4,704/- (O.T. charges) + Rs.2,300/- (investigation charges) + Rs.23,000/- (surgeon/ doctor's fee) subject to verification from the hospital about the variable rates applicable to different category of rooms under 1.2C & D. If such variable charges exist these expenses should be allowed as per entitled category. The insurer was directed to recalculate and pay the amount to the complainant.

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Kolkata Ombudsman Centre
Case No. 211/11/G1/NL/06/2012-13

Shri Duli Chand Chhajer

-vs-
The New India Assurance Company Ltd.,

Date of Order : 28th February, 2013
FACTS/SUBMISSIONS

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

The complainant, Shri Duli Chand Chhajer has stated in his complaints dated 20.10.2011 and 20.06.2012 that he was admitted at Belle Vue Clinic, Kolkaa on 22.12.2010 where he underwent right direct inguinal hernia on the same day and he was discharged on 24.12.2010.

At the time of hospitalization the TPA of the insurance company allowed Rs.65,000/- on cashless basis. Subsequently, he lodged a claim on 28.12.2010 for Rs.49,044/- to the TPA of the insurance company. Insurance company vide their letter dated 21.03.2011 settled Rs.38,111/- towards full and final settlement of the claim. He represented to the insurance company on 10.10.2011 against partial settlement, but the same was turned down.

The insurance company in their written submission dated 30.07.2012 have stated that an amount of Rs.10,933/- was deducted as per terms, conditions and limitations of policy, the clarification of which are given item-wise are noted below:-

(A) <u>DURING HOSPITALISATION</u>

Sl. No.	Date	Amount	Not payable
i)	23.12.2010	Rs. 500.00	RMO charge is not payable
ii)	23 & 24.12.2010	Rs.5,000.00	Since 1% of sum insured is agreed to be paid as per policy condition for room charge. Hence 1% of Rs.2 lakh is Rs.2,000/-. This multiplied by 2 days = Rs.4,000/- is payable and balance comes under deduction.
iii)	23.12.2010	Rs.1,663.40	Non-admissible item.
iv)	23.12.2010	Rs. 525.00	RMO charge is not payable
v)	23.12.2010	Rs.1,300.00	Charge for extra cot is not payable
vii)	23.12.2010	Rs. 350.00	Non-admissible item.
viii)	23.12.2010	Rs. 600.00	Non-admissible item.

(B) <u>PRE-POST HOSPITALISATION</u>

Sl. No.	Date	Amount	Not payable
i)	17.12.2010	Rs. 21.00	Charges for Xerox copies are not payable
ii)	27.12.2010	Rs.316.00	Medicine purchased without proper advice for medicine is not payable.
iii)	16.12.2010	Rs.158.00	Medicine purchased without proper advice for medicine is not payable
iv)	16.12.2010	Rs.500.00	Medicine purchased without proper advice for medicine is not payable

In view of the above the above amount is outside the scope of cover and their TPA is justified in deducting the non-admissible items as per terms and conditions of the policy.

DECISION:

The complainant had approached this forum against partial settlement of his claim due to deduction of inadmissible items. He has not disputed the deduction of Rs.5,000/- out of his claim of Rs.9,000/- in respect of bed charges. As regards consultation charges he has submitted the prescription and bill of Dr. S.J. Baig for Rs.500/-, therefore this amount is allowable. The charges of R.M.O of Rs.500/- + Rs.525/- are also allowable as these are not excluded in the policy conditions. Moreover, the charges had been included in the hospital bill. However, the fee of Dr. A.K. Agarwal cannot be considered for payment as there was no prescription. Similarly the deductions under medicines are not supported by prescription and original bills, therefore these disallowances are in order. The amounts disallowed under miscellaneous expenditures are in accordance with the policy terms and conditions.

In view of the above, the insurance company is directed to pay Rs.500/- towards consultation charges of Dr. S.J.Baig and R.M.O charges of Rs.500/- + Rs.525/- totalling Rs.1,525/- (Rupees one thousand five hundred twenty five only) to the complainant.

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Kolkata Ombudsman Centre
Case No. 225/11/G1/NL/06/2012-13

Shri Suman Neogy

-vs-

The New India Assurance Company Ltd.,

Date of Order : 28th February, 2013
FACTS/SUBMISSIONS

This complaint was filed against repudiation of claim under Individual Mediclaim Policy issued by The New India Assurance Company Ltd. on the ground that the treatment for ARMD fell outside the scope of the policy.

The complainant, Shri Suman Neogy has stated in his complaint dated 25.06.2012 that his mother Smt. Khuku Neogy was suffering from right eye problem and as per advice of Dr. P.K. Chatterjee she was admitted at Swasti Eye & Superspeciality Nursing Home, Kolkata on 12.07.2011 where intravitreal injection Lucentis was administered in her right eye and she was discharged on 13.07.2011.

He lodged a claim on 03.08.2011 for Rs.74,426/- to the TPA of the insurance company. The TPA vide their letter dated 09.08.2011 repudiated the claim stating that *"application of injection Lucentis is not payable under the scope of the policy".* He represented to the insurance company on 12.11.2011 against repudiation, but the same was turned down. Being aggrieved, by the decision of the insurance company, he approached this forum for redressal of his grievance seeking monetary relief of Rs.74,426/- as per 'P-II' form details. The complainant has given his unconditional and irrevocable consent for the Insurance Ombudsman to act as a mediator between himself and the insurance company and to give recommendation as per Form – P-III dated 20.07.2012.

The insurance company in their written submission dated 27.08.2012 have stated that as per their office circular No. HO/HEALTH/ CIRCULAR/04/ 2009-IBD ADMN: 14 dated 09.02.2009, administration of drugs like Avastin or Lucentis or Macugen and other related drugs for treatment of Age Related Macular Degeneration (ARMD) is excluded from the scope of cover under mediclaim policy (2007), Janata Mediclaim Policy, Sr. Citizen Mediclaim Policy, Group Mediclaim Policy. To this effect the following stamps are affixed on each subject policy.

1. 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.

2. All treatments like Age Related Macular Degeneration (ARMD) and of chorodial Neo Vascular Membrance done by administration of Lucentis/Avantis/Macugen/Avastin and other related drugs as intravitreal injection, Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), and Hyperberic Oxygen Therapy are excluded under this policy.

In view of the above, their TPA repudiated the claim on 09.08.2011 and the same is strictly in accordance with the existing terms and conditions of the policy.

The insurance company has also given their consent for the Insurance Ombudsman to act as a mediator between the complainant and themselves and give his recommendation for the resolution of the complaint.

DECISION:

The complainant has approached this forum against repudiation of his claim in respect of eye treatment of his mother with Lucentis injections and the treatment was considered as OPD procedure by the insurance company. From the facts presented to this forum we find that the insured was admitted in Swasti Eye & Superspeciality Nursing Home, Kolkata from 12.07.2011 to 13.07.2011 for administering the treatment. The claim was repudiated by the TPA of the insurance company vide insurance company's Head Office Circular dated 09.02.2009 considering the treatment for application of Lucentis is not payable under the scope of the policy.

The complainant has argued that in the policy issued to him during 20.01.2011 to 19.01.2012, there was no stipulation that the treatment may be treated as non-admissible. We have verified the policy document and find that the policy does not contain any endorsement regarding the exclusion of the treatment of ARMD with Lucentis. However, since the circular dated 09.02.2009 was already in existence at the time of the renewal of the policy on 20.01.2011, the case of the insured is to be guided by this circular. Although hospitalization was recommended by the doctor in this case, but the medical opinion is divided on the issue whether the treatment can be done in OPD/ Day Care Centres. In several cases, the treatment is administered without 24 hours admission. We are therefore, of the view that although the procedure requires sterilized conditions of an O.T. it cannot be strictly treated as a surgical procedure requiring compulsory hospitalization. However, we find that the contents of the circular were not communicated to the insured. He was totally in the dark regarding admissibility of the claim. The insured is an old customer of the company and deserves some relief for deficiency in service.

Considering all the above facts, we allow some relief by way of ex-gratia payment of Rs.20,000/- which will meet the ends of justice. We direct the insurance company to pay the above ex-gratia payment of Rs.20,000/- (Rupees Twenty Thousand only) to the complainant.

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