AHMEDABAD

GENERAL=INDIVIDUAL MEDICLAIM

Case No.11-009-1037-12
Mr. Bhadresh C. Borad Vs. Reliance General Insurance Co. Ltd.
Award dated 1st April 2013
Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Stress Urinary incontinence TOT placement and expense incurred for Rs.54,223/- was repudiated by the Respondent invoking exclusion clause No.19.

Investigation Report shows Valve insertion and at that time proved weakly positive pregnancy. Under policy clause 6, complication related pregnancy is excluded.

Complainant had not provided previous treatment papers.

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

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Case No.11-002-1055-12
Mr. Shailesh H. Satwara Vs. The New India Assurance Co. Ltd.
Award dated 2nd April 2013
Partial repudiation of Mediclaim

Complainant lodged a hospitalization expense claim of Rs.2,23,254/- for the treatment of surgery of Thrombosis-Left Tpo basis infarct was settled by the Respondent for Rs.1,38,018/- and balance amount of Rs.85,236/- deducted under condition No.2.3, 2.4 and note 2 of 2.6 of the mediclaim policy.

Complainant paid Surgeon charge separately by cash and doctor's home visit charges and also paid Anesthetist charge which was not payable by the Respondent. Hospital bill was not shown these expenses.

Considering all the above, Respondent's decision to settle the claim partially is right and proper so complaint dismissed.

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Case No.11-017-0085-13
Mr. Dipak R. Shah Vs. Star Health & Allied Insurance Co. Ltd.
Award dated 2nd April 2013
Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Laparoscopic Hysterectomy and claim lodged for Rs.61,533/- was repudiated by the Respondent invoking policy condition No.1- pre-existing disease.

As per records, hysterectomy was prior to the inception of policy. First consultation date of the doctor was 21-10-2010 and inception of policy was 20-12-2010.

This is the first year policy and pre-existing disease excluded for first 48 months from inception of policy.

In view of this, the complaint dismissed.

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Case No.11-004-0129-13
Mr. Amrutlal H. Acharya Vs. United India Insurance Co. Ltd.
Award dated 2nd April 2013
Repudiation of Mediclaim

Complainant underwent Robotic Prostatectomy at Asian Heart Institute, Mumbai and expense incurred Rs.3,90,463/- was repudiated by the Respondent stating that Robotic Prostatectomy is still considered as unproven and not get clearance by Insurance Company.

Complainant has history of HTN & DM. He is residing at Vadodara, not submitted any first consultation paper or reference letter from any doctors of Vadodara or Ahmedabad for recommend him to go to Mumbai Hospital.

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

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Case No.11-009-1054-12
Mr. Bhanubhai J. Bharwad Vs. Reliance General Insurance Co. Ltd.
Award dated 3rd April 2013
Repudiation of Mediclaim

Complainant hospitalized for treatment of his left leg injured due to fall and underwent plastic surgery for which incurred expense of approx. Rs.20,000/- was repudiated by the Respondent under Terms and Condition No.15 and 2 of Reliance Health wise policy.

Complainant had policy since 3 years but his claim rejected as No Claim.

As per Indoor case papers, the insured patient sustained injury due to fall down and because of monsoon season the injury was not healed hence resulted in to plastic surgery.

These are not believable by this forum hence complaint dismissed.

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Case No.11-004-1165-12
Mr. Jayeshkumar Shah Vs. United India Insurance Co. Ltd.
Award dated 4th April 2013
Partial settlement of Mediclaim

Complainant's wife hospitalized for treatment of Retinal detachment surgery and expense incurred for Rs.51,637/- was partially settled by the Respondent and deducted Rs.27,143/- invoking policy condition No.1.2.

Complainant's argument he is a policy holder since 2006-07 for S.I. Rs.50,000/- so his claim should be paid fully.

Respondent explained all deductions in details to the deduction memo which is right and proper.

Therefore complaint dismissed.

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Case No.14-009-0047-13
Mr. Kaushik D. Modi Vs. Reliance General Insurance Co. Ltd.
Award dated 4th April 2013
Partial repudiation of Mediclaim

Complainant's wife hospitalized for Knee replacement and expense incurred for Rs.2,05,213/- was partially settled by the Respondent for Rs.1,64,259/- on non standard basis which was accepted by the Complainant as full and final settlement of the claim.

There was no query within 7 days from the date of settlement of claim so Respondent fully discharged from the liability. Non compliance of required documents within 45 days from the date of claim file, Respondent settled claim on non standard basis.

Therefore complaint dismissed.

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Case No.11-009-0005-13
Smt. Kusumben B. Jadav Vs. Reliance General Insurance Co. Ltd.
Award dated 4th April 2013
Repudiation of Mediclaim

Complainant treated for Acute Dysentry AGE and expense incurred for Rs.31,023/- was repudiated by the Respondent under clause 15 and 2 of the Health wise policy.

Looking to the available documents of both the parties, the Forum also denied the claim, so complaint dismissed.

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Case No.11-004-1143-12
Smt. Sumanben Patel Vs. United India Insurance Co. Ltd.
Award dated 5th April 2013
Repudiation of Mediclaim

Complainant's deceased hospitalized for chemotherapy 3 time and three claims lodged totaling Rs.2,59,265/- was repudiated by the Respondent stating that chemo restricted to Sum Insured Rs.2.00 Lacs limit exhausted.

The insured was cancer patient and in the year of 2004 Carcinoma operation done total five claims paid amounting to Rs.2,06,793/- in all and declined remaining claims.

However complaint dismissed.

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Case No.11-004-1171-12
Mr. Jayesh A. Patel Vs. United India Insurance Co. Ltd.
Award dated 5th April 2013
Partial repudiation of Mediclaim

Complainant's son hospitalized for treatment of Dengu fever and expense claimed for Rs.15,329/- was partially settled by the Respondent for Rs.12,000/- as per PPN rate signed by the hospital and deducted by Rs.3.329/- on the ground of reasonable and customary charges.

The Respondent clearly explained the deductions and complainant failed to submit the P-II & P-III Proforma.

In view of this complaint dismissed.

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Case No. 11-004-1195-12
Mr. Hemant C. Mehta Vs. United India Insurance Co. Ltd.
Award dated 5th April 2013
Repudiation of Mediclaim

The Complainant took dental treatment due to accidental injury and expense incurred for Rs.16,871/- was repudiated by the Respondent invoking clause 2.3 and hospitalization period was less than 24 hours.

Complainant is a policy holder since 2003, treated due to bike accident but 24 hours hospitalization was not there.

Respondent not produced original claim papers for verification. On the basis of Xerox copies, the insured treated on OPD basis which is outside the scope of policy, hence complaint dismissed.

****

Case No.11-004-1202-12
Mr. Rajendra D. Shah Vs. United India Insurance Co. Ltd.
Award dated 5th April 2013
Partial repudiation of Mediclaim

Complainant hospitalized for treatment of B.P.H with structure Urethra with Bladder outlet obstruction and expense incurred for Rs.73,577/- was partially settled by the Respondent for Rs.38,251/- and balance deducted for Rs.35,326/- on the ground of reasonable and customary charges.

On scrutiny of claim documents, it is observed that no date in claim form and not mentioned policy number. Date of admission 2-6-2011 and date of discharge 3-6-2011 but Doctor issued a receipt dated 6-6-2011 for Rs.67,600/-, in the Discharge summary not signed by the doctor.

Considering all the Respondent's decision to deduct the claim partially is upheld and complaint dismissed.

****

Case No.11-002-1194
Mr. Prakash K. Solanki Vs. The New India Assurance Co. Ltd.
Award dated 8th April 2013
Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of back pain and expense incurred for Rs.13,764/- was repudiated by the Respondent as per clause 4.4.13 of Individual Mediclaim policy.

As per treating doctor, the treatment was related to pregnancy so claim rejected invoking clause 4.4.13.

Complainant could not prove the treatment was not related to pregnancy hence complaint dismissed.

****

Case No. 11-017-0128-13
Mr. Maganlal M. Wadhwani Vs. Star Health & Allied Insurance Co. Ltd.
Award dated 8th April 2013
Repudiation of Mediclaim

Complainant treated for CAG+PTCA and incurred Rs.1,52,405/- was repudiated by the Respondent giving reason that in the hospitalization period the policy was in break condition.

As per condition No.9, there was a grace period of 15 days from the date of expiry of policy is available whereas the policy renewed within 13 days from the date of expiry but hospitalization was in the break period so claim rejected by the Respondent.

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Case No.11-005-0078-13
Mr. Govind D. Patel Vs. Oriental Insurance Co. Ltd.
Award dated 8th April 2013
Repudiation of Mediclaim

Complainant treated his both the eyes for OT+ FFA+ Intra Vitreal Avastin Surgery +Laser Surgery and expense incurred for Rs.34,675/- was repudiated by the Respondent under clause 4.23, 5.4 and 5.5.

Respondent proved the treatment done on OPD basis and claim intimation and claim papers were not submitted in time.

Hence complaint dismissed.

****

Case No.11-008-1060-12
Shri Chandragopal K. Parikh Vs. Royal Sundram Allianz Insurance Co. Ltd.
Award dated 8th April 2013
Repudiation of Mediclaim

Complainant hospitalized for treatment of fever and incurred expense for Rs.12,000/- was repudiated by the Respondent under policy terms and condition No.6, overwriting in date of admission and no investigation was done related to ailment.

On scrutiny of available documents, it is proved the decision of the Respondent to repudiate the claim is upheld and complaint dismissed.

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Case No.11-002-1062-12
Mr. M.B. Chauhan Vs. The New India Assurance Co. Ltd.
Award dated 8th April 2013
Partial repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Laparoscopy + Lymphnode + Appendectomy and expense incurred for Rs.46,173/- was partially settled by the Respondent by deducting an amount of Rs.20,997/- invoking Policy condition No.2.3 and 2.4 note 2.

Respondent explained all deductions in detail, so the Forum also denied the remaining amount hence complaint dismissed.

****

Case No.11-008-1065-12
Mr. Manishkumar Patel Vs. Royal Sundaram Alliance Insurance Co. Ltd.
Award dated 9th April 2013
Repudiation of Hospitalization Benefit

Complainant claimed 6 days Hospitalization benefit for Rs.6000/- (1000 x 6) for treatment of Chronic gastritis with gall bladder was repudiated by the Respondent under pre-existing disease.

Hospital papers reveals, the symptoms for the past 1-2 years which is outside the scope of the policy, hence complaint dismissed.

****

Case No.11-009-1138-12
Mr. Rajesh Shah Vs. Reliance General Insurance Co. Ltd.
Award dated 9th April 2013
Repudiation of Mediclaim

Complainant treated for Retinal surgery and expense incurred for Rs.84,478/- was repudiated by the Respondent under clause 4.1 pre-existing disease and non disclosure of material information.

Complainant underwent surgery in the year of 2007 and policy incepted in the year 2008. Current illness is related to previous surgery which is considered pre-existing disease so complaint dismissed.

****

Case No.11-003-0143-13
Mr. Asitkumar D. Shah Vs. National Insurance Co. Ltd.
Award dated 9th April 2013
Partial repudiation of Mediclaim

Complainant's 73 years old mother hospitalized for treatment of eye surgery and expense incurred for Rs.62,309/- was partially settled by the Respondent for Rs.47,217/- by deducting an amount of Rs.15,092/- invoking policy condition 3.12.

Respondent explained reasons for deductions which is valid and proper hence complaint dismissed.

****

Case No.11-004-0091-13
Mr. Prakash J. Sangdane Vs. United India Insurance Co. Ltd.
Award dated 9th April 2013
Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Acute Bronchitis and expense incurred for Rs.16,816/- was repudiated by the Respondent due to discrepancy in date and time of admission & discharge and also discrepancy in age of the insured patient.

On scrutiny of available documents, the forum also denied the claim hence complaint dismissed.

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Case No.11-009-1174-12
Mr. Mohankumar C. Arora Vs. Reliance General Insurance Co. Ltd.
Award dated 9th April 2013
Partial repudiation of Mediclaim

Complainant hospitalized for treatment of piles and expense incurred for Rs.1,31,369/- was partially settled by the Respondent for Rs.80,000/- and deducted an amount of Rs.51,369/- on the ground of reasonable and customary charges.

The insured had not appealed to Insurance Company or TPA of the Respondent against the partial settlement of claim within 7 seven days from the date of receipt of payment.

In view of this complaint dismissed.

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Case No. 11-004-1209-12
Mr. Nitin R. Shah Vs. United India Insurance Co. Ltd.
Award dated 9th April 2013
Repudiation of Mediclaim

Complainant hospitalized for treatment of Cervical Epidural and expense incurred for Rs.25,298/- was repudiated by the Respondent invoking clause 2.3, the hospitalization is less than 24 hours.

On scrutiny of available documents proved that the insured was treated with pain killer for less than 24 hours. Hence Respondent's decision to reject the claim is upheld and complaint dismissed.

****

Case No.11-005-0009-13
Mr. Swetal H. Shah Vs. Oriental Insurance Co. Ltd.
Award dated 9th April 2013
Partial settlement of Mediclaim

A hospitalization expense of complainant's mother for Chronic Myositis and incurred for Rs.35,487/- was partially settled by the Respondent for Rs.30,404/- as full and final settlement of the subject claim which was agreed by the Complainant after Hearing.

In view of this complaint stands closed without any loss of the Complainant.

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Case No.11-002-0056-13
Mr. Shashikant C. Shah Vs. The New India Assurance Co. Ltd.
Award dated 9th April 2013
Partial repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Umbilical Hernia and incurred expense for Rs.28,093/- was partially settled by the Respondent for Rs.24,943/- and deducted an amount of Rs.3,150/- invoking policy condition No.3.13 and non medical items.

On scrutiny of available documents, it is proved the Respondent has rightly settled the claim hence complaint dismissed.

****

Case No.11-002-0074-13
Smt. Dinaben Patel Vs. The New India Assurance Co. Ltd.
Award dated 10th April 2013
Partial settlement of Mediclaim

Complainant's husband hospitalized for treatment of Metasta sis ER Neck and expense incurred for Rs.58,686/- was partially settled by the Respondent for Rs.35,090/- and deducted an amount of Rs.23,596/- invoking condition No.2.3.

On scrutiny of available documents, it is proved that the Respondent's decision to settle the claim partially is upheld and complaint dismissed.

****

Case No.11-009-1198-12
Shri Trunal R. Patel Vs. Reliance General Insurance Co. Ltd.
Award dated 10th April 2013
Repudiation of Mediclaim

Complainant hospitalized for treatment of ACL Tear Lt. Knee and expense incurred for Rs.66,870/- was rejected by the Respondent invoking pre-existing disease.

Respondent proved the insured was suffering from Knee problem for which insured was taking treatment since 2009 which was not disclosed in the proposal form.

In view of this complaint dismissed.

****

Case No.11-002-0051-13
Mr. Jawalant R. Patel Vs. The New India Assurance Co. Ltd.
Award dated 10th April 2013
Partial repudiation of Mediclaim

Hospitalization expense of the insured Complainant for treatment of Acute Fissure in Ano and incurred for Rs.54,647/- was partially settled by the Respondent for Rs.38,816/- and deducted Rs.18,661/- as per the PPN rate fixed by the Insurer with the PPN network hospitals.

Looking to the available documents, the Forum also denied the claim hence complaint dismissed.

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Case No.11-020-0101-13
Mr. Arjanbhai S. Makwana Vs. Universal Sampo General Ins. Co. Ltd.
Award dated 10th April 2013
Repudiation of Mediclaim

Complainant underwent cataract surgery and claim lodged for Rs.16,535/- was repudiated by the Respondent giving reasons that the treating hospital was having only 2 beds and another reason that the insured renewed the policy after a break of 4 days so it is considered as fresh policy and cataract surgery is not admissible in the first year.

Looking to all, the Respondent's decision is upheld and complaint dismissed.

****

Case No.11-004-1069-12
Mrs. Nrupa Ashwinbhai Patel Vs. United India Insurance Co. Ltd.
Award dated 10th April 2013
Partial repudiation of Mediclaim

Complainant hospitalized for surgery of Breast Cancer and expense incurred for Rs.85,707/- was partially settled for Rs.50,000/- and deducted Rs.35,707/- on the ground of MOU with PPN rate.

The insured patient directly contacted the cancer surgeon and admitted accordingly so there is no cashless facility allowed to the insured, so hospital had charged usual rate. Therefore complainant had no eligibility to get refund of remaining amount.

In view of this, complaint fails to succeed.

****

Case No. 11-005-1052-12
Shri Dineshbhai Ratanlal Shah Vs. Oriental Insurance Co. Ltd.
Award dated 11th April 2013
Partial repudiation of Mediclaim

Complainant hospitalized for treatment of both knees replacement and expense incurred for Rs.1,98,039/- was settled by the Respondent for Rs.1,70,500/-.

Respondent approved as per Sum Insured Rs.1,50,000/- + C.B Rs.22,500/- - Rs.2,000/- in each claim = Rs.1,70,500/- which is in order hence complaint dismissed.

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Case No.11-011-1064-12
Mr. Ehtiram Alam Khan Vs. Bajaj Allianz General Insurance Co. Ltd.
Award dated 12th April 2013
Repudiation of Mediclaim

A 20 years old insured daughter of the Complainant hospitalized for treatment of Vascular headache disease and expense incurred for Rs.14,616/- was repudiated by the Respondent under exclusion clause C-15 of the Individual Health Guard policy.

Policy incepted since March 2005, premium paying regularly without any break since last 7 years so medical expense relating to any hospitalization is not admissible is not a valid ground.

The same Health Guard policy condition A- cover medical expense, if you are hospitalized on the advice of a doctor because of illness then we will pay you reasonable and customary medical expense.

Considering all, the Respondent's decision is set aside and directed to pay admissible amount within 15 days from the date of receipt consent from the complainant.

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Case No.11-003-1068-12
Mr. Samir J. Shah Vs. National Insurance Co. Ltd.
Award dated 12th April 2013
Partial Repudiation of Mediclaim

Complainant hospitalized for treatment of Coronary Angiography and Angioplasty and total claim lodged for Rs.1,95,364/- was partially settled by the Respondent for Rs.94,250/- as per old Sum Insured.

The treatment taken was pre-existing which was a cap of four years. The enhanced Sum Insured is in the year of 2008-09 i.e. the treatment taken in the 3rd year of the policy hence claim considered on the basis of old Sum Insured.

Considering all above, Respondent's decision to settled the claim partially is upheld and complaint dismissed.

****

Case No.11-005-0103-13
Mr. Kush B. Shah Vs. Oriental Insurance Co. Ltd.
Award dated 12th April 2013
Repudiation of Mediclaim

Complainant's mother hospitalized for treatment of left hip fracture due to fall down and expense incurred for Rs.1,19,522/- was repudiated by the Respondent invoking late intimation and late submission of claim papers.

Complainant intimated to the Respondent late by 21 days from the date of hospitalization and submission of claim papers late by 12 days.

On scrutiny of hospital papers, it is observed that no signature of treating doctor in Discharge Summary and no first consultation paper is available.

In view of this, complaint dismissed.

****

Case No.11-002-0096-13
Mr. Hasmukhbhai R. Rathod Vs. The New India Assurance Co. Ltd.
Award dated 12th April 2013
Partial repudiation of Mediclaim

Complainant hospitalized for treatment of Head injury+ Lip injury+ Teeth injury and incurred expense for Rs.30,756/- was partially settled by the Respondent by deducting an amount of Rs.17,791/- invoking policy condition No.2.1, 2.3 and 2.4.

Out of this deducted amount of Rs.17,791/- dental treatment cost of Rs.14,700/- which is not admissible as per clause No.4.4.5. Hence Respondent's decision to settle the claim partially is upheld and complaint dismissed.

****

Case No.11-017-0055-13
Mr. Rashmin V. Patel Vs. Star Health & Allied Insurance Co. Ltd.
Award dated 15th April 2013
Repudiation of Mediclaim

Complainant's 4 years old son was hospitalized for treatment of Idiopathic Thrombocytopenic purpura and incurred expense for Rs.22496/- was repudiated by the Respondent on the ground of pre-existing disease. There is a cap of 4 years for the subject treatment hence Respondent's decision is upheld and complaint dismissed.

****

Case No.11-002-0073-13
Mr. Jagdishchandra Bhatt Vs. The New India Assurance Co. Ltd.
Award dated 15th April 2013
Repudiation of Mediclaim

Complainant treated for Cancer of Duodenum and expense incurred for Rs.98,596/- was rejected by the Respondent on the grounds of pre-existing disease due to the habit of tobacco chewing since 20 years.

On scrutiny of available documents, it is proved the Respondent's decision is right and proper hence complaint dismissed.

****

Case No.11-003-1076-12
Mrs. Nirmalaben J. Thakkar Vs. National Insurance Co. Ltd.
Award dated 15th April 2013
Repudiation of Mediclaim

Complainant hospitalized for treatment of frequent syncopal attack and complete heart block for which claim lodged for Rs.1,62,643/- was repudiated by the Respondent on the ground of pre-existing disease and non disclosure of material facts in the proposal.

As per hospital records insured was a known case of HTN & Diabetes since 15 to 22 years. Policy coverage of the insured is 4 years, this is the 4th year policy. Claim repudiated under exclusion clause 4.1 and 5.13 is right and proper.

In the result complaint fails to succeed.

****

Case No.11-002-1074-12
Smt. Varshaben H. Shah Vs. The New India Assurance Co. Ltd.
Award dated 15th April 2013
Partial settlement of Mediclaim

Complainant hospitalized for treatment of Right Trigeminal Neuralgia and total claim lodged for Rs.45,282/- was partially settled by the Respondent for Rs.17,787/- by deducting an amount Rs.27,495/-.

On scrutiny of treatment papers, create suspicion regarding inpatient treatment could be a case of OPD. There was no surgery but surgery charges shown as Rs.27,000/-.

Therefore Respondent settled the claim partially as per terms and condition No.2.10 is just and proper hence complaint dismissed.

****

Case No.11-002-1088-12
Mr. Trilokbhai N. Shah Vs. The New India Assurance Co. Ltd.
Award dated 16th April 2013
Partial repudiation of Mediclaim

Complainant hospitalized for treatment of double vessel disease and surgical treatment of PTCA done for which claim lodged for Rs.1,46,175/- was partially settled by the Respondent for Rs.35,000/- on the basis of old Sum Insured of Rs.35,000/- and rest of the amount rejected under exclusion clause 4.1.

Complainant S.I increased to 1.00 Lac in the year of 2008 but not disclosed the know case of DM & HTN in the proposal form or not paid additional premium for pre-existing disease.

Therefore Respondent's decision to repudiate partial payment under exclusion clause 4.1 & 5.5 is valid and proper. Hence complaint dismissed.

****

Case No.11-005-0118-13
Mr. Girdharilal Sarof Vs. Oriental Insurance Co. Ltd.
Award dated 16th April 2013
Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of viral fever and expense incurred for Rs.9,810/- was rejected by the Respondent stating that hospitalization is not required could have been on OPD basis.

On the opinion of the panel doctor, the insured underwent for fever and back pain but medicine prescribed was not related to fever only pain killer was given which could be on OPD basis.

In view of this, complaint dismissed.

****

Case No.11-004-0097-13
Mr. Sihrid B. Sheth Vs. United India Insurance Co. Ltd.
Award dated 16th April 2013
Partial settlement of Mediclaim

Cataract surgery expense of both the eyes of the complainant's wife was claimed for Rs.62,675/- was partially settled by the Respondent for Rs.50,175/- and deducted Rs.12,500/-on the ground of reasonable and customary charges under clause 3.11.

Complainant's argument as per policy condition No.1.2 N.D – Limits to be restricted to actual expense or 25% of S.I whichever is less, is valid and proper hence complaint succeeds.

****

Case No.11-005-0131-13
Mr. Shirishbhai R. Shah Vs. Oriental Insurance Co. Ltd.
Award dated 16th April 2013
Partial settlement of Mediclaim

A 73 years old insured complainant treated Cataract surgeries for his both eyes and total expense lodged for Rs.1,36,400/- was partially settled by the Respondent for Rs.1,03,000/- by deducting an amount of Rs.33,400/- as per reasonable and customary charges.

On scrutiny of available documents, it is proved that the Respondent rightly deducted the excess amount. Therefore complaint dismissed.

****

Case No.11-003-1095-12
Mr. Narendrasingh N. Vaghela Vs. National Insurance Co. Ltd.
Award dated 16th April 2013
Repudiation of Mediclaim

Complainant hospitalized for treatment of Cardio Embolic Infarct LV Myxoma and expense claimed was repudiated by the Respondent invoking clause 4.1 i.e. pre-existing disease.

According to Respondent the claim lodged in the 1st year of the policy and pre-existing disease covered after 4 years from inception of policy.

According to the complainant, policy incepted in the year of 2007 and renewed without any break up to 2010. In the year of 2011 the policy was cancelled by endorsement stating reason that cheque of the policy was cancelled due to Drawer Signature differ. Therefore 4th year policy considered as fresh one.

Hospital's paper does not show any previous history. Past history of treatment is not available.

In view of this, the complaint dismissed.

****

Case No.11-003-1067-12
Mr. Bipin S. Khatri Vs. National Insurance Co. Ltd.
Award dated 23rd April 2013
Repudiation of Mediclaim

Complainant's 2 years old baby girl was hospitalized for treatment of excision of bony growth and total expense lodged for Rs.25,285/- was repudiated by the Respondent invoking exclusion clause of 4.8 of the mediclaim policy which states congenital external disease or defects are excluded.

On scrutiny of available documents, the decision of the insurer is found in order. Therefore complaint dismissed.

****

Case No.11-002-1136-12
Mr. Prabodh A. Thakor Vs. The New India Assurance Co. Ltd.
Award dated 24th April 2013
Partial settlement of Mediclaim

Complainant's wife hospitalized for treatment of Rt. Breast Lump and expense claimed for Rs.96,120/- was partially settled by the Respondent for Rs.35,820/- and deducted Rs.60,300/- as per permanent exclusion clause of reasonable and customary expenses.

Hospital papers shows the 83 years old female has a known case of HBP & D.M since last 10 years, also P/H – 2 surgeries and 3 FTND but policy does not show any pre-existing disease.

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

****

Case No.11-002-1137-12
Mrs. Rohini R. Parekh Vs. The New India Assurance Co. Ltd.
Award dated 24th April 2013
Partial settlement of Mediclaim

Complainant hospitalized for knee joint replacement surgery and incurred an amount of Rs.3,54,036/- was partially settled by Respondent for Rs.2,27,500/- and denied Rs.1,24,000/- on the ground of policy condition No.3.6.

According to the Respondent, treating Surgeon is her son so Rs.1,10,000/- deducted for surgeon fee and assistant surgeon fee of Rs.14,000/- deducted because name of the assistant surgeon was not mentioned in the hospital documents.

All deductions and paid amount are clearly explained by the Respondent hence complaint dismissed.

****

Case No.11-004-0138-13
Mr. Kalpesh P. Shah Vs. United India Insurance Co. Ltd.
Award dated 25th April 2013
Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Vertigo and vomiting for which incurred expense for Rs.18,443/- was repudiated by the Respondent giving reason that the hospitalization was only for investigation purpose which is not payable as per policy terms and conditions.

On scrutiny of hospital papers it is proved that there was no line of treatment, it could have been taken on OPD basis hence complaint dismissed.

****

Case No.11-003-1107-12

Mr. Narayanbhai C. Patel Vs. National Insurance Co. Ltd.

Award dated 25th April 2013

Repudiation of Mediclaim

Complainant hospitalized for treatment of Convulsion, Confusion, Headache, Fever etc and expense claimed for Rs.50,000/- was repudiated by the Respondent giving reason that the insured was taken treatment in a declined list of hospital for cashless and reimbursement claims.

Respondent proved by submitting Judgment of Gujarat High Court hence complaint dismissed.

****

Case No.11-002-1146-12

Mr. Jayantilal P. Khamar Vs. The New India Assurance Co. Ltd.

Award dated 25th April 2013

Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Heart disease and claimed for Rs.15,811/- was repudiated by the Respondent under exclusion clause No.4.1

As per treating doctor's certificate the patient was a known case of HTN since 7-8 years. Further Respondent proved with concrete evidence that the Insured female has suppressed material facts in the Proposal dated 7-9-2007 while increasing S.I.

In view of this, the complaint dismissed.

****

Case No.11-004-0065-13

Mr. Kamleshkumar B. Gangwani Vs. United India Insurance Co. Ltd.

Award dated 25th April 2013

Repudiation of Mediclaim

Complainant's 14 years old son hospitalized on 16-11-2011 for treatment of blocked V/n Shut Rt. In an operative case of meningitis in October 2007 and incurred expense of Rs.85,395/- was repudiated by the Respondent on the grounds of late intimation and conditions pertaining to congenital disease.

Complainant stated that his son previously treated in the year of 2007 which papers were not produced, the disease is congenital diseases are excluded from the scope of coverage.

In the result complaint dismissed.

****

Case No.11-004-0086-13
Mr. Bhanushanker Bhatt Vs. United India Insurance Co. Ltd.
Award dated 25th April 2013
Partial repudiation of Mediclaim

Complainant hospitalized for treatment of Rt. Tibia & Fibula and incurred total expense of Rs.54,272/- was partially settled by the Respondent for Rs.44,819/- and deducted Rs.9,653/- as per clause 1.2A, C & D.

Complainant also claimed post hospitalization expense for Rs.4,681/- which was sanctioned for Rs.97/- but complainant have not received the same. Respondent agreed to release the amount immediately.

Complainant's argument to get penalty for late payment of 5 months, is not acceptable by this forum.

In view of this complaint dismissed.

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Case No.11-005-0139-13
Mr. Pankaj N. Mehta Vs. Oriental Insurance Co. Ltd.
Award dated 26th April 2013
Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Acute Appendicitis and expense incurred for Rs.16,846/- was repudiated by the Respondent invoking clause No.5.4 of the mediclaim policy.

Complainant informed the claim intimation given by fax to the TPA of the Respondent on the same day of the hospitalization and copy of the fax shown to this forum which is not legible. There is no other concrete evidence to prove that the claim intimation was given in time.

In view of this, complaint fails to succeed.

****

Case No.11-004-1214-12
Mr. Ajit K. Shah Vs. United India Insurance Co. Ltd.
Award dated 26th April 2013
Partial Repudiation of Mediclaim

Complainant treated for right Inguinal hernia and total claim lodged for Rs.26,227/- was settled by the Respondent for Rs.17,669/-as per PPN MOU rate.

According to the Respondent, the excess amount collected by the hospital should be refunded to the insured.

Respondent settled the claim as per policy condition No.3.11 – reasonable and necessary. Thus complaint dismissed.

Case No.11-009-0048-13
Mr. Sudhirbhai T. Pawar Vs. Reliance General Insurance Co. Ltd.
Award dated 26th April 2013
Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of low back pain and expense incurred for Rs.25,778/- was rejected by the Respondent on the grounds of no active treatment taken during hospitalization period invoking exclusion clause of the policy.

Complainant's argument his wife was admitted as per the advice of the doctor hence his claim should be paid.

The insured patient hospitalized for investigation purpose for only one day, the very next day patient discharged from hospital. The treatment could have been done on OPD basis.

Considering all the above complaint dismissed.

****

Case No.11-004-0058-13
Mr. Shailesh C. Shah Vs. United India Insurance Co. Ltd.
Award dated 26th April 2013
Partial repudiation of Mediclaim

Complainant hospitalized for treatment of Ring Finger due to injury and incurred total expense of Rs.19,080/- was partially settled by the Respondent for Rs.5,937/- and deducted Rs.13,143/- as per clause 1.2.

Hospital bill submitted with claim form was for Rs.1,500/-, subsequently complainant produced one another bill for Rs.11,500/- which can not be accepted.

Considering all above Respondent's decision to settle the claim partially is valid and proper hence complaint dismissed.

****

Case No.11-005-0117-13
Mr. Shirish P. Shah Vs. Oriental Insurance Co. Ltd.
Award dated 26th April 2013
Repudiation of Mediclaim

Complainant's hospitalization expense for treatment of Incisional Hernia with Septicemia for Rs.2,59,806/- was rejected by the Respondent giving reason that as per case papers of the treating hospital proves the insured underwent treatment related to Obesity grade –II.

Normally Hernia treatment cost comes to Rs.32,000/- to 49,500/- whereas the claim amount is Rs.2,59,806/-.

In the result complaint fails to succeed.

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Case No.11-002-0120-13
Shri Raman Vadilal Shah Vs. The New India Assurance Co. Ltd.
Award dated 26th April 2013
Repudiation of Mediclaim

Complainant's wife treated for Left eye Intra Vitreal Avastin Injection and incurred expense for Rs.65,026/- was repudiated by the Respondent giving reason that the said treatment can be an OPD basis which is excluded from the scope of cover.

On scrutiny of hospital papers shows one bill for Rs.3,200/- and another bill shows Rs.10,000/- which appears to be a case of administration for injection on different dates and not cataract surgery.

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

****

Case No.11-005-0011-13
Mr. Chirag Vakhariya Vs. Oriental Insurance Co. Ltd.
Award dated 30th April 2013
Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of abdominal pain and expense incurred for Rs.20,512/- was repudiated by the Respondent giving reason that current illness is complication of LSCS done in 2008 which is permanent exclusion clause 4.12 of Individual Mediclaim policy.

In the result complaint fails to succeed.

****

Case No.11-004-1213-12
Mr. Kamlesh P. Ghiya Vs. United India Insurance Co. Ltd.
Award dated 30th April 2013
Repudiation of Mediclaim

Complainant have mediclaim policy since last 14 years and this is the first claim he lodged for treatment of bilateral Inguinal Hernia for Rs.52,100/- was repudiated by the Respondent under policy condition 5.3.

Respondent submitted that in addition to clause 5.3, Exclusion clause 4.3 is operative as the treatment is excluded for 2 years, the subject policy is 2nd year.

Investigation Report shows past illness DM- since 5 years and present complaint since 6 months.

In view of this, complaint fails to succeed.

****

Case No.11-002-1100-12
Mr. Punjiram M. Patel Vs. The New India Assurance Co. Ltd.
Award dated 30th April 2013
Partial repudiation of Mediclaim

A 70 years old female insured was hospitalized for treatment of # of Tibia/Febula radius and Ulna for which expense incurred for Rs.94,399/- was partially settled by the Respondent for Rs.72,347/- and remaining amount of Rs.32,912/- deducted as per policy clause 2.1, 2.3 and 2.4.

The age of the insured patient shows in the policy as 66 years whereas hospital papers shown as 70 years. Pre-existing diseases shown in the policy as No whereas hospital papers reveal as known case of HTN and severe Arthritis. No additional premium has paid as per policy condition.

Claim Form indicates accidental injury for which no evidences are available.

Considering all the above, Respondent's decision to settle the claim partially is right and proper hence complaint dismissed.

****

Case No.11-002-1177-12
Mr. Sunil J. Shah Vs. The New India Assurance Co. Ltd.
Award dated 1st May 2013
Partial repudiation of Mediclaim

Complainant's wife underwent Hysterectomy surgery and expense incurred for Rs.47,827/- was settled by the Respondent for Rs.26,076/- and deducted Rs.21,751/- as per policy condition No.2.3 and note 2 of policy condition No.2.

On scrutiny of available documents of both the parties, the forum also denied the remaining amount of claim and complaint dismissed.

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Case No.11-002-1178-12
Mr. Jayeshbhai C. Patel Vs. The New India Assurance Co. Ltd.
Award dated 1st May 2013
Partial repudiation of Mediclaim

Complainant's wife hospitalized for treatment of accidental injury and expense incurred for Rs.85,685/- was settled by the Respondent for Rs.78,082/- and deducted Rs.7,000/- as per policy clause 3.13.

Since both the parties failed to submit relevant document, the Forum could not proceed for further, so complaint dismissed.

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Case No.11-009-0171-13
Mr. Bakulbhai K. Solanki Vs. Reliance General Insurance Co. Ltd.
Award dated 1st May 2013
Repudiation of Mediclaim

Complainant's wife treated for Enteric Fever and expense incurred for Rs.23,504/- was repudiated by the Respondent stating that the insured was treated in a declined list of hospital.

Looking to the available documents of both the parties, the Forum also denied the claim, so complaint dismissed.

****

Case No.11-002-1179-12
Mrs. Kavita Jain Vs. The New India Assurance Co. Ltd.
Award dated 1st May 2013
Partial repudiation of Mediclaim

Complainant underwent LAP Hernia surgery and expense incurred for Rs.1,69,234/- was settled by the Respondent for Rs.1,04,659/- and deducted Rs.64,575/- as per policy condition No.2.0 to 2.6 and 4.4.21 etc.

It is a suspicious complaint that one Mr. Sanjay Jain appeared for Hearing on behalf of Mrs. Kavita Jain who has reported that he is brother-in-law of the complainant and at present she is residing at Kolkatta on temporary basis.

In the complaint letter stated that my wife Kavita S. Jain but in the proposal form no where has mentioned her husband's name.

Considering all the above, complaint dismissed.

****

Case No.11-005-1144-12
Mr. Sumit Trivedi Vs. Oriental Insurance Co. Ltd.
Award dated 2nd May 2013
Repudiation of Mediclaim

Complainant's father hospitalized for treatment of CAD + HTN and expense incurred for Rs.1,93,837/- was rejected by the Respondent as per policy terms and Condition No.4.1, 4.6 and 4.17.

As per investigation report, this is the first year of the inception of policy, the subject treatment is excluded for two years.

Treatment papers reveal that the insured patient was a habit of tobacco chewing and treatment of obesity which was not disclosed in the proposal form at the time of taking the policy.

However Respondent's decision is upheld and complaint dismissed.

****

Case No.11-003-0149-13
Mrs. Harshaben K Daftary Vs. National Insurance Co. Ltd.
Award dated 2nd May 2013
Partial repudiation of Mediclaim

Complainant treated for Eye Cataract surgery and expense incurred for Rs.98,400/- was partially settled by the Respondent for Rs.61,400/- by deducting Rs.37,000/- as per policy clause No.4.12 reasonable and customary expense.

Complainant demanded deducted amount and interest of late settlement of claim.

Respondent repudiated the claim first as per clause 4.3, thereafter claim settled partially as per the H.O Circular.

On referring the available documents, the Respondent's decision to settle the claim partially is upheld and complaint dismissed.

****

Case No.11-002-1170-12
Mr. Indravadan M. Shah Vs. The New India Assurance Co. Ltd.
Award dated 2nd May 2013
Partial settlement of Mediclaim

Complainant underwent two operations as Supra Umbilical Mesh Hernioplasty and TURP and expense claimed for Rs.68,819/- was partially settled by the Respondent for Rs.54,938/- by deducting Rs.13,525/- as per policy clause No.2.

Respondent paid 100% for the first surgery and up to 50% for the second surgery, both surgeries were performed in continuation under single O.T. The deduction details are clearly explained in the settlement sheet.

Considering all the complaint dismissed.

****

Case No.11-004-1112-12
Mrs. Pushpaben D. Bhatt Vs. United India Insurance Co. Ltd.
Award dated 3rd May 2013
Partial repudiation of Mediclaim

Complainant's son hospitalized for treatment of Viral Hepatitis and expense incurred for Rs.25,487/- was partially settled by the Respondent for Rs.14,038/-as per the PPN rate with MOU.

Respondent explained in details for deductions but the complainant argued that he was not received any information about PPN rate and list of hospitals and also list of diseases. This information was published in News paper issued on May 14, 2011 by all four public sector General Insurance Companies which includes the Respondent.

In view of this complaint dismissed.

****

Case No.11-003-0148-13
Mrs. Sarojben V. Patel Vs. National Insurance Co. Ltd.
Award dated 6th May 2013
Repudiation of Mediclaim

Complainant's husband hospitalized for treatment of stricture Urethra and expense incurred for Rs.35,348/- was repudiated by the Respondent giving reason that patient was having pre-existing disease.

Complainant argued that for pre-existing diseases, extra premium was paying hence claim should be payable.

Extra premium was collected by the Respondent but in the proposal form only HTN & DM was mentioned, TURP operation and solitary kidney was not disclosed in the proposal.

Therefore Respondent claim repudiated due to non disclosure of material facts are right and proper and complaint dismissed.

****

Case No.11-003-0165-13
Mr. Dinesh M. Shah Vs. National Insurance Co. Ltd.
Award dated 6th May 2013
Partial repudiation of Mediclaim

Complainant hospitalized for removal of Ureteric Stone and expense incurred for Rs.41,186/- was partially settled by the Respondent by deducting an amount of Rs.19,964/- as per PPN MOU rate fixed to the hospital.

Respondent explained all deduction in details to the complainant as well as to this forum which is right and proper so complaint dismissed.

****

Case No.11-002-0161-13
Smt. Laxmiben R. Patel Vs. The New India Assurance Co. Ltd.
Award dated 6th May 2013
Partial repudiation of Mediclaim

Complainant treated for knee replacement and expense incurred for Rs.1,45,000/- was partially settled by the Respondent for Rs.35,000/- and deducted Rs.1,10,000/- as per Policy condition No. 4.1,4.2 & 4.3. The old Sum Insured was Rs.35,000/- up to 2008 thereafter enhanced sum insured Rs.1.00 Lac but there is a waiting period of 4 years for knee replacement.

In view of this, complaint dismissed.

****

Case No.11-004-1190-12
Mr. Rajesh Ramanlal Panchal Vs. United India Insurance Co. Ltd.
Award dated 6th May 2013
Partial repudiation of Mediclaim

Complainant hospitalized for treatment of IHD + Rheumatoid asthma and expense incurred for Rs.65,157/- was partially settled by the Respondent for Rs.20,164/-as per the PPN rate with MOU.

Respondent explained in details for deductions but the complainant argued that he was not received any information about PPN rate and list of hospitals and also list of diseases. This information was published in News paper issued on May 14, 2011 by all four public sector General Insurance Companies which includes the Respondent.

In view of this complaint dismissed.

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Case No.11-004-1110-12
Mr. Mahendra M. Kapadia Vs. United India Insurance Co. Ltd.
Award dated 6th May 2013
Partial repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Chickun Gunia like viral fever and expense incurred for Rs.31,288/- was partially settled by the Respondent for Rs.16,291/-as per the PPN rate with MOU.

Respondent explained in details for deductions that as per PPN rate fixed for the subject disease from 10,000/- to 14,500/- depending upon hospital grade. In this case Respondent settled Rs.16,291 in all which appears to be valid. The PPN rate was published in News paper issued on May 14, 2011 by all four public sector General Insurance Companies which includes the Respondent.

In view of this complaint dismissed.

****

Case No.11-003-0175-13
Mr. Dineshchandra M. Bhatt Vs. National Insurance Co. Ltd.
Award dated 6th May 2013
Repudiation of Mediclaim

Complainant hospitalized for treatment of Stricture Urethra and Inguinal Hernia and expense incurred for Rs.42,814/- was repudiated by the Respondent under policy clause 4.3.

The insured was above 65 years, as per guidelines of Baroda Health policy cover should not be after 65 years so complainant given wrong date of birth.

In view of this complaint dismissed.

****

Case No.11-004-1189-12
Mr. Harish K. Mehta Vs. United India Insurance Co. Ltd.
Award dated 6th May 2013
Partial repudiation of Mediclaim

A claim amount of Rs.36,356/- was lodged by the Complainant for his eye cataract surgery was partially settled by deducting Rs.15,000/- without any reason and according to the Respondent there was excess billing by hospital.

As per policy clause 1.2 – N.D cataract expense will be restricted to the actual incurred or 25% of S.I whichever is less. The S.I is Rs.2.00 Lac so the Forum directed the Respondent to make balance payment within 15 days after receipt of consent from the complainant.

****

Case No.11-003-0174-13
Smt. Nutanben R. Shah Vs. National Insurance Co. Ltd.
Award dated 6th May 2013
Partial settlement of mediclaim

Complainant's daughter hospitalized for treatment of Viral fever + Septicemia and expired during hospitalization due to cardio respiratory arrest. The total expense incurred was for Rs.44,256/- which was partially settled for Rs.35,500/- by the Respondent by deducting Rs.8,656/- due to exhaustion of limit C.

On scrutiny of available documents, Respondent settled the claim well within the terms and conditions of the policy.

Hence complaint dismissed.

****

Case No.11-004-1192-12
Shri Ashish K. Shah Vs. United India Insurance Co. Ltd.
Award dated 7th May 2013
Repudiation of Mediclaim

A claim amount of Rs.25,442/- was lodged by the Complainant for Naturopathy treatment was repudiated by the Respondent as per policy condition No.4.13 and 4.14.

Complainant's doctor certified this treatment is scientific approved but Respondent not accepted the clarification.

As per policy condition 4.14, Naturopathy treatment, acupuncture, acupressure, experimental and unproven treatments are not payable hence complaint dismissed.

****

Case No.11-003-0156-13
Shri Kailash N. Shah Vs. National Insurance Co. Ltd.
Award dated 7th May 2013
Partial settlement of mediclaim

A claim amount of Rs.50,000/- lodged by the Complainant for Cataract surgery expense of his insured wife was partially settled by the Respondent for Rs.38,260/- and deducted balance amount of Rs.11,740/- as per policy condition No.3.12.

Complainant had not submitted the original claim papers to the Respondent, if complainant can produce original hospital papers, Respondent agreed to pay Rs.7,000/-in addition.

Therefore complaint dismissed.

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Case No.11-002-0177-13
Mr. Maheshkumar R. Shah Vs. The New India Assurance Co. Ltd.
Award dated 7th May 2013
Partial repudiation of Mediclaim

Complainant's wife hospitalized for treatment of acute allergic bronchitis and expense incurred for Rs.18,538/- was partially settled by the Respondent for Rs.11,901/- and deducted Rs.6,637/- as per clause 2.3 and 2.4 of the Mediclaim policy.

Complainant produced doctor's written submission that due to non availability of eligible category room, hospital provided A.C room to the patient which is not acceptable by the Respondent.

Respondent deducted excess amount as per terms and conditions of the policy. Therefore complaint dismissed.

****

Case No.11-002-1196-12
Mr. Kairav U. Shah Vs. The New India Assurance Co. Ltd.
Award dated 7th May 2013
Partial repudiation of Mediclaim

Complainant done Kidney transplantation surgery and expense incurred for Rs.6,95,947/- was partially made cashless payment of Rs.2,33,000/- and repudiated Rs.4,62,947/- by the Respondent invoking Clause 4.4.16.

On request of the Insured, the TPA wrongly paid Rs.2,33,000/- as cashless which was asked the insured to refund after submission of claim papers.

On scrutiny of available documents, the forum also denied the claim hence complaint dismissed.

****

Case No.11-004-1192-12
Shri Ashish K. Shah Vs. United India Insurance Co. Ltd.
Award dated 7th May 2013
Repudiation of Mediclaim

A claim amount of Rs.25,442/- was lodged by the Complainant for Naturopathy treatment was repudiated by the Respondent as per policy condition No.4.13 and 4.14.

Complainant's doctor certified this treatment is scientific approved but Respondent not accepted the clarification.

As per policy condition 4.14, Naturopathy treatment, acupuncture, acupressure, experimental and unproven treatments are not payable hence complaint dismissed.

****

Case No.11-003-0156-13
Shri Kailash N. Shah Vs. National Insurance Co. Ltd.
Award dated 7th May 2013
Partial settlement of mediclaim

A claim amount of Rs.50,000/- lodged by the Complainant for Cataract surgery expense of his insured wife was partially settled by the Respondent for Rs.38,260/- and deducted balance amount of Rs.11,740/- as per policy condition No.3.12.

Complainant had not submitted the original claim papers to the Respondent, if complainant can produce original hospital papers, Respondent agreed to pay Rs.7,000/-in addition.

Therefore complaint dismissed.

****

Case No.11-002-0177-13
Mr. Maheshkumar R. Shah Vs. The New India Assurance Co. Ltd.
Award dated 7th May 2013
Partial repudiation of Mediclaim

Complainant's wife hospitalized for treatment of acute allergic bronchitis and expense incurred for Rs.18,538/- was partially settled by the Respondent for Rs.11,901/- and deducted Rs.6,637/- as per clause 2.3 and 2.4 of the Mediclaim policy.

Complainant produced doctor's written submission that due to non availability of eligible category room, hospital provided A.C room to the patient which is not acceptable by the Respondent.

Respondent deducted excess amount as per terms and conditions of the policy. Therefore complaint dismissed.

****

Case No.11-002-1196-12
Mr. Kairav U. Shah Vs. The New India Assurance Co. Ltd.
Award dated 7th May 2013
Partial repudiation of Mediclaim

Complainant done Kidney transplantation surgery and expense incurred for Rs.6,95,947/- was partially made cashless payment of Rs.2,33,000/- and repudiated Rs.4,62,947/- by the Respondent invoking Clause 4.4.16.

On request of the Insured, the TPA wrongly paid Rs.2,33,000/- as cashless which was asked the insured to refund after submission of claim papers.

On scrutiny of available documents, the forum also denied the claim hence complaint dismissed.

****

Case No.11-003-1186-12
Mr. Laxmanbhai P. Solanki Vs. National Insurance Co. Ltd.
Award dated 8th May 2013
Partial repudiation of Mediclaim

Complainant's daughter hospitalized for removal of Urinary Tract Infection and expense incurred for Rs.21,459/- was partially settled for Rs.11,929/- by the Respondent by deducting an amount of Rs.9,530/- as per policy condition No.3.12.

Respondent explained all deduction in details to the complainant as well as to this forum which is right and proper so complaint dismissed.

****

Case No.11-003-1106-12
Shri Mukesh J. Shah Vs. National Insurance Co. Ltd.
Award dated 8th May 2013
Partial settlement of mediclaim

Complainant's 82 years old mother hospitalized for treatment of Acute Renal failure and expense incurred for Rs.1,06,552/- was partially settled for Rs.50,000/- and deducted Rs.56,552/- by the Respondent giving reason that as per policy condition, Sum Insured was restricted only Rs.50,000/- for the treatment of Heart disease which was printed on the face of the policy. This rule was going on since 2003-04 up to 2010, there was no question arose by the complainant.

In view of this, complaint dismissed.

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Case No.11-002-0164-13
Mr. Prakashbhai R. Parikh Vs. The New India Assurance Co. Ltd.
Award dated 8th May 2013
Partial repudiation of Mediclaim

Complainant's wife treated for Ovarian Cyst and multiple Fibroids and expense incurred for Rs.8-,210/- was partially settled by the Respondent for Rs.48,634/- by deducting an amount of Rs.31,573/- as per policy condition No.2.3, 2.4 and Note 1 which was explained in the settlement sheet.

On scrutiny of available documents it is proved the Respondent deducted above amount is as per terms and conditions of mediclaim policy 2007 hence complaint dismissed.

****

Case No.11-003-1188-12
Mr. Manish P. Shah Vs. National Insurance Co. Ltd.
Award dated 9th May 2013
Repudiation of Mediclaim

Complainant hospitalized for treatment of Morbid Obesity and expense incurred for Rs.5,70,713/- was repudiated by the Respondent as per policy exclusion condition No.4.19.

Complainant produced a favourable award issued by this forum for same disease in 2008 so his claim should be paid.

Respondent proved through hospital papers and available documents the claim is not admissible hence complaint dismissed.

****

Case No.11-005-0166-13
Mr. Berulal G.Shamaria Vs. Oriental Insurance Co. Ltd.
Award dated 9th May 2013
Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Umbilical Hernia + HTN and expense incurred for Rs.36,244/- was repudiated by the Respondent as per exclusion clause No.4.19 of the policy.

Respondent informed the surgery of Hernia was due to morbid obesity which is permanently excluded as per policy condition No.4.19.

In view of this complaint dismissed.

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Case No.11-017-0228-13
Mr. Rameshbhai C. Lad Vs. Star Heal & Allied Insurance Co. Ltd.
Award dated 10th May 2013
Repudiation of Mediclaim

Complainant underwent bypass surgery and expense incurred for Rs.1,53,424/- was repudiation by the Respondent under clause 7 the policy which says non disclosure of material facts.

Complainant produced leave record of his employer where he is working since last 21 years and he has taken only one leave within five years which prove the insured complainant was good health.

Hospital papers reveal the treatment was for Triple Vessel Disease which will not develop within 3 months, the policy incepted before three months of treatment.

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

****

Case No.11-002-1104-12
Mr. Juzer Taherbhai Diwan Vs. The New India Assurance Co. Ltd.
Award dated 10th May 2013
Partial settlement of Mediclaim

A claim of Rs.30,786/- lodged by the complainant for surgery of his daughter for Rt. Tumpanoplasty (Type-I) was partially settled by the Respondent for Rs.15,787/- and deducted remaining amount of Rs.14,999/- under terms and condition No.2.1, 2.3 & 2.4 of Mediclaim policy.

Respondent clearly explained the deductions in the settlement letter which is as per policy terms and conditions.

In view of this complaint dismissed.

****

Case No.11-005-0178-13
Mr. Haresh C. Gidwani Vs. Oriental Insurance Co. Ltd.
Award dated 10th May 2013
Repudiation of Mediclaim

A claim amount of Rs.49,920/- lodged by the complainant for his treatment expense of Pneumonia and Gabhraman was repudiated by the Respondent giving reason that the insured was treated in a declined list of hospital. The copy of declined list of hospital is also dispatched with the policy hence Respondent's decision is upheld and complaint dismissed.

****

Case No.11-002-1104-12
Mr. Juzer Taherbhai Diwan Vs. The New India Assurance Co. Ltd.
Award dated 10th May 2013
Partial repudiation of Mediclaim

Complainant's 21 years old daughter hospitalized for treatment of Rt. Tumpanoplasty (type-II) and expense incurred for Rs.30,786/- was partially settled by the Respondent for Rs.15,787/- and balance Rs.14,999/- was deducted as per policy terms and condition No.2.1, 2,3 and 2.4.

On scrutiny of available documents, the forum also denied the remaining amount of claim, hence complaint dismissed.

****

Case No.11-002-1105-12
Mr. Hitendra S. Modi Vs. The New India Assurance Co. Ltd.
Award dated 10th May 2013
Partial repudiation of Mediclaim

Complainant's daughter hospitalized for treatment of Acute Appendicitis and expense incurred for Rs.69,360/- was partially settled by the Respondent for Rs.25,238/- by deducting Rs.44,122/- on the ground of MOU with PPN rate.

Respondent explained in details for deductions but the complainant argued that he was not received any information about PPN rate and list of hospitals and also list of diseases. This information was published in News paper issued on May 14, 2011 by all four public sector General Insurance Companies which includes the Respondent.

In view of this complaint dismissed.
****

Case No.11-003-0242-13
Shri Ashwinbhai R. Patel Vs. National Insurance Co. Ltd.
Award dated 11th May 2013
Repudiation of Mediclaim

Complainant's wife hospitalized for Hysterectomy surgery and expense incurred for Rs.98,038/- was repudiated by the Respondent giving reason that the insured was treated in a declined list of hospitals.

Respondent produced copy of judgment dated 14-05-2010 of Gujarat High Court for declined list of hospitals under four public section insurance companies wherein no cashless or no reimbursement of claim will be entertained from such hospitals. The insured was hospitalized after this decision so Complaint dismissed.
****

Case No.11-003-0239-13
Shri Rakeshhai R. Shah Vs. National Insurance Co. Ltd.
Award dated 11th May 2013
Repudiation of Mediclaim

Complainant's wife hospitalized for Vaginal Hysterectomy surgery and expense incurred for Rs.39,942/- was repudiated by the Respondent under pre-existing clause No.4.1.

Complainant's argument that this is the 5th year policy, four years continued with United India Insurance Co. and this is the first time renewed with National Insurance Co. so claim is applicable.

Respondent issued fresh Parivar policy on the basis of proposal form filled by the Complainant. At the time of taking policy complainant had not completed portability procedure to get continuity of other Insurance Co., so policy considered as fresh and there is a cap of four years for subject treatment.

Considering all the above, complaint dismissed.

****

Case No.11-002-1203-12
Mr. Hardik N. Shah Vs. The New India Assurance Co. Ltd.
Award dated 13th May 2013
Partial repudiation of Mediclaim

Complainant hospitalized for treatment of fever with chills, headache, body ace, weakness etc and expense incurred for Rs.16,746/- was partially settled by the Respondent for Rs.12,346/- by deducting Rs.4,400/- on the ground of MOU with PPN rate.

Respondent explained in details for deductions but the complainant argued that he was not received any information about PPN rate and list of hospitals and also list of diseases. This information was published in News paper issued on May 14, 2011 by all four public sector General Insurance Companies which includes the Respondent.

In view of this complaint dismissed.

****

Case No.11-002-1121-12
Mr. Mihir J. Barot Vs. The New India Assurance Co. Ltd.
Award dated 13th May 2013
Partial repudiation of Mediclaim

Complainant hospitalized for treatment of bleeding piles and expense incurred for Rs.37,309/- was partially settled by the Respondent for Rs.32,124/- by deducting Rs.5,185/- as per policy clause 3.13.

Respondent explained in details for deductions vide letter dated 5-2-2012 to the complainant.

In view of this complaint dismissed.

****

Case No.11-002-1123-12
Mr. Ashokbhai N. Shah Vs. The New India Assurance Co. Ltd.
Award dated 13th May 2013
Repudiation of Mediclaim

Complainant treated his lower teeth due to accidental fall in bathroom and expense incurred for Rs.26,706/- was repudiated by the Respondent invoking clause 1.0 of Mediclaim policy 2007 as there is no hospitalization.

The treating doctor's certificate also reveals procedure were done outdoor patient basis.

However complaint dismissed.

****

Case No.11-002-0168-13
Mr. Milan D. Bodawala Vs. The New India Assurance Co. Ltd.
Award dated 14th May 2013
Repudiation of Mediclaim

A claim amount of Rs.1,45,409/- lodged by the Complainant for treatment of Carcinoma Mucal Bucossa was repudiated by the Respondent under clause 4.4.6 of the Individual Mediclaim Policy.

Respondent proved through treatment papers that the insured patient had a habit of tobacco chewing since last 10 years.

On scrutiny of available documents, the forum also denied the claim and complaint dismissed.

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Case No. 11-002-0001-13
Mrs. Pravinaben L. Patel Vs. The New India Assurance Co. Ltd.
Award dated 14th May 2013
Partial repudiation of Mediclaim

Complainant's son hospitalized for treatment of Dengu fever and expense incurred for Rs.28,772/- was partially settled by the Respondent for Rs.17,500/- by deducting an amount of Rs.11,272/- under clause 2.1 of the mediclaim policy and also as per rate of PPN with MOU.

Therefore complaint dismissed.

****

Case No.11-004-0162-13
Mrs. Manjulaben B. Pandit Vs. United India Insurance Co. Ltd.
Award dated 15th May 2013
Repudiation of Mediclaim

Complainant hospitalized for treatment of Pneumonia, Asthma & HTN for which expense incurred for Rs.20,042/- was repudiated by the Respondent as per clause 4.1 of the Individual Mediclaim policy.

Complainant's argument she had covered mediclaim since last 4 years but as per record the previous policies are tailor made group mediclaim issued to a Master Policy holder there is no insurable interest. Individual policy covered since 2011 which is fresh one.

Therefore Respondent's decision is upheld and complaint dismissed.

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Case No.11-004-1091-12
Mr. Pritesh B. Trivedi Vs. United India Insurance Co. Ltd.
Award dated 15th May 2013
Partial repudiation of Mediclaim

Complainant hospitalized for Enteric Fever and expense incurred for Rs.16,150/- was partially settled by the Respondent for Rs.8,283/- giving reason that as per policy conditions and in order to entitled room category.

Complainant submitted another modified bill for availing benefit which was considered as bogus bill.

In view of this, Complaint dismissed.

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Case No.11-005-0150-13
Mr. Rajesh V. Macwana Vs. Oriental Insurance Co. Ltd.
Award dated 15th May 2013
Partial repudiation of Mediclaim

Complainant's wife operated for abdominal hysterectomy with appendectomy and expense incurred Rs.79,332/- was partially settled by the Respondent for Rs.44,849/- and rejected Rs.34,483/- as per the rate of PPN with MOU.

Respondent directed the hospital to refund the excess amount collected from the Complainant but the hospital replied that they have already withdrawn the PPN rate with MOU.

Respondent further stated that if hospital charging higher amount, the Insurer could pay limited amount only and balance will be rejected as per reasonable and customary expenses.

In view of this complaint dismissed.

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Case No.11-008-0157-13
Mr. Vipul Khokhar Vs. Royal Sundaram Alliance Insurance Co. Ltd.
Award dated 16th May 2013
Repudiation of Mediclaim

A claim amount of Rs.7,467/-lodged by the complainant for treatment of Enteric Fever by one insured female 27 years old was repudiated by the Respondent giving reason that fabricated records submitted for making fraudulent claim.

As per investigation, present hospitalization, when the policy is not in force hence complaint dismissed.

****

Case No.11-004-0179-13
Dr. Hirak I Desai Vs. United India Insurance Co. Ltd.
Award dated 16th May 2013
Partial repudiation of Mediclaim

Complainant hospitalized for treatment of varicose veins both lower limbs with pigmentation at ankle and claimed for Rs.95,830/- was partially settled by the Respondent for Rs.91,430/-by deducting Rs.4,400/- giving reason that Rs.400/- Admn. Charges & Rs.4000/- Anesthetist fee which is other than part of hospital bill.

On scrutiny of available documents, it is proved that the Respondent has rightly settled the claim hence complaint dismissed.

****

Case No.11-005-0163-13
Mr. Kamlesh V. Parikh Vs. Oriental Insurance Co. Ltd.
Award dated 16th May 2013
Repudiation of Mediclaim

Complainant hospitalized two times and two claims were lodged one for calculus treatment for Rs.47,678/- and another for Anterior cervical microdisectomy for Rs.66,104/-were repudiated by the Respondent as per policy condition No.4.3.

Complainant was having policy with United India which was not family floater policy so no eligibility to continuity. This is second year policy with Respondent and subject diseases excluded for first two years.

In the result complaint dismissed.

****

Case No.11-004-0160-13
Shri Kirit J. Mehta Vs. United India Insurance Co. Ltd.
Award dated 17th May 2013
Repudiation of Mediclaim

Complainant underwent 25 sitting of enhanced external counter pulsation therapy (EECP) @ Rs.3,500/- each sitting and total claim lodged for Rs.90,302/- was rejected by

the Respondent giving reason that the treatment could have been on OPD basis and it was an unproven method of treatment.

As per clause 2.3, minimum period of 24 hours hospitalization expenses is admissible. The subject claim the treatment taken on OPD basis so Respondent's decision is upheld and complaint dismissed.

****

Case No.11-017-0151-13
Shri Indravadan B. Bhavsar Vs. Star Health & Allied Insurance Co. Ltd.
Award dated 17th May 2013
Partial repudiation of Mediclaim

Complainant treated for Inguinal Hernia and expense incurred for Rs.46,325/- was partially settled by the Respondent for Rs.31,000/- by deducting Rs.15,325/- which includes non medical items, pre and post expenses under exclusion No.5 .

The policy is specially framed only for Senior citizens, therefore these conditions framed.

In view of this complaint dismissed.

****

Case No.11-004-0169-13
Mr. Ashwin H. Patel Vs. United India Insurance Co. Ltd.
Award dated 17th May 2013
Repudiation of Mediclaim

A claim amount of Rs.14,725/- lodged by the complainant for treatment of right sided Epidedymo Orchitis with funiculitis was repudiated by the Respondent as per policy condition No.4.3. This is the second year policy and the subject treatment is excluded for two years.

Hence complaint dismissed.

****

Case No.11-008-0158-13
Mr. Vipul Khokhar Vs. Royal Sundaram Alliance Insurance Co. Ltd.
Award dated 17th May 2013
Repudiation of Mediclaim

Complainant treated for Dengu fever and claim lodged for Rs.7,167/- was repudiated by the Respondent on the ground of fraudulent.

The claim form prepared by agent and submitted to Insurance Company by agent only which was not signed by the insured.

Therefore complaint dismissed.

****

Case No.11-003-0207-13
Mr. Jignesh K. Batavia Vs. National Insurance Co. Ltd.
Award dated 18th May 2013
Partial repudiation of Mediclaim

Complainant's son hospitalized for treatment of high grade fever on & off, pain in abdomen, nausea, vomiting, weakness etc and expense incurred for Rs.19,946/- was partially settled by the Respondent for Rs.12,869/- by deducting Rs.6,577/- on the ground of MOU with PPN rate.

Respondent explained in details for deductions but the complainant argued that he was not received any information about PPN rate and list of hospitals and also list of diseases. This information was published in News paper issued on May 12, 2011 by all four public sector General Insurance Companies which includes the Respondent.

In view of this complaint dismissed.

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Award Dated 13.06.2013
Case No. 11-002-0200-13
Sri P M Bhambha V/S New India Assurance Company Ltd.
Mediclaim Policy- Total Repudiation

The mediclaim was rejected as insured failed to produce hospital discharge summary.

The decision of the Respondent was upheld.

Award Dated 13.06.2013
Case No. 11-009-0201-13
Sri S A Patel V/S Reliance General Insurance Company Ltd.
Mediclaim Policy- Total Repudiation

The mediclaim for critical illness was rejected under clause 7 of the policy which states that claim for critical illness is payable only once in life of insured. As already claim for critical illness was paid, no claim was again payable.

The decision of the Respondent was upheld.

****

Award Dated 03.06.2013
Case No. 11-004-0173-13
Sri Piyush A Parekh V/S United India Insurance Company Ltd.
Mediclaim Policy- Partial Repudiation

The mediclaim was partially rejected under reasonable & necessary clause no. 1.2 (C) of the policy.

The decision of the Respondent was upheld.

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Award Dated 03.06.2013
Case No. 11-005-0170-13
Sri Mansinh D PArmar V/S Oriental Insurance Company Ltd.
Mediclaim Policy- Total Repudiation

The mediclaim was for treatment of Valve of heart, which was excluded for 4 years under clause 4.1 of the policy. This was second year of the policy.

The decision of the Respondent was upheld.

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Award Dated 03.06.2013
Case No. 11-004-0182-13
Sri M A Shah V/S United India Insurance Company Ltd.
Mediclaim Policy- Partial Repudiation

The mediclaim was partially rejected under reasonable & necessary clause of the policy. The hospital was covered under PPN MOU. So, claim was settled as per PPN rates fixed by the company.

The decision of the Respondent was upheld.
****

Award Dated 03.06.2013
Case No. 11-004-0167-13
Sri Ramesh R PAtel V/S United India Insurance Company Ltd.
Mediclaim Policy- Total Repudiation

The mediclaim was rejected due to late intimation and late submission of claim files violating clause 5.3 & 5.4 of the policy.

The decision of the Respondent was upheld.

****

Award Dated 04.06.2013
Case No. 11-009-0186-13
Sri N S Sheth V/S Reliance General Insurance Company Ltd.
Mediclaim Policy- Total Repudiation

The mediclaim was repudiated under pre-existing clause no. 1 of the company as insured had past history of Koch treatment, which was not disclosed at the time of taking insurance.

The decision of the Respondent was upheld.

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Award Dated 05.06.2013
Case No. 11-005-0180-13
Sri Devang C Brahmabhatt V/S Oriental Insurance Company Ltd.
Mediclaim Policy- Total Repudiation

The mediclaim was for cataract, which was excluded for 2 years under clause 4.3 of the policy. This was second year of the policy.

The decision of the Respondent was upheld.

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Award Dated 26.06.2013
Case No. 11-004-0212-13
Sri Prerak A Choksi V/S United Insia Insurance Company Ltd.
Mediclaim Policy- Total Repudiation

The mediclaim was rejected as insured was suffering from Lung disease before taking policy & same was not disclosed while taking policy. As per pre-existing clause, pre-existing disease is not payable during first four years of the policy. This was second year of the policy.

The decision of the Respondent was upheld.
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Award Dated 24.06.2013
Case No. 11-002-0213-13
Sri P N Patel V/S New India Assurance Company Ltd.
Mediclaim Policy- Partial Repudiation

The mediclaim was partially rejected under reasonable & necessary clause of the policy, as maximum Rs. 24000/- was payable for cataract under the policy as per policy condition.

The decision of the Respondent was upheld.
****

Award Dated 25.06.2013
Case No. 11-002-0209-13
Sri K J Gajjar V/S New India Assurance Company Ltd.
Mediclaim Policy- Partial Repudiation

The mediclaim was partially rejected under reasonable & necessary clause no. 3.13 of the policy.

The decision of the Respondent was upheld.
****

Award Dated 25.06.2013
Case No. 11-003-0215-13
Sri J C Jadeja V/S National Insurance Company Ltd.
Mediclaim Policy- Total Repudiation

The patient renewed the policy after 45 days, so it was treated as fresh policy. Hence pre-existing clause was operative. The claim for bowel disease was not payable during first three years of the policy. Hence, claim was repudiated. This was first year of the policy.

The decision of the Respondent was upheld.

****

Award Dated 28.06.2013
Case No. 11-004-0221-13
Sri S T Patel V/S United Insia Insurance Company Ltd.
Mediclaim Policy- Total Repudiation

The mediclaim was Hernia, which was due to Obesity. As per clause 4.9, Obesity related claims are not payable. So, claim was repudiated.

The decision of the Respondent was upheld.

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Award Dated 28.06.2013
Case No. 11-004-0225-13
Sri A J Patel V/S United Insia Insurance Company Ltd.
Mediclaim Policy- Total Repudiation

The mediclaim was repudiated due to late intimation of claim, which deprived company to investigate the veracity of hospital admission and genuineness of claim papers.

The decision of the Respondent was upheld.

****

Award Dated 28.06.2013
Case No. 11-004-0224-13
Smt S M Shah V/S United India Insurance Company Ltd.
Mediclaim Policy- Partial Repudiation

The mediclaim was partially rejected under reasonable & necessary clause no. 1.2 C of the policy.

The decision of the Respondent was upheld.

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Award Dated 27.06.2013
Case No. 11-004-0216-13
Sri Kantilal D Makwana V/S United India Insurance Company Ltd.
Mediclaim Policy- Partial Repudiation

The mediclaim was partially rejected under clause no. 1.2 C of the policy which states that other than part of hospitalization bill is not payable. As separate receipt was issued for Anesthetist fees etc, partial amount was rejected.

The decision of the Respondent was upheld.

****

Award Dated 19.06.2013
Case No. 11-002-0205-13
Sri M C Gadani V/S New India Asssurance Company Ltd.
Mediclaim Policy- Partial Repudiation

The mediclaim was partially rejected under reasonable & necessary clause of the policy. The hospital was covered under PPN MOU. So, claim was settled as per PPN rates fixed by the company.

The decision of the Respondent was upheld.

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Award Dated 11.06.2013
Case No. 11-004-0187-13
Sri B J Solanki V/S United India Insurance Company Ltd.
Mediclaim Policy- Total Repudiation

The mediclaim was for Sinus, which was excluded for 2 years under clause 4.3 of the policy. This was second year of the policy.

The decision of the Respondent was upheld.

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Award Dated 10.06.2013
Case No. 11-004-0193-13
Sri Amrut J Patel V/S United India Insurance Company Ltd.
Mediclaim Policy- Total Repudiation

The mediclaim was rejected due to late intimation and late submission of claim files violating clause 5.3 & 5.4 of the policy.

The decision of the Respondent was upheld.
****

Award Dated 11.06.2013
Case No. 11-004-0192-13
Sri Sandip V Patel V/S United India Insurance Company Ltd.
Mediclaim Policy- Total Repudiation

The mediclaim was rejected due to congenital disease and misleading information provided by the insured.

The decision of the Respondent was upheld.
****

Award Dated 11.06.2013
Case No. 11-002-0190-13
Sri K N Bhatt V/S New India Assurance Company Ltd.
Mediclaim Policy- Partial Repudiation

The mediclaim on increased sum insured was repudiated as per pre-existing clause 4.3 of the policy.

The decision of the Respondent was upheld.
****

Award Dated 06.06.2013
Case No. 11-002-0189-13
Sri D C Gadani V/S New India Assurance Company Ltd.
Mediclaim Policy- Partial Repudiation

The mediclaim was partially rejected under reasonable & necessary clause of the policy. The hospital was covered under PPN MOU. So, claim was settled as per PPN rates fixed by the company.

The decision of the Respondent was upheld.

****

Case No.11-004-0256-13
Award dated 12.7.2013

Shri Shailesh V. Pujara Vs. United India Insurance Co. Ltd.

Repudiation of Mediclaim
Cashless claim for Rs.13,142/- was already settled by the Insurance Co. Post Hosptialistion claim for Rs.7979/- was repudiated as per clause 5.4 of terms and conditions of the policy. The post hospitalisation claim papers submitted were submitted late by 16 days. The claim was repudiated on 18.1.2010 pertains to the year 2009. The complainant approached the forum only in the year August 2012. Thus it is beyond the jurisdiction of this Forum as per RPG Rules, 1998 Rule no. 13(3).
****

Award dated 10.7.2013
Case No.11-008-0236-13
Shri Haribhai Patel Vs. The Royal Sundaram Alliance Insurance Co. Ltd.
Repudiation of Mediclaim
Mediclaim of son of the complainant was repudiated by the Respondent giving reason that hospitalisation papers were found to be fraudulent. Elaborate investigation report of the Respondent found the claim inadmissible as per policy condition no.11. The decision of the Respondent was upheld.
****

Award dated 17.7.2013

Case No.11-002-0260-13

Shri Chintan M Patel Vs. The New India Assurance Co. Ltd.

Repudiation Mediclaim

Mediclaim was settled partially deducting R.6120/- on the grounds of clause 3.13 i.e., reasonable and customary charges. The decision of the Respondent was found proper and upheld.

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Award dated 16.7.2013

Case No.11-004-0252-13

Smt. Pushpaben N. Patel Vs. United India Insurance Co. Ltd.

Repudiation of Mediclaim

Mediclaim for Rt. Eye Cataract of the Complainant was partially settled after deducting Rs.9731/-. The complainant underwent treatment at Vadodara Hospital, while Insured's address as per policy belonged to Mumbai. There was no clear evidence as to show that the Insured person and the patient are one and the same. Hence the demand for balance claim amount could not be accepted and the complaint was dismissed.

****

Award dated 12.7.2013

Case No. 11-005-0244-13

Shri Mihir Vaghani Vs. Oriental Insurance Co. Ltd.

Repudiation of Mediclaim

Mediclaim of the father of the complainant aged 61 years for Neurological deficit + HTN for Rs.87,269/- was settled only for Rs.675/- giving reason that the subject disease was not payable in first two years of the policy and disease was pre-existing at the time of taking policy. The complainant failed to provide consultation papers. There was no new ground found to interfere with the decision of the Respondent to repudiate the subject claim as per policy clause 4.3 (xx) and 4.1.

The complaint was dismissed.

****

Award dated 11.7.2013

Case No. 11-003-0249-13

Shri Kalpesh Toliya Vs. National Insurance Co. Ltd.

Repudiation of Mediclaim

Mediclaim of Master Yash Toliya, son of the complainant for "Nutritional Anemia" was denied by the Insurance Company on the grounds of exclusion clause no. 4.8 i.e., General debility excluded. The discharge summary and doctor's certificate stated that the Insured was suffering from Nutritional Anemia.

The complaint was dismissed.

****

Award dated 11.7.2013

Case No.11-002-0235-13

Shri Kamal Mangaldas Vs. The New India Assurance Co. Ltd.

Repudiation of Mediclaim

Mediclaim for treatment of Bilateral Ingunial Hernia was settled partially deducting Rs.1,38,000/- on the grounds of policy clause 2.3 and 2.4 stating the insured opted for higher room category. Insured was eligible for 1% of S.I. Rs.5 lacs Rs.5000/- per day. Whereas the Insured opted for room for Rs.8000/- per day. Accordingly further deductions were made. The decision of the Respondent was found proper and upheld.

Award dated 11.7.2013

Case No.11-002-0237-13

Shri R S Gami Vs. The New India Assurance Co. Ltd.

Repudiation of Mediclaim

Mediclaim for treatment of TIBP + CAD was settled partially deducting Rs.91,478/- out of total claim of Rs.3,02,288/-. Since the Respondent was absent, the claim papers could not be verified in absence of original claim/policy papers. The complaint was dismissed.

Award dated 10.7.2013

Case No.11-013-0232-13

Shri SURESH M PATEL Vs. The HDFC Ergo General Insurance Co. Ltd.

Repudiation of Mediclaim

The Complainant reportedly fell from the bike and sustained injuries for which he was hospitalized. During the treatment, he was diagnosed with Unstable Angina and was treated with Angioplasty. Myocardial Infarction angina was specifically excluded from the policy. There was no new ground found to interfere with the decision of the Respondent to repudiate the claim as per policy section III. The complaint was dismissed.

Award dated 19.7.2013

Case No. 11-005-0258-13 Roopsingh Verma Vs. Oriental Insurance Co. Ltd.

Repudiation of Mediclaim

Mediclaim of the wife of the complainant aged 56 years for CAG + CABG for Rs.1,32,500/- was settled only for Rs.50,000/- as cashless invoking policy condition no. 4.1 to 4.3 pre-existing disease. The claim payment was made to insured whatever sum insured was applicable i.e., Rs.50,000/-. The Insured underwent CABG Surgery, the disease related to heart cannot be developed overnight. The decision of the Respondent was upheld.

Award dated 22.7.2013

Case No.11-002-0262-13

Smt. Usha Rao Vs. The New India Assurance Co. Ltd.

Repudiation of Mediclaim

Mediclaim for treatment of Accidental Injury was settled by the Respondent. Whereas the post hospitalisation claim for Physiotheraphy was denied by the Insurance Company on the grounds of permanent exclusion clause no. 4.4.17. There was no advice for Physiotheraphy after the date of discharge. Thus the claim was beyond the scope of the policy. the complaint was dismissed.

Award dated 16.7.2013

Case No. 11-005-0243-13

Shri Dhruv S. Mehta Vs. Oriental Insurance Co. Ltd.

Repudiation of Mediclaim

Mediclaim of the father of the complainant aged 53 years for CAD + Unstable Angina for Rs.1,78,374/- was repudiated invoking policy condition no. 4.3 pre-existing disease has waiting period for 2 years. The complaint was dismissed.

Award dated 16.7.2013

Case No.11-002-0253-13

Shri Ashok T. Ganatra Vs. The New India Assurance Co. Ltd.

Repudiation of Mediclaim

Mediclaim for total Rs.43,412/- for treatment of fracture of right femur was settled partially for Rs.38,507/- deducting Rs.4,905/-. The deduction was found proper as per clause 1.0D. The complaint was dismissed without any further relief to the complainant.

Award dated 16.7.2013

Case No.11-009-0250-13

Shri Alkesh M. Shah Vs. The Reliance General Insurance Co. Ltd.

Mediclaim Policy

Mediclaim for total Rs.39,198/- for treatment of Para Umbilical Hernia of wife of the complainant was rejected under policy exclusion clause no. 10. The illness was due to obesity. Hence the repudiation was found proper. The complaint was dismissed without any relief to the complainant.

Award dated 15.7.2013

Case No.11-002-0245-13

Shri Sanjiv B. Kapadia Vs. The New India Assurance Co. Ltd.

Repudiation of Mediclaim

Mediclaim for total Rs.96,329/- for surgery of Parotid Tumor was rejected on the grounds of waiting period of 2 years. Though the Insured was insured with United India Insurance Co. ltd. before having insured with the New India Assurance Co. Ltd. The Complainant did not submit any details in respect of previous insurance. The decision of the Respondent was upheld.

Award dated 16.7.2013

Case No.11-002-0248-13

Shri Niren N. Shah Vs. The New India Assurance Co. Ltd.

Mediclaim Policy

Mediclaim for total Rs.1,18,861/- for treatment of sleep amnoea alongwith respiratory failure was partially settled only for Rs.28,351/-. The dispute was about non payment of Rs.90,000/- incurred for rent of BIPAP machine after discharge. There was no ground to interfere with the decision of the Respondent to repudiate the claim partially as per policy permanent clause no. 4.4 (15) of Individual Mediclaim Policy, which excluded Instrument used in sleep anpe syndrome etc.

Award dated 16.7.2013

Case No.11-002-0248-13

Shri Niren N. Shah Vs. The New India Assurance Co. Ltd.

Repudiation of Mediclaim

Mediclaim for total Rs.1,18,861/- for treatment of sleep amnoea alongwith respiratory failure was partially settled only for Rs.28,351/-. The dispute was about non payment of Rs.90,000/- incurred for rent of BIPAP machine after discharge. There was no ground to interfere with the decision of the Respondent to repudiate the claim partially as per policy permanent clause no. 4.4 (15) of Individual Mediclaim Policy, which excluded Instrument used in sleep anpe syndrome etc.

Award dated 12.7.2013

Case No.11-004-0238-13

Shri Yogesh Mehta Vs. The United India Assurance Co. Ltd.

Repudiation of Mediclaim

Mediclaim for Angioplasty for total Rs.1,92,470/- was rejected on the basis of diabetes invoking clause no. 4.1 pre-existing diseases not covered until 48 months of continuous coverage. The subject policy issued to a Group Master Policyholder without insurable interest in 2008. The complaint was dismissed.

Award dated 4.7.2013

Case No.11-002-0227-13

Shri U P Patel Vs. The New India Assurance Co. Ltd.

Repudiation of Mediclaim

Mediclaim for total Rs.33,340/- was paid for Rs.27,254/- deducting Rs.6086/- invoking clause 2.1, 2.3 and 2.4 for treatment of Ureteric colic. Room rent opted by the complainant was higher than the eligibility. The eligibility of room was 1% of S.I. which was exceeded. Accordingly, other deductions were made and were found proper. The complaint was dismissed.

Award dated 37.2013

Case No.11-004-0219-13

Shri Prakash K. Chauhan Vs. The United India Assurance Co. Ltd.

Repudiation of Mediclaim

Mediclaim for Angioplasty for total Rs.1,35,621/- was rejected on the basis of k/c/o Diabetes Mellitus and High Blood Pressure invoking clause no. 4.1 pre-existing diseases not covered. The complaint was dismissed.

Award dated 2.7.2013

Case No.11-002-0222-13

Shri Vinodkumar P. Sanghvi Vs. The New India Assurance Co. Ltd.

Repudiation of Mediclaim

Mediclaim for total Rs.1,45,008/- was rejected on the basis of k/c/o Hypertension invoking clause no. 4.1 pre-existing diseases not covered. The past history has been wrongly mentioned by the Doctor was not accepted and the complaint was dismissed.

Award dated 8.7.2013

Case No.11-002-0240-13 & Case No. 11-002-0241-13

Ms. Ritaben J. Shah Vs. The New India Assurance Co. Ltd.

Repudiation of Mediclaim

Two mediclaims were lodged by the same complainant for Fibriod Uterus. First claim for Rs.40,106/- was partially settled for Rs.33,698/-, whereas second claim for Rs.70,153/- was partially settled for Rs.62,153/-. The second hospitalisation was immediately after the discharge from the first Hospital. The deductions under both the claims were proper as per clause 3.13 i.e., customary and reasonable expenses. The complaint was dismissed without further relief to the complainant.

Award dated 8.7.2013

Case No. 11-005-0234-13

Shri Abhishek Mehrotra Vs. Oriental Insurance Co. Ltd.

Repudiation of Mediclaim

The mediclaim of new born male child after delivery was repudiated by the Insurance Company as the treatment was for congenital disease of the new born child which was excluded under special conditions applicable to maternity and new born child cover benefit extension. Further the complaint was lodged beyond the one year period specified in the RPG Rules. The complaint was dismissed.

Award dated 8.7.2013

Case No. 11-005-0231-13

Shri Bhavesh R. Shah Vs. Oriental Insurance Co. Ltd.

Partial Repudiation of Mediclaim

Mediclaim for Rs. 15,876/- for hospitalisation of son of the complainant for viral fever was settled in partial for Rs.10,180/- as per Preferred Provider Network Hospital. There was no advice for admission also. The decision of the Respondent to settle the claim in partial was upheld.

Award dated 17.7.2013

Case No. 11-020-0259-13

Shri Narendra Sangani Vs. Universal Sompo General Insurance Co. Ltd.

Repudiation of Mediclaim

The mediclaim for Rt. Eye Cataract of wife of the complainant was repudiated invoking clause no. 1 i.e. Misdescription and non-disclosure of surgery of left eye while filling proposal form. The explanation that the Proposal form was signed blank was not accepted. The decision of the respondent was upheld.

Award dated 15.7.2013

Case No. 11-003-0246-13

Shri Dhiren M. Patel Vs. National Insurance Co. Ltd.

Repudiation of Mediclaim

Mediclaim for Rs.11,551/- of the wife of the complainant for acute bronchitis was rejected by the Respondent invoking clause no. 4.2 i.e., waiting period of 30 days. Insured underwent treatment during first 30 days of commencement of policy. Insured was holding policy with another insurance company before this policy and continuity benefit was not given to the Insured.

The complaint was dismissed.

Award dated 16.7.2013

Case No. 11-003-0255-13

Shri Rasiklal M. Zatakia Vs. National Insurance Co. Ltd.

Repudiation of Mediclaim

Mediclaim of wife of the complainant for Kidney Care Dialysis was repudiated on the grounds of clause no. 4.15 which stated that such disease PKD is genetic disorder which falls outside the scope of the policy.

The complaint was dismissed.

Award dated 23.7.2013

Case No. 11-005-0268-13

Shri S. V. Vasani Vs. Oriental Insurance Co. Ltd.

Repudiation Mediclaim

Smt. Nishaben Vasani, wife of the complainant was treated for Multiple Uterine Fibroids. The mediclaim for Rs.34,465/- was denied by the Respondent invoking clause no. 4.3 i.e., waiting period of two years. The symptoms of illness manifested in the 2nd year of policy which attracted clause 4.3(9). The complaint was dismissed.

Award dated 29.7.2013
Case No.11-002-0278-13
Shri Shammi L. Sheth Vs. The New India Assurance Co. Ltd.
Repudiation of Mediclaim
The mediclaim for ectopic kidney for Rs.72,990/- was partially settled for Rs.12,355/- under clause 3.13 i.e., Customary and reasonable expenses and under clause 4.4.21 which stated that expenses including convenient items for personal comfort are not payable. The deductions found were proper and the complaint was dismissed without any further relief to the complainant.

Award dated 29.7.2013
Case No. 11-005-0276-13
Smt. Sarojben Patel Vs. Oriental Insurance Co. Ltd.
Repudiation Mediclaim
Complainant was treated for lt.
Renal Pelvis Calculus and got cashless claim of Rs.17,109/-. The maximum payable amount was already paid as per terms and conditions of GIPSA PPN with hospital. Hence the complaint was dismissed.

Award dated 26.7.2013
Case No.11-004-0280-13
Shri Narayan K. Verma Vs. The United India Assurance Co. Ltd.
Repudiation of Mediclaim
Mediclaim for Typhoid for total Rs.80,000/- was rejected on the grounds of claim papers submitted late. Delay in submission of claim papers prevented the insurer to investigate into the matter which aggravated the claim. The decision of the Respondent was upheld.

Award dated 29.7.2013
Case No.11-002-0263-13
Dr. Niranjan D. Modh Vs. The New India Assurance Co. Ltd.

Repudiation Mediclaim

The mediclaim of the son of the complainant lodged for Mediastinal Lymph Node and Mediastinoscopy + biopsy for Rs.78,542/- was partially settled for Rs.41,329/- under clause 2.1, 2..3 and 2.4. The complaint was dismissed.

Award dated 29.7.2013

Case No.11-002-0272-13

Shri Saurin R. Patel Vs. The New India Assurance Co. Ltd.

Repudiation Mediclaim

The mediclaim of Rs.12,053/- for surgery circumcision was partially settled for Rs.4233/- as per PPN MOU. Further, the Respondent stated that as per permanent exclusion clause no. 4.4.2, circumcision is not payable. The complaint was dismissed.

Award dated 29.7.2013

Case No.11-004-0265-13

Shri Vinayak M. Parekh Vs. The United India Assurance Co. Ltd.

Repudiation Mediclaim

Two mediclaims of Complainant self and his wife Smt. Renukaben, were partially settled by the complainant. First claim of wife of the Complainant for Rs.31517/- was settled for Rs.22,016/-. Second claim for treatment of dislocation of Lt. shoulder for Rs.5014/- was settled for Rs.4364/-. Third claim of wife of the complainant again for Rs.9060/- was settled for Rs.7081/- on the grounds of excess nursing charges. The decision of the Respondent was upheld without any further relief to the complainant.

Award dated 9.7.2013

Case No. 11-003-0223-13

Smt. Mini Somrajan Vs. National Insurance Co. Ltd.

Repudiation Mediclaim

Mediclaim lodged for Rs.1,24,000/- plus for Lt. Frontal Glioma and underwent Navigation guided frontal Craniotomy and excision of Lesion. The Insurance Company repudiated the claim under the clause 4.1 of pre-existing disease. The Pre-existing disease is not payable during first four years of the policy. This was the 4th year of the policy. The complaint was dismissed.

Award dated 5.7.2013

Case No.11-004-0226-13

Shri Anil N. Patel Vs. The United India Assurance Co. Ltd.
Repudiation Mediclaim

Mediclaim for treatment of complainant's wife for swelling on Lt. Foot was repudiated by the Insurance Company on the grounds of clause 4.10 i.e., no active line of treatment given and the admission was only for Diagnostic purpose. The decision of the Respondent was upheld.

Award dated 29.7.2013
Case No. 11-005-0281-13
Ms. Bina S. Shah Vs. Oriental Insurance Co. Ltd.

Right Eye treatment taken by the mother-in law of the complainant through Intra-vitreal Avastin Injection was repudiated by the Insurance Company on the grounds that the said treatment falls outside the purview of the terms and conditions of the policy. The complaint was dismissed.

Award dated 30.7.2013

Case No. 11-003-0282-13
Shri Ketan B. Patel Vs. National Insurance Co. Ltd.
Repudiation Mediclaim
The Mediclaim treatment of the wife of the complainant for treatment of Tympanoplastry of Rt. Ear was repudiated on the grounds of waiting period of one year. The policy was in continuation but was earlier with Reliance Insurance Co. Ltd. The portability was not exercised by the Insurer. The complaint was dismissed.

Award dated 26.7.2013

Case No. 11-005-0269-13
Mr. D.D. Shah Vs. Oriental Insurance Co. Ltd.
Repudiation Mediclaim

Heath checkup claim lodged for complainant and his wife was repudiated as per policy condition no. 6 i..e., insured is entitled for reimbursement at the expiry of every block of 4 years continuous claim free underwriting years. The claim was repudiated because previous policy showed mediclaim taken by wife of the complainant for Lower RTI and the claim was lodged by the daughter of the complainant for her parents.
Since each insured should be treated as separate entity for the purpose of clause 6 of Health check up policy, the award was passed in favour and Rs.2900/- was asked to reimburse. The complaint succeeded.

Award dated 27.7.2013

Case No.11-002-0274-13

Shri Parthiv S. Pathak Vs. The New India Assurance Co. Ltd.

P.A. Policy

The TTD Claim in respect of accident of the complainant for Rs.23000/- was passed for Rs.4200/- in total. As there was no proof of accident, i.e., FIR, MLC etc., the complaint was dismissed.

Award dated 26.7.2013

Case No. 11-005-0273-13

Mr. Rajendra P. Patel Vs. Oriental Insurance Co. Ltd.

Award dated 23.7.2013

Case No. 11-005-0268-13

Shri S. V. Vasani Vs. Oriental Insurance Co. Ltd.

Repudiation Mediclaim

Smt. Nishaben Vasani, wife of the complainant was treated for Multiple Uterine Fibroids. The mediclaim for Rs.34,465/- was denied by the Respondent invoking clause no. 4.3 i.e., waiting period of two years. The symptoms of illness manifested in the 2nd year of policy which attracted clause 4.3(9). The complaint was dismissed.

Award dated 29.7.2013

Case No.11-002-0278-13

Shri Shammi L. Sheth Vs. The New India Assurance Co. Ltd

Repudiation Mediclaim

The mediclaim for ectopic kidney for Rs.72,990/- was partially settled for Rs.12,355/- under clause 3.13 i.e., Customary and reasonable expenses and under clause 4.4.21 which stated that expenses including convenient items for personal comfort are not payable. The deductions found were proper and the complaint was dismissed without any further relief to the complainant.

Award dated 29.7.2013

Case No. 11-005-0276-13

Smt. Sarojben Patel Vs. Oriental Insurance Co. Ltd.

Repudiation Mediclaim

Complainant was treated for lt. Renal Pelvis Calculus and got cashless claim of Rs.17,109/- . The maximum payable amount was already paid as per terms and conditions of GIPSA PPN with hospital. Hence the complaint was dismissed.

Award dated 26.7.2013

Case No.11-004-0280-13

Shri Narayan K. Verma Vs. The United India Assurance Co. Ltd.

Repudiation Mediclaim

Mediclaim for Typhoid for total Rs.80,000/- was rejected on the grounds of claim papers submitted late. Delay in submission of claim papers prevented the insurer to investigate into the matter which aggravated the claim. The decision of the Respondent was upheld.

Award dated 29.7.2013

Case No.11-002-0263-13

Dr. Niranjan D. Modh Vs. The New India Assurance Co. Ltd.

Repudiation Mediclaim

The mediclaim of the son of the complainant lodged for Mediastinal Lymph Node and Mediastinoscopy + biopsy for Rs.78,542/- was partially settled for Rs.41,329/- under clause 2.1, 2..3 and 2.4. The complaint was dismissed.

Award dated 29.7.2013

Case No.11-002-0272-13

Shri Saurin R. Patel Vs. The New India Assurance Co. Ltd.

Repudiation Mediclaim

The mediclaim of Rs.12,053/- for surgery circumcision was partially settled for Rs.4233/- as per PPN MOU. Further, the Respondent stated that as per permanent exclusion clause no. 4.4.2, circumcision is not payable. The complaint was dismissed.

Award dated 29.7.2013

Case No.11-004-0265-13

Shri Vinayak M. Parekh Vs. The United India Assurance Co. Ltd.

Repudiation of Mediclaim

Two mediclaims of Complainant self and his wife Smt. Renukaben, were partially settled by the complainant. First claim of wife of the Complainant for Rs.31517/- was settled for Rs.22,016/-. Second claim for treatment of dislocation of Lt. shoulder for Rs.5014/- was settled for Rs.4364/-. Third claim of wife of the complainant again for Rs.9060/- was

settled for Rs.7081/- on the grounds of excess nursing charges. The decision of the Respondent was upheld without any further relief to the complainant.

Award dated 9.7.2013

Case No. 11-003-0223-13
Smt. Mini Somrajan Vs. National Insurance Co. Ltd.
Repudiation of Mediclaim
Mediclaim lodged for Rs.1,24,000/- plus for Lt. Frontal Glioma and underwent Navigation guided frontal Craniotomy and excision of Lesion. The Insurance Company repudiated the claim under the clause 4.1 of pre-existing disease. The Pre-existing disease is not payable during first four years of the policy. This was the 4th year of the policy. The complaint was dismissed.

Award dated 5.7.2013
Case No.11-004-0226-13
Shri Anil N. Patel Vs. The United India Assurance Co. Ltd.
Repudiation of Mediclaim
Mediclaim for treatment of complainant's wife for swelling on Lt. Foot was repudiated by the Insurance Company on the grounds of clause 4.10 i.e., no active line of treatment given and the admission was only for Diagnostic purpose. The decision of the Respondent was upheld.

Award dated 29.7.2013

Case No. 11-005-0281-13
Ms. Bina S. Shah Vs. Oriental Insurance Co. Ltd.
Repudiation of Meddiclaim
Right Eye treatment taken by the mother-in law of the complainant through Intra-vitreal Avastin Injection was repudiated by the Insurance Company on the grounds that the said treatment falls outside the purview of the terms and conditions of the policy. The complaint was dismissed.

Award dated 30.7.2013

Case No. 11-003-0282-13
Shri Ketan B. Patel Vs. National Insurance Co. Ltd.
Repudiation of Mediclaim

The Mediclaim treatment of the wife of the complainant for treatment of Tympanoplastry of Rt. Ear was repudiated on the grounds of waiting period of one year. The policy was in

continuation but was earlier with Reliance Insurance Co. Ltd. The portability was not exercised by the Insurer. The complaint was dismissed.

Award dated 26.7.2013

Case No. 11-005-0269-13
Mr. D.D. Shah Vs. Oriental Insurance Co. Ltd.
Repudiation of Health check up claim
Heath checkup claim lodged for complainant and his wife was repudiated as per policy condition no. 6 i..e., insured is entitled for reimbursement at the expiry of every block of 4 years continuous claim free underwriting years. The claim was repudiated because previous policy showed mediclaim taken by wife of the complainant for Lower RTI and the claim was lodged by the daughter of the complainant for her parents.
Since each insured should be treated as separate entity for the purpose of clause 6 of Health check up policy, the award was passed in favour and Rs.2900/- was asked to reimburse. The complaint succeeded.

Award dated 26.7.2013

Case No. 11-005-0273-13
Mr. Rajendra P. Patel Vs. Oriental Insurance Co. Ltd.

Repudiation of Medical

The mediclaim of wife of the complainant for treatment of Abscess for total expenses of Rs.12,732/- was partially settled for Rs.4649/- stating that the claim is settled as per PPN rate. The total amount settled by the Respondent was found proper and the complaint was dismissed.

Award dated 25.7.2013

Case No.11-002-0275-13

Repudiation of Medical
Shri Pankaj C. Gajjar Vs. The New India Assurance Co. Ltd.
The claim for Koch's Encephalitis of the son of the complainant for Rs.1,.82,000/- was partially settled for Rs.1,44,587/-. The balance was not sanctioned by the Insurance Company on the grounds of two years waiting period for the said disease. The benefit of earlier policy was given to the Insured and accordingly Rs. 1 lac was sanctioned. The complaint was dismissed without any further relief to the complainant.

Award dated 23.7.2013

Case No.11-019-0264-13

Shri D. A. PATEL Vs. Apollo Munich Health Insurance Co. Ltd.

Repudiation of Medical

The mediclaim for treatment of chronic fissure/fistula in Anus for Rs.15,865/- was rejected by the Respondent on the grounds of two years waiting period. The claim was lodged during the first year of the policy. The Insured had previous policies with Star Health and United India. The continuity benefit was not given to the Insured. The exclusion clause no. 6 was applied and the repudiation was found proper and the complaint was dismissed.

Award dated 25.7.2013

Case No.11-002-0275-13

Repudiation of Mediclaim

Shri Pankaj C. Gajjar Vs. The New India Assurance Co. Ltd.

The claim for Koch's Encephalitis of the son of the complainant for Rs.1,.82,000/- was partially settled for Rs.1,44,587/-. The balance was not sanctioned by the Insurance Company on the grounds of two years waiting period for the said disease. The benefit of earlier policy was given to the Insured and accordingly Rs. 1 lac was sanctioned. The complaint was dismissed without any further relief to the complainant.

Award dated 23.7.2013

Case No.11-019-0264-13

Shri D. A. PATEL Vs. Apollo Munich Health Insurance Co. Ltd.

Repudiation of Mediclaim

The mediclaim for treatment of chronic fissure/fistula in Anus for Rs.15,865/- was rejected by the Respondent on the grounds of two years waiting period. The claim was lodged during the first year of the policy. The Insured had previous policies with Star Health and United India. The continuity benefit was not given to the Insured. The exclusion clause no. 6 was applied and the repudiation was found proper and the complaint was dismissed.

Award dated 23.7.2013

Case No.11-004-0270-13

Repudiation of Mediclaim

Ms. Ipsha Jain Vs. The United India Assurance Co. Ltd.

Mediclaim of the mother of the complainant was repudiated on the grounds of clause 4.8, 5.4 and 5.11 which was found proper and the complaint was dismissed.

Award dated 24.7.2013

Case No.11-009-0257-13

Repudiation of Medical

Shri Bharat C. Shah Vs. The Reliance General Insurance Co. Ltd.

Mediclaim of the complainant was repudiated on the grounds of pre-existing disease clause no 1 and as per policy condition no. 2. The Insured underwent treatment of Ca Colon. There were on records prescription of treatment undertaken by the Insured. The complaint failed to succeed.

Case No.11-004-0283-13

Shri K. J. Jariwala Vs. United India Insurance Co. Ltd.

Award dated 2nd August 2013

Repudiation of Mediclaim

Complainant treated for HTN + Paralysis and expense incurred for Rs.23,460/- was repudiated by the Respondent on the ground of non submission of required documents.

Complainant stated that he was insured since 12 years but proof submitted since 2007 only. Respondent required his previous history of HTN which was not submitted by the complainant hence claim repudiated under clause 5.5 of the Mediclaim policy.

In the result complaint fails to succeed.

Case No.11-005-0287-13

Mr. Jignesh C. Shah Vs. Oriental Insurance Co. Ltd.

Award dated 6th August 2013

Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of adhesion in abdomen and operative Laparoscopy done and expense incurred for Rs.24,257/- was repudiated by the Respondent under exclusion clause 4.12.

As per doctors certificate, insured underwent caesarian section in the year of 1996 and present treatment is related to past operation.

In view of this Respondent's decision to repudiate the claim is upheld and complaint dismissed.

Case No.11-003-0291-13

Mr. Jaimin N. Shah Vs. National Insurance Co. Ltd.

Award dated 6th August 2013

Partial settlement of Mediclaim

Complainant's mother hospitalized for treatment of shoulder fracture and expense incurred for Rs.97,936/- was partially settled by the Respondent for Rs.89,762/- by deducting an amount of Rs.8,174/- invoking policy condition 3.12.

On scrutiny of both the parties, it is proved that the decision of the Respondent to settle the claim partially is right and proper.

In the result complaint fails to succeed.

Case No.11-004-0289-13
Mr. C.U. Tulshani Vs. United India Insurance Co. Ltd.
Award dated 7th August 2013
Partial repudiation of Mediclaim

Complainant's son hospitalized for treatment of sinus twice in different hospital and claimed two hospitalization expenses separately and two post hospitalization also. Out of which two hospitalization expenses and one post hospitalization are paid by the Respondent and remaining one post hospitalization partially repudiated because supporting documents were not properly received by the Respondent.

Complainant was absent in the Hearing scheduled by this forum.

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

Case No.11-004-0288-13
Shri Kanubhai B. Patel Vs. United India Insurance Co. Ltd.
Award dated 7th August 2013
Partial repudiation of Mediclaim

A Cataract surgery expense claimed by the complainant for Rs.48,677/- was partially settled for Rs.36,455/- by the Respondent giving reason that there are bills other than hospital bills are not payable.

In view of this complaint dismissed.

Case No.11-003-0293-13
Mr. Jigish M. Jhaveri Vs. National Insurance Co. Ltd.
Award dated 7th August 2013
Repudiation of Mediclaim

A claim amount of Rs.47,946/- lodged by the Complainant for treatment of Sinusitis Disorder was repudiated by the Respondent under exclusion clause 4.3 as the subject disease is excluded for two years and the policy is in the second year.

Complainant covered mediclaim with Reliance General Insurance since 2009 and 2010 he converted the policy with the Respondent because the Govt. Insurance Company is better than Private Insurance Company but not given continuity.

In view of this complaint dismissed.

Case No.11-004-0297-13
Shri Rajendra Gupta Vs. United India Insurance Co. Ltd.
Award dated 7th August 2013
Partial repudiation of Mediclaim

Complainant treated for Left Inguinal Hernioplasty and expense incurred for Rs.46,762/- was partially settled for Rs.18,750/- by deducting an amount of Rs.28,012/- giving reason that 25% of Old S.I Rs.75,000/-is applicable which comes to Rs.18,750/-. Increased sum insured is a waiting period of two years for the subject treatment.

Therefore Respondent rightly deducted the partial claim hence complaint dismissed.

Case No.11-002-0296-13
Mr. S. M. Doshi Vs. The New India Assurance Co. Ltd.
Award dated 8th August 2013
Partial repudiation of Mediclaim

Complainant hospitalized for treatment of Umbilical Hernia and incurred expense for Rs.88,011/- was partially settled by the Respondent for Rs.30,065/- by deducting an amount of Rs.57,946/- as per policy condition No.2 Note 3(b).

Complainant paid all amount by cash to different doctors, Anesthetist etc., and receipt submitted by the doctor was not signed properly and discrepancy shown in the Discharge Certificate signed by the same doctor.

Looking to all Respondent's decision to settle the claim partially is upheld and complaint dismissed.

Case No.11-002-0292-13
Mr. V.H. Majithia Vs. The New India Assurance Co. Ltd.
Award dated 8th August 2013
Partial repudiation of Mediclaim

Complainant's wife hospitalized two times for different diseases first for removal of stone and second for bronchial asthma. Complainant lodged claim amount of Rs.60,197/- against first hospitalization was partially settled by the Respondent for Rs.50,917/- by deducting Rs.9,280/- and second claim settled for Rs.89,134/- against 91,695/-.

Complainant's demand that he should be received total deducted amount plus interest for late settlement.

No hospital papers are produced for both the treatment. Respondent has not produced original claim papers and not attended the hearing scheduled by this Forum so proceeded exparte.

Considering all the above, complaint dismissed.

Case No.11-002-0295-13
Smt. Daniben V. Parmar Vs. The New India Assurance Co. Ltd.
Award dated 8th August 2013
Repudiation of Mediclaim

Complainant herself treated Cyst in her urinary and expense incurred for Rs.11,068/- was repudiated by the Respondent under clause 4.3 of policy condition.

This is first year policy, there is a waiting period of two years for the subject treatment hence complaint dismissed.

Case No.11-002-0299-13
Ms. Priyanka G. Pathak Vs. The New India Assurance Co. Ltd.
Award dated 19th August 2013
Repudiation of Mediclaim

Complainant's daughter hospitalized for treatment of abdominal pain and vomiting and expense incurred for Rs.9,374/- was repudiated by the Respondent invoking clause No.4.4.6 of mediclaim policy.

As per consultation paper, past history shows accidental injury six months back which was not disclosed in the proposal.

Therefore complaint dismissed.

Case No.11-005-0298-13
Shri Ramesh K. Thakkar Vs. Oriental Insurance Co. Ltd.
Award dated 19th August 2013
Repudiation of Mediclaim

Complainant's wife hospitalized for eye laser surgery and expense incurred for Rs.50,000/- was repudiated by the Respondent giving reason that as per policy condition No.4.6, surgery for correction of eye vision is not payable.

As per investigation report, the same treatment was done last year also and claims have been paid Rs.53,000/- and Rs.11,000/-. In the claim intimation shows Rs.50,000/- whereas payment made only Rs.3,000/-.

Considering all, the complaint dismissed.

Case No.11-002-0300-13
Shri Mukesh R. Shah Vs. The New India Assurance Co. Ltd.
Award dated 21st August 2013
Partial settlement of Mediclaim

Complainant's son hospitalized for fever, headache & vomiting and expense incurred for Rs.14,135/- was partially settled by the Respondent for Rs.11,515/- by deducting an amount of Rs.2,620/- as per clause 3.13, reasonable and customary charges.

Respondent clearly explained the deductions in the Discharge Voucher addressed to the Complainant which is right and proper.

Hence, complaint dismissed.

Case No.11-005-0304-13
Mr. Y.N. Rathod Vs. Oriental Insurance Co. Ltd.
Award dated 23rd August 2013
Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Fibromyoma of Uterus and expense incurred for Rs.51,823/- was repudiated by the Respondent under clause 4.3 – the subject treatment is excluded for two years.

Complainant's renewal premium cheque was dishonoured so paid late by 11 days which was considered as fresh policy.

Therefore complaint dismissed.

Case No.11-004-0301-13
Mr. Parasmal H. Shah Vs. United India Insurance Co. Ltd.
Award dated 26th August 2013
Partial repudiation of Mediclaim

Complainant's Lt. Knee replacement expense incurred for Rs.2,18,534/- was partially settled by the Respondent by deducting Rs.48,534/- invoking policy condition No.3.11 (Customary & Reasonable charges).

Complainant's argument that his second claim for Rt. Knee replacement for Rs.2,25,150/- was fully sanctioned on cashless basis so his earlier claim should also be paid fully.

Respondent submitted that claim amount sanctioned as per total package rate of tie up with hospital and as per rules printed in the policy.

In view of this complaint dismissed.

Case No.11-002-0302-13
Mr. Dinesh M. Fulmali Vs. The New India Assurance Co. Ltd.
Award dated 26th August 2013
Partial settlement of mediclaim

Complainant's son hospitalized for treatment of Dengu fever and expense incurred for Rs.24,117/- was partially settled by the Respondent for Rs.17,904/- by deducting Rs.6,213/-under the rate of PPN with MOU fixed to the hospital.

On scrutiny of available documents, the forum also denied the claim hence complaint dismissed.

Case No.11-009-0305-13
Mr. Devendra Thakkar Vs. Reliance General Insurance Co. Ltd.
Award dated 26th August 2013
Partial repudiation of Mediclaim

Complainant hospitalized for treatment of removal of kidney stone and expense incurred for Rs.84,332/- was settled by the Respondent for Rs.67,116/- by deducting an amount of Rs.17,216/- giving reason that due to late submission of claim papers late by 18 days.

On scrutiny of available documents, it is proved that the Respondent's decision to settle the claim partially is just and proper.

Therefore complaint dismissed.

Case No.11-004-0306-13
Mr. Kanahiyalal S. Patel Vs. United India Insurance Co. Ltd.
Award dated 26th August 2013
Partial repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Acute Gastro Enteritis with shock and expense incurred for Rs.16,573/- was partially offered to pay Rs.10,000/- by the Respondent which was refused to accept by the Complainant. Thereafter Respondent agreed to pay Rs.15,773/- by deducting Rs.800/-during the Hearing but the Complainant had not submitted required documents along with claim file which create doubt about genuineness of the claim.

In view of this complaint dismissed.

Case No.11-002-0310-13
Smt. Arunaben A Shah Vs. The New India Assurance Co. Ltd.
Award dated 27th August 2013
Repudiation of Mediclaim

Complainant herself hospitalized for treatment of HT+PCTA+ vertigo and incurred expenses for Rs.24,061/-was rejected by the Respondent invoking clause 4.4(11) permanent exclusion of the policy.

As per available hospital papers proved that there is no active line of treatment was done, hospitalization was only for investigation purpose. Therefore complaint dismissed.

Case No. 11-003-0312-13
Mr. Ramaniklal V. Jobanputra Vs. National Insurance Co. Ltd.
Award dated 27th August 2013
Partial settlement of Mediclaim

Complainant treated for Eye cataract surgery and expense incurred for Rs.54,973/- was partially settled by the Respondent for Rs.40,973/- by deducting Rs.14,000/- on the ground of policy condition No.3.12.

Respondent has given additional benefit of discount in premium by way of CB for family and Sr. Citizen also.

In view of this complaint dismissed.

Case No. 11-003-0309-13
Mr. Dinesh S. Patil Vs. National Insurance Co. Ltd.
Award dated 27th August 2013
Repudiation of Mediclaim

Complainant's 8 years old son hospitalized for treatment of prepusal skin and zip injury for which expense incurred for Rs.9,910/- was repudiated by the Respondent under exclusion clause 4.8 of the mediclaim policy.

Respondent stated that the patient has very long prepusal skin and zip injury is normally not possible which is congenital external disease and falls under permanent exclusion clause No.4.8.

Therefore complaint dismissed.

Case No.11-004-0286-13
Mr. C.B. Mehta Vs. United India Insurance Co. Ltd.
Award dated 27th August 2013
Partial repudiation of Mediclaim

Complainant himself hospitalized for two days for treatment of B.P & Sugar for which incurred expense was paid by the Respondent. Again Complainant lodged a claim of Rs.7,286/- for post hospitalization expense which was rejected by the Respondent stating that the claim file submitted by the Complainant after 66 days which is not admissible.

First hospitalization was from 14-6-2011 to 16-06-2011 and post hospitalization period up to 16-08-2011 whereas complainant submitted claim papers on 24-08-2011 which is clearly indicate late submission of claim file.

In view of this complaint dismissed.

Case No. 11-011-0314-13
Shri Prakash Sharma Vs. Bajaj Allianz General Insurance Co. Ltd.
Award dated 29th August 2013
Repudiation of Mediclaim

Complainant's wife hospitalized for treatment of Fibroid Uterus and expense incurred for Rs.50,008/- was rejected by the Respondent stating that the treatment underwent was prior to taking the insurance coverage which is considered as pre-existing disease.

Policy incepted in 2008 and treatment taken in 2011 i.e. forth year of the policy. There is a cap of 4 years so claim repudiated.

Further in the proposal form no information for previous illness. According to doctor insured was suffering abdominal pain since 5 years which is considered as non disclosure of material fact.

Considering all the above complaint dismissed.

Case No. 11-004-0311-13
Mr. Rashmin R. Shah Vs. United India Insurance Co. Ltd.
Award dated 29th August 2013
Repudiation of Mediclaim

Complainant's 12 years old daughter treated for eye surgery and expense incurred Rs.26,481/- was repudiated by the Respondent giving reason that as per treatment papers proved the disease was squint which is congenital disease. Therefore claim rejected under clause 4.1 & 4.8.

On scrutiny of available documents, the forum also denied the claim hence complaint dismissed.

Case No.11-017-0313-13
Shri Prakash V. Patel Vs. Star Health & Allied Insurance Co. Ltd.
Award dated 29th August 2013
Repudiation of Mediclaim

Complainant hospitalized for treatment of Anemia and expense incurred for Rs.20,000/- was repudiated by the Respondent under permanent exclusion clause 11 of the policy.

On referring the treatment papers, it is proved that the insured was treated for Anemia which is permanently excluded from the mediclaim.

Therefore complaint dismissed.

Case No. 11-004-0311-13
Mr. Rashmin R. Shah Vs. United India Insurance Co. Ltd.
Award dated 29th August 2013
Repudiation of Mediclaim

Complainant's 12 years old daughter treated for eye surgery and expense incurred Rs.26,481/- was repudiated by the Respondent giving reason that as per treatment papers proved the disease was squint which is congenital disease. Therefore claim rejected under clause 4.1 & 4.8.

On scrutiny of available documents, the forum also denied the claim hence complaint dismissed.

Case No.11-017-0313-13
Shri Prakash V. Patel Vs. Star Health & Allied Insurance Co. Ltd.
Award dated 29th August 2013
Repudiation of Mediclaim

Complainant hospitalized for treatment of Anemia and expense incurred for Rs.20,000/- was repudiated by the Respondent under permanent exclusion clause 11 of the policy.

On referring the treatment papers, it is proved that the insured was treated for Anemia which is permanently excluded from the mediclaim.

Therefore complaint dismissed.

Case No.11-003-0315-13

In the matter of
Mr. Kiranchandra.B.Thakar
Vs
Respondent – National Insurance Company Ltd.
Award Date: 29th day of August, 2013
Repudiation of Mediclaim

This Mediclaim was for hospitalization of Mr. Kiranchandra.B.Thakar, aged 61 Years. Complainant was diaognised of Senile Enlargement of Prostate. Total expense incurred by him was Rs. 24446. Complainant submitted that the claim has been repudiated on the ground that it has occurred during the first policy year & under Policy Condition No. 4-Exclusion-Sub Condition No. 4.3 which states that claim in First Policy Year shall not be admissible under above disease. It is injustice to him as there is no such condition in the policy nor he was informed regarding such clause.

"As per policy condition laid down in Point No. 4-Exclusions,sub-point 4.3 which reads as-"During the period of twelve months from the date of inception of the policy,the

expenses on treatment of diseases such as Cataract,Benign Prostatic Hypertrophy & ……etc.These diseases,if preexisting,will be covered only after three consecutive claims free policy years".

From the submission of the parties and discussion as at above, the Complaint lacks merit & therefore there is no new ground to interfere with the decision of the Respondent to repudiate the claim as per policy exclusion clause no. 4-sub clause no. 4.3 which is based on reliable evidences.

In the result the complaint fails to succeed.

Case No.11-003-0312-13

In the matter of
Complainant –Mr. Ramniklal.V.Jobanputra
Vs
Respondent – National Insurance Company Ltd.
Award Date: 27th day of August, 2013
Repudiation of Mediclaim

This Mediclaim was for hospitalization of Mr. Ramniklal.V.Jobanputra, aged 72 Years. Complainant was diaognised of Right Eye Cataract & surgery was done. Total expense incurred by him was Rs. 54973. Complainant submitted that the claim has been partially repudiated on the ground of Polciy Condition No. 3.12 which relates to reasonableness of the expenses.Complainant is of opinion that there is no limit of any amount under the definition of reasonable expenses & how one can justify the reasonableness of any claim? The Complainant has implanted Multi focal lens which are of good quality, i.e for the better vision. Therefore the amount deducted is towards betterment which falls under Policy Condition No. 3.12-Reasonable & Customery Expense. They have given Max. Rs. 16000 towards IOL Charges & they believe that it is a part of Cosmetic Surgery.Their TPA are the experts who decides the reasonableness of the expenses.

From the submission of the parties and discussion as at above, the Complaint lacks merit & therefore there is no new ground to interfere with the decision of the Respondent to repudiate the claim as per policy condition no. 3.12.

In the result the complaint fails to succeed.

Case No.11-003-0317-13

In the matter of
Complainant –Mr. Sudhir N Patel
Vs
Respondent – National Insurance Company Ltd.
Award Date: 30th day of August, 2013
Repudiation of Mediclaim

This Mediclaim was for hospitalization of Mr. Sudhir N Patel, aged 69 Years. Complainant was diaognised of Ischaemic Heart Disease.

Total expense incurred by him in this regard was Rs. 212634. Complainant submitted he is holding Mediclaim Policy since 20/07/2001 i.e 13 Years . The S.A under the same is 200000+ 60000 Bonus therefore total of 260000. No new rule shall be applicable to such a

old policy. His claim was settled for Rs. 1,70,000 only & Rs. 42634 have been deducted by the Insurance Company quoting New Terms & Conditions, which is a big amount for him as a Senior Citizen.. No consent of his was taken when the rules were changed.

"As per policy condition laid down in Point No. 1-Salient Features of the Policy,sub-point 1.2(C) which reads as-"Anaesthesia……..cost of stent & implant the maximum limit per illness-50% of Sum Insured. They have accordingly made the payment considering the 50% of S.A(200000 S.A+ 60000 Bonus)i.e Rs. 130000 & Balance payment made as per 25% of Medicinal Expenses & 25% of Instrument Charges Therefore the company is not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any insured person in connection with.

Complaint lacks merit & therefore there is no new ground to interfere with the decision of the Respondent to settle the claim partially as per Point No. 1-Salient Features of the Policy,sub-point 1.2(C),which is based on reliable evidences.

In the result the complaint fails to succeed.

Case No.11-009-0320-13

In the matter of

Complainant –Mr. Dipak R Dani

Vs

Respondent – Reliance General Insurance Company Ltd

Award Date: 2nd day of September, 2013

Repudiation of Mediclaim

This Mediclaim was for hospitalization of Mrs.Rekha D Dani W/o Complainant , aged 48 Years. Complainant was diaognised of Acute Gastroentritis.

Total expense incurred by him in this regard was Rs. 17476. Complainant submitted his claim was rejected for the reason that Hospital is debarred etc. According to Complainant he was not given the list of Hospitals which were debarred by the Company. Had he been provided the debarred list he would have taken her wife for treatment in a Hospital which in the approved list nor he was advised ,when the representative of the Company, visited for investigation in the Hospital.

The Complainant had taken the treatment from the Hospital which comes in debarred list. Another reason for rejecting the claim is that despite of severe Diarrhhoea & dehydration no input/output chart was maintained by the Hospital. Another discrepancy they found that in the first consultation letter it is mentioned patient was having complaint since 2 days,whereas as per Dr. Mahesh Shah letter patient was treated on 2nd & 3rd April,2012, that means before 7 days of admission, which again shows discrepancy in the duration of complaints. They feel that the bills produced is also fabricated. At the time of admission in the Hospital they have not consulted their Family Physician.They provide the list of debarred Hospital with every Policy Document.Therefore their Company's decision to reject the claim is correct.

Considering all the above the Complaint lacks merit & therefore there is no new ground to interfere with the decision of the Respondent to reject the claim,which is based on reliable evidences.

In the result the complaint fails to succeed.

Case No.11-017-0324-13

In the matter of

Complainant –Mr. Bhupendra S Patolia

Vs

Respondent – Star Health & Allied Ins. Co.

Award Date: 4th day of September, 2013

Repudiation of Mediclaim

This Mediclaim was for hospitalization & operation of Complainant's wife Mrs. Pushpaben B Patolia, aged 38 Years. She was diaognised of Left Knee Anterior Cruciate Ligament & surgery was done. Total expense incurred by him was Rs. 69334. Initially Company first settled Rs. 43247 on 10/7/2012. Then again Rs. 17000 was settled on 14/12/2012. Therefore Total Rs. 60247 reimbursement claim was paid by the Respondent. Rs. 7500 they have deducted towards Operation Charges without giving any valid reason. Complainant submitted that the claim has been partially repudiated on the ground of Polciy Clause which relates to reasonableness of the expenses.

The Complainant's wife Mrs. Pushpaben B Patolia had undergone for Surgery of Left Knee Asterior Cruciate Ligament Tear. The amount deducted towards Operation Charges under Policy Clause of Reasonable & Customery Expenses. Company is having having tie up with one of the renowned Hospital Narayan Rugnalay where the same operation is done at Rs. 58500/-,inclusive of all. So they have considered the reasonableness of the operation charges of same nature & accordingly they have settled the claim. Despite of this they have made the payment to the tune of Rs. 60247.So the amount deducted by the Company towards Operation Charges is just & right.

the Complaint lacks merit & therefore there is no new ground to interfere with the decision of the Respondent to partially settle the claim as per Policy Clause of Reasonable & Customery Expenses.

In the result the complaint fails to succeed.

Case No.11-004-0346-13

Smt.Hasuben C. Vaishnani V/s. United India Insurance Co.Ltd.

Award dated 2nd September, 2013

Repudiation of Mediclaim

The insured was hospitalized for treatment of Eye – Superior temporal branch vein occlusion with macular oedema, which was repudiated by the Insurer invoking Exclusion clause 4.19, the treatment underwent by the insured falls outside the scope of the policy. From the nature of treatment as evident from claim paper clearly reveal itg falls outside the scope of the subject policy.

In the result complaint fails to succeed.

Case No.11-002-0347-13
Shri Shashikant J.Talesara V/s. United India Insurance Co. Ltd.
Award dated: 19.09.2013
Repudiation of Mediclaim

Insured was hospitalized for the treatment for Fissurectomy + Haemorroidectomy. The claim was rejected on the grounds of "Allopathic treatment was given by Ayurved Doctor. As per Indian Medical council, the doctor having only MBBS degree is considered as Medical practitioner. The claim was rejected invoking policy Exclusion clause no.2.7, as per claim papers submitted by the insured.

In the result complaint fails to succeed.

Case No.11-004-0350-13
Shri Chaturbhai S. Patel V/s. United India Insurance Co. Ltd.
Award dated: 19.09.2013
Partial Repudiation of Mediclaim

Insured hospitalized for accidental injury on Rt.Ellbow and lodged claim for Rs. 69,146/-, out of which Rs.59,331/- paid by the Respondent deducting for Rs. 9,815/- on the grounds of reasonable and customary head invoking Exclusion clause no.1.2. The main deductions were main from surgery charges Rs.5000/- as claimed amount is Rs. 23000/-, Rs.2500/- towards IITV charges which is not admissible.

In the result complaint fails to succeed.

Case No.11-009-0351-13
Ms.Jayabala v.Maheshwari V/s. Reliance General Insurance Co. Ltd.
Award dated: 20.09.2013
Repudiation of Mediclaim

Insured admitted for the treatment of Rt.Eye and given intra ocular avastatine injection, which can be given on OPD basis and there is not for hospitalization procedure, hence claim has been rejected on the grounds of OPD base so claim is being rejected as per policy preamble terms.

In the result complaint fails to succeed.

Case No.11-004-0352-13
Shri Rajeshbhai Balda V/s. United India Insurance Co. Ltd.
Award dated: 19.09.2013
Repudiation of Mediclaim

The insured hospitalized during 07-12 November 2011 for the treatment of infective hepatitis and lodged claim for Rs.16007/-. The claim was rejected on the grounds of non submission of intimation of the claim. Non-receipt of intimation prevented the TPA to ascertain the genuineness of a inpatient treatment from 07.11.11 to 12.11.11 in the hospital.

In the result complaint fails to succeed.

Case No.11-002-0344-13
In the matter of
Complainant –Mr. Gopesh K Patwa
Vs
Respondent – The New India Insurance Company Ltd.
Award Date: 19th day of September, 2013
Repudiation of Mediclaim

This Mediclaim was for hospitalization of Mr. Gopesh K Patwa, aged 58 Years. Complainant was diaognised of Right Eye Vitreous Haemorrhage & surgery was done. Total expense incurred by him was Rs. 69511. Complainant submitted that the Insurance Company had partially settled claim for Rs. 41,511/- & deducted Rs. 28000-the break up of deductions is Rs. 2800 towards Procedural Charges,Rs. 3500 towards Equipment Charges, Rs. 1700 towards Nursing Charges & Rs. 20000 towards Disposable Items.
Company have settled the claim partially & deducted Rs. 28000 as per Policy Condition No. 4.4 Permanent Exclusions sub-clause No. 4.4.4 which states as-"Cost of braces,equipment or external prosthetic devices, non-durable implants,eye glasses…….durable medical equipments"- falls under permanent exclusions. So the amount paid & deducted by the Company is as per the guidelines laid down in Policy Terms & Conditions.

the Complaint lacks merit & therefore there is no new ground to interfere with the decision of the Respondent to partially repudiate the claim as per policy condition no. 4.4 Permanent Exclusions sub-clause No. 4.4.4.

In the result the complaint fails to succeed.

Case No.11-002-0344-13

In the matter of

Complainant –Mr. Gopesh K Patwa

Vs

Respondent – The New India Insurance Company Ltd.

Award Date: 19th day of September, 2013

Repudiation of Mediclaim

This Mediclaim was for hospitalization of Mr. Gopesh K Patwa, aged 58 Years. Complainant was diaognised of Right Eye Vitreous Haemorrhage & surgery was done. Total expense incurred by him was Rs. 69511. Complainant submitted that the Insurance Company had partially settled claim for Rs. 41,511/- & deducted Rs. 28000-the break up of deductions is Rs. 2800 towards Procedural Charges,Rs. 3500 towards Equipment Charges, Rs. 1700 towards Nursing Charges & Rs. 20000 towards Disposable Items.

Company have settled the claim partially & deducted Rs. 28000 as per Policy Condition No. 4.4 Permanent Exclusions sub-clause No. 4.4.4 which states as-"Cost of braces,equipment or external prosthetic devices, non-durable implants,eye glasses…….durable medical equipments"- falls under permanent exclusions. So the amount paid & deducted by the Company is as per the guidelines laid down in Policy Terms & Conditions.

the Complaint lacks merit & therefore there is no new ground to interfere with the decision of the Respondent to partially repudiate the claim as per policy condition no. 4.4 Permanent Exclusions sub-clause No. 4.4.4.

In the result the complaint fails to succeed.

Case No.11-002-0344-13

In the matter of

Complainant –Mr. Gopesh K Patwa

Vs

Respondent – The New India Insurance Company Ltd.

Award Date: 19th day of September, 2013

Repudiation of Mediclaim

This Mediclaim was for hospitalization of Mr. Gopesh K Patwa, aged 58 Years. Complainant was diaognised of Right Eye Vitreous Haemorrhage & surgery was done. Total expense incurred by him was Rs. 69511. Complainant submitted that the Insurance Company had partially settled claim for Rs. 41,511/- & deducted Rs. 28000-the break up of deductions is Rs. 2800 towards Procedural Charges,Rs. 3500 towards Equipment Charges, Rs. 1700 towards Nursing Charges & Rs. 20000 towards Disposable Items.

Company have settled the claim partially & deducted Rs. 28000 as per Policy Condition No. 4.4 Permanent Exclusions sub-clause No. 4.4.4 which states as-"Cost of braces,equipment or external prosthetic devices, non-durable implants,eye glasses…….durable medical equipments"- falls under permanent exclusions. So the amount paid & deducted by the Company is as per the guidelines laid down in Policy Terms & Conditions.

the Complaint lacks merit & therefore there is no new ground to interfere with the decision of the Respondent to partially repudiate the claim as per policy condition no. 4.4 Permanent Exclusions sub-clause No. 4.4.4.

In the result the complaint fails to succeed.

Case No.11-004-0355-13
Shri Murali A.Punjabi V/s. United India Insurance Co. Ltd.
Award dated: 19.09.2013
Repudiation of Mediclaim

Insured a female patient hospitalized for the treatment of uterine prolapse, which was rejected on the grounds of instrumental delivery in the year 2007 invoking policy Exclusion clause no. 4.11, Insured stated that there is no relevance of old surgery in the year 2007 and current surgery which is related to uterine prolapse. Considering the papers available, it is established that the repudiation of the subject claim is valid and proper.

In the result complaint fails to succeed.

Case No.11-002-0357-13
Dr.Prashant K. JAni V/s. The New India Assurance Co. Ltd.
Award dated: 26.09.2013
Repudiation of claim damage to Telescope.

Insured is covered under Office Protection shield Insurance policy covering doctors hospital instruments etc. wherein claim is lodged for the damages to Telescope during the surgery was repudiated by the insurer on the grounds of Warranty condition u/s VII of the policy. The instrument Telescope was broken during the continuation of surgery hence doctor has to get it repair for use of surgery purpose, but company has refused to repair but offered him buy-back scheme and insured (doctor) has purchased new Telescope at Rs.87500/-, as against actual cost of Telescope is at Rs.1,24,00/-. From the documentary evidences submitted by the both the parties it is established that repudiation of the claim is valid as per provisions of the policy conditions.

In the result complaint fails to succeed.

Case No.11-004-0358-13
Smt. Shardaben G.Patel V/s. United India Insurance Co. Ltd.
Award dated: 27.09.2013
Partial Repudiation of Mediclaim

Insured hospitalized for the treatment of knee replacement for which lodged claim for Rs.1,82,000/-, which was partially settled for Rs.52,500/- only after deducting Rs.1,29,500/- stating the reason that major illness eligible amount would be 70% of old sum insured of Rs.75000/-. Respondent stated that insured is covered under the policy since 2001, in the year 2008-09 increased in sum insured for Rs.1,00,000/- and subsequently again increased in sum insured 2011-12 for Rs.175000/-. Insured underwent surgery is treated as major surgery, hence the sum insured is calculated by the insurer for the year 2008 i.e. Rs.75000/- and 70% amount had been approved.

In the result complaint fails to succeed.

Case No.11-002-0374-13
Shri K K Shah V/s. The New India Assurance Co. Ltd.
Award dated: 30-.09.2013
Partial Repudiation of Mediclaim

Insured hospitalized for lower uretric calculus and lodged claim for Rs.95,830/- which was partially settled for Rs.71,033 deducting for Rs.24,797/- invoking policy condition no.2.0 that deductions were made on the grounds of reasonable and customary basis. The major deductions were made under the head of Surgery charges claimed 44000/- and sanctioned Rs.25000/- deducting Rs.19000/-. Rs.10,000 claimed for O.T.charges, sanctioned Rs.5000/- and deducted Rs.5000/-. Respondent submitted that at for the same treatment package charges at Sal hospital would be Rs. 41,500/-/. And at Apollo hospital package charges would be Rs. 71,250/-, at sterling hospital same surgery package charges would be Rs.68i,500/- Hence, deduction made from the claim amount is under the head of Reasonable and customary. Which is valid and proper.

In the result complaint fails to succeed.

Case No.11-004-0369-13
Shri Chimanbhai D.Dabhi V/s. United India Ins. Co. Ltd.
Award dated: 30.09.2013
Partial Repudiation of Mediclaim

Complainant lodged two claims, one for his own illness for the treatment of Denue fever and second d claim for his wife for the treatement of UTI with retention for Rs.20,065/- & 14,865/- respectively. The claim was rejected on the basis of non-disclosure of material benefit to the insurer. In proposal for insured stated age of insured person as 41 years and 39 years. The age mentioned in treatment papers as 36 years and 38 years misleading the insurer. There are certain ambiguity found in claim papers. Hence, it is not possible to interfere in the matter.

In the result complaint fails to succeed.

Case No.11-002-0368-13
Shri J R Postwala V/s. The New India Assurance Co. Ltd.
Award dated: 30-.09.2013
Partial Repudiation of Mediclaim

Insured hospitalized for the treatment of Rt. Multipel renal stone & lodged claim for Rs.33,941/had been partially settled for Rs. 23,049/- after deducting Rs. 10,891/-. The deduction were made as per policy clause 2.3, surgeon fees bill Rs.20,000/- deducted because bill submitted other than hospital bill, wherein maximum limit is Rs.10,000/-. Insured stated that deductions were made on the basis of internal circular between insurer and TPA, hence his partial deduction is not justified. In reply Respondent stated that policy clause 2.0 under note:2, reads: "No payment shall be made under 2.3 other than part of the hospitalization bill."

The Respondent relaxed this conditions vide circular dated 22.09.2008, and allowed Rs.10,000/- instated of declining the entire bill amount. Hence, deductions are genuine and reasonable.

In the result complaint fails to succeed.

Case No.11-004-0366-13
Shri S.D.Panchal V/s. United India Co. Ltd.
Award dated: 30-.09.2013
Repudiation of Mediclaim

The insured hospitalized for the treatment of Internal Haemorrhoids and Haemorrhoidectomy was done. As per clause 2.1 Ayurvedic treatment expenses are admissible only when the treatment is taken in Government hospital. In subject claim treatment is taken in private hospital. Hence, claim had been rejected.

In the result complainant fails to succeed.

Case No.11-005-365 & 470-13
Shri R B Shukla V/s. Orfiental Ins. Co. Ltd.
Award dated: 30-.09.2013
Repudiation of Mediclaim

The insured hospitalized for the treatment of Lt.Eye & Rt.Eye cataract and lodged claim for Rs.30,137/ & Rs.30,222 respectively, which had been partially settled for Rs.16,137/- and 16,22/- by the insurer after deducting Rs. 14000/- and Rs.14000/- from both the claims on the grounds of customary and reasonable expenses clause. The deduction made from the cost of lens. As such lens implanted by the insured is having more extensive for better vision without glass, hence deduction made from the claim is justified.

In the result complainant fails to succeed.

Case No.11-005-0364-13

Shri V/s. Oriental Ins. Co. Ltd.

Award dated: 30-09.2013

Repudiation of Mediclaim (under Group Mediclaim family floater policy)

The Group floater policy was issued to unconventional Group Viz. PHPL. Wherein insurance certificate was issued to person covering the insurance details and sum insured. The premium details were not mentioned in the certificate.

The insured hospitalized for the treatment of Coronary Angiography. A claim lodged for Rs. 12500/- with the insurer's TPA. The complaint lodged with this office for delay in settlement of the claim. Respondent stated that TPA has written letter dated 12.4.12 and 02.05.12 for submission of Original Discharge card with compete details items wise break of bill amount of Rs.4000/- and reason for no intimation of the claim to their TPA.

In the result complainant fails to succeed.

Case No.11-004-0356-13

In the matter of

Complainant –Mr. Lalsang Ramsang

Vs

Respondent – United India Insurance Company Ltd.

Award Date: 24th day of September, 2013

Repudiation of Mediclaim

This Mediclaim was for hospitalization of Mrs. Kantaben, Female aged 48 Years for Vaginal Hysterectomy. Total expense incurred was Rs. 45268. Complainant submitted,through his letter dated 14/03/2012, that the claim has been repudiated on the ground that it has occurred during the Second policy year & under Policy Condition No. 4-Exclusions-Sub Condition No.4.3 which states that such claim in First Two Policy Years shall not be admissible under above disease. It is injustice to him as when First Mediclaim Policy was taken it was mentioned in that Hysterectomy will be considered from Second Policy Year.

"As per policy condition laid down in Point No. 4-Exclusions,sub-point 4.3 which reads as-"During the first two years of the operation of the policy,the expenses on treatment of diseases such as……Hysterectomy….are not Payable". Therefore the company is not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any insured person in connection with.

Therefore the Complaint lacks merit & there is no new ground to interfere with the decision of the Respondent to repudiate the said claim.

In the result the complaint fails to succeed.

Case No.11-005-0364-13
In the matter of
Complainant –Mr. Jatin S Shah
Vs
Respondent – Oriental Insurance Company Ltd.

Award Date: 24th day of September, 2013
Repudiation of Mediclaim

This Mediclaim was for hospitalization of Mr. Jatin S Shah's Wife Arti J Shah, aged 48 Years. She was diaognised of Coronary Angiography. Total expense incurred by him in this regard was approximately Rs. 12500/-. Complainant submitted his claim but not settled till date.All requirements have been complied as per his belief. The details of claim is known to his Agent,he told.According to the Complainant,some of the requirements were sent.
claim is not settled for want of requirements called for by the T.P.A of the Company-Paramount Health Services(TPA) Pvt. Ltd.

They called for the following Three requirements:

1) **Original Discharged Card with complete details.**
2) **Item wise & Cost wise detailed break up of Rs. 4000/- charged in final hospital bill required.**
3) **A letter from insured stating reason for no intimation of hospitalization is required.**

Considering all the above the Complaint lacks merit.
In the result the complaint fails to succeed

Case No.11-005-0372-13
In the matter of
Complainant –Mr. Krunal P Joshi
Vs
Respondent – Oriental India Insurance Company Ltd.
Award Date: 27th day of September, 2013
Repudiation of Mediclaim

This Mediclaim was for treatment of Mr Krunal Joshi, aged 31 Years for alleged accident.He reportedly submitted that he met with an accident on 19/12/2011 & during the course of Dental treatment he incurred total expense of Rs. 45577 Which was repudiated. Complainant submitted that the claim has been repudiated on the ground of Policy Condition No. 4.7 & 5.4. As per Policy Clause No. 2.3 point no. A-viii & xxv of the Policy Conditions my claim becomes payable. For Condition No. 5.4-Notice of Claim as he was unconscious at the time of accident thereafter his agent intimated Insurance Co. about happening & the same was acknowledged.

"As per policy condition laid down in Point No. 4.7 we have repudiated the claim,which reads as-"Any dental treatment or surgery……which requires hospitalization for treatment". Further the receipts produced by the Claimant are not valid, the treatment taken by the Claimant is OPD. So the decision of the Company to repudiate the claim is correct.Therefore the company is not be liable to make any

payment under this policy in respect of any expenses whatsoever incurred by any insured person in connection with.

Therefore the Complaint lacks merit & there is no new ground to interfere with the decision of the Respondent to repudiate the said claim.

In the result the complaint fails to succeed.

<u>Case No.11-003-0375-13</u>

In the matter of
Complainant –Mr. Rajesh Shah
Vs
Respondent – National Insurance Company Ltd.
Award Date: 30th day of September, 2013
Repudiation of Mediclaim

This Mediclaim was for hospitalization of Mrs. Sonal Shah, aged 42 Years. She was diaognised of Right Uretha Stone.

She was reportedly admitted in Hitesh Hospital,Ahmedabad from 07/08/2012 to 08/08/2012 for the treatment of Right Uretha Stone.

Total expense incurred by him was Rs. 37264. Complainant submitted that the claim has been settled for Rs. 29764 & again for Rs. 3000 after deducting Rs. 4500/- charges paid by him towards Endoscopy Camera citing Policy Condition No. 4-Exclusion-Sub Condition No. 4.16 which states which states that External/durable medical……..any medical equipment which could be used at home subsequently. So he feels that there is no such rule & the condition on which his claim is rejected is not acceptable & the amount should be reimbursed to him.

The Respondent submitted "As per policy condition laid down in Point No. 4-Exclusions,sub-point 4.16 which reads as-" External/durable medical/Non-medical eauipments of any kind used for diagnosis/treatment including CPAP,CAPD,infusion Pump etc.,ambulatory devices like walker/crutches/belts/collars/caps/splints/slings/braces/stockings/diabetic footwear/gluco meter & similar related items & any medical equipment which could be used at home subsequently. We have already paid Professional Charges, O.T Charges & Implant Charges. So the Charge of Endoscopy Camera of Rs. 4500 is of durable nature & therefore we have disallowed the same. Therefore the company is not be liable to make any further payment under this policy in respect of any expenses whatsoever incurred by any insured person in connection with.

From the submission of the parties and discussion as at above, the Complaint lacks merit & therefore there is no new ground to interfere with the decision of the Respondent to deduct the claim,partially, as per policy exclusion clause no. 4-sub clause no. 4.16 which is based on reliable evidences.

In the result the complaint fails to succeed

Case No.11-002-0338-13

In the matter of

Complainant –Mr. Minesh Shah

Vs

Respondent – New India Assurance Company Ltd.

Award Date: 17th day of September, 2013

Repudiation of Mediclaim

This is mediclaim for hospitalization of Smt. Falguniben, aged 42 years wife of the Complainant, at Pooja Hospital from 06.04.2012 to 10.04.2012 for treatment of Laparoscopic surgery for a grand total expense of Rs.38,511/-. This is within the period subject Policy was in force.

The Respondent's TPA E-Meditek has repudiated the claim vide letter dated 01.10.2012. Further Divisional Office II issued letter dated 1.11.2012 stating as under:"Subject policy is first issued on 5.11.2010 as fresh policy, Sr.no. 7 for details of previous Insurance, is kept blank in proposal form, this clearly indicates that you do not have any previous policy and proposal was accepted as fresh proposal, without continuity of previous Insurance.Your wife Mrs. Falguniben was operated for Hysterectomy, Disease is excluded for two years as per clause 4.3 of Mediclaim Policy (2007). Your policy is not two years old. On basis of which claim was treated as NO Claim. Just because of non disclosure of material facts regarding previous Insurance by you, pre condition for admissibility of claim for Hysterectomy Disease does not satisfy.We cannot alter this policy at this stage, Policy is issued as per proposal form signed by you, WE agree with decision of our TPA E-meditek for treating your claim as 'No claim."

The arguments of the Complainant that the Insured was holding policies with Reliance General Insurance Co. Ltd. and he had not availed any claim payment from them cannot be accepted now. This also attracts Policy condition no. 5.5 – Fraud, Misrepresentation, Concealment etc. In view of all the above findings, it is not possible to intervene in the decision of the Respondent Insurer to reject the mediclaim.

In the result the complaint fails to succeed.

Case No. 11-002-0319-13

Complainant:-Mr. Pankaj D. Shah V/S Respondent:- The New India Insurance Co. Ltd.

Award dated-18TH Sep, 2013.

Complainant's wife was hospitalized for underwent cataract surgery in both eyes at Mumbai. But the Respondent has partially repudiated the claim under policy condition no. 2.10.C.iii which stipulated that person paying premium in Zone III & taking treatment in Zone I will have to bear 20% of each claim. The maximum liability of the company will not exceed 80% of the sum insured.

As per policy terms and conditions and as per H.O. circular there is no new ground to interfere with the decision of the Respondent to partially repudiate both the claims.

In the result complaint fails to succeed.

Case No. 11-013-0321-13

Complainant:-Smt. Shila Kirtibhai Patel V/S HDFC Ergo General Insurance Company Ltd.

Award dated 04TH Sep, 2013.

The claim of credit shield and critical illness was repudiated by the Respondent giving reason that the Insured did not die due to accident and claim cannot be processed as per policy terms- Section 2 (Accidental Death) and section 5 (credit shield). Further the critical illness section no. 1 warrants survival of the Insured for a minimum of 30 days from the date of diagnosis.

The complainant failed to fulfill all the requirements as per policy conditions to demand her claims.

In the result complaint fails to succeed.

Case no. 11-002-323-13

Complainant:- Mr. Bharatbhai N. Gandhi V/S Respondent:- The New India Insurance Co. Ltd.

Award dated 17TH Sep, 2013

Complainant's wife was hospitalized for treatment of fracture of shaft femur. Respondent has partially repudiated the claim due to treatment was taken from relative (Daughter – In-Law) Also fee was exorbitantly high and physiotherapy treatment two times in a day was not at all justifiable. And as per policy condition no. 2.8 ambulance services 1% of the sum insured or actual.

Claim settled as per policy terms and conditions so there is no new ground to interfere with the decision of the Respondent to partially repudiate the claims.

In the result complaint fails to succeed.

Case No. 11-002-0325-13

Complainant: - Shri Chandreshbhai P. Shah V/S The New India Assurance Co. Ltd.

Award dated 5TH Sep, 2013.

Complainant's wife has hospitalized for treatment for Brain Hemorrhage. Insurance company has reject the claim that as per IPD papers of Life Care Institute patient is having HTN 200/110 mm of HG at the time of admission so its concluded that present ailment is developed due to accelerated HTN. As per policy clause no. 4.3 of mediclaim policy (Waiting period for specified disease from the time of inception).

The arguments of the complainant that the insured was medically examined while taking the policy is not a valid ground for intervention. The hospital discharge certificate shows multiple diagnosis which would not have developed within 10 months of taking the policy.

So there is no new ground to interfere with the decision of the Respondent to repudiate the claims.
In the result complaint fails to succeed.

Case No. 11-04-0326-13

Complainant: - Mr. Ashok S. Shah V/S United India Insurance Company Ltd.
Award dated 5TH Sep, 2013.
Complainant's wife has hospitalized for knee replacement but the Respondent has partially repudiated the mediclaim as per policy condition of Individual Health Insurance Policy-2009, as per norms of the policy 70% of sum assured is admissible so deducted amount as per the conditions of the policy.
Complainant has failed to produce evidence of senior citizen's policy coverage. It is established that there is no new ground to intervene.
In the result complaint fails to succeed.

Case No. 11-004-0330-13

Complainant:- Mr. Vasudev P. Adnani V/S United India Insurance Co. Ltd
Award dated 18TH Sep, 2013.
Complainant has hospitalized for treatment of Acute Coronary Syndrome and total expenses of treatment was Rs. 3, 86,491/- born by the complainant. But the Respondent has settled the claim only for Rs. 204962/- Claim was partially repudiated under clause 4.1 i.e pre-existing disease and under clause 5.5 i.e non disclosure of material facts.
In view of all the case file there is no new ground to interfere in the decision of the Respondent to repudiate the mediclaim as per exclusion clause no. 4.1 of the super top up policy.
In the result complaint fails to succeed.

Case No. 11-005-332-13

Complainant: - Sh. Hitesh H. Shah V/S The Oriental Insurance Co. Ltd.
Award dated 19TH Sep, 2013.
Complainant has hospitalized for treatment of Squamish cell carcinoma papillary growth right lower GB sulcus. The claim was repudiated by the Respondent the complainant has history of tobacco chewing under clause 4.8 of the policy i.e diseases arising due to misuse or abuse of drugs/alchofhol/or use of intoxicating substances or such abuse of addiction etc.
As per hospital opinion tobacco chewing is the major contributing factor for oral cavity squamous cell carcinoma development. Looking to the above, there is no new ground to interfere with the decision of the respondent to repudiate the claim.
In the result complaint fails to succeed.

Case No. 11-002-0333-13

Complainant: - Smt. Hetalben U. Patel V/S The New India Assurance Company Ltd.
Award dated 12TH Sep, 2013.

Complainant's husband has hospitalized as OPD patient on 18.04.2012 and died on the same day. The lodged claim for Rs. 19033/- was repudiated by the Respondent on the ground of OPD treatment, since insured was not admitted in hospital as per clause no. 1.0 and 3.4 of the policy conditions i.e patient was treated on OPD and hospitalization period requires minimum period of 24 consecutive hours.

It is established that the repudiation of the subject claim made by the Respondent is valid and proper.

In the result complaint fails to succeed.

Case No. 11-004-0336-13

Complainant:- Shri Trikam Bhai M. Makwana V/S The United India Assurance Co. Ltd.
Award dated 17TH Sep, 2013.

Complainant has lodged a claim under a householder policy against damaged of picture tube of T.V. due to voltage fluctuation. And the claim was repudiated by the Respondent under general condition no. 2 and section VI of the policy i.e. "This policy shall be void and all premium paid hereon shall be forfeited. Therefore in the event of misrepresentation, misdescription or non-disclosure of material particular."

In the result complaint fails to succeed.

Case No. 11-003-0337-13

Complainant:- Sh. Aniruddh B. Patel V/S National Insurance Company Ltd.
Award dated 17TH Sep, 2013.

Complainant has lodged a claim for 68 days for Temporary Total Disablement (TTD) under Individual Personal Accident but the claim was sanctioned by the Respondent only for 3 weeks after expert opinion of medical officer instead of 68 days, which was not accepted by the complainant.

Complainant failed to prove the injury sustained was due to an accident caused by external, violent and visible means as envisaged in the subject PA policy.

It is established that there is no new ground to interfere with the decision of the respondent to repudiate the claim.

In the result complaint fails to succeed.

Case No. 11-005-0339-13

Complainant:- Sh. Tapan C. Shah V/S Oriental Insurance Company Ltd.

Award dated 12TH Sep, 2013.

Complainant has lodged a claim under Group Mediclaim Policy of his mother she was hospitalized for the treatment of Eye cataract surgery. The Respondent has rejected the claim on the ground of exclusion clause no. 4.3 waiting period of 2 years from the date of the policy. Complainant has received partially amount after his complaint registered at this office. Inspite of the policy clause no. 4.3 claim appears to have been paid partially or as per the cap mentioned on the policy at their own risk and responsibility.

It is established that there is no new ground to interfere with the decision of the respondent to repudiate the claim.

In the result complaint fails to succeed.

Case No. 11-005-0340-13

Complainant: - Sh. Dineshbhai P. Popat V/S The Oriental Insurance Co. Ltd.

Award dated 19TH Sep, 2013.

Complainant has lodged a complaint under Group Mediclaim Tailormade Policy for reimbursement of expenses towards right knee replacement.

As per policy condition S.A. limit was increased from 2 lac to 3 lac in year 2011-12 so as per clause no. 4.3 the increased S.A. is not payable within 2 years form date of increasing the S.A. So as per terms claim payable only upto S.A. 2 lac and claim was settled correctly.

It is established that there is no new ground to interfere with the decision of the respondent to repudiate the claim.

In the result complaint fails to succeed.

Case No. 11-004-0341-13

Complainant:- Sh. Ajay R. Shah V/S United India Insurance Co. Ltd.

Award Dated 17TH Sep, 2013.

Complainant's wife has hospitalized for treatment of Paraumlical Hernia and claim was partially rejected by the Respondent in different category on reasonable head. As per respondent statement the deduction was made on the ground of PPN (preferred Provider Network) rates of hospital. As per the network hospital agreement had with TPA.

Considering all the above it is not possible to interfere in favour of the Complainant.

In the result complaint fails to succeed.

Case No 11-004-0342-13

Complainant: - Sh. Arun V. Choksi V/S Unitee India Insurance Co. Ltd.
Award dated 17TH Sep, 2013.
Complainant's wife has admitted for Post Hospitalization treatment for Lt. Re Revision TKR. Earlier cashless claim has been settled by the Respondent but above claim stands rejected as per policy provisions "Customary and reasonable expenses."
As per the Respondent arguments full payment made in cashless as per PPN. It is an agreement between Network Hospital and TPA; Hence, TPA has rightly made maximum payment in respect of Re-revision of TKR.
It is established that there is no new ground to interfere with the decision of the respondent to repudiate the claim.
In the result complaint fails to succeed.

CHANDIGARH OMBUDSMAN CENTER

CASE NO. GIC/667/OIC/11/11

Deepak Kumar Vs The Oriental Insurance Company Ltd.

ORDER DATED : 4th April, 2013 MEDICLAIM

FACTS

The complaint was filed by Shri Deepak Kumar about a mediclaim policy No. 231100/31/2009/1002 and Personal Accident policy No. 231110/48/2009/1001 from Oriental Insurance Company Ltd., as claims lodged under these policies for treatment on account of accidental injuries, were rejected by the insurer. Hence, feeling aggrieved, he had approached this office for a settlement of the claim.

FINDINGS

The insurer submitted that insured had met with an accident in 2008 and took surgical treatment in Post Graduate Institute of Medical Education & Research, Chandigarh. He had taken mediclaim and Personal Accident policies for the first time in March 2009

only. It was pointed out that surgical treatment in March, 2010 was related to accidental injuries sustained in 2008, which preceded the commencement of policies. Hence, both the claims were denied on the ground of pre-existing injury. Shri Deepak Kumar represented that he was leading a normal life after an orthopedic surgery, with insertion of a nail in the fractured leg. However, due to another accidental fall in March, 2010, nail protruded out and again surgical treatment was taken but claims lodged under both the policies were not paid.

DECISION

It was held that co-relating treatment taken in 2010 with accidental injuries sustained in 2008 is not logical since cause of injury i.e. accidental fall necessitating surgical treatment, is an subsequent event. Therefore, rejection of claims is not justified. Accordingly, an award was passed with a direction to the insurance company to settle both the claims as per their admissibility under the respective policies

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CHANDIGARH OMBUDSMAN CENTER

CASE NO. GIC/532/UII/11/12

Anjana Jain Vs United India Insurance Company Ltd.

ORDER DATED : 13th May, 2013 MEDICLAIM

FACTS

This complaint was filed about a Mediclaim policy obtained by complainant for Senior Citizens. During the policy tenure she was hospitalized in Dayanand Medical College & Hospital, Ludhiana. An amount of Rs.85,231/- was spent on the treatment, however, claim was settled by the company with a deduction of Rs.9,700/- only.

FINDINGS

The insurer clarified that as per policy provisions major deduction of Rs. 9,100/- was owing to Room Rent limit and an amount of Rs. 600/- was denied for want of X- ray report. Complainant represented that policy was meant for Senior Citizens,

wherein there was no capping of Room Rent and X -ray report was provided to the company, hence there should not be any such deduction.

DECISION

Held that company's decision for deductions on the ground of Room Rent limit and lack of X - ray report, is not justified since the policy is without any capping and

X-ray report was indeed provided. Accordingly, insurance company was directed to pay an additional amount Rs. 9,700/-.

CHANDIGARH OMBUDSMAN CENTER

NO. GIC/59/STAR/11/12

Bansal V s. Star Health & Allied Insurance Company Ltd.

ORDER DATED: 5th August, 2013 **MEDI-CLAIM**

FACTS:

A Mediclaim insurance was obtained by the complainant for the period 26.04.2010 to 25.04.2011 and during the currency of the policy a claim was lodged for the reimbursement of expenses on 'umbilical cord banking' under the 'newborn' cover of the policy. The claim was denied on the ground of being out of scope of policy.

FINDINGS:

The complainant, who was a doctor by profession, pleaded that he had taken mediclaim policy, mentioning 'new born cover' with an understanding that expenses incurred on the 'cord banking' would be payable under the policy. He told that during the currency of the policy, he was blessed with a child and for the future health and anticipated ailment/ treatment of mother and child, procedure under stem-cell banking was adopted. The company's representative had clarified that policy provided for the payment of expenses in the event of contracting actual disease or sustaining injury by mother or the child, which was absent in the present case.

DECISION:

The complaint was dismissed, keeping in view the fact that Complainant had remained ill-informed about the scope of policy as there was merit in the contention of the Company that insurance did not provide compensation against precautionary arrangement of future anticipated ailments.

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CHADNIGARH OMBUDSMAN CENTER

CASE NO. GIC/487/UII/11/12

Naresh Dewan Vs. United India Insurance Company Ltd.

ORDER DATED: 12th August, 2013 **MEDI-CLAIM**

FACTS:

The complainant and his wife were covered under the regular medi-claim policy of the Company for the period 17.10.2010 to 16.10.2011. Subsequently during the currency of the policy, complainant's wife was hospitalized in Rajiv Gandhi Cancer Institute & Research Centre, New Delhi for the treatment of 'Lung Cancer' and its claim was settled by the Company after deducting an amount of Rs. 50,845/-.

FINDINGS:

The complainant had pleaded during the hearing that deduction was mainly about a test, which on the advice of the attending doctor, was arranged from out-side the hospital and test report, in original form and mentioning of patient's name on the payment receipt could not be provided. The representative of the Company had insisted that name of the patient on the payment receipt and test report in original form was required for considering its payment.

DECISION:

It was noted that in the absence of patient's name on the payment receipt, her hospital registration number was sufficient for identification and acceptance of the document and demand for original test report was unjustified owing to the fact that test report was issued by an American Laboratory and as per adopted procedure, test report was obtained from the internet with the help of password conveyed from over-seas.

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CHANDIGARH OMBUDSMAN CENTER

CASE NO. GIC/210/NIA/11/13

Tirloki Nath Modi Vs New India Assurance Company Ltd.

ORDER DATED : 5th September, 2013 MEDICLAIM

FACTS

This complaint was filed about a mediclaim policy issued for a period from 31.08.2010 to 29.08.2011. Thereafter, insured had taken surgical treatment of 'Cataract' and a sum of

Rs. 32,621/- was paid for its treatment. However, against the admissible amount of Rs. 24,000/-, only Rs. 9,000/- was given to him

FINDINGS

The representative of the company clarified that Senior Citizen Medi-claim policy was different from the normal policy as it provided for restricted reimbursement of expenses owing to lower premium and submitted a set of terms & conditions of Company's Senior Citizens policy to clarify the issue of cataract surgery ceiling, which at its maximum is Rs. 10,000/- only. However, insured presented the copy of policy provided to him by office, wherein maximum limit for cataract surgery was mentioned to be Rs.24,000/- only.

DECISION

It was held that company's decision to restrict its liability to Rs. 10,000/- was not justified since the given document mentions about Rs. 24,000/- as the maximum limit for cataract surgery even when insured was holding senior citizen policy. Accordingly, an award was passed with a direction to the insurance company to settle insured's claim for Rs. 24,000/- along with interest @8% from the date of complaint.

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CHANDIGARH OMBUDSMAN CENTER

CASE NO. GIC/482/NIA/11/12

Vijender Kumar Garg Vs New India Assurance Co. Ltd.

ORDER DATED : 5th September, 2013 MEDICLAIM

FACTS

This complaint was filed about a mediclaim policy issued for a period from 28.01.2011 to 27.01.2012. During its currency, he had to go for 'Cataract Surgery' of right eye, however, the operation was not successful resulting with damage of retina. In order to save the eye he had to take an advanced treatment in Centre for Sight Hospital, New Delhi and a claim for an reimbursement of total expenses of Rs. 90,204/- was preferred, which was settled for Rs. 24,000/- only.

FINDINGS

It was observed that cataract surgery was conducted in Yamuna Nagar and an amount of Rs. 20,000/- was spent on its treatment. However, during the surgery the retina got damaged. As a precautionary measure insured went for advanced treatment in New Delhi and an additional amount of Rs. 70,000/- was spent to rectify the eye. Company settled the claim by restricting to maximum liability of Rs. 24,000/- as per policy terms and conditions.

DECISION

It was held that company's decision to restrict its liability to the basic package for 'cataract surgery' of Rs. 24,000/- is not justified since treatment in New Delhi was on account of some complication, which needed to be treated separately from the simple 'cataract surgery'. Accordingly, an award was passed with a direction to the insurance company to settle insured's claim for Rs. 90,204/- as per its admissibility under the terms and conditions of the policy after adjusting Rs.24,000/- already paid to the insured.

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CHANDIGARH OMBUDSMAN CENTER

CASE NO. GIC/482/NIA/11/13

Chiranji Lal Vs. New India Assurance Company Ltd.

ORDER DATED: 5th August, 2013 MEDI-CLAIM

FACTS:

An Over-seas Medi-claim policy was obtained by the complainant for a period from 01.04.2011 to 29.07.2011. During the currency of the policy, he was hospitalized in Nepal, however its claim was denied by the Company on the ground of a 'general exclusion' under the policy.

FINDINGS:

The Complainant, who was working in the local Police Department, had gone to Nepal for participating in an expedition of Mount Everest. Unfortunately, during the period of acclimatization at the base camp, he had developed chest infection and breathing problem. Consequently, he was airlifted for hospitalization at Kathmandu and a sum of USD 14,485/- was incurred on transportation and treatment. The representative of the Company had explained that in Nepal, insured had participated in Mountaineering Expedition and suffered 'high altitude sickness' and related problems. He clarified that policy covered expenses on treatment during travelling over-seas for 'holiday & business purposes' and taking part in hazardous activities/ sports was specifically excluded under the policy and a book-let, containing the terms & conditions of the policy, was provided at the time of insurance.

DECISION:

The decision of the Company to reject the claim under the policy ' general exclusion' clause about participation in adventurous activities/ sports was up-held,

in particular in view of the fact that complainant did not disclose his participation in mountaineering activity during stay in Nepal.

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DELHI OMBUDSMAN CENTRE

Case No.GI/01/UII/12

In the matter of Sh. Hans Kumar Jain

Vs

United India Insurance Company Ltd.

AWARD DATED 11.4.2013 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 mediclaim.**

2. **Complainant stated that he has been taking mediclaim policy from United India Insurance Company Ltd. for the last 15 years. He had to get admitted in Ganga Ram hospital for treatment on 12.06.2011 and he had incurred an expenditure of Rs. 1,70,557 on treatment. He was allowed cashless facility to the extent of Rs. 1, 01135 and the remaining amount he had to given to the hospital amounting to Rs. 69,422. He further submitted that he had requested Vipul Medicorp for payment of balance amount. Thereafter, a cheque dated 08.11.2011 for an amount of Rs. 23,624 was submitted to him. He further submitted that company claimed to have settled the claim on the basis of the sum insured when his disease was detected. He submitted that company be directed to pay the balance amount of Rs. 45,798. He further submitted that his claims should have been settled with reference to sum of Rs. 4.5 lacs. During the course of hearing, it was pleaded by him that his clam was settled with reference to Rs. 3.5 lacs and the same should have been settled with reference to the sum insured of Rs. 4.5 lacs. His disease was detected when his sum insured was Rs. 4.5 lacs.**

3. **Representative of the company pleaded that claim was correctly settled with reference to sum insured of Rs. 3.5 lacs. Company also filed written reply dated 07.05.2012 wherein, it was stated that insured Sh. Hans Kumar Jain was having a history of 4 years for pain in the belateral left bubunocele with left ingiunodynia (Hernia) (2), Hypertensive (3), Hypothyroid (4) dyslipidemi (5) Vitamin D deficiency (6) CAD (Post Pyeloplasty Residual Hydronephorosis. Company settled the claim with reference to sum of Rs. 3.5 lacs subject to policy conditions relating to room rent and proportionate recovery to other expenses when the patient stays in a**

higher category norm. It was further mentioned in the written reply that claim was settled as per terms and conditions of the policy.

4. **I have considered the submissions of the complainant as well as of the representative of the company. I have also perused the written reply of the company which is placed on record. After due consideration of the matter, I hold that claim was not correctly settled by the insurance company because company had settled the claim with reference to sum insured of Rs. 3.5 lacs whereas, the same should have been settled with reference to sum of rs. 4.5 lacs thus complainant is further entitled to some relief. Accordingly an Award is passed with the direction to the insurance company to make further payment of Rs.21,703.**

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 CENTRE

Case No.GI/615/STAR/11
In the matter of Sh. Rajiv Jain.
Vs
Star Health & Allied Gen. Insurance Company Ltd.

AWARD DATED 12.4.2013 INADEQUATE SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Rajiv Goel (hereinafter referred to as the complainant) against Star Health & Allied Gen. Ins. Co. Ltd. (Hereinafter referred to as respondent insurance company) relating to Mediclaim.**

2. **Complainant submitted that he claimed reimbursement for an amount of Rs. 3, 43,231 towards medical expenses of CAD-UNSTABLE ANGINA, TVD treatment at Sir Ganga Ram Hospital. All other queries and requirements were also fulfilled. He was surprised to receive a cheque for Rs. 2, 30,117 against his claim, thus he had been paid less by an amount of Rs. 1, 13,114. He submitted an application for reconsideration and payment of balance payment but the**

same was also rejected. He has come to this forum with a request to instruct the insurance company to make payment of the balance amount. During the course of hearing complainant, pleaded that company had paid a sum of Rs. 2, 90,117 against the claim of Rs. 3, 43,231. He pleaded that company be directed to pay balance amount.

3. **Representative of the company was required to submit process sheet and other claims settlement sheets.**

4. **I have considered the submissions of the complainant as well as of the representative of the company. I have also perused process sheets and also the letter dated 30.06.2012. After due consideration of matter I hold that claim was not adequately settled and I find that complainant needs to be further paid some amount. Accordingly an Award is passed with the direction to the insurance company to make further payment of Rs. 51,950.**

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 CENTRE

Case No.GI/617/OIC/11
In the matter of Sh. Vijay Arora.
Vs
Oriental Insurance Company Ltd.

AWARD DATED 12.4.2013 PARTIAL SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Vijay Arora (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 holder of policy issued by Oriental Insurance Company Ltd. It is a health insurance policy bearing no. 272302/48/20/12/258. In July,2011 his wife Smt. Rita Arora got operated for Mennorhagia at Asian Hospital of Faridabad. Papers relating to the surgical Procedure before the operation were submitted to E-Meditek Corporation. First approval was received for Rs. 60,000 which was subsequently reduced to Rs. 28,000 but full payment could not be received. Complainant had taken up the matter with the company for reconsideration of the case but his case was not reconsidered. He has come to this forum with a request to provide solution to his problem. During the course of hearing it was pleaded by him that claim was payable but company had denied it due to pre-existing disease.**

3. **Representative of the company pleaded that claim not payable due to pre-existing disease. Company also filed reply dated 24.02.2012 wherein it was mentioned that after careful examination the claim was rejected by the insurance company. The claim was rejected on account of pre-existing heath condition.**

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 rejecting the claim on the ground of pre-existing disease because the disease for which treatment was taken by the insured and submitted the bill was not there before the inception of the policy. The ground of rejection of the claim was untenable. In my considered view claim was payable and company ought to have paid it. Accordingly an award is passed with the direction to the insurance company to make payment of Rs. 53,436.**

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 CENTRE

Case No.GI/33/NIC/12
In the matter of Sh. Yogesh Kr. Saraf.
Vs
National Insurance Company Ltd.

AWARD DATED 18.4.2013 DENIAL OF MEDICLAIM

1. **This is a complaint filed by Sh. Yogesh Kr. Saraf (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 had taken an individual mediclaim policy for self and his other family members for sum insured of Rs. 5 lacs from National Ins. Co. Ltd for the period 22.04.2010 to 21.04.2011 vide policy bearing no. 354301/48/10/8500000275. This policy was renewed for the subsequent period. Unfortunately he felt pain in his chest on 25.09.2011 and he was hospitalized in M.K.W Hospital & research centre, Rajouri Garden and thereafter he was shifted to Medanta Hospital, Gurgaon for further treatment. Hospital sent the pre-authorization request form duly filled in for granting cashless facility. The cashless facility was denied to him stating that disease has exclusion application as per clause 4.3 of the policy. Therefore he submitted reimbursement claim. He was shocked to know that T.P.A rejected the claim citing 4.3 clause of the policy. He further submitted that at the time of taking policy, he was not suffering from any disease. He has come to this forum with a request to instruct the insurance company to settle the claim. During the course of hearing, it was pleaded that claim was payable but company had denied it.**

3. **Representative of the company argued that claim was reconsidered and the same was found payable. The representative of the company assured to settle the claim shortly.**

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 rejecting the claim because the same was payable. As a matter of fact, the representative of the company admitted that claim was later on found payable and he promised to settle the claim but such assurances**

was not kept. Accordingly an award is passed with the direction to the insurance company make payment of Rs. 3, 50,200 along with the penal interest at the rate of 8% from the date of repudiation to the date of actual payment.

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

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

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DELHI CENTRE

Case No.GI/27/NIA/12
In the matter of Sh. Shailesh Gupta.
Vs
New India Assurance Company Ltd.

AWARD DATED 18.4.2013 DENIAL OF MEDICLAIM

1. **This is a complaint filed by Sh. Shailesh Gupta (hereinafter referred to as the complainant) against New lndia Assurance Co. Ltd. (Hereinafter referred to as respondent insurance company) relating to mediclaim.**

2. **Complainant submitted that he had taken a mediclaim policy from New India Assurance Company Ltd. covering himself, wife and his son. This policy was valid from 07.12.2010 to 06.12.2011. The policy is continued for the last 4 yrs. His son Divyansh Gupta fell from height of about 10 feet and got severe injuries in left thigh as well as in his scalp on 11.08.2011. He was immediately taken to the nearby hospital medicare centre, Noida in the emergency ward at about 6 p.m. After necessary investigation and treatment, he was allowed a room at about 8 p.m. he was kept under observation and discharged at about 2.30 p.m, and the claim was lodged with the company's TPA for an amount of Rs. 27,186. The claim was repudiated by the TPA on the ground that hospitalization was for the period less than 24 hours. The matter was represented to the TPA and also to the Grievance Cell requesting them to reconsider the matter. He further submitted that the claim was genuine and payable though the patient remained**

in the hospital for a period less than 24 hours. He has come to this forum with a request to get the claim settled along with the penal interest and damages. During the course of hearing also it was pleaded by him that claim was payable but company denied it.

3. **Representative of the company argued that claim was not payable for the reasons as mentioned in the repudiation letter.**

4. **I have considered the submissions of the complainant as well as of the representative of the company. I have also perused the repudiation letter. After due consideration of matter I hold that company was not justified in denying the claim because insured got injured due to fall from height and admitted in the hospital and got treatment. In my considered view hospitalization was not required in this type of injury suffered by the insured for a period more than 24 hours, therefore claim was payable. Accordingly an Award is passed with the direction to the insurance company to make payment of Rs.27, 186.**

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 CENTRE

Case No.GI/19/ICICI/12

In the matter of Sh. Rakesh Kumar.

Vs

ICICI Lombard Gen. Ins. Company Ltd.

AWARD DATED 18.04.2013 NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Rakesh Kumar (hereinafter referred to as the complainant) against ICICI Lombard Gen. Ins. Co. Ltd. (Hereinafter referred to as respondent insurance company) relating to mediclaim.**

2. **Complainant submitted that he submitted all requisite documents to the insurance company but all such documents were returned back without settling his claim. He also sent his representation to the grievance redressal officer of the company but he did not receive any reply. He has come to this forum with a request to get his claim settled. During the course of hearing complainant was required to submit original documents to the insurance company and the same were handed over by him to company's representative.**

3. **Representative of the company submitted that claim would be considered on receipt of the original documents. Company also filed written reply dated 21.03.2013 wherein it was mentioned that claim was rejected on 26.12.2011 but later on reconsidered and it was decided that complainant will be given the benefit of doubt and claim would be settled on receipt of the original documents.**

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 I rejecting the claim because the same was payable. During the course of hearing company's representative was already handed over the original documents relating to claim. Company ought to have settled the claim by now but no report was submitted subsequently. Accordingly an award is passed with the direction to the insurance company to make payment of Rs……..**

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 CENTRE

Case No.GI/352/NIA/12
In the matter of Sh. Ajay Singhal.
Vs
New India Assurance Company Ltd.

AWARD DATED 23.4.2013 NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Ajay Singhal (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 he has been insured with the insurance company for the last many years and has been regularly paying the premium. Company had given him detailed policy terms and conditions. He further submitted that he never used alcohol or any other drug neither he is a smoker. The company had rejected his claim on flimsy grounds. He has come to this forum with a request to get his genuine claim paid. During the course of hearing also it was pleaded by him that claim was payable but company had denied it. He never used alcohol and neither he ever smoked. The basis of rejection of claim was totally unjustified.**

3. **Representative of the company pleaded that he did not receive the file from the concerned office.**

4. **I have considered the submissions of the complainant as contained in the complaint and as verbally made during the course of hearing. I have also perused the discharged summary and other documents placed on record. After due consideration of matter, I hold that company was not justified in repudiating the claim because claim was payable. I have no reason not to believe to the version of the complainant that he never smoked nor used liquor, therefore claim was payable and company should have not declined the claim on that basis. Accordingly an award is passed with the direction to the insurance company to make the payment of Rs. 67,010.:**

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 CENTRE

Case No.GI/17/OIC/12

In the matter of Sh. Rakesh Kumar Jain
Vs
Oriental Insurance Company Ltd.

AWARD DATED 2.5.2013 REPUDIATION OF MEDICLAIM

1. **This is a complaint filed by Sh. Rakesh Kumar Jain (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 submitted that hospitalization claim of his mother Smt. T. Sundari Jain was denied by the TPA on account of delay of submission of claim papers. The delay was explained. Documents relating to treatment were submitted. Complainant also approached the GRO of the company. He has come to this forum with a request to intervene and instruct the insurance company to settle the claim. During the course of hearing, it was pleaded that 2 claims were pending but company had not settled the claims so far. All requisite documents were submitted. Request was also made for condoning the delay for late submission of documents. He further submitted that he did not receive the cheque for an amount of Rs. 32,271.**

3. **Representative of the company pleaded that one claim was settled and cheque for an amount of Rs. 32,271 was sent but second claim for an amount of Rs. 41,443 was not settled. During the course of hearing representative of the company promised to settle both the claims within a week time.**

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 delay in submission of the requisite documents. It is quite surprising that despite the commitment to settle both the claim, by the representative of the company, no reply was submitted till date. Claim otherwise payable could not be declined on technical ground. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 73,714 relating to both the claims as a sum of Rs. 33,721 was not received by the complainant so far along with penal interest at the rate of 8% w.e.f. the date one month after the receipt of the requisite documents 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 CENTRE

Case No.GI/32/UII/12
In the matter of Sh. Vinod Gupta
Vs
United India Insurance Company Ltd.

AWARD DATED 2.5.2013 NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Vinod 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 non settlement of mediclaim.**

2. **Complainant submitted that he had taken medicalim policy in 2007 from Reliance General Insurance Company Ltd. and in 2009, the mediclaim policy was taken from United India Insurance Company Ltd. He further stated that while giving medicalim**

policy insurance company assured him that policy would be considered in continuation of the earlier policy but when Sh. Vinod Kumar became ill, it was informed by the company that mediclaim policy would be considered only from 2009 and claim would not be admissible to him whereas, infact his policy was from 2007. He also provided a copy of the policy taken in 2007 but the same was not considered. He incurred an expenditure of Rs. 16,130. All documents have been furnished. Complainant has come to this forum with request to get the claim settled. Complainant did not attend on the date of hearing.

3. **Representative of the company pleaded that claim was not payable due to lack of continuity in the policy. Though complainant had taken mediclaim policy since 2007 from reliance but from this company, he had taken policy from 2009.**

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 for denial of the claim. After due consideration of the matter, I hold that company was not justified in repudiating the claim because claim was payable while taking the policy from present insurer in 2009, complainant was under the bonafide belief that he would be given the continuity benefits of the mediclaim policy taken by him for the first time in 2007 from Reliance General Insurance Company Ltd. Complainant was not suffering from any pre-existing disease. In my considered view complaint deserves to be given the benefit of continuity of the mediclaim policy taken for the first time in 2007 from Reliance General Insurance Company Ltd. The claim is found payable. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs.16130.**

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 CENTRE

Case No.GI/36/Star/12

In the matter of Sh. M.L. Gupta

Vs

Star Health & Allied General Insurance Company Ltd.

AWARD DATED 18.4.2013 NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. M.L. 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 non settlement of mediclaim.**

2. **Complainant submitted that he remained covered by mediclaim policy since 22.06.2009 and 3rd renewal was valid until 21.06.2012. He underwent a surgery for Hernia in AIIMS for which he remained admitted during 31.10.2011 to 03.11.2011 under intimation to the insurance company. He submitted the claim for Rs. 47,359 (30% less as co pay from a total claim of Rs. 67,776) but the claim was repudiated by the company stating that he had under gone MECP which he had undergone in 2006 which was not declared by him for underwriting consideration. Therefore, non disclosure of MECP exclusion no. 7 of the policy terms and conditions and will result in rejection of the claim. Complainant submitted that he had Asthma and B.P. at the time of taking the policy in 2009 which have been declared and are endorsed in policy all through since 2009-2012. He had undergone other ailments such as TIA in 1986, MECP in 2006 and Vasectomy as shown in discharge summary of AIIMS but he did not suffer from anty of these ailments in 2009. Therefore, he did not disclose it while taking policy in 2009. He further submitted that clause 7 of the policy was not applicable in his case because his claim was not fraudulently made. Moreover, doctor M.C. Mishra certified that in his case Hernia is not a complication of Pre-existing-disease. Therefore, he has come to this forum with a request to instruct the insurance company to make him payment of Rs. 47,359. During the course of hearing, also he argued that claim was payable but company had denied it. He further stated that he did not fill the proposal form. He merely signed the proposal form and other information was filled in by some other person or by the agent.**

3. **Representative of the company pleaded that claim was not payable due to suppression of some information. Company also filed written reply dated 28.05.2012 wherein, it was submitted that Sh. M.L.Gupta had taken a policy covering himself and his wife for sum insured of Rs. 1 lakh each under Senior Citizen Red Carpet Insurance Policy for the period 22.06.2009 to 21.06.2010 through telesales. Company received the claim for the treatment of Sh. M.L. Gupta. Company came to know from the discharge summary that insured was a known case of COPD/TIAin 1986. While proposing for insurance, he did not disclose the past history. Company had rejected the claim under condition no. 7 of the policy.**

4. **I have considered the submissions of the complainant as well as of the representative of the company. I have also perused the written reply of the company which is placed on record. I have also perused condition no. 7 very carefully. After due consideration of the matter, I hold that company was not justified in repudiating the claim because condition no. 7 was not applicable to the facts and circumstances of the claim of the complainant. Claim was not made fraudulent. It appears to be genuine claim and therefore, it was payable. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 47197.**

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 CENTRE

Case No.GI/614/Star/11

In the matter of Sh. Dharmender Jain

Vs

Star Health & Allied General Insurance Company Ltd.

AWARD DATED 2.5.2013 NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Dharmender Jain (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 had purchased 2 policies from Star Health & Allied General Insurance Company Ltd. the policy nos. are P/700002/01/2011/000640 dated 13.01.2011 covering Sh. D.C. Jain and Smt. Vimla Devi, policy no. 2, P/700002/01/2012/000499 dated 18.05.2011 covering sh. D.C. Jain. Sh. D. C. Jain underwent a heart surgery and he declared the same at the time of obtaining the policy. He had received the policies through courier without any riders attached to it mentioning the terms and conditions. Sh. D.C. Jain was treated for replacement of pace maker, he got admitted to Max Hospital. A penal doctor from the insurance company visited the hospital and checked the patient. After the discharged from the hospital, he had sent all original documents with detailed cover note with the Mumbai office of the company. He waited for 3 weeks for the**

settlement of the claim. He persuaded the matter further with the insurance company. However, a insurance company rejected the claim on the ground of pre-existing disease. The matter was again taken up with the insurance company. During the course of hearing, it was pleaded that company had paid a sum of Rs. 70,800 out of total claim of Rs. 2,40,000.

3. **Representative of the company pleaded that co-pay condition was applicable.**

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 complainant was entitled to Rs. 76,723 as per policy terms and conditions whereas, he was given only a sum of Rs. 70,000. Thus he is further found entitled to a sum of Rs. 70,000. Thus he further found entitled to a sum of Rs. 5923. Accordingly an Award is passed with the direction to the insurance company to pay further a sum of Rs. 5923.**

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 CENTRE

Case No.GI/343/UII/12
In the matter of Sh. Shyam Sunder

Vs
United India Insurance Company Ltd.

AWARD DATED 1.5.2013 NON SETTLEMTN OF MEDICLAIM

1. **This is a complaint filed by Sh. Shyam Sunder (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 submitted that he was hospitalized at Saket Hospital, Jaipur between 11.07.2011 to 13.07.2011. He was allowed cashless facility. Thereafter, on 22.12.2011, he filed claim documents for pre and post hospitalization expenses for an amount of Rs. 9370 but the TPA refused to pay the claim. He had already sent his representation to the GRO of the company but he did not receive any satisfactory reply. He has come to this forum with request to get him paid his claim. During the course of hearing, representative of the complainant submitted that claim relating to post hospitalization expenses was payable. He admitted that the claim was filed late but there was valid reason due to which complainant was prevented from filling claim in time. Due to accident of family member, the claim could not be filed in time.**

3. **Representative of the company pleaded that claim was not payable due to late submission of the claim and related documents. Though, he clearly admitted that claim was payable on merits. Company also filed written reply dated 22.01.2013 wherein, it was mentioned that insured was admitted in Saket Hospital, Mansarovar, Jaipur on 11.07.2011 for the diagnosis of acute upper respiratory infection and discharged on 13.07.2011. Insured had submitted the claim documents around two months after the due date and therefore, on account of non submission of documents in time, 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 repudiation letter and the 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 only on the ground that documents were filed late. There was reasonable cause due to which delay occurred in submission of the claim documents. On merits it was also admitted by the representative of the company, that the claim was payable. Thus a claim otherwise payable could not be denied on technical ground. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 9370 along with penal interest at the rate of 8% from the date of repudiation to the date of actual payment.**

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

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

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DELHI CENTRE

Case No.GI/446/UII/12

In the matter of Sh. R.S. Mathur

Vs

United India Insurance Company Ltd.

AWARD DATED 1.5.2013 PARTIAL SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. R. S. Mathur (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 partial settlement of claim.**

2. **Complainant submitted that claim was not settled properly. Though claim was payable with reference to the sum insured of Rs. 3,25,000 for the period 2010-11 but company settled the claim with reference to sum insured of Rs. 2,50,000 which was the sum insured during the period 2007-2008. Complainant has come to this forum with a request to direct the insurance company to settle the claim with reference to the sum insured of Rs. 3,25,000.**

3. **Representative of the company pleaded that claim was settled properly with reference to the sum insured of Rs. 2,50,000 which was sum insured for the policy period 2007-2008 because the insured suffered from the same disease in the policy period 2011-2012 as he suffered in 2001. Company also filed written reply dated 05.04.2011 wherein, it was mentioned that company had issued policy bearing no. 140604/48/11/97/00000094 to the complainant for sum insured of Rs. 3,25,000 for the period 23.04.2011 to 22.04.2012. Complainant was admitted in Fortis hospital, New Delhi on 19.03.2012 and was diagnosed for Abdominal Aortic Aneurysm and discharged on 01.04.2012. Patient was known case of same disease since April 2001 and was diagnosed Infra Ranal Abdominal Aortic Aneurysm in this hospitalization. The company settled the claim with reference to the sum insured of Rs. 2,50,000 in the year 2006-2007.**

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 other documents placed on record. After**

due consideration of the matter, I hold that there was no justification to settle the claim with reference to the sum insured of Rs. 2.5 lacs which was the sum insured for the policy period 2006-2007. During the course of hearing, representative of the company could not justify and produce any evidence in support of the argument that claim was payable with reference to sum insured of Rs. 2.5 lacs which was the sum insured for the policy period 2006-07. Policy was taken for the first time. Having due regards to the treatment of the disease for which claim was submitted there was no justification what so ever, to settle the claim with reference to the sum insured less than the sum insured when insured was admitted in the hospital. In my considered view claim is payable with reference to the sum insured of Rs. 3,25,000 which was the sum insured for the policy period 2011-12 when Insured was admitted and got treatment on (19.03.2012). Accordingly an Award is passed with the direction to the insurance company to make the further payment of Rs. 75,000 (Rs. 3,25,000 – Rs. 2,50,000 already paid).

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 CENTRE

Case No.GI/388/UII/12

In the matter of Sh. Dilip Chandra

Vs

United India Insurance Company Ltd.

AWARD DATED 1.5.2013 PARTIAL SETTLEMENT OF MEDICLAIM

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

2. **Complainant submitted that his claim was settled for Rs. 2,10,000 by M/s Vipul Pvt. Ltd., Jaipur on cashless basis. He was covered for Rs. 3 lacs under the mediclaim policy bearing no. 140301/48/10/97/00001313. He was also covered under Super Top up policy bearing no. 140301/48/10/36/00001314 and thus he pleaded that he was entitled to full amount of Rs. 3 lacs as Angioplasty is a specific treatment/procedure and not surgery as defined under policy conditions. He**

submitted further that Vipul Medicorp is not making the payment of difference amount of Rs. 90,000 which was payable to him under Super Top up Policy. He has persued the matter but did not get any response. He did not attend the date of hearing though he was allowed an opportunity.

3. **Representative of the company submitted that Super Top Up Policy was not considered while settling the claim. Individual policy was considered and claim was settled for an amount of Rs. 2, 10,000. Company also filed the written reply dated 05.04.2013 wherein, it was mentioned that company had issued policy bearing no. 140301/48/10/36/00001314 to the complainant for sum insured of Rs. 3 lacs. He was admitted in Fortis hospital, Jaipur on 04.06.2011 wherein, he underwent Angioplasty and discharged on 07.06.2011. He was paid 70% of sum insured i.e. he was paid a sum of Rs. 2,10,000 as per policy terms and conditions. The claim was rightly settled.**

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 05.04.2013 which is placed on record. I have also perused the individual health insurance policy bearing no. 140301/48/10/97/00001313 for the period 18.07.2010 to 17.07.2011 and also Super Top up Policy bearing no. 140301/48/10/36/00001314 for the period 18.07.2010 to 17.07.2011. After due consideration of the matter, I hold that company had settled the claim only with reference to the individual health insurance policy bearing no. 140301/48/10/97/00001313 and paid 70% of sum insured in this policy but had not considered Super Top Up Policy while settling the claim. Complainant had put up the claim for Rs. 3,17,460. In terms of individual policy bearing no. 140301/48/10/36/00001314, insured was entitled to a sum of Rs. 2,10,000 and the balance claim was suppose to be considered in Super Top up policy which was not considered by the insurance company. When insured had taken both the policies, he could have been given the benefit of both the policies. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 1,07,210 (3,17,460 – 2,10,000 – 250).**

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

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

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DELHI CENTRE

Case No.GI/346/NIC/12

In the matter of Sh. Jai Prakash Rai
Vs
National Insurance Company Ltd.

AWARD DATED 2.5.2013 NON SETTLEMENT OF MEDICLAIM

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1. **This is a complaint filed by Sh. Jai Prakash Rai (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 settlement of mediclaim.**

2. **Complainant submitted that individual mediclaim policy bearing no. 361203/48/2000/8500056 for the period 18.07.2000 to 17.07.2001 was issued. It was renewed from time to time and present policy no. 361203/48/11/8500000768 for the period 28.12.2011 to 27.12.2012 was issued and the premium amount was Rs. 7,888. Complainant got admitted on 14.04.2011 at Medanta hospital and was discharged on 19.04.2011 after giving necessary documents to the TPA on 18.07.2011. At the time of admission the hospital required the patient to give the case history and it was informed by the patient that he was feeling depression from 6 to 7 months but in the record it was wrongly mentioned as 7 years. He has come to this forum with a request to issue direction to the insurance company to settle the claim bearing no. 51628 for Rs. 28,848. During the course of hearing, it was pleaded that claim was payable but company did not settle the claim neither communicated any decision on the mediclaim submitted by the insured.**

3. **Representative of the company pleaded that he did not have record with him. Therefore, he was not in a position to make any comment. He was required to submit reply within the week time 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. As mentioned above that company representative was desired to file reply, but no reply was submitted by the company so far. After**

due consideration of the matter, I hold that company was not justified in not taking any decision on the claim filed by the complainant. In my considered view, after perusing the details of treatment discharge summary claim was payable. Accordingly, an Award is passed with the direction to the insurance company to make the payment of Rs. 15849.

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 CENTRE

Case No.GI/37/NIA/12

In the matter of Sh. Ravinder Oberoi
Vs
New India Assurance Company Ltd.

AWARD DATED 30.5.2013 INADEQUATE SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Ravinder Oberoi (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 inadequate settlement of mediclaim.**

2. **Complainant submitted that he was admitted to Centre for sight, B5/24 Safdarjung Enclave, New Delhi on 14.10.2011 and discharged on 14.10.2011. The centre for Sight presented a preauthorization request for Rs. 55000 to E-Meditek TPA Services Ltd. but E-mditek approved only Rs. 47862 and excluded assistant surgeon fee of Rs. 7138. He had also written a letter to the GRO of the company. He was not able to understand as to why TPA had not approved the payment made to assistant surgeon. He has come to this forum with a request to instruct the**

insurance company to pay a sum of Rs. 7138 being assistant surgeon's fee. Complainant did not attend on the date of hearing.

3. **Representative of the company argued that claim was settled reasonably and a sum of Rs. 47,862 was paid as against the total claim of Rs. 55,000.**

4. **I have considered the submissions of the complainant as contained in the complaint. I have also considered the verbal arguments of the representative of the company. After due consideration of the matter, I hold that company was not justified in not paying the assistant surgeon's fee because policy terms and conditions do not exclude the payment of assistant surgeon fee when the insured had paid this amount, he is required to be compensated by the insurance company. Accordingly an Award is passed with the direction to the insurance company to make the further payment of Rs. 7,000.**

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 CENTRE

Case No.GI/45/UII/12

In the matter of Sh. Shiv Kumar Sharma

Vs

United India Insurance Company Ltd.

AWARD DATED 31.5.2013 NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Shiv Kumar 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 settlement of mediclaim.**

2. **Complainant submitted that company was not justified in not releasing the payment in respect of hospitalization in St. Stephen's Hospital even after lapse of one year. Claim was made under policy bearing no. 040700/48/10/06/00002231. During the course of hearing, it was pleaded that two claims are pending.**

3. **Representative of the company pleaded that company desired certain information from the insured which was not given therefore, company rejected the claim.**

4. **I have considered the submissions of the complainant as well as of the representative of the company. I have also perused letter dated 12.12.2011 of the company informing the insured that his claim was closed. I have also perused other documents placed on record. After due consideration of the matter, I hold that company was not justified in closing the claim because both the claims are payable. Accordingly an Award is passed with the direction to the insurance company to make the payment of admissible amount of both the claims.**

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

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

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DELHI CENTRE

Case No.GI/51/NIA/12
In the matter of Sh. Narinder Kumar
Vs
New India Assurance Company Ltd.

AWARD DATED 31.5.2013 NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Narinder Kumar (herein after referred to as the complainant) against the decision of New India Assurance Company Ltd. (herein after referred to as respondent Insurance Company) relating to non settlement of mediclaim.**

2. **Complainant submitted that he had filed mediclaim for Rs. 1,50,778 on 18.10.2011. he also visited Raksha TPA to know the status of his claim. He came to know that the claim was rejected by citing clause 4.3 of the policy. He informed the TPA that his policy is in continuation with previous policies and he is having mediclaim policy since 1997 till date. He has shifted his mediclaim policy from Oriental**

Insurance Company Ltd. to New India Assurance Company Ltd. in 2009. He has come to this forum with a request to instruct the insurance company to make the payment of the claimed amount. During the course of hearing, it was also pleaded by him that claim was payable but company had denied it wrongly. He pleaded further that continuity benefit is required to be given to him as he has shifted from one Public Sector Company to another public sector company.

3. **Representative of the company pleaded that claim was not payable as the disease for which claim was made has 4 years waiting period and insured is not entitled to continuity benefit of the policy as he had taken mediclaim policy from the present insurer only w.e.f. 12.03.2009. Company also filed written reply dated 20.05.2013 wherein, it has been mentioned that complainant has lodged the claim for hospitalization in Primus Super Specialty Hospital, Chanakyapuri for the period from 10.09.2011 to 19.09.2011 for his mother Mrs. Prakash Wati for Knee joint pain on 20.10.2011 for Rs. 1,50,778 to Raksha TPA Ltd. as pr clause 4.3, OA is payable only after 4 years from the date of inception whereas in this case, the policy is in 3rd year running period. Therefore, claim stands not payable.**

4. **I have considered the submissions of the complainant as well as of the representative of the mapany. I have also perused the written reply of the company and other documents placed on record. After due consideration of the matter, I hold that company was not justified in rejecting the claim because the same was payable. The company had allowed renewal the policy from earlier date. The policy is continued since 1997. As a matter of fact, the company had allowed the continuity in the policy and also given the cumulative bonus at the time of renewing the policy. Moreover, insured was earlier insured by another public sector company and the policy is continued without any break. Therefore, in my view. Company was not justified in rejecting the claim. The claim is admissible. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 1,50,778.**

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 CENTRE

Case No.GI/38/NIC/12

In the matter of Sh. Krishan Kumar

Vs

National Insurance Company Ltd.

AWARD DATED 31.5.2013 NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Krishan Kumar (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 settlement of mediclaim.**

2. **Complainant submitted that he was covered under group mediclaim policy for the last 20 years with New India Assurance Company Ltd. through his employer M/s Escorts Limited. He retired from the company on 31.08.2010. Before retirement his employer issued a certificate about the coverage under the policy and he himself approached the National Insurance Company though authorized agent to get the insurance policy well before the expiry of the policy and thus company issued the policy on the expiry of the policy on 31.08.2010. On 10.10.2010, while on morning walk, he fell down on road and family members rushed him to Kalra hospital in unconscious condition and he was admitted in the ICU up to 13.10.2010. He has come to this forum with a request to ensure settlement of the claim. During the course of hearing, it was also pleaded by the complainant that he filed the claim for Rs. 29000 and company had denied the claim.**

3. **Representative of the company pleaded that claim was not payable due to Pre-existing disease and the proposer did not cover the pre-existing disease. Company also filed written reply dated 26.06.2012 wherein, it was mentioned that complainant was having Hypertension and Diabetes since 9 to 10 years as per information given during hospitalization from 06.08.2011 to 14.08.2011. Patient had not given extra premium for covering Hypertension and diabetes. As the disease related to hypertension and diabetes, it was repudiated under clause 4.1 of the policy.**

4. **I have considered the submissions of the complainant as well as of the representative of the company. I have also perused written reply of the company which is placed on record. After due consideration of the matter, I hold that company was not justified in holding that claim was not payable due to pre-existing disease because no evidence was brought on record to the effect by the**

company that insured was suffering from the disease for which claim was preferred at the time of inception of the policy. In my view 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 the payment of Rs.18218/- Subject to deduction of the amount already paid if any.

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 CENTRE

Case No.GI/49/NIC/12

In the matter of Sh. Ravinder Wadhwa

Vs

National Insurance Company Ltd.

AWARD DATED 31.5.2013 NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Ravinder Wadhwa (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 settlement of mediclaim.**

2. **Complainant submitted that his wife Smt. Prem Wadhwa suffered from Cataract in both eyes and operated at Vision Eye Centre on 13.05.2011 and 06.06.2011. East West Assist TPA Pvt. Ltd. denied the settlement of the claim on the ground that there was break in the policy and eye cataract treatment has two years waiting period. He further submits that his insurance policy is in continuation for last 4 years and there was gap of only 2 days on renewal of the policy which expired on 22.02.2009 and renewed from 24.07.2009 and it was agreed by the Divisional Manager of the company Mr. Sharma for which he had applied vide letter dated 27.07.2011 which were duly received by the company to condone the gap of two days. He was not aware about the procedure therefore, he did not follow up the issue. He also had taken the matter with GRO of the company as well as of at Regional office. He has come to this forum for intervention and instruction to the insurance company to settle the claim. During the course of hearing, the complainant submitted that he filed reimbursement claims for eye operations for both the eyes. Company did not respond to the claims.**

3. **Representative of the company pleaded that company did not decide the claims on account of gap in 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 not settling the claims of the complainant so far. There was gap only of 2 days and complainant had requested for condonation of gap for two days. There was no inordinate delay in renew of policy which the company could not consider. In my considered view, claims were payable and company was not justified in not taking the decisions so far. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 49,868.**

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 CENTRE

Case No.GI/44/UII/12

In the matter of Sh. Sovinder Singh
Vs
United India Insurance Company Ltd.

AWARD DATED 31.5.2013 NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Sovinder 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 Settlement of Mediclaim.**

2. **Complainant submitted that he had taken unicare insurance policy from United India Insurance Company Ltd. which covered risk of valuables and other house hold items. The policy was valid up to 24.06.2012. He filed the claim for loss of valuables with United India Insurance Company Ltd. on 07.06.2011. All the documents such as police FIR and police untraceable report etc. were also enclosed along with the claim. He had submitted reimbursement to the company on 06.07.2011 and on**

11.08.2011 but he had been given no response. He also approached the IRDA and chairman of the company. He had also approached the GRO of the company. He has come to this forum with a request to ensure settlement of the claim. During the course of hearing, complainant submitted that in his case sum insured was only Rs. 1 lakh. He also informed this forum that he had already got a sum of Rs. 50,000 from the bank against the loss and he is entitled to a sum of Rs. 1 lakh from the insurance company against the claim filed.

3. **Representative of the company pleaded that insured did not give papers to the insurance company. If papers are made available to the insurance company, it will look into the papers and decide the case within two weeks. Company was also required to submit reply within a week but so far no reply was submitted.**

4. **I have considered the submissions of the complainant as well as of the representative of the company. I have also considered the written reply of the complainant dated 24.05.2013 wherein, he had mentioned that he had already submitted the requisite documents to the insurance company as required during the course of hearing, on 23.05.2013. After due consideration of the matter, I hold that company was not justified in not settling the claim so far. There is no reason not to accept the version of the insured that he had already submitted requisite documents to the insurance company besides submitting the same on 23.05.2013. A part of the loss was already paid by the bank amounting to Rs. 50,000 and the remaining loss in my considered view is to be compensated by the insurance company equalent to the sum insured of Rs. 1 lakh. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 1 lakh.**

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

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

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DELHI CENTRE

Case No.GI/539/RGI/11

In the matter of Sh. Sanjeev Saini

Vs

Reliance General Insurance Company Ltd.

AWARD DATED 31.5.2013 NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Sanjeev Saini (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 submitted that he had purchased online Family floater plan w.e.f. 05.12.2008 to 04.12.2009. The policy was renewed subsequently. His wife was diagnosed as CKD stage 5 and was on dialysis. He submitted that when he purchased family floater policy, she was suffering from CKD problem or for that matter any disease. Not only she but any other member of the family was suffered from any disease at the time of taking the policy. When his family was not suffering from any disease at the time of taking the policy, there was no question of declaring any disease. On 28.09.2011, his wife got kidney transplant operation her mother was the donor. Operation was done by Dr. Ramesh and Dr. Ambar Khan in Moolchand Hospital, Delhi. TPA was not justified in denying the claim on the ground of Pre-existing-disease and non declaration of such disease. He has come to this forum with a request to instruct the insurance company to make the payments relating to his pending 6 claims. During the course of hearing, it was pleaded by him that all the claims relating to policy period 2010-2011 are payable.**

3. **Representative of the company was required to submit detailed reply but no reply was filed.**

4. **I have considered the submissions of the complainant as well as of the representative of the company and other documents brought on record. After due consideration of the matter, I hold that company was not justified in denying the claims on the ground of Pre-existing disease because company had not brought on record any evidence to the effect that insured was suffering from the disease for which she was treated and claims were made prior to taking the policy. Moreover, the disease for which claims were filed did not have any waiting period. Therefore, in my considered opinion claims were payable and company was not justified in**

denying the payment of such claims. All the six claims are payable. Accordingly an Award is passed with the direction to the insurance company to make the payment of Rs. 1,44,598 (Rs. 8370+ Rs.9281+ Rs. 15750+ Rs. 29796+ Rs. 19079+ Rs. 62322).

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 CENTRE

Case No.GI/368/BAJAJ/12

In the matter of Sh. Chain Singh Panwar.

Vs

Bajaj Allianz Gen. Insurance Company Ltd.

AWARD DATED 3.5.2013 DENIAL OF MEDICLAIM

1. **This is a complaint filed by Sh. Chain Singh Panwar (hereinafter referred to as the complainant) against Bajaj Allianz Gen. Ins. Co. Ltd. (Hereinafter referred to as respondent insurance company) relating to mediclaim.**

2. **Complainant submitted that he had taken an insurance policy from Bajaj Allianz Gen. Ins. Co. Ltd. Before taking insurance he intimated the company that he was diabetic and was taking tablet Zyril-1. He suddenly suffered from fever in month of July, 2012 and after advice of Dr. He was hospitalized on 24.07.2012. He claimed hospital cash allowance but the same was denied to him. He submitted that it was a fraud with insured person. He has come to this forum with a request to redress the grievance. Complainant did not attend the hearing as he was away from the town. However he pleaded that his case be decided on the basis of documents placed on record.**

3. **Representative of the company pleaded that claim was not payable as insured suffered from the disease which was a complication of diabetes. Company also filed written reply dated 15.04.2013 wherein it was mentioned in so many words that claim was not payable and the same was rightly repudiated.**

4. **I have considered the submissions of the complainant as contained in the complaint. I have also considered the verbal arguments of the representative of**

the company and also perused 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 claim was payable. The company had repudiated the claim on flimsy grounds. The claim is held payable. Accordingly an award is passed with the direction to the insurance company to make payment as per policy terms and conditions i.e. at the rate of Rs. 500 per day for 12 days.

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 CENTRE

Case No.GI/445/NIC/12
In the matter of Smt. Prem Lata Goyal.
Vs
National Insurance Company Ltd.

AWARD DATED 3.5.2013 : NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Smt. Prem Lata Goyal (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 she underwent an eye operation on 15.03.2011 at Rajasthan eye center and she was discharged on 16.03.2011. She duly intimated the insurance company about the Eye operation on 14.03.2011. She submitted the claim on 11.03.2011 for an amount of Rs. 6,878. The company repudiated the claim on 28.08.2011. She has come to this forum with a request to instruct the insurance company to make the payment of the claim. During the course of**

hearing it was pleaded that claim was payable but company had denied it wrongly.

3. **Representative of the company argued that claim was not payable due to late filing of the claim.**

4. **I have considered the submissions of eth 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 otherwise admissible and payable claim can not be declined only on the ground of late submission of the claim. Accordingly an award is passed with the direction to the insurance company to make the payment of Rs. 6,878.**

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 CENTRE

Case No.GI/379/NIC/12
In the matter of Sh. Prakash Chand Garg.
Vs
National Insurance Company Ltd.

AWARD DATED 3.5.2013 NON SETTLEMENT OF MEDI CLAIM

1. **This is a complaint filed by Sh. Prakash Chand Garg (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 took the policy on 09.02.2009 from National Ins. Co. Ltd. During the policy period with effect from 09.02.2010 to 08.02.201,**

he and his wife were insured for an amount of Rs. 1 lac each. During the course of treatment on 6.04.2010, he came to know that his wife Smt. Gyan Garg had cancer and treating Dr. advised her to immediately rush to Mumbai for getting treatment for the disease. Accordingly, he started for Mumbai on 7.04.2010. He intimated about the treatment to the insurance company through his agent and he was assured as was stated to him by the agent, by the manager of the insurance company that he should get his wife treated as advised by the Dr. The cancer was confirmed and his wife was operated on 21.04.2010. Thereafter she underwent radiation and chemotherapy. After treatment in Mumbai, he returned in month of July, 2010. He had submitted full details to the insurance company after coming from Mumbai. The patient was advised to consult after every three months. He remained busy with the treatment of his wife. He came to know that company had repudiated 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 delay occurred in filing the claim as the priority was to get the patient treated as soon as possible. However intimation of hospitalization was given to the insurance company. The patient suffered with a deadly disease and due to attending the patient, delay occurred in submitting the claim.

3. **Representative of the company argued that claim was not payable due to late filing of the claim.**

4. **I have considered the submissions of the complainant as well as of the representative of the company. I have also perused documents placed on record including repudiation letter. After due consideration of matter, I hold that company was not justified in repudiating the claim because claim was payable undoubtedly insured suffered with a deadly disease and had to get operated and treated. Disease was detected and confirmed during the policy period. Insured was hospitalized and treated during the policy period. Merely because claim was filed late that too with some justification, the same can not be denied as it was otherwise payable. Accordingly an award is passed with the direction to the insurance company to make the payment of Rs. 1 Lac being maximum sum incurred.**

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.**

DELHI CENTRE

Case No.GI/405/Star/12

In the matter of Sh. Mukesh Aggarwal

Vs

Star Health & Allied General Insurance Company Ltd.

AWARD DATED 31.5.2013 NON SETTLEMENT OF MEDICLAIM

1. **This is a complaint filed by Sh. Mukesh Aggarwal (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 submitted that he had taken the health insurance policy from Star Health & Allied insurance Company Ltd. for the first time on 23.11.2009 covering himself, his wife and son for Rs. 4 lacs floater. The policy no. was P/161100/01/2010/006188. This policy was renewed subsequently as and when due and is continued. In January 2012, his wife Smt. Neetu Aggarwal underwent a surgery at Primus hospital, 2, Chandragupta Marg, Chanakyapuri, New Delhi. The claim was submitted for cashless surgery but the same was denied by the insurer. So, after surgery he submitted the claim papers for reimbursement but company rejected the claim quoting condition no. 7 of the policy. He has submitted further that company was not justified in denying the claim. He further clarified that in January 2012, his wife suffered a fresh problem i.e. pain in right abdomen off and on radiating to back for one week. For this she consulted Dr. Harish Kapoor at Primus Hospital, 2, Chanakyapuri Marg, New Delhi. As per the advice of Doctor Harish, she was operated on 10.01.2012 for a fresh CBD stone in abdomen and discharged on 12.01.2012. Company was not justified in linking the surgery of 2009 with the surgery done in 2012. Both surgeries were independent. This fact was also certified by doctor Harish Kapoor. He has come to this forum with a request to instruct the insurance company to make the payment of claim amounting to Rs. 91996. During the course of hearing also it was pleaded by him that claim was payable and company was not justified in denying the same.**

3. **Representative of the company pleaded that claim was 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. After due consideration of the matter, I hold that**

company was not justified in holding that claim was not payable due to pre-existing disease because the condition quoted by the company while declining the claim was not applicable because surgeries done in 2009 and in 2012 were independent. The surgery done in 2012 for which claim was preferred was not related in any way to the surgery done in 2009. There was no evidence brought on record by the company to the effect that disease for which claim was filed and denied by the company was existing prior to taking the policy in 2009. 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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GUWAHATI

GUWAHATI OMBUDSMAN CENTRE
Complaint No. 11-G16-072/12-13

Mr. Banwari Chandak

- **Vs -**

Star Health and Allied Ins. Co. Ltd.

Date of Order : 29.07.2013

Complainant: The Complainant stated that he procured Family Health Optima Insurance Policy No. P/191311/01/2012/001509 for his entire family members from the above Insurer covering the period from 04.01.2012 to 03.01.2013. While the policy was in force, his wife Mrs. Ritu Chandak was admitted in International Hospital, Guwahati on 13.06.2012 due to acute abdomen pain and breast pain and was discharged on 14.06.2012. After completion of usual treatments, he lodged a claim for Rs.14,750/- 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 as per the discharge summary, the Insured Mrs. Ritu Chandak was admitted with history of pain abdomen with bilateral breast pain and clinical summary states that all vital functions - pulse, BP, Chest – normal. P/A (Per Abdomen), soft PS + (Peristaltic +),

bilateral tender breast, nipple discharge +, non definite lump felt. She was thoroughly investigated – complete blood tests, USG abdomen, X-Ray chest and breast, thyroid profile, urine protein examination and culture histopathology of nipple discharge, CA 15-3 and mammography.

All the above mentioned tests were reported as normal. She was started on oral drugs and advised to continue the same. Hence the admission was clearly for investigation purposes. It is to be noted that no drugs were given for her alleged pain abdomen. All the above investigation and treatment could have been carried out on OP basis and did not warrant admission. Hence, the claim is rejected as per Exclusion No. 12/13 of the policy.

Decision : The Insurer has repudiated the claim as the patient Mrs. Ritu Chandak was admitted in the Hospital for investigation and evaluation purpose only. It is an established fact that Hospital is not a place of entertainment. Nobody wants to get admitted himself in the Hospital on his own choice. Considering the gravity of the disease of the patient, Doctor decides whether patient is to be admitted in the Hospital or it can be managed as out patient. Although the Insurer opined that the patient was admitted for investigation only, but the Discharge Certificate of International Hospital, Guwahati clearly shows that the patient was admitted in the Hospital for investigation and treated conservatively which proves that the patient did not stay in the Hospital only for investigation and evolution. There was treatment of the patient in the Hospital as the Doctor considered it necessary. In such a situation, I don't find any reason as to why the Insurer did not consider it to be sufficient. The claim appears to have been repudiated on a ground which is considered unjustified and unreasonable and hence the repudiation action of the Insurer is set-aside.

Insurer is accordingly directed to settle the claim within 15 days allowing penal interest @ 8% P.A. on the premium amount.

GUWAHATI OMBUDSMAN CENTRE
Complaint No. 11-G4-036/12-13

Mr. Pukhraj Nahata

- Vs -

The Oriental Insurance Co. Ltd.

Date of Order : 17.05.2013

Complainant: The Complainant stated that he procured Individual Mediclaim Policy No. 322300/48/2011/586 for spouse from the above Insurer covering the period from 29.05.2010 to 28.05.2011. During the policy coverage period, his wife Mrs. Madhu Devi Nahata was admitted in S.M. Hospital, Bongaigon on 29.03.2011 and

was discharged on 02.04.2011. After completion of usual treatments, he lodged a claim before the Insurer along with all supporting documents. But the Insurer has repudiated the claim without any justified ground. Being aggrieved, the Complainant has filed this complaint.

Insurer : The Insurer has stated in their "Self Contained Note" that the E-Meditek TPA vide reminder dated 09.08.2011 has asked from the Complainant for the history of disease mentioning all complains at the time of first consultation duly certified by the treating Doctor. But the Complainant neither submitted the same nor any reply was received from the Complainant. As such "No Claim" letter was sent by TPA on 12.08.2011. It is evident from the discharge certificate that the patient was diagnosed in the nature of Acute disease which needs clarification for arriving at their liability. Hence, TPA has asked for clarification since when the patient was having complains and asked for the details of medical treatment undergone. But, the Complainant did not reply to the queries made by TPA, hence the claim was treated as 'No Claim'.

Decision : The copy of claim forwarding letter dated 18.04.2011 submitted by the Complainant before the Insurer discloses that the Complainant submitted seven nos. of documents to the Insurer. Insipte of the above documents, the TPA of the Insurer had requested the Insured to submit the document like – The H/o Disease Since When (Mentioning all complies at the time of first consultation) certified by the treating Doctor. Due to non-receipt of above document the TPA had finally closed the claim file of the Complainant. The Complainant stated in his statement that his wife Madhu Devi Nahata suddenly developed some problem in stomach for which she was admitted in the Hospital. The Insured was first time admitted in the Hospital. As the Insured suffered first time for the above disease, wherefrom the Complainant will collect the previous treatment particulars. It is the burden of the Insurance Company to collect the previous treatment particulars of the Insured through their investigator. Hence, there is no relevancy on the query of the Insurer to submit the first consultation certified by the treating Doctor by the Complainant. But, the Insurer failed to produce any previous treatment particulars of the Insured. Therefore, the Insurer is liable to pay the entire claim amount as per terms and conditions of the policy.

The Insurer is accordingly directed to reopen the matter and arrange to settle the claim within 15 days from the date of receipt of the order allowing penal interest @ 8% P.A. on the settled amount. With this observation, the complaint is treated as closed.

GUWAHATI OMBUDSMAN CENTRE
Complaint No. 11-G7-049/12-13

Mr. Shyamal Sen

- Vs -

Royal Sundaram Alliance Insurance Co.Ltd.
Date of Order : 07.05.2013

Complainant: The Complainant stated that my wife Suchitra Sen procured Family Health Protector Insurance bearing Policy No. HMA 0018814000100 for entire family members from the above Insurer covering the period from 14.03.2011 to 13.03.2012. The said policy was being renewed from 14.03.2010. While the policy was in force, my wife/Insured Suchitra Sen was admitted in International Hospital on 09.02.2012 due to fever, cough, breathing difficulties and chest pain. and was discharged on 01.03.2012. He thereafter lodged a claim before the Insurer along with all supporting documents. But, the Insurer has repudiated the claim without any justified ground. Feeling aggrieved, he has lodged this complaint.

Insurer : The Insurer contended that the cashless facility as well as the claim being made by the Complainant for Rs. 99,436.00 for treatment and investigation carried out at both the Hospitals namely viz. M/s International Hospital and Apollo Hospital for the ailment of Lung Carcinoma is inadmissible as policy as all treatments and investigations made for any Carcinoma ailment are expressly excluded under the policy terms under the two year exclusion clause. Therefore, they have repudiated the claim of the Complainant.

Decision : Although Complainant has stated that the above policy was being renewed from 14.03.2010 but he did not produce the previous policy before this Authority. If he took the policy in the year 2010 even then the relevant policy did not cross the two years term. It appears that the Complainant lodged the claim before the Insurer within the second year term of the policy. It reveals from the copy of Discharge Certificate that the Insured Suchitra Sen was admitted in International Hospital, Guwahati on 09.02.2012 and was discharged on 01.03.2012. It discloses from the Discharge Certificate and other Laboratory Reports that the Patient was treated for Lung Carcinoma. The Complainant also stated in his complaint petition that the Broncoscopy report of Apollo Hospital, Chennai dated 08.03.2012 confirmed Lung Carcinoma and the patient was given the first dose of Chemotherapy at Guwahati on 29.03.2012. Presently she is undergoing treatment under the supervision of Dr. C. Bhuyan, Oncologist. It is manifestly clear from the medical documents and the statements of the parties that the patient was suffering from Lung Carcinoma. On a close perusal of the policy terms and conditions, it is clearly mentioned in the column of Exclusion that the Company shall not be liable under this policy for any claim in connection with or in respect

of treatment of any type of Carcinoma for the two years from the commencement date of the cover with them under this Family Health Protector Policy.

Considering the entire facts and circumstances, I have no hesitation to hold that the decision of the Insurer in repudiating the claim of the Complainant was just and reasonable. Finding no ground to interfere with decision of the Insurer, the complaint is dismissed and is treated as closed.

GUWAHATI OMBUDSMAN CENTRE
Complaint No. 11-G4-023/13-14

Mr. Adhar Deka

- Vs -

The Oeiental Insurance Co. Ltd.
Date of Order : 19.09.2013

Complainant : The Complainant stated that he procured an Happy Family Floater Policy No. 321204/48/2013/20131518 including his parent from the Oriental Insurance Co. Ltd. covering the period from 21.08.2012 to 20.08.2013. While the policy was in force, his father Mr. Upen Deka was admitted in Sanjevani Hospital, Guwahati on 14.01.2013 and was discharged on 16.01.2013. After completion of usual treatments, he lodged a claim for Rs. 28,000/- before the Insurer along with all supporting documents. But, the cashless facility was denied by the TPA of the Insurer due to known smoker. Feeling aggrieved, this complaint was lodged.

Insurer : The Insurer has contended in their "Self Contained Note" that the patient was diagnosed with COPD with acute exacerbation. Inflammatory (Chronic) changes in the lung tissues observed. The patient is a known smoker and the ailment is related to smoking. The history of smoking is clearly recorded in the prescription dated 14.01.2013 of Dr. Rajesh Sarma which was submitted to Raksha TPA with pre authorization form to avail cashless benefit. It is mentioned in the discharge certificate that the patient is a known smoker. They have obtained opinion from Dr. S. Mitra, their penal Doctor & on careful observation of the patient's hospitalization documents, their penal Doctor is of the opinion that the disease is normally related to smoking, air pollution etc. The disease is also chronic in nature. Hence, the claim was repudiated under clause 4.8 as per policy terms and conditions.

Decision : I have gone through the clause 4.8 of the policy terms and conditions and found that the word 'smoking' has not found place in that clause. I have also carefully gone through all the medical documents produced by the Insurer and nowhere it is mentioned that the disease of the Insured Mr. Upen Deka is directly related to smoking. Panel Doctor of the Insurer Dr. S. Mitra mentioned in his certificate (Annexure – E) that the disease is normally related to smoking, air

pollution etc. He never firmly stated that this disease is related to smoking only. It reveals from the statement of the representative of the Complainant that his father Mr. Upen Deka was a smoker but he gave up the smoking after 2003 on their protest. Although it is mentioned in the Discharge Certificate (Annexure – C) that the Insured Mr. Upen Deka is a known smoker but the certificate dated 16.01.2013 issued by Dr. Rajesh Sarma that Mr. Upen Deka reveals that Mr. Upen Deka is an occasional smoker and has no past treatment. The above documents make it crystal clear that although the Insured Mr. Upen Deka is an occasional but no where it is mentioned that the disease of the Insured is caused by smoking.. Therefore, the decision of the Insurer in repudiating the claim is not just and proper. The decision of the Insurer is set-aside. The Insurer is liable to make payment of entire claim amount of the Complainant.

Insurer is accordingly directed to settle the claim within 15 days allowing penal interest @ 8% P.A. on the premium amount

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KOCHI

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/ KCH/GI/14-005-831/2011-12

Silphy Elizabeth Joseph

Vs.

Oriental Insurance Co Ltd.

Award No.GI/ 3/2013-14 dt. 4.4.2013

The complainant had a medical insurance policy with the respondent insurer. She was hospitalized and underwent a surgery for removal of ovarian cyst. When she preferred a claim, the same was rejected. She made a representation to the insurer. There was no response. Hence, the complaint.

Respondent-insurer entered appearance and filed a self-contained note. The claim was repudiated as treatment for ovarian cyst is excluded in the first year under policy condition No. 4.3(ii).

The Point: As per medical evidence, the complainant underwent surgery and the diagnosis was ovarian cyst with focal peritonitis. As per clause 4.3 of the policy conditions

which deals with exclusions, the waiting period for which claims are not payable, is one year for Policystic ovarian diseases. The insurance cover was for the period from 17.6.2010 and the hospitalization was on 12.5.11. The waiting period of one year has not expired.

Decision: The complainant is not entitled to any relief as the repudiation of the claim is sustainable. In the result, the complaint is dismissed. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/ KCH/GI/11-005-835/2011-12

K Manoj Kumar

Vs.

Oriental Insurance Co Ltd

Award No.GI/4/2013-14 dt. 4.4.2013

The complainant and his family members were covered under happy Family Floater policy issued by the respondent-insurer. Mother of the complainant was hospitalized and claim for reimbursement of hospital expense was preferred. The insurer repudiated the claim. Hence, this complaint.

There was no representation from the insurer. No self contained note was filed. So, it is to be inferred that the respondent-insurer is impliedly admitting the averments made in the complaint.

The point: The TPA had repudiated the claim as per clause 4.3 of the policy conditions which excludes payment for the relevant period stated against each disease. For hypertension, the waiting period is two years. As per medical evidence, the mother of the complainant had taken treatment for Ischemic heart Disease. As per the attending doctor's certificate, she had never been hypertensive in her life. Hence, Ischemic heart disease suffered by her cannot be considered as a complication of hypertension. The hospital records would reveal that the blood pressure of the mother of the complainant was always within the normal parameters. So, there is no material available to relate Ischemic heart disease suffered by the mother of the complainant with hypertension.

Decision. An award is passed directing the respondent-insurer to pay to the complainant an amount of Rs. 7949/- within the period prescribed with cost of Rs. 500/-. Failing which Rs. 7949/- shall carry interest @ 9% pa from the date of filing of complaint till payment is effected.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-004-854/2011-12

N C Jacob

Vs

United India Insurance Co. Ltd

AWARD No. IO/KCH/GI/09/2013-14 dated 11.04.2013

The complainant had been taking Mediclaim policy from the Respondent-Insurer since 1999. In connection with treatment of CIDP he was admitted in Amrita Hospital. The claim for the same was repudiated by the insurer on the ground that the treatment could have been done on OPD basis. Therefore, the complaint.

The complainant submitted that the admission was as per the advice of the treating doctor and active treatment was given. Also claim for treatment of the same ailment was admitted by the insurer earlier.

The insurer submitted that the treatment could have been taken on OPD basis and the claim is hit by Note to Clause 2.3 and 4.10 of the policy conditions. The repudiation is on valid grounds.

Decision:-The discharge summary shows the diagnosis as CIDP. It also reveals that he was on steroids and was having respiratory infection as well. He was provided treatment for respiratory infection, skin disease and CIDP during hospitalization. He was also provided Physiotherapy. Investigations were done for evaluation of the ailments and proper diagnosis. There is nothing to suggest that the treatment could have been done on OPD basis. So, Note to Clause 2.3 is not applicable in this case. Medical records shows that there was active line of treatment during hospitalization. Moreover, hospitalization was on the advice of the treating doctor, who is the most competent person to decide the same. So, repudiation of the claim under Clause 4.10 of the policy conditions can not be sustained. In the result, an award is passed directing the insurer to pay an amount of Rs. 32660/- 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.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/ KCH/GI/11-005-884/2011-12

Sri K V Mahadevan

Vs.

National Insurance Co Ltd.

Award No.GI 13/2013-14dt.16.04.2013

The complainant's wife, who was covered by medical insurance policy with the above insurer, was hospitalized and the complainant submitted a claim for reimbursement of expenses incurred. The claim was rejected. He followed up the matter with the Insurer but the Regional Office of the insurer also confirmed repudiation. Hence this plea.

Respondent-insurer entered appearance and filed a self-contained note. They submitted that the wife of the complainant had suffered only Gr II Ankle sprain for which treatment could have been taken on OPD basis and no hospitalization was required.

The Point: The medical documents revealed that the wife of the complainant suffered Gr II ankle sprain (rt) . The hospitalization records would further suggest that hospitalization was perfectly justified and there is nothing therein to suggest that treatment which could have been given on OPD basis had been converted to in-patient treatment. On account of the overwhelming evidence which justifies hospitalization, clause 4.23 cannot be invoked in the present case. So, repudiation is not sustainable.

Decision: An award is passed directing the respondent-insurer to pay to the complainant, an amount of Rs. 3605/- within the prescribed period failing which, the amount shall carry interest @ 9% pa from the date of filing of complaint till payment is effected. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/ KCH/GI/11-005-909/2011-12

D Chandrasekhara Menon

Vs.

Oriental Insurance Co Ltd.

Award No.GI 14/2013-14 dt. 17.4.2013

The complainant was covered by CABAL's Insurance policy for continuous ambulatory peritoneal dialysis patients. He suffered recurrent Peritonitis. Catheter implanted was removed and he was under haemodialysis twice weekly. Again, reinsertion of catheter was attemped. It failed. He submitted claims forms seeking reimbursement of hospital expenses. It was repudiated. He represented again to the insurer. Now, this prayer before this Forum.

The respondent insurer entered appearance and filed a self-contained note. They had referred the file to a medico legal expert for his opinion. On the basis of the same, the claim was repudiated. However, the file was again sent to the medico legal expert after receipt of a letter from the complainant along with a certificate issued by the treating doctor. As per the medico legal expert's opinion, the respondent-insurer authorized payment of Rs. 35,282/-. In the first hospital admission, catheter was removed and in the second admission, there was an attempt for reinsertion of catheter. The policy reimburses hospital expense if only there is peritoneal infection. In the second admission, as the procedure could not be carried out, the claimant was allowed 50% of the expenses in relation to the second admission.

The point: In the discharge summary relating to the second admission, it is stated that the procedure was abandoned. A thorough scrutiny of the medical documents available would reveal that it was not a case of failure. It was a case where the procedure was carried out but the desired result could not be accomplished. The respondent-insurer failed to highlight any policy condition which would approve their action which suggested that in such a situation, their liability will be 50% of the expenses only. Hence, they are not authorized to reduce the claim by 50% on account of the alleged failure of reinsertion of CAPD catheter.

Decision: All the expenses incurred by the complainant are supported by medical bills. In the circumstance, the complainant is entitled to get reimbursement of the entire medical expense. The liability of the respondent-insurer is fixed at Rs. 47368/- which he should pay within the period prescribed failing which Rs. 47368/- shall carry interest @ 9% pa from the date of filing of complaint till payment is effected. Also, a cost of Rs. 2500/- should be paid to the complainant.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-004-873/2011-12

Chandra Bose

Vs

United India Insurance Co. Ltd

AWARD No. IO/KCH/GI/15/2013-14 dated 17.04.2013

The complainant had taken Individual Health Insurance policy from the Respondent-Insurer . The hospitalization claim of one of the covered was not settled by the insurer in spite of several reminders. Therefore, the complaint.

The complainant submitted that the claim was submitted within the time limit and there is no reason for not reimbursing the same.

The insurer submitted that there was delay in submission of the claim and the clarifications sought from the insured were not given.

Decision:- The genuineness of the medical documents and bills are not challenged by the insurer. No prejudice has been caused to the insurer in processing the claim, on account of delay, if any, occasioned. So, the repudiation of the claim on the hyper-technical ground of delay can not be sustained. Discharge summary and certificate from the Hospital shows the diagnosis as Balanoposthetis with secondary phimosis. He showed symptoms such as inability to pass urine etc. at the time of admission. The need for hospitalization is not questioned by the insurer. So, the claim is payable as the claim does not come under any of the exclusion Clauses. The complainant is entitled to Rs. 1075/- as pre-hospitalisation expenses and Rs. 7971/- as hospitalization expenses. In the result, an award is passed directing the insurer to pay an amount of Rs. 9046/- 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.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/ KCH/GI/11-004-866/2011-12

M Sowmya

Vs.

United India Insurance Co Ltd.

Award No.GI 16/2013-14 dt. 17 .4.2013

The complainant had been taking mediclaim policy from the respondent-insurer for the last fifteen years without any break. She submitted a claim for reimbursement of Rs.56010.80 in connection with her treatment in Kottakkal Arya Vaidyasala. After a lapse of seven months, the insurer settled the claim partially. Representation made by the complainant to the insurer did not evoke a positive response. Now, this complaint.

During hearing the insurer was represented by their duly appointed advocate. She submitted that the TPA doubted the genuineness of certain bills submitted by the complainant and hence, the claim was partially settled.

The Point: It is noted that the insurer had not filed their self contained note controverting the averments contained in the complaint. So, the inference that can be drawn is that the insurer is impliedly admitting the averments in the complaint. The courses of treatment provided in the hospital is not disputed by the insurer. The genuineness of the medical documents is not disputed by the insurer. The bill would reveal that the complainant had paid Rs. 56010.80 for her treatment out of which Rs. 31819/- was settled by the insurer. The reason for non-settlement of the remaining expenses is not explained by the insurer. Even at the time of hearing they could not properly explain non-settlement of the entire claim.

Decision: The hospital bill produced by the complainant would reveal that the hospital had collected Rs. 200/- towards registration fee and Rs. 800/- towards service charges. These are not payable. In the result, an award is passed directing the insurer to the pay to the complainant, an amount of Rs. 23191/- with cost of Rs. 1000/- within the prescribed period failing which the amount of Rs. 23191/- shall carry interest @ 9% pa from the date of filing of complaint till payment is effected.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/ KCH/GI/11-005-885/2011-12

S Varghese

Vs.

Oriental Insurance Co Ltd.

Award No.GI /19/2013-14 dt. 19.04.2013

The complainant was covered by a Mediclaim Policy issued by the above insurer. He was hospitalized and underwent treatment at Amala Ayurvedic Hospital and Research Centre, Thrissur. The claim preferred by him was repudiated by the Insurer. Hence, this complaint.

The Respondent Insurer submitted that the claim was repudiated based on Note to Clause 2.1 of the policy conditions, on the ground that the complainant had taken treatment from a private Ayurvedic Hospital. The complainant stated that he was not aware that the policy provides reimbursement if only treatment was taken in a government hospital or medical college hospital.

Decision: Amala Ayurvedic Hospital and Research Centre is accredited by the National Accreditation Board for Hospitals (NABH). It is a private hospital. It is neither a government hospital nor a medical college hospital. So, the claim is not admissible as per note to clause 2.1. The Respondent Insurer has no liability to reimburse the hospital expenses. Repudiation is in consonance with the policy conditions.

In the result, the complaint is dismissed. No cost.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-014-881/2011-12

Jose G Thekkekkara

Vs

Chola MS General Insurance Co. Ltd

AWARD No. IO/KCH/GI/22/2013-14 dated 25.04.2013

The complainant had taken a Health Insurance policy from the Respondent-Insurer through South Indian Bank. His wife and son were hospitalized. The claim for the same was repudiated by the insurer on the ground of delay and insufficient documents. Therefore, the complaint.

The complainant submitted that he had submitted the claim form and copies of the documents to the South Indian Bank with out any delay. He is entitled to reimbursement of the entire hospital expense.

The insurer submitted that there was delay of more than 57 days in submitting the claim. Also the original discharge summaries were not produced by the complainant in spite of reminders. The repudiation is legal and proper.

Decision:-Repudiation is taken on the ground of delay and not on the basis of non-submission of original discharge summaries. There is evidence that all the claim papers including medical documents and bills were routed through South Indian Bank. The insurer has no contention that on account of delay in receiving the claim forms, they were prejudiced in processing the claim. When the complainant had explained the delay satisfactorily, the repudiation of the claims on the ground of delay can not be justified. The allegation of overdose of medicines is a trespass into the territory of the treating doctor who is the best person to assess the condition of the patient and can be viewed only as a filmsy ground for denial of the claim. So, the entire amount under the two claims is reimburseable by the insurer. In the result, an award is passed directing the insurer to pay an amount of Rs. 2980/- 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.

. OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-019-875/2011-12

Sabin K George

Vs

Apollo Munich Health Insurance Co. Ltd

AWARD No. IO/KCH/GI/23/2013-14 dated 25.04.2013

The complainant had taken Easy Health policy from the Respondent-Insurer.. His son suffered injuries while playing and admitted to the Hospital.. The claim for the same was repudiated by the insurer. Therefore, the complaint.

The complainant submitted that his son was admitted in the hospital on the advice of the treating Doctor and hospitalization was required in the nature of the injury suffered. The repudiation is not proper.

The insurer submitted that treatment could have been done on OPD basis and as such, hospitalization was unwarranted. The repudiation was based on the Medical Report and treatment records. As per Section 6(e)(xv) of the policy conditions, the claim is not payable.

Decision:- The Discharge summary would reveal that the son of the complainant suffered contusion injury left knee with gross Hemarthosis and injury to Anterior curciate ligament. The Doctor, based on the gravity of the injury suffered, advised hospitalization. Course of Future treatment required is also mentioned in the Discharge Summary. The wisdom of the Doctor to admit a patient in the hospital can not be disputed by the TPA or the insurer without valid and cogent reasons. For effective treatment, the patient has to submit to the directions given by the treating doctor. Here there is nothing to show that the treatment which was given as in-patient , could have been given on OPD basis. So, the available evidence do not attract Section 6(e)(xv) of the policy conditions. The repudiation of the claim can not be justified. In the result, an award is passed directing the insurer to pay an amount of Rs. 7488/- with cost of Rs. 500/- within the prescribed period failing which the amount shall carry interest at 9% per annum from 03.02.2012 till the payment is effected.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-004-886/2011-12

Suresh L Sejpal

Vs

United India Insurance Co. Ltd

AWARD No. IO/KCH/GI/26/2013-14 dated 02.05.2013

The complainant had taken Individual Mediclaim policy from the Respondent-Insurer. His hospitalization claim was repudiated on the ground that the ailment was pre-existing. Therefore, the complaint.

The complainant submitted that the treatment was in no way connected with Diabetes Mellitus and the ailments were not related to or arising out of DM. Repudiation of the claim under Clause 4.1 can not be sustained.

The insurer submitted that DM was a pre-existing ailment. So an ailment which is a complication of a pre-existing ailment is also a pre-existing one and therefore, the claim was repudiated under exclusion Clause 4.1 of the policy conditions.

Decision:- Discharge summary shows the diagnosis as 'Necrotizing skin and soft tissue infection left foot, DM and Peripheral vascular disease. Incision-drainage and slough excision were done. The treating doctor's certificate mentions that DM is only a co-existing condition. Also it states that the present ailment is not a complication of any pre-existing ailment. The medical evidence available reveals that the ailment for which the complainant underwent treatment was independent of DM. In Clause 4.1, there is no mention that any complication arising from a pre-existing disease is also to be treated as pre-existing disease. So, exclusion Clause 4.1 is not at all attracted in the case of the complainant and as such the repudiation is not sustainable. In the result, an award is passed directing the insurer to pay an amount of Rs. 48746/- 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/11-004-904/2011-12

C D Johny

Vs

United India Insurance Co. Ltd

AWARD No. IO/KCH/GI/27/2013-14 dated 03.05.2013

The complainant had been taking Mediclaim policy from the Respondent-Insurer since 2002. His wife was admitted in hospital for treatment of Carcinoma. The claim for the same was settled partially only by the insurer. Therefore, the complaint.

The complainant submitted that during the course of hospitalization, he had renewed the policy without any break. The sum insured of the renewed policy was also available for settlement of the claim. Partial repudiation is not legal and proper.

The insurer submitted that the claim was settled based on the policy which was prevailing when the ailment was contracted. The balance sum assured available in the 2010-11 policy was settled. The sum assured in the renewed policy is not available for settlement of the claim. Claim was settled based on Clause 1.1 of the policy conditions.

Decision:-A close reading of Clause 1.1 would reveal that it does not envisage a situation where the hospitalization spans over two policy periods. Even in a case where the hospitalization extends beyond the policy period and the policy is not renewed and the ailment was contracted during the policy, the claim will be settled for available sum assured. There is clear anomaly in the contention of the insurer that the sum assured in the renewed policy period is not available to a disease contracted during the previous policy period. Renewal of policy without break will be rendered meaningless if such an absurd interpretation is given to Clause 1.1 of the policy conditions. As hospitalization was a continuous one, each day's hospitalization gives rise to a fresh cause of action and therefore, hospitalization from 11.09.2011 is to be construed as a fresh hospitalization. So, the stand taken by the insurer is not legal and proper. In the result, an award is passed directing the insurer to pay an amount of Rs. 50000/- 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/11-017-882/2011-12

Kanaka Prasad

Vs

Star Health & Allied Insurance Co. Ltd

AWARD No. IO/KCH/GI/28/2013-14 dated 03.05.2013

The complainant had taken medical insurance policy from the Respondent-Insurer on 05.02.2009. His wife was hospitalized for Hernia surgery and the claim was not settled by the insurer. Therefore, the complaint.

The complainant submitted that he is entitled to get reimbursement of the entire hospital expense.

The insurer submitted that no claim was intimated to them by the insured person. So, no claim was registered under the policy. So, there was no occasion to process the claim. Also it was submitted that the liability of the insurer in relation to surgery on account of Hernia during the first policy year is excluded under Clause 3.5 of the policy conditions.

Decision:-The contention of the insurer that they did not receive any intimation at all from the complainant can not be accepted, in view of the acknowledgement card produced by the complainant. At the same time, there is lack of evidence that the complainant had submitted a proper claim seeking reimbursement. The medical evidence shows that the wife of the complainant had undergone Hernia repair and abdominoplasty. As per Clause 3.5 of the policy conditions, the liability of the insurer is excluded in case of Hernia surgery during the first policy year. Here the surgery was during the first year of insurance cover. So, exclusion Clause 3.5 is attracted. Therefore, if at all there was a proper claim, by virtue of Clause 3.5 of the policy conditions, the insurer has no liability to settle the claim. The complainant is not entitled to any relief. In the result, the complaint is dismissed. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-002-905/2011-12

S Ramesh

Vs

New India Assurance Co. Ltd

AWARD No. IO/KCH/GI/29/2013-14 dated 15.05.2013

The complainant had been taking Individual Mediclaim policy from the Respondent-Insurer from 21.03.2006 onwards. The hospitalization claim of his wife was repudiated on the ground that the ailment was pre-existing. Therefore, the complaint.

The complainant submitted that his wife had undergone treatment for the same ailment in 2007 and the same was repudiated by the insurer and later admitted as per the order of the State CDRC. There is no evidence to the effect that she had contracted the illness prior to the inception of the first policy. The repudiation of the claim is against policy conditions.

The insurer submitted that the present repudiation is based on the repudiation of the claim relating to treatment for the same ailment in 2007. The present treatment is a continuation of the treatment in 2007. So the claim was repudiated under exclusion Clause 4.1 of the policy conditions.

Decision:- The present repudiation is based on the repudiation of the earlier claim submitted in 2007. There is evidence that the CDRF and State Commission had found that the repudiation of the claim in 2007 was illegal and improper. As per exclusion clause 4.1, to designate an ailment as pre-existing, the insured should have contracted the same prior to the inception of the first policy issued by the insurer. The available evidence is to the effect that the wife of the complainant had contracted the ailment during the 2nd policy period. So, in this case it can be concluded that the repudiation under Clause 4.1 is illegal and against policy conditions In the result, an award is passed directing the insurer to pay an amount of Rs. 68316/- with interest @9% from the date of filing of the complaint till the date of award with cost of Rs. 3000/- 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.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-005-927/2011-12

Siby Mathew

Vs

Oriental Insurance Co. Ltd

AWARD No. IO/KCH/GI/32/2013-14 dated 16.05.2013

The complainant had taken Individual Mediclaim policy from the Respondent-Insurer. The hospitalization claim of his son was not settled by the insurer. Therefore, the complaint.

The complainant submitted that his son was hospitalized in connection with severe fever and cough. The admission was on the advice of the doctor and active treatment was provided there. Investigations were done for proper diagnosis of the ailment. Exclusion Clause 4.10 is not at all attracted.

The insurer submitted that during hospitalization there was no active line of treatment and the patient was conservatively managed. So, the claim was rejected under Clause 4.10, 5.4 and 5.5 of the policy conditions.

Decision:- Discharge Summary shows the diagnosis as Wheeze associated with lower respiratory infection. The attending doctor's certificate also reveals that the patient suffered cough, fever and breathlessness for 3 days. The patient was treated with antibiotics, bronchodilator and antipyretics. The competent person to decide whether a patient is to be treated as in-patient or Out-patient is the treating doctor who has first hand direct information regarding the patient and the ailments. Active treatment is such treatment which is required for the cure of the ailments. Investigations were done for proper diagnosis of the ailments and this is necessary for proper treatment and medication. So, this is a case where hospitalization was required and during hospitalization, the patient was provided with active treatment. So, Clause 4.10 is not attracted. In the result, an award is passed directing the insurer to pay an amount of Rs.2266 /- with interest @9% from the date of filing of the complaint 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/11-003-914/2011-12

C Bhargavan Nair

Vs

National Ins. Co. Ltd

AWARD No. IO/KCH/GI/36/2013-14 dated 23.05.2013

The complainant had been taking Mediclaim policy from the Respondent-Insurer since 1996. The wife of the complainant had undergone surgery for Carpel Tunnel Syndrome at Pariyaram Medical College. The claim for the same of Rs.4253/- was not settled by the insurer. Therefore, the complaint.

The complainant submitted that no settlement was received by him till date from the insurer and he is not having any A/c with BOI .

The insurer submitted that the claim was settled for Rs. 4073/- and the same was credited to the A/c of the complainant with BOI.

Decision:- The insurer did not produce any evidence to show that the A/c No. of BOI into which they are claiming that they have credited the claim amount, belongs to the complainant. Also who provided the bank A/c details to them is not revealed. The complainant has confirmed that he is not having any account with BOI and no amount has been credited to his A/c with SBI. The insurer has failed to prove that the claim payment was made to the complainant and because of that, he had been benefited On account of delay and hardships , the complainant is entitled to interest and cost also. In the result, an award is passed directing the insurer to pay an amount of Rs. 4073/- with interest @9% from the date of filing of the complaint till the date of award with cost of Rs. 500/- 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.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-003-918/2011-12

Albeena Johny

Vs

National Ins. Co. Ltd

AWARD No. IO/KCH/GI/37/2013-14 dated 23.05.2013

The complainant had taken Mediclaim policy from the Respondent-Insurer. She suffered intermittent fever and admitted in MIMS Hospital. Though several investigations were done,there was no diagnosis of the ailment. The claim for the same was repudiated by the insurer. Therefore, the complaint.

The complainant submitted that the claim was rejected by the insurer without assigning any valid reason. She is entitled to get the same.

The insurer submitted that only investigations were done during hospitalization and there was no treatment as well as diagnosis of the ailment. So, exclusion clause 4.10 was clearly attracted. The repudiation is legal and proper.

Decision:- As per the Discharge Summary and the Medical Certificate, though investigations were done during hospitalization, there was no final diagnosis as to the existence of any ailment. As there was no diagnosis of the ailment, no treatment was provided during hospitalization. As the investigations and evaluations were not followed by active treatment, exclusion Clause 4.10 is attracted. So, the repudiation of the claim is proper and as per policy conditions. In the result, the complaint is dismissed. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-012-935/2011-12

C S Bijumon

Vs

ICICI Lombard General Ins. Co. Ltd

AWARD No. IO/KCH/GI/38/2013-14 dated 24.05.2013

The complainant had been taking Health Care policy from the Respondent-Insurer for the last 3 years. He was hospitalized for 1 day on account of stomach discomfort. The claim for re-imbursement was rejected on the ground that he was having Hypertension for the last several years. The complainant had received policy termination letter from the insurer. Therefore, the complaint.

The insurer submitted that the hospital records would reveal that the complainant had been suffering from Hypertension for the last 8 years. The claim was rejected on the ground of non- disclosure of pre-existing ailment. Non-disclosure of actual health status had vitiated the policies and they were terminated and the complainant had been provided refund of the premiums paid by him.

Decision:- Discharge summary and medical certificate shows the diagnosis as GERD and gastric erosions. There it is mentioned that the complainant is a known hypertensive on treatment since 8 years. Hypertension was not an ailment contracted within 48 months of the inception of the policy. So, Hypertension is not a pre-existing ailment as defined in Clause 1 of Part II of the policy schedule. So, the contention of the insurer that the claim related to a pre-existing ailment can not be sustained.

The complainant did not disclose his actual health status when he took his first policy from the insurer. The insurer is contending that the non-disclosure relates to a material fact. The non-disclosure of a material fact would amount to fraud and fraud would vitiate a contract. So, at the time of taking the policy, the complainant had not acted in good faith. That would vitiate the policy. The repudiation of the claim on the ground that the complainant had not disclosed his actual health status at the time of taking the policy is perfectly justifiable. Also the policy had been cancelled and the premium paid had been refunded and the complainant had not challenged the cancellation in the complaint. In the result, the complaint is dismissed. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-014-945/2011-12

Geethadevi E

Vs

Cholamandalam MS General Ins. Co. Ltd

AWARD No. IO/KCH/GI/39/2013-14 dated 24.05.2013

The complainant had taken Health Insurance policy from the Respondent-Insurer in 2010 and renewed in 2011. She was hospitalized for Bilateral internal Carotid aneurism and underwent surgery at AIMS, Kochi. The claim for re-imbursement was rejected on the ground that the present ailment was a complication of Hypertension which was existing prior to the inception of the policy. Therefore, the complaint.

The complainant submitted that the ailment suffered by her was not a complication of Hypertension and there is a Medical Certificate to that effect by the treating doctor. She is entitled to get the claim amount.

The insurer submitted that the complainant had been suffering Hypertension for the last 7 years. As per expert opinion, the present ailment is a complication of Hypertension. So, the claim was repudiated based on the policy conditions.

Decision:- Discharge summary and medical certificate shows the diagnosis as 'intra cranial aneurism, Systemic Hypertension and DM. There it is mentioned that the complainant is a known hypertensive on treatment since 7 years. The treating doctor had rendered his definite opinion that the 'cerebral aneurism' suffered by the complainant is not a complication of Hypertension. He is the one who had the first hand information and knowledge about the ailment suffered by the complainant. The other expert opinions are general in nature. From the records available, it is seen that the insurer had miserably failed to establish that the 'aneurism' suffered by the complainant is a complication of Hypertension. Hypertension was not an ailment contracted within 24 months of the inception of the policy. So, Hypertension is not a pre-existing ailment as defined in the policy. So, the contention of the insurer that the claim related to a pre-existing ailment can not be sustained. As Hypertension and aneurism suffered by the complainant are not pre-existing ailments, as defined in the policy conditions, exclusion Clause 1 is not at all attracted. So, the repudiation of the claim is illegal and irregular and therefore, can not be sustained. In the result, an award is passed directing the insurer to pay an amount of Rs. 174828/- with cost of Rs. 2500/- to the complainant 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.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-012-926/2011-12

T K Haridas

Vs

ICICI Lombard General Ins. Co. Ltd

AWARD No. IO/KCH/GI/41/2013-14 dated 27.05.2013

The complainant had taken a health Insurance policy from the Respondent-Insurer from 06.01.2010 to 05.01.2012. He underwent treatment at Sunrise Hospital, Kochi. The claim for the same was repudiated by the insurer on the ground that the claim related to pre-existing illness. Therefore, the complaint.

The complainant submitted that he had not intentionally suppressed any material fact and the repudiation is without any basis.

The insurer submitted that it was found that the complainant was suffering from Type II DM since 4 years and he did not disclose the same at the time of inception of the policy. As the claim relates to pre-existing disease, it is hit by Clause 3.1 of the policy conditions.

Decision:- As per Clause 1 , any illness existing at the time of inception of the policy is a pre-existing illness. As per Clause 3.1, claim for any pre-existing illness shall be excluded from the scope of the cover of the policy untill 4 years are elapsed . Discharge summary and medical report reveals that the complainant was suffering from DM for the last 4 years. Also there is evidence that the complainant had taken treatment for DM in May 2010 from Sunrise Hospital. As per the medical records , the complainant is a known diabetic at least from 2006 onwards. The present treatment is one for Acid peptic disease and the same is not a pre-existing ailment. So, the repudiation of the claim under Clause 3.1 is not sustainable. Another ground taken by the insurer is non disclosure of material facts. Here the complainant had suppressed material facts regarding his health at the time of inception of the policy. He had violated the policy condition to that effect also. So the repudiation of the claim on the ground of suppression of material facts is legal and based on policy conditions. The complainant is not entitled to any relief in the complaint. In the result, the complaint is dismissed. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-005-929/2011-12

K U Jose

Vs

Oriental Insurance Co. Ltd

AWARD No. IO/KCH/GI/42/2013-14 dated 28.05.2013

The complainant had taken Mediclaim policy from the Respondent-Insurer . His wife was admitted at San Joe Hospital , Perumbavoor due to breathlessness. The claim was repudiated by the insurer on the ground that there was no need for hospitalization. Therefore, the complaint.

The complainant submitted that he had purchased the medicines as per the prescription of the visiting Cardiologist which was lost. There was active treatment and he is entitled to get the re-imbursement.

The insurer submitted that there was no active line of treatment during hospitalization. Only investigations were made and prescription is also not available for certain medicine bills submitted. The rejection of claim is based on policy conditions.

Decision:- The diagnosis as per Discharge summary is Chronic Obstructive Pulmonary Disease and severe pulmonary Hypertension. Also it is noted that opinion of Cardiologist was taken and ECHO cardiogram was suggested by him. Also treatment details are provided. The medical records would reveal that during hospitalization, investigations done were followed by active line of treatment. So, the repudiation of the claim invoking Clause 4.10 of the policy conditions can not be sustained. In the result, an award is passed directing the insurer to pay an amount of Rs. 3490/- to the complainant 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/11-004-932/2011-12

K George Mathew

Vs

United India Ins. Co. Ltd

AWARD No. IO/KCH/GI/44/2013-14dated 29.05.2013

The complainant had been taking Individual Health Insurance policy from the Respondent-Insurer for more than 5 years without break. His wife took treatment as in-patient at Sree Agasthya Medical Centre, Tripunithura for Lumbar disc prolapse and Cervical Spondylosis. The claim was rejected by the insurer on the ground that the wife of the complainant had taken treatment in a private hospital. Therefore, the complaint.

The complainant submitted that the special condition relied on by the insurer to repudiate the claim was not intimated in advance to the insurer while renewal of the policy was made. The repudiation is against legal principles and also natural justice.

The insurer submitted that as per the special condition in the policy, the treatment expenses incurred by the complainant in a private ayurvedic hospital is not eligible for reimbursement. The repudiation is based on policy conditions.

Decision:- In the definition of the term 'Hospital', no distinction is made out in the policy between Govt. hospital and private hospital. So, the special condition restricting treatment only in Govt. Ayurvedic hospitals is against the definition of the term 'Hospital' made in Clause 2.1 of the policy conditions. The Apex court in Eiman Krishna Bose Vs UII, 2001 CCC175 (NS) held that "it may be that on renewal, a new contract comes into being, but the said contract is on the same terms and conditions as that of the original policy". An identical situation had arisen here. The special condition was incorporated while renewing the policy without the knowledge of the complainant and without having fresh proposal and contract. So the special condition restricting treatment in Govt. Ayurvedic hospitals only is not binding on the insured. 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. 28060/- with cost of Rs. 2000/- to the complainant 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.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-004-942/2011-12

K Chandran Pillai

Vs

United India Ins. Co. Ltd

AWARD No. IO/KCH/GI/45/2013-14dated 30.05.2013

The complainant had taken medical insurance policy from the Respondent-Insurer on 19.07.2011. On account of ulceration on his tongue, he consulted a doctor and after biopsy , treated for carcinoma at AIMS, Kochi. The claim was rejected by the insurer on the ground that the ailment was a pre-existing one. Therefore, the complaint.

The complainant submitted that he was not suffering from the ailment prior to the inception of the policy. Carcinoma was not diagnosed within 30 days from the date of commencement of the policy. So, Clause 4.1 and 4.2 are not attracted. The repudiation is against the policy conditions.

The insurer submitted that medical evidence available would reveal that the complainant had been suffering ulceration of tongue even prior to the inception of the policy. There is also evidence that he was diagnosed for Carcinoma within 30 days from the date of commencement of the policy. So, the claim is hit by Clause 4.1 and 4.2 of the policy conditions.

Decision:- Medical documents reveal that Carcinoma – tongue was first detected on 07.09.2011 by virtue of the biopsy report issued from Mar Baselios Dental College. Discharge summary shows the diagnosis as Carcinoma-Tongue and the procedure done as wide excision. Policy condition 4.1 deals with pre-existing disease. Pre-existing disease is one which was in existence prior to the inception of the 1st policy. Clause 4.2 deals with diseases contracted during the 1st 30 days of the policy. A conjoint reading of both the clauses would reveal that these clauses are mutually exclusive. As per medical evidence the complainant had first consultation for ulceration of tongue on 10.08.2011 and Carcinoma was provisionally detected first in point of time on 07.09.2011. So, Note (b) to exclusion Clause 4.1 and 4.2 comes to the aid of the complainant. So, repudiation of the claim under Clause 4.1 and 4.2 is not justifiable. In the result, an award is passed directing the insurer to pay an amount of Rs.64825/- to the complainant 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/11-003-959/2012-13

M P Jayasree

Vs

National Insurance Co. Ltd

AWARD No. IO/KCH/GI/40/2013-14dated 27.05.2013

The complainant had taken Mediclaim policy from the Respondent-Insurer covering her family. Her husband had undergone investigations and treatment for Cirrhosis. The claim was rejected by the insurer under Clause 4.8 of the policy conditions. The rejection was on the assumption that the ailment was due to consumption of alcohol. Therefore, the complaint.

The complainant submitted that the patient had stopped consumption of alcohol and smoking atleast 3 years prior to his hospitalization. In 2002. Further he was not a habitual drinker. There is no evidence to the effect that the Liver Cirrhosis was on account of consumption of alcohol. The repudiation is illegal.

The insurer submitted that in the referral letter issued from Thangam Hospital, there is specific mention that the patient is a known alcoholic and smoker. Continuous consumption of alcohol had caused Liver Cirrhosis. Repudiation of the claim was done , as per exclusion Clause 4.8.

Decision:- As per Clause 4.8, if the ailment for which hospitalization was made was contracted on account of consumption of alcohol, the claim is not payable. In the Discharge summary there is no mention that the patient was a habitual drinker and the ailment was on account of consumption of alcohol. Only the referral letter mentions about this , though it is subsequently rebutted by the same doctor's certificate. As per medical literature, consumption of liquor is only one of the reasons for Liver Cirrhosis and so many other reasons are also there . Here there is no positive evidence to establish the nexus between alcohol consumption and Liver Cirrhosis suffered by the patient. In the absence of any such definite evidence, the repudiation of the claim invoking Clause 4.8 can not be justified. Therefore, the repudiation of the claim is not sustainable. In the result, an award is passed directing the insurer to pay an amount of Rs.62009/- with cost of Rs. 5000/- to the complainant within the prescribed period failing which the amount shall carry interest at 9% per annum from the date of award till the payment is effected.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-004-953/2011-12

Margaret A Chirayath

Vs

United India Insurance Co. Ltd

AWARD No. IO/KCH/GI/49/2013-14dated 05.06.2013

The complainant had been taking Individual Health Insurance policy from the Respondent-Insurer since 2001. her mother who is also covered under the policy, suffered lung cancer and underwent treatment at Amala Hospital, Trichur. The claim for the same was partially settled by the insurer. Therefore, the complaint.

The complainant submitted that doctors prescribed tablet for oral consumption apart from Parenteral Chemotherapy given to the patient. The insurer had allowed claim to the extent of expenses incurred for Chemotherapy injections only. There is no valid reason or ground for partial repudiation of the claim.

The insurer submitted that they had settled the entire claim for the sole hospitalization from 19.09.2011 to 20.09.2011. Parenteral Chemotherpy is an exception to Clause 2.3 which insists 24 hours of hospitalization for making a claim. So, they have re-imbursed the expenses for Chemotherpy injections without hospitalization. Nothing more is payable.

Decision:- The legal principle is that the rights and liabilities of the parties to an insurance contract is governed by the policy conditions and they are to be strictly construed. As per Clause 2.3 of the policy conditions, hospitalization claims are admissible for minimum period of 24 hours only. Parenteral Chemotherpy is specifically excluded from this condition . So, even without hospitalization that is payable. The term "parenteral" denotes any medication route other than the alimentary canal. Parenteral Chemotherpy is an intravenous injection. Getfonib tablet is to be consumed orally. So, the medication route is alimentary canal. Even if it is construed that Getfonib tablet is a substitute for Parenteral Chemotherapy, its consumption route is alimentary canal. So, the exception to Clause 2.3 is not attracted. So, the re-imbursement offered by the insurer is strictly based on policy conditions and the complainant is not entitled to any further amount. In the result, the complaint is dismissed. No cost.

OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-004-942/2011-12

K Chandran Pillai

Vs

United India Ins. Co. Ltd

AWARD No. IO/KCH/GI/45/2013-14dated 30.05.2013

The complainant had taken medical insurance policy from the Respondent-Insurer on 19.07.2011. On account of ulceration on his tongue, he consulted a doctor and after biopsy , treated for carcinoma at AIMS, Kochi. The claim was rejected by the insurer on the ground that the ailment was a pre-existing one. Therefore, the complaint.

The complainant submitted that he was not suffering from the ailment prior to the inception of the policy. Carcinoma was not diagnosed within 30 days from the date of commencement of the policy. So, Clause 4.1 and 4.2 are not attracted. The repudiation is against the policy conditions.

The insurer submitted that medical evidence available would reveal that the complainant had been suffering ulceration of tongue even prior to the inception of the policy. There is also evidence that he was diagnosed for Carcinoma within 30 days from the date of commencement of the policy. So, the claim is hit by Clause 4.1 and 4.2 of the policy conditions.

Decision:- Medical documents reveal that Carcinoma – tongue was first detected on 07.09.2011 by virtue of the biopsy report issued from Mar Baselios Dental College. Discharge summary shows the diagnosis as Carcinoma-Tongue and the procedure done as wide excision. Policy condition 4.1 deals with pre-existing disease. Pre-existing disease is one which was in existence prior to the inception of the 1st policy. Clause 4.2 deals with diseases contracted during the 1st 30 days of the policy. A conjoint reading of both the clauses would reveal that these clauses are mutually exclusive. As per medical evidence the complainant had first consultation for ulceration of tongue on 10.08.2011 and Carcinoma was provisionally detected first in point of time on 07.09.2011. So, Note (b) to exclusion Clause 4.1 and 4.2 comes to the aid of the complainant. So, repudiation of the claim under Clause 4.1 and 4.2 is not justifiable. In the result, an award is passed directing the insurer to pay an amount of Rs.64825/- to the complainant 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/11-004-954/2011-12

P P Varghese

Vs

United India Insurance Co. Ltd

AWARD No. IO/KCH/GI/50/2013-14dated 05.06.2013

The complainant who had taken a Health Insurance policy from the respondent-Insurer had submitted a claim in connection with the treatment of his son. The claim was repudiated by the insurer under Clause 4.10 of the policy conditions. Therefore, the complaint.

The insurer submitted that their Medical Officer had now opined that in the nature of the injury suffered by the son of the complainant, in-patient treatment was necessary and therefore, the claim is admissible. They are ready to pay the claim amount to the complainant.

Decision:- The discharge summary shows the diagnosis as Meniscus injury (right knee). Medication and bandage were provided during hospitalization. MRI scan was also advised and taken. Now the insurer has admitted the need for IP treatment and MRI scan. So, exclusion Clause 4.10 is not at all attracted. The complainant had submitted bills for Rs. 9575/- and he is entitled to get re-imbursement of the entire hospital expenses. On account of delayed payment, the complainant is entitled to interest on the claim amount. In the result, an award is passed directing the insurer to pay an amount of Rs. 9575/- with interest @9% from the date of filing of the complaint 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/11-004-958/2011-12

V Vijayakumar

Vs

United India Insurance Co. Ltd

AWARD No. IO/KCH/GI/53/2013-14dated 18.06.2013

The complainant had taken Family Medicare policy from the Respondent-Insurer. He suffered serious injuries in a motor vehicle accident and underwent major surgeries. The claim for the same was only partially settled by the insurer. Also he is entitled to Hospital Cash Benefit of Rs. 5000/-. Therefore, the complaint.

The complainant submitted that the partial repudiation of the claim is illegal and he is entitled to full re-imbursement.

The insurer submitted that reason for disallowing each item is specified in the "Disallowance details" mentioned in the claim discharge voucher. The decision was taken based on policy conditions.

Decision:- As per the provisions relating to Hospital Cash Benefit in the policy, the complainant is entitled to the maximum amount of Rs. 5000/- as he has undergone hospitalization for more than 20 days. The insurer is liable to pay the same. The discharge summary would reveal that the complainant suffered fracture left clavicle, both column fracture left acetabulum and Mallet Finger. On a perusal of the disallowance sheet, it is found that out of the total deduction of Rs. 29327/- , the insurer is entitled to deduct only Rs. 2848/- legally as per the policy conditions. So , the complainant is also entitled to receive the excess deduction of Rs. 26479/- made by the insurer. In the result, an award is passed directing the insurer to pay a further amount of Rs. 31479/- to the complainant with cost of Rs. 1000/- within the prescribed period failing which the amount shall carry further interest at 9% per annum from the date of filing of the complaint till the payment is effected.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-002-1025/2011-12

A K Varghese

Vs

New India Assurance Co. Ltd

AWARD No. IO/KCH/GI/54/2013-14dated 19.06.2013

The complainant had taken Mediclaim policy from the Respondent-Insurer. He suffered infection and swelling in his neck and was hospitalized for treatment. The claim was repudiated by the insurer stating that he had suffered skin disease and the same is not covered for the first 2 years of insurance cover. Therefore, the complaint.

The complainant submitted that he was hospitalized in 2 hospitals in connection with the disease. The repudiation of the claims is illegal and irregular and he is entitled to get the hospital expenses.

The insurer submitted that both the claims were repudiated under Clause 4.3 of the policy conditions as the complainant had suffered skin disease , which is not covered during the first 2 years of insurance cover. The repudiation is legal and in accordance with the policy conditions.

Decision:- Clause 4.3 of the policy conditions provides waiting period of 2 years from the inception of the policy, for 'Skin disorders". In the Discharge summary and case summary from Little Flower Hospital, the diagnosis is Submandibular Abscess. In the Discharge Summary from Medical Trust Hospital, the final diagnosis is " Submental space infection". So, the complainant had suffered swelling and infection under his chin. So, the definite medical evidence is to the effect that the treatment taken by the complainant had no relation with skin disorder. The claim is not hit by Clause 4.3 of the policy conditions and hence, the repudiation of the claim can not be sustained. On account of delay, complainant is entitled to interest also. In the result, an award is passed directing the insurer to pay an amount of Rs. 10824/- with interest @9% from the date of filing of the complaint 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/11-003-1000/2011-12

Sajan Varghese

Vs

National Insurance Co. Ltd

AWARD No. IO/KCH/GI/55/2013-14dated 20.06.2013

The complainant had been taking Health Insurance policies from the Respondent-Insurer since 2007. He underwent a surgery at Lakeshore Hospital , Ernakulam and the claim for the same was only partially settled by the insurer. Therefore, the complaint.

The complainant submitted that he is entitled to get reimbursement of the entire hospital expense met by him. Though the insurer had offered a further amount of Rs. 50802/-, he not willing to receive the same , as it does not represent the entire balance cliam.

The insurer submitted that certain bills submitted by the complainant did not provide split up details. So they had to conduct further investigations and now they are ready to settle a further amount of Rs. 50802/-.

Decision:- The disallowed portion of the claim is Rs. 7591/- as per the computation sheet. On a perusal of the denied items and amount , it is seen that the complainant is entitled to a further amount of Rs. 2980/- . So the total liability of the insurer will come to Rs. 53782/-. In the result, an award is passed directing the insurer to pay an amount of Rs. 53782/- to the complainant within the prescribed period failing which the amount shall carry further 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/11-022-999/2011-12

Rajinder Paul Singhal

Vs

Bharti AXA General Insurance Co. Ltd

AWARD No. IO/KCH/GI/56/2013-14dated 20.06.2013

The complainant had taken Health Insurance policy from the Respondent-Insurer for 2010 – 11 covering his daughter. She underwent surgery in connection with ovarian cyst at Sagar Hospital, Bangalore. The claim for the same was not settled by the insurer. Hence, the complaint.

The complainant submitted that he is entitled to get reimbursement of full medical expenses met by him.

The insurer submitted that the claim was repudiated under exclusion Clause 4 of the policy conditions. Treatment of internal cysts etc. is not payable within the first 2 years from the inception of the policy.

Decision:- Discharge summary shows the diagnosis as left paraovarian cyst with left tubo ovarian torsion. Laparoscopic left paraovarian cystectomy was done. So from the medical records , it is evident that the treatment and surgery were related to cyst in the left ovary. As per policy Clause 5.4 , treatment related to cyst is excluded for the first two policy years. Therefore, the claim is hit by exclusion No. 4 of Clause 5 of the policy conditions. The repudiation is strictly based on the policy conditions. In the result, the complaint is dismissed. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-002-969/2011-12

Annie Joy

Vs

New India Assurance Co. Ltd

AWARD No. IO/KCH/GI/57/2013-14dated 21.06.2013

The complainant had taken medical insurance policy under SASS Welfare Services , Ernakulam from the Respondent-Insurer. She underwent Hysterectomy. The claim for the same was only partially settled by the insurer,. Hence, the complaint.

The complainant submitted that she is entitled to get the entire hospitalization expenses. This was what promised at the time of taking the policy.

The insurer submitted that .package rate is provided under the MOU of the Group policy for certain treatments. Originally , for Hysterectomy, package rate was Rs. 23000/-, which was reduced to Rs. 18000/- with effect from 07.07.2011. The claim was settled for Rs. 18000/- based on the policy conditions.

Decision:- The policy conditions governing the Group Insurance Policy is narrated in the MOU. In the Schedule of Payment, the package rate for Hysterectomy is shown as Rs. 23000/-. The MOU and Schedule of Payment form part of the policy. So, it is a part of the contract of insurance. In the Minutes of the meeting held on 10.08.2011, with the Office bearers of the Society and the Insurer, it was decided to reduce the package rate for Hysterectomy to Rs. 18000/- w.e.f. 07.07.2011. ie, with retrospective effect. The benefit, which had already been provided can not be taken away, that too, with retrospective effect without notice to the individual beneficiaries , who pay the premium. At the most, the revised rate can be made applicable w.e.f. 10.08.2011 only. When the complainant underwent hospitalization and surgery , the prevailing package rate was Rs. 23000/- . So, she is entitled to get reimbursement of Rs. 23000/-. In the result, an award is passed directing the insurer to pay an amount of Rs. 5000/- with interest @9% from the date of

filing of the complaint 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/11-002-962/2011-12

Dr. Leon Joseph

Vs

New India Assurance Co. Ltd

AWARD No. IO/KCH/GI/58/2013-14dated 24.06.2013

The complainant had been taking Mediclaim Insurance policy from the Respondent-Insurer for the last few years. During 2009-10, the Sum Insured was enhanced to Rs. 1 lac from Rs. 50000/-. The policy was renewed for 2010-11. He was hospitalized and incurred an amount of about Rs. 2 lacs during this period. The sum insured available including Cumulative Bonus was Rs. 105000/-. The insurer had settled an earlier claim for Rs. 33778/- during the same policy year. The balance sum assured available was Rs. 71222/-. But the insurer settled the claim for Rs. 18722/-.only. Therefore, the complaint.

The insurer submitted that the complainant underwent treatment for a pre-existing ailment which he contracted in 2008. So, the enhanced portion of the sum insured is not available for re-imbursement. As far as the enhanced portion of the sum assured is concerned , the ailment is a pre-existing one and the claim was settled accordingly for Rs. 18722/-. Nothing more is payable now.

Decision:- The Discharge Summary would reveal that the complainant was under medication for the ailment (severe MVR) since 2008. So, the complainant had contracted the ailment and had been undergoing treatment for the same from 2008 onwards which is within 48 months prior to the enhancement of the sum insured. Pre-existing disease/ ailment is defined in Clause 3.1 of the policy conditions. As per Clause 6, all the restrictions applicable to a fresh policy will also be applicable to the enhanced sum insured. So, as per Clause 3.1 and Clause 6 of the policy conditions, the ailment suffered is a pre-existing one in relation to the enhanced portion of the sum assured. The complainant contracted the ailment while the sum insured was only Rs. 50000/-. So, the

insurance cover available is the pre-enhanced Sum Insured with accrued bonus which comes to Rs. 52500/-. So, the balance sum insured available was Rs. 18722/- only and the insurer had already paid the same. The payment made by the insurer is in accordance with the policy conditions. The complainant is not entitled to any further amount. In the result , the complaint is dismissed. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-004-629/2012-13

K T Mathew

Vs

United India Insurance Co. Ltd

AWARD No. IO/KCH/GI/59/2013-14dated 24.06.2013

The wife of the complainant had been taking Individual Health policy from the Respondent- Insurer for more than 10 years. She was treated for bilateral Knee Osteoarthritis at Sai Snehdeep Hospital, Mumbai. She made a claim for Rs. 118280/- which was repudiated by the insurer on the ground that there was no hospitalization and also the treatment was Naturopathy. Therefore, the complaint.

The complainant submitted that his wife underwent Sequential Programmed Magnetic Field therapy and the same is not Naturopathy, but a proven method of therapy in the medical field. Due to advancement of technology, hospitalization for 24 hours is not required for certain treatments and he is entitled to get re-imbursement of the entire hospital expense.

The insurer submitted that SPMF therapy is not a recognized therapy and it would essentially come under Naturopathy, which is excluded under Clause 4.13 of the policy conditions. Also there was no hospitalization as contemplated under Clause 2.3 of the policy conditions. So, the claim is not admissible.

Decision:- Admittedly, the insured underwent SPMF therapy. The complainant is relying on two decisions rendered by the CDRF, Mumbai and Belgaum. It is revealed that in both the cases, the course of treatment was RFQMR therapy which is also known as Cytotron therapy. It is seen that RFQMR therapy had been recognized by competent authorities. That aspect was considered by the CDRFs in their decision. No evidence is available that SPMF therapy had been recognized or accepted as safe therapy by the competent

authorities. So, it is an experimental and unproven therapy. Therefore, exclusion clause 4.13 is attracted. Also the exception clause that " 24 hours hospitalization will not be insisted , if due to technological advances, the hospitalization required is less than 24 hours" , is not present in the policy of the case in hand though the same was available in the cases considered by the CDRFs. So, the complainant can not claim benefit of a provision which is not incorporated in the policy conditions. In the instant case , as per treatment records , there was no hospitalization for more than 24 hours on any of the occasions. So, even if SPMF therapy is a recognized therapy, as there is no hospitalization, as provided under Clause 2.3 of the policy conditions, the claim is not admissible.The complainant is not entitled to any relief. In the result, the complaint is dismissed. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-017-973/2011-12

Jacob P Issac

Vs

Star Health & Allied Insurance Co. Ltd

AWARD No. IO/KCH/GI/60/2013-14dated 27.06.2013

The wife of the complainant had taken medical insurance policy from the Respondent-Insurer in 2010. The same was renewed from time to time. She was hospitalized in Caritas Hospital, Kottaym from 30.7.2011 to 18.08.2011 and incurred an expense of Rs. 17000/-. The claim for the same was rejected by the insurer. Therefore, the complaint.

The insurer submitted that the treatment was for DM and Hypertension. There is medical evidence to the effect that the wife of the complainant had been suffering from Hypertension since 3 years. In the proposal form, this material fact was not disclosed by the complainant or his wife. So, the policy is vitiated. The repudiation of the claim is legal and proper.

Decision:- In the proposal form definite questions are provided regarding the health status of the proposer and all of them are indicated in negative by the complainant. Discharge summary shows the diagnosis as Type II DM and Hypertension. In the history portion, it is noted that the patient is a known diabetic and hypertensive. The complainant was treated with anti-hypertensive and other medicines during hospitalization. Treating doctor's certificate mentions the duration of hypertension as 3 years. So, the complainant had been hypertensive even prior to the submission of the proposal form for taking the first policy. The complainant had not contended that he or his wife was not aware that she was hypertensive at the time of submission of the proposal form. The information

furnished in the medical certificate would have been provided by the complainant or his wife herself. So, from the available evidence, it is evident that the complainant had not disclosed the actual health status of his wife in the proposal form., thereby depriving the insurer of their opportunity to assess the risk properly. As far as health insurance policy is concerned, the health status of the insured assumes much importance. Non-disclosure of actual health status would amount to fraud and fraud would vitiate the policy. Here the policy is vitiated. The repudiation of the claim on the ground of suppression of material fact is legal and proper. In the result, the complaint is dismissed. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-017-1013/2011-12

P Ramachandran

Vs

Star Health & Allied Insurance Co. Ltd

AWARD No. IO/KCH/GI/62/2013-14dated 28.06.2013

The complainant had taken Family Health Optima policy from the Respondent-Insurer covering himself and his family members. His daughter was admitted at Nimhans, Bangalore for treatment. The claim for the same was repudiated by the insurer on the ground of non co-operartion and mis-representation by the complainant. Therefore, the complaint.

The complainant submitted that all the available documents were submitted along with the claim. There was no prior treatment at Pariyaram Medical College. No records were available regarding the Ayurvedic treatment as the same was from a local indigenous ayurvedic practitioner. The repudiation is against medical evidence and policy conditions.

The insurer submitted that they requested to produce details of treatment at Pariyaram Medical College and also of Ayurvedic treatment taken, The complainant did not produce any of these. He had willfully violated policy condition No.s 4 & 6. The repudiation of the claim is legal and proper.

Decision:- Discharge summary shows the diagnosis as "Young Onset Parkinsonism". Duration of hospitalization, the diagnosis done, treatment provided etc. are given in the Discharge summary as well as the treating doctor's certificate. The OP record from Pariyaram Medical College would reveal that no treatment was given there, only

consultation was made and they referred the patient to Nimhans, Bangalore. When there is nothing to show that any treatment was taken from Pariyaram MC, it is imprudent on the part of the insurer to direct the complainant for production of documents which are not in existence. The contention of the complainant that no records were available regarding the Ayurvedic treatment as the same was from a local indigenous ayurvedic practitioner who generally do not keep records is prima facie acceptable as the insurer has no other evidence to prove vice versa. Production of documents by the complainant which are not in existence can not be taken as violation of Condition No. 4. When the medical records supports the case of the complainant and his submission, the insurer can not contend that he had made mis-representation for allowing the claim. So it is evident that there is no violation of policy condition No.s 4 and 6. So, the repudiation is not sustainable. In the result, an award is passed directing the insurer to pay an amount of Rs. 18287/- to the complainant with cost of Rs. 2000/- 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.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-004-1008/2011-12

Suresh Z Shah

Vs

United India Insurance Co. Ltd

AWARD No. IO/KCH/GI/65/2013-14dated 04.07.2013

The complainant had been taking Mediclaim policy from the Respondent-Insurer through Andhra Bank. He had chest and back pain and was admitted at National Hospital, Calicut for treatment. The claim for the same was repudiated by the insurer on the ground that there was no active treatment and hospitalization was for investigations only.. Therefore, the complaint.

The complainant submitted that the hospitalization was for treatment and not for investigations alone. There was hospitalization of more than 24 hours and the claim is not hit by Clause 4.10 of the policy conditions and he is entitled for full re-imbursement.

The insurer submitted that there is no evidence that the hospitalization was for 24 hours or more. During hospitalization, there was no active line of treatment and the hospitalization was mainly for investigations. So, the claim is hit by Clause 4.10 of the policy conditions and the repudiation is legal and proper.

Decision:- The insurer had contended that for making a claim, minimum 24 hours hospitalization is required as per Clause 2.3 of the policy conditions. But the Clause relied

on by the insurer is conspicuously absent in the policy conditions and such a contention was not raised by them at the time of repudiation. In the absence of definite evidence to prove or disprove the period of hospitalization, the contention now advanced by the insurer without the support of the policy conditions can not be accepted. Discharge summary shows the diagnosis as "Positional Vertigo Central, Peripheral-Old Ischemic Stroke, Systemic Hypertension. Details of investigations, medicines prescribed etc. are also mentioned. Investigations are mainly done for proper diagnosis and also to rule out the existence of certain ailments. Discharge summary would reveal that the MRI with MRA was taken to rule out Vertebrobasilar Insufficiency. It can be seen that the investigations done during hospitalization are consistent with the diagnosis made and was provided active treatment for the diagnosed ailments. So the claim is not hit by 4.10 of the policy conditions and hence, the repudiation is not sustainable. In the result, an award is passed directing the insurer to pay an amount of Rs.6832/- to the complainant with interest @9% from 23.03.2012 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/11-004-995/2011-12

T S Bhuvaneswary

Vs

United India Insurance Co. Ltd

AWARD No. IO/KCH/GI/67/2013-14 dated 05.07.2013

The complainant had been taking Mediclaim policy from the Respondent-Insurer since 2005. Due to stroke she was admitted at Lakeshore Hospital, Ernakulam and incurred an amount of Rs. 29048/-. The claim for the same was partially settled by the insurer for Rs. 5711/- only. Therefore, the complaint.

The complainant submitted that she had suffered a serious ailment and the unilateral settlement arrived at by the insurer is not acceptable to her. She had not accepted the settlement and the cheque had not been encashed. She is entitled to the full claim amount.

The insurer submitted that the amount payable to the complainant was computed based on Clause 1.2 of the policy conditions and the entitlement was found to be only Rs. 5711/- and the same was offered. The complainant is not entitled to any further amount.

Decision:- The rights and liabilities of the insurer and the insured are governed by the policy conditions and it is well settled law that the policy conditions are to be construed strictly like conditions in other contracts. Clause 1.2 of the policy conditions enumerates the expenses which are reimburseable. They are enumerated under 5 heads, viz A,B,C,D and E. Perusal of the medical bills would reveal that the complainant is entitled to reimbursement under Head A, C and D only. Under Head A and D, the maximum entitlement per day is limited to 1% of the sum insured , which comes to Rs. 500/- per day in this case. Here the hospitalization was for a period of 5 days. So, as per policy conditions, the entitlement of the complainant in this claim is Rs. 5775/-. As the complainant had not encashed the earlier cheque received by her, the liability of the insurer is fixed at Rs. 5775/- . In the result, an award is passed directing the insurer to pay an amount of Rs. 5775/- to the complainant within the prescribed period failing which the amount shall carry interest at 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/11-004-1023/2011-12

P C Paul

Vs

United India Insurance Co. Ltd

AWARD No. IO/KCH/GI/71/2013-14 dated 11.07.2013

The complainant had taken Indian Bank Arogya Raksha Mediclaim policy from the Respondent-Insurer covering himself and his wife. Wife of the complainant was taken ill and underwent Chemotherapy. The claim for the same was repudiated by the insurer under Clause 2.4 of the policy conditions. Therefore, the complaint.

The complainant submitted that his wife suffered Carcinoma-ovary and had underwent surgery. She had taken Chemotherapy. The repudiation of the claim is against policy conditions and he is entitled to reimbursement of the entire claim.

The insurer submitted that the complainant's wife was given treatment in the OP dept. and there was no hospitalization for 24 hours. So, the claim was repudiated under Clause 2.4 of the policy conditions.

Decision:- The fact that the patient had underwent Chemotherapy is not disputed by the insurer. Clause 2.4 of the policy conditions states that "Expenses for hospitalization is admissible for a minimum period of 24 hrs. However specific treatments like Chemotherapy etc. are excluded from the purview of this rule. The TPA as well as the insurer ignored this portion of Clause 2.4 and repudiated the claim. As per Clause 2.4, Chemotherapy is specifically excluded from 24 hrs hospitalization stipulation. So, it is very evident that the repudiation of the claim is against policy conditions and the same is not sustainable. The complainant had suffered much mental agony and strain on account of the denial of the claim. So, he is entitled to cost and also interest for delay. In the result, an award is passed directing the insurer to pay an amount of Rs. 33714/- with 9% interest from the date of filing of the complaint till the date of award and cost of Rs.2000/- to the complainant within the prescribed period failing which the amount 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/11-004-1018/2011-12

K V Gangadharan

Vs

United India Insurance Co. Ltd

AWARD No. IO/KCH/GI/73/2013-14 dated 16.07.2013

The complainant had been taking Individual Mediclaim policy from the Respondent-Insurer from 2001 onwards. The complainant developed kidney related disease in the year 2004. He underwent treatment at Amrita Hospital, Kochi.in 2011. The claim for the same was rejected by the insurer on the ground of pre-existing disease. Therefore, the complaint.

The complainant submitted that the kidney disease was diagnosed only in 2004. So, there was no occasion for him to give details of the ailment in the proposal form submitted in 2001 or in 2002 for taking a fresh policy. The delay occasioned in submitting the claim was explained to the insurer. He had not suppressed any fact in the proposal form with knowledge and fraudulent intention. He is entitled to the entire amount claimed.

The insurer submitted that the medical records produced by the complainant would reveal that he had been suffering from Hypertension for the last 15 years and kidney disease for the last 10 years. So, even prior to the inception of the first policy, the complainant was having those diseases. Therefore, they were pre-existing diseases. As

there was no continuous insurance cover, Clause 4.1 of the policy conditions is attracted and therefore, the claim is not payable. It was also revealed that the complainant had not disclosed all the material facts relating to his health status in the proposal form. So, the complainant is guilty of suppression of material facts. The policy is vitiated. Also the complainant had not submitted the claim form in time. The repudiation is in order and as per policy conditions.

Decision:- The policy schedule would reveal that the Sum Insured is Rs.3,75,000/-. Date of proposal and declaration based on which the policy was issued is 14.08.2002. So, all the renewals were based on the proposal dated 14.08.2002. The very contention of the Respondent-Insurer is that in the proposal form dated 14.08.2002, the complainant had not disclosed his actual health status in answer to the various questions in the proposal form. But the contents of the proposal form dated 14.08.2002 is not in evidence. There is no explanation from the side of the Respondent-Insurer for the non-production of the proposal form dated 14.08.2002. As the proposal form dated 14.08.2002 is not available, the materiality or otherwise of the suppression or revelations made in the proposal form does not arise for consideration. In the circumstances, the only inference that can be taken is that there is no suppression of material facts by the life insured.

The Discharge Summary issued from the hospital is produced. The diagnosis was Autosomal Dominant Polycystic Kidney Disease, Cyst hemorrhage, systemic hypertension, chronic kidney disease stage 5 and external hemorrhoids. During hospitalization, renal transplantation and right simple nephrectomy were done on 22.02.2011 The Discharge Summaries would reveal that the complainant was diagnosed to have Renal failure in 2004. And thereafter, he was on regular follow up with a Nephrologist at a center near his home. The insurer is relying on the noting given in the history portion in the Discharge summaries to repudiate the claim. Even while the Respondent-Insurer would contend that the complainant was having kidney disease/renal failure prior to inception of the policy, they have not succeeded in producing any document which would reveal that the complainant was diagnosed with Renal failure/kidney disease prior to 2004. So also, there is no evidence regarding any treatment taken by him for the ailment prior to 2004. There is also no evidence that the complainant had knowledge of kidney disease prior to 2004 when the same was diagnosed in a hospital at Ahmedabad. In the absence of any evidence that the complainant was aware of any ailment relating to kidney prior to 14.08.2002, it cannot be contended by the Respondent-Insurer that the claim is hit by Clause 4.1 of the policy conditions.

Even if the complainant was afflicted with the disease prior to 14.08.2002, that ailment is no more a pre-existing disease after 14.08.2006, on completion of 48 months of continuous insurance cover, as a pre-existing disease loses that character on completion of 48 months of continuous insurance cover. Therefore, exclusion Clause 4.1 is not attracted even if it is assumed that the ailment was a pre-existing one. The evidence is to the effect that there was continuous insurance cover for the complainant with the

Respondent-Insurer from 14.08.2002 onwards. By virtue of these findings, repudiation of the claim on the ground of suppression of material facts and exclusion Clause 4.1 of the policy conditions is not sustainable.

The mental and physical condition of the complainant who underwent two major surgeries and transplantation were ignored by the Respondent-Insurer while initially rejecting the claim under Clauses 5.3 and 5.4 of the policy conditions. As no prejudice has been caused to the Respondent-Insurer on account of the delay, I am satisfied that the contention based on technicalities cannot be sustained. The Sum Insured was Rs.3,75,000/-. So, the complainant is entitled to get reimbursement of Rs.3,75,000/-.

In the result, the an award is passed directing the Respondent-Insurer to pay to the complainant an amount of Rs.3,75,000/- with 9% interest per annum from the date of filing of the 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/11-017-005/2012-13

Suja V

Vs

Star Health & Allied Insurance Co. Ltd

AWARD No. IO/KCH/GI/74/2013-14 dated 18.07.2013

The late husband of the complainant had taken Health Insurance policy from the Respondent-Insurer. He was admitted at K G Hospital, Coimbatore and the insurer provided cashless facility to the tune of Rs. 80000/- . The claim seeking the balance amount of Rs. 20000/- was not settled by the insurer. Therefore, the complaint.

The complainant submitted that the balance amount was paid only on 16.05.2012. Without any reason, the payment of balance amount was delayed by the insurer. On account of the delay, she is entitled to interest and compensation.

The insurer submitted that they have settled the full sum insured of Rs. 1 lac to the complainant. There was no inordinate delay in settling the claim.

Decision:- Though the claim form for balance amount was received by the insurer on 21.01.2012, they settled the same only on 16.05.2012 after filing the complaint before this Forum. Unnecessary delay of more than 3 months had been caused from the side of the

insurer in settling the balance claim. Merely because of the delay occasioned in settling the claim, the complainant was compelled to approach this Forum. Much agony and pain had been caused to the original and additional complainant on account of the delay occasioned in settling the balance claim. For the same , the complainant has to be compensated. In the result, the an award is passed directing the Respondent-Insurer to pay to the complainant interest @9% per annum for a period of 3 months on Rs. 20000/- and cost of Rs. 2000/- 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/11-002-435/2012-13

Suja V

Vs

New India Assurance Co. Ltd

AWARD No. IO/KCH/GI/75/2013-14 dated 19.07.2013

The original complainant had been taking Individual Health Insurance policy from the Respondent-Insurer since 2007. He suffered Astrocytoma and underwent radiation and Chemotherapy at K.G. Hospital, Coimbatore. Later he continued Chemotherpay in tablet form as an out-patient. The claim for the same was repudiated by the insurer stating that there was no hospitalization.. Therefore, the complaint.

The complainant submitted that Chemotherapy in tablet form is due to advancement in medical technology and therefore, there is no requirement of hospitalization for 24 hours or more. Clause 3.4 is not at all attracted. There is no valid reason or ground for repudiation of the claim.

The insurer submitted that Parenteral Chemotherpy is an exception to Clause 3.4 which insists 24 hours of hospitalization for making a claim. The complainant had taken Chemotherapy in tablet form and that is not exempted under Clause 3.4 of the policy conditions. The repudiation of the claim is strictly based on the policy conditions.

Decision:- The legal principle is that the rights and liabilities of the parties to an insurance contract is governed by the policy conditions and they are to be strictly construed. As per Clause 3.4 of the policy conditions, hospitalization claims are admissible for minimum

period of 24 hours or more. Parenteral Chemotherpy is specifically excluded from this condition . So, even without hospitalization that is payable. The term "parenteral" denotes any medication route other than the alimentary canal. Parenteral Chemotherpy is an intravenous injection. In the present case, tablets were taken and the medication route was alimentary canal. So it won't come under Parenteral Chemotherapy. When Parenteral Chemotherapy is specifically included in the exception list, other forms of Chemotherapy are omitted from the purview of the exception Clause. There was no hospitalization. So, the repudiation of the claim by the insurer is strictly based on policy conditions and the complainant is not entitled to any relief.. In the result, the complaint is dismissed. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-003-004/2012-13

K J Thomas

Vs

National Insurance Co. Ltd

AWARD No. IO/KCH/GI/78/2013-14 dated 26.07.2013

The complainant had been taking mediclaim policy from the Respondent-Insurer covering himself and his wife for the last 5 years. His wife was admitted in Hospital in connection with pain and swelling on her leg. The claim for the same was not settled by the insurer. Therefore, the complaint.

The complainant submitted that his wife was admitted in hospital on the advice of the treating doctor for traction and physiotherapy and the same could not have been done on OPD basis. The repudiation of the claim is against policy conditions.

The insurer submitted that as per discharge summary the treatment provided was 'rest and physiotherapy". There is no mention of traction. The treatment could have been done on OPD basis. There was no active line of treatment during hospitalization. The claim is hit by Clause 2.6 and 4.10 of the policy conditions. The repudiation is legal and proper.

Decision:- Discharge summary shows the diagnosis as "Early osteo arthritis knee – right". In the column for treatment it is shown as "rest and physiotherapy". Medicines prescribed are also mentioned. In the treating doctor's report as well as the certificate obtained later from the Surgeon, it is mentioned that the patient was given traction, physiotherapy and NSAID during hospitalization. Traction is normally not an OPD procedure. So, also physiotherapy need not necessarily be an OPD procedure. That will depend on the physical condition of the patient. Here the patient was on traction and she was not

allowed to move about. So, hospitalization was unavoidable. Also traction and physiotherapy are active courses of treatment. So, exclusion Clause 4.10 and Note to Clause 2.6 are not attracted in this case. Therefore, the repudiation of the claim is not sustainable. In the result, an award is passed directing the insurer to pay an amount of Rs. 7493/- to the complainant 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/11-011-054/2012-13

G Radhakrishnan

Vs

Bajaj Allianz General Insurance Co. Ltd

AWARD No. IO/KCH/GI/80/2013-14 dated 31.07.2013

The complainant had taken Individual Health Guard policy from the Respondent-Insurer. He was admitted at Lakeshore Hospital , Kochi on account of low back pain and was discharged on the next day. The claim for the same was rejected by the insurer. Therefore, the complaint.

The complainant submitted that the hospitalization was on the advice of the attending Doctor and he was provided proper treatment. Investigations were done for proper diagnosis. The repudiation of the claim is illegal.

The insurer submitted that as per exclusion Clause C-15 and C-16, as the hospitalization was merely for investigations and no active treatment was given during hospitalization, the complainant is not entitled to get re-imbursement of hospital expenses.

Decision:- Discharge summary shows the diagnosis as Intervertebral Disc Prolapse L4-L5, L5-S1. The patient was presented with low back pain with radiation to either flanks- 4 month and difficulty in walking. It is further revealed that clinical examination and investigations revealed Intervertebral Disc Prolapse. Prudence demands hospitalization and observation by a competent Doctor when the patient is in such a condition. He was provided medicines during hospitalization. The investigations were done for proper diagnosis and treatment. From the medical evidence available , it is enormously evident that Clause C-15 and C-16 are not attracted in the case of the complainant. He had been provided in-patient care as provided in Clause B-7 of the policy conditions. So, the repudiation of the claim is not sustainable. In the result an award is passed directing the

insurer to pay to the complainant an amount of Rs. 8824/- with 9% interest from the date of filing of the 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/11-017-041/2012-13

George Joseph

Vs

Star Health & Allied Insurance Co. Ltd

AWARD No. IO/KCH/GI/81/2013-14 dated 01.08.2013

The complainant had taken Family Health Optima Insurance policy from the Respondent-Insurer. His wife was admitted in Hospital due to respiratory infection. The claim for the same was partially settled by the insurer. Therefore, the complaint.

The complainant submitted that no treatment was provided in connection with pregnancy during the hospitalization. The deduction of Rs. 1696/- is unauthorized and against policy conditions. He is entitled to get full re-imbursement of the hospital expenses.

The insurer submitted that no split up bills relating to purchase of medicines were produced by the complainant. So, 20% of the cost was not paid on the inference that there would have been treatment for pregnancy. Room rent entitlement is only 1% of the sum insured. Service charges and cost of nebulisation mask are not payable. The payment made is strictly in accordance with the policy conditions.

Decision:- Admittedly, the wife of the complainant was pregnant at the time of hospitalization. The policy does not cover pregnancy related treatment. The Discharge Summary as well as the attending Doctor's certificate reveal that though the wife of the complainant was pregnant at the time of admission in the hospital, treatment was provided for lower respiratory tract infection only. No treatment for pregnancy was provided. So, there is no need for any confusion regarding the ailment for which treatment was provided. The room rent is limited to 1% of the Sum Insured per day as per policy conditions. So, the deduction of Rs. 600/- from the room rent is justified. All other deductions made by the insurer are essentially part of treatment expenses. In the result

an award is passed directing the insurer to pay to the complainant an amount of Rs.1096/- with 9% interest from the date of filing of the complaint till the date of award with cost of Rs. 500/- 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/11-010-062/2012-13

P G Mukundakshan Nair

Vs

Bajaj Allianz General Insurance Co. Ltd

AWARD No. IO/KCH/GI/82/2013-14 dated 02.08.2013

The complainant had taken Individual Health Guard policy from the Respondent-Insurer covering Senior Citizens. He was admitted at PVS Hospital , Kochi and was diagnosed with Obscure Gastro Intestinal Bleed. The claim for the same was rejected by the insurer stating that DM and Systemic Hyper tension were pre-existing. Therefore, the complaint.

The complainant submitted that Investigations were done for proper diagnosis. No treatment was provided for Hemorrhoids and polyps. So, also, there was no treatment for pre-existing Hyper Tension and DM. The repudiation of the claim is illegal and irregular.

The insurer submitted that the investigations revealed presence of Hemorrhoids and polyps and was provided treatment for the same also. These are not covered under the policy for the first 2 years. Hypertension and DM were pre-existing. The origin of GI Bleed could not be ascertained So, the treatment was mainly for pre-existing diseases and Hemorrhoids and polyps. The repudiation of the claim is valid and legal..

Decision:- Discharge Summary shows the diagnosis as Obscure GI Bleed- small bowel origin, DM, systemic Hypertension, Bilateral Renal Artery Stenosis and Mild Renal Failure. Various investigations were done for proper diagnosis. He was managed with blood transfusions and antibiotics. There is complete lack of evidence that Hemorrhoids and polyps were bleeding and the complainant was given treatment related to Hemorrhoids and polyps during hospitalization. So, also, there is no evidence that GI Bleed was detected, diagnosed or treated , earlier to the inception of the policy. No evidence for treatment for DM and Hypertension is also available. Treatment for GI Bleed is not excluded under Clause C-2 of the policy conditions. So, it can be safely concluded that repudiation of the claim under exclusion Clause C-1 and C-2 is not sustainable. As the

complainant was treated in a non-network hospital , he has to bear 20% of the expenses as per policy conditions. In the result an award is passed directing the insurer to pay to the complainant an amount of Rs.70814/- with cost of Rs. 2000/- within the prescribed period failing which, the amount shall carry interest @9% per annum from the date of 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/11-017-073/2012-13

Jayasreedevi Narayanan

Vs

Star Health & Allied Insurance Co. Ltd

AWARD No. IO/KCH/GI/83/2013-14 dated 02.08.2013

The complainant had taken a policy from the Respondent-Insurer covering her mother-in-law. The insured was referred to SUT Hospital, TVM for angiogram by attending Cardiologist. The claim for the same was repudiated by the insurer on the ground of pre-existing disease. She had never been treated for any Cardiac problem prior to the present hospitalisation. Therefore, the complaint.

The insurer submitted that there is medical evidence that the insured had suffered exertion angina atleast two years prior to the inception of the policy. The complainant is guilty of suppression of material facts in the proposal form. The treatment was taken for a pre-existing ailment. The policy is vitiated and the repudiation is on valid grounds.

Decision:- Discharge Summary shows the diagnosis as Atypical chest pain, FC-II DOE, SR, Good LV Function, poorly controlled DM and HTN. In the history portion it is mentioned that she had history of DM and FC-II EA for two years. DM had already been declared in the proposal form by the insured. There is no mention regarding earlier diagnosis of any heart related ailment or treatment underwent by the insured. In this case, there is nothing in evidence which would impute knowledge of any pre-proposal illness relating to cardiovascular system. So, the contention of the insurer that the complainant had suppressed material fact relating to pre-proposal health status of the insured in the proposal form, is without any basis. Here there is no evidence that she was diagnosed with cardiac problem within 48months prior to the inception of the policy. In the instant case , there is no evidence at all that the insured had taken any treatment for the ailment, during the immediately preceding 12 months from the date of proposal. So, exclusion Clause 1 in relation to pre-existing disease is also not attracted in this case. So, the repudiation of the claim on the ground of suppression of material fact and pre-existing disease can not be sustained. Here as per policy conditions 30% co-payment is to be made

by the insured. In the result an award is passed directing the insurer to pay to the complainant an amount of Rs.8915/- within the prescribed period failing which, the amount shall carry interest @9% per annum from the date of 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/11-003-037/2012-13

Muraleedharan Nair

Vs

National Insurance Co. Ltd

AWARD No. IO/KCH/GI/84/2013-14 dated 06.08.2013

The complainant had taken Mediclaim policy from the Respondent-Insurer. He suffered severe neck pain and was taken to Hospital and admitted there. The claim for the same was repudiated by the TPA of the insurer under exclusion Clause 4.10. Therefore, the complaint.

The complainant submitted that he was provided active treatment during hospitalization. He was kept under observation as the pain was severe in nature. He is entitled to get the re-imbursement.

The insurer submitted that medical evidence would reveal that the complainant was not provided active treatment during hospitalization. He had incurred expenses only for investigations. So, the claim was hit by Clause 4.10 of the policy conditions. The repudiation is legal and based on policy conditions.

Decision:- Discharge summary shows the diagnosis as Cervical Spondylolisthesis. This is the forward slipping of one vertebra on the one below it. He was provided with analgesics and muscular relaxants. Severe Cervical Spondylolisthesis can lead to numbness of upper limbs and it can also affect the mobility of the upper limbs. So, the Doctor who attended him, prudently decided to admit the complainant and keep him under observation and on medication. Proper diagnosis of the ailment was made and treatment was provided for the ailment diagnosed. When investigations leads to proper diagnosis and on proper diagnosis, proper and sufficient treatment is provided for the ailment, it is nothing less than active treatment. So, exclusion Clause 4.10 is not at all attracted in this case. In the result an award is passed directing the insurer to pay to the complainant an amount of Rs.3721/- with cost of Rs. 500/- within the prescribed period failing which, the amount

shall carry interest @9% per annum from the date of 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/11-008-064/2012-13

George K Varghese

Vs

Royal Sundaram Alliance Insurance Co. Ltd

AWARD No. IO/KCH/GI/91/2013-14 dated 28.08.2013

The complainant had been taking Health Shield policy from the Respondent-Insurer since 2006. His son was admitted at AIMS, Kochi for treatment of Sacral pressure sore which developed about one month before. The claim for the same was repudiated by the insurer stating that the treatment was for complications arising out of a congenital external ailment. Therefore, the complaint.

The complainant submitted that the ailment suffered by his son was not congenital in nature and hence the exclusion clause is not at all attracted. He is entitled to re-imbursement of the hospital expenses , daily hospital cash benefit as well as convalescence benefit.

The insurer submitted that the son of the complainant is a known case of spinabifida and he had been suffering from a congenital disease viz, lumbar meningomylocele. As per expert opinion. the present ailment is a complication of the congenital disease suffered by him The repudiation of the claim is strictly based on policy conditions as the treatment comes under the Exclusions provided in the policy.

Decision:- Discharge Summary shows the diagnosis as sacral pressure sore, known case of spinabifida with lower limb paralysis and urinary incontinence. He underwent multiple wound debridements and vaccum assisted wound dressing. In the Discharge Summary as well as the treating doctor's report, it is stated that the sacral pressure sore suffered by the patient was not a congenital disease or a complication arising out of it. Treating doctor has got first hand personal information regarding the condition of the patient. The insurer can not claim primacy for the expert opinion obtained by them based on medical records , over the certificate issued by the treating doctor. Medical literature also do not reveal that sacral pressure sore is possible only in the case of persons suffering from spina

bifida. When the claim is repudiated based on an exclusion Clause, it is the bounden duty of the insurer to adduce satisfactory evidence that the claim is hit by the exclusion Clause. Here the insurer had utterly failed to discharge their burden. Therefore, the repudiation of the claim is without any basis. It can not be sustained. So, the complainant is entitled to a total amount of Rs. 150561/- towards hospitalization expenses, pre & post hospitalization expenses, Hospital cash benefit and Convalescence Benefit. In the result, an award is passed directing the insurer to pay an amount of Rs.150561/- with cost of Rs.3,000/- within the period prescribed failing which, the amount shall carry interest at 9% per annum from the date of complaint till payment is effected.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-008-056/2012-13

P Syed Shaik Koya

Vs

Royal Sundaram Alliance Insurance Co. Ltd

AWARD No. IO/KCH/GI/92/2013-14 dated 29.08.2013

The complainant had taken policy from the Respondent-Insurer covering himself and his family. His daughter was admitted in Welcare Hospital, Ekm for treatment of Pelvic Inflammatory Disease . The claim for the same was repudiated by the insurer. Therefore, the complaint.

The complainant submitted that no treatment was provided to his daughter in connection with infertility or conception. Repudiation of the claim relying on exclusion Clause is without any basis. He is entitled to receive reimbursement of hospital expense and Daily Hospital Cash Benefit in the policy.

The insurer submitted that the Discharge Summary as well as expert opinion reveal that hospitalization and treatment were for infertility and conception. The claim is hit by exclusion Clause 25 of the policy conditions. The repudiation is legal and proper.

Decision:- Discharge Summary shows the diagnosis as Pelvic Inflammatory Disease. The treating doctor had given a certificate to the effect that no treatment was given for infertility during the hospitalization. In the report along with the claim it is noted that the patient was provided antibiotics and anti-inflammatory drugs. The insurer is relying on the expert opinion obtained by them, to repudiate the claim. Treating doctor has got first hand personal information regarding the condition of the patient. The insurer can not

claim primacy for the expert opinion obtained by them based on medical records , over the certificate issued by the treating doctor and Discharge Summary. The insurer failed to bring in any acceptable evidence that the treatment at Welcare Hospital related to fertility or secondary infertility so as to attract the embargo contained in exclusion Clause 25 of the policy conditions. Therefore, the repudiation of the claim is not sustainable. The policy in question does not provide reimbursement of hospital expense. It provides only Hospital confinement Daily Benefit. The complainant is entitled to Rs. 3000/- under this Benefit. In the result, an award is passed directing the insurer to pay an amount of Rs.3000/- with cost of Rs.1,000/- within the period prescribed failing which, the amount shall carry interest at 9% per annum from the date of complaint till payment is effected.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-005-903/2012-13

Justice K Sreedharan

Vs

Oriental Insurance Co. Ltd

AWARD No. IO/KCH/GI/93/2013-14 dated 02.09.2013

The complainant had been taking Mediclaim policies from the Respondent-Insurer for the last 10 years covering himself and his wife. They underwent treatment at Kottakkal Arya Vaidya Salafrom 06.09.2012 to 20.09.2012. Hospitalisation was on medical advice. The claim for the same was repudiated by the insurer. Therefore, the complaint.

The insurer submitted that the complainant had been taking policy from 2004 onwards. The policy conditions were amended w.e.f.15.02.2006 incorporating Note to Clause 2.1 of the policy conditions. The relevant policy was for the period 2011-12. The complainant and his wife took treatment in a private Ayurvedic Hospital. Hospitalisation expenses in a private Ayurvedic Hospital are not covered under the policy. So, the claim was validly repudiated.

Decision:- The sole dispute is relating to Note to Clause 2.1 of the policy conditions invoked by the insurer to repudiate the claim. It says that "In case of Ayurvedic/Homeo/Unani treatment , hospitalization expenses are admissible only when the treatment is effected as in-patient in a Govt. Hospital/ Medical College Hospital ". Admittedly, the complainant and his wife were treated in a Private hospital. It is learnt that the Note to Clause 2.1 was added into the policy conditions w.e.f. 15.02.2006. Prior to this there was no such Exclusion Clause. As far as the complainant is concerned , he had taken his first policy in 2004. All the renewals were based on the proposal submitted by him in 2004 while taking the 1st policy from the insurer. There is no case for the insurer that when the policy conditions were amended incorporating Note to Clause 2.1 of the

policy conditions, notice of the same was issued to the existing policy holders. So also, the insurer did not care to take a new proposal from the existing policy holders. An existing benefit had been taken away / restricted by the insurer without knowledge or consent of the complainant as well as other existing policy holders. So, the amended policy conditions adding Note to Clause 2.1 is not binding on the complainant and his wife. 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 54085/- to the complainant within the period prescribed failing which, the amount shall carry interest at 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/11-017-103/2012-13

Ginu Jose

Vs

Star Health & Allied Insurance Co. Ltd

AWARD No. IO/KCH/GI/94/2013-14 dated 10.09.2013

The complainant had taken Family Health Optima insurance policy from the Respondent-Insurer on 22.12.2010. The said policy was renewed for 2011-12. The complainant underwent Tonsillectomy on 21.12.2011 on the advice of the Doctor. The claim was repudiated by the Insurer on the ground that the hospitalisation was in connection with a pre-existing disease. Therefore, the complaint.

The complainant submitted that he was diagnosed with Tonsillitis only on his admission in the hospital. The complainant had not suppressed any material fact in the proposal form. The ailment for which he underwent hospitalisation and surgery was not a pre-existing one. The repudiation is against the policy conditions.

The insurer submitted that the Medical Certificate issued by the attending Doctor would reveal that the complainant was having recurrent throat pain since three years. There is evidence that even at the time of submission of the proposal form he was suffering from throat ailment/disorder. So, it was a pre-existing ailment. Pre-existing ailments are not covered for the first 48 months from the date of inception of the policy. The complainant is not entitled to any benefit under the policy.

Decision:- The Discharge Summary shows the diagnosis as chronic Tonsillitis. He underwent Tonsillectomy under general anesthesia. It is noted in the claim medical

Certificate that the patient was having complaints of recurrent throat pain for about three years. Throat pain can be due to several reasons. Throat pain can be associated with Tonsillitis also. Throat pain is the main symptom of Tonsillitis. Now, the medical evidence before this Forum is that recurrent throat pain suffered by the complainant have paved way for persistent throat pain and finally ended in Tonsillitis. So, the recurrent throat pain was a symptom of Tonsillitis. The complainant had submitted before this Forum that he had taken occasional treatment for throat pain even before the submission of the proposal form. The complainant had symptoms of Tonsillitis prior to the inception of the first policy and within 48 months of the inception of the said policy. The insurance cover had incepted on 22.12.2010. He was having throat pain as per the medical evidence atleast from early 2009. So, recurrent throat pain suffered by the complainant prior to the inception of the policy is a symptom of Tonsillitis, which squarely comes within the definition of the term 'pre-existing disease'. The hospitalisation was during the second policy period. Pre-existing disease is not covered for the first 48 months from the inception of the policy. So, exclusion No.1 is attracted in the case of the complainant. The conclusion is that the repudiation of the claim is in tune with the policy conditions and therefore, in order. In the result, the complaint is dismissed. No cost.

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OFFICE OF THE INSURANCE OMBUDSMAN, KOCHI

Complaint No. IO/KCH/GI/11-004-095/2012-13

C S Balasubramanian

Vs

United India Insurance Co. Ltd

AWARD No. IO/KCH/GI/95/2013-14 dated 11.09.2013

The complainant had been taking Mediclaim policy from the Respondent-Insurer from 1995 onwards. He suffered Herpes Zoster in January 2011 and doctor advised complete rest. When the disease aggravated, though the Doctor was ready to admit him in the clinic, the other patients objected to his admission in the hospital and therefore, he was advised to continue domiciliary treatment. Medicines were prescribed. His claim for the same was repudiated by the Insurer. The repudiation is against policy conditions. Therefore, the complaint.

The insurer submitted that the claim submitted by the complainant did not satisfy the conditions for Domiciliary hospitalisation enumerated in Clause 2.5 of the policy conditions. There was no need or occasion for Domiciliary Hospitalisation of the complainant. The claim was repudiated strictly based on the policy conditions.

Decision:- The Doctor who attended on the complainant had certified that the complainant could not be shifted to hospital due to the contagious nature of the ailment.

As per medical literature, Herpes zoster is an acute infectious viral disease. Painful vesicular eruption occurs along the course of the infected nerve and is always unilateral. Infectious viral disease will spread from one person to another. The case of the complainant is that he was first taken to the clinic and the Doctor advised hospitalisation. But the other patients in the hospital objected his admission because of the virulent infectious condition of the ailment. Then the Doctor advised domiciliary hospitalisation. The Doctor who attended on the complainant thought that the best way to provide treatment was by way of domiciliary hospitalisation. That was done in the case of the complainant. The Doctor had certified that the patient was not in a position to be shifted to the hospital and therefore, he advised domiciliary hospitalisation. So, the case of the complainant squarely comes within the meaning of the term 'Domiciliary hospitalisation' provided under Clause 2.5 of the policy conditions The repudiation of the claim is against the spirit of Clause 2.5 of the policy conditions. . Hence the repudiation is not sustainable. In the result, an award is passed directing the Respondent-Insurer to pay to the complainant an amount of Rs.4,447/- with 9% interest per annum from the date of filing of the complaint (03.05.2012) till the date of award within the prescribed period failing which, Rs.4,447/- shall carry further interest at 9% per annum from the date of award till payment is effected. No cost.

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KOLKATA

MEDICLAIM

Kolkata Ombudsman Centre
Case No. Case No. 250/11/G4/NL/07/2012-13
Smt. Puspa Bhartia
-Vs-
The Oriental Insurance Company Ltd.,

Date of Order : 18th April, 2013
FACTS/SUBMISSIONS

This complaint was filed against partial repudiation of claim under Individual Mediclaim Policy issued by the Oriental Insurance Company Ltd.

The complainant, Smt. Puspa Bhartia had stated in her complaint dated 03.07.2012 that she was suffering from pain in both knees and was admitted at Peerless Hospital & B.K. Roy Research Centre, Kolkata on 23.08.2011 where she underwent right total knee arthroplasty on 25.08.2011 and was discharged on 31.08.2011. As per discharge summary

the diagnosis of the disease was *'Tri-compartmental Osteoarthritis of both knees, right worse than left'.* At the time of hospitalization TPA of the insurance company settled Rs.2,35,000/- out of the total hospital bill of Rs.2,50,805/-. Further she lodged sixty days post hospitalization claim – 1st seven days for Rs.15,595/-; 2nd next 23 days for Rs.6,531/- and 3rd and final 30 days for Rs.14,040/-. Out of the above, TPA of the insurance company settled the first claim of Rs.12,474/- on 29.09.2011 and second claim of Rs.811/- on 12.12.2011 but did not settle the third claim. She represented to the insurance company on 03.07.2012 but the same was turned down.

The insurance company had stated that Smt. Puspa Bhartia, the insured, was admitted at Peerless Hospital, Kolkata on 23.08.2011 with complaint of pain in both knees and it was diagnosed as Bilateral Osteoarthritis. Total knee replacement was done on 25.08.2011 and she was discharged on 31.08.2011. Out of the total hospital bill of Rs.2,50,804/- they had settled for Rs.2,35,000/- on 19.09.2011. Subsequently, they had received pre and post hospitalization claim for Rs.22,648/- and it was settled for Rs.12,474/- and Rs.811/-. Further, insurance company has settled Rs.13,905/- on 17.08.2012.

DECISION:

The complainant had approached this forum against partial settlement of her claim on account of certain deductions made by the TPA. Out of total claim of Rs.2,50,805/- the insurance company had settled Rs.2,35,000/- considering the sum insured of Rs.3,00,000/- . They had also settled Rs.12,474/- + Rs.811/- under pre and post hospitalization expenses. As per Hon,ble Ombudsman was of the opinion that the following amounts were not payable and rightly rejected by the insurance company.

Payable	Not Payable
Bill of Rs.170/- on 19.10.2011	Bill of (Dr. Surajit Roy) Rs.5,250/- 07.09.11
Bill of Rs.200/- on 19.10.2011	Bill of (Dr. Surajit Roy) Rs.5,600/- 22.09.11
Bill of Rs.276/- on 21.10.2011	Bill of (Dr. Surajit Roy) Rs.5,250/- 22.10.11
Total : Rs.646/-	Bill of (Dr. Surajit Roy) Rs.2,800/- 30.10.11

Thus, the complainant was further payable of Rs.646/- as the doctors prescription are available. The insurance company is directed to pay Rs.646/-.

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Kolkata Ombudsman Centre
Case No. 266/11//G2/NL/07/2012-13
Shri Asok Kumar Hazra
-Vs-
National Insurance Company Ltd.

Date of Order : 08th April, 2013
FACTS/SUBMISSIONS

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

The complainant, Shri Asok Kumar Hazra had stated that his wife Smt. Archana Hazra was suffering from uneasiness, sweating, nausea, giddiness etc. and was admitted at Uma Medical Related Institute Pvt. Ltd. Kolkata 10.09.2011 where permanent pacemaker was implanted on 13.09.2011 and she was discharged on 17.09.2011. As per discharge summary the diagnosis of the disease was *'complete heart block, old CVA (ICH), right sided pleural effusion'.*

He lodged a claim on 26.09.2011 for Rs.2,39,803/- to the TPA of the insurance company. TPA vide their letter dated 08.02.2012 settled Rs.44,500/- deducting Rs.1,95,303/- towards full and final settlement of the claim. He represented to the insurance company on 02.03.2012 for balance amount of Rs.38,650/-, but the same was turned down

The insurance company had stated that the insured lodged a claim of Rs.2,39,803/- for his wife Smt. Archana Hazra who was admitted at Uma Medical Related Institute Pvt. Ltd. on 10.09.2011 with complaints of uneasiness, sweating, nausea, giddiness, vomiting and was discharged on 17.09.2011. Smt. Hazra was a known case of hypertensive, trigeminal neuralgia and post CVA (ICH). As per policy condition and subject to sub-limit, their TPA has settled the claim of Rs.44,500/- which is quite reasonable and justified.

DECISION:

The complainant had approached this forum against partial repudiation of his claim on the ground of pre-existing disease as per policy exclusion clause no. 5.12. From the facts presented to this forum we find that the complainant obtained a hospital benefit policy for the first time with National Insurance Company Limited D.O. XV, Kolkata, w.e.f. 11.05.2006 and continued till 10.05.2010 without any break. Subsequently, the policy was shifted to National Insurance Company Limited D.O. XIX, Kolkata with sum insured of Rs.75,000/- and renewed w.e.f 11.5.2011 with enhanced sum insured of Rs.1,00,000/- and Cumulative Bonus of Rs.12,500/- till 10.5.2013. The complainant lodged a claim for his

wife Smt. Archana Hazra who admitted on 10.9.2011 at Uma Medical Related Institute Pvt. Ltd., and discharged on 17.9.2011 i.e., within the policy period from 11.5.2011 to 10.5.2012 during which the sum insured was enhanced from Rs.75,000/- to Rs.1,00,000/-. From the Discharge Summary, it is found that the patient was a known case of Hypertensive which is covered only after 4 claim free year as per policy exclusion clause no.4.1.

It was further seen that the Dr. Jayanta Sharma issued a certificate dated. 16.12.2011, confirming the fact that the patient was suffering from CVA (ICH) since 15.04.2007 with hypertension since December 2006, so the pre-existing disease exclusion is applicable on the enhanced sum insured from Rs.50,000/- onwards and calculation of claim should be restricted to the sum insured of Rs.50,000/- & Rs..12,500/- towards Cumulative Bonus (as per policy year from 11.5.2007 to 10.5.2008) for diseases related to CVAICGH and Hypertension as per policy clause no. 5.12 which reads as follows:-

"Sum insured under the policy…… continuing or recurrent nature of diseases/ complaints which the insured has ever suffered will be excluded from the scope of cover so far as enhancement of sum insured is considered."

After careful evaluation of all the facts and circumstances of the case, Hon,ble Ombudsman was of the opinion that the claim had been rightly settled as per policy condition no. 5.12 since the waiting period of 4 years had not traversed. The enhanced sum insured could not be considered for settlement of the claim. However, the insurance company had agreed to allow the Cumulative Bonus of Rs.12,500/- which was inadvertently ignored by the TPA.

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Kolkata Ombudsman Centre
Case No. 278/11/G3/NL/07/2012-13
Shri Amit Kumar Shaw
-Vs-
United India Insurance Co Ltd

Date of Order : 24th April, 2013

FACTS/SUBMISSIONS

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

The complainant, Sri Amit Kr Shaw had stated that his father Late Tarak Nath Shaw (M-61) was covered under Group Mediclaim Policy taken by his employer M/s Religare Securities Ltd and hospitalized in three different Nursing Homes for treatment of Septesemia with ARA Jaundice. Ultimately his father expired at Charring Cross Nursing Home (P) Ltd on 06.11.2010. Claim form alongwith all documents relating to above three hospitals were submitted in original through his employer on 24.12.2010. But the insurance company rejected the claim due to late submission of claim documents. He represented to the insurance company referring to condition no. 5.4 requesting that the delay of the same may be waived in extreme cases of hardship. He also submitted the reasons for condonation of delay but his representation was turned down.

The insurance company had stated that they had issued Group Mediclaim Policy No. 041300/48/09/41/00002631 to M/s Religare Enterprises Ltd covering their employees and dependents. The complainant lodged a claim for his father, who was admitted in various hospitals suffering from Liver Jaundice and ultimately died in Sterling Hospital on 06.11.2010 due to Hepatic Encephalopathy, Septicemia.

On 03.01.2011, the Insured Sri Amit Kumar Shaw submitted claim documents to the TPA after 58 days from the date of discharge. The insurance company repudiated the claim for violation of condition no. 5.4 of the policy, which stated that all supporting documents related to claim must be filed within 30 days from the date of discharge from the Hospital. Subsequently, the Insurer had sent a mail to this forum on 10.4.2013, wherein they had stated that their Competent Authority had condoned the delay in submission of documents.

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DECISION:

The complainant had approached this forum against repudiation of his claim due to delay in submission of claim documents. From the facts presented to this forum we find that the insured was treated in different hospital for septesemia with ARA Jaundice and ultimately

expired on 06.11.2010. The insurance company repudiated the claim for delay in submission of the claim documents. However, the delay had now been condoned by the competent authority and TPA had settled the claim. The complainant was directed by the Hon'ble Ombudsman to comply with the requirement of the insurance company and submit the bank details.

KOLKATA **Ombudsman Centre**
Case No. 306/11/G1/NL/07/2012-13
Shri Bir Kumar Kothary

-Vs-
The New India Assurance Co Ltd

Date of Order : 24th April, 2013

FACTS/SUBMISSIONS

This complaint was filed against partial settlement of claim under Mediclaim Policy issued by The New India Assurance Company Ltd.

The complainant, Shri Bir Kumar Kothary had stated that he was suffering from nocturia and swelling of lower limbs and was admitted in Park Clinic, Kolkata on 22.10.2011 where he underwent cystoscopy + saline TURP on 24.10.2011 and he was discharged on 30.10.2011. As per discharge summary the diagnosis of the disease was '*enlarged prostate, history of chronic retention of urine'.*

He lodged a claim for Rs. 1,13,710/-, to the TPA had settled Rs.91,617/- towards full and final settlement of the claim deducting Rs.22,093/-. He represented to the insurance company on 26.04.2012 against partial settlement, but the same was turned down.

The insurance company in their written submission dated 08.10.2012 have stated that the difference in quantum was under heads Doctor's fees (Rs.3,143/-) and Nursing charges (Rs.3,000/). They explained the reasons as under :

(i) Total Doctor's fees charged by the Hospital was Rs.32,000/- out of which they paid for Rs.22,857/-. As per Mediclaim clause the amount of Doctor's fees payable under condition no. 2.3 and 2.4 Note 1 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 under condition 2.1, the charges payable under condition no. 2.3 and 2.4 shall be limited to the charges applicable to the entitled category.

(ii) Rs.3,000/- for nursing charges are not payable as per the policy condition No. 3.7, wherein it has been stated that a nurse should be holding a certificate of a recognized council and employed on recommendations of the attending Medical Practitioner.

DECISION:

The complainant had approached this forum against partial repudiation of his claim on account of disallowance of certain items. From the facts presented to this forum we find that the insurer has deducted an amount of Rs.9,143/- under the head "Doctor's fee" as per policy condition no. 2.3 and 2.4 Note 1. According to the insurer, the insured availed higher category of room (Rs.2,800/- per day) against his entitled category of Rs.2,000/- per day and accordingly, they have paid the doctor's fee of Rs.32,000/- proportionately as per rates applicable to eligible room rent. The insurance company and the complainant have submitted separate confirmation from the TPA and the hospital that there are no variable rates for the doctor's fees and investigation charges according to the category of room.

Under the circumstances, the proportionate deduction of doctor's fees is not justified as the insurer has to allow the charges applicable to the entitled category. In the absence of variable charges, the full amount is to be allowed subject to other cappings in the policy. As regards nursing charges of Rs.3,000/- the same was not payable as per policy condition no. 3.7 and the deduction is justified. The insurance company was directed to pay the balance amount of doctor's fee of Rs.9,143/- (Rupees nine thousand one hundred forty three only).

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Kolkata Ombudsman Centre
Case No. 309/11/G1/NL/07/2012-13
Shri Ashok Kr Dutta
-Vs-
The New India Assurance Co Ltd

Date of Order : 24th April, 2013

FACTS/SUBMISSIONS

This complaint is filed against partial settlement of claim under Mediclaim Policy issued by New India Assurance Co Ltd.

The complainant, Sri Ashok Kr Dutta had stated in his complaints dated 24.05.2012 and 30.07.2013 that as per advice of Dr. Biswanath Mitra, he was admitted in Astha Nursing

Home Pvt Ltd , Kolkata with chest pain from 25.06.2011 to 08.07.2011. He lodged a claim to the Medicare TPA Services (I) Pvt. Ltd. TPA paid Rs.37,500/- as full and final settlement of his hospitalization claim and deducted Rs.45,613/-. According to the Insured, at the material time of hospitalization, policy sum insured including cumulative bonus was Rs.1,20,000/- and a further amount of Rs.55,000/- was payable to him. .

The insurance company had stated that the claim was settled as per clause 4.1, and restricted the claim up to pre-enhanced sum insured of Rs.25,000/- plus available cumulative bonus of Rs.12,500/- as the insured was a patient of diabetes since July 2007 as evidenced from the prescription of Dr.Supriya Banerjee and Dr. A Roy. Moreover, he was having Urinary sugar with Urea 84 which implies Renal Failure. As there is Renal failure due to Diabetic Nephropathy there is always fluid retention in the body. This is also evident in Pleural effusion as per X Ray. Fluid retention in lungs in a case of Diabetic Nephropathy with renal failure is a seat of lung infection or Pneumonia. So it was directly correlated with pneumonia. Considering above, they have settled the claim of Rs.37,500/- , with full sum insured considering the pre-enhanced sum insured.

DECISION:

The complainant had approached this forum against partial repudiation of his claim on the ground of pre-existing diabetic mellitus. From the facts presented to this forum we find that the complainant was admitted in Astha Nursing Home Pvt. Ltd. from 25.06.2011 to 08.07.2011 with serious chest pain. The final diagnosis was type -2 DM – poor glycemic control, pneumonia, psynpneumenic effusion dyselectrotylemia. Psynpneumenic effusion means accumulation of fluid between layers of the membrane lining the lung and the chest cavity. The term dyselectrotylemia means an electrolytic disorder caused by the imbalance of certain ionized salts. There is no noting by the doctor in the hospital records that he was suffering from renal failure and Diabetic Nephropathy. The insurance company had not produced any supporting evidence to show that the present ailment was caused by the pre-existing Diabetic Mellitus.

Kolkata Ombudsman Centre
Case No. 318/11/G2/NL/07/2012-13
Mr. Gordon Robinson
-Vs-
National Insurance Company Ltd.,

Date of Order : 18th April, 2013

FACTS/SUBMISSIONS

This complaint was filed against partial repudiation of claim under Group Mediclaim Policy issued to Church's Auxiliary for Social Action for their Employees issued by the National Insurance Company Ltd.

The complainant that Smt. Rahelamma Thomas, one of their employee had an accidental fall in office and was admitted at Woodlands Medical Centre Limited, Kolkata on 04.01.2011 where she underwent excision of comminuted fragments of lower pole of patella followed by repair of patella on 06.01.2011 and was discharged on 12.01.2011. As per discharge summary the diagnosis of the disease was *'comminuted fracture lower end (right) Patella'.*

At the time of hospitalization, TPA sanctioned Rs.64,600/- out of the total hospital expenses of Rs.91,837/-. Further he lodged a claim for Rs.34,867/- to the TPA. Subsequently, TPA vide their letter dated 04.05.2011 settled Rs.10,028/- in favour of Church Auxiliary for Social Action towards full and final settlement of the claim. He represented to the insurance company on 17.05.2011 against partial repudiation requesting them to settle the balance claim, but the same was turned down.

The insurance company had stated in their written submission dated 09.10.2012 that Smt. Rahelamma Thomas was admitted in Woodlands Medical Centre Limited, Kolkata on 04.01.2011 for surgery of fracture patella of right leg and was discharged on 12.01.2011. Out of the total hospital expenses of Rs.91,837/- they had settled Rs.64,600/- on cashless basis in favour of the hospital on 02.03.2011.

They had further stated that insured submitted claim for pre and post hospitalization expenses for Rs.30,083/- on 09.03.2011 and they have settled Rs.10,028/- on 06.05.2011 and deducted Rs.20,055/- towards full and final settlement of the claim. As per terms and conditions of the policy maximum liability for surgical fees is 25% of sum insured which is Rs.50,000/- in this case. Against total surgical fees claim of Rs.40,000/-, they had released Rs.25,000/-. However, they had reviewed the claim and found that they can release Rs.15,000/- in Category 'B'.

DECISION:

The complainant had approached this forum against partial repudiation of his claim on account of certain deductions made by the TPA. From the facts presented to this forum we find that out of the total claim amount of Rs.91,837/- the insurance company has settled Rs.64,600/- on cashless basis. They had further settled Rs.10,028/- out of the total claim of Rs.30,083/- for pre and post hospitalization expenses. They had submitted a statement giving the details of the items disallowed by the TPA which had been verified by this forum and found to be correct. Considering the policy conditions, we find that the following amount is further payable to the insured.

A) Hospital Expenses

Room	**-**	**Rs.16,000/-**	**Not payable as per policy**
Doctor	**-**	**Rs.40,000/-**	
Other	**-**	**Rs.29,183/-**	**a) O.T. Consumable – Rs.6,088/-**

Total	**-**	**Rs.85,183/-**	**b) Registration charge – Rs. 150/-**
Paid to Hospital	**-**	**Rs.64,600/-**	**c) N.I.C.U - Rs. 240/-**
Paid by Self	**-**	**Rs.20,583/-**	**Rs.6,478/-**
Not Payable	**-**	**Rs. 6,478/-**	
Further payable by Insurance Company	**-**	**Rs.14,105/-**	

B) Post Hospitalization

Doctor + Physiotherapist = 500/- + 3,500/- + 500/- + 600 /- = Rs. 5,100/-

Others = a) Medicine - 20/- + 370/- + 48/- + 71/- + 205 = Rs. 714/-

b) O.T. – 1,865/- + 200/- = Rs. 2,065/-

Rs. 7,879/-

Paid by the insurance company - Rs.10,028/-

Excess paid by the insurance company- (-) Rs. 2,149/-

Total payable by (A – B) = Rs.14,105/-

(-) Rs. 2,149/-

Rs.11,956/-

The above calculation had been agreed to by the insurance company as well as the complainant. The insurance company was directed to pay the above Rs.11,956/-..

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Kolkata Ombudsman Centre
Case No. 320/11/G3/NL/07/2012-13
Shri Om Prakash Pasari
-Vs-
United India Insurance Co Ltd

Date of Order : 24th April, 2013

FACTS/SUBMISSIONS

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

The complainant, Shri Om Prakash Pasari had stated that his wife Smt. Indu Pasari was admitted in Shee Medical Centre, Kolkata on 14.08.2011 for cataract surgery and was discharged next day. He lodged a claim for Rs.26,278/- to the TPA. TPA settled Rs.8,790/- after disallowing Surgeon's fee Rs.15,000/- as the same was not included in the

Hospital Bill. He has further stated that as per the practice of the hospital the amount was paid directly to surgeon. The TPA also disallowed Rs.1600/- (Rs.400 x 4) on account of Surgeon's consultation fee for want of printed receipt. Subsequently, he submitted the printed receipt but it was not allowed. He represented to the insurance company on 05.012012 but the same was turned down.

The insurance company had stated that the complainant paid surgeon's fee of Rs.15,000/- directly to Dr. Ashis Bhattacharya and later on he issued money receipt for the same. The Complainant has also submitted a money receipt towards four consultations amounting to Rs.1,600/-. But they did not allow the fees as the same was not included in the hospital bill. In support of their action, they referred Policy clause no. 1.2 (C) Note 2, wherein it is mentioned that no payment shall be made under head Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialist Fees other than as part of the hospitalization bill.

DECISION:

The complainant has approached this forum against disallowance of surgeon fees and consultation charges on the ground that these were not included in the hospital bills. From the facts presented to this forum we find that the complainant was admitted in the nursing home for cataract surgery. He submitted a hospital bill which did not include surgeon's fee as he paid the consultation charges separately as per the practice of the nursing home. We find that both the surgeon and the nursing home authority have given a certificate confirming the payment outside the nursing home bills. Surgeon has also given a separate pre-printed money receipt acknowledging the payment. The insurance company have admitted their liability but surprisingly they did not allow the surgeon fees and deducted an amount of Rs.16,600/- citing note 2 of the policy condition no. 1.2 C which states that no payment shall be made under 1.2 C other than as part of the hospitalization bill. In this case, the surgeon's fee for cataract surgery is an essential component of the hospitalization expenses otherwise it will lead to an absurd situation that operation was done free of cost or without engaging the services of a surgeon. The insured does not have any control over the method of raising bill by the nursing home and the doctors. However, the genuineness of the claim is not in dispute and the surgery stands confirmed by the medical papers.

The decision of the insurance company to deduct Rs.16,600/- was not justified and the insurance company was directed by the Hon.ble Ombudsman to pay Rs.16,600/- (Rupees sixteen thousand six hundred only) to the complainant.

-Vs-
National Insurance Company Ltd.,

Date of Order : 31st May, 2013

FACTS/SUBMISSIONS

This complaint was filed against repudiation of claim under Individual Mediclaim Policy issued by National Insurance Company Ltd. as per exclusion clause no. 4.3 of the policy.

The complainant, had stated in his complaints dated 02.05.2012 and 25.06.2012 that he was suffering from high fever for 3 - 4 days and as per advice of the doctor was admitted in Charnock Hospital Kolkata on 04.11.2011 where he was treated conservatively and was discharged on 11.11.2011. As per discharge summary the diagnosis of the disease was STI/Honk/WG/Drug induced Neutropenia (Cyclophosphamide) newly detected DM.

He lodged a claim on 23.11.2011 for Rs.1,53,714/- to the TPA of the insurance company. However, the insurance company vide their letter dated 14.12.2011 repudiated the claim as per exclusion clause no. 4.3 of the policy. He represented to the insurance company on 30.12.2011 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.1,53,714/- as per 'P-II' form details.

The insurance company had stated that Shri Subhadeep Acharyya was admitted in the Charnok Hospital, Kolkata on 04.11.2011 and was discharged on 11.11.2011 for the treatment of Wegners Gyanulomtosis, a chronic disease. He submitted a claim to their TPA for reimbursement. Their TPA after going through all the allied treatment/ diagnosis/ lab tests/ history of the patient have come to the conclusion that it was a pre-existing disease and finally repudiated the claim vide letter dated 05.12.2011 as per exclusion clause no. 4.3 of the policy.

DECISION:

The complainant had approached this forum against repudiation of his claim for hospitalization expenses on the ground of pre-existing disease as per exclusion clause no.4.3 of the policy. From the facts presented to this forum we find that the insured was covered under Parivar Mediclaim Policy for a sum insured of Rs.5 lakh for the period from 15.11.2010 to 14.11.2011. He was hospitalized in Charnock Hospitals Pvt. Ltd. Kolkata on 04.11.2011 with complaints of fever and dehydration. As per discharge summary of the hospital the final diagnosis of the disease was STI/Honk/WG/Drug induced Neutropenia (Cyclophosphamide) newly detected DM. Subsequently he lodged a claim for Rs.1,53,714/- to the TPA of the insurance company. The insurance company repudiated the claim on the ground that patient was hospitalized for treatment of Wegners Gyanulomtosis, a chronic auto immune disorder that affects multi system mainly lungs, URTI, skin and eyes. Moreover, the patient's blood sugar levels were also raised which proves that he was suffering from DM as mentioned in the consultation paper.

Considering these facts, they are of the opinion that the diseases are pre-existing in nature and therefore, they have repudiated the claim as per clause 4.1 and 4.3 of the policy. After verifying the hospital reports we find that the patient underwent treatment for Wegners Gyanulomtosis along with host of other diseases including DM which are not pre-existing. There was acute infection which needed hospitalization and management with I/V antibiotics. Moreover, there is no conclusive evidence that Wegners Gyanulomtosis was the primary cause for other ailments. Under the circumstances, total denial of the claim is not justified but at the same time treatment cost of WG (pre-existing disease) and STI (specifically excluded under the policy conditions) are not payable.

After careful evaluation of all the facts and circumstances of the case, we are of the opinion that the insured was admitted for the treatment of several diseases, some of which are not pre-existing in nature. We, accordingly, allow 40% of the admissible claim amount towards the treatment of allowable diseases under the policy. The insurance company was accordingly directed to settle and pay 40% of the admissible claim amount as per terms and conditions of the policy.

Kolkata Ombudsman Centre
Case No. 303/11/G2/NL/07/2012-13
Shri Pulak Deb
-Vs-
National Insurance Company Ltd.,

Date of Order : 31st May, 2013

FACTS/SUBMISSIONS

This complaint is filed against repudiation of claim under Individual Mediclaim Policy issued by National Insurance Company Ltd. as per exclusion clause no. 4.3 of the policy.

The complainant, had stated that his son Master Ishan Kumar was suffering from high fever and throat pain and was admitted at Desun Hospital & Heart Institute, Kolkata on 01.09.2010 where he underwent necessary investigations and was discharged on 08.09.2010. As per discharge summary the diagnosis of the disease was '*hypertrophied adenoid, maxillary and ethmoid sinusitis, deviated nasal septum*'. Again he was admitted at the same hospital on 17.09.2010 where he underwent adenoidectomy and was discharged on 19.09.2010. As per discharge summary the diagnosis of the disease was *'recurrent adenoiditis in a patient with hypertrophied adenoids'.*

He lodged a claim on 13.10.2010 for Rs.77,875/- to the insurance company. The insurance company vide their letter dated 17.05.2012 repudiated the claim as per exclusion clause no. 4.3 of the policy stating that there is two years waiting period for the treatment of sinusitis. He represented to the insurance company on 25.05.2012 stating that his son was

treated for adenoiditis (with waiting period of one year) and not for sinusitis, but the same was turned down.

The insurance company had stated that the insured was admitted twice in the hospital for the period from 01.09.2010 to 08.09.2010 and 17.09.2010 to 19.09.2010 at Desun Hospital & Heart Institute, Kolkata for the treatment of 'Hypertrophied Adenoid Maxillary & Ethmoid Sinusitis, deviated nasal septum'. The claim was thoroughly scrutinized by their TPA and they have come to the conclusion that the claim is not payable due to a waiting period of 2 years for sinusitis under clause 4.3 of the policy.

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DECISION:

The complainant had approached this forum against repudiation of his claim on the ground that the disease i.e., adenoiditis was interlinked with sinusitis which has a waiting period of two years under policy exclusion clause no. 4.3. From the facts presented to this forum we find that the insured was admitted with complaints of throat pain and high fever on 01.09.2010 i.e. after 1 year and 18 days of the inception of the policy. The diagnosis as per first discharge summary was 'Hypertrophied Adenoid, Maxillary and Ethmoid Sinusitis, Deviated Nasal Septum'. According to the insurance company sinusitis is not payable for the first two years of the policy as per exclusion clause no. 4.3 of the policy. Deviated Nasal Septum is a congenital internal disease which is not payable at all as per policy condition no. 4.8. The insured was again admitted in the same hospital on 17.09.2010 with chief complaints of chronic tonsillo-adenoiditis, hypertrophied adenoid. As per second discharge summary the procedure involved adenoidectomy under general anesthesia. It is seen from the policy condition no. 4.3 that adenoidectomy is covered after completion of first year of the policy. The insurance company had argued that infection of adenoid gland is a type of sinusitis, but we find that medically both the ailments are different; former being the pre-stage of the latter. This difference justifies a shorter waiting period of 1 year for adenoidectomy as against 2 years for sinusitis under policy clause no. 4.3. If both the ailments were same, then there was no need for different waiting periods for the two diseases. Since in this case the insured had undergone adenoidectomy and not treatment for sinusitis, the claim was admissible after completion of first year of the policy with pre and post hospitalization benefits.

Kolkata Ombudsman Centre
Case No. 321/11/G1/NL/08/2012-13
Smt. Rita Shaw
-Vs-
The New India Assurance Company Ltd.,

Date of Order :10th May, 2013

FACTS/SUBMISSIONS

This complaint was filed against repudiation of claim under Mediclaim Policy issued by The New India Assurance Company Ltd. as per exclusion clause no. 4.4.6 of the policy.

The complainant, had stated in her complaints dated 11.06.2012 and 31.07.2012 that she was suffering from vertigo, generalized weakness, nausea & vomiting and was admitted in B.P.Poddar Hospital & Medical Research Ltd., Kolkata on 26.12.2011 where she was treated conservatively. She was discharged on 03.01.2012. As per discharge summary the diagnosis of the disease was *'Obsessive Compulsive Disorder'*.

She lodged a claim on 11.02.2012 for Rs.43,469/- to the TPA of the insurance company. TPA vide their letter dated 21.02.2012 repudiated the claim stating that 'as per policy condition psychiatric ailment & its complication is not covered under the policy. Hence the claim stands rejected'. She represented to the insurance company against repudiation on 28.03.2012, but the same was turned down.

The insurance company had stated that the insured Smt. Rita Shaw lodged a claim for her hospitalization at B.P.Poddar Hospital & Medical Research Ltd., Kolkata for the period from 26.12.2011 to 03.01.2012. As per discharge summary the diagnosis of the disease was 'Obsessive Compulsive Disorder and Gastritis'. As per exclusion clause no. 4.4.6 of the policy stating that psychiatric treatment and its complication are not covered under the policy. Hence the claim was repudiated vide letter dated 21.02.2012.

They further stated that on receipt of the representation dated 28.03.2012 from the insured for review of her claim, their TPA sent a letter dated 06.04.2012 to the insured for submission of complete set of indoor case papers including the history sheet. In response the insured vide her letter dated 01.05.2012 has forwarded the copy of the discharge summary of the hospital and claim form which were already submitted. TPA has again sent letters dated 11.05.2012 and 31.05.2012 to the insured for submission of the above documents but due to non-receipt of the same the claim file was finally closed.

DECISION:

The complainant had approached this forum against repudiation of her claim as per exclusion clause no. 4.4.6 of the policy. From the facts presented to this forum we find that the complainant was admitted in the hospital with complaints of gastric trouble, vertigo and general weakness. The final diagnosis as per the discharge summary was Obsessive Compulsive Disorder (OCD) and gastritis. The insurance company has repudiated the claim on the ground that the patient had psychiatric problem and its treatment is not covered under the policy condition no. 4.4.6. They have further asked the complainant to submit the entire case paper to review the claim. The complainant on the other hand has contended that apart from psychiatric problem she was also treated for gastric problem which is admissible under the policy. On scrutiny of the papers submitted by both the parties, we find that Dr. (Mrs.) S. Mandal had referred the complainant's case vide her prescription dated 09.12.2011 to Dr. Amar Mishra (Neurologist) for EEDF. According to the discharge certificate, the final diagnosis was OCD which is an anxiety disorder characterized by intrusive thoughts that produce uneasiness, apprehension, fear, or worry, by repetitive behaviours aimed at reducing the associated anxiety, or by a combination of such obsessions and compulsions. In addition, she had also undergone treatment for gastric problem which was overlooked by the TPA. Since it is difficult to bifurcate the treatment expenses relating to the two diseases, we allow 35 % of the admissible amount towards the treatment of gastric problem.

Kolkata Ombudsman Centre
Case No. 323/11/G1/NL/08/2012-13
Shri Klinkar Nath Mukherjee
-Vs-
The New India Assurance Company Ltd.,

Date of Order :10th May, 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 Klinkar Nath Mukherjee has stated in his complaints dated 22.04.2012 and 31.07.2012 that his wife Smt. Ratna Mukherjee was suffering from gynecological problem and was admitted in Woodlands Multispeciality Hospital Limited, Kolkata on 13.11.2011 where she underwent total abdominal hysterectomy with BSO on 14.11.2011. She was discharged on 18.11.2011. As per discharge summary the diagnosis of the disease was '*Post Menopausal Bleeding*'.

At the time of hospitalization, out of the total hospital bill of Rs.69,240/- the TPA of the insurance company allowed Rs.50,500/- on cashless basis. Further he lodged a claim for Rs.27,841/- including pre and post hospitalization expenses of Rs.9,200/- to the TPA of the insurance company. The TPA vide their letter dated 19.12.2011 & 07.04.2012 settled Rs.8,788/- and Rs.958/- respectively towards full and final settlement of the claim. He represented to the insurance company on 18.06.2012 against partial settlement, but the same was turned down. Being aggrieved, by the decision of the insurance company, he approached this forum for redressal of his grievance without mentioning any quantum of relief 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 03.09.2012.

The insurance company had stated that the insured was admitted at Woodlands Multispeciality Hospital Limited for the period from 13.11.2011 to 18.11.2011. Out of the hospitalization bill of Rs.69,240/- the TPA approved Rs.50,500/- on cashless payment. She further lodged a claim of Rs.18,740/- they had further paid Rs.958/- disallowing Rs.17,782/- as per the reason mentioned below :-

i) **Room charges for Rs.2,000/- deducted as per clause no. 2.1 of Mediclaim Policy (2007)**
ii) **As per clause 2.0 (Note 1) of Mediclaim Policy (2007) if the insured opts for a room with rent higher than the entitled category all other expenses (except**

medicines and consumables) shall be limited to the charges applicable to the entitled category.

Therefore, Rs.28,929/- as reasonable amount is paid against doctor/surgeon/ anesthetist/ assistant charges of Rs.40,500/- deducting Rs.11,571/-, Rs.4,642/- is paid against operation theatre charge of Rs.6,500/- deducting Rs.1,858/-, Rs.2,357/- is paid against investigation charges of Rs.3,300/- deducting Rs.943/- since the insured opts for a room with rent higher than the entitled category.

iii) Other non-medical expenses like sponge cloth Rs.52/-, URO bag Rs.58/-, sheet Rs.192/-Hand care gloves Rs.51/-, Sanitary pad Rs.180/-, Micro shield charge Rs.160/-, under paid Rs.595/- and Hand Wash Rs.122/- as per clause 4.4.21 of the policy.

In view of the above, they had also paid Rs.8,788/- to the insured towards pre and post hospitalization expenses of Rs.9,200/- deducting Rs.412/- vide cheque no. 667664 dated 01.02.2012.

DECISION:

The complainant had approached this forum against partial settlement of his claim due to certain proportionate deductions made by the TPA as per clause no. 2.3 and 2.4. From the facts presented to this forum we find that the insured was admitted in a higher category of room but her eligibility is limited to 1% of the sum insured for five days. Thus the deductions of Rs.2,000/- made under this head is correct. However, proportionate deductions made under the head consultation fees, OT charges, miscellaneous expenses and investigation expenses are not correct. As per note 1 under policy clause nos. 2.3 and 2.4, the amount payable shall be at the rates applicable to the entitled room category and if the insured opts for a room with higher rent then the charges shall be limited to the rates applicable to the entitled category. The TPA has not obtained any confirmation from the hospital whether there is a system of variable rates as per different categories of rooms. In the absence of variable rates, the full amounts under 2.3 and 2.4 as incurred by the insured are payable. The formula applied by the Insurer to arrive at the proportionate deduction is neither prescribed under the policy condition nor fair to the insured. We, therefore, direct the insurance company to verify the rates under the above heads as applicable to the entitled category from the hospital and settle the claim accordingly. If variable rate exists in relation to room rent then applicable rates should be applied otherwise full payment is to be made subject to policy condition. As regards the non-medical expenses amounting to Rs.1,410/- the deductions has been correctly made.

Kolkata Ombudsman Centre
Case No. 325/14/G4/NL/08/2012-13
Smt. Suparna De
-Vs-
The Oriental Insurance Company Ltd.,

Date of Order :10th May, 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. Suparna De has stated in her complaints dated 27.06.2012 and 30.07.2012 that her mother-in-law Smt. Shephalika De was suffering from weakness of limbs and was admitted in Medica Superspeciality Hospital, Kolkata on 24.02.2012 where she was treated conservatively and was discharged on 06.02.2012. As per discharge summary, the diagnosis of the disease was 'Obstructive Jaundice, Chronic calculus cholecystitis, suspected GB mass, CKD, Anaemia'.

She lodged a claim for Rs.1,06,932/- on 10.03.2012 to the TPA of the insurance company. The TPA asked to submit certain documents and the same was complied on 17.05.2012. But after submission of all the required documents her claim was not settled. She represented to the insurance company on 24.06.2012, but the claim is still pending. Being aggrieved, by the delay in settlement of the claim, she approached this forum for redressal of her grievance seeking monetary relief of Rs.2 lakh 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 05.09.2012.

The insurance company had stated that the complainant lodged a claim in respect of her mother-in-law Smt. Shephalika De who was admitted at Medica Superspeciality Hospital, Kolkata on 24.02.2012 and was discharged on 06.03.2012. As per discharge summary the diagnosis of the disease was Obstructive Jaundice, Chronic calculus cholecystitis, suspected GB mass, CKD, Anaemia. Their TPA vide their letter dated 29.03.2012 and 05.04.2012 requested the insured to submit the required additional documents. Due to non submission of required documents, the claim file was closed by their TPA.

DECISION:

The complainant has approached this forum against delay in settlement of her claim for the hospital treatment of her mother-in-law. From the facts presented to this forum we find that the claim is pending due to non-availability of certain documents required by

the insurance company. The complainant has confirmed that the original documents were submitted with her letter dated 15.05.2012. The TPA has given a proper acknowledgement for 38 (thirty eight) original documents submitted with the said letter. However, she is ready to again submit the copies of the required documents to the insurance company.

In view of the above, the insurance company was directed to settle the claim and pay the same as per terms and conditions of the policy.

Kolkata Ombudsman Centre
Case No. 332/11/G3/NL/08/2012-13
Shri Ajoy Roy
-Vs-
United India Insurance Co Ltd.,

Date of Order :14th May, 2013

FACTS/SUBMISSIONS

This complaint was filed against partial repudiation of claim under Individual Health Insurance Policy – 2009 issued by United India Insurance Company Ltd.

The complainant, Shri Ajoy Roy had stated in his complaints dated 31.03.2012 and 06.08.2012 that he was suffering from eye problem and as per advice of Dr. Arnab Biswas he was admitted in Health Point (A Multispeciality Hospital) Kolkata on 06.12.2011 where he underwent Ophthalmic Operation and was discharged on 07.12.2011

He lodged a claim on 20.12.2011 for Rs.22,773/- to the TPA of the insurance company. TPA vide their letter dated 22.03.2012 settled Rs.4,342/- towards full and final settlement of claim, but it was not accepted by him. He represented to the insurance company on 15.05.2012 against partial settlement requesting them to settle his balance claim, 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.18,000/- 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 05.09.2012.

The insurance company had stated that the insured had undergone surgery for Ectropion Correction and submitted documents to their TPA for reimbursement. The TPA observed violation of Policy condition no. 1.2 A,B, C, D,E to be read with Note 1 & 2 and deducted Rs.15,181/- on the said ground. The Insurer deducted Rs. 750/- from room rent as eligible amount for room rent was 1% of Sum Insured i.e., Rs.1250/- but he stayed in a room having rent of Rs. 2,000/-. Further they disallowed cost of some medicines for Rs. 2,500/- being not supported with prescription. Accordingly the insurance company paid Rs. 4342/- for full and final settlement of the claim.

DECISION:

The complainant had approached this forum against partial repudiation of his claim on account of certain deductions made by the TPA. Out of total claim of Rs.22,773/-, the TPA had allowed only Rs.4,343/- after disallowing the Surgeon and Anesthetist fees totally and

making proportionate deductions under other heads. From the statement submitted by the insurance company we find that the deduction made for room rent has been correctly done. As the insured was admitted in a higher category of room was limited to 1% of the sum insured. However, the proportionate deductions made under the head O.T. and related charges are not correct as the insurance company has not ascertained whether there is a system of variable charges under different heads applicable to the entitled category of room rent. In the absence of variable charges according to the room rent, the full amount incurred by the insured has to be allowed under this head subject to policy sub limits if any. The surgeon's fee of Rs.10,000/- and Anesthetist Fees of Rs.3,000/- has not been allowed by the insurance company as per policy condition 1.2 C Note 2. However, these deductions are not justified as these constitute part of the hospitalization expenses. Since the payments are supported by proper money receipts issued by the doctors, these have to be allowed by the insurance company. As regards the deductions for non-medical items the same is correct since the bills of these items were not shown separately.

In view of the above the insurance company was directed to pay the Surgeon fee of Rs.10,000/- and the Anesthetist charges of Rs.3,000/- along with O.T related charges.

Kolkata Ombudsman Centre
Case No. 337/11/G3/NL/08/2012-13
Shri Siddheswar Mukherji
-Vs-
United India Insurance Co Ltd.,

Date of Order :10th May, 2013

FACTS/SUBMISSIONS

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

The complainant, Shri Siddheswar Mukherji has stated in his complaints dated 02.05.2012 and 05.07.2012 that he was suffering from left eye retina detachment and was admitted in Disha Eye Hospitals & Research Centre, Barrackpore, North 24 Parganas on 06.12.2011 where intravitreal injection Avastin was administered in his left eye and was discharged on the same day.

He lodged a claim for Rs.6,205/- on 09.12.2011 to the TPA of the insurance company. But after a lapse of six months his claim was not settled. He represented to the insurance company on 05.07.2012 requesting them to settle his claim, but did not get any reply.

The insurance company had stated that Shri Siddheswar Mukherjee was covered under mediclaim policy from the year 2011. The insured has submitted a claim for retina detachment of left eye and treatment given was avastin injection. Based on the Circular No. HO:TPA:054:09 dated 09.09.2009 issued by their Head Office, their TPA has repudiated the claim on 02.01.2012. Moreover, from the documents submitted by the insured, it is evident that though the insured had submitted a discharge certificate there was no admission at all. Therefore, the claim is purely an OPD claim and thus not admissible under the policy condition.

DECISION:

The complainant had approached this forum against repudiation of his claim under Individual Mediclaim policy. That the insured was admitted in Disha Eye Hospitals & Research Centre, on 06.12.2011 where intravitreal injection Avastin was administered in his left eye and was discharged on the same day. The claim was denied by the insurer as per their Circular No. HO: TPA:054 : 09 dated 09.09.2009 which specifically excludes the treatment of ARMD with injections. Since the circular was already in existence at the time of the renewal of the contract, the present claim fell within its purview. Considering all the above facts, Hon'ble Ombudsman was of the opinion that total repudiation of the claim was not justified and she allowed some relief by way of ex-gratia payment of Rs.3,000/- to the complainant, which will meet the ends of justice

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KOLKATA Ombudsman Centre
Case No. 341/11/G4/NL/08/2012-13
Smt. Tripti Chakraborty
-Vs-
The Oriental Insurance Co. Ltd.,

Date of Order :14th May, 2013

FACTS/SUBMISSIONS

This complaint was filed against partial repudiation of claim under Happy Family Floater Policy issued by the Oriental Insurance Company Ltd.

The complainant, had stated in her complaints dated 10.07.2012 and 13.08.2012 that she had Individual Mediclaim Policy with Sum Insured of Rs 1,25,000/- since 2002 and subsequently she migrated to Happy Family Floater Policy with enhanced sum insured of Rs.5,00,000/- from 9th July 2010. Her husband was admitted in Charnock Hospital, Kolkata on 15.12.2011 and subsequently transferred to Apollo Gleneagles Hospital, Kolkata on the same day for better management and was discharged on 31.12.2011. At Apollo Gleneagles, she was admitted with history of dizziness and severe onset of bifrontal headache and altered sensorium. As per discharge summary the final diagnosis of the disease was Cerebellar Haematoma with Cerebral Oedema and obstructive Hydrocephalous. Again he was admitted in Dafodil Nursing Home, Kolkata on 31.12.2011 and discharged on 24.02.2012. As per discharge summary the diagnosis of the disease was 'Cerebellar Ich with Brain Stem Frent'.

She lodged two claims for Rs.3,94,310 and Rs.3,50,000/- to the TPA of the insurance company. TPA settled Rs.1,15,329/- towards full and final settlement of the claim. She represented to insurance company on 11.04.2012, but the same was turned down

The insurance company had stated that although the policy was continuously renewed since 09.07.2007 but sum insured was enhanced on 09.07.2010. Considering that the disease was pre-existing in nature, the insurance company settled the claim based on pre enhanced Sum Insured of Rs.1,25,000/-.

DECISION:

The complainant has approached this forum against partial settlement of her claim on the ground of pre-existence of the disease. From the facts presented to this forum, we find that the insured, a young man of 41 years of age with no history of HTN or Cerebellar disease was admitted into Charnok Hosptial, Kolkata on 15.12.2011 following a Cerebellar Haematoma. However, he was shifted on the same date to Apollo Gleneagles Hospitals, Kolkata for better management where he stayed upto 31.12.2011. At the time of

admission in Apollo Gleneagles Hospitals, his condition was very critical and the treating doctor has noted a history of dizziness and severe onset of bifrontal headache and altered sensorium. The final diagnosis was Cerebellar Haematoma with Cerebral Oedema and Obstructive Hydrocephalous. There is nothing either in the discharge summary or in any other medical record which shows the pre-existence of the disease. The patient was later shifted to Daffodil Nursing Home (P) Ltd., Kolkata for subsequent treatment. The insurance company has settled the claim on the basis of previous sum insured of Rs.1.25 lakh since 2002 ignoring the enhanced sum insured of Rs.5 lakh under his Happy Family Floater Policy taken from 09.07.2010. The insurance company could not provide any document which can establish that the disease Cerebellar Haematoma/ stroke was pre-existing in nature i.e., the patient was suffering from the disease prior to enhancement of sum insured. We find from the prescription of Dr. Manjul Kumar Roy dated 15.12.2011 (who had advised urgent hospitalization) that his Blood Pressure was 130/70 which indicated that the patient was not hypertensive at the time of hospitalization.

After careful evaluation of all the facts and circumstances of the case we are of the opinion that the ground of pre-existence of the disease could not be established by the insurance company with any supportive documentary evidence. Under the circumstances, settlement of the claim on the basis of Rs.1.25 lakh is not justified and the decision of the insurance company is set aside. The insurance company was directed to settle the claim on the basis of the enhanced sum insured of Rs.5 lakh and pay the balance amount as per terms and conditions of the policy.

Kolkata Ombudsman Centre
Case No. 346/11/G2/NL/08/2012-13
Shri Sanjay Bhattacherjee
-Vs-
National Insurance Company Ltd.,

Date of Order :14th May, 2013

FACTS/SUBMISSIONS

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

The complainant had stated in his complaint dated 20.06.2012 that he was suffering from eye problem and was admitted in AMRI Hospital, Kolkata on 18.10.2011 where he underwent cataract operation (Left eye Phaco-folding lense) and was discharged on the same day. As per discharge summary the diagnosis of the disease was 'cataract (left eye).

At the time of hospitalization TPA of the insurance company settled Rs.22,400/- towards full expenses of the hospital. Further he lodged pre and post hospitalization claim of Rs.2,466/-. TPA vide their letter dated 03.12.2011 has settled Rs.1,566/- and deducted Rs.900/- towards full and final settlement of the claim. He represented to the insurance company on 09.04.2012 against partial settlement, but the same was turned down.

The insurance company had stated that Shri Sanjay Bhattacherjee was covered under Mediclaim policy w.e.f 28.5.2011 to 27.05.2012 with sum insured of Rs.1,50,000/-. The policy was continuously renewed with them since 1999. Shri Bhattacherjee was hospitalized on 18.10.2011 for the treatment of left eye cataract. He availed cashless facility during hospitalization expenses of Rs. 22,450/- which the insurance company paid directly to the hospital. Subsequently, he submitted a claim for Rs. 2,466/- for pre and post hospitalization expenses. TPA settled the claim for Rs.1,566/- deducting a total amount of Rs.900/-under heads (i) Rs. 150/- for consultation fees as no prescription was available and (ii) Rs.750/- for cost of OCT Charges for Right eye, as the patient was hospitalized for cataract operation of Left Eye.

DECISION:

The complainant had approached this forum against partial repudiation of his claim for cataract operation of left eye. From the facts presented to this forum, we find that the complainant was hospitalized for cataract operation of left eye for which he was sanctioned cashless payment of Rs.22,450/-. Subsequently he submitted a claim for Rs.2,466/- for pre and post hospitalization expenses out of which the TPA has settled Rs.1,566/- deducting Rs.900/- which included Rs.750/- for OCT charges of right eye as the

patient was hospitalized for the surgery of left eye. We find that OCT of both the eyes was done on 22.09.2011 prior to his surgery on 18.10.2011. As there was no adverse finding, no treatment followed and his admission was only for cataract surgery for which he has been paid in full. Therefore the deduction of Rs.750/- made for OCT charges for the right eye is correct. However, the consultation fee of Rs.150/- is payable as the prescription is available on the record.

In view of the above, the insurance company is directed to pay Rs.150/- (one hundred fifty only) towards consultation fee to the complainant.

Kolkata Ombudsman Centre
Case No. 379/11/G1/NL/09/2012-13
Shri Asit Kumar Dutta
-Vs-
The New India Assurance Company Ltd.

Date of Order :31st May, 2013

FACTS/SUBMISSIONS

This complaint is filed against partial repudiation of claim under Individual Mediclaim Policy issued by The New India Assurance Co. Ltd.

The complainant, had stated that he was admitted in Peerless Hospital & B.K.Roy Research Centre, Kolkata on 18.07.2011 where he underwent surgery for prostate problem on 19.07.2011 and was discharged on 26.07.2011. As per discharge summary the diagnosis of the disease was *'Prostatomegaly, Hypertension, Diabetes Mellitus'.*

At the time of hospitalization out of the total expenses of Rs.93,612/- TPA of the insurance company had sanctioned Rs.56,293/- on cashless basis. Subsequently he lodged a claim on 19.09.2011 for Rs.37,319/- to the TPA of the insurance company. TPA has settled Rs.3,075/- deducting Rs.34,244/- towards full and final settlement of the claim. He represented to the insurance company on 16.06.2012 for settlement of balance claim, but the same was turned down.

The insurance company had stated that the subject claim was lodged under individual mediclaim policy for sum insured of Rs.1,50,000/- plus cumulative bonus of Rs.75,000/-. The claim was lodged in respect of hospitalization treatment of the insured for the period from 18.7.2011 to 26.7.2011.

The total bill during hospitalization was for Rs.78,277/- out of which TPA paid Rs.51,496/- on cashless basis and out of pre and post hospitalization bill of Rs.15,335/-, TPA subsequently paid Rs.3,075. Hence, out of total claim amount of Rs.93,612/-, TPA paid a total amount of Rs.54,571/- The Insurance company has furnished the following statement justifying the deductions made: -

Services	Claimed	Admissible	Inadmissible	Reason
Hosp/N.M Charges	17600/-	12000/-	5600/-	As per clause 2.1 of the policy (1% of S.I per day)
Physician, Surgeon & Anest/Asst	31360/-	21382/-	9978/-	As per clause 2.0 (Note 1) of the policy if the insured opts for a room with rent higher than the entitled category all other

				expenses will be paid proportionately as per entitled room category.
Medicines & injs from stock	**12380/-**	**8441/-**	**3939/-**	**As per clause 2.0 (Note 1) of the policy if the insured opts for a room with rent higher than the entitled category all other expenses will be paid proportionately as per entitled room category.**
Operation Theater	**9100/-**	**6205/-**	**2895/-**	**As per clause 2.0 (Note 1) of the policy if the insured opts for a room with rent higher than the entitled category all other expenses will be paid proportionately as per entitled room category.**
Miscellaneous	**3132/-**	**260/-**	**2872/-**	**Non Medical expenses deducted as per clause 4.4.21 of the policy.**
Investigation	**4705/-**	**3208/-**	**1497/-**	**As per clause 2.0 (Note 1) of the policy if the insured opts for a room with rent higher than the entitled category all other expenses will be paid proportionately as per entitled room category**
Total bill during Hospitalisation period	**78277/-**	**51496/-**	**26781/-**	
Total Bill during Pre and Post Hospitalisation period	**15335/-**	**3075/-**	**12260/-**	**Rs. 11560/- (Rs. 3320/- + Rs. 8150/- + Rs. 90/-) towards investigation cost during the pre hospitalization period deducted due to non submission of supporting doctors prescriptions. Rs. 350/- (pre hospitalization period) and Rs. 350/- (post-hospitalization period) towards consultation charges deducted due to non submission of supporting doctors prescriptions.**
TOTAL	**93612/-**	**54571/-**	**39041/-**	

They had further stated vide their letter dated. 4th January, 2013 that the Insured was entitled for a room of Rs. 1500/- per day (1% of Sum Insured i.e., 1% of Rs.1,50,000/-) and he stayed in AC Single category room with rent of Rs. 2200/- per day. They have collected the tariff chart of Peerless Hospital which shows that the hospital did not have room in the entitled category. As such the claim has been settled by deducting other charges on proportionate basis. Proportionate deduction was effected for medicines and consumables also.

DECISION:

The complainant had approached this forum against partial settlement of his claim on account of various deductions made by the insurance company for inadmissible items. From the facts presented to this forum we find that the major differences in the claim amount is due to interpretation of clause no. 2.0 (Note 1) which states that the doctors fees and investigation charges will be admissible at the rate applicable to the entitled room category. The insurance company has settled the claim on proportionate basis, although specific rates are available in the hospital tariff for doctors, surgeon fees and O.T. charges. The insurance company has also admitted that based on the hospital tariff a further amount of Rs.9,109/- is payable to the complainant under the head O.T charges, medicines and investigations. As regards the disallowances of miscellaneous non medical items, we find that the deduction has been made correctly by the insurer as per policy condition. The complainant has not submitted treating doctor's prescription in respect of pre and post hospitalization bills for Rs.12,260/-. This amount is also admissible subject to submission of the doctor's prescription by the complainant.

In view of the above, the insurance company was directed by the Hon'ble Ombudsman to pay Rs.9,109/- along with pre and post hospital expenses subject to submission of doctor's prescription by the complainant.

LUCKNOW

OFFICE OF INSURANCE OMBUDSMAN
UTTARPRADESH & UTTARAKHAND
6th Floor, Jeevan Bhawan Phase-2,
Nawal Kishore Road, Hazaratganj,
LUCKNOW

Award No.IOB/LKO/04/207/03/13-14

In the matter of

Sri Umesh Chandra Shukla(Complainant)
vs

United India Insurance Company Ltd. (Respondent)

Complaint No. G-035/11/03/13-14

FACT:-Sri Umesh Chandra Shukla and his wife were insured under mediclaim policy with united india insurance co.ltd.,The complainant's wife Mrs Sharda Shukla felt stiffness in neck and numbness in legs on 28.07.2012. She consulted Dr. Abhishek Shukla who prescribed certain medicines to her. The complainant submitted a claim for Rs. 8,088/-. The insurer found that there was no admission in hospital for atleast 24 hours and treatment was taken as a OPD patient. The insurer repudiated the claim.

Findings:- Policy clause requires admission for minimum period of 24 hours. In case of certain specified diseases this limit can be relaxed. Moreover the admission should be justified by proper treatment. Here in this instant case there is no admission in hospital. The T.P.A. in its recommendation to the insurer observed that treatment taken falls under 'OPD' category hence not payable.

The complainant relied on letter dated 03.12.12 written by Dr Abhishek Shukla which reads as under " She was advised for complete rest & to be admitted in the

hospital but she preferred to stay at her home due to medical & physical problem of her husband."

The complainant, in order to stress his point, enclosed prescriptions of various doctors.

Now, the question therefore arises- what type of expenses are covered under –the impugned policy. The preamble of the policy under" coverage"-reads- "Policy covers hospitalisation expenses". Expenses on hospitalisation for minimum period of 24 hours are admissible. However, this time limit is not applied to specified treatments as detailed in the policy.

Thus the policy condition itself specifies certain treatments where 24 hours admission is not mandatory. The instant case does not fall in the exclusions specified in the policy. The forum found that repudiation made by the insurer is in order. The appeal is dismissed being devoid of any merit.

OFFICE OF INSURANCE OMBUDSMAN
UTTARPRADESH & UTTARAKHAND
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LUCKNOW

Award No.IOB/LKO/04/353/01/13-14

In the matter of
Sri Shyama Charan Shukla (Complainant)

vs

The New India Assurance Company Ltd. (Respondent)

Complaint No. G-58/11/01/13-14

FACT:-:

The complainant Sri Syama Charan Shukla was covered under LIC group mediclaim policy for period 01.04.2011 to 31.03.2012. He alongwith his wife met with accident on

29.11.2011. They were admitted at City Hospital Allahabad, for treatment . His wife was discharged on 01.12.2011. The insured complainant submitted two claims in connection with himself and his wife. His own injury claims stands settled by the insurer. The second one related to his wife has not been settled so far. The New India Assurance Company Ltd. did not settle his mediclaim on the ground that original bills/ cashmemos had not been submitted by the insured .

FINDINGS:-The insured alleged that the insurer had misplaced original papers at their end and advised him to submit photocopies of bills/ cashmemos duly attested by an officer of his corporation. He has already submitted same but the insured is not settling his genuine claim. The insurer on the other hand submitted that original bills/ cashmemos are required for settlement of the claim.

DECISION:-The insurer have not raised any doubt towards genuineness of the claim. It is not established whether original documents have been lost by the insured or have been misplaced at insurer's end. Anyhow benefit of doubt must go to the insured complainant. The forum awarded to pay Rs. 6020/- as claimed by the insured .

MUMBAI CENTRE

MEDICLAIM

Complaint No. GI- 1466 of 2011-2012
Award No. IO/MUM/A/ GI /2013-2014
Complainant : Mr. Kunal S. Kamath
Respondent : The New India Assurance Co. Ltd.

The complainant was covered under Mediclaim Policy 2007 bearing No.11180034110100001669 issued by the New India Assurance Co. Ltd. for the period 21.6.2011 to 20.6.2012 for Sum Insured of Rs.3,00,000/- with 20% CB. Complainant approached this Forum with a complaint against the Insurance Company that when he lodged a claim for Rs.51,059/- under the Policy towards his hospitalisation in Bombay Hospital And Medical Research Centre from 17.8.2011 and 19.8.2011 for the complaints of retrosternal pain, vomiting, M/s TTK Healthcare TPA Pvt.Ltd., TPA of the Insurance Co. repudiated the same stating that treatment related to Psychiatric disorder is not payable as per exclusion clause 4.4.6 of the Policy. When complainant represented to the Insurance Company, they upheld TPA's decision. They also took a stand that the admission in the hospital was purely for diagnostic purpose with no positive existence of fresh ailment.

Insurance Company submitted that insured is on their books since 1999 and has lodged a first claim for his hospitalisation in Bombay Hospital in the month of July 2011 for the complaints of Gastro Esophageal Reflux Disease with newly detected DM, which has been settled by them for Rs.25,262/-. He further mentioned that insured thereafter was under the treatment of Dr. H.G. Desai, who advised him to undergo Coronary CT. Thereafter insured consulted Dr. Wagle on 16.8.2011 for retrosternal discomfort and next day was admitted to Bombay Hospital under his care. The claim for the said hospitalisation has been repudiated by them on the ground that during hospitalisation the patient was treated with only oral medications and a few investigations were carried out which could have been done on OPD basis. He further mentioned that insured was diagnosed a case of Anxiety Disorder and hence the claim was also rejected on the ground that the psychiatric & psychosomatic treatments are not payable under the Policy. Dr. Shruti mentioned that at the time of admission in the hospital and during the entire period of hospitalisation the vitals of the patient were normal, his BP & sugar was well under control. She also pointed out to the Nurse's Daily Record, wherein it is mentioned that "New case got admitted at 5.20 pm. Patient came walking alone". She said that this fact itself indicates that there was no emergency as such for getting admitted to the hospital and the patient was already suffering from a problem of retrosternal pain and the medical papers strongly suggest that he was admitted in the hospital purely for the investigations purpose. When Dr. Shruti was specifically asked as to whether patient was admitted in the hospital for psychiatric treatment and whether he was treated for the same in the hospital, she replied in negative.

During this hospitalisation, the complainant underwent various investigations viz. blood test, CT Angio, CT scan chest, Echo/Stress Test and was treated with oral medications. ECG, HRCT chest, CT Coronary Angiography, 3D Echo revealed normal study. Finally, he was diagnosed to have Diabetes with Anxiety disorder and was discharged on 19.8.2011.

The claim reported under the Policy has been rejected by the TPA/Company on two grounds : 1) Psychiatric ailment is not covered under the Policy, 2) There was no emergency that would have warranted admission in the hospital. The patient was treated with oral medication throughout the admission and only investigations were done and no aggressive management was done. In support of their decision, Company obtained medical opinion from M/s Adroit Consultancy Medicolegal Services. Complainant however has contended that due to uncontrolled diabetes, his doctor advised him to get admitted to the hospital. The treating doctor of the complainant however has stated that complainant was admitted under his care with retrosternal pain with vomiting. He has diabetes and hence coronary artery disease could not be ruled out. However since all the investigations were turned out to be normal he was diagnosed to have anxiety disorder and they did not suspect this at the time of admission considering uncontrolled diabetes.

A scrutiny of the above position would reveal that prior to admission in the hospital, complainant was treated for Gastro Esophageal Reflux Disease. The UGI scopy was normal. However, even after treating for GERD, Shri. Kamath had persistent complaints of Retrosternal discomfort, for which he consulted the doctor. Prior to admission in the hospital, he was suffering from retrosternal pain & generalized weakness since three days and vomiting since two days. Cardiac and esophageal causes may share similar symptoms as these two structures have the same nerve supply. However, in the instant case the complainant was already treated for GERD. Retrosternal pain may also be a symptom of ischemic heart disease. Considering this possibility, it would be illogical to ask the patient or his relatives not to get the patient admitted to the hospital. It should also be noted that the complainant initially tried his best to take the treatment from the Casualty Department of the Hospital and also from his Treating doctor. Further, complainant was only 28 years old and was also suffering from uncontrolled Diabetes. It is a known fact that at this age, with uncontrolled diabetes, it is quite vulnerable for a person to get a first heart attack which is always massive and almost irrecoverable if not treated immediately. Although, it is a fact that during hospitalisation the complainant underwent battery of investigations and was treated only with oral medications, but the fact should not be overlooked that he had presenting complaints of retrosternal pain, generalised weakness and vomitting. Nobody would take a chance of keeping such patients at house and go on treating him without proper evaluation of the health status. It is well understood that if any expenses are incurred for the tests done in the hospital by way of mere check up, it will not be payable under the policy. However, thiss is not a case of mere check up. In that context hospitalisation was justified. Further, the most appropriate investigations would be essential ones and unless those are done the diagnosis is not fool-proof and hence in order to arrive at final diagnosis it is necessary to make some investigations to rule out the possibilities of the cardiac ailments. Although the Company contended that there was no emergency as such for admission in the hospital, but the facts remains that the complainant had uncontrolled diabetes and was on medication for the same and also had presenting symptoms and got

himself admitted in the hospital on the advices of the doctor for diagnosis and treatment of the same.

It should be further borne in mind that to analyze a medical case based only on the papers especially after the incidence has happened would put it in a different light than in a live situation where a patient is being treated for seemingly alarming symptoms. The priorities in both the situations would be abundantly different because when one studies the papers, it is passive approach and all the results are there before you to assess the situation whereas when you actually treat a patient, you have no clue as to what is causing him problems and hence your approach would be very cautious. Hence, rejection of the claim on the ground that hospitalisation was not warranted is not tenable.

As regards the contention of the Company that the hospitalisation was related to psychiatric treatment, it should be noted that the complainant was primarily hospitalized for physiological complaints and was investigated mainly to rule out the possibility of Coronary artery disease and since all the investigations were turned out to be normal, he was diagnosed to have anxiety disorder. Further, during hearing, the TPA doctor admitted that patient was admitted to the hospital not for psychiatric treatment and was not treated for the same.The New India Assurance Co. Ltd. was directed to settle the claim of complainant in respect of his hospitalisation at Bombay Hospital And Medical Research Centre from 17.8.2011 and 19.8.2011 for the complaints of retrosternal pain, vomiting for the admissible expenses.

Complaint No. GI-2593 of 2011-2012

Award No. IO/MUM/A/ /2013-14

Complainant: Shri J.S.Kadam
V/s
Respondent: Iffco Tokio Gen.Insurance Co. Ltd.,

Complainant, was covered along with his wife under the group mediclaim insurance of the within mentioned Company issued to the employees of Bombay Dyeing & Mfg. co.Ltd vide policy bearing number 52177369. The policy was valid for the period 1.12.2010 to 30.11.2011. Claim arose under the policy when, wife of the complainant allegedly got admitted to Kaustubh Nursing Home from 11.9.2011 to 15.9.2011 for treatment by way of surgery for fistula in ano.

The claim when preferred on the Company was denied by them contending that there was misrepresentation and anomalies under the claim. Aggrieved by the same, the complainant approached this forum for redressal.

During the hearing the forum directed the Company to liaison with the complainant and make an appointment of the doctor concerned and seek appropriate clarification. The complainant is also directed to co-operate with the Company in meeting and seeking clarifications. The parties are given a time of 10 days to do as directed and the Company should revisit the claim in the light of information so obtained under information to the forum.

The company reverted with the meeting details and from the same it was found that the doctor concerned was not available at the appointed hour but however, the wife of the doctor who was available stated that no surgeries were done in Kaustubh Nursing Home and the medical shop was also closed since last two years. She also stated that all the treatment was carried out on day care basis. The representatives of the Company also confirmed in writing that at the time of their visit, no inpatients were found admitted. They also confirmed that the recording with the wife of the doctor was available with them. The doctor who later was available stated that the surgery was done in the same hospital. To a question by the representative of the Company as to why the details of the anesthesia given or the anesthetist was not found in the medical papers, he seems to have replied that such records were not being maintained by them.

Though the copy of the bill and the IP papers were given, the Company states that the OT register was not available with them.

The observations of the forum are as follows:

- **Mediclaim claims are processed only on the basis of the submitted papers and its imperative that such papers should be beyond any doubt.**
- **Not mentioning of the name of the anesthetist on the discharge card or the indoor case papers amounts to serious lapse on the part of the hospital. Even assuming that it was missed, at least after pointing out the same, the hospital should have proper back up papers from which they can elicit the information at a later date. In the instant case, there are no such set of papers being maintained by the hospital. Although the insured has seldom a role to play in such matters, there is no way the claim can be settled unless his papers are clear.**
- **Any registered hospital will have to follow certain procedures for documentation to help both themselves and the patient failing which reimbursement from an insurer will not be possible since the claim is dealt after the incident is over only on the basis of the submitted papers. The submitted papers should be above board.**
- **Further the recording of the wife of the concerned doctor is also confirmed to be in the possession of the Company and though this forum is not empowered to treat it as an evidence, the fact that the facts given by her were contrary to the ones given by the doctor cannot be simply set aside. This would involve cross examination.**

Such being the case, I would like to reiterate that the proceedings at this forum are essentially summary in nature under RPG Rules 1998 and disputes like these in which third party is also involved requires calling for them and their witnesses and cross examining them under oath. Such proceedings are outside the purview of this Forum.

In view of the above facts and circumstances, the complaint is closed at this Forum with an advice to the complainant to approach any other suitable forum for redressal of his grievance.

Complaint No. GI-1487 of 2011-2012

Complainant: Smt.Kala M Nair
V/s
Respondent: Cholamandalam MS Gen.Insurance Co. Ltd.,
Award 08/2013 ----------

Complainant, was covered along with her family members under the individual health insurance of the within mentioned Company vide policy 2828/00022496/000/01, valid for the period 5.10.2009 to 4.10.2010. She was covered for a sum insured of Rs.3 lacs. From the submitted papers, it is observed that she was covered with the Company from the year 2008 onwards. Claim arose under the policy, when the complainant got admitted to PKC hospital and Medical Research Centre on 3.3.2010 with complaints of acute calculous cholecystitis. She underwent laproscopic cholecystectomy and was discharged on 16.3.2010. When a claim of Rs.105258 was lodged on the Company, the same was denied by them under the pre-existing illness clause stating that the medical papers submitted by the complainant recorded history of similar episodes two years ago and as per the same, the illness was prior to their policy inception and was hence not tenable.

Aggrieved by the same, the complainant approached this forum for redressal. During the hearing, the Ombudsman asked the representatives of the Company whether they had any documents which shows that the complainant underwent treatment for the said complaints or if she was diagnosed for the same and had withheld this information from the Company to which the representatives stated that they did not have such papers on record as the complainant had not provided any but three different doctors had recorded the history and hence such history recorded in the hospital papers cannot be set aside.

The Ombudsman gave the complainant 15 days time to get the treatment papers which she took 1½ - 2 years before and submit the same to the Company. He directed the Company to revisit their decision in the light of such papers received, if any and report back.

Let us first examine the medical papers available on record. The discharge card records the diagnosis of acute calculus cholecystitis. Her presenting symptoms as per submitted documents is " pain in right hypochondriac region since yesterday…vomiting one episode since yesterday…" There are notings in a couple of places which states that the complainant was suffering from similar episodes 1½ - 2 years back. Based on the same, the Company has denied the claim stating that it was pre-existing prior to the inception of their policy. It must be noted here that experiencing similar episodes will not constitute to suffering from the same diagnosed illness in the past. The symptoms of pain in abdomen and vomiting are such generic symptoms that they can be attributed to many illnesses and not necessarily cholecystitis. Moreover, if they were so serious enough, then it would have warranted immediate medical intervention then and it would not be possible for the complainant to prolong it for two years to claim benefit under the policy.

Unless there was a diagnosed illness in the past prior to the inception of the policy and which was voluntarily withheld by the insured, the Company cannot plead denial under pre-existing illness simply based on the notings in the medical papers that she suffered from similar symptoms in the past. It should also be appreciated that it generally so happens in the hospitals that the initial notings at the time of admission is generally noted down by other doctors examining the patient subsequently and does not amount to the history being recorded individually by each one of them from the patient.

Further, the policy of the Company has incepted on 3.10.2008 and the complainant has sought medical treatment on 3.3.2010. Even if we reckon that she was indeed suffering from the said disease since last 1½ years, it would almost fall within the policy period.

The Company has not proved the pre-existence of the disease with cogent proof and hence I am inclined to give the benefit to the complainant. The insurer was directed to pay to the complainant the admissible expenses under her claim for her admission to PKC hospital from 3.3.2010 to 16.3.2010 for cholecystectomy.

Complaint No. GI-1240 of 2011-2012

Complainant: Shri Kishor M Mahajan
V/s
Respondent: Apollo Munich Health Insurance Co. Ltd.,

<u>Award dated 09/2013</u>

Complainant, was covered under the floater group mediclaim policy issued by the within mentioned Company to M/s.Legrand (India) Pvt.Ltd., vide policy bearing number 160100/12001/2010/A001267. The policy was valid for the period8.7.2010 to 7.7.2011.

Claim arose under the policy, when the complainant got admitted to Khachane Hospital from 25.2.2011 to 5.3.2011 for complaint of viral diarrhea. It is observed from the submitted documents that the complainant was administered Allopathic treatment The claim of Rs.8869 preferred by him on the Company was denied by them stating that the doctor who treated the complainant did not fit the definition of the medical practitioners as per their policy wording.

The complainant represented with the gazette notification issued by the Govt of Maharashtra but the Company however upheld their stand of rejection and aggrieved by the same, the complainant approached this forum for redressal. The hearing took place at the appointed hour and place between the parties to the dispute.

The scrutiny of the submitted documents reveals that the complainant was admitted to Khachne hospital for treatment of viral diarrhea from 25.2.2011 to 5.3.2011 under the care of treating doctor, Dr.P.S.Khachne, who was a BAMS qualified doctor. The claim preferred by the complainant was denied by the Company for non-conformance of

the definition of the treating doctor of the complainant with that of the medical practitioners as per their policy definition. The complainant countered this by producing the following Gazette notification issued by the Govt. of Maharashtra bearing reference number CIM 1091/CR-179/91 (Part V_ Act, which stated as follows: – " In exercise of the Powers conferred by the proviso to section 33, read with clause (fa) of section 2 o the Maharashtra Medical Practitioner Act, 1961, the Government of Maharashtra hereby directs that the Ayurvedic Practitioners enrolled on the state Register of Practitioners of Indian Medicine, shall be eligible to practice the modern system of medicine which is known an allopathic system of medicine. By order and in the name of Government of Maharashtra."

The contention of the Company was that the treating doctor of the complainant did not fit into the definition of a medical practitioner as per their policy wording. The said definition is reproduced here for better understanding. " Medical practitioner means a person who holds a qualification in medicine from a recognized institution and is registered by the state council governed by the Medical council of India in which he operates and is practicing within the scope of such licenses and will include but is not limited to physicians, specialists and surgeons who satisfy the aforementioned criteria." The Company emphasized that the medical practitioners as per their definition would be one registered with Medical Council of India and not by Central Council of Indian Medicine. In the instant case, as the treating doctor was not a one registered with State Council, governed by Medical Council of India but one registered with the Central council of Indian Medicine and empowered to practice Allopathy by a special gazette notification, the stand of the Company cannot be faulted. Therefore in the facts and circumstances of the case, I am constrained to agree with the decision of the Company.

Complaint No.GI-330/2012-13
Complainant : Shri Damodar Agarwala
Respondent : National Insurance Co. Ltd.

Shri Damodar Agarwala was covered under Individual Mediclaim Policy No. 260300/48/10/8500003847 for the period 31.12.2010 to 30.12.2011 for Sum Insured of Rs.3,00,000/- with 50% C.B., issued by National Insurance Co. Ltd. Shri Agarwala approached this Forum with a complaint against the Insurance Company in respect of short-settlement of claims lodged for Cataract surgeries undergone by him at Bombay Hospital on 17.09.2011 & 05.04.2012.

Records were perused and a joint personal hearing of the parties to the dispute was held. Shri Damodar Agarwala appeared and deposed before the Ombudsman. He submitted that he is insured with National Insurance Co. Ltd. since the year 2001 for S.I. of Rs.3 lacs without any claim in all these years except the present two claims lodged for Cataract surgeries undergone by him. Before going in for the surgery, he enquired and found that Bombay Hospital was listed in the Company's preferred network, hence he opted for the said hospital. On admission to the hospital, he was informed by the TPA representative present there that in case he wishes to avail of Cashless facility under his policy, they would pay only Rs.24,000/- being the Agreed Package rate for Cataract. However, since he insisted for a particular type of lens, he was told by the hospital authorities that he would be shifted to a higher package which would cost him around Rs.46,000/- and the difference in the amount would have to be borne by him. He protested against this saying that he does not wish to be shifted to a higher package but was willing to bear the difference in the cost of the lens of his choice and that allowed under the Company's Agreed Package rate. Despite this, the hospital insisted on a written undertaking from him agreeing to bear the differential cost of the higher package, which he did but only after recording his protest as "subject to any objection he would raise against the Company for the same" after which they proceeded with the surgery. On discharge, the hospital billed him Rs.46,445/- and collected the balance amount of Rs.22,445/- from him while the TPA made cashless payment of Rs.24,000/- to the hospital. Thereafter he lodged a claim with the Company for reimbursement of the balance amount which was rejected by them stating "As per hospital tariff (PPN) settled in cashless claim". He stated that the ground given by the Company for disallowing the balance amount was not acceptable to him, particularly since his policy did not stipulate any restriction on expenses incurred for cataract surgery.

National Insurance Co. Ltd. was represented by Shri P.A. Shetty, Dy. Manager alongwith Dr. Nilesh of TPA. Shri Shetty submitted that the TPA had settled the claim as per PPN rate list agreed with Bombay Hospital for cataract surgery undergone by the patient. He stated that in the instant case the hospital had charged the extra amount to the patient as he had voluntarily opted for a higher category of package for which he had given an undertaking to the hospital agreeing to bear the excess amount charged by the hospital on his own account and not to claim it from the Insurance Company. In view of the same,

he expressed Company/TPA's inability to pay the balance amount to the insured. He further stated that even for the cataract surgery undergone by the insured in the second eye, he had opted for higher package against which claim also, they had paid only Rs.24,000/-.

On hearing the depositions of both the parties, the Company representative was directed to submit their clarification to the Forum within 7 days on the following points:

1. **What was the cost and type of the lens suggested by the Company within the Package rate of Rs.24,000/- agreed for cataract surgery?**
2. **What was the type of lens used in the case of Shri Damodar Agarwala?**
3. **Whether the policy issued to the complainant specifically prohibits the use of the particular type of lens used by the complainant in the instant case.**

However, the Company did not submit the clarification as called for by the Forum.

From the available papers coupled with the depositions of both the parties, it is observed as under:

- **The claims of the complainant were settled by the TPA on cashless basis as per PPN rate list of the Hospital for the surgeries undergone him.**
- **As per MOU entered into by the TPA with the hospital, it was agreed that the Provider will not collect any extra charges over and above the agreed package charges and in case the same is observed and the insured claims the same for reimbursement, the amount will be recovered from the provider.**
- **However, in the subject case it was contended by the Company that Shri Damodar Agarwala on his own, had opted for a higher category of Package (in a single room) and had given an undertaking to the hospital wherein he had agreed to bear the difference between the PPN Package and the higher package rate charged by the hospital on his own account and not to claim it from the Insurance Company. In view of the same Company/TPA expressed their inability to reimburse the balance amount to the insured and to recover the same from the hospital.**
- **Shri Agarwala however contested the Company's stand saying that he had only requested the hospital to provide him a lens suitable to his requirement and not for any higher package or single room. He also pointed out that he had given the undertaking as insisted by the hospital only after recording his "protest" against the same as he had no other option at the time.**

On an analysis of the facts of the case, the following points emerge:

- **Though the policy provides that in case of treatment taken in any of the PPN Hospitals, the Company would pay as per the agreed PPN rates, despite a specific query the Company has failed to justify the basis of fixing the amount of Rs.24,000/- for cataract surgery in case of PPN hospitals.**
- **There is no specific capping in the policy for cataract surgery.**

- **Also, there is no express restriction in the policy on the type of lens to be used for the said surgery which implies that the insured has the liberty to go in for a lens of his choice.**
- **The Company has not looked into the averment of the complainant that he did not opt for a higher package but only insisted for a lens of his preference. Also, he had clearly qualified the undertaking given by him to the hospital as "subject to any objection he would raise to the Insurance Company" since as rightly stated by him, he had no other option at the time.**

This being the case, restricting the settlement of claim to Rs.24,000/-, when the insured is enjoying a sufficiently higher Sum Insured, amounts to arbitrariness on the part of the Company and hence cannot be accepted. It is felt that the Insurance Companies should examine the grievances of their customers on case to case basis based on individual merits instead of applying a single yardstick to all the cases by taking shelter under the MOU entered into with the hospitals. Only then, would such facilities prove beneficial in the real sense to their customers.

Under the facts and circumstances of the case,National Insurance Co. Ltd. is directed to settle the balance claim of the complainant Shri Damodar Agarwala for the admissible expenses incurred on Cataract surgeries undergone by him at Bombay Hospital on 17.09.2011 & 05.04.2012.

Complaint No. GI-2248/2011-2012
Award No. IO/MUM/A/GI- /2013-14
Complainant: Shri Dinesh Chandavarkar
Respondent: United India Insurance Company Ltd.

Shri Dinesh Chandavarkar was covered vide Insurance Certificate No. 70300/2010-2011/00140/01 for the period 01.11.2010 to 31.10.2011 under Can Comfort Policy issued to card-holders of Canara Bank by United India Insurance Co. Ltd. Shri Chandavarkar approached this Forum with a complaint against the Insurance Company in respect of short-settlement by Rs.3,266/- of the claim lodged for his admission to P.D. Hinduja Hospital, Mumbai from 12.09.2011 to 15.09.2011 for the treatment of Inguinal Hernia. In addition to this, he also raised certain issues about delay in receipt of policy document and identity cards, issuance of wrong photo I.D.s by TPA, misinformation about hospital tie-ups for cashless facility, excess premium charged etc.

The matter was scrutinized on the basis of the documents made available to the Forum by both the parties. It was observed that Shri Chandavarkar lodged a claim under the policy for a total amount of Rs.58,755/- against which the Company reimbursed him an amount of Rs.55,587/-, thus there was short-settlement of Rs.3,266/-; however the insured was not given the details about the items of disallowance despite his repeated requests. The Company vide their written statement dt. 09.04.2012 submitted to this Forum, has given the break-up of deductions from the claim amount as under:

Admn. Charges	**:**	**Rs. 100.00**
Drap Hirut	**:**	**Rs. 39.00**
Sut 3M Steristrip R 1547	**:**	**Rs. 68.00**
Digital Thermometer	**:**	**Rs. 200.00**
Electrods Adult pcs	**:**	**Rs. 14.00**
Mask	**:**	**Rs. 80.00**
Plastic Airways 4 pcs	**:**	**Rs. 61.00**
Anne French Remover	**:**	**Rs. 84.00**
Q-syte Pcs Ref. 385100	**:**	**Rs. 190.00**
Undersheet (Under pad)	**:**	**Rs. 120.00**
Lab Medicine	**:**	**Rs.2310.00**
Total	**:**	**Rs.3266.00**

The Company has stated that on verification it was found that the expenses claimed under the head "Lab Medicine" actually pertained to expenses incurred for laboratory tests done and hence could be considered for settlement. Further, they have also submitted their clarification on the other issues raised by the complainant.

On analysis of the case, disallowance of the above-mentioned expenses other than Laboratory test charges from the total claim amount, was found to be in order. The Company has expressed their willingness to settle the Lab test charges amounting to Rs.2,310/-. As regards the issues regarding delay in receipt of policy document and Identity cards, issuance of wrong photo I.D.s by TPA, misinformation about hospital tie-ups for cashless facility, excess premium charged etc., these being administrative in nature fall outside the purview of this Forum and hence the Forum would not go into the details of the same. However, a copy of the Company's written statement wherein they have clarified these points raised by the complainant, is being appended with this Award for the sake of the complainant's information. In case he requires any further details in this regard, he may approach the Insurance Company's office and take up the matter directly with them.

Complaint No. GI-2243/2011-2012
Complainant : Dr. Smita P. Vora
Respondent: The New India Assurance Co. Ltd.

Dr. Smita Prakash Vora was covered under Individual Mediclaim Policy No.111900/34/10/11/00009948 for the period 28.01.2011 to 27.01.2012 for S.I. of Rs.5 lacs plus 5% C.B., issued by The New India Assurance Co. Ltd. Dr. Vora approached this Forum with a complaint against repudiation by the Insurance Company of the claim lodged for Rs.25,752/- for left eye cataract surgery undergone by her on 08.08.2011 at The Vission Eye Centre, Mumbai.

Records were perused and a joint hearing of the parties to the dispute was held before the Forum on 13.02.2014 at 11.15 a.m. Dr. Smita Vora presented herself and deposed before the Ombudsman. She submitted that she is insured with New India since October, 2002 continuously. In the year 2009, she paid the premium for renewal of her policy for the period 14.10.2009 to 13.10.2010; however the cheque towards the premium got dishonoured and this fact was intimated to her by the Company after a period of two months. When she approached the Company for renewal, Company insisted on pre-insurance medical check-up, which was promptly done by her. Thereafter, Company issued them policy for the period 28.1.2010 to 27.1.2011 and the said policy was further renewed for a period of one year. She underwent left eye cataract surgery on 8.8.2011 and lodged a claim for the same on the policy issued for the period 28.1.2011 to 27.1.2012. The said claim has been repudiated by the Company on the ground that it was falling on the second year of the Policy. She stated that the decision of the Insurance Company is not acceptable to her since she is insured with New India since 2002. She said that the break in the policy in the year 2009 was an unfortunate episode and it was not intentional and further there was a lapse on the part of the Company also; as she was informed about the cheque dishonor only after two months. She requested for settlement of claim.

Insurance Company was represented by Shri. Ashok Shirsat, AO and he was assisted by Dr. Nilesh of TPA. Dr. Nilesh submitted that insured's policy for the period 14.10.2009 to 13.10.2010 was cancelled due to dishonor of cheque. Thereafter, they issued her a fresh policy for the period 28.1.2010 to 27.1.2011 as there was a break of 106 days as her earlier policy was expired on 13.10.2009. The claim for left eye cataract surgery was reported on the policy issued for the period 28.1.2011 to 27.1.2012. As per policy clause 4.3.5, the expense incurred on the treatment of cataract and age related eye ailments are not payable under the policy two years. Since the claim was reported on the second year of the policy, the same has been repudiated by them based on the policy condition. He defended their stand.

During hearing, Insurance Company was advised to submit their explanation on the following points within a period of 7 working days:

1) **What are the guidelines for giving continuity benefits in cheque dishonoured cases?**
2) **In the instant case, when the complainant was informed about her dishonour of cheque. To submit documentary evidence.**
3) **Company to submit their view points on the admissibility of the claim in the light of the queries raised above.**

The Company vide their letter dt. 20.02.2014 clarified as under:

1. **The claimant paid the premium for renewal of the policy for the period 14.10.2009 to 13.10.2010, however the cheque was dishonored and as soon as they received intimation from the Bank, they intimated the same to the claimant on 30.11.2009 through Regd. A.D.**
2. **The policy is valid subject to realization of the cheque only. Section 64VB not complied under the said policy.**
3. **Insured approached the Insurance Company after gap of 106 days and fresh policy was issued from 28.01.2010 to 27.01.2011 without continuity benefit as agreed by the insured with all terms and conditions of fresh proposal.**
4. **The insured lodged a claim for left eye cataract surgery on 08.08.2011 which fell in the second year of policy and was not payable for first two years. Hence the claim was rejected by the TPA as per clause 4.3 of the policy.**

On scrutiny of the papers submitted before the Forum coupled with the deposition of both the parties, it is revealed that although the insured remitted the premium cheque for renewal before the expiry of her previous policy on 13.10.2009, the cheque was returned uncleared by the bank for the reason "Funds Insufficient". The Insurance Company intimated the fact of cheque dishonor and consequent cancellation of the policy since inception, to the insured on 30.11.2009. Effectively, if the cheque would have been honoured the insurance cover would have been continued. In other words at the material time i.e. the period within which renewal was to be arranged, there was non-clearance of the cheque and consequently non-payment of insurance premium which made the earlier contract non-renewable.

Section 64 VB of the Insurance Act which governs the premium payment regulations, makes it mandatory that premium should be paid in advance to enable the Insurer to carry the risk. The said Section is a statutory provision and no authority lies with anybody to amend, modify, alter or tamper with this provision. It should always be the duty of the Insured to ensure that premium is paid and received by the Insurance Company before the expiry of the policy and if it is intended to be paid by a cheque, then to ensure sufficiency of funds and clearance before the renewal. Failure on his part to do so would amount to dishonouring the financial commitment given to the party in whose favour the cheque is issued besides making him liable for an offence under the Negotiable Instruments Act.

The complainant has argued that the Company did not intimate her immediately about the dishonor of cheque, otherwise she could have reinstated the policy well within time of

grace period allowed by the insurer. In this connection, the Company has stated that as soon as the intimation was received from the Bank, the claimant was informed about the same on 30.11.2009. Smt. Vora confirmed that the letter was received by her on 04.12.2009. It is noted that thereafter she approached the Company only in the month of January 2010 and after completion of formalities viz. pre-insurance medical check-up and payment of premium, a fresh policy was issued w.e.f. 28.01.2010. Thus, it is seen that even after receipt of intimation about dishonor of cheque and consequent cancellation of policy, she did not approach the Company immediately for renewal. The allowance of grace period for granting continuity benefit from the previous policy, which the Companies exercise under exceptional circumstances to accommodate deserving cases is a discretionary provision and cannot be insisted in each and every case as a matter or right. Again, this is a policy provision and it is not envisaged to modify it to extend beyond the stipulated period to cover other cases falling beyond the time limit.

Notwithstanding the above facts it should be noted that at the material time when the cheque was dishonoured by the Bank due to insufficient funds, the cover automatically ceased and alongwith it the associated benefits as a continuation of the previous policy.

Exclusion Clause 4.3 of the policy clearly stipulates a Waiting period for diseases/ailments/ conditions specified thereunder as per the duration shown against each of these and further states that this exclusion will be deleted after the duration shown, provided the policy has been continuously renewed with the Company without any break. The subject claim was lodged during the second year of the policy renewed after a break.

Having regard to the facts as stated above, repudiation of the claim by the Company not being adversarial to the policy terms and conditions, I do not find any valid ground to intervene with the decision of the Insurance Company in the matter and hence no relief can be granted to the complainant.

Complaint No. GI-2299/2011-2012
Complainant: Shri Jitendra Shinde
Respondent: Reliance General Insurance Co. Ltd.

The complainant was covered under Reliance Healthwise Policy No.1105712825001550 for the period 23.08.2011 to 22.08.2012 for Sum Insured of Rs.2,00,000/-, issued by Reliance General Insurance Co. Ltd. He approached this Forum with a complaint against the Insurance Company in respect of rejection of the claim lodged for Rs.8,000/- towards expenses incurred on his admission to Suvarna Hospital, Mira Road (E), from 16.12.2011 to 17.12.2011 for the treatment of Acute Gastritis.

Records were perused and a joint hearing of the parties to the dispute was scheduled. However, he did not appear for the hearing despite Notice of hearing dt. 23.012.2013 having sent to him, for which a POD dt. 26.12.2013 has been received by this office. On contacting him over telephone, he denied having received any such Notice and expressed his inability to attend the hearing. The deposition of the representative of the Insurance Company was taken.

The company representative stated that the complainant was referred to Suvarna Hospital by Dr. Prabhunerurkar, an Ayurvedic doctor. The patient had complaints of retrosternal burning sensation, nausea since 15 days and loose motions 15 days back. Basic investigations such as pathological tests and USG abdomen were carried out prior to admission on 15.12.2011. Patient was admitted on 16.12.2011 and further evaluated by Gastroscopy and few other blood tests. He was discharged on 17.11.2011. During the course of hospitalization, all his vitals were normal and he was administered Inj. Monocef and Emeset. Thus, going by the claim papers it was felt that hospitalization was primarily for evaluation and treatment rendered during hospitalization did not necessitate inpatient admission. Hence the claim was repudiated.

Scrutiny of the case papers submitted on record did not indicate any compelling reasons for indoor admission. Under the circumstances, the Forum in its considered opinion found it necessary to obtain the views of the complainant's family physician who referred him to the hospital, as to the need for hospitalization and his presenting symptoms at the time. However, since the complainant did not present himself for the personal hearing, a copy of the Minutes of the hearing was forwarded to him with advices to submit necessary clarifications from his physician, to the Forum within 7 days from receipt thereof to enable it to arrive at an appropriate decision.

However, there was no response from the complainant thereafter. Since the complainant has failed to substantiate his claim with proper documentary evidence despite the

opportunity given to him, this Forum does not find any valid reason to intervene with the decision of the Company to deny the claim, based on the available documents.

Complaint No. GI-350/2012-2013
Complainant: Mr. Joseph Pereira
Respondent: The New India Assurance Co. Ltd.

The complainant was covered under Individual Mediclaim Policy 2007 No.111700/34/11/01/00015109 for the period 22.03.2012 to 21.03.2013 for S.I. of Rs.1,00,000/- plus 30% C.B., issued by The New India Assurance Co. Ltd. The complainant approached this Forum with a complaint against the Insurance Company on account of repudiation of the claim lodged for Rs.1,13,278/- in respect of his hospitalization at Bhartiya Arogya Nidhi Sheth Kantilal C. Parikh General Hospital, Vile Parle, Mumbai from 09.02.2012 to 14.02.2012 for the treatment of ADPKD - ESRD.

Records were perused and a joint hearing of the parties to the dispute was held . The complainant submitted that he was insured with The Oriental Insurance Co. Ltd. from the year 2000 to 2005 after which he shifted the policy without any break to The New India Assurance Co. Ltd. The claim lodged for his hospitalization from 09.02.2012 to 14.02.2012 for the treatment of End stage renal disease was rejected by the Company stating that as per ICP he was suffering from the said disease and also from hypertension since 1998 which was pre-existing to the policy inception with the Company and he had not paid loading of premium for the same. He stated that the history was mentioned erroneously in the hospital papers which were signed by his wife without knowing its repercussions since she was not in a proper state of mind at the time due to his illness. He then forwarded a revised certificate from his treating doctor clarifying that he was suffering from ESRD since 6 months and CKD since 3.5 years. As regards HTN since the year 1998, he argued that at the time of proposing for insurance he was 58 years of age but was not subjected to any medical check-up which implies that the Company had accepted to cover him with his pre-existing condition. However, the Company refused to settle the claim. He further pointed out that he was a sea-farer employed as a steward on the ship and has been going on sea voyages continuously till the year 2008 after which he signed off which itself goes to show that he was not suffering from any such ailments as they are subjected to strict health check-ups without which they are not permitted to sail. He requested for settlement of the claim.

The company representative submitted that as per discharge summary, the complainant was suffering from Hypertension since the year 1998, which fact was not disclosed to the Company while taking the policy. As per policy terms and conditions, in case of pre-

existing HTN or DM, the insured has to pay an extra loading on the premium. Since the complainant had not paid the extra loading for HTN and the present claim was for an ailment which is a complication of HTN, the same was rejected by the TPA.

On hearing the depositions of both the parties, the Forum made the following observations:

- **The complainant is insured with the Company since the year 2005 and prior to that with Oriental Insurance Co. Ltd. since the year 2000 without any single claim except the present one lodged in all these years.**
- **Even considering the recording of h/o HTN and other diseases since 10-12 years, the same may not necessarily date back prior to inception of the policy in the year 2000.**
- **From the fact that he was a sea-farer and in active service till the year 2008 which required him to undergo stringent medical check-ups, it was quite unlikely that he could be suffering from these ailments for such a long period.**
- **The Company has chosen to rely only on the history of 10-12 years mentioned in the hospital papers but has not made any attempt to get clarification on the certificate issued by the same treating doctor, correcting the history thereafter, especially in view of his service background given by the insured.**

Under the circumstances, the complainant was directed to submit copies of his service record alongwith his Health Reports for the past years to the Insurance Company with copies to this Forum within 10 days. The Company was directed to re-visit the case in the light of the documents submitted by the insured and inform their final decision to the Forum within 15 days.

Post-hearing, the complainant forwarded copies of the relevant documents to the Insurance Company. The Company vide e-mail dt 03.01.2014 informed the Forum that the claim was reconsidered and settled for Rs.49,191/- deducting Rs.64,087/- from the total claim amount as per details mentioned therein. On perusal of the payment particulars, it was observed that the settlement amount was arrived at by restricting the room rent to 1% of SI and all other expenses were scaled down in proportion to the entitled room category and disallowing certain non-medical expenses. In this connection, it may be noted that while disallowance of room rent in excess of the insured's eligibility being as per policy terms and conditions was in order, there was no justification for reducing other charges in proportion to the entitled room category in the absence of any such specific mention in the policy condition, unless the hospital has a room based rating structure. The deduction of non-medical expenses and investigation charges for which reports were not submitted, are held to be in order. Under the circumstances, the complainant was directed to release to the complainant a further amount of Rs.52,558/- deducted on proportionate basis from all other charges (in addition to the settlement amount of Rs.49,191/- arrived by them) in case the hospital does not have a class-based rating structure, within 10 days from receipt of this Order and inform payment particulars to this Forum immediately. If, however, it is confirmed that the hospital has class-based rating

system, the claim to be settled as per the rates corresponding to the complainant's entitled category and in case there is no room category in the hospital as per his entitlement, the rates applicable to the immediate next higher room category to be considered. There is no order for any other relief. The case is disposed of accordingly.

Complaint No. GI-580/2011-2012
Complainant: Shri Kamlesh Kumar Jain
Respondent: National Insurance Co. Ltd.

The complainant along with his mother was covered under the Tailor-made Group Mediclaim Insurance Policy No. 154400/10/8500000412 for the period 30.07.2010 to 29.07.2011 for floater Sum Insured of Rs. 2 lacs, issued by National Insurance Co. Ltd. to cover members of M/s. Karvy Stock Broking Ltd. Shri Kamlesh Kumar approached this Forum with a complaint against the Insurance Company due to non-settlement of the claim lodged under the policy in respect of hospitalization of Smt. Bhawaridevi Jain for cataract surgery undergone by her on 16.02.2011.

Records were perused and a joint hearing was scheduled to be held. However, no representative from the Company appeared for the hearing despite Notice of hearing served on them. The complainant submitted that the claim lodged for the hospitalization of his mother for cataract surgery undergone by her on 16.02.2011 was not settled by the TPA and they kept on asking him to produce Karvy Customer id proof with supportive document prior to inception of the policy for settlement of the claim. He stated that he was not a member of nor had any connection with Karvy and that he had paid the premium to the Insurance Company through an agent and the Company/TPA had issued him a receipt and ID cards without verifying his membership with Karvy at that time. He also mentioned that the Company had settled one claim lodged in respect of hospitalization of his mother earlier under the same policy without raising any such requirement.

Since the Company absented themselves from the hearing despite serving of Notice, a copy of the Minutes of the hearing was sent to them with directions to forward their comments to the Forum on the following points within 7 days:

1. **The complainant stated that he is not a member of or in any way connected with Karvy Stock Broking Ltd. If the Group Policy was designed to cover only the existing customers of KARVY STOCK BROKING LTD. (KSBL) how was Shri Jain (a non-member) along with his dependant covered under the said policy.**
2. **Having received the premium and issued him the policy, how the Company can insist on production of membership ID proof after the occurrence of claim which they ought to have done at the time of accepting the proposal.**

The Insurance Company vide their e-mail dt. 10.09.2013 addressed to the Forum, submitted their reply as follows:

- **The member was covered under the Group Mediclaim Policy of Karvy Stock Broking Ltd. with policy start date 30.07.2010. It was a first year policy. Age of the member was 62 years with sum insured Rs.2 lacs. The member got admitted in Keniya Eye Hospital on 16.02.2011 for the surgery of Cataract in Right eye which was documented in Discharge Summary. She was discharged from the hospital on the same day.**
- **As per MOU with Karvy Stock Broking Ltd. only the existing customers of Karvy are entitled to get coverage under this policy, so the TPA, FHPL raised query whether the member had any documentary evidence to prove that he was a Karvy customer prior to inception of the policy vide their letter dt. 28.03.2011 & 20.04.2011. But they did not receive any response complying their requirement. Therefore, they had no option but to close the file as "No claim" and informed the claimant accordingly.**

On an analysis of the case the Forum observed as under:

- **The Insurance Company has stated that the policy was issued on the basis of proposal forwarded by KSBL on good faith. This in itself is violation of the provisions of the MOU with KSBL which lays down that only the existing customers of KSBL would be brought under the ambit of the Group Mediclaim policy. Having laid down such a condition, the Company should have taken adequate care by verification of necessary documents to ensure that the proposers included in the list forwarded by KSBL, were in fact members of KSBL.**
- **Also, the MOU was entered between KSBL and National Insurance Co. Ltd. It is not clear as to how a person proposing for insurance would be aware about the existence of any such MOU and of its provisions.**
- **The premium cheque was collected in the name of National Insurance Co. Ltd. and receipt for the same was also issued by 'National". I have to admit that the public at large take such policies in good faith based on the implicit trust they have in the brand name of the Company and by and large they tend to fall a prey to the clever manipulation played by the organizer of the group or the intermediary.**
- **ID cards were issued to the individual insured persons by the Company's TPA M/s Family Health Plan TPA Pvt. Ltd.**
- **The Insurance Company has not taken adequate care to verify that the proposers were in fact, existing members of KSBL at the time of issuing the policy resulting into covering non-members also. Apparently, the persons covered under this group do not have relation with the said agency in the capacity of either depositors or employees or members. The principle of homogeneity of group required for a Group Mediclaim Policy as laid down by the Regulator, has thus been given a go. This amounts to gross violation of the basic principles of underwriting.**
- **It is generally observed that in such type of Group policies, which contemplate to cover even pre-existing diseases, only the primary member belongs to the younger age group alongwith whom one or more family members falling under higher age-group are covered who cannot get an**

insurance cover in their individual capacity, which in itself results in adverse selection against the Company. But the Companies have been knowingly accepting such kind of business and after suffering from adverse claims ratio, they try to alleviate their losses by resorting to such kind of practices.

In view of the above, it is felt that having accepted and enjoyed the premium without verifying the membership of KSBL, depriving the insured persons of the benefits of insurance by raising the issue of membership after the claim has arisen is against the principle of natural justice. Besides, the complainant has also stated that his previous claim under the policy was settled by the Company without insisting for membership proof. Under the circumstances, the Company cannot absolve itself of its contractual liability to the Insured beneficiary and the forum is constrained to state that the complainant is entitled to get relief from the Insurance Company.

Complaint No. GI-1949/2012-2013
Complainant: Shri V.M. Waichal
Respondent: The New India Assurance Company Ltd.

The complainant was covered under Individual Mediclaim Policy No.142100/34/11/01/00203194 for the period 24.08.2011 to 23.08.2012 for Sum Insured Rs.5,00,000/- plus 25% C.B., issued by the insurer . Shri Waichal approached this Forum with a complaint against the Insurance Company in respect of short-settlement of claim lodged for his admission to K.D. Ambani Hospital, Mumbai from 05.04.2012 to 09.04.2012 for the treatment of Acute gastritis.

Records were perused and parties to the dispute were called for a personal hearing. Mrs. Vrushali Waichal that Shri Vijay Waichal expired on 13.06.2013 and hence she would be representing the case on his behalf. She stated that Shri Waichal was admitted to K.D. Ambani hospital from 05.04.2012 to 09.04.2012 for the treatment of Acute Gastritis. He lodged a claim for a total amount of Rs.71,691/- for the said hospitalization under the policy held with the insurer. However, the Company's TPA settled the claim only for Rs.30,311/- stating that the expenses incurred for PET Scan undergone by him during the hospitalization could not be paid as the said test was not relevant to the ailment for which he was admitted. Smt. Waichal argued that Shri Waichal suffered drastic weight loss within a year and hence the said test was conducted on the advices of the treating doctor to ascertain the exact cause for the same, to decide on the further line of treatment and hence the same could not be termed as irrelevant. She requested for settlement of the balance claim amount.

The company representatives stated that the claim of the insured was settled after deducting the charges for PET scan test undergone by him since the patient was admitted for the treatment of Acute Gastritis to which the said test was not related. He pointed out

that the patient had complaints of breathlessness since two years for which the PET scan was conducted on him, which was possible on OPD basis and did not warrant hospitalization. Hence these charges stood inadmissible as per Clause 4.4.11 of the policy which excludes payment of expenses for Diagnosis, X-ray or Laboratory examination not consistent with or incidental to the diagnosis of positive existence and treatment of any ailment, sickness or injury, for which confinement is required at a hospital/Nursing home.

On analysis of the facts of the case coupled with the depositions of both the parties, it is observed that Shri Waichal was mainly admitted to the hospital for complaints of Acute Gastritis and was treated for the same. The Company has paid most of the expenses for the same. As for the PET Scan conducted on him, it was for ascertaining the cause of his suffering from breathlessness and rapid loss of weight within a year. From the papers, it is seen that these complaints were however persisting since the previous one/two years and were not the proximate cause for his subject hospitalization and for which he could have been investigated even on OPD basis without the need for hospitalization. Thus it can be said that the hospitalization was utilized for an additional test which could have been conducted even otherwise as an outpatient. As the exclusion clause 4.4.11 of the policy is specific to that effect, the decision of the Company to disallow the expenses incurred on PET Scan test is found to be in order and the forum do not find any valid ground to intervene with the decision of the Company in this regard. At the same time, it is also observed that besides PET Scan charges, the Company has deducted an amount totalling to Rs.5,830/- from other investigation charges on the ground of reasonability which cannot be upheld without any supporting evidence.

Complaint No. GI-2493/2011-2012
Complainant: Shri Rajendra Khairnar
Respondent: Reliance General Insurance Co. Ltd.

The complainant Shri Rajendra Khairnar was covered under Reliance HealthWise Policy No.1704702825000176 for the period 16.04.2010 to 15.04.2011 for S.I. of Rs.1,00,000/- (on floater basis), issued by Reliance General Insurance Co. Ltd. Shri Khairnar approached this Forum with a complaint against the Insurance Company in respect of repudiation of the claim lodged for his hospitalization at Uma Nursing Home, Nasik from 31.03.2011 to 04.04.2011 for the treatment of Acute Gastroenteritis.

Records were perused and a joint hearing of the parties to the dispute was held on 23.09.2013 at 3.00 p.m. at Camp, Nasik. Shri Rajendra B. Khairnar appeared and deposed

before the Ombudsman. He submitted that he is insured with Reliance General Insurance Co. Ltd. continuously since the last 3-4 years. He had complaints of vomiting which became serious and with the help of neighbours he got admitted to Uma Nursing Home, Nasik from 30.03.2011. He was discharged after 4-5 days. He gave intimation to the Insurance Company by fax on 03.04.2011 and forwarded the claim papers to the TPA immediately after discharge. However he received a letter dt. 16.05.2011 from the TPA rejecting his claim. He repeatedly represented to the Insurance Company against the rejection; however failed to receive any response from them. On 22.07.2011 the Company even cancelled the policy without his consent. He pleaded for settlement of the claim.

Reliance General Insurance Co. Ltd. was represented by Dr. Dhiraj Mhatre, Manager (Claims) & Shri Amit Sharma, Legal Manager. Dr. Mhatre submitted that they had received suspicious/irregular claims from Uma Nursing Home, Nasik in the past. After receiving the claim documents in the instant case, certain irregularities were observed and hence the claim was investigated when it was noted as under:

1. **Patient was admitted for Gastroeneteritis with altered kidney functions but surprisingly, no input/output chart was maintained.**
2. **The patient was suffering from fever, but no Temperature chart was maintained by the hospital.**
3. **The ICPs did not mention the patient's name, date of admission, name of the Doctor incharge. Also, all the ICPs were written by only one person at one go.**
4. **The date of discharge was 04.04.2011 whereas the ICPs did not contain any notes written by the doctor on the said date. As per ICPs, the patient was started on Inj. Falcigo on 03.04.2011.**

5. **Further, the drugs written on Discharge card to be taken after discharge did not mention Inj. Falcigo nor was there any prescription paper dt. 04.04.2011for the said injection.**

6. **As per ICPs, the patient was started on Inj.Falcigo one day before discharge suddenly for treating Malarial fever and these injections were continued even after discharge and it was taken by the insured from his family doctor as alleged by him. However, the drugs written on Discharge card to be taken after discharge did not mention Inj. Falcigo nor was there any prescription paper dt. 04.04.2011for the said injection. There was a prescription written by the Nurse prescribing injection Falcigo but there was no date on the prescription. To a question by the Insurance Company to the complainant as to rote of injection given to him he replied that he took it on his buttocks and when he was not comfortable it was given by the Nurse to his arms. The company countered this saying that these injections are never given on the buttock and arms but it is given intravenous as per medical practice.**

He stated that based on the above, the claim was denied under condition 2 of the Policy.

During the hearing the complainant mentioned that he was admitted for complaint of vomiting. However, the Discharge Card states he had complaints of Fever,vomiting & loose motion. But Indoor case paper does not mention his complaint of fever.

After hearing the parties to the dispute it was observed that based on the discrepancies pointed out by the Company as above, there was no valid ground for this Forum to intervene with the decision of the company. However, if the complainant was able to provide documentary evidence to contradict the above discrepancies pointed

by the Company then he should submit the same to the Insurance Company to enable them to examine the matter afresh. The complainant was given 7 working days for submission the same to the Insurance Company under advice to the Forum.

The complainant did not furnish any further documents either to the Insurance Company or to this Forum within the time granted to him. Under the circumstances, I pass the following Order:

If this Award is not acceptable to the complainant, he is at liberty to approach any other Forum for redressal of his grievance, as deemed fit.

ORDER

The complaint of Shri Rajendra B. Khairnar against repudiation of the claim by Reliance General Insurance Co. Ltd. for his hospitalization at Uma Nursing Home, Nasik from 31.03.2011 to 04.04.2011 for the treatment of Acute Gastroenteritis does not sustain. The case is disposed of accordingly.

Complaint No. GI-2486/2011-2012
Complainant: Shri Sanjay D. Kothari
Respondent: The New India Assurance Co. Ltd.

The complainant along with his family members was covered under Individual Mediclaim Policy-2007 No.111800/34/11/01/00006948 for the period 20.07.2011 to 19.07.2012 for S.I. of Rs.5,00,000/- plus 30% C.B. each, issued by the insurer. He lodged a claim under the policy for Rs.51,370/- in respect of expenses incurred on his admission to Saifee Hospital from 13.10.2011 to 15.10.2011 for the treatment of L4-L5 Disc Bulge Mild. The claim was repudiated by M/s. TTK Healthcare TPA Pvt. Ltd. under Exclusion clause 4.4.11 of the policy stating that hospitalization was primarily for investigation purpose and the treatment given did not necessitate hospitalization. Aggrieved, he approached this Forum for intervention in the matter requesting directions to the Company for settlement of his claim
Records were perused and parties to the dispute were called for a personal hearing.

On an analysis of the case, it is seen that at the time of admission to hospital, Shri Kothari suffered from sudden onset of lower back pain, weakness in both lower limbs, radiating pain and difficulty in walking. Investigations undergone by him evidenced disc bulge and degenerative changes. He was examined by an orthopedic surgeon who advised him to get hospitalized and during the course of hospitalization he was treated with physiotherapy and oral medicines. The Insurance Company's contention is well taken that this line of treatment was possible as an out-patient without indoor confinement. However, the applicability of the exclusion clause cited by the Company has to be seen with reference to analysis which has been made in totality and not in isolation. The fact cannot be denied that Shri Kothari had presenting complaints of pain radiating to lower limbs and inability to move/walk for which he was advised admission to the hospital by the doctor. Under such circumstances, a patient would generally not choose to take a risk by going against the doctor's advice as the need for hospitalization is decided by the doctor. Considering the fact that further investigations and treatment were consistent with presence of positive ailment and the diagnosis plus on advice by the doctor for admission, invoking clause 4.4.11 of the mediclaim policy is not justified. Mediclaim policy enjoins liability upon the Insurance Company to pay expenses for hospitalization done on the advice of a duly qualified medical practitioner and therefore the argument of the Company that admission was only for diagnostic purpose not followed by active line of treatment, does not sustain.

As regards the complainant's claim for compensation for mental harassment etc., it should be noted that as per terms and conditions of the policy and as per RPG rules, the claim/compensation can be awarded only for the loss suffered by the insured as a direct consequence of the insured peril; hence compensation on the ground of harassment and costs is out of the purview of this Forum and therefore, cannot be awarded. The insurer was directed to settle the claim of Shri Ssanjay D. Kothari for the admissible expenses incurred on his admission to Saifee Hospital, Mumbai from 13.10.2011 to 15.10.2011 for the treatment of L4-L5 Disc Bulge Mild.

Complaint No. GI-1728/2011-2012
Complainant: Smt. Shailaja Salian
Respondent: National Insurance Co. Ltd.

The Complainant alongwith her family members was covered under Baroda Health Policy No. 260300/48/11/8500000269 for the period 07.04.2011 to 06.04.2012 for Sum Insured of Rs.5,00,000/- on floater basis, issued by National Insurance Co. Ltd. On 07.07.2011 her husband Shri Girish Salian was admitted to K.D. Ambani Hospital with complaints of fever with altered sensorium with GI bleed. During the course of his treatment in the hospital, he unfortunately expired on 14.07.2011. The claim lodged under the policy for reimbursement of hospitalization expenses of Rs.3,07,413/-/- was denied by M/s. Heritage Health TPA Pvt Ltd. invoking Exclusion no. 4.1 of the policy stating that the

patient was treated for cirrhosis of liver which cannot happen in 2-3 months and was pre-existing to the inception of the policy. Aggrieved, she approached this Forum for intervention seeking relief in the matter.

Records were perused and parties to the dispute were called for a personal hearing. Shri Niranjan Bangera duly authorized by the Complainant Smt. Shailaja Salian appeared and deposed before the Ombudsman. He submitted that his brother-in-law Shri Girish Salian was insured with National Insurance Co. Ltd. since April 2010 for floater SI of Rs.5 lacs. In July 2011, he suffered from fever for 10 days and started passing blood through stools for which he was admitted to K.D. Ambani Hospital on 07.04.2011 where he was diagnosed of liver disease. While undergoing treatment at the hospital he unfortunately expired on 14.07.2011. The claim lodged under the policy for Rs.3,07,413/- was repudiated by the TPA stating that Liver Cirrhosis cannot happen in 2-3 months and was pre-existing in this case. He pointed out that the repudiation letter also mentioned the date of policy inception as 07.04.2010 which itself indicated that the policy had run for 15 months before the claim was reported. He also mentioned that Shri Salian never suffered from any liver disease and there was no hospitalization or any claim in the past and hence denial of the claim as for pre-existing disease was not acceptable to them.

The company representative submitted that the hospital papers mentioned that Shri Girish Salian was a k/c/o Liver Cirrhosis with portal hypotension and had fatty liver disease. As per available medical literature, liver cirrhosis is a chronic disease which takes several years to develop and has long-lasting complications. Since the claim had occurred in the second year policy, it could be said that the disease was pre-existing to the inception of the policy. Shri Shetty submitted that the policy taken by Shri Salian was a Baroda Health Policy issued to account-holders of Bank of Baroda which did not require pre-insurance medical check-up and the policy covered pre-existing diseases after 36 months of continuous coverage since inception of the policy with their Company, irrespective of the fact whether the insured had knowledge of the pre-existence or not. Hence the claim could not be admitted under the policy.

The Ombudsman asked the Company representative the following questions:

1. **Why did they accept a policy of a person aged 54 years for Rs.5 lacs without medical examination and what do they mean by excluding pre-existing disease whether it is known or unknown to the insured at the time of taking the policy.**
2. **Whether they had any documentary evidence to show that the insured had knowledge of his disease and had intentionally suppressed the said fact at the time of taking the policy.**
3. **Though the hospital papers mentioned that he was a k/c/o Liver Cirrhosis, it did not mention since when was he suffering from the said disease. Whether the Company had tried to find out the exact duration of the ailment from the hospital authorities before concluding that it was pre-existing to the policy inception and denying the claim on that basis.**
4. **If the insured was already suffering from Liver Cirrhosis, how could it be that he was never required to be treated earlier for the same and not a single claim was reported during the 15 months for which the policy had run.**

5. **Why did the TPA in their Rejection letter mention that "Liver Cirrhosis cannot happen within 2-3 months" when the policy was in force for more than 15 months.**

The Company representative replied stating that they had no documentary evidence to prove the duration for which Shri Salian was suffering from the said disease and the TPA had not approached the hospital for a clarification on the same. The Complainant as well as the Company was advised to obtain the necessary clarification from the hospital authorities and inform the Forum within 7 days.

Smt. Salian under cover of her letter dt. 16.09.2013 forwarded a certificate issued by the treating doctor of Ambani Hospital, Dr. Geeta Billa stating that after admission to the hospital on 07.07.2011, Shri Salian was investigated and diagnosed with Cirrhosis based on which hospital notes on 12.07.2011 mention him as a "k/c/o Cirrhosis". She has further stated that previous h/o or records of this diagnosis were not present.

The Insurance Company vide their letter dt. 20.09.2013 submitted the following clarifications to the queries raised by the Forum:

1. **This policy was issued under Baroda Health Policy meant for account holders of Bank of Baroda and their family (optional) wherein the health check up provision was waived. Under the said policy all diseases existing on the date of inception of policy are excluded till completion of 36 months of continuous coverage with their Company.**
2. **They did not have documentary evidence to show that the insured had knowledge of his disease and had intentionally suppressed the said fact at the time of taking policy. It is practically not possible since, it is purely within the Insured's personal knowledge and Insurance Company cannot investigate thousands of hospitals all over India, searching for his previous treatment and the Insured will not disclose it if it affects his claim adversely.**
3. **They have enclosed a letter from the TPA explaining in detail the various stages of the said disease and the period required to reach the state in which the insured person was, at the time of admission to the hospital on 07.07.2011 along with supporting literature downloaded from medical websites.**
4. **Knowing fully well that the said disease is not covered for first 36 months, the insured might not have claimed from Insurance Company, though treated earlier in any of the hospitals of their choice. This cannot be proved by Insurance Company, since the insured can go and take treatment in any hospital in India and/or abroad.**
5. **The TPA's statement in the repudiation letter that "Liver Cirrhosis cannot happen within 2-3 months" was only a clerical error through oversight since the policy taken from their office was actually 3 months prior to the date of admission while the previous year policy was issued by a different office.**

On examination of the papers submitted on record, it is observed that Shri Girish Salian, aged 53 years was admitted to the hospital on 07.07.2011 with h/o fever with chills since 10 days and altered sensorium with melena since 2 days. He was admitted to ICU and emergency Endoscopy was done which showed varices which were banded. He was put

through various investigations which revealed increased lactate along with severe acidosis, low hemoglobin and increased bilirubin. Patient's blood culture showed evidence of E-coli. He was treated with IV antibiotics, injections and other supportive treatment. He remained in a state of encephalopathy, had to be intubated, but developed anuria, hypotension, became acidotic and succumbed to death on 14.07.2011. Cause of death was mentioned as Septicemia with hepatic encephalopathy & Cirrhosis of liver.

Insurance Company rejected the claim as for pre-existing ailment based on notings of "K/c/o Cirrhosis" in the hospital papers. The Complainant however has contested the Company's decision stating that Shri Salian never suffered from any liver disease in the past and also produced a certificate from the treating doctor stating that cirrhosis was diagnosed only after admission.

In view of the rival contentions of the parties, the forum went through the information available about the ailment as available from various internet sites and observed that Cirrhosis is a disease in which the liver becomes severely scarred, usually as a result of many years of continuous injury. Also varices and hepatic encephalopathy are complications of advanced stage of cirrhosis. The policy has been in force only for a period of 15 months. In view of the same and also based on the notings in the I.C.P.s that the patient was a "k/c/o Cirrhosis", the argument of the Insurance Company that it was pre-existing to the inception of the policy cannot to totally ruled out. However, as the exact duration of the ailment is not conclusively established, looking at the nature of ailment suffered by Shri Salian and also in view of the fact that he is no more, taking a considerate view of the situation, the forum is inclined to allow 50% of the admissible claim on ex-gratia basis.

Complaint No. GI-1569/2011-2012
Complainant: Smt. Sumedha V. Ranbhare
Respondent: The New India Assurance Co. Ltd.

The complainant was covered under Individual Mediclaim policy No.130600/34/10/11/00009097 for the period 06.10.2010 to 05.10.2011 for differential S.I. of Rs.1 lac with 15% C.B. and Rs.2 lacs with nil C.B., issued by The New India Assurance Company Ltd. Smt. Ranbhare was admitted to Lilavati Hospital from 26.04.2011 to 30.04.2011 and underwent Lap. Hysterocopy with Endometriotic Ovarian Cystectomy. The claim lodged under the policy for the said hospitalization for a total amount of Rs.1,66,985/- was repudiated by M/s. Vipul Medcorp TPA Pvt. Ltd. under clause no.4.4.6 of the policy stating that the patient had undergone treatment related to infertility. Aggrieved, she approached this Forum requesting intervention in the matter of settlement of the claim.

Records were perused and a joint hearing of the parties to the dispute was scheduled to be held. However no official from the Insurance Company appeared for deposition despite Notice of hearing sent to them .The Complainant stated that around December 2010 she started experiencing frequent pain in the abdomen. On the advice of their family doctor, she underwent USG of abdomen/pelvis whereupon it was learnt that she had cysts in both her ovaries. She then opted for Ayurvedic treatment which did not help and she again went in for USG in April 2011 which revealed that the cysts were increasing in size. She then consulted Dr. Ranjana Dhanu, Gyanaecologist at Lilavati Hospital and on her recommendations, underwent surgery for removal of cysts. She stated that initially on intimating the TPA about her hospitalization, they were informed that the claim would be payable. However, when the final claim was lodged for reimbursement, the TPA denied the claim stating that the treatment was related to infertility and hence not covered under the policy. .

The Complainant was advised to submit copies of the following documents to this Forum:

1. **First and subsequent consultation papers/reference notes of family/consulting doctors.**
2. **Indoor case papers of Lilavati Hospital for the period of admission.**
3. **Any other papers/reports relevant to the treatment.**

The complainant submitted copies of the required documents .On processing the claim, the TPA replied to the insured as follows: "In view of Pt. 31 years female nulligravida came for Laproscopy. On detailed examination found that follicular study was performed. Pt. was diagnosed Lt. mild terminal Hydrosalphinx with Rt. ovaian cyst. Hysteroscopy with Lap ovarian cystectomy done. In our view patient's case is infertility-related. Hence should be rejected under clause 4.4.6. However, if you want to reply otherwise we are open for your view from the treating doctor". Smt. Ranbhare then forwarded to the TPA, a certificate dt. 28.09.2011 issued by Dr. Ranjana Dhanu stating that Smt. Ranbhare was admitted for abdominal pain due to endometriotic cyst and was operated for the cyst which was not related to infertility. The TPA/Insurance Company however maintained their stand of rejection of the claim.

In the instant case, the USG Reports of Smt. Ranbhare though were suggestive of endometriotic cyst, there was no evidence of any ovarian or adnexal mass lesion , could be said to have resulted into infertility although of course, it could be the other way round that failure to conceive could also have caused endometriosis which however, has also not been established in the instant case. It is observed that the TPA/Insurance Company denied the claim stating that the treatment undergone by the patient was related to infertility. However, in their letter dt. 01.10.2011 addressed to the insured, they had sought the view of the treating doctor on the said issue against which the insured did, in fact, submit a certificate from Dr. Dhanu stating that Smt. Ranbhare was admitted for management of pelvic pain due to endometriosis and not for fertility evaluation. However, the Company decided to maintain their stand of rejection. It is noted that while reviewing the claim, the Company did not refer the matter to an independent specialist in

the field to verify the appropriateness of the statement given by the treating doctor and thus their decision to repudiate the claim was not supported by an expert medical opinion.

It is possible that endometriotic cyst could generally be the cause of infertility. But, from the documents produced before the Forum, it is seen that the complainant consulted Dr. Geeta Vaidya and Dr. Ranjana Dhanu for complaints of pelvic pain and it is nowhere mentioned that the consultation/treatment was for the purpose of infertility. During the course of investigations for pelvic pain, she was diagnosed to have endometriotic cysts for which she was operated. Whether it was the cause of infertility or not, the point of essence for our consideration here is: would it be wise to keep the cyst and keep living with it till it results into a fatal disease or to get it removed by surgical intervention. Removal of the cyst of 7.6X4.3 cm size which was increasing over a period of time, was necessary to avoid any future complications in the body, though as a secondary benefit after the obstacle was removed this might result into enhancing the chances of conceiving.

The Insurance Company has neither substantiated their decision with a medical opinion nor has taken any efforts to defend their stand by causing appearance before the Forum for the personal hearing or thereafter when a copy of the Minutes of hearing was sent to them. Under the circumstances, going by the evidence produced on record, the forum is not in a position to uphold the stand taken by the Company

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Complaint No. GI-2166/2011-2012
Complainant: Smt. Nisha Pandye
Respondent: The Oriental Insurance Co. Ltd.

Complainant was covered under the Group Mediclaim Policy No.124500/48/2011/4250, issued by the insurer to cover employees of M/s. J.B. Chemicals & Pharmaceuticals Ltd. Smt. Pandye approached this Forum with a complaint against the Insurance Company in respect of short-settlement of the claim lodged for her hospitalization at Suchak Hospital, Malad (E), Mumbai from 28.05.2011 to 04.06.2011 for the treatment of Lumbar Disc Prolapse.

Records were perused and a joint hearing of the parties to the dispute was held. Smt. Nisha Pandye appeared and deposed before the Ombudsman. She submitted that on 28.05.2011 she was admitted to Suchak Hospital for complaints of severe back pain. During the course of hospitalization, she was put on traction and on the treating doctor's advice, had to undergo MRI wherein she was detected of L3-L4, L4-L5 disc prolapse and treated for the same. Thereafter she was made to undergo USG when it was learnt that

she was 5-weeks pregnant. Since she was already exposed to MRI, the doctor advised her to terminate the pregnancy considering the possibilities of an abnormal child and hence she had to go in for MTP. The claim lodged under the policy for the said hospitalization for a total amount of Rs.41,527/- was settled by the TPA only for Rs.26,854/-, disallowing expenses incurred on MTP citing Clause 3.20© of the policy and certain other expenses without mentioning the reasons for the same.

The company representative submitted that as per the TPA's settlement voucher, Smt. Pandye had submitted a claim for a total amount of Rs.34,054/- against which they had reimbursed an amount of Rs.26,854/- towards expenses incurred on the treatment of Lumbar Prolapse disc while the charges for MTP were disallowed as per Clause 4.12 which excludes expenses incurred in connection with or in respect of any treatment arising from or traceable to pregnancy, childbirth, miscarriage, caesarean section, abortion or complications of any of these. She further stated that the employer of the complainant, who was the master policy-holder had not opted for the Maternity Expenses and New Born Child cover Benefit Extension available under clause 3.20 of the policy on payment of additional premium.

After hearing the depositions on behalf of both the parties and on perusal of the documents submitted, it was observed as under:

- **Though the Company representative cited clause 4.12 of the policy for disallowance of part- claim, the Company's letter states Clause 3.20 © as the basis of deduction which, in fact, was not applicable to the present case. The Company representative was not in a position to explain the reason for mis-quoting the policy clause.**
- **The complainant had to undergo MTP due to the negligence of the treating doctor. Since it was out of a medical emergency, it could well be termed as an "accident" and not done out of her own volition. Hence, the Company's decision to disallow expenses for MTP under the pretext that voluntary medical termination of pregnancy is excluded under the policy, is not found to be appropriate and hence not sustainable.**
- **While the complainant stated that her total claim was for Rs.41,527/-, the Company's TPA had acknowledged the claim only for Rs.34,054/-. The Company representative did not have the supporting papers to justify the TPA's stand.**
- **A scrutiny of the claim papers by the Company's official, as submitted by the complainant during the course of hearing, revealed that the expenses for tests conducted outside the hospital on the basis of prescriptions by the hospital were not considered by the TPA while processing the claim.**

In view of the above, the Insurance Company was advised to consider the expenses incurred on MTP undergone by Smt. Pandye on ex-gratia basis treating it as a medical emergency arising out of the doctor's negligence in carrying out an MRI on a patient who was 5-weeks pregnant. The Company was further directed to make payment of all the balance amount of admissible expenses for tests conducted outside the hospital provided the same were supported by proper prescriptions. The payment to be made within 10 days under intimation to the Forum, with details of payment. The complainant was

advised to provide the Company with a set of bills pertaining to the balance unpaid amount.
